



**University of Nevada School of Medicine
Department of Surgery**

SYLLABUS

SURGERY CLERKSHIP

2009-2010

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WELCOME

First of all, welcome to your Surgery Clerkship. We hope we will teach you much of what you need to know about surgery in order to be a good and safe physician, regardless of specialty choice. Our faculty, residents and fellows are dedicated to teaching.

Clerkship activities occur at three sites: the University Medical Center (UMC), the Veterans Affairs System in Las Vegas and the Veterans Affairs Sierra Nevada Health Care System, Reno (VA SNHCS, Reno). These three medical facilities offer differing and complementary components to the surgical clerkship, but the clerkship requirements, faculty, textbooks, priorities, evaluations, and goals remain constant throughout the rotation.

Our Department of Surgery website address is:

www.medicine.nevada.edu/residency/lasvegas/surgery . Exploration of this site will provide some information about the academic, clinical, and research interest of our faculty as well as our Residency, Clerkship, and Research Programs. The Surgery Clerkship Syllabus can be found under the student section of the Department of Surgery website.

DEPARTMENT CONTACT NUMBERS

CHAIRMAN

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CLERKSHIP COORDINATORS

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FACULTY AND FELLOWS - LAS VEGAS	
LAS VEGAS FACULTY	TEAM*
Annabel Barber, MD (General)**	UMC1
Jennifer Baynosa, MD** (General)	UMC1
Richard Baynosa, MD**	Hand Fellow
Neri Blanco, MD	UMC2
Leslie Browder, MD (General/Colorectal)**	UMC2
Tim Browder, MD **	Trauma/CC/UMC1
Michael Casey, MD**	Trauma/CC/UMC1
Annie Cheanvechai, MD	Vascular
Jay Coates, DO**	Trauma/CC/UMC1
Dylan Curry, MD (Desert West Surgery)	UMC1
Neel Dhudshia, MD	UMC3/Cardiac & Vascular
Harry Donias, MD	UMC3/Cardiac & Vascular
Cassandra Joffs-Dunn, MD (General)	LVVA
Kevin Dunn, MD (General)	LVVA
Alexander Feliz, MD**	Pediatric Surgery
John Fildes, MD**	Trauma/CC/UMC1
John Gosche, MD, PhD**	Pediatric Surgery
Craig Iwamoto, MD (Desert West Surgery)	UMC1
Elijah Johnson, MD (Desert West Surgery)	UMC1
Zane Kelly, DO**	Surgical Critical Care Fellow
Kayvan Khiabani, MD (Hand) Plastics**	Specialty
Daniel M. Kirgan, MD (Surgical Oncology)**	UMC1
Deborah Kuhls, MD**	Trauma/CC/UMC1
Pratibha Lal, MD	LVVA
Terry Lewis, MD (Desert West Surgery)	Trauma/UMC1
James Lovett, MD (Desert West Surgery)	UMC1
Eddie Luh, MD	UMC2

Ken McIntyre, MD (Vascular)**	LVVA/UMC3
John Menezes, MD (Plastics)**	Specialty
Shawn Nessen, DO**	Surgical Critical Care Fellow
Tsungju O-Lee, MD (ENT)**	Specialty
Juanne Osigweh, MD**	Acute Care Surgery Fellow
Nathan Ozobia, MD	Trauma/UMC2
Vincente Narciso, MD	LVVA
Matthew Ng, MD (ENT)**	Specialty
Lee Reese, MD (Desert West Surgery)	UMC1
Kelly Rippey, MD**	Acute Care Surgery Fellow
Himansu Shah, MD (Plastics)	LVVA
Frederick Schechter, MD (Thoracic)	LVVA
Gary Shen, MD (Transplant/General)**	UMC3
Joseph Thornton, MD (General/Colorectal)**	UMC2
Shawn Tsuda, MD**	UMC2
Robert Wang, MD (ENT)**	Specialty
Wei Wang, MD**	Research
Wydell Williams, MD (Desert West Surgery)	UMC2
William A. Zamboni, MD (Plastics)**	Chairman, Depart. of Surgery, Specialty Serv.
Las Vegas Teams: UMC1 (General, UNSOM, Desert West), UMC2 (General, Minimally Invasive, Private), UMC3 (General, CVT, Vascular and Transplant), Specialty (Plastics, ENT), Trauma/Critical Care ** Full-Time Faculty	

FACULTY AND FELLOWS - RENO	
RENO FACULTY	TEAM
Patricia Eubanks May, MD**	General
Michael Gainey, MD	General
John Haller, MD	General
Mitzi Miller, MD	Cardiothoracic
John Ryan, MD	Vascular
Anthony Twite, MD	Ortho

OBJECTIVES OF SURGERY CLERKSHIP

1. **A broad knowledge of the surgical implications of and current therapy for benign and malignant diseases of:**

*** Denotes Focus of your initial general surgery reading**

- a. The esophagus
- b. The stomach and duodenum
- c. The small and large intestine, rectum, anus, and appendix *
- d. Hernias, all types including inguinal, umbilical, ventral, femoral and other types *
- e. The pancreas, gall bladder, biliary tract, liver, and spleen *
- f. The thyroid, parathyroid, larynx, pharynx, and oral cavity
- g. The breast *
- h. The cardiac and vascular systems, including aorta, carotid and peripheral vascular
- i. The skin, soft tissues, and bone
- j. The lung and the pleural cavity
- k. Endocrine systems including adrenal, pancreas, thyroid and parathyroid
- l. Evaluation and resuscitation of patients with traumatic injury utilizing concepts in the TEAM book.
- m. Overview of ENT, Orthopedic Surgery, Neurosurgery, Urology, plastic surgery
- n. Pediatric diseases of the abdomen and chest including congenital anomalies.

2. **Knowledge of general topics that relate to the care of surgical patients, including the following:**

- a. Preoperative evaluation of patients
- b. Common post-operative surgical complications, including wound complications
- c. Wound healing
- d. Evaluation and treatment of the acute abdomen *
- e. Coagulopathy
- f. Nutrition, its assessment and provision
- g. Pain control following surgery
- h. Fluid and electrolytes
- i. DVT prophylaxis and treatment
- j. Indications for transfusion of packed red blood cells and other blood products
- k. Transplantation
- l. Types of shock diagnosis and treatment
- m. Burns, including evaluation and resuscitation
- n. Infections and appropriate antibiotic use
- o. Cancer
- p. Management of critically ill patients, including ventilator management, indications for invasive monitoring, including central and arterial line, and pulmonary artery monitoring

3. **Competency in the following areas that relate to patient care and surgical technique:**

- a. A history and examination of surgical patients with abdominal, breast, vascular, soft tissue pathology
- b. Develop list of appropriate differential diagnoses, develop plans, and work-up of

- potential surgical diseases of the abdomen, chest, soft tissue and breast
- c. Admission orders, daily progress or “soap” notes, preoperative notes, post-operative notes, critical care note.
 - d. Present a surgical and critical care patient on rounds.
 - e. Placement of IVs, placement of Foley catheters
 - f. Management of surgical drains, tubes, catheters, tracheostomy, NG Tube
 - g. Understand management of surgical wounds and demonstrate basic techniques.
 - h. Assist with Chest Tube Insertion and Removal
 - i. Assist with Central Line, Arterial Line insertion, Femoral Venipuncture
 - j. Proficiency in simple interrupted and running suture techniques
 - k. Understand basic principles of laparoscopic surgery, ability to drive camera.
 - l. Understand and demonstrate principles of sterile technique, universal precautions and universal protection technique.
 - m. Identification of key surgical equipment and function.
 - n. Understand components of patient safety in surgical procedures
 - o. Key principles of giving bad news to patients.

4. INTERPERSONAL COMMUNICATION SKILLS

- a. Ability to present a complete history and physical.
- b. Ability to present patient on daily ICU and non ICU team rounds.
- c. Ability to work with the surgical team including non-physician healthcare providers in the supervised care of assigned surgical patients.
- d. Ability to interact with patients and family members in a professional manner in a variety of patient related settings including in-patient and out-patient.

CLERKSHIP CURRICULUM

Orientation

Students will be expected to attend orientation on the first day of their surgery rotation. Students beginning their surgery rotation in Reno will attend by Pictel. During orientation, we will cover:

1. The structure of the clerkship, including conferences, rotation schedules; review syllabus
2. Surgical teams, including resident, attending and student roles
3. Administrative paperwork will be completed for UMC and the LV VA
4. Call schedules and responsibilities; other schedules
5. Weekly lecture and conference schedules, including self-study Wise MD modules with post tests due weekly
6. Surgical Histories and Physicals, daily notes, including critical care notes.
7. Introduction to surgical scrub and sterile technique unless previously covered by OB/GYN
8. Introduction to patient safety measures and considerations on surgical services
9. Hands-on suture lab (May be done separately at Reno VA)
10. Introduction to evaluating patients with abdominal pain
11. Introduction to key critical care topics
12. Student selection of a surgery student liaison
13. Patient and other logs.

Weekly Lecture and Conference Schedule

Every Friday Gloria Brown will be emailing you a schedule for the next week. This schedule will

include lectures which are available to students in Reno by Pictel. **ALL students are expected to attend lectures.** The only exceptions are for rare surgeries like a Whipple procedure, open AAA, total thyroidectomy that you may not have an opportunity to see again. If you are going to miss a lecture it needs to be **approved by Gloria Brown, Dr. Kuhls, or Dr. Baynosa.** If you have any questions, call Gloria Brown, Dr. Kuhls, or Dr. Baynosa.

Case Conferences

Several General Surgery Case Conferences will be scheduled during the twelve weeks where **students** present clinical cases via Power Point. The surgery student liaison will organize these conferences. Cases are presented beginning with the patient's initial presentation, with key H&P findings, review of labs, radiologic images and, most importantly, developing a logical differential diagnosis at each step along the process of patient evaluation. The discussion will emphasize problem-based learning, development of differential diagnoses and diagnostic approaches to identify the most likely diagnosis. Appropriate surgical decision-making and intervention will be emphasized. Students on general surgery rotations at UMC and VAMC's will be responsible for choosing general surgery cases. All students are expected to attend Case Conferences, and these are typically scheduled during the middle six weeks when all students are in Las Vegas.

