Richmond University Medical Center
Residency Manual
For the Podiatric Medicine and Surgery Residency
2025/2026

Director:

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Richmond University Medical Center
355 Bard Avenue
Staten Island, New York 10310

TRAINING

I. GOALS:

The Residency Training Program at Richmond University Medical Center provides the recent graduate with the opportunity to gather extensive experience in the conditions associated with a general podiatric medical and surgical practice and to study advanced and related sciences essential for the practice of podiatric medicine and surgery.

The teaching program will provide the Resident effective methods for improving community foot and ankle health and to better prepare the Resident for his/her position in the total community healthcare structure.

Since podiatric medicine may be defined as "That specialty of medicine and surgery which is concerned with the prevention, diagnosis and treatment of disease and disorders which affect the human foot and ankle with it contiguous lower extremity structures," it is recognized that the podiatric Resident will be one who specialized in the lower extremity. However, it is the goal of the podiatric residency training program at Richmond University Medical Center to strive to produce a well rounded Podiatrist who is appreciative of the total patient's medical well being.

This manual describes the Residency Program at Richmond University Medical Center. In its design both the program and the manual fulfill the standards, criteria and guidelines for Evaluating Podiatric Residency Programs as defined in CPME publication 320 and CPME publication 330.

II. PURPOSE:

The Podiatric Residency Training Program in the hospital is designed to:

A. Provide an opportunity for supervised advanced clinical experience in the recognition and management of foot and ankle pathology. The resident will learn to recognize foot & ankle manifestations of the various pathology together with the concept of secondary prevention of chronic diseases as they relate to the foot and ankle.
B. Emphasize the relationship of the basic sciences to clinical practice by affording the opportunities to study and utilize the complete physical record of the patient before, during and after podiatric treatment.
C. Familiarize the podiatric resident with the hospital procedure, the scope and functions of other divisions of health services, with an emphasis on the importance of working within a multidisciplinary team for the common interest of the patient.

To achieve these purposes, experience and training in all of the major areas for the treatment of podiatric conditions have been approved through educational, clinical, research and public health programs. Education will be provided through schedules lectures, seminars and conferences devoted to the integration of the basic sciences with the clinical treatment of patients.

The value and importance of a close liaison between allopathic, osteopathic and podiatric professionals will be stressed to the resident.

To still further enhance this interprofessional relationship, consultation between the professions is encouraged and is available at all times. The Resident will rotate in each of the major departments of the hospital or affiliate institutions for further observation and training in the particular branch of medicine and surgery. The Residency Training Program will be guided by recommendations of the Council on Podiatric Medical Education, the Program Director, Committees, and Chairpersons.

III. DIRECTORS, COMMITTEES, & CHAIRPERSONS:

PROGRAM DIRECTOR: Michael Piccarelli, DPM

The Program Director is to set the Competencies of the Residency Training Committee and give overall guidance to the functioning of the Residency Program.

It is the Director's responsibility to ensure that the first, second and third year residents abide by and live up to their agreement as delineated in this manual and their contract.

It is the responsibility of the Director to initiate those disciplinary steps as outlines in this manual, when necessary to ensure the proper functioning of the residents during both in-house and outside Training Resources as assigned to them by the Director.

The Director is to serve as a liaison when necessary, between the residents and Directors of other hospital departments in conjunction with the Assistant Program Director. It is the responsibility of the Director to appoint other Committee members to the Residency Training Committee, (i.e., Assistant Director, Research Committee Director, Extern Director, etc.).

It is the Program Director's responsibility to initiate steps leading to the dismissal of any appointed Director should such action by necessary. Dismissal of an appointed Director shall require a majority vote of the Residency Training Committee, (not to include the stated individual's vote).

The Program Director is responsible to the Podiatric Staff of Richmond University Medical Center, the Board of Directors and the Hospital Administrator. The Director is to serve as the Director of Podiatric Medical Education.

The position of Program Director shall require a unanimous vote, (excluding that of the Program Director) of the Residency Training Committee.

The Program Director oversees all academic Training Resources and coordinated resident schedule. Any difficulties or conflicts which develop during a Training Resource are handled by the Program Director.

The Program Director shall be in good standing with the American Podiatric Medical Association and the New York State Podiatric Medical Association. Further, the Director shall possess Board Certification by the American Board of Podiatric Surgery in both Foot Surgery and Reconstructive Rearfoot and Ankle Surgery.

When conflicts arise between an attending podiatric physician, or other hospital personnel and the resident, the resident is to contact the Program Director.

ASSISTANT PROGRAM DIRECTOR: Anna Bryk Nemeth, DPM

The Assistant Director is appointed by the Program Director. The Assistant Director, in conjunction with the Program Director, is directly responsible for the daily functions of the residency program and addressing any direct conflicts or questions which arise with the residents and hospital staff or protocol. The Assistant Director reports directly to the Program Director and the Program Director will be informed and consulted if the issue is not resolved. The Assistant Director also functions as the interim Program Director if the Program Director is not available until a new Director may be elected.

Chief of Podiatry: Henry Habib, DPM

RESEARCH DIRECTOR OF RUMC: Dr. Bloomfield

PODIATRIC RESEARCH DIRECTOR: To Be Named

The Research Director is to be appointed by the Program Director.

The Research Director, in conjunction with the Program Director, is responsible for the residents performing their assigned research project. The Director will meet with the residents over the course of the research project to ensure that the residents are completing their assigned task as outlined in the Research Manual. The Director also will coordinate the Residency Committee approved research projects which may require resident participation. The Research Director is to be a member of the Residency Training Committee and Selection Committee.

The Resident, during orientation, will have introduction to basic research methods beginning in July 2014. In addition, during the year Richmond University Medical Center research department will have 12 lectures covering research skills and subjects. All residents of RUMC are invited to attend.

EXTERNSHIP DIRECTOR: Michael Piccarelli, DPM

The Extern Director is to be appointed by the Program Director. The Extern Director's responsibilities are as follows:

A. Orientation of the podiatric externs and evaluation of their performance during their month visitation. Should an extern's performance be below standard, then the Extern Director will meet with the extern to delineate his/her deficiencies. A letter is to be dictated to outline the deficiencies and to outline the recommended solutions. Should the extern continue to perform below standard, then the Extern Director has the authority to release the extern. A letter delineating the reasons is to be dictated to the Academic Dean of his/her school and a copy placed into the extern's file.
B. Coordination of the selection process on a yearly basis. Externs will only be selected during this process and at no other time of the year.
C. Coordinate protocol regarding students function in patient care.
D. Revision of learning Competencies of the students, as configuration of hospital and teaching program changes.

EDUCATION COMMITTEE: Michael Piccarelli, DPM, Anna Bryk Nemeth, DPM, Chief Residents

The Education Committee is appointed by the Program Director. The Education Committee's responsibilities are as follows:

A. Coordinate all medical and surgical Training Resources for the first, second and third year residents.
B. Create new Training Resources; phase out non-productive Training Resources.
C. Yearly and monthly reminder letters to all participation physicians.
D. Training Resource evaluations from all physicians (monthly).
E. Receive direct feedback from Residents about Training Resources.
F. Report to Residency Training Committee periodically.
G. Determine "switch over" monthly dates for Training Resources.

ACADEMIC COORDINATOR: Anna Bryk Nemeth, DPM, Chief Residents

The Academic Coordinator is to be appointed by the Program Director, and responsibilities in conjunction with the Program Director are as follows:

A. Coordination of Journal Club. Review of permanent articles and assignment of articles to members of Journal Club. Journals include: "Journal of Bone & Joint Surgery," "Journal of Foot and Ankle Surgery," "Foot & Ankle International," Journal of American Podiatric Medical Association," and many other permanent journals.
B. Coordination of Book/Topic Review Club. Responsible for choosing the books or topics of interest then coordinating the copying of needed articles and distribution to the Book Club members. The Residents will be involved in the clerical aspects of the Book/Topic Review Club, and will also be expected to have read all the materials so that they may participate fully in all the discussions.
C. Responsible for assigning monthly physician lectures to the residents and assigning Resident Lectures for the year.
D. Coordination of Cadaver Labs.
E. Coordination of Grand Rounds.
F. Continuing modification and improvement of academic/didactic programs.

RESIDENCY TRAINING COMMITTEE

This committee is responsible for the overall direction and regulation, as well as the day by day functioning of the Residency Training Program. It is composed of the Program Director, Assistant Program Director, Chief of Podiatry, Externship Chairman, Education Committee, Academic coordinator, Research Director, and any active hospital staff members involved in the resident's training. Appointments to this committee are made annually by the Director of Residency Training. Appointments to this committee should be made as soon as possible following the election of the Director of Residency Training. The function of this committee is to develop the course and Competencies of the training program as are recommended by the Continuing Podiatric Education Committee. All residents with take both ABFAS and ABPM in training exams. It is the aim of this committee to have all residents achieve board qualification status by ABFAS Foot and RRA and by ABPM at the time of graduation. In addition, this committee will mediate and arbitrate conflicts arising within the teaching program, whether they are generated by the podiatry staff, medical staff, nursing staff or administration. This committee will have the power to recommend the dismissal of the resident should the situation arise. The Committee will meet no less than quarterly, in order to review the program, the residents and future plans for improvement. The Director of Residency Training will be the chairman of this committee, and will be responsible to schedule the meeting dates of the committee.

RESIDENCY SELECTION COMMITTEE:

Michael Piccarelli, DPM Henry Habib, DPM Anna Bryk Nemeth, DPM

A. The Program Director, Chief of the Podiatry, Assistant Program Director, Chief residents and members of the podiatric staff as determined by the Program Director, are to make up the Residency Selection Committee for determination of new residents.
B. The Program Director may also appoint other members to this committee as needed. The residency candidates must complete the written, oral, and personal interview examination given each year by the Residency Selection Committee. The committee members must be in attendance to vote, and voting by proxy or absentee ballot will not be allowed. It will be the responsibility of all committee members to screen each application prior to attending the final selection meeting. During the final meeting, the applications under consideration will be evaluated and discussed in detail.
C. Applications for the Residency Program will be accepted primarily from students in their senior year, with exceptions only if agreed unanimously by the Residency Selection Committee.
D. The selection protocol for the interview weekend will be agreed upon by the Committee prior to the interview date. If no questions or changes are recommended, then the protocol used the previous year will be in force. Once in place it will not be changed until the following year.

IV. TRAINING COMPETENCIES/GENERAL MANDATORY COMPETENCIES

The Competency of Richmond University Medical Center Podiatric Residency Training Program is to provide the residents with the education and training necessary to acquire the experience and to develop the skills and attitudes to assure the special competence and judgment expected of today's foot and ankle specialist.

A. The Competencies to be achieved by the residents in this program are:
    1. Acquire an understanding of systemic diseases, their treatment, prognosis and prevention of complications and how they affect the foot and ankle
    2. Increase ability in examination, diagnosis and recognition of abnormalities, disease and conditions of the foot, ankle and related structures and manifestations of systemic disease.
    3. Acquire knowledge of podiatric diagnostic imaging (to include CT, MRI, Ultrasound, Bone Scan, etc.)
    4. Develop an in depth understanding of Diabetic Foot including the management of soft tissue infection, osteomyelitis and Charcot.
    5. Develop an understanding of indications for hospitalization, and patients who require podiatric services.

6. Acquire knowledge and experience adequate for evaluation of a patient's physical ability to undergo general or local anesthesia for pedal surgery and for the administration of local anesthesia.
7. Acquire experience in the management and treatment of patients who may hemorrhage during or following podiatric surgery.
8. Acquire experience in the examination, diagnosis, and treatment of abnormalities of the lower extremities affecting posture and gait.
9. Increase experience in the understanding of the pathology and treatment of benign and malignant tumors.
10. Increase experience in the examination, diagnosis and treatment of injuries affecting the foot, such as fracture, lacerations, dislocations, subluxations.
11. Increase experience in the application of pharmacology and therapeutics.
12. Acquire experience in the management of post-operative patients and potential complications of therapy.
13. Develop functional biomechanical knowledge for operative and non-operative management of patients
14. Acquire more experience in the application of clinical test and procedures, their evaluation and interpretation.
15. Improved general medical and surgical knowledge
16. Develop a greater appreciation of the utilization of consultative services.
17. Obtain experience in trauma pertaining to the field of podiatry.
18. Acquire skills in all phases of foot surgery, including surgical treatment of trauma and forefoot/rearfoot reconstruction.
19. Acquire experience in muscular and neurological evaluations.
20. Acquire experience and develop knowledge of good podiatric practice management.
21. Develop skill in performing complete history and physical examinations.
22. Develop and practice skills of public speaking.
23. Develop an understanding of physical medicine and rehab
24. Develop proper charting methodology appropriate for medico-legal review. Gain insight into the medico-legal aspects of practice.
25. Develop the appropriate skills for completing a research project.
26. Develop an understanding of applications of advanced wound care techniques
27. Develop the understanding and the skill of surgical planning

B. Resident Evaluation Process

1. The residents are evaluated biannually by the director on their performance on outside as well as in house Training Resources. Evaluations are based on the fulfillment of the Competencies for the individual Training Resources and on evaluations submitted by members participating in the resident's education.
2. Incident reports filed by hospital personnel are considered as well.
3. Recommendations for improvement are made by the Residency Training Committee and reassessed at the next evaluation.
4. Residency Daily and Surgical logs are reviewed and signed monthly.
5. Required biannual evaluation processes will occur by the teaching staff.
6. Annual Reports will be completed in July of each year.

V. REQUIREMENTS FOR RESIDENCY

A. Residents are required to have a maintained a satisfactory level of scholarship, performance and competency. Residents are required to be graduates of a Podiatric Medical College, approved by the Council on Podiatric Medical Education. Official transcripts, curriculum vitae, two letters of

recommendation, national board scores, cover letter with photograph and application fee (to be determined on a yearly basis). Residents are expected to be worthy in character, manners and ethical conduct. Applicants must pass both Part I and Part II of the NBPME prior to beginning the Residency. And as per RUMC policy all resident will pass NBPME part III before December 15 of their second year.

B. Appointees to the Residency Program should make application to the American Podiatric Medical Association, New York State Podiatric Medical Association, and American College of Foot & Ankle Surgeons. First year residents do have free membership.

VI. PHYSICAL FACILITIES

The hospital shall provide a physical plant, free from hazards and properly equipped to provide a post-graduate training program. Additional affiliations with private physician's offices, hospitals and surgical centers may be formed for additional training experience.

VII. THE TEACHING STAFF

The Podiatry Staff consists of those podiatric physicians privileged to work in the hospital, as defined by the Bylaws. The program for Podiatric Residents is supervised by the Program Director, in conjunction with the Department of Surgery, and the Residency Training Committee.

All members of the Podiatric Staff may participate in the teaching program of the Podiatric Resident. The specific areas of responsibilities are assigned to represent all the areas of clinical podiatric practice.

