EMERGENCY MEDICINE RESIDENCY

PROGRAM MANUAL

2018 – 2019
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The following material is a program-specific supplement to the Graduate Medical Education (GME) manual. Referral to, and familiarity with, each manual is expected by your Program Director and the Graduate Medical Education Committee.

Program Mission & Education Statement

Mission:

The Emergency Medicine Residency is operated by AdventHealth East Orlando, a not-for-profit health care institution, to further its mission “To extend the healing ministry of Christ.” We do so by preparing compassionate and competent emergency medicine physicians.

In its striving for excellence, the residency program is committed to serving the community, the sponsoring institution, the faculty, staff, and resident physicians.

Education:

Emergency medicine is a specialty which focuses upon the initial evaluation, diagnosis, and stabilization of patients with acute illnesses or injuries. In addition, the emergency medicine physician initiates treatment, involves consultants, makes disposition decisions, and makes appropriate follow-up arrangements for patients discharged from the Emergency Department.

The purpose of the Emergency Medicine Residency is to provide a progressive, organized educational program with guidance and supervision which facilitates the resident’s personal and professional development while ensuring appropriate and safe patient care. Residents in our program join a department that emphasizes lifelong learning, creativity, and professionalism. Our aim is to provide this training through a continuity of didactic and clinical experience. Our goal is to produce a physician capable of a high level of performance who is certified by the American Board of Emergency Medicine.

The goal of our residency is to produce physicians trained to:

- Integrate basic medical sciences with clinical medicine in an orderly, progressive, and academic manner.
- Provide the recognition, resuscitation, stabilization, evaluation, and care of the acutely ill or injured patient.
- Arrange appropriate follow-up or referral as required.
- Participate in the management of the emergency medical system providing pre-hospital care.
- Provide appropriate patient education directed toward the prevention of illness and injury.
- Utilize the services of consultants and ancillary departments, as appropriate, in the treatment of patients.
- Engage in the administration and teaching of emergency medicine, including mentoring of medical students, and be familiar with research methodologies and their application.
- Participate in department and committee meetings and didactic sessions.
• Carry out their responsibilities in a professional manner at all times and comply with the American College of Emergency Physicians (ACEP) Code of Ethics which can be found at: https://www.acep.org/Clinical---Practice-Management/Code-of-Ethics-for-Emergency-Physicians/
• Be respective of all patients, patient’s family members, staff and all hospital staff.

We commit to:

• Provide residents the opportunity to learn the fundamentals of basic science as applied to emergency medicine.
• Require residents to participate in research and provide teaching and mentoring of medical students.
• Provide residents with the opportunity to learn continuity of care for the patients they have treated in the emergency setting by following their progress through their hospital stay through electronic medical records and consultation with their care team.
• Provide residents and faculty with educational goals and objectives at the beginning of each rotation and the opportunity to evaluate each other at the end of the rotation.
• Provide each resident with a summative evaluation of performance on a semi-annual basis to show progression of expertise.
• Provide each resident with supervisory lines of responsibility, fair grievance policies, and resources for mental/emotional support.
• Provide a sufficient number of cases, as determined by RRC standards of achievement, to advance skills and judgment.
• Provide 5 hours of planned educational experiences per week in a rotating 18 month cycle based on the Model Curriculum of Emergency Medicine... Attendance is mandatory.
• Provide a working environment that is optimal for resident education and patient care. This environment will be safe and will provide adequate space for sleep, food, and lounge/study facilities.

Program Personnel

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**AdventHealth East Orlando East Orlando Main Telephone Numbers:**

Critical EM: 407-832-8665  
Non Critical EM: 407-832-6794  
Radiology Dictation Line: 407-303-7944  
Needle Stick Hotline: 1-866-258-6259  
Transfer Center Number: 1-800-824-0085  
Sexual and Assault Hotline: 407-497-6701

**AdventHealth East Orlando South Main Telephone Numbers**

ED: 407-303-1940  
Orthopedic Trauma: 407-303-7689  
Anesthesia: 407-303-1529

**Accreditation Council of Graduate Medical Education (ACGME):**

The ACGME is the accrediting body for the Emergency Medicine residency program. They may be contacted with questions via their website at: [www.acgme.org](http://www.acgme.org) or by mail and phone at: 515 North State Street, Suite 2000, Chicago, IL 60610-4322, Phone (312) 755-5000, and fax (312) 755-7498.

**Recruitment, Eligibility & Selection:**

**Recruitment:**

Goal: To recruit and train physicians committed to excellence in Emergency Medicine who:

A. Will promote, practice, and respect the mission of AdventHealth East Orlando.  
B. Will be compassionate providers of whole person care.  
C. Will likely wish to practice in the State of Florida following their training.

Means:

I. Provide organized recruitment teams who will focus on in-state medical schools and affiliates (Florida State University, University of Florida, University of Miami, University of South Florida, University of Central Florida, Florida International University, Lake Erie College of Medicine, Nova Southeastern University, and Loma Linda University).

II. Recruit through ERAS and participate in NRMP selection process.

III. Provide pertinent summary of the program through AdventHealth East Orlando’s Graduate Medical Education website.
IV. Offer Clinical Clerkships to medical students from accredited Medical and Osteopathic schools

**Eligibility:**

I. Medical School

A. LCME (Liaison Committee of Medical Education) graduates:

   a) Doctor of Medicine diploma without reservations
   b) Dean’s Letter
   c) Letter from residency program director (if applicable)
   d) Successfully passed USMLE I and USMLE II (United States Medical Licensing Examination) at first attempt with a score of 200(80)
      i. Transcript directly from the FSMB (Federation of State Medical Boards)
   e) Acceptable explanation of any break in education (if applicable)
   f) Demonstrated written and spoken fluency in English language
   g) Proof of citizenship or resident alien status as required by AdventHealth East Orlando Human Resources

B. AOA graduates:

   a) Doctor of Osteopathy diploma without reservations
   b) Dean’s Letter
   c) Letter from residency program director (if applicable)
   d) Successfully passed COMLEX (Comprehensive Osteopathic Medical Licensing Examinations) I and COMLEX II at first attempt with a minimum score of 500(80)
      i. Transcript directly from the NBOME (National Board of Osteopathic Medical Examiners)
   e) Acceptable explanation of any break in education (if applicable)
   f) Demonstrated written and spoken fluency in English language
   g) Proof of citizenship or resident alien status as required by AdventHealth East Orlando Human Resources.

C. International Medical Graduates (IMG’s):

   a) Doctor of Medicine diploma (or equivalent) without reservation (translation to English by certified translator and notarized if necessary)
   b) Successfully passed USMLE at first attempt (see above, I. A. d.)
   c) Current and valid ECFMG (Education Council of Foreign Medical Graduates) certificate
   d) Letter from residency program director (if applicable)
   e) Acceptable explanation of any break in education (if applicable)
   f) Demonstrated written and spoken fluency in English language
g) Proof of citizenship or resident alien status as required by AdventHealth East Orlando Human Resources

II. ERAS Application

A. Completed application through ERAS (Electronic Residency Application Service) through the AAMC (American Association of Medical Colleges) and participation in the NRMP (National Resident Match Program) match.

- On-line application
- Personal statement
- CV
- Diploma (if IMG)
- ECFMG certificate (if IMG)
- Transcript
- Dean’s Letter
- Three letters of recommendation by emergency medicine physicians
- USMLE Scores, Part I and II
- Photograph

III. Reasons for Ineligibility:

A. Applicant does not demonstrate sufficient commitment to the specialty of Emergency Medicine:
   i. No advanced-level electives during medical school
   ii. No letters of support from surgeons
B. Applicant did not present favorable impression to faculty and/or resident physicians during elective time spent at AdventHealth East Orlando
C. Quality of interaction during preliminary contact with staff suggests incompatibility with the mission and values of AdventHealth East Orlando
D. Quality of personal statement (content, typographical and grammatical errors), including no obvious commitment to General Surgery
E. Limited verbal and written English skills, including the inability to write clearly and legibly

IV. Non-eligible candidates will not be offered an interview or accepted into AdventHealth East Orlando Graduate Medical Education residencies.

V. Applicants must have successfully participated in formal clinical training, medical school, residency training, or full-time clinical practice within the last 24 months (from date of application to the residency program).

VI. The Program Director may permit the waiver of one or more of these requirements under special circumstances.

VII. A personal interview at the AdventHealth East Orlando Emergency Medicine program is required for applicants who meet the eligibility criteria.
Selection:

I. Applicant must complete the ERAS application process.

II. Application must be complete by December 1st of application year and applicant must meet eligibility requirements in order to be considered for interview.

III. When application is complete in ERAS, the file will be downloaded and reviewed by the selection committee.

IV. If interview is offered, applicant will be contacted via letter, telephone, email, or through the ERAS post-office and applicant will be instructed to contact the Medical Education office to arrange for an appointment.

V. Interviews will take place between November and January and must be in person at the AdventHealth East Orlando Emergency Medicine program office.

VI. The interview process is conducted as follows:

   A. The applicant reports to the Emergency Medicine Medical Education office at AdventHealth East Orlando, East at 6:45AM
   B. The applicant is interviewed by: The Program Director and/or the Associate Program Director, the Behavioralist, select Emergency Medicine Faculty and select current residents.
   C. The applicant tours AdventHealth East Orlando East Emergency Medicine Department, AdventHealth East Orlando South Emergency Medicine Department and facilities.

VII. Each interviewer completes an evaluation form which includes four areas:

   A. Professional direction
   B. Personal characteristics and interpersonal communication skills
   C. Clinical competence
   D. Overall potential as a resident in our program.

   The scores are calculated and summarized (Interview Composite Score)

VIII. The files are reviewed and screened by the Program Director and Residency Coordinator. The following criteria are utilized:

   A. Personal statement
   B. Transcript score
   C. Dean’s Letter
   D. USMLE scores
E. Letters of recommendation

The scores are calculated and summarized (Screening Composite Score)

IX. An overall score is calculated for each applicant based on 40% of the Interview Score and 60% of the Screening Score.

X. The files are reviewed by the residents (when applicable) at the monthly resident meeting in January/February and a rank list is created.

XI. All applicants who have been interviewed will be reviewed for ranking by the selection committee made up of faculty and resident leaders in early February with the resident rank list taken into account.

XII. The Program Director will contact applicants to determine continued level of interest and to answer any questions. The rank order list will be compiled and submitted to the NRMP. The Match list is at the discretion of the Program Director and is confidential.

XIII. New residents who have matched will be sent a Letter of Intent, sample contract, and other required documents within two weeks. Required documents will include a Resident Manual, GME Manual, schedule request form, malpractice application, training license application and vacation request form.

XIV. Final personalized contracts are prepared, sent through the corporate approval process, and forwarded to the new residents within the next month.

XV. Orientation schedules, dates and requirements are sent to the new residents as soon as available.

Examinations, Licensure & Certification:

USMLE:

All interns must complete USMLE Step 3 prior to the end of the PGY-1 year. We urge you to take USMLE Step 3 as soon as possible. The cost of application is paid by the program upon receiving a passing score. All application paperwork should be submitted directly to the residency coordinator for processing.

To obtain an application for USMLE Step 3, go to their website and download it.

http://www.fsmb.org

Or you can call them directly at (800) 876-5396

Once you have filled out and submitted the application (along with a copy of your medical school diploma), please let the residency coordinator and chief residents know immediately when you
schedule the exam since the Department will need to adjust coverage for time you are off your service. Taking the exam means two days away from your rotation. The exam may only be taken during EM rotations.

You will also need to submit a “Certification of Post-Graduate Training” form to the residency coordinator to fill out. This form can be obtained from the website when you download the application forms.

**Licensure:**

Until such time as the USMLE Step 3 is completed and the resident is eligible to apply for full licensure in the State of Florida, the resident must maintain a Florida Department of Health Training License. The application for this will be sent to the newly-matched resident directly after the Match results are in. The training license fees will be paid by the Program, and the application and all supporting documents must be sent to the Department of State by the Program not later than April 1st in order to give adequate time to process the application for a start date of July 1st in the training program.

Upon completion of USMLE Step 3, the resident will be expected to complete the application for full medical licensure in the State of Florida. This must be completed by December of PGY-2 year. The fee for this will be paid by the Program. Application for license can be obtained from the Program Coordinator or via the Department of Health website. Make sure to download all forms and read directions carefully to expedite your application (EBAHR, National Practitioner Data Bank Self Query, AMA Profile), also, request a fingerprint card from the coordinator or at the website.

MD Applicants:  [www.doh.state.fl.us/mqa/medical/me_applications.html](http://www.doh.state.fl.us/mqa/medical/me_applications.html)

DO Applicants:  [www.doh.state.fl.us/mqa/osteopath/os_applications.html](http://www.doh.state.fl.us/mqa/osteopath/os_applications.html)

**Certifications:**

Residents in the Emergency Medicine Program are required to maintain current certifications in ACLS/BLS, PALS, NRP, and ATLS in order to be able to participate in the training program. Residents are required to obtain these certifications prior to the start of residency (excluding ATLS, which will be completed during the first month of training). Further recertification will be paid by the Program.

Copies of all certifications must be given to the residency coordinator for permanent record.

**American Board of Emergency Medicine Requirements:**

The American Board of Emergency Medicine has defined guidelines for certification eligibility after training. Senior residents applying for board certification should coordinate applications through the residency coordinator.
**Procedure logs:**

The Emergency Medicine Residency Review Committee has recently instituted a new guideline regarding the average minimum number of procedures and resuscitations that each resident must complete over the course of their training program. Documentation of these procedures and resuscitations will be used to determine each program’s compliance with the Program Requirements for Emergency Medicine and their ability to continue in the EM training program. This will be followed by an assigned Core Faculty member who will report compliance to the Clinical Competency Committee. Further, employers and hospitals are increasingly asking for actual documentation of procedures performed by potential employees during their residency for purposes of hospital credentialing.

As such, each resident is required to document all procedures and resuscitations performed during their residency on New Innovations Medical Management Suite. This includes all medical resuscitations, pediatric resuscitations, and trauma resuscitations and ultrasound procedures. Procedure documentation will be one component of your semi-annual evaluation and one component of determining advancement to subsequent years of residency training. Failure by the resident to log in procedures will end up in placement on immediate probation. The policy for logging procedures on New Innovations is as follows:

a. Update procedure logs in NI on a weekly basis (Sunday to Saturday). **All residents will complete the procedures from the week before by 0900 every Monday morning.**
   a. All information must be complete when filling out procedure log. Also required is adding a brief synopsis of patient presentation in the “comments” section.
   i. Procedures logged without this brief synopsis may be rejected.

*Residents are encouraged to keep a paper copy of their procedure logs, in addition to the New Innovations log.

- **The nine categories and minimum numbers:** The numbers in parentheses are the *average minimum number* recommended by the Emergency Medicine RRC, not what is necessarily considered “best practice” for residency training. The Residency Director makes ultimate determination of whether a resident is competent in performing a certain procedure.

  o **Resuscitation:**
    - Adult Medical Resuscitation (45)
    - Adult Trauma Resuscitation (35)
    - Peds Medical Resuscitation (15)
    - Peds Trauma Resuscitation (10)

  o **Airway:**
    - Rapid Sequence Induction
    - Orotracheal Intubation and Nasotracheal Intubation (35)
    - Cricothyrotomy (3)
    - Procedural Sedation (15)
Thoracic:
- Defibrillation/Cardioversion (10)
- Chest Tube (10)
- Pericardiocentesis (3)
- Thoracotomy
- Cardiac Pacing (6)
  - Transcutaneous
  - Transvenous

Central Venous Access: (20)
- CVC – Femoral
- CVC – Internal Jugular
- CVC – Subclavian

Skin/Skeletal:
- Laceration Repair (50)
- I & D – Abscess (10)
- Nailbed Repair
- Regional Nerve Block
- Dislocation Reduction (10)
- Closed Fracture Splinting (20)
- Arthrocentesis (5)
- Arterial Line Insertion

OB/Gyn:
- Vaginal Delivery (10)
- C-Section
- Sexual Assault Exam

HEENT:
- Lateral Canthotomy
- Nasal Packing (3)
- Nasal Cautery
- Peritonsillar Abscess

Diagnostic Plus:
- Lumbar Puncture (15)
- DPL Peritoneal Lavage
- Paracentesis
- Suprapubic Cath

Ultrasound (175): TO BE LOGGED IN Q-PATH
- FAST: 25 scans (5 positive)
- Aorta: 25 scans (2 positive)
- Cardiac: 25 scans (5 positive)
- **Gallbladder**: 25 scans (10 positive)
- **Pelvic Ultrasound**: 25 scans (10 positive)
  - Transabdominal Pelvic: 15 scans
  - Transvaginal Pelvic: 10 scans
- **Renal**: 25 scans (5 positive)
- **Ultrasound Guided Procedures**: 15 scans
  - Central Venous Access: 5 scans
  - Peripheral IV lines: 5 scans
  - Procedural US (Abscess, FB, etc): 5 scans
- **Miscellaneous and Advanced Applications**: 10 scans

*Notes for logging procedures completed during Trauma Rotation:
- **All procedures done during the TRAUMA ROTATION should be logged under Dr. Adewale**
- **Note the supervising physician’s name and a detailed description of the case in the ‘comments section’: Dr. Adewale will forward the information for approval all at once.**

- **What procedures should be documented?** The preceding list of procedures, broken down into nine categories, should be documented throughout the residency. The list was developed from the new guidelines issued by the Emergency Medicine RRC, as well as for credentialing requirements from several regional hospitals. **Note that the minimum numbers of procedures and resuscitations required by the RRC include both clinical practice and laboratory simulations. Thus it is important to document simulated experiences performing resuscitations and procedures (i.e. ACLS/ATLS/PALS certification courses).** If you were a senior resident who closely supervised a junior resident for an entire procedure such as a central line or laceration repair, be sure to include this on your list of procedures. This will give you credit for the procedure in which you played an integral teaching and supervisory role.

- **What information should be documented?** The following table is an example of the information needed for your procedure log. You may set this up in a database or spreadsheet program. (Remember that **patient confidentiality** is of the utmost importance, and your log must be kept strictly confidential. If you are not able to activate password protection, do not share your PDA or home computer with anyone else.

- **In-Service Examination:** All residents are required to take the annual American Board of Emergency Medicine In-Service Examination each academic year. This examination is most helpful in the resident’s and the faculty’s assessment of clinical and basic science knowledge and allows the resident to be able to compare his own academic progress with his peers on a nationwide basis. Although performance on this examination alone is not the sole determinant in promotion and progression in the residency, it is a helpful tool in assessing that the resident will be able to pass the ABEM Certification Examination. Residents are expected to score above the 50th percentile nationally for the appropriate year in training. Emphasis is also placed on the In-Service results when applying for fellowship. All residents who score below the 50th percentile must participate in
Academic Remediation program, which consists of concentrated program of study designed in collaboration with the resident, the resident’s mentor, and the residency associate program director to support the successful mastery of the emergency medicine didactic curriculum. A score below the 25th percentile on the ABEM in-training examination will require that you be placed on academic warning. Failure to achieve improvement above the 25th percentile on successive in-training examinations or deterioration of consecutive scores that fall below the 25th percentile may result in formal academic probation including the possibility of delayed graduation and additional postgraduate training beyond thirty-six months. If poor performance on this exam is thought to be based on learning disabilities, the program director may refer the resident for evaluation and help. The examination is customarily given on the last Wednesday in February (date to be announced annually). Residents must inform their rotation preceptor that they will not be present on their rotation on that date and make appropriate plans no later than December 15th if they will not be present in Orlando at the time of the exam (outside elective rotation).

**Program Curriculum:**

The curriculum of the Program will provide experience in all areas mandated by the Residency Review Committee. For any requirements not available at AdventHealth East Orlando, the Program will make such arrangements as necessary in order to provide the resident with the requisite experience. If such arrangements mandate rotations in remote sites, the Program will provide living facilities at its expense.

At this time, the only program not available at AdventHealth East Orlando is Trauma. Residents will therefore rotate at Lakeland Regional Medical Center during their PGY-1, PGY-2, and PGY-3 years in order to gain the necessary experience.

Through the collaborative efforts of AdventHealth East Orlando and Florida Emergency Physicians a premier Residency Program committed to excellence in Emergency Medicine began on July 2008. The focus of this program has been to provide well-trained Emergency Medicine Physicians to practice in any environment including rural Emergency Departments.

The Emergency Departments at all of the AdventHealth East Orlando seven campuses have been utilized for this program. The combined volumes for these institutions are well over 480,000 patients per year. The acuity breakdown ensures that between the institutions, the trainees will have an adequate exposure to critically ill as well as more routine patients. Our relationship with the Emergency Medical Services system also ensures that the residents will have an excellent exposure to patients in a pre-hospital setting.

Additionally, the program we have developed is unique in that it builds on the strengths of our Hospital, intensely involving, among others, the Department of Surgery, Anesthesiology, Internal Medicine, Radiology, Critical Care Medicine and the Neuroscience’s institute all as described below. We will additionally involve our residents in the care of the critically ill patient and in the operating room environment in a collegial fashion. Furthermore, the trainees will have extensive exposure to community and rural medicine through our sites at:
1. AdventHealth East Orlando Orlando (AHO)
2. AdventHealth East Orlando Children’s Hospital
3. AdventHealth East Orlando East Orlando (AHEO)
4. AdventHealth East Orlando Altamonte (AHAIt)
5. AdventHealth East Orlando Kissimmee (AHK)
6. AdventHealth East Orlando Celebration (AHC)
7. AdventHealth East Orlando Winter Park (AHWP)
8. AdventHealth East Orlando Apopka (AHA)
9. Lakeland Regional Medical Center (LRMC)

Our core faculty represents numerous prestigious Academic institutions and has participated at regional, national, and international meetings and as faculty and presenters in this area. Residents will be exposed to State-of-the-Art Information Technology including an Electronic Medical Records system and a fully integrated Informatics curriculum.

The presence of an Emergency Medicine training program will enhance AdventHealth East Orlando, Florida Medical Center and the College of Health Sciences in several ways:

1. We will create a cadre of physicians who will be of assistance to our institution in the future by training and sending throughout the state and the nation, physicians who will have an intense interest in referring patients to our institution.
2. AdventHealth East Orlando will become a national leader in Medical Education, Graduate Medical Education and Comprehensive medical care.
3. As new regional medical schools mature we will become a premier progressive training site.
4. Establishing AdventHealth East Orlando as a leader in comprehensive state medical education and expansion of our graduates and trainees into rural areas could increase AdventHealth East Orlando’s Medicare funding for training and patient care.
5. Patient care will improve with a core group of team residents interested in the area and facility in which they are working. This collaboration with on-call specialists will shift the attitude to “on-duty” thus strengthening all members of our medical staff.
6. A strong Emergency Medicine residency at AdventHealth East Orlando East Orlando will form the foundation of a center of excellence.
7. Academic/research productivity will be improved, which will enhance the profile of the institution at the national level.

AdventHealth East Orlando

AdventHealth East Orlando is a 1,432-bed medical complex serving Central Florida, much of the Southeast, the Caribbean, and South America. The eight-campus health system is the largest healthcare provider in Central Florida, and the second largest private not-for-profit hospital in the state. AdventHealth East Orlando offers a wide range of health services for the entire family, including many nationally and internationally recognized programs in cardiology, cancer, women’s
medicine, neurology, diabetes, orthopedics and rehabilitation. For the last three years, U.S. News & World Report has recognized AdventHealth East Orlando as one of "America's Best Hospitals".

COMMITTED TO QUALITY
The hospital, which was founded by the Seventh-day Adventist church in 1908 as a 20-bed health facility, is still guided by its Christian mission. In 1992, AdventHealth East Orlando received the Healthcare Forum's prestigious Commitment Award and in 1994, the hospital received the Governor's Award for Quality.

CENTERS OF EXCELLENCE
AdventHealth East Orlando is a recognized leader in the following areas:

**Internal Medicine:**

AdventHealth East Orlando Medical Center is right in the middle of Orlando and is the largest hospital in Central Florida at nearly 1,000 beds. AdventHealth East Orlando offers medical care from primary through quaternary levels including kidney, liver, pancreas, heart and lung transplant services, as well as world renowned robotic and minimally invasive surgeries.

The training program philosophy starts with a caring, humane attitude to each person we encounter. To this, we add the highest possible level of learning expectation of our residents, role modeled by highly dedicated faculty.

**Neurosciences:**

The AdventHealth East Orlando Neuroscience Institute is the first facility in Central Florida to offer interventional neuroradiology services and has the only Interventional Neuroradiologist in Central Florida. Interventional neuroradiology generally uses a minimally invasive approach with catheters placed through the arteries or veins to treat vascular diseases of the central nervous system. First dedicated SMART (Stroke Management and Rehabilitation Team) unit, established for the Central Florida region to provide aggressive therapies for stroke patients. Highlights The Institute treats the highest number of stroke patients in the state of Florida. The Institute performs the second highest number of neurosurgeries in the State of Florida-treating 1,272 patients, just 44 patients below Jackson Memorial Hospital. Bolstered by extremely strong neuroradiology and computer-assisted surgical planning divisions, physicians at the Brain Tumor Center use the latest diagnostic and treatment protocols for tumors of the central and peripheral nervous system. State-of-the-art neuroimaging (CT, MRI/MRA, biplane digital angiography and SPECT) is utilized and is essential in all phases of treatment. On January 01, 2003 through a collaborative effort between the Neuroscience institute and the Department of Emergency Medicine AdventHealth East Orlando became the first designated Brain Attack center in Central Florida.

**Oncology:**
The Walt Disney Memorial Cancer Institute (WDMCI) at AdventHealth East Orlando offers comprehensive, state-of-the-art oncology treatment, research, education and support services to about 3,400 patients a year, making it one of the largest and busiest cancer centers in the Southeast.

The WDMCI offers some of the most powerful cancer treatment equipment in the country, including the Gamma Knife, which was added in April 1996. This unique and revolutionary tool incorporates noninvasive surgery with radiation therapy to treat various brain tumors, arteriovenous malformations and functional disorders of the brain. In October 1996, The WDMCI teamed up with the Duke Comprehensive Cancer Center to provide the only pediatric and adult bone marrow transplant unit of its kind in Central Florida.

**Rehabilitation:**

The AdventHealth East Orlando Rehabilitation Center offers comprehensive specialized programs for stroke, cancer, spinal cord injury, neurological disorders, amputation, head injury, trauma and orthopedic disabilities. Orthopedic services offer comprehensive care for total joint replacements, joint injuries, back injuries and other extremity injuries. For outpatients, the AdventHealth East Orlando Center for Rehabilitation and Sports Medicine offers comprehensive programs for orthopedics, sports medicine, neurology, amputee, hand injury, stroke, speech, burn, vestibular, audiology and day treatment. The center offers one of the most sophisticated biofeedback programs in the United States for neuromuscular reeducation.

**Psychiatry:**

The AdventHealth East Orlando Center for Behavioral Health offers the only Psychiatric Medical unit in Central Florida in which services are provided for those experiencing a Psychiatric crisis whose medical condition would preclude treatment in traditional inpatient psychiatric programs.

**Women's medicine:**

The AdventHealth East Orlando Women's Center was designed for women by women. The center offers a menopause clinic, mammography, educational programs on women's health topics, a 38-bed Women's Pavilion, family-centered maternity care and a maternal-infant unit.

**Obstetrics and Pediatrics:**

Over 4,000 babies are delivered every year at AdventHealth East Orlando Orlando. A level III neonatal intensive care unit for critically ill babies is adjacent to the labor and delivery area.

**New Innovative Healthcare Facility:**
In November 1995, AdventHealth East Orlando broke ground on its new innovative healthcare facility, Celebration Health. The first phase of the health facility opened in the Fall of 1997 in the town of Celebration, a unique community created by The Celebration Company. Celebration Health will provide the very best diagnostic and medical procedures in the world for residents and visitors to Central Florida and eventually to the 20,000 residents of Celebration.

**Education:**

The AdventHealth East Orlando College of Health Sciences offers several associate-degree programs including nursing, radiation therapy, radiography and sonography. In 1996, the college, located on the campus of AdventHealth East Orlando Orlando, received full accreditation from the Southern Association of Colleges and Schools.

**Services/Specialties:**

Addictions treatment; Allergy; Anesthesiology; ASK-A-NURSE(r); Audiology; Auxiliary volunteers; Breast screening; Bronco-esophagology; Cardiac center; Cardiovascular surgery; Chemotherapy; Clinical dietetics; Colon/rectal surgery; Community health; Critical care medicine; CT scanner; Dentistry; Dermatology; Diabetes management; Dialysis; Eating disorders program; Emergency medicine; Endocrinology; Endoscopy; Family practice; Gastroenterology; General surgery; Genetics; Geriatrics; Gynecology; Head/neck surgery; Health promotion; Health testing laboratory; Heart catheterization; Helicopter transport; Home health care; Hyperbaric medicine; Immunology; Infectious diseases; Intensive care; Internal medicine; Kidney transplants; Laboratory services; Laryngology; Lithotripsy/lasertripsy; MRI; Mammography; Metabolic support; Microsurgery; Neonatology; Nephrology; Neurology; Neuro-ophthalmology; Neuroscience center; Neurosurgery; Nuclear medicine; Nursery, intensive care, sick baby, well baby; Obstetrics/gynecology; Occupational therapy; Oncology/hematology; Open-heart surgery; Ophthalmology; Organ procurement and transplantation; Orthopedic surgery; Osteoporosis education and screening; Outpatient services; Pain medicine; Parent education; Pathology; Pediatrics; Pediatric allergy, surgery, intensive care, cardiology, interventional cardiology, radiology hematology/oncology, bone marrow transplant, neurosurgery, endocrinology/metabolic disorders, neurology, dermatology, epilepsy, urology, development/growth/nutrition, gastroenterology, intensive care, emergency medicine, nephrology, infectious disease, cardiovascular surgery, ENT, pulmonary, neurology, orthopedics, ; Perinatal services; Peripheral vascular surgery; Physical medicine; Physical therapy; Plastic surgery; Podiatry; Preventive medicine; Progressive care; Psychiatry; Pulmonary medicine; Radiation medicine; Radiation therapy; Radiology; Rebound head injury unit; Recreational therapy; Rehabilitation and Sports Medicine; Respiratory care; Rheumatology; Same-day surgery; Sleep disorders center; SPECT camera; Speech therapy; Thermography; Thoracic surgery; Ultrasound; Urology; Vocational rehabilitation; Walk-in Medical Clinics; Women's medicine; Workers' compensation program; Wound care center.
Major Teaching Facilities:

Located in Orlando, Florida, AdventHealth East Orlando Orlando uses the latest technology to treat over 32,000 inpatients and 53,600 outpatients annually. This nearly 1,000-bed, acute-care community hospital also serves as a major tertiary facility for much of the Southeast, the Caribbean and South America. This campus is known for state of the art cardiac care (invasive diagnostic cardiology, including angiography and PTCA, and cardiac surgery program). AdventHealth East Orlando includes centers of excellence in Oncology, Internal Medicine, and Pediatrics. The Main Campus' Admission rates from the ED exceed 30% of the 76,000 plus visits, evidence of the advanced medical care available. The Children’s Emergency Center is a 17 room state-or-the-art department within the ED. It is staffed with dedicated BC/BE Pediatric Emergency Medicine/Emergency Medicine specialists as well as board certified pediatricians, during 22 hours of the day. Dedicated X-ray and CT scanner are available 24 hours a day, with 24-hour radiologist coverage, and remote display of scanned films is available via the PACS. A 24 bed Critical Decision Unit/Emergency Department Admission Unit helps to move stable patients toward an inpatient bed. Cardiac surgery, thoracic surgery and neurosurgery cases are transferred to AdventHealth East Orlando Orlando from outlying campuses. AdventHealth East Orlando Orlando does provide back up when Orlando Regional Medical Center, the central Florida Level I trauma center is unable to handle excess cases.

AdventHealth East Orlando East Orlando is located at the eastern end of metropolitan Orlando, and provides emergency services to the fast growing suburban communities in this locale. Further, as closest ED to Orlando International Airport, this is the first stop for acute air travel medical problems. In the past ten years, (since FEP began coverage) AdventHealth East Orlando East's ED census has risen from 16,000 to over 84,000 annually, and is currently the busiest AdventHealth East Orlando ED campus. A new 67-bed ED went into service in December 2013, providing separate areas for acute and subacute care, express care (less urgent ED visits), and recently an eight bed pediatric urgent care facility was added. Admission rates reflect the suburban nature of this population, at 13%. Inpatient OB/Gynecology and critical pediatric patients are transferred to AdventHealth East Orlando Orlando. Medical, surgical, and Pediatric care is available at the East campus. AdventHealth East Orlando East Orlando is a full-service hospital, licensed for 265 beds, serving the residents of East Orange County. Its services include Pediatric unit, Pediatric rehabilitation, Hearing Center, ICU and PCU, Cancer Center with full Oncology and Radiation services, Cardiac Cath center, Cardiology services and Cardiac rehabilitation. Surgical services include ENT, Urology, Orthopedics, Podiatry, Ophthalmology, General Surgery, and Thoracic Surgery. Community wellness programs, Diabetes services, Outpatient endoscopic services, and Outpatient Clinics for General Medical, and Pediatrics are also provided. Medical Students, Interns and Residents rotate through the Emergency Department every month. Emergency services also include access to Florida Flight 1 helicopter transport, and a full radiology department 24 hours a day.
**Experiential Curriculum:**

The following sections contain and describe the comprehensive and experiential program curriculum. The curriculum follows the Emergency Medicine Model curriculum and involves a balanced set of clinical block rotations and a didactic curriculum, with each covering the model curriculum. Each block rotation has written major instructional goals and objectives (referenced back to the model), methods of achieving goals (implementation) and an evaluation and feedback component. The method of achieving these goals and the process of evaluation is listed under each block rotation with references back to the core model curriculum. Special emergency medicine skills such as resuscitation, Emergency medical services, critical care, and administrative aspects of emergency medicine are included as discrete block rotations when possible or included under objectives for the three levels of emergency medicine training. Emergency medicine has a great breadth of knowledge with learning objectives frequently spanning more than one discrete block rotation since the specialty overlaps a variety of fields.

The didactic curriculum follows the core content and includes general and specific goals and objectives. Under each topic are included methods of implementation such as core reading, additional readings, and lectures or case conferences presented on these topics. The didactic curriculum also lists and labs, demonstrations or workshops that are used to implement a particular topic. Finally, there is a cross reference to on and off service rotations which teach a particular body of knowledge through patient care.
The didactic curriculum is presented over an 18-month period by emergency medicine faculty, residents, and specialists from within and outside the institution. The conference series includes five hours of planned educational experience weekly on Thursday mornings from 7:00 am-12:00 noon. A quarterly journal club will occur in addition to those already in the didactic curriculum. During the evening meetings, additional time will be spent to discuss various topics related to “the art of emergency medicine”. These topics are diverse and will include issues such as: the problem patient, interview techniques, how to respond to abusive patients, how to deal with families, how to discuss death etc...

At the beginning of the EM1 year, residents are certified in Advanced Cardiac Life Support and Basic Life Support as developed by the American Heart Association along with Pediatric Advanced life support and Neonatal Resuscitation Program. Residents will also become certified in Advanced Trauma Life support as developed by the American College of Surgeons during their residency training. Residents will be encouraged to become ACLS instructors. Residents are required to maintain current certifications throughout the entire residency program.

Between the block rotations and the didactic curriculum, the resident receives exposure to both clinical experiences and a lecture and literature based curriculum which together provide a comprehensive residency training experience. The expected outcome is for the residents to learn, to synthesize, and to develop competence in each of these block rotations while integrating those clinical and interpersonal skills necessary to produce a skilled clinician and independent practitioner of emergency medicine.

There will be six, first year house officers in the usual situation. A house officer will participate in thirteen four week rotations during the first year. The general objectives of the first year rotations are:

1. Demonstrate proficiency in working up patients and in providing ongoing care for the patients in a variety of in-patient and out-patient settings
2. Participate as an assistant in some operations.
3. Perform procedures of a minor magnitude felt appropriate by the Resident Preceptor.
IMPLEMENTATION

The First Year:

Specific knowledge and procedural skills are acquired on each of the clinical rotations by resident participation in patient care activities. On each service during the first year, the resident is rotated into the call schedule and takes on physician responsibilities for the service which are appropriate to his/her level of training.

The in-patient and out-patient facilities at AdventHealth East Orlando are state-of-the-art. AdventHealth East Orlando prides itself on being a leader in high-tech medical advancements and has all major diagnostic and therapeutic modalities available to the training programs. Residents at the PGY-1 level work with a separate service "team" each month that report to a specific chief on that service. Each chief is responsible to the physicians in his/her department.

Every service on which the PGY-1 resident rotates has an attending supervisor. The attending is available to review cases at any time of the day and can provide direct bedside instruction for the in-patient and out-patient units. Attending rounds are conducted twice daily (morning and afternoon) on all inpatient services through which the PGY-1 rotates. On the out-patient services (clinics and E.D.) Attendings are immediately on-site to see all patients directly with the PGY-1 resident and to provide direct bedside teaching for physical exam and procedures.

Library facilities are available at AdventHealth East Orlando and online through the University of Central Florida College of Medicine (once the resident completes a dedicated teaching module). The Main Library for the Hospital has extensive collections of peer review journals and reference texts. The library index has been completely computerized and Med-line can be accessed at no charge to the resident from multiple sites in the Library and the Hospital.

In addition to the Main Library, we have developed a Personal Learning system that includes an iPAd Mini which we will assist the residents in loading on software germane to online resources of interest to the practicing EM physician. These hospital and departmental libraries are available to the residents rotating on our service twenty-four hours per day.

Specialty consultants from every specialty service are available to both in-patient and out-patient units on a 24 hour per day basis. Consults are provided by Attendings on medical and surgical specialty services. OB/GYN consults are provided by a resident-attending team. Pediatric specialty consults are done by their Pediatric/Pediatric Emergency Medicine trained attendings. All of these consult physicians are willing to provide bedside teaching and supervision for procedures.
Laboratory Services and Radiology Services operate twenty-four hours per day at AdventHealth East Orlando. All tests available during business hours in these services are available on nights, evenings and weekends including radio-immunoassays from the lab and MRI from Radiology. Laboratory Services provides a Drug Toxicology Screen at night.

All services at AdventHealth East Orlando have attending on-call at night. The Attendings for each specialty handle referrals from other hospitals directly. Attendings on-call for surgical services must come into the hospital at night if a patient is going to the O.R. and must be present in the O.R. at the start of any case. Therefore, on the surgery and Ob/Gyn cases, the Attendings are immediately available to teach during invasive procedures.

Lectures are given by each of the services on which the PGY-1 rotates. In addition to these, the EM Residency lectures occur each Thursday from 7:00am- 12:00. Quality Improvement conferences are held monthly by the Department of Emergency Medicine and are held concomitantly with the Residency lectures every other month. Specialty conferences such as tumor conferences and research conferences are held monthly. These resources, conferences and teaching activities are available to the PGY-1 as he/she rotates through the services. Procedural skills and factual knowledge will be acquired through this experience.

The Second Year:

On each service during the second year, the resident is rotated into the call schedule and takes on physician responsibilities for the service which are appropriate to his/her level of training. All major diagnostic and therapeutic modalities are available to the training programs. Residents at the PGY-2 level work with a separate service "team" that report to a specific chief on that service.

Every service on which the PGY-2 resident rotates has an attending. The attendings are available to review cases at any time of the day and can provide direct bedside instruction for the in-patient and out-patient units. Attending rounds are conducted twice daily (morning and afternoon) on all inpatient services through which the PGY-2 rotates. On the out-patient services (clinics and E.D.) attendings are immediately on-site to see all patients directly with the PGY-2 resident and to provide direct bedside teaching for physical exam and procedures.

Library facilities are available at AdventHealth East Orlando and thru the University of Central Florida College of Medicine Library online. The Main Library for the Hospital has extensive collections of peer review journals and reference texts. The library index has been completely computerized and Med-line can be accessed at no charge to the resident from multiple sites in the Library and the Hospital.

In addition to the Main Library, we have developed a Personal Learning system that includes an iPad Mini which we will assist the residents in loading on software germane
to online resources of interest to the practicing EM physician. These hospital and departmental libraries are available to the residents rotating on service twenty-four hours per day.

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All services at AdventHealth East Orlando have attending on-call at night. The attendings for each specialty handle referrals from other hospitals directly. Attendings on-call for surgical services must come into the hospital at night if a patient is going to the O.R. and must be present in the O.R. at the start of any case. Therefore, on the orthopedic and Trauma cases, the attendings are immediately available to teach during invasive procedures.

Lectures are given by each of the services on which the PGY-2 rotates. These occur in the Emergency Medicine curriculum Thursday’s from 7:00am-12:00 noon. Quality Improvement conferences are held monthly by the Department of Emergency Medicine. Specialty conferences such as tumor conferences and research conferences are held monthly. These resources, conferences and teaching activities are available to the PGY-2 he/she rotates through the services. Procedural skills and factual knowledge will be acquired through this experience.

The Third Year:

Each third year rotation is four weeks long. The Senior Resident will be responsible for coordinating Quality improvement conferences as well as coordinating the Journal Clubs and some of the daily lectures that will occur in the Emergency Department. The Senior Resident will also work with the faculty members on a clinical or basic research project that will result in a paper of publication quality. Most of the residents will have selected a topic during their second year and should be to a point during their research month where a concentrated effort will complete their investigational work.

A Senior Resident will be included in all meetings of the Program Evaluation Committee of the Emergency Medicine Residency. He/she will also be responsible for organizing student lectures during the month and participating in simulation cases.
The third year also has a difference in the resident responsibilities while working in the AdventHealth East Orlando Emergency Department. Third year residents, when on duty, will not only participate in direct patient care but will also be responsible for interacting with the pre-hospital care of the patients by directing the paramedics and will direct the nurse-paramedics on the Florida Flight One flight team which is based out of the Emergency Department at AdventHealth East Orlando. The senior resident will, in general, administer the Emergency Department when he/she is on duty and will be responsible for knowing every patient in the emergency department. The Senior Resident will also take presentations from senior medical students who are working as externs in the AdventHealth East Orlando Emergency Department.

With the institution of a residency program, the authority for giving physician orders would be delegated to the Senior Resident from Emergency Medicine working in the Emergency Department. The Senior Resident would be responsible for giving orders to paramedic personnel for pre-hospital care and would be responsible for giving orders to the Florida Flight One flight team.

For critical patients in the field or in other hospital emergency departments, the third year resident will be allowed to travel with the Florida Flight One Flight Program to administer care at the scene. This opportunity will be on a volunteer basis only. Residents will not be forced to fly on the AdventHealth East Orlando Helicopter Program if they do not wish to.

The senior resident returns to Lakeland for another month of the Lakeland Regional Medical Center Trauma Service functioning this time as a senior member of the team. At a third year level, the residents will take charge of trauma resuscitations under the watchful eye of the attending trauma surgeon. Also, the senior resident directs resuscitations in the SICU and is allowed to independently perform procedures such as arterial catheterization, endotracheal intubation, central line placement, and ventilator management. The resident is expected to take call during the month at the Trauma Center averaging every third night.

