



**a place of mind**

THE UNIVERSITY OF BRITISH COLUMBIA

# **UBC Neurosurgery Resident Handbook 2011 - 2012**

# Table of Contents

Calendar of events 2011-2012 .....	3
Summary of the Division of Neurosurgery .....	4
Academic Activities	
Vancouver General Hospital .....	4
BC Children's .....	8
Research projects .....	9
BC Neuosciences Day .....	9
Wet Lab dissection sessions .....	9
Resident Research Day .....	9
Clinical Responsibilities .....	10
Chief resident .....	10
Log of procedures .....	10
BC Children's Hospital .....	11
Off Site rotations .....	11
Lions Gate Hospital .....	11
Victoria General Hospital .....	11
Elective Rotations .....	12
Resident Evaluations .....	12
Trainee Evaluation of Program .....	12
Vacation and Leave .....	13
Statutory Holidays .....	14
Resident Education Funds .....	15
Funded Courses .....	15
Presentation of Paper at Meetings .....	15
Travel expense guidelines .....	16
Community Rotations Reimbursement policy	
UBC Accommodation Policy for distributed training sites .....	17
Payroll information .....	18
On-call / Chief allowances	
Parking Passes to on-call residents	
Maternity and Paternal Leaves	

Personal and extended sick leave	
Harassment Issues – Equity Office .....	21
Communication .....	21
Phone numbers	
Address Changes.....	22
Frequently asked questions .....	24
<b>APPENDIX</b>	
Resident Evaluation and Appeals Policy Faculty of Medicine, University of British Columbia.....	25
T-RES.....	34
Specialty Training Requirements in Neurosurgery – Royal College.....	36
Teaching by Residents in the Undergraduate .....	37
Information for Residents & Fellows about Medical Student Feedback on Clinical Teaching .....	38
Resident Transfers.....	39
Physician Documentation.....	40
Medication Reconciliation for Elective Surgery.....	42

## Calendar of Events 2011-2012

July 1, 2011	Start of the academic year
November	4th Annual Resident Research Day
January or February	CaRMS Interviews
January or February	Royal College Neurosurgery Practise Exam
March	CaRMS Match Day
March	BC Neuroscience Day - Peter Moyes lecture
May	RCPSC Neurosurgery Condensed Examination (R6) Resident Sports Day and Department of Surgery Graduation Day
June 30, 2012	End of academic year

# Summary of the Division of Neurosurgery

The Division of Neurosurgery at the Vancouver General Hospital I (VGH) is the major adult neurosurgical service in the Vancouver Coastal Health Authority associated with the University of British Columbia, Faculty of Medicine. More than 1500 are treated as inpatients, many are complex cases requiring specialized care referred from other neurosurgical units. There are approximately 5000 ambulatory patients visits at the Neurosurgery Clinic at the Gordon and Leslie Diamond Health Care Centre and the Neuro-Oncology Clinic at the BC Cancer Agency

Subspecialty programs and Clinics are provided in the following areas:

- Cerebrovascular Surgery
- Epilepsy Surgery
- Interventional Neuroradiology
- Major Peripheral Nerve Surgery
- Neuro-Endocrine Surgery
- Neuro-Oncology
- Skull Base Surgery
- Stereotactic and Functional Neurosurgery
- Stereotactic Radiosurgery

**Neurosurgical ward:** T5 and T6, Jim Pattison Pavilion South Tower, VGH  
Consists of 40 ward beds plus an eight bed neurosurgical intensive care unit (T5A).

**Resident Ward Rounds:**  
0630-0745 Mon. to Fri 0800-0900 Sat. and Sun.

Round is conducted with the nursing staff. The priorities are to see all patients in the ICU, all immediate postoperative cases, and to attend to nursing concerns for the day. Those residents preparing to be in the operating room should be there by 0745 hours

## Academic Activities

### Monday

0700-0800 **Spine Rounds**  
Conducted weekly with all members of the unit: new case presentations, and review.  
Mandatory for residents on the spine service (optional/encouraged for residents on other rotations)

1330-1430 **Epilepsy Rounds**  
Multidisciplinary case discussions attended by Neurosurgery, Neurology, Neuroradiology, and Neuropsychology. (These rounds are not mandatory but resident attendance is encouraged for those not involved in the OR during this time.)

### Wednesday

A full academic day. No elective operations are scheduled. All residents are requested to give the Wednesday activities their utmost priority and are excused from clinical duties. Attending staff at each

institution are expected to cover call and perform any emergency surgery without resident assistance during these times.

- 0700-0800 **Department of Surgery Grand Rounds.** (monthly)
- 0800-0900 **Neuroscience Grand Rounds**  
A multidisciplinary Grand Rounds, attended by Neurosurgery, Neurology, Neuroradiology, Neuropathology, Neuro-Ophthalmology, as well as associated disciplines such as nursing, physiotherapy, occupational therapy, speech therapy, social work, and psychology. Clinical or basic science topics are presented by the teaching faculty of one the Neuroscience disciplines or, frequently, a visiting professor.
- 0900-1000 **Case Presentation or a Clinical Pathological Conference (CPC)**  
Presented by a neurosurgical or neurology resident, assigned on a rotation basis. The case presentation should involve participation by the audience and be concluded by a discussion on the topic of presentation.
- 1000-1230 **BC Children's Hospital Morbidity / Mortality Conference**  
These rounds occur every 6 months at the BC Children's Hospital. The on-service Pediatric Neurosurgery resident presents all in-patient cases/complications for discussion. Each complication/death is discussed in detail. Emphasis is placed on those aspects of complications that represent areas in which practice can be modified to prevent future complications of a similar nature. These rounds are attended by all of the Neurosurgical attending staff and residents.
- 1010-1045 **Professor's Rounds**  
The attending neurosurgeons, on a rotating basis, present case management problems to the neurosurgical residents, usually in an oral exam type format. An emphasis is made on the teaching points. At the faculty's discretion, the format of these rounds may be varied.
- 1045-1125 **Correlative Rounds**  
Cases selected and presented by the Chief Resident to the neurosurgical staff and residents, selected for discussion because of their educational value with respect to management issues, surgical approaches and strategies, pathology, and post-operative care as well as outcome. Emphasis is placed on correlation of neuroanatomy, imaging, pathology, operative strategy, and complication avoidance.
- 1130-1200 **Morbidity / Mortality Conference**  
At this weekly Quality Assurance Ward Audit, the management and course of all in-patients is discussed, including all operative and other major procedures, and all complications. Each death is discussed in detail. Emphasis is placed on those aspects of complications that represent areas in which practice can be modified to prevent future complications of a similar nature. These rounds are attended by all of the Neurosurgical attending staff and residents as well as the Head Nurse and a data analyst from QUIST (Quality Utilisation and Information Support Team). This is a source of material which can serve as the basis for a variety of resident research projects and quality assurance reviews.
- 1230-1400 **Journal club**  
These rounds which occur every second Wednesday of every month are a forum to discuss current journal articles as selected by the Chief resident. Presentation of the articles are done on a rotating basis by the residents. (lunch provided)
- 1300-1600 **Resident Ambulatory Care Clinic**

The residents attend an outpatient Neurosurgery Clinic in the Academic Ambulatory Care Centre. New consultations as well as follow up visits with patients with whom they have been involved are seen under the supervision of one of the faculty neurosurgeons.

1300-1400 **Stereotactic Radiation Conference**

Weekly case conference conducted at BC Cancer Agency adjacent to VGH. Clinical cases with their pathology and radiology are reviewed by a multidisciplinary team for recommendations regarding appropriateness for focused radiation treatments. (These rounds are not mandatory but resident attendance is encouraged for those not involved in other activities.)

1700-1800 **Department of Surgery 512/513 Resident Seminar Series**

A seminar series with topics selected based on the Objectives of Training and Specialty Training Requirements in Neurosurgery and the CanMEDS roles. The seminar is presented by one of the residents, assigned on a rotating basis, under the supervision of one of the neurosurgical teaching faculty or an invited guest. For example, there are topics on medical ethics, in which an ethicist is invited to supervise, and topics on communication, and dealing with interpersonal conflicts, supervised by a social worker with expertise in these areas. The residents are to meet with the supervisor well in advance of the seminar in order to discuss specific objectives and to receive guidance in the selection of resources and background material. The Program Director spends at least one session at the beginning of each academic year going over the program's goals and objectives with all of the residents, reviewing the CanMEDS competencies, and all of the UBC postgraduate policies relevant to their training. These sessions have also been used for discussions on topics of health advocacy such as law and policy relating to drinking and driving, mandatory use of helmets, and restraint devices, competency and consent, and withdrawal of care.

**Friday**

0800-0900 **Brain Tumour Conference**

A weekly case conference conducted at the BC Cancer Agency, adjacent to VGH. Clinical cases are reviewed with their pathology in the context of a multidisciplinary setting for management recommendations. Dr. Toyota is the Provincial Chair of Neuro-Oncology and supervises these sessions. (These rounds are not mandatory but resident attendance is encouraged for those not involved in the OR during this time.)

Other organized scholarly activities (e.g., specialized teaching sessions, courses, and seminars relevant to the specialty)

Each attending staff makes rounds on his patients at some time throughout the day, but because of the nature of clinical practice, this may not occur at a regular time. Residents should take the opportunity to go on round with attending staff, and to use this opportunity to ask questions and draw out an exchange of ideas.

## **BC's Children's Hospital**

### **Monday**

- 0730-0830      **Neurosurgery Teaching Rounds**  
Formal rounds in the radiology library with all members of the neurosurgical staff present.
- 0900-1700      **Pediatric Outpatient Clinic**  
The resident attends an outpatient pediatric neurosurgery clinic in association with the attending staff.

### **Wednesday**

- The pediatric neurosurgical resident is required to attend Neuroscience Grand Rounds, Case Presentation, Professor's Rounds, Correlative Rounds and the Postgraduate Seminar. In addition:
- 1215-1315      **Pediatric Neuroradiology Rounds**  
This weekly teaching session is run by the Pediatric Neuroradiologists.
- 1330-1500      **Pediatric Epilepsy Conference or Clinic**  
A multidisciplinary conference to discuss patients potentially requiring surgical treatment for epilepsy. This conference alternates with a clinic, where patients are assessed prior to and after surgery for epilepsy.

### **Thursday**

- 0900-1230      **Spina Bifida Clinic**  
This is a multidisciplinary clinic for children with myelomeningocele and associated types of abnormalities. The neurosurgical attending staff and resident will attend the clinic to perform neurosurgical follow up assessments of these patients.
- 1300-1400      **Oncology Case Discussions**  
The resident will attend this round when any neuro-oncology patient is being presented. This occurs approximately twice per month.
- 1400-1600      **Neuro-Oncology Clinic**  
A multidisciplinary clinic for brain tumour patients, conducted once per month.
- 1400-1630      **Pediatric Neurosurgery Ambulatory Clinic**  
The resident will conduct an office clinic with one of the staff, when there is no Neuro-oncology Clinic.

### **Research projects:**

The residents are expected to contribute to the scientific basis of neurosurgery. It is expected that a resident will prepare from PGY-2 onwards a minimum of one paper in each year of his training. This project will ideally come to fruition in the form of publication in a peer-reviewed journal and/or presentation at an appropriate meeting. The residents will be supported to attend an educational meeting under the following guidelines:

- a) That they prepare and present a paper.
- b) That the paper has as a co-author one of the neurosurgical attending staff.
- c) That there is an intent to publish the paper
- d) That the presentation of the paper will be supported only once
- e) That they are expected to attend as many academic sessions as they can while at meetings.
- f) They are expected to attend social activities in order to meet and get to know some of the senior and accomplished participants.