Location-Specific Conferences

1. **All Las Vegas Services.** All students in Las Vegas are expected to attend Morbidity and Mortality Conference (M&M) each Tuesday at 8am on the 6th floor of the 2040 W. Charleston Blvd building. Additional hours of resident teaching follow, some of which is appropriate for students and will be included on your weekly schedule. On the first Tuesday of each month, Surgical Grand Rounds is at 8am, followed by M&M. Resident lectures follow M&M and we will indicate which of those you should attend. Once a month, Evidenced Based Reviews in Surgery (EBRS) is scheduled during the educational time. The week before, Gloria will send the articles for you to read before the lecture. In addition, each service has its own conference schedule.
2. **Reno and Las Vegas VA Services.** VA facilities also have their own M&M and other conferences. (See appendices).
3. **Trauma and Critical Care Services.** Students on this rotation will have Trauma Morning Report, where interesting trauma cases are discussed each Wednesday from 11-12 noon. On Thursday there is a trauma lecture from 11-12 noon and on Friday there is a critical care lecture from 11-12 noon. All are held in the classroom in the Trauma Resuscitation area. Attending teaching rounds occur daily in the ICU beginning at 8:30 am.
5. **UMC General Surgery Services.** You will be expected to attend at least one Wednesday morning Cath Lab Conference on the 6th floor of the 2040 Building. In this conference, cardiologists, cardiothoracic surgeons and others participate in a discussion of how to manage individual patients who have significant cardiac pathology that has the potential for surgical intervention. **Attending teaching rounds** for UMC1 and UMC2 are held each Thursday at 7:00 am. Students may ask to present patients.
6. **Interdisciplinary Grand Rounds in Las Vegas.** On the third Tuesday of each month Interdisciplinary Grand Rounds are scheduled in Las Vegas. All students on rotations at UMC are required to attend.

Attending Teaching Rounds

Teaching Rounds are conducted on several surgical services and students participate in these. These are typically multi-disciplinary walk rounds, where a problem-based learning approach is

utilized. Residents and students are expected to present patients and discuss relevant clinical medical problems. Chief residents conduct work rounds daily on each service and are expected to include resident and medical student teaching. Morning attending rounds are conducted at each VA location.

ROTATIONS/OUTPATIENT EXPERIENCES

The twelve week surgery clerkship is divided into four three week rotations, as follows:

1. UMC 1 and 2 - General Surgery; UMC3 - Cardiothoracic, Vascular Surgery, and Transplant
2. Trauma Surgery and Surgical Critical Care
3. Specialty Service, which emphasizes Plastic Surgery including facial reconstruction, hand surgery non-facial reconstruction, burns, cosmetic surgery, and ENT.
4. VA and Pediatric Surgery
 - Reno VA, (three week rotation) which emphasizes General Surgery and Vascular Surgery. Other specialty surgery opportunities are available. Speak with your Site Coordinator, Dr. May. Students who complete their VA experience at the Reno VA will be assigned time with pediatric surgeons during their UMC3/Pediatric Las Vegas rotation.
 - Las Vegas VA (two week rotation) which emphasizes General Surgery and Vascular Surgery. Other specialty surgery opportunities are available. Speak with your Site Coordinator, Dr. McIntyre. Students who complete their VA rotation in Las Vegas will rotate for one week in Pediatric Surgery.

Other Specialty Experiences

If you have specific surgical interests that are not specifically addressed in the syllabus, please see Dr. Kuhls, Dr. Baynosa or Gloria Brown. We will make every attempt to accommodate your interests.

1. **Transplant** experience consists of kidney transplants and multiple organ harvests on patients donating organs. The UMC3 Service handles organ transplants and renal dialysis access. Students should coordinate their surgical experience so that as many students as possible participate in a kidney transplant and organ harvest. Additionally, while students are on General Surgery call, they should scrub into all organ harvests and/or organ transplants.
2. **Orthopedic Surgery, Neurosurgery, and Burns**: While you are on Trauma/Critical Care you are ***encouraged to participate in specialty surgery on trauma patients***, such as orthopedic surgery, neurosurgery, ophthalmology and others. Private Trauma Attendings and UNSOM plastic surgery faculty admit burn patients. There are opportunities to evaluate acute burn patients and to scrub on burn surgeries while on Trauma or Specialty Service. Your Senior Resident on Trauma and your specialty service residents will know the schedule. Additionally, Specialty Service admits burn patients several days per month.
3. **Open Heart and Thoracic Surgery**. During your UMC general surgery rotations, each student is expected to participate in at least one open heart surgery and other UMC3 cardiothoracic or vascular cases. Please check the OR schedule that is posted at approximately 7 pm for the next day. Your chief resident can help identify cases and introduce you to cardiothoracic surgeons.

Clinics and Attending Private Office Hours – One on One Time with Attending

During UMC1, UMC2, Specialty, Pediatric and Trauma rotations you will be assigned to outpatient private office hour experiences at the PCC *specifically for students*. Residents do not

attend these office hours, so these give you one-on-one time with attending surgeons. In addition, most rotations have several clinics that students, residents and Attendings attend.

1. UMC1 Students - Dr. Kirgan's multi-disciplinary Oncology Clinic with the Residents on Thursdays at 9:00 am on the 5th floor at UMC, main hospital. (UMC2 students are also welcome to attend)

UMC 1 General Surgery Clinic is scheduled every Tuesday at 2:00 pm at TLC.

H & P Clinic is scheduled every Friday at 8:30 am at TLC.

2. UMC2 Students

Dr. Thornton and Dr. L. Browder have office hours every Tuesday and Thursday in Suite 160, Patient Care Center. Gloria will specify on your schedule when you are to participate in the office hours.

UMC2 General Surgery Clinic is scheduled every Thursday at 1:00 pm at TLC.

H & P Clinic is scheduled every Friday at 8:30 am at TLC.

3. UMC3 Students

UMC3 students will rotate on service with the UMC3 residents. During this week the students will also spend one clinic with either Dr. Gosche or Dr. Feliz and spend one day in the operating room with them. During this week students are expected to cover all vascular, cardiothoracic, and transplant cases.

Gloria will specify on your schedule when you are to participate in office hours and which day in the operating room with the pediatric surgeon.

4. Pediatric Surgery

Dr. Feliz has scheduled surgery blocks on Thursdays and Dr. Gosche has scheduled surgery blocks on Fridays. Students will have the opportunity to participate in those surgeries and attend their clinics while on their Pediatric/UMC3 week.

5. Specialty Students –Students on Specialty Service will be assigned to ENT private office hours and TLC Clinics. ENT books are available to be checked out from Gloria.

All Specialty students should also attend Plastics Clinic in BCU on Wednesday at 10:00 am.

In addition, one student will be assigned to attend each of Dr. Zamboni's office hours, and one of either Drs. Menezes or Khiabani's office hours during the three week rotation. Their private office hours are held in Suite 190, Patient Care Center, phone 671-5110.

CALL RESPONSIBILITY AND BEEPERS

All Call is In-House, except for the Reno and Las Vegas VA rotations, where call is from home. On other rotations, in-house call is scheduled and if call is missed due to illness or emergency it must be rescheduled by Gloria.

Beepers are to be passed in person from student to student. They are not to be left in cars or call rooms. Lost beepers will be the responsibility of the student who last had the beeper.

Call Log

A log of call nights, signed by the resident on call each night will be completed and turned in at the end of the 12 weeks.

1. Trauma and Critical Care Call (student trauma beeper # 381-0369)

While on **Trauma/Critical Care**, the on-call student carries **two beepers**: a student trauma beeper #381-0369, as well as a trauma activation beeper. The Trauma Junior Resident on call beeper is 381-0155. The trauma/ICU resident beeper is 381-0700.

Immediately following Trauma ICU rounds, the on-call student should report to Trauma Resuscitation. Introduce yourself to the unit secretary, give the unit secretary your cell phone or beeper number and also contact the Junior Resident on Trauma call at # 381-0155. At 5pm a new resident team arrives, so the on-call student should page the Junior Resident #381-0155. On week-ends students will begin to respond to Trauma Activations after ICU notes are written.

Students who are post call on Saturday will round with the residents, write notes and review them with the residents, and then can go home. The on-call student will round with the team.

2. General Surgery Call – Las Vegas (student beeper #381-0027)

General surgery call is taken by students on UMC1, UMC2, Pediatric, and Specialty rotations. Call is taken with the in-house on-call resident at night. **Students are expected to call the resident on call at night (Beeper 381-0069) at approximately 5pm and to stop by the OR to see what surgeries are scheduled and are in progress.** Refer to the resident call schedule for the name of the resident on call. The Specialty resident on call may also call you to assist with overnight specialty activities.

Students are expected to participate in all on-call activities, including ER evaluations, Operative Cases including transplant and organ harvest, Floor Calls, etc.

General surgery students on call will carry beeper 381-0027. On weekdays, one of the general surgery teams will take daytime call but beginning at 5pm the Night Resident will begin taking call. Students on general surgery rotations take call with their team during the day and beginning at 6pm will take call with the Night General Surgery Resident.

Students on Specialty Service begin taking general surgery call at 5pm and again need to call the Night Resident at that time on beeper 381-0069.

On weekends, call begins at 5pm on Friday and your responsibilities will end after you have rounded with the residents, written notes and reviewed them with the residents on Saturday morning. Saturday's call begins after rounds on Saturday morning and goes until 10:00 pm Saturday night. Sunday's call begins after morning rounds on Sunday and goes through morning rounds on Monday. Even if you are on your Specialty service rotation you are to stay with the general surgery team for your call on weekends. You will round with your team but then immediately start general surgery call.

If you are scheduled for call the day before a holiday, you are expected to fulfill your call requirements until after rounds the next morning (the first day of the holiday). If you wish to make travel plans for a holiday period, please check your call schedule. **No changes in the call schedule will be permitted unless requested to Gloria Brown and approved by Dr. Kuhls or Dr. Baynosa.** The last call day of the twelve-week rotation will be the Saturday before final examinations.

3. VA Call

VA students have call from home in both Reno and Las Vegas. Students who are post-call typically participate in all of the following day's activities as it is rare to be in-house late at the VA hospitals. Speak with your Chief Resident if you have concerns.

In House Call on Trauma and General Surgery Services

During the week days, students who are post-call from an all night the night before will be excused from their duties by 12 noon. On week-ends, post-call students leave after they have written notes and rounded with their resident teams. Students are not required to stay for attending rounds on week-ends when post-call. On Monday nights call responsibilities will end at 10:00 pm so you can rest in order to maximize your learning from the Tuesday lectures. Saturday's call goes until 10:00 pm Saturday night. This allows every student at least one day off per week.

PROCEDURES AND MEDICATIONS

Medical students on the surgery clerkship generally do not administer medications and are to only administer medications under the DIRECT supervision of an Attending. Procedures are always supervised by resident physicians and/or attending physicians.

LECTURES, TIME OFF AND STUDY TIME

All students are required to attend lectures. Pictel to students in Reno and Las Vegas allows students in both locations to participate in lectures.

Students who are not on call should leave their responsibilities no later than 6:00 pm during week days.

Students will have one day off per week.

Bring reading materials to the hospital. There will be "down time" between cases, etc. We highly recommend that you read every day.