The expanded medical teaching staff consists of those allopathic and osteopathic physicians privileged to work in the hospital, as defined by the Bylaws. All members of the Medical Staff may participate in the teaching program of the Podiatric Resident. The specific areas of responsibilities are assigned to represent all the areas of clinical practice relevant to the particular physician's specialty. The Podiatric Residents will be assigned to supervisors of rotations (training resources) who are specialists in that specialty, but all staff physicians who practice that specialty may participate in the training, if they so desire. Furthermore, during the Podiatric Residents' surgery month, the residents will scrub all cases related to foot and ankle surgery, regardless of the attending physician's specialty, if the attending physician is willing to participate in the training program. Additionally, during their surgery rotation, if there is no foot and ankle surgery taking place, the residents may scrub cases other than foot and ankle surgery, with attending physicians of other specialties, if the attending wish to participate. The residents will benefit from experiencing a high volume of well-rounded surgery with physician attending from multiple specialties.

VIII. PROGRAM

A. Education- Since this is the primary purpose of the Residency Program, residents are encouraged to attend all scientific and professional meetings sponsored by the various departments and committees of the hospital whenever it is possible. Those required professional educational programs shall be posted and the residents shall attend when so notified. Attendance is required at all ward rounds, all teaching conferences, all clinical pathological conference, all radiology conferences, wound checks, residency training committee meetings, and grand rounds.

B. Orientation- Just before the beginning of the residency year, a period of approximately 2 weeks in orientation and instruction in duties, responsibilities and privileges of the podiatric resident is provided, so that each resident may attain a working knowledge of the functions and administration of the hospital's Podiatric service.

The following subjects are included in this period of instruction:

1. Tour of the hospital to meet the medical staff and other department heads, general orientations to specific departments.
2. General policies of the hospital related to the podiatric resident's responsibilities.

3. Standard procedures in the hospital related to patient care.
4. General policies and procedures of the Podiatric Medicine and Surgery section.
5. Explanation of the training program.
6. Explanation of the proper use of podiatric medical records for recording all clinical and laboratory findings, as well as the therapy employed.
7. Demonstrations and lectures covering the various phases of clinical podiatry are given the newly appointed podiatric resident. These lectures and demonstrations are so presented that the new podiatric resident will adapt to the hospital atmosphere.
8. There will be a separate orientation set up by the Residency director for the residents each June to review specifics of the training program, responsibilities and introduction of committee members.

C. Duties and Responsibilities:

1. While your obligation to yourself, your profession, your hospital and patients will be expressed by implication throughout this manual, the following reminders are added as a guide and check list, and are intended to summarize many of the details not specifically mentioned.
2. The resident must be familiar with and abide by the Rules and Regulations of the Professional Staff, departments and committees.
3. Residents shall report as members of the house staff the last 2 weeks of June to the Program Director, and begin orientation process.
4. Cooperate in the conservation of supplies.
5. Members of the resident staff are expected to abide by the policies of the hospital, to be cooperative and well groomed/well dressed, in accordance with the hospital's dress code policies.
6. ***Be alert to the paging system, calls, texts during duty hours, if you are going to be where you cannot hear the paging system, notify the operator***. Each resident will be issued a numeric pager. Residents should submit the "on-call" beeper number to the front desk of the emergency room at Richmond University Medical Center as well as the main operator of all facilities visited by the residents.
7. ***Residents are not to accept fees or gratuities from patients, their relatives or friends. A resident will not, practice or assist any physician outside the hospital- except by an affiliation agreement or permission for educational purposes only, which may be granted through the Director of Residency Training only. Moonlighting is prohibited, unless cleared by the program director and only in the second half of the third year of training.***
8. No alcoholic beverages are permitted in the hospital. No person who has been drinking may attend a patient.
9. Smoking on hospital property is prohibited for everyone.
10. **AT ALL TIMES, YOUR PATIENTS ARE TO BE YOUR FIRST CONSIDERATION.**
11. Each of your patients will be rounded on and the attending updated daily unless directed otherwise by the attending, give them such conscientious professional care as the attending physician directs and make progress notes of all significant events in the development of the case. Any treatment provided is to be approved and/or supervised by the attending
12. Provide complete privacy for each patient during dressings and examinations in which he or she might be exposed. Curtains are furnished in multiple bed rooms.
13. Do not sit on the patient's bed unless it is necessary for examination.
14. Do not prop feet on beds, desks, or chairs.
15. Protect your patients by refusing information about him/her to lawyers, insurance people, and news media people, unless he/she specifies that he/she wishes to see them. Refer such inquiries to administration.
16. Refer any questions about your patient's financial arrangements to the Business Office.

17. Refer any requests for extra visiting privileges to administration requests for transfer to other accommodations to the Admitting Office, and inquiry about discharge from the hospital, etc., to the patient's attending physician.
18. Report promptly on the Incident Report Form any unusual occurrences in the hospital such as accidents, fire, or a disturbed patient.
19. Always be HIPPA compliant. Guard against unnecessary or unwise talking in public areas.
20. Never disparage any physician or the hospital to a patient. Avoid inciting damage suits by a patient who thinks he/she has been the victim of malpractice.
21. Residents may use hospital computers, phones etc, if they pertain to the residency program
22. Residents will not order materials, supplies, or surgical equipment directly from outside vendors. If the resident desires to order materials and supplies, approval will be obtained from the Program Director prior to submitting to the administrator for approval.
23. Residents may use the hospital duplicating equipment in the medical education department's library to copy articles and periodicals, lectures for staff and meetings, or as it pertains to the residency program.
24. The first year residents and second year residents are under direction of the chief resident, attending assistant director, and the Residency Director.

D. Academic Calendar 7/1-6/30

Grand Rounds: First Thursday of every month at 7:00a.m.

Attending Lectures: To be scheduled on weekly basis

Attending case discussions: Monday, Tuesday, Wednesday, Thursdays

Journal Club: Second and Third Thursday of every month at 7:30a.m.

Resident Lecture: Monthly to be scheduled

Weekly video lecture: via a variety of on line resources assigned by the Program Director or Chief Resident

- **July**: Grand Rounds- Topic to be determined
- **August**: Grand Rounds- Topic to be determined
- **September**: Grand Rounds- Topic to be determined
- **October**: Grand Rounds- Topic to be determined
- **November**: Grand Rounds- Topic to be determined
- **December**: Grand Rounds- Topic to be determined
- **January**: Grand Rounds- Topic to be determined
- **February**: Grand Rounds- Topic to be determined
- **March**: Grand Rounds- Topic to be determined
- **April**: Grand Rounds- Topic to be determined
- **May**: Grand Rounds- Topic to be determined
- **June**: Grand Rounds- Topic to be determined

E. Didactic Programs:

Academic lectures are held in Richmond University Medical Center Podiatry Office unless otherwise advised. The video lectures as advised. Additional cadaveric labs and lectures will be posted and distributed by the Program or Assistant Program Directors to all involved residents and faculty. All residents are expected to attend all lectures. If you wish to give a lecture, or if you know someone who does, contact the Program Director's office to schedule a date and time. All residents are expected to attend all lectures and journal club

meetings. All Podiatric residents are invited to attend other services lectures when available. They will also be required to attend any lecture given while on an outside rotation.

Presentations for Grand Rounds can be:

- Case presentations w/EBM added to evaluate the surgery/treatment and discuss if there are other or better options for the pathology.
- Article Review/Chapter Review

This is for the residents' benefit and learning. Putting time and thought into each presentation ensures that it will be educational for all. All faculty are invited to attend.

F. Attendance Policy

All residents are expected to attend all lectures unless they are off service or in the Operating Room.
The Resident is expected to arrive on time, and remain for the entirety of the lecture in order to be counted in attendance, unless on an authorized leave of absence from the program. There will be excused absences for illness, rotation requirements, meetings, vacation days, or other as approved by the Program Director
The Program Director may assign appropriate punitive measures for lateness and/or failure to attend lectures.

G. Resident Duties and Responsibilities:
   1. RUMC Podiatry Department policy for patient transfers and for sign out rounds is SBAR (see attachment)
   2. The first year residents (PGY-1) are responsible for keeping track of all in-house patient lists and the patient's status when on service. They are also responsible for updating the second and third year residents and attending on these patients. Morning rounds are to be completed before 7AM and all updates by 10AM. Afternoon rounds are to be completed before leaving the hospital for the day. Residents will work together as a team to ensure that all rounds are completed. The ED will be the responsibility of the floor/call residents.
   3. Second year residents (PGY-2/3) are responsible for overseeing the management on the in-house patients through the updates of the first year residents. Initial consults are to be evaluated and signed off by the second/third year resident during or following its completion by the PGY-1.
   4. Third year residents (PGY-3) on chief duty will have the ultimate responsibility for all surgical and in-house patient care. He/She will be available to evaluate patients and/or answer questions for the junior residents regarding patient care and management.
   5. PGY-2 on service are responsible for checking the surgery schedules routinely and updating senior residents of additions or cancellations of cases. ALL CASES WILL BE COVERED. Priority will go to senior residents on their surgery Training Resource and responsibility for coverage will trickle down.
   6. ***All residents will maintain a cellular phone and be accessible as per their schedule. If a resident is derelict in their duties it will be ground for punishment and possible dismissal from the program***
   7. The resident assigned to a particular in house case is responsible for ensuring the patient's NPO status, medical clearance and consent for surgery. For all cases, the resident should be well informed of the patient thorough history, medications, allergies, pre op lab values, etc. before the attending arrives for the case. ANY concerns are to be immediately conveyed to the attending. For all level 5 cases, the resident should become familiar in depth with the rational for the procedure chosen, having reviewed all previous x-rays, notes and preoperative conservative treatment regimens from the attending's office if at all possible. The residents should also make every effort to follow these patients post operative progress as well.
      The resident claiming the primary level of participation for a particular case is responsible for completing all post op notes, orders and dictations immediately following the case. ALL

DICTATIONS WILL BE COMPLETED AT THE HOSPITAL BEFORE LEAVING FOR THE DAY-NO EXCEPTIONS.

H. Dress code

White jackets and RUMC name plate badges are provided before reporting for duty, and must be worn on duty at all times. The white jackets should be kept as clean as possible. If unduly soiled through the normal routine of work, residents are required to change linen often enough to present a clean, well-groomed appearance at all times. Scrubs are permitted while in house but not to be worn outside of the hospital. Residents shall assure that the podiatric externs refrain from wearing surgical suits off the hospital area, and that they wear a white jacket when attending to patients. A while jacket must also be worn over scrubs when on the floor or outside of the OR. Hair styles and wardrobe should be professional and shoes enclosed. Refer to hospital's dress code policy for details.

I. Hours on Duty:

**Under no circumstances will any resident's hours on duty exceed an average of 80 hours per week during any 4 week time frame* as per IPRO*

Typical hours will be 7:00 to 5:00 PM during the week. Residents will arrive at the hospital each morning in time to be updated by the call residents. They will stay at the hospital until all duties for the day are completed, including meetings, rounds, dictations, etc. Residents will not be required to sleep at the hospital but must be within 30 minutes of RUMC when on call. Residents will have call schedule made by the chief resident and approved by the program director. Call switches will be allowed as long as duty hour limits are followed.

Chief Resident do not take primary call on the weekend but alternate as first back up

On weekends, the on call residents will round at least once per day on all in-house patients unless directed otherwise by the attending and see all patients with during attending rounds

On call duties include the following:

1. Available to report for all foot, ankle cases which present to the ER within 30 minutes of being called.
2. Coverage of all after hours and weekend foot and ankle surgical cases.
3. Hospital Rounds and Consults on the weekends.
4. If the on a call resident is sick the next resident due to be on call will take the spot and the sick resident will then cover the next call (adjustments may need to be made for duty hrs or consecutive days)
5. Residents who are fatigued shall report to the program director and arrangements will be made to cover the resident's duties for the day.
6. If the on -call resident feels fatigued from the scheduled call they should call the program director and will be granted post call after am sign out.
7. A third year resident is to be available for weekend backup coverage if the assigned resident is unable to cover call in an emergency

On call residents are NOT required to sleep at the hospital and will go home when duties are complete- but will simply remain available by pager to report to the hospital, within 30 minutes or less, in the event of an emergency!* If a resident fails to respond to calls as above they will lose home call privilege and subsequent incidents will lead to punishment and /or dismissal

The floor resident on duty will be notified and report for all Emergency Room calls cases involving the lower extremity if contacted by the ER Physician or other attending. The resident may not diagnose and treat the patient over the phone.

Hours of duty vary based on the particular day and rotation. However, an average day will require that the resident be present at the hospital between 7:00am and 5PM. Leave at times other than specified above may be

granted under reasonable circumstances by the Program Director or Assistant Director only. This request and permission for leave is to be made to the chief resident and the cleared by the PD or APD.

If leaving the hospital for any reasons: i.e., outside Training Resource, office visitation, etc, the switchboard operator will be notified upon leaving, giving destination and estimated time for returning.

J. Relationship of Resident to Hospital, Staff, Physicians and Hospital Personnel:

All resident will attend sign and sign-out rounds unless off service or in the OR. And will round with attendings when they come to the hospital.

In no case will the resident change the treatment without the permission of the attending. Supervision, of the junior residents, is by the Chief resident and the PD, APD, and attendings.

Disagreement or criticism of any member of the nursing staff must be discussed with the Program Director who will take any necessary action. Questions or criticisms relating to the general hospital operation or personnel may be brought to the Program Director, who may discuss them with the hospital administrator. Those questions relating to the podiatric residency training program will be discussed with the Program Director and the residents.

Residents are expected, while in the hospital, to conduct themselves with professional dignity in the relationship not only with patients, but also with nurses and other hospital employees. Both on and off duty, be true to your reputation as a gentleman/lady and a doctor.

Cooperate in every way possible, and maintain friendly relations with all professional services, administrative departments and other hospital personnel. You have no disciplinary jurisdiction over nurses or other hospital employees. If any personnel difficulties arise, talk them over with the Program Director. All formal complaints are to be in writing. Remember always that the attending physician is in full charge of his/her patient. Inform him/her promptly of any major change in the patient's condition. Work closely and conscientiously under their direction, and let them know that you want to learn from them.

All complaints for any instance must be in writing, and will be considered by the Program Director.

ANY problems or questions concerning patient care are to be directed to the appropriate department head and the Program Director.

K. Resident Daily Log:

The residents will:

1. Keep a surgical logs as per Podiatry Residency Resource containing patient name, patient number, procedures performed or assisted, level of participation and date of operation **for both podiatric and non-podiatric cases**. **..**
2. Keep a log of daily activities on in house and outside in PodiatryRR They will be reviewed at the end of each month by the residency director.
3. Resident logs will be reviewed and verified monthly by the PD
4. Utilize the **Resident Resource Program** effectively.

L. Responsibility:

ANY questions or problems concerning issue with residents, whether they are from podiatric, medical administrative or nursing staff, should be brought to the attention of the Program Director.

M. Role of Podiatric Residents:

Podiatric residents in training at Richmond University Medical Center serve as designated first, second, or third year house officers who function to provide services under the direct and/or indirect supervision of a Program

Director and affiliated licensed attending physicians/surgeons who are staff members of Richmond University Medical Center.

