

Queen's University Emergency Medicine Resident Handbook

Guidelines and General Information (Updated June 2018)

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Introduction

This handbook is intended to formally outline all aspects of the Emergency Medicine Residency Program for our residents. It is intended to give incoming residents an overview of the teaching program and should be useful for residents at all stages of the program to help understand the direction of the educational mandate we have.

This manual includes:

- A preamble to the clinical and academic curriculum of the Emergency Medicine residency training program
- Important policies
- A concise table with the clinical rotations taken in the five years of the program
- A description of each year from PGY1 to PGY5 and the rotation specific goals and objectives
- A description of the overall program goals and objectives. Residents are expected to demonstrate achievement of this standard by the end of their training.
- A description of Emergency Medicine training expectations and level of responsibility for each year of the training program
- A description of electives and elective policies
- A schedule and description of Academic rounds
- A content list for the core curriculum, scholar competency curriculum and administrative series

The curriculum for the residency program consists of clinical rotations and academic sessions and has been carefully laid out, developed and refined since the inception of the Emergency Medicine Residency Program at Queen's. Please pay particular attention to the descriptions of each year and the section of Emergency Department rotations.

Jaelyn Caudle
Program Director

Queen's University Emergency Medicine Residency Program Mission Statement

The Queen's University Emergency Residency Program is committed to providing a program of educational and clinical excellence to transform Emergency Medicine residents into specialist emergency physicians. This program will be rigorous but also enjoyable and compassionate. Our goal is to create a culture and environment in which our residents enjoy working and learning as much as we do.

The program is dedicated to producing:

- Specialist Emergency Medicine Physicians who are outstanding clinicians and compassionate, humane caregivers.
- Specialist Emergency Medicine Physicians who are leaders in research, administration and educational scholarship dedicated to the advancement of knowledge in the specialty of Emergency Medicine.
- Specialist Emergency Medicine Physicians, who demonstrate a commitment to a physician wellness, maintain a sustainable career in Emergency Medicine and continue professional development.

Section 1: A Little Bit About Queen's EM

History of Emergency Medicine in Canada and Queen's University

Emergency Medicine has had a growing profile at Queen's University starting in 1971 with the staffing of both of Kingston's Emergency Departments by Emergency Physicians and culminating in the granting of University Departmental status in 1996.

Important dates and events in our specialty and in our residency program are:

1972	Council (RCPSC) requests proposals for education programs in Emergency Medicine
1972	Council (RCPSC) accepts the concept of specialty in Emergency Medicine
1972	McGill begins residency program
1974	Guidelines for training programs in Emergency Medicine
1975	Emergency Medicine receives Divisional status in the Department of Surgery at Queen's University
1976	UWO begins residency program
1977	Queen's University begins residency program
1978	CAEP formed
1979	Approval of Emergency medicine as modified Conjoint Board in the United States
1980	Approval by RCPSC as new Canadian specialty
1996	Emergency Medicine receives departmental status at Queen's University

To date over 100 residents have graduated from the Emergency Medicine Residency program at Queen's University. Our residents have and continue to have leadership roles in Academic Emergency Medicine across the country. A list of our graduates are included.

The CCFP(EM) program at Queen's is run through the Department of Family Medicine and we are proud to have played a part in the clinical and academic training of the residents in this program.

Our program is fully accredited by the RCPSC and last accreditation was in 2011. We accept four residents per year into the five-year program. Our success rate for the RCPSC exams has been excellent. We anticipate our tradition of success to continue due to the high quality of residents we attract each year and the excellent academic and clinical support we receive from our Emergency Medicine Faculty.

Department of Emergency Medicine Residents 2018-2019

Resident	Level	Medical School
Dr. Mackenzie Howatt	PGY 5	University of Toronto
Dr. Emily Robinson	PGY 5	Northern Ontario School of Medicine
Dr. Graeme Ross	PGY 5	Queen's University
Dr. Zachary Warren	PGY 5	Memorial University
Dr. Savannah Forrester	PGY 4	University of Calgary
Dr. Eve Purdy	PGY 4	Queen's University
Dr. Kristen Weersink	PGY 4	University of Ottawa
Dr. Ali Yakhshi Tafti	PGY 4	Queen's University
Dr. Amy Burton	PGY 3	Memorial University
Dr. Andrew Helt	PGY 3	Western University
Dr. Kirsten Litke	PGY 3	McMaster University
Dr. Chris Meyer	PGY 3	McMaster University
Dr. Stacey Hryciuk	PGY 2	University of Alberta
Dr. Taylor Oliver	PGY 2	University of Saskatchewan
Dr. Casey Petrie	PGY 2	Queen's University
Dr. Paul Prochazka	PGY 2	Western University
Dr. John Van Tuyl	PGY 2	University of Calgary
Dr. Melissa Bouwsema	PGY 1	University of Calgary
Dr. Amar Chakraborty	PGY 1	University of Toronto
Dr. Taylor Nikel	PGY 1	University of Alberta
Dr. Evan Russell	PGY 1	Queen's University
Dr. Nathaniel Walker	PGY 1	Queen's University

Department of Emergency Medicine Faculty 2017 - 2018

Name	University Rank	Specialty Qualifications	Sub-specialty	Nature of Interaction with Resident (e.g. clinical, teaching, research)
Susan Bartels	Associate Professor	FRCP	MPH	Clinical/ Teaching/Research/International Emergency Medicine
Al Bell	Assistant Professor	CCFP(EM)		Clinical/Teaching
Colin Bell	Assistant Professor	FRCPC		Clinical/Teaching/Ultrasound
Elizabeth Blackmore	Assistant Professor	CCFP(EM)		Clinical/Teaching
Danielle Blouin	Professor	FRCPC, FACEP	MHPE, PhD	Clinical/Teaching/Research
Jason Bornstein	Assistant Professor	FRCPC		Clinical/Teaching
Erin Brennan	Assistant Professor	FRCPC		Clinical/Teaching
Robert Brison	Professor	CCFP, FRCPC	MPH	Clinical/Teaching/Research
Steven Brooks	Associate Professor	FRCPC	MHSc	Clinical/Teaching/Research
Eric Bruder	Assistant Professor	FRCPC		Clinical/Teaching/Research
Jennifer Carpenter	Associate Professor	FRCPC, CCFP	MSc	Teaching/Global Health
Jaelyn Caudle	Assistant Professor	FRCPC	EMDM	Clinical/Teaching/Disaster Medicine
Tim Chaplin	Assistant Professor	FRCPC		Clinical/Teaching/Simulation and Trauma
Ken Collins	Assistant Professor	CCFP(EM)		Clinical/Teaching
Frances Crawford	Assistant Professor	FRCPC, FACEP		Clinical/Teaching
Damon Dagnone	Associate Professor	FRCPC	MMEd	Clinical/Teaching/Research
Stuart Douglas	Assistant Professor	FRCPC		Clinical/Teaching
Paul Dungey	Assistant Professor	FRCPC		Teaching/Administration
R. Kenneth Edwards	Assistant Professor	CCFP(EM), FRCPC, FACEP		Clinical/Teaching/ED safety
Chris Evans	Assistant Professor	FRCPC	MSc	Clinical/Teaching/Research/Trauma
Mark Froats	Assistant Professor	FRCPC		Clinical/Teaching/EMS
Karen Graham	Assistant Professor	CCFP(EM), FCFP		Clinical/Teaching/Administration
Andrew Hall	Assistant Professor	FRCPC	MMEd	Clinical/Teaching/Research/Simulation
Daniel Howes	Professor	FRCPC		Teaching/Critical Care
Gordon Jones	Associate Professor	FRCPC		Clinical/Teaching/Administration
Drew Knight	Assistant Professor	CCFP(EM)		Clinical/Teaching
James Landine	Assistant Professor	FRCPC		Clinical/Teaching/Sports Medicine

Mike McDonnell	Assistant Professor	FRCPC		Clinical/Teaching
Robert McGraw	Associate Professor	FRCPC,	MEd	Clinical/Teaching/Research
Colin Mercer	Assistant Professor	FRCPC		Clinical/Teaching/Critical Care
David Messenger	Associate Professor	FRCPC	MM, FCCP	Clinical/Teaching/Critical Care Department Head
Max Montalvo	Assistant Professor	FRCPC		Clinical/Teaching
Kieran Moore	Professor	CCFPEM, FRCPC	MPH	Teaching/Public Health
Heather Murray	Associate Professor	FRCPC	MSc	Clinical/Teaching/Research
Joseph Newbigging	Assistant Professor	CCFP(EM)	FCFP	Clinical/Teaching/Ultrasound
Terry O'Brien	Assistant Professor	CCFP(EM), FRCPC		Clinical/Teaching/Administration
Armita Rahmani	Assistant Professor	CCFP(EM)		Clinical/Teaching
Louise Rang	Assistant Professor	FRCPC	RDMS	Clinical/Teaching/Ultrasound
Andrew Reed	Assistant Professor	FRCPC	MSc	Clinical/Teaching/EMS
Nicole Rocca	Assistant Professor	FRCPC		Clinical/Teaching/Critical Care
Aaron Ruberto	Assistant Professor	FRCPC		Clinical/Teaching
Stephanie Sibley	Assistant Professor	FRCPC		Clinical/Teaching/Critical Care
Marco Sivilotti	Professor	FRCPC, FACEP	FACMT	Clinical/Teaching/Research/Toxicology
Matt Stacey	Assistant Professor	CCFP(EM)		Clinical/Teaching
Adam Szulewski	Assistant Professor	FRCPC	MHPE, PhD Candidate	Clinical/Teaching/Research, Resuscitation and Reanimation Fellowship Program Director
Melanie Walker	Assistant Professor	PhD		Teaching/Research
Heather White	Assistant Professor	FRCPC		Clinical/Teaching
Matthew White	Assistant Professor	FRCPC		Clinical/Teaching

Department of Emergency Medicine Past Graduates (2008 – Present)

Resident	Graduating Year	Resident	Graduating Year
Dr. Mikayla Brenneis	2018	Dr. Stephanie Sibley	2014
Dr. Stuart Douglas	2018	Dr. April Tozer	2014
Dr. Aaron Ruberto	2018	Dr. Chris Evans	2013
Dr. Heather White	2018	Dr. Rachel Poley	2013
Dr. Matthew White	2018	Dr. Andrew Robinson	2013
Dr. Caley Flynn	2017	Dr. Mark Froats	2012
Dr. Carly Hagel	2017	Dr. Andre Lui	2012
Dr. Sharleen Hoffe	2017	Dr. Jennifer Tang	2012
Dr. Eric Mutter	2017	Dr. Jason Bornstein	2011
Dr. Colin Bell	2016	Dr. Donna Lee	2011
Dr. Colin Mercer	2016	Dr. Geoff Sanz	2011
Dr. Nicole Rocca	2016	Dr. Mike Geddes	2010
Dr. Katherine Stuart	2016	Dr. Tom Kaul	2010
Dr. Erin Brennan	2015	Dr. Eric Bruder	2009
Dr. Andrew Hurst	2015	Dr. Alison Kabaroff	2009
Dr. Jody Stasko	2015	Dr. Jaelyn Caudle	2008
Dr. Adam Szulewski	2015	Dr. Bruce Cload	2008
Dr. Tim Chaplin	2014	Dr. Trevor Jain	2008
Dr. Andrew Hall	2014	Dr. Kari Sampsel	2008
Dr. Conor McKaigney	2014		

Section 2: Important Policies

Registration

New Residents and returning residents both can register on-line with our Postgraduate Office.

Instructions and log on information are available on the Postgraduate Website at:
<https://meds.queensu.ca/academics/postgraduate/current/registration>

Registration must be completed before 4pm on June 29, 2018 for the upcoming year.

Emergency Medicine Residency Program Safety Policy (Reviewed June 2018)

The purpose of these guidelines is to enhance the health and well-being of our residents by offering guidelines for personal safety during clinical shifts in the Emergency Department. These guidelines are made available in the on-line residency manual and are reviewed yearly at resident retreats. Key items will be covered in the core curriculum.

Preamble: The environment in the Emergency Department poses many threats to the personal safety of Emergency Medicine residents and staff Emergency Physicians. The risks are due to:

- Threat of communicable disease
- Threat of physical violence, intimidation and harassment
- Risk of harm related to shift work
- Risk of legal action by patients and families
- Risk of legal action caused by use of social media

Guidelines are as follows:

1. Residents should wear appropriate protective gear during high-risk patient interactions (trauma patients, airway management procedures, bleeding patients, and patients presenting with febrile illnesses) when necessary.
2. Residents must receive and maintain appropriate fit testing for personal protective equipment (i.e. N95 mask) prior to clinical shifts in the Emergency Department.
3. Residents should adhere to hospital Infectious Disease prevention and reporting policies.
4. Residents must possess adequate knowledge of technical skills and practice appropriate technique to protect themselves and others from needle stick injuries. Residents must recognize the importance of reporting adverse events and be aware of the indications for post exposure prophylaxis.
5. Residents should recognize patients who pose a threat of physical violence and understand measures that can be taken to prevent and protect themselves from physical harm (nonviolent crisis intervention, panic buttons, safe interview rooms, police or security presence, physical and chemical restraints).

6. Residents must understand the threats related to shift work including signs of physician burnout or substance misuse, impact of shift schedules (ie. Short shifting) and the impact of shift work on interpersonal relationships. Residents are advised to seek assistance from available resources (Program Director, Occupational Health, Employee and Family Assistance Program) if they are experiencing negative effects of shift work
7. Residents should be aware of the importance of safe transportation to and from work. The use of security escorts to transportation home especially after evening shifts is encouraged.
8. Residents must understand the physiology and importance of good sleep hygiene.
9. Residents are advised to have a chaperone for pelvic, breast and rectal exams on women and male patients.
10. Residents are advised to ask for a witness during anticipated or developing difficult patient encounters and the importance of careful documentation of these encounters.
11. Residents are advised of the importance of careful documentation in patient encounters that are likely to proceed through the judicial system (i.e. sexual assault, motor vehicle accidents, and physical assault/domestic violence).
12. Residents should be aware of the Queen's University policy on intimidation and harassment. Residents are encouraged to report events according to the policy.

Residents are encouraged to review the following guidelines established by the Postgraduate Medical Education office:

Blood Borne Diseases and the Health Care Worker

<http://www.cpso.on.ca/Policies-Publications/Policy/Blood-Borne-Viruses>

Communicable Diseases Protocol

<https://www.oha.com/labour-relations-and-human-resources/health-and-safety/communicable-diseases-surveillance-protocols>

Immunization

<http://cou.on.ca/papers/immunization-policy/>

KGH Workplace Health and Safety Review

http://meds.queensu.ca/education/postgraduate/policies/workplace_health

Maintaining Appropriate Boundaries and Preventing Sexual Abuse

<http://www.cpso.on.ca/policies-publications/policy/maintaining-appropriate-boundaries-and-preventing>

Physicians and Health Emergencies

<https://meds.queensu.ca/sites/default/files/inline-files/emergencies.pdf>

Resident Health and Safety Policy

<https://meds.queensu.ca/academics/postgraduate/current/policies/safety>

Resident Intimidation and Harassment Policy

https://meds.queensu.ca/sites/default/files/inline-files/FINAL_Resident_Harassment_Policy.pdf

Social Media

<https://meds.queensu.ca/sites/default/files/inline-files/FHS%20Social%20Media%20Policy%202017.pdf>

Resident Intimidation and Harassment Policy

The Queen's Emergency Medicine residency program strives to promote a culture of inclusiveness and collegiality. Our program adheres to the PGME policy on intimidate and harassment.