STUDENT SAFETY/PARKING - UMC

UMC parking policies allows students with UMC parking stickers to park in the Shadow Lane and surface lots. Student parking is not allowed in the UMC Trauma parking garage. See Appendix V, page 25 for alternate parking directions for the overflow parking lot.

If you are leaving the hospital or medical school in the evening or at night and would like to a security guard escort to accompany you to your car, call the security dispatch office at 383-1810.

If you are having parking issues or problems with your UMC ID badge, you can call 383-2776.

VAMC ISSUED PAGERS AND SCRUBS - RENO VA

While rotating at the Reno VA you will be given digital pagers, managed by the Department of Surgery. These pagers are provided as a courtesy to students. Students will be responsible for returning pagers on the final day of their rotation to the Department.

Scrubs are available in the OR area and are the property of the VA and are not to be worn off premises.

Grades will be withheld until pager accounts are settled. Students rotating at the Las Vegas VA will not take call and will not have VA issued beepers. A VA representative will discuss any special procedures during orientation.

EXCUSED ABSENCES

Please request any planned absence to Gloria Brown. Dr. Kuhls or Dr. Baynosa must approve all planned absences. Although any absences require notification of your senior surgical resident as well, the senior surgical resident does not have the authority to approve changes in the student schedule.

If you have an emergency such as illness, you must notify Gloria Brown (671-2338) or Dr. Baynosa or Dr. Kuhls directly as well as your senior resident.

HIPAA POLICY AND PROFESSIONAL ATTIRE

Your dress, hygiene and behavior must be appropriate for your future profession as a physician. Wear your white coat and identification badge at all times and remember to bring your stethoscope, a pen light and appropriate pocket books. Scrubs need to be worn in the OR and can be worn while on the Trauma/Critical Care service. However, professional attire must always be worn to Tuesday morning conferences and when out of the OR. If ties are worn by men, a tie tack should also be used to decrease the spread of infection. Long scarves have the same potential to spread infection. Jewelry, piercing, tattoos and other personal effects that interfere with patient care and distract from your professional image should not be visible. Clothing that exposes midriff and strapless or spaghetti straps are not appropriate. Jewelry that could potentially fall into the operative field should not be worn in the OR. Fingernails must be trimmed short and fingernail polish and false fingernails cannot be used on the surgery rotation due to infection considerations. Only closed toe shoes should be worn, to both protect you and for infection control considerations. If you wear contact lenses you should wear a face shield while in the OR.

Remember to follow the HIPAA Privacy and Confidentiality Policies and not discuss patient information in public areas such as hallways and elevators. Patients, families and all members of the healthcare team should be treated as you would want to be treated.

You are expected to prepare for assigned operative cases. Your chief resident should assign elective cases the day before. Residents should review all student notes either on rounds or later that day. If residents aren't able to review your notes early in the day, make a copy, carry in your pocket and discuss with your resident between cases or other available time.

MEDICAL STUDENT FLUID EXPOSURE PROCEDURES LAS VEGAS/UNIVERSITY MEDICAL CENTER

Procedure:

Who do I inform if I have an exposure?

Medical students report the exposure to the **On Duty Administrator** and fill out a C-1 exposure form. The attending physician, resident or nurse should know who this On Duty Administrator is and how to contact them.

- A. **Monday-Friday, 8 – 5 p.m.**, (regular working hours): A member of the Exposure Evaluation Team will meet with the student as soon as possible to provide counseling, risk assessment and reach a decision with the student about the need for post-exposure prophylaxis.
- B. **Night, weekend, holiday**: A member of the Exposure Evaluation Team will be on-call and respond by beeper/phone to the talk with the medical student.

Should I go to the emergency room?

Emergency room visits will only be required if the injury requires emergency care. The **Employee Health Nurse Practitioner** will meet with the student within 72 hours of the exposure to review lab results.

Does my insurance pay for the care I receive?

Medical students are considered Health Care Workers by University Medical Center (UMC). **UMC will provide, at NO COST to all Health Care Workers, all necessary blood tests, initial counseling and early evaluation, and, if appropriate, a 28-day HIV post-exposure prophylaxis, as outlined in the Fluid Exposure Protocol.** All Health Care Workers will be evaluated and counseled within two hours by the UMC Exposure Evaluation Team.

What types of exposures does this protocol cover?

This protocol is designed to evaluate post-exposure treatment for HIV and Hepatitis B.

Should I get any follow-up care?

The protocol at UMC is designed to provide care/medications (if required). Students should follow up with the primary care clinics in Las Vegas.

Where can I read the complete protocol?

The complete UMC Fluid Exposure Protocol is available for review by students in the Office of Recruitment and Student Affairs, as well as the Department of Surgery and the Department of Obstetrics/Gynecology.

Do all exposures put me equally at risk?

Students who experience percutaneous injuries are the most at risk for exposures. Students who experience mucous membrane or non-intact skin exposures are less at risk. Complete information on procedures for the different exposure types are available in the Fluid Exposure Protocol at the locations lists above.

What if I get told to do something different?

This is a new policy and procedure adopted at the end of June 06 at UMC. It may take time for the information to get distributed to everyone. You can contact the Office of Recruitment and Student Affairs or your Clerkship Coordinator if you have questions.

SURGERY CLERKSHIP TEXTBOOKS

A separate listing of electronic resources available through Savitt Library is provided. Several books have been purchased by the department or donated for your use during the clerkship. Gloria Brown can check books out for your use during the rotation. Dr. Kuhls and Gloria Brown will discuss each book during orientation. You should plan on purchasing a general surgery text for your personal library, since you will almost certainly be treating patients with surgical disease, regardless of the specialty you choose. All borrowed books must be returned by the end of the surgery rotation. Several general surgery books are available at the Reno VA for student use.

Highlighted titles are suggested and are appropriate for student use. It is expected that you read recommended texts and not just review books in order to gain depth and breadth of knowledge. The general surgery texts that are not highlighted are available as reference materials and are too detailed for general student reading.

RECOMMENDED GENERAL SURGERY TEXTS

<u>TITLE</u>	<u>AUTHOR</u>	<u>PUBLISHER</u>
Current Surgical Diagnosis & Treatment	Way & Doherty	Lange
Essentials of General Surgery	Lawrence	
Essentials of Surgery	Becker	Saunders
The ICU Book	Marino	Lippincott Williams
Current Critical Care	Bongard & Sue	Lange
Handbook of Evidenced Based Critical Care	Marik	
Trauma Handbooks		
Question and Answer Books (NMS, Appleton & Lange)	Iverson	Little Brown

SUGGESTED REFERENCE BOOKS

Textbook of Surgery (REF)	Sabiston	W.B. Saunders
Surgery – Scientific Principles and Practice (REF) or	Greenfield	J.B. Lippincott
Principles of Surgery 7TH Ed (REF)	Schwartz	McGraw/Hill

ALL TEXTS ARE AVAILABLE FOR PURCHASE AT THE UNR BOOKSTORE OR AT THE
COMMUNITY COLLEGE HEALTH SCIENCES BOOKSTORE ON WEST CHARLESTON BLVD AND
FOR REFERENCE AT SAVITT MEDICAL LIBRARY AND UMC LIBRARY

Student Urology Curriculum American Urological Association’s tutorial of essential knowledge in urology for third year medical students entitled, “National Medical Core Curriculum” To be completed by the end of the surgery clerkship.

http://www.auanet.org/content/education-and-meetings/med-stu-curriculum.cfm?WT.mc_id=EML1032NET

Wise MD Virtual Patient Cases and Modules Students must complete all modules before the end of the clerkship. How to Register and sign in information for MedU Virtual Patient Cases and Modules is under Appendices, page 29.

Wise MD Module Weekly Schedule with Post-Test Due Dates

<u>Week</u>	<u>Topic</u>	<u>Due Date</u>
Week 1	Appendicitis	April 13
Week 2	Cholecystitis	April 20
Week 3	Hernia	April 27
Week 4	Colon Cancer	May 4
Week 5	Trauma Resuscitation	May 11
Week 6	Skin Cancer	May 18
Week 7	Carotid Stenosis	May 25
Week 8	Adrenal Adenoma	June 1
Week 9	AAA	June 8
Week 10	Thyroid Nodule	June 15

SURGERY CLERKSHIP LIBRARY

General Surgery

- Cardiac Surgical Care***, John Hopkins Manual (1)
- Clinical Evidence Concise***, William W. McGuire, MD (1)
- Cope’s Early Diagnosis of the Acute Abdomen***, William Silen (2)
- Current Consult Surgery***, Gerard M. Doherty, MD (2)
- Current Essentials of Surgery***, Gerard M. Doherty, MD (1)
- Current Surgical Diagnosis & Treatment***, Lawrence W. Way (5)
- Dripps/Eckenhoff/Vandam Introduction to Anesthesia***, 8th Ed, DE Longnecker FL Murphy(3)
- Essentials of General Surgery***, Peter F. Lawrence (6)
- Essentials of Surgery***, James M. Becker, MD, Arthur F. Stucchi, PhD (4)
- Essentials of Surgery Specialties***, Peter F. Lawrence (3)
- NMS Surgery***, 4th Edition, Bruce E. Jarrell, R. Anthony Carabasi (3)
- Pocket Surgery***, Lippincott Williams & Wilkins (1)
- Principles of Surgery***, 7th Edition, Schwartz, Shires, Spencer (4)
- Sabiston Textbook of Surgery***, Townsend (1)
- Schwartz’s Manual of Surgery***, F. Charles Brunnicardi (1)
- Surgery*** 6th Edition, Samuel Eric Wilson, MD (1)
- Surgery, A Competency-Based Companion***, Barry D. Mann (3)
- Surgery on Call***, Alan T. Lefor, Leonard G. Gomella (1)

Surgical Secrets, Charles M Abernathy, Alden H. Harken (2)
The Mont Reid Surgical Handbook, The University of Cincinnati Residents (2)
Textbook of Surgery-Pocket Companion – Sabiston. Lyerly (1)
Washington Manual-Surgery Survival, Jeremy Goodmans, Nirmal K Veeramachaneni (1)

Trauma Surgery Books (To be checked out only on Trauma/CC rotation)

Handbook of Trauma Pitfalls and Pearls, Robert F. Wilson (2)
Trauma Manual, Ernest E. Moore, Kenneth L. Mattox, David V. Feliciano (2)
Trauma Secrets, Naude (1)
TEAM – Trauma Evaluation and Management, American College of Surgeons (6)

Critical Care Books (To be checked out only on Trauma/CC rotation)

Handbook of Critical Care, J B Hall & P. Murphy (1)
Handbook of Evidenced-Based Critical Care, Paul Ellis Marik (3)
ICU Book, 2nd Edition, Paul L. Marino (4)
ICU Book, 3rd Edition, Paul L. Marino (2)
Sepsis Handbook, 2nd Ed. Society of Critical Care Medicine (5)