N. Responsibility of Podiatric Residents:

Podiatric residents are responsible for completing a series of supervised rotations in compliance with standards set by the Council on Podiatric Medical Education (CPME) for core and elective training environments existing within the framework of the Hospital and its affiliated medical service sites/centers/ The CPME standards can be found in documents 320 and 330: To view CPME 320 right click on the hyperlink provided in this document, then click "open hyperlink": CPME 320>. To view CPME 330 right click on the link provided in this document, and then click "open hyperlink": CPME330>. Residents are responsible for reporting directly to the licensed consulting physician/surgeon responsible for the individual patients within the hospital system. Residents should convey information on patient care and treatment to the designated attending on a timely basis. Residents will participate in pre-operative care of hospital patients. Residents are responsible for keeping logs on a daily basis, consisting on both surgical logs and activity logs. Residents are responsible for producing these logs on a regular basis and submitting them for review to the Program Director on a timely basis.

O. Patient Care Activities:

Podiatric Residents are responsible for providing patient care under the supervision of an attending physician/surgeon. Residents are subject to the limits of their training and expertise in a given circumstance as outlined in the Podiatry Residency Manual as well as State Law and National Guidelines set forth by the Council on Podiatric Medical Education.

P. Process of Supervision and Evaluation:

At the completion of each rotation, the Resident shall be evaluated by the appropriate professional staff member designated as rotation supervisor. These evaluations shall be signed by the rotation supervisor, the resident and the Program Director. At the completion of each month as well as each annual cycle, the resident shall also evaluate the rotation and program. Such evaluations shall be subject to review by the Program Director and Residency Training Committee. Evaluation of residents by staff is done through New Innovations When indicated, recommendations will be advanced through the appropriate avenues for implementing changes to improve the effectiveness of the program. Residents are supervised on a tiered basis. All residents are supervised by attending on staff throughout the process of treating patients.

RESIDENCY BENEFITS

The stipend for residents will be discussed at the time their contracts are signed and the application approved as per the hospital contract and HSA agreement .

A. Sickness and Injury:
   1. Residents will be covered under the hospital's major medical plan during the tenure of the contract. ANY injury of a serious nature should be reported immediately to the Program Director, who shall make arrangements or assist the resident in establishing a physician for care. In the event of illness which does not require hospitalization, but is of a serious nature to prevent the resident from performing his/her duties, it shall be reported within 24 hours to the Program Director either by phone or in person. In illnesses which require hospitalization the same procedure shall be in force. Normally, it shall be the responsibility of the resident to report any illness to the Program Director within 24 hours of onset and decision of hospitalization shall be left entirely to the physician caring for the resident. Approved and verified sick time will be paid in accordance with the hospital policies.
   2. If for any reason a resident is going to take a leave of absence longer than provided for by vacation, sick and personal days that time will have to be made up.

3. Health Insurance: Medical and Hospitalization coverage is provided to the resident at a reduced cost consistent with the Hospital's Employee Benefits Package. The resident may choose from the plans among the Medical Plan Options and Dental Plan Options.
4. Life insurance: provided as per contract/HSA
5. Long term/short term disability insurance as per contract/HSA
6. Professional liability insurance (Malpractice): The sponsoring institution will provide professional liability insurance resident that is effective when training commences and continues for the duration of the training program. This insurance will cover all training experiences at all training sites and will provide protection against awards from claims reported or filed after the completion of training if the alleged acts or omissions of the resident were within the scope of the residency program. The sponsoring institution will provide the resident with proof of coverage.
7. Cafeteria Fund: as per contract/HSA
8. Uniform allowance as per contract/HSA
9. ACLS certification course provided or reimbursement
10. Days Off: as per contract HSA
11. Educational Fund: as per contract/HSA
12. Conference Fund: as per contract /HSA
13. Board Review Stipend: as per contract /HSA
14. Each Resident is provided with an IPad that they can keep upon graduation.
15. Base salaries:

B. Vacation time: will be submitted though the chief residents and approved by the PD. If more than one resident request the same days and can't be accommodated the senior resident take priority

C. Library:

Residents will maintain a library of periodicals in the resident's quarters. Resident is welcome to utilize the library and education facilities at Richmond University Medical Center. ANY request for books or periodicals must be submitted to the Residency Training Committee.

D. Seminars:
   1. Must be approved by the PD and a request must be submitted by the resident.
   2. Contractual allowances are determined each year with the new contracts from the hospitals.

IX. SOCIAL ACTIVITIES OF RESIDENTS

Residents are cordially welcomed and encouraged to participate in social and athletic activities sponsored by the hospital when it does not interfere with the training schedule.

X. POLICIES FOR PATIENT RELATIONS

A. Admission procedure:

Patients must be admitted under the service of an allopathic or osteopathic physician.

Patient transfers:

It is the policy of the Richmond University Medical Center- Richmond Program that each residency program develops standards that provide for the safe transfer of responsibility for patient care. The format for transfer of care may vary, but each program's standards must ensure continuous, coordinated delivery of care in settings that are appropriate to patients' needs, including arrangements that extend beyond the inpatient setting into the community and the home.

A handoff is the process of transferring information and authority and responsibility for a patient during transitions of care. Transitions include changes in providers, whether from shift to shift, service to service, or hospital or clinic to home. Transitions also occur when a patient is moved from one location or level of service to another.

Both written and verbal handoffs are important, and each has a different purpose. Written handoffs can provide detailed information that serves as a reference for the receiving provider. Verbal handoffs allow discussion and cross-checking with the receiving provider to be certain that he/she has understood the information being provided.

1. **Policy Structure**:

Each residency program must develop a handoff policy that outlines the expectations for transfer of responsibility for patient care in all the settings and situations in which handoffs occurs. The amount of information to be included in the process will vary depending on the functional role of the resident or fellow in patient care. Resident and fellow providing continuous and direct care and taking responsibility for order writing require a higher level of information exchange than those with less continuous duties, such as consultative or supervisory services. At a minimum, that policy must address the following:

a. The time and place that routine handoffs should be expected to occur.

   The location should be chosen so as to minimize distractions and interruptions and where all needed resources are available (e.g., appropriate information systems). Verbal handoffs are required for PGY1 residents and preferred for all residents and fellows follows SBAR protocol The handoff process MUST allow the receiving physician to ask questions, so written handoff alone if not acceptable. The time chosen should be as convenient as possible for all participants.

b. The structure of protocol for handoffs.

   Verbal handoffs should follow a predictable structure. Mnemonics may be helpful in this regard.

   SBAR FORMAT

   - Appendix A provides an example of a commonly used mnemonic. Time for questions must be a part of all verbal handoffs.

Written handoffs must be structured and organized so that information is provided in a predictable format or is readily available for each patient. Written information for residents providing continuous care and taking responsibility for order writing should include the following:

- Identifying information—Name, location, history number, hospital day
- Diagnosis, procedures, condition
- Problem list
- Medications and other treatments
- Pertinent laboratory results
- Pending laboratory and other studies
- Important contact information (e.g., patient's attending of record, referring physician)

Written information for trainees in a supervisory or consultative role must include sufficient information to understand and address active problems likely to arise during a brief period of temporary coverage, or to assume care without error or delay when care is transferred at a change of rotation or service.

2. All patients for whom a resident is responsible must be included in the handoff.

B. Notification of Trainees

Each residency and fellowship program must inform their trainees about the institutional and program-specific handoff policies. Trainees must be informed about the reasons for these policies and the expectation that the policies be followed.

C. Evaluation of Trainees

Each program must develop a system for assessing the effectiveness of resident handoffs and for monitoring compliance with handoff policies.

D. Transfers of service
   1. Except for transfers in emergency situations, a transfer note must be provided by the "sending" resident when a patient is transferred to a different level of care or to a different service. No transfer note is required if a patient is being relocated but will be cared for by the same service; when a patient is being admitted from the Emergency Department, the Emergency Department record serves as the transfer note. A "transfer acceptance note" must be documented by the receiving service.
   2. An "off-service" note must be written by the responsible resident when the entire resident care team rotates off service on the same day and the team has cared for the patient for more than 48 hours (24 hours for ICU care). This note should provide a sufficient summary of the patient's hospitalization and proposed plans so that the next resident(s) can assume knowledgeable care of the patient in an efficient manner.
   3. When the responsible prescriber (resident) changes, nursing staff and all others who may need to contact the provider promptly must be notified of the change before noon of the day of service change.

E. Discharges
   1. The discharging the resident must ensure that prescriptions for discharge medications are written and available at the time of discharge.
   2. The discharging resident must ensure that the discharge worksheet is completed and is accurate. The discharge worksheet must not be changed after the patient has been discharged.
   3. The discharging resident is responsible for ensuring that information about clinically important laboratory, radiologic, or other results that come to a prescriber after a patient leaves the hospital is conveyed either to the patient or his/her primary care provider. This contact should be documented in the medical record.

Appendix A:

A commonly used handoff mnemonic-SBAR

A communication technique for the transfer of patient information is situation-background-assessment-recommendation (SBAR).

Situation and background are objective components; assessment and recommendation are components that allow delivery of subjective information, including opinion, coupled with a request for a specific intervention.

Developed by the U.S. Navy to improve communication of critical information, SBAR was implemented by a multidisciplinary team of health care providers at Kaiser Permanente of Colorado. This tool creates redundancy, which establishes an expected pattern of communication.

--Situation:

Identify yourself, your position, the patient's name, and current situation. Describe what is currently going on with the patient.

--Background:

State the relevant H&P, physical assessment, treatment and clinical course summary, and any pertinent changes.

--Assessment

Offer your conclusions-what is the problem in your opinion?

--Recommendations:

What needs to be done?

- SBAR
    - ***S***ituation
    - ***B***ackground
    - ***A***ssessment
    - ***R***ecommendation

Communication between providers must be interactive and allow-even promote-questions between the giver and receiver of information.

This information must be accurate, complete, and up to date. Residents must include recent or anticipated changes, and there must be an opportunity for the receiving to review test results and relevant historical data.

Interruptions during the handoff should be limited. Conduct handoffs in face-to-face encounters whenever possible, in an atmosphere free of unnecessary noise and interruptions. In patient information is provided electronically or via fax or hard copy form, a follow-up telephone conversation is strongly encouraged to allow for feedback and an opportunity for questions.

Allow for a verification process, such as write-down/readbacks as appropriate (alarm values, specifically).

F. First contact with patient:

Introduce yourself as a podiatric member of the house staff. Explain that the attending requested you to perform the H&P. As soon as the patient is in bed, the resident who is responsible for the case according to the schedule takes the history and makes the physical examination. He then calls the staff physician for orders if not already obtained. The history and physical examination must be signed, whether the report is handwritten or dictated and typed. Each new admission should be seen within one hour, and preliminary procedures should be completed within 24 hours. In the absence of written or telephone orders from the attending physician, the resident writes the preliminary routine orders on the order sheet, with permission note on the chart, except for emergency cases.

G. History and Physical Examination:

All podiatric patients admitted to the hospital will be given a complete history and physical examination supervised or performed by the first year resident. If podiatric externs are not available, it is the responsibility of the first year resident in-house to perform those H&P's.

The history should be as complete as possible and should include:

1. Chief complaint
2. Present illness
3. Past medical history
4. Family history
5. Review of systems

The history should record clear, concise statements pertinent to the patient's story of his complaints and illnesses, including onset and duration of each. The report of the physical examination is the result of a thorough examination of the patient by the resident and is a detailed description of his observations and findings. The terms "negative" and "normal" are opinions and not facts and should not be used except when summing up the facts.

Genitourinary, rectal or breast examinations are not routinely done on podiatric surgical cases unless the particular case requires such an examination. In this event the resident should seek assistance from the physician responsible for the medical management of the patient or other responsible physician.

A complete physical examination does not include pelvic examinations unless otherwise specified by the attending physician's orders. It is performed only with the patient's permission and always in the presence of a nurse. No vaginal examination should be made of an unmarried female under 21years of age without the consent of her mother, guardian or some other legally responsible member of the patient's family.

Please refer to "History and Physical Examination" format on the following pages.

HISTORY AND PHYSICAL EXAMINATION

(Note: Standard abbreviations may be used if written in longhand: i.e., C.C.H,P.I., etc.) Date of Admission to the Hospital

C.C. or CHIEF COMPLAINT

The entrance complaint is generally a brief state-statement of the patient's subjective symptoms as some abnormality of sensation, pain or even some psychological reaction of which the patient, himself is aware.

A concise statement of complaints, preferable in the patient's own words, and should be an introduction to, and closely correlated with the present illness.

H.P.I or HISTORY OF PRESENT ILLNESS

An orderly story of the onset and course of the illness that gave rise to the chief complaint, with reasons, signs, severity, location and duration of each symptom. The date of onset should be given, or the numbers of days, as "two days ago."

The illness may be a brief episode, such as an accident which occurred just prior to admission. Or, it may be an illness which began years ago and was marked by repeated attacks with periods between which, apparently, no subjective symptoms were noted.

In the case of chronic disease which may recur at intervals, details of the more recent events of the illness should be given. Interval treatment given in such cases may be described.

Since most symptoms, i.e., pain, nausea, vomiting, headache, dyspnea, etc., may be produced by widely divergent cause, the physician should learn as much about each symptom as possible; onset location, quality, intensity, possible radiation, distribution, persistency, or intermittency, duration and relationship to other complaints or certain body functions, such as eating, bowel movement, micturition, sleeping, working, menses, and also any measures which may grant relief.

P.M.H. or PAST MEDICAL HISTORY

A summary of the patient's past health status. This should include all operations with dates, injuries, complications, or experience which might have a bearing on the present illness. The patient should also be questioned for any problems with anesthesia in the past or in other family members.

Question the patient specifically on each of the following and record each condition he has had, P.H., or i.e., measles, whooping cough, mumps, chicken pox, scarlet fever, diphtheria, rheumatic fever, typhoid fever, malaria, dysentery, arthritis, asthma, tonsillitis, influenza, pleurisy, pneumonia, tuberculosis, or tuberculosis contact, amebiases, lues, gonorrhea, etc.

Include history of allergy of drug reaction.

Other subdivisions of the past history may be contributory:

Birth and early development

Environmental history
Intellectual and social development
Occupation-Habit
Marital history

PFH or FAMILY HISTORY

A record of familial tendencies, such as tuberculosis, cancer, diabetes, arthritis, heart disease, kidney disease, allergy, high blood pressure, epilepsy, and any other which might have a bearing on the cause and development of the disease.

The health of immediate relative (father, mother, siblings, children, ages at death, and causes of death should also be recorded.)

SYSTEMS REVIEW or ROS

The subdivision of the past medical history. The purpose of this is to reveal subjective symptoms which the patient forgot to describe, or may have considered unimportant. This should also give a clue to the diagnosis and indicate the nature and extent of the physical examination.

General Nutrition, fever, night sweats, falling hair, tremor, weight gain, weight loss, other.

