DALHOUSIE FAMILY MEDICINE:
Creation of a Rotation Orientation Handbook in Sydney, NS

Medical Education Tool

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Based off the Resident Project Guide 2022-2023

Abstract

Background: The aims of this study were to investigate the impact of orientation on residents, and utilize Gifford et al's orientation template to create a rotation orientation handbook (Appendix B) for the Dalhousie Family Medicine Residency Sydney site.

Methods: This was a mixed methods research project. Current medical residents from the Sydney and Inverness Dalhousie Family Medicine sites were invited to participate in a survey to provide feedback on the orientation process and on specific rotations. All rotation lead preceptors were invited to meet individually with the principal investigator to provide feedback on the handbook. The handbook was created based on the Gifford et al. template, feedback provided by staff and residents, and prior rotation information.

Results: The degree of orientation information affected residents' well-being (92%), academic performance (75%) and ability to provide patient care (57%). 64.2% of residents were generally dissatisfied (57.1% "dissatisfied" and 7.1% "very dissatisfied") with prior orientation information. 92.9% found the Gifford et al template to be generally helpful (78.6% helpful and 14.3% very helpful).

Interpretation: Clinical learning environment orientation impacts residents' academic performance, patient care and well-being. Gifford et al's template was seen as a helpful tool in creating an orientation handbook for the Cape Breton Dalhousie Family Medicine programs.

Personal Reflection

Throughout my medical and residency training, I have found that the rotations that provided a thorough orientation and addressed my learning goals set me up for success. I would find myself experiencing whiplash when rotating through various specialties as some provided no orientation while others set aside time to address pertinent information and expectations. I hope that this project highlights the need for innovative orientation practices in clinical learning environments to benefit learners, teachers, and patients. This is especially important at the Cape Breton Regional Hospital, where a new medical school and hospital are being built.

There is concern for the longevity of this project, especially as rotations continually change, however my hope is that each lead resident divides the sections amongst the residents and updates them on a yearly basis. I hope that this project is a jumping point for future work in Dalhousie medical education.

Introduction

Medical residency is a large transition point for medical students, often causing significant personal and professional stress.[1,2] It involves frequent transitions between new clinical learning environments (CLEs), or rotations, that each have unique preceptors, staff, systems, locations, and cultures.[3] Without proper orientation to each CLE, expectations may be unclear leading to miscommunication between learners and staff, and can create discrepancy between learners' objectives and rotation opportunities.[4,5] As a result, academic performance[4] and patient care[3,6]

may be at risk. Moreover, these frequent rotation changes may contribute to poor resident wellbeing and burnout.[1,5]

The goals of orientation are to benefit both the resident and the staff physician, or preceptor. Orientation fosters feelings of "self-worth, a sense of belonging, an attitude of pride and confidence in oneself and in the organization, and a desire to succeed" for the trainee when acclimating to a new role.[4] A proper orientation promotes the trainee to learn and grow their competencies.[7] On the trainers' side, Wiese et al. found that physicians goals during orientation are to confirm that trainees are "ready" to practice with adequate knowledge and skills required, are "steady" or acclimated into the new environment, and can safely "go" practice.[3]

In any new position, key orientation information is required to facilitate role acquisition.[1,4,7–9] A prioritized checklist of paperwork, people to meet, and places to orient are necessities.[7] Schedules, contact information, objectives, roles, responsibilities, and evaluation standards are also integral to successful role acquisition. Residents generally look to their peers and orientation manuals for reliable information regarding responsibilities, preceptor preferences, and key resources.[9] In addition, residents hope to learn clinical needs, ie: call duties and patient problems during their orientations.[10] Orientation packages may be provided to new trainees for convenient reference.[7]

Multiple orientation models have been studied to optimize the orientation of residents into new CLEs. Gifford et al created questions and themes to guide orientation for CLEs by answering the questions “who”, “what”, “where”, “when”, “why” and “how” (Appendix A).[8,9] Emergency medicine rotations seem to benefit from sim-based orientations as much of their practice is situation-based.[11,12] An “intern passport” was a helpful checklist tool to introduce emergency interns and pertinent specialists to eachother.[13] Resident-lead orientations decreased radiology resident anxiety as they started new rotations.[14] Multimedia videos,[15,16] phone apps,[17–19] and comics[20] have been effective orientation adjuncts for services with frequent changeovers of learners. For adolescent medicine residents, a 40-question multiple choice quiz was helpful for residents to prepare and review key knowledge before starting the rotation.[21]

Background

The Cape Breton Family Medicine Residency Program in Sydney, Nova Scotia (NS) is a satellite site of Dalhousie University that is block-based, requiring frequent transitions between specialties. This site also shares rotations with the Inverness, NS site and visiting residents from various specialties. Currently, residents receive varying amounts of orientation information prior to their rotation. This may hinder resident performance, well-being, and patient care. A concise, up-to-date, synthesized document including the key information highlighted by Gifford et al may improve the experience of both residents and staff.

The primary goals of this project are to:

1. Gather feedback on the orientation experiences from learners;
2. Update the orientation packages based on Gifford et al's template (Appendix A) and feedback gathered from learners and staff; and
3. Create a comprehensive handbook that includes updated orientation packages for each clinical rotation (Appendix B).

Study Design/Methods

Initiation

A scoping literature review was completed after discussing search terms with a Dalhousie medical librarian. After their consultation, the specific Pubmed search terms identified were "rotation"[Title/Abstract] AND "orientation"[Title/Abstract] AND ("education, medical"[MeSH Terms] OR "medical education"[tiab] OR residen*[tiab]). 109 articles between 1993-2023 were found with this search term, and 21 were included in the review. The inclusion criteria were: 1) English language papers, 2) research question focused on CLE orientation. The exclusion criteria were: 1) other languages and 2) research questions not relating to CLE orientation. Google Scholar was also utilized with the term "residency orientation".

As this project is a medical education tool, ethics was not required from Dalhousie University. Article 2.5 in Chapter 2 of TPCS states that: "Quality assurance and quality improvement studies, program evaluation activities, and performance reviews, or testing within normal educational requirements when used exclusively

for assessment, management, or improvement purposes, do not constitute research for the purposes of this Policy, and do not fall within the scope of REB review." An REB exemption was approved by Nova Scotia Health.

An initial meeting was held with the Dalhousie Cape Breton medical education committee to discuss the goals and objectives of the project. Pertinent stakeholders were identified, including the following staff at the Cape Breton residency sites: preceptor leads, site lead, and Cape Breton family medicine residents.

Creation

All identified groups were offered to provide feedback. An anonymous survey (Table 1) was sent to current Cape Breton residents (Sydney and Inverness) via email and WhatsApp. The survey questions were created based on the literature review and survey question guidelines outlined by Dalhousie University, including using neutral questioning and alternating answers. Data collection was obtained from October 4, 2023 to January 15, 2024.

An email requesting a meeting was sent to each rotation lead preceptor. 30-minute meetings were scheduled with as many lead preceptors as possible. During these informal meetings, the draft product was presented to the rotation lead preceptor, and they provided feedback and offered suggestions. The document was edited live during the meeting to reflect their suggestions.

The handbook was continually curated based on prior orientation information, feedback from residents, and suggestions from lead preceptors. The style of the handbook was based on the official font (Public Sans) and colours of Dalhousie University. The Dalhousie content team was contacted, and they provided official images and designs to include in the handbook.

Table 1: Resident Survey

General Questions	
Which site are you?	*Sydney, Inverness*
What year are you in?	*PGY1, PGY2*
How satisfied are you with the orientation information you receive for each rotation?	*Very satisfied, satisfied, neutral, dissatisfied, very dissatisfied*
Does the quality of orientation impact your academic performance?	*n/y*
Does the quality of orientation impact your ability to provide patient care?	*y/n*
Does the quality of orientation impact your well-being?	*n/y*
Please choose what aspects are important to you in a rotation orientation	*Multi-select*
If a handbook is created that includes orientation info for each rotation, what info would you like included?	*Multi-select*
What medium would be best to receive the handbook?	*Multi-select*
Rotation Specific	
What specific info would you like to see included for each rotation?	*Open*
Gifford et. al	
What do you think of Gifford et. al's template?	*Very unhelpful, unhelpful, neutral, helpful, very helpful*

Review

Once the draft of the handbook was completed and the initial survey was closed, the draft was shared with residents, rotation lead preceptors and the site lead to offer final feedback before submission.

Results

14 of 22 residents in the Sydney and Inverness sites participated in the survey (Figure 1, 2). 85.7% were in the Sydney site and 64.3% were PGY2's. 7.1% of residents were generally satisfied (7.1% "satisfied" and 0% "very satisfied") with previous orientation information, 28.6% neutral and 64.2% were generally dissatisfied (57.1% "dissatisfied" and 7.1% "very dissatisfied"). Residents believed that the degree of orientation information impacted academic performance (78.6%), ability to provide patient care (57.1%) and personal well-being (92.9%) (Figure 3).

Figure 1: Demographics

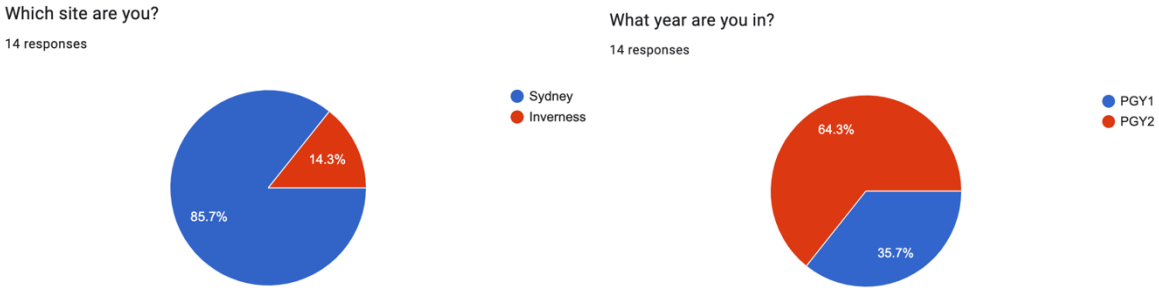


Figure 2: Satisfaction with orientation information

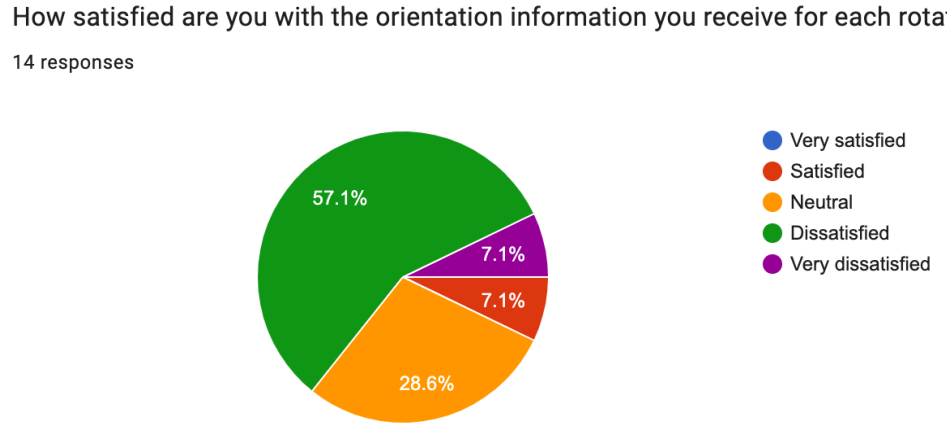
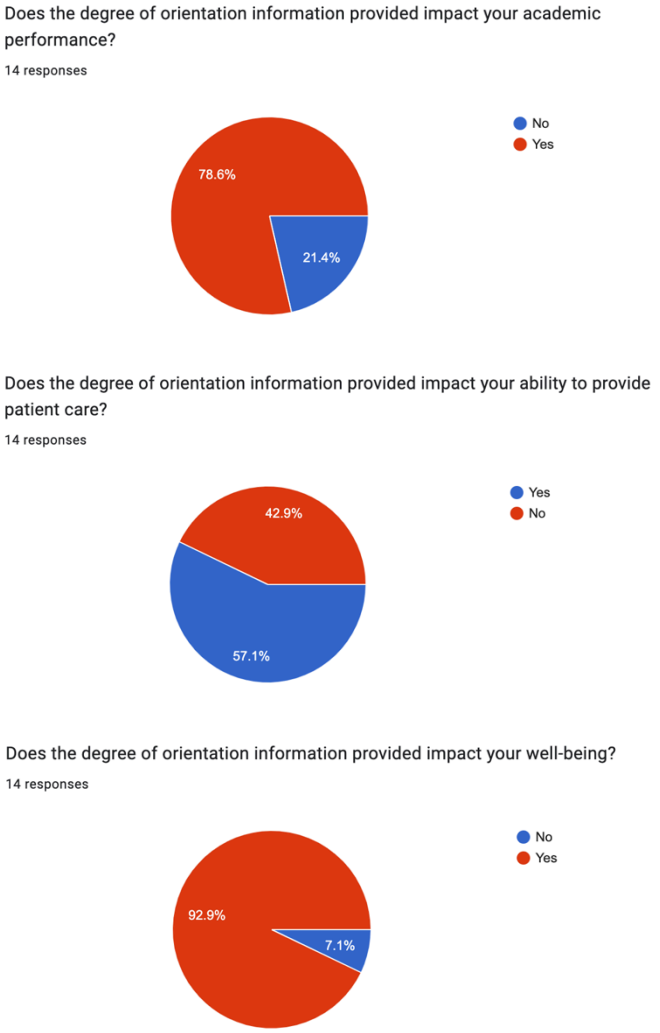


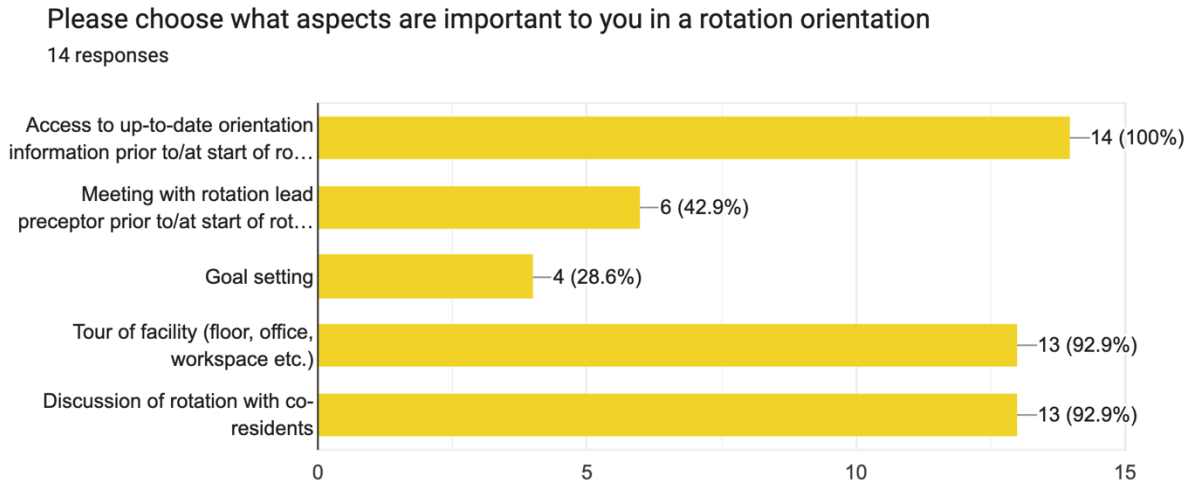
Figure 3: Impact of orientation information

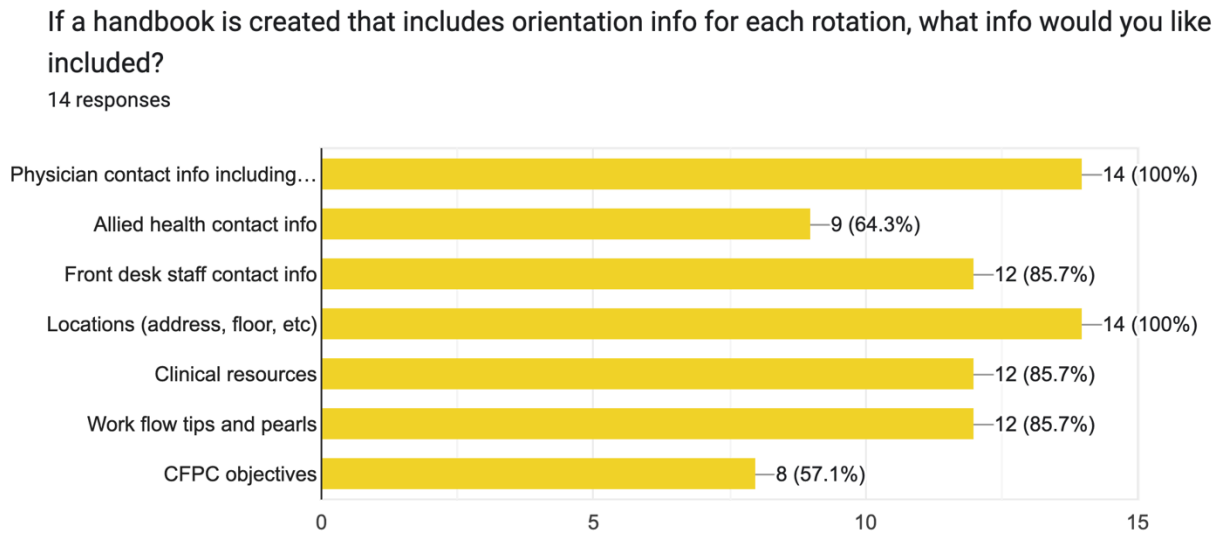


The most valued aspects to include in a rotation orientation (Figure 4) were “access to up-to-date orientation information prior to/at start of rotation” with votes from all residents. “Discussion of rotation with co-residents” and “tour of facility” received 13 votes (92.9%). “Meeting with the rotation lead preceptor prior to/at start of rotation” received 6 votes (42.9%) and “goal setting” received 4 votes (28.6%). Every resident deemed “physician contact information including dictation numbers” and “locations (addresses, floor, etc)” as important information to include in an

orientation handbook. 12 residents (85.7%) voted for “clinical resources”, “workflow tips and pearls” and “front desk staff info.” 9 residents (94.3%) voted for “allied health contact info” and “CFPC Objectives” were important to 8 residents (57.1%).

