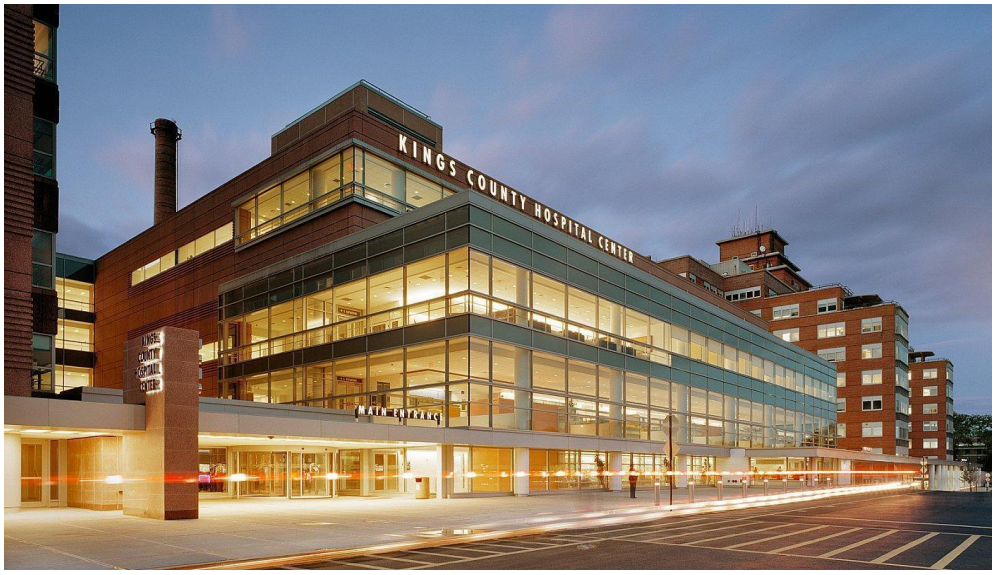

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SUNY DOWNSTATE/ KINGS COUNTY HOSPITAL RESIDENT HANDBOOK

TABLE OF CONTENTS

UHD EMERGENCY SERVICES
- UHD Junior Resident Clinical Role
- UHD Senior Resident Clinical Role

ADMISSION HANDOFF

NYU-BROOKLYN ED

EDUCATIONAL OBJECTIVES
- PGY 1
- PGY 2
- PGY 3
- PGY 4

OFF SERVICE ROTATIONS
- PGY-1 OFF-SERVICE ROTATIONS
  - PGY-1 Ultrasound Rotation
  - ED-Based Trauma
  - Obstetrics
  - MICU
  - Internal Medicine Floors at KCH
- PGY-2 OFF SERVICE ROTATIONS
  - PGY-2 Ultrasound Rotation
  - Airway Management
  - CCU
  - NICU
  - SICU
  - Neurology
  - Emergency Orthopedics/Fast Track
- PGY-3 OFF SERVICE ROTATIONS
  - EMS
  - Toxicology
  - Research
  - Senior Emergency Ultrasound Rotation
  - Selectives
- PGY-4 OFF SERVICE ROTATIONS
  - Administration
  - Toxicology
  - Electives

SUPERVISION

EDUCATION

MODEL OF CLINICAL PRACTICE OF EM

IN-SERVICE EXAMINATION

BOARD REVIEW GROUP

EMERGENCY MEDICINE BOARD EXAMINATION

ONLINE RESOURCES / CIS / INTERNET / EMAIL / TECHNOLOGY

PREFACE

Welcome to the updated 2023-24 Edition of our Emergency Medicine Residency Handbook!
Please read this handbook carefully since it contains information about the residency, our department, the affiliates, various rotations, protocols, guidelines, and policies.
This handbook was written not only for the residents, but also for faculty members, attendings, students and anybody involved in our department. It contains vital information for the smooth operation of the department and successful completion of your residency.
We would like to thank everyone who has contributed to this new edition. Please feel free to contact us about any discrepancies, questions, comments and suggestions.
It is important that you read through the handbook carefully. As always, several changes have been initiated. Please note changes in policies, rotations and affiliates.
We wish you the best of luck!

Sincerely
James Willis, MD Residency Director
Pamela Janairo, MD Associate Residency Director
James Hassel, MD Assistant Residency Director
Carolina Camacho Ruiz, MD Assistant Residency Director
Natassia Buckridge, MD Assistant Residency Director
Joshua Schechter, MD EM/IM Residency Director
Ray Beyda, MD EM/IM/CCM Residency Director

CHAIRMAN'S WELCOME

Welcome! We are all very pleased that you will be spending the next four or five years of your career in the Emergency Departments of SUNY-Downstate and Kings County Hospital. You have chosen to train at one of the busiest Emergency Departments in the country. We are a full academic department. Our residents rotate through three of the twenty-one affiliated emergency departments in the SUNY-Brooklyn system. While rotating through these facilities, you will be working with the finest emergency medicine physicians in the New York City area. The combined census for these three emergency departments is over 300,000 patients/year, more than any other residency program in the nation. You will be exposed to an arena of pathology rivaled by no other program in the United States. From critical care and infectious disease, to cardiovascular disease, as well as an unparalleled community hospital experience in Kings County and University Hospital of Downstate, you will "see...do...then teach", as your peers merely read.

This does not come without a price. I expect you to work hard, be a caring physician, and to teach. As a resident in one of the finest university systems in the country, you have the responsibility to teach your colleagues, your students, your staff and your patients. Our goal is to turn you into academicians and lifetime teachers. We are looking to train the future leaders in the field of emergency medicine.

I look forward to our bedside presentations, lively discussions at Wednesday conference and searches for the diagnosis at 2am. We, together, are about to grow... it's the reason why I'm here.

Welcome, and good luck.

Sincerely,

Michael P. Lucchesi, M.D M.S.

Chairman of Emergency Medicine

RESIDENCY DIRECTOR'S WELCOME

Welcome to the Categorical Emergency Medicine Residency & the Combined EM-IM program at SUNY Downstate Medical Center/Kings County Hospital and its affiliates.

What am I getting out of this? This question drives adult learners to be selective with their education. As residents have completed graduate education, and now enter an apprenticeship, their education is driven by their own motivation. Thus as educators, it is our responsibility to act as guides, using scaffolding (supportive teaching) to allow the residents to define their own educational experience.

The resident enters as an intern with a certain level of domain knowledge, which is a foundation, set by their medical school education. The clinical experience then builds upon their gestalt and heuristics, or learning from experience, which makes up the bulk of their future practice. The remainder of the residency program comes from the curriculum, which includes formal didactics, mini-fellowship (career development), research and the practical use of evidence based medicine, teaching experience, administrative exposure, asynchronous/self-directed learning, evaluation/feedback, professional board preparation, and leadership training. It is our job as educators to provide you with a varied training experience in preparation for you to establish your own practice of emergency medicine.

We are proud to continue the tradition of producing the best and brightest leaders in the field of emergency medicine. Our residency program provides the residents with a combination of great clinical exposure along with superb academics from the most respected emergency physician faculty in the country. It is my belief that our residency is the training ground for the future leaders in healthcare.

It is your job as a resident to take advantage of all that our program has to offer. First and foremost, we expect professionalism at every level. Our department and its faculty are proud to practice patient- centered care, and expect our residents to be empathetic towards the needs of each and every patient. Residency is difficult, and a pivotal time in one's career and life. We, as faculty and residency leadership, are here to help guide you through these formative years.

Best of luck to each of you along your journey as residents and the start of your careers as emergency medicine physicians.

Sincerely,

James Willis, MD

Residency Program Director

****This handbook serves as your guidebook through residency. It contains many useful tips as well as some very basic rules. Please read the manual carefully. It is implied that by signing a receipt for this book that you are familiar with its content.****

“The Doctor can have a stronger impact on the patient than any drug.” -- Paracelsus

VISION STATEMENT

Our residency program is one of the most competitive training programs for emergency medicine physicians. We are a diverse program with residents from different personal and professional backgrounds.
Our most important goal is to produce residents who are exceptional clinical and empathetic physicians. After which, we are dedicated to training residents who will be community advocates, leaders in emergency medicine, and academicians.
Our residents take on leadership roles in the department, the hospital, and on local, national, and global levels. Through a residency training that includes clinical rigor, strong academics, cultural diversity, and the delivery of compassionate, patient-centered care, each resident from our program graduates with the confidence to practice emergency medicine in a variety of health care environments. Our residency program and department are dedicated to the patient's we serve and the communities from which they arise. Our commitment, as medical educators, is to impact not only one patient, but a population through the training of the future physicians of the world.

Work Environment

The department will create an environment for our residents that is conducive to learning; intellectually stimulating; personally satisfying; safe from physical and emotional harm; and free of discrimination based on the residents' sexual orientation, spiritual beliefs, race, ethnicity, identified gender, or socioeconomic background.

ACGME CORE COMPETENCIES

Criteria by which residents' performance will be judged is outlined below:

PATIENT CARE (PC)

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

• Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
• Gather essential and accurate information about their patients
• Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
• Develop and carry out patient management plans
• Counsel and educate patients and their families
• Use information technology to support patient care decisions and patient education
• Perform competently all medical and invasive procedures considered essential for the area of practice
• Provide health care services aimed at preventing health problems or maintaining health
• Work with health care professionals, including those from other disciplines, to provide patient-focused care

MEDICAL KNOWLEDGE (MK)

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 clinical decision making. Residents are expected to:

• Demonstrate analytic thinking and a systematic approach to clinical situations
• Know and apply the basic and clinically supportive sciences that are appropriate to the Emergency Dept.
• Develop an appropriate differential diagnosis.

PRACTICE-BASED LEARNING AND IMPROVEMENT (PBL)

Residents must be able to investigate and to evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

• Analyze practice experience and perform practice-based improvement activities using a systematic methodology

• Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems

• Obtain and use information about their own population of patients and the larger population from which their patients are drawn

• Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness

• Use information technology to manage information, access on-line medical information; and support their own education

• Facilitate the learning of students and other health care professionals

INTERPERSONAL AND COMMUNICATION SKILLS (ICS)

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates. Residents are expected to:

• Create and sustain a trusting and effective relationship with patients and family members

• Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills

• Work effectively with others as a member or leader of the health care team

PROFESSIONALISM (P)

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 respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development

• Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices

• Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

SYSTEMS-BASED PRACTICE (SBP)

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. Residents are expected to:

• Understand how their patient care and other professional practices affect other healthcare professionals, the health care organization, and the larger society and how these elements of the system affect their own practice

• Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
• Practice cost-effective health care and resource allocation that does not compromise quality of care
• Advocate for quality patient care and assist patients in dealing with system complexities
• Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

These competencies will be assessed via the Emergency Medicine ACGME Milestones

KCH ADULT ED

KCH Administration

Elias Youssef, MD, MBA Chief
Konstantinos Gus Agoritsas, MD MBA, Associate Chief Medical Officer
Richard Leno, MD, Medical Director
Brittany Choe MD, MBA Director of Quality
Donald Doukas, MD, MMM Director of ED Observation
Cleopatra Morris MSHA., Coordinating Manager
Ingrid Browne, Assistant Analyst

Welcome to the Kings County Hospital Center Emergency Department. At over 135,000 patient visits per year, it is one of the largest Emergency Departments in the country. The patient volume and the high acuity will serve as the classroom for one of the most hands-on, educational experiences you will have during your training. When you start your first clinical shift, you should ask the senior resident for a tour of the ED and a description of the available resources and supplies.

Our E.D. is subdivided into several areas based upon triage and patient age:

1. CCT – Critical Care and Trauma
2. Main ED aka Suite A/B – General medical/surgical illness/obstetrics/ gynecology
3. Pediatrics
4. Fast Track
5. Observation Unit

Critical Care Trauma (CCT)

This area is what makes your residency experience at Kings County so special. It is essentially an ICU based in the ED where the most acute patients are stabilized and treated. This includes both medical and trauma patients. One attending with a senior and junior resident staff the CCT. You will be expected to perform procedures including but not limited to lumbar punctures, central lines, tube thoracostomy and arterial lines. There is good nursing staffing and a PCT in the CCT but be expected to put in IV lines if the patient is in extremis. Juniors, it is expected of you to arrive at your shift **at least 15 to 20 minutes early** to check the resuscitation bay and stock your airway equipment to ensure you are ready to handle anything that comes in. Use your time in the CCT to learn from your attendings, seniors, and patients.

Main Adult ED (Suite A/B)

The majority of your KCH Adult ED shifts will be here. The cases you will encounter here will challenge your knowledge of basic medicine and recognition of potential emergencies, such as acute myocardial infarction, pulmonary embolism, diabetic ketoacidosis, sickle cell crisis, and impending respiratory failure in asthmatics. You will experience a good degree of independence. Reading for this area should be focused on interesting cases that you see. Our advice is to pick one topic each day to review or learn, based on what you saw during your shift.

Suite A/B is divided into a quad system, geographic mapping of the ED into 4 regions. Each region consists of resident(s), 2-3 nurses and 1-2 PCT/PCAs. Residents will usually be assigned to 2 quads per shift. Quads 1/2 are located next to the main entrance (beds 1-13, exam 3-4, and

the asthma room) while Quads 3/4 are situated towards the back next to radiology (beds 14-27 and exam 1-2). The hallways in main ED have been labeled to facilitate patient identification and location. There is usually one attending physician for each half of main ED (Quads 1-2 and Quads 3-4). Quad assignments will be included in your amion schedule.
Residents are to work, round and sign-out only in their assigned area (i.e Quads 1/2 or Quad 3/4). Residents and attendings are not supposed to call pts into the ED. If you are ready to see a pt, and the next patient is in the waiting room, discuss this with the charge nurse or flow nurse. Please introduce yourselves to your team members (i.e. nurse, PCA/PCT). Changing Quad assignments must be discussed with your attending and in conjunction with the Residency Director on Call.
In the main ED, there are usually several nurses, patient care associates (PCAs), patient care technicians (PCTs), physician assistants, and a respiratory therapist, who will cover the asthma room during the day. Huddles occur in the clinical area between Quad 1/2 and Quad 3/4 and involve physicians, nursing and ancillary staff. Please be sure to attend your designated huddle when it is announced.
Placement of IVs and phlebotomy in this area should be performed by a phlebotomist and nurses. In critical or urgent circumstances you may perform these tasks and override the printing of labels in Epic. Otherwise coordinate with nursing and PCAs to ensure the best and safest care for our patients. In regards to imaging, the CT and x-ray transporters will come and pick up your patient when they are ready to perform the study. For all issues please escalate to your attending and in conjunction with them to nursing leadership.
Please ask questions! This is an excellent time to learn from the attending staff. You will be asked questions about your choice of management during sign out rounds, so make sure you know why you are managing a patient a certain way. Also, challenge yourself to practice your differential diagnosis skills.

FAST Track - as part of the Ortho/FT rotation

A day in the Fast track, as with other areas of the department, starts off with informal sign out rounds. The fast track area offers an excellent opportunity to manage minor trauma, laceration repairs, I&Ds, orthopedics, ophthalmology and ENT cases. You will be given a great deal of independence in this area and the majority of your cases will be managed to completion. The fast track may be one of our less acute areas; however, don't be fooled, many times sick patients present there.

Roles and Responsibilities of Resident Physicians

Morning Report:

Morning report is the opportunity for our department to discuss cases in a more formalized manner. This educational experience is held after morning rounds on Mondays, Tuesdays, Thursdays, and Fridays. Senior residents will present a case or short didactic pearls for discussion. Attendance is mandatory for all residents working the day shift and residents who worked the previous overnight shift. If morning report is not started by 7:30 AM overnight residents waiting are permitted to go home. The residents will be assigned by the scheduling chief. Ideally an electronic handout should be included to share with residents and faculty. These morning reports can be repurposed as a blog post for III credit.

Sign Outs:

If you are leaving the ED for lunch, lecture or at the end of your shift, all patients assigned to you must be signed out. The attending that has reviewed the patient with you should be aware that you are leaving. Always inform the most senior person if you are leaving the clinical area.

Consults:

Specialty consultations are available in all services. If consultations are needed, call the page operator at x3141, give the operator the requesting service and your call back number. All consults must be ordered in the EMR. If you are having difficulty contacting a given service, you are to discuss this immediately with the attending of record for the case.

OB-GYN consultation for pregnant patients less than 20 weeks will take place in the ED. All pregnant patients greater than 20 weeks who arrive via EMS must first be triaged in the ED.

Admitting Process:

Once you and the attending on record for a case have reached a disposition, please be sure to inform the patient. The nurse should also be notified of the admission. Order an Utilization consult for all admissions, this will prompt the care manager to review the case. When given the name of the admitting attending and team, place an admission order. Complete a "Disposition Note" in Epic updating your clinical decision making and reasons for admission. This will place the patient on the bed board and notify admitting so that a bed can be procured.

Please note that all admissions to the Medicine service must be endorsed to the PIC. All admissions to the ICU or another specialty service must first be discussed with the appropriate provider from that service.

See Admission Guidelines when Deciding which service to admit a patient: http://clinicalmonster.com/wp-content/uploads/2019/07/KCH-Admitting-Guidelines-final-7.25.19.pdf

Radiology Services

The Department of Radiology provides full-service radiological services. Preliminary readings of films may be obtained by the radiology resident by calling (x1407) or walking over to the radiology reading room located on S1. All plain films are to be reviewed by yourself and the Attending Physician of record on the PACS system, located on each computer.

The radiology senior should be contacted at x1406 to discuss all off-hour specialty studies, i.e. MRI

Physician Documentation

Currently, we utilize Epic for electronic charting, order entry and results review. You will need to become familiar with it. It is expected that you will complete the patient chart, providing all pertinent historical, physical, and laboratory/radiological/EKG interpretive information—both positive and negative—prior to patient disposition. History, physical exam, and initial assessment and plan should be documented in the Initial Assessment Note. The Progress Notes can be used to report pertinent lab or imaging results, reassessments, events or pre-attending notes. The final disposition, admission vs discharge, is done in the Disposition Note.

If a patient is to be discharged, all patients must have specific discharge instructions, including time and place of follow up appointments, return instructions, and any medication/care instructions.

Clinical Schedule

The Scheduling Chief Resident is responsible for the making and distribution of the monthly KCH ED schedule. The Chief Resident on-call is the most important person with respect to the intricacies of the daily schedule and is the first person to approach with scheduling questions and requests. All schedule changes must be approved by Chief Resident on-call. The following is a brief outline of policies related to the monthly schedule.

• Any late requests will not be accepted.

• Please check the schedule, even if you requested certain days off. Requests are not guaranteed, but every effort will be made to honor them.

Please refer to the “Resident Schedule” section for details.

Educational Objectives

Emphasis will be placed on orientation to the different emergency department environments. Residents should learn to document a chart appropriately (C,PC,MK,P), prioritize and organize activities, perform basic procedural skills, work with EMS (C,P,PC), deal with friends and families of patients (particularly those who are critically ill or dying (P,PC,C,SBP) and deliver quality patient care (P,PC,MK). The resident should demonstrate accurate and appropriate history and physical exam skills, practice generating differential diagnoses and care plans and exhibit the appropriate usage of x-rays and labs (PC,SBP,MK). A PGY 1 should evaluate no more than one to two new patients at a time. They should not accept responsibility for more patients until a senior staff member has evaluated his present patient. Their total caseload will be determined by their need for supervision, as well as patient acuity. PGY 2 and PGY 3 residents will be expected to further develop their clinical acumen, sharpen their physical exam techniques and hone their procedural skills. Their organizational abilities are expected to be more refined and they should be able to manage more patients simultaneously. PGY 4 residents are expected to “run the room” and act as junior attendings. They should know all the patients in the ED, facilitate their management and disposition, and supervise and teach junior residents and medical students.

At the completion of this rotation, residents should be able to demonstrate competency in and be able to:

• Decide which patients require admission, transfer, or discharge (MK,PC,SBP)
• Perform histories and physicals on Emergency Department patients (MK,PC)
• Understand the necessity for prioritizing patients (PC,SBP)
• Prioritize their activities (SBP,PC)
• Formulate differential diagnoses on their patients (PC,MK)
• Plan appropriate work-ups based on their differential diagnoses (PC,MK)
• Plan admission, transfer and discharges (PC,MK,SBP)
• Appropriately order and utilize laboratory data and ancillary studies (PC,SBP)
• Carefully understand and utilize universal precautions (MK,SBP)
• Appropriately utilize specialty consultation (P,C,PC)

- Function as a team member during resuscitations (P,C)
- Maintain patient follow up and rotation evaluation (PBL)

KCH Main ED Junior Resident Clinical Role

The junior shifts at KCH offer a variety of unique learning experiences. The expectations of the junior residents at KCH are as follows:

1) The junior resident is to follow each of their patients through to completion including initiating a workup, following diagnostic study results, obtaining appropriate consults, dispositioning the patient, and arranging appropriate follow up.
2) If the attending picks up a patient primarily (which should be the exception and not the norm), the attending may ask you to perform any procedures for its educational value
3) When the senior resident comes on shift, the junior may be assigned patients by the senior
4) The residents are expected to precept medical students if there are no senior residents.
5) As a benchmark, junior residents should try to see 1 patient per hour (PPH) in the main ED.
6) As a junior resident you may be assigned to different areas of the Emergency Department by the Residency Director On Call.
7) The junior resident is expected to maintain timely, thorough, and complete medical records in Epic.
8) If no senior resident is present in their quad, the junior resident should assist the attending in keeping track of the patients in their area.
9) The junior residents should also watch the white board to ensure that all ESI 2 patients are seen and evaluated promptly.
10) The junior resident is scheduled for 10 hours of clinical duty.
11) Junior Residents are expected to arrive at least 15 minutes early for assigned CCT shifts in order to ensure CCT Checklist is complete
http://clinicalmonster.com/wp-content/uploads/2021/11/CCT-Checklist-2.pdf

KCH Junior Shift Requirements

	4 Week (28 day) Rotation	**2 Week (14 day) Rotation**
PGY 1	20	11
PGY 2	19	10

KCH Main ED Senior Resident Clinical Role

The Senior Resident is responsible for overseeing overall patient flow, disposition, and patient management for Quads 1+2 or Quads 3+4 in the main ED. This includes both primarily seeing patients as well as supervising junior residents. The attendings assigned to Q1+2 or Q3+4 will provide overall supervision for their respective sides of the ED.

The KCH senior should assign cases to the junior residents based on level and complexity. The KCH senior will also see patients primarily.

The following is expected of the senior resident:

1) See at least 1.5 patients per hour

2) Be aware of and direct care for all ESI 2 patients (may include assigning patient to junior resident)

3) Expedite dispositions and help manage flow on their assigned quads

4) When precepting junior residents, the senior is expected to write an ED Progress Note

5) Provide guidance and feedback to junior residents All residents are expected to maintain timely, thorough, and complete medical records in Epic. The supervising attending must verify all resident documentation.

KCH Senior Shift Requirements

	4 Week (28 day) Rotation Total	**2 Week (14 day) Rotation** Total
PGY 3	19	9
PGY 4	18	9

Pre-attending Role

Location: Kings County Hospital Center Emergency Department

Resident levels: EM4 and EM-IM 5

Responsibilities in clinical area:

• The pre-attending will work under the direct supervision of an attending at all times.

• The pre-attending is responsible for maintaining patient care, safety, and overall flow for Q3 + Q4. They may assign patients to residents and see their own patients in order to fulfill this responsibility.

• Resident supervision: The pre-attending is responsible for overseeing the care provided by all residents and students assigned in Q3 + Q4. This includes taking presentations, helping formulate a plan of care, ensuring timely testing, treatment, and disposition, as well as writing a brief assessment and plan for all patients in which care was supervised.

The pre-attending will be expected to direct rounds and assign sign-outs during change of shift for Q3 + Q4.

KCH Observation Unit

Introduction:
The KCH ED Observation Unit (OU) is a closed, protocol driven unit. The OU is intended for patients whose clinical needs are expected to exceed six hours of ED care, but can realistically be fulfilled between 12 and 48 hours of hospitalization. These patients will have a single acute problem with a well-defined plan for management. Within this time frame all management including testing, treatment, observation and disposition should be completed. On final evaluation, the patient will be admitted to the appropriate service or discharged if indicated. For an in depth breakdown of policies use this link:
http://clinicalmonster.com/obs-guideline/

Location:
The ED OU is located in the C-Building - Ground Floor adjacent to the current Short Stay Unit (SSU).

Hours:
The KCH ED Observation Unit is open 24/7.

Staffing: During operating hours, the unit will have 24-hour coverage with consistent staffing.

1. Resident:

a. The OU will be staffed with an EM or EM-IM resident during all shifts with the following exceptions:

i. Wednesday 7AM-3PM - A mid-level provider will cover.

a. All weekday resident shifts in the OU will be 8 hours, weekend shifts will be 12 hours.

    a. At change of shift, the incoming resident will report to the observation unit and receive patient sign out from the outgoing resident.

1. Attending:

a. The OU will be covered by an Emergency Medicine attending.

Resident Roles and Responsibilities

1. The resident is responsible for all observation unit patients. Responsibilities include:

a. Admission

i. Once the decision to place a patient in observation is met, the ED provider will discuss the case with the covering OU attending. Upon acceptance by the OU attending, the ED provider will enter observation unit disposition. The ED provider will then endorse the case to the OU resident.

i. Prior to or upon arrival to the unit, the OU resident and nurse will perform an intake assessment and documentation.
ii. See the Observation Unit Admission Guidelines for in depth breakdown: http://clinicalmonster.com/wp-content/uploads/2020/01/ALL-Observation-Protocols-12192019.pdf

a. Orders

i. The OU resident will place initial orders based on applicable protocol. The OU resident may initiate orders, consults and testing in the observation unit as necessary, however they are expected to follow the predetermined protocol unless clinical situation dictates otherwise.

a. Documentation

i. Initial evaluation: Upon presentation to the unit, the OU resident must perform an initial evaluation and document this evaluation. The OU resident will also document the plan of care.

i. Progress Notes: Progress notes should include patient's current status and response to treatments, results of repeat interventions (i.e blood work, ekg) if applicable. A progress note should be documented within 4 hours after the patient's initial OU evaluation. Thereafter notes should be completed 6-8 hour intervals or more frequently, if needed. If a patient has a planned discharge within 2 hours of a required note, then the discharge note will suffice.

i. Upon meeting criteria for discharge (see section on Discharge and follow up below), discharge instructions will be completed which will include the patient's clinical course in the unit, the final examination, final diagnosis, and instructions for continued care and follow up.

a. Consultations

i. Consult as needed, similar to regular ED function

a. Testing (stress tests, imaging, etc)

i. For stress testing, see last section on "provocative testing."

a. Medication Reconciliation

i. Although a formal medication reconciliation is not required, any changes in medications (additions, removals) should be documented in the patient's discharge instructions.

i. In addition, any chronic medication that a patient takes, i.e. hypertensive medications, should be ordered.

a. Discharge and Follow Up

i. All discharges must be discussed with the OU attending prior to completion.

i. Discharge Home:

1. When the patient meets the predefined criteria, the patient will be discharged home from the observation unit.

1. All usual ED discharge processes must occur, i.e. teaching, appropriate follow up and written instructions.

1. Prior to discharge, the OU resident must document the patient's clinical course, final diagnosis, and examination.

1. Upon discharge, all patients will be provided with a discharge summary and plan for follow up. Consider utilizing Post-ED Follow up visit order for high risk discharges.

i. Upgrade to Hospital Admission:

1. If a patient deteriorates during the observation stay or at the 24-hour mark the patient requires further clinical care, the patient will be admitted to the hospital for further management.

1. However, if the clinical situation strongly suggests that discharge may occur within 2-3 hours of the 24 hour mark, a grace period for observation may be extended.

1. Admissions to the hospital from the observation unit will occur in the same process as admissions from the ED:

a. The admitting service (PIC - Physician in Charge) will be contacted by the observation unit provider and given an endorsement of the patient. Upon endorsement, the admitting service will be responsible to write all orders and direct additional management of the patient.

a. The OU provider will intervene in cases of emergency while the patient is still in the unit.

a. The now admitted patient will then await transfer to SSU or to the inpatient floor. Unless clinical circumstances dictate otherwise, observation unit patients who are moved to admitting status will be given priority over ED patients for inpatient beds.

a. If a patient is in extremis or admitted to ICU and no ICU bed available, the patient will be transferred back to the ED for appropriate management.

a. Emergencies

i. If the patient becomes unstable at any time, interventions as necessary will be performed, a “code 66”, rapid response team, will be called and if necessary, the patient will be admitted to the appropriate service. The KCH-ED Rapid Response Team will be the team which responds to code 66’s in the OU in the same manner in which they are responsible for all codes called on the ground floor from the E-building to the B-building.

a. Communication with attending overseeing the department

i. If there are any questions regarding a patient’s course or non-emergent concern, the OU resident will contact the ED attending for assistance and/or guidance.

KCH PEDIATRIC EMERGENCY DEPARTMENT

Administration

Dr. Konstantinos Agoritsas is the Director of the Division of Pediatric Emergency Medicine. Mrs. Loretta Lawrence Reid is our pediatric head nurse.

Pediatric EM, EM and pediatric faculty staff the Pediatric ED. Pediatric Emergency Medicine fellows, residents from the departments of EM, Pediatrics, Family Medicine and the combined EM/IM program rotate through the Pediatric ED. Third and 4th year medical students, as well as PA students also rotate through the Pediatric ED.

About 30,000 sick and injured children are seen in the Pediatric ED annually.

Age criteria

Please use age limit criteria as guidelines and do not let patients suffer because the patient is presenting in a “wrong ER with a wrong age”.

a) Medical emergencies <19 years of age = Ped ED
b) Minor blunt trauma <19 years of age = Ped ED
c) Major blunt or penetrating trauma <15 years of age = Ped ED
d) Major blunt or penetrating trauma 15 years of age or older = Adult CCT
e) Surgical emergencies up to 18 years of age = Consult Pediatric surgery
f) Surgical emergencies in patients older than 18 years of age = Consult General Surgery

If a patient is followed regularly by one of our subspecialty clinics (e.g. asthma or sickle-cell clinic), we will generally see these patients up to their 21st birthday. If a discrepancy exists, the attending of record will make the ultimate decision as to where the patient is seen.

Triage

When the patient first comes to the Peds ED, he/she is first evaluated by the visual triage nurse who will determine if the patient needs to be seen immediately or if stable, to be triaged and then seen by the physician. Simultaneously, the clerical staff will log in the patient to our registration system. The area clerk will complete full registration later. The triage nurse will then assign acuity of visit (ESI). Triage policies can be obtained from the Pediatric ED Nursing office and are available on the KCHC intranet.

All patients brought by EMS are triaged at the EMS receiving area in the Pediatric ED. After triage, a physician can determine if the patient can wait in the waiting room, depending on ESI

triage category, and conditions in the ED. Make sure the patient is triaged before the patient is asked to wait in the waiting room.
Patients presenting with acute asthma are seen by the triage nurse at the front desk or by the main EMS triage nurse and brought immediately to the asthma room for treatment. The nursing staff assigned to the asthma room gives nebulization treatments.

Patient care areas

• Rooms #1-5 are generally used for sicker children, but may be used by any patient.
• Room # 1 has a Pediatric Broselow cart and can be used as a resuscitation bay when necessary. It is preferred that resuscitations are performed in Pediatric CCT Room 3.
• Room # 6 is a closed door room and generally used for fractures, procedural sedation and analgesia.
• Room # 7 is a closed door room and generally used for surgical procedures such as lacerations, I&D, etc.
• Room # 8-10 are closed door rooms and are equipped with monitors, oxygen, and suction.
• Room #11 is a closed door room, has stirrups for GYN exams and contains GYN supplies.
• Room #12 is an isolation room equipped with negative pressure and has its own bathroom and monitor. Any patient with exposure to measles, chickenpox, TB or other infectious disease requiring isolation will be placed in the isolation room and evaluated there by the physician.
• Every room except rooms #7 and #11 are equipped with monitors.
• Asthma Room – Has dedicated chairs/recliners to manage patients with asthma, bronchiolitis, or other respiratory conditions. There is a bed with curtains in the back for examinations. Patients with minor “fast track” complaints can also be seen in this area, but please use discretion and discuss this with the charge nurse.
• Pediatric CCT Room 3R - This is a dedicated pediatric critical care resuscitation bay. It has all the required supplies for a resuscitation, which includes: chest tubes, central lines, tracheostomies, airway equipment, etc. Make sure to look around so that you familiarize yourself with this room. It is the preferred room for pediatric resuscitations. However, at times there is an adult patient in this room. It is important that the patient placed in this room can be moved easily if needed and once the room is empty the room/beds are prepared for the next patient.

Critical patients

If a patient is critically ill, they may be taken to the Pediatric CCT area or managed in one of the bays in pediatrics, usually Room 1, based on the attending’s preference and room availability. The charge nurse and the attending/PEM fellow are responsible for assigning the roles during the resuscitation. Please visit the CCT Pediatric Trauma Room and get to know where equipment and materials are located. A Pediatric Broselow cart is available in the CCT Pediatric Trauma Room and in Room #1 of the pediatric ED.

Pregnant patients

Pregnant patients <19 years old with a fetus of < 20 weeks gestation are to be seen in the Pediatric ED.
Those presenting for something unrelated to pregnancy (eg - laceration/tooth pain/sprained ankle etc.), are to be cared for in the pediatric ED.
Patients with a fetus greater than 20 weeks gestation and/or in active labor should be sent to Labor and Delivery Suite after initial triage and ED stabilization.

Telephone triage

We do not give advice over the phone. Parents calling from home seeking advice are advised to seek treatment at the KCHC pediatric walk-in clinic, ED or their primary medical doctor. However, if the patient was seen within 72 hrs and has a question related to the ED visit, you

should answer their question and document a Follow Up note in the EMR. In all cases, make sure to inform them that they can return to the ED if they have any concerns.

Nursing

A charge Nurse is assigned 24 hours a day and is responsible for knowing the general status of the ED at all times and managing any issues that come up. The charge nurse can help coordinate admissions, discharges and transfers. The nursing staff is comprised of clinical nurses, nursing support technicians and unit assistants. Each patient, once registered, is evaluated and a primary nurse is assigned. Emphasis is placed on collaborating with the nursing team for patient care and decision-making.

Discharge instructions

It is very important that you document the following on all discharge instructions:

1) When to follow up: Many discharged patients require mandatory follow up. Other patients do not warrant mandated follow up and thus the disease/illness will simply run its natural course. However, it is important to advise “as needed” follow up when it is appropriate to do so. It is important to document these instructions and follow ups in the EPIC “disposition” tab. Please ensure it is written on the discharge papers before handing them to the patient/family.

2) With whom and where to follow up: Specify a date, time, and location and with which specialty the patient is to follow up. To make a referral to the KCHC E Building clinic, in the disposition tab in EPIC, under “Rx/Ref/Disch Orders” tab, type in “ambulatory referral to (clinic name)” and place an order for the referral as you would a regular prescription. After placing the order, please ask the unit clerk to make an appointment for the patient. The clerk will print out a copy of the referral with appointment date, and the appointment should also show in in EPIC in the “encounters” tab as a future date. If no appointments are available, the clerk will advise the patient that someone will call them in the next few days to schedule an appointment. If the follow up clinic is at KCHC, under the “follow up – look up” area in EPIC, you can also search for the clinic directly by typing in “KC (clinic name)”. This will add the clinic name and contact information to the discharge papers and the patient will be able to call the number listed to make a follow up appointment.

Please advise the parent to seek additional assistance with their primary care provider. If the patient requires immediate follow up at KCHC, an appointment can be made for less than 72 hrs. If you want them to follow up and they can not, then have them return to the Pediatric ED.

3) Provide instructions in plain, simple language.

4) Avoid the use of medical abbreviations and medical lingo. Please write in a clear language that the patient can understand. For example, instead of “q” or “P.O.” write “every” or “by mouth”.

5) Provide discharge instructions in the language of the speaking patient/parent.

6) Document that a translator was utilized when discharging a patient with the assistance of a translator. Always record the name of the translator or ID number on the discharge instructions or in the medical record of the ED visit.

7) Document a discharge diagnosis, even if it is an impression.

8) Provide specific instructions regarding home care for the patient’s injury or illness.

These instructions can range from brief instructions such as PRICE (Protect, Rest, Ice, Compression, Elevation) after an orthopedic injury to extensive information with computerized discharge instructions. Please search for appropriate discharge instructions in EPIC and print them for every patient prior to discharge.

There are also discharge instructions for several common pediatric illnesses on the clinicalmonster.com website. These instructions must be edited to fit the patient who is discharged home. Make sure to review them before printing. Do not just cut and paste. These instructions were created with the intention that they will be modified.

Follow-up

• Try to NOT schedule patients to return to ER for follow-ups. Appropriate ED follow ups are for complicated wound checks, and extenuating circumstances. If you do ask the patient to return to the Peds ED for follow up, ask them to return between 8-10am.

• Appointments for KCHC patients can be made by the clerical staff of Ped ED or by calling the clinic appointment desk at telephone # 245-3325. Refer to the “Discharge Instructions” section above for specific instructions.

• There is a schedule (time/day) of all the clinics with their telephone numbers posted in the ED.

Social work

• Social work can call ACS (Administration for Child Services). There is NO RULE that only physician can call ACS. Social work can also help in providing referral to community resources and agencies. Usually a 24-hour coverage and assessment is available for child abuse and neglect cases. Page AOD if you cannot locate the social worker.

• Consider social work consults for adolescents that present as victims of violence and assault. The social worker may consult KAVI for these patients.

Physical and sexual abuse

• Patients 18 years and younger fall under child protective services/specialist (CPS) laws and therefore, should have a pediatric consult. The Pediatric ED must ensure proper referrals to CPS, Social Services and appropriate counseling.

• There is a camera on a computer on wheels (COW) available in the Ped ED to document the signs of abuse. These photos must be uploaded into EPIC. The phone app EPIC Haiku also as a camera function to upload images to the patient’s chart. Please speak to the head nurse for assistance. You must document the name, MR# and who took the picture on each photo. Also, if you are documenting signs of physical abuse, place a ruler or another object (quarter) next to the physical finding in order to provide a perspective on the injury severity.

• Please refer to the pink binder in the pediatric ED for the latest instructions on follow ups for suspected cases of abuse/neglect.

Sexual Assault in Patients greater than 13yo

• Consult Sexual Assault Response Team through the page operator (# 3141). A general history and physical should be done, lab work drawn as per SART protocol. Social work should be consulted.

• These patients should be referred to adolescent medicine for follow up. Please refer to the pink binder in the pediatric ED for the latest instructions on follow ups in these cases

• If they receive medication for HIV prophylaxis, please be sure to tell them that although they receive medications/ prescriptions for 7 days, the entire course is 30 days.

Consults

• Consults can be called via the page operator at 3141 or 2*#21. If the operator states that the consult must be called through Downstate, please call 718-270-2121.

• All consult requests must be placed in the computer as an order.

• If the patient is to leave the ED for consults to dental, ophthalmology, ENT, Gyn, make sure that patient is sent with a nurse’s aide/tech. Please make sure to provide all pertinent information in EPIC.

• Please make sure that the patient is not discharged directly by the sub specialist. You must coordinate discharge and follow-up with the consultant service.

Psychiatric Consultations

• Child psychiatry will consult case in the Peds ED 24/7. The psychiatry on call individual will come to the PED to evaluate the patient, and if the patient requires admission, he/she will be transferred to R building CPEP after medical clearance.

• All patients that are transferred to the R building need to be "medically cleared" and tneed to be signed out to the internist in the R building ED. Their extension is 2310/2312

• Once the above communications have occurred, the patient may be transferred to R building with and aide and hospital police, along with a copy of the chart.

• If the child can go home, it is important that we refer them to the walk-in clinic in R building open M-F 9:00a.m. – 2:00 p.m.

• REMEMBER: Medical clearance in the Pediatric ED does not automatically mean routine blood tests like CBC and CMP. Patient can be medically cleared just by a history, and well-performed physical examination. Blood tests are ordered only when indicated.

Admitting Process to Pediatrics

Inpatient Service

When you need to admit a patient to the pediatric inpatient unit, the chain of contact is as follows:

1) Page or call the residents. Phone numbers are listed in the physician area of the Peds ED.
2) If there is no response in 15 minutes, page the Pediatric Chief Resident at 9177600089.
3) Then the attending on call. The on call schedule for pediatric attendings is available in the Pediatric ED Resource Binder (pink binder) and in sharepoint under Physician Schedules.
5) Then Dr. Bhattacharya(Director, Pediatric Inpatient Unit)
6) Finally Dr. Desai the Chief of Pediatrics.

PICU

All admissions to the PICU require a discussion between the PEM/EM attending in the Peds ED and PICU attending before the patient goes upstairs. The PICU resident can not accept the patient, unless the attending is aware. The resident in the Peds ED should then inform the PICU resident about the admission.

Other Important Notes about admissions

• Teens with gynecological issues, early (<14 weeks) pregnancy issues and or major medical problems needing pediatric care will be admitted to pediatric service on a pediatric unit and will be followed jointly by both services (Pediatric team as the primary and OB as consulting).

• All indicated diagnostic work-up, including labs, intravenous access, and first dose of antibiotics, (if indicated) are to be done in the ED. However, there are no routine lab tests that are required for admission (thus, a child getting admitted for Status Asthmaticus who is not dehydrated does not need BMP just because you are admitting him or you have extra blood drawn by a nursing staff).

• All the admissions to PICU need to be accompanied by a nurse and a physician. Physician-to- physician communication and nursing –to- nursing communication must be done in detail at the time of admission.

Remember: No one from the in-patient service or PICU has a right to refuse an admission (provided there is a bed available). Please page the AOD, and director of service (if required), if you have any difficulty admitting patients.

Admissions of status asthmaticus

GUIDELINES FOR MONITORING PATIENTS WHO WERE TREATED WITH INTRAVENOUS MAGNESIUM SULFATE

BACKGROUND: Intravenous Magnesium Sulfate is considered an adjunct therapy for patients with moderate to severe status asthmaticus and may be given to those who have had an

inadequate response to first-line medications. Serious adverse reactions after a single dose of intravenous Magnesium Sulfate are rare, yet the potential for development of hypotension and arrhythmia warrants close cardiac monitoring during infusion.
At the time of the writing of this policy, there are no large clinical studies addressing the issue of optimal length of monitoring after Magnesium Sulfate infusion, and the following proposed guidelines are based on current clinical practice and knowledge about the pharmacologic properties of Magnesium Sulfate when given intravenously.
• All patients who have received intravenous Magnesium Sulfate should be placed on a cardiac monitor for ONE hour after completion of the dose. In most cases, this will be accomplished while the patient remains in the Emergency Room.
• Nursing report and physician hand-out need NOT be delayed until the end of the one hour observation period.
• Patients being admitted to the general pediatric ward before the required observation period has been completed should be placed in MONITORED BEDS. Patients deemed clinically stable for floor status may be moved from a monitored bed to a regular floor bed ONE hour after completion of the Magnesium Sulfate infusion.
• If monitored bed on the inpatient ward is not immediately available, patients should remain in the ED until one hour observation period is satisfied.
• In case no monitored bed is available, the floor team under attending guidance will review and assess the clinical status of the patients currently occupying monitored beds and make reasonable efforts to downgrade patients to regular floor status in order to accommodate a patient requiring close observation after Magnesium Sulfate. If the above is not possible, the floor team should discuss admission to the PICU for monitoring with the respective PICU team.
• If an agreement about a patient's ultimate disposition cannot be reached between ED, inpatient and /or the PICU teams, the discussion should be escalated to the Directors of Service as per existing policy.

In-patient wards

Pediatric In–patient ward is on D-6. (in-patient tower / "D" building 6th floor). PICU (8 beds) is located also on the D-6 North.
Neonatal ICU is located on D-5 ("D" building 5th floor) along with regular nursery.

Transfers

Outside ED to KCHC ED:

• Document pertinent information on ED Transfer/Referral Form located in the Transfer-Referral Binder. For all transfers requiring subspecialty care, you must confirm that the subspecialty accepts the patient prior to transfer. This includes urology, trauma, neurosurgery, orthopedics. Make sure that all transfers are routed through the HHC transfer center. You can reach the transfer center through the operator

Direct Admissions: Outside ED/Inpatient/PICU to KCHC Inpatient/PICU:

• Admissions to the PICU should be directed to the PICU Attending on-call. (See Resource Binder for PICU Attending on-call schedule and pager #'s. Please do not give out direct cell phone #'s.)
• Admissions for transfer to the Pediatric Inpatient Service should be referred to the HHC transfer center who will then contact the appropriate subspecialty.
• Documentation on the ED Transfer/Referral Form should be performed for all referrals to KCHC.
• Direct transfers from other institutions do NOT routinely need to come through the ED. However, in select circumstances, the Inpatient or PICU Attending may request that the patient

be brought through the ED for reassessment or stabilization. This must be discussed attending to attending. All transfers should go through the HHC transfer center
ED to ED transfers can only be accepted by the PED attending or Fellow. Please document information about the transfer in the blue “Transfer Book”. If a PEM fellow speaks with the referring hospital, the attending must be informed of the referral immediately.

Helpful hints

- If you get overwhelmed in the Ped ED (multiple injured or ill children), you can always call Adult ED and speak to the attending in charge. He/she can always send some help whenever possible
- There is NO “SIGNING OUT AGAINST MEDICAL ADVICE” in Ped ED. Be an advocate for a child and always try to resolve the differences of opinion with parents in such a way that a child’s health does not suffer.
- Parents are not allowed to leave children of any age alone. We will try to relieve them, if possible.
- The computer generates all lab slips. Each specimen must be labeled and placed in individual bags. Almost all specimens can be sent to the lab via the pneumatic system.
- Procedure notes must be written for each procedure done. Always obtain consent prior to performing procedures (e.g. Procedural sedation). Always document “Time Out” when indicated.
- The physician performing the procedure is expected to discard the used items after the procedure.
- No patient can be discharged until the patient is presented to the Attending who will then complete the chart. Please ensure that all the residents / medical students / PA students working with you are aware of these.

Extramural Deliveries

See Extramural policy available on sharepoint, but the general procedure is as follows:

1. The Medical and Nursing staff of the CCT and the Pediatric ED (hence forward referred as “CCT team” for CCT physicians and nursing staff and “Pediatric team” for Pediatric ED physicians and pediatric nursing staff) will prepare for the extra mural birth.
2. Emergency Department staff will notify Labor & Delivery at extension 4570 or 4571. If necessary, Neonatal ICU should also be called at extension 7048.
3. On arrival in the ED, the mother and baby will be assessed by the ED physician, registered by the clerical staff and appropriately identified with a mother and baby ID band placed on both mother and baby (the baby will have the mother’s band in addition to the baby’s band and the mother will have the baby’s band and the mother’s band).
4. After mother and baby are determined to be stable, both will be transported to Labor & Delivery by the CCT nursing staff where foot printing will be done.
5. If the baby requires admission to Neonatal ICU, the pediatric ED nurse member who identified the mother and baby in the E.D will go to the unit to ID the baby to the Neonatal ICU staff to confirm baby, while the mother will be transferred to L&D. Foot printing will be done by the Neonatal ICU staff.

Call back or radiology over-reads:

If you receive a phone call from radiology regarding an overread, you should document what you did in response to this information as a follow up note in EPIC. If you were not able to speak with the patient or family member, an attending must be informed of the call back information and management decision.

Subspecialty services

Urology

• Pediatric Urology Physician Coverage - Currently there is no pediatric urology services at KCHC and at UHD. Both KCHC and UHD will have pediatric urologic emergencies covered by general urology. Do not refer to outpatient pediatric urology at SUNY Downstate as they do not have pediatric urology services.. You should refer these patients to Bellevue Hospital, Maimonides, or to their pediatrician for referral to a pediatric urologist.

Neurosurgery

• Neurosurgery – There is no formal pediatric neurosurgery coverage at KCHC. Neurosurgery will evaluate all ED consults and make recommendations. General Neurosurgery will consult and assist in the management of these patients.

• Neurosurgery will evaluate and manage patients age 14 or older with neurotrauma/intracranial emergencies. The decision to transfer will be at the discretion of the neurosurgery attending.

• All patients under the age of 14 with intubation due to neurotrauma, declining mental status or intracranial blood will be transferred to appropriate accepting facility. The nearest pediatric neurosurgery centers are Bellevue (HHC) and Maimonides.

• Patients with low likelihood of deterioration who require observation due to symptomatology, e.g. post concussive symptoms, single seizure, may be managed at KCHC based on discussion with neurosurgery/PICU.

Pediatric Trauma

• KCHC is currently not a designated pediatric trauma center. However EMS may bring children who suffered traumatic injuries to the PED.

• Pediatric traumas that arrive to the PED should be evaluated upon arrival by a physician, and appropriate pediatric trauma level should be called if indicated. There is a poster outlining pediatric level 1/2/3 indications outside of room 1.

• The KCHC adult trauma service will consult on all pediatric traumas. They will discuss the case with on call pediatric surgery if necessary. Decision to transfer will after discussion between the trauma service and PED.

• The preferred trauma center for transfer is Bellevue. Please coordinate pediatric trauma transfers through the HHC transfer center.

Sign out and Rounds in the Peds ED

• Rounds must occur at change of shift at 7a/3p/7p/11pm.

• Rounds are a time for education.

• All patients MUST be signed out to an attending and a resident. This includes ADMITTED patients. An attending plus/minus a resident MUST know of the patient at all times. There is no such thing as patient is admitted so no sign out.

• Admitted patients in the Pediatric ED belong to us until they leave to go upstairs.

• Eating in the area is not acceptable. Please use the breakrooms to eat your meals.

Escalation Policy for the Peds ED Stepwise Approach

Konstantinos Gus Agoritsas

1. (347) 672-9865 (work cell)
2. (917) 923-6600 (personal cell)
3. If the above don't work and is urgent, you can text and email (Email preferred - konstantinos.agoritsas@nychhc.org). Service in the hospital is not great, so phone calls may not go through, but texts or emails work better somehow.
4. Home # is (718) 225-2745

DO NOT LEAVE A MESSAGE ONLY IF THE ISSUE IS URGENT.

KCH Pediatric ED Resident Clinical Role

The shifts at KCH offer a variety of unique learning experiences. The expectations of the residents at KCH peds are as follows:
1) The resident is to follow each of their patients through to completion including initiating a workup, following diagnostic study results, obtaining appropriate consults, dispositioning the patient, and arranging appropriate follow up.
2) The resident is expected to meet EMS as they bring patients into the ED.
3) The residents are expected to be present at all notifications and pediatric resuscitations.
4) When a PEM Fellow comes on shift all EM residents should expect to be precepted by the fellow starting in Block 7 of their first year of fellowship.
5) The residents are expected to precept medical students.
6) As a benchmark, junior residents should try to see 1.5 patient per hour (PPH) and 2.0 pph for seniors.
7) As the resident you may be assigned to different areas of the Emergency Department by the RDOC.
8) The resident is expected to maintain timely, thorough, and complete medical records in the T system and EPIC
9) The residents should also watch the whiteboard to ensure that all ESI 1 and 2 patients are seen and evaluated promptly.

KCH PROCEDURE GUIDELINE

General:

-Faculty have final say in real time on all decisions in patient care. This document is a guideline and should not dictate or alter safe patient care

-Procedures and resuscitation roles should only be assigned to residents scheduled in that area of the ED unless extraordinary circumstances occur.

-Example 1- a resident scheduled for ultrasound should not have preference to do a chest tube over the junior resident assigned to CCT.

-Example 2- a PEM fellow assigned to CCT should not have preference over an EM resident for an airway in the Peds ED.

Peds ED:

-Peds ED patients are defined as any patient assigned to the Pediatric ED irrespective of their location. For example a pediatric resuscitation occurring in CCT3 is a Peds ED patient. Pediatric trauma is considered 14 years old or less. The location for the resuscitation (Usually CCT3 or Peds Room 1) is at the discretion of the Peds ED attending.

-PEM Fellows assigned to the Pediatric ED will have the right to refusal of all procedures performed in the Peds ED.

-All procedures performed in the Peds ED should be inclusive of all residents/fellows' education. For example if the PEM fellow is performing a chest tube, the EM junior should be able to gown and glove to participate.

-For Pediatric Resuscitations, the ideal scenario is that roles will be discussed and assigned beforehand. The typical roles to be discussed should be team leader, airway, procedure right/left. Once roles are assigned they cannot be changed except in extraordinary circumstances and no one should be assigned to more than one role. For example a resident/fellow cannot be running the resuscitation and performing the airway.

-If roles are not predetermined the general assignments should follow this ranking :

-Team Leader: Senior PEM fellow → Junior PEM Fellow* → Senior EM resident
-Airway: Junior PEM fellow → Senior EM Resident → Junior EM Resident
-Procedure Right/Left: EM Resident → Peds Resident

*Junior PEM Fellow is defined as a fellow in the first year of their fellowship

CCT:

-The Senior EM resident has the right to refuse all procedures in CCT. Trauma airways are expected to be a senior EM resident procedure

-PEM Fellows are considered an EM junior resident when assigned to CCT. This includes all responsibilities of a junior resident including room setup and an equitable distribution of procedures with assigned EM junior residents

-When junior residents (includes PEM Fellows assigned to CCT) are overlapping time in CCT the team should discuss procedure priorities but generally the guideline should be:

7am-5pm Junior:
Gets default priority for procedures from **7am-3pm** (1pm-3pm while with other junior)

1pm-11pm Junior:
Gets default priority for procedures from **3pm-11pm** (9pm-11pm while with other junior)

9pm-7am Junior:
Gets default priority for procedures from **11pm-7am**

A brief discussion at 1pm and 9pm is encouraged to discuss specific learning needs and load of procedures during the day. All final decisions will be by CCT attending.

