

**CCFP-EM GUIDELINES**  
**(updated June 2019)**

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**DEPARTMENT OF EMERGENCY MEDICINE  
GUIDELINES FOR POSTGRADUATE TRAINEES  
(CCFP-EM)**

**You should have a professional attitude and presence. This includes appropriate dress (no blue jeans, no bare feet) and males should be clean-shaven. Your hospital I.D. badge must be worn and be clearly visible. You should introduce yourself as "Dr. Jones" working with "Dr. Smith" the attending Emergency Physician**

## **INTRODUCTION**

Welcome to the Department of Emergency Medicine. We hope your rotation will be enjoyable and provide you with an opportunity to develop and improve your skills in the practice of this discipline. These guidelines will explain the organization of the Department, outline your role and responsibilities including how you will be supervised, how to approach patients in the Emergency Department and how to avoid problems and describe proper record keeping. Also included is a description of the Department's educational activities and the evaluation process.

## **ORGANIZATION OF ROTATION**

Rotations in Emergency Medicine occurs in the Kingston Health Sciences Centre (KHSC). The KHSC has two sites: the Hotel Dieu Urgent Care Centre (HDH UCC) and the Kingston General Hospital Emergency Department (KGH ED). The HDH UCC is open from 08:00 to 20:00, 7 days a week, and sees ambulatory adult and pediatric patients. The KGH ED is a full service 24-hour Emergency Department that receives all ambulance patients and provides a Regional Trauma Service. To provide you with exposure to the total range of Emergency Medicine patients, you will generally be scheduled to work at both departments during your rotation.

Your schedule is arranged before your rotation and any time off or holiday requests need to have been made well in advance and in accordance with the policies of the Department. Typically, this requires scheduling requests to be made to the chief resident or program coordinator in accordance with guidelines outlined under "Shift Scheduling". There is no formal orientation session at the beginning of your rotation. It is therefore essential that you read these guidelines, so you may more quickly understand how we operate and what your role will be. On your first shift, you will be shown the layout of the department, how patient care and the paper work flow from registration to admission or discharge and how investigations are ordered. There are important differences in these processes between the two hospitals.

It is also important to learn what research projects are ongoing in the Department so you can be alert to recruit patients and understand what your involvement might be. The research nurses can be paged if you have questions about potential research subjects – ask the ward clerk in the ER.

## **SUPERVISION**

Please refer to the College of Physicians and Surgeons of Ontario (CPSO) 2011 guidelines regarding the supervision of postgraduate trainees.

(<https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Responsibilities-in-Postgraduate-Medi>)

### **Senior Residents (PGY 3, 4, 5)**

In the interest of development of independent decision-making skills and in keeping with the concept of graded responsibility inherent in any training program, senior residents may exercise discretion in determining the need to discuss with the Emergency Physician the management of patients with minor problems prior to discharge. However, all charts will be reviewed by the attending physician.

The Emergency Physician must be informed of any seriously ill patient, patients with uncertain diagnosis or when management is unclear. Consultations and clinic referrals should be discussed with staff. The Emergency Physician must be informed whenever a patient or substitute-decision maker express concerns over the care being provided.

When a senior resident is supervising an intern/junior resident, the Senior Resident will discuss and normally see the patient with the junior and decide if the Emergency Physician needs to be advised before the patient is discharged. Involvement of the Senior Resident in such cases should be documented by his/her adding an appropriate signed note.

## **CLINICAL EXPERIENCE**

As a CCFP-EM resident at Queen's University, you are expected to function at the level of a senior resident in the Emergency Department. Your role as a senior resident includes the following expectations:

- Increasingly independent assessment, treatment and disposition of all Emergency Department patients.
- All charts must be reviewed by the attending physician in charge.
- Patients with simple, uncomplicated problems can be discharged without immediate discussion with the staff physician although all cases will eventually be reviewed.
- Patients with complex, complicated or serious medical problems need to be discussed with the attending physician during the patient's stay in the ED and prior to discharge.

