LLU Emergency Medicine Residency Program

POLICIES AND PROCEDURES
(LAST UPDATE 6-29-2016, EFFECTIVE 6-29-2016)

The LLU Emergency Medicine Residency Policy and Procedure manual is written to memorialize many of the expectations the EM residency has for Emergency Medicine residents. The following EM residency policy and procedure manual is written in support of the policies and procedures of LLUMC and it's recognized affiliated institutions. If conflicts exist between the policies in this manual, and LLUMC, the policies of LLUMC will be considered the authoritative policy.

ADMINISTRATIVE PERFORMANCE

Residents must comply with multiple administrative requirements throughout residency. An incomplete listing of these include: Medical records, residency required paperwork, and House Staff Office requirements. Timely completion of these requirements falls into the Professionalism competency domain. The residency tracks compliance with these requirements. Upon requests from the residency for letters of recommendation the residency will review this performance and include in the letter a statement of compliance with requirements. The statements will be one of the following depending on the resident's performance:

1. This physician demonstrated outstanding administrative performance, requiring virtually no administrative prompting for timely completion of requirements.
2. This physician demonstrated good administrative performance, requiring minimal administrative prompting for timely completion of requirements.
3. This physician demonstrated average administrative performance, requiring occasional and periodic administrative prompting for timely completion of requirements.
4. This physician demonstrated some difficulties with administrative performance, requiring above average administrative prompting for timely completion of requirements.

ADVANCEMENT

Residents are NOT automatically advanced simply for completing 12 months of residency, but instead are advanced based upon achieving expected milestones.

AWARDS AND CERTIFICATES

The residency would like to recognize and congratulate residents for outstanding performance in many fields. Accordingly, the residency facilitates multiple awards and certificates as follows:

- *Resident of the Year from the ED Nursing Staff*: Awarded at annual Christmas party to resident who exemplifies teamwork, communication and empathy.
- *Director's Award for Administrative Excellence*: Awarded periodically to those residents who meet all of their administrative duties (medical records, required program paperwork, etc) without requiring administrative intervention.
- *Chairs Gold Star Award for Outstanding Patient Care or Leadership*: Awarded periodically to physicians whose actions exemplify the mission of the department
- ITE Achievement Award: given to the individuals scoring highest among their class on the annual in-training examination.
- LLUEMx Grand Prize: awarded to best senior grand rounds talk at the annual LLUEMx senior grand rounds event.

BENEFITS

The residency program pays for the following for each resident, as departmental funding permits:

- Membership in the American College of Emergency Physicians (ACEP), which includes a subscription to *Annals of Emergency Medicine*
- Membership in the Society for Academic Emergency Medicine (SAEM), which includes a

subscription to *Academic Emergency Medicine*
- Membership in the Emergency Medicine Residents Association (EMRA)
- The costs of the following provider courses: ACLS, ATLS, Base station physicians

Final decisions regarding the funding of emergency medicine resources and conference opportunities for residents is dependent on available funding and is at the discretion of the program director.

BLOCK ROTATION LOTTERY

In the spring, the residency director will distribute the various block rotations available for the upcoming year. Residents will provide their order of preference for these block rotations. A lottery will then be held in which resident names will be randomly drawn and the block rotations assigned according to resident rank ordering. Given the commitment of the program to international emergency medicine, residents who receive block rotations with international electives are expected to go. Residents chosen to go on an international expedition are expected to provide a non-refundable monetary deposit early in the academic year to reserve their position on the expedition. Residents should not list block rotations with international elective on their request form if they are not committed to going. The lottery will proceed in the following order:

- PGY-2 residents
- PGY-1 residents
- Incoming PGY-1 residents

At the completion of the lottery, residents may elect to switch block rotations with other residents in their PGY year. Individual months may be switched with the permission of the chief residents and residency director. All month or block rotation switches must be communicated in writing to residency coordinator, the residency director, the resident schedule administrator AND the chief residents.

CHARTING

Medical documentation at LLUMC ED is performed on the EPIC system. Immediate documentation of all medical charts is encouraged unless higher acuity patients are waiting to be seen, in which case documentation is generally deferred until a time where the ED is again caught up. Because of the higher acuity of adult patients, residents working on the adult side should generally avoid documenting patients during a shift when there are “orange dot” patients waiting to be seen. The lower acuity of the pediatric ED allows for more immediate documenting of charts. Within the context of coordinating patient care with the attending physician on duty, emergency medicine residents may document pediatric cases during their pediatric ED shift even if there are lower acuity patients waiting to be seen. To ensure the timeliness and accuracy of the medical record, however, **it is mandatory that all documentation be completed the same day that the patients were seen**. This often requires staying past the end of busy shifts to “catch up” on documentation. This is common practice in most Emergency Departments you will work in after graduation. Hours spent documenting, whether at the hospital or at home, count as duty hours.

LLUMC Adult ED utilizes scribes for documentation. Scribes are assigned to attendings. Residents present to the attending while the scribe transcribes the H&P. Residents are encouraged to dictate the Medical Decision Making portion of the chart, however the attending is ultimately responsible for completing and signing the chart. Residents should coordinate with scribes to input procedure notes and any updates to the chart which need to be made. All information needs to be given to the scribe before the end of the scribe’s shift.

RUHS ED uses scribes as well. When available, using the scribes will greatly improve your efficiency. Take the scribe to the bedside with you. Staying caught up with your documentation is difficult but imperative, especially here. Efficient documentation is a skill and takes practice. Talk with attendings and senior residents about ways to become more efficient.

California law has strict guidelines regarding how long a patient record may be incomplete. LLUMC monitors the number of outstanding medical records for each resident.

If the ED chair, medical director, residency leadership, or House Staff Office determines that a resident is unusually delinquent in their medical records, they have the authority to suspend the resident from clinical duties until their medical records are current. **As residents are required to chart on the date of service during ED months, residents should not expect a warning prior to suspension for delinquent charts during their ED months.** If a resident is suspended from clinical duties in this manner, it is the delinquent resident's **first** duty to locate another resident at similar or higher level to cover their shift(s). If they have difficulty arranging this, they will contact a Chief Resident for assistance. Their **second** duty is to then bring the medical records up to date within 24 hours. Automatic loss of standing will result if medical records are not current within 24 hours. The delinquent resident's **third** duty is that for every shift another resident has covered for them, they will cover TWO of that resident's subsequent shifts (ie, a make-up shift AND a penalty shift). The make-up and penalty shifts will be chosen by the covering resident and may be night, weekend, or holiday shifts.

CHIEF RESIDENTS

There will be two Chief Residents per year. The residency directors choose them after consultation with the entire faculty and confidential balloting by the residents. These residents will each be scheduled for three less shifts per month, must remain in preferred standing throughout the entire year, be willing to accept and maintain a strong commitment to the residency program, and demonstrate outstanding leadership qualities and communication skills. Chief Residents are scheduled for an additional 0.5 less shifts for each day they interview medical students for the interview season. In addition to following the policies and procedures of LLUMC & its affiliated hospitals, some of their responsibilities are summarized as follows:

- *Hospitals* - The chief residents will each be administratively assigned to LLUMC or RUHS. This may or may not be the site at which they are clinically rotating in any month.
- *Residency Policy* - The chief residents serve as residency advocates and liaisons between residents and faculty as policy is developed.
- *Interviews* - The chief residents will be regularly available most Tuesdays in October, November, December, and January to assist with residency interviewing. Their duties will include individual interviewing, providing orientation tours to applicants, and assisting with applicant ranking.
- *Didactics & Teaching* - The chief residents will be responsible for each coordinating didactics, teaching and testing as directed by the residency. See the Chief Resident Job Description for further details of this role.
- *Resident Shift Schedules* - The chief resident prepares the resident shift schedules each month under the supervision of Dr. James Moynihan at LLUMC and Dr. Mark Thomas at RUHS. They are responsible for changes to the schedule as may be needed from time to time, and for ensuring uniform coverage within the confines of total number of resident shifts available. The LLUMC schedule is made by the LLUMC resident schedule administrator, not the LLUMC chief resident.
- *Intern Orientation Program* - The chief residents will organize the annual intern orientation program.

CURRICULUM

The Model of Clinical Practice of Emergency Medicine serves as the curriculum outline for the residency program. Defined goals and objectives for the training program are maintained by the department and revised periodically. The goals and objectives are available on New Innovations and are expected to be reviewed by residents throughout their three years of training.

DIDACTICS (CONFERENCES) EM RESIDENT

EM Resident teaching conferences occur weekly, Wednesdays from 8:00 am to 12:00 pm. One hour of asynchronous learning is allowed each week and is prepared by the program. The times and locations of journal club conferences vary throughout the year. Residents are expected to be at ALL conferences unless on pre-approved vacation or ICU rotations. As unexpected events such as a car

breaking down or a family emergency will occasionally occur during residency we adhere to the RRC mandated 70% attendance for a resident to be eligible for graduation from the program. **As didactics are to be considered in the work duty hour totals it is the residents responsibility to ensure they do not exceed the maximum work duty hours due to attending didactics. Additionally, residents are expected to ensure they do not exceed the consecutive hours limitation as outlined in duty hours. If, after working a night shift, they are unable to complete the 4 hours of continuous didactics due to work duty hour conflicts they are to leave didactics to meet the duty hour obligations. It is the residents responsibility to track their didactic attendance to ensure an appropriate buffer exists in their overall conference attendance percentage to allow for the occasional required leaving of conference due to duty hours. Didactics missed to ensure work duty hours are not exceeded are not considered "excused" by the RRC and count toward the 30% of all conferences residents are allowed to miss according to the ACGME.** Due to the numerous off service rotations during the PGY 1 year, and need to reconnect with EM specific educational goals, PGY 1 residents are expected to have 80% or better conference attendance. All residents interested in participating in international electives are expected to have attendance 80% or better. **Attendance will be taken immediately at the start of conference. Residents arriving more than 5 minutes past the scheduled start time of conference will not receive credit for that hour of conference attendance**. Residents are excused from ED duties at both RUHS and LLUMC during scheduled conference periods, including journal clubs.

For residents scheduled on an ED shift during conference day:

- Each resident should check out his or her patients to the attending at the beginning time of conference.
- If the conference for some reason ends early, the resident is expected back on duty immediately following the actual end of the conference.
- **It is each resident's responsibility to be back on duty within 30 minutes following the "official" end of conference, regardless of whether the conference is running overtime**.
- Residents on duty in the ED on journal club days are expected to check out his or her patients to the attending physician 30 minutes prior to the start of the large group discussion, typically 6 pm.