Residents are encouraged to review the PGME available at:

https://meds.queensu.ca/sites/default/files/inline-files/FINAL_Resident_Harassment_Policy.pdf

Guidelines for Prescription of Controlled Drugs (Reviewed March 2017)

Physicians in the Department of Emergency Medicine at Queen's University agree to the following guidelines for the prescription of opioid analgesics and other controlled drugs upon discharge of patients from the Emergency Department at KGH and the Urgent Care Centre at HDH. The document "Ontario Consensus Guidelines on Opioid-Prescribing in Emergency Departments"¹ is attached for reference. These guidelines are intended to promote standardization and best practices for outpatient prescribing of opioids and other controlled drugs in the ED/UCC setting. We acknowledge that deviation from the guidelines may at times be necessary and acceptable in the professional judgment of the treating physician, but that the reasons for such deviation should be communicated to the patient and documented in the medical record.

1. The attending physician will carefully supervise the prescribing of controlled drugs for patients being discharged from the ED or UCC. Prescriptions written by residents will be reviewed by the attending physician with regards to the agent, dose, interval, instructions and quantity of the controlled substance being prescribed in light of the patient's condition.
2. Non-opioid and non-pharmacologic options will also be considered for all patients with pain.
3. Patients with chronic pain will be discouraged from obtaining prescription renewals at either the ED or UCC. As a department, we have had a policy in effect since 2009 and signage at triage that we will not renew expired, lost, stolen or destroyed prescriptions for controlled substances. Any deviation from this policy should be considered an exceptional event, and the singular nature of this exception should be explained to the patient. The medical record should detail the dose and amount of controlled substances reportedly received by the patient in the recent past, efforts and results of efforts to corroborate this medication history from independent sources, and the presence or absence of stigmata of withdrawal. Moreover, the discussion regarding how future requests of this nature will be handled must be documented in the medical record to assist in their management.
4. Physicians are encouraged to advise patients presenting in opioid withdrawal that: 1) tolerance is already being lost; 2) there is a substantial risk of accidental fatal overdose should they resume dosing at their prior dose, or seek illicit sources of opioids or "alternatives;" and 3) supervised detoxification options exist in the community. These notions also apply to some extent to withdrawal from sedative/hypnotic agents.

5. Prescriptions for opioids in the emergency department should be administered in limited quantities at appropriate doses for short intervals for acute and recent injury or illness. These prescriptions should be accompanied with information regarding the use of alternatives to opioids including over-the-counter analgesics and non-pharmaceutical adjuncts.
6. Physicians should avoid initiating sustained-release formulations of opioids and be mindful of drug-drug interactions with sedatives, ethanol, other prescription opioids and illicit drugs.
7. Patients with chronic pain should be encouraged to seek primary care from a family physician, and be considered for referral to multidisciplinary pain clinics, practitioners and services for management of chronic pain when appropriate.
8. Patients with addiction may be referred to the Street Health Centre who will attempt to see all referrals from the ER within the week for assessment for counseling, opioid agonist treatments, naloxone training and kit provision, referral for residential treatment etc. Contact information and referral forms can be found on the Links section of EDIS.

Restricted Registration Policy (Sept 2017)

Queen's Emergency Medicine allows senior residents to participate in the College of Physicians and Surgeons of Ontario Restricted Registration Program within the following guidelines:

1. Residents must complete the mandatory rotations in Critical Care, Anaesthesia and Cardiology before consideration will be given to an application for restricted registration.
2. In general, residents will be permitted to moonlight in the disciplines of Emergency Medicine or Critical Care Medicine.
3. Residents who wish to apply for the Restricted Registration Program must apply in writing to the Program Director. Applications must identify the clinical area, number of requested shifts and rationale for the application.
4. To be considered for restricted registration, residents must fully meet the criteria of the CPSO Restricted Registration Program plus:
 - Consistently demonstrate clinical excellence on all rotation evaluations.
 - Consistently fulfill all the requirements of the training program.
 - Consistently demonstrate good citizenship and professionalism within the residency training program.
5. Each application for restricted registration will be presented at the quarterly Promotions and Appeals Committee for discussion. The decision is binding and will not be considered for appeal.
6. Residents who are granted permission to participate in the Restricted Registration Program will provide the dates of all moonlighting shifts to the Program Director for each block prior to the start of the block.

7. The maximum number of shifts permitted in each block is two (2) shifts unless approved, in advance, by the Program Director. Restricted Registration (moonlighting) shifts cannot interfere with participation in any activities of the residency training program.
8. Residents who are denied permission to participate in the Restricted Registration Program will receive feedback on the reasons underlying the decision. Residents may submit another application to the Program Director in advance of the next scheduled Promotions and Appeals Committee meeting provided significant improvement in any previously identified deficiencies has been made.
9. All residents in the Restricted Registration Program will be reviewed quarterly to determine if they continue to meet the inclusion criteria. Residents who no longer fulfill the inclusion criteria, will be notified and the Program Director will rescind permission with the CPSO.

Section 3: Resident Work Life Balance

Annual Social Functions

A key component of physician wellness is work-life balance. To that end, the Department of Emergency Medicine hosts several social events:

- Orientation BBQ – to welcome our new PGY 1, CCFP(EM) and Resuscitation and Reanimation fellow residents – July
- Annual summer party – Another welcome to residents and staff - July or August
- Pub Crawl – usually a team based pub-golf pub crawl to introduce our new members to several of Kingston's finest watering holes - August
- The Big Mac Challenge – a leisurely group ride to Gananoque followed by a big mac meal and a full out sprint back to Kingston. The race starts once everyone has their big mac, large fries, apple pie and large drink. Several prizes are up for grabs - July or August
- Departmental Christmas Party – dinner and dancing - December
- Resident Retreats – the winter retreat brunch is held at a local restaurant. The summer retreat is an overnight sleepover at a staff cottage - June & December
- CaRMS Social – traditionally held at the Grizzly Grill, faculty on the selection committee and all residents play host to the CaRMS candidates to showcase our awesome program – January
- Resident Appreciation Day – Coinciding with the release of the CaRMS Match results, a pizza lunch is offered to celebrate the wonderful residents and celebrate our newest additions to the team – March
- Departmental Golf Tournament and Graduating Resident Farewell – a friendly golf tournament including our nursing and paramedic colleagues to celebrate and say good-bye to the graduating PGY 5 and CCFP(EM) residents – June

Resident Health and Wellness Resources

Physician wellness is essential to a happy, sustainable career in Emergency Medicine. Our program has an open-door policy and residents may approach any of the faculty if feeling distressed. The Program Director is always available to counsel residents in crisis. During quarterly review meetings with Program Director, residents will be asked whether they are experiencing any issues and are reminded about resources on the Postgraduate website.

The Postgraduate office at Queen's University offers urgent psychiatric and personal support for residents in crisis in a timely and effective fashion with a core of excellent professionals available at any time. This service can be accessed at the request of the Program Director or the resident. Kingston General Hospital also offers an employee assistance service.

A full list of wellness resources can be accessed on the PGME Resident Health and Wellness website available at:

<https://meds.queensu.ca/education/postgraduate/wellness>

There are specific goals and objectives on physician wellness in the Resident Handbook – Overall Curriculum Goals and Objectives. To promote resident wellbeing and resiliency, we include formal teaching is provided on the following topics related to wellness:

- Resident life and resources
- How to cope with medical errors
- Critical Incident stress debriefing
- Communication skills sessions on “how to give bad news” and conflict resolution
- Stress management in the Emergency Department
- Personal safety issues in Emergency Medicine
- Personal wellness strategies: physiology and scheduling

A lending library of books related to resilience and wellness is available in our Department Library.

There is a dedicated bulletin board in the resident lounge where wellness resources are posted to facilitate anonymous access to resources. There is also a link to the PGME Resident Health and Wellness page on our departmental website.

To promote a culture of wellness in our department, we hold a TMTL (There's More to Life...) half day where faculty and residents are encouraged to provide a brief (10 minutes) presentation on any non-medical topic of importance to them. Topics that have been presented in recent years include: favorite books, recent travel, bird watching, letters written to grandparents as a child, fun things to do in the snow, etc. This session is highly valued and well attended by faculty and residents.

Section 4: Teaching and Clinical Facilities

Kingston General Hospital

All in-hospital core rotations with the exception of Obstetrics and Orthopedics take place at KGH. KGH is a 480-bed tertiary care hospital and is the referral center for a population of 500,000. KGH is the regional trauma center receiving an average of 380 multiple trauma patients (defined by an Injury Severity Score of greater than 15) per year. The Emergency Department is staffed 24 hours per day with triple coverage by attending physicians from 1200 – 0200 daily. The Emergency Department patient volume is 60,000 unscheduled visits yearly and the admission rate is approximately 19%. The Emergency Department consists of six patient areas and has 44 active treatment beds, 15 overflow patient care beds and 12 chairs for ambulatory patients. There are 21 monitored beds and the acute resuscitation area has 9 beds. Triage nurses assess all patients on arrival. Residents, staff physicians, nurses and other staff in the Department are linked with cordless telephones to facilitate communication. Paramedics have direct phone link communication with the attending staff and senior residents. All medical records, including patient charting, laboratory and radiology investigation and physician order entry is performed on the Emergency Department Information System (EDIS).

Hotel Dieu Hospital

All outpatient clinics and a large outpatient imaging service are located at the HDH. The Urgent Care Center is open from 0800 – 2000 daily and is equipped to handle ambulatory emergencies. There is double coverage from attending physicians from 1100 – 2000 daily. The patient volume is 40,000 patients per year. Upon arrival, all patients are assessed by a triage nurse. The HDH is an excellent facility for the teaching of less serious outpatient medical problems and minor procedural skills.

Children's Hospital of Eastern Ontario

Pediatric Emergency rotations take place at CHEO. Residents do one block of Pediatric Emergency Medicine at CHEO in first year as a junior resident and two blocks in PGY3 at the senior resident level. CHEO is a University of Ottawa teaching hospital and is the tertiary pediatric referral center for Eastern Ontario.

Other Teaching facilities

Toxicology rotations are based at the Ontario Regional Poison Information Centre located at the Hospital for Sick Children in Toronto. The Obstetrics and Gynecology are arranged through the Department of Family Medicine and takes place in Oshawa. An Orthopedic Surgery rotation also takes place at the Oshawa General Hospital.

Residents may pursue mandatory rotations outside of the usual locations listed above upon approval of the Program Director. Residents will be required to fund associated accommodation and transportation costs.

Section 5: Resident Funding and Resources (Reviewed June 2018)

The Department of Emergency Medicine Academic Fund provides generous financial support for the academic activities/educational resources. Residents may apply to the Department of Emergency Medicine Academic Committee for financial support for other worthwhile academic pursuits not included in the list below.

Conference Support

1. Residents will receive a travel stipend of up to Cdn\$750 to attend the ACEP Scientific Assembly once during their residency training (usually during the PGY2 or PGY3 year).
2. Residents will receive a travel stipend of up to Cdn\$750 to attend the SAEM Annual Meeting once during their residency training (usually during the PGY3 or PGY4 year).
3. Residents will receive a travel stipend of up to Cdn\$500 to attend the CAEP Annual Meeting once during their training.
4. Residents will receive up to Cdn\$500 or CAEP registration fee (whichever is less) for up to three (3) resident team members annually to represent Queen's Emergency Medicine in the Simulation Olympiad at CAEP. Individual residents may only receive this funding twice during their training.
5. Residents presenting an oral or poster abstract at a national meeting will usually have travel, hotel and early registration costs reimbursed, provided the following:
 - The conference is a national emergency medicine meeting (i.e. CAEP Annual Meeting, SAEM Annual Meeting or ACEP Scientific Assembly), or the national meeting of the subspecialty related to the abstract being presented (e.g. North American Congress of Clinical Toxicology, National EMS Meeting)
 - The conference is on the North American continent.
 - All travel and accommodation arrangements are made by the resident using the most economical means possible.
 - Funding under category 4 can only be used for a single conference for the materially same research/abstract. This does not preclude the use of conference funding under categories 1, 2 or 3 to support travel to the additional conferences. In each case, the Academic Committee Chair will be the final judge of duplicate presentation.
 - Application for funding under category 4 can be made more than once during residency subject to the restrictions above regarding duplicate presentation.

For all conference support, application must be made, **in writing, to the Chair of the Academic Committee at least one month in advance of the early registration deadline of the conference.**

When applying under category 4, the application must be made seven days prior to the abstract submission deadline, and must be accompanied by the abstract, as well as any related abstracts previously submitted from the same project.

Funds will only be released with the written authorization of the Academic Committee, typically in the form of the minutes of the Academic Committee meeting at which the application is approved.

Funding Support for Mandatory Academic Activities

1. Membership fees will be provided annually as follows:
 - Emergency Medicine Residents Association (EMRA) of ACEP – residents are automatically registered by office
 - Canadian Association of Emergency Physicians (CAEP) - residents must register and are reimbursed
2. Enhanced Training and Certification Courses – tuition fees will be reimbursed once for each of the following courses during the residency program:
 - ACLS Instructor's course
 - ATLS
 - ATLS Recertification
 - ATLS instructor's course
 - PALS
 - National Review Course (PGY 5 year; max \$900.00)
3. Examination preparation - Examination fees will be paid annually directly by the department for:
 - ABEM Exam annually
 - FRCP Canadian In-Training Exam (CITE)
4. Miscellaneous Benefits - reimbursement will be provided once for:
 - Purchase of a textbook in Emergency Medicine (max \$350.00)
 - Purchase of work boots for EMS ride-outs (max \$100.00)
 - Up to Date - a hospital subscription is available for use
5. To improve teaching skills, residents are encouraged to register for the Resident as Teacher sessions through the Faculty Development in the PGME Office. Resident who attends both sessions will receive a certificate. Tuition for these sessions is covered by the PGME office directly.

Funding Support for Accommodation and Transportation for Mandatory Out of Town Rotations

Accommodations for mandatory out of town rotations are provided through the Regional Education Office at Queen's University. Residents will receive an automated notification through the MedTech system sent to their "@queensu.ca" account asking them to confirm the accommodations. The email contains a link detailed information regarding the accommodation.

If accommodation requests for mandatory rotations surpass Regional Education Office's capacity residents will receive an accommodation allowance of \$800 per month and the residents will be required make their own arrangements.

