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Our-“mission” is to train outstanding Obstetricians and Gynecologists who:

- become leaders in our field, possess an excellent fund of knowledge with sound surgical skills.

- are prepared to pursue any avenue and practice they desire.

- are prepared to practice independently, act as an expert consultant in the medical community, subspecialty training or academic medicine.

- act as a teacher and role model for physicians of the future and be committed to excellent education and compassion.
Preface

The University of Nevada Las Vegas, School of Medicine Department of Obstetrics & Gynecology Resident Handbook is provided to establish a ready source of information that will allow each new resident to integrate quickly into the program. This handbook should remain a reference to you, throughout your residency.

Improving Our Image with Our Patients

What Ambrose Pare’ (surgeon) said in the 15th Century is true today:

Querir Parpoid Cure Sometimes
Soulaglo Souvent Relieve if Possible
Consoler Tousfois Console Always

You are the image the patient remembers!

Joseph A. Rojas, Sr., M.D.

Believe nothing!
No matter where you read it
or who has said it;
Not even if I have said it;
Unless it agrees with your own reason and common sense!

Jon M. Hazen, M.D., 2003
SECTION I

Residency Overview
Content of Curriculum

The UNSOM OB/GYN Residency Program provides the opportunity for each resident physician to achieve the knowledge, skills, and attitudes essential to the practice of obstetrics, gynecology and the healthcare for women. Competencies are obtained through participation in graduated levels of patient care with appropriate supervision and formal instruction provided within the didactic experience.

Upon completion of the four year residency, each physician will have competencies in the following areas:

- **Patient Care** that is compassionate, accurate, respectful, and effective for the treatment of medical problems and the promotion of health.

- **Medical Knowledge** about established and evolving biomedical, clinical, and cognitive sciences and the application of this knowledge to patient care.

- **Practice-Based Learning and Improvement** that involves investigation and evaluation of patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

- **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.

- **Professionalism**, manifested through a commitment to carrying out responsibilities, adhering to ethical principles, and sensitivity to a diverse patient population in an appropriate manner.

- **Systems-Based Practice**, by actions that demonstrate an awareness of the larger system of health care and the ability to effectively call on resources to provide care that has optimal value.
Four Years in Brief

PGY 4 - The Chief Residents. Each chief resident is responsible for every patient that is evaluated and admitted to their OB, GYN and ONC service. The Chief Resident will be responsible for their own service in addition to delegating tasks to junior residents and medical students. They are also responsible for resident and medical student education. The Administrative Chief Resident (ACR) has additional responsibilities including call schedules, managing the Outpatient Residents Clinic Schedules and coordinating medical student rotations and orientations. In addition, the ACR serves as liaison between the administration or faculty and the residents.

PGY 3 - The senior year resident also acts as the chief resident on rotations such as L&D, oncology, and Urogynecology. On their specialty rotations, they will manage endocrine and perinatal patients while rotating with subspecialty faculty. The bulk of daily inpatient care rests on the senior most residents. The Attending Physician must be informed of all patient care decisions or changes.

PGY 2 - Obstetric and gynecologic rotations in the second year emphasize medical and surgical complications. Four months will be on the GYN service under the guidance of the GYN Chief Resident. Time for Research is provided to establish a project and begin the collection of data.

PGY 1 - The Intern spends most of the first year on L&D. There are rotations through MFM/OB Ultrasound, NICU, ICU and one month in the Family Planning and Outpatient Clinic to familiarize them with the Family Planning service and start building their own patient clientele.

Administrative Chief Resident (ACR)

Each PGY 4 resident will be Administrative Chief Resident (ACR) for an equal share of the year. Chief Residents will have four consecutive months as ACR. ACR residents will simultaneously act as Chief of their service on OB, GYN, and the Outpatient Clinic. ACR responsibilities will begin on May 1st of the third year of residency.

The ACR is responsible for all schedules, vacations, time away, changes, and conduct of the residents. All resident complaints and problems will be directed to the ACR. Any issues that cannot be resolved by the ACR should be referred to the Residency Director.

Duration of Appointment and Conditions for Reappointment

The duration of this residency program in obstetrics and gynecology is a required total of 48 months. During this period, a resident is permitted vacation, sick leave and educational leave as described in this Handbook. If a resident cannot honor their time commitment, they must notify the Program Director in a timely fashion or risk an unsatisfactory evaluation.

Reappointment is considered annually, based upon the recommendation of the Clinical Competency Committee (CCC) following the annual meeting of that committee. All requirements of the program must be met and an overall satisfactory evaluation must be received prior to recommendation for reappointment. Refer to the Graduate Medical Education Handbook, Resident Appointment/Reappointment for more reappointment requirements http://medicine.nevada.edu/gme/current-residents/resident-handbook
Disciplinary action for deficiencies may be carried out and monitored by appointed residents, faculty, Program Director, or the Chair of the Department. Disciplinary action may consist of reprimand, counseling, non-promotion, prescriptive assignments, remediation, withholding of privileges, repeat rotations, extension of the program duration, probation, dismissal, or non-renewal of the annual contract.

**Resident Responsibilities**

1. All residents are expected to:

   a. Develop a program of learning and foster continued professional growth with appropriate guidance from their faculty mentor.

   b. Fully participate in the educational activities of the program and assume responsibility for supervising and teaching other residents and medical students.

   c. Attend and participate in scheduled High Risk OB rounds, Gyn rounds, Resident/Faculty meetings, lectures, Interdisciplinary Grand Rounds and Journal Club meetings. It is understood that scheduled conferences (i.e. didactics) are considered **protected time** to foster resident education. Exceptions can be made if the resident is on a rotation where leaving could jeopardize the welfare of patients. Residents will be required to sign in to document greater than 80% attendance at scheduled lectures. Inadequate attendance may result in an unsatisfactory annual evaluation, and be considered grounds for non-promotion or dismissal from the program.

   d. Participate in “work” rounds. Residents are expected to provide complete, succinct case presentation for discussion and patient care direction. In addition, a resident may be asked to discuss a particular case because of its extraordinary educational value. Residents are expected to participate in the weekly didactic educational program assigned by the Residency Director. Residents are expected to be present the entire session without cell phone or beeper interruption.

   e. Provide safe, effective, and compassionate patient care commensurate with their level of responsibility.

   f. Respect and adhere to the established practices, procedures, and policies of obstetrical and gynecological practice including timely completion of medical records and resident case statistics.

   g. Provide thorough, complete and contemporaneous documentation of all aspects of patient care.

   h. **Notify their Administrative Chief Resident and the Residency Coordinator of any unscheduled leave.** It is the resident's responsibility to be on their service and make appropriate notification.

   i. Fulfill clinic and call obligations.

   j. Regularly evaluate medical students, other residents, faculty and their own educational experiences.

   k. Keep attending faculty immediately informed of any change in patient status, moral, legal or ethical problem.
I. Dress and act in a professional manner. See Dress, Grooming and Behavioral Standards for Residents.

m. Provide adequate and timely follow-up care for hospital and clinic patients.

n. Residents should be aware and adhere to the chain of command:
   Medical Student ➔ Junior Resident ➔ Senior Resident (ACR) ➔ Attending Physician ➔
   Program Director ➔ OB/GYN Department Chair

The Working Environment

The Program will provide residents with a sound academic and clinical education carefully planned and balanced with concerns for patient safety and resident well-being. The program will ensure that the learning objectives are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education has priority for residents’ time and energies. Duty hour assignments recognize that Attending faculty have ultimate responsibility for the safety and welfare of patient

Resident Supervision Policy

A. General Inpatient Supervision

1. All residents are supervised by teaching attending physicians. High risk patients should be managed by upper level residents in consultation with the Attending or the Perinatologist (OB).  

2. Residents are made aware of the responsible attending physician schedules by posted rosters.

3. Supervising GYN physicians must maintain constant availability by phone or be physically present.

4. House staff on Labor and Delivery have 24/7 in-house teaching Attendings to provide immediate counsel and physical support for patient care.

5. GYN attending physicians are separate and independent from the OB in-house attendings.

6. Senior residents with appropriate training and competency can supervise and evaluate junior residents, (the attending physician has ultimate responsibility)

Low Risk OB Patients:

1. Interns should be appropriately supervised, gaining increasing independence as competency is achieved.

2. The senior resident should know every patient on his/her service

3. The in-house Attending should be notified of all patient admissions.
High Risk OB Patients:

1. The most senior resident should discuss all management plans with the perinatologist. The in-house attending should be aware of all admitted patients and care plans.

2. Intern involvement should be primarily educational. If a higher level resident is unavailable, the in-house attending must take the responsibility of both the senior resident and the in-house attending.

3. The admission H&P, daily notes, and orders should be written by a PGY 2 or higher.

4. There should be clear written documentation of what higher level physician was involved (“seen with or discussed with Dr. . . . , etc.”).

B. Documentation

The interaction between resident and teaching physician during the course of patient care is documented in the medical record to confirm concurrent supervision. The Attending physician is designated by any of the following:

a. The attending physician’s name appears on the admission face sheet of the medical record.

b. The resident admitting note should clearly identify the designated attending physician.

c. The attending physician can personally create an independent note in the Medical Record.

d. The hospital requires an attending co-sign all admission H&P’s, dictated procedure reports, and dictated discharge summaries.

Progress Notes

Progress notes must be contemporaneous with patient evaluations, treatments, procedures, conference discussions or attending communication by phone. The resident or attending physician should document these interactions in one of the following ways:

a. The resident progress notes should identify the attending physician consulted.

b. Countersignature of a resident progress note, by the attending physician.

c. The attending physician can personally create an independent progress note in the medical record.

d. The attending physician may countersign dictated resident summaries or operative procedures.

e. Complex or critical cases must have written documentation of direct attending physician involvement.

f. Attending physicians have no restrictions for making chart entries.
In addition to the daily progress notes, there should be documentation of any of the following:
   Change in patient status
   Significant change in management
   Evaluation of a problem

Countersignatures

Countersignature of the discharge summary identifies the attending physician of record. It does not reflect concurrent management or immediate supervision during the hospitalization. Contemporary entries in the record confirm concurrent management. Personal entries by the teaching physician are the preferred method of confirming physical presence of the responsible Attending physician.

All Students are supervised. Supervising residents or attending physicians must personally countersign any order by a student, before the order can be implemented. Verbal agreements by a supervising resident to implement a student written order is not permitted.

All student notes should be countersigned by the supervising resident and/or attending. These student notes do not take the place of appropriate documentation by the resident and/or attending. The resident documentation must still include all pertinent positives, negatives, assessment, and plan.

C. Procedures

The responsible attending physician must be identified in the resident note or dictation that describes the technical procedure. This is true for ambulatory and inpatient operative experiences. The method of acknowledging attending physician supervision must include one of the following:

1. The resident operative note acknowledges the presence of the attending physician.
2. The operative note acknowledges direct “hands-on” involvement of the attending physician.
3. An operative note may be personally dictated, or written, by the attending physician.
4. Countersignature by the teaching physician of the resident dictation.

Graduated levels of responsibility are developed by the program during resident training. Competency levels for each PGY level are established. Delineation of privileges is identified at each PGY level. Supervising attending physicians approve residents to perform procedures consistent with the residents’ knowledge, skill, and judgment.

Dated, timed, personal handwritten entries in the medical record, by the attending physician, is the ideal method to identify concurrent management and physical presence of the attending physician.

D. Discharge or Transfer of Care.

Residents must precisely state any discharge or transfer has involved consultation of the supervising physician. This must be done by one of the following:

1. A resident progress note indicates the attending physician was consulted, and approved of the decision for discharge or transfer. A Chief Resident may provide approval only in emergency circumstances.
2. A written order indicating that the discharge or transfer was approved by the attending physician.
3. A descriptive note by the resident can be approved by the attending physicians' countersignature.

4. An attending physician may dictate, or write a personal note.

5. Discharge or transfer by students is not permitted under any circumstance.

E. Outpatient (Ambulatory) Supervision

1. Responsibility for supervision in the ambulatory setting is the assigned teaching, attending physician.

2. Appropriate Senior Resident supervision is acceptable in the ambulatory environment.

3. All junior residents are supervised by a senior resident or the attending physician.

4. Confirmation of the attending physician’s supervision of the resident can be demonstrated by one of the following:
   a. The attending physician's personal note in the record
   b. Countersignature of the resident’s note by the teaching physician
   c. A resident progress note indicating that the attending physician has been consulted and approves of care plan.

5. Confirmation of the physical presence of an attending physician is indicated by one of the following:
   a. The attending physician’s personal note in the record
   b. A resident progress note indicating the attending physician was present during significant portions of the procedure.
   c. Dated, timed entries in the record by the Attending confirm concurrent management.
   d. Students must always consult with a resident or attending physician before evaluating patients or writing chart entries. Chart entries by medical students are encouraged, but are limited by the EMR.

6. Attending / Teaching Physician
   a. Attending/teaching physicians are present for patient safety and resident teaching.
   b. Ambulatory care sites have attending physicians for supervision and counseling of residents.
   c. The attending physician’s presence in the ambulatory care site is documented. They should initial a sign-in list and co-sign resident entries in the medical record.
   d. The standard for the clinic attending physician is:
      i) Attend assigned clinics, or make personal coverage arrangements.
      ii) The attending should ensure patient satisfaction and safety, maximize the educational experience of the resident, and maintain quality expectation of the program.
      iii) Must be present for (and/or examine) all procedures, annual exams and level IV or V encounters.
Guidelines for Attending Physician Supervision of Resident Patients

A. Labor and Delivery

1. The OB attending physician must be in-house, immediately available to the resident at all times.

2. “In-house” includes UMC, and the 2040 building.

3. The attending physician should participate in rounds around 7:00 a.m. each weekday morning and 5:00 p.m. each evening to become aware of the patients. Weekend rounds will be at 7:00 a.m. and 7:00 p.m. Written documentation of attending participation in transition, including plan of care for all patients will be the senior OB resident’s responsibility.

4. The attending physician must be present for each vaginal delivery and be scrubbed for every operative vaginal delivery. The actual amount of attending participation will depend on their judgment and should take into account the level and abilities of the resident.

5. The attending physician should be scrubbed for key portions of every Cesarean delivery. (See D.5)

6. Attendance and participation by the attending is necessary for billing

B. Inpatient Obstetric Service

1. The Maternal Fetal Medicine (MFM) physician will be readily available.

2. The MFM physician should round daily with the residents. The MFM physician should have an admit note and a daily progress note on all high-risk antepartum and postpartum patients.

3. Personal contact and documentation by the attending physician is necessary for billing.

C. Outpatient Clinic – Obstetrics and Gynecology

1. The attending physician will be present in the outpatient clinic from the time residents’ start seeing patients until the last patient has been reviewed.

2. Each patient should be presented to an attending physician or Chief Resident.

3. The attending physician does not need to examine each patient. He/she can rely upon their judgment considering the level and abilities of the resident.

4. Personal contact and documentation by the attending physician is necessary for billing.

D. Surgery

1. The attending physician must be scrubbed for the key portions of all resident surgeries. (See D. 3, 4, 5)

2. Any additional amount of attending involvement in surgical cases is left to the judgment of the attending physician. He/she will take into account the level of difficulty of the case, and the level and ability of the resident.
3. Key portions of Laparoscopy procedures include trocar insertion and any intra peritoneal procedure.

4. Key portion of laparotomy procedures include incision, dissection and removal of any organs.

5. Key portions of Cesarean Sections include incision, delivery of fetus, and establishing hemostasis.

6. Personal attending participation and documentation is necessary for billing.

E. Emergency Department and Consultations

1. All emergency department patients and consultations will be presented to the OB in-house attending physician. The OB Attending must agree with any discharge from the emergency department or admission to the hospital.

2. The GYN attending physician will round on all gynecology admissions within 24 hours.

3. Personal contact and documentation by the attending is necessary for billing.

4. GYN emergency admissions for medical management will be supervised by the OB attending until AM rounds then by the GYN attending for the week, who will assume care of the patient.

5. The GYN attending must be called to the hospital to perform any surgery with the residents. The only exception is D&E for first trimester pregnancy loss that in-house OB attending will cover on weekends and evenings. For all other procedures the attending on call for GYN must come in.

F. Inpatient Gynecology Service

1. The GYN attending will be available to the resident. The attending physician will see the patient with (or after) the resident has completed their evaluation.

2. The OB attending physician must agree and supervise all emergency admissions until the GYN attending assumes care of the patient. The GYN attending will agree and supervise all scheduled GYN admissions.

3. The GYN attending or Chief Resident will round daily on GYN inpatients.

4. The OB in-house attending will round on gynecology patients on weekends and holidays. The gynecology attending can be called in by the OB in-house physician, if needed.

4. Personal contact and documentation by an attending physician is necessary for billing.

G. Off-Service Rotations

Resident supervision on off-service rotations will be in accordance with the policies of the individual Department in charge of that specific rotation.
H. There is MANDATORY notification of the attending by ANY resident that becomes aware of one of the following:

1. Patient admission.
2. Consideration to perform an invasive procedure.
3. Deterioration of patient’s condition.
4. Patient’s course deviates from the expected.
5. Patient leaving against medical advice (AMA).
6. Patient (or family) requesting contact with the attending.
7. Patient demonstrating hostile or suicidal tendency.
8. Significant abnormal test results.
9. Significant change in patient’s condition (even if expected).
10. Patient’s need for increased level of acuity of care.
11. Transfer of patient to different service or level of care.
12. Discharge of patient from hospital or emergency department.

On Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as work hours beyond the normal workday when residents are required to be immediately available in the assigned duty site.

Within the framework of the Duty Hours requirements listed below this chapter:

- PGY2 residents and above must not be scheduled in-house call more frequently than every third night, averaged over a four week period.
- Residents must not be scheduled for more than six consecutive nights of night float.
- At-home call (pager call) is defined as call taken from outside the assigned institution. We do not permit “At Home Call”.

Transition of Care (“Handoff”)

Transition (“handoff”) must occur at the end and beginning of each shift. A list will be maintained for all patients on each service including all pertinent details of patient management. The attending must be present to review this list and participate in the care plan discussion of each patient.

Physicians are expected to have a keen sense of personal responsibility for continuing patient care that is not automatically discharged at any given hour or day. Clinical events in obstetrics and gynecology take place 24 hours a day, seven days a week. Resident on-call schedules are prepared monthly by the ACR and reviewed by the Program Director. Attending Physicians provide backup so patients receive safe and effective care.

Clinical assignments are specifically designed to minimize the number of transitions in patient care. Structured handoffs occur at all shift changes. Handoffs are conducted in an appropriate setting to ensure patient safety and privacy. An electronic list of patients is provided as patients are handed off from one team to another.
Rotations are at least one month long to provide continuity of patient care. Residents (PGY2-4) typically do 12 hour or 24 hour shifts with transition of care no more than two times per day. The night team is assigned the same patients and the same service for four to five consecutive nights in a row, again to minimize hand-offs.

Residents have two hand-off transitions in patient care daily on all services. Residents from each of the services, gynecology, obstetric, Maternal Fetal Medicine and Gynecologic Oncology, printout respective case lists that are comprehensive and updated daily. These are printed out to be used as a paper document for each sign out. Transition of care is now digitally reviewed by the Associate Director of Maternal Fetal Medicine on a daily basis. Patient care requiring acute review is addressed immediately. Global trends are addressed in a quarterly summary presented to the department.

**Obstetrical Transition of Care**

**Attending Sign out.**
At the completion of each 12 or 24-hour period of Attending direct supervision, there is always an attending-to-attending communication in order to provide a smooth transition of care.

**Board Sign Out:**
Who: Supervising attending, Night 4th, 3rd or 2nd year to OB Day 3rd and 4th year Residents, family practice obstetrical fellow, outside residents, medical students, charge nurse, nurses from labor floor (when issues related to volume and transfers from one floor to another are discussed).

Where: Board on L&D or Resident work room

Visual Aids: L&D Board, Paper printout of in-patients, Electronic Fetal Monitoring System information for each patient:
- age
- GxPxxxx
- gestational age
- chief complaint and/or reason for admission
- pregnancy complications
- labor course
- fetal heart tracing category
- follow up care
- availability of follow up care

**Gynecology Transition of Care**

Who: Supervising attending, the night Gyn and chief resident, the day Gyn team, medical students on service
Patients: Med Surg floor, ED, OR, SICU, and MICU as applicable

Information for each patient:
- Age
- GxPxxxx
- Chief complaint
- Reason for admission
- Pending labs, images, and consults
- Diet
- Plan
Primary and Preventative Patient Care

Continuity of care is a recognized core value of the specialty of obstetrics and gynecology and must be a priority in each program.

Residents will prepare for their roles as providers of primary and preventive care. The program provides a closely supervised experience by appropriately educated generalist faculty members that ensures continuity of care of specific patients by an individual resident. Increasing responsibility will be given to residents under the supervision of a qualified, on-site, attending staff/faculty member. Residents will develop and maintain a continuing physician-patient relationship with a panel of patients, at least one half-day per week, for at least 30 months throughout the four years of education.

Statistical Information (Case Logs)

Four-year statistical summaries of resident experiences are mandatory information required by the ACGME and is crucial in the residency program accreditation process. In order to perform procedures with progressively increasing skills, it is necessary that residents document procedures they have accomplished. In developing their program of study, residents should make every attempt to acquire training and experience required in each procedure. These skills are to be certified in writing by the involved attending physician on the Procedure Competence Form (Section III). The resident’s procedure competence file is maintained by the Residency Coordinator so specific privileges can be accorded in a timely manner.

Residents are closely monitored for procedure competence. It is the responsibility of every resident to complete their Obstetrical/Gynecological Case Log records at least weekly. Any resident who is not in compliance with the established policy will be assigned extra hours or shifts of in-house call by the Administrative Chief Resident or the Program Director. (See Section V for detailed information)

Duty Hours

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and all scheduled academic activities such as conferences. All residents are required to keep track of their hours worked. Work hours are to be tabulated by the residents on a daily basis into the New Innovations Duty Hours program. (See Section IV, Logging Duty Hours) Any resident who is not in compliance with the established policy may be assigned additional call time (within the 80-hour rules) by the Residency Director. Additional call may be scheduled until 100% compliance is achieved.

- Duty hours do not include reading and preparation time away from the duty site.
- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. The four week period must be within the same rotation, i.e. a two week research rotation cannot be averaged with a clinical rotation.
- Duty periods for PGY1 residents must not exceed 16 hours in duration.
Duty periods for PGY2 residents and above may be scheduled up to a maximum of 24 hours and must not be assigned additional clinical responsibilities after 24 hours of continuous duty. These residents may be allowed to remain on-site for a maximum of four additional hours (28 hours total in house) in order to accomplish effective transitions of care, participate in didactic activities, and maintain continuity of medical and surgical care.

No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the resident has not previously provided care.

Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

PGY1 and PGY 2 residents should have 10 hours and must have eight hours free of duty between scheduled duty periods.

Intermediate level residents (PGY 2) must have at least 14 hours free of duty after 24 (plus 4 hours) of in house duty.

See ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology, Section VI. Resident Duty Hours in the learning and Working Environment for a complete description of the duty hour’s requirements.


New Innovations is the system used for tracking resident work hours. The department must document the number of hours each resident works each week and submit to the Graduate Medical Education Office monthly. (See Section IV, Logging Duty Hours)

Moonlighting

Moonlighting is not recommended while in residency training. The focus should be on the education and training provided to the resident. Residency education is a full-time endeavor.

Nevada Revised Statute 630.265 (which deals with the limited license for resident physicians) states:

“The holder of a limited license may practice medicine only in connection with his duties as a resident physician or under such conditions as are approved by the Director of the Program and the Nevada State Board of Medical Examiners.”

Moonlighting is not permitted in the OB/GYN Program.

Fatigue Management

Faculty cover patient care responsibilities directly when it is recognized that residents are fatigued. Quiet male and female call rooms are provided to take naps when needed. Remaining residents also adjust their responsibilities to cover services. Senior residents get involved with more hands on when the service gets busy. The in-house attending staff help out the residents whenever necessary. There is a back-up second attending on call who comes in for all emergent Gyn cases (other than D&Es).
When patient care volume exceeds the ability of those residents and attendings to provide quality care, the Maternal Fetal Medicine faculty member who is on call from home will come to the hospital to assist the attending and residents on the obstetrical service and the Gynecologic oncologist will come to the hospital to assist the attending and residents with gynecologic care.

Financial Support, Annual Leave and Benefits

The University of Nevada Las Vegas, School of Medicine Department of Obstetrics and Gynecology provides the following financial support and benefits for OB/GYN resident physicians.

a. Annual Salary: (Check with department for salary changes that may have occurred recently)
   - First Year Resident: $50,384.00
   - Second Year Resident: $52,179.00
   - Third Year Resident: $53,874.00
   - Fourth Year Resident: $55,771.00 (does not include Chief stipend)

1. Annual leave (Vacation) of up to 15 days at full salary per year will be available starting August 1 of each year. There is no carry-over of annual leave to the next year. Residents shall not be paid for any unused annual leave upon termination or graduation. Annual leave shall be taken at a time approved by the ACR and Program Director. Vacation days are Monday through Friday. Weekends are not included in the 15 day count and are given as a courtesy if at all possible. Only one week of vacation should be scheduled during OB rotations. All resident vacation schedules need to be approved by the Program Director. Only two residents should be on vacation at the same time, and they must be on different services. No vacations are allowed past June 15th or during the month of July unless the Program Director approves. If any Clinic is left uncovered due to a scheduled vacation, the ACR needs to ensure coverage.

2. Sick leave will be granted as required, up to 15 days at full salary, available at any time during the initial 12 months of service. Beginning 12 months after the starting date of his or her contract, the Resident will begin to accrue additional sick leave at a rate of 1-1/4 days per full month of service to add to any remaining balance of unused sick leave from the first 12 months of service. Sick leave may be accrued from year to year not to exceed 15 workdays at the last day of each month. Residents shall not be paid for any unused sick leave upon termination of employment. Residents may use accumulated sick leave for temporary disabilities, which includes child bearing. Unpaid child rearing leave may be requested by either parent. Request for child rearing leave must be accompanied by a statement from a qualified professional source if there is a medical or psychological need for the parent to be given leave. Resident Physicians are also entitled to the leave benefits provided in federal and state law including the Family and Medical Leave Act of 1993.

   a. The resident must notify the ACR and Program Director that she is pregnant as soon as possible so that resident rotations may be adjusted. The pregnant resident will be assigned to appropriate duties that will not compromise her health or the health of the fetus.

   b. Leaves of absence and vacation may be granted to residents at the discretion of the program director in accordance with local policy. If, within the four years of graduate medical education, the total of such leaves and vacation, for any reason, (e.g., vacation, sick leave, maternity or paternity leave, or personal leave) exceeds eight (8) weeks in any of the first three years of graduate training, or six (6) weeks during the fourth graduate year, or a total of twenty (20)
weeks over the four years of residency, the required four years of graduate medical education must be extended for the duration of time the individual was absent in excess of these guidelines. (American Board of Obstetrics and Gynecology Requirements)

3. Funds to pay for group health and life insurance, unemployment compensation coverage, or other group insurance plans will be provided to the Residents by the agency that provides salary funds for the Resident.

4. Residents are required to participate in a 403(b)-retirement plan, with contributions of 6.2% of salary, made by both the employer and the Resident.

5. Residents will be covered under the state’s workers compensation program and Medicare.

6. Professional Liability insurance will be provided by the University while Residents are on contract with the University of Nevada Las Vegas. After contract termination, the insurance policy will cover the Residents’ contracted activities during the contract. (i.e. A TAIL policy is unnecessary) This insurance does not provide coverage during any outside employment. (i.e. moonlighting)

7. Grants-in-aid for tuition and fees are not provided by the University.

8. Resident Physicians and Dentists with appointments of half time or more, along with the spouse and dependent children, will be considered in-state Residents for tuition purposes.

9. Meal Cards are provided for all residents and amount is based on the rotation and the average amount of calls taken.

10. Lab coats and scrubs are provided for residents. New residents are provided with 2 lab coats, and then are eligible for one additional each year thereafter.

**Academic Year**

The academic year begins July 1 and ends on June 30th each year. Chief Residents are expected to continue full participation in the Program until relieved by the Program Director.

**Use of Vacation Time, Sick Time and Other Time Away from Program**

Vacation schedules must be submitted at the beginning of the academic year to allow for appropriate patient care. Residents can choose their vacations with those residents having the most seniority receiving preference. Residents are responsible for submitting to the Residency Coordinator, an approved request for leave prior to departing on their scheduled vacations. Vacations during the months of June and July may not be approved. Recognized University of Nevada Las Vegas holidays:

- Independence Day - July 4
- Labor Day - September (First Monday)
- Thanksgiving - November (Thursday and Friday)
- Christmas - December 25
- New Year’s Day - January 1
- Martin Luther King, Jr.’s Birthday - January (3rd Monday)
- Memorial Day - May (Last Monday)

Residents observing other religious or cultural days must work equal number of approved state holidays in exchange, or use vacation days.
When sickness precludes work, the resident will be expected to cover call nights for those who covered while he/she was ill. If you are too sick to work, the ACR and the Residency Coordinator must be notified. A Time Away form will need to be filled out accounting for all sick time. Any sick time over 2 days requires a note from a doctor. The Program Director may request a physician’s statement for any period of sick leave. The determination as to whether or not the resident will be required to make up time missed due to sick leave will be made by the Program Director.

All time away from the program is based on the American Board of Obstetrics and Gynecology (ABOG) requirements found online at https://www.abog.org/new/default.aspx and the Graduate Medical Education Resident Handbook found online at http://medicine.nevada.edu/gme/current-residents/resident-handbook

Absenteeism

Being present, on time, for residency duties, services, rotations and electives is expected. There must be written explanation when residents cannot attend to their responsibilities. This is an ethical and legal issue for the University of Nevada Las Vegas and University Medical Center Hospital.

The Residency Coordinator has proper forms to request leave time for any reason. Residents truant from their responsibilities, or out of available contact, will loose pay for that day or be charged a day of vacation.

Educational Leave

Attendance at a medical or educational meeting may be granted by the Program Director. This is an earned privilege, is not automatic, and is limited to a maximum of five days per year of training. Participation as a speaker, department representative, reporter, or a presenter is optimal. Leave to attend special meetings is not considered vacation time, and must be approved by the Program Director.

At least four weeks advance notice is required by the resident wanting to attend a program. Funding for this leave is the residents’ responsibility. The Department Chair may fund certain educational activities that are deemed supportive or beneficial to the growth and development of the educational or research goals of the Department or if the resident will be presenting.

Residents are expected to present the details of the educational value to the Program Director and Department Chair, for approval. Educational leave must not to be used as vacation time.

Procedures for travel are included in the Addendum’s Section of this Handbook.

Educational Retreat

A Retreat may take place one day per year. Format for the day must have significant educational content. The agenda must be approved by the Residency Director. Only residents in good standing will be allowed to participate. Residents in good standing is demonstrated by having all stats and evaluations up to date, all hospital charts completed, 80% attendance at weekly lectures, and prompt attendance.

Residents must be available for rounds and transfer care before they leave at 0800. Residents must be available for regular nighttime duty.
Requests to Participate in Community Activities

Participation in community activities must not interfere with clinical or academic responsibilities. All requests to give lectures or provide speaking engagements, etc. must be approved by the Program Director prior to the event. Related correspondence will be copied to the Program Coordinator’s office. Documentation will become a part of the resident's permanent file.

Requests from Outside Agencies

Occasionally there may be a request from outside agencies, such as attorneys' offices, for information regarding a particular patient or a patient's care. All such requests should be directed to the Residency Program Coordinator who will then distribute to the appropriate authority. **No information should be distributed without prior authorization from the UNSOM legal council.**

Dress, Grooming and Behavioral Standards for Residents

Dress, grooming, and personal cleanliness standards contribute positively to the morale and professional image the resident physician presents to patients and their families. It represents a form of patient respect.

Standards for Dress/Grooming:

1. Conservative and professional attire is appropriate when not in operating or delivery areas.

2. Shoes should always be clean.

3. Hair should be neat, clean and arranged in a manner and length that does not interfere with patient care.

4. Proper scrub wear is appropriate only in procedure and patient care areas, labor and delivery floors, and in operating suites. It should be neat and clean whenever worn outside the immediate patient care areas. It is permissible to wear scrubs to conference or administrative areas immediately adjacent to the hospital.

5. Protective covering of all kinds (shoe covers, gowns, goggles, gloves, masks and caps) should be worn only in areas specifically requiring their use (per OSHA regulations).

6. The following clothing is **NOT** acceptable or appropriate:
   - Leather or denim shirts, dresses, skirts, jackets or trousers (jeans); tank tops, t-shirts
   - Sheer clothing; tight fitting clothing (leotards, spandex)
   - Oversized or baggy shirts or pants; sweat pants or sweat shirts
   - **Uncovered feet**, sandals, flip flops, moccasins.

7. Personal adornments **NOT** acceptable or appropriate:
   - Jewelry that interferes with patient care activities and distracts from the conservative, professional image
   - **Visible** skin piercing, (other than appropriate earrings), body markings or tattoos

8. Labcoats: All residents are provided with lab coats. They may be worn in patient care areas and when worn should be relatively clean. Lab coats are required at the clinic.
Standard for Professional Behavior:

Professionalism is how a physician relates to patients, families, other physicians, residents, students, and to nursing and administrative persons at all patient care levels. These professional attitudes include (but are not limited to), courtesy, agreeability, confidentiality, sympathy, helpfulness, respect, and ethical behavior. A positive working relationship with hospital clerical and nursing staff is especially important.

Other Standards:

1. Personal cell phone calls are NOT appropriate during educational activities. (Exceptions: critical or urgent patient care needs). When such calls unavoidably interrupt educational activities, the call should be completed in privacy away from others engaged in the educational activity.

2. Resident or attending children are NOT allowed in patient care areas; there are no exceptions and violations may result in disciplinary action.

Procedures for Discipline, Promotion, and Dismissal of Residents

Written complaints, patient complaints, and/or noted unsatisfactory performance will be reviewed by the Program Director (PD) and discussed with the resident. If the PD deems it necessary the complaint(s) can be referred to the Clinical Competency Committee (CCC). Informal disciplinary action for deficiencies will be appropriate for the event and may be carried out and monitored by supervisory residents, faculty, the ACR, Program Director or Chair of the Department.

At the discretion of the Program Director and/or the CCC, residents demonstrating deficiencies solely in the areas of humanistic qualities or moral and ethical behavior may be denied credit until additional training and/or a specified period of close supervision is completed. Disciplinary action may also consist of reprimand, counseling, non-promotion, prescriptive assignments, remediation, withholding of privileges, probation, dismissal, or non-renewal of annual contract. All disciplinary actions, which cannot be resolved informally, will be referred for Resident Due Process in the office of Graduate Medical Education and a decision in accordance with the Graduate Medical Education Resident Handbook. The handbook can be found at [http://medicine.nevada.edu/gme/current-residents/resident-handbook](http://medicine.nevada.edu/gme/current-residents/resident-handbook)

Faculty / Attending Physicians

ATTENDING PHYSICIAN: Board Certified/Eligible OBGYN, MFM, GYNONC, UROGYN, FPMRS or REI physicians that have ACADEMIC appointments with the University, a contractual arrangement with UNSOM or a written Affiliation agreement with UNSOM that provides malpractice coverage while working with residents. They must be credentialed in all facilities where they will be overseeing, assisting or directing surgery or patient care activities of residents.

The administrative structure of the residency program is outlined on the flow chart presented in the beginning of this handbook. The day-to-day clinical responsibility for the residents and their patients is held by the attending physician. Attendings are responsible for making rounds on obstetric and gynecologic patients and being “scrubbed” for all surgical procedures and deliveries.
It is the responsibility of the Chief Resident on each service to contact the attending physician regarding patients on the service. During rounds, attending physicians must place a supporting note in the patient’s chart.

All hospital admissions will be discussed and approved by the attending physician.

Resident surgical cases for the next week will have preoperative evaluation and approval by the attending surgeon for the case. It is the gynecology Chief Residents’ responsibility to present and get approval from the attending surgeon. This surgical work up can be carried out in any of the resident clinics.

Attending physicians are responsible for providing in-house supervision of care provided for all OB/GYN patients.

Patients may present to UMC for care and have a private physician. It is the responsibility of the residents who see these private patients on L&D or in the ER to completely evaluate these patients. The resident must contact the private attending and apprise them of the patient evaluation. Patients may be discharged to the care of private physicians only when the patient and her fetus are stable. If the resident has been instructed by a private physician to discharge a patient who has not been fully evaluated, the most senior resident is to communicate directly with the responsible UNSOM attending physician. He/she must ensure appropriate care and disposition is given to every patient.

**Security Services**

Security Services/Public Safety at University Medical Center are available 24 hours each day. The Security Dispatch Service can be reached at 702-383-2777. UMC Medical Staff Office updates 4th year residents ID cards to access the doctor’s parking lot, which offers controlled parking.

**Quality Assurance**

Several methods are in place to monitor quality assurance. The graded levels of responsibility provide for faculty supervision of all residents. At the beginning of each academic year, residents are assigned a mentor. Faculty mentors will be available at all times, and have mandatory meetings twice a year at which time they generate a report for the resident’s semi-annual review with the Program Director, and for the Clinical Competency Committee if necessary. The semi-annual meetings with their mentors will include a review of the Milestones, as listed by ACGME. Residents and their mentors will review the milestones, and report on where the resident falls on each. This report will be included in their semi-annual report to the Program Director (See Section III for samples and information on The Milestones).

Residents are required to attend the monthly Perinatal Morbidity and Mortality, OB and GYN and GYN/ONC Morbidity and Mortality meetings where specific cases are reviewed and discussed.

Attending Physician rounds promote discussion of all admissions with particular attention to more difficult patient problems. Problems and opportunities to improve care are identified and brought to the attention of the Administrative Chief Resident or the Program Director. Written responses are provided to UMC Quality Improvement critiques if needed.

Each PGY year will have a joint QI project they work on during their residency. The status of the project will be presented periodically at the weekly didactic sessions. This will be a formal presentation with a PowerPoint presentation included.
Resident Evaluation

Residents are evaluated on their performance by monthly and semi-annual computer generated questionnaires of their activities and through periodic dialogue with the Program Director. All evaluations are anonymous. Resident evaluations, activities and competencies are also discussed at the semi-annual Clinical Competency Committee meetings and the annual Program Evaluation Committee meeting. Feedback from these meetings are discussed with each resident at their semi-annual meeting with the Program Director and documented in their semi-annual review evaluation. These evaluations are reviewed and signed by each resident, then become a part of the resident’s permanent file. (See Section III for detailed information and sample evaluations)

CREOG In-Training Exam

In January, the annual CREOG In-Training exam is a required exam for all residents. Attendance is mandatory.

CREOG Score Remediation Policy

In selecting residents, the program makes a commitment to fully support the resident’s development into a competent Ob/Gyn physician. Since individuals arrive with varied backgrounds, aptitudes, and skill sets, it is expected that each resident will travel a unique path in their professional development. Remediation is an educational resource that we provide to residents when they need additional support.

When performance deficits are noted, in most cases residents are able to make necessary corrections on their own. Remediation exists for residents requiring direct, formal educational support from the program. While residents are encouraged to seek support on their own, it is sometimes necessary for the residency program to initiate a remediation program based on CREOG exam results. CREOG results are expressed as SEM (Standard Error of mean). Score of 200 is considered as mean and 2 standard deviations from the mean (score less than 190) results in a plan for remediation.

The process for remediation is as follows:

• Program Director meets with the resident and reviews the CREOG results and areas of specific deficiencies are discussed. The exam results are reported in 7 distinct categories (Obstetrics, Gynecology, REI, Gyn ONC, Genetics, general considerations and Primary care)
  - The CREOG score report is shared with resident mentors so they can work with mentees towards improving their performance
  - CREOG reading list of missed questions by individual resident is used to identify deficiencies
  - Review of Prologs, review of particular sections in the Challenger program are used as resources
• The mentor submits a follow-up report to the program director when remediation goals are met
Resident Research and Presentation

Resident participation in research is a requirement. All residents are required to complete a research project during their first three years, with a manuscript submitted for publication to a peer reviewed journal. The resident’s research will be presented at the Medical School's Annual UNSOM Resident Research Paper Day in their PGY 3 year. Guidance and assistance to each resident is available through members of the faculty. PGY 2 residents will have time set aside to establish their project and start collecting data.

Protected Time

Friday 0700 to 1000 is protected time for didactic presentations. During this time, Attending Physicians provide patient care on Labor and Delivery and the Emergency Room. A lecture series based on the CREOG “Educational Objectives, Core Curriculum in Obstetrics and Gynecology 10th Edition” is presented. The lectures are assigned by the Residency Director. Lecture schedules are prepared and distributed for the following month. Presentations are by faculty, residents, attending physicians and invited guests. Presenters/lecturers are encouraged to begin on time. Residents are to be in attendance for all presentations. Failure of a resident to give an assigned lecture is non-compliance of assigned duties. Pagers / cell phones are to be turned to “vibrate” during educational sessions.

Committees and Councils with Resident Attendance

UMC - Quality and Patient Safety, Chief Resident/Nursing Management OB QI,

UNSOM, Administration - Graduate Medical Education Committee (GMEC), GME Resident Forum.

Resident responsibility for “notes” on L&D and Hi-risk.

The PGY 1 resident on the OB service should use a standard “SOAP” format note on each patient, every day. The PGY 2 should round on antepartum patients and those with complications. The senior resident shall place a note on all patients with complications, or high risk, detailing the treatment plan.

ON LABOR & DELIVERY, no patient is sent home or admitted without the senior resident or attending being informed.

<table>
<thead>
<tr>
<th>Triage patient being sent home:</th>
<th>Note:</th>
<th>OB/GYN Intern (senior resident aware)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine labor patient admission:</td>
<td>H&amp;P:</td>
<td>OB/GYN Intern (senior resident aware)</td>
</tr>
<tr>
<td></td>
<td>2-hour notes:</td>
<td>FP, Ed, OB intern (senior resident aware)</td>
</tr>
</tbody>
</table>

HIGH-RISK WARD:

<table>
<thead>
<tr>
<th>High-risk labor patient admission or antenatal patients not being delivered</th>
<th>H&amp;P:</th>
<th>Senior Resident or PGY 2 (with Senior aware)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily note:</td>
<td>Senior Resident or PGY 2 (with Senior aware)</td>
<td></td>
</tr>
<tr>
<td>2-hour labor note:</td>
<td>Senior Resident or PGY 2 (with Senior aware)</td>
<td></td>
</tr>
</tbody>
</table>

Operative procedure (C-section, cerclage):

H&P must include a note explaining decision for procedure: PGY 2-4
Post-procedure, post-partum, post-operative:

Routine: Daily note: OB/GYN Intern
High Risk condition continues: Daily note: Senior resident or PGY 2 (with Senior aware)

If the Chief Resident is not on Labor & Delivery, then the most senior resident present should write the note.

Medical student notes are not acceptable by themselves. They require additional chart documentation.

1. Resident to do an independent evaluation
2. Write a note including the following:
   a. State that patient was “seen and examined”
   c. Assessment of problem
   d. Plan of care
3. Resident CANNOT WRITE, “Agree w/medical student note”

Each resident is provided with his / her own self-inking name stamp to be used daily, and applied below the resident signature in the medical record. Participation / supervision by the attending physician must be documented in the patient chart and identified in all dictations.

On L&D, H&P’s are completed for all patients admitted to the resident service. Delivery summaries must be dictated for all deliveries and unexpected or untoward events such as maternal or fetal trauma, fetal depression, or excessive blood loss. Any surgical procedures such as repair of lacerations more than minor in nature, or puerperal sterilization also requires a dictation. Attending’s are required to review and co-sign each dictation.

On the GYN service, the residents are responsible for daily "SOAP” notes on patients. All admissions, discharges, and surgical procedures require a dictation. All admissions and discharges should be run by the chief and the attending.

*Junior Resident is PGY 1 or PGY 2
*Senior Resident is PGY 3 or PGY 4

Discharge Summaries

Discharge summaries are required for all patients admitted to the hospital with inpatient or observation status except uncomplicated vaginal deliveries. Discharge summaries should be completed for any patient with an extended or complicated hospital course. These include (but are not restricted to) medical or surgical complications, uncommon puerperal interventions, and patients discharged with special requirements or therapeutics after departure.

The discharging resident is responsible for the summary. If verbal orders are given to discharge a patient and no summary is done, it is appropriate to refer the chart in medical records to the discharging resident. Dictations may be done through the telephone connected dictating service by calling extension 383-8045.

In cases in question, Quality Improvement review and decision will govern policy in individual cases. It is suggested that all circumstances, which result in QI review by protocol, be included in the guidelines for required summaries.
The requirement for dictated delivery and discharge summaries on all uncomplicated vaginal delivery and patients not qualifying under the above is waived. Dictation's may be done if desired, but are not mandatory.

Discharge Summary Must Include:
- Date of admission
- Date of Discharge
- the reason for hospitalization
- the procedures performed
- Consultations obtained
- the care, treatment, and services provided
- the patient’s condition and disposition at discharge
- information provided to the patient and family
- provisions for follow-up care

Joint Commission Standard RC.02.04.01

Gynecologic Surgery Dictation

Operative Report
The operative report is the primary clinical record that documents the need for an operation and what transpired during the operative procedure. The operative report is increasingly being used for other purposes, such as a medico-legal document, and as insurance and reimbursement record. As such, the operative report may be used by insurance reviewers to determine the accuracy of codes submitted and the level of payment owed to the surgeon, or it may be reviewed by support staff in order to pick the most accurate codes before the claim is submitted.

There are certain kinds of information that should be included in an operative report, as well as certain terminology that might be used to aid the billing staff in selecting the proper CPT or ICD-9 codes for any given operative session. The following suggestions will provide guidance in dictating an operative report so that it will serve as an adequate medical financial and legal record.

Not everyone who will be reading the operative report will have the same level of medical knowledge regarding anatomy and terminology. Billing staff, the hospital peer review committee, or the insurance claims reviewer, nurse, or medical director are all people who may be reading your operative reports for different reasons.

The essential elements of an operative report include:

Summary:

Preoperative Diagnosis:
Include symptoms that would illustrate the medical necessity of performing diagnostic procedures! Do not overstate suspected diagnoses. Do not use the terms “rule out”, “suspected”, or “possible”. Dictate symptoms or abnormal findings as indications. This should be a succinct summary of the preliminary diagnosis of the patient’s condition.

Postoperative Diagnosis:
Do not dictate “Same”. Do not bury valuable postoperative diagnostic information in the body of the operative report. It is the postoperative diagnosis that will determine the ICD-9 codes utilized.
Be sure to include, the nature of tissue removed, such as malignant or benign, or the more definitive terminology, such as “leiomyomata” rather than “uterine fibroids”; “Endometrial adenocarcinoma” rather than “uterine cancer”.

Procedure Performed:
Numerically list the procedures performed. Do not use language like “wide local excision” but rather “excision and repair of 4 cm. benign neoplasm.” Be sure to include measurements in the Summary for excisions and repairs.

Surgical Responsibility:
Clearly identify who was the attending physician, primary surgeon, or assistant. Use first and last names. Identify consultants or others that join the surgery and the reason they were included, and the time in and out of the procedure.

Indications:
Describe the reasons for the surgery, and state the medical necessity for the operative procedure. If there were unusual circumstances, be sure to succinctly describe them using descriptive language, such as “This procedure, which normally requires 45 minutes, lasted 3 hours due to the extensive nature of the adhesions to the colon which required lengthy, meticulous dissection”

Body:
Describe in detail the procedure from beginning to end. The body of the operative report must support the summary information. (Do not claim extensive lysis of adhesions in the summary and then barely describe any lysis in the body.)

Medical Records

In medical records, all charts are checked for signatures on orders and notes. The incomplete charts are then placed in the resident's inbox to be completed. It is the responsibility of each resident to check their deficiencies periodically. Weekly reports are issued by medical records.

Residents posted in the delinquent category by medical records have one week from the date of notice to complete the records identified or they will get an automatic FULL “Education” day to complete those medical records. Once residents have completed their delinquencies they may be required to bring a copy of a signed release from the Director of Medical records to the Residency Coordinator. It is the resident’s responsibility to clear delinquent records and verify clearance with the Residency Coordinator.

Services

Obstetric Service
Morning patient rounds by the PGY 1 on postpartum, begins at 0600. These rounds should be completed on-time so that residents are on time for scheduled cases and Attending rounds at 0700. The PGY 1 on service takes over L&D at 0600 Mon-Fri. The PGY 1 takes care of patients on L&D and then helps finish morning rounds with the PGY 2. PGY 2 and PGY 3 or 4 residents round on antepartum high risk patients. At 0700, resident rounds are made with the Attending and all residents presenting antepartum and complicated cases. The PGY 2 and PGY 4 resident presents complicated patients on L&D and postpartum

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to the Attending OB. Perinatologist makes teaching rounds with the residents on OB. When morning rounds are completed, the PGY 1 on the OB service is briefed by the PGY 2 of the patients on L&D and the treatment plan for each.

The PGY 2 is responsible for supervising the PGY 1 resident and keeping the senior resident and attending informed. All monitor strips of patients in the unit are reviewed. The PGY 1 is instructed by the PGY 2 regarding the operation of the unit and the interpretation of tests.

During the day, the PGY 1 remains on L&D with the PGY 2 supervising. The PGY 2 should be kept informed of conditions on L&D and will consult with the Senior Resident. The responsible Attending Physician is kept informed by the Senior Resident of all admissions, deliveries and potential or ongoing problems.

The exception to contacting the PGY 2 only occurs when an emergency presents. In this instance, the Senior Resident and Attending Physician should be contacted directly while preparations are being made to care for the patient.

The PGY 1 checks out the board to the resident on call at 1700 Mon-Fri. The antepartum and postpartum patients with complications are seen in the afternoon and presented to the on call resident before the PGY 1 leaves. On weekends and holidays the shifts are from 7am to 7pm.

The Attending Physician is to be kept informed by the Senior Resident responsible for the service of all complicated or high risk patients. The in-house Attending Physician is informed of all admissions and deliveries. All decisions regarding major issues should be approved by the Attending Physician.

**Gynecology Service**

Attending GYN rounds are 0700 Monday through Friday for the inpatient service. The PGY 2 and PGY 4 complete working rounds before 0700 Rounds. If surgery is scheduled that day, pre-op notes are completed by this time. The Senior Resident rounds and is responsible for each patient. The Senior Resident is responsible for notifying the Attending Physician of the start time for all cases.

During the day, the PGY 2 on the GYN service carries the beeper and provides coverage for the emergency room. Leaving clinic to evaluate an ER patient should be cleared with the Senior Resident. At the discretion of the Senior Resident, the PGY 2 may provide consults for other services.

On the GYN service, the residents are responsible for daily “SOAP” notes on patients. An Attending note should be on each patient confirming the treatment plan. All admissions, discharges, and surgical procedures require a dictation and agreement with the Attending physician.

*Junior Resident is PGY 1 or PGY 2, Senior Resident is PGY 3 or PGY 4*

After clinic is done, the GYN team makes afternoon rounds and then checks out to the residents on call, giving up the beeper with a list of patients. The resident designated to carry the beeper during the day is responsible for picking up the beeper each morning. It is the responsibility of all GYN residents to be present for Attending GYN rounds.

The PGY 4 on the GYN service should check the OR schedule daily for private patients. The Chief Resident can then assign residents to these cases if the attending agrees. When a resident is assigned to a private case, he or she should see the patient in the preoperative holding area, review the chart and write a preoperative note. That patient should then be seen daily by the resident participating in the case.
Students may write notes only at the discretion of the private physician. It is also the responsibility of the residents to enter ALL cases into their statistics.

**Outpatient Clinic**
Outpatient clinic occurs at the Women’s Healthcare Center of Las Vegas. PGY 2, 3, 4 residents are assigned to a weekly continuity clinic. Morning clinic begins promptly at 0800 and afternoon clinic begins at 1300. If a resident expects to be late to clinic, it is his/her responsibility to inform the chief of the clinic service as well as the clinic staff.

**Emergency Room**
Patients who present to the ER are evaluated by the ER staff. ER consults are done by the PGY 2 on GYN during the day and the PGY 2, 3, or 4 residents, during the night. The Chief Resident will assign a resident to cover the ER on surgery days.

Night back up (home call) can be called in to cover the deck or ER if a patient is unstable or the deck is too busy for the assembled residents to respond in a reasonable period of time.

Every ER patient should be seen by a PGY 2 (or higher) resident. No procedure should be done in the ER without a senior resident or OB/GYN attending in the room. No patients will be admitted without notifying the Attending Physician.

**Patient Transfers**
At various times residents may be contacted by physicians outside the residency program, midwives or other agencies regarding transfer of patients to this facility. All such requests for transfers should be directed to the OB Attending Physician. It is his/her responsibility to accept or decline the patient. It is the policy of this Program never to deny a patient care once they have arrived at UMC labor and Delivery. If there are questions regarding the appropriateness of the transfer, such as transfers from lay midwives or when the patient is transferred for non-medical reasons, they should be referred to UMC Quality Assurance Department. All requests for transfer of high risk obstetric patients must be directed to the Perinatologist on call.

**Monitoring/Observation**
All patients presenting to L&D for evaluation should be assessed based on their complaint, with consideration given to any known underlying condition. It is not necessary for everyone to be treated as a high-risk patient. In normal instances, the patient can be seen and evaluated for her current complaint only.

It is not mandatory to monitor every patient’s fetal heart patterns. High-risk patients requiring fetal assessment include:

- Hypertension
- Diabetes mellitus (insulin-dependent)
- Suspected IUGR
- History of prior pregnancy loss
- Threatened preterm labor
- Post-dates (beyond 40 weeks)
- Decreased fetal movement
- Multiple gestations
- Suspected ruptured membranes
Bleeding
Trauma victims
Patients with high-risk problems that can affect the fetus
Anyone else deemed concerning by the Resident

The patient's presenting complaint and related information should be documented and her chart should be reviewed for background information. If required by history or present status, she should be monitored and fetal well-being recorded. If monitored, the baby should be reactive before dismissal.

Patients who are high risk or who have been followed in our high-risk clinic should be brought to the attention of the Perinatologist before management decisions are made. The Perinatologist may also be called to consult on any OB patient about whom the Senior Resident or Attending Physician has concern.

Interventions

In a very busy care area such as L&D, it is to everyone's advantage to foster efficient labor and delivery. Such principles encourage not tying up rooms for unnecessarily extended periods. Any labor can result in progressive dehydration and calorie deprivation of the mother, and acidosis on the part of the child. We should try to move labors along by efficient patterns of management. Friedman curves, amniotomy, augmentation, and a positive attitude will foster this. Any patient at term who presents with complaints of contractions and who is found to be favorable for augmentation of labor should be considered for this intervention. Only if our facilities are too crowded to offer proper care, should we discourage this plan.

Admissions/Discharges

All patients seen on L&D have a decision made regarding admission status as soon as feasible. Options include:

1) Formal admission
2) 23-hour observation
3) Discharge

OB/GYN junior residents may not independently admit or dismiss any patients from the L&D area. This must be a decision made by a senior resident or attending. Any decision to discharge a patient must reflect who the decision was discussed with. That discussion must be recorded. Junior OB/GYN House Staff do not independently render consultations to the ER or other services. Care may be provided and advice given only after review with a senior resident or attending.

Guidelines for OB Patients Confined to the ICU

1) Any patient required to be in ICU/CCU should have her situation reported to the Perinatologist by the Senior Resident on call.
2) As long as such a patient remains on the OB Service, the physicians from that service shall be her primary physician and write her orders. Consultants utilized in the care of such patients shall be reported to the Perinatologist and/or Attending Physician, and all recommendations made by consultants brought to their attention for disposition.
SECTION II

Educational Goals and Objectives
Curriculum Overview

This curriculum prepares resident physicians for competency in the independent practice of obstetrics and gynecology, and subsequent Board certification.

This course of study, based on the Educational Objectives published by the Council on Resident Education in Obstetrics and Gynecology (CREOG), provides direction in establishing a knowledge base, acquiring professional skills, and developing clinical judgement. This book can be found at: 
http://medicine.nevada.edu/Documents/unsom/obgyn/CREOGEducationalObjectives10thEdition.pdf . This should be used in connection with the course descriptions that follow. All residents will be responsible for the goals and objectives as outlined in General Considerations, which deals with professional growth and practice management.

Critical to the success of this program is evaluation of progress toward satisfactory completion of learning objectives, acquiring performance skills, and developing clinical judgement. The evaluation process has many facets including assessment of:

a. The depth and breadth of the knowledge base by means of -
   Annual CREOG scores
   Journal club presentations
   Didactic Education conference presentations
   Chart review
   Formal and informal faculty interaction
   Attending Rounds

b. The acquisition of performance skills by means of –
   Direct observation by faculty during procedures
   Direct observation by senior level residents during procedures
   Critique and counsel by attending faculty of resident surgeons

c. The development of clinical judgement by means of –
   Direct faculty observation during patient rounds and clinic patient encounters
   Direct faculty critique and counsel during case presentations
   Performance at M & M conferences
   Review of chart documentation and care plans

Evaluation documents have been developed to classify each of the above assessments. The resident is required to formally and informally evaluate each course so faculty can be assured there is an optimum educational environment. (See Section III)

Each time component is a focused experience in an aspect of obstetrics and gynecology that for the purposes of organization, is referred to as a “rotation.” The following Goals and Objectives for each rotation and each level of resident training gives Information about the length of the rotation, its location, learning resources, learning objectives pertinent to maximizing achievement, and performance skills that should be acquired. It is recognized that competence in these areas is a dynamic learning process of increasing complexity, the mastery of which is ultimately accomplished by the fourth year of the residency. It is the resident’s responsibility to master the desired outcome of each rotation.
Learning resources include cited standard texts, medical journals, accredited continuing medical education courses, professional commercial video, ACOG Prolog, Precis, and update modules, Educational Objectives- Core Curriculum in Obstetrics and Gynecology, Compendium and internet resources.

Advancement to each subsequent year of the residency can only be granted if competence is achieved and maintained through each level of the residency. Advancement through the residency is decided by the Program Director, based on documented resident performance in all the areas described above. Should there be areas of deficiency; opportunities for remediation can be made available by the Residency Director.

The resident’s active participation in clinical activities and personal dedication to scholastic achievement is critical to a successful completion of residency training goals.

The Goals and Objectives of all rotations in the program are listed in this chapter by Post Graduate Year.
Goals and Objectives Distribution

Goals and Objectives of all rotations are distributed through the New Innovations program. All Goals and Objectives are available to all residents at the beginning of each rotation. All Goals and Objectives are available to all faculty at the beginning of each year. To confirm reading of these goals and objectives it is required to sign-off as having done so in the New Innovations system. This is the process:

Confirm Curriculum

- Go to Home Page
- In the Notifications section, under Curriculum, click Unconfirmed curriculum for your review

  ![Unconfirmed curriculum for your review](image)

- Click the link in the Curriculum column. For example, click 0 of 1 confirmed.

Block Scheduling Views

- Scroll down to the bottom and click Confirm
The Night Float system was established to accommodate the 80-hour limitation on resident work hours and to provide adequate coverage for night-time OB/GYN services. It involves a resident covering in-house from 5:00 p.m. to 6:00 a.m. Friday through Wednesday for R1 and Tuesday for R2 & 3. Resident’s responsibilities vary depending on their level of advancement in the program.

Resident Level 1 -
Perform coverage for the triage unit, admission of laboring patients, post-partum patients, evaluation for pregnancy related problems, and coverage for labor and deliveries during the hours of assignment.

Resident Level 2, 3
Primarily involved with emergency room coverage, seeing all gynecologic and trauma patients that present during the hours of assignment, and High Risk OB admissions and management. They are also first backup for the resident on the labor and delivery service. They will scrub on all emergency Gyn surgeries. Will function in a supervisory role for the labor and delivery suite during the hours of assignment, also cover night call for gynecologic oncology and will be directly responsible to their Chief Resident or the in-house attending physician.
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Residency Program Goals and Objectives

**ROTATION:** Ryan Family planning rotation PGY 1-4  
**LOCATION:** Women’s Healthcare Center of Las Vegas  
**DURATION:** 1-2 months yearly

Note: residents will be scheduled for this rotation one or two months each year, but may opt-out if desired. Elective termination of viable pregnancy is not provided at the Women’s Healthcare Center of Las Vegas at this time.

**Patient Care**
- Counsel a patient on contraception and sexually transmitted diseases
- Determine pregnancy viability using patient history, laboratory results and ultrasound findings
- Determine gestational age based on physical examination and ultrasound findings
- Counsel a patient on options for non-viable pregnancy termination, including induced medical abortion, induced surgical abortion, and observation
- Obtain a consent for surgical abortion
- Perform a 1st trimester medical abortion
- Perform a 1st trimester surgical abortion
- Manage common complications of induced abortion
- Triage major complications of induced abortion

**Medical Knowledge**
- Compare and contrast the indications, contraindications, and complications of medical and surgical abortion
- List appropriate preoperative laboratory studies and diagnostic imaging needed in the management of induced abortion
- Describe the protocols for medical and surgical abortion
- Develop a plan for management of common complications of induced abortion such as infection, hemorrhage, retained products of conception, genital trauma, and persistently elevated hCG
- Describe how to triage major complications of induced abortion

**Practice-Based Learning and Improvement**
- Maintains logs of cases and competencies
- Incorporates experience and scientific evidence into clinical practice
- Learns from mistakes and accepts constructive criticism

**Interpersonal and Communication Skills**
- Counsel a patient on contraception and sexually transmitted diseases
- Counsel a patient on the risks, benefits and alternatives to medical and surgical abortion
- Communicates effectively with colleagues and staff
- Maintains timely, accurate and legible records
- Teaches students effectively
Professionalism
- Demonstrates honest and ethical behavior
- Maintains patient confidentiality
- Accepts responsibility for patient care
- Provides medically accurate, unbiased information on options and risks of induced abortion
- Accepts preferences and psychosocial attitudes of patients
- Maintains appropriate demeanor and appearance
- Respects others

Systems-Based Practice
- Demonstrates awareness of different healthcare insurance models
- Demonstrates awareness of factors limiting access to healthcare including cost

LEARNING RESOURCES AND TEXTS:
Glick E, Surgical Abortion, 1998
Apuzzio JJ, Vintzileos AM, Operative Obstetrics, 3rd Ed 2006

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the completion of this rotation, the resident physician should be able to:
- List topics which should be discussed when counseling and obtaining consent for induced abortion
- List preoperative laboratory studies and diagnostic imaging needed in the management of induced abortion and the rationale for them
- Describe the protocols for the medical and surgical induction of abortion including management of complications
- Compare and contrast the indications, contraindications, and complications of medical and surgical abortion

PERFORMANCE SKILLS: At the completion of this rotation, the resident physician should be able to:
- Counsel a patient on options for termination of non-viable pregnancy
- Obtain a proper consent for surgical abortion
- Determine gestational age and viability of early pregnancy
- Perform and manage a medical induction of abortion
- Perform and manage a 1st trimester surgical abortion
- Manage common complications of induced abortion
- Triage major complications of induced abortion
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**ROTATION:** Obstetrics (OB) PGY 1

**LOCATION:** UMC Hospital

**DURATION:** 4 months

**Patient Care**
- Conduct a thorough evaluation of pregnant patients presenting with signs of labor.
- Triage pregnant patients to admission, surgery, or discharge
- Perform examinations, history and physical, ultrasound and other indicated tests.
- Notify senior residents of all admissions, discharges or complications

**Medical Knowledge**
- Analyze dysfunctional labor using Friedman labor curves
- Describe conditions that precede the development of dystocia
- Identify conditions that require electronic fetal monitoring and interpret uterine function and fetal heart rate tracings
- Assess fetal lie and presentation by means of physical examination and obstetrical ultrasound
- Conduct a normal spontaneous vaginal delivery
- Repair an episiotomy
- Assist at cesarean section

**Practice-based Learning and improvement**
- Identify conditions that require consultation
- Record and submit documentation of your clinical experience
- Maintain case statistics and procedure competency log.

**Interpersonal and Communication Skills**
- Utilize consultants appropriately, e.g., continuing management is uncertain when elements of the history and/or physical examination are unclear, ambiguous, or confusing; when there is a question about the interpretation of electronic monitoring findings, diagnostic imaging studies or laboratory results; when procedures require advanced competence

**Professionalism**
- Appear and act appropriate
- Establish a relationship of mutual respect between the patient, her support group, peers, students, and support staff.
- Communicate effectively with the patient, her support group, peers, students, and support staff.
- Accept constructive criticism in a mature fashion
- Correct deficiencies and display an eagerness and ability to learn.

