

**Coney Island Hospital (CIH)  
Wound Care Fellowship**



**Policies and Resource Manual**

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## **MISSION STATEMENT**

The mission of the Wound Care Fellowship Training Program is as follows:

1. To deliver appropriate patient care to patients requesting or requiring wound care treatment utilizing established protocols.
2. To instruct physicians in-training on the methods, applications, and utilization of Wound Care Therapy and Regenerative Medicine .
3. To train new physicians to become competent, effective, and highly respected practitioners of Wound Care Medicine.
4. To spread knowledge about Wound Care and Regenerative Medicine to other medical specialties through medical education.
5. To promote research into the field of Wound Care and Regenerative Medicine.
6. To provide service to the community, the Coney Island Hospital system and the specialty of Wound Care.
7. To track wound progress in an interdisciplinary environment utilizing WEMR (wound electronic medical record)
8. To promote an interdisciplinary team approach to Wound Care at Coney Island Hospital
9. To develop an awareness of disparities in Wound Care

**Coney Island Hospital**  
**Wound Care Fellowship**  
**Ethics Code**

I agree to abide by the moral standards and ethical behavior deemed suitable for a training physician in Wound Care and Regenerative Medicine. I will treat patients, staff, and my peers with respect. I will present all patient cases and patient examinations in a truthful manner, to the best of my knowledge and capabilities. I will not condone patient, student, or House Officer abuse or degradation.

I have reviewed the Coney Island Wound Care Fellowship Program Policy Manual with the Fellowship Director, and I understand its contents.

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_

## **I. Purpose**

The Wound Care Fellowship Training Program is designed as a 12 month training experience including the following essential training experiences:

1. Clinical experience, providing an appropriate opportunity to expand the fellows competencies in the care of diseases, disorders, and injuries related wounds, by medical, biomechanical and surgical means.
2. Clinical experience, providing participation in complete preoperative and postoperative patient care in order to enhance the Fellow's competencies in the peri-operative care of wounds.
3. Didactic experience, providing an opportunity to expand the Fellow's knowledge in the breadth of infectious disease and vascular medicine.

A. **Competencies**: The program will strive to enhance the Fellow's level of competence in the following :

1. Prevent, diagnose, and manage diseases, disorders, and wounds by nonsurgical (educational, medical, physical, biomechanical) and surgical means.
2. Assess and manage the patient's general medical status.
3. Practice with professionalism, compassion, and concern, in a legal, ethical, and moral fashion.
4. The ability to communicate effectively and function in a multidisciplinary setting.
5. Has the capacity to manage individuals and populations in a variety of socioeconomic and health care settings.
6. Has the capacity to manage patients in a multitude of health care delivery settings.
7. Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice.

## **II. Committees**

### **A. Fellowship Training Committee**

This committee is responsible for the overall direction, regulation and functioning of the fellowship training program. It is composed of the Director of the Wound Care Fellowship, the Rotation Directors, appropriate representatives of the Medical Teaching Staff, a representative of the Administration of CIH, and other members as deemed appropriate by the Committee and/or affiliated institutions. The Committee should not exceed 15 members. Appointments to this committee are made by the Director and include the Rotational Directors following their appointment by their respective centers.

The function of this committee is to set policies for the program, develop the curriculum of the training program and review overall Fellow and program performance. In addition, this committee will mediate conflicts arising within the teaching program, whether they are generated from the fellows, podiatry staff, medical staff, nursing staff or administration. This committee will have the power to recommend the dismissal of the Fellow should the situation arise. Each member of the Committee will have one vote unless stated otherwise below. The Director of the

Wound Care Fellowship will be the chairman of this committee and will be responsible to schedule the meeting dates of the committee at least semi-annually. The committee may serve as the Evaluation/Grievance committee (see below)

The responsibility of the Director of the Wound Care Fellowship is to oversee the general administration of the fellow. It is the Director's responsibility to insure that the fellow follows the guidelines established for them within their contracts and within this manual. If the need arises the Director of the Wound Care Fellowship appoints individuals or committees to assist him in his responsibilities as Director. The Director or Rotation Director will coordinate the various rotations. If a conflict should arise in respect to the curriculum and/or management of a rotation, the Fellowship Committee in consultation with the staff of the involved rotation will make the final decision regarding the rotational structure. The Director of the Wound Care Fellowship is directly responsible to the Fellowship Committee. The Director serves as the liaison with the Council on Podiatric Medical Education. The Director may only vote to break a tie. The Director may hold additional positions on the committee including their voting rights. The Coney Island Hospital GME committee appoints the Director. The choice of appointee should be based heavily on the individual's ability to do the job and the availability of the 20+ hrs per week it requires. Coney Island Hospital upon 30 days written notice may revoke the appointment.

The Director of the Wound Care Fellowship must meet all CPME requirements for Directors. The Rotation Director will assume any or all of the Director's responsibilities in the event the Director is temporally unable to perform those duties or on an interim basis until a new director can be recruited if the Director leaves the program.

The position of Rotation Director at the affiliated institution will be held by a member of the staff from that institution as long as the affiliation between the fellowship and institution is in force. The affiliated institution may choose that individual by any method they wish as long as the term of office is at least one year. The Rotation Director will be responsible for the day by day functioning of the Fellows at their institutions. The Rotation Director will serve as an advisor to the fellow and a liaison with the heads of the various rotations and departments affiliated with the fellowship at their institution.

## **B. Fellowship Selection Committee**

The Fellowship Selection Committee will be made up of a subcommittee of the fellowship training committee appointed by the Director. The Director shall chair the Committee unless the Director has appointed another committee member to assume chairmanship. 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 applicants under consideration will be discussed in detail. The current fellows may be asked to comment on the applicants. If the committee can not reach a consensus, a final vote by the Committee members will be held by closed ballot.

### **C. The Fellowship Evaluation/Grievance committee**

The Fellowship Evaluation Committee will be made up of the Director, at least one other member of the fellowship training committee appointed by the Director and an Administrative Representative. The Director shall chair the Committee unless the Director has appointed another committee member to assume chairmanship. The committee will review the progress of the fellow(s) at least monthly to determine the status and progress status of each fellow. The committee will also review (self assess) the program on an annual basis and make recommendations to the Fellowship Training Committee regarding any needed changes or program enhancements. The committee will meet more frequently in cases where fellows are having academic problems and will meet at least monthly when a fellow is on academic probation. The committee will serve as the initial hearing body for any appeal of a fellow evaluation.

### **III. Wound Care Fellow Selection Policy / Process**

To be eligible for appointment to the Podiatric House staff at CIH, an applicant must:

Be a graduate of a college of Podiatric medicine accredited by the Council on Podiatric Medical Education (CPME).

Successfully completed a Podiatric residency approved by the CPME.

All Fellowship applicants must provide the following:

- \_ Curriculum Vitae and Personal Statement
- \_ Podiatry College transcripts
- \_ Three letters of recommendation
- \_ Letter from current/former program director
- \_ Notarized proof of graduation from podiatry school with date of graduation
- \_ Certificate of successful completion of Podiatry Residency Program
- \_ **All applicants must obtain a New York State Permit prior to the start of fellowship**

The Program will provide applicants the following information on request:

- \_ Instructions for submitting the application and required documentation
- \_ Program training and policy manuals

- A statement that “IMC does not discriminate on the basis of sex, race, age, religion, color, national origin, disability, or veteran’s status.”

Candidates for this program are selected based on their preparedness, ability, academic credentials, communication skills, and personal qualities such as motivation and integrity.

A designated committee member reviews applicants who meet the criteria. Based on the quality of the application packet and academic credentials, the applicant is subsequently invited, if appropriate, for an interview. At the conclusion of the interview, the interviewers complete a standard evaluation form for each applicant they interviewed.

Appointees to the fellowship must obtain a New York State Permit/or license prior to the start of fellowship.

#### **IV. Physical Facilities**

The physical plant will be well maintained and properly equipped to provide an environment conducive to teaching, learning, and providing patient care. Adequate patient treatment areas, adequate training resources and a health information management system will be available for Fellow training. These facilities will have sufficient library resources including electronic retrieval capabilities, and personnel. The library hours are as follows:

Mon-Thu 8:00 AM- 8:00 PM  
Fri 8:00 AM- 4:00 PM  
Sat 9:00 AM- 1:00 PM  
Sun 1:00 PM- 5:00 PM

The library is available after hours by contacting the Hospital Police Supervisor at ext 4422

## **V. Conduct of the Fellow**

### **A. Orientation**

At the beginning of the fellowship year, a period of orientation and instruction in duties, responsibilities and privileges of the Wound Care fellow is provided so that each fellow may attain a working knowledge of the function and administration of the hospital, the departments and its affiliated institutions.

The following subjects are included in this period of instruction:

1. New hire orientation
2. Committee of Interns and Residents (CIR) benefits
3. Salary and benefits
4. BCLS/ACLS
5. Fellow schedule.
6. Policies manual
7. Program Competencies
8. Demonstrations and lectures covering the various phases of wound are given the newly appointed Wound Care fellow throughout the year. These lectures and demonstrations are presented in order for the new fellow to adapt to the hospital atmosphere.
10. Orientation for Winthrop Hospital

### **B. Dress Code**

The Wound Care fellow must adhere to all Department of Surgery guidelines in addition to all CIH Guidelines

#### **Purpose**

To present a professional appearance to patients, staff, and the public at all training sites, and comply with Joint Commission standards where applicable.

#### **Policy**

Fellow appearance and conduct should at all times reflect the dignity and standards of the medical profession. Dress guidelines for Fellows assist in achieving this goal while also acknowledging individual desires for diversity and self-expression. Following are guidelines for professional attire. It is recognized that each department or specialty may have requirements which are more specific or less rigorous than the guidelines outlined herein. It is the purpose of this policy to provide general guidelines to assist each department or specialty in developing its own dress code policy to meet its specific needs. These guidelines apply to each work day, including days with no patient care responsibilities.

#### **Specific Standards:**

Name Tags: Proper identification as required by each training site must be worn and clearly displayed at all times while on duty.

White coats: White coats are recommended, and must be clean and neat. If wearing scrubs outside the operating area, it is recommended that a clean white coat be worn over the scrubs.

Scrubs: Scrubs should not be worn outside of the hospital premises. Scrubs are expected to be clean and pressed. Scrubs may be worn in the operating room, delivery areas, or on the following rotations only unless otherwise delineated by departmental policy: Emergency room and ICUs. In patient care areas, a lab coat with name tag **MUST** be worn over the scrubs.

Scrubs may not be worn in hospitals that they don't belong to.

Each rotational director has the authority for specific attire guidelines related to their rotation

Shoes: Footwear must be clean, in good condition, and appropriate. Open-toed shoes and sandals are not permitted in patient care areas for safety and infection control reasons.

Style: No tank or halter tops, midriffs or tube tops. No sweatshirts or shirts with messages, lettering or logos. No shorts. Jeans are discouraged. A tie is recommended for men on weekdays.

Fragrance: No strong colognes or perfumes as patients may be sensitive to strong fragrances.

Hands: Fingernails must be clean and short to allow for proper hand hygiene, use of instruments, prevent glove puncture and injury to the patient. Artificial nails do not allow for proper hand hygiene.

Hair: Mustaches, hair longer than chin length, and beards must be clean and well trimmed. Fellow s with long hair who render patient care should wear hair tied back to avoid interfering with performance of procedures or coming into contact with the patient.

Jewelry: Should not be functionally restrictive or excessive.

Piercings: There should be no visible body piercings, with the exception of ears. Nose Tattoos piercings which have religious significance are acceptable. There should be no visible tattoos.

Violation: If a Fellow is in violation of his/her department's guidelines, he/she may be asked to return home to change into more appropriate attire. Repeat violations will result in a letter being placed in the Fellow's permanent file, addressing deficiencies in the professionalism competency portion of training.

### **C. Relation to Staff and Personnel**

Supervision, control and discipline of the Fellow is vested in The Fellowship Committee. The fellow will make careful notes of orders given by the staff. In no case will the fellow change the treatment plan without the knowledge of the staff members. Disagreement with or criticism of any member of the nursing staff must be discussed with the appropriate Rotation Director who will take any necessary action. Questions or criticisms relating to general hospital operation or personnel may be brought to the appropriate Rotation Director who may discuss them with the

hospital administrator. Those questions relating to the Wound Care Fellowship training program will be discussed with the appropriate Rotation Director or Director the Wound Care Fellowship.