If a resident chooses not to stay in the arranged accommodations when there is availability, the resident will be responsible for arranging their own accommodations at their expense and an allowance will not be provided.

Mandatory out of town rotations for Queen's Emergency Medicine are:

CHEO (1 block in PGY 1 and 2 blocks in PGY 3)

- Accommodation: Arranged by EM Program Administrator and provided through the Regional Education Office at Queen's University as described above.
- Travel: Costs to be reimbursed by the Regional Education Office at a rate of \$105 per 2 weeks or \$210 per month.

Toxicology rotation (1 block in PGY 4 or PGY 5)

- Accommodation: Arranged by EM Program Administrator and provided through the Regional Education Office at Queen's University as described above.
- Travel: Costs to be reimbursed by the Regional Education Office at a rate of \$120 per 2 weeks or \$240 per month.

Orthopedics Oshawa (1 block Obstetrics in PGY 2)

- Accommodation: Arranged by EM Program Administrator and provided through the Regional Education Office at Queen's University as described above.
- Travel: Costs to be reimbursed by the Regional Education Office at a rate of \$110 per 2 weeks or \$220 per month.

Additional Resources Available to Support Academic Activities

To support the educational and academic mandate of our residency training program additional resources are available for residents including:

- Research nurses at Kingston General Hospital and Hotel Dieu Hospital – available to facilitate clinical resident research
- Departmental Epidemiologist – available to provide assistance with selection of research methodology and statistical analysis
- Emergency Department library with up to date texts and journal selections
- Three computer work stations in the library
- Departmental lap top computer
- Computer Data Projector

By application to the Program Director, the costs for the following will be supported **if prior approval is obtained:**

- Slides for presentations at regional/national meetings
- Defray travel costs for presentations at regional/national meetings
- Paper costs for research projects
- Poster presentations

Department Library

The Departmental Library is maintained by the Department of Emergency Medicine Academic fund.

There are collections of relevant texts in both Emergency Departments for immediate access. These texts are for the use of members of all departments in the Emergency Department.

The library is located in the resident room on Victory 3 at KGH and is intended for use by departmental staff and residents only. It is a secure area. The library is stocked with textbooks in Emergency Medicine and other relevant disciplines. This is your library and you are asked to follow some simple rules to keep the library functional.

- Re-shelve all books after use
- Keep the library tidy
- Books are not to be removed from the library

The library also has three-computer workstations with Internet access (lots of Emergency Medicine links), Ovid access, the hospital PCS, and EDIS.

Section 6: Resident Committee Responsibilities

Emergency Medicine residents are expected to take part in various departmental committees. Resident involvement is very important in maintaining the educational standards and working environment of our residency program. The Department values input provided by resident members on these committees.

Residents participate in the following committees:

- Residency Program Committee (see attached Terms of Reference)
This Committee oversees the academic mandate and evaluation of the residency training program. There is one resident member elected by the resident cohort who is the delegated liaison for the resident group with the Program Director and faculty. Residents are automatically committee members during the Chief Resident year (PGY4). Representatives from the other training years are elected annually by their peers.
- Residency Selection Committee (see attached Terms of Reference)
This Committee is tasked with the selection of residents into our program, usually through the CaRMS process but may be asked to evaluate applications for transfers into our program. All PGY 3 residents are involved in the screening, interviewing and ranking of applicants as official Selection Committee members. During the CaRMS process, the other residents are involved in designated tasks.
- Department of Emergency Medicine Clinical Care Committee
This Committee is tasked with the oversight of the clinical care, quality improvement and health care policy development for the Department of Emergency Medicine. The acting Chief Resident is automatically a committee member.

Residents may participate in other committees of interest within the hospital, School of Medicine, Queen's University or an external organization such as PARO with approval of the Program Director.

Department of Emergency Medicine

Residency Program Committee Terms of Reference (Updated Mar 2018)

In keeping with the mandate of the RCPSC and the CFPC, the Residency Program Committee (RPC) is present to assist the Program Directors in the planning, organization and supervision of the Emergency Medicine Training Programs at Queen's University. As of June 2005, the FRCPC and CFPC (EM) Residency Program Committees meet conjointly. Meetings are co-chaired by the FRCPC and CFPC (EM) Program Directors.

Committee Membership:

- FRCPC Program Director (Co-Chair)
- FRCPC Assistant Program Director
- FRCPC Program Administrator
- CFPC (EM) Program Director (Co-Chair)
- CFPC (EM) Assistant Program Director
- CFPC (EM) Program Administrator
- FRCPC Chief Resident (PGY4)
- CFPC (EM) Chief Resident
- CFPC (EM) Resident
- One FRCPC resident from each year PGY1, 2, 3 and 5 elected by their peers
- CBME Lead (Chair of FRCPC Competence Committee)
- Ultrasound Director
- Resident Research Director
- Simulation Director
- Trauma Services Director
- Professional Competency Lead
- Faculty Member at large
- CFPC Enhanced Skills Program Director (corresponding member)
- Surgical Foundations Program Director (Site Liaison for surgical rotations-corresponding member)
- CHEO Emergency Medicine Program Director (Site Liaison for CHEO-corresponding member)
- Lakeridge Health Obstetrics and Gynecology Rotation Site Liaison (corresponding member)
- Lakeridge Health Orthopedic Rotation Site Liaison (corresponding member)

Membership Term:

Resident members will be elected annually.

Faculty members with a portfolio title will serve on the Residency Program Committee for the duration of the position.

Faculty member at large will be elected for a two-year term, renewable once.

Voting:

Decision making will be done by consensus when possible. Each member, with the exception of corresponding members, is entitled to one (1) vote.

Meetings:

Meetings will be held on a quarterly basis. Minutes will be recorded for each meeting and distributed to all committee members, residents in both programs and the Department Head. Minutes will also be posted in the resident lounge.

Responsibilities:

The Residency Program Committee will monitor the educational mandate of the residency program and facilitate communication between the residents and the faculty members in the Department of Emergency Medicine.

The Residency Program Committee will ensure, through the Selection Committees, a fair selection of candidates for our residency programs.

The Residency Program Committee, with the help of the Program Directors, will aid in the process of residency evaluation, promotion and remediation or appeal should the need arise. The Chair of the Competence Committee will submit a report to the Residency Program Committee quarterly regarding individual FRCP resident progress and recommendation for promotion or remediation as appropriate.

The Residency Program Committee and the Program Directors will ensure that mechanisms are in place to provide career planning and wellness resources for residents in the program.

The Residency Program Committee will aid the Program Directors in the process of program evaluation.

Subcommittees:

- FRCP Selection Committee
- CFPC (EM) Selection Committee
- Promotions and Appeals Committee
- FRCP Competence Committee

Joint Residency Program Committee

FRCP Selection Committee Terms of Reference (Reviewed June 2018)

The Selection Committee is responsible for the fair selection of residents into our program maintaining a high standard for admission. Most resident selection will occur through the CaRMS match process.

Committee Membership

- FRCP Program Director (Chair)
- FRCP Past Program Director if appropriate (one year term, renewable)
- FRCP Assistant Program Director
- Four Faculty Emergency Physicians
- FRCP Residents in their PGY 3 year

Meetings

The Selection Committee will meet a minimum of three times during the CaRMS process. The Selection Committee may be convened on an *ad hoc* basis to evaluate the merit of non-CaRMS applications (typically transfers) if appropriate funding and training space is available.

Responsibilities

CaRMS Selection Process

- Committee members will complete CaRMS file review individually using a standardized review form.
- The Committee will meet once in November/December to rank all of the CaRMS applications and determine which students will be selected for interviews.
- The PGY 2 residents will contact all candidates invited for an interview by telephone or email and will forward a program information package via mail.
- The Committee will meet in January to interview the candidates. Interviews will be done by two teams; each team will consist of two staff physicians and one or two PGY3 residents depending on the number of resident members available. A standardized interview rating form will be used. All candidates will participate in an exit interview with the Program Director and Assistant Program Director. The exit interview will not be rated.
- On interview day, PGY1 Residents will offer tours of Kingston hospitals and important city landmarks. The PGY2 and PGY4 residents will present an orientation information session. Additional faculty may participate in the orientation information session if appropriate.
- The Committee will reconvene immediately following the interviews to determine the final rank order of candidates for submission to CaRMS. An initial rank order will be generated from the composite scores of both interview sessions for each candidate. The Program Director will facilitate discussion during the rank order process; however, the final rank order list will be decided by consensus.

Non-CaRMS (Transfer) Process

- Candidates will be subject to the same selection committee process used for the CaRMS process (i.e. suitability for our program based will be assessed based on the merit of the candidate).
- The candidate must ensure funding is available prior to initiating the application process.

- The Residency Program Committee will determine if there is appropriate training space and resources available to proceed with the application.
- If funding and training space are available, the applicant will be asked to provide an application to the Program Director that includes: a letter of intent to transfer, three letters of reference, medical school transcripts and all resident evaluations received to date.
- The Selection Committee will review the applicant's file to decide whether to offer an interview.
- Following an interview, the Selection Committee will meet to make a final decision whether or not to formally accept the candidate into the residency program. This decision will be communicated to the Post Graduate Medical Education Office.
- The Selection Committee will adhere to the PGME policy on internal transfers available at: <https://meds.queensu.ca/academics/postgraduate/current/policies/transfer-information>

Section 7: Electives

Electives can be taken during the residency program but **must be discussed with and approved by the Program Director** and meet the standards of the Royal College Emergency Medicine Specialty Committee.

All requests for electives should be submitted in writing to the Program Director and must include a list of learning objectives and measurable outcomes.

Mandatory off-service rotations can be taken at other hospitals **after approval by the Program Director**. It is the responsibility of the resident to ensure that the rotation is approved by the hospital, college and licensing board of the facility involved. Travel and accommodation costs are the responsibility of the resident.

Electives in other areas are usually taken during the PGY 3-5 years. Electives can be in core type rotations (General Surgery etc.) or in the Emergency Medicine subspecialty areas that may include (not inclusive):

- Emergency Medical Services
- Disaster Medicine
- Trauma
- Toxicology
- Critical Care Medicine
- Research
- Public Health
- Global Health
- Wilderness Medicine
- Medical Education

The resident is responsible for obtaining the electives, initiating the paperwork and covering any associated costs. Time spent in these electives can be considered part of fellowship training in some subspecialties.

Residents may also do Emergency Medicine electives in other centers (academic or community based).

Section 8: Resident Evaluation and Progression

Resident Evaluation Methods

The evaluation process consists of many steps to help you become a competent consultant in Emergency Medicine and to help you pass the RCPSC Specialty Exams held in spring of the PGY5 year. For residents entering through the CBME Curriculum, specialty examinations will be completed in the spring of the PGY 4 year.

Daily Evaluations

Residents will be evaluated on a daily basis using a workplace based assessment of Stage Specific Entrustable Professional Acts (EPAs). The evaluation will be performed electronically on the MedTech platform and will include an assessment of milestone achievement and a global entrustment score. Written feedback may be included. The evaluation should occur immediately following the period of direct observation, however, may occur at some later time due to clinical demands. **Residents are required to obtain at least one evaluation per clinical shift in the Emergency Department.**

Residents can review their evaluations and track overall progress on their personal electronic dashboard on MedTech.

OSCE

Formative OSCE examinations will be completed in the Simulation Lab twice yearly. These assessments will be videotaped to allow each resident to self-reflect on his/her performance and learning issued identified by the OSCE preceptor.

Multi-disciplinary Evaluation

Residents are required to obtain evaluation from nursing and allied health professionals annually using a 360 Evaluation Tool twice per year. The multi-source feedback form is available electronically via MedTech and can be triggered in the same format as EPA workplace-based assessments.

ITERS

ITERS will no longer be completed for most rotations following transition to a CBME Curriculum model. ITERS may still be completed for out of town rotations and longitudinal experiences (e.g. Trauma Team).

Periodic Performance Assessment

Residents may receive a periodic performance assessment to provide a global evaluation of performance on some rotations where the use of EPAs workplace based assessment may not be feasible or consistent (all hospital based rotations except anaesthesia). In this regard, Periodic Performance Assessments function similar to a rotation ITER but **are expected to be completed weekly** instead on once per rotation.

Self-Reflection

Residents are required to complete a self-assessment tool prior to each quarterly review to encourage a lifelong commitment to principles of professional development, highlight milestone achievements and facilitate a discussion on learning needs or issues. Each month you will receive, by email, a file of return visits of your patients. Patients who return to the KGH or UCC within 7 days of discharge are included in this list. Review of this list in a thoughtful manner provides you with an opportunity to reflect on your practice patterns and resource stewardship and identify any missed or incorrect diagnoses with the intent to improve patient safety and quality care.

Oral Examinations

Practice oral exams are scheduled once per block during the academic year. All PGY levels are involved on a rotational basis with increasing frequency as resident progress through their training. On average, PGY 1 residents may expect to participate in one oral examination/year whereas PGY 5 residents may expect to participate in oral examinations monthly. Participation in oral examinations is mandatory.

Written Examinations

Three written examinations are offered annually. **Written examinations are considered mandatory training experiences and residents must receive permission from the Program Director to be absent or to write the examination outside of Queen's University**

- Canadian In-Training Exam (CITE): a 4-hour short answer exam produced national and offered twice per year. Performance on this exam will be benchmarked against the Canadian resident cohort for each PGY year of training (October/November and March/April of each year)
- ABEM written exam: a 4-hour multiple choice exam, a standardized exam for all North American EM residency Programs (February of each year)
- National Review Course for all PGY5 residents – includes practice oral examinations by an examiner outside of Queen's University

Process for Resident Promotion and Remediation

Quarterly Review

The Program Director will meet individually with each resident on a quarterly basis to go over evaluations, future rotations, career planning, and the goals and objectives for upcoming rotations. Any problems the resident is having can be discussed at these meetings although all residents are encouraged to contact the Program Director at any time for help with personal or professional problems.

Academic Advisor Review

Resident will meet with his/her assigned Academic Advisor usually quarterly but at minimum once per stage of training. Prior to the meeting, the resident will be tasked to complete a self-assessment of their progress toward completion of the required training experiences for his/her stage of training. Based on this review, the resident will prepare a personal learning plan that includes a minimum of two learning goals, each of which reference at least two CanMEDS roles. The personal learning plan should also identify the action plan, time frame and outcome objectives of these learning goals. Academic Advisors will thoroughly review resident progress prior to the meeting and assist the resident to refine or expand their personal learning plan as necessary. During subsequent meetings, Residents will be asked to document the outcome of their existing personal learning plans.

Competence Committee Review

The Competence Committee consists of the Program Director, the CBME Lead and Academic Advisors. The Committee will meet quarterly to review resident progress and make decisions on resident promotion or remediation.

For CBME curriculum resident cohort: The Committee decision will be forwarded to the Residency Program Committee Promotions and Appeals Committee for discussion and endorsement.

For the traditional curriculum resident cohort: The Committee decision will be included as one data point for discussion by the Residency Program Committee Promotions and Appeals Committee who will make the final decision regarding promotion or remediation.