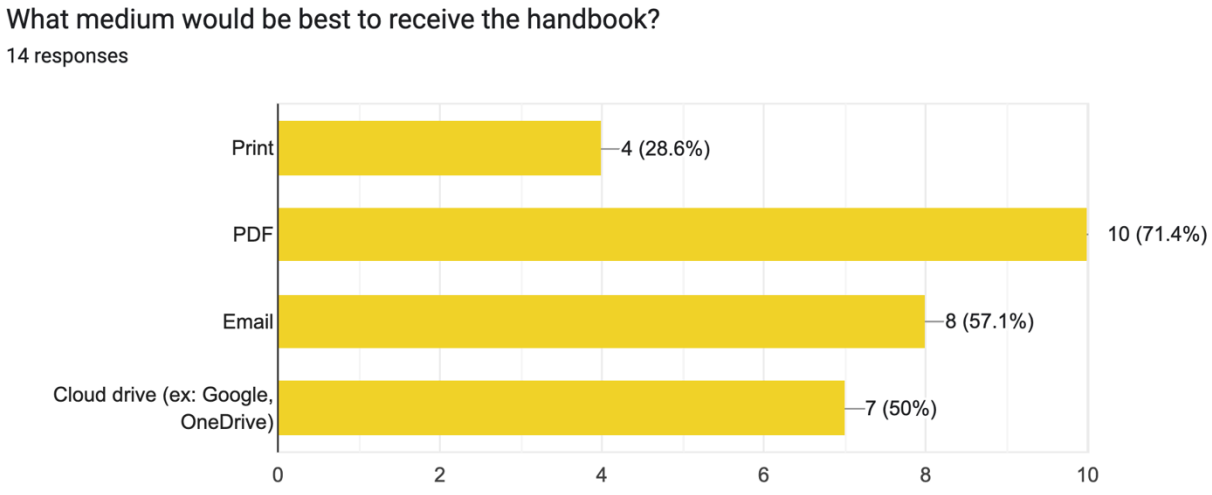
Figure 4: Valued aspects in a rotation orientation handbook





Regarding medium of choice, PDF was the most favoured at 10 votes (71.4%), followed by email, Cloud drive, and print at 8 (57.1%), 7 (50%) and 4 (28.6%) votes respectively. (Figure 5).

Figure 5: Medium of Choice



When asked for specific rotation feedback, similar themes emerged (Table 2 and Figure 6). Many individuals provided resources, including “iCCS app” for Cardiology, or “Pedistat” for Pediatrics. Contact information, workflow tips, locations, and expectations for call were common themes throughout. For cardiology, relevant order sets and a consultation/dictation guide were requested. “Lists of important cases…” and “…lists of services available to inpatients/for discharge” were suggested for the Hospitalist rotation. In Orthopedics, a resident wrote: “Specific subspecialities/interests each surgeon has… to have the opportunity to reach out if wanting to get more exposure”. Another resident requested guides to physical exams for the Orthopedics rotation. High yield CPS statements for Pediatrics was

suggested. In Family OB, day-to-day expectations and structure was voiced, as well as prenatal and SOGC resources and note/dictation templates. For the Emergency rotation, “tour of the department” and “peer orientation to ED prior to rotation…” were both suggested as helpful. For the rural blocks, places to live and to eat and things to do were common requests. When all this feedback was categorized into Gifford et al’s template, 28.2% fit into the “how”, 23.9% fit into the “what”, 16.9% were “who” and “where”, 12.7% were “when” and 1.4% were “why” categories (**Figure 6**).

Table 2: Rotation specific feedback from residents

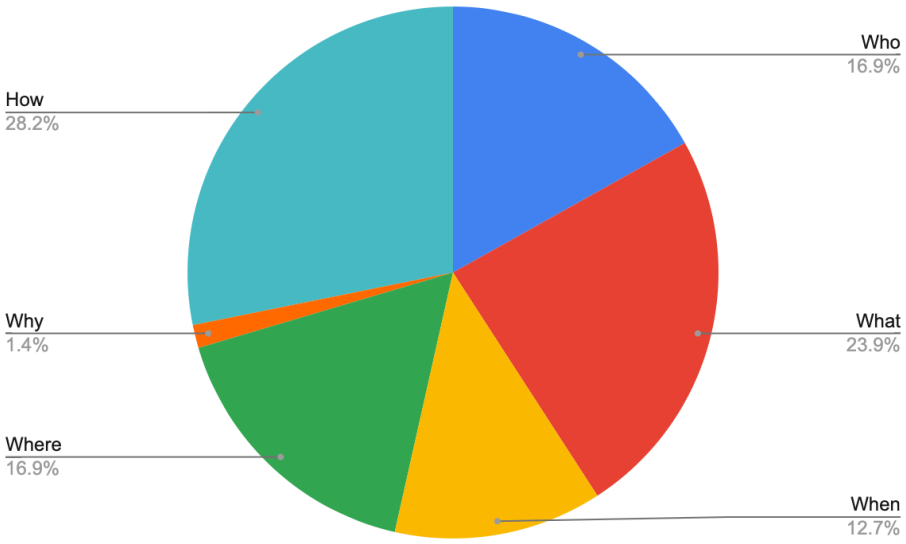
Rotation	**Comments**	**Relevant Gifford et al section**
YEAR 1		
Cardiology	*List of topics to review prior to rotation, staff phone numbers*	Why, Who
	iCCs is a good app!	How
	Condensed version of STEMI and NSTEMI order sets	How
	Working schedule for each staff, what a day in cardiology looks like	When, What
	Template admission/transfer dictation. Review of high yield apps (like the iCCS). Review of management/doses for NSTEMI, rapid afib, etc	How
	Example of a consult dictation, with cardiac risk factors	How
	iCCS app	How
	Objectives for the rotation and the best locations to obtain them eg. Atrial fibrillation medication titration/mgt - Heart function clinic	What, Where
Emergency	*List of good resources: pedistat, palm EM*	How
	Peer orientation to ED prior to rotation very helpful!	Where
	Tour of the department	Where
	Apps	How
	Useful apps/webpages/algorithms	How

ENT & General Surgery	*Contact information for the surgeons/places like CBRH OR, Ambulatory Care in North Sydney.*	Who, Where
	Work flow, contact info	What, Who
	information of where all the offices are and generally what time they start in the morning	Who, When
	Very useful to know what is expected of residents re: where to be, when to be there especially rounds.	Where, When
Family	*Just in general having all the previously listed contact info, details readily available before starting so that residents don't have to go back and forth to gather it. My preceptor was really good about this so it wasn't as much of an issue, but I think as general practice would be beneficial to all!*	Who, What
	Nothing to add!	n/a
	Reminder about 10 patient feedback forms, Narrly	What
FP-OB	*Expectations on responsibilities on LDR and how to prioritize these, contact info for all the staff you are expected to work with*	What, Who
	More information regarding the structure of the Family Med - OB. Who covers call for who?	What
	how to properly put on sterile gloves independently,	How
	How are calls!!! What is expected from residents overall!	What
	Link to NS prenatal record supplemental file, RCP handout on important investigations to order at specific prenatal visits, PDFs to the high yield SOGC guidelines (can get through dal library but ++ time consuming), template assessment in LDU, admission orders for LDU, template delivery summary, template discharge summary for mom + baby	How
	Family Med Obs providers phone numbers, maybe a mock schedule or general overview of how the days are scheduled (I.e Check in with LDU, round on Mom/Baby, check in for c-sections @ 8AM, etc)	Who, When
Gynecology	*Clinic phone numbers, names of admins, dictation numbers, office locations, general start/end times for clinic days.*	Who, When, Where

	Location of various clinics/OR days, times of clinic start if known ahead of time, contact information for staff including cell phone numbers	Who, When, Where
	Good orientation. Learning objectives provided - should align more with the CFPC objectives.	What
	Resources and apps	How
Hospitalist	*Better information regarding call schedule + booking call.*	When
	Clear expectations re call	What
	Work flow, apps	How
	Names of ward clerks, CNLs, and allied health for each unit. Codes to exit locked units. High yield apps (MD on call). Lists of services available to inpatients/for discharge (smoking cessation, home care services, etc)	Who, How
	List of important cases for one to aim at covering during the rotation.	What
	Call expectations, how call works for the hospitality's I.e. Resident will be forwarded list of all lines, resident will be required to assign patients to MRPs, if the info page contains phone numbers of the different units (in case one wants to call back). Also a template of pertinent info when discussing with ER physician about patient admission eg. Name, Age, DOB, Diagnosis, Inv so far, pending stuff, consults requested, Code status etc.	What, How
Orthopedics	*Dictation guide, dictation numbers for physicians, list of commonly asked questions by surgeons (haha I got pimped a lot)*	Who, How
	Specific subspecialties/interests each of the surgeons has - i.e., shoulders, knees, special surgeries etc to have the opportunity to reach out if wanting to get more exposure.	Who
	Maybe Dr. McKinnon X ray slides	What
	Guides to physical examination - RheumTutor through McMaster has excellent resources for a quick but thorough MSK exam for all joints	How
Pediatrics	*Pedistat is a good resource!*	How
	Working hours,	When
	High yield CPS statements, ADHD meds, review of hyperbilirubinemia/resp distress for NICU, services available in the community (strongest families, etc)	How

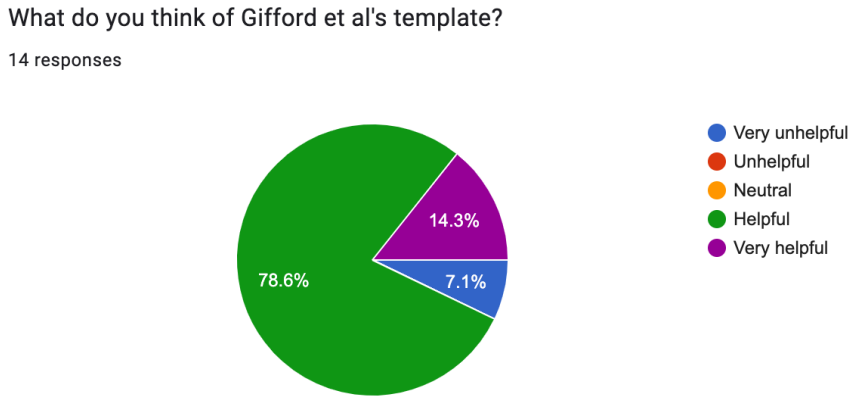
	Pediastat	How
Rural	*Fun stuff to do in each of the communities - restaurants, hikes, live music, etc!*	Where
	Potentially a list of places people have stayed at previously - Neil's harbour - Back Cove Cottages, Foundation House, Arichat - the fancy airbnb place, the blue cottage on the water, etc. etc.	Where
	Info about each location, work flow, hours	Where, When
	Places to stay, places to eat, places to run/hike/bike. Things to do. Pearls for each community/hospital. Specific learning experiences to ask for (ex ask Nicola to book you a procedures clinic)	Where, What, How
YEAR 2		
Geriatrics	*location of the offices - ie in the basement!! Components of a comprehensive geriatric assessment*	Where, What
ICU	*Dr. Burkes slides*	What
	Example of how to write a good ICU rounds note	
Palliative		*No feedback given*
Psychiatry	*A booklet with an overview of important topics in Psychiatry.*	What

Figure 6: Gifford et al. categories based on rotation specific feedback



Overall, 92.9% of residents found the Gifford et al template to be generally helpful (78.6% helpful and 14.3% very helpful) (Figure 7).

Figure 7: Gifford et al



Discussion

This project illustrates the importance of orientation to clinical learning environments. More than half of the residents were neutral or dissatisfied with the existing information provided, and the majority believed that the Gifford et al's template would be helpful. This identifies the need for improvement in the CLE orientation process at the Sydney site.

Interestingly, residents' well-being was the most impacted by the degree of orientation information provided. Dysfunctional educational environments – not individual attributes – foster burnout in medical students and residents.[22] This demonstrates that proper orientation is a resident wellness priority. As supported in the literature, further downstream effects of improper orientation were highlighted. More than 75% of residents claimed their academic performance was impacted.[3,6]

Just over half of residents believed patient care was affected. This is contrary to prior studies; the first week of resident orientation to an ICU rotation has been found to be an independent risk factor for hospital mortality in a developing country, compared to the rest of the weeks on rotation.[6] This may highlight a blindspot of residents' perception.

Almost all resident feedback fit into the Gifford et al's orientation template, suggesting that the template adequately addressed residents' concerns. This could be because Gifford et al's template focuses on process-oriented instruction by answering the cognition ("what do I learn?"), affect ("why should I learn?"), and metacognitive regulation ("how should I learn?") factors of learning.[23] When reviewing the specific feedback provided, residents seemed more concerned about the "who", "what" and "how" of a rotation, or the need for information during their orientation, rather than the "why" or specific "goal setting". This may highlight the "ready" step in the "ready-steady-go" model by Wiese and Bennett.[3] However, other studies have seen success with goal-setting in the orientation setting, and the concept of mastery goal orientation is a well-documented successful learning theory in medical education.[24,25] This discrepancy may be due to an improper focus on performance goal orientation versus mastery goal orientation, or simply that residents are adult learners whom practice self-regulated learning and don't require a formal goal-setting session with their preceptor.[25] Mastery goal orientation, or achievement goal motivation may be another avenue to improve medical student and resident well-being.[26]

Many of the “where” concerns from residents were in respect to rural rotations. This is likely due to the unfamiliar environment and need for basics including housing, food, and enjoyable activities. This highlights that residents may have differing priorities when on rural electives versus home, and the importance of basic needs to resident life.

Peer support and discussion was deemed valuable in the orientation process.[14] Several residents suggested in-person orientations for the Emergency rotation, in keeping with the literature on simulation-based, hands-on learning for ER orientations and the importance of peer mentorship.[9,11,12]

One resident voted that the Gifford et al template was “very unhelpful”, which may have been an error as their other responses were “dissatisfied” with the prior information provided and a positive final comment of “Keep up the good work Em!” This could have been a result from the alternating of the quantitative answers to improve survey bias.

Limitations

There are many limitations to this research project. The sample size is very small, limiting statistical significance. Lower-than-expected turnout may have resulted from the size of the survey, the information requested being extensive or solely seen as another “to-do” by the residents. The survey results are subjective and

may suffer from survey bias. There were no objective measures for resident well-being, academic performance, or patient care, again illustrating the subjective nature of this project. However, a residents' personal and learning experience is important and cannot be discredited. The categories chosen for each feedback was based on the Gifford et al. template, however there is overlap in the "who", "what", "where", "when", "why", and "how" categories, limiting the accuracy of the percentages. A post-survey was not conducted after the handbook was completed, which could have illustrated the impact of the handbook on the measurables.

Conclusions

Clinical learning environment orientation impacts residents' academic performance, patient care and well-being. Gifford et al's template was seen as a helpful tool in creating an orientation handbook for the Cape Breton Dalhousie Family Medicine programs. Future collaboration will be required with the addition of the CBU medical school campus and new hospital construction in the coming years.

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Appendix

Appendix A: Table 1 from Gifford et al.'s Resources for clinical learning environment orientation

Table 1. Question themes and strategies to guide orientation.