Otolaryngology (To be checked out only on SPECIALTY rotation) (4)

Otolaryngology, A Case Study Approach, Tami, Seiden, Pensak, Gluckman, Cotton (1)

Question and Answer and Case-Based Books

Abernathy's Surgical Secrets, Alden H. Harken, Ernest Moore (1)
Appleton & Lange Surgery Review, Wapnick, Cayten, Goldber, Agarwal, Savino (2)
Boards and Wards, USMLE Steps 2 & 3, Carlos Ayala, Brad Spellberg (1)
Case Files: General Surgery, Eugene C. Toy, MD, Terrence H. Liu, MD (5)
Field Guide to the Difficult Patient Interview, Frederic W. Platt, Geoffrey H. Gordon (1)
First Aid for the Surgery Clerkship, Latha G. Stead, S. Matthew Stead, Matthew Kauffman (2)
Pretest-USMLE Step 2, McGraw Hill (1)
Pulmonary Pathophysiology, 2nd Edition, Juzar Ali, Warren Summer, Michael Levitzky (1)
Surgery Pretest, Lillian Kao (3)
Surgical Recall, LH Blackbourne, (3)
Surgical Attending Rounds, Cornelius M. Dyke, Eric J. DeMaria (3)

Other Textbooks

Case Studies in Neuroscience, Jozefowicz, Holloway (1)
Cranial Nerves, Anatomy and Clinical Comments, Wilson-Pauwels, Akesson, Stewart (1)
Clinical Anatomy Made Ridiculously Simple, Stephen Goldberg, MD (1)
Handbook of Fractures, 3rd Ed., Koval, Zuckerman (2)
Introduction of Anesthesia, Longnecker, Murphy
Medicine, 2nd Ed, Allen R. Myers (1)
Medicine, 3rd Ed, Fishman, Hoffman, Klauser, Thaler (2)
Medicine Recall, James D, Bregin (1)
Operative Pediatric Surgery, Spitz & Coran (1)

Pediatric Surgery 4th Ed., Ashcraft, Hocomb, Murray (1)
Plastic Surgery, Grabbs & Smith (1)
The Johns Hopkins Atlas of Human Functional Anatomy, Leon Schlossberg (1)
The Washington Manual, Manual of Medical Therapeutics, Washington Univ Schl of Med (1)

Other Reference Books

Iserson's Getting Into a Residency, Iserson (1)
What Color is Your Parachute? Richard Nelson Bolles (2)

Other Recommended Reference

SAVITT LIBRARY has Access Surgery, an on-line surgery text, and more

Pocket reference cards - Clerkship Series – www.medquickcards.com

Reference website - www.emedicine.com

FREE interactive anatomy review site for medical students

<http://www.winkingskull.com/navigation.aspx>

Can be customized to review images with/without anatomical labels, you can be tested on its recognition.

Websites for Evidenced Based Medicine

1. The Oxford Centre for Evidence-Based Medicine – <http://www.cebm.net/>
2. Toronto's Centre for Evidence-Based Medicine – <http://www.cebm.utoronto.ca/>
3. The Centre for Health Evidence – <http://cche.net/>
4. The University of Alberta's EBM toolkit – <http://med.ualberta.ca/ebm/ebm.htm>
5. The EBM Resource Center in New York – <http://www.ebmny.org/>
6. The U Mass EBM site – <http://library.umassmed.edu/EBM/>
7. BMJ's EBM On-Line – <http://ebm.bmjournals.com/>
8. Family Medicine's Evidence-Based Practice – <http://www.ebponline.net/>
9. Best BETs – <http://www.bestbets.org/>
10. The McMaster Online Rating of Evidence – <http://hiru.mcmaster.ca/MORE/>
11. EBM Tools by Alan Schwartz – <http://araw/mede/uic.edu/~alansz/tools.html>
12. AHRQ Clinical Resource Page – <http://www.ahrq.gov/clinic/>
13. The University of Sheffield's Netting the Evidence <http://www.shef.ac.uk/scharr/ir/netting/>
14. The society for Academic CME – http://www.sacme.org/Research/EBM_resources.htm
15. The JAMA Users' Guides – <http://www.cche.net/usersguides/main.asp>
16. The Cochrane Library – <http://www.cochrane.org/>
17. CATwalk – <http://www.library.ualberta.ca/subject/healthsciences/catwalk/index.cfm>
18. Entrez PubMed – <http://www.ncbi.nlm.nih.gov/entrez>

GRADING POLICIES

Our grading policies follow the University Of Nevada School Of Medicine's as defined in the Student Handbook. The grading scheme of the University Of Nevada School Of Medicine includes final grade assignments of Honors, High Pass, Pass, Fail, and Marginal.

DEPARTMENTAL GRADING AND EVALUATIONS

Clinical Performance Evaluations by Faculty and Residents (50% of Your Grade)

Attending surgeons, fellows and resident physicians on each rotation provide evaluations. E-Value, an on-line system of computer generated evaluation forms, is currently being used. Details of the E-value system are introduced during the Transition Course and will be available to you during orientation. Evaluations will be weighted by the amount of exposure that evaluators have with you and they indicate this on the evaluation forms they complete.

National Board of Medical Examiners' (25% of Your Grade)

This is a standardized exam, which tests your factual knowledge. The examination must be taken at the site of your last surgery service rotation.

Surgical subspecialties, like neurosurgery, orthopedic surgery and plastic surgery are included. We recommend practice questions such as those for the USMLE Part II for preparation. There is a minimum pass score for this examination. Any student failing the written examination must re-take the examination at a time determined by Dr. Kuhls and the highest final grade for anyone not passing the written examination will be Pass.

In order to get a final grade of Honors in surgery, students must score in the 70th percentile or better. 70th percentile on the written exam however does not equate to an Honors on the written exam. The set point for a Pass, High Pass, or Honors grade on this exam is made according to the national averages for the Shelf Exam and NBME recommendations.

Oral Examination (25% of Your Grade)

You will select your oral examiner by drawing a name from a list of faculty available for your examination in Las Vegas. Oral examiners in Reno will be assigned by a designated faculty member. Each examiner is given a booklet of standard cases that can be used. Cases are evenly chosen from the subject areas of: General Surgery, Metabolic and Wound Healing, and Trauma. The test lasts approximately one-half to one hour. Dr. Kuhls gives a review session for the oral examination approximately 3-4 weeks before the end of the clerkship. Practice oral examinations can be requested by any student.

Students who fail the oral examination must re-take the examination with another examiner at a time determined by Dr. Kuhls. The highest grade for subsequent oral examinations will be a Pass. The highest final grade for anyone not passing the oral examination will be Pass.

Grades for clinical Performance evaluations and examinations

- H (Honors)
- HP (High Pass)
- P (Pass)
- M (Marginal)
- F (Fail)

Your FINAL GRADE will determined mathematically based upon the above weighting. Final

grades will be Honors, High Pass, Pass, Marginal or Fail. Any student with a final grade of Fail must re-take the rotation. Any student found to be cheating will receive a Fail for that examination.

Any student failing the course or one of the examinations will meet with Dr. Kuhls to formulate a plan to address areas of weakness. Oral and written examinations make to retaken twice and if a student still has a failing examination grade, the clerkship must be repeated.

Contact Gloria Brown for your final grade if Dr. Kuhls or Dr. Baynosa has not contacted you.

Mid-clerkship Feedback and One-On-One Discussions with Dr. Kuhls and Dr. Baynosa

Any concerns about performance or any other issues should be brought to Dr. Kuhls' attention immediately. Dr. Kuhls and Dr. Baynosa will meet with each student early in the third three week block to discuss the rotations thus far, patient logs, clinical performance evaluations, as well as student progress in reading on topics discussed earlier in this document and studying for the final examination. Dr. Kuhls and Dr. Baynosa are available to meet with students at any time during the clerkship.

ACADEMIC OR OTHER ISSUES

Your medical education is a high priority of the Department of Surgery. Any issues or problems that arise during your clerkship, which impact your education, need to be discussed with Dr. Kuhls.

Each group of students will designate a student liaison representative who can bring forth any concerns anonymously to either Dr. Kuhls, Dr. Baynosa or Gloria Brown.

4TH YEAR CAREER COUNSELING AND LETTER OF RECOMMENDATION

As the third year progresses, you will be required to choose both your senior electives as well as the residency training programs in your selected field of post graduate education. These are very important decisions that are inter-related. The surgical faculty is available to assist you in both endeavors. A commitment to a surgical career is not a prerequisite before discussing your academic future with any surgical faculty member. The faculty stands ready to provide information not only regarding a career in surgery, but the more broad questions of what electives are valuable in the senior year as well as the process of selecting a career pathway and appropriate residency program. Do not hesitate to utilize our expertise in these important areas.

Any students contemplating a career in surgery should meet with members of the surgical faculty early in the planning process. Our professional and experienced advice can be a valuable tool in evaluating a career in surgery as well as maximizing your ability to match to a surgical residency program that will satisfy your academic requirements. If during this planning process you change career directions the insights into the residency match provided by the surgical faculty will remain a valuable tool for whatever field of study you select.

Deborah Kuhls, MD	Las Vegas	(702) 671-2338	dkuhls@medicine.nevada.edu
Jennifer Baynosa, MD	Las Vegas	(702) 671-2338	idelapena@medicine.nevada.edu

4TH YEAR SURGERY ELECTIVES

Students are responsible for scheduling and obtaining approval signatures on the elective course schedule form furnished by the Office of Medical Education. **ALL SURGERY ELECTIVES ARE HANDLED THROUGH THE SURGERY DEPARTMENT LAS VEGAS OFFICE BY GLORIA BROWN.** Contact Gloria Brown (702) 671-2338 for elective availability, any special requirements, and to obtain a signature for all surgery electives.

Electives may be scheduled in two to four-week blocks depending on the students needs. Electives are scheduled on a first come, first served basis. While completing each surgery elective you are expected to participate in assigned office hours and surgeries. We offer these electives to our students first, but students from other medical schools can sign up for electives after the deadline has passed for UNSOM students. The deadline to submit your completed (including signatures) elective course schedule to the Office of Medical Education is May of each year.

E-Value elective evaluation forms will be completed by the course instructors at the conclusion of your elective. You will be required to complete an E-Value elective and preceptor evaluation at the end of each of your surgery electives for your final grade to be released for your transcript.

RESEARCH OPPORTUNITIES

All full time faculty have active clinical research projects ongoing throughout the year. In addition, several faculty, both in Las Vegas and Reno, have basic science laboratories conducting investigations relevant to surgical diseases.

Students interested in becoming involved with either clinical or basic science research projects should contact Dr. Kuhls to be directed to the appropriate faculty member.