Fellow 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. 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 appropriate Rotation Director.

Remember, always, that the attending physician is in full charge the patient. Inform them 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 must be in writing and presented to the Rotation Director, Program Director or the Training Committee as appropriate.

#### **D. Leave Policy**

**Vacation Leave:** Each fellow directly employed by CIH is allotted 20 days of vacation per year. The fellow must request their vacation at least 30 days in advance. The request must be made in writing to the Program Director. Fellows may not take vacation in July. No more than 2 weeks may be taken at any one time. Unused vacation is lost at the end of each year.

**Authorized leave:** Each fellow will be eligible for 5 days of leave to attend seminars. The leave must be approved 30 days in advance (see vacation above). A maximum of one travel day will be allowed.

**Sick leave:** Each fellow must report sick days taken to the rotation involved at the beginning of the day of the absence and an email also at the beginning of the day sent to the Director's attention. A Doctor's note is required for absences greater than 4 successive days. All sick time occurring during the day must be reported to Surgery department and Occupational Health Services.

Any fellow failing to abide by these policies after progressive discipline will be placed on corrective action with loss of all leave privileges (first offense) and suspended for 30 days without pay with makeup at end of program (second offense) or terminated (third offense).

**Leave taken for medical reasons falls under The Family Medical Leave Act of 1993:** The Family and Medical Leave Policy for house staff and fellows at CIH meets the requirements of the Family Medical Leave Act of 1993, allowing up to 12 weeks of leave per year for eligible employees. To be eligible for FMLA leave, a house officer/fellow must have been employed for at least 4 months and must be requesting leave for a serious medical condition (birth or adoption of a child; serious medical condition of a spouse, parent, or child; serious medical condition of the employee).

Illness which result in a periods of absence longer than a week will be handled under the Family Medical Leave Act. House staff must inform the program director and the GME Office immediately about any needed medical leave to allow time to arrange clinical coverage. Upon learning that a house officer is requesting FMLA leave, the program director or program coordinator will contact the GME Office with the information, and will require that the house officer contact a Benefits Office representative to apply for FMLA. Employees are required to provide the Benefits Office with at least 30 days notice before FMLA is to begin, or within two (2) business days in the case of an unforeseen emergency. The Benefits Office will approve or disapprove the FMLA leave.

**Emergency leave:** On a case by case basis emergency leave may be granted (with or without make up) at the discretion of the Program Director, or if they are unavailable any member of the fellowship committee. The definition of emergency will be at the discretion of the program and the Fellow agrees to abide by the decision of the committee, whose available members will be polled in the case of a disagreement. Failure to abide by the decision will result in termination of the fellow.

Unused leave is lost annually and will not be paid at the end of training. **Leave taken for any reason that exceeds 30 days must be made up (without compensation unless prior arrangements have been made) in order to complete the program.**

**Unexcused absences:** Any unexcused absence will be treated as a violation of the sick leave policy above with the same penalties applying. An unexcused absence is defined as anytime a Fellow is not in attendance at a conference or other Fellowship function without prior arrangements being made.

## **E. Podiatric Fellow Work Hours**

### **1. Work Hours**

1. Work hours are defined as all clinical and academic activities related to the fellowship program. This includes patient care, administrative duties related to patient care, provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Work hours do not include reading and preparation time spent away from the work site.

2. Work hours will be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

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

4. A 10-hour time period for rest and personal activities will be provided between all daily work periods.

5. Fellow may be required to periodically track their work hours so they can document that the number of hours Fellows works on various rotations doesn't violate these rules.

**2. At Home On-Call Activities:**

1. At-home call (pager call) is defined as call taken from outside the assigned institution.

a. The frequency of at-home call is not subject to the every-third-night limitation. However, at-home call will not be so frequent as to preclude rest and reasonable personal time for each Fellow. Fellow taking at-home call will be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a four-week period.

b. When Fellows are called into the hospital from home, the hours Fellow spend in-house are counted toward the 80-hour limit.

c. The program may monitor the demands of at-home call by reviewing Fellow work hour on a periodic basis, a separate category of hours will be recorded as called to hospital.

**3. Moonlighting of the Fellows in Podiatric Programs**

Professional and patient care activities that are external to the educational program are called "moonlighting." The Wound Care Fellowship Program permits moonlighting. However, hours are closely monitored to ensure compliance with the duty hour regulations.

**4. Back-Up System:**

The program's back-up system to cover patient care responsibilities when those responsibilities are unusually difficult or prolonged, or if unexpected circumstances create fellow fatigue sufficient to jeopardize patient care will include coverage of those duties by attending physicians and/or the temporary reassignment of the fellow from less demanding rotations to assist in the patient care duties. Any negative impact on fellow education will be considered and to the greatest extent possible avoided in making reassignments. As a last resort patient care will be rescheduled.

**5. Employment Hours:**

Each fellow is responsible to be prepared to start the day at 8AM and finish when all tasks for the day are completed and in compliance with fellowship by-laws. Sign in sheets will be monitored and must have time in/out. Any UN-excused lateness and/or absence will become part of the fellow's file and will be reflected in any letter of recommendation. Chronic lateness and/or absenteeism will not be tolerated and will be referred to Department of Human Resources. The Fellow may not leave the premises

without specific permission from Director of the Wound Care Fellowship or designee. A fellow will be considered Absent Without Leave (AWOL) if said permission is not granted and subject to suspension from program.

#### **F. Miscellaneous Responsibilities**

While your obligation to yourself, your profession, your hospital and patients will be expressed by implication through out 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. Members of the Fellow staff are expected to abide by the policies at all times.

1. The fellow must be familiar with and abide by the rules and regulations of the hospital staff, departments, and committees of all affiliated institutions.
2. Fellow shall report to the Director as a member of the house staff on or before the Monday of the last full week of June or sooner if informed in writing by the program.
3. Cooperate in the conservation of supplies.
4. Fellows are not to accept fees or gratuities from patients, their relatives or friends. You will not practice your profession or assist any physician outside the affiliated institutions.
5. No alcoholic beverages are permitted in the hospitals. No person who has been drinking may attend a patient.
6. Smoking in the hospital is prohibited.
7. At **all** times, your patients are to be your first consideration.
8. Visit each of your inpatients at least once daily, give them such conscientious professional care as the attending physician directs and make progress notes of all significant events in the development the case.
9. Provide complete privacy for each patient during dressings and examinations in which he or she might be exposed. Curtains are furnished in the multiple-bed rooms.
10. Do not sit on the patient's bed unless it is necessary for examination.
11. Protect your patient's privacy. Refer information release inquiries to the appropriate department at the institution.
12. Refer any questions about your patient's financial arrangements to the appropriate individual at the institution.

13. Refer any requests for extra visiting privileges to the Director of Nurses, requests for transfers to other accommodations to the Admitting office, and inquiry about discharge from the hospital, etc., to the patient's attending physician.
14. Report promptly on an Incident Report Form any unusual occurrences in the hospital; such as accidents, fire or a disturbed patient.
15. Guard against unnecessary or unwise talking in the hearing of a patient coming out from anesthesia or from alcoholic or other stupor. Patients sometimes hear, and remember, surprisingly well.
16. Never disparage any physician or the hospital to a patient. Avoid inciting damage suits by a patient who thinks he has been the victim of malpractice.
17. Fellows will not order materials, supplies or surgical equipment directly from outside vendors unless directed to by an appropriate individual.
18. Fraternalization with patients is prohibited.
19. **Communication:** Pagers must be answered within 5 minutes. Batteries shall be checked at the beginning of each transfer of long range beeper. Not answering a page in a timely fashion will be considered a dereliction of duty and subjected to immediate suspension from the program.
20. Each fellow must have an official HHC e-mail and all notices, journals and schedule changes will be communicated through this media.

## **VI. Supervision/Evaluation**

The Fellowship Training Committee expects all fellows to observe such rules of decorum and order in the hospitals, clinics, and/or private podiatric offices as are becoming to professional men and women. In the event that the fellow 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 staff or the administration of the hospital, it is understood and agreed that the hospital may suspend the Fellow's contract immediately and without prior notification to the Fellow subject to appeal (see below). In the event that the fellow'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 fellowship program. It is clearly understood that any contract between a fellow and the program may be terminated at any time by mutual consent.

*Grievance Policy (Due Process Policy)*

The grievance procedure for the Wound Care Fellowship Program at Coney Island Hospital is determined by the programs representation by the committee of Interns and Fellows.

**Section 1.**

The term “grievance” shall mean:

- a. A dispute concerning the application or interpretation of the terms of this collective bargaining agreement;
- b. A claimed violation, misinterpretation, or misapplication of the rules or regulations, authorized existing policy, or orders of the Corporation affecting the terms and conditions of employment;
- c. A claimed regular or recurrent assignment of House Staff Officer’s to duties substantially different from those stated in their job specifications;
- d. A question regarding the non-renewal of the appointment of a House Staff Officer.
- e. The provisions of this Article XIV shall not apply to a grievance under Article VII, Section 1 and 2.

**Section 2.**

**Step I.** The Employee and/or the Committee shall present the grievance in writing to the Chief of Service or to the Executive Director or the Director’s designee no later than 90 days after the date on which the grievance arose, and in grievances brought under Section 1(D) the grievance shall be presented no later than ninety (90) days after the date on which written notice of non-renewal is received. The individual to whom the grievance was presented shall take any steps necessary to a proper disposition of the grievance and shall reply in writing by the end of the tenth (10<sup>th</sup>) work day following the date of submission, except for grievances brought under Section 1(D), where the reply shall be in writing by the end of the fifth (5<sup>th</sup>) working day following the date of submission.

For all grievances as defined in Section 1 (c), no monetary award shall in any event cover any period prior to the date of the filing of the Step 1 grievance unless such grievance has been filed within thirty (30) days of the assignment to the alleged out-of-title-work.

**Step IIa.** An appeal from an unsatisfactory determination at Step I, except for an appeal brought under Section 1 (d), shall be presented in writing to the Corporation’s Director of Labor Relations. The appeal must be made within ten (10) working days of the receipt of the Step I determination. The Corporation’s Director of Labor Relations or his designated representative, if any, may meet with the Employee and/or the Committee for review of the grievance and shall in any event issue a determination in writing by the end of the tenth (10<sup>th</sup>) workday following the date on which the appeal was filed.

**Step II(b).** An appeal from an unsatisfactory determination at Step I in regard to a grievance brought under Section I(d) must be brought within fifteen (15) days of the receipt of the Step I determination to the House staff Affairs Committee of the Medical Board for evaluation and

determination. A House Staff Office and/or CIR appealing to the House staff Affairs Committee shall be given advance written notice of when the House staff Affairs Committee will consider the appeal. The House staff Affairs Committee will render a written decision and provide it to the House Staff Office and/or CIR. All decisions of the House staff Affairs Committee may be reviewed by the Medical Board. If the Medical Board reviews the case, advance notice and a written decision will be provided the House Staff Officer and/or CIR. The decision of the Medical Board in all such matters shall be final.

**Step III.** An appeal from an unsatisfactory determination at Step II(a) may be filed by the Committee with the Office of Collective Bargaining for impartial arbitration within thirty (30) days of receipt of the Step II(a) decision. The Corporation shall have the right to appeal any grievance determination under Section 1, except for grievances brought under Section 1(d) directly to arbitration. Such appeal shall be filed within thirty (30) days of the receipt of the determination being appealed. The Committee and/or Corporation shall commence such arbitration by submitting a written request therefore to the Office of Collective Bargaining. A copy of the notice requesting impartial arbitration shall be forwarded to the opposing party. The arbitration shall be conducted in accordance with the Consolidated Rules of the Office of Collective Bargaining, except that each party shall be separately responsible for any costs or fees of any member of the arbitration board selected by such party, other than the impartial arbitrator. The cost and fees of such arbitration shall be borne equally by the Committee and the Employer. The determination or award of the arbitrator or the arbitration board noted in Section 8 of this Article shall be final and binding and shall not add to, subtract from, or modify any contract, rule, regulation, authorized existing policy, or order mentioned in Section 1 (b) and 1(c) of this Article existing at the time the grievance arose.