### **B.C. Neurosciences Day (March)**

B.C. Neurosciences Day is a forum at which the local B.C. neuroscience community come together to share/present topics of interest for the neuroscience community. The residents are encouraged to present a paper based on their original research. It is an expectation for the B.C. Neurosciences Day that each resident will prepare a paper for oral presentation, with the hopes that it will be publishable. A visiting professor is invited for a day of academic learning activity. A best resident paper prize is presented to the best neurosurgical and neurology papers.

### **Cadaver dissection sessions**

Sessions will be organized on a bi-yearly basis utilizing the excellent lab space and equipment available at the Center of Excellence for Surgical Education and Innovation. Residents are assigned a cadaver in groups to solidify surgical anatomy and knowledge working on cadavers supervised by staff neurosurgeons. Various topics and surgical approaches are selected with feedback from the residents.

### **Resident Research Day (Nov/Fall)**

A full day of activities centered around presentation of projects by residents. All residents PGY-2 and up are expected to present a project. A guest professor is asked to attend from another institution who critiques and selects the 'best' resident paper, which comes with a monetary prize. The visiting professor also provides formal teaching around cases he/she provides as well as suggestions for managing interesting local cases presented by the residents.

# Clinical Responsibilities

Education in clinical medicine is gained by the opportunity and responsibilities of patient care activities. Residents learn by taking care of ill patients. This requires some understanding of the opportunities and "ground rules". It is to be recognized that patient care activities are part of the educational activities and part of the requirements of employment for which residents are paid. While on the neurosurgical service residents are expected:

1. To participate in daily patient ward rounds 0630-0745
2. To take an active part in the day-to-day management of patients, under the supervision of senior residents and/or staff.
3. To admit elective patients, discuss with senior resident or staff, and follow these patients' in-hospital course.
4. To participate in surgical procedures as designated during regular OR time.
5. To ensure proper communication of patient care issues and follow-up to medical and paramedical colleagues.
6. To plan and help coordinate patient discharges/follow-up/transfers.
7. To attend weekly rounds and seminars (schedule attached).
8. To ensure that service work does not conflict with scheduled academic activities or medical school seminars and teaching sessions.
9. To ensure continuity of learning and continuity of care, residents who admit cases should scrub on the case and should assume responsibility for postoperative management. On weekend change over continuity should be arranged by a combined "change over round".

## Chief Resident:

The Chief Resident is in charge of the day to day management of the neurosurgery patients, under the supervision of the attending staff. He/she also makes up the call schedule for each month, approves holidays for house staff, and designates the cases to be presented at weekly Neurosurgery Correlative Rounds. Assignment of house staff to cases in the operating room are done by the Chief resident at the beginning of each week to allow junior residents to prepare for cases.

## Log of procedures

Residents are expected to keep a log of patients/procedures that they have been involved in. Recording date/diagnosis/procedure/operation and the level of surgical interaction (ie. 1<sup>st</sup>/2<sup>nd</sup> assist, primary operator). This can be recorded by a number of means, see T- Res in appendix.

# BC Children's Hospital

The pediatric neurosurgery program provides comprehensive, specialized care to children, youth and young adults with neurosurgical disorders.

It is the only program of its kind in BC and the only resource for tertiary and quaternary care in BC, with about 300 surgical procedures per year. Conditions treated include: brain and spinal tumours, cerebral palsy, Chiari malformations, craniosynostosis, epilepsy head injuries, hydrocephalus, intrauterine fetal counseling, motor disorders/spasticity program, moya moya disease, syringomyelia, spina bifida and trauma. There is a robust epilepsy and epilepsy surgery program

## Off Site Rotations

Opportunity for 'community' neurosurgery experience will be provided through rotations at Lion's Gate and Victoria General Hospitals. These residents will be assigned to mid and senior level residents who will be the sole resident on service. These rotations are for residents to be involved in all aspects of patient care, from diagnosis to treatment, and to experience more independent management of patients under direct supervision of staff neurosurgeons in a busy clinical setting. Appropriate on-call with staff supervision (PAR-guidelines) and attendance at ambulatory clinics are expected. All staff at these sites have UBC appointments. These rotations count towards the overall number of resident's clinical neurosurgical in-training months/requirements.

### Lion's Gate Hospital Neurosurgery Rotation

#### Description of Service

1) Clinical mix and volume:

Total Case volume: 1000-1100 cases per year

Cranial: 25%

Spine: 65%

Peripheral Nerve and misc. 10%

A large spine service full range of cases - complex instrumented to minimally invasive

Largest kyphoplasty program in BC

20 – 30 intradural spine cases per year

3) Outpatient Clinic

Rapid access spine clinic - 50 new patients a week

Each surgeon office 1 to 2.5 days/wk

### Victoria Neurosurgery Rotation

#### Description of Service

1) Clinical mix and volume

Total Case volume: 1000 - cases per year

Cranial: 40%

Spine: 55%

Peripheral Nerve and misc. 5%

An excellent range of clinical neurosurgery is available. The neurosurgery service manages all surgical cranial disorders as well as 95% of the spinal problems for the whole of Vancouver Island. The resident should expect to become particularly familiar with the management of patients with spinal trauma, including operative indications. Exposure to minimally invasive surgery for discectomy, fusion and fracture as well as kyphoplasty will be significant.

### **Elective rotations**

There will be opportunity for elective rotations to be done at other UBC affiliated sites or other academic institutions in North America. These can be arranged with consultation with the program director depending on individual interests. These rotations need to be done after assuring adequate number of in-training months can be achieved at UBC sites for Royal college requirements. Residents will be expected to fund their travel and accommodations themselves for these rotations.

### **Resident Evaluations**

- a) During the Principles of Surgery core year, in addition to patient care activities, the residents attend a lecture series and seminars and are evaluated by a written examination at the end of that year. Each trainee is eligible to sit the Royal College of Physicians and Surgeons Principles of Surgery examination at the end of his second year of training. He must pass this successfully to continue his program and to be eligible to take the Fellowship examinations.
- b) Practice written and oral examinations will be administered annually.
- c) The resident's progress will be assessed at the end of each rotation using The University of British Columbia on-line assessment forms, based on the One-45 Web Eval software.
- d) Trainees will meet with the Program Director every six months for a review of their progress.
- e) Each resident is expected to keep a record of all surgical procedures done, as an assistant and as a primary operator. The residents are provided with a Palm Pilot personal digital assistant, with T-Res software. Data from the residents' palm pilots is up-loaded periodically onto a central server for review by the Program Director.
- g) It is expected each trainee will sit the Royal College Specialty Examination in Neurosurgery upon completion of the requirements for training. This examination consists of a written examination and an oral examination. Eligibility to take the examination requires a satisfactory Confirmation of Completion of Training form (CCT) from the Program Director and a pass in the Principles of Surgery examination. At the present, the examinations are held in May or June where the written and orals are given in the same week.

### **Trainee Evaluation of the Program**

It is an important part of the training program that trainees evaluate and have a feed-back into their training program. Each resident will be expected to complete an evaluation form at the end of each rotation or six month period. The residents will be asked:

- a) To evaluate the organized teaching sessions on Wednesday morning and Wednesday evening.
- b) To evaluate the teaching and the learning experience of the patient care related activities.
- c) To evaluate the quality of the operating room experience.
- d) To evaluate each rotation.
- e) To evaluate feedback to staff teaching by specific faculty evaluations.

# Vacation and Leave

## 1. Division Policy

All residents must request vacation time in writing, from the Program Director on whose service they will be rotating when they wish to take the vacation, and also must notify the Neurosurgery secretary of their planned holidays. This allows the Neurosurgery secretary to check for any conflict in dates, i.e. that others are not away at the same time, and to ensure appropriate coverage. The approved vacation dates are kept up to date on the Call Schedule, as well as in the Divisional files. The approval is the responsibility of the Neurosurgery Program Director only for on-service residents, after he is advised of the coverage on the ward at the time of the vacation request.

It is important that the Division of Neurosurgery is kept aware of the dates of vacation time as well as the total vacation time taken by each resident, regardless of what service the resident is on at the time of the vacation. It is also important that we be aware of conference leave taken by each resident. Residents are required to advise the Neurosurgery secretary in writing of all vacation and conference time taken.

For off service residents on the VGH Neurosurgery service, the Chief Resident can approve vacations on behalf of the Program Director.

**2. Reasonable leave** is granted for each resident for either Christmas or New Year's, assuming appropriate coverage, usually 5 days.

## 3. Surgical Service (PAR-BC article)

5.1 Seniors shall have priority in holiday requests over more junior residents (i.e. R4s over R2s); otherwise, 'first-come, first-served' prevails.

5.3. If a resident is on call on a statutory holiday, they will be entitled to a day off to make up for it, and this **MUST BE ARRANGED WITH THE SERVICE THE RESIDENT IS ON AT THE TIME** (PAR-BC: 12.02).

## 4. PAR-BC Article 14 – Vacation Leave

- a) All residents are granted vacation according to the policy as laid down by the PAR-BC
  - 4 weeks holiday (20 working days per year)
  - Up to two consecutive weeks of this can be taken as a block

Scheduling of vacations shall be determined by the Program or Educational Director in accordance with operational and educational requirements. Residents will submit their requests to the Program or Educational Director in writing. The approval of the vacation request shall not be unreasonably withheld taking into consideration the operational and educational requirements of the program.

- b) Subject to operational requirements, every effort will be made to permit a Resident at least his/her second or third choice for his/her vacation period.

Under Article 12.04 it is stated that every resident shall be entitled to at least five (5) consecutive days off during the 12 day period that encompasses Christmas, New Year's Day and two full weekends. Those 5 days are to account for the three (3) statutory holidays, Christmas, Boxing Day, New Year's Day, and two (2) weekend days.

Residents are eligible for additional pay when they work on a statutory holiday as defined in the HEABC/PARBC Collective agreement (Article 12). You can inform to Neurosurgery secretary to request Stat Holiday Pay to Dean's office.

## 5. Conference Leave

Conference leave must be approved by the Program Director, and requested a minimum of three months in advance.

Further policy issues on vacation and leave are laid out on the PAR-BC agreement, which can be found on web site [www.PAR-BC.org](http://www.PAR-BC.org).

## Statutory Holidays

Under **Article 12.04** it is stated that every resident shall be entitled to at least five (5) consecutive days off during the 12 day period that encompasses Christmas, New Year's Day and two full weekends. Those 5 days are to account for the three (3) statutory holidays, Christmas, Boxing Day, New Year's Day, and two (2) weekend days.

After a STAT day has been worked, residents must report the STAT day to the neurosurgery secretary. The secretary submits a Request for Stat Holiday Pay form to the Dean's Office. The statutory pay will be included in your biweekly paycheque. It takes approximately four weeks for the pay to be processed.