Institutional Objectives for Medical Students at the University of Nevada School of Medicine

1. Medical Knowledge

Students shall acquire the body of knowledge and thinking processes necessary to becoming a competent physician. Students shall:

- acquire and retain the basic science knowledge base essential to becoming a physician
- demonstrate the application of basic science principles to clinical practice
- develop well-rounded and in-depth clinical knowledge
- demonstrate the ability to formulate a differential diagnosis
- demonstrate advanced critical thinking skills
- demonstrate the ability to assimilate information, comprehend conceptual issues, analyze and correlate clinical information
- demonstrate an understanding of normal human behavior and the impact of human behavior on health and illness.

2. Patient Care

Students shall acquire the skills necessary to provide competent care for their patients. Students shall:

- demonstrate the skills necessary to perform a complete and accurate history and physical examination
- demonstrate the appropriate application of diagnostic studies including laboratory testing, diagnostic imaging, and other testing
- demonstrate the ability to process the information gathered on a patient into a diagnostic and therapeutic plan, i.e. develop good problem solving skills
- demonstrate the ability to critically read the medical literature and apply this information appropriately in the treatment of individual patients in order to practice up-to-date, evidenced-based medicine
- demonstrate appropriate procedural skills, sterile technique, and universal precautions
- seek appropriate consultation for their patients
- work effectively within a team to provide patient-centered care
- provide care with compassion and respect for all patients.

3. Practice-Based Learning

Students will become self-directed learners particularly within the patient care setting and will strive for ongoing professional improvement. Students shall learn to:

- assess their own learning needs
- develop the skills to effectively use information technology and other resources to obtain information from the medical literature for optimum patient care
- practice evidence-based medicine
- perform ongoing self-assessment and plan for continuing improvement as a physician.

4. Interpersonal Communication Skills

Students must demonstrate effective communication skills necessary to functioning as a competent physician. Students shall:

- demonstrate effective listening skills
- demonstrate proficiency with interviewing and counseling patients and families
- demonstrate efficient and accurate verbal patient case presentations
- demonstrate accurate, appropriate, timely and legible documentation in the patient record
- communicate effectively as a member of a team with other health care providers.

5. Professionalism

Students shall demonstrate the behaviors befitting an ethical professional at all times. Students shall:

- exhibit respect, compassion, humility, altruism, duty, and honesty with patients, staff, faculty, fellow students, and themselves
- be punctual, reliable, and conscientious in fulfilling professional duties
- demonstrate a commitment to excellence
- accept responsibility for their own actions
- respect patient confidentiality
- practice sensitivity for patients with regard to culture, age, gender, race, ethnicity, sexual orientation, and disabilities
- demonstrate professionalism in dress, hygiene, and demeanor.

6. Systems-Based Practice

Students shall begin to develop an understanding of the setting in which they will practice medicine and the challenges of providing cost effective care. Students shall:

- be a patient advocate
- demonstrate comprehension of community health and epidemiology
- understand the importance of quality improvement measures and demonstrate a commitment to patient safety
- demonstrate an awareness of the types of healthcare coverage currently available
- demonstrate an appreciation for providing cost effective care.

Appendix II

Las Vegas VA

- Rounds start at 6:00 am.
- Dr. McIntyre's vascular clinics are on Wednesday, Thursday, and Friday each week. Each student will attend two clinics each week on a rotating basis at the direction of the residents.
- M & M's are the 3rd Thursday of each month at 7:15 am.
- Call is from home.
- Contact Information:
 - Betty Akins, Ward 3C
(702) 653-2791
 - Janet Newhart, 2410 Fire Mesa Street, Suite 130
(702) 636-3000 ext 3553
 - Angel McDonald, Infection Control Coordinator
(702) 636-3000 x6993

Appendix III

Goal for students during the 3rd year surgical clerkship at the VA

Vascular

- Obtain an accurate history and perform a physical examination on a patient with peripheral arterial disease (PAD)
- Learn the indications for intervention (open and endovascular) on patients with PAD
- Learn the interpretation of ankle/brachial index
- Learn the natural history of symptomatic and asymptomatic carotid stenosis
- Learn the indications for intervention on patients with symptomatic and asymptomatic carotid stenosis
- Learn the duplex scan criteria for diagnosing hemodynamically significant carotid stenosis
- Learn the indication for repair of asymptomatic abdominal aortic aneurysm (AAA)
- Learn the pathophysiology of varicose veins and both the conservative and surgical treatment
- Learn the correct preoperative evaluation based on risk stratification in the vascular surgery patient

Appendix IV

LAS VEGAS VA CLINIC SCHEDULE					
Time	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:30 AM	<u>Ortho</u> (Erickson)	<u>Plastics</u> (Shah)	<u>Plastics</u> (Shah)	<u>Vascular</u> (McIntyre)	<u>Wound</u>
	<u>General Surgery</u> (Dunn) (Joffs) (Narciso)	<u>General Surgery</u> (Dunn) (Narciso)	<u>General Surgery</u> (Lal)	<u>Ortho</u> (Erickson)	
		Minor Procedures on 2nd Tuesday each month (Dunn)		<u>General Surgery</u> Minor Procedures (Narciso)	
1:00 PM	<u>Ortho</u> (Erickson)	<u>Plastics</u> (Shah)	<u>Vascular</u> (McIntyre)	<u>Vascular</u> (McIntyre)	<u>Vascular</u> (McIntyre)
	<u>General Surgery</u> (Joffs) (Dunn)	<u>General Surgery</u> (Dunn) (Lal) (Narciso)	<u>General Surgery</u> (Lal)	<u>Ortho</u> (Erickson)	<u>General Surgery</u> (Joffs)
			<u>Plastics</u> (Shah)	<u>General Surgery</u> Minor Procedures (Narciso)	<u>Plastics</u> (Shah)

Appendix V

UMC parking policies.

- Medical students, with UMC parking stickers, can still park in all surface lots and the Shadow Lane garage.
- When those lots are full, you are NO longer eligible to park in the Trauma garage.
- Students will now be directed to the overflow lot behind Lied Clinic, and be able to get shuttle service back to UMC.
- Every time you use the shuttle you get a coupon, from the driver, for \$2.50 off cafeteria food.

If you are routed to this overflow lot:

- **Call 383-1810 on your way to the lot to request shuttle service**, identify yourself as a medical student. The shuttle should be there waiting for you.
- If you know when you need to return to the lot, make arrangements with the driver for a pick up time at the NEW main entrance to UMC (the one facing Shadow Lane/Charleston).
- The shuttle runs 6 a.m. to 7 p.m.
- After 7 p.m., you can still get taken to the lot by a public safety officer. Call the same number and the dispatcher will have an officer pick you up.

Appendix VI

Speak Up For Safety

After a brief review of the notes, Tracy Reick, RN, BSN, an operating room nurse at the Nebraska Medical Center in Omaha, Neb., noticed that the patient about to undergo surgery had renal insufficiency, a piece of information critical to anesthesiologists when administering medications during surgery.

While timeouts have been used in the OR for several years, the new OR timeout briefing — changed to a very structured and team-oriented procedure with specific questions that are covered before every surgery — presented the perfect opportunity for Reick to voice her concern. As a result of her speaking up before surgery, medications were adjusted, preventing a possible adverse reaction.

It is incidents like this — in which potential errors or concerns are caught and resolved before they become serious — that the Nebraska Medical Center hopes to see more often since the implementation of crew resource management. CRM is a safety program involving communication tools and safety processes adopted by the aviation industry over the last 25 years that have resulted in dramatic decreases in accident rates. CRM was so effective that in 1992 the Federal Aviation Administration required CRM programs for all U.S. commercial airlines. The military, other government flight organizations, and foreign airlines quickly followed suit. Hospitals such as the Nebraska Medical Center hope CRM will have the same results in healthcare.

According to studies by the Institute of Medicine, the root cause behind the majority of medical errors appears to be communication. Between January 1995 and December 2004, the Joint Commission on Accreditation of Healthcare Organizations found the primary cause of patient harm reported in 2,966 sentinel events was communication failure, accounting for 66% of all incidents.

The goal of CRM is to improve communication and teamwork among healthcare teams, translating into fewer errors and the loss of fewer lives. When CRM was first developed, the majority of airline crashes, as many as 70%, were caused by failures in communication among crew members. At the time, airline crew members often viewed the captain as supreme commander, someone whose decisions or judgments could not be challenged. CRM set out to standardize communication and teamwork and resulted in significant improvements in aviation errors and safety. A similar shift in philosophy applies to healthcare.

While CRM can be applied to any area of a hospital in which care is provided by a team, most hospitals have focused on high-pressure areas such as critical care units, operating rooms, catheterization labs, intensive care units, EDs, chest pain teams, and trauma units. “These are the areas that generally have more communication and teamwork problems, start-and-stop situations, high stress, and time pressures,” says Stephen Harden, a former Navy Top Gun pilot and president of Memphis, Tenn.-based LifeWings Partners, LLC, the principal architect of LifeWing’s CRM program.

The Nebraska Medical Center recently implemented CRM in its operating rooms and plans to continue training additional staff and eventually adapt the process to all procedure-based areas.

“The use of CRM creates an atmosphere of mutual responsibility, not only for making sure everyone does his or her job, but also for making sure everyone on the team is informed,” says Shelly Schwedhelm, RN, director of perioperative and emergency services at the Nebraska Medical Center. “By replacing guessing and assumptions with clear communication techniques and tools, CRM enhances safety and optimizes clinical performance.”

A key component of CRM is the use of safety tools such as standardized presurgical routines, timeouts, debriefings, hand-off tools, and checklists that help standardize procedures and routines.

For the Nebraska Medical Center, the impact was beneficial during the first week of implementation. While conducting the presurgical timeout briefing, Schwedhelm says issues were identified in three different cases that prevented a potential error during surgery. These included incidents in which an equipment problem was identified, timely delivery of antibiotics did not occur, and ordered blood was not ready.

“Not everyone feels comfortable speaking up if they have a concern [in the OR]. This process forces the group to verbalize the goals and objectives of the procedure and provides an opportunity for each member of the team to speak up so everyone is in agreement,” says Kathy Wonder, RN, BSN, lead coordinator for the hospital’s orthopedics, oral, and dental services.

At the end of the surgery, the team also conducts a debriefing. Questions such as “What went well?” and “What could we do better?” are asked, with the junior person on the team speaking first. “The briefing and debriefing procedures take just a minute or two,” says Wonder. “For the safety of the patient, it’s definitely worth it.”

The University of Missouri Hospital (UMH) in Columbia, Mo., which began implementation of CRM in spring of 2003, has seen similar results. One of the first areas in which CRM was implemented was in the ICUs. “Our unit has always prided itself on teamwork,” says Christina Vollrath, RN, BSN, assistant manager for the medical and neurosurgical ICU at UMH. “The problem was that our teams were divided between nursing, physicians, and other ancillary departments. Now we function as a team.”