Questions	Theme descriptions	Orientation approaches
Why am I here?	Learners identify educational goals and opportunities, and the rationale behind the structure of the clinical service	• Use probing questions to explore learner interests and goals • Have learners write goals and share them with team members
Who is the team?	Team members, roles, and relationships	• Introduce team members and have them explain their roles • Post pictures of staff members and roles on the wall and/or include in orientation materials • Provide an overview of the patient population served
What do I do? ***What*** are my expectations, needs, and limits?	Learner roles, expectations, limits and situational factors, tools, and resources related to their responsibilities	• Describe learners' responsibilities and educational opportunities • Emphasize the importance of recognizing limits and asking questions • Give examples of situations that may require asking for help and how to reach out for help • Describe the approach to assessment of the learner
Where are things?	Location of patients and resources in the physical workplace as well as data and information in virtual space	• Create a map of the clinical learning environment • Review a patient chart in the electronic medical record with the learner • Give an overview of electronic or hard copy resources and policies
When do things happen?	Clinical and educational schedules	• Create a schedule or calendar • Develop workflow diagrams for common patient care processes • Include time for mutual feedback
How do I navigate patient care and learning?	Navigating the healthcare system, patient safety, learning, and continuous improvement	• Share tips of how to get things done • Deliver tutorials for specific clinical skills • Discuss integration of work responsibilities and learning

Appendix B: Orientation Handbook (see next pages)

Cape Breton Family Medicine Rotation Orientation Handbook

Created by Emily Lerhe
Last updated: Feb 11, 2024

Table of Contents

How To's

First Year

Second Year

Table Of Contents

Acronyms

General

AAT: activity as tolerated
BPMH: best possible medication history
CC: chief complaint
CNL: clinical nurse lead
DAT: diet as tolerated
Dx: diagnosis
ERP: ER physician
HCN: health care number
HPI: history of presenting illness
Hx: history
MRN: medical record number (CB#)
NICU: neonatal intensive care unit
NRT: nicotine replacement therapy
OS: order set
p/w: presenting with
RMO: requisition made out
ROS: review of systems
RT: respiratory therapy
RTC/RTER: return to care/ER
POD: post op day #
PMHx: past medical history
PSxHx: past surgical history
PT: physiotherapy
SOAP: subjective, objective, assessment, plan
s/p: status/post
SW: social work

OB Specific

BPP: Biophysical profile
CCHD: critical congenital heart disease screen
C/S: C section
EDD: estimated date of delivery
EFM: external fetal monitoring
FHR: fetal heart rate
FNU: family newborn unit (previously known as MBU: mother babe unit)
GA: gestational age
GTPAL: gestation, term, preterm, abortion, living
IOL: induction of labour
LDU: labour and delivery unit
LMP: last menstrual period
OA, OP: occiput anterior, occiput posterior
ROM: rupture of membranes
PPD: postpartum day #
PPH: postpartum hemorrhage
SFH: symphysis fundus height
SVD: spontaneous vaginal delivery
TOLAC: trial of labour after C/S

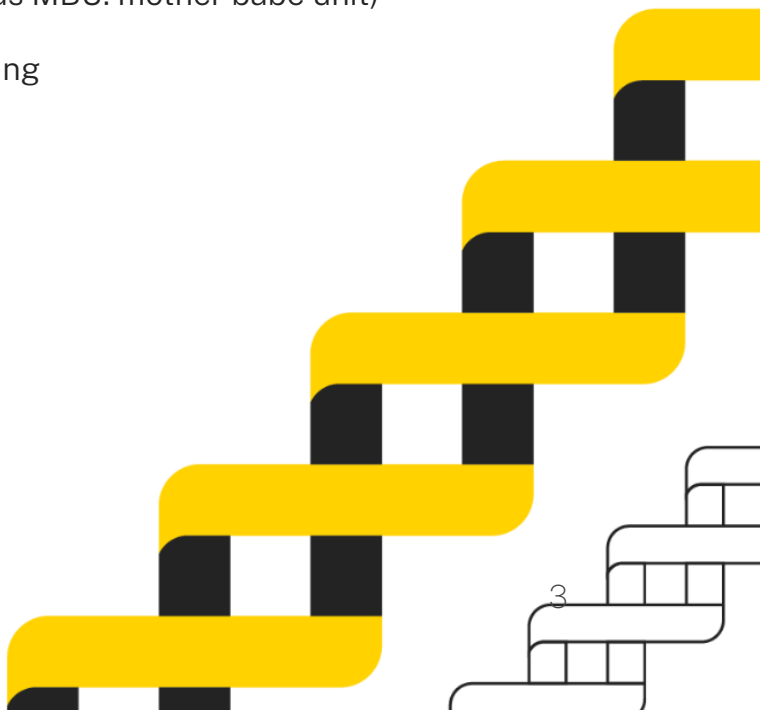


Table Of Contents

Tips

1. Email the lead preceptor at least 1-3 months in advance to book vacation, academic half days, family day back's and PGY2 protected time.
2. Check in with Kathleen or lead preceptor if you haven't received a schedule.
3. **For reporting details, please first call the clinics or department, and if that doesn't work then text the preceptor during working hours only (to avoid evening texts).**
4. Save each preceptor into your contacts with their cellphone and dictation ID.
5. Ask a friend to orient you to the space prior to starting the rotation.
6. Try to keep up with your field notes! For example, go through your dictations that week and pick one patient a day to write on.
7. If you are rounding (ex: LDU, peds), you can call the unit the night before or in the morning to ask number of patients, IOLs, etc.
8. Review CFPC Objectives and Priority Topics as you go.

Dictation Instructions

1. 902-567-6655 (save this in your phone!)
2. Dictation ID (your CPSNS ID) #
3. Location number (**CBRH: 87**, Buchanan: 15, Sacred Heart: 47, Inverness: 34) #
4. Patients MRN (CB00___) # - *don't need leading zero's*
5. Document types:

1	History and Physical	**9**	Outpatient Consultation
2	Inpatient Consultation	**7**	Progress Note
3	Emergency Room	**14**	Transfer Note
5	Discharge Summary	**16**	Clinical Outpatient Summary
6	Clinic Note	**18**	Labour and Delivery Note
		19	Palliative Care Consultation

6. Preceptor's CPSNS ID and full name
7. Press 2 to dictate
8. Press 2 to pause and then 2 again to restart
9. Press 9 if priority/stat
10. Press 8 to finish dictation
11. Be ready to write down the dictation number! Press * to hear the number again
12. To edit and sign dictations: www.escription-one.ca/inquiry
    a. Login in your CPSNS ID, your own password, and "newz".
    b. To find previous dictations, search all with "Dictator" as you.

Table Of Contents

First Year

Cardiology

Who?

Preceptors

DR. DONGSHENG GAO
Cardiology Lead
+ electrocardiologist
C: (902) 322-9508
O: (902) 567-7747
dongs_gao@yahoo.com
CBRH 3rd floor
15960

Dr. Bilal Hussain
O: (902) 270-5920
Suite 407 Health Park
19024

Dr. Paul Morrison
+ cardiac rehab
C: (902)412-2499
O: (902) 567-6302
Paul.Morrison@nshealth.ca
Suite 408 Health Park
15571

Dr. Paul MacDonald
C: (902) 304-6335
DrPaul.MacDonald@nshealth.ca
CBRH 3rd floor
07834

- The cardiologists are on inpatients for one week at a time, starting on Tuesdays.

Allied Health

Chris Browner, NP
+ ER NP
C: (902) 574-3359

BJ, NP
C: (902) 577-5115

4A: (902) 141-2909
CCU: (902) 141-2730

- PT, OT, dietician, SW, and the Stop Smoking Program are all valuable resources to consult for your admissions PRN.

Patients

- As you can imagine, this a heterogenous population. You will see multiple interesting cases, with the most common being:
  - Post-STEMI/NSTEMI – management and secondary prevention
  - CHF – new or exacerbation
  - Arrhythmias – atrial fibrillation/flutter, blocks, SVT

- This rotation is heavily focused on modifiable risk factor management and on first-line treatment; for example, treating HTN and DLD while optimizing heart failure medications.
- Lastly, always make sure you have a good social history, including occupation, drug coverage and substance use. Dr. MacDonald usually likes to know their social history at the beginning of your case presentation.

What?

Background

- The cardiology team rounds on CCU and sees cardiology consults in the ER or medical floors. They also respond to Code Blue's during working hours, so you will likely see Code Blues during your rotation. They also do stress tests, transesophageal echo's, pacemaker placements, and bubble tests throughout the day.
- **Dress code**: scrubs or clinic clothes

Roles and Responsibilities

- You are responsible to round on CCU daily with the team, complete consults, and respond to Code Blue's with your team.
    - When you see a new consult, you are responsible for completing a thorough history, physical exam and develop a proposed plan and orders – you will review this with your staff.
- When you are on call, you are on INTERNAL MEDICINE call – this means that you may see a DKA or pneumonia on your cardiology rotation! Your preceptor will call you to let you know when there is a consult; you may only get the floor number or name of the patient, so you might have to do some digging on Meditech or ask the floor nurses to help you. You will also respond to Code Blue's.
- Always call your staff if you need backup and support.

When?

Day to Day

- Usual start time is around 0800h in the CCU for rounds. Dr. Gao usually meets you in his office on your first day.
- After rounds, the cardiologist has a list of consults for the day, and they will be divided between yourself and the NPs.
- You will usually start with one consultation in the morning and one in the afternoon and may build as you progress.
- Work usually finishes around 1700h when you have completed your consultations and dictations.

Call

- Amount: ~1 in 4
- Weekdays: 1700h – 0000h. If you stay later than midnight, you are allowed to take a post-call day.
- Weekends: 0800h – 0800h.
- How to schedule call:

Evaluations with Dr. Gao or most prominent preceptor

- Save some time at the end of your rotation for feedback.
- Attempt to have the same amount of fieldnotes as days on the rotation.

Where?

- The CCU is on the 3rd floor and connected to the ICU.
- 4A is where most cardiac inpatients are, however if you have consults throughout the hospital your patients may be on different floors.
- Most of your consults will be from the ER.

Why?

CFPC Objectives

ACLS	Multiple Medical Problems
Atrial Fibrillation	Obesity
Chest Pain	Palliative Care
Heart Failure	Renal Failure
Hyperlipidemia	Shortness of Breath
Hypertension	Smoking Cessation
Ischemic Heart Disease	Thyroid
Lifestyle	

How?

Order Sets

- Heart Failure
- STEMI
- NSTEMI
- Cardiac Routine Admission
- Targeted Temperature Management after Cardiac Arrest
- CCU Admission
- CCU Additional
- ICU/CCU Electrolyte Replacement

- ICU/CCU Subcutaneous Insulin

Resources

- Apps: iCCS, Thrombosis
- Calculators (MDCalc)
  - **ACS**: GRACE, TIMI Risk score (NSTEMI or STEMI), HEART score, Sgarbossa's criteria LBBB
  - **PE**: PERC score
  - **Atrial fibrillation**: HAS-BLED, CHADS2
  - **Heart Failure**: NYHA Functional Class
  - ECG corrected QTc
- CCS Handbooks
  - Heart Failure Pocketbook
  - Atrial fibrillation Pocketbook
  - Dyslipidemia Pocketbook
  - Antiplatelet Therapy Pocketbook
  - Cardiorenal Risk Reduction
  - Cardiac Resynchronization

Emergency

Who?

Preceptors

Dr. MIKE MACDONALD
Emergency Lead
C: (902) 217-0547
macdonaldmj@me.com

Dictation type: 3
CBRH Switchboard: (902) 567-8000
Doctors Paging: (902) 563-4059
On call schedule: NS Health intranet

Dr. Emmanuel Ajuwan	C: (902) 322-6722
Dr. Catherine Buhariwalla (“Boo-Harry-Walla”)	C: (902) 304-4912
Dr. Farokh Buhariwalla (“Boo-Harry-Walla”)	C: (902) 565-2094
Dr. Nathan Chow	C: (902) 307-4645
Dr. Charlie Coish (“Kosh”)	C: (902) 371-1158
Dr. Ian Doyle	C: (902) 919-4087
Dr. Margaret Fraser	C: (902) 304-2765
Dr. Ev Fuller	C: (902) 577-1546
Dr. Lisa Gammell	C: (902) 578-5709
Dr. Herman Greeff (“Griff”)	C: (250) 600-0567
Dr. Andrew Holmes	C: (902) 295 7151
Dr. Rose MacKay	C: (902) 371-0485
Dr. RJ MacKenzie	C: (902) 574-6472
Dr. Neil MacVicar	C: (902) 578-3206
Dr. Jennifer Lange	C: (902) 565-3076
Dr. Dayo Oladipo	C: (902) 580-3376
Dr. Jason Osborne	C: (902) 452-6455
Dr. Jeff Power	C: (902) 537-2101
Dr. Laura Whyte	C: (902) 565-8953

Allied Health

Rapid Assessment Team (RAT): PT, OT, continuing care, SW. Monday to Friday. Consult order needed, RN arranges

Physician Assistants (soon): Stew
Chris Browner, NP: (902) 574-3359
Crisis: Mental Health assessments, psychiatry on call: (902) 567-1974

Table Of Contents

What?

Background

- CBRH is the regional tertiary referral centre and trauma centre for Cape Breton. It serves a population of over 100,000 people. The ER has 28 rooms, 2 trauma rooms, with multiple “hallway” beds.
- CBRH has about 55,000-60,000 ER visits per year.
- There are usually 2-4 doctors on at a time. Each shift is 8hrs, except for one shift being 9hrs. You will occasionally need to stay late if you are still dispositioning someone’s care or dealing with an emergency.

Roles and Responsibilities

- You will work with many different physicians that have different styles and preferences. Check in with them at the beginning of your shift.
- You are responsible for seeing patients, ordering tests, following up on said tests and dispositioning the patients. The ERPs are very supportive.
- **Dress code**: personal scrubs

When?

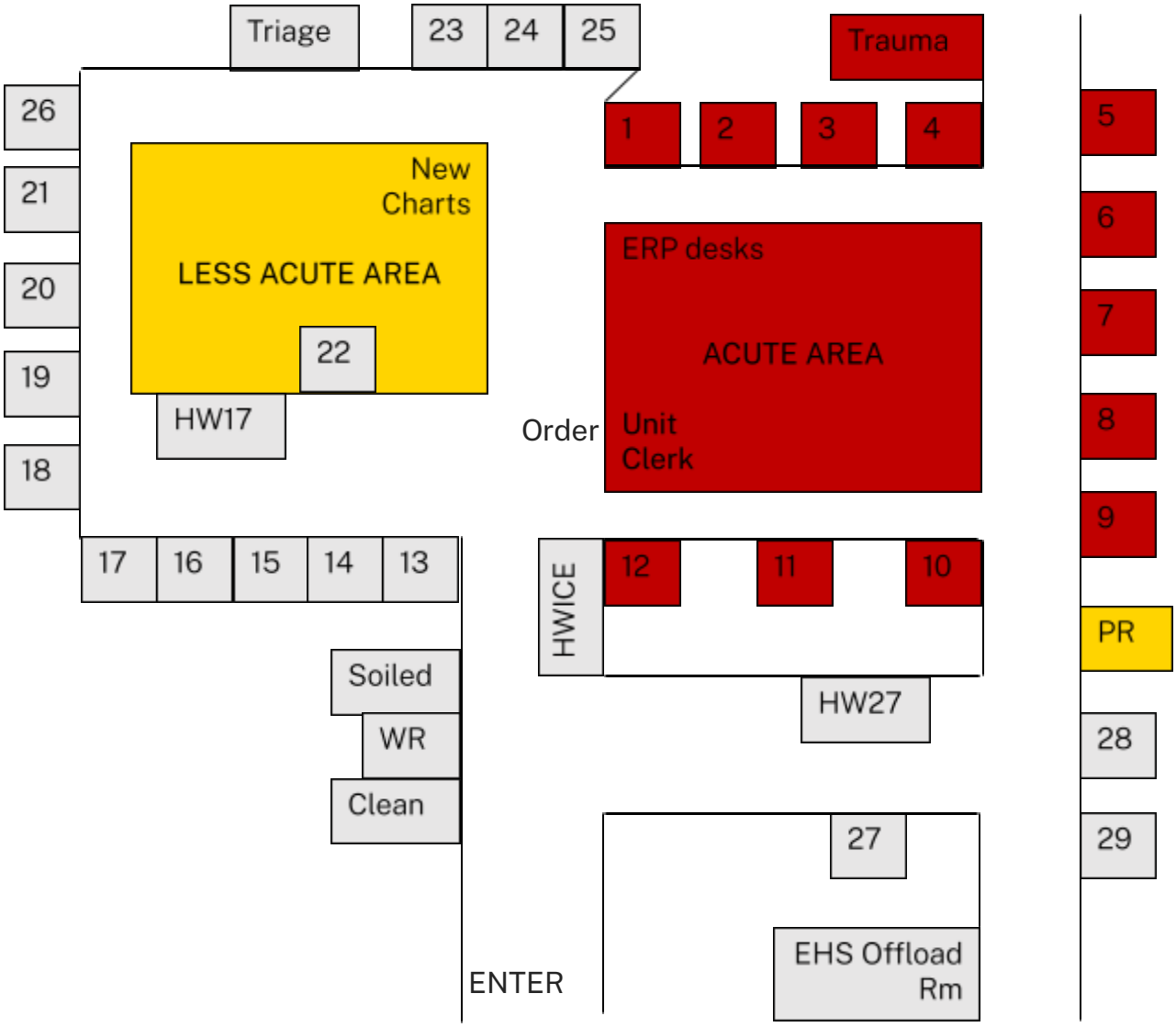
Schedule

- Dr. MacDonald will usually reach out 3 weeks before regarding your schedule to ask about academic days, day’s back, etc – have those ready.
- Dr. MacDonald will send your schedule via a spreadsheet that shows when you are working and who you are working with.
- You are required to complete 16 shifts (if no vacation taken), with a mix of day shifts, night shifts and weekends.
- Vacation is pro-rated; if you wanted to take a week of vacation, it would result in 4 less shifts (7:4 ratio).
- Occasionally there are last minute changes (shift change, illness), so you may show up for your shift and the doctor you were meant to be with isn’t there; keep the same shift time and work with the new doc who is scheduled.

Evaluations

- Your evaluations are completed at the end of each of your shifts on the ER evaluation sheet, which you can find in the ERP desks.
- You are to record your cases throughout the shift onto the eval sheet.
- You will electronically send these evaluations to Dr. MacDonald at the end of the rotation, and he will write your evaluation based on this feedback. Make sure to include procedures on these sheets as well!
    - It’s best to take pictures of them and put them in a note/folder on your phone in case you misplace them.

Where?



New Charts	Triaged, ready-to-be-seen patients
Order	Filing system for orders, above unit clerk's desk
Acute	1-12. Charts are on the wall. Processed orders on the wall.
Less acute	13-28, HWs. Charts in filing cabinet. Processed orders on top.
PR	Physician's room with washroom, code 243*
Lunchroom	Code 1503*
WR	Patient washroom
Soiled	Where to put dirty suture equipment
Clean	Sandwiches, water, blankets
Unit Clerk	Your BFF
Rm 17	GYNE
Rm 21	HEENT

If you can't find a chart, look in the orders area, the nurses' stations, desks, and processed order areas. Once the patient is discharged, you have completed your note and your staff has signed it, bring the chart back to the RN so they can complete their paperwork.

Why?