UHD EMERGENCY SERVICES

Introduction

The purpose of this orientation manual is to orient you to the UHD Emergency Services (UHDES) and to help you prepare for your rotation through our department. It is assumed that by this time you have received your clinical shift schedule and spoken with the UHD Chief resident to prepare for the rotation. You will receive a tour of the facility highlighting the physical plant and a description of the available resources and supplies (including airway medications and supplies, resuscitation carts, etc.). In addition, you are expected to be familiar with the UHDES Policy and Procedure Manual, a copy of which can be found on the unit or any UHD computer.

The University Hospital of Downstate

UHD is a 400-bed tertiary care hospital located in the Flatbush section of Brooklyn, New York. The hospital is affiliated with SUNY Downstate Medical School, with a graduating medical school class of 200 physicians/year. The hospital's capabilities include all surgical sub-specialties, dialysis, cardiac catheterization, OB/GYN, NICU, and transplant surgery.

Description of Unit

UHDES is a comprehensive Emergency Department. Our physical plant has expanded to a 9,000 square-foot unit with dedicated pediatric, adult and fast track areas. The annual census of the department is approximately 50,000 patients generating greater than 10,000 admissions to the inpatient wards. The unit is a FDNY EMS-designated 911 receiving center and is able to accept both BLS and ACLS ambulances from both the FDNY & private ambulance companies.

Roles and Responsibilities of Resident Physicians

The role of the Resident Physician in the ED is to provide excellent, timely and courteous medical care to our patients. In return, the resident can expect to experience fast-paced Emergency Medicine with a focus on quality medical care. The resident will encounter a "community-type" setting amidst a tertiary care atmosphere. Residents are expected to discuss all patient interactions with a faculty attending physician, and all medical decision-making must be initiated in concert with the attending's supervision.

Patient Flow

All patients who present to UHDES will be triaged based on severity of illness and receive an appropriate medical screening exam for their stated medical complaint. It is the policy of UHDES that all patients are to be triaged within fifteen minutes of presentation. Financial information may be obtained during the medical screening process but may not impede the completion of the medical screening exam. All patients will receive a medical screening exam to determine if an emergency medical condition exists. Patients who are determined to have an emergency medical condition will be stabilized utilizing the full resources of the institution irrespective of the

patient's ability to pay. After notification of the inpatient service the attending physician may admit patients who require admission. You must discuss all admissions with the faculty attending physician prior to initiating the admission process. Patients who require services not provided at UHD will be offered transfer to an appropriate facility.

Consults

Specialty consultations are available in all services offered by UHD. Consult services may be contacted via the pager operator (X2121) or via amion.com (login: downstate). The consult policy mandates that all emergency consultations be answered by phone within 10 minutes and in person within 30 minutes. It is expected that consultations must be completed within 3 hours of initial consultation. Consultation reports can be found in healthbridge, however a paper copy of the consult must be maintained for ED records. If, as the resident physician, you are having difficulty contacting a given service, you are to discuss this immediately with the ED faculty attending of record for the case The details of the consultation policy may be found in the UHDES Policy and Procedure Manual. Patients may only be sent to outpatient suites [dental, ENT, GYN (suite G)] for emergent consultations at the discretion of the attending physician, and only if accompanied by qualified medical personnel. In addition, patients should not be sent for follow-up care at outside institutions (i.e. KCHC, etc.).

UHD Admitting Process

There are a number of inpatient admitting services at UHD that each have a process for accepting ED admissions.

Family Practice:

The FP service cares for its clinic and private patients when they are admitted. For patients that are followed in Suite B (resident and attending clinic) and Lefferts Ave Family Health Services, call the FP resident-on-call. If necessary, you can page the patient's attending physician as well but this is not always necessary. When you have identified a patient of theirs that will likely require admission, start the process early as they may want some consults before taking the patient on their service.

Medicine:

The Internal Medicine department have two possible admission pathways:

1. Private patient Service: You need to recognize the names of the private MDs that admit to their service and a list is present in the ER. You must speak with the private physician to request admission to their service. After discussing the patient with the PMD and admission is agreed upon, a brief call to the Medical Admitting Resident is needed to endorse the patient.

2. Hospitalist service: Patients that do not have a primary care MD with admitting privileges to UHD but require inpatient care are cared for by the Hospitalist service. The UHD Hospitalist group admissions go through the Medicine Admitting Resident.

ICU Admissions

The respective unit must accept patients who require admission to either the MICU or CCU. If a dispute arises about the ICU admission the discussion must be attending-to-attending and all involved services must be part of the discussion. Currently there is an intensivist in-house 24-hours daily. If the ICU cannot take the patient because of operating above capacity, the ICU team may accept the patient as a boarder and care for the patient in the ED. If the ICU will not care for the patient the director of the ICU, the administrator on duty, and UHDES Medical Director are to be notified.

Cardiology:

Critical Cardiac patients may be admitted to the CCU. In order to have a patient considered for CCU admission, consult Cardiology and discuss care with the Fellow on call.

Renal:

The renal service accepts admissions for patients that require inpatient care who receive their dialysis at Parkside, the Downstate Ambulatory Dialysis Center. These patients should be evaluated by the on-call Renal Fellow.

Neurology:

During the day there are two neuro consult services: stroke and non-stroke. The stroke consult resident will respond to all stroke codes. For all other consults, please contact the non-stroke consult residents. Weekends and overnights there is only one neuro resident covering all consults.

Surgery:

General and all the surgical subspecialties require consultation prior to admission. There is an in-house Surgical Hospitalist attending available 24/7 for all consults/admissions.

Orthopedics:

The orthopedic service can and should admit appropriate patients. There is an agreement between the ED, Ortho, and Medicine departments regarding patients with significant comorbidities that will require orthopedic inpatient care. If the ortho service is uncomfortable with a patient with uncontrolled medical issues, they can request a Medicine consult. If it is determined by Medicine and the ED attending that the patient is stable for ortho admission, they are admitted to Orthopedics. If the patient has uncontrolled medical problems with a concurrent orthopedic condition, they can be admitted to medicine with orthopedics as a consult service.

Boarders

Patients who are admitted to the hospital but who do not have beds are to be cared for by the admitting service. The transition to the in-patient team takes place at the time admitting is called and the team notified, NOT at the time a bed is assigned. The inpatient team is expected to write admitting orders and provide care. The ED attending is expected to intervene if any emergency arises or the patient's status changes. The details of the boarder's policy are in the UHDES Policy and Procedure Manual.

Transfer Agreements

Transfer agreements are in place and protocols approved for the following inter-facility transfers once initial stabilization has been achieved:

- Burn: Patients requiring burn unit admission are to be transferred to NY Hospital, Cornell University or Staten Island University Hospital.
- Hyperbaric: Patients requiring hyperbaric therapy are to be transferred to Jacobi Hospital.
- Trauma: Patients requiring admission to either of these services are to be transferred to Kings County Hospital Center.
- Pediatric Psychiatry: Patients requiring admission to psychiatry are to be transferred to Kings County Hospital Center.
- Psychiatry: There is no in-patient psychiatry at UHD. If a patient requires inpatient psychiatry services, please consult psychiatry who will determine whether or not a patient needs to be transferred for inpatient admission. Social work and case management can help with finding an appropriate location for the patient to be transferred.
- Neurosurgery: If transfer is needed Maimonides commonly accepts our transfers however any facility with neurosurgery services should be able to accept our patients.

All transfers must be discussed with an accepting physician at the receiving institution, and prior to transfer, all patients must have a transfer form (UHD #7-83) completed by the Attending Physician, including reason for transfer and the name of the accepting physician at the receiving institution. In addition, Dr. Mehta is to be notified prior to transfer.

Pediatrics

Pediatric patients comprise approximately 25% of the UHDES patient census, and as such will comprise a significant portion of your clinical duties. Our facilities provide a dedicated pediatric ED, including full- time pediatric triage, nursing and physician and physician-extender coverage under the direction of Dr. Nooruddin Tejani, Director of Pediatric Emergency Services. During periods when there is not a dedicated pediatric attending or pediatric resident, you will be expected to care for pediatric patients. Pediatric admissions (NS 42) are to be discussed with the pediatric resident on-call, who can be contacted by calling the pediatric unit. Any child who you feel requires ICU or step-down monitoring must be discussed with the pediatric attending intensivist (NOT the Chief Resident). A large segment of our pediatric population is primarily cared for by Downstate Pediatric Associates (718-998-5076) who request that they be notified of all patients affiliated with their group who present to the ED for care. The pediatric ED also

keeps a log of all cultures that are taken on a daily basis. The residents will be expected to help follow up the culture results and call back patients as needed.

UHD Administration

- Wayne Riley, MD, President
- Charles Brudicardi, MD, Dean
- Michael Lucchesi, MD, MS, Chairman Department of Emergency Medicine
- Ninfa, Mehta, MD, Medical Director Emergency Department
- Cynthia Benson MD, Assistant Medical Director
- Nooruddin Tejani, MD, Director of Pediatric Emergency Services
- Gerard Eaddy, RN, Associate Director of Nursing, Emergency Department
- Regina Auletta, Administrator of Emergency Services

Ancillary Staff

Ancillary services in UHDES are provided by the EKG technicians and Healthcare Assistants (HCA I and II). The EKG technicians' responsibilities include phlebotomy (but not intravenous access), performing EKG's, patient transport and clerk relief. The HCA's responsibilities include patient transport, lab delivery, and patient care assistance. As a Resident Physician, it is expected that your time here will be spent on direct patient care, rather than ancillary duties. All IV access is to be obtained by either the RN or MD. Techs & HCA's can NOT obtain IV access.

Nursing

The UHDES nursing staff is composed of one charge nurse, two triage nurses and at least eight RN's per tour. UHDES nurses are all BLS/ACLS/PALS certified, and as such are qualified to provide care for Emergency Department patients. Intravenous access is to be obtained by the nurse assigned to that patient. Please be diligent in actively involving the nursing staff in your on-going management decisions regarding patient care. Many of the newly hired staff are young and eager to learn, but may need guidance in Emergency Medicine patient management.

Radiology Services

The Department of Radiology has made a commitment to our department to provide efficient, full- service radiology services. "Wet readings" of films may be obtained by paging the radiology resident on call during off hours or calling the radiology department during the day. We currently have an ED radiologist present in the reading room by CT. All plain films are to be reviewed by yourself and the attending physician of record on the PACS system located in the ED. The senior radiology resident on call should be contacted to discuss all off-hour specialty studies, and the page operator should be utilized to page the technician. If there is difficulty contacting the technician, the AOD is to be notified and the radiology administrator is to be paged. Any persistent difficulties in obtaining studies should be referred to the attending radiologist on-call. All radiological studies are available 24 hours a day, 7 days a week, 365 days a year.

Laboratory Services

Lab studies are available 24-hours daily. It is your responsibility to discuss all lab test results with the faculty attending of record prior to disposition of the patient. Whole blood analysis for blood gases, chemistries, metHb and COHb are presently available on a STAT basis (turnaround time in minutes) 24 hours daily.

Physician Documentation

All patients who present to UHDES are required to register and undergo triage, at which time a chart will be generated. Currently, we utilize Healthbridge. It is expected that you will complete the patient chart, providing all pertinent historical, physical, and laboratory/radiological/EKG interpretive information—both positive and negative—prior to patient disposition. All patients must be discussed with a faculty attending physician. It is your responsibility to note on the chart which attending was involved in your supervision of the care of this patient (i.e. “d/w Dr. X”, etc.). If a patient is to be discharged, all patients must have specific discharge instructions (“exit-writer”), including time and place, return instructions, and any medication/care instructions. All charts must be locked by the end of your shift.

Protocols

Code H: We have a STEMI pathway (called “code H”) that is to be initiated IMMEDIATELY upon presentation of any patient with a STEMI. Initiation of the cascade is to be signaled upon notification by FDNY EMS that a patient is en route with a suspected STEMI. The pathway is posted in the ED (outside the resuscitation room). Please make sure that the attending is involved immediately in any STEMI case.

Code S: This is the pathway for stroke patients. Initiation of the cascade is to be signaled upon notification by FDNY EMS that a patient is en route with a suspected CVA within the 3-hour window AS WELL AS the 3-4.5 hour extended window.

Code Sepsis: This pathway is to be initiated once a patient meets the criteria for severe sepsis or septic shock. You can also initiate this code if you suspect severe sepsis.

Code ICE: This pathway is to be considered for patient who had cardiac arrest and a return of spontaneous circulation. There is a Code ICE policy located on the UHD intranet.

For both situations, please DO NOT call the operator yourself. Please ask one of our clerical staff as they are required to complete a logbook with the sequence of events and the times they occur.

Scheduling

ALL SCHEDULE REQUESTS ARE DUE AT LEAST FOUR (4) WEEKS PRIOR TO YOUR STARTING DATE. This is to ensure timely completion of your schedule and maximum clinical benefit from your rotation. No written or verbal requests will be honored. You will be assigned a number of clinical shifts (ten hours in length for juniors, 8 hours for seniors) in accordance with your clinical requirements as dictated by the Department of Emergency Medicine. (Please note any religious commitments well in advance when making your schedule requests).

Of course, you are expected to be on time (10 minutes early) and to stay in the clinical area at all times. You must stay in the clinical area until your relief has arrived to ensure appropriate patient “sign- out”. The Director or Associate Director of UHDES must approve all scheduling changes and “covered shifts” in advance. In addition, in the case of a personal emergency or illness, you MUST contact Dr. Benson or Dr. Mehta, as soon as you know you will not be able to attend your shift. You must also contact Ms. Chelsea Cole, the Chief Resident on-call and the Residency Director, Dr. Willis. All missed shifts will be made up.

Dress Code

Scrubs are permitted for residents working at UHD.

PMD Notification

UHDES is committed to fostering a close, professional, and efficient relationship with the primary care physicians in our community. In an effort to enhance this partnership, you are asked to be diligent in your effort to discuss your care and disposition plans of all patients with known PMD’s who present to the ED. This includes both admissions and discharges. Please document on the medical record the name and time of the attending with which you discussed the case. Please pay particular attention to the patients who are followed by the Family Practice service. They do have an inpatient service at UHD, and are almost always willing to accept admissions for their patients. The FP outpatient service is located in Suite B.

Ground Floor Response

In accordance with the EMTALA regulations, UHDES has accepted the responsibility to respond to all calls for assistance originating from the basement, ground floor of the hospital/medical school, and within a 250-yard perimeter of hospital/medical school grounds, including the Primary Care Annex. The attending physician is expected to provide medical coverage for these calls in conjunction with the “code team” response unit. This policy is outlined in the UHDES Policy and Procedure Manual. You may be asked to accompany the attending physician on one of these calls during your rotation.

Resources

UHDES is dedicated to providing the resident physician with the most up-to-date, clinically relevant Emergency Medicine resources available. To that end, internet access is available in the clinical area to allow you to research current guidelines in diagnostics and therapeutics.

Summary

In summary, we welcome you to our ED and look forward to working with you to develop your clinical skills and to facilitate patient care in our ED. We feel that our facility will provide you a unique Emergency Medicine experience, combining a community atmosphere with a tertiary care setting. Please remember that we are very open to suggestions on ways to improve our rotation—we want to work with you. Your feedback is very important to the success of your

rotation, especially if you discuss your concerns in real-time--please do not wait until the end of your rotation to voice a concern or raise a suggestion. Again, welcome to UHDES.

Useful Phone Numbers

Nooruddin Tejani, MD
Bpr: (917) 760-0800
Email: nooruddin.tejani@downstate.edu

Ninfa Mehta, MD
Office Phone: (718) 270-8296
Cell: (917) 642-6139
Email: Ninfa.Mehta@downstate.edu

UHD Chief Resident
Email: UHDchief@gmail.com

Ms. Regina Auletta, Administrator
Office Phone: 718-270-6135
Email: regina.auletta@downstate.edu

Aquila Lewis
Office Phone: 718-270-4442

UHD Junior Resident Clinical Role

The junior shifts at UHD offer a variety of unique learning experiences. The expectations of the junior residents at UHD are as follows:

1. When the junior resident is the sole resident in the main ED, it is expected that they meet EMS as they bring patients into the ED.
2. The juniors are expected to be present at all notifications and medical resuscitations when they are the sole resident provider.
3. The junior resident is to follow each of their patients through to completion including initiating a workup, following diagnostic study results; obtaining appropriate consults, dispositioning the patient, and arranging appropriate follow up.
4. If the attending picks up a patient primarily, the attending may ask you to perform any procedures for its educational value
5. When the senior resident comes on, the junior may be assigned patients by the senior
6. The residents are expected to precept medical students if there are no senior residents.
7. As a benchmark, junior residents should try to see 1 patient per hour (PPH) in the main ED, 1.5 PPH in the Peds ED, or 1.5 PPH in the Fast Track.
8. As the junior resident you may be assigned to different areas of the Emergency Department by the attending.

9. The junior resident is expected to maintain timely, thorough, and complete medical records in the Healthbridge. All charts are to be completed within 24 hours without exception.

UHD Junior Shift Requirements

	4 Week (28 day) Rotation	**2 Week (14 day) Rotation** Total
PGY 1	19	9
PGY 2	18	9

UHD Senior Resident Clinical Role

The Senior Resident is responsible for overseeing overall patient flow, disposition, and patient management in the main ED. This includes both primarily seeing patients as well as supervising junior residents.

1. Expected to see at least 1.5 patients per hour in the main area

2. Be aware of and direct all resuscitations

3. Expedite dispositions and help manage flow through the main ED

4. When precepting junior residents, writing a progress notes and assessments on sick patients is expected

5. Provide guidance and feedback to junior residents

All residents are expected to maintain timely, thorough, and complete medical records in the T system. All charts are to be locked within 24 hours without exception.

UHD Senior Shift Requirements

	4 Week (28 day) Rotation Total
PGY 3	18

PGY 4	17

ADMISSION HANDOFF PROCESS

Introduction:

You've finished working up your patient while in the ED, and you have decided to admit them to the hospital. You are now at the most important part of the admission process: the handoff. You diligently took care of your patient, and the handoff will ensure that your patient's safety is maintained and important information isn't lost in the transition of care.

While there are many standard handoff tools, Kings County Hospital and SUNY Downstate have adopted I-PASS.

I-PASS, in short, answers four main questions:

1. **What did your patient come to the ED for?**
2. **What did you find in your workup?**
3. **What did you do for your patient?**
4. **What does the admitting team need to watch out for?**

These are the components of I-PASS:

I	**Illness Severity**	• **Stable, "watcher", unstable**
P	**Patient Summary**	• **Summary statement** • **Events leading up to admission** • **ED course** • **Ongoing assessment**

		• Plan
A	Action List	• To do list • Timeline and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

The following is a breakdown of the components of I-PASS:

I - Illness Severity - stable, unstable, watcher

This section sets the tone of the handoff and tells the admitting team whether the patient is okay (stable), sick with vital sign abnormalities (unstable), or may decompensate and needs to be reassessed frequently based on your gut feeling (watcher), at least for now.

P - Patient Summary

In this section you summarize the patient and their ED course. Start with what the patient is being admitted for and what happened leading up to the admission. Include the patient's pertinent past medical history, what you found working up the patient (significant exam findings, critical lab values (NOT all the lab results), imaging findings including bedside ultrasound, and what medications you gave your patient (don't forget how much fluid you gave your patient).

It's important to include "criticals", which are actionable findings (critical lab values, critical imaging findings, critical physician interventions i.e, things to maintain hemodynamics).

This section should be concise, utilize semantic qualifiers, and focuses on active issues. See the appendix of this section for a list of important semantic qualifiers.

Here is a sample patient summary, for someone who is being admitted for a CHF exacerbation:
***65 y/o M with hx of COPD, CHF, p/w SOB x 3 days, ran out of his medications last week. No f/c, no cough. Vital signs 190/100, otherwise normal. Exam with mild resp distress and crackles b/l, 2+ pitting edema. B lines present on US, and BNP 4000. Given nitro paste, and lasix 80mg IVP*.**

A - Action List

In this section, if there are additional things that need to be done, precisely state what needs to be done for the patient, including how soon (timeline), level of priority, with clearly signed responsibilities (if applicable), and the reason they need to be done. Examples include *tests that need to be followed up, consults that have given recommendations but not yet written their note, etc.* If there is nothing to do, simply say nothing to do, or omit this section.

S - Situation Awareness & Contingency Planning

This is perhaps the most important part of the hand off. This is where you let the team know what you are worried about that might go wrong,, and what to watch out for. Let them know what the plan should be. And if there were interventions that you tried that didn't work, this is where you let the team know also. For stable changes, you can say "I don't anticipate anything will go wrong".

If there are any social issues that are important for the patient's hospital course, for example if they have a home health aid or will need physical therapy evaluation for inability to ambulate, state it in this section.

For example, if your patient needed BIPAP for their COPD exacerbation and they were able to come off of BIPAP while in the ED, but you are concerned they may need it again, this is the section where you let the admitting team know. Let them know which settings too.

S - Synthesis by Receiver

This is where the person you are signing out to has the opportunity to re-state the important information you provided. It is the opportunity for them to demonstrate that they understood the information given, and can clarify elements of the handoff. Most importantly it is their chance to ask questions. We recommend you start this section by asking, "Do you have any questions about anything I've told you?"

TROUBLESHOOTING

Sometimes the handoff process doesn't go seamlessly. They may not want to use I-PASS. The person you are signing out to, may interrupt you, or ask for information that would be considered extraneous (i.e, every lab value on the BMP). Here is how you may troubleshoot the situation:

1. **If the person you are signing out to is not using IPASS, encourage them to use the I-PASS system. "Let's use I-PASS, it will be better for our handoff, and for the patient's safety."**
2. **If the person you are signing out to is interrupting you, kindly ask them to hold their questions until the end of your presentation. "Please hold your questions until the end of the handoff so that you can properly get an idea of what's happening with our patient."**

3. **Email the handoff committee at emimhandoffproject@downstate.edu with any concerns.**

Here are the steps for a proper handoff:

1. **Review the patient's chart to ensure all tests and imaging have resulted, and review their results. Review the interventions you have provided. Reassess the patient if they are unstable, or someone who is a watcher, if you haven't already. Obtain repeat vitals.**
2. **The I-PASS note consists of all the items above, except for the synthesis by receiver. In Healthbridge at UHD, document this mnemonic in your Disposition Note and your "Admit to Inpatient"/"Place in Observation" order. In Epic at KCH, document the handoff in your dispo note (see appendix C for the dot phrase). It's really important to properly document the reasons for admission (aka their primary and secondary diagnoses (see appendix item B for more information), their ED course, and any contingencies, not only for handoff purposes, but for billing. This will also prepare you for verbal handoff.**
3. **Provide verbal handoff. Answer any questions.**
4. **Document who you provided handoff to.**

APPENDIX

A. **Semantic Qualifiers**

Semantic Qualifiers

Symptoms	
Acute /subacute	Chronic
Localized	Diffuse
Single	Multiple
Static	Progressive
Constant	Intermittent
Single Episode	Recurrent
Abrupt	Gradual
Severe	Mild
Painful	Nonpainful
Bilious	Nonbilious
Sharp/Stabbing	Dull/Vague

Problem Characteristics	
Ill-appearing/ Toxic	Well-appearing/ Non-toxic
Localized problem	Systemic problem
Acquired	Congenital
New problem	Recurrence of old problem

B. A side benefit of documenting a good handoff note, is doing a proper documentation in the EMR. In addition, it is an exercise that helps improve your documentation, by having you review the patient's chart, make a note of their principle admitting diagnosis, and their secondary diagnoses (significant abnormalities found during workup that need to be addressed).

For example, in working up someone with undifferentiated shortness of breath, you found that they have sepsis due to multifocal pneumonia, acute kidney injury, and electrolyte abnormalities (low magnesium, elevated potassium). In your IPASS note you could say that the patient has: severe sepsis secondary to multifocal pneumonia, acute kidney injury, hypomagnesemia, and hyperkalemia. This practice will be important for you after you graduate and become an attending for medicolegal and billing purposes.

C. At Kings County, we have created an Epic SmartPhrase to facilitate your use of I-PASS. It's .dispo. You need to save it once, and then it will be available for you for all future dispo notes. Use the steps below to save the phrase:

1. **Epic Icon -> Tools -> SmartPhrase manager -> "Enter"**

2.  **-> User: “Sweeny, Andrew” -> choose him from the list -> “Enter”**
3. **Select all the SmartPhrases you would like to share (DISPO is the one you need for your note!)**
4.  **-> Enter**

When you write your dispo note, delete the generated contents of the note. Other HHC facilities decided on this default note but it has too much information and is unhelpful. Once you have a blank note, type “.dispo” to pull up the SmartPhrase.

D. Here are links to the orientation materials:

Powerpoint:https://docs.google.com/presentation/d/1vRibNhEgTgNJQFEZG0j_vDUrjwYk1zDF5Nxz4KHS2zk/edit?usp=sharing

Epic-tips:https://docs.google.com/document/d/1sV7_TCvMo9w4OIB7fXEKA33Cqdv29zqzNUVJXay2tOI/edit?usp=sharing

Cheat-sheet:https://docs.google.com/document/d/19H9Q5ZH_5Srgomjz9Bf_fPQGkDq3zAgTZMFDFxhHhDE/edit?usp=sharing

NYU LANGONE - BROOKLYN HOSPITAL

EMERGENCY MEDICINE ROTATION

(For Downstate Residents)

Nathan Franck, MD
Director of Medical Education
Department of Emergency Medicine

Ian Wittman, MD
Chief of Service
Department of Emergency Medicine

A. INTRODUCTION

Welcome to the NYU Langone Hospital-Brooklyn Department of Emergency Medicine. The following document reviews important emergency department clinical operations, educational objectives, and resources to guide student and resident learning while on rotation.

The emergency department is a unique clinical environment, where potentially high volumes of patients arriving at unmetered intervals with varied acuity receive simultaneous care. This poses special challenges to the department and its providers. It also allows for a rich environment in which learners have the opportunity to first assess undifferentiated patients, hone diagnostic skills, carry out procedures, and practice acute care management in a supervised setting. We hope that each rotator makes the most of this educational experience, and we look forward to your participation with our care team.

B. ROTATION LOGISTICS

Important Contacts

Nathan Franck, MD
Clinical Assistant Professor, Ronald O. Perelman Department of Emergency Medicine
Educational Site Director, NYU Langone Brooklyn

Email: nathan.franck@nyulangone.org
Cell: (607) 316-8028

Alessia Toscano
Administrative Coordinator, Ronald O. Perelman Department of Emergency Medicine
Email: alessia.toscano@nyulangone.org
Phone: (347) 377-5536

Handbook and orientation review

Prior to your rotation, please ensure that you've read through the following document in its entirety. The audiovisual orientation module distributed in the welcome email should also be completely reviewed prior to your first clinical shift. It is also important that any requests made by Alessia Toscano for information related to GME clearance on site be attended to in advance of your rotation.

EVALUATIONS

Your leadership has emphasized the need for consistent, formative, and specific resident feedback. We will try to give real time feedback on shift and you will receive summative evaluation at the end of your rotation on new innovations. In addition please send real time feedback about your rotation. And at the end of your rotation you will receive a link to send us anonymous feedback about the rotation.
https://forms.gle/i666jkzZwBjYyYZe8

CLINICAL SCHEDULE

PGY-2 residents should expect to work 18 12 hour shifts.
PGY-3 residents should expect to work 17 10 hour shifts.

Schedule Requests

Schedule requests should be sent as far as possible in advance of your rotation. You may request 1 weekend and 1 weekday off only. Please e-mail request to: Alessia.Toscano@nyulangone.org. We attempt to accommodate schedule requests when able. Unfortunately, there are limitations in what can be facilitated due to department staffing and ACGME requirements. If you have any major conflicts/concerns with regards to your schedule, notify Alessia Toscano as soon as possible. Only educational or career-related requests will be honored after the schedule has published. Otherwise, you are entitled to facilitate a shift swap with a fellow resident, however this change must be approved by Alessia Toscano via email or in person.

Schedule Review

Please review the schedule immediately as it is released (usually 3-4 weeks before the rotation) via email in order to ensure there are no conflicts or errors. If one is noted, please contact Alessia Toscano immediately so appropriate changes can be made.

Sick Call Policy

If you need to call out, you should:

1. Notify Dr. Franck and Alessia Toscano (see contacts below) by phone/email with as much notice as possible
2. Contact your chiefs to activate sick call for coverage
3. If you are calling out the day of, you must also call the ED charge nurse at 929-481-1432 so they may notify the attending on your team

Roles/Responsbilties

PGY-2

As a second year resident you should continue to concentrate on building the foundation of your clinical knowledge by seeing a wide variety of cases. Your shifts will occur on Teams 1-3 on the N or B side of the ER. Second years may also participate in the care of critically ill patients on the A side along with PGY-3 seniors or directly with attendings.

PGY-3

As a third year resident you should be able to demonstrate increased competence in managing complex and critically ill patients. You will be a leader of your team, though you will continue to see patients primarily and staff cases with an attending physician. We appreciate that you are a senior resident, and we will attempt to allow you to operate with ample autonomy while keeping safety a core focus. We expect you to communicate your decisions to the attending on your team and to be open to feedback from your supervisors.

A-SIDE SHIFT

If monthly staffing allows, we attempt to schedule senior residents occasional "A-side shifts" over the course of the rotation. This shift has proven a wonderful opportunity to learn important emergency stabilization and resuscitation of a multitude of critically care ill patients at once. Due to the variability in monthly resident staffing, we cannot guarantee any number of these shifts. If you are assigned to an "A-side shift", please pick up/sign out the critical care resident phone and check in with the triage nurses at the beginning of the shift. The role of the A-side resident is to manage all critically ill patients assigned to the A side on teams 1, 2 and 3. You should present these cases to the respective attendings assigned to those teams.

NYU/DOWNSTATE COLLABORATION

It is with great fortune and pride that the NYU Brooklyn emergency department is staffed with rotators across Downstate/Kings County and NYU/Bellevue residencies. We realize that each home institution provides a breadth of diverse backgrounds and educational experiences that make working alongside one another especially unique and synergistic. We have learned that each individual stands to learn a great deal from his/her colleagues across institutions, and we encourage residents to take advantage of this wonderful opportunity by working closely and collaboratively. ***Fostering a collective learning environment is central to our mission.***

C. DIDACTICS

Tuesday AM Didactics

Faculty-led teaching will occur once weekly on Tuesday mornings at 9:35-10:00 AM in the ED conference room between the ED offices and 2601 (B side). These 25-minute sessions are designed to cover a broad range of high-yield emergency medicine subjects. Attendance to these sessions is required for those working clinically on the day of lecture. As an exception, any resident working a 12-hour clinical shift is excused so as to not violate duty hours.

Trauma Simulation

Trauma simulation occurs on the second and fourth Tuesday of every month in the trauma bay. This runs 8:30am on the 2nd Tuesday and 11:00am on the 4th Tuesday, though times are subject to change. The designated trauma resident and airway resident assigned for the day are expected to attend these simulations. Trauma simulation will be incorporated into clinical shift times so as to not violate resident duty restrictions.

E. CLINICAL PROTOCOLS

The emergency department has developed and maintains a series of protocols for select clinical scenarios in order to ensure efficient, quality care of all emergency patients. These protocols are revised and reiterated on an ongoing basis. As direct care providers, students and residents should be aware of and adhere to these procedures, which are detailed in the orientation module video. A list of common protocols to review is listed below:

Sepsis
Stroke
STEMI
Trauma (see below)
Elopement mitigation
Opioid use disorder/overdose RELAY program

Diabetes screening

Trauma Responsibilities

Assignment:

Each day, one resident will be assigned as the designated trauma resident and one as the senior trauma airway resident. This will be notated on your Amion schedule, which you should review before each shift, and listed on the weekly schedule posted in the ED offices.

Notification:

The trauma resident is expected to respond to all trauma evaluations sent to the trauma bay. The trauma airway resident is expected to go to all level 1 traumas. Phone calls or notifications may first go to the Team 4 attending. It is the expectation that attendings will immediately notify the trauma residents to join them in the trauma bay. Otherwise notifications for Level 1 and 2 traumas may occur by overhead page.

Roles:

Trauma resident

Once in the trauma bay, the following role has been established for the trauma resident on the *right side* of the bed:

1. If trauma team not yet present, performs primary and secondary survey with EM attending until trauma team arrives in bay (If trauma present, performed by "Left doctor")
2. When trauma team arrives, gives handoff to trauma leader with EM attending
3. Takes direction from trauma team leader at foot of bed
4. Assists with patient exposure
5. Prepares ultrasound machine. Performs and saves eFAST exam once directed
6. Performs procedures (central access, etc.) on the right side as directed by team **at present, chest tube procedures will be performed by trauma team**
7. Assists with CPR and other procedures as directed

Trauma airway resident

Trauma airway residents should be head of bed for all level 1 traumas for first attempts at intubation when needed at the direction of the trauma and ER attending. Second attempts will fall to the EM attending or anesthesia team. Assistance with c spine immobilization, patient rolling/exposure, and pupillary exam while at head of bed are also expected.

Trauma Simulation:

See above

F. ED OPERATIONS

Patient Arrival

Patients arrive to the ED by self (ambulatory) or by ambulance. Non-critical patients are typically registered/triaged in the holding area, assigned a team, and then transported to a designated clinical area Occasionally, patients are directly bedded, whereby they are registered/triaged after being brought directly to the clinical area. Critical patients are most often brought directly to the acute care area prior to registration and triage.

Clinical Area Assignment

The ER is divided into specific clinical areas (N, A, and B) to which patients are distributed after triage. Non-critical patients are triaged to either area N or B, which are located at opposite sides of the department. Critical patients are triaged to area A, which

is located in the middle of the department. Area N consists of rooms that begin with 2400, area A 2500, and area B 2600, respectively. Trauma patients are triaged to the trauma bay, which is located next to Area B.

Clinical Team Assignment

After patients are triaged, they are additionally assigned to a clinical team. A clinical team is led by a single attending and is comprised of a specific group of nurses, students, residents, PAs, and ancillary staff. Teams 1 and 2 are open 24 hours/day. Team 3 provides additional staffing between 10am-1am. Team 4 is open 9am-1am and specifically manages leveled trauma patients in addition to seeing non non critical B side patients. Team 5 is open from 9am-9pm and see low acuity ESI 4-5 patients it is staffed by a PA. Students and residents are generally assigned to shifts on Teams 1-4. Work stations for teams 1 and 3 are located in area N. Work stations for teams 2 and 4 are located in area B.

Provider Assignment and Evaluation

After a patient arrives to the clinical area and team assignment is complete, he or she will appear on the EPIC ED trackboard. Students/residents should assign themselves to new patients on EPIC, perform a focused history and physical, and return to their work station to present to an attending, place orders, and document their interactions. Medical students are encouraged to confirm appropriateness of patients with the attending prior to their assignment. If students or residents have any immediate concerns about patients' clinical status during interview, they are encouraged to discontinue history and physical prior to completeness in order to notify an attending as soon as possible.

Presentation to Attending

Once clinical evaluation is complete, students/residents should present cases directly to the attending of their team. All providers are required to discuss all aspects of patient care with their attending physicians to ensure appropriateness of workup, therapy, and disposition. Diagnostic studies and therapeutic medications will be reviewed by assigned attendings, and changes will be directed on an as needed basis.

Documentation

After presentation to an attending, students/residents should document their encounters as detailed in their pre-requisite EPIC training. Learners should be mindful that documentation has multiple functions, including provider-provider communication of clinical care, both contemporaneously and retrospectively; quality review; medicolegal application; and billing. For all of these reasons, it is paramount that documentation be timely, accurate, and complete. All notes should be completed before the end of shift and should include all the components required to bill a Level of Service (LOS) 5 chart. Please see orientation module video for details.

Disposition

Once a patient's emergency workup is complete and adequate time for reassessment of clinical status has elapsed, disposition should be pursued. With a few caveats, patients will generally be discharged or admitted/placed on obs. Prior to disposition, all cases should be discussed with and reviewed by the case manager on staff, who is available 24 hours in the ED. Case managers have a thorough knowledge of observation and inpatient admission appropriateness criteria, and in certain circumstances they may be able to arrange special outpatient services for patients in order to avoid unnecessary admissions.

Telephone Communication

At the start of your clinical shift, you should ***pick up and sign-out an iPhone*** from the bin next to the area A clerk. Phones are labeled according to team. When you sign in to a computer, you should ***add this phone number to your EPIC profile***. Assigning your phone number in EPIC and having the phone on your person for the duration of your shift is essential. Its contact list includes important hospital phone numbers you will need to call out of the ER, and it also allows direct communication to you from nurses, consultants, laboratory, etc. calling into the ER. At the end of the shift, you may pass the phone to an oncoming resident or place it back in the charging station in Area A. Please be careful not to take phones with you out of the department after your shift.

Patient Safety Intelligence

Patient Safety Intelligence (PSI) is a web-based hospital-wide patient safety and incident reporting tool. All staff are encouraged to enter a PSI event whenever they see something that may pose a threat to patient safety. Issues include (but are not limited to) medication errors, adverse drug events, equipment and supply issues, falls, procedural or test errors, as well as communication issues with other services. We want to hear about adverse events, near misses, as well as unsafe conditions or delays. Each PSI event is personally reviewed by ED departmental leadership. Responses may include reaching out to leadership from other departments or disciplines to address the specific concern, or monitoring the department for similar events to identify trends that may require future intervention. Depending on the topic or location of the event, managers from other departments (e.g., medicine, ICU, surgery) or disciplines (e.g., nursing, pharmacy, labs, security, etc.) may also be copied into PSI reports to help address the issue.

Of note when filling out a PSI you will be asked to assign a “harm score” from 1-9, those rated above 6 automatically involve senior hospital leadership to the level of the CMO and are scrutinized and taken very seriously. To determine the correct harm score there is a guide to assign the correct score found by clicking “?” Next to area to assign a score. Please reach out to your attending, me or Dr. Wittman with any questions on the form or the PSI process.

The PSI form can be accessed here: https://datwcdcpvm002.nyumc.org/Datix/Live/index.php?action=login or within epic it can be accessed under the resources tab

Everyone has automatic access to the anonymous reporting by clicking the button the top left "Anonymous event entry/Non-Clinical users click here” on the PSI page. For non anonymous reporting (which is helpful as further information on the event and feedback can be communicated with the reporter) please login with your Kerberos ID.

Of note Downstate residents don’t automatically have an account for non-anonymous reporting. To create an account in the PSI system you have to login once with your Kerberos ID and it will create a profile at the end of that same day.

G. TIPS FOR PATIENT CARE

Please keep the following in mind to help optimize patient care:

1. Respect patient privacy.
2. Identify early any cultural, language, religious, and age related needs, and seek to meet these needs as best you can.
3. Employ patient-centered care and shared decision making for diagnostic tests and therapeutic interventions when possible.
4. Establish reasonable expectations up front with patients, as most patients are unfamiliar with average wait times. Be clear that work-ups in the ER may take many hours and that your availability as a provider may be limited.
5. Treat pain expediently when warranted.
6. Keep patients up to date with respect to test results, status of care plan, and disposition. If a patient requires admission, discuss the rationale for admission and the expected trajectory of care. Confirm their willingness to stay for further management in the hospital.
7. Empathize with the vulnerability of the patient's ER experience.
8. Keep a constant line of communication open with clerks, nurses, techs, and other care providers. Communicate your intentions. Don’t delegate communication only via computer.
9. Practice efficiency, in decision making, in communication with patients, in communication with other providers, and in clinical task completion
10. Limit interruptions, as they are dangerous and inefficient.

EDUCATIONAL OBJECTIVES

A. METHODS:

Clinical environment exposure
Bedside and non-bedside clinical management instruction
Classroom didactics
Role modeling
Self-directed learning

B. CORE COMPETENCIES

PATIENT CARE
GOALS AND EXPECTATIONS:

1. Learn how to evaluate a variety of patients in the Emergency Department:
   a. Gather accurate and essential patient information by history and physical
   b. Formulate basic differential diagnostic and therapeutic plans
   c. Make informed diagnostic and therapeutic decisions based on patient preference, clinical judgment, and up-to-date clinical and scientific evidence
2. Learn how to formulate a cost effective and an appropriate diagnostic action plan with the least risk to the patient.
1. Learn how to manage patients that span the entire medical field (including Internal Medicine, Surgery, OB-Gyn, Pediatrics, and Psychiatry).
4. Learn how to manage the ED patients through the final disposition.
5. Learn how to develop and carry out patient management plans.
1. Learn how to counsel and educate patients and their families in a compassionate manner.
7. Learn to use information technology to support patient care decisions.
8. Gain experience in care of a variety of patients that visit the ED.
1. Learn how to work as a team member with ED attendings, nurses and as professionals in other disciplines to deliver complete patient care for ED patients.

MEDICAL KNOWLEDGE
GOALS AND EXPECTATIONS:

1. Understand the basic principles of ED care and management.
2. Understand the ability to work with a variety of doctors, nurses, consults, and other medical professionals.
3. Learn how to recognize and manage the myriad of complaints that present to the ED.

INTERPERSONAL AND COMMUNICATION SKILLS
GOALS AND EXPECTATIONS:

1. Relate to patients in a sound ethical manner.
2. Use effective listening skills, elicit and provide information using effective non-verbal, verbal and writing skills.
3. Work effectively with other members of the ED team and professional groups.

PROFESSIONALISM
GOALS AND EXPECTATIONS:

1. Adhere to ethical practices.

    a. Understand the relationship between the demands of cost containment and those providing greater access to health care for all people.
    b. Understand the relationship between a physician's duty towards his/her patients and societies obligation to provide a fair allocation of limited health care resources across the population.
    c. Provide quality patient care in a moral and ethical manner putting the patient's needs first.
2. Demonstrate compassion, respect and integrity to patients and peers.
3. Maintain patient confidentiality.
    a. Understanding and practicing under HIPPA and New York State guidelines
4. Demonstrate a commitment to patient care and professional responsibilities.
    a. Residents will learn the importance of placing the needs of their patient's ahead of one's self-interest.
5. Understand how to properly obtain an informed consent for ED procedures.

PRACTICE-BASED LEARNING AND IMPROVEMENT
GOALS AND EXPECTATIONS:

1. Locate and appraise evidence from scientific studies related to their patient's health problems.
2. Acknowledge gaps in personal knowledge and skills in the care of the ED patient and access information to further their own education.
3. Learn how to apply knowledge of study designs and statistical methods to appraise clinical studies and information on diagnostic and therapeutic effectiveness.
4. Develop the skills necessary for evidence-based practice. These include precisely defining the patient problem, conducting a literature search, selecting the best studies, and applying the rules of evidence to determine their validity, and applying it to the patient problem.
5. Evaluate their own performance and use the knowledge gained from peers and mentor review to improve the quality of patient care delivered.

SYSTEMS-BASED PRACTICE
GOALS AND EXPECTATIONS:

1. Care for ED patients and interact with other health care professionals.
1. Advocate for quality care and assist patients in dealing with the complexities of the system.
3. Understand the social service needs of ED patients.
4. Practice cost effective health care without compromising quality of care.
5. Assure appropriate follow-up care.
1. Assist with appropriate disposition of ED patients with coordination of outpatient management with the PMDs.

EVALUATION

At the completion of each shift, the attending with whom learners are assigned will complete an automatically-distributed daily evaluation form, which assesses performance of the above core competences. Direct verbal feedback is also encouraged. Monthly summative evaluations will be completed by the director of education for residents at the end of the rotation based on these feedback forms. These evaluations reflect the average performance review of daily evaluations described above.

EDUCATIONAL RESOURCES

Texts

Rosen's Emergency Medicine (reference)
Tintinalli's Emergency Medicine (reference)
Roberts and Hedges' Clinical Procedure in Emergency Medicine (reference)

ACLS/ATLS/PALS workbooks/cards

EMRA Books:
- Basics of Emergency Medicine
- EM Fundamentals
- PressorDex
- Ortho Guide
- Antibiotic Guide
- Top Pediatric Clinical Problems

Society Journals

Annals of Emergency Medicine
Academic Emergency Medicine

Free Online Access Material

coreem.net
emergencymedicinecases.com
first10em.com
aliem.com
emdocs.net
rebelem.com
lifeinthefastlane.com

Podcasts

EMCases
EMCrit
ERCast
Academic Life in Emergency Medicine
FeminEM
AAEM/RSA Podcast
Ultrasound Podcast

Suggested High-Yield Topics for Review

Airway:
- Bag Valve Mask Ventilation
- BIPAP/CPAP
- Intubation Checklist/Equipment
- Airway Rescue Techniques
- Standard Ventilatory Settings
- ARDS Management

Cardiopulmonary:
- Basic ECG Interpretation
- Acute Coronary Syndrome/Myocardial Infarction

- Congestive Heart Failure
- Pulmonary Embolism
- Asthma/COPD
- Pneumothorax
- Aortic Aneurysmal Rupture
- Aortic Dissection
- Cardioactive medications/Pressors

Gastroenterology:

- Cholecystitis/Choledocolithiasis/Cholangitis
- Appendicitis
- Diverticulitis
- Bowel obstruction
- Mesenteric Ischemia
- Perforated Viscous

Neurology:

- Transient Ischemic Attack/Cerebrovascular accident
- Subarachnoid/Intracranial hemorrhage
- Seizure/Status Epilepticus
- Meningitis

Trauma:

- ATLS
- Head Trauma
- Blunt Trauma
- Perforating Trauma
- Burns

Toxicology:

- General approach to the poisoned patient
- Alcohol Intoxication and withdrawal
- Opioid Intoxication
- Acetaminophen Toxicity

EDUCATIONAL OBJECTIVES

PGY 1

Emphasis during this year will be placed on orientation to the different emergency department environments. By the end of the year, the resident will demonstrate the ability to prioritize and organize activities; chart documentation; perform basic procedural skills; work with hospital staff; deal with friends and families of patients (particularly those who are critically ill or dying); and most importantly, perform quality patient evaluations. The resident should: demonstrate accurate and appropriate history and physical examination skills; know how to generate differential diagnoses and care plans; and learn the appropriate usage of x-rays and lab tests. A PGY-1 should evaluate no more than one or two new patients at a time. They should not accept responsibility for more patients until he or she presents the patient to a senior resident or attending. Their total caseload will be determined by their need for supervision, as well as patient acuity. The PGY-1 should expect their evaluation to be repeated by their supervisor. A PGY-1 cannot make independent admission, transfer or discharge decisions, but they should formulate and offer their plan for the aforementioned. A faculty member must co-sign all charts.

PGY 1 Rotations

Rotation	**Number of Blocks**
Orientation	1
KCH Adult	4
KCH Peds	1
UHD Adult	1.5
UHD Peds	1
Medicine	1
MICU	1
Trauma	0.5
GYN Sono	0.5
L&D	0.5
Vacation	1

At the completion of this training year, the resident will demonstrate competence in and be able to:

• perform histories and physicals on Emergency Department patients (adults and children)

• understand the necessity for prioritizing patients
• prioritize their activities
• formulate differential diagnoses on their patients
• plan appropriate work-ups based on their differential diagnoses
• plan admission, transfer and discharges
• appropriately order and utilize laboratory data and ancillary studies
• carefully understand and utilize universal precautions
• appropriately utilize specialty consultation
• function as a team member during resuscitations

Description of clinical experiences:

First Year Residents should have experience and demonstrate competence in the following procedures:

• physical examination• basic wound management
• oxygen administration• I&D of simple abscesses
• bag-valve mask device usage• basic suturing
• closed chest compression• splinting of strains and sprains
• oropharyngeal and nasopharyngeal airways• nasal packing
• pelvic examination• paracentesis
• phlebotomy• arthrocentesis
• peripheral intravenous lines• lumbar puncture
• Foley catheter placement• central line placement
• arterial blood gas sampling• vaginal deliveries
• nasogastric tube placement• thoracentesis

Core Competencies

Patient care

• Procedural practice
• Physical exam
• Formulate treatment and disposition plans
• Triage of patients and prioritization
• Practice experience
• Skills labs
• Simulator time
• SDOT

Medical Knowledge

• Conference attendance and participation
• Topic review groups
• Webtests
• Inservice exam
• Bedside teaching rounds
• Responsibility for preparing case conferences
• Participation is skills labs
• Simulator time

• SDOT

Professionalism & Interpersonal

• Modeling of behavior by faculty
• Observation during clinical shifts
• Web-eval system
• SDOT
• Simulator time
• Responsibility for presenting case conferences

Communication

• Modeling of behavior by faculty
• Observation during clinical shifts
• Web-eval system
• SDOT
• Simulator time

System based practice

• Observation during clinical shifts
• Web-eval system
• SDOT
• Simulator time
• Participation in CQI committee
• Participation in M&M committee

Practice based learning

• Simulator time
• Participation in CQI committee
• Participation in M&M committee
• Participation in weekly conference
• Resident portfolio and reflective statement

PGY 2

After successful completion of the PGY-1 year, the second year resident should be comfortable evaluating any patient who presents to the Emergency Department. During this year, the residents will be expected to develop their clinical acumen, sharpen their physical exam techniques and hone their procedural skills. Their organizational abilities should improve to the point that at least three to four patients can be managed simultaneously. Emphasis will also be placed on the importance of patient follow-up. The PGY-2's demeanor should be calm and professional, reflecting their increasing competence and confidence in their abilities and in those of the staff around them. They will be expected to develop their teaching abilities at this stage as well. They will supervise PGY-1's during procedures for which they have been credentialed; they will teach medical students, Physician Assistant students, and EMT students in the clinical setting.

PGY-2 residents will take active part in weekly conferences. Research projects will begin during this academic year.

PGY-2 residents will be directly supervised by PGY-4 residents and faculty members, and will require their superior's authorization for the admission, transfer or discharge of patients. A faculty member must sign all patient charts.

PGY 2 Rotations

Rotation	**Number of Blocks**
KCH Adult	3.5
KCH Peds	1
UHD Adult	1
NYU-B	1
Ultrasound	0.5
Airway/Research	0.5
CCU	1
SICU	1
NICU/PICU	1
FT/Ortho	1
Neuro	0.5
Vacation	1

At the completion of this training year, the residents will demonstrate competence in and be able to:

• refine their history and physical exam skills

• document the medical record accurately and concisely
• recognize patients with potentially life-threatening conditions
• institute immediately life-saving therapy when necessary
• improve their ability to prioritize their activities
• formulate more extensive differential diagnoses on their patients
• plan appropriate work-ups based on their differential diagnoses
• plan admission, transfer, and discharges for their patients
• more appropriately utilize laboratory data and ancillary studies in the care of their patients
• carefully understand and utilize universal precautions
• more appropriately utilize specialty consultation
• function as a team member during resuscitations, and may act in leadership positions in supervised situations

Description of clinical experiences:

Second year residents should have experience and demonstrate competence in the following procedures:

• all procedures previously delineated for PGY-1's• rape-victim evaluation
• tube thoracostomy• management of burns
• arterial line placement• intra-osseous infusion
• endotracheal intubation• fracture reduction
• plastic suture techniques• slit lamp examination
• closed reduction of non-fractured displaced joints• removal of otic foreign bodies
• abdominal and pelvic ultrasound
• casting and splinting of non-displaced fractures

Core Competencies

Patient care

• Procedural practice and teaching of these procedures
• Honing and demonstrating of physical exam skills
• Formulate treatment and disposition plans
• Triage of patients and prioritization of resuscitative efforts
• Participation in resuscitations
• Practice experience
• Skills labs
• Simulator time
• SDOT

Medical Knowledge

• Conference attendance and participation
• Topic review groups
• Inservice exam
• Bedside teaching rounds
• Responsibility for preparing case conferences
• Participation is skills labs
• Simulator time

• SDOT

Professionalism & Interpersonal

• Modeling of behavior by faculty
• Observation during clinical shifts
• SDOT
• Simulator time
• Responsibility for presenting case conferences

Communication

• Modeling of behavior by faculty
• Observation during clinical shifts
• Web-eval system
• SDOT
• Simulator time

System based practice

• Observation during clinical shifts
• Web-eval system
• SDOT
• Simulator time
• Participation in CQI committee and M&M committee

Practice based learning

• Simulator time
• Participation in CQI committee
• Participation in M&M committee
• Participation in weekly conference
• Resident portfolio and reflective statement

PGY3

In the third postgraduate year the residents will grow in confidence while working independently. They will have an increased role in Junior Resident supervision, will refine their teaching skills, and carry out administrative tasks assigned by faculty members. In addition, PGY-3 residents will demonstrate increased competence in management of multiple critically ill or injured patients simultaneously. Research projects will continue this academic year. The third year resident will have the ability to make admission, transfer and discharge decisions, after discussing the case with a faculty attending physician. All charts must be co-signed by a faculty member. By the completion of this year of training they should be comfortable managing the full range of pathology that can present to an Emergency Department.