The senior residents in Emergency Medicine will be allowed to participate in paramedic education. All procedure labs will utilize the Emergency Medicine Residents as teachers for the paramedics and medical students. The paramedic training is ongoing and includes skills such as endotracheal intubation, cricothyrotomy, needleling of the chest for tension pneumothorax, the use of mast trousers, and various techniques for IV insertion.
Curriculum

ADMINISTRATION (PGY-III, 2 Weeks)

Overview: The Emergency Medicine residents rotate through “Administration” at the EM3 level. The program is extremely pleased with the educational opportunities offered to the Emergency Medicine residents as they rotate through this service. The purpose, educational objectives, methods, resident responsibilities, educational materials, as well as interdepartmental relationships are outlined below. These objectives will be accomplished by attending departmental meeting that involve decision-making in the areas of scheduling, capital budget planning, complaint resolution, interdisciplinary relationships, staffing patterns, and other management issues, develop a process-improvement project and participating in teaching shift with both medical students and residents alike. Upon completion of this rotation, residents will receive written evaluations from the attending staff. These evaluations will focus specifically on interpersonal/communication skills, teaching skills, as well as completion of educational objectives. The focus of the end of rotation evaluations will be the completion of Core Competency objectives. The Program Director and his designee will review all evaluations and make them available to the resident during regular business hours. The faculty supervisor is Dr. Miguel Acevedo.

Purpose
1. To expose residents to the administrative duties and the teaching responsibilities that accompanies emergency physicians on the day to day business in an emergency department.
2. To provide an instructional tool for the residents, in the training of the basics aspects of administration of an emergency department.
3. To acquire knowledge in the following areas: coding & billing, patient satisfaction, risk management & quality assurance, adequate transfer of patients, and overcrowding.
4. To learn and practice various teaching techniques used in medical education.

Educational Objectives

Medical Knowledge
1. Discuss common teaching techniques that are used in medical education
2. Learn common techniques to provide feedback to medical students and residents
3. To demonstrate knowledge about common topics in Emergency Department administration (examples: EMTALA, Emergency Medicine Department director, overcrowding, EM billing and coding, as outlined by the instructional manual)

Patient Care
1. Gather accurate, essential information in a timely manner from all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic procedures.
2. Integrate diagnostic information and generate an appropriate differential diagnosis.
3. Competently perform therapeutic procedures considered essential to the practice of emergency medicine.
4. Demonstrate ability to appropriately prioritize and stabilize multiple patients and perform other responsibilities simultaneously.
5. Demonstrate the ability to teach medical students and residents the essential skills for quality patient care

Practice – Based Learning
1. Create and implement a quality and process improvement project
2. Locate, appraise, and assimilate evidence from scientific studies related to the health problems of their patients
3. Obtain and use information about their own population of patients and the larger population from which the patients are drawn
4. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
5. Use information technology to manage information, access online medical information and support their own education
6. Facilitate the learning of students and other health care professionals

Professionalism
1. Arrive on time and prepared for work
2. Appropriate (inoffensive) dress and cleanliness
3. Evaluates medical records honestly and keeps confidentiality.
4. Is responsive to input and feedback of administration team members and ED Clinical Director.
5. Participates in peer-review process.
6. Treat patients/family/staff/paraprofessional personnel with respect
7. Protect staff/family/patient's interests/confidentiality
8. Demonstrate sensitivity to patient's pain, emotional state, and gender/ethnicity issues
9. Actively seek feedback and immediately self-corrects
10. Unconditional positive regard for the patient, family, staff, and consultants
11. Accept responsibility/accountability
12. Open/responsive to input/feedback of other team members, patients, families, and peers
13. Uses humor/language appropriately

Interpersonal and Communication Skills
1. Demonstrate ability to present cases in academic setting.
2. Demonstrate the ability to teach and effectively give feedback in a respectful and non-confrontational manner.
3. Portray the attitudes and attributes of emergency physician at departmental meetings.
4. Demonstrate the ability to respectfully, effectively, and efficiently develop a therapeutic relationship with medical students, residents, patients and their families
5. Demonstrate respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences in patients and other members of the health care team
6. Demonstrate effective listening skills and be able to elicit and provide information using verbal, nonverbal, written, and technological skills
7. Demonstrate ability to develop flexible communication strategies and be able to adjust them based on the clinical situation
8. Demonstrate effective participation in and leadership of the health care team
9. Demonstrate ability to negotiate as well as resolve conflicts
10. Demonstrate effective written communication skills with other providers and to effectively summarize for the patient upon discharge
11. Demonstrate ability to effectively use the feedback provided by other

**Systems-Based Practice**

1. Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care.
2. Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
3. Practice cost-effective health care and resource allocation that does not compromise quality of care.
4. Advocate for and facilitate patients’ advancement through the health care system.

**Methods of Achieving Goals and Objectives**

1. Meet with the faculty rotation supervisor on the first day and last day of the rotation
2. Become familiar with the educational material provided about ED administration/academic
3. Attend four predetermined administrative meetings
4. Perform five junior attending teaching shifts
5. Review peer charts
6. Develop, implement and write an abstract for a process improvement project
7. Present an “Morbidity and mortality” case at weekly EM lecture series
8. Complete (Rosh Review module if not Cord Question Bank test) “Administration”
9. Attendance at Emergency Medicine lectures

**Resident Responsibilities**

The Emergency Medicine (EM) residents will:

1. Residents will be required to attend four predetermined administrative meetings. Listed below are possible predetermined administrative meetings.
   a. ED clinical standard
   b. AdventHealth East Orlando Pharmaceutical and Therapeutic Committee
   c. ED Medical Directors and Leadership
   d. AdventHealth East Orlando East Orlando Patient Safety and Quality (PSQ) Assurance
   e. Medical Ethics
   f. Medical Informatics or ED IT
   g. Sepsis or Acute Coronary Syndrome Committee
2. Residents will be required to participate in five (5) junior attending teaching shifts from 7am-7pm. During this time, they will actively engage in a leadership role during ED work by providing clinical teaching for medical students and resident.

3. Residents will be expected to perform quality chart review. These charts will be selected at random and the chart review process will be completed using PSRINC.net web services.

4. Residents will present a “Morbidity and Mortality” case at weekly EM lecture series. The purpose of this case is to improve patient care and engage residents in a quality improvement activity.

5. Residents will be required to develop and implement a process-improvement project. They will create an abstract about their project and present it to the Medical Director of the ED, program director and faculty.

6. Residents are expected to read and become familiar with concepts involved in ED administration and medical education, therefore they are required to complete the CORD Tests (or ROSH Review) on “Administration” by the end of the rotation.

7. Residents are expected to attend lectures, journal clubs and other academic activities of the Department during the rotation. The trainee is encouraged to actively participate in these activities.

8. Residents are expected to attend the EM program academic activity scheduled every Thursday at 7:00 a.m.

9. EM 3 residents are to follow duty hours rules as specified by ACGME guidelines. It is the responsibility of the Emergency Medicine resident to notify the Emergency Medicine Program Director of potential duty hour violations in order to avoid possible disciplinary action. This will also be monitored through the New Innovations online system.

10. During this rotation, residents can be called on short notice for duty at the AdventHealth East Orlando ED in case of an emergency or special situation due to an impending or developing disaster.

11. Residents are required to keep a log of the procedures done in this rotation in New Innovations online system.

**Educational Material**

1. Residents attend Emergency Medicine conferences in which the administration and teaching curriculum is incorporated.

2. The education resources and facilities of the AdventHealth East Orlando Medical Center will be available to each resident. These resources include the medical library, including books and periodical reference materials, abstract and literature research services, as well as audio-visual references. Additionally, the medical records department will be available to the resident for completion of charts and chart reviews.

3. Residents will be required to view the following webinars throughout the rotation:
   a. ACEP Reimbursement Department – Web video

4. Residents will also be required to complete the following reading requirements throughout the rotation:
   a. Rosen’s Emergency Medicine 7th Ed: Chapters 196-203
   b. ACEP: The Fundamentals of Reimbursement: What Every Graduating Resident Should Know Before Starting Practice (ACEP Reimbursement Committee)
c. Instructional manual provided for this rotation
d. Other optional readings are:
   i. Tintinalli’s Emergency Medicine, 7th Ed:
   ii. Carol River’s Written Board Review for Emergency Medicine 6th Ed:
       Administration section

**Evaluation**
The Emergency Medicine Residency faculty will evaluate EM residents using the evaluation form provided by the Emergency Medicine Department. Close interaction with supervisors is encouraged in order to maximize learning experiences. The evaluation sheet is completed using New Innovations. Emergency Medicine Residency faculty is encouraged to notify Program Director or Associate/Assistant Program Director of any difficulties with an EM resident as soon as these arise, preferably **within the first week** of the rotation.

In order to pass a rotation, the resident must complete all of the above mentioned tasks and the resident must earn an average score of three (3) or higher in each of the following six general competencies: patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice. A resident who fails to obtain a score of three (3) in any category **WILL NOT** pass the rotation, regardless of how high the other five scores may be.

Each resident’s knowledge will be tested throughout the year specifically with their performance on In-Training examination, simulation performance, procedural competencies and content specific questions throughout the academic year.

**Feedback**
The Program Director and/or Associate/Assistant Program Director are responsible of notifying residents of any problems noted as soon as possible. Written/online evaluations are available for formal review with the residency director at semi-annual progress meetings. At the end of the rotation, the resident will evaluate the strengths and weaknesses of the “Administration” rotation using the “Clerkship Evaluation Form” available through New Innovations. Feedback will also be given in a semi-annual resident evaluation.
ANESTHESIA Medicine (PGY-I, 4 Weeks)

Goals & Objectives

Patient Care

1. Gather accurate, essential information in a timely manner from all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic procedures.
2. Integrate diagnostic information and generate an appropriate differential diagnosis.
3. Competently perform diagnostic and therapeutic procedures considered essential to the practice of emergency medicine.
4. Demonstrate ability to appropriately prioritize and stabilize one patient and perform other responsibilities simultaneously.

Medical Knowledge

1. Demonstrate an investigatory and analytic thinking approach to clinical situations.
2. Demonstrate correct use of the bag-valve-mask device.
3. Demonstrate knowledge of the anatomy of the upper airway.
4. Demonstrate basic familiarity with endotracheal intubation’s as well as the indications and complications.
5. Demonstrate basic familiarity with endotracheal intubation’s as well as the indications and complications.
6. State the dosages, indications and contraindications for inhalation anesthetic agents, intravenous analgesic, anesthetics, and neuromuscular blocking agents.
7. Demonstrate ability to use standard monitoring techniques.
8. Demonstrate ability to manage a patient on a ventilator.
9. Demonstrate competent use with Laryngeal Mask Airway.
10. Demonstrate competent use in advance airway with use of glidescope and fiberoptics.
11. Demonstrate ability to Perform Central line placement, peripheral intravenous placement and arterial line placement.

Practice – Based Learning

1. Locate, appraise, and assimilate evidence from scientific studies related to the health problems of their patients
2. Obtain and use information about their own population of patients and the larger population from which the patients are drawn
3. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
4. Use information technology to manage information, access online medical information, and support their own education
5. Facilitate the learning of students and other health care professionals

**Professionalism**
1. Arrive on time and prepared for work
2. Appropriate (inoffensive) dress and cleanliness
3. Appropriate use of symptomatic care
4. Treat patients/family/staff/paraprofessional personnel with respect
5. Protect staff/family/patient's interests/confidentiality
6. Demonstrate sensitivity to patient's pain, emotional state, and gender/ethnicity issues
7. Actively seek feedback and immediately self-correct
8. Unconditional positive regard for the patient, family, staff, and consultants
9. Accept responsibility/accountability
10. Open/responsive to input/feedback of other team members, patients, families, and peers
11. Use humor/language appropriately

**Interpersonal and Communication Skills**
1. Demonstrate the ability to respectfully, effectively, and efficiently develop a therapeutic relationship with patients and their families
2. Demonstrate respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences in patients and other members of the health care team
3. Demonstrate effective listening skills and be able to elicit and provide information using verbal, nonverbal, written, and technological skills
4. Demonstrate ability to develop flexible communication strategies and be able to adjust them based on the clinical situation
5. Demonstrate effective participation in and leadership of the health care team
6. Demonstrate ability to negotiate as well as resolve conflicts
7. Demonstrate effective written communication skills with other providers and to effectively summarize for the patient upon discharge
8. Demonstrate ability to effectively use the feedback provided by others

**Systems - Based Practice**
1. Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care.
2. Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
3. Practice cost-effective health care and resource allocation that does not compromise quality of care.
4. Advocate for and facilitate patient’s advancement through the health care system.
DESCRIPTION OF CLINICAL AND DIDACTIC EXPERIENCES

The program has designed a combine four-week rotation of Anesthesia with Ultrasound at AdventHealth East Orlando. During the rotation the Emergency Medicine (EM) residents will:

1. Work with the Anesthesia team and participate in direct patient care under the supervision of an Anesthesia attending at all times.
2. Attend the EM Program academic activity scheduled every Thursday at 7:00 a.m. The Department of Anesthesia will be informed in advance in case of any additional EM academic activities to which the resident must attend.
3. Duty Hours rules must be followed as specified by ACGME guidelines. It is the responsibility of the emergency medicine resident to notify the Emergency Medicine Program Director of potential Duty Hours violations in order to avoid possible disciplinary action. It will also be monitored through New Innovations online system.
4. Be called on short notice for duty at the AdventHealth East Orlando ED in case of an emergency or special situation due to an impending or developing disaster.
5. Complete ROSH Review with pass rate of 75% from on-line data bank

EVALUATION

The Anesthesia faculty will evaluate EM residents using the evaluation form provided by the Emergency Medicine Department. Close interaction with supervisors is encouraged in order to maximize learning experiences. The evaluation sheet will be forwarded at the end of the rotation to the Anesthesia Department office. It will then be returned to the EM Department at the AdventHealth East Orlando. Anesthesia Department faculty is encouraged to notify Dr. Dale Birenbaum (Program Director) or Dr. Steve Nazario (Associate Program Director) at 407-303-6413 of any difficulties with an EM resident as soon as these arise, preferably within the first two weeks of the rotation.

In order to pass a rotation, the resident must earn an average score of three (3) or higher IN EACH OF THE FOLLOWING six general competencies: patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice. A resident who fails to obtain a score of three (3) in any category WILL NOT pass the rotation, regardless of how high the other five scores may be. The criteria used to award a score in each category are listed in the "Resident Evaluation by Teaching Faculty Form".

FEEDBACK

The Program Director and/or Associate/Assistant Program Director are responsible of notifying residents of any problems noted as soon as possible. Written evaluations are available for formal review with the residency director at semi-annual progress meetings. At the end of the rotation, the resident will evaluate the strengths and weaknesses of the Anesthesia rotation using the “Clerkship Evaluation Form” available through E-value online evaluation program. The faculty supervisor is Dr. Alfredo Tirado. The Anesthesiology
CRITICAL CARE UNIT – Pediatric: PICU (PGY-II, 4 Weeks), PICU-Procedural Sedation and Analgesia (PGY-II, 4 weeks)

Overview

Welcome to the AdventHealth East Orlando for Children’s Pediatric Intensive Care Unit rotation.

Your clinical rotation is done at the Pediatric Intensive Care Unit located on the 5th floor of the Walt Disney Pavilion at AdventHealth East Orlando for Children, a full-service children’s hospital with broad pediatric sub-specialty backup. The unit is staffed by board-prepared pediatric intensivists. Each room offers highly interactive technology as well as ambient lighting.

This rotation has been developed based on the ACGME outlined competencies. You will be supervised by a board-eligible/certified Pediatric ICU physician. You will be responsible for assisting the team with the initial evaluation of all pediatric ICU patients. You will be expected to formulate a plan for their evaluation and treatment, which you will then present to the attending faculty member. The preceptors for the PICU experiences are Drs. B. Antonyrajah (PICU) and H. Liriano (Procedural Sedation and Analgesia).

Learning Resources

Residents are to keep a log of all patients seen during the rotation as well as of all procedures performed. All residents will:

a. Prepare and present (in PowerPoint format), a pediatric specific case/lecture from patients seen during the rotation, at a designated time and date. The attending physician for that case will aid and orient the resident as he/she prepares for the presentation.

b. Discuss cases admitted cases with consultants (after discussion with the Peds ICU attending).

c. Turn in log of all patients seen throughout the rotation.

d. Reading from Rogers’ Pediatric Intensive Care textbook.

e. Complete an evaluation of the Peds ICU rotation at the end of your block.

Residents will be encouraged to approach the complaints of pediatric intensive care unit patients in the same way in which they approach those of adult patients – to consider life-
threatening conditions first and to rule out such conditions even if they are perceived to be rare in children.

**Goals and Objectives**

### Patient Care

1. Provide family-centered patient care that is development and age appropriate, compassionate, and effective for the treatment of health problems and the promotion of health.
2. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their parents.
3. Use a logical and appropriate clinical approach to the care of Pediatric ICU patients, applying principles of evidence-based decision-making and problem-solving, and demonstrating the ability to prioritize. Perform accurate ED triage.
4. Demonstrate the ability to multi-task by providing simultaneous care to multiple patients, with varying levels of acuity and severity of illness.
5. Use appropriate timing of diagnostic and therapeutic interventions.
6. Use the clinical history, laboratory, and X-ray database to derive a differential diagnosis for a given patient.
7. Provide sensitive support to critically ill patients and their families; arrange for ongoing support and/or preventive services if needed.
8. Counsel and educate patients and their families.

### Medical Knowledge

1. Understand the scope of established and evolving biomedical, clinical, epidemiological and social-behavioral knowledge needed by a pediatrician; demonstrate the ability to acquire, critically interpret and apply this knowledge in patient care.
2. Demonstrate a commitment to acquiring the base of knowledge needed for the care of children in the PICU.
3. Demonstrate the ability to efficiently access medical information, evaluate it critically and apply it to pediatric care in the ICU.
4. Rapidly recognize and assess emergent patients, such as those in respiratory failure or shock.
5. Establish and manage the airways of infants, children and teens, recognizing the need for assistance with ventilation and/or oxygenation.
6. Establish vascular access in the critically ill child as indicated, including cannulation of peripheral veins and intraosseous needle insertion.
7. Explain indications and describe technique for central venous access and arterial access.
8. Manage fluid and pressor therapy in the initial resuscitation of patients in distributive, hypovolemic, and cardiogenic shock.
9. Demonstrate proficiency at cardiopulmonary resuscitation by obtaining and maintaining certification as a provider of Advanced Pediatric Life Support, directing resuscitation
efforts in mock codes and in actual emergency situations and using resuscitation drugs appropriately.

Practice-based Learning and Improvement
1. Demonstrate knowledge, skills and attitudes needed for continuous self-assessment, using scientific methods, and evidence, to investigate, evaluate, and improve one's patient care practice in the pediatric ICU.
2. Identify personal learning needs, systematically organize relevant information resources for future reference, and plan for continuing acquisition of knowledge and skills.
3. Search and integrate evidence of scientific studies related to their patients’ health problems.
4. Support their own education with the use of on-line medical journals and technology to be able to improve or contribute in improving patient care.
5. Search information based on their diverse patient population census.

Interpersonal Skills and Communication
1. Demonstrate interpersonal and communication skills that result in information exchange and partnering with patients, their families and professional associates.
2. Provide effective patient education, including reassurance, for a condition(s) commonly seen in the PICU.
3. Participate effectively as part of an interdisciplinary team in the PICU to create and sustain information exchange, including communication with the primary care physician.
4. Provide case-based teaching related to clinical situations encountered in the PICU (for students, colleagues, other professionals and/or laypersons).
5. Maintain accurate, timely and legally appropriate medical records in the PICU setting.
6. Communicate the diagnosis, treatment plan and follow-up care with sensibility and empathy to patients and family.
7. Develop and ethically-based relationship with patients and family to be able to give the best therapeutic care.
8. Respect patient confidentiality for sensitive issues.

Professionalism
1. Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity.
2. Demonstrate a commitment to professionalism despite the pace and stress of the PICU setting.
3. Adhere to ethical and legal principles, and be sensitive to diversity.
4. Identify and describe potential ethical dilemmas that one may encounter in the PICU (e.g., such as resuscitation of patients with little hope of recovery; treatment of disabled patients; providing confidential care to mature minors, foregoing life-sustaining treatment; identifying and referring organ donors).
5. Discuss key principles and identify resources for information about legal issues of importance to practice in the ED (e.g. laws regarding inter-hospital patient transfer; rights of parents to refuse treatment and legal options of providers; reporting of child abuse and neglect; death reports; and obligations of physicians in the PICU to facilitate follow-up care).

6. It is expected that the resident will arrive on time every day and be dressed in professional attire.

7. Demonstrate respect, compassion, integrity, and empathy to every patient.

8. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent.

9. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.

**Systems-Based Practice**

1. Understand how to practice high-quality health care and advocate for patients within the context of the health care system.

2. Identify key aspects of health care systems, cost control, billing, and reimbursement as this relates to PICU care and follow-up.

3. Demonstrate sensitivity to the costs of care in the PICU setting and take steps to minimize costs without compromising quality.

4. Recognize and advocate for families who need assistance to deal with system complexities.

5. Recognize one's limits and those of the system; take steps to avoid medical errors.

6. Learn to advocate for quality patient care.

7. The resident will learn when to obtain consultations from pediatric sub-specialists.

8. Be aware and responsive to the larger context of health care. Call effectively on the resources in the system to provide optimal care.

**Methods of Achieving Goals:**

1. Management of patients in the Pediatric ICU.


5. Attendance to Pediatric Rounds and Pediatric Departmental conferences.

6. Attendance to Emergency Medicine lectures in Pediatrics

7. Assigned Readings

**Evaluation and Feedback on Goal Achievement:**

1. Written formal evaluation by Pediatric ICU attending.

2. Clinical performance under supervision of the Pediatric ICU attending staff.

3. Performance on In-Training examination.
4. Resident feedback:
   A. Evaluation at end of rotation.
   B. Semi-annual resident evaluation.

**EM-I (PGY-I, 28 Weeks)**

**Overview**

Your experiences during the patient-care experiences in the Emergency Department represent the core your training in Emergency Medicine. This rotation has been developed based on the ACGME outlined competencies.

Your time in the Emergency Department will be supervised by Emergency Medicine faculty. You will be responsible for the initial evaluation of patients presenting to the Emergency Department and formulating a plan for their treatment.

**Learning Resources**

Didactic lectures with the Emergency Medicine faculty, bedside rounds on all cases presenting to the Emergency Department. During the discussions, physiology, pathogenesis, and clinical presentations shall be reviewed. Relevant topics will be assigned for reading. You are expected to perform routine searches of the medical literature relevant to the patient care issues encountered during your rotation.

**Goals and Objectives**

**Patient Care**

1. Communicate effectively and demonstrate caring and respect when interacting with patients and their families.
2. Identify the common and important medical conditions which present to the emergency department.
3. Outline the general approach to common clinical presentations to the Emergency Department.
4. Learn to focus on the differential diagnosis in the appropriate clinical setting.
5. Residents will learn to obtain a clinical history to aid in the differential diagnosis.
6. Learn to counsel and educate patients and their families.

**System Based Practice**
1. Residents will learn to develop, implement and evaluate treatment plans for patients presenting to the Emergency Department.
2. Will learn when to obtain consultations from consultants
3. Will learn to advocate for quality patient care

**Professionalism**

1. It is expected that residents will arrive on time every day and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity and empathy to every patient, their families and medical staff.
3. Be committed to the ethical principles in all aspects of clinical care.
4. The resident should be sensitive to the patient’s culture, gender, age and disabilities (if any).

**Interpersonal and Communication Skills**

1. Communicate the diagnosis, treatment plan and follow-up care with the patient and their family.
2. Develop an ethically-based relationship with patients and their family to be able to give the best therapeutic care.
3. Respect patient confidentiality.
4. Work effectively with medical students, fellow Emergency Medicine residents, residents from other services, consultants and nursing staff.

**Practice Based Learning and Improvement**

1. Search and integrate evidence of scientific studies related to their patient’s health problems.
2. Using a systemic methodology, residents will apply practice based improvement activities to develop treatment plans to help manage patients.
3. Support their own educations with the use of on-line medical journals and electronic databases to improve patient care.

**Medical Knowledge**

1. Develop basic skills of emergency medicine patient evaluation.
2. Learn principles of emergency medicine care.
3. Develop competence in the diagnosis and management of acute and common problems seen in patients presenting to the Emergency Room, with particular emphasis on the following symptoms:
   a. Headache.
   b. Altered mental status.
   c. Dizziness, weakness, syncope, vertigo.
   d. Shortness of breath.
   e. Chest pain, palpitations.
f. Abdominal pain.
g. Nausea, vomiting, diarrhea, feeding problems, weight loss.
h. Gastrointestinal bleeding.
i. Dysuria, hematuria.
j. Vaginal/obstetrical complaints.
k. Minor trauma, soft tissue and bone injuries.
l. Fever, chills.
m. Skin rashes.
n. Earache, sore throat, eye complaints, nose bleeds.
o. Overdose, drug interactions.
p. Human/animal bites.
q. Urogenital complaints.

4. Become familiar with the indications for and interpretation of state-of-the-art diagnostic modalities:
   a. Plain film radiography and contrast studies.
   b. Ultrasound.
   c. Tomography.
   d. Computerized axial tomographic (CAT) scanning.
   e. Magnetic resonance imaging (MRI).
   f. Nuclear Medicine studies.
   g. Electrocardiography.
   h. Endoscopy.
   i. Arterial blood gases.
   j. Chemistry and hematologic studies.
   k. Urinalysis.
   l. Slit lamp examination.

5. Acquire expertise in the following skills:
   a. History and physical examination.
   b. Initial stabilization.
   c. Patient - physician communication.
   d. Fluid, electrolyte and blood component therapy.
   e. Oxygen therapy.
   f. Venous catheterization, arterial puncture.
   g. Urinary bladder catheterization.
   h. Wound closure, wound care.
   i. Nasogastric tube, gastric lavage - bowel decontamination.
   j. Pharmacologic intervention.
   k. Incision & drainage procedures.
   l. Nasal packing.
   m. Eye patching.

6. Develop competence in the following areas of wound management:
   a. Demonstrate ability to perform appropriate history and physical exams on patients with traumatic wounds.
   b. Demonstrate an understanding of wound pathophysiology, including cellular response, static and dynamic wound tensions, growth factors and tensile strength.
   c. Demonstrate an understanding of the predictors of wound sepsis.
d. Demonstrate effective wound cleansing skills.

e. Describe the appropriate use, limitations and potential complications of wound cleansing solutions.

f. Describe the appropriate use, limitations and potential complications of antimicrobials in the management of traumatic wounds.

g. Demonstrate an understanding of various imaging modalities in the detection of soft tissue foreign bodies.

h. Demonstrate appropriate use of universal precautions in wound treatment.

i. Demonstrate skill in various wound closure techniques including intradermal suture, fascial closure, interrupted skin sutures, running skin sutures, vertical and horizontal mattress sutures, half-buried horizontal mattress sutures, tape closure and use of staples.

j. Demonstrate appropriate use of delayed closure techniques.

k. Demonstrate appropriate management of special wound types, including skin ulcers, human bites, animal bites, snake bites, plantar puncture wounds, dermal abrasions and tar burns.

l. Demonstrate skill in the management of complex lacerations.

m. Demonstrate skill in the provision of analgesia and anesthesia to patients with traumatic wounds including use of local infiltration, topical administration and conscious sedation.

n. Demonstrate ability to apply wound dressings.

o. Demonstrate ability to thoroughly document historical and physical exam data relating to wound care.

p. Describe indications for specialty referral of traumatic wounds.

q. Demonstrate ability to diagnose and manage complication of traumatic wounds.

Methods of Goal Achievement

1. Management of patients in the Emergency Department
4. Article presentation, critique, and discussion at Journal Club.
5. Teaching ACLS, ATLS, PALS and suture techniques.
6. Teaching third year and fourth year medical students.
7. Consultations with various medical specialists.
8. Attendance and participation at the Lakeland Trauma rounds.
9. Textbook readings

Evaluation and Feedback

1. Bedside evaluation of residents' history and physical examinations, oral presentations, clinical, and procedural skills by Emergency Department attending staff.
2. Written formal evaluation by Emergency Department attending staff.
3. Daily review of resident's charts.
5. Performance evaluation at Journal Club and Trauma Conferences.
7. Performance on In-Training Examination.
8. Resident feedback:
   a. Evaluation at end of rotation.
   b. Semiannual resident evaluation.
9. Daily shift card evaluation

**PEDIATRIC EM (PGY-II & PGY-III, 4 weeks)**

**Overview**

Welcome to the AdventHealth East Orlando for Children’s Pediatric Emergency Medicine rotation. Orientation will be provided on your first day.

Your clinical rotation is done at the Children’s Emergency Center located in the ground floor of the Ginsburg Tower at AdventHealth East Orlando South. The CEC is part of the AdventHealth East Orlando for Children, Walt Disney Pavilion, a full-service children’s hospital with a broad pediatric sub-specialty backup. The department is staffed with board-certified pediatric emergency medicine physicians as well as board-certified emergency physicians with special interest in pediatrics. The department is a 17 bed-unit, separate from the adult ED, and staffed with dedicated pediatric nurses. Each room offers highly interactive technology as well as ambient lighting.

This rotation has been developed based on the ACGME outlined competencies. You will be supervised by a board certified Pediatric Emergency or Emergency Medicine physician. You will be responsible for assisting the team with the initial evaluation of all pediatric patients, under the age of 18, presenting to the ED. You will be expected to formulate a plan for their evaluation and treatment, which you will then present to the attending faculty member.

We expect you to:

a. Be on time to work.
b. Behave in a highly professional manner, maintaining appropriate standards of conduct, dress, and hygiene.
c. Always treat patients as customers to whom a service is being provided.
d. Complete patient documentation and medical records in a timely manner.

**Learning Resources**

Residents are to keep a log of all patients seen during the rotation as well as of all procedures performed. All residents will:

a. Prepare and present (in PowerPoint format), a pediatric specific case/lecture from patients seen during the rotation, at a designated time and date. The attending
physician for that case will aid and orient the resident as he/she prepares for the presentation.

b. Run a mock code on a weekly basis – One of the PEM faculty will call upon the resident and will choose a case scenario.

c. Follow 5 patients admitted through the CEC until discharged from the hospital. A brief (one or two paragraph) write up for each admission is expected to be turned in at the end of the rotation.

d. Make follow-up calls on 5 patients seen in the department (provide documentation, including telephone number called)

e. Read Jill M. Barren's, Pediatric Emergency Medicine, chapters 1, 2, 3, 6, 7, 8, 11, 13, 28, 30, 32, 45, 56, 57, 105, 110, 119, 138, 146, 154 and 159 (A 50-question written exam will be given at the end of the rotation)

f. Discuss cases for admission with consultants (after discussion with the Peds ED attending).

g. Attend a 1-hour lecture by Child Life

h. Attend a 1-hour lecture by Pastoral care on delivering bad news to family (parents) and grieving process.

i. Attend a 1-hour lecture by pediatric respiratory therapy on airway management, ventilator management and other “tips and tricks of the trade”.

j. Turn in log of all patients seen throughout the rotation.

k. Complete an evaluation of the Peds ED rotation at the end of your block.

Residents will be encouraged to approach the complaints of pediatric emergency department patients in the same way in which they approach those of adult patients – to consider life-threatening conditions first and to rule out such conditions even if they are perceived to be rare in children. The faculty supervisors are Drs. D. Hernandez and C. Martinez.

Goals and Objectives

Patient Care

1. Provide family-centered patient care that is development and age appropriate, compassionate, and effective for the treatment of health problems and the promotion of health.

2. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their parents.

3. Use a logical and appropriate clinical approach to the care of emergency patients, applying principles of evidence-based decision-making and problem-solving, and demonstrating the ability to prioritize. Perform accurate ED triage.

4. Demonstrate the ability to multi-task by providing simultaneous care to multiple patients, with varying levels of acuity and severity of illness.

5. Use appropriate timing of diagnostic and therapeutic interventions.

6. Use the clinical history, laboratory, and X-ray database to derive a differential diagnosis for a given patient.

7. Adjust pace to ED patient acuity, volume and flow.
8. Provide sensitive support to critically ill patients and their families; arrange for ongoing support and/or preventive services if needed.

9. Be sensitive to the needs of families who use the ED for minor illness care (e.g., need for better orientation to the health care system, lack of community services or medical home).

10. Counsel and educate patients and their families.

**Medical Knowledge (see addendum A)**

1. Understand the scope of established and evolving biomedical, clinical, epidemiological and social-behavioral knowledge needed by a pediatrician; demonstrate the ability to acquire, critically interpret and apply this knowledge in patient care.

2. Demonstrate a commitment to acquiring the base of knowledge needed for the care of children in the ED.

3. Demonstrate the ability to efficiently access medical information, evaluate it critically and apply it to pediatric care in the ED.

4. Rapidly recognize and assess emergent patients, such as those in respiratory failure or shock.

5. Establish and manage the airways of infants, children and teens, recognizing the need for assistance with ventilation and/or oxygenation.

6. Establish vascular access in the critically ill child as indicated, including cannulation of peripheral veins and intraosseous needle insertion.

7. Explain indications and describe technique for central venous access and arterial access.

8. Manage fluid and pressor therapy in the initial resuscitation of patients in distributive, hypovolemic, and cardiogenic shock.

9. Demonstrate proficiency at cardiopulmonary resuscitation by obtaining and maintaining certification as a provider of Advanced Pediatric Life Support, directing resuscitation efforts in mock codes and in actual emergency situations and using resuscitation drugs appropriately.

10. Evaluate and manage common signs and symptoms in infants, children, and adolescents that present to the ED.

11. Recognize and manage common illnesses and injuries that present emergently.

**Practice-based Learning and Improvement**

1. Demonstrate knowledge, skills and attitudes needed for continuous self-assessment, using scientific methods, and evidence, to investigate, evaluate, and improve one's patient care practice in the ED.

2. Identify personal learning needs, systematically organize relevant information resources for future reference, and plan for continuing acquisition of knowledge and skills.

3. Search and integrate evidence of scientific studies related to their patients’ health problems.

4. Support their own education with the use of on-line medical journals and technology to be able to improve or contribute in improving patient care.
5. Search information based on their diverse patient population census.

**Interpersonal Skills and Communication**
1. Demonstrate interpersonal and communication skills that result in information exchange and partnering with patients, their families and professional associates.
2. Provide effective patient education, including reassurance, for a condition(s) commonly seen in the ED.
3. Participate effectively as part of an interdisciplinary team in the ED to create and sustain information exchange, including communication with the primary care physician.
4. Provide case-based teaching related to clinical situations encountered in ED (for students, colleagues, other professionals and/or laypersons).
5. Maintain accurate, timely and legally appropriate medical records in the ED and urgent care settings.
6. Communicate the diagnosis, treatment plan and follow-up care with sensibility and empathy to patients and family.
7. Develop and ethically-based relationship with patients and family to be able to give the best therapeutic care.
8. Respect patient confidentiality for sensitive issues.

**Professionalism**
1. Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity.
2. Demonstrate a commitment to professionalism despite the pace and stress of the ED setting.
3. Adhere to ethical and legal principles, and be sensitive to diversity.
4. Identify and describe potential ethical dilemmas that one may encounter in the ED (e.g., such as resuscitation of patients with little hope of recovery; treatment of disabled patients; providing confidential care to mature minors [pregnancy termination, STDs, substance abuse]; foregoing life-sustaining treatment; identifying and referring organ donors).
5. Discuss key principles and identify resources for information about legal issues of importance to practice in the ED (e.g., emergency care for indigent patients; laws regarding inter-hospital patient transfer; consent-to-treat issues in the emergency treatment of minors; rights of parents to refuse treatment and legal options of providers; reporting of child abuse and neglect; death reports; and obligations of physicians in the ED to facilitate follow-up care).
6. It is expected that the resident will arrive on time every day and be dressed in professional attire.
7. Demonstrate respect, compassion, integrity, and empathy to every patient.
8. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent.
9. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.

**Systems-Based Practice**
1. Understand how to practice high-quality health care and advocate for patients within the context of the health care system.
2. Identify key aspects of health care systems, cost control, billing, and reimbursement as this relates to ED care and follow-up.
3. Demonstrate sensitivity to the costs of care in the ED setting and take steps to minimize costs without compromising quality.
4. Recognize and advocate for families who need assistance to deal with system complexities.
5. Recognize one's limits and those of the system; take steps to avoid medical errors.
6. Learn to advocate for quality patient care.
7. The resident will learn when to obtain consultations from pediatric sub-specialists.
8. Be aware and responsive to the larger context of health care. Call effectively on the resources in the system to provide optimal care.

**Methods of Achieving Goals:**
1. Management of patients in the Pediatric ICU.
5. Attendance to Pediatric Rounds and Pediatric Departmental conferences.
6. Attendance to Emergency Medicine lectures in Pediatrics (see addendum B)
7. Assigned Readings

**Evaluation and Feedback on Goal Achievement:**
1. Written formal evaluation by Pediatric attending physician staff.
2. Clinical performance under supervision of the Pediatric attending staff.
3. Resident feedback:
   - A. Evaluation at end of rotation.
   - B. Semi-annual resident evaluation.
4. Performance on In-Training examination.
EM-II (PGY-II, 32 Weeks)

Overview

Your experiences during the patient-care experiences in the Emergency Department represent the core of your training in Emergency Medicine. This rotation has been developed based on the ACGME outlined competencies.

Your time in the Emergency Department will be supervised by Emergency Medicine faculty. You will be responsible for the initial evaluation of patients presenting to the Emergency Department and formulating a plan for their treatment.

Learning Resources

Didactic lectures with the Emergency Medicine faculty, bedside rounds on all cases presenting to the Emergency Department. During the discussions, physiology, pathogenesis, and clinical presentations shall be reviewed. Relevant topics will be assigned for reading. You are expected to perform routine searches of the medical literature relevant to the patient care issues encountered during your rotation.

Goals and Objectives

All of those listed for EM-I plus:

Patient Care

1. Communicate effectively and demonstrate caring and respect when interacting with patients and their families.
2. Identify the important medical conditions which present to the emergency department.
3. Identify the immediately life-threatening conditions and their treatment.
4. Outline the general approach to most clinical presentations to the Emergency Department.
5. Learn to focus on the differential diagnosis in the appropriate clinical setting.
6. Residents will continue to hone their clinical history and interviewing skills.
7. Learn to counsel and educate patients and their families.
Medical Knowledge

1. Become competent in resuscitation and stabilization of critically-ill patients in the Emergency Department, with particular emphasis on the following:
   b. Cardiovascular instability.
   c. Unstable cardiac arrhythmias.
   d. Cardiac arrest.
   e. Respiratory arrest.
   f. Obstructed airway.
   g. Shock: cardiogenic, septic, hypovolemic, anaphylactic, neurogenic.
   h. Increased intracranial pressure.
   i. Fluid overload.
   j. Major trauma.
   k. Organ failure: hepatic, renal, endocrine, bone marrow.
   l. Burn (thermal, chemical, electrical) patients.

2. Acquire expertise in the following skills:
   a. ACLS, ATLS and PALS.
   b. Fluid and electrolyte resuscitation.
   c. Airway access and control.
   d. Cerebrospinal stabilization.
   e. Hemorrhage control.
   f. Drug/electrocardioversion.
   g. Arrhythmia recognition and interpretation.
   h. Pharmacologic intervention.
   i. Circulatory and ventilatory support.
   j. Pericardiocentesis.
   k. Closed tube thoracostomy.
   l. Open thoracostomy.
   m. Peritoneal lavage.
   n. IV access, peripheral and central venous catheterization.
   o. Arterial catheterization.
   q. Initial interaction with pre-hospital care personnel.
   r. Serial patient evaluation.

3. Learn to manage multiple patients simultaneously.
4. Acquire educational skills and teach medical students.

System Based Practice

1. Residents will continue to develop, implement and evaluate treatment plans for patients presenting to the Emergency Department.
2. Continue to learn when to obtain consultations from consultants
3. Advocate for quality patient care
Professionalism

1. It is expected that residents will arrive on time every day and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity and empathy to every patient.
3. Be committed to the ethical principles in all aspects of clinical care.
4. The resident should be sensitive to the patient’s culture, gender, age and disabilities (if any).

Interpersonal and Communication Skills

1. Communicate the diagnosis, treatment plan and follow-up care with the patient and their family.
2. Develop an ethically-based relationship with patients and their family to be able to give the best therapeutic care.
3. Respect patient confidentiality.
4. Work effectively with medical students, fellow Emergency Medicine residents, residents from other services, consultants and nursing staff.

Practice Based Learning and Improvement

1. Search and integrate evidence of scientific studies related to their patient’s health problems.
2. Using a systemic methodology, residents will apply practice based improvement activities to develop treatment plans to help manage patients.
3. Support their own educations with the use of on-line medical journals and electronic databases to improve patient care.

Methods of Goal Achievement

1. Graduated responsibility as a more senior resident including supervision of junior residents.
2. Resident demonstration of clinical and administrative skills under direct Emergency Medicine faculty supervision.
3. Attendance at Emergency Medicine lecture series.
4. Presentations at Emergency Medicine Conferences.
5. Article presentation, critique, and discussion at Journal Club.
6. Teaching ACLS, ATLS, suture techniques.
7. Teaching third year and fourth year medical students.
8. Consultations with various medical sub-specialists.

Evaluation and Feedback
1. Bedside evaluation of residents' history and physical examinations, oral presentations, clinical, and procedural skills by Emergency Department attending staff.
2. Written formal evaluation by Emergency Department attending staff.
3. Daily review of resident's charts.
5. Performance evaluation at Journal Club and Trauma Conferences.
7. Performance on In-Training Examination.
8. Resident feedback:
   a. Evaluation at end of rotation.
   b. Semiannual resident evaluation.
   c. Daily Shift card evaluations
EM-III (PGY-III, 36 Weeks)

Overview

Your experiences during the patient-care experiences in the Emergency Department represent the core your training in Emergency Medicine. This rotation has been developed based on the ACGME outlined competencies.

Your time in the Emergency Department will be supervised by Emergency Medicine faculty. You will be responsible for the initial evaluation of patients presenting to the Emergency Department and formulating a plan for their treatment.

Learning Resources

Didactic lectures with the Emergency Medicine faculty, bedside rounds on all cases presenting to the Emergency Department. During the discussions, physiology, pathogenesis, and clinical presentations shall be reviewed. Relevant topics will be assigned for reading. You are expected to perform routine searches of the medical literature relevant to the patient care issues encountered during your rotation.

Goals & Objectives

All of those listed for EM-I and EM-II plus:

Patient Care

1. Communicate effectively and demonstrate caring and respect when interacting with patients and their families.
2. Identify the important medical conditions which present to the emergency department.
3. Identify the immediately life-threatening conditions and their treatment.
4. Outline the general approach to most clinical presentations to the Emergency Department.
5. Learn to focus on the differential diagnosis in the appropriate clinical setting.
6. Residents will continue to hone their clinical history and interviewing skills.
7. Learn to counsel and educate patients and their families.
System Based Practice

1. Residents will continue to develop, implement and evaluate treatment plans for patients presenting to the Emergency Department.
2. Continue to learn when to obtain consultations from consultants
3. Advocate for quality patient care

Professionalism

1. It is expected that residents will arrive on time every day and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity and empathy to every patient.
3. Be committed to the ethical principles in all aspects of clinical care.
4. The resident should be sensitive to the patient’s culture, gender, age and disabilities (if any).

Interpersonal and Communication Skills

1. Communicate the diagnosis, treatment plan and follow-up care with the patient and their family.
2. Develop an ethically-based relationship with patients and their family to be able to give the best therapeutic care.
3. Respect patient confidentiality.
4. Work effectively with medical students, fellow Emergency Medicine residents, residents from other services, consultants and nursing staff.

Practice Based Learning and Improvement

1. Search and integrate evidence of scientific studies related to their patient’s health problems.
2. Using a systemic methodology, residents will apply practice based improvement activities to develop treatment plans to help manage patients.
3. Support their own educations with the use of on-line medical journals and electronic databases to improve patient care.

