



Reading Hospital

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Emergency Medicine Residency Program Manual

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Emergency Medicine Residency Program

POLICIES AND PROCEDURES MANUAL

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Introduction

This manual complements the basic orientation of the residents of Emergency Medicine and it is a source of first reference for policy clarification. Although every attempt is made to make it as current and complete as possible, situations will undoubtedly arise which are not included in the manual. Faculty, residents, and staff will be notified by email of any changes. If a situation is not covered by a policy delineated in the manual, or if the interpretation is ambiguous, the Program Director, in consultation with appropriate administrators, managers, faculty, and/or Chief Residents, will make the necessary decision or interpretation.

Aims of the Residency

Program Aims:

1. To educate residents to work in a high-volume, high-acuity environment and enable residents to develop excellence in procedural competence
2. To cultivate a culture and provide tools to enable a thirst for life-long learning
3. To teach evidence-based and cost-effective care
4. To create a culture of professionalism while leading a health care team
5. To integrate seamlessly into team-based care
6. To participate in and lead individual, departmental and institutional quality improvement initiatives
7. To advocate for patients and families, including those with social and economic disparities
8. To recruit highly motivated residents emphasizing a goal of diversity
9. To develop an understanding of the need for research to further the field of Emergency Medicine

The primary purpose of the Emergency Medicine Residency Program is to provide an educational environment that fosters personal and professional growth. The program aims to graduate physicians who are well-trained, competent, and caring clinicians and who are able to effectively and independently practice the specialty of Emergency Medicine. A graduate of the program should be able to enter the community not only as a skilled physician, but also as an advocate, an advisor, an educator, a leader and a manager of emergency healthcare needs.

The program aspires to teach the knowledge, attitudes, and skills necessary to provide the competent practice of emergency medicine in local, national, and/or international communities. The program aims to model the attitudes, behavior, and skills necessary for collecting, assimilating, and articulating the vast amounts of information required to practice as a competent and sensitive Emergency Physician. This program will make strives to advance the program's facilities, clinical experience and academic program to achieve the vision of the department as well as meet the healthcare needs of the community it serves. We are committed to producing graduates that will be able to lead the complex changing nature of health care through supporting research conducted by the residents and faculty. The ACGME define six areas of Competency which define the framework for which the curriculum is developed. Residents will be evaluated in these areas on a regular basis. The six areas are:

Patient Care and Procedural Skills: Residents must be able to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and promotion of health. Resident must be able to competently perform all medical, diagnostic and surgical procedures considered essential for the area of practice.

Medical Knowledge: Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral science as well as the application of this knowledge to patient care.

Practice-based Learning and Improvement: Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Interpersonal and Communication Skills: Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families and health professionals.

Professionalism: Residents are expected to demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

System-based Practice: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Educational Standards

Competency requirements are adapted from the standards defined by the Accreditation Council on Graduate Medical Education (ACGME). (For further details refer to <http://www.acgme.org>)

Mission

The Mission of the Emergency Medicine Residency Program is to educate future Emergency Medicine Physicians to provide evidence-based, accessible, high quality, cost effective care in order to advance health and transform lives.

Program Goals and Objectives

Our educational goal at the Reading Hospital Emergency Department is to train and educate Emergency Medicine (EM) residents to achieve clinical competence and acquire the ability to care for a wide range of acute conditions while integrating the responsibility of a lifetime of learning. The Reading Hospital EM residency graduates will gain knowledge in clinical emergency medicine while gaining confidence in managing a wide-array of patient conditions in a variety of settings. Residents will learn to provide efficient, compassionate, and cost-effective care with the patient's best interest in mind. Residents will profit from strong clinical experiences enabling them to assume leadership roles immediately following graduation and continue educating throughout their careers. We strive to shape independent, efficient, and caring Emergency Physicians that will diagnose, stabilize and manage all patients presenting to the Emergency Department.

To achieve these goals, we will provide:

1. High-quality didactic teaching
2. Supervised clinical experiences through simulation labs

3. Direct supervised patient care
4. Quality Improvement, Research and Scholarly Activity
5. Wellness Program

Progressive responsibilities will provide residents with a solid foundation for skills to build upon during the three-year residency program.

The didactic schedule provides ample opportunities to achieve competence in the specialty of Emergency Medicine and also affords opportunities to teach junior residents and medical students.

Core Faculty and Health System Resources will mentor and guide residents through research opportunities and Quality Improvement (QI) initiatives.

The Following is a General Outline of Resident Responsibilities:

PGY-1

Under the Supervision of the Attending Physician and Senior Residents, the PGY-1 resident will evaluate stable patients with non-life-threatening problems. During the academic year, PGY-1 residents will assist in evaluating patients with potential life-threatening complaints and conditions only under the direct supervision of attending Physicians. The PGY-1 residents will not have supervisory responsibilities.

PGY-2

Under the Supervision of the Attending Physician and Senior Residents, PGY-2 residents are responsible for the evaluation and treatment of stable, unstable and medical cardiac arrest patients. Second year residents will manage the airway for trauma activations. PGY-2 residents will also participate in trauma resuscitations as well as medical and pediatric resuscitations led by Senior Residents and Attending Physicians.

PGY-3

PGY-3 residents will be the senior resident physicians until the conclusion of the academic year, at which time PGY-2 resident will assume the senior role, when on duty.

Under the supervision of the Attending Physician, the residents will be responsible for the clinical needs of a section of the department, maintaining patient flow, prehospital calls, receiving transfer calls, and handling administrative issues. They will provide support and guidance for first and second-year residents. PGY-3 residents will be responsible for the supervision of medical students and residents from other hospital services while on their EM rotation.

Senior residents will lead trauma resuscitations, medical and pediatric resuscitations, and provide back up for the second-year residents managing the airway in all trauma activations. They will be responsible for airway management in Trauma activations when there is no PGY-2 resident available for this procedure.

Duration and Scope of Education

The American Council of Graduate Medical Education (ACGME) and American Board of Emergency Medicine (ABEM) requires that there be at least 36-month full-time EM residency education which shall include:

At least 60% of the time must be spent in the emergency department. At least 50% of time must be spent in the Emergency Department during PGY-1 year. Residents will be supervised by EM faculty during this time.

Residents will have at least 4 months of dedicated critical care experience with at least 2 months in the PGY-2 year or above.

20% of all ED encounters will be dedicated to the care of pediatric emergency patients.

Education will be focused on the six core competencies, as well as the EM milestones as described in the ACGME Program Requirements.

ABEM Credentialing Requirements for Initial Certification:

- Successful completion of accredited EM Residency training program by the ACGME.
- Must fulfill ABEM policy on medical licensure.

Link for ABEM certification policy:

<https://www.abem.org/public/docs/default-source/default-document-library/understanding-eligibility-infographic-and-related-policies.pdf?sfvrsn=8>

Or See Appendix.

Procedures Required

Residents must meet standards of cognitive competence (indications, contraindications, sterile technique, specimen handling, interpretation of results and appropriately obtaining informed consent) for all of the following:

1. Adult Medical resuscitations
2. Adult trauma resuscitations
3. Cardiac pacing
4. Central Venous Access
5. Chest tubes
6. Cricothyroidotomy
7. Dislocation reduction
8. Emergency department bedside ultrasound
9. Intubations
10. Lumbar puncture
11. Pediatric medical resuscitations
12. Pediatric trauma resuscitations
13. Pericardiocentesis
14. Procedural sedation
15. Vaginal delivery
16. Wound management

- Please note that the listed requirements are subject to change per ABEM policies, and the resident should review the ABEM website for the most up-to-date version.
- Residents will record all procedures and resuscitations in New Innovations. These procedures will be verified by an Attending Physician and reviewed by the Program Director at least yearly. The Clinical Competency Committee will also review resident procedure logs every 6 months.

Emergency Medicine Organizational Structure and Personnel

Program Director

Dr. Kristen Sandel serves as the Program Director.

The Program Director:

- Monitors licensure requirements.
- Supervises resident orientation, develops the program of study with each resident, and finalizes all recommendations for modifications of the curricular program.
- Reviews all forms of resident feedback, along with the resident's mentor,
- Will define the resident's progress and determine appropriateness of advancement.
- Organizes the in-training examination program and will orchestrate the development of programs of remediation in concert with the Clinical Competency Committee (CCC).
- Monitors resident stress, fatigue, and general well-being.
- Oversees the didactic and clinical curriculums and assures that the curriculum is consistent with requirements established by the ACGME for Emergency Medicine training programs.
- Maintains a process of continuous improvement for the individual resident, EM faculty, the program, and the patients cared for by resident services.
- Meets with each resident biannually and creates a summary statement of the resident's progress based on CCC recommendations.
- Will routinely notify each resident by February 15 of the intent to advance the resident for the upcoming year. The Program Director will create a summary document of all graduating residents.
- Will appoint members for the CCC and the Program Evaluation Committee.
- Update WebAds as needed and ensure that the program strictly adheres to ACGME policy.

Faculty

Educational faculty support the Program Director in assuring the creation and implementation of an individualized program of learning that will support each resident's goal of mastery of the six core competencies and progression in EM Milestones as defined by the ACGME.

Core Faculty are the backbone of the EM residency program. They are selected due to their didactic teaching experience, bedside teaching ability, and their vision for EM scholarly activity and QI initiatives.

Each resident will be assigned a mentor, who will provide individualized attention to the personal and professional development of that resident. The mentor will formally meet with the resident at least quarterly to review resident progress.

An Academic or Core faculty member will be scheduled all times in the ED and is available to immediately discuss any patient care issues.

The administrative call schedule is posted online and can be obtained from the ED operator. Each resident is assigned a faculty advisor who is a core faculty member and will meet with residents regularly to review academic performance.

Residency Program Coordinator

The residency program employs a full-time Program Coordinator. The coordinator is responsible for assisting the Program Director with administering policies that govern the function of medical education.

The program Coordinator is responsible for implementing and overseeing strategies to track resident performance and in ensuring compliance to all regulatory requirements.

Job Descriptions

Emergency Medicine Residency Program Director Job Description

The duties of the Emergency Medicine Program Director are:

- 1) Education
 - a. Administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas.
 - b. Develop and execute a successful Emergency Medicine (EM) residency curriculum.
 - c. Assist faculty with development of rotation goals and objectives.
 - d. Develop and oversee the allocation of residents in their various rotations in order to satisfy ACGME and Residency Review Committee (RRC) requirements for successful completion of an emergency medicine residency.
 - e. Continuously re-evaluate anticipated educational needs of residents as RRC and ACGME requirements change and as EM practices evolve.
 - f. Implement structural and educational changes to the program to address identified opportunities or implement improvements to the emergency medicine residency curriculum.
 - g. Aid residents in ideas and facilitate connection with mentors for development of required scholarly and quality improvement project.
 - h. Review procedure logs to ensure adequate numbers of procedures are obtained for educational competence.
 - i. Organize, facilitate, and implement resident retreats.
 - j. Plan, schedule, and execute Grand Rounds monthly for the Department of Emergency Medicine.
 - k. Oversee weekly conferences for resident/faculty education.
 - l. Participate in faculty development sponsored by the institution.
 - m. Coordinate faculty development sessions for EM faculty
- 2) Evaluation
 - a. Evaluate the EM residency educational program at least annually to determine strengths, weaknesses and adherence to educational objectives.
 - b. Evaluate specific rotations to determine strengths, weaknesses, and adherence to educational objectives.
 - c. Develop and maintain a system of competency-based/milestone evaluations of EM residents by their attending physicians and supervisors.
 - d. Develop and maintain a system of competency-based evaluations of attending physicians by EM residents.
 - e. Evaluate program faculty incorporating feedback from EM residents and other appropriate sources.

- f. Develop and maintain a system of 360-degree competency-based/Milestone evaluation of EM residents, which includes evaluation of the EM resident by their attending, supervising resident, nursing staff, and EM patients.
 - g. Develop and maintain a teaching evaluation system whereby residents can evaluate attending physicians at the completion of each rotation.
 - h. Monitor completion of evaluations by residents.
 - i. Monitor completion of evaluations by faculty.
 - j. Give feedback to residents on at intervals complying with ACGME standards with the assistance of associate program directors.
 - i. At these meetings, the resident's evaluations and milestones are reviewed, common themes discussed, and a plan to remediate any issues/weaknesses is formulated.
- 3) Recruitment
- a. Identify and recruit Emergency Medicine residents to the program
 - b. Review all ERAS resident applications to assist in the ranking process.
 - c. Interview resident candidates.
 - d. Hold resident selection committee meetings during recruitment season
 - e. Coordinate development of recruitment strategies for emergency medicine interns.
 - f. Coordinate the evaluation of prior season's recruitment and development of intern recruitment logistics and interview day agenda
 - g. Organize preparations for the new interns' arrival including scheduling issues ensuring contracts are signed and necessary documentation received, ensuring any required training (such as online modules) are done prior to intern arrival.
- 4) Mentoring
- a. Initiate a mentoring system for residents whereby each resident is assigned a faculty mentor and a senior resident mentor.
 - b. Monitor the mentoring relationship during annual program director meetings.
 - c. Meet with each resident twice a year to ensure they are progressing academically, review evaluations, and to provide career counseling and advice.
 - d. Meet with residents on an "as needed" basis to help with problem solving and career counseling.
 - e. Advise residents on faculty and career development.
- 5) Administration of the Emergency Medicine Residency Program
- a. Approve the selection of program faculty
 - b. Approve the selection of the Associate Director(s)
 - c. Approve the continued participation of program faculty based on evaluation
 - d. Monitor resident supervision at each site
 - e. Prepare for and participate in both internal and external reviews of the residency program by the accrediting bodies and respond to any concerns or deficiencies that arise as a result of these reviews.
 - f. Coordinate and participate in selection of residents for annual teaching and service awards.
 - g. Meet with the Associate Program Director(s) and the Chair monthly to discuss programmatic issues.
 - h. Write letters of recommendation for residents applying for jobs and fellowship positions.

6) Regulatory Compliance

- a. Prepare and submit all information required and requested by the ACGME.
- b. Comply with institutional written policies and procedures
- c. Be familiar with and comply with ACGME and RRC policies and procedures
- d. Submit any additions or deletions of participating sites routinely providing and educational experience required for all residents, of one month full time equivalent or more through the ACGME Accreditation Data System
- e. Ensure residents are not violating duty hour rules and if identified, address and resolve these issues.
- f. Ensure residents are meeting programmatic and RRC requirements to be eligible to sit for the board examination upon completion of their residency
- g. Attend Council of Emergency Medicine Residency Directors Annual Meetings to ensure that the residency program is up-to-date with new requirements.
- h. Attend local GME meeting which occurs bi-monthly.
- i. Ensure residents are logging procedures and duty hours.

Emergency Medicine Residency Assistant Residency Program Job Description

Assistant Director will report to the Emergency Medicine Residency Director

The duties of the Emergency Medicine Assistant Director are:

1) Education

- a. Devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and have a strong interest in the education of residents
- b. Administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas
- c. Assist with development of rotation goals and objectives.
- d. Aid residents in ideas and facilitate development of required scholarly and quality improvement project.
- e. Assist with review of procedure logs to ensure adequate numbers of procedures are obtained for educational competence.
- f. Assist in planning and implementing resident retreats.
- g. Participate in weekly conferences for resident/faculty education
 - i. At least 20% of planned didactic experiences
- h. Develop educational sessions for weekly conferences
- i. Participate in faculty development sponsored by the institution
- j. Participate in faculty development sessions for EM faculty
- k. Develop and implement a Wellness Curriculum for the residents

2) Evaluation

- a. Chair Clinical Competency Committee (CCC)
- b. Evaluate residents using a system of competency-based/milestone evaluations as per program requirements
- c. Advise Program Director on resident progress, promotion, as well as and needs for remediation after CCC
- d. Evaluate Program Director and associate director(s) incorporating feedback from EM residents and other appropriate sources
- e. Provide feedback to residents as needed and in accordance with Program Director/Associate Director
- f. Participate in the Program Evaluation Committee

- 3) Recruitment
 - a. Assist in review of all ERAS resident applications to contribute to the ranking process.
 - b. Interview resident candidates.
 - c. Participate in resident selection committee meetings during recruitment season
 - d. Assist in development of recruitment strategies for emergency medicine interns
 - e. Participate in the evaluation of prior season's recruitment and development of intern recruitment logistics and interview day agenda
 - f. Assist in preparations for the new interns arrival including scheduling issues ensuring contracts are signed and necessary documentation received, ensuring any required training (such as online modules) are done prior to intern arrival.
- 4) Mentoring
 - a. Meet with each resident mentee at least twice a year to ensure they are progressing academically, review evaluations, and to provide career counseling and advice
 - b. Meet with mentees on an "as needed" basis to help with problem solving and career counseling.
 - c. Advise residents on faculty and career development.
- 5) Administration of the Emergency Medicine Residency Program
 - a. Assist in preparing for and participate in both internal and external reviews of the residency program by the accrediting bodies and respond to any concerns or deficiencies that arise as a result of these reviews.
 - b. Participate in selection of residents for annual teaching and service awards
 - c. Meet with the Program and Associate Program Directors monthly to discuss programmatic issues
 - d. Write letters of recommendation for residents applying for jobs and fellowship positions
- 6) Scholarly Activity
 - a. Establish and maintain an environment of inquiry and scholarship with an active research component
 - b. Encourage and support residents in scholarly activity
 - c. Assist and encourage Quality and Safety projects with EM residents as per the ACGME guidelines
 - d. Produce at least one piece of scholarly activity per year averaged over five years
 - i. At minimum, this must include one scientific peer-reviewed publication for every five core physician faculty members averaged over five years as per ACGME guidelines
- 7) Clinical Hours
 - a. The Assistant Director will not average more than 24 clinical hours per week.

Emergency Medicine Associate Residency Program Director Job Description

The duties of the Emergency Medicine Program Director are:

- 1) Education
 - a. Assist the Program Director to administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas.

- b. Assist faculty with development of rotation goals and objectives.
 - c. Assist Program Director to implement structural and educational changes to the program to address identified opportunities or implement improvements to the emergency medicine residency curriculum.
 - d. Develop a curriculum to foster residents in ideas and facilitate connection with mentors for development of required scholarly and quality improvement (QI) projects.
 - e. Assist Core Faculty and other Emergency Physicians to develop scholarly activity and QI projects.
 - f. Assist with the facilitation of resident retreats.
 - g. Participate in faculty development sponsored by the institution.
- 2) Evaluation
- a. Evaluate specific rotations to determine strengths, weaknesses, and adherence to educational objectives.
 - b. Develop and maintain a system of competency-based/milestone evaluations of EM residents by their attending physicians and supervisors.
 - c. Monitor completion of evaluations by residents.
 - d. Monitor completion of evaluations by faculty.
 - e. Give feedback to residents on at intervals complying with ACGME standards
 - i. At these meetings, the resident's evaluations and milestones are reviewed, common themes discussed, and a plan to remediate any issues/weaknesses is formulated.
- 3) Recruitment
- a. Assist with identification and recruitment of Emergency Medicine residents to the program
 - b. Review ERAS resident applications to assist in the ranking process.
 - c. Interview resident candidates.
 - d. Participate in resident selection committee meetings during recruitment season
 - e. Participate in the evaluation of prior season's recruitment and development of intern recruitment logistics and interview day agenda
- 4) Mentoring
- a. Participate in a mentoring system for residents whereby each resident is assigned a faculty mentor and a senior resident mentor.
 - b. Meet with residents on an "as needed" basis to help with problem solving and career counseling.
 - c. Advise residents on faculty and career development.
- 5) Administration of the Emergency Medicine Residency Program
- a. Participate in both internal and external reviews of the residency program by the accrediting bodies and respond to any concerns or deficiencies that arise as a result of these reviews.
 - b. Participate in selection of residents for annual teaching and service awards.
 - c. Meet with the Program Director and the Chair monthly to discuss programmatic issues.
 - d. Write letters of recommendation for residents applying for jobs and fellowship positions.
- 6) Regulatory Compliance
- a. Comply with institutional written policies and procedures
 - b. Be familiar with and comply with ACGME and RRC policies and procedures
 - c. Ensure residents are not violating duty hour rules and if identified, address and resolve these issues.

- d. Ensure residents are meeting programmatic and RRC requirements to be eligible to sit for the board examination upon completion of their residency as per the Clinical Competency Committee
 - e. Attend Council of Emergency Medicine Residency Directors Annual Meetings to ensure that the residency program is up-to-date with new requirements
 - f. Ensure residents are logging procedures and duty hours.
- 7) Clinical Hours
- b. The Assistant Director will not average more than 24 clinical hours per week.

Emergency Medicine Residency Program Core Faculty Job Description

Core Faculty will report to the Emergency Medicine Residency Director

The duties of the Emergency Medicine Core Faculty are:

- 1) Education
 - a. Devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and have a strong interest in the education of residents
 - b. Administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas
 - c. Assist with development of rotation goals and objectives.
 - d. Aid residents in ideas and facilitate development of required scholarly and quality improvement project.
 - e. Assist with review of procedure logs to ensure adequate numbers of procedures are obtained for educational competence.
 - f. Participate in resident retreats.
 - g. Participate in weekly conferences for resident/faculty education
 - i. At least 20% of planned didactic experiences
 - h. Develop educational sessions for weekly conferences
 - i. Participate in faculty development sponsored by the institution.
 - j. Participate in faculty development sessions for EM faculty
- 2) Evaluation
 - a. Evaluate residents using a system of competency-based/milestone evaluations as per program requirements
 - b. Evaluate program director and associate director(s) incorporating feedback from EM residents and other appropriate sources.
 - c. Give feedback to residents as needed and in accordance with program director/associate director.
- 3) Recruitment
 - a. Assist in review of all ERAS resident applications to contribute to the ranking process.
 - b. Interview resident candidates.
 - c. Participate in resident selection committee meetings during recruitment season
 - d. Assist in development of recruitment strategies for emergency medicine interns.
 - e. Participate in the evaluation of prior season's recruitment and development of intern recruitment logistics and interview day agenda
 - f. Assist in preparations for the new interns arrival including scheduling issues ensuring contracts are signed and necessary documentation received, ensuring any required training (such as online modules) are done prior to intern arrival.
- 4) Mentoring
 - a. Meet with each resident mentee at least twice a year to ensure they are progressing academically, review evaluations, and to provide career counseling and advice.

- b. Meet with mentees on an “as needed” basis to help with problem solving and career counseling.
 - c. Advise residents on faculty and career development.
- 5) Administration of the Emergency Medicine Residency Program
 - a. Assist in preparing for and participate in both internal and external reviews of the residency program by the accrediting bodies and respond to any concerns or deficiencies that arise as a result of these reviews.
 - b. Participate in selection of residents for annual teaching and service awards.
 - c. Meet with the Program and Associate Program Directors monthly to discuss programmatic issues.
 - d. Write letters of recommendation for residents applying for jobs and fellowship positions.
- 6) Scholarly Activity
 - a. Establish and maintain an environment of inquiry and scholarship with an active research component.
 - b. Encourage and support residents in scholarly activity.
 - c. Assist and encourage Quality and Safety projects with EM residents as per the ACGME guidelines.
 - d. Produce at least one piece of scholarly activity per year averaged over five years
 - i. At minimum, this must include one scientific peer-reviewed publication for every five core physician faculty members averaged over five years as per ACGME guidelines
- 7) Clinical Hours
 - a. Core faculty must not average more than 28 clinical hours per week or 1344 clinical hours/year.

General EM Administrative Policies and Procedures

Orientation of New Personnel

Institutional orientation occurs during the first few days of residency training. This is followed by department-specific orientation.

Some Educational modules may be sent to resident prior to the start of their residency.

All new employees will receive computer training by the Information Management Systems (Reading Health Connect) department.

The Program Coordinator will coordinate this training.

The new employee will receive official feedback after the first month, the third month, and the sixth month, in accordance with hospital policies.

Dress and Demeanor

All staff must wear the hospital ID badge at all times per hospital policies.

Residents and staff are expected to act and dress in a manner consistent with their profession or position. All clothing should be neat, clean, and professional appearing. Clothing should match and fit. Short dresses, shorts, jeans, jumpsuits, tee shirts, and tank tops should not be worn. Sheer clothing, tight, clinging, or revealing garments, low necklines, extreme or conspicuous styles, colors, or prints should be avoided. Sweaters worn with uniforms must not clash with uniform color. Soiled or untidy uniforms should never be worn on duty.

White coats are provided to residents and faculty and should be worn where appropriate. Scrubs will be provided to the residents for appropriate services. Proper personal hygiene and grooming are expected.

Some personnel are required to wear uniforms as specified by the department. The department chooses what color uniforms to wear. The hospital may purchase two lab jackets for each employee yearly. Uniforms purchased by employees must comply with departmental requirements and be consistent with the guidelines above.

Leisure sandals or slippers are not acceptable footwear. Open-toed or heeled shoes are not allowed in areas where heavy equipment, such as carts, beds, or litters, are regularly moved.

Hairstyles should be simple and clean. Make-up, if worn, should be natural-looking.

Pins with the employee's name, job title, or department, and Reading Hospital service award pins are acceptable to wear while on duty. Other pins, badges, and insignias, slogans or other items which could possibly be deemed as controversial, annoying, or offensive to patients, visitors, and/or other employees cannot be worn while on duty.

Professional Standards and Ethics

Mature interactions are expected with patients as well as with office and hospital personnel at all times. Patient confidentiality must be guarded at all times. In clinical settings, physicians and staff should avoid noise and laughter, refrain from open discussion of sensitive issues, and be mindful of any information that may be overheard, respecting patient confidentiality.

Use of property and equipment of the Emergency Department for personal use is not permitted. Residents are expected to wear their Voceras (communication devices) at all times while on duty in the ED. All physicians, residents, and employees are expected to keep their designated areas within the ED Administrative suite reasonably neat and clean.

Smoking, alcoholic beverages, and illicit substances are prohibited on the premises and during hours of work-related duties and responsibilities. Violation of this ordinance will result in disciplinary actions. Eating and snacking in the patient care area are violations of Pennsylvania law. Physicians, residents, and employees' personal health must be maintained in accordance with the employee health policies of the hospital.

Residents and faculty should conform to the code of ethics set forth by organized medicine. They must maintain a professional code of conduct and means of communication appropriate to a professional person. They must demonstrate responsibility and integrity by reporting to duties on time, adhering to schedules, and cooperating with their colleagues.

Absence from Program

Vacations and Holidays

Residents should contact the Program Coordinator to determine vacation eligibility, as well as to receive approval for proposed vacation schedule.

With prior written approval of the Program Director and the Human Resources Department, residents may choose to substitute a religious holiday of choice in lieu of one of the traditional six holidays. Residents should make this request through their Program Manager at the **START** of the year but no less than 60 days prior to proposed vacation.

- PGY-1's are granted 2 weeks (10 days) of vacation plus one week (5 days) at Christmas/New Year.
- Upper years are granted 3 weeks (15 days) of vacation plus one week (5 days) at Christmas/New Year.

Unless there are major exceptions (approved by the Program Director), the following rules should apply for vacations, holidays and conferences:

- Vacations should be taken in 1-week (5 day) blocks. Vacations should be taken only during designated rotation blocks.
- In Lieu of one week of vacation, five single days may be used during ED and Research rotations. No more than three consecutive single days may be used at a time during Research rotation.
- Changes to vacations may be made only with approval of the Program Director and Coordinator and must occur a minimum of 30 days before the start of the earliest affected rotation.
- Holiday Break- each resident will be assigned a holiday break at the start of the academic year. Resident Schedules may be adjusted to cover clinical shifts in the

Emergency Department surrounding the holiday breaks to ensure adequate coverage in the department.

- Vacation requests for the year must be submitted to the Program Director no later than the end of Block 2 so that any conflicts can be addressed and preceptors can schedule accordingly. Those not submitting requests will be assigned vacation time.
- Two vacation blocks may not be utilized during a single block.
- Vacation will not be granted during the EM Orientation rotation block.
- Per hospital HR policy, there is no payout for unused vacation, and full use of vacation time is strongly encouraged.

Sick Day (IPT) Policy

It is the policy of The Reading Hospital residency programs to support positive health behaviors for its trainees. Residents are expected to obtain a primary care provider and follow a positive lifestyle program that promotes healthy behavior. Twelve days per year are set aside as allowable sick days before the resident would be required to utilize vacation time. In the event that the resident's illness or injury precludes work for two or more consecutive days, a physician's note will be requested by the Program Director. In addition, at the discretion of the Program Director, a physician's note may be requested in the setting of repeated absences averaging one or more per month. It is required that each resident not reporting for duty at their regularly scheduled time due to injury or illness notify the main office of the Department of Emergency Medicine, the Residency Coordinator, and their assigned Attending Physician of the absence. On weekends, a resident must notify the faculty member on call as well as the administrative resident on call if they are not intending to be present for their clinical shift. This process applies to all residents on rotations. Please note that sick days are counted by the accrediting bodies as time away from the residency, and therefore will need to account for when determining whether extension of residency is needed.