### **Section 3.**

As a condition to the right of the Committee to invoke impartial arbitration set forth in this Article, the Employee or Employees and the Committee shall be required to file with the Director of the Office of Collective Bargaining a written waiver of the right, if any, of the Employee or Employees and the Committee to submit the underlying dispute to any other administrative or judicial tribunal except for the purpose of enforcing the arbitration's award.

### **Section 4.**

Any grievance of a general nature affecting a large group of House Staff Officers and which concerns the claimed misinterpretation, inequitable application, violation, or failure to comply with the provisions of this Agreement shall be filed at the option of the Committee at Step II(a) of the grievance procedure, without resort to the previous step.

### **Section 5.**

If the Employer exceeds any time limit prescribed at any step in the grievance procedure, the grievant and/or the Committee may invoke the next step of the procedure, except, however, that only the Committee may invoke impartial arbitration under Step III.

**Section 6.**

The Employer shall notify the Committee in writing of all grievances filed by House Staff Officers, all grievance hearings, and all determinations. The Committee shall have the right to have a representative present at any grievance hearing and shall be given forty-eight (48) hours' notice of all grievance hearings.

**Section 7.**

Each of the steps in the grievance procedure, as well as time limits prescribed at each step of this grievance procedure, may be waived by mutual agreement of the parties.

**Section 8.**

At the request of both parties, after the appointment of an arbitrator, or at the request of one party and the arbitrator, there shall be constituted a tripartite arbitration board consisting of the impartial arbitrator, a physician or dentist designated by the Committee, and a physician or dentist designated by the Corporation. The arbitrator shall be the chairperson and presiding member of the arbitration board and shall be the only voting member of the arbitration board. The determination or award of the arbitration board shall be final and binding and shall not add to, subtract from, or modify any contract, rule, regulation, authorized existing policy, or order mentioned in Section l(b) and l(c) of this Article existing at the time the grievance arose.

**Section 9.**

The grievance and arbitration procedure contained in this agreement shall be the exclusive remedy for the resolution of disputes defined as "grievances" herein. This shall not be interpreted to preclude either party from enforcing the arbitrator's award in court.

**Section 10.**

House Staff Officers may be assisted at all stages of the procedures herein set forth in this Article by representatives of the Committee.

**Section 11.**

The institutional Grievance Committee will consist of the following members of the Graduate Medical Education Committee (GMEC): Director of Medical Education, Chairmen of the Departments of Medicine, Surgery, Pediatrics, Obstetrics and Gynecology and Psychiatry (excluding the Chairman of the affected House Officer's Department), Representative of the Committee of Interns and Residents (CIR), Representative of the Human Resources Department and Representative of the Hospital Administration and/or Corporation

## *Grievance Policy II (Discipline and Dismissal Policy)*

Proposed disciplinary actions against a Fellow in the Podiatry Wound Care Fellowship Program at Coney Island Hospital are adjudicated through representation of the house officer by the committee of Interns and Residents.

### **Section 1.**

House Staff Officers shall have the right to a hearing before being subject to disciplinary action except as hereinafter provided. There shall be no disciplinary action taken against a House Staff Officer except for cause and pursuant to and after the completion of the procedures herein provided. Notwithstanding the provisions of Section 6(d) below, when a charge of failure to complete delinquent charts is sustained following proper notice and hearing as below, the proposed discipline may be implemented before the completion of those procedures by the Hospital Medical Director when it is a reprimand or by the Corporate Director of Labor Relations when it is other than a reprimand.

### **Section 2.**

It is understood that a House Staff Officer may be reassigned from medical responsibilities without a hearing when the House Staff Officer's continued presence is deemed to risk the successful operation of the hospital. Following such reassignment by either the Chief of Service or the Medical Director of the hospital, the Committee shall have the right to an immediate appeal to an arbitrator or arbitration board as hereinafter provided.

### **Section 3.**

When disciplinary action against a House Staff Officer is contemplated either by a Chief of Service or Medical Director, written charges and proposed disciplinary action shall be presented by the Medical Director to the Committee and to such House Staff Officer, who shall be notified of the House Staff Officer's right to appear before the Medical Director or duly designated representative for the purpose of an informal hearing before such Medical Director or designee. The Medical Director shall have the right to affirm, rescind, or modify the charges and/or proposed action after such informal hearing.

### **Section 4.**

The House Staff Officer or Committee shall be entitled to a conference with the Corporation Director of Labor Relations or the Director's designee in the event that the Medical Director does not rescind the charges and proposed disciplinary action, and the said Director of Labor Relations shall be authorized to affirm, rescind, or modify said charges and/or proposed action after such conference.

### **Section 5.**

The written charges and proposed disciplinary action shall become final unless: (i) rescinded by the Medical Director; or (ii) rescinded by the Corporation Director of Labor Relations; or (iii) the

Committee requests in writing to the Office of Collective Bargaining, with simultaneous notice to the Corporation and the Medical Director, within fifteen (15) days after the receipt by the Committee of the original written charges and proposed disciplinary action, that said charges and action be submitted to arbitration pursuant to this Article XV.

#### **Section 6.**

- a. Arbitration hereunder shall determine whether just cause or basis exists to sustain the charges and, if so, whether there is just cause or basis for the proposed disciplinary action. The arbitrator shall be authorized to accept, reject or modify the charges or proposed disciplinary action. The determination or award of the arbitration shall be final and binding and shall not add to, subtract from, or modify any contract, or any rule, regulation, existing authorized policy, or order mentioned in Section 1 (B) and (C) of Article XIV existing prior to the notice provided by Section 3 thereof.
- b. Arbitration hereunder shall be conducted in accordance with the Consolidated Rules of the Office of Collective Bargaining, except as modified in (c ) of this Section. The costs and fees of such arbitration shall be borne by the Committee and the Corporation as provided in Article XIV, Section 2.
- c. At the request of both parties after the appointment of an arbitrator, or at the request of one party and the arbitrator, there shall be constituted as tripartite arbitration board consisting of the impartial arbitrator, a physician or dentist designated by the Committee, and a physician or dentist designated by the Corporation. The arbitrator shall be the chairperson and presiding member of the arbitration board and shall be the only voting member of the arbitration board. The determination or award of the arbitration board shall be final and binding and shall not add to, subtract from, or modify any contract, rule, regulation, authorized existing policy, or order mentioned in Section 1(B) and (C) of Article XIV existing prior to the notice provided by Section 3 hereof.
- d. No disciplinary action shall be imposed upon a House Staff Officer until said action has become final pursuant to Section 5 hereof or said action has been subject to a determination and award in arbitration pursuant to Section 6 hereof.

#### **Section 7.**

The Hospital will arrange the schedules of House Staff Officers who are involved in disciplinary or grievance procedures so as to permit reasonable time off.

\*Refer to CIR Policy

## ***Fellow Evaluation Policy***

### **I. Purpose:**

A. The Graduate Medical Education Committee of CIH has responsibility for the overall academic quality of each of the graduate medical training programs. A part of that quality can be measured by the performance of the Fellow. The program expects a progression of knowledge in the specialty area from beginning to end of training, and such progress needs to be monitored.

B. The training of effective and competent physicians is the goal of each training program, and all evaluations will be directed at that ultimate objective.

## **Standards of Performance**

### **I. Policy:**

The program will have a written set of standards of performance for the Fellow. These standards include: A definition of clinical competence, including:

1. **Appropriate behavior** by the fellow, towards patients, colleagues and staff while attaining the following competencies (see specific competencies and indicators later in this manual)

- a. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity wounds.
- b. Assess and manage the patient's general medical status.
- c. Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.
- d. Communicate effectively and function in a multi-disciplinary setting.
- e. Manage individuals and populations in a variety of socioeconomic and healthcare settings.
- f. Understand podiatric practice management in a multitude of healthcare delivery settings.
- g. Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.

## **2. Graduation**

The Fellow is eligible for graduation upon the satisfactory completion of the training program. During the Wound Care Fellowship the fellow shall maintain satisfactory academic performance, demonstrate clinical competence and complete responsibilities to all institutions affiliated with the program.

At least two months prior to the completion of the fellow's training year, the Fellowship Training Committee will review the fellows performance. At this time, the Fellowship Training Committee

will or will not recommend that the fellow is able to graduate. A negative recommendation may be accompanied by a proposed remediation plan including the type of remediation the location and expected duration. If the plan extends beyond the end of the current training appointment a statement regarding employee status of the position (i.e. with/without compensation) will be attached. However, in cases where corrective action/remediation has already been attempted the decision will be final subject to the institutional due process procedure.

Certification of completion of the fellowship will be made by an approval vote from the Fellowship Training Committee. Following approval the Director of Wound Care Fellowship will issue to the Fellow a certification or diploma evidencing the successful completion of the fellowship.

### **3. Remediation**

Any Fellow who fails to perform satisfactorily in a rotation will be given the opportunity to remediate the deficiencies identified in the evaluation of any rotation where the overall assessment is minimally acceptable or deficient.

If the grade of minimally acceptable is received one of the following remediation methods will be used:

1. If the specific objectives which were graded below the director will emphasize those areas. If the Fellow performs satisfactorily in the areas in question the deficiency will be considered to have been satisfied.
2. Extra clinical and/or didactic work in the area will be assigned. The clinical work if needed will be worked into the fellow's schedule. The Fellow must obtain a satisfactory rating on the work assigned.

If the grade of deficient is received the following remediation method will be used:

Remediation will not extend beyond 3 months. Any Fellow still failing after that period will be dismissed without a certificate.

A written copy of these standards will be given to each fellow on or before the first day of training in that program, and a copy will also be filed with the Office of Graduate Medical Education. The policy shall spell out the method and frequency of evaluation for Fellow's in the training program.

### **4. Academic Evaluation**

- A. In addition to regular contact with supervisors, each Fellow will be evaluated in writing at least quarterly.
- B. The written evaluations will be placed in the Fellow's file, and will be available for review by the Fellow upon request.
- C. Supervisors are responsible for early detection of problems, and a remedial program must be established.

D. For any evaluation of less than satisfactory performance, for whatever reason, the program director will:

- a. Discuss the evaluation with the Fellow.
- b. Outline in written form and in the discussion any corrective action to be taken to remedy the deficiency, and how the Fellow will be evaluated to determine if the problem has been corrected.
- c. Notify the evaluation committee of the unsatisfactory evaluation.

E. The Fellow will be allowed to refute in writing any evaluation, which will be placed in the Fellow's file along with the evaluation.

F. The Wound Care Fellowship program will designate an evaluation committee. That committee will meet at least quarterly to review performance of all fellows. Any Fellow having performance difficulty may need to be placed on a special program immediately, so the problem can be resolved. The evaluation committee may make recommendations on corrective action as described below.

The Fellowship Evaluation committee: The Fellowship Evaluation Committee will be made up of the Director, at least one other member of the fellowship training committee appointed by the Director, and Administrative representation. The Committee shall be chaired by the Director unless (s)he has appointed another committee member to assume chairmanship. The committee will also review (self assess) the program on an annual basis and make recommendations to the Fellowship Training Committee regarding any needed changes or program enhancements. The committee will meet more frequently in cases where Fellows are having academic problems and will meet at least monthly when a Fellow is on academic probation. The committee will serve as the initial hearing body for any appeal of a Fellow evaluation.

G. It is the responsibility of each Fellow to secure evaluation forms and submit them to their supervisors. Failure to complete the evaluation form at the end of each rotation will result in disciplinary action

H. The Fellow will meet with the program director quarterly to review the accumulated written evaluations of the year's performance.

I. A final written evaluation will be done for each Fellow who completes the program, or changes to another program. That evaluation must include a review of the Fellow's performance during the final period of training and should verify that the Fellow has demonstrated sufficient professional ability to practice competently and independently. This Final evaluation should be part of the fellow's permanent record maintained by the Department.

## **5. Academic Probation**

Any Fellow who receives an unsatisfactory rating on any rotation or who is otherwise not performing in a satisfactory fashion, as defined by the program standards of performance, should be reviewed for corrective action. Such corrective actions can include repeating the year, a special program, which might include special supervision, or termination, if previous corrective action has not been successful, or academic probation in addition to any of the above. Each program will designate who has authority for instigating corrective action, i.e., the evaluation committee or the program director. The Director of Graduate Medical Education should be notified at this time.