Medical Knowledge

1. Develop expertise in overall clinical management of a busy Emergency Department, including:
   A. Applying ethical principles relevant to emergency medicine.
   B. Applying emergency medicine and ethical principles to patient encounters to assist in decision making.
   C. Managing patient flow
   D. Teaching and supervision of medical students and junior residents.
E. Communicating with consultants and private attending physicians.
F. Mediating intra-departmental and interdepartmental medical disputes.
G. Learning basic legal principles relevant to emergency medicine.
H. Directing cardiac and trauma codes.
I. Recognizing dysrhythmias associated with cardiac arrest and their treatment.
J. Learning AHA recommendations and develop skill in the performance of standard resuscitative procedures.
K. Learning the principles of pharmacotherapy and the routes and dosages of drugs recommended during cardiac arrest and following resuscitation.
L. Learning standard monitoring techniques.
M. Learning indications for withholding and terminating resuscitation.

2. Recognize the interplay among the various elements of the regional EMS System including Base Station Medical Command for paramedics.
3. Develop ED administrative skills to facilitate resolution of interdepartmental difficulties, facilitate patient transfers into the hospital and to other facilities.
4. Develop leadership skills and understand the concept of teamwork.
5. Demonstrate knowledge of the various etiologies of adult and pediatric cardiac arrest and the corresponding therapeutic approaches.
6. Demonstrate knowledge of the factors affecting blood flow, oxygen delivery and consumption during cardiac arrest.
7. Demonstrate ability to recognize dysrhythmias associated with cardiac arrest and knowledge of ACLS protocols for their treatment.
8. Demonstrate ability to manage the airway during cardiac arrest, including mouth-to-mouth ventilation, bag valve mask ventilation, endotracheal intubation, cricothyroidotomy, and recognition of the obstructed airway.
9. Demonstrate ability to perform external closed chest cardiopulmonary resuscitation according to American Heart Association guidelines.
10. Discuss the dosages, indications, and contraindications for pharmacologic therapy during cardiac arrest and following resuscitation.
11. Demonstrate knowledge of the techniques for drug administration including peripheral and central venous, endotracheal, intra-osseous and intra-cardiac administration.
12. Demonstrate ability to safely perform internal and external defibrillation.
13. Demonstrate ability to safely perform internal and external cardiac pacing.
14. Demonstrate ability to perform standard monitoring techniques during cardiac arrest and resuscitation including arterial blood gases, blood pressure monitoring, right heart and pulmonary artery catheterization and end-tidal CO2 monitoring.
15. Demonstrate understanding of “Do Not Resuscitate” orders, advance directives, living wills and brain death criteria.
16. Discuss the historical, philosophical, and practical implications of beneficence, autonomy, justice, truth-telling and confidentiality to emergency medical practice and research.
17. Demonstrate ability to assess patients’ decisional capacity/competency.
18. Discuss the role of the expert witness in medico-legal proceedings.
19. Discuss the importance of proper documentation in medico-legal proceedings.
20. Demonstrate ability to apply ethical principles to resuscitation, including advance directives, decision to forego resuscitation, euthanasia, and organ transplantation.
21. Demonstrate knowledge of cost containment, resource allocation, quality of care and access to care issues.
22. Describe basic principles of medical malpractice.
23. Demonstrate familiarity with managed care plans.
24. Discuss the components of hospital administration and interactions as they relate to emergency medicine.
25. Discuss the components and responsibilities of physician-physician relationships.
26. Demonstrate knowledge of laws regarding reportable diseases, patient care, and patient transfers.
27. Demonstrate knowledge of laws regarding reporting of deaths and appropriate documentation.
28. Discuss laws relating to drug dispensing, regulation, and abuse.

Methods of Goal Achievement
1. Responsibility as clinical chief resident while on shift in the Emergency Room. Learning to “run the side”.
2. Optional responsibility as administrative chief resident to plan resident's schedules, assign selected conference topics, direct monthly resident administrative meeting.
3. Resident demonstration of clinical and administrative skills under direct Emergency Medicine faculty supervision.
5. Presentations at Emergency Medicine Trauma Conference.
6. Article presentation, critique, and discussion at Journal Club.
7. Teaching ACLS, ATLS, suture techniques.
8. Teaching third year and fourth year medical students.
9. Consultations with various medical subspecialists.
10. Journal and textbook readings.

Evaluation and Feedback
1. Bedside evaluation of residents' history and physical examinations, oral presentations, clinical, and procedural skills by Emergency Department attending staff.
2. Written formal evaluation by Emergency Department attending staff.
3. Daily review of resident's charts.
5. Performance evaluation at Journal Club and Trauma Conferences.
7. Performance on In-Training Examination.
8. Resident feedback:
   a. Evaluation at end of rotation.
   b. Semiannual resident evaluation.
   c. Daily Shift Card evaluations
BEHAVIORAL MEDICINE (PGY I, II, & III, Didactic and Longitudinal)

Goals & Objectives

Patient Care
1. Develop the skills to diagnose common disorders and provide appropriate treatment and counseling plans including adjustment disorders, mood disorders, anxiety disorders, substance abuse disorders, attention deficit disorders, and eating disorders.
2. Develop the skills to provide appropriate stress management plan to deal with the impact of illness within the context of the patient and family system.
3. Demonstrate ability to assess suicide risk.
4. Discuss the indications for physical and chemical restraint and demonstrate ability to use restraint appropriately.

Medical Knowledge
1. Apply the understanding of family systems to patient care.
2. Apply the understanding of life-cycles, developmental tasks, and stressors (including family violence) to patient care.
3. Develop an understanding of basic behavioral modification methodologies.
4. Develop an understanding of basic principles for cognitive – behavioral therapy.
5. Discuss the indications for emergent psychiatric consultation.
6. Discuss organic causes of altered mental status including dementia and delirium.
7. Demonstrate ability to differentiate organic and functional causes of altered mental status.
8. Develop an understanding of life-cycles, developmental issues and stressors.
9. Develop an understanding of family systems.
10. Develop an understanding of family violence.
11. Develop familiarity with common psychotherapeutic agents.
12. Develop an understanding for the development of moral and spiritual values.

Practice Base Learning and Improvement
1. Develop the skills for literature and/or web searches to provide scientific evidence for beneficial interventions on behavioral topics.

Interpersonal and Communication Skills
1. Develop the skills to build an effective doctor-patient relationship.
2. Develop the skills for interviewing and psychological history taking.
3. Develop the skills to effectively interact with patients with personality disorders including antisocial, borderline, compulsive, dependent, histrionic, and passive-aggressive.
4. Develop the skills to perform spiritual assessment when appropriate.
5. Develop the skills for counseling those facing death and dying issues.
6. Demonstrate ability to perform a mental status exam in patients with normal and altered mental status.
7. Develop the skills for building therapeutic relationships and negotiations with patients.
8. Develop the skills for appropriate communications regarding medical information, dealing effectively with the patient’s and/or family’s emotional reactions.
9. Develop the skills to exercise cultural sensitivity and proficiency.

**Professionalism**
1. Enhance personal resilience skills as a means of maintaining psychological and physical well-being

**System Based Practice**
1. Discuss the indications for routine psychiatric consultation.
2. Discuss the process of voluntary and involuntary commitment.
3. Identify dysfunctional systems and intervene for referral to the appropriate resources.

**Methods of Achieving Goals**
1. Participation in Resiliency program developed by Dr. T. Spruill
2. Management of patients in the E.D. presenting with psychological diagnoses
3. Consultation with Psychiatry Dept. staff on patients believed to be suicidal
4. Attendance at EPCDU rounds.
5. Attendance at Emergency Medicine lectures on Psychiatry
6. Attendance at the POWER series lectures and small group learning activities that are part of the EM Residency curriculum.

**Evaluation and Feedback on Goal Achievement:**
1. Formal evaluation by E.D. attending physicians.
2. Resident feedback:
   a. Evaluation at end of rotation.
   b. Semi-annual resident evaluation.
3. Performance on In-Training examination.
EMS (PGY-I, 2 Weeks)

Overview

This rotation has been developed based on the ACGME outlined competencies with emphasis on applying them on the pre-hospital settings.

You will be supervised by EMS Faculty and Fellows in training about the importance of the initial interaction between patient and health professional. Also, you will interact with EMS personnel to see the “other side” of patient care in the pre-hospital setting.

Learning Resources

Didactic lectures with the attendings and fellows, participating in many of the monthly meetings involving the Orange County EMS, and reviewing charts and protocols will be part of your experience during this rotation.

This rotation will occur in the Orange County EMS system during the PGY I year. Supervision will be provided by the EMS fellow and faculty. The resident will be assigned to the Office of the Medical Director (OMD) for the Orange County EMS system and all activities for the rotation will be coordinated through the OMD.

Responsibilities will include, but not be limited to: observation ride-alongs with ground ALS transport units, exposure to EMS dispatch, communications, quality management, and disaster preparedness. The resident will not have on-call responsibilities, but will be expected to deliver a didactic lecture to the EMS system, as well as perform an evidence-based review of one, or a component of one, of the system treatment protocols. Current ACGME work duty hour restrictions will be adhered to.

Participating all regularly scheduled E.M. conferences and any EMS conferences that occur during the rotation are required to achieve a 70% overall minimum conference attendance to planned E.M. educational experiences.

Goals and Objectives

Patient Care

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Learn principals of pre-hospital triage and emergency medical care delivery
3. Participate as an observer or team member in ground and optional air medical transport systems.
Medical Knowledge

1. Develop familiarity with EMS system design and operations
2. Develop familiarity with online medical control and base station operations
3. Develop a power point (voiced over) didactic clinical educational module to a group of EMS providers
4. Develop an awareness of medical oversight and medical director responsibilities within an EMS system
5. Become familiar with disaster management and regional disaster preparedness
6. Understand the scope of practice of EMT-basics and paramedics

Practice Base Learning and Improvement

1. Perform an evidence-based review of one of the EMS system treatment protocols
2. Support their own education with the use of online medical journals and technology to be able to improve or contribute in improving patient care.
3. Search information based on their diverse patient population census.

Interpersonal and Communication Skills

1. Demonstrate effective communication with patients, their families, and professional associates
2. Communicate the diagnosis, treatment plan and follow up care with sensibility and empathy to the patients and family
3. Develop an ethically based relationship with patients and family to be able to give the best therapeutic care.
4. Respect patient confidentiality for sensitive issues

Professionalism

1. Demonstrate respect, compassion, and integrity
2. It is expected that the resident will arrive on time every day and be dressed in professional attire.
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent
4. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.

System Based Practice

1. Learn the basic resources available for the out-of-hospital care of the patient
2. Discuss the importance of quality assurance and total quality management in an EMS system
3. Residents will learn to develop, implement and evaluate treatment plans for pre-hospital patients
4. Residents will learn the different roles of the local pre-hospital health department
5. Learn to advocate for quality patient care

Methods of Achieving the Goals

1. Simulated and actual radio operator calls.
2. Participation with paramedic ground ambulance units.
3. Participation in pre-hospital stabilization.
4. Participation in Quality Assurance conferences and chart review.
5. Optional teaching of paramedics.
6. Attendance at city and county EMS functions.
7. Attendance at Emergency Medicine lectures in EMS.

Evaluation and Feedback on Goal Achievement:

1. Formal evaluation by EMS attending physician staff.
2. Resident feedback:
   A. Evaluation at the end of rotation
   B. Semi-annual resident evaluation.
3. Performance on In-Training examination
4. Case presentation, participation, and critique at quarterly pre-hospital care conferences
INFECTIONOUS DISEASE (Selective PGY-I, 2 weeks)

Overview

Your experience during the patient-care experience on the wards will be process for learning and develop your clinical skills and management of the different infectious diseases. This rotation has been developed based on the ACGME outlined competencies with emphasis on applying them on the infectious diseases patients.

You will be supervised by an Infectious Diseases faculty member, Dr. Sniffen. You will also be responsible for assisting the consult team with the initial evaluation of patients with infections and will formulate a plan for their evaluation and treatment, which you will then present to the attending faculty member during rounds.

Learning Resources

Didactic lectures with the attending, bedside rounds on all new consults and hospital follow ups, assigned readings and review articles. During the discussions, physiology, pathogenesis, clinical presentations and natural history of infectious disorders is reviewed. Relevant topics of Up to Date will be assigned. You are also expected to perform routine searches of the medical literature relevant to the patient care issues encounter during your rotation. The hospital provides a wide variety of medical journals available on-line free of charge.

Goals and Objectives

Medical Knowledge

1. Understand the approach to the febrile patient, including fever of unknown origin.
2. Know immunization recommendations for adults and children.
3. Identify infectious diseases with prominent cutaneous manifestations.
4. Understand the diagnosis and management of HIV as appropriate for the emergency medicine physician.
5. Understand the diagnosis and management of tuberculosis and interpretation of PPD skin testing.
6. Have knowledge of CNS infections diagnosis and treatment, including bacterial meningitis, the aseptic meningitis syndrome, and encephalitis.
7. Recognize and manage soft tissue infections, including cellulites and necrotizing fasciitis.
8. Identify major infection control procedures for communicable diseases.
9. Manage bacteremia.
10. Know how to diagnose and treat endocarditis.
11. Know the diagnosis and treatment of sexually transmitted diseases including syphilis, gonorrhea, Chlamydia, genital herpes, and trichomoniasis.
12. Know how to manage septic arthritis and osteomyelitis.
13. Manage upper and lower respiratory infections.
15. Manage urinary tract infections.
16. Know the rational use of the clinical microbiology laboratory.
17. List one or two reasonable antibiotic choices if given a clinical scenario and identify the major toxicities of each antibiotic chosen.
18. List the major infectious pathogens for a given clinical scenario.
19. Select appropriate antibiotic(s) for a given infection or clinical scenario, be able to justify use and list major side effects.
20. Perform and interpret Gram stains.

Patient Care
1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Identify the common and important syndromes in infectious diseases and outline their general management.
3. Learn to focus on the infectious disease differential diagnosis in the appropriate clinical setting.
4. Use the clinical history, laboratory, and X-ray database to derive an infectious disease differential diagnosis for a given patient.
5. Take a careful history including travel, sexual, occupational, and environmental exposures to aid in the differential diagnosis of the patient with suspected infection.
6. Counsel and educate patients and their Families

Practice Base Learning and Improvement
1. Search and integrate evidence of scientific studies related to their patients infectious health problems.
2. Using a systematic methodology, residents will apply practice base improvement activities to develop and implement treatment plans to help manage patients with infectious diseases.
3. Support their own education with the use of on line medical journals and technology to be able to improve or contribute in improving patient care.
4. Search information based on their diverse patient population census.

Interpersonal and Communication Skills
1. Communicate the diagnosis, treatment plan and follow up care with sensibility and empathy to the patients and family.
2. Develop an ethically-based relationship with patients and family to be able to give the best therapeutic care.
3. Respect patient confidentiality for sensitive issues.
4. Work effectively with medical students, residents from other services, consultants and nursing staff.
5. Have recognition of stigma associated with certain infections (tuberculosis, STD’s, HIV) so that patients’ unspoken fears and concerns can be addressed.

**Professionalism**
1. It is expected that the resident will arrive on time every day and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity, and empathy to every patient
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent
4. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.
5. Overcome stereotyping and negative attitudes toward patients with HIV/AIDS.

**System Based Practice**
1. Residents will learn to develop, implement and evaluate treatment plans for infectious diseases patients
2. Will learn when to obtain consultations from infectious diseases specialists
3. Will develop the ability to select the most cost effective treatment plans for infectious diseases patients always meeting the national quality standards
4. Residents will learn the different roles of the local health department
5. Learn to advocate for quality patient care

**Methods of Achieving the Goals**
1. Management of patients in the Emergency Department and the Infectious Diseases Ward
2. Management of patients on the Emergency Department Rotations
3. Attendance at teaching rounds and Infectious diseases conferences
4. Attendance at Emergency Medicine lectures on infectious diseases.

**Evaluation and Feedback on Goal Achievement**
1. Formal evaluation by Infectious Diseases attending physician staff.
2. Resident feedback:
   C. Evaluation at the end of rotation
   D. Semi-annual resident evaluation.
3. Performance on In-Training examination
INTERNAL MEDICINE (PGY-I, 4 weeks)

General description of the rotation including educational purpose, rationale or value:
The General Medicine teams form the basis of inpatient medical services. Patients are admitted from the emergency room, medical clinics or private physicians’ offices. Residents care for patients with a broad variety of medical illnesses under the guidance of full-time faculty. Through the use of patient care rounds and teaching rounds by the attending, residents learn the basic and advanced clinical skills necessary for internal medicine. Emphasis is placed on cost containment, medical ethics and preventative medicine when applicable. Residents are encouraged to use computer applications to obtain current citations to answer their questions about disease processes and clinical management.

Resident responsibilities and Supervision:
The resident team is supervised by the attending physician. The resident is expected to function as the supervisor of all other members of the team and guide the clinical care of the patients and the educational development of the interns and students. The interns have primary care responsibility for all patients admitted to them, including a complete history and physical examination, daily progress notes, documentation of all procedures. All residents are expected to attend Morning Report, Continuity clinic and Core Conference.

Residents are expected to read the material from the reading list. Readings are assigned for each month of wards and at each resident level. They will be posted prior to the beginning of the rotation.

Educational Objectives: An expanded version of the competencies is listed under Core Competencies in Internal Medicine. Those listed here are specific to this rotation.

During this rotation, the resident will:

Patient Care
1. Develop increasing independence in patient evaluation and management.
2. Admit up to 5 patients in 24 hours (or 8 in 48 hours); detailing comprehensive history, physical examination, evaluation and management plan.
3. Write daily progress notes for all patients assigned to the intern.
4. Develop efficiency in providing cross-coverage to patients cared for by other interns and on other teams.
5. Evaluate the causes of and initiate the appropriate diagnostic and therapeutic processes for the following common medical conditions in hospitalized patients: chest
pain, dyspnea, headache, delirium, coma, abdominal pain, fever, rashes, edema, nausea/vomiting, diarrhea, hematemesis, hematochezia, cough, arthritis, and weakness.

**Medical Knowledge**
1. Expand knowledge base in internal medicine.
2. Begin certification in diagnostic procedures, e.g., thoracentesis, paracentesis, joint aspiration, lumbar puncture, arterial puncture for arterial blood gas determination and therapeutic procedures, e.g., central line placement.
3. Become familiar with the causes, diagnostic processes and treatment procedures for the medical conditions listed in Patient Care.
4. Read the assigned readings for the rotation and take the test.

**Practice-Based Learning**
1. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems

**Interpersonal and Communication Skills**
1. Enhance their leadership, interpersonal and teaching skills.

**Professionalism**

**System-Based Practice**
1. Practice cost-effective health care and resource allocation that does not compromise quality of care.
2. Advocate for quality patient care and assist patients in dealing with system complexities.
3. Partner with health care managers and health care providers to assess, coordinate, and improve health care through interdisciplinary rounds.

**Check all principal teaching methods used during this rotation:**
- [x] Attending teaching and management rounds
- [x] Patient Management discussions
- [x] Individual instruction of procedures
- [x] Review of diagnostic studies, including radiology
- [x] Other: _____________________________

**Describe the most important educational content, including the mix of diseases, patient characteristics, types of clinical encounters, procedures and services:**
Residents care for patients with a broad mix of general medical illnesses. The service attending is the physician of record for patients without a designated physician who comprise much of the service. The service attending teaches on all patients. Clinical encounters include bedside rounds, work rounds, attending rounds, direct primary care by R-1’s and clinical evaluation and supervision by upper level residents. Procedures are done by R-1’s when appropriate under the guidance and supervision of a certified resident and the attending.
Check the principal ancillary education materials used:
[x] Reading lists
[x] Radiologic studies
[x] Other noninvasive studies
[x] Core conferences
[x] Pathologic material

Methods used to evaluate the resident and the rotation:
[x] Evaluation of resident performance by attending
[x] Evaluation of attending teaching skills and other attributes by resident
[x] Review of the resident’s history/physical exam, progress notes and documentation of procedures in the chart.
[x] Mini CEX
[x] Resident’s attendance of rounds and conferences monitored
[x] Evaluation of resident performance by peers
MEDICAL INTENSIVE CARE UNIT: (PGY-I, 4 weeks)

Overview

Your experiences on the Critical Care Units will be a process for learning and developing your clinical skills and management of the most complex and challenging cases. This rotation has been developed based on the ACGME outlined competencies with special emphasis in applying them on the critically ill.

You will be supervised by an attending on the Critical Care faculty. You will be responsible for assisting in the initial evaluation of the critically ill and will formulate plans directed at their evaluation and proposed treatment. The MICU at AdventHealth East Orlando is supervised by Drs. Mahmood Ali and Eugene Go. Dr. Nazario serves as the faculty liaison.

Learning Resources

Didactic lectures with the attending, bedside rounds in the ED and the respective Critical Care area. There will be assigned readings and review articles. You will be expected to perform literature searches of medical conditions experienced by your patients during your rotation.

Goals & Objectives

Patient Care

1. Communicate effectively and demonstrate caring, respectful behaviors when interacting with patients and their families.
2. Identify the important syndromes in critical care medicine and outline their general management.
3. Learn to focus on the critical care differential diagnoses in the appropriate clinical settings.
4. Use the clinical history, laboratory and radiologic studies to derive a critical care differential diagnosis for a given critically ill patient.
5. Take a careful history including travel, occupational, and environmental exposures to aid in the development of a differential diagnosis in the critically ill.
6. Counsel and educate patients and their families.

Medical Knowledge

1. Understand the approach to the critically ill patient.
2. Develop the ability to rapidly evaluate, diagnose, stabilize, and make a disposition on critically ill adult patients.
3. Learn respiratory, cardiovascular, renal and neurologic physiology and the pathophysiology of trauma, shock, sepsis, cardiac failure, and respiratory failure that affect critically ill patients.
4. Learn the principles of medical instrumentation and hemodynamic monitoring and be able to utilize them in the care of critically ill patients.
5. Learn the indications and develop the technical skills needed to perform diagnostic and therapeutic interventions in critically ill patients.
6. Learn the rational use of laboratory, radiographic and other diagnostic tests in the management of critically ill patients.
7. Demonstrate the ability to perform the following procedures: oral endotracheal intubation, nasotracheal intubation, cricothyrotomy, needle thoracostomy, tube thoracostomy, central intravenous placement, pulmonary artery catheter placement, trans-venous cardiac pacing, arterial line placement, and indwelling urinary-bladder catheterization.
8. Demonstrate the ability to use and interpret data from ECG's and monitors, cardiac outputs, hemodynamic monitoring, arterial blood gases, pulse oximetry, end-tidal CO2 monitors and ventilators.
9. Describe the dosages, indications and contraindications of pharmacological interventions for shock, cardiac failure, dysrhythmias, sepsis, trauma, respiratory failure, hepatic failure, renal failure, and neurologic illnesses.
10. Demonstrate the ability to manage a patient on a ventilator.
11. Demonstrate appropriate judgment in the management of critically ill patients.
12. Demonstrate appropriate prioritization of diagnostic and therapeutic interventions in critically ill patients.
13. Demonstrate ability to diagnose and treat shock, sepsis, fluid and electrolyte abnormalities, cardiac failure, cardiac dysrhythmias, renal failure, hepatic failure, and toxicological emergencies.

Practice Based Learning and Improvement

1. Search and integrate evidence of scientific studies to their patient’s health problems.
2. Using a systematic methodology, residents will apply practice based improvement activities to develop and implement treatment plans to help manage patients who are critically ill.
3. Residents are expected to support their own education with the use of on-line medical journals and technology to be able to improve patient care.
4. Search information based on their diverse patient population census.

Interpersonal and Communication Skills

1. Communicate the diagnosis, treatment plan and prognosis with empathy to the patients and their families.
2. Respect patient confidentiality.
3. Work effectively with medical students, residents on rotating services, consultants and nursing staff.
Professionalism

1. Residents are expected to arrive on time daily. They must be dressed in professional
dress and be ready for work.
2. Demonstrate respect, compassion and empathy for every patient and their family
members.
3. Be committed to the ethical principles in all aspects of critical care including patient
confidentiality and informed consent.
4. The resident should be sensitive to the patient’s culture, gender, age and disabilities.

System Based Practice

1. Residents will learn to develop, evaluate and implement treatment plans for the critically
ill.
2. Will learn when to obtain consultations from Critical Care specialists and relevant
subspecialists.
3. Will develop the ability to select the most cost effective treatment plans for critically ill
patients while meeting national quality standards.
4. Learn to advocate for patient safety measures.

Methods of Achieving Goals

1. Management of patients in critical care units.
4. Certification as ACLS Provider/Instructor.
5. Attendance at daily teaching rounds and any M&M rounds.
6. Attendance at Emergency Medicine lectures on critical care topics.

Evaluation and Feedback on Goal Achievement

1. Formal written evaluation by Critical Care attending staff.
2. Resident feedback:
   A. Evaluation at end of rotation.
   B. Semi-annual resident evaluation.
3. Successful completion of ACLS Provider/Instructor Courses.
4. Performance on In-Training Examination.
Overview

Your experience during the patient-care experience on the rotation will be the process for learning and to develop your clinical skills and management of neurosurgical conditions. This rotation has been developed based on the ACGME outlined competencies with emphasis on applying them on neurosurgery patients.

You will be supervised by a neurosurgical faculty member. You will also be responsible for assisting the team with the initial evaluation of patients and will formulate a plan for their evaluation and treatment. You will also present to the attending faculty member during rounds. As a senior resident on service in the neuro-intensive care unit you will direct resuscitations and are allowed to independently perform procedures such as arterial catheterization, endotrachael intubation, central line placement, and ventilator management. The resident is expected to take call during the month averaging every third night.

Learning Resources

Didactic lectures with the attending, bedside rounds on all new consults and hospital follow ups, assigned readings and review articles. During the discussions, physiology, pathogenesis, clinical presentations and natural history of disorders are reviewed. Relevant topics of Up to Date will be assigned. You are also expected to perform routine searches of the medical literature relevant to the patient care issues encounter during your rotation. The hospital provides a wide variety of medical journals available on-line free of charge.

Goals and Objectives

Medical Knowledge

1. Discuss principles of resuscitation of multi trauma patients including appropriate fluid resuscitation, and explain the anticipated effects of shock and resuscitation on fluid shifts and electrolyte balance.

2. Name an initial choice for intravenous fluids for a newly admitted Neuro Intensive Care Unit (NICU) patient with the following diagnoses and explain changes in that choice based upon specific changes in the patient's diagnosis, clinical condition, electrolyte and volume status:
   a. head injury
   b. stroke
   c. tumor
   d. infection
   e. hydrocephalic

3. Propose appropriate initial ventilator settings for patients with different types of common
neurosurgical conditions and explain changes in that choice based upon specific changes in the patient's metabolic or pulmonary status.

4. List the mechanisms of action and potential complications of agents used to treat shock.

5. Discuss indications, pharmacologic mechanism, duration of action, and effect on the neurologic examination for sedative, paralytic, and analgesic agents commonly used in the NICU.

6. Explain the indications, advantages, and risks for various hemodynamic monitoring tools (e.g., pulmonary artery catheters, indwelling arterial lines) used in critically ill patients.

7. Discuss the pathophysiology and management of coagulopathy after head injury.

8. Describe basic principles of nutritional management in neurosurgical critical care.


10. Outline basic principles of NICU management of patients with spinal cord injury.

11. Name the major structures supplied by the major vessels of the brain and spinal cord.

12. Discuss the evaluation, treatment, and prognosis of subarachnoid hemorrhage, both traumatic and spontaneous.

13. Explain the pathophysiology and treatment of cerebral vasospasm.

14. Formulate a diagnosis and treatment plan for patients with cerebral ischemia.

15. List principles of rehabilitation of different types of neurosurgical patients.

16. Define brain death and discuss methods of making such a diagnosis.

**Patient Care**

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.

2. Identify the common and important neurologic conditions and outline general management.

3. Use the clinical history, laboratory, and X-ray database to derive a differential diagnosis for a given patient.

4. Take a careful history including travel, sexual, occupational, and environmental exposures to aid in the differential diagnosis of your patients.

5. Counsel and educate patients and their families.

**Practice Base Learning and Improvement**

1. Search and integrate evidence of scientific studies related to their patients’ health problems.

2. Using a systematic methodology, residents will apply practice base improvement activities to develop and implement treatment plans to help manage patients with neurosurgical emergencies.

3. Support their own education with the use of online medical journals and technology to be able to improve or contribute in improving patient care.

4. Search information based on their diverse patient population census.

**Interpersonal and Communication Skills**

1. Communicate the diagnosis, treatment plan and follow up care with sensibility and empathy to the patients and family.

2. Develop an ethically-based relationship with patients and family to be able to give the best therapeutic care.

3. Respect patient confidentiality for sensitive issues.
4. Work effectively with medical students, residents from other services, consultants and nursing staff

**Professionalism**
1. It is expected that the resident will arrive on time every day and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity, and empathy to every patient
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent
4. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.
5. Overcome stereotyping and negative attitudes toward all patients.

**System Based Practice**
1. Residents will learn to develop, implement and evaluate treatment plans for neurosurgical patients.
2. Will learn when to obtain consultations from neurosurgical specialists
3. Will develop the ability to select the most cost effective treatment plans for patients always meeting the national quality standards
4. Residents will learn the different roles of the subspecialty clinics
5. Learn to advocate for quality patient care

**Methods of Achieving the Goals**
1. Management of patients in the Emergency Department and Neurointensive care unit.
3. Attendance at teaching rounds and Neuroscience conferences.
4. Attendance at Emergency Medicine lectures on neurosurgical conditions.

**Evaluation and Feedback on Goal Achievement**
1. Written formal evaluation by Neurosurgical attending physician staff
2. Resident feedback:
   A. Evaluation at end of rotation.
   B. Semi-annual resident evaluation.
3. Performance on In-Training examination.
**OBSTETRICS/GYNECOLOGY (PGY-I, 4 weeks)**

The Emergency Medicine residents rotate in the Obstetrics and Gynecology (Ob/Gyn) service at the EM1 level. The program is extremely pleased with the educational opportunities offered to the Emergency Medicine residents as they rotate through this service. The purpose, educational objectives, methods, resident responsibilities, educational materials, as well as interdepartmental relationships are outlined below. These objectives will be accomplished by way of direct patient care, evaluation of patients as they are admitted and within the emergency department, daily supervisory rounds in which specific patients and illnesses are discussed, weekly grand rounds, as well as formal daily conferences devoted to specific subject matters. Upon completion of the month’s rotation, residents will receive written evaluations from the attending staff. These evaluations will focus specifically on patient assessment and management skills, as well as completion of educational objectives. The focus of the end of rotation evaluations will be the completion of Core Competency objectives. The Program Director and Associate/Assistant Program Director will review all evaluations and make them available to the resident during regular business hours. The faculty preceptor at AH Orlando is Dr. M. Crider. The faculty supervisor is Dr. C. Molins.

**Purpose**
1. Learn the anatomy, pathophysiology, presentation, and management of common Obstetrics and Gynecology system disorders.
2. Develop skills in the performance of screening and detailed evaluation of Obstetrics and Gynecology patients.
3. Develop skills in the use and performance of diagnostic procedures in the evaluation of Obstetrics and Gynecology patients.
4. Integrate components of the ACGME-defined Core Competencies into the resident’s practice of emergency medicine, including patient care, expanded medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

**Educational Objectives**

**Patient Care**
1. Gather accurate, essential information in a timely manner from all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic procedures.
2. Integrate diagnostic information and generate an appropriate differential diagnosis.
3. Competently perform obstetrics and gynecology therapeutic procedures considered essential to the practice of emergency medicine.
4. Demonstrate ability to appropriately prioritize and stabilize multiple patients and perform other responsibilities simultaneously.
Medical Knowledge
1. Demonstrate ability to adequately perform gynecologic history and exam.
2. Discuss pathophysiology and clinical presentation of the following conditions:
   a. abnormal vaginal bleeding
   b. pelvic inflammatory disease
   c. sexually transmitted diseases
   d. vaginal discharge
   e. acute and chronic pelvic pain
   f. ectopic pregnancy
   g. hydatidiform mole
   h. hyperemesis gravidarum
   i. premature rupture of membranes
   j. pre-eclampsia / eclampsia
   k. placenta previa
   l. abruptio placenta
   m. third trimester vaginal bleeding
   n. ovarian torsion
   o. Contraceptive methods
   p. culdocentesis
3. Demonstrate ability to adequately perform vaginal deliveries in the various presentations.
4. List the indications for cesarean section and for post-mortem cesarean section.
5. Discuss the clinical characteristics and emergency management of incomplete, threatened, and complete abortion.
6. Demonstrate ability to diagnose postpartum complications including retained products, endometritis, and mastitis.
7. Discuss the adequate procedure in the evaluation of sexual attack victims.

Practice – Based Learning
1. Locate, appraise, and assimilate evidence from scientific studies related to the health problems of their patients.
2. Obtain and use information about their own population of patients and the larger population from which the patients are drawn.
3. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
4. Use information technology to manage information, access online medical information, and support their own education.
5. Facilitate the learning of students and other health care professionals.

Professionalism
1. Arrive on time and prepared for work.
2. Appropriate (inoffensive) dress and cleanliness.
3. Appropriate use of symptomatic care.
4. Complete medical records honestly and punctually.
5. Treat patients/family/staff/paraprofessional personnel with respect.
6. Protect staff/family/patient’s interests/confidentiality.
7. Demonstrate sensitivity to patient’s pain, emotional state, and gender/ethnicity issues.
8. Actively seek feedback and immediately self-corrects.
9. Unconditional positive regard for the patient, family, staff, and consultants.
10. Accept responsibility/accountability.
11. Open/responsive to input/feedback of other team members, patients, families, and peers.
**Interpersonal and Communication Skills**

1. Demonstrate ability to perform adequate history and physical examinations in patients with obstetrics and gynecology disorders.
2. Demonstrate the ability to respectfully, effectively, and efficiently develop a therapeutic relationship with patients and their families.
3. Demonstrate respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences in patients and other members of the health care team.
4. Demonstrate effective listening skills and be able to elicit and provide information using verbal, nonverbal, written, and technological skills.
5. Demonstrate ability to develop flexible communication strategies and be able to adjust them based on the clinical situation.
6. Demonstrate effective participation in and leadership of the health care team.
7. Demonstrate ability to negotiate as well as resolve conflicts.
8. Demonstrate effective written communication skills with other providers and to effectively summarize for the patient upon discharge.
9. Demonstrate ability to effectively use the feedback provided by other.

**Systems- Based Practice**

1. Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care.
2. Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
3. Practice cost-effective health care and resource allocation that does not compromise quality of care.
4. Advocate for and facilitate patients’ advancement through the health care system.

**Methods of Achieving Goals and Objectives**

1. Management of patients in OB/GYN Outpatient Clinic.
2. Management of patients in Labor and Delivery.
3. Management of sexual assault patients in the Crisis Center.
4. Management of patients on Emergency Department rotations.
5. Attendance at OB/GYN rounds.
6. Attendance at Emergency Medicine lectures.

**Resident Responsibilities**

The program has designed a four-week rotation in the Obstetrics and Gynecology Department at the AdventHealth East Orlando Medical Center. The Emergency Medicine (EM) residents will:

1. Spend four weeks with the Ob/Gyn team and will participate in direct patient care under attending supervision at all times.
2. Have the same duties and responsibilities as a first year resident of the Family Medicine residency program while rotating Ob/Gyn service.
3. Be assigned to the obstetrics evaluation room, areas of acute care and evaluation.
4. Be on duty as frequently as any Family Medicine PGY-I.
5. Attend lectures, journal clubs and other academic activities of the Department during the rotation. The trainee is encouraged to actively participate in these activities.

6. Attend the EM program academic activity scheduled every Thursday at 7:00 a.m. The Department of Obstetrics and Gynecology be informed in advance in case of any additional EM academic activities to which the resident must attend.

7. EM 1 Residents will spend one week in night float system while rotating through Ob/Gyn rotation. During that week, and that week only, EM 1 in Ob/Gyn rotation will be excused from the EM program academic activity.

8. EM 1 residents are to follow duty hours rules as specified by ACGME guidelines. It is the responsibility of the Emergency Medicine resident to notify the Emergency Medicine Program Director of potential duty hours violations in order to avoid possible disciplinary action. This will also be monitored through the New Innovations online system.

9. Be called on short notice for duty at the AdventHealth East Orlando ED in case of an emergency or special situation due to an impending or developing disaster.

10. Residents are required to keep a log of the procedures done in this rotation in New Innovations online system.

Educational Material

5. Residents attend Emergency Medicine conferences in which the Obstetrics and Gynecology curriculum is incorporated. Additionally, the Obstetrics and Gynecology attending will review specific topics during the rotation.

6. The education resources and facilities of the AdventHealth East Orlando Medical Center will be available to each resident. These resources include the medical library, including books and periodical reference materials, abstract and literature research services, as well as audio-visual references. Additionally, the medical records department will be available to the resident for completion of charts and chart reviews.

7. Residents will also be required to complete the following reading requirements throughout the Ob/Gyn rotation
   e. Rosen’s Emergency Medicine 7th Ed: Chapters 96,98,175-179
   f. Roberts and Hedges, Clinical Procedures in Emergency Medicine, 5th Ed: Chapters 56-59
   g. Other optional readings are:
      iii. Tintinalli’s Emergency Medicine, 7th Ed: Chapters 99-109

Evaluation

The Obstetrics and Gynecology faculty will evaluate EM residents using the evaluation form provided by the Emergency Medicine Department. Close interaction with supervisors is encouraged in order to maximize learning experiences. The evaluation sheet will be forwarded at the end of the rotation to the Obstetrics and Gynecology Department office. It will then be returned to the EM Department at the AH East Orlando. Obstetrics and Gynecology Department faculty is encouraged to notify Program Director or Associate/Assistant Program Director of any difficulties with an EM resident as soon as these arise, preferably within the first two weeks of the rotation.
In order to pass a rotation, the resident must earn an average score of three (3) (A score of 3 equals “Meets expectations”) or higher in each of the following six general competencies: patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice. A resident who receives two (2) “marginally meets expectations” (assigned score 2) or “fails to meet expectations” (assigned score 1) WILL NOT pass the rotation, regardless of how high the other scores may be.

Each resident’s knowledge will be tested throughout the year specifically with their performance on In-Training examination, simulation performance, procedural competencies and content specific questions throughout the academic year.

**Feedback**

The Program Director and/or Associate/Assistant Program Director are responsible of notifying residents of any problems noted as soon as possible. Written/online evaluations are available for formal review with the residency director at semi-annual progress meetings. At the end of the rotation, the resident will evaluate the strengths and weaknesses of the Obstetrics and Gynecology rotation using the “Clerkship Evaluation Form” available through New Innovations. Feedback will also be given in a semi-annual resident evaluation.
OPHTHALMOLOGY (Selective PGY-I, 2 Weeks)

Overview:
Ophthalmologic emergency is a common presentation to the Emergency department. Understanding common presentations and appropriate management is an invaluable tool for emergency medicine physicians. This rotation will allow you to work with a staff ophthalmologist both in the office setting and in the operating room in order to accomplish these goals. The faculty supervisor is Dr. A. Adewale. The faculty preceptor is Dr. Auerbach.

Goals & Objectives

Medical knowledge:
1. Develop relevant history and physical ophthalmological examination skills.
2. Learn to recognize and treat emergent causes of visual loss.
3. Learn the principles of ocular trauma management.
4. Learn the evaluation and management of common ophthalmologic complaints.
5. Demonstrate an understanding of normal ocular anatomy.
6. Demonstrate ability to perform an ocular exam.
7. Recognize and discuss the differential of abnormal funduscopic findings.
8. Demonstrate the technique of slit lamp examination.
9. Demonstrate ability to measure intraocular pressures.
10. Demonstrate ability to patch an eye.
11. Demonstrate knowledge of the dosages, indications and contraindications of topical and systemic ophthalmologic medications.
12. Discuss the differential diagnosis of acute loss of vision.
13. Discuss the differential diagnosis and demonstrate correct evaluation of patients presenting with a painful eye.
14. Discuss the differential diagnosis and demonstrate correct evaluation of patients presenting with a red eye.
15. Demonstrate ability to evaluate and manage chemical injuries of the eye.
16. Demonstrate ability to evaluate and manage blunt and penetrating trauma to the eye and surrounding tissues.
17. Demonstrate ability to evaluate and manage ocular foreign bodies.
18. Discuss the presenting signs, symptoms and management of acute angle closure glaucoma.
19. Discuss the presenting signs, symptoms and management of orbital and periorbital cellulitis.
20. Describe and identify the various patterns seen on fluorescein staining of the eye.
21. Discuss the ocular manifestations of systemic disease.
22. Discuss the indications for emergent ophthalmologic consultation.
23. Discuss the indications for routine ophthalmologic consultation.

Patient care:
1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Identify the common and important ocular diseases and outline their general management.
3. Learn to focus on ocular disease differential diagnosis in the appropriate clinical setting.
4. Use the clinical history, laboratory, and X-ray database to derive an ocular disease differential diagnosis for a given patient.
5. Take a careful history including travel, sexual, occupational, and environmental exposures to aid in the differential diagnosis of the patient with suspected ocular disease.
6. Counsel and educate patients and their families

Practice Base Learning
1. Search and integrate evidence of scientific studies related to their patients’ ocular problems
2. Using a systematic methodology, residents will apply practice base improvement activities to develop and implement treatment plans to help manage patients with ocular emergencies
3. Support their own education with the use of online medical journals and technology to be able to improve or contribute in improving patient care.
4. Search information based on their diverse patient population census.

Interpersonal and Communication Skills
1. Communicate the diagnosis, treatment plan and follow up care with sensibility and empathy to the patients and family
2. Develop an ethically-based relationship with patients and family to be able to give the best therapeutic care.
3. Respect patient confidentiality for sensitive issues
4. Work effectively with medical students, residents from other services, consultants and nursing staff
5. Have recognition of stigma associated with certain chronic ocular problems unspoken fears and concerns can be addressed.

Professionalism
1. It is expected that the resident will arrive on time every day and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity, and empathy to every patient
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent
4. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.
5. Overcome stereotyping and negative attitudes toward patients with blindness or ocular prosthetics

System Based Practice
1. Residents will learn to develop, implement and evaluate treatment plans for ocular emergency patients
2. Will learn when to obtain consultations from an ophthalmologist
3. Will develop the ability to select the most cost effective treatment plans for ocular
emergency patients in accordance with the national quality standards

4. Learn to advocate for quality patient care

Methods of Achieving Goals:

1. Management of patients in the Eye Clinic.
2. Management of patients on Emergency Department rotations.
4. Attendance at Ophthalmology Rounds.
5. Attendance at Emergency Medicine lectures in Ophthalmology.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Ophthalmology attending physician staff.
2. Written evaluation by Emergency Department attending physician staff.
3. Performance of procedures under supervision.
4. Resident feedback:
   A. Evaluation at end of rotation.
   B. Semi-annual resident evaluation.
5. Performance on In-Training examination.
ORAL & MAXILLOFACIAL SURGERY (Selective/Elective, 2 – 4 Weeks)

Overview

Your experience during the patient-care experience on the rotation will be the process for learning and to develop your clinical skills and management of OMFS conditions. This rotation has been developed based on the ACGME outlined competencies with emphasis on applying them on OMFS patients.

You will be supervised by a faculty member. You will also be responsible for assisting the team with the initial evaluation of patients and will formulate a plan for their evaluation and treatment. You will also present to the attending faculty member during rounds. Dr. Langan is the senior attending in charge of supervising the rotation.

Learning Resources

Didactic lectures with the attending, bedside rounds on all new consults and hospital follow ups, assigned readings and review articles. During the discussions, physiology, pathogenesis, clinical presentations and natural history of oral maxillofacial conditions will be reviewed. Relevant topics of Up to Date will be assigned. You are also expected to perform routine searches of the medical literature relevant to the patient care issues encountered during your rotation. The hospital provides a wide variety of medical journals available on-line free of charge.

