



Rawalpindi Medical University

RESIDENCY PROGRAM

TRAINEE'S GUIDE

Prof. Muhammad Umar
Prof. Bushra Khaar



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"No greater opportunity, responsibility, or obligation can fall to the lot of a human being than to become a physician. In the care of the suffering, he needs technical skill, scientific knowledge and human understanding. He who uses these with courage, with humility, and with wisdom will provide a unique service for his fellow men, and will build an enduring edifice of character within himself. The physician should ask of his destiny no more than this; he should be content with no less".

The Editors, Harrison's Principles of Internal Medicine

A GOOD DOCTOR

"One who uses the ever growing body of rigorously obtained evidence (the science of medicine) in a sensible, compassionate manner (the art of medicine)".

EVIDENCE BASED MEDICINE

"The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients",

Sackett

MISSION STATEMENT

SERVICE	For ailing humanity, by the well trained doctors using latest knowledge and equipment
EDUCATION	For Undergraduate and Postgraduate
RESEARCH	To enhance the medical knowledge and to see the pattern of disease in local perspective



Contents

PREFACE	8
INTRODUCTION	9
OBJECTIVE	10
SECTION - I	11
SOPS FOR PATIENT CARE	11
SOPs FOR INDOOR PATIENTS	12
SOPs FOR EMERGENCY DEPARTMENT	15
SOP'S FOR OUT PATIENT DEPARTMENT	18
SOP's FOR INTENSIVE CARE WARD	19
FORMATION OF ITC	20
SOPS FOR PROCEDURE ROOM	22
SOPS FOR ENDOSCOPY ROOM / ECHOCARDIOGRAPHY	23
SOPs FOR STAFF NURSES	24
SOPs FOR WARD SERVANTS	25
JOB DESCRIPTION OF ATTENDING STAFF	27
ASSOCIATE PROFESSOR/ASSISTANT PROFESSOR/SENIOR REGISTRAR	28
HOUSE OFFICERS TRAINING PROGRAM	29
CLINICAL TRAINING PROGRAM (STRUCTURE)	30
SECTION - II	32
OVERVIEW OF THE TRAINING PROGRAM IN MEDICINE	33
SHORT CASES	38
LONG CASES	39
SEMINARS	40
REGISTRARS SEMINARS	41
JOURNAL CLUB	42
INTERACTIVE SESSION	43
PROBLEM CASE PRESENTATION	44
ECG TUTORIAL	45
RADIOLOGY TUTORIAL	46
A MORNING MEETING	47
EVENING ROUNDS FORMAT	48
CONSULTANT COVER	49
EFFECTIVE WORKING HOURS	50
MANDATORY WORKSHOPS	51
MANDATORY DISSERTATION / PAPERS	58
LOG BOOK	59
PORTFOLIO	60
SECTION - III	61
EVALUATION OF TRAINEES	61

PREFACE

This training manual created by Prof. Umar and Prof Bushra is a great guide for residents and House Officers working in medical department.

With the untiring efforts of Prof. Umar the institute has achieved another mile stone and with the advent of Rawalpindi Medical University new horizons of training and research are now available.

Although this manual is already an updated document, but slight changes have been made in reference to the changing scenario, especially incorporation of MD training program.

Special thanks to Prof. Bushra Khaar, Associate Prof. Fazal-ur-Rehman, Associate Prof. Saima Ambreen for their guidance, Dr. Zahid Minhas for his support and Mr. Jahanzeb for his technical assistance.

Dr. Tayyab Saeed Akhter
MBBS, FCPS
15th March 2018

INTRODUCTION

The Medical department of Holy Family Hospital comprises of Medical Unit I & II with 54 beds each, ICU & CCU with 12 beds each, Gastroenterology department with 14 beds, Nephrology department with 17 beds, Department of infectious diseases (DID) with 70 beds respectively.

It not only caters the catchments area of Rawalpindi city, patients are also referred from all other Cities of Rawalpindi Division, and from Azad Kashmir & Northern Areas particularly for treatment of GI and the liver diseases.

Each year approximately 80-100 young doctors are trained in the unit. Each trainee works in one of the three domains including inpatient, emergency/out patient and critical care. They are trained for the patient's care, which includes history taking, clinical examinations, investigations and treatment. The trainees are responsible for writing the progress notes, meeting the family members and dealing with difficult situations encountered during training. For those interneers who are here for three months will be working in one rotation for one month and those who are here for six months they will be working in one rotation for two months.

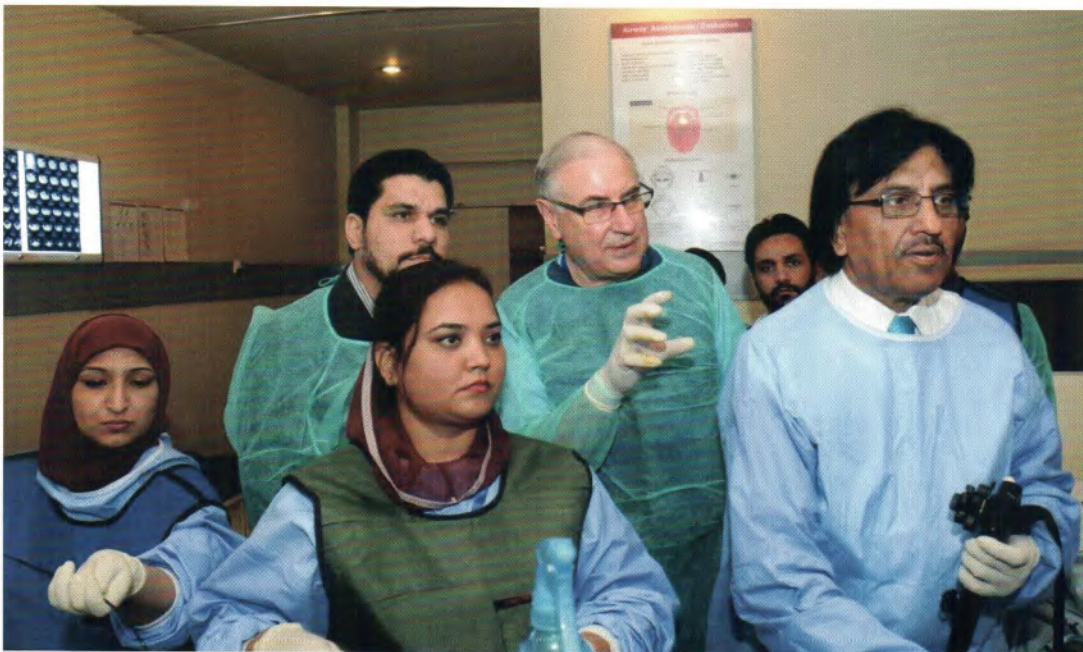
The interneers are welcome and encourage joining multiple academic activities going through the Institute. Their clinical responsibilities towards patients care will take precedence over all academic activities. The progress of each interneer will be monitored in accordance with the plan schedule. An experience certificate will be given at the end of internship will reflect the performance of interneers on multiple parameters.

OBJECTIVES

1. To provide a working guideline for the young doctors, house officers and post graduate trainees in the form of standard operating procedures(SOPs) related to different sections of medical department
2. To give overview of the training program
3. To have an insight to the evaluation system
4. To acclimatize the new trainee regarding all the aspects of working and training in medical department

SECTION-I

SOPS FOR PATIENT CARE



SOPs FOR INDOOR PATIENTS

Inpatient: (Male/Female/Officers/ICU Wards)

All shifts should follow strict timings

Daily Notes and Evaluation

1. House officers and residents are primarily responsible for writing daily notes on each of their patients.

SOAP Format should be used for daily notes

2. Subjective: What patient says and what nursing staff reports in past 24 hours
3. Objective Factual Information/Vitals/Physical Exam/Lab Results/Lines and tubes include X-rays and other studies, intake and output, side effects of drugs
4. Assessment and Plan: Usually categorized by problem or organ system in order of importance. Always include Fluids/Electrolytes/Nutrition as well as code status in every note. Also include Discharge planning/status and Goals etc.
5. Active Medicines are often listed in side column. Review medications daily. Include day no for Antibiotics and other loading dose medications.
6. Every lab result/investigation report should be analyzed carefully and countersigned by House officer/Resident Abnormal investigations is be highlighted.
7. Formulate Active Problem list.
8. Draw algorithm of patient's symptoms, where applicable.
9. House officers, should write in blue and registrars in red ink.

Drug Reviews

1. Drug dosage, side effects and interactions should be checked daily and major points should be noted down in patients file.

Daily Reviews

2. Do IV lines need to be changed?
3. Can IV medicines be changed to Oral?
4. Can you discontinue Foley, NG and IV Cannula?
5. Can you advance diet and increase patient's activities?
6. Is patient moving his/her Bowels?
7. Are all medicines adjusted for Renal and Hepatic Function?
8. Every lab test or study needs to be followed up.
9. When in doubt ask and ask again.

Admissions

1. For new admissions immediately receive patient, check vitals before digging through old records, lab results, old discharge summary and old charts.
2. After assessment and patient's physical exam, complete admission orders including drug prescription immediately.
3. For stat orders inform nursing staff immediately or carry out by yourself.
4. House officer on call should complete notes on History & physical Examination for all admissions
5. House officer incharge for bed will write his/her initial summary within 24 hours of admissions and will complete notes in detail.
6. In case of transfer of patient from one bed/ward to other concerned HO/registrar will write his/her own summary.

7. PGT incharge for the bed will write his/her own summary upon receiving the patient. He/She will be held responsible for the completion and maintenance of patients file in a systematic way.

Procedure Notes

1. Procedures should be done with a proper written consent.
2. Should include name, site, indications, consent, sterile prep and anesthesia of procedure, description of specimen, or fluid, what and where they are sent for, with brief clinical notes.
3. Inform patient regarding indication, complication and past procedure precautions.
4. Never forget pending follow up studies like post procedure X-ray.
5. If certified in a certain procedure only then trainee will be allowed to perform independently other wise procedure should be done under supervision of a senior/certified person.

Discharges

1. All discharges will be made by the PGTs.
2. Keep in mind pending issues and studies.
3. Communicate with all involved parties for smooth discharge.
4. Start discharge planning on admission.
5. Make sure patient and family are aware of possible discharge dates so they can arrange / schedule transportation.
6. Preferably change IV antibiotics to oral one day before discharge, avoid orders on morning of discharge unless absolutely necessary.
7. Give clear instructions regarding meds schedule/side effects/precautions and Restrictions on activities/travel/diet in Urdu/local language. Make sure by repetition that patient can repeat/recall your instructions.
8. Write discharge diagnosis clearly.
9. D/C summary should include chief complaints and H/O present illness, hospital course, your name/ward name/Hospital name/DOA &DOD/Principal and secondary diagnosis and procedures.
10. Mention follow-up/condition on discharge/attach diet chart if required.

Sign Outs

1. Sign-out time shall be 3 pm. After this time the on call PGT and HOs team will be responsible to look after the Inpatients.
2. For on-call batch, outgoing House officer will give written information about their patient's active issues and it should include Name of patient, ward/bed no., diagnosis, active issue or pending critical labs., consultations and procedures. Also, include certain criteria to act on e.g. Transfuse one unit packed cell if Hct is less than 28.
3. CODE Status must be specified.
4. Highlight worrisome patient's issue of concern and suggestions to deal with them.

Death/ Expirations

1. DNAR (Do not attempt resuscitation) status should be decided after discussion with consultant on call.
2. On being called to pronounce death, you must perform certain steps.
3. On arrival to bed side observe for respirations, auscultate for heart sound palpate for pulse, check pupils and corneal reflex.
4. Obtain an ECG with straight line as evidence of death and attach with patient file.
5. Complete death notes on progress sheet and fill death certificate as early as possible.
6. File of patient along with relevant record should be handed over to the charge nurse after the death of the patient.

Pre Rounds

1. For pre-rounds allow 30 min to one hour before consultant rounds but it depends on no of patients under your care.
2. Get your sign out from Night flat or cross cover team. You must know any major event that happened over night and this will dictate how you spend your time pre-round.
3. Try to read relevant text for your patient from pocket handbook or guide before attending rounds.

Occupational Risks

1. Standard barrier nursing and isolation techniques should be employed in cases of patients with infectious communicable disease.
2. These measures include:
 1. Gloves
 2. Masks
 3. Careful needles/sharp objects handling.
1. Prophylaxis in cases of exposure if indicated (e.g. meningococemia)
2. In case of mishap/exposure, event should be reported to consultant on call, immediately.

Accountability

1. In case of an incident, a committee of ward consultant will review the entire case in detail and will decide about warning/penalty.

Ethical Issues

2. Best interest of the patient should be watched, in case of conflict or confusion issue should be discussed with consultant on call.

Confidentiality Of Patient's Data

3. Patient's record and data should be kept confidential to watch his/her interests and diagnosis prognosis should not be discussed with attendants without permission of patient/close attendant.

Patient Education

4. During in patient stay, every opportunity should be availed to educate patients and their family regarding their illness and management.

