table of contents

WHO’S WHO
PD & Chiefs - 2
Educational Support - 2
Clinical Support - 2
PGME Contacts - 2
Important Numbers - 3

THE NITTY GRITTY
Email - 3
Fellow/Resident Room - 3
Mail - 4

CALL
Call Responsibilities - 4
Tips for Being on Call - 5

THE MAZANKOWSKI
CCU - 8
Admitting Patients - 9
Ward - 10
Consults - 10
Triage - 11
Clinic - 11

ACADEMIC REQUIREMENTS
Schedule - 12

FUNDING
Conference - 13
Rossal Family Scholarship - 13

UAH INFORMATION
Access - 13
Radiology Results - 14
Lab Results - 14
Locating - 14

RESIDENT WELLNESS
Stress Management -
Resident in Crisis
Intimidation & harassment policy -
pd and chiefs

DR CRAIG BUTLER
craig.butler@albertahealthservices.ca

DR MIKE RACO AND DR ROBBIE SIDHU
cardres@ualberta.ca

educational support

All education support is provided by the Cardiology Residency Coordinator, Nicole Firth. She can be contacted via email at medncard@ualberta.ca and via telephone at 780-248-1441. Nicole supports you in the following ways:

- Orientation
- System access
- Assessment tracking (ITERs, OSCEs, STACERs, other exams, etc.)
- Rotation, Vacation, and Leave scheduling
- Letters confirming your current residency status
- Funding
- Other miscellaneous

clinical support

As part of the training program, there is a longitudinal residency clinic. Clinical support is provided by Debbie Smith. She can be contacted via email Debbie.Smith5@albertahealthservices.ca and via telephone 780-407-6507.

pgme contacts

DR RAMONA KEARNEY
Associate Dean
rkearney@ualberta.ca, 780-492-9722

DR WINNIE WONG
Assistant Dean
winnie.wong@ualberta.ca, 780-248-2931

*Remediation, Internal Reviews*
important numbers

- All numbers in the hospital are (780) 407–xxxx
- To dial any number in the hospital dial 7-xxxx
- To dial an outside number dial 9 then the outside number
- For long distance numbers there is a long distance code required (eg. for the CCU the code is 6485–2240)
- Locating/Switchboard: 76191 / 0
- Contacting Switchboard from outside lines: (780) 407-8822
- CCU Main Line - 76140
- CCU Charge Nurse - 74117
- CCU Fax - (780) 407-7459
- CCU Signover/Work Room - 74507
- 5A5 – 76165
- 5A6 – 76101
- Ward Charge Nurse - 74210
- RAAPID North – (780) 735–0811 or (780) 735-0812
- Echo Lab (Michelle) – 77209
- Echo Lab (Reading Room) – 74265
- Cath Lab – 76919
- Holter / EKG – 76364
- MIBI – 78415
- Pacemaker Clinic – 76207
- Bed Manager Direct Number - 71148

the nitty gritty

EMAIL

Ensure you are using your ualberta account. All PGME and information from the Chiefs and Cardiology Residency Coordinator will only be sent via ualberta. It is imperative that you check your email regularly and respond within a timely fashion. Any patient related e-mail will be sent to your AHS e-mail. Any patient concerns should be addressed within 48 hours.
FELLOW/RESIDENT ROOM
Cardiology fellows and residents share a break/locker room. The room number is 3A5.035 and it is located in the Mazankowski. You already have a locker assigned to you. Passcode is 5865*

MAIL
You have your own mail box in room 2C2 which is where patient reports, etc. will be sent. The address is as follows:

Division of Cardiology, University of Alberta Hospital
2C2 - 8440 112 Street NW
Edmonton, AB T6G 2B7

call responsibilities

While on call at the Mazankowski Alberta Heart Institute (MAHI), you are responsible for:

➔ Backup call for the 2 junior residents on call (one covering CCU / wards and consults to patients admitted to other services; the other resident covering new consults from patients in ER). You are to remain in–house on call.
   ✔ You are to review ALL consults overnight in person.
   ✔ STEMI calls will go directly to you and you should see emergently with the junior

➔ Respond to ALL codes in the MAHI
   ✔ You do NOT need to go to Code Blues or “Medical Emergency Team (MET)” calls (which are “pre--codes” for the main hospital.) in the Walter Mackenzie Centre (main hospital), as those are attended to be the ICU team.
   ✔ We do go to codes in WMC to help out when there are 2–3 back to back Code Blues
   ✔ Because there is no MET team in the MAHI the ward will call a “code blue” for both code blue appropriate patients and MET type patients. Ward nurses are not ACLS trained.