For residents on off-service rotations during conference day:

- Residents on CCU, MICU, NMCCS, PICU, and VA MICU rotations may be able to attend conference as their clinical responsibilities permit. However, generally the educational value of the intensive care rotations supersedes conference. These missed conferences are not considered "excused" and count toward the 30% of all conferences residents are allowed to miss according to the ACGME. CCU has made a commitment to rounding on EM resident patients first, barring an emergently decompensating patient, so residents can attend conference asap after rounds.
- Residents on other off-service rotations are expected to attend Wednesday morning conference. Residents should discuss arrangements with their team prior to conference. Normally, residents round on their patients, write daily progress notes, and then come to conference.
- Residents are expected to return to their clinical duties within 30 minutes of the end of conference.
- If conference extends beyond 1:00 pm, residents are expected to leave conference to return to clinical duties.
- Residents who are post call on didactic days must still adhere to work duty hours. Conference time missed due to the necessity of leaving to prevent work duty hour violations are not excused by the EM RRC but may be considered part of the 30% missed didactic sessions allowed.
- Residents on call rotations are not typically excused from their service to attend evening journal club when on call. These missed conferences are not considered "excused" and count toward the 30% of all conferences residents are allowed to miss according to the ACGME.

Residents are required by the Residency Review Committee to attend at least 70% of conferences. The only "excused absence" allowed by the RRC is approved vacation. Conference attendance will be entered by the residency, and residents will be considered in violation of this policy if they do not attend 70% of available conferences during any given six month period, or 80% during the PGY 1 year. This data is available on NI and it is the residents

responsibility to know if they are meeting the requirement. High attendance during one period will not excuse inadequate attendance during another. Excused absences (vacation) are excluded from both the numerator and denominator of this attendance calculation. The Program Director and Associate Program Director may increase the required attendance and/or change resident status if a resident fails to meet the 70% attendance objective. **Residents who do not meet *80%* conference attendance may not be eligible for international electives.**

Residents who complete 36 months of training and complete all other residency requirements but who have not attended 70% of educational conferences will not be considered to have graduated from the residency and are therefore not eligible for the ABEM examinations. The residency will calculate the number of hours of missing conference time and the resident may then complete this requirement by either: 1) coming to LLU residency conferences following graduation until the required hours are met; 2) forwarding proof of attendance at CME conferences at an off-site institution until the requirements are met (not online or medical journal CME). Eligibility for the ABEM examinations will not be granted until this requirement is met. Residents are responsible for tracking their conference attendance independently from the residency. Totals are available on New Innovations. It is the residents responsibility to be aware of any deficiencies they may have in conference attendance and correct it without prompting by the residency. Any discrepancies with what is entered in NI must be brought to Serena's attention within 2 weeks of the disputed date.

Each resident will often be responsible for presenting multiple 20-60 minute lectures during some of the months he or she is on an ED rotation. The subjects are assigned from the Clinical Model of Emergency Medicine. Keynote or similar computer presentations, or significantly developed interactive sessions are expected and copies of their presentations should be submitted to the residency coordinator for safe keeping in the residents RRC file.

Each resident is required to give a top-quality Pediatric Emergency Medicine lecture during his or her EM2 year. The topic must be approved by the Pediatric EM fellowship director 2 months prior to the date of the assigned lecture. All handouts and slides should be submitted to the Pediatric EM fellowship director 4 weeks prior to the scheduled lecture for review. Failure to meet either of these deadlines may result in a second Pediatric EM lecture assignment and an additional Pediatric ED shift. The final keynote presentation is to be submitted to the residency coordinator, Serena Harper, for submission in the residents file.

Each resident is required to give a top-quality Grand Rounds lecture during his or her EM3 year. Keynote or similar computer presentations are required. The topic should be arranged at least two months in advance with the Associate Residency Director. Residents are expected to confirm their presentation and computer works on the AV equipment in the scheduled conference room one week prior to the presentation. Residents may be required to produce a second Grand Rounds lecture if the first fails to meet the standards of the residency. The final keynote presentation is to be submitted to the residency coordinator, Serena Harper, for submission in the residents file.

DMAT TEAM

Residents are encouraged to become members of our regional Disaster Medical Assistance Team (DMAT). DMATs are government-sponsored units that can be "activated" in the event of disaster either here in the US or worldwide. Volunteers and supplies are airlifted to specific disaster scenes where medical care is provided from tents or outdoors. In the event of our team's activation, attempts will be made to include at least one volunteer resident in the relief effort. The Residency Director will work with DMAT leadership to determine which residents will be offered the opportunity to participate. Residents wishing to register as DMAT team members should contact Dr. Lea Walters for more information.

DUE PROCESS

The Emergency Medicine Residency abides by the Loma Linda University Medical Center Operating Policy GMEC-20, "House Staff Grievance Policy and Procedure." A copy of this procedure is included in the orientation packet and is attached to the Resident Information Booklet. Residents should refer to this policy if they have any issues, concerns, or dissatisfactions arising out of the services provided during the residency program.

ED ROTATIONS

Clinical duties are structured as follows:

Standing	*EM1 residents*	*EM2 and EM3 residents*
On track for Promotion	220 hours per month	200 hours per month
Remediation	220-240 hours per month	200-220 hours per month
Remediation – Reportable	240 hours per month	220 hours per month
Probation	240 hours per month	220 hours per month

General policies

- *Absent for Shift:* Residents who miss a scheduled shift are required to make up the missed shift at a time determined by the chief residents. The residency will review the circumstances of the missed shift. If it is believed that there was a deliberate disregard for the shift, or that there was negligent care taken in reviewing a schedule or confirming a shift switch, the residency will take disciplinary actions as deemed appropriate. Residents who repeatedly miss shifts (deliberately or otherwise) also may face loss of standing, probation, or dismissal from the program.
- *Punctuality*: Residents are expected to be in the ED ready to see patients 15 minutes prior to the time their shift begins. Attendings will record when residents are late for shifts, and this will become part of the resident's monthly evaluation. Peer evaluations will also assess punctuality.
- *Meals:* Each shift will have one appropriate meal break, to be arranged with the resident in charge. Other breaks or absence from the department are only at the discretion of the attending physician and resident in charge.
- *Resident responsibility:* It is expected that residents will be seeing patients throughout their shifts. The primary duty of attendings is to supervise and teach. At busy times, however, the attendings will also be seeing patients.
- *Productivity:* Residents are expected to apply themselves conscientiously, and to evaluate as many patients as they can in a safe and educational manner.
- *Pass-ons*: At the transition between shifts, it is expected that the off-going resident will check out any remaining patients to the oncoming resident. *All such cases must have been presented to an attending prior to check out*, and the attending must be made aware of the checkout.
- *Attire*: Residents must appear professional at all times while on duty. Clean attire and nametags are mandatory. Jeans, T-shirts, or sandals are unacceptable. Scrubs, white coats, and name badges with the name of another institution visible are NOT allowed.
- *Schedule requests*: All schedule requests must be in writing and submitted to the RUHS Chief Resident and LLUMC Resident Schedule Administrator (RSA) well in advance (ask the Chief and RSA for their guidelines and deadlines). There are two types of schedule requests. The first is an official vacation request and count toward your official vacation leave. The second type of request is a “special” request, which does not count toward your official vacation leave and will be granted only when feasible at the Chief Residents’ discretion.
- *Schedule review*: Chief residents will make every effort to generate ED resident shift schedules that when reviewed over a years time are both equitable and meet the educational goals and objectives of the residency. Due to the multiple variables that must be considered in making the ED schedule all EM resident physicians are responsible for reviewing their shift schedules within one week of distribution of the schedule. **Any concerns with the schedule, or problems with work duty hours not brought to the attention of the scheduling chief within one week of the schedules distribution become the responsibility of the individual resident to solve.**
- *Switching Shifts*: Residents may switch shifts with other residents of the same year or higher, subject to the following restrictions:
    - No RRC work hour violations occur (at least 10 hours off between shifts, no more than 72 hours a week, one day off a week averaged over 4 weeks). Both residents are responsible for ensuring no work duty violations will occur.
    - The Chief Resident and RSA must be informed in writing of all shift switches. In addition the written schedule posted on medrez.net is the official schedule. **The resident listed on the schedule is responsible for the shift.**
    - The residents switching shifts are responsible for assuring that they have no other

responsibilities that will interfere with the trade. If subsequent responsibilities are discovered by a resident who has agreed to pick up the shift, including a work duty violation, it is their responsibility to find coverage for the shift. If a back up resident must be called in to work a shift due to a conflict in schedule or work duty hours the resident called in will have two shifts worked by the resident who did not meet their shift obligations (a payback shift plus a penalty shift)

- **There is a master ED shift schedule online (LLUMC and RCRMC). A shift switch is NOT complete until the change is reflected on the schedule. The name on the schedule in the ED is ultimately responsible for a shift. If you fail to confirm that the schedule reflects the correct resident you will be responsible for covering the shift.**

- ***"Shift Debt":*** **While the residency recognizes the occasional need to change a shift with a colleague, changes should be infrequent, well planned, and paid back promptly. At no time should any resident owe more than three payback shifts total. For example, resident "A" may owe 2 shifts to one resident and 1 additional shift to a second resident. Resident "A" can trade no more shifts until they have worked at least one of the payback shifts they already owe.** Failure to follow this policy may result in loss of the privilege to trade shifts, submit special requests, and participate in some electives.

ELECTIVES

Residents in remediation may not have the privilege of participating in electives. Elective request forms must be completed and turned in to the Residency Coordinator 2 months prior to the elective start date. The Associate Residency Director must approve all electives. **If an elective is not arranged in the timely manner outlined by the residency, the elective experience may be forfeited and the resident will be assigned elective time which may include ED shifts.** If a resident is on probationary or satisfactory standing during the elective, the elective experience will be forfeited and the resident will be scheduled in the LLUMC ED instead.

The following are historically the most popular electives:

- *Dental Anesthesia* - This elective allows extensive experience with facial nerve blocks and nasotracheal intubation. The dental anesthesiologists are enthusiastic about having EM residents work with them. Contact Dr Lyman or Dr Mashni at 824-4611 to arrange.
- *ECG Reading* - Arranged with Michael Kiemeney MD. Residents complete focused reading and review of hundreds of ECG's from previous LLUMC patients. Each morning M-F the resident gets any ECG's not yet read in the ED and interprets them. They then submit the ECG's for review by the flow attending who will provide feedback on areas for focus. **This elective is based out of LLUMC and in person review of ECG's with the elective mentor is expected.**
- *EPS Studies* - LLUMC cardiology division, numerous central lines and ECG reading.
- ***International Emergency Medicine*** – These are determined at block rotation assignment. Notify the residency director of your interest prior to submitting block rotation requests in the Spring. Typically the international rotation destinations are not definitively known at the time of block rotation scheduling. Residents should only sign up for international electives if they are willing to go to any location the residency determines is acceptable to achieve educational goals.
  1. **Due to the extensive planning, work, and commitment the residency makes for international elective opportunities it will be rare that residents assigned to international electives will be released from going on their international elective. A request for a release from the international elective will only be considered if it is made 8 weeks before the scheduled international elective is to begin. In making the necessary elective & schedule changes, priority will be given to filling the open international elective spot with an alternative interested resident. After the open international slot is successfully filled the preferences of the resident giving up the international elective slot will be considered. The individual giving up their international elective may be required to forfeit their elective time and work in the ED instead. If the request is made less than 8 weeks before the international elective is scheduled to begin the resident will be expected to participate in the international elective. All requests for changes in international elective rotations must be approved by the international fellowship director.**
  2. **Residents are expected to provide a monetary deposit to reserve their position on the**

international elective shortly after block rotation selection has be completed by residency leadership. The amount of the deposit will be determined by the international fellowship director. The deposit will be applied towards lodging or other related expenditures for the international elective. The deposit will be forfeited if the resident is one of the rare individuals granted a release from attending the international elective.