Goals and Objectives

Medical Knowledge

1. Become familiar with the diagnosis and treatment of common oral surgery problems, including:
   A. Dental caries.
   B. Alveolar abscess.
   C. Infections of oral mucosa; viral, bacterial, fungal
   D. Oral and maxillofacial trauma.
   E. Oral neoplasia.
2. Develop expertise in the following skills:
   A. Regional nerve blocks.
   B. Plastic closure of intraoral and circum-oral lacerations
   C. Interpretation of diagnostic radiologic studies for facial fractures.
   D. Pharmacological intervention with systemic and topical agents.
3. Learn the evaluation and management of common problems of the head and neck.
4. Learn the evaluation and management of facial trauma.
5. Learn use of the diagnostic imaging modalities available for evaluation of head and neck disorders.
6. Demonstrate ability to correctly perform a history and physical in patients with disorders of the head, ears, nose, pharynx, neck and larynx.
7. Demonstrate ability to diagnose and treat infections of the head and neck including rhinitis, otitis, labyrinthitis, sinusitis, mastoiditis, laryngitis, pharyngitis, epiglottitis, stomatitis, and gingivitis.
8. Demonstrate ability to perform incision and drainage of oropharyngeal abscesses.
9. Demonstrate knowledge of common dental emergencies and indications for emergent referral.
10. Demonstrate ability to evaluate and manage disorders of the mandible, including fractures, dislocations, and infections.
11. Demonstrate ability to evaluate and manage trauma to the head, neck, face, teeth.
12. Demonstrate ability to diagnose and treat disorders of the salivary glands.
13. Demonstrate knowledge of uncommon but life threatening infections of the head and neck including cavernous sinus thrombosis, Ludwig’s angina, and malignant otitis.

Patient Care
1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Identify the common and important maxillofacial conditions and outline general management.
3. Use the clinical history, laboratory, and X-ray database to derive a differential diagnosis for a given patient.
4. Take a careful history including travel, sexual, occupational, and environmental exposures to aid in the differential diagnosis of your patients.
5. Counsel and educate patients and their families.

Practice Base Learning and Improvement
1. Search and integrate evidence of scientific studies related to their patients’ health problems.
2. Using a systematic methodology, residents will apply practice base improvement activities to develop and implement treatment plans to help manage patients with maxillofacial conditions.
3. Support their own education with the use of online medical journals and technology to be able to improve or contribute in improving patient care.
4. Search information based on their diverse patient population census.

Interpersonal and Communication Skills
1. Communicate the diagnosis, treatment plan and follow up care with sensibility and empathy to the patients and family.
2. Develop an ethically-based relationship with patients and family to be able to give the best therapeutic care.
3. Respect patient confidentiality for sensitive issues.
4. Work effectively with medical students, residents from other services, consultants and nursing staff.

Professionalism
1. It is expected that the resident will arrive on time every day and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity, and empathy to every patient
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent
4. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.
5. Overcome stereotyping and negative attitudes toward all patients.

**System Based Practice**

1. Residents will learn to develop, implement and evaluate treatment plans for patients
2. Will learn when to obtain consultations from oromaxillofacial specialists
3. Will develop the ability to select the most cost effective treatment plans for patients always meeting the national quality standards
4. Residents will learn the different roles of the subspecialty clinics
1. Learn to advocate for quality patient care

**Methods of Achieving the Goals**

1. Management of patients in the Oral Surgery Clinic.
2. Management of patients on Emergency Department rotations.

**Evaluation and Feedback on Goal Achievement:**

1. Written formal evaluation by Oral & Maxillofacial Surgery attending physician staff.
2. Resident feedback:
   A. Evaluation at end of rotation.
   B. Semi-annual resident evaluation.
3. Performance on In-Training examination.
**PEDIATRIC INTENSIVE CARE UNIT (PGY-II, 4 weeks)**

**Overview**

The pediatric ICU rotation at AHFC helps lay the fundamentals for critical care training. On this rotation, residents are exposed to a wide variety of disease processes ranging from neurosurgery patients to trauma, sepsis, and end organ dysfunction. Residents will learn the recognition and preliminary management of overarching critical care pathophysiologic processes such as respiratory failure, shock, and organ dysfunction. The Pediatric ICU at AHFC is a 22 bed ICU providing care from both medical and surgically critically ill patients. Diagnoses of patients admitted to the PICU include: sepsis, respiratory distress and pneumonia, solid organ/bone marrow transplants, post neurosurgery, post-airway reconstruction, organ failure (kidney, lung, liver, heart), patients with neurologic deterioration, trauma and any other child with rapidly progressive critical illness. Residents will be exposed to a broad range of diagnoses in the ICU and should learn the essentials of managing pediatric patients with critical illness.

- Rotation Director: Kimberly Fenton, MD; Kimberly.fenton.md@flhosp.org
- Rotation Contact Person: Ramin Nazari, MD; Ramin.Nazari.md@flhosp.org
- EM Faculty Liaison: Dennis Hernandez, MD; dmkhern@aol.com

**Evaluation & Feedback**

The methods of evaluation for the PICU will consist of:

1. Global Rating Scales – NI Resident Evaluations, Faculty Evaluations, Rotation Evaluations
2. Verbal feedback from attendings while on the rotation – Be sure to elicit feedback if not provided. These evaluation tools will be included in each resident’s portfolio.

Feedback to the supervisor should be provided by the PICU attending on a weekly basis focusing on competency-based goals and objectives and leadership of a patient care team.

**Goals & Objectives**

The goals and competencies for the rotation listed below are a distilled list derived from the ACGME listing.

1. Recognize an acutely ill child
2. Resuscitation & stabilization of decompensating / arresting pediatric patients
3. Formulating management plans for critically ill patients incorporating clinical assessment and laboratory data
4. Invasive and non-invasive techniques for monitoring the patient
5. Vascular access methods
6. Recognition and management of single & multi-organ system failure
7. Pre-operative and Post-operative management of surgical patients
8. Respiratory management: respiratory failure, asthma, stridor, hypoxia, ARDS, foreign body aspiration
9. Basic ventilator management
10. Cardiac management: heart failure, arrhythmias, congenital heart disease
11. Shock: recognition and appropriate treatment
12. Hepatic failure
13. Renal failure
14. Fluid, electrolytes, and metabolic disorders
15. Infection control / treatment
16. Increased ICP: recognition and treatment
17. Metabolic disorders: DKA, DI, SIADH
18. Drowning
19. Trauma management
20. Acute Abdomen

These core competencies will be achieved by both bedside teaching, various lectures during the rotation as time permitted, and of course by daily care and management of the various ICU patients. See competency-based goals and objectives list starting on next page.
<table>
<thead>
<tr>
<th>Resident Objectives</th>
<th>Instructional Strategies</th>
<th>Assessment of Competence</th>
<th>ACGME Competency Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Discuss the settings on a ventilator and identify the physiologic changes adjustments are likely to generate (PGY2, PGY3)</td>
<td>bedside teaching</td>
<td>Observation on rounds and in the course of patient care</td>
<td>PC—Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems. MK—Demonstrate knowledge evolving sciences and apply this knowledge to patient care</td>
</tr>
<tr>
<td>2. Demonstrate ability to initiate and titrate non-invasive mechanical ventilation (PGY2, PGY3)</td>
<td>bedside teaching</td>
<td>Questioning during bedside teaching</td>
<td>PC—Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems. MK—Demonstrate knowledge evolving sciences and apply this knowledge to patient care</td>
</tr>
<tr>
<td>3. List indications for invasive and non-invasive mechanical respiratory support (PGY2)</td>
<td>patient care bedside teaching</td>
<td>Observation on rounds and in the course of patient care</td>
<td>PC—Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems. MK—Demonstrate knowledge evolving sciences and apply this knowledge to patient care</td>
</tr>
<tr>
<td>4. Interpret arterial blood gas measurements (PGY2, PGY3)</td>
<td>patient care presentations on rounds</td>
<td>Observation on rounds with immediate feedback on accuracy of interpretation</td>
<td>PC—Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems. MK—Demonstrate knowledge evolving sciences and apply this knowledge to patient care</td>
</tr>
<tr>
<td>5. Describe the properties of commonly used paralytic agents and indications for use in a ventilated patient</td>
<td>patient care presentations on rounds</td>
<td>Observation on rounds with immediate feedback</td>
<td>PC—Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems. MK—Demonstrate knowledge evolving sciences and apply this knowledge to patient care</td>
</tr>
<tr>
<td>6. List indications for mechanical ventilation (PGY2, PGY3)</td>
<td>patient care rounds</td>
<td>Discussion on rounds</td>
<td>PC—Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems. MK—Demonstrate knowledge evolving sciences and apply this knowledge to patient care</td>
</tr>
<tr>
<td>7. Define, identify, and list strategies for the management and prevention of acute lung injury and ARDS</td>
<td>patient care rounds</td>
<td>Observation on rounds in the course of patient care</td>
<td>PC—Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems. MK—Demonstrate knowledge evolving sciences and apply this knowledge to patient care</td>
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### Goal 2. Develop familiarity with sedation in an ICU setting

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</thead>
</table>
| 1. List the commonly used narcotics and sedatives and describe their distinct properties (duration of effect, analgesic vs. anesthetic vs. both, side effects, important adverse effects) (PGY2) | Independent reading: "Sedation in the ICU" (Pediatric ICU Resident Handbook Page 109-116)  
Patient care | Direct observation of sedation on rounds  
Verbal feedback from attending | PC — Provide effective healthcare services  
MK — Demonstrate Knowledge evolving sciences and apply this knowledge to patient care |

### Goal 3. Develop familiarity with common medical conditions requiring intensive care

<table>
<thead>
<tr>
<th>Resident Objectives</th>
<th>Instructional Strategies</th>
<th>Assessment of Competence</th>
<th>ACGME Competency Goals</th>
</tr>
</thead>
</table>
| 1. Demonstrate the ability to initiate care for a patient with DKA  
FE characteristics that inform care  
Initial laboratory studies  
Initial fluid management  
Serial laboratory studies  
Adjustments in fluid management (PGY1, PGY2) | Participation in patient care or rounds  
Reading: "DKA" (Pediatric ICU Resident Handbook Page 113-114) | Review of resident orders  
Direct observation of patient care | PC — Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems  
MK — Demonstrate Knowledge evolving sciences and apply this knowledge to patient care |
| 2. Review the physiologic consequences of liver failure  
Cirrhosis  
Hypoproteinemia  
Sulfur accumulation  
Hepatocellular syndrome | Participation in patient care  
Reading: "Acute Renal Failure" (Pediatric ICU Resident Handbook Page 146-152) | Direct observation | PC — Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems  
MK — Demonstrate Knowledge evolving sciences and apply this knowledge to patient care |
| 3. Review the physiologic consequences of renal failure  
Electrolyte disturbance  
 Fluid overload  
Hemotologic disturbance  
Hypertension  
Immune compromise | Participation in patient care  
Reading: "Liver Failure" (Pediatric ICU Resident Handbook Page 92-101) | Direct observation | PC — Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems  
MK — Demonstrate Knowledge evolving sciences and apply this knowledge to patient care |
| 4. Illustrate an understanding of management of increased ICP  
Signs and symptoms reflective of elevated ICP  
Treatment of acutely herniating patient  
Approach to increased ICP | Participation in patient care  
Reading: "ICP" (Pediatric ICU Resident Handbook Page 92-101) | Direct observation by attending | PC — Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems  
MK — Demonstrate Knowledge evolving sciences and apply this knowledge to patient care |
### Goal 4: Demonstrate competency in handling end-of-life issues

<table>
<thead>
<tr>
<th>Resident Objectives</th>
<th>Instructional Strategies</th>
<th>Assessment of Competence</th>
<th>ACGME Competency Goals</th>
</tr>
</thead>
</table>
| 1. Understand the considerations involved in decision to withdraw support | • Attending example  
• Reading “End-of-Life Issues” | • Observation in the context of patient care | P—Demonstrate commitment to carrying out professional responsibilities and adherence to ethical principles. PLI. Evaluate your care of patients, appraise scientific evidence, and improve care through self-evaluation and lifelong learning. SBP. Be aware and responsive to the larger context of health care, call effectively on the resources in the system to provide optimal care |
| 2. Understand culture-specific content to end-of-life decision making | • Attending example | • Observation in the context of patient care | ISC—Communicate effectively with patients, families, and the public as appropriate across a broad range of socioeconomic and cultural backgrounds. |
| 3. Demonstrate understanding of appropriate timing of discussions with family regarding DNR/DNI status (allowing for natural death) | • Attending example  
• Reading “End-of-Life Issues” | • Observation in the context of patient care | ISC—(a) Communicate effectively with physicians, other health professionals, and health-related agencies; (b) Work effectively as a member or leader of a health care team |
| | • Attending example  
• Patient care  
• Reading “End-of-Life Issues” | • Observation in the context of patient care | SBP—Be aware and responsive to the larger context of health care. Call effectively on the resources in the system to provide optimal care. ISC—(a) Communicate effectively with physicians, other health professionals, and health-related agencies; (b) Work effectively as a member or leader of a health care team |

### Goal 5: Acquire ability for overall assessment of a critically ill child

<table>
<thead>
<tr>
<th>Resident Objectives</th>
<th>Instructional Strategies</th>
<th>Assessment of Competence</th>
<th>ACGME Competency Goals</th>
</tr>
</thead>
</table>
| 1. Incorporate FE findings into development of plan of care | • Bedside rounds and rounds with feedback on rounds | • Attending feedback on the course of patient care  
• PR evaluation | FC—Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems |

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1. Incorporate data from telemetry monitoring equipment in development of plan of care
   - Pulse oximetry (POT1, POT3)
   - Heart rate (POT2, POT3)
   - BP (POT2, POT3)
   - Cardiac tracing (POT1, POT3)
   - End tidal CO2 (POT2, POT3)
   - Intravascular and non-invasive SB (POT2, POT3)
   - CVP (POT2, POT3)
   - ICP monitor (POT3)

<table>
<thead>
<tr>
<th>Rounds</th>
<th>Pre-rounds and rounds with feedback on rounds</th>
<th>Direct observation followed by timely verbal feedback</th>
<th>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems</th>
</tr>
</thead>
</table>

2. Incorporate information from ancillary studies in development of plan of care
   - Review radiology results prior to rounds
   - Review laboratory results prior to rounds

<table>
<thead>
<tr>
<th>Rounds</th>
<th>Pre-rounds and rounds with feedback on rounds</th>
<th>Direct observation during rounds with on-the-spot verbal feedback</th>
<th>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems</th>
</tr>
</thead>
</table>

3. Demonstrate an understanding of the indications for initiation of various invasive and non-invasive monitoring modalities, e.g.
   - Pulse oximetry
   - Heart rate
   - Cardiac tracing
   - End tidal CO2
   - Intravascular and non-invasive EF
   - CVP
   - ICP monitor

| Rounds | Direct observation during rounds | Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems |
### Goal 5. Understand the assessment, classification and management of patients in shock

<table>
<thead>
<tr>
<th>Resident Objectives</th>
<th>Instructional Strategies</th>
<th>Assessment of Competence</th>
<th>ACGME Competency Goals</th>
</tr>
</thead>
</table>
| 1. List the causes and contrasting characteristics of septic, cardiogenic, and hypovolemic shock (PGY 1) | • Reading: “Shock”, “Shock Tables”  
(Pediatric ICU Resident Handbook Page 55-60) | • Direct observation during rounds with verbal feedback | MK—Demonstrate knowledge evolving science and apply this knowledge to patient care. |
| 2. Measure a patient in shock utilizing treatment in sepsis | • Reading: “Shock”, “Shock Tables”  
(Pediatric ICU Resident Handbook Page 55-60) | • Direct observation during rounds with verbal feedback | MK—Demonstrate knowledge evolving science and apply this knowledge to patient care. |
| 3. List the commonly used inotropes and vasopressors and identify their indications | • Independent reading: “Inotropes and Vasopressors”, “Inotropes”  
(Pediatric ICU Resident Handbook Page 59-61)  
- DOPAMINE  
- Dobutamine  
- Epinephrine  
- Norepinephrine  
- Milrinone  
- Vasopressin  
- Phenylephrine (PGY 3) | • Direct observation during rounds with verbal feedback | MK—Demonstrate knowledge evolving science and apply this knowledge to patient care. |
<table>
<thead>
<tr>
<th>Goal 7. Demonstrate competency in resuscitation and stabilization of an acutely decompensating or arresting child</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resilient Objectives</strong></td>
</tr>
<tr>
<td>1. Rete participates in a code or mock code addressing one of the following scenarios required of each life support unit:</td>
</tr>
<tr>
<td>- Bradycardia with poor perfusion</td>
</tr>
<tr>
<td>- Ventricular fibrillation</td>
</tr>
<tr>
<td>- Ventricular tachycardia</td>
</tr>
<tr>
<td>- Pulseless ventricular tachycardia</td>
</tr>
<tr>
<td>- Asystole/PEA (POT 2, PHT 3)</td>
</tr>
<tr>
<td>2. Rete the PALS algorithm for the following code scenarios:</td>
</tr>
<tr>
<td>- Bradycardia with poor perfusion</td>
</tr>
<tr>
<td>- Ventricular fibrillation</td>
</tr>
<tr>
<td>- Ventricular tachycardia</td>
</tr>
<tr>
<td>- Pulseless ventricular tachycardia</td>
</tr>
<tr>
<td>- Asystole/PEA (POT 2, PHT 3)</td>
</tr>
<tr>
<td>3. Demonstrates the correct use of a defibrillator and carries out the following steps:</td>
</tr>
<tr>
<td>- Indications</td>
</tr>
<tr>
<td>- Pad/paddle position</td>
</tr>
<tr>
<td>- Selection of voltage</td>
</tr>
<tr>
<td>- Safety steps (POT 2)</td>
</tr>
<tr>
<td><strong>Instructional Strategies</strong></td>
</tr>
<tr>
<td>1. Mask codes</td>
</tr>
<tr>
<td>2. CAPE (prior to start of rotation)</td>
</tr>
<tr>
<td>3. PALS manual</td>
</tr>
<tr>
<td>4. PALS cards</td>
</tr>
<tr>
<td><strong>Assessment of Competence</strong></td>
</tr>
<tr>
<td>1. Direct observation with feedback from code process</td>
</tr>
<tr>
<td><strong>ACME Competency Goals</strong></td>
</tr>
<tr>
<td>1. MK - Demonstrate knowledge evolving science and knowledge in patients care to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems.</td>
</tr>
<tr>
<td>2. SC - Demonstrate effective communication with physicians, other health professionals, and health-related agencies.</td>
</tr>
<tr>
<td>3. Work effectively as a member or leader of a health care team.</td>
</tr>
</tbody>
</table>
### Goal 8. Develop skills in pre and post-operative management in patients requiring post-operative intensive care

<table>
<thead>
<tr>
<th>Resident Objectives</th>
<th>Instructional Strategies</th>
<th>Assessment of Competence</th>
<th>ACGME Competency Goals</th>
</tr>
</thead>
</table>
| Understand management of and potential complications from surgical procedures (intracranial procedures, airway reconstruction, major orthopedic and plastic surgery procedures, solid organ transplants)  
- Fluid and electrolyte imbalance  
- Bleeding  
- Diffuse sepsis  
- Hypodynamic state  
- Infection  
- ICP change  
- Primary dysfunction of compliant organs (PGY12, PGY13) | Participation in patient care or rounds  
Surgical attendings | Direct observation |  
NP — Demonstrate knowledge of evolving sciences and apply this knowledge to patient care  
PAC — Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems |

### Goal 9. Demonstrate competency in airway management and respiratory support

<table>
<thead>
<tr>
<th>Resident Objectives</th>
<th>Instructional Strategies</th>
<th>Evaluation</th>
<th>ACGME Competency Goals</th>
</tr>
</thead>
</table>
| Understand differences between oxygen delivery devices and their indications  
Standard nasal cannula  
High flow nasal cannula  
Simple face mask  
Partial rebreathing mask  
Non-rebreathing mask (PGY 1, 2, 3) | Independent reading: “Airway Management” (Pediatric ICU Resident Handbook Page 25-34)  
Basie care | Discussion, case-based  
Lecture |  
PAC — Provide effective health care services  
NP — Demonstrate knowledge of evolving sciences and apply this knowledge to patient care |
Basie care | Direct observation |  
PAC — Provide effective health care services  
NP — Demonstrate knowledge of evolving sciences and apply this knowledge to patient care |
| Demonstrate correct technique in endotracheal intubation, including preparation for intubation  
Selection of appropriate equipment (blades type and size, ET, suction) | Independent reading: “Airway Management” (Pediatric ICU Resident Handbook Page 25-34)  
Basie care | Direct observation |  
PAC — Provide effective health care services  
NP — Demonstrate knowledge of evolving sciences and apply this knowledge to patient care |

PBLI = practice-based learning and improvement  
ICS = interpersonal and communication skills  
P = professionalism  
NP = medical knowledge  
PAC = patient care  
SRP = systems-based practice
RADIOLOGY SERVICE (Longitudinal)

Overview

The ability to interpret basic radiograph and CT-scans is needed to facilitate flow and throughput in the emergency department. Developing these skills is an integral part of the emergency medicine training. This is a longitudinal service that’s developed based on the ACGME outlined competencies with emphasis on applying them to patient care. The faculty supervisor is Dr. S. Nazario and the preceptor is Dr. L. Bancroft.

Goals & Objectives

This longitudinal service is modeled to meet the ACGME competencies listed below:

Patient Care

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Identify the common and important radiographic diagnosis and outline their general management.
3. Learn to focus on the radiographic findings differential diagnosis in the appropriate clinical setting.
4. Use the clinical X-ray findings to corroborate history and physical examination findings.
5. Take a careful history including travel, sexual, occupational, and environmental exposures to aid in the differential diagnosis of the patient with suspected infection.
6. Counsel and educate patients and their Families.

Medical Knowledge

1. Develop the ability to select and interpret a wide variety of radiologic images.
2. Learn use of the diagnostic imaging modalities available to the radiologic specialist such as contrast material, ultrasound, nuclear medicine, computed tomography and magnetic resonance imaging (MRI).
3. Describe how conventional radiographic projections are defined (i.e. A.P., P.A., etc.).
4. Learn to distinguish a nutrient artery from a fracture.
5. Describe the five classifications of Salter-Harris fractures.
6. Develop the ability to know how and when skull and facial films are indicated and how to interpret them.
7. Demonstrate the ability to evaluate cervical spine radiographs (i.e. lines of integrity, open mouth, prevertebral space, pseudosubluxation of C2-C3). 
8. Describe the abnormality mechanism, and radiographic findings of the following fractures: hangman’s clay shoveler’s compression or wedge, teardrop, odontoid, and Jefferson (“burst”).
9. Review the anatomy of the thoracic and lumbosacral spine on A.P. and lateral.
10. Demonstrate the ability to interpret a normal chest x-ray.
11. Describe the significance of upper, lower, and pediatric rib fractures.
12. Describe some of the classic findings for pulmonary edema, emboli, and ARDS.
13. Review normal anatomy as seen in abdominal, upright plain films.
14. Review the normal anterior, posterior, and lateral pelvic anatomy.
15. Review the normal skeletal anatomy of the upper extremity and lower extremity, alone
   with common fractures.
16. Demonstrate knowledge of contrast medium reactions and methods of prophylaxis and
   prevention.
17. List an indication for barium enema in the Emergency Department.
18. Describe the study of choice for evaluating patients with possible traumatic rupture of the
   aorta and when it is ordered.
19. Discuss an approach to evaluate the lower extremities in the diagnosis of deep venous
   thrombosis.
20. Describe how ultrasound is used in diagnosing appendicitis.
21. Review the normal CT anatomy of the head and its inner structure along with subdural,
    epidural, SAH, and contusions.
22. Review the normal CT anatomy of the chest, abdomen, and pelvis.
23. Describe in basic terms how nuclear medicine imaging is done.
24. Discuss when the bone scan is most useful in diagnosing osteomyelitis.
25. Choose the clinical situation in which MRI is useful in the Emergency Department.
26. Describe in basic terms how MRI functions and any hazards of its use.

Practice Base Learning and Improvement

1. Search and integrate evidence of scientific studies related to their appropriate radiograph
   for specific disease process
2. Using a systematic methodology, residents will apply practice base improvement
   activities to develop and implement treatment plans to help manage patients with
   infectious diseases diagnosed by radiography
3. Support their own education with the use of on line medical journals and technology to
   be able to improve or contribute in improving patient care.
4. Search information based on their diverse patient population census.

Interpersonal and Communication Skills

1. Communicate the diagnosis, treatment plan and follow up care with sensibility and
   empathy to the patients and family
2. Develop an ethically-based relationship with patients and family to be able to give the
   best therapeutic care.
3. Respect patient confidentiality for sensitive issues
4. Work effectively with medical students, residents from other services, consultants and
   nursing staff
5. Have recognition of stigma associated with certain infections (tuberculosis, STD’s, HIV)
   so that patients’ unspoken fears and concerns can be addressed.

Professionalism
1. It is expected that the resident will arrive on time every day and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity, and empathy to every patient
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent
4. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.
5. Overcome stereotyping and negative attitudes toward patients with foreign bodies in unusual orifices

**System Based Practice**

1. Residents will learn to develop, implement and evaluate treatment plans by determining the utilization of appropriate radiographic studies
2. Will learn when to obtain direct communication with radiologists to expedite official interpretation of a particularly troublesome findings on the radiograph
3. Will develop the ability to select the most cost effective resource utilization that meets the national quality standards
4. Learn to advocate for quality patient care

**Methods of Achieving Goals:**

2. Evaluation of radiographs and other diagnostic modalities while on Emergency Department rotation.
3. Attendance at Radiology teaching rounds and lectures.
4. Attendance at Emergency Medicine lectures in radiology.

**Evaluation and Feedback on Goal Achievement:**

1. Written, formal evaluation as part of Emergency Medicine rotations by Emergency Medicine attending physician staff.
2. Performance on In-Training examination.
**RESEARCH (PGY-III, 2 Weeks)**

**Overview:**
Understanding research methodologies is needed to appropriately interpret publications that may change practice patterns. All residents are encouraged to think like a researcher when approaching every aspect of patient care. This service provides that foundation while facilitating the completion of the residents’ scholarly research activities.

**Competency based Objectives**

**Patient Care**

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Identify the common and important landmark studies in the field of emergency medicine and its applications to patient care.
3. Learn to focus on the utilization of evidence based treatment in the appropriate clinical setting.
4. Use the clinical history, laboratory, and X-ray database in addition to available evidence to generate differential diagnosis for a given patient.
5. Counsel and educate patients and their Families using the current best practice.

**Medical Knowledge**

1. Demonstrate the skills necessary to write a publishable manuscript by completing a research project.
2. Understand methods of hypothesis development and testing.
3. Understand various types of study design and methodology.
4. Learn various methods of obtaining consent for biomedical research.
5. Understand basic statistical methods.
6. Learn techniques of analyzing biomedical research.
7. Understand the ramifications of ethical considerations in research.
8. Learn the skills to develop a manuscript that is acceptable for publication in a peer-reviewed journal.
9. Understand grants writing and funding of research.
10. Demonstrate an understanding of the advantages and disadvantages of various study designs, including the randomized clinical trial, case-control, cohort, and cross-sectional studies.
11. Demonstrate an understanding of null and alternative hypotheses.
12. Demonstrate an understanding of the practical and ethical ramifications of implied and non-implied consent as they apply to hospital and pre-hospital research.
13. Understand the differences between interval, ordinal, nominal, parametric, and non-parametric data.
14. Understand the differences between independent and dependent variables.
15. Demonstrate an understanding of methodologies and variable types analyzed by the following statistical tests: t-test, analysis of variance, chi-squared, Fischer exact test, and non-parametric tests for interval and nominal data.

16. Demonstrate an understanding of the terms “paired” and “tailed” (one and two).

17. Demonstrate an understanding of type I and type II errors as they relate to sample size and variance.

18. Demonstrate an understanding of alpha, beta, and statistical power.

19. Demonstrate an understanding of the differences between statistical and clinical significance.

20. Define sensitivity, specificity, positive predictive value, and negative predictive value.

21. Define mean, median, mode, standard deviation, and variance.

22. Demonstrate an understanding of confidence intervals.

23. Describe correlation and regression to the mean.

24. Discuss the advantages of single- and double-blind studies.

25. Demonstrate facility with at least one computer statistical program.

26. Demonstrate an understanding of basic ethical issues in research including consent and researchers’ interactions with corporate funding sources.

27. Demonstrate an understanding of research funding.

Practice Base Learning and Improvement

1. Search and integrate evidence of scientific studies related to patient care
2. Using a systematic methodology, residents will apply practice base improvement activities to develop and implement treatment plans to help manage patients with specific medical diagnosis
3. Support their own education with the use of online medical journals and technology to be able to improve or contribute in improving patient care.
4. Search information based on their diverse patient population census.

Interpersonal and Communication Skills

1. Application of available data to educate patient and families about disease processes
2. Develop an ethically-based relationship with patients and family to be able to give the best therapeutic care and advice based on available evidence
3. Respect patient confidentiality for sensitive issues
4. Work effectively with medical students, residents from other services, consultants and nursing staff
5. Able to effectively present findings on assigned journal articles during journal club.

Professionalism

1. It is expected that the resident will arrive on time every day and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity, and empathy to every patient
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent
4. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.

**System Based Practice**

1. Residents will learn to develop, implement and evaluate treatment plans for infectious diseases patients
2. Will learn when how to assess the library resource for current evidence applicable to a specific disease entity
3. Will develop the ability to select the most cost effective treatment plans based on the available data
4. Learn to advocate for quality patient care

**Methods of Goal Achievement:**

1. Attendance at Emergency Medicine lecture and research series.
2. Article presentation, critique, and discussion at Journal Club.
3. Presentations at Emergency Medicine Trauma Conference and Multidisciplinary Trauma Conference.
4. Journal and textbook readings.
5. Research project.
ORTHOPEDIC TRAUMA (PGY II, 4 Weeks)

Overview

Your experience taking care of patients on this service will be a process for learning and developing your clinical skills and management of orthopedic problems. This rotation has been developed based on the ACGME outlined competencies with emphasis on applying them to orthopedic patients.

You will be supervised by Orthopedic faculty members. You will be responsible for assisting the team with the initial evaluation of patients and formulating a plan for their treatment and management which you will present to the attending faculty member during rounds.

Learning Resources

Didactic lectures with the attending, bedside rounds on all new consults and hospital follow-ups in addition to assigned readings. During the discussions physiology, pathogenesis, clinical presentations and natural history of orthopedic disorders are to be reviewed. You are expected to perform routine searches of the medical literature relevant to the patient care issues encountered during your rotation. The faculty preceptor is Dr. Cole and the faculty supervisor is Dr. S. Nazario.

Goals & Objectives

Patient Care

1. Communicate effectively and demonstrate caring, respectful behaviors when interacting with patients and their families.
2. Identify the common and important orthopedic conditions and outline their general management.
3. Learn to focus on an Orthopedic differential diagnosis in the appropriate clinical setting.
4. Use of the clinical history and imaging database to derive a differential diagnosis for the orthopedic patient.
5. Counsel and educating patients and their families.

Medical Knowledge

1. Develop relevant history and physical exam skills.
2. Learn use of the diagnostic imaging modalities available for the evaluation of orthopedic disorders.
3. Develop skill in the evaluation and management of musculoskeletal trauma.
4. Develop skill in the diagnosis and treatment of inflammatory and infectious disorders of the musculoskeletal system.
5. Learn principles of acute and chronic pain management in patients with musculoskeletal disorders.
6. Develop ability to correctly perform a history and physical in patients with musculoskeletal disorders.

7. Demonstrate ability to correctly order and interpret radiographs in patients with orthopedic injuries.

8. Demonstrate understanding of the anatomy, mechanism of injury, presentations, complications, management and prognosis of common musculoskeletal injuries.

9. Demonstrate knowledge of standard orthopedic nomenclature.

10. Demonstrate knowledge of appropriate aftercare and rehabilitation of orthopedic injuries.

11. Demonstrate knowledge of the differences in pediatric and adult skeletal anatomy and indicate how those differences are manifest in clinical and radiographic presentations.

12. Demonstrate ability to apply orthopedic devices, including compressive dressings, splints and immobilizers.


14. Demonstrate ability to prioritize and manage the treatment of orthopedic injuries in multiple trauma patients.

15. Describe the presentation of patients with inflammatory and infectious disorders and demonstrate ability to diagnose and treat them.

16. Demonstrate ability to diagnose and treat soft tissue foreign bodies.

17. Describe the presentations, complications, diagnosis, management and prognosis of patients with human and animal bites.

18. Describe the presentations, complications, diagnosis and management of compartment syndromes.

19. Demonstrate ability to provide regional anesthesia, including hematoma blocks, Bier blocks and radial, ulnar median, axillary, posterior tibial and sural nerve blocks.

20. Discuss the dosages, indications, contraindications and side effects of standard analgesic and sedative agents used to treat patients with acute orthopedic trauma and demonstrate skills in their use.

21. Discuss the dosages, indications, contraindications, side effects and relative potency of standard oral analgesics used in treatment of patients with musculoskeletal disorders.

22. Discuss the differential diagnosis, historical features, physical and examination findings of patients with low back pain.

23. Demonstrate ability to recognize and treat soft tissue infections involving muscle, fascia, and tendons.

24. Describe diagnosis and treatment of overuse syndrome.

25. Describe how to evaluate and preserve amputated limb parts.


27. Discuss evaluation and treatment of soft tissue injuries such as strains, penetrating soft tissue injuries, crush injuries, and high-pressure injection injuries.

**Practice Based Learning and Improvement**

1. Search and integrate evidence of scientific studies related to their patient’s orthopedic ailment.
2. Using a systematic methodology, residents will apply practice based improvement activities to develop and implement treatment plans to help manage patients with orthopedic conditions.
3. Residents are expected to support their own education with the use of on-line medical journals and technologies to be able to improve patient care.

**Interpersonal and Communication Skills**

1. Communicate the diagnosis; treatment plan and follow-up care with sensibility and empathy to patients and their families.
2. Develop an ethically-based relationship with patients and their families to be able to give the best therapeutic care.
3. Respect patient confidentiality for sensitive issues.
4. Work effectively with medical students, residents from other services, consultants and nursing staff.

**Professionalism**

1. The resident is expected to arrive on time daily and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity and empathy to every patient.
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent.
4. Residents are expected to be sensitive to the patient’s culture, gender, age and disabilities (if any).

**System Based Practice**

1. Residents will learn to develop, implement and evaluate treatment plans for orthopedic patients.
2. Will learn when to obtain consultations from Orthopedic consultants.
3. Will develop the ability to select the most cost effective treatment plans for orthopedic patients while applying national quality standards.

**Methods of Achieving Goals**

1. Management of patients on Orthopedic Trauma / Sports Medicine rotation.
2. Management of patients on Emergency Department rotations.
3. Management of patients with orthopedic trauma on the Trauma Service.
4. Performance at splinting and casting workshops and demonstrations.
5. Attendance at Emergency Medicine lectures in orthopedics.

**Evaluation and Feedback on Goal Achievement**
1. Written formal evaluation by the Orthopedic attending physician staff.
2. Resident feedback:
   A. Evaluation at end of rotation.
   B. Semi-annual resident evaluation.
3. Performance on In-Training examination.
SELECTIVE (Overview)

The Emergency Medicine residents rotate through “Selective” at the EM1 level. The program is extremely pleased with the educational opportunities offered to the Emergency Medicine residents as they rotate through these subspecialties. The EM1 resident will be allowed to choose between a select group of rotations available. This includes Infectious Disease, Ophthalmology, Oral-Maxillofacial Surgery and Neurosurgical Critical Care. It is the responsibility of the resident to notify the Program Coordinator of the rotation within the first week of the academic year. Osteopathic trained residents will be required to choose the infectious disease selective. The Program reserves the right to use this rotation for remediation purposes if the need should arise. The purpose, educational objectives, methods, resident responsibilities, educational materials, as well as evaluation/feedback are outlined below. Upon completion of this rotation, residents will receive written evaluations from the subspecialty attending staff. These evaluations will focus specifically on Milestones as they relate to emergency medicine namely interpersonal/communication skills, professionalism, as well as completion of educational objectives. The focus of the end of rotation evaluations will be the completion of Core Competency objectives. The Program Director and Assistant Program Director will review all evaluations and make them available to the resident during regular business hours.

Purpose:
1. To engage in a subspecialty with an emphasis on how it relates to emergency medicine.
2. To develop the clinical skills necessary for diagnosis and management of these subspecialty conditions
3. To gain experience in clinical procedures as they relate to this subspecialty, through observation and/or direct contact

Educational Objectives
Each selective subspecialty will have individual educational objectives. These will be divided into six categories; medical knowledge, patient care, problem based learning, professionalism, interpersonal/communication skills and system based practice.

Resident Responsibilities
The Emergency Medicine (EM) residents will:
1. Residents will be responsible for notifying the program coordinator within the first week of the academic year which subspecialty they choose for this rotation. (Osteopathic trained residents will be required to choose the infectious disease selective. Also note that the program reserves the right to use this rotation for remediation purposes if the need should arise.)
2. Residents are required to be present for didactic lectures with the attending, bedside rounds on all new consults, hospital follow ups, and office visits, as these relate to the subspecialty. Specifically, in Neurosurgical critical care rotation, the resident is expected to take call on average every third night.
3. Residents are responsible for performing assigned readings and review articles, in which the physiology, pathogenesis, clinical presentations and natural history of disorders are reviewed.
4. Residents expected to perform routine searches of the medical literature relevant to the patient care issues encounter during the rotation.
5. Residents are expected to attend lectures, journal clubs and other academic activities of the Department during the rotation. The trainee is encouraged to actively participate in these activities.
6. Residents are expected to attend the EM program academic activity scheduled every Thursday at 7:00 a.m.
7. EM 3 residents are to follow duty hours rules as specified by ACGME guidelines. It is the responsibility of the Emergency Medicine resident to notify the Emergency Medicine Program Director of potential duty hour violations in order to avoid possible disciplinary action. This will also be monitored through the New Innovations online system.
8. During this rotation, residents can be called on short notice for duty at the AdventHealth East Orlando ED in case of an emergency or special situation due to an impending or developing disaster.
9. Residents are required to keep a log of the procedures done in this rotation in New Innovations online system.

**Educational Material**

1. Residents attend Emergency Medicine conferences in which the infectious disease, ophthalmology, oral-maxillofacial, neurosurgical topics are discussed.
2. The education resources and facilities of the AdventHealth East Orlando Medical Center will be available to each resident. These resources include the medical library, including books and periodical reference materials, abstract and literature research services, as well as audio-visual references.
3. Residents will also be required to complete the following subspecialty reading requirements throughout the rotation in the following texts:
   h. Rosen’s Emergency Medicine 7th Ed
   i. Other optional readings are:
      v. Tintinalli’s Emergency Medicine, 7th Ed
      vi. Carol River’s Written Board Review for Emergency Medicine 6th Ed

**Evaluation**
The Emergency Medicine Residency faculty will evaluate EM residents using the evaluation form provided by the Emergency Medicine Department. Close interaction with supervisors is encouraged in order to maximize learning experiences. The evaluation sheet is completed using New Innovations. Emergency Medicine Residency faculty is encouraged to notify Program Director or Assistant Program Director of any difficulties with an EM resident as soon as these arise, preferably within the first week of the rotation.

In order to pass a rotation, the resident must complete all of the above mentioned tasks and the resident must earn an average score of three (3) or higher in each of the following six general competencies: patient care, medical knowledge, practice-based learning, interpersonal and
communication skills, professionalism, and systems-based practice. A resident who fails to obtain a score of three (3) in any category WILL NOT pass the rotation, regardless of how high the other five scores may be.

Resident’s knowledge will be tested throughout the year specifically with their performance on In-Training examination, simulation performance, procedural competencies and content specific questions throughout the academic year.

**Feedback**

The Program Director and/or Associate/Assistant Program Director are responsible of notifying residents of any problems noted as soon as possible. Written/online evaluations are available for formal review with the residency director at semi-annual progress meetings. At the end of the rotation, the resident will evaluate the strengths and weaknesses of the “Selective” rotation using the “Clerkship Evaluation Form” available through New Innovations. Feedback will also be given in a semi-annual resident evaluation.
GENERAL SURGERY (Selective/Elective, 1-2 Weeks)

The General Description of the Rotation

The general surgery rotation consists of 4 weeks of an immersive experience in caring for the general surgical patient. It is expected that during these weeks the resident will be focused on the history taking, physical exam, differential diagnosis, appropriate investigation and management of the patient. This will include pre-operative assessment, intra-operative considerations and post-operative care. It will be expected that the resident is able to follow a patient on their journey from admission to surgery and immediate post op care, as well as an office follow up after discharge from the hospital.

Goals & Objectives

1. Develop skill in the overall assessment of the general surgical patient. (PC, MK)
2. Develop familiarity with common general surgical disorders. (PC, MK)
3. Develop procedural skills relevant to general surgery. (PC)
4. Learn indications for consultation and surgical intervention in patients with acute abdominal pain. (MK, PC)
5. Learn the principles of care of the pre and post-operative patient. (PC, MK)
6. Demonstrate ability to perform an appropriate history and physical exam in patients with general surgical disorders, including an appropriate preoperative evaluation. (PC, MK, COM)
7. Discuss the differential diagnosis of acute abdominal pain and demonstrate ability to evaluate, treat and obtain appropriate consultation. (PC, MK)
8. Demonstrate ability to diagnose and treat common disorders of the breast. (MK, PC)
9. Demonstrate ability to diagnose and treat common disorders of the anus and rectum. (MK, PC)
10. Demonstrate ability to perform common procedural skills including gastric intubation, tube thoracostomy, placement of central venous lines, wound closure and abscess incision and drainage. (PC, MK, SBP)
11. Demonstrate ability to assist in the operative and perioperative therapy of surgical patients. (MK, PC)
12. Discuss the common fluid and electrolyte disturbances in surgical patients and demonstrate ability to manage patients with these disorders. (PC, MK)
13. Demonstrate appropriate prophylaxis and treatment of surgical infections. (MK, PC, SBP)
14. Demonstrate ability to manage pain in surgical patients. (MK, PC)
15. Discuss the role of abdominal radiographs in the evaluation of abdominal pain and demonstrate ability to appropriately order and interpret imaging modalities in surgical patients. (MK, PC)
16. Demonstrate ability to manage patients with soft tissue infections. (PC, MK)
17. Demonstrate ability to diagnose common structural defects of the abdominal wall. (MK, PC)
The General Surgical rotation will address core competencies as outlined below:

**Patient Care**
1. Excellence in surgical patient care is expected.

**Medical Knowledge**
1. The resident is expected to show analytical thinking and apply the concepts of basic science.

**Practice-Based Learning**
1. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems

**Interpersonal and Communication Skills**
1. Enhance their leadership, interpersonal and teaching skills.

**Professionalism**
1. The resident is expected to show ethically sound practice and be sensitive to cultural issues.

**System-Based Practice**
1. Practice cost-effective health care and resource allocation that does not compromise quality of care.
2. Advocate for quality patient care and assist patients in dealing with system complexities.
3. Partner with health care managers and health care providers to assess, coordinate, and improve health care through interdisciplinary rounds.

**Structure of rotation**

The general surgical rotation will consist of 1 week of night float duties. The resident will be on call for assessment of the emergency patient in the ER, in-house surgical coverage and critical patient post-operative assessment. There will be one half day a week attendance at the post-operative resident clinic and one half day a week at the attending led clinic. There will be opportunities to attend the Operating Room and assist with surgery.