➔ Cover CCU patients
   ✔ Often nurses will call you directly for complicated patients, especially ventilated / balloon pump patients.
   ✔ You will be solely responsible for cooled, post--arrest patients, as juniors are not allowed to write orders on them. You may be called about things such as inotropes, which juniors may not be comfortable dealing with.

➔ Outside Calls
   ✔ We are one of the few programs in Canada that has senior residents take outside calls. See section below for details and tips.

➔ Bed Management
   ✔ Although there is always a bed manager on call, it’s helpful to keep track of how many beds you have on each ward (5A5 and 5A6) as well as in the CCU (5A7). Can be paged anytime through locating
   ✔ CCU generally caps at 8 patients, but often can take a 9th in an emergency unless there are several intubated/balloon pumped patients. In addition, there are 4 short stay beds (see below section on CCU).
   ✔ ALWAYS talk to the charge nurse in CCU. Communication between the charge nurse and senior is key to make sure you both are on the same page on which patients are coming to CCU / being transferred out.
Echocardiograms / Device Interrogation

- Often ER, CVICU, and General Systems ICU (GSICU) will ask you to do an urgent echo on a patient. The senior resident is responsible for triaging if this is an appropriate test to do overnight urgently, or wait till AM.
- Echos done overnight or on weekends, ideally should be coded in Xcelera, with your conclusions written, so that the echo staff on the next day can finalize your report. You can get credit for on--call echos, and if you do the full report will get credit for reading it as well.
- Patients with ICDs/pacemakers may come in with alarms/shocks etc., requiring device interrogation overnight.
- ENSURE THAT ALL EQUIPMENT IS CLEANED AND RETURNED BEFORE 7AM THE NEXT DAY
  - The echo department and device clinic use the machines first thing in the morning
- You will have a backup senior on call with you for the first 6 blocks to help you with doing echos and device interrogations on call (along with lines / transvenous pacers). Do not hesitate to call for backup. If there are issues with backup call, please contact the chief residents.

tips for being on call

DEALING WITH STEMIS

- “Vital Heart”
  - The majority of STEMI calls will go through our regional STEMI Program “Vital Heart”
  - There are 5 cardiologists in the city (at the Mazankowski and Royal Alex Hospitals, the two cath centres) that alternate call for STEMI calls.
  - Our regional strategy incorporates EMS as well, so paramedics can call the physician directly and email them an ECG. They can give ticagrelor/ASA on scene and bring them straight to ER/Cath lab ready for angioplasty.
  - Vital Heart will likely not do a full cardiology consult but make a decision on whether or not this is a STEMI and if so what strategy to pursue (eg. primary PCI vs lytic). All STEMIs will need to be sent to a CCU regardless of reperfusion strategy. The Vital Heart physician will call your CCU or you to let you know that the patient is being transferred to you. This may not always happen and sometimes patients will arrive in ER and triage there will call you directly. These patients need to be assessed ASAP as ER may not see them right away
  - When the STEMI arrives to the CCU you should assess the patient with your junior.
  - If the patient is lysed with TNK, make sure that they meet reperfusion criteria (pain free and at least 50% ST resolution at 90 minutes.) If there is any concern that there is either persistent pain or insufficient ST resolution, talk to the CCU staff ASAP, as the patient may require rescue PCI urgently

STEMIs in the ER

- Often patients will be diagnosed as STEMI in ER. The ER doctors will likely call you directly rather than your junior. Go see these patients urgently, make an assessment, confirm the diagnosis and call your staff ASAP. They may ask you to call the staff who is on call for intervention directly to tell them the story.
- Make sure the patient gets ASA 600mg, ticagrelor 180mg or clopidogrel 600mg, as well as anticoagulation (enoxaparin [IV and SC] vs heparin) ASAP if not already done. Get the paperwork done quickly to assist in getting the patient to the cath lab ASAP and subsequently admitted to the CCU.