- *Medical Education Elective:* Arranged with Michael Kiemeney and Tim Young. This experience aims to refine your teaching skills and expose you to additional education opportunities. Bedside teaching, simulation, and small group facilitation will be involved. A high quality, digital educational project is expected at the completion of the elective.
- *Pediatric Critical Care Transport*: Electives doing peds transport are highly recommended, and historically provide excellent opportunities to direct resuscitations. This elective also has flexibility, in that not all transport "shifts" need to be done during the elective period itself. For a half-month elective, it is expected that the resident will accomplish *prior to the official end of the elective time* (but will likely begin before its initiation) 10 transport call days above and beyond any scheduled as part of EM3 duties. For a one-month elective, 20 transport call days.
- *Pediatric Emergency Medicine* - An elective in pediatric emergency medicine with a concentrated experience in the LLUMC Pediatric ED can be arranged through the Division of Pediatric Emergency Medicine. Contact Shelley, PEM Division Administrative Assistant, to arrange this elective
- *Radiology* - LLUMC offers a number of radiology experiences, such as general radiology, peds radiology, bone radiology, neuroradiology (e.g., CT & MRI), and ultrasound. This experience may be supplemented with online radiology training, but in conjuncture with in-house radiology reading.
- *Research* - Each research elective must have a supervising faculty member, and must be preapproved by the Associate Residency Director. Research involving original data collection, analysis, and reporting is eligible for four weeks elective while case reports and other lesser publications are eligible for two weeks. Less elective time may be allotted as the associate residency director deems appropriate.
- *Simulation Elective* – Arranged with Michael Kiemeney MD and Dustin Smith MD. Residents spend time in the simulation center running simulations, developing curriculum, and learning about this relatively new field of academic emergency medicine.
- *Transfer Center Elective* – Arranged with Dr. Lea Walters. Residents spend time in the transfer center and work with Dr. Walters on focused reading regarding EMTALA and associated issues.
- *Toxicology Elective* – Arranged with Dr. Wolk. Based out of LLUMC, residents spend time learning the subspecialty of toxicology through providing consultations, meeting with the Elective mentor, performing required reading and assigned projects. This may be spread over the course of the year, ask the program director for more options.
- *Ultrasound* – May be arranged with the EM US director and/or key US teaching staff such as Dr. Vi Dinh, Dr. Stephanie Tseeng, Dr. Zan Jafry, Dr. Brian Wolk, or the residency program director. Residents will complete didactic studies on ultrasound, provide QI on ED ultrasound, and focus on hands-on experience with ultrasound in the ED. This elective requires 40 hours per week minimum of scanning and additional elective work.

Electives on many LLUMC inpatient services are possible, including pediatric ICU, trauma surgery, pediatric surgery, neurosurgery, etc. Clinic electives at LLUMC can also be arranged: ophthalmology, ENT, oral surgery, dermatology, pain clinic, etc. Other elective ideas include psychiatry and hyperbaric medicine. Elective ideas generated by a resident are often possible but require generation of goals and objectives in line with the RRC requirements. **Electives at RUHS or unaffiliated sites are not permitted unless the resident can arrange for their salary and malpractice to be covered by the outside entity.**

All elective rotations must be completed to the satisfaction of the rotation supervisor. If the supervisor does not believe the rotation was completed due to attendance, educational issues, or other difficulties the resident may be required to complete additional projects to complete the rotation. This determination is made by the program directors with input from the rotation supervisor, the resident, and the remediation committee (as required).

E-MAIL

Residents are each provided Internet access and a hospital e-mail address. **The provided Loma Linda Email account is the official communication method of the residency**. **Residents are required to check their email at least every other day when not on vacation. The residency is not responsible for official communication that fails to reach a resident due to forwarding email or a non-LLU receiving server being down.** In addition to email communication, residents may on occasion need to be contacted by the residency or institution with non electronic mail. All residents are required to maintain a mailing address that is capable of receiving certified mail or other communication that requires confirmation of receipt by a signature. This official address must be submitted to the Emergency Medicine residency and house staff office. Changes to the address must be given to the residency and house staff office within 3 business days of the change.

EMERGENCY MEDICAL SERVICES (EMS)

Training in EMS consists of several separate components.

- *Base Station Physician Course:* Residents are required to attend the scheduled course put on by the faculty.
- *EMS rotation*: Each resident has a structured EMS training experience of paramedic ride-alongs during their PGY-2 EMS month. Additional experiences are scheduled by the EMS director during the EM2 and EM3 year (e.g., ride-alongs, teaching prehospital personnel, attending EMS administrative meetings).
- *Disaster drills and planning*: Residents should be involved in periodic disaster drills and planning.

EMERGENCY MEDICINE RESIDENCY ASSOCIATION (EMRA)

The residency encourages residents to remain active in EMRA and consider serving as an officer.

EVALUATIONS OF FACULTY AND THE PROGRAM

Residents evaluate faculty members at least yearly using online anonymous evaluations or anonymous paper-and-pencil evaluations. Anonymous comments from residents are incorporated into official faculty evaluations. At least once a year the residents evaluate the entire program curriculum using anonymous online evaluations.

EVALUATIONS OF OFF-SERVICE ROTATIONS

Residents complete anonymous evaluations of their EM and Off-service rotations. EM rotations are included in the end-of-the-year program evaluation. Off-Service evaluations are completed after each such rotation. Off-service rotation evaluations are not reviewed by the directors until at least 3 are received (to maintain anonymity).

EVALUATIONS OF RESIDENTS

The residency has incorporated multiple evaluation techniques to assess each of the general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning and improvement, and interpersonal relations and communication skill) and subcompetency milestones.

Residents are evaluated using multiple techniques for each of the core competencies:

Canvas Shift Evaluations: A minimum of 10 times a month a resident is required to engage with an attending to obtain a shift evaluation at the end of their shift.

Nursing Evaluations: at least once a year ED nurses complete evaluations on all residents. They are asked to comment on patient care, interpersonal relations and communication skills, and professionalism.

ED Staff and Technicians: at least once a year ED staff (administrative and secretarial) and ED

technicians complete an evaluation commenting on interpersonal relations and communication skills and professionalism.

Peer Evaluations: Once a year all ED residents are asked to anonymously evaluate their peers on the following Professionalism dimensions: Arrives on time, Willingly sees patients throughout the shift, Provides effective sign-out, effective team leadership (for PGY2 and PGY3 residents).

Self-Evaluations/Personal Career Goals: Twice a year, residents complete a self-evaluation and career development plan prior to the face-to-face review (the "semi-annual evaluation").

Written Examinations: May occur at any time during the training period. As often as possible the methods used will be through web based educational software or similar electronic means.

In-Service Examination: Once a year, residents take the written in-service examination provided by ABEM. Typically this is the last Wednesday in February. Detailed results of this examination are recorded including sub-sets, content areas, specific weaknesses and strengths. **Residents are required to be at the inservice exam. Vacation is not granted during this period.**

Unannounced Periodic Exams: Periodic unannounced examinations assess immediate recall of critical resuscitation information such as dosing of intubation medications.

Oral Examinations: At least twice a year residents take oral board examinations in which they are required to simulate the care of one or more patients while being examined by a face-to-face proctor. These examinations assess for all 6 core competencies and results are recorded by core-competency performance.

Chart Review: The charts of all patients who die in the ED or within 72 hours of admission from the ED are reviewed for clinical performance and documentation. Results of these chart reviews are recorded. The charts of all patients, seen by residents, who undergo CQI review, are reviewed for clinical performance and documentation. The results of these evaluations are recorded.

Procedure Logs: Residents maintain procedure logs of all clinical procedures and resuscitations. The resident procedures are compared to ACGME guidelines as well as class averages.

Attending Consensus of Performance: Up to twice a year the clinical competency committee reviews the resuscitation and procedural performance of all residents. This review is recorded.

Direct Observation of Patient Care: During LLUMC ED months residents may be observed in a patient encounter by a designated attending physician. This attending will evaluate the resident's interaction during the evaluation of this patient and of any procedures completed during the shift.

LLUMC Online Core Curriculum: Residents may be required to complete online courses sponsored by LLUMC as outlined by HSO. The results of their post-tests and course grades are provided to them.

Simulation Training: Residents practice some critical procedures and multiple resuscitations on simulators. They are evaluated and their results recorded on their semi-annual evaluations.

Formal Testing Sessions: Multiple times a year the residency conducts a Formal Testing Session during which you will rotate through multiple stations:

1. A simulated resuscitation using high fidelity manikins that specifically addresses the PGY goals and objectives for resuscitation. During this simulation you may be required to simulate a procedure taken from the year specific procedures goals and objectives.
2. A standardized oral examination (NOT an oral board exam) that will require you to answer specific questions about a chief complaint from the year specific chief complaints goals and objectives.
3. A series of rhythm strip and/or ECGs that will require you to interpret them. The specific content of this station parallel your year specific goals and objectives.
4. A series of radiographs and/or ultrasound images that will require you to interpret them. The specific content of these images will parallel your year specific radiology goals and

objectives.

5. Residents will periodically have one on one reviews of their LLUMC charts to evaluate patient care/medical knowledge - medical decision making, systems based practice skills including billing and medical-legal issues.

Peer Evaluations of Teaching: Residents are required to present a formal lecture during the PGY2 and PGY3 years. Faculty and residents evaluate these lectures using a written evaluation form. The aggregate results of these evaluations are provided back to the residents and compared to the class averages.

Patient Safety and CQI Performance: Beginning in their PGY 1 year residents must complete multiple tasks related to patient safety training and CQI. Included in this is the design, implementation, and evaluation of a project designed to improve the quality of care. These projects are placed in the resident's portfolio.

Procedural Competency: Residents must have attending physicians or senior residents sign off on certain procedures on their procedure cards to document competency in these procedures.

Scholarly Project: Residents are required to complete a scholarly project including a written work product such as a poster, abstract, or manuscript. These are added to the resident's portfolio.

Semi-Annual Evaluation: Twice a year the residents meet with the directors face-to-face and review a document that summarizes all of the above evaluations, progress along the milestones and provides suggestions for improvement.

Grievance Policy: Residents must follow the grievance policy as outlined in the House Staff Manual.