**Systems-based Practice**
- Utilize consultants appropriately. Work as a team player with colleagues, get help when procedures require advanced competence
LEARNING RESOURCES AND TEXTS:


STUDY GUIDELINES FOR GOALS AND OBJECTIVES

**LEARNING OBJECTIVES**: At the conclusion of this rotation, the resident physician should be able to:

- analyze dysfunctional labor
- describe conditions that precede the development of dystocia
- identify conditions that require electronic fetal monitoring and interpret uterine function and fetal heart rate tracings
- identify conditions that require consultation

**PERFORMANCE SKILLS**: At the conclusion of this rotation, the resident physician should be able to:

- assess fetal lie and presentation by means of physical examination and obstetrical ultrasound
- conduct a normal spontaneous vaginal delivery
- repair an episiotomy
- assist at cesarean section
- record and submit documentation of your clinical experience
Residency Program Goals and Objectives

**Rotation:** Gynecology (GYN) PGY-1  
**Location:** UMC Hospital  
**Duration:** 1 month

### Patient Care
- Efficiently elicit a thorough history from the patient or patient’s representative
- Perform a thorough physical and be able to report the physiologic and anatomic bases of normal and abnormal findings.
- Recognize and describe appropriate treatment and clear with attending
- Monitor patient progress; respond to change in patient condition during medical treatment
- Identify and initiate corrective action for laboratory abnormalities
- Conduct a thorough preoperative evaluation of patients requiring surgery with particular emphasis on addressing medical, socioeconomic, ethical, and medicolegal matters
- Manage routine pre- and postoperative care of the gynecologic patient
- Medical management of appropriate Gyn problems
- Perform a diagnostic laparoscopy
- Perform a diagnostic hysteroscopy
- Perform a tubal sterilization procedure

### Medical Knowledge
- Review the elements of preoperative evaluation and management including medical, socioeconomic, ethical and medicolegal matters
- Assess carefully various types of anesthesia, the indications, contraindications and complications of each
- Categorize cervical dysplasias, and their appropriate diagnosis and treatment
- Detail the technique of dilation and curettage, cervical biopsy, endocervical curettage and endometrial biopsy; list the indications, contraindications, complications, and post-procedure management of each
- Describe the technique for performing a laparoscopy with particular emphasis on instrumentation and safety
- State the indications, contraindications, complications and failure rate of tubal sterilization procedures
- Describe the technique for performing hysteroscopy with particular emphasis on instrumentation and safety
- List the indications, contraindications and complications of hysteroscopy
- Describe surgical techniques for the treatment of adnexal conditions including ovarian cystectomy, salpingo-oophorectomy, salpingectomy, and salpingostomy
- Anticipate the risks and benefits of anesthetic techniques used during surgery
- Perform directed biopsies, dilation and curettage, endocervical curettage, and endometrial biopsy
- Biopsy and treat vulvovaginal conditions
- Assist at laparotomy
- Manage routine pre- and postoperative care of the gynecologic patient
Practice-Based Learning and Improvement
- Record and submit documentation of your clinical experience
- Maintain case statistics and procedure competency log

Interpersonal and Communication Skills
- Participate in the education of medical students including meaningful evaluation
- Communicate and cooperate with paraprofessional staff

Professionalism
- Cooperate in medical student and paraprofessional education
- Record and submit documentation of your clinical experience

Systems-Based Practice
- Review the elements of preoperative evaluation and management including medical, socioeconomic, ethical and medico-legal matters
- Conduct a thorough preoperative evaluation of patients requiring surgery with particular emphasis on addressing medical, socioeconomic, ethical, and medico-legal matters

LEARNING RESOURCES AND TEXTS:

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- know the elements of preoperative evaluation and management including medical, socioeconomic, ethical and medico-legal matters
- assess carefully various types of anesthesia, the indications, contraindications and complications of each type
- categorize cervical dysplasias, and their appropriate diagnosis and treatment
- detail the technique of dilation and curettage, cervical biopsy, endocervical curettage and endometrial biopsy; list the indications, contraindications, complications, and post-procedure management of each
- describe the technique for performing a laparoscopy with particular emphasis on instrumentation and safety
- state the indications, contraindications, complications and failure rate of tubal sterilization procedures
- describe the technique for performing hysteroscopy with particular emphasis on instrumentation and safety
- list the indications, contraindications and complications of hysteroscopy
- describe surgical techniques for the treatment of adnexal conditions including ovarian cystectomy, salpingo-oophorectomy, salpingectomy, and salpingostomy

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- perform directed biopsies, dilation and curettage, endocervical curettage, and endometrial biopsy
- biopsy and treat vulvovaginal conditions
- assist at laparotomy
- manage routine pre- and postoperative care of the gynecologic patient
- perform a diagnostic laparoscopy
- perform a diagnostic hysteroscopy
- perform a tubal sterilization procedure
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Residency Program Goals and Objectives

ROTATION: Maternal Fetal Medicine (MFM) and OB Ultrasound PGY-1

LOCATION: MFM Offices, UMC, Sunrise Hospital

DURATION: One month

Patient Care
- Assess and propose a management plan for patients with obstetrical, medical, and fetal conditions
- Identify fetal lie and presentation, amniotic fluid volume, placental location and grade on an ultrasound scan.
- Record and submit documentation of your clinical experience

Medical Knowledge
- Describe the clinical assessment required for patients with common obstetrical complications of pregnancy: hypertensive disorders, premature labor and premature rupture of the membranes, third trimester bleeding
- Describe the clinical assessment required for patients with these medical complications during pregnancy: diabetes mellitus, maternal cardiac disease
- Describe the clinical assessment for the following fetal conditions: common fetal malformations, multiple gestation
- Describe the basic components of a level one ultrasound examination
- Discuss the physics of ultrasound as they relate to the available equipment and patient characteristics
- Explain how fetal pathophysiology is reflected in the elements of the biophysical profile and the non stress test (NST)

Practice-Based Learning and Improvement
- Record and submit documentation of your clinical experience
- Maintain statistics and procedure competency log

Interpersonal and Communication Skills
- Communicate and cooperate with paraprofessionals and colleagues
- Cooperate with the certified nurse midwife personnel and medical students

Professionalism
- Record and submit documentation of your clinical experience
- Act and appear appropriate with patients and paraprofessionals

Systems-Based Practice
- Review elements of high risk obstetric patients that need consultation and guidance of perinatologists

LEARNING RESOURCES AND TEXTS:

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the completion of this rotation, the resident physician should be able to:

- describe the clinical assessment required for patients with common obstetrical complications of pregnancy: hypertensive disorders, premature labor and premature rupture of the membranes, third trimester bleeding
- describe the clinical assessment for fetal conditions: common fetal malformations, multiple gestation
- describe the basic components of a level one ultrasound examination
- discuss the physics of ultrasound
- explain how fetal pathophysiology is reflected in the elements of the biophysical profile and the NST

PERFORMANCE SKILLS: At the completion of this rotation, the resident physician should be able to:

- assess and propose a management plan for patients with obstetrical, medical and fetal conditions
- identify fetal lie and presentation, amniotic fluid volume, placental location and grade on an ultrasound scan
- record and submit the documentation of your clinical experience
- perform appropriate and accurate Level I ultrasound of pregnant patients.
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Rotation: Ambulatory Care (OPC) PGY-1
Location: Women's Healthcare Center of Las Vegas

Patient Care
- Conduct a routine ambulatory gynecologic visit including appropriate use of diagnostic imaging and laboratory studies
- Identify and provide care for common gynecologic conditions, e.g., contraception, lower genital tract infections, abnormal uterine bleeding
- Conduct a routine antepartum visit and manage minor problems of pregnancy, e.g., headache, backache, constipation
- Conduct a routine ambulatory gynecologic visit including appropriate use of diagnostic imaging and laboratory studies
- Conduct a routine antepartum visit and manage minor problems of pregnancy, e.g., headache, backache, constipation

Medical Knowledge
- Describe the conduct of an annual gynecologic examination
- Describe the rationale of a routine antepartum visit
- Describe common maternal complications of pregnancy, e.g., bleeding, hypertension, preterm labor
- Identify and provide care for common gynecologic conditions, e.g., contraception, lower genital tract infections, abnormal uterine bleeding
- Identify the pregnancy at risk for complications and procedures for the referral of same

Practice-Based Learning and Improvement
- Review fundamentals of an ambulatory practice as demonstrated in the PCC, including scheduling
- Review the importance of generating a complete medical record, the completion of documents required for coding and correct billing
- Record and submit the documentation of your clinical experience

Interpersonal and Communication Skills
- Identify conditions that require consultation
- Utilize consultants appropriately when procedures require advanced competence
- Communicate accurate, pertinent patient information to colleagues and staff

Professionalism
- Record and submit the documentation of your clinical experience
- Punctual attendance
- Appear and perform in appropriate manner

Systems-Based Practice
- Review fundamentals of an ambulatory practice as demonstrated in the PCC, including scheduling, generating a complete medical record, the completion of documents required for correct billing
- Identify conditions that require consultation
- Utilize consultants appropriately when diagnoses or procedures require advanced competence
LEARNING RESOURCES AND TEXTS:


STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the completion of this rotation, the resident physician will understand:

- the conduct of an annual gynecologic examination
- the rationale of a routine antepartum visit
- common maternal complications of pregnancy, e.g., bleeding, hypertension, preterm labor
- fundamentals of an ambulatory practice as demonstrated in the PCC, including scheduling, generating a complete medical record, and completion of documents required for correct billing.

PERFORMANCE SKILLS: At the completion of this rotation, the resident physician should be able to:

- conduct a routine ambulatory gynecologic visit including appropriate use of diagnostic imaging and laboratory studies
- identify and provide care for common gynecologic conditions, e.g., contraception, lower genital tract infections, abnormal uterine bleeding
- conduct a routine antepartum visit and manage minor problems of pregnancy, e.g., headache, backache, constipation
- identify the pregnancy at risk for complications and procedures for the referral of same
- identify conditions that require consultation
- record and submit documentation of your clinical experience
Residency Program Goals and Objectives

**ROTATION:** Neonatal Intensive Care (NICU) PGY-1

**LOCATION:** UMC Hospital

**DURATION:** 2-4 weeks

**Patient Care**
- Recognize clinical and laboratory signs of sick newborn and develop appropriate treatment plans
- Establish vascular access
  - Umbilical artery catheterization
  - Umbilical vein catheterization
  - Peripheral venous line
  - Peripheral arterial line
- Develop procedural skills in newborn resuscitation and emergency intervention

**Medical Knowledge**
- Develop procedural skills in newborn resuscitation and emergency intervention
- Understand the pathophysiology and treatment of common newborn diseases
- Recognize clinical and laboratory signs of sick newborn and develop appropriate treatment plans
- Recognize common congenital malformation and syndromes
- Recognize the importance of long term neurological outcome
- Be familiar with intubation and mechanical ventilation
- Understand the importance of the coordination between Neonatologist and OB/GYN for the High-Risk obstetrical patients and babies

**Practice-Based Learning and Improvement**
- Record documentation of clinical experience
- Maintain case statistics and procedural competency log

**Interpersonal and Communication Skills**
- Communicate and cooperate with students, paraprofessionals, consultants
- Participate in educational experience of colleagues.

**Professionalism**
- Understand the importance of the coordination between Neonatologist and Obstetrician.
- Function and appear in professional manner
- Adhere to professional code of ethics

**Systems-Based Practice**
- Recognize the importance of long-term neurological outcome.
- Understand effective communication with colleagues and parents of neonate.

**LEARNING RESOURCES AND TEXTS:**


STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the completion of this rotation, the resident physician should be able to:

- understand the importance of the coordination between Neonatologist and Obstetrician.
- develop procedural skills in newborn resuscitation and emergency intervention
- understand the pathophysiology and treatment of common newborn diseases
- recognize clinical and laboratory signs of sick newborn and develop appropriate treatment plans
- recognize common congenital malformation and syndromes
- recognize the importance of long term neurological outcome

PERFORMANCE SKILLS: At the completion of this rotation, the resident physician should be able to:

- accomplish intubation and mechanical ventilation of neonate
- establish vascular access including:
  - umbilical artery catheterization
  - umbilical venous catheterization
  - peripheral venous line
  - peripheral arterial line
OVERVIEW

EDUCATIONAL PURPOSE
The purpose of this two week rotation is to provide education and experience in the care of patients requiring acute critical care. Patients can be admitted through the Emergency Department, accepted in transfer from the floor, or accepted in transfer from another acute care facility. At the conclusion of this rotation, residents will have gained insight into the diagnosis and management of critically ill patients, the role of subspecialty consultation in the management of acutely ill patients, diagnostic and therapeutic methods, the natural history of disease and strategies for cost-effective and evidence-based evaluation and treatment. This curriculum was developed from the “Guidelines for Resident Physician Training in Critical Care Medicine”, Guidelines/Practice Parameters Committee, American College of Critical Care Medicine of the Society of Critical Care Medicine (Crit Care Med, Nov 1995; 23(11): 1920-1923.)

Intensive care residents will provide care to the patients under the supervision of an intensive care attending physician. The most senior resident will supervise, lead, manage and teach junior residents and medical students. Interns are also encouraged to participate in the supervision and teaching of medical students.

TEACHING METHODS
The rotation will be under the supervision of the attending critical care specialist. The residents will admit all patients to the intensive care unit, write the initial notes, begin therapy, and discuss the presentation, management and any diagnostic/therapeutic strategies with the attending intensivist. After reviewing the case and examining the patient, the intensivist will plan, with the resident, for any further investigation(s) and treatment(s) of the patient.

Daily rounds will occur with the attending physician no later than 9 am, at which time instruction in the unique aspects of critical care will be provided. The residents and attending will review and discuss any required reading and/or presentations.

In addition, to clinical teaching during rounds, there will be daily didactic rounds that will encompass topics in critical care medicine chosen by the faculty. Daily didactic sessions will be no longer than 1 hour after morning patient rounds. A schedule will be posted for all lectures. Residents are expected to review the available material (available on the departmental shared drive) prior to each session. Four high fidelity simulation sessions will be incorporated into the scheduled didactic sessions. The schedule for the didactic and simulation sessions will be posted every month. Attendance is excused for any resident that is involved in the admission of a
patient at the time of the session, during emergency situations, such as a cardiopulmonary arrest in the ICU, on a scheduled day off, and in the evaluation of an acutely ill patient during the didactic session. Otherwise attendance is required and there will be a sign in sheet to document attendance. Any other excused attendance will be discussed between the attending and resident. Residents will have access to and are expected to review the didactic materials (from a shared drive) for any sessions they miss due to illness / days off / other clinical emergencies.

MIX OF DISEASES AND COMMON CLINICAL PRESENTATIONS

A. Cardiovascular: recognition and acute management of
   a. Circulatory shock: cardiogenic, hypovolemic, septic, neurogenic
   b. myocardial infarction
   c. aortic dissection
   d. cardiac tamponade
   e. acute valvular insufficiency
   f. cardiac arrhythmias
   g. cardiogenic pulmonary edema
   h. acute cardiomyopathies
   i. hypertensive emergencies/urgencies
   j. principles of vasoactive and inotropic therapy
   k. arterial, central venous, and pulmonary artery catheterization and monitoring
   l. cardiovascular physiology in the critically ill patient

B. Metabolic and endocrine: recognition and acute management of
   a. adrenal insufficiency
   b. pheochromocytoma
   c. thyrotoxicosis
   d. myxedema coma
   e. diabetes insipidus
   f. hyperglycemic states: diabetic ketoacidosis, hyperosmolar hyperglycemic state
   g. principles of enteral and parenteral alimentation

C. Gastrointestinal disease: recognition and acute management of
   a. Acute gastrointestinal bleeding
   b. mesenteric ischemia
   c. acute hepatic failure
   d. perforation of viscous
   e. acute pancreatitis
   f. complications of hepatic cirrhosis

D. Hematologic disorder: recognition and acute management of
   a. bleeding disorders
   b. hemolytic disorders
   c. hematologic dysplasias and their complications
   d. sickle cell crisis
   e. thrombotic disorders
   f. principles of anticoagulation and fibrinolytic therapy
   g. blood product therapy
h. plasmapheresis for acute disorders including neurologic and hematologic disorders

E. Infectious diseases: recognition and acute management of
   a. Systemic Inflammatory Response Syndromes: SIRS, sepsis, severe sepsis, septic shock
   b. prevention and management of nosocomial infections
   c. opportunistic infections
   d. HIV/AIDS and its associated infections
   e. principles of antibiotic selection and dosage schedules in the critically ill patient

F. Neurologic diseases: recognition and acute management of
   a. coma
   b. drug overdose
   c. acute hydrocephalus
   d. brain death evaluation
   e. cerebrovascular diseases, i.e. ischemic cerebrovascular accidents, intracranial hemorrhage, subarachnoid hemorrhage
   f. status epilepticus
   g. intracranial infection
   h. intracranial hypertension
   i. spinal cord injury
   j. delirium
   k. appropriate use of sedation in the ICU

G. Respiratory diseases: recognition and acute management of
   a. acute and/or chronic respiratory failure
   b. pulmonary embolism
   c. status asthmaticus
   d. massive hemoptysis
   e. pneumothoraces
   f. hypoxemia/hypoxia
   g. hypercapnia
   h. smoke inhalation and injury
   i. difficult airway management
   j. upper airway obstruction including airway foreign body
   k. pneumonia
   l. noncardiogenic pulmonary edema
   m. adult respiratory distress syndrome and acute lung injury
   n. arterial blood gas analysis
   o. oxygen therapy
   p. invasive and noninvasive mechanical ventilation including indications, modes, complications, and weaning

H. Renal: recognition and acute management of
   a. fluid and electrolyte disturbances
   b. acute and chronic renal insufficiency
   c. acid-base disorders
   d. drug dosing in renal insufficiency
   e. fluid and electrolyte therapy in the critically ill patient
   f. renal replacement therapies
I. Psychiatric: recognition and acute management of
   a. serotonin syndrome
   b. malignant hyperthermia
   c. drug poisonings and toxicities
   d. drug and alcohol withdrawal
   e. delirium tremens

J. Oncology: recognition and acute management of
   a. blast crisis
   b. cord compression
   c. tumor lysis syndrome

K. Palliative care/ethics/end-of-life care:
   a. advance directives/code status
   b. bioethics
   c. difficult discussions
   d. analgesia in end-of-life care versus palliation
   e. error disclosure
   f. decision making and surrogates
   g. utilization of medical resources

Patient Characteristics
The patient population is diverse, male and female, of all ages from adolescent to geriatric, representing most ethnic and racial backgrounds, from all social and economic strata. The hospital serves primarily the medically underserved population of the city of Las Vegas.

Types of Clinical Encounters
All patient encounters are in the inpatient medical intensive care setting as the primary care team.

Close interactions with various other healthcare team members including consultants, care managers, discharge planners, home health agency representatives, inpatient nurses, respiratory therapists, physical therapists, and patient care technicians occur daily.

Resident Supervision
Residents have readily available on site supervision as well as daily personal supervision in their patient care. Intensivists are available 24 hours daily. It is expected that residents will notify the intensivist of any acute and/or critical changes in patients regardless of the time of day. Additionally, it is expected that residents will contact the intensivist for guidance or clinical support (including a request to come to the ICU overnight) in the event of a clinical situation being considered unsafe for patient (i.e. more admissions than the current level of resident staffing can handle, procedures that are urgently required without available credentialed residents, or an unstable patient that actively requires a level of expertise beyond that of the resident).

Procedures and Services
Procedures and services include those typically performed in an intensive care unit:
   - endotracheal intubation
   - central venous catheter placement
- arterial catheter placement
- lumbar puncture
- diagnostic and therapeutic paracentesis
- diagnostic and therapeutic thoracentesis
- management of mechanical ventilation (both invasive and non-invasive)
- use of ultrasound in diagnostic and therapeutic roles
- hemodynamic monitoring and management.

Didactic Teaching
Attending Rounds - daily
Didactic Sessions will be held daily as stated above in Teaching Method. These sessions will be moderated by critical care medicine faculty physicians. They will occur every day for 45 - 60 minutes after regular management rounds. Each resident is required to review intensive care topics.

CORE READING MATERIALS
Collection of seminal articles in critical care medicine available on the UNSOM shared drive “Pulmonary / Critical Care” folder.
Harrison’s Principles of Internal Medicine, 16th ed., McGraw Hill
Cardinal Manifestations of Disease, pp. 53 - 360.
Irwin and Rippe's Intensive Care Medicine, 6th ed, Lippincott Williams & Wilkins
Housestaff Syllabus, 1999
Reading Syllabus, Division of Pulmonary and Critical Care Medicine, 1998

Ancillary Educational Materials
Subspecialty Texts of Cardiology, Neurology, Pulmonary Medicine, Nephrology, Endocrinology, Infectious Diseases, Rheumatology, as well as General Medical References are available 24 hours a day, seven days a week in the resident lounge.
Savitt Medical Library On-Line
Residents have access to the on-line services of the University of Nevada Las Vegas via their personal computer and in the resident room. Access to this room is available 24 hours a day, seven days a week.

Full text is available for many peer-review journals including, but no limited to:
ACP Journal Club
American Journal of Respiratory and Critical Care Medicine
Annals of Internal Medicine
British Medical Journal
Cancer
Chest
Circulation
Critical Care Medicine
Journal of the American College of Cardiology
The Lancet
New England Journal of Medicine
Stroke
Also available on-line:
Harrison’s Principles of Internal Medicine, 14th ed.
Guide to Clinical Preventive Services, 2nd ed.
The Cochrane Library
Medline and GratefulMed Databases

Pathological Material and Other Educational Resources
Residents are expected to review the pathological reports on patients for whom they have cared and to follow the hospital care of those patients. If a patient for whom the resident has cared should die and have an autopsy, the resident is encouraged to attend the post-mortem session.

Training Sites

University Medical Center
All of the medical intensive care experience occurs at University Medical Center (UMC) under the supervision of one of the full-time critical care attendings.

The goals of the intensive care rotation should be achieved through the following learning venues, and will be evaluated as per the following chart:

Competency-based Goals and Objectives
Intensive Care Unit Rotation

<table>
<thead>
<tr>
<th>Learning Venues</th>
<th>Evaluation Methods</th>
<th>Level Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Direct patient care/consultations</td>
<td>A. Attending evaluation</td>
<td>R-1 = 1</td>
</tr>
<tr>
<td>2. Attending Rounds</td>
<td>B. Direct Observation</td>
<td>R-2 = 2</td>
</tr>
<tr>
<td>3. Residency core lecture series</td>
<td>C. Nurse/Ancillary staff evaluations</td>
<td>R-3 = 3</td>
</tr>
<tr>
<td>4. Self study</td>
<td>D. Written Examination</td>
<td></td>
</tr>
<tr>
<td>5. Morning Reports</td>
<td>E. Resident/Self Evaluation</td>
<td></td>
</tr>
<tr>
<td>6. ACLS/Airway Training</td>
<td>F. Patient Evaluation</td>
<td></td>
</tr>
</tbody>
</table>

Competency Patient Care

<table>
<thead>
<tr>
<th>Learning Venues</th>
<th>Evaluation Methods</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiently elicit a thorough, hypothesis-driven history from the patient or patient’s representative.</td>
<td>1, 2, 4, 5</td>
<td>A, B, C, E</td>
</tr>
<tr>
<td>Perform a thorough physical and be able to report the physiologic and anatomic bases of normal and abnormal findings.</td>
<td>1, 2</td>
<td>A, B, C</td>
</tr>
<tr>
<td>Obtain old records including, but not limited to, discharge summaries, blood and fluid analysis, and results of radiographic studies.</td>
<td>1, 2</td>
<td>A, C, E</td>
</tr>
<tr>
<td>Generate differential diagnosis, define and initiate therapeutic plan, and modify</td>
<td>1, 2, 3, 4, 5</td>
<td>A, B, D, E</td>
</tr>
</tbody>
</table>
therapy, as needed.

<table>
<thead>
<tr>
<th>Competency Patient Care</th>
<th>Learning Venues</th>
<th>Evaluation Methods</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write orders for patients requiring admission to the critical care unit with attention to nutrition (enteral and parenteral), IV fluids, sedation, analgesia, neuromuscular blockade, after airway maintenance (not induction) and antibiotics.</td>
<td>1, 2, 3, 4, 5</td>
<td>A, B, C, D, E</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Make informed decisions and recommendations about preventive, diagnostic and therapeutic options and interventions based upon clinical judgment, scientific evidence and patient preference.</td>
<td>1, 2, 3, 4, 5</td>
<td>A, B, C, D, E</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Provide initial consultation and direct the management of patients.</td>
<td>1, 2, 5</td>
<td>A, B, C, E</td>
<td>2, 3</td>
</tr>
<tr>
<td>Recognize and initiate appropriate treatment and notify attending for specific emergency situations.</td>
<td>1, 2, 3</td>
<td>A, E</td>
<td>2, 3</td>
</tr>
<tr>
<td>Demonstrate competency in airway management (maintenance of an open airway in the non-intubated patient, ventilation by bag-mask systems, tracheal intubation, recognition and management of pneumothorax).</td>
<td>1, 2, 3, 4, 5, 6</td>
<td>A, B, C, D, E</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Demonstrate competency in circulatory management (arterial puncture and cannulation, insertion of central venous catheters, pericardiocentesis in acute tamponade, dynamic electrocardiogram interpretation, cardioversion, pulmonary artery catheterization, transcutaneous pacing).</td>
<td>1, 2, 3, 4, 5, 6</td>
<td>A, B, C, D, E</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Monitor patient progress; respond to change in patient condition during medical treatment and interventional procedures.</td>
<td>1, 2</td>
<td>A, B, C, E, F</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Identify and initiate corrective action for common laboratory abnormalities and procedure complication.</td>
<td>1, 2, 3, 5</td>
<td>A, B, C, D, E</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Focus primarily on learning the skills and techniques that lead to successful procedural outcomes.</td>
<td>1, 2</td>
<td>A, B, C, D, E</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Be willing and able to assist junior colleagues in skill acquisition.</td>
<td>1, 2</td>
<td>A, B, C, D, E</td>
<td>2, 3</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Know presentation and management of common diseases (i.e. GI bleed, sepsis and septic shock, respiratory failure, intracranial hemorrhage, acute renal failure, hepatic failure, cardiac arrhythmia, hypertensive crisis and neurological illness).</td>
<td>1, 2, 3, 4, 5</td>
<td>A, B, D</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Know indication and interpretation of EKG, Chest X-Ray, echocardiography, CT or MRI scans of brain, chest, abdomen, pelvis, and extremities, and PFT.</td>
<td>1, 2, 3, 4</td>
<td>A, B, D</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Knowledge of the principles of sedation, analgesia, and neuromuscular blockade in critically ill patients.</td>
<td>1, 2, 3, 4</td>
<td>A, B, C, D</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Know BLS and ACLS protocols.</td>
<td>1, 2, 3, 4</td>
<td>A, B, D</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Be able to recall the basic differential diagnosis for each item in their problem list with particular attention to those diagnoses that are</td>
<td>1, 2, 3, 4</td>
<td>A, B, D</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Recognize common complications of critical care and then initiate the appropriate therapy.</td>
<td>1, 2, 3, 4</td>
<td>A, D</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Recognize the indications for transfer of patient care to and from an intensive care unit setting.</td>
<td>1, 2</td>
<td>A, B, C</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Interact in an effective way with physicians, residents, nurses and medical support staff.</td>
<td>1, 2</td>
<td>A, B, C</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Interact in an effective way with physicians, residents, nurses and medical support staff.</td>
<td>1, 2</td>
<td>A, B, C</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td><strong>Competency: Professionalism</strong></td>
<td><strong>Learning Venues</strong></td>
<td><strong>Evaluation Methods</strong></td>
<td><strong>Level</strong></td>
</tr>
<tr>
<td>Treat team members, primary caregivers, and patients with respect and empathy.</td>
<td>1, 2</td>
<td>A, B, C, E, F</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Understand, practice and adhere to a code of medical ethics.</td>
<td>1, 2</td>
<td>A, B, C, E</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Participate actively during rounds.</td>
<td>1, 2</td>
<td>A, B, C</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>Attend and participate in all scheduled conferences.</td>
<td>3, 5</td>
<td>Attendance, A</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td><strong>Competency: Practice-Based Learning</strong></td>
<td><strong>Learning Venues</strong></td>
<td><strong>Evaluation Methods</strong></td>
<td><strong>Level</strong></td>
</tr>
<tr>
<td>Incorporate case studies with relevant research outcomes and report those findings during clinical rounds.</td>
<td>1, 2, 4, 5</td>
<td>A, E</td>
<td>2, 3</td>
</tr>
</tbody>
</table>
Review the outcomes of patient care in order to reflect on the approach taken in the delivery of care.

| 1, 2, 4, 5 | A, E | 2, 3 |

Utilize established practice guidelines for individual diseases to devise care strategies.

| 1, 2, 4, 5 | A, E | 2, 3 |

4. Identify limitations of one’s medical knowledge in evaluation and management of patients and use medical literature (primary and reference) to address these gaps in medical knowledge.

| 1, 2, 4, 5 | A, E | 1, 2, 3 |

**Competency: Systems-Based Practice**

<table>
<thead>
<tr>
<th>Learning Venues</th>
<th>Evaluation Methods</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understand need for effective communication between multiple caregivers (i.e. emergency room, critical care unit, nurses, physicians, transporters, outpatient clinic, radiology, chest pain center, echo technicians).</td>
<td>1, 2, 3, 4</td>
<td>A, E</td>
</tr>
<tr>
<td>2. Understand clinical trial design and the statistical methods for evaluating scientific studies, in cooperation with attendings and research nurses/personnel.</td>
<td>1, 2, 3, 4, 5</td>
<td>A, B, C, E</td>
</tr>
<tr>
<td>3. Understand and utilize patient safety network reporting systems to identify and record both patient hazards and harms presenting as near-misses or different degrees of adverse events.</td>
<td>1, 2</td>
<td>A, B, C, D</td>
</tr>
</tbody>
</table>

**EVALUATION**

**A. Of Residents**
At the completion of each rotation, all clinical faculty are required to complete the standard ABIM resident evaluation form. All clinical faculty are required to provide face-to-face feedback with the residents. In addition, residents may receive interim feedback utilizing the ABIM’s Praise and Early Warning cards. Additionally, an examination covering the topics presented in didactic sessions and on clinical rounds will be administered on the last Friday of the rotation. In the event of a resident being unavailable that day (i.e. due to call schedule, days off, or illness) they will be required to make alternate arrangements with the Pulmonary / Critical Care faculty to complete the exam.

**B. Of Rotation and Preceptor**
All residents are encouraged to evaluate the rotation, and the clinical faculty member at the completion of the rotation. This evaluation form is included at the end of this
document. These evaluations are then converted to type and shared anonymously with the clinical faculty.

The program director also discusses the rotation with the residents to ensure rotation quality and satisfaction.

**Critical Care Rotation Resident Check List**

1. Evaluation reviewed at mid-block and end of rotation by the supervising faculty member and resident.

2. Completed assigned readings

3. Attended all assigned activities (excluding scheduled time away, required clinics and emergencies).

4. Completed required case report abstracts and/or posters if assigned by the supervising faculty member.

5. Demonstrated understanding of the basic principles of critical care

6. Receive verbal feedback from attending at end of rotation.
University of Nevada Las Vegas
School of Medicine
Department of Obstetrics and Gynecology
Residency Program Goals and Objectives

**Rotation:** Obstetrics (OB) PGY-2

**Location:** UMC Hospital

**Duration:** 3 months

**Patient Care**
- Actively manage shoulder dystocia
- Perform a primary cesarean section and manage postoperative complications
- Manage third trimester bleeding
- Manage patients with preterm premature rupture of the membranes
- Manage patients in preterm labor
- Conduct medical induction of labor
- Perform a low forceps or vacuum assisted delivery and manage complications

**Medical Knowledge**
- Describe the indications, contraindications, and complications of an operative delivery
- Generate a differential diagnosis of third trimester bleeding
- Be prepared to actively manage shoulder dystocia
- Develop a strategy for identifying and managing patients with preterm labor
- Develop a strategy for identifying and managing premature rupture of the membranes
- Understand diagnostic imaging and biochemical tests of fetal lung maturity
- Identify indications and technique of vaginal instrument delivery
- State the criteria required for the successful induction of labor
- Identify and manage the cause of third trimester bleeding
- Identify and manage patients with preterm premature rupture of the membranes
- Identify and manage patients in preterm labor
- Understand principals of medical induction of labor

**Practice-Based Learning and Improvement Interpersonal and Communication Skills**
- Utilize diagnostic imaging or biochemical means to test fetal lung maturity
- Assist colleagues with cesarean deliveries
- Record and submit documentation of your clinical experience

**Interpersonal and Communication Skills**
- Cooperate in medical student instruction
- Participate in the education of colleagues and paraprofessionals

**Professionalism**
- Cooperate in medical student evaluation
- Participate in the meaningful evaluation of colleagues and paraprofessionals
- Record and submit documentation of your clinical experience

**Systems-Based Practice**
- Maintain case statistics and procedure competency log
- Establish team player concept with other professionals
LEARNING RESOURCES AND TEXTS:


STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- Describe the indications, contraindications, and complications of an operative delivery
- Generate a differential diagnosis of third trimester bleeding
- Be prepared to actively manage shoulder dystocia
- Develop a strategy for identifying and managing patients with premature rupture of the membranes and preterm labor
- Evaluate the condition of the fetus by diagnostic imaging or biochemical means
- State the criteria required for the successful induction of labor
- Participate in medical student instruction and evaluation

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- Perform a low forceps or vacuum assisted delivery
- Perform a complicated cesarean section
- Manage third trimester bleeding
- Manage patients with preterm premature rupture of the membranes
- Manage patients in preterm labor
- Deliver patient with shoulder dystocia
- Conduct medical induction of labor
- Provide meaningful evaluation of medical student education
University of Nevada Las Vegas  
School of Medicine  
Department of Obstetrics and Gynecology  
Residency Program Goals and Objectives

**ROTATION:** Gynecology (GYN) PGY-2

**LOCATION:** UMC Hospital, Valley Hospital, Sunrise Hospital

**DURATION:** 4 months

**Patient Care**
- Efficiently elicit a thorough history from a Gynecologic patient
- Perform a thorough Gynecologic physical exam
- Initiate appropriate medical treatment of Gynecologic conditions
- Monitor patient progress appropriately; respond to change in patient condition during treatment
- Identify and initiate corrective action for laboratory abnormalities
- Perform directed cervical biopsies, dilation and curettage, endocervical curettage, and endometrial biopsy
- Biopsy and treat vulvovaginal conditions
- Assist at hysterectomy and Laparotomy
- Manage routine pre- and postoperative care of the gynecologic patient
- Treat a tubal ectopic pregnancy surgically
- Perform a diagnostic laparoscopy
- Perform a diagnostic hysteroscopy
- Perform a tubal sterilization procedure

**Medical Knowledge**
- Review the elements of preoperative evaluation and management including medical, socioeconomic, ethical and medicolegal matters
- Be able to report the physiologic and anatomic basis of normal and abnormal findings.
- Describe the technique for assisting abdominal hysterectomy, and laparotomy procedures
- State the indications, contraindications, and complications of endoscopic procedures
- Describe the technique for performing a laparoscopy with particular emphasis on instrumentation and safety
- State the indications, contraindications, complications and failure rate of tubal sterilization procedures
- Describe the technique for performing hysteroscopy with particular emphasis on instrumentation and safety
- Describe surgical techniques for the treatment of adnexal conditions including ovarian cystectomy, salpingo-oophorectomy, salpingectomy, and salpingostomy
- Assess carefully various types of gynecologic anesthesia, the indications, contraindications and complications of each
- Categorize cervical dysplasias, and their appropriate diagnosis and treatment
- Understand basis for routine pre- and postoperative care of the gynecologic patient

**Practice-Based Learning and Improvement**
- Record and submit documentation of your clinical experience
- Maintain case statistics and procedural competency log

**Interpersonal and Communication Skills**
- Cooperate in medical student instruction and evaluation
- Participate in the education of medical students including meaningful evaluation
Professionalism

- Participate in the meaningful evaluation of colleagues and paraprofessionals
- Record and submit documentation of your clinical experience

Systems-Based Practice

- Utilize the elements of preoperative evaluation and management including medical, socioeconomic, ethical and medicolegal matters

LEARNING RESOURCES AND TEXTS:

Perez-Medina, Font, Diagnostic and Operative Hysteroscopy, 2007

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- describe the elements of preoperative evaluation and management including medical, socioeconomic, ethical and medicolegal matters
- assess various types of gynecologic anesthesia, their indications, contraindications and complications of each
- categorize cervical dysplasias, and the appropriate diagnosis and treatment of each
- Detail the technique of dilation and curettage, cervical biopsy, endocervical curettage and endometrial biopsy; including the indications, contraindications, and complications of each
- describe the technique for assisting an abdominal hysterectomy, and laparotomy
- describe the technique for performing a laparoscopy with particular emphasis on instrumentation and safety
- state the indications, contraindications, complications and failure rate of tubal sterilization procedures
- list the indications, contraindications and complications of hysteroscopy

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- perform directed cervical biopsies, dilation and curettage, endocervical curettage, and endometrial biopsy
- biopsy and treat vulvovaginal conditions
- assist at hysterectomy and Laparotomy
- manage routine pre- and postoperative care of the gynecologic patient
- diagnose and treat a tubal ectopic pregnancy surgically
- perform a diagnostic laparoscopy
- perform a diagnostic hysteroscopy
- perform a tubal sterilization procedure
University of Nevada Las Vegas
School of Medicine
Department of Obstetrics and Gynecology
Residency Program Goals and Objectives

**ROTATION:** Ambulatory Care (OPC) PGY-2

**LOCATION:** Women’s Healthcare Center of Las Vegas

**Patient Care**
- Obtain an accurate and complete history and physical examination emphasizing thyroid, breasts, abdomen, pelvic, and rectal areas
- Diagnose and treat a tubal ectopic pregnancy medically or surgically
- Counsel the geriatric patient with regard to exercise, weight control, nutrition, sexuality and safety
- Catalogue and review the medications geriatric patients take and their compliance
- Prescribe indicated immunizations for geriatric patients
- Arrange for preventative care screening tests on geriatric patients
- Assess the preoperative status of surgical candidate, identifying contraindications in a timely fashion
- Diagnose the origin of a pelvic mass
- Comply with clinic procedures and government regulations that expedite patient care

**Medical Knowledge**
- Recognize the importance of preoperative preparation for surgery with particular emphasis on conditions that can adversely affect surgical success
- Establish criteria for the medical and surgical diagnosis and treatment of an ectopic pregnancy
- Outline the elements of preventative care of the geriatric patient including immunizations, and screening tests
- Recognize the importance of life-style changes on the geriatric patient
- Generate a plan for the evaluation of a pelvic mass including myomata, endometriosis and Tubo ovarian abscess
- Discuss the probable diagnosis of a pelvic mass
- Understand the need for periodic evaluation of the geriatric patient including a review of preventative health
- Know how to counsel the geriatric patient with regard to exercise, weight control, nutrition, sexuality and safety
- Catalogue and review the medications geriatric patients take and their compliance
- Understand reasons and mechanism of immunizations for geriatric patients
- Understand rationale of preventative care screening tests on geriatric patients

**Practice-Based Learning and Improvement**
- Record and submit the documentation of your clinical experience
- Maintain statistics and procedure competency log

**Interpersonal and Communication Skills**
- Develop a strategy for obtaining an accurate and complete history and physical examination
- Cooperate in medical student instruction
- Participate in the education colleagues and paraprofessionals

**Professionalism**
- Obtain an accurate and complete history and physical examination while maintaining patient confidence
- Provide preoperative preparation for surgery with particular emphasis on morbid conditions
- Practice fundamentals of ambulatory care as demonstrated in the PCC, including scheduling, generating a complete medical record, completion of documents required for correct billing
- Cooperate in medical student instruction
- Comply with government regulations that expedite patient care
Arrange for preventative care screening tests on PCC patients
Record and submit the documentation of your clinical experience

**Systems-Based Practice**
- Practice fundamentals of an ambulatory care as demonstrated in the PCC, including scheduling, generating a complete medical record, and completion of documents required for correct billing
- Comply with clinic procedures that expedite patient care

**LEARNING RESOURCES AND TEXTS:**


**STUDY GUIDELINES FOR GOALS AND OBJECTIVES**

**LEARNING OBJECTIVES:** At the conclusion of this rotation, the resident physician should be able to:

- provide a strategy for obtaining an accurate and complete history and physical examination emphasizing the thyroid, breasts, abdomen, pelvic, and rectal areas
- recognize the importance of preoperative preparation for surgery with particular emphasis on morbid conditions
- generate a plan for the evaluation of a pelvic mass including myomata, endometriosis, and Tubo ovarian abscess
- establish criteria for the medical and surgical diagnosis and treatment of gynecologic problems
- review fundamentals of an ambulatory practice as demonstrated in the PCC, including scheduling, generating a complete medical record, and completion of documents required for correct billing
- outline the elements of preventative care of the gynecologic patient including immunizations and screening tests
- recognize the importance of life-style changes on the female patient
- instruct in medical students

**PERFORMANCE SKILLS:** At the conclusion of this rotation, the resident physician should be able to:

- assess the preoperative status of surgical candidate, including contraindications and risk
- diagnose the origin of a pelvic mass
- diagnose and treat a tubal ectopic pregnancy
- comply with clinic procedures and government regulations that expedite patient care
- perform a periodic evaluation of the geriatric patient including a review of preventative health
- counsel the geriatric patient with regard to exercise, weight control, nutrition, sexuality and safety
- catalogue and review the medications geriatric patients take and their compliance
- prescribe indicated immunizations for female patients
- arrange for preventative care screening tests on gynecologic patients
- participate in the meaningful evaluation of medical students
- record and submit the documentation of your clinical experience
University of Nevada Las Vegas  
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Residency Program Goals and Objectives

**ROTATION:** Research PGY-2

**LOCATION:** UMC, UNSOM, 2040 Building, and Associated Offices

**DURATION:** 1 month

**Practice-Based Learning and Improvement**
- Review and critically analyze research in the literature and the potential benefits or harm to patients.

**Patient Care**
- Identify potential study patients and enroll patients willing to participate in medical research project.
- Educate patients on a particular active research project.
- Educate patients on the importance of medical research.

**Medical Knowledge**
- Initiate IRB approved research project
- Analyze collected data and apply the basics of statistical analysis and their interpretation.
- Generate a conclusion on research project.
- Record and submit the documentation of your research project.
- Identify the influence of research project on patient care.

**Interpersonal and Communication Skills**
- Interact with paraprofessionals, project supervisor, and Director of Research in a professional manner.
- Meet with project supervisor and Director of Research on a regular basis.
- Educate patients on a particular on-going research project and educate patients on the importance of medical research.

**Professionalism**
- Appear and act appropriately at all times.
- Accept constructive criticism in a professional manner.
- Maintain HIPPA compliance and patient confidentiality

**Systems-Based Practice**
- Review costs of research.
- Identify benefits of research.
- Identify potential changes to patients' treatment as a result of research findings.

**STUDY GUIDELINES FOR GOALS AND OBJECTIVES**

**LEARNING OBJECTIVES:** At the conclusion of this rotation, the resident physician should be able to:
- Develop and complete a research project.

**PERFORMANCE SKILLS:** At the conclusion of this rotation, the resident physician should be able to:
- Initiate an IRB approved research project
- Complete data collection and analysis
- Begin formulating a formal paper for possible publication.
- Begin formulating a presentation for presentation the Department's Paper Day and national meetings.
- Exhibit professional character while conducting Research.
University of Nevada Las Vegas
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Residency Program Goals and Objectives

**ROTATION:** Clinical Management of Pregnancy Termination, PGY 2-4

**LOCATION:** Birth Control Care Center

**DURATION:** On-going

**Patient Care**
- Provide appropriate contraception counseling
- Appropriately perform a medical induction of abortion
- Appropriately perform a 1st trimester surgical abortion
- Appropriately perform a 2nd trimester surgical abortion
- Appropriate triage of major complications of outpatient pregnancy termination

**Medical Knowledge**
- Describe the proper conditions for obtaining a consent for elective termination of pregnancy
- List the elements in counseling patients for induced abortion
- Indicate appropriate preoperative laboratory studies and diagnostic imaging needed in the management of elective abortion
- Develop a plan for the management of common complications of abortion such as infection, hemorrhage, retained products of conception, genital trauma and continued pregnancy
- Describe the protocols for the medical and surgical abortion
- Compare and contrast the indications, contraindications, and complications of medical and surgical abortion
- Discuss the unlikely long-term sequelae of elective abortion on the psyche, and fertility.
- Describe a plan and protocol for the management of common complications of abortion such as infection, hemorrhage, retained products of conception, genital trauma and continued pregnancy.
- Know how to appropriately triage major complications of outpatient pregnancy termination.
- Obtain a proper consent for abortion
- Properly counsel a patient regarding the performance of a abortion and its unlikely risks and complications.
- Correctly diagnose the duration of early pregnancy by means of physical examination and diagnostic imaging procedures.

**Practice-Based Learning and Improvement**
- Maintain case statistics and procedure competency log

**Interpersonal and Communication Skills**
- Describe the proper conditions for obtaining a consent for therapeutic termination of pregnancy
- Properly counsel a patient regarding the performance of a therapeutic abortion
- Provide appropriate contraception.

**Professionalism**
- Appear and perform in appropriate manner
- Cooperate with paraprofessionals and colleagues

**Systems-Based Practice**
- Summarize those portions of the Nevada Revised Statutes pertinent to therapeutic abortion
LEARNING RESOURCES AND TEXTS:

- Glick E, *Surgical Abortion*, 1998

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the completion of this rotation, the resident physician should be able to:

- summarize those portions of the Nevada Revised Statutes pertinent to therapeutic abortion.
- describe the proper conditions for obtaining a consent for termination of pregnancy
- list the elements in counseling patients for elective abortion with specific consideration of anesthesia, future family planning options and medical and psychological considerations.
- indicate appropriate preoperative laboratory studies and diagnostic imaging needed in the management of abortion and the rationale for them.
- describe the protocols for the medical and surgical abortion including management of complications
- compare and contrast the indications, contraindications, and complications of medical and surgical abortion.
- discuss the lack of long-term sequelae of elective abortion on the psyche, and fertility.

PERFORMANCE SKILLS: At the completion of this rotation, the resident physician should be able to

- obtain a proper consent for therapeutic abortion
- correctly diagnose the duration of early pregnancy by means of physical examination and diagnostic imaging procedures
- perform and manage a medical induction of abortion
- perform and manage a 1st trimester surgical abortion
- perform and manage a 2nd trimester surgical abortion
- Manage common complications of abortion such as infection, hemorrhage, retained products of conception, genital trauma and continued pregnancy.
- Triage major complications of outpatient pregnancy termination.
RESIDENCY PROGRAM GOALS AND OBJECTIVES

Clinical Management of Pregnancy Termination, **Elective** PGY 2-4

**LOCATION:** A-Z Women’s Center

**DURATION:** 1-4 weeks

**Patient Care**
- Provide appropriate contraception counseling
- Appropriately perform a medical induction of abortion
- Appropriately perform a 1st trimester surgical abortion
- Appropriately perform a 2nd trimester surgical abortion
- Appropriate triage of major complications of outpatient pregnancy termination

**Medical Knowledge**
- Describe the proper conditions for obtaining a consent for elective termination of pregnancy
- List the elements in counseling patients for induced abortion
- Indicate appropriate preoperative laboratory studies and diagnostic imaging needed in the management of elective abortion
- Develop a plan for the management of common complications of abortion such as infection, hemorrhage, retained products of conception, genital trauma and continued pregnancy
- Describe the protocols for the medical and surgical abortion
- Compare and contrast the indications, contraindications, and complications of medical and surgical abortion
- Discuss the unlikely long-term sequelae of elective abortion on the psyche, and fertility.
- Describe a plan and protocol for the management of common complications of abortion such as infection, hemorrhage, retained products of conception, genital trauma and continued pregnancy.
- Know how to appropriately triage major complications of outpatient pregnancy termination.
- Obtain a proper consent for abortion
- Properly counsel a patient regarding the performance of a abortion and its unlikely risks and complications.
- Correctly diagnose the duration of early pregnancy by means of physical examination and diagnostic imaging procedures.

**Practice-Based Learning and Improvement**
- Maintain case statistics and procedure competency log

**Interpersonal and Communication Skills**
- Describe the proper conditions for obtaining a consent for therapeutic termination of pregnancy
- Properly counsel a patient regarding the performance of a therapeutic abortion
- Provide appropriate contraception.

**Professionalism**
- Appear and perform in appropriate manner
- Cooperate with paraprofessionals and colleagues

**Systems-Based Practice**
- Summarize those portions of the Nevada Revised Statutes pertinent to therapeutic abortion

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*University of Nevada Las Vegas*
*School of Medicine*
*Department of Obstetrics and Gynecology*
*Residency Program Goals and Objectives*
LEARNING RESOURCES AND TEXTS:

Glick E, *Surgical Abortion*, 1998

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the completion of this rotation, the resident physician should be able to:

- summarize those portions of the Nevada Revised Statutes pertinent to therapeutic abortion.
- describe the proper conditions for obtaining a consent for termination of pregnancy
- list the elements in counseling patients for elective abortion with specific consideration of anesthesia, future family planning options and medical and psychological considerations.
- indicate appropriate preoperative laboratory studies and diagnostic imaging needed in the management of abortion and the rationale for them.
- describe the protocols for the medical and surgical abortion including management of complications
- compare and contrast the indications, contraindications, and complications of medical and surgical abortion.
- discuss the lack of long-term sequelae of elective abortion on the psyche, and fertility.

PERFORMANCE SKILLS: At the completion of this rotation, the resident physician should be able to

- obtain a proper consent for therapeutic abortion
- correctly diagnose the duration of early pregnancy by means of physical examination and diagnostic imaging procedures
- perform and manage a medical induction of abortion
- perform and manage a 1st trimester surgical abortion
- perform and manage a 2nd trimester surgical abortion
- Manage common complications of abortion such as infection, hemorrhage, retained products of conception, genital trauma and continued pregnancy.
- Triage major complications of outpatient pregnancy termination.
University of Nevada Las Vegas  
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**ROTATION:** Obstetrics (OB) PGY-3  
**LOCATION:** UMC Hospital  
**DURATION:** 1-3 months

**Patient Care**
- Perform / teach shoulder dystocia maneuvers
- Perform / teach forceps deliveries
- Perform / teach vacuum extractor deliveries
- Manage patients with PROM, PTL and inductions
- Manage VBAC patients
- Perform difficult cesarean sections
- Assist on cesarean hysterectomy

**Medical Knowledge**
- Describe the indications, contraindications, and complications of an operative delivery
- Generate a differential diagnosis of third trimester bleeding
- Be prepared to actively manage shoulder dystocia
- Develop a strategy for identifying and managing patients with preterm labor
- Develop a strategy for identifying and managing premature rupture of the membranes
- Understand diagnostic imaging and biochemical tests of fetal lung maturity
- Identify indications and technique of vaginal instrument delivery
- State the criteria required for the successful induction of labor
- Identify and manage the cause of third trimester bleeding
- Develop a strategy for identifying and managing patients requiring C/S Hysterectomy

**Practice-Based Learning and Improvement Interpersonal and Communication Skills**
- Utilize diagnostic imaging or biochemical means to test fetal lung maturity
- Assist colleagues with cesarean deliveries
- Record and submit documentation of your clinical experience

**Interpersonal and Communication Skills**
- Cooperate in medical student instruction
- Participate in the education of colleagues and paraprofessionals

**Professionalism**
- Cooperate in medical student evaluation
- Participate in the meaningful evaluation of colleagues and paraprofessionals
- Record and submit documentation of your clinical experience
- Provide meaningful evaluation of medical student education

**Systems-Based Practice**
- Maintain case statistics and procedure competency log
- Establish team player concept with other professionals
LEARNING RESOURCES AND TEXTS:


STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- Describe the indications, contraindications, and complications of an operative delivery
- Generate a differential diagnosis of third trimester bleeding
- Be prepared to actively manage shoulder dystocia
- Develop a strategy for identifying and managing patients with premature rupture of the membranes and preterm labor
- Evaluate the condition of the fetus by diagnostic imaging or biochemical means
- State the criteria required for the successful induction of labor

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- perform a low forceps or vacuum assisted delivery
- perform a difficult cesarean section and assist with C/S hysterectomy
- manage third trimester bleeding
- manage patients with preterm premature rupture of the membranes
- manage patients in preterm labor
- deliver patient with shoulder dystocia
- conduct medical induction of labor
University of Nevada Las Vegas
School of Medicine
Department of Obstetrics and Gynecology
Residency Program Goals and Objectives

**Rotation:**
Gynecology (GYN) PGY-3

**Location:**
UMC Hospital, Valley Hospital, Sunrise Hospital

**Duration:**
1 month

**Patient Care**
- Efficiently elicit a thorough history from the Gynecology patient.
- Perform a thorough gynecologic exam.
- Recognize and initiate appropriate treatment of Gynecologic patients.
- Monitor patient progress; respond appropriately to change in patient condition during treatment.
- Initiate corrective action for laboratory abnormalities.
- Review the indications, complications, and contraindications of surgical procedures such as LAVH, operative laparoscopy, operative hysteroscopy, repair of rectovaginal fistula, laser, cryo and Argon beam treatment of vulvovaginal lesions.
- Perform exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, retropubic bladder suspensions, and laser, cryo anf Argon beam treatment of vulvovaginal lesions, and cystoscopy.

**Medical Knowledge**
- Review the indications, complications, and contraindications of surgical procedures such as exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, repair of rectovaginal fistula, laser, cryo and Argon beam treatment of vulvovaginal lesions.
- Counsel patients requiring major surgical procedures.

**Practice-Based Learning and Improvement**
- Deploy the resident staff effectively and efficiently to meet the needs of the gynecology service and resident education.
- Record and submit documentation of your clinical experience.

**Interpersonal and Communication Skills**
- Evaluate the capabilities of assistant and junior residents, identify areas needing improvement and provide remediation.
- Counsel patients requiring surgical procedures such as exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, repair of rectovaginal fistula, simple vulvectomy, treatment of vulvovaginal lesions, and retropubic bladder suspensions and cystoscopy.
- Direct and supervise junior residents in performing gynecologic surgical skills.
- Support and encourage interpersonal, and interdepartmental, relationships.

**Professionalism**
- Evaluate the capabilities junior residents, identify areas needing improvement and provide remediation.
- Deploy the resident staff effectively and efficiently to meet the needs of the gynecology service and resident education.
- Support and encourage interpersonal, and interdepartmental, relationships.
- Record and submit documentation of your clinical experience.
- Maintain case statistics and procedure competency log.
Systems-Based Practice

- Recognize the importance of compliance with requirements of governmental, hospital, and accrediting agencies
- Support and encourage interpersonal and interdepartmental relationships

LEARNING RESOURCES AND TEXTS:

- Cosson M, Querleu D, Darqent D, *Vaginal Surgery*, 2006

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- review the indications, complications, and contraindications of major surgical procedures such as exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, retropubic bladder suspensions, and vulvovaginal lesions
- recognize the importance of compliance with requirements of governmental, hospital, and accrediting agencies

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- perform exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, retropubic bladder suspensions, and treat vulvovaginal lesions, cystoscopy, and colposcopy
- direct and supervise assistant and junior residents in learning their gynecologic surgical skills
- direct the junior residents to run a safe and effective gynecology service.
University of Nevada Las Vegas
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Residency Program Goals and Objectives

ROTATION: Gynecologic Oncology (ONC) PGY-3
LOCATION: UMC, Valley Hospital, Sunrise Hospital
DURATION: 3 months

**Patient Care**
- Care for complications in gynecologic oncology patients
- Carry out a thorough evaluation of patient with a possible gynecologic malignancy
- Use the laboratory and diagnostic imaging services in a cost-effective way
- Collaborate with an oncologist, patients receiving chemotherapy
- Collaborate with a radiation therapist, patient receiving radiation therapy
- Surgical assist in standard and radical hysterectomy
- Surgical assist for bladder or bowel revisions or diversions
- Surgical assist at second-look or debulking procedures

**Medical Knowledge**
- Adapt history and physical examination strategies for patients with possible gynecologic malignancies
- Review the costs, advantages, disadvantages, indications, contraindications, and complications from diagnostic and therapeutic interventions used in evaluating malignant conditions
- Classify various chemotherapeutic agents used in the treatment of gynecologic malignancies
- Review the use of radiation therapy in the treatment of gynecologic malignancies
- Review the epidemiology of gynecologic cancer
- Describe staging procedures for gynecologic procedures
- Recognize common postoperative complications in gynecologic oncology patients
- Review plans for terminal care of patients with particular regard for using community resources
- Surgical assist at second-look or debulking procedures
- Understand postoperative complications such as, incisional, gastrointestinal, respiratory, hemorrhagic, thrombotic, or infectious conditions

**Practice-Based Learning and Improvement**
- Plan treatment for postoperative complications such as, incisional, gastrointestinal, respiratory, hemorrhagic, thrombotic, or infectious conditions

**Interpersonal and Communication Skills**
- Collaborate with an oncologist, patients receiving chemotherapy
- Collaborate with a radiation therapist, patient receiving radiation therapy
- Counsel patient about terminal illness

**Professionalism**
- Record and submit documentation of your clinical experience
- Maintain case statistics and procedural competency log

**Systems-Based Practice**
- Review the costs, advantages, disadvantages, indications, contraindications, and complications from diagnostic and therapeutic interventions used in evaluating malignant conditions
- Review plans for terminal care of patients with particular regard for using community resources
- Use the laboratory and diagnostic imaging services in a cost-effective way
LEARNING RESOURCES AND TEXTS:

Baggish MS, Barbot J, Valle RF, *Diagnostic and Operative Hysteroscopy, A text and Atlas*, 1999

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- adapt history and physical examination strategies for patients with possible gynecologic malignancies
- review the costs, advantages, disadvantages, indications, contraindications, and complications from diagnostic and therapeutic interventions used in evaluating malignant conditions
- classify various chemotherapeutic agents used in the treatment of gynecologic malignancies
- review the use of radiation therapy in the treatment of gynecologic malignancies
- review the epidemiology of gynecologic cancer, including the most common presenting signs and symptoms
- describe staging procedures for gynecologic procedures
- recognize common postoperative complications in gynecologic oncology patients
- review plans for terminal care of patients with particular regard for using community resources

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- carry out a thorough evaluation of patient with a possible gynecologic malignancy
- use the laboratory and diagnostic imaging services in a cost-effective way
- monitor patients receiving chemotherapy
- monitor patients receiving radiation therapy
- perform a paracentesis
- surgical assist in radical hysterectomy
- surgical assist for bladder or bowel revisions or diversions
- surgical assist at second-look or debulking procedures
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**Rotation:** Ambulatory Care (OPC) PGY-3

**Location:** Women’s Healthcare Center of Las Vegas

**Patient Care**
- Evaluate amenorrhea with or without hirsutism and/or galactorrhea
- Provide contraceptive methods according to acceptance, effectiveness, safety contraindications, and complications
- Counsel patients regarding preconceptual care with particular emphasis on common heritable conditions, serious cardiovascular and metabolic disorders, and other conditions which adversely affect pregnancy
- Integrate physical findings, mammography and breast ultrasonography into a plan of management that will maximize outcome
- Comply with government regulations and clinic routines including scheduling, generating a complete medical record, the completing of documents required for correct coding and billing
- Counsel patients with common heritable diseases including pedigree analysis and surveillance during pregnancy
- Provide ambulatory care to geriatric patients
- Perform gynecologic ultrasound including pelvic anatomy and abnormalities
- Perform endometrial biopsy and vulvar biopsy
- Insert an IUD or Implanon and manage complications

**Medical Knowledge**
- Review fundamentals of an ambulatory practice as demonstrated in the PCC
- Review the essentials specific to the care of the geriatric patient
- Learn concepts and skills of gynecologic ultrasound
- Classify common abnormalities of the female breast including types of nipple discharge, a list of strategies for their detection
- Formulate a strategy for managing a breast mass in the adolescent, women of reproductive age, perimenopause, and menopause
- Indicate the utility of mammography in the surveillance of breast pathology
- Be prepared to evaluate amenorrhea with or without hirsutism and/or galactorrhea
- Classify contraceptive methods according to acceptance, effectiveness, safety and contraindications
- Be prepared to counsel patients regarding preconceptual care with particular emphasis on common heritable conditions, serious cardiovascular and metabolic disorders, and other conditions which adversely affect pregnancy
- Learn concepts and skills of gynecologic ultrasound
- Understand evaluation to diagnose the etiology of amenorrhea with or without hirsutism and/or galactorrhea
- Learn basis for counseling patients with common heritable diseases including pedigree analysis and surveillance during pregnancy

**Practice-Based Learning and Improvement**
- Review fundamentals of an ambulatory practice as demonstrated in the PCC, including scheduling, generating a complete medical record, and the completion of documents required for correct billing
- Use physical findings, diagnostic imaging and clinical laboratory studies to diagnose the etiology of amenorrhea with or without hirsutism and/or galactorrhea
- Counsel patients with serious cardiovascular and metabolic conditions regarding the advisability of pregnancy and alternatives to pregnancy
**Interpersonal and Communication Skills**
- Be prepared to counsel patients regarding preconceptual care with particular emphasis on common heritable conditions, serious cardiovascular and metabolic disorders, and other conditions which adversely affect pregnancy
- Counsel and prescribe contraception in accordance with patient needs
- Counsel patients with common heritable diseases including pedigree analysis and surveillance during pregnancy

**Professionalism**
- Formulate a strategy for managing a breast mass in the adolescent, women of reproductive age, perimenopause, and menopause
- Be aware of governmental regulations and their impact on the delivery of health care
- Classify contraceptive methods according to acceptance, effectiveness, safety contraindications, and complications
- Be prepared to counsel patients regarding preconceptual care with particular emphasis on common heritable conditions, serious cardiovascular and metabolic disorders, and other conditions which adversely affect pregnancy

**Systems-Based Practice**
- Indicate the utility of mammography in the surveillance of breast pathology
- Review fundamentals of an ambulatory practice as demonstrated in the UWC, including scheduling, the importance of generating a complete medical record, the completion of documents required for correct coding and billing, and potential sources of assistance
- Be aware of governmental regulations and their impact on the delivery of health care
- Comply with government regulations and clinic routines including scheduling, generating a complete medical record, the completing of documents required for correct billing, and supporting applications for assistance

**LEARNING RESOURCES AND TEXTS:**


**STUDY GUIDELINES FOR GOALS AND OBJECTIVES**

**LEARNING OBJECTIVES:** At the conclusion of this rotation, the resident physician should be able to:
- classify common abnormalities of the female breast including types of nipple discharge, and list strategies for their detection
- formulate a strategy for managing a breast mass in the adolescent, women of reproductive age, perimenopause, and menopause
- indicate the utility of mammography and ultrasound in the surveillance of breast pathology
- utilize governmental regulations and their impact on the delivery of health care
- evaluate amenorrhea with or without hirsutism and/or galactorrhea
- classify contraceptive methods according to acceptance, effectiveness, safety, contraindications, and complications
- counsel patients regarding preconceptual care with particular emphasis on common heritable conditions, serious cardiovascular and metabolic disorders, and other conditions which adversely affect pregnancy
- review the essentials specific to the care of the geriatric patient
- explain concepts and skills of gynecologic ultrasound
PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- use physical findings, diagnostic imaging and clinical laboratory studies to diagnose the etiology of amenorrhea with or without hirsutism and/or galactorrhea
- counsel and prescribe contraception in accordance with patient needs
- insert an IUD or Implanon and manage complications should they arise
- comply with government regulations and clinic routines including scheduling, generating a complete medical record, the completing of documents required for correct billing, and supporting applications for assistance
- counsel patients with common heritable diseases including pedigree analysis and surveillance during pregnancy
- counsel patients with serious cardiovascular and metabolic conditions regarding the advisability of pregnancy and alternatives to pregnancy
- record and submit the documentation of your clinical experience
- perform basic gynecologic ultrasound including pelvic anatomy, abnormalities, and disease progression
University of Nevada Las Vegas
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**ROTATION:** Maternal-Fetal Medicine (MFM) PGY-3

**LOCATION:** UMC Hospital, Sunrise Hospital, MFM Offices, Summerlin Hospital, Valley Health System

**DURATION:** 1-2 months

**Patient Care**
- Assist with amniocenteses for prenatal diagnosis and fetal lung maturity
- Assist an external cephalic version
- Perform a biophysical profile
- Perform a NST or CST and interpret the results
- Assist with performing a cervical cerclage and manage patient thereafter
- Assist with performing a cesarean hysterectomy; anticipate and manage postoperative complications
- Assist with performing a low transverse, low vertical and classical cesarean section; anticipate and manage postoperative Complications
- Demonstrate proficiency in using ultrasound in obstetrics by identifying and dating a first trimester intrauterine pregnancy, early pregnancy failure, a molar pregnancy, normal fetal anatomy at 18 to 20 weeks, estimating gestational age, and assessing fetal growth

**Medical Knowledge**
- Devise strategies to diagnose and manage multiple gestations
- List the indications, contraindications, and complications of placing a cervical cerclage
- Describe the procedure of placing a cervical cerclage
- List the indications, contraindications and complications of external cephalic version
- Detail the procedure for performing an external cephalic version
- Specify the indications, contraindications and complications of a cesarean hysterectomy
- List the indications, contraindications, and complications of a low transverse, low vertical and classical cesarean section
- Understand the management of an isoimmunized pregnancy
- Understand the management of a post-term pregnancy
- Describe the effect of collagen vascular disease on pregnancy
- Specify the impact of psychiatric disorders on pregnancy
- Formulate a strategy for diagnosing and/or managing comorbid malignant conditions in pregnancy
- List tests of fetal well-being, the indications for their use and limitations of each
- State the basic physical principles of ultrasound and the indications for medical ultrasonography
- Describe the NST, CST and biophysical profile and interpret the results and margin of error of each

**Practice-Based Learning and Improvement**
- Identify, clarify complicated obstetric conditions
- Maintain case statistics and procedure competency log

**Interpersonal and Communication Skills**
- Clarify function and value of Perinatal consultants to OB generalist
- Interact and cooperate with paraprofessionals and perinatologist in professional manner

**Professionalism**
- Record and submit the documentation of your clinical experience
- Appear and act appropriately
- Accept constructive criticism in mature fashion
Systems-Based Practice

- Utilize consultants appropriately to further diagnose, manage and share responsibility of OB generalist patients

LEARNING RESOURCES AND TEXTS:


STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- devise strategies to diagnose and manage multiple gestations
- list the indications, contraindications, and complications of placing a cervical cerclage
- list the indications, contraindications and complications of external cephalic version
- specify the indications, contraindications and complications of a cesarean hysterectomy
- list the indications, contraindications, and complications of a low transverse, low vertical and classical cesarean section
- devise a strategy for managing isoimmunization in pregnancy
- formulate a plan for diagnosing and managing a post-term pregnancy
- describe the effect of collagen vascular disease on pregnancy
- specify the impact of psychiatric disorders on pregnancy
- formulate a strategy for diagnosing and/or managing comorbid malignant conditions in pregnancy
- list tests of fetal well-being, the indications for their use and limitations of each
- state the basic physical principles of ultrasound and the indications for perinatal ultrasonography

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- perform amniocenteses for prenatal diagnosis and fetal lung maturity
- perform an external cephalic version
- perform a biophysical profile
- perform a NST or CST
- assist with placement of cervical cerclage
- assist with a cesarean hysterectomy
- perform a low transverse, low vertical and classical cesarean section
- manage an isoimmunized pregnancy
- manage a post-term pregnancy
- demonstrate proficiency in using ultrasound in obstetrics by identifying and dating a first trimester intrauterine pregnancy, early pregnancy failure, a molar pregnancy, normal fetal anatomy at 18 to 20 weeks, estimating gestational age, and assessing fetal growth
Patient Care

- demonstrate the ability to provide infertility patient care that is compassionate, appropriate, and effective for the treatment of infertility and pregnancy losses and the promotion of health in REI.

Medical Knowledge

- demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences pertinent to infertility and reproductive losses, as well as the application of this knowledge to patient care in ART.