The Fellow will have an opportunity to remediate unsatisfactory performance. The program will determine the length of the probationary period, and what must be accomplished in order for the Fellow to be removed from probation. In general, the probationary period will not extend past the end of the current agreement year, unless the agreement year ends within three months, in which case the program has the option of extending the probationary period into the next agreement year, but that extension shall not exceed three months. At the time the house officer / Fellow is removed from probation, the program has the option to:

1. Allow the Fellow to complete the remainder of the training year
2. Not Allow the Fellow to complete the remainder of the training year

Virtually all actions of a house officer/fellow in connection with the performance of duties relate to the suitability of the house officer/fellow as a medical practitioner. Therefore issues of integrity; abusive behavior to patients, the public, or other health professionals; tardiness or unexcused absences; theft or abuse of property, substance abuse, or insubordination, will be considered as part of the comprehensive academic evaluation.

### *Fellow Supervision*

Fellow Supervision Policy -- Summary of Main Points

#### **Key principles**

1. An attending physician must be identified for each episode of patient care involving a Fellow.
2. The attending physician is responsible for the care provided to these assigned patients.
3. The attending physician is responsible for determining the level of supervision required to provide appropriate training and to assure quality of patient care.
4. Fellow supervision must be documented.
5. The Program Directors directs and supervises the program.

## **Key supervision issues**

### **1. Attending physician/staff practitioner responsibilities**

#### **a. Inpatient**

- i. Attending physician is identified in the chart.
- ii. Meet with the patient within 24 hours of admission
- iii. Document supervision with progress note by the end of the day following admission.
- iv. Follow local admission guidelines for attending notification.
- v. Ensures discharge is appropriate.
- vi. Ensures transfer from one inpatient service to another inpatient service is appropriate.

#### **b. Outpatient**

- i. Attending physician is identified in the chart
- ii. Discuss patient with Fellow during initial visit -- Document attending involvement by either an attending note or documentation of attending supervision in the Fellows progress note.
- iii. Countersign note

#### **c. Emergency Room**

- i. An attending physician must always be available.

#### **d. Consultation**

- i. Discuss with Fellow doing consultation within 24 hours
- ii. Document supervision of consultation by the end of the next working day.

#### **e. Surgery/Procedures**

- i. Attending physician is identified
- ii. Attending meets with the patient before procedure/surgery

- iii. Documents agreement with surgery/procedures
- iv. Countersign procedure note

**f. Sign initial DNR orders and document compliance with local DNR policies**

**2. Program director/program coordinator**

- a. Establish and write program specific supervision policy
- b. Orientation for Fellows
- c. Education of attending physicians
- d. Implementation and follow--up of policy

***1. Policy For Supervision Of Wound Care Fellowship Trainees***

**I. Definitions:**

- a. Graduate Medical Education: Postgraduate medical education is the process by which clinical and didactic experiences are provided to fellow to enable them to acquire those skills, knowledge, and attitudes, which are important in the care of patients. The purpose of graduate medical education is to provide an organized and integrated educational program providing guidance and supervision of the Fellow, facilitate the fellow's professional and personal development, and ensure safe and appropriate care for patients. Graduate medical education programs focus on the development of clinical skills, attitudes, professional competencies, and an acquisition of detailed factual knowledge in a clinical specialty.
- b. Program Director: The Program Director is responsible for the quality of the overall affiliated education and training program in the Wound Care Fellowship and for ensuring the program is in compliance with the policies of the Council on Podiatric Medical Education.
- c. Fellow: The term "fellow" refers to individuals who are engaged in advanced postgraduate training program in podiatry.
- d. Attending Physician: Attending physician refers to licensed, independent physicians, who have been formally credentialed and privileged at the training site, in accordance with applicable requirements. The Attending physician may provide care and supervision only for those clinical activities for which they are privileged.
- e. Supervision: Supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the Fellow and to ensure the quality of care delivered to each patient by any Fellow. Such control is exercised by observation, consultation and direction. It includes the imparting of the

- practitioner's knowledge, skills, and attitudes by the practitioner to the Fellow and assuring that the care is delivered in an appropriate, timely, and effective manner.
- f. Documentation: Documentation is the written or computer--generated medical record evidence of a patient encounter. In terms of Fellow supervision, documentation is the written or computer--generated medical record evidence of the interaction between a supervising practitioner and a Fellow concerning a patient encounter.
  - g. Supervising Practitioner: Supervising Practitioner must provide an appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the Fellow and of the complexity of the patients' health care needs.

## **II. Policy:**

- a. In a health care system where patient care and the training of health care professionals occur together, there must be clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or staff. It is recognized that as Fellow trainees acquire the knowledge and judgment that accrue with experience, they will be allowed the privilege of increased authority for patient care.
- b. The hospital must comply with the institutional requirements and accreditation standards of the Joint Commission and other health care accreditation bodies. Qualified health care professionals with appropriate credentials and privileges provide patient care and provide supervision of Fellows.
- c. The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver that care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training for future health care professionals
- d. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician educator is the appropriate supervision of the Fellows as they acquire the skills to practice independently.
- e. The principles of good training and educational supervision are not likely to change radically over time. Rules governing billing and documentation, however, will inevitably evolve. This policy focuses on Fellow supervision from the educational perspective.
- f. CPME requirement: The fellowship program shall ensure that the fellow is afforded appropriate faculty supervision during all training experiences. This process is the underlying educational principal for all Wound Care Fellows. Clinician educators involved in this process must understand the implications of this principle and its impact on the patient and the fellow.
- g. The Wound Care Fellowship program must be approved by CPME (Council for Podiatric Medical Education) and have approval of the Graduate Medical Education (GME) committee.

## **Responsibilities:**

a. **Fellowship Program Director.** The Fellowship Program Director is responsible for the quality of the overall education and training program in Wound Care and for ensuring that the program is in compliance with the policies of CPME. The Fellowship Program Director defines the levels of responsibilities for the training year by preparing a description of the types of clinical activities Fellows may perform and those for which the a Fellow may act in a teaching capacity.

- i. Assess the attending physician's discharge of supervisory responsibilities. At a minimum, this includes written evaluations and interviews with the Fellows and other practitioners and other members of the health care team.
- ii. Structure training programs consistent with the requirements of CPME and the affiliated sponsoring entity.
- iii. Arrange for all Fellows entering the program to participate in an orientation to policies, procedures, and the role of Fellow within the affiliated training program
- iv. Ensure that Fellows are provided the opportunity to contribute to discussions in committees where decisions being made may affect their activities.

b. **Attending physician.** The attending physician is responsible for and must be personally involved in the care provided to individual patients in inpatient and outpatient settings as well as long--term care and community settings. When a Fellow is involved in the care of the patient, the responsible attending physician must continue to maintain a personal involvement in the care of the patient. The attending must provide an appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the Fellow and of the complexity of the patient's health care needs. The procedures through which the attending physician provides and document appropriate supervision is outlined below in section 5.

c. **Fellow.** The Fellow, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Each Fellow is responsible for communicating significant patient care issues to the attending physician. Such communication must be documented in the record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible attending physician may result in the removal of the Fellow from patient care activities.

## **III. Procedures:**

**Fellow Supervision by the attending physician.** Attending physicians are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of such responsibility requires

personal involvement with each patient and each Fellow who is providing care as part of the training experience. Each patient will be assigned an attending physician whose name will be clearly identified in the patient's record. It is recognized that other attending physicians may, at times, be delegated responsibility for the care of a patient and provide supervision instead of, or in addition to, the assigned practitioner. It is the responsibility of the attending physician to be sure the Fellow involved in the care of the patient are informed of such delegation and can readily access an attending physician at all times. Such a delegation will be documented in the patient's record. The attending physician is expected to fulfill this responsibility, at a minimum, in the following manner:

i. The attending physician will direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the Fellow being supervised. Medical, surgical or mental health services must be rendered under the supervision of the attending physician or be personally furnished by the attending physician. Documentation of this supervision will be by progress notes entered into the record by the attending physician or reflected within the Fellow 's progress note at a frequency appropriate to the patient's condition. The medical record must reflect the degree of involvement of the attending physician, either by staff physician progress note, or the Fellow 's description of attending involvement. . The fellow note shall include the name of the attending physician with whom the case was discussed as well as a summary of that discussion. The attending may choose to countersign and add an addendum to the Fellow note detailing his/her involvement and supervision. Pathology and radiology reports must be verified by an attending physician. Attending physicians will be responsible for following the admitting procedures required by the institutions at which they are admitting patients is association with Fellow.

ii. For patients admitted to an inpatient team, the attending physician must meet the patient early in the course of care (within 24 hours of admission including weekends and holidays). This supervision must be personally documented in a progress note no later than the day after admission. The attending physician's progress note will include findings and concurrence with the Fellow 's initial diagnosis and treatment plan as well as any modifications or additions. The progress note must be properly signed, dated, and timed. Attending physicians are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the trainee.

iii. Discharge from Inpatient Status. The attending physician, in consultation with the fellow, ensures that the discharge of the patient from an inpatient service is appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen; this may include physical activity, medications, diet,

functional status and follow-up plans. Evidence of this assurance must be documented by the attending physician countersignature of the discharge summary.

iv. Transfer from One Inpatient Service to Another, or Transfer to a Different Level of Care. The attending physician, in consultation with the Fellow, ensures that the transfer of the patient from one inpatient service to another or transfer to a different level of care is appropriate and based on the specific circumstances of the patient's diagnoses and condition. The attending physician from the transferring service must be involved in the decision to transfer the patient. The attending physician from the receiving service must treat the patient as a new admission and write an independent note or an addendum to the Fellow's transfer acceptance note.

v. Intensive Care Units (ICU), including Medical and Surgical ICUs. For patients admitted to, or transferred into an ICU the attending physician must physically meet, examine, and evaluate the patient as soon as possible, but no later than 24 hours after admission or transfer, including weekends and holidays.

vi. Out Patient clinic. All patients to the clinic for which the attending physician is responsible should be supervised by the attending physician. This supervision must be documented in the chart via a progress note by the attending physician or the Fellow 's note and include the name of the attending physician or cosigned by the attending. New patients should be supervised as dictated by graduated level of responsibility outlined for each discipline. The supervision for new patients should be documented by either independent attending physician note, an addendum to the Fellow's note or attending co-signature. Unless otherwise specified in the graduated levels of responsibility, new patients should be seen by and evaluated by the attending physician at the time of the patient visit. Return patients should be seen by or discussed with the attending physician at such a frequency as to ensure that the course of treatment is effective and appropriate. This supervision must be documented in the record via a note by the attending physician or the Fellow 's note that indicates the nature of the discussion with the attending physician. The medical record should reflect the degree of involvement of the attending physician, either by staff physician progress note or the Fellow 's description of attending involvement. The attending may choose to countersign and add an addendum to the Fellow's note detailing his/her involvement. All notes must be signed, dated, and timed by the Fellow. The Attending's co-signature of the Fellow's note is an acceptable method for the attending physician to document Fellow supervision.

viii. The attending physician is responsible for official consultations on each specialty team. When trainees are involved in consultation services, the attending physician will be responsible for supervision of these Fellows. The supervision of Fellows performing consultation will be determined by the graduated levels of responsibility for the Fellow. The attending physician must document this official consultation supervision by writing a personal progress note, by writing his/her concurrence with the Fellow consultation note or by co-signature by the close next

working day. The attending may choose to countersign and add an addendum to the Fellow note detailing his/her involvement.

ix. Emergency Department. An emergency department attending physician must be physically present in the emergency department. Each new patient to the emergency department must be seen by or discussed with an attending physician. The attending physician, in consultation with the Fellow, ensures that the discharge of the patient from the emergency department is appropriate.

x. Emergency room consultations. Emergency room consultations by Fellows may be supervised by a specialty attending physician or the emergency room attending physician. All emergency room consultations by Fellows should involve the attending physician supervising the Fellow 's discipline specific specialty consultation activities for which the consultation was requested. After discussion of the case with the discipline specific attending physician, the Fellow may receive direct supervision in the emergency room from the emergency room attending physician. In such cases where the emergency room attending physician is the principal provider of care for the patient's emergency room visit, the specialty specific attending physician does not need to meet directly with the patient. However, the specialty specific attending physician's supervision of the consultation should be documented in the medical record by co-signature of the consultation note or be reflected in the Fellow's consultation note.

xi. Assure all Do Not Resuscitate (DNR) orders are appropriate and assure the supportive documentation for DNR orders are in the patient's medical record. All DNR orders must be signed or countersigned by the attending physician.