EXAMINATIONS

The department creates and schedules written, oral, and practical examinations multiple times throughout the year. These examination sessions are required for all residents, unless prior excusal from the residency director has been obtained. **All residents are required to sit for the ABEM inservice exam at the end of February, and excusal from this examination is not permitted.** Residents who do not earn a score on the ABEM inservice exam during their PGY-2 year that predicts at least a 95% chance of passing the ABEM qualifying exam may be sent to a written board preparation course (residency's choice) rather than to National ACEP. The resident may still attend National ACEP, but the residency will not be able to fund this travel or registration. Scores between 85-95% chance of passing ABEM exam may be required to complete online board preparation courses.

FATIGUE

The residency takes great effort to educate faculty and residents about the signs and impact of fatigue. Additionally, the following policies are designed to reduce the potential negative effects of fatigue:

1. Any resident working in the ED who believes they are fatigued to the point that they cannot safely manage patients must immediately notify the attending physician on duty. Together the resident and attending will determine if the resident should be sent home for the remainder of their shift or if they should take a nap and be reassessed. They are not, however, to resume patient care activities.
2. Any resident working in the ED who is judged by an attending to appear too fatigued to safely care for patients will either be sent home or sent to nap as in # 1 above.
3. Residents who believe they are chronically fatigued to the point where their patient care, personal well being, or family life are in jeopardy must meet with the residency directors to determine how balance can best be achieved. This may require a reduced work load and extension of training beyond 36 months.
4. Residents who are concerned that they may be too tired to safely drive home have the following options:
    a. They should obtain access to a designated sleep room and nap prior to driving.
    b. They may use Uber, Lyft, or a taxi for transportation home. HSO will reimburse these

expenses. Additionally, the resident may opt to sleep at the Loma Linda Inn with expenses reimbursed.

5. Residents are periodically expected to review signs of fatigue and pass a written exam.

FLIGHT PROGRAM

The residency does not require any resident to fly in either fixed wing or rotary wing aircraft. The majority of flying occurs during the PICU month and during pediatric transport shifts. Residents who do not wish to fly must notify the residency director in writing prior to these clinical experiences.

GENERAL COMPETENCIES

The residency will follow the ACGME Emergency Medicine Program Requirements which can be found at ACGME.ORG. Briefly, the 6 general competencies are:

a. **Patient Care**

b. **Medical Knowledge**

c. **Practice-Based Learning and Improvement**

d. **Interpersonal and Communication Skills**

e. **Professionalism**

f. **Systems-Based Practice**

GOALS AND OBJECTIVES

The residency maintains specific goals and objectives for each of the rotations as well as for each of the years in the program. **These goals can be viewed online at the residency management site, *New Innovations*.**

HOLIDAYS

There are eight official LLU resident holidays: New Years, President's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, the Friday after Thanksgiving, and Christmas. While on outside rotations, residents will typically either receive the holiday itself off, or a day within one week of the holiday. Such holiday scheduling is at the discretion of the attending physician supervising the outside rotation. While on ED rotations, each holiday is considered 1 less clinical hours per month. Whether you receive the actual holiday itself off is dependent upon scheduling and cannot be guaranteed.

HOUSE STAFF OFFICE POLICIES

Residents are responsible for reading and abiding by all House Staff Office and Institutional policies and procedures.

LETTERS OF RECOMMENDATION AND REQUESTS FOR INFORMATION FROM MEDICAL BOARDS AND OTHER AGENCIES

LETTER OF RECOMMENDATION

The Residency Director and faculty are willing to write letters of recommendation for job prospects. For positions after graduation, residents should be aware that most employers call the Residency Director for a verbal balanced appraisal of their performance, strengths, weaknesses, and level of productivity. The usual questions include:

1) Is this resident any slower than the average graduating resident?
2) Does this resident create conflict with nurses or patients/families?
3) Does this resident complete medical records and other administrative duties on time?
4) Has this resident had more than the average number of cases presented in QI?
5) Has the resident failed to show up for a shift or repeatedly called in sick?
6) What is the residents greatest weakness?

Additionally, most letters of recommendation specifically ask if any disciplinary action or remediation was required. The residency will complete these letters accurately and honestly. In an effort to write a valid and accurate letter of recommendation the resident may be asked by the program to write a several sentence narrative to be inserted into the letter that outlines their own area(s) of weakness.

REQUESTS FOR INFORMATION FROM MEDICAL BOARDS AND OTHER AGENCIES

Many state licensing and other agencies require reporting of areas of concern that have arisen during a residents training. The residency will report required information to State Licensing Boards and other appropriate agencies or institutions upon request. At a minimum, actions or patterns resulting in a residents termination or placement on probation will be reported upon the request of the appropriate boards, agencies, or institutions. Placement of a resident into an individualized education plan may not necessarily result in the reporting of the incident depending on the State. Residency is a time of learning and individualized education plans/remediation plans written by the residency will typically clarify whether or not the plan for improvement/remediation is considered a reportable concern to a state agency or simply part of the normal learning process of residency. Any questions the resident may have regarding how their performance will be reported to State Licensing Boards, or other Agencies, or Institutions should be made to the program director by the resident.

LEVELS OF STANDING, REMEDIATION, SUSPENSION, & TERMINATION

The Emergency Medicine residency follows the LLUMC remediation policy as developed by the LLUMC GMEC (Graduate Medical Education Committee). It is available online or from the House Staff Office for review. Residents are expected to contact the EM program director or House Staff Office in writing with any questions they have regarding the institutional policy or the EM policy outlined below.

As resident performance directs, the Residency Director assigns each resident one of the following levels of standing: on track for promotion, remediation, remediation (reportable), probation, dismissal. All residents begin the program on track for promotion. Residents may be reclassified to other standing, if performance towards mastery of the milestones is deemed inadequate. Attempts will be made to give prior warnings, however this may not always be possible. With each change, residents will be informed in writing of the performance necessary to regain a standing in which they are on track for promotion.

*To maintain **on track for promotion**, at a minimum, residents are required to:*

- Meet the expected milestones
- Maintain appropriate professional, academic, and interpersonal skills & communication standards.
- Score at level on the ABEM inservice exam that predicts at least a 95% chance of passing the written qualifying exam on the first attempt (within confines of ABEM regulations)
- Score satisfactorily on departmental written, oral, and practical exams
- Receive satisfactory evaluations on all rotations
- Avoid any letters of warning for delinquent residency paperwork
- Keep their medical records up to date
- Comply with all requirements outlined in this manual
- Complete CQI project by the deadline
- Complete the scholarly project by the deadline

Residents who fail to meet these standards will be assigned a satisfactory standing. Significant disciplinary, clinical, or administrative lapses will result in further demotion to probationary standing.

The level of standing affects the number of ED shifts per month, the ability to take electives, the ability to attend regional and national conferences, and the ability to advance from year to year (from PGY-1 to 2, etc.).

	Shifts/month (PGY1,2,3)	Can take elective?	Can attend ACEP?	Will advance in PGY?

On track for promotion	22,20,20	Yes	Yes	Yes
Remediation (either type)*	24,22-24,22-24	Maybe*	Maybe*	Yes
Probationary	24,24,24	No	No	No
Suspended	None until cleared	No	No	No

* Depends on why they are in remediation. Residency Director determines eligibility.

Residents on Probationary Standing also:

- Cannot be graduated from the program or recommended for board examinations until they are promoted to satisfactory standing
- May be assigned additional remedial duties or projects at the discretion of the Residency Director

Residents may be dismissed from the program if their clinical, academic, or professional performance fails to meet required standards. A copy of the due process policy is found in the *LLUMC Resident Information Booklet* available online or from the Housestaff Office.

LIBRARY, EM ACADEMIC

The EM library is your office space to study, relax, prepare lectures, etc. **Please keep it clean.** Keycard access to the library is restricted to EM faculty, fellows, residents, and office staff.

Computers
Use of computers is first-come, first-serve. Residents may store files on these machines; however it is recommended that each resident regularly make back-ups of any important materials, as information services routinely deletes non-approved files without warning.

Refrigerator
A refrigerator for beverages only is provided. **Frequently this refrigerator will be stocked with sodas courtesy of the residency and attending physicians. These are ONLY for residents staffing the emergency department, faculty, and office staff.** Any food items found in the refrigerator will be discarded. There is a refrigerator in the ED conference room adjacent to the resident library where food can be stored for shifts.

LIFE SUPPORT COURSES

The following courses are required of all EM residents:

- *Basic Life Support (BLS)*: This course teaches basic CPR principles, and is designed for physicians, nurses, and non-medical persons. BLS is a departmental and institutional requirement for all residents taking care of patients unless the resident has a current ACLS or PALS card.
- *Advanced Cardiac Life Support (ACLS):* This course teaches the advanced management of cardiac dysrhythmias, and is designed for physicians and nurses. ACLS is a departmental requirement and must be kept current throughout residency.
- *Advanced Pediatric Life Support (APLS):* This course teaches management of critically ill children, and is designed for physicians. It is typically put on in July of the EM1 year.
- *Advanced Trauma Life Support (ATLS)*: This course teaches the advanced management of trauma victims, and is designed for physicians only. Residents typically take it sometime during the EM1 year. ATLS is a departmental requirement and must be taken at some point during the residency.
- *Base Station Physicians (BSP):* This course provides an overview of Emergency Medical Services, and in the use of radios to facilitate prehospital care. It is designed for physicians only. It is typically put on in June of the EM1 year.

These courses may be scheduled *only* outside of other scheduled clinical duties. Thus, they may be taken only on ED and elective months, not on outside rotations. It is the responsibility of each resident to work with the scheduling Chief Resident to ensure that their ED shifts do not conflict with scheduled courses.

These courses are expensive; however our department has chosen to pay the tuition for you. These courses do not give refunds for no-shows! **Thus, if a resident schedules a course and then either fails to attend or cancels after the course's last withdrawal date, the resident will be charged the cost of that course.**

Instructor classes in ACLS, PALS, and ATLS are offered only to motivated residents with outstanding performance on the Provider courses. Teaching these courses is excellent experience and adds impressive credentials to your resume.

LOGBOOK, FOLLOW-UP

Follow-up logs are encouraged for each month worked at LLUMC ED and RUHS ED, but beginning in this year a follow up log book is not required. Residents should keep a list of interesting patients seen during the given month, for which follow-up would be interesting and/or educational. Throughout the month the resident performs follow-up at their convenience, usually through chart review and personal phone calls to the patient. Residents should follow-up on both patients admitted to the hospital and those discharged home.

LOGBOOKS, PROCEDURE AND RESUSCITATION

Why do we have to do this?

The residency has a procedure and resuscitation logging system for three reasons:

1. The Residency Review Committee, the program's accrediting organization, mandates it.
2. It allows the program to track resident procedural experience, to ensure that adequate educational opportunities are being provided.
3. To provide each resident a list upon graduation of all procedures performed during their training. This will assist with hospital credentialing in future practice.