***Late submission means that your pay will be delayed, as your request for STAT pay may not be processed until the pay period comes around.***

### 2011-2012 STATUTORY HOLIDAYS

Thursday, July 1, 2011	<b>Canada Day</b>
Monday, August 1, 2011	<b>BC Day</b>
Monday, September 5, 2011	<b>Labour Day</b>
Monday, October 10, 2011	<b>Thanksgiving Day</b>
Thursday, November 11, 2011	<b>Remembrance Day</b>
Sunday, December 25, 2011	<b>Christmas Day</b>
Monday, December 26, 2011	<b>Boxing Day</b>
Monday, January 2, 2012	in lieu of Sunday <b>New Year's Day</b>
Friday, April 22, 2011	<b>Good Friday</b>
Monday, April 25, 2011	<b>Easter Monday</b>
Monday, May 23, 2011	<b>Victoria Day</b>

The most asked question is whether Residents receive stat pay for working on the lieu day. A lieu day is an alternate day taken off work to make up for a stat day. Typically, the Monday immediately following the stat is taken as the lieu day. It is not a stat day itself, and will not result in additional pay.

All Residents are entitled to either the stat day off or an alternate day off (lieu day). Although it is common to take the Monday as the lieu day, Article 12 of the collective agreement states that it is to be taken at a time chosen by mutual agreement between the program and the resident.

# Resident Education Funds

## Funded Courses

The Division of Neurosurgery will cover the travel expenses for residents to attend the following mandatory education events:

- Advanced Trauma Life Support Course
- Toronto Microsurgical Course
- Calgary Spine and Peripheral nerve course

## Supplementary Policies

Once per year full support of individual residents for presentation of a particular paper at a meeting within the continental North America.

For international meetings - 50% funding for papers being presented upon approval.

For exceptional papers, support for additional presentations will be considered. Prior approval is required.

All resident projects must acknowledge their origin at The University of British Columbia and must have a staff person at The University of British Columbia as an associate investigator and co-author.

Support for presentations at meetings must involve the presentation of a paper or abstract not previously presented, except under the most exceptional of circumstances which would require prior approval, before an undertaking of funding. A copy of the abstract approved for presentation should accompany the request for approval.

Residents submitting a paper to a particular meeting must give due notice well ahead of time of his/her intent to submit a paper to a particular meeting, and give some idea of the anticipated total cost, if the paper is accepted.

Residents are encouraged to take courses at meetings that are relevant to the practice of neurosurgery and appropriate for their level of training. A request for registering at these meetings with the costs involved must be submitted for approval if reimbursement is expected.

With the approval of the Program Director, and providing appropriate coverage for the service can be arranged, residents may elect to attend a meeting at which they have neither a platform nor poster presentation. Expenses for these are expected to be met entirely by the resident under these circumstances, except for the senior resident in his/her last year who is entitled to an all expenses paid North American meeting of his/her choice.

It is a requirement that a platform presentation, given at a meeting, be presented at a local forum here in Vancouver to an appropriate audience, and poster presentations be put up for viewing immediately after the meeting at which it was presented at some conspicuous spot in the Division of Neurosurgery areas, such as on the ward.

# Travel Expense Guidelines

(refer UBC Travel Procedures Policy #83 and Faculty of Medicine Travel Expense Guidelines)

1. A single economy return air fare to the meeting site.
2. Ground transport from the airport to and from the hotel.
3. Hotel coverage paid at the most economical room rate offered, and where possible that residents should double up, to again help preserve the funding resource.
4. Cost of meals: travelers may be reimbursed for the cost of meals either by submitting receipts for actual meal costs claimed should not be in excess of the per diem rates.

## Travel within Canada (per day)

Breakfast	\$10.70
Lunch	\$10.45
Dinner	\$29.35
Total =	\$50.50 / day (CDN)

## Travel within US and other countries (per day)

Breakfast	\$10.70 (USD)
Lunch	\$10.45 (USD)
Dinner	\$29.35 (USD)
Total =	\$50.50 / day (USD)

5. Original detailed receipts are required to support a claim. UBC will not accept any travel agency invoices, cancelled cheques, photocopies or credit card statement. If original receipts are not available a missing receipt memo must be included.
6. Exchange rate expenses can be claimed through submission of a credit card statement listing the cost of purchases in Canadian dollars or through the average exchange rate on the trip duration by the on-line UBC Finance requisition system will be used.

## Community Rotation

The Post Graduate office is required to house/reimburse mandated scheduled resident rotations (but not elective rotations requested by residents). Residents have to pay monthly rental fees, and submit their receipts for rental and travel for reimbursement. Before your rotation, the program assistant will remind you to contact following person.

Contact person:                      Susanne Phillips – Victoria  
(as of May 2010)                      Carri Fork – Kelowna

[Susanne.phillips@viha.ca](mailto:Susanne.phillips@viha.ca)  
[carri.fork@interiorhealth.ca](mailto:carri.fork@interiorhealth.ca)

## Reimbursement Policy by Faculty of Medicine (January 29, 2008)

Should a resident be required to commute to mandatory rotation where the mileage is greater than 40km one way, the resident will be reimbursed at the rate of **\$0.50/km**.

For example, within Vancouver, using Vancouver General Hospital as the home base, locations within the 40km radius include Lions Gate Hospital to the North; Richmond General, Delta Hospital, Surrey Memorial to the South; Burnaby General, Royal Columbian, Riverview and Eagle Ridge to the East.

Locations **out side** the boundary include:

Peace Arch to the South; and Ridge Meadows, Langley, MSA and Mission to the East.

***This policy applies to all Royal College residents doing rotations at all sited, including our distributed sites on Vancouver Island and Prince George.***

## UBC ACCOMMODATION POLICY - DISTRIBUTED TRAINING SITES

### PREAMBLE

The health authorities, with the assistance of the Postgraduate Deans' Office, have leased housing at the distributed training sites in the province for residents' use during rotations. All of the properties have been pre-paid in advance so that residents do not have to incur out-of-pocket expenses for housing.

The properties fulfill the requirements outlined in the memorandum of understanding between HEABC/PAR-BC:

- *Accommodation will be secure and will have consideration for privacy*
- *Accommodation should be clean and well-maintained, self-contained, have access to full kitchen, bathroom, and laundry facilities.*

All suites have high-speed internet access, cable television, and a telephone, and are located in close proximity to the hospital(s).

### POLICY

#### 1. HOUSING

- Residents assigned to rotations at distributed training sites where housing has been provided are required to stay in this housing should it be available at the time of the rotation. Residents are requested to contact Susanne Phillips in Victoria to access housing on Vancouver Island (Victoria, Duncan, Nanaimo); and Lisa Lakusta in Prince George for housing in Prince George PRIOR to the rotation.
- Requests for alternate housing must be pre-approved by the Postgraduate Deans' Office. Such requests will be considered only on the grounds of physical limitations or health reasons (written documentation required).
- Should a resident refuse to stay in the accommodation provided by the health authorities for reasons other than physical limitations/health (e.g. decor not to their liking), alternate housing will not be provided. Residents may find alternate accommodation; however, they will not be reimbursed for the rent.
- Should the provided accommodations become uninhabitable due to unforeseen circumstances (flooding, fire, etc.), staff at the distributed sites will make a reasonable attempt to find temporary alternative accommodation at a B&B and/or hotel/motel. It should be recognized that temporary alternative housing may not be immediately available due to local accommodation conditions (i.e. high tourist season, shortage of housing in rural locations).
- ***Residents may return to their home base only upon approval from the specialty site director and/or their home program director.***

#### 2. CARE OF ACCOMMODATIONS

- All suites are professionally cleaned prior to arrival and once per month thereafter.

- Residents are required to maintain the premises in a reasonable state of cleanliness while staying in provided suites.
- Residents are responsible for any damages they cause to happen above and beyond normal wear and tear.

### 3. *SMOKING*

- Smoking is prohibited in all properties leased by the health authorities.

### 4. *PETS*

- Pets are prohibited at all properties leased by the health authorities.

### 5. *KEYS*

- Residents are responsible for any keys they are provided for access to the accommodation during the rotation.
- Residents are required to adhere to policies in place at the distributed sites for pick-up and return of keys at the beginning and end of rotation.
- Residents are responsible for any costs incurred should keys in their possession become lost or misplaced. Should keys be stolen, residents are required to provide proof of theft (police report, incident report from hospital, etc.).

### 6. *LOSS OF PROPERTY*

- All leased properties have security systems installed (where available).
- ***The health authorities and/or the University are not responsible for the loss or theft of personal property from any of the distributed training sites' leased properties.***

Ratified May 29, 2007 by Faculty Residency Executive Committee

Please request "UBC procedures for reimbursement" document for specifics from Program Coordinator

## Payroll Information

The payroll department of VCH processes Resident payroll, acting as the central paying agency for all Residents, regardless of their working location. The following Payroll definitions and procedures have been assembled in order to answer many frequently asked Payroll questions.

### 1. Payroll Pay Periods

Although Residents aren't paid an hourly wage, their salary is represented on their pay stub as a daily rate of 7.5 hours, which is 75 hours for a full two week pay period. Residents are paid every two weeks, with pay day being one week after the last day of a pay period.

The first pay period that includes time worked in the new academic year - June 26th to July 9th - will be paid on July 17th. This means that for new Residents, this first pay day will not be for a full two week period.

## 2. On-call and Chief Allowances

Residents may not see on-call, meal, or chief allowances on their July 17th pay stub. This delay in payment can occur every July and January, as on-call information is gathered from the program offices, compiled, and then submitted to Payroll for processing. Any allowances not paid in this period will be paid retroactively on a future pay day.

The monthly on-call allowance is made in two payments each month. This results in 24 payments per year. Since there are 26 pay days per year, 2 pay days have no allowances. The first of these will occur on November 6th pay day. We will send reminders to the program offices when these pay days occur.

Chief allowances are paid monthly. If the chief position is shared between two residents, the chief allowance will be paid every second month (ie, August, October, December, February, April, and June). If a program has a number of chiefs per year, the allowance will be paid out according to the months designated by the respective program office.

## 3. Pay stubs

As the central paying agency for all Residents, Payroll distributes pay stubs according to information provided by the program offices to the Dean's Office.

Residents working at Vancouver Hospital, BC Women's, BC Children's, Royal Columbian, St. Paul's, and Victoria will have their pay stubs sent to the hospital site for the months that they are working at that site. Payroll will not mail pay stubs to Residents' homes unless they are located outside of these locations. If Residents believe that pay stubs are being delivered to the wrong location based on incorrect rotation information, they should contact their program office for clarification.

Payroll's designated drop-off locations:

Vancouver General Hospital	Mailroom, First Floor, Centennial Pavilion
St. Paul's Hospital	Residents' Mail slots Doctor's Lounge Main Floor, Burrard Building
Capital Health Region	Eric Martin Pavilion Room 186 - 2334 Trent St., Victoria Attn: Josie Terlesky
BC Children's	4480 Oak Street Room C400 Attn: Debra Cannon

## 4. Payroll Enquiries

For general payroll inquiries: 1-888-875-4747 or email [PayrollServicesInquiries@VCH.ca](mailto:PayrollServicesInquiries@VCH.ca)

Be sure to inform them that this is an inquiry regarding a medical resident, as different rules apply to different employee groups

## 5. Parking Passes to on-call residents in the VGH

Parking passes for on-call Residents, enable them to park (free) in the VGH Courtyard between 5pm and 8am, and on weekends. The Residents need to contact Abdul Pirbhai and arrange a time to stop by the

parking office to fill out a parking application and take receipt of their pass. The application is needed so we are able to keep track of who is using the passes, vehicle info, etc.

Abdul Pirbhai: 604-4147-6545, between 7am and 3pm to arrange a time they can meet him and pick up.