Vacation Considerations for Residents

The first-year resident is allotted two weeks of vacation while the second-year and third-year residents are entitled to three weeks' vacation per year. In addition, residents are granted additional time off around the Christmas/New Year holidays. **At least one week of vacation must be taken in the first six months of the academic year.**

All resident vacations must be approved by the Program Director and Coordinator. The resident will complete the time off request form and submit it to the Program Coordinator.

Exceptions to the above rules will be examined on an individual basis.

Protocol for Requesting and Reporting Time Off & Leave

ETO and Vacation Requests

All Vacation and Time off Requests must be submitted to the Program Coordinator to initiate the approval process.

- Vacation Blocks (5 Days) should be submitted to the Program Manager/ Coordinator no less than 60 days in advance in order to assure adequate coverage in the department.

- If resident would like to utilize individual vacation days, Vacation requests of three days or less should be submitted to the Program Manager/ Coordinator no less 30 days in advance in order to assure adequate coverage in the department.
- If vacation is **not** requested during designated blocks and the resident has not made alternate plans for individual days, a vacation block will be assigned.

Conference Time

Any resident planning to attend a conference is required to submit a Request to Attend email to Leah Stephens for upload to CONCUR. Request to attend a Conference must be submitted at least 60 days prior to meeting dates to allow time for the approval process and coordination of travel details.

Request to Attend emails must include:

- Conference Name, Location and Dates
- Estimated Expenses

A Request to Attend a meeting must be submitted and approved by Departmental Leadership 60 day prior to Meeting to receive reimbursement.

Sick Time

It is required that each resident not reporting for duty at their regularly scheduled time due to injury or illness notify the main office of the Residency Coordinator, and their assigned Course Director, Attending Physician or Designated personnel of the absence.

Maternity/ Paternity Leave

If leave is foreseeable, FMLA must be applied for 30 days before commencement of leave unless impractical to do so under the circumstances, in which case notice must be given as soon as possible. If you need to apply for FMLA, contact Leah Stephens (x3529) for instructions.

Interview Time

Should be approved by the Program Coordinator and Program Director 30 days in advance in order to assure adequate coverage in the department.

Holiday Time

Requests for every-other holiday off will be considered for approval. Requests for every Holiday off, both Institutionally recognized and Non- Recognized holidays, will not be considered for approval.

Definitions and Details for ETO/IPT/FMLA

Emergency Medicine Residency Program

EM Residents don't accrue ETO & IPT as do traditional Reading Hospital employees, so the policy on the use of ETO and IPT differs from a traditional employee. EM Residents receive a lump sum at the beginning of every academic year because they are viewed as a yearly contracted employee. The traditional employee accrues/receives increments of ETO and IPT each pay period. See table below for explanation of how much time off is received for each year as a resident.

Year of residency	ETO	IPT	Holiday Week (40 hours)
1st	80 hours	96 hours	Yes
2nd	120 hours	96 hours + carry over from previous year	Yes
3rd	120 hours	96 hours + carry over from previous year	Yes

ETO – Earned Time Off

IPT – Income Protection Time (also known as sick time)

FMLA – Family and Medical Leave Act

ETO is to be used so you can be paid when you aren't at work.

IPT is to be used for when you are **personally** injured, ill and not able to work or for FMLA.

FMLA is job protection for your absence from work **but not a guarantee of pay**. If leave is foreseeable, FMLA must be applied for 30 days before commencement of leave unless impractical to do so under the circumstances, in which case notice must be given as soon as possible. Being away from work for less than 7 working days, applying for FMLA is not required. An eligible employee is entitled up to 12 work weeks of FMLA job-protected leave per rolling 12 month look back period.

Reading Hospital processes FMLA through a company called FMLA Source. It requires forms to be completed via website or telephone. It includes submitting a medical certification and a review by FMLA Source. After a decision is made for your leave dates, approval is sent to you and Program Director. If you need to apply for FMLA, contact Leah Stephens (x3529) for instructions.

Absence

Limitation on Absence

Emergency Medicine residents must have a deep feeling of personal responsibility for the continuing, comprehensive care of the patient. Outside activities that interfere with the proper discharge of this responsibility should not be permitted.

Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of second year and first month of third year in sequence). A resident does not have the option of reducing the total time required for the residency (36 calendar months) by forgoing vacation time.

“Away rotations” must be approved by the Program Director and may not exceed one month during the third year. An “away rotation” form, which lists the site, preceptor, dates, and goals and objectives, must be submitted prior to approval. This form is to be submitted as early as possible but at least three months prior to the rotation. International experiences are governed by the hospital’s International Rotations policy.

Time away from the residency program for educational purposes, such as workshops or continuing medical education activities, are not counted in the limitation on absences, but should not exceed five days annually.

Time off from the residency in excess of one month within the academic year (first, second, or third year) must be made up before the resident advances to the next training level. The time must be added to the projected date of completion of the required 36 months of training.

Residents are expected to perform their duties as resident physicians for a minimum period of 11 months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed one month per calendar year. One month is interpreted as 21 calendar days.

The Board recognizes that vacation/leave policy varies with programs and is the prerogative of the Program Director so long as it does not exceed the Board's time restriction.

Who can apply for FMLA (RHS Employee):

- Anyone who has completed at least 12 months of service and have worked 1,250 hours in previous 12 months.
- Anyone who is facing the following:
 - Birth of a child
 - Care for an injured service member
 - Adoption or foster care
 - Care for your own serious health condition
 - Care for child, spouse or parent with serious health conditions

Common Uses for FMLA (there are more):

Medical Leave

- Maternity Leave
- Qualifying Family/Parental Leave

While on FMLA:

The **IPT** time is used first. When the IPA time is exhausted, ETO will be used for the remainder of the time away.

Maternity/Paternity Leave

Leave for all employees is outlined in the hospital benefits packet. Residents who require maternity or paternity leave will be allowed to use accumulated sick leave and vacation up to 30 days. Additional leave will have to be taken without pay and will necessitate extension of the residency training. The details of the leave and the schedule of rotations will be worked out on an individual basis with the Program Director.

In general, efforts will be made to schedule rotations in which the resident is non-essential just prior to the estimated due date (EDD) and to avoid call during the month prior to EDD or while on leave. However, the resident will be expected to make up call either prior to or after the leave.

The resident should notify the Program Director as soon as the pregnancy is confirmed. Paternity leave will be granted in compliance with established hospital policy. All leave must comply with requirements established by the ACGME-RRC in Emergency Medicine.

Conference Time

PGY2 and PGY3 residents have one conference time per year as approved by the Program Director with financial support up to \$1,500 per conference (restricted to the continental United States). Residents may attend a second conference if they are the first author. **Interns are not routinely given conference time**, but attendance to present at a conference will be supported if a submission is accepted for presentation.

No rental cars will be paid for by the residency without documented proof of necessity; taxi/shuttle transportation to and from the airport at the conference site will be covered. If a resident owns a car and plans to drive to the conference, a rental car will not be approved. The resident must stay at the hotel where the conference is located unless they provide proof that the hotel is filled to capacity. The expectation of the institution is that if they are paying for you to

attend the conference, you will attend the conference and be able to provide proof of such after the event.

Duration of **conference time** should be determined in conjunction with the mentor and Program Director. If the resident is allowed to attend a second conference in a year, in order to present findings at the meeting, the duration of time away should be minimized. Funding for the second conference will come from the resident's educational fund or out-of-pocket. Five days total will be allowed for conference from the resident's educational fund.

Flex Day

Residents who rank in the 80th percentile on the ABEM In-Training Exam, will earn a flex day to be used during Emergency Department Rotations. Flex day privileges will be effective for one year following the receipt of Exam results.

Interview Time

Interview days off should be approved by the Program Director and should also follow the usual Department of Emergency Medicine process for time away. Third Year residents are allowed three personal days to interview for prospective jobs in addition to their regular vacation and educational time. Request for Interview time must follow the same request process as vacation.

Emergency Time

Emergency needs for absence should be made known to, and approved by, the Program Director. Any time taken off from the program without prior approval of the Program Director or designee (with the exception of illness) will be considered unexcused absences (for which you are not paid), and potentially must be made up.

More than 30 days of absence in an academic year for all reasons (health, vacation, interviews, or emergency) may require extension of the training year to obtain Pennsylvania licensure and ABEM credit for that academic year. The American Board of Emergency Medicine states: "Up to one month per academic year is permitted for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities. Training must be extended to make up any absences exceeding one month per year of training. Vacation leave is essential and should not be forfeited or postponed in any year of training and cannot be used to reduce the total required training period. ABEM recognizes that leave policies vary from institution to institution and expects the program director to apply his/her local requirements within these guidelines to ensure trainees have completed the requisite period of training."

The ABEM has taken the position that it is not educationally sound that such duties (maternity and child care) should substitute for training experiences, nor is it educationally justifiable that residents who do not use parental leave be required to train longer than those that do. If a resident finish by the end of August, he/she will be eligible to sit for the Certifying exam. If the end date is in September or later, the candidate will have to wait to take the exam until the following year. The start of fellowship will be delayed an equivalent length of time, although this generally has not been a barrier in the past for residents finishing a few months out of cycle. The Pennsylvania State Board of Medicine requires a minimum of 11 months of training at each level of training to meet the graduate education requirements for unrestricted licensure.

No more than 20 business days per contract year of leave may be granted for any purpose without extending the program.

If trainee is given a leave of absence for reasons of maternity, physical or mental disabilities and returns to duty, he/she may continue the training to completion.

The Program Director has the authority to extend the trainee contract for a period of up to 3 months for leave, illness or remediation purposes without requesting approval for overlap of trainee numbers from the specialty college.

The training institution shall assist the trainee in obtaining confidential counseling, medical and psychological support services when indicated, including physician impairment assistance.

Sanctions Policy When the Resident does not Follow Process for Absence from the Program

Effective: 4/11/16

Respect for your patients and your colleagues are a cornerstone of being a physician. Processes are in place to define appropriate situations where resident absence from scheduled duties is appropriate and to allow the program to adjust for such absence. When a resident is absent and does not observe the formal notification process, he/she may impair patient care and also put undue burden on their resident colleagues. Observing this process is viewed as an important measure of professionalism. Lapses will be dealt with at the discretion of the Program Director and the Clinical Competency Committee.

All functions of the hospital will be continued during periods of inclement weather unless approval is given by hospital administration to curtail services or change work schedules.

All employees scheduled to work are expected to report to work on time during unusually bad weather. Employees should leave home earlier than usual to provide needed travel time.

ALL EMPLOYEES ARE EXPECTED TO BE AT WORK AT THEIR DESIGNATED STARTING TIME REGARDLESS OF ANY WEATHER EMERGENCY THAT HAVE BEEN DECLARED BY THE HOSPITAL.

Sleeping quarters are available to all Hospital staff during a weather emergency. Please check the online communication center for details.

Salary and Benefits

Emergency Medicine residents have the same salary and benefits for a year of training as all other residents in the hospital. Please refer to the Residency Manual from Academic Affairs for these items.

Wellness Curriculum

The Wellness Curriculum was developed to meet the needs of the resident. The resident wellness program focuses on providing residents with strategies to balance work/career responsibilities and home life management. Residents will enroll as Emergency Medicine Resident Association (EMRA) members and utilize career planning opportunities to ease the transition from resident to attending physician. Sessions concerning finance, investing, insurance, and contracts will be included in the curriculum. The program will ensure that residents have a place to rest and have designated resident space. A resident sleep room is dedicated to the EM Residency and there are additional sleep rooms available in the hospital for

residents who need an area to rest. The hospital also has a variety of options for obtaining rides to their homes when they are fatigued.

Programs include:

1. Yearly resident retreat
2. Group sessions to debrief about stressful cases and components about resident life
3. Grand Rounds concerning Wellness
4. Sessions concerning life after residency
5. Mentor sessions to discuss work-life balance
6. AMA – Introduction to the Practice of Medicine Programs
7. Social events as planned by Core Faculty and Chief Residents
8. Participation in institutional Wellness Programs such as FitBit Challenge

Resident Wellness

Definition: to ensure the continuation of a wellness culture amongst the emergency medicine residency.

The specific goals:

- Promote a healthy work-life balance.
- Provide physical, psychological, social and professional wellness education and resources.
- Maintain a peer support and advocacy network for the residents.

Food

- Free food program while on clinical shift: Starbucks and various cafeterias
- Good eats in the area: breweries, cultural restaurants
- Lancaster Farm Fresh co-op availability

Exercise

Various discounts at local gyms: (see hospital main page for further details)

- *Anytime Fitness West Lawn*
- *Bikram Yoga West Reading*
- *BLDG. 7 Yoga*
- *CrossFit Fidelity*
- *Crossfit Rhythm*
- *Down Under Sports & Fitness*
- *East Coast Karate*
- *Etchfit (boxing)*
- *Flying Hills Fitness Center and Colonial Hills Fitness Center*
- *Hillcrest Racquet Club*
- *Home Fitness Solutions*
- *iAMFit Studios*
- *Keys 2 Fitness*
- *Retro Fitness Kenhorst*
- *Wyomissing Fitness and Training*
- *YMCA*
- Yoga at work free: offered Mondays, Tuesdays, Thursdays, and Fridays. (see details under Your Life – wellness at work tab hospital main page)
- Fitbit Challenge: hospital discount on devices (up to two); hospital wide challenges

- Bike Share: available at the 7th Avenue Parking Garage and the McGlenn Cancer Institute Garage/Entrance.

Mindfulness

- Whil: is the leading well-being and mindfulness training app designed to help employees reach their most important health, performance, relationship and sleep goals. (App available through hospital webpage: 'your life')
- Quest: anonymous mental health counseling resources.
 - Contact: Tad Santos, Case Manager 717-851-1451

Formal Events to Decrease Burnout

- Intern Welcome Social
- Interview season evening mixers with the candidates / Match Day Party
- Intern Retreat and Senior retreats.
- Resident appreciation day

Increasing time spent with the patient and away from the computer

- iPads for interns
- Quality Improvement project to implement multidisciplinary, patient-centered care

Providing support

- Intern Advisory/Mentorship groups

Identifying Burnout

We have dedicated conferences to discuss burnout and to re-iterate resources for preventing and treating burn out. The program director meets with each resident semi-annually.

Financial Planning

Provide resources for financial guidance at conferences

Diamond Credit Union on campus: located on G1 for more information or call 610-326-5490.

Resident Benefits:

- iPad
- Scrubs 3 sets/year
- 3-4 weeks of vacation dependent on year of training
- Professional liability insurance
- Medical, dental, disability and life insurance
- On call room
- Meals: free for residents while on clinical duty
- Housing allowance: \$100 pretax/month for those residents who do not rent a RH apartment or dormitory room
- Parking: no charge
- Annual educational fund: up to \$3000 for first year, increases to up to \$4500 for senior residents
- Membership to ACEP, EMRA, AMA, AOA (if osteopathic physician)
- License and DEA

Resident Physician Wellness

Depression and other mental health issues occur frequently during training. The Tower Health System offers access to emergency and routine mental health services for physicians. We do so without regard to any discriminatory issues, including the availability of funds. All access is confidential, within the confines of the law.

- During business hours, the physician should call or submit information to set up a confidential appointment. The phone number is 484-628-9898. If preferred, there is a secure website to submit information: www.readinghealth.org/physicianwellness

If the situation is an emergency, the physician should present to the Emergency Department, or call 911. Once in the emergency Department, the physician will have a mental health evaluation and be referred to the appropriate level of care. There are times when the resident physician may desire care outside of the Tower Health System, or even outside of the Reading area. The referral line is answered by members of the Department of Psychiatry, including the Chair of the Department of Psychiatry. These professionals can assist with the appropriate referral to the provider that is best suited to the resident physician's needs.

Physician Well-Being

The problem of impairment is complex, and the investigation and hearing process is not usually appropriate in this situation. The American Medical Association defines the impaired physician as "one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the loss of motor skills, or excessive use or abuse of drugs, including alcohol." This policy and the steps to be taken are intended to provide some overall guidance and direction on how to proceed when confronted with a potentially impaired physician, and are taken from a template provided by the Pennsylvania Medical Society.

Tower Health Medical Staff believes that the key to a successful rehabilitation program is not only to provide an educational program for residents regarding physician impairment, including substance abuse, but also to structure its program in a noncoercive, non-disciplinary manner. At the same time, the Medical Staff recognizes its obligation to the patients it serves.

If the degree of impairment of the resident physician may affect the ability of the resident to practice safely, then the individual in question should voluntarily relinquish all privileges. These privileges should be relinquished until it has been determined that it is safe to restore them. The individual shall still be a member of the residency staff, but without privileges.

The CAO and the CMO, in consultation with the Medical Staff Health Committee, shall evaluate and investigate all reports regarding:

- impairment of the physician's ability to practice with reasonable skill and safety;
- serious mental, emotional, or physical problems;
- alcohol or drug abuse;
- unethical conduct.

If the validity of the complaint is substantiated, the CAO and the CMO shall attempt to obtain agreement by the resident physician about the nature of the problem and his/her consent to participate in a rehabilitation program tailored to meet the resident physician's specific situation.

If the resident physician agrees to participate in a rehabilitation program, the Medical Staff Health Program will then arrange for a suitable program. If the resident does not agree to participate fully in the Physicians Health Program, the Program Director shall take action as described in the Resident Manual under Due Process.

As a general principle, we provide emergency intervention for any interns or residents who are members of the House Staff of Reading Hospital. We do so without regard to any discriminatory issues, including the availability of funds.

All House Staff, however, are covered by Quest and by the EAP benefits available to members of Quest, and that needs to be taken into consideration.

When a member of the House Staff is either referred, or refers himself/herself for services, they are to call 610-988-8070 and ask in order for the following in terms of availability: The Director of the Department; the Clinical Director of the Center for Mental Health; Director of the Group Center; the Director of Behavioral Health. Any one of those clinicians, who are senior within the department, will then take the appropriate measures to make certain that the House Staff person is given the level of care needed. If, on the rare occasion, none of those individuals are available, the House Staff person or the person making the referral may call the administrator for the Center for Mental Health who will then make the most suitable arrangements for services.

When individuals refer themselves for services, complete confidentiality will pertain, as with any other patients who present themselves.

When an individual is referred by a supervisor or by the Director of a department because of administrative reasons, feedback to the referral source will be made after appropriate informed consent has been given by the House Staff person.

The House Staff person will be eligible for three sessions under EAP and subsequently 20 sessions per year under Quest.

For those individuals who are not covered under Quest, who may be covered under other insurance such as the spouse's insurance, the appropriate limitations will apply.

However, in those cases where more service is needed, the coverage issues associated with the case will be reviewed with Administration and the Department Chair for resolution. On those rare occasions when a member of the House Staff needs more intensive care or hospitalization, all efforts will be made to respect the confidentiality of the individual, and, unless it is an extreme emergency, give that person the option of going to another hospital, preferably in the Quest system.

In those cases where the primary issue is drug and/or alcohol, the appropriate referral will be made. In addition, referral will be made to the Pennsylvania Medical Society Physicians Health Committee for appropriate monitoring and testing. The reporting to PHP will be done through the CMO's office through the PHP Committee of the Hospital.

The above points refer to services within the Department of Psychiatry at Reading Hospital. Clearly, there is also the option of being seen outside the department at places such as DGR, Spring Psychological, and other appropriate providers. It is anticipated that the issue of where the individual gets services will include not only the use of internal resources, but also the use of community providers.

Role of the ED in the Disaster Plan

In the event there is a disaster, the ED's responsibility is listed in the Disaster Plan Policy Book. Current hospital policies will be followed. Detailed information concerning the hospital disaster plan and the Emergency Department disaster plan may be found in binders in the Emergency Department. These are located behind the facilitator desk. They outline roles and responsibilities of each team member.

The Medical Record

Patient information is stored in an Electronic Medical Record, herein referred to as "EMR". There are several features to help manage workflow and quickly update patient records. The hospital utilizes Epic, and some of the following are specific to this:

- The EMR protects patient privacy, providing security features that ensure user's access to patient health information is appropriate to their role in providing health care services.

As with paper charts, the EMR includes the following information: patient demographic data; list of problems and health maintenance profile; list of medications; list of known allergies; list of immunizations; progress notes; diagnostic data (labs, x-rays, etc.); flow sheets; referral information to and from outside agencies; and patient health history.

EMR Downtime Procedures

There may be times when the EMR system is unavailable. This may be due to internal (ED) equipment problems, networking problems, power failure, etc.

- Ascertain what the problem may be and call the appropriate help line (x8151), i.e. IMS or maintenance.
- Attempt to get patient information for that day printed elsewhere and hand delivered or faxed.
- Obtain "downtime packets" which contains documents needed to care for patients (blank paper progress notes, blank paper prescriptions, paper lab and radiology slips, etc.) Packets located at the facilitator desk.
- The nurse should handwrite the vitals and the Residents write their H&P as well as any progress notes on the History and Physical note template.

Documentation Guidelines

All patient interactions by faculty, residents, nurses, and staff must be documented in the patient record.

Resident documentation must accurately reflect the preceptor's level of involvement in the care of the patient.

Patient Confidentiality

Any information regarding a patient is never given to anyone—verbally or written—without the patient’s written permission.

Remember that you need to have the patient’s special permission to release information about sexually transmitted diseases (STDs), pregnancy, diseases reported to the Centers for Disease Control, mental health (14 years of age or older), drug and alcohol, and HIV.

Discussion of a patient’s medical condition in public or to unauthorized persons may be cause for employment termination per hospital policies.

If the patient is a minor (under 18 years of age), information may not be released without written permission from the parent. Information regarding non-emancipated minors may be released to the parent or legal guardian by the clinical staff. Per Pennsylvania law, however, certain issues can be addressed with parent consent.

Parents or guardians may not be given information about emancipated minors without their consent.

Patient Rights and Responsibilities

The Emergency Department is committed to providing patients with information about their rights as patients of the hospital, the hospital’s responsibilities to them as patients, and their responsibilities to the hospital as patients. The department will support the doctrine which the hospital has established. The ED will post a notice in the patient waiting room area. Patient Rights and Responsibilities, the hospital-printed document RH3079, will be made available for all patients to take with them. Spanish and English versions are available. Brochures are placed in the literature rack near the entrance door.

Informed Consent

Informed consent refers to the process in which a patient’s permission for a procedure, test, treatment, or other intervention is obtained by a caregiver after careful discussion which clearly describes to the patient the nature, risks, benefits, and alternatives to what they are giving permission for. Informed consent refers to the discussion itself, not the piece of paper. The paper that the patient signs provides documentation that the discussion took place. In addition to whichever form is used, the resident should reference any standard or procedure-specific guidelines used and provide brief documentation in the EMR chart note as well.

The resident should develop and practice communication skills that maximize ability to discuss the details of a proposed treatment or intervention with a patient. Depending on the nature of the treatment for which consent is sought, the informed consent discussion may range from serious to routine. There are several common circumstances in which informed consent is required in the ED. These include, but may not be limited to, consent for procedures, required for opt out HIV Testing, opt out consent, drug screening, and treatment of minors.

Provision of Care and Consent for Treatment of a Minor

Permission to treat any patient under the age of 18 must be obtained from a parent or legal guardian, except in an emergency. Consent may be given verbally but preferably in writing. The provisions of the law within the state of Pennsylvania must be fully complied with.

There are exceptions in which a minor may be treated without parental consent:

- **Emergency:** If emergency conditions require immediate treatment, treatment may be given without parental consent. In minor emergencies, such as slight lacerations, etc., the treatment will be given to a minor after a reasonable effort is made to obtain appropriate consent.
- **Emancipation:** Under some circumstances, a minor is considered to have adult status and may consent to his or her own treatment. A person under 18 years of age may consent to his or her own treatment if any one of the following conditions have been met:
 - Graduated from high school
 - Has been married
 - Has been pregnant
 - Seeking treatment for an STD or reproductive health concern

A statement must be added to the consent form showing which condition is met by the individual. When seeking treatment for STD or reproductive health concern, minors should be encouraged to discuss these issues with their parent/guardian when appropriate.

Compliance Hotline

The Compliance Hotline is always available, by calling 1-855-261-6653 (toll-free) or going online to <https://readinghealth.alertline.com>

Reports are promptly investigated and resolved. Those who report concerns, even those who choose to remain anonymous, can check back to exchange information or obtain status updates.

You can use the Compliance Hotline to report suspected:

- Theft, fraud, or other form of dishonesty
- Harassment or discrimination
- Financial irregularities
- On-the-job drug or alcohol use
- Violence or threatening behavior
- Violations of laws, regulations, policies, or procedures
- HIPAA Privacy or security violations

Please feel free to contact the Chief Compliance Officer (kathleen.wetzel@towerhealth.org; 484-628-8685) with any questions.

External Hotline/Reporting Phone Numbers for Abuse

These hotline numbers should be used to report suspected incidents of abuse.

- PA Child Line 1-800-932-0313
- Safe Berks 610-372-9540
- Division of Nursing Care Facilities (for the Hospital for Post-Acute Rehabilitation Transitional Care Center) - 610-865-2117
- Berks County Office of Aging 610-478-6500
- PA Department of Aging Protective Services 1-800-490-8505

Institutional Support

Sponsoring Institution

The Reading Hospital serves as the sponsoring institution. The Hospital assures that an environment is created which allows for excellence in medical training. Details of the System's commitment to residency education are outlined in the Reading Hospital Resident Manual, which is updated yearly.

Away Rotations

Upon approval of the Program Director, a resident may arrange a rotation at another institution if it offers an experience not available in the Tower Health System. An agreement shall be created as described in Section IV of the Reading Hospital Resident Manual, which will include: the name of the supervisor at the host site; the inclusive dates of assignment; responsibilities of the supervisor to assure teaching, supervision and evaluation; financial arrangements and benefits; policies and procedures to be followed by the resident; and goals and objectives for the rotation. In doing so, the sponsoring institution and Program Director will assure appropriate quality of the away elective rotation. At least 90 days prior to the date of the away rotation, the Away Rotation Request form shall be obtained from the program coordinator, completed, and submitted. A maximum of one away rotation will be permitted over a three-year period.

Facilities and Resources

Information Systems

Medical Library – There are over 6,000 e-journals and more than 1,500 eBooks available to residents through the library at the Reading Hospital. These resources are available to learners at all times via the library's online collection. The library's web site provides access to a robust collection of subscription databases, a customized Emergency Medicine Residency page, copyright resources, free citation management tools as well as mobile apps.

Medical Records – All patient history, physicals, and discharge summaries will be dictated/typed into Epic and become a part of the patient's lifetime clinical record. Similarly, consultations should also be dictated/typed. The resident will use electronic signature to sign these reports. The residents will utilize Epic to maintain their patient ambulatory records.

Facilities

Sleep Quarters – On-call sleep quarter is located on A3. A key is available for a call room. An emergency key may be obtained through the Department of Emergency Medicine but must be returned the next day. There is a call room located in the EM Physician locker room. This call room is available on a first come first serve basis.

Emergency Medicine Residency Lounge and Computer Lab –

Code:2468

Important announcements for residents are commonly posted here.

K-Building Second Floor (K2) area – Entry code is 714*. Please do not share this with others. K2 has an exercise facility for residents including a treadmill, stepper, and weight equipment. A television is located in the exercise room.

R3 Resident Lounge- The resident lounge can be access through code 2468#. This code should not be shared with others. A television, lounge chairs, food and beverage are available. This room and study house three computers with M*Modal microphones and printers.

Department of Emergency Medicine Office – Staff of the Department of Emergency Medicine Office on T-ground may be reached by dialing ext. 3529. The department administrative assistants support the residency educational program by facilitating communication between residents and Core Faculty, collecting attendance forms, supporting data collection on the New

Innovations database, supporting the interview process for resident applicants, supporting the student education programs, and helping residents with general “system” issues. The Residency Program is also staffed by a Program Coordinator; in conjunction with the Director, the Program Coordinator is responsible for overall management of the residency program. In addition, the Program Coordinator assures compliance with the RRC and Institutional Requirements to maintain accreditation.

Support Services

The Emergency Department (ED) is well equipped and staffed by ancillary services to support the education and clinical workload of the EM residency.

The department has dedicated laboratory services housed in the ED to perform both point of care and other laboratory testing.

There are three CT scanners available for patient studies in the ED and there is a radiologic suite in the ED for plain radiographs, as well as multiple portable digital radiography machines. Residents will be able to review radiographs in real-time on the portable machines and will be able to review radiographs via a PACs system which is housed in the EMR, Epic. MRI and Ultrasound studies are also available 24/7 and there is a dedicated ultrasonographer who is housed in the ED at all times. Residents will also be encouraged to perform their own bedside diagnostic evaluations utilizing one of the SonoSite ultrasound machines currently available in the ED and the Trauma Bay. Radiologists are on-site until 11 PM to review all radiologic studies performed. Between 11 PM and 6 AM, a service off-site is available for all reads with the exception of plain radiographs, which can be read by the on-call radiologist at ED physician request.