The "Program Requirements" of the RRC state that: "Programs must maintain a record of all major resuscitations and procedures performed by each resident. The record must document ... the type of procedure; the location (ED, ICU, etc); age of patient; and admission diagnosis. Only one resident may be credited with the direction of each resuscitation and the performance of each procedure."

How does the program evaluate this?

Residents will enter information onto their procedure logs on New-Innovations. This may be done on the computers or iPads provided by the residency. Ongoing statistics will be kept on the number of procedures performed, and numerical comparisons will be made of each resident's procedural tally with historical precedent and the number logged by other residents. This will permit identification of individuals who may either be failing to consistently comply with procedure logging, or who may be receiving inadequate opportunities to perform procedures. This information will be included in semiannual evaluations, and progress tracked. It is the residents responsibility to ensure they meet at least the minimum number of required procedures prior to graduation. Low procedural numbers may be remedied by a return to clinical environments such as ICUs or trauma rotations instead of electives if residents fail to record enough of their procedures.

What exactly must be logged and how?

New Innovation allows for direct logging of procedures into the database. **The database must be updated within 15 days of the completion of a given rotation month, even if no procedures were performed in the given month.** To be valid, each logged entry must include:

1. Procedure or resuscitation name (see list to follow)

2. Date
3. Patient file # or "simulation" if not a hospital patient
4. Supervising attending
5. Age
6. Diagnosis
7. Location (ED, ICU, Ward, simulation lab)
8. For Resuscitations the resident should indicate whether they were a participant or director.

Unless indicated otherwise, it is assumed that for all logged entries the resident was the principal individual performing the procedure under supervision. Watching a procedure doesn't count. Only one resident may be credited with each specific procedure or with directing resuscitation.

1. 2017 FAQ RRC "index procedures"
    a. Adult Medical Resuscitations 45
    b. Adult Trauma Resuscitations 35
    c. Cardiac Pacing 6
    d. Central Venous Access 20
    e. Chest Tubes 10
    f. Cricothyrotomy 3
    g. Dislocation Reduction 10
    h. ED bedside US 150
    i. Intubations 35
    j. Lumbar Puncture 15
    k. Pediatric Medical Resuscitations 15
    l. Pediatric Trauma Resuscitations 10
    m. Pericardiocentesis 3
    n. Procedural Sedation 15
    o. Vaginal Delivery 10

    Additional milestone procedures including ABG, arterial line, pain management, etc are also listed on the NI site and should be recorded appropriately despite the ACGME being unclear on the specific number required to be logged. It is assumed competency of the residents in performing these procedures is more of a goal than the specific numbers obtained. Nevertheless additional data is helpful in making an assessment.

    2017 FAQ RRC:
    The responsibility for the determination of procedural competence rests with the program director, the members of the faculty, and the members of the Clinical Competency Committee.

    The Review Committee expects programs to assess the competence of residents in performing all key index procedures. At the time of its review, the program will need to demonstrate how it assesses resident competence for three procedures, one of which must be Emergency Department bedside ultrasound.

RESUSCITATION is defined by the RRC as "patient care [successful or unsuccessful] for which prolonged physician attention is needed and interventions such as:
1. defibrillation,
2. cardiac pacing,
3. treatment of shock
4. intravenous use of drugs (e.g., thrombolytics, vasopressors, neuromuscular blocking agents, or transfusion),
5. or invasive procedures (EGD, cutdowns, central line insertion, tube thoracostomy, endotracheal intubation)

…are necessary for stabilization and treatment."

Please log ALL patients meeting the above definition, including whether a trauma and whether adult vs pediatric. Do not forget resuscitations directed on outside rotations, or when the patient expires (unsuccessful resuscitations are still resuscitations). For example, an unsuccessful medical code may include the following separate logged entries: (1) adult resuscitation, (2) intubation, (3) defibrillation, and (4) pericardiocentesis.

In the accompanying table is the "official" program procedure list. You may record other procedures not on this list, but the program will not tally them for comparative or statistical purposes.

It is expected that all residents will be able to log the MINIMUM REQUIRED number of procedures prior to graduation. Rare procedures may be supplemented by simulations or cadaver lab experiences. The residency director will work with residents who are failing to achieve these guidelines to ensure that they are receiving adequate opportunities for procedural experience. Residents should continue to log specific procedures performed even after they have met the minimum number for that procedure.

Procedures on simulation mannequins or cadavers should also be logged. Under patient file number put "simulation" and under location put "lab."

Residents cannot complete the program until the minimum number of procedures have been logged. This may require that residents who finish the 36 month training program demonstrate proficiency in the procedures by either: 1) returning to the residency to complete simulations until the number of procedures is met, or 2) submitting a letter signed by your medical director stating that you have completed the number of procedures necessary to meet the minimum requirements. While the residency will work to facilitate experiences to meet these requirements, the resident is ultimately responsible for documenting their exposures.

MAILBOXES

Your e-mail address, your LLUMC resident library mailbox, and your RUHS ED mailbox (located in the administrative office adjacent to the ED) are the locations for "official" residency communications. Rarely an official communication will be mailed to the most recent address on record with the residency program. It is required that you check these locations at least weekly for work mailboxes and every other day for email and home "snail mail" mailboxes (except while on approved vacation, of course). Failure to check your mailbox will never be accepted as an excuse for being unaware of information placed there! Please do not have personal mail, journals, or bills sent to your resident library mailbox.

MEDIA

LLUMC has a policy covering interaction with the media. Residents are expected to be familiar with this policy. To reach media relations the easiest route is to call the operator and ask them to page the media relations specialist on call.

MEDICAL STUDENT TEACHING

Medical students have group classes that are taught by Attending EM physicians. Residents are encouraged to teach medical students on the wards, in the emergency department, and for those interested, in simulations or classrooms.

MOONLIGHTING

Moonlighting is a privilege, not a right. It is permitted only for residents in preferred standing, and is subject to the following restrictions:

- Moonlighting must not interfere with the performance of expected resident duties.
- The ACGME does not allow moonlighting during the PGY 1 year.
- The residency directors may prohibit any resident from moonlighting.
- Moonlighting must not violate any of the ACGME work duty hours. Specifically, any moonlighting shifts must comply with the following:
  - Residents must have 10 hours off between duty hours including the moonlighting shift
  - Residents must not work more than 80 hours a week averaged over 4 weeks and must not work more than 72 hours in any actual 7 day week.
  - Residents must have one 24 hour period off a week, averaged over 4 weeks
  - Residents must not evaluate a new patient for more than 24 hours in a row and they may not

be in the hospital for more than 28 consecutive hours.

- Residents are required to notify the residency director PRIOR to participating in any extracurricular clinical work.
- Moonlighting at any affiliated institution (RUHS, Kaiser-Fontana, Arrowhead Regional Medical Center, etc.) requires submission of actual monthly work schedule to the residency to determine compliance of the ACGME work duty hours (this is an RRC requirement). Failure to do so will result in loss of moonlighting privileges.
- MSE shifts count as moonlighting.
- Moonlighting at other institutions MAY require submission of work schedule at the program director's discretion; however, residents are required to comply with the same work duty hour requirements.
- Moonlighting during a period in which a resident is scheduled as sick call back up resident is not allowed.
- **Extra-curricular clinical activity is NOT covered under the LLUMC malpractice insurance**
- The residency will not verify a physician is competent to practice independently until all requirements of the residency training program has been met, including a minimum of 36 months of training in Emergency Medicine.
- **Residents are required to log their moonlighting hours on New-Innovations.**

Residents found in violation of any moonlighting policy including any work duty hours requirements will receive, at a minimum, automatic change in standing. To comply with accreditation requirements, the program reserves the right to review the nature of residents moonlighting activities, within the confines of California law.

MILESTONES

The ACGME requires that upon graduation the program confirms a resident physician is able to practice independently without direct supervision. They have developed a series of steps or "milestones" a resident learner should become proficient with prior to a program certifying the resident is proficient. For further details on the specific milestones search for The Emergency Medicine Milestone project on the American Board of Emergency Medicine website: https://www.abem.org/PUBLIC/portal/alias__rainbow/lang__en-US/tabID__4341/DesktopDefault.aspx

NEW INNOVATIONS

The residency uses an online residency management program to assist in administration of the program. New Innovations can be accessed at www.new-innov.com. The residency coordinator can provide information on how to access your account. New Innovations allows for online evaluations of faculty, residents, and the program. It also stores personnel information, block rotation schedules, conference schedules, conference attendance, procedure logs, and so forth.

PAGERS

The House Staff Office provides residents a pager. Residents must have the pager with them and turned on at all times other than while on vacation, when sleeping, or when required to be off by work duty hour standards. Residents completing a night shift may turn the pager off temporarily to ensure uninterrupted sleep during the day.

The emergency medicine residents are uniquely qualified to respond to a public disaster or mass casualty incident. In such an event, all residents must be accessible by pager (or cell phone) to assist. Additionally emergency medicine residents must be available by pager as the sick call back-up resident must be able to contact residents to determine their availability to cover an unexpectedly uncovered shift. The residency may periodically confirm that residents respond to pager calls. Failure to do so will result in a warning and then potential loss of standing.

PATIENT SAFETY & QUALITY IMPROVEMENT PROJECT

The RRC requires residents be trained in patient safety and quality improvement methods. In addition residents are required to participate in patient safety projects every year. To facilitate learning this important professional skill all residents are required to complete a patient safety project during their residency. The project will require significant investment of time and effort on the part of the resident, often during periods when not working clinical shifts. To facilitate the learning process

resident physicians will be allotted additional non-clinical administrative time beginning their PGY 2 year.

PEDIATRIC TRANSPORT CALL

EM3 residents and those EM2 residents who have completed their PICU rotation may be scheduled for 1-2 pediatric transport calls during each month assigned to the LLUMC ED. The hours for this call are 4:30 pm to 7 am, and for scheduling purposes each call is considered one shift. On designated LLU holidays the transport call begins at 7am and ends 7am the following day. Residents may have the opportunity to ride on helicopters, but are not required to do so.

PERSONNEL

- Interim Chief and Chair: Tammi Thomas, MD, FACEP
- Administrative Assistant to Dr. Thomas: Joanna Lopez
- Vice Chair for Education & Medical Simulation Center Director: Dustin Smith, MD, FACEP
- Vice Chair for Operations: Lance Brown, MD, FACEP
- Adult Medical Director: Lea Walters, MD
- Pediatric Medical Director, QI Director: Jim Moynihan DO
- Interim Division-Chief, Adult EM: Lance Brown, MD, FACEP
- Division Chief, Pediatric EM: Lance Brown, MD, MPH, FACEP
- Director, Emeritus: Steve Green MD, FACEP
- Residency Director: Mike Kiemeney MD
- Associate Residency Directors: Tim Young, MD, FACEP, Mindi Guptill MD, FACEP, Brian Wolk
- Associate Residency Director RUHS: Tim Nesper MD, FACEP
- Assistant Residency Director RUHS: Korbin Haycock MD, FACEP
- RUHS Director of Education: Mark Thomas DO, FACEP
- Residency Coordinator: Serena Harper
- Director of International EM and International Fellowship Director: Besh Barcega, MD
- Pediatric Emergency Medicine Fellowship Director: Tim Young MD, MPH, FACEP
- Pediatric EM Fellowship Coordinator: Shelley Nelson
- Research Director: Ellen Reibling PhD

The Residency Coordinator and other office support staff do NOT have available time for resident secretarial support. **Please do not have your personal phone calls or mail directed to our office**. Please don't ask the office staff to type your lecture handouts or do your photocopying.