SKIN: A record of eruptions, cyanosis, jaundice, or other skin conditions.

HEAD: Headache, history of trauma, syncope, or other affections.

EYES: Eye strain, diplopia, photophobic, lacrimation, glasses for correction of vision.

EARS: Deafness, discharge, tinnitus, dizziness, other.

NOSE: Colds, epistaxis, sinusitis, obstruction, postnasal drip, other.

THROAT: soreness, redness, hoarseness, dysphagia, etc.

NECK: diseases of the neck are usually expressed by some disturbance in movement, pain and swelling. The causes may be classified into the etiologic factors of disease: congenital anomalies, trauma infections, tumors, degenerative and functional entities. A wide variety of systemic disturbance may be interrelated.

C.R. or CARDIORESPIRATORY:

Chest pain, hemoptysis, sputum, dyspnea and shortness of breath following ordinary exertion. If he coughs, determine the character of the couch, i.e., whether it is dry hacking, paroxysmal, explosive, persistent, and of equal importance, whether it is productive or nonproductive. Insofar as the cardiac system is concerned, as Paul White has emphasized, “the first heart symptom is the keystone on which further examination of the cardiac patient depends.” Inasmuch as the chief symptoms of heart disease- dyspnea, substernal or precordial pain, and palpitation- may not only be readily be confused with each other one cannot stress to greatly the development of the symptoms of the cardiac patient, with careful observation concerning time, character, intensity, variability, and relationship to extraneous or precipitation factors.

G.I. or GASTROINTESTINAL

Questions concerning the appetite, distress, pain, nausea, vomiting, belching, flatulence, constipation, diarrhea, stool, (shape, color, mucus, blood) hemorrhoids, hernia, other.

G.U. or GENITOURINARY

Covers such items as frequency of urination, abnormal color of urine, pain or burning on urination, any passage of stones, or inability to pass urine.

OR

Discharge, sores, frequency, nocturia, incontinence, pyuria, hematuria, pain, other.

Female reproductive (menarche or catamenia) Menstrual cycle, age at first appearance, date of last period, regularity, type, duration, and any sign of abnormality in this respect. Abortions, if any, pregnancies (type and complication), labor (type and complications).

N.M. or NEUROMUSCULAR

Emotional state, headaches or convulsions. Includes questions concerning loss of sensation in any part of the body, difficulty in walking and pain in muscles or joints.

P.E. or PHYSICAL EXAMINATION

(Age, T.P.R., B.P., Weight, Height)

This part of the report is based on the Competency findings of the physician in physician in his physical examination.

Opening statement concerning general condition of the patient. Example: "A well developed, well nourished white adult male lying in a right lateral recumbent position complaining of pain in the right, lower quadrant."

SKIN: The skin should be examined not only for the presence of an eruption, nut also for changes which are indicative of symptomatic disease, such as pallor cyanosis, edema, jaundice, hemorrhage, and changes of texture, elasticity, moisture and sensibility.

Also observe for scars, excoriation, ulcers, tumors and distribution of hair.

HEAD: Examination may include the symmetry or lack of symmetry of the skull, exostosis or bumps, as well as tenderness in certain areas, conditions of the scalp and hair. Special considerations for traumatic injuries.

EYES: Symptoms of common diseases can be detected through their examination. Examine pupils for regularity and reaction. Abbreviations may be used, as pupils are "round, regular and equal", (R.R.E.) and that react to light and accommodations", (R. to L. & A.) and the external ocular movements are normal (E.O.M.) ANY exophthalmus or bulging of the eye is noted, so too, lacrimation or photophobia.

EARS: Should be examined by the otoscope if the present illness indicates a disease related to the ears. The degree of hearing is sometimes tested with a watch or tuning fork. Check drums, hearing, discharges, mastoid, etc.

Note airways, conditions of mucosa, discharge, deviation of perforation of nasal septum. Sinuses; not location of pain, tenderness upon pressure, related muscosal redness or swelling nasal discharges. May examine by trans-illumination.

THROAT: Signs of infection and pressure or absence of tonsils and adenoids may be noted.

PHARYNX: Examinations may show a congested or inflamed pharynx or uvula.

MOUTH: Ulcerations, pigmentation and odor of breath are significant findings.

TEETH: If in poor condition, might be very significant as the foci of an infection.

GUMS: Bleeding or pale gums, pyorrhea, etc.

LARYNX: The character of the voice can be diagnostic. If the present illness indicates trouble in the larynx laryngoscopic examination may be indicated.

NECK: Note any disturbances of movement (stiffness and rigidity), pain and swelling. Palpitation of the cervical lymph glands, salivary glands and thyroid gland may show abnormality, and if so, the findings may be significant.

CHEST: Shape, symmetry, equality of expansion, respiratory rate, presence of rales, the character of the breathing, as deep or shallow, etc.

BREAST: Should be deferred to attending physician and not performed unless specifically requested by referring doctor.

HEART: The apex beat of the heart, if felt at the left fifth intercostals space known as the point of maximum impulse- P.M.I., is considered normal. ANY deviation may indicate an abnormal size of the heart. Check P.M.I. pulsation, rate, rhythm, and valve sounds- M-1, A-2, P-2 murmurs, fraction, thrill, etc.

LUNGS: Usually examined by means of percussion and auscultation. Check fremitus, percussion, breathing sounds, adventitious sounds, spoken voice, whispered voice, etc.

ABDOMEN: If symptoms are related to the abdominal region, important findings are masses, tenderness, presence of hernia, incisional scars and other diagnostic signs. Check contour, peristalsis, fluid, scars, tenderness, rigidity, hypertrophy of liver, gallbladder kidneys, and spleen.

GENITALIA (female): Should be deferred to attending physician and not performed unless specifically requested by referring doctor.

GENITALIA (male): Should be deferred to attending physician and not performed unless specifically requested by referring doctor.

RECTAL: Should be deferred to attending physician and not performed unless specifically requested by referring doctor.

BONE, JOINTS, MUSCLES: Deformities, swelling, redness, tenderness, limit of motion, etc. Includes testing for reflexes and range of motion of both upper and lower extremities. All podiatric findings. Check color, edema, tremor, clubbing, ulcers, varicosities, pulsations, etc.

NEUROLOGICAL: Cranial nerves, motor, sensory, coordination, gait, reflexes, romber, etc.

BIOMECHANICAL EXAMINATION: Narration of positive findings should also include complete listing of all podiatric findings. Biomechanical findings will be discussed in detail with the second year resident. Gait evaluations must be performed and documented for all Biomechanical Exams.

TENTATIVE DIAGNOSIS: Usually a statement of early diagnosis made before any tests have been completed or a final diagnosis has been reached. Diagnosis should include items described in attending admission diagnosis.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

BIOMECHANICAL EXAM SHEET

Pathology specific forms are used in resident's exam and included in clinic notes

H. Progress Notes:

Progress notes are specific statements by the physician relative to the course of the disease, special examinations made, response to treatment, new signs and symptoms, complications, and surgical cases, removal of drains, splints, and stitches, abnormal laboratory and x-ray findings, condition of surgical wound, development of infection and any other information pertinent to the course of the disease. The frequent use of general statements such as "condition fair", "general condition, good" and "no complaints", is unscientific and valueless. Progress notes should be written daily. If these is a change of resident services during the stay of the patient, the resident leaving the service should be sure that the progress notes are up-to-date and should summarize the condition of the patient on the day the resident leaves the case. The resident coming on the service should carry on the progress notes from that time. Remember this is not only a medical notation, but also a legal notation!

I. Orders- First Year Resident Guidelines:

The resident may write orders for the patient on behalf of the attending podiatrist. These orders may include: necessary tests, therapy, etc. All orders written by residents are subject to the approval of the admitting podiatrist. Prior to writing orders, the resident should make an effort to contact the podiatrist by telephone, or have written permission in the orders.

J. Consultations-

ANY podiatric consultation requested by the medical staff is to be handled on a rotating basis consistent with the emergency podiatric call schedule, unless a specific podiatrist is requested. Residents will be on call to aid the consulting podiatrist in the diagnosis and treatment of disorders. In accordance with the resident's contract, the resident shall not be permitted to participate in professional or clinical work outside of the hospital wherein others collect compensation (total) for the resident's services.

K. Completeness and Accuracy:

The values of the medical record is in direct proportion to the thoroughness and accuracy with which it is written. It should be remembered that any record may be summoned for legal use, such as in compensation, accident, alcoholic, and criminal cases. Prompt and accurate recording of the facts is particularly beneficial in such instances. All entries in the medical record must be complete and accurate. Both the success of handling a patient efficiently and the basis for good teaching and medical research are dependent upon the degree of accuracy with which the records are prepared. Incorrect information is worse than none.

L. Corrections:

Erasures and blanked-out alterations on records are illegal and make the record valueless to the patient of the hospital in case of litigation. If corrections are necessary, a single line should be drawn through the words to be deleted, and the new entry should be made. Chart entries are permanent and must be in black ink. It is the policy of the hospital to use ink and write the records in longhand. Pencils and carbon copies are prohibited. The original reports, not the carbon copies, of special examinations, such as x-ray and pathological examinations, are incorporated into the medical record. **Neat**, well kept, complete records may help to advance medical knowledge, and the condition of our records is one of the factors determining our approval by the Joint Commission of Accredited Hospitals. Not only is the patient's record a permanent reference file for subsequent admissions and for medical research, it is also a legal document and should be regarded as such. Notations tinged with frivolity, inappropriate remarks, or implied criticisms have no place in these documents. Notes or messages for attending physicians or other members of the house staff should not be written on the permanent records; these may be written and attached to the outside of the chart, if desired.

M. Legibility:

All entries **must be legible**, and they must be signed, not initialed. Treatments and medications should be carefully recorded as ordered, including dosage. Dates and hours should be carefully specified. Entries should be made consecutively, with a minimum amount of space between them. Abbreviations should be avoided except for a few recognized to be in common usage.

N. Care of Records:

Records are privileged and confidential documents and must be safeguarded as such. Care must be taken that records do not fall into the hands of persons not authorized to review them. Therefore, insurance representatives, attorneys, etc., are required to present written permission of the patient and of the attending physician before reviewing a medical record. Information regarding the medical records is given to the patient only by his physician. Records should be handled with care and treated with respect, particularly if they are bulky or show signs of wear.

O. Rules for Patient's Records:

Complete all information on each sheet of the chart and sign it, whether typed or handwritten, before chart goes to the Medical Record Room. Record all information about your patients fully, including progress noted. Avoid the addition of extraneous material to the charts, and never use humor or flippancy.

Records are not to be removed from Medical Records in the following instances:

1. Must not be removed from the hospital.
2. Must not be taken to the Resident's quarters.
3. Must not be kept in desks or file drawers outside of the Medical Records Department.
4. Must not be kept in locked offices.

Records are to be removed from the Medical Records Department for the following purposes only:

1. For use by the physicians upon re-admission to the hospital or return to the hospital for out-patient care.
2. For use by the Resident or attending staff for reference or study with the Medical Records Librarian's knowledge and permission.
3. For use by other authorized hospital personnel upon request.
4. For use in court upon subpoena.

ANY record may be requisitioned by members of the Intern and Resident Group or attending staff for use within the hospital building for teaching purposes only. No record should be taken from the Medical Records Departments without the knowledge of some members of the personnel in this department. If a record is required during hours when this department is closed, a request form should be completed and left in the record librarian's office.

In case of emergency, the Director of Nurses or the Administrator of the hospital may obtain the record on request. Occasional special permission maybe granted by the medical records librarian for use of a copy of the record at a scientific meeting outside the hospital, but these records must be properly charged out to specific individuals or divisions and must not be moved from one place to another without notifying the Medical Records Department. Careful adherence to these regulations will facilitate the prompt location of records so that they may be made readily available when needed.

P. Requirement for Completing Records:

Residents, like attending physicians, are required to complete their records within two weeks after the patient's dismissal. No member of the house staff is allowed to have any record incomplete for longer than 14 days. Those records which are over two weeks old, subject the attending physician to the loss of his staff privileges.

Q. Discharges:

When a patient is discharged **at the attending physician's discretion only**, the resident is responsible for discharging podiatric patients (on the authority of the attending podiatrist). It is the resident's responsibility to discharge the patient with the following:

1. Post-operative instructions including weight bearing status.
2. Post-operative shoes, walker, or crutches.
3. Instruction to call the doctor's office for an appointment, specifying the time frame, for observation and redressing.
4. Prescriptions for necessary medications. The resident should check with the attending podiatrist for types of medications preferred and/or special instructions.

Discharge medications: The resident may be asked to write prescriptions for discharge medications for the patient. The resident is to write for medications to last only until the patient returns to the attending doctor's office for the post-operative visit. RX that require DEA number are not to be written by the resident

ANY questions or problems concerning types or quantity of medication should be brought to the immediate attention of the Director of Residency Training or his Assistant for discussion and action (if necessary).

Unauthorized Discharges (AMA): The resident is responsible in every case for the following, which should be noted on the discharge summary:

Occasionally, a patient may become dissatisfied, demonstrate non-compliance and wish to leave the hospital without his doctor's permission. The Resident should explain the seriousness of such a step to the patient and try to dissuade him. If the patient insists, he must be requested to sign the form on the back of the admitting document, "Release from Responsibility for Discharge", stating the fact that he is leaving without his doctor's permission, and releasing the hospital and his doctor from all responsibility for any complications which might arise because of his unauthorized departure. The form must be signed in the presence of the resident or nurse and witnessed. The resident is to dictate a discharge summary following the discharge, when requested by the attending physician.

R. Deaths:

The Podiatric Resident shall not pronounce patients dead and is not allowed to sign death certificate.

XI. TEACHING CONFERENCES, DIDACTIC ACTIVITIES, REPORTS AND MEETINGS

A. Meetings will be held between the residents and the Directors of Residency training to evaluate the resident's performance and to evaluate the training program. The evaluation will be based on input from the attending podiatric staff, hospital administrator and Department Heads.

The Program Coordinator will take the minutes on the Residency Training Committee Meeting and perform the necessary dictation.

B. The podiatric resident is required to attend all conference conducted by the various hospital departments and to participate whenever a podiatric case is presented.

C. The podiatric resident is required to attend all conferences conducted under the medical educational programs. The resident will attend, if at all possible, all in-hospital training lectures, osteopathic, allopathic and podiatry. A list will be provided by the medical education department.

D. The residents should attempt to attend all local, state and regional official podiatric seminars and meetings, if coverage is available at the hospital.

E. Each resident will be required to give a presentation to an individual department. Example: ER- posterior splint and no cast padding.

F. "Journal/Book Club" monthly in the Richmond University Medical Center with the Director of Residency Training and members of the residency training program. Review of pertinent articles in journals including: "Journal of Bone & Joint Surgery", "Journal of Foot and Ankle Surgery", "Foot & Ankle International", "Journal of American Podiatric Medical Association", and many other pertinent journals.

G. Topic Review Resident Lecture Series- Residents will lecture to attending and fellow residents on a weekly basis at on a rotating schedule following the list of topics assigned by the Residency Training Committee.