**Methods of Achieving Goals:**

1. Management of patients on General Surgery rotation.
4. Participation with operative procedures.
5. Performance of minor surgical procedures.
6. Attendance at surgical rounds.
7. Attendance at Emergency Medicine lectures on general surgical conditions.

Evaluation and Feedback on Goal Achievement:

1. Evaluation of resident performance by attending
2. Evaluation of attending teaching skills and other attributes by resident
3. Review of the resident’s history/physical exam, progress notes and documentation of procedures in the chart.
4. Performance on In-Training Exam
5. Resident evaluation of rotation
6. Semi-Annual Evaluation of Resident
TRAUMA SERVICE (PGY I, II & III, 4 Weeks)

Overview

The care of trauma patient is an integral aspect of emergency medicine residency. Developing a trauma rotation that exceeds the national standard for emergency medicine is the goal of this service. The residents will work under the direct supervision of the trauma surgeons and an integral part of the trauma team. This rotation is designed to accomplish all the required competencies defined by the ACGME. The faculty preceptor is Dr. Sobowale. The faculty supervisor is Dr. A. Adewale.

Goals & Objectives

Patient Care

1. Communicate effectively and demonstrate caring, respectful behaviors when interacting with patients and their families.
2. Identify common and important preventable trauma presentations and outline their general management.
3. Learn to focus on the injury patterns and develop a differential diagnosis in the appropriate clinical setting.
4. Use the clinical history, laboratory, and radiographic database to derive an appropriate trauma care algorithm and differential diagnosis for a given patient.
5. Take a careful history including from patients, families and paramedics to gain more information on events leading to the trauma.
6. Counsel and educate patients and their families.

Medical Knowledge

1. Learn basic principles of care of the trauma victim.
2. Develop an organized approach to the assessment, resuscitation, stabilization and provision of definitive care for the trauma victim.
3. Learn use of the diagnostic imaging modalities available for evaluation of the trauma victims.
4. Develop procedural skills needed in the evaluation and management of trauma.
5. Learn to recognize immediate life and limb threatening injuries.
6. Learn special considerations in the evaluation and management of the pregnant trauma victim.
7. Learn special considerations in the evaluation and management of the pediatric trauma victim.
8. Learn special considerations in the management of the geriatric trauma victim.
9. Learn principles of disaster management.
10. Learn principles of burn management.
11. Learn a systems approach to trauma management at the local and state levels.
12. Learn the principles of pre-hospital trauma care.
13. Demonstrate ability to rapidly and thoroughly assess victims of major and minor trauma.
14. Demonstrate ability to establish priorities in the initial management of victims of life-threatening trauma.
15. Demonstrate ability to manage fluid resuscitation of trauma victims.
16. Demonstrate ability to manage the airway of trauma victims.
17. Discuss the definitive care of the trauma victim, including operative, post-operative and rehabilitative phases of care.
18. Demonstrate ability to perform the following procedures: oral and nasogastric intubation, venous cut-downs, insertion of large bore peripheral and central venous lines, insertion of arterial lines, tube thoracotomy, local wound exploration, peritoneal lavage, vessel ligation, repair of simple and complex lacerations, splinting of extremity fractures, and reduction and immobilization of joint dislocations, cricothyroidotomy, resuscitative thoracotomy, pericardiostomy, cardiography, aortic cross-clamping and extensor tendon repair.
19. Demonstrate ability to interpret radiographs on trauma patients, including chest, cervical/thoracic/lumbar spine, pelvis and extremity films.
20. Discuss the importance of mechanism of injury in the evaluation and treatment of the trauma victim.
21. Demonstrate ability to calculate the Glasgow Coma Score and discuss its role in the evaluation and treatment of head injured patients.
22. Demonstrate ability to use spine immobilization techniques in trauma victims.
23. Demonstrate ability to diagnose and manage trauma victims with extremity fractures, dislocations and subluxations.
24. Demonstrate ability to manage soft tissue injuries including lacerations, avulsions and high-pressure injection injuries.
25. Discuss the diagnosis and management of compartment syndromes.
26. Discuss the diagnosis and management of urogenital injuries.
27. Demonstrate appropriate use of analgesics and sedatives in trauma patients.
28. Demonstrate appropriate use of antibiotics in trauma patients.
29. Demonstrate ability to direct a trauma team during complex resuscitations.
30. Demonstrate ability to coordinate consultants involved in the care of multiple trauma patients.
31. Demonstrate ability to use and interpret imaging modalities in the evaluation of trauma patients.
32. Demonstrate ability to arrange appropriate consultation and disposition of trauma patients.
33. Demonstrate ability to direct the care of trauma victims in the pre-hospital setting.
34. Discuss principle of disaster management and participate in disaster drills.
35. Discuss the role of pre-hospital systems in the management of trauma patients.
36. Demonstrate ability to direct pediatric trauma resuscitations.
37. Demonstrate ability to direct geriatric trauma resuscitations.
38. Discuss the evaluation and management of spinal cord injuries.
39. Demonstrate ability to diagnose and manage tendon injuries.
40. Demonstrate ability to manage amputation injuries and discuss the potential for re-implantation.
41. Demonstrate the ability to manage the acutely burned patient, including minor and major injuries.
42. Demonstrate the ability to diagnose and treat smoke inhalation.
43. Demonstrate the ability to assess and manage facial trauma.
44. Demonstrate the ability to evaluate and manage anterior neck injuries.
45. Demonstrate the ability to assess and manage penetrating and blunt chest trauma.
46. Demonstrate the ability to evaluate and manage blunt and penetrating abdominal trauma.
47. Demonstrate the ability to diagnose and treat pelvic fractures.
48. Learn teaching & supervision skills. (PGY-III only)

**Practice Base Learning and Improvement**

1. Search and integrate evidence of scientific studies related to their trauma patients
2. Using a systematic methodology, residents will apply practice base improvement activities to develop and implement treatment plans to help manage multiple trauma
3. Support their own education with the use of on line medical journals and technology to be able to improve or contribute in improving patient care.
4. Search information based on their diverse patient population census.

**Interpersonal and Communication Skills**

1. Communicate the diagnosis, treatment plan and follow up care with sensibility and empathy to the patients and family
2. Develop an ethically-based relationship with patients and family to be able to give the best therapeutic care.
3. Respect patient confidentiality for sensitive issues
4. Work effectively with medical students, residents from other services, consultants and nursing staff
5. Have recognition of stigma associated with certain trauma especially those resulting from domestic abuse so that patients’ unspoken fears and concerns can be addressed.

**Professionalism**

1. It is expected that the resident will arrive on time everyday and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity, and empathy to every patient
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent
4. The resident should be sensitive and respond to the patient’s culture, gender, age and disabilities.
5. Overcome stereotyping and negative attitudes toward patients unusual trauma such as gunshot wound to the buttocks
System Based Practice

1. Residents will learn to develop, implement and evaluate treatment plans for trauma patients.
2. Will learn when to obtain consultations from traumatologists and when to transfer patients to a trauma center.
3. Will develop the ability to select the most cost effective treatment plans for minor trauma patients that meet national quality standards.
4. Residents will learn about the different roles of local health departments.
5. Residents will learn to advocate for quality trauma care of patients.

Methods of Achieving Goals:

1. Management of patients on trauma rotations.
2. Management of patients on Emergency Department rotations.
3. Performance of trauma related procedures.
4. Certification in ATLS Provider/Instructor course.
5. Presentations and attendance at Emergency Medicine trauma case conferences.
6. Attendance at trauma surgery lectures given on trauma related topics.
7. Attendance at Emergency Medicine lectures given on trauma related topics.

Evaluation and Feedback on Goal Achievement:

1. Formal written evaluation by Trauma Service attending physician staff.
2. Performance and evaluation of technical skills under direct attending physician supervision.
3. Evaluation of trauma case presentations at trauma case conferences and at multidisciplinary trauma rounds.
4. Resident feedback:
   A. Evaluation at end of rotation.
   B. Semi-annual resident evaluation.
5. Successful completion of ATLS Provider/Instructor course.
6. Performance on In-Training examination.
TRAUMA CRITICAL CARE (PGY-II, 4 Weeks)

Overview

Your experiences on the Trauma Critical Care Unit will be a process for learning and developing your clinical skills and management of the most complex and challenging trauma cases. This TICU rotation has been developed based on the ACGME outlined competencies with special emphasis in applying them on the critically ill trauma patients.

You will be supervised by a member of the Trauma faculty at Lakeland Regional Medical Center led by Dr. Sobowale. You will be responsible for assisting in the initial evaluation of the critically ill trauma patients and will formulate plans directed at their evaluation and proposed treatment. The faculty supervisor for TICU is Dr. Adewale.

Learning Resources

There will be a combination of didactic lectures with the trauma attendings, bedside rounds in the ED and the Trauma Critical Care area. There will be assigned readings and review articles. You will be expected to perform literature searches of surgical and trauma conditions experienced by your patients during your rotation.

Goals & Objectives

Patient Care

1. Communicate effectively and demonstrate caring, respectful behaviors when interacting with patients and their families.
2. Identify the important syndromes in trauma critical care and be able to outline their general management.
3. Learn to focus on the critical care differential diagnoses in the appropriate clinical settings.
4. Use the clinical history, laboratory and radiology database to derive a critical care differential diagnosis for a given patient.
5. Take a careful history including travel, occupational, and environmental exposures to aid in the development of a differential diagnosis in the critically ill trauma patient.
6. Counsel and educate patients and their families.

Medical Knowledge

1. Understand the approach to the critically ill trauma patient.
2. Develop the ability to rapidly evaluate, diagnose, stabilize, and make a disposition on critically ill trauma patients.
3. Learn respiratory, cardiovascular, renal and neurologic physiology and the pathophysiology of trauma, shock, sepsis, cardiac failure, and respiratory failure that affect critically ill trauma patients.
4. Learn the principles of medical instrumentation and hemodynamic monitoring and be able to utilize them in the care of critically ill trauma patients.
5. Learn the indications and develop the technical skills needed to perform diagnostic and therapeutic interventions in critically ill trauma patients.
6. Learn the rational use of laboratory, radiographic and other diagnostic tests in the management of critically ill trauma patients.
7. Demonstrate the ability to perform the following procedures: oral endotracheal intubation, nasotracheal intubation, cricothyrotomy, needle thoracostomy, tube thoracostomy, central intravenous placement, pulmonary artery catheter placement, transvenous cardiac pacing, arterial line placement, and indwelling urinary-bladder catheterization.
8. Demonstrate the ability to use and interpret data from ECG's and monitors, cardiac outputs, hemodynamic monitoring, arterial blood gases, pulse oximetry, end-tidal C02 monitors and ventilators.
9. Describe the dosages, indications and contraindications of pharmacological interventions for shock, cardiac failure, dysrhythmias, sepsis, trauma, respiratory failure, hepatic failure, renal failure, and neurologic illnesses.
10. Demonstrate the ability to manage a patient on a ventilator.
11. Demonstrate appropriate judgment in the management of critically ill trauma patients.
12. Demonstrate appropriate prioritization of diagnostic and therapeutic interventions in critically ill trauma patients.
13. Demonstrate ability to diagnose and treat shock, sepsis, fluid and electrolyte abnormalities, cardiac failure, cardiac dysrhythmias, renal failure, hepatic failure, and toxicological emergencies.

**Practice Based Learning and Improvement**

1. Search for and integrate evidence of scientific studies related to a patient’s specific trauma issues.
2. Using a systematic methodology, residents will apply practice based improvement activities to develop and implement treatment plans to help manage patients who are critically ill.
3. Residents are expected to support their own education with the use of on-line medical journals and technology to be able to improve patient care.
4. Search information based on their diverse patient population census.

**Interpersonal and Communication Skills**

1. Communicate the diagnosis, treatment plan and prognosis with empathy to the patients and their families.
2. Respect patient confidentiality.
3. Work effectively with medical students, residents on rotating services, consultants and nursing staff.

**Professionalism**

1. Residents are expected to arrive on time daily. They must be dressed in professional attire and be ready for work.
2. Demonstrate respect, compassion and empathy for every patient and their family members.
3. Be committed to the ethical principles in all aspects of critical care including patient confidentiality and informed consent.
4. The resident should be sensitive to the patient’s culture, gender, age and disabilities.

**System Based Practice**

1. Residents will learn to develop, evaluate and implement treatment plans for the critically ill trauma patients.
2. Will learn when to obtain consultations from surgical sub-specialists.
3. Will develop the ability to select the most cost effective treatment plans for critically ill trauma patients while meeting national quality standards.
4. Learn to advocate for patient safety measures.

**Methods of Achieving Goals**

1. Management of patients in critical care units.
4. Certification as ATLS Provider/Instructor.
5. Attendance at daily teaching rounds and any M&M rounds.
6. Attendance at Emergency Medicine lectures on trauma topics.

**Evaluation and Feedback on Goal Achievement**

1. Formal written evaluation by Trauma attending staff at Lakeland Regional Medical Center.
2. Resident feedback:
   A. Evaluation at end of rotation.
   B. Semi-annual resident evaluation.
3. Successful completion of ATLS Provider/Instructor Courses.
4. Performance on In-Training Examination.
TOXICOLOGY (LONGITUDINAL)

Overview

Your experiences during the patient-care experiences in the Emergency Department represent the core your training in Emergency Medicine. This rotation has been developed based on the ACGME outlined competencies. Your time in the Emergency Department will be supervised by Emergency Medicine faculty. You will be responsible for the initial evaluation of patients presenting to the Emergency Department and formulating a plan for their treatment.

Learning Resources

Didactic lectures with the Emergency Medicine faculty, bedside rounds on all pertinent cases presenting to the Emergency Department. During the discussions, physiology, pathogenesis, and clinical presentations shall be reviewed. Relevant topics will be assigned for reading. You are expected to perform routine searches of the medical literature relevant to the patient care toxicologic issues encountered during your rotation.

Goals & Objectives

Patient Care

1. Communicate effectively and demonstrate caring and respect when interacting with patients and their families.
2. Identify the important medical conditions which present to the emergency department.
3. Identify the immediately life-threatening conditions and their treatment.
4. Outline the general approach to most clinical presentations to the Emergency Department.
5. Learn to focus on the differential diagnosis in the appropriate clinical setting.
6. Residents will continue to hone their clinical history and interviewing skills.
7. Learn to counsel and educate patients and their families.

Medical Knowledge

1. Learn the pertinent aspects of the history and physical exam relative to acute poisoning with particular emphasis on clinical recognition of major toxic syndromes (toxidromes).
2. Learn the generic aspects of clinical management of poisoning, including stabilization and decontamination.
3. Understand the principles, methods, and controversies of decontamination and enhancement of elimination of toxins.
4. Learn the presenting signs, symptoms, laboratory findings, pathophysiology and treatment of common therapeutic drug poisonings, drugs of abuse, natural toxins, and general household poisons.
5. Learn the common hazardous materials (HAZMAT) of the workplace and prehospital operations with regard to HAZMAT incidents.
6. Learn the principles of clinical operational toxicology and the major occupational toxins of Western society.
7. Learn the fundamentals of poisoning epidemiology, pharmacokinetics, and biotransformation, including the effects of pregnancy and lactation.
8. Learn to recognize, diagnose, assess and emergently manage acute and chronic complications of substance abuse.
9. Learn the use of adjunctive services, including the toxicology laboratory and poison center, in the management of acute poisonings.
10. Learn the specific indications and implementation of specific therapeutic modalities, such as the use of antidotes, hemodialysis, and hyperbaric oxygen.
11. Demonstrate the ability to perform gastric lavage, whole bowel irrigation, skin and eye decontamination, and administration of activated charcoal.
12. Discuss the indications, contraindications, dosages, and side effects of the currently available antidotes and antivenoms.
14. Demonstrate knowledge of the principles of hemodialysis and hemoperfusion and the toxic agents that can be removed by these methods.
15. Demonstrate ability to recognize common venomous animals and poisonous plants and their clinical presentations and treatments.
16. Demonstrate knowledge of the diagnostic laboratory including methods, limitation and costs.
17. Demonstrate knowledge of the drug interactions, side effects, and therapeutic levels of the commonly used therapeutic agents.
18. Demonstrate the proper technique for handling a HAZMAT contaminated patient in the Emergency Department and the prehospital environment.
19. Demonstrate knowledge of the common household poisons, pesticides, hydrocarbons and metals, their effects and treatments.
20. Demonstrate the knowledge and clinical skills necessary to manage a patient poisoned by any of the following: acetaminophen, amphetamines, anticholinergics, aspirin, barbiturates, benzodiazepines, beta blockers, calcium channel blockers, carbon monoxide, caustics, cocaine, cyanide, cyclic antidepressants, digitalis, ethanol, ethylene glycol, INH, iron, lithium, methanol, opiates, organophosphates, phenytoin, theophylline and venomous animals.
21. Demonstrate knowledge of basic principles of drug absorption, redistribution, metabolism, and elimination.

**System Based Practice**

1. Residents will continue to develop, implement and evaluate treatment plans for patients presenting to the Emergency Department.
2. Continue to learn when to obtain consultations from consultants
3. Advocate for quality patient care
Professionalism

1. It is expected that residents will arrive on time everyday and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity and empathy to every patient.
3. Be committed to the ethical principles in all aspects of clinical care.
4. The resident should be sensitive to the patient’s culture, gender, age and disabilities (if any).

Interpersonal and Communication Skills

1. Communicate the diagnosis, treatment plan and follow-up care with the patient and their family.
2. Develop an ethically based relationship with patients and their family to be able to give the best therapeutic care.
3. Respect patient confidentiality.
4. Work effectively with medical students, fellow Emergency Medicine residents, residents from other services, consultants and nursing staff.

Practice Based Learning and Improvement

1. Search and integrate evidence of scientific studies related to their patient’s health problems.
2. Using a systemic methodology residents will apply practice based improvement activities to develop treatment plans to help manage patients.
3. Support their own educations with the use of on-line medical journals and electronic databases to improve patient care.

Methods of Achieving Goals

1. Evaluation of lab reports on Emergency Medicine rotations.
2. Chart review of related cases of patients admitted to the hospital.
3. Attendance at Emergency Medicine lectures on toxicology.
4. Journal and Textbook readings
5. Article presentation, critique and discussion at Journal Club

Evaluation and Feedback on Goal Achievements

1. Bedside evaluation of residents' history and physical examinations, oral presentations, clinical, and procedural skills by Emergency Department attending staff.
2. Written formal evaluation by Emergency Department attending staff.
3. Daily review of resident's charts.
5. Evaluation by junior residents.
6. Performance on In-Training Examination.
7. Resident feedback:
   a. Evaluation at end of rotation.
   b. Semiannual resident evaluation.
   c. Daily Shift card evaluations
ULTRASOUND

Introduction:

Focused ultrasound began to make its ways to the emergency departments in the late 1980s with the first emergency ultrasound publication in 1988 addressing the utility of echocardiography performed by Emergency Department (ED) physicians. Since, emergency ultrasound has become a standard emergency physician skill that is taught in emergency medicine (EM) residencies, tested on boards, and endorsed by professional societies, including America College of Emergency Physicians (ACEP). The ability to perform bedside examination, accessibility and low cost of equipment has helped ultrasound emerge as a useful diagnostic tool for a variety of clinical situations in the emergency department (ED). Focused-emergency ultrasound is utilized to diagnose acute life-threatening conditions, guide invasive procedures, and treat emergency medical conditions ultimately improving patient care. It has also been demonstrated to speed care, enhance patient satisfaction, save lives, and decrease procedure complications. Residents will learn this essential skill as part of their residency training.

Goal:

Provide the knowledge, skill, and experience to perform focused ultrasound (US) examinations in the standard applications outlined by the America College of Emergency Physicians (ACEP) guidelines (updated 2016) and to incorporate its uses in daily practice as a means to provide immediate information and answer specific questions about patients’ physical conditions.

A. Core US Curriculum:

1. First year residents (PGY-I)

   a. Introductory Course

   Emergency Medicine (EM) residents will begin their US experience during their first month of orientation, receiving a five-day comprehensive course covering all primary applications over a twenty (20) hour period. Didactic lectures and practical education will be included in the Sonography Lab at AdventHealth East Orlando College utilizing ultrasound simulation, phantoms, and student volunteers. During the orientation month, one day each week (Thursday) will be dedicated for ultrasound education and training, from 1pm-5pm. Two forty-five (45) to sixty (60) minute lectures will be given per day followed by an hour of scanning after each presentation. This course will also cover ultrasound physics, instrumentation (Refer Table 1), and primary indications as outlined by ACEP guidelines.²–⁵

<table>
<thead>
<tr>
<th>Table 1. Physics and Knobology</th>
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<tr>
<td>1. Define necessary terms to include:</td>
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<tr>
<td>a. Piezoelectric effect</td>
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2. Understand the role of instrumentation in image acquisition:
   a. Image mode
   b. Gain
   c. Time gain compensation
   d. Basic transducer technology
   e. Depth
   f. Focus
   g. Calipers

3. Understand types of ultrasound artifacts and their role in image acquisition
   a. Reverberation
   b. Side lobe
   c. Mirror
   d. Shadowing
   e. Enhancement
   f. Ring-down

Primary Indications for EM Ultrasound Evaluation:

1. **FAST (Focused Assessment with Sonography for Trauma).** This examination is used to evaluate the peritoneal, pericardial and pleural spaces by combining several focused ultrasound assessments of the chest, heart, abdomen, and pelvis. The primary indication for this application is in the rapid identification of pathological free fluid released from injured organs or structures. Residents will learn all four standard views of the FAST (Morrison’s pouch, Left splenorenal, pelvic, subxiphoid and long parasternal views) in order to facilitate trauma care as well as extended views in order to recognize pneumothorax and hemothorax.

2. **Abdominal Aorta Aneurysms (AAA).** Ultrasound has been shown to be accurate in identifying both aneurysmal and normal aortas. Training will include complete evaluation of the abdominal aorta from diaphragm to its bifurcation for recognition of aneurysm. A complete examination will include transverse and longitudinal views of proximal, middle segment, and distal aorta, including iliacs. If an AAA is identified, the resident will also need to assess for free intraperitoneal fluid suggestive of rupture.

3. **Echocardiography.** The primary applications of cardiac emergency ultrasound examinations are in the diagnosis or exclusion of pericardial effusions, cardiac tamponade, and the evaluation of gross cardiac function, especially in patients undergoing active resuscitation. Residents will also learn the advanced ultrasound techniques of gross estimation of intravascular volume status and identification of right ventricular dysfunction in the setting of unexplained chest pain, dyspnea, or hemodynamic instability. Residents
will learn the following four standard views: subxiphoid, short parasternal, long parasternal, and apical.

4. **Biliary**. Residents will learn to incorporate ultrasound assessment in the evaluation of abdominal pain, especially right upper quadrant (RUQ) and epigastric pain, for diagnosis of biliary disease. The gallbladder will be evaluated with emphasis on identification of cholelithiasis and identification of signs of cholecystitis. Residents will learn to evaluate gallbladder wall thickness, the size of the common bile duct (CBD), pericholecystic fluid, and the sonographic Murphy’s sign.

5. **Pelvic Ultrasound**. Residents will learn transabdominal and transvaginal sonographic techniques for the limited evaluation of first and second trimester pregnancies. First trimester evaluation will focus on evaluation of the uterus to detect first trimester intrauterine and ectopic pregnancies. Second and Third trimester evaluations will focus on detection of fetal heart rate (FHR) and fetal movement.

6. **Renal Ultrasound**. The primary indication for evaluation of the kidneys and bladder is to assess for obstructive uropathy and acute urinary retention. Residents will learn to recognize hydronephrosis, and evaluate bladder size for outlet obstruction.

7. **Procedural Ultrasound**. The major use for ultrasound-guided procedures is for central venous access. The Agency for Healthcare Research and Quality highlighted ultrasound-guided central line placement as a key intervention that should be implemented immediately into twenty-first century patient care to reduce procedural complications. Research has shown utility of ultrasound imaging in the evaluation of abscess formation, foreign bodies, nerve blocks, pericardial effusions, pleural effusions, ascites, and lumbar punctures. Residents will be expected to learn procedural ultrasound with special emphasis to central venous access and peripheral access. Also residents will learn to assess for difficult central venous access, venous thrombosis, and small caliber vessels as part of the initial scanning of the vessel to be canalized. Other ultrasound procedures will be taught as part of the ultrasound curriculum.

8. **Deep Venous Thrombosis (DVT)**. The primary application for venous imaging with ultrasound is in the evaluation for DVT in the proximal lower extremities. Residents will learn limited DVT screening for examination of the common femoral vein to its bifurcation and the popliteal area to trifurcation, searching for compressibility and augmentation. Additionally, all central lines will require anatomic visualization of the vessel before placement.

9. **Soft Tissue & Musculoskeletal**. The use of emergency US in soft-tissue has focused on soft-tissue infection, foreign bodies, and cutaneous masses. Although a host of musculoskeletal applications of bedside US have been studied by EPs, among the most common and best described is the assessment of cellulitis and abscess at the bedside. Residents will learn to identify relevant US anatomy and findings for soft tissue infections, foreign bodies, subcutaneous fluids collections, tendon injury and fractures.
Residents will also learn how to integrate this findings for patient care.

10. **Thoracic-Airway.** The use of emergency US in the thorax has been for the detection of pleural effusion and pneumothorax, interstitial and inflammatory disorders. Bedside US for the evaluation of thoracic disorders was described in the 1990s in European critical care settings. Since then, emergency physicians have utilized the technology for the detection of pneumothorax and other acute pathology. Residents will learn how to identify pneumothorax, pleural effusions, alveolar interstitial syndromes including pneumonia and pulmonary edema, as well as normal tracheal and esophageal anatomy as it concerns procedures (like endotracheal intubation). Residents will learn how to integrate this findings into clinical practice.

11. **Ocular.** The use of emergency US in the eye has described for the detection of posterior chamber and orbital pathology. Specifically US has been described to detect retinal detachment, vitreous hemorrhage, and dislocations or disruptions of structures. In addition the structures posterior to the globe such as the optic nerve sheath diameter may be a reflection of other disease in the central nervous system. Residents will learn relevant findings to evaluate for ocular pathology.

12. **Bowel.** Abdominal US can aid in the diagnosis a wide array of bowel pathology. Increasing data suggest the use of ultrasound can improve diagnostic as well to decrease radiation exposure and length of stay on the following conditions: appendicitis, ileus, small bowel obstruction, pneumoperitoneum, diverticulitis, abdominal wall masses and suspected hernias. Ultrasound also plays a particularly important role in the pediatric population, and is the initial diagnostic method of choice for both intussusception and pyloric stenosis. Residents will learn sonographic findings to diagnose the above describe conditions as well as relevant pathological findings to integrate in their clinical practice.

13. **Miscellaneous and Advanced Ultrasound Applications.** Residents will have the opportunity to learn advanced applications to include ocular ultrasound and testicular ultrasound as part of an elective as senior residents.

<table>
<thead>
<tr>
<th>Table 2. Emergency Ultrasound General Indication Requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total of 175-300 scans (ACEP guidelines 2016)</strong></td>
</tr>
<tr>
<td><strong>FAST:</strong> 25-50 scans (5 positive)</td>
</tr>
<tr>
<td><strong>Aorta:</strong> 25-50 scans (2 positive)</td>
</tr>
<tr>
<td><strong>Ecocardiography (Cardiac): 25-50 scans (5 positive)</strong></td>
</tr>
<tr>
<td><strong>Biliary:</strong> 25-50 scans (10 positive)</td>
</tr>
<tr>
<td><strong>Pelvic Ultrasound:</strong> 25 scans (10 positive)</td>
</tr>
</tbody>
</table>
**Transabdominal Pelvic:** 15 scans
**Transvaginal Pelvic:** 10 scans

**Renal:** 25-50 scans (5 positive)

**Ultrasound Guided Procedures:** 15 scans
- Central Venous Access: 5 performed
- Peripheral IV lines: 5 scans performed
- Procedural US: 5 scans performed
  - Paracentesis
  - Thoracentesis
  - Nerve Blocks
  - Pericardiocentesis
  - Lumbar Puncture
  - Foreign Bodies
  - Abscess drainage
  - Arthrocentesis
  - ETT Confirmation

**Deep Venous Thrombosis:** 10 Scans (2 positive)

**Soft Tissue & Musculoskeletal:** 10 Scans (4 Positive)
- Abscess (recognition and drainage)
- Cellulitis
- Foreign bodies
- Tendons/Fractures

**Thoracic-Airway:** 10 scans (4 Positive)
- Pneumothorax
- Pleural Effusion
- Alveolar Interstitial Syndrome

**Ocular:** 10 scans (2 Positives)

**Miscellaneous and Advanced Applications:** 10 scans:
- Testicular Ultrasound
- Bowel (Appy, SBO, Intussusception)
- Advance Echo
- Trans Esophageal Echo (TEE)
- Arterial/Vascular Doppler
- Adnexal Pathology
- ENT/Infectious
- Contrast studies

---

**Table 3. Skill Summary for PGY-I Introductory Course**

<table>
<thead>
<tr>
<th>Cognitive Skills</th>
<th>Able to recall and comprehend anatomy and pathology of diseases, recognize ultrasound images for primary US applications, Ultrasound technology, probe recognition Limited ability applied Facts/information</th>
</tr>
</thead>
</table>

122
<table>
<thead>
<tr>
<th>Psychomotor Skills</th>
<th>Limited experience with ultrasound applications, probe placement, and image acquisition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background Knowledge</td>
<td>Limited knowledge of ultrasound applications: FAST, Aorta, Renal, First Trimester Bleeding, Echo, Gallbladder, procedural ultrasound, deep venous thrombosis and ocular.</td>
</tr>
<tr>
<td>Clinical Rotations</td>
<td>Emergency department, trauma, and OB-GYN</td>
</tr>
</tbody>
</table>

1) PGY-I objective: Familiarize first year residents with ultrasound terminology, imaging fundamentals, and applications of focused bedside ultrasound.

2) PGY-I requirements:
   i. Complete a twenty-hour introductory course.
   ii. Save and submit ultrasound scans from ED rotations.
   iii. Machine maintenance.

Residents will need to save images and submit them as evidence of completion of 175-300 scans requirement, to obtain certification at the end of three-year period (Refer image submission Section B.1).

b. First Year Ultrasound Rotation

A four-week rotation will be included in the core curriculum during the first year (PGY-I) as part of the anesthesia rotation to further strengthening ultrasound skills. Residents will start their rotation, Monday through Friday from 1pm to 5pm, after completing their morning duties in anesthesia. This experience will provide an opportunity for residents to perform bedside ultrasound in the emergency department, and complete requirements for graduation, under direct supervision and image review with the Emergency Ultrasound Director (Dr. Tirado) or credential faculty members.

1) Objectives for 4-weeks rotation:
   i. Complete 175-300 scans required for certification before graduation.
   ii. Acquire competency in the primary indications for EM Ultrasound Evaluation (as describe in Table 2)
   iii. Literature review with reading assignments.
   iv. Involvement in administrative aspects of ultrasound training program to include: machine maintenance, supplies, and record keeping.
   v. Learn video storage and data management from different video formats.
   vi. Involve resident in on-going ultrasound research.
   vii. Incorporate focused ultrasound in clinical practice.

2) Requirement for 4-week rotation:
   i. Pre-elective meeting for outlining objectives of rotation.
   ii. Review online ultrasound modules.
iii. Fifteen to twenty hours of direct supervised scanning over elective period.

iv. An additional sixty hours of time spent independent scanning.

v. Assigned reading will be provided, from journals and ultrasound textbooks.

vi. Ultrasound review sessions will be provided Thursdays in the afternoon.

vii. Submission of two ultrasound cases for teaching file will be required.

viii. Practical evaluation will be required at end of rotation.

ix. Completion of ultrasound questions from available modules (passing 70%) available online.

x. Completion of online evaluation form.

Residents will need to save images and submit them as evidence of completion of 175-300 scans requirement, to obtain certification at the end of three-year period (Refer image submission Section B.1). Non-completion of these requirements will earn the Resident an incomplete (I) in their rotation. Ultrasound education is a requirement by the Residency Review Committee (RRC) for maintaining accreditation status. If a resident does not complete requirements by graduation they will not pass the ultrasound rotation and consequently fail to graduate.

### Table 4. Skill Summary for PGY-I Ultrasound Rotation

<table>
<thead>
<tr>
<th>Cognitive Skills</th>
<th>Able to recall, comprehend, and apply information; Recognize ultrasound images for primary US applications, Ultrasound technology, probe recognition, Ability to analyze synthesize, and evaluate information obtain from ultrasound imaging for primary indications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychomotor Skills</td>
<td>Able to satisfactorily perform ultrasound applications, probe placement, and image acquisition</td>
</tr>
<tr>
<td>Background Knowledge</td>
<td>Adequate foundation of knowledge in primary US applications: FAST, Aorta, Renal, First Trimester Bleeding, Echo, Gallbladder, procedural ultrasound, deep venous thrombosis (DVT), soft tissue/MSK, thoracic/airway, ocular and bowel.</td>
</tr>
<tr>
<td>Clinical Rotations</td>
<td>Emergency department, ED US Rotation</td>
</tr>
</tbody>
</table>

### LEARNING OBJECTIVES

**Patient Care**

5. Gather accurate, essential information in a timely manner from all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic procedures.

6. Integrate diagnostic information and generate an appropriate differential diagnosis.

7. Competently perform diagnostic and therapeutic procedures considered essential to the practice of emergency medicine.
8. Demonstrate ability to appropriately prioritize and perform other responsibilities simultaneously.

**Medical Knowledge**

2. Demonstrate investigatory and analytic thinking approach to clinical
3. Demonstrates Appropriate Use of Equipment - selects correct transducer & technical factors; adjusts gain & focal zone appropriately; identifies artifacts & optimizes image
5. Identifies & demonstrate knowledge of anatomy properly of area of interest with anatomic landmarks.
6. Demonstrates Scanning Skills – appropriate patient positioning & correct transducer orientation
7. Analyzes Completed Exams (for thoroughness, technical components, secondary findings) – analyzes the sonographic exam for completeness; recognizes pathology, & scanning artifacts
8. Demonstrates that can correlate findings with patient history & Clinical assessment – correlates sonographic anatomy to academic knowledge; correlates findings to patient’s clinical history, lab data; uses available information to provide differential diagnosis

**Practice – Based Learning**

6. Locate, appraise, and assimilate evidence from scientific studies related to the health problems of their patients
7. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
8. Use information technology to manage information, access online medical information, and support their own education
9. Facilitate the learning of students and other health care professionals

**Professionalism**

1. Arrive on time and prepared for work
2. Appropriate (inoffensive) dress and cleanliness
3. Appropriate use of symptomatic care
4. Treat patients/family/staff/paraprofessional personnel with respect
5. Protect staff/family/patient's interests/confidentiality
6. Demonstrate sensitivity to patient's pain, emotional state, and gender/ethnicity issues
7. Actively seek feedback and immediately self-correct
8. Unconditional positive regard for the patient, family, staff, and consultants
9. Accept responsibility/accountability
10. Open/responsive to input/feedback of other team members, patients, families, and peers
11. Use humor/language appropriately

**Interpersonal and Communication Skills**
9. Demonstrate the ability to respectfully, effectively, and efficiently develop a therapeutic relationship with patients and their families
10. Demonstrate respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences in patients and other members of the health care team
11. Demonstrate effective listening skills and be able to elicit and provide information using verbal, nonverbal, written, and technological skills
12. Demonstrate ability to develop flexible communication strategies and be able to adjust them based on the clinical situation
13. Demonstrate effective participation in and leadership of the health care team
14. Demonstrate ability to negotiate as well as resolve conflicts
15. Demonstrate effective written communication skills with other providers and to effectively summarize for the patient upon discharge
16. Demonstrate ability to effectively use the feedback provided by others

**Systems - Based Practice**

5. Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care.
6. Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
7. Practice cost-effective health care and resource allocation that does not compromise quality of care.
8. Advocate for and facilitate patient’s advancement through the health care system.

**EVALUATION**

The rotation will be evaluated using the evaluation sheet provided in Appendix A. Each resident will be required to complete this evaluation form at the end of each rotation.

The Emergency ultrasound faculty will evaluate EM residents using the evaluation form provided in Appendix B. Close interaction with supervisors is encouraged in order to maximize learning experiences. The evaluation sheet will be forwarded at the end of the ultrasound rotation to the EM Department at the AdventHealth East Orlando. Emergency ultrasound faculty is encouraged to notify Dr. Dale Birenbaum (Program Director) or Dr. Steve Nazario (Assistant Program Director) at 407-303-6413 of any difficulties with an EM resident as soon as these arise, preferably within the first two weeks of the rotation.

In order to pass a rotation, the resident must earn an average score of three (3) or higher IN EACH OF THE FOLLOWING six general competencies: patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice. A resident who fails to obtain a score of three (3) in any category WILL NOT pass the rotation, regardless of how high the other five scores may be. The criteria used to award a score in each category are listed in the "Resident Evaluation by Teaching Faculty Form".
FEEDBACK

The Program Director and/or Assistant Program Director are responsible of notifying residents of any problems noted as soon as possible. Written evaluations are available for formal review with the residency director at semi-annual progress meetings. At the end of the rotation, the resident will evaluate the strengths and weaknesses of the Anesthesia rotation using the “Clerkship Evaluation Form” available through E-value online evaluation program.

AGREEMENT

The Anesthesia Program Director reviewed and agreed with the terms and conditions of the rotation as described.

2. Third year residents (PGY-III)- US Elective

Third year residents will have the option to take a two or four week elective as senior residents with a focus on completing requisites for graduation and advanced ultrasound applications. Seniors will be involved in administrative, teaching, and research aspects of EM Ultrasound.

a. Objectives for senior elective:
   i. Complete 1750-300 scans required for certification before graduation.
   ii. Acquire competency in the advance indications for EM Ultrasound Evaluation (as describe in Table 2)
   iii. Involvement in administrative aspects of ultrasound training program including video review for quality assurance (QA process).
   iv. Involve senior resident in teaching and proctoring PGY-I and PGY-II residents as well as medical students.
   v. Involve resident in on-going ultrasound research.
   vi. Incorporate focused ultrasound in critical care thinking.

b. Senior elective requirements
   i. Pre-elective meeting for outlining objectives for elective.
   ii. Review online ultrasound module.
   iii. Six to eight hours of direct supervised scanning during elective period.
   iv. An additional hundred hours of time spent independent scanning.
   v. Senior residents will be in charge of ultrasound journal club.
   vi. Ultrasound review sessions will be provided Thursdays in the afternoon.
   vii. Submissions of four ultrasound cases are required for teaching file.
   viii. Practical evaluation will be required at end of rotation with direct supervision.
   ix. Completion of online evaluation form
Residents will need to save images and submit them as evidence of completion of 175-300 scans requirement, to obtain certification at the end of three-year period (Refer image submission Section B.1). Non-completion of these requirements will earn the Resident an incomplete (I) in their rotation. Ultrasound education is a requirement by the Residency Review Committee (RRC) for maintaining accreditation status. If a resident does not complete requirements by graduation they will not pass that rotation and cannot graduate.

Table 5. Skill Summary for PGY-III

<table>
<thead>
<tr>
<th>Cognitive Skills</th>
<th>Able to analyze, synthesize, and evaluate information obtain from ultrasound imaging for primary and advance ultrasound applications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychomotor Skills</td>
<td>Experience in performing all ultrasound application and advance applications.</td>
</tr>
<tr>
<td>Background Knowledge</td>
<td>Good foundation of knowledge regarding US applications: FAST, Aorta, Renal, First Trimester Bleeding, Echo, Gallbladder, Procedural ultrasound (Central line, PIV, Paracentesis, Pericardiocentesis, Thoracentesis, Arthrocentesis, Nerve Blocks), Venous Thrombosis, Soft Tissue/MSK (Abscess recognition and drainage, Cellulitis, Foreign bodies, fractures and tendons), Thoracic/Airway (Pneumothorax, Pleural Effusions, Alveolar Disease) Ocular, Bowel, Miscellanous &amp; Advance Testicular, Lumbar Puncture, Bowel</td>
</tr>
<tr>
<td>Clinical Rotations</td>
<td>Emergency department, ED elective US Rotation</td>
</tr>
</tbody>
</table>

LEARNING OBJECTIVES

Patient Care

1. Gather accurate, essential information in a timely manner from all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic procedures.
2. Integrate diagnostic information and generate an appropriate differential diagnosis.
3. Competently perform diagnostic and therapeutic procedures considered essential to the practice of emergency medicine.
4. Demonstrate ability to appropriately prioritize and stabilize one patient and perform other responsibilities simultaneously.

Medical Knowledge

1. Demonstrate investigatory and analytic thinking approach to clinical
2. Demonstrates Appropriate Use of Equipment - selects correct transducer & technical factors; adjusts gain & focal zone appropriately; identifies artifacts & optimizes image
5. Identifies & demonstrate knowledge of anatomy properly of area of interest with anatomic landmarks.
6. Demonstrates Scanning Skills – appropriate patient positioning & correct transducer orientation
7. Analyzes Completed Exams (for thoroughness, technical components, secondary findings) – analyzes the sonographic exam for completeness; recognizes pathology, & scanning artifacts
8. Demonstrates that cant Correlate findings with patient history & Clinical assessment – correlates sonographic anatomy to academic knowledge; correlates findings to patient’s clinical history, lab data; uses available information to provide differential diagnosis

**Practice – Based Learning**

1. Locate, appraise, and assimilate evidence from scientific studies related to the health problems of their patients
2. Obtain and use information about their own population of patients and the larger population from which the patients are drawn
3. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
4. Use information technology to manage information, access online medical information, and support their own education
5. Facilitate the learning of students and other health care professionals

**Professionalism**

1. Arrive on time and prepared for work
2. Appropriate (inoffensive) dress and cleanliness
3. Appropriate use of symptomatic care
4. Treat patients/family/staff/paraprofessional personnel with respect
5. Protect staff/family/patient's interests/confidentiality
6. Demonstrate sensitivity to patient's pain, emotional state, and gender/ethnicity issues
7. Actively seek feedback and immediately self-correct
8. Unconditional positive regard for the patient, family, staff, and consultants
9. Accept responsibility/accountability
10. Open/responsive to input/feedback of other team members, patients, families, and peers
11. Use humor/language appropriately

**Interpersonal and Communication Skills**
1. Demonstrate the ability to respectfully, effectively, and efficiently develop a therapeutic relationship with patients and their families
2. Demonstrate respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences in patients and other members of the health care team
3. Demonstrate effective listening skills and be able to elicit and provide information using verbal, nonverbal, written, and technological skills
4. Demonstrate ability to develop flexible communication strategies and be able to adjust them based on the clinical situation
5. Demonstrate effective participation in and leadership of the health care team
6. Demonstrate ability to negotiate as well as resolve conflicts
7. Demonstrate effective written communication skills with other providers and to effectively summarize for the patient upon discharge
8. Demonstrate ability to effectively use the feedback provided by others

**Systems - Based Practice**

1. Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care.
2. Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
3. Practice cost-effective health care and resource allocation that does not compromise quality of care.
4. Advocate for and facilitate patient’s advancement through the health care system.