Practice-Based Learning and Improvement

- demonstrate the ability to investigate and evaluate their care of infertility patients while on the ART rotation, to appraise and assimilate scientific evidence pertaining to infertility, ART, and pregnancy losses, and to continuously improve infertility patient care based on constant self-evaluation and lifelong learning in REI;
- identify strengths, deficiencies, and limits in one’s knowledge and expertise in the field of reproductive endocrinology and infertility;
- set learning and improvement goals in REI;
- identify and perform appropriate learning activities pertaining to REI;
- describe the methodology in place at the ART facility to systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- describe how formative evaluation feedback is incorporated into daily practice at the ART facility;
- locate, appraise, and assimilate evidence from scientific studies related to infertility patients’ health problems;
- use information technology to optimize learning during the ART rotation;
- participate in the education of patients, families, students, residents and other health professionals relating to the ART facility.

Interpersonal and Communication Skills

- demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals on the ART rotation
- communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds in providing patient care at the ART facility;
- communicate effectively with physicians, other health professionals, and health related agencies with regard to infertility and pregnancy losses;
- work effectively as a member of the health care team at the ART center;
- demonstrate a medical knowledge base compatible with acting in a consultative role to other physicians and health professionals in matters of infertility and pregnancy loss;
- maintain comprehensive, timely, and legible medical records of all patient care activities conducted while on the ART rotation.
Professionalism

- demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles in the ART setting;
- show compassion, integrity, and respect for patients with infertility or pregnancy losses;
- demonstrate responsiveness to needs of infertility patients;
- manifest respect for patient privacy and autonomy in all aspects of care in the ART facility;
- describe evidence of accountability to patients, society and the profession in the provision of patient care on the ART rotation; and
- demonstrate sensitivity and responsiveness to the diverse patient population with infertility or pregnancy losses, including but not limited to diversity in age, culture, race, religion, disabilities, and sexual orientation.

Systems-Based Practice

- demonstrate an awareness of the place of infertility care and ART within the larger health care system, as well as the ability to call effectively on other resources in the system to provide optimal ART care;
- work effectively in the ART facility;
- explain coordination of infertility treatment and ART within the health care system;
- discuss considerations of cost awareness and risk-benefit analysis in providing ART;
- demonstrate the process for monitoring the level of quality in ART services being provided;
- describe the interactions of inter-professional team members needed in ART, and protocols used to enhance patient safety and improve patient care quality; and
- list methods used in identifying system errors and implementing potential systems solutions in the ART facility.

LEARNING RESOURCES AND TEXTS:


STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- Discuss clinical presentation of developmental anomalies or delayed sexual development
- Manage menstrual disorders using laboratory and imaging studies
- Approach the infertile couple including appropriate surgical conditions
- Discuss potential success of assisted reproductive technology (ART), including cost, risks and complications.
- Evaluate and treat menopausal symptoms and maladies

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- Counseled patients affected with developmental anomalies or delayed sexual development.
- Utilized consultation and referrals appropriately
- Diagnosed and treated ovarian and adrenal endocrinopathies affecting reproductive and hormonal function.
- Diagnosed and treated disorders of menstruation
- Diagnosed and treated infertile couples with common causes of infertility.
- Performed myomectomies and minor uterovaginal anomalies
- Recorded and submitted documentation of his/her clinical experience.
University of Nevada Las Vegas  
School of Medicine  
Department of Obstetrics and Gynecology  
Residency Program Goals and Objectives

**Rotation:**  
Urogynecology (GYN) PGY-3 & 4

**Location:**  
UMC Hospital, Valley Hospital, Sunrise Hospital

**Duration:**  
1 month

**Patient Care**  
- Counsel patients requiring surgical procedures such as pelvic floor suspension procedures, repair of vesicovaginal fistula, stress urinary incontinence.
- Perform procedures e.g. pelvic floor suspension procedures, repair of vesicovaginal fistula, repair of rectovaginal fistula, stress incontinence.
- Diagnose symptomatic pelvic relaxation.
- Diagnose etiology of urine incontinence.
- Perform a systemic evaluation of the urinary bladder and by cystometrics.
- Perform colpoperineorrhaphies, and transabdominal procedures for the correction of stress urinary incontinence.
- Perform procedures e.g. pelvic floor suspension procedures, repair of vesicovaginal fistula, repair of rectovaginal fistula, and stress urinary incontinence.
- Diagnose symptomatic pelvic relaxation.
- Diagnose the etiology of urine incontinence.
- Perform a systemic evaluation of the urinary bladder by cystometrics.
- Perform colpoperineorrhaphies, and transabdominal procedures for the correction of stress urinary incontinence.

**Medical Knowledge**  
- Describe operations used to treat uterovaginal prolapse and stress urinary incontinence.
- Review the indications, complications, and contraindications of advanced surgical procedures such as pelvic floor suspension procedures, repair of vesicovaginal fistula, repair of rectovaginal fistula, mesh suspension of bladder.
- Describe the normal anatomical relationships of pelvic viscera and the pathophysiology involved in pelvic floor dysfunction.
- Describe the tests useful in diagnosing pelvic floor dysfunction.
- Describe the technique of cystoscopy and urodynamics.
- Describe operations used to treat uterovaginal prolapse and stress urinary incontinence.

**Practice-Based Learning and Improvement**  
- Record and submit the documentation of your clinical experience.
- Maintain case statistics and procedure competency log.

**Interpersonal and Communication Skills**  
- Counsel patients requiring surgical procedures such as pelvic floor suspension procedures, repair of vesicovaginal fistula and repair of rectovaginal fistula.

**Professionalism**  
- Counsel patients requiring advanced surgical procedures such as pelvic floor suspension procedures.
- Advise the Residency Director of situations which potentially or directly and adversely effect the residents, hospital, and/or teaching faculty.
- Record and submit the documentation of your clinical experience.
Systems-Based Practice

- Recognize the importance of compliance and encourage compliance with requirements of governmental, hospital, and accrediting agencies
- Deploy the resident staff effectively and efficiently to meet the needs of the urogynecology service

LEARNING RESOURCES AND TEXTS:


STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- describe the indications, complications, and contraindications of advanced surgical procedures such as pelvic floor suspension procedures, repair of vesicovaginal fistula, repair of rectovaginal fistula, mesh sling procedures
- describe the normal anatomical relationships of pelvic viscera and the pathophysiology involved in pelvic floor dysfunction
- describe the technique of cystoscopy and urodynamics
- describe operations used to treat uterovaginal prolapse and stress urinary incontinence, their indications, contraindications, complications, and success rates

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- perform pelvic floor suspension procedures, repair of vesicovaginal fistula and repair of rectovaginal fistula, sling mesh procedures
- perform a systemic evaluation of the urinary bladder cystoscopically and by cystometrics
- perform colpoperineorrhaphies, and transabdominal procedures for the correction of stress urinary incontinence
University of Nevada Las Vegas
School of Medicine
Department of Obstetrics and Gynecology
Residency Program Goals and Objectives

**Patient Care**
- Evaluate the capabilities of assistant and junior residents, identify areas needing improvement, and provide remediation.
- Manage the major complications of pregnancy
- Deliver breech presentations vaginally
- Deliver twin gestations vaginally
- Perform vacuum and forceps maneuvers
- Perform cesarean hysterectomy

**Medical Knowledge**
- Develop a strategy for the diagnosis and treatment of abnormalities of the third stage of labor including postpartum hemorrhage
- Review the indications, contraindications, and complications of operative vaginal deliveries including vaginal breech delivery, vaginal delivery of twins, mid-forceps maneuvers
- Understand candidates for instrument vaginal delivery
- Understand candidates for breech vaginal delivery and how to effect
- Understand candidate for vaginal twin delivery and how to effect safely
- Understand candidates for cesarean hysterectomy

**Practice-Based Learning and Improvement**
- Review the indications, contraindications, and complications of operative vaginal deliveries including vaginal breech delivery, vaginal delivery of twins, mid-forceps maneuvers
- Develop a strategy for the diagnosis and treatment of abnormalities of the third stage of labor including postpartum hemorrhage
- Evaluate the capabilities of assistant and junior residents and identify areas needing improvement and provide remediation
- Manage the major complications of pregnancy

**Interpersonal and Communication Skills**
- Evaluate the capabilities of assistant and junior residents, identify areas needing improvement and provide remediation
- Deploy the resident staff effectively and efficiently to meet the needs of the obstetrical service
- Direct and supervise assistant and junior residents in accomplishing mastery of their Learning Objectives and Professional Skills
- Support and encourage interpersonal, interdepartmental, and intradepartmental relationships that enhance the goals and objectives of the residency
- Advise the Administrative Chief Resident of situations which potentially or directly and adversely affect the residents, hospital, and/or teaching faculty
Professionalism
- Direct and supervise assistant and junior residents in accomplishing mastery of their Learning Objectives and Professional Skills
- Support and encourage interpersonal, interdepartmental, and intradepartmental relationships that enhance the goals and objectives of the residency
- Maintain case statistics and procedure competency log

Systems-Based Practice
- Recognize the importance of compliance with requirements of governmental, hospital, and accrediting agencies
- Advise the Administrative Chief Resident of situations which potentially or directly and adversely affect the residents, hospital, and/or teaching faculty

LEARNING RESOURCES AND TEXTS:

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- review the indications, contraindications, and complications of operative vaginal deliveries including vaginal breech delivery, vaginal delivery of twins, mid-forcep maneuvers
- develop a strategy for the diagnosis and treatment of abnormalities of the third stage of labor including postpartum hemorrhage
- Review indications for cesarean hysterectomy

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- manage the major complications of pregnancy
- deliver breech presentations vaginally
- deliver twin gestations vaginally
- perform mid-forceps maneuvers
- perform a cesarean hysterectomy
University of Nevada Las Vegas  
School of Medicine  
Department of Obstetrics and Gynecology  
Residency Program Goals and Objectives

**ROTATION:**  
Gynecology (GYN) Chief PGY-4

**LOCATION:**  
UMC Hospital, Valley Hospital, Sunrise Hospital

**DURATION:**  
4 months

**Patient Care**
- Efficiently elicit a thorough history from the Gynecology patient
- Perform a thorough gynecologic exam
- Recognize and initiate appropriate treatment of Gynecologic patients
- Monitor patient progress; respond appropriately to change in patient condition during treatment
- Initiate corrective action for laboratory abnormalities
- Review the indications, complications, and contraindications of surgical procedures such as LAVH, operative laparoscopy, operative hysteroscopy, repair of rectovaginal fistula, laser, cryo or Argon beam treatment of vulvovaginal lesions
- Perform exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, repair of rectovaginal fistula, and laser, cryo and Argon beam, treat vulvovaginal lesions, and cystoscopy

**Medical Knowledge**
- Review the indications, complications, and contraindications of surgical procedures such as exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, repair of rectovaginal fistula, laser, cryo and Argon beam treatment of vulvovaginal lesions
- Counsel patients requiring major surgical procedures and cystoscopy

**Practice-Based Learning and Improvement**
- Deploy the resident staff effectively and efficiently to meet the needs of the gynecology service and resident education
- Record and submit documentation of your clinical experience

**Interpersonal and Communication Skills**
- Evaluate the capabilities of assistant and junior residents, identify areas needing improvement and provide remediation
- Counsel patients requiring surgical procedures such as exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, repair of rectovaginal fistula, simple vulvectomy, treatment of vulvovaginal lesions, and retropubic bladder suspensions
- Direct and supervise junior residents in accomplishing mastery of gynecologic surgical skills
- Support and encourage interpersonal, and interdepartmental, relationships

**Professionalism**
- Evaluate the capabilities junior residents, identify areas needing improvement and provide remediation.
- Deploy the resident staff effectively and efficiently to meet the needs of the gynecology service and resident education
- Support and encourage interpersonal, and interdepartmental, relationships.
- Maintain case statistics and procedure competency log
Systems-Based Practice

- Recognize the importance of compliance with requirements of governmental, hospital, and accrediting agencies
- Support and encourage interpersonal and interdepartmental relationships

Learning Resources and Texts:

- Cosson M, Querleu D, Darqent D, *Vaginal Surgery, 2006*
- Bent, Cundiff, Swift, *Ostegard’s Urogynecology and Pelvic Floor Dysfunctions, 6th Edition, 2007*

study guidelines for goals and objectives

Learning Objectives: At the conclusion of this rotation, the resident physician should be able to:

- review the indications, complications, and contraindications of major surgical procedures such as exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, retropubic bladder suspensions, repair of rectovaginal fistula, and vulvovaginal lesions,
- recognize the importance of compliance with requirements of governmental, hospital, and accrediting agencies

Performance Skills: At the conclusion of this rotation, the resident physician should be able to:

- perform exploratory laparotomy, vaginal hysterectomy, LAVH, operative laparoscopy, operative hysteroscopy, retropubic bladder suspensions, repair of rectovaginal fistula, and treat vulvovaginal lesions, cystoscopy and colposcopy
- direct and supervise assistant and junior residents in accomplishing mastery of their gynecologic skills
- administer the junior residents to run a safe and effective gynecology service.
Residency Program Goals and Objectives

**Rotation:** Ambulatory Care Clinic (OPC) Chief PGY-4

**Location:** Women’s Healthcare Center of Las Vegas

**Patient Care**
- Independently manage obstetrical, gynecological, primary care complaints of female patients
- Review reports of consultants, laboratory studies, diagnostic imaging studies, and any other reports that affect patient care and prescribe modifications in management the results suggest
- Perform colposcopy, biopsy, and LEEP procedures
- Perform ultrasound on obstetric and gynecologic patients

**Medical Knowledge**
- Understand evidence based medicine to manage obstetrical and gynecological, primary care complaints of female patients

**Practice-Based Learning and Improvement**
- Review medical records of patients cared for on a daily basis
- Review reports of consultants, laboratory studies, diagnostic imaging studies, and any other reports that affect patient care and prescribe modifications the results suggest
- Record and submit the documentation of your clinical experience

**Interpersonal and Communication Skills**
- Encourage, compliance with requirements of governmental, hospital, and accrediting agencies
- Direct and supervise junior residents in accomplishing mastery of managing obstetrical, gynecologic or primary care of female patients

**Professionalism**
- Direct and supervise junior residents
- Deploy the resident staff effectively and efficiently to meet the needs of the Clinic service
- Support and encourage interpersonal, and interdepartmental relationships that enhance the goals and objectives of the residency
- Encourage, compliance with requirements of governmental, hospital, and accrediting agencies
- Supervise all residents and medical students working in the PCC and LIED
- Review medical records of patients cared for on a daily basis
- Review reports of consultants, laboratory studies, diagnostic imaging studies that affect patient care and prescribe modifications in management
- Advise the Administrative Chief Resident of situations which potentially or directly and adversely affect the residents, hospital, and/or teaching faculty
- Record and submit the documentation of your clinical experience
- Maintain case statistics and procedure competency log

**Systems-Based Practice**
- Support and encourage interpersonal, interdepartmental, and intradepartmental relationships that enhance the goals and objectives of the residency
- Encourage compliance with requirements of governmental, hospital, and accrediting agencies
- Deploy the resident staff effectively and efficiently to meet the needs of the Clinic office service
- Record and submit the documentation of your clinical experience
LEARNING RESOURCES AND TEXTS:


STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- Direct and supervise junior residents in accomplishing mastery of their clinic skills
- Deploy the resident staff effectively and efficiently
- Support and encourage interpersonal, interdepartmental, and intradepartmental relationships
- Encourage, compliance with requirements of governmental, hospital, and accrediting agencies

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- Independently manage obstetrical, gynecological, primary care complaints of female patients
- Supervise all residents and medical students working in the PCC and LIED
- Review medical records of patients cared for on a daily basis
- Review reports of consultants, laboratory studies, diagnostic imaging studies that affect patient care and prescribe modifications in management
- Perform all procedures normally done in an obstetric and gynecologic outpatient facility
University of Nevada Las Vegas  
School of Medicine  
Department of Obstetrics and Gynecology  
Residency Program Goals and Objectives

**ROTATION:** Gynecologic Oncology (ONC) PGY-4  
**LOCATION:** UMC, Valley Hospital, Sunrise Hospital  
**DURATION:** 1 month

**Patient Care**
- Care for complications in gynecologic oncology patients  
- Carry out a thorough evaluation of patient with a possible gynecologic malignancy  
- Use the laboratory and diagnostic imaging services in a cost-effective way  
- Collaborate with an oncologist, patients receiving chemotherapy  
- Collaborate with a radiation therapist, patient receiving radiation therapy  
- Perform abdominal, vaginal and minimally invasive hysterectomy  
- Perform bladder or bowel revisions or diversions  
- Perform second-look or debulking procedures

**Medical Knowledge**
- Adapt history and physical examination strategies for patients with possible gynecologic malignancies  
- Review the costs, advantages, disadvantages, indications, contraindications, and complications from diagnostic and therapeutic interventions used in evaluating malignant conditions  
- Classify various chemotherapeutic agents used in the treatment of gynecologic malignancies  
- Review the use of radiation therapy in the treatment of gynecologic malignancies  
- Review the epidemiology of gynecologic cancer, including the most common presenting signs and symptoms  
- Describe staging procedures for gynecologic procedures  
- Recognize common postoperative complications in gynecologic oncology patients  
- Review plans for terminal care of patients with particular regard for using community resources  
- Understand postoperative complications such as, incisional, gastrointestinal, respiratory, hemorrhagic, thrombotic, or infectious conditions

**Practice-Based Learning and Improvement**
- Plan treatment for postoperative complications such as, incisional, gastrointestinal, respiratory, hemorrhagic, thrombotic, or infectious conditions

**Interpersonal and Communication Skills**
- Collaborate with an oncologist, patients receiving chemotherapy  
- Collaborate with a radiation therapist, patient receiving radiation therapy  
- Counsel patient about terminal illness

**Professionalism**
- Record and submit documentation of your clinical experience  
- Maintain case statistics and procedural competency log

**Systems-Based Practice**
- Review the costs, advantages, disadvantages, indications, contraindications, and complications from diagnostic and therapeutic interventions used in evaluating malignant conditions  
- Review plans for terminal care of patients with particular regard for using community resources  
- Use the laboratory and diagnostic imaging services in a cost-effective way
LEARNING RESOURCES AND TEXTS:

Baggish MS, Barbot J, Valle RF, Diagnostic and Operative Hysteroscopy, A text and Atlas, 1999

STUDY GUIDELINES FOR GOALS AND OBJECTIVES

LEARNING OBJECTIVES: At the conclusion of this rotation, the resident physician should be able to:

- adapt history and physical examination strategies for patients with possible gynecologic malignancies
- review the costs, advantages, disadvantages, indications, contraindications, and complications from diagnostic and therapeutic interventions used in evaluating malignant conditions
- classify various chemotherapeutic agents used in the treatment of gynecologic malignancies
- review the use of radiation therapy in the treatment of gynecologic malignancies
- review the epidemiology of gynecologic cancer
- describe staging procedures for gynecologic procedures
- recognize common postoperative complications in gynecologic oncology patients
- review plans for terminal care of patients with particular regard for using community resources

PERFORMANCE SKILLS: At the conclusion of this rotation, the resident physician should be able to:

- carry out a thorough evaluation of patient with a possible gynecologic malignancy
- use the laboratory and diagnostic imaging services in a cost-effective way
- monitor patients receiving chemotherapy
- monitor patients receiving radiation therapy
- perform a paracentesis and thorocentesis
- perform vaginal and abdominal hysterectomies using minimally invasive technique
- perform appropriate portions of bladder or bowel revisions or diversions
- perform appropriate portions of second-look or debulking procedures
- perform retroperitoneal dissections
SECTION III

General Competencies
Procedure Competencies
Evaluation Overview
Milestones Assessments
Evaluation/Improvement Committees
New Innovations Samples Documents
The Competencies Defined
The Goals of Residency Programs Related to the General Competencies

Patient Care: (What you do)
- The performance of patient history and physical examinations
- Technical procedure skills required by the program
- Deductive reasoning in the management of patients
- Constructing meaningful management plans
- Techniques related to counseling, instructing and educating patients about their clinical condition
- Health promotion, maintenance, and disease prevention
- Responsibilities as a collaborative member of the health care team

Medical Knowledge: (What you know)
- Evidenced based factual medical knowledge
- Analytic and deductive reasoning
- Applications of basic anatomy, physiology and pathology

Practice Based Learning: (How you improve)
- Use of scientific evidence: evidence based medicine as a guide to standards of care development
- Self evaluation of practice experience
- Statistical methods
- Use of information technology

Interpersonal and Communication Skills: (How you relate)
- Interaction with patients, peers and colleagues
- Listening and language skills
- Attentiveness, interest
- Comprehension and self awareness of patient/physician interaction

Professionalism: (How you act)
- Respect, understanding, sympathy, empathy
- Sensitivity to varied cultures and national origins
- Awareness of issues related to age, gender, religion and disability
- Ethical and legal concepts
- Collaborative attitudes with peers and associates
- Patient advocacy issues

Systems Practice: (How the team improves)
- Operation and goals of health care systems and managed care
- Awareness of cost effective practices, resource alternatives, and risk/benefit considerations
- Patient management and therapeutic alternatives
Obstetric and Surgical Procedure Competency Verification

Each resident will be given ‘Resident Procedure Competency’ forms to carry on their person. These are to be filled out by the resident on, at a minimum, all procedures listed on the ACGME Obstetric and Gynecologic Procedure Competency reports. The attending scrubbed on the case needs to complete the lower portion of the card and rate the resident’s performance, skill and knowledge. These sheets are then submitted to the Residency Coordinator as a source of evaluation, to be transferred into their overall rating on the designated procedures.

Completed forms turned into the Residency Coordinator are reviewed at the resident’s semi annual review with the Program Director and progress is logged on the master ‘Procedure Competence’ form. This form is submitted semi-annually to the hospitals that residents function at, to the residents own file, and to the GME office.

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** RESIDENT PROCEDURE COMPETENCY**

Resident (Print): ___________________________ Faculty Evaluator (Print): ___________________________

Diagnosis: ____________________________________________

Procedure(s): __________________________________________ Date: ____________

<table>
<thead>
<tr>
<th>Performance Characteristic</th>
<th>Score Each</th>
<th>Worst</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Best</th>
</tr>
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<tbody>
<tr>
<td>Respect for Tissue</td>
<td></td>
<td>Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments</td>
<td>Careful handling of tissue but occasionally caused inadvertent damage</td>
<td>Consistently handled tissues appropriately with minimal damage</td>
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<tr>
<td>Time and Motion</td>
<td></td>
<td>Many unnecessary moves</td>
<td>Efficient time/motion but some unnecessary moves</td>
<td>Clear economy of movement and maximum efficiency</td>
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<tr>
<td>Instrument Handling</td>
<td></td>
<td>Repeatedly makes tentative awkward or inappropriate moves with instruments</td>
<td>Competent use of instruments but occasionally stiff or awkward</td>
<td>Fluid moves with instruments and no awkwardness</td>
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<tr>
<td>Knowledge of Instruments</td>
<td></td>
<td>Frequently asked for wrong instrument or used inappropriate instrument</td>
<td>Knew names of most instruments and used appropriate tool for task</td>
<td>Obviously familiar with the instruments and their names</td>
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<tr>
<td>Flow of Operation</td>
<td></td>
<td>Frequently stopped operating and seemed unsure of next move</td>
<td>Demonstrated some forward planning with reasonable progression of procedure</td>
<td>Planned course of operation effortless from one move to the next</td>
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<tr>
<td>Use of Assistants</td>
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<td>Failed to use assistants</td>
<td>Appropriate use of assistants most of the time</td>
<td>Strategically used assistants to the best advantage at all times</td>
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<td>Knowledge of Specific Procedure</td>
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<td>Required specific instruction at most steps</td>
<td>Knew all important steps of the operation</td>
<td>Familiar with all aspects of the operation.</td>
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<td>Overall Performance</td>
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<td>Unable to perform operation independently</td>
<td>Competent, could perform operation with minimal teaching assistance</td>
<td>Clearly superior, able to perform operation independently with confidence</td>
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TOTAL SCORE

Complications: ____________________________________________________________

Knowledge of PATHO-Physiology: ____________________________________________

☐ Qualified to perform with direct Attending involvement (D) ☐ Qualified to perform with Attending present (I)

☐ Qualified to supervise with Attending present (S) Faculty Signature: ___________________________
** University of Nevada Las Vegas  
School of Medicine  
Obstetrics and Gynecology  
Procedure Competencies

<table>
<thead>
<tr>
<th>PGY</th>
<th>Spontaneous Delivery</th>
<th>Cesarean Deliveries</th>
<th>Operative Vaginal Deliveries</th>
<th>Obsteric Ultrasound</th>
<th>Abdominal Hysterecomy</th>
<th>Vaginal Hysterecomy</th>
<th>Laparoscopic Hysterecomy</th>
<th>Incontinence and Pelvic Floor</th>
<th>Cystoscopy</th>
<th>Laparoscopy</th>
<th>Operative Hysterectomy</th>
<th>Abortion</th>
<th>Transvaginal Ultrasound</th>
<th>Surgery for Invasive Cancer</th>
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I = Qualified to perform with Attending present  
S = Qualified to supervise with Attending present
Evaluations

The Accreditation Council for Graduate Medical Education (ACGME) requirements include critical competency based evaluations and counseling for residents. Accurate and complete documentation of each resident’s experience for each year is mandatory, including performance and technical skills. Evaluation requirements contained in the ACGME Program Description for Residencies in Obstetrics/Gynecology include:

1. Evaluation of residents by the faculty at the completion of each assignment
2. Objective assessment of competence in all the core competencies based on the specialty-specific Milestones
3. Evaluation of residents by multiple evaluators (e.g., peers, self, patients, and other professional staff)
4. Document progressive resident performance improvement appropriate to educational level.
5. The resident staff will evaluate the faculty at least semi-annually.
6. The resident staff will evaluate the total residency at least annually.
7. A formal evaluation on each resident in the program on a standard form in collaboration with the Clinical Competency Committee on a semi-annual basis with surgical experience, and technical growth in surgical competence.
8. The educational objectives of the program will be evaluated annually by the Program Evaluation Committee.
9. At the completion of the 4-year period, graduating Chief Residents will evaluate the total program to verify that all objectives have been satisfied and completed prior to graduation.
10. Periodic summary of resident procedure statistics regarding volume and variety of clinical experience.

The Program Director must establish methods of periodically and systematically evaluating and documenting the level of performance, experience and technical skills of the residents. This program follows all the above requirements in the timeframes listed.

On a semi-annual basis, the Program Director will meet and inform each resident of their individual progress, emphasizing strong points and offering guidance with regard to correcting deficiencies. These evaluations, as well as a list of skills which each resident has mastered, must be documented and available at the time the program is reviewed for accreditation approval.

All evaluations are coordinated by the Program Coordinator using the New Innovations computerized evaluation system. All evaluators will complete their evaluations through this system. Patients will complete paper evaluation forms. Completed resident evaluations are summarized and made a part of the resident’s permanent file. Evaluations, which indicate unsatisfactory performance in any area, will be immediately brought to the attention of the Program Director.

ALL evaluations are anonymous.

Final Summative Resident Evaluation

A final summative evaluation for each graduating Chief Resident is completed by the Program Director and reviewed as part of the exiting review process. This form also certifies the resident is independently competent to practice obstetrics and gynecology and becomes a permanent part of the resident file.
Faculty Evaluation

Faculty performance as it relates to the educational program is evaluated annually. These evaluations will include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. It must include semi-annual written confidential evaluations by the residents.

The performance of the faculty will be reviewed by the Program Director and Chair. The resident's semi-annual evaluations of the faculty will be reviewed. The Chair will use this information as part of the annual faculty review for the faculty member's continuing participation, advancement or termination of teaching responsibilities. Summarized faculty evaluations will be maintained in their official evaluation file of the residency program maintained by the Program Coordinator.

See samples of all evaluations later in this chapter.

Milestones Assessment

ACGME, ABOG, and ACOG developed outcomes-based milestones for resident performance within the six domains of clinical competence. The Milestones are competency-based developmental outcome expectations that can be demonstrated progressively by residents from the beginning of their education through graduation to the unsupervised practice of their specialty. Resident's performance on milestones is a source of specialty-specific normative data for the specialty Review Committees to use in assessing the quality of residency programs and facilitating improvements to program curricula and resident performance if and when needed. The Milestones will also be used by the ACGME to demonstrate accountability of the effectiveness of graduate medical education within the program in meeting the needs of the public. The Milestones will be reviewed and completed by residents and their mentors at their semi-annual meetings. The report will be submitted to the Program Director for review and discussion at the resident's semi-annual review with the program Director and will become part of the residents permanent file. See descriptions later in this chapter.

Committees for Program and Resident Evaluation and Improvement

Clinical Competency Committee (CCC)

The Clinical Competency Committee meets twice a year to review resident performance. Advancement is contingent upon satisfactory overall evaluation. The committee is comprised of three core faculty, Program Director, and Program Coordinator. This committee reviews:

- All resident evaluations
- Resident performance from both personal experience and reporting documentation
- Procedure logs
- CREOG Scores
- Challenger report
- Milestone reports
- Prepares the reporting document for Milestones on each resident that is reported to the ACGME
- Problem reports and updates on previous problems addressed in the committee
- Advises the program director regarding resident progress, including promotion, remediation, and dismissal.

After final recommendations have been approved, the Program Director will inform residents of their individual progress at their semi-annual review, emphasizing strengths and offering guidance for correcting deficiencies.

At the final CCC meeting of the year the Committee will review the resident's performance for the entire year, and provide final recommendations. The Program Director then makes the final decision regarding increased privileges and promotion to the next level. The recommendations from the CCC will become part of the resident's formal written 'semi-annual evaluation,' and will be made a part of the residents' permanent file.
Program Evaluation Committee (PEC)

The Program Evaluation committee meets annually, usually in June. It is comprised of the core faculty, one Chief Resident, Program Director, and Program Coordinator. This committee is responsible for documenting formal, systematic evaluation of the curriculum and is responsible for rendering a written Annual Program Evaluation (APE) to the UNSOM Designated Institutional Official (DIO).

This committee will participate actively in:

- planning, developing, implementing, and evaluating educational activities of the program
- reviewing and recommending revisions of competency-based curriculum goals and objectives
- addressing areas of non-compliance with ACGME standards
- the annual program review using evaluations by faculty, residents, and others
- reviewing and reporting on progress of the previous year’s action plan(s).

The PEC will prepare a written plan of action to document initiatives to improve performance in the areas listed above, as well as delineate how they will be measured and monitored. The action plan will be reviewed and approved by the committee and documented in meeting minutes.

New Innovations Evaluation System

New Innovations is the software system used for processing evaluations. Residents receive their login name and password during their hiring process. The login name and password are used to access New Innovations through their website www.new-innov.com. Residents and faculty receive evaluations that need to be completed in their email at the end of every rotation for all rotations, and semi-annually or annually for others. They will come once, then every 7 days for 8 weeks until they are completed or suspended. The different evaluations and their frequency follow later in this chapter.

The following pages show the process to complete evaluations taken from the New Innovations help section.
Complete an Evaluation

Complete an evaluation using auto-login link in the email from New Innovations

1. Click the Auto Login link in your notification
2. You may have to copy and paste the link into the web address bar if your email is set to Plain Text instead of HTML.

Use the conventional login by going to www.new-innov.com and sign in

1. On your Home page, scroll down to the **Notifications** section
2. Click the link that states **"evaluations to complete"**
3. Click **Evaluate** beside the evaluation you want to complete
4. Complete the questions on the form.
5. Click **Submit Final**

If you feel you cannot evaluate because of not enough time spent with the person put a check in the box by the name and click on the blue link “Submit Selected Evaluation as NET”
**Complete an Evaluation - Mobile**

The steps below will show you how to use your mobile device to complete an evaluation.

**Log In**

1. Enter www.new-innov.com
2. Enter your institution (Nevada), username and password
3. Tap **Log In**

**Notes:**

- If this is your first time logging into New Innovations, you’ll be prompted to change your password.
- Tap **Remember Password** to have your device remember your password.
- Tap **Forgot Your Password** to reset your password.
Menu

The mobile menu will appear on your screen.

Welcome Jimmy Hendrix

Notifications  
My Schedule  
Duty Hours  
Evaluations*  
Procedure Logger

* We haven't optimized this for your device yet

My Account

Change Department

1. Tap **Evaluations**
2. Tap **Evaluate** in front of the person or rotation you want to evaluate
3. Complete the evaluation
4. Options at bottom of screen:
   1. Tap **Submit Final** to submit your evaluation
   2. Tap **Save Draft** to save a copy of your evaluation so that you can return to it later

If you feel you cannot evaluate because of not enough time spent with the person put a check in the box by the name and click on the blue link “Submit Selected Evaluation as NET”

Residency Evaluations (2)

Submit Selected Evaluations as NET (Not Enough Time with subject)

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Count: 2
Complete an On-Demand Evaluation

This evaluation gives you the opportunity to write up Praise or a Concern about a person. (Resident or Faculty)

1. In the Notification panel on the Home Page, click **Choose a person or rotation to evaluate**
2. Click **Choose Subject**
3. Select the Subject, Rotation and Interval
4. Click **Create this evaluation**
5. The header on the evaluation form displays the information selected
6. Evaluator completes evaluation and clicks **Submit as Final**
AD HOC EVALUATIONS

- Praise Card about a Trainee
- Praise Card about an Educator
- Concern Card about a Trainee
- Concern Card about an educator
Praise Card About a Trainee

[Subject Name]  
[Subject Status]  
[Subject Rotation]  
[Evaluation Dates]  

Evaluator

[Evaluator Name]  
[Evaluator Status]

REASON FOR PRAISE

My praise about the performance of this physician is based on his/her demonstration of exceptional ability in the following: (please check)

☐ Clinical Judgment
☐ Clinical Skills
☐ Medical Knowledge
☐ Communication Skills
☐ Teaching
☐ Professionalism
☐ Team management and leadership
☐ Critique of medical/scientific literature
☐ Conduct of research
☐ Humanistic Qualities

Praise Comments

Remaining Characters: 5,000

Return to Questionnaire List
Praise Card About an Educator

[Subject Name]  
[Subject Status]  
[Subject Rotation]  
[Evaluation Dates]  

Evaluator

[Evaluator Name]  
[Evaluator Status]

REASON FOR PRAISE

My praise about the performance of this physician is based on his/her demonstration of exceptional ability in the following: (please check)

☐ Clinical Judgment
☐ Clinical Skills
☐ Medical Knowledge
☐ Communication Skills
☐ Teaching
☐ Professionalism
☐ Team management and leadership
☐ Critique of medical/scientific literature
☐ Conduct of research
☐ Humanistic Qualities

Praise Comments

Remaining Characters: 5,000

Return to Questionnaire List
Concern Card About a Trainee

[Subject Name]  
[Subject Status]  
[Subject Program]  
[Subject Rotation]  
[Evaluation Dates]  

Evaluator

[Evaluator Name]  
[Evaluator Status]  
[Evaluator Program]  

Reason for Concern

My concerns about the performance and/or professional behavior of this physician are based on:

- [ ] Critical Incident
- [ ] Gut level reaction
- [ ] Series of "red flags"
- [ ] Complaints by nursing staff
- [ ] Complaints by other personnel

Concern Comments

Please add comments about your concerns.

Remaining Characters: 5,000

Discussed with Physician

I have discussed my concerns with the physician.

Yes  No

Discomfort with discussion of concern

I feel uncomfortable discussing my concerns with the physician.

Yes  No

Call about concern
Please call me about these concerns.

Yes  No

Return to Questionnaire List
Concern Card About an Educator

[Subject Name]
[Subject Status]
[Subject Program]

[Subject Rotation]
[Evaluation Dates]

Evaluator

[Evaluator Name]
[Evaluator Status]
[Evaluator Program]

Reason for Concern

My concerns about the performance and/or professional behavior of this physician are based on:

☐ Critical Incident
☐ Gut level reaction
☐ Series of "red flags"
☐ Complaints by nursing staff
☐ Complaints by other personnel

Concern Comments

Please add comments about your concerns.

Remaining Characters: 5,000

Discussed with Physician

I have discussed my concerns with the physician.

Yes ☐ No ☐

Discomfort with discussion of concern

I feel uncomfortable discussing my concerns with the physician.

Yes ☐ No ☐

Call about concern
Please call me about these concerns.

Yes  No

Return to Questionnaire List
MONTHLY EVALUATIONS

- Faculty of Resident
- Resident of Rotation
PATIENT CARE

• History and physical exams thorough and accurate
• Ability to assess and integrate information accurately
• Deductive reasoning and clinical management skills are well organized and appropriate
• Interviewing skills are well developed (PC)
• Self-confident, with good operative skills
• Adapt appropriately to intraoperative conditions
• Manages post-operative complications well

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MEDICAL KNOWLEDGE

• Core factual knowledge is extensive and well integrated
• Clinical problem solving is well developed
• Applies basic science principles as correlated with clinical practice
• Uses analytical and critical thinking techniques in accumulating knowledge base
• Understands research systems, critical literature review, statistical methods

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PRACTICE-BASED LEARNING AND IMPROVEMENT
- Uses scientific evidence based experience and data as a guide to patient care
- Applies 'best practices' to patient care
- Understands basics of statistical methods
- Oral (verbal) presentations skills are effective
- Charting, writing and prescription skills are concise, appropriate, legible, timely, comprehensive
- Communicates effectively with patients/families (use of listening, questioning, narrative skills)
- Interviewing skills are well developed (PBL)

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INTERPERSONAL AND COMMUNICATION SKILLS

- Evaluates own performance on experimental basis
- Open minded to willingness to learn from errors
- An effective teacher
- Educates students and other health care professionals
- Collaborates effectively with all health care professionals (peers, other residents and students, and healthcare workers)
- Gets along with Para-professionals

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PROFESSIONALISM

- Honest, trustworthy
- Adheres to principles of confidentiality, scientific/academic integrity, duty to and responsibility for patient care
- Shows ethical behavior in patient and peer relationships
- Tolerance of ethnic, racial, gender and cultural differences
- Appreciates psychosocial attitudes of patients
- Accepts responsibility for own actions
- Dress and appearance is appropriate
- Displays proper hygiene
- Team player, helps other staff
- Respectful of peers and administrators

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SYSTEM-BASED PRACTICE

- Understands principle of a healthcare system
- Knowledgeable about systems access, resources, provider responsibilities, alternate choices in a managed care setting
- Aware of regulatory patient care, academic and program accrediting issues
- Understands issues relating to community health, epidemiology, demographic and population health concerns
- Aware of HMO, PPO, IPA and fee for source
- Understand medical legal aspects of profession

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Comments

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Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
GYN/ONC (PGY 3 & 4) Faculty of Resident

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluation Dates]

Evaluator
[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

- Coordinates critical care management of gynecologic oncology patients
- Demonstrates ability to manage surgical hemorrhage independently responds to consultations and provides an accurate differential diagnosis and management recommendations
- Prescribes the appropriate therapy for gynecologic malignancies

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PATIENT CARE/SURGICAL

- Performs TAH, BSO, EUA, exploration of the abdomen and pelvis, ICRT, simple vulvectomy or wide local excision; Accesses the retroperitoneum and identifies the ureters and major vessels
- Assists in major gynecologic oncology surgeries, including radical hysterectomy; ovarian cancer staging/debulking; lymph node dissection, radical vulvectomy

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MEDICAL KNOWLEDGE

- Determines the stage of all gynecological cancers and correlate stage with prognosis
- Describes the histology of gynecologic malignancies and how it relates to prognosis
- Demonstrates in depth knowledge of surgical anatomy of the pelvis
- Describes medical, radiation and surgical modalities for palliation of symptoms in terminally ill patients.
- Describes the mechanisms of action of the most commonly used chemotherapy agents
- Demonstrates basic knowledge of radiation biology, physics, safety and its therapeutic uses

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INTERPERSONAL AND COMMUNICATION SKILLS

- Able to discuss end-of-life issues with patients and their families
- Educates medical students and incorporates them to the health care delivery team
- Uses audience-appropriate language and terminology when communicating medical information
- Writes at least one daily progress note which is complete, organized, legible and accurate

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PROFESSIONALISM

- Enters all cases into ACGME case log at least once a week
- Dictates all operative note within 24 hours
- Serves as leader and role model for junior residents and medical students

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PRACTICE-BASED LEARNING AND IMPROVEMENT

- Completes death certificates as required
- Recognizes untoward complications in the treatment of cancer
- Presents a case at M&M with a literature review
- Knows the hospital policy for restraints

N/A
### SYSTEM-BASED PRACTICE

- Obtains appropriate informed consent following hospital regulations
- Knows how a living will works and how to implement it
- Knows how to do not resuscitate orders works and how to implement them
- Uses consultants appropriately and effectively
- Assists patients with complexities of the health care system including arranging social services, home health care, rehabilitation services and hospice care when necessary

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Comments:

Remaining Characters: 5,000

Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
Where the are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

- Develop core knowledge of: Contraceptive options, Gynecological emergencies, Infections that primarily affect the vagina and vulva, Physiology of the normal menstrual cycle, Pelvic anatomy, Types of abortion, Sterile technique, Informed Consent process, Normal postoperative care, Postoperative pain management
- Differentiate between types of abortion Threatened, Incomplete, Complete, Inevitable and Septic
- Interpret BHCG results in normal and abnormal pregnancy

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Comments

Remaining Characters: 5,000

PATIENT CARE/SURGICAL

- Able to perform Pelvic exams, Pap smear, Wet prep, ER and floor consultation
- Able to perform Non-pregnant dilation and curettage, Insertion of a Word Catheter, Diagnostic Hysteroscopy, Diagnostic Laparoscopy, Laparoscopic Tubal ligations

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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- States the differential diagnosis for chronic pelvic pain; order and interpret appropriate tests; devise management plan
- Describes the appropriate preoperative evaluation for a geriatric patient including consultation with other medical disciplines as indicated
- Describes all methods for treatment of benign sources of OUB
- Describes the normal anatomic supports and dynamics of the vagina, bladder, urethra, uterus and rectum
- Explains the current staging system for prolapse, and nomenclature for lower urinary tract function
• Explains pathophysiology/non-surgical and surgical options for the management of stress urinary incontinence and pelvic organ prolapse

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Comments

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PROFESSIONALISM

• Demonstrates compassion and integrity in the interaction with all patients
• Demonstrates respect and professionalism in interactions with staff
• Provides guidance and assistance to the younger residents as necessary

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Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

• Writes at least one daily progress note which is complete, organized, legible and accurate
• Uses audience-appropriate language/terminology with patients and families
• Demonstrates ability to educate students

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Comments

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PRACTICE-BASED LEARNING AND IMPROVEMENT

• Attends scheduled call and takes care of scheduled group of patients
• Obtain an informed consent
• Dictate operative notes and discharge summaries in the recommended time
• Demonstrates commitment to continued learning through reading, self-study, performing literature searches and giving presentations
• Understand chain of command, possess list of all beepers for residents and faculty and understand the need to consult with upper level residents and/or faculty about all clinical care decisions
• Receptive to instruction and feedback

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SYSTEM-BASED PRACTICE

- Aware of the cost of surgical versus medical options for treating fibroids, ectopic pregnancies, etc.
- Practices cost-effective health care that does not compromise quality of care

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Remaining Characters: 5,000

OVERALL

Overall Comments

Remaining Characters: 5,000

Return to Questionnaire List
Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

- Formulates and implements a management plan for the critically ill post operative patient
- Performs a complete sexual history; identify sexual dysfunction disorders; know when to seek referral
- Assesses a patient’s risk for osteoporosis; order and interpret appropriate tests counsel patient on lifestyle changes and risk/benefits of medications if prescribed

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Comments

Remaining Characters: 5,000

PATIENT CARE/SURGICAL

- Gains surgical skills to be a primary surgeon for common major gynecologic procedures including but not limited to: abdominal hysterectomy, vaginal hysterectomy, laparoscopic assisted vaginal hysterectomy, myomectomy, advanced operative hysteroscopy, advanced operative laparoscopy
- Develops competency in performing cystoscopy for determining the patency of the ureters.
- Identifies and manages intra-operative complications; involve other specialties if appropriate

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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- States the differential diagnosis for chronic pelvic pain; order and interpret appropriate tests; devise management plan
- Describes the appropriate preoperative evaluation for a geriatric patient including consultation with other medical disciplines as indicated
- Explains the pathophysiology of osteoporosis
- Describes all methods for treatment of benign sources of DUB

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Comments

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PROFESSIONALISM

- Interacts effectively and ethically with entire obstetric team
- Demonstrates compassion and integrity in the interaction with all patients
- Demonstrates respect and professionalism in interactions with staff.
- Provides guidance and assistance to the younger residents as necessary

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Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- Writes at least one daily progress note which is complete, organized, legible and accurate
- Uses audience-appropriate language/terminology with patients and families
- Demonstrates ability to educate students

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Comments

Remaining Characters: 5,000

PRACTICE-BASED LEARNING AND IMPROVEMENT

- Attends scheduled call and takes care of scheduled group of patients
- Demonstrates commitment to continued learning through reading, self-study, performing literature searches and giving presentations.
- Researches, appraises and assimilates evidence from literature to provide quality gynecologic care
- Receptive to instruction and feedback

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Comments

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SYSTEM-BASED PRACTICE

- Is cognizant of the procedural and diagnostic reimbursement codes
- Practices cost-effective health care that does not compromise quality of care

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Comments

Remaining Characters: 5,000

Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
MFM (PGY 3) Faculty of Resident

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluation Dates]

Evaluator

[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

- Able to perform an anatomic survey in the second trimester
- Able to perform a vaginal ultrasonic cervical evaluation
- Evaluates and manages all antenatal admissions and rounds on these patients daily

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Comments

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PATIENT CARE/SURGICAL

- Perform amniocentesis and list the indications for intrauterine transfusion

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Comments

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MEDICAL KNOWLEDGE

- Interprets non-stress testing, biophysical profile and discuss its underlying physiology
- Describe the clinical significance of heritable diseases, such as cystic fibrosis, hemoglobinopathies, Tay-Sachs disease, and hemophilia.
- Counsel patients about the techniques for and implications of testing for heritable diseases.
- Discuss treatment and surveillance options for patients or newborns with genetically derived diseases.
- Describes Doppler flow studies
- Differentiate preterm labor from nonsignificant uterine contractions
• Diagnose remediable causes of preterm labor and manage them
• List indications and contraindications of various pharmacological tocolytic agents. Describe the principles of management of labor and delivery of the preterm fetus

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Comments

Remaining Characters: 5,000

• Learns basic genetic counseling, reporting and documentation of ultrasound and communicates results clearly
• Discusses issues of sensitivity with the obstetric patient and her family with empathy
• Communicates effectively with faculty, technicians, nurses

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Comments

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PROFESSIONALISM

• Demonstrates compassion and responsiveness to the needs of the pregnant patient and her family
• Listens and provides relevant information to the high-risk obstetric patient/family using appropriate language

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Comments

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INTERPERSONAL AND COMMUNICATION SKILLS

• Writes at least one daily progress note which is complete, organized, legible and accurate
• Uses audience-appropriate language/terminology with patients and families
• Demonstrates ability to educate students

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PRACTICE-BASED LEARNING AND IMPROVEMENT

- Learns who to and how to offer perinatal testing
- Critically researches, evaluates and reports on relevant perinatal literature
- Demonstrates receptiveness to instruction and feedback

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SYSTEM-BASED PRACTICE

- Exhibits the skills to take a genetic history and perform basic genetic counseling
- Recognizes the cost of antenatal technology and uses it appropriately
- Uses the broad spectrum of health care providers when necessary

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Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
MFM/Ultrasound (PGY 1) Faculty of Resident

[Subject Name]  
[Subject Status]  
[Subject Rotation]  
[Evaluation Dates]

Evaluator

[Evaluator Name]  
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

MEDICAL KNOWLEDGE

- Describe the indications for an ultrasound procedure
- Recognize the components of a basic obstetrical ultrasound as defined by ACOG and AIUM
- Describe the components of a biophysical profile

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PATIENT CARE

- Identify: Placental location
- Identify: Fetal presentation
- Identify: Fetal number
- Identify: Fetal heart rate
- Measure: Amniotic fluid index
- Measure: Head circumference
- Measure: Biparietal diameter
- Measure: Abdominal circumference
- Measure: Femur length
- Measure: Cervical length
- Perform: Biophysical profiles
- Perform: Transvaginal ultrasound in the first trimester for dating

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Comments

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PRACTICE-BASED LEARNING AND IMPROVEMENT

- Analyze the value of screening ultrasounds
- Analyze the value of targeted ultrasounds
- Analyze the value of ultrasound for the detection of Trisomy 21

Remaining Characters: 5,000

SYSTEM-BASED PRACTICE

- Understand how anomaly detection affects the cost of health care
- Understand indications for an ultrasound that are billable and the ones for which the patient is financially responsible

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- Counsel patients on the limitations of ultrasound
- Communicate pregnancy abnormalities such as missed abortion to the patient and family

Remaining Characters: 5,000

PROFESSIONALISM

- Analyze the value of screening ultrasounds
- Analyze the value of targeted ultrasounds
- Analyze the value of ultrasound for the detection of Trisomy 21

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Comments

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Return to Questionnaire List
Night Float (PGY 1) Faculty of Resident

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluation Dates]

Evaluator

[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE

- Triages labor patients
- Manages normal labor
- Performs obstetric ultrasound (EFW, EGA, AFI, lie and placentation)
- Performs biophysical profiles under supervision
- Recognizes abnormal labor conditions
- Performs spontaneous vaginal deliveries and repairs
- Performs primary/uncomplicated Cesareandeliveries
- Recognizes postpartum/postoperative complications
- Maintains accurate medical records

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MEDICAL KNOWLEDGE

- Describes common antenatal conditions (PTL, PPROM, bleeding, preeclampsia)
- Describes labor induction
- Describes abnormal labor conditions (FHR categories, arrest)
- Describes abnormal delivery (malpresentation, shoulder dystocia, hemorrhage)
- Describes episiotomy types and repairs
- Describes common postpartum and postoperative complications

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Comments

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INTERPERSONAL AND COMMUNICATION SKILLS

- Establishes rapport
- Communicates care plans and risks to patients
- Communicates care plans to staff
- Presents well during rounds
- Updates the team appropriately

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Comments

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PROFESSIONALISM

- Accepts feedback well
- Maintains an appropriate demeanor
- Maintains a collaborative working relationship with colleagues and staff
- Maintains a record of all procedures performed
- Reports punctually

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Comments

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PRACTICE-BASED LEARNING AND IMPROVEMENT

- Incorporates feedback into practice
- Researches management protocols as assigned

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Comments

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SYSTEM-BASED PRACTICE
- Obtains records from outside hospitals
- Coordinates with specialists
- Demonstrates an awareness of healthcare costs

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Overall Comments:

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Remaining Characters: 5,000

Return to Questionnaire List
Night Float (PGY 2) Faculty of Resident

[Subject Name]  [Subject Status]  [Evaluator Name]  [Evaluator Status]
[Subject Rotation]  [Evaluation Dates]  

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE

- Performs operative vaginal deliveries and repairs
- Performs repeat/complicated Cesarean deliveries
- Evaluates and manages post-partum complications requiring surgery
- Evaluates and manages GYN emergencies
- Provides appropriate care for medically complicated patients
- Maintains accurate medical records

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MEDICAL KNOWLEDGE

- Describes common antenatal conditions (PTL, PPROM, bleeding, preeclampsia)
- Describes labor induction
- Describes abnormal labor conditions (FHR categories, arrest)
- Describes abnormal delivery (malpresentation, shoulder dystocia, hemorrhage)
- Describes episiotomy types and repairs
- Describes common postpartum and postoperative complications

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Comments

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INTERPERSONAL AND COMMUNICATION SKILLS
• Establishes rapport
• Communicates care plans and risks to patients
• Communicates care plans to staff
• Presents well during rounds
• Updates the team appropriately

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PRACTICE-BASED LEARNING AND IMPROVEMENT

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SYSTEM-BASED PRACTICE

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Comments:

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Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
### Night Float (PGY 3) Faculty of Resident

**[Subject Name]**  
**[Subject Status]**  
**[Subject Rotation]**  
**[Evaluation Dates]**

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

#### PATIENT CARE/CLINICAL

- Manages the obstetric service at night safely and effectively.
- Supervises and teaches the junior residents and students.
- Maintains good patient flow while preserving quality of care.
- Performs transabdominal and transvaginal ultrasound including BPP.
- Performs and supervises all OB and GYN surgery.
- Manages postpartum/postoperative complications.
- Provides appropriate care for medically complicated patients.
- Maintains accurate medical records.

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#### MEDICAL KNOWLEDGE

- Describes current protocols for labor, antenatal, and GYN emergency patients.
- Demonstrates knowledge of the diagnosis and plan of all patients on the service.

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#### INTERPERSONAL AND COMMUNICATION SKILLS

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PROFESSIONALISM

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PRACTICE-BASED LEARNING AND IMPROVEMENT

- Incorporates feedback into practice.
- Researches management protocols or delegates research as appropriate.

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SYSTEM-BASED PRACTICE

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Comments

Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
OB (PGY 1-2) Faculty of Resident

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

• Develop core knowledge of: The components of prenatal care, Prenatal labs, Normal and abnormal labor, Antepartum and intrapartum fetal monitoring, Normal physiological changes of pregnancy, Obstetrical lacerations, Routine postpartum care, Indications for operative vaginal deliveries and Indications for cesarean delivery

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Comments

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PATIENT CARE/SURGICAL

• Recognize common abnormalities in the obstetrical exam such as abnormal fundal height, abnormal blood pressure
• Perform: Obstetrical dating, Appropriate labs for uncomplicated patients, Fundal height measurement, Fetal heart tone, Leopold’s maneuver for presentation and estimated fetal weight, Cervical dilation, effacement, station, and position, Spontaneous vaginal delivery, Outlet vacuum delivery, Midline episiotomy and repair, Repair first and second degree lacerations, Primary low transverse cesarean sections, Fetal scalp electrode placement, Artificial rupture of the membranes, Intrauterine pressure catheter placement, amnioinfusion, Sterile speculum exam to diagnose ruptured membranes and Neonatal circumcision
• Able to prescribe RhoGAM, Antibiotics, Pitocin, Cervical ripening agents, Postpartum contraception, Postpartum analgesia,

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Comments

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MEDICAL KNOWLEDGE

• Interpret non-stress tests
• Recognize factors in the history and/or physical that indicates possible medical, genetic, or obstetrical complications.
• Recognize and treat postpartum complications such as:
  • Endometritis
  • Postpartum Hemorrhage
  • Deep Vein Thrombosis
• Describes Doppler flow studies
• Differentiate preterm labor from nonsignificant uterine contractions
• Diagnose remediable causes of preterm labor and manage them
• List indications and contraindications of various pharmacological tocolytic agents
• Describe the principles of management of labor and delivery of the preterm fetus

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INTERPERSONAL AND COMMUNICATION SKILLS

• Provide patients with an explanation of pain control options in labor
• Provide patients with an explanation of routine procedures such as intrauterine catheter placement, artificial rupture of membranes and fetal scalp electrode placement
• Communicate a thorough sign-out on patients to ensure the continuity of care

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Comments

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PROFESSIONALISM

• Demonstrates compassion and responsiveness to the needs of the pregnant patient and her family
• The resident is required to log all cases into OpLog at least once a week
• Understand the components of informed consent
• Demonstrate a commitment to patient confidentiality
• Incorporate the team concept in taking care of patients which includes the faculty, students, and nurses
• Increase awareness of the patient's expectations of her birthing experience

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PRACTICE-BASED LEARNING AND IMPROVEMENT

- Dictate intraoperative notes and discharge summaries in a timely manner
- Concentrate on using only hospital approved abbreviations
- Critically appraise medical literature and apply the highest level of evidence available to clinical care
- Incorporate feedback from patients and faculty into daily practices

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SYSM-BASED PRACTICE

- Offer patients who are breast-feeding the option of a lactation consultant and follow-up home health nursing if needed
- Direct clinic visits in consultation with on-site nutritionists, pharmacists, and social workers
- Understand the criteria that necessitates neonatal physician presence at a delivery
- Understand patient, family and neonatal issues that require social work intervention.

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Overall Comments:
OB (PGY 3-4) Faculty of Resident

[Subject Name]  
[Subject Status]  
[Subject Rotation]  
[Evaluation Dates]

Evaluator

[Evaluator Name]  
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

- Preconception care – history, physical examination and diagnostic studies.
- Assessment of the patient’s access to a plan of prenatal care
- Consult with or refer to experts on specific conditions that may arise during pregnancy

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Comments

Remaining Characters: 5,000

PATIENT CARE/SURGICAL

- Develop proficiency in Delivery, vacuum extractor
- Delivery, vaginal breech, including breech second twin
- Delivery, cesarean
- Cesarean hysterectomy
- Cervical cerclage
- External cephalic version

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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- Develop core knowledge of critical care for obstetric patients
- Expand core knowledge of:
- Antepartum Care
- Intrapartum Care
- Management of medical complications of pregnancy
- Management of fetal heart rate abnormalities
- Operative vaginal and abdominal deliveries
- Management of postpartum hemorrhage, obstetric shock and infection
- Intraoperative complications
- Postpartum Care
- Procedures
- Obstetric anesthesia, including induction anesthesia, general anesthesia, and local anesthesia techniques, including the management of anesthetic-related complications such as hypotension, seizures, and respiratory arrest

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Comments


Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- Develop skills in counseling:
  - Medical, legal, and ethical implications
  - Ability to address a variety of normal and complicated obstetric conditions
  - Counsel patients regarding additional expertise in complicated obstetric conditions
- Communicate a thorough sign-out on patients to ensure the continuity of care.

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Comments


Remaining Characters: 5,000

PROFESSIONALISM

- Demonstrates compassion and responsiveness to the needs of the pregnant patient and her family
- The resident is required to log all cases into OpLog at least once a week
- Demonstrate a sensitivity to health care members who take care of obstetric patients
- Recognize how family dynamics impact the care of obstetric patients
- Demonstrate a commitment to patient confidentiality

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PRACTICE-BASED LEARNING AND IMPROVEMENT

- Understand obstetrical procedures (including indications, contraindications, and principles) and be able to perform them independently

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SYSTEM-BASED PRACTICE

- Offer patients who are breast-feeding the option of a lactation consultant and follow-up home health nursing if needed
- Direct clinic visits in consultation with on-site nutritionists, pharmacists, and social workers
- Understand the criteria that necessitates neonatal physician presence at a delivery
- Understand patient, family and neonatal issues that require social work intervention

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</table>
Outpatient Clinic (PGY 1 & 2) Faculty of Resident

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

- Demonstrates the ability to perform a new patient history and physical exam in the office setting.
- Demonstrates the ability to perform a problem focused history and physical exam
- Orders age appropriate screening tests
- Reviews immunization history and orders appropriate vaccines
- Reviews Nutrition History including healthy diet, exercise and weight management
- Creates a basic plan of care including diagnostic tests therapeutic intervention and referrals appropriate for common medical conditions.

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Comments

Remaining Characters: 5,000

PATIENT CARE/SURGICAL

- Demonstrates appropriate performance of endometrial biopsy
- Demonstrates appropriate performance of cervical and vulvar biopsy
- Performs and documents gynecologic ultrasounds
- Performs and documents all trimester OB ultrasounds and B.P.P.
- Perform interprets, document NST
- Manage post op complications appropriately (wound care)

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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE
- Demonstrates ability to create a problem list and possible differential diagnosis concordant to findings for common problems.
- Demonstrates the ability to provide basic patient education on common health problems and disease prevention.
- Can discuss pathophysiology of common obstetric and gynecologic.
- Can discuss physiology of therapeutic modalities recommended to patients

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Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- Demonstrates the ability to effectively communicate with patients in order to take a medical history.
- Reviews plan of care and provide patient education.
- Demonstrates the ability to effectively communicate with all members of the health care team.
- Demonstrates the ability to effectively communicate with patients’ families.
- Oral patient presentations are effective and accurate

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Comments

Remaining Characters: 5,000

PROFESSIONALISM

- Demonstrates compassion and integrity in the interaction with all patients
- Demonstrates respect and professionalism in interactions with staff.
- Demonstrates professional interaction with attending faculty
- Chart documentation is accurate and legible.
- Ethical behavior with patients and peers.
- Respectful of peers and administrators

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Comments

Remaining Characters: 5,000
PRACTICE-BASED LEARNING AND IMPROVEMENT

- Attends each scheduled clinic
- Learns principles of health promotion and supervision.
- Demonstrates commitment to continued learning through reading, self-study, performing literature searches and giving presentations.
- Receptive to instruction and criticism
- Is an effective teacher of students and colleagues

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Comments

SYSTEM-BASED PRACTICE

- Appraises the internist’s role among specialists and other clinical care providers in coordinating quality of care for patients.
- Demonstrates integration of medical problems and health promotion with respect to individual patient’s culture, socioeconomic status, occupation, and environment.
- Understands the role support staff play in the delivery of health care in the ambulatory setting.
- Including: nursing staff, medical assistants, LPNs (Licensed Practical Nurses), RNs (registered nurses), social services, nutritionists, physical therapy and rehabilitation programs.
- Practices cost-effective care and advocate for patients within the system.

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Comments

Remaining Characters: 5,000

Return to Questionnaire List
Outpatient Clinic (PGY 3 & 4) Faculty of Resident

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluation Dates]

Evaluator
[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

- Demonstrates the ability to perform a problem focused history and physical exam
- Creates a basic plan of care including diagnostic tests, therapeutic intervention and referrals appropriate for common medical conditions.
- Formulates and implements a management plan for the complex benign GYN cases.
- Assesses a patient’s risk for osteoporosis; order and interpret appropriate tests, counsel patient on lifestyle changes and risk/benefits of medications if prescribed.
- Performs a focused physical examination to identify specific pelvic floor defects including: a) Anterior vaginal wall prolapse; b) Aprical and uterine prolapse; c) Posterior vaginal wall prolapse; d) Chronic disruption of the anal sphincter complex

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Comments

Remaining Characters: 5,000
MEDICAL KNOWLEDGE

- Demonstrates ability to create a problem list and possible differential diagnosis concordant to findings for common problems.
- Demonstrates the ability to provide basic patient education on common health problems and disease prevention.
- Can discuss physiology of therapeutic modalities recommended to patients.
- States the differential diagnosis for chronic pelvic pain; order and interpret appropriate tests; devise management plan.
- Describes the appropriate preoperative evaluation for a geriatric patient including consultation with other medical disciplines as indicated.
- Describes all methods for treatment of benign sources of DUB

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Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

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PROFESSIONALISM

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PRACTICE-BASED LEARNING AND IMPROVEMENT

- Attends each scheduled clinic
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SYSTEM-BASED PRACTICE

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- Demonstrates integration of medical problems and health promotion with respect to individual patient’s culture, socioeconomic status, occupation, and environment.
- Understands the role support staff play in the delivery of health care in the ambulatory setting
- Including: nursing staff, medical assistants, LPNs (Licensed Practical Nurses), RNs (registered nurses), social services, nutritionists, physical therapy and rehabilitation programs.
- Practices cost-effective care and advocate for patients within the system.
- Understands medicolegal aspects of patient care and documentation

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Comments

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Return to Questionnaire List
REI (PGY 3) Faculty on Resident

[Subject Name]  
[Subject Status]  
[Subject Rotation]  
[Evaluator]  

[Evaluator Name]  
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

- Assess critical elements of fertility history: previous contraception, conception, sexually transmitted disease, complications
- Develop working knowledge of the diagnosis and treatment of benign diseases of female genital tract and skills necessary to make surgical treatment plans
- Describe a basic infertility workup, including BBT charting, HSG, Postcoital testing, Laparoscopy, Semen analysis, and Principles of reproductive surgery

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Comments

Remaining Characters: 5,000

PATIENT CARE/SURGICAL

- Develop Knowledge of anatomy, instrumentation, and surgical techniques
- Participate in laparotomy (myomectomy, tubal anastomosis), hysterectomy and other benign gynecologic procedures
- Assist in advanced Operative laparoscopy with and without the laser, to improve fertility or obliterate disease (and adhesions), and fallopian tube disease

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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE
- Expands knowledge of surgical anatomy and surgical gynecology.
- Synthesizes and restates menstrual physiology including FSH, inhibin B, estradiol rise in LH surge, and aspects of ovulation.
- Describe the relationship between ovarian and adrenal androgen production and hyperinsulinemia.
- Describe the pharmacology of hormone therapy and SERMs.
- Describe the normal process of steroid hormone biosynthesis.

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Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- Develops skills in interviewing, informed decision-making, and the development of surgical treatment plans.
- Understand role of reproductive surgery in reproductive medicine.

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PROFESSIONALISM

- Resident will be evaluated on their demonstration of caring and respectful behaviors to patients, and staff in operating room and on the floor.

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Comments

Remaining Characters: 5,000

PRACTICE-BASED LEARNING AND IMPROVEMENT

- Critically interprets journal articles: salient points, statistical strengths
- Employs principles of evidence basis in decision-making
- Receptive to instruction and feedback

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<th>Agree</th>
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</table>
SYSTEM-BASED PRACTICE

- The resident understands the interaction of OR scheduling and case coverage.
- The resident should practice cost effective care and advocate for patients within the system.
- Coordinates relationships with other physicians and caregivers.
- Implements proper charts for purpose of communication

Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
Research - Faculty of Resident

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluation Dates]

Evaluator

[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE

- Demonstrates knowledge of the role of research in care of patients

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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- Applies basic science principles as correlated with clinical practice
- Uses analytical and critical thinking techniques in accumulating knowledge base
- Understanding of research systems, critical literature review, statistical methods
- Demonstrates knowledge of how to access new medical information related to care of patients

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Comments

Remaining Characters: 5,000

PRACTICE-BASED LEARNING AND IMPROVEMENT

- Understands basics of statistical methods
- Is the problem identified and researched by this resident medically relevant and interesting
- Is the problem explored with an appropriate level of depth and sophistication
- Does the resident use references appropriately? (Quality and number, breadth of sources, etc.)
- Do the findings match data presented, and do they follow logically
- Did the resident develop the ability to research a problem independently and competently
- Has the presentation of the work, both written and verbal, been clear, organized and professional?