XII. RESEARCH PROJECTS

A. Each podiatric resident selected for the training program at Richmond University Medical Center is responsible for the initiation, collection of data, the formulation of data, and the completion of this data into a research project.

B. Each Podiatric resident, will choose a research project, under the guidance of the Program Director. The research project must relate to reconstructive foot and or ankle surgery or medicine. Isolated case reports or literature reviews *may* be accepted as qualifying for this research as well, per resident. Also, each resident is responsible for the submission of one poster presentation for an approved scientific conference per year. They may choose to use their case presentation/literature review article, research paper or an additional topic of their choice, as approved by the Research Director.

C. Should the resident anticipate delay in gathering the above materials for the stated deadlines he/she may petition the Research Director in writing for a stated period of delayed time. It is the prerogative of the Research Director whether he/she will accept this request for delay.

XIII. RESIDENCY DISCIPLINARY ACTIONS

The Residency Training Committee expects all residents to observe such rules of decorum and order in the hospital, clinic and private podiatric offices as are becoming to professional men and women. In the event that the resident fails to fully and faithfully perform each and all of his obligations as stated in his contract and as contained in this manual or conducts himself in a manner objectionable to the hospital, the attending podiatric staff or the administrator of the hospital, it is understood and agreed that the hospital and the Residency Training Committee may suspend the resident's contract immediately and without prior notification to the resident.

In the event that the resident's contract is terminated, the same shall be of no further force or effect and each of the parties hereto shall be relieved and discharged of any and all further obligations pertaining to the residency

program. It is clearly understood that any contract between a resident and a hospital may be terminated at any time by mutual consent.

In the event the hospital suspends the residents' contract, the resident may appeal this decision through the Graduate Medical Education Committee as is described in the medical staff bylaws. At the completion of the appeal process the Graduate Medical Education Committee may either reinstate the resident or reaffirm his dismissal.

A. Infringements of Rules:
   1. Leaving the Hospital without emergency call services. It is the Resident's responsibility to make sure the beeper is in working order.
   2. Leaving early (before duty hours are over).
   3. Tardiness (severely or consistently).
   4. Leaving the Hospital with no adequate reason.
   5. Not wearing required uniforms.
   6. Sloppily dressed or unshaven.
   7. Lack of respect to Doctors, Nurses, and Hospital personnel.
   8. Not coming in when scheduled.
   9. Taking off days not allowed or authorized.
   10. Not attending lectures, conference, and meetings.
   11. Not performing assigned duties, lectures and readings.
   12. Incomplete or unsatisfactory evaluation for any outside Training Resource.
   13. Misuse of authority should be immediately reported to the Program Director.
   14. Lying to or deceiving attendings, fellow residents, hospital staff or patients.
   15. Failure to work as a team player while respecting the chain of command.

- After the committee has decided that the resident is in violation of any of the above rules, the resident will be given a written memo. This way the resident will always be appraised of their position. These memos will become part of the residency file.

Warning Period: It is the responsibility of the department or division to document a warning period prior to dismissal or failure to reappoint a Podiatry Resident and to demonstrate efforts for the provision of opportunities for remediation. It should be unusual to dismiss a resident without a probationary period except in instances of flagrant misconduct (see next paragraph). Opportunities must be provided and documented for the resident to discuss with the department or division's program director or chair the basis for probation, the expectation of the probationary period and the evaluation of the resident's performance during the probation.

Dismissal Without Warning: Several specific examples of misconduct for which an individual may be subject to immediate dismissal include (but is not limited to) the following: being under the influence of intoxicants or drugs; disorderly conduct, harassment of other employees (including sexual harassment), or the use of abusive language on the premises; fighting, encouraging a fight, or threatening, attempting, or causing injury to another person on the premises.

B. Penalties:

In those cases where the resident refuses or fails to comply with the above regulations as well as those within the Residency Training Manual, the sequence of discipline will be as follows:

1. **First offense** of that particular regulation will result in verbal reprimand from the Program Director.
2. **Second offense** Will result in having a letter of reprimand placed the resident's file and possibly additional call. (in compliance with duty hours)
3. **The third offense** Will result in suspension without pay As determined at a meeting with GME. The resident at this point will be placed on **probation**. In addition, the resident will also be

required to comply with all the duties stated in the second offense. This action will be documented in the resident's file.

4. **The fourth offense,** recommendation for dismissal from the program.
5. At the discretion of any training committee member a resident can be prohibited from scrubbing in surgery as a punitive measure.

C. Appeals:

When the recommended dismissal of a Resident, the Executive Committee will be notified of this action in writing, and the Resident shall be given the opportunity for a review hearing before this committee. The aggrieved party shall have twenty (20) days from receipt of the notice to file with the Director of the Podiatric Residency Program in writing a grievance letter.

The grievance shall state the facts upon which the grievance is based and requested remedy sought. The Program Director shall respond to the grievance with a written answer no later than ten (10) calendar days after he/she received it.

If the Resident is not satisfied with the response, he/she may then submit, within ten (10) days of receipt of the Program Director's response, a written request for a hearing.

Hearing: The hearing procedure will be coordinated by the Program Director, who will preside at the hearing, but will not be a voting participant. The hearing will be scheduled within thirty (30) days of the Resident's request for a hearing.

The Hearing Panel will consist of at least two (2) members of the Medical Executive Committee, Medical Staff President, Executive Vice President and Vice President of Medical Affairs. The Program Director will determine the time and site of the hearing in consultation with the resident and program leadership.

Counsel: The resident shall have a right to self-obtained legal counsel at his/her own expense; however retained counsel may not actively participate or speak before the hearing participants, nor perform cross-examination.

Format: Format of the hearing will include a presentation by a departmental representative; an opportunity for a presentation of equal length by the resident; an opportunity for response by the representative, followed by a response of equal length by the resident. This will be followed by a period of questioning by the Hearing Panel.

The resident will have a right to request documents for presentation at the hearing and the participation of witnesses.

Decision: A final decision will be made by a majority vote of the Committee participants and will be communicated to the Resident within ten (10) working days after the hearing. This process will represent the final appeal.

D. Remediation:

In cases of unsatisfactory resident performance, the resident is reviewed quarterly by the residency director and performance is discussed at these evaluations to hopefully prevent any on-going performance or disciplinary problem. Depending on the deficiency, such as not fulfilling the required academic readings or lectures, the resident will be assigned appropriate material to make up the deficiency with reevaluation by the committee in 1 month. If the unsatisfactory performance or failure occurs with any outside Training Resource, the resident must repeat the month and pass without incident. If the resident fails to fulfill the requirements satisfactorily, the director of the residency program will recommend dismissal from the program. The resident may then proceed through the appeals process as outlined above.

XIV. GRADUATION

The first and second year podiatric residents will not receive a certificate for completion of the 12-24 month residency training years. At the end of the third year, the resident will receive a PMSR certificate with the added credential of reconstructive rearfoot/ankle surgery from the residency program upon the satisfactory completion

of his/her training program. During his/her Residency Program, the Resident shall maintain satisfactory academic performance, demonstrate clinical competence, and complete responsibilities as outlines Residency Training Manual.

XV. RESIDENT'S SCHEDULE

A. All residents will follow the prescribed Residency Program training schedule.

B. All residents will report to their designated assignments at the prescribed time.

C. All unexcused absences may be made up during or at the end of the program before certification of completion of the prescribed program can be made.

D. Training Resources will be divided into mandatory and elective Training Resource types:

1. Mandatory: As the name implies these Training Resources are required. They have been selected for their essential value to the education of the resident.

2. Elective: Second and third year residents may choose from the list of available elective Training Resources in Section XV11. B.2. Selection of elective Training Resources should be submitted to the Director of Residency Training six months prior to the beginning of the Training Resource. The Program Director and the Residency Training Committee will grant electives based solely on their discrepancy as it relates to the individual resident. The elective Training Resources are limited to those approved by the Residency Training committee and with Affiliation Agreements in place of off site.

E. Arrangements for any departure from the schedule with the person to whom you report and from whom you take your assignments must be made. You will have a designated primary service schedule assignment and secondary one will be appointed to report to if the primary service activity is completed or inactive. There will be some natural normal combination of services.

XVI. TRAINING RESOURCES (ROTATIONS)

A. The following Training Resources are designed to give the resident graded experiences and responsibility in the management of patients and recognition and understanding of clinical entities (this will have reference particularly to the field of foot and ankle surgery, but will also refer to all related medical and surgical areas). The residents will be given an educational program on the post graduate level which will emphasize the basic and clinical sciences. Instruction will be provided primarily by the medical, surgical and podiatric staff members of Richmond University Medical Center. Under no circumstances may the resident spend more than 6 months at a training site beyond daily commuting distance from Richmond University Medical Center. *Throughout the length of the training program, the residents will have full privileges as a house physician to practice in the particular area of medicine in which they are training at the time and/or in which the immediate present supervising attending practices.*

PGY 1. All first year Training Resources are mandatory, in block format and take place in house at Richmond University Medical Center.

PGY 2. All second year Training Resources are mandatory, in block format and take place in house at Richmond University Medical Center.

PGY 3. The PMSR third year resident will be chief and then will follow these scheduled Training Resources for the remainder of the year. (Elective Training Resources may be chosen.) All third year Training Resources are in block format.

B. Specific Training Resources and Related Competencies:
1. Mandatory Training Resources/Competencies
c. Podiatric Surgical Training Resource:

Location: Richmond University Medical Center- During this Training Resource, the first year residents are responsible to the Director of Residency Training, second year residents and chief resident on duty. In addition, all the first year podiatric residents have teaching responsibilities to rotating podiatric student externs, visiting medical students, interns, and residents. **Podiatric surgeries will take precedence over all other duties**. Proper arrangements will be made by the resident to make up any missed Training Resources. Where the residents feel that there is a discrepancy in criteria or judgment, they are not obligated to take an active part in the case in questions. However, they are obligated to notify the Director of Residency Training of this action in writing.

Duties while on Podiatric Surgical Training Resource are:

- Perform H & P's on all podiatry patients as assigned by the chief resident.
- Be able to perform the H&P for both ambulatory and regular admitted patients.
- Instruct and supervise the extern in performing H&P's. The extern should be oriented in performing these duties during the first week and be observed during the second week.
- Under normal circumstance, the extern will not perform more than one H&P on given day.
- Check the following on all H&P's performed by externs:
    1. Cardiac, Medications, Laboratory findings
    2. Lungs, Allergies
    3. Vascular, Lower Extremities
    4. Podiatric Findings
- Review cases with second residents, extern and surgeon prior to surgery.
- Review Lab, EKG, and X-rays prior to surgery each night.
- First year residents will act as assistants in foot surgery and will assist in the pre-operative and post-operative care of patients as directed by the attending surgeon.
- First year residents will make morning checks on all charts of patient scheduled that day for surgery. This is to ensure that all work has been completed as ordered in preparation for surgery. ANY abnormal results should be brought immediately to the attention of the surgeon. The residents are also responsible for writing a pre-surgical note in the progress notes section of the patient's chart for regular admissions.
- Scrub in on all podiatric surgeries as time allows, and directed by the chief resident.
- First year residents will be present and available in the operating room <u>prior</u> to the scheduled time for surgery.
- First year residents will be available to observe, scrub, and/or assist in specialty or general surgery where applicable and when there is no ongoing podiatric surgery, in order to enhance their education, and as approved by the chief resident.
- First year residents will remain in the operating suite until completion of the case unless otherwise directed by the surgeon.
- First year residents will function at the discretion of the surgeon.
- First year residents may not perform any surgical procedure without proper supervision by a physician.
- Post-operatively, the first year residents are to write orders for the patient's care, unless otherwise directed by the surgeon. The first year resident will enter a post-operative note in the progress notes section of the patients' chart.

- At the discretion of the attending podiatrist, the first year resident may be called upon to dictate operative reports on cases in which he participated, perform redressing, etc.
    - Operative Reports: The resident claiming 1st assistant participation is responsible, at the surgeon's request, for the dictation of any podiatric operative procedures which he/she has participated in. The dictation should be completed as soon as possible. The podiatric surgeon will be final judge of the quality of the completed operative report. The surgeon may request the report be re-dictated, if it does not represent an accurate report; i.e., contains errors or omissions. These dictations will be completed before leaving the hospital the same day.
    - Dressing Changes: The first year resident is to change a patient's dressings only when authorized by the attending.. The first year resident is to report the status of the surgical site to the podiatrist following the dressing change. The resident is expected to observe aseptic technique while changing the patient's dressing.
- The first year resident is required to make an AM and PM progress note on each and every podiatric patient or medical requiring podiatric care on each and every day. It is not enough just to countersign the extern's progress note. The second year resident is required to make a note on each and every day on those patients which he has participated either scrubbing in or managing its podiatric medical care.
- Each resident no on in-house Training Resource is required to give on extern lecture each month at his/her and extern's mutual convenience. The second year resident (in house) will be responsible for submitting an organized lecture handout to the Extern and Program Director for each month.
- All resident functions, including Grand Rounds, early morning rounds, resident lectures, Journal Club and other assorted educational meetings will be absolutely mandatory for all six residents. The obvious exceptions will be when a resident is at another site, covering surgery or specific duties relevant to that particular Training Resource he/she is on. There will be no exceptions unless previously cleared with the Program Director.
- Morning rounds will be required for on service surgical residents (first and second year residents and externs).
- As time allows, PGY-3 residents will visit the office of the Program Director for exposure to pre and post op podiatric care and general office Podiatry.
- Below is a sample yearly schedule. This can be changed /adjusted to fulfill requirements as determined by the PD

Richmond University Medical Center Podiatry Residency Rotation Schedule 2024-2025

Month	*PGY 1*	*PGY 1*	*PGY 2*	*PGY2*	*PGY3*	*PGY3*
July	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery
ugust	Internal Medicine (4 weeks)	Podiatry/ Podiatric Surgery	Podiatry/Surgery Radiology (2 weeks)	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery
Sept	Internal Medicine (4 weeks)	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/Pod Surgery Radiology (2 weeks)	Anesthesiology (2 weeks) Podiatry/Surgery	Podiatry/Surgery Anesthesiology (2 weeks)
ctober	Podiatry/ Podiatric Surgery	Internal Medicine (4 weeks)	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery
Nov	Podiatry/ Podiatric Surgery	Internal Medicine (4 weeks)	Podiatric Surgery (2 wks) Behavioral Health (2 wks)	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Wound Care (4 weeks)
Dec	ER (4 weeks, 8AM and 8 PM shifts)	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatric Surgery (2 wks) Behavioral Health (2 wks)	Wound Care (4 weeks)	Podiatry/ Podiatric Surgery
Jan	Podiatry/ Podiatric Surgery	ER (4 weeks, 8AM and 8PM shifts)	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery
Feb	Infectious Disease (4 weeks and pod call)	Podiatry/ Podiatric Surgery	General Surgery (4 weeks)	Podiatry/ Podiatric Surgery	Physical Medicine and rehab (2 weeks) Podiatry/Surgery	Podiatry/ Surgery Physical Medicine and Rehab (2 weeks)
Vlarch	Podiatry/ Podiatric Surgery	Infectious Disease (4 weeks and pod call)	Vascular Surgery (4 weeks)	General Surgery (4 weeks)	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery
April	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Vascular Surgery (4 weeks)	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery
May	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery
June	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery	Podiatry/ Podiatric Surgery

a. Elective Rotations:

Each third year resident can choose an elective rotation. Elective rotations must be approved by the Program Director no less than sixty (60) days in advance. Failing to submit a request in a timely manner may result in your elective being assigned. Elective Rotation can be done at Richmond University Medical Center or another facility if a rotation agreement is approved by the PD and RUMC administration.