## **6. Benefits**

All benefit inquiries and forms can be addressed to the Records and Benefits Office of Employee Engagement at 1-866-875-5306.

## **7. Maternity and Parental Leaves**

Residents planning to take a maternity leaves should note of the following:

1. Contact the program assistant once you have a start date for the leave so that a change form can be generated for the Deans office
2. Contact the VCH Employee Engagement Office at 1-866-875-5306 to get your Record of Employment (ROE).
3. Information regarding Employment Insurance (EI) during leaves can be found at the Service Canada Website <http://www.servicecanada.gc.ca/>
4. Contact PAR-BC if there are further questions

Personal Leaves and extended Sick Leaves

Please inform the program assistant regarding all leaves. This information is essential to determine completion date of training.

## **8. Contacts at Deans Office**

If Residents wish to contact the Deans office, please contact Delfa Miranda, the Financial Processing Coordinator, at 604-875-4834, or [delfa.miranda@postgrad.med.ubc.ca](mailto:delfa.miranda@postgrad.med.ubc.ca)

## Harassment Issues – Equity Office

The University of British Columbia is committed to providing its employees and students with the best possible environment for working and learning, an environment that allows friendship and collegiality to flourish. It is essential that the University faculty, staff and residents share responsibility to create a hospitable climate in which we all feel safe, respected and free to pursue our work and training.

There are two offices which provide assistance to those experiencing intimidation or harassment: For staff – the UBC Equity Office, and for faculty and learners, the Office of the Associate Dean, Equity. Both offices work to prevent discrimination and harassment in the workplace and learning environment. We believe that individuals need to be able to discuss their concerns and to seek advice and assistance in a safe and private environment.

If you experience any discrimination or harassment, contact Lori Chavat, Associate Dean, Equity at 604-827-3664 or e-mail: [equity@medd.med.ubc.ca](mailto:equity@medd.med.ubc.ca)

## Communication

### VGH Location

Resident on-call room: **Room 290C**, 2F, Centennial Pavilion, VGH Access Code: **8472**

Doctor's Lounge: CP 281, 2F, Centennial Pavilion, VGH.  
Access: hold down **1 & 5** at the same time, then press **2**.

Residents' Mail Room: Room 160, 1F, Centennial Pavilion, VGH.  
0700-1700 Mon to Fri. Messenger Services Coordinator 5-4085.

### VGH Phone Numbers (5 digits for internal call)

Main Switchboard	604-875-4111	Operating Room	Booking desk	5-4472
VGH Voice Mail	5-5555	Lounge		6-6352
Admitting	5-4300	Theatre 17		6-6417
Emergency Dept.	5-4995	Theatre 18		6-6418
ER Admitting	5-4311, 6-2238	PAR		6-6300
Health Records	5-4070			
Paging/locating	5-5000	Radiology	Main desk	5-4533
Patient Information	5-4000	Angiography		6-8612
Surgical Day Care	5-4455	CT/MRI booking		5-4366
OR desk	5-4472	Emergency X-ray		6-2520
		Film Loan Desk		6-3741
		Ultrasound		5-4340

### WARDS (Jim Pattison Pavilion)

Day Bed	5-4078	ICU	5-4275
2T JPS Burns/Plastic	5-4069	Trauma SCU	5-5881
4A JPS Acute Med	5-4182	8A Vasc/Gen Surg	5-4186
5A JPS Neuro ICU	5-4281	8B Vasc/Gen Surg	5-4170
5B JPS Neurology	5-4188	9A Gen Surgery	5-4169
T5T Step-down Unit	6-2718 + 6-2451	9B Gen Surgery	5-5278
6A JPS Neurosurgery	5-4530	10A Urology	5-4330
6B JPS Neurosurgery	5-5279	T10D-Ortho Overflow	6-2117
7A Ortho Trauma	5-4053	14A/B Spine	5-5800
7B Ortho Recon	5-4172	T16 Palliative Care	5-4715

## University of British Columbia

Post Graduate Dens' Office Interim Executive Associate Dean Dr. Kamal Rungta Co-Assistant Dean Drs Jill Kernahan / Eric Webber	604-875-4834  604-875-4834
Associate Dean, Equity Dr. Lori Charvat	604-827-3664 (confidential voice mail) <a href="mailto:Med.equity@ubc.ca">Med.equity@ubc.ca</a>
Payroll inquiries	604-875-4738 or 1-888-875-4747
Benefits	604-876-5306 or 1-888-875-5306

## Address Changes

Residents are responsible to keep their personal information up to date with the various administrative offices. If there are any changes to your contact information or status, please contact:

1. Program assistant [sachiyo.kaneko@vch.ca](mailto:sachiyo.kaneko@vch.ca)
2. STAR UBC <https://starpp.med.ubc.ca>
3. Employee Engagement for Payroll and Benefit [vchrecordbenefitforms@vch.ca](mailto:vchrecordbenefitforms@vch.ca)
4. College of Physicians and Surgeons of BC <http://www.cpsbc.ca/node/135>
5. PAR-BC office [par@par-bc.org](mailto:par@par-bc.org)
6. UBC Registrars <http://students.ubc.ca/ssc>

## External Contacts

### BCMA

British Columbia Medical Association  
1665 West Broadway, Suite 115  
Vancouver, BC V6J 5A4

Tel: 604-736-5551  
Fax: 604-736-4566  
<http://www.bcma.org>

### CMPA

Canadian Medical Protective Association  
P.O. Box 8225  
Station C  
Ottawa, ON K1G 3H7

Tel: 1-800-267-6522  
Fax: 613-725-2336  
<http://www.cmpa.org>

### College of Physicians and Surgeons of BC

#400-858 Beatty Street  
Vancouver, BC V6B 1C1

Tel: 604-733-7758  
Fax: 604-733-3503  
<http://www.cpsbc.ca>

The College of Physicians and Surgeons of BC licenses all doctors in BC. In order to work as a resident you require an educational license.

### PAR-BC

Professional Association of Residents – BC  
601 West Broadway, Suite 900  
Vancouver, BC V5Z 4C2

Tel: 604-876-7636  
Fax: 604-876-7690  
<http://www.par-bc.org>

PAR-BC is the union representing all residents, and acts as your agent with regards to employment and educational issues.

### **RCPSC**

Royal College of Physicians & Surgeons of Canada Tel: 1-800-668-3740

774 Echo Drive

Ottawa, ON K1S 5N8

Fax: 613-730-2410

<http://rcpsc.medical.org>

The RCPSC is the governing body for all specialties in Canada. It is involved in a broad range of activities related to specialized medicine in Canada. Three areas described below are of particular importance to residents.

The RCPSC has recently instituted resident membership. There is no change for such membership and you are encouraged to join.

- a) **Credentials:** This section reviews the training that residents have received, to ensure that they are eligible to take RCPSC examinations (i.e. they look at medical school education as well as the duration and nature of rotations within the residency). This is generally straightforward if all of one's training has been within Canada, but may be more complicated if this has not been the case.

Note: Before taking any examination, you require an Assessment of Training by the RCPSC Credentials Section. Please note deadlines of this and for examination are often many months before the actual examination.

- b) **Evaluations:** The RCPSC administers the Principles of Surgery (POS) Examination and the final Certification Examination in Neurosurgery. The POS Examination is offered in the spring and is open to residents in the RII year or higher. This examination is based on the objectives for Core Surgery. The final Certification Examination in Neurosurgery is offered (both written and oral components) in the spring of the final year of residency. This examination is based on the objectives for Neurosurgery.
- c) **Accreditation:** All specialty programs in Canada must meet RCPSC guidelines. The RCPSC accredits all programs with on-site surveys on a six-year cycle, and more frequently for programs which have been found to have significant deficiencies. As residents you will have a major role in this survey process; the primary concern to the surveyors is that the residents are receiving a high standard of education in an appropriate environment.

### ***Objectives of Core Training in Surgery and Outline of Contents for the Examination on the Principles of Surgery***

[http://rcpsc.medical.org/residency/certification/training/corsur\\_e.html](http://rcpsc.medical.org/residency/certification/training/corsur_e.html)

### ***Preliminary Assessment of training***

<http://rcpsc.medical.org/residency/certification/assessment/>

### ***Objectives of Training and Specialty Training Requirements in Neurosurgery***

[http://rcpsc.medical.org/residency/certification/training/neurosurg\\_e.html](http://rcpsc.medical.org/residency/certification/training/neurosurg_e.html)

# Frequently Asked Questions

***Who is my employer? Who pays me?***

Residents are paid by BC Interns & Residents Paying Agency and are considered employees of the hospitals.

***Am I a UBC student?***

Even though you are issued a UBC student number for administrative purposes, technically you are not considered a student because you do not pay tuition or student fees.

***Do I need CMPA?***

No. All UBC residents are covered by the University's liability policy regardless of where they are training. CMPA coverage can be purchased at residents' own expense. The employer or the University will not be responsible for the cost of extra insurance.

***How long does it take for the statutory holiday pay to process?***

The statutory pay will be included in your biweekly pay cheque. It takes approximately 4 to 6 weeks for the pay to be processed.

***What to do if a work injury occurs?***

Report to the Health & Safety department of the hospital you are working at.

# **Resident Evaluation and Appeals Policy**

## **Faculty of Medicine**

### **University of British Columbia**

This document outlines the appeal and evaluation process for Residents in the Faculty of Medicine at the University of British Columbia.

#### **1. DEFINITIONS**

1.1 In this Policy:

“Associate Dean” means the Associate Dean of Residency Training of the Faculty of Medicine at the University.

“Collective Agreement” means the collective agreement between PAR-BC and HEA-BC.

“CFPC” means the College of Family Physicians of Canada, a national, voluntary organization that sets standards for continuing medical education for family physicians.

“College” means the College of Physicians and Surgeons of British Columbia, the professional licensing body for physicians in British Columbia.

“Dean” means the Dean of the Faculty of Medicine at the University.

“FITER” means a Final In Training Evaluation as described in paragraph 14.1 hereof.

“Faculty of Medicine” means the Faculty of Medicine at the University.

“HEA-BC” means the Health Employees Association of British Columbia, an association representing the hospitals that employ Residents.

“ITER” means an In Training Evaluation Report, which is a formal written evaluation that is part of the Resident’s normal post-graduate medical training program and is not an evaluation given during a period of remediation or probation.

“PAR-BC” means the Professional Association of Residents of British Columbia, a recognized trade union in the province of British Columbia that represents Residents.

“Probation Committee” means the individuals enumerated in sub-paragraphs 7.1(a)-(c) who appear at a meeting held pursuant to Section 5.

“Program Director” means the member of the Faculty of Medicine responsible for the overall conduct of a post-graduate training program in a specific medical discipline and who is responsible to the Associate Dean.

“RCPSC” means the Royal College of Physicians and Surgeons of Canada, a national organization that sets standards for medical specialists.

“Resident” means a physician in a post-graduate medical training program that:  
(a) leads to RCPSC or CFPC accreditation; and  
(b) is administered by the University.

“Rotation” means the period of time a Resident is assigned to a clinical service for which there are specific, defined learning objectives.

“Rotation Preceptor” means the faculty member in the Faculty of Medicine who has direct responsibility for the Resident’s clinical academic program during a Rotation and who may be the Program Director in certain circumstances.

“Resident Staff Appeals Committee” means the committee described in Section 11 of this Policy.