PGY 3 Rotations

Rotation	**Number of Blocks**
KCH Adult & Peds	6.5
UHD Adult & Peds	2
NYU-B	1
Elective/Selective	1
Research	0.5
EMS	0.5
Ultrasound	0.5
Vacation	1

At the completion of this training year, the resident will demonstrate competence in and be able to:

• perform rapid, accurate histories and physical diagnoses on all patients presenting to the Emergency Department
• create comprehensive differential diagnoses for their patients
• create and carry out treatment and disposition plans for all patients presenting to the Emergency Department
• supervise the activity of more junior residents in their area
• conduct teaching/management rounds in all patient care areas, including the direct supervision of care provided by PGY-1 and 2 residents
• be an effective member of the Continuous Quality Improvement system
• be comfortable directing all patient resuscitation situations, and managing the critically ill and injured
• improve their lecturing and teaching skills

Description of clinical experiences:

Third year residents should have experience and demonstrate competence in the following procedures:

- all procedures previously delineated for PGY-1 and 2
- pulmonary artery catheter placement
- extensor tendon repairs
- cricothyroidotomy
- umbilical catheterization
- supra-pubic bladder aspiration (pediatric)
- transthoracic echocardiography
- abdominal and pelvic sonography
- utilization of rapid-sequence and neuro-intubation techniques
- utilization of conscious sedation techniques

Core Competencies

Patient care

- Procedural practice and teaching of these procedures
- Demonstration of physical exam skills
- Supervision of junior practitioners
- Independent formulation of treatment and disposition plans
- Triage of patients and prioritization of patients
- Direction of resuscitative efforts
- Practice experience
- Skills labs participation
- Skills labs teaching
- Simulator time
- SDOT

Medical Knowledge

- Conference attendance and participation
- Supervision of select educational conferences
- Topic review groups participation
- Topic review groups mentoring
- Webtests
- Inservice exam
- Bedside teaching rounds
- Responsibility for preparing case conferences
- Participation in skills labs
- Simulator time
- SDOT

Professionalism & Interpersonal

- Modeling of behavior by faculty
- Observation during clinical shifts
- Web-eval system
- SDOT

• Simulator time
• Responsibility for supervising case conferences

Communication

• Modeling of behavior by faculty
• Observation during clinical shifts
• Web-eval system
• SDOT
• Simulator time
• Responsibility for supervising case conferences

System based practice

• Observation during clinical shifts
• Web-eval system
• SDOT
• Simulator time
• Participation in CQI committee• Supervision of M&M conference

Practice based learning

• Simulator time
• Participation in CQI committee
• Participation in M&M committee
• Participation in weekly conference
• Resident portfolio and reflective statement

PGY 4

In this last year of training the resident will receive progressive responsibility for the overall clinical and operational management of the Emergency Department. In essence, the PGY-4 should be ready to assume an attending-like position. With the guidance of Emergency Medicine faculty members, the Senior Resident will manage patient flow; train and assist in the evaluation of Junior Residents, Medical Students, Physician Assistant students and Pre-hospital personnel; assist with all admission, transfer and discharge decisions in their patient care area; and lead resuscitation situations. PGY-4 Residents will prepare and present curricula lectures; present cases at weekly discussions; run Morbidity and Mortality Rounds; and will assist Junior Residents in identifying cases for presentation and case reports. PGY-4 Residents will be able to independently admit, transfer or discharge patients after informing the faculty attending physician. All charts must still be co-signed by a faculty member.

PGY 4 Rotations

Rotation	**Number of Blocks**
KCH Adult & Peds	6.5
UHD Adult & Peds	2
Toxicology	1
Administration	0.5
Elective	2
Vacation	1

At the completion of this training year, the resident will demonstrate competence in and will be able to:

• perform rapid, accurate histories and physical diagnoses on all patients presenting to the Emergency Department
• create comprehensive differential diagnoses for their patients
• confidently and competently create and carry out treatment and disposition plans for all patients presenting to the Emergency Department
• manage the activities of all more junior residents in their area, and be aware of all the patients in that area
• be comfortable conducting teaching/management rounds in all patient care areas, including the direct supervision of care provided by PGY-1 and 2 residents
• be an effective member of the Continuous Quality Improvement system
• be able to perform the administrative responsibilities of an Attending Physician
• be comfortable directing all patient resuscitation situations
• be comfortable managing critically ill and injured patients
• be an effective lecturer and teacher

Description of clinical experiences:

Fourth year residents should have had exposure and demonstrate competence in the following procedures:

- All procedures previously delineated for PGY-1, 2 and 3
- Emergency Department thoracotomy
- Transvenous pacemaker placement
- Fiberoptic laryngoscopy/intubation

Core Competencies

Patient care

- Procedural practice and teaching of these procedures
- Demonstration of physical exam skills
- Supervision of care by junior practitioners
- Independent formulation of treatment and disposition plans
- Triage of patients and prioritization of patients
- Direction of resuscitative efforts
- Practice experience
- Skills labs participation
- Skills labs teaching
- Simulator time
- SDOT

Medical Knowledge

- Conference attendance and participation
- Supervision of educational conferences
- Topic review groups mentoring
- Webtests
- Inservice exam
- Bedside teaching rounds
- Participation in skills labs
- Simulator time
- SDOT

Professionalism & Interpersonal

- Modeling of behavior by faculty
- Observation during clinical shifts
- Web-eval system
- SDOT
- Simulator time
- Responsibility for supervising case conferences

Communication

- Modeling of behavior by faculty
- Observation during clinical shifts
- Web-eval system
- SDOT
- Simulator time
- Responsibility for supervising clinical encounters

System based practice

- Observation during clinical shifts
- Web-eval system
- SDOT
- Simulator time
- Participation in CQI committee
- Supervision of M&M conference

Practice based learning

- Simulator time
- Participation in CQI committee
- Participation in M&M committee
- Participation in weekly conference
- Resident portfolio and reflective statement

OFF SERVICE ROTATIONS

PGY-1 OFF SERVICE ROTATION

PGY-1 JUNIOR ULTRASOUND ROTATION

LENGTH: 2 WEEKS

YEAR OF TRAINING: PGY 1

LOCATION: KINGS COUNTY HOSPITAL EMERGENCY DEPARTMENT

FACULTY LIAISONS:
Dr. Kelly Maurelus
Cell: 347-733-5710
Email: maurek01@gmail.com
Dr. Christopher Hanuscin
Cell: 818-590-2103
Email: chanusci@gmail.com

OBJECTIVES:

1. To obtain clinical experience with point-of-care ultrasound in the management of patients presenting to the emergency department with gynecological complaints.
2. To learn the differential diagnosis, workup, and management of patients presenting with common gynecologic complaints.
3. To become proficient at performing and interpreting the transabdominal and transvaginal pelvic ultrasound exam.
4. To become proficient in performing and interpreting the AAA, Renal, and FAST ultrasound exams.

SCHEDULE:

Please email Dr. Hanuscin **or Dr. Maurelus at least one week prior to the start of your rotation for further instruction.**
Clinical shifts: 11am-11pm on Mondays/Tuesdays/Fridays the first week of rotation. Second Week of the rotation is 7pm to 7am on Monday/Tuesday with Thursday Tape Review (see below) and Friday 11am-11pm.

Exceptions**:**
-First Monday of Rotation: Orientation will take place with a member of the ultrasound faculty. Times will vary based on availability. You will report for your shift after your orientation.
-Wednesday conference
-Thursday Tape Review: First meet in US conference room for QA, then report to suite A for your shift. Times will vary depending on faculty schedule.
Ultrasound didactic shifts: Wednesdays, after Conference and/or on weekends. You are not expected to see patients primarily. Your only responsibility is to perform ultrasound scans.

Any requests for changes in the schedule must be reviewed and approved by Dr. Bon prior to the start of your rotation (catharine.bon@gmail.com).

ROTATION DESCRIPTION:

At the beginning of the rotation the resident will meet with one of the ultrasound faculty for orientation on transvaginal and transabdominal pelvic ultrasound exams, FAST/AAA/Renal exams, the use and maintenance of the ultrasound machines, as well as receive didactic material which will be posted online at sunykchsono.com.

Residents on their GYN rotation will be expected to primarily pick up patients with gyn-related chief complaints. The resident will evaluate the patient as per usual clinical care with the addition of performing a pelvic ultrasound exam whenever clinically indicated. These patients should be presented to and followed by a faculty attending that is working clinically during the shift.

Endocavitary probes are located in exam room 5 (by the asthma room). When you are ready to perform a transvaginal exam, inform the charge nurse so that he or she may obtain the probe. Fill out the trophon-tracking sheet, which can be found in a binder in the exam room. There should be a label in the tray with the probe that you should include on the sheet. When performing the exam be sure to use a sterile glove or probe cover. When finished place the probe back in the tray and on the cart in exam room 5. Notify the charge nurse so that the probe may be taken down to central sterile for cleaning. Please notify us right away if you have any issues with the endocavitary probes.

If there are no patients with gynecological complaints to be seen, the resident is expected to primarily pick up patients with relatively simple chief complaints and quick dispositions. In addition to pelvic ultrasounds, the resident is also expected to become proficient in FAST, Renal and AAA ultrasounds. During this rotation, the resident is required to perform and accurately interpret **at minimum 25 ultrasounds in each application**.

All pelvic ultrasounds MUST be done under the DIRECT SUPERVISION of attending faculty. Clinically indicated ultrasound scans must be documented in EPIC by ED Quicknote or included in the initial provider note or ED disposition note. Additionally, all ultrasound images and interpretations should be saved with results documented on the Ultrasound Data Sheet (found on clinicalmonster.com) which will be turned in at the end of the rotation. All ultrasound studies will be reviewed with a member of the ultrasound faculty every Thursday at 9 am in the ultrasound office.
The rotating intern will be responsible for maintaining all appropriate supplies and keeping the ultrasound machine clean and in its designated area. Any problems with the machine should be immediately reported to Dr. Hanuscin or Dr. Maurelus, or any member of the ultrasound faculty.

In case of an unexpected absence the resident must contact the Chief Resident-on-call, the Director-on-call, and Dr. Hanuscin or Dr. Maurelus. Each absence will be handled on a case-by-case basis, but in general any missed shifts will be expected to be made up either on the weekend or at another predetermined time.

EDUCATIONAL MATERIALS:

It is suggested that you review the following lectures at http://emergencyultrasoundteaching.com/narrated_lectures.html

- Aorta
- FAST
- Ob/Gyn

Additional resources may be found at http://www.sunykchsono.com.

ED-BASED TRAUMA

Meeting Place: KCH ED
Contact Number: EM Chiefs
Faculty Liaison: Dr. Carolina Camacho
Schedule: The EM Trauma intern will be expected to function the same as our regular EM interns but will have a different shift distribution.

Description of rotation:

During the Trauma rotation, the PGY-1 Emergency Medicine Residents will rotate through the KCH ED for a 2-week time period. During that time, they will be responsible for 5 CCT shifts and 4 Pod A shifts. They should try to focus on traumatized/injured patients but can and should see any patient that presents to their area that needs to be cared for.

During the rotation the resident is expected to lay down a basic fundamental knowledge of trauma and read Section 22 and 23 of Tintinalli or Volume 1, Part 2, Trauma- sections 1,2 and 3 in Rosen's. There will also be a number of trauma-oriented PDF papers that can be downloaded. The resident is responsible for reading these papers prior to the completion of their PGY 1 residency year. Lastly, there will be a reading list made available on the KCH EM web site.

The Emergency Medicine Resident will have direct patient care responsibility: In the Emergency Room, they will be doing what all of the other PGY 1's are doing that month with the exception being that they are supposed to be concentrating on traumatized patients. Just like the other PGY 1's in the ED that month, the resident rotating on trauma will have to attend regular Wednesday didactic EM Conference and morning reports according to the usual rules for absence. During the shifts in the Main ED, the resident will focus on injured patients. If no injured patients are waiting to be seen, then the resident will see ED patients with any chief complaint.

All trauma resuscitations are to be documented in New Innovations for credit.

At the completion of this rotation the resident will demonstrate competence in care for the traumatized patient by completion of a simulation module as well as complete a trauma module CORD examination. The resident will be expected to request the first Tuesday after their block off to attend trauma SIM. They will be expected to run a trauma code and show basic knowledge of specific procedures, including but limited to central line placement, IO placement, pelvic binding, chest tube placement. The resident will also be expected to be competent in the following:

MEDICAL KNOWLEDGE, PATIENT CARE

• Recognition of the various stages of traumatic shock, including its earliest manifestations (PC,MK)
• The principles and endpoints of resuscitation, including the roles of:
    o Crystalloid volume replacement
    o Colloidal volume replacement
    o Blood volume replacement
    o Inotropic support (PC,MK)
• The initial assessment of the multiply injured patient (ABC's) (PC,MK)

• Identification and treatment of immediately life-threatening injuries after the initial assessment (PC,MK)
• The role of radiographic studies in the initial and subsequent management of the injured patient (PC,MK)
• Common injury patterns associated with penetrating head trauma (PC,MK)
• Common injury patterns associated with blunt head trauma (PC,MK)
• How the presence of a closed head injury impacts management of a multiply injured patient (PC,MK)
• Management of elevated intracranial pressure (PC,MK)
• The anatomic zone system of the neck, and appropriate work-up and management of a penetrating injury to each of the zones (PC,MK)
• Indications for operation in penetrating chest trauma (PC,MK)
• Identification and management of patients at risk for pericardial tamponade (PC,MK)
• Recognition of a widened mediastinum on X-ray, its significance and work-up (PC,MK)
• Physiologic scoring (PC,MK)
• Evaluation of blunt abdominal trauma including:
o Physical exam o Diagnostic peritoneal lavage o Abdominal CT scanning o Abdominal sonography o Laparoscopy o Non-operative management (PC,MK)
• Classification of pelvic fractures and radiographic studies used for their diagnosis (PC,MK)
• Diagnosis and management of the bleeding associated with pelvic trauma, including:
    o external fixation
    o angiography (PC,MK)
• Diagnosis and management of urologic complications associated with pelvic trauma (PC,MK)
• Evaluation and management of gross hematuria following trauma (PC,MK)
• Signs of peripheral vascular injury and the indications for angiography and operative management (PC,MK)
• Special concerns in the care of patients with spinal injuries (PC,MK,SBP)
• Special concerns in diagnosis and management of elderly injured patients (PC,MK,SBP,P)
• Importance of long bone fractures in the short and long term outcome of the multiply injured patient (PC,MK)
• Appropriate utilization of specialty consultants in the management of multiply injured patients (PC,MK,C,P,SBP)
• The concept of triage within the confines of available resources, including recognition of non-salvageable patients (PC,SBP,MK)
• Pulmonary artery catheterization for hemodynamic monitoring
• Identification of potential organ donors and their management to maximize yield of organ procurement(PC,SBP,P,C)
• Patient discharge and transfer decisions, including formulation of long-term care plans for patients with spinal cord injuries and major disability(PC,P,C,SBP)
• Compassionately interact with patients and their families during the stress of illness and death, including the ability to obtain DNR orders(PC,P,C)
• The patterns and demographics of the urban trauma patient(PC,SBP,PBL)

Educational Expectations:

The following topics should be covered in the resident's reading during this rotation:

- ATLS
- Hemodynamic monitoring
- Volume resuscitation (crystalloid and colloid)
- Neuro-intubation
- Resuscitation with blood products
- Rapid sequence intubation
- Inotropic support
- Intubation with cervical spine trauma
- SVO2 as a guide to resuscitation
- Intubation with facial trauma
- Lactate and base deficit to monitor perfusion deficit
- Mechanical ventilation
- Shock (hemorrhagic,neurogenic,cardiogenic)
- Spinal trauma
- Physiologic scoring
- Spinal shock
- Tissue ballistics
- Penetrating and blunt thoracic trauma
- Penetrating and blunt abdominal trauma
- Penetrating and blunt neck trauma
- Head trauma
- Glasgow Coma Scale
- Pelvic trauma
- Facial trauma
- Long bone fractures (open and closed)
- Vascular injury
- Trauma in pregnancy
- Trauma in the elderly
- Pediatric trauma

OBSTETRICS

Meeting Place: S building 5th floor
Daily Schedule: Report to KCH C521 to Ms Miller at 9am on Day 1
Schedule: Contact Ms. Avana Miller (OB residency coordinator) (718) 245-4744, milleri2@nychhc.org
If unable to reach Ms. Mark, the Chief resident of OB at KCH should be able to help. You can reach the OB Chief Resident through the KCHC operator at (718) 245- 3141
Contact Dr. Grueso leading up to your rotation to schedule a simulation session- daisey.grueso@nychhc.org
EM Faculty Liaison: EM- Dr. Carolina Camacho, OB Dr. Lee-McBrien email Catherine.Lee-McBrien@nychhc.org

Educational Objectives:
PGY-1 Emergency Medicine residents will spend a two-week block on the Obstetrics In-patient service at Kings County Hospital. Residents will also rotate through the outpatient clinics. The Emergency Medicine Residents will be under the direct supervision of an Obstetrics/Gynecology Senior or Chief Resident and Attending Physician. They will act in the role of a PGY-1 OB/GYN Resident, providing direct patient care, and assisting with in-patient care and Emergency Department consultation. They will also assist in the operating rooms. The Emergency Residents will attend the Department of Gynecology's daily conferences and monthly Grand Rounds, the resident is excused from EM Wednesday conference, if patient care requirements allow. The purpose of this rotation is to perform at minimum the 10 deliveries required by the RRC for graduation. All deliveries are to be documented in New Innovations for credit. Please log these deliveries under your EM faculty advisor if the OB/GYN attending can not be found in new innovations.
At the completion of this rotation, the resident will demonstrate competence in and be able to:
• Evaluate and treat the patient with pre-eclampsia/eclampsia and other gynecological medical disorders (PC,MK)
• Make admission, transfer and discharge decisions on OB patients (PC,MK,C,SBP,P)
• Utilize laboratory data and ancillary studies appropriately in the care of pregnant patients (PC,MK)
• Utilize in-patient OB/GYN consultation appropriately (PC,MK,C,P,SBP)
• Compassionately interact with patients and their families during the stress of illness and death (PC,C,P)
Description of clinical experiences:
Residents will have experience in and demonstrate competence in the following procedures:
• Vaginal deliveries
• Assisting in C-sections
• Monitoring of patients in labor
• Management of the ecclamptic patient
• Management of episiotomies
• Assisting in the operating room
• Pelvic sonography
• Pelvic examination
• Assisting with the treatment of incomplete and complete abortions
• Appropriate bacterial and viral culture techniques
• Repair of vaginal lacerations
• Removal of vaginal foreign bodies
Description of didactic experiences:
The residents will participate in the daily, weekly, and monthly OB/GYN conferences as well as the Emergency Medicine conferences if it is does not interfere with patient care requirements.

The following topics should be covered in the Resident's reading during this rotation:

- Pelvic and abdominal pain
- Sexual assault
- Abnormal vaginal bleeding
- Contraception
- Ovarian cysts and rupture thereof
- Drug & radiation exposure in pregnancy
- Tubo-ovarian abscess
- Diagnosis of pregnancy
- Spontaneous abortion
- Nausea and hyperemesis gravidarum
- Threatened abortion
- Premature rupture of membranes
- Endometriosis
- Vaginal bleeding in early pregnancy
- Pelvic inflammatory disease
- Molar pregnancy
- Ectopic pregnancy
- Contraception
- Uterine incarceration
- Hysterectomy
- Ovarian torsion
- Pelvic relaxation
- Mittelschmerz
- Amenorrhea
- Vaginitis/vaginosis/vulvitis
- Vaginal foreign bodies
- Urinary tract infection
- Infertility
- Sexually transmitted disease
- Atrophic vaginitis

MICU

Meeting Place: KCH MICU D building 3rd Floor
Contact Number: (718) 245-3774 (KCH), MICU # 718-245-7580
Daily Rounds:
Usually at 7am in D3 South Conference room. Contact KCH Medical Chief Resident for the block 917-760- 1320, 917-760-1321.
Schedule:
intmedchiefresidents@downstate.edu (only accepts emails from downstate email addresses)

EM Faculty Liaison: Dr. Ray Beyda
Special Considerations:
The Medical Intensive Care Unit at Kings County Hospital is a four week rotation for PGY-1 Emergency Medicine Residents. The Emergency Medicine Resident will function as a PGY-1 Internal Medicine Resident, providing direct patient care. A Senior Medical Resident, Critical Care Fellow and the Intensive Care Unit Attending Physician will supervise the Emergency Medicine Resident. The Emergency Medicine Resident will attend daily Attending Rounds, daily lectures with the Department of Internal Medicine, weekly Critical Care Conferences, monthly Internal Medicine Grand Rounds, and participate actively in the monthly Emergency Medicine / MICU interdisciplinary conference.
At the completion of this rotation, the resident will demonstrate competence in and be able to:
• Perform a comprehensive history and physical examination on critically ill patients (MK,PC)
• Develop differential diagnoses for life-threatening problems, and create cohesive care plans based on these diagnoses (MK,PC,PBL)
• Manage critically ill patients in an intensive care unit setting(MK,PC,PBL)
• Make admission, transfer and discharge decisions for patients with life-threatening and potentially life-threatening illness(MK,PC,C)
• Appropriately utilize and interpret invasive monitoring(MK,PC)
• Appropriately utilize and interpret culturing techniques, results and use of antibiotics(MK,PC)
• Utilize laboratory data and ancillary studies appropriately in the care of critically ill patients(MK,PC,SBP)
• Utilize in-patient consultation appropriately(MK,PC,C,P,SBP)
• Compassionately interact with patients and their families during the stress of illness and death(PC,P,C)
Description of clinical experiences:
Residents should have experience with and demonstrate competence in the following procedures on this rotation:
• Airway management and endotracheal intubation• Lumbar puncture
• Placement and care of central venous catheters• Thoracentesis
• Placement and care of arterial catheters• Chest tube placement
• Placement and care of pulmonary artery catheters• Abdominal paracentesis
• Interpretation of Swan-Ganz-catheter readings
• Utilization of oxygen delivery devices and mechanical ventilators

• Arterial blood gas sampling and analysis
• Placement of esophageal/gastric balloons

Description of didactic experiences: (MK,PC)

The Emergency Medical resident will actively participate in the interdepartmental conferences. The following topics should be covered in the resident's reading during this rotation:

• Airway management and endotracheal intubation• Gastrointestinal hemorrhage
• Mechanical ventilation• Intracerebral bleeding/CVA
• ACLS• Hepatic encephalopathy
• Interpretation of invasive monitoring• Shock
• Drug induced paralysis• Sepsis
• ARDS• Uremic encephalopathy
• Asthma/COPD• Anticoagulant therapy• Pneumonia• Pulmonary embolism
• Meningitis• Coma/brain death examination
• Opportunistic infection• Cardiogenic pulmonary edema
• Super-infection• Dysrhythmias
• Broad spectrum antibiotics• Fever
• Acute renal failure• Acid base derangements
• Hemodialysis/peritoneal dialysis• Electrolyte abnormality
• Nutrition: parenteral and enteral• Hemolysis
• Disseminated intravascular coagulation

INTERNAL MEDICINE FLOORS AT KCH

Meeting Place and Time: D Building 7Th floor North- Conference Room at 7am

Pagers for KCH Medical Chief Residents: 917-761- 1320

917-761- 1321

Schedule and Inquiries: Contact the medicine chief resident at least 4 weeks before the start of the rotation:

intmedchiefresidents@downstate.edu (only accepts emails from downstate email addresses)

EM Faculty Liaison: Dr. Joshua Schechter

Educational Objectives:

PGY-1 Emergency Medicine Residents will rotate for a four-week block on the inpatient Medical Services at the KCHC. The Emergency Medicine Residents will be integrated into the schedule of the Department of Medicine by the respective Chief Medical Residents. The Emergency Medicine Residents will function in the role of a PGY-1 Internal Medicine Resident, and will have direct patient care responsibility. They will be under the direct supervision of a PGY-3 Medical Resident and Internal Medicine Attending Physician. Residents will also attend daily attending rounds, daily educational conference, weekly Medicine Department Grand Rounds and the monthly Morbidity and Mortality Review.

At the completion of this rotation the resident will be familiar with and demonstrate competence in:

• Performance of a comprehensive history and physical examination on acutely and chronically ill patients(PC,MK)

• Development of an integrated problem list for patients, including detailed differential diagnoses.(MK,PC)

• Management of complex medical problems on an acute and chronic basis.(MK,PC,SBP)

• Transfer and discharge planning.(SBP,PC,P)

• Utilization of laboratory data and ancillary studies in the care of internal medicine patients(MK,PC)

• Blood and body fluid precautions(MK,SBP)

• Necessary precautions for Tuberculosis and other airborne pathogens(PC,MK,SBP)

• Appropriate utilization of specialty consultation(C,P,PC,MK)

Medical Knowledge and Patient Care:

• Management of the immunocompromised patient

• Management of the patient with accelerated hypertension, and hypertensive urgencies

• Management of congestive heart failure

• Management of asthma/COPD

• Management of gastrointestinal bleeding

• The evaluation and management of fluid and electrolyte disorders

• The evaluation and management of hypothermia and hyperthermia

• The evaluation and treatment of suspected spinal cord compression

• Management of diabetes: its acute (DKA, Hyperosmolar Coma), and chronic (leg ulcers, renal failure, neuropathy, retinopathy) manifestations

• The evaluation and treatment of acute and chronic renal failure

• The metastatic work-up
• Nutrition: parenteral and enteral
• Initial management of myocardial ischemia
• Recognition and treatment of the initial stages of septic shock
• The differential diagnosis of wide-anion gap and non-anion gap metabolic acidosis
• Management of pneumonia
• Diagnosis and management of patients with CNS and systemic infections
• Evaluation and treatment of patients with vasculitis and connective tissue disorders; lupus, scleroderma, mixed connective tissue disorder
• Development of the Doctor-Patient relationship as the resident interacts with patients and their families during the stress of illness and death

Description of clinical experiences:

Residents should have experience and demonstrate competence in the following procedures on this rotation:

• Advanced Cardiac Life Support• Blood and tissue culture techniques
• Emergent airway management• Viral culture techniques
• Diagnostic lumbar puncture• Nasogastric intubation
• Abdominal paracentesis• Debridement of decubitus ulcers
• Peripheral blood smear analysis• Urinalysis
• Thoracentesis• Central IV placement and care
• Arterial blood gas sampling and its analysis• Peripheral IV catheter placement
• Lymph node aspiration for cytology diagnosis

Description of didactic experiences:

The resident will attend all lectures offered by the Internal Medicine department.
The following topics should be covered in the resident's reading during this rotation:

• Hypertension• Pulmonary embolism
• Diabetes insipidus• Deep vein thrombosis
• Diabetes mellitus• Malignancy
• Diabetic ketoacidosis• Paraneoplastic syndromes
• Diabetic hyperosmolar state• Lymphoma/leukemia
• Electrolyte disturbances• Metabolic acidosis
• Acute and chronic renal failure• Asthma/COPD
• Anemia• Pneumonia
• Hemolysis• Sepsis
• AIDS• TB
• Brain abscess• Infectious diarrhea
• Connective tissue disorders• Vasculitis
• TTP• ITP
• Acid-peptic disorders• Spinal cord compression
• Pancreatitis• Hepatitis
• Upper GI bleeding• Lower GI bleeding
• Congestive heart failure• Myocardial ischemia
• Atrial fibrillation• Atrial tachycardias

- Sarcoidosis

PGY-2 OFF SERVICE ROTATIONS

PGY-2 ULTRASOUND ROTATION

DURATION: 2 Weeks

LOCATION: UHD AND KCH ED

FACULTY LIAISONS:

Dr. Kelly Maurelus
Cell: 347-733-5710
Email: maurek01@gmail.com

Dr. Christopher Hanuscin
Cell: 818-590-2103
Email: chanusci@gmail.com

OBJECTIVES:

1. To understand basic physics and instrumentation of medical ultrasound equipment

2. To learn how to use the ultrasound systems available in KCH and UHD Emergency Departments

3. To review normal sonographic anatomy and pathophysiology of the thorax, abdomen and pelvis

4. To understand indications and limitations of bedside emergency ultrasound

5. To become proficient in core emergency ultrasound applications, as outlined by ACEP ultrasound guidelines

a. Extended Focused Assessment with Sonography in Trauma (E-FAST)
b. Focused Gynecologic and Obstetric Ultrasound
c. Abdominal Aortic Aneurysm (AAA)
d. Emergent Echocardiography and Hemodynamic Assessment
e. Focused Biliary Ultrasound
f. Focused Renal Ultrasound
g. Soft-tissue and Musculoskeletal Ultrasound Applications
h. Thoracic Ultrasound
i. Ocular Ultrasound
j. Bowel Ultrasound
k. Vascular Ultrasound
l. Ultrasound-guided Procedures

SCHEDULE:

Supervised scanning times may vary depending on the availability of ultrasound faculty, but residents are expected to scan in the department from 9 am – 4 pm daily, with the exception of Wednesday conference. Attendance at Wednesday Conference is mandatory. On Thursday the residents will meet with a member of the ultrasound faculty for QA and tape review. Residents will have the weekend off.

Residents on rotation must e-mail Dr. Maurelus or Dr. Hanuscin prior to the start of their rotation for further information on the schedule and rotation expectations. **Any requests for changes in the schedule must be discussed with and approved by Dr. Bon PRIOR to the start of your rotation (catharine.bon@gmail.com). Residents will be expected to make up any missed scanning shifts by coming in on the weekend and scan from 9 am - 4 pm.**

ROTATION REQUIREMENTS:

Residents should report to the clinical area during their scanning shifts and perform any clinically indicated scans that may be needed in the ED. In addition to any clinically indicated scans, **residents should individually perform at minimum 6 FRAGEL examinations** (FAST, Renal, Aorta, Gallbladder, Echo and Lung) **during each scanning shift**. **If scanning as a group, then the group is expected to perform a minimum of 10 FRAGEL exams per scanning shift.** If a member of the ultrasound faculty is not present during any clinically indicated scans, studies should be reviewed with the attending staffing the case. **PGY2 residents should especially focus on improving their skills in performing gallbladder, cardiac and lung exams.**

Required Scans: Residents will be required to fulfill approximately 200 scans during their rotation with a minimum of the following breakdown by examination type:

Echo – 25
FAST – 20
Gallbladder – 15
Renal – 15
Lung – 15
DVT - 5
Aorta – 10
Ocular – 5
MSK - 5

During their rotation, residents will be expected to take online quizzes and submit their results for evaluation. Quizzes are available at the following website:

- http://www.slredultrasound.com/quizzes.html

Scores of less than 75% will not be accepted. The following quizzes should be done and turned in prior to the end of the resident's rotation.

PGY2
Physics
Cardiac
Lung
Biliary
Renal
Vascular
Abscess/Cellulitis

Upon completion of the rotation, the resident will be evaluated based on his/her attendance, motivation, didactic knowledge, procedural skills, and test results. Residents who have not met the minimum requirements of the rotation, as decided by ultrasound faculty, will be required to participate in remediation. Residents will also be asked to evaluate the rotation and provide suggestions on areas of improvement.

Additionally, **all residents will be expected to give a mini-presentation** during one of the tape review sessions. Options for the presentation include the following:

- **Case follow-up:** Follow-up on one of the patients that you performed an ultrasound on to see how your ultrasound may have impacted the course of care for the patient and also to see if your findings correlate with what was ultimately found for the patient
- **Journal Club**: Present an article on a topic of interest related to ultrasound
- **Mini-lecture:** Give a 15-20 minute presentation on a topic of choice

Please be sure to discuss your plans for your presentation with the faculty in charge of tape review during your rotation.

Residents may be asked to participate in teaching sessions with medical students in lieu of scanning shifts.

EDUCATIONAL MATERIALS:

It is suggested that you review the following lectures at
http://emergencyultrasoundteaching.com/narrated_lectures.html

- Physics
- Cardiac/IVC
- Biliary/Gallbladder
- Thoracic/Airway

All suggested reading materials are available online at http://www.sunykchsono.com/resource. All textbooks are available at the Downstate Medical Library and in on-line format. Certain textbooks are available in the ultrasound office and are available for use by the residents.

AIRWAY MANAGEMENT

Location: NYU Brooklyn
Contact: Dr. Curtis Thornhill (718) 630-6324 Curtis.Thornhill@nyumc.org
Liaison: Dr. James Willis
Shifts begin in the OR at 7:15 each day. Scrub attire is necessary.
Access to the scrub machine will be arranged for the residents.

Overview:

• Airway anatomy
• Airway assessment
• Mask ventilation technique
• Airway equipment
• Pharmacology of commonly used drugs for producing intubation conditions
• Difficult airway algorithm

Managing airways in the OR:

• Practice session on airway mannequin
• Airway management in the OR

Course goals and objectives:

• Properly class the airway
• Demonstrate proper mass technique
• Be able to describe the pharmacology of the common drugs used to facilitate intubating conditions
• Demonstrate proper intubating technique

CCU

Meeting Place: CCU, NS26 2nd floor UHD
Schedule: intmedchiefresidents@downstate.edu (only accepts emails from downstate email addresses)
EM Faculty Liaison: Dr. Pam Janairo

Educational Objectives:

The Coronary Care Unit at UHD will be the PGY-2 Emergency Medicine Resident's introduction to the cardiac patient. They will be providing direct patient care in the CCU. Emergency medicine residents will be supervised by a cardiac fellow, or a cardiology attending. The Emergency Medicine Resident will attend daily Attending Rounds and Unit lectures as well as all daily lectures with the Department of Internal Medicine.

Daily Schedule:

Day-to-Day Assignments: q4 24 hour overnight call, work hours on call days 7am-10am, work hours on non-call days 7 AM to 5 PM, off on post-call days plus on additional day per week

Typical Day:

7 AM to 8:00 AM – Sign out rounds, work rounds, and notes
8 AM to 10 AM- Attending management and teaching rounds
12 Noon- Cardiology or Medicine conference (Lunch)
1 PM to 4:00 PM afternoon work rounds, check results and consultations etc.
4-5 PM- sign out rounds
Conferences: Daily Internal Medicine Noon conference- see monthly schedule

At the end of your CCU rotation you will be required to turn in one interesting EKG that will eventually be posted on the blog site. If you do not have the ability to scan the EKG into digital format, you can ask Dr. Janairo or anyone else to help you. The EKG should portray some interesting pathology that will spark an academic conversation. These images should be turned in to Dr. Janairo or someone he designates. Images need to be accompanied by an "answer" explaining why the image is important.

At the completion of this rotation, the Resident should demonstrate competence in and be able to:

• Perform a comprehensive history and physical examination on cardiac patients (PC, PROF)
• Develop differential diagnoses for chest pain and cardiac problems, and create cohesive care plans based on these diagnoses (PC, MK, SBP)
• Manage cardiac patients in an intensive care unit setting (SBP, PC, MK)
• Make admission, transfer and discharge decisions for patients with cardiac disease and potentially life-threatening illness (SBP, PC)
• Diagnose and treat supraventricular and ventricular dysrhythmias (PC, MK)
• Evaluate and treat hypertensive crisis (PC,MK)
• Evaluate and manage myocardial ischemia (PC.MK)
• Evaluate and manage acute myocardial infarction and its complications, including wall rupture, valve failure, congestive failure, dysrhythmias and pericarditis (MK, PC, SBP)
• Evaluate and manage dissecting thoracic aortic aneurysm (MK,SBP,PC)
• Evaluate and manage hypertrophic cardiomyopathy (MK,PC)

• Evaluate and manage cardiogenic pulmonary edema (MK,PC)
• Evaluate and manage class III and IV congestive cardiomyopathy (MK,PC)
• Evaluate and manage infective endocarditis (MK,PC)
• Evaluate and manage failed or infective prosthetic heart valves (MK,PC)
• Evaluate and manage pericardial tamponade (MK,PC, SBP)
• Evaluate and manage pericarditis (MK,PC)
• Run a cardiac arrest situation (MK,PC, PROF, COM, SBP)
• Appropriately utilize thrombolytic therapy and manage its complications (PBL, SBP)
• Interpret EKG's quickly and accurately (MK,PC)
• Appropriately utilize and interpret invasive monitoring (MK, SBP, PC)
• Utilize laboratory data and ancillary studies appropriately in the care of critically ill patients (MK, PC, SBP, PBL,)
• Utilize in-patient consultation appropriately (COM, SBP, PROF)
• Compassionately interact with patients and their families during the stress of illness and death (PROF, COM)

Description of clinical experiences: (MK,PC)

Residents should have experience and demonstrate competence in the following procedures on this rotation:
• Advanced Cardiac Life Support
• Airway management and endotracheal intubation
• Placement and care of central venous catheters
• Placement and care of arterial catheters
• Placement and care of pulmonary artery catheters
• Utilization of oxygen delivery devices and mechanical ventilators
• Arterial blood gas sampling and interpretation
• Exercise stress testing
• 24 hour ambulatory monitoring
• Bedside echocardiography
• Alternative EKG lead placement for the diagnosis of dysrhythmias and infarction
• Internal and external temporary pacemaker placement

Description of didactic experiences: (MK,PC, PBL, SBP)

The following topics should be covered in the Resident's reading during this rotation:
• Chest pain (differential diagnosis of)• Coronary artery disease
• Hypertensive crisis• Dissecting aortic aneurysm
• Coronary artery spasm• Cardiogenic pulmonary edema
• Acute myocardial infarction-diagnosis• Treatment of AMI
• Myocarditis• Pericarditis
• Pericardial tamponade• Congestive heart failure
• Restrictive cardiomyopathy• Hypertrophic cardiomyopathy
• Congenital heart disease• Nitrates/Beta-blockers/Digoxin
• Calcium channel blockers• Heparin/coumadin
• Thrombolytic therapy• Pacemakers
• Dysrhythmias-supraventricular• Dysrhythmias & Antidysrhythmics

• ACLS protocol• Cardiac catheterization
• Echocardiography• Electrophysiologic studies
• Stress testing• Nuclear cardiology
• Invasive pressure monitoring• Intra-aortic assist devices
• Heart blocks• Wolff-Parkinson-White syndrome

NICU/PICU

NICU
Meeting Place: 7 am NS35, NICU, 3rd Floor UHD
EM Faculty Liaison: Dr. Pam Janairo
Contact : sunypedschiefs@gmail.com
Schedule: Email requests to Pediatrics Chief Residents (sunypedschiefs@gmail.com) 2 months ahead of time

Educational Objectives:

As a PGY-2, the resident will rotate for two weeks in the NICU in the role of a junior resident. The resident will work under the supervision of an Attending Neonatologist. The resident will also be present at deliveries and gain experience in neonatal resuscitation and stabilization.

• To become competent in the initial resuscitation of the premature and term neonate during both complicated and routine deliveries. (MK,PC)
• To understand and manage the unique respiratory and nutritional needs of the premature infant. (MK,PC)
• To properly order and interpret laboratory and radiographic tests for the purpose of diagnosis and treatment of the neonate in the intensive care unit. (MK,PC,SBP)

Clinical Experience:

The resident will demonstrate competence in the evaluation and management of the following neonatal disorders:

• Esophageal reflux• Congenital cysts
• Aganglionic megacolon• Bronchopulmonary dysplasia
• Congenital GI lesions• Bacterial pneumonia
• Acquired GI conditions (NEC)• Perinatal and congenital infections
• Hernias• Congenital kidney abnormalities
• Malrotation of bowel• Undescended testes
• Dysrhythmias• Vaccination
• Congenital heart disease• Hypoglycemia
• Neonatal Jaundice• Anemias
• Meningitis• Neonatal seizures
• Pharyngeal – Tracheal lumen airway• Hydrocephalus

The resident will understand and demonstrate competence in the mechanics of assisted ventilation and the proper methods for monitoring adequate oxygenation:

• Mechanical ventilation
• End-tidal CO_2 monitoring
• Pulse oximetry

The resident will demonstrate competence in the following procedures:

• Umbilical vein catheterization
• Umbilical artery catheterization
• Familiarity with chest tube placement in neonates

• Use of paralytic and sedation agents
• Orotracheal intubation

Description of didactic experiences:

The resident will attend all educational conferences and meetings while on the NICU Service. The resident will be responsible for the list of suggested readings for the NICU Rotation in addition to any provided by the NICU Service. The resident will be fully incorporated into the NICU Care Team and participate in all rounds, conferences and didactics including Perinatology Conference and Neonatal Morning Report weekly. Attendance at the Wednesday Emergency Department Conferences will be at the discretion of and with the permission of the NICU attending on service if patient care needs allow.

PICU

Meeting Place: NS 43 UHD 4th floor at 7am

Contact: Dr. Rohit Pinto

EM Faculty Liaison: Dr. Pam Janairo

Schedule: Pediatric Chiefs

Educational Objectives:

As a PGY-2, the resident will rotate for two weeks in the PICU in the role of a junior resident. The resident will work under the supervision of an Attending Pediatric Intensivist.

• To become competent in the resuscitation of infant and pediatric patients. (MK,PC)
• To understand and become competent in the management of sepsis in pediatric patients. (MK,PC)
• To understand and become competent in the management of respiratory emergencies including respiratory failure, vent management and NIV in pediatric patients. (MK,PC)
• To understand and become competent in the management of fluids and electrolytes in critically ill pediatric patients. (MK,PC)
• To properly order and interpret laboratory and radiographic tests for the purpose of diagnosis and treatment of a pediatric patient in the intensive care unit. (MK,PC,SBP)

Clinical Experience:

The resident will demonstrate competence in the evaluation and management of the following Pediatric disorders:

• DKA • Complications of Sickle Cell Disease
• Sepsis • Respiratory Failure
• Status Epilepticus• Upper Airway Obstruction

The resident will understand and demonstrate competence in the mechanics of assisted ventilation and the proper methods for monitoring adequate oxygenation:

• Mechanical ventilation
• End-tidal CO_2 monitoring
• Pulse oximetry

The resident will demonstrate competence in the following procedures:

• Central Line Placement
•Endotracheal Intubation

Description of didactic experiences:

Documents below need to be read prior to the first day of the rotation:
Welcome to the PICU! During your 4 week rotation through the PICU, we intend to provide you with an education that fosters an understanding of managing critically ill children who present with a variety of medical and surgical conditions. This document contains pearls to help you survive and thrive in the PICU. Your formal curriculum and hand book can be found on New Innovations and the PICU computer desktops.

1. Be prepared to Round at 9:00 am!!!!!!!!
    1. Discuss pending admissions or overall logistics/concerns first
    2. Ideally, one person presents the patient while the other enters orders
    3. Remember to give full presentations for new admissions from overnight and to emphasize YOUR assessment and plan
    4. For old patients present:
        - Brief summary of hospital course
        - Significant interval events overnight
        - Vital signs, physical examination, laboratory results by system
        - Overall Assessment/Summary
        - Plan by Systems or Problems with emphasis on ***GOAL DIRECTED CARE*** (ie Goal RR, Goal O2 sat, Wean PEEP by 1 Q6h if O2 sat above 92% and PaO2 above 80 mm Hg)
    5. Rounds are useless without involvement of nursing team
    6. Utilize rounding checklists to facilitate communication of plans with nursing staff
        - For maximal efficiency, complete checklists with goals before rounds and then review on rounds through your presentation
        - For patients who you plan to discharge or transfer, checklist is not needed
        - Have nurses adjust parameters on the cardiopulmonary monitor to match the goals set on rounds…..this is a key part of alarm fatigue management
    7. Orders
        - Enter orders on rounds!!!!!!!
        - NO VERBAL ORDERS!!!!...unless in a code situation
        - For urgent situations (ie sedation, sepsis), place order and ask nurse to obtain medication from ***PYXIS OVERRIDE***
        - Verify that current orders are correct and that nothing has “fallen off”
        - Any goals that have been selected on rounds should be entered into EMR
        - ***DO NOT PRINT LAB SPECIMENT ORDERS IF YOU ARE NOT OBTAINING THE SPECIMENT YOURSELF***
            - Ø If you obtain the specimen, use the ***TWO-PATIENT IDENTIFIER*** system to reconcile the patient’s identification info in the label with the patient’s ID band
2. Note Writing in Healthbridge
    1. General Pearls
        - Complete pertinent review of systems & select “all other systems negative”
        - Please complete the physical exam for as many systems as appropriate and provide at least 2-3 pertinent negative or positive findings for each.

- For all labs/images you have reviewed that have played a role in your assessment, please select and check off the box on the left.
- ***SELECT A SECONDARY DIAGNOSIS***, which is any part of the patient's history that impacts the manner in which you are managing the patient OR any new diagnoses you have made during the patient's course that you are currently managing**.** This applies to almost all of our patients. Make sure that the selected secondary diagnosis is also checked off on the left hand side.
    - Ø For example, "Post tonsillectomy pain management," is a secondary diagnosis for post operative T&A.
- The assessment in Healthbridge is organized by problem. For each problem, please describe the problem and then outline a plan that emphasizes ***GOAL DIRECTED CARE***. The goals should match your goals completed on the rounding checklists. Remember, any abnormal history, physical exam, lab/imaging should be addressed in your assessment and plan.
    - Ø Keep in mind that aspects of a patient's careplan will likely exceed their "problems." These should be included in separate problem boxes. For example, a patient with septic shock still has to have a nutrition plan; therefore, FEN/GI will be a separate "problem"

2. Admission Note
    - Complete all portions of the note, they are there for a reason
    - PMH, PSH, and FH MUST be completed. Make sure that the selected diagnosis is also checked off on the left hand side.
    - Admission diagnosis MUST be completed. Make sure that the selected diagnosis is also checked off on the left hand side.
    - ***USE PICU ADMISSION ORDERSET FOR NEW ADMITS***
3. Progress Notes
    - Interval history should be brief & only include SIGNIFICANT events within the past 24 hours (ie fluid balance belongs in FEN/GI)
    - Select a diagnosis and check the box for PMH, if applicable.
    - Vital signs should be manually entered in vital sign portion of note.
4. ***START DISCHARGE SUMMARIES ON ADMISSION & UPDATE DAILY!!!***
5. Event notes should be written should a patient's clinical status change. Include the plan discussed with the attending and your post intervention assessment.
6. Transfer Notes should be written instead of Progress Notes for patients being transferred to NS 42
7. Transfer/Acceptance Notes should be written for patient's transferred from NS 42
8. For discharges, a progress note and discharge summary are required
    - D/C summary should include ***A PRIMARY DISCHARGE DIAGNOSIS*** follow up appointment and "Return for x,y, and ***OR FOR ANY CONCERNS,"*** in the instructions
    - ***DO NOT PRINT DISCHARGE INSTRUCTIONS***

3. Execute stat procedures/test, discharges, and consults early in the day. If a patient's status changes or if the plan of the day cannot be executed, alert the attending ASAP
4. This is a CLOSED UNIT. All other services are consultants, and as such, discuss their recommendations with the attending physician prior to implementation.

5. Carry the code pager at all times ***AND*** hillrom locator badge hand it off to the night resident. **Please answer the test pages.**
6. ***WATCH CRASH CART INSERVICE VIDEO*** here
7. Cardiopulmonary Alarm Management-***NO PASS ZONE***
    1. Everyone on the unit is responsible for responding to alarm
    2. If an alarm is ringing, it is your responsibility to go to the room in question and assess the patient…even if it is a patient you are not the primary resident for
    3. If the alarm does not demand a critical response (ie ABC intervention), discuss with the nursing and medical teams how to address the alarm.
        - For example, a 2 year old admitted for status asthmaticus has a RR rate alarm maximum limit set to 30. However, the alarm continues to ring because the patient is breathing at 40. You arrive to assess the patient and determine that they are stable on the current intervention. The patient's primary resident is with another patient at CT. You huddle with the nurse and determine that the patient's RR max limit on the monitor should be set to 50 to limit unnecessary alarms and to prevent this alarm from over shadowing a critical alarm
    4. Do not silence an alarm without discussing with the patient's nurse

PLEASE ADDRESS ANY CONCERNS TO THE CHIEF RESIDENTS OR I AS THEY OCCUR SO THE MATTER CAN BE ADDRESSED IN A TIMELY FASHION!!!

PEDIATRIC CRITICAL CARE AT SUNY UHD

RESIDENTS: PL-3 Categorical Pediatrics, PGY-2/3 Emergency Medicine Residents

PREREQUISITES

PL-3 Categorical Pediatrics: Completion of rotations and practice in curricular objectives for general pediatric inpatient and neonatal experiences as junior residents with satisfactory summative evaluations. Must have current PALS certification.

PGY 2 or 3 Emergency Medicine: Completion of rotations and practice in curricular objectives for emergency medicine and adult critical care as junior residents with satisfactory summative evaluations. Must have current PALS certification.

Responsibilities and Evaluations

\PGY-3 Pediatric Residents and PGY 2/3 Emergency Medicine residents who did not complete a residency in general pediatrics, will work alongside the PICU Physician Assistants and serve as the primary caretakers for patients admitted or transferred to the Pediatric Intensive Care Unit at SUNY UHD PICU.

The responsibilities of all residents include:

1. Participating in all aspects of patient care according to your level of training.
2. Be prepared to attend and participate in resuscitations in children anywhere in the hospital including the wards, the ED, and outpatient clinic areas.
3. Attend and participate in departmental conferences:
    1. Morning Report
    2. Grand Rounds
    3. Patient Management Conferences
    4. Morbidity and Mortality Conferences
4. Attend rounds to patient care rounds
    1. Work Rounds
    2. Attending Rounds
    3. Subspecialty service rounds and consultations
    4. Psychosocial or Ethics Rounds as needed
    5. Monthly Interdisciplinary Performance Improvement Meeting
    6. Sign-out Rounds
5. Master of core competency and rotation objectives outlined below

EVALUATIONS

There will be ongoing formative feedback throughout all activities by all supervisory staff, including nursing staff. There will be a mid-point evaluation verbal evaluation given by the PICU director or designee where strengths and opportunities for improvement will be discussed. This will also be your chance to voice any concerns your have regarding your PICU experience. At the end of the rotation, the PICU director or designee will constructively discuss the final summative evaluation with the resident. This verbal evaluation will be reflected in the evaluation submitted via New Innovations. The supervising faculty will subsequently discuss the resident's performance at the monthly housestaff affairs committee meeting attended by the program director (or designee) and representative faculty.

1. Observation for attainment of objectives by:
    1. Chief residents
    2. Supervising attending faculty
    3. Nursing staff
2. Review of medical records by:
    1. Chief residents
    2. Supervising attending faculty
3. Presentations during various rounds and conferences.
4. Participation in discussions during rounds and small-group activities.
5. Demonstration of attributes of professionalism.
6. Successful performance of procedures and documentation.
7. Nursing, patient, and family member comments including compliments and complaints.
8. Patient outcomes.
9. Involvement in total quality management: performance improvement (QA) trending files, incident reports, risk management reports.
10. Presentation on critical care topic during the rotation to students, residents, fellows, and nurses.

The resident is expected to complete and submit an evaluation of the rotation, peers and teaching faculty at the conclusion of the rotation through New Innovations.

Core Competencies and Rotation Goals

PATIENT CARE: Residents must be able to provide family-centered care for infants, children and adolescents who require intensive care. This care must be developmentally and age appropriate. The care must be compassionate and include effective treatment of the underlying current and potential future health and social problems confronting the patient and family.

GOAL I: Gathering Data by History or Interview. Learn to conduct effective interviews with patients, parents, and family members. The initial interview must be focused and directed to the rapid stabilization and initiation of optimal care for the patient. Follow-up interview must be sufficiently detailed and appropriate to ensure quality of on-going care, follow-up and discharge planning including health care promotion and anticipatory guidance and needs.

OBJECTIVES:

1. Adapt communication strategies to specific clinical situations and settings.
2. Demonstrate appropriate strategies for communicating based on the patient's and parent's educational and developmental level taking into account sociocultural differences.
3. Select questions that appropriately address the presenting clinical problems and prior risk factors.
4. Ask open-ended questions to elicit maximum information combined with limited closed-ended questions to make interview more efficient.
5. Accurately obtain a relevant history of pregnancy, prenatal and perinatal events.
6. Obtain and interpret detailed history from patients and parents including health concerns, social history, sexual history, etc.
7. Make use of all resources in gathering information: parents, family members, specialty services, primary care providers, emergency department, EMS, etc.
8. Avoid judgmental questions and responses.
9. Use openings, transitions, and closures sensitively and effectively.
10. Gather necessary information:
    1. History of present illness
    2. Birth history
    3. Past medical and surgical history
    4. Developmental history
    5. Nutritional history
    6. Family history
    7. Social history
    8. Review of systems
11. Summarize findings to verify or clarify.

GOAL II: Gathering Data by Physical Examination. Understand how to perform an appropriate physical exam, demonstrate technical proficiency and sensitivity to needs of the child/parent and the clinical situation.

OBJECTIVES:

1. Use strategies for approaching children of different ages for physical examination, including ways to put them at ease and gain their trust.
2. Use an examination sequence most likely to result in a successful examination and rapid attainment of critical information for management and stabilization.

3. Recognize clinical situations that require a rapid focused exam and those which allow for a complete and comprehensive exam.
4. Demonstrate sensitivity to the needs of the child and parent when performing the exam.
5. Demonstrate technical proficiency in the comprehensive examination of infants, toddlers, children, preadolescents, and adolescents.
6. Appropriate hand-washing and infection control.
7. Effective use of observation.
8. Thoroughly and accurately assess respiratory, circulatory, neurological status and stability.
9. Complete each step of the exam in a technically proficient manner
10. Perform a gender specific and age appropriate exam
11. Perform a detailed organ-specific examination when the patient is stabilized and able to tolerate it.
12. Know when parent should be excluded from the area and when parent or other adult should provide accompaniment.
13. Respect patient privacy and need to not damage the child's self-image.
14. Discuss consent and confidentiality with respect to treating adolescent patients and parental involvement. Discuss when confidentiality can or should be abrogated.
15. Pursue, confirm, and explain abnormal findings
16. Record findings accurately
17. Assign scores as needed (e.g. Glascow, APACHE, MODS)
18. Identify common and important abnormalities of all major organ systems (e.g. recognize range of normal for given ages).
19. Describe findings in terms of anatomy and physiology.

GOAL III: Resuscitation and Stabilization. Understand how to rapidly resuscitate and stabilize the critically ill child in the PICU setting.

OBJECTIVES:

a. Learn and perform steps in resuscitation and stabilization, particularly airway management and resuscitative pharmacology.

b. Recognize the common causes of acute deterioration in the previously stable patient.

c. Function appropriately in codes and resuscitations as part of the PICU team.

GOAL IV: Continuum of Care. Understand the continuum of care for children with acute illness/injury from initial presentation (office, clinic, ED), through acute care (including transfer in and out of PICU), to discharge planning, which includes establishing follow-up care and/or home health services.

OBJECTIVES:

1. For a representative sample of children and families, provide/participate in care across the full continuum of services, including:
    1. Presentation in clinic/office, transferring medical facility, or ED.
    2. Decision to admit to the PICU.
    3. Acute and sub-acute care.

4. Decision and criteria for transfer out of the PICU.
5. Discharge planning to facilitate transition to home care or alternative care facility.
6. Post hospital care (coordinating home health services, providing office/clinic follow-up care, communication with primary/subspecialty care providers, etc).