Patient transporters are available at all times and there is a wealth of support staff to assist with patient record requests and transfer of patients to other facilities. A respiratory therapist is also available in the ED at all times for emergent airway needs as well as aerosol treatments.

An aeromedical unit is available for expedited transfer of patients to other facilities when necessary. There is a strong relationship with the EMS agencies in the county as well as over thirty EMS agencies who transport patients to the ED regularly. An EMS liaison also works with the administration of the department to ensure continuity between the ED and the EMS services. Reading Hospital contracts with a transport service and has a process to expedite transfers to other facilities when necessary.

Case managers and social workers are available in the ED from 0700 to 2300 to assist with patient needs that are beyond the scope of the EM resident or Attending Physician. They assist in coordinating outpatient follow up as well as specialty follow up for patients who require these services. They also are able to assist in medication and equipment needs.

A mental health worker is present in the ED at all times to assist with the care and disposition of the mental health patient. There is a dedicated Psychiatric Emergency Service Area to assist with meeting the needs of mental health patients in the ED.

Attending Physicians in Critical Care, Obstetrics and Gynecology, Trauma Surgery, Anesthesiology And Hospitalist Service are available on site at all times for direct supervision of residents as well as consultation to ensure safe and efficient patient care.

Infection Control Policies

The Infection Control Manual is located on the OCC, Under Quality & Patient Safety, Epidemiology & Infection Prevention. All infection control policies that are acceptable at Reading Hospital are explained in detail within that manual.

Surveillance of Infections

Nursing personnel are responsible for reporting highly contagious infections or reportable diseases to the Infection Surveillance Nurse, using Form 3.21—Infection and Communicable Disease Report.

This includes infections among patients and personnel.

Personnel

- All personnel will wear clean attire and shoes.
- All personnel are subject to Employee Health policies as described in the Personnel Policy Manual and Infection Control Manual.
- All personnel should carry out aseptic hand-washing technique as described in the Infection Control Manual.

Education

All resident staff will complete the Health Streams educational courses on infection control.

Reporting Communicable Diseases

The Pennsylvania Department of Health has compiled a list of disease or disease entities that must be reported. Guidelines for this process are found in the Infection Control Manual. Note that Reading Hospital Laboratory automatically reports many positives.

Legal Obligations and Reporting Laws

For questions concerning legal obligations, the resident should consult the Program Director, Medical Director's office, or hospital attorney. There is an ED administrator on call at all times for immediate concerns.

Chronic Opioid Guideline

The ED has created a guideline for chronic opioid use and abuse for the Emergency Department. This guideline is based on the Pennsylvania ACEP guidelines published in 2014. A copy of this guideline can be found on the online resource page for the ED as well as posted in the physician offices in the ED.

Incident Report Mechanisms

A resident is able to & encouraged to complete an incident reports on any patient care-related problem. If any incidents occur in the area of the Emergency Department, then it is the responsibility of the Assistant Nurse Manager to coordinate the incident report filing. A physician may need to be notified to examine the individual and complete the incident form. The incident report must be filed. The proper location of the incident report can be found on the homepage of the hospital intranet under E-Apps, Incident Reporting (RL Solutions).

Advanced Directives/DNR Orders/Pronouncement of Death

- Code status will be addressed and documented per current hospital policies.
- Any resident can pronounce a patient.
- If the physician feels that an autopsy is indicated, — and the death is not a coroner's case — the pathologists of Reading Hospital will perform the autopsy free of charge. It is imperative that the permission form be signed by the family before notifying the pathologist. Physicians should discuss the case with the pathologist prior to speaking with the family.
- At the time of death, a note should be placed in the patient's chart indicating whether an autopsy was requested and whether the patient was a candidate for organ/tissue donation.
- In general, when a patient dies, family members should be notified by the attending physician unless the resident has an especially close relationship with the family. Circumstances should first always be discussed with the Attending Physician.
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Library Services

There are over 6,000 e-journals and more than 1,500 eBooks available to residents through the library at the Reading Hospital. These resources are available to learners at all times via the library's online collection. The library's web site provides access to a robust collection of subscription databases, a customized Emergency Medicine Residency page, copyright resources, free citation management tools as well as mobile apps.

There are also a variety of textbooks available in print in the Emergency Department. Residents have access to Tintinalli's Emergency Medicine, Rosen's Emergency Medicine, Roberts and Hedges Clinical Procedures in Emergency Medicine, Goldfrank's Toxicologic Emergencies, as well as various other EM print resources.

Residents may access the library at all other times through use of their hospital ID badges once they have been electronically coded to this access. Residents are not to loan their ID badges to anyone. The library is located on B3.

Reference services are available from the Medical Librarians during working hours: M-F 0800-1700.

Reference books may not be signed out of the library, and other books may be signed out for three weeks. Renewals may be made by telephone, email or in person. Print journals are not to be removed from the library.

Resident Appointment **Resident Eligibility**

Applicants with one of the following qualifications and who are eligible for a Graduate Training License in the Commonwealth of Pennsylvania are eligible for selection:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education;
2. Graduates of colleges of osteopathic medicine in the United States accredited by the AOA;
3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:

- Have received a currently valid ECFMG certificate,
 - Or have a full and unrestricted license to practice medicine in a United States licensing jurisdiction
4. Graduates of medical schools outside the United States and Canada who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

Resident Selection

Residents are selected from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities, such as motivation and integrity. Non-eligible residents will not be considered for enrollment at Reading Hospital. Reading Hospital does not discriminate on the basis of race, color, religion, creed, sex, age, national origin, disability, sexual preference, or veteran status.

All candidates must complete an application for the Emergency Medicine Residency Program. Written documentation of a completed application is to be provided through ERAS (Electronic Resident Application Services).

Enhancing criteria for selection include: election to honorary academic organizations (Phi Beta Kappa, Alpha Omega Alpha); positive evaluations for experiences during medical school; high scores on USMLE Steps 1 and 2, or the corresponding osteopathic examinations; Strong Standard Letters of Evaluation as well as letters of endorsement from deans and/or department chairs; and documentation of academic success (i.e., class standing, research publications, student awards).

All candidates must complete a successful personal interview with Program Director and designated faculty members and a senior resident. A faculty-resident group contributes to final rankings for selection to the NRMP after review based on consideration of the above criteria.

Reading Hospital strongly supports the Match programs. At the discretion of the Program Director, however, some positions may be filled outside the Match, based on the above-listed criteria and established NRMP guidelines.

To determine the appropriate level of education for residents who are transferring from another residency program, the Program Director must receive written primary source verification of previous educational experiences and a statement regarding the performance evaluation of the transferring residents, including assessment of competence in the six competencies (see page 1 – 10), prior to acceptance into the program.

The Program Director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

Residents shall not be accepted for advanced standing from programs not accredited by ACGME.

Resident Transfers

Any resident who wishes to transfer from another program must provide records to support that he/she meets acceptance criteria, as well as a letter from his/her current Program Director. This letter must summarize the competencies already accomplished. Placement level will be based on competency evaluation and milestones achievement.

USMLE 3 Examination

All residents must pass USMLE 3 examination before they can advance to the PGY 3 year. This is a requirement for Pennsylvania State Licensure. We strongly encourage residents to take the examination by the completion of the PGY1 year.

Number of Residents

The Emergency Medicine Residency at Reading Hospital is approved for 24 residents by the Emergency Medicine Residency Review Committee of the ACGME. It is the desire and expectation of the staff that all first-year EM residents will complete their three years of training at Reading Hospital.

Residency Curriculum and Policies General Information

First Year	Second Year	Third Year
ED Orientation 5 blocks Emergency Medicine 1 block Trauma/ General Surgery 1 block Pediatric ED 1 block Obstetrics 1 block Medical ICU 1 block Ultrasound ED 1 block Anesthesia 1 block Observation/ Research	5 blocks Emergency Medicine 1 block Trauma/ SICU 1 block SICU/Neuro ICU 1 block EMS Aeromedical/ Research 1 block Ortho/ Sports Medicine/ Radiology 1 block Neonatal ICU 2 blocks Pediatric ED 1 block Toxicology ED	7 blocks Emergency Medicine 1 block Trauma/SICU 1 block ED/Urgent Care 1 block Pediatric ED 1 block Administrative 1 block Research 1 block Elective

Choice of rotations:

Each resident is responsible to review the requirements for ACGME/EM training and work with the academic advisor to assure that all requirements are met.

Didactic Program

All Didactic and Educational Conferences are a Mandatory and Required part of Resident training. Resident must follow protocol for reporting absence.

Survival Series – Frequent lectures in July focus upon knowledge and skills to manage acute problems that will face the resident during training. All Lecture information is available upon request. Residents will also be certified in ACLS, PALS and ATLS during this orientation month.

Didactic Experience- Didactics will be held each Thursday from 8am-1pm. These planned learning experiences are geared toward the EM Model and preparation for the ABEM Written Certification Exam as well as the Oral board portion of certification. 80% attendance is required as a minimum. One hour weekly of asynchronous learning may be provided weekly. Residents are assigned exams via ROSH Review that correspond to weekly reading assignments.

Morbidity and Mortality/QI Conferences – At these sessions, relevant cases are chosen by the assigned upper-year resident with the assistance of the Core Faculty, Program Director and peer review committee chair. The resident develops a patient safety assessment in conjunction with the QI office and peer review committee chair.

Journal Club – On a monthly basis, a Senior resident or Core Faculty member will provide a formal critical review of a journal article of clinical import to the audience, emphasizing search strategy, methods and statistical analysis, as well as importance of the article in advancing the field.

QI Project – Residents will work with their quality mentor and the research director creating, implementing, and studying a Quality Improvement measure with their peers. Residents will develop an understanding of the difference between process improvement and research activities, learn the techniques for change including use of PDSA cycle, learn to critically analyze their own practices, learn how to be agents of change within a system, learn how to operate a database and work within a team structure. QI issues will be incorporated into the didactic curriculum.

Simulation Program: Residents will learn leadership in critical situations through the simulation education program. In this program, they will respond to pre-programmed simulations developed from actual cases as well as cases they may encounter in the ED. They may work alongside the EM nurses and a respiratory therapist, and other personnel. Residents will gain experience in leading a team, rapidly developing a therapeutic plan and instituting that plan. Faculty will give feedback during a debriefing session with regards to the performance of the team. The residents, rating will be using a mastery learning model, meaning that residents will continue to participate until it is clear that they have mastered the subject area.

Procedural Competencies

Emergency Medicine Defined Key Index Procedure Minimums

Review Committee for Emergency Medicine

The following are key index procedures identified by the Review Committee as essential to the independent practice of emergency medicine (based on the Program Requirements, the Emergency Medicine Milestones, and the Model of the Clinical Practice for Emergency Medicine).

Residents are required to perform the minimum numbers indicated for each key index procedure below by the time of graduation from the program.

Adult Medical Resuscitation 45
Adult Trauma Resuscitation 35
Cardiac Pacing 6
Central Venous Access 20
Chest Tubes 10
Cricothyrotomy 3
Dislocation Reduction 10
ED Bedside Ultrasound 150
Intubations 35
Lumbar Puncture 15
Pediatric Medical Resuscitation 15

Pediatric Trauma Resuscitation 10

Pericardiocentesis 3

Procedural Sedation 15

Vaginal Delivery 10

No more than 30 percent of required logged procedures performed in simulated settings can count toward the required minimum, with the exception of rare procedures, namely pericardiocentesis, cardiac pacing, and cricothyrotomy. One hundred percent of these rare procedures may be performed in the lab.

Performance of these procedures under supervision and certification by the supervisor are required before the resident can be allowed to perform independently. Other procedures are encouraged, and some will be required, based upon future career goals. Clinical Competency Committee will review resident progress and assess for competency for independence. All Procedures must be tracked in New Innovations. It is the responsibility of the residents to ensure the accuracy of the procedure log. Supervisors or Program Director will confirm performance of procedures and document independent function in New Innovations.

Process to accomplish above: Cognitive component of procedures will be presented and certified in the intern survival series. Retention of cognitive component will also be evaluated by the supervisor of procedure. Orientation sessions provide simulation/model training in many of the procedures stated above.

Sign Out

The residents will be scheduled for day, evening, and night shifts in the Emergency Department seven days a week. Each shift will provide at least 30 minutes of overlap to allow for patient handoffs and for concluding patient care. All Residents will be observed performing a patient handoff during orientation month to assess for competency and undergo simulation training in handoff using iPASS tool.

Hospital Dictation

Every hospitalized and Emergency department patient must have an H&P completed within 24 hours.

When on Off Service Rotations the Discharge Summary should be dictated at the time of discharge. The discharge diagnoses should correlate as much as possible with the diagnoses listed on the Summary Sheet. For hospital billing procedures, the Summary Sheet must be filled out completely at the time of discharge, and the discharge summary should be available as soon as possible. Discharge Summaries for patients discharged to nursing homes or rehabilitation facilities must be dictated 24 hours prior to discharge so that it can accompany the patient.

Medication Reconciliation – Accurately updating all medication changes at the time of patient discharge is essential using the appropriate forms. This must be carefully reviewed with patient and family.

Policy for Supervision of Residents

Supervision of Emergency Medicine Residents

The Emergency Medicine (EM) Program Director has established appropriate responsibility for each level of residency training as required by ACGME and Joint Commission. The Program Director is responsible for determining that each resident has supervision. The DME and GMEC coordinate the activities of all programs. When in the clinical setting, all residents are supervised by the Attending Physician in that Department who is ultimately responsible for patient care.

Provisions for supervision include the following:

- All resident supervisors must hold Hospital staff privileges;
- All residents in the Emergency Department have indirect supervision with direct supervision immediately available at all times;
- First-year EM residents must have an on-site supervisor available at all times;
- A staff obstetrician/gynecologist must be on site at all times to supervise EM residents rotating on the OB-GYN service as required by their Residency Review Committee;
- For other departments, if Attending Physicians are not readily available at bedside when needed, the on-site supervising physician can be an individual who is in an upper year of graduate training ("Readily available" for this purpose is interpreted to mean within 20 to 30 minutes.);
- Assessment and authorization of the abilities of each trainee to perform specific treatments and procedures must occur. EM Residents are approved to perform specific treatments and procedures only after submitting documentation of prior experience, or observation and assessment of their skill by the Program Director and Faculty Members based on milestone progression.
- The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and faculty members, based on the milestone progression of that resident.
- When on inpatient services, staff physicians must review all residents' Hospital admissions, round with the residents, review Progress Notes, discuss and review all discharge plans, and sign Discharge Summaries written by residents. Patient progress and treatment plans must be reviewed during daily Hospital rounds with residents;
- Supervisors shall foster a learning environment with graded responsibility as defined by the EM department policies, curriculum, as well as the resident advancement in milestones.

- It is the responsibility of the supervising physician to provide review of procedures/encounters with feedback provided after the care is delivered.
- Specific guidelines for communication with supervising faculty members while on individual rotations are referenced in the course curriculum for that rotation and/or the resident manual.

**READING HOSPITAL
Department of Emergency Medicine**

RESIDENT RESPONSIBILITY AND SUPERVISION POLICY

The Reading Hospital Department of Emergency Medicine is committed to providing a learner-centered educational experience to our resident physicians. Our goal is to ensure that every resident service is oriented toward advancing their education. Toward this effort, the residents will have ample opportunity for supervision and support.

Emergency Medicine Residents will always provide clinical care of Emergency Department patients under the supervision of Emergency Medicine Teaching Faculty and Attending Physicians. Supervision will be either direct (supervising physician will be physically present with resident and patient) or indirect supervision (supervising physician will be present in the Emergency Department available to provide immediate direct supervision). The resident professional responsibility will progressively increase throughout the training program according to individual capabilities and the PGY level as outlined below.

Progressive Responsibility description for Resident handbook for Emergency Medicine Program:

PGY-1

Clinical Duties: The PGY-1 resident will present a comprehensive history and physical to Attending Physician or Senior EM resident immediately after initial patient evaluation. After this evaluation and presentation to the Attending Physician or Senior EM resident, the resident will place orders for diagnostic testing and perform any necessary procedure. Procedures will be performed under the direction supervision of an Attending Physician or Senior EM resident. All patients must be evaluated by the Attending Physician prior to discharge or departure from the Emergency Department.

Teaching: Residents will be required to prepare and present at least two lectures on topics relevant to EM during the planned didactic teaching sessions.

Supervision of other residents/ medical students: None

Administration: When requested: Participate in formal resident interviews

PGY-1 Residents are required to become ACLS, ATLS and PALS certified during the first year.

Scholarly Activity and Quality Improvement: Residents will be expected to participate in Quality Improvement initiatives as well as scholarly activity projects.

PGY-2

Clinical Duties: The PGY-2 resident will care for critically ill and injured patients and perform invasive procedures during resuscitations. The resident will manage multiple patients simultaneously and learn to prioritize them. PGY-2 residents may place orders for diagnostic testing prior to presenting to Attending Physician or Senior EM resident. All patients must be evaluated by the Attending Physician prior to discharge or departure from the Emergency Department.

Teaching: Residents will be required to prepare and present at least two lectures on topics relevant to EM during the planned didactic teaching sessions. PGY-2 residents will supervise medical students and PGY-1 residents (when faculty grant responsibility)

Supervision of other residents/ medical students: PGY-2 residents may supervise medical students.

Administration: When requested: Participate in formal resident interviews, participate and contribute to hospital committee as selected, such as Quality Improvement, Pharmacy and Therapeutics, etc.

Scholarly Activity and Quality Improvement: Residents will be expected to participate in Quality Improvement initiatives as well as scholarly activity projects.

PGY-3

Clinical Duties: The PGY-3 resident will care for critically ill and injured patients, as well as direct Emergency Department resuscitations. Residents will be expected to manage and prioritize multiple patients simultaneously. They will be responsible to manage operations in the area of the ED dedicated to Resident Education. Prior to patient discharge the resident will ensure that patient case has been presented to the Attending Physician.

Teaching: Residents will be required to prepare and present at least two lectures on topics relevant to EM during the planned didactic teaching sessions. They will be expected to supervise medical students and Junior residents. PGY-3 residents may present EM lectures to off-service residents and medical students.

Supervision of other Residents/ medical students: Supervise Junior Residents and Medical students

Administration: One/Two residents are selected as Chief residents, their tasks include: attending appropriate ED meetings, participating in formal resident interviews, chairing the monthly resident meetings, and scheduling the resident shifts in the ED as well as off-service rotations.

Each senior resident will act as administrative residents for one month each and duties include:

Participating in formal resident interviews, participating and contributing to hospital committees as selected, developing Grand Rounds schedules, selecting M&M and case conference cases, teaching off-service residents and medical student lectures, and organizing social activities.

Scholarly Activity and Quality Improvement: Residents will be expected to participate in and present Quality Improvement initiatives as well as scholarly activity projects during their final year of residency.

Responsibilities and Surveillance

All Faculty and residents have the responsibility of patient safety. Therefore, they will be held responsible and accountable for safe, effective and appropriate resident supervision and progression of responsibilities. No critical decision will be made without real-time input from the Attending Physician.

Importance of Documenting Resident Experiences

It is essential for each resident to document procedures performed and quantities of patients treated with different conditions. Performing or assisting in procedures, must be recorded. Patients cared for in the MICU, SICU, NICU, ED and Trauma Unit should have their procedures logged in New Innovations. This information will become essential in the future as physicians apply for clinical privileges in hospitals and for credentialing information and medical insurance organizations.

When graduates apply for privileges, (such as procedures, ability to interpret tests, etc. They may be required to document the quantity, the dates, the degree of involvement, and the experience in the related procedures or with special patients. This process will be expedited if residents keep a running documentation of experiences and procedures encountered during residency.

For both out-patient and in-patient procedures, residents are responsible for documenting their own experience in the New Innovations database in real time. As a backup to the system, it is strongly suggested that residents keep the same information in their personal possession, along with supporting documentation.

Medical Students

Medical students frequently participate in third-year or fourth-year clerkships in Emergency Medicine. These students from a variety of university medical schools have specific goals and objectives to be learned during their clerkships.

The residents and faculty may be responsible for completing evaluation forms of each student's performance and attitudes during the rotation in the ED. The form is for abbreviated assessment of the student's daily encounters with patients.

Medical students will be assigned shifts in the ED and may be supervised by Senior residents at the Attending Physician discretion.

Please remember that the medical students provide a tremendous recruitment opportunity for our residency program.

Research/Scholarly Activity and Quality Improvement

Each resident is required to participate in a scholarly activity project per current policy. These activities are to be discussed with the faculty advisor.

Residents will have multiple opportunities to participate in scholarly activities. Each resident will conduct a Quality Initiative (QI) and a research initiative of interest to them. The QI projects will focus on patient experience initiatives, Emergency Department through-put, and Evidence-based practices which would improve quality and safety of patient care. QI projects may be conducted as a group. A Core Faculty mentor will guide the residents through Problem Solving and Rapid Improvement Events.

The research initiatives will stress case reports, literature reviews, and observational studies. We are also engaged in interdisciplinary research projects with other Residency Programs at the institution, including Trauma Services and the Internal Medicine Department. All residents will meet with the research director to act as a mentor for the research activity. Residents may conduct group research projects.

Residents will have the opportunity to present findings at an annual Emergency Medicine Conference as well as at other regional and national conferences. In addition, third-year residents will present their activities at ED Grand Rounds.

Residents have access to the Hospital library 24/7 to compile supporting data and similar research.

Residents also have access to a biostatistician to assist them in study designs and analysis.

Residents will attend the multidisciplinary core lecture series on research. This series of 24 lectures will cover all aspects of conducting research from formulating a question, picking a research design, understanding statistics and epidemiology, to writing an abstract and paper.

Resident research activities are also supported by the Hospitals Research Advisory Council. The Research Advisory Council (RAC) is composed of a multidisciplinary group of clinicians who possess skills in the elements of scientific inquiry. Members include clinicians from major clinical departments. The Director of Nursing Research, a member of the Nursing Research Council, and the Research Unit's Director of Clinical Trials Research are also represented. The Chair is selected by the committee at large. The Council may invite other members of the staff to Council meetings, when they offer expertise that advances the Council's mission. The EM Associate Program Director is a member of the Council and assists in reviews.

The Research Advisory Council was created for two major purposes:

1. To provide informal guidance to members of the Reading Hospital community who wish to participate in investigator initiated research.

These members include EM faculty.

2. To formally review all investigator initiated research proposals prior to Institutional Review Board (IRB) review, and to provide the IRB with an opinion regarding the scientific merit of the proposal.

To enhance resident scholarly activity and foster scholarly activity amongst Core Faculty, the EM Research Director will guide and facilitate Core Faculty on individual projects.

All resident scholarly activity will be supervised by an EM faculty member and oversight will be provided by the EM Research Director.

Research Block

Residents will have ample time to prepare and complete scholarly activity. Dedicated time to develop, implement, and complete scholarly activity projects has been given to residents during each year of their training. Pre-requisite planning is described in the Research Block Curriculum. For residents with a special interest in research, the elective may be taken on more than one occasion. In that case, a deeper level of involvement is expected and Program Director support is required.

A PGY2 resident should be able to read and understand the medical literature, to reproduce basic study design, to know how to utilize basic statistics, to seamlessly integrate electronic resources, and to develop a knowledge and understanding of IRB's, research ethics, database management and research team integration.

At the completion of the rotation, in addition to the objectives for a PGY2 resident, a PGY3 resident should be able to use the above skills to reach the written manuscript phase.

Resident Computers

Computers intended for resident use are located in the Emergency Administration Suite on T-Ground. The primary function is to allow residents access to literature searching, Reading Health Connect (Epic) and New Innovations. They may also be used for personal word processing, spreadsheet applications, or other personal use.

Computer policies follow:

- Assistance is available from faculty and the residency administrative staff.
- Do not enter any personal files onto the hard disk, or modify the autoexec.bat file or any other hard disk file.
- Code numbers and passwords for database access are meant for official residency use only. Any personal, non-residency related use of these codes is unethical conduct.
- Please do not enter any programs on the desktop other than those you have been instructed to enter. Entering into unfamiliar programs can cause serious computer problems.

Conferences

Conferences and Meetings

The resident is encouraged to attend other departmental conferences whenever feasible. A weekly list is available on the hospital home page.

Occasionally, additional conferences, workshops, or residency-related educational functions will be held. Residents will be informed in advance whether these are optional or mandatory.

Conferences are offered for the educational benefit of the residents. Attendance will be monitored. The standard is minimum 80% attendance at conferences.

Evaluations Evaluation of Residents

Global Assessment – Summative and formative evaluation is a component of each rotation and the continuity experience. The Attending Physician will offer formative feedback on a regular basis. He/she will meet with the intern or resident on the first day of rotation, mid

rotation, and at the end of rotation, at which time a summative evaluation will be provided. A global assessment of resident function which includes patient care, medical knowledge, practice-based learning, interpersonal communication skills, professionalism, and systems-based practice will be completed by the Attending Physician, and will become a permanent component of the resident's file. It is expected that average ratings will be 3 or above on a 5 point scale. Below average rating would not be viewed as a satisfactory completion of that rotation and will require remediation to be defined by the Program Director and Core Competency. Milestones-based assessment forms will soon be used for all rotations to provide more specific feedback.

Direct Observation – Regular evaluations of resident performance during interactions with patients and colleagues will be carried out by Attending Physicians. These evaluations will deal with aspects of patient care, interpersonal and communication skills, professionalism, or systems-based practice. Standard forms will be utilized. Formative feedback will be provided, and these observations will also serve as a component of the global rotation evaluation.

Surveys – A nursing and ancillary staff survey of the resident's performance in the ED will be assessed twice a year at the CCC. A patient survey of resident performance will be obtained once yearly. A survey will be completed by peers, ED Nurses, and case managers for residents on the ED rotation. The CCC will meet twice yearly for the purpose of feedback for 360° evaluation. Patient and nurse surveys will assess competencies, including patient care, interpersonal and communication skills, and professionalism. Feedback will be provided by mentors, and will serve as a component of the report to the Program Director. Consistent deficiency could prompt a requirement for remedial action. A representative from nursing is a member of the CCC.

Procedures – Procedure documentation will be maintained through the New Innovations system. Residents are expected to meet procedural goals for their year of training. Mastery of the procedures required of medical residents by the American Board of Emergency Medicine is a component of the patient care competency. It is expected that the resident take responsibility for appropriately documenting procedures performed, and notify the Chief Resident, Mentor, and Program Director of needed procedures in order to meet requirements in the allotted time. Procedure competence is a component of the Patient Care Competency. Compliance with procedure requirements will be monitored by the CCC semi-annually as well as the Program Director yearly.

In-Training Examination – All emergency medicine residents are required to participate in the in-training examination on a yearly basis. Although not used as a criterion for promotion, information will be considered in the context of other ratings of the resident's medical knowledge and discussed at the CCC.

Lecture Attendance – It is expected that all emergency medicine residents will maintain an average attendance at conference of at least 80%. These measures will be reviewed quarterly with the Mentor, and uncorrected attendance problems will become a component of the report to the Program Director. Attendance at lectures reflects competencies of medical knowledge and professionalism.

Record Completion – Reports of the resident's timeliness of completion of medical records will be forwarded to the Clinical Competency Committee, Mentor and Program Director. Consistent tardiness of record completion could prompt required remedial action by the Program Director, including potential loss of vacation time in order to correct the deficiency. Note that

documentation is an important component of patient care, communication skills, and professionalism competencies.

Advancement

Progress from the first to second and from the second to third years requires satisfactory levels of performance as measured by the Evaluation Tools described above. Based upon these measures, there must be consensus on the part of the CCC that the resident has acquired a passing level of knowledge, skills, and attitudes as enumerated above.

Due Process

Approach to Remediation, Academic Supervision and Dismissal are described in the Hospital's Resident Manual.

The Emergency Medicine Residency Program policies for remediation, academic supervision, dismissal, and grievance conform to the Institutional policies as stated in Part I of the Resident Manual.

A recommendation for dismissal would be made by the Program Director to the Department's Clinical Competence Committee. The affected resident has a right to be present at the committee meeting for that discussion. If the Clinical Competence Committee concurs in the recommendation and the resident wishes to appeal that decision, the resident would notify the Hospital's Medical Director (or Director of Medical Education at TRHMC), and an appeal would be arranged by the Medical Director or DME.

Evaluation and Promotion

Written evaluations are provided by the individual faculty member responsible for the immediate supervision of each resident during a given segment of time. Attending Emergency Medicine (EM) Physicians who work with residents will be required to provide daily shift feedback cards as well as end of rotation evaluations in New Innovations for the residents being supervised. Off-service Attending Physicians will also provide a written evaluation using New Innovations at the conclusion of the rotation. A copy of these evaluations is kept in the Program Director's office and are housed in New Innovations. The resident will receive a formal evaluation with the Program Director at least two times per year after the Clinical Competency Committee (CCC) meetings.

