Introduction

PURPOSE STATEMENT

Pharmacists completing the PGY1 residency program at Rush will complete a program that will build upon pharmacy education and outcomes to contribute to the development of clinical pharmacists responsible for medication-related care of patients with a wide range of conditions, eligible for board certification, and eligible for postgraduate year two (PGY2) pharmacy residency training.

PGY2 pharmacy residency programs build on Doctor of Pharmacy (Pharm.D.) education and PGY1 pharmacy residency programs to contribute to the development of clinical pharmacists in advanced or specialized areas of practice. PGY2 residencies provide residents with opportunities to function independently as practitioners by conceptualizing and integrating accumulated experience and knowledge and incorporating both into the provision of patient care that improves medication therapy. Residents who successfully complete an accredited PGY2 pharmacy residency should possess competencies that qualify them for clinical pharmacist and/or faculty positions and position them to be eligible for attainment of board certification in the specialized practice area, if available.

PHILOSOPHY AND GOALS

Philosophy
The pharmacy residency programs provide in-depth professional, patient directed training and experience at the post-graduate level. It offers the resident the opportunity and stimulus to develop, to the highest degree attainable, his/her professional expertise as a clinical practitioner, emphasizing skills required to optimally deliver pharmaceutical care. In addition, the resident will be exposed to the management of a pharmacy department and gain insight into the responsibility one has toward accepting leadership and making a contribution back to the profession of pharmacy.

A basic tenet of our philosophy of training is that while being experientially based and focused, the residency program does not exist exclusively to provide service to the department or hospital per se. All service components of the department’s program can function in the absence of residents’ participation, however residents are critical to our department’s vitality and professional development.

PGY2 Residency Goals
The primary goal of the PGY2 programs is to develop independent clinicians with a core set of clinical, administrative, teaching and research skills to be able to design and deliver care for patients in a specialized practice area. This overarching goal will be completed through exposure to a variety of experiential opportunities where the resident will serve as an integral member of the rounding team by participating in medication therapy management, answering clinical questions and serving as a drug information resource to the healthcare team.
Additionally, the clinical experience is supplemented by the resident on-call program, where the resident will provide in-house service for emergency response and drug information. The resident will have an opportunity to enhance teaching abilities through didactic lectures to other disciplines in the medical center as well as at colleges of pharmacy, self and peer evaluation and being a preceptor to first year pharmacy residents and doctor of pharmacy students. The program will also develop research skills through completion of a longitudinal research project and manuscript preparation.

**Structure and Rotation Outline**

**STRUCTURE OF THE PGY2 Critical Care RESIDENCY PROGRAM**

**Required rotations (4 weeks in duration):**
- Orientation (unless early committed resident)
- Medical ICU (MICU I)
- Cardiac ICU (CICU)
- Surgical ICU (SICU I)
- Neuroscience ICU (NSICU I)
- Emergency Medicine (ED)
- Cardiovascular ICU (CVICU)

**Elective rotations (limited to 2 off-site experiences per year, 4 weeks in duration unless otherwise specified):**
- MICU II
- SICU II
- NSICU II
- Infectious Diseases
- Perioperative services/critical care administration
- Clinical nutrition (1 week)
- Clinical toxicology (2-4 weeks, onsite)
- Pediatric Intensive Care Unit (PICU) (4 weeks)
- Critical Care Administration (2 weeks)
- Trauma/Burn Intensive Care Unit (offsite)

**Longitudinal experience**
- Professional development and personal leadership
- Clinical research
- Clinical and operational staffing
- On-call program
- Grand rounds (1)
- Journal clubs and pro/con debate
### Typical Monthly Schedule:

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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<th>Saturday</th>
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<tbody>
<tr>
<td>1 7am - 4pm: service On-call</td>
<td>2 Post-call</td>
<td>3 7am - 4pm: service</td>
<td>4 7am - 4pm: service</td>
<td>5 7am - 4pm: service</td>
<td>6 Staffing</td>
<td></td>
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<tr>
<td>7 Staffing</td>
<td>8 7am - 4pm: service</td>
<td>9 7am - 4pm: service 1pm - PGR</td>
<td>10 7am - 4pm: service</td>
<td>11 7am - 4pm: service</td>
<td>12 7am - 4pm: service</td>
<td>13 Off</td>
</tr>
<tr>
<td>14 Off</td>
<td>15 7am - 4pm: service</td>
<td>16 7am - 4pm: service 1pm - PGR On-call</td>
<td>17 Post-call</td>
<td>18 7am - 4pm: service 12pm CC/EMJC</td>
<td>19 7am - 4pm: service</td>
<td>20 Off</td>
</tr>
<tr>
<td>21 Off</td>
<td>22 7am - 4pm: service</td>
<td>23 7am - 4pm: service 1pm - PGR</td>
<td>24 7am - 4pm: service 12n-MGR</td>
<td>25 7am - 4pm: service</td>
<td>26 7am - 4pm: service</td>
<td>27 Off</td>
</tr>
<tr>
<td>28 On-call</td>
<td>29 Post-call</td>
<td>30 7am - 4pm: service 1pm - PGR</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

MGR=Medicine Grand Rounds; PGR=Pharmacy Grand Rounds; CC/EMJC=Critical Care/Emergency Medicine Journal Club

### Successful Completion for all the PGY2 Residency Programs

Structured evaluations using PharmAcademic will be conducted throughout the residency program to provide feedback regarding both resident’s performance and effectiveness of training. Orientation to PharmAcademic will be conducted during July of each residency year. It is important to complete these evaluations in a timely manner so that comments are useful for subsequent rotations, both for preceptor and resident. **A “timely manner” is defined as within one week of the completion of the learning experience.** Residents and preceptors should complete their respective evaluations independently, and then meet in person within a week of the end of the rotation to discuss the evaluation.

All required goals and objectives (as indicated by an “R” below) will be taught and evaluated at multiple points and during multiple learning experiences during the residency year. The extent to which these goals and objectives must be achieved for the residency in order to successfully complete the program is outlined below.

The requirements for successful completion of the residency program have been updated in all documents to be the following:

1. 100% of R1 goals
2. At least 80% of all R2-R4 goals
3. Fulfillment of pharmacy practice service weekend and holiday coverage
4. Successful completion of the primary research project  
   a. The research project must be presented in a final written form, manuscript  
      format, to the residency RPD and the residency research advisor (if different)  
      AND be acknowledged as successful, prior to receiving the residency certificate  
5. Successful completion of the medication use evaluation  
   a. The MUE must be presented in a final written form and to an interdisciplinary  
      committee AND be acknowledged as successful by the RPD  
6. Successful completion of all required presentations  
   a. Grand rounds I  
   b. Grand rounds II  
   c. Residency research conference (e.g., ILPRC or GLPRC)  
7. 100% completion of PharmAcademic evaluations with at least 90% completed within 7  
      days of the due date  

Achievement for the residency (ACHR) for non-R2 goals is defined as achievement of a given  
goal in a single learning experience as evaluated by an individual preceptor (a “4” or “5” on  
the PharmAcademic evaluation scale).  

**Required Activities and Projects**  

**ON CALL PROGRAM/CODE AND RAPID RESPONSE TEAM**  

Residents, both 1st and 2nd year, will participate in an in-house on call program. This will  
include being in the hospital for 24 hours followed by a day off before returning to the hospital  
the following day (on call 7a -7a, return the following day for rotation). There is a duty free  
period included to allow the resident a period of time to rest within each call period.  

There will be a suitable training session set up at the beginning of the year. The schedule for  
being on call will be decided amongst the residents. The on call program must be maintained  
365 days/year. Consequently, the on call program schedule around ASHP Midyear and the  
Illinois Pharmacy Residency conference will need to be managed separately in order to  
optimize the days the resident attends the respective meeting, while also meeting the on call  
obligation.  

See practice obligation and department policy in Policystat for the on call program and rapid  
response team (Res 2 – Resident On Call Program).  

**PHARMACY PRACTICE EXPERIENCE (STAFFING)/ON CALL**  

A departmental policy in Policystat will be reviewed during orientation on this topic (Resident  
Staffing and PTO/Duty Hours).  