Vollrath says the ICU team starts its day with a 9 AM briefing that is attended by nurses, doctors, respiratory therapists, pharmacists, dietitians, managers, unit clerks, and housekeeping. “Each one of these individuals may have contact with the patient at some point in the day. We don’t want people to feel uncomfortable speaking up when they notice something isn’t right,” she says.

The briefing begins with an introduction of each team member and then goes through a series of seven questions: How many patients are on service today? Will there be any transfers out today? Any new admissions that are pending? Who needs to be seen first? Are there any extubations? Any patients with a Glasgow Coma Scale of five or less? Does anyone have any safety issues or concerns? The briefings conclude with “As always, if you see anything you are uncomfortable with, please speak up.”

A 16-day observation period documented incidents in which one or more individuals spoke up with a concern during 10 of 16 briefings, accounting for a total of 15 patient issues, notes Karen Cox, PhD, manager of quality improvement and patient safety, Office of Clinical Effectiveness for UMH. As a result of concerns raised, seven patients were treated differently, from changing

medications, to ordering diagnostic tests, to implementing order changes, to ordering an extubation.

“CRM has changed the overall dynamics and atmosphere of the unit,” says Vollrath. “Today, we are more team-oriented and very focused on safety. We have less of a blame culture. If something goes wrong, the attitude is that we are all in this together. Team members feel comfortable speaking up and know that their opinions will be heard. That, in and of itself, saves lives.”

UMH wants to see this same culture change permeate the entire institution and plans to implement CRM hospital-wide. Cox estimates they are 65% of the way there. CRM tools are being used in many areas of the hospitals. For instance, when changing staff in adult ICUs, clinicians are required to use a 21-step process that includes important data on lab reports, physical assessments, medications, IVs, and even family issues.

UMH also implemented a “one-minute game plan” when admitting a patient from the ER to an inpatient bed. The senior resident from the ER is required to call the charge nurse to provide a game plan of care and priorities. Now nurses are able to better anticipate patients’ care needs and order the right equipment and meds ahead of time. As a result, physicians believe they are receiving fewer calls from nurses once patients are admitted, notes Cox.

“In healthcare, we are always looking for ways to save time while improving patient safety,” says Vollrath. “In the past, we wouldn’t have taken the time to do a checklist; now we can’t afford not to. It’s a change in culture that has led us down more paths than we ever would have gone down before.”

UMH has also witnessed a gradual increase in nursing and overall employee satisfaction over the past few years, which it attributes, in part, to the implementation of CRM. From 2005 to 2006, the UMH nursing satisfaction percentile rose from 23rd to 66th based on Press Ganey measurements, Vollrath says.

The introduction and successful implementation of CRM takes support and a firm commitment from hospital leadership, says Vollrath. “You really need physician embracement and a management team that wants to make it work,” she says. Since the implementation of CRM, Schwedhelm says they are seeing a greater awareness of safety and quality issues throughout the Nebraska Medical Center. “People are bringing more issues to the forefront, and they are finding ways to implement CRM tools to improve the efficiency and effectiveness of all sorts of processes and procedures,” she says.

Susan Meyers is a freelance writer.

Appendix VII

Wise MD

MedU Virtual Patient Cases and Modules

TO REGISTER:

Students are required to self-register by going to www.med-u.org <<http://www.med-u.org/>> and selecting Register at the top right-hand corner. By registering, you are requesting student access to MedU. As a result, please expect to receive an email from "support@CASUS.net <<mailto:>> ". Select the embedded link in this email to prompt a second email from "i-intime@instruct.de <<mailto:>> ". Please follow the instructions in these emails accordingly as these steps complete the registration process.

Tips:

- * MedU offers a single sign-on interface allowing users to use one login and password for all cases to which your institution subscribes.
- * If you are currently registered for MedU cases, please do not attempt to register a second time.
- * In most cases, your login is your institutional email address and a self-selected password.
- * If you registered prior to December 2008, you do not need to re-register. Simply use your existing login. (An existing login may be your last name followed by a hyphen and the first two letters of your first name, ex: smith-jo).
- * During your registration, if you do not receive the first email from "support@CASUS.net <<mailto:>> ", please check your spam filter.

AFTER REGISTRATION

Once you have completed registration, please go to www.med-u.org <<http://www.med-u.org/>> .

For Students:

-Registration is required to begin viewing the cases.

-Students can access cases in four different ways using their login and password:

- From the MedU Homepage
- From the Virtual Patient Cases tab
- From Communities tab
- From The Login Button in the upper right-hand corner of the MedU Homepage.

Support:

Please go to the Support tab on the MedU site and select "Ask MedU Support <http://www.med-u.org/support/ask_medu_support/> " if you need further assistance.

Thank you,

MedU Support

Reno VA Surgery Clerkship Rotation Welcome!

1. Attending Rounds daily: 7:30 am in the ICU.
2. Conferences
 1. M & M Conference weekly, Friday 8:30 am, Room 1D197.
 2. Thoracic Conference, 3rd Friday of month, 12 pm, 3rd floor Surgery conference room.
 3. Vascular Conference, 1st and 3rd Thursdays, 12 pm, 3rd floor Surgery conference room.
 4. Journal Club: cyber journal club monthly.
 5. Breast Tumor Board, St. Mary's Hospital weekly, Friday, 7:00am.
 6. VA Tumor Board, 1st Friday, 12 pm, Room 1D197.
3. OR

Monday – Friday 8:00 am – approx. 5:00 pm.
*Check your mailbox, 3rd floor Surgery office, for next day's OR schedule in afternoon.
4. Clinics

General Surgery- Dr. Miller, Dr. Haller: Monday 9 am – 12pm; Dr. Haller: 1 – 3pm.
General Surgery – Dr. May: Tuesday 9 am – 12 pm.
Thoracic Surgery: Monday 1pm – 3 pm
Vascular Surgery: Thursday 8:45 am – 12 pm.
Breast Clinic: Thursday 9:00 am – 12 pm.
* Alternate Vascular Clinic and Breast Clinic attendance on Thursdays.
5. Call

Call for students is 1 in 4; residents 1 in 3. Call will be adjusted for travel needs during clerkship changes.
Home call. Must carry beeper/be available to come back for consults, patient care, or operative cases.

General Surgery Service

1. One Chief Resident and Two Junior Residents: UCSF-East Bay Surgery Residency
2. One Family Practice Resident: UNSOM
3. Providers: Beth Bomberger, APN; Don Moore, FNP; Zola Ferguson, PA.

Additional Information

Contacts:

Sue Kerley, AO. Surgery Office #775-328-1737.

Sandy Kosinski, AA. Surgery Office #775-328-1242. She will issue you beeper and orientation schedule first day of rotation after Rounds.

Patricia May, M.D., Site Coordinator, #775-328-1242; beeper #775-689-0270; home #775-825-0445; cell #775-742-0615.

NEEDLESTICK FOLLOW-UP

1. **PURPOSE:** To establish a policy for the care, follow-up, and post exposure prophylaxis (PEP) of employees who are exposed to blood and body fluids by needlestick, sharp injury, or splash.
2. **POLICY:** All employees exposed to blood or body fluids by needlestick, sharp injury, or splash will be cared for and followed up medically by the Employee Health Clinician or Medical Officer of the Day (MOD), as soon as possible and within one (1) to two (2) hours of exposure.
3. **RESPONSIBILITIES:** All employees will report needlestick or sharp injuries immediately to their supervisor.
4. **PROCEDURES:**
 - a. Any employee injured by a contaminated (used on a patient) needle or sharp object will wash the area immediately with soap and water and then report to their supervisor.
 - b. The supervisor will send the employee to the Employee Health Clinician immediately (and within one hour of exposure).
 - c. On weekends, evenings, nights, and holidays, the employee is to see the MOD in the Triage area (extension 1214).
 - d. The physician will complete the CPRS note titled, "Occupational Exposure." This note is in algorithm format and provides detailed information regarding post-exposure prophylaxis. The National Clinicians' Post-exposure Prophylaxis Hotline (PEP line) may be contacted for expert consultation if needed at 1-888-448-4911 for any provider uncertainty.
 - e. For possible Human Immunodeficiency Virus (HIV) exposure, incidences where the PEP line (1-888-448-4911) should be called for expert consultation include if the exposed person is known or suspected to be pregnant or breastfeeding; if the exposed person has renal insufficiency (creatinine clearance less than 50mL/min); if delayed exposure is reported (more than 24-36 hours); if the source patient is unknown (i.e. needle in sharps container, laundry); and/or if the source patient is known to be HIV-positive (long-standing HIV treatment with possible drug resistance).
 - f. The employee and source will be asked to consent to baseline HIV (Attachment H) and Hepatitis testing.
 - g. Lab personnel will draw blood for HIV, Hep panel, chem. panel, and CBC. This lab order set is available in CPRS orders, titled "Occupational blood/fluid exposure."
 - h. The employee will be evaluated for the Hepatitis B vaccine series as a person who upon sharp injury is considered high risk for blood borne disease. The employee may refuse the vaccine. The vaccine is useless in Hepatitis B virus carriers and is unnecessary in those already immune to Hepatitis B, i.e., Hepatitis B surface antibody present. HBIG prophylaxis is also unnecessary in the carrier state (Attachment J).
 - i. IG no longer has a role in post exposure prophylaxis of Hepatitis B because of the availability of HBIG and the wider use of HB vaccine.