CONCLUSION

Residents completing this program will be highly trained to care for patients with all types of injuries and conditions affecting the human foot, ankle and lower leg in the hospital, out-patient, and office settings. The young physicians will have developed an appreciation for the team approach to healthcare. They will be specialists in care of patients with conditions of the foot and ankle. They will have developed an engrained desire to remain professionally inquisitive, life-long learners and teachers, using research based protocols, scholarly activity and information technology to continuously enhance professional knowledge and its employment in the clinical practice of Podiatric Medicine and Foot and Ankle Surgery. In an effort to continually improve the quality of the program, this manual may be modified from time to time with the approval of the Residency Training Committee and the notification of the Council on Podiatric Medical Education and the residents themselves.

XVII. COMPETENCIES AND ASSESSMENTS

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR ANESTHESIOLOGY

During your rotation in the Anesthesia Department, you will gain experience in the initial work-up, management and care of patients preoperatively, intraoperatively and post-operatively. You will learn how to recognize and manage anesthesia related problems and complications and you will become familiar with a variety of anesthetic agents and techniques of administration.

At the conclusion of this rotation, you should be able to:

1. Document a clear and accurate patient anesthesia history.
2. Determine a patient's anesthesia risk group.
3. Become familiar with the methodology used to select the type of anesthesia to be administered.
4. Gain experience in the manual aspects of IV therapy, regional blocks, and intubations.
5. Recognize anesthesia related emergencies and complications and proper methods of prevention and treatment.
6. Monitor patients appropriately in the immediate post-operative period.
7. Evaluate patients' medical problems which have a direct impact on the use of anesthesia for surgical procedures.
8. Gain knowledge in the proper use of a variety of anesthetic agents and techniques.
9. Demonstrate knowledge of various modes of anesthesia as well as various monitoring systems.
10. General knowledge of out-patient pain management.
11. Act in a professional manner and demonstrate care and concern for every patient.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR ANESTHESIOLOGY

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

	5	**4**	**3**	**2**	**1**	**0**
1. DOCUMENT A CLEAR AND ACCURATE PATIENT ANESTHESIA HISTORY.						
2. DETERMINE A PATIENT'S ANESTHESIA RISK GROUP.						
3. BECOME FAMILIAR WITH THE METHODOLOGY USED TO SELECT THE TYPE OF ANESTHESIA TO BE ADMINISTERED.						
4. GAIN EXPERIENCE IN MANUAL ASPECTS OF IV THERAPY, REGIONAL BLOCKS AND INTUBATION.						
5. RECOGNIZE ANESTHESIA RELATED EMERGENCIES AND COMPLICATIONS AND PROPER METHODS OF PERVENTION AND TREATMENT.						
6. MONITOR PATIENTS APPROPRIATELY IN THE IMMEDIATE POST-OPERATIVE PERIOD.						
7. EVALUATE PATIENT'S MEDICAL PROBLEMS WHICH HAVE A DIRECT IMPACT ON THE USE OF ANESTHESIA FOR SURGICAL PROCEDURES.						
8. GAIN KNOWLEDGE IN THE PROPER USE OF A VARIETY OF ANESTHETIC AGENTS AND TECHNIQUES.						
9. DEMONSTRATE KNOWLEDGE OF VARIOUS MODES OF ANESTHESIA AS WELL AS VARIOUS MONITORING SYSTEMS.						
10. ACTS IN PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						
11. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR BEHAVIORAL SCIENCE

Richmond University Medical Center is committed to providing care to the poor, disadvantaged, homeless, and all persons in need of health care without regard to their ability to pay. The practice of community podiatry is therefore consistent with the mission of the hospital itself.

To enhance this experience a specific rotation in the Behavioral Science is included in your education.

During all of your inpatient and outpatient rotations throughout the training year, you will be exposed to:

1. Patients from extended care facilities.
2. Patients with psychosocial disorders limiting their ability to function in society.
3. Homeless.
4. Under-served minorities.
5. Medically disenfranchised.
6. Participate in the medical management of a variety of individuals with emotional, behavioral, psychiatric, and learning problems.
7. Participate in the discharge planning of disadvantaged patients.
8. Provide podiatric treatment to psychiatric patients.
9. Educate and instruct patients on their self-care management.
10. Recognize the implications of life changes on health and disease.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR BEHAVIORAL SCIENCE

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	**4**	**3**	**2**	**1**	**0**
1.	MANAGEMENT OF PATIENTS FROM EXTENDED CARE FACILITIES.						
2.	MANAGEMENT OF PATIENTS WITH PSYCHOSOCIAL DISORDERS.						
3.	TREATMENT AND MANAGEMENT OF HOMELESS PATIENTS.						
4.	TREATMENT AND MANAGEMENT OF UNDER-SERVED MINORITY PATIENTS.						
5.	TREATMENT AND MANAGEMENT OF MEDICALLY DISENFRANCHISED PATIENTS.						
6.	MEDICAL MANAGEMENT OF EMOTIONAL, BEHAVIORAL, PSYCHIATRIC, AND LEARNING PROBLEMS.						
7.	DISCHARGE PLANNINH OF DISADVANTAGE PATIENTS.						
8.	PODIATRIC TREATMENT TO PSYCHIATRIC PATIENTS.						
9.	ABILITY TO EDUCATE AND INSTRUCT PATIENTS ON SELF CARE MANAGEMENT.						
10.	RECOGNIZE THE IMPLICATIONS OF LIFE CHANGES ON HEALTH AND DISEASE.						
11.	ACT IN A PROFESSIONAL MANNER AND DEMONSTRATE CARE AND CONCERN FOR EACH PATIENT.						
12.	OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR EMERGENCY ROOM

In the course of your interactions in the Emergency Department, you will be exposed to patient presenting with a wide variety of acute medical and surgical conditions. You will learn how to evaluate, diagnose, and manage patient requiring immediate interventions.

At the conclusion of the program rotation, you should be able to:

1. Elicit an accurate history of patients presenting complaints and symptoms.
2. Perform a physical exam and diagnostic work-up to reach a diagnosis in patients presenting with acute problems.
3. Use ancillary services (Lab, Radiology, etc.) appropriately in confirming or ruling out a specific diagnosis.
4. Determine what clinical manifestation warrant immediate surgical interventions.
5. Distinguish how to prioritize appropriately when triaging patients according to severity of condition.
6. Become familiar with a variety of illnesses and symptoms requiring immediate assessment and intervention.
7. Gain knowledge in the management of the acutely ill diabetic patient.
8. Gain knowledge in the insertion of chest tubes and central lines/
9. Have a better understating of EMD field activity and EMS techniques for immobilization and pre-hospital care interventions.
10. Apply your technical abilities with a greater degree of confidence, e.g. cast applications, suture techniques, acute trauma care, hemorrhage control, trephination, venous access techniques, etc.
11. Act in professional manner and demonstrate care and concern for each patient.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR EMERGENCY ROOM

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	**4**	**3**	**2**	**1**	**0**
1.	ELICIT AN ACCURATE HISTORY OF PATIENTS PRESENTING COMPLAINTS AND SYMPTOMS.						
2.	PERFORM A PHYSICAL EXAM AND DIAGNOSTIC WORK-UP TO REACH A DIAGNOSIS IN PATIENT PRESENTING WITH ACUTE PROBLEMS.						
3.	USE ANCILLARY SERVICES APPROPRIATELY IN COMFORMING OR RULING OUT A SPECIFIC DIAGNOSIS.						
4.	DETERMINE WHAT CLINICAL MANIFESTATIONS WARRANT IMMEDIATE SURGICAL INTERVENTION.						
5.	DISTINGUISH HOW TO PRIORITZE APPROPRIATELY WHEN TRIAGING PATIENTS ACCORDING TO SEVERITY OF CONDITION.						
6.	BECOME FAMILIAR WITH A VARIETY OF ILLNESSES AND SYMPTOMS REQUIRING IMMEDIATE ASSESSMENT AND INTERVENTION.						
7.	GAIN KNOWLEDGE/SKILL IN THE MANAGEMENT OF ACUTELY ILL PATIENTS.						
8.	GAIN KNOWLEDGE/SKILL IN THE MANAGEMENT OF SEPSIS AND SEPTIC SHOCK.						
9.	GAIN KNOWLEDGE/SKILL IN THE INSERTION OF CHEST TUBES AND CENTRAL LINES.						
10.	UNDERSTANDING OF EMS FIELD ACITIVTY AND EMS TECHNIQUES FOR IMMOBILIZATION AND PRE-HOSPITAL CARE INTERVENTIONS.						
11.	GAIN TECHNICAL ABILITIES (CAST APPLICATIONS, SUTURE TECHNIQUES, ETC).						
12.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						

13. OVERALL RATING OF RESIDENTS PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR GENERAL SURGERY

Your rotation in General Surgery is planned to continue to provide you with the opportunity to evaluate and manage patients with conditions requiring elective surgical intervention as well as emergency patients presenting with acute conditions requiring surgery.

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

1. Obtain a good surgical history from patients and generate a differential surgical diagnosis.
2. Determine which clinical presentations warrant surgical intervention.
3. Be able to appropriately prepare patients with significant medical histories (diabetes, renal disease, steroid dependencies, etc.) for surgery.
4. Provide and document routine post-operative care and manage post-operative complications appropriately.
5. Become familiar, through lectures and personal reading, with a variety of complex surgical procedures.
6. Act in a professional manner and demonstrate care and concern for each patient.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR GENERAL SURGERY

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	**4**	**3**	**2**	**1**	**0**
1.	OBTAIN A GOOD SURGICAL HISTORY FROM PATIENTS.						
2.	GENERATE A DIFFERENTIAL SURGICAL DIAGNOSIS.						
3.	DETERMINE WHAT CLINICAL PRESENTATION WARRANTS SURGICAL INTERVENTIONS.						
4.	ASSIST AT A VARIETY OF OPERATIVE PROCEDURES IN BOTH GENERAL SURGERY AND SUBPSECIALTIES.						
5.	PROVIDE AN DOCUMENT ROUTINE POST-OPERATIVE CARE.						
6.	BECOME FAMILIAR, THROUGH LECTURES AND PERSONAL READING, WITH A VARIETY OF COMPLEX SURGICAL PROCEDURES.						
7.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						
8.	OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR INFECTIOUS DISEASE

Richmond University Medical Center sees large numbers of patients whose problems include problems of an infectious disease nature. As such the hospital maintains an active infectious disease service.

As part of the PMSR the resident rotates with infectious disease for 1 month. To enhance their experience significant interaction with the Infectious Disease Service is included in your education.

The resident will participate in the infectious disease service which will include, but is not limited to the following experiences:

1. Recognizing and diagnosing common infectious processes in the adult patient.
2. Interpreting laboratory data including blood cultures, gram stains, microbiological studies, and antibiosis monitoring.
3. Exposure to local and systemic infected wound care.
4. You will learn to prevent, diagnose and manage diseases, disorders and injuries of the adult lower extremity which involve infectious processes, by surgical and non-surgical means.
5. Demonstrate the ability to interact with, and communicate effectively in a multi-disciplinary setting.
6. Demonstrate the ability to manage diabetic foot infections
7. Act in a professional manner and demonstrate care and concern for each patient.

As in all of your other experiences at Richmond University Medical Center, you will be expected to practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion, and be lifelong inquisitive learners and teachers.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR INFECTIOUS DISEASE

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	4	3	2	1	0
1.	RECOGNIZING AND DIAGNOSING COMMON INFECTIOUS DISEASE PROCESSES IN THE ADULT PATIENT.						
2.	INTERPRETING LABORATORY DATA INCLUDING BLOOD CULTURES, GRAM STAINS, MICROBIOLOGICAL STUDIES, AND ANTIBIOSIS MONITORING.						
3.	EXPOSURE TO LOCAL AND SYSTEMIC INFECTED WOUND CARE.						
4.	YOU WILL LEARN TO PREVENT, DIAGNOS AND MANAGE DISEASES, DISORDERS AND INJURIES OF THE ADULT LOWER EXTREMITY WHICH INVOLVE INFECTIOUS PROCESSES, BY SURGICAL AND NON-SURGICAL MEANS.						
5.	DEMONSTRATE THE ABILITY TO INTERACT WITH, AND COMMUNICATE EFFECTIVELY IN A MULTI-DISCIPLINARY SETTING.						
6.	DEMONSTRATE THE ABILITY TO MANAGE DIABETIC FOOT INFECTIONS.						
7.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						
8.	OVERALL RATING OF RESIDENTS PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR INTERNAL MEDICINE

Your involvement in Internal Medicine is designed to provide you with exposure to a variety of disease processes in a varied group of patients. Over the period of two months you will be presented with the pathophysiologic, diagnostic and therapeutic aspects of an assortment of medical conditions, during the course of your rotation. You will also follow selected outpatients on an ongoing primary care basis through the medical clinic under the aegis of a clinical supervisor.