2. Develop case management skills for patients with a complex set of medical and psychosocial issues in a high stress environment using principles of decision-making analysis and problem solving.
3. Develop and maintain a detailed problem list with accurate prioritization.
4. Make informed diagnostic and therapeutic decisions based on patient information, current scientific evidence, and clinical judgment.
5. Develop and carry out patient care management plans in conjunction with the nursing team, physician assistant, attending physician, consultant services, and others on the patient care team.
6. Recognize the burdens of illness and limitations of health care resources in an underprivileged urban population.
7. Recognize the burden and impact of chronic illness on the child, parents, and family unit.
8. Mobilize appropriate support services to help meet the long-term care needs for a child with chronic illness, such as social work, case management, palliative care, etc.
9. Utilize information technology to optimize patient care.
10. Coordinate orderly transfer of care to another institution when a higher level of care is necessary or institutional resources have been exhausted.

GOAL V: Diagnostic Testing. Understand the indications, limitations, and interpretation of common laboratory tests and imaging studies utilized in pediatric intensive care.

OBJECTIVES:

The following objectives apply to each of the laboratory or diagnostic tests listed below:

1. Understand and explain the indications and limitations of each test and be aware of the age-appropriate normal results.
2. Follow up on results in a timely fashion.
3. Interpret results and abnormalities in the context of specific physiologic derangements as well as the prevalence of disease in the community.
4. Discuss therapeutic options for correction of abnormalities when appropriate.
5. Understand the cost-effective use of diagnostic tests.
6. Enter orders accurately into the electronic medical record.
7. Communicate orders appropriately to other healthcare staff.

Laboratory Tests (include bedside point-of-care tests):

A. CBC with differential, platelet count, indices
B. Blood chemistries: electrolytes, glucose, calcium, magnesium, phosphate
C. Renal function tests
D. Tests of hepatic function and damage
E. Drug levels and toxicological studies
F. Coagulation studies: platelets, PT/PTT/INR, fibrinogen, FSP, D-dimer
G. Point of care testing including: Arterial, capillary, and venous blood gases, blood glucose and electrolytes
H. Cultures, rapid antigen tests and other studies for infectious agents

I. Urinalysis
J. CSF analysis
K. Blood typing and cross matching
L. Other tests as indicated by the individual patients' condition.

Imaging Studies

A. Chest x-ray
B. Abdominal series
C. Skeletal survey
D. Computerized tomography
E. MRI
F. Ultrasound
G. Echocardiogram

GOAL VI: Proficiency in Therapeutic and Technical Procedures. Gain exposure or demonstrate technical proficiency and appropriate use of procedures and technical skills required of general pediatricians.

OBJECTIVES:
The following objectives apply to each of the procedures listed below:

1. Understand the indications, contraindications, complications, risks, benefits, and alternatives
   for these procedures.
2. Obtain informed consent for invasive procedures and/or sedation.
3. Understand related ethical, legal and financial issues.
4. Provide accurate, timely and appropriate written documentation.

Procedures

1. Moderate/Deep sedation
2. Topical anesthesia
3. Arterial line insertion (Seldinger technique)
4. Bladder catheterization
5. Cardiopulmonary resuscitation
6. Cardioversion
7. Central venous line insertion (Seldinger technique)
8. Endotracheal intubation
9. Rapid sequence intubation
10. Electrocardiography
11. Gastric tube placement
12. Injection/medication (including fluids and nutrients) delivery

GOAL VII: Monitoring and Therapeutic Modalities. Understand the indicatons, limitations, and methods of interpreting physiologic monitoring and special technology and treatment in the PICU setting.

OBJECTIVES:

1. The following objectives apply to each of these invasive monitoring modalities,:
    1. Physiologic monitoring
        i. Blood pressure

ii. Heart Rate
iii. Respiratory Rate
iv. Oxygen Saturation
v. Body Temperature
vi. Ins and outs

1. Central venous pressure monitoring
2. Arterial blood pressure monitoring
3. Mechanical Ventilation waverforms and alarms
4. Intracranial pressure monitoring

2. Participate in the daily care of "technology dependent" children describe key issues for on-going management both in the hospital and at home.
3. For the common therapies listed, learn to integrate understanding of physiology and pathophysiology to determine the appropriate use of therapy and how to monitor its effect and describe potential complications of therapy:
    1. Therapeutic gas administered invasively or non-invasively:
        i. Oxygen
        ii. Nitric oxide
        iii. Heliox
        iv. High Flow Nasal Cannula
    1. Positive pressure ventilation and basic ventilator management.
    2. Analgesics, sedatives, and paralytics.
    3. Enteral and parenteral nutrition.
    4. Blood and blood product transfusions.
    5. Vasoactive drugs (vasopressors, inotropes, and anti-hypertensive infusions).
4. Demonstrate understanding of risks, benefits, and alternatives to treatment modalities (such as antibiotics, anticonvulsants, parenteral fluids and enteral nutrition, diuretics, cardiac drugs, respiratory medications, immunomodulators, etc).
5. Discuss management of complex subspecialty patients with the appropriate service.
6. Discuss management options with patients (when of assenting age) and parents in the decision making process.
7. When using therapeutics:
    1. Consistently strive to keep up-to-date on efficacy information, contraindications, complications, and costs.
    2. Recognize variables such as age, weight, co-existing conditions, allergies, drug interactions which may require modification of standard practices.
    3. Use correct procedures for instituting and monitoring therapy and response.
    4. Complete orders, prescriptions and maintain medical records properly.
    5. Discuss factors that may contribute to variations in pharmacokinetics.
    6. Describe and take into consideration key factors that affect compliance.
8. Effectively utilize available resources including medical informatics (computers), libraries, and consultant specialists.

MEDICAL KNOWLEDGE: Residents must demonstrate knowledge about established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, and the application of this knowledge to care of the critically ill infant, child and adolescent. The resident will demonstrate an investigatory and analytic thinking approach to clinical situations. The

resident will critically evaluate and use current medical information and scientific evidence for patient care.

GOAL VIII: Common Signs and Symptoms. Understand how to evaluate and manage common signs and symptoms seen in critically ill children, including when to transfer to an intensive care setting.

OBJECTIVES:

The following objectives apply to each of the signs and symptoms listed below, which may herald the onset of serious or life-threatening events in infants, children, and adolescents:

1. Rapidly recognize the sign and/or symptoms as heralding the onset of critical illness disease or injury and perform a directed history and physical examination.
2. Format an age-appropriate differential diagnosis.
3. Know clinical significance and pathophysiologic basis.
4. Understand indications for admission to the PICU and indications for emergent intervention, as well as procedures for stabilization prior to transport to the intensive care setting.
5. Formulate a plan for stabilization, further evaluation, diagnosis and definitive management, and be able to describe the physiologic basis for therapies.

Signs and symptoms (PICU)

A. **Respiratory:** Tachypnea, bradypnea, apnea, dyspnea, accessory muscle use, poor air movement, cyanosis/hypoxia, wheezing, stridor, hemoptysis,

B. **Cardiovascular:** Hypotension, hypertension, wide pulse pressure, rhythm disturbance, bradycardia, tachycardia, asystole, poor capillary refill, bounding/decreased/asymmetric pulses, cold extremities

C. **Dermatologic:** Rash, petechiae, purpura, ecchymoses, urticaria, edema, extensive desquamation or tissue loss.

D. **ENT:** Trauma, airway edema, epistaxis, craniofacial abnormalities.

E. **Endocrine:** Polydipsia, polyuria, tetany, weakness, lethargy.

F. **GI/Nutrition/Fluids:** Diarrhea, vomiting, dry mucous membranes, inadequate intake, dysphagia, abdominal pain, abdominal distension, acute lower or upper gastrointestinal hemorrhage, peritoneal signs, jaundice, altered mental status.

G. **GU/Renal:** Hematuria, oliguria, polyuria, anuria, abdominal mass

H. **Hematologic/Oncology:** pallor, abnormal bleeding, anemia, purpura, priapism, mass.

I. **Musculoskeletal:** trauma, inability to ambulate, extremity pain.

J. **Neurologic:** Intractable seizures, altered mental status, coma, head trauma, altered speech, focal motor or sensory loss, gait instability, generalized weakness, visual field deficits, inability to handle secretions, abnormal respirations.

K. **Infectious Disease:** Fever, hypothermia, rash.

GOAL IX: Common Conditions. Understand how to assess and manage (as reasonably expected of a general pediatrician) common childhood conditions cared for in the PICU setting.

OBJECTIVES:
The following objectives apply to the conditions/diagnoses listed below, which may require intensive care management:

1. Understand the pathophysiologic basis of the disease or injury
2. Describe criteria for admission to and discharge from PICU.
3. Formulate a plan for the PICU evaluation, diagnosis, monitoring and treatment.
4. Know the progression of the condition from presentation through improvement with an understanding of the potential acute and long-term consequences and complications of the disease and treatment.
5. Avoid unnecessary interventions and testing.
6. Consider psychosocial implications and interactions.
7. Describe principles of discharge planning.
8. Arrange for appropriate discharge follow-up and outpatient therapy.
9. Utilize medical information sciences to obtain current knowledge.

List of Common Conditions

1. General: Cardiopulmonary arrest, Acute life threatening event, submersion injury, systemic inflammatory response syndrome (SIRS), shock (cardiogenic, hypovolemic, distributive, obstructive), burns (thermal, electrical), common intoxications,

2. Pulmonary: Adult type respiratory distress syndrome (ARDS), respiratory failure/insufficiency, status asthmaticus, upper airway obstruction, foreign body, pneumonia/pneumonitis, bronchiolitis, pneumothorax, chest trauma (blunt, penetrating), severe pleural effusion

3. Cardiovascular: Dysrhythmias, myocarditis, congenital heart disease, cardiomyopathy, congestive heart failure, myocardial ischemia, hypertensive urgency, hypertensive emergency, pericardial effusion

4. Allergy/Immunology: Acute hypersensitivity reactions/drug allergies/anaphylaxis, complications of congenital immunodeficiency/acquired immunodeficiency (AIDS), complications of collagen-vascular and autoimmune disease

5. Fluids, electrolytes, metabolic: Severe dehydration/vascular volume depletion, diabetic ketoacidosis, syndrome of excess ADH secretion, diabetes insipidus, cerebral salt wasting, metabolic acidosis/alkalosis, severe electrolyte derangements, inborn errors of metabolism, failure to thrive

6. GI/Surgery: stress ulcer, acute upper or lower gastrointestinal bleeding, abdominal trauma (blunt, penetrating), bowel obstruction, perforated appendicitis, foreign body, acute hepatitis with encephalopathy, acute pancreatitis, inflammatory bowel disease

7. GU/Renal: Acute renal failure, end stage renal disease, hypertensive urgency, hypertensive emergency, renal tubular acidosis, lupus nephritis

8. Hematology/Oncology: Acute chest syndrome, splenic sequestration, idiopathic thrombocytopenic purpura, disseminated intravascular coagulopathy, tumor lysis syndrome, chemotherapy administration for various oncologic diagnoses, fever & neutropenia

9. Infectious Disease: Meningitis, sepsis, encephalitis, hospital acquired infection

10. **Neurology:** Status epilepticus, hypoxic ischemic encephalopathy, diffuse axonal injury, stroke, cerebral edema, increased intracranial pressure, shunt malfunction

11. **Pre- and post-op evaluation of surgical patients:**
    a. Demonstrate knowledge about available surgical resources.
    b. Demonstrate ability to evaluate patients and provide medical clearance with regard to risk of anesthesia, ASA status, and comorbidities that may complicate the procedure.
    c. Provide care for post-operative surgical patients with attention to monitoring for cardiopulmonary instability, fluid and electrolyte therapy, fever, bleeding, and other complications.
    d. Typical post-operative cases include:
        i. Scoliosis Repair
        ii. Tonsillectomy and Adenoidectomy
        iii. Appendectomy
        iv. Exploratory laparotomy
        v. Airway Repair
        vi. Cleft Palate Repair
        vii. Renal transplant
        viii. Nephrectomy
        ix. Hemodialysis catheter placement
        x. Peritoneal dialysis catheter placement

12. **Moderation/Deep Sedation:** The PICU team provides moderate and deep sedation for various procedures performed by other services. During your rotation you will learn how to:
    a. Work with subspecialty services to determine if the patient is fit to undergo the procedure given comorbidities, risks, etc.
    b. Evaluate a patient's level of illness using the ASA classification system
    c. Evaluate a patient's airway prior to administering sedative medications (malampatti classification, thyromental distance, craniofacial abnomralities, etc)
    d. Evaluate a patient's allergy and anesthesia history
    e. Evaluate a patient's NPO status prior to administering sedative medications
    f. Prepare the necessary equipment needed to perform the sedation, monitor the patient, and manage any emergencies/complications
    g. Determine which sedatives and analgesic medications are appropriate for various clinical scenarios
    h. Administer sedative medications
    i. Monitor patients who are sedated and undergoing a procedure and how to intervene to manage any complications

j. Evaluate a patient who has undergone moderate/deep sedation to determine if he/she is stable for discharge or transfer

PRACTICE-BASED LEARNING AND IMPROVEMENT: Residents must be able to use scientific methods and evidence to investigate, evaluate, and improve their patient care practices.

GOAL X: Performance Improvement. Residents will participate in the analysis of their own and other's practice experience and perform practice-based improvement activities using a systematic methodology.

Objectives:

1. The learner will analyze his/her practice experience to recognize one's strengths, deficiencies and limits in knowledge and expertise. He/she will use evaluations of performance provided by peers, patients, and superiors to improve practice. Residents are expected to acknowledge medical errors and develop mechanisms to prevent them.
2. Residents will be able to locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
3. Residents will obtain and use information about their own population of patients and the larger population from which their patients and families are drawn.
4. Knowledge of study design and statistical methods will be attained and applied to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
5. Information technology will be used to manage information, access on-line medical information and support their education in the course of the pediatric intensive care experience.
6. Residents will facilitate the learning of students, parents, families and other health care professionals.

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.

GOAL XI: Communication. Understand and appreciate the basic principles of effective communication with children and families.

OBJECTIVES:

1. Consider the following during communication with children and family:
    1. Learning style
    2. Developmental stage of patient and family
    3. Educational level of family
    4. Cultural, ethnic, socioeconomic issues
    5. Language barriers
    6. Hearing, vision, speech impairments
    7. Health and religious beliefs
    8. Personal factors
2. Non-verbal communication skills and cues
3. Need to negotiate effectively
4. Listen, avoid interruptions and allow for periods of silence
5. Demonstrate empathy, reassurance, encouragement and supportive communication
6. Respond non-defensively and non-judgmentally
7. Avoid medical jargon
8. Attend to privacy and confidentiality
9. Verify understanding
10. Create and sustain a therapeutically and ethically sound relationship with parents
11. Work effectively with others as a member of a health care team
12. Be able to act in a consultative role to other physicians and health care professionals
13. Utilize read backs and closed-loop communication to minimize errors that may occur due to miscommunication.

GOAL XII: Medical Records. Understand how to maintain accurate, organized, timely and legally appropriate medical records using the electronic medical record in the pediatric ICU setting.

OBJECTIVES:

1. Complete all aspects of the history & physical examination note for every admission
2. Complete daily progress notes that include
    1. Brief history and review of significant interval events
    2. Review of systems
    3. Vital signs and physical examination
    4. Laboratory, microbiology, and imaging studies that you have used to arrive as your assessment and plan
    5. The patient's primary and secondary diagnoses, and relevant past medical history
    6. A problem or systems based assessment and plan that includes a comprehensive and organized outline of the patient’s medical and psychosocial issues and the plans that have been discussed on rounds, which will address

each problem. Be sure that any abnormalities noted in the history, review of systems, physical examination, or ancillary studies are explained in your assessment and plan.
7. Document consultant recommendations and why you will or will not follow their recommendations
8. Document that the plans have been discussed with the family and any discussions that took place with the family, for example, multidisciplinary family meetings
9. Indicate that assessments and plans were discussed with the attending on service/call

3. Appropriately select those cases when more frequent than daily documentation is required, such a change in the patient's status
4. Review notes written by other providers and consultants.
5. Prepare appropriate and timely discharge summaries, transfer notes and off-service notes, including written communication with the primary care provider.
6. Avoid abbreviations

GOAL XIII: Teaching. Understand the methods for teaching parents, patients, and other members of the healthcare team.

OBJECTIVES: Use of different teaching methods to educate various individuals about critical illness

1. Reading textbooks and evidenced base literature to expand own fund of knowledge
2. Giving formal lectures to residents, medical students, and nurses
3. Informal teaching of the medical team on rounds pertaining to the best practices in managing critical conditions currently encountered in the PICU
4. Explaining procedures, diagnoses, indications for testing and monitoring, etc to parents without using medical jargon and through providing them reference material.

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. Residents must practice quality health care and advocate for patients in the health care system.

GOAL XIII: Patient Support and Advocacy. Understand how to provide sensitive support to patients and families of children with acute critical illness, and arrange for on-going support and/or preventive services at discharge.

OBJECTIVES:

1. Demonstrate awareness of the unique problems involved in the care of children with critical illness
2. Demonstrate the ability to work with other services to assist in managing the psychosocial aspects of critical illness such as social work, child life specialists, and child psychiatry for such patients.
3. Demonstrate respect, sensitivity and skill in dealing with death and dying with the child, family, and other health care professionals.
4. Demonstrate the ability to work with other service in managing end of life issues such as ethics, palliative care, and pastoral care.
5. Listen carefully to the concerns of families, and provide appropriate information and support.
6. Identify and attend to issues such as growth and nutrition, developmental stimulation and rehabilitation during hospitalizations.
7. Identify problems and risk factors in the child and the family even outside the scope of this PICU admission (e.g., immunizations, social risks, developmental delay) and appropriately intervene or refer
8. Contact outside agencies as appropriate (Poison Control, FDA, ACS, DOH, etc.)
9. Demonstrate sensitivity to family, cultural, ethnic, and community issues when assessing patients and making health care plans.
10. Demonstrate the ability to work with other services to facilitate the transition to home care or rehabilitation care, such as social work and case management.
11. Act as a patient advocate by seeking appropriate responses to address the needs of patients and families.
12. When there are competing options and/or other constraints on therapy, base decisions on the overall best interest of the whole patient, his/her functional status, and the family's needs and limitations.
13. Demonstrate the ability to incorporate these issues into your assessment and plan

GOAL XIV: Financial Issues and Cost Control. Understand key aspects of cost control, billing, and reimbursement in the PICU setting.

OBJECTIVES:

1. Demonstrate familiarity with the common mechanisms of PICU cost, including pre-authorization, concurrent review, and discharge planning.
2. Develop an awareness of costs of PICU care and its impact on families.
3. Practice cost-effective health care and resource allocation that does not compromise quality of care
4. Practice appropriate utilization of consultants and other resources.
5. Show concern for financial circumstances of the patient and refer for social service support as needed.
6. Know approximate costs of hospital care, devices, medications, supplies

7. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs, assuring quality and allocating resources.

PROFESSIONALISM: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a patient population.
Diverse

GOAL XV: Personal Attitude. Understand the need to function professionally and responsibly.

OBJECTIVES:

1. Accept responsibility for patient care and continuity of care.
2. Demonstrate respect, honesty, integrity compassion, and empathy.
3. Be responsive to the needs of patients and society that supersedes self-interest.
4. Be accountable to patients, society, and the profession.
5. Demonstrate a commitment to excellence and on-going professional development.
6. Respect patient and family privacy and autonomy.
7. Demonstrate high standards of ethical behavior with a commitment to ethical principles pertaining to clinical care, confidentiality, informed consent, and business practices.
8. Demonstrate sensitivity and responsiveness to patients'/families' and colleagues' culture, gender, age, disabilities, ethnicity, sexual orientation.
9. Recognizes hierarchal authority.
10. Effectively balance common sense, clinical impressions, anecdotal information and intuition.
11. Respect the roles of and interact well with peers, faculty, nursing and other health care providers.
12. Function well as a member of the healthcare team.
13. Accepts feedback, suggestions and criticisms; acknowledges mistakes and makes every effort to correct.
14. Feels competent but accurately acknowledges appropriate limits of ability, skills and knowledge.
15. Recognize limits of tolerance for stress and ask for help as needed.
16. Seeks assistance when needed and not when unnecessary.
17. Accepts responsibility for own education and professional development.
18. Demonstrates initiative and interest in self-directed learning.
19. Behave in a reliable, dependable, trustworthy and responsible manner.
20. Is punctual and completes all duties and responsibilities in a timely manner, and is readily available and willing to participate in all clinical and educational activities.

Suggested Reading

Mejia RM, Fields A, Greenwald BM, Stein F. *Pediatric Fundamental Critical Care Support Manual.* Society of Critical Care Medicine.

SICU

Meeting Place: SICU D3

Contact Number: (718) 245-4522/3982

Dr. Michelle Feinberg- feinberm3@nychhc.org

PD Liaison: Dr. Pam Janairo

Daily Rounds: 6:30 am daily

Schedule: Contact Dr. Boudourakis, Leon.Boudourakis@nychhc.org. The on-call schedule is made by the Department of Surgery PGY3. EM residents will have similar call responsibilities as surgical residents

Residents will NOT be required to attend the weekly ED educational conferences

Educational Objectives:

The purpose of this rotation is to provide residents with the knowledge and skills necessary to care for critically ill and complex surgical patients. PGY-2 Emergency Medicine Residents will spend four weeks in the SICU at Kings County Hospital. The Emergency Medicine PGY-2 resident will function as PGY-2 Surgical Residents. They will have critical care patient responsibilities under the direct supervision of a PGY-3 general surgery resident and general surgery/trauma/critical care attending physicians. While on rotation they will attend daily patient care work rounds and attend daily educational rounds.

At the completion of this rotation, the Resident will demonstrate competence in and will be able to:

• Perform initial ICU assessment of critically ill and injured patients using history and physical examinations

• Understand the indication for invasive monitoring and its goals and complications

• Master the principles of shock resuscitation especially as defined by oxygen transport parameters

• Understand the indications, dosing and complications of inotropes, vasopressors, preload reducing agents, and afterload reducing agents

• Understand the indications for, dosing and complications of paralytics, sedatives and analgesics

• Understand the proposed mechanisms of multiple organ failure including mediators of the inflammatory response and therapies designed to modulate this response

• Understand the modifications necessary in resuscitation of patients with severe head injuries

• Master a variety of positive pressure ventilator modes, including initiation, maintenance and weaning of ventilator support. Understand mechanism and management of pulmonary pathology including but now limited to ALI, ARDS

• Understand and manage complications of massive transfusion, including TRALI and TACO

• Understand the indications for and use of enteral and parenteral nutritional support

• Identify the signs and symptoms of early sepsis and the work-up necessary for full investigation

• Understand the rationale for antibiotic use in the Intensive Care unit: prophylactic and therapeutic

• Assess renal function in critical illness, including the use of creatinine clearance, free water clearance and fractional excretion of sodium as diagnostic tools
• Understand indications for and management of renal replacement therapy
• Understand the evaluation of hepatic function in critical illness
• Manage life threatening gastrointestinal bleeding
• Manage drainage tubes
• Understand the mechanism and treatment of common coagulopathies associated with organ failure in critical illness
• Compassionately interact with patients and their families during the stress of illness and death, including management of end of life issues, palliative care and the ability to obtain DNR orders

Description of clinical experiences:

Residents demonstrate competence in the following procedures on this rotation:
• Cardiopulmonary resuscitation
• Airway management and endotracheal intubation (nasal and oral)
• Management of ICP monitors and ventricular drains
• Placement and care of central venous catheters
• Placement and care of arterial catheters in all sites
• Placement and care of pulmonary artery catheters
• Utilization of oxygen delivery devices and mechanical ventilators
• Lumbar puncture
• Obtaining cultures from all sites and tissues
• Placement of enteral feeding tubes
• Arterial blood gas sampling and analysis
• Abdominal paracentesis
• Thoracentesis
• Tube thoracostomy
• Placement of esophageal/gastric balloons
• Assisting in performance of peritoneal dialysis and continuous A-V hemofiltration
• Assisting in endoscopic examination of the upper and lower GI tracts
• Assisting in bedside percutaneous tracheostomy

Description of didactic experiences:

The residents will attend daily, weekly and monthly surgical/critical care/ trauma conferences.
The following topics should be covered in the resident's reading during this rotation:
• Airway management• Interpretation of invasive monitoring
• ACLS• ARDS
• Mechanical ventilation• High frequency ventilation
• Post-operative management• Wound management
• Pneumonia• A-V hemofiltration
• Blood product usage• Super-infection
• Broad-spectrum antibiotics• Acute renal failure
• Hemodialysis/peritoneal dialysis• Gastrointestinal hemorrhage
• Intracerebral bleeding/CVA• Hepatic encephalopathy
• Shock• Sepsis

• Uremic encephalopathy• Anticoagulant therapy
• Pulmonary embolism• Coma/brain death examination
• Cardiogenic pulmonary edema• Dysrhythmias
• Fever• Acid base derangements
• Electrolyte abnormalities• Nutrition: parenteral and enteral
• Disseminated intravascular coagulation• Hemolysis
• Sedation• Drug induced paralysis

Core Competencies addressed in this rotation

Patient Care

• Mastering surgical resuscitation.
• Experience with longitudinal care of the trauma patient
• Experience with the complications of severe fractures
• Experience with the complications of severe thorax injuries
• Experience with the complications of severe vascular injuries
• Experience with the complications of severe head injuries
• Experience with the complications of multi-organ dysfunction
• Experience with the complications of respiratory failure
• Post-operative care of the critical patient
• Ventilator Management

Medical Knowledge

• Learning and avoiding common errors in surgical critical care
• Gaining an understanding of the unique issues pertinent to surgical patients
• Gaining an understanding of the unique issues pertinent to post-op patients
• Pain control strategies
• Cognitive mastery of emergent trauma care
• Ventilator weaning protocols and procedures

Interpersonal and Communication Skills

• Working with surgical, trauma, orthopedic, ENT, OMFS, nutrition, rehab, neurosurgical and medical professionals
• Working with respiratory, Social Services, PT ancillary services
• Integration into an ICU team with critical injuries
• Patient/family communication and comfort
• Presenting critically ill patients to members of ICU and consulting teams

Professionalism

• Integration into an surgical critical care team
• Pain Management

Systems-Based practice

• Integration into the ancillary services of Social Services, discharge planning, utilization review, OT and PT.
• Admission and transfer criteria for critical surgical patients

Practice Based Learning and Improvement

• Participate in CQI system of surgical department
• Participate in trauma/surgical M&M case conferences

- Maintain resident portfolio

NEUROLOGY

Meeting place: Kings County Hospital. D2s Conference Room
Contact: Neurology Chief: downstate.neurology@gmail.com
Daily Rounds: 6:45 AM
Faculty Contact: Dr. Jonathan Perk 917-664-6575 Jonathan.Perk@downstate.edu
EM Faculty Liaison: Dr. Pam Janairo
Responsibilities: Full participation in the Neurology service at KCH, including:
• Patient care under the direction of the Neurology Senior resident and Attending Staff
• Resident rounds at 7 AM Monday - Sunday
• All conferences and educational activities required for neurology residents
Educational Objectives:
PGY-2 Emergency Medicine Residents will rotate for one week on Neurology Consult service (with assigned call) at KCHC and one week in the Neuro ICU (with assigned call). Prior to the start of the rotation you must complete the NIHSS training at the link below and forward your certificate to the stroke clinical coordinator.
This the link for the NIHSS:
https://secure.trainingcampus.net/uas/modules/trees/windex.aspx?rx=nihss-english.trainingcampus.net
Stroke clinical coordinator Yelena Ilyasova (Yelena.Ilyasova@nychhc.org)

They should be there at 7AM every day except for Wednesdays. On Wednesdays they are to show up for the regular EM conference at Kings County Hospital at 7 AM, but are expected to report Wednesday afternoon to resume usual duties. Residents should be prepared with their pager, a white coat and reflex hammer. Residents should expect to be involved in neurology presentations and didactics while they are on service usually with an EM focus in mind.
Contact the chief resident at least one month in advance for schedule requests and expect your schedule to be finalized a week before the rotation starts. You should not expect a full weekend off but requests off will be most likely to be granted if within reason.
At the completion of this rotation the resident will demonstrate competence in the following concepts:
• Performance of a comprehensive neurologic history and physical exam. (MK,PC)
• Development of an integrated problem list for patients, including detailed differential diagnoses. (MK,PC)
• Learn to localize neurological lesions in the CNS after performing a comprehensive neurological history and physical examination. (MK,PC)
• Management of stroke; ischemic and hemorrhagic. (MK,PC)
• Basic understanding of the principles of Neuro-critical Care (MK,PC)
• Evaluation and treatment of the Transient Ischemic Attack. (MK,PC)
• Basic Head CT and MRI interpretation. (MK,PC)
• Development of the Doctor-Patient relationship as the resident interacts with patients and their families during the stress of illness and death. (PC,C,P)
Description of clinical experiences:
Residents should demonstrate competence in the following procedures on this rotation:
Lumbar puncture

Description of didactic experiences:

The following topics should be covered in the resident's reading during this rotation:

- Stroke etiology, evaluation, and management
- Ischemic stroke
- Thrombolysis in Stroke
- Transient ischemic attack
- Angiography and endovascular treatment in stroke
- Intracerebral hemorrhage
- Subarachnoid hemorrhage
- Cerebral aneurysm
- Arteriovenous malformation

Neurologic emergencies:

- Status epilepticus
- Cord compression
- Infections (meningitis, encephalitis).
- Approach to headache
- Myasthenic crisis
- GBS
- Bell's palsy

EMERGENCY ORTHOPEDICS/FAST TRACK

Contact- Dr. Joel Gernsheimer 917-750-1145, gernsh@gmail.com

Orthopedics is a major component of the daily cases seen by Emergency Medicine physicians. The goal of this rotation is to increase orthopedic exposure to the emergency medicine residents so that they feel comfortable managing various orthopedic emergencies. The other goal of this Orthopedic / Fast Track Rotation is to be able to evaluate and manage patients with all types of minor emergencies. All necessary information and materials for both parts of the rotation will be given to the EM resident prior to starting this rotation by Dr.Gernsheimer.

The rotation is 4 weeks spent in the fast track emergency department at Kings County Hospital. Two weeks will be spent on the Orthopedic Rotation and two weeks will be spent on the Fast Track Rotation. When there are 2 EM Residents or both an EM & an EM / IM Resident on this Rotation at the same time, the schedule will be made so that one resident will be on Ortho and one on the Fast Track Rotation, and then for the next two weeks the residents will “flip their assignments” with the Ortho Resident switching to the Fast Track Rotation, and the Fast Track Resident switching to the Ortho Rotation. We will try as much as possible not to schedule more than one Resident on the Ortho Rotation at the same time.

Orthopedics

During this part of the rotations the resident is to evaluate as many orthopedic emergency cases as possible that come through the emergency department. The resident will be based in the Fast Track Area. The residents are allowed to “cherry pick” orthopedic cases from the “White Board” of the Fast Track Area. If there are no traumatic orthopedic injuries on the “Board”, then the resident will see patients with non-traumatic musculoskeletal complaints. If there are no orthopedic type cases at all in the Fast Track Area, then the resident will see cases that involve procedures, such as suturing and incising & draining abscesses. If there are none of any of the above type cases, then the resident will see “regular fast track cases”. When orthopedic cases are identified in the main Adult ED, the Pediatric ED, CCT, or Fast track by other ED attendings or residents, the EM orthopedic resident will be paged to those areas to see these patients. The EM orthopedic Resident should also pick up orthopedic cases by perusing the White Boards in all the ED areas. If a patient in any of the ED areas has a simple, straight forward purely orthopedic problem then the EM Ortho Resident can see the patient as the primary ED physician, including writing up the chart. However, if the patient is more complicated, such as a multiple trauma patient or a patient with syncope who sustained a fracture, then the EM Ortho Resident should be consulted to help manage the patient, but not to be the primary physician or write up the chart for that patient. There is an orthopedic pager (917-219-1976) – pick it up from Dr. Gernsheimer. The EM Orthopedic Resident should post his or her name and the Pager Number and/or a texting number in all the ED areas at KCH, so that she or he can be called if there is an Ortho case that the attending or resident in the other ED areas want our EM Ortho Residents to see. When paged to any of the ED areas, the ED Ortho Resident should go to that area. As noted above, when working in the Fast Track area, if there are no orthopedic trauma cases, such as fractures or sprains, the resident should see musculoskeletal cases. If there are no orthopedic or musculoskeletal cases, the resident should see regular fast track cases, but especially cases involving performing minor procedures.

The Resident on the Ortho Rotation must let his/her supervising Attending in Fast Track know where he or she is when doing consults or working in another ED area.

Log Sheets

The EM Resident on the Ortho Rotation should record important cases and procedures on the Ortho Patient Log Sheets. A copy of these sheets should be handed in to Dr. Gernsheimer at the end of the

Orthopedic Rotation. Dr. Gernsheimer will send a blank Ortho Log Sheet to the Resident just before the start of his/her Ortho Rotation, and the resident can make as many copies of this sheet as needed. The Resident should log all required procedures on her/her procedure log in New Innovations.

Consults

If an orthopedic case requires surgical intervention, admission, additional assistance, or is beyond the scope or comfort of the Emergency Medicine attending, the orthopedic consult resident should be called. When possible the EM resident on the Ortho Rotation should be consulted first, and then be the one calling the orthopedic resident for the consult, so that our EM Resident can learn from the orthopedist, and assist him with any procedures. This applies to all ED areas, including the Pediatric ED, where the EM Resident on the Ortho Rotation should serve as a liaison with the Orthopedics service.

Orthopedics Morning Report

On days when the emergency medicine resident on the Ortho Rotation is scheduled to work starting at 6:30 am (the first Monday and Tuesday of the Rotation), the resident is expected to go to the Orthopedics morning report and orthopedic surgery resident rounds to go over the patients that were formally consulted the previous day. Be prepared to answer questions. These rounds and morning reports are held every weekday morning starting at 6:30 am on the third floor of the C Building at KCH. This is a good way for our EM residents to get to know the orthopedics residents, so that they will work more closely with our residents when they are called to the ED to do consults.

Schedule

The resident work schedule is usually the following:

On the first Monday and Tuesday of the Rotation 6:30 am-4:30 pm: Morning report is at 6:30 am on the third floor of the C Building and you are required to be there. After Ortho Morning Report the resident should report to the Fast Track ED at KCH. The Resident should see Ortho patients in all the ED areas at KCH, but the Fast Track should serve as his/her base of operations.

On the 2nd Monday and Tuesday of the Rotation: 11 am to 9 PM: Seeing orthopedic patients in the KCH Fast Track and the other ED areas.

Please note that sometimes on Tuesdays Dr. Walter Valesky, who in addition to being trained in EM is also trained in Sports Medicine and Ultrasound, is the attending in the Fast Track Area. Dr. Valesky will teach the EM Residents how to evaluate and treat many common orthopedic problems, including traumatic and non-traumatic illnesses. The EM Residents on the Ortho Rotation should try to spend as much time as possible with Dr. Valesky when he is working in the ED.

Thursdays 9a – 7p: The resident will spend the morning from 9-12 in the Ortho Follow-up Clinic (which is held on the 8th floor of the E Building) with the Sports Medicine Attending and will return to FT by 1:00 pm to see orthopedic patients in the FT and other ED areas as usual.

Friday 11a - 9p: The EM resident will see Orthopedic patients in the Fast Track and other ED areas

The Resident on the Ortho Rotation should also Contact Dr. Willis, who will assign the Resident todo a special Ortho Project.

On Wednesdays the residents on the Ortho Rotation and on the Fast Track Rotation will attend the morning conferences and any other academic activities they are assigned to for that day, such as Board Review or Simulations, and then they will be free to read. The EM/IM residents assigned to Ortho and Fast Track will attend their Primary Care Clinics in the afternoon.

On the second Wednesday of the month from 2 PM – 4 PM, there is a Mid-Level Provider Conference held in our Main EM Conference Room, and I am requiring the Categorical EM Residents to attend this conference.

Please note that the schedule for the Resident on Ortho noted above is only a basic schedule that may have to be changed by Dr. Levine in order to insure that our Residents are always supervised by an EM Boarded/Eligible Physician, and that there is appropriate coverage for patient care in the KCH Fast Track Area. Therefore, when the monthly schedule comes out, the Resident is expected to check his or her final schedule, which may vary from the basic schedule noted above.

Also, special schedule requests must be submitted to Dr. Levine at least 4 weeks prior to starting the rotation. Please note that residents on the Ortho Rotation are discouraged from asking to be off on Tuesdays, because they will miss the opportunity to work with Dr. Valesky, and to be off on Thursdays, as they will miss the opportunity to work in the Ortho Follow up Clinic.

Changes in the above schedule must be approved by Dr. Jeffrey Levine, the Director of KCH Fast Track: e-mail:JTL8499@aol.com and Dr. Gernsheimer

Supervision: When working in the Fast Track Area, the EM Residents should be supervised by an EM Boarded/Eligible Physician. When seeing Ortho patients in the other areas, the EM Residents should be supervised by an EM Boarded/Eligible Attending or PEM Attending.

Contact Dr. Gernsheimer prior to the start of your rotation – gernsh@aol.com, cell – 917-750-1145.

The orthopedic pager – 917-219-1976 will be carried by the EM Resident on the Ortho part of the rotation and this number should be posted in all the ED areas, so that the resident can be called for Ortho Consults if needed. In addition the EM Resident on Ortho can also let the EM physicians in all the KCH ED areas, the best way to reach her or him, for example by texting.

Prior to starting this rotation, Dr. Gernsheimer will supply you with important information regarding this rotation including: your specific schedule, a syllabus, a special orthopedics curriculum written by Dr. Valesky for this rotation, a summary of this section from the Hand Book, the Ortho Patient Log, the Ortho Pager, the Ortho Exam and a copy of the Emergency Orthopedics Text by Simon.

Orthopedic Examination Required Reading

1. General Principles of Orthopedic Injuries (from Rosen's) – You can access this online from our library.
2. Ankle and Foot – (from Rosen's). – you can access this online from our library
3. Injury to the Hand and Digits – Tintinalli p1665-1674
4. Wrist Injuries – Tintinalli p 1674-1684
5. Injuries to the Shoulder Complex and Humerus – Tintinalli p1695-1702
6. Knee Injuries – Tintinalli p1726-1734
7. Leg Injuries – Tintinalli p1734-1736
8. **** Emergency Orthopedics by Robert Simon. I will provide a copy for you to use while you are on the Ortho part of the rotation. It is also available online from our library. It is my favorite Emergency Ortho Text, and I encourage you to carry it with you and take it home.
9. Dr. Valesky strongly recommends that you also use the Ortho Bullets Web Site!
10. Also Dr. Gernsheimer will send out some excellent articles on specific orthopedic emergencies from the Emergency Medicine Clinics of North America to you at the beginning of the rotation.

11. On the 2nd shelf above the computers near the Fast Track Holding Room, there are copies of the Emergency Orthopedics Book by Simon, a Fracture Book from EMRA, an Orthopedics Anatomy Book and the Minor Emergencies Book for the use of the Residents.
The residents on the Ortho Rotation will be given an open book Emergency Orthopedics examination attached to the Orthopedics Orientation Email. The exam will consist of multiple-choice questions and five essays. The essays will consist of interpretation of orthopedic x-rays, including injury complications, correct orthopedic fracture nomenclature and management of these various injuries.The Resident is expected to send the completed exam by the end of the Rotation to Dr. Gernsheimer, who will then send the Resident the Answer Key.
Part of your "final examination" in orthopedics will be to turn in your Orthopedics patient log to Dr. Gernsheimer. The log should include the important cases that you have seen, the procedures that you did, and interesting x-rays that you saw. "Required procedures" should also be logged on New Innovations.

Fast Track
During this two-week period of the rotation, the assigned resident will work in Fast Track and see Fast Track cases from the Fast Track Epic Board. They will not go to do consults in the other ED areas.The resident can also be given the call back list by Dr. Levine and will be responsible for contacting patients on the list. We would like the residents to try to do as many minor procedures as possible, and log these procedures in the usual manner on New Innovations. Therefore, if the resident becomes aware of a minor procedure, for example a laceration, the resident should try to sign up for that patient. While on the FT Rotation, we want the resident to get very confident and competent in managing all types of minor emergencies.
Supervision:
While on this part of the Rotation the EM Resident will be supervised by EM Boarded/Eligible Attending Physicians in the KCH Fast Track Area.
Schedule:
The preliminary schedule will usually be:
Mondays, Tuesdays, Thursdays and Fridays: 11 am - 9 pm
The Resident on the FT Rotation will be given one shift to work on a weekend day during the 2 week Rotation by Dr. Levine. If you have a special request as to which weekend day to work or not to work, you need to contact Dr. Levine at least 4 weeks prior to starting the Rotation.
Wednesday – Morning Conferences from 8a – 12 noon, and then any academic activities that the resident has been assigned to. On the 2nd Wednesday of the month this resident will attend the Mid- Level Provider Conference from 2 PM – 4 PM.
PLEASE NOTE: Dr. Levine may have to adjust this schedule to insure that the FT Resident is always with an Emergency Medicine Boarded Attending. Therefore, the schedule shown above is only a basic schedule which may need to be adjusted by Dr. Levine, and the resident is expected to check and comply with the actual schedule that is sent out prior to starting the rotation.
Special Schedule requests must be made to Dr. Levine at least 4 weeks prior to starting the rotation. Once the schedule is made, you are expected to read it carefully and follow it. Please note that when the Resident is on the Fast Track Rotation, she or he is discouraged from asking to be off on Fridays, as that is the day that the Resident has the opportunity to work with Dr. Gernsheimer.
Also the following applies to both the Fast Track and Ortho Parts of the Rotation:, if you are ill and cannot come in or you have an emergency or if you are going to be late, you must call Dr.

Levine at 516-424-5383, and you should also call the Attending in the Fast Track 718-245-4610.

Reading:
While on the Fast Track Portion of this rotation, the resident is expected to read on all the different types of cases that she or he sees.
References:
1. Minor Emergencies by Philip Buttaravoli. Dr. Gernsheimer will supply you with a copy of this very practical text when you are on this part of the rotation. There is also a copy of this book on the shelf in the Fast Track Clinic.
2. Emergency Medicine: A Comprehensive Study Guide by Judith Tintinalli
3. Rosen's Emergency Medicine: Concepts and Clinical Practice by Peter Rosen
4. Clinical Procedures in Emergency Medicine by Roberts and Hedges.
The last 3 books on this list are available on-line via the Downstate Library.
Any questions or problems regarding the Orthopedic / Fast Track Rotation should be addressed to Dr. Gernsheimer and Dr. Levine at the contact information listed above..

PGY-3 OFF SERVICE ROTATIONS

EMS

Contact: Dale Garcia (917) 770-2080, Dale.Garcia@nyulangone.org
Mitch Powell Director Ambulance Services (718) 630-7133 mitchell.powell@nyulangone.org

Ambulance Department Policy and Procedure

Section: NYU-LMC-EMS Emergency Residency Observation Program Update: May 18, 2015

Welcome to the NYU -Brooklyn Medical Center EMS Department. It is a pleasure to have you at NYU- B and to offer you the unique experience of Pre-Hospital Care. As part of the NYU-B Emergency Department Residency Program you will be observing on board the 911 dispatched ambulances.

The NYU-B Ambulance Department provides Pre-Hospital Emergency Medical Services to the citizens of New York through the NYC 911 System. NYU-B Ambulances are staffed by certified Emergency Medical Technicians and Paramedics who are certified by the NYS DOH to provide emergency medical care to the sick and injured. NYU-B staffs both basic and advanced life support ambulances that respond to emergency medical calls 24 hours a day and seven days a week. EMT's and Paramedics are permitted to render care understanding order protocols set in place by NYSDOH and NYC REMSCO.

NYU-B Basic Life Support (BLS) Ambulances are dispatched to some of the following call types: Cardiac Arrest, Overdoses, Asthma, Trauma, Pedestrian Struck, Motor Vehicle Accidents, General Emergencies, OB/GYN, EDP Calls and (etc).

NYU-B Advanced Life Support (ALS) Ambulances are dispatched to higher priority call types such as: Cardiac Arrest, STEMI /AMI, Cardiac Symptoms, Respiratory Distress, Severe Asthma, COPD, CHF, Altered Mental Status, OB/GYN Complication, Unstable Trauma, Burns, Pain Management for Injuries and any time ACLS care is requested by BLS.

EMT and Paramedics will demonstrate the use and indications of EMS equipment on board the ambulance to the residents.

Protocols and equipment that will be demonstrated to the Residents:

- Airway management equipment (Oral & Nasal Airways, King Tubes, ET Tubes)
- AED and Cardiac Monitor / Defibrillators / STEMI Transmission Procedures
- Extrication equipment
- Weapons of Mass Destruction
- BLS Medications
- ACLS Medications
- Transport Procedures
- STEMI / Hypothermia Procedures
- On-Line Medical Control Contact
- Dispatch Criteria
- Specialty Referral Centers and criteria

Purpose of this Policy:

To set forth policy guidelines for EMT, Paramedic, and Clinical staff (Physicians, Residents, or Medical Students) that will observe as students onboard a NYU-B Medical Center Ambulance

Policy: The purpose of the policy is to ensure that all Residents comply with all regulations while on an NYU-B Ambulance.

Scheduling:

Contact Dale Garcia 2 weeks before your rotation to set a schedule. When enrolled in the residency program where mandatory ambulance rotations must be completed, it is the responsibility of the Emergency Department to pre-schedule the residents for rotations. Only one Resident per vehicle will be permitted to complete the rotation. If more than one Resident arrives, one must be moved to another unit or reschedule their shift.

Attendance:

On the day of rotations all Residents should arrive fifteen minutes prior to the start of their shift so that they can introduce themselves to the EMS crew. Security: To comply with all agreements with the FDNY and NYS Department of Health Bureau of EMS, identification must be worn. Any Resident on board an NYU-B-EMS Ambulance must wear a hospital ID card. Please do not bring any electronic equipment with you while on rotations. NYU-B will not be responsible for lost or stolen personal items.

Safety:

1. Residents are restricted from carrying patients at any time for their own safety.
2. Residents are not to be left alone with a patient at anytime.
3. All Residents must ride in the rear patient compartment with their seat belt on at all times.

Appropriate Dress:

While on rotations, all Residents are expected to be appropriately dressed according to Medical Center Standards. Residents are expected to be neat, clean, and presentable. Attire shall be consistent with the professional environment and image of NYU-B.

The following are guidelines that must be worn while on rotations:

➢ Black rubber soled shoes or Non-skid shoes. (No sneakers allowed). ➢ Navy / Black trouser pants ➢ A white shirt with no emblems (button down or golf style are acceptable). Ø Scrubs are prohibited ➢ No dangling jewelry

RESEARCH

Active participation in a research project is a requirement for all residents in the Department of Emergency Medicine. Residents will receive a two-week period during the second year of residency and a two-week period during the third year of residency dedicated to their research projects. These research periods will be assigned during an Emergency Department rotation at Kings County. In order for this time to be productive, it is extremely helpful to have a project planned BEFORE you begin the initial two-week period. The resources necessary to successfully complete your project, including statistical and administrative support will be provided by the department.

If the resident does not contact the research division at least 4 weeks prior to beginning the research rotation, the resident will be scheduled for shifts in the ED.

How to Start?

On the first Wednesday of every month, ongoing projects are reviewed and new research projects are presented during conference. This information is available on the ED website in the Research Update newsletter. The Research Update is also posted monthly on the research bulletin board outside of the conference room. All PGY II and III residents should contact Dr. Zehtabchi (shahriar.zehtabchi@downstate.edu) at least one month prior to the start of their research rotation to set up a project. Residents are strongly encouraged to start a new project, starting from literature search, study design, planning the logistic aspects of the project, etc. However, they may join projects already in development, and completing or helping to complete a research project of suitable quality for publication may fulfill the requirement. For authorship in a manuscript, residents need to meet the criteria outlined in the authorship policy that is published in the monthly research update.

CITI Certification

Residents are required to complete the CITI training on Social & Behavioral Investigators and Key Personnel modules by the end of your research block of PGY3. Please visit https://www.citiprogram.org to log-in to your account. To add the modules, register for SUNY - Downstate Medical Center and select Add Course ("Group 2: Social / Behavioral Investigators and Key Personnel"). A score of >75% is needed across the 15 modules. Please print both your Completion Report and Certificate and send it to the Research Chief by the end of your research block.

Didactic Research Lectures:

The first Wednesday of each month, the research division will have a one hour lecture dedicated to research methodology, biostatistics, and evidenced-based medicine. All residents and faculty are welcome to attend these lectures. The topics of these lectures are published at the beginning of each year in the annual research update handbook.

Research Office Hours:

Every Wednesday Dr. Sinert and Dr. Zehtabchi will be available in their offices (9 am to 4 pm) to meet with faculty and residents on research issues. Please contact them one week in advance to set up a time

How to Choose a Project:

The department of emergency medicine offers the residents research projects in a variety of emergency medicine fields. Residents are welcomed to start their own projects or to join the investigators of one of the active projects. The faculty and residents of the department of emergency medicine have conducted several research projects in the field of Trauma and Hemorrhagic Shock, Sickle cell Anemia, Toxicology, Evidenced-Based Medicine, and Medical Student/Resident Education.

Policy: Authorship and Contributorship

Byline Authors

An "author" is generally considered to be someone who has made substantive intellectual contributions to a published study, and biomedical authorship continues to have important academic, social, and financial implications. (1) In the past, readers were rarely provided with information about contributions to studies from those listed as authors and in acknowledgments. (2) Some journals now request and publish information about the contributions of each person named as having participated in a submitted study, at least for original research. Editors are strongly encouraged to develop and implement a contributorship policy, as well as a policy on identifying who is responsible for the integrity of the work as a whole.

While contributorship and guarantorship policies obviously remove much of the ambiguity surrounding contributions, it leaves unresolved the question of the quantity and quality of contribution that qualify for authorship. The International Committee of Medical Journal Editors has recommended the following criteria for authorship; these criteria are still appropriate for those journals that distinguish authors from other contributors.

• Authorship credit should be based on 1) substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; 2) drafting the article or revising it critically for important intellectual content; and 3) final approval of the version to be published. Authors should meet conditions 1, 2, and 3.

• When a large, multi-center group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript (3). These individuals should fully meet the criteria for authorship defined above and editors will ask these individuals to complete journal- specific author and conflict of interest disclosure forms. When submitting a group author manuscript, the corresponding author should clearly indicate the preferred citation and should clearly identify all individual authors as well as the group name. Journals will generally list other members of the group in the acknowledgments. The National Library of Medicine indexes the group name and the names of individuals the group has identified as being directly responsible for the manuscript.

• Acquisition of funding, collection of data, or general supervision of the research group, alone, does not justify authorship.

• All persons designated as authors should qualify for authorship, and all those who qualify should be listed.

• Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

Some journals now also request that one or more authors, referred to as "guarantors," be identified as the persons who take responsibility for the integrity of the work as a whole, from inception to published article, and publish that information.

Increasingly, authorship of multi-center trials is attributed to a group. All members of the group who are named as authors should fully meet the above criteria for authorship.
The order of authorship on the byline should be a joint decision of the co-authors. Authors should be prepared to explain the order in which authors are listed. .
For further information on this and other policies visit http://www.icmje.org.

Research Contact Numbers:

Dr. Richard Sinert:
Director of Research
Telephone extension 2973
E-mail: nephron1@gmail.com
Dr. Shahriar Zehtabchi
Associate Director of Research
E-mail: shahriar.zehtabchi@downstate.edu
Dr. Lorenzo Paladino
Assistant Director of Research
lorenzopaladino@yahoo.com

Scholarly Project

All emergency medicine and combined EM/IM residents are required to complete a scholarly project during the course of residency training. This project may take the form of a research project (clinical or lab), book chapter, or other scholarly activity. The research rotation in the 3rd year is a good time to complete this project, but it can be completed anytime during residency. **The project must be completed by May 15th of the 4th year for categorical EM residents or 5th year combined EM/IM residents. The resident must complete this project under the supervision of a faculty member. The scholarly project form below must be completed by the above date.**

There is a new electronic scholarly project form (Please see link below) to be completed when doing your scholarly project and will be approved by Dr. Willis.

New Scholarly Project Form

SENIOR EMERGENCY ULTRASOUND ROTATION

SENIOR EMERGENCY ULTRASOUND ROTATION

YEAR OF TRAINING: PGY 3
DURATION: 2 WEEKS
LOCATION: UHD and KCH ED

FACULTY LIAISONS:

Dr. Kelly Maurelus
Cell: 347-733-5710
Email: maurek01@gmail.com
Dr. Christopher Hanuscin
Cell: 818-590-2103
Email: chanusci@gmail.com

OBJECTIVES:

1. To understand basic physics and instrumentation of medical ultrasound equipment
2. To learn how to use the ultrasound systems available in KCH and UHD Emergency Departments
3.To review normal sonographic anatomy and pathophysiology of the thorax, abdomen and pelvis
4. To understand indications and limitations of bedside emergency ultrasound
5. To become proficient in core emergency ultrasound applications, as outlined by ACEP ultrasound guidelines

a. Extended Focused Assessment with Sonography in Trauma (E-FAST)
b. Focused Gynecologic and Obstetric Ultrasound
c. Abdominal Aortic Aneurysm (AAA)
d. Emergent Echocardiography and Hemodynamic Assessment
e. Focused Biliary Ultrasound
f. Focused Renal Ultrasound
g. Soft-tissue and Musculoskeletal Ultrasound Applications
h. Thoracic Ultrasound
i. Ocular Ultrasound
j. Bowel Ultrasound
k. Vascular Ultrasound
l. Ultrasound-guided Procedures

SCHEDULE:

Supervised scanning times may vary depending on the availability of ultrasound faculty, but residents are expected to scan in the department from 9 am – 4 pm daily, with the exception of Wednesday conference. Attendance at Wednesday Conference is mandatory. On

Thursday the residents will meet with a member of the ultrasound faculty for QA and tape review. Residents will have the weekend off.