- The senior resident on duty will run all resuscitation cases (including trauma cases) with the supervision of the staff physician or the trauma team leader.
- All referrals to consultants must be discussed with the staff physician.
- The senior resident at KGH is expected to handle EMS paramedic calls into the Emergency Department. In order to appropriately undertake this responsibility, you must be familiar with paramedic protocols and the treatment modalities that they have available. There is a binder in the KGH Emerg that contains all of the paramedic protocols and all standing orders are listed on our website for your reference. You will be provided with information sessions about taking EMS “patch calls” with Dr. Andy Reed during your initial orientation.
- The senior CCFP-EM resident will generally do 14-18 shifts per month in accordance with feedback from previous CCFP-EM residents and the input of the CCFP-EM Program Director, Dr. Joey Newbigging.
- Senior Emergency residents are expected to prepare Emergency Medicine Grand Rounds and teach Junior Resuscitation Rounds during assigned weeks. Most residents will be assigned 1-2 rounds during their four blocks of Emergency Medicine in Kingston.
- The senior resident can provide supervision to Junior Housestaff and medical students and is asked to co-sign and make a summary note on the chart of patients seen with these trainees.
- Participation at all weekly Core Emergency Medicine Rounds, weekly Senior Resuscitation Rounds, monthly Trauma Rounds and monthly Journal Clubs during your Kingston Emergency Medicine rotations is expected and encouraged. You are also welcome and encouraged to attend rounds when off-service and available.
- CCFP-EM residents are an integral part of our Emergency Medicine Group at Queen's and are encouraged to discuss any rotation concerns with any of our staff physicians.
- Daily Feedback Forms must be completed at the end of every shift with your Attending Emergency Physician. It is the resident's responsibility to initiate the end-of-shift feedback discussion. Feedback written by residents on the Daily Feedback Forms about their attending physician will be collated with other residents' feedback and provided to the physician anonymously with the resident's identity protected. Residents should also ensure that at least two Multisource Feedback Forms are completed per block. Again, this feedback process must be initiated by the resident. Summative evaluations of the rotation will be completed by the CCFP-EM Assistant Program Director at the end of each block.

## PREHOSPITAL RESPONSIBILITIES FOR SENIOR RESIDENTS

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

It is mandatory that you familiarize yourselves with the standing orders, protocols, and medications used by paramedics. A copy of these standing orders will be issued to you. In addition, copies are

available at the clerk's desk in Section A of KGH. Finally, a short quiz is to be completed prior to you starting in the EM.

The paramedics are relying on you to know their capabilities and limitations. Please take the time to prepare for their calls. As part of your CCFP-EM year, you will be assigned one EMS "ride-out" observation shift that will be scheduled during one of your KGH-EM blocks.

## **APPROACH TO PATIENTS IN THE EMERGENCY DEPARTMENT**

### **Introduction**

Patients present to the Emergency Department with a wide range of problems, varying in severity from trivial to life threatening and unfortunately, the latter can sometimes present in the guise of the former. The Emergency Department is usually very busy with a high volume of patients with complex problems taxing the resources of the department. This reality requires a somewhat non-traditional approach to patients.

- Assessments are often two phased – a quick "primary" survey, checking the ABC's and determining the need for resuscitation or urgent intervention, followed by a more complete "secondary" survey.
- Consider the possibility of a serious cause for the patient's problem.
- Treatment and diagnosis often occur simultaneously. One often cannot wait for a test result before acting.
- A specific diagnosis may not be possible and not all patient problems can be solved in the time frame of the emergency visit.
- Time is often employed as a diagnostic tool.
- Successful management of the patient's problem often ultimately depends on clear discharge advice and instructions to the patient or family and arranging timely and appropriate follow up care.

### **Specific Patient Problems**

Formal management guidelines and protocols are beyond the scope of this document and are generally not established for most patient problems seen in our Emergency Department. There are, however, some treatment protocols included in the Hospitals' Policy Manuals, which are kept for reference in each department. Some general information may be helpful:

#### ***Chest Pain***

Patients with chest pain receive priority to identify candidates for STEMI protocol PCI.