Residents will be notified in writing of Competence Committee decisions and recommendations.

Residency Program Committee Promotions and Appeals Subcommittee

For residents in the traditional curriculum cohort: Based upon review of resident evaluations, academic performance, participation in the activities of the residency training program and staff feedback, the Program Director facilitates a discussion regarding promotion or remediation with members of the Residency Program Committee Promotions and Appeals subcommittee.

For CBME curriculum resident cohort: The Competence Committee decision regarding resident promotion or remediation will be forwarded to the Residency Program Committee Promotions and Appeals Committee for discussion and/or endorsement.

See attached committee Terms of Reference.

PGME Assessment, Promotions and Appeals Policy

Formal remediation and probation periods are organized in consultation with the resident, PGME office and take place in accordance with the Queen's University PGME Assessment, Promotion and Appeals policy available at:

<http://meds.queensu.ca/education/postgraduate/policies/apa>

NOTE: The PGME policy is currently being reviewed to align with the CBME Curriculum Model.

Resident Responsibility in Programmatic Assessment

Residents are asked to participate in the evaluation of all aspects of the residency training program. These systematic evaluations are essential for our training program to maintain full accreditation and the results are used to guide curriculum development and program improvements.

Evaluation of the Residency Training Program

Residents are asked to evaluate the education program on a yearly basis. Evaluations will be distributed and collected through MedTech electronic platform. These evaluations will inform the Residency Program Committee's annual curriculum review.

Resident Evaluations of Attending Staff and Emergency Medicine Rotations

Residents will be required at the end of each block to evaluate their EM rotation as well as staff physicians they have worked with in the Department. Evaluations will be distributed and collected through MedTech electronic platform. These evaluations will be shared anonymously with the Attending Staff and the Program Director and will be included in the annual performance review for all Attending Staff.

Joint Residency Program Committee

Promotions and Appeals Committee

Terms of Reference (Updated June 2018)

Mandate

The Promotions and Appeals Committee is a sub-committee of the Joint Residency Program Committee (RPC). The purpose is to demonstrate our accountability as medical educators to the public, that our graduates will provide high quality, safe care to our patients and maintain the standards of the health care system. The committee is responsible for decisions regarding resident promotion and the need for remediation.

Membership

FRCP Program Director (Co-Chair)
CCFP(EM) Program Director (Co-Chair)
FRCP Assistant Program Director
CCFP(EM) Assistant Program Director
CBME Lead
Ultrasound Director
Simulation Director
Resident Research Director
Director of Trauma Services
Professional Competency Lead
Faculty Member at Large on RPC

Responsibilities

- Review each resident's progress and the recommendation of the FRCP Competence Committee (where applicable) usually quarterly. For FRCP residents in the CBME track, reviews will occur at least once during each stage of training.
- Synthesize the results from multiple sources to make decisions related to:
 - promotion of residents to the next stage of training
 - review and approval of individual learning plans developed to address areas for improvement, in consultation with the PGME Education Advisory Board
 - readiness to challenge the Royal College examinations
 - readiness to enter independent practice on completion of the transition to practice stage
 - the determination that a trainee is failing to progress within the program
- Monitor the outcome of any learning or improvement plan established for an individual resident in conjunction with the Program Director and Academic Advisor (when appropriate).
- Follow the defined Queen's University PGME Appeals Process
 - 1st level Appeal – Residency Program Committee
 - 2nd level Appeal – Postgraduate Associate Dean (ARB)
 - 3rd level Appeal – Dean School of Medicine (Tribunal Board)
- Review resident applications for the Restricted Registration Program and monitor current participants to ensure inclusion criteria continue to be met.

Terms

Terms of membership will be determined by the terms of each member's applicable positions.

Frequency of Meeting:

Meetings will be held four times per year in conjunction with the Joint Residency Program Committee Meetings.

Quorum

Minimum of 50% of voting membership

Decision Making

By consensus whenever possible

Minutes

The agenda is to be circulated prior to the meeting. The minutes of the meeting are to be recorded and prepared by the EM Program Assistant for distribution to the members of the committee and the Joint Residency Program Committee.

Section 9: Level of Responsibility and Performance Criteria for Residents in the Emergency Department

The majority of clinical rotations will be spent in Emergency Medicine during the residency. Residents will spend a total of 14 blocks in PGY1 and 2 in the ED as a junior resident and 28 blocks in the ED in PGY 3-5 year as a senior resident.

Emergency Medicine rotations will take place either at the HDH Urgent Care Centre or the KGH Emergency Department. Pediatric Emergency Medicine rotations are usually completed at CHEO. The Community EM rotation is at a non-teaching site of your choosing. In PGY1 and 2, residents will spend time equally between the two departments. In PGY 3-5, the majority of training will take place in the tertiary care setting at KGH to provide exposure to a high volume of acute and critical care cases. Senior residents will continue to work at the HDH UCC where there is typically a high volume of lower acuity patients requiring many procedures. This exposure offers the senior resident a chance to work in a community hospital setting and to develop skills in running a high-volume department.

Levels of Training

There are separate sets of responsibilities, supervision rules and performance expectations for residents at each level of training

- Residents at the PGY1 and PGY2 levels are considered to be junior residents.
- Residents at PGY3, PGY4, and PGY5 levels are considered senior residents.
- The resident in the latter half of the PGY5 year is at the level of a graduating resident.

Graded Responsibility and Staff Supervision

Graded responsibility and staff supervision are linked and discussed as a single entity. It is expected that residents will take on increasing levels of clinical responsibility with less supervision as they progress through the five years of the program.

The junior resident at the basic clinical year level is supervised closely in the initial stages. The staff physician will confirm history and physical findings with the resident prior to ordering tests, treatment or discharge. The staff physician will directly observe the resident doing clinical duties. The resident early in PGY1 is encouraged to deal with only one or two patients simultaneously. Residents at the junior resident level are required to be present for all resuscitation cases in the department and will act under the supervision of the attending staff or senior resident. Junior residents are encouraged to perform as many simple procedures as possible with staff supervision.

As the junior resident progresses through first and second year more independence is given. There is less staff observation and the resident is encouraged to examine the patient and order initial investigations and treatment independently. A junior resident at the end of PGY2 is encouraged to perform simple procedures independently and is permitted to see an increasing volume and number of patients simultaneously. Junior residents must discuss all cases with the attending staff physician prior to discharge.

The senior resident is given more independence and responsibility through each of PGY3 to PGY5 years. No other resident intervenes between the staff physician and the senior resident. The senior resident is expected to take an increasing, graduated independent role in all clinical

situations including critical care, resuscitations, EMS patches and Emergency Department management. Staff supervision will remain close and the resident is expected to review all cases with the staff physician. The resident should discuss all referrals with the attending staff physician. **Senior residents are expected to see patients in all sections of the department when on shift; i.e. the senior resident should pick up new patients in sections of the department other than their "assigned" section particularly on the night shift in a manner similar to the Emergency Physician on duty.**

Senior residents will participate in the department's Quality Assurance processes for laboratory and radiographic studies (see Guide to Look Ups). Senior residents are responsible for presenting Grand Rounds, Resuscitation Rounds and Journal Club. Staff supervisors will be assigned on a rotational basis by the Resident Research Director.

Junior and senior residents will be observed and evaluated in the CanMEDS competencies using the workplace-based EPAs.

All residents are involved in clerkship teaching as outlined in our "Clerkship Manual" <http://emergencymed.queensu.ca/education/undergrad>

Performance Criteria

We realize that all residents develop skills and learn at different rates. We have developed performance criteria for the junior, senior and graduating resident in the following areas:

Criteria	Junior Resident (PGY 1/2)	Senior Resident (PGY 3/4)	Graduating Resident (PGY 5)
Medical Knowledge and Basic Science	Good general knowledge in common clinical problems	Excellent knowledge base in common clinical problems, developing knowledge in uncommon problems	Excellent knowledge base in common and uncommon problems
Clinical Knowledge and Skills	Able to diagnose and manage common clinical problems consistently	Able to diagnose and manage common and complex clinical problems	Able to diagnose and manage common, complex and uncommon clinical problems
Procedural Skills	Able to perform basic procedures relevant to EM	Understands and can perform all relevant ED procedures	Understands, performs and teaches all ED procedures with expertise
Judgement and Decision Making	Good clinical judgement in common problems	Good clinical judgement in common and complex problems	Excellent clinical judgement in all types of problems at the consultant level
Resuscitation Skills	Recognizes sick patients, able to outline management and works as part of the team	Good knowledge base and procedural skills, developing leadership skills in resuscitation	Provides expert management and leadership concurrent with a teaching role in resuscitation
Communication Skills	Effective and appropriate, learning	Effective and appropriate, able to	Excellent skills in dealing with patients,

Criteria	Junior Resident (PGY 1/2)	Senior Resident (PGY 3/4)	Graduating Resident (PGY 5)
	to deal with complex issues	communicate effectively in difficult situations	and coworkers, understands racial, cultural and gender issues
Teaching Skills	Motivated, able to give a good presentation, developing one-on-one teaching skills	Motivated, good bedside and group teaching	Superb bedside and group sessions, has real concept of teaching methodology
ED Management	Understands concepts of ED management, begins to take ownership of patient flow in designated sections of the department	Runs department efficiently under normal circumstances	Superb leadership can run department and teach on difficult shifts, aware of risk management and QA issues
Professional Attitudes	Responsible, reliable, motivated and organized	Always responsible, reliable, motivated, organized with minimal supervision	Always responsible, motivated, organized, reliable with very little supervision, superb leadership skill

Documentation on Patient Charts

All residents are required to complete patient documentation in a timely manner. **Junior residents must document on each patient's chart immediately after completing an assessment.** Senior residents may delay documentation during clinical shifts if the focus of learning is on managing patient volume, however, must document immediately on the chart for any complicated or seriously ill patient. Monitoring documentation is one strategy faculty use to supervise your clinical care and timely documentation is essential to facilitate an increasing level of responsibility. To facilitate billing, all residents must use the prepopulated procedure notes when documenting procedures performed.

On-line Medical Direction for EMS by Senior Residents

Included in your list of responsibilities while working as a Senior EM Resident, is answering paramedic patch calls to KGH ED. Kingston Base Hospital is responsible for the training and supervision of six ambulance services in our region, including two services that employ advanced care paramedics. Dr. Andy Reed is the Base Hospital physician for the Southeastern Ontario region.

It is mandatory that you familiarize yourselves with the standing orders, protocols, and medications used by paramedics. A copy of these standing orders will be issued to you. In addition, copies are available at the clerk's desk in Section A of KGH. Finally, a short quiz is to be completed prior to you starting in the ED.

The paramedics are relying on you to know their capabilities and limitations. Please take the time to prepare for their calls. If you are interested in doing a ride-out with the paramedics that can be arranged by contacting Dr. Andy Reed.

Role of Chief Resident

The PGY 4 resident is designated as the Chief Emergency Medicine Resident. All residents in their PGY 4 will share in the Chief Resident duties for a portion of the academic year.

The Chief Resident is expected to:

- administer the residents' schedule.
- act as liaison between the residents and the Program Director and other faculty members.
- provide leadership in the academic and social activities of the other residents.
- serve as the academic conscience at teaching sessions and rounds.
- participate in hospital committees as required.
- deal with administrative problems that arise while on duty in the Emergency Department

Role of the Elected Resident Representative on the Residency Program Committee

Each year one resident will be chosen by the resident group to serve as the elected representative on the Residency Program Committee (RPC).

The Resident Representative is expected to:

- act as a liaison in regards to presenting issues or concerns of the entire resident cohort at RPC meetings.
- communicate important information and decisions of the Residency Program Committee to the resident cohort.
- participate in any administrative duties if a resident representative of the RPC is required by the PGME office.

Section 10: Shift Scheduling and PARO Agreement Leave Benefits

The EM chief residents are responsible for making the resident schedules for the HDH UCC and KGH ED. As per the PARO-CAHO Agreement, the upcoming block's schedule is posted on the website 14 days prior to the commencement of each block. Occasionally some last-minute revisions need to be made and all residents will be notified by email if a revised schedule is posted. Making the schedule is a difficult and time-consuming process so please take note of the following information.

As numbers of residents vary each month, the number of shifts worked in a month may vary to ensure adequate resident coverage. Residents typically are assigned 10-16 shifts per block and are scheduled to work two weekends each block.

The Chief Resident tries to achieve a balanced distribution of shifts between the two training sites to provide a comprehensive exposure to both acute and less urgent illness/injury. This may mean that resident have several consecutive days of work, or shifts may be spaced more widely apart. Residents are encouraged to contact the appropriate Chief Resident, indicated on each block schedule, with any questions or concerns related to the schedule.

Residents may trade shifts with another resident at the same level of training (i.e. junior or senior resident). Residents making the shift changes are required to notify the unit clerk at both sites and to note the changes on the master schedule located on the bulletin board on Victory 3. Do not send your shift changes to the scheduler.

Freedom to Attend Academic Sessions

The Department of Emergency Medicine Academic Day takes place every Thursday from 08:30 – 15:00 hours and residents from PGY1 – PGY5 are excused from clinical duties to attend. Residents are also excused from clinical duties to attend Journal Club, Junior Resuscitation Rounds on Friday mornings (PGY 1 and 2 residents), participate in oral examinations, complete quarterly reviews with the Program Director or Academic Advisor and when assigned teaching responsibilities through our program if indicated.

Notification of Illness and Emergency Shift Coverage

In the event that you suddenly become ill and are unable to work, please notify the chief resident as soon as possible, and attempt to arrange for someone else to cover your shift. If you are unable to do either please notify the staff physician on duty at that time.

Some resident shifts have been deemed to be essential. These are the Nk and Eh shifts for senior residents and the Nk shift for junior residents. In the event of an unexpected absence for residents assigned to work an essential shift, the Chief Resident will enact the Emergency Shift Coverage policy (see attached).

Emergency Department Resident Absence Policy

Kingston Health Sciences Centre

July 2018- December 2018

1. As soon as a resident knows they are unable to cover any scheduled shift it is their responsibility to find a replacement and notify the Chief Resident by text or phone call as soon as possible. Once a replacement is found confirmation should be sent to Mary Lee and the current Chief Resident. The Chief Resident for each block will send out their contact information by email at the beginning of the block.
2. If the resident is unable to find a replacement, the Chief will then attempt to find a replacement.
3. If a replacement cannot be found, the shift will go uncovered unless it is deemed "essential" (described below). It is the resident's responsibility to contact the Unit Clerk at HDH or KGH to ensure a message is passed along to the Attending Physician.

For Senior Residents:

1. Only the Nk and Eh are to be considered "essential" shifts.
2. If either of these shifts are not able to be worked by a resident, and the above policy has not resulted in a volunteer then the D3 resident will be asked to cover this shift.
3. If there is no D3 coverage, or this resident is unable to switch, then the A1 resident will be asked to switch.
4. If there is no A1 coverage, or this resident is unable to switch, then the Dh resident will be asked to switch.