CFPC Objectives

General	Rural and Remote Medicine
ALL	ALL

FM Procedures (one45, CFPC)

Integumentary Procedures
Abscess incision and drainage
Wound debridement
Insertion of sutures; simple, mattress, and subcuticular
Laceration repair; suture and gluing
Skin biopsy; shave, punch, and excisional
Excision of dermal lesions, e.g., papilloma, nevus, or cyst
Cryotherapy of skin lesions
Electrocautery of skin lesions
Skin scraping for fungus determination
Use of Wood's lamp
Release subungual hematoma
Drainage acute paronychia
Partial toenail removal
Wedge excision for ingrown toenail
Removal of foreign body, e.g., fish hook, splinter, or glass
Pare skin callus

Local Anesthetic Procedures
Infiltration of local anesthetic
Digital block in finger or toe

Eye Procedures
Instillation of fluorescein
Slit lamp examination
Removal of corneal or conjunctival foreign body
Application of eye patch

Ear Procedures
Removal of cerumen
Removal of foreign body

Nose Procedures
Removal of foreign body
Cautery for anterior epistaxis
Anterior nasal packing

Gastrointestinal Procedures
Nasogastric tube insertion
Fecal occult blood testing
Anoscopy/proctoscopy
Incise and drain thrombosed external hemorrhoid

Genitourinary and Women's Health Procedures
Placement of transurethral catheter
Cryotherapy or chemical therapy genital warts
Aspirate breast cyst
Pap smear
Diaphragm fitting and insertion
Insertion of intrauterine device
Endometrial aspiration biopsy

Obstetrical Procedures
Normal vaginal delivery
Episiotomy and repair
Artificial rupture of membranes

Musculoskeletal Procedures
Splinting of injured extremities
Application of sling—upper extremity
Reduction of dislocated finger
Reduce dislocated radial head (pulled elbow)
Reduce dislocated shoulder
Application of forearm cast
Application of ulnar gutter splint
Application of scaphoid cast
Application of below-knee cast
Aspiration and injection, knee joint
Aspiration and injection, shoulder joint
Injection of lateral epicondyle (tennis elbow)
Aspiration and injection of bursae, e.g., patellar, subacromial

Resuscitation Procedures
Oral airway insertion
Bag-and-mask ventilation
Endotracheal intubation
Cardiac defibrillation

Injections and Cannulations
Intramuscular injection
Subcutaneous injection
Intradermal injection
Venipuncture
Peripheral intravenous line; adult and child
Peripheral venous access—infant
Adult lumbar punctur

CFPC Residency Training Profile

- **Emergency Care** (pg. 17-19)
- **Table 4:** Procedures skills in Family Medicine

Dalhousie FM

- **Medical Expert 7.** Contribute generalist abilities to address complex, unmet patient or community needs and emerging health issues, demonstrating community-adaptive expertise. **(7.1 – 7.5)**
    - **Medical Expert 7.1.** To recognize and appropriately manage acute, urgent and emergent presentations **(7.1.1 – 7.1.16)**

How?

Flow tips

- Writing the MD time and discharge time on the chart is super important!
- Keep a sheet of patient stickies and write what you're going to reassess and when (ie: to-do's).
- Use ETracker to update your name and your preceptor's name.
- If patient is safe to go to a hallway bed, you can make an order to go to hallway bed, or if you need them to stay in room (ie: to complete DRE) then can make an order for the same
- It's not the resident's job to maintain unit flow! Focus on patient care.
- Within the last 90 minutes of your shift, try to choose the "cherries": suturing, URTI's, etc. Don't pick up "abdominal pain" or "weak & dizzy".

Order sets

ACLS

- Cardiac Arrest Algorithm
- Bradycardia
- Tachycardia
- Post-Cardiac Arrest

Admission OS

- AECOPD Admission OS
- Alcohol Withdrawal OS
- CAP Non-ICU Admission OS
- Cardiac Routine OS
- DKA Adult OS
- General Surgery Admission OS
- Gynecology Routine OS
- Heart Failure Admission OS

Pediatrics

- Pediatric Asthma ER OS
- Pediatrics Anaphylaxis Action Plan and Prescription ER OS
- Pediatrics Anaphylaxis ER OS
- Pediatrics DKA ER OS
- Pediatrics Fever <28 days ER OS
- Trekk Asthma
- Trekk Asthma Algorithm (PRAM)
- Trekk Critically Ill Newborn
- Trekk Pediatric DKA
- Trekk Pediatric Multisystem Trauma
- Trekk Pediatric Sepsis
- PALS Pediatric Bradycardia

- Hospitalist Admission OS
- ICU Admission OS
- Massive Transfusion Protocol
- NRT OS
- NSTEMI OS
- Sepsis OS
- STEMI OS

Misc.

- Consultation Report
- Diagnostic Imaging Req
- Laboratory Req
- Multidisciplinary Progress Note
- OT Referral OS
- Physician Orders
- PALS Pediatric Cardiac Arrest
- PALS Pediatric Tachycardia
- NRP

Stroke/VTE OS

- Alteplase for Acute Ischemic Stroke
- Outpatient VTE OS
- Stroke Admission OS
- Tenecteplase for Acute Ischemic Stroke
- TIA Clinic Referral

Resources

Trekk	Patient and family resources, clinician algorithms and order sets
Apps	iCCS, Pedistat, PalmEM, Trekk, MD on call, Firstline, Bugs and Drugs, MDCalc, eyeCuity, Thrombosis, Sepsis (ESCAVO), Pallium Central, iPal Global, InfantRisk HCP, Sanford Guide ($)
Podcasts	EM Cases, Core EM

ENT

Who?

Preceptors

Dr. Blair Williams
ENT Lead
+ minor procedures, pediatrics
C: (902) 577-2880
O: (902) 567-2731
Blair.Williams@nshealth.ca
336 Kings Rd, Suite 115
15633

Dr. Hisham Wasl
+ ears, sinus
336 Kings Rd, Suite 115
18006

What?

Roles and Responsibilities

- While you are on your general surgery rotation, you will have a dedicated week to work with the ENT physicians in Cape Breton.
- You will be working in the OR, clinic, and ambulatory care.
    - In the OR, you will be observing various surgeries including myringotomy tube insertions/replacements, tonsillectomies +/- adenoidectomies, septoplasties, and thyroid/parathyroid surgeries
    - In clinic, you will be seeing new consults and follow-up patients. You will also observe flexible nasopharyngoscopy. Dr. Williams and Dr. Wasl use Accuro EMR.
    - In ambulatory care, you will be seeing consults and completing minor procedures (excisional biopsies). This is a great opportunity to practice your suturing skills!
- You can expect one night of home call until 0000h.

When?

- You will receive your schedule from Kathleen.
- Call the clinic to confirm start time.
- OR: ~0745h-1700h.
- Ambulatory care/Clinic: ~0745h-1600h.

Where?

- CBRH OR (usually OR 1)
- CBRH Ambulatory Care
- Northside Ambulatory Care
- Glace Bay OR (minor procedures, ORs)
- Clinics as above

Why?

CFPC Objectives

Cough
Croup
Dizziness
Earache
Epistaxis
Neck Pain
Upper Respiratory Tract Infections
Multiple Medical Problems
Thyroid

Dalhousie FM

- **Medical Expert 1.1.2.5**. Ear, nose, and throat disorders. **(1.1.2.5.1 – 1.1.2.5.5)**
- **Medical Expert 1.3.3**. Pediatric ear, nose, and throat disorders. **(1.3.3)**
- **Medical Expert 3.1.8.** Eye, ear, throat and nose procedural skills. **(3.1.8.1 – 3.1.8.8)**

How?

Resources

- Dr. Williams: **Common ENT Problems**
- HeadMirror Survival Guide
- ENT Canada
  - Patient pamphlets
- CPS Acute Otitis Media Guidelines

Family

Who?

Preceptors

- Each of you will be paired with a unique family medicine preceptor for the totality of your two/three-year residency (FM or FM/EM).
- Your residency practice will reflect your preceptors; many physicians have a varied practice including but not limited to ER, hospitalist, well-women's clinic, youth clinics, urgent care, MAiD assessments, long-term care, etc.

What?

Roles and Responsibilities

- Your role is that of their family physician; the earlier you adopt this mindset, the more interest you will take in their care and more learning you will receive.
- You are responsible for seeing your patients and reviewing with your preceptor; you will discuss flow and expectations with them, and will gradually work on independence throughout your residency.
- It is advised to follow ordered labs and results – this may be challenging based on your EMR. You can ask your secretary to keep any faxed results and give them to you.

Evaluations

- You are responsible for completing field notes via Narrly every day that you are on family medicine (~1 field note per day).
- 10 patient feedback forms need to be completed every school year.
- Primary Preceptor logs need to be completed prior to your 6 month reviews.

When?

General

- Throughout your residency, you will have family day-back's every two weeks. You and your preceptor will decide what day of the week works best.
- First year: 2-3 months block (FM and FM/EM, respectively)
- Second year: 4 months block

Day to day

- This will be very individual as each preceptor's practice is different.

Where?

- Again, very individual depending on your preceptor.

Why?

CFPC Objectives

General	Rural and Remote Medicine
ALL	ALL

How?

Sydney/Inverness Google Drive

NS Resources

General

- YourHealthNS
- HealthyNS
- ns211
- Continuing Care
- Screening
  - Cervical - NSHealth
  - Breast – NS Breast Screening Program
  - Colon - NSHealth

Helpful Patient Links

Illness-related

- NSHealth Patient Pamphlets
- CBT-i: mySleepTutor app
- Trekk – pediatrics
- Diabetes Canada
- Choosing Wisely
- SugarHealth – sexual health NS
- Anxiety/depression: Tranquility app, Anxiety Canada, MindShift, Mental Health and Addictions
- Stop Smoking Program

Learning

- FM Learner

- McGill Study Website
- Clinical Webinar Series

Guidelines

- Canadian Task Force
- Diabetes
- Dyslipidemia – PEER Simplified
- Osteoporosis – CMAJ
- Depression – CANMAT
- Anxiety Disorders – Katzman et al
- Hypertension – Hypertension Canada

FP Obstetrics

Who?

Preceptors

DR. MADDY ZISS
FM Obstetrics Lead
C: (902) 595-0354
O: (902) 567-7621 (CBRH)
maddy.ziss@gmail.com
Perinatal Clinic, 3rd floor near FNU
17121

Dr. Caitlin Bennett
O: (902) 567-7621 (CBRH)
18598

Dr. Lauren Brodie
Eskasoni Community Health Centre
14950

Dr. Stephanie Ellerker
O: (902) 863-1558 (GB)
633 Main St, Glace Bay
12274

Dr. Danuta Kajetanowicz
O: (902) 562-0988
08070

Dr. Sarah Mader
O: (902) 567-7621 (CBRH)
18876

Contact info can be found on LDU
Call clinics for reporting details

Allied Health

ALL ON THIRD FLOOR
FNU: (902) 567-7841
LDU: (902) 567-7834
NICU: (902) 567-7839

Perinatal Clinic (ex: lactation consultants) O: (902) 567-7621

Jillian Delorey (SW) C: (902) 574-2437

What?

Background

- Obstetrical care in Cape Breton is shared between FM OBS and OBGYN.
  - Low risk obstetrics = FP-OB (this rotation)
  - Above low risk obstetrics = OBGYN (gyne rotation)
- Each parent & baby are under a certain FP-OB physician.
- You will round on all inpatients (antepartum, postpartum, newborns), and complete labor delivery unit (LDU) assessments/labor management for patients cared for by certain family physicians. **The most up-to date list of preceptors will be provided to you by Dr. Ziss.**

- If you are unsure who is MRP for the patient, the whiteboard in each unit usually has the MRP listed, or you can ask one of the nurses.
- Dress code: clinic clothes or personal scrubs for rounds. Scrubs for deliveries, surgeries and on call. If in OR, wear specific OR scrubs found outside of OR locker rooms

Roles and Responsibilities

LDU

- **IOLs**: Patients requiring IOL are scheduled in the morning at ~0700h. Your role as the FM-OB is to assess and request a consultation to the OBGYN. The schedule for the IOLs is listed in a binder at the nurse's station; make sure to check this before each shift so you can budget your time the next morning.
- **Labour and deliveries**: You are responsible for assessing progress of labour, delivering baby and placenta, and repairing 1st and 2nd degree perineal lacerations (taught by Dr. Hudgins 2x/yr). You will be supported by your preceptor.
- **Medical assessments**: You are responsible for assessing pregnant people over 20 weeks gestation.
- **C/S**: There are a few C/S's per week at 0800h, 0930h, or 1100h; you are welcome to attend if the parent is under a FP-OB teaching physician.
- Stay in the LDU break room as much as possible when not providing patient care – nurses are more likely to involve you if you are on the unit.

FNU (Family Newborn Unit)

- The family newborn unit consists of postpartum care and occasionally antepartum care if high risk.
- This is where you will complete rounds every morning.
- There is an updated whiteboard that lists the MRP, room number and nurses name for each patient. There are also daily print outs usually on the nurses' desk that you can write on for your rounds.
- Prioritize sick patients and possible discharges. Next, prioritize patients you have seen or delivered, or patients under the same physician.
- You will complete discharge exams, paperwork and dictations for parent & baby.

Perinatal Clinics

- You will be with the perinatal group or with Dr. Ellerker in Glace Bay.
- You will fill out the Nova Scotia prenatal records for each patient.
- Make sure to record the birth parent's BP, SFH, FHR, and baby's position (Leopold's).
- You will be using Accuro when you are with the perinatal group.
- If LDU and FNU are quiet, you may ask to join the perinatal group for the day.

Call

- Call is suggested to be in-house call.
- Physicians are either in a call group or cover their own call. Ask the nurses to show you the on-call binder.
- You may convert evening call to 24-hour call if desired when cases run past midnight, but you will still be expected to do rounds before going home.
- You may pick up or change evening calls to capitalize on busy nights.
- Please communicate call changes with Dr. Ziss and Kathleen.

When?

- Dr. Ziss will give you a schedule prior to the rotation including your perinatal clinic days and call schedule.
- Post your schedule in the LDU and FNU; annotate any schedule changes so staff know when you will be working.

Day to day

- The mornings are busy! The following are your priorities:
  - Labour assessments or active labouring in LDU
  - IOL assessments in LDU
  - FNU rounds
- The goal is to have completed IOL assessments and rounds on the FNU by 0900h. The OBGYN usually arrive around 0800h for IOLs, and family physicians usually complete rounds between 0830h-0900h (before their clinics).
- Arrive as early as you need to achieve these tasks.
- You are expected to stay until 1700h or until tasks are complete.

Evaluations with Dr. Ziss

- Set a time for midpoint and end-of-rotation feedback.
- Complete field notes for each objective on Dr. Ziss' sheet.
- Field notes can be completed by RNs and lactation consultants.

Where?

- LDU, FNU and the perinatal clinic are all on the third floor.
- Dr. Ellerker's perinatal clinic is in Glace Bay.

Why?

CFPC Objectives

General	Intrapartum and Perinatal Care
Abdominal Pain	Normal labour and delivery
Contraception	Fetal Health Surveillance during labour
Counselling	Pain in labour
Dehydration	Labour dystocia
Domestic Violence	Vacuum assisted delivery (+procedure)
Dysuria	Shoulder dystocia (+procedure)
Family Issues	Postpartum hemorrhage
Gender Specific Issues	Perineal lacerations (+procedure)
Infertility	Antepartum bleeding >20w
Pregnancy	Non-cephalic presentation
Rape/Sexual Assault	Pre-labour ROM, Preterm labour
Sex	TOLAC
UTI	IOL
Vaginal Bleeding	Peripartum mental health
	Gestational HTN/preeclampsia
	Gestational DM
	Breastfeeding
	First weeks of life
	Working in teams, Limits of practice

Dalhousie FM

- **Medical Expert 1.4**. Establish and maintain clinical knowledge, skills and attitudes required in maternal and newborn care. **(1.4.1 – 1.4.38)**
- **Medical Expert 3.2** Plan and perform procedures and therapies for assessment and/or management in maternal and newborn care **(3.2.1 – 3.2.20)**

Dr. Ziss will provide you with these specific objectives to complete.

How?