#### ***Pediatric Patients***

Children require careful and timely assessments and the possibility of child abuse/neglect must always be considered.

### ***Obstetrical Patients***

The possibility of pregnancy must be considered in any woman of childbearing age. Pregnant patients are high-risk patients. Patient's  $\geq$  20 weeks pregnant are referred directly to the Obstetrical Unit (Connell 5-KGH).

### ***Poisonings***

Each department has the Poisondex on the Departmental Computer located in the Emergency Department. More information can be obtained from the Ontario Poison Information Center at the Hospital for Sick Children in Toronto. We have one toxicologist on staff.

### ***Trauma***

The Trauma Team manages serious trauma at KGH. You will take part in the Trauma Team Resident Captain (TTC) call rotation. It is imperative that you have ATLS prior to starting your TTC call.

### ***Dental Problems***

The community dentists and the local dental surgeons provide back up to the Emergency Department.

### ***Substance Abuse***

Once medically stable, patients requiring drug and/or alcohol detoxification can be referred to the Detox Centre on Brock Street (administered by HDH). Prescriptions for medications to be dispensed at the Detox Centre can be faxed to Princess Street and Division Street Shopper's Drug Mart Pharmacy and they will deliver medications directly to the Detox Centre. The Detox Centre will provide taxi transit for patients to their facility from the hospital.

### ***Wound Care***

Wounds need careful assessment. Tetanus prophylaxis is administered as needed.

### ***Workers Compensation***

The Emergency Physician will complete the WSIB forms that are attached to the chart of the injured worker. It is imperative that clear discharge instructions with work limitations discussed with the patient are well documented on the chart. Completing the WSIB form can only be done if a clear history of the injury, a description of findings of the exam, an outline of treatment and advice about work are recorded on the chart. Consider return-to-work with accommodations/limitations advice as opposed to just advising time-off-work.

### ***Diagnostic Investigations***

Deciding which diagnostic investigations are appropriate is an important skill in Emergency Medicine. Unnecessary or inappropriate tests will increase costs and can prolong a patient's stay in the Emergency Department. Consider the following advice when ordering investigations:

- Only order tests that are relevant to the patient's presenting problem and that are likely to help in the Emergency Department resolution of the problem.
- If unsure of investigations decisions, discuss it with your attending Emergency Physician. Consider evidence-based decision rules such as the Ottawa-Ankle-Rules, Well's Criteria etc.
- Ensure that the results of significant test (whether positive or negative) are documented on the chart.
- X-rays should be reviewed with your attending Emergency Physician. The interpretation must be documented on the PACS system in the form of a "sticky note". Ask your attending staff for instruction on this task if you are not familiar with it.
- The physician who orders a test is **legally responsible** for following up the result. This can be a challenge in Emergency Medicine as test results may not be available at the time of discharge or end of the physician's shift. As well, not infrequently the initial interpretation can change (e.g. X-Ray discrepancy). Reliable follow-up arrangements must be made in these situations. Ensure that the patient's telephone number on the EDIS is correct. If a patient is just temporarily in Kingston, document on the chart how they can be reached.

### **Consultations**

Consultation requests need to be discussed with the Emergency Physician before the service is contacted. This is to ensure that the consult is both appropriate and that the correct service is consulted. If the appropriate service for consultation is unclear, a "KGH Admission Algorithm" is available on the ED computer desktops and at the Unit Clerk's Desk at HDH and Section A KGH.

If a consult is needed on a patient seen at HDH, it frequently means the patient has to be transferred to KGH.