“Training Committee” means the committee responsible to the Program Director for organizing the training of Residents and includes the Program Director.

“University” means the University of British Columbia.

## **2. STATUS OF RESIDENTS**

2.1 All Residents are employees of the hospitals in which they work.

2.2 Residents, as members of PAR-BC, have a Collective Agreement.

2.3 All Residents hold a licence from the College and, as with all other physicians, the College is responsible for maintaining professional standards.

2.4 All Residents are registered as Residents with the University, and the academic portion of their training is evaluated by the University. Residents are also registered as Residents programs under the auspices of either the RCPSC or the CFPC.

## **3. EVALUATION**

3.1 Regular and timely evaluations and ongoing verbal feedback should occur throughout each Rotation.

3.2 Each Resident must receive an In Training Evaluation Report (ITER) for every Rotation they complete and, in any case, at least once every three (3) months, irrespective of the length of the Rotation.

3.3 ITERs should be completed by the Resident’s entire teaching faculty for that Rotation where practicable. The evaluation must recognize the difference in expectations of skills and knowledge between junior and senior residents.

3.4 The Rotation Preceptor must meet with the Resident to discuss each ITER with the Resident and review the strengths and weaknesses documented by the teaching faculty in the ITER. The Resident must sign the ITER form to acknowledge that the evaluation has been discussed with the Rotation Preceptor. If the Resident does not agree with the evaluation, he or she has the right to place a written comment on the form and/or appeal the ITER in accordance with Section 4 of this Policy.

3.5 The Resident will receive a copy of the ITER and the signed ITER form will be submitted to the Program Director to be placed into the Resident’s file no later than two (2) months after the end of the Rotation.

3.6 The Rotation Preceptor and Chief Resident should collaborate to make sure that all Residents are evaluated according to this Policy.

## **4. APPEAL OF EVALUATIONS**

4.1 A Resident has the right to appeal any ITER made pursuant to this Policy to the Training Committee. A request for such an appeal must:

- (a) be submitted in writing to the Program Director within ten (10) days of the Resident signing the ITER; and
- (b) detail the procedural or factual basis for the appeal.

4.2 The Program Director will forward the Resident's appeal to the Training Committee, which will assess the merits of the appeal. The Training Committee may contact the Resident or any of the evaluators named on the ITER if further information is required.

4.3 Once the Training Committee has assessed the Resident's appeal it will determine either that:

- (a) the appropriate process for evaluation has been followed and the ITER will remain in the Resident's file; or
- (b) the Resident's appeal is successful, either in whole or in part, and a new ITER will be written by the Program Director, signed by the Resident, and placed in the Resident's file. The appealed ITER will be removed from the Resident's file and destroyed.

4.4 Appeals of evaluations to the Training Committee are final. Once a Resident has appealed an ITER he or she may not appeal that ITER again and a Resident cannot appeal a replacement ITER created pursuant to sub-paragraph 4.3(b).

## 5. DISMISSAL OF A RESIDENT FROM A TRAINING PROGRAM

5.1 A Resident's position and progress in his or her academic program is dependent upon the maintenance of their standing as an employee, as a licensed physician, and as a Resident under this Policy. Residents may be dismissed from a University post-graduate medical training program in any of the following three ways:

(a) **Dismissal by the University**

Residents in either RCPSC or CFPC training programs are routinely evaluated, both formally and informally, according to RCPSC or CFPC guidelines. Failure of a Resident to meet the requirements of these accrediting organizations, or failure of a Resident to meet the requirements of the University will lead to dismissal pursuant to the procedures set out in this Policy.

(b) **Dismissal by the Hospital**

Residents can be dismissed by the hospital in accordance with the terms of their Collective Agreement. Residents dismissed by the hospital in which they are employed cannot continue with their post-graduate medical training program. In the event that a Resident is suspended by the hospital then they will be unable to continue with their post-graduate medical training program for the duration of the suspension.

(c) **Loss of Licensed Professional Status with the College**

All Residents are either on the full or temporary register of the College. The College may entertain complaints against Residents and, after appropriate investigation, remove their licence to practice medicine. These mechanisms are outlined in the *Medical Practitioners Act*, R.S.B.C. 1996, c. 285. Residents who permanently lose

their licensed professional status with the College cannot continue with their post-graduate medical training program. Residents who have their licensed professional status with the College suspended cannot continue their post-graduate medical training program for the duration of the suspension.

## **6. IDENTIFICATION OF WEAKNESSES AND REMEDIATION**

6.1 In the first instance, it is the responsibility of the Program Director to bring any academic weakness or other problem to the attention of a Resident and to suggest and arrange remediation. Notice of such weakness, along with the suggested remediation and a specified time to effect such remediation, should be given by the Program Director to the Resident in writing and should be signed by the Resident who will be given a copy to retain.

6.2 Remediation is a defined period of time with training components structured to address an area or areas of weakness identified by the Program Director. It includes special evaluations, which may be of more than one kind, and may be performed by multiple internal or external evaluators. The evaluations will be discussed with the Resident, and signed by the Resident, the evaluator(s) and the Program Director.

6.3 After having received a notice of weakness and having been provided with remedial training, a Resident is expected to improve his or her performance in the identified area or areas of weakness. At the end of the specified remediation period the Program Director will either:

- (a) notify the Resident that the weakness has been corrected within the specified time period and permit the Resident to continue in their postgraduate medical program; or
- (b) notify the Resident that the weakness has not been corrected within the specified time period, that the Program Director intends to place the Resident on probation and the time and place of a meeting to be held with a Probation Committee to discuss the terms of the probation.

## **7. PROBATION**

7.1 A Probation Committee will be convened by the Program Director to meet with a Resident in any case where the Program Director deems it necessary to place the Resident on probation. The circumstances in which a Probation Committee will be convened include, but are not limited to, those set out in sub-paragraph 6.3(b).

7.2 A Probation Committee will consist of the following individuals:

- (a) the Program Director, who will chair the Probation Committee;
- (b) the Head of the Staff Member's Department or the head of the hospital in which the Resident is employed; and
- (c) one member of the Training Committee.

7.3 A Resident who is to appear before a Probation Committee has the right to have another Resident, who may be a PAR-BC representative, accompany them and act as an advocate for them, at any such meeting.

7.4 A meeting held pursuant to this Section 7 between a Resident and a Probation Committee will be relatively informal in nature and the Probation Committee will discuss the terms of the probation with the

Resident. The minutes of this meeting should be recorded and one copy of these minutes should be given to the Resident and another copy kept in the office of the Program Director.

7.5 After the Probation Committee has met with the Resident and decided whether to place the Resident on probation, and if so, on the terms of the probation, the Program Director will communicate the following to the Resident in writing:

- (a) whether or not the Resident is being placed on probation;
- (b) the weakness or weaknesses that need to be corrected, if any;
- (c) the duration of the probation, if any; and
- (d) the course of training and evaluation that the probation will entail, if any.

The Resident will acknowledge receipt of the foregoing by signing it and will receive a copy to retain.

7.6 The probationary period is a defined period of time, structured to address identified areas of weakness. It includes special evaluations which may be of more than one kind, and may be performed by multiple internal or external evaluators. The Resident will have an opportunity to read and discuss each evaluation with the evaluator(s) before each evaluation is signed by the Resident, the evaluator(s) and the Program Director.

7.7 At the end of the probationary period the Probation Committee will meet again with the Resident to discuss his or her progress. The Probation Committee will then decide whether to reinstate or dismiss the Resident. The Program Director will then communicate the decision of the Probation Committee to the Resident in writing. A decision to dismiss the Resident must include the specific weaknesses that have not been addressed by the Resident within the period of the probation.

## **8. IMMEDIATE DISMISSAL - "UNSUITABILITY FOR THE PROGRAM"**

8.1 Sections 6 and 7 of this Policy document the usual procedures for when a Resident's weakness is remediable. However, there will be instances in which Residents may be deemed by the Program Director to be unsuitable for the program for reasons that cannot be remediated. Such reasons may include, but are not limited to, the following:

- (a) the lack of a basic skill (such as physical dexterity in the case of a surgical specialty);
- (b) the presence of a personality problem related to the Resident's ability to practice medicine;
- (d) conduct unbecoming a member of the medical profession; or
- (e) other qualities of the Resident which make them unfit for the practice of medicine.

8.2 The decision to dismiss a Resident because they are unsuitable for the program is made by the Program Director but must be approved by the Head of the Resident's Department in the Faculty of Medicine prior to any action being taken.

8.3 Once the decision has been made to dismiss a Resident because of unsuitability, and this decision has been approved by the Head of the Resident's Department in the Faculty of Medicine, then the Resident and the Associate Dean must be informed in writing of the decision and the reason for the unsuitability by the Program Director.

## **9. DISMISSAL**

9.1 If a decision is made to dismiss a Resident pursuant to the provisions set out in either Section 7 or 8 of this Policy, then the Program Director will advise the hospital in which the Resident is employed and that hospital will terminate the Resident's employment, but if the Resident appeals the dismissal then the hospital will suspend the Resident's employment until the conclusion of the appeal process and will reinstate the Resident if the appeal is successful or terminate the Resident if the appeal is unsuccessful.

9.2 If a Resident is dismissed from the program then written confirmation of this decision should be sent to the RCPSC or CFPC by the Program Director as soon as practicable, but if the Resident appeals the dismissal then this confirmation will await the conclusion of the appeal process and only be sent if the dismissal is upheld on appeal.

9.3 Along with written notice of his or her dismissal pursuant to either paragraph 7.6 or 8.3, a Resident who is dismissed from the program will receive a copy of this Policy and be informed of his or her right to appeal the dismissal.

## **10. APPEAL OF DISMISSAL**

10.1 A Resident has the right to appeal a dismissal under either Section 7 or 8 of this Policy to the Resident Staff Appeals Committee. To appeal a dismissal a Resident must communicate this intention to the Associate Dean, in writing, within ten (10) days of their receipt of the notice of dismissal.

10.2 Within ten (10) days of giving notice of the Resident's intention to appeal the dismissal to the Associate Dean the Resident must submit the following to the Associate Dean in writing:

- (a) a copy of the notice of dismissal which is being appealed;
- (b) the factual or procedural basis for the appeal;
- (c) copies of any documents or supporting materials that the Resident wishes the Resident Appeals Committee to consider; and
- (d) the names of any witnesses whom the Resident wishes to speak on his or behalf before the Resident Appeals Committee.

10.3 Upon receipt of the documents submitted by the Resident pursuant to paragraph 10.2, the Associate Dean will forward copies of these documents to the Program Director and the Program Director will then respond to these submissions by providing the Associate Dean with the following, in writing:

- (a) confirmation of the decision which the Resident is appealing;
- (b) the Program Director's response to the substance of the Resident's appeal;
- (c) copies of any documents or materials which support the decision taken by the Program Director; and
- (d) the names of any witnesses the Program Director wishes to present evidence before the Resident Appeals Committee.

10.4 After receipt of the documents submitted by the Program Director pursuant to paragraph 10.3, the Associate Dean will set a date for a hearing before the Resident Appeals Committee and forward copies of the documents submitted pursuant to paragraph 10.3 to the Resident and copies of the documents submitted pursuant to both paragraphs 10.2 and 10.3 to each member of the Resident Staff Appeals Committee.