Order Sets

- IOL OS
- Intrapartum OS
- Intrapartum Insulin Management OS
- Newborn Admission OS
- Newborn Routine OS
- NRP Algorithm
- Postpartum OS

Resources

- **LDU Cheat Sheet**
- **SOGC Guidelines (also found in green binder on LDU)**
  - Breastfeeding Troubleshooting
- Reproductive Care Program of Nova Scotia
  - Nova Scotia Prenatal Record Mar 2022
  - Birth Record Mar 2019
  - Newborn Admission/Discharge
- Websites
  - **www.perinatology.com** – best due date calculator and umbilical artery doppler normal values
  - Bili Tool
  - Teach Me OBGYN
- Apps
  - **The Perinatal Memo** – $, has all the up-to-date Canadian obstetrics and primary newborn care guidelines
- **CPS Guidelines**
  - Hypoglycemia
  - Jaundice
  - Discharges of healthy term infant
- Podcasts
  - Procedure Ready: OB/Gyn
  - OB-G in YEG

Notes and Dictations

LABOUR ADMISSION – NOTE (THERE IS A FORM)

ID: *37yo G2P1 @ 39+1* , GBS+, A+, gHTN
Reason for admission: *?PROM*
HPI:
- **Contractions**
- **PV bleeding**
- **Fluid (?ROM)**
- **Fetal movements**

ROS*
Hx of current pregnancy:
- EDD (US > dates)
- LMP
- Labs (blood type, serologies)
- U/S (BPP, placental position)

Past OBS Hx: (GTPAL, details of deliveries)
PMHx

Physical Exam*
- Maternal vitals, FHR
- EFM – accels, decels, baseline
- CV, Resp, GI
- SFH, Leopold's, contractions
- Cervical check – dilation, effacement, station, consistency, position. ie: 3cm/50%/-2/soft/mid position

Investigations
Impression
Plan

**HTN: headache, scotomas, edema, CP, SOB, abdo pain, n/v, RUQ pain, reflexes, edema*

PSxHx	**PPROM: always sterile speculum exam, no VE*
Meds	
Allergies	**Placenta previa, or unknown and bleeding: No VE*
FamHx/Social Hx	

LABOUR PROGRESS – NOTE

ID: Age, GTPAL, GA	*37yo F @ 39+1*
CC:	*Admitted in early labour with SROM*
Subjective:	*Coping well*
Objective: vitals, EFM, contractions, VE exam	*EFM normal, VE 2cm/50%/anterior*
Impression:	*Good/slow progress*
Plan:	*Recheck 2h, increase oxy, epidural*

DELIVERY – NOTE

ID	*Age, GTPAL, GA*
Labour	*IOL/augmentation. Times: 2nd stage, fully dilated, pushing.*
Type of Delivery	*SVD, vacuum assist, C/S*
Baby info	*Sex, time, APGARS, birth weight, ?vigorous, position (OA/OP)*
Nuchal cords?	*Y/N*
Meconium?	*Y/N*
Oxytoxin	*Anterior shoulder/delivery*
Cord clamp	*Delayed, immediate*
Placenta	*Spontaneous/manual, time, #vessels, complete?*
Tears	*Degree*
Cord gases	*Collected*
Repair	*Procedure note: suture material, analgesia, counts correct*
EBL	*Amount, fundus firm/boggy*
Special notes	*Abx, PPH medications*

POST PARTUM PROGRESS – NOTE

ID: G_ now P_ PPD #__ from (type of birth)
Subjective:
- ❖ Diet, Voiding, Flatus, BM, Lochia
- ❖ Pain
- ❖ Ambulation
- ❖ Breastfeeding

The B's: "Bleeding, Bowels, Bladder, Breast/bottle, Blues, Birth Control"

Objective:
- ❖ Vitals
- ❖ CV
- ❖ Abdo

❖ Incision	*Fundus height and texture*
❖ Lochia	*Intact, erythema or drainage?*
Investigations	*Should be normal/heavy period*
Impression/Plan	

BIRTH PARENT DISCHARGE – DICTATION

Date of Admission	
Date of Discharge	
Discharge Dx	*"SVD live female infant, early PP care"*
ID	*"Age, GTPAL, presented to LDR at GA with ___."*
Delivery	*Brief! Intrapartum course, delivery mode/complications.*
Postpartum Care	*Complications/tears, incision, lochia, BF/latch, Pain, BM, Void*
Vitals	*Especially BP!*
Lab work	*If any (Hb).*
Follow up	*Perinatal clinic apt, f/up family doc. Red flags, when to RTC.*

BABY DISCHARGE – DICTATION

Date of Birth	
Date of Discharge	
Discharge Dx	*"Born via C/S, early newborn care"*
ID/Birth Details	*"Baby girl was born via C/S on Sept 21, 2023 at 0821h. Her APGARS were 5 @1min, 9 @5min." Any resusc*
Newborn Exam	*BW, length, HC. Head to toe (follow newborn sheet) Last weight (% lost).*
Hospital Course	*Feeding, stool, void, vitals, labs (TcB/TsB, CCHD, blood screen, hearing).*
Discharge Plan	*Perinatal clinic, fam doc. ?rpt TcB. Hearing screen if not done*

Tips

- **Three P's that affect duration of active phase (labour dystocia):**
  1. **POWER** – strength and freq of cxns. ?oxytoxin
  2. **PASSENGER** – size of baby. ?fetal malposition
  3. **PASSAGE (PELVIS)** – size and shape. ?cephalopelvic disproportion
  4. **PAIN**
  5. **PSYCHE** – maternal mindset, mental health, coping

- **Three signs of placental separation:**
  1. Gush of blood
  2. Cord lengthening
  3. Firm and forward uterus

Definitions of Labour

Labour: first stage	Regular uterine contractions accompanied by cervical dilatation and/or effacement. The first stage of labour includes the latent and active phases.
Latent phase	Presence of uterine activity resulting in progressive effacement and dilatation of the cervix proceeding to active phase. It is complete when a nulliparous woman reaches 4 cm dilatation and a parous woman reaches 4 to 5 cm. Cervical length is generally less than 1 cm.
Active phase	Presence of a pattern of contractions leading to cervical effacement and dilatation at 4 cm or greater in a nulliparous woman or 4 to 5 cm dilatation in a parous woman.
Labour: second stage	Full dilatation to delivery of the baby.
Passive second stage	Full dilatation but without active pushing.
Active second stage	Full dilatation with active pushing.
Labour: third stage	Immediately after delivery of the baby to delivery of the placenta.
Labour: fourth stage	Immediately after delivery of the placenta to 1 hour postpartum.
Dystocia	Delayed or arrested progress in labour, irrespective of cause.
In active first stage	Greater than 4 hours of $<$ 0.5 cm/hour dilatation or no dilatation over 2 hours.[1]
In active second stage	Greater than 1 hour of active pushing without descent of the presenting part.[2]
Obstructed labour	No cervical dilatation or descent over 2 hours despite evidence of strong contractions (caput, molding, or measured using an IUPC).

SOGC: Management of spontaneous labour at term in Healthy Women

General Surgery

Who?

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What?

Background

- General surgery is a busy service that serves all of Cape Breton.
- You will spend time in the OR, colonoscopy suites, and outpatient clinics with many of the physicians above.
- You will spend time with Dr. Phil Smith for minor procedures at the NSGH.
- You may ask to spend time in the wound care clinic.

- Most common cases:
  - ER: appendicitis, diverticulitis, cholecystitis, bowel obstructions, food boluses, trauma, upper/lower GI bleeds.
  - Clinic: breast/colon/melanoma (Dr. Kagedan), pilonidal cysts, GERD, follow up on above procedures, hemorrhoids, hernias, wounds, ischiorectal abscess
- Dress code: OR scrubs only with OR appropriate shoes. Scrubs are found outside of the OR change rooms/lunchroom. You may wear a cotton scrub cap.

Roles and Responsibilities

Rounding

- You are expected to round on patients you have admitted or have completed surgery on. Review with the MRP surgeon.
- You are not expected to round on patients when you are at another hospital.

OR

- Call or visit the OR to review the list of patients and procedures for your OR day. It is helpful to review their PMHx and types of procedures.
- Introduce yourself to the patient and review their EMR/chart.
- Introduce yourself to the nurses and write your name and glove size on the whiteboard of your OR suite.
- You will be first or second assist in surgeries, including driving the laparoscopy and suturing.
- You may complete the postop order set; review with your preceptor.
- It is also helpful to connect with the physician on call and the ER to see if you can help with any consults throughout the day.

Call

- You are responsible for seeing consultations in the ER and assisting in ward issues as they arise.
- You will assist in surgeries; see above.

When?

- Kathleen will provide you with a schedule prior to your rotation.
- Check with clinics or the OR for start time.
- OR: ~0745h – 1700h
- Weekday call: 1700h – 0000h.
- Weekend call: 0800-0800h. You will round with the on-call preceptor.

Table Of Contents

Where?

Locations

- ER – consults
- 4A, 4D, ICU – most common wards
- CBRH OR
- Glace Bay OR – colonoscopy
- Northside GH – Dr. Smith minor procedures
- CBRH Ambulatory Care – wound care

Evaluations

- Arrange a time to meet with Dr. Archibald at the end of your rotation and bring your completed field notes. Aim to have 1-2 field notes per day.

Why?

CFPC Objectives

Abdominal Pain	Dyspepsia
Antibiotics	GI Bleed
Breast Lump	Hepatitis
Cancer	Infections
DVT	Trauma

Dalhousie FM

- **Medical Expert 3.1** Plan and perform procedures and therapies for assessment and/or management, generally and in the care of adults. **(3.1.1 – 3.1.11.10)**

How?

Order Sets

- General Surgery Admission
- General Surgery Postop

Notes/Dictations

- General Surgery Primer UBC (go to Appendix)

Resources

- Surgery Orientation Reference UBC, Suture Material

- ❖ Postop Care Primer - good for rounds
- ❖ Churchill's Pocketbook of Surgery
- ❖ Apps/Websites:
    - Firstline, Bugs and Drugs, Teach Me Surgery, Surgery 101 (website free, app $1, notes $5/yr), Surgical Recall ($), Best Practices in Surgery (has wound care algorithm), NCCN Guidelines (melanoma and breast cancer guidelines), Thumbroll

Gynecology

Who?

Preceptors

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LDU (3rd floor): (902) 567-7843
FNU (3rd floor): (902) 567-7841

Code to Suite 203: 351*

What?

Background

- The OBGYNs in Cape Breton provide higher risk obstetrical and gynecological services for the Island.
- **Outpatient experiences**: clinic, colposcopy, ambulatory care, outpatient ORs (CBRH, Glace Bay), local ORs (Glace Bay)
  - Dress code: clinic clothes or personal scrubs
- **Inpatient experiences**: Rounding, high risk deliveries, OBGYN surgeries, and on call shifts
  - Dress code: clinic clothes or personal scrubs for rounds. Scrubs for deliveries, surgeries and on call. If in OR, need specific OR scrubs found outside of OR locker rooms

Roles and Responsibilities

Rounding

- Prior to clinic, you are responsible for rounding daily on patients you have delivered, consulted on, or assisted in surgery.
- If you and your clinic preceptor are on call, complete IOL assessments prior to clinic as well.
- After you have seen and assessed, discuss your proposed plan with your preceptor and write a progress note.
- If you will be away for vacation or on another service, you may write an order in the charts stating that you will not be seeing the patient that day. You are expected to round even if you are off-site (Glace Bay OR, Northside Colposcopy).

Clinic

- You will be scheduled with one preceptor per day in their outpatient clinic.
- For each patient, you are responsible for completing a thorough history and physical exam and proposing a management plan. For obstetrical patients, this includes filling their prenatal record, and completing a BP, SPH, Leopold's and FHR using Doppler.
- Most physicians use Accuro EMR – you are responsible for writing consult notes, progress notes, and completing the prenatal record in the chart.

Colposcopy/Ambulatory Care

- These clinics are generally faster-paced, and you will often be observing. You will have the chance to see abnormal cervix presentations, lichen sclerosis, and endometrial biopsies. Let your preceptor know you are interested in hands-on experience during the day.
- Review cervical cancer screening and diagnostic guidelines.

Call

- Home call.
    - Caveat: if you are near the LDU, you have a higher chance of being called.
- Leave your call schedule in the LDU and FNU, and check in with the nurses at the start of your shift and after nursing shift change
- Types of calls:
    - Labour assessments
    - Ward calls (LDU/FNU)
    - Obs consultation by FP-OB
    - Gyne consults (ER or inpatient)
    - Peripheral sites for Obs or Gyne

- **Weekend call**: you are responsible for rounding on all obstetrical and gynecological patients under an OBGYN, including LDU, FNU and other inpatient floors (4D, 3A, etc.) Discuss expectations with the preceptor.

OR

- Call or visit the OR to review the list of patients and procedures for your OR day. It is helpful to review their PMHx and types of procedures.
- The OBGYNs usually book an assistant in OR, but expectations should be that you are first assist in a surgery – either C/s or gyne OR
- Dr. Hudgins teaches proper donning/doffing techniques twice per year.

When?

- Kathleen will provide you a schedule at the beginning of your rotation.
- **Clinic, colposcopy**: Start time is usually between 0800h and 0900h, and finishes between 1500h – 1700h depending on the preceptor. Check in with preceptor or their office to confirm start time. It's best to arrive 10-15min early to review the first patient's chart.
- **Rounding; IOL assessments on call**: Before clinic.
- **OR**: generally 0800h start, but may be delayed by C/S or ECT
- **Weekday call**: 1700h – 0000h.
- **Weekend call**: 0800h – 0800h.

Evaluations

- Set a time to meet with Dr. Hudgins at the end of the rotation. Aim to have as many field notes as days on the rotation. Many pearls will come from Dr. Hudgins' sticky-note teachings!

Where?

Work

- **Clinics**: See above for preceptor office locations
- **Colposcopy**: Either in CBRH Ambulatory Care (2nd floor near ER) or North Sydney (2nd floor).
- **OR**: CBRH (3rd floor) or Glace Bay.
- **DI**: Hysterosalpingograms
- **LDU, FNU**: 3rd floor

Information

- **Up-to-date Guidelines**: There is a large green binder in LDU near the whiteboard that is home to printed OBS resources including SOGC guidelines! Electronic copies: FP-OB section or Google Drive.

- List of IOL assessments: There is a black binder at the nurses' station that has a list of IOL assessments for the week
- C-Section schedule: LDU, in small nurses' room on the wall – ask an RN

Why?

CFPC Objectives

General	Intrapartum and Perinatal Care
Abdominal Pain	Normal labour and delivery
Breast Lump	Fetal Health Surveillance during labour
Contraception	Pain in labour
Counselling	Labour dystocia
Dehydration	Vacuum assisted delivery (+procedure)
Domestic Violence	Shoulder dystocia (+procedure)
Dysuria	Postpartum hemorrhage
Family Issues	Perineal lacerations (+procedure)
Gender Specific Issues	Antepartum bleeding >20w
Infertility	Non-cephalic presentation
Menopause	Pre-labour ROM, Preterm labour
Osteoporosis	TOLAC
Pregnancy	IOL
Rape/Sexual Assault	Peripartum mental health
Sex	Gestational HTN/preeclampsia
STIs	Gestational DM
UTI	Breastfeeding
Vaginal Bleeding	First weeks of life
Vaginitis	Working in teams, Limits of practice

Dalhousie FM

- **Medical Expert 1.4.** Establish and maintain clinical knowledge, skills and attitudes required in maternal and newborn care. **(1.4.1 – 1.4.38)**
- **Medical Expert 1.8.** Establish and maintain clinical knowledge, skills and attitudes required in women's health care. **(1.8.1 – 1.8.20)**
- **Medical Expert 3.2.** Plan and perform procedures and therapies for assessment and/or management in maternal and newborn care **(3.2.1 – 3.2.20)**

How?

Order Sets

- Gynecology Routine OS
- Intrapartum OS
- Intrapartum Insulin Management OS

- Oxytocin IOL OS
- Postpartum OS
- Pre/Postoperative C/S OS

Clinical Guidelines

- Breastfeeding Troubleshooting
- Chronic Pelvic Pain
- Contraception
  - Combined OCP
  - Emergency Contraception
  - Intrauterine Contraception
  - Progesterone-only Contraception
- Dysmenorrhea
- Endometriosis
- Infertility - Female
- IOL
- Menopause and Genitourinary Health
- Ovarian Mass
- PCOS

Resources

- **See resources in FP-OB section**
- SOGC Patient Information
  - HPV Info
  - It's a Plan: contraception decision-making tool
  - Menopause and U: SOGC patient resource on menopause, med chart
  - Pregnancy Info
  - Sex and U: SOGC patient resource on sex-related topics
  - SOS: stay on schedule after missing oral contraception
  - Your Period

Lectures

Notes/Dictations

OR GYNE - NOTE

Date	
Surgeon	
Assists	*Include yourself*
Anesthesia	
Preop Dx	
Postop Dx	

Procedure	*Total abdominal hysterectomy, bilateral oophorectomy, etc.*
Complications	
EBL	
Disposition	

OR C/S - Note

Date	
Surgeon	
Assists	*Include yourself*
Anesthesia	
Preop Dx	*Elective repeat C/S, Failed IOL, CPD*
Postop Dx	
Procedure	*LSCS (lower segment C/S), 2 layer closure, +/- tubal ligation*
Findings	*Live female infant, APGARs, birth weight*
Complications	
EBL	
Disposition	*To FNU for postpartum care*

OBS DELIVERY – Note

ID	*Age, GTPAL, GA, risk factors/OBS hx. Reason for OBGYN.*
Anesthesia?	*Epidural*
Labour	*IOL/augmentation. Times: 2nd stage, fully dilated, pushing.*
Type of Delivery	*SVD, vacuum assist, C/S*
Baby info	*Sex, time, APGARS, birth weight, ?vigorous, position (OA/OP)*
Nuchal cords?	*Y/N*
Meconium?	*Y/N*
Oxytoxin	*Anterior shoulder/delivery*
Cord clamp	*Delayed, immediate*
Placenta	*Spontaneous/manual, time, #vessels, intact?*
Tears	*Degree*
Cord gases	*Collected*
Repair	*Procedure note: suture material, analgesia, counts correct*
EBL	*Amount, fundus firm/boggy*
Special notes	*Abx, PPH medications*
→PPH:	*Treatment*
→Shoulder dys:	*Time delay b/t head&body (ask RNs), maneuvers*
→Operative:	*(VAVD, forceps). Parental consent, in&out, #pulls, #popoffs*

Procedures

- ❖ Vaginal deliveries
- ❖ Repair vaginal laceration – Dr. Hudgins teaches a few months prior to rotation

- IUD insertion/removal
- Nexplanon insertion/removal – Dr. Hudgins teaches once per year
- Endometrial biopsy
- Pessary changes
- Vulvar biopsies

Hospitalist

Who?

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Patients

- You will see a wide variety of adult patients. Think everyone but OBGYN.
- Common presentations:
  - Mainly acute exacerbations of chronic conditions including DM, COPD, CHF, cirrhosis, CKD, or all the above ☺.
  - Electrolyte abnormalities, strokes, sepsis.
- Hospitalization is an opportunity to get patients on appropriate therapy!

Allied Health

- CNL's are greatly helpful.
- RNs, SW, RT (stop smoking program), dietician, PT, pharmacy.
  - To consult these services, you can write an order on the chart.
  - You can also call if more urgent (RT, pharmacy) by calling switchboard or asking the ward clerk.

What?

Background

- The hospitalist team cares for most patients in the CBRH, with a current capped maximum of 105 patients.

- They accept patients from the emergency room for admission, accept transfers from internal medicine or ICU, follow them in hospital and discharge them safely to the community.