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Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- Evaluates own performance on experiential basis
- Open minded to willingness to learn from errors

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Comments

Remaining Characters: 5,000

PROFESSIONALISM

- Honest, trustworthy
- Adheres to principles of confidentiality and scientific/academic integrity
- Shows ethical behavior in research methods
- Accepts responsibility for own actions
- Dress and appearance is appropriate
- Displays proper hygiene
- Team player; helps other staff
- Respectful of peers and administrators

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Comments

Remaining Characters: 5,000

SYSTEM-BASED PRACTICE

- Aware of regulatory issues in research
- Understands issues relating to community health, epidemiology, demographic and populations health concerns
- Understand medical legal aspects of medical research

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Comments

Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
Ryan Family Planning Faculty of Resident

[Subject Name]  
[Subject Status]  
[Subject Rotation]  
[Evaluation Dates]

Evaluator  
[Evaluator Name]  
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE

- Counsel a patient on contraception and sexually transmitted diseases
- Determine pregnancy viability using patient history, laboratory results and ultrasound findings
- Determine gestational age based on physical examination and ultrasound findings
- Counsel a patient on options for non-viable pregnancy termination, including induced medical abortion, induced surgical abortion, and observation
- Perform a 1st trimester medical abortion
- Perform a 1st trimester surgical abortion
- Manage common complications of induced abortion

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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- Demonstrates an adequate fund of knowledge pertinent to medical/surgical abortion indications, techniques and complications
- Demonstrates adequate specific knowledge of abortion procedures
- Demonstrates knowledge of complications and approaches for management

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Comments

Remaining Characters: 5,000

PRACTICE-BASED LEARNING AND IMPROVEMENT
- Maintains an accurate and complete case log
- Incorporates experience and scientific evidence into clinical practice
- Learns from mistakes and accepts constructive criticism

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Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- Communicates effectively with patients and families
- Presents patients accurately and efficiently to colleagues
- Maintains accurate, timely and legible records
- Teaches medical students effectively

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Comments

Remaining Characters: 5,000

PROFESSIONALISM

- Demonstrates honest and ethical behavior
- Maintains patient confidentiality
- Accepts responsibility for patient care
- Accepts preferences and psychosocial attitudes of patients
- Respects others

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SYSTEM-BASED PRACTICE
- Demonstrates awareness of different healthcare insurance models
- Demonstrates awareness of healthcare costs and limitations of access

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Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
UROGYN (PGY 3 & 4) Faculty on Resident

[Subject Name]  
[Subject Status]  
[Subject Rotation]  
[Evaluator Name]  
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE/CLINICAL

- Formulates and implements a management plan for the critically ill post operative patient
- Performs a focused physical examination to identify specific pelvic floor defects including: a) Anterior vaginal wall prolapse; b) Aprical and uterine prolapse; c) Posterior vaginal wall prolapse; d) Chronic disruption of the anal sphincter complex

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Comments

Remaining Characters: 5,000

PATIENT CARE/SURGICAL

- Develops competency in performing cystoscopy for determining the patency of the ureters.
- Performs competently procedures considered essential for generalist practice in reconstructive vaginal techniques, such as vaginal hysterectomy, colporrhaphy and other procedures in Female Pelvic Floor Medicine.

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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- Describes the appropriate preoperative evaluation for a geriatric patient including consultation with other medical disciplines as indicated
- Describes the normal anatomic supports and dynamics of the vagina, bladder, urethra, uterus and rectum.
- Indicate the normal neurophysiologic processes of urinary and fecal storage and evacuation.
• Explains the current staging system for prolapse, and nomenclature for lower urinary tract function.
• Describes the principles and clinical usefulness of urodynamic testing.
• Explains pathophysiology/ nonsurgical and surgical options for the management of stress urinary incontinence and pelvic organ prolapse

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Comments

Remaining Characters: 5,000

PROFESSIONALISM

• Interacts effectively and ethically with entire obstetric team
• Demonstrates compassion and integrity in the interaction with all patients
• Demonstrates respect and professionalism in interactions with staff.
• Provides guidance and assistance to the younger residents as necessary

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Comments

Remaining Characters: 5,000

PRACTICE-BASED LEARNING AND IMPROVEMENT

• Attends scheduled call and takes care of scheduled group of patients
• Demonstrates commitment to continued learning through reading, self-study, performing literature searches and giving presentations.
• Researches, appraises and assimilates evidence from literature to provide quality gynecologic care
• Receptive to instruction and feedback

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Comments

Remaining Characters: 5,000

SYSTEM-BASED PRACTICE

• Is cognizant of the procedural and diagnostic reimbursement codes
• Practices cost-effective health care that does not compromise quality of care
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**Comments:**

Remaining Characters: 5,000

**Overall Comments:**

Remaining Characters: 5,000

Return to Questionnaire List
Rotation by Resident

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

**ROTATION**

The clinical patient volume and variety experience is excellent

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Comments

Remaining Characters: 5,000

The teaching/learning experience is excellent

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Comments

Remaining Characters: 5,000

The curriculum and expectations are clear and reasonable

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Comments

Remaining Characters: 5,000

Evaluations are reasonable and fair and understandable
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Comments

Remaining Characters: 5,000

My strengths and weaknesses are openly and fairly discussed with me

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Comments

Remaining Characters: 5,000

The lectures and rounds were informative and of high quality

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Comments

Remaining Characters: 5,000

The goals and objectives of the Rotation have been met

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Comments

Remaining Characters: 5,000

Indicate topics, subjects or clinical training you did not experience, or did not experience fully, but would have liked to

Remaining Characters: 5,000
<table>
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Remaining Characters: 5,000

Return to Questionnaire List
## GYN/ONC Rotation Evaluation by Resident

[Subject Name]  
[Subject Status]  
[Subject Rotation]  
[Evaluation Dates]  

Evaluator  
[Evaluator Name]  
[Evaluator Status]  

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

### OVERALL

- The clinical patient volume and variety experience is excellent  
- The teaching/learning experience is excellent  
- Critique is reasonable, fair and understandable  
- The rounds were informative and of high quality

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Comments

Remaining Characters: 5,000

### ONCOLOGY ROTATION

- Discussed diagnosis and operative plan  
- Discussed post operative management  
- Discussed adjuvant therapy, chemo or radio therapy  
- Instructed surgical technique of radical hysterectomy  
- Instructed bladder, bowel, adhesion surgical technique  
- Discussed, demonstrated surgical staging procedure

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Comments

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Indicate topics, subjects or clinical training you did not experience, or did not experience fully, but would have liked to
**Ryan Family Planning Rotation Evaluation**

*Subject Name*  
*Subject Status*  
*Subject Rotation*  
*Evaluation Dates*  

Evaluator  
*Evaluator Name*  
*Evaluator Status*  

*Where there are scores of 2 or lower in any category, the evaluator should enter comments.*

### ROTATION

The clinical patient volume and variety experience is excellent  

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<th>Strongly Agree</th>
<th>N/A</th>
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<tbody>
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<td>5</td>
<td>6</td>
<td>N/A</td>
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</tbody>
</table>

Comments

Remaining Characters: 5,000

The teaching/learning experience is excellent  

<table>
<thead>
<tr>
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<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>5</td>
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<td>N/A</td>
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</tbody>
</table>

Comments

Remaining Characters: 5,000

The curriculum and expectations are clear and reasonable  

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>5</td>
<td>6</td>
<td>N/A</td>
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</tbody>
</table>

Comments

Remaining Characters: 5,000

Evaluations are reasonable and fair and understandable
My strengths and weaknesses are openly and fairly discussed with me

The lectures and rounds were informative and of high quality

The goals and objectives of the Rotation have been met

Indicate topics, subjects or clinical training you did not experience, or did not experience fully, but would have liked to
SEMI-ANNUAL EVALUATIONS

- Resident of Faculty
- Resident Self Assessment
- Resident Peer Evaluation
- Nurse of Resident – GYN
- Nurse of Resident – OB
- Patient Satisfaction Questionnaires – (English & Spanish)
- OB/GYN Resident Annual & Semi-Annual Review Form – Program Director on Resident
Faculty by Resident

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluation Dates]

Evaluator

[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE

- Clinical skills are excellent
- Manages complex and dynamic situations well
- Accepts a duty and responsibility for patients' care
- Is available for patients' needs
- Is careful and thorough
- Addresses psychosocial aspects of patient care

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>2</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- Knowledge is extensive and well integrated
- Assesses diagnostic information accurately and clearly
- Able to reason deductively
- Patient skills are appropriate and well developed

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>2</td>
<td>6</td>
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</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

PRACTICE-BASED LEARNING AND IMPROVEMENT

- Effectively uses own experiences as examples
- Aware of shortcomings and takes steps to correct them
INTERPERSONAL AND COMMUNICATION SKILLS

- Communicates effectively with patients and patients' families
- Writes clear and concise notes and prescriptions
- Communicates effectively with peers, co-workers, residents and students
- Demonstrates respect, compassion and sympathy to patients and families
- Listens carefully to patients' concerns, and allows patients to express them fully

PROFESSIONALISM

- Honest, trustworthy, ethical
- Accepts responsibilities for actions and mistakes
- Respects professional knowledge and skills of others
- Respects cultural, age, gender, sexual and religious differences and preferences

SYSTEM-BASED PRACTICE

- Understands the role of patients and residents in integrated managed care health systems.
- Aware of cost efficiency balanced with the provision of quality care
- Knowledgeable about health promotion and disease prevention issues, and about aspects of community health concerns
TEACHING QUALITIES

- Attending is knowledgeable
- Attending is effective as a teacher in communicating and analyzing patient issues or subject matter
- Encourages critical thinking skills and use of evidence based medicine
- Contributes to teaching conferences

Overall Comments:

Return to Questionnaire List
Resident Semi-Annual Self Assessment

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluation Dates]

Evaluator
[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE

- My clinical skills are excellent
- I manage complex and dynamic situations well
- I accept a duty and responsibility for my patients' care
- I am available for my patients' needs
- I am careful and thorough
- I address psychosocial aspects of patient care

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
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<tbody>
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<td>5</td>
<td>6</td>
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</tbody>
</table>

Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- My knowledge is extensive and well integrated
- I assess diagnostic information accurately
- I am able to reason deductively
- My H&P skills are appropriate and well developed

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
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<td>4</td>
<td>5</td>
<td>6</td>
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</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

PRACTICE-BASED LEARNING AND IMPROVEMENT

- I can effectively assimilate and correlate experiences in care, and apply what I have learned
- I am aware of my shortcomings and take steps to correct them
- I seek areas to improve my knowledge, skills and attitudes

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
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<td>4</td>
<td>5</td>
<td>6</td>
<td>O</td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- I communicate effectively with my patients
- I communicate effectively with my patient's families
- I write clear and concise notes and prescriptions
- I communicate effectively with peers, co-workers
- I demonstrate compassion and sympathy to patients and families
- I show respect to patients' thoughts and feelings
- I listen carefully to patients' concerns, and allow patients to express them fully

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
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<tbody>
<tr>
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<td>4</td>
<td>5</td>
<td>6</td>
<td>O</td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

PROFESSIONALISM

- I am honest, trustworthy
- I am ethical
- I accept responsibilities for actions and mistakes
- I respect professional knowledge and skills of others
- I am available (dutiful)
- I respect cultural, age, gender, sexual and religious differences and preferences

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>O</td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

SYSTEM-BASED PRACTICE
- I understand the role of patients and myself in integrated managed care health systems
- I am aware of cost efficiency balanced with the provision of quality care
- I am knowledgeable about health promotion and disease prevention issues, and about aspects of community health concerns.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree 3</th>
<th>Agree 4</th>
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<th>Strongly Agree 6</th>
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<tbody>
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Comments:

Remaining Characters: 5,000

Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
Resident Peer Evaluation

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluation Dates]

Evaluator

[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE

- Demonstrates knowledge and capability in care of patients
- Non-judgmental of patients or families
- Collaborates well with all co-workers
- Available to patients and co-workers

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- Demonstrates knowledge and capability in care of patients

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
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<td></td>
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</tbody>
</table>

Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- Demonstrates skill in interpersonal relationships with patients
- Communicates effectively (verbally, written)
- Shows compassion, sympathy
- Respects co-workers
- Courteous

N/A
### PROFESSIONALISM

- Collaborates well with all co-workers
- Accepts responsibility for own actions and decisions
- Accepts responsibilities for care of patients; dutiful
- Honest
- Available to patients and co-workers

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
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**Comments**

Remaining Characters: 5,000

**Overall Comments:**

Remaining Characters: 5,000

*Return to Questionnaire List*
Nurse of Resident - GYN

[Subject Name]
[Subject Rotation]
[Evaluation Dates]

Evaluator

[Evaluator Name]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE

- Demonstrates knowledge and capability in care of patients
- Non-judgmental of patients or families
- Collaborates well with all co-workers
- Available to patients and co-workers

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- Demonstrates knowledge and capability in care of patients

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<th>Agree</th>
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<th>Strongly Agree</th>
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</table>

Comments

Remaining Characters: 5,000

INTERPERSONAL AND COMMUNICATION SKILLS

- Demonstrates skill in interpersonal relationships with patients
- Communicates effectively (verbally, written)
- Shows compassion, sympathy
- Respects co-workers
- Courteous

N/A
PROFESSIONALISM

- Collaborates well with all co-workers
- Accepts responsibility for own actions and decisions
- Accepts responsibilities for care of patients; dutiful
- Honest

Available to patients and co-workers

<table>
<thead>
<tr>
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<th>Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
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<td>5</td>
<td>6</td>
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Comments:

Remaining Characters: 5,000

Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
Nurse of Resident - OB

[Subject Name]
[Subject Status]
[Subject Rotation]
[Evaluation Dates]

Evaluator

[Evaluator Name]
[Evaluator Status]

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

PATIENT CARE

- Demonstrates knowledge and capability in care of patients
- Non-judgmental of patients or families
- Collaborates well with all co-workers
- Available to patients and co-workers

<table>
<thead>
<tr>
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<th>Agree</th>
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Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

- Demonstrates knowledge and capability in care of patients

<table>
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<th>Agree</th>
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Comments

Remaining Characters: 5,000

Medical Knowledge Comments: (Please use comments field to explain your rankings above)

INTERPERSONAL AND COMMUNICATION SKILLS
- Demonstrates skill in interpersonal relationships with patients
- Communicates effectively (verbally, written)
- Shows compassion, sympathy
- Respects co-workers

### Courteous

<table>
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<th>Agree</th>
<th>Strongly Agree</th>
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<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
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</tbody>
</table>

Comments

Remaining Characters: 5,000

### PROFESSIONALISM

- Collaborates well with all co-workers
- Accepts responsibility for own actions and decisions
- Accepts responsibilities for care of patients; dutiful
- Honest

### Available to patients and co-workers

<table>
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<tr>
<th></th>
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<th>Agree</th>
<th>Strongly Agree</th>
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Comments

Remaining Characters: 5,000

### PRESENTATION, ROUNDS AND SPECIALTY CONFERENCES ARE:

Additional Comments

Remaining Characters: 5,000

Return to Questionnaire List
<table>
<thead>
<tr>
<th>Doctor's Name</th>
<th>Date</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>(circle one)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Poor</td>
<td>Fair</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Patient Satisfaction Questionnaire</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HOW IS THIS DOCTOR AT...</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greeting you warmly; calling you by the name you prefer; being friendly, never crabby or rude</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Letting you tell your story while listening carefully; asking thoughtful questions; not interrupting you while you are talking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Showing interest in you as a person; not acting bored or ignoring what you have to say</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Treating you like you're on the same level; never &quot;talking down&quot; to you or treating you like a child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Informing you during the physical exam about what he/she is going to do and why; telling you what he/she finds</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Explaining what you need to know about your problems, how and why they occurred, and what to expect next</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Using words you can understand when explaining your problems and treatment; explaining any technical medical terms in plain language</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Discussing options with you and asking your opinion; offering choices and letting you help decide what to do; asking what you think before telling you what to do</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Encouraging you to ask questions; answering them clearly; never avoiding your questions or lecturing you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Telling you everything; being truthful, upfront and frank; not keeping things from you that you should know</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Adapted from ABIM Questionnaire
<table>
<thead>
<tr>
<th>Nombre del médico ___________________________ Fecha ___________________________</th>
<th>Paciente hospitalizado</th>
<th>Paciente ambulatorio</th>
<th>(marque uno con un círculo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CÓMO ES ESTE MÉDICO PARA...</td>
<td>Malo</td>
<td>Regular</td>
<td>Bueno</td>
</tr>
<tr>
<td>Saludarle cálidamente, llamarle por el nombre de su preferencia; ser amigable, nunca estar malhumorado ni ser grosero</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Permitirle contar su historia mientras escucha atentamente; hacer preguntas bien pensadas; no interrumpirle mientras está hablando</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Mostrar interés en usted como persona; no actuar de manera aburrida ni ignorar lo que usted tenga que decir</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Tratarle como si usted estuviera en el mismo nivel; nunca tratarle en forma condescendiente o como niño</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Informarle durante el examen físico sobre lo que él/ella está haciendo y por qué; decírle lo que encuentra</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Explicar lo que usted necesita saber sobre sus problemas, cómo y por qué ocurrieron y qué esperar después</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Usar palabras que usted pueda entender cuando está explicándole sus problemas y tratamiento; explicar cualquier término médico técnico en lenguaje común</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Discutir opciones con usted y pedir su opinión; ofrecer opciones y dejar que usted le ayude a decidir qué hacer; preguntar qué piensa antes de decirle qué hacer</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Alentarle a realizar preguntas; responderlas claramente; nunca evitar sus preguntas ni darle sermones</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Decirle todo; ser sincero, honesto y franco; no ocultarle cosas que usted debería saber</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Adaptado del cuestionario ABIM
OBSTETRICS AND GYNECOLOGY ANNUAL/SEMI ANNUAL EVALUATION

Name: M.D.                                    Date of Review:

Served in the following capacity:               Month/Year – Month/Year

- First Year OB/GYN Resident
- Second Year OB/GYN Resident
- Third Year OB/GYN Resident
- Fourth Year OB/GYN Resident

7/1/20 – 6/30/20

To our knowledge this individual was:

a) Subjected to academic probation?             Yes  No
b) Subjected to disciplinary action by University of Nevada SOM? Yes  No
c) Subjected to disciplinary action by the state licensure board? Yes  No

Affirmative answers (yes) for any question above must be described in detail below. Additional documentation shall be appended as appropriate.

Summary evaluation of Resident performance:

<table>
<thead>
<tr>
<th>Category</th>
<th>Exceptional</th>
<th>Acceptable</th>
<th>Unacceptable</th>
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</thead>
<tbody>
<tr>
<td>Patient Care – Clinical judgment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Care – Clinical skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalism – Ethics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalism – Reliability/dependability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalism – Humanistic skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal skills and communication with patients</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Interpersonal skills and communication with members of the health care team</td>
<td></td>
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<tr>
<td>Practice Based Learning – Evidence Based Practice</td>
<td></td>
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<tr>
<td>Systems-based Practice – Resource Utilization</td>
<td></td>
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</tbody>
</table>

Note: Unacceptable responses to any category above must be described below. This must include counseling, remediation or direction.
Evaluations:


Research:

Project Name: ____________________________
Preceptor: ________________________________
Status of Research Project: ____________________________


Case Logs:


Chart Reviews:


Overall Strengths & Weaknesses:


Signature: ____________________________
Program Director
Date ____________________________

Print Name: Vani Dandolu, M.D.
Program Director
OB/GYN Specialty

I have read this evaluation and have had an opportunity to discuss with the Residency Director.

Signature: ____________________________
Resident
Date ____________________________

Print Name: ____________________________
M.D.
Resident
OB/GYN Specialty

Copy to: Office of Graduate Medical Education if unacceptable or affirmative answers are present.
ANNUAL EVALUATIONS

- Resident Annual Assessment of Program (Dept)
- Faculty Assessment of Program is completed via an online Graduate Medical Education Office Evaluation. (Not included here)
- Additional Resident Assessment of Program is completed via an online Graduate Medical Education Office Evaluation. (Not included here)
- Final Summative Evaluation of Graduating Residents
**Resident Annual Assessment of Program**

Where there are scores of 2 or lower in any category, the evaluator should enter comments.

### PROGRAM

The clinical patient volume and variety of experience is excellent

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
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<tbody>
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</tbody>
</table>

Comments

Remaining Characters: 5,000

The teaching/learning experience is excellent

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
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</table>

Comments

Remaining Characters: 5,000

The program leadership is effective and concerned with residents

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
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</tbody>
</table>

Comments

Remaining Characters: 5,000
The orientation and Resident Handbook are helpful

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
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</table>

Comments

Remaining Characters: 5,000

The curriculum and expectations are clear and reasonable

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
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<tbody>
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<td>5</td>
<td>6</td>
<td></td>
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</tbody>
</table>

Comments

Remaining Characters: 5,000

Evaluations are reasonable and fair and understandable

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>5</td>
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</tbody>
</table>

Comments

Remaining Characters: 5,000

My strengths and weaknesses are openly and fairly discussed with me

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
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<td>5</td>
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</tr>
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</table>

Comments

Remaining Characters: 5,000

Corrective actions are fair, and guidance is available to me

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
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<tbody>
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<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>
### The Program Departmental Staff (program coordinator and secretarial assistance) are helpful to me

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td></td>
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<td>5</td>
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</tbody>
</table>

**Comments**

Remaining Characters: 5,000

### The Institutional GME Administration (Office of Graduate Medical Education) is helpful to me

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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<td>5</td>
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</tbody>
</table>

**Comments**

Remaining Characters: 5,000

### There is opportunity to voice concerns in a confidential manner without fear of intimidation or reprisal

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
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<td>5</td>
<td>6</td>
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</table>

**Comments**

Remaining Characters: 5,000

### The working environment, including the hours of duty, is satisfactory and allows personal time for family and recreation

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
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<tbody>
<tr>
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<td>5</td>
<td>6</td>
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</tbody>
</table>

**Comments**

Remaining Characters: 5,000
The goals and objectives of the Program have been met

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Strongly Agree</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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Comments

Remaining Characters: 5,000

Overall Comments:

Remaining Characters: 5,000

Return to Questionnaire List
Dr. (A) has satisfactorily completed the residency-training program in Obstetrics & Gynecology at the University of Nevada School of Medicine, Department of OB/GYN, Las Vegas, Nevada. Her/His performance during training was evaluated by both faculty and peers. Her/His surgical skills were deemed excellent / very good / good / average / fair / poor. Her/His knowledge base was excellent / very good / good / average / fair / poor. She/He was viewed as professional and competent to practice medicine. She/He has accomplished the educational goals and objectives of the program and has demonstrated proficiency in the core competencies for residents.

### MEDICAL KNOWLEDGE

<table>
<thead>
<tr>
<th>Superiors</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic professional knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical thinking ability</td>
<td></td>
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<td></td>
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</table>

### PATIENT CARE

<table>
<thead>
<tr>
<th>Superiors</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and physical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical/Technical Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpret and apply diagnostic tools</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtain consultations when needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional judgment</td>
<td></td>
<td></td>
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</table>

### COMMUNICATION & INTERPERSONAL SKILLS

<table>
<thead>
<tr>
<th>Superiors</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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</thead>
<tbody>
<tr>
<td>Cooperativeness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to work with others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner-patient relations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counsel and educate patients/families</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtain informed consent</td>
<td></td>
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### SYSTEMS BASED PRACTICE

<table>
<thead>
<tr>
<th>Superiors</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in committee activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocate for quality patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice cost effective care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate commitment to patient safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in peer review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in quality improvement</td>
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</tbody>
</table>

### PRACTICE BASED LEARNING

<table>
<thead>
<tr>
<th>Superiors</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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<tbody>
<tr>
<td>Case presentations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical use of the literature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analyze practice patterns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commitment to ongoing education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commitment to quality improvement</td>
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</table>

### PROFESSIONALISM

<table>
<thead>
<tr>
<th>Superiors</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
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<tbody>
<tr>
<td>Sense of responsibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical conduct</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respect</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Dr. (A) began her/his training on July 1, 20 and completed her/his training on June 30, 20. Dr. (A) has demonstrated sufficient professional ability to practice competently and independently in the field of Obstetrics & Gynecology.

We certify that:

~ Dr. (A) followed satisfactorily the course of instruction designed for this program.

~ Dr. (A) has taken leaves of absence and vacation not to exceed 8 weeks in years 1, 2, 3; 6 weeks in year 4, or a total of 20 weeks over the four years of residency.

~ Dr. (A) achieved the appropriate knowledge, ability and judgment in order to provide competent clinical care in obstetrics and gynecology, as documented by ongoing evaluation during the entire residency program.

~ Dr. (A) demonstrated the necessary technical skills to perform:

  (1) major abdominal and vaginal surgical procedures upon the female pelvis and related structures,

  (2) spontaneous and operative obstetric deliveries,

  (3) surgical exploration of the abdomen,

  (4) endoscopic procedures including laparoscopy and hysteroscopy,

  (5) diagnostic evaluation including electronic fetal monitoring, ultrasound, colposcopy, and amniocentesis

  (6) diagnosis and treatment of complications of the above

~ Dr. (A) demonstrated good moral and clinical character.

~ Dr. (A) has demonstrated sufficient professional ability to practice competently and independently.

~ Dr. (A) is board eligible, with clinical competence certified to the American Board of Obstetrics and Gynecology.

I hereby authorize and consent to the release by University of Nevada School of Medicine, the Graduate Medical Education Office and representatives to other training programs, hospitals, their medical staff and their representatives, physician foundations, payers, and to medical associations this final evaluation and any additional necessary information the University of Nevada School of Medicine, the Graduate Medical Education Office and representatives may have concerning my professional competence, ethics, character and other professional qualifications, as long as such release is done in good faith and without malice, and I hereby release from liability the University of Nevada School of Medicine, the Graduate Medical Education Office and representatives for so doing.

__________________________________________
Signature of Chair / Program Director
Vani Dandolu, M.D.

__________________________________________
Signature of Resident
Resident Name
The Obstetrics and Gynecology Milestone Project

A Joint Initiative of
The Accreditation Council for Graduate Medical Education,
The American Board of Obstetrics and Gynecology,
and
The American College of Obstetrics and Gynecology

September 2013
The Obstetrics and Gynecology Milestone Project

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.
Obstetrics and Gynecology Milestones

Chair: Jessica Bienstock, MD, MPH

**Working Group**

Karen E. Adams, MD
AnnaMarie Connolly, MD
Laura Edgar, EdD, CAE
Gary N. Frishman, MD
Alice R. Goepfert, MD
Robert V. Higgins, MD, FACOG, FACS
Lee A. Learman, MD, PhD
Rebecca McAlister, MD
Mary Joyce Turner, RHIA, MJ
George Wendel, MD
Christopher M. Zahn, MD

**Advisory Group**

Timothy P. Brigham, MDiv, PhD
Mary Ciotti, MD
Larry C. Gilstrap III, MD
Hal C. Lawrence III, MD, FACOG
John R. Potts III, MD

*Acknowledgements. The authors, all of whom participated in milestone development as members of the Obstetrics and Gynecology Milestone Working Group, wish to thank the members of the original Obstetrics and Gynecology Working Group for their contributions to this work: Haywood L. Brown, MD; Tamara T. Chao, MD; Missy Fleming, PhD; Diane Hartmann, MD; Frank Ling, MD; Krista Reagan, MD; Jeffrey M. Rothenberg, MD; Andrew Satin, MD; Howard Shaw, MD; David Soper, MD; Ronald C. Strickler, MD; Susan Swing, PhD.*
Milestone Reporting

This document presents milestones designed for programs to use in semi-annual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. In the initial years of implementation, the Review Committee will examine milestone performance data for each program’s residents as one element in the Next Accreditation System (NAS) to determine whether residents overall are progressing.

For each period, review and reporting will involve selecting milestone levels that best describe each resident’s current performance and attributes. Milestones are arranged into numbered levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert. These levels do not correspond with post-graduate year of education.

Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels (see the diagram on page v).

**Level 1:** The resident demonstrates milestones expected of an incoming resident.

**Level 2:** The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.

**Level 3:** The resident continues to advance and demonstrate additional milestones, consistently including the majority of milestones targeted for residency.

**Level 4:** The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.

**Level 5:** The resident has advanced beyond performance targets set for residency and is demonstrating “aspirational” goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.
Additional Notes

Level 4 is designed as the graduation target but does not represent a graduation requirement. Making decisions about readiness for graduation is the purview of the residency program director. Study of milestone performance data will be required before the ACGME and its partners will be able to determine whether milestones in the first four levels appropriately represent the developmental framework, and whether milestone data are of sufficient quality to be used for high-stakes decisions.

Examples are provided with some milestones. Please note that the examples are not the required element or outcome; they are provided as a way to share the intent of the element.

Some milestone descriptions include statements about performing independently. These activities must occur in conformity to the ACGME supervision guidelines, as well as institutional and program policies. For example, a resident who performs a procedure independently must, at a minimum, be supervised through oversight.

Answers to Frequently Asked Questions about the NAS and milestones are available on the ACGME’s NAS microsite: [http://www.acgme-nas.org/assets/pdf/NASFAQs.pdf](http://www.acgme-nas.org/assets/pdf/NASFAQs.pdf).
The diagram below presents an example set of milestones for one sub-competency in the same format as the milestone report worksheet. For each reporting period, a resident’s performance on the milestones for each sub-competency will be indicated by:

- selecting the level of milestones that best describes that resident’s performance in relation to the milestones
- or
- for Patient Care and Medical Knowledge milestones, selecting the option that says the resident has “Not yet rotated” or
- for Interpersonal and Communication Skills, Practice-based Learning and Improvement, Professionalism, and Systems-based Practice, selecting the option that says the resident has “Not yet achieved Level 1”

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as some milestones in the higher level(s).
## Antepartum Care and Complications of Pregnancy — Patient Care

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demonstrates basic knowledge of normal antepartum care and common medical complications seen in pregnancy</strong></td>
<td><strong>Provides complete antepartum care for women with uncomplicated pregnancies</strong></td>
<td><strong>Manages common medical complications (e.g., hypertension, diabetes, infectious diseases)</strong></td>
<td><strong>Demonstrates a comprehensive understanding of the varying patterns of presentation and treatment options for a variety of medical and obstetrical complications</strong></td>
<td><strong>Manages patients with complex and atypical medical and obstetrical complications</strong></td>
</tr>
<tr>
<td>Recognizes basic risk factors, symptoms, and signs of common medical complications (e.g., hypertension, diabetes, infectious diseases)</td>
<td>Recognizes basic risk factors, symptoms, and signs of common obstetrical conditions (e.g., post-term gestation, abnormal placentation, third trimester bleeding)</td>
<td>Manages common obstetrical complications (e.g., previous Cesarean section, abnormal fetal growth, multifetal gestation)</td>
<td>Recognizes atypical presentations of medical and obstetrical complications; identifies indications for consultation, referral, and/or transfer of care for patients with medical and obstetrical complications</td>
<td>Applies innovative approaches to complex and atypical antepartum conditions and implements treatment plans based on emerging evidence</td>
</tr>
</tbody>
</table>

**Comments:**

Not yet rotated
### Care of Patients in the Intrapartum Period — Patient Care

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<tbody>
<tr>
<td>Demonstrates basic knowledge of routine/uncomplicated intrapartum obstetrical care including, conduct of normal labor</td>
<td>Provides intrapartum obstetrical care for women with uncomplicated pregnancies (e.g., identification of fetal lie, interpretation of fetal heart rate monitoring, and tocodynamometry)</td>
<td>Manages abnormal labor Manages intrapartum complications (e.g., cord prolapse, placental abruption)</td>
<td>Provides care for women with complex intrapartum complications and conditions Identifies indications for consultation, referral, and/or transfer of care for patients with intrapartum complications Effectively supervises and educates lower-level residents in intrapartum care</td>
<td>Applies innovative approaches to complex and atypical intrapartum conditions and implements treatment plans based on emerging evidence</td>
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<td>Differentiates between normal and abnormal labor</td>
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<td>Recognizes intrapartum complications (e.g., chorioamnionitis, shoulder dystocia)</td>
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<tr>
<td>Demonstrates basic knowledge of normal postpartum care</td>
<td>Provides postpartum care for women with uncomplicated pregnancies, including lactation counseling</td>
<td>Manages common postpartum complications</td>
<td>Manages patients with complex complications of the postpartum period (e.g., septic pelvic thrombophlebitis, pulmonary embolism)</td>
<td>Applies innovative approaches to complex and atypical postpartum conditions and implements treatment plans based on emerging evidence</td>
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<tr>
<td>Recognizes basic risk factors, symptoms, and signs, of common postpartum complications (e.g., postpartum hemorrhage, infection, venous thromboembolism, depression)</td>
<td>Correctly interprets the results of obstetric pathology and laboratory reports to ascertain the etiology of obstetrical outcomes</td>
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| Demonstrates basic surgical principles, including use of universal precautions and aseptic technique | Performs basic obstetrical skills, including:  
  - assessment of cervical dilation  
  - spontaneous vaginal delivery  
  - ultrasound for assessment of fetal number, lie, presentation, viability, and placental location | Performs obstetrical procedures, including:  
  - ultrasound to obtain fetal biometry  
  - biophysical profile  
  - repair of second degree perineal or vaginal lacerations  
  - primary Cesarean section  
  - uterine evacuation in the second trimester (e.g., induction, postpartum curettage) | Educates and supervises lower-level residents in performing obstetrical procedures  
  Collaborates and provides consultation to other members of the health care team in performing obstetrical procedures  
  Performs complex obstetrical procedures, including:  
  - operative vaginal delivery  
  - repair of 3rd- and 4th-degree perineal lacerations  
  - repeat Cesarean section  
  - cervical cerclage  
  - breech vaginal delivery (including second twins)  
  - cystotomy repair  
  - surgical management of postpartum hemorrhage (e.g., Cesarean hysterectomy, peripartum hysterectomy) | Applies innovative and complex approaches obstetrical care and implements treatment plans based on emerging evidence  
  Manages and repairs uterine rupture or perforation |

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<tr>
<td>Performs initial warming and drying of a non-depressed infant</td>
<td>Demonstrates the performance of Apgar testing</td>
<td>Performs initial resuscitation of a depressed infant</td>
<td>Capable of performing neonatal resuscitation that does not include administration of medications (may be demonstrated by satisfactory completion of the Neonatal Resuscitation Program [NRP] Provider Course [including hands-on skills stations and simulation] and receipt of a Provider Course Completion Card)</td>
<td>Manages both the resuscitation and the team in caring for infants who require resuscitation</td>
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<td>Identifies an infant in need of resuscitation</td>
<td>Alerts appropriate team for assistance</td>
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Immediate Care of the Newborn — Patient Care
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<tr>
<td>Demonstrates knowledge of basic abdominal and pelvic anatomy</td>
<td>Works effectively as a surgical assistant</td>
<td>Demonstrates appropriate tissue handling, request for instruments, and flow of the procedure</td>
<td>Independently performs gynecologic procedures</td>
<td>Applies innovative and complex approaches to laparotomy and implements treatment plans based on emerging evidence</td>
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<tr>
<td>Demonstrates basic surgical principles, including use of universal precautions and aseptic technique</td>
<td>Performs simple abdominal incision and closure</td>
<td>Understands and uses various forms of energy sources used in surgery</td>
<td>Demonstrates good intra-operative decision making, including the ability to modify a surgical plan based on operative findings</td>
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<tr>
<td>Positions patient appropriately for surgery</td>
<td>Demonstrates basic surgical skills, including: - knot tying - simple suturing - suture and staple removal</td>
<td>Performs uncomplicated gynecologic procedures</td>
<td>Demonstrates the ability to recognize and manage surgical complications, including the appropriate use of intra-operative consultation</td>
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<td>Recognizes surgical complications and formulates an initial management plan</td>
<td>Applies an evidence-based approach to the adoption of new technologies</td>
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<td>Effectively supervises and educates lower-level residents regarding laparotomy</td>
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<td>Collaborates and provides consultation to other members of the health care team regarding laparotomy</td>
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<tr>
<td>Demonstrates knowledge of basic pelvic anatomy</td>
<td>Works effectively as a surgical assistant</td>
<td>Displays appropriate tissue handling, request for instruments, and flow of the procedure</td>
<td>Independently performs vaginal procedures</td>
<td>Applies innovative and complex approaches to vaginal surgery and implements treatment plans based on emerging evidence</td>
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<tr>
<td>Demonstrates basic surgical principles, including use of universal precautions and aseptic technique</td>
<td>Performs simple vaginal or vulvar incision and repair</td>
<td>Understand and uses various forms of energy sources used in surgery</td>
<td>Demonstrates good intra-operative decision making, including the ability to modify a surgical plan based on operative findings</td>
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<tr>
<td>Positions patient appropriately for surgery</td>
<td>Demonstrates basic surgical skills, including:</td>
<td>Performs uncomplicated procedures</td>
<td>Recognizes surgical complications and formulates an initial management plan</td>
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<td>Recognizes surgical complications and formulates an initial management plan</td>
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### Gynecology Technical Skills: Endoscopy (Laparoscopy, Hysteroscopy, Cystoscopy) — Patient Care

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<tr>
<td>Demonstrates basic understanding of abdominal and pelvic anatomy</td>
<td>Assembles endoscopic instruments and checks proper functioning</td>
<td>Performs diagnostic procedures</td>
<td>Performs operative endoscopy independently (e.g., hysterectomy, myomectomy)</td>
<td>Applies innovative and complex approaches to endoscopy and implements treatment plans based on emerging evidence</td>
</tr>
<tr>
<td>Demonstrates basic surgical principles, including use of universal precautions and aseptic technique</td>
<td>Performs proper insertion of endoscopic instruments</td>
<td>Performs operative procedures</td>
<td>Demonstrates good intra-operative decision making, including the ability to modify surgical plan based on operative findings</td>
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<tr>
<td>Positions patient appropriately for surgery</td>
<td>Demonstrates an understanding of the indications for endoscopy</td>
<td>Displays appropriate tissue handling, request for instruments, and flow of the procedure</td>
<td>Recognizes and manages surgical complications, including the appropriate use of intra-operative consultation</td>
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<td>Uses various forms of energy sources used in surgery</td>
<td>Applies an evidence-based approach to the adoption of new technologies</td>
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<td>Recognizes complications and formulates an initial management plan</td>
<td>Effectively supervises and educates lower-level residents regarding endoscopy</td>
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<td>Collaborates and provides consultation to other members of the health care team regarding endoscopy</td>
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### Peri-operative Care — Medical Knowledge

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<tr>
<td>Demonstrates knowledge of basic abdominal and pelvic anatomy</td>
<td>Demonstrates knowledge of:</td>
<td>Demonstrates knowledge about the management of:</td>
<td>Demonstrates advanced knowledge necessary for management of medically complex patients</td>
<td>Applies innovative approaches to complex and atypical peri-operative care and implements treatment plans based on emerging evidence</td>
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<td>relevant surgical anatomy</td>
<td>medical comorbidities relevant to gynecologic surgery</td>
<td>demonstrates the ability to recognize and manage peri-operative complications</td>
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<td>common procedural indications</td>
<td>appropriate procedural options for the relevant gynecological condition</td>
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<td>comorbidities relevant to gynecologic surgery</td>
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<td>prophylactic strategies to reduce post-operative complications</td>
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</table>
| Demonstrates a basic understanding of patients presenting with abdominal/pelvic pain regarding:  
  • risk factors  
  • signs and symptoms | Demonstrates the ability to formulate a differential diagnosis  
Demonstrates an understanding of initial:  
  • evaluation  
  • treatment options | Demonstrates the ability to:  
  • utilize focused diagnostic approaches  
  • formulate comprehensive management plans | Demonstrates an in-depth knowledge regarding patients presenting with abdominal and pelvic pain relevant to:  
  • varying patterns of presentation  
  • treatment options  
  • refractory pelvic pain | Leads a multidisciplinary team for care of patients with chronic pelvic pain  
Manages patients with complex and atypical chronic pelvic pain  
Demonstrates the ability to formulate comprehensive plans of management for patients with multiple and/or complex comorbidities |

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### Abnormal Uterine Bleeding (Acute and Chronic) — Medical Knowledge

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<tbody>
<tr>
<td>Demonstrates basic knowledge about what constitutes normal and abnormal uterine bleeding</td>
<td>Demonstrates the ability to formulate a differential diagnosis</td>
<td>Demonstrates in-depth knowledge of the physiology of the normal menstrual cycle</td>
<td>Demonstrates an in-depth knowledge regarding patients presenting with abnormal uterine bleeding relevant to:</td>
<td>Applies innovative approaches to complex and atypical abnormal uterine bleeding and implements treatment plans based on emerging evidence</td>
</tr>
<tr>
<td>Verbalizes the phases of the normal menstrual cycle</td>
<td>Demonstrates an understanding of initial:</td>
<td>Demonstrates the ability to:</td>
<td>• varying patterns of presentation</td>
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<td>• evaluation</td>
<td>• utilize focused diagnostic approaches</td>
<td>• comprehensive treatment options</td>
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<td>• treatment options</td>
<td>• formulate a comprehensive management plan</td>
<td>• refractory bleeding</td>
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### Pelvic Mass — Medical Knowledge

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</table>
| Demonstrates a basic understanding of patients presenting with a pelvic mass, including:  
- differential diagnosis  
- signs and symptoms | Demonstrates the ability to formulate a focused differential diagnosis | Demonstrates the ability to:  
- utilize focused diagnostic approaches  
- formulate a comprehensive management plan | Demonstrates an in-depth knowledge regarding patients presenting with a pelvic mass relevant to:  
- varying patterns of presentation  
- comprehensive treatment options | Applies innovative approaches to complex and atypical pelvic mass and implements treatment plans based on emerging evidence |

- Demonstrates an understanding of initial:  
  - evaluation  
  - treatment options
- Determines the need for consultation, referral, or transfer of patients
- Demonstrates the ability to formulate comprehensive management plans for patients with multiple and/or complex comorbidities
- Effectively supervises and educates lower-level residents regarding pelvic mass
- Collaborates and provides consultation to other members of the health care team regarding pelvic mass

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**Pelvic Floor Disorders (Urinary Incontinence, Pelvic Prolapse, Anal Incontinence) — Medical Knowledge**

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<tbody>
<tr>
<td>Demonstrates basic knowledge of normal pelvic floor anatomy</td>
<td>Demonstrates knowledge of basic pelvic floor physiology and functional anatomy</td>
<td>Demonstrates knowledge of abnormal pelvic floor anatomy and physiology</td>
<td>For patients with uncomplicated pelvic floor disorders:</td>
<td>Effectively supervises and educates lower-level residents regarding complex and atypical pelvic floor disorders</td>
</tr>
<tr>
<td>Demonstrates a basic understanding of patients presenting with pelvic floor disorders relevant to:</td>
<td>Demonstrates an understanding of patients presenting with pelvic floor disorders relevant to:</td>
<td>For patients with uncomplicated pelvic floor disorders:</td>
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<td>Collaborates and provides consultation to other members of the health care team regarding pelvic floor disorders</td>
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<tr>
<td>- risk factors</td>
<td>- evaluation and interpretation of results</td>
<td>• utilizes focused diagnostic approaches</td>
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<td>Treats patients with complicated, atypical, or recurrent pelvic floor disorders</td>
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<tr>
<td>- symptoms</td>
<td>- treatment options</td>
<td>• uses non-surgical and surgical therapies</td>
<td></td>
<td>Applies innovative approaches to complex and atypical pelvic floor disorders and implements treatment plans based on emerging evidence</td>
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<td>- physical exam findings</td>
<td>Formulates an initial plan of management for patients with uncomplicated pelvic floor disorders</td>
<td>• formulates comprehensive management plans for patients with comorbidities</td>
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<td>Demonstrates the ability to formulate a differential diagnosis</td>
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<td>• determines the need for consultation, referral, or transfer of patients</td>
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## First Trimester Bleeding — Medical Knowledge

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<td>Demonstrates basic understanding of normal early pregnancy development, including implantation, early embryology, and placental development</td>
<td>Demonstrates the ability to formulate a differential diagnosis (e.g., ectopic pregnancy, spontaneous abortion, non-obstetric etiologies)</td>
<td>Counsels patients regarding natural history and treatment options</td>
<td>Manages patients with complications of first trimester bleeding or its management (e.g., hemorrhage, infection)</td>
<td>Applies innovative approaches to complex or atypical first trimester bleeding and implements treatment plans based on emerging evidence</td>
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<td>Utilizes non-surgical and surgical methods to manage patients with:</td>
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<td>- ectopic pregnancy</td>
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<td>- abortion (spontaneous, induced)</td>
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<td>- other etiologies</td>
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<td>Demonstrates an understanding of complications related to first trimester bleeding and its management</td>
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**Family Planning — Patient Care**

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<td><strong>Verbalizes basic knowledge about common contraceptive options</strong></td>
<td><strong>Demonstrates a basic understanding of the effectiveness, risks, benefits, complications, and contraindications of contraception, including emergency contraception, and pregnancy termination</strong></td>
<td><strong>Counsels on the effectiveness, risks, benefits, and contraindications of available forms of contraception</strong></td>
<td><strong>Formulates comprehensive management plans for patients with medical diseases complicating their use of contraceptive methods</strong></td>
<td><strong>Applies innovative and complex approaches to family planning and implements treatment plans based on emerging evidence</strong></td>
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<tr>
<td><strong>Ambulatory Gynecology — Patient Care</strong></td>
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<tr>
<td>Demonstrates basic knowledge about common ambulatory gynecologic problems</td>
<td>Performs the initial assessment, formulates a differential diagnosis, and initiates treatment for common ambulatory gynecologic problems (e.g., sexually transmitted infections, vaginitis)</td>
<td>Formulates management plans and initiates treatment for complex ambulatory gynecologic problems (e.g., cervical dysplasia, infertility, ovulatory disorders, breast disorders)</td>
<td>Effectively cares for patients with complex presentations (e.g., refractory to initial management, unusual presentations, complications)</td>
<td>Applies innovative approaches to complex and atypical ambulatory gynecology and implements treatment plans based on emerging evidence</td>
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<td>Performs colposcopy, basic gynecologic ultrasound, and other indicated office procedures</td>
<td>Uses a multi-disciplinary approach and makes appropriate referrals when caring for patients with complex ambulatory gynecologic problems (e.g., sexual dysfunction, menopausal symptoms, vulvovaginal syndromes and lesions)</td>
<td>Understands and applies principles of office management (e.g., billing)</td>
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<td>Leads an inter-professional team, including supervision, education, and coordination of care</td>
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<td>Monitors one’s own outcomes to improve practice</td>
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**Comments:**

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### Care of the Patient with Non-Reproductive Medical Disorders — Patient Care

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<tbody>
<tr>
<td>Demonstrates an understanding of common non-reproductive medical disorders</td>
<td>Performs history and physical, forms a differential diagnosis, and evaluates for common non-reproductive medical disorders (e.g., chronic hypertension, obesity, depression)</td>
<td>Interprets test results and screens for related conditions of non-reproductive medical disorders (e.g., metabolic syndrome, BRCA mutation, eating disorders)</td>
<td>Initiates management plans for patients with complex non-reproductive medical disorders (e.g., osteoporosis, metabolic syndrome, BRCA mutation, eating disorders, human immunodeficiency virus [HIV] infection) and provides referrals</td>
<td>Provides on-going, comprehensive care for patients with complex and atypical non-reproductive medical disorders</td>
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### Health Care Maintenance and Disease Prevention — Medical Knowledge

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<tbody>
<tr>
<td>Demonstrates knowledge of the characteristics of a good screening test</td>
<td>Demonstrates knowledge of evidence-based, age-appropriate guidelines for women’s health maintenance and disease prevention (e.g., breast screening, cervical cancer screening)</td>
<td>Interprets age- and risk-appropriate tests (e.g., bone mineral density, mammogram, lipids, thyroid studies)</td>
<td>Formulates comprehensive management plans for high-risk patients (e.g., vulnerable populations)</td>
<td>Manages patients with highly complex medical diseases for health care maintenance and disease prevention</td>
</tr>
<tr>
<td>Demonstrates knowledge of indications and limitations of commonly used screening tests</td>
<td>Recommends age- and risk-appropriate vaccinations</td>
<td>Develops patient-centered management plans to maintain health and prevent disease</td>
<td>Monitors one’s own outcomes to improve practice</td>
<td>Applies innovative and complex approaches to health care maintenance and disease prevention and implements treatment plans based on emerging evidence</td>
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### Systems-based Practice Milestones

#### Systems-based Practice Milestones

**Patient Safety and Systems Approach to Medical Errors: Participate in identifying system errors and implementing potential systems solutions — Systems-based Practice**

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<tbody>
<tr>
<td>Recognizes limitations and failures of a team approach (e.g., hand-offs, miscommunication) in health care as the leading cause of preventable patient harm</td>
<td>Demonstrates knowledge of institutional surveillance systems to monitor for patient safety (e.g., surgical site infection, medical error reporting)</td>
<td>Participates in patient safety reporting and analyzing systems</td>
<td>Reports errors and near-misses to the institutional surveillance system and superiors</td>
<td>Contributes to peer-reviewed medical literature</td>
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<td>Participates in “time-out”</td>
<td>Participates in team drills</td>
<td>Recognizes when root cause analysis is necessary, and is capable of participating in root cause analysis</td>
<td>Organizes and leads institutional QI/patient safety projects</td>
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<td>Appropriately utilizes checklists to promote patient safety (e.g., medication reconciliation)</td>
<td>Demonstrates knowledge of national patient safety standards, as well as their use/application in the institution</td>
<td>Actively participates in quality improvement (QI)/patient safety projects</td>
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<td>Demonstrates knowledge of the epidemiology of medical errors and the differences between near misses, medical errors, and sentinel events</td>
<td>Reports errors and near-misses to the institutional surveillance system and superiors</td>
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<tbody>
<tr>
<td>Understands the importance of providing cost-effective care</td>
<td>Is aware of common socioeconomic barriers that impact patient care</td>
<td>Demonstrates the incorporation of cost awareness into clinical judgment and decision making</td>
<td>Practices cost-effective care (e.g., formulary drugs, generic drugs, tailoring of diagnostic tests)</td>
<td>Participates in advocacy or health care legislation locally, regionally, or nationally</td>
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<tr>
<td>Understands the role of physicians in advocating for appropriate women’s health care</td>
<td>Demonstrates an awareness of the need for coordination of patient care and patient advocacy</td>
<td>Coordinates and advocates for needed resources to facilitate patient care (e.g., effective discharge planning)</td>
<td>Analyzes patient care options from a quality of life (QOL)/cost-of-care perspective, and includes in patient counseling</td>
<td>Effectively communicates within health care systems to advocate for the needs of patient populations</td>
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<td>Effectively communicates within his or her own hospital/clinic to advocate for patient needs</td>
<td>Demonstrates an understanding of the political economics of health care legislation locally, regionally, and nationally</td>
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### Practice-based Learning and Improvement Milestones

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<tr>
<td>Demonstrates an understanding of critical appraisal of the literature</td>
<td>Identifies resources (e.g., texts, search engines) to answer questions while providing patient care</td>
<td>Applies patient-appropriate use of evidence-based on review articles or guidelines on common topics in practice</td>
<td>Tailors evidence-based practice based on the values and preferences of each patient</td>
<td>Designs a hypothesis-driven or hypothesis-generating study</td>
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<tr>
<td>Demonstrates responsiveness to constructive feedback</td>
<td>Recognizes limits of knowledge, expertise, and technical skills</td>
<td>Critically reviews and interprets the literature with the ability to identify study aims, hypotheses, design, and biases</td>
<td>Reads and assesses strength of evidence in current literature and applies it to one’s own practice</td>
<td>Contributes to peer-reviewed medical literature</td>
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<td>Describes commonly used study designs (e.g., randomized controlled trial [RCT], cohort; case-control, cross-sectional)</td>
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<td>Analyzes his or her own outcomes as compared to national standards</td>
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**Comments:** Not yet achieved Level 1
## Quality Improvement Process: Systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement — Practice-based Learning and Improvement

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<tr>
<td>Has a commitment to self-evaluation, lifelong learning, and patient safety</td>
<td>Demonstrates understanding of the basic concepts of QI</td>
<td>References and utilizes national standards or guidelines in patient care plans</td>
<td>Participates in departmental or institutional QI process/committees</td>
<td>Analyzes department or institutional outcomes</td>
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<td>Reads appropriate information, as assigned by the program or related to patient-specific topics</td>
<td>Identifies quality of care issues within one’s own practice with a systems-based approach</td>
<td>Implements changes with a goal of practice improvement</td>
<td>Contributes to peer-reviewed medical literature</td>
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<td>Understands level of evidence for patient care recommendations</td>
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<td>Organizes and leads effective institutional QI/patient safety projects</td>
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### Professionalism Milestones

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<tr>
<td><strong>Compassion, Integrity, and Respect for Others</strong> — Professionalism</td>
<td><strong>Demonstrates sensitivity and responsiveness to patients</strong></td>
<td><strong>Consistently shows compassion, integrity, and respect in typical situations with patients, peers, and members of the health care team</strong></td>
<td><strong>Consistently demonstrates sensitivity and responsiveness to diversity of patients’ ages, cultures, races, religions, abilities, or sexual orientations</strong></td>
<td><strong>Accepts constructive feedback to improve his or her ability to demonstrate compassion, integrity, and respect for others</strong></td>
</tr>
<tr>
<td><strong>Understands the importance of compassion, integrity, and respect for others</strong></td>
<td><strong>Consistently shows compassion, integrity, and respect for patients who decline medical advice or request un-indicated tests or treatments, for patients who have psychiatric comorbidities, and for team members in circumstances of conflict or high stress</strong></td>
<td><strong>Consistently models compassion, integrity, and respect for others</strong></td>
<td><strong>Modifies one’s own behavior based on feedback to improve his or her ability to demonstrate compassion, integrity, and respect for others</strong></td>
<td><strong>Assumes long-term or leadership role in community outreach activities to improve the health of vulnerable populations</strong></td>
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### Accountability and Responsiveness to the Needs of Patients, Society, and the Profession — Professionalism

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<tr>
<td>Understands that physicians are accountable to patients, society, and the profession</td>
<td>Is consistently punctual for clinical assignments and responsive to requests for assistance; completes administrative duties (e.g., medical records, reports) on time and without reminders</td>
<td>Serves as an example for others in punctuality, responsiveness, and timely completion of duties</td>
<td>Coaches others to improve punctuality and responsiveness; offers assistance to ensure patient care duties are completed in a timely fashion</td>
<td>Participates in institutional or community peer counseling related to professionalism</td>
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<td>Acts with honesty and truthfulness</td>
<td>Understands the signs and symptoms of fatigue, stress, and substance abuse</td>
<td>Recognizes signs and symptoms of fatigue, stress, and substance abuse</td>
<td>Demonstrates self-awareness of fatigue and stress, and mitigates the effects</td>
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<tr>
<td>Understands the importance of respect for patient privacy and autonomy</td>
<td>Shows respect for patient privacy</td>
<td>Assesses a patient’s capacity for medical decision making</td>
<td>Successfully navigates ethically complex clinical issues involving patient autonomy</td>
<td>Successfully leads others through complex and atypical clinical issues involving patient autonomy</td>
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<td>Understands the ethical principles of appropriate patient-physician relationships</td>
<td>Elicits patient goals for care, and patient preferences regarding treatment alternatives</td>
<td>Successfully navigates conflicts between patient preferences that are discordant with personal beliefs</td>
<td>Balances patient privacy with ethical and legal requirements in complex circumstances</td>
<td>Longitudinally participates on hospital ethics committee</td>
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<td>Demonstrates an understanding of ethical principles, including boundary issues, and consciously applies them in patient care</td>
<td>Efficiently counsels patients to help align treatment decisions with individual preferences</td>
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### Communication with Patients and Families — Interpersonal and Communication Skills

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<tr>
<td>Demonstrates adequate listening skills</td>
<td>Checks for patient and family understanding of illness and management plan</td>
<td>Communicates effectively in stressful, emergent, and complex situations</td>
<td>Delivers bad news to families about complications or death</td>
<td>Capable of effective communication in the most challenging situations, and invites participation from all stakeholders</td>
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<td>Communicates effectively in routine clinical situations</td>
<td>Allows for opportunities for patient questions</td>
<td>Capable of delivering bad news to patients and families regarding poor prognoses</td>
<td>Capable of informing patients and families about a medical error that caused harm</td>
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<td>For hospitalized patients, maintains communication with patient and family regarding plan of care</td>
<td>For hospitalized patients, maintains communication with patient and family regarding plan of care</td>
<td>Communicates effectively with patients and families across a broad range of socio-economic and cultural backgrounds</td>
<td>Incorporates risk management in this process</td>
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<td>Role models effective communication to junior colleagues</td>
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<td>Participates in education of patients and families</td>
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**Comments:** Not yet achieved Level 1
## Communication with Physicians and Other Health Professionals and Teamwork — Interpersonal and Communication Skills

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<tr>
<td>Understands the importance of relationship development, information gathering and sharing, and teamwork</td>
<td>Demonstrates an understanding of the roles of health care team members, and communicates effectively within the team</td>
<td>Works effectively in interprofessional and interdisciplinary health care teams</td>
<td>Leads inter-professional and interdisciplinary health care teams to achieve optimal outcomes</td>
<td>Educates other health care professionals regarding obstetrics and gynecology</td>
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<td>Demonstrates an understanding of transitions of care and team debriefing</td>
<td>Participates in effective transitions of care and team debriefing</td>
<td>Leads effective transitions of care and team debriefing</td>
<td>Provides effective consultation in complex and atypical patients</td>
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<td>Communicates effectively with physicians and other health care professionals regarding patient care</td>
<td>Responds to requests for consultation in a timely manner and communicates recommendations to the requesting team</td>
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### Informed Consent and Shared Decision Making — Interpersonal and Communication Skills

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<tr>
<td>Understands the importance of informed consent</td>
<td>Begins to engage patients in shared decision making, and obtains informed consent for basic procedures</td>
<td>Uses appropriate, easy-to-understand language in all phases of communication, utilizing an interpreter where necessary</td>
<td>Organizes and participates in multidisciplinary family/patient/team member conferences</td>
<td>Models and coaches shared decision making in complex and highly stressful situations</td>
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<td>Engages in shared decision making, incorporating patients’ and families’ cultural frameworks</td>
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<td>Leads multidisciplinary family/patient/team member conferences</td>
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<td>Obtains informed consent for complex procedures</td>
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**Comments:** Not yet achieved Level 1
Select the level corresponding to the resident's knowledge, skills, attitudes, and other attributes in each area below. Your selections should take into account the resident's demonstration of milestones throughout the program with updates to reflect recent progress. Evaluations must be based on evidence with an emphasis on that obtained by direct observation.

Milestone levels do not correspond to the resident's year in your program. Selecting a level implies that milestones in that level and in lower levels have been substantially demonstrated. Selecting a radio button between levels indicates that milestones in lower levels have been substantially demonstrated as well as some milestones in the higher level(s). Mouse over the radio buttons to read the milestones for each level. After completing that evaluation, click the “Submit” button at the bottom of the form to finalize it. Alternatively, click the “Save Progress” button to save your current changes and complete the form later. You MUST use the “Submit” button to finalize the form before the deadline for this evaluation period. Incomplete evaluations will NOT be accepted.

There may be cases in which a resident had no experiences within a subcompetency area during the previous six months. In this case, the reported milestone level should remain the same as the one reported during the previous evaluation. Do not increase (or decrease) the milestone level simply because time has passed; an evaluation of each subcompetency area must occur every six months. To review previously completed milestone evaluations, go to the ‘Reports’ tab in ADS and select “Milestone Evaluations”.

### Patient Care

<table>
<thead>
<tr>
<th>Milestone</th>
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<tbody>
<tr>
<td>a) Antepartum Care and Complications of Pregnancy—Patient Care</td>
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<td>b) Care of Patients in the Intrapartum Period—Patient Care</td>
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<tr>
<td>c) Care of Patients in the Postpartum Period—Patient Care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>d) Obstetrical Technical Skills—Patient Care</td>
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<tr>
<td>e) Immediate Care of the Newborn—Patient Care</td>
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<tr>
<td>Gynecology Technical Skills: Laparotomy (e.g., Hysterectomy, Myomectomy, Adnexectomy)—Patient Care</td>
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<td>g) Gynecology Technical Skills: Vaginal Surgery (e.g., Vaginal Hysterectomy, Colporrhaphy, Mid-urethral Sling)—Patient Care</td>
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<tr>
<td>h) Gynecology Technical Skills: Endoscopy (Laparoscopy, Hysteroscopy, Cystoscopy)—Patient Care</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>i) Family Planning—Patient Care</td>
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<td>j) Ambulatory Gynecology—Patient Care</td>
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### Medical Knowledge

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<tr>
<td>c) Abnormal Uterine Bleeding (Acute and Chronic)—Medical Knowledge</td>
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<tr>
<td>d) Pelvic Mass—Medical Knowledge</td>
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<tr>
<td>e) Pelvic Floor Disorders (Urinary Incontinence, Pelvic Prolapse, Anal Incontinence)—Medical Knowledge</td>
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<td>f) First Trimester Bleeding—Medical Knowledge</td>
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<tr>
<td>g) Health Care Maintenance and Disease Prevention—Medical Knowledge</td>
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### Systems-Based Practice

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<td>![ ]</td>
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### Professionalism

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<tr>
<td>the Needs of Patients, Society, and</td>
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<tr>
<td>Respect for Patient Privacy,</td>
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### Interpersonal and Communication Skills

<table>
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<th>Level 1</th>
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<th>Level 4</th>
<th>Level 5</th>
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</thead>
<tbody>
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</tbody>
</table>

For any comments, concerns or suggestions about Milestone Evaluations, contact us
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SECTION IV

Logging Duty Hours
Logging Duty Hours

New Innovations is the system used for tracking resident work hours. The department must document the number of hours each resident works each week and where they worked them, being sure all ACGME rules and regulations are followed. These reports are then submitted to the Graduate Medical Education Office on a monthly basis.

See Section I of this handbook for a summary of the duty hour’s regulations we adhere to. See ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology, Section VI. Resident Duty Hours in the Learning and Working Environment for a complete description of the duty hour’s requirements.

www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/220_obstetrics_and_gynecology_07012014.pdf

The following pages give directions on the input of work hours into the New Innovations system using both the regular online and mobile device processes.
Duty Hours - Log

From GME Help

Contents
- 1 Overview
- 2 Enter Duty Hour Logs Online
  - 2.1 Copy a Log to Multiple Days
  - 2.2 Copy a Week of Duty Hour Logs to Other Weeks
  - 2.3 Navigation and Preferences
- 3 Rule Violations on the Entry Grid
- 4 Record a Cause for a Violation
- 5 Justifications for Staying Late or Returning Early to Duty
  - 5.1 Smartphones

Overview

Residents can easily log their Duty Hours either online or on a smart phone or tablet. They can indicate start and end times, what activity they were doing, and the location of the activity.

Enter Duty Hour Logs Online

When residents log in to New Innovations, they will see a duty hours panel on their Home Page. This panel displays information about hours they have logged for the first time. It also provides them with a link, Log My Hours, to take them right to the logging page.

<table>
<thead>
<tr>
<th>Week</th>
<th>Hours</th>
<th>V/L</th>
<th>Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 10 - Jul 16</td>
<td>72.0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Jul 17 - Jul 23</td>
<td>72.0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Jul 24 - Jul 30</td>
<td>72.0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Jul 31 - Aug 06</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Rotation Information: Log My Hours>

- ANESTHESIA-EM (Anesthesiology) 7/1/2011 - 7/31/2011

Hours can also be logged by going into the Duty Hours module:

1. Go to Duty Hours > Log Hours
2. Click the Duty Type or Assignment Definition from the list on the right side of the page
3. Optional: Choose Training Location
4. Log Hours:
   1. Click and drag the cursor over the cells that represent the time worked
   2. Right + Click the cells on a day you want to log hours for and Set the Exact Date and Time
5. Click Save
Copy a Log to Multiple Days

1. Right-click the log you want to copy
2. Select Copy Log
3. Click the days you want to copy the log to
4. Click Save
Navigation and Preferences

Previously saved logs are indicated with a gray hatch pattern and can be edited by right-clicking any cell that is part of the entry.

If there is more than one log in a cell, you will see red hash marks. Hover over the cell to see a description of the logs it contains.

Click the navigation arrows in the corner of the timeline to advance to the next week or return to the prior week.

Click the year or Preferences to set logging preferences and use a calendar to navigate to a different date.
Click **Edit in Bulk** to adjust all the details for all previously saved entries for the current week.

Click **Cancel** to delete all unsaved entries.

Click **Preferences** to select dates and set logging preferences.

*Hours cannot be logged to a locked date range unless a user has privileges to override the lock. To adjust locked entries, contact the administrator listed below the Schedule Lock Notice.*

## Rule Violations on the Entry Grid

Entries that cause violations to the rules configured for a department will be outlined in red on the entry grid.

Click to expand the Violation Detail Panel that appears to the right of the log to see the list of each violation and the rule that was broken.

## Record a Cause for a Violation

Residents can record one or more of these causes for any violation.

- Working my scheduled hours
- Completing administrative work
Justifications for Staying Late or Returning Early to Duty

The ACGME requires that residents document why they stayed over or came back on duty early and Program Directors must review every occurrence (Common Program Requirements, VI.G.4.b)(3)). Here is a general overview of the process in New Innovations:

- Residents enter a log that indicates they saw patients past the 24 hour mark or came back early from a break
- Residents submit a justification for staying over 24 hours or coming back to work with less than 8 hours off
- Administrators review justifications and can:
  - Request information
  - Excuse violations
  - Decline justifications
- Residents and Administrators can report on justifications

There are several reasons why a resident might stay on duty past the 24-hour mark and continue to work with patients:

- To observe or participate in a rare educational opportunity
- To serve a single patient who is very ill or unstable
- To serve a patient and his or her family for humanistic reasons
- To cover a scheduling gap so that other personnel might take a break

The first three reasons are considered good reasons for staying over or coming back early, according the ACGME. Ultimately, this is up to the Program Director to decide.


If you log justifiable violations, you will receive a notice like this at the top of the log page:

![You have 2 new violations to review. Click here](#)

Clicking on this notice will take you to this popup:
Violations to Review

Some violations can be removed by the Program Director if sufficient justification is provided. Review the violations below and decide whether or not to submit a justification.

<table>
<thead>
<tr>
<th>Log Date</th>
<th>Rule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/20/2011 7:00 AM</td>
<td>ACGME 24-4 (2011)</td>
<td>25 Consecutive Hour(s) Worked. May Not Work Over 24 Hour(s) Doing Non-Transitional Activities.</td>
</tr>
<tr>
<td>4/20/2011 7:00 AM</td>
<td>ACGME 24-4 (2011)</td>
<td>26 Consecutive Hour(s) Worked. May Not Work Over 24 Hour(s) Doing Non-Transitional Activities.</td>
</tr>
</tbody>
</table>

Click Justify to enter an explanation or Defer to let the violation stand.