### **Clinic Referrals**

Referral to an outpatient clinic also needs to be discussed with the attending Emergency Physician to ensure it is appropriate and to determine the timing of the appointment. Generally, **urgent appointments (i.e. < 2 weeks) can only be arranged when there is direct physician contact with the service involved**. The exception is routine fracture clinic follow-up (which occurs in 1-2 weeks). When completing the referral form you must clearly indicate the desired clinic and timing of appointment. If an urgent appointment has been requested, you should document the name of physician on the consulting service with whom you discussed the referral.

The Children's Outpatient Clinic (COPC) at HDH will see pediatric patients without an appointment, Monday to Friday (08:00-16:00), excluding statutory holidays.

The Emergency Eye Clinic at HDH has daily emergency clinics 7 days a week. Similarly there are Rapid Response Cardiac, Mental Health Social Work, Child and Adolescent Psychiatry and Renal Stone Clinics where direct appointments can be arranged for patients (deemed safe to go home) but need close follow-up. There is a binder in which you can assign patients to a clinic time in each ED.

**Note:** It is important for your learning to follow up on your patients. This can be difficult. However, you are encouraged to discuss your patient with the consultant and check on your admitted patients. The Emergency Physician often receives a letter from the clinic about your patient and usually will share this with you. Often the easiest way to do this is to make sure that you keep one of the patient's chart stickers or take note of the CR number to follow the case. Most information can be found in the PCS at a later date. Dana will forward you with a bounceback list of cases every quarter.

### **Discharge and Follow-up**

Most patients are discharged from the Emergency Department. Since few patient problems are completely resolved during the emergency visit, there is usually a need for a clear discussion with the patient or family regarding:

- diagnosis;
- treatment plan;
- any diagnostic uncertainty (including how test results will be followed up);
- what to expect;
- what should require a return visit to the Emergency Department;
- when the patient should see their own Family Physician; (**If the patient is to see the Family Doctor in a few days give the patient a copy of the Emergency Department chart to take with them since the ED charts typically take a week to arrive at the FP's office. A telephone call to the GP is often a good idea.**) As well, it is easy to print lab/imaging results and a visit summary from the EDIS for the patient to take with them for followup appointments.
- the arrangements for clinic visits or further diagnostic testing. (Since these arrangements can fall apart, always tell the patient what to do in such an eventuality);
- any need for Homecare and how it will be arranged;
- any restrictions, short term or long term, to the patient's ability to drive safely should be discussed.

To facilitate this process some "Advice Sheets" are provided at K.G.H. for head injuries, wounds, casts, renal colic, vaginal bleeding, use of inhalers, sprains, and children with fever.

Homecare (CCAC) referral is becoming increasingly a critical component of the care of patients discharged from the Emergency Department. Referrals are made using forms kept in each Department. It is often advisable to speak directly to the on call or intake CCAC person to facilitate arrangements.

**Note:** If a patient you are caring for is not discharged at the end of your shift, you must hand over his/her care to the attending Emergency Physician – NOT the resident replacing you. Discuss your anticipated care plan with your attending Emergency Physician before handing over patients to the incoming emergency physician.

## EMERGENCY DEPARTMENT RECORD/DOCUMENTATION

Good record keeping is an essential part of good emergency care. A complete record must contain:

- accurate and complete patient demographic information;
- a relevant history;
- a record of the physical exam;
- a record of the results of investigations;
- a record of treatment given and response to treatment;
- a record of any reassessment and status of the patient on discharge;
- a clearly written diagnosis;
- a clearly written treatment plan, including follow up arrangements that is consistent with the diagnosis.
- the nursing note is part of the medical record and must be reviewed;
- use only accepted abbreviations.

Remember the medical legal adage "If it was not charted, it was not done."

## ADVICE – HOW TO SURVIVE, BE HAPPY AND STAY OUT OF TROUBLE IN THE EMERGENCY DEPARTMENT

### **Learn to work as part of the team.**

Not only do you need to interact with other physicians, nurses and support staff in the Emergency Department, you need to deal effectively with the large number of professionals that can be involved with patients seen in the Emergency Department: police, EMS providers, lab techs, RTs, consultants, fellow residents, social workers, homecare providers etc.