For Junior Residents:

1. Only the NK is to be considered an "essential" shift.
2. If this shift is not able to be worked by a resident, and the above policy has not resulted in a volunteer then the AB3 resident will be asked to cover this shift.
3. If there is no AB3 coverage, or this resident is unable to switch, then residents in the following order will be asked to cover the Nk until one is available: AB2, D2, Dh, DB1

If an essential shift is unable to be covered despite the exhaustive measures above then it is the Chief Resident's responsibility to contact the Attending Physician.

Requests for Vacation/ Education Leave

In compliance with PARO Agreement, all requests for leave must be submitted on a Department Leave Request Form (available on the website) to the chief account, **at least 30 days prior to the block** in which leave is requested. **Emailed or verbal requests are not acceptable.** The type of leave requested (Vacation vs. Educational) must be indicated. Generally, only one week of vacation should be taken during a one block rotation. If the requested dates fall between two blocks, please complete and submit two separate request forms.

We do our best to accommodate all requests that we receive by the specified deadline. In cases where requests conflict, priority for time off will be given to residents taking educational leave followed by vacation requests. We will notify you as soon as possible if your vacation request cannot be accommodated.

PARO Policy on Vacation (Updated Sept 2017)

<http://www.myparo.ca>

11.1

Residents shall be entitled to four (4) weeks paid vacation during each year.

11.2

Vacations may be taken by housestaff at any time, but, subject to article 11.4, the timing of vacation may be delayed only where necessary, having regard to the professional and patient responsibilities of the hospital department for the time the vacation is requested.

11.3

Housestaff may request their vacation to be taken in one (1) continuous period, in one or more segments of at least one (1) week in duration, or in segments of less than one week, which request will be scheduled provided professional and patient responsibilities are met.

11.4

Requests for vacation shall be submitted in writing to the department head at least four (4) weeks before the proposed commencement of the vacation. In, addition each resident taking a certification examination in the Spring shall have until one month prior to the date of the examination to make a written request for one week of his/her vacation entitlement. Vacation requests submitted before March 1, or one month prior to the date of a certification examination, will be considered in priority to those submitted after that time. All vacation requests must be confirmed or alternate times agreed to, in accordance with Article 11.2, within two (2) weeks of the request being made. Where the hospital department rejects the vacation request, it will do so in writing and include the reasons for rejecting the original vacation proposal.

11.5

There will be no adjustment to vacation entitlement for up to seventeen (17) weeks in the case of pregnancy leave of absence and/or up to thirty-seven (37) weeks in the case of parental leave of absence. Where a resident is entitled to, takes pregnancy leave, is also entitled to, and takes parental leave, there will be no adjustment to vacation entitlement for up to an additional thirty-five (35) weeks. If an employee is on pregnancy or parental leave, any

accrued vacation shall be taken immediately after the leave expires, or at such later date if agreed to between the resident and the hospital.

11.6

The Hospital shall not institute policies that restrict the amount of vacation that residents can take over a given rotation, it being understood that the hospital continues to have the right to delay an individual resident's request where necessary having regard to the professional and patient care responsibilities of the hospital department pursuant to Articles 11.2 and 11.3.

PARO Policy on Professional Leave (Updated Sept 2017)

<http://www.myparo.ca>

12.1

In addition to vacation entitlement, residents shall be granted additional paid leave for educational purposes. Such educational leave, up to a maximum of seven (7) working days per annum, shall be consecutive if requested by the resident, and shall not be deducted from regular vacation entitlement. Such leave may be taken by housestaff at any time, provided only that professional and patient responsibilities are met to the satisfaction of the hospital department head.

12.2

Each resident shall be entitled to paid leave for the purpose of taking any Canadian or American professional certification examination: for example, Royal College examinations, LMCC, ECFMG, and CFPC. This leave shall include the exam date(s) and reasonable travelling time to and from the site of the examination. This leave shall be in addition to other vacation or leave.

12.3

- a. Subject to operational requirements and at the request of a resident, a resident will not be scheduled for call duties for a period up to fourteen days prior to a CFPC or RCPSC certification exam.
- b. Subject to operational requirements and at the request of a resident, a resident will be granted up to seven consecutive days off during one of the four weeks preceding a CFPC or RCPSC certification exam.

PARO Policy on Statutory Holidays (Updated Sept 2017)

<http://www.myparo.ca>

13.1

All housestaff shall be entitled to the following recognized holidays:

1. New Year's Day
2. Family Day
3. Easter Friday
4. Victoria Day

5. Canada Day
6. August Civic Holiday
7. Labour Day
8. Thanksgiving Day
9. Christmas Day
10. Boxing Day
11. One (1) floating holiday

13.2

All housestaff shall be entitled to at least five (5) consecutive days off during a twelve (12) day period that encompasses Christmas Day, New Year's Day and two (2) full weekends. These five (5) days off are to account for the three (3) statutory holidays (Christmas Day, Boxing Day, New Year's Day), and two (2) weekend days.

13.3

If a resident is scheduled to work on a recognized holiday, he/she shall be entitled to a paid day off in lieu of the holiday to be taken at a time mutually convenient within ninety (90) days of the holiday worked.

PARO Policy on Pregnancy and Parental Leave (Updated Sept 2017)

<http://www.myparo.ca>

15.1

A resident shall receive up to seventeen (17) consecutive weeks of pregnancy leave at her discretion. In no case will she be required to return to her duties sooner than six (6) weeks following delivery. A resident shall be required to give four (4) weeks' notice of her intentions regarding timing of said leave in order to ensure that professional and patient care responsibilities are met. A resident who is eligible for a pregnancy leave may extend the leave for a period of up to twelve (12) months duration, inclusive of any parental leave.

15.2

A resident who is the parent of a child shall receive up to thirty-five (35) weeks parental leave if the resident took pregnancy leave, or thirty-seven (37) weeks if the resident did not take pregnancy leave, following the birth of the child or the coming of the child into custody, care and control of the resident for the first time at the resident's discretion. Parental leave may begin no more than fifty-two (52) weeks after the day the child is born or comes into the custody, care and control of a parent for the first time. A resident shall be required to give four (4) weeks written notice of her/his intention regarding the timing of such leave in order to ensure that professional and patient care responsibilities are met. A resident who is eligible for a parental leave who is the natural father or who is an adoptive parent may extend the parental leave for a period of up to twelve (12) months duration, inclusive of any parental leave.

15.3

Pregnancy shall not constitute cause for termination of employment.

15.4

In the event that a resident takes pregnancy or parental leave, subsequent to the completion of the leave she or he shall be entitled to work for the same period as the leave in order to complete her or his year of post-graduate training.

15.5

All benefits and conditions of work concerning pregnancy/parental leave shall apply equally to the adoption of a child as to the birth of a child.

15.6

When a resident is absent on an approved leave of absence or because of disability, he/she shall be entitled to work for the same period of time as the leave in order to complete his/her training requirements as set out by the appropriate accrediting body and a suitable position shall be provided within twelve (12) months of the date the resident advises that he/she is ready and able to commence work.

15.7

Pregnancy Leave

On confirmation by the Employment Insurance Commission of the appropriateness of the Hospital's Supplemental Unemployment Benefit (SUB) Plan, a resident who is on pregnancy leave as provided under this Agreement who is in receipt of Employment Insurance pregnancy benefits shall be paid a supplemental employment benefit. That benefit will be equivalent to the difference between eighty-four per cent (84%) of the resident's regular weekly earnings and the sum of the resident's weekly Employment Insurance benefits and any other earnings. Such payment shall commence following completion of the two (2) week Employment Insurance waiting period, and receipt by the Hospital of the resident's Employment Insurance cheque stub as proof that she is in receipt of Employment Insurance pregnancy benefits, and shall continue for a maximum period of fifteen (15) weeks. The resident's regular weekly earnings shall be determined by multiplying her regular hourly rate on her last day worked prior to the commencement of the leave times her normal weekly hours.

Parental Leave

On confirmation by the Employment Insurance Commission of the appropriateness of the Hospital's Supplemental Unemployment Benefit (SUB) Plan, a resident who is on parental leave as provided under this Agreement who is in receipt of Employment Insurance parental benefits shall be paid a supplemental employment benefit. That benefit will be equivalent to the difference between eighty-four (84%) percent of the resident's regular weekly earnings and the sum of her or his weekly Employment Insurance benefits and any other earnings. Such payment shall commence following completion of the two week Employment Insurance waiting period, and receipt by the Hospital of the employee's Employment Insurance cheque stub as proof that she or he is in receipt of Employment Insurance parental benefits and shall continue while the resident is in receipt of such benefits for a maximum period of twelve (12) weeks. The resident's regular weekly earnings shall be determined by multiplying her or his regular hourly rate on her or his last day worked prior to the commencement of the leave times her or his normal weekly hours.

15.8

It is understood and agreed that the hospital's obligations for payment under the SUB Plan shall not extend beyond the period of the contracted appointment if the resident has completed her training requirements as set out by the appropriate accrediting body.

Resident Scheduling Rules (Updated June 2018)

1. The base number of shifts per block is 14.
2. Residents who request formal vacation will receive a shift reduction of three (3) shifts/week of vacation or education leave:
 - One week vacation - shift reduction = 3
 - Two week vacation - shift reduction = 6
 - Less than one week of vacation/leave = one (1) shift per every two (2) days of vacation/leave
 - Unless approved by the Program Director in advance, the absolute minimum number of shifts per block is eight (8) in order to receive an evaluation.
3. Unless approved by the Program Director (or designate) vacation will be limited to one (1) week per block in order to ensure there is an adequate clinical exposure to provide a meaningful evaluation of resident performance.
4. Residents who request their shifts be "stacked" but who do not take formal vacation will not receive a shift reduction. The decision to allow shift stacking is solely at the discretion of the Chief Resident as requests of this nature may create undue pressures for the scheduler. Abuse of this system will result in termination of this option.
5. Double senior resident coverage – during blocks where there is a relative surplus of senior residents (typically block 1 and 2), the CCFP-EM resident may be assigned to additional shifts in order of priority - KGH BF, KGH DB1, AB2, KGH AB3, in order to meet the minimum base shift count of 14 shifts/block. Overlap with an Emergency Medicine PGY 1/2 assigned to the KGH AB2 or AB3 shift should be avoided when possible to maximize the learning experience in Section A for both learners.
6. Senior shift priorities - during months when there is a relative deficit in senior residents the priority for scheduling seniors will be: KGH night, HDH E, KGH A1, KGH D3, HDH D. When shifts must be eliminated due to resident numbers the shift reduction will start with the lowest priority senior shifts (ie HDH D) and progress in a reverse manner. The FRCP and CCFP-EM Program Directors must be notified in advance when shifts will be dropped for a given block.
7. Junior shift priorities – during months when there is a relative deficit in the junior resident coverage the order of priority for scheduling shifts will be: KGH night, HDH D, KGH AB2, KGH AB3, KGH DB1, KGH D2. When shifts must be eliminated due to resident numbers the shift reduction will start with the lowest priority junior shifts (ie KGH D2) and progress in a reverse manner. The FRCP and CCFP-EM Program Directors must be notified in advance when shifts will be dropped for a given block.
8. PGY5 (senior) teaching shifts – during months when there is a relative surplus of senior residents (usually block 1 and 2 or blocks when seniors are assigned less than 12 shifts excluding periods of shift reduction for exam preparation) PGY5s may be scheduled for a designated teaching shift that will occur on the KGH AB2 or AB3 (section A) shift when there is an Emergency Medicine PGY1 or 2 assigned to that shift. The purpose of these shifts will be for a mentored experience in teaching for the assigned PGY5 and enhanced bedside teaching for the assigned PGY1/2. A teaching shift will be counted toward the base number of shifts for the assigned PGY5 residents.

9. On Academic Days (Thursdays) an off service junior resident will be assigned to the KGH A1 shift in lieu of the senior resident whenever possible.
10. On Fridays, a senior resident will be assigned to the KGH DB1 shift in lieu of a junior resident whenever possible.
11. Ultrasound teaching shifts - Ultrasound shifts do not count toward the base shift count for CCFP-EM residents. The US shift may be included in the base shift count for FRCP residents only on months when the base count per senior resident equals or exceeds 12 shifts and when including the shifts would result in an excessive number of shifts per week (greater than five (5) shifts in a row including academic full day).
12. Shift reduction for PGY5 exam preparation - A shift reduction will be negotiated with the FRCP Program Director annually based on the timing of the examination. **As this shift reduction is intended to provide residents with additional time to study, it is understood that if a resident chooses to use the shift reduction, they will not pick up any additional clinical work during this period.** In general, the shift reduction will occur as:
 - No night shifts starting January (typically block 8 or equivalent block)
 - 12 shifts for block 8
 - 10 shifts for block 9
 - 10 shifts for block 10
 - 8 shifts for block 11 (block immediately before the exam)
 - 8 shifts for block 12 (block between written and oral examination)
 - Full complement of shifts (including nights) for block 13
13. Fellows - Residents completing the Resuscitation and Reanimation fellowship are to receive a maximum of eight (8) shifts per block.
14. Shift reduction for PGY4 special interest programs - PGY4s who are completing a master's degree or equivalent will be scheduled for a maximum of ten (10) shifts per block. The shift reduction is to be negotiated with the FRCP Program Director prior to the start of the academic program.
15. The chief resident will attempt to distribute the shifts equitably among residents including the mix between KGH and HDH and the section D and Section A shifts. Residents are not allowed to self-schedule or identify preferences for shift patterns.
16. Unless approved by the Program Directors, academic days (conference, mandatory academic activities) do not count toward the base number of shifts for any given resident.
17. When required due to low senior resident numbers, PGY2 Emergency Medicine residents may be advanced onto the senior schedule once they have completed a rotation in Critical Care and Anaesthesia. The FRCP Program Director must give prior approval for this scheduling option. The PGY2 resident can only be assigned to the HDH E, KGH D3, KGH A1 and HDH D senior shifts (i.e. not assigned to the KGH night as a senior).
18. PGY5 exam days - PGY5s will receive two (2) days for the written examination and one (1) day plus one (1) travel day for the oral examination without the need to take either vacation or education leave. There is no corresponding shift reduction for these exam days unless formal leave (vacation, education) is requested. The PGY 5 residents may

take a total of up to seven (7) days off prior to one exam without the need to take vacation leave.

PGY 5 Shift Reduction Policy and Academic Responsibilities (Updated June 2018)

Shift Reduction

PGY 5 residents will negotiate with the Program Director a reasonable shift reduction to facilitate additional study time. The shift reduction will be determined, in part, by the timing of the written and oral portions of the FRCP Certification Examination. See Schedule Rules above for typical shift reduction pattern.

Academic Responsibilities During PGY 5 Year

Given the multiples roles of PGY5 residents at rounds, journal club and other academic events, it is the expectation that they will attend all academic events until four (4) weeks in advance of the written exam and one week prior to the oral exam. This requirement does not apply if on a formal vacation or personal leave.