Ward In-Charge Resident Duties

5. Maintenance and cleanliness of all ward facilities (Electricity ports / fans / tubes etc).
6. Maintenance of Admission and discharge register by HO / Nurses and Registrar concerned.
7. Updating of information board.
8. Facilities regarding patient's attendants.
9. Check crash trolley / Emergency cart and maintenance daily.
10. Record and maintenance of all ward items (Stretcher / Wheel chair / Drip set stands / bed with railing / Bed pans / Bath room maintenance and cleanliness check). In female ward class room maintenance.

Dress Code

1. Dressing should be simple but decent. No informal clothing (jeans & T. shirts for males), party wears or excessive jewelry (for females) is allowed, during duty hours.
2. For female doctors there should be no hanging dupatas and male doctors should wear dress pant and shirt with tie. Scrubs can also be used as alternatives.
3. Every doctor should wear neat & clean overall, with properly displayed ID card or Nameplate.

SOPs FOR EMERGENCY DEPARTMENT

All shifts should follow strict timings.

Notes and Evaluation

1. House officers and residents are primarily responsible for managing patients in Emergency during their call day.
2. Referred patients should be seen within 10 minutes of referral by CMO. Immediately receive patient, check vitals before digging through old record, lab results, old discharge summary and old charts.
3. SOAP format should be used for patient notes. Proper documentation of symptoms, management and diagnosis will be done for every patient. Serious patients should be immediately seen and resuscitated. Procedure of referral & consultation will proceed side by side. Monitoring notes should be properly maintained including fluids given and output of patient.

Admissions

1. Duty registrar should decide all admission through ER.
2. After assessment and patient's examinations complete admission orders including drug prescription should be written clearly and immediately.
3. For stat labs inform nursing staff immediately or carry out by your self.
4. Notes on history and examination file should be completed before shifting to In-Patient.
5. Complete shifting notes before shifting to the ward.
6. Para-med staff should accompany every admitted patient during shifting to the ward In case of serious patient, house officer should accompany.
7. Before shifting, inform the ward staff on call.
8. If beds are not available in wards, retain patients in ER till arrangement are made; If required discuss with consultant on call or DMS ER.

Procedure Notes

1. Write notes for every procedure, which should include Name, Site, Indication, Consent, Sterile prep and anesthesia of procedure. Description of specimen of Fluid and what and where they are sent for with brief clinical notes.
2. Inform patient regarding indications, complications and post-procedure precautions.
3. Get signatures on informed consent.
4. Never forget pending follow up studies like Post-Procedure X-ray.

Discharges

1. No patient should be discharged without being evaluated by the duty registrar.
2. Keep in mind pending issued and studies.
3. Communicate with all involved parties for smooth discharge.
4. Give clear instructions regarding medicines schedule/side effects/precautions and restrictions on activities/travel/diet in Urdu/local language Make sure by repetition that patient can repeat/recall your instructions.
5. Write **discharge diagnosis** clearly.
6. Notes should include Chief complaints and H/O Present illness, hospital stay course, Your Name, Hospital No/principal and secondary diagnosis and Procedures.
7. Mention Follow-up plan/condition on discharge/attach Diet chart if required.

Signouts

1. For on-call batch, out going House officer will give written information about their patient's Active issues and it should include Name of patient, ward/bed no. diagnosis, active issue or pending critical labs.,

consultations and procedures. Also, include certain criteria to act on e.g. Transfuse one unit packed cell if Hct is less than 28.

2. CODE Status must be specified.
3. Highlight worrisome patients, issue of concern and suggestions to deal with them.

Death / Expirations

1. On being called to pronounce death you must perform certain steps.
2. On arrival to bed site observe for respirations, auscultate for heart sound palpate for carotid pulse, check pupil and corneal reflex.
3. Complete death notes on progress sheet and fill death certificate as early as possible.
4. Attach ECG strip as evidence of death with patient file.

Urgent Thrombolysis

1. In patients with indications for Thrombolysis, every possible effort should be made to achieve urgent Thrombolysis to decrease "door-to-needle-time" in order to save precious myocardium.

Occupational Risks

2. Standard barrier nursing and isolation techniques should be employed in cases of patients with infectious communicable diseases.
3. These measures include:
 1. Gloves
 2. Masks
 3. Careful needle/sharp object handling
 4. Prophylaxis in cases of exposure if indicated (e.g. meningococemia).

In case of mishap/exposure, event should be reported to consultant on call, immediately.

Accountability

1. In case of an incident, a committee of ward consultant will review the entire case in detail and will decide about warning/penalty.

Ethical Issues

2. Best interest of the patient should be watched, in case of conflict or confusion, issues should be discussed with consultant on call.

Confidentiality of Patient's Data

3. Patient's record and data should be kept confidential to watch his/her interests and diagnosis/prognosis should not be discussed with attendants without permission of patient/close attendant.

Senior Consultation

4. On call consultant/senior registrar should be contacted on phone if required by the registrar on call. If he/she may request to see the patient then on call consultant should try to attend the patient personally within 1 hour of the request.

Consultations from Other Departments / Urgent Scans

5. Consultants and scans should be decided by the duty registrar and call to the respective department should be written with clear indications exact questions to be observed and urgency of the consultation.

Patient Transfer to Other Facilities

6. Once decision is made to transfer the patient to the other hospital for management, contact the concerned doctor/staff there first on telephone and discuss the case in detail and request them to make sure the bed is available for the patient.

7. Note down the contact person's name and designation.
8. Provide detailed notes on the referral slip.
9. Provide ambulance preferably by the hospital through coordination with DMS/CMO, and if patient is serious, a doctor should accompany while transportation.
10. Ambulance should be equipped with resuscitation equipment.

Record Keeping

1. ER register shall be filled properly with composite diagnosis or relevant differential for every patient.
2. Duty registrar will sign register at the end of duty, and counter-signed by covering consultant for that day before morning meeting.
3. Record of consultations provided to other department should be kept in the registrar.
4. Death notes for patients who expired in ER should be written in the ER register immediately after the event.

Drugs & Investigations

1. List of drugs and lab profile available in hospital for ER patients should be available to each shift of ER staff.

Duty Timings

2. House officer = 8 am to 8 pm- second shift 8pm to 8am (nm)
3. Registrar = 8am to 8 am (nm) (batch on call should adjust the timing with mutual understanding)

BLS/ACLS Training

1. House officers and registrar should be trained in BLS/ ACLS before performing duties in E.R.

Dress Code

2. Dress should be conservative & modest. No informal clothing (jeans & T-shirts for males), party wears or excessive jewelry (for females) is allowed, during duty hours.
3. Every doctor should wear neat & clean overall, with properly displayed ID card or name plate.

SOP'S FOR OUT PATIENT DEPARTMENT

1. The batch of House Officers on duty will reach the OPD at 8 'O' in the morning on OPD days.
2. The registrar has to reach the OPD up to 9:00 am after giving the ward report.
3. The consultant will reach the OPD up to 9:30 am after attending the morning session.

HOUSE OFFICERS

1. The house officer will take the history of the patient and write the summary in SOAP format.
2. He will discuss the case with registrar and will act accordingly.
3. No house officer is allowed to send any patient without consulting the registrar.
4. House Officer can also consult the consultant as per requirement.
5. He will write everything clear, medicines in capital letter and prescription and will sign the chit and also will write his / her name clearly.

REGISTRARS

1. Registrar will see all the patients seen by the house officer and will give proper and clear advice regarding diagnosis,
2. Management and education of the patient.
3. He will also consult all new patients with consultant and follow up cases if necessary. He will admit the patients if required and can send patient to ER for ER management.
4. He will be responsible for the proper supervision and guidance of the house officers.
5. He will immediately inform the consultant on call for any mishap and try to resolve the issue.

CONSULTANTS

1. All patients requested by the house officer or registrar will be seen by the consultant.
2. He will make a diagnosis of the disease, will teach and train the registrars and house officers and implement the training program for patient care.
3. He will keep the discipline and supervise every house officer and registrar.

SOP's FOR INTENSIVE CARE WARD

All shifts should follow strict timings.

1. House officers and residents are primarily responsible for writing daily notes on each of their
2. patients.
3. **S.O.A.P. format** should be used for daily notes.
4. Drug dosage, side effects and interactions should be checked daily and major points should be
5. noted down in patients file.

Daily Reviews

1. Do IV Lines need to be changed?
2. Can IV Meds be changed 100 Oral?
3. Can you discontinue Foley, NG and IV Cannula?
4. Can you advance diet and increase patient's activities?
5. Is patient moving his/her Bowels?
6. Are all meds are adjusted for Renal and Hepatic Function?
7. Every lab test or study needs to be followed up
8. When in doubt ask and ask again.

Equipment, Resuscitation Drugs and Crash Cart Check.

1. With the help of duty staff nurse, house officer will daily check for working of equipment, drug availability.
2. Resident will counter sign daily check list for drugs and equipment's.
3. Any discrepancy should be reported to concerned DMS/AMS in writing and record should be kept for every application.

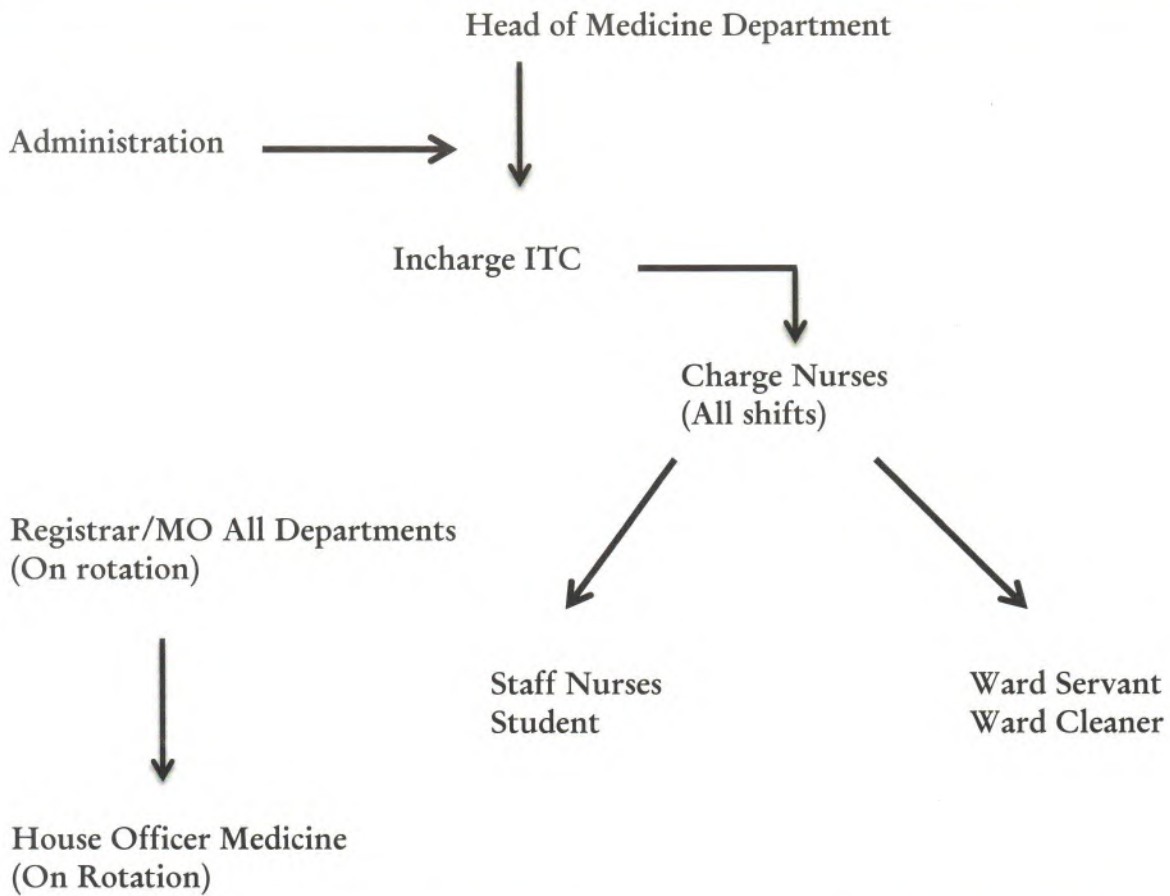
FOR DISINFECTION FOLLOW DISINFECTION PROTOCOL.

FOR ALL ADMISSIONS & DEATHS FOLLOW SOP FOR WARD PATIENT CARE.