Calling in the Cath Lab
◆ There is an on call team for the cath lab including an attending interventionalist, often a cath fellow, radiology technician, nurses. Your job is to call the attending interventionalist. If they accept the case, they may ask you to call the CCU charge nurse who can then call the rest of the team in.

DEALING WITH OUTSIDE CALLS

→ Always document all outside calls. (As a suggestion, consider writing all calls on a consult form). Always write down the phone number and person calling, as well as location, so that you have a way of contacting them again in the future.

→ RAAPID North

◆ MOST calls will come through our regional critical care line called “RAAPID North”.
◆ This is a system where physicians from other hospitals can call a main number, a RAAPID North nurse can triage the call and get them in contact with a specialist
◆ RAAPID will page you to their main line (735-0812). Try to respond in a timely manner. If you are paged to 735-0811 this means the consult is on a critical patient and needs response ASAP. If you yourself are dealing with a critical patient, call RAAPID and they can get a hold of the next specialist.
◆ RAAPID usually alternates between the four CCUs in the city, however you may get paged more often for consults if the other CCUs are full and the MAHI has more beds. Also, you may get paged in regards to more critical patients that may require higher level of care that can only be offered at the University (eg. transplant)
◆ The advantages of RAAPID North are that all cases are recorded (keep this in mind when you are speaking on the phone…) and they can also assist with transferring patients
◆ If there is an emergent situation, RAAPID can page your staff to have them present for the conference call.
◆ If you think another service (eg. ICU) should be involved, you can ask them to be patched into the call as well.
◆ When you take the call, start by getting demographics, and ideally have a computer ready in front of you.
  ● Name of the patient
  ● ULI / PHN (this is synonymous with the Alberta Health Care Number) – allows you to start looking up the patient simultaneously on NetCare
  ● Start by taking a standard history and always document pertinent vitals / physical exam / investigations
  ● Get the physician to fax you the ECG (easiest is to fax to our CCU 780--407--7459). This also gives you time to review the case, consolidate a plan, and discuss with your staff on call.
  ● After you have a plan call the physician back through RAAPID North
◆ Sometimes through the course of the consult the patient will actually be a STEMI. Do not tell the other physician to just call back through Vital heart. Proceed to take the call as you would normally and have the CCU attending/interventionalist patched in as needed. In addition, sometimes Vital heart has technical issues and you will be the go to person in those situations

→ Transferring Patients

◆ Make sure you ask the physician where they are, what their facilities are (eg. do they have cardiac monitoring, a higher acuity care setting like an ICU or high--observation bed) and if they are comfortable looking after the patient. Although patients may be stable, they sometimes require to be transferred because they have presented to a very small centre that does not have certain capabilities (eg. cardiac monitoring).
◆ You need to make a decision of where the patient needs to be transferred.
• Talk to the bed manager on call if you need to see if there are beds/telemetry available on the wards. It is often nice to actually talk to them at the beginning of your shift so you know what you are dealing with for the rest of the night.

• CCU 5A7 – ANYONE transferred or admitted to be CCU needs to have their case discussed with the attending on call so that they can agree to take over the care of the patient. Generally any STEMs or NSTEMIs with high troponin or any ACS with active chest pain should come to CCU. If you are on from 5pm – 8am the Sr Resident is the physician responsible for deciding admission to CCU

• Wards 5A5/5A6 – Generally this should be reserved for stable patients. Examples would be rapid atrial fibrillation, decompensated heart failure, pain--free unstable angina or NSTEMIs with mild troponin elevation. Telemetry is still available on the wards (but can be in short supply).

• Emergency department – if a patient is unstable, or you cannot tell for certain if this is ACS vs. PE vs Type II MI etc... DO NOT directly admit to cardiology. The safest thing to do is have them transferred to the ER at the University for assessment. RAAPID can often patch in an ER physician and you can tell them a quick story on the conference call. Sometimes if the patient is already assessed by another ER physician in the periphery the ER physician here will ask to not be involved. This is often reasonable, and you can ask that the patient come to ER for a direct cardiology assessment and consult (not necessarily admission). If it ends up being clearly not cardiac, you have the ability to then consult the appropriate service for assessment/admission (eg. General Internal Medicine, Pulmonary etc.)