In the four (4) weeks prior to the written exam and one (1) week prior to oral exam, PGY5 residents are encouraged to come to academic events however, it will not be required. Attendance requirements return to normal following completion of the examination.

Any unique circumstances not outlined above will be considered on a case-by-case basis by the Program Director.

Section 11: Rounds and Teaching

QCARE

Queen's Postgraduate Medical Education Office has introduced a common academic half-day into the postgraduate training program for all PGY1 Residents. Topics include physician wellness, financial management, ethics, skill development in teaching and evaluation and clinical documentation. These sessions are mandatory for all PGY1 residents with limited exception (i.e. post-call or out-of-town rotation) and residents are excused from their clinical duties to attend.

QCARE+

Queen's Postgraduate Medical Education Office offers a common academic half day twice a year that is mandatory for all residents in their final year of training. These sessions address issues related to transition to practice including financial wellness, contract negotiation, practice management and managing medico-legal risk. Residents are excused from their clinical duties to attend.

Formative Practice OSCE for the MCCQE Part 2 Exam

Queen's Postgraduate Medical Education Office provides a formative OSCE for all PGY2 residents in preparation for the MCCQE Part 2 Clinical Examination held annually in the fall or spring depending on which session you have applied for. Residents are excused from clinical duties to participate in the OSCE.

Summer Series (July – August)

The Summer Series is an eight-week curriculum of key topics and skills essential to the practice of Emergency Medicine and is mandatory for all EM residents throughout their training program. Topics include trauma, prehospital care, procedural sedation and analgesia, ethics and pediatric resuscitation. Sessions are offered on physician wellness and the humanities are also included. Specific procedural skills include suturing, slit lamp examination central lines, casting/splinting, airway management, thoracentesis and paracentesis, fracture reduction, nerve blocks and lumbar puncture. Point of Care Ultrasound will be taught and it is expected that by the end of the summer most residents will have completed the required 50 scans in each of the primary domains required for certification. At the end of summer, residents will participate in a formative OSCE examination on a high-fidelity patient simulator. OSCE examinations will be videotaped to provide the residents with an opportunity for self-reflection and assessment.

For PGY1 residents, the Summer Series will provide a "bootcamp" orientation experience to ensure that all incoming residents have a standard skill set on which to build their clinical expertise in Emergency Medicine. In the PGY 2-5 years, residents will again be exposed to these skills with the expectation that they achieve greater levels of competency as they advance in training. By the PGY 4 and 5 years, it is expected that residents will assume some of the teaching responsibilities for the summer series, thereby expanding on both their clinical competence as well as their consultant level CanMEDs competencies in professional, communication, scholar and collaborator roles.

Cadaver Training

Residents will participate in a cadaveric procedural skills lab at least once per year. The focus of the 2018/19 Cadaveric Lab is airway management.

Academic Rounds Template (Sept – June)

Week	Wednesday	Thursday	Friday
1	FRCP Practice Orals	<ul style="list-style-type: none"> • Grand Rounds 0830 – 1000 • Core Rounds 1000 - 1200 • Senior Resuscitation Rounds 1330 - 1530 • Critical Appraisal/Clinical Reasoning Series (PGY1) 1300 – 1500 • Presentation skills coaching session (PGY3) 1300-1500 	<ul style="list-style-type: none"> • Junior Resuscitation Rounds 0800 - 1000
2		<ul style="list-style-type: none"> • Grand Rounds 0830 – 1000 • Core Rounds 1000 - 1200 • Senior Resuscitation Rounds 1330 – 1530 • Trauma Case Review 1200-1300 	<ul style="list-style-type: none"> • Junior Resuscitation Rounds 0800 - 1000
3	Journal Club 1900 -2100	<ul style="list-style-type: none"> • Grand Rounds 0830 – 1000 • Core Rounds 1000 - 1200 • Senior Resuscitation Rounds 1330 - 1530 	<ul style="list-style-type: none"> • Junior Resuscitation Rounds 08:00 - 10:00
4	Trauma Rounds 0730 - 0830	<ul style="list-style-type: none"> • Grand Rounds 0830 – 1000 • Core Rounds 1000 - 1200 • Senior Resuscitation Rounds 1330 - 1530 	<ul style="list-style-type: none"> • Junior Resuscitation Rounds 0800 - 1000

Locations of the activities are:

- FRCP Practice Oral Exams – Staff offices, Kingston General Hospital
- Grand Rounds – Richardson Amphitheatre L104
- Core Rounds – Simulation Centre, The School of Medicine
- Senior Resuscitation Rounds – Simulation Centre, The School of Medicine
- Junior Resuscitation Rounds - Simulation Centre, The School of Medicine
- Journal Club – Hosting Faculty member's home
- Trauma Rounds – Etherington Hall

Department of Emergency Medicine Grand Rounds

Attendance at Grand Rounds is mandatory for all residents on Emergency Medicine rotations. Residents who are rotating off service are strongly encouraged to attend rounds whenever possible.

Senior Emergency Medicine Residents will be assigned to present Grand Rounds on a rotational basis. Attending staff will also give a brief case presentation at the session. Topics to be presented should be discussed with the staff physician assigned to supervise rounds that week. Topics can be case-based, topic-based or problem-based and should include a review of the current literature on the topic discussed. The rounds provide the resident with an excellent opportunity to develop teaching skills and feedback should be given and sought.

Core Rounds

Attendance at Core Rounds is mandatory for residents when completing an Emergency Medicine rotation and whenever possible during off-service rotations.

A detailed curriculum list is provided in Section 14 of this manual. Core Rounds take place following Grand Rounds on Thursdays and it is the responsibility of the staff physicians assigned to the rounds to present the rounds to the residents. Residents are strongly encouraged to prepare in advance by reviewing the objectives and completing the recommended reading.

Topics are presented in a two-year cycle; year one covers "Disorders of the Body Systems" and year two covers trauma, special populations, toxicology, environmental emergencies and prehospital care. The topic breakdown comes from the Core Content Listings in Rosen's Emergency Medicine as well as the RCPSC Objectives of Training. Topics have been narrowed down to specific relevant aspects in each area to allow a more focused approach. We can't cover everything in these rounds and you will need to read to fill in the gaps.

Teaching of Non-Medical Expert CanMEDS Competencies

Teaching of the non-medical expert competencies (Communicator, Collaborator, Manager, Scholar, Professional and Health Advocate) occurs in formal teaching sessions integrated into the Core Rounds curriculum cycle. The general headings for these sessions include:

- ED Administration
- Ethics and The Law
- Advanced Communication Skills
- Physician Wellness and Career Management
- Critical Appraisal
- Crisis Decision Making and Leadership in Critical Care
- Violence, Abuse and Crisis Intervention
- Preventative and Population Health

In addition, specific learning goals and objectives for these competencies are established for rotations throughout the Resident Training Program (see Rotation Specific Goals and Objectives).

Residents will be evaluated on each of these competencies in the clinical setting, during practice written, oral and OSCE examinations, junior and senior resuscitation rounds and at the FRCP certification examination.

EMS Bootcamp

Each year residents participate in the EMS bootcamp. For the last several years, the bootcamp has been offered as a collaborative event with the University of Ottawa EM residents. Residents become familiar with the paramedic standing order protocols, equipment available to paramedics, prehospital triage and mass casualty medicine.

Senior Simulation Rounds

Attendance is mandatory for senior residents when completing a rotation in Emergency Medicine and encouraged whenever possible during off-service rotations.

The aim of this curriculum is to help senior EM residents develop their crisis resource management skills and learn/refine their management approach to cardinal acute patient presentations in resuscitation and critical care, including clinical presentations, which may be rarely encountered in actual clinical practice.

The curriculum consists of a weekly two-hour session on Thursday afternoons, facilitated by one of a small group of faculty instructors. Each session focuses on a cardinal emergency presentation (e.g. – hypotension, tachycardia, dyspnea, altered level of consciousness). Using a high-fidelity patient simulator in a realistic clinical environment, trainees are presented with a series of acute patient scenarios in which they must, as a clinical team, perform patient assessments, order and interpret investigations, formulate and implement management plans, and respond to unexpected clinical events. Following each simulated patient encounter, a debriefing session is held in which both the team's medical management and their communication, leadership and teamwork are discussed. This is often followed by a brief didactic presentation by the instructor focusing on a key element of resuscitative care or crisis resource management highlighted by the simulated case.

Junior Resuscitation Rounds

Attendance at rounds is mandatory for junior residents while completing rotations in Emergency Medicine and encouraged whenever possible during off-service rotations.

The aim of this eight week course is to introduce junior learners to simulation and cardiac resuscitation in a safe, energetic, and supportive environment. Diverse learners from the Schools of Nursing and Medicine (clinical clerks and junior residents) work together as they practice basic ACLS principles. Residents will be expected to lead an inter-professional cardiac arrest team in a simulated patient care setting. Residents should already possess ACLS certification and will be expected to apply knowledge learned in the ACLS course to these scenarios.

Specific objectives for knowledge, skills and attitudes has been developed for each topic:

[Week 1: Introduction to Simulation](#)

[Week 2: Communication, Teamwork & Roles](#)

[Week 3: Tachycardia](#)

[Week 4: Pulseless Electrical Activity](#)

[Week 5: Introduction to Simulation Part 2](#)

[Week 6: Communication, Teamwork & Roles Part 2](#)

[Week 7: Bradycardia](#)

[Week 8: Resuscitation Ethics and Special Circumstances](#)

Pediatric Simulation Rounds

Pediatric Simulation Rounds take place approximately three times per year. These rounds are offered in collaboration with the Department of Pediatrics to allow residents an opportunity to practice common pediatric resuscitation scenarios using a high-fidelity simulator. Debriefing and brief didactic teaching occurs following each resuscitation scenario to highlight high yield teaching points. Attendance is mandatory for residents while completing rotations in Emergency Medicine and encouraged whenever possible during off-service rotations.

Trauma Rounds

Faculty Trauma Team Leaders present varied topics related to trauma care. Attendance at these sessions is encouraged on all rotations.

Journal Club

Attendance at Journal Club is mandatory for residents while completing rotations in Emergency Medicine and encouraged whenever possible during off-service rotations.

Two senior residents (one FRCP and one CCFP(EM)) will be assigned on a rotational basis to present an article of interest in Emergency Medicine literature and lead a discussion on critical appraisal appropriate to the type of research study chosen. Residents will also facilitate a higher-level discussion on the integration of the evidence in an emergency medicine practice.

Senior resident responsibilities are:

- The assigned residents coordinate the article(s) chosen.
- At least one week prior to Journal club, forward your articles AND your objectives to the Program Administrator for distribution to all faculty and residents.
- Plan the learning activities for your Journal Club (large group or breaking into small groups, quizzes, Jeopardy, panel discussions, exercises, etc.).
- Conclude by highlighting the teaching points of your session and any clinical take-home messages.
- Collect attendance and evaluation forms. These will have been provided to you prior to your Journal club and must be returned to the Program Administrator.

A Faculty host will briefly present a second recent article of interest and lead a discussion on the impact of the article on changing practice.

Critical Appraisal and Clinical Reasoning/EBM Series

PGY1 residents will learn critical appraisal skills and clinical reasoning/evidence based medicine in a seminar series focused on eight cardinal emergency department presentations. The cardinal presentations are: shock, syncope, chest pain, headache, shortness of breath, altered level of consciousness, abdominal pain and vertigo. Each block, residents will participate in a seminar that highlights cognitive biases, risks and potential pitfalls in the diagnosis and management of a cardinal presentation assisting residents to develop and evidence based

approach to that presentation. During the second half of the session, residents will critically appraise a landmark emergency medicine related study that focuses on cardinal presentation. The studies chosen cover the key research methods and critical appraisal concepts. Each block residents will complete a quiz to demonstrate competency in the skills and knowledge covered. Attendance is mandatory for PGY1 residents. Attendance is optional for PGY2 residents completing a rotation in Emergency Medicine or whenever possible during off-service rotations.

Ultrasound

Ultrasound is offered longitudinally over the course of residency during the summer series, integration into core rounds on a two-year rotating curriculum and through an advanced ultrasound rotation in the PGY3 year. There are defined goals and objectives for ultrasound training activities included with the Rotation Specific Goals and Objectives.

TMTL Rounds

Work life balance is essential for a long sustainable emergency medicine career. TMTL Rounds are held once a year following the Winter Resident Retreat. During the rounds, staff and residents present a brief topic of anything of interest or importance to their lives outside of medicine. These rounds help us maintain our collegial working environment and remind us that TMTL (There's More to Life...)

Section 12: Summary of Other Aspects of the Academic Program

Medical Education

We believe that residents need to be competent educators to be fellowship trained Emergency Physicians and encourage the development of teaching skills by various means. Residents learn teaching methodology in the core curriculum non-medical expert CanMEDs content. Senior residents are given increasing teaching responsibility in one-on-one settings, small group and large group settings. PGY5 residents will participate in designated teaching shifts where they are paired with a junior Emergency Medicine resident on shift. The PGY5 resident will be responsible for all clinical supervision, didactic and bedside teaching for the junior resident and will, in turn, be supervised and mentored in their teaching role by the faculty member on duty. All residents are supported to achieve instructor status in PALS, ACLS, and/or ATLS and are encouraged to teach these programs during residency and after graduation. Residents are encouraged to register for the faculty development sessions (formerly Residents as Teachers) through the Postgraduate Medical Education Office. The tuition for these sessions is waived by the PGME office. Finally, residents will be asked to help teach Clinical Skills and Problem Based Learning to Queen's Medical students and will receive protected time for that. Residents will be given feedback from faculty and course participants in all of these areas.

Trauma

KGH is the designated lead trauma facility for the Southeastern Ontario region. KGH has an infrastructure consisting of readily available Trauma Team Leader and Trauma Team, Trauma Medical Director, Trauma Coordinator, and a Data Analyst. KGH receives on average 380 patients with an Injury Severity Score of 15 or above. Emergency Medicine residents are automatically members of the trauma team when doing Anaesthesia, Orthopedic Surgery and General Surgery and are expected to be involved with trauma care during those rotations. Emergency Medicine residents are involved with the Trauma Team during all ED rotations. Senior Residents act as the Resident Trauma Team Captain when they are on duty in the department and direct the trauma resuscitation under the supervision of the Trauma Team Leader. The KGH trauma Program audits performance of the trauma team and the patient care given. Our residents take part in teaching ATLS. This enhances teaching skills, trauma knowledge and while providing the resident insight into the problems faced in the community setting. Residents desiring enhanced trauma experience have done electives in American Trauma Centers and Sunnybrook Hospital and these can be arranged if desired. Dr. Chris Evans Howes is the Director of the Trauma Service and several of our faculty are staff Trauma Team Leaders.