Each PGY1 resident is required to work two 8-hour shifts every fourth weekend, one 4 hour  
shift one weekday evening every other week (Monday through Thursday) and be on call in  
rotation with the 14 total residents. The assigned location for weekend staffing will be either  
in an adult or pediatric environment, depending on where the resident is trained. The PGY1  
resident will work mostly in a distributive/order verification position early in the year.
Each PGY2 resident is required to work two 8-hour shifts every fourth weekend and be on call in rotation with the 14 total residents.

Residents should be at their work site on the weekends at the scheduled time. Tardiness will not be permitted. Shiftplanning is a computer software program that is used to see schedules and to request time off or to trade shifts with another resident or pharmacist. Access and orientation to this software program will occur in July.

If a resident desires a particular weekend off, he/she should attempt to trade with another resident to get the desired weekend off, as long as the resident will be working in an environment that he/she has been trained in. Any trading of shifts must be with the approval of a manager. If a resident desires a prolonged vacation (such as a full week off), this request should also be made as far in advance as possible, so the preceptor for that rotation is made aware.

The on call program will be utilized to provide clinical coverage overnight in addition to the night pharmacists. There will be set expectations communicated to the resident and an on call room provided for the overnight on call responsibility. Further details on the on call program will be discussed separately.

RESEARCH

IRB

Please see file folder on the shared K drive within the Resident’s folder: K/Residents/Institutional Review Board Sample Applications. Each resident will receive training on the IRB portal prior to submitting their research project for IRB review. The investigational pharmacists in the department are good resources to use when preparing and submitting your research proposal online.

RESEARCH PROJECT

See Policystat for official policy (RES 1 – Residency Research Project).

Each resident is expected to complete a major project, producing a paper of publishable quality. The residents are urged to submit the paper for publication in an appropriate journal.

a. Objective of the Major Project
   The objective of the project is for the resident to learn to investigate a question or problem in an objective, scientific manner. Their project should also provide answers or data that will ultimately contribute to the progress and development of the Department or the profession at large.
b. Scope of Project
The project may involve any area of hospital pharmacy practice that has a reasonable potential of contributing to the profession's knowledge, if an advisor in the field is available and willing to advise the resident. It must be feasible to complete the project within the one-year residency appointment, or 2 years for the nontraditional resident.

A meeting in July will be arranged with the residency's preceptors to present project ideas. These ideas will have been vetted by the research committee to ensure the projects are feasible and worthwhile.

c. Major Project Proposal
A concise project proposal on an appropriate topic must be submitted and approved before any major project may be conducted. An appropriate consenting major project advisor should be proposed.

The project proposal should be developed by the resident and the project advisor as early as possible and submitted to the RTF and the RPD **no later than July 26th.**

Project proposals will be presented to the Pharmacy Department for feedback prior to finalization. This will occur in late August/early September.

Please see file folder on the shared K drive labeled "residency research project resource guide" within the Resident's folder: K/Residents/IRB documents

Sample proposals are available for review from the RPD and on the K drive

The following format should be followed for the proposal (and paper):

- **Goal**—a clear explanation of the question/problem and purpose of the project.
- **Objectives**—a listing of the specific objectives to be met by the project
- **Need**—the rationale of the project and value of potential results
- **Methodology**—a description of the hypotheses, experimental design, data collection, analysis, and evaluation methods.
- **Resource needs**—the fiscal/personnel/physical resources required to satisfy methodology.
- **Patient consent forms (if necessary)**—patient consent forms should be drafted for studies directly involving patients according to recommendations of the Human Investigation Committee.
- **Bibliography**—should be listed to reflect literature search leading to identification of project problem, general purposes, or hypotheses.
- **Literature review**—a brief synopsis of a preliminary literature review.
d. Major Project Advisor
   The RPD advises residents until an appropriate major project advisor is appointed by the RPD.

   The appointed major project advisor is responsible for the supervision and evaluation of the resident's actual project performance and manuscript preparation. The appointed major project advisor and the RPD determine when the project and paper have been satisfactorily completed. **Residency certificates will be withheld until this occurs.**

e. Final manuscript format
   i. Introduction
      This section should include background justification for the research project. Articles and case reports addressing prior research or information pertaining to the subject reviewed and referenced. The goal of the research project should be clearly stated.

   ii. Methodology
      The subjects, materials and methods should be clearly outlined in a manner so that any investigator might follow the protocol.