**b. Assignment and Availability of Attending physicians.**

i. Within the scope of the training program, all Fellow, without exception, will function under the supervision of attending physicians. A responsible attending physician must be immediately available to the Fellow in person or by telephone and able to be present within a reasonable period of time (generally considered to be within 30 minutes of contact), if needed. Each discipline will publish, and make available "call schedules" indicating the responsible attending physician(s) to be contacted.

ii. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the Fellow in the ambulatory setting, it is expected that an appropriately privileged attending physician will be available for supervision during clinic hours. Patients followed in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.

iii. Facilities must ensure that their training programs provide appropriate supervision for all Fellows as well as a duty hour schedule and a work environment that are consistent with proper patient care, the educational needs of Fellows, and all applicable program requirements.

**c. Graduated Levels of Responsibility.**

i. Each training program will be structured to encourage and permit fellow to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment.

ii. As part of their training program, Fellows should be given progressive responsibility for the care of the patient. The determination of a Fellow 's ability to provide care to patients without a supervisor present or to act in a teaching capacity will be based on documented evaluation of the Fellow 's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the attending physician as to which activities the Fellow will be allowed to perform within the context of the assigned levels of responsibility. In general, however, Fellows are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, Fellows are allowed to certify and re-certify certain treatment plans (e.g., Physical Therapy) as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising practitioner over and above standard setting specific documentation requirements. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the attending physician.

iii. The Wound Care Fellowship Program Director will define the levels of responsibilities of training by preparing a description of the types of clinical activities fellows may perform and those for which fellows may act in a teaching capacity. The documentation of the assignment of graduated levels of responsibility will be made available to other staff as appropriate. These guidelines will include the knowledge, attitudes, and skills which will be evaluated in order to allow a Fellow to assume increased responsibilities.

**d. Supervision of Procedures.**

i. Diagnostic or therapeutic procedures require a high level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part of the education of the Fellow, such procedures may be performed only by Fellows with the required knowledge, skill, and judgment and under an appropriate level of supervision by attending physicians. Examples include operative procedures performed in the operating suite, angiograms, endoscopy, bronchoscopy, and any other procedures where there is the need for informed consent. Attending physicians will be responsible for authorizing the

performance of such procedures, and such procedures should only be performed with the explicit approval of the attending physician. NOTE: Excluded from the requirements of this section are procedures that, although invasive by nature, are considered elements of routine and standard patient care. Examples are the placing of intravenous and arterial lines, nail procedures, simple skin biopsies, injections, aspirations, wound debridement, and drainage of superficial abscesses.

ii. Attending physicians will provide appropriate supervision for the patient's evaluation, management decisions and procedures. For elective or scheduled procedures, the attending physician must evaluate the patient and write a pre-procedural note or addendum to the Fellow's pre-procedure note describing the findings, diagnosis, plan for treatment, and/or choice of specific procedure to be performed. This pre-procedural evaluation and note may be done up to 30 days in advance of the surgical procedure. All applicable JCAHO standards concerning documentation must be done. Other services involved in the patient's operative care (e.g., Anesthesiology) must write their own pre-procedure notes (such as for the administration of anesthesia) as required by JCAHO, but such documentation does not replace the pre-operative documentation required by the surgery attending physician.

iii. During the performance of such procedures, an attending physician will provide an appropriate level of supervision. Determination of this level of supervision is generally left to the discretion of the attending physician within the context of the previously described levels of responsibility assigned to the individual Fellow involved. This determination is a function of the experience and competence of the Fellow and of the complexity of the specific case.

**h. Emergency Situation.**

An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment of the health of a patient. In such situations, any Fellow, assisted by other clinical personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending physician will be contacted and apprised of the situation as soon as possible. The Fellow will document the nature of that discussion in the patient's record.

**i. Evaluation of Fellows and Supervisors.**

i. Each fellow will be evaluated according to CPME requirements on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior, and overall ability to manage the care of a patient. Evaluations will occur as indicated by the CPME at the end of the Fellow 's rotation or every six months, whichever is more frequent. Written evaluations will be discussed with the Fellow.

ii. If a Fellow 's performance or conduct is judged to be detrimental to the care of a patient(s) at any time, action will be taken immediately to ensure the safety of the patient(s).

iii. At least monthly, each Fellow will be given the opportunity to complete a confidential written evaluation of attending physicians and of the quality of the Fellow 's training. Such evaluations will include the adequacy of clinical supervision by the attending physician. The evaluations will be reviewed by the Administrator and summary results will be given to the Program Director.

iv. All written evaluations of Fellows and attending physicians will be kept on file by the Department of Surgery for the required time frame according to the guidelines established by CPME.

**j. Monitoring Procedures.**

i. The goal of monitoring Fellow supervision is to foster a system-wide environment of peer learning and collaboration among managers, attending physicians and Fellows. The monitoring process involves the use of existing information, the production of a series of evaluative reports, the accompanying process of public review of key findings, and discussion of policy implications. Monitoring of compliance with these procedures will be performed by the program director and as part of the scheduled internal program reviews.

ii. The basic foundation for fellow supervision ultimately resides in the integrity and good judgment of professionals (attending physicians and Fellows) working collaboratively in well-designed health care delivery systems.

## **VII. Sexual Harassment**

Sexual Harassment will not be tolerated by the Fellowship program. Sexual Harassment will be dealt with by the method prescribed in the Sexual Harassment policy of the institution where the problem occurred (policies available on request).

## VIII. Fellow logs

***Clinical log*** - *The Fellow is required to log all patients on Podiatry Residency Resource (podiatryrr.com). The cases will not be subject to MAV. Random audits of fellow's logs are conducted by the Program Director. The director at his/her sole discretion will determine the adequacy and completeness of the log. Repeated/chronic logging delinquency is grounds for dismissal without appeal. Any Fellow not completing their logs at the end of each quarter will be suspended without pay until the logs are completed.*

Activity log (didactics only) – Are kept on PRESENT ([www.podiatry.com](http://www.podiatry.com)) and each Monday must be current through the previous Friday. Failure to complete the assigned lectures for the week will result in suspension from program until assigned lecture is completed

## IX. Teaching conferences/Seminars

### **Wound Care Multidisciplinary Rounds (Podiatry, Vascular, Wound Care Team):**

8am Every Tuesday

### **Journal Club**

4pm Every Thursday

### **Grands Rounds**

Every Thursdays at 12pm

The Fellow should also participate in the teaching conferences and rounds provided by the services they collaborate with.

**The Fellow is required to give one grand rounds lecture/presentation per quarter (4 for the academic year) to include at a minimum internal medicine and dietary,**

### **Seminars:**

Fellow must attend at least one national wound care symposium e.g. DfCON, SAW, APPCA

Fellow are encouraged to attend seminars from the approved list below.

National APMA

Local APMA

Symposium of Advanced Wound care

Additional programs are also options but must be approved by the Training Committee.

## **X. Academic requirements for Fellows**

The following will be required of all Fellows in order to complete this fellowship:

1. One paper on a wound care or regenerative medicine related subject of a quality consistent for publication. Completed by prior to the end of the fellowship year.
2. Two formal (including audiovisuals and all relevant data) presentations of cases seen in the clinics suitable for inclusion in a teaching file.
3. Two lectures per year on topics in Wound Care and regenerative medicine suitable for presentation at Journal Club (including audiovisual aids etc.).
4. A minimum of twelve case presentations for Podiatry conferences (short audiovisuals optional).
5. Fellows are provided funds for educational purposes through CIR.

## **XI. Policies for Patient Relation**

### **A. Admission Procedure**

Patients are admitted to the hospital and assigned beds through the Admitting Office. The attending physician or Fellow calls these offices to make a reservation and to give the admitting diagnosis and other preliminary information. An H&P and admitting orders must be completed at the time of admission.

### **B. In Regard to Transfer of Patients**

After a patient has been admitted, transfer from one room to another is accomplished only through the Nursing Supervisor and/or Admitting Office. Transfers to other services require completion formal transfer orders and a transfer summary.

### **C. History and Physical Examination:**

All patients admitted to the hospital will be given a complete diagnostic workup is considered essential to a case. The history should be as complete as possible and should include.

- a. Chief complaint
- b. History of present illness
- c. Past medical history
- d. Social history
- e. 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 for the patient by the Fellow 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 stated facts. Pelvic examinations are not routinely done. If the particular case requires such an examination the Fellow should seek assistance from the physician responsible for this aspect of care.

#### **D. 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 data pertinent to the course of the disease. The frequent use of general statements such as "condition fair", "general condition, good", and "no complaints", is valueless. Progress notes should be written by the Fellow. A note should be written at least once a day on all patients. An admitting progress note is to be written by the attending physician. A Fellow 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 he leaves the case. The person coming on the service should carry on the progress notes from that time. All notes should be signed by the person writing the note and cosigned as necessary.

#### **E. Orders**

The Fellow can write orders for the patient. These orders may include necessary tests, therapy, etc. Orders changes by the Fellow should be discussed with the attending in a timely fashion.

#### **F. Consultations**

Any consultation requested by the medical staff is to be handled directly by the Fellow in consultation with an attending. Fellow s will be on call to aid the consulting podiatrist in the diagnosis and treatment of disorders. In accordance with the Fellow 's contract, the Fellow shall not be permitted to participate in professional or clinical work wherein others collect compensation for the Fellow 's services.

#### **G. Discharges**

When a patient is discharged, the attending physician writes the discharge except when the Fellow has been given responsibility of discharging podiatric patients on the attending podiatrist's authority. It is the Fellow 's responsibility to discharge the patient with the following:

1. Post-operative instructions.
2. Post-operative shoes, walker, or crutches.
3. Instructions to call the doctor's office for an appointment

4. Prescriptions for necessary medications. The Fellow should check with the attending podiatrist for types of medications preferred and/or special instructions. The Fellow is to dictate or record a discharge summary following the discharge.

### **Discharge Medications:**

The fellow may be asked to write prescriptions for discharge medications for the patient. The Fellow is to write for medications to last only until the patient returns for the first post-operative visit.

Any questions or problems concerning types or quantity of medication should be brought to the immediate attention of the appropriate Rotation Director or the Director of Fellowship Training or a member of the Fellowship Committee for discussion and action (if necessary).

The fellow must in every case of discharge against medical advice do the following, which should be noted on the discharge summaries:

Occasionally, a patient may become dissatisfied and wish to leave the hospital without his doctor's permission. The Fellow 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 a form or note indicating they left against medical advice 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 Fellow or nurse and witnessed. The attending physician must be notified immediately if at all possible. If the patient refuses to sign that fact must be documented by both the Fellow and the nursing staff.

### **H. Completeness and Accuracy**

The value of the medical record is directly proportional to the thoroughness and accuracy with which it is written. It should be remembered that any record may be summoned for legal use. All entries in the medical record must be complete and accurate. Both the efficient of handling patients and good teaching and medical research are dependent upon the degree of accuracy with which the records are prepared. Incorrect information is worse than none.

### **I. Corrections**

Erasures and blanked-out alterations on records are illegal and make the record valueless to the patient or 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. Correction to electronic medical records shall be made as an addendum to the note being corrected. Chart entries are permanent and must be in permanent ink. The original reports, not 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 certifying committees.

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 record; these may be written and attached to the outside of the chart, if desired.

### **J. Legibility**

All entries must be readable, 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 abbreviations which are in common usage in the medical profession in general.

### **K. Rules for Patient's Records**

Complete all information on each sheet of the chart and sign it, whether typed or handwritten, before the chart goes to the Medical Record Room. Sign all electronic notes in a timely fashion. Record all information about your patients fully, including progress noted. Avoid the addition of extraneous materials to the charts, and never use humor or flippancy. Records are not to be removed from Medical records except for brief periods to complete documentation. The following rules must be followed:

1. Must not be removed from the hospital.
2. Must not be taken to Fellow '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.
5. Electronic charts must be closed if you walk away from them.