The Program Director and resident will develop a personalized training program that will encompass all of the following competencies as outlined in the ACGME Program Requirements:

1. **Patient Care and Procedural Skills:** Residents are expected to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must also be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

Components

- caring and respectful behavior
- interviewing skills
- informed decision making
- developing and carrying out effective management plans

- counseling and educating patients and families
- performing appropriate physical examination and procedures
- preventive health service/working effectively within a team

2. **Medical Knowledge:** Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Components

- knowledge and application of basic sciences
- open minded, analytic approach to acquire new knowledge
- access and critically evaluate current medical information and scientific evidence
- apply this knowledge to clinical problem solving
- Commitment to life-long learning

3. **Practice-Based Learning and Improvement:** Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Components

- utilize practice experiences and implement strategies to continually improve the quality of patient care
- maintain a willingness to learn from and use errors to improve the system or processes of care
- use information technology and other methodology to access medical information
- support patient care decisions and enhance both patient and physician education
- facilitate learning of others

4. **Professionalism:** Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Components

- demonstrate respect, compassion, integrity, trustworthiness, and altruism in relationships with patients, families, and colleagues
- commitment to excellence in practice
- sensitive to cultural, age, gender, sexual orientation, race, religion, and disability issues
- adhere to high ethical and moral standards and to principles of confidentiality
- academic integrity
- informed consent

5. **Interpersonal and Communication Skills:** Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Components

- creation of therapeutic relationship with patients
- listening skills

- effective interaction with consultants
- comprehensive medical record
- work effectively as a member or leader of the health care team

6. **Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Components

- understand, access, and utilize the resources, providers, and systems necessary to provide optimal care
- knowledge of practice and delivery systems
- apply evidence-based, cost-conscious strategies to prevention, diagnosis, and disease management
- collaborate with other members of the healthcare team to assist patients in dealing effectively with complex systems and to improve systematic processes of care
- advocate for patients within the healthcare system

Promotion

Residents are expected to develop clinical, administrative, and educational skills as outlined below in the section Annual Promotion Criteria. Development and attainment of these objectives is evaluated at the conclusion of each clinical rotation and during the Clinical Competency Committee meetings (see Policy for Resident Evaluation). The decision to promote a resident to the next EM level will be collaborative amongst the faculty. Residents must have attained the requisite clinical, administrative, and educational skills as referenced above in order to be promoted to the next level. Promotion decisions will be made prior to preparation of Housestaff Contracts, generally in May of each year.

Annual Promotion Criteria

1. EM1

- i) Completes all rotations with acceptable evaluations as determined by the Program Director.
- ii) Attends > 80% of residency conferences.
- iii) Completes all assigned readings as evidenced by satisfactory exam scores, which will normally be considered > 70% on periodic written exams or passing make-up exams.
- iv) Accomplishes EM-1 goals and objectives satisfactorily as determined by the Program Director.
- v) Adequate progress on scholarly project as determined by the Program Director & Research Director. For a scholarly project in research, this generally is regarded as an adequate oral presentation of hypothesis, literature search, and methodology of project.
- vi) Adequate completion of procedure logs, follow-up cases, and other administrative responsibilities as determined by the Program Director.
- vii) Satisfactory completion of assigned lectures as determined by the Program Director.
- viii) Practices in a safe, expedient manner, well versed in initial evaluations and common ED complaints.

- ix) Demonstrates confidence and clinical competence to progress to a less supervised role as determined by consensus of the faculty and Clinical Competency Committee.
- x) Progress along thru the ACGME Milestones

2. EM2

- i) Completes all rotations with acceptable evaluations as determined by the Program Director.
- ii) Attends > 80% of residency conferences.
- iii) Completes all assigned readings as evidenced by satisfactory exam scores, which will normally be considered > 70% on periodic written exams, or make-up exams.
- iv) Accomplishes EM-2 goals and objectives satisfactorily as determined by the Program Director.
- v) Adequate progress on scholarly project as determined by the Program Director. A scholarly project in research will generally be regarded as an adequate oral presentation of data and submission of a completed abstract of adequate quality.
- vi) Adequate completion of procedure logs, follow-up cases, and other administrative responsibilities as determined by the Program Director.
- vii) Satisfactory completion of assigned lectures as determined by the Program Director.
- viii) Able to act independently with a wide variety of patients, with expeditious, directed evaluations and work-ups, as determined by the faculty.
- ix) Satisfactory ability to manage patient flow in assigned areas of the ED as determined by the faculty and Clinical Competency committee.
- x) Satisfy Progress in EM milestones as per the CCC and Program Director.

3. EM3 (Graduation Criteria)

- i) Completes all rotations with acceptable evaluations as determined by the Program Director.
- ii) Attends > 80% of residency conferences.
- iii) Completes all assigned readings as evidenced by satisfactory exam scores, which will normally be considered > 70% on monthly written exams or make-up exams, and "pass" on oral exams.
- iv) Accomplishes EM-3 goals and objectives satisfactorily as determined by the Program Director.
- v) Completion of a scholarly project as determined by the Program Director. A scholarly project in research will generally be regarded as a completed and submitted manuscript of adequate quality.
- vi) Adequate completion of procedure logs, follow-up cases, and other administrative responsibilities as determined by the Program Director.
- vii) Satisfactory completion of assigned lectures as determined by the Program Director.
- viii) Proven capable of independently managing all aspects of the ED, including patient care, patient flow, teaching, and personnel management and supervision as determined by the Clinical Competency Committee.
- ix) Demonstrates competence in administrative and managerial aspects of Emergency Medicine as determined by Program Director.
- x) Satisfy Progress in EM milestones as per the CCC and Program Director.

Failure to Attain Promotion

Failure to demonstrate adequate progression is identified at an early stage, and is handled with individual intervention and counseling. Residents are evaluated at a minimum of three months for progress. Persistent failure to progress may prevent advancement to the next EM level. Residents who risk failure to promotion are informed by the Program Director as early as possible and are reviewed at a minimum of every three months. At time of being informed of the risk of failure of promotion, a corrective action plan will be outlined in writing and provided to the resident and placed in the resident's file. The corrective action plan is individualized, addressing the resident's deficiencies, and specifies objectives and a time table for obtaining those objectives necessary for promotion to the next EM level.

Graduation

Residents are considered graduates of the program when they have successfully completed 36 months of education as outlined in the Program Curriculum and have satisfactorily attained the required goals and objectives. Active participation in a scholarly activity or research project and attendance of residency didactic conferences per requirements of the Program Curriculum is necessary to meet eligibility for the American Board of Emergency Medicine Certification Examination. The Program Director makes the determination of graduation when a resident has met the residency training requirements for the Emergency Medicine Certification Examination.

Residents will also be advised by the Program Director on their educational progression using the EM milestones as required by the ACGME twice yearly. Clinical Competency Committee recommendations will be taken under consideration for graduation.

Residents experiencing deficiencies will be expeditiously counseled, and a plan to correct such deficiencies will be developed.

All residents whose performance is deemed satisfactory will be notified of advancement in the eighth month of the current contract year.

Upon completion of the Graduate Medical Education program, each resident will receive a certificate from Reading Hospital.

Evaluation of Rotations and Faculty

At the end of each rotation, the resident will complete the end-of-rotation evaluation and faculty evaluation forms. A separate form may be completed for up to three faculty members with whom the resident worked most closely during the rotation.

Graduate/Employer Survey

Graduates of the program will be surveyed one year after completion of training. Employers of recent graduates will also be surveyed.

Evaluation of Program

The Program Evaluation Committee will meet yearly to review the program and ensure continuous improvement based on the feedback of residents and faculty. The committee is comprised of representatives from each PGY level as well as EM faculty (at least two core faculty) and off-service faculty who supervise residents. The PEC will make recommendations based on feedback to revise current practices as well as ensure the program is compliant with ACGME standards. They will also review the action plan from the previous year to evaluate

progress. These surveys will also be reviewed yearly by the PEC to incorporate changes to improve and enhance the Residency Program.

This committee prepares a written plan of action each year for program improvement. The PEC will also review the performance of the graduates of the program and ensure an 80% board pass rate. The Program Coordinator is responsible for taking minutes during these meetings. The committee will adhere to the requirements set forth by the RRC in the ACGME program requirements.

Committee Members are appointed by the Program Director to evaluate and improve the Residency Program.

Member Responsibilities include but may not be limited to:

1. Planning, developing, implementing, and evaluating educational activities of the program
2. Reviewing and making recommendations for revision and competency-based curriculum goals and objectives
3. Addressing areas of non-compliance with ACGME standards
4. Reviewing the program annually using evaluations of faculty, residents, and others including:
 - a. Resident performance
 - b. Faculty development
 - c. Graduate performance including a pass rate of at least 80% first pass for the ABEM
 - d. Program quality including using annual evaluations from faculty and residents to improve the program
 - e. Review progress on the previous year's action plan
5. Preparing a written plan of action to document initiatives to improve the performance in one or more areas listed above.

The Program Coordinator's Responsibilities include:

1. Taking minutes at the PEC
2. Assisting in writing the plan of action to document the activity

Disciplinary Measures for Residents

See Reading Hospital Resident Manual for additional details and institutional policies.

If any discrepancies exist between the Emergency Medicine manual and Reading Hospital Resident Manual, Reading Hospital Manual materials will be followed.

Resident Responsibilities

The "Essentials of Accredited Residencies" of the ACGME lists the following responsibilities of residents:

- To develop a personal program of self-study and professional growth with guidance from the teaching staff;
- To participate in safe, effective, and compassionate patient care under supervision, commensurate with their level of advancement and responsibility;

- To participate fully in the educational activities of their program, and, as required, assume responsibility for teaching and supervising other residents and students;
- To participate in institutional programs and activities involving the Medical Staff and adhere to established practices, procedures, and policies of the institutions;
- To participate in institutional committees and councils, especially those that relate to patient care review activities;
- To apply cost containment measures in the provision of patient care.

Not included in ACGME essentials but also considered essential to satisfactory resident performance are the following:

- Attendance on all rotations unless otherwise excused;
- Being on time for shifts and scheduled events unless otherwise excused;
- Reliability of service to patients and families;
- Responsive attitude toward assigned duties;
- Maintenance of rapport toward other professionals and staff within the hospital and ED
- Constructive use of feedback from evaluations and counseling.

Remediation

The Clinical Competency Committee evaluates residents semi-annually to review resident progress in EM milestones and Core Competencies. Residents who are not performing satisfactorily based on the standards and evaluation procedures must be immediately notified, and a written plan describing deficiencies and expectations must be developed. Examples of corrective actions include special assignments, direct supervision, repeating rotation(s), or, in severe cases, academic supervision. The Program Director has the authority to initiate corrective actions, and develop and monitor the plan. The plan of action should be specific and include measurable objectives.

Academic Supervision/Suspension

If remediation efforts have been unsuccessful, the Program Director has the authority to place individuals on academic supervision or suspend them. A letter of academic supervision will be provided to the resident that will include the following:

- the specific reason for academic supervision;
- duration of the academic supervision (not generally less than 60 days, or more than six months);
- expectations;
- plan to assist the individual in meeting expectations;
- mechanism of evaluation to determine improvement;
- consequences if expectations are not met.

Written feedback must be provided at least monthly to the resident during the academic supervision period.

Probation

Consistent failure to meet responsibilities in the above areas will be grounds for placement on probation. The conditions of probation will be outlined in writing at the time the probation begins.

However, every effort will first be made to identify residents who are having difficulty and address issues prior to disciplinary action being taken (see appropriate policy).

Both types of probation require the Program Director, in conjunction with the faculty, to document in writing the remedial actions to be taken by the resident on probation.

Probationary periods may vary in length depending on the type of problem requiring remediation. There may be consequences to a resident's career, licensing, and credentialing if they are placed on probation.

Dismissal

Dismissal may be considered for residents who have been unsuccessful in correcting the deficiencies that prompted academic supervision. A recommendation for dismissal may be made by the Program Director, and requires the support of the Clinical Competency Committee.

Prior to dismissing a resident except for cause as outlined below, a Program Director must verify that the resident was notified in writing of his or her performance problems, was given the opportunity to remediate his or her deficiencies, and was provided feedback on his or her efforts.

Automatic dismissal or suspension may be considered for the following causes

- misrepresentation of facts or falsification of employment documents
- conviction of a felony while enrolled in the residency program
- failure to comply with or satisfactorily complete terms outlined in the Resident Manual

If termination is recommended, the resident will be informed both verbally and by certified mail return receipt requested. Within 10 days of written notification, the resident may request a hearing with representation, if so desired, by a person of the resident's choice. The hearing will be scheduled as promptly as possible. The Hearing Committee will be comprised of the Program Director, CAO, Department Chair, CMO, and Assistant Vice President/Human Resources. The decision of the majority will be considered binding and conclusive.

A resident who is terminated will receive his or her stipend up to the day on which notice of termination was sent. Any unused vacation to that date shall be paid. At termination, the resident forfeits all rights to any other benefits from Reading Hospital. If the decision to terminate the resident is rescinded or modified following review of written comments or a hearing, the decision shall also state which rights, including compensation, shall be restored.

If the resident incurs incapacitating illness or disability and is unable to perform assigned duties for a period of three months, the CMO may terminate the appointment by notifying the resident in writing, or, at the recommendation of the Program Director, the resident may be placed on a leave of absence.

Non-Renewal

Non-renewal must be based on the criteria established for dismissal. With rare exception, the Program Director will provide the resident with a written notice of intent not to renew a current contract no later than four months prior to the end of the contract.

Delay of Advancement

The resident must meet all criteria outlined by the ACGME and RRC for advancement to the next year of training. Occasionally, the Program Director may believe that a resident has the potential for advancement, but requires more time than that usually allotted for attaining that

level of competency. The resident and Program Director may then establish a longer timeline to accomplish the necessary competencies. Planning should be consistent with ACGME and RRC. Areas of deficiency and means to overcome these deficiencies should be documented in the resident's file.

Every effort will be made by Program Directors to provide up to four months of notice of intent to delay advancement in those situations when delay of advancement is considered appropriate

Suspension and Termination

See Reading Hospital Residency Manual

Policy on Completion of USMLE Step Examinations

- An applicant who has failed to attain a passing score upon taking Step II or Step III of the USMLE more than three times is ineligible for enrollment in a Reading Hospital Emergency Medicine residency or fellowship training program.
- The United States Medical Licensing Exam (USMLE) STEP III must be taken within the PGY1 year of residency training.
- Any resident who fails to take STEP III by June 30th of the PGY1 year of training will be placed on immediate probation, for which remediation requires a non-paid leave of absence (LOA) as outlined within Chapter XIV. Such Leave of Absence will remain in effect until STEP III has been completed and supporting documentation is obtained. The Departmental Chair and/or the Program Director will determine the maximal duration for which the LOA will be permitted after which the resident is then in violation of his or her probation and immediate termination will be enacted.
- Residents transferring into Reading Hospital programs during their second year of training must have taken Step III in order to be eligible for enrollment.
- STEP III must be passed by December 31st of the PGY2 year of residency training.
- Failure to pass STEP III by December 31st of the PGY2 year may result in a formal letter of non-renewal of contract for the upcoming academic year.

Policy for Resident Promotion and Graduation/Criteria for Advancement

All residents must demonstrate reasonable skills in the following areas. The second and third years of residency require many abilities that are more complex than that of the first-year resident. Some of these are:

- Multi-tasking (patient care)
- Independence (systems-based practice, responsibility)
- Sound clinical judgment (patient care, professionalism, medical knowledge)
- Ability to interact professionally with other attending's, patients, and ancillary staff (interpersonal and communication skills, respect, compassion, ethical principles)
- Ability to lead the clinical team (systems-based practice management, interdisciplinary approach to care)
- Prioritizing (professionalism, patient care)
- Working efficiently and expeditiously (patient care)

In order to assure that residents are ready for these responsibilities, they will be required to:

- Score a passing grade on all licensure exams required for a given level of training.
- Score no less than the lowest 10th percentile on the in-training examination in two areas (patient care, medical knowledge)

- Scoring less than 10th percentile in any one area will require remediation in that area tailored to the individual resident's needs in discussion with his/her advisor. Examples of such a remediation program would be studying the Core Content Review.
- If, in that given area, the resident scores less than 30th percentile on the subsequent in-training examination, the applicable rotation will be repeated (medical knowledge).
- Pass all of his/her rotations (professionalism, systems-based care, medical knowledge).
- Satisfactorily complete the required days and/or hours of all required and elective rotations as established by the ACGME.
- Achieve satisfactory performance during each and every completed rotation as indicated through the evaluations completed by the appropriate preceptors/course evaluators. Any residents receiving an unsatisfactory final evaluation during any rotation (required or elective) will be required to complete a remedial assignment as determined by the course preceptor and the faculty of the residency. Only after satisfactory completion of all remediation, may a resident be promoted to a level of higher responsibility. Remediation may include repeating a rotation in place of elective time. .
- Document procedural skills performed and requested clinical experiences during residency training.
- Comply with terms of the yearly resident's contract.
- Comply with policies and procedures established by Reading Hospital.
- Satisfactorily complete all medical records and related patient care responsibilities.
- Comply with the normal and ethical standards of care established by Reading Hospital and the Department of Emergency Medicine.
- Have the confidence of the faculty in his/her abilities.
 - The faculty recognizes that, as part of the learning process, residents will make errors of various degrees. If a resident has an established pattern of making serious errors and this pattern is not significantly improved upon, then the faculty may not advance the resident to a higher level of independence and responsibility until safe performance has been demonstrated.

The following list of errors gives a sense of the severity of different mistakes that may occur:

- Error of minimal clinical impact (e.g., wrong date)
- Error of potential serious impact (e.g., failure to pick up red flags in history/physical)
- Error that violates HIPAA regulations or major omission of obvious clinical finding (e.g., 3/6 heart murmur)
- Error of high potential to adversely harm patient if not caught by other personnel (e.g., wrong medication)
- Error that may inflict harm to the patient and be reportable under hospital policy

Action Plan after In-training Examination

In order to improve on the results of the In-training Examination, this action plan has been developed and will be implemented to assist each resident. The plan is designed to improve not only on their scores for future In-training Examinations and subsequent Emergency Medicine Boards, but also to improve medical knowledge in clinical patient care. The action plans include both individualized learning plans for residents who need assistance as well as an overall program plan.

Program Action Plan:

1. Weekly examinations
 - a. Each resident will be assigned an exam that correlates with the reading assignment weekly.
 - b. Each resident is expected to obtain at 75% or higher score on each exam
 - c. If the resident scores below the 75% mark they will have additional education on missed questions in reading during conference.
2. Didactic content
 - a. Didactic experiences must include information from the EM Model based on readings in Tintinalli and Rosen textbooks.
 - b. Each didactic lecture will include board-style questions to review.
 - c. Content will be more evenly divided throughout the year on the major content areas as listed in the ITE.
3. Didactic Length
 - a. Additional hour of didactic time will be spent for review of material that was assigned for board review.

Individual Action Plans:

1. Each resident who scores **below the 50th percentile** of the same PGY level test takers will be assigned additional questions to complete weekly.
2. Each resident who scores **below the 30th percentile** of the same PGY level test takers will be assigned additional reading in areas of concern and will meet with their academic advisors monthly to ensure their retention of the material.
3. Each resident who scores **below the 10th percentile** of the same PGY level test takers will be assigned additional reading and will meet with their academic advisor to ensure not only retention of material, but also to discuss their progress weekly.
 - a. Additionally, residents who meet the above criteria will not be eligible for leadership positions in the residency.

Licensure

Training Licenses

In order to participate in this residency program, or any graduate medical education program in Pennsylvania, during the PGY-1, PGY-2, and PGY-3 years, the resident must have a graduate license with a number in the format of MT-000000 or OT-000000 from the Commonwealth of Pennsylvania.

- In order to advance from one year to the next in the residency program, documentation of training requirements must be on file in Harrisburg.
- In order to participate in graduate medical training at a second-year level (PGY2), a resident must first have passed Parts 1 and 2 (CK and CS) of the United States Medical Licensing Examination (USMLE) or a similar examination acceptable to the Pennsylvania State Board of Medicine.
- To participate in graduate medical training at a third-year level or higher, a resident must pass all three parts of the United States Medical Licensing Examination (USMLE) or a licensing examination acceptable to the Pennsylvania State Board of Medicine.
- If a resident has not met the criteria to advance to the next year's level of training, he/she will continue with the duties and responsibilities of the current year of training.

The resident must, however, complete all requirements at the earliest possible date.
Total residency training cannot exceed 48 months.

For more information, contact the Program Coordinator to review the Rules and Regulations of the State Board of Medicine.

Unrestricted Licenses

- Accredited Allopathic Medical Schools : At the end of the PGY-2 year (no sooner than 15 days prior to completion of the PGY-2 year), the resident may apply for an unrestricted license, provided he/she has passed all parts of the United States Medical Licensing Examination (USMLE). This license number will be in the format of MD-000000-L or E.

NOTE: If a resident did additional training elsewhere at the PGY-1 level, he/she must still complete the PGY-2 year before applying for the unrestricted license.

- Unaccredited Allopathic Medical Schools (IMGs): The resident must complete three years of approved graduate training, one each at the PGY-1, PGY-2, and PGY-3, before applying for an unrestricted license. The resident must also pass all parts of the United States Medical Licensing Examination (USMLE).
- Osteopathic Medical Schools: The Osteopathic Practical component is included in COMLEX-USA Level 2-PE exam as of 2005. It is taken along with the written section for the COMLEX Level 2 exam. This exam is generally taken in medical school, and the COMLEX Level 3 exam is taken at the end of the PGY-1 year. For more information, residents can refer to the National Board of Osteopathic Medical Examiners website at: www.nbome.org/examiners.htm

DEA Licenses

A resident may apply for a DEA number once he/she has applied for an unrestricted license. If there are any questions, contact the Residency Coordinator OR the following agencies:

State Board of Medicine
PO Box 2649
Harrisburg, PA 17105-2649
Telephone: 717-783-1400

State Board of Osteopathic Medicine
PO Box 2649
Harrisburg, PA 17105-2649
Telephone: 717-783-4858

Scholarly Activity Policy
READING HOSPITAL
Department of Emergency Medicine

Institutional Policy: **Requirement for Scholarly Activity**

Definitions:

Scholarly activity is broadly defined as follows:

- The Scholarship of Discovery encompasses those scholarly activities which extend the stock of human knowledge through the discovery or collection of new information. This includes basic or original research.

- The Scholarship of Integration encompasses scholarly activities which are primarily interdisciplinary or interpretive in nature. Such scholarship seeks to better understand existing knowledge by making connections across disciplines, illuminating data in a revealing manner, drawing together isolated factors, or placing known information into broader contexts. It synthesizes, interprets, and connects the findings in a way that brings new meaning to those facts.

- The Scholarship of Application encompasses scholarly activities which seek to relate the knowledge in one's field to the affairs of society. Such scholarship moves toward engagement with the community beyond academia in a variety of ways, such as by using social problems as the agenda for scholarly investigation, drawing upon existing knowledge for the purpose of crafting solutions to social problems, or making information or ideas accessible to the public.

- The Scholarship of Teaching encompasses scholarly activities which are directly related to pedagogical practices. Such scholarship seeks to improve the teaching and advising of students through discovery, evaluation, and transmission of information about the learning process.

Pursuing excellence in patient care requires a life-long commitment to learning by internists. During residency training, participating in the generation of new knowledge and dissemination of that knowledge are required by the Residency Review Committee for Emergency Medicine. Your faculty's desire is to apply the above standards to support your life-long goals, in order to allow you to develop the career path that suits you best.

Resources for Research Assistance

All projects in early stages should be brought to the attention of your Mentor for development guidance or direction to a specific research Mentor and the Research Director. Statistical support is available through the Department of Emergency Medicine on an as-needed basis. Contact the Program Director directly with your specific needs.

Research Rotations

Research Rotations require preparation. Residents should meet with their mentors and clearly define goals of the research project, and complete adequate preparation that will allow adequate use of the designated research time. Research questions and investigational methods should be approved by the mentor, the Research Director, and Program Director.

**Yearly Evaluation of Program
READING HOSPITAL
Department of Emergency Medicine**

Program Evaluation Committee

The Program Evaluation Committee will meet yearly to review the program and ensure continuous improvement based on the feedback of residents and faculty. The committee is comprised of representatives from each PGY level as well as EM faculty (at least two core faculty) and off-service faculty who supervise residents. The PEC will make recommendations based on feedback to revise current practices as well as ensure the program is compliant with ACGME standards. They will also review the action plan from the previous year to evaluate progress.

This committee prepares a written plan of action each year for program improvement. The PEC will also review the performance of the graduates of the program and ensure an 80% board pass rate. The Program Coordinator is responsible for taking minutes during these meetings. The committee will adhere to the requirements set forth by the RRC in the ACGME program requirements.

Committee Members are appointed by the Program Director to evaluate and improve the Residency Program.

Members must include but is not limited to at least two core faculty members and representatives from each PGY level, Off-service attending physicians who supervise and are responsible for the rotations will also be invited to participate.

Member Responsibilities include but may not be limited to:

1. Planning, developing, implementing, and evaluating educational activities of the program
2. Reviewing and making recommendations for revision and competency-based curriculum goals and objectives
3. Addressing areas of non-compliance with ACGME standards
4. Reviewing the program annually using evaluations of faculty, residents, and others including:
 - a. Resident performance
 - b. Faculty development
 - c. Graduate performance including a pass rate of at least 80% first pass for the ABEM
 - d. Program quality including using annual evaluations from faculty and residents to improve the program
 - e. Review progress on the previous year's action plan
5. Preparing a written plan of action to document initiatives to improve the performance in one or more areas listed above.

The Program Coordinator's Responsibilities include:

1. Taking minutes at the PEC
2. Assisting in writing the plan of action to document the activity

Clinical Competency Committee

A Clinical Competency Committee comprised of Core Faculty and other members of the Emergency Department who are appointed by the Program Director will evaluate each resident semi-annually. The purpose of this committee is to ensure that residents are progressing in their Core Competencies and EM milestones as well as to evaluate each resident's ability to take on increasing responsibility. The committee must have at least three Core Faculty members and the Program Director. Resident daily feedback and end of rotation evaluations will be reviewed, as well as feedback from fellow residents, ancillary staff, nursing, and patient experience surveys. The committee will adhere to the requirements set forth by the RRC and will ensure that residents who are experiencing challenges are identified and can be mentored or placed on a remediation plan where appropriate. The Program Coordinator will be responsible to take minutes at each meeting.

Responsibilities of the Committee Members:

Chair Responsibilities:

1. Meet with the Program Coordinator prior to the meeting to ensure that appropriate documents are available for the Committee to review:
2. Start and end meeting on time
3. . Ensure a collegial atmosphere during the meeting
4. Meet with the Program Director after the meeting to review results and recommendations as well as possible remediation plans based on feedback.

Member Responsibilities:

1. Follow through with any assigned tasks including reviewing relevant documents prior to meeting.
2. Understand the purpose of the committee as well as Core Competencies, EM milestones, guidelines, and review process
3. Maintain a collegial atmosphere
4. Ensure that own voice is heard
5. Ensure that discussion is confidential
6. Attend each semi-annual meeting

Coordinator Responsibilities:

1. Schedule meeting and location
2. Notify attendees
3. Aggregate data for review prior to meeting
4. Summarize data
5. Take minutes
6. Document information in resident's record
7. Record milestones for each resident
8. Schedule meetings with Program Director, Resident Mentor, and resident to review meeting recommendations and EM milestones
9. Assist the Program Director with EM milestone submission on the ACGME website

Additional Members:

1. Provide feedback from staff concerning resident performance, especially concerning Core Competencies and EM milestones.

**READING HOSPITAL
Duty Hours
Department of Emergency Medicine**

Program Policy: **Duty Hours**

Effective: **June 2018**

Emergency Medicine Residency Program Duty Hours Policy is as follows:

Policy:

- Residents will not be scheduled for more than 80 duty-hours per week (averaged over a four (4) week period). Inclusive of all in-house clinical and educational activities, clinical work done from home and all moonlighting.
- Duty hours comprise all clinical duty time and conferences, whether spent within or outside the residency program, including all on-call hours.
- Resident should have eight hours off between scheduled clinical and educational periods.
- 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.
- As a minimum, residents will have one full day off in seven days, free of any clinical or academic responsibilities,
- Night float must occur within the context of the 80-hour and one-day off-in-seven requirements.
- Residents must be scheduled for a minimum of one day in seven free of clinical and required education (when averaged over four weeks). At-home call.
- Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
- There may be circumstances where residents must stay on duty to care for their patients or return to the hospital after shorter intervals. This must occur within the context of the 80-hour and the one-day-off-in-seven requirement.
- Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignment. 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
- In addition, the Program Director will assure adequate back-up support when patient care responsibilities are difficult and/ or prolonged, if an unexpected need creates resident fatigue sufficient to jeopardize patient care.