Residents on rotation must e-mail Dr. Maurelus or Dr. Hanuscin prior to the start of their rotation for further information on the schedule and rotation expectations. **Any requests for changes in the schedule must be discussed with and approved by Dr. Bon PRIOR to the start of your rotation (catharine.bon@gmail.com). Residents will be expected to make up any missed scanning shifts by coming in on the weekend and scan from 9 am - 4 pm.**

ROTATION REQUIREMENTS:

Residents should report to the clinical area during their scanning shifts and perform any clinically indicated scans that may be needed in the ED. Findings should be discussed with the attending physician in charge. In addition to any clinically indicated scans, **residents should individually perform at minimum 6 FRAGEL examinations** (FAST, Renal, Aorta, Gallbladder, Echo and Lung) **during each scanning shift**. **If scanning as a group, then the group is expected to perform a minimum of 10 FRAGEL exams per scanning shift.** If a member of the ultrasound faculty is not present during any clinically indicated scans, studies should be reviewed with the attending staffing the case.

In addition to the requirement of FRAGELs, residents should perform a **minimum of 5 DVT, ocular and soft tissue/MSK scans** during the course of the rotation. This is to ensure that each resident meets the minimum graduation requirement (see below).

Required Scans: Residents will be required to fulfill approximately 200 scans during their rotation with a minimum of the following breakdown by examination type:

Echo – 25
FAST – 20
Gallbladder – 15
Renal – 15
Lung – 15
DVT - 5
Aorta – 10
Ocular – 5
MSK - 5

During their rotation, residents will be expected to take online quizzes and submit their results for evaluation. Quizzes are available at the following website:

- http://www.slredultrasound.com/quizzes.html (no login required)

Minimum required quizzes are based on the residents' PGY level and listed below. Scores of less than 75% will not be accepted.

PGY 3

Physics
DVT
Vascular/Procedure
Cardiac
Abscess Cellulitis
Lung
Biliary

Upon completion of the rotation, the resident will be evaluated based on his/her attendance, motivation, didactic knowledge, procedural skills, and test results. Residents who have not met the minimum requirements of the rotation, as decided by ultrasound faculty, will be required to participate in remediation. Residents will also be asked to evaluate the rotation and provide suggestions on areas of improvement.

Additionally, **all residents will be expected to give a mini-presentation** during one of the tape review sessions. Options for the presentation include the following:

- **Case follow-up:** Follow-up on one of the patients that you performed an ultrasound on to see how your ultrasound may have impacted the course of care for the patient and also to see if your findings correlate with what was ultimately found for the patient
- **Journal Club**: Present an article on a topic of interest related to ultrasound
- **Mini-lecture:** Give a 15-20 minute presentation on a topic of choice

Please be sure to discuss your plans for your presentation with the faculty in charge of tape review during your rotation.

Residents may be asked to participate in teaching sessions with medical students in lieu of scanning shifts.

EDUCATIONAL MATERIALS:

It is suggested that you review the following lectures at
http://emergencyultrasoundteaching.com/narrated_lectures.html

- Appendicitis/Small Bowel
- DVT
- Ocular

- Skin and Soft Tissue/MSK

All suggested reading materials are available online at http://www.sunykchsono.com/resource. All textbooks are available at the Downstate Medical Library and in on-line format. Certain textbooks are available in the ultrasound office and are available for use by the residents.

SELECTIVES

The Selective Rotation is a 2-week clinical rotation that is meant to augment the senior resident's clinical practice. The resident may select one of the below options in an area they feel more clinical exposure is needed. The resident must notify their Class Dean and Ms. Chelsea Cole one month in advance as to which Selective Rotation they are choosing. The resident is responsible for contacting the selected department, and arranging their schedule accordingly. The resident may choose the Selective Rotation during their Third Year or Fourth Year. The expectations for each rotation are listed. If a resident feels there is another selective opportunity they wish to pursue that is not outlined below, they may contact Dr. Willis and Dr. Hassel for approval. They must submit information about the desired selective, the contact information for the person from the department of interest, approval given by the department of interest, and the proposed schedule for the selective. Selectives should be conducted at one of the three associated hospitals (Kings, UHD, NYU Brooklyn) but in special circumstances may be considered in other NYC area hospitals if the main hospitals lack the desired departmental experience. Residents will still be expected to attend Wednesday's conference irrespective of the location of their rotation. **You must attend Wednesday Conference as usual during the Selective Rotation.**

AIRWAY
Location: KCHC **Contact:** Omotola Dawodu, OmotolaTemilolu@nychhc.org
EM Faculty Liaison: Dr. Hassel
Description of Rotation:
The resident will rotate through both pediatric and adult operating rooms at KCHC 5 days a week with the exception of Wednesday mornings when the resident will attend conference.
Goals and Objectives:
To gain experience managing difficult airways and learn advanced techniques in airway management under the supervision of Anesthesia senior residents and attendings.

Sports Medicine
Location: KCHC ED, E-Bldg, Parkside and Montague Clinics
Contact: Dr. Patrick Cleary Email: patrick.cleary@downstate.edu
EM Faculty Liaison: Dr. Hassel
Description of Rotation: The resident will spend Monday afternoons from 3-6 pm and Thursday mornings 8- 12 pm working with Dr. Cleary in his sports clinics. The rest of the week will be spent working with the orthopedics consult resident to gain experience managing orthopedic patients in the ED. The resident will attend Wednesday's conference.
Goals and Objectives: To gain better understanding of anatomy, orthopedic exams, and advanced skills in reduction, splinting, casting and joint injection.

OMFS
Location: KCHC Dental Clinic
Contact: Dr. Yusupov yuriy.yusupov@nychhc.org
EM Faculty Liaison: Dr. Hassel
Description of Rotation: The resident will spend 5 days a week, with the exception of Wednesday mornings when the resident will attend conference, in the dental clinic. This rotation is available from September – June.

Goals and Objectives: To gain experience evaluating and managing common dental conditions and procedures including:
Oral and dental anatomy Gingivostomatitis, Tooth replacement, Temporomandibular joint disorders, Plastics repair of lip lacerations, Suppurative parotitis, Odontogenic abscess I&D, Sialolithiasis, Local and regional block anesthesia techniques

OPHTHALMOLOGY
Location: KCHC Ophthalmology clinic
Contact: Dr Scott Email: wayne1966scott@yahoo.com or Saskia #718-245-2167
EM Faculty Liaison: Dr. Hassel
Description of Rotation: The resident will rotate through the ophthalmology clinic. Clinic schedule is Monday – Friday with the exception of the ophthalmology conference Thursday afternoon. Residents attend Wednesday conference. Rotation available from July 15-June 30.
Goals and Objectives:
The resident will demonstrate competence performing a slit lamp exam and in the evaluation and treatment of common ophthalmologic complaints.

ENT
Location: KCHC ENT Clinic
Contact: Nicole Fraser, Nicole.Fraser@downstate.edu
EM Faculty Liaison: Dr. Hassel
Description of Rotation: The resident will rotate for two weeks on the Otolaryngology service at Kings County Hospital. The EM Resident will function in the capacity of a junior Otolaryngology Resident. The resident will see patients in the clinic, in the operating room, as a consultant to the Emergency Department, on the general floors and in the critical care units of the hospital. The Resident will be under the direct supervision of an Otolaryngology Attending Physician and senior Otolaryngology residents. Residents can attend daily attending rounds, daily educational conferences, and weekly Otolaryngology Grand Rounds. The clinic schedule is from 1:00 pm to 4:00 pm every day except Thursday. The resident is expected to attend Wed conference.

Goals and Objectives:
To gain experience evaluating and managing common ENT complaints including trauma, infections, tracheostomy complications, acute and chronic hearing loss, salivary gland problems, etc. To become proficient with fiberoptic laryngoscopy.

PEDIATRICS
Location: KCHC & UHD
Contacts: Dr. Khan & Tejani
EM Faculty Liaison: Dr. Hassel
Description of Rotation: The resident will work 8, 8 hour shifts in the peds ED at either KCHC or UHD. The shift schedule will be at the discretion of the chief resident and director of the peds ED according to staffing needs. If there is no fellow during scheduled shifts the resident may act as a “pre-attending” at the discretion of the pediatric attending. The resident will be expected to attend the weekly peds conference on Fridays.
Goals and Objectives:
To gain additional experience evaluating and managing common pediatric emergencies and additional opportunities to direct pediatric resuscitations and perform procedures.

RADIOLOGY
Location: KCHC radiology department
Contact: Dr. Scott Email: jinel.scott@nychhc.org
EM Faculty Liaison: Dr. Hassel
Description of Rotation: Residents will review ED imaging with senior radiology residents and attendings Mon- Fri from 12 – 8pm. May not be available from November to June.
Goals and Objectives: To gain experience interpreting Emergency Department imaging studies.

PGY-4 OFF SERVICE ROTATIONS

ADMINISTRATION

UHD Faculty Director: Ninfa Mehta, MD, MPH Email: ninfa.mehta@downstate.edu / ninfa.mehta@gmail.com Cell Phone: (917) 642-6139, Dr Cynthia Benson, Cynthia.benson@downstate.edu, Cell Phone: (917) 940-0672

The Emergency Department (ED) plays an important role within the healthcare system. It is a dynamic, unpredictable and complex environment operating twenty-four hours per day. The ED requires unique knowledge and skills to ensure successful patient outcomes and to coordinate the multiple processes needed in a single patient encounter. In addition, the impact of hospital, financial, political and social forces add to the complexity of ensuring effective ED management. Residents need to be prepared for the realities of medical administrative practices and forces which will influence their future practice.

The administrative rotation will provide an innovative and rigorous curriculum focused on exposing the resident to common administrative tasks while building his/her leadership and managerial skills. During the rotation, the resident will become an active member of the ED management team and will work closely with ED administrators.

We aim to give you an overview of ED Admin to assist you in your future career as an ED physician.

Summary

- Overview/Structure
- Schedule
- Special Circumstances
- Absences/leave
- Reading List

Overview/Structure

We want you to have an overview of what ED admin does and sees as well as a basic view of the back end of emergency medicine for after residency. Your learning/activities will be broadly divided into 4 categories: Quality/Process improvement, Risk management/Medicolegal, Coding/Billing/Documentation, and ED Operations.

Two weeks prior to your rotation, please email Dr. Mehta, Dr. Benson and Dr. Youssef to let them know that you will be starting the rotation.

On the first day of your rotation, you will meet with Dr. Mehta and Dr. Benson to go over your schedule for the 2 weeks.

Quality/Process Improvement

Requirements:

- *IHI basic certificate*
- *QI project proposal*

The IHI Open School offers online training and certification in quality, patient safety and leadership. If not completed previously, residents must have all training completed by the end of their admin rotation. The certificates should be submitted to Chelsea Cole.

All residents in ACGME accredited residency programs are required to actively participate in emergency department continuous performance quality improvement programs. Residents must demonstrate evidence of development, implementation, and assessment of a project to improve care. This project may include but is not limited to the development of a clinical pathway, a patient satisfaction survey, or improvement of a recognized problem area. To

ensure satisfaction of this requirement, all residents must complete the "Quality Improvement Project Form" which consists of two parts. Interns during the 2nd ½ of the year are required to meet with Dr Mehta or Dr Youssef to discuss their quality projects. They will be required to fill out the quality project proposal by the end of 2nd year which needs to be signed off by one of the administration rotation attendings. The second part requires that the resident complete their QI project by the end of their Administration rotation in their PGY4 year for categorical EM residents or PGY5 year for EM/IM residents.

Risk Management/Medicolegal

Requirements:
Attend RCAs
Prepare/present peer review case

Law has a significant influence on the practice of emergency medicine. In addition to diagnosing patients correctly, physicians must be knowledgeable of the complex legal and regulatory systems that govern medicine.

Root Cause Analysis [Text Wrapping Break]Root Cause Analysis (RCA) is a structured method used to analyze serious adverse events. It is a retrospective method widely used as an error analysis tool in health care. Main focus is to identify underlying problems that increase the likelihood of errors while avoiding focusing on mistakes by individuals. Residents will have the opportunity to observe the RCA process in KCH and/or UHD. In an ED related RCA the resident may be asked to research the case and/or supporting evidence based medicine. The resident will be notified of the date, time and place of RCAs as they occur during their rotation. If there is no RCA during the time of your rotation but you are interested in attending one, please let Dr. Mehta know and you will be placed on a mailing list.

Peer Reviews
Peer reviews are a method used to analyze cases brought up by peers and evaluate performance on a given case in an anonymous platform. Cases are prepared and presented in short form to a group of faculty and residents and are subsequently graded on how closely they meet standard of care. If the peer review falls during your rotation and you are comfortable presenting, you will be given a case by Dr. Benson to review and present to the group.

Coding/Billing/Documentation

Requirement:
Review 5 insurance denials either at UHD or KCH
LogixHealth Modules

Medical billing and coding are important facets to the healthcare industry and based on physician documentation. Proper medical coding and billing is important on many levels, from ensuring accurate payment for physicians to creating a valid
record of patient care history. There will be an online learning module through logixhealth (our coding company) that can be done online during the administration rotation.

ED Operations

Requirements:

- *Reading: Chapters 1-5 of EMRA Advocacy Handbook:*
    - *https://www.emra.org/books/advocacy-handbook/advhbook-toc/*

Schedule

At the beginning of the rotation, you will receive any RCAs, M&Ms, Healthcare Quality Council, or additional meetings you will need to attend. If you are required to assist with interviews, this takes priority over any meetings listed below.

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1	nterviews ED Clinical eadership Meeting KCH pm - Mortality neeting UHD	JHD Clinical eadership Meeting pm: KCH QA/PI neeting nsurance Denials	CONFERENCE PM - Faculty Meeting f applicable)	nterviews :15AM: ED Operations UHD	ogix Modules Reading EMRA nodules
Week 2	nterviews ED Clinical eadership Meeting KCH pm - Mortality neeting UHD	JHD Clinical eadership Meeting pm: KCH QA/PI neeting nsurance Denials	CONFERENCE PM - Peer Review Meeting (if applicable)	nterviews :15AM: ED Operations UHD	Work on Quality mprovement Project

Absences/leave

Inform Dr. Benson and Dr. Mehta right away if you anticipate needing to miss any rotation activities during your block. REASONABLE requests for leaves made in a timely fashion will be considered but are NOT guaranteed.

Professional courtesy is a requirement of this rotation like any other; you must ask and receive permission prior to making any arrangements. Please note that you would need approval by the UHD admin team for any leave.

Reading List (suggested)

The Five Dysfunctions of a Team by Patrick Lencioni
Drive by Dan Pink
Patients Come Second by Paul Spiegelman
Emotional Intelligence by Daniel Goleman
Leadership That Gets Results by Daniel Goleman

TOXICOLOGY

EM Faculty Liaison: Dr. Sage Wiener
Location:
NYU/Bellevue Hospital Center

New York City Poison Control Center
Schedule: Weekdays: 8:15 AM - 4:00 PM
Contact: Dr. Rana Biary, Director, Fellowship in Medical Toxicology
Catherine Castro- ccastro2@health.nyc.gov
Tel: (212) 447-8150 or (212)-263-3293

Description and Goals of Rotation:

The rotation at the New York Poison Control Center (NYCPCC) is your opportunity to exclusively focus on medical toxicology. During the rotation you should make an effort to become familiar with general approaches to the poisoned patient and clinical presentations of common toxidromes. You should also develop a basic understanding of poison prevention techniques, pharmacokinetics, toxicokinetics, resuscitation of the poisoned patient and commonly used antidotes.

Meeting Place:

8:15 AM in the Bellevue Hospital Emergency Department conference room for morning report. After morning report, residents should go to the New York City Department of Health/NYCPCC ground floor conference room. The address is 455 1st Avenue (corner of 26th Street). Check in with one of the toxicology fellows upon arrival.

Special Considerations:

1) Attendance at the Bellevue Department of Emergency Medicine Morning Report is mandatory.
2) The morning will be spent doing follow-up calls and the afternoon generally is dedicated to didactic teaching rounds.
3) All residents rotating at the poison center are required to present a topic (project) that interests them by the end of their rotation. When deciding on a presentation topic, , discussion with one of the toxicology fellows is imperative so that you may be properly focused. The talk should be designed to educate the group (toxicology attendings, fellows, residents and medical students) and attempt to answer a question that has been raised regarding a specific clinical case. The talk should be at most 10 minutes in length. A handout may be helpful but a formal PowerPoint slide presentation is excessive.
4) Once a month, there will be a Consultants' Conference meeting scheduled on the first Thursday at 2:00 PM. It is usually held in the ground floor auditorium of the Department of Health building where the poison control center is located. You are welcome to continue going to these conferences during other blocks if you are free, and you can get two hours of asynchronous learning credit if you do this (note that you do NOT get asynchronous credit for attending the conference while you are on your toxicology rotation, since it is a basic requirement of the rotation). Attending extra conferences during other blocks is an especially good idea if you are considering applying for a toxicology fellowship.
5) Take advantage of your time at the NYCPCC as other physicians from all over the United States and other countries come to New York City to participate in the elective. This is not the month to "blow off" days. Be on time and actively participate in toxicology rounds.
6) Residents are required to attend weekly KCH Wednesday Emergency Medicine Departmental Conference

ELECTIVES

EM Faculty Liaison: Dr. James Hassel

The elective rotation is an opportunity for residents in their final years of training to gain experience in an aspect of Emergency Medicine that is not part of our formal residency curriculum or in-depth study of a field of EM. In very general terms, the goal of the rotation is for the resident to strengthen an area of clinical weakness or to learn more about one of the subspecialty areas of Emergency Medicine.

General guidelines used for elective approval include something that is an adjunct to EM training, to build a niche or should have a deliverable

You are responsible for setting up your own elective.

Rotations away from SUNY Downstate are acceptable (for now) but require planning on your part.

Any away elective must be approved and coordinated through the GME office. See the instructions and form below.

Any elective away from Downstate needs to be applied for at least three months in advance. You need to obtain an Away Elective Planner/ Worksheet from the residency coordinator.

Possibilities for outside rotations include Hyperbarics, Radiology, Burn Unit, Ultrasound training, International Emergency Medicine (Brazil, South Africa, Lesotho, Mexico, Nepal, Sweden, Haiti, Malawi, Botswana, Jamaica, Turkey, Romania and others), Research, Rural Emergency Medicine, Sonography, EMS, Pediatrics, or Toxicology and many others.

Creativity in planning your rotation is encouraged, but you must develop an education plan for the rotation. The Program Director will want to see your Goals and Objectives for the rotation, so plan them and put them in the elective planner. All rotations need to be approved by Dr. Willis before arrangements are made with an outside institution. At least 28 days before the rotation, please review your educational plan with Dr. Willis and fill out the elective planner (available from Chelsea Cole and below). If you buy plane tickets or make travel plans without having an approved elective, then YOU HAVE MADE A GRAVE ERROR.

If you are going to do an international elective, then you need to fill out an international elective planner IN ADDITION TO the standard elective planner. See the next section for the international elective planner.

If you are going to work in a clinical area, malpractice insurance coverage may be an issue. Your standard residency malpractice coverage only applies to resident activities, and your coverage will apply only to SUNY, its affiliates, and HHC hospitals. It is also possible to apply for SUNY to cover/provide malpractice coverage and have SUNY cover your elective. This takes time to set up, so start early (at least three months in advance). You can apply with the form below. Dr. Willis does not make the decision to provide this coverage, but will help you set up the elective. Attached is a simple form to be completed while planning your rotation. Finally, upon returning to SUNY Downstate, you will need a letter certifying proof of the rotation, and to submit a short written synopsis of the rotation or prepare a brief oral presentation.

Please Note:
Omission or Failure to adequately plan your Elective as outlined above in the appropriate time frame will result in irrevocable loss of your Elective time. You will be scheduled for clinical shifts instead. Please comply with this rule.
No Exceptions!!!!

Please click the link below for the elective worksheet-

New Elective Worksheet

TIMELINE, INSTRUCTIONS AND CONTACT LIST FOR EXTRAMURAL ELECTIVES

As soon as the program is contacted by a resident (for extramural electives or visiting rotators), but no later than 8 weeks prior to the expected start date, all actions to receive required approvals and obtain signed agreements must be put into effect. Some Program Letters of Agreement can take 2- 4 months to negotiate and execute.

The GME office will not process extramural elective rotations without proper authorization, approvals and ensuring appropriate malpractice indemnification.

Note the following timeframes:

- **In-state electives require at least 8 weeks to process.**
- **Out-of-state electives require at least 10 weeks to process.**
- Requests for electives to occur in July or August must be submitted to the GME office no later than the preceding May 1st as additional time must be allowed for processing during this academic year transition period.
- ***Failure to meet the 8 or 10 weeks' minimum timeframe will result in denial of request.***

****** Even if the request is received within the specified 8 or 10 weeks timeframe, due to circumstances beyond our control, SUNY Downstate cannot guarantee that all applications will be completely processed in time for planned elective start date.******

Please be sure that the following steps are fulfilled:

a. For all extramural electives, submit a completed (with Program Director review and approval acknowledged). Request for Approval form is submitted to the GME office (Natalie Arrindell, 718-270-4220) with a copy to the Office of Planning (Miriam Burr, 718- 613-8641)

b. All extramural rotations must be for valid educational purposes consistent with the goals and objectives of the resident's or fellow's training program and for experiences not adequately provided or available within our institution or the program's participating affiliated sites.

c. The Office of Planning will draft and execute an agreement for each extramural elective and determine need for malpractice liability indemnification.

d. Malpractice coverage from the NYS Office of the Attorney General for extramural electives must be applied for 3-4 weeks in advance if the rotation is within New York State (Office of Risk Management, 718-270-3768). Coverage must be privately purchased if it is for an out-of-state rotation.

e. Resident benefits (health insurance) must remain in effect and cover the resident in the location and during the period of the extramural rotation.

f. During the course of an extramural rotation, any time the resident/fellow spends within Downstate or one of the program's participating affiliated sites must be indicated in New Innovations rotation schedules.
g. The program must assure that any resident participating in an extramural rotation is appropriately supervised, taught and evaluated in a manner fully consistent with the policies of the sponsoring institution and of Downstate's training program. The program remains responsible for the resident even during extramural or away experiences.
h. Residents will not be permitted extramural electives under any circumstances for locations identified by the U.S. Department of State as having travel warnings.
****** SUNY Downstate cannot guarantee any application will be processed on time for the anticipated elective, even if documents are submitted within the 8 or 10 weeks' timeframe.***

REQUEST FOR Approval for SUNY Downstate Resident/Fellow Extramural Rotation
Resident Name (FN LN): _____
Resident SS#: _____-_____-_____ Training Program Level: _____
SUNY Department _____SUNY Training Program _____
Resident Contact Phone: _____ Email: _____
Extramural Rotation Requested:

_____

Specialty/Subspecialty:

_____

Rotation Duration (days/weeks): _____ Start Date: _____ End Date: _____
Anticipated number of work shifts and duty hours during rotation: _____
Return to home program for clinics? □ Yes □ no
Return to home program for calls? □ Yes □ no
Assigned overnight or weekend calls at extramural site? □Yes □ no
Is this extramural rotation needed to fulfill training requirements? □ Yes □ no
Is this or a similar experience available at SUNY or affiliated sites? □ Yes □ no
Justification for extramural (objectives, fulfillment of requirements, unique training opportunities, etc.):

_____

_____

_____

Extramural supervising physician: _____Licensed? □ Yes □ no Bd Cert? □ Yes □ no Extramural evaluating physician: _____Licensed? □ Yes □ no Bd Cert? □ Yes □ no
Name Location/Institution of Rotation: _____ Address of extramural site:

_____

City, State and Zip Code:

_____

Extramural Contact Telephone:

_____

Extramural Contact E-mail:

_____

Salary during extramural rotation provided by: _____
Health benefits during extramural rotation provided by: _____
Source of malpractice indemnification during extramural rotation:
_____ (A letter confirming indemnification must accompany this request including liability coverage from SUNY or KCH/HHC) Time during extramural rotation to be charged as:

□Work/Training (facility claiming effort?_____)
□Annual Leave □Education Leave □Unpaid Leave
□Other (explain)

_____

Is there an appropriate program letter of agreement with extramural site? □ Yes □ no If not, is an appropriate program letter of agreement in preparation? □ Yes □ no N.B. – all agreements including a fully executed PLA must be available before rotation commences

Approved as justified □ Denied □

_____ _____ _____

Downstate Program Director Signature Name (print) Date

.....Approved □ Denied □

_____ _____ _____ *SUNY Downstate GME Office Signature Name/title of GME Official Date A completed and signed Request for Approval with all requested information and attachments must be on record with the SUNY Downstate GME Office and copied to Office of Planning and the Program before a resident can proceed with an extramural rotation.*

****** Even if the request is received within the specified 8 or 10 weeks' timeframe, due to circumstances beyond our control, SUNY Downstate cannot guarantee that all applications will be completely processed in time for planned elective start date.******

INTERNATIONAL ELECTIVE

One year ahead

1. Pick a place (general; or specific if you already know it)
2. Consult the SUNY/KCH international elective database
3. Talk to your contacts/make new contacts through networking
4. Talk to departmental faculty
5. Ask Dr. Bloem
6. Define your learning objectives
7. Consider doing a project (or part of one)
8. Plan your budget and look for funding if needed
9. Consult the SUNY/KCH international elective database

6 months ahead

1. Plan a meeting to discuss your elective plan with Dr. Bloem
2. Submit your Elective Plan sheet

By one month after the completion of your elective

1. Submit your reflective statement addressing your experience and how you met your learning objectives, as well as at least one suggested way to positively impact the health system (emergency or otherwise) of the place where you worked. Please make sure to fill out the accommodations, budget, and contact information section for the sake of future rotators and projects.

International Elective Plan

Date: _____

Name of resident: _____

Location of planned international elective: _____

Elective Point-Of-Contact Person and Title: _____

Contact Address: _____

Contact Phone: _____

Second Elective Point-Of-Contact Person and Title: _____

Contact Address: _____

Contact Phone: _____

Accommodation Type (aka, house, apt, dorm): _____

Address: _____

Phone: _____

ESTIMATED BUDGET

Travel cost: _____

Accommodation cost: _____

Food/daily expenses cost: _____

Learning Objectives:

Please describe below your objectives for your international elective. Include what you hope to learn, how many hours you plan to work, what activities you will be involved with, and whether this elective will be related to an International Division project.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reflective Statement (Must be completed within 1 month following elective)
Please describe in at 1-2 pages what your experience abroad was like. Include what your responsibilities were, what kind of activities you participated in, how their system and patient population differed. State how you met or were unable to meet your learning objectives (as per your Elective Plan).
Please list at least one suggested way to positively impact the health system (emergency or otherwise) of the place where you worked. If you have an idea for a project for the International Division (great!), please describe it here briefly.
Please make sure to fill out the accommodations, budget, and contact information section below for the sake of future rotators and projects.

Resident name: _____
Location of international elective: _____
Point-Of-Contact Person and Title: _____
Contact Address: _____
Contact Phone: _____
Second Point-Of-Contact Person and Title: _____
Contact Address: _____
Contact Phone: _____
Accommodation Type (aka, house, apt, dorm): _____
Address: _____
Phone: _____
EXPENSES
Travel cost: _____
Accommodation cost: _____
Food/daily expenses cost: _____
Other expenses (please describe): _____
_____

SUPERVISION

General Principles and Definitions

1. Every patient evaluated in the Kings County,University Hospital Downstate and NYU-B must have an identifiable attending physician, who is,appropriately credentialed with privileges by the Medical Staff of said institution OR licensed mid-level clinical practitioner who is responsible and accountable for the patient's care. This individual is identifiable to residents, all members of the ED health care team, and patients.

2. Supervision shall be provided for all residents in a manner that is consistent with the proper patient care, the educational needs of the residents and the applicable program requirements.

3. All attending, residents, and medical students on duty in the ED must introduce themselves to the patients for whom they provide direct patient care and inform patients of their respective roles in the patient's care.

4. To promote oversight of resident supervision while providing for progressive, graded authority and responsibility **only the following classification of supervision will be used in the SUNY Downstate / Kings County residency program**:

a. ***Direct Supervision***

i. The supervising physician is physically present with the resident and patient

b. ***Indirect Supervision***

i. With Direct Supervision Immediately Available: the supervising physician is physically within the ED and is immediately available to provide Direct Supervision

5. Indirect Supervision with Direct supervision available & Oversight are not employed as supervision methods in the Emergency Department. With clinical staffing of EM trained attending physicians available 24hrs a day 7 days a week, we are able to provide Direct Supervision & Indirect Supervision with direct supervision immediately available.

6. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care will be assigned to each resident by the program director and faculty based on evaluations of each resident's abilities by the clinical competency committee (CCC) and program director utilizing specific criteria guided by the ACGME EM Milestones and Core Competencies to include procedure logs.

7. All patients seen by:

a. PGY-1: All patients must be presented to a supervising attending after evaluation. The attending physician provides direct supervision consisting of but not limited to repeating the H&P, documentation, orders and discussing the assessment and plan.

b. PGY-2: All patients are presented to a supervising attending after the resident has developed and initiated the initial plan of care

c. PGY-3/4: All patients are presented to a supervising attending prior to disposition

8. Faculty and clinical teaching attending supervising residents must delegate portions of care to residents based on the needs of the patient and the skill of the resident. However, faculty and clinical teaching attending maintain the ultimate responsibility for each patient and will review the resident's clinical decision making and see the patient personally prior to the patient's disposition from the ED (discharge, admit, or place in observation). The severity and complexity of each patient's condition and patient safety issues will be considered when determining each resident's degree of independence.

9. Senior residents are expected to serve in a supervisory role to junior residents in recognition of their progress towards independence, based on the needs of each patient and the skills of the resident.

10. Circumstances under which a resident must communicate with their supervising attending are identified in the program's Communication with Attending Policy. Residents will be informed of the circumstances under which a resident must communicate with their supervising attending during their July orientation into the program.

11. In residency training, as in any clinical practice, it is incumbent upon a physician to be aware of his/her own limitations in providing patient care and to consult a physician with more expertise when necessary. If at any point during the course of a patient's evaluation by a resident in the ED the resident has any doubt about the need for supervision, the attending supervising physician is directly available.

12. Residency core faculty supervision assignments will be of sufficient duration and frequency in order to assure sufficient time to be able to accurately and fully assess the knowledge and skills of each resident. In general this will be achieved by scheduling faculty in the ED for a minimum of eight hours per week on average forty-five weeks per year.

EDUCATION

READING

“To see patients without reading is like a ship without a rudder, and to read and not see patients is like never having gone to sea”

-Sir William Osler

“What one knows, one sees.”

-Goethe

Each resident is ultimately responsible for his or her education. Kings County provides a rich environment to practice medicine, but it cannot be stressed enough the importance of reading. Residents must develop a method for acquiring the myriad of information required to competently practice Emergency Medicine. Some people find success with a structured reading list, while others find it more fruitful to do focused reading based on cases seen in the ED. The faculty at Kings County has allowed the residents great autonomy in their clinical education and will not dictate which method of study is best. Also, each of the major Emergency Medicine texts has strengths and weaknesses. The resident should choose one of the texts and develop a method to comprehensively go through it early in their residency. If you have questions about what to read or methods for review, ask one of the senior residents or faculty members for help.

MODEL OF CLINICAL PRACTICE OF EM

The “old” SAEM core content for EM was felt to be too unwieldy and was thus replaced by “The Model of Clinical Practice of Emergency Medicine”. In essence, it is a similar list as the Core Content but weighted in view of our daily emergency medicine practice as analyzed from over 1300 EM physicians.

It contains three components:

1. An assessment of patient acuity
2. A description of tasks that must be performed to provide appropriate emergency medical care
3. A listing of common conditions

This model was a collaborative effort by the following six organizations governing the practice of EM:

ABEM (American Board of Emergency Medicine)
ACEP (American College of Emergency Medicine)
CORD (Council of Emergency Medicine Residency Directors)
EMRA (Emergency Medicine Resident’s Association)
RRC-EM (Residency Review Committee for Emergency Medicine)
SAEM (Society of Academic Emergency Medicine)

The actual document is too long to be printed here but may be easily accessioned at:
Model of Clinical Practice of EM

Reading this document gives you a good insight about what you should learn over the next four years or what you should know when graduating from your residency

IN-SERVICE EXAMINATION

The national emergency medicine in-service exam is held every year on the last Wednesday of February. The exam format is similar to the ABEM written examination. The exam is a 4.5 hour-long multiple-choice exam containing approximately 210 questions. While the exam is not perfect and does not necessarily predict who will become a competent clinician, the exam is written by the same question writers who contribute to the specialty board exam. Therefore, performance on the In-service Exam correlates exceptionally well with success on the ABEM written exam (see attached graph).

Proper preparation requires an ongoing effort of reading on core topics in Emergency Medicine and reviewing board-type questions. A strong fund of knowledge will be required to perform well on the in- service exam and the best preparation is to start early in your residency with regular reading and review. Residents who do not perform well on the examination when compared to the national average for their respective PGY year, are not eligible for exemption from the In-training and Board prep conference. Please see the section on that conference elsewhere in this book.

Please Note: No vacation or away electives can be scheduled during In-service exam week. You MUST take this exam.

Recommended Reading:

Tintinalli – Emergency Medicine study guide

Rivers, Carol – Preparing for the Written Board Exam, text and questions

Peer 9 Question Bank

Coach Question Bank

Koenig – Emergency Medicine Pretest Self-Assessment and Review

Pearls of Wisdom – Emergency Medicine Written Board Review

Rosen-- Text of EM

Last Minute Emergency Medicine - Wagner

BOARD REVIEW GROUP

EM Faculty Liaisons:

Dr. Joel Gernsheimer – cell: 917-750-1145; email: gernsh@aol.com

Dr. James Hassel - email: james.hassel@downstate.edu

Description and Goals:

Participation in the Board Review Group is an opportunity for residents to enhance their preparation for the yearly in-service examination and for the ABEM written board examination. The goals of this activity are to:

• Improve medical knowledge

• Improve test taking skills

• Improve scores on the annual In-Service Exams

• Improve scores on the ABEM Board Certification Examinations

All residents are invited to attend the Board Review Sessions, but the following Residents are automatically in the Board Review Group, and are expected to attend all the Board Review Sessions, unless they have a legitimate excuse as described below.

You are included in the Emergency Medicine Board Review Group based on you last in-service score if:

1) You are an EM PGY-1 that had a score on your last In-service exam that gave you an 85% chance or less of passing the boards

2) You are an EM PGY-2 or PGY-3 with a score that gave you a 90% chance or less of passing the boards

3) You are an EM/IM PGY-1 that had an 80% chance or less of passing the boards

4) You are an EM/IM PGY-2 that had an 85% chance or less of passing the boards

5) You are an EM/IM PGY-3 or PGY-4 that had a 90% chance or less of passing the boards

These residents in the BR Group will be given clinical time off between 12:15 PM and 1 PM to attend these sessions if needed from their clinical schedules, but must let their supervising Attendings in the clinical areas know this.

Interns with low USMLE scores will be encouraged to attend the Board Review Group Sessions and will be given the clinical time off to do so, if they receive permission from the Program Director, Dr. James Willis.

Residents who have done well in the In-service are welcomed to attend the group's sessions, but will not be given special clinical time off to attend these meetings.

Interns and Residents with less than 20th percentile score on the In-service exam (not % chance of passing the Boards) twice in a row will be referred to the Academic Development Program at the medical school for discussion of test taking skills, making study plans and

psychometric testing (if that is available) by the Program Director, Dr. James Willis. Residents who scored less than 20% on only one exam can voluntarily request to be referred to the Academic Development Group or may be referred there by the Program Director at his discretion.
If there is a question regarding the eligibility of a Resident to opt out of the Board Review Group, the final decision for EM Residents will be made by the EM Categorical Program Director, and for EM/ M Residents by the EM/IM Program Director.

Residents for which board review is mandatory, who do not complete assignments (or are not on time with assignments) or do not show up without an excused absence, will be given a 4 hour penalty. Once two 4 hour penalties have accrued, an extra shift will be added to their next KCH Block.

The sessions will usually be held on Wednesdays after morning conference for 45 minutes to one hour. For the usual sessions, the Coach questions on that topic will be distributed by the Dr. Hassel Leadership as a quiz. The Residents that are in the group are required to complete these Coach quizzes prior to the upcoming related session, and Dr. Hassel will monitor this. The format of these sessions will be a review of the questions from the Coach Quiz, especially the questions that the Residents did not do well on the Quiz, and with an emphasis on covering the type of questions that appear on the Written Board and In-training Exams. There will also be emphasis on covering the core content and test taking techniques. In addition Dr. Hassel will be assigning 2-3 Residents from the Board Review Group to each review a difficult Coach Question in depth. Also Dr. Gernsheimer will be sending out a Quiz with questions from reliable sources, such as PEER 9 & 1,2OO Questions to Help Pass the Written EM Boards. These Questions will then be reviewed during the session as well. How much you get out of doing the quizzes and from attending the sessions depends on how much effort you put into preparing for these sessions and participating in the discussion.Dr. Gernsheimer and Dr. Hassel will continue to be the Co-Directors of the Board Review Group during this Academic Year.
From November through February special sessions will be held almost every week. These special sessions will be given by one of the Faculty, who has a special interest and expertise in this area. The format of these special sessions will be the review of an important topic similar to those from the Ohio ACEP course. The biggest categories from the In-training and Written Board Exams will be included in these special review sessions. We will try to have as many

Special Faculty Board Review sessions as possible. Please note that Coachquizzes will be sent to the Residents in the group for these special sessions, as well as the usual sessions. Please note that the schedule for both the usual sessions, and the special sessions may need to be modified because of other Residency Activities.

Penalties for Residents: Residents who have been assigned to the group and do not show up to the meetings without having an excused absence, or do not do the quizzes without a legitimate excuse or do not do their assigned discussions will be given a 4 hour penalty. Once two 4 hour penalties have been accrued an extra 8 hour shift will be added to their next KCH ED Block. This rule will be enforced!

If there are any questions regarding anything explained above, please contact Dr. Gernsheimer and Dr. Hassel.

Please note that the following are more specific explanations, but the most important points were covered above.

Meeting place/time:

The Board Review Group will usually meet every other week from August through June for 45 minutes to one hour immediately after Wednesday's conference (12:15 to 1 or 1:15PM). This may sometimes be changed, because of holidays or "away conferences". You may bring your lunch. A detailed schedule will be handed prior to the first meeting and may be revised throughout the year. If you are scheduled for a clinical shift immediately after conference, you must let the attending in the clinical area know prior to the beginning of your shift that you will be one hour "late". Sometimes the clinical attending will insist that you go to the clinical area immediately, if he or she feels that attending the session will affect patient care adversely. Any conflict should be discussed with Dr. Gernsheimer or Dr. Hassel, but patient care always comes first!

If you cannot attend Board Review Group for whatever reason, you must notify Dr. Gernsheimer and Dr. Hassel by email or phone or in person.

The reasons to be excused from a particular Board Review Group Session are the same ones as for being excused from the morning Conferences (annual leave, being ill, working in the ICU, etc.), but you still must notify Dr. Gernsheimer and Dr. Hassel and let them know this, before Midnight of the day of that particular Board Review Group session, or you will owe 4 hours. For every 2 sessions you miss without notifying Dr. Gernsheimeror Dr. Hassel, you will be given an 8 hour clinical shift. Please note that this rule will be strictly enforced.

Please note that if you are assigned to do a Simulation Session that day, you should come to the Board Review Group at 12:15 and then go to the Simulation Session at 12:30.

Attendance is mandatory for all residents in both the EM & EM/IM programs, who have been assigned to the Board Review Group, unless you are excused for legitimate reasons as noted above and you have informed Dr. Gernsheimer or Dr. Hassel of this.

Doing the Coach Quiz prior to that week's session is mandatory, EVEN If you are excused from that Board Review session for legitimate reasons. The only reason for not doing the Quiz is that you are on vacation, or you are on an away Elective where you do not have internet access. You must inform the Board Review Faculty Leadership of this. The quiz should be done prior to the related session. The Coach quizzes have been arranged so that when you take them, we are immediately notified.

We will try to incorporate at least several Pediatric EM based questions in each quiz as applicable.

Some topics like Trauma and Cardiology may require more than one session.

Sessions are usually held in our main EM conference room. You will be notified prior to each session where that session will be held.

Structure:

Residents will be given the topics of the scheduled sessions in July. Attempts to follow the Modular Curriculum Schedule, as much as possible, will be made.

The Board Review Group Leadership will distribute the Coach quiz for each session one week prior to that session for both the usual sessions and the Special Faculty Board Review Sessions. We will send out the quizzes one week ahead of time, so that the Residents will have time to complete the Quiz. The Coach Quizzes are made so that the Resident gets immediate feedback on her/his answers. At the usual sessions the answers to these questions will be discussed by everyone in the group. In the interest of time, we will try to discuss the more difficult questions, and the ones that have valuable teaching points, especially if they highlight test taking techniques in answering them. At the Special Faculty Board Review Sessions, it is up to the Special Faculty Attending to decide how she/he wants to do the session, and often they will do it as a more didactic session with audience participation. Whenever possible, we will send out topic related quizzes at least one week prior to these special sessions for the Residents to complete. We will use the Coach Quizzes, so that the Residents will get immediate feedback when they answer the questions.

Please note that the extra questions that Dr. Gernsheimer sends out will be answered during the session. Also, Dr. Gernsheimer will send out the answers after that session is over to all the Residents. Dr. Gernsheimer will not send out these extra Questions for the Special Faculty Board Review sessions.

Please note that the Coach Quizzes will be sent out to all our Residents, but only the Residents that are in the Board Review Group are REQUIRED to do them.

The first meeting of the Board Review Group in August will be devoted to going over the goals and the rules of the group, and will also be a “Study Plan & Test Taking Skills Session”. The residents included in this group will be expected to bring a “study plan”, which addresses their academic weaknesses, as indicated by the areas in the In-Service Exam that they did poorly in. Faculty will be available to assist the residents with formulating and carrying out their study plans.

Finally, it should be noted that each session of this group will count as an hour of Self Directed Learning. Even residents, who have not been assigned to be in the group, can still attend it in order to earn Self Directed Learning hour. Attendance will be taken to verify that the residents actually attended these sessions, and deserve credit for this activity. Residents who attend the sessions should send the requests for asynchronous learning credits to Dr. Gernsheimer or Dr. Hassel via New Innovations.

We will also try to have some special board review sessions for EM/IM, and Dr. Hassel will try to arrange that with the EM/IM Chief Resident.

Also, we know that some Residents cannot usually attend the Board Review Sessions, because they are Chief Residents or are Simulation Leaders. Dr. Gernsheimer will be glad to arrange some sessions at different times for these Residents. Interested Residents should contact him regarding this.

As per the requests of the Residents, we will be scheduling Oral Board Review Sessions during Morning Conference Time throughout the academic year.

Any questions or suggestions should be brought up to Dr. Gernsheimer and Dr. Hassel, as we greatly value your input.

Copies of PEER 9 and VIII, 1000 and 1200 Questions to Pass the EM Boards, Last Minute Emergency Medicine, Just the Facts, the Carol Rivers Written Board Review Texts, and EM Pearls of Wisdom will be made available for your use via Dr. Gernsheimer. Please contact him if you would like to review any of these very useful review books. EM Coach should be available to all the Residents. If there is any problem in accessing it, please contact Ms. Chelsea Cole, our Program Coordinator.

EMERGENCY MEDICINE BOARD EXAMINATION

The American Board of Emergency Medicine certification exam is the final exam hurdle to full board certification in EM. The exam is a two-part exam taken upon completion of an accredited residency training program in EM. The two parts consist of a written exam portion and an oral exam portion.

Written Exam

The first part of the exam is a written test given in the fall (typically the first week in November) at a national computer testing center. The written exam is a six and a half (6.5) hour, 340 criteria referenced question exam. The candidate must answer 80% of the questions correctly to pass the exam. The scope and depth of the exam is similar to that of the annual in-service exam. Residents will receive an information packet from ABEM in the spring of their final year that contains an application and fee schedule. The written exam is about $1,380 (this includes a $420 application fee), and the oral exam is approximately $1160.

The big question is how and what to study. The good news is that most people who graduate from an EM residency will pass the exam (last year's pass rate was >95%). One may be able to roughly predict their degree of preparedness based on their yearly in-service exam scores. To restate from the previous sections of this handbook, the best method of obtaining the required information to pass the exams is to develop good reading habits early in residency.

Most people spend a considerable amount of time in the fall after graduation preparing for the exam but the four years of residency is the time to develop the core knowledge required to be a competent EM physician. Details about the test are probably best referred to the residency directors or recent graduates who are taking the exam.

Contact:

American Board of Emergency Medicine (ABEM) 3000 Coolidge Road East Lansing, Michigan 48823-6319 Tel: 517-332-4800 Fax: 517-332-2234 www.abem.org

ABEM WRITTEN EXAM CONTENT

Signs, Symptoms and Presentations 9%
Abdominal & GI disorders 9%
Cardiovascular disorders 10%
Cutaneous disorders 2%
Endocrine/metabolic/ nutrition disorders 3%
Environmental disorders 3%
ENT disorders 5%
Hematologic disorders 2%
Immune disorders 2%
Systemic infectious disorders 5%
Musculoskeletal disorders (not trauma) 3%
Nervous system disorders 5%
Obstetrics and Gynecology 4%
Pediatrics disorders 8%
Psychobehavioral disorders 3%

Renal and Urogenital disorders 3%
Thoracic/respiratory disorders 8%
Toxicology 4%
Trauma disorders 11%
Administrative 2%
EMS/disaster 3%
Clinical Pharmacology 2%
Procedure/Skills 6%

ORAL BOARD EXAM

The oral certification exam is offered to candidates who successfully complete the written exam. The exam is offered in the spring (late April) and the fall (early October). Assignment to the spring or fall exams is completely random and occurs after successfully passing of the written exam.

The Oral Examination is given in a half-day session at the O'Hare Marriott hotel in Chicago, Illinois. It consists of seven patient scenarios (cases) that you will be expected to handle as though the simulated patients are your patients in the Emergency Department. There are three different types of cases: five eOral single patient cases, and two traditional cases involving multiple patients, commonly known as "triples."

The exam can be a stressful experience. Practice is an important aspect of preparation and preparation is the best way to pass the oral board examination. Oral board review during Wednesday conference is an important starting point, and Dr. Hassel and D. Gernsheimer will be holding Oral Board Review sessions throughout the Academic Year.

See the ABEM website for more information.

https://www.abem.org/public/emergency-medicine-(em)-initial-certification/oral-examination/oral-examination-information-for-candidates

USMLE EXAMINATION REQUIREMENTS

Residents must have passed USMLE step I & II before matriculation in residency and must pass Step III before November of their PGY 2 year. Applications may be acquired from the NY State Board of Education by calling (518) 474-3817.

Passing Step III will be required by the end of November of your 2nd year of residency and is part of your promotion criteria into the PGY3 year in the categorical and the combined programs.

Passing Step III is required for obtaining a medical license in every state.

SUNY has set up an institution-wide policy. If for some reason you have not PASSED Step 3 by the end of your PGY-2 year, then SUNY GME will terminate your contract. This means you are no longer a part of the residency. This is not a joke.

If you have not passed Step-3 by the end of your PGY-2 year, you will be given a notice of non-renewal.

You do not have to apply for a New York state medical license in order to be promoted, but you are strongly encouraged to.

New York (NY) State no longer requires licensing fees and NY state application at the time of registration for the exam (about $600), i.e. you may sit for Step III without applying for NY state licensure. CIR will reimburse your costs of getting a license.

DEPARTMENTAL CONFERENCES

MORNING REPORT

Morning report gives the opportunity to discuss interesting cases that present to the ED in a relatively formalized manner. It is an excellent educational forum for the residents and faculty and a time for a brief discussion of both core topics in EM as well as evolving medical therapies.
Faculty Liaison: Dr. Ian DeSouza
Time and Place: Morning report is to be held following morning rounds on Mondays, Tuesdays, Thursdays, and Fridays in a location designated by the attending physicians.
Structure:
• Only senior residents will be asked to present a case for discussion. Any one resident should be required to do no more than two morning reports during a single ED block. The resident scheduled to present will be designated on the schedule.
• Monday is pediatric topic, Tuesday is Trauma, Thursday is EKG/Cards and Friday is the resident's choice.
• All residents scheduled to work at 7 AM or who are post-overnight at KCH ED are required to attend. Residents scheduled at UHD at 7 AM are encouraged to attend at the discretion of the UHD Attending. Residents must first report to UHD for rounds and are to report back promptly at the conclusion of the case.
The purpose of the exercise is to provide the presenter an opportunity to present a case that he/she was personally involved with and to educate his/her colleagues. The objective of the presenter is to extract the most essential Emergency Medicine teaching points and convey these to the group. In order to accomplish this goal, we have decided to initiate some guidelines to follow in preparing your morning report:
1) Morning report should NOT be presented in an Oral Board format. The total presentation time should not exceed 10-15 minutes depending on patient needs. Remember there are residents and faculty present who worked overnight and do not want to hear a long presentation.
2) The first 5 minutes should be devoted to a case presentation by the presenter. This is not a history-taking lesson nor is it a free-for-all guessing game. The presenter will provide all pertinent positive and negative historical facts at his/her discretion. He/she can stop at any time to elicit specific interventions at any time—life-saving procedures, etc.—but the primary focus of this portion is to provide all the necessary information for the second part of the case.
3) The group should then be pressed to provide a differential diagnosis—either round robin or by picking specific audience members, preferably the most junior first (MS3, MS4, PGYI, etc.). Obviously, focus on any life- or limb-threatening injuries, diagnoses, or interventions first, and be as complete as possible.
4) Finally, the presenter will spend no more than 5 minutes highlighting the most important points that each person in the room should walk away with (at least three). This should be concise and to-the-point, and SHOULD BE ACCOMPANIED BY SOME TYPE OF HANDOUT OR STIMULUS (copies of EKG's, X-RAY's, diagrams etc.).

5) If the morning report has not finished by 8am, the individuals that worked the previous overnight shift that are in attendance are excused and may leave to head home regardless of when the morning report started.
6) If you would like to receive III credit for your morning report follow the instructions outlined in the III Section of this handbook.

WEDNESDAY CONFERENCE

The Wednesday conference is the traditional EM academic conference that covers the core topics in emergency medicine over approximately a two-year period. Conference for EM residents will be held each Wednesday from 8am – 12pm. The conference is composed of various didactic lectures covering the core curriculum of emergency medicine, specialized case discussions pertaining to pediatrics, the MICU and trauma, a morbidity and mortality conference, an annual CPC competition, and grand rounds. The curriculum will be covered in a modular format

ALL RESIDENT LECTURES MUST BE E-MAILED TO THE CONFERENCE LEADERS FOR REVIEW AT LEAST ONE WEEK BEFORE THE CONFERENCE. SOME SPECIFIC SERIES MAY REQUIRE DIFFERENT TIMELINES.

**Clinical Pearls requires topics to be sent two weeks prior and presentation outline to be sent the week before conference talk.

**You will be advised about the preparation requirements for CBL literature review well in advance and must comply with the requested timeline.

**EM-CCM has a specified template and timeline, which will be given by the faculty leader and senior resident coordinators. Please follow their requested guidelines.

PLEASE EMAIL THE FACULTY LEADER AND THE SENIOR RESIDENT COORDINATORS.

The list of faculty and senior residents for each lecture series is provided in the handbook.

ED CONFERENCE ATTENDANCE GRADUATION REQUIREMENTS

The RRC requires that every EM resident must be present for 70% of the Wednesday conferences during your residency training (35% for EM/IM residents).

You must be there for the full 4 hours to get credit for the day, or for the total hours required based on the attendance policy (please see below). If you leave early or come late outside of the current handbook policy on Wednesday conference attendance, you will not get credit for that conference day.

It is your responsibility to keep track of your conference attendance and know how close you are to that 70% level. Your conference attendance can both be viewed on new innovations. If you

have concerns, this number can be reviewed with a residency director at your 6-month evaluation meeting or you can make an appointment with a director to discuss this at any time. You can meet the 70% requirement through a combination of Independent Interaction Instruction (III) activities and traditional didactic lectures. You must have 168 hours of total conference (traditional and III) time averaged per year. If you do the maximum III of 48 hrs per year you will need a minimum of 120 hours of traditional conference time averaged per year (but you can do more). 120 hours is equal to 30 weeks of conference attendance.

Below is a sample table of the minimum amount of conference attendance you should have by the end of each PGY year for categorical residents assuming you do 48hrs of III. This is a guideline. You may of course have more conference attendance one year and less the other as long as you meet the requirement by the end of your 4th year. You may also have higher conference attendance and require fewer III to reach 672 combine by graduation.

PGY	Conference Hours	III Hours	Cumulative Total
1	120	48	168
2	240	96	336
3	360	144	504
4	480	192	672

If by some terrible chance of “luck”, graduating residents are below the required 70% (35%), they will have to attend conference during their elective or during July to make the minimum requirement in order to graduate the program. The 70% (or 35% for EM/IMs) RRC conference attendance requirement is not negotiable and you cannot graduate from ANY EM residency without fulfilling it.

<u>EM/IM</u>

You can meet the 35% requirement through a combination of Independent Interaction Instruction (III) activities and traditional didactic lectures. You must have 84 hours of total conference (traditional and III) time per year. If you do the maximum III of 48 hrs per year you will need a minimum of 36 hours of traditional conference time per year (but you can do more). 36 hours is equal to 9 weeks of conference attendance.

Below is a sample table of the minimum amount of conference attendance you should have by the end of each PGY year assuming you do 48hrs of III. This is a guideline. You may of course have more conference attendance one year and less the other as long as you meet the requirement by the end of your 4th year. You may also have higher conference attendance and require fewer III to reach 420 combined by graduation.

PGY	Conference Hours	III Hours	Cumulative Total
1	36	48	84
2	72	96	168
3	108	144	252
4	144	192	336
5	180	240	420

ED CONFERENCE ATTENDANCE POLICY

Conference day is considered a workday, thus conference attendance is mandatory!!! Every Academic year each resident has 4 passes for conference. These include sick days, family emergencies and mental health days. Please email the conference Chief), if you plan to miss conference. During conferences done virtually attendance credit is given only if the resident is engaged with their camera on. Permission may be granted to attend without your camera on by the Program Director in advance.