PHOTOCOPYING

Photocopiers are available for your use in the Coleman Pavilion library, the LLUMC ED, and the RUHS ED.

PHOTOGRAPHS

Both LLUMC and RUHS have departmental policies regarding the taking of photographs in the ED (including those that do not include identifying patient characteristics). Residents must be familiar with these policies.

PRIOR PROGRAM GRADUATES

For your interest, below is a list of all graduates of our residency program.

2017	Brad Alice (Chief), Nathan Silvestri (Chief), Emily Barrett, Darren Brockie, Morgaine Daneils, Joseph Fargusson, Michael Fargusson, Whitney Hampton, Sarah Peterson, Karan Singh, Erik Smith, Joshua Westeren, Audra Wisham
2016	Andrew Davis (Chief), Lizveth Fierro (Chief), Allen Chiou, Nellie Ekmekjian, John Henderson, Andrew Johnson, Brad Lawing, John O'Neal, Sonya Stokes, Tim Widener
2015	Seth Dukes (Chief), Ann Serafin (Chief), Chelsea Cosand, Andrew Flanery, Sassan Ghassemzadeh, Bradford Hardesty, Natalie Hoover, Joseph Kopp, Cesar Olmedo, Jennifer Prigge, Anne Serafin, Micah Treuer, Omar Washington, Kenny Wu.

2014	Matt Barden (Chief), Michelle Iwaki (Chief), Vlatka Agnetta, Erik Axene, Kyle Bonar, Sha Brennan, Eric Castleberg, Randy Frederick, Natasa Jenson, Maria LaPlant, Aakanksha Mehta, Graham Mooy, Eric Zahorecz
2013	Caleb Bailey (Chief), Heather Kuntz (Chief), Shannon Brumund, Reuben Castillo, Carrie Charlton, Veeran Davy, Amy Douglas, Jesus Gomez, Jesse Kellar, Dallas Koperski, Michael Lockwood, Stephanie Loe, Rohn McCune.
2012	Jason An (Chief), ViAm Dinh (Chief), Victoria Gillis, Joshua Hong, Bryce Inman, Sarah Korando, Katherine Kuo, Lisa Nguyen, Kristin Ratnayake, Karyn Ridgeway, Christopher Steckling, Jessica Sutton
2011	JT Brown, Steven Cherry (Chief), Augusto Cigliano, Zeke Foster, Rodney Jay, Michael Kang, Lisa Kinney-Ham, Sam Ko, Albert Nguyen, Melanie Randall (Chief), Sherrie Suzuki, Brent Yamashiro
2010	Daniel Chang, Scott Fredrickson, Jeremy Hammel (Chief), Brenden Hansen, Yasmine Henze, Michael Homeyer, Eddie Lares, Vinit Madhvani (Chief), Seth Oskie, Heather Torrez, Rebecca Diaz (Chief), Nancy Warner
2009	Aaron Breit, Paul Frandsen, Shannon Gates, Joslin Gilley-Avramis, Mindi Guptill, Kris Lyon, Lee Maas, David Main, Davi Paletz, Josh Sheridan, David Smith, Seth Thomas(Chief), Justin Wagner (Chief)
2008	Deborah Behringer, Leslie Cho, Thomas Cho, Roberta Dunn (Chief), Thomas Forney, David Gregorius, Jacqueline Le, Serena Lee, David Maxwell (Chief), Joshua Mou, Julie Phillips, Rebecca Walker, Kelvin Wong
2007	Isaac Bingham, J Wayne Burris, Ian Butler-Hall (Chief), Joanne Davis, Jonathan Dyreyes, Andrew Givner, Wender Hwang (Chief), Eddie Lam, Travis Parker, Lisa Vincijanovic, Joe Whittington, John Wu, Tim Young
2006	Jennifer Cohen Smith (Chief), Michelle Goodman, Mike Guirguis, Sean Kness(Chief), John Lee, Laura Leistiko, Kevin Martens, Avi Patil, Jon Rosenthal, Renee Schroetlin, Ben Wakamatsu, Edwin Wells
2005	Jack Anderson, Jenny Hargrove, Eugene Hu, Don Janes (Chief), Shant Kalanjian, Michael Lowe, Mark Oh, Geoffrey Pableo, Jamie Ropacki, Scott Walker (Chief), Debbie Washke
2004	John Abdelshehid, David Cadogan, Heather Crane, Matt Madden, David Reiley (Chief), Tania Shaw, Marcus Voth, Kelli Westcott (Chief), Marcus Voth
2003	Tim McNaughton (Chief), Tae Kim (Chief), Vaughn Browne, James Frenchik, Korbin Haycock, James Kim, Nyda Pamintuan, Javier Perez, Gerardo Salcedo, Chien Sun, Andrew Tomasi
2002	Holly Cooper (Chief), Heather Heileson (Chief), Mary Beth Johnson, Jana Kokkonen, Torrey Laack, Kathy McCue, Steve Patterson, Paul Razo, Ryan Stolworthy, Rosella Storing
2001	Brian Anderson, Brennen Beatty, Ryan Brenchley, Jon Chock, Jaime Gonzales, Kevin Parkes (Chief), Dustin Smith (Chief), Mike Walger
2000	Jon Cline, Greg Guldner (Chief), Kevin Hegewald (Chief), Steve Kim, Brad King, Carlos Martinez, Dave Merin, Louis Tran, Matt Underwood, Reza Vaezazizi
1999	Ian Ashley, Jennifer Cobb, Jon Daniell, Wayne Garrett, Troy Harris, Jai Ho, Alan Hopkins, Steve Rodriguez (Chief), Eric Siedenburg, Barbara Victor
1998	Darilyn Campbell (Chief), David Chen, Glynda Crabtree, Charles Gerardo, John Hamilton, Darryn Myers, Kieu Nguyen, Khanh Tran, Lorna Turner, Victor Wu
1997	Ellen Baker, Eric Brown, Eric Chin, Jeff Grange, Jon Hayden, Lea Lynch, Carl Menckhoff, Mark Richmond (Chief), John Vowels
1996	Gil Arroyo, Rodney Borger, Dave Christensen, Bernie Dannenberg, Tom Edholm, Angel Iwai, Robin Knauss (Chief), Mike Mammone, Ramin Sarshad
1995	Sean Bush, Glen Carlson, David Farstad, Jim Keany, Laura Milker, Brett Nelson (Chief)
1994	Tony Chow, Lynda Daniel, Julie Gorchynski, Ed Leiken, Chris Rooke (Chief), Sally Sidman
1993	Greg Burke (Chief), Carolyn Chooljian, Eileen Gorton, Anil Gupta, Brad Howeiler, Shari Williams
1992	Kathy Clem (Chief), Debbie Letai, Mike Nelson, Ed Pillar, Mike Simmons, Mark Thomas
1991	Mark Bauer, Stephen Corbett, Chris Hummel, Laura Mellick, Lenny Teitz, Jerry Thrush (Chief)
1990	Debbie Bervel, Ken Gramyk, Gail Pignatiello, John Rush, Mike Salomon, Tamara Thomas
1989	Doug Coon, Steve Dick, Henk Goorhuis, Steve Rothrock, Linda Sturges
1988	Anita Borrowdale, Karin Covi, Steve Green, Debbie Marks, Brad Reinke

1987	Richard Green, Chris Melville, Cathy Putnam, Mick Ratter, Eric Stone, Nedra Vincent

PRISONERS

At RUHS residents will care for prisoners both in the ED and on inpatient services in the specified Detention Ward. Be aware that it is a criminal offense for health care workers to communicate scheduling information (eg, date and time of clinic appointments) to either prisoners or their relatives or friends, as this information might potentially be used to plan an escape attempt. Tell prisoners that they will return "on another day" for clinic follow-up, and use law enforcement or detention personnel to facilitate any needed communicate with outside sources.

PROXIMITY OF LIVING

No resident may live more than 45 miles from LLUMC. Residency is a full-time endeavor, and prolonged commuting significantly detracts from the overall quality of the learning experience and places residents at greater risk of motor vehicle collisions. All residency applicants were made aware of this requirement on their interview days.

Residents are required to be able to safely arrive at the hospital within 30 minutes of being paged when rotating on a service allowing home call (such as pediatric transport shifts.) If residents live at a location that would not typically allow them to safely arrive within the designated 30 minute period – either due to distance or traffic – they are required to submit a plan to the residency in writing how they will address this issue. Possible solutions include staying at a local hotel at the residents expense, staying in a call room if available, staying with a friend or family member who lives closer to the hospital, etc.

READING PROGRAM

The LLU residency believes that an aggressive personal reading program is essential to mastering the core knowledge of emergency medicine. Each resident is expected to organize and initiate a personal reading program of an approved Emergency Medicine textbook, the cost of which is supplemented by the residency. Substitutions for specific chapters in the resident chosen book is authorized if residents find primary sources or reviews that cover the same information. Residents are required to keep some sort of personal log or accounting system such that they can readily ascertain which chapters they have read and which they have not. On a quarterly basis residents are required to complete a form documenting their progress in this reading program. These forms must be turned in by the 15th of the month following the end of each quarter.

The following reading progress is required:

- By the conclusion of the EM2 year, each resident is expected to have read 100% of the chapters in the text.
- During the EM3 year, each resident is expected to tailor his or her personal reading plan to areas of weakness. The prior year's ABEM inservice exam may be useful in suggesting such areas.

Residents should make a habit of regularly reading *Annals of Emergency Medicine* and *Academic Emergency Medicine*, the two premier journals of our specialty. Another recommended resource is *Emergency Medical Abstracts* and *EM Rap,* provided to you by the residency through membership in residency associations.