**Ultrasound Milestones**

**PC12. Other Diagnostic and Therapeutic Procedures: Ultrasound (Diagnostic / Procedural)**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the indications and limitations of limited, goal directed emergency ultrasound</td>
<td>Explains how to optimize ultrasound images and identify the proper probe for each of the focused ultrasound applications</td>
<td>Performs focused ultrasound exams such as Intrauterine pregnancy, MA, Cardiac, Biliary, Urinary Tract, Soft tissue/musculoskeletal, Thoracic, Procedures and Ocular complaints</td>
<td>Performs a minimum of 150 focused ultrasound examinations</td>
<td>Expands ultrasonography skills to include: advanced Echo, TEE, boxel, adrenal and testicular pathology, and transcranial Doppler</td>
</tr>
<tr>
<td>Performs an eFAST</td>
<td>Correctly interprets acquired images</td>
<td>Uses ultrasound for procedural guidance for central venous access</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

**Suggested Evaluation Methods:** OSCE, SDOT, videotape review, written examination, checklist
## Ultrasound Milestones

<table>
<thead>
<tr>
<th>Level</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Completes ED US Introduction Lecture</td>
</tr>
<tr>
<td>1.5</td>
<td>Completed Ultrasound Intro Course, not done rotation</td>
</tr>
<tr>
<td>2</td>
<td>Completed US Course, can explain how to optimize ultrasound images and identify the proper probe for each of the focused ultrasound application. Can perform an eFAST in the clinical setting and correctly interprets acquired images. Can use ultrasound for procedural guidance for central venous access.</td>
</tr>
<tr>
<td>2.5</td>
<td>Completed US Intro Course. Started but not completed US Rotation Online Course, or failed the final test. Pending completion of 25-50 studies for primary and extended ultrasound applications as described in ACEP 2016 Guidelines. Pending completion of (+) Studies criteria. Has a Competency Eval.</td>
</tr>
<tr>
<td>3</td>
<td>Completed US Rotation &amp; US Intro Course, has completed most of the 25-50 studies for primary and extended ultrasound applications as described in ACEP 2016 Guidelines, still pending (+) Studies criteria. Has a Competency Eval.</td>
</tr>
<tr>
<td>3.5</td>
<td>Completed US Rotation and US Intro Course. Completed 25-50 studies per application and extended ultrasound applications as described in ACEP 2016 Guidelines, Pending (+) Studies criteria. Has a Competency Eval.</td>
</tr>
<tr>
<td>4</td>
<td>Completed US Intro Course &amp; US Rotation, completed all 25-50 studies per application, extended applications (Total 150-300) with Review and QA; and (+) Studies criteria. Has a Competency Eval.</td>
</tr>
<tr>
<td>4.5</td>
<td>Uses some of the Expands ultrasonography skills like: advanced Echo, TEE, bowel, adnexal and testicular pathology, and transcranial Doppler, but not all</td>
</tr>
<tr>
<td>5</td>
<td>Expands ultrasonography skills to include: advanced Echo, TEE, bowel, adnexal and testicular pathology, and transcranial Doppler</td>
</tr>
</tbody>
</table>

The rotation will be evaluated using the evaluation sheet provided in Appendix A. Each resident will be required to complete this evaluation form at the end of each rotation.

The Emergency ultrasound faculty will evaluate EM residents using the evaluation form provided in Appendix B. Close interaction with supervisors is encouraged in order to maximize learning experiences. The evaluation sheet will be forwarded at the end of the ultrasound rotation to the EM Department at the AdventHealth East Orlando. Emergency ultrasound faculty is encouraged
to notify Dr. Dale Birenbaum (Program Director) or Dr. Steve Nazario (Assistant Program Director) at 407-303-6413 of any difficulties with an EM resident as soon as these arise, preferably within the first two weeks of the rotation.

In order to pass a rotation, the resident must earn an average score of three (3) or higher in each of the following six general competencies: patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice. A resident who fails to obtain a score of three (3) in any category will not pass the rotation, regardless of how high the other five scores may be. The criteria used to award a score in each category are listed in the "Resident Evaluation by Teaching Faculty Form".

**FEEDBACK**

The Program Director and/or Assistant Program Director are responsible of notifying residents of any problems noted as soon as possible. Written evaluations are available for formal review with the residency director at semi-annual progress meetings. At the end of the rotation, the resident will evaluate the strengths and weaknesses of the Anesthesia rotation using the “Clerkship Evaluation Form” available through E-value online evaluation program.

**B. Emergency Ultrasound Education/Credentialing**

1. **Submission of Ultrasound Scans**

   Residents will need to submit 175-300 scans in a three-year period as described in the Emergency Ultrasound Indications Requirements section. Residents will learn photo and video modalities for capturing findings as part of the certification process. For chart documentation, residents will be required to complete CERNER documentation. Residents will also be required to save and complete worksheets to submit studies using the Q-Path Server. Residents will be responsible for entering patient information and report findings. The Ultrasound Director, ultrasound fellowship trained physicians, ultrasound fellows or credential reviewers will review images. They will assess for presence of standard views, identification of pathology, and adequacy of images for credit. Residents can also save videos for credit.

2. **QA of Submitted Ultrasound Scans**

   The Ultrasound Director will review sonographic images and videos with the resident and provide feedback regarding quality and accuracy Q-Path Server. All ultrasound examinations performed in the emergency department will require confirmatory testing if not performed by credential provider which may include computed tomography (CT), Magnetic Resonance Imaging (MRI), and/or complete sonographic examination if not observed by a Level III sonographer.

3. **Ultrasound Logging System (Q-Path)**
Q-path is a workflow management tool used to help manage ultrasound credentialing, quality assurance, over-read, teaching, collaboration, research, storage and more. Within Q-path residents will be able to review, and edit images from prior scans. It also provides image archiving solutions. All scans must document patient information, the physician’s name, and images for reviewing. Images are wirelessly and securely transfer within the firewalls of AdventHealth East Orlando network, maintaining HIPAA compliance.

4. **Completion of Ultrasound Requirements is a Pre-requisite to Graduation**

Residents need to complete 175-300 ultrasound examinations (updated ACEP US Guidelines 2016) by the end of the third year in order to meet ultrasound requirements and to be certified. Successful completion of the ultrasound requirement is a pre-requisite for graduation from the EM residency program. If the resident has not met requirements by the midpoint of the third year, the resident will be required to complete them during the elective time. At the end of the three-year period, residents will be tested on knowledge of sonographic anatomic and pathology through written examination and through image evaluation.

5. **AdventHealth East Orlando Adventist University- Sonography Lab**

As part as their ultrasound experience, residents will have use of the AdventHealth East Orlando College sonography lab, managed by the Chair and Professor Charlotte Henningsen. This lab contains 6 stretchers, 6 ultrasound machines (including one GE Logic e and a Sonosite M Turbo), an ultrasound simulation machine and various phantoms for scanning and performing procedures (Refer Appendix C). Residents will be able to scan each other and student volunteers from the AdventHealth East Orlando College to gain ultrasound knowledge and apply techniques. The lab will be available once a week for resident practice while on their 2-week rotation and elective rotation. Also, the lab will be used to present cases and clinical scenarios to assess competency in ultrasound at the end of each rotation.

6. **Ultrasound Web-Based Learning- Rotation**

Ultrasound lectures will be available for self-directed learning and ongoing resident education for the ultrasound rotation. These lectures with voice over and videos will help solidify knowledge learned from conferences and enhance image recognition of normal and abnormal anatomy required for accurate diagnosis of bedside emergency ultrasound.

7. **Ultrasound Online Final Examination- Rotation**

To obtain the ultrasound certificate of completion and future letters for US privileges, residents will be required to complete a forty question online examination, as part of their rotation. Residents will take examination at the end of their ultrasound rotation. 75percentis required for successful completion. In case of failure, the senior elective will be mandatory as means of remediation and an examination will be provided at the end of their rotation, with expected pass rate of 75%. In case of second attempt failure, it will be
the ED Ultrasound Directors prerogative to permit the resident to attempt the examination a third time. This will depend on the resident’s overall ultrasound performance and availability of time. Failure to pass the test will result in inability to receive ultrasound certification and future letters of recommendations for US privileges. Ultrasound Education Methods

8. **Ultrasound SonoSim® Simulation & online modules**

Residents will have the opportunity to further strengthening ultrasounds concepts through the use of simulation. The SonoSim® are patient based virtual ultrasound training systems. This platform aids in the education and visualization of different pathologies as well as fundamentals of imaging. With it’s updated version, residents will have the opportunity of further learn through online didactic courses, hands-on training, and knowledge assessment tools.

To reinforce concepts residents will be required to complete, the online Sonosim modules and online Quizzes, using [https://sonosim.ttlms.com/](https://sonosim.ttlms.com/). All simulation and quiz results will be available using the SonoSim performance tracker by accessing [https://instructor.sonosim.com/](https://instructor.sonosim.com/). Residents will need to complete all modules during their three years of residency.

9. **Ultrasound conferences**

Emergency medicine residents will start their ultrasound education as first years with a five-day comprehensive course, covering all primary applications over twenty (20) hour period. Lectures will be forty-five minutes to an hour in length followed by one hour of hands-on practical experience. Each lecture will have well-defined objectives with pertinent anatomic review, ultrasound technique with protocol, and pathologic findings. Residents will receive a USB flash drive that will contain handouts of all lectures to review content and make notes on specific topics.

10. **Bedside learning**

Residents will be provided eight to ten hours of direct supervised scanning over the ultrasound rotation period, providing for an excellent opportunity for bedside teaching by supervising physicians. Residents will have the opportunity to learn with each patient interaction as they apply sonographic findings pertinent to anatomy and pathology, while improving patient care. Residents do not make clinical decisions without direct supervision, and when findings are equivocal or non diagnostic, official studies must be ordered.

11. **Ultrasound Conferences for Grand Rounds**

Ultrasound education will also be included in the Grand Round lecture series with at least four dedicated ultrasound conferences given each year to emphasize core and
advanced ultrasound applications. Conferences will also be available for review on the resident web page.

12. Ultrasound Case-Small groups

Residents will participate in ultrasound small group-case discussion as a way to assess for competency and/or introduce new topics and applications. For this sessions will be adding Free Open Access Medical (FOAM) education podcasts and narrated lectures in digitalchalk for the residents to complete prior to event. During activity, residents will be assign a series of cases for interactive discussion with ultrasound fellowship trained physicians, fellows and residents. During the experience will be the SonoSim simulators and de-identified images from real patient encounters in the ED. The purpose of the activity is to help teach required knowledge and psychomotor skills needed in EUS, as well as provide the flipped EUS classroom experience, where learners participate actively on their education.

13. Ultrasound Simulation Lab

Simulation is currently playing an increasingly important role as both an EUS educational method and assessment measure. Use of simulation for ultrasound education has demonstrated equivalent results on image acquisition, interpretation, and operator confidence in comparison to traditional hands-on training. This US simulation session, with the use of the SonoSims, will provide the opportunity for deliberate practice of a new skill in a safe environment prior to actual clinical performance. The use of simulation has the added benefit of deliberate practice improvement to increase success rate of invasive procedures and reduces patient complications. Additionally, these sessions will help expose residents to a wider spectrum of pathology and common variants than typically encountered during an EUS rotation.

These simulation sessions, will also provide a valid assessment measure of each component of EUS competency. The faculty will help to appropriately design cases to assess trainee’s ability to recognize indications, demonstrate image acquisition and interpretation, as well as apply EUS findings to patient and ED management.

14. Ultrasound Journal Club

Once every two months, residents will review up to date ultrasound articles from current and pertinent medical journals. During ultrasound rotations residents will discuss these articles for learning and as means of encouraging research. It will be the senior resident duty to select pertinent articles and facilitate one article discussion.

b. Objective:
   i. Learn how to select journal club
   ii. Improve knowledge
   iii. Critically appraise an article
iv. Review current literature
v. Review classic article
c. Requirements:
   i. Advance Med Search
   ii. Discussion of article with US Director
   iii. Organize journal club
   iv. Discuss journal club
   v. Develop research

C. Ultrasound Resources

Core Text books:


Both texts are new and will provide excellent images and helpful commentaries on scanning techniques and interpretation of ultrasound examinations in the Emergency Department.

D. Internet resource:

1. https://sonosim.ttlms.com/

E. Emergency Ultrasound Faculty:

1. Alfredo Tirado-Gonzalez, MD
   Director of Emergency Ultrasound
   Ultrasound Fellowship Trained at Brown University
2. Charlotte Henningsen, MS RT, RDMS, RVT, FSDMS
   Chair & Professor
   Diagnostic Medical Sonography Department
   AdventHealth East Orlando College of Health Sciences
3. Emergency Ultrasound Fellowship Trained Faculty
   i. Douglas Haus, DO
   ii. Peter Alamia, MD
   iii. Hugo Basterrechea, MD
   iv. Roberto Campis, MD
4. Emergency Ultrasound Credential Faculty from AdventHealth East Orlando
F. Resources:

5. AMA (resolution 802) support of ultrasound in different specialties
6. AMA Policy 230.989
G. Appendices:

1. **Appendix A: Ultrasound Evaluation**

**Ultrasound Rotation Evaluation**

Program: ____________________ Rotation Location: ____________________
Period of Rotation: _______________ Faculty Member(s): ____________________

Directions: Please take a moment to assess the clinical rotation using the scale below. If an item is not applicable to this rotation, please circle N/A.

4 = Excellent  
3 = Very Good  
2 = Fair  
1 = Poor  
N/A = Not applicable

**Organization**
Clinical duties and assignments, education goals and learning objectives, and evaluation process were presented 1 2 3 4 N/A

Daily Schedule for scanning and teaching was structured efficiently 1 2 3 4 N/A

**Faculty Leadership and Role Modeling**
Demonstrated good "bedside manner" and positive interpersonal communication skills with patients, family members, and staff 1 2 3 4 N/A

Treated each team member in a courteous and respectful manner 1 2 3 4 N/A

Was usually prompt for teaching assignments and always available and accessible as a supervisor 1 2 3 4 N/A

Showed respect for physicians in other specialties/subspecialties and other health care professionals 1 2 3 4 N/A

Recognized own limitations and used these situations as opportunities to show me how he/she learns in order to keep up-to-date 1 2 3 4 N/A

**Patient Care**
Patient volume was sufficient to meet the educational goals and objectives 1 2 3 4 N/A

 Variety of patient problems provided adequate learning experiences 1 2 3 4 N/A
Opportunities to perform scans were sufficient to achieve the learning objectives 1 2 3 4 N/A

Overall patient management emphasized an interdisciplinary team care approach 1 2 3 4 N/A

**Patient Care Teaching**
The faculty member(s) devoted an appropriate amount of time to discussing patients and patient care decisions 1 2 3 4 N/A

The faculty member(s) observed my scans and provided instructive feedback and guidance 1 2 3 4 N/A

The faculty member(s) communicated their thoughts and ideas clearly but also allowed me to exercise my clinical judgment 1 2 3 4 N/A

The faculty member used relevant medical/scientific literature to support clinical advice 1 2 3 4 N/A

**Didactic (Classroom Instruction)**
The faculty gave well-organized presentations and provided opportunities for questions and interactions 1 2 3 4 N/A

The faculty provided references, articles, or other materials that stimulated me to read, research, and review pertinent topics. 1 2 3 4 N/A

**Evaluation and Feedback**
My overall performance was reviewed at the end of the rotation pointing out my strengths and areas for improvement 1 2 3 4 N/A

The faculty member demonstrated “fairness” by adhering to established criteria, explaining reasons for the scores, and allowing me to respond 1 2 3 4 N/A

OVERALL, I WOULD RATE THIS CLINICAL ROTATION AS:

POOR (No Benefit)
FAIR (Little Benefit)
VERY GOOD (Beneficial)
EXCELLENT (Very Beneficial)

Would you recommend that this rotation be continued in this program? Yes/No
Would you recommend that the faculty member(s) continue to teach this program? Yes/No

COMMENTS,
2. **Appendix B: Clinical Competency Evaluation**

**CLINICAL COMPETENCY EVALUATION – ED Ultrasound Program**

Student______________________________ Clinical Site________________________

Date__________Type of exam _____________________ Evaluator_______________

(See back for grading criteria)

<table>
<thead>
<tr>
<th>Clinical Competency Evaluation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PERFORMANCE CRITERIA</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Demonstrates Scanning Skills (appropriate for current level of training) – appropriate patient positioning &amp; position changes; correlates patient history, lab work, other imaging studies; correct transducer orientation; demonstrates relevant anatomy</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Demonstrates Appropriate Use of Equipment - selects correct transducer &amp; technical factors; adjusts gain &amp; focal zone appropriately; identifies artifacts &amp; optimizes image</td>
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<tr>
<td>3. Works Efficiently – performs in professional manner; recognizes when to obtain an image; performs complete exam in appropriate time &amp; in a logical sequence</td>
<td></td>
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</tr>
<tr>
<td><strong>CRITERIA FOR EVALUATION OF IMAGE</strong></td>
<td></td>
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<tr>
<td>4. Recognizes Anatomical Representation – identifies &amp; demonstrates anatomy properly; area of interest is centered on image; anatomic landmarks are identified; measurement are accurately made</td>
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<td></td>
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<tr>
<td>5. Identifies Patient &amp; Correctly Annotates – clearly identifies patient, date of exam, “right &amp; left”, and sectional plane</td>
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<tr>
<td>6. Analyzes Completed Exams (for thoroughness, technical components, secondary findings) – analyzes the sonographic exam for completeness; recognizes pathology, &amp; scanning artifacts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAL KNOWLEDGE</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7. Correlates findings (with patient history &amp; Clinical assessment) – correlates sonographic anatomy to academic knowledge; correlates findings to patient’s clinical history, lab data; uses available information to provide differential diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Analyzes findings (review of exam with supervising sonographer or physician; discussion of findings &amp; differential diagnosis, as appropriate) – analyzes the sonographic exam for completeness; recognizes pathology, &amp; scanning artifacts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNICATION SKILLS</strong></td>
<td></td>
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<tr>
<td>9. Communicates Effectively – addresses patient appropriately; makes patient feel comfortable; uses correct terminology to describe exam; presents exam in professional manner &amp; with confidence; recognizes deficiencies in the exam; presents organized &amp; complete case for interpretation.</td>
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</tbody>
</table>
"PATIENT TYPE":  Circle the correct degree of difficulty.

1 = Easy
2 = Average
3 = Difficult
4 = Very Difficult

SCORING:
4 Superior
3 Satisfactory
2 Needs Improvement
1 Unsatisfactory

Document examples of why any skill (by number) did not receive a “2”,

Resident __________________________ EVALUATOR _________________

AdventHealth East Orlando
EMERGENCY MEDICINE
Block Rotations

The block rotation system offers a background of specialty information to balance the emergency medicine experience. While the emergency medicine aspects of specialty fields are learned in the emergency department, these short blocks add additional depth to the emergency physician's training. We are committed to a quality program. Each rotation has been carefully selected to offer the maximal educational benefit to our residents. Since curriculums are rarely static, we will carefully audit our residents' rotation experiences and continuously modify the residency curriculum based upon this feedback.

Block Rotation Schedule

<table>
<thead>
<tr>
<th>EM-1</th>
<th>EM-2</th>
<th>EM-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>EM – 28 weeks</td>
<td>EM – 32 weeks</td>
<td>EM – 36 weeks</td>
</tr>
<tr>
<td>Anesthesia/ US – 4 weeks</td>
<td>Peds EM – 4 weeks</td>
<td>Peds EM – 4 weeks</td>
</tr>
<tr>
<td>Medical ICU – 4 weeks</td>
<td>Pediatric ICU – 4 weeks</td>
<td>Elective – 4 weeks</td>
</tr>
<tr>
<td>Internal Medicine – 4 weeks</td>
<td>Trauma ICU – 4 weeks</td>
<td>Trauma – 4 weeks</td>
</tr>
<tr>
<td>OB/GYN – 4 weeks</td>
<td>Surgical ICU – 4 weeks</td>
<td>Admin – 4 weeks</td>
</tr>
<tr>
<td>Trauma – 4 weeks</td>
<td>Ortho Trauma – 4 weeks</td>
<td>Vacation – 20 days</td>
</tr>
<tr>
<td>EMS – 2 weeks</td>
<td>Vacation – 20 days</td>
<td>CME – 20 days</td>
</tr>
<tr>
<td>Selective – 2 weeks</td>
<td>CME – 5 days (optional)</td>
<td>CME – 5 days (optional)</td>
</tr>
<tr>
<td>Vacation – 20 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Block Rotation Locations

<table>
<thead>
<tr>
<th>Rotations</th>
<th>Rotation Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>EM: ER Pediatrics</td>
<td>AHO</td>
</tr>
<tr>
<td>EM:East ER</td>
<td>AHEO</td>
</tr>
<tr>
<td>Emergency Medical Services</td>
<td>AHO</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>AHO</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>AHO</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>AHEO</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>AHO</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>AHO</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>AHO</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>AHO</td>
</tr>
<tr>
<td>Orthopedic Trauma</td>
<td>AHO</td>
</tr>
<tr>
<td>Peds ICU</td>
<td>AHO</td>
</tr>
<tr>
<td>Administration</td>
<td>AHEO</td>
</tr>
<tr>
<td>Research</td>
<td>AHEO</td>
</tr>
<tr>
<td>OB</td>
<td>AHO</td>
</tr>
<tr>
<td>Anesthesiology/Ultrasound</td>
<td>AHO/AHEO</td>
</tr>
<tr>
<td>Peds ICU- Subspecialty</td>
<td>AHO</td>
</tr>
<tr>
<td>Off-Site:EM:Trauma &amp; Trauma ICU</td>
<td>Lakeland Regional Medical Center</td>
</tr>
<tr>
<td>Surgery</td>
<td>AHO</td>
</tr>
</tbody>
</table>
**Selectives & Electives:**

Residents have one 4-week block of elective time in the PGY-3 year and one 2-week block of selective time in the PGY-1 year. Selective and Elective opportunities should be discussed with Program Director before the start of the PGY-1 and PGY-3 year.

- Selective Opportunities: Infectious Disease, Oral Maxillofacial Surgery, Ophthalmology, Neurosurgery
- Elective Opportunities: Research, Toxicology, Sports Medicine, Hyperbarics, Peds EM, Emergency Ultrasound, Infectious Disease, Orthopedics

**End of Academic Year Schedule:**

The end of June is a special time with the following demands:

- From the last day of Block 13: 0700 Monday until 0700 July 1 residents should expect to be available to cover the ED. This becomes especially prescient since the new interns can't start until July 1 due to malpractice issues. All current EM residents are expected to abide by this.
- Residents will not be allowed to take vacation or extend any days scheduled "off" during this period without the explicit written approval of Dr. Adewale.
- The June schedule will need extra vigilance for this reason.
- Any vacation or time "off" from clinical work occurring at the end of one block and extending another block will require explicit written approval of Dr. Adewale.
The Evidence Based Emergency Medicine curriculum consists of didactic and workshop type sessions. They are held during the Thursday conference day.

An emphasis will be placed on how to locate the latest high quality information at the bedside. PDA resources and the AdventHealth East Orlando Library Online will be used in the teaching sessions and while “on duty” in the Emergency Department. The aim is to simplify the gathering of information and integrate this into patient care in real time. Dr. C. Martinez will serve as the faculty supervisor.

Using technology in a patient encounter has its own considerations and special attention will be paid to this situation.

The expectations of the residents during the didactic and workshop sessions will vary by postgraduate year. They will become progressively more comprehensive as they go through the program.

PGY 1 will be expected to formulate a question based on a clinical encounter and be able to design a search strategy.
PGY 2 will be expected to critically appraise an article for Journal Club.
PGY3 will be expected to put the whole process together and formulate a critically appraised topic.
Each year will have a Record of Achievement to complete.
ADVENTHEALTH EAST ORLANDO
EMERGENCY MEDICINE RESIDENCY PROGRAM
RESEARCH/SCHOLARLY ACTIVITIES CURRICULUM

REQUIRED:       PYG-1, PGY-2 and PGY-3

DURATION: Longitudinal

AVAILABLE TIME: Two (2) weeks of research elective could be requested for both research/scholarly projects but must be pre-approved by respective research mentor. Arrangements could be made through Residency Coordinator.

FACULTY
RESEARCH COORDINATOR: Ademola Adewale, MD

RESEARCH MENTOR: Faculty of choice

GOAL
Upon completion of the research/scholarly activities, the resident will meet the goal of AGME in advancing the residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

OBJECTIVES
The resident will demonstrate competency in his/her ability to:
• Understand the concepts of and principles behind evidence based medicine.
• Critically evaluate medical literature and its applicability to clinical practice.
• Participate in scholarly activities and convey findings to peers.

PROCESS
This requirement will be accomplished through one-on-one mentoring by faculty of choice and/or team work with peers and staff. The resident will also be responsible for completion of certain task on own and through guidance from faculty and research coordinator.

REQUIREMENTS
In order to graduate from the Emergency Medicine Residency Program, residents are required to complete:
1) **IRB certifications (NIH, Research HIPAA & CV)**
   → PGY-1 will complete these requirements within the first 3 months of residency. *See Page 3 for more information*

2) **Scholarly projects**
   → Conduct research project (elective time given) – investigator initiated, 
     *or*
   → Write a case report submitted for publication in peer review journal, 
     *or*
   → Write a literature review article submitted for publication in peer review journal, *or*
   → Present a poster or an oral presentation at a regional or national conference.

**EVALUATION**

1) Completion of items 1 and 2 listed in the requirements section upon graduation.
2) Present an oral or poster presentation of chosen scholarly activity project to peers during research week prior to graduation during OGME-3.
3) Submit a written paper in a publishable format on the chosen scholarly project prior to graduation.

**REQUIRED READING/RESOURCES**

- Protecting Personal Health Information in Research: Understanding the HIPAA Privacy Rule – *See Page 3 for more information*

**RECOMMENDED READING/RESOURCES**

- AdventHealth East Orlando Institutional Review Board Handbook
- Outlines and articles of how to write up case report, literature review, or scientific papers are available through research coordinator.
- Guidelines on how to prepare presentations available through research coordinator.
INSTITUTIONAL REVIEW BOARD (IRB) CERTIFICATION

COMPLIANCE REQUIREMENTS

Please submit the following documents to Research Coordinator by the end of the 3rd month of PGY-1:

1) Current CV
   - signed and dated at top right corner of front page

2) Certification of completion of the NIH tutorial for Human research protection.
   - go to http://phrp.nihtraining.com
   - register as new user
   - complete quiz from all 4 modules
   - print out certificate

3) Verification of Research HIPAA Privacy Rule.
   - go to www.flhosp.org
   - click on “All Services”
   - click on “Institutional Review Board”
   - click on “Requirements to Conduct Research at AdventHealth East Orlando”
   - read through “HIPAA in Research Booklet” (pdf.)
   - print, sign and date “Verification of HIPAA Privacy Rule Information”

IMPORTANT REMINDERS
FOR RESEARCH OR PUBLISHABLE PROJECTS

1) ALL research projects must be submitted to the Office of Research Administration (ORA) and Institutional Review Board (IRB).

2) DO NOT begin study until IRB approval has been obtained.

3) Data collected prior to IRB approval cannot be included in the current research.

4) Any changes to a research protocol and/or investigators must be submitted to and approved by IRB.
5) All resident projects, posters, and research writing must have faculty member sponsorship and are property of the AdventHealth East Orlando Department of Emergency Medicine.

BASIC REQUIREMENTS FOR RESEARCH PROJECTS

1) IRB/FDA Requirements:
   NIH certificate, Research HIPAA Verification Form, CV, License

2) Protocol

3) IRB Applications (contact Research Coordinator to decide which forms are needed pertaining to your project).

- All documents should be typed and submitted to Research Coordinator electronically.
- Contact Info: (407) 303-7369 or josephine.gaabucayan@flhosp.org

Timeline:

The timeline below is created to help Residents pace their research project in a timely manner. Tasks can be completed ahead of schedule but must be completed no later than the last day of the corresponding month, unless prearranged with mentor.

Residents may choose their own topics or they may select one from the list provided by the Residency Faculty.

PGY-1:

Complete and submit NIH certificate, Research HIPAA Verification, and CV (signed and dated) September

Meet with mentor to decide on scholarly project i.e. Research/Case Report/Literature Review Article, etc. March

Meeting with mentor to discuss research topic and/or design.
Do literature search on chosen topic.  May

PGY-2:

Write up research protocol (Research)  August

Contact Research Coordinator and complete IRB application (Research)  September

Collect Data once IRB approval obtained  Ongoing

PGY-3:

Data analysis (Research)  January

Submit abstract of Research/Case Report/Literature Review Article  February

Prepare Poster/Oral presentation  March

Prepare final draft of paper  April/May

Poster/Oral presentations of projects  TBD

Submit final Draft Paper  June

Research Award:

A winner from each DME campus will be awarded the “Research Investigator of the Year”. The recipient of this award demonstrates outstanding skills in the investigation, preparation, presentation, and submission of all documents in a timely manner. This Resident makes a significant contribution to the program’s research endeavors that far exceed curricular expectations.

Faculty from the Research Committee will judge each eligible research paper based on the following criteria: Problem statement, literature review, hypothesis, variables, study design, analysis, conclusion, implications, organizations, scientific value and clinical application.

Scholarly Achievement Award

The Scholarly Achievement Award will be presented to any resident who has his or her research paper/case report accepted for publication in a peer review journal during the course of residency program. The resident will be presented with a certificate and a cash award.

National/Regional Poster Presentation
In order to promote active participation in national/regional medical conferences, DME will pay for the resident’s trip and registration fee if the oral or poster presentation submission of the resident’s research project is accepted during the course of residency program. This will be covered apart from the resident’s allotted CME allowance.

**EM Conferences and Teaching Rounds**

At least 5 hours of planned educational activities will be arranged per week. Residents will be expected to attend and will be given dedicated time to participate. Attendance will be monitored via New Innovations. Conferences will meet the goals and objectives as outlined in the model curriculum for Emergency Medicine. Both Faculty and Residents will be responsible for conferences. Presentation of conferences is a good learning experience as well as teaching experience. PGY-1 residents will present adult and pediatric case conferences along with toxicology and trauma case conferences. PGY-2 residents will present multitrauma Case Conferences, core lectures and journal club. At the PGY-3 level, residents will present Senior grand rounds and core lectures along with a variety of case conferences. Periodically, residents will be asked to prepare Critical Literature Review presentations. The conferences will include Rosen Reviews, Trauma cases, campus cases along with Roberts & Hedges procedural reviews, toxicology presentations and critical literature updates.

**Conference Attendance**

Conferences are held weekly on Thursdays from 7:00AM – 12:00PM. For those who have clinical responsibilities following conferences, there is an expectation that they should arrive prepared to work no later than 12:30PM if conferences were located at AH East Orlando and 1:00PM if conferences were located at AH Orlando.

**EM Resident Conferences**

EM Case Conference
Residents should prepare a 30-minute case with a discussion at the end (15 min for review of case, 10 min topic high yield review and 5 min discussion/questions). Residents will be paired with a faculty member for the presentation. Contact the faculty member at least 2 weeks prior to the presentation to review the case and the teaching points. Residents may select any interesting case but it should be applicable to emergency medicine. The case should be presented as an unknown and the audience should attempt to derive the diagnosis. This presentation should be highly INTERACTIVE with audience.

PICU Case Presentation Conference
Residents should prepare a 30-minute PICU case with a discussion at the end (15 min for review of case, 10 min topic high yield review and 5 min discussion/questions). Residents will be paired with a PICU faculty member for the presentation. Contact the PICU faculty member at least 2 weeks prior to the presentation to review the case and the teaching points. Residents may select any interesting case but it should be applicable to emergency medicine. The case should be...
presented as an unknown and the audience should attempt to derive the diagnosis. This presentation should be highly INTERACTIVE with audience.

Core Lecture
Residents will present a comprehensive lecture on a topic from reading in 45 minutes. (30 min content information, 10 min high yield review questions and 5 min discussion/questions)
Preparation is essential. Primary source for these lectures will be the Rosen’s Emergency Medicine Concepts and Clinical Practice, 8th edition. Other sources may be used, including EM textbooks, EM Board review books and current literature. (Site all the sources) The goal is to effectively present the material using audio-visual aids and summarizing key points. Residents should contact Dr. Molins at least 2 weeks prior to the presentation to review the presentation and the teaching points.

Trauma Case Conference
Residents should prepare a 30 minutes Trauma case with a discussion at the end. (15 minutes for review of case, 10-minute topic high yield review and 5-minute discussion/questions). Residents will be paired with a faculty member for the presentation. Contact the faculty member at least 2 weeks prior to the presentation to review the case and the teaching points. Residents may select any interesting case but it should be applicable to emergency medicine. The case should be presented as an unknown and the audience should attempt to derive the diagnosis. This presentation should be highly INTERACTIVE with audience.

Senior Grand Rounds
EM Senior Residents will have an hour to present a “State of the Art “Conference. The resident should select a relevant emergency medicine topic with a body of literature to review. Examples include shock, pediatric head trauma, acute coronary syndrome. The most important point will to be to make the talk practical and interesting. Talks based on unique experiences (International EM, Disaster Relief) may also be appropriate. Faculty should be able to obtain new insight from the topic. Residents should also utilize recognized experts and complete an exhaustive literature search. Prepare early and practice. Review your topic choice with a faculty member. Choose topic June of year preceding. A comprehensive handout (not a copy of the slides) must be provided for distribution with a bibliography.

Emergency Medicine Reviews
Formal readings and chapter reviews, as well as assigned podcasts or other educational modalities, have been fully integrated into the EM Didactic curriculum. Residents are required to read, present and summarize information which will be monitored with CORD Tests or quizzes like Rosh Review.

JOURNAL CLUB
Coordinator: Carmen J. Martinez, MD

Introduction:
Journal Club is an integral part of residency training. We have developed a model of journal club based upon the principles of evidence-based medicine.

**Goals:**

- Improve resident and faculty participation
- Teach critical reviewing skills
- Validate and/or update clinical practice
- Integrate clinical and didactic teaching
- Reinforce research / statistics curriculum
- Practical experience in literature searches
- Encourage critical thinking in clinical arena
- Identify potential areas of future research

**Choosing an Article:**

- Articles will be chosen from the recent medical literature. Emergency Medicine articles will be featured, but other medical or surgical specialty journals may also be reviewed.

**Possible Conclusions from Journal Club**

- Question is answered, validating current practice or suggesting change
- Leads to further questions and journal club subjects
- No answer found in literature, possible future research topic

The schedule for Journal Club and resident presenters will be posted and distributed. Please contact the resident coordinators at least 1 month in advance for topic and article assignments.

**EVIDENCE BASED MEDICINE CONFERENCE**

**Purpose:**

- To address a focused clinical question that pertains to the everyday practice of emergency medicine.
- To conduct a comprehensive literature search for all evidence that pertains to the question chosen
- To synthesize the data and formulate the most reasonable conclusion to the question asked based on the available evidence.
• To present the background, evidence, and conclusions in a concise and conclusive talk.

**Format:**

• 2 separate EBM topics will be presented during the one-hour lecture block.
• Residents may design their own clinical question or select one from the list provided. Topics must be approved by the conference supervising attending.
• The speaker should first address why the clinical question was chosen and how it affects our clinical practice.
• The discussion should include a brief- no more than 5 minute- review of the issue including background on the topic.
• The bulk of the discussion should focus on a review of the evidence found.
• The speaker should present his or her own conclusions, leaving 5 minutes at the end for discussion with the audience.
• The talk should be no more than 20 minutes duration, and contain no more than 15-20 slides.
• Review the talk with assigned faculty member at least 2 weeks prior to presentation.

**Evaluations Process**

**ACGME Core Competencies:**

Accreditation of the residency program is predicated on adherence in training to the ACGME-defined Core Competencies in six areas. All residents will be continually evaluated based on the following six competencies. In addition to the six Core Competencies, there are 23 sub competencies which comprise the milestones initiative.

1. **Patient Care:** Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and promotion of health. Among other things, residents are expected to:
   • Gather accurate information in a timely manner.
   • Generate an appropriate differential diagnosis...
   • Implement an effective patient management plan.
   • Competently perform the diagnosis and therapeutic procedures and emergency stabilization.
   • Prioritize and stabilize multiple patients and perform other responsibilities simultaneously.
   • Provide health care services aimed at preventing health problems or maintaining health.
   • Work with health care professionals to provide patient-focused care.

2. **Medical Knowledge:** Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral)
sciences and the application of this knowledge to patient care. Among other things, residents are expected to:

- Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information.
- Properly sequence critical actions for patient care and generate a differential diagnosis for an undifferentiated patient.
- Complete disposition of patients using available resources.

3. Practice-Based Learning: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Among other things, residents are expected to:

- Analyze and assess their practice experience and perform practice-based improvement.
- Locate, appraise and utilize scientific evidence related to their patient’s health problems.
- Apply knowledge of study design and statistical methods to critically appraise the medical literature.
- Utilize information technology to enhance their education and improve patient care.
- Facilitate the learning of students and other health care professionals.

4. Interpersonal and Communication Skills: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates. Among other things, residents are expected to:

- Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences.
- Demonstrate effective participation in and leadership of the health care team.
- Develop effective written communication skills.
- Demonstrate the ability to handle situations unique to the practice of emergency medicine.
- Effectively communicate with out-of-hospital personnel as well as non-medical personnel.

5. Professionalism: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to demonstrate a set of model behaviors that include but are not limited to:

- Treats patients/family/staff/paraprofessional personnel with respect.
- Protects staff/family/patient’s interests/confidentiality
- Demonstrates sensitivity to patient’s pain, emotional state, and gender/ethnicity issues.
- Able to discuss death honestly, sensitively, patiently, and compassionately.
- Unconditional positive regard for the patient, family, staff, and consultants.
• Accepts responsibility/accountability.
• Openness and responsiveness to the comments of other team members, patients, families, and peers.

6. Systems-Based Practice: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Among other things, residents are expected to:
  • Understand access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care.
  • Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
  • Practice cost-effective health care and resource allocation that does not compromise quality of care.
  • Advocate for and facilitates patients’ advancement through the health care system.

**Resident Performance:**

Residents will be evaluated by the faculty/preceptor at the end of each rotation, as well as by daily shift evaluations during Emergency Medicine rotations. Evaluations are based upon the six core competencies established by the ACGME:

1. Patient care
2. Medical knowledge
3. Practice based learning
4. Interpersonal and communication skills
5. Professionalism, and

Evaluations will be reviewed periodically, by the faculty and Program Director meeting as a Clinical Competency Committee (CCC). Faculty evaluations and written examinations will be utilized by the RPEC in determining the progress of the resident. The Program Director will meet with the resident at least biannually to review performance. Any necessary remediation or counseling will be determined by the Program Director and when indicated, individuals may be placed on probation or suspended. Evaluations will be kept on file in the resident’s personnel file and will be accessible to the resident through the office of Emergency Medicine Education.

**Faculty Teaching:**

Residents will turn in written, anonymous evaluations of the program, rotations, and faculty on an on-going basis. The results of these evaluations will be reviewed by the Program Director and appropriate feedback will be given to individual faculty members. The information will also be used by the Core Curriculum Committee to revise and alter the educational content of the program and its rotations.
Other Evaluations of Residents:

Residents will be evaluated by means of a 360-degree approach which will include evaluations by peers (senior residents), nurses, and patients. The results of these evaluations will also be discussed with the resident during biannual meetings.

Confidentiality Process:

All evaluations, counseling and probationary actions involving a resident will be kept in a confidential fashion. Under no circumstances will such actions be discussed in a public forum. Additionally, all evaluations of faculty by residents will be treated as confidential by the Program Director.

Scholarly Activity Check List:

Shift Cards
2 shift cards should be completed by the end of each week of the Emergency Medicine Rotation, for a total of 8 cards per EM block. There is a designated shift card for each week (labeled Shift Card –Week 1-4). These can be found on New Innovations and are to be completed electronically at the end of each shift.

Follow up Log
Requirement is for 1 patient follow up per week of the Emergency Medicine Rotation. For eg. If on the EM rotation for 4 weeks then 4 follow ups will be required. If on rotation for 3 weeks due to vacation then 3 follow up logs will be required. Follow up logs are held in Scholarly Activities section of Portfolio under “Follow up”.

360 Evaluation
Requirement is for 1 360 Evaluation per quarter – this means a total of 4 per year; however, they must be done at some point within each 3-month period of time. Use the forms provided and return completed forms to EM Residency Office. These forms will be uploaded and held in Scholarly Activities section of Portfolio under “360 Evaluation”.

Journal Club and Critical Literature Review
The resident will give 1 Journal Club presentation per year for each of the 3 years, and critical literature reviews as assigned by Program Director. This will be held on Scholarly Activities section of Portfolios under “Journal Club”.

Core Lectures
EM1 residents will be required to give 1 core lecture.
EM2 residents will be required to give 2 core lectures.
EM3 residents will be required to give 3 core lectures.
All residents will be required to participate in Pearls conference program and will upload their Pearls, as assigned.
A copy of these presentations will be kept in Scholarly Activities in Portfolio under “Presentations”.

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Case Presentations
The resident will give 1 case presentation per year for each of the 3 years. A copy of this presentation will be kept in Scholarly Activities in Portfolio under “Presentations”.

Trauma Presentations
The resident will give 1 trauma presentation per year for each of the 3 years. A copy of this presentation will be kept in Scholarly Activities in Portfolio under “Presentations”.

Senior Grand Rounds Presentations
EM3 residents will be required to give 1 M&M presentation during the 3rd year. A copy of this presentation will be kept in Scholarly Activities in Portfolio under “Presentations”.

Log and Learn/ PBLI project
Residents will be required to complete 4 “Log and Learn” activities per year for each of the 3 years. These will be kept in Scholarly Activities in Portfolio under “Log and Learn”.

Procedure Logs
All procedures need to be monitored and entered real time into New Innovations.

Supervision Policy:
Every resident is assigned to a designated service block rotation. The attending physician is ultimately responsible for the overall care of each individual patient being treated during that shift as well as for the supervision of the resident(s) assigned to the patient. It is the responsibility of the resident(s) to make sure the attending is aware of the history and physical presentation of the patient as well as their plan for treatment. The attending will approve or revise the treatment plan. There is a clear chain of command centered on graded authority and clinical responsibility.

Emergency Medicine residents function under direct supervision or indirect supervision with direct supervision immediately available. The resident can evaluate patients, write prescriptions, write orders and progress notes, and otherwise complete medical records. Residents cannot perform invasive procedures (e.g., chest tube, arterial line, central line, and endotracheal intubation) without direct supervision until they have completed an ACLS course and proven clinical competency in the Emergency Department. Residents cannot function without direct or indirect supervision by an attending physician who has privileges at AdventHealth East Orlando for patient care and to perform indicated procedures.

The attending physician is expected to:

- Confirm (or change) the diagnosis
- Approve procedures and timing
- Be available or physically present (as dictated by his/her judgment) during any procedures and assure that they are properly carried out
- Supervise post-procedural care
The resident will keep the attending fully informed and document patient care with written notes. It is expected that the residents introduce themselves and inform every patient that they are Emergency Medicine Residents. The residents are expected to communicate with the attending physicians for any critical decisions (i.e. admission to ICU or withholding of care). The residents are also expected to be in constant communication with the entire team providing care to the patients (i.e. respiratory therapy, nurses, paramedics, technicians, etc).