Persons who are repeatedly late will be marked as absent. 3 tardies = the use of one conference absence or one extra clinical shift if you already have 4 absences.

Residents who are excused from Conference include:

1. Residents on vacation
2. Selected Tuesday/Wednesday Shifts: To meet ACGME and NYS resident duty hours, based on your scheduled Tuesdays/Wednesday shifts you may be excused from conference, be required to attend 1hr or come late at 9:30am. Please see “Special Shifts” for a detailed listing.

If Wednesday is the only 24 hours in seven that you are not scheduled for a clinical shift you may miss conference. Please email the Education Chief or program director.

3. Off Service Rotations: To facilitate better learning, on some off-service rotations you are excused. Please see “Off Service Rotations” for a full listing. It is also explained in more detail in the sections of the handbook that describe your responsibilities during each off-service rotation

4. Personal Day: If you are sick, have another obligation or have an unforeseen circumstance in which you are unable to make it to conference you have 4 days per academic year as a free pass. These passes will be recorded. If you take more than 4 days during an academic year you will be expected to make up this time in the clinical area

SPECIAL SHIFTS

Residents have to report to the clinical area immediately after conference. You have the option of leaving at 11:30am to grab lunch prior to your shift. However, everyone must be on time for shifts starting at 12p. We ask that on days where there are guest lecturers, please bring lunch with you, so that we do not have everyone leaving conference early.

The following are the requirements for conference attendance that take into account resident work hours and current ACGME and NY State guidelines. If you have any questions as to whether or not you need to attend conference please contact Dr. James Willis (james.willis@downstate.edu) and the educations chief.

ACGME and NY State guidelines

Tuesday Shift	Wednesday Shift	Conference Attendance
7AM-5PM		
	OFF	8AM-12PM
	7AM-5PM	8AM-12PM
	9AM-7PM	8AM-12PM

	11AM-9PM	8AM-12PM
	1PM-11PM	8AM-12PM
	9PM-7AM	8AM-11AM
9AM-7PM		
	OFF	8AM-12PM
	7AM-5PM	8AM-12PM
	9AM-7PM	8AM-12PM
	11AM-9PM	8AM-12PM
	1PM-11PM	8AM-12PM
	9PM-7AM	8AM-11AM
11AM-9PM		
	OFF	8AM-12PM
	9AM-7PM	8AM-12PM
	11AM-9PM	8AM-12PM
	1PM-11PM	9AM-12PM
	9PM-7AM	8AM-9AM
1PM-11PM		
	OFF	9AM-12PM
	11AM-9PM	9AM-12PM
	1PM-11PM	9AM-12PM
	9PM-7AM	OFF
9PM-7AM		
	OFF	8AM-9AM

	9PM-7AM	OFF
OFF	OFF	8AM-12PM
	7AM-5PM	8AM-12PM
	9AM-7PM	8AM-12PM
	11AM-9PM	8AM-12PM
	1PM-11PM	8AM-12PM
	9PM-7AM	8AM-12PM

OFF-SERVICE ROTATIONS

Below is a summary of the policy for each rotation. Please refer to the Clinical Responsibilities section of this handbook under the specific rotation heading for more detailed schedule information.

PGY 1	PGY 2	PGY 3	PGY 4
Medicine – Excused MICU – Excused L&D - Excused Trauma –ED shift rules GYN Sono – Attend all	CCU – Excused NICU/PICU – Excused SICU – Excused NYU-B– 2/4 Conference are expected to be attended Ortho – Attend all Fasttrack – Attend all Airway – Attend all ENT – Attend all Neuro – Attend all	Electives – Excused NYU-B– ¾ Wednesday Conferences are expected to be attended EMS – Attend all Toxicology – Attend all Research – Attend all Selective – Attend all Sono – Attend all	Electives – Excused Admin – Attend all Selective – Attend all Sono – Attend all

ZOOM ETIQUETTE

When attending conference via zoom you are expected to be engaged and participating in conference. This means you must have your camera on in a stationary position and awake. The chat function is utilized but verbal engagement is preferred.

Resident Lecture Conference Series 2021-2022.
Below is pertinent information, updates, and background information about the 2020-2021 Conference curriculum

This year's conference will be broken down into three broad topics:

- ➔ Interactive Learning Sessions
- ➔ Core Content and EBM
- ➔ Professional Development

Under each topic, you will find the different lecture series that will be present in conference this year.

- ➔ **Interactive Learning Sessions**
  - ◆ Clinical Pearls/Oral Boards
  - ◆ CBL
  - ◆ Topic Review
  - ◆ Procedure Day
- ➔ **Core Content and EBM**
  - ◆ M&M (Morbidity & Mortality)
  - ◆ EMCCM (EM-Critical Care Medicine)
  - ◆ EBM (Evidence Based Medicine)
  - ◆ EM Controversies (EBM Debates)
  - ◆ Small Talks
  - ◆ Sono/EKG/Rads/Pharm
  - ◆ Grand Rounds
- ➔ **Professional Development**
  - ◆ Admin & Policy
  - ◆ Attending Advice
  - ◆ Social & Ethics of EM
  - ◆ Wellness
  - ◆ Senior Lectures
- ➔ **Pediatric Conference**

- ➔ **Clinical Pearls**

- Attending Coordinator: Dr. Delgado
- Duration of each lecture: 15 minutes per lecture
- PGY Presenting: PGY1
- Description: Clinical pearls is a lecture series in which junior residents give presentations on Procedural Pearls or “Bread and Butter” emergency medicine topics. Juniors are to select a case and then focus on covering ONLY key teaching points. Emphasis is on demonstrations and interactions with the audience. Presentations are limited to nine slides and these should be reserved for vital signs/labs and images.

➔ **Oral Boards**
- Attending Coordinators: Dr. Hassel and Dr, Gernsheimer
- Duration of each lecture: 1 hour
- PGY Presenting: none
- Description: Oral Board review sessions are given to the senior residents and the junior residents. Some of these sessions will be joint sessions with both Senior and Junior Residents, and some sessions will be only for the Senior Residents. These sessions are “simulated testing sessions”; where the residents break up into small groups of 4 or 5, while faculty facilitate a case in oral board format with a resident. The cases we will be using are going to be based off of: “Emergency Medicine: Oral Board Review Illustrated” by Yasuharu Okuda and Bret P. Nelson. (https://drive.google.com/open?id=1bigRfeLARwT1tJq1qVRKt_8s70RyqlYT)

➔ **CBL (Case-based learning)**
- Attending Coordinator: Dr. Surles
- Duration of each lecture: 1 hours
- PGY Presenting: : Each PGY class chooses an article and questions for their respective class, residents in each group will answer the PGY questions accordingly
- Description: CBL or case-based learning is a series where a case is designed with four questions to base literature searches on. Residents read their designated PGY year papers before the session. During the session there is small group discussion lead by representatives of each PGY year with a faculty facilitator. Questions are chosen for each PGY year with basic general EM topics for interns and graded complexity every subsequent year. At least one paper for the PGY1 and 2 levels have a guideline or clinical summary. The primary responsibility of residents preparing CBL are to perform the literature search and choose papers and write summaries for the papers with learning points and the answer for the clinical question.

➔ **Topic Review**
- Attending Coordinator: Dr. Gernsheimer

- Duration of each lecture: 45 minutes: 25 minute small group discussion of questions, and then a 20 minute Quiz Show.
- PGY Presenting: PGY2/PGY3
- Description: Topic Review is a lecture series that is based on textbook chapters from Tintanelli's textbook. This series consists of questions focusing on high-yield EM topics and including basic core concepts. The residents will be divided into groups of 10-12. Each group will be led by faculty if available, and, if not, by a senior resident. A rotating approach to questions will be taken so everyone in each group will have at least one question per lecture. The questions will be sent out to all the residents prior to the lecture along with the assigned readings from Tintanelli's book. The assigned resident will put together 8 questions based on the Tintinalli reading. The assigned resident will also prepare the answers to these questions with a brief discussion of the important learning points of each question. The resident will send the questions out to all the residents prior to the conference. The resident will send out the questions with the answers to Dr. Gernsheimer prior to the conference, who will then distribute them to the facilitating faculty. After the conference is over the assigned resident will send the questions and answers out to all the residents.
- The assigned resident will also prepare a "Quiz Show" consisting of 10-12 short Board Review Type Questions. The resident will then, using his or her desired Quiz Show format, present these Questions with a brief discussion of the answers via a powerpoint presentation.

➔ **Procedure Day**
- Attending Coordinator: Dr. Janairo/Dr. Camacho
- Duration of each lecture: 1 hours
- PGY Presenting: PGY3
- Description: Procedure days are days in conference in which the Procedure/SIM team organizes simulations of procedures that are under the realm of EM physicians. These procedures range from complicated resuscitation procedures to simple common procedures. The residents are split into teams that rotate through different simulated procedure stations and practice with an attending and resident coordinator. To assist and optimize learning, videos and textbook content about the indications, methods, and common pitfalls of these procedures is sent prior to this conference day for residents to review. These procedures can be logged as well.

➔ **M&M (Morbidity & Mortality)**
- Attending Coordinator: Dr. Schecter
- Duration of each lecture: 20 minutes
- PGY Presenting: PGY2-PGY4
- Description: M&M is a lecture series in which a resident reviews a clinical case and discusses a medical error or quality issue pertinent to the case. The goal of

M&M is to provide an opportunity to evaluate errors and adverse events in a systematic manner to improve practice and support a safe culture. Once the presentation is over, there is a faculty panel that will answer and discuss questions presented by the lecturer in ways these issues could have been avoided or improved for futuire instances. M&M also give residents an opportunity to learn from these cases, grow professionally, and develop skills to identify system issues and discuss methods of quality improvement.

➔ **EMCCM (EM-Critical Care Medicine)**
- ◆ Attending Coordinator: Dr. DeSouza/Dr. Eden Kim/Dr. Beyda
- ◆ Duration of each lecture: 45 minutes
- ◆ PGY Presenting: PGY3-PGY4
- ◆ Description: EM-CCM is a lecture series in which a senior resident presents a critical care case assigned by the faculty advisor. Senior presenters review the clinical course of the case and chose critical care topics to further discuss. The overview of these topics is based off of an extensive literature review and essentially an evidence based analysis. This lecture series differs from M&M as this series highlights the management of critical care patients in the emergency department. There is dedicated time for faculty commentary to present advanced learning points, commentary from the audience and facilitate discussion.

➔ **EBM (Evidence Based Medicine)**
- ◆ Attending Coordinator: Dr. Sinert/Dr. Zehtabchi
- ◆ Duration of each lecture: 30 minutes per lecture
- ◆ PGY Presenting: PGY3-PGY4
- ◆ Description: EBM is a lecture series that focuses on teaching residents on how to critically appraise literature. There also is a focus on reviewing core principles and basic concepts of research as well on how to appropriately interpret medical literature. Other lectures will focus on reviewing landmark papers in emergency medicine. These lectures will be presented by our research faculty as well as senior residents.

➔ **EM Controversies (EBM Debates)**
- ◆ Attending Coordinator: Dr.Willis
- ◆ Duration of each lecture: 45 minutes (20 minute for PRO lecture, 20 minutes for CON lecture)
- ◆ PGY Presenting: PGY3-PGY4
- ◆ Description: EM Controversies is a new lecture series in which controversial topics in emergency medicine will be discussed. Two residents will be assigned a topic that has been debated throughout the course of emergency medicine. The initial bases of the discussion will be based on a clinical case. Each resident will be assigned (or chose) a different stance on the topic pertinent to the clinical

case. Each resident will have 20 minutes to discuss the evidence behind their stance. Each stance should be supported by literature. At the end of the discussion, there will be an open panel for discussion amongst residents and faculty. The goal of this lecture series is to expose the nuances to different topics and provide residents with the literature behind different topics so residents can come to educated conclusions of various medical topics.
    - (examples are in attachment: https://docs.google.com/document/d/1BV-YYyMoP0xs6hz8DZIfWRoMciGIM_5MhTGlPdF8ZA4/edit?usp=sharing)

➔ **Small Talks**
- Attending Coordinator: Dr. Turner
- Duration of each lecture: 15 minutes
- PGY Presenting: PGY1-PGY2
- Description: Small Talks is a lecture series that is geared towards promoting creativity and autonomy to resident lecturers. This session will essentially be a potpourri of presentations never extending past 15 minutes. The resident assigned to a small talk has complete independence to present the conference topic in a unique/creative manner. This lecture series gives residents an opportunity to practice giving concise and engaging lectures and assist in shaping their presenting skills.

➔ **Sono/EKG/Rads/Pharm**
- Attending Coordinator: Dr.Kilpatrick/Dr. Tang/Dr. Kathawala
- Duration of each lecture: 20 minutes
- PGY Presenting: PGY1-3
- Description: This lecture series focuses on the additional skills that residents are exposed to and expected to know. These lectures will be 20-30 minutes long and review topics such as ultrasound, EKGs, common radiographic pathologies, and pharmacology reviews. The ultrasound lectures will focus on the basics of emergency ultrasound and its seven core clinical applications. EKG lectures will review common EKG concepts and common pathologies seen on EKG (which will primarily be based off of Martindale's EKG book-EKG Curriculum). The radiology lectures will review common radiographic pathologies that emergency physicians should be able to independently identify and its associated management (Radiology Curriculum). Lastly, the pharmacology lectures will review the important pharmacological interventions, the evidence behind specific interventions, medications in specific demographics (Pharmacology curriculum)

➔ **Admin & Policy**
- Attending Coordinator: Dr. Mehta/Dr. Brewster
- Duration of each lecture: 20-30 minutes
- PGY Presenting: PGY2-PGY4

- Description: The Admin & Policy lecture series are lectures covering topics such as health policy, ED operations and quality improvement methods. The aim is to educate residents on administrative aspects of emergency medicine and how to navigate and understand changing policy at a organization, state, and national level.(Admin & Policy Curriculum)

➔ **Attending Advice**
- Attending Coordinator: Hassel/Willis
- Duration of each lecture: 20-30 minutes
- PGY Presenting: Attending Lectures
- Description: This lecture series will focus on administrative skills needed for the practice of emergency medicine within an academic and community setting. We will also discuss topics that allow emergency physicians to practice good business skills. Lecture topics include: • Malpractice Insurance • Practice Environment (Academic vs. Community vs. Private vs. Locum Tenens) • Loan Repayment • Contract Signing • Documentation • Resume/Portfolio •ED Flow

➔ **Social & Ethics of EM**
- Attending Coordinator: Aurrecochea
- Duration of each lecture: 20-30 minutes
- PGY Presenting: PGY3-PGY4
- Description: Social & Ethics of EM is a new lecture series that focuses on an array of topics. Including lectures that focus on highlighting the effects of social forces on communities and general health of different populations, lectures on the basics of ethics in terms of the physician-patient relationship, and lectures on palliative medicine and end-of-life patient care. Each resident has autonomy to choose a topic personal to their journey as a physician or a topic they wish to gain further knowledge on. Social & Ethics of EM Curriculum

➔ **Wellness**
- Attending Coordinator: Dr. Camacho
- Duration of each lecture:20-30 minutes
- PGY Presenting: PGY2-PGY4
- Description: The Wellness lecture series are a set of lectures that discuss methods and practices of maintaining one's emotional, intellectual, and physical health during residency. This both consists of didactic and non-didactic lectures. This is generally coordinated by the wellness committee.

➔ **Senior Lecture**
- Attending Coordinator: Dr. Hassel
- Duration of each lecture: 30-40 minutes
- PGY Presenting: PGY4

- Description: Given by a fourth year resident to discuss whichever topic they choose. Most highlight their learning lessons from residency, or topics in which they have interest and have developed through their four years.

➔ **Pediatric Conference**

- These conference days are dedicated to pediatric emergency medicine, and includes the following lecture series: Peds Case Conference, Peds M&M, Peds Journal Club, Peds CBL, as well as lectures given by the PEM faculty and fellows. There is a dedicated PEM Fellow, who is in charge of the didactics on this day, who works with the EM education chief

PRESENTATION PREPARATION POLICY

Resident lecture presentation is an integral part of resident education. Resident presentation allows residents to become experts in the topic discussed. In addition, learning how to give a presentation becomes the foundation of your educational experience. For those continuing careers in academics, giving lectures will be a large amount of your non-clinical responsibilities, thus this becomes an important part of our residency education. Resident presentations should be viewed as a professional event, where proper business casual attire and behavior is required.

Lectures must be submitted to Senior Lecture Coordinators, Faculty Lecture Advisor at least one week prior to the scheduled presentation to allow time for feedback.

We realize that you may have other obligations the month before or the month of your presentation. Therefore, you will need to plan ahead to make sure you have adequate time to prepare your presentation and have it submitted for review 1 week (7 days) prior to your presentation. The yearly schedule of presentations is published on Clinical Monster and available from the Education Chief Resident.

Please contact Dr. Willis and the Education Chief well in advance if there are any issues with presentation preparation; particularly, if there is no response with feedback from the Senior Resident Lecture Coordinators or Faculty Advisor.

Simulation

EM faculty liaisons:
Dr. Stetz - stetzjessica@yahoo.com
Dr. Wolfram - sigrid.brooklyn@gmail.com

Description and Goals:
Participation in simulation is an opportunity to develop and reinforce their medical knowledge in a safe and controlled setting. The goals of this activity are to:

- Improve medical knowledge
- Improve communication skills
- Improve teamwork
- Improve on procedural skills
- Improve medical management/team dynamics with interdisciplinary services

Each Wednesday after conference, residents will be scheduled for a simulation session. ***Each resident from PGY1- PGY5 level will be scheduled for at least four simulation sessions during the academic year***. The simulation schedule will be available from the beginning of the academic year and ***every resident is responsible to request the night prior and the morning of their scheduled session***, similar to when a resident is requesting off to lecture for conference. This request will not count towards your personal requests for the year.

Every resident is responsible to arrive at the Simulation Room at 12:10pm on your assigned day. If you are late and the session has already started without you, you will need to discuss with the simulation faculty options to make up your session. Each resident will receive 1 hour of asynchronous credit for each simulation session and may log every procedure performed during the session in New Innovations. Please select the simulation faculty member running the session on your assigned day to verify your attendance and receive credit.

Please note that the simulation schedule may need to be modified because of other Residency Activities as the year progresses. You will be informed ahead of time if any changes are being made.

The reasons to be excused from a particular Simulation Session are the same ones as for being excused from the morning Conferences (annual leave, being ill, working in the ICU, etc.), but you still must notify Drs. Stetz, Wolfram and Kim and let them know this, on the Monday before that particular simulation session, or you will owe 4 hours. For every 2 sessions you miss without notifying Drs. Stetz, Wolfram and Kim, you will be given an 8 hour clinical shift. Please note that this rule will be strictly enforced. The residency leadership understands that unforeseen circumstances can occur, which accounts for only 4 clinical hours to be accrued for the first occurrence of minor infractions.

The residency leadership reserves the right to review each case, depending on the circumstances of the situation and act accordingly.

Please note that if you are assigned to do a Simulation Session that day, you should come to the Board Review Group at 12:15 and then go to the Simulation Session at 12:30. Please inform simulation faculty of your involvement in Board Review ahead of time.

If there are any questions or concerns regarding your schedule, please contact Drs. Drs. Stetz, Wolfram and Kim. If you are unable to attend your scheduled simulation session, you may swap with another resident within your PGY year. All swaps, however, must be approved by Drs. Stetz, Wolfram and Kim at least a week in advance of your scheduled session.

INDIVIDUALIZED INTERACTIVE INSTRUCTION (III) (Asynchronous Learning)

Each resident must complete a minimum of 36 hours (18 hours for EM/IM residents) prior to May 15th of each respective academic year for the purposes of promotion and/or graduation. A maximum of 48 hours per academic year counted from July 1st to June 30th is permitted and encouraged. Remember that III hours are required toward satisfaction of the overall conference requirement!

How to log asynchronous hours in New Innovations:

For each 1 hour of credit, you must input a separate entry in the "Procedure Logger" selecting "1 hour of Individualized interactive instruction " as the procedure. The following is a list of required fields to complete for each entry:

1. Patient ID: NA
2. Last Name: NA
3. Patient Type: Asynchronous Learning
4. Date Performed: Date activity was completed
5. Procedure: 1 hour of Individualized interactive instruction
6. Supervisor: Name of supervising attending
7. Role: Performed Procedure
8. Diagnosis Text: Name of activity completed - be specific! (i.e. EB Medicine: Title of article completed)

If you need to submit learning objectives or a certificate along with the hour, please **email** it to your class dean. If the activity is worth more than 1 hour of credit, you must log the activity an additional time for each additional hour of credit (i.e. upon completion of the IMSAL Advanced Airway Skills Course, you would log the activity 4 times to receive all 4 hours of credit but please place “hour 1, hour 2 ….. in the comments section). You will receive credit upon verification by the supervising attending of your participation and satisfactory completion of the activity.

Warning: If an entry in New Innovations is incomplete or incorrectly submitted, it may be refused or deleted upon review.

1. **EB Medicine**: Each resident has free access via their EMRA membership to ebmedicine.net. Each resident will receive 1 hour of credit for each completed article. To receive credit, you must have the opportunity to discuss learning objectives and questions with your Class Dean or Faculty Advisor and email your class dean the CME certificate. Please list 5 learning objectives in the comments section as well. Each resident may receive credit up to a maximum of 20 hours per academic year for this activity.
2. **Critical Decisions:** Each resident has free access via their EMRA membership to http://www.acep.org/cdem/. Each resident will receive 1 hour of credit for each completed article. To receive credit, you must have the opportunity to discuss learning objectives and questions with your Class Dean or Faculty Advisor and email your class dean the CME certificate. Please list 5 learning objectives in the comments section as well. Each resident may receive credit up to a maximum of 20 hours per academic year for this activity.
3. **EM:RAP**: Each resident has free access via their EMRA membership to EM:RAP. Each resident will receive 2 hours of credit for each completed podcast. To receive credit, you must have the opportunity to discuss learning objectives and questions with your Class Dean or Faculty Advisor and email your class dean the CME certificate. Please list 5 learning objectives in the comments section as well. Each resident may receive credit up to a maximum of 20 hours per academic year for this activity.

4. **ALiEM AIR Modules**: Each resident will receive the recommended number of hours of credit for completion of each module. Each module must be completed per the instructions on the ALiEM site. To receive credit, you must have the opportunity to discuss learning objectives and questions with your Class Dean or Faculty Advisor and email your class dean the CME certificate. Please list 5 learning objectives in the comments section as well.
5. **Board Review:** Each resident will receive 1 hour of credit for each session. You must log your attendance in New Innovations* and select the supervising attending to verify your attendance and receive credit.
6. **Simulation**: Each resident will receive 1 hour of credit for each simulation session. This also includes Trauma Simulation, Procedure Simulation, Student Simulation, and Cadaver Lab sessions. You must log your attendance in New Innovations* and select the supervising attending to verify your attendance and receive credit.
7. **Pediatric EM Fellowship Conference**: Each resident will receive 1 hour of credit for each hour of attendance at the PEM conference (maximum of 3 hours per week). You must log your attendance for each hour of participation in New Innovations* and select the supervising attending to verify your attendance and receive credit.
8. **Food and Journal Club**: Each resident will receive 1 hour of credit for each meeting. You must log your attendance in New Innovations* and select the supervising attending (usually Dr. Wiener) to verify your attendance and receive credit.
9. **NYCPCC Consultants Conference**: Each resident will receive 2 hours of credit for each conference attended. You must RSVP to Dr. Wiener in advance to ensure that he will be present to verify your attendance. You will not receive credit for attending this conference during your toxicology rotation, as this is already a requirement for that rotation. You must log your attendance in New Innovations* and select Dr. Wiener to verify your attendance and receive credit.
10. **Slit Lamp Sessions**: Each resident will receive 1 hour of credit for each session. You must log your attendance in New Innovations* and select the supervising attending (usually Dr. Silverberg) to verify your attendance and receive credit.
11. **Resident as Teacher:** Each resident will receive 1 hour of credit for each educational activity. You must log your participation in New Innovations* and select the supervising attending to verify your attendance and receive credit.
12. **Mini-Fellowship Conferences**: Each resident will receive 1 hour of credit for each conference. You must log your attendance in New Innovations* and select the supervising attending to verify your attendance and receive credit.
13. **IMSAL Advanced Airway Skills Course**: Each resident will receive 4 hours of credit for completing the course. To receive credit, you must copy and paste the CME certificate into the comments section as you log your submission in New Innovations* selecting Dr. Kim.
14. **Education Conferences (ACEP, AAEM, SAEM, CORD):** Each resident will receive 1 hour of credit for each educational session attended up to a maximum of 5 hours for each conference. To receive credit, you must contact a participating faculty member in advance of the session who will attend the session with you and discuss and evaluate the educational objectives of the lecture immediately after the session. You must log your attendance in New Innovations* and select the supervising attending to verify your participation and receive credit.
15. **Morning Report:** We ask that you prepare your morning report in .doc format with the following criteria:

- Write post in a way so that it makes sense to those who were not able to attend your morning report presentation.
- Use a recent review paper - you can still cite up-to- date or medscape, but

you should not be using these as your PRIMARY sources.
- Whenever possible and if the topic permits, please cite at least 1 relevant primary study that's a higher level of evidence (systematic review, meta-analysis, RCT)
- Remember to cite all FOAM/podcasts/blogs, links are helpful for interested peers.
- Include any good discussion points that were brought up during your presentation (controversy, questionable management)
- Meet the deadline for editing and review prior to posting (1wk after your morning report).

Send drafts to Dr. deSouza (juicemd@yahoo.com) within a week. If all of these are met sufficiently, you will be awarded 1-hour of asynchronous learning credit (to be logged in New Innovations under Dr. DeSouza).

16. **Case, Controversies & Conversations**: Start up/join a clinical conversation on the blog. http://blog.clinicalmonster.com/2016/04/case-conversations/http://blog.clinicalmonster.com/2016/04/case-conversations/
http://blog.clinicalmonster.com/2016/04/case-conversations/
Send a case with a clinical question and 1 possible answer w/ a reference & get 1 hour of III.

Post a comment on a case and get points toward asynchronous.
- 10 points = 1 hour asynchronous
- 1 point for relevant comment
- 5 points for reference to a relevant online resource
- 5 points for reference to relevant articles

All posts will be approved by Dr. deSouza and should be logged in New Innovations.

17. **Blog Posts:** Write a blog post with up to 4 references for 2 hours of asynchronous credit, an additional hr for 4 more references. Ex- 4 -7 references = 2 hrs. 8-13 references 3 = hrs, etc.

Note: Credit for other conferences not explicitly mentioned above is given on a case by case basis if it complies with RRC guidelines. To receive credit in these instances, approval must be given by the Program Director or his/her designee prior to participation at the conference.

PROGRAM POLICIES AND PROCEDURES

RESIDENT RESPONSIBILITIES AND DUTIES

In accordance with the recommendations of the Accreditation Council for Graduate Medical Education (ACGME), and the SUNY-Downstate Graduate Medical Education Committee, the resident will be provided with an opportunity to:

1) Develop a personal program of self-study and professional growth with guidance from the teaching staff.
2) Participate in safe, effective, and compassionate patient care, under supervision, commensurate with their level of advancement and responsibility.
3) Participate fully in the educational scholarly activities of their program and, as required, assume responsibility for teaching and supervision of other residents and students.
4) Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.
5) Participate in institutional committees and councils, especially those that relate to patient care review activities.
6) Participate in evaluation of the quality of education provided by the program.
7) Develop an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education and of how to apply cost containment measures in the provision of patient care.
8) Residents shall perform their duties and at all times conduct themselves in compliance with all applicable departmental rules and regulations, as well as applicable Hospital policies and procedures, both personnel and operational and such specific rules and regulations.

It is therefore expected that the resident always acts in a professional manner. Dishonesty, disinterest, and unkindness are serious offenses and may be grounds for dismissal from the program.

POLICY ON ELIGIBILITY AND SELECTION OF RESIDENTS

Candidates for residency will have graduated from an LCME-accredited medical school or a medical school fulfilling ECFMG standards. Candidates will have passed the USMLE step 2 or the Complex Step 2 prior to entry into the training program. Residents will hold a medical degree from an allopathic or osteopathic medical school or an equivalent degree if from a foreign medical school.

All applications for PGY1 positions are accepted through the ERAS program. At the discretion of the Program Director, residents may also enter the program through special international education programs. These residents may function outside or as part of the main residency program. The Residency Director and the Assistant Directors screen completed applications for

specific criteria. Interviews are offered to approximately 200 applicants based on their personal statement, letters of recommendation, board scores, transcripts and dean's letter. Interviews are held twice a week, with 10 applicants per session. Applicants are given an introductory slide presentation, which describes the key aspects of the program including the length of the program. Usually, the residency director, and the assistant residency directors, and a resident interview candidates. The interviews are one on one or two on one and run approximately 20 minutes each. During the interview day, applicants are offered an opportunity to meet with residents for a question/answer session and tour of the facilities. Recruitment for the combined program is done similarly in concert with the Internal Medicine Program Director.
The Interviewers rank the applicants based on their prior academic performance and future growth potential, their interview presence and interpersonal skills, their commitment to Emergency Medicine, ethnic and cultural diversity, and the desire to work and learn in an inner city hospital environment.

MILESTONE EVALUATION

The RRC has designed milestones that are designed to represent knowledge and abilities needed to be an effective EM physician. The milestones are designed to track a resident through residency in order to inform the resident and residency leadership of their adequate progress. The milestones are not designed to define promotion or graduation, that is still left to the residency leadership but it will be a more standardized approach to evaluation.

The EM RRC has developed 23 milestones ranging from patient care to system-based practice. There are 5 levels to each milestone with anchors within each level (see below for a list of all milestones). When a resident has completed all anchors they can be moved up in milestone level. The levels were designed in a way that a graduating medical student should be a level one, a graduating resident should be a level 4 and a level 5 can reflect a 3-4 year attending. These distinctions are just guidelines and each physician will be different.

In order to have objective data to evaluate the residents during EM rotations, each resident must submit "shift cards" through new-innovations for every week that the resident rotates in an ED setting except when at NYU-B. Four-week rotations require the resident to ask for 4 shift cards while 2-week rotations require 2 shift cards. Please try to choose the "correct" week in New Innovations when you send out shift cards. For example, if you are on a 2-week rotation in the second half of the block, please request a "Week 3, Red" shift card for your first week and a "Week 4, Yellow" shift card for your second week. (Each different color shift card is associated with different milestones to be evaluated by the selected faculty member) Ideally this should be done at the end of the shift in order to get a face-to-face evaluation and the most accurate information. All other rotations will have evaluations assigned to attendings the residents should have worked with on that rotation. Below there will be a tutorial on how to submit evaluations.

Each resident must be assessed and assigned a milestone level every 6 months. This must be done with the input of multiple faculty members within a group called the Clinical Competency Committee (CCC). The description of the CCC, its members and responsibilities is written below. During 6 month evaluations, the milestones will be reviewed with each resident. Residents can view them on new-innovations through the portfolio tab.

Shift Card Tutorial

Log into www.new-innov.com and scroll down to the evaluation tab. Click "Advanced Request." Scroll to the attending you wish to evaluate you and choose their name. A list of available evaluation choices will appear. Choose the shift card corresponding to the week of the block you are currently on. All weeks must be used during a block because there are different milestones evaluated. You may also choose to send additional shift cards focusing on areas you wish to receive specific feedback, ie documentation, a procedure.

Clinical Competency Committee

Purpose: Clinical Competency Committee (CCC) duties are to review multi-source assessment data and make recommendations to the Program Director (PD) regarding attainment of milestones, readiness for progression in training, and potential plans for improvement (if milestones not attained).

Frequency of meetings: Individual CCC class meetings take place at the discretion of group leaders. Every resident must be evaluated semi-annually at least one month prior to the six-month evaluation with the PD. There will be a semi-annual session with group leaders and Program Director for a final milestone assessment.

Data to be reviewed:
1. Global evaluations
2. Shift evaluation cards
3. Rotation evaluations
4. In-service scores
5. Conference Attendance
6. Follow up Logs
7. Ultrasound numbers
8. QI projects
9. Resident CVs/education portfolios

Process: Each member of the CCC will review 3-5 resident's evaluations, in-service scores, attendance and ultrasound numbers, follow up logs, QI projects and resident portfolios. Most of this data will be provided by the program directors and new-innovations. It is encouraged to reach out to the residents for their CVs/portfolios in order to take into account personal projects and accomplishments. An assessment and proposed milestone score will be placed in new-innovations. This will be discussed with the group leader and an overall recommendation will be made. All recommendations will be submitted on new innovations including comments. The group leaders will then meet with the PD before the semi annual submission to the ACGME and finalize milestone submissions as well as any action plans for remediation. Consensus is the goal for each milestone with the final decision as per the PD.

Informing the Resident: The resident will be informed of the committee's determination at the 6-month evaluation, or sooner if the action recommended by the committee mandates greater urgency. The resident and the evaluator will then determine how to implement the plan of action and whether formal actions must be taken as a result of deficiencies in performance.

EM Milestones

https://www.acgme.org/Portals/0/PDFs/Milestones/EmergencyMedicineMilestones2.0.pdf?ver=2021-02-24-104718-043

PROMOTION/GRADUATION CRITERIA

Education in emergency medicine is a lifelong journey, not a destination. We, as a program, will teach you the fundamental skills, knowledge and humanistic qualities that constitute the foundations of emergency medicine practice. Under the guidance and supervision of qualified faculty, residents need to develop a satisfactory level of clinical maturity, judgment and technical skill. Upon completion of this program, residents should be capable of practicing emergency medicine independently, be able to incorporate new skills and knowledge during their careers, and be able to monitor their own physical and mental well-being and that of others.

The Resident Education Committee has established specific educational and administrative criteria for promotion to the next program level and graduation from this program. Educational requirements are outlined for each program year in the "Educational Objectives" section in this handbook. Furthermore, ACGME core competencies criteria and Emergency Medicine Milestones by which residents' performance will be judged, is outlined in the "Evaluations" section in this handbook. Please read these sections carefully.

Other promotion/graduation criteria include, but are not limited to:

• **Procedure and Resuscitation log:** Residents must document all procedures via the procedure tracking module of New Innovations. Remember to log every resuscitation in your online procedure log— the RRC thinks we do not do enough resuscitations. Procedure and resuscitation log review will be performed by the Residency Directors or your faculty advisor at regular intervals and at your 6-month evaluation. Please pay special attention to logging pediatric medical and trauma resuscitations and make sure to document your role in these resuscitations.

• **Competencies:** The RRC for EM mandates that every resident across the country be evaluated for competency. They dictate that a faculty member must watch you do 5 chief complaints, 3 procedures (1 must be an ultrasound) and 1 resuscitation each year of residency. This is supposed to be an extensive evaluation where the attending must actually watch you perform the interview/procedure and document your competency for all 9 of these encounters so please do not leave this to the last second. The competencies are logged in New Innovations as if they were procedures. Please chose the correct competency and then put a description of the competency in the "Diagnosis Text" section so the attending knows which encounter they are signing off on.

Requirements- Every resident must log:

• 5 chief complaints per year

• 3 procedures per year. (One of these procedures must be an ultrasound, Ultrasound guided central lines do not fulfill this requirement)

• 1 resuscitation per year

• Patient Care Follow-ups: Residents will be required to keep online documentation of patient care and clinical questions encountered for EM patients. You must do 4 follow-ups per year and each one will require a lit review and an answer to some clinical question. These will be recorded New Innovations. You will notice you are assigned 1 follow up each block for the first 4 blocks. They will appear as evaluations to fill out at the bottom of your home-screen in New Innovations. You may start them at the end of the 1st block of each academic yr when they are "opened." Complete this by May 15th.

• **Six-month evaluation:** Twice yearly the Residency Directors will review each resident's performance and discuss progress, achievements, advancements, problems, and projects with the resident. Residents must fill out an extensive self–evaluation package prior to their six-month evaluation. This is obtained from the residency coordinator.

• **Morning Report:** All residents scheduled to work Monday, Tuesday, Thursday and Friday at KCHC at 7 AM or coming off the preceding overnight shift are required to attend. Residents scheduled at UHD are encouraged to attend at the discretion of the UHD Attending. Residents must first report to UHD for rounds and are to report back promptly at the conclusion of the case. The resident presenting the morning report is required to submit a one-page write-up to the residency coordinator for his/her Portfolio on each topic that he/she presents. The write-up should consist of a brief summary of the case with the pertinent teaching points highlighted.

• **Wednesday conference attendance:** The RRC mandates at least 70% conference attendance by all residents. Therefore, all residents are required to attend Wednesday conference, unless they are excused because of ACGME work hour requirements (see "Monthly Schedules" section in this handbook) or they are on an ICU-based off service rotation. Remember, you will already miss a significant portion of conference during vacation and off-service rotations. If you need to miss a conference, you must speak with one of the residency directors or a chief resident.

• **USMLE Step 3:** Passing Step III will be required by the end of your 2nd year in your residency training. You will be placed into a status called "non-renewal" if you do not have step 3 completed by the end of your second year. If you are still in "non-renewal" by the end of your third year, you will not be offered a contract to enter into your fourth and final year of training and you will lose your spot in the residency. Do not take this lightly. It is hospital policy and not arguable.

• **Summary of Resident portfolio**: Residents are required to write a summary of their resident portfolio in order to be promoted to the next PGY level or to graduate. Please see the portfolio section of the handbook for more information. This will be reviewed by a residency director during your 6-month eval.

• **Faculty advisor**: Your faculty advisor should meet with you at least every 3 months, although this will occur more or less frequently depending on the advisor. It is your responsibility to approach your advisor. Please inform the Residency Directors if there are any problems with meeting with your advisor or if you wish to be assigned to a different advisor for any reason.

PLEASE BE AWARE: Compliance with the fulfillment of these regulations has been a problem in the past, especially during the last months of the final year. Please follow these rules carefully - it is ultimately the Program Director's decision on whether to promote or graduate you.

SUPERVISION OF RESIDENTS AND ESCALATION POLICY

Introduction

All patient care should be performed by residents with appropriate faculty supervision and conditional independence. The supervision of trainees is designed to provide gradually increased responsibility and maturity in the performance of the skills attendant with competence of a specialist in this discipline. The appropriately supervised and qualified trainee should, at the end of training, have acquired the knowledge, skills, attitudes, and trustworthiness necessary for unsupervised practice. All supervising faculty members are expected to not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship.

General Principles

1. Every patient evaluated in our EDs must have an identifiable attending physician who is appropriately credentialed with privileges by the Medical Staff of the appropriate institutions. This individual is responsible and accountable for patient care and must be identifiable to residents, all members of the emergency department (ED) healthcare team, and patients.
3. All attendings, residents, and medical students on duty in the ED must introduce themselves to the patients for whom they provide direct patient care and inform patients of their respective roles.
4. The medical staff have overall responsibility for the quality of the professional services provided to patients, including patients under the care of the residents/fellows. It is, therefore, the responsibility of the medical staff to ensure that supervising faculty members are granted clinical privileges through the medical staff credentialing process.
5. The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

Definitions

1. Resident: Any post-graduate trainee in the specialty of emergency medicine (EM)
a. Senior Resident: A post-graduate trainee in his/her 3rd or 4th year of EM residency training.
2. Faculty Attending: A licensed physician who is board-eligible or board-certified through the American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine and is credentialed by SHC to perform clinical duties and procedures specific to the specialty of emergency medicine.
3. Supervising Physician: This may be a faculty attending or, within our graduated responsibility model, a senior resident.
a. A senior resident who serves as a supervising physician for a more junior resident is expected to staff all supervised patients with a faculty attending prior to patient disposition.
4. Our EDs are staffed with faculty attendings 24 hours/day for 7 days/week and will use

only two levels of supervision:
a. Direct Supervision
i. The supervising attending is physically present with the resident in the ED exam room during key portions of the patient interaction or is concurrently monitoring patient care through appropriate telecommunication technology.
b. Indirect Supervision with direct supervision immediately available
i. The supervising attending is in the ED and immediately available to provide direct supervision, however is not present physically or via telecommunication during patient interaction
1. A senior resident may provide direct supervision of key portions of patient interaction as part of graduated responsibility. An attending must be immediately available to provide Direct Supervision.
Policy
1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care will be granted to each resident based on the resident's abilities. These abilities will be guided by the Milestones and assessed via:
a. Clinical Competency Committee (CCC) and program director (PD) which meet on a quarterly basis to review:
i. Procedure logs
ii. Formal and informal faculty and peer feedback, which is both quantitative and qualitative in nature and based primarily on authentic workplace-based assessment which documents the level of supervision faculty provide on a given shift for specific workplace tasks
b. Direct clinical observation
c. ACGME EM Milestones
2. Supervising physicians must delegate portions of patient care to residents based on the needs of the patient and skill of the resident. However the faculty attending maintains ultimate responsibility for each patient and will review the resident's clinical decision making and see the patient personally prior to the patient's disposition (discharge, admit to inpatient or observation). Factors such as patient safety, complexity, acuity, urgency, and risk of serious adverse events will be considered when determining each resident's degree of independence.
3. Minimum supervision standards by PGY:
a. PGY-1: All patients must be presented to the supervising physician after initial evaluation. The supervising physician provides direct supervision consisting of, but not limited to:
i. Obtaining (repeat) history and physical
ii. Orders
iii. Documentation
iv. Patient communication
v. Procedures
b. PGY-2: All patients must be presented to the supervising physician after the

resident has developed and initiated the initial plan of care. The supervising physician provides direct supervision consisting of, but not limited to:
i. Documentation
ii. Patient Communication
iii. Procedures
c. PGY-3: All patients must be presented to the supervising physician prior to procedures or disposition decisions. The supervising physician provides direct supervision consistent of, but not limited to:
i. Documentation
ii. Key portions of procedures
d. PGY-4: All Patients must be presented to the supervising faculty attending prior to procedures or disposition decisions. The supervising physician provides direct supervision consistent of, but not limited to:
i. Documentation
ii. Key portions of procedures
e. All patients in the EDs must be seen and formally evaluated by a faculty attending at some point in the course of their ED stay
4. The supervision policy will be distributed to trainees and faculty attendings annually.
5. The program director has responsibility, authority, and accountability for the supervision of residents.
6. Circumstances and events where residents must communicate immediately with faculty attendings are reviewed in the supplement to this policy (see below).
7. In residency training, it is incumbent upon a physician to be aware of his/her own limitations and consult a physician with more expertise when necessary. If at any point during the course of a patient's evaluation by a resident in the ED the resident has any doubt about the need for supervision, the supervising faculty attending is directly available.
8. Residency core faculty supervision assignments will be of sufficient duration and frequency in order to assure sufficient time to be able to accurately and fully assess the knowledge and skills of the residents. In general this will be achieved by scheduling faculty in the ED for a minimum of eight hours per week for 52-weeks each year.
9. All ED patients must be seen and evaluated by a faculty attending prior to their disposition from the ED.
10.Facesheets with residents' names, photos, and PGY level will be displayed in the ED to allow nurses and physicians to readily identify a resident's PGY level and requisite level of supervision.

Residents working in the ED will be supervised by ABEM board-eligible or board certified attending physicians who are licensed in the state of their practice. When residents rotate on non-EM services, they will be supervised in accordance with the ACGME/RRC faculty supervision guidelines for that specialty. Residents rotating in the Pediatric Emergency

Department may be supervised by faculty boarded or board-eligible in Pediatric Emergency Medicine.
Residents rotating in the Pediatric Emergency Department may also be immediately supervised by fellows enrolled in an ACGME-accredited Pediatric Emergency Medicine fellowship. However, these residents will also have immediate access to a faculty member who is board-certified/board-eligible in EM or Peds EM (see PEM rotation for more details).
All EM residents are ultimately under the supervision of the Program Director of Emergency Medicine regardless of their present rotation.
In the ED, each patient encounter MUST be presented to a faculty member prior to disposition. All charts MUST be countersigned by an attending in a timely manner.
Junior residents can be supervised by senior residents in the ED or the respective specialty under which they are rotating, but they must ultimately be under a supervising faculty meeting the above criteria. Residents must be under direct supervision during all procedures until they are credentialed in that procedure. After that time, they will perform all procedures under general supervision. In the ED, there is always an attending in the clinical area to supervise all procedures. Faculty will not provide coverage from outside of the clinical area. As the resident progresses in their level of training, they are given more autonomy in regards to patient management plans, procedures, and disposition.
Senior residents will be responsible for supervising the junior residents working in their assigned clinical area. Residents are also responsible for supervising and monitoring medical students. However, all patient encounters must ultimately be presented to the faculty in the clinical area. Residents will also work in conjunction with the nurse and clerical staff to assure that optimum patient care is given.
Further delineation of supervisory policies can be found in the resident handbook under that rotation summary.

Residents are encouraged to communicate with supervising faculty any time they feel the need to discuss any matter related to patient care. Direct supervision by faculty attendings is always immediately available in our Emergency Departments.
In addition, there are defined circumstances and events when a resident must communicate immediately with the supervising faculty:
1. Patients with anticipated admission to ICU
2. End of life discussions including Do Not Resuscitate status
3. Any new patient encounter with a clinically unstable patient based on vital signs, physician/nurse concern, or clinical presentation
4. At request of another physician or nurse, either within the ED or from another department
5. At request of patient or family
6. Prior to any procedure (see Table 1)
7. After an error or unexpected adverse event
8. A patient who presents as hostile or violent
9. Initiation, continuation, or cessation of life-supporting interventions

Table 1: Level of supervision required by PGY level for key index procedures in EM
This table serves as a general graduated supervision guideline based on time in training. However, in an effort to implement competency-based education and make data-informed, outcomes-oriented decisions about preparedness for the next phase of graduated supervision, the Clinical Competency Committee may recommend that individual residents have more supervision than indicated on the table if they are delayed in meeting competency expectations for their given level of training and have not yet achieved competence in one or more domain.

Procedure	PGY1	PGY2	PGY3	PGY4
Adult Medical Resuscitation	D	D	D	D
Adult Trauma Resuscitation	D	D	D	D
Cardiac Pacing	D	D	D	D
Central Venous Access	D	I	A	A
Chest Tubes	D	D	D	I
Cricothyrotomy	D	D	D	D
Dislocation Reduction	D	D	I	A
ED Bedside Ultrasound	D	I	A	A
Intubation	D	D	D	I
Lumbar Puncture	D	D	I	A
Pediatric Medical Resuscitation	D	D	D	D
Pediatric Trauma Resuscitation	D	D	D	D
Pericardiocentesis	D	D	D	D
Procedural Sedation	D	D	D	D
Vaginal Delivery	D	D	D	D
Laceration Repair	D	I	A	A
Cardioversion	D	D	I	A

D=direct supervision for full procedure by attending physically present in the room
I=direct supervision for key portions of the procedure by attending physically present in the room
A= attending is immediately available but not physically present in the room

POLICY ON RESIDENT WORK HOURS

Purpose:

To comply with the New York Health Code Section 405 Regulations, ACGME Common Program Requirements and to establish a work environment with physicians fit for duty and conducive to resident/fellow education and the provision of safe and effective patient care. The following GME Committee policy has been accepted by the New York State Department of Health and conforms to NYSDOH Section 405 regulations and ACGME requirements revisions which became effective July 1, 2017. https://acgmecommon.org/2017_requirements

Definitions:

Attending Physician: An appropriately privileged member of the medical staff who accepts full responsibility for a specific patient's medical/surgical care.

Continuity clinic: Setting for a longitudinal experience in which residents develop a continuous, long- term therapeutic relationship with a panel of patients.

Duty Hours: time spent in all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

External moonlighting: Voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites.

Faculty: Any individuals who have received a formal assignment to teach resident/fellow physicians. At some sites appointment to the medical staff of the hospital constitutes appointment to the faculty.

Fatigue management: Recognition by either a resident or supervisor of a level of resident fatigue that may adversely affect patient safety and enactment of a solution to mitigate the fatigue.

Fitness for duty: Mentally and physically able to effectively perform required duties and promote patient safety.

Night shift or night float: A duty assignment which takes place during night time hours and is distinct from on-call assignment.

On-Call: A period during which a resident is assigned to be in-house or available at home in addition to the regularly scheduled duty activities.

Residents or Fellows: Physicians engaged in a program of graduate medical education under the tutelage and supervision of appropriately qualified faculty and attending staff.

Scheduled duty periods: Assigned duty within the institution encompassing hours which may be within the normal work day, beyond the normal work day, or a combination of both.

Strategic napping: Short sleep periods, taken as a component of fatigue management, which can mitigate the adverse effects of sleep loss.

Transitions of care: The relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the health care setting.

The ACGME Work Hours: (effective 7/1/2017)

Maximum Hours of Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house call clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Duty Clinical Work and Education

The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.

Residents should have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house duty call.

Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Clinical Work and Education Period Length

Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.

Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions

In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

To continue to provide care to a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or to attend unique educational events.

These additional hours of care or education will be counted toward the 80-hour weekly limit.

A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

In preparing a request for an exception, the program director must follow the clinical and educational hour exception policy from the ACGME Manual of Policies and Procedures.

Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.

Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety.

Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.

PGY-1 residents are not permitted to moonlight.

In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (The maximum number of the consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.)

Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

At-Home Call

Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to teh every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

Emergency Medicine Specific Regulations

While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. There must be at least one equivalent period of continuous time off between scheduled work period. A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week. Emergency medicine residents must have a minimum of one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period.

Policy on Difficult and Prolonged Patient Care

1. In the event that a resident may no longer be able to perform his/her patient care responsibilities due to the demands of difficult and prolonged patient care and/or resident fatigue the resident must immediately inform his/her supervising attending who will make arrangements for the safe transfer of the resident's patient care responsibilities to ED attending and resident staff on duty as appropriate to the clinical condition and patient care needs of each patient.

2. Additional circumstances in which arrangements for the transfer of patient care from a resident to other clinical providers on the ED patient care team will be made by a resident's supervising attending physician include resident illness, family, and personal emergencies.

3. Transfer of patient care responsibilities from a resident to other clinical providers on the ED patient care team due to any of the circumstances listed in 1 and 2 will occur without

any negative or adverse consequences to the resident who is unable to provide the clinical work.

4. In the event a resident experiences excessive fatigue that would preclude the ability to safely drive or utilize other transportation methods to return home the resident will have access to a quiet, resident sleep space within the hospital where the resident can obtain adequate rest to ensure the ability to safely return home.

EVALUATIONS AND FEEDBACK

Residents will be evaluated on each clinical and non-clinical rotation using the following evaluation & feedback mechanisms. The six (6) core competencies and 23 EM milestones will be addressed in these evaluations as they apply to the individual rotation.

Evaluation process:

1. Resident Evaluation and Feedback

Multiple tools are used in the evaluation of the residents. They include oral feedback, written monthly evaluations, the New Innovations computerized system, 6-month reviews with the Residency Directors, faculty advisor meetings, self-evaluation forms and during computerized high fidelity simulated patient encounters (SIM sessions).

• Oral feedback is often provided by supervising faculty during or after each clinical shift. If it is not, it can/should be sought. Generalized feedback like “you did great” should not be accepted. Ask for specific points. Pre-attending senior residents can also provide feedback.

• Brief written evaluation will be completed at the end of every rotation by supervising faculty for each clinical rotation block. Additionally, the Residency Education Committee will fill out an in-depth evaluation on each resident at least twice per year to better pinpoint growth areas for each resident. Each resident is responsible for soliciting "shift cards" for every week they rotate in an ED except when at NYU-B. All of these evaluations can be found in New Innovations (NI) and can be reviewed at any time by the residents but must be signed prior to the resident completing their regular 6-month evaluations. When in the ED, Senior Residents will also fill out electronic evaluation forms in NI for Junior Residents and vice versa, which will be reviewed by the Resident Education Committee. These evaluations are all open to review by the resident and faculty at all times. Residents review and sign all of these evaluations regularly but no less often than at their 6 month evaluations. (Next bullet)

• Twice yearly, one of the Residency Directors will review each resident’s performance and discuss progress, achievements, advancement, problems/concerns and projects with the individual resident. Six Month Evaluations will follow the general framework.

-All Evaluations will cover- procedure logs, Scholarly Activitiy, Residency Concerns, Personal Goals, Wellness, Feedback review, Professionalism
PGY1a- informal checking, adjusting
PGY1b- Transition to Senior Role in ICU/Not being the Intern
PGY2a- Wellness Framework
PGY2b- Senior Resident- Leadership Skills, Elective Planning
PGY3a-Capstone, Career Check-in, Chief Resident
PGY3b- Career Planning, Documentation, Elective Planning
PGY4a- Documentation, Teaching, Holes in Knowledge
PGY4b- Exit Interview

• Residents must fill out an extensive self-evaluation package prior to each six-month evaluation.

• Residents are responsible to meet with their faculty advisor at least once quarterly for evaluation and feedback on performance. Advisors have full access and may look at their

resident's personal files including their portfolio, procedure certification and their "problems and concerns" file if any issues have been placed in this location.
• Annual competencies logged in New Innovations require direct observation by a faculty member in the clinical setting for approximately 10-20 minutes per encounter. The resident is required to get an attending to observe 5 patient interviews of different chief complaints, 3 procedures (including 1 sonogram) and 1 resuscitation each academic year. These numbers can be manually altered for certain residents that the Resident Education Committee feels needs to be evaluated more or less often than the general resident population. The goal is to evaluate the residents with specific attention paid to the elements of the 6 core competencies and 23 EM milestones. Both faculty and resident are able to provide immediate feedback about that specific clinical encounter.
• Resident charts will be reviewed on a random basis as part of the Emergency Department's ongoing Quality Assurance Program.