 ➔ Dealing with calls directly to you from switchboard
   ◆ Sometimes physicians will call the University directly asking for a cardiology consult. Although this can be frustrating because you can get multiple non--urgent consults while you are covering a busy CCU and dealing with calls from RAAPID, be kind to the physicians on the other line. Don’t forget that they are calling you because they need help.
   ◆ You can deal with the call over the phone directly, however make sure to get direct contact info for the physician so that you can call them back. RAAPID will have NO documentation in regards to the case.
   ◆ Most of these calls will be for advice only. If it is more complicated or the patient may need transfer, then it may be easier to ask the physician to call you back through RAAPID North, or you can ask them for contact info, call RAAPID and ask them to connect you to them. This way RAAPID has this conversation recorded, can help coordinate transfer if necessary, and will also take this into account that you have done another “outside call” (keep in mind they alternate their outside calls amongst the four CCUs).

CHEST PAIN PROTOCOL/CLINIC

 ➔ Just so you are aware, there is a protocol that ER physicians follow for non--specific / atypical chest pain with 2 negative troponins. They refer to the chest pain clinic, where a nurse practitioner sees the patient (usually the next day) with an exercise stress test. You will hear about these patients on call if either the troponin becomes positive or the story becomes more concerning for cardiac chest pain.

 ➔ If you have seen someone in the ER in consultation, you are NOT to refer to the chest pain clinic. This duplicates work, as an NP ends up redoing the history / physical that you have already done. It is your responsibility to determine the outpatient plan (eg. outpatient risk stratification with exercise stress test vs MIBI, vs other imaging) and follow up plan (see below).

DISCHARGING PATIENTS FROM THE ER

 ➔ You may encounter seeing patients in ER that do not require admission.

 ➔ If you think that a patient is stable to go home, you can discharge them from ER, however you should discuss the overall plan with your on call staff before officially sending them home.
Make sure that you have a clear cut plan, including follow up. Make sure to see if the patient already has a cardiologist in the city that they can follow up with, otherwise you can see them in your resident clinic.

the mazankowski ccu

STRUCTURE OF THE CCU

- The team consists of 1 senior resident, usually 4–5 junior residents and one staff. Junior residents are usually internal medicine R2s, and R1s from off–service programs (e.g., surgical subspecialties or family medicine).
- The staff alternate every two weeks. They will cover call Monday 8AM to Friday 5PM (they cover all the evenings that week). A new staff takes over for Friday evening, Saturday, and Sunday.
- Make sure to discuss with your team on day one what the expectations of the rotation are.
- Junior residents generally are expected to divide up the CCU patients before rounds and do a pre-round on their patients. Even if they have teaching in the morning, that means they should be in extra early to get to know the issues from overnight and learn new patients.
- Rapid Rounds take place in CCU in the last empty patient room (just past the charge room) at 9AM (only about 5 minutes). Most members of the allied health team are present and you will decide a rounding order and can let the teams know of which patients need urgent tests, procedures, etc.
- Rounds are usually 9AM – 12PM. C2s and C3s on CCU often will be allowed to do more independent rounds with their team, however most staff will round with you as a C1, and will not give you the same independence just yet.
- On rounds, you should have the unit manager (Glenda) or a charge nurse with you, along with a pharmacist (often Jade). Juniors will present the brief case history, bedside nurses will give their full nursing report. Other members of the team go through labs and pharmacist will run through medications. The junior responsible for the patient will then be expected to come up with a plan, and you will see the patient/family as a team. Communication with the family will most often be done by yourself, or by your staff (depending on who is on service with you).
- During the afternoons, you will supervise/assist juniors with procedures. Juniors will be expected to write notes etc.
- Ask your juniors to start filling out pertinent information in the discharge summary while they are looking after the patient in the CCU. If the patient ends up being transferred over to the ward pre-discharge, it makes it easier for the ward staff to discharge the patient if most of the paperwork is already done.