Residents will see this when they choose to justify a violation:

Once a justification is entered, the following people can receive email notifications:

- Program Director as identified in Program Demographics
- Associate Program Directors as identified in Program Demographics
- Duty Hours Administrators who have level 5 privileges in Duty Hours for the current department

Go to Setup > Notifications to identify who should receive these emails.
Duty Hours - Log Mobile

From GME Help

The steps below will help you use your mobile device to log your duty hours.

Log In

1. Enter www.new-innov.com
2. Enter your institution, username and password
3. Tap Log In

Notes:

- If this is your first time logging into New Innovations, you’ll be prompted to change your password.
- Tap **Remember Password** to have your device remember your password.
- Tap **Forgot Your Password** to reset your password.

**Menu**

The mobile menu will appear on your screen.

![Menu Image](image)

**Enter Duty Hours**

1. Tap **Duty Hours**
2. Tap **Select Activity**
3. The next screen displays the rotation, duty type and training location. Select your duty type and tap **Done**
4. Tap **OK**
5. Enter your time using one of these methods:
1. Use the slide bars to indicate your Start and Stop times
2. Use the Clocked In and Clocked Out buttons to record your time on task
6. Tap **Save**
SECTION V

ACGME Case Log System
(Your Stats)
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page #’s</th>
</tr>
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<tbody>
<tr>
<td>Part I: New Case Logs Introduction</td>
<td>3-5</td>
</tr>
<tr>
<td>Part II: Case Entry</td>
<td>6-14</td>
</tr>
<tr>
<td>Part III: Case Search</td>
<td>15-18</td>
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<tr>
<td>Part IV: Manage Favorite Lists</td>
<td>19-24</td>
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<tr>
<td>Part V: Update Case Year</td>
<td>25-28</td>
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<tr>
<td>Part VI: Reports Menu</td>
<td>29-36</td>
</tr>
<tr>
<td>Part VII: Download Case(s)</td>
<td>37-40</td>
</tr>
</tbody>
</table>
PART 1: CASE LOGS INTRODUCTION
INTRODUCTION

**Login** to the Resident Case Logs (RCL) system at: [www.acgme.org/connect](http://www.acgme.org/connect)

Type in your ACGME username and password to login to the system.

**Forgot your password?**

Choose the “Forgot your password” button [circled below]

Type in either your username OR your program ID + email address

An email will be sent to your email address with a link to reset your password.
**Quick Links Toolbar**
Located at the right hand side of the screen
Use this as a navigation tool to switch between pages
PART 2: CASE ENTRY
After signing in to the system, you will be directed to the Case Entry screen below.
CASE ENTRY

Choose case/encounter details from the drop downs [highlighted below]
CASE ENTRY

Choose procedure(s) to be added to your case/encounter

You have 4 options to search for procedures to add:

1. Favorite list
2. Area/type
3. Code
4. Specialized Code Search (only available for some specialties)
CASE ENTRY

Enter in search criteria under one of the tabs and press ‘Go’

<table>
<thead>
<tr>
<th>Area</th>
<th>Type</th>
<th>Keyword</th>
<th>GO</th>
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<tbody>
<tr>
<td>PEDIATRIC</td>
<td>All</td>
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CASE ENTRY

You will see a code, code description, area and type in the search results.

When you have found the code that best matches the procedure performed, press ‘Add’.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
<th>Area</th>
<th>Type</th>
<th>Fav</th>
<th>Add</th>
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<td>21740</td>
<td>Reconstructive repair of pectus excavatum or carinatum; open</td>
<td>PEDIATRIC</td>
<td>REPAIR DEFORMITY CHEST WALL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21742</td>
<td>Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopic repair</td>
<td>PEDIATRIC</td>
<td>REPAIR DEFORMITY CHEST WALL</td>
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<tr>
<td>21743</td>
<td>Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopic repair</td>
<td>PEDIATRIC</td>
<td>REPAIR DEFORMITY CHEST WALL</td>
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<tr>
<td>33822</td>
<td>Repair of patent ductus arteriosus; by division, younger than 18 years</td>
<td>PEDIATRIC</td>
<td>OTHER MAJOR PEDIATRIC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
When you have successfully added a procedure, you will see an exponent next to **Selected Codes**. Click on **Selected Codes** to see the codes you have already added to this particular case/encounter.

Add all procedures that were performed on the particular case/encounter you are entering.
CASE ENTRY

Note: Click on the yellow star next to a procedure to add it to a “Favorite List”. For information on how to manage your favorite lists, go to Part 4 of this guide.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
<th>Area</th>
<th>Type</th>
<th>Keyword</th>
<th>Fav</th>
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<tbody>
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<td>PEDIATRIC</td>
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<tr>
<td>21742</td>
<td>Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy</td>
<td>PEDIATRIC</td>
<td>REPAIR DEFORMITY CHEST WALL</td>
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<tr>
<td>21743</td>
<td>Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy</td>
<td>PEDIATRIC</td>
<td>REPAIR DEFORMITY CHEST WALL</td>
<td></td>
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<td>Add</td>
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<tr>
<td>33822</td>
<td>Repair of patent ductus arteriosus; by division, younger than 18 years</td>
<td>PEDIATRIC</td>
<td>OTHER MAJOR PEDIATRIC</td>
<td></td>
<td></td>
<td>Add</td>
</tr>
</tbody>
</table>
CASE ENTRY

Press the green submit button at the very top of page to submit your case.
PART 3: CASE SEARCH
CASE SEARCH

To view/edit cases you have already entered, choose the Search Case(s) link under the Quick Links toolbar.
CASE SEARCH

Select input criteria and press ‘Search’

Press ‘Advanced’ (next to ‘Search’) for more input options
CASE SEARCH

Your search results will generate on the screen

You can **Edit** or **Delete** any case/encounter by using the tools to the right

<table>
<thead>
<tr>
<th>Resident</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Example</td>
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<table>
<thead>
<tr>
<th>Residents in Program Yr</th>
<th>Institution</th>
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</thead>
<tbody>
<tr>
<td>All</td>
<td>All</td>
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</table>

<table>
<thead>
<tr>
<th>Attending</th>
<th>Institution</th>
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<tbody>
<tr>
<td>All</td>
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**Search Results**

<table>
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<th>Attending</th>
<th>Institution</th>
<th>Case ID</th>
<th>Resident Role</th>
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<tbody>
<tr>
<td>10/22/2013</td>
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<td>AA, Example</td>
<td>Children's Hospital</td>
<td>Example</td>
<td>Teaching Asst.</td>
</tr>
<tr>
<td>10/22/2013</td>
<td>1</td>
<td>AAA, Example</td>
<td>Children's Hospital</td>
<td>1234</td>
<td>Surgeon Chief</td>
</tr>
</tbody>
</table>

- **Edit** button
- **Delete** button

Sort by any column header using the arrows
PART 4: MANAGE FAVORITE LISTS
FAVORITE LISTS

To add codes to a favorite list, so you can easily choose your most-used codes during case entry, choose **Manage Favorite Lists** from the Quick Links toolbar.

![Quick Links](image-url)
FAVORITE LISTS

Select ‘Add a Favorite List’ to create a new list
FAVORITE LISTS

Enter in an identifying name and click ‘Add Favorite List’
FAVORITE LISTS

Press ‘Set Codes’ to add codes to the list you created
FAVORITE LISTS

Search for procedure codes by area and type, code or defined category (for some specialties only)

Press ‘Add’ next to the procedure you wish to add

A blue confirmation banner will appear when a code has been added
PART 5: UPDATE CASE YEAR
UPDATE CASE YEAR

If your cases are not showing correct resident year, you can bulk update the year using the Update Case Year function under the Quick Links toolbar.
UPDATE CASE YEAR

Select year of case(s) you want to update

Select exact date range of case(s) you want to update

Select a new case year at the bottom of the screen and press the ‘Save’ button
UPDATE CASE YEAR

Once you press save, the system will tell you how many cases were updated.

To see individual case information, go back to the Case Search screen.
PART 6: REPORTS MENU
REPORTS MENU

To view reports of the cases you have logged, choose the **Reports Menu** link under the Quick Links toolbar.
Reports available will differ by specialty. Reference the ‘Description’ column for a summary of what each report entails.

Press ‘Go’ next to the report you wish to view.
REPORTS MENU

Depending on the type of data you wish to view, select any applicable criteria and press ‘Run Report’.

*Note: if you leave the start and end dates blank, all dates will be included*
A **NEW** window will open. Please ensure that your pop-up blockers are turned off so the report opens.

### Resident Experience Report By Year

**Primary Procedures**
- **Program ID:** 0123456789
- **Program Name:** Example Medical Center
- **At All Institutions**
- **All Attendings**
- **Resident:** Example A
- **For All Resident Roles / All Patient Types / All Rotations**
- **For All Defined Categories**
- **For All CPTs in All Areas and All Types**
- **Procedures in All Years**
- **As Of 10/22/2013**

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If you would like to save a PDF copy of a report, press the save button on the report.

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Save the report as a PDF file to your computer.
To view a different report, select the ‘Back to Reports Menu’ button in the first window.
PART 6: DOWNLOAD CASE(S)
DOWNLOAD CASE(S)

You may want a data file of your residents’ cases for reference for future employers, etc. Using Download Case(s) will provide you a .txt data file of all cases including comments.
DOWNLOAD CASE(S)

Choose the resident and date range of cases you want exported and press ‘Search’.

Download Case(s)

Resident:
A. Example

From

To

Search

~ back to top
DOWNLOAD CASE(S)

A preview of your export will appear on the screen. You can click ‘Save to Excel’ to generate an Excel export of all the data.

Note: Below is a preview of your data. If you wish to search, sort, or see all of your data, please use the “Save to Excel” button below.

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Showing 1 to 2 of 2 entries

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If you have any questions about the new ACGME Case Logs system, email us at webads@acgme.org
SECTION VI

Medical Student Clerkship
MEDICAL STUDENT CLERKSHIP

**General Information**

Residents are important participants in the teaching, supervision, and evaluation of third and fourth year medical students during their clerkship and elective experience in our department. Medical students get a significant portion of their clinical experience with, and teaching by, residents. Students model their professional behavior on their observations of resident performance.

Eight clerkship rotations of between 6 and 9 students are scheduled during the academic year. Students are assigned to participate in patient care on Labor & Delivery, the Gynecology Service and at the Women's Healthcare Center Resident Clinic.

While on the OB (The Birthing Experience) and GYN Services, the student workday begins at 5:00am and the Ambulatory Clinic Service starts at 8:00am. We must know where students are at all times when they are on duty. The Clerkship Director or the Clerkship Administrator must be notified in a timely manner if students have unexcused absences from their assigned duties. Expected student behaviors on this clerkship are included in the appendix at the end of this chapter.

Students are to be excused from clinical assignments in a timely fashion so they may attend their conferences.

**Obstetrics (“The Birthing Experience” or “Labor & Delivery”)**

On the students’ first day of this clerkship and at the beginning of each 2 week rotation, the residents should assist the students in learning their responsibilities. Each weekday morning at 5:00am starting with Rounds, the students on this service are to be assigned to accompany the residents on Labor & Delivery (The Birthing Experience). While on L & D, responsibilities of the students include participating in care for newly admitted patients, triaging outpatients, and participating in spontaneous and operative deliveries.

**Night Float (“Labor & Delivery”)**

On the students’ first day of this clerkship and on the first day of each 2 week rotation at 7:00pm, there will be at least 2 students scheduled for duty. The residents should assist the students in learning their responsibilities and assign each student a different activity during their 2 weeks. For example, one student may cover L&D triage, one may cover L&D laboring patients, and one may cover GYN/GYN ONC patients/consults, etc.

**Gynecology/Gynecologic Oncology (“In-Patient Women’s Healthcare”)**

On the students' first day of this clerkship and at the beginning of each 2 week rotation beginning at 5:00am, the residents should assist the students in learning their responsibilities while on that service. The students should be assigned to accompany a resident, and participate, under supervision, in the care of gynecology patients.
Other Specialty Experiences include Mini Electives in OBGYN Sub Specialties

Students have the option of choosing an elective, depending on how busy the service is, they can find out from the supervising attending and/or resident what would be the best day to do a mini elective while on that service. Please make sure that the students know at least one of them is on the service per rotation. If there is more than one student on a service, they are to work amongst each other to take turns doing mini-electives.

Conferences and Lectures

Student educational conferences are usually scheduled after Didactics on Friday mornings. A current student schedule of educational conferences is posted on the bulletin board at the 2040 Building in Suite 200 and a copy is emailed to faculty, residents and clinic managers at the beginning of each clerkship.

Student Evaluations

Evaluation of personal performance should be a constructive process.

Students have been provided with a list of expected behaviors for this clerkship, appended to this chapter. Before writing an evaluation, residents should review the list of expectations.

Students have performance competencies to be verified by residents and clinical faculty and will be asking residents individually to verify their competencies. Please suggest remedies for deficiencies identified in situations where competency cannot be verified. If there are any questions, please consult the Clerkship Director.

Performance Evaluation

A. Clinical Abilities/Performance/Assessment

I. Knowledge, which includes: Understanding basic pathophysiology of disease, is knowledgeable about common problems, is able to acquire and retain facts.

II. Problem solving which includes: Ability to assimilate information and problem solve in a logical fashion, analyze and correlate clinical information, formulate an appropriate problem list and differential diagnosis, understand basic therapeutic plans and diagnostic strategies.

III. Clinical Skills, which includes: Ability to perform a history and physical exam, present in a clear and concise manner, garner appropriate clinical information from a variety of sources, document daily records appropriately, perform routine procedures, adapt to a variety of clinical environments.

B. Personal Qualities and Values

I. Interpersonal Skills, which includes Communication skills, cooperation, empathy, teamwork, sense of humor, and consideration for others.

II. Professional Characteristics, which includes integrity, honesty, initiative, consistency, ethical, respectful, recognizes limitations, responsible, reliability, and flexibility.

III. Motivation and Enthusiasm, which includes being conscientious, punctual, committed, and actively involved.
Medical Student Expected Behaviors in Clinic Performance

1. Taking responsibility for one’s own medical education.

2. Showing up on time, staying for the duration of the work day.

3. Writing legible, thorough and accurate progress notes.

4. Appearing professional, i.e., courteous, neat, responsible, respectful of patients and personnel.

5. Seeking out learning opportunities, not waiting around in the call room to be called by nurses or residents for “interesting” patients.

6. Enthusiastic to learn.

7. Showing an interest in the health and welfare of patients, e.g., establishing rapport with a laboring patient; learning medical Spanish.

8. Being a “team player” when interacting with house staff.

9. Identifying and independently reading about issues that arise during patient care, e.g., learning about the indications, contraindications, and complications of drugs, and operative procedures, learning about the advantages, disadvantages, and limitations of diagnostic imaging studies, and laboratory tests.

10. Accessing not only standard texts but also the current medical literature to meet that responsibility.

11. Asking for help when an unfamiliar or unclear situation arises.

Examples of Behaviors Associated with an Honors Grade in Clinic Performance

1. A willingness to go the extra mile in carrying out clinic responsibilities. e.g., stay ahead of the house staff.

2. Independently rounding on patients whose medical condition requires more than just a cursory visit, and reporting changes in clinical status to responsible house staff in a timely fashion.

3. Becoming actively involved in clinic situations, e.g., being available to participate in surgical procedures, neonatal intubation, suturing, etc.

4. Arranging for mini electives in either neonatal intensive care, radiology, pathology, etc., and submitting a short evaluation of the experience to the Clerkship Administrator.

5. Independently researching issues that arise during rounds and conferences and reporting back to the group.
Evaluating Medical Student Competencies

Instructions for Residents

Medical students are required to have achieved specific competencies during their rotation on this service. Residents can help certify medical student competencies.

Teaching others is part of resident education in obstetrics and gynecology. Residents evaluating student competencies will add a dimension to resident education that will improve their own skills and professionalism.

Enclosed you will find guidelines for verification of competencies. If the student sufficiently demonstrates a given competency, please verify your observation by signing and dating the appropriate space in the student's “Competencies” card.

If the student has not demonstrated competency, an opportunity for remediation should be presented. The specifics of deficiencies should be discussed with the student and the student should be given the opportunity for reevaluation.

Guidelines for Verification of Competencies

**Instructions**: If student sufficiently demonstrates evidence of the following competency, verify your observation by signing the appropriate space in the students “Competencies” card.

1. **Competency**: Ability to establish rapport with a patient during an encounter

   The student has been observed to:
   - Establish a relationship of mutual respect between the patient and her support system
     - Appear and act professionally
   - Appreciate and adjust interpersonal skills to the clinical situation
   - Respect patient confidentiality and privacy
   - Maintain verbal patient communication during the physical examination.
   - Accept constructive criticism in a mature fashion
   - Correct deficiencies and display an eagerness and ability to learn

2. **Competency**: Obtain a thorough obstetric and gynecologic history

   The student has been observed to:
   - Establish a relationship of mutual respect between the patient and her support system
     - Appear and act professionally
   - Identify and accurately record the patient’s obstetrical and gynecologic problems in the framework of a general medical history in a time-efficient manner
     - the medical history is thorough, concise, organized, pertinent, legibly written
     - previous hospital admission or outpatient records are researched and summarized
     - supplementary information such as recent diagnostic imaging or laboratory studies, consultation or referral reports has been obtained
   - Accept constructive criticism in a mature fashion
   - Correct deficiencies and display an eagerness and ability to learn
3. **Competency: Perform an appropriate well-woman examination**

The student has been critically observed to:

- Appreciate and adjust interpersonal skills to the clinical situation
- Respect patient confidentiality and privacy
- Perform a general physical examination in an organized and orderly fashion
  - Distinguish normal from common abnormal physical findings
  - Seek instruction when unfamiliar or abnormal physical findings are encountered
- Maintain verbal patient communication during the gynecologic examination, advise the patient with regard to what she can expect to feel during a speculum and bimanual examination, explain the purpose of each element of a pelvic examination including collection of specimens, reassure the patient of normal findings, emphasizing the importance of periodic preventative care, e.g., pap smears, BSE, mammograms, etc.
- Respond, to patient concerns and defer definite statements regarding diagnosis and treatment to the responsible physician
- Maintain verbal patient communication during the obstetrical examination, explain the purpose of each element of an obstetrical examination including the results of routine surveillance, e.g., vital signs, urinalysis, weight, reinforce essential elements of routine prenatal care that contribute to a successful outcome
- Accept constructive criticism in a mature fashion
- Correct deficiencies and display an eagerness and ability to learn

4. **Competency: Perform a pelvic examination (under anesthesia)**

The student has been observed to:

- Review the patient’s preoperative medical record, determining the indication for surgery and the working diagnosis
- Correlate laboratory and diagnostic imaging results with preoperative findings
- With permission of the patient and the operating surgeon, perform a pelvic examination
- Reconcile the intraoperative pelvic examination with the operative findings and clinical presentation

5. **Competency: Obtain a satisfactory Pap smear and specimens for common sexually transmitted diseases**

The student has been observed to:

- Review the techniques of cervicovaginal cell sampling, and the technique for taking specimens for detection of chlamydia, gonococcus, and streptococcus.
  - know the reliability of each test and the confounding factors that impact on their sensitivity and specificity
- Maintain verbal patient communication during the gynecologic examination, advise the patient with regard to what she can expect to feel during a speculum and bimanual examination, explain the purpose of each element of a pelvic examination including collection of specimens, reassure the patient of normal findings, emphasizing the importance of periodic preventative care, e.g., pap smears, BSE, mammograms, etc.
- Respond, in a general way, to patient concerns and defer definite statements regarding diagnosis and treatment to the responsible physician.
6. **Competency: Estimate gestational age by means of physical examination, and where appropriate, detect the fetal heart rate**

The student has been observed to:

- Maintain verbal patient communication during the obstetrical examination, inform the patient of the purpose of the examination, reinforce essential elements of routine prenatal care that contribute to a successful outcome
- Demonstrate the ability to estimate gestational age by means of physical examination
- Identify the parameters of fetal growth as determined clinically
  - Classify discordant growth according to possible etiology
- Demonstrate the ability to accurately perform McDonald measurements and/or Leopold maneuvers
- Detect the fetal heart rate depending on estimated gestational age and the results of Leopold maneuvers.
- Seek instruction when unfamiliar or abnormal findings are encountered

7. **Competency: Generate and prioritize a problem list, select the most likely diagnosis, and propose an effective management plan**

The student has been observed to:

- Assess clinical data in the context of the patient’s status
- Utilize appropriate learning resources including texts and current medical literature, the Internet, consultation with peers, senior colleagues, and allied health professionals
- Formulate a problem list for both acute and long-term problems based on an informed understanding of the patient’s clinical status
- Generate a provisional and appropriate diagnostic and therapeutic plan
- Review findings and conclusions with responsible house staff
- Obtain necessary supplementary information and reassess the patient’s status at appropriate intervals
- Revise the problem list and plan as the patient’s clinical condition evolves
- Accept constructive criticism in a mature fashion
- Correct deficiencies and display an eagerness and ability to learn

8. **Competency: Under supervision, first assist an uncomplicated vaginal delivery**

The student has been observed to:

- Understand the elements of satisfactory intrapartum care
- Assume a supportive role while participating in the care of a parturient,
- Follow the progress of labor with timely evaluations of cervical dilatation
- Correctly interpret a partogram with regard to normal progress of labor
- Recognize when a normal spontaneous vaginal delivery is imminent
- Demonstrate knowledge of the mechanics of a normal spontaneous vaginal delivery
- Evaluate the condition of the newborn
  - Identify conditions requiring aggressive resuscitation of the newborn
  - Perform neonatal nasopharyngeal suction
  - Calculate an Apgar score
- Be familiar with complications of the third stage of labor
- Perform an examination of the placenta with regard to completeness, the status of the membranes, and the vessels of the umbilical cord.
- Appreciate the dynamics of maternal-newborn bonding
- Seek instruction when unfamiliar or abnormal findings are encountered
- Complete appropriate documentation that reflects the details of the delivery
9. **Competency: Perform a focused postpartum examination**

The student has been observed to:

- Design an approach to the care of the postpartum patient that takes into consideration by way of medical record review:
  - Preexisting medical conditions
  - Antepartum, intrapartum, and postpartum complications
  - Neonatal complications
- Detail the expected physiologic changes encountered during a normal postpartum course
- Describe the elements necessary for the development of successful breast feeding
- Develop a style of examination that expedites evaluation of the puerperal patient with regard to:
  - Development of parenting skills
  - Postpartum depression
  - Contraception and sterilization
  - The development of healthy life styles
  - Breasts, uterus, perineum, lochia, lower extremities
- Generate a plan for continuity of care including self-care for and pharmacologic management of bowel and bladder dysfunction, care of the perineum, anemia, responsible sexuality, contraception/sterilization, and antepartum complications such as abnormal pap smears, sexually transmitted diseases, Rh or other blood group alloimmunization conditions, carbohydrate intolerance and obesity.
- Discuss and review the patient’s postpartum course with the responsible physician

10. **Competency: Under supervision, assist at the closure of an abdominal incision**

The student has been observed to:

- Using knowledge of the anatomy of the lower abdomen, appreciate how different skin incisions change the technique of abdominal closure
- Review from standard texts or other generally accepted authorities, the technique for closing a lower abdominal transverse or midline incision, recognizing the advantages of a layered closure
- From the viewpoint of an assistant to the operating surgeon, maximize the effectiveness of an assistant at surgery by anticipating the surgeon’s requirements in accomplishing a satisfactory closure in a timely and efficient manner
- Demonstrate the correct technique for using instruments necessary for suturing
- Exhibit proficiency in the ability to suture and tie knots
- Describe manifestations of immediate and delayed complications of lower abdominal wound closure, and the management of each
- Seek instruction when unfamiliar or abnormal findings are encountered

11. **Competency: Cooperate with the health care team and the patient’s support system in the delivery of health care**

The student has been observed to:

- Demonstrate concern for, interest in, and is respectful of patients' health and welfare
- Understand the use of and contributes constructively to the medical record
- Subscribe to characteristics associated with professional conduct
  - Is punctual, reliable, trustworthy and honest
  - Appearance is appropriate to the medical environment
- Advance personal educational Mastery
  - Contribute to the learning environment
• Seek out and take advantage of learning opportunities
• Be enthusiastic and motivated to learn
• Refine manual dexterity in the pursuit of performance skills
- Integrate personal style into positive group dynamics
  • Cooperate with the health care team in fulfilling its mission
  • Appreciate and respect residents’ patient responsibilities
  • Readily aspire to achieve rapport with colleagues, house staff, and attendings
  • Recognize his/her limitations; aggressively attempt to resolve

What Students need to do

Goals of The Clerkship

Upon completion of the basic clerkship, each student should be able to:

A. Demonstrate skills in independent learning and critical thinking.

B. Obtain and record clearly a complete medical history, conduct a complete physical examination and,

  (1). Identify normal and abnormal patterns (physical, intellectual and social).

  (2). Identify and accurately record the patient's problems (physical, intellectual and social).

  (3). Assess the data in the context of the patient's status; formulate a problem list for both acute and long-term problems, and a provisional diagnostic and therapeutic plan.

  (4). Obtain necessary supplementary information and reassess the patient's status at appropriate intervals; and revise the problem list and plan utilizing the resources note under (3) above.

  (5). Develop communication skills to efficiently and effectively expedite the transmission of medical information in a professional setting.

C. Establish a relationship of mutual respect between the physician, patient and the patient's family, residents, staff, and health care team, and acquire the basic interpersonal skills which facilitate this relationship.

D. Appreciate the role of community agencies, practicing physicians and community health care programs in facilitating optimal care.

E. Appreciate the importance of translational research in developing evidence-based criteria.

F. In carrying out the above, utilize appropriate learning resources including texts and literature, consultation with peers, senior colleagues and/or allied professionals.

G. Develop positive attributes which will serve as the basis for a successful professional career.

H. Develop study habits which will enhance lifelong learning.
Clerkship Check List

ORIENTATION:

1. _____ Complete Paperwork & Check-Out Books – Complete contact form and hospital credentialing packet and check out books. (see clerkship coordinator)

MIDCOURSE:

1. _____ Midcourse Scheduling – You will receive an email with detailed instructions for midcourse meetings and your presentations. Get with your Team Leader to set up your midcourse meetings and provide your presentation topics. The meetings will be held at Dr. Young’s office at the 2040 Building Suite 200 location and following are the items you will need to complete and/or bring with you.

2. _____ Observed H&P - Try to have your required observed H&P done by this time.

3. _____ APGO uWISE Practice Questions - You are required to have all the Unit Questions completed by midcourse at the time specified on the midcourse email. (We will provide the report)

4. _____ Patient Logs - Have Patient Logs up-to-date on One45 by the time specified on the midcourse email. (We will provide a print out of your logs)

5. _____ Yellow Competencies Card - Bring your Yellow Competencies Card to the meeting

6. _____ Year 3 Mid-course Student Form – Complete this form online by the time specified on the midcourse email.

STUDENT PRESENTATIONS:

1. _____ Copy of your Presentation - On your scheduled presentation day, you are required to turn in a copy of your presentation (you can email a copy ahead of time to clerkship coordinator)

2. _____ LCME Biostatistical Data – and turn in the completed LCME Biostatistical data sheet. (This can also be emailed ahead of time.)

LAST DAY OF THE CLERKSHIP INSTRUCTIONS:
One week before the end of the clerkship, you will receive an email with detailed instructions on what you need to take care of prior to the clerkship exit meeting.

1. _____ Call Room - Students using call room, please be sure to pick up after yourselves and do not share code with other students as it is for OBGYN clerkship students ONLY!

2. _____ Books - Turn in borrowed books (after test if you need them to study)

3. _____ Cards & Paragraphs - Turn in your Competencies (yellow card), Mini Electives (orange card), and a brief paragraph on Mini Elective Experiences if you did any.

4. _____ Patient Logs - Have Patient Logs completed in One45 by Noon the day before the exam.

5. _____ Evaluations - And last but not least, please COMPLETE ALL Evaluations on one45 - Your grades cannot be released until all of your evaluations are 100% complete.
**Course Activities**

**Case Conferences/Lectures/Didactics**

On days and times specified on the educational Calendar, there will be a faculty-directed conference/lecture scheduled. Students should consider preparing in advance so they may actively participate. The educational conferences/lectures are listed on the educational calendar and are posted on the bulletin board in the OBGYN Department Offices in Suite 200. Students are excused from clinical assignments to attend their conferences/lectures. Your attendance at these conferences is required, however, if a surgical opportunity arises and you have an opportunity to participate, you are required to contact the clerkship coordinator either by phone or by email that you will be participating in a procedure and will need to miss the conference. The topics are: Conduct of Labor, Preterm Labor, and Contraception Overview.

**Friday Didactics** – Your attendance at the Friday resident didactics is required for everyone except for those on Labor & Delivery who are assisting with a procedure, if a student case conference/lecture is scheduled, or there is a supplemental instruction session scheduled. Friday Didactics Calendar is provided at Orientation.

**Attending Teaching Rounds**

Hospitalized patients are seen on a priority basis; antepartum and post-operative patients first. Students make brief presentations about their patients from note cards or memory while the resident reviews the patient's chart. Students are present at all times during rounds unless instructed otherwise by a resident.

Questions regarding rounds and presentation should be directed to the Chief Resident of the OB or GYN Service. Personal cell phones are to be turned off when participating in clinical responsibilities, e.g. rounds, operating room. Evening rounds are held after the completion of clinic or late afternoon conference.

The students will be assigned on a rotational basis to Obstetrics “The Birthing Experience or Labor & Delivery” 2 weeks, Night Float “Labor & Delivery” 2 weeks and Gynecology/Gynecologic Oncology “In-Patient Women’s Healthcare” 2 weeks.

The Chief Resident(s) will make assignments on a day to day basis for students who will participate in patient care. If they cannot fulfill their clinical responsibilities, it is essential that they notify the clerkship administrator and their chief resident in a timely fashion. In order to maximize clinical experience, they are expected to take every opportunity to participate in the care of patients in each location, and follow their subsequent clinical course, even if different from the venue of the initial encounter.

**Patient Log:** The Patient Log is a record their clinical experience. They are to list the patients in whose care they have participated. All of their experiences need to be entered into the Patient Log in One45. They are to have all of their experiences entered into One45 prior to midcourse review and again prior to the end of the clerkship. Their Patient Log is an important element of their final grade and evaluation.

**Documentation of Competencies:** To document that they have achieved the competencies as outlined in the Goals and Objectives contained in the syllabus, they will be given a pocket card that indicates the competencies they must achieve and spaces for verification by supervising staff of their accomplishments.

They will ask their supervising resident or attending to verify their required experiences and competencies. No resident should verify more than 3 competencies without prior approval of the Clerkship Director. In other words, Students should not “shop” for resident certifiers.
Obstetrics and Gynecology  
Medical Student Rotation Essential Clinical Competencies

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<th>Competency</th>
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<td>1. Ability to establish rapport with patients during an encounter</td>
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<td>2. Obtain a thorough obstetric and gynecologic history</td>
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<td>3. Perform an appropriate well-woman examination</td>
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<td>4. Perform an appropriate female pelvic examination</td>
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<tr>
<td>6. Estimate gestational age by means of physical examination, and where appropriate detect the fetal heart rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Generate and prioritize a problem list, select the most likely diagnosis, and propose an effective management plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Under supervision, first assist an uncomplicated vaginal delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Perform a focused postpartum examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Under supervision assist at the closure of an abdominal incision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Cooperate with the health care team and the patient’s support system in the delivery of health care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Medical Student Rotation Essential Clinical Experiences

## A. THE BIRTHING EXPERIENCE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Objective(s)</th>
<th>Date</th>
<th>Supervising Faculty or Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Labor &amp; delivery</td>
<td>IVa.A-F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Cesarean Section</td>
<td>IV.F.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Preeclampsia</td>
<td>VI.E.1-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Antepartum bleeding</td>
<td>XX.E.1-2, XIV.A.1-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. UTI in Pregnancy</td>
<td>XVI.C.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Antenatal Testing (eg, CST/NST)</td>
<td>VI.E.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## B. IN-PATIENT WOMEN'S HEALTHCARE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Objective(s)</th>
<th>Date</th>
<th>Supervising Faculty or Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vaginal hysterectomy (TVH/LAVH)</td>
<td>VIII.D.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Abdominal hysterectomy ± S&amp;O</td>
<td>VIII.D.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Ectopic pregnancy</td>
<td>XIV.K.2, 3, XIII.1-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. D&amp;C</td>
<td>I.C.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Diagnostic laparoscopy</td>
<td>XII.C.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## C. AMBULATORY WOMEN'S HEALTHCARE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Objective(s)</th>
<th>Date</th>
<th>Supervising Faculty or Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Menstrual Abnormalities</td>
<td>I.C.3, II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Vaginitis</td>
<td>XXII.B.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Obstetrical Ultrasound</td>
<td>XXIII.D.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Prenatal care</td>
<td>XXIII.D.3 XVI, V, XV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Diabetes in Pregnancy</td>
<td>XVI.B., 1 D.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Menopause</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Student Rotations

Obstetrics (“The Birthing Experience” or “Labor & Delivery”)

Students assigned to The Birthing Experience work with the residents at UMC on Labor & Delivery located on the 7th floor of the hospital. The hours while on duty will be from 5:00 A.M. until 7:00 P.M. Monday through Saturday for 2 weeks. ONE EXCEPTION TO THESE HOURS WILL BE DURING PRESENTATIONS/MIDCOURSE EVALUATION WEEK, WHEN THE HOURS WILL BE 5:00 A.M. UNTIL 1:00 P.M. OR UNTIL THE LEARNING ACTIVITY IS COMPLETED)

Students will participate in the management of laboring patients and patients on the Postpartum Service. Morning rounds start at 5:00 a.m. Students should report to the residents on Labor & Delivery. The residents will orient students to the service and to their responsibilities. These will include care for newly admitted patients, triaging outpatients, caring for antepartum and postpartum patients, and participating in spontaneous and operative deliveries. On morning and afternoon rounds, each student is responsible for reviewing the clinical course in the medical record of their assigned patients, interviewing and examining patients, and charting their findings for co-signature by their resident and attending faculty. Under supervision, students participate in patient care such as patient evaluation, discussion of physiology and complications, and discharge planning with regard to continuity of care, proper use of medications, sexuality, contraception, parenting skills, nutrition, and follow-up on medical conditions discovered during pregnancy.

While on The Birthing Experience rotation, there will often be more than 2 students on duty simultaneously. Residents may direct students to participate in other activities if there is a lack of activity on the Labor & Delivery floor. E.g. students may be offered the opportunity to go to the Women’s Healthcare Clinic, where the Residents see their patients.

Students should be given a list of possible topics for discussion on rounds (as listed in the previous section), in addition to actual patient conditions and complications.

    Students should take every opportunity to participate with supervision in patient care as follows:

A. Labor & Delivery:
   1. Before you see the patient, review her chart and be sure that you understand her clinical course to date (review problem lists, nurse's notes, etc.).
   2. Confirm that you have permission to see the patient.
   3. In the event one of your assigned patients is ready to deliver, you may not deliver the patient without a supervising resident or faculty member physically present in the delivery room. If there is no supervision present, the nurse will deliver the infant.

B. Postpartum patients:
   1. First, check with the nursery about the condition of the infant before you see the patient. Then, review her chart and be sure that you understand her clinical course to date (review problem lists, nurse's notes, etc.).
   2. Be sure that you have the most recent available laboratory or radiographic results. Call for them if necessary.
   3. Confirm that you have permission to see the patient and have a chaperone if necessary.
   4. Be sure that you have all the instruments you will need to perform an examination.
   5. Introduce yourself to the patient. Respecting her confidentiality and privacy, indicate what you intend to do and why.
   6. Take an interval history and perform the appropriate physical examinations.
7. Write SOAP notes.
8. Present the patient to your assigned resident and be sure that you get feedback. Expect the resident or faculty to see the patient. Make sure the senior resident or faculty member signs your Experiences and Competencies Card if appropriate.

**Night Float (“Labor & Delivery”)**

Students will be assigned to 2 weeks of night float duty on Labor & Delivery. The Hours while on duty will be from 7:00 P.M. until 9:00 A.M. the next morning from Monday nights through Friday mornings (SEE BELOW for exceptions). Night Float Students will go to Resident Didactics on Friday mornings unless there is a student lecture or SI session scheduled.

On most days, there will be a 4 hour overlap from 5 A.M. until 9 A.M. when both The Birthing Experience & Night Float Students will be there to participate in patient rounds with attendings.

While on Night Float, there will be at least 2 students scheduled for duty. We suggest the Residents separate the students to participate in different activities during their 2 weeks. For example, one student may cover L&D triage, one may cover L&D laboring patients, and one may cover GYN/GYN ONC patients/consults. Of course if one service gets overwhelmed with patients, any Night float student can be asked to help with that as well.

**EXCEPTIONS TO THE ABOVE SCHEDULED DUTY HOURS:**

1. On the nights before simulations, night shift will be from 7:00 P.M. until 2:00 A.M.
2. On simulation days, night shifts will be from 3:00 P.M. until 5:00 A.M.
3. On presentation/midcourse review week, night shifts will be from 1:00 P.M. until 10:00 P.M.
4. All Thursday night shifts, EXCEPT for midcourse week, will be from 10:00 P.M. until Noon and there will be no Friday night shift.

The Students’ OB Call Room is located on the 6th floor across from the Resident Call Rooms. Location and access information for the call room are provided at Orientation.

Specific call activities are assigned by the resident on call, and include histories and physicals, deliveries, consultations from other services, evaluation of Emergency Room patients, and care of all hospitalized patients, in participation with residents. To maximize the students on-call experience, we suggest they stay close to the resident, since professional staff (nursing, attendings, and residents) may not be able to call students to participate in patient care.

**Gynecology/Gynecologic Oncology (“In-Patient Women’s Healthcare”)**

Students will be assigned to 2 weeks of the GYN Service. General Hours for this portion of the rotation will be from 5 A.M. until surgical cases are done (Usually by 7 P.M.). GYN Students will not be scheduled to work Saturdays or Sundays. Morning rounds begin at 5:00 am. On the first day of this rotation, students must confirm the day’s plan with their residents. General responsibilities include participation, under supervision, in the care of gynecology patients (including pre- and postoperative care, and gynecologic illness such as pelvic infection) in the hospital. On morning rounds, each student is responsible for reviewing the clinical course in the medical record of their assigned patients, interviewing, and examining patients under supervision, and charting their findings for co-sign by their resident and attending faculty. Under supervision, students participate in patient care such as patient evaluation, discussion of therapeutic
course and complications, and discharge planning with regard to continuity of care, postoperative convalescence, incisional care, warning signs of complications proper use of medications, sexuality, contraception, parenting skills, nutrition, and follow-up on medical conditions. Students have been given a list of possible topics for discussion on rounds, in addition to actual patient conditions and complications. GYN students are included in all resident surgeries, and other surgeries assigned by the resident assisting on those cases.

Students assigned the GYN Service first finish their morning rounds then see the patients who are scheduled for surgery that day. GYN service surgery is scheduled on the GYN block days, which are usually Tuesday and Thursdays, and private GYN Surgeries are scheduled throughout the week. If there are no GYN service surgeries scheduled, students may participate in surgery with private attendings after obtaining their permission. Appropriate activity for operative cases includes preparation by reading about the planned procedure before the case starts and then participating in the surgical management of these patients, such as admission history and physical evaluations, assisting at the operating table, and post-operative care. Additionally, the student will participate in the care of their patients on the Gynecology Service during their hospital stay. Students also participate in the hospital care of all non-surgical gynecologic patients.

During times when there are no scheduled surgeries, students will be able to go to the Women's Healthcare Clinic with the Residents to see clinic patients. There may also be opportunity for a student to have self study time depending on how busy the service is and how many students are present. Students should consider this a special treat should this opportunity arise. I.e. students should not expect this luxury. Students are expected to study on campus during self-study times unless otherwise directed by the Resident/Attending in charge.

Rounds

Hospitalized patients are seen on a priority basis; antepartum and post-operative patients first. Students make brief presentations about their patients from note cards or memory while the resident reviews the patient's chart. Students are present at all times during rounds unless instructed otherwise by a resident.

Questions regarding rounds and presentation should be directed to the Chief Resident of the OB or GYN Service. Personal cell phones are to be turned off when participating in clinical responsibilities, e.g. rounds, operating room. Evening rounds are held after the completion of clinic or late afternoon conference.

Other Specialty Experiences include Mini Electives in OBGYN Sub Specialties:

Students have the option of choosing an elective, depending on how busy their service is, they should find out from their supervising attending and/or resident what would be the best day to do a mini elective while on that service. The students are to make sure that at least one student is on service per rotation. If there is more than one student on a service, they are to work amongst each other to take turns doing mini-electives.

Each clinical elective may be selected one time only and is for one open morning or afternoon only. If they plan to be off campus for a mini-elective, they are to notify their chief resident.
## Mini Electives

<table>
<thead>
<tr>
<th>Focus and Time</th>
<th>Faculty</th>
<th>Location</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion Services</td>
<td>Dr. William Ramos</td>
<td>A-Z Women’s Center 1670 E. Flamingo, Suite C</td>
<td>OFFICE MANAGER 702-892-0660</td>
</tr>
<tr>
<td>Maternal-Fetal Medicine</td>
<td>Drs. Adashek &amp; Wilkes</td>
<td>Desert Perinatal Associates 5761 S. Fort Apache, LV</td>
<td>REBECCA MCCOY, RN 702-341-6610</td>
</tr>
<tr>
<td>Maternal-Fetal Medicine</td>
<td>Dr. David Jackson</td>
<td>UNSOM MFM 1707 W Charleston Blvd., Suite 110</td>
<td>DR. JACKSON 702-265-6148</td>
</tr>
<tr>
<td>Neonatology</td>
<td>UMC NICU Faculty</td>
<td>University Medical Center 7th Fl. Neonatal Intensive Care Unit</td>
<td>GO TO NICU ON L&amp;D TO SET UP</td>
</tr>
<tr>
<td>Radiology</td>
<td>UMC Radiology Faculty</td>
<td>University Medical Center 1st Fl. Dept. of Radiology</td>
<td>ADRIENNE ZAMORA 702-383-7830</td>
</tr>
<tr>
<td>Pathology</td>
<td>UMC Pathology Faculty</td>
<td>University Medical Center 3rd Fl. Dept. of Pathology</td>
<td>GO TO PATHOLOGY DEPT. AT UMC TO SET UP</td>
</tr>
<tr>
<td>General Obstetrics and Gynecology</td>
<td>Dr. Jeffrey Wrightson</td>
<td>10105 Banbury Cross, Suite 460 in Summerlin</td>
<td>DR. WRIGHTSON <a href="mailto:iildvru@mac.com">iildvru@mac.com</a></td>
</tr>
<tr>
<td>General Obstetrics and Gynecology</td>
<td>Dr. David Kartzinel</td>
<td>3196 S. Maryland Parkway, Suite 410, LV</td>
<td>AMBER 702-731-8402</td>
</tr>
</tbody>
</table>
3rd Year Medical Student Clerkship
Department of Obstetrics and Gynecology
Las Vegas, Nevada

3rd YEAR MEDICAL STUDENT EVALUATION

Student Name: ___________________________ Rotation Dates: ___________________________

Evaluator Name: ___________________________ Rotation Name: ___________________________

*Please indicate frequency of contact with this student

☐ Extensive (Almost daily)
☐ Frequent (At least weekly)
☐ Occasional (1 or 2X per Clerkship)

A. CLINICAL ABILITIES/PERFORMANCE/ASSESSMENT

I. KNOWLEDGE

Unable to Rate Fail Marginal Pass High Pass Honors

Definition: Understands basic pathophysiology of disease; is knowledgeable about common problems; is able to acquire and retain facts.

COMMENTS: ____________________________________________________________

II. PROBLEM SOLVING

Unable to Rate Fail Marginal Pass High Pass Honors

Definition: Ability to assimilate information and problem-solve in a logical fashion; analyze and correlate clinical information; formulate an appropriate problem list and differential diagnosis; understand basic therapeutic plans and diagnostic strategies.

COMMENTS: ____________________________________________________________

III. CLINICAL SKILLS

Unable to Rate Fail Marginal Pass High Pass Honors

Definition: Ability to perform a history and physical exam; present in a clear and concise way; garner appropriate clinical information from a variety of sources; document daily records appropriately; perform routine procedures; adapt to a variety of clinical environments.

COMMENTS: ____________________________________________________________

B. PERSONAL QUALITIES AND VALUES

I. INTERPERSONAL SKILLS

Unable to Rate Fail Marginal Pass High Pass Honors

(e.g. Communication skills; cooperation; empathy; teamwork; sense of humor; care of others, etc.)

COMMENTS: ____________________________________________________________

________________________________________________________
II. PROFESSIONAL CHARACTERISTICS  Unable to Rate  Fail  Marginal  Pass  High Pass  Honors  
(e.g. Respect; honesty; altruism; duty; humility; excellence; consistent; ethical; recognizes limitations; responsible; reliable; flexible; receptive to feedback, etc.)

COMMENTS: 

III. MOTIVATION/ENTHUSIASM  Unable to Rate  Fail  Marginal  Pass  High Pass  Honors  
(e.g. Initiative; conscientious; punctual; committed; actively involved; etc.)

COMMENTS: 

C. OVERALL EVALUATION  Unable to Rate  Fail  Marginal  Pass  High Pass  Honors  

FORMATIVE COMMENTS: (This is an opportunity for you to give constructive feedback to the student. These are comments for the student's information only. They will not be included in the Dean's letter.)

SUMMATIVE COMMENTS: (For comments summarizing the student's performance. For verbatim use in the Dean's letter. Attach extra pages if necessary.)

EVALUATOR CONCERN: YES / NO (circle)  (MUST COMMENT IF "YES"). Indicate here ANY concerns you have about the student's performance that are not severe enough to lead to a failing grade:

Evaluator's Signature: ____________________________  Date: ____________________________
SECTION VII

UNSOM Savitt Medical Library
SAVITT MEDICAL LIBRARY
Service to Medical Residents, Las Vegas

Savitt Medical Library Contact Information:
Phone: 775-784-4625
Library web site: http://guides.library.unr.edu/savitt-medical
Savitt Medical Library Director: Mary Shultz, mshultz@medicine.nevada.edu  775-682-7313
Clinical Librarian – Las Vegas: Alexander Lyubechansky, alexl@medicine.nevada.edu
Office phone: 702-676-3637; Cell phone: 775-453-8272.
Medical Library – Las Vegas Hours: 7:30am-4:00pm, Monday-Friday. Limited after-hours access is available.

GETTING STARTED
Access to most library resources and services requires authentication using a UNR NetID logon. All residents are assigned a NetID through the UNSOM IT department. Any questions about obtaining or using your logon should be addressed to: Robert Boyd, Help Desk Manager, rboyd@medicine.nevada.edu  775-682-5000. Help with connecting to or using library information resources or computing/information management issues can be found in tutorials at: http://guides.library.unr.edu/medhelp

DOCUMENT DELIVERY
The library features a rapid and convenient Document Delivery Service which provides you with copies of journal articles or books which are not held locally in our collections. Requests for items are initiated electronically by the user through links on the library website. Requested items are typically delivered as digital file in .PDF format. Additional information on procedures and fees can be found at: http://guides.library.unr.edu/savitt-libservices/interlibrary-loan.

Requests for articles are most easily submitted using the “Find It” icon located on article citations in PubMed and other databases. Selecting the “Find It” icon will lead to the full-text of the article if available. If not, a link is provided to our Interlibrary Loan service through ILLiad.

Information about this is provided on the website listed above and by contacting Alexander Lyubechansky, alexl@medicine.nevada.edu
702-676-3637 in Las Vegas or contact Norman Huckle, Head Document Delivery Service, nhuckle@medicine.nevada.edu at 775-682-7328.

ELECTRONIC JOURNALS, BOOKS, & DATABASES
The library licenses numerous online health sciences journals. E-journals are available from any web enabled computer through the Savitt Medical Library website. The Library also licenses over 1,200 online texts covering basic science and clinical disciplines. Among the clinical resources available through the Savitt Medical Library website are Dynamed, ClinicalKey, FirstConsult, Cochrane Library, The Medical Letter, Access Medicine, and Web of Science. Suggestions for acquisition of additional resources are welcome.

INSTRUCTION & REFERENCE SERVICE
The Library conducts an ongoing series of seminars, some of which include accredited CME. These focus on the use of online information resources in clinical medicine. Classes are held both in Reno and Las Vegas. We are also available to give individual assistance in helping you use print and electronic
resources to meet your information needs, and to answer reference questions. The primary contact for classes or reference assistance is:
Clinical Librarian – Las Vegas: Alexander Lyubechansky, alexl@medicine.nevada.edu 702-676-3637.

Print Collections
The library maintains a small collection of textbooks, reference works, and general monographs in support of the educational, research, and patient care activities of the medical school program. Books can be requested for offsite delivery through our Document Delivery Services Department.

TECHNOLOGY SUPPORT
The Information Technology Department provides assistance in most areas of computing. Residents at any UNSOM location throughout the state may obtain help with anti-virus software installation/setup, email configuration, hand-held device configuration (such as setting up email and/or wireless on an iPhone, iPad, Android, etc.) and general computing issues (i.e. troubleshooting access to Web Campus or setting up access to wireless in School of Medicine facilities in Reno and Las Vegas).

All Residents will be issued an email account. The email login and password will also be used to access Web Campus as well as electronic library resources. Additionally, Residents in Las Vegas will be provided an additional account (separate from the email login/password) that will allow them to access computers in the various School of Medicine facilities in Las Vegas.

For assistance, please contact the School of Medicine Help Desk. In Las Vegas, please call 671-5100 and select option 2; in Reno and all other areas in Nevada, please call 775-682-5000 and select option 2.
SECTION VIII

University Medical Center Policies & Procedures
UMC Supervision Policy
PURPOSE:

To outline policy and procedural requirements pertaining to the supervision of Medical Students, Residents and/or Fellows in all inpatient and ambulatory patient care settings.

POLICY:

It is the policy and responsibility of the University Medical Center of Southern Nevada in conjunction with the University of Nevada School of Medicine (UNSOM) to implement procedural requirements governing Medical Students, Residents and/or Fellow supervision which are consistent with University Medical Center (UMC) policy, standards of applicable accrediting bodies, Medical & Dental Staff Bylaws, Rules and Regulations (as signed by Residents and Fellows and Staff Practitioners) and policy of the University Medical Center of Southern Nevada School of Medicine (UNSOM); provide for a quality teaching environment; and ensure the quality and safety of inpatient and outpatient care at this Health care Facility.

DEFINITIONS:

A. Graduate Medical Education (GME): Graduate medical education is the process by which clinical and didactic experiences are provided to Residents and/or Fellows to enable them acquire skills, knowledge, and judgment which are important to the care of patients. The purpose of GME is to provide an organized and integrated educational program providing guidance and supervision of the resident/fellow, facilitate their professional and personal development, and ensure safe and appropriate care for patients. GME programs focus on the development of clinical skills, attitudes, professional competencies and an acquisition of detailed factual knowledge in a clinical specialty.

B. Program Director: The Program Director is a University of Nevada School of Medicine (UNSOM) faculty member and also a member of the Medical Staff of University Medical Center who is responsible for the quality of the overall education and training program in a given discipline and for ensuring that the program is in compliance with the policies of the respective accrediting ensuring that the program is in compliance with the policies of the respective accrediting and/or certifying body(ies). A current list of the Program Directors is provided to the Chief of Staff from the UNSOM Office of Graduate Medical Education.

C. Clerkship Director: The Clerkship Director is a University of Nevada School of Medicine (UNSOM) faculty member who is also a member of the Medical Staff of the University Medical Center who is responsible for the clinical education of medical students. A current list of Clerkship
Directors is provided to the Chief of Staff from the UNSOM Office of Medical Education.

C. Medical Student: The term “Medical Student” refers to an individual who is training to become a physician. Students complete clerkships, preceptorships and electives in Family Medicine, Internal Medicine, Pediatrics, Surgery, Obstetrics and Gynecology, Psychiatry, Emergency Medicine and Anesthesiology as well as any specialty areas of these disciplines. They participate in their clinical training under the direct supervision of residents, fellows and faculty/attending physicians.

D. Resident: The term “Residents” refers to individuals who are engaged in a post-graduate training program sponsored by the UNSOM which includes the specialties of Internal Medicine (Appendix A), Surgery (Appendix B), Obstetrics/Gynecology (Appendix C), Family Practice (Appendix D), Pediatrics (Appendix E), Dentistry (Appendix F), Psychiatry, Plastic Surgery, and Emergency Medicine participating in patient care under the direction of faculty and attending physicians (see below). Such programs must be accredited by the Accreditation Council for Graduate Medical Education (ACGME).

E. Fellow: The term “Fellow” refers to a physician who has completed the requirements for eligibility for first board certification in a specialty and who is engaged in a post-residency program to obtain advanced training and education in a sub-specialty. These programs are subject to the policies and procedures for supervision as described in this policy. Fellowship programs must satisfy one of the following criteria:
   1. ACGME Approved Fellowships:
      a. Must be appropriately supervised for the advanced training, complex decision making, and new clinical learning required for the subspecialty as described in this policy.
   2. Not ACGME Approved Fellowships:
      a. Must be credentialed as a member of the Medical and Dental Staff of UMC in the specialty for which eligibility for first board certification has been earned. As such, this member of the medical staff can independently practice within the approved delineation of privileges.
      b. Must be appropriately supervised for the advanced training, complex decision making, and new clinical learning required for the subspecialty as described in this policy.

F. The Supervising Staff Practitioner/Teaching Physician: This refers to any teaching physician who in accordance with the Medical & Dental Staff Bylaws, Rules & Regulations, and policies of University Medical Center has been successfully and formally fully credentialed (i.e., unrestricted, off monitorship), (Associated/Provisional and/or Active) on UMC’s Medical Staff. This physician is also full-time or adjunct faculty with UNSOM. This Physician has been granted clinical privileges that reflect the Residents’, Fellows’ and students patient care responsibilities.

The supervising practitioner must provide an appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the resident or fellow and the complexity of patients’ health needs. Students must always have direct supervision.

G. Attending Physician: The Physician of Record at any given point of time during the patient’s hospitalization and/or care.

H. Admitting Physician: The Physician of Record at the time of patient admission.

I. Supervision: For the purpose of this document supervision refers to the authority and responsibility that a Supervising Staff Practitioner/Teaching Physician exercises over the care delivered to
patients by the Resident and/or Fellow. Supervision by the Supervising Staff Practitioner/Teaching Physician may be provided in a variety of ways, including person-to-person contact with the resident and/or Fellow in the presence of a patient, person-to-person contact in the absence of the patient, through consultation via the telephone and other electronic methods such as email and texting. All supervision with medical students must be person-to-person.

Supervision refers to the dual responsibility that an Attending Physician has to enhance the knowledge of the Resident/fellow/medical student and to ensure the quality of care delivered to each patient by any Resident/fellow/medical student. Such control is exercised by observation, consultation and direction. It includes the imparting of the practitioner’s knowledge, skills and attitudes by the practitioner to the resident/fellow/student and assuring that the care is delivered in an appropriate, timely and effective manner.

J. **Supervising Resident and/or Fellow**: This term refers to a Resident and/or Fellow who has previously been certified by his or her Program Director to perform specific medical activities acting under the appropriate supervision of a Supervising Staff Practitioner/Teaching Physician. Supervising Residents and/or Fellows are provided graduated responsibilities related to post graduate levels of training. In this role they may provide guidance and/or assistance to medical students and to less experienced Residents and/or Fellow(s) in various clinical activities, including but not necessarily limited assistance/guidance in the performance of invasive procedures and surgical interventions.

K. **Associate Dean for Graduate Medical Education**: This individual also serves as the University of Nevada School of Medicine’s Designated Institutional Official (DIO), responsible for the maintenance of the institution’s accreditation with the ACGME as well as the accreditation for all UNSOM residency training programs and answers directly to the Dean who serves as the chief academic officer for UNSOM. The Associate Dean for Graduate Medical Education and the Graduate Medical Education Committee (GMEC) ensure that the training programs are structured to meet the accreditation requirement for their specific disciplines. Further, this individual works closely with the Assistant/Associate Dean for Medical Education to coordinate the integration of medical students into the training programs.

L. **Associate Dean for Academic Affairs**: The Associate Dean for Academic Affairs is the Principal Academic Officer for medical student education at the Las Vegas campus of UNSOM. The Associate Dean for Academic Affairs reports to the Senior Associate Dean for Academic Affairs. These individuals are responsible for the curriculum of medical students, all policies that relate to medical students and to adhere to the LCME requirements for medical education of students. These individual are responsible for upholding educational standards that maintain the institution’s accreditation with the LCME through collaboration with curricular committees and the clinical departments. Further, these individuals work closely with the Associate Dean for Graduate Medical Education to coordinate the integration of medical students into the residency training programs in compliance with LCME accreditation standards.

M. **Dean of the University of Nevada School of Medicine**: This individual is the chief academic officer for the school of medicine responsible for all activities of the school.

N. **Documentation**: documentation is the written or computer-generated medical record evidence of a patient encounter. In terms of resident supervision, documentation is the written or computer-generated medical record evidence of the interaction between a supervising practitioner and a resident/fellow or student concerning a patient encounter.
PROCEDURES:

A. General Principles:

1. The University of Nevada School of Medicine and the University Medical Center maintain the highest standards for the education of medical students. In the clinical setting the parties place a premium on face-to-face faculty contact, resident teaching, and active involvement in the care of a diverse population of patients. This standard of excellence is valued by University of Nevada School of Medicine graduates who consistently cite clinical teaching, individual attention, accessible faculty, faculty-student interaction and hands on patient care as strength of their training in both nationally and internally administered surveys.12

2. The Liaison Committee for Medical Education (LCME), the accrediting body for American schools awarding the MD degree, requires that clinical education of students include the following:
   a. Setting of intellectual challenge
   b. Spirit of inquiry
   c. Acquisition of critical judgment based on teaching and experience
   d. Supervision of the learning experience to be provided by members of the faculty
   e. Evaluation of achievement assessed by direct observation
   f. Sufficient numbers of faculty to meet the needs of the education program
   g. Adequate numbers and types of patients

Furthermore, accommodating requests of visiting students must not significantly diminish resources available to enrolled students and visiting students should be at a commensurate level of training as enrolled UNSOM students. Therefore, it is optimal in the clinical training environment to have no more than 1-2 students on any medical team. Limiting the number of students on a team allows for direct supervision, training and assessment of students as individuals.

3. The University of Nevada School of Medicine/University Medical Center's residency/fellowship training programs maintain the highest standards for the training and education of residents and fellows. The Accreditation Council for Graduate Medical Education (ACGME) grants accreditation to the residency and fellowship programs sponsored by the parties. The education of trainees in a well supervised environment is critical to the maintenance of these high standards and accreditation. The ACGME restricts the learning environment to a maximum of eight learners per teaching service and does not accept dilution of learning experiences by visiting residents, students and other learners. These terms have been adapted for nonaccredited programs. These programs exist to provide training in areas in which accreditation at the present time does not exist.

4. Supervising Staff Practitioners/Teaching Physicians are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of such responsibility requires personal involvement with each patient and each Resident/ Fellow and/or medical student who is providing care as part of the training experience. Each patient as part of the Teaching Program will be assigned a staff practitioner whose name will be clearly identified in the patient's record. It is recognized that other Supervising Staff Practitioners/Teaching Physicians may, at times, be delegated responsibility for the care of a patient and provide supervision instead of, or in addition to that provided by the Supervising Staff Practitioner/Teaching Physician. Such a delegation will be documented
in the patient’s record by the Supervising Staff Practitioner/Teaching Physician initially assigned.

5. All Medical Students, Residents and/or Fellows, without exception, will function under the supervision of Supervising Staff Practitioner(s) Teaching Physician(s). Every School of Medicine Residency Program must ensure that adequate supervision is provided for Residents and/or Fellows at all times. A responsible Supervising Staff Practitioner/Teaching Physician must be immediately available to the Resident and/or Fellow in person, by telephonic or electronic modalities and the availability to be present in person within a reasonable period of time, if needed. Each clinical department of UMC will publish, and list Physician/Teaching Physician(s) to be contacted at any given time in accordance with Medical Dental Staff Bylaws, Rules and Regulations, and Policy.

6. Each training program will be structured to encourage and permit Residents and/or Fellows to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment. The determination and documentation of graduated levels of responsibility is outlined in paragraph F.V.C.

7. This facility will adhere to current accreditation requirement as set forth by the ACGME for all matters pertaining to the training program, including the level of supervision. The requirements of the various certifying bodies, such as the pertinent member of the American Board of Medical Specialties (ABMS) will be incorporated into this Medical Center’s training programs to ensure that each successful program graduate will be eligible to sit for a certifying examination.

8. These provisions are applicable to all UMC inpatient and outpatient care services.

9. At all times there will be an appropriately privileged Supervising Staff Practitioner/Teaching Physician onsite and immediately available to the Resident and/or Fellow in the outpatient clinic setting. Patients being followed in more than one clinic will be assigned a Supervising Staff Practitioner/Teaching Physician for each clinic who will be onsite during the times residents see patients. Supervising Staff Practitioners/Teaching Physicians are responsible to ensure continuity and acceptable levels of care provided to patients in the outpatient clinics.

10. Each program will set specific guidelines for circumstances and events in which residents/fellows must communicate with appropriate supervising faculty members, i.e. transfer of a patient to an intensive care unit or decisions about end of life issues.

11. Supervising Staff Practitioners/Teaching Physicians are to ensure compliance with University Medical Center policies governing all aspect of patient care and applicable Medical and Dental Staff Bylaws, Rules Regulations.

B. Roles and Responsibilities:

1. The Dean of the School of Medicine is responsible for implementation of, and compliance with, these requirements; for ensuring that monitoring activities are fulfilled; and responsible for the quality of the residency training programs as well as the education of medical students. At a minimum of semi-annually the Dean of the University of Nevada School of Medicine, or designee(s) will provide a report to the Medical Executive Committee and Joint Conference Committee describing the safety and quality of patient care provided by Residents and/or Fellows and the related educational and supervisory needs of the participants in all professional
graduate education programs. Additionally, the Dean or designee will report on the undergraduate medical education of medical students.

2. The Chief of Staff’s (COS) responsibility includes ensuring through Performance Improvement processes that quality care is provided by Supervising Staff Practitioners/Teaching Physicians and Residents and/or Fellows.

3. The Associate Dean for Academic Affairs, in coordination with the Office of Student Affairs, is responsible for ensuring that medical students entering their first UMC rotation participate in an orientation to Hospital policies, procedures, and the role of Medical Students within the UMC health care system.

4. The Program Directors are responsible for ensuring that Supervising Staff Practitioners/Teaching Physicians are appropriately fulfilling their responsibilities to provide supervision to Residents and/or Fellows, and that ongoing evaluations of those Residents and/or Fellows are conducted. The Program Director will:

   a. Assess the Supervising Staff Practitioner’s/Teaching Physician’s discharge of supervisory responsibilities, at a minimum, from evaluations and interviews with Medical Students, Residents and/or Fellows, other practitioners and other members of the health care team.

   b. Structure discipline specific training programs consistent with the requirements of the accrediting bodies and the University of Nevada School of Medicine programs in conjunction with the Associate Dean for Graduate Medical Education.

   c. Work with the Clerkship Director to integrate medical student teaching and supervision into the structure of the residency program as required and recommended by the LCME in conjunction with the Assistant/Associate Dean for Medical Education and Clerkship Directors.

   d. Arrange for all Residents and/or Fellows, entering their first UMC rotation to participate in an orientation to Hospital policies, procedures, and the role of Medical Students, Residents and/or Fellows within the UMC health care system. This orientation must be accomplished prior to their first clinical rotation.

   e. Ensure that Residents and/or Fellows are provided the opportunity to contribute to discussions and participate in Hospital committees where decisions being made may affect their activities and/or patient care. Resident and/or Fellow representation is encouraged on committees such as Infection Control, Pharmacy & Therapeutics, Medical Record, and Performance Improvement/Utilization Management.

   f. Work with faculty and staff supervising physicians to evaluate each resident’s/fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

5. The Supervising Staff Practitioner/Teaching Physician is responsible for Residents/Fellows to “cover” patients for inpatient services and/or to provide care in ambulatory setting. This does not diminish the standard of availability required by Medical and Dental Staff Bylaws, Rules and Regulations. The Supervising Staff Practitioner/Teaching Physician will be notified by the Resident and/or Fellow at the time of each patient admission. Supervising Staff Practitioners/
Teaching Physicians must be available to participate in patient care as if Residents were not involved. The staff practitioner is expected to fulfill this responsibility, at a minimum, in the following manner:

a. Know the patients on his/her service and provide direct supervision and input into the management of patients based on the nature of the patient’s condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the Resident and/or Fellow being supervised. Documentation of this supervision will be via progress notes, and/or counter-signature of, or reflected within, the Resident’s and/or Fellow’s progress note at an appropriate frequency warranted by the patient’s condition and as required in the UMC Medical and Dental Staff Bylaws, Rules and Regulations. In all cases where the provision of supervision is reflected within the Resident’s and/or Fellow’s progress note, the note shall include the name of the Supervising Staff Practitioner/Teaching Physician with whom the case was discussed and the nature of that discussion.

b. Meet the patient early in the course of care (for inpatients, within 24 hours/ one day of admission for ICU within two hours) and document, in a progress note, concurrence with the Resident’s and/or Fellow’s initial diagnoses and treatment plan. At a minimum, the progress note (regardless of setting) must state such concurrence and be properly signed, and dated, and timed.

c. Participate in attending rounds. Participation in rounds requires the Supervising Staff Practitioner/Teaching Physician to see every patient in person each day and write a progress note in the chart. In addition, there should be physical presence of the Supervising Staff Practitioner/Teaching Physician in the facility for sufficient time to provide appropriate supervision to Residents and/or Fellows; direct supervision is required for key and/or critical elements of care. PGY1 residents should be supervised either directly with direct supervision immediately available.