3. Faculty Evaluation:

• All residents are required annually to evaluate all faculty members at KCH/Downstate and the affiliates using New Innovations. These evaluations are anonymous. This set of forms is electronically released at the start of block 6-7 to every resident for completion prior to May 15th. If you have not finished these evaluations before May 15th date, you may not be eligible for promotion into the next yr of residency training including graduating from the program.
• Residents have the opportunity to evaluate faculty during their six month evaluation with the program directors as well

4. Rotation Evaluation

• Residents must evaluate each of their rotations at the end of the block. Evaluations are done online in New Innovations. They are generated each time a rotation ends. These forms will become part of the resident electronic file in New Innovations and will be reviewed by the program directors regularly. If you have not finished these evaluations prior to that May 15th date, you may not be eligible for promotion into the next year of residency training including graduating from the program.

5. Program Evaluation

• The program's ability to achieve its stated goals and objectives is evaluated on a yearly basis by both faculty and residents through specially designed forms available from the residency coordinator.

6. Anonymous Feedback

The program takes resident feedback very seriously. All faculty and rotation evaluations submitted in New Innovations are anonymous. If you would like to provide additional anonymous feedback use the google form link below.
https://docs.google.com/forms/d/e/1FAIpQLSfpF5er6qRxdMrCMs2uy38J9ZlB9wt9KEbAN16aXGoukqZPow/viewform?usp=sf_link

Sign-on to: emresidency.kch.UHD@gmail.com
Password: CountyStrong

PLEASE BE AWARE: Compliance with the fulfillment of these requirements has been a

problem in the past. We will therefore deal with non-compliance very strictly. Residents in non-compliance will have to meet with one of the residency directors in person. They may be given extra assignments or may even be prevented from advancing to the next year of their residency training (even graduating) if these goals have not been fulfilled.

SUNY Downstate/ Kings County Emergency Medicine Residency Resident Feedback Guide Form

meant to act as a guide to in person feedback after the shift

What went well today?

What can I improve on from today's shift?

What should I work on for the future?

RESIDENT PORTFOLIO

The resident portfolio is a useful tool to document all of your educational activities, assist you in the development of expertise and promotion, and will give you a sense of satisfaction and accomplishment. This is the first step on your lifelong journey as a teacher and educator. At some point in your career you will have to present the same or similar information to your chairman when negotiating promotion and tenure as a faculty member.

Portfolios will be built throughout your residency and should be updated whenever a new activity is performed. At every 6 month evaluation this will be reviewed and should be up to date at least at every 6 month interval of residency.

There are two main parts of the portfolio described below.

1. A quantitative summary of teaching/scholarly/research activities:
    - Formal didactic presentations (all lectures to faculty, seniors, juniors, medical students, journal club, CPC, Grand Rounds etc.)
    - Workshops/seminars/panels (EKG/Splinting workshop, ACLS, etc.) o advising/mentoring of medical students and residents
    - Textbook chapters
    - Products of educational merit (videos, CD-ROM's, computer based instruction, websites, exams)
    - Curriculum/courses designed/coordinated
    - Committee involvement/service activity o educational courses attended (ACEP, SAEM, etc.) o awards and honors
    - Evaluations (recommendation letters, lecture evaluation form, thank you letters)
    - Research (grants, published research papers, abstracts, poster presentation)
    - Published articles

2. A narrative/reflective statement:

This is the reflective statement that will be reviewed at every 6 month evaluation. It can be expanded on every 6 months with revisions of goals, activities and future plans. At the end of residency this can be reformatted to be a summary/mission statement.

It should include your clear goals, how you prepared to be an educator/researcher/administrator, what methods you used, what significant results you achieved, effective presentation of teaching materials, and reflective self-critique that allows you to improve. It is not supposed to be an existential statement on your progress or your life; it is intended to be based on the contents of your portfolio. It should indicate what you believe is important about your research/teaching/scholarly activity and how you put these beliefs into practice with specific regard to the five dimensions:

• Expertise in Content
• Instructional Design
• Instructional Delivery
• Course Management Skills
• Evidence of Student Learning

PLEASE NOTE: The portfolio should be updated after every educational activity and reflective statement updated before every 6 month evaluation. It should be available and will be reviewed during the 6-months evaluation by the Residency Directors.

Mathers NJ, Challis MC, Howe AC, Field NJ. Portfolios in continuing medical education--effective and efficient? Med Educ. 1999 Jul; 33(7):521-30.

Challis M, Mathers NJ, Howe AC, Field NJ. Portfolio-based learning: continuing medical education for general practitioners--a mid-point evaluation. Med Educ. 1997 Jan; 31(1):22-6.

Portfolios can be built on new innovations by using the portfolio tab.

Whenever possible, you should include proof of quality of teaching/scholarly activity including awards and evaluations or letters by faculty, peers, and medical students. You can upload them on New- Innov.

QUALITY IMPROVEMENT (QI) PROJECT

All residents in ACGME accredited residency programs are required to actively participate in emergency department continuous performance quality improvement programs. Residents must demonstrate evidence of development, implementation, and assessment of a project to improve care. This project may include but is not limited to the development of a clinical pathway, a patient satisfaction survey, or improvement of a recognized problem area. To ensure satisfaction of this requirement, all residents must complete the “Quality Improvement Project Form” which consists of two parts. The first part requires that the resident, under the supervision of a faculty project mentor, complete a proposal for a QI project by May 15th of their PGY3 year for categorical EM residents or PGY4 year for EM/IM residents. The second part requires that the resident complete their QI project by the end of their Administration rotation in their PGY4 year for categorical EM residents or PGY5 year for EM/IM residents. While the requirement may be fulfilled at any time during the residency prior to the deadlines listed above (i.e. a QI research project or RIE completed during the PGY 2 year), both parts must be signed by the resident, project mentor, and the program director by the stated timeframes to satisfy completion of this residency requirement.

SUNY Downstate / Kings County Hospital Emergency Medicine Residency Program Quality Improvement (QI) Project Form:

As a requirement of the RRC, all residents must complete a quality improvement project during their residency. This project must be found satisfactory by the program director or his/her designee. In order to verify completion of this requirement, both parts 1 and 2 of this form must be submitted by the stated timeframes.

Please click the links below for the QI project forms-

New QI Project Form Part 1
New QI Project Form Part 2

SCHOLARLY PROJECT

All emergency medicine and combined EM/IM residents are required to complete a scholarly project during the course of training. This project may take the form of a research project (clinical or lab), book chapter, or other scholarly activity. The research rotation in the 3rd year is a good time to complete this project, but it can be completed anytime during residency. Please see that section above. The project must be completed by May 15th of the 4th year for categorical EM residents or 5th year combined EM/IM residents. The resident must complete this project under the supervision of a faculty member. The scholarly project form below must be completed by the above date. Department of Emergency Medicine Scholarly Project Completion Form All residents are required to complete a scholarly project during their residency. This project must be found satisfactory by the Program Director or his/her designee.
New Scholarly Project Form

CAPSTONE PROJECT

Faculty Liaison- James Hassel

Residency at SUNY Downstate / Kings County is more than becoming an amazing emergency clinician. We aim to have our residents develop other aspects of leadership, academic pursuit, and involvement outside the clinical area as well. To this end, all residents will be responsible for completing a capstone project prior to graduation.

Definition

Traditionally, a capstone project is the final work to show your academic prowess during your pursuit of a degree or title. Typically, this involves utilizing what you have been taught to solve a problem by performing in-depth research and investigation and producing either a thesis or research project. In the context of residency, we define a capstone as a project you have completed outside of your GME mandated graduation requirements to show what else you have accomplished during your training and development. This will be variable depending on your future career plans and passions during residency, however projects will likely fall into at least one of three groups:

- Research as a primary investigator/author
- Projects that help you develop/explore a niche for your future career
- Projects that solve a problem, fill a gap, or allow you to explore an interest either clinically or extra-clinically

You will receive formal lectures about the process of developing and completing a capstone project during Wednesday conference.

Timeline

Capstone idea submission should be completed by the end of EM PGY-3/EM-IM PGY-4 and the project should be finalized by the end of Block 7 of EM PGY-4/EM-IM PGY-5. Dr. Hassel will review your ideas during your 6 month evaluations of your PGY3 year for categorical EM residents and in separate sessions for the EM-IM residents. During your first evaluation, you should come with your ideas so implementation, feasibility, and goals of your potential project can be discussed. During your second evaluation, you will finalize your choice of project and discuss planning and completion.

Capstone Submission Format

All capstone projects must have a deliverable component to show what you have completed. In addition to any presentations, protocols, or other material that might have been created from your project, each final submission should include a one-page document that describes your objective/purpose/reason for pursuing your project choice, your methods in developing/implementing your project, your outcomes, and future directions based on your results. Abstract submission meets this requirement if your capstone is a research paper.

Capstone Examples

Projects can come in many forms and any ideas you have should be discussed – there is likely a way to make any of your ideas into a successful and productive capstone! They should be different from your QI or scholarly projects but can be inclusive of any work you accomplished during those submissions. You

can – and should - utilize your mini-fellowship directors to help you brainstorm ideas and complete your projects if your capstone falls within their purview. Some examples of completed capstones are:

- Creating a DEIHC council to promote a culture of social change on campus
- Drafting an application to make the UHD ED an accredited geriatric ED
- Developing a bedside teaching elective curriculum for residency training
- Creation of an ultrasound curriculum for the medical students
- Developing a palliative extubation protocol for use in the emergency department
- Creating a parental leave policy during residency
- Many first-author peer-reviewed published articles/research

This is just a small sampling of projects that have been submitted. If you have an idea that explores an interest, a passion, or a problem you want to solve, it is likely a perfect capstone project.

MINI-FELLOWSHIP GUIDELINES

Teaching Mini-Fellowship Curriculum

Mission

The Teaching Mini Fellowship is an academic program within the emergency medicine residency at SUNY Downstate and Kings County Hospitals. It aims to nurture a passion for teaching and to train residents to successfully impart their knowledge to their peers, colleagues, patients, students, and more.

Leadership

Advisor:
James Willis, MD
Medical Education Fellow
SUNY Downstate | Kings County Hospital Center
Department of Emergency Medicine

Goals & Objectives

Resident Education

The teaching mini-fellowship will aim to develop residents into educators. The mini-fellowship curriculum will include frequent journal clubs and occasional lectures in Wednesday conference. All residents will be encouraged to explore aspects of undergraduate, graduate, and continuing medical education, and can get involved in medical student lectures, resident skills workshops, and other opportunities.

Projects

Residents will also be encouraged to create an educational project, research question, or curriculum. Residents can reach out to faculty in the department for advice and mentorship.

Potential mentors include:

Dr. James Willis
Dr. Teresa Smith
Dr. Jane Kim
Dr. Rob Gore
Dr. Antonia Quinn

Dr. Linda Fan
Dr. Nayla Delgado
Dr. Esther Kwak
Dr. Carolina Camacho Ruiz

Curriculum Topics

- Educational Theory
- Educational Framework
- Skills Teaching
- Bedside Teaching
- Educational Consulting
- Feedback
- Curriculum Design, Implementation and Evaluation

Curriculum Requirements

To be considered a mini-fellow upon graduation, residents will need to meet the following criteria.

Required for All Mini-Fellows:

- Present a 5-minute lecture at a TMF meeting
- Attend CORD at least once during residency
- Attend at least 6 TMF meetings (2 if 4th year)

Residents will then be required to fulfill *3 "major events" and 5 "minor events."* These events are subject to approval by the TMF leadership and are negotiable based on the amount of time remaining in a candidate's residency. Possible examples of major or minor events include:

Undergraduate Medical Education

- Minor events:
    - Assist a physical exam skills lab for the 1st/2nd year medical students with Dr. Quinn
    - Assist a clinical skills session with Drs. Willis or Gernsheimer
    - Assist a transition to clerkship/cric lab with Dr. Kim
    - Teach a lecture or ultrasound/procedure session with Drs. Fan or Delgado
    - Teach a lecture for MMSEM

- Major
    - Develop a new curriculum with Drs. Quinn, Fan, or Gore
    - Manage a twice per week PBL for a block

Graduate Medical Education

- Minor
    - Work a Family Practice teaching session
    - Attend a GME committee meeting with Dr. Smith
    - Give a conference lecture on an educational topic
    - Work a splint/suture/procedure lab for residents or new interns

- Major:
    - Plan and run family practice teaching sessions
    - Present an abstract at a conference
    - Conference leadership
    - ACEP teaching fellowship
    - Plan and run procedure labs for residents/interns

Continuing Medical Education

- Minor:
    - Work with Mid-level provider conference
    - Teaching Academy meetings with Dr. Quinn

- Major:
    - Plan US/disaster training for the hospital
    - Publish a paper in an educational journal

The above are suggestions. There are many realms of medical education, and there are many ways to get involved. If you think of something not on the list, just bring it to the attention of leadership and we will decide how it scores.

Ultrasound Mini-Fellowship

Through point-of-care-ultrasound (POCUS) participants in the ultrasound mini-fellowship will have the opportunity to expand their basic knowledge of emergency ultrasound beyond the required ultrasound rotation via participation and teaching of ultrasound medical student sessions, team journal club activities, active participation in tape review, ultrasound scanning shifts and possible involvement in research opportunities within the ultrasound division.

Aims & Learning Outcomes:

- Develop in-depth knowledge of key ultrasound topics in Emergency Medicine
- Remain current of new literature involving point of care ultrasound
- Improve bedside ultrasound technique and image acquisition
- Heavy involvement in teaching POCUS to medical students, fellow residents via hands on sessions and min-lectures
- Participation in team sono journal club that meet regularly to discuss new and innovative topics in the field of ultrasound

Expectations:

Residents who are enrolled into the fellowship are expected to complete the following requirements

- Attendance of at least 4 Team Sono Journal Club meetings
- Facilitate and discuss at least 2 articles at Journal club meetings
- Scanning shifts with medical students on rotation based on schedule
- Teaching and hands on session with at least 2 medical student ultrasound courses
- Attendance of at least 4 tape review sessions while not on ultrasound rotation
- Possibility of a research project based on availability and current opportunities in the division

Textbook:

Emergency Ultrasound. Ma and Mateer. Third Edition 2013

Educational Credits:

Formal recognition upon completion of specialized track within the SUNY Downstate Emergency Medicine Residency Training Program

Wilderness Medicine Mini-fellowship

- Each month on the 2nd Tuesday of the month, all of the residents participating in the Mini-fellowship will get together and review an article pertaining to wilderness medicine
    - If possible, this will take place outside of the department in some fine-dining establishment or someone's home with food provided
    - The article should be distributed to the group at least 1 weeks before the meeting so people can read it.
    - The presenter will be responsible for generating a 1 page summary to post on the WM blog.

- Each resident will be encouraged to produce 1 lecture per year on a wilderness medicine topic. (This can be for a required conference like MICU or Trauma of just as an additional lecture)
- We can have a question/answer session after each lecture to discuss pertinent facts presented
- Examples include:
    - Introduction to Wilderness medicine
    - Water Treatment
    - Hyperthermia
    - Hypothermia
    - Lightning
    - Submersion injuries
    - Animal attacks
    - Poisonous reptiles
    - Arthropod (spiders/scorpions/bee/ant) envenomations
    - High altitude illness
    - Wilderness survival
    - Travel illness
    - Poisonous plants
- Dr. Silverberg and the other attendings interested in WM will also try to get outside speakers to give these lectures if they are a specialist on the topic

- If the conference lecture schedule allows, Dr. Silverberg will personally lecture on
    - Hyperbaric/dive medicine
    - Marine envenomations
    - Water rescue

- We will try to take one guided trip each academic year. Destinations include:
    - Bronx zoo reptile house (With Jacoby residents?)
    - Brooklyn Aquarium-poisonous fish
    - Brooklyn Botanical Garden-poisonous plants
    - Atlantis marine world-poisonous fish
    - Hikes in NY/NJ

- Other destinations/projects can also be suggested. Examples include
    - A hike in the woods with demonstrations on splinting/wilderness first aide

- In your final year of residency, it will be encouraged that each candidate take the Wilderness Medicine course in Big Sky Montana (or any other comparable WMS course). Financing can be discussed with residency leadership depending on how well the department finances look.

Geriatric Emergency Medicine Mini-Fellowship

Faculty Advisor: Joel Gernsheimer, MD, FACEP

THE GERIATRIC MINI-FELLOWSHIP IS AVAILABLE TO BE DONE STARTING IN THE SECOND YEAR OF TRAINING.

1. The Geriatric Emergency Medicine (GEM) Fellow will meet with her/his Faculty Advisor, Dr. Gernsheimer, on a regular basis to discuss special clinical issues in GEM. These include, but are not limited to:
   A. General Principles of Geriatric Emergency Medicine
   B. Altered Mental Status and Cognitive Impairment in Older Patients
   C. Adverse Drug Reactions and Polypharmacy
   D. Trauma in the Elderly and Falls
   E. Infections in the Elderly
   F. Abdominal Pain in the Elderly
   G. Cardiovascular Emergencies in Older Patients
   H. Neurologic Emergencies in the Elderly
   I. Resuscitation of Older Patients
   J. End of Life and Social Issues in Geriatric Emergency Medicine

2. Assist Dr. Gernsheimer in running the Geriatric Emergency Medicine Journal Club including:
   A. Finding GEM articles to discuss with Dr. Gernsheimer
   B. Leading the discussion of chosen articles at GEM Journal club meetings
   C. Organizing Joint GEM Journal Clubs with other EM Specialties

3. Giving Lectures on Topics in Geriatric Emergency Medicine to:
   A. Residents (EM & FM)
   B. Medical Students
   C. PA Students
   D. Mid-Level Providers
   E. Nurses

4. Research Project on a GEM Topic
   A. The Resident will be assisted in this by Dr. Gernsheimer
   B. Dr. Sinnert will also assist in writing and getting this project presented and/or published

5. Capstone Project
   A. Selecting an approved Capstone Project with the help of Dr. Gernsheimer and Dr. Hassel
   B. Completing the project with the assistance of Dr. Gernsheimer
   C. Writing up the project and submitting it to Dr. Gernsheimer and Dr. Hassel

D. Assisting Dr. Gernsheimer in completing the current Capstone Project of the current GEM Mini-Fellow Dr. Surriya Ahmad which is Obtaining Geriatric ED Accreditation for the UHD ED

6. Involvement with National GEM Organizations
   A. ACEP's GEM Division
   B. SAEM's GEM Division
   C. The GEDA Consortium
   D. The American Geriatrics Society

7. Other Opportunities that can be arranged for depending on the interest of the GEM Mini-Fellow:
   A. Visiting Geriatric Programs, such as the one at New York Presbyterian, where Dr. Ahmad is a GEM Fellow
   B. Mount Sinai that has an approved Geriatric ED
   C. St. Joseph's Medical Center in Patterson that has an approved GED
   D. Attending the Geriatric Clinic at Kings County
   E. Field Trip to the Susan B. McKinney Nursing Home

The Administration Mini-Fellowship
will be a learning and networking group on the business and administration of emergency medicine. Our activities will include the following:

- Meet on a monthly basis to discuss educational topics
- Serve as an outlet for administrative career and fellowship exploration
- Host networking events with health care leaders at KCH/NYCHHC/Downstate and beyond
- Keep each other aware of local and national events, resources, and organizations that will facilitate our learning and career advancement.

To join the list-serve, login to your Google account, and go to
https://groups.google.com/d/forum/downstateadmin

Leadership

Advisor:
Dr. Ninfa Mehta

The Administration Mini-Fellowship
The Critical Care Mini-Fellowship is a specialized academic track created for Emergency Medicine (EM) residents to develop a deeper understanding of critical care medicine (CCM) with the goal of improving care of critically ill patients. Secondarily, this mini-fellowship will allow for earlier recognition of career goals while helping residents become more competitive applicants for a CCM fellowship. This curriculum is designed to foster higher level thinking and discussion. Participants are expected to complete reading assignments prior to meetings and be prepared to use the literature to guide discussion of how these topics relate to patient care and current practices. All residents/attendings are welcome to attend meetings.

Aims
& Learning Outcomes:
Primary
Aims

Develop in-depth knowledge of key CCM topics relevant to the Emergency Department

-

Stay abreast of current CCM research with the goal of helping residents set up an academic project
within the field with potential for publication in an academic journal

-

Secondary
Aims

Improve ultrasound and procedural skills for the care of the critically ill patient

-

Expectations:

Once
enrolled in the course, residents are expected to complete course requirements within the academic year. The minimum expectations are:

Attendance of at least four Critical Care Mini-Fellowship meetings

-

Facilitate at least 1 meeting discussion which entails development of 2-3 critical questions

- as the literature relates to practice.

SUNY Downstate International/Global EM Mini-Fellowship

Director: Monalisa Muchatuta, MD MS

Background and Enrollment:
All residents in the International Mini-Fellowship (IMF) will apply to the director of the program at the beginning of the PGY2 year. The international mini-fellowship will be open to all residents and there is no limit on the number of mini-fellows per year.

IMF Portfolios:
All residents in the IMF will maintain a portfolio to collect their projects, lectures, publications, and evaluations. The portfolio will be kept by the resident and will be presented every 12 months to the Director of the IMF at annual evaluations. Each evaluation meeting will identify advances in the past 12 months and areas for future growth.

The IMF Portfolio will contain any material that the resident feels is demonstrative of education and/or experience in international medicine, public health, or grant-seeking.

Mini-Fellowship Goals

- Graduate residents that would make excellent fellows
- Increase cultural competence in Global/International Emergency Medicine

Completion Requirements

*Mini-fellows should complete **all the required bolded items** below in order to receive credit for completing the mini-fellowship. They should also complete **3 out of 5** of the other items below.*

- **Attend 1 international medicine/global health activity per year (conference, lecture, event, program)**
- **Attend at least 1 IMF lecture or journal club per year**
- **Contribute one educational article to global health journal club per year**
- **Contribute to at least one active project in the International Division (this may include data analysis, project planning/design, materials development, project implementation, publication) over the course of residency **note each month-worth of contribution counts for 1 credit**

- **Mini Fellowship yearly evaluation with Director and portfolio review using CUGH/ACGMEmilestone progression to minimum Level 2-3 in mini-fellowship priority areas**
- Plan and complete international elective(s) for PGY4/5
- Lead one journal club/small group discussion session or help run the mini-fellowship
- Mentor visiting international observer residents and/or students

Annual Mini-Fellowship Evaluation Milestones

** Adapted from CUGH and ACGME. The number preceding the milestone indicates the level.
Level 1 = novice (no GH experience at all)
Level 5 = expert/international leader

***** Residents graduating in the mini-fellowship should be at least level 2-3 in all mini-fellowship priorities by graduation ******

** **Bold** – Mini-fellowship priorities
** *Italics* – crossover into ACGME milestones/other tracks

1. **Travel Safety and skills**
    1. 1: Demonstrate understanding of food safety, vaccine readiness, basic first aid and hygiene, and travel basics.
2. **Research**
    1. 1: Demonstrate understanding on how to critically analyze publications
    2. 1: Demonstrate familiarity with the working body of global health literature and current issues
    3. 2: Publish/present a scholarly work
3. **Professional practice**
    1. **3: demonstrates the ability to adapt clinical practice or discipline-specific skills in a resource limited setting**
    2. **3: acknowledges one's limitations in skills, knowledge, and abilities**
    3. **3: contributes to or participates in interventions, quality assurance, or educational projects**
4. **Ethics**
    1. **2: acts in accordance with basic principles of medical ethics when participating in global health experiences**

2. **2: demonstrates an ability to resolve common ethical issues and challenges that arise when working within global health experiences, with vulnerable populations, and/or in low-resource settings**
3. 3: thinks critically about ethical and professional issues that arise in responding to humanitarian emergencies
4. **3: Understands the ethical issues surrounding research in international settings**

5. **Capacity strengthening**
    1. **2: participates in host/partner organization's program and can articulate capacity at the level they are working**
    2. **2: understands and communicates the status of community capabilities and current health assets and disparities within the community**
    3. **2: participates in activities that facilitate the host/partner organization to utilize the community assets to benefit the population**
    4. 3: identifies features that will make programs sustainable within their community and participate in activities that facilitate program sustainability
6. **Social and environmental determinants of health**
    1. **2: describes how cultural context influences perceptions of health and disease (eg cultural beliefs about basis of and remedies for disease, etc)**
    2. **2: recognizes how bias impacts the way patients think about health and disease**
    3. **2: demonstrates understanding of the major causes of morbidity and mortality between and within countries and identifies contributing social/environmental factors**
    4. 3: synthesizes available data to identify social, economic, and environmental determinants of health
7. Collaboration, partnering, and communication
    1. **2: communicates with all members of the team in a respectful & cultural appropriate manner**
    2. 2: participates in observational experiences with focus on partnership and relationship building
    3. 3: participates in and contributes to advancing a long-term collaborative project
    4. **3: recognizes how own personal beliefs and values affect interactions and manages them appropriately**
    5. **3: demonstrates an understanding of the importance of compassion, integrity, respect, sensitivity, and responsiveness and exhibits these attitudes consistently in complicated situations**
8. **Health equity and social justice**

1. **2: Demonstrates a basic understanding of the relationships between health, human rights, and global inequities**
2. **2: develops an awareness of the healthcare system and barriers to care in the developing world, and the factors that contribute to this**
3. 2: participates in observational experiences with a focus on cultural understanding
4. **3: demonstrates a commitment to social responsibility**

9. **Sociocultural and political awareness**
    1. **2: performs self-assessment of one's own potential biases**
    2. **2: articulates anticipated barriers that may arise while working in new cultural context**
    3. 3: critically analyzes a program or intervention for potential socio-cultural or political conflicts
    4. **3: adopts tools to mitigate cultural barriers.**
    5. **3: Recognizes own biases**
10. Global burden of disease
    1. 2: understands historical context of health disparities and burden of disease
    2. **2: Describes major current and historical public health efforts to reduce disparities in global public health**
11. Globalization of health & health care
    1. **2: Describes how different health care systems impact health care outcomes and expenditures**
    2. 2: describes how global political and cultural events, commerce, and trade contribute to the spread of communicable and chronic diseases
    3. 3: describes general trends and influences in the global availability and movement of health care workers
12. Strategic analysis
    1. 2: demonstrates the ability to apply a planning framework to a disease issue or situation
13. Program management
    1. 2: Describes some pitfalls of ineffective programs
    2. 2: describes features of effective programs and the characteristics that lead to efficacy in policy, practice, and health outcomes

Relevant ACGME Milestones:

1. Professional values: Demonstrates compassion, integrity, and respect for others as well as adherence to the ethical principles relevant to the practice of medicine.

    1. 3: Recognizes how own personal beliefs and values impact medical care; consistently manages own values and beliefs to optimize relationships and medical care
    2. 3: Develops alternate care plans when patients' personal decisions/beliefs preclude the use of commonly accepted practices
    3. 4: Develops and applies a consistent and appropriate approach to evaluating appropriate care, possible barriers and strategies to intervene that consistently prioritizes the patient's best interest in all relationships and situations
    4. 4: Effectively analyzes and manages ethical issues in complicated and challenging clinical situations
2. Patient Centered Communication: Demonstrates interpersonal and communication skills that result in the effective exchange of information and collaboration with patients and their families.
    1. 3: Effectively communicates with vulnerable populations, including both patients at risk and their families
    2. 4: Uses flexible communication strategies and adjusts them based on the clinical situation to resolve specific ED challenges, such as drug seeking behavior, delivering bad news, unexpected outcomes, medical errors, and high-risk refusal-of-care patients
3. Team Management: Leads patient-centered care teams, ensuring effective communication and mutual respect among members of the team.
    1. 3: Develops working relationships across specialties and with ancillary staff
    2. 3: Ensures transitions of care are accurately and efficiently communicated
    3. 3: Ensures clear communication and respect among team members
    4. 4: Uses flexible communication strategies to resolve specific ED challenges such as difficulties with consultants and other health care providers
    5. 4: Communicates with out-of-hospital and non-medical personnel, such as police, media, and hospital administrators

Simulation Mini-Fellowship

Faculty: Carolina Camacho, Pamela Janairo, Jane Kim, Esther Kwak, Jessica Stetz, Sigrid Wolfram

Objective

The goal of the Simulation Mini-Fellowship is to allow residents to gain exposure to and experience in various aspects of emergency medicine simulation. These will generally fall within the categories of Service & Teaching, Leadership & Administration, Academics & Scholarly Contributions, and Education & Professional Development. The requirements are structured to allow residents to select pursuits based on their personal interests.

Requirements

Residents will be required to accumulate a total of **15 credits** over the course of their residency to complete the Simulation Mini-Fellowship. The following table will serve as a guideline for credits awarded but may be adjusted by faculty on a case-by-case basis. Residents may propose additional pursuits outside those listed, which will be awarded credits by faculty on a case-by-case basis.

Pursuits	Credits
Service & Teaching	
Facilitate 1 simulation session	1
Develop & lead 1 in situ simulation	5
Leadership & Administration	
Attend 1 monthly sim division meeting	1
Serve as liaison with another dept for interdisciplinary sim for 1 yr	5
Develop & execute the annual resident simulation schedule	5
Serve on a national/regional simulation committee for 1 yr	5
Academics & Scholarly Contributions	
Lead 1 simulation journal club or workshop	1
Develop and submit 1 simulation case	2
Develop and utilize 1 simulator model	5
Present 1 poster/abstract at a simulation related conference	5
Publish 1 simulation-related article in a peer-reviewed journal	5
Education & Professional Development	
Attend 1 journal club or simulation workshop	1
Attend 1 simulation-related conference	2
Obtain Society for Simulation in Healthcare CHSE certification	10

RESIDENT REMEDIATION

In the course of training, residents progress at varying rates. Occasionally it becomes apparent that a resident may need more guidance than his or her peers. This could be in areas of medical knowledge, clinical performance, or professionalism. This is often based on direct observation, evaluations, in-service scores, and other modes of evaluation.

Remediation is used to address areas where a resident may be struggling. A personalized plan is made with the resident that could include study plans, meetings, readings, simulation sessions, or other resources. This is solely for the benefit of the resident. Persons usually involved in this process are the resident's class dean, other members of the resident education committee, and the resident's advisor. Other faculty may be involved depending on the remediation plan. The reasons for remediation and action to be taken will be documented, but not made part of any public record. This means it will not be reported to future employers or the GME.

If the resident fails to progress or follow the set remediation plan she/he may be placed on probation. This will include more stringent action and will be reported to future employees and the GME.

DEPARTMENT OF EMERGENCY MEDICINE

TRAVEL, CME and REIMBURSEMENT PROCEDURES - Residents

CONFERENCE and TRAVEL PROCEDURES

PRIOR TO ANY BOOKING, Institutional Approval MUST BE RECEIVED, *you will receive an email from Regina Aultetta advising if/when you have final approval*

1. **Submit travel approval request form – even for conference registration only**

(original document must be typed with original signatures, electronic signatures not accepted, per Finance Dept.)

Complete and submit a travel approval request form with the below items at ***least*** 2-3 months *prior* to the event to obtain all approvals.

Forms *are* to be submitted to Chelsea Cole for Dr. Willis' review /approval with the below

a. Documentation to justify conference
   Ex: acceptance letter, front page of the brochure or copy of registration form

b. A Lodging Justification form if you are requesting hotel funding

c. If you intend to rent a car, a letter justifying the need for the expense will be required.

d. Go to **https://gsa.gov/portal/content/104877** to identify the per diem lodging rate for the city you will be staying in. Where indicated on the form enter that per diem rate and the actual cost per night of the hotel you will be staying at. Then check off the appropriate box on form. Most times it will be the 1st box but read your choices before selecting. Sign the form & attach along with your travel approval request.

Signed forms will be given to Ms. Auletta to submit for departmental and institutional approval.

Please address any questions to Mrs. Cole prior to the event.

You do not have to have definitive plans to submit a request.
The process may take 3 months or longer if it is foreign travel (President's approval needed) so even if you are considering any type of travel, submit the request as early as possible. Do not wait for your abstract/poster to be accepted. You are not making a commitment, just a request.

2. Once Email Approval is Received

The process for out of pocket reimbursement has become extremely arduous and frustrating so please follow the below guidelines to avoid having to do this.

REGISTRATION - contact Mrs. Cole to arrange to pay for your registration with the department's state credit card. **Please bring her a print out of your approval email**

REGISTRATION DOES NOT GO ON YOUR TRAVEL CARD

AIR/RAIL – If you have a state travel card you may go to **WWW.CONCURSOLUTIONS.COM** and book your travel, log in information below

USER NAME: ***(Beginning of your email address) @suny.edu***
PASSWORD: ***Same as USER NAME***

There is no out of pocket for airlines or rail travel expenses. They are paid directly through your SUNY Travel Card.

If you DO NOT have a state travel card, please contact Ms. Auletta (contact info listed later in document) to book your travel.

HOTEL -After you receive the approval email, you may make your hotel reservations

IF YOU ARE PAID BY SUNY

You will have a state travel card which you will use to book your hotel and present to hotel when you arrive. If this is the first time booking your travel card will be at Regina Auletta's office.

IF YOU ARE NOT PAID BY SUNY

1. Book hotel using your own card and request "*credit card authorization form*" from the hotel

2. Submit form and copy of your reservation confirmation to Ms. Auletta. She will complete so the hotel will charge her travel credit card instead of yours.

After the conference you **MUST** ensure Ms. Auletta receives your ***final hotel bill, boarding passes, certificate of attendance, receipts for luggage, taxis and etc.*** All Receipts

Please be sure to follow the above procedures to avoid the lengthy out of pocket expense reimbursement process.

FORMS

FORMS REFERENCED ABOVE CAN BE LOCATED THROUGH THIS LINK

[SUNY DOWNSTATE MEDICAL CENTER Accounts Payable]

YOU MAY REQUEST THE FORMS VIA EMAIL from Chelsea Cole

To schedule an appointment to book travel for Non-State Paid Residents please contact:

Regina Auletta
Administrator
Department of Emergency Medicine
SUNY Downstate
450 Clarkson Ave - MSC 1289
Room #440-1R
Brooklyn, NY 11203

Office-(718) 270-6315
Cell- (631) 867-8366

REIMBURSEMENT FOR NON-TRAVEL ACTIVITIES

Approval should be received from Dr. Willis prior to incurring these expenses and payment options should be discussed with Chelsea Cole prior paying out of your pocket

If you need to be reimbursed for any non-travel related expenses (i.e wellness events, supplies for procedure labs, etc) please fill out the below form and submit it to Dr. Willis to sign before leaving in Regina Auletta's mailbox at KCH or UHD

If the reimbursement is for a meal or food for a meeting the form must be accompanied by a list of who attended the function. If this is not received the request will be sent back.

DEPARTMENT OF EMERGENCY MEDICINE
REIMBURSEMENT VOUCHER

(other than travel related activities)

Name_____**Date**_____

Address_____

SS#:_____**Only needed first time with W-9**

Activity:_____

Date of Activity:_____

Detailed legible receipt must be attached:

1_____**$**_____
Company or store name
2_____**$**_____
Company or store name
3_____**$**_____
Company or store name

TOTAL AMOUNT TO REIMBURSE: $_____

_____ ***Date:***_____
Authorized Signature

FACULTY ADVISORS

Each resident will be assigned a faculty advisor at the beginning of their intern year. The role of the advisor is to facilitate the resident's progress through the residency. The resident is encouraged to utilize his or her faculty advisor with all aspects of resident life. Faculty advisors should be a source of feedback and inspiration for the residents. The faculty advisor may be particularly helpful in assisting the resident to achieve set academic goals. It is required that the faculty member and the advisee meet at least every three months to review the resident's progress. Residents may ask their advisors to be present during their bi- annual evaluation with the residency director and during any remediation discussions with the residency directors.

It is the resident's responsibility to approach his/her advisor. If there are problems scheduling a meeting with your advisor or you would like to change your advisor for any reason, please let the Residency Directors know.

However, the role of the advisor shall not be limited to mandatory meetings but shall be proactive and visible in the resident's academic development.

This can be accomplished in a variety of ways and should consist of, but not be limited to, some of the following:

- Literature review
- Reading assignments
- Meetings with oral board type scenarios
- Case review
- Review of advisee's follow-up sheets
- Round table discussions
- Question & answer settings
- Review of multiple choice questions
- Review of ethical and administrative issues
- Review of resident's procedural skills and help in achieving excellence
- Review of the resident's ethical and professional growth and guidance towards excellence
- Mentoring during times of personal duress or stress
- Resolution of conflicts with the department or other staff

Please inform the Residency Directors if there are any problems with meeting with your advisor or if you wish to be assigned to a different advisor for any reason.

SICK CALL POLICY

The Department of Emergency Medicine has set up a sick call system to cover the ED when residents are ill or unable to work scheduled shifts. During the PGY-2 and PGY-3 years residents will be assigned two separate two-week blocks of sick call.

Historically, these rotations have been during non-ICU and non-ED rotations, such as ENT, Ultrasound, Toxicology, and Research. While on sick call, the resident might be called to cover any sick EM resident scheduled for the UHD & KCH adult or pediatrics EDs. The sick call schedule will be posted on clinical monster.

Typically, PGY-2 residents cover junior residents and PGY-3 residents cover senior residents. However, at the discretion of the EM Chief or residency directors, any sick call resident may be activated for any sick resident irrespective of year or parent department.

The sick call resident will be available by cell phone and text for the entire time on sick call and is expected to be available and free from the influence of alcohol or other substances at all times during their call period, including weekends and nights. The resident must also stay within cell phone and text range of the hospital. The resident must be within 45 minutes of the hospital while on sick call. If you need to leave the NYC area, then arrange coverage from a peer.

Not having a cell signal is not an excuse to miss a call. Any resident who is unavailable during their sick call will be held accountable for the missed clinical time.

If 2 residents are on call, usually there is only one resident who would be called in. HOWEVER, if a second one is needed, that other person MUST be available. You can't split the sick call time in half. Occasionally, 2 people call in for shifts where 1 person cannot work both of them. Residents alternate when 2 people are on call.

The sick call residents are usually used when another EM resident calls in sick, the ED is busy, and extra help is required to ensure adequate patient care. Do not abuse the Sick Call System. It is not to be used for recreational or personal needs.

The only people who are authorized to activate the sick call resident are the Chief-on-call or one of the Residency Directors. If the sick call resident is called in by another person, the called resident is to immediately refer the matter to the Chief Resident on call or one of the residency directors.

See the procedures below for an ill resident to activate the sick call system.

Residents paid by Kings County can receive compensation through their Union, CIR. Downstate paide resident will be compensated with a shift reduction during a future ED block.

PLEASE NOTE:

STRICT ADHERENCE TO THESE GUIDELINES IS MANDATORY AND WILL BE ENFORCED.

Cell Phone numbers

Dr. Willis 516-860-5095
Dr. Hassel 914-661-1115
Dr. Janairo 617-276-2481
Dr. Camacho 787-405-0435
Dr. Schechter 646-281-1136

Dr. Buckridge 347- 255-9907

Phone numbers
Residency Coordinator 718-245-3318
UHD Adult ED 718-270-4580
UHD Peds ED 718-270-8267
UHD Fast Track 718-270-8289
KCH Adult ED 718-245-4616
KCH Peds ED 718-245-3638
KCH Critical Care ED 718-245-4603
KCH Fast Track 718-245-4610

Sick Call Procedure:

This procedure has to be followed for all rotations.
For clinical rotations, check to see if there is anyone who can switch with you. Contact that person. You must call the Chief-on-call either way. If you can find coverage for yourself, call the chief-on-call and tell the chief who will be covering your shift. If not, you need to call the chief-on-call and tell them that you will require sick call coverage. If you are able to find coverage you must email the chief on call stating who will cover you and cc that resident on the email as well.
You must contact the Chief on call and if they instruct you do so, the Residency Director on call as well. Leaving a voicemail or email is **UNACCEPTABLE**, you must speak with the Chief and/or Director.
A Residency Director and/or the Chief-on-call will decide IF the sick call resident will be called after evaluating present coverage and the state of the clinical area involved. We only use sick call when absolutely necessary. If you are called in it will be for a minimum of 3 hours coverage.
****Only the Chief-on-call or one of the Residency Directors can activate the sick call coverage system.****
If you need to call out for reasons not related to your personal illness or death in the family, please attempt to find your own coverage. If you cannot find your own coverage, then contact the Chief and director as is the current policy. You must pay back the sick call person any shift, which was covered for reasons not related to personal illness/family death.
If 2 residents are on call, usually there is only one resident who would be called in. HOWEVER, if a second one is needed, that other person MUST be available. You can't split the sick call time in 1/2. Occasionally, 2 people call in for shifts where 1 person cannot work both of them. Residents alternate when 2 people are on call.

Sick Call Procedure: Off-service and Affiliate EDs

Same as above, in addition:
• You must notify the clinical site director for ED rotations and the Chief residents for off-service rotations.
• Residents will adhere to established sick call policies at these sites.
• Any difficulties with sick call policies should be referred to the Residency Directors.

Sick Call Procedure Conference Days

As per RRC regulations every resident is required to attend 70% of conference days. There is no negotiation on this point. If you are sick, don't come in. However, if you miss more than 30% of all conference days for ANY reason, then you cannot graduate the program until this is rectified. See Wednesday conference section for specific procedure for conference absences.

Extended Sickness

If a resident is sick and misses more than 3 consecutive days they may be required to provide a physician's note as per institutional policy.

If a resident misses more than 2 weeks of training due to illness or for any other reason she/he will be required to make up any additional time missed. This is based on ACGME policies.

Any extended leaves should be discussed with the program director.

MISSED REQUIREMENT POLICY

Even though residency is an extension of your education to becoming a competent Emergency Medicine physician, it is also a job. As with any job, there are consequences for not fulfilling job expectations. This policy delineates the consequences for not following the rules and regulations set forth by the conference and extra-conference faculty liaisons. Please consult the sections of the handbook for the specific requirements for each division and clinicalmonster.com for all schedules (i.e. simulation, board review, lecture preparation, skills labs).

Whenever a resident fails to meet a specific job requirement, he or she accrues 4 to 8 hours of clinical time based on the severity of the infraction judged by the Program Director. For every 8 hours accrued, the resident will be assigned to work an 8-hour shift by the KCH scheduling chief resident.

The residency leadership understands that unforeseen circumstances can occur, which accounts for only 4 clinical hours to be accrued for the first occurrence of minor infractions. This policy applies to but is not limited to the following:

- Missing a required simulation session
- Missing/failure to prepare for a required board review session
- Missing required skills labs
- Failure to submit lectures for review by the required deadline
- Failure to come in for a shift
- A pattern of chronic lateness to shifts

The residency leadership reserves the right to review each case, depending on the circumstances of the situation and act accordingly.

WORK ATTIRE POLICY

When working in the clinical area, you are expected to look professional with your attire and personal hygiene. While we do not want to enforce a strict dress code, we would like to set a standard.

When working clinically at both Kings County and UHD, scrubs are acceptable for residents; or alternatively, business casual in non- procedure areas. Jeans are never acceptable and neither is any shirt that does not cover the entire abdomen/torso. At UHD, we encourage wearing white coats, however, their use is not mandatory.

Please be mindful of your attire during Wednesday conference, as this is an academic and professional time period. If you are giving a lecture, you should have business casual and be well groomed. This means:

1. No scrubs when giving a lecture. If you are working at 12 noon or worked the overnight, you can change into your scrubs before or after your lecture
2. No jeans, t-shirts, or sweatshirts when giving a lecture

If you have questions, see the link below:

http://www.businessinsider.com/what-business-casual-really-means-2014-8

While clothing does not equal competence, they do making lasting first impressions. Thus, if you want to be taken seriously as a professional, then dress the part.

MOONLIGHTING

Moonlighting during residency is a controversial topic in Emergency Medicine. A number of residents moonlight to make some extra money, and for the added clinical experience of practicing in a different environment. Supporters of moonlighting feel it can be an important transition towards solo practice. The department's stand on moonlighting is neutral; however, residents who moonlight will have to get approval from their class Dean. This approval is contingent on satisfactory clinical and academic performance (including the in-training exam). The Program Director has final say on moonlighting privileges.

Moonlighting at other institutions is only allowed in the graduating year and CAN NOT BE IN A SINGLE COVERAGE ED. There must be a board-eligible EM attending working with you, even if you are functioning as the attending. This is to protect you and the integrity of the specialty.

There will occasionally be opportunities to "moonlight as a resident" at KCH or UHD in the senior years of residency. These shifts are paid, cannot be in conflict with your other residency responsibilities, and are under the supervision of EM faculty. You function as a resident during these shifts, not as an attending. These shifts are allowed at the discretion of and with the agreement of the residency directors and the medical directors. This approval also is contingent on satisfactory clinical and academic performance (including in-training exam).

There may also be an opportunity to conduct chart reviews for monetary compensation. These chart reviews are considered moonlighting; and thus, residents must follow the moonlighting policy in order to be able to conduct these chart reviews. The only exception is that we will allow junior residents to do the chart reviews.

All moonlighting schedules have to be reviewed with the class Dean (and/or program director) prior to the beginning of the month. The purpose of this is to ensure moonlighting does not compromise any resident's departmental duties as well as educational obligations. Moonlighting may also not interfere with ACGME or the New York State DOH 405 regulations. All internal and external moonlighting counts towards the duty hours limits.

Please Note: Failure to adhere to this policy will result in loss of moonlighting privileges and/or other adverse actions. Moonlighting without the permission of the Program Director is a serious act of misconduct.

POLICY ON CHIEF RESIDENT SELECTION

Being a chief resident is a challenging and rewarding experience. Chiefs will gain a tremendous amount of supervisory and administrative experience during that year. Chief residents in the program are graduating year residents and are elected for service by the Program Director, the faculty, and the residents (all have equal vote).

Our chief resident selection is very close to a completely democratic process. However, the Program Director reserves the right to make final decisions and alterations in this selection process that he/she feels is in the interest of the resident, program, and the department.

The normal procedure for chief selection is as follows:

- Residents of the appropriate year will have an opportunity to add or remove their name for consideration for chief resident.
- This list will be approved by the Program Director in consultation with the residency and departmental leadership.
- Residents that have been on Academic Probation for clinical, academic, or professional reasons are not eligible for chief candidacy.
- The Program Director can remove candidates from the list if he/she feels that the candidate cannot serve effectively in the chief resident role.
- The final list becomes a ballot and is voted on by the entire department with 1 vote for each physician. The residency coordinator also has 1 vote.
- Candidates for chief will be asked to write a “Letter of Intent” for the position

Chief residents are selected from both programs. Only 1 EM/IM residents can be selected as chief. The chief of the EM/IM program will always be an EM/IM resident. The 1 EM/IM resident, and 4 categorical EM residents, with the most votes will become chiefs. This process can be altered by the program director if he/she feels it is in the best interest of the program.

Chief candidate qualifications:

- Model resident
- History of strong contribution to the residency and department
- Academically solid
- Superior leadership skills
- Strong interpersonal and communication skills
- Has not been on probation or formal remediation during the program

Departmental Resident Due Process and Grievance Policy

Residents who do not meet departmental academic or professional requirements as set forth in this handbook, and accordingly are judged by the Residency Directors to have failed to maintain satisfactory performance resulting in disciplinary action and/or dismissal or termination of contract prior to completion date, may challenge this decision by appealing to the Departmental Resident Grievance Committee.
This committee is chaired by the chairperson of the department and includes the resident's faculty advisor, a member of the departmental steering committee, one of the Chief residents, and a resident representative.

A request for review of any disciplinary action by this committee has to be done in writing to the Chairperson of the department. The committee then convenes and will review the case in a timely fashion. Results of this review will be forwarded to the Residency Director and the institutional GME committee for further action.
If the unfavorable issue is upheld or not resolved by this committee, the institutional GME Committee may be contacted for review of the action.

In the case of a violation of departmental academic and/or professional standards and/or serious patient care issues by a resident, the program director will issue a written warning. This warning will also outline expected corrections, suggestions how to achieve them, and in which time frame. The resident will be given a copy of the warning, the signed original will stay in the resident's file, and another copy will be forwarded to the GME office. In the unlikely event of a repeated negative action, the resident will be placed on probation. If a performance review after the specified time or a third negative action occurs, and if the resident has been given proper due process, the resident will be dismissed from the program.
However, certain serious patient care issues as judged by the departmental leadership, may lead to immediate dismissal

INSTITUTIONAL POLICIES AND PROCEDURES

GME DUE PROCESS POLICY SUNY Downstate Medical Center Graduate Medical Education

Purpose:

To establish a policy for all post-graduate medical programs of SUNY Downstate Medical Center for use in addressing all actions that can result in altering the intended career path of a resident or fellow. To provide residents and fellows with fair, reasonable and readily available policies and procedures for grievance and due process through a decision-making process while minimizing conflict of interest by adjudicating parties.

Scope:

This policy applies to all programs and house officers (residents and fellows) participating in graduate medical education programs sponsored by SUNY Downstate. This policy applies to actions taken as a result of academic deficiencies or misconduct.

Definitions:

Due Process: an individual's right to be adequately notified of any changes or proceedings involving him or her, and the opportunity to be meaningfully heard with respect to those proceedings.

House Staff or House Officer: refers to all interns, residents or fellows enrolled in post-graduate medical training or research program or activity

GME Program: refers to a residency or fellowship educational program

Adverse Action: disciplinary actions taken against a resident which alter the intended career development or timeframe. Such actions are reportable and allow a request for review and due process Adverse actions include the following:

Dismissal: act of terminating a house officer participating in a GME program prior to successful completion of the course of training whether by early termination of a contract or by non-renewal of a contract.

Non-renewal: act of not reappointing a house officer to subsequent years of training prior to fulfillment of a complete course of training.

Non-promotion: act of not advancing a house officer to the next level of training according to the usual progression through a program

Extension of Training: act of extending the duration of time required by a house officer to complete a course of training generally resulting from repeating unsatisfactory rotation assignments or remediating poor performance or needing additional time to demonstrate achievement of required competence in one or more domains.

Probation: placement of a resident under close monitoring for specific performance concerns which if not successful resolved may result in other adverse actions including dismissal. This action is reportable to state licensing authorities and health care institutions.

Suspension: Withdrawal of privileges for participating in clinical, didactic or research activities associated with appointment to the training program or hospital staff. This action is taken if, in the judgment of the Program Director, Department Chairperson or institutional leadership (Associate Dean, Dean, Medical Director) a resident's or fellow's competence or behavior is such that patients may be endangered, the educational process disrupted or other peers, staff,

faculty are subjected to an adverse and unacceptable work environment. Under such circumstances, suspension may be implemented immediately pending further investigation and determination of other appropriate action. Suspension may be with salary or salary may be withheld after consultation with the labor relations department of the employing facility.

Policy:

Academic Matters:

The SUNY Downstate GME Academic Performance Policy affords due process to residents/fellows who are subject to adverse actions or whose intended career development is altered by an academic decision of a program. See Academic Performance Policy for delineation of specific processes provided.

Misconduct Matters:

The SUNY Downstate Resident/Fellow GME Misconduct Policy affords due process to residents/fellows who are subject to adverse actions or dismissed from a GME program in a manner that alters their intended career development. See Resident/Fellow GME Misconduct Policy for delineation of specific processes provided.

Policy revised & updated 5/13/2011. This Policy supersedes prior, similar &/or related versions and revisions. Revisions approved by GMEC 5/18/11. Effective immediately upon approval.

GME Academic Performance Due Process Policy SUNY Downstate Medical Center Graduate Medical Education

Purpose:

To establish a policy and procedure for all post-graduate medical programs of SUNY Downstate Medical Center to use in addressing deficiencies in the academic performance, competence or progress of a resident or fellow enrolled in a graduate medical education program. To provide fair, reasonable and readily available policies and procedures when a resident/fellow is not meeting the academic expectations of a program or fails to progress.

Scope:

This policy applies to all programs and house officers (residents and fellows) participating in graduate medical education programs sponsored by SUNY Downstate. This policy applies to actions taken as a result of academic deficiencies that may involve the knowledge, skills, attitudes or the core clinical competencies of medical knowledge, patient care, systems-based practice, practice-based learning and improvement, communications and interpersonal skills and aspects of professionalism which are not addressed by the GME Misconduct Policy. This policy describes minimum expectations providing residents with an opportunity to be notified of deficiencies and an opportunity to cure those deficiencies.

Definitions:

Due Process: an individual's right to be adequately notified of any changes or proceedings involving him or her, & the opportunity to be heard with respect to those proceedings.

House Staff or House Officer: refers to all interns, residents or fellows enrolled in post-graduate medical training or research program or activity. The terms house officer, house staff, residents, fellows or subspecialty residents or fellows may be used interchangeably.

GME Program: refers to a residency or fellowship educational program

Letter of Deficiency: a non-reportable warning issued to a resident/fellow when there are concerns that routine feedback is not effecting necessary improvement. Such a letter provides

the house officer with formal notice and opportunity to cure any deficiencies. The Program Director can choose to alter a resident's assignments or have a resident repeat rotation(s) or make other adjustments in the resident's program in order to provide opportunity to cure the deficiency. It is an academic notification which is not reported to outside agencies and is not subject to appeal or review. The letter should summarize deficiencies and may identify expectations for demonstrating improvement as well as the consequences of not successfully resolving the deficiencies. Copies of Letters of Deficiency, signed and dated by the Program Director, should be retained in the resident's training record with copies to the GME Office. It is advisable to have the resident indicate receipt of Letters of Deficiency by signature or by witness or other documentation. These letters are sometimes also referred to as "Letter of Warning."

Monitored Performance: an academic function involving a heightened level of monitoring and assessment of house officer performance in the course of training program activities usually used to further assess for improvement in noted areas of deficiency, often as part of a program for remediation. This is not an adverse action, not reportable and not subject to appeal.

Adverse Action: disciplinary actions taken against a resident which alter the intended career development or timeframe. Such actions are reportable and allow a request for review and due process. Adverse actions include the following:

Dismissal: act of terminating a house officer participating in a GME program prior to successful completion of the course of training whether by early termination of a contract or by non-renewal of a contract.

Non-renewal: act of not reappointing a house officer to subsequent years of training prior to fulfillment of a complete course of training.