Pediatric Emergency Medicine

Skills and knowledge in Pediatric Emergency Medicine are crucial for Emergency Physicians. Residents will spend three (3) months at CHEO but will also gain exposure to pediatrics during the Pediatrics rotation at the Children's Outpatient Clinic in PGY1. Exposure to a pediatric patient population will also occur during core rotations in Neurosurgery, General Surgery, ICU, Anesthesia and Orthopedic Surgery as KGH looks after all tertiary pediatric care for Southeastern Ontario.

There is a significant pediatric experience during Emergency Medicine Rotations at both HDH and KGH as up to 15% of the total Emergency visits are for patients 18 years of age and younger. We are fortunate to see such a high volume of pediatrics in our program.

Prehospital Care

EMS is covered in the Core Rounds and during the EMS month in PGY1. PGY3 residents will receive an orientation to on-line medical direction in the summer series before they are assigned base hospital physician numbers and allowed to answer the paramedic patch phone.

Quality Assurance and ED Administration

Administration Curriculum

Formal teaching in these areas takes place during the core sessions. A one month rotation in ED Administration is offered. This will solidify the formal teaching on administrative topics you have received in the Administrative Series. Details of the rotation are included in Section 14: The Administrative Curriculum.

Discrepancy Process

Managing laboratory and radiographic discrepancies and taking ownership for the follow-up of investigations ordered is a key responsibility for certified emergency physicians and often one of the more difficult aspects of practice to navigate. Starting in PGY3 year, residents begin to take responsibility for managing the Emergency Department discrepancy process for radiographic and laboratory studies. The senior resident on the HDH D shift will spend the first half hour of the shift reviewing the discrepancies on the Unresolved Issues track on EDIS. The resident will determine the need for follow-up of the discrepancy and will contact the patient (or substitute decision maker as appropriate) to discuss the discrepancy, arrange appropriate follow-up studies or consultation and document appropriately on the patient's chart. The faculty on duty will provide assistance and supervision for this process.

See Section 13: Guide to ED Look Ups

Patient Safety

Formal teaching on patient safety occurs in the core curriculum and administration curriculum. Residents may be asked to participate in the hospital Critical Incident Review process if they have been involved in the clinical care of a patient who suffers significant harm. There are goals and objectives for Patient Safety.

Morbidity and Mortality Review

In the PGY3 year, each resident is required to complete one Morbidity and Mortality review of one critical incident or a case in which an actual or potential patient safety risk occurred. The resident Residents are encouraged to select a case in which they had personal involvement whenever possible. The Ottawa 3M model for morbidity and mortality rounds is used to assist the resident in the analysis of the system and human factors that contributed to the negative patient outcome. During the grand rounds session, the resident will present the case with attention to maintaining patient confidentiality, outline his/her analysis of the event and then lead the group discussion. Following the rounds, the resident will submit a summary of the key

issues and potential solutions/remedies to the Department Head as part of our department processes for patient safety.

Disaster Medicine

Formal teaching on disaster preparedness and planning is included in the core curriculum and EMS Bootcamp. Topics will vary annually to cover the breadth of this field including: Incident Command, Triage, Hazard Assessment and Risk Mitigation, Mass Gatherings, Bioterrorism and Chemical Weapons and Specific Environmental Disasters. These sessions may run as paper exercises. All residents are encouraged to review the Disaster section of the Emergency Procedures Manual in the KGH Emergency Department. Resident participation is expected at future hospital and community disaster exercises.

An online module that addresses key concepts for disaster planning and preparedness is available at:

<https://meds.queensu.ca/central/community/disasterpreparedness>

Ethics and Medicolegal Issues

Formal teaching on ethics and medicolegal issues occurs in the core curriculum, administration curriculum and the summer series. Residents will be mentored in responding formally to any patient complaints. Senior residents may be asked to draft medicolegal reports if they have been involved in cases requiring this documentation. There are goals and objectives for Ethics and the Law.

Communication Skills

Excellent verbal and written communication skills are essential in Emergency Medicine. Communication skills are taught formally in the summer series, core curriculum as well as during the Junior and Senior resuscitation rounds. Communication skills are evaluated in the daily evaluation, direct observation and OSCEs.

Career Counselling

Sessions to help with career counselling and fellowship opportunities are offered formally in the core curriculum. One of the purposes of the quarterly review process with the Program Director is to assist with career planning and finding a job. Resources for career planning are posted on a bulletin board in the resident library.

Financial Planning

Sessions on individual financial planning and billing techniques are offered by the PGME Office in QCARE+ sessions during which the CMA and MD Management offer a Practice Management session for Queen's residents on an annual basis. These sessions are mandatory once for residents in their PGY4 or PGY5 year.

Community Experience

Residents have the opportunity to do community Emergency Medicine elective rotations in their senior years. Residents do OBGYN and Orthopedic rotations in community hospitals. Shifts at the HDH offer a community Emergency Medicine experience for the resident as well.

Section 13: Guide to ED Look Ups (Discrepancy Process)

(Updated June 2018)

General Principles

- Responsibility for the discrepancy process will be shared, whenever possible, by the Nurse Practitioner (NP), senior resident and attending physician. Senior residents should initiate a discussion with all parties to determine who is most able to address the discrepancies in a timely manner (i.e. patient care takes priority).
- Do this at the beginning of your shift. It should take less than 30 min. At HDH, it should be the Day shift.
- For missed fractures: When you call patients remember that how you approach it affects how the patient feels about their missed finding. Be polite, honest and apologize—and aim to make their return visit (if needed) as efficient as possible. (see below) If true, emphasize how undisplaced the fracture is.
- Leave a message simply to call back about their results, rather stating what those results are. Tell them your name, KGH or HDH emergency department phone number, when you are working until, and that if they call back after this, they should say they are a “call back about results” to streamline their interaction with the unit clerk. Also try the work number but don't leave a message here.
- If a message has been left yesterday, then try calling next of kin today to see if they have another contact number for patient. Don't disclose results to NOK. (unless a child)
- If no contact x 2days, try family MD if possible to see if they have other phone numbers for them.
- If no contact x 2 days, then talk to staff. For non-urgent things, simply fax the report to the FD with a note stating that we have been unable to contact the patient about this report.
- Make a note in the EDIS chart to say what you have done. If you have sorted it out then MD disposition it from the UI track by clicking on MD Dispo>>remove from track and send updated report.
- If it is not sorted, leave it on the UI track and use the Message column in EDIS with the date and your initials to show what you have done. (eg. 19 Sep + strep. LM. LR) LM= left message.
- Some discrepancies are not—they were recognized. If this is the case, simply MD Disposition the chart off the UI track with no further record update.
- Delete the x-rays from the PACs folders when it is sorted it out. (Right click>>remove from folder) Double check that the unit clerk has given you the info from BOTH discrepancy folders for the site you are at. (one is called follow up and one is called discrepancy).
- If the patient is admitted, talk to the admitting service about the result. Don't assume that reports are always checked.

Specific Cases

Missed fractures

- **Avulsions etc. that need nothing more**—call patient to let them know the result and that there will be a longer healing time but there is no change in management.
- **Fracture present, but already splinted**—call patient to let them know, organize fracture clinic follow up by typing in the EDIS DC page field you would normally. Print it and give it to unit clerk.

- **Fracture present but not splinted, needs to come back for splinting**—try to make this efficient by telling them to say at triage they are a callback. Tell the triage RN to call you when they get there. At KGH, tell the unit clerk to add them to the en route list. Watch the track and try to get them brought in as fast as possible. At HDH, tell these patients to come in through the ambulance doors and report to charge RN. Tell the charge RN that they are coming.
- **Fracture present, needs a CT** – call and tell the patient, and tell them CT will call them with a time. They should go directly to Imaging Department and then back to ED for results after. Going to CT first avoids them waiting at triage for us to see them and order the ct. Fill out outpatient CT requisition on the EDIS DC tab, print it and have unit clerk send it AND call CT to emphasize that it is for today. Tell the triage RN to call you when the patient arrives. At KGH, tell the unit clerk to add them to the en route list. Watch the track.
- **Needs a repeat x-ray in X days**- call the patient and tell them the plan. Give them option of doing this thru their FD or coming back for an x-ray and then back thru ED for results. If they come back thru ED, try to get them to come in the morning and never on a HDH Monday. Tell them to go to HDH imaging department first for their x-ray, and then back to UCC. (Ideally do this thru HDH) Fill out the outpatient x-ray requisition on the DC tab, print it and have unit clerk send it to Imaging at whichever hospital you have sent the patient to.
- If you are not sure what the treatment for this fracture is then talk to your staff.

Things that need further testing within days/week or two (e.g. significant lung mass)

- Call the patient, tell them that we need to do some further testing, and that we will organize the test. They will get a phone call to come in for a scan, and then they should make an appointment for a few days later with their FD for results.
- Fill out outpatient CT requisition on the EDIS DC tab, print it and have unit clerk send it to radiology. CT will then call patient with a time to come in.
- Call the FD to tell them the concern, and ask them to follow the testing. If no family MD, talk to your staff about which clinic to get them into for follow up.

Things that need following in X weeks or months (e.g. pneumonia, lung nodules, ovarian cysts etc.)

- Call the patient, tell them what needs to be done and ask them to do this via FD.
- Have the unit clerk fax the report to the FD with a note on it asking them to order and follow.
- If you have a chance, call the FD also. If they have no FD then talk to your staff.

Labs

- If they were seen and DC by a consulting service, check the consult sheet in PCS—it might have the information about antibiotics etc. Page the consulting service and ask them to follow up with the patient where appropriate.
- **Blood cultures** - Gram negative rods are always bad. Call these patients as soon as you get the result. They will almost always need to come back to the ED for a recheck that day. Tell the triage RN to call you when they get there. Write orders for basic labs + VBG + lactate + blood cultures at triage. Tell the unit clerk to add them to the en route list. Watch the track and try to get them brought in as fast as possible. If you can't get hold of these people talk to your staff.
- **Other blood cultures** – The issue is whether the culture results reflect a contaminant vs real bacteremia. If these are positive quickly (<24h after drawn) or are in more than one (1) bottle, it is more likely real and follow the above. If not, the result is more likely due to a contaminant—look at the patient's story (history of immunosuppressed/chemo,

etc.) and if high risk, act as above. If not, then call the patient and see if they have had more fevers etc. If the patient remains febrile or symptomatic, follow the above. If they are feeling well then it is safe to wait for the speciation tomorrow.

- **Urine cultures**- check DC tab for what they were treated with. If it was a fluoroquinolone, you can call the lab to get the sensitivity. If you need to change the prescription, call the patient and ask if they are better, since in vivo sensitivity may be better. If they are then don't bother changing. If not, tell them you will change it and ask which pharmacy is best. Have the unit clerk fax a prescription (you can do this on paper or on the DC tab and print.) Note in EDIS what you used.
- **Throat swabs, stool cultures**—ask the patient first if they are better. They might not need antibiotics. If they are not then fax a prescription into the pharmacy of their choice and make a note in EDIS as to what you used.
- **Skin swabs**—can almost always be ignored except if MRSA present. Talk to your staff if they are not known to be MRSA +
- **Mono spot**—remember to tell them about possibility of splenic rupture—signs and symptoms to watch for, avoid contact sports for 6 weeks.
- **Bacterial Vaginosis** - only treat if they are symptomatic.

Section 14: Core Content Curriculum

There are two key components to the formal teaching curriculum in the Emergency Medicine Residency program at Queen's – the Core Content and the Non-Medical Expert CanMEDS Competencies. These sessions cover the breadth of knowledge in Emergency Medicine. The sessions are given in a two-year cycle so that resident will have had a chance to cover the material at least once or twice before completion of residency. These rounds are part of the Academic Day and residents from PGY1 – PGY5 are released from clinical responsibilities to attend.

Medical Expert CanMEDS Competency

- Thursday mornings from Sept-June following Grand Rounds
- Topics are taken from Core Content of Emergency Medicine and are all clinical topics.
- Year 1 topics cover "Disorders of Body Systems" and include mostly Internal Medicine Related topics. Investigative modalities are discussed in the context of each clinical disorder.
- Year 2 topics include all other clinical areas: trauma, special populations (pediatrics, geriatrics), toxicology, environmental emergencies, prehospital care, disaster medicine and manipulative procedural skills.
- It is impossible to cover absolutely everything in the Core Content Series related to each general topic. You will note that the sessions cover the important aspects of each topic as they relate to Emergency practice but leave out other less important aspects that can be covered by self-study and review of the standard texts.

Non-Medical Expert CanMEDS Competencies

Teaching of the non-medical expert competencies (Communicator, Collaborator, Manager, Scholar, Professional and Health Advocate) occurs in formal teaching sessions integrated into the Core Rounds curriculum cycle. The general headings for these sessions include:

- ED Administration
- Ethics and The Law
- Communication Skills/Teaching
- Physician Wellness
- Career Management
- Critical Appraisal Skills
- Crisis Decision Making and Leadership in Critical Care
- Violence, Abuse and Crisis Intervention
- Preventative and Population Health

In addition, specific learning goals and objectives for these competencies are established for rotations throughout the Resident Training Program (see the Rotation Specific Goals and Objectives).

Residents will be evaluated on each of these competencies in the clinical setting, during practice written, oral and OSCE examinations, junior and senior resuscitation rounds and at the FRCP certification examination.