Roles and Responsibilities

- You will be responsible for the day-to-day care of your patients including admissions, daily rounding and progress notes, consults, discharge summaries, dictations, and family meetings.
- You will start with 1-2 consults and will work towards having a list that is interesting and beneficial for your learning.
- **Dress code**: scrubs or clinic clothes

When?

Day to day

- Usual start time is around 0800h, and work finishes when you have completed your rounds, to-dos and notes, between 1500h – 1700h.
- You will review with your preceptor daily, whether it is after each patient or at the end of your rounds.

Call

- **Amount**: Minimum of 2 nights of call and one weekend of call per block.
- **Weekdays**: 1700h – 0800h. You are allowed to take a post-call day if busy.
- **Weekend days**: Saturday and Sunday rounding.
- **How to schedule**: You will most likely be on call with your preceptor; discuss this with them.

Evaluations

- Schedule a check-in halfway into the rotation and save some time near the end of your rotation for feedback.
- Attempt to have the same amount of field notes as days on the rotation.

Where?

CBRH Floors

3A	**3B**	**4A**	**4B**	**4C**	**4D**	**4E (An Cala)**
Ortho	Med	Cardiac/ Med/Surg	Med	Med	Med/Surg	Palliative

New ER Consults

- You can find the patient's room number on the ER screens.
- If you're ever not sure, ask the nurses to point you in the right direction.
- Important papers including orders, consults, and progress notes can be found in the cubbies at the ERP desks. The ER clerk can print papers and order sets.

Rounds

- You can check Meditech to see what floor/room number your patient is in.
- The charts (should be) on rolling cabinets, but they may be on the desks, with the clerk, with the patient if gone for imaging, or with another physician.

Why?

CFPC Objectives

ALL!

How?

On Call

- At the start of your shift, your preceptor will forward handover documents from each hospitalist to you.
- While on call, you will receive calls from physicians for possible admissions or from ward nurses.
- "Tuck in rounds": visit each floor and see if there are any orders the nurses need. It is usually best to go around 8pm once the nurses are settled from shift change. This will save you calls throughout the night!
- Make your own handover document at the start of your shift with the following titles:
    1. Admissions
        - Get the correct name of the patient, age, and the name of their family doctor. The ERP will tell you the story, just make sure you understand what they have done to treat the problems and what the patient needs for admission. You want to make sure they will be safe overnight as they won't be assessed until the morning.
            - You must tell the ERP who will be the admitting hospitalist.
    2. Ward Calls
        - For significant calls, keep track of the patient's name and MRP, and write a quick note. Can also write a progress note in chart if needed.
- Send your handover document to your preceptor in the morning so they can forward it to the hospitalists. ***If you make a Microsoft document through your Dal email, you can simply share it with your preceptor!***

Dictations and Orders

Admission Dictation

1. ID
2. CC
3. HPI and ROS (+/- collateral)
4. PMHx
5. PSxHx
6. Social/Fam Hx
7. Home meds
8. Allergies
9. Physical exam
10. Labs and Imaging
11. Impression and Plan

Discharge Dictation

1. Admission Date
2. Discharge Date
3. Most responsible dx
4. Secondary dx's during admission
5. PMHx
6. Code status
7. Allergies
8. Operations and procedures
9. Course in hospital (problem list)
10. Medications
    a. Discontinued
    b. Changed
    c. Unchanged
    d. Started
11. Post-discharge Follow-Up Plan

Admission Orders (OS)

1. Admit under Dr. ___ to unit ___
2. Diagnosis:
3. Diet: (cardiac, renal, diabetic)
4. Activity: (AAT, 2P assist, etc.)
5. Vitals: (routine, q4hr, etc.)
6. Investigations: BW, imaging, consults ["RMO"]
7. Drugs: P's
    - Poo – constipation
    - Pain – analgesia, withdrawal
    - Puke - antiemetic
    - Pus - antibiotics
    - Prophylactic – DVTp (OS)
    - Precedent - BPMH (OS)
8. Goals of Care (OS)

Progress Note

1. *"ID: 66yo M (A) 10/11/23 p/w SOB and cough, ?pna"*
2. Subjective
3. Objective – vitals, investig.
4. Assessment
5. Plan – break into problem list:
    1. CHFe
    2. Hypokalemia
    3. DVTp
    4. Disposition

Resources

- **Apps**: MD on call, Pallium, Firstline, Bugs and Drugs, Up to Date, Thrombosis Canada, Sepsis (ESCAVO), iCCS
- Dr. Keating: **On-call Cheat Sheet**
- **Outpatient resources**:
    - Stop Smoking Program
    - Continuing Care: personal care, light housekeeping
    - VON: nursing level care; dressing changes, medications, vitals
    - Primary Care Clinics for unattached patients
    - Community Paramedic Program: PCPs check in on patients after discharge for one week, provide POC bloodwork
    - Special Patient Program: EHS support at home for palliative patients

Internal Medicine

Who?

Rotations

Dermatology
Endocrinology
Nephrology
Oncology
Rheumatology

What?

Background

- This is a two-week block that is partnered with your CCU block.
- You will have the chance to work with one of these teams during your two weeks.
- Scheduling, call, roles and expectations will be dependent on the service.

Orthopedics

Who?

Preceptors

Dr. Donald Brien
O: (902) 539-5954
242 Newlands Ave
11997

Dr. James Collicut
+ outpatient only, injections
O: (902) 567-0772
1487 George St, Suite 10
11025

Dr. Faith Dodd
+ hands, knees, hips
O: (902) 567-0509
faithdodd@yahoo.com
35 Glenwood St
14519

Dr. Chris Hamilton
+ shoulders/upper extrem, hips
C: (902) 830-5239
O: (902) 270-5878
Christopher.Hamilton@nshealth.ca
Suite 301 Health Park
17936

Dr. Christy MacKinnon
+ lower extremities, feet, wounds
C: (902) 789-0077
O: (902) 270-3355
Christy.McKinnon@nshealth.ca
Suite 308 Health Park
17372

Dr. Michelle O'Neill
+ hip, knee
C: (902) 371-6412
O: (902) 270-3778
Michelle.ONeill@nshealth.ca
35 Glenwood St
12705

Dr. Johnny Rayes
O: (902) 270-9444
31 Riverside Dr
18635

What?

Background

- You will be paired with one of the above physicians for your month-long rotation. This includes OR, outpatient clinic, and ortho clinic.
- You will have to opportunity to join other orthopods to increase breadth of exposure – see above for specialties.
- **Please review Dr. Dodd's primer and clinical skills prior to your rotation.**
- Dress code: scrubs in OR and ortho clinic. Clinic clothes in outpatients.

Roles and Responsibilities

Outpatient Clinic

- You will be responsible for obtaining thorough histories and physical exams and presenting these to your preceptor with a proposed impression and plan. Note-taking will be preceptor-dependent.

OR

- You will be responsible to review cases (including imaging) prior to OR day and have a general knowledge of the cases.
- You will be second assist for most cases, with the opportunity to sew cutaneous layers depending on your preceptor.

Ortho clinic:

- This is a faster-paced clinic of subacute injuries (fractures, injections, etc.) where you will see about half of the patients during the day.
- You will be responsible for your dictations; take notes on the ambulatory sheets as you may often have up to 20 (short) dictations to complete by the end of the day.
- You can ask the ortho techs to practice circumferential casting.
- You can also refer to same-day physio assessment if they are in house.

Rounding

- You will round on your preceptor's inpatients prior to clinic or OR. Discuss expectations with your preceptor.

When?

- Outpatient clinics: Preceptor-dependent, contact their office for more info.
- OR: ~0745h – 1700h.
- Ortho clinic: ~0800h – 1600h
- Weekday call: 1700 – 0000h
- Weekend call: 0800 – 0800h

Where?

- 3A: Main ortho ward
- CBRH OR
- Ortho clinic: CBRH 2nd floor near ER
- Outpatient clinics: as above
- Ambulatory care (wound): 2nd floor near ER

Why?

CFPC Objectives

Chronic Pain	Low Back Pain
Deep Vein Thrombosis	Neck Pain
Disability	Obesity
Fractures	Pain
Joint Disorder	Trauma

Dalhousie FM

- **Medical Expert 1.1.2.10.** Musculoskeletal disorders. (1.1.2.10.1 – 1.1.2.10.2)
- **Medical Expert 1.3.6.** Pediatric musculoskeletal disorders (1.3.6.1 -.1.3.6.2)
- **Medical Expert 3.1.10.** Musculoskeletal procedures (3.1.10.1 – 3.1.10.8)

Orthopedic Specific Objectives

How?

Order Sets

- Post Op Ortho
- Pain Management Ortho
- Ortho VTE

Resources

- **Dr. Dodd's primer**
- **Ortho Clinical Skills**

Pediatrics

Who

Preceptors

DR. KATHARINE KELLOCK
Pediatrics Lead
C: (902) 574-5797
O: (902) 270-3175, Kayleigh
katharine.kellock@nshealth.ca
Suite 403B Health Park
15509

Dr. Heidi Budden
+ gender affirming care, youth clinics in Eskasoni and New Waterford
C: (902) 549-0730
O: (902) 562-6664, Donna
heidi.budden@nshealth.ca
Suite 203 Health Park, ESK HS, NW HS
13554

Dr. Kelcie Lahey
C: (403) 816-9792
O: (902) 567-7700, Darlene
kelcie.lahey@nshealth.ca
Peds Floor CBRH
18064

Dr. Rebecca McEachern
+ endocrinology (diabetes) specialty
C: (902) 574-7712
O: (902) 562-0215, Vanessa
rebecca.mceachern@nshealth.ca
Suite 203 Health Park
11715

Dr. Simon-Peter Gom
O: (902) 562-6664
19964

Dr. Andrzej Kajetanowicz
+ neonatologist
C: (902) 537-1226
O: (902) 567-7838
CBRH right outside NICU
10442

Dr. Langley: (902) 578-6680
Dr. Salah: (902) 577-0012
Dr. RJ Mackenzie: (902) 574-6472

Allied Health

Tara Baker - Peds CNL

Peds Ward (4th floor): (902) 567-7845
NICU Ward (3rd floor): (902) 567-7839

What?

Background

- Pediatrics is a mixture of outpatient and inpatient medicine.
- You will likely work with all the pediatricians during your rotation.

Roles and Responsibilities

Outpatient Pediatrics

- You are responsible for completing a thorough history and physical exam, then presenting an impression and plan to the pediatrician. Afterward, yourself and the pediatrician will collaborate on the plan with the caregivers.
- You will write notes on the patients you see based on each physician's style/template. Most of the physicians use Accuro EMR. You will use a recorder to dictate notes in Dr. Kellock's office that Kayleigh then transcribes.
- **Dress code**: clinic clothes

Youth high school clinics

- **Dr. Budden**: Wednesday's in Eskasoni (morning) and New Waterford (afternoon). Discuss transportation with Dr. Budden.
- **Dr. Langley/Dr. Salah**: Memorial High on Monday afternoons and Friday afternoons, respectively.
- **Dr. RJ Mackenzie**: Riverview High
- Review contraception, gender-affirming care and mental health concerns.

Ward Weeks (2 weeks, pediatrics and nicu)

Ward

- You are expected to round on all inpatients admitted under pediatricians and write notes.
- Discuss your proposed management plan with staff before writing orders.
- If you have admitted someone on call, it is recommended to round on them prior to clinic duties even if you are no longer on ward weeks.
- Call the pediatrics ward first thing in the morning to check on patient numbers. If any patients were admitted overnight, it is helpful and good learning to complete the H&Ps if not already completed.
- You can also see patients in the ambulatory care clinic if there are no admitted patients. Or see Tara Baker, CNL to do some simulations/teaching.

NICU

- After your morning rounds, you will lead multidisciplinary rounds on the NICU babies. This involves reading the charts, and evaluating weights, intake, medications etc. If you're feeling nervous about the physical exam (they are tiny!), ask a nurse to help you. It is good practice to hear murmurs, see jaundice, jitters, etc. The NICU nurses are your best friends – ask them what they think and include them in the plan!

ER Shifts

- You will complete 2 ER shifts with a pediatric focus.
- When you are on shift, let your ERP and triage nurse know that you are there to see pediatric patients.
- Keep track of your cases – Dr. Kellock will give you a log.
- **Dress code**: personal scrubs

Where?

- Clinics and wards: see above

When?

- Dr. Kellock will provide you with a schedule prior to your rotation.

Example: Ward Weeks

	Mon	Tues	Wed	Thurs	Fri
AM	Ward/NICU	Ward/NICU	Ward/NICU	Ward/NICU	Ward/NICU
PM	YHC	ER	Office	Office	AHD

Example: Office Weeks

	Mon	Tues	Wed	Thurs	Fri
AM	Office	Office	YHC	Family	Office
PM	Office	ER	YHC	Family	Office

Clinic

- Call the office for start time and arrive 15 min early to review the first patient.
- Usual start time is between 0830h or 0900h and ends between 1700h-1800h.

Ward Weeks

- On the peds floor, allow yourself time to finish rounds before 0830h. The pediatricians come round before their clinics, so it's nice to have your impression and plan ready for when they arrive. If a staff member is not in to round in the AM, feel free to text or call them to discuss plans before you leave the ward.
- You will then proceed to the NICU by 0930h.
- Rounds in NICU are at 1130h – 1300h.

ER

- 1600-0000h usually on Tuesdays.
- Reach out to Dr. Mike MacDonald for scheduling, being mindful of family day backs and Journal Club.
- These shifts count as your call for the week.

Call

- **Amount**: 1 weekend per block
- **Weekends**: 0800 – 2200h. You will round on peds floor, NICU floor, respond to consults, and deliveries.
- **How to schedule call**: Dr. Kellock will schedule these for you. You can switch shifts if needed, but you need confirmation from involved preceptors and Dr. Kellock.

Evaluations with Dr. Kellock

- Mid-point at 4 weeks: **schedule with Dr. Kellock**
- End of rotation: **schedule with Dr. Kellock**
- Attempt to have 1-2 field notes per day; Dr. Kellock uses these to complete midpoint and end of rotation ITARs.

Why?

CFPC Objectives

Abdominal Pain	Earache	Shortness of Breath
ACLS	Eating Disorders	Substance Use and Addiction
Allergy	Fever	Trauma
Anxiety	Fractures	Vaginitis
Asthma	Immunization	Well-Baby Care
Behavioural Problems	In Children	Septicemia
Cough	Infections	Pediatric Emergencies
Croup	Lacerations	Procedural sedation
Domestic Violence	Learning	Developmental disability and delay
Dysuria	Poisoning	

Know the A's of pediatrics: ADHD, autism, anxiety, asthma

Dalhousie FM

- **Medical Expert 1.3**. Establish and maintain clinical knowledge, skills and attitudes required to meet the needs of children and adolescents. **(1.3.1 – 1.3.17).**
- **Communicator 3**. Share health care information and plans with patients and their families generally and in the following specific situations. **(3.1.1-3.1.3).**

How?

Notes/Dictations

H&P – Dictation/Note

History

1. ID
2. CC
3. HPI
4. ROS – think head to toe
5. PMHx – pregnancy complications, birth, postnatal care, hospitalizations
6. Immunization Status, COVID
7. PSxHx
8. Medications
9. Allergies
10. Social – parents names & employment, drug plan, household, pets, school & grade, HEADS. Any adverse childhood events?
11. FamHx

Physical

1. HEENT
2. Resp
3. CV
4. GI
5. MSK
6. Derm
7. Neuro

- *Complete full exam for every patient*
- *Think head to toe, or peripheral to central*
- *Much of the exam is observation!*
- *Leave scary/painful things for last*
- *Make things fun ☺*

NICU – Note

Date:
Gestational age, corrected:
Problems:
1.
2.
3.

Birth weight:
Today's wt (change in 24hr)

TFI: ml, ml/g/24hr
Feeding type:
Medications:
Urine:
Stool:
Labs: *bili (ABO, Hb), prenatal screen, imaging (head U/S)*

Order Sets

- Anaphylaxis ER
- Anaphylaxis Action Plan and Prescription ER
- Asthma ER
- Asthma Inpatient
- DKA ER
- Fever <28 Days ER
- NRP Algorithm
- PALS Bradycardia
- PALS Cardiac Arrest
- PALS Tachycardia
- Trekk DKA ER
- Trekk Critically Ill Newborn
- Trekk Multisystem Trauma

- Neonatal Abstinence Syndrome
- Trekk Sepsis

Resources

- CPS Position Statements
- PedsCases – podcast and website, has cases and resources to practice
- CADDRA – ADHD resources, including flowcharts based on age, guidelines, and medication chart – **useful to print this off or have it on hand!**
- Parachute – injury prevention, concussion
- Trekk – ER knowledge for pediatrics, as well as lots of patient-centred resources (ear aches, croup, RSV, etc).
- Strongest Families 1-855-922-1122– self-referral programs for difficult behaviour and anxiety.
- Pedistat App – worth the $!
- BC Guidelines – pediatric asthma, has table of inhalers
- PsychDB – for DSM5 criteria

Table Of Contents

Rural Family - Arichat

Who?

Preceptors

Dr. LAWRENCE MACNEIL
Arichat Lead
O: (902) 226-1674
lmacneil66@yahoo.ca
2372 Hwy 206, Arichat
06516

Dr. Scott MacNeil
C: (902) 631-4121
2372 Hwy 206, Arichat

Allied Health

Admin: Lorna, Julia, Annette
FPRN: Phoebe
LPN: Gloria

Social work: Holly
Dietician
Pharmacy: (902) 226-3133

What?

Background

- Arichat is a small Acadian fishing town on Isle Madame in Cape Breton.
- St. Fraser Xavier's University began in Arichat!
- Arichat is derived from a Mi'kmaq word meaning camping ground or worn rocks.
- Much of the community speaks French, but this will not hinder your experience if you do not speak French.