SOP's FOR INTENSIVE CARE UNIT(ICU)

1. All shifts should follow strict timings:
 1. Morning 07:30 14:00
 2. Evening 13:30 20:00
 3. Night 19:30 08:00
2. All fixed ITC staff, if possible, should wear OT dress and doctors will wear gowns/scrubs.
3. Strict aseptic measures should be taken in ITC i.e. Masks, Gloves, Caps, Shoes etc.
4. No attendant, who so ever he/she is, NOT ALLOWED TO ENTER ITC except during following hours:
 1. Morning 07:00 07:30
 2. Evening 13:00 14:00
 3. Night 17:30 20:30
5. No staff member except doctor will ask attendants to buy medicines from medical store. The concerned doctor will duly sign the prescription slip.
1. All lab/radiological tests will be requested on presented request forms signed by MO/PGT of ICU.
6. The decision about the shifting of the patients to ITC must be made by registrars with full clinical notes and indications and House Officer of the concerned department should be there to receive the patient. **No VIPs/protocols or non bed availabilities in other wards should be considered.**
7. Patients admitted/shifted in ITC by any Department, the House Officers of concerned Department must stay round the clock with their patients, abiding by all the rules and regulations of ITC. **No chit system** will be entertained; the house officer of concerned department on call will be present at all times.
8. House Officers/Medical Officers/Registrars rosters of all departments should be displayed on ITC notice board.
9. All non-concerned doctors/staff will enter inside ITC after changing shoes.
10. Staff/Doctors on duty in ITC will not leave their place of duty in any case.
11. A complaint box will be placed in ITC for complaints of patients/attendants of ITC.
12. Any complaints/problems/suggestion by any doctors/staffs or any hospital employee concerning ITC should be submitted with In Charge ITC.
13. No visitor of any duty staff/doctors of ITC should be entertained during duty hours.
14. There will be **three shifts in-charge nurses** and they will have their own medicine cupboards and maintain their record.
15. Morning In-charge staff will also keep stock of linen (All shifts).

FORMATION OF ITC



SOPS FOR PROCEDURE ROOM

Procedures to Be Done

1. Lumbar Puncture
2. Pleurocentesis
3. Abdominal Paracentesis
4. Pericardiocentesis
5. Liver Biopsies
6. Pleural Biopsies

Format

1. One registrar and one house officer will be appointed on one month rotation as incharge of procedure room under supervision of consultant incharge.
2. The incharge will be responsible for maintenance and audit of
 1. Essential drugs
 2. Stock
 3. Cleanliness
3. Incharge will keep one set of keys with them and one set of keys will be with the staff of the west wing.

Procedure Protocols

1. All elective procedures should be done before 2:00 pm.
2. Emergency procedures can be done at any time.
3. Entry of attendants is not allowed in procedure room.
4. All the doctors and paramedics and patients are supposed to wear shoe covers or change their shoes on entering the room.
5. All procedures performed should be entered in the procedure room register.



SOPS FOR ENDOSCOPY ROOM / ECHOCARDIOGRAPHY

1. One day prior to endoscopy, the registrar on call will depute a house officer to make the list of the patients.
2. They will prepare the patients as per requirement.
3. For upper GI endoscopy, the patient will be kept NPO after 12 AM.
4. For colonoscopy, the patient has to be put on liquid diet for 03 days, daily intestinal laxatives, klean enema one night before sending the patient to colonoscopy suite.
5. The patients with upper GI bleed have to be properly washed before sending to endoscopy room.
6. The registrar on duty will make a list of all patients who have reached in procedure room.
7. The registrar will nominate one house officer for BP, pulse, cannula, IV solution and other mandatory requirements before shifting the patients.
8. One house officer will write report while one other house officer will explain the proper indication and diagnosis along the test reports to the consultant doing the procedure.
9. All other house officers will assist the procedure.
10. All house officers are required to properly observe the procedure protocol, and will also come with learning outcome at the end of their duties.
11. Registrars will assist the consultants and learn the sterilization, procedure under supervision.
12. The echo list will be made and assisted accordingly.



SOPs FOR STAFF NURSES

1. All staff nurses must have key of store and bed sheets.
2. Must wear OT dress (for ITC).
3. Must not leave respective ward and so should not sit at nursing station.
4. Report any non-availability of drugs to concern house officer and not just write N/A on treatment sheet.
5. Must maintain proper intake / output, treatment and other charts.
6. Report register of staff nurses will also be maintained in which they will write about the problems regarding working of students, nurses, ward servants, ward cleaners, availability of medicines and working equipments.
7. Should take over charge at the start of their duty bed to bed and strictly maintain handling / taking.
8. Staff nurses are responsible of feeding, mouth care and general care of patients.
9. Vital sign charts should be maintained on hourly basis.
10. Intake / output chart should be maintained properly and output should be entered twice daily i.e. 6:00 AM and 6:00 PM.
11. Should check the proper working of ward servants, ward cleaners, and report any irregularity on report register.
12. In case of any problem regarding patients should immediately inform doctors on duty.
13. Will draw the samples using full aseptic measure and dispatch on register.
14. Check list provided by doctors should be checked and sign by staff nurses.
15. If anything lost or damaged during dy any staff, she should be responsible for it.
16. Over should be given by students.
17. All staff should know how to operate and interpret cardiac monitor.
18. Should have knowledge about defibrillator.
19. They are also responsible for maintenance and working of all equipments and cleanliness if the ward in their duty hours.
20. Responsible for proper bedding etc.
21. Dispose used syringes / cannulas / IV sets properly.
22. Patient's register will be maintained and should contain all information regarding admission and progress of patient in each shift.

SOPs FOR WARD SERVANTS

1. Must follow proper timing.
2. Must wear OT dress (for ITC).
3. Must stay in ward.
4. Should not follow any personal orders i.e. to bring tea for staff on duty.
5. Evening and night duty ward servants should clean the ward.
6. They are also responsible for the entrance of attendants at times other than visiting hours.
7. They should help in shifting the patients and preparing the dead bodies.
8. Responsible for non-medical articles i.e. beds, wheel chairs, side tables, stands etc.
9. Report any irregularity to staff nurse.
10. They are not allowed to interfere or help staff nurses in preparation and administration of medicines.
11. They are also responsible for oxygen supply and cleanliness and working of compressor.

1. Must follow strict timings.
2. Wear OT dress (for ITC).
3. Should not leave during their duty hours, in the absence of ward servant must stay at entrance to check entrance of attendants.
4. Responsible for emptying of urine bags after informing staff on duty.
5. Care of bowl i.e. to provide urinals / pans to patients.
6. Clean the ward at least once during their duty hours.
7. Emptying of buckets and dustbins properly before duty finishes.

JOB DESCRIPTION OF ATTENDING STAFF

PROFESSOR

- > Incharge of administrative affairs for Ward. He may assign his staff assist members to him to carry out such affairs effectively.
- > Overall supervision of Patient care, Academic activities and Services delivered through medical Unit in EM OPD and IN-PATIENT.
- > Selection and Recruitment of Post graduate Trainees, House officers according to rules devised by Academic council and Recruitment Committee.
- > Overall monitoring of record keeping by medical staff.
- > Research Publication: Aally one paper publication in PMDC Recognized Medical Journal and active participation in process of research project selection, planning, supervision and paper writing.
- > Supervision of Clinical Rounds.
- > Participation and Representation in Academic meetings, National and International medical conferences.
- > Participation in Academic Council Meeting and Meetings called by Hospital administrators.
- > Third on call for Emergency room cover and Inpatient management. Second on call consultant may call head of Unit II, if he Wants his assistance or thinks that matter is serious enough and should be brought in notice of Professor Incharge.
- > Incharge of teaching program for medical students. He may assign duties to Associate and Assistant professor/ SR for teaching and training of medical students.
- > He will make sure that training program is fully compliant with recommendations of PMDC (Pakistan Medical and Dental council) and CPSP (College of physicians and surgeons Pakistan) -

ASSOCIATE PROFESSOR/ASSISTANT PROFESSOR/SENIOR REGISTRAR.

- > Administrative affairs for Ward and Hospital as assigned by Head of Department.
- > Supervision of patient care and services delivered through medical Unit in EIU OPD and Ward.
- > During OPD duty OPD patient care, support & Supervision of Medical residents and House Officers.
- > Monitoring of record keeping by medical staff.
- > Research Publication: Annually one paper publication in PMDC recognized Medical Journal and active participation in process of research project selection, planning, supervision and paper Writing
- > Clinical Rounds.
- > Active participation and supervision of training program for resident staff.
- > Participation and representation in Academic meetings.
- > National and International medical conferences.
- > Second on call for Emergency room cover and Ward cover after 2 PM on their respective call days.
- > Teaching and training of medical students as assigned by Head of Department.



HOUSE OFFICERS TRAINING PROGRAM

> In first few days of training you will be going through an orientation period which would Include an introduction to the unit and its working environment. There would be facilitative sessions to help them with.

1. History taking
2. Clinical examination
3. Eliciting basic pathophysiology

> Each trainee will work in one of the three rotations at unit. He/ She will be responsible for the inpatient care, which includes history taking, clinical examinations, investigations and treatment. He / She will also be responsible for writing the progress notes, meeting the family members and dealing with difficulties encounter by either. For those interneers who are here for three months will be working in one rotation for one month and those who are here for six months they will be working in one rotation for two months.

> The interneers will complete bio data form during the first week of their rotation. The consultant incharge of the trainees will hold weekly meetings with them and Head of Unit will see all trainees every month. This would certain the progress, difficulties and the work carried out by the interneers. During these meetings the interneers will bring their progress form for discussion.

> The interneers are welcome and encourage joining multiple academic activities going through the institute. Their clinical responsibilities towards patients care will take precedence over all academic activities.

> The progress of each interneer will be monitored in accordance with the plan schedule.

> An experience certificate will be given at the end of internship will reflect the performance of interneers on multiple parameters.

> At the end of stay we request you to fill the feed back form which would help us organized and improve training for the future.

FOR HOUSE OFFICERS

- 1st Half = Ward Duty
2nd Half = ER/ OPD / Procedure Room

CLINICAL TRAINING PROGRAM (STRUCTURE)

Clinical Staff

1.	Professor	01
2.	Associate professor	01
3.	Assistant Professor	03
4.	Consultants.	02
5.	Total Residents	10-15
6.	Total House officers	25-40

Morning Meeting.

1. Monday to Thursday & Saturday (8:30 am - 9:30 am), Friday (10:30 am- 12 Midday)
2. Admission summary / Morning report
3. Serious patients / Summary / Problem case discussion
4. Mortality
5. Consultations in last 24 hours
6. Resident Seminar
7. Weekly Mortality Audit

Morning Academic Rounds

(9:30am -12:00 mid day) Monday and Wednesday (grand round by professor, all teaching staff PGT's and house officers will attend)

(8 :30 am- 12:00 midday) Tuesday Thursday Saturday (round by respective consultants)

(8 :30am- 10:30 am) Friday (round by respective consultants)

Afternoon Conference (12:30pm- 2.00 pm) Monday, Wednesday. Friday

1. Long cases
2. Case Summaries
3. Short cases .
4. Radiology seminars
5. Pathology Seminars

Emergency classes/BLS/ACLS(12:30 pm-2:00 pm)

For House Officers

ECG Tutorials.

Conducted by consultant and alternate with ER Management classes

Journal club.

Usually articles are read from following journals

1. NEJM
2. BMJ
3. JCPSP

House Officer's Tests

MORTALITY AUDIT CONFERENCE

Key Point:

- > Maintenance of record
- > Disease and mortality trends
- > Assessment of Serious patient care
- > Final Outcome Mortality Summary
- > Group discussion

Format:

Mortality audit conference is held every Monday. One senior house-officer will be responsible to collect the data of deaths both from the Ward & the emergency during the Week, compile it, and collect the files of expired patients to maintain a register. Then annual data will be published.

Components:

- > Total no of admissions via OPD/ER
- > Total no of male/ female patients admitted
- > No & % of deaths
- > Youngest & Oldest expiry
- > Male: Female death ratio
- > Weekly Mortality rate

Details

Each expired patient is discussed individually. The HO/MO pair presents the death summary, the cause of death, outcome summary, actions taken by the medical-officer & the house-officer, consultant's opinion on the management plan & issue regarding availability of drugs, equipment's senior help on time was analyzed in detail. The final comment-outcome is documented in file. A detailed departmental inquiry may be ordered in specific cases by the Professor headed by Associate / Assistant Professor.

SECTION-II

CLINICAL TRAINING PROGRAM FOR HOUSE OFFICERS AND POSTGRADUATE TRAINEES



OVERVIEW OF THE TRAINING PROGRAM IN MEDICINE

All training will be supervised directly under the supervision of Head of the Department.

Duration of the program

A supervised training of two years is required before the trainee is able to take up IM and 4 yrs for FCPS II examination or MD examination.

Training Program

The Head of the Department will ensure that the training arrangements are designed to offer the maximum support to trainees, so that they can maintain good progress and have the opportunity to complete their training within the stipulated period. Training requires a steady progression of the trainee's competence (with increasing level of responsibility) through the planned program. The process of reviewing trainee's progress will be evidence-based With opportunity for discussion between the assessor and the trainee. A planned, managed and open approach will be adopted so that a constructive and regular feedback is provided on performance.

Structuring the training programs

A simple guideline for developing a structured training program would be to:

1. Specific Learning Objectives of training program in terms of What the trainee is expected to achieve in the cognitive, psychomotor and attitudinal domains relevant to the objectives are listed.
2. Instructional Strategy with timeline for achievement of each objective.
3. Resource requirements (e. g. skills laboratory, equipment, patients and other teaching learning material) Will be provided.
4. Provide the learning environment (e. g. space, logistics, motivation) appropriate to foster achievement of learning objectives.
5. Build in learning experiences necessary for the attainment of competencies.
6. Develop a system of appraisal (for feedback) and assessment for monitoring of progression through the program.