## **11. COMPOSITION OF THE RESIDENT STAFF APPEALS COMMITTEE**

11.1 The Resident Staff Appeals Committee will be composed of the following three individuals:

- (a) the Associate Dean, or an alternate appointed by the Dean of the Faculty of Medicine, who will chair the Resident Staff Appeals Committee;
- (b) two Program Directors from other departments or hospitals, appointed by the Associate Dean.

11.2 At a hearing before the Resident Staff Appeals Committee the Resident is entitled to have an advocate present of their own choosing. This advocate may be a PAR-BC representative, a friend, a family member or legal counsel. If the Resident is to be represented by legal counsel then notice must be given to the Resident Staff Appeals Committee and to the Office of the University Counsel at least fourteen (14) days prior to any hearing before the Resident Staff Appeals Committee.

## **12. TERMS OF REFERENCE OF THE RESIDENT STAFF APPEALS COMMITTEE**

12.1 The Resident Staff Appeals Committee will confine itself to questions of procedural fairness. The Resident Staff Appeals Committee cannot overturn an academic evaluation of the Resident's evaluator(s) unless such an academic evaluation is patently unreasonable under the circumstances.

12.2 The Resident Staff Appeals Committee may consider any relevant evidence and the Chair of the Resident Staff Appeals Committee may make any procedural decision necessary to ensure a fair and transparent process and that the principles of natural justice are served.

12.3 In the case of a Resident dismissed at the end of a probation period pursuant to paragraph 7.7 of this Policy, the Resident Staff Appeals Committee will determine whether the procedures set out herein have been adhered to in dismissing the Resident. There must be documentation to support the dismissal and there must be written evidence, whether from ITERs or other forms of evaluation, indicating that the Resident's progress has been fully evaluated.

12.4 In the case of a Resident dismissed for unsuitability pursuant to Section 8 of this Policy, the Resident Appeals Committee must satisfy itself that the reasons for the dismissal are both sound and fair.

12.5 The Chair of the Resident Appeals Committee may seek a legal opinion on any matter arising out of the deliberations of the Resident Appeals Committee.

## **13. PROCEDURES FOR THE RESIDENT STAFF APPEALS COMMITTEE**

13.1 At a hearing before the Resident Staff Appeals Committee the following individuals will be in attendance:

- (a) all members of the Resident Staff Appeals Committee;
- (b) the Resident making the appeal;
- (c) the Program Director from the Department or hospital in question;
- (d) witnesses to be called by the Resident, the Program Director, or the Committee.

13.2 At a hearing before the Resident Staff Appeals Committee, subject to the rule of the chair, the following procedure will be followed:

- (a) the Program Director may make an opening statement;
- (b) the Program Director may call and examine any witnesses named in accordance with sub-paragraph 10.3(d);
- (c) the Resident may cross-examine the Program Director or any witnesses called by the Program Director;
- (d) the Resident may make an opening statement;
- (e) the Resident may call and examine any witnesses named in accordance with sub-paragraph 10.2(d);
- (f) the Program Director may cross-examine the Resident or any of the witnesses called by the Resident.
- (g) the Program Director may make a closing statement;
- (h) the Resident may make a closing statement; and
- (i) any member of the Resident Appeals Committee may question any witness, the Program Director, or the Resident, at any time.

13.3 The Resident Staff Appeals Committee may request that it be provided with additional information from either the Resident or Program Director. If such additional information is requested, both the Program Director and the Resident must have an opportunity to consider this additional information and respond to it before the Resident Staff Appeals Committee prior to a final decision being made.

13.4 The Resident Staff Appeals Committee may adjourn and reconvene at the discretion of the chair.

13.5 The Resident Staff Appeals Committee will arrive at a decision on the basis of a simple majority vote.

13.6 The decision and the reasons of the Resident Staff Appeals Committee will be communicated in writing to the Resident, the Program Director and the Dean of the Faculty of Medicine within ten (10) days of the last day of hearings before the Resident Staff Appeals Committee.

13.6 If, in the case of academic weakness, the Resident Staff Appeals Committee finds that there has been a procedural error of sufficient magnitude to warrant reinstatement of the Resident or that the academic judgement of the Program Director or other faculty members is patently unreasonable then the Resident Staff Appeals Committee will recommend either that the Resident be fully reinstated in their post-graduate medical training program or be placed on probation in accordance with the terms of Section 7.

13.7 If there has been some procedural deficiency of a minor nature identified, but the Resident Staff Appeals Committee is satisfied that this procedural error could not have resulted in an erroneous decision, the appeal may be denied.

## **14. FINAL IN TRAINING EVALUATION**

14.1 Upon the completion of a post graduate medical program a Resident will receive a Final In Training Evaluation (FITER) for the purpose of credentialing with either the RCPSC or CFPC.

14.2 If the Resident wishes to appeal an FITER then the Resident must address this appeal to the Resident Staff Appeals Committee within ten (10) days of receiving the Final In Training Evaluation and must follow the procedures set out in Sections 10 to 13 hereof.

14.3 If a Resident chooses to appeal an FITER then that FITER will not be sent to either the RCPSC or CFPC until after the conclusion of the appeal

14.4 Once the Resident Staff Appeals Committee has assessed the Resident's appeal it will determine either that:

- (a) the appropriate process for evaluation has been followed and the FITER will remain in the Resident's file and will be communicated to either the RSPSC or CFPC, as appropriate; or
- (b) the Resident's appeal is successful, either in whole or in part, and a new FITER will be written by the Program Director, signed by the Resident, placed in the Resident's file and the new FITER will be communicated to either the RSPSC or CFPC, as appropriate. The appealed FITER will be removed from the Resident's file and destroyed.

14.5 Appeals of FITERs to the Resident Staff Appeals Committee are final. Once a Resident has appealed an FITER he or she may not appeal that FITER again and a Resident cannot appeal a replacement FITER created pursuant to sub-paragraph 14.3(b).

*Ratified November 29, 2004 by Faculty Residency Executive Committee.*

# T-RES

## What is T-Res?

T-Res is a PDA and Web-enabled application that allows you to easily document clinical activities and experience. We strongly encourage you to record at least your interventions/ procedures. Please talk with your program director about the specific requirements for your program.

## How to Use T-Res?

To use T-Res on the Web, simply log in with your user name and password to create, view, or export your activities. T-Res can also be used on a BlackBerry, Pocket PC or Palm OS device. Please refer to the device-specific guides under the "Help" section on the T-Res website.

## Why Use T-Res?

"What gets measured tends to improve."

Only you can provide specific information about what and how you are doing. Learning the discipline of documenting clinical activities is important and journaling supports reflective learning.

The information you create benefits you and the people who are responsible for your education.

If you have any difficulties, contact Resilience Software support at [support@t-res.net](mailto:support@t-res.net) or call: Office (604) 693-2323; Toll Free (866) 694-2323 x.300

## Specialty Training Requirements in Neurosurgery – Royal College

These training requirements apply to those who begin training on or after July 1st, 2010.

### MINIMUM TRAINING REQUIREMENTS

Six years of approved residency training. This must include:

1. Twelve (12) months in foundational training which must include:
  - 1.1. Critical Care Medicine
  - 1.2. Trauma surgery or Emergency Medicine, which must include trauma experience
  - 1.3. Additional training relevant to the Objectives of Surgical Foundations Training which may include but is not limited to:
    - 1.3.1. Plastic Surgery
    - 1.3.2. Orthopedic Surgery
    - 1.3.3. Otolaryngology
    - 1.3.4. Vascular Surgery
    - 1.3.5. Thoracic Surgery
    - 1.3.6. Cardiac Surgery
    - 1.3.7. General Surgery
    - 1.3.8. Anesthesiology
    - 1.3.9. Internal Medicine
2. Forty-two (42) months of training in Neurosurgery, including twelve (12) months as Chief Resident, in an approved program providing progressively increasing responsibility for patient care. Up to six (6) months of this period may be spent in pediatric Neurosurgery
3. Three (3) months of residency in Neurology
4. Three (3) months of residency in Neuropathology
5. Twelve (12) months of additional training relevant to the objectives of the specialty and acceptable to the director of the training program, at a hospital or university centre in Canada or abroad:
  - 5.1. Additional training in Neurosurgery
  - 5.2. Training in related clinical or basic neuroscience disciplines
  - 5.3. Clinical or basic research
  - 5.4. Additional scholarly activities

### NOTES:

Royal College certification in Neurosurgery requires all of the following:

1. Successful completion of a 2-year Surgical Foundations curriculum;
2. Successful completion of the Principles of Surgery examination;
3. Successful completion of a 6-year Royal College accredited program in Neurosurgery; and
4. Successful completion of the certification examination in Neurosurgery.

The six year program outlined above is to be regarded as the minimum training requirement. Additional year(s) of training may be required by the program director to ensure that clinical competence has been achieved.

REVISED – 2009

# Teaching by Residents in the Undergraduate

## Rationale:

The Royal College affirms the value of providing opportunities to develop teaching skills and experience during residency training. Teaching is highly valued by the University of British Columbia, Faculty of Medicine. (See attachment.)

## Guiding Principles:

1. There will be a consistent system across departments that will recognize teaching contributions, innovation, and excellence by residents (e.g. annual departmental Residents' Undergraduate Teaching Awards.).
2. Residents will be engaged in teaching for its intrinsic educational value and will not be used to substitute or usurp the faculty's central role in the undergraduate curriculum.
3. Residents will receive educational training and support including constructive feedback and formative evaluation from the Faculty.

## Policy:

1. Residents should all have both the opportunity and expectation to teach medical students.
2. Residents will be offered educational support and development pertinent to their teaching in the Undergraduate Curriculum.
3. Teaching will be most concentrated during the medical student pre-clerkship clinical skills blocks and during clerkship rotations.
4. However, residents who *wish* to teach during FPC, or a PBL/DPAS block may be permitted to teach *with prior approval of their Postgraduate Program Director*, if this meets their educational objectives and does not detract from their clinical commitments.
5. Recognition in teaching excellence will be built into Residency Training Awards presented to residents by their department (e.g. Medicine, Surgery, Pediatrics, Psychiatry, Radiology, Pathology, Ob/Gyn, and Family Practice).
6. Clinical faculty will not receive honorarium for teaching done by residents, nor will individual GFT faculty members receive teaching time equivalents for teaching done by residents.
7. Honorarium payment will not be given to salaried residents unless their teaching activity is clearly outside of the hours of their residency contract and is outside the content area of their specialty training (e.g. exam preparation, invigilation, OSCE participation,). Approval of such payment must come from the Undergraduate Dean's Office (not the Departments).

## ATTACHMENT:

In the Royal College of Physicians and Surgeons of Canada General Standards of Accreditation (September 1997) there are two relevant statements under Standard B& Academic and Scholarly Aspects of the Program:

Item 4: The program must ensure that residents learn effective communication skills for interacting with patients and their families, colleagues, students and co-workers from other disciplines. Clearly defined educational objectives for teaching these skills and mechanisms of formal assessment should be in place.

Item 6: Residents must be given opportunities to develop effective teaching skills by teaching junior colleagues and students as well as **through conference presentations, clinical and** scientific reports, and patient education.

These principles are also echoed in the CanMEDS 2000 Project document involving scholarly competencies. These include: Item 3: Facilitate the learning of patients, students, residents and other health professionals. This includes the ability to: help others define learning needs and directions for development, provide constructive feedback, and apply the principles of adult learning in interaction with patients, students, residents, colleagues and others. The CanMEDS specific objectives indicate the following: Item 3: Education: a: Demonstrate and understanding of, and the ability to apply, the principles of adult learning with respect to oneself and others; b: Demonstrate an understanding of preferred learning methods in dealing with students, residents and colleagues.