RELATIONSHIP WITH INDUSTRY

The pharmaceutical and medical supply industries have tremendous influence on physicians. Policies and procedures in dealing with industry are periodically reviewed at the institutional and residency level. It is expected the residents will familiarize themselves with any changes in these policies as they occur through the year. To ensure that the resident physician has the greatest opportunity to recognize this influence and mitigate against its effects the residency has the following policies:

- Residents will have mandatory exposure to, and discussion about, ethical guidelines, drug formularies, applying cost-benefit analysis to prescribing practices, the approach to interactions with industry representatives, dealing with patient requests for medications that are based on direct-to-consumer marketing, and the impact of industry marketing on physician behavior.
- Full and appropriate disclosure of sponsorship and financial interests will occur at all program and institution-sponsored events, above and beyond those already governed by the Standards for Commercial Support promulgated by the ACCME.
- Full disclosure of research interests must be published in keeping with the local policies of our institutional review board and following the recommendations of the Association of American Medical College's (AAMC) Task Force on Financial Conflicts of Interest in Research.
- Industry representatives may not sponsor conferences and journal clubs including providing food and gifts of non-substantial value (pens, etc.).
- The residency does not allow any industry sponsored and/or referred speakers at our conferences.
- The residency does not allow industry sponsors access to any clinical area including the Emergency Department.
- Residents are evaluated on their ability to apply cost-benefit analysis of prescription medications when advocating for patients.

RESEARCH, REQUIRED PROJECT

The RRC requires that each resident participate in a scholarly project during the course of his or her training. The resident must formally designate at least one research project as the research they intend to submit for completion of their scholarly project. The project designated as the formally approved research/project must be feasible, developed no further than the design stage when the resident joins the project, have reasonable demands on the resident's time and result in a written product for the resident's file in the residency office before graduation. A resident may work on any other faculty project at any point in the research process no matter how long it will take to complete the project as long as the resident's participation is deemed appropriate by the Residency Director, the supervising faculty member, and the resident. These are not the required projects, but if completed, Residency Director may deem the research/project requirement met.

All residents must have a proposal for their research project approved by the residency directors by October 1st of their EM2 year. **If a resident has not arranged a suitable project by this time, one will be assigned. A signed mentorship agreement between the resident and research mentor will be required as evidence of commitment between the resident and attending. Additionally the scholarly activity is to be logged into New Innovations by the resident physician. The initial mentorship agreement will be entered by the residency coordinator but all other documents and supporting files are to be uploaded by the resident physician.** Residents may be provided a stipend to present research at yearly ACEP or SAEM meetings, if their projects are accepted for presentation and residency budget allows. **The research project must be completed by March 31st of the PGY-3 year. PGY 3 residents will be expected to present their finished research project at a designated didactic session in the spring of their PGY 3 year.**

Requirements for Completion

The residency has reviewed the RRC requirements and CORD guidelines regarding the completion of the scholarly requirements. The fundamental aspects of the research requirement include:

1. Problem identification and/or hypothesis formulation.
2. Some form of information gathering or data collection.
3. An analysis of data or some evidence of analytical thinking.
4. A statement of conclusion or interpretation of results.
5. Documentation in a written form (there must be a work product).
6. Some form of literature review.
7. An attempt to disseminate the information to others (publication, presentation, poster).

Generally acceptable means of completing the scholarly requirement include:

- Peer Review – This refers to resident participation in the dissemination of knowledge through the preparation of a scholarly paper published in journals indexed in PubMed, including original contributions of knowledge published in journals listed in Thomson Reuters (formerly ISI), Web of Knowledge, or MEDLINE®. Abstracts, editorials, or letters to the editor do not qualify. Submissions to online venues, with the exception of Med Ed PORTAL, do not qualify.
- Non-Peer Review – This includes all submissions to journals or online venues that do not fulfill the peer-review criteria. This also includes abstracts, editorials, collective review, case reports, or letters to the editor of peer-reviewed journals, educational videos, DVDs, and podcasts.
- Textbooks/Chapters – This includes resident participation in the writing and submission of such works where the faculty mentor served as the chapter author.
- Conference Presentations – This refers to presentations at local, regional, or national organizational meetings, including the presentation of abstracts and posters, panel discussions, and serving as forum leader.
- Participation in Research – This refers to active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an Emergency Department quality improvement project.
- Very rarely, a research project cannot be completed due to factors beyond the control of the resident (as determined by the residency director). Should this occur, and there is inadequate time to complete another project, the resident will submit a manuscript to the director that discusses: 1) the initially proposed project, 2) the progress to date, 3) the barriers to completion of the project, and, 4) an analysis of how these barriers may have been predicted and prevented. This manuscript/analysis must be approved by the residency director prior to the scholarly project being completed.

This research requirement is not considered fulfilled until the manuscript, poster, or equivalent has been reviewed and approved by the resident's research preceptor, ED research director, and the Residency Director.

Residents must submit their research proposal to the program director or associate directors for approval before it will be considered an approved project. Similarly, the program director or associate directors, with input from the faculty involved, determines when a project is complete.

Research Supervision
All research projects are required to have an affiliated attending supervisor who may also be an author.

Faculty sponsors for research
All research bearing the LLU or LLUMC name must have a faculty sponsor, although this sponsor can be from another department. The faculty sponsor should actively work with the resident in the design, organization, and implementation of the research project.

Occasionally there are disputes regarding order of authorship on research papers, and it is recommended that authorship as well as specific duties and responsibilities be clearly stipulated in advance. Residents are referred to "Guidelines on authorship of medical papers" (*Ann Intern Med* 1986; 104:269) for advice on appropriate standards for authorship.

Institutional Review Board Approval
All research involving human subjects, **including retrospective chart reviews and surveys**, must be approved by the Institutional Review Board prior to proceeding in data collection. Your faculty advisor, the research director, or residency director can assist you in IRB applications.

Research Completed in Medical School
The ACGME requires a scholarly project to determine competency in Practice-Based Learning and Improvement. A scholarly product that was completed or partially completed in medical school does

not allow the residency to supervise the process and confirm both involvement and competency in the multiple steps required to develop a final product. Accordingly, a scholarly product that has proceeded beyond the design stage while the resident was in medical school cannot be considered for the residency required scholarly project.

ROTATIONS

While on outside rotations, residents will be expected to fulfill the duties similar to those of other residents on the service. These may include clinic duties.

YEAR	ROTATION	MONTHS	INSTITUTION
EM1	Emergency Department	2.5	LLUMC
	Emergency Ultrasound	0.5	LLUMC
	Emergency Department	1	RUHS
	General Surgery	1	RUHS
	Trauma Surgery	1	LLUMC
	Coronary Care Unit	1	LLUMC
	LLUMC Medical Intensive Care Unit	1	LLUMC
	Pediatric ED	1	LLUMC
	Anesthesia	1	LLUVAH
	Orthopedic Procedures	1	LLUMC
	OB / GYN	1	LLUMC
EM2	Emergency Department	3½	LLUMC
	Emergency Department	4	RUHS
	Pediatric ED	1	LLUMC
	VA Medical Intensive Care Unit	1	LLUVAH
	NMCCS	½	LLUMC
	Pediatric Intensive Care Unit	1	LLUMC
	Elective	1	LLUMC
EM3	Emergency Department	6	LLUMC
	Emergency Department	4	RCRMC
	Pediatric ED	1/2	LLUMC
	Elective	1½	LLUMC

SEXUAL HARASSMENT

The residency program will not tolerate any form of sexual harassment. If you are the subject of any type of such harassment or an observer of such language or activity, please report the incident to the LLUMC Human Resources Management Department immediately (x44345). Be assured that a thorough and fair investigation will be conducted. If it is determined that some form of sexual harassment has occurred, appropriate corrective action will be taken against any offender.

Occasionally behavior is noted that does not officially constitute sexual harassment but is considered offensive or demeaning by others. Residents who exhibit such behavior will be subject to disciplinary

action and will be required to undergo a formal "sensitivity and awareness" training program administered by LLUMC.

SICK LEAVE

Sick leave is supervised by LLUMC HSO and Human Resources. For direction regarding sick leave please contact either of these two entities for further direction. Each resident is allowed up to 10 days of yearly sick leave. These days are allowable for significant illness only, and are not intended to serve as extra vacation days. Cumulative totals of sick leave days will be kept. If residents exceed 10 days in a given calendar year, the Residency Director will arrange mandatory make-up time to meet ABEM/ACGME/RRC requirements for EM training. If a resident is found to have taken a sick leave day falsely, he or she will automatically face a loss of standing for a minimum of two months.

Outside Rotations
If a resident judges that he or she is too sick to work while on an outside rotation, he or she must notify the outside rotation supervisor, and the EM Residency Coordinator (who will then notify the House Staff Office).

ED Rotations
The ED rotation illness policy for residents is like that used by faculty physician groups at both LLUMC and RCRMC. The culture of Emergency Physicians toward "calling in sick" of necessity differs from that of other specialties, in that the ED cannot shut down like an office and must be regularly and consistently covered. The residents are expected to approach the resident ED schedule in the same manner they will approach the ED schedule coverage in the groups they will work in upon graduation. Specifically, all scheduled shifts should be covered every time. It is vital that residents learn and appreciate this specialty ethic early, as it is an integral part of their chosen career.

If an EM PGY 1 resident judges that he or she is too sick to work while on an ED rotation, the resident is responsible for arranging with a member of their PGY – 1 class who will cover the shift. If no PGY 1 is available to work the shift the EM sick call resident should be contacted. If an EM PGY 2 or PGY 3 resident judges that he or she is too sick to work while on an ED rotation, the resident is responsible for arranging another similar-level resident (or higher) to cover the shift. PGY EM -2 residents may provide coverage for sick PGY EM – 3 residents if no PGY 3 resident is available. If the resident is for some reason unable to arrange coverage, he or she will contact the designated sick call back up resident for assistance. The sick call back-up resident must be continuously available by beeper. It may be necessary for the back-up resident to work the shift in question. The resident working the shift for the sick resident will be scheduled for one less shift in a future month. A chief resident will serve in the capacity of the back-up resident if the back-up resident is unable to resolve the scheduling problem. However, the back-up resident is expected to make significant efforts to resolve the situation prior to calling the chief resident. This includes calling or paging residents who may be available to work the shift. The ED attending on duty, or the LLUMC HSO, may either require an ill resident to present to the ED for evaluation or supply a doctor's note from the residents' personal physician.

EM 2 and 3 residents are scheduled for sick call coverage on a daily basis as organized by the chief residents. Kathy Haimson has the master copy of the sick call schedule, and Mark Thomas and the chief residents have a copy. **Sick call coverage is home call. However the sick call resident must be able to respond immediately, and if necessary be in the ED within an hour of being contacted for coverage. The sick call resident must be capable of dedicating substantial time on short notice to arrange coverage (which may include them working the shift in question). Moonlighting during sick call is incompatible with this requirement.**

If a resident has prolonged illness such that more than a single shift is involved, the sick call back-up resident with the assistance of the Chief Residents will reassign resident shifts such that the schedule is covered as best as possible. Residents who work "extra" shifts that month as a result of such rescheduling will receive an equivalent time subtracted from the shift schedule on a later ED month at the same hospital. At no time will exceptions to the work duty hours be allowed, even for covering for

a sick colleague.