Teaching rounds may include a variety of interactions such as chart rounds, radiology review sessions, pre-op reviews, or informal patient discussions. If the assigned Supervising Staff Practitioner/Teaching Physician is unable to be present, another appropriately privileged Supervising Staff Practitioner/Teaching Physician must substitute. Progress notes on patients awaiting extended care facility placement must be written daily if the patient is on a teaching service.

d. Ensure that all technically complex diagnostic and therapeutic procedures which carry a significant risk to the patient are: medically indicated, fully explained to the patient, follow all applicable policies and procedures (Informed Consent, Universal Protocol) properly executed, correctly interpreted, evaluated for appropriateness, effectiveness and required follow-up.

e. Work with Residents to facilitate appropriate modifications of care as indicated in response to significant changes in diagnosis or patient status. Evidence of this supervision will be documented via a progress note, or counter-signature (this does not necessarily satisfy third party billing requirements) or, reflected within, the Resident’s and/or Fellow’s progress note.

f. Ensure that the appropriate information is present within the patient’s medical record at the
time of transfer to another service, or upon receipt of a patient from another service. Documentation will be evident in the patient’s record via a progress note, or counter-signature of, or reflected within, the Resident’s and/or Fellow’s progress note.

g. Ensure that discharge or transfer of the patient from the Medical Center or clinic is appropriate based on the specific circumstances of the patient’s diagnoses and treatment. The patient will be provided appropriate information regarding the prescribed therapeutic regimen, including specifics on physical activity, medications, diet, functional status, and follow-up plans. At a minimum, documentation by the Supervising Staff Practitioner/Teaching Physician will be evident by a counter-signature of the hospital discharge summary or clinic discharge note.

5. The Supervising Staff Practitioner(s)/Teaching Physician(s) with patient care and Resident and/or Fellow physician’s supervision is/are to be documented in the medical record. The medical record documentation will reflect day to day involvement by Residents for medical/surgical patients, at a minimum every 24 hours, for all inpatients in and more frequently for critically ill patients in Special Care/Intensive Care Units. Evidence of this assurance will be documented in the patient’s record via a progress note(s) or counter-signature of, or reflected within, the Resident’s and/or Fellow’s progress note(s).

6. The Supervising Staff Practitioner/Teaching Physician is responsible for ensuring that Residents and/or Fellows are supervised at the appropriate level when they perform any procedures, but especially those procedures that are high risk or technically complex. This requires that the Supervising Staff Practitioner/Teaching Physician be knowledgeable of the Residents and/or Fellows abilities and assigned level of responsibility.

7. It is the responsibility of the Program Directors (Family Practice Residents and/or Fellows, Internal Medicine Residents and/or Fellows, Surgery Residents and/or Fellows, OB/GYN Residents and/or Fellows, Pediatric Residents and/or Fellows, Psychiatry Residents, Plastic Surgery Residents and Emergency Medicine Residents) of The University of Nevada School of Medicine in conjunction with their faculty, to assign the PGY level and, for appropriate procedures, to authorize the level of supervision and ability to serve in a teaching/supervisory capacity. The Program Director shall maintain records of these assignments and authorizations in their offices, along with the evaluations required in IV.C.8.

C. Graduated Levels of Responsibility:

1. The residency process is a continuum of graduated experience and responsibility, which is generally designated by post-graduate years (PGY). Procedures that are required as common and basic to patient care must be identified by each Residency Program, and each starting Resident (PGY1) must be certified as capable in performing them before performing them independently on patients.

2. Other procedures and responsibilities (other than “basic” ones) must be identified by the requirement of the postgraduate year and the ability to perform the procedure, and certified accordingly by the Program Director. The Program Director will certify at a minimum of every six months that the Resident and/or Fellow has demonstrated the ability to perform the “procedure and/or activity” without direct supervision. For those activities that cannot be delegated to Residents and/or Fellows to initiate and perform independently, the Supervising Staff Practitioner/Teaching Physician will provide supervision until a resident/fellow can be perform the procedure independently. Supervising Residents and/or Fellows may also be
authorized to act as teachers for specific procedures and surgical operations once they have been certified and have performed the procedures independently.

3. The Residency List of “basic” and “individually approved” procedures should be available in the relevant Program Director’s office. Copies of all approved procedures for each Resident and/or Fellow must be available and updated at a minimum of biannually in the Medical Staff Office as well as Nursing Administration, Surgical Suites, Emergency/Trauma Departments, Special Care Units, and Nursing Care Units. For surgical and other high risk procedures that must be individually authorized, the Supervising Staff Physician/Teaching Physician shall document in the patient’s chart the level of Resident and/or Fellow supervision for the case.

a. Post-Graduate Year 1. Individuals in the first post-graduate year should not perform technically complex diagnostic and therapeutic procedures or high risk medical treatments without direct supervision by a Supervising Staff Practitioner/Teaching Physician or a senior level Resident and/or Fellow designated as a “senior Resident and/or Fellow.” Individuals in the first post-graduate year may do such things as take history and physical, start peripheral IV lines, place a Foley catheter or nasogastric tube, perform LP, simple non-cosmetic suturing, or skin biopsies, and write medication and/or diagnostic testing orders, without direct supervision once they have been certified in the procedure. In general PGY 1 individuals should be closely supervised by senior level Residents and/or Fellows and Supervising Staff Practitioners/Teaching Physicians as defined within the programs identified in Appendix A through H.

b. Senior Level Residents and/or Fellows (last PGY’s of residency or in fellowship). Individuals in the senior PGY years may supervise more junior Residents in the routine activities of their respective post-graduate years once certified and approved as a supervisor.

Individuals in the senior year may perform virtually all diagnostic and therapeutic procedures not usually performed by subspecialists, without immediate supervision, provided that the Residents and/or Fellows have been previously certified by their Program Directors. These include some technically complex or high risk procedures as would normally be performed by individuals trained in the specialty of the Resident and/or Fellow. For those procedures requiring a pre-procedure by a Supervising Staff Practitioner/Teaching Physician, then the Supervising Staff Practitioner/Teaching Physician has great latitude in determining which cases are suitable for the individual in the senior year to perform, or to act as a senior Resident and/or Fellow.

c. Each residency program director will determine the level of supervision necessary to perform procedures, and will update performance and capabilities of Residents every six months.

4. Each Resident and/or Fellow will have documentation of their assigned level of responsibility. This documentation will be kept by each of the School of Medicine’s Program Directors.

Each residency program must define when supervision requires the actual presence and/or availability of consultation by the Supervising Staff Practitioner/Teaching Physician. The Supervising Staff Practitioner/Teaching Physician may need, as each patient requires, to determine the degree of direct, physical presence and assistance to the Resident.
5. Supervision of Resident and/or Fellows performing: surgical interventions; high risk or technically complex procedures that require a pre-procedural note by the Attending Practitioner; and procedures which are normally restricted to a Specialist.

a. Such procedures requiring surgical skin incision may be performed only by Residents and/or Fellows who possess the required knowledge, skills, and judgment, and under an appropriate level of defined supervision. Supervising Staff Practitioners/Teaching Physicians, with guidance from the Program Directors, will be responsible for authorizing the performance of such procedures or operations on a case-by-case basis. Residents and/or Fellows may be given general authority to perform such procedures or operations in all cases. The name of the Supervising Staff Practitioner/Teaching Physician performing and/or directing the performance of a procedure must appear on the informed consent form, “Consent to Operation, Administration of Anesthetics, and the Rendering of Other Medical Services,” to be signed by the patient prior to initiating the procedure (with the exception of emergency procedures).

b. During the performance of such procedures or operations, a Supervising Staff Practitioner/Teaching Physician will provide an appropriate level of supervision. Determination of this level of supervision is generally left to the discretion of the Supervising Staff Practitioner/Teaching Physician and is a function of the experience and competence of the Resident and/or Fellow, and of the complexity of the specific case.

c. The staff involvement will be documented on the procedure/pre-operative report, the procedural/surgical log, and/or other appropriate documents.

d. As a general rule, Post-Graduate Year (PGY) 1 and 2, Residents and/or Fellows, will be supervised by the actual physical presence and availability of consultation by the Supervising Staff Practitioner/Teaching Physician. If the Supervising Staff Practitioner/Teaching Physician is not present, a senior Resident and/or fellow may be assigned. Such a determination will be made by the staff practitioner on a case-by-case basis considering the Resident’s and/or Fellow’s level of skill, knowledge, and judgment, and the complexity of the specific case. Residents and/or Fellows PGY 3 and higher may be appropriately available to junior Residents for consultation and support, via telephone or in person. If the Resident and/or Fellow requests the presence of the responsible Supervising Staff Practitioner/Teaching Physician, the Supervising Staff Practitioner/Teaching Physician will proceed expeditiously to the point of patient care.

6. Supervising Staff Practitioners/Teaching Physicians, in collegial consultation with their respective Program Directors, will provide appropriate supervision for the evaluation of patients by Residents, inclusive of: scheduling of cases, assignment of priority, pre-procedural, procedural, and post-procedural care of patients. Fulfillment of this responsibility will be carried out, at a minimum, in the following manner:

a. In all cases of elective or scheduled known high risk technically complex procedures, and if the circumstances permit in cases of emergency procedures, the Supervising Staff Practitioner/Teaching Physician will evaluate the patient and write a pre-procedural note (or admission note) confirming the Resident’s and/or Fellow’s findings, diagnostic plan for treatment and choice of specific procedure to be performed. Also, for each scheduled case, the Supervising staff Practitioner’s/Teaching Physician’s name will be identified on the procedure/operating room schedule, prior to the day of the procedure. When the pre-
procedural evaluation is completed as part of an outpatient pre-admission process, the Supervising Staff Practitioner’s/Teaching Physician’s pre-procedural note in the outpatient record, or on a pre-admission form, may be regarded as valid based on Medical and Dental Staff Rules and Regulations for patients with stable diseases, or conditions, undergoing elective procedures.

b. In emergency cases, the Resident and/or Fellow must, if at all possible, consult with and obtain approval from a Supervising Staff Practitioner/Teaching Physician who will be available to assist or advise as appropriate. The Supervising Staff Practitioner/Teaching Physician will be physically present in the procedural/operating suite during all Resident cases.

If circumstances do not permit the Supervising Staff Practitioner/Teaching Physician to write a pre-procedural note, the Resident’s and/or Fellow’s note will include the name of the responsible Supervising Staff Practitioner/Teaching Physician, and will indicate that the details of the case, including the proposed procedure(s), were discussed with and approved by the Supervising Staff Practitioner/Teaching Physician. In such cases, a Supervising Staff Practitioner/Teaching Physician must see the patient and counter-sign the Resident’s and/or Fellow’s pre-procedural note within 24 hours.

c. The procedure/operative (examples include but are not limited to: endoscopies, lumbar punctures, general surgery) report will be done immediately upon conclusion of the procedure and in addition to the Medical Staff approved components of post procedure progress note will include:

1. The name of the Supervising Staff Practitioner/Teaching Physician,
2. name(s) of the practitioner(s) performing the procedure,
3. assistant(s), including the name of the Resident and/or Fellow assigned as a senior Resident and/or Fellow who was present, if applicable,
4. Supervising Staff Practitioner’s/Teaching Physician’s authentication of the procedure/operative report by counter-signing with full name and date,
5. and the name of the Supervising Staff Practitioner/Teaching Physician responsible for post-procedural care.

d. At a minimum, prior to discharge, the Supervising Staff Practitioner/Teaching Physician will evaluate the patient’s response to the procedure and discuss with the patient the consequence or outcome of the procedure. Evidence of such a conversation will be documented via a progress note, or counter-signature of, or reflected within, the Resident’s and/or Fellow’s note. The Supervising Staff Practitioner/Teaching Physician will also counter-sign the discharge summary.

7. Excluded from the requirements of this section are defined by Program Director with Hospital are procedures, that although invasive by nature, are considered elements of routine and standard patient care. Examples are insertion/removal of intravenous or arterial lines, routine wound debridement, and drainage of superficial abscesses. Supervision for these types of activities are addressed and identified in “Graduated Levels of Responsibility.”

a. Emergency Situations
An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or prevent serious impairment of the health of a patient. In such situations, any Resident and/or Fellow, assisted by UMC personnel shall, consistent with local informed consent provisions, be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate Supervising Staff Practitioner/Teaching Physician will be contacted and apprised of the situation as soon as possible. The Resident and/or Fellow will document the nature of this discussion in the patient’s record.

8. Monitoring Procedures:
   a. The Medical Staff Leadership of University Medical Center fulfills all responsibilities identified within this section.
   b. The Chairperson of Medical Staff Departments whose service provides graduate education will participate in the facility monitoring process.
   c. Facility monitoring will document at a minimum:
      1. Residents and/or Fellows involvement in patient care.
      2. Review for compliance with the documentation requirements as part of the clinical pertinence record review.
      3. Review for consistency the supervision noted in the procedure/operating room log, and in the procedure/operative report.
      4. Monitoring of invasive procedures with complications to ensure that the appropriate level of supervision occurred.
      5. Monitoring of all incidents/risk events with complications to ensure the appropriate level of supervision occurred.
      6. Communication via Medical Executive Committee and Joint Conference Meeting Minutes, regarding the report from the Dean of the School of Medicine, or designee, to include educational needs and performance of the participants in the Program.
   d. The Medical Staff will:
      1. Annually review compliance with documentation requirements related to the determination and assignment of graduated levels of responsibility.
      2. Annually review with the Dean of the Medical School or designee, the overall quality of the training program(s) in each service and fulfillment of responsibility in accordance with this policy.

9. Medical Students: Third and fourth year students participating in clinical clerkships and in elective rotations will perform the following procedures under direct supervision of a resident and/or a Supervising/Teaching Physician:
a. History and physical examinations on patients; the student findings must be confirmed by the supervising physician.

b. Write patient notes; student notes must be reviewed and cosigned by a supervising physician within 24 hours.

c. Write orders on patients with the supervising physician physically present; these orders must be cosigned by the supervising physician immediately.

d. Procedures at the discretion of the supervising physician; the supervising physician must be physically present for any student procedures.

e. Participate in care at labor and delivery at the discretion of the supervising physician; the supervising physician must be physically present.

f. Scrub in on surgeries at the discretion of the supervising physician; the supervising physician must be physically present.

REFERENCES:

- Informed Consent Manual, University Medical Center Administrative Policy & Procedural Manual, Bylaws, Rules and Regulations of the Medical and Dental Staff of University Medical Center, Las Vegas, Nevada, Performance Improvement Plan, Patient Safety Plan, Managing Patient Flow Plan,
- ACGME Common Program Requirements July 1, 2011.
- UNSOM Definition and Procedures for Resident Supervision.
- AAMC Graduate Questionnaire 2006-2010
- Graduates' Evaluation of UNSOM Medical Education Program survey of classes 2000 to 2010
- Function & Structure of a Medical School Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree, Liaison Committee on Medical Education, 2012 Ed., Updated February 2012 http://www.lcme.org/functionslist.htm
- ACGME Program Requirements for Internal Medicine, July 2009
- UNSOM Resident, Resident and Fellow Handbook, May 2012
- Student Handbook, University of Nevada School of Medicine, http://www.medicine.nevada.edu/dept/asa/students/downloads/StudentHandbook.pdf
UNIVERSITY MEDICAL CENTER
LAS VEGAS, NV

MEDICAL, STUDENT, RESIDENT AND/OR FELLOW SUPERVISION POLICY

Brian Brannman
Chief Executive Officer

Dale Carrison, DO
Chief of Staff

Thomas Schwenk, MD
Dean University of Nevada School of Medicine

2/20/2013
Date

5/9/13
Date

5/23/15
Date
To ensure security measures are in place to protect the access to UMC information.

PROCEDURE PURPOSE:

To establish guidelines outlining the acceptable use of UMC and personal mobile devices/smartphones by UMC workforce members, non workforce members, medical personnel while on UMC premises.

Scope/Applicability:

This procedure is applicable to all employees, contractors, vendors or other individuals who otherwise have access to UMC data.

General

1. UMC mobile devices/smart phones may be issued to workforce members, non workforce members and medical personnel as needed to conduct UMC business.

2. The purchase of UMC mobile devices/smart phones and accessories must be approved by the department head and division administrator in writing and forwarded to the Information Technology (IT) Department for processing.

3. Workforce members, non workforce members and medical staff shall limit personal use of UMC mobile devices/smart phones to occasions when duties make such use necessary. Cost incurred to the UMC for use should be nominal.

4. Workforce members, non workforce members and medical personnel are responsible for reimbursing any cost incurred as a result of personal use.

5. No personal use is allowed outside of UMC business, including personal internet access, email or text messaging.

6. Periodic audits will be performed to ensure compliance. Failure to comply may result in the deduction of taxable wages from the employee for the total cost of the UMC mobile device/smart phone, as well as withholding of additional payroll taxes.
7. Prior to receiving the UMC mobile device/smart phone, the employee must sign the Acknowledgement and Receipt of UMC Property form (See attachment).

8. Lost, damaged, stolen, or missing UMC mobile devices/smart phones should be immediately reported to the IT Department. Workforce members, non workforce members and medical personnel may be responsible for damage and replacement costs for UMC equipment.

9. Discharged batteries must be exchanged at the time of receiving replacement batteries.

10. A landline must be used whenever possible to reduce expenses to UMC. When working in an area where landlines are available, inform the caller you will call him/her back when a landline is available.

11. No UMC owned data is allowed to be stored on personal mobile devices/smart phones.

UMC Issued Mobile Devices/Smart Phones Devices

1. Workforce members, non workforce members and medical personnel are responsible for reviewing each monthly bill and paying UMC for the total personal call minutes multiplied by the established per-minute rate.

2. All payments must be made to UMC within 30-days of receipt of bill, unless the total amount due from the employee is less than $10.00. If the total amount due from the employee is less than $10.00, the employee may combine reimbursements and report on a quarterly basis, with all payments due within 90-days of the receipt of the first bill.

UMC Issued Pagers

1. UMC pagers may be issued to workforce members, non workforce members and medical personnel as needed to conduct UMC business.

2. The purchase of UMC pagers and accessories must be approved by the department head and division administrator in writing and forwarded to the Information Technology (IT) Department for processing.

3. Prior to receiving the UMC pagers, the employee must sign the Acknowledgement and Receipt of UMC Property form (See attachment).

4. Discharged pager batteries must be turned in at the time of receiving replacement batteries.

5. Lost, damaged, stolen, or missing UMC pagers should be immediately reported to the IT Department/PBX. Workforce members, non workforce members and medical personnel may be responsible for damage and replacement costs for damaged or lost UMC equipment.

Personal Mobile Devices/Smart Phones

1. Workforce members, non workforce members and medical personnel may not make personal calls using personal mobile devices/smart phones while on UMC time. Workforce members, non workforce members and medical personnel may use personal mobile devices/smart phones before and after work and while on break and lunch in break areas.
2. Under certain circumstances, a workforce member or medical personnel's position may require the use of personal mobile devices/smart phones for company business. Workforce members and medical personnel needing to use their personal mobile devices/smart phones must have advanced written authorization from the employee's administrative division head.

3. When using mobile devices/smart phones, caution should be taken when entering patient areas to prevent unintended interruptions to patient care.

4. In the event the division head authorizes the use of personal mobile devices/smart phones for business purposes, the employee shall provide a copy of the monthly bill to the department manager/director, indicating which call is business related.
   a. Upon receipt, the manager will validate the information and authorize the payment due using the following formula:
      i. Take the total minutes used for business purposes divided by the total number of minutes used for the plan,
      ii. Multiply the bill by percentage in “i.” above for UMC’s portion of the bill,
      iii. Remit the bill to accounts payable utilizing normal accounting / finance policies and procedures for payment.
   b. Payment by accounts payable will be NET 30, made payable to the employee.

Safety Issues for Mobile Devices/Smart Phones Devices
1. Workforce members, non workforce members and medical personnel whose job responsibilities include regular or occasional driving and who are issued mobile devices/smart phones for business use are expected to refrain from using their mobile devices/smart phones while driving.

2. Workforce members, non Workforce members, and medical personnel whose job responsibilities do not specifically include driving as an essential function, but who are issued mobile devices/smart phones device for business use, are also expected to abide by the provisions above.

3. Workforce members, non workforce members and medical personnel who are charged with traffic violations resulting from the use of the mobile devices/smart phones while driving will be solely responsible for all liabilities resulting from such actions.

HIPAA Privacy and Security Issues
1. Workforce members, non workforce members and medical personnel must exercise caution when using mobile devices/smart phones to avoid inadvertent disclosures of protected health information. Most mobile device/smart phone conversations are vulnerable to interception by unauthorized individuals.

2. To avoid unauthorized disclosure of protected health information, do not use voice or image capable mobile devices/smart phones in any UMC area for any reason. UMC provides digital cameras for patient care purposes. UMC utilizes contracted business associates authorized to photograph patients, such as newborn children.

3. Patients and visitors' use of voice or image capable mobile devices/smart phones should be supervised to ensure the privacy rights of other patients are not violated.
4. No protected health or other sensitive information is to be stored on UMC or personally owned mobile devices/smart phones.

5. Mobile devices/smart phones may be used in most areas of the hospital, such as lobbies, public waiting rooms, and the cafeteria. Video and/or audio recording with any device, including cell phones, is expressly prohibited in all patient care areas. Please adhere to signs restricting use. Photographing or recording of hospital

6.

Violation of this policy exposes UMC to risks including, but not limited to patient care and safety issues, financial, reputational and legal issues. Additionally it may lead to disciplinary action up to suspension pending termination.

Related Policies/Procedures:

1-212 Information Security Program
1-207 Appropriate Use of Information Resources
Acknowledgement and Receipt of UMC Property

Department: _______________ Employee Name: ______________________

Date: ________________________ Employee Signature: ______________________

Equipment Procured: ________________________

1. I have received, understand, and will comply with the Personnel Policy Manual (specifically Policy XV: Ethical Standards) and all policies in relation to use of the above equipment.

2. I will endeavor not to use UMC property for personal use. In the event I use UMC property for personal use, I understand and accept that all charges and fees (including but not limited to long distance, roaming, and all usage expenses) incurred from my personal use will reimburse to UMC. I will review my bill monthly for personal use and pay all charges to UMC within 30-days of receiving the bill, unless the total amount due from me is less than $10.00. If the total amount due from me is less than $10.00, I have the option of combining reimbursements and reporting on a quarterly basis, with all payments due within 90-days of the receipt of the first bill.

3. By signing below, I authorize UMC to deduct from my paycheck(s) the amount equal to charges incurred from my personal use of UMC’s property should I not pay for personal usage within the 30-day timeframe or the 90-day timeframe depending on the amount of personal usage. (See Number 2 above.) (For charges of $50.00 or more, payment plan options can be arranged.) The actual charges due and payable will be provided to me in writing (from a bill or similar instrument of debt) no later than the 20th of the month following UMC’s receipt of the instrument for services used. If I am terminated or resign before making complete payment of all funds owed UMC, I authorize that amount to be deducted from my final paycheck.

4. I understand and acknowledge that I am responsible for safeguarding and protecting UMC property I received from damage, loss, or theft. I may be charged for damage, loss, or theft caused to UMC property as a result of my actions. (For charges of $50.00 or more, payment plan options can be arranged.) If I am terminated or resign before reimbursing UMC for damaged, lost or stolen property, I authorize the equipment amount to be deducted from my final paycheck.

5. I also understand that usage of UMC property may be monitored. All policies established regarding use of property must be followed. UMC may monitor my usage of UMC property and violations of policies may lead to disciplinary action, up to and including suspension, pending termination.

6. Upon my separation from employment (or suspension pending employment action) I will be required to provide all UMC property to my supervisor or UMC representative. Equipment must be in proper working order. Failure to return all UMC property at separation may lead to collection efforts to recover property or the value of the property at time of recovery efforts.

7. For those departments that rotate mobile information, cell phones and communication devices, each employee will be responsible for the loss or damage that occurs to UMC property while in his/her possession. Efforts will be made to determine when the property sustained the adverse impact.
**Purpose**

To provide guidelines for surgical attire including jewelry, clothing, shoes, head coverings, masks, jackets, and other accessories worn in the semi-restricted and restricted areas of the surgical or invasive procedure setting that will lessen the opportunity for healthcare providers to serve as the potential source of infection to patients, promote worker safety, and a high level of cleanliness and hygiene within the perioperative environment.

**Policy**

All personnel, including surgeons, anesthesiologists, residents, non-employee contractors, vendors, forensic/correctional officers, students, and non-departmental employees working in or visiting the surgical suites, labor & delivery suites, cath lab, special procedures, and sterile processing are required to follow the AORN Standards and Recommended Practices outlined within this policy.

**Procedure**

A. **Surgical attire should be made of low-linting material, contain shed skin squames, provide comfort, and promote a professional appearance**
   a. Surgical attire fabrics should be tightly woven, stain resistant, and durable. Surgical attire should provide comfort in terms of design, fit, breathability, and the weight of the fabric.
   b. Surgical attire and/or jackets made of cotton fleece should not be worn.

B. **Clean surgical attire, including shoes, head covering, masks, jackets, and identification badges should be worn in the semi-restricted and restricted areas of the surgical or invasive procedure setting.**
   a. Facility-approved, clean, and freshly laundered or disposable surgical attire should be donned daily in a designated dressing area before entry or reentry into the semi-restricted and restricted areas.
      - Scrubs worn into UMC from other facilities or internal ancillary departments will be changed to minimize potential for contamination from uncontrolled environments.
      - **UMC provided scrub tops and pants are the only acceptable surgical attire.**
   b. When donning surgical attire, care should be taken to avoid contact of the clean attire with the floor or other possibly contaminated surfaces.
   c. When wearing a two-piece scrub suit, the top of the scrub suit should be secured at the waist, tucked into the pants, or fit close to the body to prevent skin squames from being dispersed into the environment.
d. Health care personnel should change into street clothes whenever they leave the health care facility or when traveling between buildings located on separate campuses.

e. Jewelry including earrings, necklaces, watches, and bracelets that cannot be contained or confined within the surgical attire should not be worn. Jewelry that cannot be confined within the surgical attire should be removed before entry into the semi-restricted and restricted areas.
   - Rings, watches, and bracelets should be removed before hand washing or using hand rubs.
   - Earrings, if worn, will be small posts contained within the surgical head cover.

f. Persons entering the semi-restricted or restricted areas of the surgical suite for a brief time for a specific purpose (e.g., law enforcement officers, parents, biomedical engineers) should cover all head and facial hair and should don either freshly laundered surgical attire; single-use attire; or a single-use jumpsuit (e.g., coveralls, bunny suit) designed to completely cover outside apparel.
   - Non-employee contractors or non-departmental employees are also required to wear personal protective equipment—hat and shoe covers at a minimum, and a mask if entering an open OR suite.

g. Shoes worn within the perioperative environment should be clean.
   - Shoes worn within the perioperative environment should have closed toes and backs (enclosed heels), low heels, non-skid soles, and must meet Occupational Safety & Health Administration (OSHA) and the health care organization’s safety requirements.
     o Surgical clogs shall be **washable** rubber surgical clogs with enclosed heels.
     o **Clogs made of any type of fabric are not allowed.**
     o Cloth clogs, open toed shoes, flip flops, sandals, and shoes with vents on the top of the shoe (e.g., Crocs) are not allowed, as these do not offer protection against sharp items that may be dropped, spilled liquids, and blood or body fluids.
     o Socks or hose are **required** for all personnel.

h. Identification badges should be worn by all personnel authorized to enter the perioperative setting.
   - Identification badges should be secured on the surgical attire top, be visible, and be cleaned if they become soiled.
     o Vendors must obtain a vendor badge from a kiosk prior to entering the Surgery Department and sign-in at the OR Front Desk

i. Cover apparel
   - Cover apparel should be laundered daily.
     o No garments, with the exception of a cotton/cotton blend fabric (non-fleece) warm-up jacket or paper cover jacket are to be worn over surgical attire.
   - Lab coats **are not allowed** (either worn or carried) in the *semi-restricted or **restricted areas
     o Lab coats will be hung in the designated dressing area or on the coat hooks at the entryway of the semi-restricted (substerile) hallways

j. Stethoscopes should be clean and not worn around the neck.
   - Fabric stethoscope tubing covers should not be used.

k. Fanny packs, backpacks, suitcases, purses, rolling totes, personal bags, and briefcases that are porous and cannot be wiped down, will not be taken into the semi-restricted or restricted areas of the perioperative suite or if the item is necessary for transport of medical equipment or patient care, will be placed inside a plastic bag.

C. All individuals who enter the semi-restricted and restricted areas should wear freshly laundered surgical attire that is laundered at a health care-accredited laundry facility or disposable surgical attire provided by the facility and intended for use within the perioperative setting.
   a. Surgical attire should be changed daily or at the end of the shift.
• Reusable or single-use contaminated attire should be placed in appropriately designated containers after use.

• Surgical attire that has been penetrated by blood or other potentially infectious materials should be removed immediately or as soon as possible and replaced with freshly laundered, clean surgical attire. When extensive contamination of the body occurs, a shower or bath should be taken before donning fresh attire.

• Wet or contaminated surgical attire should not be rinsed or soaped in the location of use.

• Surgical attire contaminated with visible blood or body fluids must remain at the health care facility for laundering or be sent to an accredited laundry facility contracted by the health care organization.
  o UMC issued scrubs are not to be removed/worn from UMC property, as surgical attire has been exposed to contamination with blood, body fluids, and potentially infectious pathogens.

b. When in the semi-restricted or restricted areas, all non-scrubbed personnel should wear a freshly laundered or single-use long-sleeved warm-up jacket snapped closed with the cuffs down to the wrists.

• All personal clothing should be completely covered by the surgical attire. Undergarments such as T-shirts, which can be contained underneath the scrub top, may be worn; personal clothing that extends above the scrub top neckline or below the sleeve of the surgical attire should not be worn.
  o Undergarments, such as turtlenecks, long-sleeved shirts, sweatshirts, jackets, long underwear, or any other garments not completely covered by surgical scrub attire are not allowed.

D. All personnel should cover head and facial hair, including sideburns and the nape of the neck, when in the semi-restricted and restricted areas.
  a. A clean, low-lint surgical head cover or hood that confines all hair and covers scalp skin should be worn. The head cover or hood should be designed to minimize microbial dispersal.
    • Used single-use head coverings should be removed and discarded in a designated receptacle daily or when contaminated.
      o Vendors will wear a RED disposable bouffant head covering, obtained from the Charge Nurse, when working in the Surgery Dept.
    • Reusable head coverings are allowed. Reusable head coverings should be laundered after each daily use.
      o Baseball caps, bandanas, ‘do-rags’, and other personal caps are prohibited—even if covered by a disposable surgical hat.
    • Men with beards must wear the ‘hood’ style scrub hat and must cover their beards completely, preferably with a ‘bouffant’ style scrub hat or mask while in the semi-restricted* and restricted** areas.
    • Long hair should be pulled back and contained in a manner as to not interfere with safety or infection control.

E. Surgical attire should be laundered in a health care-accredited laundry facility.
  a. Laundered surgical attire should be protected during transport to the practice setting to prevent contamination.
    • Surgical attire should be transported in a clean vehicle and enclosed carts or containers.
  b. Clean surgical attire should be stored in a clean, enclosed cart or cabinet
    • Surgical attire may not be stored in a personal locker.

F. All individuals entering the restricted areas should wear a surgical mask when open sterile supplies and equipment are present.
a. The mask should cover the mouth and nose and be secured in a manner to prevent venting.
b. A fresh, clean surgical mask should be worn for every procedure. The mask should be replaced and discarded whenever it becomes wet or soiled.
   - Masks should not be worn hanging down from the neck.
c. Surgical masks should be discarded after each procedure. Masks should be removed carefully by handling only the mask ties. Hand hygiene should be performed after removal of masks.
d. Only one surgical mask should be worn at a time.

G. Health care personnel should receive initial and ongoing education and demonstrate competency on appropriate surgical attire.
   a. Health care personnel should receive education and guidance on appropriate articles of surgical attire worn in the perioperative environment at orientation and after changes are made.

H. Personal Protective Equipment (PPE)
   a. Shoe covers are required personal protective equipment. Shoe covers should be changed whenever they become torn, wet, or soiled.
   b. Protective eyewear, face shields, or masks with built-in face shields, must be worn whenever activities could place personnel at risk for splashing or spraying of blood or body fluids. Personnel include UMC employees, students, residents, and physicians.
   c. Additional protective attire (e.g. liquid resistant aprons, etc) should be worn when exposure to blood, body fluids, or potentially infectious materials is reasonably anticipated.
   d. Personal protective equipment, such as masks, shoe covers, disposable hats, gowns, aprons, and gloves must be removed upon exiting from semi-restricted* or restricted** areas and upon entrance to public areas.

I. Miscellaneous
   a. All staff will refrain from wearing perfumes, colognes, body sprays, or other scents in the Surgery Dept.
   b. All surgery personnel issued a radiology badge will wear the badge at the collar during the work shift

Definitions

* Semi-restricted areas include peripheral support areas such as storage areas for clean and sterile supplies, work areas, storage and processing of instruments and corridors leading to restricted areas of the operating room, labor and delivery, cath lab, sterile processing, and special procedure areas.

** Restricted areas include operating rooms, labor and delivery rooms, special procedural rooms, cath lab, sterile processing area and the sterile supply and instrument storage areas.

References


The following Recommended Practices for Surgical Attire were developed by the AORN Recommended Practices Committee and have been approved by the AORN Board of Directors. They were presented as proposed recommendations for comments by members and others. They are effective November 1, 2010. These recommended practices are intended as achievable recommendations representing what is believed to be an optimal level of practice. Policies and procedures will reflect variations in practice settings and/or clinical situations that determine the degree to which the recommended practices can be implemented. AORN recognizes the various settings in which perioperative nurses practice. These recommended practices are intended as guidelines adaptable to various practice settings. These practice settings include traditional operating rooms (ORs), ambulatory surgery centers, physicians’ offices, cardiology catheterization laboratories, endoscopy suites, radiology departments, and all other areas where surgery and other invasive procedures may be performed.

Purpose

These recommended practices provide guidelines for surgical attire including jewelry, clothing, shoes, head coverings, masks, jackets, and other accessories worn in the semirestricted and restricted areas of the surgical or invasive procedure setting. The human body and inanimate surfaces inherent to the surgical environment are major sources of microbial contamination and transmission of microbes; therefore, surgical attire and appropriate personal protective equipment (PPE) are worn to promote worker safety and a high level of cleanliness and hygiene within the perioperative environment. These recommended practices are not intended to address sterile surgical attire worn at the surgical field or all PPE.

Recommendation I

Surgical attire should be made of low-linting material, contain shed skin squames, provide comfort, and promote a professional appearance.

In a prospective interventional study of surgical attire that was motivated by an increase in endophthalmitis after cataract surgery, researchers compared several types of polyester scrub attire and cotton scrub attire. They found that surgical attire made of 100% spun-bond polypropylene decreased the bacterial load in the air by 50% compared to cotton surgical attire. Researchers also found that surgical attire helps contain bacterial shedding and promotes environmental control. In another study researchers found that the design of the surgical attire was not as important as the material of which it was made.

I.a. Surgical attire fabrics should be tightly woven, stain resistant, and durable. Surgical attire should provide comfort in terms of design, fit, breathability, and the weight of the fabric.

Cotton fabrics with pores greater than 80 microns may allow microorganisms attached to skin squames to pass through the interstices of the material’s weave. Tightly woven surgical attire (cotton and polyester [50/50] with 560 × 395 threads/10 cm) reduced the amount of bacteria shed into the air by two to five times, with the exception of methicillin-resistant Staphylococcus epidermidis (MRSE) from MRSE carriers.

I.b. Surgical attire made of 100% cotton fleece should not be worn.

Some fabrics made of cotton fleece material collect and shed lint. Lint may harbor microbial-laden dust, skin squames, and respiratory droplets. In addition, fleece is made up of a napped surface with low density, which renders it more flammable.

Cotton fiber is one of the most flammable fibers, and 100% cotton fleece without fire-retardant chemical treatment does not meet the federal flammability standard. Cotton blended with 10% to 20% polyester may reduce the flammability, but this is not always successful. Application of a fire-retardant chemical still may be required.

Recommendation II

Clean surgical attire, including shoes, head covering, masks, jackets, and identification badges should be worn in the semirestricted and restricted areas of the surgical or invasive procedure setting.

Clean attire minimizes the introduction of microorganisms and lint from health care personnel to clean items and the environment.

II.a. Facility-approved, clean, and freshly laundered or disposable surgical attire should be donned daily in a designated dressing area before entry or reentry into the semirestricted and restricted areas.

Changing from street apparel into facility-approved, clean, and freshly laundered or disposable surgical attire in a designated area decreases the possibility of cross-contamination and assists with traffic control.
II.a.1. When donning surgical attire, care should be taken to avoid contact of the clean attire with the floor or other possibly contaminated surfaces.

II.a.2. When wearing a two-piece scrub suit, the top of the scrub suit should be secured at the waist, tucked into the pants, or fit close to the body to prevent skin squames from being dispersed into the environment.

Loose scrub tops may allow skin squames to disperse into the environment from the axilla and chest. The major source of bacteria dispersed into the air comes from health care providers’ skin. When skin squames come off the body surface, they carry any microorganism that is found on the surface of the individual’s skin. Every individual loses a complete layer of skin every four days (about 10^7 skin squames every day). With just the movement of walking, this may cause a loss of 10^8 squames per minute.

II.a.3. Health care personnel should change into street clothes whenever they leave the health care facility or when traveling between buildings located on separate campuses.

Surgical attire may become contaminated by direct or indirect contact with the external environment.

II.b. Jewelry including earrings, necklaces, watches, and bracelets that cannot be contained or confined within the surgical attire should not be worn. Jewelry that cannot be confined within the surgical attire should be removed before entry into the semirestricted and restricted areas.

Necklaces on the skin may contaminate the front of the sterile gown if they are not confined within the surgical attire.

Wearing finger rings, nose rings, and ear piercings increases bacterial counts on skin surfaces both when the jewelry is in place and after removal. One study showed that earrings had bacterial counts more than 21 times higher beneath the earrings than on the surface of the earrings. Bacterial counts were nine times greater on the skin beneath finger and nose rings than on the rings themselves.

The removal of watches and bracelets allows for more thorough hand washing. Researchers sampled 100 wristwatch wearers in the health care environment and found that immediately after they removed their watches, 25% of the wristwatch wearers’ wrists had positive cultures for Staphylococcus aureus.

II.b.1. Rings should be removed before hand washing or using hand rubs.

Several studies have shown that wearing rings may result in colonization of health care providers’ hands with gram-negative and gram-positive pathogens. Finger rings have been found to increase skin surface bacterial counts. Although hand washing reduces these counts, there are more bacteria under rings than on the adjacent skin or the opposite hand. The pathogens identified in one study were coagulase-negative staphylococci, other skin flora, gram-negative cocci, Pseudomonas spp, and Staphylococcus aureus.

Removing rings before hand washing may decrease the potential for pathogens to remain on hands after hand washing. Removing rings before hand hygiene may enhance the effectiveness of the hand hygiene process.

II.c. Persons entering the semirestricted or restricted areas of the surgical suite for a brief time for a specific purpose (eg, law enforcement officers, parents, biomedical engineers) should cover all head and facial hair and should don either freshly laundered surgical attire; single-use attire; or a single-use jumpsuit (eg, coveralls, bunny suit) designed to completely cover outside apparel.

Clean and freshly laundered surgical attire, single-use attire, or single-use jumpsuits donned before entry into the semirestricted and restricted areas may minimize the potential for contamination of the environment and cross-contamination of the attire (eg, animal hair, cross-contamination from other uncontrolled environments, spores in soil).

II.d. Shoes worn within the perioperative environment should be clean.

Soiled shoes have been found to contribute to environmental contamination within the perioperative environment. A study of shoes worn outdoors and shoes worn only in the surgical suite showed 98% of the outdoor shoes were contaminated with coagulase-negative staphylococci, coliform, and bacillus species compared to 56% of the shoes worn only in the surgical suite. Bacteria on the perioperative floor may contribute up to 15% of colony-forming units (CFUs), which are dispersed into the air by walking. Shoes that are worn only in the perioperative area may help to reduce contamination of the perioperative environment.

II.d.1. Shoes worn within the perioperative environment should have closed toes and backs, low heels, non-skid soles, and must meet Occupational Safety & Health Administration (OSHA) and the health care organization’s safety requirements.

Shoes that enclose the foot with backs, low heels, and non-skid soles may reduce the risk of injury from slips and falls and from dropped items. The OSHA regulations require the use of protective footwear in areas where there is a danger of foot injuries.
II.e. Identification badges should be worn by all personnel authorized to enter the perioperative setting. Health care personnel as well as patients should be able to identify caregivers.

Identification badges assist in identifying persons authorized to enter the perioperative setting, and support security measures.

II.e.1. Identification badges should be secured on the surgical attire top, be visible, and be cleaned if they become soiled.

Badge holders such as lanyards, chains, or beads pose a risk for contamination and may be very difficult to clean. One study of identification badges and lanyards showed that the median bacterial load isolated was 10-fold greater for lanyards (3.1 CFU/cm²) than for identification badges (0.3 CFU/cm²). The microorganisms recovered from lanyards and identification badges were methicillin-sensitive Staphylococcus aureus (MSSA), methicillin-resistant Staphylococcus aureus (MRSA), Enterococcus spp, and enterococci on their clothing, and pockets of the coats were the most contaminated. In one study of cover coats worn by 100 physicians, Staphylococcus aureus was isolated from 25 of the cover coats. The cuffs and pockets of the coats were the most contaminated.

In another study of 100 medical students, microorganisms were found on the cuffs and side pockets of the students’ cover apparel. Contamination was found on their dominant hand sleeve cuffs and the backs of the cover apparel 10 cm down from the collar. These areas were contaminated with Staphylococcus sp on all cover apparel, Acinetobacter sp on seven students’ cover apparel, and diphtheroids on 12 students’ cover apparel.

In a study of health care practitioners’ cover apparel, researchers found that cover apparel in inpatient and outpatient areas, intensive care units, administration areas, and the OR was contaminated with Staphylococcus aureus, which included susceptible and resistant isolates. Health care personnel with colonization were more likely to have home-laundered their cover apparel. Two-thirds of the health care practitioners perceived their cover apparel to be dirty because it had not been washed in more than a week.

II.f. The use of cover apparel (eg, lab coat, cover gown) may be determined at each individual practice setting based on state regulatory requirements and the culture of the health care organization.

Wearing cover apparel over surgical attire outside of the perioperative suite may be required for some health care personnel in some health care organizations for a variety of reasons, which may include professional appearance. This may be based on the belief that cover apparel decreases the risk of infection. The use of cover apparel has been found to have little or no effect on reducing contamination of surgical attire.

II.f.1. Cover apparel should be laundered daily in a health care-approved or -accredited laundry facility. (See Recommendation V.)

Health care personnel may carry staphylococci and enterococci on their clothing, which may include surgical attire and cover apparel. Studies of cover apparel have shown that rather than protecting the clothing underneath the cover gown, cover apparel may contaminate the clothes worn under the cover apparel. Researchers have found that cover apparel is not always discarded daily after use or laundered on a frequent basis.

In one study of cover coats worn by 100 physicians, Staphylococcus aureus was isolated from 25 of the cover coats. The cuffs and pockets of the coats were the most contaminated.

In another study of 100 medical students, microorganisms were found on the cuffs and side pockets of the students’ cover apparel. Contamination was found on their dominant hand sleeve cuffs and the backs of the cover apparel 10 cm down from the collar. These areas were contaminated with Staphylococcus sp on all cover apparel, Acinetobacter sp on seven students’ cover apparel, and diphtheroids on 12 students’ cover apparel.

In a study of health care practitioners’ cover apparel, researchers found that cover apparel in inpatient and outpatient areas, intensive care units, administration areas, and the OR was contaminated with Staphylococcus aureus, which included susceptible and resistant isolates. Health care personnel with colonization were more likely to have home-laundered their cover apparel. Two-thirds of the health care practitioners perceived their cover apparel to be dirty because it had not been washed in more than a week.

II.g. Stethoscopes should be clean and not worn around the neck.

Inanimate objects, such as contaminated stethoscope tubing and diaphragms, may transmit pathogens such as MRSA by indirect contact (eg, by wearing the stethoscope around the
neck and contaminating the skin and surgical attire). Cleaning stethoscopes in combination with health care personnel washing their hands between caring for patients decreases the possibility of transmission of pathogens to patients and environmental surfaces.

Stethoscopes may be the most widely used medical device in a health care facility. Although stethoscopes are not considered part of the surgical attire, health care providers often wear them around their necks as though they were part of surgical attire. Stethoscopes come in direct contact with patients’ skin and could provide an opportunity for transmission of microbes from patient to patient, to health care personnel, or from health care personnel to patients. One study verified that stethoscopes could be a vector for transmission to patients. Another study conducted on stethoscope diaphragms noted that, when cultured before cleaning, 79.8% of the cultures grew gram-positive bacilli, 74.8% had Staphylococcus species non-aureus, 2.5% of baseline cultures showed MSSA, and group A streptococcus was found in 1% of cultures.

A study showed recontamination of stethoscopes can occur by the fifth time the stethoscope is used on different patients. The number of bacteria on a stethoscope increases with each use.

Cleaning the stethoscope daily may not be adequate; cleaning stethoscopes may be required between each patient use. Several studies on contamination of stethoscope diaphragms and earpieces have been conducted and show that 66% to 100% of the diaphragms are contaminated. One study noted that to avoid increasing emergent strains, routine cleaning of stethoscopes may help reduce bacterial colony counts.

II.g.1. Fabric stethoscope tubing covers should not be used. Adding fabric covers to stethoscope tubing may result in the covers acting as fomites. One study of stethoscope fabric covers isolated gram-positive aerobic bacteria, gram-negative aerobic bacteria, anaerobes, and yeast. The average length of time between stethoscope cover laundering was 3.7 months, with some fabric covers that were never laundered.

II.h. Fanny packs, backpacks, and briefcases should not be taken into the semirestricted or restricted areas of the perioperative suite. Items brought into the OR, such as fanny packs, backpacks, briefcases, and other personal items that are constructed of porous materials, may be difficult to clean or disinfect adequately and may harbor pathogens, dust, and bacteria. Pathogens have been shown to survive on fabrics and plastics. Dust is made up of skin particles, hair, fabric fibers, pollens, mold, fungi, insect parts, glove powder, and paper fibers, among other things. Bacteria may be transported from one location to another by carriers such as dust or liquids, and may contaminate fanny packs, backpacks, and briefcases.

The type of environmental surface and its ability to support microbial growth will influence microbial carriage. Gram-positive cocci (eg, coagulase-negative staphylococci) may persist in dry settings. Settings that are moist and soiled may support gram-negative bacilli (eg, floors). Fungi favors moist, fibrous material and are also found in dust.

Recommendation III

All individuals who enter the semirestricted and restricted areas should wear freshly laundered surgical attire that is laundered at a health care-accredited laundry facility or disposable surgical attire provided by the facility and intended for use within the perioperative setting.

Surgical attire helps contain bacterial shedding and promotes environmental cleanliness. An individual sheds millions of skin squames daily. Five percent to 10% of skin squames carry bacteria. In a study on dispersion of MRSE, carriers of MRSE were seen as possible sources of air contamination in ORs.

III.a. Surgical attire should be changed daily or at the end of the shift. It has been reported that surgical attire may have bacterial colony counts that are higher when scrub clothing is removed, stored in a locker, and used again. Microbes have been shown to survive for long periods of time on fabrics such as surgical attire. Worn reusable surgical attire should be left at the health care facility for laundering.

III.a.1. Reusable or single-use contaminated attire should be placed in appropriately designated containers after use. Worn reusable surgical attire should be left at the health care facility for laundering.

III.a.2. Surgical attire that has been penetrated by blood or other potentially infectious materials should be removed immediately or as soon as possible and replaced with freshly laundered, clean surgical attire. When extensive contamination of the body occurs, a shower or bath should be taken before donning fresh attire.

Changing contaminated, soiled, or wet attire reduces the potential for contamination and protects personnel from prolonged exposure to potentially harmful bacteria. Wet or contaminated surgical attire should not be rinsed or sorted in the location of use.
Rinsing or sorting contaminated reusable attire may expose the health care worker to blood, body fluids, or other liquids that may contain potentially infectious agents and may contaminate the patient care environment.\(^4\)

III.a.4. Surgical attire contaminated with visible blood or body fluids must remain at the health care facility for laundering or be sent to an accredited laundry facility contracted by the health care organization.\(^5\)\(^6\)\(^7\)\(^8\)\(^9\) Controlled laundering of attire contaminated by blood or body fluids reduces the risk of transferring pathogenic microorganisms from the facility to the home or general public.\(^10\) (See Recommendation V.)

III.b. When in the semirestricted or restricted areas, all nonscrubbed personnel should wear a freshly laundered or single-use long-sleeved warm-up jacket snapped closed with the cuffs down to the wrists.

Wearing the warm-up jacket snapped closed prevents the edges of the front of the jacket from contaminating a skin prep area or the sterile surgical field. Long-sleeved attire helps contain skin squames shed from bare arms.\(^1\)

III.b.1. All personal clothing should be completely covered by the surgical attire. Undergarments such as T-shirts with a V-neck, which can be contained underneath the scrub top, may be worn; personal clothing that extends above the scrub top neckline or below the sleeve of the surgical attire should not be worn.

Personal clothing is not laundered by a health care-accredited laundry facility. (See Recommendation V.)

Recommendation IV

All personnel should cover head and facial hair, including sideburns and the nape of the neck, when in the semirestricted and restricted areas.

Head coverings contain skin squames and hair shed from the scalp. It is important to prevent shed skin squames from falling onto the sterile field.\(^11\)\(^12\) Although group A streptococcus is isolated in less than 1% of surgical site infections (SSIs) (ie, 1 per 10,000), it is a serious cause of SSIs and can be carried on the scalp.\(^13\) An outbreak of SSIs was attributed to group A \(\beta\)-hemolytic Streptococcus carried on the scalp of perioperative personnel. The report identified group A \(\beta\)-hemolytic Streptococcus in 20 patients with an SSI. In the outbreak investigation, 88 perioperative personnel were cultured. One was found to have erythema and scaling on the scalp and ears and under the breast. The individual was treated with medication and relocated to a non-patient work area, and the outbreak was resolved.\(^14\)

Human hair can be a site of pathogenic bacteria such as MRSA. Routine shampooing of hair with neutral detergents does not remove MRSA or have a bactericidal effect.\(^15\)

IV.a. A clean, low-lint surgical head cover or hood that confines all hair and covers scalp skin should be worn. The head cover or hood should be designed to minimize microbial dispersal.

Hair acts as a filter when it is uncovered and collects bacteria in proportion to its length, waviness, and oiliness. Studies have shown that Staphylococcus aureus and Staphylococcus epidermidis have a tendency to colonize hair, skin, and the nasopharynx.\(^16\) Head coverings designed to contain hair and scalp skin will minimize microbial dispersal.\(^17\) Skull caps may fail to contain the side hair above and in front of the ears and hair at the nape of the neck.

IV.a.1. Used single-use head coverings should be removed and discarded in a designated receptacle daily or when contaminated.

Placing contaminated head coverings in a designated receptacle assists in maintaining a clean and orderly area and decreases the possibility of cross-contamination.

IV.a.2. Reusable head coverings should be laundered in a health care-accredited laundry facility after each daily use.\(^18\) (See Recommendation V.)

Recommendation V

Surgical attire should be laundered in a health care-accredited laundry facility.

Surgical attire; street clothing; PPE; and other hospital textiles (eg, bed linens, towels, privacy curtains, washcloths) may become contaminated by bacteria and fungi during wear or use. In one study, researchers found that microbes can survive on hospital textiles for extended periods of time. These textiles included

- 100% cotton clothing;
- 60% cotton and 40% polyester blend (eg, scrub suits, lab coats);
- 100% polyester clothing; and
- polyethylene plastic aprons.

Researchers inoculated these textiles with staphylococci under laboratory conditions. The textiles were allowed to remain in ambient air without any laundering for various periods of time. Results showed that the staphylococci survived one to 56 days on polyester and up to 90 days on polyethylene plastic. The larger the microbial inoculum of staphylococci on polyester and polyethylene, the longer the staphylococci survived. Even if only a few hundred staphylococci survived, they were viable for days on most textiles. The shortest time for enterococci survival on textiles was 11 days.\(^19\)\(^20\)

Researchers in another study tested fungal survival under laboratory conditions on

- 100% cotton clothing;
60% cotton and 40% polyester blend (eg, scrub suits, lab coats, clothes);
• 100% polyester clothing; and
• polyethylene plastic aprons.

The microorganisms used as the inoculum were Candida albicans, Candida tropicalis, Candida krusei, Candida parapsilosis, Aspergillus flavus, Aspergillus fumigatus, Aspergillus niger, Aspergillus terreus, Fusarium sp, Mucor sp, and Paecilomyces sp. These pathogens were isolated in the researchers’ health care facility. The data collected showed that candida, aspergillus, mucor, and fusarium, which are known to be health care-associated infectious agents, survived on fabrics and plastics for at least one day and often for weeks. The survival of these microorganisms on these textiles and plastics shows that they may serve as reservoirs or vectors for fungi. Another study showed that Staphylococcus aureus and Pseudomonas aeruginosa bind to polyester and acrylic fibers.

Health care-accredited laundry facilities are preferred because they follow industry standards. The Healthcare Laundry Accreditation Council (HLAC) offers voluntary accreditation for those laundry facilities that process reusable health care textiles and which incorporate OSHA and the Centers for Disease Control and Prevention (CDC) guidelines and professional association recommended practices. The HLAC standards for accreditation include, but are not limited to,

• Textile quality control procedures are defined and implemented.
• The inventory system is adequate to ensure supply.
• Soiled and contaminated textile areas are separated by a physical barrier.
• The ventilation is controlled with negative pressure in the soiled area, positive pressure from the clean textile area through the soiled textile area, 6 to 10 air exchanges per hour, and air vented to the outside.
• Clean textiles are stored in an area free of vermin, dust, and lint and at room temperatures of 68° F to 78° F (20° C to 25.6° C).
• Storage shelves are 1 inch to 2 inches from the wall, the bottom shelf is 6 inches to 8 inches from the floor, and the top shelf is 12 inches to 18 inches below the ceiling.
• Hand washing facilities are located in all areas with soiled textiles; hand washing or antiseptic dispensers are in the clean textile area; and employees perform hand washing after glove removal and restroom use, before eating, and when hands are contaminated with blood or other potentially infectious materials.

Working surfaces are clean and are disinfected if they become contaminated with blood or other potentially infectious materials.
• The OSHA Exposure Control Plan is in place and PPE is supplied and available.
• Personnel training is provided and documented.
• Quality control monitoring and processes are in place.

Material Safety Data Sheets are available for each chemical used.
• Water quality is tested on a regular basis for hardness, alkalinity, iron content, and pH.
• Soiled health care textiles are handled, collected, and transported according to local, state, and federal regulations.
• Each wash load is monitored and applicable data and the vehicle interiors are cleaned on a regular basis.

Routine monitoring of laundry processes, including cleaning of work areas, equipment, and good hand hygiene practices, is important to minimize cross-contamination of clean textiles. An accredited health care facility laundering process includes monitoring correct measurement of chemicals, sufficient water, correct temperature, mechanical action, and the duration of the washing cycle. Cleaning and disinfecting the work area includes, but is not limited to, the washers, extractors, dryers, and conveyor belts. The presence of skin bacteria on processed textiles and environmental surfaces in one study directed attention to hand hygiene of the laundry facility workers, air contamination, inadequate separation of soiled and clean work areas, and the cleaning and disinfecting of all of the equipment and work surfaces. Water can be a source of bacterial transmission, which makes thorough drying of textiles vital.

Home laundering is not monitored for quality, consistency, or safety. Exposure of health care personnel and their family members to blood and other potentially infectious materials may result from improper handling and decontamination of surgical attire. Home washers may have a lower temperature (ie, < 160° F [71.1° C]) or washing parameters and temperatures may not be adjustable. Home washers may have limited capacity for chemical additives and may not have directions for using alkalis and acids.

Home laundering may not meet the specified measures necessary to achieve a reduction in microbial levels in soiled surgical attire. These measures involve mechanical, thermal, and chemical components, including diluting and agitating the water to remove microorganisms and bioburden;
• selecting suitable chemicals, if low-temperature cycles (< 160°F [< 71.1°C]) are used;
• using proper chemical concentrations if low-temperature cycles are used;
• using water temperatures > 160°F (> 71.1°C) for more than 25 minutes for hot-water cycles;
• using chlorine bleach, which gives added microbicidal benefit; and
• adding chemicals known as “sour” to the water to neutralize alkalinity in the water, soap, or detergent.

These measures cause a shift in pH from 12 to 5, inactivating some microorganisms. Low temperatures (ie, < 160°F [< 71.1°C]) may be used so long as the drying temperatures and ironing temperatures provide the additional microbicidal benefits to ensure surgical attire is clean.

A study on bacterial contamination of home-laundered uniforms began by culturing uniforms worn at the beginning of the shift. Thirty-nine percent of the uniforms identified as “clean” had one or more microorganisms (eg, vancomycin-resistant enterococci, MRSA, Clostridium difficile) identified. Uniforms were tested again at the end of the shift and 54% had one or more microorganisms; some that were positive at the beginning of the shift were negative at the end of the shift. In one demonstration, bacillus spores were transferred from health care providers’ aprons and cotton uniforms to a mock patient.

A study of home-laundered uniforms involved taking surveillance cultures from five patients. Results showed that three of the patients were colonized with the same strain of microorganism as that cultured from the health care providers’ uniforms. With uniforms contaminated with microorganisms at the beginning of a shift, the researchers suggested that inappropriate laundering practices may be the cause.

Home laundering has been shown to be less effective for cleaning surgical attire than laundering by health care facilities or commercial laundries.

A quantitative study was performed in 20 different geographical areas. Eight laundering methods were studied:
• reusable clean scrubs laundered at the facility in which they were used;
• reusable worn scrubs laundered at the facility in which they were used;
• reusable clean scrubs that were home laundered;
• reusable worn scrubs that were home laundered;
• reusable clean scrubs laundered by an outside laundry facility;
• reusable worn scrubs laundered by an outside laundry facility;
• packaged, clean, single-use, non-woven scrubs; and
• packaged, worn, single-use, non-woven scrubs.

Results of the study showed that the bioburden on home-laundered surgical attire was significantly greater than on surgical attire that was facility-laundered; laundered by a third-party; or single-use, disposable. Home-laundered clean scrubs at the beginning of the day had the same amount of organisms as did worn scrubs at the end of the work day.

A quantitative study was performed on cotton strips of fabric that were inoculated with 10 mL of a viral suspension to discover if enteric viruses (ie, adenovirus, rotavirus, hepatitis A virus) survived a home-laundering process. The inoculated fabric strips were washed, rinsed, and dried on a 28-minute permanent press cycle in home washers. It was found that enteric viruses remained on the fabric strips after they were washed.

V.a. Laundered surgical attire should be protected during transport to the practice setting to prevent contamination.

Proper transfer and storage of surgical attire protects surgical attire from contamination by
• preventing any physical damage to laundry,
• minimizing microbial contamination from environmental surfaces, and
• preventing any deposits from airborne sources such as dust to settle on laundry.

V.a.1. Surgical attire should be transported in a clean vehicle and enclosed carts or containers.

Laundry vehicles can be a source of contamination. Cleaning and disinfection on a regular basis are required.

V.b. Clean surgical attire should be stored in a clean, enclosed cart or cabinet.

Storing clean surgical attire in a locker with personal items from outside of the hospital may contaminate the clean surgical attire. Enteric viruses have been detected in lockers where contaminated attire can act as reservoirs for viral transmission.

V.b.1. Surgical attire may be stored in a dispensing machine. Dispensing machines should be routinely emptied and cleaned according to the manufacturer’s directions.

Attire-dispensing machines may be used to increase individual accountability, promote cost containment, facilitate an adequate supply, and provide clean storage for surgical attire.

Recommendation VI

All individuals entering the restricted areas should wear a surgical mask when open sterile supplies and equipment are present.

A surgical mask protects both the surgical team and the patient from transfer of microorganisms. The surgical mask protects health care providers from droplets greater than 5 micrometers in size. Examples of diseases that produce droplets include group A streptococcus, adenovirus, and Neisseria meningitides. A single surgical mask is worn to protect the health care provider from contact with infectious material from the patient (eg, respiratory secretions, sprays of blood or body fluids) and to protect the patient from exposure to

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infectious agents carried in the provider’s mouth or nose. Surgical masks protect surgical team members’ noses and mouths from inadvertent splashes or splatters of blood and other body fluids. A study involving 8,500 surgical procedures showed that 26% of exposures to blood were to the heads and necks of scrubbed personnel, and that 17% of blood exposures were to circulating personnel outside the sterile field.\textsuperscript{76}

VI.a. The mask should cover the mouth and nose and be secured in a manner to prevent venting.

A mask that is securely tied at the back of the head and behind the neck decreases the risk of health care personnel transmitting nasopharyngeal and respiratory microorganisms to patients or the sterile field. Infectious particles can reach the wearer’s nose and mouth by passing through leaks at the mask-face seal.

VI.b. A fresh, clean surgical mask should be worn for every procedure. The mask should be replaced and discarded whenever it becomes wet or soiled.

The filtering capacity of a mask is compromised when it becomes wet. In a study to determine microbial barrier efficacy of surgical masks with 95% bacterial filtration at one-, two-, three-, and four-hour intervals showed that after four hours, the masks had decreased efficacy. Avoiding unnecessary speaking and keeping in mind the patient’s possible immunological status are important. This research study showed that all counts of CFUs were lower than $4 \times 10^2$, which could cause an SSI in patients with poor immunity, those with surgical wound complications (eg, ischemia, hematoma), or those undergoing surgery with an implant.\textsuperscript{12}

VI.b.1. Masks should not be worn hanging down from the neck.

The filter portion of a surgical mask harbors bacteria collected from the nasopharyngeal airway. The contaminated mask may cross-contaminate the surgical attire top.

VI.c. Surgical masks should be discarded after each procedure. Masks should be removed carefully by handling only the mask ties. Hand hygiene should be performed after removal of masks.\textsuperscript{12}

Removing masks by the ties prevents possible contamination of the hands. The filter portion of the mask harbors bacteria collected from the nasopharyngeal airway.

VI.d. Only one surgical mask should be worn at a time.

Masks are intended to contain and filter droplets of microorganisms expelled from the mouth and nasopharynx during talking, sneezing, and coughing.\textsuperscript{12} Use of a double mask creates an impediment to breathing and does not increase filtration; therefore, this is not recommended.\textsuperscript{22}

**Recommendation VII**

Health care personnel should receive initial and ongoing education and demonstrate competency on appropriate surgical attire.

Competency assessment verifies that health care personnel have an understanding of the articles and purpose of surgical attire. This knowledge is essential for reducing the risk of health care-associated infections.

VII.a. Health care personnel should receive education and guidance on appropriate articles of surgical attire worn in the perioperative environment at orientation and after changes are made.\textsuperscript{14,15} Health care personnel should be informed of and be compliant with the health care organization’s surgical attire policy, including laundering policies.

Ongoing education of perioperative personnel facilitates the development of knowledge, skills, and attitudes that affect patient and worker safety.

VII.a.1. Health care personnel should understand the risk of becoming colonized or infected with microorganisms from patients or the environment when surgical attire is cleaned improperly.

**Recommendation VIII**

Policies and procedures for surgical attire should be developed, reviewed periodically, and be readily available within the practice setting.

Policies and procedures serve as operational guidelines and establish authority, responsibility, and accountability within the organization. Policies and procedures also assist in the development of patient safety, quality assessment, and improvement activities.

VIII.a. Surgical attire polices and procedures should include, but not be limited to, requirements related to

- facility-approved and standardized surgical attire,
- areas where surgical attire is worn,
- infection prevention and control,
- use of PPE,
- laundering,
- transport and storage of clean attire, and
- compliance monitoring.

An understanding of surgical attire policies and procedures assists health care personnel in protecting the patient, themselves, and their family members.

VIII.b. Policies and procedures should be introduced and reviewed in the initial orientation, when new surgical attire is introduced, and during ongoing education of health care personnel.

Review of policies and procedures assists health care personnel in being knowledgeable
IX.b. Quality assurance monitoring of laundry processes should be ongoing.

A study of the risk of *Clostridium difficile* cross-contamination in the laundry process illustrates that cross-contamination occurs with the use of nonsporicidal disinfectants, but that the use of sporicidal disinfectant cloths showed significantly reduced CFUs. The researcher concluded that cleaning *Clostridium difficile*-contaminated surfaces with nonsporicidal disinfectants creates a vector for cross-contamination to other textiles via the laundering process. Cleaning contaminated surfaces with sporicidal disinfectant may not completely eliminate this vector, but does significantly reduce associated risk.  

A rare outbreak of zygomycosis in a hospital was investigated by the CDC using standard outbreak protocols. Zygomycosis is an invasive fungal infection caused by mucormycetes, which includes a Rhizopus species (ie, a group of molds that is commonly found in the environment). Infections with this microorganism are rare and usually occur in people who have underlying medical conditions. A cluster of six cases occurred from August 2008 to July 2009. Of the six cases, five patients died (ie, premature children up to age 13). All five children had risk factors for zygomycosis, which included acidosis (ie, four children) and bone marrow transplant (ie, one child). Hospital linens were the only items common to these cases. Environmental cultures taken at the hospital revealed Rhizopus species on 26 out of 65 swabs (40%) of clean linens and areas in contact with clean linens, and on 1 out of 25 samples (4%) of items not in contact with linens. Clean linen closets were cultured, including those in the OR, where two items were found to be Rhizopus-positive. Researchers determined the hospital linens to be the most likely vehicle of transmission to patients’ skin. Contamination of linens may have occurred during laundering, en route to the hospital, or during delivery to the hospital. The hospital changed commercial laundry facilities, replaced all of its linens, disinfected all linen storage closets, and used a different delivery area for its linens in an effort to prevent reoccurrence of this type of outbreak.

Glossary

**Restricted area:** Includes the OR and procedure room, the clean core, and scrub sink areas. People in this area are required to wear full surgical attire and cover all head and facial hair, including sideburns, beards, and necklines.

**Semirestricted area:** Includes the peripheral support areas of the surgical suite and has storage areas for sterile and clean supplies, work areas for storage and processing instruments, and corridors leading to the restricted areas of the surgical suite.

**Surgical attire:** Nonsterile apparel designated for the OR practice setting that includes two-piece pantsuits, cover jackets, head coverings, shoes, masks, protective eyewear, and other protective barriers.

**References**

RP: Surgical Attire


RP: Surgical Attire

textile laundering process: the importance of selecting an appropriate hard surface disinfectant. Paper presented at: International Conference on Healthcare-Associated Infections; March 19, 2010; Atlanta, GA.


Acknowledgments

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PURPOSE:

To provide guidance to perioperative personnel for hand hygiene for surgical and other invasive procedures.