# Information for Residents & Fellows about Medical Student Feedback on Clinical Teaching

April 2010

Starting in May 2010, year 3 medical students will be invited to provide feedback on resident/fellow clinical teaching during core year 3 rotations. Students will anonymously complete an electronic form (no more than 3 per rotation) on One45.

The medical school must collect the information for quality assurance purposes. Only in cases of major bullying or abuse concerns (extremely rare, with a notification email electronically triggered by a "1" rating in item 1) will the medical school identify a resident or student, and then only for purposes of investigation to protect students. Otherwise, data on the medical school side, shared with clerkship directors and administration, will be compiled in a yearly report without student/resident/fellow names.

On the postgraduate side, the medical school has offered to share helpful data with individual residents and their program directors. Individual residents will have access to their own feedback data through their home program directors, offered every six to 12 months. Data will not be shared with residents/program directors unless at least 4 medical students have provided feedback, to preserve students' anonymity.

Students tend to highly regard resident/fellow teaching. Residents may use their feedback data as desired in their teaching dossiers, or may provide it with job applications, as evidence of teaching proficiency.

## Year 3 Core Clerkship Rotation Objectives

### *Rotation Objectives: Patient Encounters*

#### Year 3 MUST-SEEs

##### **Patient with:**

- Abdominal pain, acute
- Abdominal pain, child
- Back Pain
- Blood pressure low, shock
- Breast problem
- Chest pain
- Diarrhea, Adult
- Dyspnea
- Fever, Adult
- GI Bleed, Acute
- Hernia
- Liver abnormality, Adult
- Perianal problem
- Pain, Acute
- Prostate complaint
- Trauma, multisystem

### *Rotation Objectives: Procedures*

#### Year 3 MUST-SEEs

##### **Perform:**

- Arterial puncture (ABGs)
- Assisting in major surgery
- CXR reading
- Excision of small skin lesion
- Injections: administer SC, IM, IV push agents, perform intradermal
- PPD
- Intravenous insertion (IV)
- Nasogastric intubation (NG)
- Surgical knots (hand and instrument)
- Suture laceration/wound
- Urinary catheter insertion – female
- Urinary catheter insertion – male
- Venipuncture
- Wound dressing using sterile technique

##### **Assist:**

- Drains, remove
- Spine immobilization

##### **Observe:**

- Cardiopulm resuscitation (CPR)
- Chest tube/Thoracostomy tube insertion
- Lumbar puncture

## **Resident Transfers**

1. Resident to have valid and substantive reasons for switching programs. Normally, such a process would take place after an appropriate exposure to the discipline.
2. Resident contacts potential recipient program director to determine acceptability. The potential recipient program director indicates to a resident that (s)he is acceptable and the program is willing to transfer a PGY-1 position to donor program. Alternatively, the program director clearly indicates to resident that although the resident is acceptable, they will not agree to PGY-1 transfer. An additional option would be for the program director to indicate clearly to the residents that (s)he is not acceptable.
3. Resident discusses transfer with home program director.
4. Donor program director and recipient program director agree to resident transfer and terms of transfer.
5. Associate Dean's Office receives letters from donor and recipient program directors indicating transfer agreement.

### **ALTERNATIVE MECHANISM**

1. If disagreement between program directors regarding transfer arrangements, a committee of three, consisting of Postgraduate Dean and 2 unrelated program directors will investigate the transfer request and make a decision binding on the programs and resident.

### **TERMS OF REFERENCE**

1. The principles of the CaRMS match are paramount and residents cannot use the transfer mechanism to enter into a program "through the back door".
2. The training programs are given allocations determined by physician resource needs. No program should train residents beyond these needs. Physician resource needs will be considered before allowing any transfer.
3. Family Medicine and all Royal College programs will participate equally in any transfer arrangements.
4. Only a single transfer will be considered for a resident.

# Memorandum

Date:	April 1, 2011
To:	All VCH Medical Staff - New Appointments
From:	Dr. Dean Chittock, Senior Medical Director, VA Dr. Jonathan Fenton, Senior Medical Director, RHS Dr. Richard Lupton & Dr. John Maynard, Co-Senior Medical Directors, Coastal Dr. Ron Carere, VP, Medical Affairs PHC Yoel Robens-Paradise, Executive Director, Lower Mainland Health Information Management
Re:	Physician Documentation: Information and Education

As you are aware, quality of care depends upon accurate, complete and timely documentation of patient diagnoses, problems, treatment and progress. Medical staff rules outline regulations governing chart completion, stating that patients' health records should be completed at the time of discharge.

The move to standardized discharge summaries via dictation occurred on April 1, 2011. To support this, the target turnaround times for patient discharge to completion of physician documentation will be 48 hours. The Transcription Service targeted turnaround time to complete reports will be 24-48 hours.

The following information and resources are available for physicians:

- Standardized Discharge Summary Template
- Reference Cards (dictation and discharge summary template content)
- Introduction of the Discharge Instructions form (VA)
- On-line Presentation – Copy of live presentation: Physician Documentation (Note: Silverlight must be installed to view)  
Link: <http://mediasite.mediagroup.ubc.ca/MediaGroup/Viewer/?peid=8459c8a789d84a609a8c6cfbaadc40581d>
- On-line Presentation – Physician Documentation (Approximately 30 minutes)
  - Link: <https://ccrs.vch.ca/catalog.aspx?cid=2252>
  - Note: This link is searchable in Course Catalogue Registration System (CCRS) by typing in the word 'physician'. To attend the on-line presentation you will require your log in and password for CCRS. If you have forgotten your login and/or password, please contact [learnwithus@vch.ca](mailto:learnwithus@vch.ca).

The expectation is that VCH physicians complete dictated Discharge Summary Reports for patients discharged within the timelines noted above.

Implementation of the new policy related to deficiency notification and temporary suspension of admitting privileges will apply in cases of non-compliance.

These changes will help support direct communication of discharge summary information to family physicians and support the provincial Electronic Health Records strategy, better integrating primary care and disease management to support the continuity of care.

Thank you for your ongoing commitment to support quality patient care. If you have any questions or concerns regarding the above, please contact [HIM@providencehealth.bc.ca](mailto:HIM@providencehealth.bc.ca) or your Department Head.



## Discharge Summary Template

The Discharge Summary Template approved by the VCH Health Authority Medical Advisory Committee (HAMAC) provides a standard framework for physicians to consistently and effectively complete and communicate critical patient care information. The Discharge Summary should contain the following content if applicable.

**Most Responsible Diagnosis:** The reason for the longest acute length of stay/care or treatment

**Pre-Admit Diagnoses:** Medical conditions which existed prior to admission and affected the care/treatment and/or length of stay. Important to add if patient has an infection or colonization of MRSA/VRE/C-Difficile

**Post-Admit Diagnoses:** Medical conditions which arose since the time of admission including complications and affected the care/treatment and/or length of stay, even if they have resolved by the time of discharge. Important to add if patient became infected or colonized with MRSA/VRE/C-Difficile

**Secondary Diagnoses:** Other diagnoses that did not affect the care/treatment and/or length of stay but are important to communicate for continuity of care

**Code Status:** Indicate the status of the patient with respect to the desire for resuscitation

**Operative Interventions:** Interventions done in the formal Operating Room/Procedure Room

**Other Interventions:** Minor interventions performed outside of the formal Operating Room/Procedure Room that are important to communicate for continuity of care

**Flagged Interventions:** If the following interventions from the table were performed, they **must** be stated as they directly affect Patient-Focused Funding:

Cardioversion	Endoscopic /Percutaneous Biopsy	Per-office Endoscopy
Cell Saver	Feeding Tube	Pleurocentesis
Central Lines – PICC/Portacath	Heart Resuscitation	Tracheostomy
Chemotherapy	Mechanical Ventilation	Radiotherapy
Dialysis	Paracentesis	Total Parenteral Nutrition

**Names of Relevant Specialists:** Physicians that provide advice and/or treatment regarding the patient's condition

**Allergies:** Abnormal reactions of the immune system that occur in response to medications

**Medications on Discharge:** Details of discharge medications, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment

**Post-Discharge Follow-Up:** Follow-up instructions and specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations and outstanding tests and advanced directives if applicable

**Discharge Disposition:** The disposition and/ or the status of the patient on discharge (transferred to other institution, discharged home, sign-out, death, stillbirth or didn't return from a pass)

**Treatment/Course in Hospital:** Brief summary of the management of each of the active medical problems during the admission including major investigations, treatments and outcomes. Please include any vaccines given.

**Remember to copy relevant physicians** Author: Lower Mainland Health Information Management Coding Services (Feb 2011)





# Medication Reconciliation for Elective Surgery

Developed by:

Shelley Novak  
Medication Safety Pharmacist  
Fruzsina Pataky  
Regional Medication Safety Coordinator  
VCH-PHC Pharmacy Services

Revised February 2011

# Medication Reconciliation Form for Elective Surgery Patients

## **Background**

Seven out of 100 patients admitted to VGH will experience an adverse event. For every 100 patients admitted post-elective surgery in a Toronto hospital, 30 had a medication discrepancy, 9 of these had significant potential for harm. Many patients suffer harm from their hospital visit due to omission of medications that the patients were taking prior to admission.

For example

1. A patient with epilepsy may be admitted for routine surgery and their phenytoin is omitted and they have a seizure post-op.
2. A patient who normally takes warfarin to prevent stroke - never gets it ordered post-op or on discharge; and 3 months later has a stroke.

This kind of harm is completely preventable.

## **Purpose of Form**

To implement a process that ensures all pre-admission medications are documented and accounted for.



This form will

1. Capture patient's pre-admission medications
2. Verify medication history in the PAC
3. Re-verify patient's pre-admission medications in PCC
4. Provide a way to capture the surgeon's acknowledgement and intent to order or modify the patients' pre-admission medications

For any questions or problems, please page the Medication Safety Pharmacist at 604-205-3639

**Procedure for Surgery residents:**

1. When writing post-op orders for all elective surgery patients, look for the **Peri-Operative Medication Reconciliation Orders** in the Physician's Orders section of the patient's chart:

<b>IF YOU RECEIVED THIS FACSIMILE IN ERROR, PLEASE CALL IMMEDIATELY</b>		<i>Facility Patient Label</i>
  <p style="text-align: center;"><b>Peri-Operative</b></p> <p style="text-align: center;"><b>MEDICATION RECONCILIATION ORDERS</b></p> <p style="text-align: center;">(Page 1 of 5 )</p> <p style="text-align: center;">Printed on: 2010 Nov 29 14:07</p>	<p><b>PATHNET, TERESA I</b></p> <p>Birthdate: <b>1955 Jun 2</b>    Gender: <b>F</b></p> <p>PHN: <b>BC-9030146737</b></p>	

Clinical Information as per PharmaNet: 0 found.  
 Adverse Reaction(s) as per PharmaNet: PENICILLIN G POTASSIUM

The following is a PharmaNet extract as of **2010 Nov 29 14:07** of the most recent filled or discontinued prescriptions for the above patient in the province of British Columbia in the last **\*\* 6 Months \*\***

**\*\*\*Do not assume the patient is currently taking these medications or in these doses\*\*\* Please review each medication with the patient.**

Please note that changes MAY have been made to the patient's provincial medication records since this report was printed. In addition, it MAY contain discontinued medications and does NOT contain updated instructions the patient may have received from their physician or such items as non-prescription drugs, samples, investigational or clinical trial drugs, complementary and alternative therapies, selected prescriptions obtained through provincial programs (e.g. antiretrovirals), or prescriptions obtained from outside the province or over the Internet.