At the conclusion of this rotation, you should be able to:

1. Elicit a detailed and accurate patient history and perform a complete physical examination in a timely fashion.
2. Discuss the differential diagnosis and use ancillary services appropriately in confirming or ruling out a diagnosis for a variety of common medical conditions.
3. Demonstrate proficiency in the interpretation of clinical and laboratory findings in various aspects of Internal medicine and establishing a differential diagnosis before assigned attendings.
4. Discuss management plans for cardiac disease, hypertension, hypercholesterolemia, renal insufficiency.
5. Establish safe and effective discharge planning for a variety of patient situations and medical problems.
6. Actively participate in the daily medical management and in the discharge planning for all in-house podiatric patients.
7. Discuss the management of podiatric in-house patients with attending in various aspects of Internal Medicine.
8. Discuss management plans for Diabetes.
9. Discuss management plans for neurological conditions.
10. Act in a professional manner and demonstrate care and concern for each patient.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR INTERNAL MEDICINE

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	**4**	**3**	**2**	**1**	**0**
1.	ELICIT A DETAILED AND ACCURATE PATIENT HISTORY AND PERFORM A COMPLETE PHYSICAL EXAMINATION IN A TIMELY FASHION.						
2.	DISCUSS THE DIFFERENTIAL DIAGNOSIS, DIAGNOSTIC EVALUATION, MEDICAL MANAGEMENT AND DISCHARGE PLANNING FOR A VARIETY OF MEDICAL CONDITIONS.						
3.	DEMONSTRATE PROFICIENCY IN THE INTERPRETATION OF CLINICAL AND LABORATORY FINDINGS IN VARIOUS ASPECTS OF INTERNAL MEDICINE AND ESTABLISHING A DIFFERENTIAL DIAGNOSIS.						
4.	DISCUSS MANAGEMENT PLANS FOR CARDIAC DISEASE, HYPERTENSION, HYPERCHOLESTEROLEMIA, RENAL INSUFFICIENCY.						
5.	ESTABLISH SAFE AND EFFECTIVE DISCHARGE PLANNING FOR A VARIETY OF PATIENT SITUATIONS AND MEDICAL PROBLEMS.						
6.	ACTIVELY PARTICIPATE IN THE DAILY MEDICAL MANAGEMENT AND IN THE DISCHARGE PLANNING FOR ALL IN-HOUSE PATIENTS.						
7.	DISCUSS MANAGEMENT PLANS FOR DIABETES.						
8.	DISCUSS MANAGEMENT PLANS FOR A VARIETY OF COMMON MEDICAL CONDITIONS WITH NEUROLOGICAL IMPLCATIONS.						
9.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER

PODIATRIC MEDICINE AND SURGERY RESIDENCY

Evaluation of Rotation Form

COMPETENCIES FOR PHYSICAL MEDICINE AND REHABILITATION

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

Your rotation in Physical Therapy will enable you to formulate an effective foot and ankle rehabilitation plan.

At the conclusion of this rotation, you should be able to:

1. Determine the proper timing for a physical therapy referral.

2. Evaluate and formulate a plan for lower extremity rehabilitation.

3. Examination of motor muscle strength, range of motion, and sensation.

4. Examination of gait dysfunction, balance and weight bearing status.

5. Determine a rehabilitation protocol for Achilles tendonitis/tendinosis.

6. Determine a rehabilitation protocol for s/p ankle fracture ORIF.

7. Determine a rehabilitation protocol for ankle sprain.

8. Determine a rehabilitation protocol for s/p bunionectomy.

9. Determine need for assistive device.

10. Determine need for pain medication.

11. Demonstrate in crutch training.

12. Demonstrate knowledge in gait and balance training.

RICHMOND UNIVERSITY MEDICAL CENTER

PODIATRIC MEDICINE AND SURGERY RESIDENCY

Evaluation of Rotation Form

ASSESSMENT FOR PHYSICAL MEDICINE AND REHABILITATION

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN

MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

	5	**4**	**3**	**2**	**1**	**0**
1. DETERMINE THE PROPER TIMING FOR A PHYSICAL THERAPY REFERRAL.						
2. EVALUATE AND FORMULATE A PLAN FOR LOWER EXTREMITY REHABILITATION.						
3. EXAMINATION OF MOTOR MUSCLE STRENGTH, RANGE OF MOTION AND SENSATION.						
4. EXAMINATION OF GAIT DYSFUNCTION, BALANCE AND WEIGHT BEARING STATUS.						
5. DETERMINE A REHABILITATION PROTOCOL FOR ACHILLES TENDONITIS/TENDINOSIS.						
6. DETERMINE A REHABILITATION PROTOCOL FOR S/P ANKLE FRACTURE ORIF.						
7. DETERMINE A REHABILITATION PROTOCOL FOR ANKLE SPRAIN.						
8. DETERMINE A REHABILITATION PROTOCOL FOR S/P BUNIONECTOMY.						
9. DETERMINE NEED FOR ASSISTIVE DEVICE.						
10. DETERMINE NEED FOR PAIN MEDICATION.						
11. DEMONSTRATE IN CRUTCH TRAINING.						
12. DEMONSTRATE KNOWLEDGE IN GAIT AND BALANCE TRAINING.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR PODIATRIC MEDICINE AND CLINIC

This rotation provides didactic as well as clinical training in the evaluation of patients with foot and ankle problems. You will participate in the diagnosis and treatment of an acceptable volume and diversity of cases identified with podiatric pathology.

At the conclusion of this rotation, you will be able to:

1. Work-up patients with foot and ankle problems.
2. Interpret foot and ankle x-rays for podiatric pathology.
3. Develop an understanding of abnormal pathology.
4. Gain technical skills in performing a variety of podiatric procedures.
5. Discuss the diagnostic work-up, diagnosis and treatment plan with Podiatrists on patients with a variety of foot and ankle problems.
6. Become familiar with a variety of complex podiatric pathologies.
7. Manage newborn through geriatric patients, with emphasis on treatment of patients.
8. Develop effective patient-physician communication skills.
9. Demonstrates ability to perform a comprehensive lower extremity biomechanical exam.
10. Perform the assigned charting and documentation in a timely manner.
11. Properly obtain record and complete history and physical examination including neurological, vascular, dermatological, musculoskeletal, biomechanical, systems, and treat appropriately.
12. Perform, order and interpret medical imaging, hematological, microbiological, and histological studies.
13. Organize and present cases.
14. Formulate a plan of diagnosis and therapy.
15. Understand the various common concepts and techniques utilized in a variety of medical/surgical sub-specialties.
16. Understand the common drugs and their dosages.
17. Detail proper procedures in managing common emergencies.
18. Order and interpret laboratory data and correlate it with clinical findings to develop a more definitive diagnosis.
19. Act in a professional manner and demonstrate care and concern for each patient.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR PODIATRIC MEDICINE AND CLINIC

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	4	3	2	1	0
1.	WORK-UP PATIENTS WITH FOOT AND ANKLE PROBLEMS.						
2.	INTERPRET FOOT AND ANKLE X-RAYS FOR PODIATRIC PATHOLOGY.						
3.	DEVELOP AN UNDERSTANDING OF ABNORMAL PATHOLOGY.						
4.	GAIN TECHNICAL SKILLS IN PERFORMING A VARIETY OF PODIATRIC PROCEDURES.						
5.	DISCUSS THE DIAGNOSTIC WORK-UP, DIAGNOSIS AND TREATMENT PLAN ON PATIENTS WITH A VARIETY OF PODIATRIC PROCEDURES.						
6.	BECOME FAMILIAR WITH A VARIETY OF COMPLEX PODIATRIC PATHOLOGIES.						
7.	MANAGEMENT AND TREATMENT OF PATIENTS.						
8.	PATIENT-PHYSICIAN COMMUNICATION SKILLS.						
9.	PROPERLY OBTAIN RECORD AND COMPLETE HISTORY AND PHYSICAL EXAMINATION INCLUDING NEUROLOGICAL, VASCULAR, DERMATOLOGICAL, MUSCULOSKELETAL, BIOMECHANICAL, SYSTEMS, AND TREAT APPROPRIATELY.						
10.	PERFORM THE ASSIGNED CHARTING AND DOCUMENTATION IN A TIMELY MANNER.						
11.	COMMUNICATE EASILY AND EFFECTIVELY WITH ALL PATIENTS.						
12.	ORGANIZE AND PRESENT CASES.						
13.	FORMULATE A PLAN OF DIAGNOSIS AND THERAPY.						

14.	PROPERLY OBTAIN AND RECORD A COMPLETE HISTORY AND PHYSICAL EXAM.						
15.	DETAIL PROPER PROCEDURES IN MANAGING COMMON EMERGENCIES.						
16.	ORDER AND INTERPRET LAB DATA AND CORRELATE WITH CLINICAL FINDINGS TO DEVELOP A MORE DEFINITIVE DIAGNOSIS.						
17.	UNDERSTANDING OF VARIOUS COMMON CONCEPTS AND TECHNIQUES UTILIZED.						
18.	TECHNICAL ABILITIES.						
19.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						
20.	OVERALL RATING OF RESIDENTS PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR PODIATRIC SURGERY

The fundamental goal of this rotation is to provide the resident with a well-rounded exposure to inpatient and outpatient surgical environments in preparation for management of podiatric conditions and diseases as they are related to surgical conditions in the lower extremities.

At the conclusion of this second year rotation, you should be able to:

1. Comprehend and complete preoperative history and physical examination.
2. Develop a differential diagnosis for foot and ankle pathology.
3. Interpret preoperative lab values and tests.
4. Complete preoperative charting and dictation techniques.
5. Act as first assistant.
6. Assist/perform soft tissue surgery.
7. Assist/perform digital surgery.
8. Assist/perform lesser metatarsal surgery.
9. Assist/perform first metatarsal surgery.
10. Assist/perform midfoot (Cuneiform,cuboid,navicular) surgery.
11. Assist/perform rearfoot and ankle surgery.
12. Assist/perform internal fixation techniques in the foot and ankle.
13. Assist/perform application of casts to the foot and ankle.
14. Recognize and manage perioperative complications.
15. Outpatient charting and protocol.
16. Detailed history and physical taking.
17. Performance and observation of specialized radiographic techniques such as angiography, venography, Doppler, etc.
18. Interpretation of standard radiographs of the entire body.
19. Attend lectures and seminars given by the staff as well as other specialties.
20. Understand the indications for ambulatory surgery.
21. Develop an understanding of pathological states of the human body.
22. Develop experience in the performance and interpretation of pedal radiographs, CT scan, MRI
23. Develop experience in the prevention and treatment of diabetic emergencies, shock, cardiopulmonary emergencies as well as seizures.
24. Act in a professional manner and demonstrate care and concern for each patient.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR PODIATRIC SURGERY

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	4	3	2	1	0
1.	UNDERSTAND THE PRINCIPLES OF CASTING, TRACTION, AND IMMOBILIZATION.						
2.	APPLY CASTS TO SIMPLE FRACTURES OF EXTREMITIES.						
3.	GAIN KNOWLEDGE ON THE PROPER USE OF A VARIETY OF ORTHOPEDIC EQUIPMENT.						
4.	REVIEW CLINICAL SYMPTOMS AND RADIOLOGY FINDINGS WITH ATTENDINGS TO DETERMINE THE APPROPRIATE TREATMENT REGIMEN FOR PATIENTS.						
5.	EVALUATE PATIENTS IN THE POST-OPERATIVE PERIOD AND RECOGNIZE ANY POTENTIAL COMPLICATIONS.						
6.	DOCUMENT A CLEAR AND CONCISE HISTORY.						
7.	UNDERSTANDING OF OPEN AND CLOSED FRACTION REDUCTION.						
8.	UNDERSTAND BASIC ORTHOPEDIC PROSTHESIS AND INSTRUMENTATION.						
9.	ELICIT AN ACCURATE HISTORY OF PATIENTS' COMPLAINTS AND SYMPTOMS AND PERFORM A PREOPERATIVE PHYSICAL EXAM IN PATIENTS.						
10.	CORRELATE RADIOGRAPHS WITH DIAGNOSIS AND PROCEDURE.						
11.	DETERMINE WHAT CLINICAL PRESENTATIONS WARRANT SURGICAL INTERVENTION.						
12.	WORK-UP PATIENTS AND DEVELOP AND IMPLEMENT APPROPRIATE TREATMENT PLANS.						
13.	ACT AS AN APPROPRIATE ASSISTANT INTRAOPERATIVELY.						
14.	TECHNICAL ABILITIES INTRAOPERATIVELY.						
15.	ABLE TO PERFORM FOREFOOT SURGERY.						
16.	COMPREHEND/COMPLETE PREOPERATIVE HISTORY AND PHYSICAL EXAM.						
17.	DEVELOP A DIFFERENTIAL DIAGNOSIS FOR FOOT AND ANKLE PATHOLOGY.						
18.	COMPLETE PREOPERATIVE CHARTING AND DICTATION TECHNIQUES.						

19.	PERFORM SOFT TISSUE SURGERY.						
20.	PERFORM DIGITAL SURGERY.						
21.	PERFORM LESSER METATARSAL SURGERY.						
22.	PERFORM MIDFOOT SURGERY.						
23.	PERFORM REARFOOT AND ANKLE SURGERY.						
24.	PERFORM RESIDENTSAL FIXATION.						
25.	PERFORM APPLICATION OF CASTS.						
26.	RECOGNIZE AND MANAGE COMPLICATIONS.						
27.	OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						
28.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						
29.	OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR RADIOLOGY

Your rotation in Radiology will enable you to become familiar with the various techniques and procedures used to enable the clinician to accurately diagnose a variety of disease processes.

At the conclusion of this rotation, you should be able to:

1. Evaluate and interpret MRIs for the abnormal and normal in the lower extremity.
2. Evaluate and interpret CT scans for the abnormal and normal in the lower extremity.
3. Evaluate and interpret bone scans for the abnormal and normal in the lower extremity.
4. Determine which test to use based on standard criteria.
5. Use x-ray findings to develop a course of treatment for a variety of conditions.
6. Gain an understanding of various radiological studies and evaluate the results toward the establishment of diagnoses relative to structural, traumatic, infectious, metabolic, neoplastic, or neurovascular disease of the body.
7. Evaluate and interpret chest x-rays.
8. Act in a professional manner and demonstrate care and concern for each patient.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR RADIOLOGY

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	**4**	**3**	**2**	**1**	**0**
1.	EVALUATE AND INTERPRET MRIs FOR THE ABNORMAL AND NORMAL IN THE LOWER EXTREMITY.						
2.	EVALUATE AND INTERPRET CT SCANS FOR THE ABNORMAL AND NORMAL IN THE LOWER EXTREMITY.						
3.	EVALUATE AND INTERPRET BONE SCANS FOR THE ABNORMAL AND NORMAL IN THE LOWER EXTREMITY.						
4.	DETERMINE WHICH TEST TO USE BASED ON STANDARD CRITERIA.						
5.	USE X-RAY FINDINGS TO DEVELOP A COURSE OF TREATMENT FOR A VARIETY OF CONDITIONS.						
6.	GRAIN AN UNDERSTANDING OF VARIOUS RADIOLOGICAL STUDIES AND EVALUATE THE RESULTS TOWARD THE ESTABLISHMENT OF DIAGNOSES RELATIVE TO STRUCTURAL, TRAUMATIC, INFECTIOUS, METABOLIC, NEOPLASTIC, OR NEUROVASCULAR DISEASE OF THE BODY.						
7.	EVALUATE AND INTERPRET CHEST X-RAYS.						
8.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						
9.	OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR VASCULAR SURGERY

During this rotation, you will work closely with the vascular surgeons and follow patients from admission through discharge. You will have the opportunity to work in the vascular lab and clinic, as well as to assist in the operating room. You will learn to diagnose and manage vascular problems in a variety of situations.