Implementation:

It is Reading Hospital's responsibility to promote patient safety and education through duty-hour assignments and faculty availability. The institution will assure compliance to meet these needs in the following ways:

- Program Director, faculty, and residents will be educated to recognize the signs of fatigue and instructed in the effects of sleep loss and fatigue.
- Program Director and faculty will monitor resident assignments for those in which work-hour responsibilities or level of intensity are likely to produce sufficient resident fatigue to affect patient care or learning.

- Program Director will monitor moonlighting and other outside work for pay activities, which will be included in the work-hour calculations. (Please refer to Moonlighting Police for details)
- The GME office will independently evaluate duty hours. Resident Council members will be queried quarterly regarding rotations that may exceed the standards described above. Under the direction of the GME office, confidential time studies will be performed by residents on those services. Feedback will be provided to the Program Director, and follow-up actions will be requested.
- All residents will be required to sign an agreement supporting the Duty Hours Policy.
- The Department of Emergency Medicine will report semi-annually (June and December) to GMEC on duty-hour compliance.
- An annual report will be provided by GMEC to the governing body on duty-hour compliance.
- Duty Hours will be reviewed annually by the Program Evaluation Committee.

Protocol for Remaining Beyond Scheduled Hours
READING HOSPITAL
Department of Emergency Medicine

Protocol for Remaining Beyond Scheduled Duty Period:

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must appropriately hand over the care of all other patients to the team responsible for their continuing care; and, document the reasons for remaining to care for the patient in question in New Innovations and notify the program director. The program director must review each occurrence of additional service in New Innovations, and track both individual resident and program-wide episodes of additional duty.

To ensure that this does not become a reoccurring issue, the Program Director must sign off on the resident staying beyond their scheduled hours. The Program Director must discuss the circumstances that required the resident to stay and evaluate the situation to see if there is anything that can be done in the future to prevent this from happening again.

If this becomes a reoccurring issue, the program director will formally warn the resident and then investigate what is causing the reoccurrence (i.e. problem in the ED policies and/or staff, call schedules need to be changed, etc.)

Reference Duty Hours policy for specific details on hours worked.

Fatigue Mitigation Policy
Reading Hospital
Department of Emergency Medicine

All Tower Health ACMGE-accredited Graduate Medicine Education programs will be required to:

1. Educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation.
2. Educate all faculty members and residents in alertness management and fatigue mitigation processes.
3. Encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

Tower Health will provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

All Tower Health residents will be required to attend a lecture, led by the Program Director or designee, regarding resident fatigue during Orientation. Topics will include recognizing the signs of fatigue and sleep deprivation, strategies to manage fatigue when possible, and how to transfer clinical responsibilities. All Graduate Medical Education program faculty members will also be required to monitor residents for signs of fatigue.

Following this lecture, residents will be required to monitor themselves, as well as other residents, for signs of fatigue. Program faculty, who will supervise the residents daily, will also be required to closely and continuously monitor the residents for signs of fatigue.

If the resident begins to display signs of fatigue, he or she must stop and acquire rest as soon as possible. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in "Resident Transition of Care" and "Well-Being" if a resident may be unable to perform their patient care responsibilities due to excessive fatigue.

If a resident is sufficiently fatigued to potentially impair his/her ability to perform, the resident must transfer clinical responsibilities to another resident or to an attending. Supervising faculty will assist with the transfer of clinical responsibilities when a resident has been identified, either by staff, other residents, or the resident him/herself as unable to perform and all attempts to transfer responsibilities to other residents have failed.

If a resident or supervising attending feels that the resident is too fatigued to drive home safely after clinical and educational work hours are completed, the resident has the following options:

1. Sleep in an available call room until able to drive safely;
2. If no call rooms are available, the resident will be reimbursed for taxi travel home; or
3. If no call rooms are available and the resident is outside the Tower Health area, a hotel room will be provided.

All efforts must be made to implement and utilize these policies without fear of negative consequences for the resident who is unable to provide the clinical work.

NOTE: All Tower Health Graduate Medical Education Policies and Procedures supersede Departmental Policies.

Moonlighting Policy
READING HOSPITAL
Department of Emergency Medicine

Institutional Policy: **“Moonlighting” and Other Outside Work for Pay**
Effective: **November 2016**

Definitions:

Moonlighting is defined as work outside residency program duties that requires possession of a license without restriction or an interim limited license. Functions that are performed may replace those of another independent licensed practitioner in non-hospital locations.

Other outside work for pay is defined as non-curricular work that does not require possession of a physician license beyond the graduate-training license. An example of such work is performing history and physical examinations for an independent licensed practitioner who assumes supervisory responsibility.

Moonlighting and other outside work for pay are not required of any Emergency Medicine (EM) resident.

All moonlighting and other outside work for pay must be approved by the EM Program Director. The following conditions must be met before “moonlighting” or other outside work is initiated by the EM resident.

- The EM resident must be in his/her third year of training.
- The EM resident must be performing in a satisfactory manner in the residency program as defined by the EM Program Director.
- The sum of weekly resident duty hours and outside work hours should not exceed 80 hours per week. Moonlighting shifts may not precede an Emergency Department shift
- The EM resident must not have a J-1 Visa status, as such residents are prohibited by the Federal government from any form of moonlighting (Code of Federal Regulations – 22CFR 62.16).
- The outside work should be deemed of educational value by the Program Director. In addition “moonlighting” requires a license without restriction or interim limited license in the state of Pennsylvania. (See <http://www.pacode.com/secure/data/049/chapter17/s17.1.html>)

Responsibilities:

The resident must notify the EM Program Director of his/her intent to work outside the program, the nature of the responsibilities, and the assurance that total hours worked in curricular and outside work activities do not exceed 80 hours per week.

The EM Program Director must authorize in writing that he/she is aware that the resident is involved in outside work activity, and provide appropriate documentation in the resident’s file. A copy should be forwarded to the GME office.

The EM Program Director will monitor the performance of residents engaged in moonlighting/outside professional activities for the effect of these activities upon resident performance. Adverse effects of these activities upon performance may lead to withdrawal of permission.

The EM resident and EM Program Director should clarify liability coverage and obtain approval from Hospital Administration for any institution-related activities. Liability coverage for non-hospital related functions will be the responsibility of the resident and the institution hiring the resident.

Reading Hospital accepts no responsibility for resident malpractice coverage for outside work not involving the institution or its active staff.

An EM resident found to be in violation of this policy may face disciplinary action up to and including dismissal from the training program.

Request for Approval to Moonlight

Resident: _____

Department: Emergency Medicine

The following conditions must be met before “moonlighting” or other outside work is initiated by the resident.

- _____ The resident must be in his/her third year of training.
- _____ The resident must be performing in a satisfactory manner in the residency program as defined by the Program Director
- _____ The sum of weekly resident duty hours and outside work hours should not exceed 80 hours per week.
- _____ The resident must not have a J-1 Visa status, as such residents are prohibited by the Federal government from any form of moonlighting.
(Code of Federal Regulations – 22CFR 62.16).
- _____ The outside work should be deemed of educational value by the Program Director.
- _____ License without restriction or interim limited license in the state of Pennsylvania for moonlighting position only. (See www.pacode.com/secure/data/049/chapter17)
- _____ The resident assures that the total hours worked in curricular and outside work activities do not exceed 80 hours.
- _____ Adequate liability coverage is verified.
- _____ The resident understands that liability coverage for non-hospital related function is the responsibility of the resident and the institution hiring the resident.
- _____ The resident understands that Reading Hospital accepts no responsibility for resident malpractice coverage for outside work not involving the institution or its active staff.
- _____ A completed copy of this form is provided to the central GME office.

Nature of outside employment

responsibilities: _____

Please note: A resident found to be in violation of this policy may face disciplinary action up to and including dismissal from the training program.

Resident agrees to the above information:

Resident Name (please print)

Signature of Resident

Date

Request for Approval to Moonlight approved:

Signature of Program Director

Date

Circumstances Requiring Faculty Involvement
Reading Hospital
Department of Emergency Medicine

Purpose:

To provide minimal standards to guide residents with a set of clinical conditions that requires immediate Attending Physician notification.

Scope:

The following policy applies to all residents.

1. Escalation of Care:

Any urgent patient situation should be discussed immediately with the supervising Attending Physician.

This includes:

- Patient death
- Unexpected deterioration in patient's medical condition
- Patient is in need of invasive operative procedures
- Instances where patient's code status is in question and faculty intervention is needed
- A patient is transferred to or from a more acute care setting (floor to ICU and vice versa)
- A patient's condition changes requiring MATT or Code Blue activation
- Any other clinical concern whereby the resident feels uncertain of the appropriate clinical plan

2. Timeliness of Attending Notification:

It is expected that the resident will notify the Attending Physician as soon as possible after an incident has occurred. Notification of the Attending Physician should not delay the provision of appropriate and urgent care to the patient. If despite the best efforts, the resident cannot reach the assigned Attending Physician, then they should notify the Program Director, Medical Director of the service or the Chair of the department for guidance.

3. Bedside Procedures and Level of Training:

PGY 1 Resident:

Direct supervision by senior resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity and competency. Procedure logs are reviewed by the CCC semi-annually and yearly by the Program Director.

PGY 2 and Higher Resident:

Direct supervision by peer upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated.

**Policy Performance of Procedure
Reading Hospital
Department of Emergency Medicine**

1. It is the policy of Reading Hospital that all trainees performing a bedside procedure discuss the clinical appropriateness of the procedure with the Senior resident or Attending Physician. PGY2 and PGY-3 GME trainees should discuss the clinical appropriateness of a bedside procedure with the Attending Physician as needed.
2. The Attending Physician is responsible for determining the appropriate level of supervision required for performing a bedside procedure, the appropriate indication for the procedures, discussion of risk-benefit with residents and patients (as necessary), assessing the risk of the procedure, determining the qualification of the resident performing the procedure and providing adequate support to the trainee performing the procedure.
3. It is expected that a resident shall inform the faculty member or senior resident when he/she does not feel capable of performing a bedside procedure.
4. The resident performing a procedure should make sure that there is adequate backup (such as Senior resident, Fellow, Attending, interventional services, surgical services) before performing the procedure.
5. The resident should attempt the procedure no more than three times before stopping and re-evaluating the clinical situation and asking for a Senior resident, Fellow, Attending Physician, interventional service, or surgical service to take over the performance of the procedure.
6. The resident should call the senior resident, fellow or the attending if he/she has attempted the procedure three times unsuccessfully before attempting the procedure again.
7. The procedure should be aborted and alternate plans discussed with the Attending Physician when the risk of the procedure including discomfort to the patient outweighs the benefit of repeated attempts beyond three.
8. In case of emergency, greater than three attempts can be made but should be justified with clear documentation of the need to do so in the procedure note

Emergency Medicine Curriculum

Administrative Curriculum (PGY-3)

1. **Educational Purpose:** The purpose of the administrative rotation is become familiar with the administrative aspects of emergency medicine. Residents will be exposed to medical and legal issues that face emergency department administration.
2. **Brief Rotation Description:** The resident rotating on the administrative rotation will meet with the Program Director at the beginning of the rotation to obtain a schedule of meetings, possible clinical shifts, and on-call duties that they might have during their month of rotation. The resident is expected to attend meetings in a variety of areas that the administrative attending physicians attend on a weekly or monthly basis.
3. **Competencies/Goals and Objectives:**
 - a. **Goals:**
 - i. Assist the resident in his/her understanding administrative and regulatory components of Emergency Medicine (SBP, P)
 - ii. Develop skills and knowledge necessary to understand the legal climate for practicing Emergency Medicine (SBP, P)
 - iii. Understand Physician relationship with other administrative staff of an Emergency Department (P, IPC)
 - iv. Understand the QA process involved in emergency medicine (PBL, MK)
 - v. Understand the complexity of patient throughput and flow as well as its impact on patient safety (PBL, SBP)
 - b. **Objectives:**
 - i. Understand hospital administration and emergency administration hierarchy and reporting mechanisms of the institution and other institutional formats (SBP)
 - ii. Obtain an understanding of administrative functions and management of the emergency department. (SBP)
 - iii. Learn how Hospital bylaws, physician credentialing rules, and emergency services policies and protocols are developed. (SBP)
 - iv. Understand medical/legal risks and protection in the in operation of emergency services including care plans, discharge instructions, patient-physician communication, order writing, and patient education.(ICP)
 - v. Understand medical legal terminology (IPC,P)
 - vi. Understand coverage of malpractice insurance (P)
 - vii. Understand EMTALA as well as other federal regulatory bodies (SBP)
 - viii. Understand the administration of an emergency medicine residency program (SBP, IPC, P, PBL)
 - ix. Understand the triple/quadruple aim of medicine and how the emergency department fits into this model (SBP, IPC, P, PBL)
 - x. Begin to understand developing budgets for emergency department (SBP, P)
 - xi. Participate in QA activities including peer review, quality committee, and other quality aspects of emergency department administration. (PBL, MK, PC)
 - xii. Prepare and present cases for the case conference weekly at the emergency medicine didactic sessions (P, IPC, MK, PC)
 - xiii. Assist in the preparation of the Morbidity and Mortality Conference (P, IPC, MK, PC)

4. **Teaching Methods/Rotation Schedule:** The rotation schedule be distributed at the start of the rotation. The resident will meet with the Program Director on the first day of the rotation to outline rotation goals and objectives. They will be provided an office area within the ED Administration Suite for the month. There may be on-call opportunities. Most of the rotation hours will occur from 7:00 a.m. until 5:00 p.m., Monday through Friday. Duty hours will be adhered to at all times. Residents will be excused for and participate in Planned Didactic Experiences.
5. **Types of Clinical Encounters:** There will be limited clinical activity during that the administrative month. The resident may be called upon to cover a shift as they are part of the on-call team. Duty hours will be strictly enforced.
6. **Resident Supervision:** The resident will be under the supervision of the program director or his/her designee. During clinical responsibilities, the resident will have indirect supervision with direct supervision immediately available at all times.
7. **Reading List and Educational Materials:**
 - a. Emergency Medicine (Tintinalli's) – Section 25, 26
 - b. Additional reading material as signed by the administrative attending physicians
8. **Method of Evaluation:** The resident will be evaluated by the Program Director at the end of the rotation. Evaluation will be completed in New Innovations. They will also meet with Program Director or his or her designee daily.

Anesthesia Curriculum (PGY-1)

1. Educational Purpose: The purpose of the anesthesia rotation is to expose the resident to airway stabilization in a controlled environment under the supervision of the anesthesiologist. The resident will also be introduced to the phases of sedation and the appropriate pharmacologic options for the patient situation and setting.

2. Brief Rotation Description: The ED resident will rotate with anesthesiologists for four weeks. They will perform airway procedures under the direct supervision of the anesthesiologist and will participate in the care of procedural sedation patients. Residents will also develop a proficiency with the use of medication for rapid sequence intubation as well as monitored anesthesia. They will be exposed to pain management strategies during the rotation as well under the supervision of pain management specialists.

2. **Course Director:** David Matson, DO, Robert McMurtrie, DO (Pain Management)

3. Course Contact:

David Matson, David.matson@towerhealth.org

Jeff Marshall, Jeffery.marshall@towerhealth.org

4. Competencies/Goals and Objectives:

Goals:

1. Develop an understanding of airway anatomy and reasons for difficult airways (MK, PC)
2. Develop airway management skills (MK, PC)
3. Learn to monitor patients and monitoring techniques (MK, PC)
4. Develop an understanding of common agents used in anesthesia and sedation (MK, PC)
5. Learn procedural sedation/monitored anesthesia care (MAC) techniques (MK, PC)
6. Develop an understanding of pain management (MK, PC)
7. Understand ventilator management (MK, PC)

Objectives:

1. Demonstrate the understanding of the airway anatomy (MK, PC)
2. Know how to identify a potential difficult airway (MK, PC, PBL)
3. Demonstrate the correct use of the bag-valve mask (MK, PC)
4. Demonstrate the ability to use rapid sequence intubation and to perform endotracheal intubation (MK, PC)
5. Know medications, dosages, indications, and contraindications to analgesic and anesthetics, as well as neuromuscular blocking agents (MK, PC, PBL)
6. Demonstrate the ability to monitor patients (MK, PC)
7. Demonstrate the ability to manage patients who require ventilator support (MK, PC)
8. Demonstrate the need for airway intervention (MK, PC)
9. Demonstrate the use of pharmacologic agents in procedural sedation and MAC (MK, PC)

10. Demonstrate an understanding of pain management and its role in the health care system (SBP)
11. Demonstrate the ability to work in the setting of a health care team in a collaborative setting (P, IPC, SBP)
12. Provide compassionate and patient-centered care (P, IPC)
13. Understand the role of anesthesia and moderate sedation in the context of the health care system (SBP)
14. Understand the role of Neuromuscular Blocks in Pain management and patient care. (PC, MK)

5. Teaching Methods/Rotation Schedule:

- a. This is a four-week rotation under the supervision of anesthesia. Residents should report to the anesthesia offices (OR Admin Suite) on the first day of their rotation to meet with the course director. They will be given their schedule which generally starts at 7 AM. There will be no overnight call during the rotation. Residents will participate in all conferences offered by the anesthesia department. They will also be excused for EM didactic conferences. Learning objectives will be based on the EM model. All duty hours will be strictly adhered to at all times.
- b. A portion of the rotation will be on the pain management service with Dr. McMurtrie. The schedule for pain management week of the rotation will be distributed prior to the rotation. Residents will report to Pain Management office on D1.

6. Types of Clinical Encounters:

- c. Residents will be involved in the care of a variety of patients on the anesthesia rotation. They will participate in the care of surgical patients and may also participate in the care of patients requiring sedation in the hospital.

7. Procedures:

- d. Endotracheal intubation
- e. Use of bag-valve mask
- f. Peripheral IV insertion
- g. Arterial line insertion
- h. Central venous access
- i. Moderate/Procedural sedation
- j. Ventilator management
- k. Neurological blockades

Residents must document all procedures and resuscitations in New Innovations for review by the Attending Physician. Procedures will also be reviewed by the Clinical Competency Committee semi-annually as well as the Program Director, annually.

8. Resident Supervision:

- l. Residents will be under the direct supervision of the attending physician during procedures. They will also have indirect supervision with direct supervision available at all times while not performing procedures.

9. Reading List and Educational Materials:

- m. Emergency Medicine (Tintinalli's) – Section 4, 30, Section 5
- n. Required reading as supplied by the course director

10. Method of Evaluation

- o. Residents will be evaluated by the course director at the conclusion of the rotation based on the feedback of the Attending Physicians who they work with during the rotation. Evaluations will be based on the EM milestones as well as the six Core Competencies.

Cardiology Curriculum (Elective)

1. Educational Purpose:

The Cardiology Rotation will expose Emergency Residents to a variety of cardiovascular disorders on the Cardiology inpatient or consult service. Under the supervision of a cardiology attending, the residents will develop the skills to accurately and efficiently evaluate, diagnose, and provide initial treatment to patients presenting with cardiovascular symptoms.

2. Brief Rotation Description

- a. Training year – PGY-3 elective
- b. Length – 4 weeks
- c. Hours / call – in accordance with ACGME rules and regulations
 - i. Will include both weekday and weekend coverage
 - ii. Night call
- d. Faculty: THMG Cardiology

3. Competencies/Goals and Objectives

a. Patient care

- i. To expose residents to a wide variety of cardiovascular pathology
- ii. To understand the anatomy, pathophysiology, presentation and management of common cardiovascular disorders (see types of encounters below)
- iii. Develop the skills to perform a thorough and detailed cardiac history and physical exam
- iv. Diagnose, stabilize and provide initial treatment for cardiovascular disorders
- v. Review and understand current Evidence-Based practice guidelines and apply them to the care of patients.

b. Medical Knowledge

- i. Understand the pharmacology, indications, side effects and contraindications for major classes of cardiovascular therapeutics
 1. Thrombolytics
 2. Antiplatelet agents
 3. Anti-coagulants, including new oral anti-coagulants
 4. Anti-hypertensive agents
 5. Anti-dysrhythmic agents
 6. Inotropic agents
- ii. Develop the skills in the use and performance of diagnostic testing
 1. Acquiring and Interpreting ECGs
 2. Bedside Ultrasound for Emergency Cardiovascular presentations
 3. Interpreting pertinent laboratory studies
 - a. Troponin
 - b. D-dimer
- iii. Understand clinical indications for ancillary cardiac testing
 1. Stress testing
 2. Cardiac catheterization
 3. Pacemaker / ICD placement
 4. Loop recorders
 5. Cardiac ablation / EP intervention

- iv. Hemodynamic monitoring and interpretation
 1. Pulse oximetry
 2. ABG
 3. Swan-Ganz Catheter / Central Venous Catheter readings

c. Communication / Interpersonal Skills

- i. Demonstrate ability to perform an appropriate patient evaluation and to communicate findings in a verbal report and in written notes
- ii. Demonstrate ability to communicate the diagnosis and medical decision making to patients and their families
- iii. Demonstrate ability to communicate with other members of the health care team

d. Professionalism

- i. Demonstrate a professional and caring attitude with patients and their families
- ii. Demonstrate the ability to work in an efficient and timely manner
- iii. Demonstrate an ability to interact with fellow residents and attending physicians from various services in a collegial and patient-centered model of coordinated care
- iv. Demonstrate an ability to utilize resources in a cost-effective manner

e. System based Care

- i. Understand the role of ancillary staff in caring for patients with cardiac pathology.
- ii. Sensitivity to disability issues - Understand interaction of complex social stressors that contribute to noncompliance of medical plan
- iii. Understand and demonstrate the use of appropriate referrals and consultations

4. Teaching Methods/Rotation Schedule

- a. Care of inpatients on the Cardiology inpatient / consult service
- b. Bedside teaching during patient care “rounds”
 - i. General medical floor
 - ii. Intermediate Medical Unit
 - iii. Surgical and Medical Intensive Care Unit
- c. One-on-One precepting by attending cardiologist
- d. Weekly ECG reading with Cardiologist
- e. Cardiology didactic lectures
- f. Emergency Medicine didactic lectures on Cardiovascular Disease
- g. Assigned readings

5. Types of Clinical Encounters

- a. Acute Coronary Syndrome
 - i. STEMI
 - ii. NSTEMI / UA
 - iii. Low risk chest pain
- b. Arrhythmia
 - i. Atrial
 - ii. Ventricular
- c. Pacemaker function, indications and complications
- d. Valve disorders

- i. Stenosis and regurgitation
 - ii. endocarditis
- e. Cardiac Failure
 - i. High and low output
 - ii. Ischemic heart disease
 - iii. Cardiomyopathy
 - iv. Cor pulmonale
- f. Pericarditis
- g. Diseases of the Aorta
- h. Thromboembolic Disorders
- i. Syncope as a presentation of the above disorders

6. **Procedures**

- a. ECG acquisition and interpretation
- b. Transcutaneous pacing
- c. Electrical Cardioversion
- d. Echocardiography
 - i. Principles of
 - ii. Application to Emergency Medicine
 - 1. Detection of cardiac tamponade / pericardial effusion
 - 2. RV dilation / strain
 - 3. Asystole
 - 4. Gross interpretation of Ejection Fraction
- e. ABG / venous access
- f. Chest Xray interpretation

7. **Resident Supervision:** Attending cardiologists will supervise Emergency Residents during rotation on Cardiology Service. Residents will also report to Cardiology Fellows on the Service as well. Residents will have direct supervision or indirect supervision with direct supervision immediately available.

8. **Reading List and Educational Materials**

- a. Braunwald's heart disease: A textbook of cardiovascular medicine (RHS library holding)
- b. Cardiovascular Emergencies (Resident Library)
- c. ECGs for Emergency Physician 2 – Mattu and Brady (Resident Library)
- d. ACC/AHA Practice Guidelines – Various guidelines from Journal of the American College of Cardiology

9. **Method of Evaluation**

- a. Performance
 - i. Daily observation of clinical duties by preceptor
 - ii. End of rotation written evaluation
 - iii. Attendance at expected conferences, lectures and meetings
 - iv. Participation in daily care of patients and integration onto Cardiology Service
- b. Rotation evaluation
 - i. Residents will provide feedback on rotation to EM faculty
 - ii. EM Residency and Program Director will review rotation for completion of goals and review resident evaluations

10. Points of importance

The cardiology rotation will provide Emergency Residents the opportunity to understand the care of the cardiovascular patient after the initial Emergency Department (ED) care. Residents will understand the importance of initial ED management and its downstream effects. In addition, they will understand the subsequent inpatient diagnostic and treatment course.

Residents will complete the rotation with a strong fund of knowledge of common cardiology problems, including their presentation, exam findings and initial first line therapies. The residents will incorporate their understanding of appropriate use of diagnostic testing and how to interpret those test results in developing ongoing medical care.

CRITICAL CARE MEDICINE (PGY-1)

1. **Educational Purpose:**

The purpose of the critical care medicine rotation is to provide the EM resident with experience in the evaluation and management of a variety of patients with critical illnesses with emphasis on the multidisciplinary approach. Critical care medicine encompasses the diagnosis and treatment of a wide range of clinical problems representing the extreme of human disease. Critical care patients require intensive care by a coordinated team with initial encounter in the emergency department where they are resuscitated/stabilized and transferred to ICU. The EM resident must have command of a broad range of conditions and devices used in the patients and must be familiar with the technologic procedures and devices used in the intensive care setting. The care of critically ill patients raise many complicated ethical and social issues and the intensivist must be competent in such areas as end-of-life decisions, advance directives, estimating prognosis, and counseling of patients and their families.

2. **Trainees** – Department of Emergency Medicine PGY-1 and PGY-3 residents

3. **Duration of rotation** – 1 month

4. **EM Course Director** – James Kim, MD

5. **Rotation Contact** – James Kim, MD

6. **Method of Evaluation** – Direct observation by the attending physician and senior resident. The attending physician will provide regular formative feedback, midterm assessment of performance, and final summative evaluation in each of the six competency areas with particular focus upon the objectives described below.

7. **Location** – Reading Hospital MICU, N4

8. **Required Reading:**

a. Emergency Medicine 7th ed. (Tintinalli's), Section 3,4,5

i. Educational materials are provided online via the Electronic Medical Library, as well as on program issued iPads. There are also a variety of textbooks available in the Emergency Department for quick reference during admission. PEPID and Up To Date are also readily available for reference.

ii. Marino PL. The ICU Book. (All relevant topics should be read during rotation)

iii. Articles for required reading will be provided by the course director

9. **Goals and Objectives:**

PGY-1 – By the completion of the rotation, the intern will show:

- Capacity to obtain and convey a complete H&P on critical care patients with a variety of problems (**PC**)
- Capacity to provide primary care for several critical care patients concurrently, performing complete clinical evaluations, showing capacity to systemically review data, and with the assistance of senior resident and attending, prioritizing work tasks (**PC**)
- Capacity to succinctly present complex medical problems to team members and consultants, clearly communicating active clinical issues (**PBL, IPC, P**)

- Knowledge of the indications for mechanical ventilation, describe initial settings based on the type of respiratory failure or airway compromise **(MK)**
- Ability to critically interpret arterial blood gas measure and define acid base status **(MK)**
- Ability to define volume status on the critically ill patient **(MK, PC)**
- Ability to interpret chest radiographs of acutely ill patients, including line and tube placement and accurate description of parenchymal and cardiac pathology **(MK, PC)**
- Ability to implement enteral and parenteral alimentation **(MK, PC)**
- Ability to accurately describe level of consciousness and interpret Glasgow scale **(MK, PC)**
- Knowledge of the mechanisms of actions of medications commonly used in the ICU setting including paralytic agents, sedatives, vasopressors, vasodilators, diuretics, bronchodilators, narcotics, anticoagulants, and antibiotics as well as the indications for blood product transfusion **(MK)**
- Successfully perform the arterial blood glass procedure and nasogastric tube placement **(PC)**
- Begin to develop skills in the following: central line placement, endotracheal intubation, thoracentesis, lumbar puncture, arterial line placement **(PC)**
- Offer supportive care, sensitive to the needs of the critically ill patient and his/her family **(P)**
- Ability to use resources, including textbooks, Uptodate, DynaMed Plus, Medline to advance personal knowledge of the care of his/her patients **(PBL)**
- Develop a positive working relationship with nursing and respiratory care, and other ancillary staff **(SBL)**

PGY3 – The PGY3 should reach a level of organizational, procedural, and communication skills that will allow the resident to fully organize the team, define work priorities, and provide independent team leadership function in the ICU, with oversight by the attending. In addition to knowledge and skills demonstrated by PGY1, the PGY3 resident will:

- Effectively distribute clinical tasks among team members and fully coordinate care of the team's patients with oversight by the attending (Systems based practice, Interpersonal and communication skills)
- Demonstrate knowledge of parameters appropriate for intubation, weaning or extubation, and reveal to the attending good judgment in the decision to intubate and extubate patients, as well as the specific elements of weaning (Medical knowledge, Patient care)
- Provide high quality didactic sessions for resident team (Medical knowledge, Interpersonal and communication skills)
- Effectively coordinate care of the ICU patient who has end-of-life issues. Be knowledgeable of the Gift of Life Program and be able to effectively interact with transplant physicians and other program personnel (Interpersonal and communication skills, Professionalism, Systems based practice)
- Demonstrate the ability to evaluate practice patterns of the team relative to national standards and current literature (Medical knowledge, Practice based learning)

10. **Procedures:** Resident will demonstrate competency in performing the following procedures along with understanding when the below procedures are indicated.