Core Content Topics (Choosing Wisely recommendations included where applicable)	
YEAR 1	YEAR 2
Respiratory: Asthma, COPD	Crisis Decision Making and Leadership in Acute Illness and Injury
CV: ECG Interpretation	Principles in Critical Care and Resuscitation of the Critically Ill Patient
CV: Cardiac Arrhythmias	Trauma: Neurotrauma (include imaging)
CV: Acute Coronary Syndromes / CHF	Trauma: Multiple Trauma (include imaging)
CV: Physical Exam of CV System	Trauma: Face and Neck Excluding Spine (include imaging)
CV: Hypertension and Pharmacological Agents in CV Disorders	Trauma: Abdominal (include imaging)
CV: Disorders of the Aorta, Arteries, Veins, SBE, Myo/pericarditis	Trauma: Musculoskeletal and Spine (include imaging)
Dental and ENT Emergencies	Trauma: Hand, Wrist and Soft Tissue Injuries/Compartments (include imaging)
Procedural Skills: Miscellaneous (Ophtho, ENT, Dental, Foreign Bodies)	Trauma: Urogenital (include procedures/imaging)
Ophthalmology Emergencies	Trauma: Chest and CV System (include imaging)
GI: Hepatobiliary Disorders, GI Bleeds, Vomiting, Diarrhea	Critical Appraisal Part 1 – Stats Review
GI: Surgical Disorders (hernia, bowel obstruction, appendicitis, anorectal disorders)	Critical Appraisal Part 2 – Advanced Concepts
GU: STD's, Vaginal Bleeding (non-pregnancy), Sexual assault	Peds and Neonatal Resuscitation and Trauma
GU: UTI, Acute and Chronic Renal Failure	Peds: Jaundice, Neonatal Presentations, Failure to Thrive
GU: Pregnancy Emergencies	Peds: Vomiting, Diarrhea, Dehydration, Respiratory Distress
GU: Nephrolithiasis	Peds: Approach to Fever and Seizures
Dermatology Emergencies	Peds: Infectious Disorders in Childhood
Career Management	Peds: MSK/Ortho Injuries (include imaging)

Core Content Topics (Choosing Wisely recommendations included where applicable)	
YEAR 1	YEAR 2
Hematology/Oncology Emergencies	Child Abuse, Domestic Violence and Elder Abuse
Neuro 1- Neuroanatomy, Neuro Exam, Neuro Imaging	Geriatrics: Physiology of Aging, Pharmacokinetics and Specific Presentations
Neuro 2 – Headache, Cerebrovascular Disease	Tox: Toxidromes and their Management
Neuro 3 – Seizures and CNS Infections	Tox: Important Overdoses (TCAs, ASA, Acet, Fe, Alcohols, Lithium, Benzos, cardiac drugs)
Neuro 4 – Coma, Dizziness	Tox: Rare Plant Toxins, Food Poisons, Toxins produced by Biological Agents
Endocrine Emergencies – Disorders of the thyroid, adrenal system and glucose metabolism	Enviro 1: Thermal Injuries (Heat Illness, Cold Injuries)
MSK – MSK Exam and Anatomy	Enviro 2: Hyperbaric/Hypobaric Syndromes, Contamination of Air, Radiation Exposure Syndromes
MSK Non-traumatic MSK disorders <ul style="list-style-type: none"> • Neck, thoracic, lumbar pain • Rheumatology • Disorders of Bursa and Joints • Shoulder Pain 	Enviro 3: Microwave/Laser, Electrical Injuries, Chemical Burns
Allergy & Immunology – Allergic Reactions, HIV	Enviro 4: Animal Bites, Insect and Arthropod Bites/stings, Transport of Hazardous Materials
Acid Base, Fluid and Electrolyte Disorders	Procedural Skills - Resuscitation and Critical Care
Psychiatry 1 – Axis I and Axis II Disorders, suicide assessment	Procedural Skills - ED Anaesthesia, Analgesia, Wound Management, Minor plastic procedures
Psychiatry 2 – Psychotropic Medications	Preventative Medicine and Population Health: Immunization, tetanus, diphtheria, rabies
Psychiatry 3 – Substance Abuse	Cadaver Training - rare and heroic procedures
Emergency Medicine Ethics and The Law	Tropical Medicine and Emerging Infectious Diseases
Physician Wellness	Patient Safety
Communication Skills – Giving Bad News, Crisis Intervention	Disaster Medicine

Section 15: Leader Competency Curriculum (Reviewed Nov 2016)

The FRCP residency Admin rotation is a one month block usually done in 3rd year. The resident will do approximately 50% clinical shift load for that month and in addition will:

- a) Do independent reading around the topics listed below and meet weekly with the physician leader of the Admin block to discuss
- b) Participate in chart mortality review for patients presenting DOA or DIE in the Emergency Department
- c) Prepare and present one morbidity and mortality grand rounds for emergency medicine (may be presented earlier or later than actual admin month)
- d) Participate in one departmental Clinical Care and Quality Assurance meeting
- e) Attend one hospital MAC meeting and one Emergency Department Program Council meeting
- f) Optional – participate in one departmental quality assurance activity or other structured activity related to ED function, patient safety, etc.

Topics for independent reading and review with Administration rotation supervisor:

1. Patient Safety

- Discuss the principles of patient safety in the hospital environment
- Demonstrate use of the hospital Safe Reporting System
- Discuss the format and function of a critical incident review and critical incident debriefing
- Discuss the indications for notification of the coroner

2. Quality Assurance

- Discuss 5 different categories of quality assurance activities and give one example of each as it pertains to the Emergency Department
- Describe pay for performance metrics for Emergency Departments

3. Structure and Function of the Health Care System

- Discuss the role of various levels of government in the functioning of the health care system and the Emergency Department (i.e. MOHLTC, LIHN, SEAMO)
- Outline the role of various professional organizations as it pertains to practice in Emergency Medicine (i.e. CMPA, CPSO, RCPSC, CAEP, OMA)
- Discuss the administrative structure of a hospital and the role of physicians in the administrative function of the hospital (i.e. Board of Directors, CEO, VP medical, MAC and subcommittees, MSA)

4. ED Funding Models and Physician Remuneration

- Discuss models of ED physician funding (FFS, EDFAFA, Academic AFA)

5. ED Patient Flow and ED Management

- Discuss options to enhance patient flow in the ED, specifically describing a RAZ unit, Fast track, physician at triage and RAFT unit
- Describe the format and purpose of the Canadian Triage and Acuity Scale
- Describe the function and give examples of medical directives, patient care protocols at triage and patient care plans
- Discuss the causes and management strategies for ED overcrowding
- Outline 5 personal strategies a physician can use to improve ED patient flow and patient care.
- Give examples of how an Emergency Department can be “senior friendly”

6. Role of the ED Physician as a Consultant

- Outline the principles of inter-hospital patient transfer
- Discuss the principles for giving advice over the phone
- Discuss the principles and options for both consultations and patient handover

7. Dealing with Complaints from Patients, Family or Colleagues

- Describe the role of the hospital and the ED program in addressing patient complaints.
- Outline the common causes and reasons for patient complaints as they pertain to Emergency Medicine
- Outline the responsibilities of the physician for dealing with patient complaints
- Describe the role of the CMPA and the CPSO in dealing with patient complaints or adverse outcomes

8. Resource Allocation and Cost Appropriate Care

- Describe the Choosing Wisely campaign as it pertains to Emergency Medicine
- Give examples of how strategies for monitoring or reducing utilization can lead to improvement in cost appropriate care.

9. Miscellaneous

- Discuss the principles of dealing the police in the ED. (i.e. disclosure to the police, mandatory notification of events)
- Give 5 tips for running a meeting.
- Describe the different levels of hospital and academic medical appointments

Section 16: Critical Appraisal Curriculum

Study Type	Possible Concepts to Address
Therapy / Harm	AR, ARR, RRR, NNT, NNH
	RR, OR
	Types of studies and hierarchy
	Random errors; biases
	Concealment; blinding
	Intention-to-treat analysis
	Surrogate markers
	Drug-class effect
	p value, Type I and II errors, CI
	Applicability issues
Diagnosis	Sensitivity; Specificity, PPV, NPV
	SpIN, SnOUT
	+LR, -LR, Fagan nomogram
	Gold standard
	Representative enrollment
	Bias
	p value, CI
	ROC curve
	Agreement coefficients (kappa)
Applicability issues	
Clinical Decision Rules	Levels of rules
	Sensitivity; Specificity, PPV, NPV, LR
	Impact analyses
	Applicability issues
Systematic Review / Meta-analysis	Contrast between syst review and meta-analysis
	Jaddad score
	Funnel plots
	Fixed-effect models
	Blobbagrams
	OR, CI
Applicability issues	
Prognosis	Difference between prognosis and risk factors
	Importance of homogeneity
	Outcome measure
	Correlation, Regression
	Survival curve
Applicability	

Section 17: Scholar Competency Curriculum (Updated June 2018)

Resident's Responsibilities for Academic Contribution

All FRCP program residents are required to complete at least one academic project during their training. While this requirement has traditionally been considered to represent a formal research project, various additional projects could be used to fulfill this requirement. Such projects might include (but not be limited to):

- conduct of a high-quality audit of clinical care that will include recommendations for enhancement of quality or efficiency of clinical care
- development of a clinical practice guideline for consideration of use within Kingston emergency departments
- development of an educational instrument for use in an undergraduate or postgraduate medical education setting

The Departmental expectation is that this project will, in the minimum, lead to presentation of this work at Resident Research Day or Departmental Grand Rounds, but residents should strive for presentation at a national level meeting and/or publication of the project in a peer-reviewed journal

Overview of the Resident Scholar Competency Curriculum

CBD Stage of Training: Transition to Discipline (Summer Seminar Series – First 3 Months)

As part of the summer seminar series, PGY-1 residents will have an orientation session by members of the academic and research committee that describes the research program as well as expectations for performance.

CBD Stage of Training: Foundations of Discipline (PGY1)

In the first year of the residency program, trainees will complete a critical appraisal and clinical reasoning seminar series related to cardinal emergency medicine presentations. Each tutorial session will include the completion of an assignment that will be assessed by the faculty facilitator.

The critical appraisal and research methodology covered includes:

1. Introduction to the research program
2. Data variables and management
3. Introduction to statistics
4. Observational study designs
5. Diagnostic tests
6. Systematic reviews and meta-analysis
7. Randomized controlled trials
8. Clinical decision rules

CBD Stage of Training: Core of Discipline (PGY 2-4)

In their PGY2 year, residents will receive an orientation to the expectations around the completion of a critically appraised topic (CAT) project, identify an appropriate faculty supervisor for the project and then progress through the following milestones during the *Foundations of Discipline* phase of training:

- Receive an introduction and orientation session on CAT projects (Summer-Fall of academic year)

- Provide CAT question to Resident Research Director (Fall of academic year)
- Provide list of articles identified through literature search to Resident Research Director (December of academic year)
- Submit completed CAT project report to Resident Research Director (February of academic year)
- Present completed CAT project at Department of Emergency Medicine Research Day (April of academic year)

Building on their understanding of research methods and using the critical appraisal skills developed during their earlier years of residency, all PGY3 and PGY4 residents will be expected to develop further Scholar competencies through additional teaching and administrative opportunities, including:

- Undertaking a further academic project based on their clinical interests and career goals. As discussed in the introduction, the project may be a research study, clinical audit, development of a clinical practice guideline, a novel educational intervention, or others, pending approval by the resident's Academic Advisor, Program Director, or Resident Research Director. Residents will present their project at Department of Emergency Medicine Research Day in both the PGY3 and PGY4 years (see table below).
- Acting as the resident presenter/facilitator for one departmental Journal Club per academic year.
- Presenting one Grand Rounds presentation on a "Morbidity and Mortality" topic that highlights opportunities to improve care based a structured literature review, critical appraisal, and clinical guidelines, where appropriate. Where possible, this will be scheduled during the Administration block.

Queen's University FRCPC Emergency Medicine Resident Research Program – EPAs, competencies, milestones, and expected outcomes.

	Stages of Training/Competence Continuum			
	<u>Transition to Discipline</u>	<u>Foundations</u>	<u>Core</u>	<u>Transition to Practice</u>
	First 3 months	PGY 1	PGY 3-4	PGY 5
Stage Specific EPAs				
Key and Enabling Competencies	Scholar Enabling Competencies CanMEDS 2015 - 2.4, 2.5, 2.6, 3.1, 3.2, 3.3, 3.4?, 4.1, 4.2, 4.3, 4.4, 4.5			
Required learning experiences/exposure	Receive orientation on CAT project (summer)	Complete online research training modules Attend research skills tutorial sessions	Complete "CAT project" (written report and presentation at research day of PGY2) Undertaking an additional academic project based on their clinical interests and career goals. Presenter/facilitator for one departmental journal club per academic year.	

			Presenting one grand rounds presentation on a "Morbidity and Mortality"	
			Provide effective review of co-resident rounds and presentations	
Assessments tools & completion requirements (Performance evidence)		Research training module assignments	CAT Project Submission	
			Research day presentations:	
			PGY3: Proposal/methodology for academic project	
			PGY4: Results/outcomes of academic project	
			Academic project presented at national academic meeting and/or publication in peer-reviewed journal	
			Satisfactory journal club feedback peer-review	
			Satisfactory rounds feedback peer-review	

Evaluation of Academic Project

Each resident's progress towards and success in completing an academic project will be reviewed on an ongoing basis during meetings with their Academic Advisor, the Program Director, and the Resident Research Director. The Competency Committee will make the final decision on whether the resident has completed all of the requirements for the "Scholar" portion of the training program, including the Academic project.

'Academic' Electives

Some residents may wish to devote a period of focused academic time to completing their academic project. This would be in the form of a formal "Academic" elective ranging in time from one to three (six-week) blocks, the latter time period for particularly rigorous academic projects.

Academic electives must be planned out well in advance of the anticipated date of starting them (i.e. in general at least 3 months). Residents who wish to take an academic elective will need to coordinate a meeting involving their Academic Advisor, the Program Director, and the Resident Research Director to discuss their proposed activities for the elective. They will also need to develop a proposal for the academic elective including a description of their academic project, the rationale for taking the elective, and the specific measurable goals and outcomes for the elective period. This proposal will be reviewed by the Academic Advisor, the Program Director, and the Resident Research Director before approval is granted for any academic electives.

Section 18: The FRCP Examination and How to Prepare

The purpose of completing the Emergency Medicine Residency program is to learn the skills to become an Emergency Physician. You must also pass the Royal College of Physicians and Surgeons of Canada Specialty exam in Emergency Medicine.

The exam in its current form takes place yearly in March (written) and May (oral).

There is a formal process that needs to be completed to be eligible for the exam including an official RCPSC Assessment of Training and completion of various forms by the Program Director and the resident. **Please watch for deadlines closely, as it is your responsibility to return documents and exam fees on time.**

The Exam

The exam consists of a written and an oral component.

- The written exam consists of two short answer papers; each of three hours duration. The exam takes place in Kingston. Questions will cover the depth and breadth of Emergency Medicine including relevant anatomy, pathophysiology, pharmacology, clinical management, systems administrator, recent literature and research methodology.
- The Multiple Station Oral Exam Component will be approximately 2 hours in duration in Ottawa and will consist of approximately six examination rooms. Exam rooms are staffed by one examiner, Candidates are asked questions dealing with the breadth and depth of Emergency Medicine and relevant basic science. This is achieved utilizing single or multiple real case scenarios and by direct questioning. Candidates may encounter visual stimuli, such as x-rays, EKGs, laboratory data and pictures during these sessions.

How to Prepare

The Core Content seminars provide an excellent framework for formal study. While not all areas can be covered in the sessions, you are advised to read beyond the material for each session during your preparation. Most residents use the standard Emergency textbooks to guide their study. It is expected that the resident will have completed Tintinalli by the end of PGY3 and concentrate on Rosen's Emergency Medicine text in PGY4 and PGY5.

You cannot study all the time. Take days off and pace yourself. It is common in the last six months to feel overwhelmed with the amount of information you need to know and feel you have to study all of the time. Remember – most of the questions are clinically based and cover things you see and deal with every day. You can break up your studying by looking at the Atlases in the library (pictures, ECGs, x-rays etc). Solving case problems in the various texts and looking at the many cases now available on the Internet are also fun and meaningful ways to study.

A final note on exam preparation – the best way to put it all together is using this knowledge while you are looking after patients in the ED or teaching your knowledge to students and junior learners.

Section 19: Addendum

Core Content Listings

<https://www.abem.org/public/publications/em-model/reference>

Objectives of Training and Specialty Training Requirements in Emergency Medicine

http://www.royalcollege.ca/cs/groups/public/documents/document/y2vk/mdaw/~edisp/tztest3rcpsce_d000895.pdf