Residents have graded and progressively increasing responsibilities during their Emergency Medicine training as evidenced by the following:

**PGY-1:**
- Rotate in the main Emergency Department and present to PGY-3 residents or attending
- Rotate in Urgent Care area and present cases to PGY-2 residents or attending
- Attend didactic lecture series and present case conferences, Multi-Trauma Case Conferences, Core Lectures, and Journal Club as assigned

**PGY-2:**
- Manage Urgent and Emergency cases in the main Emergency Department
- Perform many technical procedures
- Directly participate in major resuscitations
- Supervise and run the Urgent Care area and teach medical students and PGY-1 residents on minor care. This supervision creates an environment for increased responsibility
- Attend didactic lecture series and present case conferences, Multi-Trauma Case Conferences, Core Lectures, and Journal Club as assigned

**PGY-3:**
- Supervise over-all Emergency Department patient flow
- Provide clinical teaching and supervision to medical students, PGY-1 and PGY-2 residents with faculty oversight
- Direct cardiac and trauma resuscitations
- Handle incoming patient telephone calls and rescue squad reports
- Maintain a high autonomy in providing patient care and running the department
- Attend didactic lecture series and present case conferences, Multi-Trauma Case Conferences, Core Lectures, Senior Grand Rounds, and Journal Club as assigned

**Chief Resident Duties:**

The Chief Resident has administrative duties for which s/he is responsible to the Program Director and Associate Program Director. Besides the clinical responsibilities of a senior resident, the Chief Resident's responsibilities also include the following:

1. Ensure that the residents on their team adhere to the mandated duty hour restriction.
2. Ensure that all residents have at least an average of one day off in seven.
3. Monitor all residents on their team for signs of fatigue or other possible impairment.
4. Ensure that all patients are staffed with the proper attending physicians.
5. Notify the proper attending staff member of any change in patient condition.
6. Ensure attendance of their team members at educational conferences.
7. Supervise and educate medical students.
8. Monitor the interaction of junior residents with hospital staff, patients and families.
9. Notify the Program Director of any problems related to the previously described responsibilities.
10. Responsible to serve as liaison between faculty and residents.
11. Responsible for setting up and acquiring audiovisual equipment, keys, cords for conferences.

**Chief Resident Responsibilities**

1. Scheduling
   a. Assist with
      i. Year long schedule
      ii. Monthly schedule
2. Administrative
   a. Assist in organization of Residency
      i. Assist the Residency Coordinator
      ii. Assist the Residency leadership
   b. Applicant interviews
      i. Assist in interviewing
      ii. Assist in applicant tours
3. Clinical
   a.
4. Resident related
   a. Beeper coverage
   b. Discipline
      i. Identify potential problems
      ii. Assist in monitoring trends of concern (e.g. recurrent lateness / absences)
      iii. Keeping a log of absences / lateness
      iv. Keeping a log of how various interactions have been handled
         1. Individual resident schedule changes or adjustments
         2. Multi-party shift switches
         3. Scheduling disputes
         4. Must cc the PD / APD for these
   c. Resident representation at Faculty meetings
   d. Incoming Intern orientation and education
5. Teaching
   a. Assist in organization of residency lectures
      i. Journal Clubs
      ii. EBM forums
   b. Assist in Medical Student teaching
      i. Assist Clerkship Director in simulation with medical students: each Chief Resident should assist with 2 two-hour Wednesday sessions per month
c. Assist in Simulation sessions
d. Actively participate in CORD Chief Resident Listserve discussions and relay pertinent information to program leadership (website: [CORD Chief Resident Listserve](#))

6. Research
   a. Assist in ascertaining compliance with progress
   b. Assist in IRB process
   c. Monitor resident participation with Dr. Adewale

7. Miscellaneous
   a. Attendance at Chief Resident Forum at SAEM Scientific Assembly
      i. Takes place late May or early June yearly
   b. Emergency Medicine Chief Resident Survival Guide
      i. EMRA bookstore
   c. Resources – CORD listing

**Patient Charting Responsibilities:**

**Charting:**

The Emergency Department uses an electronic medical record (EMR) system and template paper documentation system. Residents are encouraged to learn to chart concurrently with patient care. Ordering labs, x-rays and medications during the visit is mandatory. Charts are expected to be completed during the visit. This includes electronic signature on any outstanding orders in the EMR.

**Delinquent Charts:**

Prompt and timely completion of charts is expected and is a professional responsibility.

Accumulation of charts longer than one (1) week will result in issuance of a notification.

Failure to complete charts within 2 weeks will result in an additional shift in the ED at a time scheduled by the chief resident.

**Medical Records:**

- Health care providers must maintain adequate medical records to:
  o Afford continuity of patient care
  o Document that quality care has been rendered
  o Justify payment for services rendered
  o Serve a defense against malpractice claims
Function as a basis for submitting required reports to appropriate governmental agencies

- All patient reports should be completed at the time of service. They should contain sufficient information concerning the reason for presenting and the diagnosis and treatment methods. Correct terminology and diagnosis codes are essential.
- Keep in mind that a patient’s records could become a legal document, which you may be asked to interpret and defend in a court of law many years from now. It, therefore, should not be treated as a forum for unproven opinions, personality comments, assumptions, or derogatory statements to consultants, patients, peers, etc.: record the facts/omit opinions, judgments and assumptions. Never EVER alter a medical record after a query regarding the care of a patient.
- Death Certificates must be completed within 72 hours of the patient’s death.
- Medico-legal issues, such as adverse events, angry patients or family members, etc. should be relayed to the Program Director and Faculty immediately. A lack of timely intervention frequently exacerbates problems.
- Delinquency in record completion may result in loss of vacation time in order to correct deficiencies.

Confidentiality:

Compliance with HIPPA regulations is mandatory. All information presented to you by a patient, by a doctor about a patient, by a patient’s family about a patient, with few exceptions, is CONFIDENTIAL.

- Do not discuss patients with others while walking in the halls, in the elevator, in the cafeteria, or while in any public areas.
- During Grand Rounds and conferences, patients are never to be presented by their names.
- Copies of discharge summaries, operative reports, and other medical data are confidential and must be disposed of by acceptable legal means when no longer needed.
- Confidential, locked shred bins are provided in the Emergency Department as well as on the units. Do not place any confidential information in waste baskets or other receptacles that eventually end up in a commercial or city dump.
- In all instances, patients are to be treated with the same respect and confidentiality that you would afford your own family members.

Faculty Mentors:

Each resident will be assigned a faculty mentor at the beginning of residency training. The faculty member will be considered a mentor of the resident and will be expected to meet with the resident at a minimum on a biannual basis. These meetings will be arranged by the advisors throughout the year. However, all of our faculty members are eager to be of assistance to residents, and you should feel free to discuss problems, situations, ideas, etc. with the faculty at any time.

Policy Statement on Safe Handover of Patients

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Policy Statement

1. Effective clinical handover is an essential team process and a critical component in the delivery of safe quality health care to the patient across the entire spectrum of health care providers.

2. Clinical handover processes must be timely, patient-centered, structured and contribute to safe patient care. Clinical handover formalizes the transfer of accountability and responsibility of some or all relevant aspects of patient care.

3. The Department is committed to implementing systems that ensure effective, consistent and agreed upon processes to support clinical handover. This ensures timely clinical handover processes free from significant distractions other than emergent patient interventions, utilizing an appropriate environment and systems to deliver continuous safe quality clinical care.

Definitions

“Clinical handover” is the communication process that enables the “transfer of clinical responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or healthcare team on a temporary or permanent basis” .

Policy Rationale

The purpose of this policy is to enhance patient safety by improving clinical handover, ensure a consistent approach to clinical handover across healthcare teams, and to ensure processes and practices are in place to enable continuity of care to occur within and across healthcare services provided in the Emergency Department.

Standards

To ensure the following standards are met:

1. Participation in clinical handovers by all relevant staff during rounds directly supervised by the attending physician

2. Documentation (including time and participants) for clinical transfers of patient care by all care givers (eg. through electronic medical record) and that clinical handover processes and procedures are supported by appropriate documentation (including clinical notes, lab and imaging follow-up and interpretation, etc.)
3. Shift to shift clinical handover occurs as a regular, consistent, and mandatory event, and the fundamentals of effective teamwork and communication are demonstrated in the process of clinical handovers during rounds.

4. Policies of confidentiality, privacy, patient identification and medical records are appropriately applied to clinical handovers and transfers.

5. An acknowledged transfer of clinical accountability and responsibility must occur (e.g., through documentation in the medical record in addition to verbal confirmation during rounds).

6. Included in faculty development and resident training, conferences are held related to safe handoffs and transitions of care, and educational materials be made available to residents and faculty related to handoffs and patient safety in general.

7. Sufficient resources are in place to enable effective clinical handover, including staff training in clinical handover.

8. Incidents relating to clinical handovers are reported via the appropriate process to the Residency Program Director, Associate Program Director, Assistant Program Director, or the Director of the Emergency Department.

9. Admission Handovers: patient handovers from the Emergency Department to an admitting team occurs over the phone and in person. Initially the treating ED physician will contact the proper admitting service over the phone and will highlight the critical history and presentation of the patient, critical actions taken during the patient’s stay, pending diagnostic tests and consultations, and current status of the patient. This conversation is documented on the record. When the admitting physician arrives in the ED, it is encouraged that the emergency physician updates the admitting team on any current developments of the patient between the time of the phone conversation hand-off and the face-to-face meeting.

**Responsibilities and Surveillance**

All faculty and residents have the responsibility for patient safety. To that end, all will be held accountable for safe and effective transitions of care of all patients in the Emergency Department. The Residency Program Director is responsible for dissemination and implementation of this policy to the faculty and residents of the program. The Residency Program Director will periodically review the implementation and effectiveness of the policy and associated guidelines in consultation with department faculty and residents, including strategies for improvement. In addition, in an effort to provide on-going training in safe and effective handoffs, lessons learned from the management of clinical handover issues will be discussed during relevant conferences including PI meetings, resident meetings, faculty meetings, multi-disciplinary conferences, simulation labs, etc. On-going surveillance of the handoffs policy and other patient safety initiatives in the ED will undertaken by the Residency Program Director.
Clinical Competency Committee:

CCC Policy

Purpose

A Clinical Competency Committee (CCC) is a term used by the ACGME to describe a group of reviewers who evaluate a resident’s clinical competency based on identified criteria.

The purpose of the CCC is to provide competency-based and milestone-specific evaluation of each residents’ progress related to graded responsibility (promotion), feedback with opportunity to improve (remediation), and verification of competence to practice without supervision (graduation).

At all times the procedures and policies of the CCC will comply with those of the Department of Emergency Medicine, Emergency Medicine Residency Training Program and the AdventHealth East Orlando Graduate Medical Education Office.

Membership

The CCC will be appointed by the Program Director, Emergency Medicine and will consist of three or more faculty members who interact with residents in different settings and who are dedicated to resident education, willing to serve, reliable and professional. One of the selected faculty members will be designated as the facilitator with the remainder taking the role of support staff.

Responsibilities

CCC members are responsible for discussing each resident’s achievement of milestones and making a concrete recommendation based on data to the program director for resident progress, including promotion, remediation and dismissal.

The CCC is responsible for advising the Program Director regarding each resident’s progress, including promotion, remediation and dismissal.

The Residency Office is responsible for reporting of Milestone evaluation of each resident semi-annually to the ACGME and maintaining CCC meeting minutes.

Format
Meetings will occur semiannually and will be scheduled based upon ACGME reporting dates. An ad hoc meeting to address pressing issues that cannot wait until the next regularly scheduled meeting may also occur.

Documentation available for review includes:
- Written evaluations of faculty, peers, medical students and other health care professionals
- Clinical assessments.
- Procedure log
- New Innovations Electronic Resident Portfolio
- ABEM in-service exam scores
- Mock Oral Board scores
- Confirmation of completion of program requirements (ATLS, ACLS, PALS, etc.)
- Duty hour report
- Conference attendance report
- Scholarly Activity

Criteria for promotion*
- Consistently average or above average evaluation scores in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice and overall clinical competence.
- Adherence to program and institution requirements
- Demonstrated professionalism and communication in providing patient care
- Successful completion of rotations.
- Satisfactory rating in moral and ethical behavior.
- Successful achievement of milestones
  - **Level 1:** The resident demonstrates milestones expected of an incoming resident.
  - **Level 2:** The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.
  - **Level 3:** The resident continues to advance and demonstrates additional milestones, consistently including the majority of milestones targeted for residency.
  - **Level 4:** The resident has advanced so that he/she now substantially demonstrates the milestones targeted for residency.

Criteria for remediation and/or dismissal
- Consistently low or unsatisfactory evaluation scores in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice and overall clinical competence.
- Consistent lack of adherence to program and institution requirements
- Demonstrated conduct that is deemed to be grossly unprofessional, incompetent, erratic, and potentially criminal or threatening to the well-being of patients, staff or the resident.
- Situations in which continuation of clinical activities by a resident is deemed potentially detrimental or threatening to patient safety or the quality of patient care.
- Serious acts of incompetence, impairment or unprofessional behavior by a resident.
*See advancement checklist for PGY level specific requirements.

**Academic Advancement**

The Program Director, upon the recommendation of the Emergency Medicine Core Clinical Faculty, has the authority to advance a resident from one year to the next. The criterion for advancement follows the guidelines set forth within the AdventHealth East Orlando Graduate Medical Education Manual. This includes direct observation of the resident, rotation evaluations, correspondence between departments and written examinations (e.g. Core content tests, Inservice). It is expected that the residents participate in all aspects of the curriculum, as well as in the periodic evaluation of educational experiences and teachers. It is further expected that residents complete all administrative responsibilities of a resident (e.g. licensing, credentialing, etc.) in a timely fashion. The resident must have medical records that are thorough, comprehensive and completed in a manner consistent with AdventHealth East Orlando Medical Staff requirements. All evaluations (rotation requirements, preceptor and resident evaluation) must be documented prior to the resident semi-annual evaluation.

The criteria for advancement shall be based on six competencies set forth by the ACGME, all of which need to be evaluated as competent for the appropriate level of advancement. These parameters are:

1. **Medical Knowledge** – fund of knowledge, clinical performance rotation evaluation, clinical judgment, understanding and appropriate use of evidence-based medicine. PGY I residents must have successfully passed USLME III to be advanced to the second year.

2. **Patient Care** – ability to provide effective care of patients in both outpatient and inpatient settings; establish an appropriate doctor-patient relationship; application of knowledge to individual patient needs; effective gathering of patient information; procedural competence and experience.

3. **Practice-Based Learning and Improvement** -- able to analyze practice experience, recognize limitations and make systematic improvements; ability to locate, appraise and assimilate evidence from scientific studies; use of information technology to manage information, access on-line medical information and support own education.

4. **Professionalism**– positive working relationship with others; acceptance of responsibility; punctuality; reliability; respect; compassion; ethical principles; cultural sensitivity; integrity; responsiveness to the needs of patients and society that supersedes self-interest. There must be an absence of impaired function due to mental or emotional illness, personality disorder, substance abuse and other adjustment disorders. All residents, at every level, are expected to teach and supervise more junior residents and medical students.

5. **Interpersonal and Communication Skills** – effective information exchange with patients, their patient’s families and professional associates; work effectively with others as a member or leader of health care team.

6. **Systems-based Practice** – awareness of and responsiveness to the larger context and
system of health care; ability to effectively call on system resources to provide care that is of optimal value; practice cost-effective health care and resource allocation that does not compromise quality of care.

7. In addition to the six Core Competencies, there are 23 sub competencies which comprise the milestones initiative.

There are three steps that shall be evaluated: the PGY1 to PGY2, the PGY2 to PGY3, and PGY3 to graduation. At each level, acceptable progress in the six competencies will need to be documented. Additionally, the PGY2 and PGY3 resident must be judged competent to act with limited independence. Before graduation, the resident must be judged competent to act independently.

PGY1-PGY2
- USMLE III complete
- All post tests complete
- Patient logs and procedures logged into New Innovations
- Medical Records up to date
- Satisfactory completion of rotations Blocks 1-13 (post-tests, assignments and evaluations)
- PGY1 research requirements complete
- In-Training Exam scores above 50th percentile (for their respective year of training) or Residency Performance Evaluation Committee Individual Education Plan requirements complete.

PGY2-PGY3
- Licensure application complete
- Medical Records up to date
- Patient logs and procedures logged into New Innovations
- Satisfactory progress of ultrasound procedures logged into New Innovations
- Satisfactory progress of critical care resuscitations logged into New Innovations
- PGY2 research requirements complete
- Satisfactory completion of rotations Blocks 1-13 (post-tests, assignments and evaluations)
- In-Training Exam scores above 50th percentile (for their respective year of training) or Competency Committee Individual Education Plan requirements complete.

PGY3-Graduation
- Satisfactory completion of rotations Blocks 1-13 (post-tests, assignments, and evaluations)
- Completed Research/Scholarly Activity project presented
- All evaluations of rotations completed (faculty of resident and resident of faculty)
- All post tests and faculty-assigned projects complete
- All EM-required procedures logged in to New Innovations (Satisfactory progress must have been demonstrated by March of predicted graduation date).
• All Ultrasound procedures and scans logged into Qpath and New Innovations (Satisfactory progress must have been demonstrated by March of predicted graduation date).
• All minimum number of procedures completed and logged into New Innovations (e.g. OB, Orthopedics, etc.)

**Academic Probation**
Additionally, in the course of residency training certain individuals may need special attention addressing specific needs. Among these are issues related to academic remediation / probation plans as well as disciplinary concerns. For this reason a *Clinical Competency Committee* will be charged with supervising such concerns. This committee exists as an ad hoc committee made up of at least three of the clinical faculty with Dr. Nazario serving as chair. The Clinical Competency Committee will assist the Program Director by developing an appropriate course of action.

For instance in developing a Remediation Plan, the Clinical Competency Committee will convene to develop an assessment of the resident’s progress and their recommendation towards a resident’s developing cognitive, clinical, psychomotor and behavioral skills. This meeting is to be attended by the Clinical Competency Committee Members, along with the Program Director. At its discretion the committee may use various factors in reaching their conclusions. These may include, and are not limited to:

Inservice results
Semi-annual reviews
Psychometric testing
Referral to Physician Support Services
Intense periodic evaluations – Daily shift Cards, Formative evaluations by selected faculty, Patient logs, etc.
Referral to a Board review course

Failure to show progress in any of the areas detailed above may result in an administrative recommendation or action. This may include the requirement of remedial work, limitation of moonlighting, extension of the training period, denial of promotion, termination of the Agreement, or denial of the certificate of completion. A resident who fails ANY rotation in a year may be denied promotion. The failure of a rotation is determined by a failed rotation evaluation and/or core content test.

**Chain of Command Issues**
If a resident experiences a difficulty with a decision from the Chief Residents, they should attempt to resolve the issue with the Chiefs. If the Chiefs cannot resolve the impasse, then the issue is brought to either the Associate PD or the Assistant PD (APD). They will serve as the final arbitrator for the great majority of these discussions. There should be exceedingly few dilemmas that cannot be resolved in this manner. Then, and only then, should the Program Director be contacted by either one of the APDs regarding said issue.
As a matter of professionalism, the chain of command assures that appropriate channels have been approached in a timely manner. This sets the stage for expectations in one’s future employment and work in the field of medicine. Failure to comply with this may be considered as a breach of professionalism and will be referred to the Clinical Competency Committee.

**Dismissal, Non-Renewal & Grievance:**

Dismissal or non-renewal may occur because of failure of the resident to comply with his/her responsibilities or failure to demonstrate appropriate medical knowledge or skill as determined by the program’s supervising faculty. Dismissal may also occur where there is misconduct. Examples of misconduct include but are not limited to: being under the influence of intoxicants or drugs; disorderly conduct, harassment of other employees (including sexual harassment); the use of abusive language, fighting or encouraging a fight; threatening, attempting, or causing injury to another person while on the premises. Please refer to the GME Policy Manual for specific policies.

A resident is usually not dismissed without a warning period, except in instances of flagrant misconduct. In other circumstances, it is the responsibility of the residency program director to document a warning period prior to dismissal or failure to reappoint a house officer and to demonstrate efforts for the provision of opportunities for remediation if needed. Such opportunities must be provided and documented and placed in the resident’s training file. The resident is entitled to a copy of the documentation upon request.

In the event that a resident is to be dismissed or his/her contract not renewed, s/he may initiate a formal grievance procedure. Grievance procedures will follow the policy stated in the GME Policy Manual.

**Program Evaluation Committee:**

**PEC Policy**

**Purpose:**
The Program Evaluation Committee is responsible for the planning, development, implementation, and evaluation of educational activities, as well as reviewing and revising competency-based curriculum, and goals and objectives. The committee will also address any noncompliance with ACGME standards.

The committee will review the program semi-annually using input from the residents, faculty, and others. The committee will generate a written annual program evaluation (APE) and produce an action plan to improve any deficiencies and/or implement changes. This action plan must be approved by the teaching faculty and documented in the meeting minutes.

**Membership:**
The Program Evaluation Committee will include the Program Director who will also appoint at least three other faculty members to the committee. Additionally, two resident members will be selected and participate on the committee. All members on the committee will be considered voting members. The chairperson of the committee will be determined by the majority vote of the committee. The chairperson will be a member other than the program director. Members will be asked to participate in one year terms.

Meetings and Quorum:

A quorum of this committee will be defined as consisting of 50% plus one additional member of the committee.

The committee will be scheduled to meet at a minimum on a semi-annual basis. Regular meetings will be held in June and December annually. Special meetings may be called by any voting member as needed.

The committee chairperson or designee in cooperation with the program coordinator will set the meeting agenda, keep attendance, and maintain minutes as well as provide feedback to the Program Director.

Materials to review at the meeting will include, but not be limited to:

1. Resident evaluation of program
2. ACGME resident survey
3. ACGME faculty survey
4. Resident evaluation of faculty
5. Resident evaluation of program (also includes eval of didactics)
6. Resident evaluation of rotation
7. RN evaluation of resident
8. Other Areas as determined by committee or program

Duties and Tasks:

The committee will conduct an annual review of the residency program which will include a formal annual program evaluation. Focus will be on answering questions about program effectiveness and efficiency. The review will address questions such as how the program could be improved, whether the program is meeting its goals, and how effectively residents are being trained.

Specific evaluation objectives include:

Assessment of program design
Assessment of how the program is being implemented (i.e., is it being implemented according to plan?)
Are the program’s processes maximizing possible outcomes?
Assessment of the program’s outcomes (i.e., what has actually achieved)
Annual Program Evaluation Report:

1. The committee will provide a written review and evaluation of the residency program.
2. This will include a written plan of action for all areas identified as problematic.
3. The committee will present the improvement plan of action to the GMEC.
4. The committee via the program director will be responsible for reporting to the RRC any required materials for continued accreditation.

Professional Relationships:

Patient Care:

- Team: The team (attending physician, chief resident, intern/resident, nurse, and student) is responsible for each patient’s care. Quality care for the individual patient is the ultimate goal of each team member.
- PGY-1 resident: The PGY-1 resident rotates in the Emergency Department and in Urgent Care. In the Emergency Department setting, s/he should evaluate the patient and present findings to the PGY-3 resident and attending. In the Urgent Care setting, the resident evaluates the patient and presents the findings to the PGY-2 resident and attending.
- PGY-2 resident: The PGY-2 resident manages both the urgent and emergent cases in the main Emergency Department. S/he performs many technical procedures and directly participates in major resuscitations. S/he supervises and runs the Urgent care area and teaches medical students and PGY-1 residents in minor care procedure.
- PGY-3 senior resident staff: The senior resident supervises over-all emergency department patient flow and provides clinical teaching and supervision to medical students and PGY-1 and PGY-2 residents with faculty oversight. The PGY-3 resident directs cardiac and trauma resuscitations. S/he also handles incoming patient telephone calls and rescue squad reports.
- Attending Physician: The attending physician holds ultimate responsibility for every aspect of patient care. S/he is also actively engaged in teaching and is responsible for providing guidance and experience in all facets of the patient’s care.

Nursing Staff:

- The nursing staff is an integral part of the health-care team. Personal and professional courtesy will be extended to the nursing staff at all times. The nursing staff will be included in the patient’s course of care at all times and should be advised of any changes in treatment/diagnostic plans, special requests, or anticipated problems.
- Residents are responsible for a significant contribution to the education of the nursing staff. Such information is vital to assist them in taking better care of the patients. Explanation and thoughtfulness will yield manifold results.
• Simple “pick-up-after-yourself” and care in performance of procedures will allow the nursing staff more time with your patients.

**Pharmacy Staff:**

• The pharmacist is another vital member of the health-care team. S/he is responsible for all medications dispensed in the hospital.
• S/he is also a ready source of information on the various therapeutic agents, their dosages, compatibilities, toxicities, administration forms, and combinations.
• It is the pharmacist’s legal and professional responsibility to ensure that the intent of your order is fulfilled. When the pharmacist questions an order, s/he is doing so to ensure that the patient receives the appropriate medication in the appropriate dosage.
• If you are paged by the pharmacist, it is your duty to respond quickly and courteously.

**Resident Interaction with Medical Students:**

All residents will be expected to participate in the education and mentoring of medical students. This will enhance their training and will include:

• Teaching requisite patient care procedures
• Instructing in the development of logical approaches to clinical problems
• Encouraging reading in Emergency Medicine texts and journals, providing the student with select review articles on topics concerning their patients
• Instructing and assisting in the development of good patient care and treatment
• Reviewing each student’s “work-ups” and providing constructive criticism
• Treating the medical student in a professional and courteous manner
• Assigning cases and patients
• Enforcing reading and preparation for specific cases that they will observe in the Emergency Department.

**Continuity of Care/Night Call Activities:**

**Continuity:**

Continuity of care is an important facet of residency training. There are multiple ways of obtaining this training. One method is follow-up of interesting/complicated patients after their transfer from the Emergency Department; another is the night-call experience.

Emergency Medicine residents are expected to follow-up on interesting/complicated patients that they saw in the Emergency Department. This can easily be accomplished by adding the patient to the sign-on list in the hospital computer system which enables the resident to receive daily follow-up, including operative reports, autopsy reports, discharge summaries, etc. Residents may also track who is currently caring for their patients in the even that they would like verbal
follow-up to discuss the progress of these patients with the admitting service. Residents must be able to provide examples of this tracking to their attending.

**Call Duties:**

**Night Call:**

Another means of continuity in training is the call experience. The purpose of night call is to provide residents with patient care experiences throughout a 24 hour period. There are specific guidelines that provide for this experience while still maintaining adherence to duty hours policy:

- In-house call must occur no more frequently than every third night, averaged over a four-week period
- Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, or conduct outpatient continuity clinics.
- No new patients may be accepted after 24 hours of continuous duty, except in outpatient continuity clinics. A new patient is defined as any patient for whom the resident has not previously provided care.

In the first and second years of training, residents will have an average of 1.9 days per week of call, and in the third year of training, the amount of call will reduce to an average of 1 day per week.

**On-Call duties for EM residents:**

In order to provide full coverage in the Emergency Department during most of the week, residents will be placed on-call for a block at a time in the event that a resident who is scheduled to work is absent. The on-call resident must be in the city of Orlando and available to report to work within 1 hour being called to cover the absent resident. The resident who is on-call is excused from his activities on the rotation that he/she is on for that day. For those residents covering 7am-7pm shift, he/she is excused that day from his/her activities in whichever outside rotation the resident is on, and for those residents covering 7pm-7am shift, he/she is excused from his/her activities on the rotation he/she is on the following day. The Chief residents are responsible for notifying the preceptor that the on-call resident is covering a shift.

The resident that is scheduled to work and is absent will be sanctioned as per the rules set in the disciplinary action section of the handbook.

The on-call duty schedule can be found on the homepage of New Innovations
- PGY1 residents will cover shifts when another PGY1 is absent.
- PGY2 residents and PGY3 residents will cover either one. PGY3 from July to December and PGY2 from January to July.

The rotations that will be used to assign the on-call residents are as follows:
- PGY1 resident during his/her EMS/Selective rotation and another block assigned by the Chief Resident
- PGY2 resident will be on call in a block assigned by the Chief Resident
- PGY3 resident during his/her Administration/Elective rotation

**At-Home Call:**

At-home call is defined as call taken from outside the assigned institution.

- The frequency of at-home call is not subject to the every third night limitation. However, pager call must not be so frequent as to preclude rest and reasonable personal time for each resident.
- Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
- When the resident is called to the hospital from home, the hours spent in house will be counted toward the 80-hour limit.
- The program director and faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
- In case of critical overload of sick patients, on call residents will aide in patient care.

**On-Call Guidelines:**

- The GMEC adheres to ACGME guidelines regarding the frequency of call. The policy may be found in the GME manual.
- Responsibilities while on call shall include responding to all calls in a prompt and courteous manner, either by phone or by personal evaluation of the patient, as appropriate. Additionally, any significant changes in patient coordination will be communicated to a senior resident and the responsible attending physician.

**Duty Hours:**

Duty hours are defined as all clinical and academic activities related to residency training, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site. The ACGME sets forth the following guidelines for training of residents in Emergency Medicine.

**Duty Hours -- Emergency Medicine rotations:**
• As a minimum, residents shall be allowed an average of 1 full day in 7 days away from the institution and free of any clinical or academic responsibilities, including planned educational experiences.
• While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. Residents must have at minimum eight (8) hours off between shifts and, if possible, should have ten (10) hours off (as specified in ACGME VI.G.5.b)). The scheduled clinical shift is the basis for the required time off and allows the other clinical time (finishing documentation, handing off, etc.) to count towards the total duty hours average.
• A resident should not work more than 60 scheduled hours per week seeing patients in the ED and no more than 72 duty hours per week.

Duty Hours -- Non-Emergency Department Rotations:

• Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
• Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
• Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.

Emergency Medicine residents at all levels of training shall be allowed an average of one day in seven (averaged over a four-week period) free of clinical responsibilities (see above).

Residents will be relieved of their clinical duties no later than 1:00 pm the day following in-house night call (a maximum of 6 hours post call).

Lack of compliance by any resident will result in the “Emergency Duty Hour Call Plan”

Other Policies:

Disaster Plan (Hurricane):

At the issue of a Hurricane WATCH by State and/or local governments for Brevard, Volusia, Seminole, Osceola, or Orange counties, faculty, residents, students, and staff will follow initial preparations guidelines.

At the issue of a Hurricane WARNING by State and/or local governments for Brevard, Volusia, Seminole, Osceola, or Orange counties, a team of faculty, residents, and students will be activated for first 24 hour shift including overnight at the hospital in anticipation or preparation for the disaster. This is to ensure coverage in the event roads are not passable after the initial stages of the disaster. The second team will report to the hospital at 7:00 am the next day or as soon as
physically possible to travel on the roads to relieve the first team that stayed overnight at the hospital. (See attached Team Assignments.) All Team Members should contact Medical Education to advice of status, location, and current phone numbers.

**Initial Preparations:**

At the issue of a Hurricane Watch, Team 1 should begin emergency preparations. Check pagers and have a fresh battery. Externs are to come to Medical Education and provide current phone number.

**Notification of Disaster (Hurricane) Warning:**

Teams will be activated. Normal rotations will be suspended until recovery is complete at a time determined by the DME.

All residents are to:

1. Report to the command center.
2. Support resident service areas if needed and available.
3. Keep attendings, Chiefs, and Command Center appraised of location and availability.
4. Both teams may be called in initially and the shifts worked out according to workload demands.

Teams will thereafter go to twelve-hour shifts with a twelve-hour recovery shift, or other shifts as assigned, before returning to normal rotations. Normal dress code regulations will be suspended for the duration of the emergency. Scrubs may be worn.

Medical Education office will be closed at the discretion of the DME. All faculty, residents, externs, and other personnel are to wear name badges at all times while in the hospital. If name badge is missing, employee is to go to the command center check-in and be arm banded.

Faculty will release employees after discussion with the DME and not without Command Center notification and agreement. All employees will be available when in the hospital to provide whatever services Command Center may need. All employees are to be present at assigned location. Failure to appear will result in a review and possible disciplinary action up to and including termination.

Employees may bring immediate family members with them when they report to work. All family members are to bring three-day kits and bedding. Each person is to check in and be arm banded before taking them to their assigned location. Pets are not allowed.

All activities are to be coordinated with the Command Center.

**After the Disaster (Hurricane)**
The DME will meet with the Command Staff for debriefing. Disaster (Hurricane) Report will be provided to Administration.

Command Center:

The Command Center will begin functioning at the determination of the Hospital Administrator and will be located in the Emergency Department Conference Room. The DME or DME representative will attend all scheduled Command Center meetings prior to, during, and after disaster to assist with coordination.

**Phone Numbers:**

- Special Needs Patients (Orange County) 836-7115
- Medical Education AHEO 303-8683
- Command Center Extensions at AHEO 6842, 6843, 6844, 6845, 6846, 6847, 6848, 6849, 6850, 6851
- Cell phone number: 342-8232

**Team Assignments:**

**AdventHealth East Orlando East Orlando – Department of Medical Education Team Assignments**

<table>
<thead>
<tr>
<th>Team 1</th>
<th>Team 2</th>
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<tr>
<td>Ryan Peterfy</td>
<td>William Kotler</td>
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<td>Day Zayas</td>
<td>Julian Trivino</td>
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<td>Shayne Gue</td>
<td>Brian McMaster</td>
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<td>Katie Laun</td>
<td>Kenneth Frye</td>
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<td>Casey Arnold</td>
<td>Eli Kennedy</td>
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<td>Andrew Gibson</td>
<td>Shannon Armistead</td>
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<td>Ashley Gregory</td>
<td>Elizabeth Kim</td>
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<td>Ambar Marin</td>
<td>Bradley Parrish</td>
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<td>Mohammad Ramadan</td>
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**Dress and Grooming:**

All individuals on the Emergency Medicine service are expected to look and act as responsible physicians. Professional appearance and manners are to be exercised at all times in all environments, even though the work and conditions may be very stressful. Appropriate grooming and attire are always required. Good personal hygiene is mandatory. Use of deodorant is encouraged, and to be considerate of patients and fellow staff, residents should not wear strong fragrances.

The resident will be expected to follow the dress code as printed in the GMEC manual. The policy on wearing scrubs is as follows: “Scrubs may be worn in the hospital when appropriate
(ED, ICU, OB, Anesthesia, Surgery, Night rotations). AdventHealth East Orlando scrubs are not to be worn outside of the hospital. Athletic footwear may be worn in the hospital if the resident is wearing surgical scrubs. Physician white coats should be worn at all times if the resident is not wearing the approved scrubs or if scrubs do not have the residents name embroidered. When attending academic activities in hospital, residents are to dress in professional attire and wear their physician white coat, as well. The use of torn or worn jeans, shorts, t-shirts, flip-flops or other inappropriate clothing is strictly prohibited.

**Work Environment:**

Providing a sound academic and clinical education must be balanced with concerns for patient safety and resident well-being. The program will ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents’ time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of our patients.

**Leave:**

The American Board of Emergency Medicine requirements for residency training in order to qualify for certification are specific regarding the amount of time that must be accomplished; the physician must successfully complete a minimum of thirty-six (36) months of post-medical school training under the control of an Emergency Medicine residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). The ABEM has adopted a policy regarding resident absence from a training program as it relates to the Board’s credentialing requirements. The policy is as follows: “Leaves of absence, vacation time, sick time, etc., that exceed six weeks in an academic year require extension of the residency program. Such leave time cannot be accrued from year to year. Therefore, the Board defines an acceptable year of training as a minimum of 46 weeks.” The program director is ultimately responsible for verifying successful completion of a resident’s training time to fulfill the Board’s minimum credential requirements. The ABEM further states that if a residency program already has a policy in effect for leave time that is less than six weeks, the program’s policy may take precedent over the ABEM policy.

Further, it is the policy of AdventHealth East Orlando that no time-off requests are permitted during the last two weeks of a resident’s contract period. General guidelines for time away can be found in the GME manual.

**Program-specific guidelines:**

- **Vacation/Sick Days/Holidays:** Residents will be provided with 20 paid days off per year. This time includes vacation days, sick days, and holidays and is in addition to granted days for Board Examinations.
- **No vacation time will be permitted during required planned educational conferences such as EKG and critical care conference, symposium on emergency medicine, ACLS, PALS,**
NRP and ATLS, along with the annual GME retreat. The program director will have to approve all vacations. Residents should not purchase tickets to any destination or confirm arrangements until you have been given explicit written approval by the Program Director.

- **Education:** AdventHealth East Orlando provides the resident with an annual continuing medical education allowance (CME) and paid leave to attend educational activities that will contribute to the quality of their training.
- With the exception of the education leave allowance, leave may not be carried over from one appointment year to the next, and there is no payment for unused time.
- **FMLA:** Please refer to the GME Manual for specific policy on family and medical leave, extended sick leave, maternity leave, paternity leave, and adoption leave.
- Written request for time off is mandatory and must be submitted to the Program Director. Initial requests will be solicited prior to the start of the academic year while the annual schedule is being written. Requested vacation periods are not guaranteed. Requests for changes must be accompanied by prearrangement of who will cover the resident’s absence on a service with mandatory coverage.
- **Unexcused absences:** If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident or Program Director, the absence will be considered unexcused. Unexcused time will be taken from the resident’s leave bank. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending on the severity and frequency of the infraction. Arrangements for “payback” to the other residents who may be assigned to cover in the resident’s absence will be made at the discretion of the Program Director. Unexcused absence will result in an additional shift and 30 minutes lecture on a Thursday that will be scheduled in advance. It is common courtesy to let your attending, chief resident or directors know that you are going to be late or not show up to your shift as early as possible.
- **The faculty considers lateness an issue of professionalism.** Any lateness to either an ED shift or EM lecture may incur a penalty of an additional shift being added in the future. Drs. Adewale and Nazario will be the arbiters of the decision. For instance, people are expected to arrive and be ready to work prior to their assigned start time. ED shifts usually begin at 0700 and 1900, so arrival beforehand to settle in and log on and be prepared to see patients at the hour are the expectation.

**Moonlighting:**

Please refer to the GME Manual for the policy on resident moonlighting.

**Stress, Fatigue and Impairment:**

There is a growing awareness that fatigue has an adverse effect on performance. Symptoms of fatigue and/or stress are normal and expected to occur periodically during residency as well as after, just as it would in other professional settings. In residency training, impaired performance means missed opportunities for learning the potential of harm to patients.
The Department of Emergency Medicine follows the Policy for Fatigue. Faculty and residents shall be educated to recognize the signs of fatigue. Policies and procedures shall be developed to prevent and counteract the potential negative effects of fatigue. Every faculty member and resident will receive a copy of the policy.

Purpose: The Accreditation Council for Graduate Medical Education (ACGME) requires all training programs to educate faculty and residents to recognize the signs of fatigue and adopt and apply policies to prevent and counteract their potential negative effects.

Responsible Parties: Faculty and Residents of the AdventHealth East Orlando Emergency Medicine Residency.

AdventHealth East Orlando Resources:
Fellow residents
Chief residents (available 24 hours/day)
Attending physicians
Program Director (available 24 hours/day)
Employee Assistance Program (EAP): 1-888-802-5821 (available 24 hours/day)
Physician Support Services 407-303-9674

Signs of Fatigue Include
Involuntary nodding off
Waves of sleepiness
Problems focusing
Lethargy
Irritability
Mood lability
Poor coordination
Difficulty with short-term recall
Tardiness or absences at work
Inattentiveness to details
Impaired awareness (falling back on rote memory)

Fatigued Residents Typically Have Difficulty With:
Appreciating a complex situation while avoiding distraction
Keeping track of the current situation and updating strategies
Thinking laterally and being innovative
Assessing risk and/or anticipating consequence
Maintaining interest in outcome
Controlling mood and avoiding inappropriate behavior

High Risk Times for Fatigue-Related Symptoms
Midnight to 6 am
Early hours of day shift
First night shift or call night after a break
Change of service
First 2 to 3 hours of a shift or end of shift
Early in residency or when new to night call

Processes to limit fatigue-related problems include:
- 80-hour work week (60 hours for Emergency Medicine)
- Residency workload with as little variability in work schedule or day-night cycles as possible
- Consistent scheduling templates with predictability
- Many physical illnesses can present as fatigue and should be ruled out when daytime fatigue seem out of proportion to the resident workload
- Medical evaluation with possible sleep study
- Depression and other psychiatric syndromes may first be manifest as fatigue. Proper diagnosis and treatment are needed

Prevention

The department of Emergency Medicine residency program:

- Incorporates discussions regarding the management of fatigue into the program conference curriculum for both faculty and residents.
- Monitors resident and program compliance with Institutional and Program-specific duty hour policies
- Minimizes prolonged work (no more than 12 hours of clinical duties)
- Protects periods designed to address sleep debt (i.e., the minimum of at least 24 hours off each week free from all clinical responsibilities and at least 10 hours off between duty periods)
- Incorporates the topic of prevention, identification and management of fatigue into multi-disciplinary Institutional Curriculum conferences.
- Where appropriate, assists residents during semi-annual reviews with the Residency Faculty to identify co-existent medical issues which impair their sleep (i.e. undiagnosed sleep disorder, depression, stress)
- Provides safe and secure call rooms for residents on call or who elect to rest before driving post-call.
- Provides cab ride home for residents who show signs of fatigue following an ED shift.

Recognition

Restricting duty hours alone does not preclude fatigue. The Emergency residency program must identify the presence and effects of persistent fatigue and strategies to ameliorate the impact. We have a responsibility to ensure that faculty and residents are educated to become knowledgeable about sleep science as it applies to resident performance and health. Resident stress may increase if residents are concerned about losing significant learning opportunities, procedural experience and interaction with colleagues. Residents may feel support is lacking from senior residents and faculty who may have an inadequate understanding of the rules surrounding duty hour mandates. As has been reported widely, fatigue, similar to the effects of alcohol, slows reaction time, saps energy, diminishes attention to detail and degrades communication and decision-making skills---all things that hinder patient safety and the safety of our residents. Fatigue, called by some
authors "excessive daytime sleepiness", may be due to a variety of factors. These may exist alone or in combination and include:

- too little sleep
- fragmented sleep
- disruption of the circadian rhythm (such as may occur with night float work)
- other conditions which may masquerade as fatigue such as anxiety, depression, thyroid disease or other medical conditions, or medical side effects
- primary sleep disorders

Too little sleep may be the most common reason for sleepiness among residents, occurring when residents get less sleep than optimal. Although there is individual variation, most adults require an average of 8 hours of sleep each night. Residents may not have developed good sleep habits in college and medical school for adequate sleep even on their nights off. Further, sleep deprived subjects are often unaware of the severe degradation of their decision-making skills.

**Resident Self-Care**

Residents need to consider the following:

- refrain from driving if drowsy; get a ride from a taxi service, take a nap using day room service first and/or pull over and take a nap if necessary
- become educated and learn to recognize the signs of fatigue. Do not be embarrassed to discuss these issues openly.
- make sleep a priority; be appropriately selfish about needed sleep time. Excessive fatigue can affect every facet of life.
- keep to routine as much as possible.
- get adequate exercise but avoid exercising directly before sleep.
- protect sleep time. Turn off phone. Ask your family/significant others, friends to help you. Make efforts not to incur a sleep debt from non-work activities.
- get as much light exposure as possible when awake.

**Departmental Response**

Excessive fatigue and/ or stress may occur in patient care settings as well as non-patient care settings such as lecture and conference. In patient care settings, patient safety and well-being of the patient mandates implementation of an immediate and proper response sequence. In non-patient care settings, the response may vary based on the severity of and the demeanor of the resident’s appearance and perceived condition. The following is a general guideline for those recognizing or observing excessive resident fatigue and/ or stress.

**Identification of the fatigued resident when involved in patient care:**

Faculty and other residents are to report such concerns of sleepiness, tardiness, resident absences, inattentiveness, or other indicators of possible fatigue or excessive stress to the supervising attending or Program Director.
Responsibilities of the Attending Physician:

If the attending physician notices evidence of excessive fatigue and/ or stress and appears to be disabled as a result, the Chief Resident or Residency Program Director (or Associate Program Director) must be called and the resident should be released from any further patient care responsibilities at time of recognition. If a supervising resident notices this, he or she must make the attending aware so that this process may be initiated. The attending or supervising resident should privately discuss his/ her opinion with the resident, attempt to identify the underlying reason for the fatigue, and discuss the amount of rest needed to alleviate the situation. The resident will be relieved of clinical duties. Decisions related to staff replacement will take into account the remaining staffing level and volume and acuity of patients in the Emergency Department and the on call resident may be activated.