- a. ABG
- b. Arterial Line placement
- c. Central Venous Catheter placement
- d. NG tube placement

- e. Thoracentesis
- f. Lumbar puncture
- g. Endotracheal Intubation
- h. Bronchoscopy
- i. Foley placement

11. **Types of Clinical Encounters**

The resident will be responsible for a full spectrum of patients requiring care in the MICU as well as SICU patients who require medical consultations. Problems include, but are not limited to, cardiac arrest and post arrest care, multi-organ failure, shock, respiratory failure, sepsis syndromes, overdose, GI hemorrhage, renal failure, stroke, coma, hypertensive emergency, status epilepticus, and liver failure

12. **Teaching Methods/Rotation Structure**

Resident will review the rotation curriculum prior to the 1st day of rotation and bring the curriculum on the 1st day of rotation block. The resident will report to the ICU at **7 am** on the 1st day of the rotation. At that time, the resident will meet with the ICU attending and discuss goals and expectations of the rotation.

13. **Topics to be covered in Didactic Sessions**

- a. Basic critical care management
- b. Acid/Base Disorder
- c. Ventilator Management
- d. Treatment of sepsis
- e. Line infections
- f. Anesthetics and sedation
- g. Oxygen therapy and delivery devices
- h. TPN/tube feeds
- i. Physical and occupational therapy
- j. Radiology cases
- k. Journal Club
- l. Ethics in ICU
- m. Spiritual care
- n. Palliative care

14. **Admissions/Rounds**

EM residents will be assigned to the teaching intensivist team. The resident will provide admission and continuity of care to that team's patients, as well as special care to the ICU patients, covered by intensivist Physicians requesting admission of patients to the ICU will contact the intensivist, who will define appropriateness of the admission. The admitting attending will then contact the resident on call to discuss admission plans. PGY-1 residents will be expected to admit approximately 3 patients when on call. Residents will also be involved in acute problem solving on ICU patients when on call, working in conjunction with the senior resident and intensivist. PGY-3 residents will have a supervisory role while on the rotation and may also assist with admissions and bedside rounding.

Rounds:

The resident team will round with the intensivist attending each morning. Bedside teaching will occur in this setting. Each PGY-1 resident should oversee the care of 3-5 ICU patients on average. PGY-3 residents may oversee care of patients and also provide guidance to junior residents during rounding.

EM residents are excused from rounds for EM weekly didactic conferences and Journal club.

ICU pager: Admitting resident will carry ICU pager: speed dial #2073

On call schedule: To be determined by ICU attending in compliance with duty hour rules

On call rooms: Resident on all with use assigned sleep quarters on R3. Resident will check with nursing on each pod prior to retiring, regarding any outstanding issues. It is anticipated that the resident will be caring for patients or actively studying throughout the majority of the call. Given the schedule, an occasional 1-hour nap is encouraged in order to minimize any negative impact of fatigue.

15. **Resident Supervision**

The resident will be under the direct supervision of the attending physician at all times, as described in the department manual. The attending will be informed immediately for all admissions to the ICU and will approve such admissions. The attending will review the case with the admitting resident and determine how acutely the attending should be personally available; therefore, the level of supervision will be either direct supervision or indirect supervision with direct supervision immediately available depending on the case. The attending physician will personally evaluate all patients daily and will provide daily feedback to the resident.

Structure of ICU Workday

7A -- 8A	Resident pre-rounds
8A --12P	Teaching rounds with attending
12P – 1P	Lunch/Noon conference
1P – 2P	Rounds/new admissions/procedures
2P – 3P	Didactics/Journal Club
	Monday – didactic by intensivist
	Tuesday – Other discipline topics (pharmacy, ID, and palliative care)
	Wednesday – Other discipline topics (chaplain, respirator therapy, nutrition, and PM&R)
	Thursday – ICU journal club
	Friday – Radiology rounds (4P – 430P)
3P – 5P	Rounds/new admissions/procedures
6P – 7P	On-call resident/attending sing out rounds*
11P – 12 A	Rounds with the on-call attending

*5P – 6P on Friday, Saturday, and Sunday

Curriculum in Emergency Medicine (PGY 1-3) **At Reading Hospital**

1. Educational Purpose: The Emergency Medicine (EM) rotation will provide the EM resident with experience in the evaluation and treatment of a spectrum of acute care problems. The clinical experience will emphasize early diagnosis and intervention for established diseases as well as triage and management of Emergency Department presentations. EM residents will be given increasing responsibilities based on their progression in their PGY years as well as their EM milestones and Core Competencies, as defined by the Clinical Competency Committee and Program Director.

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2. Competencies/Goals and Objectives

Objectives based on level of training

At the completion of the rotation a PGY 1 resident should:

Patient Care

- Elicit an accurate history and physical examination, and document completely and efficiently in the EMR.
- Efficiently review previous records to produce a complete database for a recorded history and physical
- Effectively prioritize work tasks, as appropriate for severity of patient illness.

Medical Knowledge

- Demonstrate knowledge of the criteria for diagnosis of common EM problems
- Know the first-line therapies for most the common EM conditions
- Appropriately order and interpret radiologic and laboratory tests
- Prioritize patients for interventions based on history, physical exam and laboratory/radiographic studies

Interpersonal and communication skills

- Communicate safe, effective and concise patient handoffs
- Perform a concise oral presentation
- Utilize non-verbal techniques and empathetic listening skills during the interview process
- Communicate effectively with attending physicians, nursing and ancillary staff, and consulting physicians while highlighting key issues as appropriate for that listener
- Communicate plan of care, results, and disposition with the patient and their families

Professionalism

- Demonstrate respect for patients, families, and co-workers
- Work effectively and as a patient care team with attending physicians, other residents, bedside nurses, nurse coordinators, social services, and other ancillary staff

Practice Based Learning

- Begin to formulate and answer clinical questions arising from clinical cases
- Understand resources for answering questions and their relative benefits

Systems Based Practice

- Learn the role of ancillary staff (social service, case management, nutrition, physical/occupational therapy, home care services, hospice care) in the care of the EM patients

At the completion of the rotation, in addition to the objectives for a PGY1 resident, a PGY2 resident should:

Patient Care

- Accurately and efficiently handle a larger volume of patients
- Perform a focused and directed history and physical
- Know first and second-line therapies for most common medicine therapies, as well as major side effects of each

Medical Knowledge

- Demonstrate knowledge of criteria for diagnosis of common and less common EM problems
- Know indications for ordering and interpret results for less common laboratory and radiologic tests
- Lead discussion with team on above topics

Interpersonal and Communication Skills

- Plan and lead family discussions
- Overcome barriers and conversations with difficult patients and families
- Efficiently teach patients about their diseases and their options through use of patient-centered communication techniques
- Be able to concisely present information to attending physicians, fellow residents and consultants
- Be able to effectively consent patients for invasive procedures

Professionalism

- Display effective advocacy role for patients with hospital systems, consultants and ancillary staff
- Build positive relationships with consultants, ancillary staff, families and fellow team members

Practice Based Learning

- Demonstrate ability to independently create treatment plans for emergency patients on a regular basis
- Identify and utilize sources of high-quality evidence-based information that applies to the unique patient situation

Systems Based Practice

- Understand nuances of ancillary staff roles (social service, case management, nutrition, physical/occupational therapy, home care services, hospice care) in support of patient care
- Describe barriers of current system to provide effective care to our patient population, and consider strategies to improve that system

At the completion of the rotation, in addition to the objectives for a PGY2 resident, a PGY3 resident should:

Patient Care

- Teach prioritization skills to interns, medical students, and/or ancillary staff (and possibly co-residents) on the service.
- Recognize errors and omissions in the management of interns or ancillary staff when applicable

- Manage and guide use of limited resources (fellow residents, ancillary staff) and direct those resources to attend to problems in order of priority

Medical Knowledge

- Describe the indications, contraindications, risks and benefits of common and uncommon medicines and procedures used in the EM setting, including patients on other service
- Become familiar with and utilize newer technologies in EM and trauma care

Interpersonal and Communication Skills

- Overcome barriers and engage in respectful, productive conversations with difficult patients and families
- Effectively communicate with ancillary staff and develop an understanding of how they may view problems differently.
- Demonstrate the ability to be the leader of the EM health care team
- Build bridges with all nursing and ancillary staff to improve communication
- Ensure effective and safe patient hand-offs

Professionalism

- Show ability to professionally manage challenging ancillary staff relations

Practice Based Learning

- Develop understanding of new therapies and paradigms of care for common and unique EM problems
- Develop understanding of surgical and interventional techniques via observation as well as participation in procedures on patients followed by resident

Systems Based Practice

- Understand pharmacoeconomic issues including medication costs and insurances
- Understand costs to society of new imaging modalities in a value-based system
- Understand the role and efficacy of ancillary staff in disease management
- Manage an area of the Emergency Department and all aspects of its functions

3. Duty Hours/Rotation Schedule

- A schedule will be distributed prior to the rotation.
- A resident will not work more than 60 scheduled hours per week seeing patients in the Emergency Department and not more than 72 duty hours per week
- Duty hours comprise all clinical duty time and conferences, whether spent within or outside the residency program.
- While on duty in the Emergency Department, residents may not work longer than 12 continuous scheduled hours and there must be at least an equivalent period of continuous time off between scheduled work periods.

4. Teaching Methods

- Residents will be exposed to a full spectrum of problems and age ranges.
- Residents will receive bedside teaching from EM Faculty and Attending Physicians during their clinical shifts.
- Residents will provide initial assessment and present all patients to the Attending Physicians. Focus should be an expeditious assessment of the presenting complaint, concise clinical presentation to the attending colleague, and appropriate triage.
- The resident should share learning experiences with fellow residents and students.
- Residents will be given adequate time to provide a concise handoff using iPASS.

5. Types of Clinical Encounters

The resident's rotation experience will center on the Emergency Medicine patient. The resident will have firsthand experience with all types of patient presentations as well as a direct role in evaluation, management, and disposition.

6. Procedures

The resident will have the opportunity to assist with and perform procedures in the ED with the appropriate supervision. Such procedures may include but are not limited to intubations, lumbar punctures, central venous catheter placement, chest tube placement, suture repair, wound management, arterial blood gas, blood draws, and peripheral intravenous line placement.

Emergency Bedside Ultrasound will also be utilized during each EM rotation on appropriate patients.

All procedures and resuscitations must be logged into New Innovations for confirmation by the supervising Attending Physician.

7. Resident Supervision

Residents are under direct supervision of indirect supervision in the Emergency Department with direct supervision immediately available at all times.

Oversight for procedures is provided by the supervising physician, with feedback given immediately after the procedure is completed. Progressive supervision will be given based on the PGY level and the resident milestones achieved as reported by the Clinical Competency Committee and Program Director.

8. Computer Access

All residents will have access to the electronic medical record (EMR). During orientation, all residents will be required to attend Reading Health Connect training concerning the electronic medical record.

9. Reading List and Educational Materials

Educational materials are provided online via the Electronic Medical Library, as well as on program issued iPads. There are also a variety of textbooks available in the Emergency Department for quick reference. PEPID, DynaMed Plus, and UpToDate are also readily available for reference via the online medical library.

10. Method of Evaluation

The resident will receive a general global evaluation of their performance as well as an evaluation according to specific outcome goals, which are reviewed at the beginning of the rotation. The resident will be provided feedback daily after their shift by the Attending Physician who he or she has worked with during the shift. Residents will also be provided with written end of rotation evaluations by the teaching faculty. Additional evaluations will be provided by nursing, ancillary staff, peers, and patients.

11. Points of importance

1. Documentation:

- Residents will document each patient encounter in the EMR.
- Attending Physicians must attest to the resident note and add additional information as needed.
- Residents assign their note for attestation to the Attending Physician of record.

- All orders should be clearly communicated to the patient's bedside nurse.
- 2. Number of Patients Evaluated
 - The number of patients evaluated will be dependent on the volume of patients in the ED as well as the complexity of patients. On average,
 - PGY-1 are expected to evaluate between 0.73 and 1.06 patients per hour
 - PGY-2 are expected to evaluate between 0.85-1.33 patients per hour
 - PGY-3 are expected to evaluate between 1.05-1.41 patients per hour
 - Patients per hour may vary depending on severity of illness and the pod in which the resident is assigned.

Curriculum in Emergency Medicine – Chestnut Hill (PGY-2 and PGY-3)

1. Educational Purpose: The Emergency Medicine (EM) rotation at Chestnut Hill Hospital will provide the EM resident with experience in the evaluation and treatment of a spectrum of acute care problems in a community setting. The clinical experience will emphasize early diagnosis, intervention and stabilization of patients with a wide spectrum of acuity. Residents will also understand when to transfer patients to higher levels of care based on Hospital resources. EM residents will be given increasing responsibilities based on their progression in their PGY years as well as their EM milestones and Core Competencies, as defined by the Clinical Competency Committee and Program Director.

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2. Competencies/Goals and Objectives:

At the completion of the rotation a PGY2 resident should:

Patient Care

- Elicit an accurate history and physical examination, and document completely and efficiently in the EMR.
- Efficiently review previous records to produce a complete database for a recorded history and physical
- Effectively prioritize work tasks, as appropriate for severity of patient illness.
- Accurately and efficiently handle a larger volume of patients
- Perform a focused and directed history and physical
- Know first and second-line therapies for most common medicine therapies, as well as major side effects of each
- Understand the need for transfer of patients to higher levels of care or facilities who are able to care for specialized medical conditions when resources are not available in the hospital.

Medical Knowledge

- Demonstrate knowledge of the criteria for diagnosis of common EM problems
- Know the first-line therapies for most the common EM conditions
- Appropriately order and interpret radiologic and laboratory tests
- Prioritize patients for interventions based on history, physical exam and laboratory/radiographic studies
- Demonstrate knowledge of criteria for diagnosis of common and less common EM problems
- Know indications for ordering and interpret results for less common laboratory and radiologic tests
- Identify patient who may need transfer to higher level of care
- Lead discussion with team on above topics

Interpersonal and Communication Skills

- Communicate safe, effective and concise patient handoffs

- Perform a concise oral presentation
- Utilize non-verbal techniques and empathetic listening skills during the interview process
- Communicate effectively with attending physicians, nursing and ancillary staff, and consulting physicians while highlighting key issues as appropriate for that listener
- Communicate plan of care, results, and disposition with the patient and their families
- Plan and lead family discussions
- Overcome barriers and conversations with difficult patients and families
- Efficiently teach patients about their diseases and their options through use of patient-centered communication techniques
- Be able to concisely present information to attending physicians, fellow residents and consultants
- Be able to effectively consent patients for invasive procedures

Professionalism

- Demonstrate respect for patients, families, and co-workers
- Work effectively and as a patient care team with attending physicians, other residents, bedside nurses, nurse coordinators, social services, and other ancillary staff
- Display effective advocacy role for patients with hospital systems, consultants and ancillary staff
- Build positive relationships with consultants, ancillary staff, families and fellow team members

Practice Based Learning

- Begin to formulate and answer clinical questions arising from clinical cases
- Understand resources for answering questions and their relative benefits
- Demonstrate ability to independently create treatment plans for emergency patients on a regular basis
- Identify and utilize sources of high-quality evidence-based information that applies to the unique patient situation

Systems Based Practice

- Understand nuances of ancillary staff roles (social service, case management, nutrition, physical/occupational therapy, home care services, hospice care) in support of patient care
- Describe barriers of current system to provide effective care to our patient population, and consider strategies to improve that system
- Learn the role of ancillary staff (social service, case management, nutrition, physical/occupational therapy, home care services, hospice care) in the care of the EM patients
- Understand EMTALA and the role of the transferring physician and hospital

At the completion of the rotation, in addition to the objectives for a PGY2 resident, a PGY3 resident should:

Patient Care

- Teach prioritization skills to interns, medical students, and/or ancillary staff (and possibly co-residents) on the service.
- Recognize errors and omissions in the management of interns or ancillary staff when applicable
- Manage and guide use of limited resources (fellow residents, ancillary staff) and direct those resources to attend to problems in order of priority

Medical Knowledge

- Describe the indications, contraindications, risks and benefits of common and uncommon medicines and procedures used in the EM setting, including patients on other service

- Become familiar with and utilize newer technologies in EM and trauma care

Interpersonal and Communication Skills

- Overcome barriers and engage in respectful, productive conversations with difficult patients and families
- Effectively communicate with ancillary staff and develop an understanding of how they may view problems differently.
- Demonstrate the ability to be the leader of the EM health care team
- Build bridges with all nursing and ancillary staff to improve communication
- Ensure effective and safe patient hand-offs

Professionalism

- Show ability to professionally manage challenging ancillary staff relations

Practice Based Learning

- Develop understanding of new therapies and paradigms of care for common and unique EM problems
- Develop understanding of surgical and interventional techniques via observation as well as participation in procedures on patients followed by resident

Systems Based Practice

- Understand pharmacoeconomic issues including medication costs and insurances
- Understand costs to society of new imaging modalities in a value-based system
- Understand the role and efficacy of ancillary staff in disease management
- Manage an area of the Emergency Department and all aspects of its functions

3. Duty Hours/Rotation Schedule

- A schedule will be distributed prior to the rotation.
- A resident will not work more than 60 scheduled hours per week seeing patients in the Emergency Department and not more than 72 duty hours per week
- Duty hours comprise all clinical duty time and conferences, whether spent within or outside the residency program.
- While on duty in the Emergency Department, residents may not work longer than 12 continuous scheduled hours and there must be at least an equivalent period of continuous time off between scheduled work periods.

4. Teaching Methods

- Residents will be exposed to a full spectrum of problems and age ranges.
- Residents will receive bedside teaching from EM Faculty and Attending Physicians during their clinical shifts.
- Residents will provide initial assessment and present all patients to the Attending Physicians. Focus should be an expeditious assessment of the presenting complaint, concise clinical presentation to the attending colleague, and appropriate triage.
- The resident should share learning experiences with fellow residents and students.
- Residents will be given adequate time to provide a concise handoff using iPASS.

5. Types of Clinical Encounters

The resident's rotation experience will center on the Emergency Medicine patient. The resident will have firsthand experience with all types of patient presentations as well as a direct role in evaluation, management, and disposition.

6. Procedures

The resident will have the opportunity to assist with and perform procedures in the ED with the appropriate supervision. Such procedures may include but are not limited to intubations, lumbar punctures, central venous catheter placement, chest tube placement, suture repair, wound management, arterial blood gas, blood draws, and peripheral intravenous line placement.

Emergency Bedside Ultrasound will also be utilized during each EM rotation on appropriate patients.

All procedures and resuscitations must be logged into New Innovations for confirmation by the supervising Attending Physician.

7. Resident Supervision

Residents are under direct supervision or indirect supervision in the Emergency Department with direct supervision immediately available at all times.

Oversight for procedures is provided by the board-certified or board-eligible Emergency Medicine supervising physician, with feedback given immediately after the procedure is completed. Progressive supervision will be given based on the PGY level and the resident milestones achieved as reported by the Clinical Competency Committee and Program Director.

8. Computer Access

All residents will have access to the electronic medical record (EMR). During orientation, all residents will be required to attend Reading Health Connect training concerning the electronic medical record in their PGY-1 year. Chestnut Hill also uses Epic for clinical care.

9. Reading List and Educational Materials

Educational materials are provided online via the Electronic Medical Library, as well as on program issued iPads. PEPID, DynaMed Plus, and UpToDate are also readily available for reference via the online medical library.

10. Method of Evaluation

The resident will receive a general global evaluation of their performance as well as an evaluation according to specific outcome goals, which are reviewed at the beginning of the rotation. The resident will be provided feedback daily after their shift by the Attending Physician who he or she has worked with during the shift. Residents will also be provided with written end of rotation evaluations by the teaching faculty. Additional evaluations will be provided by nursing, ancillary staff, peers, and patients.

11. Points of importance

3. Documentation:

- Residents will document each patient encounter in the EMR.
- Attending Physicians must attest to the resident note and add additional information as needed.
- Residents assign their note for attestation to the Attending Physician of record.
- All orders should be clearly communicated to the patient's bedside nurse.

4. Number of Patients Evaluated

- The number of patients evaluated will be dependent on the volume of patients in the ED as well as the complexity of patients. On average,
 - PGY-2 are expected to evaluate between 0.85-1.33 patients per hour
 - PGY-3 are expected to evaluate between 1.05-1.41 patients per hour

- Patients per hour may vary depending on severity of illness and the area in which the resident is assigned.

12. Housing and Transportation

Due to the distance from the primary academic site, residents will be provided with housing at Chestnut Hill College which is a few blocks away from the hospital. They will also be offered transportation when they are traveling to and from Chestnut Hill Hospital/Reading Hospital.

Curriculum in Emergency Ultrasound (PGY-1)

2. **Educational Purpose:** This course is designed for PGY1 residents and will be tailored to their level of clinical competency. The resident is expected to gain a proficient level of competency in Emergency Ultrasound (EUS) that allows for the expeditious evaluation, treatment, and diagnosis of pathologies central to the practice of Emergency Medicine. Through completion of this course residents will be expected to know when and how to use EMBU as an adjunct to their clinical skills for both procedures and diagnostics.
3. **Brief Rotation Description:** This is a 4-week rotation designed for PGY1 residents to gain first-hand experience in the use of EUS. While most learning will take place in a clinical setting at the patient's bedside, there will also be an appropriate amount of learning through didactic lectures and clinical skills workshops, including the use of SonoSim. Residents will learn the basic principles behind the functions of the ultrasound, proper technique for procedures and diagnostic evaluation, and how ultrasound can complement the physical exam. SonoSim modules will be available to assist in the initial education of the resident. Residents will also have weekly dedicated time with the cardiology department, performing and reviewing echocardiograms, and with the ultrasound department performing ultrasounds and interpreting with radiologists.
4. **Competencies/Goals and Objectives:** By the end of the course, residents will be expected to be facile with EUS so they can use it for procedures as well as obtain images for diagnosing core applications. The core applications for EUS, as outlined in the ACEP Policy Statement: "Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine" (June 2016), are in the areas of:
 - i. Trauma
 - ii. Intrauterine Pregnancy
 - iii. AAA
 - iv. Cardiac
 - v. Hemodynamic Assessment
 - vi. Biliary
 - vii. Urinary Tract/Renal
 - viii. DVT
 - ix. Soft-tissue/musculoskeletal
 - x. Thoracic/Airway
 - xi. Ocular
 - xii. Bowel
 - xiii. Procedural Guidance
 - b. **Objectives**
 - i. Perform the above scans both in a simulation setting as well as on patients in the ED (PK, MK)
 - ii. Understand the uses of ultrasound in specific clinical circumstances (MK, PC)
 - iii. Understand the "knobology" of the ultrasounds used in the ED (MK, PC)
 - iv. Treat patients with respect and demonstrate patient modesty and compassion during scans (P, IPC)
 - v. Continuously assess performance to promote growth and improvement of skills (PBL)
 - vi. Understand how the use of bedside ultrasound integrates into the Emergency Department and Health System as a whole (SBP)

5. **Teaching Methods/Rotation Schedule:** Residents will attend clinical shifts alongside the EUS Course Director for bedside instruction. There will also be didactic sessions to review images, recordings, and cases related to patients seen in prior week. Residents will rotate weekly with the ultrasound and cardiology departments obtaining images. They will also review interpretation of echocardiograms and ultrasounds with the cardiologists and radiologist. Two clinical skills workshops will take place to practice infrequently encountered procedures. Residents will also have access to the SonoSim modules. All duty hours will be strictly adhered to at all times. Residents will be excused from their clinical duties for planned didactic conferences.
6. **Types of Clinical Encounters:** Residents will be expected to screen patients in the emergency department to determine the appropriateness for EUS guided care through procedural assistance and/or diagnostic imaging. When patients are deemed appropriate, the resident will offer their assistance to the treating provider and after approval will conduct their evaluation. The EUS Course Director will be available for assistance, direction, and clinical evaluation of the resident.
7. **Procedures:** Through completion of the rotation, residents will be expected to be able to use EUS for procedural assistance (e.g. central line placement, abscess drainage, paracentesis, etc), resuscitation evaluation, adjunct to the physical exam, and diagnostic imaging with relation to the core applications.
8. **Resident Supervision:** The resident will work along-side the EUS course director during the rotation for both direct and indirect supervision. The degree of procedural supervision will correlate to the skill level of the resident. In most cases, residents will be under indirect supervision with direct supervision immediately available at all times.
9. **Reading List and Educational Materials:** Educational materials are provided online via the Electronic Medical Library, as well as on program issued iPads. There are also a variety of textbooks available in the Emergency Department for quick reference. PEPID and Up To Date are also readily available for reference. SonoSim will be used for educational modules as asynchronous learning.
10. **Method of Evaluation:** Evaluation will be conducted at the bedside, in procedural workshops, and through written examination at the completion of the rotation. SonoSim modules completion will also be evaluated as part of the resident evaluation.
11. **Points of importance:** This course is will act as a basis for the clinical skills and knowledge needed to use EUS in clinical practice throughout residency and beyond. Residents are expected to continue to grow in their fund of knowledge as well as clinical skill set during their residency.

EMS Curriculum (PGY-2)

1. Educational Purpose:

- a. To understand general concepts of Emergency Medical Services (EMS)
 - i. EMS System Organization
 - ii. EMS Operations
 - iii. EMS Education
 - iiii EMS and its relationship with the Emergency Department (ED)
- b. To become competent in medical direction both on and off-line
 - i. Become familiar with EMS Protocols
 - ii. Become familiar with roles and skill sets of EMS providers
 - iii. Become a medical command physician
- c. To understand utilization of aeromedical transport in the healthcare system
- d. To become familiar with disaster medicine and the ED role in mass casualty and disaster situations.

2. Brief Rotation Description:

Residents shall gain knowledge and experience of the pre-hospital environment. In order to accomplish this goal, the residents will rotate with ambulance services in Berks County. They will also be offered the opportunity to rotate with PennStar, on an aeromedical rotation. The residents will meet with the EMS director regularly to review EMS and disaster medicine topics. Residents will also participate in mass casualty drills at least twice during their residency.

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4. Competencies/Goals and Objectives

- a. **Patient Care:** Residents shall be able to provide competent, compassionate, appropriate, and effective patient care to pre-hospital/EMS patients for the treatment of acute health problems while also advocating for the promotion of health.
- b. **Medical knowledge:** Residents shall demonstrate knowledge about established as well as ever changing and new clinical, biomedical and cognitive sciences and the appropriate application of such knowledge in the pre-hospital/EMS setting. Residents will also be exposed to disaster medicine and learn about the various types of disasters and the roles they will play in diagnosis, management, and disposition of patients during a disaster or mass casualty incident.
- c. **Practice Based Learning Goals:** Residents shall demonstrate their ability to investigate, evaluate their own patient care practices as well as evaluate and assimilate scientific evidence and thereby improve their own practice based on knowledge and experience acquired while on EMS service.
- d. **Interpersonal & Communication Skills and Goals:** Resident must be able to demonstrate interpersonal and communications skills which result in effective education and information exchange with their patients, patients' families as well as other team members and professional associates all with diverse background and experiences. They will learn effective communication and handoff skills in the pre-hospital and ED environment.

e. **Professionalism Goals:** Residents must demonstrate a commitment to professional responsibilities, adherence to ethical practices, and sensitivity to a diverse patient and professional population.

f. **Systems-based practice goals:** Residents shall demonstrate an awareness the role of EMS in the health care system. They will also understand EMS role in the transport of patients between facilities.

5. Teaching Methods/Rotation Schedule

- a. Schedule will be distributed prior to the two-week rotation in the PGY-2 year
- b. Resident shall not work longer than 12 continuous scheduled hours and there must be at least an equivalent period of continuous time off between scheduled work periods.
- c. Utilize New Innovations to log all procedures and resuscitations.
- d. Residents will be exposed to a full spectrum of problems and age ranges.
- e. Resident will provide initial assessment and present all patients to their supervision physicians. Focus should be an expeditious assessment of the presenting complaint, concise clinical presentation to your attending colleague, and appropriate triage.
- f. The resident should share learning experiences with fellow residents and students
- g. Teaching will be based upon the EM Model topics as well as EM milestones and core competencies as outlined by the ACGME.

6. Types of Clinical Encounters

- a. The resident's rotation experience will center on the pre-hospital emergency medicine patient. The resident will have firsthand experience at all types of patient presentations as well as having a direct role in management.

7. Procedures:

EM resident will have the opportunity to participate in as well as perform procedures in the pre-hospital setting with appropriate supervision within the scope of practice of pre-hospital providers.

Procedures include but are not limited to endotracheal intubation, peripheral IV insertion, and wound management.