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 Fellow or attending staff for reference or study with the Medical Records Librarian's knowledge and permission and in the case of research an IRB approval or waiver..
3. For use by other authorized hospital personnel upon request.
4. For use in court upon subpoena (copies only).
5. Never give a patient or anyone else a copy of any part of a medical record. The patient should be sent to medical records to sign an appropriate release form.

Any record may be requisitioned by a Fellow or attending staff for use within the hospital building for teaching purposes only. No record should be removed from Medical Records

without the knowledge of that department. Careful adherence to these regulations will facilitate the prompt location of records so that they may be made readily available when needed.

## **XII. Basic Hospital Charting**

### *Admitting Orders*

1. Admit Mrs. H, A. Smith to Hospital.
2. List diagnosis including medical diagnosis when appropriate.
3. Labs: SMA 12, CBC with differential, PT, UA, others as appropriate.
4. Chest X-rays, PA and lateral (as necessary).
5. Foot X-rays (as desired).
6. EKG (as necessary).
7. H & P and medical consult by Dr. Jones Admit.
8. Diet
  - a. Regular diet.
  - b. Special instructions to dietician (eg: 1800 calorie ADA diet for diabetics).
9. Dalmane 30 my po hs sleep (or sleep medication of choice).
10. NPO after midnight.
11. Sterile below the knee bone prep.
12. Dr. (list names of Fellow and assistant surgeon) may write orders and assist in management.
13. Signature and degree

You may desire to include other orders for completion pre-operatively such as incentive spirometry or crutch training. It should be remembered, however, that all pre-operative orders become completely and immediately invalidated the moment the patient enters surgery.

### *Admitting Note*

The chart of every patient admitted to the hospital should have an admitting note included in the chart.

1. Date of admission, time.

2. Mrs. I.P. Smith, age 54, is admitted to Hospital for surgical/medical treatment of (list admitting diagnosis).

3. History of present illness/chief complaint. (HPI of C/C)

a. Chief complaint

b. Location and duration

c. Previous therapy with effect

d. Type of conservative treatment and proposed surgery.

4. Past medical history (PMH)

a. Include serious illnesses-injuries

b. current medications

c. allergies.

d. past surgical history

e. review of systems

5. Full body examination including.

a. vital signs

b. biomechanical exam

6. Assessment and plan for all current medical and podiatric problems

7. Note any contraindications or state that no contraindications to surgery are evident.

8. Signature and degree.

### ***Postoperative Note***

Every hospitalized patient should have a post-op note recorded in the progress notes. This may be delegated to the Fellow. And, as always, all notations must be dated and timed.

1. Surgeon, 1st assistant, 2nd assistant

2. Pre-operative diagnosis

3. Post-operative diagnosis

4. Procedures performed

5. Primary anesthetic: agents, route of administration, and amount.

6. Injectable: (steroid, type of local at close of case).
7. Hemostasis: type (thigh cuff), pressure (250 mm Hg), time.
8. Materials: type of sutures, pins or wire, implants, drains.
9. EBL (estimated blood loss).
10. Pathology (eg: soft tissue sent for gross and micro).
11. Dressing, splint, or cast.
12. Complications.
13. The patient tolerated the procedure well and left the OR for the R.R. in apparent satisfactory condition (this summary statement should be altered if the procedure was not well tolerated or the patient was not in satisfactory condition). Note on new vascular status.
14. Signature and degree.

### ***Post-Operative Orders***

The following list is only an outline and should be modified to meet the specific needs of the patient or the preferences of the surgeon. Order writing maybe delegated to the Fellow but must be countersigned. In general, experts agree, surgeons tend to under medicate post surgical patients with insufficient analgesics. It is preferable to give a little more medication a little more often to abolish pain during the first day or two. Remember, all pre-op orders have been discontinued and must be rewritten.

1. Monitor vital signs q 15 min. until stable, then q shift.
2. Activity level (CBR - complete bed rest, BRP - bathroom privileges).
3. Diet (liquid to regular diet as tolerated).
4. Elevate FOB, dispense foot cradle.
5. I.M. analgesic (Demerol 50mg/Vistaril 50mg I.M. q 3-4h prn severe pain).
6. Oral analgesic (Tylox caps, po q 3-4h prn moderate pain).
7. Antiemetic (Trilafon 5 mg I.M. TID prn N/V).
8. Sleep medication (Dalmane 30 mg po hs prn sleep).
9. P.O. X-rays
10. Orders for any I.V., antibiotics, anti-inflammatories, or other medications.

11. Therapeutic adjuncts such as mini-heparinization, incentive spirometry, breathing exercises, physical therapy.
12. Notify Dr. of any unusual circumstances.
13. Signature and degree.

### ***Operative Report***

This is a report of operative findings and of the procedures used by the attending doctor during surgery, and it should be dictated immediately after the operation. Details may be overlooked if there is a delay in completing the report. The Fellow may dictate the operative report if he participated and was scrubbed in for the case. The following is a detailed explanation of the contents of the operative report. All points are important for an accurate report of operation.

1. Name - Spell out completely for identification and clarification.
2. Hospital number - This is also important for identification and clarification.
3. Surgeon - The actual surgeon who performed the procedure.
4. First assistant/other assistant - Mention of these names will insure that these individuals receive copies of the report for the records.
5. Type of anesthesia - Local or general.
6. Date - Actual date of surgery.
7. Preoperative diagnosis
8. Postoperative diagnosis
9. Procedure - The exact operative procedures used during surgery, designated by the site. For example: arthroplasty, left foot, 5th digit. Include all procedures.
10. Operation and findings - This, which is the main body of the report, should be concise but must be complete to alleviate confusion and verbose reports. It describes the following:
  - a. The prepping and draping.
  - b. Administration of local anesthesia including type and amount and manner, or administration of general anesthesia.
  - c. Type of hemostasis (cuff, etc.)
  - d. Type and length of incision.
  - e. The procedures used in relationship to the disease entity, using correct medical terminology.

- f. Any pathology related to the disease entity, using correct medical terminology
- g. All methods of closure, including type and suture material.
- h. Dressing.
- i. Condition of patient upon completion of surgery. The information on this report must be consistent, i.e., the post-operative original reports must be signed by the surgeon. To insure that a report has been dictated accurately, listen to the entire report before signing off or re-read the entire report before signing.

### ***Progress Notes***

The specific information that should be included in a proper progress note will be listed below. Many physicians prefer to use the SOAP method of recording progress notes. This technique aids the physician in organizing his thoughts and then expressing them in the chart. It also aids any other readers of the chart in following the findings and the intents of the attending physician. The SOAP method provides for four sections in a progress note. Each is designated by the representative letter. "S" = subjective findings, "O" = objective findings, "A" = assessment, and "P" = plan.

1. Date
2. Time
3. Patient's general condition or comments.
4. Medications/Allergies
5. Vital signs
6. Condition of bandages
7. LE exam
  - a. Neurovascular status of feet
  - b. Evaluation for DVT
  - c. Description of surgery site and or wound (if applicable)
8. Condition of lungs
9. Assessment of patient's progress
10. List proposed future plans for the patient or changes in treatment.
11. Note anything you did or said or anything the patient did or said that may be important to the case.
12. Sign with name and degree.

### **XIII. Medical Permit Information**

All fellows must obtain a New York State Permit/or New York State License prior to the start of the program. [www.op.nysed.gov](http://www.op.nysed.gov). Wound Care Fellow cannot start their program without an official affidavit from NYS permitting a Fellow to practice Podiatry in NYS. It is the Fellow's responsibility to procure this document and the required signatures. Any fellow, knowingly practicing without this document will be immediately terminated from the program and have the results of their termination be part of their permanent file and letters sent out to any entities.

### **XIV. Additional Program Information**

CPME requirements, Residency Resource, PRESENT (didactic lectures)

[CPME 820 – www.cpme.org](http://www.cpme.org)

[CPME 830 – www.cpme.org](http://www.cpme.org)

Residency Resource – [www.podiatryrr.com](http://www.podiatryrr.com)

Case logging

PRESENT – [www.podiatry.com](http://www.podiatry.com)

Didactic lectures

## **XV. Competencies**

The following are designed to give the Fellow graded experiences and responsibility in the management of patients and recognition and understanding of clinical entities. The Fellow will be given an educational program on the post-graduate level which will emphasize the basic and clinical sciences. Included are the competencies to be achieved in each training experience. The Fellow will be responsible to the attending physician(s) .

### ***General Surgery and Vascular Competencies***

#### **Competency:**

1. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examinations).
  - 1.1 vital signs
  - 1.2 head, eyes, ears, nose, and throat (HEENT)
  - 1.3 chest
  - 1.4 heart/lungs
  - 1.5 abdomen
  - 1.6 genitourinary
  - 1.7 rectal
  - 1.8 musculoskeletal
  - 1.9 neurologic examination
2. Assess and manage the patient's general medical status. Formulate an appropriate differential diagnosis of the patient's general medical problem(s).
3. Recognize the need for and the appropriate timing of additional diagnostic studies when needed, including:
  - 3.1 EKG
  - 3.2 Medical imaging studies including plain radiography, nuclear medicine imaging, CT, MRI, diagnostic ultrasound
  - 3.3 Laboratory studies including hematology, serology/immunology, blood chemistries, toxicology/drug screens, coagulation studies, blood gases, microbiology, urinalysis
4. Understands principles of perioperative management including fluid and electrolyte balance, pain management and blood and/or component therapy
5. Recognizes and demonstrates knowledge of conditions and problems that may be encountered in the management of the patient postoperatively including assessment of fever, postoperative infection, pulmonary function, fluid management, and gastrointestinal function
6. Understands management of the preoperative and postoperative surgical patient with an emphasis on complications.
7. Able to recognize intra-operative and/or postoperative complications and treatments available.
8. Understands surgical principles and procedures applicable to common pathologies of the human body.
9. Demonstrates proficient sterile techniques within the operating room.
10. Recognizes **at-risk surgical patients** and be knowledgeable of necessary precautions which should be employed.

11. Perform and interpret the findings of a thorough problem-focused vascular history and physical examination
12. Perform (and/or order) and interpret appropriate diagnostic studies including: vascular imaging and/or non-invasive vascular studies.
13. Perform (and/or order) and interpret appropriate diagnostic laboratory tests, including: hematology, blood chemistries, coagulation studies
14. Understands appropriate pharmacologic management in vascular surgery/medicine including peripheral vascular agents and anticoagulants
15. Understands the role of minimally invasive techniques such as angioplasty, stenting and atherectomy.
16. Formulate and implement an appropriate plan of management, including appropriate medical/surgical management when indicated for ulcerations or wounds.
17. Understands and develops knowledge regarding amputations of when/why to perform and at what level best performed.
18. Demonstrates an understanding of the diabetic patient and the effect of vascular disease in this patient population.
19. Understands the indications and different means of lower extremity bypass surgery in the vascular compromised patient.

### ***Infectious Disease Competencies***

#### **Competency:**

1. Performs and interprets the findings of a problem focused medical examination
2. Understands the indications and interpretation of common laboratory tests used to assess and manage patients with infectious diseases.
3. Demonstrates knowledge of the clinical signs and symptoms of infections in different parts of the body
4. Recognizes and understands the diagnosis and management of osteomyelitis.
5. Recognizes and understands the diagnosis and management of HIV and related pathology.
6. Understands the means of evaluating patient with hepatitis through clinical and laboratory methods.
7. Understands the means of evaluating clinically and through laboratory methods patients with other viral illnesses.
8. Demonstrates knowledge of the use, selection, indications, and adverse reactions of antibiotics
9. Appropriately interprets bacterial cultures, sensitivities, MIC/MBC studies

### ***Radiology Competencies***

#### **Competency:**

1. Recognize basic chest film pathology including: pulmonary edema, cardiomegaly, pneumonia, atelectasis, neoplasia
2. Recognize basic components of skeletal radiology via different imaging techniques including: Neoplasms, fractures, anatomic variants
3. Recognize the indications for additional imaging studies when indicated.
4. Understands the indications and advantages of different imaging modalities MRI vs. CT.
5. Recognizes the indications for CT and MRI imaging with and without contrast.