### **Be effective in your interactions with your patients and their families.**

Visits to the Emergency Department are usually very stressful, confusing, and fraught with delays and often accompanied by pain. You should be courteous, empathetic and considerate of your patient's needs. You should inform patients as to what is happening, the reason for delays, whom they are going to be seen by and why. You need to attend to the patient's safety (i.e. put up side rails etc).

### **Be complete and accurate in your record keeping.**

Avoid using any pejorative or demeaning terms in your notes or conversation.

### **Know your limitations.**

### **Consider the issues of consent:**

- Patients with immediate life threatening problems can be treated without consent.
- Most consent in the Emergency Department is implied or presumed.

- For any procedure or treatment with risk, it is good practice to explain the issues to the patient and obtain his/her expressed and informed consent. For the consent to be valid, the patient must have Decision Making Capacity (i.e. able to understand the information relevant to making a decision regarding treatment). A child under 16 can be capable and there are many reasons an adult may be incapable.
- For some procedures, hospital policy requires completion of a consent form to document this discussion. When a form is not mandated, a note on the chart is advisable. (Note: recent legislation requires that a discussion regarding risks and benefits occur before giving immunizing products to patients.)
- Do not release information about patients without authorization. Notes to employers need only contain the date a patient was seen and any modification to ability to work. Police officers can be given general information about patients involved in incidents that they are investigating. Information that is more specific requires a warrant.

**Beware of the following high risk situations:**

- Patients presenting with chest pain, abdominal pain, headaches, pregnancy.
- Febrile children under 18 months of age.
- Wounds that may conceal tendon or nerve injuries or foreign bodies.
- Patients who make unscheduled return visits for the same problem.
- Angry or intoxicated patients.
- Patients who leave against medical advice.

All such patients should be carefully reviewed with the Emergency Physician.

**Do not give advice over the telephone.**

To do so may establish a doctor-patient relationship with all the accompanying responsibilities and liabilities.

## **EVALUATION PROCESS**

1. The resident will be evaluated on a daily basis near the end of the shift. An assessment needs to be triggered on Elentra by the resident and completed by the attending physician. When at all possible, it is preferential to have the attending physician complete the form in person with the resident, as opposed to sending the form by email. Our experience is that emailed assessments do not get completed, and residents lose out on face-to-face feedback and mentoring.

2. The Program Director will use these daily forms in consultation with department attendings to complete your evaluations at the end of your rotations. Rotations of more than one block may allow for an interim evaluation and remediation, if necessary.
3. Resident evaluations are done on Elentra and sent electronically to the resident to review.
4. The Assistant CCFP-EM Program Director will compile all KHSC EM evaluations. If you have concerns about your evaluation, an interview with the Assistant CCFP-EM Program Director or another Emergency Physicians can be arranged. Your evaluations will be discussed with you by the Program Director at your quarterly review sessions and sooner if needed.

## SHIFT SCHEDULING

The EM Chief Residents are responsible for making the block schedules for junior and senior housestaff in both Emergency Departments. We do our best to ensure that the upcoming block's schedule is posted on the website 14-days prior to the commencement of each block; however, occasionally some last-minute revisions need to be made. You will be notified by email if a revised schedule is posted. Making the schedule is a difficult and time-consuming process.

As numbers of housestaff vary each block, the number of shifts you work in a block may vary to ensure adequate resident coverage. Typically, you will be scheduled to work between 14 and 18 shifts in a block. You should expect to work two weekends each month.

The shifts assigned to senior residents are:

HDH	KGH
Dh Days 08:00-16:00 Eh Evenings 15:00- Close *Ah 14:00- 22:00 (used only when the number of shifts to be covered is greater than the number of people available)	A1 07:00- 15:00 (Section A and B) D3 17:00-01:00 (Section D) Nk 23:00- 07:00 (Section A and B)  Occasionally in times of high senior resident volume, an BF (15:00-23:00) shift will be assigned (Section B and F)

We do our best to ensure you have a balanced schedule that provides exposure to acute and less-urgent illnesses/injuries at both sites. This may mean that you have several consecutive days of work, or your shifts may be spaced more widely apart. If you have questions/concerns about the schedule, contact the appropriate Chief Resident (indicated on each block's schedule).