All procedures are to be logged and confirmed by the supervising attending physician.

8. Resident Supervision:

EM Resident shall be under the overall supervision of the Chair of the Department of Emergency Medicine and the daily supervision of the EMS provider to whom they are assigned.

9. Reading List and Educational Materials:

- a. Emergency Medicine (Tintinalli's) – Sections 1 and 2
- b. Assigned readings from EMS Journals

10. Method of Evaluation:

The resident will receive a general global evaluation of their performance as well as an evaluation according to specific outcome goals, which are reviewed at the beginning of the rotation. The resident will be provided feedback from the EMS crews they rotate with daily. Residents will also be provided with written end of rotation evaluations by the teaching faculty.

11. Points of Importance:

Residents will be offered the opportunity of an aeromedical experience. They must complete the PennStar waiver, as well as the application to ride as an observer. This experience is optional and will not affect the evaluation of the resident.

NEUROLOGICAL/NEUROSURGICAL INTENSIVE CARE UNIT (NSICU) (PGY-2)

1. **Educational purpose:**

The purpose of the Neurological/Neurosurgical Intensive Care Unit (NSICU) is to provide the EM resident with experience in the evaluation and management of variety of patient with neurological emergencies/illnesses with emphasis on the multidisciplinary approach. Such illnesses include ischemic and hemorrhagic stroke, subarachnoid hemorrhage, status epilepticus, central nervous system infections, myasthenia gravis, spinal cord injury, traumatic disorders of the head and brain (skull fracture/intracranial hemorrhage)

2. **Trainees:**

Department of Emergency Medicine PGY2 resident

3. **Course Director:** James Peoples, MD

4. **Rotation contact:** Deb Dreisbach

5. **Method of Evaluation:** Direct observation by the attending physician. The attending will provide regular formative feedback, midterm assessment of performance, and final summative evaluation in each of the six competency areas with particular focus upon the objectives described below

6. **Location:** Reading Hospital, NSICU

7. **Required Reading:**

a. Emergency Medicine 7th ed. (Tintinalli's)

i. Section 14

ii. Section, 21, Head Trauma, Spine and Spinal Cord Trauma

b. Educational materials are provided online via the Electronic Medical Library, as well as on program issued iPads. There are also a variety of textbooks available in the Emergency Department for quick reference during admissions. PEPID and Up To Date are also readily available for reference

8. **Goals and Objectives:**

- Gain an understanding of the multidisciplinary nature of the NSICU (**PC, SBP**)
- Gain a deeper understanding of which Emergency Department patients require NSICU admission, why, and what happens when they reach the NSICU (**PC, MK, SBP**)
- Demonstrate understanding of the following disease processes: (**PC, MK**)
 - Ischemia Stroke
 - Hemorrhagic Stroke
 - Subarachnoid Hemorrhage
 - Central Nervous System (CNS) Infections
 - Myasthenia Gravis
 - Seizure (including status epilepticus)
 - Traumatic Disorders of the Head and Brain
 - Skull Fractures
 - Intracranial Hemorrhage
- Demonstrate knowledge of indications, contraindications, complications, and technique of performing the following procedures: (**PC, MK**)
 - Arterial Cannulation: Radial/Femoral
 - Central Venous Cannulation: Internal Jugular, Subclavian, Femoral, all with and without ultrasound guidance

- Endotracheal intubation
- Bronchoscopy
- Lumbar puncture
- Ventriculostomy
- Bedside Tracheostomy
- Spinal Immobilization and Stabilization
- Demonstrate knowledge and appropriate interpretation of the following diagnostic studies: **(PC, MK)**
 - Intracranial Pressure (ICP) Monitoring
 - Central Venous Pressure (CVP) Monitoring
 - Arterial Blood Gas (ABG)
 - Mixed Venous Blood Gas
 - Oxygen Saturation
 - Spirometry
 - Declaring Brain Death
- Demonstrate knowledge and appropriate use of the following therapeutic options: **(PC, MK)**
 - Pressor use
 - Antihypertensive Use
 - Modalities to decrease ICP
 - Steroid use for spinal injuries
 - Blood product administration

9. **Types of Clinical Encounters:**

The resident will be responsible for a full spectrum of patients requiring care in the NSICU. Problems include, but are not limited to ischemic and hemorrhagic stroke, subarachnoid hemorrhage, status epilepticus, central nervous system infections, myasthenia gravis, spinal cord injury, traumatic disorders of the head and brain (skull fracture/intracranial hemorrhage)

10. **Teaching Methods/Rotations Structure:**

Participate fully as a member of the NSICU team, which includes: **(PC, PBL, C, P, SBP)**

- a. Work all clinical hours as assigned per NSICU standards (while abiding by ACGME work hour limits)
- b. Follow an equivalent number of patients as other team members
- c. Communicate clearly with other members of the NSICU team including:
 - i. Attendings
 - ii. Residents
 - iii. Consulting services
 - iv. Nursing
 - v. Pharmacologist
 - vi. Social workers
 - vii. All other team members
- d. Consistently demonstrate high professional standards including:
 - i. Behavior
 - ii. Punctuality
 - iii. Attention to detail
 - iv. Dedication

11. **Admissions/Rounds**

- Report to the NSICU at 0600 the first day of the month (regardless of if it is a weekday or weekend **(P)**)
- Attend and participate in all NSICU didactic experiences **(MK, PBL, P)**
- Attend and participate in all Department of Surgery, Neurosurgery, and Neurology didactic experiences that are attended by the NSICU team **(MK, PBL, P)**
- You are excused to attend all EM didactic sessions **(MK, PBL, P)**

12. **Resident Supervision**

The resident will be under the direct supervision of the attending physician at all times, as described in the department manual. The attending will be informed immediately for all admissions to the ICU and will approve such admissions. The attending will review the case with the admitting resident and determine how acutely the attending should be personally available; therefore, the level of supervision will be either direct supervision or indirect supervision with direct supervision immediately available depending on the case. The attending physician will personally evaluate all patients daily and will provide daily feedback to the resident.

Neonatal Intensive Care Unit (NICU) Rotation (PGY-2)

Educational Purpose and Goals: The educational purpose of the Neonatal Intensive Care Unit (NICU) Rotation is to expose the Emergency Medicine resident to neonatal emergencies including resuscitation, stabilization, and the general care of newborns admitted to the NICU.

Brief Rotation Description:

Residents will work side by side with board-certified or board-eligible neonatologists to care for the needs of the NICU patient. They will participate in and become more familiar with Neonatal resuscitations as well as the general care of the neonatal ICU Patient.

Training Level: PGY-2

Length of rotation: 4 weeks

Call/In house: As per the NICU course director but within the ACGME guidelines for duty hours

Course Director: Nicholas Obiri, MD; Section Chief, Neonatology

Objectives of the Rotation:

Medical Knowledge

1. The resident will be able to discuss the following topics in the pathophysiology and management of newborn care:

Fluid electrolytes and nutrition

Temperature control

Hyperbilirubinemia

Respiratory distress syndrome

Chronic lung disease

Pathophysiology and management of anemia

Intracerebral hemorrhage

Infants of diabetic mothers

Neonatal infections

Hypoxic ischemic encephalopathy (HIE)

Apnea and sudden infant death syndrome

Intrauterine growth (normal and abnormal)

Congenital infections

Neonatal Abstinence Syndrome

Intrabdominal emergencies including necrotizing enterocolitis

Patient Care

1. The resident will be able to demonstrate skills, including suctioning and intubation, that are essential for the resuscitation and stabilization of the distressed newborn.
2. Residents will develop and demonstrate skills in vascular access including umbilical access and intraosseous placement, as well as lumbar puncture.
3. The resident will demonstrate knowledge and skills to become NPR (Neonatal Resuscitation Program) certified prior to the course and utilize these skills while caring for patients on rotation.

Practice Based Learning

1. Accept formative feedback and utilize it to develop the ability to continually improve one's patient care.

2. Identify, analyze and utilize evidence-based information to improve patient care and enhance practice performance.
3. Assess one's own strengths and weaknesses regarding the knowledge and skills learned on this rotation.

Communication/Interpersonal Skills

1. Demonstrate the ability to take an appropriate history and present information effectively in verbal and written form.
2. Demonstrate the ability to clearly explain medical information and provide education to patient's families.
3. Demonstrate the ability to communicate and work effectively with other members of the health care team.

Professionalism

1. Demonstrate compassion and respect for all patients.
2. Demonstrate integrity and ethical behavior in all aspects of one's physician duties.
3. Demonstrate sensitivity for diversity among patients, including issues of race, gender, culture and socioeconomic status.
4. Demonstrate understanding of the role of race, gender, culture and socioeconomic status in illness and access to health care resources.

Systems-Based Practice

1. Demonstrate the ability to work as a member of a health care team understanding the role of each care provider.
2. Demonstrate awareness of various health resources available through medical, social service, and other community health resources.
3. Demonstrate the ability to make appropriate referrals, provide consultation and follow-up care in one's primary care role in the local health care system. Demonstrate the ability to co-ordinate patient care, utilizing appropriate community resources.

Recommended Readings:

Tintinalli: Chapters 114-116

Gomella's Neonatology – Eighth Edition

Assigned readings as per course director

Duties and Responsibilities:

1. Report to orientation in Dr. Obiri's office at 8 AM on first day
2. The resident is expected to attend any NICU conferences during the rotation
3. Residents will be excused when appropriate for their Emergency Medicine didactic sessions
4. Residents are expected to be in the NICU during their shift to optimize educational experience
5. Residents will have one week of night float 7P-7A
6. Residents will be expected to be present for sign-out and rounds at 8 AM daily when not on night float (Monday-Friday)

Evaluation:

The resident will receive timely prospective feedback from attendings. A written summative evaluation will be provided at the conclusion of the rotation.

Observational Medicine Rotation (PGY-1)

Educational Purpose:

The purpose of this rotation is to introduce Emergency Medicine (EM) Residents to the field of Observational Medicine. As the health care system changes from hospital-centric to ambulatory-focused, more patients are qualifying for observation status. This two-week rotation will provide the EM Resident with insight into the role of Observation in the health system as well as introduce them to appropriate patient populations and management of these populations.

Brief Rotation Description

This rotation occurs during the EM resident's intern year. The resident will spend two weeks on the Observation Service which is directed by the Hospitalist program. The resident will be expected to assist with patient placement orders, evaluations, treatment plans and discharges. They will work hand in hand with the hospitalist to ensure quality of care and safety of the patient during their stay in the Observation area.

Contact Information

- a. Rotation/Course Director: John Derderian, MD
 - i. 484-628-5556 or john.derderian@towerhealth.org
- b. Location: R4 Observation Unit or R3South Observation Unit

Competencies/Goals and Objectives:

- a. **Goals:** The overall goal of the rotation is to ensure EM residents are exposed to observational service and understand the role of observation in the health care system.
- b. **Objectives:**
 - a. Introduce the resident to observational medicine (MK, PC, SBP)
 - b. Discover the types of disease processes that lend themselves to observational medicine (MK, PC, SBP)
 - c. Perform focused history and physical examinations on observation appropriate patients (MK, PC)
 - d. Recognize patients who are more appropriate for an alternative level of care and ensure safe transfer to those services (PC, MK, SBP, PBL)
 - e. Arrange appropriate disposition and follow up for patients as needed (SBP, PC)
 - f. Ensure accurate communication across all transitions of care and patient handoffs (P, IPC)
 - g. Provide compassionate, professional care to patients evaluated (P, IPC)
 - h. Maintain professionalism at all times (P)

Teaching Methods/Rotation Schedule

- a. Residents will rotate Monday through Friday from 7AM to 7 PM on the service. They will be excused from their patient care responsibilities to attend EM didactic sessions. Residents will be expected to review the reading list and to meet with the director of the course to ensure their comprehension of the material. Residents will be responsible to provide appropriate handoff of their patients at the end of their shift.
- b. Residents may also be able to attend Lunch and Learn or Internal Medicine conferences at noon as time permits.

Types of Clinical Encounters

Residents will only be responsible to evaluate and treat patients who qualify and are placed in observation. They will participate in all clinical rounds and will be responsible for no more than five patients at a time while on service.

Procedures

Residents may perform procedures under the supervision of the hospitalist service as the patient's care dictates. These procedures may include but are not limited to arterial blood gases, peripheral IVs, arthrocentesis, and lumbar punctures.

Resident Supervision

Residents will be supervised under indirect supervision by the hospitalist service physicians with direct supervision immediately available at all times.

Reading List and Educational Materials

- c. **Emergency Medicine, Tintinalli's**
 - i. Syncope
 - ii. Chest Pain
 - iii. Asthma
 - iv. Abdominal pain
 - v. Deep Vein Thrombosis
 - vi. Spinal Headaches
- d. Materials assigned by the Attending Physician in Observation Unit

Method of Evaluation

Residents will be evaluated by their supervising Attending Physician on the service using New Innovations. They will be evaluated on the course objectives and goals as well as the six core competencies and EM milestones appropriate for this service.

Obstetrics Rotation (PGY-1)

1. Educational Purpose: The purpose of the Obstetrics rotation is to introduce the EM resident to the care of the Obstetric patient. They will also be exposed to common non-obstetrical emergencies while on rotation via consults while on service.

2. Brief Rotation Description: This rotation exposes the resident to the process of labor and delivery with an emphasis on building the medical knowledge, procedural skills and judgment. The resident on this rotation will learn to recognize the various common Obstetrical labor and delivery medical conditions that a patient may present with during pregnancy. In addition, they need to develop basic proficiency in interpretation of fetal monitoring, common procedures and work flow processes needed to care for the Obstetrical patient. Residents will also be exposed to common and uncommon obstetrical issues early in pregnancy, as well as in the later trimesters.

3. Course Director:

Peter Schnatz, DO – Residency Director, Obstetrics and Gynecology

Peter.schnatz@towerhealth.org

Terri Chervanick- Residency Manager, Obstetrics and Gynecology

Terri.chervanick@towerhealth.org

4. Competencies/Goals and Objectives:

a. Goals

- i. Provide knowledge of common and uncommon obstetrical conditions in all trimesters of pregnancy (MK, PC)
- ii. Understand the role of the ED physician in initial diagnosis and management of obstetric conditions (PC, SBP, MK)
- iii. Gain knowledge of procedures and equipment used when caring of the obstetric patient (MK, PC)
- iv. Develop skills in the examination of the obstetrical patient (MK, PC, P, IPC)
- v. Learn about non-obstetrical conditions including vaginal bleeding, contraception, pelvic pain, and vagina discharge (MK, PC)

b. Objectives

At the conclusion of the rotation the resident will be able to as assessed by the Chief Resident and Dr. Schnatz

1. Accurately and efficiently admit a patient to the maternity floor performing a focused Obstetrical History and Physical (MK, PC)
2. Identify/recognize common fetal Monitoring tracings and their meaning within the context of the overall labor process. (MK, PC)
3. Identify and know the importance and management of common obstetrical medical problems as they commonly present such as pre-eclampsia, pre-term labor, premature rupture of membranes, chorioamnionitis, shoulder dystocia, post-partum hemorrhage. (MK, PC)

4. Demonstrate their ability to correctly and accurately perform a gynecological exam. (PC, MK)
5. Demonstrate the ability to treat vaginal bleeding in obstetric and non-obstetrical patients (PK, MK)
6. Demonstrate the ability to diagnose and treat genitourinary infections (PC, MK)
7. Discuss various contraceptive methods as well as their potential complications (PC, MK)
8. Discuss the normal stages of labor (PK, MK)
9. Demonstrate the ability to manage non-complicated and complicated vaginal deliveries (PC, MK)
10. Demonstrate the ability to manage post-partum complications including but not limited to retained products, endometritis, and mastitis (PC, MK)
11. Discuss RH incompatibility (PC, MK)
12. Accepts formative feedback and utilizes it to develop the ability to continually improve one's patient care. (PBL)
13. Identify, analyze and utilize evidence-based information to improve patient care and enhance practice performance. (PBL, MK, PC)
14. Assess one's own strengths and weaknesses regarding the knowledge and skills learned on this rotation. (PBL, MK)
15. Demonstrate the ability to take an appropriate history and present information effectively. (PC, IPC)
16. Demonstrate the ability to clearly explain medical information and provide education to patients and families. (PC, IPC)
17. Demonstrate the ability to communicate and work effectively with other members of the health care team. (IPC, P)

4. Demonstrates compassion and respect for all patients with an understanding of the role of race, gender, culture and

18. socioeconomic status in illness and access to health care resources. (P, PC)
19. Attends all scheduled sessions (or notifies the appropriate personnel in a timely fashion). (P)
20. Completes all of the assignments in a timely fashion. (P)

21. Demonstrates the ability to work as a member of a health care team with an understanding the role of each care provider. (SBP)
22. Demonstrates awareness of various health resources available through medical, social service, and other community health resources. (SBP)
23. Demonstrates the ability to make appropriate referrals, provide consultation and follow-up care in one's primary care role in the local health care system. (SBP)

5. Teaching Methods/Rotation Schedule:

- c. Residents will spend two weeks on night float on the Labor and Delivery Service. They will be scheduled to work from 7P-7A from Friday to Monday weekly. They will be excused to attend the weekly EM didactic sessions.
- d. Residents will spend an additional two weeks in OB Triage on R2. They will work Monday-Friday from 7A-4P and be excused for their weekly EM didactic sessions. Residents are encouraged to attend OB conferences held each Morning at 7 AM.

6. Types of Clinical Encounters:

- e. Residents will be exposed to a variety of patients while on the OB service including inpatient and outpatients. They will also be assisting in consultations in the ED while on the OB service.

7. Procedures (include but are not limited to):

- f. Vaginal deliveries
- g. Gynecologic examinations
- h. C-sections

8. Resident Supervision

- i. Residents will be under direct supervision of the OB Attending Physicians during deliveries. They will be under indirect supervision with direct supervision immediately available at all times during the rotation. An OB Attending Physician is available in house 24/7.

9. Reading List and Educational Materials:

- j. Emergency Medicine (Tintinalli's) – Section 11
- k. Assigned reading from the course director

10. Method of Evaluation:

- l. Residents will be evaluated at the conclusion of the rotation by the course director based on feedback from the Attending Physicians, OB Chief Resident, senior residents on the rotation.

Orientation Month (PGY-1)

1. **Educational Purpose:** The purpose of the orientation month is to expose the residents to both Tower Health and the Emergency Department. Residents will begin working clinically in the Emergency Department after their hospital and department orientation. They will also have a variety of didactics concerning basic Emergency Medicine topics, including procedural workshops.

2. **Course Director: Kristen Sandel, MD**
Kristen.sandel@towerhealth.org
484-628-4224

3. **Course Contact: Leah Stephens**
Leah.stephens@towerhealth.org
484-628-3529

4. **Brief Rotation Description:** Residents will initially complete both their hospital and department orientations. They will also complete ALCS, ATLS, and PALS during the rotation. Didactic sessions will be held to introduce Emergency Medicine residents to basic emergency medicine topics including procedural instruction. Residents will also be expected to work clinical shifts in the Emergency Department to orient them to the department, staff, and patient care. They will have their orientation to resident wellness as well during this block.

5. **Competencies/Goals and Objectives:**
 - a. **Goals:**
 - i. Provide residents with basic knowledge of typical emergency medicine clinical situations and diagnoses. (MK, PC)
 - ii. Introduce residents to the Emergency Department and its relationship to the health care system (SBP)
 - iii. Provide skills laboratory sessions on basic emergency medicine procedures (MK, PC)
 - iv. Introduce residents to patient handoff skills and other communication skills. (PC, IPC, P)
 - v. Provide residents the ability to develop a rapport with attending physicians, Emergency Department staff and other residents. (IPC, P, SBP)
 - vi. Introduce the residents to practice-based learning and improvement as well as self-evaluation of performance. (PBL)
 - b. **Objectives:**
 - i. Develop a basic understanding of common emergency department complaints. (MK, PC)
 - ii. Developed an approach to common complaints in countered in the emergency department. (MK, PC)
 - iii. Become certified in ACLS, ATLS, PALS (MK, PC)
 - iv. Development of familiarity with both Hospital and Emergency Department administrative procedures. (SBP)
 - v. Become familiar with common procedures performed by Emergency Medicine physicians. (MK, PC)

- vi. Develop an understanding of documentation in the emergency department using the electronic medical record. (P, MK, PC)
 - vii. Developed an understanding of documentation required for coding and other administrative purposes (P)
 - viii. Develop an understanding of the emergency department place in the healthcare system (SBP)
 - ix. Develop strategies to appraise clinical work and to improve based on the appraisal (PBL)
6. **Teaching Methods/Rotation Schedule:** Rotation schedule be distributed to the residents prior to arrival to the residency program. All duty hours will be strictly enforced. Residents will participate in didactic conferences and will be excused from clinical duties to participate. A list of didactic experiences will be provided at the start of the rotation.
7. **Types of Clinical Encounters:** Residents will evaluate patients in the Emergency Department during this rotation. They will be under the supervision of Attending Physicians and Senior EM residents when available.
8. **Procedures:** Procedure workshops will be held during this rotation. Procedures in countered will include but are not limited to
- a. Endotracheal intubation
 - b. Arterial line insertion
 - c. Central venous catheter placement
 - d. Cardiac Pacing
 - e. Chest tube placement
 - f. Peripheral IV
 - g. Interosseous lines
 - h. Pericardiocentesis
 - i. Hemocult evaluation
 - j. Lumbar Puncture
 - k. Procedural sedation/pain management/Anesthesia
 - l. Adult Traumatic resuscitations
 - m. Adult Medical resuscitations
 - n. Pediatric resuscitations (trauma and medical)
 - o. Cricothyroidotomy
 - p. Pelvic examination
 - q. Wet mount interpretation
 - r. Dislocation reduction
 - s. Wound Management
9. **Resident Supervision:** Residents will have indirect supervision with direct supervision immediately available at all times in the clinical areas.
10. **Reading List and Educational Materials:**
- a. Required reading will be distributed to the resident's prior to and during the rotation.
 - b. Additional reading materials may be distributed during the rotation based on the area of focus for the experience.

11. **Method of Evaluation:** Residents will be evaluated daily during their clinical shift in the Emergency Department. They will also be evaluated on their level of participation and engagement during the didactic sessions. Residents will receive a global evaluation at the end of the rotation.

Orthopedics/Sports Medicine/Radiology Curriculum (PGY-2)

1. **Educational Purpose:** The purpose of the orthopedics/sports medicine/radiology rotation is to introduce the EM resident to the emergent aspects of orthopedic care, as well as the role of sports medicine in the health care system. During this rotation, residents will also be exposed to the radiology aspect of EM and orthopedics by reviewing radiologic studies with board-certified radiologists.
2. **Brief Rotation Description:** Residents will be exposed to orthopedic emergencies and urgent issues while rotating with the orthopedics service. They will be able to evaluate and treat patients seen in the ED who are referred to the orthopedics service for continued care. They may also be part of the consultation team treating patients with emergent orthopedic issues in the ED. Residents will also rotate with our Sports Medicine physicians for a non-operative sports medicine experience. In addition, the residents will spend time with an attending radiologist reviewing radiologic studies from the ED and other areas of the health system.
3. **Core Directors:** Gary Canner, MD – orthopedics, Brent Wagner, MD - radiology
4. **Course Contact:** Same as directors
5. **Competencies/Goals and Objectives:**
 - a. **Goals:**
 - i. Provide residents with an understanding of the field of sports medicine and orthopedics (MK, PK, SBP)
 - ii. Introduce residents to orthopedic procedures they may be responsible to perform in an ED setting (PC, MK)
 - iii. Understand the role that radiology plays in the ED setting (MK, PC, SBP)
 - iv. Understand the types of radiologic studies available and their indications for ED patients (MK, PC)
 - v. Develop basic competency in reviewing radiologic studies commonly performed in the ED (MK, PC)
 - b. **Objectives:**
 - i. Develop an understanding of concussions and other non-orthopedic related sports medicine issues. (MK, PC)
 - ii. Develop competencies in splinting, casting, and removing casts (MK, PC)
 - iii. Perform reductions of joint dislocations and displaced fractures requiring reduction (MK, PC)
 - iv. Develop an understanding of normal anatomy and radiologic presentation in various mediums (MK, PC)
 - v. Develop skills in reviewing a variety of radiologic imaging (MK, PC)
 - vi. Learn indications for ordering radiologic studies based on patient presentations (PC)
 - vii. Understand limitations of radiologic studies in the care of the emergency patient (PC, MK)
 - viii. Understand the role of orthopedics and sports medicine in the health care system (SBP)
 - ix. Understand the utilization of appropriate and cost-effective testing, as well as evidence-based practice (SBP, PBL)

- x. Understand effective communication between health care providers as well as patients (IPC, P)
6. **Teaching Methods/Rotation Schedule:** Residents will spend two weeks to with Dr. Canner seeing patients in various healthcare settings. Residents may also cover sporting events at local colleges and universities. Schedule is based on the availability and office schedule of Dr. Canner. Residents will also spend one week with radiologist reading in the C1 radiology area. The schedule will generally be 8 AM -4 PM and be posted prior to the rotation. In most cases, there will be no nights or weekends, unless there is an athletic event that is being covered by Dr. Canner. Residents will also have the opportunity to take a week of vacation during this rotation.
 7. **Types of Clinical Encounters:** Residents will be exposed to both acute and ambulatory clinical encounters. They will participate in the care of the orthopedic emergency in the ED as well as the follow up care by orthopedics.
 8. **Procedures:** Procedures performed will include but are not limited to:
 - a. Joint reductions
 - b. Joint aspirations
 - c. Joint injections
 - d. Casting
 - e. Cast removal
 9. **Resident Supervision:** Residents will be under the indirect supervision of the orthopedics attending with direct supervision available at all times. Residents will be under the direct supervision of radiologist during this portion of the rotation.
 10. **Reading List and Educational Materials:**
 - a. Emergency Medicine (Tintinalli's) – Sections 22 and 23
 - b. Accidental and Emergency Radiology
 - c. Assigned reading as per the course directors
 11. **Method of Evaluation:** Residents will be evaluated formally by the course directors at the end of their rotations based on the clinical competencies. Informal feedback will be given daily by the attending physicians that the residents work with regularly.

Pediatric Curriculum (PGY1-3) **Emergency Medicine Residency**

Overview:

A. Clinical Expectations

- 1) Meet training requirements as outlined by the ACGME in accordance with the milestones
 - a. Five (5) FTE months, or 20% of all emergency department encounters, dedicated to the care of patients less than 18 years of age
 - i. At least 50% of the five months should be in an emergency setting
 - ii. This experience should include the critical care of infants and children
 - iii. At least 60% of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the emergency department must take place under the supervision of emergency medicine faculty members
 - iv. Each resident must maintain a record of all major resuscitations and procedures performed as they pertain to pediatric care
 - v. Residents will attend Department of Pediatrics educational conferences and pediatric specific material will be integrated into weekly didactic and journal club sessions
- 2) Efficiently obtain a comprehensive history and physical exam with appropriate documentation in the health record.
- 3) Provide a succinct oral presentation to the attending physician following pediatric patient interactions
- 4) Develop a comprehensive differential diagnosis, impression and management plan for each patient encounter.