6. Recognize the principles and basics of interpreting MRI and CT images.
7. Recognizes the indications for and interprets nuclear medicine studies.
8. Recognizes the indications for and interprets diagnostic ultrasound studies.
9. Recognize the principles and basics of interpreting angiographic studies.

### ***Podiatric Medicine and Surgery Competencies***

#### **Competency:**

1. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by non-surgical (educational, medical, physical, biomechanical) and surgical means.
2. Perform and interpret the findings of a thorough problem-focused history and physical exam including:
  - 2.1 Vascular evaluation,
  - 2.2 Neurologic evaluation,
  - 2.3 Dermatologic evaluation,
  - 2.4 Biomechanical/musculoskeletal evaluation
3. Perform and interpret the findings of a comprehensive medical examination (including preoperative H&P) that includes: vital signs, HEENT, chest, heart, lungs, abdomen, genitourinary, rectal, neurologic, and musculoskeletal.
4. Perform (and/or order) and interpret appropriate diagnostic medical imaging studies including: plain radiography, nuclear medicine, CT/MRI.
5. Perform (and/or order) and interpret appropriate diagnostic laboratory tests including: hematology, pathology/microbiology [anatomic and cellular], serology, synovial analysis
6. Perform (and/or order) and interpret appropriate diagnostic studies including: electrodiagnostic and vascular studies.
7. Perform (and/or order) and interpret appropriate examinations including: biomechanical examination of the podiatric patient.
8. Prevent, diagnose, and manage diseases, disorders, and injuries of the pediatric and adult lower extremity by non-surgical (educational, medical, physical, biomechanical) and surgical means.
9. Formulate an appropriate diagnosis and/or differential diagnosis
10. Formulate and implement an appropriate plan of management with regards to anesthesia: Local, MAC, General for the podiatric surgical patient.
11. Appropriate closed management of pedal fractures and dislocations.
12. Appropriate closed management of ankle fracture/dislocation.
13. Formulate and implement an appropriate plan of management when necessary to perform injections and aspirations.
14. Appropriate pharmacologic management including the use of: NSAIDs, narcotics, antibiotics, antifungals, sedatives/hypnotics, muscle relaxants, laxatives, corticosteroids [ all either PO, IV/IM, Topical]
15. Formulate and implement appropriate medical/surgical management when indicated of an ulcer or wound
16. Formulate and implement appropriate medical/surgical management for skin lesions, including: excision or destruction of skin lesion (including skin biopsy and laser procedures).

17. Formulate and implement appropriate medical/surgical management for nail disorders including: nail avulsion or matrixectomy (partial or complete, by any means).
18. Formulate and implement appropriate medical/surgical management including repair for: **simple laceration** (no neurovascular, tendon, or bone/joint involvement) or **complex** (neurovascular, tendon, or bone/joint involvement).
19. Formulate and implement an appropriate plan of management in **digital surgery** including appropriate surgical management when indicated.
20. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **first ray surgery**
21. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **soft tissue foot surgery**
22. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **osseous foot surgery (distal to the tarsometatarsal joints)**.
23. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **osseous foot surgery of the midfoot**.
24. Formulate and implement an appropriate plan of management, including: appropriate surgical management when indicated, including: **reconstructive rearfoot and ankle surgery**.
25. Demonstrates knowledge and techniques in **internal and external fixation** especially as it applies to the foot and ankle
26. Formulate and implement an appropriate plan of management, including: appropriate consultation and/or referrals.
27. Able to assess the treatment plan and revise it as necessary including appropriate lower extremity health promotion and education.

### ***Podiatric Office/Clinical Competencies***

#### **Competency:**

1. Performs appropriate palliative management when indicated for: keratotic lesions and nail disorders.
2. Formulate and implement an appropriate plan of management including: footwear and padding when indicated for the podiatric patient
3. Formulate and implement an appropriate plan of management when indicated, including: orthotic, brace, prosthetic, and custom shoe management.
4. Formulate and implement an appropriate plan of management in the care of foot/ankle fractures/dislocations and sprains including: immobilization techniques of casting, splinting, and taping
5. Formulate and implement appropriate medical/surgical management when indicated including: debridement of ulcer or wound
6. Formulate and implement appropriate medical/surgical management when indicated, including: excision or destruction of skin lesion (including skin biopsy and laser procedures).
7. Formulate and implement appropriate medical/surgical management when indicated, including: nail avulsion or matrixectomy (partial or complete, by any means).
8. Appropriate management when indicated for manipulation/mobilization of the foot/ankle joint to increase range of motion/reduce associated pain.

9. Formulate and implement an appropriate plan of management when necessary to perform injections and aspirations.
10. Recommends appropriate pharmacologic management including the use of: NSAIDs, narcotics, antibiotics, antifungals
11. Formulate and implement an appropriate plan of management in **digital surgery** including appropriate surgical management when indicated.
12. Formulate and implement an appropriate plan of management in **first ray surgery**, including appropriate surgical management when indicated.
13. Formulate and implement an appropriate plan of management for **osseous surgery of the midfoot**, including appropriate surgical management when indicated.
14. Formulate and implement an appropriate plan of management for **reconstructive rearfoot and ankle surgery**, including appropriate surgical management when indicated.
15. Formulate and implement an appropriate plan of management, including appropriate: consultation and/or referrals.
16. Demonstrate understanding of common business and management practices as they relate to the podiatry office, including: understands health care reimbursement.

### ***Wound Care Management Competencies (Coney Island Hospital)***

**Competency:** To include *Knowledge* and *proficiency*

#### **The resident shall be *Knowledgeable* for the following:**

1. Performing complete patient evaluation including:
  - 1.1 history and physical examination,
  - 1.2 differential diagnosis, and
  - 1.3 rationale for proposed intervention.
2. Ordering laboratory and special examinations and interpretation of the results
3. Biomechanical evaluation of patients when appropriate.
4. Completion of charting and dictation.
5. Appropriate management of diabetic foot complications, including ischemic, neuropathic, and infectious processes.
6. Indications for total contact casting, use of Plastizote orthoses, and therapeutic splints and shoes
7. Indications for surgical management in diabetic or other ulcerative infections.
8. Indications for amputations such as partial foot amputation.
9. Debridement techniques and indications.
10. Wound care products, dressings and biologicals.

#### **The resident shall demonstrate *proficiency* for the following:**

11. Application and removal of total contact casts
12. Performance of complete physical examination of the lower extremity in diabetic patients to include orthopedic, vascular, neurologic, and dermatologic examinations.
13. Formulation of treatment plans for diabetic foot care patients.
14. Fabrication and adjustment of Plastizote insoles and fitting them to therapeutic shoes and splints.

15. Apply various compressive bandages.
16. Ordering and interpretation of the appropriate laboratory tests and results to include:
  - 16.1 complete blood count,
  - 16.2 chemistry profile , and
  - 16.3 urinalysis.
17. The ability to recognize ulcerative processes independent of diabetes such as:
  - 17.1 venous stasis,
  - 17.2 sickle cell anemia,
  - 17.3 lupus, and
  - 17.4 other vascularitic conditions.
18. Debridement technique.

### **c. Attitudinal and Other Non-Cognitive Competencies**

There are several competencies that by their very nature fit into the overall practice of medicine and do not reside in any one rotation. The content of this material is delivered and will be evaluated in the following areas. *These competencies apply to ALL rotations.*

#### **Competency:**

#### **Practice with professionalism, compassion, and concern in a legal, ethical, and moral fashion.**

1. Abide by state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), governing the practice of podiatric medicine and surgery.
2. Practice and abide by the principles of informed consent.
3. Understand and respect the ethical boundaries of interactions with patients, colleagues, and employees.
4. Demonstrate professional humanistic qualities.
5. Demonstrate ability to formulate a methodical and comprehensive treatment plan with appreciation of healthcare costs.

#### **Communicate effectively and function in a multi-disciplinary setting.**

1. Communicate in oral and written form with patients, colleagues, payors, and the public.
2. Maintain appropriate medical records.

#### **Manage individuals and populations in a variety of socioeconomic and healthcare settings.**

1. Demonstrate an understanding of the psychosocial and healthcare needs for patients in all life stages: pediatric through geriatric.
2. Demonstrate sensitivity and responsiveness to cultural values, behaviors, and preferences of one's patients when providing care to persons whose race, ethnicity, nation of origin, religion, gender, and/or sexual orientation is/are different from one's own.
3. Demonstrate an understanding of public health concepts, health promotion, and disease prevention.

**Understand practice management in a multitude of healthcare delivery settings.**

1. Demonstrate familiarity with utilization management and quality improvement.
2. Understand healthcare reimbursement.
3. Understand insurance issues including professional and general liability, disability, and Workers Compensation.
4. Understand medical-legal considerations involving healthcare delivery.

**Be professionally inquisitive, life-long learners and teachers utilizing research, scholarly activity, and information technologies to enhance professional knowledge and clinical practice.**

1. Read, interpret, and critically examine and present medical and scientific literature.
2. Collect and interpret data and present the findings in a formal study related to podiatric medicine and surgery.
3. Demonstrate information technology skills in learning, teaching, and clinical practice.
4. Participate in continuing education activities.

## SCHEDULE

The Fellow will begin with an orientation with the following services:

Infectious Disease  
 Pain Management / Rehabilitation  
 Vascular Surgery  
 Dietary  
 Radiology  
 Wound Care Nursing Team

Proposed Weekly Schedule (subject to change based on needs of Fellowship and patients)

Monday	Tuesday	Wednesday	Thursday	Friday
8am-10am Multidisciplinary Rounds with: Infectious Disease, Vascular, Podiatry, Social Work and the Wound Care Team  Vein/Ulcer Clinic	8am-4pm Direct Patient Care with the Wound Care Team	9am – 3pm  Wound Care Clinic	8am-12pm Direct Patient Care with the Wound Care Team  12pm Grand Rounds  1pm-4pm Direct Patient Care with the Wound Care Team  4pm Journal Club	8am-10am Direct Patient Care with the Wound Care Team  10am-12pm Patient interviews for IRB approved research  12pm – 4pm Direct patient care with the Wound Care Team

Each of the following services have didactic schedules which the fellow is encouraged to attend:

Infectious Disease  
 Pain Management / Rehabilitation  
 Vascular Surgery  
 Dietary  
 Radiology

# Coney Island Hospital Wound Care Fellowship

Dates: \_\_\_\_\_

Fellow: \_\_\_\_\_

Evaluator: Date & Signature: \_\_\_\_\_

### Legend for Competency Assessment

- 1 - Demonstrates inadequate knowledge of the task
- 3 - Performs only with constant direction.
- 5 - Performs the entire task independently

- 2 - Demonstrates knowledge but is unable to perform
- 4 - Performs with minimal direction
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam, including: problem focused history, neurologic examination, vascular examination, dermatologic examination, musculoskeletal examination						
Perform (and/or order) and interpret appropriate medical imaging: plain radiography, radiographic contrast studies, stress radiography, nuclear medicine imaging, MRI, CT						
Perform (and/or order) and interpret appropriate laboratory tests: hematology, serology/immunology, blood chemistries, microbiology, synovial fluid analysis urinalysis, anatomic and cellular pathology						
Perform (and/or order) and interpret appropriate other diagnostic studies: electrodiagnostic studies, non-invasive vascular studies						
Formulate an appropriate diagnosis and/or differential diagnosis						
Perform appropriate non-surgical management when indicated: palliation of keratotic lesions, palliation of toenails, manipulation/mobilization of foot/ankle joint(s), closed management of pedal fractures and dislocations, closed management of ankle fracture/dislocation						
Formulate and implement an appropriate plan of management: cast management, tape immobilization, orthotic, brace or prosthetic management, custom shoe management, footwear selection and/or modification, padding, injections, aspirations, physical therapy						
Perform appropriate pharmacologic management when indicated, including: NSAIDs, antibiotics, antifungals, narcotic analgesics, muscle relaxants, medications for neuropathy, sedative/hypnotics, peripheral vascular agents, antihyperuricemic/uricosuric agents, tetanus toxoid/immune globulin, laxatives/cathartics, corticosteroids, antirheumatic medications, topicals						
Formulate and implement an appropriate plan of management, when indicated, including: debridement of superficial ulcer or wound, excision or destruction of skin lesion including skin biopsy, nail avulsion (partial or complete), matrixectomy (partial or complete), repair of simple laceration, digital surgery, first ray surgery other soft tissue foot surgery, other osseous foot surgery (distal to the tarsometatarsal joints, and exostectomies), reconstructive rearfoot and ankle surgery						
Formulate and implement an appropriate plan of management, including: appropriate consultation and/or referrals, appropriate lower extremity health promotion and education, reassessment of the treatment plan with revision as necessary						
Demonstrates ability to formulate a methodical and comprehensive treatment plan with appreciation of health care costs						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

Fellow: \_\_\_\_\_

**Legend for Attitudinal Assessment**

1 - Never      2 - Some of the Time      3 - Most of the Time      4 - Always      N/A - Not Applicable

<b>Attitudinal and Regulatory Assessment</b>	1	2	3	4	N/A
Demonstrates primary concern for patient's welfare and well-being					
Abides by state, federal laws and hospital bylaws/rules and regulation governing the practice of podiatric medicine and surgery					
Practices and abides by the principles of informed consent					
Acts as a leader for the rest of the team					
Demonstrates a desire to teach junior residents and students					

**Please rate this Fellow's overall competence.**

- Deficient
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

Faculty comments: What do you find striking (negative or positive) about this fellow?