TRANSFERRING TO THE WARD

- On rounds you may be asked if a patient can be made “Ward Protocol”. This means that they can be treated as a ward patient (taken off the wired bedside monitor and put on wireless telemetry, mobilized in the unit, less frequent vitals). To do this you need to stamp the order sheet with preset ward protocol orders. Ensure the labs and frequency of xray’s (if needed) are appropriate for the patients needs.
- There are preset transfer orders that must be filled out pre–emptively at this point.
- Once ward beds are available, the charge nurse will let you know which ward the bed is available on. It is YOUR responsibility to ensure that there is adequate handover to the physician on the ward. That means making sure that your junior has written a transfer note, and that you review and sign the note; and that you have either spoken to the physician in person or over the phone.
- If you or your staff are planning on following the patient in your resident clinic, make sure that you have this written in the transfer note and on the short stay discharge summary.

SHORT STAY PATIENTS

- Short stay patients are stable patients that are admitted to CCU for either a few hours at the end of the day (e.g., post angioplasty or post EP ablation, pending femoral sheath removal) or sometimes overnight. These are
generally stable outpatients that just need to recover someplace with monitoring (and the recovery room closes for the evening).

→ The expectation is that the physician that did the procedure should have written up a discharge summary and all the prescriptions required so that you just need to assess the patient in CCU to make sure that they are stable.

→ A junior resident should see the patient and write a very brief progress note

TIPS FOR SURVIVING CARDIOLOGY 5A5/5A6/5A7

→ Get to know the staff. There are a limited number of nurses that work the CCU but all are generally very approachable and helpful. Remember, some of these nurses are very experienced and know how things are/should be done.

→ Stay in communication with your charge nurse, whether you are covering during the day or on call. Checking in with them will make sure that issues are dealt with in a timely manner and prevent you from being paged multiple times for separate individual issues.

→ Do not brush off the concerns of the nurses. Usually when they have a concern it is for a legitimate reason. Sometimes they may have concerns about the junior resident’s management plan and may want your reassessment to confirm.

→ Keep in mind these are your coworkers for the next 3 years. Get to know them and be respectful and collegial!

admitting patients

When admitting patients to the wards for cardiology consider the following:

→ Patients should have a cardiac diagnosis. Do not admit “undifferentiated chest discomfort” unless there is a clear-cut reason. Have a clear plan with cardiac investigations. If there is a multisystem patient that is reasonable for internal medicine, consult them before admission to see if the patient is appropriate for them.

→ As well do not get into “turf wars” with other services. Try to decide the best place for the patient. Sometimes bed capacity issues may push a patient to one service over another. If there are any issues on call with other services, do not hesitate to involve your attending staff

→ Assess goals of care PRIOR to admission. If someone does not want resuscitation or cardiac investigations, they may not benefit from a monitored cardiology bed compared to an internal or family medicine bed.

→ For admission to the wards, make sure that patients are stable, and are okay to have q-shift assessment

→ ALL patients admitted to the hospital (ward or CCU) MUST have a history and physical sheet filled out (this must be done on the appropriate yellow coloured H&P form.) It is NOT appropriate to write a brief history on a consult sheet. You should write a brief senior note on all admitted patients with a clear plan

→ Make sure that all appropriate paperwork is done by the junior residents or yourself. This includes:

   ◆ Admission orders. Use pre-printed HF or ACS orders if applicable (see below)
   ◆ History and Physical – including a CLEAR plan
   ◆ Requisitions – Echo reqs, cath reqs, nuclear medicine reqs
   ◆ BPMH – Best Possible Medication History. This form acts both as a history form as well as an order sheet to order patient home medications, or hold / discontinue them as necessary.
   ◆ Goals of Care designation (“code status”)

Special Order Sets

→ We do have premade order sheets for things such as Acute Coronary Syndrome, Heart Failure Admission, Vasoactive Agents, Ventilated patients, etc. Please do your best to use these standardized order sheets. They are there to make sure that all bases are covered and no important orders are missed.
the wards