Maternity, Paternity, and Family Leave
Maternity, Paternity, Family, FMLA/CFRA and similar leaves are determined by the Human Resource department. LLUMC HSO and/or the LLUMC EM residency may be able to assist you in coordinating leave as directed if requested by the Human Resources Department. Attempts will be made to accommodate maternity, paternity, and family leave using vacation days. Absences longer than available vacation leave will necessitate mandatory make-up time, as ABEM requires a minimum of 36 months of training in emergency medicine. Our program adheres to the LLUMC "Family Medical Leave Policy", which has been provided to you by the LLUMC Housestaff Office. Please review it for details.

It is requested that residents who become pregnant (or who have spouses who become pregnant) notify the program at the earliest possible time. This can often allow helpful rotation switches to prevent chaotic last-minute schedule changes at term.

SOCIAL MEDIA

The use of social media as a tool for education and professional networking is encouraged. It is important to keep in mind that all social media activity can be discoverable by the public and/or Loma Linda University Health Education Consortium (LLUHEC). It is the expectation of the Loma Linda Emergency Medicine Residency program that all EM residents will be professional, tolerant, and in keeping with the expectations of employees as set forth in the LLUH Employee Handbook. Each resident is expected to be familiar and comply with the social media policy of LLUH. Each resident will be held responsible for any activity on a social media account attributed to that resident.

STRESS & WELLNESS

Our residency program is committed to the development of a training environment in which participants can develop outstanding technical and humanistic attributes necessary for the independent practice of emergency medicine while eliminating unnecessary stress. The residency monitors resident stress through one-on-one discussions during semi-annual evaluations, monthly rotation evaluations, and a Stress & Well-Being Committee. Residents who identify an unduly stressful scenario should bring this to the attention of the residency leadership or a resident advisor (contact House Staff Office) for review. Additionally, the residency fully supports the use of the Loma Linda University Employee Assistance Plan. The Loma Linda University EAP is available to provide free of charge confidential assessment and treatment for numerous conditions including depression, anxiety, stress, burnout, marital problems, child and adolescent difficulties, post-traumatic stress, psychiatric disorders, substance abuse, alcohol abuse, eating disorders, gambling addiction, legal concerns, medical problems, financial difficulties, grief, life transitions, work-related difficulties, and many other issues. The can be reached at (909) 558-6050 (66050 on campus). Additionally the resident often is eligible for psychiatric counseling and treatment as outlined in the employee risk management policies. Residents are encouraged to take advantage of this benefit. The psychiatry department can be reached at 909-558-4505.

SUPERVISION POLICY

Guidelines for resident supervision of ED patients at LLUMC/RUHS follow. Note that these are guidelines only and that the ED attending may make individual judgments regarding the necessary supervision of any given resident depending on the patient situation at hand. The complete policy on attending supervision is available from the residency coordinator.

1. All patients presenting to the ED for medical care must have a member of the medical staff as their attending physician. Residents participate in the care of the patients within the ED with the agreement of, or at the invitation of, the ED attending physician. While residents may assess patients, write orders, and document medical care, the attending physicians retain responsibilities for the care of their patients seen by residents and must review the care of their patients. Residents must communicate with the attending physicians to assure that orders they write are consistent with the attending physician's medical treatment plan for the patient.

2. All unstable patients presenting to the ED must be immediately brought to the attention of the attending physician and a treatment plan discussed under his or her direct supervision.

3. PGY1 residents generally should not clear cervical spines in patients without supervision by an attending physician.

4. Patients who initially appeared stable, but who, during their course in the ED become unstable, must be immediately presented to an attending physician and a treatment plan discussed under his or her direct supervision.

5. Care of the complicated pediatric patient (such as those frequently seen at LLUMC) bring special risks. Similarly, residents' capabilities with pediatric patients differ based on their block rotation schedule and the total amount of clinical time with pediatric patients. Accordingly, the policy at LLUMC for pediatric EM is that residents should discuss with the attending physicians on duty on the pediatric side how they would like cases handled in terms of supervision. Some may require immediate supervision while others may allow more independence as they gain knowledge of any particular resident's capabilities. Care of the pediatric patients at RUHS follows the same supervision policy as adult patients at RUHS.

6. In order to provide residents with a progressively increasing responsibility according to their level of education, ability, and experience, the supervision policy for adult patients varies based, in general, on the resident's year of education.

    a. PGY1 residents may undertake the initial evaluation, history, and physical examination of all stable patients in the ED. They must then present their findings to the attending physician and, under the supervision of the attending, jointly initiate a diagnostic and treatment plan. All unstable patients or patients with a deterioration in their condition must be brought to the attention of the attending physician immediately.

    b. PGY2 residents may undertake the initial evaluation, history, and physical examination of all stable adult patients in the ED. They may initiate basic diagnostic and treatment plans such as plain film radiographic studies and laboratory tests, and may initiate basic treatment modalities such as respiratory therapy breathing treatments, anti-emetics, and pain medication. They must present the patient to an attending physician within a reasonable time frame, and prior to ordering advanced testing or treatment modalities such as CT scans, consultations, ultrasounds, or invasive studies. All unstable patients or patients with a deterioration in their condition must be brought to the attention of the attending physician immediately.

    c. PGY3 residents may undertake the initial evaluation, history, and physical examination of all stable adult patients in the ED. They may initiate diagnostic and treatment plans as necessary for the patient. They must present the patient to an attending physician within a reasonable time frame, and prior to the arranging for ultimate disposition of the patient (admission, consultation, or discharge). All unstable patients or patients with a deterioration in their condition must be brought to the attention of the attending physician immediately.

7. The resuscitation of unstable patients should occur under the direct supervision of an attending physician at all times. The degree to which the attending physician directly leads the resuscitation will vary based on the degree of education, ability, and experience of the resident involved.

8. Residents may perform procedures within the ED under the direct supervision of attending physicians. Residents may only perform procedures for which their attending physician has privileges. Residents may perform some procedures without the direct supervision of the attending physician. The attending physician is responsible for judging the resident's competence to perform such procedures without direct supervision. Such procedures are

typically those that are minimally invasive with a low risk of complications.

9. All patients under the care of a resident must be presented to an attending for supervision prior to the end of the resident's shift regardless of where they are in their ED course.

TELEPHONE NUMBERS

Residency Coordinator	558-4085	RUHS operator	486-4000
LLUMC operator	558-4000	RUHS ED	486-5650
LLUMC ED	558-4444	RUHS EM office	486-5644
LLUMC EM admin office	558-4344	RUHS EM office fax	486-5655
LLUMC EM office fax	558-0121	VA operator	825-7084
LLUMC Housestaff Office	558-6131	Life Support Education	824-4977

Long-distance calls from office telephones may only be made for official departmental business and with the prior approval of the Residency Coordinator or one of the faculty. Long distance personal phone calls from residency library phones are not permitted except in the case of a family emergency.

VACATION

Vacation will be scheduled and taken at times mutually convenient to the resident and the residency. EM1 residents are allowed 15 "days" (3 weeks) of vacation yearly, and EM2 and EM3 residents are allowed 20 days (4 weeks). Vacation is not allowed during the first month of the EM1 year or the last week of the EM3 year. **Vacation days may not be carried over to subsequent years.** Vacation may not be taken on the day of the ABEM inservice exam, during CQI meeting dates if the resident is scheduled as CQI senior, or during the required advanced training and assessment dates (available from the chief residents and program directors). Each resident is responsible for ensuring that he or she arranges their vacation days appropriately. **Vacation during Emergency Department rotations is not considered granted until confirmed by the appropriatete scheduler and the Program Coordinator and the resident ED shift schedule is published. The Residency Program and LLU are not responsible if a resident fails to arrange his or her vacation properly, and it is then forfeited.**

Vacation while on Outside Rotations
Taking vacation while on outside rotations is completely at the discretion of the attending physician coordinating the outside rotation. They may grant vacation time, but often they will not. Some rotations require submission of requests quite early. For example, general surgery requires at least 2 months in advance without exceptions. Do not make non-refundable plans until you have signed approval from the off-service director.

Vacation while on ED Rotations
For ED rotation vacation scheduling purposes, 1 vacation day equals 1 ten-hour shift, and one week equals 5 vacation days. **No PGY1 resident may take more than 1 week vacation in a given month, and in general no two EM2 or EM3's may take vacation during the same week at the same hospital.**

For EM2's and EM3's, their 4 weeks of vacation are awarded to a particular month at the beginning of each year. This is based on requests submitted by each resident. The exact time within each month that one takes the vacation will be decided later by the chief resident/RSA, so get your requests in early. In situations where more than one resident desires vacation during the same period, priority will be given to residents with higher level of standing and timeliness of request submission. Residents are welcome to "trade" vacation with each other **with chief resident/RSA preapproval**, as long as the same numbers of residents are taking vacation at each hospital. The resident trading the vacation must inform the residency coordinator of any changes in order to update the block rotation schedule.

The following table is used to determine how many days off the schedule can be guaranteed for a given number of vacation days.

# Vacation days	Maximum # days off the schedule	# Shifts less scheduled that month
5	7	5
4	6	4
3	4	3
2	3	2
1	1	1

Whether individual days are weekends or not is irrelevant to the above system.

Residents are excused from all residency activities, including conferences, during the approved range of vacation. **Vacation requests should not be submitted for any days in which formal testing is scheduled as they will not be granted for those days.**

Do not make non-refundable vacation plans until you have a signed approval from the residency leadership. Vacations are not considered granted until you receive this signed approval. Verbal acknowledgement of a vacation is not official. It is the responsibility of the resident making the vacation request to follow up on the status of a request.

WORK DUTY HOURS

The residency strictly adheres to the ACGME work duty hours regulations as copied below. Please report to the program director any violations of these work duty hours.

When emergency medicine residents are on emergency medicine rotations, the following standards apply:

- While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours.
- There must be at least one equivalent period of continuous time off between scheduled work period.
- A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week.
- Emergency medicine residents must have a minimum of one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period.

Maximum Hours of Clinical and Educational Work per Week

- Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Clinical Work and Education

- The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
- Residents should have eight hours off between scheduled clinical work and education periods.
- There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.
- Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
- Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on

these free days.

Maximum Clinical Work and Education Period Length

- Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
- Up to four hours of additional time may be used for
- activities related to patient safety, such as providing
- effective transitions of care, and/or resident education.
- Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions

In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

- to continue to provide care to a single severely ill or unstable patient;
- humanistic attention to the needs of a patient or family; or,
- to attend unique educational events.
- These additional hours of care or education will be counted toward the 80-hour weekly limit.

A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

The Review Committee for Emergency Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.

YEARLY REQUIREMENTS FOR HOUSE STAFF

In March, April or May of each year, residents who will be continuing in the program (i.e., who are not graduating) must complete the annual house staff requirements. These generally involve (but are not limited to) compliance training, reviewing JCAHO requirements, HIPAA requirements, and completing annual TB screening. **Residents who do not complete these requirements will not be allowed to continue until they are complete. It is the resident's responsibility to assure that these requirements are met.** Any resident pulled off of an ED shift due to a failure to complete these requirements will be required to pay back the on call resident's shift and one additional shift.