If you wish to trade shifts with another senior resident, you may do so, however, It is the responsibility of the residents making the shift changes to notify both Emergency Departments

(Section A and D at KGH, and Unit Clerk desk at HDH) and note the changes on the master schedule located on the bulletin board on Victory 3. Do not send your shift changes to the scheduler.

### **Notification of Illness**

In the event that you suddenly become ill and are unable to work, please notify the Chief Resident as soon as possible or arrange for someone else to cover your shift. If you are unable to do either please notify the staff physician on duty at that time. Not showing up for a shift without efforts to contact the Chief Resident or Attending Emergency Physician is considered extremely unprofessional and will result in a review and meeting with the Program Director.

### **Requests for Vacation/ Education Leave**

All requests for leave must be submitted on a [Time Off Request Form](#) to Dana Doll, PGY3 Program Coordinator (PGY3Programs@dfm.queensu.ca) and the EM Chief resident (queenserchief@gmail.com) **at least 30 days prior to the block** in which leave is requested. When submitting the form via email, please include in the subject line the name of the chief resident and BLOCK number. Emailed or verbal requests will not be considered. Type of leave requested (vacation vs. educational) must be indicated. Generally, only one week of vacation should be taken during a one-block rotation. If your requested dates fall between two blocks, please complete and submit two separate request forms.

We do our best to accommodate all requests that we receive by the specified deadline. In cases where requests conflict, priority for time off will be given to residents taking educational leave, followed by vacation requests.

### **Vacation and Professional Leave Policies**

(As per the 2016-2020 PARO-CAHO Agreement)

#### **Vacation**

##### **11.1**

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

##### **11.2**

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

##### **11.3**

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

##### **11.4**

Requests for vacation shall be submitted in writing to the department head at least four (4) weeks before the proposed commencement of the vacation. In, addition each resident taking a certification examination in the spring shall have until one month prior to the date of the examination to make a

written request for one week of his/her vacation entitlement. Vacation requests submitted before March 1, or one month prior to the date of a certification examination, will be considered in priority to those submitted after that time. All vacation requests must be confirmed or alternate times agreed to, in accordance with Article 11.2, within two (2) weeks of the request being made. Where the hospital department rejects the vacation request, it will do so in writing and include the reasons for rejecting the original vacation proposal.

**11.5**

There will be no adjustment to vacation entitlement for up to seventeen (17) weeks in the case of pregnancy leave of absence and/or up to thirty-seven (37) weeks in the case of parental leave of absence. Where a resident is entitled to and takes pregnancy leave and is also entitled to and takes parental leave, there will be no adjustment to vacation entitlement for up to an additional thirty-five (35) weeks. If an employee is on pregnancy or parental leave, any accrued vacation shall be taken immediately after the leave expires, or at such later date if agreed to between the resident and the hospital.

**11.6**

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

**Professional Leave**

**12.1**

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

**12.2**

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

**12.3**

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

**Statutory Holidays**

**13.1**

All housestaff shall be entitled to the following recognized holidays:

1. New Year's Day
2. Family Day
3. Easter Friday
4. Victoria Day
5. Canada Day
6. August Civic Holiday
7. Labour Day
8. Thanksgiving Day
9. Christmas Day
10. Boxing Day
11. One (1) floating holiday

### **13.2**

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

### **13.3**

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

## **ACADEMIC TEACHING SESSIONS**

All teaching activities are posted weekly on the Department website at:

<http://emergencymed.queensu.ca>. Please check the site regularly for any changes or cancellations to the teaching schedule.