Roles and Responsibilities

Minor Procedures

- You are responsible for completing punch biopsies, excisional biopsies, joint injections, and cast application.

Clinic

- You are responsible for seeing your list of patients throughout the day.
- Clinics are very busy, and you will often see 20 or more patients, however patients usually only bring one concern to their visit.
- You will be mostly independent, but Dr's MacNeil are available if needed.

- As Arichat is close to Antigonish, many of your referrals will be directed to specialists in that area.
- EMR: MedAccess

Call

- You are on call during the day for the urgent treatment centre/outpatients as well as the nursing home.
- The urgent treatment centre is CTAS 4-5.
- You can often fit in outpatients to your clinic schedule as to avoid leaving clinic mid-day.
- You are on call one or two nights per week; you will often not be called.

When?

Schedule

- Monday: 1330h – 2100h
- Tuesday, Wednesday, Thursday:
  - 0800h – 0930h minor procedures
  - 0930h – 1700h office
- Friday: 0930h – 1200h

Call

- Daily (as above).
- Nights: usually Monday and Wednesday.

Where?

Work

- Clinic: 2372 Hwy 206
- St Anne Centre: 2313 Hw 206
  - Nursing home, minor procedures, urgent care/outpatients, lab, x-ray

Sleep

D'Escousse rental - Not available in summer	todd.dewolf@gmail.com
AirBnB	Multiple options

Ask previous residents if you are struggling to find housing.

Eat

Groceries	Coop (closes early!). Some meal prep services deliver to Arichat.
Restaurants	Groundswell Pub, Kenny's Pizza, The Island Nest, Seal Cove Restaurant and Lounge, MacRae's Restaurant Pub & Patio
Cafe	Le Goélette à Pépé Café (across from clinic), Robin's Donuts

Play

- Arichat is a beautiful area with lots of oceanfront. It is an ideal place for walking, running, biking and watersports.
- **Beaches**: Pondville Beach, Point Michaud (surfing spot!)
- **Gym**: Centre iFit Isle Madame, offers student discount. Contact Felicia for membership: (902) 623-0170

Why?

CFPC Objectives

General	**Rural and Remote Medicine**
ALL	ALL

How?

See Family Section

Table Of Contents

Rural Family – Baddeck

Who?

Dr. DAVID HEUGHAN ("Hew-an")
Baddeck Lead
O: (902) 295-3701
heughan@yahoo.com
30 Old Margaree, Baddeck
14691

Dr. Elena Garcia Del Busto
O: (902) 295-3701
14687

Baddeck Hospital: (902) 295-2112
Pharmacy: (902) 295-2404

What?

Background

- Baddeck is a small community ~1 hour from Sydney that has cultural activities and tourism.
- The hospital is called Victoria County Memorial Hospital and has ~10-12 inpatient beds.
- There are four family physicians that have clinics in the hospital, and they share the urgent treatment centre hours and inpatient call weekends.
- The urgent treatment centre is open 7 days per week.

Roles and Responsibilities

Clinic

- You will be working with Dr. Heughan and Dr. Garcia Del Busto equally, and often do half days with each.
- You will work in clinic, urgent treatment centre, occasional youth health clinics and will have call weekends that cover inpatients and the urgent treatment centre.
- If Dr. Heughan has inpatients, you will round on them prior to clinic.

Call

- Call is once per month Fri-Sun.
- Rounds in morning, then UTC in afternoon.

- No nighttime call!

When?

- **UTC**: ~0800h start.
- **Clinic**: ~0845h - 1600h.
- **Typical schedule**:
  - Monday: Clinic
  - Tuesday: Clinic
  - Wednesday: UTC
  - Thursday: Clinic
  - Friday: UTC or clinic
- **Call**: one weekend per month, Friday - Sunday. No overnight call.

Where?

Work

- Everything is at the Victoria County Memorial Hospital.
- Youth Health clinics (during school months) with Dr. Garcia Del Busto are at Rankin, Wagmatcook and Whycocomagh. You will drive with her.

Sleep

- AirBNB is likely your best bet, or you can drive in daily.

Eat

Groceries	Coop The Farmer's Daughter Country Store	
Restaurants	The Freight Shed Three Doors Down Diner Tom's Pizza McCurdy's Dining Room Charlene's	The Cable Room Bell Buoy Bistro The Frozen Spoon From Billy Bistro and Pub
Cafe	Highwheeler Cafe and Bakery Bean There Cafe	

Play

- Hikes: Uisge Bàn Falls, Egypt Falls, Salt Mountain, North River Falls (technically closed), St. Anns Provincial Park

- Theatre Baddeck
- Cross country skiing: Ski Tuonela
- Baddeck Gathering Ceilidhs

Why?

CFPC Objectives

General	Rural and Remote Medicine
ALL	ALL

How?

See Family Section

Table Of Contents

Rural Family – Chéticamp

Who?

DR. MICHEL CHIASSON
Chéticamp Lead
C: (902) 224-7200
O: (902) 224-3110, Betty
drchiasson@hotmail.com
Sacred Heart Hospital
13124

Dr. Amilie Maillet
C: (902) 224-7180

Sacred Heart Hospital: (902) 224-4000
Pharmacy: Louis (902) 224-2691
Xray tech: Vanessa Courtemanche
Lab tech: Monica Ross, Jenna Deveaux
CNLs: Joanne, Christine

What?

Background

- Chéticamp is a small Acadian town on the west coast of Cape Breton that is home to ~4,000 people. The main industry is fishing and tourism.
- You may hear the term “hookers”, i.e. people skilled in making hook rugs.
- Music is bountiful, and there are often events at the local Doryman Pub.
- Chéticamp is a bilingual community; **there is no hindrance to yourself or patient care if you don’t speak French**. If you do, it can be an opportunity for you to practice with patients.
- There are four physicians that work in Chéticamp: Dr. Michel Chiasson, Dr. Paul Sonier, Dr. Kassy Sonier, and Dr. Amilie Maillet.

Roles and Responsibilities

- You will work in clinic, outpatients (ER), hospital & long-term care rounds, and the diabetic clinic. You may meet with the local pharmacist. Depending on the time of year, other opportunities may arise including youth clinics, flu clinics, and other fun things like sports medicine teams. Call allows for the opportunity to be independent, and you are always welcome to lean on Dr. Chiasson and your nursing team for support.
- While you are in Chéticamp, Dr. Chiasson will ask you to write an article for the Inverness paper, The Oran. This article is meant to educate the public on healthcare topics. If you need ideas, there is a binder of previous ones in Dr. Chiasson’s office.

When?

Day to day

- Dr. Chiasson will give you a schedule when you arrive. Rounds are completed before clinic day starts, around 0815h. You are only required to round on patients under Dr. Chiasson (the charts will be colour coded).
- Typical schedule:
  - Monday: AM clinics
  - Tuesday: Virtual clinics
  - Wednesday: clinic + outpatients (ER) – can get busy!
  - Thursday: diabetic clinic, afternoon/evening clinic
  - Friday: AM clinics

Call

- 0800h – 0800h. Every Wednesday, and at least one weekend during the month.
- Summer months are much busier for call due to tourism.
- You may go to other communities with Dr. Chiasson, ex: Neil's Harbour.
- After hours is home call.
- When you receive your schedule, the amount of call during the month may seem overwhelming initially, however you likely won't be called for some of your shifts. If the call shifts are very busy and overwhelming, your schedule will be adjusted.

Where?

Work

- Dr. Chiasson will give you a tour when you arrive. The nice thing about being in a small town is that everything is in one place, **the Sacred Heart Hospital**! This includes family clinic, diabetic clinic, outpatients (ER), inpatients, LTC, and xray/labs
- There is only one pharmacy in town: Pharmachoice.

Sleep

- As with other rural areas, accommodation can be tricky in the tourist months. Ask Kathleen if she has housing leads.
- You are welcome to sleep in the call room as needed.

Eat

- The hospital has a great kitchen, and you can place your order in the morning for lunch at the nurse's station, $5.
- The local grocery store, the Coop, is just across the street from the hospital.

- Some meal prep services deliver to Chéticamp (ex: Cook It).
- Other culinary experiences:
  - Mr. Chicken
  - L'Abri – usually need reso
  - Aucoin Bakery
  - Margeurite boutique et provisions
  - Freya and Thor Gallery and Café
  - The Doryman Pub and Grill
  - Café Les Suêtes
  - Pizza shack
  - Rusty Anchor (Pleasant Bay)
  - Dancing Goat Café & Bakery (Margaree Valley)

Play

- Outdoor activities are a must – you are right on the Cabot trail surrounded by beautiful scenery! Download AllTrails to find nearby hikes:
  - Gypsum Mine Lake
  - Acadian Trail
  - Salmon Pools
  - Petit Etang Beach
  - Blueberry Mountain
  - Skyline Trail
  - Squirrel Mountain
  - Corney Brook Trail

- Depending on the time of year, fly fishing is popular in Margaree. Many people bike the Cabot Trail in the warm months. There is a gym at the high school right beside the hospital; ask Dr. Chiasson for the details.

Why?

CFPC Objectives

General	Rural and Remote Medicine
ALL	ALL

- You will gain independence and confidence while you are on this rotation. This rotation is meant to "grow your wings" where you take care of your patients as if they are your own.

How?

See Family Section

- Dr. Chiasson's Office Magic Tricks
- Sacred Heart Staff #HoldMyHand and the Holidays

Table Of Contents

Rural Family – Neil's Harbour

Who?

DR. NICOLA SMITH
Neil's Harbour Lead
C: (902) 830-8696
O: (902) 336-2300, Margaret/Debbie
nicolarosesmith@gmail.com
Buchanan Memorial Hospital
16164

Buchanan Memorial: (902) 336-2200
Pharmacy (Chelsea): (902) 336-2398
Highland Manor: (902) 336-2895

Side door code: 0347*

What?

Background

- Neil's Harbour is a small lobster/crab fishing community of approximately 300 permanent residents on the East side of the Cabot trail.
- Buchanan Memorial Community Health Centre serves the communities of Neil's Harbor, Dingwall, Bay St Lawrence, Meat Cove, Ingonish and surrounding areas.
- There is x-ray and lab collections during business hours. After hours you will have access to POC labs drawn by RNs and POCUS. The closest CT scanner is in Inverness.
- There are three doctors that work in Neil' Harbour: Dr. Nicola Smith, Dr. Rebecca Hoffer and Dr. Carly Crewe.

Roles and Responsibilities

- You will spend time in family clinic, women's clinic, procedures clinic, youth clinic, inpatient care, outpatient (ER) care and long-term care.
- You will be responsible for seeing your own patients, ordering tests, reviewing with Dr. Smith and following up on ordered investigations (on Accuro). Call allows for the opportunity to be independent, and you are always welcome to lean on Nicola and your nursing team for support.

When?

- Dr. Smith will give you a schedule prior to your arrival.
- Typical week: 1-2 clinic days and 2-3 outpatient shifts.

Clinics

- 0900h – 1700h for family, women's, youth, procedures and long-term care.
- Arrive 10min early to review charts, get supplies ready, etc.
- **Dress code**: clinic clothes, scrubs for procedures

Call

- 0800 – 0800h, Nicola usually arrives around 0900h. It's best to arrive with enough time to complete inpatient rounds before 0900h; patients generally start registering in the ER around 0900h.
- Call is either 24hs, 48hrs or 72hrs. You will often not get called at nighttime.
- Home call after working hours, although often staying late due to volume.
- **Dress code**: personal scrubs

Where?

Work

- Almost everything is at **Buchanan Memorial Hospital**! This includes family clinic, women's clinic, inpatients, and outpatients; Nicola will give you a tour.
- The Highland Manor is the long-term care facility: 175 New Haven Rd
- The youth clinic is at Cabot Education Centre high school: 32039 Cabot Trail

Sleep

Foundation House
- Furnished 2 bedroom, 1 bathroom, laundry, kitchen

165 New Haven Rd
Rhonda.Hebb@nshealth.ca

Back Cove Cottages
- Furnished 1 or 2 bedroom, 1 bathroom, kitchen. No laundry.
- Need pre-approval from NSHA as more than $100/night

backcovecottage@ns.sympatico.ca
(902) 336-2812

Ask previous residents, Rhonda and Nicola if you are struggling to find housing.

Eat

Many places close for the winter season.

You can order lunch from the hospital as well – ask Nicola for details.
Some meal prep services deliver to Neil's Harbour (ex: Cook It).

Groceries	Coop Cabot Trail Food Market ("Red Store") Cape North Saturday Market	
Restaurants	The Markland The Chowder House Morrison's Andrews Pizzaria Rusty Anchor	Angie's Family Restaurant and Pizza Coastal Restaurant and Pub Main St Restaurant
Cafe	Salty Rose and the Periwinkle Café Main St Restaurant	

Play

- Beautiful area of the island! Download AllTrails to find nearby hikes:
  - Coastal Trail
  - Jigging Cove
  - Jack Pine, Black Brook Beach
  - Warren Lake
  - Broad Cove Mountain
  - White Point
  - Kauzmann (sketchy road)
  - Money Point (sketchy road)
  - Middle Head Trail
  - Franey
  - Clyburn Valley
  - Kapala Valley
  - Wilkie Sugar Loaf
  - Mica Hill
  - Meat Cove
  - Cape St Lawrence
- There is a public beach right in Neil's Harbour – access via stairs
- Winter activities: music at Markland, cross country skiing, snow shoeing

Why?

CFPC Objectives

General	**Rural and Remote Medicine**
ALL	ALL

.

How?

See Family Section

Second Year

Geriatrics

Who?

DR. ARLENE KELLY-WIGGINS
Geriatrics Lead
C: (902) 577-9520
O: (902) 567-3626
Arlene.kelly-wiggins@nshealth.ca
1st Floor LL01 Health Park (Geriatric Medicine and Memory Disability Clinic)
16840

Dr. Andrew Xiao ("See-ow")
Virtual (at Geriatric Clinic)
C: (902) 402-2290
O: (902) 567-3626
16871

(new docs coming in Apr and Aug)

Pharmacist: Tessa Forrest, Ellen Penny
Dictation document type: 16

What?

Background

- The Geriatric and Memory Clinic serves all of Cape Breton Island.
- There are two geriatricians, Dr. Kelly-Wiggins (in person) and Dr. Xiao who does virtual appointments from Toronto.
- Every two weeks, there is a clinic in Baddeck with Dr. Kelly-Wiggins. You may choose to attend or stay behind with Dr. Xiao.
- Initial assessments are often 2-3hrs long.

Roles and Responsibilities

- The assessments consist of cognitive testing completed by the RNs, collateral history collected by yourself (see dictation guide below) and physical exam completed by yourself.
- You will then meet with the geriatrician and nurse to discuss findings and propose a diagnosis and treatment plan.
- You will discuss this plan with the patient and their caregivers.
- Afterwards, you will dictate the consultation.
- Ask to work with Tessa or Ellen, the geriatric pharmacist a few times during your rotation.
- There is a clinic in Baddeck every three months for more urgent, younger patients that is attended by Dr. Kelly-Wiggins, Dr. Rockwood and a nurse. You will travel with them to these clinics. Review causes of dementia including

(but not limited to) frontotemporal, Lewy-body, corticobasal degeneration, multiple system atrophy, and progressive supranuclear palsy.

When?

- Clinic: ~0845-1700h.
- There is no call.

Where?

- Main clinic: as above
- Baddeck clinic every second Monday at Baddeck Hospital.

Why?

CFPC Objectives

Depression
Disability
Dizziness
Elderly
Family Issues
Multiple Medical Problems
Parkinsonism

Dalhousie FM Curriculum

- **Medical Expert 1.2**. Establish and maintain clinical knowledge, skills and attitudes required to meet the needs of elderly patients. **(1.2.1 – 1.2.17).**
- **Collaborator 1.1**. Work effectively with others in a collaborative team-based model for patient care generally and specific to: collaborate in the care of the elderly. **(1.1.1 – 1.12).**
- **Professional 3.3.** Demonstrate awareness of obligations to report situations of abuse or neglect concerning children, the elderly and other vulnerable populations.

How?

Dictations

Comprehensive Geriatric Assessment - Dictation

Thank you for asking us to see [name] re: concerns of [reason for referral]. [Name] is a [age] year old [occupation] [sex] who lives in [town] with [spouse, partner]. They were seen in consultation for a comprehensive geriatric assessment today, [date]. They were accompanied by [relative], who provided collateral history for us today.

HPI/Family Concerns:

Cognition:

1. Memory – names, repeat phrases/questions, reminders (meds, appointments), date, time, misplacing objects, forgetting recent convos/events, recognizing people/places
2. Language – word finding, meaningful conversations, read, write, understand
3. Executive function – multitask, plan (ex: make a meal), distracted, focus/attention
4. Personality – apathy, lack of empathy, OCD
5. Visuospatial – wandering, lost, not using tools/devices properly, clothes backwards

Function:

- BADL's – DEATH – dressing, eating, ambulating, toileting, hygiene (rewearing clothes)
- IADL's – SHAFT – shopping, housekeeping, accounting, food prep, taking meds, transportation, telephone

PMHx:

Meds:

Family History:

Recent Investigations: Labs, most recent head CT/MRI

Behaviour/Mood:

- Mood – sad, depressed, anxious
- AH/VH, delusions, paranoia,
- Irritability, frustration
- Disinhibited
- Agitation, aggression
- REM sleep symptoms
- Hx mental health hx
- Delirium hx

Mobility:

- Falls, aids, transfers, safety concerns (shower, stairs), neuropathy, lightheadedness, gait changes

ROS:

- Bowels, bladder, incontinence
- Appetite
- Sleep
- Energy
- Pain
- Hearing, speech, vision

Social Hx:

- Marital status, children, grandchildren
- Prev occupation/schooling
- Living situation
- Formal supports (VON, homecare)
- Family/caregiver issues
- POA/SDM
- Coverage
- EtOH, smoking

Physical Exam: *[Name] appeared well. They were dressed appropriately for the season with adequate hygiene. They were pleasant, followed directions well and actively engaged in the assessment.*

- Weight, orthostatic vitals, timed up and go
- Neuro: Gait (wide, stooped, shuffle, shortened stride, decreased arm swing, fragmented turn), tone, bulk, strength, light/pinprick sensation, tremor, reflexes, CN's, dysmetria, dysdiadokokinesia, bradykinesia, Romberg, pronator drift
- ENT
- CV
- Resp
- Abdo
- Peripheries: edema, skin

Cognitive Testing:
MMSE: _/30, _/3 recall _/5 WORLD backwards. Describe clock. Pentagon and cube are _. Fluency: _ S words, _ F words, _ animals.
MOCA: _/30
Frontal assessment battery (FAB) _/18.
Geriatric Depression Screen (GDS) _/15.