SOURCE	EMPLOYEE
Positive Hepatitis B surface antigen or clinical hepatitis picture	UNVACCINATED 1. HBIG 0.06 ml/kg IM stat within 24 hours and not after 14 days 2. Initiate Hepatitis B vaccination series
	VACCINATED 1. If adequate Hepatitis B surface antibody levels present on test, no prophylaxis needed 2. If inadequate Hepatitis B surface antibody levels on test, a Hepatitis B vaccine booster will be given plus HBIG 0.06 ml/kg IM stat – one-time dosing
Negative Hepatitis B surface antigen or clinical picture unknown	UNVACCINATED Initiate Hepatitis B vaccination series
	VACCINATED No HBIG prophylaxis
Hepatitis C positive	No prophylaxis recommended

- j. The Center for Disease Control has determined that no prophylaxis should be given after an exposure to Hepatitis C. However, baseline and follow-up labs should be drawn if the source is HCV-positive (see Occupational Exposure note in CPRS).
 - k. IG and HBIG are not contraindicated for pregnant or lactating women (MMWR 06-29-01).
 - l. Data are not available on the safety of Hepatitis B vaccines for the developing fetus. Because the vaccines contain only non-infectious Hbs Ag particles there should be no risk to the fetus. Pregnancy or lactation should not be considered a contraindication to the use of this vaccine for persons who are otherwise eligible (MMWR 06-29-01).
 - m. All employees will be scheduled for a date and time for follow-up vaccination by the Employee Health Clinician (Attachment L).
 - n. All supervisors will fill out an accident report (VAF 2162) and an occupational injury claim (CA-2) as soon as possible after the injury.
5. **REFERENCES:**
- a. Morbidity and Mortality Weekly Report (MMWR), Vol. 54, No. RR-9, dated September 30, 2005.
 - b. MMWR 2006; 55 (No. RR-14): 1-18
6. **RESCISSION:** VASNHCS Directive IC-111-24, dated July 2005.
7. **ATTACHMENTS:**
- a. Attachment A – Occupational Exposure to Blood or Body Fluids
 - b. Attachment B – HIV Fact Sheet
 - c. Attachment C – Chemoprophylaxis
 - d. Attachment D – Drug Information

- e. Attachment E – Post Exposure Prophylaxis (PEP) Consent Declination Form
- f. Attachment F – Chemoprophylaxis in Occupationally-Exposed Healthcare Workers
- g. Attachment G – Pre-HIV Test Counseling
- h. Attachment H – Consent for Human Immunodeficiency Virus (HIV) Antibody Testing
- i. Attachment I – Post-HIV Test Counseling
- j. Attachment J – Hepatitis B Fact Sheet
- k. Attachment K – Hepatitis C Fact Sheet
- l. Attachment L – Follow-Up
- m. Attachment M – Psychological Counseling
- n. Attachment N – Follow-up Employee Health Clinic Visits for Body Fluid Exposure

Submitted by:

Raymond Swarts, MD
Chairman, Infection Control Committee

Approved by:

Steven E. Brilliant, MD, FACP
Chief of Staff and
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Peggy W. Kearns, MS, FACHE
Associate Director

Kurt W. Schlegelmilch, MD, FACHE
Director

ATTACHMENT A

OCCUPATIONAL EXPOSURE TO BLOOD OR BODY FLUIDS

If the source of the exposure must be identified, complete the following on a photocopy of this form. **DO NOT INCLUDE THIS IDENTIFYING INFORMATION IN THE EMF UNLESS THE SOURCE PATIENT HAS SIGNED VA FORM 10-5345.** The photocopy must be maintained in an independent file under strict security, in accordance with confidentiality requirements of Pub.L. 100-322.

Name of exposure source: _____

SSN: _____

Ward Location: _____

Employee:

Date of exposure:

ATTACHMENT B

HIV FACT SHEET

HIV is a virus which causes the disease AIDS. The virus is transmitted by blood and body fluids being passed from one person to another. Transmission of the virus can occur when a person receives HIV contaminated blood products as a part of therapy, by using "dirty" needles with IV drugs, having unsafe sex with an HIV infected individual or through accidental body fluid exposures that occur with patient care. The HIV virus does not penetrate the healthy, intact skin barrier. HIV transmission can occur if there is an open sore or cut in the skin or mucous membranes.

HIV infection is not AIDS, but HIV infection will most likely lead to AIDS in several years. This disease causes the body's immune system to be suppressed which in turn allows many relatively benign infections to cause serious life-threatening diseases. There is no cure for AIDS but there are now drug therapies that delay the progress of the disease and extends the life expectancy of many infected individuals.

After a person has been exposed to the HIV virus, there is a period of time when it is not possible to determine if that person has become infected with the HIV virus. The current blood tests used to determine if the HIV virus is in the blood rely on testing for the antibody to the HIV virus. It takes approximately three to six months for those antibodies to be detected in the blood following infection with HIV.

It is important that the transmission of the HIV virus be prevented whenever possible. When someone is uncertain if they might be infected with the HIV virus, they should not donate blood or plasma, they should not share needles with others, and they should conscientiously practice safe sex (i.e., abstinence, the use of condoms).

HIV - RATE OF SEROCONVERSION

The rate of seroconversion (i.e., becoming HIV positive) following exposure to blood or body fluids from an HIV positive individual varies depending upon the extent and nature of the exposure. The risk from exposure of mucous membranes or skin with HIV infected blood is approximately 0.1%. Seroconversion following needlestick injury involving HIV contaminated needles is approximately 0.3% (1 in 333). The risk of seroconversions increases when the exposure injury is deeper or more extensive, when visible blood is noted on the device causing the injury, when the device had previously been placed in the source's vein or artery, and when the source dies from AIDS within 60 days of exposure (and therefore presumed to have a high titer of the HIV virus).

**ATTACHMENT C
CHEMOPROPHYLAXIS**

At present, TRUVADA (FTC/TDF) should be considered for all PEP regimens because it has data to support the efficacy of PEP in the clinical setting. KALETRA (LPV/RTV) is added to Truvada for increased antiretroviral activity in exposures with the highest risk for HIV transmission.

PEP should be initiated promptly, preferably within 1-2 hours post-exposure. Initiating therapy after a longer interval (72 hours) may be considered for the highest risk exposures; even if infection is not prevented, early treatment of acute HIV infection may be beneficial. The optimal duration of PEP is unknown; however, it is recommended that PEP be administered for 4 weeks, if tolerated.

You will be evaluated by your clinician every two weeks for six weeks, at twelve weeks, six months, and twelve months from the date of your injury. A targeted physical exam may be performed as needed at any of these visits. Laboratory tests will be performed at each visit. Discuss all medications taken, their dosage, and frequency with your clinician during your regular visit.

There are emergency PEP kits (with 5 day supplies of medications) in the outpatient pharmacy for exposures which occur on-tour and in the emergency department for those which occur off-tour hours. During on-tour hours, you need to go to Employee Health Clinic as soon as possible for initial evaluation of the exposure injury and immediate initiation of the PEP medications. Off-tour exposures need to report to the emergency department for the initial exposure evaluation and initiation of PEP therapy. You need to report to Employee Health Clinic the next working day, when you will be counseled about lab tests and given instructions on how to obtain the remainder of your 4-week supply of medications.

The recommendations below are from CDC guidelines, published in MMWR, dated September 2005.

TYPE OF EXPOSURE	SOURCE MATERIAL	ANTIRETROVIRAL PROPHYLAXIS	ANTIRETROVIRAL REGIMEN	
Percutaneous Injury	<u>Less severe</u>			
	HIV-positive, class 1	Recommended	FTC/TDF	
	HIV-positive, class 2	Recommended	FTC/TDF + LPV/RTV	
	Source HIV status unknown	Consider/Optional	FTC/TDF	
	Unknown Source	Need expert consultation	Call PEP line	
	HIV-negative	Not necessary		
	<u>More severe</u>			
	HIV-positive, class 1	Recommended	FTC/TDF + LPV/RTV	
	HIV-positive, class 2	Recommended	FTC/TDF + LPV/RTV	
	Source HIV status unknown	Consider/Optional	FTC/TDF	
	Unknown Source	Need expert consultation	Call PEP line	
	HIV-negative	Not necessary		
	Mucous Membrane and Non-Intact Skin Exposures	<u>Small volume</u>		
		HIV-positive, class 1	Recommended	FTC/TDF
HIV-positive, class 2		Recommended	FTC/TDF	
Source HIV status unknown		Generally not needed		
Unknown source		Need expert consultation	Call PEP line	
HIV-negative		Not necessary		
<u>Large volume</u>				
HIV-positive, class 1		Recommended	FTC/TDF	
HIV-positive, class 2		Recommended	FTC/TDF + LPV/RTV	
Source HIV status unknown		Consider/Optional	FTC/TDF	
Unknown source		Need expert consultation	Call PEP line	
HIV-negative		Not necessary		

ATTACHMENT C

CHEMOPROPHYLAXIS (continued)

Obtain expert consultation by contacting the National Clinicians' Post-Exposure Prophylaxis Hotline (PEP line) at 1-888-448-4911 for the following concerns:

- Known or suspected pregnancy or breastfeeding in exposed person
- Exposed person has renal insufficiency (creatinine clearance less than 50mL/min)
- Delayed (i.e. later than 24-36 hours) exposure reported
- Unknown source (i.e. needle in sharps container, laundry)
- Possible drug resistance in HIV-positive source patient

Post Exposure Prophylaxis Regimens:

- Truvada (emtricitabine 200mg/tenofovir 300mg; FTC/TDF) 1 tablet daily
- Kaletra (lopinavir 200mg/ritonavir 50mg; LPV/RTV) 2 tablets twice daily

Less severe percutaneous injury: For example, solid needle or superficial injury

More severe percutaneous injury: For example, large-bore hollow needle, deep puncture, visible blood on device, or needle used in patient's artery or vein

Small volume exposure: For example, a few drops

Large volume exposure: For example, a major blood splash

HIV-positive, class 1: Asymptomatic HIV infection or known low viral load (e.g. <1500 RNA copies/mL)

HIV-positive, class 2: Symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load

Source HIV status unknown: For example, deceased source person with no samples available for HIV testing

Unknown source: For example, a needle from a sharps disposal container or a splash from inappropriately disposed blood

**ATTACHMENT D
DRUG INFORMATION**

TRUVADA® (Other names: Emtricitabine/Tenofovir, FTC/TDF)

Please see MedFacts Patient Information on the Facts and Comparisons website at:
<http://online.factsandcomparisons.com/index.aspx?#parentmono>

KALETRA® (Other names: Lopinavir/Ritonavir, LPV/RTV)

Please see MedFacts Patient Information on the Facts and Comparisons website at:
<http://online.factsandcomparisons.com/index.aspx?#parentmono>

ATTACHMENT E

**POST-EXPOSURE PROPHYLAXIS (PEP) CONSENT
DECLINATION FORM**

I, _____, have been counseled about taking Post-Exposure Prophylaxis (PEP) to help prevent HIV infection following my recent blood/body fluid exposure. I understand the dosing schedule for the PEP medications and the recommended period of treatment. I have been advised about the side effects of PEP medications. I understand that should I choose to take the PEP medications, it will be important for me to have blood tests done every two weeks for six weeks and at three months, six months, and twelve months. I have had the opportunity to ask questions relevant to the PEP treatment and understand that if I have questions in the future, that I may contact the Employee Health Clinician.

I _____ to take post-exposure medications.
(Agree/Decline)

Employee Signature Date

Clinician Signature Date

ATTACHMENT F

**CHEMOPROPHYLAXIS IN OCCUPATIONALLY-EXPOSED
HEALTHCARE WORKERS**

Voluntary Statement of Intent to Avoid Pregnancy: Women

To the best of my knowledge, I am not currently pregnant. Furthermore, I agree to avoid pregnancy while I am taking chemoprophylaxis during the next four weeks and for four weeks thereafter. Should I have sexual relations during this period, I will practice a form of birth control (e.g., abstinence, oral contraceptives, intrauterine device, diaphragm plus condoms) that is deemed reliable by my clinician. I will immediately contact my clinician if pregnancy is suspected. I may decline to sign this statement; my declining to sign will have no effect on future treatment by my clinician except that I will not be treated with post exposure prophylaxis medications.