\_\_\_\_\_

\_\_\_\_\_

Fellow response (Circle one)    Accept      Accept with comment      Protest without action      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Infectious Disease**

Fellow: \_\_\_\_\_

Evaluator: Date & Signature \_\_\_\_\_

**Legend for Competency Assessment**

- 1- Demonstrates inadequate knowledge of the task
- 2- Demonstrates knowledge but is unable to perform
- 3- Performs only with constant direction.
- 4- Performs with minimal direction
- 5- Performs the entire task independently
- N/A- Not Applicable

<b>Competency</b>	1	2	3	4	5	N/A
Evaluation and management of patients with the following disorders: Skin and soft tissue infection, bone and joint infections, infections of prosthetic devices, infections related to trauma, sepsis syndrome, nosocomial infection						
Basic Knowledge of hospital epidemiology and infection control						
Basic knowledge of clinical microbiology						
Knowledge of dosing and monitoring of antibiotics						
Exposure to the techniques in the evaluation and management of the following disorders: Infections of reproductive organs, infections in solid organ transplant patients, infection in bone marrow transplant recipients, sexually transmitted diseases, viral hepatitis, including hepatitis B and C, infections in travelers, pleuropulmonary infections, cardiovascular infections, central nervous system infections, gastrointestinal and intra-abdominal infections, urinary tract infection, HIV infected patients with major impairment of host defenses						
By professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

<b>Attitudinal and Regulatory Assessment</b>	1	2	3	4	N/A
Demonstrates primary concern for patient's welfare and well-being					
Abides by state, federal laws and hospital bylaws/rules and regulation governing the practice of podiatric medicine and surgery					
Practices and abides by the principles of informed consent					
Acts as a leader for the rest of the team					
Demonstrates a desire to teach junior residents and students					

**Please rate this Fellow's overall competence.**

- Deficient
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

Faculty comments: What do you find striking (negative or positive) about this fellow?

\_\_\_\_\_

Fellow response (Circle one)    Accept    Accept with comment    Protest without action    Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Radiology

Fellow: \_\_\_\_\_

Evaluator: Date & Signature \_\_\_\_\_

**Legend for Competency Assessment**

- 1- Demonstrates inadequate knowledge of the task
- 2- Demonstrates knowledge but is unable to perform
- 3- Performs only with constant direction.
- 4- Performs with minimal direction
- 5- Performs the entire task independently
- N/A- Not Applicable

Competency	1	2	3	4	5	N/A
Interpret appropriate diagnostic studies, including medical imaging, including: plain radiology						
Perform and/or interpret appropriate diagnostic studies, including : medical imaging, radiographic contrast studies, stress radiology						
Interpret appropriate diagnostic studies, including: medical imaging, bone mineral densitometry, nuclear medicine imaging, MRI, CT, diagnostic ultrasound						
Recognize the need for additional diagnostic studies, when indicated, included: medical imaging, including: plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound, other diagnostic studies						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

Attitudinal and Regulatory Assessment	1	2	3	4	N/A
Demonstrates primary concern for patient's welfare and well-being					
Abides by state, federal laws and hospital bylaws/rules and regulation governing the practice of podiatric medicine and surgery					
Practices and abides by the principles of informed consent					
Acts as a leader for the rest of the team					
Demonstrates a desire to teach junior residents and students					

**Please rate this Fellow's overall competence.**

- Deficient
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

Faculty comments: What do you find striking (negative or positive) about this fellow?

\_\_\_\_\_

\_\_\_\_\_

Fellow response (Circle one)    Accept    Accept with comment    Protest without action    Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coney Island Hospital Wound Care Fellowship

# Vascular Surgery

Fellow: \_\_\_\_\_

Evaluator: Date & Signature \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 2 - Demonstrates knowledge but is unable to perform
- 3 - Performs only with constant direction.
- 4 - Performs with minimal direction
- 5 - Performs the entire task independently
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Assess and manage the patient's general medical status. Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: Problem focused medical history.						
Perform and interpret the findings of a comprehensive medical history and physical examination (including preoperative history and physical examination), including: problem focused physical examination, including: vital signs, head, eyes, ears, nose, and throat, neck, chest/breast, heart, lungs, abdomen, genitourinary, rectal, upper extremities, neurologic examination						
Assess and manage the patient's general medical status. Formulate an appropriate differential diagnosis of the patient's general medical problem(s)						
Assess and manage the patient's general medical status. Recognize the need for (and/or orders) additional diagnostic studies, when indicated, including: EKG, plain radiography, nuclear medicine imaging, MRI, CT, diagnostic ultrasound						
Assess and manage the patient's general medical status. Formulate and implement an appropriate plan of management, when indicated, including: appropriate therapeutic intervention. Prevent, diagnose, and manage diseases, disorders, and injuries of the adult lower extremity by nonsurgical (educational, medical, physical, biomechanical) and surgical means. Perform and interpret the findings of a thorough problem-focused history and physical exam, including: problem-focused history						
Perform and interpret the findings of a thorough problem-focused history and physical exam, including: vascular examination						
Order and interpret appropriate diagnostic studies, including: medical imaging, including: vascular imaging						
Perform (and/or order) and interpret appropriate diagnostic studies, including: laboratory tests, non-invasive vascular studies, appropriate non-surgical management when indicated, including: pharmacologic management						
Formulate and implement an appropriate plan of management, including: appropriate medical/surgical management when indicated						
Be professionally inquisitive, lifelong learners and teachers utilizing research, scholarly activity and information technologies to enhance professional knowledge and clinical practice. Reads, interprets, critically examines, and presents medical and scientific literature						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

Attitudinal Assessment	1	2	3	4	N/A
Accepts criticism constructively					
Acts as a patient advocate, involving the patient/family in the decision-making process					
Communicates effectively with colleagues and staff					
Communicates effectively with the patient/family, recognizing their concern for safety, comfort, and medical necessity					
Provides high quality, comprehensive care in an ethical manner					
Demonstrates moral and ethical conduct					
Respects and adapts to cultural differences					
Establishes trust and rapport with patients and peers					
Demonstrates primary concern for patient's welfare and well-being					

Vascular Surgery

Fellow: \_\_\_\_\_

**Please rate this Fellow's overall competence.**

- Deficient
- Acceptable for level of training
- Minimally acceptable: some remediation needed
- Outstanding for level of training

Faculty comments: What do you find striking (negative or positive) about this Fellow?

\_\_\_\_\_  
\_\_\_\_\_

Fellow response (Circle one)    Accept            Accept with comment            Protest without action            Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_

# Wound Care Management

Fellow: \_\_\_\_\_

Evaluator: Date & Signature \_\_\_\_\_

**Legend for Competency Assessment**

- 1 - Demonstrates inadequate knowledge of the task
- 2 - Demonstrates knowledge but is unable to perform
- 3 - Performs only with constant direction.
- 4 - Performs with minimal direction
- 5 - Performs the entire task independently
- N/A - Not Applicable

Competency	1	2	3	4	5	N/A
Performs complete patient evaluation including: history and physical examination, differential diagnosis, and rationale for proposed intervention						
Performs complete physical examination of the lower extremity in diabetic patients to include orthopedic, vascular, neurologic, and dermatologic examinations						
Orders laboratory and special examinations and interpretation of the results						
Biomechanical evaluation of patients when appropriate						
Appropriate management of diabetic foot complications, including ischemic, neuropathic, and infectious processes						
Understands indications for total contact casting, use of Plastizote orthoses, and therapeutic splints and shoes						
Understands indications for surgical management in diabetic, other ulcerative infections, and amputations such as partial foot amputation						
Knows debridement techniques and indications						
Formulates treatment plans for diabetic foot care patients						
Completes charts and dictation in a timely manner						

**Legend for Attitudinal Assessment**

- 1 - Never
- 2 - Some of the Time
- 3 - Most of the Time
- 4 - Always
- N/A - Not Applicable

Attitudinal Assessment	1	2	3	4	N/A
Accepts criticism constructively					
Acts as a patient advocate, involving the patient/family in the decision-making process					
Communicates effectively with colleagues and staff					
Communicates effectively with the patient/family, recognizing their concern for safety, comfort, and medical necessity					
Provides high quality, comprehensive care in an ethical manner					
Demonstrates moral and ethical conduct					
Respects and adapts to cultural differences					
Establishes trust and rapport with patients and peers					
Demonstrates primary concern for patient's welfare and well-being					

Please rate this fellow's overall competence.

- Deficient
- Minimally acceptable: some remediation needed
- Acceptable for level of training
- Outstanding for level of training

Faculty comments: What do you find striking (negative or positive) about this fellow?

\_\_\_\_\_

\_\_\_\_\_

Fellow response (Circle one):    Accept                      Accept with comment                      Protest without action                      Appeal

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Director on:

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Evaluation of Services- Coney Island Hospital Wound Care Fellowship**

Fellow's name \_\_\_\_\_

**Name of Service** -(check appropriate box)

- |   |   |
|---|---|
| <input type="checkbox"/> Infectious Disease             | <input type="checkbox"/> General Surgery and Vascular |
| <input type="checkbox"/> Podiatric Medicine and Surgery | <input type="checkbox"/> Internal Medicine            |
| <input type="checkbox"/> Radiology                      | <input type="checkbox"/> Wound Care (Winthrop)        |
| <input type="checkbox"/> Office and Clinical            | <input type="checkbox"/> Wound Care (Coney Island)    |
| <input type="checkbox"/> Pain Management                |   |

Please evaluate this service based on the criteria below.

The service has available education: clinical lectures, journal clubs, or clinical pathology conferences

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

5. The patient exposures are:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

6. The organization of this service is:

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

**What are the strengths of the service?**

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What are the weaknesses of the experience?**

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fellow's Signature \_\_\_\_\_ Date \_\_\_\_\_

Fellowship Director's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Glenn Donovan, DPM

**Program Evaluation - Coney Island Hospital Wound Care Fellowship**

The Fellow will evaluate the effectiveness and organization of the program.

Fellow's name: \_\_\_\_\_ Date \_\_\_\_\_

1. The planning and organization of the program is appropriate for the goals and competencies.

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

2. The resources of the program are adequate to accomplish the program goals and competencies.

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

3. The program is having a positive effect on students and residents.

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

4. The program is having a positive effect in the care of patients.

<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
<b>Excellent</b>	<b>Very Good</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
*****				

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the strengths of the program? (Circle all that apply)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the weaknesses of the program? (Circle all that apply)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommendations for improvement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fellow's Signature \_\_\_\_\_ Date \_\_\_\_\_

***Fellow Acknowledgement***

I have received the Coney Island Hospital Wound Care Fellowship manual. I understand that the manual is subject to change annually and at other times given reasonable notice and I agree to abide by the policies and procedures delineated in the manual and any subsequent changes.

Please sign that you have received the manual.

Received Date: \_\_\_\_\_

Wound Care Fellow Signature: \_\_\_\_\_