      Under the “Subject” subsection, specific inclusion and exclusion criteria should be listed. Age or gender restrictions should be clearly indicated. Whether patients or normal volunteers are the subjects should be noted.

      Under “Materials and Methods” exact methodology, specific equipment and statistical analysis should be explained. The “Methods” should address the type of study (i.e. randomized, crossover, blinded) as well as the method of drug administration, including time, route, and dose; any dietary or medication restrictions; timing of serum samples (if any); assessment criteria; handling of side effects; duration of study (single-dose vs. multiple dose; one day vs. weeks or months). Equipment being used and/or assay methodology should be described, including the specificity for the drug(s) being measured and the sensitivity of the assay. The “Statistical Analysis” subsection should describe the statistical test(s) to be employed to describe the group(s) and to assess statistical significance between groups.

   iii. Results
      The results of the study should be described but not discussed. Tables and figures should be included.

   iv. Discussion
      The results should be explained and compared and contrasted with current literature. Conclusions should be listed at the end.
v. Bibliography
The bibliography should list the references that serve as background information on the chosen topic. It should include articles or references pertaining to previous research on the drug(s) being investigated, materials and methods (if applicable), statistical analysis (if applicable), and patient population (if applicable).

f. Timeline
The schedule noted within the research policy (on Policystat) should be the template for the coming year, with regard to the residency project (2 years for the nontraditional resident). Each resident is strongly encouraged to develop a timeline such as this for their project and stick to it throughout the duration of the residency, modifying as needed. Time is allotted intermittently throughout the residency program for research. However, this time is very limited and should be used wisely. There is a timeline document in the IRB folder mentioned above that one can use as a template to develop his/her own timeline.

g. Completion
The final paper should, by virtue of its content and written style, be suitable for publication in a national professional or scientific journal. Manuscript guidelines for Annals of Pharmacotherapy, JAMA and the American Journal of Hospital Pharmacy should be helpful in achieving such style and quality.

The paper must be approved by both the major project advisor and the RPD before a residency certificate is awarded. The final paper may be submitted at any time during a resident’s appointment, but no later than June 30.

Library research and authorship of the paper should be accomplished by each resident on his/her own time. Generally, rotation time is not to be utilized for data gathering and/or analysis.

RESIDENCY ADVISORY COMMITTEE (RAC)
The Residency Advisory Committee (RAC) is made up of the Program Director, a subset of the Clinical Specialists, PGY2 program directors and the chief resident. The goals of the RAC are to oversee more directly the structure and requirements of the PGY1 and PGY2 residency programs and assist the program directors with maintaining requirements for ASHP accreditation. Goals of the RAC are as follows:

1. Maintain appropriate structure and organization of the PGY1 and PGY2 programs
2. Assist in the updating and/or development of changes to the program
3. Assist in evaluation of candidate applications
4. Provide guidance to RPD and the clinical specialists for planning of the residency rotation schedule
5. Assist in establishing a minimum standard for individuals who wish to participate in the precepting of residents
6. Any other issues that the RPDs or RAC deems necessary

PROFESSIONAL ORGANIZATION MEMBERSHIP

Each PGY1 resident is required to be a participating member of ASHP and either ICHP or NISHP. Attendance at one NISHP or ICHP meeting during the residency year is encouraged.

For each PGY2 critical resident, attendance at the Society of Critical Care Medicine (SCCM) annual meeting will be required. In addition, the residents will have the opportunity to submit and present at Illinois Pharmacy Residency Conference in the spring of their residency year.

Feedback and Evaluation

EVALUATION

Structured evaluations using PharmAcademic are conducted throughout the residency program to provide feedback regarding both resident's performance and effectiveness of training. Orientation to PharmAcademic will be conducted during July of each residency year for the PGY2 residents.

It is important to complete these evaluations in a timely manner so that comments are useful for subsequent rotations, both for preceptor and resident. A “timely manner” is defined as within one week of the completion of the learning experience. Residents and preceptors should complete their respective evaluations independently, and then meet in person on the last day of the rotation or within a week of the end of the rotation to discuss the evaluation.

The following scale will be used in PharmAcademic for evaluation of the rotations.