Participant's Signature

Date

Name (Print)

Date

Voluntary Statement of Intent of Avoid Pregnancy: Men

Should I have sexual relations during the next four weeks and for four weeks following completion of chemoprophylaxis treatment, I will practice a form of birth control with my partner(s) (e.g., abstinence, oral contraception, condoms plus diaphragm, intrauterine device) that is deemed reliable by my clinician. I may decline to sign this statement; my declining to sign will have no effect on future treatment by my physician except that I will not be treated with post exposure prophylaxis medications.

Participant's Signature

Date

Name (Print)

Date

ATTACHMENT G

*****PRE-HIV TEST COUNSELING*****

Pre-HIV antibody test counseling was provided at _____ on
_____.
(time) (date)

The following content was discussed during the counseling session:

- _____ The meaning, sensitivity, and specificity of HIV tests.
- _____ The possible social ramifications of a positive test result.
- _____ Policies and guidelines for confidentiality of test results.
- _____ The healthcare services available in the VA for patients with HIV infection.
- _____ Policy and guidelines on disclosure to Public Health authorities.
- _____ Policy on disclosure to spouse/sexual partner.
- _____ Measures to be taken for prevention of HIV transmission.
- _____ Information relative to authorized disclosures, either with or without consent, of HIV test or treatment records.
- _____ Availability of anonymous testing at test sites in the community.

The patient's response to participation in counseling session:

The patient's mental status at the time of counseling:

Assessment of the patient's comprehension of the significance, meaning, and ramifications of test:

The patient freely consents to testing.

Signature of Counselor

Date

Printed Name of Counselor

ATTACHMENT H

CONSENT FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TESTING

I have asked or been asked to have my blood tested for antibodies to HIV, the virus which causes AIDS. It has been explained to me that the test is for HIV infection. It is not a test for AIDS. If I do have antibodies to the virus (a POSITIVE test), this means that I have been infected with the virus. If I do not have antibodies (a NEGATIVE test) but am in a group of people who are at high risk for AIDS (people who have had multiple sex partners or who share needles when using drugs), this does not mean that I will not become infected in the future. In fact, I may already be infected but have not yet had time to develop antibodies.

I have been told that the blood tests for antibodies to the virus are not foolproof. In a small number of people, other things such as another virus or disease may wrongly cause a positive test. This is called a false positive test. It is also possible to have a false negative test. In this case, I do have the antibodies to the virus but the test did not show this. If the first test on my blood is positive, the test will be repeated. If positive again, a different test will be conducted. These tests will all be done on the blood taken after I sign this consent.

I have been told that HIV is spread through the blood from an infected person. It is also spread by having sex with an infected person. I understand that if my test is positive, I can spread the infection to others. I must not give blood or plasma or donate my organs or sperm if I am positive.

If I have a positive test, I should explain this to any sexual partner. If I am unable to tell my spouse or any other sexual partner whom I have identified, my doctor or counselor may do so, but only to protect the sexual partner's health.

If I have a positive test, my case may be reported to public health agencies. However, the public health staff may only use or give out that information for the public health purpose for which it was given. Otherwise, information about my HIV testing cannot be revealed to anyone outside the VA without my written permission, or a court order, a medical emergency, for research, Congressional oversight, or audit purposes, or for medical treatment provided to me by the Armed Forces.

I have been told that the results of my test (positive or negative) will be in my medical record. I understand that any VA employee who improperly releases information about my HIV testing is subject to a fine. Even though I understand every effort will be made to protect the results of my test, I also understand that disclosure of a positive test result can lead to discrimination in housing, jobs, and other areas in some communities.

I have been counseled about the HIV test and have been given a chance to ask questions. I understand what a positive and a negative test means. I understand that the test is voluntary and that I will still receive care from the VA if I refuse to have the test done.

Therefore, I give my permission for my blood to be tested for HIV antibodies.

Signature of Patient or Legal Guardian

Date

Signature of Witness
VA Form 10-0121

Date

ATTACHMENT I

POST-HIV TEST COUNSELING

Employee Name _____ Exposure Date _____

Post-HIV Antibody Test counseling was provided on _____ at _____
a.m./p.m. (date) (time)

The following content was discussed during the counseling session:

_____ NEGATIVE Test Results: window period _____ retesting _____
HIV prevention _____

_____ POSITIVE Test Results

Employee's emotional/mental status:

Resources available:

Referrals:

Partner notification:

Prevention of transmission:

Clinician/Counselor Signature

Date

ATTACHMENT J

HEPATITIS B FACT SHEET

Hepatitis B is a disease of the liver which is caused by a virus. Infection is passed from one person to another by blood and body fluids and can occur following transmission or injection of contaminated blood or blood products, use of dirty needles, sexual activity, and accidental needlestick injury. Many people who become infected will continue to carry the virus even after they have recovered from the infection. Others will have a persistent infection the rest of their lives. Hepatitis B can cause serious liver damage years after the infection has occurred. Some people will develop cirrhosis and liver cancer and may require liver transplant.

HEPATITIS B – RATE OF CONVERSION

The rate of infection with Hepatitis B following blood/body fluid exposure is approximately 33% (1 in 3). Many people previously infected with Hepatitis B are carriers of the Hepatitis B virus and can pose a risk to others through their blood and body fluids. The risk of Hepatitis B infection following body fluid exposure is greatly reduced by Hepatitis B vaccination.

Hepatitis B vaccinations involve a series of three injections given over a six month period of time. The purpose of the vaccination is to cause your body to develop antibodies to the Hepatitis B virus without giving you the disease. Once a person has the antibodies in their bloodstream, they are felt to be protected from future infection to Hepatitis B. Some people may not develop antibodies after their vaccination series and may need to go through the series two or more times before they do develop immunity. For this reason, blood tests are done after the vaccination series has been completed to ascertain if the vaccination did indeed work. It is not certain how long the immunity provided by the vaccinations will last. While many feel the immunity is lifelong, some institutions will check antibody titers after seven years and repeat a booster if the titer is too low.

ATTACHMENT K

HEPATITIS C FACT SHEET

Hepatitis C is a disease of the liver caused by the hepatitis C virus (HCV) which is found in the blood of persons who have this disease. HCV is spread by contact with the blood of an infected person. This may be through injection of contaminated blood or blood products, use of dirty needles, sexual activity, and accidental needlestick injury. It is possible to find HCV within 1 to 2 weeks after being infected with the virus. Many people who have hepatitis C have no symptoms. In people who are infected with HCV, approximately 55-85% develop long-term infection, 70% develop chronic liver disease, 5-20% develop cirrhosis over a period of 20-30 years, and 1-5% die from the consequences of long-term infection (liver cancer or cirrhosis). There is no vaccine to help prevent infection with HCV.

HEPATITIS C – RATE OF CONVERSION

Hepatitis C virus (HCV) is not transmitted efficiently through occupational exposures to blood. The average incidence of anti-HCV seroconversion after accidental percutaneous exposure from an HCV-positive source is 1.8% (range: 0%-7%), with one study indicating that transmission occurred only from hollow-bore needles compared with other sharps. Transmission rarely occurs from mucous membrane exposures to blood, and no transmission in health care personnel has been documented from intact or nonintact skin exposures to blood. Data are limited on survival of HCV in the environment. In contrast to hepatitis B virus, the epidemiologic data for HCV suggest that environmental contamination with blood containing HCV is not a significant risk for transmission in the health care setting, with the possible exception of the hemodialysis setting where HCV transmission related to environmental contamination and poor infection control practices have been implicated. The risk for transmission from exposure to fluids or tissues other than HCV-infected blood also has not been quantified but is expected to be low.

No protective antibody response has been identified following HCV infection. In the absence of post-exposure prophylaxis for HCV, recommendations for post-exposure management are intended to achieve early identification of chronic disease and, if present, referral for evaluation of treatment options.

ATTACHMENT L

FOLLOW-UP

To be completed by Employee Health Clinician the next regular workday after body fluid exposure incident.

Employee Name: _____ SSN: _____

1. Lab Test Results:

Source (Patient)	Employee
HIV: _____	HIV: _____
HBsAG: _____	HBsAG: _____
HBsAB: _____	HBsAB: _____
HBcIgM: _____	HBcIgM: _____
HAVIgM: _____	HAVIgM: _____
HEP C: _____	HEP C: _____
SGOT: _____	SGOT: _____
	Pregnancy Test: _____

Employee Notified of Results: Yes No (circle)

2. Hepatitis B Vaccination Schedule:

Hepatitis B vaccination (is/is not) _____ applicable.

DOSE	DATE DUE
1st	_____
2nd	_____
3rd	_____
Booster	_____

Employee is aware of Hepatitis B vaccination schedule: Yes No (circle)

3. Employee Was Started on Post Exposure Prophylaxis (PEP): Yes No (circle)

Side Effects Reported:

If Post Exposure Prophylaxis (PEP) was discontinued, enter the date it was discontinued: _____

Explanation:

4. Infection Control Clinician Noted of Body Fluid Exposure Incident: Yes No (circle)

If "no", explain:

5. Employee Aware of Schedule for Follow-Up Lab Tests and Clinic Visits: Yes No (circle)

6. Employee Has Been Advised Against Reproducing While Taking PEP: Yes No (circle)

ATTACHMENT M
PSYCHOLOGICAL COUNSELING

Employee is referred to _____ for psychological counseling.

Clinician Signature

Date

Clinician Printed Name

ATTACHMENT N

**FOLLOW-UP EMPLOYEE HEALTH CLINIC VISITS
FOR BODY FLUID EXPOSURE**

Employee: _____ SSN: _____

	DATE DUE	DATE COMPLETED
Exposure Date	_____	_____
Employee Health - 1st Visit (Next Day)	_____	_____
Lab Test - Prior to 2 week follow-up (CBC, chem panel)	_____	_____
Employee Health - 2 week follow-up	_____	_____
Lab Test - Prior to 4 week follow-up (CBC, chem panel)	_____	_____
Employee Health - 4 week follow-up	_____	_____
Hepatitis B Vaccination #2	_____	_____
Lab Test - Prior to 6 week follow-up (CBC, chem panel)	_____	_____
Employee Health - 6 week follow-up	_____	_____
Lab Test - prior to 3 month follow-up (HIV)	_____	_____
Employee Health - 3 month follow-up	_____	_____
Lab Test - prior to 6 month follow-up (HIV)	_____	_____

Hepatitis B Vaccination #3	_____	_____
Employee Health - 6 month follow-up	_____	_____
Lab Test - prior to 12 month follow-up (HIV, HepB-AB)	_____	_____
Employee Health - 12 month follow-up	_____	_____