In the context of postgraduate medical education, the need for developing a teaching plan and table of specification must be understood. These are important instructions that help the supervisor maintain alignment among the syllabus, assessment/ evaluation and instruction.

General Instructional Objectives of the training program

By the end of two years training in Medicine a trainee shall be able to :

1. Initially assess the patients seeking medical advice for their problems by
 - Obtaining pertinent history.
 - Performing physical examinations correctly.
 - Formulating a working diagnosis.
 - Deciding whether the patient requires
 - ambulatory care or hospitalization.
 - referral to other health professionals.
2. Manage patients requiring treatment by a physician
 - Plan an enquiry strategy i.e. order appropriate investigations and interpret the results.
 - Decide and implement suitable treatment.
 - Maintain follow up of patients at required intervals.
 - Maintain records of patients.
3. Acquire new information, assess its utility and make appropriate applications.
4. Undertake research and publish findings.
5. Recognize the role of team work and function as an effective member/ leader of the team.
6. Advise the community on matters related to promoting health and preventing disease.
7. Train paraprofessionals and other junior members of the team.

Learning Outcomes

Following is a global and extensive, yet not the total, list of learning outcomes recommended by the College.

Generic outcomes relating to:

KNOWLEDGE

General

The learning outcomes will all be at the application level since that is the gold standard. Therefore, the trainee will be able to:

1. relate how body function gets altered in diseased states.
2. request and justify investigations and plan management for medical disorders.
3. assess new medical knowledge and apply it to their setting.

4. apply quality assurance procedures in their daily work.
5. interpret, integrate the history and examination findings, arrive at an appropriate differential diagnosis and final diagnosis.
6. demonstrate competence in problem identification, analysis and management of the problem at hand by the use of appropriate resources, interpretation of laboratory results.
7. prioritize different problems within a time frame.

SYLLABUS FOR MEDICINE

The specific knowledge areas are categorized into three areas. The details of the areas are given below.

- a) Basics of medical care
- b) Common medical emergencies
- c) Medical disorders and diseases

Basic of Medical Care

1. Applied etiopathology of common medical disorder
2. Principles of diagnosis and investigations
3. Principles of management
4. Monitoring treatment plan according to standard guidelines
5. Principles of follow up
6. Principles of counseling
7. Fluid, electrolyte and acid base balance
8. Nutrition: enteral and parenteral
9. Basics of rehabilitation
10. Notifiable communicable diseases
11. Toxicology and adverse drug reactions
12. Critical appraisal of research
13. Ethical and legal issues
14. Good safety practices including proper handling of blood products
15. Teaching skills

Common Medical Emergencies

The trainee should be able to identify the problem, request appropriate investigation, start basic emergency treatment and refer appropriately patients admitted with common medical emergencies.

SKILLS

General

The trainee should be able to

- take good history
- examine the patient physically
- write correct medical records which are clear, concise and accurate. I
- demonstrate the ability to communicate clearly, considerately and sensitively with patients, relatives, other health professionals and public.
- use evidence based medicine and evidence based guidelines.
- demonstrate awareness of bio-psycho-social factors in the assessment and management of a patient.

Medical disorders and diseases

By the end of 2nd year of training in Medicine the trainee should be able to:

Diagnose and manage common and important diseases with special emphasis on diseases prevalent in Pakistan

Rotation in medicine

Three months rotation in each of the following departments is recommended.

1. Cardiology
2. Intensive care unit / emergency medicine

However, in instance when these units are not available / not equipped for the needed supervision and training the supervisor should certify exposure of the trainee to the needed level of competence.

CORE COMPETENCIES TO BE ATTAINED DURING THE FIRST TWO YEARS OF TRAINING IN MEDICINE / INTERMEDIATE MODULE.

The clinical skills, a specialist must have, are varied and complex. A complete list of the some necessary for trainees and trainers is given below. The level of competence to be achieved each year is specified according to the key, as follows:

1. Observer status
2. Assistant status
3. Performed under supervision
4. Performed independently

No	Procedures	Levels of Competence		
		Year I	Year II	Min Number Procedure
1.	Peritoneal and Pleural Paracentesis	1	3	20
2.	Pericardial Paracentesis	1	2	2
3.	Lumber Puncture	1	3	15
4.	Insertion of CVP Lines	1	2	5
5.	CardioPulmonary Resucitation (CPR)	2	4	10
6.	Bone Marrow Aspiration	1	2	10
7.	Joint Aspiration	1	1	3
8.	Urethral Catheterization	2	4	20
9.	Administration of Enema	2	4	20
10.	Nasogastric Intubation	2	4	30
11.	Chest Intubation	1	1	5
12.	Blood CP and ESR	1	2	10
13.	Urine Dipstick	2	4	50
14.	Gram Staining of CSF and Sputum Slides	1	1	10
15.	AFB Staining of Sputum and Reporting	1	1	10
16.	Pleural and Liver Biopsy	1	2	10
17.	Recording ECG and Reporting	2	3	50
18.	Proctoscopy	2	3	10
19.	Arterial Puncture	2	3	10
20.	Peritoneal Dialysis	-	1	3
21.	Haemodialysis	1	1	5
22.	Renal Biopsy	1	1	3
23.	Upper GI Endoscopy	1	1	10
24.	Lower GI Endoscopy/Sigmoidoscopy	1	1	10
25.	Brochoscopy	1	1	5
26.	Abdominal Ultrasound	1	1	10
27.	ETT	1	1	5
28.	Echocardiography	1	1	5
29.	Tracheostomy	1	1	3
30.	Administration of Blood products	2	4	20

Suggested reading list:

Standard text book of Medicine such as

- Davidson's Principles and Practice of Medicine
- Essentials of Medicine by Cecil
- Clinical Medicine by Parveen Kumar
- Clinical Examination by McCleod
- Clinical Methods by Hutchison
- Currently available text book

Reference books:

- Oxford
- Cecil
- Harrison

SHORT CASES

Postgraduate trainees are scheduled to present short cases every Week on CPSP/MD Format.

Aim:

As part of training for the PGTs'.

Formats:

- > As per CPSP/MD Format.
- > Marking done as per CPSP/MD evaluation sheet.
- > Consultant incharge will supervise / discuss feedback with trainee in detail.



LONG CASES

Postgraduate trainees are scheduled for long cases weekly as per recommendation of CPSP/MD training Program.

Aim:

As part of learning & training of the PGTs' for FCPS Part II Examination/MD examination.

Format:

- > Case allotment by the consultant
- > Approximately 30 minutes for a detailed history & examination of the patients.
- > It includes history-taking, examination of each system, details in particular of the system involved relevant investigations & a conclusive diagnosis.
- > Consultants will supervise & assess as per FCPS II/MD Format.

He who studies medicine without books sales and
unchartered sea, but he who studies medicine without
patients does not go to sea at all.

Sir William Osler

SEMINARS

Learning Outcome:

- > To develop the presentation skill
- > To improve knowledge base learning
- > Confidence building

Format:

Every house officer is scheduled to give at least 2 to 3 presentations during their 6 month house job.

Key point:

1. Allotment of a topic
2. Introduction
3. Definition
4. Classification
5. Clinical features
6. Investigations
7. Treatment options
8. Learning outcome
9. MCQs in the end for assessment of learning outcome in the topic discussed.

REGISTRARS SEMINARS

1. Approach to a patient with chest pain.
2. Approach to a patient with dyspnea/ breathlessness
3. Approach to a patient with dysphagia
4. Approach to a patient with dysphonia
5. Approach to a patient with lower GI bleed
6. Approach to a patient with upper GI bleed
7. Approach to a patient with pyrexia of unknown origin
8. Approach to a patient with dyspepsia
9. Approach to a patient with chronic diarrhea
10. Approach to a patient with black outs
11. Approach to a patient with unconscious patient
12. Approach to a patient with headache
13. Approach to a patient with shock
14. Approach to a patient with septicemia
15. Approach to a patient with hyponatremia
16. Approach to a patient with fulminant hepatic failure
17. Approach to a patient With fungal infections
18. Approach to a patient with dwarfism
19. Approach to a patient with hepatocellular carcinoma
20. Approach to a patient with pre transplant preparation
21. Approach to a patient with post transplant care
22. Approach to a patient with suspected poisoning
23. Approach to a patient with acute renal failure
24. Approach to a patient with Thyroid emergencies

25. Approach to a patient with raised ICP.
26. Interpretation of Arterial blood gases
27. Interpretation of Pulmonary Function tests.
28. Interpretation of Echocardiography
29. Interpretation of Chest X-ray/ CT Scan
30. Interpretation looking after patient with cancer
31. Interpretation Management of Alcohol Withdrawal
32. Interpretation cardiac pacemakers
33. Interpretation evidence based medicine
34. Interpretation health and medical ethics
35. Updates on Portal hypertension.
36. Updates on hypertension.
37. Updates on Diabetes Mellitus
38. Updates on Malaria treatment and prophylaxis.

JOURNAL CLUB

Aim:

As part of learning & training of the PGTs' for FCPS Part II/MD Examination.

Format:

Every PGT has to prepare and present at least 24 articles from different indexed journals.

1. Latest research articles on medicine and its related fields and also cases of interest.
2. Case summaries of different hospitals like Massachusetts.
3. Editorials.

Learning Outcome:

1. To equip every PGT with the latest advances in medicine and its related fields.
2. To bring their knowledge at the level of developed countries.

INTERACTIVE SESSION

Aim

As a part of learning & training program the interactive sessions are presented by the registrars

Format;

Registrar will prepare Session.

Components:

1. MCQs with single best answer
2. ECG
3. X-rays
4. CT-Scans
5. Clinical scenarios
6. Clinical findings
7. SEQ
8. TOAC S Material

Details-

The questions are asked from the house-officer and PGT's, detailed answers will be discussed by the presenter. Consultant will supervise the session and give his / her input.

PROBLEM CASE PRESENTATION

Aim

1. To evolve a system for undiagnosed & resolved cases in the unit.
2. Opinion of the consultants' panel.
3. Evolve a case discussion format of Massachusetts case report in NEJM

Format:

Each house-officer & medical-officer has to prepare & present a problem case as per schedule.

Components:

1. Patient profile
2. Detailed history
3. Clinical examination
4. Investigations already done
5. Briefcase summary
6. Differential diagnosis
7. Comments of consultants
8. Final diagnosis
9. Current Issues
10. How to proceed
11. Comments & opinion of radiologist / pathologist etc.

ECG TUTORIAL

Aim:

As part of the learning & teaching program the ECG classes for house officers and registrars.

Format:

1. Every Wednesday from 9:00 am to 10:00 am by the cardiologist /Assistant Professor.
2. It will comprehensively cover basics, i.e. Acute Myocardial Arrhythmias, Blocks and

Electrolyte imbalance etc.

3. At end of session there will be evaluation session.
4. There may be ECG tutorials.



RADIOLOGY TUTORIAL

Aim:

As part of learning & training program, radiology tutorials are held under the supervision of radiologist.

Format:

Radiological classes Will be held at convenience of consultant radiologist.

Components:

The discussion / presentation will include

1. CT-Scan
2. MRI
3. X-Rays
4. Ultrasound
5. Question & answer session
6. Evaluation



A MORNING MEETING

Aim

Working of unit starts with morning meeting, where all academic and administrative issues are discussed in detail.

Format:

Every member of the working staff including the Professor / Associate / Assistant Consultants, Registrars, House Officers are supposed to attend at 8:30 am on all the Working days, except staff involved in emergency, patient care and Ward duty,

Components;

1. Recitation of the Holy Quran
2. Ward report
3. Emergency report
4. Mortality audit ever\' Monday
5. Problem case every Tuesday
6. Seminars every Wednesday
7. Journal Club every Thursday
8. Interactive session every Friday
9. Research Forum every last Saturday of the month

Details:

All issues concerning the ward, house-officers, medical-officers are brought in the notice of the Professor & the consultants and there solutions are sorted out

EVENING ROUNDS FORMAT

1. Every 4m day one registrar will be on call (24 hrs). He will assess all admitted patients in the unit and others.
2. They have to keep a check of serious patients.
3. Every time the patient seen is documented with date & time.
4. Evening round will start approximately at 6 pm as per format. It is Mandatory for the house officers to attend the round.
5. Serious patients will be discussed with the consultant on call not later than 10 pm if required will be seen physically by the consultant.
6. Evening round format Will include checking history of HO confirming physical sign, teaching clinical methods and discussing patient diagnosis, investigation & management plans.
7. Registrar Will Write his own summary assessment & follow up notes as described in SOPs for Routine patients and in LTC under SOAP format

CONSULTANT COVER

1. Routine consultant cover is described on spread sheet.
2. One Assistant Professor will be 24 hrs on call. He will cover all
3. Emergency, ward calls, referred consultations. ER Calls.
4. He will do the mandatory at 1 :30 pm afternoon round in ER and next morning Wrap up round in ER at 8am
1. He can be personally called in by the Registrar any time.
2. He will also do evening round after 10pm if required.
3. He will have telephone report between 10pm to 11pm.