B. Duty Hours

- 1) Residents will conform to ACGME and RHS duty hours:
 - a. Will not exceed 12 hours per emergency department shift with an additional 30-60 minutes to ensure safe and effective transition of care
 - i. Occasionally, residents may be permitted to continue the care of an ill or unstable patient, or a patient that provides an importing learning experience (this will be documented and tracked by the program director)
 - b. Residents will have at least 10 hours off between 12-hour emergency department shifts
 - c. Will not exceed 60 hours per week averaged over 4 weeks

C. Evaluations and Feedback:

- 1) Residents in the emergency department are under direct supervision or indirect supervision with immediate assistance readily available at all times by attending emergency medicine physicians
- 2) Residents will receive ongoing feedback from attending physicians during their pediatric emergency department time
 - a. Overall performance and progress in achieving ACGME/AOA core competencies will be summarized in written form at least once during the rotation
 - b. Evaluations will be maintained in a confidential file available to the resident
 - c. Files will be reviewed with the program director at least semi-annually
- 3) Residents are expected to take Pediatric Advanced Life Support (PALS) and will be evaluated on their knowledge of neonatal and pediatric resuscitation during PALS training and other simulated events

- 4) Residents will have the opportunity to discuss the rotation and make suggestions for improvement at any time
- 5) All procedures should be tracked during the rotation
- 6) At the rotation's end as well as during semi-annual review, any deficiencies will be identified by the residency director and pediatric rotation coordinator and corrected with a focused remediation program

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Yearly Goals:

PGY-1

- Provide initial care to pediatric patients with emphasis on quality of interactions and focus on common patient presentations
- Efficiently review previous records to inform current emergency department visit
- Learn to document patient encounters completely but efficiently
- Know first line-therapies for common EM conditions
- Gain proficiency in bag-valve-mask ventilation, lumbar puncture, suture repairs, splinting, intraosseous needle placement, nursemaid's elbow reductions, arterial blood gas procurement and other common procedures with appropriate supervision
- Understand the role of support services such as social work, case management, nutrition, physical/occupational therapy, home care services, hospice in the care of patients

PGY-2

- Increase proportion of higher acuity patients including trauma (primary and secondary surveys)
- Manage common issues independently
- Learn steps in initial approach to complicated or severely ill patients
- Possess knowledge of second-line therapies for emergency conditions and common side effects of medicines
- Continue to demonstrate procedural competence with addition of complex laceration repair, procedural sedation and endotracheal intubation
- Develop awareness of patient flow with emphasis on efficiency and increased quantity of patients seen
- Prioritize work tasks based on history, physical, and diagnostic studies
- Effectively lead family discussions, overcoming barriers to communication to teach patients about their diseases and treatment plan

PGY-3

- Continued progression toward increased numbers of higher acuity patients
- Lead medical resuscitations
- Manage more seriously ill patients independently from presentation to patient disposition, complete with initial history and physical examination, ordering of diagnostic studies and

therapeutic interventions, and serial reassessments to determine subsequent medical decision-making

- Describe indications, contraindications, risks and benefits of interventions used in the emergency medicine setting
 - Precept medical students when appropriate
 - Offer procedural and management guidance to more junior residents
 - Identify and rectify quality or safety threats to the care of patients
 - Master communications skills to successfully navigate “difficult” patients and families
 - Model safe and effective patient hand-offs for junior residents
 - Guide use of resources in the emergency department to attend to problems in order of priority
 - Understand the costs to society of certain interventions in a value-based system
- Competency Based Objectives:

- I. Patient Care: Care delivered should be family centered, developmentally age appropriate, compassionate and effective
 - a. Resuscitation
 - i. Recognize and assess emergent patients (seizure, shock, respiratory distress)
 - ii. Focused physical examinations with emphasis on ABCs
 - iii. Emphasize task prioritization
 - iv. Demonstrate effective closed loop communication with care team members
 - b. Acute Care
 - i. Focus on differential diagnosis and execution of management plans
 - ii. Clearly and empathically communicate with families
 - iii. Be attentive to analgesia and anxiolysis in the ill or injured child
 - iv. Provide practical anticipatory guidance and preventive care
 - c. Chronic Illness
 - i. Recognize parents and home care nurses as vital team members
 - ii. Communicate with and seek advice from primary care physicians and subspecialist consultants
 - d. Wellness
 - i. Advocate behaviors and preventative care that promote health throughout the hospital system
- II. Medical Knowledge: Understand the scope of biomedical, clinical, and epidemiological knowledge and demonstrate ability to acquire, interpret and apply it
 - 1) Apply Pediatric Advanced Life Support algorithms when appropriate including goal directed therapy in sepsis
 - 2) Demonstrate ability to form differential diagnoses for presenting problems
 - 3) Choose diagnostic tests appropriately based on differential diagnosis
 - a. Follow-up and interpret diagnostic tests
 - b. Distinguish normal from abnormal results
 - 4) Gain comfort with pathophysiology involving various organ systems and conditions:
 - a. Neonatal shock with understanding of etiologies and resuscitative measures
 - b. Diseases of the gastrointestinal tract such as gastroenteritis, pyloric stenosis, intussusception, appendicitis, volvulus, Meckel’s diverticulum, inflammatory bowel disease, intra-abdominal masses, upper and lower GI bleeding

- c. Diseases of the cardiovascular system including stroke, ischemic heart disease, heart failure including congenital disease and myocarditis
 - i. Differentiate cyanotic and non-cyanotic heart disease, management, and complication post-repair
 - ii. Approach to the patient with syncope or chest pain
 - iii. Demonstrate ability to interpret electrocardiograms with awareness of normal physiologic differences in children
 - d. Disease of the brain, spinal cord and peripheral nervous system such as stroke, meningitis, encephalitis, hydrocephalus, increased intracranial pressure, Guillan-Barre syndrome, myopathies
 - i. Child with altered mental status
 - ii. Approach to children with febrile and non-febrile seizures
 - e. Disease of the respiratory tract
 - i. Upper airway disease such as foreign body obstruction, epiglottitis, croup, tracheitis
 - ii. Lower airway disease such as bronchiolitis, asthma, pneumonia, cystic fibrosis
 - f. Endocrinologic disorders such as congenital adrenal hyperplasia and diabetes mellitus
 - g. Disorders of the blood and hematopoietic system such as anemia, leukopenia, thrombocytopenia, hemolytic disease, sickle cell disease, and various coagulopathies
 - h. Diseases of the kidneys and urogenital tract such as urinary tract infections, nephrolithiasis, hydronephrosis, glomerulonephritis, urolithiasis, urinary outlet obstruction, vaginitis, vaginal bleeding, balanitis, testicular torsion, phimosis and paraphimosis
 - i. Direct and indirect hyperbilirubinemia
 - j. Pediatric patients presenting with limp including fractures, arthritis, synovitis, osteomyelitis
 - k. Rheumatologic or autoimmune conditions such as hypothyroidism, celiac disease, juvenile idiopathic arthritis, dermatomyositis
 - l. Common toxicologic ingestions or exposures
 - m. Traumatic injuries including closed head injuries, concussions, blunt abdominal trauma, penetrating trauma, burns
 - n. Markers of physical or sexual abuse and neglect
 - o. Mental health illnesses
 - i. Identification of physical and emotional signs and symptoms of anxiety and depression and risk factors for suicide
 - p. Skin and soft tissue wounds, rashes and infections
 - i. Viral exanthems
 - ii. Petechiae or purpura
 - iii. Life-threatening eruptions such as Stevens-Johnson, toxic epidermal necrolysis, toxic shock syndrome, staph scalded skin
- 5) Perform common technical skills and procedures with understanding of the indications, contraindications, and possible complications
- a. These procedures include oral and nasopharyngeal airway placement, laryngeal mask airways, nasogastric and orogastric tube placement, intraosseous needle placement, endotracheal tube placement, lumbar

- puncture, suprapubic bladder aspiration, incision and drainage, nursemaid's elbow reductions, wound repair
- b. Read pediatric x-rays including musculoskeletal films and appropriate splint extremity injuries

III. Practice-Based Learning and Improvement: Demonstrate knowledge, skills and attitudes needed for continuous self-improvement

- 1) Promote and maintain a collegial atmosphere by facilitating education
- 2) Effectively and correctly appraise and utilize scientific evidence, applying understanding of study design and statistical methods
- 3) Evaluate choices using algorithms, guidelines, pathways, and decision analyses
- 4) Identify one's own strengths and weaknesses
 - a. Solicit feedback from preceptors and colleagues
 - b. Target opportunities for improvement
 - c. Plan for professional growth

IV. Systems-Based Practice: Understand practice of high-quality care and advocate for patients

- 1) Appropriately incorporate care cost, resource allocation, and quality into care
 - a. Gain understanding of cost control, billing and reimbursement procedures
- 2) Help patients navigate the system by directing them to appropriate resources (insurance deficits, primary care physician communication, other patient resources such as social work, care management or child life)
- 3) Understand components of pre-hospital care and inter-hospital transfer
- 4) Promote principles of injury prevention
- 5) Apply systems to prevent medical errors
 - a. Report and analyze when actual errors or "near misses" occur

V. Professionalism: Demonstrate commitment to carrying out responsibilities sensitively and ethically

- 1) Consistently manifest respect, compassion, honesty, integrity, and responsiveness with regard to the needs of the patient, family or team
 - a. Always protect privacy and confidentiality
- 2) Demonstrate accountability
- 3) Commit to excellence and ongoing professional development
- 4) Consider the ethical, cultural, religious, and spiritual issues important to families
 - a. Understand factors impacting compliance
 - b. Discuss death and end of life issues such as "Do Not Resuscitate", advanced directives, living wills with honesty, sensitivity, patience and compassion

VI. Interpersonal/Communication Skills: Consistently engage in information exchange and partnership within and across hospital departments

- 1) Communicate effectively in developing appropriate ways to foster professional and therapeutic alliances with patients and families
 - a. Effectively and patiently obtain consent for treatments/procedures

- 2) Formulate appropriate questions/rationale for consultants based on the clinical circumstances
- 3) Deliver clear, concise, and organized patient presentations
- 4) Recognize the importance of communication with all team members
 - a. Update the attendings, nurses, respiratory therapists and other care team members on patient progress and changes in clinical status in a timely manner
- 5) Communicate safe, effective and concise patient handoffs
- 6) Document in the medical record in a timely and comprehensive

Curriculum Research / Scholarly Activity (PGY 1-3)

1. Educational Purpose:

The purpose of the research and scholarly activity requirement is to encourage Emergency Residents to become life-long learners and to contribute and advance the field in which they will practice. Participating in a scholarly activity will give residents the tools to incorporate Evidence-Based Practices into their care of ED patients.

Residents will be encouraged to answer a clinical question based on their experience evaluating patients in the Emergency Department.

2. Brief Rotation Description

- a. Dedicated 4-week rotation during 3rd year
- b. Scholarly activity will begin during year one
- c. Residents will meet with their Physician Mentors and Research Coordinator after starting clinical rotations in the ED to generate research questions based on their patient encounters.

3. Course Director: Adam Sigal, MD

Adam.Sigal@towerhealth.org

484-628-3636

4. Course Contact: Leah Stephens

Leah.stephens@towerhealth.org

484-628-3529

5. Competencies/Goals and Objectives

- a. Understand the various research designs and the benefits and limitations of each
- b. Understand the process of generating a research question
- c. Understand the history of human subject protection and the purpose of the IRB
- d. Understand basic statistics encountered in the medical literature
- e. Develop skills in generating and writing a research proposal or case report
- f. Conduct data collection and analysis
- g. Compete a final product suitable for publication
 - i. Residents can participate in an ongoing research project or initiate a project
 - ii. Write a publishable journal article or an original textbook chapter
 - iii. Create an Educational project
 1. Module to be included in EM curriculum
 2. Present completed project to EM faculty and residents
 - iv. Develop an administrative project for Quality Improvement

6. Teaching Methods/Rotation Schedule

- a. Didactic lectures on clinical research and study design
- b. Journal clubs to understand the medical literature and generate clinical questions

7. Types of Clinical Encounters

- a. Based on the study design, residents may need to obtain informed consent for study participation
- b. Many scholarly activities will involve chart reviews and not require consent or direct patient contact.

- c. Case reports will be based on prior Emergency Department encounters

8. Procedures

- a. Demonstrate skills in Abstract Writing
- b. Demonstrate skills in Manuscript Writing
- c. Demonstrate skills in Poster Creation and Presentation

9. Resident Supervision

- a. Faculty Mentor
- b. Emergency Department Research Coordinator

10. Reading List and Educational Materials

- a. Designing Clinical Research, Hulley and Cummings
- b. Medical Statistics Made Easy, Harris and Taylor
- c. Users Guide to the Medical Literature, Guyatt

11. Method of Evaluation

- a. Progression on project timeline
- b. Timeliness of completing Actions and Milestones
- c. Presentation at regional or national conferences
- d. Presentation at Resident's Research Day
- e. Publication of Abstract
- f. Publication of Manuscript

12. Points of importance

Residents should not approach the scholarly activity requirement as a burden or chore. They should view the pursuit of scholarly activity to improve patient care, their own medical knowledge, and to advance their career field.

The pursuit offers the opportunity to publish and present findings at regional and national events. It also allows Residents to become subject matter experts in a small aspect of Emergency Medicine as they master the known knowledge regarding an area of interest.

Toxicology/Addiction Medicine Curriculum (PGY-2)

1. **Educational Purpose:** The purpose of the Toxicology rotation is to expose Emergency Medicine Residents to the toxicological emergency. They will have intensive training in toxicology under the supervision of the Emergency Medicine faculty. Residents will also be exposed to Addiction Medicine and learn about both Medication Assisted Therapy (MAT) and other resources to treat addiction.
2. **Brief Rotation Description**
 - a. Training year – PGY-2
 - b. Length – 2 weeks
 - c. Hours / call – in accordance with ACGME rules and regulations
 - i. May include both weekday and weekend coverage
 - d. Faculty: EM faculty and Dr. William Santoro, Section Chief, Addiction Medicine
3. **Competencies/Goals and Objectives**

Goals

1. To learn the principles of toxicology (MK)
2. To develop an organized approach to the assessment, resuscitation, stabilization and definitive care for an undifferentiated poisoned patient (MK, PC)
3. To understand the use of laboratory and diagnostic imaging modalities available for the evaluation of the toxicology patient (MK, PC)
4. To be able to recognize and treat immediate life-threatening toxicology patients (MK, PC)
5. To understand the variability in toxicology evaluation and management with special populations, including children, pregnant and geriatric patients (MK, PC, SBP)
6. To learn a systems-based approach to toxicology management, including incorporated utilization of the regional poison control center and pre-hospital care (MK, PC, SBP)
7. To demonstrate medical knowledge about established and evolving biomedical toxic substances and the appropriate application of this knowledge to toxicology patients (MK, PC, SBP)
8. To demonstrate understanding of addiction medicine and its role in the Emergency Department (MK, PC, SBP)
9. To understand the role of MAT in addiction and appropriate therapies (MK, PC)
10. To learn to read and interpret medical toxicology literature (MK, PC, PBL)
11. To understand the role that toxicology plays in the health system (SBP)

Objectives

1. Define various features of toxidrome recognition for patients with opioid, sympathomimetic, anticholinergic and cholinergic agent poisoning. (MK, PC)
2. Describe the major aspects of general management and supportive care of the poisoned patient (MK, PC)
3. Demonstrate knowledge of the basic principles of drug absorption, distribution, metabolism and elimination (MK)
4. Discuss the indications, contraindications, dosages and side effects of the currently available antivenoms (MK, PC)
5. Demonstrate the ability to recognize common venomous animals and poisonous plants and their clinical presentations and treatments (MK, PC)

6. Discuss the indications and contraindications of the basic principles of gastric lavage, whole bowel irrigation, skin and eye decontamination, and the use of activated charcoal (MK, PC)

7. Demonstrate knowledge and clinical skills necessary to manage the following toxins: (MK, PC)

- A. acetaminophen
- B. amphetamines
- C. caustics
- D. ASA
- E. barbiturates
- F. benzodiazepines
- G. beta blockers
- H. calcium channel blockers
- I. CO
- J. cocaine
- K. cyanide
- L. cyclic antidepressants
- M. digitalis
- N. ethanol
- O. ethylene glycol
- P. INH
- Q. iron
- R. lithium
- S. methanol
- T. opiates
- U. organophosphates
- V. phenytoin
- W. pesticides
- X. hydrocarbons
- Y. metals

8. Demonstrate knowledge between a toxic from a non-toxic ingestion (medical knowledge and patient care)

9. Demonstrate an understanding of the use of print and electronic resources to assist in the management of the poisoned patient (SBP, PBL)

10. Present at conference a clinical case and discussion (MK, PBL, IPC)

11. Must demonstrate a commitment to carry out professional behavior and adhere to ethical principles with a diverse patient population (P)

12. Understand the interaction of the ED with the regional poison control center and other public health agencies (i.e. Dept of health) (SBP)

13. Learn the indications for extracorporeal drug removal via hemodialysis or hemoperfusion (MK, SBP)

4. Teaching Methods/Rotation Schedule

- a. Assigned Reading Completion: satisfactory and punctual completion of assigned readings. weekly quizzes based on Peer IX, CORD question bank, Rosh Review and McGraw Hill online resources
- b. Attendance: lectures, rotation shifts, conferences and meetings
- c. Individualized for the resident. Official schedule to be determined once the rotation is scheduled and will be compliant with the current duty hour guidelines

- d. At least two days will be spent with the addiction medicine service on consultations or in the addiction medicine clinic.
5. **Resident Supervision:** Emergency Medicine attending physicians will supervise Emergency Residents during rotation on Toxicology Service. Residents will have direct supervision or indirect supervision with direct supervision immediately available.
6. **Reading List and Educational Materials**
Tintanelli: Section 15
'Goldfrank's Toxicologic Emergencies' Goldfrank, Lewis (Reference)
7. **Method of Evaluation**
- a. Performance
 - i. Daily observation of clinical duties by preceptor
 - ii. End of rotation written evaluation
 - iii. Attendance at expected conferences, lectures and meetings
 - b. Rotation evaluation
 - i. Residents will provide feedback on rotation to EM faculty
 - ii. EM Residency and Program Director will review rotation for completion of goals and review resident evaluations
 - iii. Evaluations to be completed by the designated attending physician based on written and defined goals and objectives above.

Additional resources available for review

- Radiolab* is a nationally syndicated and award-winning radio program based in New York City, and they have produced an excellent podcast on the history of U.S. poison control centers. Please find a time to give this a listen and some thought.
<https://www.wnycstudios.org/story/poison-control>
- Read the “Tox and the Hound” blog post on pediatric poisoning by a beloved former CHOP Toxicology Fellow. <https://emcrit.org/toxhound/small-poisoned-humans/>
- Watch this 14-minute video on treatment of U.S. snakebites. You can’t do a tox rotation and not be an expert on snakes, right? <https://www.crofab.com/Treatment-With-CroFab/Resource-video>
- Go through this “interactive case” at the New England Journal of Medicine...<https://www.nejm.org/doi/full/10.1056/NEJMimc1716605?query=TOC>
- A selection of instructional journal articles will be provided to the trainee.

Recommended FOAM (Free Open Access Medical) Toxicology Education

- The “Tox and the Hound” is a website of blog posts, with link to the “Dantastic Mr Tox & Howard” podcasts, produced by a group of creative and smart toxicologists / friends. Spend some time perusing the content of this website and think about following on Twitter.
<https://emcrit.org/category/toxhound/>
- “Tox in Ten” says it’s dedicated to bringing evidence-based medical toxicology core content and trending topics in easily digestible bites. Their podcasts can be found here <https://toxinten.com/>, and think about following them on Twitter [@ToxInTen].
- “ToxNow” is a toxicology podcast supported by the American Academy of Clinical Toxicology with a mission to create a fun and educational resource for healthcare providers about the world of toxicology <http://toxnow.org/>.

□ *The Poison Review* critically reviews and rates medical journal, and lay press, articles related to toxicology and poisoning. TPR also has a podcast on iTunes and can be followed on Twitter. <http://www.thepoisonreview.com/>

TRAUMA/SURGICAL INTENSIVE CARE UNIT (SICU) (PGY-2)

1. Educational purpose:

The purpose of the Trauma/Surgical Intensive Care Unit (SICU) is to provide the EM resident with experience in the evaluation and management of variety of patient with traumatic emergencies/illnesses as well as post op care of complicated surgical patients with emphasis on the multidisciplinary approach. Resident will learn management of post-operative abdominal surgery, cardiothoracic surgery, orthopedic surgery, vascular surgery, neurosurgery, spine surgery, head and neck surgery patients requiring intensive care facility.

Additionally, the residents will participate in Trauma Activations in the Emergency Department to gain an understanding of the role of the trauma team in trauma activations. They may also be asked to consult on trauma or surgical patients in the ED.

2. Trainees:

Department of Emergency Medicine PGY-2 and PGY-3 residents

3. Course Director: Thomas Geng, DO

4. Rotation contact: Deb Dreisbach

5. Method of Evaluation: Direct observation by the attending physician. The attending will provide regular formative feedback, midterm assessment of performance, and final summative evaluation in each of the 6 competency areas with particular focus upon the objectives described below

6. Location: Reading Hospital NSICU (N4 north)

7. Required Reading:

a. Emergency Medicine 7th ed. (Tintinalli's)

i. Section 21

b. Educational materials are provided online via the Electronic Medical Library, as well as on program issued iPads. There are also a variety of textbooks available in the Emergency Department for quick reference on admission and during trauma care. PEPID and Up To Date are also readily available for reference

c. Marino PL. The ICU Book. (All relevant topics should be read during rotation)

8. Goals and Objectives:

- Gain an understanding of the multidisciplinary nature of the SICU and trauma team **(PC, SBP)**
- Gain a deeper understanding of which Emergency Department patients require SICU admission, why, and what happens when they reach the SICU **(PC, MK, SBP)**
- Demonstrate understanding of the following disease processes: **(PC, MK)**
 - Traumatic Disorders of Chest and Abdominal Trauma
 - Penetrating
 - Blunt
 - Traumatic Disorders in Skeletal Injuries
 - Traumatic Disorders in Pelvic Trauma
 - Traumatic Disorders of the Spine
 - Traumatic Subarachnoid Hemorrhage
 - Traumatic Disorders of the Head and Brain

- Skull Fractures
 - Intracranial Hemorrhage
- Demonstrate knowledge of indications, contraindications, complications, and technique of performing the following procedures: **(PC, MK)**
 - Arterial Cannulation: Radial/Femoral
 - Central Venous Cannulation: Internal Jugular, Subclavian, Femoral, all with and without ultrasound guidance
 - Endotracheal intubation
 - Bronchoscopy
 - Lumbar puncture
 - Ventriculostomy
 - Bedside Tracheostomy
 - Spinal Immobilization and Stabilization
 - Chest tube placement
 - Diagnostic Peritoneal Lavage
 - FAST (Focused Assessment with Sonography for Trauma)
 - Thoracotomy
 - Cricothyrotomy
 - Compartment pressure check
 - Pericardiocentesis
- Demonstrate knowledge and appropriate interpretation of the following diagnostic studies: **(PC, MK)**
 - Intracranial Pressure (ICP) Monitoring
 - Central Venous Pressure (CVP) Monitoring
 - Compartment pressure monitoring
 - Arterial Blood Gas (ABG)
 - Mixed Venous Blood Gas
 - Oxygen Saturation
 - Spirometry
 - Declaring Brain Death
- Demonstrate knowledge and appropriate use of the following therapeutic options: **(PC, MK)**
 - Pressor use
 - Antihypertensive Use
 - Modalities to decrease ICP
 - Steroid use for spinal injuries
 - Blood product administration

9. Types of Clinical Encounters:

The resident will be responsible for a full spectrum of patients requiring care in the SICU. Problems include, but are not limited to management of post-operative surgical patient from various surgical specialties as well as trauma

10. Teaching Methods/Rotations Structure:

Participate fully as a member of the SICU and trauma team, which includes: **(PC, PBL, C, P, SBP)**

- a. Work all clinical hours as assigned per SICU and trauma standards (while abiding by ACGME duty hour limits)
- b. Participate in Trauma Activations at the appropriate resident level
 - i. PGY-2 residents will be an active participant in the Trauma Activations. They will be required to perform procedures during

trauma resuscitations. They may be asked to lead Trauma Activations when have been granted that responsibility by the Trauma Attending Physician.

- ii. PGY-3 residents will be responsible for leading Trauma Activations while on the service. They may also perform and participate in procedures for the trauma patient in the ED and Trauma Bay.
- c. Follow an equivalent number of patients as other team members
- d. Communicate clearly with other members of the SICU team including:
 - i. Attendings
 - ii. Residents
 - iii. Consulting services
 - iv. Nursing
 - v. Pharmacologist
 - vi. Social workers
 - vii. All other team members
- e. Consistently demonstrate high professional standards including:
 - i. Behavior
 - ii. Punctuality
 - iii. Attention to detail
 - iv. Dedication

11. Admissions/Rounds

- Report to the Trauma conference room at 7 AM the first day of the rotation (regardless of if it is a weekday or weekend) **(P)**
- Attend and participate in all SICU didactic experiences **(MK, PBL, P)**
- Attend and participate in all Department of Surgery didactic experiences that are attended by the SICU team **(MK, PBL, P)**
- You are excused to attend all EM didactic sessions **(MK, PBL, P)**

12. Resident Supervision

The resident will be under the direct supervision of the Attending physician at all times, as there is 24/7 Attending Physician coverage. The attending will be informed immediately for all admissions to the ICU and will approve such admissions. The Attending will review the case with the admitting resident and determine how acutely the Attending should be personally available; therefore, the level of supervision will be either direct supervision or indirect supervision with direct supervision immediately available depending on the case. The attending physician will personally evaluate all patients daily and will provide daily feedback to the resident.

Trauma/General Surgery Curriculum (PGY-1)

1. **Educational Purpose:** The purpose of the Trauma/General Surgery rotation is to expose the PGY-1 resident to the evaluation and care of the trauma patient, as well as the evaluation of a patient with a potential general surgical concern.
2. **Brief Rotation Description:** PGY-1 Residents rotate with the trauma team during this four-week rotation. They will be exposed to a variety of surgical issues including trauma and non-trauma care. Residents will participate in trauma resuscitations in the Emergency Department as well as the care of the trauma patient after admission. They will also be consulting on both trauma and potential surgical patients in the ED and assist in the care of the surgical patient during the hospital stay.
3. **Couse Director:** Thomas A Geng, Jr., DO, FACS
Cell: 610-334-5714
thomas.geng@towerhealth.org
4. **Course Contact:** Deb Dreisbach – Surgical Services
Office: 484-628-4908
Debra.Dreisbach@towerhealth.org
5. **Competencies/Goals and Objectives:**
 - a. **Goals:**
 - i. Provide the PGY-1 resident with knowledge, skills, and attitudes necessary to care of the trauma and surgical patient. (MK, PC, IPC)
 - ii. Develop a competence in diagnosis, management, and disposition of common surgical and traumatic disorders (MK, PC, SBP)
 - iii. Gain knowledge of surgical procedures and equipment (MK, PC)
 - iv. Gain experience in pre and postoperative management of surgical and trauma patients (PC, MK, SBP)
 - v. Become familiar with pathophysiology, presentation, diagnosis, and management of surgical and traumatic disorders that include but are not limited to (MK, PC, SBP)
 1. Abdominal
 2. Gastrointestinal
 3. PVD
 4. Thoracic disorders/injury
 5. Wound Care
 6. Extremity trauma
 7. Trauma resuscitations
 8. Head injury
 9. Spinal trauma
 - vi. Gain experience with the following skills (MK, PC)
 1. History and Physical examination
 2. Fluids and electrolytes
 3. Blood components/therapy
 4. Wound closure and care
 5. Chest tube placement
 6. Central Venous Catheter placement

- vii. Become knowledgeable of the indications, complications, and contraindications of various diagnostic modalities (MK, PC, PBL)
 - 1. Laboratory studies
 - 2. Radiographic studies
 - 3. Ultrasound including POC ultrasound
- viii. Provide patient centered medical care in a professional manner at all times (P)
- ix. Effectively communicate with patients and other healthcare providers. (IPC, P)

b. Objectives:

- i. Develop basic knowledge in the perioperative, intra-operative and post-operative settings (MK, PC)
- ii. Appropriately work up a surgical or trauma patient including developing a differential diagnosis utilizing the history, physical, and pertinent diagnostic studies. (P, IPC, MK, PC)
- iii. Delivering a case presentation in organized and articulate fashion (PC, IPC)
- iv. Understand surgical presentations of disease processes (MK, PC)
- v. Manage surgical patients both preoperatively and postoperatively (MK, PC)
- vi. Perform basic surgical skills including wound care, chest tube placement, and other procedures relevant to the practice of Emergency Medicine (PC, MK, PBL)
- vii. Develop an understanding of trauma resuscitation and patients who would benefit from trauma team evaluation (MK, PC, SBP)
- viii. Understand the role of the trauma team in the care of the emergency patient (SBP)

6. Teaching Methods/Rotation Schedule: Residents will be under the supervision of trauma team attending physicians. They will rotate with other residents from other specialties. The schedule will be determined by the trauma and surgical team. Duty hours will be adhered to at all times. Residents will be excused for their weekly didactic conferences. Residents will also participate in trauma and surgical conference while on rotation.

7. Types of Clinical Encounters: Residents will be expected to evaluate patients in the Emergency Department both in consultation as well as during resuscitations in the Trauma Bay. They will also round on patients on surgical floors. They may accompany the patient to the operating room for cases pertinent to Emergency Medicine. They will be expected to admit and discharge patients as per the trauma/surgical team.

8. Procedures: Procedures that may be performed during the rotation include but are not limited to:

- a. Central venous catheter placement
- b. Central venous catheter removal
- c. Arterial blood gas and arterial line placement
- d. Chest tube insertion
- e. Chest tube management
- f. Chest tube removal
- g. Wound care, both initial and ongoing
- h. Trauma resuscitation (adult/pediatric)

- i. Peripheral IV insertion
 - j. Point of care ultrasound including FAST scan
 - k. Cricothyroidotomy
9. **Resident Supervision:** Residents will be under indirect supervision of attending physicians with direct supervision immediately available. Direct supervision will always be available in the trauma resuscitation bay.
10. **Reading List and Educational Materials:**
- a. Emergency Medicine (Tintinalli's) – Section 6, 9, 21
 - b. Required reading of the surgical/trauma service
11. **Method of Evaluation:** Residents will be evaluated at the end of the rotation by the trauma/surgical course director. This evaluation will be completed on New Innovations with the six core competencies as the basis for evaluation. Residents will be informally evaluated by the attending physicians and senior residents daily.