<table>
<thead>
<tr>
<th></th>
<th>Unacceptable performance</th>
<th>Resident is working at a student level; improvement must be demonstrated by the next evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Needs significant development</td>
<td>Resident is working at a level that is barely above what one would expect from a student; improvement must be demonstrated by the next evaluation</td>
</tr>
<tr>
<td>2</td>
<td>Appropriate progress</td>
<td>Resident is working at a level that is appropriate for this stage in the residency year; there is an expectation that continued improvement will be made</td>
</tr>
<tr>
<td>4</td>
<td>Independent</td>
<td>Resident is working independently without the preceptor having to guide each step; preceptor interaction occurs daily or every other day, but is not needed multiple times/day</td>
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</tr>
<tr>
<td>5</td>
<td>Achieved for the residency</td>
<td>Resident is working not only independently, but needs scant oversight; preceptor could be out of office and the resident could fill the void in providing service at an acceptable level</td>
</tr>
</tbody>
</table>

The following scale will be used in PharmAcademic for evaluation of preceptors:

- □ Always
- □ Frequently
- □ Sometimes
- □ Never

**MENTOR**

Each resident will choose a mentor from the Department of Pharmacy. This mentor may be a pharmacist with a practice area the resident is interested in, a pharmacist who the resident is doing research with, or someone whom the resident feels can guide them to further success and achievement of their professional goals during the course of the residency year and thereafter. The mentor should be someone who is NOT a program director or manager, as their time will be more limited. The resident-mentor relationship is relatively informal, requiring no set meetings. However, the resident’s mentor will sit in with the resident and the RPD for each of the resident’s quarterly evaluations.

**Travel, Sick Leave, and Paid Time Off**

**ILLINOIS PHARMACY RESIDENCY CONFERENCE (IPRC)**

Each PGY2 resident is required to attend and present their major project as a requirement of the PGY2 residency program. The IPRC is held in May each year at a location in Chicagoland. **Registration and abstract submission is due February 1st.** Presentation powerpoint files will be due in early April. For the nontraditional resident, this will be April 1st in either the first or second year of the two year program. The resident will present their research to the department, in practice for the IPRC, as a required presentation, several weeks prior to the conference.

**TRAVEL (AND REIMBURSEMENT FOR)**

Out-of-town travel on behalf of the institution or by assignment must be requested in advance and signed off by the appropriate Senior Vice President, whether or not any reimbursement for the travel is requested. This travel authorization form must be submitted well in advance.
of any trip (can be found on Link). The amount of reimbursement may not exceed the amount authorized on the “before trip” travel approval forms. For the Midyear meeting and the Great Lakes Pharmacy Residency Conference funding is provided to help offset the expense of travel, room and registration. Reimbursement requests must be accompanied by appropriate receipts.

Residents are provided the following for the residency year in terms of support for attending meetings:

- Reimbursement for travel/lodging: $1000 for PGY1 residents, $1500 for PGY2 residents
- 5 days for CE, not taken out of the PTO bank
- $1000 from LEAP for registration for CE meetings per calendar year

**LEAP**

LEAP stands for Linking Education and Performance. All employees are allowed $1000 per calendar year to be used toward registration at continuing education programs. In order to receive compensation, proof of attendance is required (i.e. CEU certification, copy event name tag, copy of workbook cover received on the day of the event). Not acceptable is a computer printout of materials or registration confirmation. The form for reimbursement of these activities is available through Link online. *This should be signed by a manager and submitted (emailed) with the proof of attendance and proof of payment within 30 days of the event in order to receive reimbursement.*

**VACATION (PTO)**

Each resident is entitled to approximately 22 days of vacation during the residency year. This is dependent on the day of hire and accrues at a rate throughout the year with each pay period. *PTO cannot be taken until the resident has accrued the time through working.* PTO can be scheduled pending approval from the RPD, supervisor where the resident is scheduled to work, and the preceptor whose rotation the vacation impacts. *It is imperative that the resident request time off well in advance of schedule preparation by the managers.*

Residents will be asked NOT to take any vacation time during the last two weeks of June in order to facilitate successful completion of all required resident activities.