MULTIMEDIA

As department is fully equipped With the audiovisual system, so all presentations, seminar, problem case, interactive sessions, and journal club. Endoscopy audit, mortality audit and video session will be on multimedia.

Facilities for presentation: Overhead Projector/Multimedia/ Internet

PATHOLOGY LABORATORY AND RADIOLOGY LIAISON

1. A consultant will be incharge of collaboration with pathology and radiology department and may deputise residents and house officers for various tasks.
2. He will arrange a list of available tests with exact prices during general working hours and available through ER and Evening shifts.
3. He will coordinate to arrange for Culture bottles for inoculation collected during evening & Night shifts.
4. He will coordinate to arrange for Tutorials by Radiologists and Pathologists for training of resident staff.
5. He will invite pathologist / microbiologist on regular basis for surveillance and Detection of MRS A and other communicable/ infectious diseases control. He will coordinate for training of residents and house staff for sample collection, handling and pre procedure preparation where applicable.

EFFECTIVE WORKING HOURS

RESIDENTS AND HOUSE OFFICERS

REGISTRAR CALL HOURS

Daily $6 * 6 = 36$ hours

2 calls 1 I 8 hours $x 2 = 36$

Weekly hours = 72 hours

Every third Sunday = 24 hours

Monthly hours = $72 \times 4 + 24 = 312$ hours

Net per week = $312 / 4 = 78$ hours weekly duties

HOUSE OFFICER CALL HOURS (IN-PATIENT BATCH)

Daily $6 * 6 \sim 36$ hours Alternate calls (2 calls / week)

$18 * 3 = 54$ hours I 144

2 Sundays / month = 48 hours

Net hours / month = 246 hours

Net per Week = $246 / 4 = 61.5$ hours / Week

HOUSE OFFICERS CALL HOURS (OPD-ER BATCH)

3 calls : 15 hours = $15 * 3 = 45$ hours

Offcall days = 6 hours : $6 * 3 = 18$ hours

Total = $45 + 18 = 63$ hours

Net per month $63 * 4 = 252$

2 Sundays/month = $12 * 2 = 24$ hours

Net hours / month = 276 hours

Net per Week = $276 / 4 = 69$ hours

MANDATORY WORKSHOPS

Residents achieve hands on training while participating in mandatory workshops of Research Methodology, Advanced Life Support, Communication Skills, Computer & Internet and Clinical Audit. Specific objectives are given in detail in the relevant section of Mandatory Workshops.

WORKSHOPS (3 hours each for 2-5 days)

S.NO	NAME OF THE WORKSHOP	LEARNING OBJECTIVES	TOPICS TO BE COVERED
1.	Biostatistics & Research Methodology (4 days)	• To understand the basics of Bio-Statistics • To critique why research is important? • To discuss the importance of Selecting a Field for Research • To prepare oneself for Participation in National and International Research • To prepare oneself for Participation in Pharmaceutical Company Research • To interpret the importance of research ideas & Criteria for a good research topic • To discuss Ethics in Health Research • To learn to write a Scientific Paper • To learn to make a Scientific	1. Introduction to Bio-Statistics 2. Introduction to Bio- Medical Research Why research is important? 3. What research to do? i. Selecting a Field for Research ii. Drivers for Health Research iii. Participation in National and International Research iv. Participation in Pharmaceutical Company Research v. Where do research ideas come from vi. Criteria for a good research topic 4. Writing a Scientific Paper 5. Making a Scientific Presentation & Searching the Literature

		Presentation To learn to make a purposeful literature search	
2.	Introduction to computer/Information Technology & Software (5 days)	By the end of this workshop student should be able to: - Appropriately start up and shut down your computer. - Navigate the operating system and start applications. - Perform basic functions of file management. - Perform basic functions in a word processor and spreadsheet. - Manage print settings and print documents. - Receive and send email. - Use a web browser to navigate the Internet. - work with windows, toolbars, and command menus - perform basic word processing and graphic tasks - make a Power Point presentation - explore Web browsing basics - back up files - save, copy, and organize your work - to enter data accurately in software of Statistical Package for Social Sciences	1. Hardware and Software - Understand the main components of a computer, including input and output devices. - Understand the function of communication devices such as smartphones and tablets. - Understand the role of Operating Systems, programs and apps. 2. Windows - Turning on the computer and logging on. - The Windows screen. - Running programs from the Start Menu. - Minimising, maximising, moving, resizing and closing windows. - Logging off and shutting down your computer. 3. Working with Programs - Running multiple programs. - Desktop icons and creating a desktop shortcut. - Managing programs from the taskbar. - Closing programs. 4. File Management - Managing Windows Explorer. - Creating, moving, renaming and deleting folders and files. - Understanding file extensions. - Viewing storage devices and network connections. - Managing USB flash drives. 5. Word Processing - Creating documents in Microsoft Word. - Typing text, numbers and dates into a document. - Easy formatting. - Checking the spelling in your document. - Making and saving changes to your document.

			• 6.Power Point Making Power Point presentation 7.Spreadsheets • Understanding spreadsheet functionality. • Creating spreadsheets in Microsoft Excel. • Typing text numbers and dates into a worksheet. • Easy formulas. • Easy formatting. • Charting your data. • Making and saving changes to your workbook. • Printing a worksheet. 8.Printing • Print preview. • Print settings. • Managing the print queue. 9.Using Email • The Outlook mail screen elements. • Composing and sending an email message. • Managing the Inbox. 10.Accessing the Internet • Going to a specific website and bookmarking. • Understanding how to search/Google effectively. • Copy and paste Internet content into your documents and emails. • Stopping and refreshing pages. • Demystifying the Cloud. • Understanding social media platforms such as Facebook and Twitter. • Computer security best practices. 11.Statistical Package for Social Sciences • general understanding for data entry •
3.	communication skills (3 days)	• To learn to use Non-medicinal Interventions in Communication Skills of Clinical Practice	1. Use of Non-medicinal Interventions in Clinical Practice Communication Skills 2. Counseling 3. Informational Skills 4. Crisis Intervention/Disaster

		• To discuss the importance of counseling • To role play as a counselor • To learn to manage a conflict resolution • To learn to break a bad news • To discuss the importance of Medical Ethics, Professionalism and Doctor-Patient Relationship Hippocratic Oath • To learn to take an informed consent • To illustrate the importance of confidentiality • To summarize Ethical Dilemmas in a Doctor's Life	5. Management Conflict Resolution 6. Breaking Bad News 7. Medical Ethics, Professionalism and Doctor-Patient Relationship Hippocratic Oath 8. Four Pillars of Medical Ethics (Autonomy, Beneficence, Non-maleficence and Justice) 9. Informed Consent and Confidentiality 10. Ethical Dilemmas in a Doctor's Life
4.	Clinical Audit (2 days) (Workshop is specific for MD Internal Medicine only)	Road Map for workshop: 1. Step 1:Topic selection 2. Step 2: Setting of criteria and standards 3. Step 3: First data collection 4. Step 4: Evaluation and comparison with criteria and standards 5. Step 5: Implementation of change 6. Step 6: Second data collection – evaluation of change	1. To understand clinical audit process. To help clinicians decide exactly why they are doing a particular audit and what they want to achieve through carrying out the audit. 2. To determine, how clinical audit relates to other activities related to accountability for the quality and safety of patient care. 3. To select the right subject for audit. 4. To use evidence of good practice in designing clinical audits. 5. To help clinicians formulate measures of quality based on evidence of good practice, as the basis for data collection and also to develop data collection protocols and tools and advise on data collection for clinical audits. 6. To help in understanding how to handle data protection issues related to clinical audit.

		The following are factors that may affect your choice of audit topic: • Strong impact on health • Convincing evidence available about appropriate care • Common condition which can be clearly defined • Good reasons of believing that current performance can be improved • Readily accessible data which can be collected within a reasonable length of time • Consensus on the audit topic among the practice members	7. To understand use of statistics for analyzing and presenting findings of data collection and thus help clinicians to analyze causes of problems that are affecting the quality of care. This helps in applying principles and strategies for taking action to achieve changes in clinical practice. 8. To help clinicians manage review of clinical audit findings with their colleagues. 9. To be able to prepare clinical audit reports. 10. To recognize and handle ethics issues related to clinical audit.
5.	Advanced Cardiac Life Support (4 days) (Workshop is specific for MD Internal Medicine only)	Upon successful completion of the workshop, the student will be able to: • Recognize and initiate early management of pre-arrest conditions that may result in cardiac arrest or complicate resuscitation outcome • Demonstrate proficiency in providing BLS care, including prioritizing chest compressions and integrating automated external defibrillator (AED)	The workshop is designed to give students the opportunity to practice and demonstrate proficiency in the following skills used in resuscitation: 1. Systematic approach 2. High-quality BLS 3. Airway management 4. Rhythm recognition 5. Defibrillation 6. Intravenous (IV)/intraosseous (IO) access (information only) 7. Use of medications 8. Cardioversion 9. Transcutaneous pacing 10. Team dynamics 11. Reading and interpreting electrocardiograms (ECGs) - Be able to identify—on a monitor and paper tracing—rhythms associated with bradycardia, tachycardia with adequate perfusion, tachycardia with poor

		use • Recognize and manage respiratory arrest • Recognize and manage cardiac arrest until termination of resuscitation or transfer of care, including immediate post-cardiac arrest care • Recognize and initiate early management of ACS, including appropriate disposition • Recognize and initiate early management of stroke, including appropriate disposition • Demonstrate effective communication as a member or leader of a resuscitation team and recognize the impact of team dynamics on overall team performance	perfusion, and pulseless arrest. These rhythms include but are not limited to: ○ Normal sinus rhythm ○ Sinus bradycardia ○ Type I second-degree AV block ○ Type II second-degree AV block ○ Third-degree AV block ○ Sinus tachycardia ○ Supraventricular tachycardias ○ Ventricular tachycardia ○ Asystole ○ Ventricular fibrillation ○ Organized rhythm without a pulse 12. Basic understanding of the essential drugs used in: ○ Cardiac arrest ○ Bradycardia ○ Tachycardia with adequate perfusion ○ Tachycardia with poor perfusion ○ Immediate post-cardiac arrest care
--	--	--	--

MANDATORY DISSERTATION / PAPERS

Either Dissertation submitted 9 months before the date of exam or 2 papers published in Journals indexed in Index Medicus acceptance letter submitted to CPSP 3 months before the date of exam

JRMC

Journal of Rawalpindi Medical University

Website: www.journaljrmc.com
Email: journaljrmc@gmail.com



ISSN: 1683-3562

Volume 21(1)
October-December 2017
Pages: 311-416

EDITORIAL

Plagiarism- Requiring a Holistic Approach
Dr. Nadeem Ikram

Page #

311

ORIGINAL ARTICLES

Treatment Efficacy of Sofosbuvir and Ribavirin Combination at Two Weeks in Chronic Hepatitis C

313

Aqsa Naveer, Saima Ambreen, Muhammad Fabeem, Sadia Ahmed, Madiha, Habib Ur Rehman, Humaira Naween, Fatma Aslam, Humamatal Bishra, Muhammad Umar.

Rand Ligation Versus Glue Injection for Bleeding Gastric Varices

317

Muhammad Fabeem, Muhammad Khurram, Saima Ambreen, Muhammad Arif, Waseem Anjad, Rabim Iqbal, Arshad Iqbal Satti

Dyspepsia in Cirrhotic Hepatitis C Patients

321

Maryam Jall, Fatma Aslam, Taha Khurshid Bhatti, Muhammad Umar, Humamatal Bishra

Khair

Severity of Coronary Artery Disease in Patients with or without Diabetic Retinopathy

325

Muhammad Saleem, Muhammad Mahsin, Hamdan Waqar

Effectiveness of Needle Aspiration in the Management of Spontaneous Pneumothorax

330

Kamran Rehman, Anwarulhuda Noorani, Muhammad Merajuddin Shafiq

Association of NSI Antigens, IgM, IgG Antibodies and RT-PCR in the Diagnosis of Dengue Virus Infection

335

Nasreen Samad, Fatima-Tuz-Zuhra, Nadeem Ikram, Tanveer Akhtar

Comparison of Decompressive Craniectomy and Multi-Dural Staps with Decompressive Craniectomy and Open-Dural Flap Method, in the Treatment of Acute Subdural Hematomas

339

Adil Aziz Khan, Seban Sarwar Gendel, Muhammad Mujahid Sharif, Muhammad Ali Tamsheeq

Significance of Clinical and Laboratory Variables in Early Detection and Prognosis of Malignant Lymphoma

344

Ayesha Humaira, Syed Samiullah

Hospital-Based Cancer Registry

349

Nagajothi Adnan, Gohar Raheem, Saeed Nadeem, Iqra Kamran, Usmer Fayyaz, Rabul Ahmed, Munazza Aziz, Sajid Mehmood, Syed Waqar Hassan, Nabeela Atroos, Kashif Adnan, Maryam Brikhar, Jabangir Sarwar Khan

Vascular Surprises in Calot's Triangle during Laparoscopic Cholecystectomy

354

Tariq Nawaz, Maryam Barkat, Muhammad Arif, Qasim Ali

Continued overleaf

JCPSP

ISSN (Print): 1022-386X
ISSN (Online): 1683-3168
CODEN: JSPSPH

Journal of the College of
Physicians and Surgeons Pakistan



OCTOBER 2017, VOL. 27, NO. 10

Indexed in:

Index Medicus / MEDLINE (USA)

EMBASE / Excerpta Medica, SciVerse Scopus (The Netherlands)

Impact Factor: Clarivate Analytics (USA)



LOGBOOK

Entries on the Log Book as well as E-log book (in case of FCPS training) should be completed regularly and should be countersigned monthly by supervisor. The log book should be filled in the following fashion covering all aspects of training.