At the conclusion of this rotation, you will be able to:

1. Prevent, diagnose, and manage vascular diseases, disorders, and injuries of the pediatric and adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means.
2. Perform and interpret the findings of a thorough problem-focused history and physical exam, including:, vascular examination, vascular imaging., coagulation studies.
3. Appropriate non-surgical management when indicated, including: pharmacologic management, including the use of: antibiotics, peripheral vascular agents, anticoagulants.
4. Assess and manage the patient's general vascular status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination). Formulate and appropriate differential diagnosis of the patient's problem.
5. Demonstrate the ability to communicate effectively in oral and written form with patients, colleagues, payers and the public.
6. Partner with health care managers and health care providers to assess, coordinate and improve health care.
7. Act in a professional manner and demonstrate care and concern for each patient.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR VASCULAR SURGERY

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	4	3	2	1	0
1.	PREVENT, DIAGNOSE, AND MANAGE VASCULAR DISEASE, DISORDERS, AND INJURIES OF THE PEDIATRIC AND ADULT LOWER EXTREMITY BY NONSURGICAL (EDUCATIONAL, MEDICAL, PHYSICAL, BIOMECHANICAL) AND SURGICAL MEANS.						
2.	PERFORM AND INTERPRET THE FINDINGS OF A THOROUGH PROBLEM-FOCUSED HISTORY AND PHYSICAL EXAM, INCLUDING: VASCULAR EXAMINATION, VASCULAR IMAGING, COAGULATION STUDIES, NON-INVASIVE VASCULAR STUDIES.						
3.	APPROPRIATE NON-SURGICAL MANAGEMENT WHEN INDICATED, INCLUDING: PHARMACOLOGIC MANAGEMENT, INCLUDING THE USE OF: ANTIBIOTICS, PERIPHERAL VASCULAR AGENTS, ANTICOAGULANTS AND FORMULATES AND IMPLEMENT AN APPROPRIATE PLAN OF MANAGEMENT, INCLUDING: APPROPRIATE MEDICAL/SURGICAL MANAGEMENT WHEN INDICATED, INCLUDING: DEBRIDEMENT OF SUPERFICIAL ULCER OR WOUND.						
4.	DEMONSTRATE THE ABILITY TO COMMUNICATE EFFECTIVELY IN ORAL AND WRITTEN FORM.						
5.	PARTNER WITH HEALTH CARE MANAGERS AND HEALTH CARE PROVIDERS TO ASSESS, COORDINATE AND IMPROVE HEALTH CARE.						
6.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						
7.	OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR WOUND CARE

Your rotation through the wound care service is designed to provide you with a broad exposure to a variety of wounds of differing etiologies in patients with all types of disease entities and risk factors. You will be presented with the pathophysiologic, diagnostic and therapeutic aspects of an assortment of wound care problems, during the course of your rotation. You will also follow selected outpatients on an ongoing basis through the wound care clinic under the aegis of various specialists.

At the conclusion of this rotation, you should be able to:

1. Evaluate the etiology of a lower extremity wound.
2. Identify the risk factors which have allowed this wound to develop and/or progress.
3. Manage various aspects of lower extremity wounds.
4. Determine which patients need immediate hospitalization or can be treated as outpatients.
5. Determine which patients are candidates for Hyperbarick Oxygen Therapy.
6. Determine which patients need urgent surgical intervention.
7. Determine which patients need elective surgical intervention and determine whether or not they are good candidates for these procedures.
8. Determine which procedures are appropriate for the pathology.
9. Determine the mechanics of the foot as they affect the etiology of wounds.
10. Evaluate the associated medical conditions and risk factors of patients with wounds.
11. Gain knowledge in the use of VAC therapy.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR WOUND CARE

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	**4**	**3**	**2**	**1**	**0**
1.	EVALUATE THE ETIOLOGY OF A LOWER EXTREMITY WOUND.						
2.	IDENTIFY THE RISK FACTORS WHICH HAVE ALLOWED THIS WOUND TO DEVELOP AND/OR PROGRESS.						
3.	MANAGE VARIOUS ASPECTS OF LOWER EXTREMITY WOUNDS.						
4.	DETERMINE WHICH PATIENTS NEED IMMEDIATE HOSPITALIZATION OR CAN BE TREAT AS OUTPATIENTS.						
5.	DETERMINE WHICH PATIENTS ARE CANDIDATES FOR HYPERBARICK OXYGEN THERAPY.						
6.	DETERMINE WHICH PATIENTS NEED URGENT SURGICAL INTERVENTION.						
7.	DETERMINE WHICH PATIENTS NEED ELECTIVE SURGICAL INTERVENTION AND DETERMINE WHETHER OR NOT THEY ARE GOOD CANDIDATES FOR THESE PROCEDURES.						
8.	DETERMINE WHICH PROCEDURES ARE APPROPRIATE FOR THE PATHOLOGY.						
9.	DETERMINE THE MECHANICS OF THE FOOT AS THEY AFFECT THE ETIOLOGY OF WOUNDS.						
10.	EVALUATE THE ASSOCIATED MEDICAL CONDITIONS AND RISK FACTORS OF PATIENTS WITH WOUNDS.						
11.	GAIN KNOWLEDGE IN THE USE OF VAC THERAPY.						
12.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATE CARE AND CONCERN FOR EACH PATIENT.						

13. OVERALL RATING OF RESIDENT'S PROFESSIONAL GROWTH.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

COMPETENCIES FOR ELECTIVE OFFICE ROTATION

This rotation provides clinical training in the evaluation of foot and ankle pathology in a private office setting. We will participate in the diagnosis and treatment of a variety of cases.

At the conclusion of this rotation, you will be able to:

1. Work-up patients with foot and ankle pathology.
2. Learn to perform and interpret foot and ankle x-rays.
3. Become familiar with working in a private office setting.
4. Become familiar with billing and coding.
5. Become familiar with obtaining insurance authorizations and verifications.
6. Become familiar with performing minor office procedures.
7. Formulate a diagnosis and treatment plan.
8. Act in a professional manner and demonstrate care and concern for each patient.

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

RESIDENT:_____ ROTATION DATE:_____

EVALUATOR:_____

ASSESSMENT FOR ELECTIVE OFFICE ROTATION

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

		5	**4**	**3**	**2**	**1**	**0**
1.	WORK-UP PATIENTS WITH FOOT AND ANKLE PATHOLOGY..						
2.	LEARN TO PERFORM AND INTERPRET FOOT AND ANKLE X-RAYS.						
3.	BECOME FAMILIAR WITH WORKING IN A PRIVATE OFFICE SETTING.						
4.	BECOME FAMILIAR WITH BILLING AND CODING.						
5.	BECOME FAMILIAR WITH OBTAINING INSURANCE AUTHORIZATIONS AND VERIFICATIONS.						
6.	BECOME FAMILIAR WITH PERFORMING MINOR OFFICE PROCEDURES.						
7.	FORMULATE A DIAGNOSIS AND TREATMENT PLAN.						
8.	ACTS IN A PROFESSIONAL MANNER AND DEMONSTRATES CARE AND CONCERN FOR EACH PATIENT.						

COMMENTS:

SIGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

QUARTERLY EVALUATION FORM

RESIDENT: _____ PGY: I II III QUARTER: 1 2 3 4

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT OBSERVED

CLINICAL PERFORMANCE AND CASE MANAGEMENT	**5**	**4**	**3**	**2**	**1**	**0**
1. MANAGEMENT OF ROUTINE CASES.						
2. MANAGEMENT OF DIFFICULT CASES.						
3. DETECTION AND DIAGNOSIS OF PATHOLOGY.						
4. UNDERSTANDING OF SYSTEMIC PHARMACOLOGY.						
5. MAKING APPROPRIATE REFERRALS WHEN INDICATED.						
6. WRITING REPORTS/NOTES AND RECORD KEEPING.						
7. APPROACH AND ATTITUDE TOWARDS PATIENTS.						
8. INDEPENDENCE AND FOLLOW THROUGH IN CASE MANAGEMENT.						
9. TECHNICAL APTITUDES.						
INTERPERSONAL SKILLS						
1. COMMUNICATION AND INTERACTION WITH PATIENTS.						
2. COMMUNICATION AND INTERACTION WITH PEERS AND STAFF.						
3. PROFESSIONALISM.						
LEARNING SKILLS						
1. INTEREST AND INDUSTRY; ENTHUSIASM FOR LEARNING.						
2. INTELLECTUAL CURIOSITY; GROWTH IN KNOWLEDGE AND SKILLS.						
3. PARTICIPATION IN EDUCATIONAL ACTIVITIES.						
4. CRTICIAL AND ANALYTICAL ACTIVITIES.						
5. APPLICATION OF GENERAL FUND OF KNOWLEDGE.						

CORRELATING THE RESIDENT'S EVALUATIONS TO DATE, HOW WOULD YOU RATE THE OVERALL PERFORMANCE OF THE RESIDENT THIS QUARTER COMPARED TO THE PREVIOUS ONE: **___SAME AS BEFORE ___BETTER THAN BEFORE ___NOT AS GOOD ___UNSATISFACTORY ___FIRST QUARTER**						

COMMENTS:

SIAGNATURES:

EVALUATOR: _____ DATE: _____

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: _____ DATE: _____

RICHMOND UNIVERSITY MEDICAL CENTER
PODIATRIC MEDICINE AND SURGERY RESIDENCY

EVALUATION OF ROTATION FORM

RESIDENT:_____ ROTATION DATE:_____

ROTATION:_____

USING THE FOLLOWING SCALE, PLEASE RATE THE RESIDENT'S PERFORMANCE LEVEL IN MEETING EACH OF THE COMPETENCIES AS LISTED BELOW:

5 EXCEPTIONAL **4** VERY GOOD **3** AVERAGE **2** BELOW AVERAGE **1** UNSATISFACTORY **0** NOT APPLICABLE

	CRITERIA	**5**	**4**	**3**	**2**	**1**	**0**
1.	ROTATION MET ITS STATED OBJECTIVES.						
2.	ADEQUATE NUMBER AND VARIETY OF PROCEDURES.						
3.	ABLE TO ACTIVELY PARTICIPATE IN PROCEDURES.						
4.	PROVIDED POSITIVE FEEDBACK AND CONSTRUCTIVE SUGGESTIONS.						
5.	WAS GIVEN SUGGESTIONS FOR APPROPRIATE AND CURRENT READING ASSIGNMENTS.						
6.	OVERALL RATING OF ROTATION.						

COMMENTS:

SIGNATURES:

RESIDENT: _____ DATE: _____

PROGRAM DIRECTOR: ______________________________ DATE: ______________

ADDENDUM TO THE PODIATRIC RESIDENCY MANUAL

PODIATRY BACK UP CALL POLICY

If a Resident is out from illness, etc. on a call day, the next Resident due to be on call will cover that day. The Resident who was out will then cover the other Resident's call. If necessary duty hours for the day will be adjusted to maintain compliance with regulation.

MOONLIGHTING

It is the policy of the Podiatry Department that moonlighting is will only be allowed in the last 3 months of the third year and only with the program director's approval and duty hours limits still apply.

PODIATRIC RESIDENCY PROGRAM SUPERVISION POLICY

The Supervision Policy of the Podiatric Residency Program is in accordance with the standards of CPME 320 guidelines.

In reference to the Emergency Room, the Resident contacts the attending on call to discuss the case and formulate a plan.

In reference to floor consultations, the Resident contacts the attending on call to discuss the case and formulate a plan.

Residents are to perform procedures under Direct or indirect supervision attending.

During the initial month of training, first year call is supervised by a senior Resident.

Department Policy: all inpatient consultations are to be seen within 24 hours unless a more urgent need arises.

For any unresolved conflicts, the Program Director is available at all times by cell phone.

Patient Sign Out/Handoff Policy

Policy:

- SBAR: Situation Background Assessment Recommendation.
- It is a communication method to be used during all patient transfers of care, between providers (nurses, social workers, and family), during sign in/out to/from call Resident, and with Resident reporting to attending.
- Purpose is to provide clear consistent communication between providers. SBAR provides a framework for communication about a patient's condition.

Implementation

- Interruptions should be limited to minimize the possibility of mistakes or omission of information allow for the accepting provider to ask questions to clarify and repeat back information as needed.

Situation

- Identify yourself and your department if it is an inter-department communication.
- Identify the patient and reason for report.
- Describe the specific situation (i.e. status post I&D right foot for ulcer with osteomyelitis 1st ray wound packed open: provide pertinent labs, x-rays, etc.)

Background

- Reason for admission, current meds, allergies, pertinent PMH, relevant surgical history, prior test results/pending results (i.e. 65 year old DM male admit hyperglycemia with cellulitis on Vanco/Zosyn C&S done awaiting results. History of contralateral TMA NKDA x-rays negative).

Assessment

- Provide the most up to date information and clinical impression (i.e. with patient in ER and you are calling an attending. Intra-articular calcaneal fracture/displaced no fracture blisters or concern of compartment syndrome. Do you think the attending needs to see patient urgently (gas in tissue or open fracture) or routinely (simple laceration or toe fracture)).

Recommendation

- The treatment plan for the patient and what time frame it should be done in (i.e. if the wound is not progressing does vascular need to be included, after reviewing x-rays do you recommend bone biopsy or MRI? Patient is continuing to bleed post op, do you recommend to return to OR etc.? What clinical decision you are recommending and the reasons for it.)

Resident Wellness

The wellness program for our podiatric residency is designed to foster a balanced and supportive environment that promotes both the personal and professional well-being of our residents. Recognizing the demanding nature of medical training, our program emphasizes mental, emotional, and physical health to help residents thrive in their journey.

Key Components:

1. Mental Health Support

   Residents have access to confidential mental health services, including individual counseling and therapy. Group workshops on stress management, resilience, and mindfulness are held quarterly, offering skills for handling high-stress situations common in podiatric practice.

2. Flexible Scheduling and Time-Off

   To prevent burnout, our program emphasizes balanced scheduling. Residents receive protected wellness days and the option for flexible vacation time, especially around exams or personal milestones, promoting a sustainable work-life balance. Post call and fatigue days are available as needed.

3. Physical Wellness Resources

We provide access to an on-site fitness facility. Health-focused workshops on nutrition, sleep optimization, and physical activity are offered to help residents maintain their energy and physical wellness.

4. Wellness Workshops and Residents Activities

   Richmond University organizes wellness events, such as yoga sessions, meditation classes, and social gatherings. These events encourage relaxation, networking, and camaraderie, helping residents unwind and build relationships outside of clinical duties.

5. Anonymous Feedback and Improvement Initiatives

   The program includes an anonymous feedback system that allows residents to share wellness-related concerns. This helps the residency leadership continuously improve and address any challenges affecting resident well-being.

Goals

Our wellness program aims to reduce stress, enhance job satisfaction, and promote a culture of compassion and support. BY focusing on holistic wellness, we believe our residents can achieve their personal and professional best while developing the resilience and empathy crucial to successful podiatric practice.

RICHMOND UNIVERSITY MEDICAL CENTER

RESIDENCY IN

PODIATRIC MEDICINE AND SURGERY RESIDENCY (PMSR)

I, _____, have thoroughly reviewed the Residency Training Manual of the Richmond University Medical Center's Podiatric Medical and Surgical Residency Program and agree to abide by the rules and regulations stated within. I fully understand the current disciplinary and remediation policies in place. I accept the position as Resident for the one year term as defined in the contract provided by the Hospital.

_____ _____

Signature (Resident) Date

_____ _____

Signature (Program Director) Date