- There are two cardiology wards, each of which have approximately 20 beds.
- Attending physicians take signover on Friday at 4PM usually, and alternate every two weeks.
- 5A5 – This ward usually has one attending and approximately 2 junior residents (Internal Medicine R1 or Psychiatry R1), 1 Nurse Practitioner (Skylar).
- 5A6 – This ward does NOT have junior residents, but will have one senior resident, and occasionally a student.
- There is “Rapid Rounds” every morning at 8:50AM (5A6) and 9AM(5A5) where the attending / senior resident, pharmacist, unit manager / charge nurse, social worker, PT, OT, cardiac rehab nurse, and occasionally others (including heart function clinic nurse, dietician) meet to run the list of patients on the ward and come up with discharge plans.
- Attending physicians round every morning. After 5PM, all calls for ward patients go to the on call residents. Urgent issues can be discussed with the on call CCU staff as necessary.
- Make sure you do an adequate signover in the morning post--call to BOTH attendings or senior/NP). Please do not interrupt Rapid rounds to give report.

consult service

- There is a separate cardiology consult service during the day time. They cover consults for patients that are already admitted to another service. The team consists of an attending, a cardiology resident, and usually 1--2 junior residents. The attending and juniors change every two weeks but the senior cardiology resident is on for one month.
- The consult list is currently kept on the Mazservices computer program, accessible from any computer in the hospital.
- Keep the list updated. If you are on call and add a patient to the consult service, it is your responsibility to ensure that all of the relevant information on the patient is added BEFORE you sign--over to the consult senior in the AM.
- Patient’s that are under Cardiology can be admitted to the 4th floor of the Maz when beds in Cardiology wards are not available. These patients are followed by the consult team during the day Monday- Friday and should receive handover when the patient is admitted/transferred. On evenings and weekends the sr. resident and CCU attending are responsible for their care, and should still be rounded on daily.

cardiology triage

- There is also a separate “triage” (also called Rota) cardiologist on during day time hours. The cardiologist on triage usually changes daily.
- This service covers all new consults from the emergency department, as well as outside calls from the periphery.
- The triage physician will have a junior resident with them. This is a resident from CCU that will be covering emergency room consults for the day and will review with their staff. When they are not busy on triage, they should be helping with their regular service (CCU).
- Triage physician should be at signover 07:45 AM in CCU, so if you have any outstanding ER consults that you didn’t have time to see, or have patients that are pending tests or waiting for a bed that are still in ER, they are the responsibility of the triage staff. Make sure to sign over ALL patients cardiology is seeing in ER to them, as well as any pending issues with outside calls you have taken overnight that they may get called about during the day.
The on call team should get handover from triage at 4:45 PM in CCU.

**resident clinic**

- The resident clinic is our longitudinal clinic. There is a resident clinic every week on Thursday from 1--4 PM, with 3--4 residents in clinic that day.
- Overall, that means that you get your clinic approximately once per month.
- There is a supervising physician every week that will alternate, so if you are seeing a patient in follow up, YOU are the continuity for the patient, and the supervising physician may be different from whom you initially reviewed with.
- You will see patients in your clinic from:
  - Previous patients that were seen by cardiology residents that are now graduated
  - Referrals to general cardiology that may be added to your clinic
  - Follow up patients that you have discharged from the ward, or have seen on the consult service.
  - Patients that you have discharged from the ER when on call
- The EMR system we use is eClinician. You will be able to prescribe medications, order tests, see results all on this system. It is being used by multiple services for their outpatient clinics.
- Seeing 30 patients per year in your clinic for your three years will give you credit for a clinic block.
- If you see someone on the wards, or in ER that you want to follow up with, take the patient information and send it to Debbie Smith (admin assistant for residents). It may be helpful to send Debbie a copy of your consult. She will scan it and add it under ‘media’ in eClinician. Helpful when you are seeing the patient some time later to remember what you are following them for!
- Note for all patient related e-mails you must use your AHS e-mail. You can add your AHS e-mail to your phone. If is your responsibility to check your AHS e-mail and respond to all patient related inquiries within 48 hours. If you are away we use a ‘buddy system’ where your buddy will be responsible to help out

**academic requirements**

You are responsible for attending **ALL** mandatory rounds when you are on site. You are excused from rounds when you are post--call, on elective, or off site at the Royal Alex (which will not happen in your C1 year). Even when at RAH, you are expected to attend Academic Half Days. There will be a schedule sent out to you in regards to all mandatory sessions but a general schedule below should give you an idea of what to expect.