Hand hygiene is a primary method of decreasing health care associated infections. Hand hygiene, hand washing, and surgical hand scrubs are the most effective way to prevent and control infections and represent the least expensive means of achieving both. The expected outcome is that the patient will be free from signs and symptoms of infection.

POLICY:

A traditional, standardized, anatomically-timed or counted stroke method may be used for surgical hand antisepsis scrubs. When performing surgical hand antisepsis using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2-6 minutes. Longer scrub times (e.g. 10 minutes) have not fully demonstrated increased microbial reduction.

Personnel will use either a United States Food and Drug Administration (FDA) compliant, antimicrobial scrub agent or an FDA-compliant, alcohol-based antiseptic hand rub agent that is cleared for surgical hand antisepsis and provides persistent and cumulative activity.

I. It is the policy of University Medical Center that:

- All perioperative personnel will follow established hand hygiene practices for maintaining healthy skin and fingernail condition and the wearing of jewelry.
- Artificial nails or other fingernail enhancement or resin bonding products may not be worn by health care personnel within the perioperative environment.
- All perioperative personnel will follow established practices for hand washing.
- Perioperative personnel will perform a surgical hand scrub before donning sterile gloves for surgical or other invasive procedures using a hand antiseptic or alcohol-based hand rub provided by the organization.
• Surgical hand hygiene products will be selected following an analysis of product effectiveness, application requirements, and user acceptance.
• All perioperative personnel will receive education, training, and competency validation on surgical hand hygiene products and procedures.

II. General Hand Hygiene
• Keep natural nails no more than one-quarter inch (0.64 cm) long.
• Remove chipped nail polish prior to entry into the restricted area of the perioperative environment.
• Remove rings prior to entry into the restricted area of the perioperative environment.
• Remove watches and bracelets prior to washing hands.
• Use only approved lotions.
• Personnel with cuts, abrasions, weeping dermatitis, or fresh tattoos on exposed skin should not provide direct patient care until the condition is healed and they have been cleared by the Employee Health Nurse/Epidemiology.

III. Hand Washing
Hand washing should be performed:
• upon arrival at the health care facility,
• before and after every patient contact,
• before putting on gloves and after removing gloves or other personal protective equipment (PPE),
• any time there is the possibility that there has been contact with blood or other potentially infectious materials or contaminated surfaces,
• before and after eating,
• before and after using the restroom,
• before leaving the health care facility, and
• when hands are visibly soiled.

Hand washing with soap and water should be performed in the following order:
• Remove jewelry from hands and forearms.
• Adjust water to a comfortable temperature.
• Wet hands thoroughly with water.
• Apply soap.
• Rub hands covering all surfaces including backs of hands, fingertips, inner webs, and palms.
• Wash for at least 15 seconds.
• Rinse well to remove all soap.
• Dry hands thoroughly with an absorbent towel.
• Use a disposable towel to turn the water off and open the door if hands-free controls are not available.
IV. Surgical Hand Scrub
A surgical hand scrub using an alcohol-based product should include, but not be limited to the following actions:

- Remove jewelry including rings, watches, and bracelets from hands and forearms.
- Don a surgical mask.
- If hands are visibly soiled, wash with soap and water.
- Clean subungual areas of nails under running water using a disposable nail cleaner.
- Rinse hands and forearms under running water.
- Dry hands and forearms thoroughly with a disposable towel.
- Dispense the manufacturer-recommended amount of surgical hand scrub product.
- Repeat applications as directed.
- Rub hands and forearms thoroughly until completely dry.

A traditional surgical hand scrub should include, but not be limited to the following actions.

- Remove jewelry including rings, watches, and bracelets from hands and forearms.
- Don a surgical mask.
- If hands are visibly soiled, wash with soap and water.
- Clean subungual areas of nails under running water using a disposable nail cleaner.
- Rinse hands and forearms under running water.
- Dispense the approved antimicrobial agent to wet hands and forearms using a soft sponge or soft bristle brush.
- A three- to five-minute scrub should be timed to allow adequate product contact with skin according to written manufacturer’s directions.
- Visualize each finger, hand, and arm as having four sides to be scrubbed.
- Beginning with one hand and keeping hand elevated, scrub all four sides of each finger, hand, and arm.
- Repeat the process for the opposite hand and arm.
- Turn water off to conserve water when not in use.
- Avoid splashing surgical attire.
- Discard sponges or brushes in an appropriate container.
- Rinse hands and arms under running water in one direction from fingertips to elbows.
- Hold hands higher than elbows and away from surgical attire.
- In the OR, dry hands and arms with a sterile towel before donning a sterile surgical gown and gloves.

V. Alcohol-based hand rubs
- Hand washing may be done with an alcohol-based hand rub when soil is not present on hands. The first scrub of the day should be a traditional, standardized surgical hand antisepsis scrub procedure with a soft brush.
- Alcohol-based, waterless, brushless surgical scrubs may be used for subsequent hand antisepsis until the need for a traditional, standardized surgical hand antisepsis scrub
Surgical Hand Antisepsis

- Alcohol-based hand rubs are not appropriate for use when hands are visibly dirty or contaminated with proteinaceous materials (e.g. blood, body fluids) because these hand rubs do not remove this type of soil or debris.
- A standardized protocol for alcohol-based surgical hand rubs should follow manufacturer’s written instructions and include, but may not be limited to, the following:
  - Use the recommended amount of hand rub product.
  - Rub hands covering all surfaces, including the backs of hands, fingertips, inner webs, and palms.
  - Rub hands until they are dry.

VI. Surgical hand hygiene products and hand lotions
- Surgical hand hygiene products and hand lotions will be approved by the infection prevention and product selection committees.
- Written user evaluations will be completed to determine acceptability prior to final selection and purchase.
- Selection criteria for hand hygiene products will include:
  - safety,
  - purpose and use,
  - ease of use,
  - skin comfort and reaction,
  - fragrance,
  - consistency,
  - color,
  - compatibility with other products,
  - patient and health care personnel outcomes,
  - efficacy,
  - regulatory control, and
  - cost.
- Antimicrobial surgical hand hygiene products should:
  - significantly reduce microorganisms on intact skin,
  - contain emollients and humectants to prevent skin irritation,
  - be broad spectrum,
  - be fast-acting, and
  - have a persistent and cumulative effect.

VII. Alternate Scrub Soap Options for Individuals with Product Sensitivities

- Epidemiology (Infection Control) and the Surgical Services Department will review the data provided by manufacturers to ensure that the surgical hand antisepsis agents chosen by the employees and physicians comply with current AORN Perioperative Standards and Recommended Practices and are FDA approved for use in the surgical setting.
- The surgical hand scrub chosen will be a broad-spectrum, fast-acting, and nonirritating preparation containing an antimicrobial ingredient designed to significantly reduce the number of microorganisms on intact skin. Surgical hand antiseptic agents must demonstrate both persistent and cumulative activity.
• Examples of FDA approved antimicrobial components include alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, parachloroxylenol, and quaternary ammonium compounds.

• The employee will provide UMC with physician documentation that supports the need for the use of an alternate scrub soap product. The employee will sign a declaration delineating his/her responsibility in using an alternate scrub soap product, which will be kept in the employee’s file. Failure by the employee to abide by the provisions of this agreement may lead to disciplinary action.

• UMC will provide the alternate scrub soap product at no cost to the employee.

• The employee will label the alternate scrub soap with his/her name. The employee is responsible to store the product safely and will not leave the product at the scrub sinks for use by other surgical personnel. The employee will remove the alternate scrub soap from the scrub sink area and store in his/her locker at the conclusion of the shift.

• Surgical hand antisepsis agents will be stored in clean, closed containers. Single-use containers are recommended and will be discarded when empty.

VIII. Competency

• All personnel will receive education, training, and competency validation on surgical hand hygiene products and procedures periodically and when new products are introduced.

• All personnel will receive education and guidance on identifying and reporting symptoms of irritant contact dermatitis and allergic contact dermatitis.

• All personnel should demonstrate proficiency in surgical hand hygiene practices and the use of surgical hand hygiene products.

• Fire safety education and training will be provided for all health care personnel working in the perioperative area where alcohol-based hand hygiene products are used.

References:


I have provided University Medical Center’s Employee Health Nurse with documentation from a physician stating that I have a skin condition requiring use of an alternate scrub soap product.

I agree to take responsibility to clearly label the alternate scrub soap product with my name and remove the product from the scrub sink and store safely in my locker when no longer in use.

I understand that this alternate scrub soap product is not to be distributed or made available for use to unauthorized employees, physicians, contractors, or vendors who have access to the Surgery Department.

________________________________________  _________________________
Employee name (printed)      Date

________________________________________  _________________________
Employee Signature         Product Name

Approved by: Employee Health Nurse
SCRUBBING, GOWNING, AND GLOVING

Section I: Introduction

1-1. GENERAL

a. Discussion. All members of the sterile team are required to perform a surgical hand scrub and don sterile gown and gloves before touching sterile equipment or the sterile field. The correct performance of these procedures helps protect a patient from infection by preventing pathogenic (disease-producing) microorganisms on the hands, arms, and scrub clothes of “sterile” team members from coming into contact with a patient's wound during an operation. Infection that may result from the introduction of pathogenic microorganisms into a wound could prove fatal to the patient.

(1) The surgical scrub is a systematic washing and scrubbing of the hands and forearms using especially developed techniques and the most effective antibacterial cleaning agent available for such use. This procedure is done to render the hands and arms as free as possible from microorganisms. The skin cannot be sterilized without destruction of tissue, but as many bacteria as possible can be removed by a thorough hand and arm scrub, making the skin surgically clean.

(2) Gown and glove procedures, which are performed following the surgical scrub, involve the donning of sterile surgical gowns and gloves in such a way as to maintain the sterility of the outside of both gown and gloves.

b. Purpose of the Procedures. Scrub, gown, and glove procedures are performed to eliminate some of the controllable sources of contamination in the performance of aseptic procedures. The operating room specialist assigned to scrub for an operation should adhere absolutely to the exacting techniques. The specialist must scrub his hands and arms for a prescribed length of time or for a prescribed number of brush-strokes. Such techniques will keep the patient as free from microorganisms as possible. The scrub dons sterile gown and gloves to provide a sterile covering for his clothing and hands.

c. Handwashing By the Circulating Specialist (Circulator). Although the circulator is not required to perform a surgical scrub, he should wash his hands thoroughly between tasks for his own protection and for that of the patient. Handwashing is an important factor in preventing the spread of disease. Nowhere is this procedure more important than in the operating room where the body defenses of the patient are weakened both by the disorder that makes his surgery necessary and by the surgery itself.

d. Microorganisms Normally Present. The microorganisms normally present on the skin can be classified as transient and resident.

(1) Transient organisms are those microorganisms that are introduced onto the skin surface by contact with the soil and various other substances. Mechanical scrubbing and surgical soaps will remove most of the bacteria.

(2) Resident organisms are those microorganisms whose natural habitat is the skin. They are comprised mostly of gram-positive and gram-negative bacteria. They exist in large numbers under the fingernails and in the deeper layers of the skin (such as the hair follicles, the sweat glands, the sebaceous glands). Scrubbing removes the resident bacteria from the surface and just beneath the surface of the skin. After a time, the resident organisms in the deeper layers of the skin are brought to the surface by perspiration.
and the oil secretion of the sebaceous glands and the bacterial count is again increased. For this reason, sterile gloves are worn to prevent contamination of the patient's wound and the sterile goods used in it by organisms from this source.

e. Local Policy. The local policy (Standing Operating Procedure (SOP)) is the final authority on the method employed for scrubbing the hands and arms and for the type of surgical detergents to be used; policies vary among hospitals.

Section II: Preparation for Scrubbing

1-3. INTRODUCTION

a. Personal cleanliness is of extreme importance for operating room personnel. A daily shower, frequent shampoos, and attention to hands and fingernails are most important. Because of the close contact with other members of the "sterile" team, personnel should also use a body deodorant. They should note and report to the operating room supervisor any infection, rash, or open lesion about the hands, nails, and arms. They should also report any signs of a cold or other systemic infection.

b. The specialist must make specific preparation before he begins to scrub. Such preparation, which is necessary to further eliminate factors of contamination, is discussed in paragraphs 1-4 through 1-9.

c. For the specialist to perform the scrub most effectively, certain features and equipment should be available in the scrub rooms within the surgical suite (see paragraph 1-10).

1-4. FINGERNAILS

The specialist should keep his fingernails short enough so that they are not visible over the tips of the fingers. Short nails are easy to clean and, if kept smooth, will not puncture gloves. Nails should be free of polish.

1-5. JEWELRY

The specialist is to remove all jewelry from his hands and arms. He may pin these items in a pocket of his scrub suit. Bacteria and dead skin cells accumulate beneath watches, bracelets, and rings.

1-6. SCRUB SUIT

a. The specialist is to don a clean, short-sleeved cotton scrub suit each day before entering the semi-restricted/restricted areas of the surgical suite. Street clothes or hospital uniforms are never worn in these areas. The scrub suit should cover all other clothing such as undergarments. The scrub shirt must be tucked into the trousers to avoid contamination by the shirt tail flapping on a sterile field. The trouser legs should not touch the floor as this may transport bacteria from one place to another.

b. The specialist assigned to scrub should adjust the sleeves of his scrub suit to at least four inches above his elbows.

1-7. SHOES

a. Ideally, the specialist should keep a pair of shoes for wear in the surgical suite only and he should keep these shoes clean. Shoe soles are a source of gross contamination and of cross infection from one area of the hospital to another.
b. Street shoes (military low-quarters and/or nursing white shoes) are never worn in the restricted areas of the surgical suite unless shoe covers are placed over them. Shoe covers should be worn on a single-use basis. They must be removed on leaving the restricted area and a fresh pair put on before reentrance to that area.

c. Local policy governs the wearing of the scrub suit shoes and shoe covers.

1-8. SURGICAL CAP

The specialist is to wear a clean head cover each day; most hospitals use disposable hoods and caps. He should wear it in a manner to cover the hair completely (see Figure 1-1). The wearing of the cap prevents the possible contamination of the sterile field by falling hair or dandruff.

1-9. SURGICAL MASK

a. The surgical mask is worn primarily to protect the patient from bacteria exhaled from the oro- and nasopharynx of operating room personnel. Two types of disposable masks that are standard items are, one with paired head and neck ties (see Figure 1-1) and a cup type with an elastic headband (see Figure 1-2). Both are made of a nonwoven fabric with adjustable metal nosepieces along the top of the mask. The metal stay is used to hold the mask snugly to the face, thus preventing fogging of the specialist’s glasses if worn. The mask must fit snugly around the nose and mouth to filter air through it rather than permit the passage of air around the sides. The specialist is to don a fresh mask immediately before beginning the scrub procedure. The mask is not considered sterile.

b. After the mask has become damp, droplets from the nose and mouth can easily pass through it—the mask no longer serves as a barrier to germs. Therefore, the mask should be changed after each procedure and more often if it has become damp.

c. The specialist should never allow the mask to dangle around his neck. He should never place the mask in his pocket or on a clean surface and he should not handle it except by the ties and/or elastic headband after it is removed. Careful handling of a soiled mask prevents the spread of microorganisms throughout the surgical suite.

d. When removing the mask, the specialist should handle it by the ties and/or elastic headband and should immediately place it in the designated receptacle. As soon as he removes a soiled mask, the specialist should wash his hands.

Figure 1-1 Surgical Cap and Mask

Figure 1-2 Surgical Mask
1-10. SCRUB ROOMS

Figure 1-3 Surgical Scrub Sinks

a. A scrub area should be situated between each two operating rooms and should open directly into an operating room. The sinks should be deep enough, at least one foot, so that water will not be splashed onto the scrub clothes, the floor, or the hands and arms during the procedure (see Figure 1-3). The sinks should be provided with hot and cold water faucets which should be controlled by knee levers or by foot levers. If arm or hand levers must be used, these controls must be adjusted for water temperature flow before starting to scrub. If the specialist's hands or arms accidentally touch the faucets or the sink during any phase after the scrub has begun, he has become contaminated and must begin the scrubbing cycle again. Running water is preferred because it completely and easily rinses away suds containing bacteria.

b. Containers for surgical detergents are placed between each two sinks. Foot-operated pedals attached to the containers provide a convenient method of dispensing detergents without contaminating the hands. Scrub brushes (depending on the type used) may be placed in dispensers, one between each two sinks. A clock should be provided for timing the scrub procedure when required.

Section III: Cleansing Agents in Use

1-11. INTRODUCTION

A number of surgical soaps are available for use in Army hospitals. Scrub brushes are also used. A surgical scrub brush/sponge with a nail cleaner are prepackaged, presterilized, and may be impregnated with a surgical soap. The brush is disposable and for one time use only.

1-12. SURGICAL SOAPS

a. Standard Agents. The surgical soaps available as a standard item are Povidone-iodine and Hibiclens®. These soaps are used in a concentrated liquid form in soap dispensers or in brushes impregnated with these detergents.

b. Desirable Properties. These agents are preferable for doing the surgical scrub because:

(1) They are nonirritating to most people.

(2) They leave a minimum number of microorganisms on the skin.
(3) They have a prolonged anti-bacterial effect on the skin when used regularly. Surgical detergents leave a film on the skin which keeps the resident bacteria to a minimum and yet they do not interfere with the skin's natural resistance to transient bacteria (refer to paragraphs 1-1d(1) and (2)).

(4) They will lather in either hot, cold, or hard water.

(5) The amount of detergent needed for a scrub is small (about 8 ml). Adding more water produces more lather.

1-13. ALTERNATIVES IN THE FIELD

a. Povidone-iodine and Hibiclens are two types of surgical soaps that are available as standard items. These soaps are in liquid form.

b. When surgical soaps are not available, the surgical scrub should be performed according to local standard policy.

Section IV: The Surgical Scrub

1-14. INTRODUCTION

a. Requirements for Performance of a Complete Scrub. The specialist is to perform a scrub in the following instances:

   (1) Before the first case in the morning.

   (2) Between cases.

b. Methods. As local policy prescribes, the specialist will scrub by one of the following methods:

   (1) Time method. Using a clock or some other timing device to measure brushing time, the length of the scrub varies from one institution to another. This method has been most frequently used in the past.

   (2) Brush-stroke method. A prescribed number of brush-strokes, applied lengthwise of the brush or sponge, is used for each surface of the fingers, hands, and arms.

1-15. PRINCIPLES

The specialist should follow certain principles when performing the surgical scrub (see Table 1-1).

<table>
<thead>
<tr>
<th>Rinsing time:</th>
<th>Is not to be included in the total scrub time if the timed method is to be used.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsterile objects:</td>
<td>Should not be touched once the scrub procedure has begun.</td>
</tr>
</tbody>
</table>
Entire scrub procedure: Must be repeated if an unsterile object is touched.

Same scrub procedure: Should be utilized for every scrub, whether it is the first or last one of the day.

Local policy: May specify the time lengths and brush strokes for scrub procedures between cases.

1-16. PROCEDURE

a. Both surgical scrub methods follow an anatomical pattern of scrub. One should think of the fingers, hands, and arms as having four sides or surfaces. If properly executed, both methods are effective and each exposes all surfaces of the hands and forearms to mechanical cleaning and chemical antisepsis.

b. In the following paragraphs, the brush-stroke method is described, using a disposable, prepackaged, pre-sterilized sponge/brush, impregnated with a surgical detergent.

(1) Regulate the flow and temperature of the water.

(2) Pretear package containing brush (see Figure 1-4); lay the brush on the back of the scrub sink.

Figure 1-4

(3) Wet hands and arms (see Figure 1-5) for an initial prescrub wash. Use several drops of surgical detergent, work up a heavy lather, then wash the hands and arms to a point about two inches above the elbow.

Figure 1-5
(4) Rinse hands and arms thoroughly, allowing the water to run from the hands to the elbows (see Figure 1-6). Do not retrace or shake the hands and arms; let the water drip from them.

(5) Remove the sterile brush and file, moisten brush and work up a lather. Soap fingertips and clean the spaces under the fingernails of both hands under running water (see Figure 1-7); discard file.

(6) Lather fingertips with sponge-side of brush; then, using bristle side of brush, scrub the spaces under the fingernails of the right or left hand 30 circular strokes (see Figure 1-8). When scrubbing, slightly bend forward, hold hands and arms above the elbow, and keep arms away from the body.

(7) Lather digits (see Figure 1-9); scrub 20 circular strokes on all four sides of each finger.
You may begin with the thumb or little finger (see Figure 1-10) or the right or left hand. Scrub one hand and arm completely before moving on to the other hand and arm.

(8) Lather palm, back of hand, heel of hand, and space between thumb and index finger. Choosing either of the surfaces, scrub 20 circular strokes on each surface.

(9) You are now ready to scrub the forearm. Divide your arm in three inch increments. The brush should be approximately three inches lengthwise. Use the sponge-side of the brush lengthwise to apply soap around wrist. Scrub 20 circular strokes on all four sides; move up the forearm—lather, then scrub, ending two inches above the elbow.

(10) Soap and/or water may be added to the brush at any time

(11) Repeat steps (6) through (9) above for the other arm.

(12) Discard brush.

(13) Rinse hands and arms without retracing and/or contaminating.

(14) Allow the water to drip from your elbows before entering the operating room.

(15) Slightly bend forward, pick up the hand towel from the top of the gown pack and step back from the table (see Figure 1-11). Grasp the towel and open it so that it is folded to double thickness lengthwise. Do not allow the towel to touch any unsterile object or unsterile parts of your body. Hold your hands and arms above your elbow, and keep your arms away from your body.
(16) Holding one end of the towel with one of your hands, dry your other hand and arm with a blotting, rotating motion (see Figure 1-12). Work from your fingertips to the elbow; DO NOT retrace any area. Dry all sides of the fingers, the forearm, and the arms thoroughly (see Figures 1-13 and 1-14). If moisture is left on your fingers and hands, donning the surgical gloves will be difficult. Moisture left on the arms may seep through surgical cloth gowns, thus contaminating them. (17) Grasp the other end of the towel and dry your other hand and arm in the same manner as above. Discard the towel into a linen receptacle (the circulator may take it from the distal end).

Section V: Surgical Gown Technique

1-17. PRINCIPLES

The specialist is to abide by the following principles whenever he dons a sterile gown:

a. If the specialist touches the outside of his gown while donning it, the gown is contaminated. If this occurs, discard the gown. The specialist is to touch only the inside of the gown while putting it on.

NOTE: Surgical gowns are folded with the inside facing the specialist. This method of folding facilitates picking up and donning the gown without touching the outside surface.

b. The specialist's scrubbed hands and arms are contaminated if he allows them to fall below waist level or to touch his body. The specialist, therefore, keeps his hands and arms above his waist and away from his body and at an angle of about 20 to 30 degrees above the elbows.

c. After donning the surgical gown, the only parts of the gown that are considered sterile are the sleeves (except for the axillary area) and the front from waist level to a few inches below the neck opening. If the
gown is touched or brushed by an unsterile object, the gown is then considered contaminated. The contaminated gown is removed using the proper technique. You must then don a new sterile gown.

1-18. PROCEDURE--CLOSED CUFF METHOD

<table>
<thead>
<tr>
<th>a. With one hand, pick up the entire folded gown from the wrapper by grasping the gown through all layers, being careful to touch only the inside top layer, which is exposed (see Figure 1-15). Step back from the table to allow other team members room to maneuver.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Figure 1-15" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. Hold the gown in the manner shown in Figure 1-16, near the gown's neck, and allow it to unfold, being careful that it does not touch either your body or other unsterile objects.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Figure 1-16" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c. Grasp the inside shoulder seams and open the gown with the armholes facing you.</th>
</tr>
</thead>
</table>

Figure 1-15

Figure 1-16
d. Slide your arms part way into the sleeves of the gown, keeping your hands at shoulder level away from the body (see Figure 1-17).

![Figure 1-17](image)

e. With the assistance of your circulator, slide your arms further into the gown sleeves; when your fingertips are even with the proximal edge of the cuff, grasp the inside seam at the juncture of gown sleeve and cuff using your thumb and index finger. Be careful that no part of your hand protrudes from the sleeve cuff (see Figure 1-18).

![Figure 1-18](image)

f. The circulator must continue to assist at this point. He positions the gown over your shoulders (see Figure 1-19) by grasping the inside surface of the gown at the shoulder seams.

1. The Circulator adjusts the gown over the Scrub's shoulders.

2. Note that the Circulator's hands are in contact with only the inside surface of the gown.

![Figure 1-19.1](image)
NOTE: For the reusable cloth gown (which is rarely used), use the procedures given in steps a through f. The circulator then prepares to tie the gown. The neck and back ties are tied in an up-and-down motion. He then ties the belt by grasping the gown at the back as the scrub leans forward. The circulator leans down and grasps the distal end of one belt tie; this enables the circulator to handle the belt without touching any part of the gown that should remain sterile. The circulator then brings the belt tie to the back of the gown. The scrub then swings toward the opposite side so that the circulator can grasp the other belt in the same manner. The circulator will then tie the belt in an up-and-down motion; this reduces the area of contamination on the gown. The circulator will then tuck the ends of the belt inside the gown at the back. Then the scrub; proceeds to the gloving procedure.

g. The circulator then prepares to secure the gown. The neck and back may be secured with a Velcro® tab or ties (see Figure 1-20). The circulator then ties the gown at waist level at the back. This technique prevents the contaminated surfaces at the back of the gown from coming into contact with the front of the gown.

1-19. PROCEDURE--OPEN CUFF METHOD

The procedure is the same as that for the closed cuff method with the exception of the steps described in paragraph 1-18e and in Figures 1-18 and 1-19.

a. Do not grasp the inside seam of the sleeve as described in paragraph 118e and shown in Figure 1-19. Allow your hands to protrude from the cuffs of the gown.

b. The circulator reaches inside the gown sleeves at the shoulder seams and pulls the gown over your shoulders and the cuffs over your hands instead of performing this step of the procedure as described in paragraph 1-18f and Figure 1-19. Both you and the circulator must be careful that the gown cuffs are not pulled too high on the wrists. The edge of the cuff should be at the distal end of the wrist.

NOTE: The scrub will proceed to the Glove Technique before completing final tie of gown.
Section VI: Surgical Glove Technique

1-20. INTRODUCTION

a. Gloves are packaged so that the scrub may don his gloves without contaminating the glove's outer surfaces. A pair of gloves are packaged in an individual sterile wrapper.

b. While the specialist is wearing his sterile gown and gloves, he must take particular care to avoid contaminating these sterile garments because such contamination could possibly result in the transfer of pathogenic microorganisms to the patient's wound. The specialist should therefore observe certain rules, to include the rules outlined Table 1-2.

<table>
<thead>
<tr>
<th>Table 1-2. Rules to observe while wearing sterile gown and gloves.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEVER drop his hands below the level of the sterile area at which he is working.</td>
</tr>
<tr>
<td>NEVER touch his surgical gown above the level of the axilla or below the level of the sterile area where he is working.</td>
</tr>
<tr>
<td>NEVER put his hands behind his back; he must keep them within his full view at all times.</td>
</tr>
<tr>
<td>NEVER tuck his gloved hands under his armpits, as the axillary region of his gown is contaminated.</td>
</tr>
<tr>
<td>NEVER reach across an unsterile area for an item.</td>
</tr>
<tr>
<td>NEVER touch an unsterile object with gloved hands unless ordered to do so by the surgeon.</td>
</tr>
</tbody>
</table>

**NOTE:** The surgeon will not give such an order as to allow someone to touch an unsterile object with gloved hands unless a dire emergency exists (such as cardiac arrest) when the time element is of paramount importance in saving the patient's life.

**NOTE:** If the scrub contaminates his gown and gloves in any of the ways just mentioned in Table 1-2, he needs to discard and replace his gown and gloves.

1-21. CLOSED CUFF METHOD

a. Discussion. The closed cuff method of gloving is preferable to the open cuff method when the specialist must glove himself. The closed cuff method eliminates potential hazards in the glove procedure as follows:

1. The danger of contamination of gloves caused by the glove cuffs rolling on skin is eliminated because the skin surface is not exposed.

2. The gown cuffs can be anchored securely by the gloves without the danger of contamination that exists when gloves are donned by the open cuff method.
b. Procedure.

1. Take a tuck in each gown cuff if the cuffs are loose. Make the tuck by manipulating the fingers inside the gown sleeve; do not expose the bare hands while tucking the gown cuffs.

2. The circulator opens the outer wrapper of the glove package and flips them onto the sterile field.

3. Open the inner package containing the gloves and pick up one glove by the folded cuff edge with the sleeve-covered hand (see Figure 1-21).

4. Place the glove on the opposite gown sleeve, palm down, with the glove fingers pointing toward your shoulder (see Figure 1-22). The palm of your hand inside the gown sleeve must be facing upward toward the palm of the glove.

5. Place the glove's rolled cuff edge at the seam that connects the sleeve to the gown cuff (see Figure 1-23). Grasp the bottom rolled cuff edge of the glove with your thumb and index finger.
(6) While holding the glove’s cuff edge with one hand, grasp the uppermost edge of the glove’s cuff with the opposite hand (see Figure 1-24). Take care not to expose the bare fingers while doing this.

(7) Continuing to grasp the glove (see Figure 1-24); stretch the cuff of the glove over the hand (see Figure 1-25).

(8) Using the opposite sleeve-covered hand, grasp both the glove cuff and sleeve cuff seam and pull the glove onto the hand (see Figure 1-26). Pull any excessive amount of gown sleeve from underneath the cuff of the glove.

(9) Using the hand that is now gloved, put on the second glove in the same manner. When gloving is completed, no part of the skin has touched the outside surface of the gloves. Check to make sure that each gown cuff is secured and covered completely by the cuff of the glove (see Figure 1-27). Adjust the fingers of the glove as necessary so that they fit snugly.

**NOTE:** The scrub should don the first glove in accordance with the hand he uses most of the time, i.e., a right-handed specialist can perform the closed cuff gloving procedure more quickly and efficiently by putting on the left glove first. A left-handed specialist will facilitate the procedure for himself by putting on the right glove first.
## Section VII: Final Tie of Gown

### I-22. INTRODUCTION

Now that the gloves are on, the team member is ready to complete gown tie with assistance of the circulator. The powder from the gloves is washed off before the gown's waist tie is tied and final adjustment is made in accordance with local SOP.

### 1-23. PROCEDURE

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Illustration</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The scrub will take hold of the paper tab that holds the belt and belt tie located at waist level (see Figure 1-28) and pull the tab away from the belt tie.</td>
<td><img src="image" alt="Figure 1-21" /></td>
</tr>
<tr>
<td>b. The scrub will pass the paper tab that holds the belt to the circulator (see Figure 1-29).</td>
<td><img src="image" alt="Figure 1-29" /></td>
</tr>
<tr>
<td>c. The circulator will take hold of the paper tab, being very careful not to touch the belt, and will move to the side or behind the scrub (see Figure 1-30).</td>
<td><img src="image" alt="Figure 1-30" /></td>
</tr>
<tr>
<td>d. When the circulator is properly positioned (to the side or behind the scrub), the scrub will then take hold of the belt only being careful not to touch the paper tab and pull on the belt leaving the circulator with only the paper tab in his hand (see Figure 1-31).</td>
<td><img src="image" alt="Figure 1-31" /></td>
</tr>
</tbody>
</table>

**NOTE:** The circulator must hold on tight to the paper tab so that when the scrub pulls on the belt the tab doesn't come with the
belt and contaminates the scrub.

e. Now the scrub will take hold of the belt tie that is at waist level and tie the belt to it (see Figures 1-32 and 1-33).

1-24. ADJUSTMENT OF GOWN

Now that the gloves are on and final tie of the gown is done, the circulator completes his adjustment of the gown by stooping down, grasping the outside of the side seams at the bottom of the gown, and gently pulling down (see Figure 1-34) in accordance with local SOP.
Section VIII: Gowning and Gloving Another Team Member

1-25. INTRODUCTION

After having donned his own sterile gown and gloves, the scrub will assist other members of the sterile team into their gowns and gloves. Other members of the "sterile" team include the surgeon and his medical officer assistants, as well as other operating room specialists assigned to scrub.

1-26. PROCEDURE

a. Unfold a towel so that it is folded in half lengthwise and hand it to the scrubbed team member. While he is drying his hands, unfold his gown.

| Grasp the gown near the neckband using the thumb and index finger of each hand and roll the gown so that the outside surface is over (protecting) your gloved hands (see Figure 1-35). The arm holes of the gown are facing the team member being gowned. Offer the inside of the gown to the scrubbed team member and allow him to slip his arms into the gown sleeves (see Figure 1-35). |
|---|---|
| b. The scrub pulls the gown over the team member's shoulders (see Figure 1-36). The circulator then secures the neck of the gown and ties the inside waist tie. |
| c. Grasp the right glove firmly at waist level. Keeping your thumbs extended and covered by the glove cuff, stretch the cuff so that he can introduce his hand without touching your gloves (see Figure 1-37). |

1 Assisting the team member in donning the first glove. Note that the scrub has spread the cuff wide to permit the team member to introduce his hand without touching the scrub's gloves.
2 Note also that the scrub protects his gloved fingers by holding them beneath the cuff of the glove, and his thumbs by holding them away from the partly-gloved hand.

While you are stretching the glove open, stand with one foot forward and one foot to the rear (see Figure 1-38). This stance will help you from being thrown off balance. (DO NOT snap the glove; bring it upward gently over the cuff of the gown.)

**NOTE:** Always offer the right glove first. Be careful that you **do not get thrown off balance** while the other team member introduces his hand into the glove (see Figure 1-38).

d. Repeat the technique described in paragraph c above for the left hand. The team member can assist with donning this glove (see Figure 1-39). Give the team member a moistened saline sponge so that he can remove excess powder from his gloves if the gloves are powdered.

**NOTE:** The scrub should remove the powder from his gloves again.
Section IX: Removing the Gown and Gloves Between Cases

1-27. INTRODUCTION

a. After a surgical case, the outer part of the gown and gloves are considered contaminated by bacteria from the procedure. The scrub must remove them being very careful to avoid contamination of his forearms, clothing, and hands.

b. Remove the gloves after removing the gown.

c. Follow local policy for removing the gown and gloves when they become contaminated during a surgical procedure.

1-28. PROCEDURE

a. After the circulator unties the neck and back ties, the team members perform the following procedure by themselves. Grasp the gown at the shoulders and pull the gown forward and down over the arms and gloved hands.
b. Holding the arms away from the body (see Figure 1-41), fold the gown so that the outside of the gown is folded in (see Figure 1-42); discard it into the linen hamper.

![Figure 1-42](image1)

c. Grasp the outer surface of one glove with the other gloved hand "rubber to rubber" (see Figure 1-43) and pull off the glove. Discard the glove into the designated receptacle.

![Figure 1-43](image2)

d. Place the fingers inside the cuff of the glove "skin to skin" (see Figure 1-44); discard the glove.

![Figure 1-44](image3)

e. After exiting the "sterile area," remove the mask and discard it into the proper receptacle.

REFERENCE

Recommended Practices for Sterile Technique

The following Recommended Practices for Sterile Technique have been approved by the AORN Recommended Practices Advisory Board. They were presented as proposed recommendations for comments by members and others. They are effective December 15, 2012. These recommended practices are intended as achievable recommendations representing what is believed to be an optimal level of practice. Policies and procedures will reflect variations in practice settings and/or clinical situations that determine the degree to which the recommended practices can be implemented. AORN recognizes the various settings in which perioperative nurses practice, and as such, these recommended practices are intended as guidelines adaptable to various practice settings. These practice settings include traditional operating rooms (ORs), ambulatory surgery centers, physicians’ offices, cardiac catheterization laboratories, endoscopy suites, radiology departments, and all other areas where surgery and other invasive procedures may be performed.

Purpose
These recommended practices provide guidance for establishing and maintaining a sterile field by following the principles and implementing the processes of sterile technique. Sterile technique involves the use of specific actions and activities to prevent contamination and maintain sterility of identified areas during operative and other invasive procedures. Implementing sterile technique when preparing, performing, or assisting with surgical and other invasive procedures is the cornerstone of maintaining sterility and preventing microbial contamination.

The creation and maintenance of a sterile field can directly influence patient outcomes. All individuals who are involved in operative or other invasive procedures have a responsibility to provide a safe environment for patients. Perioperative team members must be vigilant in safeguarding the sterility of the field and ensuring that the principles and processes of sterile technique are followed and implemented. Perioperative leaders can promote a culture of safety by creating an environment where perioperative personnel are encouraged to identify, question, or stop practices believed to be unsafe without fear of repercussion.

The perioperative registered nurse (RN) uses ethical principles to make clinical decisions and act on them. Adhering to the principles of and implementing the processes for sterile technique is a matter of individual conscience and an ethical obligation that applies to all members of the perioperative team. Perioperative team members should understand the professional responsibility to ensure that contamination of the sterile field is remedied immediately, and to make certain that any item for which sterility is in question is not used. Adhering to the principles of and implementing the processes for sterile technique and taking immediate action to protect the patient when breaks in sterile technique occur meets the maxim, “first, do no harm.” The perioperative team serves as the protective intermediary between patients and personnel whose practices do not meet the highest standards of sterile technique. Perioperative nurses have a long-standing reputation of advocating for patients and working together with members of the health care team to provide a safe perioperative environment for patients undergoing operative or other invasive procedures.

Although these recommendations include several references to surgical attire (including surgical masks) and hand hygiene, the focus of this document is on sterile technique. Surgical attire and hand hygiene are outside the scope of these recommendations. The reader should refer to the AORN “Recommended practices for surgical attire”2 and “Recommended practices for hand hygiene in the perioperative setting”4 for additional guidance.

Evidence Review
A medical librarian conducted a systematic review of MEDLINE®, CINAHL®, Scopus®, and the Cochrane Database of Systematic Reviews for meta-analyses, randomized and nonrandomized trials and studies, systematic and nonsystematic reviews, and opinion documents and letters. Search terms included sterile field, sterile technique, aseptic technique, aseptic practices, surgical drapes, double-gloving, assisted gloving, closed gloving, time-related sterilization, event-related sterilization, surgical attire, protective clothing, sterile supplies, sterile barriers, barrier precautions, body-exhaust suits, space suits, laminar air flow, bowel technique, (glove expansion and fluids), (glove perforation and electrosurgery), strikethrough, Spaulding’s criteria, product packaging, and equipment contamination.

The lead author and medical librarian identified and obtained relevant guidelines from government agencies, other professional organizations, and standards-setting bodies. The lead author assessed additional professional literature, including some that initially appeared in other articles provided to the author.

The initial search was confined to 2006 to 2011, but the time restriction was not considered in subsequent searches. The librarian also established continuing alerts on the topics included in this recommended practice and provided relevant results to the lead author.

Articles identified by the search were provided to the project team for evaluation. The team consisted of
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Surgical attire helps contain bacterial shedding and promotes environmental cleanliness. Head coverings and hoods minimize microbial dispersal by containing hair and scalp skin.

Perioperative personnel should perform hand hygiene before entering the OR or invasive procedure room and areas where sterile supplies have been opened. [1: Strong Evidence]

Following regular hand hygiene practices helps prevent transmission of infection and reduces health care-associated infections for patients and health care personnel.

Prevention of health care-associated infections is a priority of all health care providers. Health care-associated infections can result in untoward outcomes such as increased morbidity and mortality, longer length of stay, increased pain and suffering, and escalating cost of care. Hand hygiene, hand washing, and surgical hand scrubs are the most effective way to prevent and control infections and represent the least expensive means of achieving both.

Perioperative personnel should wear a clean surgical mask that covers the mouth and nose and is secured in a manner to prevent venting when open sterile supplies are present and when preparing, performing, or assisting with surgery and other invasive procedures, including:

- central venous catheter (CVC) insertion, peripherally inserted central catheters (PICCs), and guidewire exchange;
- regional anesthesia procedures; or
- high-risk spinal canal procedures (eg, myelogram, lumbar puncture, spinal anesthesia).

[1: Strong Evidence]

A clean surgical mask helps protect the patient and procedure site from microbial contamination by organisms carried in the provider’s mouth or nose.

Researchers studied the effectiveness of surgical masks in reducing the dispersal of bacterial contamination from the upper airways of 25 volunteers. The volunteers were asked to speak directly at an agar plate for five minutes. A surgical mask was applied and the volunteers were instructed to speak at the agar plate for three additional periods of five minutes each. The results showed a marked reduction in the bacterial contamination of the agar plates while the volunteers were wearing surgical masks.

In a study investigating the possibility that surgical masks increase vertical shedding of bacteria from the face during facial movement, volunteers were asked to speak for 20 minutes while moving their heads from side to side without a surgical mask for the first five minutes and then with a surgical mask for three additional five-minute periods. A blood agar plate was positioned 30 cm below the volunteers’
faces. The results showed a statistically significant reduction in the number of colony forming units on the agar plate when the volunteers were wearing surgical masks. The researchers recommended wearing a surgical mask, particularly when the perioperative team member’s face is in close proximity to the procedural site and when the need for speaking during the procedure is anticipated.22

In a prospective, randomized, controlled trial of 221 patients, researchers assessed the need for surgical masks during cataract surgery. Patients were randomly assigned to group A, in which the surgeon wore a clean surgical mask, or group B, in which the surgeon did not wear a surgical mask. A settle plate was secured adjacent to the patient’s head on the operative side within the sterile field during all procedures. The results showed a significant reduction of bacterial organisms falling on the operative side when the surgeon wore a surgical mask.23

In a study exploring the relationship between the use and position of a surgical mask during 30 cardiac catheterization procedures, researchers obtained bacterial samples within the draped, operative site adjacent to the femoral artery. Surgical masks were either not worn by perioperative team members, or worn in positions above and below the nose. The number of bacterial colonies recovered when no mask was worn was significantly greater than when a surgical mask was worn. Mask placement below the nose also was associated with a higher colony count than when the mask was worn above the nose. The researchers voluntarily discontinued the study after 30 patients in the interest of patient safety because of the high bacterial count associated with not wearing surgical masks.24

Surgical masks are effective in limiting the dispersal of oropharyngeal droplets25,26 and are recommended by the Centers for Disease Control and Prevention (CDC) for the placement of CVCs, PICCs, and guidewire exchange.27,28

The American Society of Regional Anesthesia and Pain Medicine recommends the use of surgical masks during regional anesthesia as a method to reduce the likelihood of site contamination from microorganisms that may be present in the upper airway of providers.29

Oropharyngeal flora was found to be the source of contamination in a number of reported cases of bacterial meningitis at lumbar puncture, spinal and epidural anesthesia, and intrathecal chemotherapy.30

In 2004, the CDC investigated eight instances of meningitis after procedures that involved placing a catheter or injecting material into the spinal canal or epidural space. The cases involved blood or cerebrospinal fluid contaminated with streptococcal species or other pathogens consistent with oropharyngeal fluid. None of the clinicians wore surgical masks during the procedures. Equipment and products used during these procedures were excluded as sources of contamination.31

In June 2007, the Healthcare Infection Control Practices Advisory Committee reviewed the cases and determined there was sufficient evidence to warrant the wearing of a surgical mask by the individual placing a catheter or injecting material into the spinal or epidural space.32

In September 2008, three cases of bacterial meningitis in postpartum women were reported to the New York State Department of Health. Two additional cases of meningitis were reported to the Ohio Department of Health in May 2009. All of the patients had received intrapartum spinal anesthesia. The investigators concluded that the New York incidents were associated with a single anesthesiologist. The anesthesiologist reported wearing a surgical mask; however, personnel reported that the presence of unmasked visitors in the procedure area was common. The Ohio incidents were found to be associated with a second anesthesiologist who did not wear a surgical mask. The findings underscore the need for adhering to aseptic practices and wearing surgical masks during spinal procedures.33

**Recommendation II**

**Surgical gowns, gloves, and drape products for use in the perioperative setting should be evaluated and selected for safety, efficacy, and cost before purchase or use.**

The safety and efficacy of surgical gowns, gloves, and drape products depends on the design of the item and the materials from which they are made.34

Quality, patient and worker safety, and cost containment are primary concerns for perioperative RNs when they participate in evaluating and selecting medical devices and products for use in practice settings.35

II.a. Surgical gowns, gloves, and drape products should be evaluated and selected for use in the perioperative setting according to:

- [2: Moderate Evidence] product-specific requirements;
- procedure-related requirements;
- end-user requirements and preferences; patient-related requirements;
- environmental considerations; compliance with federal, state, and local regulatory agencies; and compliance with standards-setting bodies.

Product-specific requirements include contractual agreements, compatibility with existing products, and implementation of new products of differing material or construction.36,37

Procedure-related requirements define what is necessary for the procedure where the surgical gowns, gloves, and drape products will be
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Surgical gowns and drape products are surgical devices, and as such are regulated by the US Food and Drug Administration (FDA). Failure of these devices is subject to medical device reporting requirements according to the Safe Medical Devices Act of 1990 as amended in March 2000 and MedWatch: The FDA Safety Information and Adverse Event Reporting Program.

The American National Standards Institute and Association for the Advancement of Medical Instrumentation standard PB70:2012, “Liquid barrier performance and classification of protective apparel and drapes intended for use in health care facilities,” establishes a common system of classification and specifies labeling requirements for manufacturers of protective apparel and drapes used in health care facilities. The classification system is based on standardized test methods for determining liquid barrier performance and compliance. The implementation of consistent classification and labeling requirements by the manufacturer aids in evaluation and selection of the most appropriate protective products for the health care organization.

II.a.1. Surgical gowns, gloves, and drape products used during operative and other invasive procedures must provide a barrier and should be resistant to tears, punctures, and abrasions.

Tears, punctures, and abrasions may allow for the passage of microorganisms, particulates, and fluids between sterile and unsterile areas and expose patients and perioperative personnel to microbial contamination and bloodborne pathogens.

Abrasions may adversely affect barrier properties by weakening the material and causing it to tear or generate lint.

In a study evaluating bacterial penetration of disposable, non-woven drapes used during total hip arthroplasty, six brands of drapes were tested after 30 and 90 minutes. The results showed that bacterial penetration was time dependent. Most of the drapes remained impervious to allowed passage of fewer than 100 colony forming units at 90 minutes; however, none of the drapes tested were completely impervious, and certain brands were more resistant to bacterial penetration than others.

In another study considering the effects of moisture and physical stress on surgical draping materials, researchers found that materials differ dramatically in the ability to resist bacterial penetration.

II.a.2. Seams and points of attachment of surgical gowns should minimize liquid penetration and passage of potential contaminants.

Wicking or pressure on a seam or point of attachment may cause liquid transfer between sterile and unsterile surfaces, and one or both sides of the gown may become contaminated.

II.a.3. Surgical gowns, gloves, and drape products used during operative or other invasive procedures should be non-abrasive and non-toxic.

Products that are abrasive and contain chemicals and other toxic materials may irritate tissue, damage the skin, and injure patients and perioperative personnel.

II.a.4. Barrier materials used for surgical gowns and drape products should be as lint free as possible.

Lint particles are disseminated into the environment where bacteria attach to them. Bacteria-carrying lint may settle in surgical sites and wounds and may increase postoperative patient complications.

II.a.5. Surgical gowns and drape products should be functional and flexible.

Gowns and drape products that do not adequately perform and are unable to conform to and closely cover the user’s body or equipment may be difficult to use and may not provide protection from contamination by blood, body fluids, and other potentially infectious materials.

II.b. Perioperative personnel should select surgical gowns, gloves, and drape products for the procedure according to the barrier performance class of the product as stated on the label and
the anticipated degree of exposure to blood, body fluids, and other potentially infectious materials.\textsuperscript{38,39} \textsuperscript{[1: Regulatory Requirement]}

Surgical gowns and drapes are labeled by the manufacturer with the level of performance determined by the barrier properties of the area of the gown or drape where direct contact with blood, body fluids, and other potentially infectious materials is most likely to occur.\textsuperscript{38,39}

Surgical gowns, gloves, and drape products are used to establish a barrier that minimizes the passage of microorganisms, body fluids, and particulate matter between sterile and unsterile areas.\textsuperscript{38,39,40,41}

Surgical gloves are worn to protect patients and perioperative team members from transmission of pathogens. The process of surgery subjects gloves to mechanical stresses (eg, twisting, pulling, stretching) and exposure to fluids, fats, and chemical substances (eg, methyl methacrylate) that may affect the integrity of the glove barrier. The barrier properties of surgical gloves may be affected by the strength of the glove material and also may be compromised by hand and finger movements and other tasks (eg, holding retractors) that are required during invasive procedures.

In a study evaluating and comparing the barrier performance characteristics of latex, vinyl, and nitrile gloves under simulated use conditions, researchers tested a total of 2,000 gloves (800 latex, 800 vinyl, 400 nitrile) from seven different manufacturers. The gloves were purchased specifically for the study, taken directly from the packages, and immediately tested. A comparative baseline was established by leak-testing 100 gloves of each brand and type. The study gloves were consistently manipulated in a manner simulating patient care activities for a period of 20 minutes. The results showed that the barrier performance of latex and nitrile gloves is comparable, and both materials are much less susceptible to material breakdown and leakage than vinyl.\textsuperscript{40}

To compare the frequency of glove defects in latex and nonlatex surgical gloves during routine surgery, researchers collected gloves at the end of 2,318 surgical procedures. They tested a total of 6,386 gloves used by 101 surgeons and residents representing 15 surgical services. Six brands of nonlatex and two brands of latex gloves were tested. The results showed that both latex and nonlatex gloves performed adequately during routine surgical use; however, nonlatex surgical gloves had a higher rate of defects than latex gloves. The data also indicated that nonlatex gloves were nearly twice as likely to fail when used in certain high-risk surgical specialties (eg, oral, dental, cardiac) that require fine motor movement, increased hand dexterity, or contact with hard surfaces and sharp bone.\textsuperscript{41}

II.b.1. Factors that should be considered when selecting surgical gowns, gloves, and drape products for surgical or other invasive procedures include the

- anticipated blood loss;
- volume of irrigation fluid;
- potential for splash, spray, pooling, or soaking;
- duration of the procedure;
- potential for leaning or pressure;
- type of procedure (eg, minimally invasive versus open, superficial incision versus deep body cavity); and
- team member’s role.\textsuperscript{24,36}

II.c. Perioperative personnel should select surgical gowns of appropriate size and sleeve length. \textsuperscript{[5: No Evidence]}

When a gown is of insufficient size or sleeve length to cover the perioperative team member’s body, it may restrict movement, increase the potential for the scrubbed team member’s unsterile skin or clothing to contact the sterile field, or fail to provide adequate coverage to prevent the scrubbed team member from exposure to blood, body fluids, or other potentially infectious materials.

When a gown is of excessive size or sleeve length, the extra gown material may brush against unsterile objects and surfaces.

II.c.1. Surgical gowns should be large enough to adequately wrap around the perioperative team member’s body and completely cover the back.

In one study evaluating various combinations of surgical attire, the addition of a wrap-around gown reduced environmental microbial contamination by 51% when compared with scrub attire worn without a gown.\textsuperscript{42}

II.c.2. Surgical gowns should be selected so the lower sleeves and gown cuffs

- conform to the shape of the wearer’s arms;\textsuperscript{32}
- are short enough to allow gloves to fully cover the cuffs and mate properly with the lower sleeves;\textsuperscript{32} and
- are of sufficient length to prevent the gown cuffs from pulling out of the gloves when the wearer’s arms are extended.\textsuperscript{32}

Recommendation III

Perioperative personnel should use sterile technique when donning and wearing sterile gowns and gloves.

Implementing sterile technique when donning and wearing sterile gowns and gloves reduces the risk of wound contamination and surgical site infections that may result from direct contact of surgical team members’ skin or clothing with the sterile field.\textsuperscript{1}
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III.a. Perioperative team members should perform a surgical hand scrub before donning sterile gowns and gloves. [1: Strong Evidence]

Surgical hand antisepsis decreases transient and resident microorganisms on the skin, which may reduce health care-associated infections. Prevention of health care-associated infections is a priority of all health care providers. Health care-associated infections can result in untoward outcomes, such as increased morbidity and mortality, greater pain and suffering, longer length of stay, and escalated cost of care. Hand hygiene, hand washing, and surgical hand scrubs are the most effective way to prevent and control infections and represent the least expensive means of achieving both.

III.b. Scrubbed team members should don sterile gowns and gloves in a sterile area away from the main instrument table and in a manner to prevent contamination of surgical attire. [3: Limited Evidence]

Donning gowns and gloves in a separate area may help prevent contamination of the main instrument table by droplets of water or skin antiseptic solution from the scrubbed team member’s wet hands. Donning gowns and gloves in a separate area also may reduce the risk of contamination of the main instrument table from potential contact with the unprotected skin and clothing of the scrubbed team member as they don sterile gown and gloves.

In a non-experimental, two-part study with a small sample size, researchers cultured water droplets from 15 surgeons’ arms after a five-minute standardized surgical hand scrub with 10% povidone-iodine followed by thorough rinsing with tap water. The water droplets from each of the surgeons’ arms were collected and cultured. Pathogenic and environmental bacteria were recovered from the water droplets from the surgeons’ scrubbed arms. In the second part of the study, the wrapping paper from two different brands of gloves was investigated for permeability and bacterial penetration. The paper packaging was found to be permeable. The researchers concluded that pathogenic bacteria could be transferred from the surgeons’ arms to the gloves by water dropped on the glove packaging during the gowning and gloving process, and this represented a theoretical source of wound contamination.

III.b.1. Sterile gloves should not be opened directly on top of the sterile gown that has been opened for donning by the scrubbed team member.

When the gown is retrieved, droplets of water or skin antiseptic solution from the scrubbed team member’s wet hands may drip onto the glove wrapper and contaminate the sterile gloves.

III.b.2. The scrubbed team member’s hands and arms should be completely dry before donning a sterile gown.

Droplets of water or skin antiseptic solution from the scrubbed team member’s wet hands and arms may drip onto the gown or gown wrapper and contaminate the sterile gown.

III.b.3. Only the inside of the sterile gown should be touched when it is picked up for donning by the scrubbed team member.

Touching only the inside of the gown when picking it up prevents the scrubbed team member’s hands from contaminating the front of the gown.

III.b.4. The sterile glove wrapper or gloves should not be touched until the sterile gown has been donned.

After donning the sterile gown, the scrubbed team member’s hands are covered by the impervious gown sleeves, which prevents the scrubbed team member’s unprotected hands from contaminating the glove wrapper and gloves.

III.c. The front of a sterile gown should be considered sterile from the chest to the level of the sterile field. [3: Limited Evidence]

In a study evaluating the most sterile areas of surgical gowns, researchers obtained samples from 50 surgical gowns at the end of 29 spinal procedures. The samples were taken at six-inch increments beginning at the neck of the gown and ending at the bottom of the gown. An additional 50 gowns were swabbed immediately after donning and before entering the sterile field to serve as negative controls. When compared with the negative controls, the contamination rates of the gowns worn during the procedures were lowest in the section between the chest and the operative field. Bacterial growth was highest in the areas above the chest and below the OR table. The researchers theorized that the increased levels of bacterial growth in the areas above the chest were likely related to microbial shedding from the scrubbed team member’s head or mask, whereas the portion of the gown below the operating table was likely contaminated by direct contact with unsterile objects below the level of the operative field. The researchers concluded the front of the gown between the chest and the sterile field to be the area of greatest sterility.

III.c.1. The neckline, shoulders, and axillary regions of the surgical gown should be considered contaminated.

The neckline, shoulders, and axillary regions are areas of friction and may not provide effective microbial barriers.
III.c.2. The surgical gown back should be considered unsterile. The back of the gown cannot be constantly monitored.

III.d. Gown sleeves should be considered sterile from two inches above the elbow to the cuff, circumferentially. [3: Limited Evidence]

   From two inches above the elbow to the cuff, gown sleeves are adjacent to the area of the gown that is considered sterile (ie, the front of the gown from the chest to the level of the sterile field44). Circumferential sterility of the gown sleeves is necessary because the scrubbed team member’s arms move across the sterile field.

III.d.1. Sleeve cuffs of the surgical gown should be considered contaminated when the scrubbed team member’s hands pass through and beyond the cuff. Sleeve cuffs are not impervious and could allow for microbial transfer from the scrubbed team member’s hand.36

III.d.2. Sleeve cuffs should be completely covered by sterile gloves and should not be exposed. Permeable sleeve cuffs that are not completely covered by sterile gloves may allow for microbial transfer and contact from the scrubbed team member’s arms to the patient, and for contact with blood and body fluids from the patient to the scrubbed team member.

III.e. The closed assisted gloving method should be used to glove team members during initial gowning and gloving for operative or other invasive procedures (Figure 1). [2: Moderate Evidence]

   The risk for glove cuff contamination increases when open assisted gloving is used. In a blinded, randomized study comparing contamination of the inside of the glove cuff during open and closed assisted gloving, two surgeons were gloved 20 times after covering their fingers and hands with a fluorescent powder. One surgeon was gloved by the closed assisted method and the other by the open assisted method. The results showed that open assisted gloving led to significantly greater glove cuff contamination than the closed assisted gloving method.22

III.e.1. During closed assisted gloving, the gown cuff of the team member being gloved should remain at or beyond the fingertips. The glove to be donned should be held open by a scrubbed team member, and the team member being gloved should insert his or her hand into the glove with the gown cuff touching only the inside of the glove.

III.e.2. Open assisted gloving, where the team member’s gown sleeve is pulled up so that the gown cuff is at wrist level, leaving the fingers and hand exposed, should be used when closed assisted gloving is not possible or practical (Figure 2).

III.f. Scrubbed team members should wear two pairs of surgical gloves, one over the other, during surgical and other invasive procedures with the potential for exposure to blood, body fluids, or other potentially infectious materials.1,1 [1: Strong Evidence]

   To provide an effective sterile barrier and prevent microbial transfer from surgical team members’ hands to the patient, and to protect surgical team members from blood, body fluids, and other potentially infectious materials from the patient, surgical gloves must be intact and without perforations. Wearing two pairs of gloves helps to reduce glove perforations to the inner glove.

   A systematic review of 31 randomized controlled trials measuring glove perforations showed that the addition of a second pair of surgical gloves significantly reduced perforations to
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the inner glove. Triple gloving, knitted outer gloves, and glove liners also significantly reduced perforations to the inner glove. More inner glove perforations were detected during surgery when perforation indicator systems were used.44

The CDC, the American College of Surgeons, and the American Academy of Orthopedic Surgeons support double gloving during invasive surgical procedures.1,47,48

III.f.1. When double gloves are worn, perforation indicator systems should be used.

A perforation indicator system is a double gloving system comprising a colored pair of surgical gloves worn beneath a standard pair of surgical gloves. When glove perforation occurs, moisture from the surgical field seeps through the perforation between the layers of gloves, allowing the site of perforation to be seen more easily (Figure 3).

A meta-analysis of five randomized, controlled trials with a combined sample size of 582 gloves showed significantly fewer perforations detected by scrubbed team members wearing standard double gloves compared with scrubbed team members using perforation indicator systems. When wearing standard double gloves, 21% of perforations were detected by the scrubbed team member. When wearing perforation indicator systems, 77% of perforations were detected.46

III.g. Scrubbed team members should inspect gloves for integrity after donning, before contact with the sterile field, and throughout use. [2: Moderate Evidence]

Careful inspection of glove integrity after donning and before contact with the sterile field may reveal holes and defects in the unused product that may have occurred during the manufacturing or donning process and could allow for the passage of microorganisms, particulates, and fluids between sterile and unsterile areas.

Careful inspection of glove integrity throughout the procedure may prevent unnoticed glove perforation. Unnoticed glove perforation during operative or other invasive procedures may present an increased risk for bloodborne pathogen transmission to perioperative team members related to prolonged exposure to blood, body fluids, or other potentially infectious materials, and also may increase the patient’s risk for wound infection related to transfer of microorganisms from the hands of surgical team members.1

To investigate the frequency of undetected glove perforation, researchers studied glove perforations from 24 thoracoscopic and 23 open thoracotomy procedures and found that unnoticed glove perforation occurred in 25% of the gloves worn by the primary surgeon and in 12% of all gloves worn during the procedures.49

III.h. Surgical gloves worn during invasive surgical procedures should be changed

- after each patient procedure; [1: Strong Evidence]
- when suspected or actual contamination occurs; [5: No Evidence]
- after touching surgical helmet system hoods and visors; [3: Limited Evidence]
- after adjusting optic eyepieces on the operative microscope; [2: Moderate Evidence]
- immediately after direct contact with methyl methacrylate; [1: Strong Evidence]
- when gloves begin to swell, expand, and become loose on the hands as a result of the material’s absorption of fluids and fats; [2: Moderate Evidence]
- when a visible defect or perforation is noted or when a suspected or actual perforation from a needle, suture, bone, or other object occurs; [1: Strong Evidence] and
Failure to change gloves after each patient procedure may lead to transmission of microorganisms from one patient to another.2

Sterile gloves that have contacted unsterile items may transfer microorganisms or other unsterile particulates to the sterile field.

Surgical helmet systems consist of an unsterile reusable helmet with a built-in ventilation fan covered with a single-use disposable sterile visor mask hood. The unsterile helmet is donned before the surgical hand scrub is performed. The sterile visor mask hood that covers the unsterile helmet is applied during the gowning and gloving process. (Figure 4).

In a study to evaluate the sterility of a surgical helmet system during six hip arthroplasty and 14 knee arthroplasty procedures, researchers sampled hoods at 30-minute intervals during, as well as at the end, of procedures. Although the small sample size was a limitation of the study, the results showed that 80% of the hoods were contaminated intraoperatively. The hoods were contaminated within 30 minutes of use and showed heavy growth of coagulase-negative Staphylococcus aureus. The researchers recommended avoiding direct contact with the surgical helmet hood system during surgical procedures or changing gloves if contact does occur.3

In another study evaluating microbial contamination of a surgical helmet system, researchers tested hoods used in 61 hip arthroplasty and 41 knee arthroplasty procedures. Samples were collected immediately after the hood was placed over the helmet and at the conclusion of the procedure. The contamination rate was 47%. The organisms found included coagulase-negative staphylococci, Micrococcus, methicillin-resistant S aureus, and methicillin-resistant S aureus. The researchers recommended changing gloves if the hood or visor is touched or adjusted during the procedure.3

Researchers conducted a study to assess the contamination rates of sterile microscope drapes used during spine surgery. The study included 25 surgical spine procedures requiring the use of the operative microscope. The microscope drapes were swabbed immediately after application as negative controls. Postoperatively, the microscope drapes were sampled in seven different places. When compared with the negative controls, all of the sampled areas were found to be contaminated with bacteria. Four of the seven areas, including the shafts of the optic eyepieces, were found to have significant contamination rates. The regions above the eyepieces and the overhead portion of the drape also were contaminated. The researchers recommended avoiding contact with the upper portion of the drape and changing gloves after adjusting the optic eyepieces.4

Studies have demonstrated that surgical gloves are permeable to methyl methacrylate.5,6 The amount of permeation depends on the type of glove and the duration it is worn.5,6 A full discussion of methyl methacrylate is outside the scope of this document. The reader should refer to the AORN “Recommended practices for a safe environment of care”7 for additional guidance.

Researchers studied the effectiveness of the barrier provided by latex surgical gloves and found that latex is subject to hydration (ie, the absorption of fluid molecules). Hydration rates are highly variable and depend on the properties of the individual glove product, the amount of perspiration from the scrubbed team member’s hand, and the amount of body fluid exposure during the procedure. Hydrated gloves showed increased permeability and porosity and a significant reduction of electrical and mechanical resistance. The researchers concluded that latex is an effective barrier; however, the combined effects of the mechanical and biological stress to which the glove is subjected require careful monitoring by the user and changing gloves before the integrity of the glove is lost.5

Surgical gloves that are intact and without defects or perforations provide an effective sterile barrier and may prevent microbial transfer from perioperative team members’ hands to the patient, and also protect the perioperative team members from transfer of blood, body fluids, and other potentially infectious materials from the patient.5

In a study measuring the concentration of bacteria passing through glove punctures under...
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surgical conditions, 128 outer and 122 inner gloves used by surgical team members during 20 septic laparotomy procedures were tested. The rate of outer glove perforation averaged 15%; however, nearly 82% of the perforations went undetected. The frequency of perforation was directly correlated with the length of time the gloves were worn for both inner and outer gloves. Direct bacterial passage from the patient through a glove puncture occurred in almost 5% of all gloves worn. The researchers recommended a strict policy of changing gloves every 90 minutes.57

In a study measuring bacterial translocation through puncture holes in surgical gloves, 98 outer and 96 inner gloves worn by surgical team members during 20 consecutive surgical laparotomy procedures were examined. Ten outer gloves and one inner glove were perforated; however, seven of the perforations were detected because of the indicator glove system worn by surgical team members. Bacterial migration was demonstrated in five of the outer gloves and one of the inner gloves. The frequency of perforation increased with the length of time the gloves were worn. The researchers recommended double gloving and a change of gloves at least every 90 minutes.58

In another prospective study, researchers from one facility collected 898 consecutive pairs of surgical gloves used during all general surgery procedures during a nine-month period. There was a positive correlation between the rate of perforation and the duration of time the gloves were worn. Gloves worn for 90 minutes or less showed a perforation rate of 15%. Gloves worn for 91 to 150 minutes showed a perforation rate of 18%, while gloves worn longer than 150 minutes showed a perforation rate of 24%. There was no significant difference in the perforation rates of gloves worn by surgeons, first assistants, or scrub persons. Previously undetected perforations were found in 19% of the gloves worn by all team members. The researchers recommended that surgeons, first assistants, and scrub persons change gloves after 90 minutes of surgery.59

The American Academy of Orthopedic Surgeons recommends changing the outer pair of gloves at least every two hours to prevent skin exposure from perforations that may occur in the gloves with use over time.60

III.i. Perioperative team members who must change their sterile gloves during operative or other invasive procedures should use the assisted gloving method. [3: Limited Evidence]

When using the assisted gloving method, one scrubbed team member touches only the outside of the new sterile glove when applying the glove to another scrubbed team member’s hand.

Researchers evaluated glove donning techniques for microbial contamination by comparing open, closed, and assisted gloving techniques. After applying an ultraviolet luminescent cream to the tips of each of the fingers on both hands, 13 individuals were observed donning surgical gowns and gloves 20 times each. Contamination of the front and back cuff areas of the gown was noted in all 20 donning procedures using the open gloving method. Contamination of the back cuff areas of the gown was noted in all 20 donning procedures using the open gloving method. Contamination of the back cuff areas of the gown was noted in all 20 donning procedures using the open gloving method. Contamination of the back cuff areas of the gown was noted in all 20 donning procedures using the closed gloving method. No contamination of any areas of the gown was noted when using the assisted gloving method.61

III.i.1. If possible, the unscrubbed team member should remove the glove to be changed from the sterile team member without altering the position of the glove cuff (ie, pulling the cuff down over the scrubbed team member’s hand).