The resident should rest at the hospital prior to driving or use a taxi service to get home. In addition, the resident should be advised that someone should pick him/ her up for transportation home. The resident who has been released from further patient care cannot appeal the decision and must have permission to resume work from the supervising attending or Residency Director.

Responsibilities of the Residents:

Other residents who notice a colleague’s fatigue have the professional responsibility to notify the supervising attending, Chief Resident, or Residency Director without fear of reprisal. A resident who feels fatigued has the professional responsibility to notify the supervising attending, Chief Resident, or Residency Director without fear of reprisal.

Additional Responsibilities of the Program Director/ Chairman:

If the removed resident’s absence results in immediate impact on other residents this should be accounted for immediately and resolved where required. The resident’s schedule, patient care responsibilities, and personal problems/ stressors will be discussed. When necessary, the rotation will be reviewed for potential changes. If the problem is recurrent or not resolved in a timely manner, the resident may be removed from patient care responsibilities indefinitely. A medical evaluation may be requested or required as the situations warrant.

Employee Assistance Program (EAP): This program assists faculty, staff, and their families with the resources they need to resolve personal, family, or job-related problems. EAP offers a comprehensive worksite-based program to assist in the prevention, early intervention, and resolution of problems that may impact job performance. The EAP is staffed with well-trained, caring professionals who listen and offer support and guidance. EAP is confidential and voluntary. You can contact EAP at: (888) 802-5821.

Employee Health Clinic: The employee health clinic handles pre-employment physicals, performs annual physical assessments and PPD tests, and administers vaccinations. It also provides triage and evaluation for work-related injuries during normal business hours and does educational promotions, blood-borne pathogen counseling and treatment, and follows up on TB
and other infectious disease exposures. The employee clinic can be reached at: (407) 303-1535 (or tie: 844-1535). Residents may opt to go to the Family Health Clinic for a charge of $10.00 per visit.

**Physician Support Service:** This confidential service is available to medical staff, residents and their immediate families. The service may be utilized by contacting (407) 303-9674. Let the residency coordinator know if you have questions about this service.

**Faculty psychologists:** The psychologists on staff as part of the staff in Graduate Medical Education are also available to the residents and their families as a resource in times of stress.

**General Information:**

**Ink Stamps:**

At the beginning of training, each resident will be issued a small pre-inked rubber stamp with his/her name. This stamp is to be used on all official documents, including, but not limited to: medical records, patient notes, and prescriptions in addition to the resident’s signature. If the stamp is lost, it will be the resident’s responsibility to notify the program coordinator and to pay for replacement when a new stamp is ordered.

**Resident File Access:**

The GMEC requires that the resident’s file is regarded as confidential, is maintained in a secure location, and is available only to the following:

1. Program Director
2. Residency Coordinator
3. Director of Academic Affairs
4. Administrator of Medical Education
5. Chair of Medical Education
6. Resident (under supervision)

The GMEC authorizes the Program Director, Director of Academic Affairs, Administrator of Medical Education, or the Chair of Medical Education to disclose the file or portions thereof to others whom they deem to have a legitimate need for the information or as authorized in writing by the resident. The GMEC policy requires that the exterior of each file will state: “Confidential Information – Access to this File and its Information is governed by the GME Manual on Resident File and Access.” Electronic files will have this statement on its opening or at a place within the file designated by the Program Director.

**Resident Loan Deferment:**
Loan deferment forms should be submitted to the residency coordinator. The department will
certify the house officer’s current academic year of training and the anticipated graduation date.

**Resident Workspace, Lockers & Mailboxes:**

Office space is provided in the Emergency Department and lockers will be provided. A
computer with inter- and intranet access will be available and access to EPIC Mailbox and EPIC
for medical records and laboratory reports will be on this computer. Space will be provided, as
well, for storage of personal items. Resident mailboxes for regular mail and schedules are also
located in this space.

**EM Resident Follow-Up Procedure**

The Emergency Medicine Residency Review Committee requires EM Residents to obtain
outcome or follow-up data on patients evaluated and treated on Emergency Department
rotations. During EM month rotations, residents are required to complete four patient follow-ups
per four week ED rotations. Residents are required to complete the Follow-up Template on the
selected patients and place them in their portfolio in New Innovations. The Follow-up template
will be made available by both electronic and paper format.

Follow –up portfolio consists of three parts. First, select an interesting, complex or confusing
case you saw. Secondly, seek information from a textbook, journal or other source (maybe
several sources). Lastly, reflect on how your new knowledge would change your approach to this
and future cases. This is the essence of practice-based learning.

Example:

1. Select one of your own cases that you felt required additional
   knowledge to treat comfortably. Patient had atypical pain but I was
   concerned because he had ECG changes and new dyspnea on
   exertion. He was young? Was this an MI or something else? If it was
   something else, could I have sent him home? How will I know next
time?

2. Obtain a copy of the chart. You may keep one of the patient’s labels
   then later print a copy of the scanned chart from FirstNet.

3. Obtain patient follow up information. Contact the admitting resident
   or access a discharge summary from the electronic medical record.
   IE the patient had pericarditis and was discharged home on NSAID’s
4. Find the answers to the questions that arose as you managed the case using textbooks, articles, online sources, consulting experts or some other source. Summarize the things you learned and list the references.

5. Reflect on what you learned. How would you have managed this case differently i.e. how does this change your future practice? This reflection could be in the form of a letter or a concluding paragraph. I’ll look for these EKG changes I missed the first time. Though he did not have all the typical features he had…….Keep all of these components and place in a folder for program director at end of four week EM period.
Emergency Medicine Residents at the R-1 level for the 2016 – 2017 Academic Year are expected to:

**General Requirements**

1. Be aware that this EM Residency is three years in duration.

2. Attend EM Residency Orientation, including ACLS, BLS, PALS, NRP and ATLS courses (or provide documentation of current card from these courses), residency orientation, East Orlando Hospital orientation and AdventHealth East Orlando Orlando orientation.

3. Review educational goals and objectives for each R-1 rotation prior to starting the rotation. These goals and objectives will be posted to New Innovations at the start of the R-1 year.

4. Review R-1 annual block schedule for the year, including assigned rotations and vacation blocks.

5. Behave in a highly professional manner, maintaining appropriate standards of conduct, dress, and hygiene. This also includes being on time to work, both on the EM rotations (shifts) and off-service rotations. Always treat patients as customers to whom a service is being provided.

6. Observe the norms of practice, call frequency, scheduling, and shift/call duration, as assigned on EM and off-service rotations.

7. Complete patient documentation and medical records in a timely manner as required by EM and off-service rotations.

8. Review rotation call/shift schedules in advance and deal with any scheduling conflicts in a timely manner.

9. Report absence from clinical responsibilities on a rotation for a break, lunch, etc. to the senior resident/faculty on that service.

10. Get prior approval from the administrative EM Chief Resident and the Residency Office for planned absences from EM and off-service rotations (e.g. vacation, USMLE exam, a day or more on off-service rotation, etc.). Also get prior approval by the involved off-service rotation Chief Resident or other appropriate personnel for planned absences (senior resident or Attending). Do not purchase tickets or commit to a purchase prior to receiving written confirmation from the Program Director.

11. Discuss unanticipated absence due to illness as early as possible with the administrative EM
Chief Resident and if rotating on off-service rotation, with Chief Resident for that service or other appropriate personnel. The R-I resident will attempt to find coverage (e.g. shift change), and follow other standard procedures for the Residency. It is expected that the R-I resident will make up the shift at a later date, preferably by covering a shift for the resident that covered the ill shift. When possible, permission will be given for unanticipated absence due to family emergency. The same rules as above apply to this situation.

12. Show up for all scheduled shifts or scheduled off-service rotation days. Failure to show up for a scheduled shift or off-service rotation day that necessitates calling in a different resident will result in a need to pay back double the amount of time. For example, if a resident fails to show up for a shift and the on call resident covers the shift, then the resident who missed the shift owes 2 shifts to the on-call person who covered the shift. This occurs automatically whenever the on-call person arrives and starts to cover the shift or off-service day.

13. Unexcused absences: If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident or Program Director, the absence will be considered unexcused. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending on the severity and frequency of the infraction. Unexcused absence will result in an additional shift and 30 minutes lecture on a Thursday that will be scheduled in advance. It is common courtesy to let your attending, chief resident or directors know that you are going to be late or not show up to your shift as early as possible.

14. Arriving late to a shift. It is unacceptable to arrive late to your shift. Unexplained lateness means arrival after the start of a shift. **Late shifts will count as unexcused absence.** Additionally the unexcused time will result in making the time up on an extra shift plus a lecture.

15. Work the full length of the shift or off-service duty period, unless intentionally released early by the supervising attending (EM blocks) or senior resident (off-service blocks). On the Pediatric EM service, this is done only with the permission of the Pediatric attending.

16. Comply with requests/deadlines from the Residency Office for information, documentation requests, etc. For example, selecting elective time by a certain date as requested.

17. Read emails in a timely manner, checking at least twice a day. The Chief Residents or Residency Office can assist you with information on how to check emails when you are off-campus on off-service rotations or at home. Per GME Policies, residents are required to check their AdventHealth East Orlando e-mail accounts at least twice a day.

18. Notify Program Director of any malpractice claim, question of impropriety, or unexpected adverse outcome on the EM or off-service rotations.

19. Notify Program Director of any serious conflicts on the EM or off-service rotations

20. Notify Residency Office (Residency Coordinator) of changes of address, phone number or e-
21. Supply Residency Office (Residency Coordinator) with updated medical licenses, DEA, as well as copies of current ACLS, BLS, NRP, PALS and ATLS cards showing successful completion of courses and expiration dates.

22. Complete daily shift cards for review and have supervising attending sign

23. Log all duty hours in New Innovations on a weekly basis (Sunday to Saturday). All residents will complete the validation of their duty hours from the week before by 0900 every Monday morning.

   a. Residents whose hours are not validated by 0900 on Monday morning will receive a notice on outlook and will be required to complete the validation by 1200. Those who have not completed their hours by 1200 will be required to present to the EM Residency Leadership in person and complete/validate their time.

While on duty at AdventHealth East Orlando Orlando attend all Grand rounds that do not conflict with the EM Didactic series:

Academic Requirements

1. Complete and stay current on all academic requirements, including conference attendance, EMS requirements, timely procedure log data entry, timely follow-up logs, examinations, and presentations at residency conference. All scholarly activity requirements are listed on the Scholarly Activity Checklist (attached to the end of this document). There may be additional academic requirements as deemed necessary by the Program Director - the resident will receive written notice of any additional requirements. A review of current status of these academic requirements will be presented to the R-I resident.

2. Attend 100% of the Residency Conferences. Inform the Residency Leadership if you are having difficulties getting back for conferences. Residency conferences are mandatory scholarly activities. All are required to attend all conferences. This time is protected from any other activities for that purpose. Attendance to conferences will be considered as a regular shift and the same rules for unexcused absences will apply.

3. Complete EMS requirements as assigned to the R-I class for the academic year, including 4 hours of 911 Call station observation and 1 EMS ride-out. There is no helicopter ride-out requirement for the Residency. But if a resident chooses to ride with the helicopter, this will replace the one EMS ride-out requirement. The EMS ride-out can also be with a system Medical Director or a shift supervisor for the EMS service. The ride-out can be done with Orlando or suburban EMS services.

4. Complete procedure log data entry, paying special attention to recording resuscitations. Data should be entered when performing procedures. The procedure log provides important documentation of resident experience, and will be reviewed when the Program Director and the Clinical Competency Committee evaluate resident clinical competency, and for recommendations
as to hospital privilege credentialing and licensing. Some hospital credentialing committees are now requesting copies of your procedure log as an adjunct to documenting skill competencies. The recording of procedures at various hospitals is also of importance to us when we review the effectiveness of an off-service rotation such as the AdventHealth East Orlando Critical Care Rotation. Of critical importance is the documentation of resuscitations. The RRC-EM defines "resuscitation" as "patient care where prolonged physician attention is needed, and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g. thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (e.g. cutdowns, central Line insertion, tube thoracostomy, endotracheal intubation) are necessary for stabilization and treatment." The resuscitation should have "director" or "participant" listed as the role of the EM resident. Please also separate Pediatric and Adult medical and trauma resuscitations. Minimum numbers of resuscitations that must be documented prior to graduation can be found on the attached list.

a. Update procedure logs in NI on a weekly basis (Sunday to Saturday). All residents will complete the procedures from the week before by 0900 every Monday morning.
   1. All information must be complete when filling out procedure log. Also required is adding a brief synopsis of patient presentation in the “comments” section.

5. Prior to graduation, EM residents will complete a scholarly activity project. This project must be approved in advance through the Program leadership. The scholarly activity project will be of publishable quality and may be original research, review article, - case report, abstract, chapter, etc. The project may be done during any of the three years, but the resident is strongly urged to decide on a project and begin the project by the mid point of the R-2 year. Follow EM Research Curriculum Guideline. All research projects and scholarly activities submitted by the residents must have a residency faculty sponsor.

6. Comply with residency for failure to complete academic requirements. Upon notification of being out of compliance, the resident will meet with the program director or designated faculty member to discuss the problem and develop an action plan. Thereafter the resident will meet every 4 weeks with the program director or designated faculty member to discuss progress in coming into compliance with the requirement. Upon notification of being out of compliance, the resident will have 28 days from notification or other time period as deemed necessary by program director or designated faculty member to come into compliance with the requirements. In addition the resident will have two 12- hour ED shifts added to the next block rotation schedules. If the resident is still out of compliance after the block, further actions including possible termination will be taken. Due process will be followed. Rotational hours will remain in compliance with RRC-EM.

7. Residents who are not current on the residency academic requirements will be counseled and other potential actions include academic probation. It should be noted that completion of all R-1 academic requirements is necessary for promotion to the R-2 level. The Department’s Due Process Policy will be followed with regards to academic probation. Additionally, a determination may be made by the Residency Leadership to assign extra shifts, decline resident requests for days off, not allow resident to participate in Wellness/Graduation activities.

Examinations
1. Participate in the annual In-Training Examination administered by the American Board of Emergency Medicine.

2. Participate and successfully complete other written examinations as required by the Program.

3. The results of examinations may be used by the Clinical Competency Committee and the Program Director to develop individual resident academic goals for the upcoming year, including but not limited to a special reading program. Low scores are of concern and the resident may have outside physician employment privileges limited or removed to encourage reading and academic endeavors to improve the resident's knowledge base.

4. The USMLE Step III exam must be completed by the end of the R-1 year and must take place during an Emergency Medicine rotation. The chief residents and residency coordinator must be notified of the test date and time as soon as possible.

Evaluations

1. Faculty and senior EM residents will evaluate performance for R-1 adult EM rotations. Composite evaluations for the EM and blocks as well as rotation evaluations for off-service rotations will be available in the Resident Portfolios. These evaluations will then be summarized in the two semi-annual evaluations. Problem evaluations will be brought to the attention of the R-1 resident and an appropriate response developed.
   a. Residents must select a preceptor or faculty member to evaluate and to evaluate them each block. These preceptor matches must be created in New Innovations within one week of the start of each block. All residents will complete the matches in New Innovations by 0900 Monday morning of the week following the start of the rotation.
      i. Residents whose matches are not completed by 0900 on the Monday morning following the start of the rotation will receive a notice on outlook and will be required to complete the matches by 1200. Those who have not completed their matches by 1200 will be required to present to the EM Residency Leadership in person and complete them in person.
   b. Residents must complete a faculty/preceptor evaluation and a rotation evaluation each block. These evaluations must be completed in New Innovations within one week of the end of each block. All residents will complete the evaluations in New Innovations by 0900 Monday morning of the week following the end of each rotation.
      i. Residents whose evaluations are not completed by 0900 on the Monday morning following the end of the rotation will receive a notice on outlook and will be required to complete the evaluations by 1200. Those who have not completed their evaluations by 1200 will be required to present to the EM Residency Leadership in person and complete them in person.

Core Competencies

1. The residency is incorporating the new ACGME required core competencies in the education and
evaluation process. All residents receive a copy of the competency-based form used for evaluation during the EM block rotations.

2. The template used for the residency curriculum is the Model Practice of Emergency Medicine that has been modified to include the core competencies.

3. The core competencies are an integral part of the overall resident evaluation process, including the rotation evaluations, the Evaluation by Direct Observation, and in the Nursing Evaluation of EM Residents.

4. Resident Portfolios are available to all EM residents in New Innovations. Contents of the Portfolio include: annual block rotation schedules, follow-up logs, procedure log updates, evaluations (including exam results), scholarly activity, performance improvement project, Rules of the Road, EMS activities.

Outside Physician Activities

1. Adhere to the policy of outside activities during the residency. Additionally, all other programs that may interfere with the resident’s duties will need prior approval from the Program Director. This includes, but is not limited to: Graduate and Post-Graduate degrees and programs.

Other Requirements

1. Do not perform patient care or procedures that are beyond the scope/training of the R-1 resident, or for which the resident feels uncomfortable. For example, if the R-1 resident doesn't feel comfortable with a procedure, then assistance from a more senior resident or faculty should be sought.

2. Be aware that the Clinical Competency Committee of the Department of Emergency Medicine will meet at least semi-annually to make recommendations to the Program Director on resident progression to the next year of training, and other matters related to the resident's clinical, professional, and academic performance.

3. Progress to the R-2 year only after successful completion of all R-1 clinical performance/competency requirements and the academic requirements.

4. Be aware that board-certified or board-prepared EM and Pediatric EM Faculty provide faculty supervision for all EM rotations.

5. Read the Education Goals and Objectives for the Residency Program document provided to all EM residents.

6. Read the Patient Care Responsibilities and Resident Supervision document provided to all EM residents.

7. Read the Resident Due Process document provided to all EM residents.
8. Be aware that the Program Director, Associate and Assistant Program Directors and Chief Residents are available 24 hours/day, 7 days/week to provide support, answer questions, and assist the R-I resident. The Residency Coordinator and other Department personnel are also available to assist the R-I resident.

9. Residents must complete all assigned Rosh Review Tests within one week following the end of each academic block/calendar month. The academic block schedule will be posted to New Innovations at the beginning of each year. This schedule will outline the topics that will be covered over each block. The residents must complete the Rosh Review Tests for the corresponding topics by 5pm on the Thursday following the end of each block.

I have read and acknowledge the 2016 - 2017 Rules of the Road.

_________________________  ___________________________
R-I Resident Signature and   Date:
Printed Name: ___________________________

_______________________________
Dale S. Birenbaum, MD, Program Director
Date: __________________________
Emergency Medicine Residents at the R-2 level for the 2016 – 2017 Academic Year are expected to:

**General Requirements**

1. Review educational goals and objectives for each R-2 rotation prior to starting the rotation. These goals and objectives were given to each resident at the start of the R-2 year.

2. Review R-2 annual block schedule for the year, including assigned rotations and vacation blocks.

3. Contact Rotation Directors/Coordinators for the R-2 off-service rotations at least 4 weeks in advance of the start of the rotation to discuss scheduling, rotation requirements, etc.

4. Behave in a highly professional manner, maintaining appropriate standards of conduct, dress, and hygiene. This also includes being on time to work, both on the EM rotations (shifts) and off-service rotations. Always treat patients as customers to whom a service is being provided.

5. Observe the norms of practice, call frequency, scheduling, and shift/call duration, as assigned on EM and off-service rotations.

6. Complete patient documentation and medical records in a timely manner as required by EM and off-service rotations.

7. Review rotation call/shift schedules in advance and deal with any scheduling conflicts in a timely manner.

8. Report absence from clinical responsibilities on a rotation for a break, lunch, etc. to the senior resident/faculty on that service.

9. Get prior approval from the administrative EM Chief Resident and the Residency Office for planned absences from EM and off-service rotations (e.g. vacation, USMLE exam, a day or more on off-service rotation, etc.). Also get prior approval by the involved off-service rotation Chief Resident or other appropriate personnel for planned absences (senior resident or Attending). Do not purchase tickets or commit to a purchase prior to receiving written confirmation from the Program Director.
10. Discuss unanticipated absence due to illness as early as possible with the administrative EM Chief Resident and if rotating on off-service rotation, with Chief Resident for that service or other appropriate personnel. The R-2 resident will attempt to find coverage (e.g. shift change), and follow other standard procedures for the Residency. It is expected that the R-2 resident will make up the shift at a later date, preferably by covering a shift for the resident that covered the ill shift. When possible, permission will be given for unanticipated absence due to family emergency. The same rules as above apply to this situation.

11. Show up for all scheduled shifts or scheduled off-service rotation days. Failure to show up for a scheduled shift or off-service rotation day that necessitates calling in a different resident will result in a need to pay back double the amount of time. For example, if a resident fails to show up for a shift and the on-call resident covers the shift, then the resident who missed the shift owes 2 shifts to the on-call person who covered the shift. This occurs automatically whenever the on-call person arrives and starts to cover the shift or off-service day.

12. Unexcused absences: If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident or Program Director, the absence will be considered unexcused. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending on the severity and frequency of the infraction. Unexcused absence will result in an additional shift and 30 minutes lecture on a Thursday that will be scheduled in advance. It is common courtesy to let your attending, chief resident or directors know that you are going to be late or not show up to your shift as early as possible.

13. Arriving late to a shift. It is unacceptable to arrive late to your shift. Unexplained lateness means arrival after the start of a shift. Late shifts will count as unexcused absence. Additionally the unexcused time will result in making the time up on an extra shift plus a lecture.

14. Work the full length of the shift or off-service duty period, unless intentionally released early by the supervising attending (EM blocks) or senior resident (off-service blocks). On the Pediatric EM service, this is done only with the permission of the Pediatric attending.

15. Comply with requests/deadlines from the Residency Office for information, documentation requests, etc. For example, selecting elective time by a certain date as requested.

16. Read emails in a timely manner, checking at least twice a day. The Chief Residents or Residency Office can assist you with information on how to check emails when you are off-campus on off-service rotations or at home.

17. Notify Program Director of any malpractice claim, question of impropriety, or unexpected adverse outcome on the EM or off-service rotations.

18. Notify Program Director of any serious conflicts on the EM or off-service rotations.

19. Notify Residency Office (Residency Coordinator) of changes of address, phone number or pager number.
20. Supply Residency Office (Residency Coordinator) with updated medical licenses, DEA and DPS certificates (if applicable), as well as copies of current ACLS, BLS, PALS, NRP, and ATLS cards showing successful completion of courses and expiration dates.

21. Complete daily shift cards for review and have supervising attending sign.

24. Log all duty hours in New Innovations on a weekly basis (Sunday to Saturday). All residents will complete the validation of their duty hours from the week before by 0900 every Monday morning.

   a. Residents whose hours are not validated by 0900 on Monday morning will receive a notice on outlook and will be required to complete the validation by 1200. Those who have not completed their hours by 1200 will be required to present to the EM Residency Leadership in person and complete(validate) their time.

While on duty a AdventHealth East Orlando Orlando attend all Grand rounds that do not conflict with the EM Didactic series:

Academic Requirements

1. Complete and stay current on all academic requirements, including conference-attendance, EMS requirements, timely procedure log data entry, timely follow-up logs, examinations, and presentations at residency conference. All scholarly activity requirements are listed on the Scholarly Activity Checklist (attached to the end of this document). There may be additional academic requirements as deemed necessary by the Program Director - the resident will receive written notice of any additional requirements. A review of current status of these academic requirements will be presented to the R-2 resident.

2. Teach and evaluate R-1 EM residents, rotating residents, and medical/PA students.

3. Attend 100% of the Residency Conferences. Inform the Residency Leadership if you are having difficulties getting back for conferences. Residency conferences are mandatory scholarly activities. All are required to attend all conferences. This time is protected from any other activities for that purpose. Attendance to conferences will be considered as a regular shift and the same rules for unexcused absences will apply.

4. Complete procedure log data entry, paying special attention to recording resuscitations. Data should be entered when performing procedures. The procedure log provides important documentation of resident experience, and will be reviewed when the Program Director and the Promotion & Competency Committee evaluate resident clinical competency, and for recommendations as to hospital privilege credentialing and licensing. Some hospital credentialing committees are now requesting copies of your procedure log as an adjunct to documenting skill competencies. The recording of procedures at various hospitals is also of importance to us when we review the effectiveness of an off-service rotation such as the AdventHealth East Orlando Critical Care Rotation. Of critical importance is the documentation of resuscitations. The RRC-EM defines "resuscitation" as "patient care where prolonged physician attention is needed, and
interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g. thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (e.g. cutdowns, central Line insertion, tube thoracostomy, endotracheal intubation) are necessary for stabilization and treatment. The resuscitation should have "director" or "participant" listed as the role of the EM resident. Please also separate Pediatric and Adult medical and trauma resuscitations. Minimum numbers of resuscitations that must be documented prior to graduation can be found on the attached document.

5. Prior to graduation, EM residents will complete a scholarly activity project. This project must be approved in advance through the Program leadership. The scholarly activity project will be of publishable quality and may be original research, review article, case report, abstract, chapter, etc. The project may be done during any of the three years, but the resident is strongly urged to decide on a project and begin the project by the mid-point of the R-2 year. Follow EM Research Curriculum Guideline. All research projects and scholarly activities submitted by the residents must have a residency faculty sponsor.

6. Comply with residency for failure to complete academic requirements. Upon notification of being out of compliance, the resident will meet with the program director or designated faculty member to discuss the problem and develop an action plan. Thereafter the resident will meet every 4 weeks with the program director or designated faculty member to discuss progress in coming into compliance with the requirement. Upon notification of being out of compliance, the resident will have 28 days from notification or other time period as deemed necessary by program director or designated faculty member to come into compliance with the requirements. In addition the resident will have two 12-hour ED shifts added to the next block rotation schedules. If the resident is still out of compliance after the block, further actions including possible termination will be taken. Due process will be followed. Rotational hours will remain in compliance with RRC-EM.

7. Residents who are not current on the residency academic requirements will be counseled and other potential actions include academic probation. It should be noted that completion of all R-2 academic requirements is necessary for promotion to the R-3 level. The Department’s Due Process Policy will be followed with regards to academic probation. Additionally, a determination may be made by the Residency Leadership to assign extra shifts, decline resident requests for days off, not allow resident to participate in Wellness/Graduation activities.

Examinations

1. Participate in the annual In-Training Examination administered by the American Board of Emergency Medicine.
2. Participate and successfully complete other written examinations as required by the Program.

3. The results of examinations may be used by the faculty and the Program Director to develop individual resident academic goals for the upcoming year, including but not limited to a special reading program. Low scores are of concern and the resident may have outside physician employment privileges limited or removed to encourage reading and academic endeavors to improve the resident's knowledge base.

Evaluations

1. Faculty and senior EM residents will evaluate performance for R-2 adult EM rotations. Composite evaluations for the EM and blocks as well as rotation evaluations for off-service rotations will be available in the Resident Portfolios. These evaluations will then be summarized in the two semi-annual evaluations. Problem evaluations will be brought to the attention of the R-1 resident and an appropriate response developed.
   a. Residents must select a preceptor or faculty member to evaluate and to evaluate them each block. These preceptor matches must be created in New Innovations within one week of the start of each block. All residents will complete the matches in New Innovations by 0900 Monday morning of the start of the rotation.
      i. Residents whose matches are not completed by 0900 on the Monday morning following the start of the rotation will receive a notice on outlook and will be required to complete the matches by 1200. Those who have not completed their matches by 1200 will be required to present to the EM Residency Leadership in person and complete them in person.
   b. Residents must complete a faculty/preceptor evaluation and a rotation evaluation each block. These evaluations must be completed in New Innovations within one week of the end of each block. All residents will complete the evaluations in New Innovations by 0900 Monday morning of the end of each rotation.
      i. Residents whose evaluations are not completed by 0900 on the Monday morning following the end of the rotation will receive a notice on outlook and will be required to complete the evaluations by 1200. Those who have not completed their evaluations by 1200 will be required to present to the EM Residency Leadership in person and complete them in person.

Core Competencies

1. The residency uses the new ACGME required core competencies in the education and evaluation process. All residents receive a copy of the competency-based form used for evaluation during the EM block rotations.

2. The template used for the residency curriculum is the Model Practice of Emergency Medicine that has been modified to include the core competencies.

3. The core competencies are an integral part of the overall resident evaluation process, including the
rotation evaluations, the Evaluation by Direct Observation, and in the Nursing Evaluation of EM Residents.

4. Resident Portfolios are available to all EM residents on New Innovations. Contents of the Portfolio include: annual block rotation schedules, follow-up logs, procedure log updates, evaluations (including exam results), scholarly activity, performance improvement project, Rules of the Road, EMS activities, Specific contents can be seen in the table of contents for each Portfolio.

Outside Physician Activities

2. Adhere to the policy of outside activities during the residency. Additionally, all other programs that may interfere with the resident’s duties will need prior approval from the Program Director. This includes, but is not limited to: Graduate and Post-Graduate degrees and programs.

Other Requirements

1. Do not perform patient care or procedures that are beyond the scope/training of the R-2 resident, or for which the resident feels uncomfortable. For example, if the R-2 resident doesn't feel comfortable with a procedure, then assistance from a more senior resident or faculty should be sought.

2. Be aware that the Clinical Competency Committee of the Department of Emergency Medicine will meet at least semi-annually to make recommendations to the Program Director on resident progression to the next year of training, and other matters related to the resident's clinical, professional, and academic performance.

3. Progress to the R-3 year only after successful completion of all R-2 clinical performance/competency requirements and the academic requirements.

4. Be aware that board-certified or board-prepared EM and Pediatric EM Faculty provide faculty supervision for all EM rotations.

5. Read the Education Goals and Objectives for the Residency Program document provided to all EM residents.

6. Read the Patient Care Responsibilities and Resident Supervision document provided to all EM residents.

7. Read the Resident Due Process document provided to all EM residents.

8. Be aware that the Program Director, Associate and Assistant Program Directors and Chief Residents are available 24 hours/day, 7 days/week to provide support; answer questions, and assist the R-2 resident. The Residency Coordinator and other Department personnel are also available to assist the R-2 resident.
9. Residents must complete all assigned Rosh Tests within one week following the end of each academic block. The academic block schedule will be posted to New Innovations at the beginning of each year. This schedule will outline the topics that will be covered over each block. The residents must complete the Rosh Tests for the corresponding topics by 5pm on the Thursday following the end of each block.

I have read and acknowledge the 2016 – 2017 Rules of the Road.

_________________________________
R-2 Resident Signature and
Printed Name: ______________________
Date: ______________________________

__________________________________
Dale S. Birenbaum MD, Program Director
Date: ______________________________
AdventHealth East Orlando Medical Center
Emergency Medicine Residency Program
Emergency Medicine Resident
R-3 RULES OF THE ROAD
2016 - 2017

Emergency Medicine Residents at the R-3 level for the 2016 – 2017 Academic Year are expected to:

**General Requirements**

1. Review educational goals and objectives for each R-3 rotation prior to starting the rotation. These goals and objectives were given to each resident at the start of the R-3 year.

2. Review R-3 annual block schedule for the year, including assigned rotations and vacation blocks. Realize that we your residency contract with AdventHealth East Orlando is through, and including, June 30th. It is your responsibility to be available for residency shifts, evaluations, testing or simulation functions up to and including June 30th. Do not make arrangements with future employers or travel until you have completed your obligations at AdventHealth East Orlando.

3. Contact Rotation Directors/Coordinators for the R-3 off-service rotations at least 4 weeks in advance of the start of the rotation to discuss scheduling, rotation requirements, etc. For elective rotations, you will need approval from both the residency office as well as the elective rotation director to take the rotation. You will need to set up elective rotations a minimum of two blocks ahead of the rotation. If this is a new rotation, you will need 3 blocks advanced planning.

4. Behave in a highly professional manner, maintaining appropriate standards of conduct, dress, and hygiene. This also includes being on time to work, both on the EM rotations (shifts) and off-service rotations. Always treat patients as customers to whom a service is being provided.

5. Observe the norms of practice, call frequency, scheduling, and shift/call duration, as assigned on EM and off-service rotations.

6. Complete patient documentation and medical records in a timely manner as required by EM and off-service rotations.

7. Review rotation call/shift schedules in advance and deal with any scheduling conflicts in a timely manner.

8. Report absences from clinical responsibilities on a rotation for a break, lunch, etc. to the senior resident/faculty on that service.

9. Get prior approval from the administrative EM Chief Resident and the Residency Office for planned absences from EM and off-service rotations (e.g. vacation, USMLE exam, a day or more on off-service rotation, etc.). Also get prior approval by the involved off-service rotation Chief
Resident or other appropriate personnel for planned absences (senior resident or Attending). Do not purchase tickets or commit to a purchase prior to receiving written confirmation from the Program Director.

10. Discuss unanticipated absence due to illness as early as possible with the administrative EM Chief Resident. If rotating on off-service rotation, with Chief Resident for that service or other appropriate personnel. The R-3 resident will attempt to find coverage (e.g. shift change), and follow other standard procedures for the Residency. It is expected that the R-3 resident will make up the shift at a later date, preferably by covering a shift for the resident that covered the ill shift. When possible, permission will be given for unanticipated absence due to family emergency. The same rules as above apply to this situation.

11. Unexcused absences: If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident or Program Director, the absence will be considered unexcused. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending on the severity and frequency of the infraction. Unexcused absence will result in an additional shift and 30 minutes lecture on a Thursday that will be scheduled in advance. It is common courtesy to let your attending, chief resident or directors know that you are going to be late or not show up to your shift as early as possible.

12. Arriving late to a shift. It is unacceptable to arrive late to your shift. Unexplained lateness means arrival after the start of a shift. **Late shifts will count as unexcused absence.** Additionally the unexcused time will result in making the time up on an extra shift plus a lecture.

13. Show up for all scheduled shifts or scheduled off-service rotation days. Failure to show up for a scheduled shift or off-service rotation day that necessitates calling in a different resident will result in a need to pay back double the amount of time. For example, if a resident fails to show up for a shift and the on call resident covers the shift, then the resident who missed the shift owes 2 shifts to the on-call person who covered the shift. This occurs automatically whenever the on-call person arrives and starts to cover the shift or off-service day.

14. Work the full length of the shift or off-service duty period, unless intentionally released early by the supervising attending (EM blocks) or senior resident (off-service blocks). On the Pediatric EM service, this is done only with the permission of the Pediatric attending.

15. Comply with requests/deadlines from the Residency Office for information, documentation requests, etc. For example, selecting elective time by a certain date as requested.

16. Read emails in a timely manner, checking at least twice a day. The Chief Residents or Residency Office can assist you with information on how to check emails when you are off-campus on off-service rotations or at home.

17. Notify Program Director of any malpractice claim, question of impropriety, or unexpected adverse outcome on the EM or off-service rotations.
18. Notify Program Director of any serious conflicts on the EM or off-service rotations.

19. Notify Residency Office (Residency Coordinator) of changes of address, phone number or pager number.

20. Supply Residency Office (Residency Coordinator) with updated medical licenses, DEA and DPS certificates (if applicable), as well as copies of current ACLS, BLS, PALS, NRP and ATLS cards showing successful completion of courses and expiration dates.

21. Complete daily shift cards for review and have supervising attending sign.

22. Log all duty hours in New Innovations on a weekly basis (Sunday to Saturday). All residents will complete the validation of their duty hours from the week before by 0900 every Monday morning.

   a. Residents whose hours are not validated by 0900 on Monday morning will receive a notice on outlook and will be required to complete the validation by 1200. Those who have not completed their hours by 1200 will be required to present to the EM Residency Leadership in person and complete/validate their time.

Academic Requirements

1. Complete and stay current on all academic requirements, including conference attendance, EMS requirements, timely procedure log data entry, timely follow-up logs, examinations, and presentations at residency conference. All scholarly activity requirements are listed on the Scholarly Activity Checklist (attached to the end of this document). There may be additional academic requirements as deemed necessary by the Program Director - the resident will receive written notice of any additional requirements. A review of current status of these academic requirements will be presented to the R-3 resident.

2. Teach and evaluate R-1 and R-2 EM residents, rotating residents, and medical/PA students

3. Attend 100% of the Residency Conferences. Inform the Residency Leadership if you are having difficulties getting back for conferences. Residency conferences are mandatory scholarly activities. All are required to attend all conferences. This time is protected from any other activities for that purpose. Attendance to conferences will be considered as a regular shift and the same rules for unexcused absences will apply.

4. Complete procedure log data entry, paying special attention to recording resuscitations. Data should be entered when performing procedures. The procedure log provides important documentation of resident experience, and will be reviewed when the Program Director and the Promotion & Competency Committee evaluate resident clinical competency, and for recommendations as to hospital privilege credentialing and licensing. Some hospital credentialing committees are now requesting copies of your procedure log as an adjunct to documenting skill competencies. The recording of procedures at various hospitals is also of importance to us when we review the effectiveness of an off-service rotation such as the AdventHealth East Orlando
Critical Care Rotation. Of critical importance is the documentation of resuscitations. The RRC-EM defines "resuscitation" as "patient care where prolonged physician attention is needed, and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g. thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (e.g. cutdowns, central Line insertion, tube thoracostomy, endotracheal intubation) are necessary for stabilization and treatment." The resuscitation should have "director" or "participant" listed as the role of the EM resident. Please also separate Pediatric and Adult medical and trauma resuscitations. Minimum numbers of resuscitations that must be documented prior to graduation can be found on the attached document.

a. Update procedure logs in NI on a weekly basis (Sunday to Saturday). All residents will complete the procedures from the week before by 0900 every Monday morning.
   i. All information must be complete when filling out procedure log. Also required is adding a brief synopsis of patient presentation in the “comments” section.

5. Prior to graduation, EM residents will complete a scholarly activity project. This project must be approved in advance through the Program leadership. The scholarly activity project will be of publishable quality and may be original research, review article, - case report, abstract, chapter, etc. The project may be done during any of the three years, but the resident is strongly urged to decide on a project and begin the project by the mid point of the R-2 year. Follow EM Research Curriculum Guideline. All research projects and scholarly activities submitted by the residents must have a residency faculty sponsor. Final research projects must be submitted by May 1 of R-3 year.

6. Comply with residency for failure to complete academic requirements. Upon notification of being out of compliance, the resident will meet with the program director or designated faculty member to discuss the problem and develop an action plan. Thereafter the resident will meet every 4 weeks with the program director or designated faculty member to discuss progress in coming into compliance with the requirement. Upon notification of being out of compliance, the resident will have 28 days from notification or other time period as deemed necessary by program director or designated faculty member to come into compliance with the requirements. In addition the resident will have two 12-hour ED shifts added to the next block rotation schedules. If the resident is still out of compliance after the block, further actions including possible termination will be taken. Due process will be followed. Rotational hours will remain in compliance with RRC-EM.

7. Residents who are not current on the residency academic requirements will be counseled and other potential actions include academic probation. It should be noted that completion of all R-2 academic requirements is necessary for promotion to the R-3 level. The Department’s Due Process Policy will be followed with regards to academic probation. Additionally, a determination may be made by the Residency Leadership to assign extra shifts, decline resident requests for days off, not allow resident to participate in Wellness/Graduation activities.

Examinations

1. Participate in the annual In-Training Examination administered by the American Board of Emergency Medicine.

2. Participate and successfully complete other written examinations as required by the Program.
3. The results of examinations may by used by the faculty and the Program Director to develop individual resident academic goals for the upcoming year, including but not limited to a special reading program. Low scores are of concern and the resident may have outside physician employment privileges limited or removed to encourage reading and academic endeavors to improve the resident's knowledge base.

Evaluations

1. Faculty and senior EM residents will evaluate performance for R-2 adult EM rotations. Composite evaluations for the EM and blocks as well as rotation evaluations for off-service rotations will be available in the Resident Portfolios. These evaluations will then be summarized in the two semi-annual evaluations. Problem evaluations will be brought to the attention of the R-1 resident and an appropriate response developed.
   a. Residents must select a preceptor or faculty member to evaluate and to evaluate them each block. These preceptor matches must be created in New Innovations within one week of the start of each block. All residents will complete the matches in New Innovations by 0900 Monday morning of the week following the start of the rotation.
      i. Residents whose matches are not completed by 0900 on the Monday morning following the start of the rotation will receive a notice on outlook and will be required to complete the matches by 1200. Those who have not completed their matches by 1200 will be required to present to the EM Residency Leadership in person and complete them in person.
   b. Residents must complete a faculty/preceptor evaluation and a rotation evaluation each block. These evaluations must be completed in New Innovations within one week of the end of each block. All residents will complete the evaluations in New Innovations by 0900 Monday morning of the week following the end of each rotation.
      i. Residents whose evaluations are not completed by 0900 on the Monday morning following the end of the rotation will receive a notice on outlook and will be required to complete the evaluations by 1200. Those who have not completed their evaluations by 1200 will be required to present to the EM Residency Leadership in person and complete them in person.

Core Competencies

1. The residency uses the new ACGME required core competencies in the education and evaluation process. All residents receive a copy of the competency-based form used for evaluation during the EM block rotations.

2. The template used for the residency curriculum is the Model Practice of Emergency Medicine that has been modified to include the core competencies.

3. The core competencies are an integral part of the overall resident evaluation process, including the rotation evaluations, the Evaluation by Direct Observation, and in the Nursing Evaluation of EM Residents.
4. Resident Portfolios are available to all EM residents in New Innovations. Contents of the Portfolio include: annual block rotation schedules, follow-up logs, procedure log updates, evaluations (including exam results), scholarly activity, performance improvement project, Rules of the Road, EMS activities, Specific contents can be seen in the table of contents for each Portfolio. In addition to the above, there will be a section added for updates on conference attendance.

**Outside Physician Activities**

3. Adhere to the policy of outside activities during the residency. Additionally, all other programs that may interfere with the resident’s duties will need prior approval from the Program Director. This includes, but is not limited to: Graduate and Post-Graduate degrees and programs.

**Other Requirements**

1. Do not perform patient care or procedures that are beyond the scope/training of the R-3 resident, or for which the resident feels uncomfortable. For example, if the R-3 resident doesn't feel comfortable with a procedure, then assistance from a more senior resident or faculty should be sought.

2. Be aware that graduation requirements for the R-3 resident include professional and clinical performance sufficient to allow the resident to practice independently and competently, as well as completion of all academic requirements of the residency. For residents who complete all requirements and graduate on time, the Verification of Training letter will be signed and returned to the American Board of Emergency Medicine in the usual manner, during the first week in July following graduation, residents who are felt to be clinically competent but who have not completed all academic requirements will not graduate formally from the program until the requirements have been met. In addition, the training verification letter to ABEM will also include this information, and the resident will not be allowed to sit for the boards until the requirements have been met and ABEM is notified accordingly.

3. Graduation will occur only after successful completion of all R-3 clinical performance/competency requirements and the academic requirements.

4. Be aware that board-certified or board-prepared EM and Pediatric EM Faculty provide faculty supervision for all EM rotations.

5. Read the Education Goals and Objectives for the Residency Program document provided to all EM residents.

6. Read the Patient Care Responsibilities and Resident Supervision document provided to all EM residents.

7. Read the Resident Due Process document provided to all EM residents.
8. Be aware that the Program Director, Associate and Assistant Program Directors and Chief Residents are available 24 hours/day, 7 days/week to provide support, answer questions, and assist the R-3 resident. The Residency Coordinator, Education Assistant, and other Department personnel are also available to assist the R-3 resident.

9. Residents must complete all assigned Rosh Review Tests within one week following the end of each academic block. The academic block schedule will be posted to New Innovations at the beginning of each year. This schedule will outline the topics that will be covered over each block. The residents must complete the Rosh Review Tests for the corresponding topics by 5pm on the Thursday following the end of each block.

I have read and acknowledge the 2016 – 2017 Rules of the Road.

______________________________
R-3 Resident Signature and
Printed Name: ____________________
Date: ____________________________

______________________________
Dale S. Birenbaum MD, Program Director
Date: ____________________________

Updated 12/20/2018