PORTFOLIO

A portfolio is a collection of products prepared by the resident that provides evidence of learning and achievement related to a learning plan. A portfolio typically contains written documents but can include video- or audio-recordings, photographs, and other forms of information. Reflecting upon what has been learned is an important part of constructing a portfolio. In addition to products of learning, the portfolio can include statements about what has been learned, its application, remaining learning needs, and how they can be met. In graduate medical education, a portfolio might include a log of clinical procedures performed; a summary of the research literature reviewed when selecting a treatment option; a quality improvement project plan and report of results; ethical dilemmas faced and how they were handled; a computer program that tracks patient care outcomes; or a recording or transcript of counseling provided to patients. Portfolios can be used for both formative and summative evaluation of residents. Portfolios are most useful for evaluating mastery of competencies that are difficult to evaluate in other ways such as practice-based improvement, use of scientific evidence in patient care, professional behaviors, and patient advocacy. Teaching experiences, morning report, patient rounds, individualized study or research projects are examples of learning experiences that lend themselves to using portfolios to assess residents.



SECTION - III

EVALUATION OF TRAINEES



Rawalpindi Medical University

Patient's Evaluation of Physician

Physician's Name: _____
Date of Evaluation: _____

1	Strongly Disagree
2	Disagree
3	Neutral
4	Agree
5	Strongly Agree

Please circle the appropriate number for each item using this scale. Please provide any relevant comments on the back of this form.

This physician:

Item	1	2	3	4	5
Introduces himself/herself and greets me in a way that makes me feel comfortable.					
Manages his/her time well and is respectful of my time.					
Is truthful, upfront and does not keep things from me that I believe I should know.					
Talks to me in a way that I can understand, while also being respectful.					
Understands how my health affects me, based on history of the details of my life.					
Takes time to explain my treatment options, including...					



Rawalpindi Medical University

Resident Evaluation By Nurse / Staff For Core Competencies

Please take a few minutes to complete this evaluation form. All information is confidential and will be used constructively. You need not answer all the questions.

Name of Resident: _____
Location of Care or Interaction: _____
(OPD/Ward/Emergency/Endoscopy Department)
Date: _____
Your Position: _____
(Nurse / Ward Servant / Endoscopy Attendant)

1	Poor
2	Fair
3	Good
4	Very Good
5	Excellent
NA	Not Applicable/Contact

Please circle the appropriate score.

Item	PARAMETER	SCORE
1	PROFESSIONALISM	
1	Resident is honest and trustworthy.	1 2 3 4 5 NA
2	Resident treats patients and families with courtesy, compassion and respect.	1 2 3 4 5 NA
3	Resident keeps me and other members of the team with courtesy and respect.	1 2 3 4 5 NA
4	Resident shows regard for my opinion.	1 2 3 4 5 NA
5	Resident maintains a professional attitude and appearance.	1 2 3 4 5 NA
6	INTERPERSONAL AND COMMUNICATION SKILLS	
6	Resident communicates well with the patients, families, and members of the healthcare team.	1 2 3 4 5 NA
7	Resident provides legible and timely documentation.	1 2 3 4 5 NA
8	Resident respects differences in religion, culture, age, gender, sexual orientation and disability.	1 2 3 4 5 NA
9	SYSTEM BASED PRACTICE	
9	Resident works effectively with nurses and other professionals to improve patient care.	1 2 3 4 5 NA
10	PATIENT CARE	
10	Resident respects patient preferences.	1 2 3 4 5 NA
11	Resident is reasonably accessible to the patients.	1 2 3 4 5 NA
12	Resident takes care of patients' comfort and dignity during procedures.	1 2 3 4 5 NA
13	PRACTICE BASED LEARNING AND IMPROVEMENT	
13	Resident facilitates the learning of students and other professionals.	1 2 3 4 5 NA
14	COMMENTS	
14	Please describe any praises or concerns or information about specific incidents.	

Please use for your use and thoughtful notes. You give a poor rate in the selection and training of the resident based on "NA".

Total Score: _____ / _____

(IMPORTANT NOTE: Please calculate the total score (EXCELLENCE) that falls for which option has been selected as "NA".)

Rawalpindi Medical University

Supervisor's Evaluation of the Resident (Continuous Internal Assessment)

Resident's Name: _____
Location of Care or Interaction: _____
(OPD/Ward/Emergency/Endoscopy Department)
Date: _____

Supervisor's Name: _____
Signature: _____
Date: _____

Parameters to be Evaluated:

PARAMETER	SCORE
1. Basic data on front page recorded	1 2 3 4 5
2. Presenting complaints written in chronological order	1 2 3 4 5
3. Presenting complaints evaluated alone	1 2 3 4 5
4. Systems review documented	1 2 3 4 5
5. All components of history documented	1 2 3 4 5
6. Complete general physical examination done	1 2 3 4 5
7. Examination of all systems documented	1 2 3 4 5
8. Differential diagnosis framed	1 2 3 4 5
9. Relevant and required investigations documented	1 2 3 4 5
10. Management plan framed	1 2 3 4 5
11. Notes are properly written and legible	1 2 3 4 5
12. Progress notes written in organized manner	1 2 3 4 5
13. Daily progress in action	1 2 3 4 5
14. Plans in organized, readable format	1 2 3 4 5
15. Investigations properly recorded	1 2 3 4 5
16. Minor findings in investigations recorded	1 2 3 4 5
17. Regulatory data on patient documented properly	1 2 3 4 5
18. Medication written in proper letter	1 2 3 4 5
19. IV fluids orders are given with rate of infusion monitored	1 2 3 4 5
20. All columns of form complete	1 2 3 4 5



Rawalpindi Medical University

Final Evaluation Scoring Sheet

PARAMETER	SCORE
1. Basic data on front page recorded	1 2 3 4 5
2. Presenting complaints written in chronological order	1 2 3 4 5
3. Presenting complaints evaluated alone	1 2 3 4 5
4. Systems review documented	1 2 3 4 5
5. All components of history documented	1 2 3 4 5
6. Complete general physical examination done	1 2 3 4 5
7. Examination of all systems documented	1 2 3 4 5
8. Differential diagnosis framed	1 2 3 4 5
9. Relevant and required investigations documented	1 2 3 4 5
10. Management plan framed	1 2 3 4 5
11. Notes are properly written and legible	1 2 3 4 5
12. Progress notes written in organized manner	1 2 3 4 5
13. Daily progress in action	1 2 3 4 5
14. Plans in organized, readable format	1 2 3 4 5
15. Investigations properly recorded	1 2 3 4 5
16. Minor findings in investigations recorded	1 2 3 4 5
17. Regulatory data on patient documented properly	1 2 3 4 5
18. Medication written in proper letter	1 2 3 4 5
19. IV fluids orders are given with rate of infusion monitored	1 2 3 4 5
20. All columns of form complete	1 2 3 4 5

TOTAL SCORE: _____ / 200

Comments: _____

Workplace Based Assessments-Multi Source Feedback Profoma

360° Evaluation Appendix "A"



Rawalpindi Medical University

Quality Enhancement Cell
360 Degree Evaluation Proforma (by Senior)
PGT, MO, HO Proforma

Reviewer

Evaluation for

Name:

Name:

Designation:

Designation:

Performance ratings

Assessment Date: _____

The following guidelines are to be used in selecting the appropriate rating:

1=Never

2= Rarely

3= Occasionally

4= Frequently

5= Always

6= Not Applicable

1. Patients Care

Implements the highest standards of practice in the effective and timely treatment of all patients regardless of gender, ethnicity, location, or socioeconomic status.

☐
☐
☐
☐
☐
☐

2. Medical Knowledge

Keeps current with research and medical knowledge in order to provide evidence-based care.

☐
☐
☐
☐
☐
☐

3. Interpersonal and Communication Skills

Works vigorously and efficiently with all involved parties as patient advocate and/or consultant.

☐
☐
☐
☐
☐
☐

4. Practice based Learning and Improvement

Assesses medical knowledge and new technology and implements best practices in clinical setting.

☐
☐
☐
☐
☐
☐

5. Professionalism

Displays personal characteristics consistent with high moral and ethical behaviour.

☐
☐
☐
☐
☐
☐

6. Systems Based Practice

Efficiently utilizes health-care resources and community systems of care in the treatment of patients.

☐
☐
☐
☐
☐
☐

Reference: Competencies identified by ACGME & ABMS

ACGME Accreditation Council for graduate medical education

ABMS American Board of Medical Specialties



Rawalpindi Medical University
Quality Enhancement Cell
360 Degree Evaluation Proforma (by Colleague)
PGT, MO, HO Proforma

Reviewer

Evaluation for

Name:

Name:

Designation:

Designation:

Performance ratings

Assessment Date: _____

The following guidelines are to be used in selecting the appropriate rating:

1=Never

2= Rarely

3= Occasionally

4= Frequently

5= Always

6= Not Applicable

1. He/she is often late to work?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

2. He/she meets his deadlines oftenly?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

3. He/she is willing to admit the mistakes?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

4. He/she communicates well with others?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

5. He/she adjusts quickly to changing Priorities?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

6. He/she is hardworking?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

7. He/she works well with the other colleague?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

8. He/she co-worker behave professionally?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

9. He/she co-worker treat you, respect fully?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

10. He/she co-worker handles criticism of his work well?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

11. He/she follow up the patient's condition quickly?

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

Reference: <http://www.surveymonkey.com/r/360-Degree-Employee-Evaluation-Template>



Rawalpindi Medical University

Quality Enhancement Cell

360 Degree Evaluation Proforma (Self-Assessment)

PGT, MO, HO Proforma

Reviewer

Evaluation for

Name:
 Designation:
 Performance

Name:
 Designation:
 Assessment

The following guidelines are to be used in selecting the appropriate rating:

1=Poor

2= Less than Satisfactory

3= Satisfactory

4= Good

5= Very Good

6= Don't know

1. Clinical knowledge

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

2. Diagnosis

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

3. Clinical decision making

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

4. Treatment (including practical procedures)

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

5. Prescribing

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

6. Medical record keeping

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

7. Recognizing and working within limitations

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

8. Keeping knowledge and skills up to date

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

9. Reviewing and reflecting on own performance

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

10. Teaching (student, trainees, others)

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

11. Supervising colleagues

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

12. Commitment to care and wellbeing of patients

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

13. Communication with patients and relatives

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

14. Working effectively with colleagues

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

15. Effective time management

1 ☐

2 ☐

3 ☐

4 ☐

5 ☐

6 ☐

Reference: www.gmc-uk.org



Rawalpindi Medical University

Quality Enhancement Cell

360 Degree Evaluation Proforma (by Attendant)

PGT, MO, HO Proforma

Reviewer

Evaluation for

Name:

Designation:

Name:

Designation:

Performance ratings

Assessment Date: _____

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

1۔ ڈاکٹر نے مریض کی صورتحال تشخیص ورتنصیل سے بتائی ہے۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

2۔ ڈاکٹر نے اپنی پریشانی بتانے کے لئے مجھے حوصلہ دیا۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

3۔ ڈاکٹر نے عزت سے میرا علاج کیا۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

4۔ ڈاکٹر نے مجھے جو تفصیلات بتائیں وہ آسانی سے سمجھ آ گئی۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

5۔ ڈاکٹر نے میرے احساسات کا خیال رکھا۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں



Rawalpindi Medical University

Quality Enhancement Cell

360 Degree Evaluation Proforma (by Patient)

PGT, MO, HO Proforma

Reviewer

Evaluation for

Name:

Designation:

Performance ratings

Name:

Designation:

Assessment Date: _____

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

1- ڈاکٹر نے آپ کا معائنہ عزت اور احترام سے کیا ہے۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

2- ڈاکٹر نے آپ کی بیماری کے متعلق آپ کو روکے ٹوکے بغیر تسلی سے سنا۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

3- ڈاکٹر نے آپ کی بات بہت توجہ سے سنی۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

4- ڈاکٹر نے آپ کی زندگی کے متعلق تفصیل سے سوالات کیے۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

5- ڈاکٹر نے آپ کے حدیثات کو اچھی طرح سمجھا ہے۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

6- ڈاکٹر نے مجھے بیماری سے متعلق تفصیل اور وضاحت سے آگاہ کیا ہے۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

7- ڈاکٹر نے مجھے بیماری سے متعلق صحیح فیصلہ کرنے میں مدد کی۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

8- ڈاکٹر نے بیماری کے علاج کا لائحہ عمل بنانے میں مجھے شامل کیا۔

☐ کبھی نہیں ☐ کم سے کم ☐ کبھی کبھار ☐ اکثر ☐ ہمیشہ ☐ لاگو نہیں

Resident Evaluation by Nurse/ Staff for core competencies

Appendix "B"

Please take a few minutes to complete this evaluation form. All information is confidential and will be used constructively. You need not answer all the questions.