III.i.2. When assisted gloving is not possible or practical, perioperative team members should change gowns and gloves using the closed gloving technique.

Recommendation IV

Sterile drapes should be used to establish a sterile field.

Sterile drapes provide a barrier that minimizes the passage of microorganisms from unsterile to sterile areas and reduces the risk of health care-associated infections.1
IV.a. Perioperative team members should place sterile drapes on the patient, furniture, and equipment in the sterile field and should handle them in a manner that prevents contamination. [1: Strong Evidence]

In a randomized controlled trial comparing the use of maximal sterile barrier precautions (ie, sterile gown, sterile gloves, surgical cap, full body drape) with the use of only sterile gloves and a small drape during CVC insertion, results showed that maximal sterile barrier precautions led to fewer episodes of catheter colonization and catheter-related bloodstream infections. One program that included using maximal sterile barriers during CVC insertion in 103 intensive care units in Michigan resulted in a 66% decrease in infection rates.

The CDC recommends maximum sterile barrier precautions, including the use of a full body drape, during the placement of CVCs, PICCs, and guidewire exchanges.

IV.a.1. Unsterile equipment (eg, Mayo stands) should be covered on the top, bottom, and sides with sterile barrier materials before being introduced to or brought over a sterile field. Sterile barrier material also should be applied to the portion of the equipment that will be positioned immediately adjacent to the sterile field.

IV.a.2. Sterile drapes should be handled as little as possible.

Rapid movement of draping materials creates air currents on which dust, lint, and other particles can migrate.

IV.a.3. Draping materials should be held in a controlled manner that prevents the sterile drape from coming into contact with unsterile surfaces.

IV.a.4. During draping, gloved hands should be shielded by cuffing the drape material over the gloved hands.

Keeping the gloved hands beneath the cuff of the draping material may protect gloves from contact with unsterile items or areas.

Researchers tested 275 outer and inner gloves that were used during 10 total hip replacements for microbial contamination. The results indicated that contamination occurred most frequently on the outside of the gloves that were used exclusively for draping.

IV.a.5. Surgical drapes should be placed in a manner that does not require scrubbed team members to lean across an unsterile area and prevents the front of the surgical gown from contacting an unsterile surface.

IV.a.6. Sterile drapes should be placed from the surgical site to peripheral areas.

IV.a.7. The portion of the surgical drape that establishes the sterile field should not be moved after it has been positioned.

IV.a.8. Only the top surface of a sterile, draped area should be considered sterile. Items that fall below the sterile area should be considered contaminated.

IV.b. Surgical equipment (eg, tubing, cables) should be secured to the sterile drapes with nonperforating devices. [2: Moderate Evidence]

Perforation of barrier materials may provide portals of entry and exit for microorganisms, blood, and other potentially infectious materials.

IV.c. The upper portion of the C-arm drape should be considered contaminated. [2: Moderate Evidence]

In a prospective study evaluating the sterility of 25 C-arm drapes used during spinal surgery, researchers obtained samples postoperatively from five different locations on a standard fluoroscopic C-arm drape. The researchers also sampled the drapes preoperatively immediately after they were applied to establish a negative control. The results showed that bacterial contamination was present at all sampled locations; however, the samples at the top of the C-arm had the greatest degree of contamination when compared with the negative controls (ie, 56% at the top and 28% at the upper front of the receiver). Lower rates of contamination were observed on the lower front, receiver plate, and mid-portion of the C-arm drape (ie, 12% to 20%), but these were not considered significant. The researchers recommended the top portion of the C-arm drape be considered unsterile, and suggested that avoiding contact with these areas may decrease the risk of postoperative infection (Figure 5).

IV.d. Plastic adhesive incise drapes should not be used for prevention of surgical site infection. [1: Strong Evidence]

In a systematic review of seven randomized, controlled studies involving 4,195 patients, researchers concluded there was no evidence to support the use of plastic adhesive incise drapes as a method for reducing infection, and that there was some evidence that infection rates may be increased when adhesive incise drapes are used. A meta-analysis of five studies included in the review, which included 3,082 participants, compared plain plastic adhesive incise drapes with no drape and showed a significantly higher number of patients developed a surgical site infection when the adhesive incise drape was used. There was no effect on surgical site infection rates according to a meta-analysis of two additional studies, including 1,113 participants, which compared iodine-impregnated plastic adhesive incise drapes...
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with no drape. The researchers theorized that the patient’s skin is not likely to be a primary cause of surgical site infection if it is properly disinfected, and they concluded that attempting to isolate the skin from the surgical wound is of no benefit and may create increased moisture and bacterial growth under adhesive drapes.65

Recommendation V

A sterile field should be prepared for patients undergoing surgical or other invasive procedures.

Preparing a sterile field for patients undergoing surgical or other invasive procedures reduces the risk of microbial contamination and is a cornerstone of infection prevention. Failure to adhere to aseptic practices during invasive procedures has been associated with surgical site infections.1

V.a. The sterile field should be prepared in the location where it will be used and should not be moved. [5: No Evidence]

Moving the sterile field from one location to another increases the potential for contamination.

V.b. The sterile field should be prepared as close as possible to the time of use. [1: Strong Evidence]

The potential for bacterial growth and contamination increases with time because dust and other particles present in the ambient environment settle on horizontal surfaces. Particulate matter can be stirred up by personnel movement and can settle on opened sterile supplies.12,13,14

There is no specified amount of time that opened sterile supplies in an unused room can remain sterile. The sterility of an opened sterile field is event-related.12

V.c. Sterile supplies should be opened for only one patient at a time in the OR or other procedure room. [4: Benefits Balanced With Harms]

Opening sterile supplies for multiple patients in a single OR or other procedure room increases the risk of cross contamination.

V.d. One patient at a time should occupy the OR or other procedure room. [1: Strong Evidence]

Concurrent procedures performed on multiple patients in the same OR or other procedure room at the same time may expose patients to a variety of hazards and increase the risk of contamination and infection. Infectious diseases may be transmitted by airborne, contact, and droplet methods.12 The risk of cross contamination may be increased when two sterile fields, two surgical teams, and two open surgical wounds are confined to a single OR or other procedure room.

V.e. Perioperative personnel should perform a surgical hand scrub and don a sterile gown and gloves before setting up sterile supplies. [1: Strong Evidence]

Surgical hand hygiene decreases transient and resident microorganisms on the skin, which may reduce health care-associated infections.4,6 Donning a sterile gown and gloves before setting up sterile supplies minimizes the potential for wound contamination and reduces patient risks for surgical site infections that may result from contact with perioperative team members’ skin or clothing.1

V.f. Only sterile items should come in contact with the sterile field. [1: Strong Evidence]

The creation and maintenance of a sterile field may influence patient outcomes.1

Using sterile items during invasive procedures minimizes the risk of infection and provides the highest level of assurance that procedural items are free of microorganisms.12

V.g. Sterile fields and instrumentation used during procedures that involve both the abdominal and perineal areas should be kept separate and should not be used interchangeably. [2: Moderate Evidence]

The perineal area has a higher microbial count than the abdominal area.22 Placing instruments and other items that have been used in the perineal area into the abdominal area can transfer microorganisms from the perineum to the abdomen and cause an infection. Meticulous sterile technique is required during gynecologic laparoscopic procedures.
when transurethral instruments and catheters are passed to prevent infections of the urinary tract. These infections are the most common type of health care-associated infection reported to the National Healthcare Safety Network.24

The defense system of the peritoneum also may be negatively affected by the pneumoperitoneum used in laparoscopic procedures.22 The mechanical distension changes the peritoneal microstructure, allowing passage of bacteria24 to the bloodstream, lungs, and kidneys.22 This is important because intra-abdominal infections often begin in the peritoneal cavity.24 Systemic response coupled with the amount of tissue damage and the duration of the procedure may potentially lead to a higher risk for infection.24

V.h. Isolation technique should be used during bowel surgery. [2: Moderate Evidence]

Isolation technique, also known as bowel or contamination technique, is implemented to reduce the potential for microorganisms that exist in the bowel to be transferred into the abdominal cavity, tissues of the abdominal wall, and the surgical site. Isolation technique includes
- no longer using instruments or equipment that have contacted the inside of the bowel or the bowel lumen after the bowel lumen has been closed,
- using clean instruments to close the wound, and
- either removing contaminated instruments and equipment from the sterile field or placing them in a separate area that will not be touched by members of the sterile team.

The distal ileum is an area of transition between the small populations of bacteria in the proximal small intestine and the large numbers of bacteria and anaerobic microorganisms in the large bowel.23,26,32,33 Only small numbers of bacteria are normally present in the duodenum and proximal jejunum.23,25,32 Excessive colonization of bacteria in the small bowel is prevented by the destructive action of gastric acid and bile, digestion by proteolytic enzymes, and bacterial clearance by intestinal peristalsis.23,25,32 Some gastrointestinal disorders that require surgical repair may be associated with an increase in the number of bacteria in the upper gastrointestinal tract (eg, obstruction, diverticula, fistula)23,25,32 and may warrant the implementation of isolation technique.

In a study evaluating contamination of surgical instruments that have contacted bowel mucosa and whether isolation technique decreases contamination of the abdominal wall and peritoneal cavity, researchers compared contamination levels of instruments used during procedures involving the large bowel (ie, cecum, ascending, transverse, descending, and sigmoid colon, rectum) with contamination lev-

V.h.1. The health care organization should develop and implement a standardized procedure for isolation technique.22,23,24

A standardized procedure for isolation technique (ie, following the same patterns and processes each time) assists in achieving accuracy, efficiency, and continuity among perioperative team members. Studies of human error have shown that many errors involve a deviation from routine practice.22

V.h.2. The use of isolation technique should begin when the gastrointestinal tract is transected and end when the anastomosis is closed.23

V.h.3. Isolation technique should be implemented using either a single setup or a dual setup.22,24

Single setup:
- Prepare one setup for the procedure, including anastomosis and closure.
- Before transection of the bowel, place clean sterile towels or a wound protector around the surgical site.
- Segregate all contaminated instruments and other items that have contacted the
bowel lumen to a designated area (eg, Mayo stand, basin).

- Refrain from touching the sterile back table while the bowel is open.
- When the anastomosis is complete, remove the contaminated instruments, towel drapes, wound protector, and any other potentially contaminated items (eg, electrosurgical pencil, suction, light handles) from the sterile field, or place them in a separate area that will not be touched by perioperative team members.
- Irrigate the wound and apply moist counted sponges or towels to protect the tissue.
- Initiate team communication announcing the change to clean closure.
- One scrubbed team member should remain at the sterile field while all other team members change into clean gowns and gloves.
- The scrubbed team member who remained at the field should remove the moist counted sponges or towels and then change into a clean gown and gloves.
- Initiate accounting procedures.
- Apply clean light handles.
- Apply clean drapes to cover the existing drapes, which may be soiled with bowel contents.
- Secure a clean electrosurgical pencil and suction to the field.
- Proceed with wound closure using only clean instrumentation and other items.

Dual setup:

- Prepare one setup for the procedure and one for the closure.
- Before transection of the bowel, place clean sterile towels or a wound protector around the surgical site.
- When the anastomosis is complete, remove the contaminated instruments, towel drapes, wound protector, and any other potentially contaminated items (eg, electrosurgical pencil, suction, light handles) from the sterile field or return all contaminated instruments and other items to the procedure setup that will not be touched by perioperative team members.
- Irrigate the wound and apply moist counted sponges or towels to protect the tissue.
- Initiate team communication announcing the change to clean closure.
- One scrubbed team member should remain at the sterile field while all other team members change into clean gowns and gloves.
- The scrubbed team member who remained at the field should remove the moist counted sponges or towels and then change into a clean gown and gloves.
- Initiate accounting procedures.
- Apply clean light handles.
- Apply clean drapes to cover the existing drapes, which may be soiled with bowel contents.
- Secure a clean electrosurgical pencil and suction to the field.
- Proceed with wound closure using only instrumentation and other items from the closure setup.

Isolation technique should be used during procedures involving resection of metastatic tumors. [2: Moderate Evidence]

The use of isolation technique is a primary precaution to prevent the potential spread of cancer cells. There have been reports of local and distant implantation of tumor cells associated with the use of instrumentation used for both resection and closure or reconstruction. In one case, a 52-year-old man underwent a subtotal resection of a metastatic gliosarcoma in the right frontal region, a second surgery four months later, and a third surgery with complete resection five months after that. The dural defect that occurred as a result of the total resection was reconstructed using a tensor fascia lata graft from the right leg. Two months later, the patient presented with subcutaneous masses in the frontal and right temporal scalp and in the right upper leg in the area where the donor graft was taken. Pathologic examination of the excised masses verified the presence of cells identical to the primary tumor mass. The patient died two months later with multiple subcutaneous masses in the scalp. Implantation of tumor cells by the use of contaminated surgical instruments used for tumor resection was believed to be the cause of the development of local and distant recurrences.

In another case, a 42-year-old man underwent sublabial transrhinoseptal incomplete resection of a clival chondroid chordoma and postoperative proton beam radiotherapy that resulted in stabilization of the residual tumor remnant. The patient experienced a painless loosening of an upper incisor 31 months later. Computerized tomography revealed a bone defect between the 11th and 12th teeth. Curettage biopsy and pathological examination showed a chondroid clival chordoma resembling the initial chordoma. The patient underwent two additional resections for intracranial recurrences and died at the age of 49 from infectious complications. Seeding during resection is believed to be the cause of the recurrence. The authors recommended removing resection instrumentation before closure and abundantly rinsing the surgical field.
In another case, a 37-year-old woman who was diagnosed at age 10 with a low-grade oligoastrocytoma underwent craniotomy with surgical resection of the tumor at the time of diagnosis. The patient underwent a second craniotomy and surgical resection of the tumor followed by chemotherapy for progression of the tumor. Seven months later, the patient noticed an area of thickening in the scalp incision and underwent resection of the scar for what was believed to be poor wound healing. Pathological examination of the skin from the scalp revealed fibrosis and subcutaneous fat necrosis with chronic inflammation and foreign body giant cell reaction; however, the deep aspect of the subcutaneous tissue showed clusters and infiltrating cords of atypical cells morphologically similar to those of the resected tumor. The development of subcutaneous scalp involvement was believed to be from tumor implantation and seeding during surgical resection.92

Recommendation VI

Items introduced to the sterile field should be opened, dispensed, and transferred by methods that maintain the sterility and integrity of the item and the sterile field.

Sterile items that are not opened, dispensed, and transferred by methods that maintain sterility and integrity may contaminate the sterile field.

VI.a. Perioperative team members should inspect sterile items for proper processing, packaging, and package integrity immediately before presentation to the sterile field. [1: Strong Evidence]

Inspecting items before presentation to the sterile field helps verify that conditions required for sterility have been met and helps prevent microbial contamination that might occur if the integrity of the container has been breached and the item is placed on the sterile field.

Sterility is event-related and depends on maintenance of the integrity of the package.71 89 90 The sterility of an item does not change with the passage of time but may be affected by particular events (eg, amount of handling) or environmental conditions (eg, humidity).

In a study of time-related contamination rates of sterilized dental instruments, researchers removed 25 sterilized examination mirrors from their packages and tested them for aerobic and anaerobic microbial contamination immediately after sterilization and at 31, 60, 90, and 124 days. Researchers found no contamination on any of the items at any time.93

In another study that evaluated whether storage time has any effect on the susceptibility of sterile packages to contamination under deliber-
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Microorganisms are shed from the skin of perioperative personnel. Maintaining distance from the sterile field decreases the potential for contamination when items are passed from unsterile to sterile areas.

VI.c. Sterile items should be presented directly to the scrubbed team member or placed securely on the sterile field. [5: No Evidence]

Items tossed onto a sterile field may roll off the edge, create a hole in the sterile drape, or cause other items to be displaced, leading to contamination of the sterile field.

VI.c.1. Heavy items or items that are sharp and may penetrate the sterile barrier should be presented directly to the scrubbed team member or opened on a separate clean, dry surface.

VI.d. Perioperative personnel should open wrapped sterile supplies by opening

1. the farthest wrapper flap,
2. each of the side flaps, and
3. the nearest wrapper flap.

[5: No Evidence]

Opening the wrapper flap that is farthest away first prevents contamination that might occur from passing an unsterile arm over sterile items.

VI.d.1. Wrapper edges should be secured when supplies are opened and presented to the scrubbed team member or sterile field. [22]

Wrapper edges are considered contaminated. Securing the loose wrapper edges helps prevent them from contaminating sterile areas or items.

VI.d.2. Instrument tray wrappers should be visually inspected for moisture and integrity before the contents are placed on the sterile field. [22]

VI.e. Peel pouches should be presented to the scrubbed team member or opened onto the sterile field by pulling back the flaps without touching the inside of the package or allowing the contents to slide over the unsterile edges of the package. [5: No Evidence]

Touching the inside of the package or allowing the contents to slide over the unsterile edges may contaminate the contents of the package.

VI.f. Rigid sterilization containers should be inspected and opened on a clean, flat, and dry surface. [3: Limited Evidence]

Opening rigid sterilization containers on a clean, flat, and dry surface facilitates removing sterile items from their containers without contaminating the items or sterile field.

VI.f.1. Perioperative team members should verify that external locks, latch filters, valves, and temper-evident devices are intact before opening rigid sterilization containers. [22]

Ensuring container locks, latch filters, valves, and temper-evident devices are intact helps to verify there has not been a breach of the container seal.

VI.f.2. Perioperative team members should verify that the external chemical indicator has changed as appropriate before opening rigid sterilization containers.

Checking for the appropriate chemical indicator change verifies that the container has been through the sterilization process and reduces the potential for opening items that have not been sterilized.

VI.f.3. The rigid sterilization container should be opened according to the manufacturer’s written instructions for use. The lid should be lifted up and toward the person opening the container and away from the container.

- The lid should be inspected for the integrity of the filter or valve and the integrity of the filter or valve and the gasket. [22]
- The container contents should be considered contaminated if the filter is damp or dislodged, or has holes, tears, or punctures.

Opening the container according to the manufacturer’s written instructions for use facilitates aseptic removal of the contents. [22]

Lifting the lid up and away from the container and toward the person removing the lid helps to prevent potential contamination from contact between the unsterile lid and the sterile inner rim, contents, and inside of the container system, and also helps to prevent the unscrubbed person from leaning over the sterile contents of the container.

VI.f.4. The scrubbed team member should avoid contacting the unsterile surfaces of the table or container while lifting the inner basket(s) out and above the container. [22]

Before the instruments are placed on the sterile field, the internal chemical indicator should be examined for the appropriate color change and the inside surface of the container inspected for debris, contamination, or damage. [22]

VI.g. Medications and sterile solutions (eg, normal saline) should be transferred to and handled on the sterile field using sterile technique. [2: Moderate Evidence]

Transferring and handling medications and solutions on the sterile field poses increased risks for contamination of the medication, solution, sterile field, and surgical site because medications and solutions are removed from their original containers, stored on the sterile field, and passed from a scrubbed team member to a licensed practitioner for administration. [22]

Using sterile technique helps prevent microbial contamination of the sterile field or medication.
VI.g.1. Medications and solutions should be visually inspected immediately before transfer to the sterile field and should not be used if the expiration date has passed or if there is any indication that the medication or solution has been compromised (eg, discoloration, particulate formation). Compromised and outdated medications and solutions may be contaminated or have reduced effectiveness.

VI.g.2. Sterile transfer devices (eg, sterile vial spike, filter straw, plastic catheter) should be used when transferring medications or solutions to the sterile field. Transfer devices are designed to reduce the potential for contamination of the sterile field by minimizing splashing and spilling and the need to reach over the sterile field.

VI.g.3. When solutions are dispensed to the sterile field, the entire contents of the container should be poured slowly into a solution receptacle that is placed near the sterile table's edge or is held by a scrubbed team member and labeled immediately.

Pouring the entire contents of the container slowly prevents splashing. Splashing may cause strike-through and splash-back from unsterile surfaces to the sterile field.

Placing the solution receptacle near the edge of the sterile table or having the scrubbed team member hold the receptacle reduces the potential for contamination of the sterile table and allows the unscrubbed team member to pour fluids without leaning over the sterile field.

VI.g.4. The edge of the container should be considered contaminated after the contents have been poured.

VI.g.5. The cap should not be replaced on opened medication or solution containers and any remaining fluids should be discarded.

The sterility of the contents of opened medication or solution containers cannot be ensured if the cap is replaced. Reuse of open containers may contaminate solutions from drops contacting unsterile areas and then running back over container openings.

VI.g.6. Medications and solutions should be dispensed to the sterile field as close as possible to the time they will be used.

VI.g.7. Stoppers should not be removed from vials for the purpose of pouring medications unless specifically designed for removal and pouring by the manufacturer.

VI.g.8. Unused, opened irrigation or IV solutions should be discarded at the end of the procedure.

Irrigation and IV containers and supplies are considered single-use. Using surplus volume from any irrigation or IV solution container or supplies for more than one patient increases the risk of cross-contamination.

Recommendation VII

Sterile fields should be constantly monitored.

The sterile field is subject to unrecognized contamination by personnel, vectors (eg, insects), or breaks in sterile technique if left unobserved.

VII.a. Once created, a sterile field should not be left unattended until the operative or other invasive procedure is completed. [5: No Evidence] Observation increases the likelihood of detecting a breach in sterility.

VII.b. When there is an unanticipated delay, or during periods of increased activity, a sterile field that has been prepared and will not immediately be used may be covered with a sterile drape. [2: Moderate Evidence]

To evaluate the contamination rate of sterile trays that have been opened in a controlled OR environment and the effect of traffic on the contamination rate, researchers opened 45 sterile trays in a positive air-flow OR and randomly assigned them to one of three groups:

- Trays were opened and left uncovered in a locked OR.
- Trays were opened and left uncovered in an OR with single-person traffic flowing in and out every 10 minutes from an unsterile corridor.
- Trays were opened, immediately covered with a sterile surgical towel, and left in a locked OR.

All trays were opened using sterile technique and were exposed for a total of four hours. Cultures of the trays were taken immediately after they were opened and every 30 minutes during the exposure period. The contamination rates for the uncovered trays were 4% at 30 minutes, 15% at 60 minutes, 22% at two hours, and 30% at four hours. There was no difference in the contamination rates between the uncovered trays in the room with traffic and those in the room without traffic. The covered trays had no contamination during the exposure period. The researchers recommended covering sterile trays that are not immediately used to minimize exposure to environmental contaminants.

In a study of 41 total joint replacements (27 hip, 14 knee) that was conducted to evaluate the effectiveness of covering instruments,
researchers found that covering the instruments during periods of increased activity (eg, patient transfer to the procedure bed, skin preparation) shortened the overall exposure time and shielded the instruments from bacterial dispersal, resulting in a 28-fold reduction of instrument contamination.82

VII.b.1. When sterile fields are covered, they should be covered in a manner that allows the cover to be removed without bringing the part of the cover that falls below the sterile field above the sterile field. When covering the sterile field, two sterile “cuffed” drapes should be used as follows:

- The first drape should be placed horizontally over the table or other area to be covered with the cuff at or just beyond the halfway point. The second drape should be placed from the opposite side of the table and the cuff positioned so that it completely covers the cuff of the first drape (Figure 6).
- The drapes should be removed by placing hands within the cuff of the top drape and lifting the drape up and away from the table and toward the person removing the drape. The second drape should be removed from the opposite side in a similar manner.

Removing the cover from the sterile field may result in a part of the cover that was below the sterile field being drawn above the sterile field, which may allow air currents to draw microorganisms and other contaminants (eg, dust, debris) from an unsterile area (eg, floor) and deposit them in sterile areas.82

VII.b.2. The health care organization should develop a standardized procedure in collaboration with infection prevention personnel for covering sterile fields to delineate the specific circumstances when sterile fields may be covered and to specify the method of covering and the length of time a sterile field may be covered.

Standardized procedures (ie, following the same patterns and processes each time) assist in achieving accuracy, efficiency, and continuity among perioperative team members. Studies of human error have shown that many errors involve a deviation from routine practice.85

VII.c. Perioperative personnel should observe for, recognize, and immediately correct breaks in sterile technique when preparing, performing, or assisting with operative or other invasive procedures and should implement measures to prevent future occurrences. [1: Strong Evidence]

Breaks in sterile technique may expose the patient to increased microbial contamination. The risk for infection increases with increased amounts of microbial contamination.2 Preventing, observing for, recognizing, and taking immediate corrective action for breaks in sterile technique may prevent or reduce microbial contamination and help minimize the risk of surgical site infection.

VII.c.1. When a break in sterile technique occurs, corrective action should be taken immediately unless the patient’s safety is at risk. When a break in sterile technique cannot be corrected immediately, corrective action should be taken as soon as it is safe for the patient.

The greater the length of time until the break in sterile technique is recognized, the more complex and difficult containment becomes and the more likely it becomes that full containment may not be possible.82

VII.d. If organic material (eg, blood, hair, tissue, bone fragments) or other debris (eg, bone cement, grease, mineral deposits) is found on an instrument or item in a sterile set, the entire set should be considered contaminated and perioperative team members should take corrective actions immediately. [1: Strong Evidence]

Organic and inorganic material that remains on a surgical instrument may be transferred to the surgical wound or other areas of the body, which increases the risk for surgical site infection or other postoperative complications.
VII.d.1. Corrective actions should include, at a minimum, removing the entire set and any other items that may have come in contact with the contaminated item from the sterile field and changing the gloves of any team member who may have touched the contaminated item. Additional corrective actions may be required subject to thoughtful assessment and the application of informed clinical judgment based on the specific factors associated with the individual event.

VII.e. If an instrument in a sterile set is found assembled or clamped closed, the entire set should be considered contaminated and perioperative team members should take corrective actions immediately. [1: Strong Evidence]

Sterilization or high-level disinfection can only be achieved if all surfaces of an item have contacted the sterilizing agent or disinfectant under the appropriate conditions and for the appropriate amount of time. Organic materials and other debris may act as barriers that interfere with sterilization or high-level disinfection or may combine with and deactivate the sterilant or disinfectant. If organic material or other debris is found on an instrument that has been through sterilization or high-level disinfection, there is no way to ensure that the sterilant or high-level disinfectant made contact with all surfaces of the item and with other items in the set. Sterility or high-level disinfection may not have been achieved; therefore, the sterility of the entire set is in question.

VII.e.1. Corrective actions should include, at a minimum, removing the entire set and any other instruments that may have come in contact with the contaminated instrument from the sterile field and changing the gloves of any team member who may have touched the contaminated item. Additional corrective actions may be required subject to thoughtful assessment and the application of informed clinical judgment based on the specific factors associated with the individual event.

Recommendation VIII

All personnel moving within or around a sterile field should do so in a manner that prevents contamination of the sterile field.

Airborne contaminants and microbial levels in the surgical environment are directly proportional to the amount of movement and the number of people in the OR or other procedure room. [2: Limited Evidence]

VIII.a. Scrubbed team members should remain close to the sterile field and touch only sterile areas or items. [5: No Evidence]

Walking outside the periphery of the sterile field or leaving and then returning to the OR or other procedure room in sterile attire increases the potential for contamination.

VIII.a.1. Scrubbed team members should not leave the sterile field to retrieve items from the sterilizer.

VIII.a.2. Scrubbed team members should wear protective devices (eg, lead aprons) that reduce radiological exposure so they are not required to leave the sterile field when x-rays are taken.

VIII.b. Scrubbed team members should keep their hands and arms above waist level at all times. [5: No Evidence]

Keeping the hands and arms above waist level allows the perioperative team member to see them constantly. Contamination may occur when a perioperative team member moves his or her hands or arms below waist level.

VIII.b.1. Scrubbed team members’ arms should not be folded with the hands in the axillary area.

The axillary area has the potential to become contaminated by perspiration, allowing for strike-through of the gown and potential contamination of the gloved hands. The axillary area of the gown is an area of friction and is not considered an effective microbial barrier.

VIII.c. Scrubbed team members should avoid changing levels and should be seated only when the entire procedure will be performed at that level. [3: Limited Evidence]

When scrubbed team members change levels, the unsterile portion of their gowns may come into contact with sterile areas.

To evaluate whether the surgical field could be contaminated by a perioperative team member stepping on and off of a footstool, researchers sprinkled starch powder on the portion of the drape below the level of the sterile field. A surgeon wearing a surgical gown made contact with the drape, and then stepped on and off a 6-inch footstool twice. The contamination level rose 6 inches with each movement. The researchers recommended that scrubbed team
members reduce the number of times they step on a footstool.\textsuperscript{139}

VIII.d. When changing position with each other, scrubbed team members should turn back to back or face to face while maintaining distance from each other, the sterile field, and unsterile areas. [5: No Evidence]

Contamination of sterile gowns and gloves and the sterile field may be prevented by scrubbed team members maintaining distance from each other and the sterile field when changing position, and by establishing patterns of movement that reduce the risk of contact with unsterile areas.

VIII.e. Unscrubbed personnel should face the sterile field on approach, should not walk between sterile fields or scrubbed persons, and should maintain a distance of at least 12 inches from the sterile field and scrubbed persons at all times. [5: No Evidence]

Contamination of the sterile field or scrubbed team members may be prevented by unscrubbed team members maintaining distance from the sterile field and scrubbed persons and establishing patterns of movement that reduce the risk of contact with sterile areas and scrubbed persons.

VIII.f. Conversations in the presence of a sterile field should be kept to a minimum. [2: Moderate Evidence]

Microorganisms are transported on airborne particles including respiratory droplets.\textsuperscript{42} Researchers studied the role of conversation in the OR by using small spherical particles of human albumin ranging in size from 10 to 35 micrometers in diameter to simulate particles that carry bacteria. Approximately 300,000 albumin particles were sprayed on the faces and in the nostrils beneath the surgical masks of the study participants. The participants read aloud continuously for periods of five, 10, 20, 30, 40, 50, and 60 minutes from a position 30 cm above a water bath simulating a surgical wound. The researchers collected particles from the water bath and processed them after each reading session. The results of the study showed that the longer the period of conversation, the greater the number of particles in the simulated wound. The effects of both time and conversation were found to be significant. The researchers concluded that conversation contributes to airborne contamination of surgical wounds.\textsuperscript{22,32,23}

VIII.g. The number and movement of individuals involved in an operative or other invasive procedure should be kept to a minimum. [1: Strong Evidence]

Bacterial shedding increases with activity. Air currents can pick up contaminated particles shed from patients, personnel, and drapes and distribute them to sterile areas.\textsuperscript{32,22,23}

Researchers conducted a prospective, observational study in three pediatric ORs. During a two-week period, surgeons, anesthesia professionals, and perioperative team members were observed during 14 surgical procedures. A medical student observer recorded parameters, including the minimum and maximum numbers of personnel in the room during the procedure, number of personnel in the procedure room at each 30-minute interval, and number of personnel changes during the procedure.

There was a positive correlation between the length of the surgery and the number of personnel changes during the procedure, and a statistically significant increase in the number of personnel during spine procedures and procedures that lasted longer than 120 minutes. The researchers also noted a trend toward increased numbers of personnel during the middle of the procedure, especially during longer procedures. It was observed that personnel frequently entered the OR to check on the progress of the procedure, ask questions, or process paperwork. The researchers noted that these factors, in combination with frequent changes in personnel for breaks and shift changes, were a cause of distraction during the procedure, which could potentially lead to errors. Although this study was limited by its small sample size, the results support the need to limit the number of people and distractions in the OR during operative or other invasive procedures.\textsuperscript{62}

In a study evaluating whether the behaviors and number of OR personnel can predict the density of airborne bacteria at the surgical site, researchers measured the number of airborne particulates and viable bacteria during 22 joint arthroplasty procedures with a range of five to 12 team members in the OR. The results indicated a relationship between the number and activity of team members present in the periphery of the OR and the number of particulates and colony forming units at the surgical site. The researchers recommended minimizing the number of team members who are present during the procedure.\textsuperscript{101}

As part of a non-experimental study with two phases, researchers examined the levels of environmental contamination in ORs without personnel and the effect of unscrubbed persons on environmental contamination. The ORs without personnel showed a mean of 13.3 colony forming units per square foot per hour. When five persons wearing scrub suits, shoe covers, hoods, and masks were present, the number of colony forming units increased significantly to 447.3 per square foot per hour. The researchers concluded that people are the major source of environmental contamination in the OR.\textsuperscript{63}
In response to an unexplained increase in surgical site infections at one facility, an observational study was conducted to monitor and record behaviors in the OR. Researchers theorized that the number of door openings increased in direct proportion to procedure length, but also had an exponential relationship with the number of team members in the OR. They randomly selected and audited 28 procedures in multiple services (eg, cardiac, orthopedic, neurosurgery, plastic, general). Data collection included the

- number of people entering and exiting the procedure room,
- role of the individuals, and
- reason for entering the room.

Researchers found that the number of door openings in some spinal procedures was as high as one door opening per minute, and there was an average rate of 40 door openings per hour during total joint procedures. With such high numbers of door openings, researchers noted that it was conceivable the door to the OR could remain open for as long as 15 to 20 minutes per hour. The greatest number of door openings occurred during the preincision period, and the most frequent reason for the door opening was requests for information. Personnel entering and exiting the room for breaks accounted for approximately 25% of door openings across every specialty. Retrieving and delivering supplies accounted for approximately 20% of door openings, and the RN circulator was responsible for 37% to 50% of door openings. The cumulative effect of increased door openings is the potential for increased numbers of microorganisms and other contaminants in the air and the surgical site. The researchers also noted that frequent door openings are distracting and have the potential to lead to errors.\[153\]

In another study of door openings, researchers used an electronic door counter and computer software to calculate and analyze the number of door openings during 46 cardiac procedures. Perioperative team members were blinded to the study. The total number of door openings was 4,273. After adjusting for procedure length and the time required for the door to close, it was found that the door to the OR was open approximately 11% of every hour. A direct correlation was found between the length of the procedure and the frequency of door openings. The data also indicated a trend toward surgical site infections with increased frequency of door openings and patients of advanced age. The researchers hypothesized that increased numbers of personnel and door openings are a distraction to the surgical team and may lead to surgical errors.\[154\]

Recommendation IX

Perioperative team members should receive initial and ongoing education and competency verification on their understanding of the principles of and performance of the processes for sterile technique.

It is the responsibility of the health care organization to provide initial and ongoing education and to verify the competency of perioperative team members to deliver safe care to patients undergoing operative or other invasive procedures.\[2\]

Initial and ongoing education of perioperative personnel on the principles and processes of sterile technique facilitates the development of knowledge, skills, and attitudes that affect safe patient care.

Periodic education programs provide the opportunity to reinforce the principles and processes of sterile technique and to introduce relevant new equipment or practices.

Competency verification measures individual performance and provides a mechanism for documentation, and may verify that perioperative personnel have an understanding of the principles and processes of sterile technique.

IX.a. Perioperative team members should receive education and competency verification that addresses specialized knowledge and skills related to the principles and processes of sterile technique. \([1: \text{Regulatory Requirement}]\)

Specialized knowledge includes empirical knowledge (eg, technical understanding), practical knowledge (eg, clinical experience), and aesthetic knowledge (eg, patient advocacy).

Ongoing development of knowledge and skills and documentation of personnel participation is a regulatory and accreditation requirement for both hospitals and ambulatory settings.\[204,113\]

IX.a.1. Education regarding the principles and processes of sterile technique may include a review of the policies and procedures and protocols for

- surgical attire\[3\];
- surgical hand hygiene;\[4\]
- preparation of ORs or other procedure rooms;
- selection and evaluation of surgical gowns, gloves, and drape products;\[5\]
- assistance with operative or other invasive procedures;
- proper use of sterile gowns and gloves, including double gloving;
- proper use of sterile drape products;
- the use of sterile items during operative or other invasive procedures;
- preparation of a sterile field for patients undergoing operative or other invasive procedures;
- isolation technique;
RP: Sterile Technique

- how to introduce items to the sterile field, including the transfer of medications and solutions;
- how to maintain a sterile field, including recognition and correction of breaks in sterile technique;
- movement within and around a sterile field;
- the number of people who are permitted in the procedure room; and
- operative or invasive procedure documentation, including reporting of breaks in sterile technique.

IX.b. Perioperative personnel should receive education that addresses human factors related to the principles and processes of sterile technique. [2: Moderate Evidence]

Human factors includes the interpersonal and social aspects of the perioperative environment (eg, coordination of activities, teamwork, collaboration, communication). Effectively implementing the principles and processes of sterile technique requires that perioperative personnel demonstrate not only procedural knowledge and technical proficiency, but also demonstrate the ability to anticipate needs, coordinate a multitude of activities, work collaboratively with other team members, and communicate effectively.

In a synthesis of the literature on perioperative nursing competency published between 2000 and 2008, researchers identified two domains of perioperative competency:
- specialized knowledge, described as familiarity with standards and guidelines of perioperative practice, and
- human factors, described as interpersonal and social team interactions.

The researchers recognized teamwork and communication as important aspects of patient safety and indicators of perioperative competency. [111]

In a qualitative, focus group study exploring the perceptions of perioperative nurses on competency, researchers identified three themes:
- technical and procedural knowledge—the knowledge, psychomotor skills, and situational awareness required for competency in the perioperative setting;
- communication skills—the need for communication and team building skills, collegial support, and the ability to decipher and share complex clinical information; and
- managing and coordinating flow—the ability to anticipate needs, organize and prioritize resources, manage conflicts, and grasp the full perspective of the situation.

The findings of the study highlight the importance of human factors as a competency requirement for perioperative nurses. [117]

In a review of the literature exploring the cognitive and social skills used by scrub persons, researchers identified communication, teamwork, and situational awareness as the most valuable and relevant skills.

Communication is vitally important because of the need to listen and interpret what is being said, to clarify any issues that are unclear, and to convey critical information accurately. The need to communicate using eye contact and nonverbal cues and to speak up when necessary while working at the sterile field was recognized as a required skill for the scrub person.

Teamwork is an important skill because of the need for scrub persons to share information to aid the team and to establish good working relationships between team members.

Situational awareness is an important skill that includes the ability of scrub persons to anticipate the actions of the surgeon and to make decisions regarding the need for additional supplies or actions that must be taken, and to anticipate future requirements of the procedure. [118]

IX.c. Relative to the principles and processes of sterile technique, the perioperative RN should
- participate in ongoing educational activities;
- identify personal learning needs;
- seek experiences to acquire, maintain, and augment personal knowledge and skill proficiency;
- share knowledge and skills;
- communicate pertinent information to perioperative team members;
- contribute to a healthy work environment by using appropriate and courteous verbal and nonverbal communication techniques; and
- develop and implement conflict resolution skills to manage difficult behavior, promote positive working relationships, and advocate for patient safety. [2: Moderate Evidence]

Education, collegiality, and collaboration are standards of perioperative nursing and a primary responsibility of the perioperative RN who practices in the perioperative setting. [112]

Recommendation X

Nursing activities related to sterile technique should be documented in a manner consistent with health care organization policies and procedures and regulatory and accrediting agency requirements.

Documentation of nursing activities serves as the legal record of care delivery. Documentation of nursing activities is dictated by health care organization policy and regulatory and accrediting agency requirements and is necessary to inform other health care professionals involved in the patient’s care. Highly reliable data collection is not only necessary to chronicle patient responses to nursing interventions, but also to
demonstrate the health care organization’s progress toward quality care outcomes.113

X.a. Significant or major breaks in sterile technique that are not immediately corrected should be documented or reported per organizational policy in consultation with infection prevention personnel. [1: Regulatory Requirement]

Perioperative documentation that accurately reflects the patient experience is essential for the continuity of outcome-focused nursing care and for effective comparison of realized versus anticipated patient outcomes.113

Effective management and collection of health care information that accurately reflects the patient’s care, treatment, and services is a regulatory and accreditation requirement for both hospitals and ambulatory settings.104-105,110-112

Recommendation XI

Policies and procedures for the implementation of sterile technique should be developed, reviewed periodically, revised as necessary, and readily available in the practice setting.

Policies and procedures assist in the development of patient safety, quality assessment, and performance improvement activities. Policies and procedures establish authority, responsibility, and accountability within the organization. Policies and procedures also serve as operational guidelines that are used to minimize patient risk for injury or complications, standardize practice, direct perioperative personnel, and establish continuous performance improvement programs.

XI.a. Policies and procedures regarding the implementation of sterile technique should be developed. [1: Regulatory Requirement]

Policies and procedures that guide and support patient care, treatment, and services is a regulatory and accreditation requirement for both hospitals and ambulatory settings.104-105,110-112

XI.a.1. Policies and procedures regarding the principles and processes of sterile technique may include:
- surgical attire3;
- surgical hand hygiene4;
- selection and evaluation of surgical gowns, gloves, and drape products27;
- proper use of sterile gowns and gloves, including double gloving;
- proper use of sterile drape products;
- isolation technique;
- the numbers of people who are permitted in the OR or other procedure room; and
- reporting of breaks in sterile technique.

Recommendation XII

Perioperative personnel should participate in a variety of quality assurance and performance improvement activities that are consistent with the health care organization’s plan to improve understanding of and compliance with the principles and processes of sterile technique.

Quality assurance and performance improvement programs assist in evaluating and improving the quality of patient care and formulating plans for corrective actions. These programs provide data that may be used to determine whether an individual organization is within benchmark goals and, if not, to identify areas that may require corrective actions.

XII.a. Performance improvement activities for sterile technique should include monitoring personnel for understanding of the principles of and compliance with the processes of sterile technique. [1: Regulatory Requirement]

Collecting data to monitor and improve patient care, treatment, and services is a regulatory and accreditation requirement for both hospitals and ambulatory settings.104-105,110-112

XII.a.1. Process monitoring for activities related to sterile technique may include monitoring compliance with policies and procedures for
- surgical attire3;
- surgical hand hygiene4;
- preparation of the OR or other procedure room;
- selection and evaluation of surgical gowns, gloves, and drape products27;
- performance of or assistance with operative or other invasive procedures;
- proper use of sterile gowns and gloves, including double gloving;
- proper use of sterile drape products;
- isolation technique;
- introduction of items to the sterile field, including transfer of medications28 and solutions;
- recognition and correction of breaks in sterile technique;
- movement within and around a sterile field;
- the number of people permitted in the OR or other procedure room; and
- reporting of breaks in sterile technique.

XII.a.2. The quality assurance and performance improvement program for sterile technique should include
- periodically reviewing and evaluating activities to verify compliance or to identify the need for improvement,
- identifying corrective actions directed toward improvement priorities, and
- taking additional actions when improvement is not achieved or sustained.

Reviewing and evaluating quality assurance and performance improvement activities may identify failure points that contribute to errors in sterile technique and help define actions for improvement and increased competency.
Taking corrective actions may improve patient safety by enhancing understanding of the principles of and compliance with the processes for sterile technique.

XII.b. Perioperative RNs should participate in ongoing quality assurance and performance improvement activities related to sterile technique by
- identifying processes that are important for quality monitoring (eg, double gloving);
- developing strategies for compliance;
- establishing benchmarks to evaluate quality indicators;
- collecting data related to the levels of performance and quality indicators;
- evaluating practice based on the cumulative data that are collected;
- taking action to improve compliance; and
- assessing the effectiveness of the actions taken.

[2: Moderate Evidence]

Participating in ongoing quality assurance and performance improvement activities is a standard of perioperative nursing and a primary responsibility of the perioperative RN who is engaged in practice in the perioperative setting.2

Glossary

Aseptic: The absence of all pathogenic microorganisms. Synonym: sterile.

Aseptic practices: Patterns of behavior and processes that are implemented to prevent microbial contamination.

Assisted gloving: Technique used when changing a contaminated glove. One scrubbed team member assists another to don a new sterile glove by touching only the outside of the new sterile glove when applying the glove to another scrubbed team member’s hand.

Barrier material: Material that minimizes or retards the penetration of microorganisms, particulates, and fluids.

Closed assisted gloving: Technique for donning sterile gloves during which the gown cuff of the team member being gloved remains at or beyond the fingertips. The glove to be donned is held open by a scrubbed team member, while the team member being gloved inserts his or her hand into the glove with the gown cuff touching only the inside of the glove.

Closed gloving: Technique used when donning surgical gloves. The scrubbed team member dons the gloves without assistance by keeping his or her hands inside the gown sleeves.

Colony forming unit: A measure of the number of viable bacterial cells in a sample.

Event-related sterility: Concept that the sterility of an item does not change with the passing of time but may be affected by particular events (eg, amount of handling), or environmental conditions (eg, temperature, humidity).

Invasive procedure: The surgical entry into tissues, cavities, or organs, or the repair of major traumatic injuries.

Isolation technique: Instruments and equipment that have contacted the inside of the bowel, or the bowel lumen, are no longer used after the lumen has been closed. Clean instruments are used to close the wound. The contaminated instruments and equipment are either removed from the sterile field or placed in a separate area that will not be touched by members of the sterile team. Synonyms: bowel technique, contamination technique.

Open assisted gloving: Technique for donning sterile gloves during which the gown sleeve of the team member being gloved is pulled up so that the gown cuff is at wrist level, leaving the fingers and hand exposed. The glove to be donned is held open by a scrubbed team member, while the team member being gloved inserts his or her hand into the glove without touching the outside of the glove.

Open gloving: Technique used to don sterile gloves without assistance. The cuff of each glove is everted to allow the team member to don sterile gloves by touching only the inner side of the glove with ungloved fingers and the outer sterile side of the glove with gloved fingers.

Perforation indicator system: A double gloving system comprising a colored pair of surgical gloves worn beneath a standard pair of surgical gloves. When a glove perforation occurs, moisture from the surgical field seeps through the perforation between the layers of gloves, allowing the site of perforation to be more easily seen.

Sterile: The absence of all living microorganisms. Synonym: aseptic.

Sterile field: The area surrounding the site of the incision or perforation into tissue, or the site of introduction of an instrument into a body orifice that has been prepared for an invasive procedure. The area includes all working areas, furniture, and equipment covered with sterile drapes and drape accessories, and all personnel in sterile attire.

Sterile technique: The use of specific actions and activities to prevent contamination and maintain sterility of identified areas during operative or other invasive procedures.

Surgical hand scrub: Antiseptic hand wash or antiseptic hand rub performed preoperatively by perioperative personnel to eliminate transient bacteria and reduce resident hand flora.

Surgical helmet system: An unsterile, reusable helmet with a built-in ventilation fan covered with a single-use, disposable sterile visor mask hood. The unsterile helmet is donned before the surgical hand scrub is performed. The sterile visor mask hood that covers the unsterile helmet is applied during the gowning and gloving process.

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Aseptic Practice

RP: Sterile Technique


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Acknowledgments

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Evidence ratings revised 2013 to conform to the AORN Evidence Rating Model.
SECTION IX

UMC Exposure Protocol
Sunrise Exposure Protocol
Required Forms
Below are the instructions for a Healthcare Worker (HCW) after a potential blood borne pathogen (BBP) exposure. If you have any questions or concerns about this process, please page Infection Control / Employee Health at 702-381-0157 for assistance. Someone is available 24 hours a day, 7 days a week.

Step 1: Wash any exposed skin with soap and water; flush any exposed mucous membranes (eyes, nostrils, or mouth) with water. Do NOT squeeze the site.

Step 2: Contact your immediate supervisor. If you are not a UMC employee (i.e. contractor, physician, resident, etc.), please contact the UMC supervisor in the unit / department where the exposure occurred.

Step 3: Complete a Notification of Injury (C-1) form. Once you have completed the top section of the form, give it to the supervisor you notified in Step 2 (above) to complete the bottom section. When they have completed the form, you should be given a copy.

Step 4: Do ONE of the following:
- If you are a UMC employee, call CORVEL (877-764-3574)
- If you are NOT an employee (i.e. contractor, physician, resident, etc.), proceed to the next step.

Step 5: The supervisor who is assisting you is responsible for filling out a Healthcare Worker Exposure Notification (NMU02499) form and determining if there is a source patient for a blood draw. The supervisor will instruct you to go to the Trauma ED to be evaluated for a blood borne pathogen exposure. Please bring your completed copy of the C-1 and the NMU02499 form with you to the Trauma ED.

Step 6: The Trauma ED will determine the best course of action following an exposure. It is important to get tested as soon as possible, since sometimes medication is necessary and may need to be started right away.

Step 7: You will receive a follow-up call from Employee Health within 72 hours. Post-exposure follow-up care is available through UMC Enterprise Quick Care (located at: 1700 Wheeler Peak Dr., Las Vegas, NV 89106) during the hours of 8:00am-5:00pm. To schedule an appointment, please call 702-383-2565.

What is a blood borne pathogen (BBP) exposure?

An exposure occurs when a person has been exposed to blood or other body fluids that transmit blood borne pathogens (a) and has a port of entry (c) for potentially contaminated fluids to enter the body. Blood borne pathogens are Hepatitis B, Hepatitis C and HIV.

a. Body fluids that DO transmit BBP: Blood, cerebral spinal fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, semen, vaginal fluids, amniotic fluids, and breast milk.

b. Body fluids that DO NOT* transmit BBP: Saliva, vomit, urine, feces, sweat, tears and respiratory secretions. *(Unless they contain VISIBLE blood, these fluids are not considered a BBP exposure.)

c. Port of Entry: The means by which potentially contaminated blood or other body fluid can enter your body. There are 3 ports of entry - percutaneous injury (needle stick or cut with a sharp object); contact of mucous membrane (eyes, mouth, or nostrils); or contact with non-intact skin (e.g. chapped, abraded, dermatitis, etc.).

d. Source: The person to whom the Healthcare Worker was exposed. If the source is known and is available, their blood will be drawn for testing.

(see reverse for additional information)
What are the potential risks following a BBP exposure?

a. **Hepatitis B Virus (HBV):**
   - Healthcare Workers who have received a Hepatitis B vaccine and who have developed immunity to the virus are at virtually no risk for infection.
   - *For an unvaccinated person, the risk from a single needle-stick or a cut exposure to HBV-infected blood ranges from 6%–62%* and depends on the Hepatitis B e antigen (HBeAg) status of the source individual.
   - Individuals who are both Hepatitis B surface antigen (HBsAg) positive and HBeAg positive have more of the virus in their blood and so are more likely to transmit HBV.

b. **Hepatitis C Virus (HCV):**
   - Based on limited studies, the estimated risk for infection after a needle stick or cut exposure to HCV-infected blood is approximately 1.8%.
   - The risk following a blood splash is unknown but is believed to be very small; however, HCV infection from such an exposure has been reported.

c. **Human Immunodeficiency Virus (HIV):**
   - The average risk for HIV infection after a needle-stick or cut exposure to HIV-infected blood is 0.3%, or approximately 1 in every 300 people who have been exposed. Stated another way, 99.7% of needle-stick or cut exposures to HIV-contaminated blood DO NOT lead to infection.
   - The risk after exposure of HIV-infected blood to a mucous membrane (e.g. eyes, nose, or mouth) is estimated to be, on average, 0.1% (or 1 in 1,000).
   - The risk after exposure of non-intact skin to HIV-infected blood is estimated to be less than 0.1%, while a small amount of blood on intact skin probably poses no risk at all.
   - There have been no documented cases of HIV transmission due to an exposure involving a small amount of blood for a short amount of time on intact skin (i.e. a few drops of blood on intact skin for a brief period of time); however, the risk may be higher if the skin is damaged (e.g. by a recent cut), if the contact involves a large area of skin, or if the contact is prolonged.
Healthcare Worker Post Exposure Instructions

All Healthcare workers must follow-up with a healthcare provider within 72hrs to receive lab work results for yourself and source patient.

WHERE TO GO FOR FOLLOW UP

All UMC employees must follow up at Enterprise Quick Care.

UNLV employees (Residents, Attending’s, etc.) may follow-up at Enterprise Quick Care.

- Please call Enterprise ASAP at 702-383-2565 ext. 1 to schedule your follow-up appointment. Walk-ins are also available. 1700 Wheeler Peak, 89106

All other healthcare workers must contact their workers compensation carrier or their primary care provider. Follow up care is available at UMC Enterprise if desired.

PRESCRIPTIONS

All UMC employees and UNLV employees have a first fill card for your prescription. A first fill card is available from Corvel. They may text you the form or a form is available in the HCW packet on the UMC Employee Health page.

All other healthcare workers must use their workers compensation carrier or their insurance provider.

OTHER INSTRUCTIONS

For all known HIV exposures, unknown source or when lab results are unavailable -

- Precautions must be used to prevent secondary transmission during the first 16 weeks of an unknown or positive HIV exposure. Precautions include
  - The use of barriers during sexual intercourse
  - Avoiding blood and tissue donations
  - Avoiding pregnancy and breast feeding if possible.

Exposures to Hep C or Hep B do not require any lifestyle changes.

Please call Employee Health/Infection Control at UMC if you are having trouble navigating this process: Beeper 702-381-015
SUNRISE BBP PROTOCOL

What to do if you have an exposure to blood and/or body fluid:

- Wash the affected area immediately.
- Report the incident to your supervisor or the House Supervisor
  Call 0 Page to the House Supervisor

They will direct you to the proper process and forms.
"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
School of Medicine
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer: Nevada System of Higher Education

<table>
<thead>
<tr>
<th>Name of Employee</th>
<th>Social Security Number</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Date of Accident (if applicable)

Time of Accident (if applicable)

Place where accident occurred (if applicable)

What is the nature of the injury or occupational disease?

List any body parts involved:

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

ATTENTION: If you suffer a puncture wound from a contaminated needle or sharp, please include the following information:

BRAND: __________________

TYPE: __________________

IF UNKNOWN, CHECK HERE: ☐

Names of witnesses:

Did the employee leave work because of the injury or occupational disease?

YES ☐ NO ☐

If yes, when (date and time)?

Has the employee returned to work?

YES ☐ NO ☐

If yes, when (date and time)?

Was first aid provided?

YES ☐ NO ☐

If yes, by whom?

Name and address of treating physician, if applicable or known

Did the accident happen in the normal course of work? (if applicable)

YES ☐ NO ☐

Was anyone else involved?

YES ☐ NO ☐

Names of others involved

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature Date Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Website: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

Employee should sign, date and retain a copy.

Original to BCN Workers' Compensation Office (MS 241), Copy to Employee

Page 410
BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any medical costs related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the Department of Administration, Hearing Officer, by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the Department of Administration, Appeals Officer. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a petition for judicial review with the District Court. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1050 E. William Street, Suite 213, Carson City, NV 89701, (775) 687-4076, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830

To File a Complaint with the Division: If you believe you have been wronged by an insurance company, you may file a complaint with the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For assistance with Workers' Compensation Issues: you may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101. Toll Free: 1-888-333-1597, Web site: http://govcha.state.nv.us, E-mail: cha@govcha.state.nv.us

D-2 (rev. 11/05)
# Employee's Claim for Compensation/Report of Initial Treatment

**Form C-4**

**PLEASE TYPE OR PRINT**

## Employee’s Claim – Provide All Information Requested

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Birthdate</th>
<th>Sex</th>
<th>Claim Number (Insurer’s Use Only)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Age</th>
<th>Height</th>
<th>Weight</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Telephone</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Primary Language Spoken</th>
</tr>
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<tbody>
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</tbody>
</table>

## Insurer

**Third-Party Administrator**

<table>
<thead>
<tr>
<th>Employer’s Name/Company Name</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Office Mail Address (Number and Street)</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Injury (if applicable)</th>
<th>Hours Injury (if applicable)</th>
<th>Date Employer Notified</th>
<th>Last Day of Work After Injury or Occupational Disease</th>
<th>Supervisor to Whom Injury Reported</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Address or Location of Accident (if applicable)</th>
<th></th>
</tr>
</thead>
</table>

**What were you doing at the time of the accident? (if applicable)**

**How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)**

**If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?**

<table>
<thead>
<tr>
<th>Witnesses to the Accident (if applicable)</th>
<th></th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Nature of Injury or Occupational Disease</th>
<th>Part(s) of Body Injured or Affected</th>
</tr>
</thead>
<tbody>
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</table>

**I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA’S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.**

## This Report Must Be Completed and Mailed Within 3 Working Days of Treatment

<table>
<thead>
<tr>
<th>Date</th>
<th>Place</th>
<th>Employee’s Signature</th>
</tr>
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<tbody>
<tr>
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</table>

## Diagnosis and Description of Injury or Occupational Disease

<table>
<thead>
<tr>
<th>Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident?</th>
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</thead>
<tbody>
<tr>
<td>☐ No  ☐ Yes (if yes, please explain)</td>
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<table>
<thead>
<tr>
<th>Treatment:</th>
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<tr>
<th>X-Ray Findings:</th>
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<thead>
<tr>
<th>From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes  ☐ No</td>
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<table>
<thead>
<tr>
<th>Is additional medical care by a physician indicated?</th>
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<tr>
<th>Do you know of any previous injury or disease contributing to this condition or occupational disease?</th>
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<tbody>
<tr>
<td>☐ Yes  ☐ No (Explain if yes)</td>
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</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Print Doctor’s Name</th>
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| Address | |
|---------||
|         | |

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Provider’s Tax I.D. Number</th>
<th>Telephone</th>
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<table>
<thead>
<tr>
<th>Doctor’s Signature</th>
<th>Degree</th>
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</tbody>
</table>

**INSURER’S USE ONLY**

**Form C-4 (rev.10/07)**

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**University of Nevada Las Vegas**

School of Medicine

Department of Obstetrics & Gynecology

Resident Handbook

**412**
SECTION X

Addendum’s
Policy: Common Circumstances Requiring Faculty Involvement

Purpose: To outline the OB/GYN residency Program’s policy defining common circumstances requiring faculty involvement

Policy:

- **Intensive Care**
  Unit PGY1 residents cannot independently care for critically ill patients/ICU patients. All senior residents must see all critically ill patients and note their findings in the patients’ record. All critically ill patients on ICU must get checked out with an attending intensivist either in person or through the eICU.

- **Do Not Resuscitate Orders**
  PGY1 residents are not allowed to complete a DNR. This must be completed by a PGY2 or above and must be discussed with an attending within 24 hours of completion.

- **OB/GYN services**
  An OB/GYN faculty member is on call and in the hospital 24 hours a day to teach and assist all residents. An additional OB/GYN faculty member is in the clinic to teach and assist residents during the entire day. (Incoming GYN faculty rounds on clinic GYN patients with the residents. Incoming OB faculty rounds on complicated OB patients with the residents). Open lines of communication are important and encouraged.

  All faculty must be notified within hours of admitting. All faculty must be notified on any significant change of the patient. No patient is to go to the Operating Room without faculty notification and participation.

- **End of Life Decisions**
  The resident and faculty are both present for all discussions about hospice care for clinic patients. In addition, residents and faculty are both present most of the time for private inpatient talks

- **Back-up mechanisms**
  There are well established back-up mechanisms to help residents when patient care volume exceeds their ability to provide quality care. First, the in-house attending becomes more hands on to take care of the work load burden. The Maternal Fetal Medicine faculty member who is on call from home will come to the hospital to assist the attending and residents on the obstetrical service and the Gynecologic oncologist will come to the hospital to assist the attending and residents with gynecologic care.
University of Nevada Las Vegas, School of Medicine
Conflict of Interest

University of Nevada Las Vegas, School of Medicine is committed to maintaining a scholarly and educational environment that actively monitors and manages conflict of interest. In 2009, the School developed new policy and is working to create procedures for review and disclosure of Conflict of Interests.

Conflict of Interest Policy

This policy applies to part-time and full-time faculty, residents, medical students and staff at the University of Nevada Las Vegas, School of Medicine and the UNSOM Practice Plan. It is a supplement to the University of Nevada Las Vegas, policy found at: http://www.

Everyone covered under this policy will be required to make a full disclosure of all industry affiliations. Such disclosures will be displayed on a publicly accessible website.

No industry representatives are permitted to market their products on University of Nevada Las Vegas, School of Medicine grounds or clinics unless invited to do so by the department chair. Representatives may only meet with faculty by appointment in faculty offices. Faculty are not allowed to participate in industry marketing activities such as participation on a speakers bureau.

No gifts (1) (including food, office supplies, scholarships or non-CME training funds) from industry are permitted. Travel support must be disclosed and approved by the COI committee. Pharmaceutical samples are restricted to those required for patient education. Any exceptions must be approved by the UNSOM Compliance Officer. Industry supported meals are prohibited.

No restricted (2) funding of CME will be permitted. We will work towards a centralized CME account.

No ghost-written or ghost-analyzed scholarly products are permitted. Sponsors of research will have no editorial rights over manuscripts or abstracts. University researchers will track the sponsor’s use of clinical data and will include in all protocols the right to analyze and publish or publicize results of clinical research in the event that a sponsor does not publish them within two years of the conclusion of the study.

No industry produced teaching materials will be permitted for medical students or residents and instructors will share all teaching materials with educational coordinators.

All practice plan purchasing decisions will exclude individuals with potential industry conflicts.

All trainees will receive instruction on these institutional policies and how industry promotion can influence clinical judgment.

(1) All gifts regardless of value
(2) This indicates that industry may not direct or restrict the content or the speaker for CME activities
RESIDENT LEAVE REQUEST FORM - RESIDENT PHYSICIANS AND DENTISTS

1. NAME: ____________________________________________
2. TITLE: Resident Physician   PGY Level _____

3. DIVISION: MDDN-UNSOM  4. DEPT: OB/GYN

5. I Request From: ___________________________ Through ___________________________ # of Days __________

5a. This request replaces leave requested from: ___________________________ To: ___________________________ or N/A □

6. CHARGED AS FOLLOWS (explain in remarks):
   □ Annual Leave  □ Sick-Self  □ Sick-Family
   □ Sick- Death in the Family  □ Family/Medical Leave  □ Leave Without Pay (requires prior approval)
   □ Educational (explain in remarks)  □ Other (explain in remarks, i.e., administrative, military, civil, etc.)

REMARKS: ______________________________________________________

Note: Medical absences of extended duration might fall under the Family and Medical Leave Act (FMLA).

7. To the best of my knowledge, the facts stated above are accurate and comply with leave requirements.

Employee's Signature: ___________________________ Date Submitted: ______________

8. APPROVAL by Chief Resident: □ Approved □ Denied

Signature: ___________________________ Date: ______________
Reason for denial/conditions: ____________________________________________________________

9. APPROVAL by Program Director: □ Approved □ Denied

Signature: ___________________________ Date: ______________
Reason for denial: ________________________________________________________________

Posting by Coordinator: ___________________________ Date: ______________

SPECIAL SECTION FOR PROGRAM REQUIREMENTS:

Out--of-town Rotation ______ Administrative leave/boards/other_______ Rotation away from FCM clinic obligation ______
Posted to schedule: ______ added after issue: ______ Nurse Supervisor __/______ Front Off Supervisor ______

Additional remarks: ___________________________

INSTRUCTIONS: This form must be completed in advance of leave except for illness, in which case the leave request must be completed and transmitted no later than two days after return to work. The original must be kept in the departmental records and posted to the leave record, and a copy returned to the employee after final action. NOTE to Coordinators: Annual and sick leave must be earned before it can be taken, refer to Board of Regents leave policy for Resident Physicians and Dentist. For Resident Physicians and Dentists, the Program Director and DIO of Graduate Medical Education signatures are necessary in cases of extended sick leave and require a health certification and appointing authorities approval.

I understand I am responsible to inform my Preceptor & Hospital Medical Records Department, update all hospital/clinic medical records before leaving and check my clinic schedule prior to leave as confirmation of this request being received and approved.

Revised caa 7/2010
GMEC - Statement of Policy Regarding Resident Pagers

Resident pagers are an important but expensive item available to and provided for residents beginning in their training. However, loss, or damage that cannot be repaired is the responsibility of the resident. The program will make an appropriate effort to have these pagers replaced without charge if they are lost, stolen, or damaged beyond repair. This effort will be made on behalf of the resident for the first incident only. In the event that the hospital is unable to reimburse for a pager, the cost will become that of the resident. Such cost may be assessed to the resident as an obligation to be fulfilled prior to successful completion of the residency program.
Recruitment, Selection, Matriculation
Department of Obstetrics and Gynecology
University of Nevada Las Vegas, School of Medicine

I. Pre-interview
A. Applicants do research to gather information on programs through their Medical Schools, FRIEDA, AMA, and various other resources.
B. When they call our program about information the coordinator answers any questions and directs them to our website for follow up information.

II. Selection and Interview
A. Candidates communicate with the Program through ERAS.
B. To be eligible candidates must have graduated from a medical school listed in the World Directory of Medical Schools at the time of their graduation.
C. For consideration for selection in the program, all documentation and forms must be complete and accessible in the ERAS system by November 1 of the current year for consideration.
D. Selection Process
   1. All candidates are reviewed through ERAS applications.
   2. An Application Review Committee considers ERAS applications for interview selection. They decide suitability of applicants for interview by ranking them based upon academic and personal credentials.
   3. Candidates selected for interview are interviewed by the Program Director, or the Department Chair, another faculty member and a resident. They have interaction with all available residents throughout the morning of their interviews. There is also a dinner with all residents and candidates the night before each interview date.
   4. All ERAS and interview information is compiled on all interviewed candidates for comparison purposes.
   5. When all interviews are complete, interviewing faculty and residents meet to discuss and rank all applicants with final approval by the Program Director. Critical determinants of acceptability are academic accomplishments, attitude, personal and communication qualities, interest and knowledge about the program, and experiences and interests beyond medicine.
   6. The program utilizes the NRMP exclusively.

E. Other
   1. The program observes the Affirmative Action / Equal Opportunity and Anti-Discrimination policies of the University of Nevada Las Vegas, in selection processes.

III. The Match
A. Candidates match with our program.
   1. Director calls to give them an informal welcome.
   2. Welcome letter from Chair and Director are sent.

IV. Matriculation
A. In April the matriculating paperwork begins through the New Innovations software system
   1. Letter of understanding regarding the grounds for hiring is sent with the initial information regarding the process for the hiring paperwork. This must be returned to the Coordinator with original signature.

B. Mandatory Training and Classes
   1. Two weeks before July 1 mandatory training and classes are held for all new residents to attend in preparation for their employment.
C. Orientation by the Graduate Medical Education office.
   1. Held during the two weeks before actual start date.
      a. Receive Graduate Medical Information regarding residency

D. Orientation by the OB/GYN Program
   1. Held on July 1 or shortly before
      a. Residency Director welcomes new residents and reviews the program.
         b. New Residents receive tools i.e.: Id card, beepers, lab coats, stamps and
            program level paperwork to complete the initial hiring process.

E. They begin their residency.