Impression and Plan:
In summary, [name] was referred for [reason]. Today, they have a clinical frailty score of _. They were seen for a comprehensive geriatric assessment, with the goal of answering the following four questions:

1. **Is there a memory problem?** Yes/no. MMSE. MOCA.

2. **What type?** Which part is impaired? Meet the criteria for dementia or MCI? *Mild impairment in new learning and memory and mild-moderate deficits in visual-spatial stills. They appear to be managing well at home without any functional impairment and therefore does not meet the criteria for dementia. Currently MCI.*

3. **What is the cause?** Alzheimer's, vascular (risk factors). Severity. *[name] has vascular risk factors including smoking and hypertension. It is likely this is a vascular cognitive impairment at a mild stage.*

4. **What can be done?**

It was a pleasure meeting [name] and their caregivers today. We will follow up in _ months. Please contact the geriatric clinic if you have questions or concerns.

Resources

Academic Resources

- Clinical Frailty Score
  - How to score
  - Tips
  - Classification Tree
- MMSE, MOCA, GDS, FAB
- Green card (will be provided, keep it with you!)
- PsychDB
- Geriatrics Referral Form
- BrainXChange – resources for dementia
- Radiology Assistant – to see various scans of dementia, strokes, etc.

Patient Resources

- Alzheimer Society Nova Scotia
- iGeriCare
- CCNS Continuing Care Nova Scotia – ns 211
- Caregivers Nova Scotia
  - The Caregiver's Handbook

Tips

- Medication review is key! Consider discontinuing or decreasing harmful medications (beta blockers, benzos, anticholinergics) where possible. Utilize the pharmacists!
- Monitor and think about possible side effects:
  - Cholinesterase inhibitors: orthostatic changes
  - Sertraline: GI upset, diarrhea
  - Escitalopram: QTc prolongation
- Consider function as well – investigate this as this is important for planning and management. Whether you are dependent on cognition or function, your frailty is the same.

STAGE	CURE (COGNITION)	IRAN (FUNCTION)
MILD	CURRENT EVENTS (news, sports, weather, etc)	IADLs (higher order functions)
MODERATE	US PRES/CAN PM (major figures)	REWEARING (personal care)
SEVERE	RELATIVES (forgetting names + relationships)	ADLs (personal care)
VERY SEVERE	EVERY ASPECT OF MEMORY/COGNITION	NON-VERBAL, NON-AMBULATORY

- Physical exam for Parkinsonism – elevated tone, tremor, bradykinesia, stoop posture, shuffle gait – can be helpful to see progression from visit to visit
  - Upper limbs, unilateral – idiopathic
  - Lower limbs, bilateral – vascular

ICU

Who?

Preceptors

DR. KEVIN KLASSEN
ICU Lead
Kevin.Klassen@nshealth.ca
C: (902) 210-5471
16177

Pharmacist: Alex

- There are two physicians per week, alternating every 24hrs at 1100h.
- ICU physicians switch every Tuesday.

The Rest

- **Please review Dr. Klassen's orientation package, schedule, and teaching topics prior to the start of your rotation!**

Notes/Dictations

ICU Progress note (see details in package)

Date	
ID	*Age, sex, p/w, ?diagnosis. Updates since admission.*
CNS	*GCS, RASS, CAM (+/-). Sedation? (propofol, ketamine).*
CVS	*HR (?NSR), BP. Physical exam. Pressors? (norepi)*
Resp	*RR, O2 sats. Exam, CXR. Highflow, CPAP, BiPAP, or vent settings. ABG/VBG. (pH/CO2/O2/bicarb/lactate)*
GI	*Physical exam, drains. Feeds*
GU	*Fluid balance 24hrs, u/o. IV Fluids*
Heme	*Labs, DVTp*
ID	*Temp. Abx. BCx, UCx, Sputum cx*
Met/endo	*(not always applicable). DKA protocol, insulin.*
Meds	*(don't have to write them all out – verbally review with pharmacy*
Impression	
Plan	*Make a management plan for each system with ddx*

Resources

- EmCrit

Palliative Care

Who?

Preceptors

DR. ANNE FRANCES D'INTINO
Palliative Lead, Hospice
C: (902) 577-5336
O: (902) 567-7804, admin: Terri-Lynn Peters
annefrances.dintino@nshealth.ca
6 Charles Herney Awti
06510

Dr. George Burns
C: (902) 578-0801
O: (902) 567-7804
12242

Dr. Brendan McCarville
brendan.mccarville@nshealth.ca
C: (902) 549-0599
16562

Dr. Andrew Giorno
C: (902) 549-2597
andrew.giorno@nshealth.ca
CBRH 3rd floor, near LDU
14979

Dr. Peter Poulos
C: (902) 565-9464
O: (902) 794-3301
poulos@eastlink.ca
145 King St, North Sydney
06343

Dr. John Ritter
john.ritter@nshealth.ca
12553

Multidisciplinary room code: 3443*
An Cala (4E): (902) 567 8596, (902) 141-2952
Hospice: (902) 567-8584

What?

Background

- Palliative care is an extensive holistic service that covers all of Cape Breton.
- There are varying levels of care:
    1. **Community outpatients**: visits done in patient's home with RN
    2. **Inpatients**:
        a. **An Cala (4E)**: acute symptoms, imminent death, ~2 week stay
        b. **Hospice**: certain criteria for admission, ~3 month life expectancy
        c. **Hospital consults**
- **Please read Dr. D'Intino's orientation package. You will receive this on your first day. There is a sample consultation included in this package as well.**

Roles and Responsibilities

- You will be responsible for completing H&P's, physical exams, reviewing medications and proposing management plans for each patient. You will be supported throughout your rotation.
- You will see patients in the community with the physician and nurse, will round on An Cala and Hospice, and respond to hospital consults when you are on inpatients or on call
- You will support patients through their health concerns and will explore their goals with empathy and curiosity.
- You will take care of your mental health and well-being on this rotation as it can be heavy and difficult. Please talk with your preceptors or your supports.

An Cala

- Ward that focuses on symptom management for palliative conditions.
- Patients are admitted under hospitalist or palliative care MD as MRP.
- Multidisciplinary team available for patient family support.
- Admission requirements:
    - Acute symptom management unit and end of life care.
    - An Cala is not for aggressive medical treatment or escalation of care to ICU or for IV chemotherapy.
    - C1/C2 goals of care; S2 levels of care best suited for other units.

Hospice

- 10-patient establishment that focuses solely on symptom management during the last months of life.
- Multidisciplinary team available for patient family support.
- Admission requirements: life expectancy <3mo, GOC strictly comfort (C2).
- There are many activities and services that patients have access to, including bingo and musical therapy.
- There is also bereavement support for families.

When?

- Check in with the preceptor for start time/location.
- **Outpatient days**: meet in the multidisciplinary room around 0900h. Usually ends around 1600h.
- **Inpatients**: Usually 0830-1700h. Hospice rounds are on Monday's at 1100h.
- **Weekday call**: 1700h-0000h.
- **Weekend call**: 0800h-0000h.

Where?

- **Community consults**: you will drive with the MD and RN. Most common communities include Sydney, North Sydney area, New Waterford, Glace Bay and Louisbourg.
- **An Cala**: 4E, near the resident lounge.
- **Hospice**: 6 Charles Herney Awti, ~1min drive from the hospital.

Why?

Dalhousie FM Curriculum

- **Medical Expert 1.7**. Establish and maintain clinical knowledge, skills and attitudes required in palliative care. (**1.7.1 – 1.7.10**)
- **Medical Expert 7.6**. To develop a compassionate and effective approach to patient requests for Medical Assistance in Dying (MAID). (**7.6.1 – 7.6.5**)
- **Communication 3.4**. Develop skills in the unique challenges of communication in palliative care situations. (**3.4.1 – 3.4.2**)

How?

Resources

Academic Resources

- Apps: Pallium, iPal Global
- LEAP Core Participant Manual
- Serious Illness Conversation Guide
- PPS Scale
- Pallium Lectures:
  - Lecture: EOL Care in ER
  - Lecture: GI symptoms in Palliative Care
  - Lecture: Pain and SOB in Palliative Care
  - Lecture: Pain in Palliative Care

Patient Resources

- Video: Better early than late
- Hospice information handout
- CaregiversNS
- Caregiver's Handbook
- Grief and Bereavement Resource Repository
- Speak Up: Advanced Care Planning
- Canadian Virtual Hospice
- Special Patient Program: EHS Palliative Care

Pallium Course

Pain

- PRN = 10% (5-20%) of total scheduled opioid per 24hr

OPIOID	Usual Starting Dose	Frail persons, very elderly & advanced heart & lung disease Start with lower doses
Codeine	15mg q 4hr PO + 15mg PO q1hr PRN*	Start with lower doses
Tramadol	37.5mg PO TID PO + 37.5mg PO QID PRN*	
Morphine	5mg q 4hr PO + 5mg PO q1hr PRN*	
Hydromorphone	1mg q 4hr PO + 1mg PO q1hr PRN*	

*** Re-evaluate pain control if using 4 or more PRNs in 24hr**

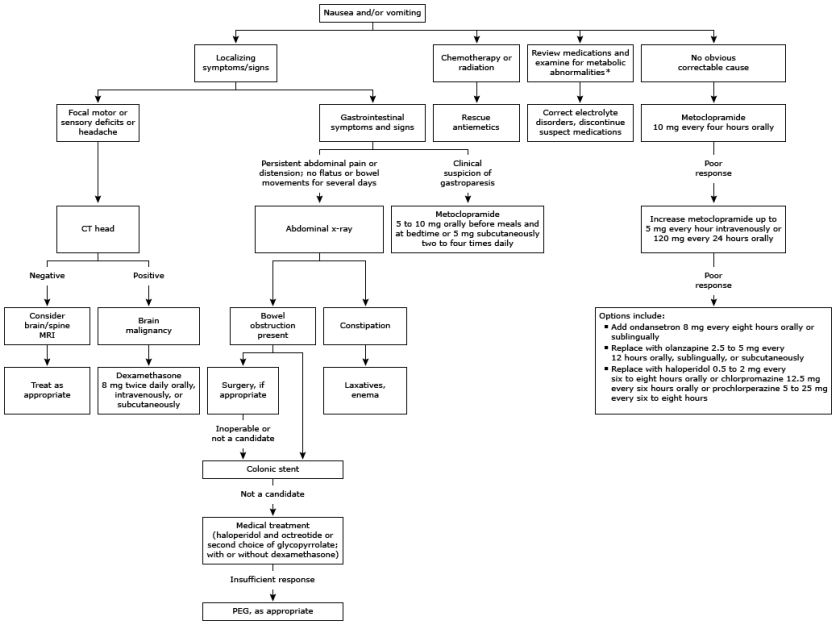
Opioid	Approximate Equivalent Dose	
	Oral	Subcut (IV)
Codeine	100mg	-
Tramadol	50mg	-
Morphine	10 mg	5 mg (3mg)
Hydromorphone	2 mg	1 mg (0.5mg)
Oxycodone	5mg-7.5mg	-
Fentanyl		50mcg
Methadone	About 1mg	

- These are approximate equivalences and serve only as guides
- When switching, reduce new opioid dose by 20%-30% in all cases

Nausea

Select antiemetic based on the cause! Rule out constipation!

- First line: metoclopramide (maxeran) 10mg PO QID, domperidone 10mg PO TID
  - EXCEPT in complete bowel obstruction as it stimulates gastric motility
- Second line: haloperidol 0.5-1mg PO daily/BID (good for bowel obstruction), ondansetron, methotrimeprazine
- Third line: Dex 4mg PO/SQ daily (good for bowel obstruction), nabilone 1mg PO BID, dimenhydrinate (don't use)



Constipation

- Senna 1-2 tabs PO qHS, PEG 17g 3350 1-2 PO daily, lactulose 15-30ml PO daily. Avoid bulking agents (psyllium), docusate.
- Fleet enema, Dulcolax or glycerin suppository, manual disimpaction.

Shortness of Breath

- Manage underlying illness if possible. Fan PRN.
- O's: oxygen and opioids. Ex: morphine 1 or 2mg PO q6hrs + PRNs

End of Life

- Stop redundant meds, stop PO, stop vitals/labs, switch to subcut
- Secretions: reposition, reassure, glycopyrrolate 0.4mg subcut q2h, scopolamine 0.4mg subcut q4h, furosemide 20-40mg subcut for pulmonary edema
- Pain, SOB: opioids
- Palliative Sedation (policy available, however preceptor must be consulted): methotrimeprazine 12.5-25mg, midazolam 0.5-1mg subcut/IV, titrate as necessary
- Risk of massive bleed: dark towels, midazolam 5mg stat, and titrate q5min as necessary

Psychiatry

Who?

Preceptors

DR. ADEWALE RAJI
Psychiatry Lead
Adewale.Raji@nshealth.ca
(902) 574-7286
16310

Dr. Javed Ali
10745

Dr. Choo Chong
+ child psych
O: (902) 567-7731
19496

Dr. Brian Foley
08153

Dr. Hussein Ibrahim
19592

Dr. Shahzada Farrakh Nawaz
19041

Dr. Sunny Singh
19572

Dr. Sukhy Singh
19586

Dr. Ajai Sharma
19852

Dr. Zaki Abu Shullaih
14478

Dr. Diepriye Tariah
19923

Outpatient Adult MH: (902) 567-8091
Crisis: (902) 567-1974
Ally Centre: (902) 578-9450

What?

Background

- Psychiatry in Cape Breton is a mix of inpatient care, ER Crisis consults, and outpatient visits.
- There are four inpatient psychiatric wards in the CBRH that are each managed by a psychiatrist and multiple clinical associates.
- Crisis is a service that provides mental health assessments in the ER. These are first completed by mental health nurses or social workers, and if they deem a patient at risk or needing physician support, they will consult the

psychiatrist/clinical associate on call. They can also refer patients to urgent care, an expedited outpatient counselling service through Mental Health.
- The Day Program is a relatively new service that provides a bridge between inpatients and discharge, with daily sessions on skill-building to succeed in community

Roles and Responsibilities

- **Inpatient**: You will join multidisciplinary rounds with the psychiatrist, clinical associates, pharmacist and nurses. You will then observe rounds.
- **Crisis**: The crisis team sees mental health consults. If they deem the need for psychiatry review, you will complete a full psychiatry consultation and review with the psychiatrist on call (not the clinical associate). Check in with the crisis nurses/SW at the beginning of the day and give them your number, and reach out to the psychiatrist on call as well.
- **Outpatient**: You will see patients and review them with your preceptor.

When?

- Clinics: ~0900h – 1600h
- Crisis: 0900h – 1900h
- Inpatient: 0900h – 1200h

Where?

1A	1B	1C	1D
Withdrawal Management	Inpatient	Inpatient	Inpatient

- Outpatient Adult Mental Health: 2nd floor CBRH.
  - Crisis: Office on left.
  - Crisis patients on whiteboard in ER by triage area
- Day program: in same area as Adult Mental Health
- Ally Health Centre: 75 Prince St, Sydney

Why?

Dalhousie FM Curriculum

- **Medical Expert 1.1.2.2.** Behavioural Medicine/Mental Health **(1.1.2.2.1 – 1.1.2.2.3.)**

How?

Order Sets

- Inpatient Psychiatry Admission

Resources

- UBC Survival Guide
- PsychDB
- CPA: Anxiety Disorders
- CANMAT: Depression 2016
- CANMAT: Bipolar disorder 2018
- SwitchRx

Dictations

CRISIS CONSULT – NOTE +/- DICTATION

ID	*"50yo M truck driver from Sydney, here with wife"*
CC/RFR	*"Increasing anxiety, low mood, suicidal ideation"*
HPI	*"After reviewing confidentiality, the patient was seen in rm 23 of the CBRH ER with his wife and later with [preceptor]. The following history was corroborated by crisis team, wife and patient"*
ROS	*Mood (MSIGECAPS), anxiety disorders (panic, social, OCD, phobia), mania, hallucinations, delusions, paranoia.*
Harm Risk	*Precipitating, provoking, protective factors*
PMHx	*seizures, traumatic brain injury*
Past Psych Hx	*Hospitalizations, self harming, suicide attempts*
Fam Hx	*Hx suicide attempts/completions, mood/anxiety, bipolar, schizophrenia*
Medications	*Previous trials, current meds (doses, frequency, adherence, levels)*
Allergies	
MSE	*ASEPTIC (appearance, speech, emotion/affect, thought process, thought content, insight/judgement, cognition)*
Investigations	*Recent labs (TSH, lytes) and imaging (?CT head)*
Impression/DSM5	*Review risk level*
Plan	*Think **bio** (meds) **psycho** (therapy) **social** (lifestyle management, housing etc.). GP or psych follow up?*