Non-promotion: act of not advancing a house officer to the next level of training according to the usual progression through a program

Extension of Training: act of extending the duration of time required by a house officer to complete a course of training generally resulting from repeating unsatisfactory rotation assignments or remediating poor performance or needing additional time to demonstrate achievement of required competence in one or more domains.

Probation: placement of a resident under close monitoring for specific performance concerns which if not successfully resolved can result in further adverse actions including dismissal. This action is reportable to state licensing authorities, employers and health care institutions.

Suspension: withdrawal of privileges for participating in clinical, didactic or research activities associated with appointment to the training program or hospital staff. This action is taken if, in the judgment of the Program Director, Department Chairperson or institutional leadership (Associate Dean, Dean, Medical Director) a resident's or fellow's competence or behavior is such that patients may be endangered, the educational process disrupted or other peers, staff, faculty are subjected to an adverse and unacceptable work environment. Under such circumstances, suspension may be implemented immediately pending further investigation and determination of other appropriate action. Suspension may be with salary or salary may be withheld after consultation with the labor relations department of the employing facility.

Structured Feedback: routine feedback regarding a trainee's performance or behavior and consistent with the educational program. Structured feedback can consist of verbal feedback,

rotational and summative evaluations, spontaneous or “on-the-fly” formal evaluations, memos or letters to a resident’s record or to the Program Director and shared with the resident, discussion and recommendations of a Program’s Clinical Competence or Resident Performance or other similar committee.

Policy:

All programs must establish a process for evaluating residents consistent with sound andragogic practice, ACGME institutional, common program and specialty specific requirements, American Board of Medical Specialties specialty board specific requirements and those of any other agency or accrediting body. Assessment of house officer performance and competence is made based upon department, program and/or specialty-specific educational requirements and expectations.

All residents and fellows should be provided with routine structured feedback that is consistent with the educational program and its policies.

Each department should establish a committee of faculty who meet regularly, no less frequent than four times per year, to review the performance, competence and/or standing in the program and progress toward program completion for all enrolled residents. This committee which may be referred to as a Clinical Competence Committee (CCC) or Performance or Evaluation Review Committee or House Staff Affairs or Assessment Committee, for example, should provide recommendations to the Program Director regarding the status of residents in the program and their progress to advanced training levels and, ultimately, program completion. The Committee’s discussions should be documented in meeting minutes. A Department can have one committee that reviews all residents and fellows in all programs in that Department. Alternatively, for Departments with multiple programs, residencies and fellowships, there may be separate and independent committees for each program. However, there must me no more than one committee with responsibility for assessing progress of all residents in a program and perspective on how all the program’s residents are performing relative to one another and longitudinally in time.

Letter of Deficiency:

When a resident or fellow has been identified as having deficiency, it is expected that he/she will receive routine structured feedback in order to identify and correct the issue. When the Program Director and/or CCC deems that routine feedback is not effecting necessary improvements, or if the Program Director and/or CCC determines that the deficiency is significant enough to warrant more than routine feedback, the Program Director and/or CCC may elect to issue a “Letter of Deficiency.” This letter formally provides the House Officer with (a) notice of the deficiency and (b) an opportunity to cure the deficiency. “Letters of Deficiency” must be signed and dated by the Program Director and copied to the resident/fellow’s record and to the GME Office. The “Letter of Deficiency” must indicate the possible outcomes of failure to fully resolve the concerns or developing deficiencies or performance problems in additional areas. The issuance of a “Letter of Deficiency” does not trigger a report to any outside agencies. The House Staff Officer should continue to receive structured feedback addressing issues consistent with the “Letter of Deficiency.” The house officer may be subjected to a period of monitored performance to appropriately assess progress in resolving deficiencies. If the house officer satisfactorily resolves deficiencies noted in the “Letter of Deficiency,” and continues to perform acceptably

thereafter, the period of unacceptable academic performance does not affect the house officer's intended career development.

Escalation:

If the Program Director and/or CCC determine that the house officer has failed to satisfactorily cure the deficiency and/or improve his/her performance to an expected and acceptable level, with consideration for what is fair and reasonable, the Program Director and/or CCC may elect to take further actions. Such actions may include but are not limited to any one or more of the following:

a) Issuance of another, new "Letter of Deficiency." (Non-reportable, not an adverse action) b) Placement on probation with establishment of adverse consequences for unsuccessfully meeting conditions of the probation c) Non-promotion to the next PGY or training level and continue in the program. d) Require repeat of training experience that in turn results in extension of required period of training e) Extension of contract which may involve extension of the defined training period (extension of training) f) Denial of credit for previously completed rotations/experiences g) Non-renewal in the training program h) Suspension from training pending further review or determination of other definitive action. i) Dismissal from the residency or fellowship program.

For all such actions, the resident must be notified verbally, when possible, and in writing. A copy of the notification signed and dated by the Program Director with documentation that it was received by the resident (resident signed acknowledgement or witnessed or other receipt verification) must be included in the resident's record and copied to the GME Office. Notice of adverse action or any action which can interfere with the resident's intended career development must inform the house officer of his/her right to review and appeal of such adverse action. The house officer should be provided with or referred to applicable policies and procedures regarding due process, review and appeal. Notifications of adverse action should be done in consultation with the GME Office.

Reportable Actions:

The decision not to promote a house officer to the next PGY level, to extend training, to deny credit for a period of training, suspension, probation, and/or terminating a house officer's participation in a residency or fellowship program are each considered "reportable actions." Such actions must be disclosed to others upon request, including without limitation, future employers, privileging hospitals, and licensing and specialty boards. House Officers who are subject to a reportable action are permitted to request a review of the decision and seek to appeal that decision. Note that routine academic performance evaluations and assessments even when unsatisfactory are standard procedures in a training program and in and of themselves are not considered adverse actions, are not reportable actions and are not subject to appeal under this policy.

Request for Review and Appeal:

A review and appeal of a Program's decision to take a Reportable Action or any action interfering with the resident's intended career development may be requested by the house officer. The request must be made in writing, addressed to the Associate Dean for GME, signed and dated, and submitted to the Director of Graduate Medical Education within 14 calendar days of the house officer learning of the Reportable Action. The request should clearly describe

the reason for requesting the review and any basis upon which an appeal is being made. Upon receipt of a Request for Review and Appeal, the Associate Dean for GME will determine whether the matter is subject to review under this Policy. If so, the Associate Dean for GME will direct the Director of GME to appoint an ad hoc Review and Appeal Subcommittee of the GME Committee. This subcommittee will be composed of neutral reviewers from Departments other than the one in which the requesting house officer is appointed. The subcommittee will consist of at least two SUNY Downstate faculty members and one resident or fellow. Additional committee members may be assigned at the discretion of the Associate Dean for GME/DIO. The subcommittee may also include institutional GME Department leadership such as the Vice Dean for GME, Associate Dean for GME, the DIO or GME Office administrative officers. SUNY Counsel may serve in an advisory capacity.

The ad hoc Review and Appeal subcommittee will:

a) Conduct confidential meeting(s) open only to committee members, GME Office and GMEC staff, and any participants invited by and approved by the Committee. b) Identify one faculty member who will serve as Chairperson of the subcommittee. The subcommittee Chairperson should be a participant on the SUNY Downstate GME Committee. c) Arrange for an individual to take notes and document a summary of minutes of meetings held. d) Committee meetings will be scheduled at the discretion of the committee Chairperson. e) Establish a process for the review. Such process will not be rigidly prescribed and is not conducted in the manner of a legal hearing process. No legal representation will be permitted. No opportunity for cross examination or questioning is offered. f) Review the resident/fellow complaint and request for review/appeal. g) Provide the house officer requesting the review or appeal the opportunity to appear before the committee to make a statement and/or present evidence of relevance for rescinding the action under review. The committee may also require the house officer to respond to questions posed by the committee. As an academic review panel and not a legal hearing, when appearing before the committee, the house officer may be accompanied by an advocate who is not an attorney. Failure of an appealing house officer to appear as scheduled before the committee without just cause could result in a summary determination against the house officer. h) If applicable, review relevant records and documentation such as the house officer's file, program records, policies, meeting minutes, etc. i) Consider any extenuating circumstances. j) The committee may meet with the Program Director or other program representative(s) and request presentation of evidence for upholding the proposed action. k) The committee may request statements from or interview other house officers, faculty, staff, administrators or members of the academic or health care team in order to gather additional information. l) The committee may consult with others, as appropriate, to assist in the decision making process. m) Determine whether this Policy was followed, the house officer received notice and an opportunity to cure, and the decision to take the reportable action was reasonably made. n) The subcommittee Chairperson is responsible for preparing the committee's report summarizing findings and making recommendations to the Associate Dean for GME/DIO regarding the review and request for appeal of reportable actions. o) The subcommittee Chairperson or designee will report the outcome of the review and appeal process to the GME Committee.

Upon receipt of the Chairperson's report from the ad hoc Review and Appeal Subcommittee, the Associate Dean for GME shall review said findings and recommendations. The Associate Dean

for GME/DIO finding the committee's review process to have followed procedure and be fair, reasonable and appropriate shall make notification to the resident of the Review and Appeal subcommittee's decision in writing with a copy to the Program Director, Department Chairperson, the employing institution, if applicable, and others as appropriate.

The decision resulting from this review is a final and binding decision. It is not subject to further formal review within the State University of New York Downstate Medical Center (Health Science Center at Brooklyn).

No Retaliation:

Initial and full inquiries will be conducted with due regard for confidentiality to the extent practicable. Under no circumstances may anyone retaliate against, interfere with or discourage anyone from participating in good faith in an initial inquiry or full inquiry conducted under this policy. A house staff officer who believes he/she may have been retaliated against in violation of this policy should immediately report it to his/her supervisor, the Director of GME, resident ombudsman, Associate Dean for GME, DIO or other any other supervisor.

Original policy completed 5/13/2011. This Policy supersedes all prior, similar &/or related versions/revisions. Reviewed/approved by GMEC 5/18/11. Effective immediately upon approval.

GME Misconduct Due Process Policy SUNY Downstate Medical Center Graduate Medical Education

Purpose:

To establish a policy and procedure for all post-graduate medical programs of SUNY Downstate Medical Center to use in addressing allegations of misconduct made against a house staff officer. To provide fair, reasonable and readily available policies and procedures regarding charges of misconduct.

Scope:

This policy applies to all programs and house officers (residents and fellows) participating in graduate medical education programs sponsored by SUNY Downstate. This policy applies to any actions taken as a result of allegations of misconduct or serious departure from standards of professionalism or professional expectations. This policy describes minimum expectations providing residents with an opportunity to be notified of allegations and an opportunity to be heard and respond to such allegations and any proposed action taken as a result.

Definitions:

Due Process: an individual's right to be adequately notified of any changes or proceedings involving him or her, and the opportunity to be meaningfully heard with respect to those proceedings.

House Staff or House Officer: refers to all interns, residents or fellows enrolled in post-graduate medical training or research program or activity at SUNY Downstate or as a visiting rotator to SUNY Downstate.

GME Program: refers to a structured educational experience in graduate medical education designed to conform to the Program Requirements of a particular specialty/subspecialty

Misconduct: refers to improper behavior; intentional wrongdoing; violation of law, rule, standard of practice, or policy of the program, department, institution or agency including NYS Education Law Section 6530 (synopsis attached as appendix 1). Misconduct may also constitute unprofessional behavior, which may also trigger action under the GME Academic Deficiencies

Policy, not to the exclusion of any action resulting from this GME Misconduct Policy. These actions may proceed simultaneously.
Monitored Performance: an academic function involving the heightened level of monitoring and assessment of house officer performance in the course of training program activities usually used to further assess for improvement in noted areas of deficiency, often as a part of a program for remediation. This is not an adverse action and it is not reportable.
Adverse Action: disciplinary actions taken against a resident which alter the intended career development or timeframe. Such actions are reportable and allow a request for review and due process. Adverse actions include the following:
Dismissal: act of terminating a house officer participating in a GME program prior to successful completion of the course of training whether by early termination of a contract or by non-renewal of a contract.
Non-renewal: act of not reappointing a house officer to subsequent years of training prior to fulfillment of a complete course of training.
Non-promotion: act of not advancing a house officer to the next level of training according to the usual progression through a program.
Extension of Training: act of extending the duration of time required by a house officer to complete a course of training generally resulting from repeating unsatisfactory rotation assignments or remediating poor performance or needing additional time to demonstrate achievement of required competence in one or more domains.
Probation: placement of a resident under close monitoring for specific performance concerns which if not successfully resolved may result in other adverse actions including dismissal. This action is reportable to state licensing authorities and health care institutions.
Suspension: withdrawal of privileges for participating in clinical, didactic or research activities associated with appointment to the training program or hospital staff. This action is taken if, in the judgment of the Program Director, Department Chairperson or institutional leadership (Associate Dean, Dean, Medical Director) a resident's or fellow's competence or behavior is such that patients may be endangered, the educational process disrupted or other peers, staff, faculty are subjected to an adverse and unacceptable work environment. Under such circumstances, suspension may be implemented immediately pending further investigation and determination of other appropriate action. Suspension may be with salary or salary may be withheld after consultation with the labor relations department of the employing facility.
Structured Feedback: routine feedback regarding a trainee's performance or behavior and consistent with the educational program. Structured feedback can consist of verbal feedback, rotational and summative evaluations, spontaneous or "on-the-fly" formal evaluations, memos or letters to a resident's record or to the Program Director and shared with the resident, discussion and recommendations of a Program's Clinical Competence or Resident Performance or other similar committee.

Policy:

A house officer, employee of the hospital, attending physician, patient, or any other person who believes that a house officer has engaged in misconduct of any kind should immediately report his/her concern to his/her supervisor, or any other supervisor in the institution, who in turn should communicate the allegations to the house officer's Program Director. Upon receipt of a

complaint regarding the conduct of a house officer, the Program Director should conduct an initial inquiry, as follows:
a) Review documentation of and in support of the complaint b) If possible, meet with the person complaining of misconduct c) Meet with the house officer to advise the house officer of the existence of the complaint, to notify him or her and provide an opportunity to respond to the allegations, and to identify any potential witnesses or other information relevant to the alleged misconduct d) Consult with GME Office to determine whether the Dean, Associate Dean for GME, Department Chairperson, Legal Affairs and/or Human Resources and/or Labor Relations should be contacted as appropriate based on the issues and the people involved e) Upon the request of the house officer, or if the Program Director, Associate Dean for GME/DIO, Department Chairperson or Human Resources decide the incident warrants more investigation, then a “Full Inquiry” must be done f) All allegations of sexual harassment, disruptive behavior or violence must be reported to Human Resources/Labor Relations in accordance with the Institution’s policies. g) Upon consensus of the Program Director and the Associate Dean for GME/DIO or designee, the accused house staff officer can be removed from duty (with or without pay) pending the outcome of a full inquiry

Full Inquiry:

A full inquiry is an internal investigation of the allegations/incident by a committee of appropriate individuals appointed by the Department Chairperson from within the Department/Institution. This may include GME staff or leadership, Program Director, Department Chairperson, key faculty, Human Resources, Legal Affairs, Labor Relations, Hospital Administration, or others. The inquiry process is administered by the Department Chairperson in consultation with the GME Office. Factual results of the inquiry along with recommendations for action will be prepared by the Chairperson and/or other responsible faculty or staff participating in the full inquiry and reported back to the Program Director and the house officer for appropriate action. A copy of this report will be submitted to the GME Office and Associate Dean for GME/DIO. If the full inquiry results in a finding that no misconduct occurred, no action will be taken against the house officer. If the house officer was suspended pending the inquiry, the house officer will be reinstated with full benefits and pay without prejudice. If the full inquiry results in a finding that the house officer engaged in misconduct, the Program Director shall determine, in consultation with the Department Chair, Human Resources, Legal Affairs, Labor Relations or other appropriate individuals, what action is appropriate under the circumstances, to remedy the situation. At all times, quality of patient care, safety of patients, staff, faculty and house officers, and integrity and security of the work and education environment must be assured. The Program may take actions including, without limitation, the following:
a) Verbal or written warning or reprimand. b) Election to not promote to the next training level. c) Non-renewal of contract. d) Suspension. e) Probation. f) Immediate termination or dismissal from residency or fellowship program.

Reportable Actions:

The decision not to promote a house officer to the next PGY level, to extend training, to deny credit for a previously completed period of training, suspension, probation, and/or terminating a house officer’s participation in a residency or fellowship program are each considered “reportable actions.” Such actions must be disclosed to others upon request, including without

limitation, future employers, privileging hospitals, and licensing and specialty boards. House Officers who are subject to a reportable action are permitted to request a review of the decision and seek to appeal that decision.

For all such actions, the resident must be notified verbally, when possible, and in writing. A copy of the notification signed and dated by the Program Director with documentation that it was received by the resident (resident signed acknowledgement or witnessed or other receipt verification) must be included in the resident's record and copied to the GME Office. Notice of adverse action or any action which can interfere with the resident's intended career development must inform the house officer of his/her right to review and appeal of such adverse action. The house officer should be provided with or referred to applicable policies and procedures regarding due process, review and appeal. Notifications of adverse action should be done in consultation with the GME Office. Note that performance evaluations and assessments, even when unsatisfactory, are standard procedures in a training program and in and of themselves are not considered adverse actions, are not reportable actions and are not subject to appeal under this policy. Verbal or written warnings and/or reprimands are also not considered adverse actions, are not reportable and are not subject to appeal under this policy.

Request for Review and Appeal:

A review and appeal of a Program's decision to take a Reportable Action or any action interfering with the resident's intended career development may be requested by the house officer. The request must be made in writing, addressed to the Associate Dean for GME, signed and dated, and submitted to the Director of Graduate Medical Education within 14 calendar days of the house officer learning of the Reportable Action. The request should clearly describe the reason for requesting the review and any basis upon which an appeal is being made. Upon receipt of a Request for Review and Appeal, the Associate Dean for GME will determine whether the matter is subject to review under this Policy. If so, the Associate Dean for GME will direct the Director of GME to appoint an ad hoc Review and Appeal Subcommittee of the GME Committee. This subcommittee will be composed of neutral reviewers from Departments other than the one in which the requesting house officer is appointed. The subcommittee will consist of at least two SUNY Downstate faculty members and one resident or fellow. Additional committee members may be assigned at the discretion of the Associate Dean for GME/DIO. The subcommittee may also include institutional GME Department leadership such as the Vice Dean for GME, Associate Dean for GME, the DIO or GME Office administrative officers. SUNY Counsel may serve in an advisory capacity.

The ad hoc Review and Appeal subcommittee will:

a) Conduct confidential meeting(s) open only to committee members, GME Office and GMEC staff, and any participants invited by and approved by the Committee. b) Identify one faculty member who will serve as Chairperson of the subcommittee. The subcommittee Chairperson should be a participant on the SUNY Downstate GME Committee. c) Arrange for an individual to take notes and document a summary of minutes of meetings held. d) Committee meetings will be scheduled at the discretion of the committee Chairperson. e) Establish a process for the review. Such process will not be rigidly prescribed and is not conducted in the manner of a legal hearing process. No legal representation will be permitted. No opportunity for cross examination or questioning is offered. f) Review the resident/fellow complaint and request for review/appeal.

g) Provide the house officer requesting the review or appeal the opportunity to appear before the committee to make a statement and/or present evidence of relevance for rescinding the action under review. The committee may also require the house officer to respond to questions posed by the committee. As an academic review panel and not a legal hearing, when appearing before the committee, the house officer may be accompanied by an advocate who is not an attorney. Failure of an appealing house officer to appear as scheduled before the committee without just cause could result in a summary determination against the house officer. h) If applicable, review relevant records and documentation such as the house officer's file, program records, policies, meeting minutes, etc. i) Consider any extenuating circumstances. j) The committee may meet with the Program Director or other program representative(s) and request presentation of evidence for upholding the proposed action. k) The committee may request statements from or interview other house officers, faculty, staff, administrators or members of the academic or health care team in order to gather additional information. l) The committee may consult with others, as appropriate, to assist in the decision making process. m) Determine whether this Policy was followed, the house officer received notice and an opportunity to be heard, and the decision to take the reportable action was reasonably made. n) The subcommittee Chairperson is responsible for preparing the committee's report summarizing findings and making recommendations to the Associate Dean for GME/DIO regarding the review and request for appeal of reportable actions. o) The subcommittee Chairperson or designee will report the outcome of the review and appeal process to the GME Committee. Upon receipt of the Chairperson's report from the ad hoc Review and Appeal Subcommittee, the Associate Dean for GME shall review said findings and recommendations. The Associate Dean for GME/DIO finding the committee's review process to have followed procedure and be fair, reasonable and appropriate shall make notification to the resident of the Review and Appeal subcommittee's decision in writing with a copy to the Program Director, Department Chairperson, the employing institution, if applicable, and others as appropriate.

The decision resulting from this review is a final and binding decision. It is not subject to further formal review within the State University of New York Downstate Medical Center (Health Science Center at Brooklyn).

No Retaliation:

Initial and full inquiries will be conducted with due regard for confidentiality to the extent practicable. Under no circumstances may anyone retaliate against, interfere with or discourage anyone from participating in good faith in an initial inquiry or full inquiry conducted under this policy. A house staff officer who believes he/she may have been retaliated against in violation of this policy should immediately report it to his/her supervisor, the Director of GME, resident ombudsman, Associate Dean for GME, DIO or other any other supervisor.

Original policy completed on 5/13/2011. This Policy supersedes all prior, similar and/or related versions and revisions. Reviewed and approved by GMEC 5/18/11. Effective immediately upon approval.

Appendix 1:

Synopsis of NYS Education Law Section 6530

a) Obtaining a license or permit fraudulently; b) Practicing the profession fraudulently or beyond its authorized scope; c) Practicing the profession with gross negligence on a particular occasion or negligence on more than one occasion; d) Practicing the profession with gross incompetence or incompetence on more than one occasion; e) Practicing the profession while impaired by alcohol, drugs, physical disability, or mental disability; f) Being a habitual abuser of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects, except if maintained on an approved therapeutic regimen which does not impair the ability to practice; g) Having a psychiatric condition which impairs the ability to practice; h) Being convicted of committing an act constituting a crime under New York State law, federal law or another jurisdiction which, if committed within New York State, would have constituted a crime under New York law; i) Refusing to provide professional service to a person because of such person's race, creed, color or national origin; j) Permitting, aiding or abetting an unlicensed person to perform activities requiring a license; k) Any willful violation of New York State Public Health Law or Education Law or Public Officers Law; l) A willful of grossly negligent failure to comply with substantial provisions of federal, state, or local laws, rules, or regulations governing the practice of medicine; m) Exercise undue influence on the patient in such a manner as to exploit the patient for financial gain; n) Directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or in connection with the performance of professional services; o) Conduct in the practice of medicine which evidences moral unfitness to practice medicine; p) Willfully making or filing a false report, or failing to file a report required by law or by the Department of Health or the Education Department, or willfully impeding or obstructing such filing, or inducing another person to do so; q) Revealing of personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the patient, except as authorized or required by law; r) Practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities which the physician knows or has reason to know that he or she is not competent to perform, or performing without adequate supervision professional services which the physician is authorized to perform only under the supervision of a licensed or appropriate privileged professional, except in an emergency situation where a person's life or health are in danger; s) Delegating professional responsibilities to a person while knowing or having reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them; t) Performing professional services which have not been duly authorized by the patient or his or her legal representative; u) Abandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment without reasonable notice and under circumstances which seriously impair the delivery of professional care to patients or clients; v) Willfully harassing, abusing, or intimidating a patient either physically or verbally; w) Failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient; x) Failure to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the physician; y) Ordering of excessive tests, treatment, or use of treatment not warranted by the condition of the patient; z) Failing to wear an identifying badge, which shall be conspicuously displayed and legible, indicating the practitioner's name and professional title

while practicing as an employee offering health services to the public; aa) Failure to use scientifically accepted barrier precautions and infection control practices as established by the Department of Health pursuant to section 230a of the public health law.

Anonymous Email

In order to give you a conduit to voice concerns regarding your training, patient safety, any type of harassment or any other interactions that may impact your ability to flourish and develop into the best possible doctor, we have created an e-mail account that you may use in order to send anonymous e-mails to the GME leadership.

By using a universal g-mail account your anonymity is fully protected. Log into the following g-mail account:

Username: Downstate.gmecomplaint@gmail.com

Password: resident (note: lower case r)

Please send your e-mail of concern from the above account to:

GMEHelp@downstate.edu

If you do not get a timely response and acknowledgement of receipt of your e-mail you may also e-mail Dr. David Wlody, Associate Dean for GME and DIO at David.Wlody@downstate.edu

EMPLOYEE HEALTH SERVICE (EHS)

In addition to your provided health care coverage each affiliate institution maintains an employee health service center. The health service center is responsible for a number of resident related issues. Each resident must obtain and maintain health clearance from the institution responsible for their salary. This usually entails an initial health screening exam and verification of PPD status and immunizations. Periodically employee health services may request repeat PPD testing and other occupational health care related training (e.g. respiratory isolation mask fitting). The other time employee health service may be utilized is with respect to illness or injury at work. One important injury that EHS is responsible for is follow up on all occupational exposure to bloodborne pathogens. All needle sticks at Kings County irrespective of resident pay source are referred to KCH EHS after initial care is provided in the Treatment Room. KCH EHS is to forward all needle stick paperwork and laboratory results to the residents' payroll institution after the initial follow up visit.

Employees Health Contact Numbers:

Kings County (718) 245-3536

UHD (718) 270-1995

There are two on-call rooms available to KCH EM residents. The rooms are located in the T-building on the 8th floor and are available on a per day basis for the residents. The rooms are for all EM residents to use and squatters will be asked to move out their belongings if they prevent other EM residents from access to the rooms. Room keys are available from the residency coordinator.

If keys are needed for the weekend, please contact the residency coordinator in advance.

NEEDLESTICK/BODY FLUID EXPOSURE PROTOCOL

Needle sticks and body fluid exposure is an unfortunate occurrence that is likely to happen, in some way or another, to every physician at some point in his/her career. It can be terrifying and anxiety provoking for the physician and her/his partner. These events SHOULD NOT be ignored. Risk of HIV infection is low and can be completely avoided with early prophylaxis. Any exposure should immediately be brought to the attention of the attending physician on duty. If there is concern contact Dr. Willis or the residency director on call.

Protocol:

Occupational exposure to infectious disease is an obvious concern at Kings County and its prevention is a priority of the department. Recently, the Centers for Disease Control has issued a recommendation concerning occupational exposure to infectious bodily fluid and the possible use antiviral medications. Please review this material and be familiar with what to do if you or a colleague suffers a body fluid exposure or needle stick. Please remember to check your Hepatitis antibody status and take appropriate steps when indicated.

All employees, residents, students, or visitors to Kings County Hospital who sustain an exposure are to be seen in the Emergency Department (24 hours a day). The needle stick packet is available at all time in the ED and has to be completed by the attending physician or an ED resident. The recommendations for antiviral medications are enclosed in the needle stick

packet and if antiviral therapy is initiated the first dose will be distributed from the supply in the Treatment room.

At discharge the exposed patient should be given a prescription for a seven-day supply. The prescription should be filled without charge in the pharmacy for all residents. Needle stick packets should be filled out completely and given to the ED Administrator on duty. Also, exposed patients and agreeing source patients should have “needlestick” bloods drawn at the time of injury. The computer has a predetermined panel that may be selected that includes all needed blood test except HIV testing.

Both the source patients and exposed health care workers can be counseled and consented for HIV testing using the consent forms in the needle stick packet.

Please follow the instructions affixed to the packet for proper processing.

All employees and residents are to follow up in employee health services the following working day.

Any questions, please contact Dr. Willis at: 718-245-4795 (office) or cell (516) 860-5095

WORKPLACE ASSAULT

In the event of a resident being injured at work related to physical violence from a patient, visitor, or another staff member, the following steps should be taken by the attending supervisor:

-The chief and residency director on call will be notified in real-time
-Hospital police will be notified immediately
-The resident should be allowed to leave the immediate area, and the resident's patient care responsibilities are to be transferred to another provider
- The resident will not continue caring for their assailant or family member. If the assailant is another staff member, they will not continue working in the same area. Nursing and department leadership to be notified as needed
-The resident should be offered the option:
    -to be assessed for medical injuries by being triaged
    -to end their tour of duty and return home for the day
    -press charges against the assailant
-The chief and residency director on call will follow up with the resident and assess further needs, including time off and referral for medical or mental health eva

INSTITUTIONAL POLICY ON DISCRIMINATION AND SEXUAL HARASSMENT

Discrimination:

SUNY Downstate does not discriminate on the basis of race, sex, color, chosen gender, religion, age, national origin, disability, marital status, status as a disabled veteran or veteran of the Vietnam era, or sexual orientation in the recruitment and treatment of students and residents.

Sexual Harassment:

In keeping with the University's efforts to establish an environment in which the dignity and worth of all members of the institutional community are respected, sexual harassment of students and employees at Downstate is unacceptable conduct and will not be tolerated. Sexual harassment may involve the behavior of a person of either sex against a person of the opposite or same sex, when that behavior falls within the following definition: Sexual harassment of employees, residents, and students at Downstate is defined as any unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature, when: (a) Submission to such conduct is made either explicitly or implicitly a terms or condition of an individual's employment or status as a student; (b) Submission to or rejection of such conduct is used as the basis for decisions affecting the employment or academic status of that individual; (c) Such conduct has the purpose or effect of unreasonable interfering with an individual's work performance or educational experience, or creates an intimidating, hostile or offensive work or educational environment. A hostile environment is created by, but not limited to, discriminatory intimidation, ridicule or insult. It need not result in an economic loss to the affected person.

Complaint Procedures:

Persons who feel that they have been subject to prohibited discrimination or who have been sexually harassed under the above definition and wish further information, or assistance in filing a complaint, should contact the Affirmative Action Officer at (718) 270-1738, Room #5-82 C, Basic Science Building. Any resident that feels they have a complaint can also bring that issue to the Program Directors or the Departmental Chairman. If residency or departmental leadership becomes aware of an instance of sexual harrassment they are mandated to report it to the compliance officers for investigation.

FAMILY MEDICAL LEAVE ACT

Effective February 5, 1994, all employees are eligible to request unpaid leave charged to leave credits under certain circumstances, for a period of up to 12 work weeks in a 12-month period due to: 1) the birth of a child or the placement of a child for adoption or foster care; 2) the employee's need to care for a family member (child, spouse, or parent) with a serious health condition; or 3) the employee's own serious health condition which makes the employee unable to do his or her job. Under certain conditions, this leave may be taken on an intermittent basis. Employees are also entitled to continuation of health and certain other insurance, provided the employee pays his or her share of the premium during this period of leave. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. FMLA makes it unlawful for any employer to 1) interfere with, restrain, or deny the exercise of any right provided under FMLA, or 2) discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA. The U.S. Department of Labor is authorized to investigate and resolve complaints of violations. An eligible employee may bring a civil action against an employer for violations. For additional information, contact SUNY Labor Relations at x3019.

Please note, that since residency is a structured educational process requiring a minimum number of months of training for Board eligibility you may take FMLA but you will need to make up the months. In other words you may end your residency at a later date.

Currently, you can only miss 6 weeks in any give academic year for any reason including vacation. This leave CANNOT be transferred from year to year. Any missed time over this limit must be made up.

RESIDENT LEAVE OF ABSENCE

Residents have access to a leave of absence for various reasons including personal or dependent illness, maternity or paternity. When considering the need for a leave of absence, contact Dr. Willis to discuss and for approval. Leave will be considered irrespective of gender, is inclusive of foster, adoptive and surrogate parents and is flexible in timing surrounding child birth. The resident should expect leave to consist of a minimum of 6 weeks without need to extend residency. Multiple leaves of absence and leave extended past 6 weeks is possible but the resident should expect to extend their graduation date. Paid leave is almost always possible but will be discussed during approval. Non clinical responsibilities, ie conference presentations and simulation, should be rescheduled with the appropriate leadership if it coincides with leave.

Pregnant Resident Scheduling Allowances

Purpose:
To create fair shift schedules for pregnant residents, taking into account the inherent health risks associated with working during pregnancy as well as individual preferences.

Scope:
This policy applies to all residents working in the emergency department at Kings County Hospital Center and/or SUNY Downstate Medical Center.

Background:
A meta-analysis found that physically demanding work was associated with preterm birth, small gestational age, and hypertension or preeclampsia.[1] Other occupational exposures significantly associated with preterm birth included prolonged standing (defined as more than three hours per day or the predominant occupational posture) (odds ratio [OR], 1.26; 95% CI, 1.13–1.40), shift and night work (OR, 1.24; 95% CI, 1.06–1.46), and high cumulative work fatigue score.[1] In addition, night shifts have been associated with increased early spontaneous pregnancy loss (n=13,018; OR, 1.29; 95% CI, 1.11–1.50).[2]

Policy:
Because early spontaneous abortion, preterm labor, and other adverse pregnancy outcomes are associated with night shifts, we offer the following accommodations, when possible, to our pregnant residents. These recommendations will not take the place of the pregnant physician's preference.

- First-trimester pregnant residents (12 weeks or fewer) and third-trimester pregnant residents (28 weeks or more) have the option to opt out of night shifts.

In addition, we will work with expecting parents on scheduling around prenatal doctors visits when possible. We will also attempt, when possible, to allow for contingency planning (ie double-staffed shifts or stacked sick call) during the last few weeks of pregnancy.

References:

1. Mozurkewich EL, Luke B, Avni M, et al. Working conditions and adverse pregnancy outcome: a meta-analysis. Obstet Gynecol. 2000;95(4):623-635.
2. Stocker LJ, Macklon NS, Cheong YC, et al. Influence of shift work on early reproductive outcomes: a systematic review and meta-analysis. Obstet Gynecol. 2014;124(1):99-110.
3. https://feminem.org/2019/09/02/best-practice-recommendations-for-clinical-scheduling-during-pregnancy/

Lactation Facilities

All employees will be supported and given the needed time for breast feeding. See below for facilities available for these needs.

KCH ED:

1. **Lactation Room:** We are excited to announce that we have allocated a private lactation area in the ED. This room is equipped with all of the essential items. The room will be in the (SART) crisis center area. Two keys are required, one to access the Main SART door and other to the dedicated Lactation room inside **(S1N27 & S1N30).** The keys will be housed in the pediatric ED in the attending drawer. Please return the keys to this destination after use.

Lactation Rooms Locations

Kings County Hospital

Building	Room
D Building	D5 North, Room 23
E Building	E5, 5th Floor Suite A, Room E5 W2
R Building	R6, 6th Floor, Room R6037

SUNY Downstate

Building	Room
NICU Area	3rd Floor, A3-469

NYU – Brooklyn ED Lactation Guidelines

1. Breastfeeding employees are allowed to breastfeed or express milk during work hours.

2. The employee will notify the ED charge nurse and attending colleagues when she is leaving the clinical area to express breastmilk, to ensure adequate cross-coverage of ED patients.

3. The employee will carry her zone phone and answer all emergent phone calls.

4. A lactation room is available on the 5th floor NICU lounge, and can be reserved by calling 718-630-8324.

5. Rooms available in the ED Administrative area for expressing breastmilk should be used in the following order of preference, depending on availability:

Assistant Chief Office
Administrator (Tricia/Alessia's) office
Chief Office
Drs. Chitnis/Behan/Kashif office (to be used as last resort since is shared amongst multiple staff members for storage.)

6. Breastmilk should be labelled with name of employee and date, and stored in the fridge in Tricia/Alessia's office.

Mental Health Resources

Personal mental health is often not a priority for physicians and especially neglected in residency. This is something at KCH/UHD we do not find acceptable. Below are some institutional and extra-institutional resources for physician mental health. Please reach out to your class dean or Dr. Willis if you need any guidance or help navigating these resources. Please reach out to discuss schedule accommodations for mental health or general health appointments or priorities.

KCH/UHD-specific Resources:

- ★ KCH Physician Mental Health & Wellness Resource site
  - **https://ess.nychhc.org/staff-wellness.html**
  -
- ★ SUNY Downstate Physician Mental Health & Wellness Resource site
  - https://www.downstate.edu/gme/wellness/

- ★ Insurance re: Therapists and Psychotherapy
  - Information regarding reimbursement depending on paysource
  - Downstate, UUP
    - NYSHIP, Empire Plan:
    - Coverage for therapy of **80%** of the 90th percentile for that zipcode
    - For additional information, please call 1-888-204-5581 if you have the Empire Plan, OR contact your insurance provider for coverage details

  - Kings County, CIR
    - The Plan will reimburse **80%** of the reasonable and customary provider for a maximum reimbursement of **$160** per visit.
    - The Plan will reimburse up to **$5,000** per person, per benefit year
    - For additional information, please visit the Mental Health Claims Form [hyperlink-https://secure.na1.echosign.com/public/esignWidget?wid=CBFCIBAA3AAABLblqZhBjdPZNU]; OR contact your insurance provider for coverage details

- ★ Downstate-specific
  - Employee Assistance Program
    - (718) 270-1000
    - (718) 270-1489
    - 800-822-0244 (available 24/7)
    - https://www.downstate.edu/eap/

- Dept of Psychiatry
  - Modes:
    - Email: covid-stress@downstate.edu
    - Text Message: (718) 550-6722
    - Phone and leave a voicemail: (718) 270-1318
  - **ALL CALLS AND INFORMATION ARE CONFIDENTIAL

★ KCH-specific
- NYC HHC System-wide Emotional Staff Support:
  - 646-815-4150: Monday -- Friday, 9AM -Midnight
  - Anonymous support hotline for all NYC HHC employees

ACEP/EMRA Physician Wellness:

★ General: Follow link and sign in to access https://www.acep.org/life-as-a-physician/wellness/

★ *ACEP Wellness & Assistance Program:* (ACEP members now have access to three, FREE confidential counseling or wellness coaching sessions, in partnership with Mines & Associates). Follow link and sign in for details -> https://www.acep.org/life-as-a-physician/ACEP-Wellness-and-Assistance-Program/

Additional Resources:

★ Healthcare Provider's Wellness Support Website set up by EM/IM grad Bonnie Brown! https://sites.google.com/view/covidwellness/home

★ Wendy Lau - EM alum who specializes in physician wellness and mindfulness
- http://wendylaumd.com/physiciansupport/

★

National Academy of Medicine
Action Collaborative on
Clinician Well-Being and Resilience

https://nam.edu/initiatives/clinician-resilience-and-well-being/clinician-well-being-resources-during-covid-19/

★ Art of Living
Art of Living is providing free opportunity for health care workers to learn more breathing meditation, and general wellness techniques during this difficult time. Faculty and residents can access the online course by visiting www.aolf.me/covid19 and register using their professional license number, or for residents without medical license, their NPI number

★ Free meditation and mindfulness content:
- www.headspace.com/ny

Hotlines specific for Healthcare professionals:

★ NYS Office of Mental Health (OMH) Emotional Support Helpline: 1-844-863-9314
- Staffed by specialty-trained volunteers and mental health professionals, trained in crisis counseling related to the mental health consequences of infectious disease outbreaks, typical stress reactions, anxiety management, coping skills, and telephonic counseling
- OMH Fact Sheet "Feeling Stressed About Coronavirus?"
  - https://omh.ny.gov/omhweb/covid-19-resources.html
- OMH COVID-19 Resource page:
  - https://omh.ny.gov/omhweb/covid-19-resources.html

★ Disaster Distress Helpline (CDC)
- 800-985-5990
- Text TalkWithUs to 66746

★ NYC WELL: 1-888-692-9355, text WELL 65173
- Available 24/7

★ Physician Support Line: 1-888-409-0141
- http://physicianmentalhealth.com/
- Hours: 8AM - 1AM ET, Mon - Sun, only for US colleagues
- Peer Support line, strictly confidential with no identifying information asked
  - NY-specific list of participating psychiatrists/therapists: https://physicianmentalhealth.com/?page_id=480#NEW%20YORK

★ Project Parachute

    - https://project-parachute.org/index.html
    - Free teletherapy by volunteer psychologists for frontline health workers

Additional Anonymous Support Hotlines

★ Suicide Prevention Hotline/US National Crisis Text Line:
    - 1-800-273-8255
    - text **Got5 or HOME** to 741741

★ NYC Employee Assistance Program: 1-212-306-7660 M-F 8AM-11PM

★ Samaritans Helpline: 877-273-8255
    - free and confidential helpline that offers support for those who are feeling concerned about themselves or others

Substance Abuse and Mental Health Services Administration (SAMHSA)

- National Hotline 1-800-662-HELP (4357), (also known as the Treatment Referral Routing Service)
- TTY: 1-800-487-4889 is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individual and family members facing mental and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations. Callers can also order free publications and other information

THE IMPAIRED PHYSICIAN

Physician impairment through alcohol and drugs is a widely recognized problem. Residents in high acuity, high stress environments are particularly prone to fall victim to alcohol and drugs. The University has outlined guidelines in its SUNY Resident Handbook on how to deal with impairment. Please refer to the appropriate pages of the SUNY Resident Handbook.

If you should notice any impairment in yourself or your peers and need help in dealing with it, please contact your faculty advisor, your Residency Directors, or your Chief Residents.

Since we are in a highly visible field of service, AOB (=Alcohol on Breath) is viewed as absolute unprofessional behavior and an early sign of a possible underlying problem.

Physicians appearing to having a drug or alcohol problem will be referred to the NYS Committee for Physician's Health.

EMERGENCY AND DISASTER PREPAREDNESS

Preparation for emergencies is a well-developed sub department at SUNY Downstate and Kings County Hospital Medical Center. The New York Institute All Hazard Preparedness has been a funded part of the Emergency Medicine Department since 2002. We work with other departments at SUNY, nationally and internationally on various research projects including but not limited to, Community Wide disaster drills and Coalition building, creating policies for vulnerable populations during a disaster, Ethical issues in a Disaster, and Critical Care throughput during a mass casualty event. We have contingency plans for ensuring that the Medical Centers would continue to operate in times of disasters.

The hospital's plans are updated and maintained by the Emergency Preparedness Committees of University Hospital, and Kings County Hospital Center they can be found on the web at: http://www.downstate.edu/emergency_medicine/disasterplans.html

The Emergency Management Plans are "All Hazard Plans" as required by Governmental and Joint Commission Standards. The Plans also address how the Medical Centers will respond to Nuclear/Radiologic, Biologic and Chemical and Mass casualty incidents. The Medical Centers have committed significant resources towards the development of a Hazardous Material (HAZMAT) Decontamination System, which includes representatives from the Emergency Department, University and Hospital Police, facilities and Environmental Services. All incoming interns are trained in HAZMAT protocols. There is an ongoing effort to enroll and train the nursing staff as well. This team is trained and certified in emergency decontamination procedures. In addition, we are committed to awareness level training in HAZMAT for all employees.

As part of our emergency preparedness efforts, both institutions conduct at least two drills per year. All residents participate in these drills. Through these drills we continue our research in disaster response systems.

The SUNY/KCHC Fellowship in Emergency Preparedness started in July 2005. The fellowship is a 1 or 2 year program.

Goals for the future:

At both hospitals we are committed to large ongoing educational programs for all departments of the hospital. We work with each department on their disaster plan and insure that it integrates well with the hospital-wide plan. We have enacted The Hospital Incident Command System (HECS) and on-going education continues. At the same time EM residents are actively involved in the Disaster Committees. They participate in local, state, national and international conferences in emergency medicine. Research continues on how best to prepare for disaster in hospitals that share resources. We will be continuing to forge a community response in Brooklyn with additional drills and trainings. Current resident projects include: surge capacity research, equipment management, hospital disaster training and education, and participation in the management of the Medical Student Support Team to name a few. We participate in INDUS-EM collaboration with All India Medical Institute.

Terrorism continues to be a threat in the United States and large accidents or natural disasters occur daily. These events can drain the resources of even the most prepared hospital. As

members of the Medical Center community, we all have important roles in our disaster plan. It is important that you know your role in the plan as well as our department's responsibility in times of an emergency. This will help ensure that we will always be able to provide the best care for our patients. A basic outline of the steps to take if a disaster is declared is attached for review. Please read this document and review your specific Emergency Management Plan.
Thank you.
Pia Daniel, MD and Mark Silverberg, MD
Associate Professor Clinical Emergency Medicine
Director Emergency Preparedness SUNY Downstate Medical Center

WHAT TO DO IF A DISASTER IS DECLARED

• Your department has a plan. Do not leave your regular post/job unless you are instructed to do so by your departmental plan or supervisory personnel.

• Do not under any circumstances speak to news media. Refer them to the Office of Institutional Advancement of UHD or Media Relations of KCHC.

• No visitors are allowed in the hospital during a disaster. Send all visitors to the Family Reception Area in the Cafeteria of UHD or T-Building of KCHC.

• Activation of the plan occurs in phases:

o Potential: Limited departmental notification – no staff changes. o Actual: Limited or complete notification –possible staff changes.

• The Hospital plan is an All Hazard Plan: Any disaster inside the hospital or on campus that endangers patients or staff and creates a possible need for evacuation or relocation.

• Anyone who learns of an occurrence that might constitute a disaster should attempt to obtain the following information and contact the Administrator on Duty immediately: In the emergency department the CCT attending or UHD Main ER attending can declare a disaster for a Mass Casualty, if unable to contact the AOD.

1. What was the occurrence? 2. What is the location of the occurrence? 3. How many casualties are estimated? 4. What are the types of injuries? 5. How many people were injured?

• 4-4-4-4 Bells or CODE D via speaker means an Actual Disaster is in progress in UHD.

• 2-2-2-2 Bells or CODE Yellow means an Actual Disaster is in progress in KCHC.

• The Emergency Operations Center coordinates all resources during a declared disaster.

• The Disaster Cabinet and Mass Casualty Incident (MCI) Packets are in the Emergency Department Ambulance Entrance.

• All patients/victims will enter through the designated areas for primary triage. Direct all victims to that location to assure that they are evaluated and treated in order of need, given the best and fastest care possible and prevent hospital contamination.

• Where will overflow patients at KCHC be evaluated and treated?

D Building Lobby Minor Medical & Minor Trauma
Peds E building Peds Medical and Peds Minor
R Building Behavioral Health

• Where will overflow patients at UHD be evaluated and treated?

Adult Emergency Department Major Casualty
Pediatric Emergency Department Peds Major Injury

Suite A Minor Medical
Suite B (Waiting area) Minor Trauma
Suite D Peds/Medical Minor Trauma
Suite I Behavioral Health
Suite J Eye Trauma

• After the evaluation and treatment of minor patients is complete, they must go the Family Reception Area to complete the proper paperwork arrange for follow up and be discharged. The Family Reception Area is in the Cafeteria at UHD. It is in the T-Building 1st floor at KCHC.
• The Nursing Staff Resource Pool is in the Nursing Office.
• De-escalation and Stand Down: At UHD the All Clear signal is 1-1-1-1 Bells. At KCHC the All Clear signal is a verbal overhead announcement, “This is an all clear.”
• Debrief: Report helpful comments recommended changes to your Department Head.

http://www.downstate.edu/regulatory/emergencyprep.html

STUDENT EDUCATION

Dr. Linda Fan, Student Education Division Director, Clerkship Director, lindafan@gmail.com
Dr. Nayla Delgado, Asst. Clerkship Director, nayla.delgado@gmail.com
Tiesha Saunders, Student Education Coordinator, tiesha.saunders@downstate.edu
General email, downstateemclerkship@gmail.com

SUNY Downstate is dedicated to patient care, student education and academic research. The College of Medicine requires all students to take a fourth year rotation in Emergency Medicine, but we also educate PA students and medical students from all years. As residents, you will have multiple opportunities to develop your skills as educators.
It will be a rare clinical moment when you find yourself entirely without a single student. You have the unique opportunity to impact the career development of your colleagues and future health care providers of our nation. We expect you to take this responsibility seriously. Teaching students is part of our job. It's not a burden; it's a privilege.Look out for the students when they are in the clinical area and get them involved in good cases.
Residents are asked to guide students through the SUNY Downstate/Kings County system (i.e., how to send labs, where supplies are, how to get medications, etc.). Senior residents and attendings will be asked to help with the didactic portion of the student rotation. Many residents also participate in medical student education activities such as patient simulation cases and interactive case-centered student lectures.

General Guidelines in clinical area:
• Before/after clinical rounds, the senior resident is charged with identifying and distributing the students appropriately between EM residents and faculty. The attending and senior resident should communicate with each other on how best to do this depending on the physician coverage and volume of patients in the area.
• In general, students should be paired with EM residents, preferably not interns until after the first half of the year. Some students will be specifically paired with their advisor or one of the program directors.
• Residents are primarily responsible for the patients they supervise with the students. In the case of senior elective students who are working primarily with the faculty, senior residents may hear the presentations and then help them organize the case for formal presentation to the attendings.
• Since every clinical area in our dept. is variable, it is good to give your student guidelines of your expectations: pick up patients vs. assign patients, prepare H&P and A/P with differential diagnosis, follow through and taking ownership of patients, write-ups. Please give the students real-time feedback (specific things that they did well and things they need to work on), bedside pearls, topics to read on, etc.
• ALL students are required to write-up their patients. It's part of their education to learn appropriate documentation. Review write-ups as time allows in the clinical area and provide feedback. This may be challenging with the EMR; you may ask students to hand you their note for review.
• Return an evaluations within 48 hours or less.
• Sign-off on all required logs and attendance sheets with your name legibly.

Student requirements:

• Write up every patient. Resident should review as many as possible. Clerkship has a minimum required 2 write-ups for review and feedback by supervising physician. Its part of their education to learn appropriate documentation.
• Case-log of chief complaints. This is a minimum requirement for students. Please help students identify patients to complete this log.
• Basic procedures /clinical skills log and attendance sheet.
• Provide an evaluation for every shift worked with faculty/resident.
• Mandatory lectures every Thursday mornings. Scheduled simulation sessions on Tuesday mornings. Elective students have Thursday afternoon additional sim - skills labs, CBL's and presentations. The NBME shelf exam is held during the last Friday of each block.

Goals and objective for EM clerkship:

1) Medical Knowledge: Generate a differential diagnosis and develop appropriate diagnostic testing and treatment plans for the undifferentiated patient. Appreciate the various presentations of acutely ill or injured patient.
2) Patient Care: Recognize acute presentation of critically ill patients and understand how to assess and manage them. Understand and perform a focused history and physical exam. Demonstrate competence in basic procedural skills and understand clinical indications of advance clinical skills.
3) Professionalism: Serve as your patient's advocate at all times. Demonstrate respect and compassion when communicating with patients of various socio-economic, cultural and educational backgrounds. Maintain patient confidentiality, especially in settings involving minors and violence.
4) Interpersonal and Communication Skills: Develop effective communication skills with patients, family members, and other healthcare professionals.
5) Problem based learning: Review most recent literature on diagnoses encountered in the ED.
6) System-based Practice: Appreciate the role the ED plays in our community and in the U.S. healthcare system. Understand appropriate ED patient management, and how practitioners can most effectively interface with the ED to optimize their patients' medical care.

EM Courses and Opportunities for students:

1) EM observational elective: MS1 or MS2 students spend one evening a week for 6 weeks shadowing physicians in the ED. They have weekly didactics and suture labs.
2) MS3 EM Elective: 2-week long elective intended for career exploration
3) MS4 Mandatory Clerkship: 4 week long rotation
4) PA Course: 6 week long rotation in basic EM
5) IPAC and Preceptorship: MS1 and MS2 Introduction to clinical experiences
6) PEM Elective
7) Ultrasound Elective
8) Toxicology Elective
9) Wilderness Elective

ONLINE RESOURCES / CIS / INTERNET / EMAIL / TECHNOLOGY

SUNY Downstate / Kings County Emergency Medicine Website
• The official department website is located at downstate.edu/emergency_medicine
• Additionally, the Education division maintains a residency website at clinicalmonster.com
Clinical Monster maintains links to all clinical and academic schedules, institution specific clinical resources, New Innovations, Wednesday conference information, individualized interactive instruction (III), the educational residency blog, and many other useful residency resources.
A copy of the Residency Handbook is made available online as well.
Many of the online resources are password protected. The username/password is always "suny/suny12".

Online Educational Resources

The Downstate Library website serves as a portal to a host of medical journals (Serials) and a variety of evidence based-medicine resources (EBM Resources).
For access, most Downstate library resources will prompt you for a username and password. This is the same as your Downstate email account.
The Clinical Monster site also contains a dedicated online resources section with links to various free educational resources in addition to the Downstate library.

Clinical Information Systems

Each resident participates in a training session for the clinical information systems used at Kings County Hospital and SUNY Downstate. The product used at Kings County is Epic. The product used at SUNY Downstate is Healthbridge.

Internet Access at Kings County Hospital

Every resident is authorized to have Internet access at Kings County Hospital. You will receive a username and password, which will be prompted when you attempt to access most sites outside of the Kings County Intranet. Internet access through Kings County is limited without a username and password. Restrict your browsing to clinically relevant domains. Completely close your web browser windows when you are finished, as your Internet activity is monitored. Without a password, you should still be able to access your e-mail accounts.

Internet Access at SUNY Downstate Hospital

Every resident is authorized to have Internet access at SUNY Downstate Hospital. There is no username or password required to get online, however some sites are blocked by the firewall. Again, please restrict your browsing to clinically relevant domains.

Email Account

All residents need to maintain at least one email account for all residency related communications and keep Ms. Cole up to date with that address. This email address should be used for membership to the SUNY EM Google Group (a mailing list) and you should check it on a regular basis for departmental communications. Additionally when sending protected health information (PHI) via email, you MUST use a dedicated KCH or Downstate email address for

each institution's respective PHI. As such you should have access to both KCH and Downstate emails which have been assigned to you.

Computers

In addition to the computers in the clinical areas, there are computers in the resident's lounge with the Microsoft Office suite and Internet access.

Smartphone/Tablet Applications

Faculty and residents use a variety of medical apps when working in the department. Feel free to ask individuals about their thoughts on apps that are most useful.

Website/Technology Development

We are looking for help in further development of our website and electronic resources. Any resident with interest in these areas is encouraged to join the Department's Website/Technology Committee.