**MONDAY**

- No specifically scheduled senior teaching

**TUESDAY**

- **7:00AM** – occasionally there will be educational rounds such as Nuclear Rounds. These are not every week, but mandatory when they are on, so make sure to look out for this on your calendars. When Dr. Paul Armstrong is in the city, we will have PWA rounds where one senior presents a high quality review on a topic of their choice (similar to grand rounds)
- **8:00AM** – one of the senior residents is scheduled to teach junior residents ECGs every Tuesday. This is usually the senior on their ECG or EP block. Occasionally will be someone who is on wards or consults.
- **11:30--1:00** – **CV surgery rounds** is where several cardiologists discuss cases to be proposed for surgery (or to discuss surgery vs PCI) as a group. This includes cardiologists at other hospitals telephone conferencing in.
- There is usually one surgeon present. Although not mandatory, this is **highly** encouraged for you to attend, and it is expected that you are there to present your patients (eg. ward, CCU, consults, or your outpatients).
➔ **12:30-1:00PM - Program Director Rounds** - Most Tuesdays before AHD Dr. Butler will run PD rounds. The format will change depending on the topic he wishes to focus on that week.

➔ **1:00–4:00PM – Academic Half Day** (lunch provided). If you are in the city this is mandatory to attend. AHD runs from September to the end of June.

---

**WEDNESDAY**

➔ **8:00AM – Cardiology Divisional Rounds** – mandatory to attend. Often it is one of your colleagues presenting (all residents are expected to do a presentation in their C2 and C3 year). There are also frequent guest speakers.

➔ **12:00PM** – every fourth Wednesday there are Mazankowski Rounds (food provided).

---

**THURSDAY**

➔ **7:00AM – Physical Exam rounds** – Whichever resident is on the wards is responsible for consenting a patient to be examined by the group of residents at 7AM. You must email the whole group and Dr. Dylan Taylor by the evening before with the ward and room number of the patient (do NOT include names or other personal identifiable information.) In July and August it will only be for the C1 residents so they can get comfortable with the basics of the physical exam. C2s and C3s join in the fall. These are very high yield sessions and prepare us well for OSCE style exams. **Be on time.**

➔ **12:00PM – Echo Rounds** (lunch provided) – you will be expected to present topics at these rounds when you are on your echo rotation. Presenters are usually all residents and echo fellows. This is usually done by presenting a topic with presentation slides and getting colleagues in the audience to work their way through echos. This means you will be directly asked questions in front of everyone so be prepared.

---

**FRIDAY**

➔ **7:00AM – Hemodynamic Rounds** – These are given by Dr. Taylor and Dr. Van Diepen. In July and August they will be delivered by the chief residents for the C1s to give you some introduction to hemodynamics. After the summer, you will be expected to draw hemodynamic tracings, pressure–volume loops on your own for various conditions. We often will also ask the resident on their cath rotation to bring any interesting hemodynamic tracings to have other residents review on the spot in front of their colleagues. These are **incredibly valuable** sessions (quite unique to Edmonton’s training program), but the onus is on you to be prepared for these rounds. **Be there and be on time.**

➔ **12:00PM – M&M Rounds** (lunch provided) – will be the last Friday of every month. The senior on CCU is expected to present any cases where there has been any significant morbidity or mortality. The point is to review any possible errors / breakdowns and discuss possible ways to prevent this from happening in the future.

There will be some variation week to week, but it is your responsibility to check the calendar and attend all mandatory teaching. Keep in mind that we have busy staff taking time off their schedules to teach us so we collectively need to make sure that **all** of us that are available are attending.

You need to check the schedule on a **regular** basis, as it is **YOUR** responsibility to know when you are presenting at rounds, or doing teaching for junior residents.

---

**funding**

**CONFERENCE FUNDING**

There are funds for resident travel/conferences from the PGME at $650 per year. Please contact the residency coordinator for information.
ROSSAL FAMILY SCHOLARSHIP
The Rossal Family Scholarship is an annual award of $10,000 – $15,000 targeted at supporting Cardiology trainee guided research. Application can be made through the RTC research committee. A one page research proposal and a brief cover letter indicating your application for the Rossal Family Scholarship should be submitted to Dr. Craig Butler (craig.butler@albertahealthservices.ca) no later than April 1, 2018. The winner will be announced at Cardiac Research Sciences Day.