Name of Resident _____

Location of care or interaction _____

(For example OPD/Ward/Emergency/Endoscopy Department), Your position (for example: nurse, ward servant, endoscopy attendant) _____

S #	Professionalism	Poor	Fair	Good	V.Good	Excellent	Insufficient Contact
1	Resident is Honest and trustworthy						
2	Resident treats patients and families with courtesy, compassion and respect						
3	Resident treats me and other member of the team with courtesy and respect						
4	Resident shows regard for my opinions						
5	Resident maintains a professional manner and appearance						
Interpersonal and communication skills							
6	Resident communicates well with patients, families, and members of the healthcare team						
7	Resident provides legible and timely documentation						
8	Resident respect differences in religion, culture, age, gender, sexual orientation and disability						
System based practice							
9	Resident works effectively with nurses and other professionals to improve patient care						
Patient Care							
10	Resident respects patient preferences						
11	Resident take care of patient comfort and dignity during procedures						
Practice based learning and improvement							
12	Resident facilitates the learning of students and other professionals						
Comments							
13	Please describe any praises or concerns or information about specific incidents						
Thanks you for your time and thoughtful input. You play a vital role in the education and training of the internal medicine resident							

Poor: 0, Fair: 1, Good: 2, V.Good: 3, Excellent: 4

Total Score _____/52

Evaluation of Patient Medical Record/ Chart Evaluation

Proforma Appendix "C"

Name of Resident _____

Location of Care or Interaction _____

(OPD/Ward/Emergency/Endoscopy Department)

S#		Poor	Fair	Good	V. Good	Excellent
1.	Basic Data on Front Page Recorded	☐	☐	☐	☐	☐
2.	Presenting Complaints written in chronological order	☐	☐	☐	☐	☐
3.	Presenting Complaints Evaluation Done	☐	☐	☐	☐	☐
4.	Systemic review Documented	☐	☐	☐	☐	☐
5.	All Components of History Documented	☐	☐	☐	☐	☐
6.	Complete General Physical Examination done	☐	☐	☐	☐	☐
7.	Examination of all systems documented	☐	☐	☐	☐	☐
8.	Differential Diagnosis framed	☐	☐	☐	☐	☐
9.	Relevant and required investigations documented	☐	☐	☐	☐	☐
10.	Management Plan framed	☐	☐	☐	☐	☐
11.	Notes are properly written and eligible	☐	☐	☐	☐	☐
12.	Progress notes written in organized manner	☐	☐	☐	☐	☐
13.	Daily progress is written	☐	☐	☐	☐	☐
14.	Chart is organized no loose paper	☐	☐	☐	☐	☐
15.	Investigations properly pasted	☐	☐	☐	☐	☐
16.	Abnormal findings in investigations encircled.	☐	☐	☐	☐	☐
17.	Procedures done on patient documented properly	☐	☐	☐	☐	☐
18.	Medicine written in capital letter	☐	☐	☐	☐	☐
19.	I/v fluids orders are proper with rate of infusion mentioned	☐	☐	☐	☐	☐
20.	All columns of chart complete	☐	☐	☐	☐	☐

Poor: 0, Fair: 1, Good: 2, V. Good: 3, Excellent: 4

TOTAL SCORE _____/80

Workplace Based Assessments - Guidelines for Supervisors for Assessment of Generic & Specialty Specific Competency

Appendix “D”

The Candidates of all MD programs will be trained and assessed in the following five generic competencies and also specialty specific competencies.

A. Generic Competencies:

i. Patient Care.

- a. Patient Care competency will include skills of history taking, examination, diagnosis, counseling Plan care through ward teaching departmental conferences, morbidity and mortality meetings core curriculum lectures and training in procedures and operations.
- b. The candidate shall learn patient care through ward teaching departmental conferences, morbidity and mortality meetings, care curriculum lectures and training in procedures and operations.
- c. The Candidate will be assessed by the supervisor during presentation of cases on clinical ward rounds, scenario based discussions on patients management multisource feedback evaluation, Direct observation of Procedures (DOPS) and operating room assessments
- d. These methods of assessments will have equal weightage.

ii. Medical knowledge and Research

- a. The candidate will learn basic factual knowledge of illnesses relevant to the specialty through lectures/discussions on topics selected from the syllabus, small group tutorials and bed side rounds
- b. The medical knowledge/skill will be assessed by the teacher during
- c. The candidate will be trained in designing research project, data collection data analysis and presentation of results by the supervisor.
- d. The acquisition of research skill will be assessed as per regulations governing thesis evaluation and its acceptance.

iii. Practice and System Based Learning

- a. This competency will be learnt from journal clubs, review of literature policies and guidelines, audit projects medical error investigation, root cause analysis and awareness of health care facilities,.
- b. The assessment methods will include case studies, personation in mobility and mortality review meetings and presentation of audit projects if any.
- c. These methods of assessment shall have equal weight-age

iv. Communication Skills

- a. These will be learn it from role models, supervisor and workshops.

- b. They will be assessed by direct observation of the candidate whilst interacting with the patients, relatives, colleagues and with multisource feedback evaluation.

v. **Professionalism as per Hippocratic oath**

- a. This competency is learnt from supervisor acting as a role model ethical case conferences and lectures on ethical issues such as confidentially informed consent end of life decisions, conflict of interest, harassment and use of human subjects in research.
- b. The assessment of residents will be through multisource feedback evaluation according to preforms of evaluation and its scoring method.

B. Specialty Specific Competences.

- i. The candidates will be trained in operative and procedural skills according to a quarterly based schedule.
- ii. The level of procedural Competency will be according to a competency table to be developed by each specialty
- iii. The following key will be used for assessing operative and procedural competencies:
 - a. **Level 1 Observer status**
 - b. The candidate physically present and observing the supervisor and senior colleagues
 - c. **Level 2 Assistant status** The
candidate assisting procedures and operations
 - d. **Level 3 Performed under supervision** The
candidate operating or performing a procedure under direct supervision
 - e. **Level 4 Performed independently** The
candidate operating or performing a procedure without any supervision

vi. **Procedure Based Assessments (PBA)**

- a. Procedural competency will assess the skill of consent taking, preoperative preparation and planning, intraoperative general and specific tasks and postoperative management
- b. Procedure Based assessments will be carried out during teaching and training of each procedure.
- c. The assessors may be supervisors, consultant colleagues and senior residents.
- d. The standardized forms will be filled in by the assessor after direct observation.
- e. The resident's evaluation will be graded as satisfactory, deficient requiring further training and not assessed at all.
- f. Assessment report will be submitted
- g. A satisfactory score will be required to be eligible for taking final examination.

Supervisor's Evaluation of the Resident (Continuous Internal Assessment)

Appendix "F"

Resident's Name: _____

Evaluator's Name(s): _____

Hospital Name: _____

Date of Evaluation: _____

1	Unsatisfactory
2	Below Average
3	Average
4	Good
5	Superior

Please circle the appropriate number for each item using the scale above.

Patient Care	Scale				
1. Demonstrates sound clinical judgment	1	2	3	4	5
2. Presents patient information case concisely without significant omissions or digressions	1	2	3	4	5
3. Able to integrate the history and physical findings with the clinical data and identify all of the patient's major problems using a logical thought process	1	2	3	4	5
4. Develops a logical sequence in planning for diagnostic tests and procedures and Formulates an appropriate treatment plan to deal with the patient's major problems	1	2	3	4	5
5. Able to perform commonly used office procedures	1	2	3	4	5
6. Follows age appropriate preventative medicine guidelines in patient care	1	2	3	4	5
Medical Knowledge	Scale				
1. Uses current terminology	1	2	3	4	5
2. Understands the meaning of the patient's abnormal findings	1	2	3	4	5
3. Utilizes the appropriate techniques of physical examination	1	2	3	4	5
4. Develops a pertinent and appropriate differential diagnosis for each patient	1	2	3	4	5
5. Demonstrates a solid base of knowledge of ambulatory medicine	1	2	3	4	5
6. Can discuss and apply the applicable basic and clinically supportive sciences	1	2	3	4	5

Professionalism		Scale				
1.	Demonstrates consideration for the patient's comfort and modesty	1	2	3	4	5
2.	Arrives to clinic on time and follows clinic policies and procedures	1	2	3	4	5
3.	Works effectively with clinic staff and other health professionals	1	2	3	4	5
4.	Able to gain the patient's cooperation and respect	1	2	3	4	5
5.	Demonstrates compassion and empathy for the patient	1	2	3	4	5
6.	Demonstrates sensitivity to patient's culture, age, gender, and disabilities	1	2	3	4	5
7.	Discusses end-of-life issues (DPOA, advanced directives, etc.) when appropriate	1	2	3	4	5
Interpersonal and Communication Skills		Scale				
1.	Demonstrates appropriate patient/physician relationship	1	2	3	4	5
2.	Uses appropriate and understandable layman's terminology in discussions with patients	1	2	3	4	5
3.	Patient care documentation is complete, legible, and submitted in timely manner	1	2	3	4	5
4.	Recognizes need for behavioral health services and understands resources available	1	2	3	4	5
Systems-based Practice		Scale				
1.	Spends appropriate time with patient for the complexity of the problem	1	2	3	4	5
2.	Able to discuss the costs, risks and benefits of clinical data and therapy	1	2	3	4	5
3.	Recognizes the personal, financial, and health system resources required to carry out the prescribed care plan	1	2	3	4	5
4.	Demonstrates effective coordination of care with other health professionals	1	2	3	4	5
5.	Recognizes the patient's barriers to compliance with treatment plan such as age, gender, ethnicity, socioeconomic status, intelligence, dementia, etc.	1	2	3	4	5
6.	Demonstrates knowledge of risk management issues associated with patient's case	1	2	3	4	5
7.	Works effectively with other residents in clinic as if a member of a group practice	1	2	3	4	5
Osteopathic Concepts		Scale				
1.	Demonstrates ability to utilize and document structural examination findings	1	2	3	4	5

2. Integrates findings of osteopathic examination in the diagnosis and treatment plan	1	2	3	4	5
3. Successfully uses osteopathic manipulation for treatment where appropriate	1	2	3	4	5
4. Practices Patient Centered Care with a "whole person" approach to medicine.	1	2	3	4	5
Practice-Based Learning and Improvement					Scale
1. Locates, appraises, and assimilates evidence from scientific studies	1	2	3	4	5
2. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies to assess diagnostic and therapeutic effectiveness of treatment plan	1	2	3	4	5
3. Uses information technology to access information to support diagnosis and treatment	1	2	3	4	5
Comments					

Resident's Signature _____

Date _____

Supervisor's Signature _____

Date _____

FACULTY EVALUATION OF RESIDENT (INTERNAL MEDICINE)

Appendix “G”

Abbreviations for six Core Competencies

- PC = Patient Care
- MK = Medical Knowledge
- ICS = Interpersonal / Communication Skills
- PBL = Practice-Based Learning and Improvement
- P = Professionalism
- SBP = Systems-Based Practice

Interpersonal and Communication Skills

Note content is appropriate and complete (ICS) (Question 1 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Interpersonal skills with patients, families and staff is appropriate and skilled (ICS) (Question 2 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Presents cases in clear, concise manner (ICS) (Question 3 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Medical Knowledge

Demonstrates understanding of clinical problems and their pathophysiology (MK) (Question 4 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Develops appropriate differential diagnosis (MK) (Question 5 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Evaluates scientific basis of diagnostic tests used (MK) (Question 6 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Reads service specific literature (MK) (Question 7 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Patient Care

Obtains accurate clinical history (PC) (Question 8 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Demonstrates appropriate physical exam (PC) (Question 9 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Identifies and reviews relevant existing patient data (PC) (Question 10 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Prioritizes problems and treatment plans appropriately (PC) (Question 11 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Effectively uses consultation services (PC) (Question 12 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Practice-Based learning and improvement.