	Medication History:	Pre-op Verification:	Post-Operative Prescriber's Orders:	PharmaNet
<b>Medications as per PharmaNet:</b>  <b>FLUTICASONE/SALMETEROL 250-25MCG INHALER</b> TWO PUFFS TWICE DAILY  2010 Nov 29 Qty: 120.0 Filled HEATHCOTE CPSID: 91/13867 [Max Daily Dose: 60.000 per PharmaNet]	Date: _____ Designation: _____ Verified by: _____  <input type="checkbox"/> Taking differently (specify):  <input type="checkbox"/> Taking as per PharmaNet <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: _____ <input type="checkbox"/> Unable to verify	Date: _____ Designation: _____ Verified by: _____  <input type="checkbox"/> Taking as per Medication History <input type="checkbox"/> Taking differently (specify):  <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: _____ <input type="checkbox"/> Unable to verify	<b>If NO ACTION is specified, medication will be DISCONTINUED</b>  <input type="checkbox"/> Resume as per Pre-op Verification <input type="checkbox"/> New Directions: <input type="checkbox"/> Dose, route and frequency as per PharmaNet <input type="checkbox"/> Start on POD# _____ <input type="checkbox"/> Hold for evaluation <input type="checkbox"/> Discontinue	PHARMA NET
<b>FUROSEMIDE 40 MG TABLET</b> TAKE ONE TABLET DAILY  2010 Oct 8 Qty: 90.0 Filled MCCANN CPSID: 91/02198 [Max Daily Dose: 1.000 per PharmaNet]	Date: _____ Designation: _____ Verified by: _____  <input type="checkbox"/> Taking differently (specify):  <input type="checkbox"/> Taking as per PharmaNet <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: _____ <input type="checkbox"/> Unable to verify	Date: _____ Designation: _____ Verified by: _____  <input type="checkbox"/> Taking as per Medication History <input type="checkbox"/> Taking differently (specify):  <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: _____ <input type="checkbox"/> Unable to verify	<input type="checkbox"/> Resume as per Pre-op Verification <input type="checkbox"/> New Directions: <input type="checkbox"/> Dose, route and frequency as per PharmaNet <input type="checkbox"/> Start on POD# _____ <input type="checkbox"/> Hold for evaluation <input type="checkbox"/> Discontinue	

ORIGINAL - ORDERS SECTION OF CHART

FAX ALL PAGES TO PHARMACY POST-OP

(Date and Time)	(College ID Number)
(Prescriber Printed Name)	(Prescriber Signature)



PHC-PH320 (Nov 10) Requested by: tpatakyl 91/13867 Dr. HEATHCOTE, JOHN at BC01300120 Lion's Gate Hospital

2. In the last two columns of the form under the "Post-Operative Orders" column, indicate the action you would like to perform. See Appendix A.
3. Add comments as necessary for changing doses, etc. Sign and date the form. Check for additional pages. See Appendix B.

APPENDIX A

**IF YOU RECEIVED THIS FACSIMILE IN ERROR, PLEASE CALL IMMEDIATELY**

<p style="text-align: center;"><b>Peri-Operative</b>  <b>MEDICATION RECONCILIATION ORDERS</b>          (Page 1 of 5)          Printed on: 2010 Nov 29 14:07</p>	<p><b>PATHNET, TERESA I</b>          Birthdate: 1955 Jun 2 Gender: F          PHN: BC-9030146737</p>
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Post-operative Orders to be filled out by surgery Resident or Surgeon.

Tick off action box for each drug.

Clinical information as per PharmaNet: 0 found.  
 Adverse Reaction(s) as per PharmaNet: PENICILLIN G POTASSIUM

The following is a PharmaNet extract as of 2010 Nov 29 14:07 of the most recent filled or discontinued prescriptions for the above patient in the province of British Columbia in the last **\*\* 6 Months \*\***

**\*\*\*Do not assume the patient is currently taking these medications or in these doses\*\*\* Please review each medication with the patient.**

Please note that changes MAY have been made to the patient's provincial medication records since this report was printed. In addition, it MAY contain discontinued medications and does NOT contain updated instructions the patient may have received from their physician or such items as non-prescription drugs, samples, investigational or clinical trial drugs, complementary and alternative therapies, selected prescriptions obtained through provincial programs (e.g. antiretrovirals), or prescriptions obtained from outside the province or over the Internet.

	Medication History:	Pre-op Verification:	Post-Operative Prescriber's Orders:
<b>Medications as per PharmaNet:</b> Date: <u>Nov 29/10</u> Designation: <u>RN</u> Verified by: <u>AB</u>	Date: <u>Jan 4/11</u> Designation: <u>RN</u> Verified by: <u>CD</u>	Date: <u>Jan 4/11</u> Designation: <u>RN</u> Verified by: <u>CD</u>	If NO ACTION is specified, medication will be DISCONTINUED
<b>FLUTICASON/SALMETEROL 250-25MCG INHALER</b> TWO PUFFS TWICE DAILY  2010 Nov 29 Qty: 120.0 Filled HEATHCOTE CPSID: 9113867 [Max Daily Dose: 60,000 per PharmaNet]	<input type="checkbox"/> Taking differently (specify): <input checked="" type="checkbox"/> Taking as per PharmaNet <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: _____ <input type="checkbox"/> Unable to verify	<input checked="" type="checkbox"/> Taking as per Medication History <input type="checkbox"/> Taking differently (specify):  <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: <u>Jan 3/11 1800</u> <input type="checkbox"/> Unable to verify	<input checked="" type="checkbox"/> Resume as per Pre-op Verification <input type="checkbox"/> New Directions: <input type="checkbox"/> Dose, route and frequency as per PharmaNet <input type="checkbox"/> Start on POD# _____ <input type="checkbox"/> Hold for evaluation <input type="checkbox"/> Discontinue
<b>FUROSEMIDE 40 MG TABLET</b> TAKE ONE TABLET DAILY  2010 Oct 8 Qty: 90.0 Filled MCCANN CPSID: 9102198 [Max Daily Dose: 1,000 per PharmaNet]	<input checked="" type="checkbox"/> Taking differently (specify): <u>40mg bid</u> <input type="checkbox"/> Taking as per PharmaNet <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: _____ <input type="checkbox"/> Unable to verify	<input checked="" type="checkbox"/> Taking as per Medication History <input type="checkbox"/> Taking differently (specify):  <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: <u>Jan 3/11 1800</u> <input type="checkbox"/> Unable to verify	<input checked="" type="checkbox"/> Resume as per Pre-op Verification <input type="checkbox"/> New Directions: <input type="checkbox"/> Dose, route and frequency as per PharmaNet <input type="checkbox"/> Start on POD# <u>2</u> <input type="checkbox"/> Hold for evaluation <input type="checkbox"/> Discontinue

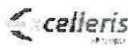
ORIGINAL - ORDERS SECTION OF CHART

FAX ALL PAGES TO PHARMACY POST-OP

<u>Jan 4/11</u> (Date and Time)	<u>12345</u> (College ID Number)
<u>D. Duck</u> (Prescriber Printed Name)	<u>D. Duck</u> (Prescriber Signature)



APPENDIX B

<b>IF YOU RECEIVED THIS FACSIMILE IN ERROR, PLEASE CALL IMMEDIATELY</b>		<i>Facility Patient Label</i>
 <b>Peri-Operative</b> (Page 1 of 5 ) Printed on: 2010 Nov 29 14:07	<b>PATHNET, TERESA I</b> Birthdate: 1955 Jun 2 Gender: F PHN: BC-9030146737	

Clinical Information as per PharmaNet: 0 found.  
 Adverse Reaction(s) as per PharmaNet: PENICILLIN G POTASSIUM

The following is a PharmaNet extract as of 2010 Nov 29 14:07 of the most recent filled or discontinued prescriptions for the above patient in the province of British Columbia in the last **\*\* 6 Months \*\***

**\*\*\*Do not assume the patient is current in these doses\*\*\* Please review each page of this report was printed. In addition, it MAY contain prescriptions for prescription drugs, samples, investigational or clinical trial drugs, complementary and alternative therapies, selected prescriptions obtained through providers or over the Internet.**

Check for additional pages.

Changes in doses or directions can be included if necessary.

Medications as per PharmaNet:	Medication History:	Pre-op Verification:	Post-Operative Prescriber's Orders:	POD#
<b>FLUTICASONE/SALMETEROL 250-25MCG INHALER</b> TWO PUFFS TWICE DAILY  2010 Nov 29 Qty: 120.0 Filled HEATHCOTE CPSID: 91/13867 [Max Daily Dose: 90.000 per PharmaNet]	Date: <u>Nov 29/10</u> Designation: <u>RN</u> Verified by: <u>AB</u> <input type="checkbox"/> Taking differently (specify): <input checked="" type="checkbox"/> Taking as per PharmaNet <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: _____ <input type="checkbox"/> Unable to verify	Date: <u>Jan 4/11</u> Designation: <u>RN</u> Verified by: <u>CD</u> <input checked="" type="checkbox"/> Taking as per Medication History <input type="checkbox"/> Taking differently (specify): <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: <u>Jan 3/11 1800</u> <input type="checkbox"/> Unable to verify	If NO ACTION is specified, medication will be DISCONTINUED <input checked="" type="checkbox"/> Resume as per Pre-op Verification <input type="checkbox"/> New Directions: <input type="checkbox"/> Dose, route and frequency as per PharmaNet <input type="checkbox"/> Start on POD# _____ <input type="checkbox"/> Hold for evaluation <input type="checkbox"/> Discontinue	
<b>FUROSEMIDE 40 MG TABLET</b> TAKE ONE TABLET DAILY .  2010 Oct 8 Qty: 90.0 Filled MCGANN CPSID: 91/02198 [Max Daily Dose: 1.000 per PharmaNet]	<input checked="" type="checkbox"/> Taking differently (specify): <u>40mg bid</u> <input type="checkbox"/> Taking as per PharmaNet <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: _____ <input type="checkbox"/> Unable to verify	<input checked="" type="checkbox"/> Taking as per Medication History <input type="checkbox"/> Taking differently (specify): <input type="checkbox"/> Holding for surgery <input type="checkbox"/> No longer taking Last taken at: <u>Jan 3/11 1800</u> <input type="checkbox"/> Unable to verify	<input checked="" type="checkbox"/> Resume as per Pre-op Verification <input type="checkbox"/> New Directions: <input type="checkbox"/> Dose, route and frequency as per PharmaNet <input type="checkbox"/> Start on POD# <u>2</u> <input type="checkbox"/> Hold for evaluation <input type="checkbox"/> Discontinue	

ORIGINAL - ORDERS SECTION OF CHART      FAX ALL PAGES TO PHARMACY POST-OP

PHC-PH320 (Nov 10) Requested by: fpataky1 91/13867 Dr. HEATHCOTE, JOHN	BC01200120 - Lion's Gate Hospital
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Jan 4/11 (Date and Time)	12345 (College ID Number)
D. Duck (Prescriber Printed Name)	D Duck (Prescriber Signature)

Date, print and sign EVERY PAGE.