### **EM Grand Rounds**

**Mandatory for residents on the Kingston, Napanee, Belleville, Brockville EM rotations as well as the Kingston POCUS block.**

Grand Rounds are held weekly Thursday mornings from 8:30-10:00 (Richardson L104) from September 1 – June 30.

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

### **Core Rounds**

**Mandatory for residents on the Kingston, Napanee, Belleville, Brockville EM rotations as well as the Kingston POCUS block.**

Core Rounds are held weekly Thursday mornings from 10:00-12:00 (Sept 1 – June 30)

Core rounds take place following Grand Rounds on Thursdays and are organized and facilitated by a Staff Emergency Physician. Advanced preparation is often required on the part of the resident to enhance the session. The topics are presented in a 2-year cycle. The topic breakdown comes from the FRCP Core Content Listings. Topics have been narrowed down to specific relevant aspects in each area to allow a more focused approach. Not everything relevant to emergency medicine and preparation for certification examinations can be covered in these rounds...you will need to read and use other resources to help fill in the gaps.

#### **Summer “Boot Camp” (July 1- Aug 31)**

During the summer months, these rounds are held from 9:00-15:00 (unless otherwise stated) at the New Medical Building, 2<sup>nd</sup> Floor (15 Arch Street). **Attendance is mandatory for ALL CCFP-EM Residents.**

List of summer series sessions are:

Core POCUS Applications	Airway Management	Chest Tubes	Disaster Med
Procedural Sedation	Nerve Blocks	Lumbar Puncture	Wound Repair
Central Lines	Ortho/Casting	Ethics	EMS
Wellness	Humanities	Peds/PALs	

#### **Journal Club**

**Mandatory for residents on Kingston Emergency Medicine blocks (and whenever possible on off-service rotations).**

Journal Club is held the 3<sup>rd</sup> Wednesday of each block at an Attending Physician's home (Sept-June) Journal Club is intended to provide the residents with a chance to develop Critical Appraisal Skills and a chance to review the current literature in Emergency Medicine

The format of Journal Club has three components:

1. An FRCP and CCFP-EM resident are assigned to a Journal Club. Together they select a research article for critical appraisal and discussion. These residents present the article at Journal Club and lead the discussion with participants in analyzing the paper.  
\*Please refer to your handbook for details.
2. The hosting Staff Physician will present and lead discussion about an article of their choosing. This should take only 10 min including following discussion. The goal of this second part is to keep participants updated with recent EM literature.
3. Dinner! The hosting Staff Emergency Physician provides dinner for participants. Journal Club is a nice opportunity to socialize with fellow residents and attending staff.

### **Senior Resuscitation Rounds**

**Mandatory for residents on the Kingston, Napanee, Belleville, Brockville EM rotations as well as the Kingston POCUS block (and whenever possible on off- service rotations).**

Thursdays 13:00-15:00 in the New Medical School Building Simulation Lab.

These rounds are for FRCP R3-R5 and CCFP-EM residents. FRCP R1-R2 residents may attend, but will not lead scenarios.

### **Junior Resuscitation Rounds**

Friday mornings 08:00 – 10:00 in the New Medical School Building Simulation Lab.

All Senior Residents will be assigned 1-2 Junior Resuscitation Rounds during the year where they will facilitate ACLS-like resuscitation scenarios with R1-R2 residents, clinical clerks and nurses. If you have never participated in Junior Resuscitation Rounds as a junior resident/clerk, it is advised that you should observe them at least once before taking on the role of instructor.

### **Trauma Rounds**

Trauma rounds take place from 0730-0830 on the last Tuesday of September, October, November, January, February, March, April, and May.

### **Trauma Case Review Rounds**

These rounds take place monthly (usually the first Thurdsay of the month, but variable), and are a detailed look at a trauma case that presented to the KHSC Trauma Team. Residents will be notified about the exact time and location of these rounds by email.

### **Toxicology Rounds**

These are monthly rounds, available via teleconference from the Ontario Poison Centre, that take place on the last Monday of each month at 1PM. Residents will receive notification and teleconference links by email.