Identifies areas for improvement and applies it to practice PBL (Question 13 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Applies lessons learned from medical errors into practice PBL (question 14 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Shows Interest in learning from complex care issues PBL (Question 15 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Professionalism

Displays a professional attitude and demeanor (P) (Question 16 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Attends rounds on time. Handles criticism of self in pro-active way (P) (Question 17 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior

0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
---	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

Cross-covers colleagues when necessary (P) (Question 18 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

System-Based Practices

Understands the different types of medical practice and delivery systems, and alternative methods of controlling health care costs and allocating resources (SBP) (Question 19 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Effectively Utilizes ancillary services SBP (Questions 20 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Uses Patient care venues appropriately SBP (Questions 21 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Advocates for quality patient care and assists patients in dealing with system complexities SBP (Questions 22 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Overall / Summary

Did resident meet course objectives? (Questions 23 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

Comments (Please provide Strengths, Weaknesses and Areas for Improvement) (Question 24 of 24)

No Interaction	Unsatisfactory	Failing	Less than Marginal	Below Average	Average	Above Average	Advanced	Outstanding	Superior
0	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐

RESIDENT EVALUATION OF FACULTY TEACHING SKILLS

Appendix "H"

Faculty Member _____

Department: _____

Period of Evaluation _____

Location _____

Direction: please take a moment to assess the clinical faculty members teaching skills using this scale

1= Poor

2=Fair

3= Very Good

4= Excellent

A. Leadership

Discussed expectations, duties and assignments for each team member and reviewed learning objectives and evaluation process

1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Treated each team member in a courteous and peaceful manner

1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Was usually prompt for teaching assignments and was always Available and accessible as a supervisor

1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Showed respect for the physician in other specialties / Subspecialties as well as for other health care professionals

1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Comments

B. Role of modeling

Demonstrated positive in interpersonal communication skills with patients, family members and staff 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Enthusiasm and interest in teaching residents 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Recognized own limitations and used these Situation as opportunities to demonstrate how he / she learn 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Used Medical / scientific literature to support clinical decisions 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Comments

C. Patient Care /Teaching and & Feedback

Demonstrate how to handle "difficult" patients encounters 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Demonstrated how to perform special physical exam techniques and / or procedures and observed me during my initials attempt 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Asked thought provoking questions to help me develop my critical thinking skills and clinical judgment 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Share his/her own thought process when discussing patient workups and patients care decisions with the team 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Highlighted important aspects of a patient case and often generalized to boarder medical concepts and principles 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Integrated social / ethical aspects of medical (cost containment, patents right , humanism) into discussion of patient care 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Provided guidance and specific "instructive feedback to help me correct mistakes and / or increase my knowledge base 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Comments:

D. Didactic (Classroom) Instructions

Was usually prompt for teaching sessions, kept interruptions to minimum and kept discussion focused on case or topic 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Gave lecture presentations that were well organized and "Interactive" () i.e., and review pertinent topics 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Provided references or other materials that stimulated me to read, research and review pertinent topics 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Comments

E. Evaluation

Reviewed my overall clinical performance at the end of the rotation pointed out my strengths and areas for improvement 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Demonstrated "fairness" by adhering to established criteria, explaining reasons for the scores and following me to respond 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A ☐

Comments

Overall, I would rate this faculty member's clinical teaching skills as

POOR ☐ FAIR ☐ VERY GOOD ☐ EXCELLENT ☐

Would you recommend that faculty member continue to teach in this program?

Yes NO

COMMENTS, COMMENDATIONS OR CONCERNS

RESIDENT EVALUATION OF FACULTY (FOR CORE COMPETENCIES)

Appendix “I”

A. Interpersonal and Communication Skills

Interpersonal and Communication Skills (Question 1 of 22)

Asks question in a non-threatening manner

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Interpersonal and Communication Skills (Question 2 of 22)

Emphasizes problem-solving (thought processes leading to decisions)

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Interpersonal and Communication Skills (Question 4 of 22)

Effectively communicates knowledge

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

B. Medical Knowledge

Medical Knowledge (Question 5 of 22)

Knowledge of specialty

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Medical Knowledge (Question 6 of 22)

Applies knowledge of specialty to patient problems

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Patient Care (Question 7 of 22)

Applies comprehensive high quality care

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

C. Patient Care

Patient Care (Question 8 of 22)

Explains diagnostic decisions

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Patient Care (Question 9 of 22)

Clinical Judgment

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Patient Care (Question 10 of 22)

Clinical Skills

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

D. Practice-Based Learning and Improvement

Practice-Based Learning and Improvement (Question 11 of 22)

Encourages self-education

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Practice-Based Learning and Improvement (Question 12 of 22)

Encourages evidence-based approaches to care

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

E. Professionalism

Professionalism (Question 13 of 22)

Sensitive caring respectful attitude towards patients

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Professionalism (Question 14 of 22)

Uses time with patients and residents effectively

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Professionalism (Question 15 of 22)

Sufficient resident teaching on rounds/clinics

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Professionalism (Question 16 of 22)

Respects all members of the health care team

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Professionalism (Question 17 of 22)

Demonstrates Integrity

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Professionalism (Question 18 of 22)

Attains credibility and rapport with patients and their family

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

F. Systems- Based Practice

Systems- Based Practice (Question 19 of 22)

Provides useful feedback including constructive criticism to team members

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

System Base Practice (Question 20 of 22)

Discusses availability cost and utility of system resources in providing medical care.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Overall/Summary (Question 21 of 22)

Overall contributions to your training

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0	1	2	3	4	5

Comments: (Question 22 of 22)

Faculty Evaluation of the Residency / Fellowship Program

Appendix “J”

Please use this scale to answer question1-10:

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. <u>PATIENT/CASE VOLUME:</u> There are a sufficient number and variety of patients/cases to facilitate high quality resident/fellow education.				
2. <u>CURRICULUM:</u> The residency/fellowship program curriculum provides the appropriate education experiences for residents/fellows to analyze investigate and improve patient care practices.				
3. <u>PROGRAM DIRECTOR:</u> The program director effectively communicates with program faculty members to understand their role in resident/fellow education and development.				
4. <u>ADMINISTRATIVE SUPPORT:</u> There is adequate administrative support service to facilitate faculty participation in resident/fellow education.				
5. <u>SUPERVISION:</u> The Program resident/fellow supervision policy has been clearly communicated to program faculty and is used by the program.				
6. <u>TRANSITION OF CARE:</u> The program transition of care/hand-off policy and tools have been distributed to program faculty and they are used.				
7. <u>EVALUATION:</u> Program faculty receives regular and timely feedback about their teaching and supervisors skills.				
8. <u>FACULTY DEVELOPMENT:</u> There are beneficial resources available for program faculty to improve their teaching and supervision skills.				
9. <u>SCHOLARLY ACTIVITY:</u> Program faculties have the adequate resources to participate in scholarly activates.				
10. <u>FACULTY:</u> The program faculty provides the diversity of experience and expertise to accomplish the goals and objectives of the program.				

RESIDENT EVALUATION OF RESIDENCY PROGRAM

Appendix “K

A. Program Goals and Objectives (Question 1 of 35)

The goals and objectives for each rotation are clearly communicated to residents.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

B. Evaluation (Question 2 of 35)

The evaluation process of the residents is constructive (computerized faculty evaluations of residents, daily clinical feedback to residents, yearly PRITE, and Director’s semi-annual resident meeting with resident).

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

C. Research (Question 3 of 35)

Residents are provided ample opportunity to develop an interest an in research.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Research (Question 4 of 35)

Residents are encouraged to participate in research.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Research (Question 5 of 35)

Residents are provided the education to develop an understanding of research.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

D. Faculty (Question 6 of 35)

The size, diversification and availability of faculty is adequate for the training program.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Faculty (Question 7 of 35)

The Knowledge of the faculty is current and appropriate.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

E. Facilities (Question 8 of 35)

The available resources necessary (library and computer) to obtain current medical information and scientific evidence are adequate and accessible.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Facilities (Question 9 of 35)

On-call rooms, when needed, are adequate to ensure rest, safety, convenience and privacy.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Facilities (Question 10 of 35)

The facilities are adequate with regard to support services (nurses, clinic aides) and space for teaching and patient care.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

F. Leadership and Logistics (Question 11 of 35)

The Program Director communicates effectively with residents.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Leadership and Logistics (Question 12 of 35)

The Associate Program Director communicates effectively with residents.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Leadership and Logistics (Question 13 of 35)

The Chief Residents communicates effectively with residents.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Leadership and Logistics (Question 14 of 35)

The Program Coordinator communicates effectively with residents.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Leadership and Logistics (Question 15 of 35)

The Program Director provides effective leadership of the residency.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Leadership and Logistics (Question 16 of 35)

There is adequate departmental support for residency education.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Leadership and Logistics (Question 17 of 35)

There is adequate departmental support for residency education.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Leadership and Logistics (Question 18 of 35)

The program is responsive regarding scheduling, course materials and other logistical concerns.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Leadership and Logistics (Question 19 of 35)

The evaluation system (E-Value) is easy to use.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

6. Training (Question 20 of 35)

Faculty adequately supervises residents' care of patients.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 21 of 35)

Training sites present a wide range of psychiatric clinical problems.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 22 of 35)

Residents see an appropriate number of patients.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 23 of 35)

Residents are given sufficient responsibility for decision-making and direct patient care.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 24 of 35)

Rounds and staffing are conducted professionally.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
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0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐
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Training (Question 25 of 35)

Rounds and staffing are conducted efficiently.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 26 of 35)

Faculty teaches and supervises in ways that facilitate learning.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 27 of 35)

The program is responsive to safety concerns at training.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 28 of 35)

The program is responsive to feedback from residents.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 29 of 35)

Residents experience an appropriate balance of educational and clinical responsibilities.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 30 of 35)

The didactic sessions provide core knowledge of the field.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 31 of 35)

The morale of the residents is good.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 32 of 35)

The morale of the faculty is good.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Training (Question 33 of 35)

Overall, I am very satisfied with the training our program provides.

Cannot Evaluate	Unsatisfactory (Comment Required)	Marginal (Comment Required)	Satisfactory	Very Good	Excellent
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐

Recommendations (Question 34 of 35)

What changes in the training program would you suggest to better prepare residents for their careers?

Additional Comments (Question 35 of 35)

Guidelines for program Evaluation

Appendix “L”

Program Evaluation Committee (PEC)

Background

The purpose of this committee is to conduct and document a formal, systematic evaluation of the program & curriculum on an annual basis.

Membership

The chair and membership of the committee are appointed by the Program Director. The membership of the committee consists of at least two members of the program faculty, and at least one resident/subspecialty resident.

Meeting Frequency

The committee meets, at a minimum, annually.

Responsibilities of the PEC

- The PEC actively participates in planning, developing, implementing and evaluating the educational activities of the program.
- The PEC reviews and makes recommendations for revision of competency-based goals and objectives.
- Addresses areas of non-compliance with the standards; and reviews the program annually using written evaluations of faculty, residents, and others.

Required Documentation of PEC Activities

The PEC provides the GMEC with a written Annual Program Evaluation (APE) in the format that is appended to this document. This document details a written plan of action to document initiatives to improve performance based on monitoring of activities described below.

The APE document provides evidence that the PEC is monitoring the following areas, at a minimum:

1. Resident performance
2. Faculty development

3. Graduate performance, including performance of program graduates on the certifying examination
4. Assessment of program quality through:

Annual confidential and formal feedback from residents and faculty about the program quality;

b. **Assessment of improvements needed based on program evaluation feedback** from faculty, residents, and others

5. Continuation of progress made on prior year's action plan

6. Prepare and submit a written plan of action to

a. document initiatives to improve performance in one of more of the areas identified,

b. Delineate how they will be measured and monitored

c. Document continuation of progress made on the prior year's action plan

Template for Documentation of Annual Program Evaluation and Improvement

Date of annual program evaluation meeting: _____

Attendees:

i. Program Director:

ii. Program Coordinator:

iii. Associate/Assistant PD:

iv. Faculty Members:

v. Residents:

	Reviewed √	Discussion, Follow up, Action Plan
1. Current Program Requirements & Institutional Requirements		
2. Most recent Internal Review Summary to ensure all recommendations are addressed		
3. Review Curriculum a. effective mechanism in place to distribute Goals & Objectives (G&O) to residents and faculty b. overall program educational goals c. up-to-date competency-based G&O for each assignment d. up-to-date competency-based G&O for each level of training e. G&O contain delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents		
4. Evaluation System a. Resident formative evaluation meets or exceeds program requirement b. Resident summative evaluation meets or exceeds program requirement c. Faculty evaluation meets or exceeds program requirement d. program evaluation meets or exceeds program requirement.		

5. Didactic Curriculum a. includes recognizing the signs of fatigue and sleep deprivation b. the didactic curriculum meets program requirements c. the didactic curriculum meets residents needs		
6. Clinical Curriculum – the effectiveness of in-patient and ambulatory teaching experience (structure, case mix, meets resident’s needs)		
7. Volume and variety of patients and procedures (case log data) meets requirements and residents’ needs		
8. Summary of written program evaluations completed by both faculty and residents		
9. Resident supervision complies with Program Requirement		
10. Recruiting results		
11. Duty hour monitoring results		
12. Track all research and scholarly activities of faculty and residents/fellows		
13. Educational outcomes: is the program achieving its educational objectives? What aggregate data (residents as a group) can be used to show the program is achieving its objectives? Board scores, in-service training exam scores, graduate surveys, employer surveys, etc.		
15. Clinical outcomes – specialty-specific metrics aligned with dept./division QI initiatives, disease outcomes, patient safety initiatives (describe resident involvement), QI projects (describe resident involvement)		

Note:

If deficiencies are found during this process, the program should prepare a written plan of action to document initiatives to improve performance in the areas that have been identified. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.