**uah information**

**ACCESS**
You should have access to NetCare, APPROACH, eClinician, and eCritical. All trainees would have received an email for some of these for you to complete the training - specifically for eCritical and eClinician. If you find you don’t have access in your first day or two, check to see if you have completed your training. If you have not received any training information and you do not have access, please contact the residency coordinator immediately.

**RADIOLOGY RESULTS**
You can access radiology and diagnostic imaging exam results that are reported but not typed via telephone. The instruction sheets are available at the level 2 radiology department. If inside the hospital dial 9 then 780-407-2800:
- The voice message will ask for an ID #
- Enter 80805#147#
- The voice message will then ask for the patient’s ID #
- Enter the number followed by the # key
- If dictated the report begins immediately
- Press 8 for additional reports on the same patient
- Press 3 to rewind to the beginning of the report

If a report is not existent this may indicate the exam has not been dictated at this time. Dictations are kept online for a week.

**LAB RESULTS**
Lab results are available on Netcare or through DKML at 780-407-7484. Microbiology at Prov. Lab are available at 780-407-7121.

**LOCATING**
Patient locating is at 780-407-6191 or 780-407-8822 at the University Hospital and 780-735-4111 at the Royal Alexandra Hospital.

**resident well being**

**PROGRAM DIRECTOR**
Any concerns residents have regarding colleagues, teaching faculty, career, or personal issues may be discussed with the Program director at any time with an expectation of confidentiality. There are also a variety of other resources to handle resident concerns that the Program Director can recommend and facilitate without becoming directly involved.
STRESS MANAGEMENT
There are several Faculty, University, and Community resources that can be accessed by residents needing counseling for stress or personal problems (see link below for detailed listing).
Faculty resources include the Office of Learner Advocacy and Wellness (LAW) and Resident Well being Committee. The Office of LAW looks after issues pertaining to learner health, wellbeing and advocacy. It is a safe and confidential place for a learner to receive support, counseling and/or referral for both academic and personal matters. The Resident Wellbeing Committee is a proactive committee, and the chairs can provide help or access to consultation for residents and their families.

University resources include the University Wellness Services (UWS) and its Psychological Services, Office of Safe Disclosure and Human Rights, and Virtual Wellness Site. The first 2 resources provide medical, psychological and counseling services, while the third resource is a “one stop shop for all members of the campus community interested in health and wellness”.
http://www.virtualwellness.ualberta.ca/

Community resources include the Alberta Medical Association Physician and Family Support Program (PFSP) and Alberta Health Services Employee Assistance Program. PFSP is a confidential service that provides assistance to residents and immediate family members.
A more comprehensive list of available resources can be found in the following link:
https://www.ualberta.ca/medicine/programs/support-wellness/postgraduate/resources

RESIDENT IN CRISIS
Resources for resident who feel like they are in crisis are listed below and can be found on the PARA website (https://para-ab.ca/crisis-resources/):

Physician and Family Support Program (PFSP):
Call 1.877.SOS.4MDS (767.4637)
24 hours a day / 7 days a week / 365 days a year
Click here for more information on the services provided by the PFSP.

Canadian Mental Health Association:
24/7 distress line – call 780.482.HELP (4357) / 1.800.232.7288 if outside of the greater Edmonton region
Online Crisis Chat
Click here for more information on the services provided by the Canadian Mental Health Association.

24-Hour Support Lines:
Edmonton: Support Network Distress Line – 1.800.232.7288
INTIMIDATION & HARASSMENT POLICY

The program fully supports the University of Alberta policies on intimidation and harassment as well as duty to accommodate. Residents are strongly encouraged to bring their concerns to the attention of the Program Director. Should the resident concerns involve the program director, then the resident is advised to bring the issue to the attention of the divisional director, or if necessary the Associate Dean for PGME. Detailed instruction on management of intimidation, Harassment, and duty to accommodate can be found using the following links: https://policiesonline.ualberta.ca/PoliciesProcedures/Pages/DispPol.aspx?PID=110