- Attendance at the ASHP Midyear Clinical meeting or other professional meetings is not considered to be a vacation time, unless it is extended beyond the meeting.
- A resident who is scheduled to work their staffing weekend or on call shift on a major holiday (i.e. Christmas), should not expect to get this day off.
• Each resident is expected to work on some holidays. Being on call represents one of these holiday coverage days. If you are scheduled on a holiday, that day is banked into your PTO bank.
• Any leftover vacation time at the end of the year will be paid out to the resident upon departure from the medical center. However residents are encouraged to take their full PTO days PRIOR to mid-June. Exception: if planning to transition to a PGY2 residency, the PGY1 resident MAY take some days in late June or early July for PTO.
• Residents are given time off for all official medical center holidays not falling on Saturday or Sunday or on call day that they would be scheduled to work.

SICK LEAVE/LEAVE OF ABSENCE

See policy in Policystat regarding taking time off for vacation, illness, CE.

Other Responsibilities

RESIDENCY END OF THE YEAR REPORT

At the end of the year, the resident will provide a summary report of all projects completed. The intent of this report is to be able to express the cost-effectiveness of having a resident as opposed to having a full time pharmacist in the same position. The RPD can provide examples of this report.

ADDRESS AND TELEPHONE NUMBER

Each resident is responsible for maintaining a correct local address and telephone number on file with the department. If any changes occur during the year, the resident should notify the RPD and department administrative assistant of these changes as soon as they are made. Changes should also be made by the resident online through LINK.

Rush business cards will be ordered for each resident early in the year in order to have in time for residency showcases and the ASHP midyear clinical meeting.

PAGER RESPONSIBILITY

Each resident will be issued a Rush pager. The resident is responsible for carrying their pager whenever they are on the Rush premises. It is also expected that the resident will responsibly sign out their pager when he/she is out of town or other appropriate times (i.e. if the resident chooses not to be available on weekends). When a resident is on a clinical service, it is expected that he/she has the potential to be paged during the evening from members of your team or pharmacy staff with questions. Like most preceptors, residents should make themselves available to answer these patient specific questions whenever possible.

Code pages will occur on resident pagers only when the resident is signed on to cover the resident on call pager.
In order to change status on the pager, dial 85- *pager number. Status “2” is available/on call; status “6” is “not available. One can also sign out their pager to a covering pager or a cell phone. The RPD will review with the resident how to set up the pager and alter settings.

**LICENSES**

Please refer to departmental policy on Policystat (*Personnel Licensure – Application, Renewal and Maintenance*). This will be reviewed during orientation.

**EMAIL**

Email is a commonly used form of communication for the department and hospital. The expectation is that email through Rush will be checked daily. Microsoft Outlook should be used to keep an updated calendar of your activities as well as for setting up meetings and reserving the pharmacy department conference room. You can set your email to reflect when you are out of town at a meeting or on vacation.

**OVERTIME/DUTY HOURS (MOONLIGHTING)**

For the duration of the residency, residents are expected to commit their full professional attention to the residency. *Working in other positions outside the Department is not permitted.*

If there are open shifts within the Rush Dept of Pharmacy, a resident may consider working these, but it must be approved by the appropriate RPD first. Residents are not eligible for overtime salaries or wages when they choose to work an extra shift on a satellite or in CFA. Pay will be given at the current extra shift stipend rate that a pharmacist would receive.

Each resident is expected to work a MINIMUM OF 40 hours per week as per a schedule established by the RPD or the rotation preceptor.

Duty hours are defined as: “….all scheduled clinical and academic activities related to the pharmacy residency program. This includes inpatient and outpatient care, in-house call, administrative duties, scheduled and assigned activities, such as conferences, committee meetings, and health fairs that are required to meet the goals and objectives of the residency program. Duty hours must be addressed by a well-documented structured process. Duty hours do NOT include: reading, studying and academic preparation time for presentations, journal clubs; or travel time to and from conferences; and hours that are not scheduled by the residency program director or preceptor.” (ASHP definition)

The limit of duty hours is consistent with ASHP accreditation terms that went into effect in July of 2013, in that hours at the hospital in the residency program is limited to 80 hours per week, averaged over a four week period. Residents must be provided one day in seven free, averaged over a four week period. Adequate time for rest and personal activities must be provided. This should consist of a minimum of 8 hours, but ideally, a 10 hour time period provided between all daily duty periods. For programs with on call programs, there should be
a minimum of 14 hours free following an on call shift. Our current staffing and on call schedule meet these expectations.

A process will be available for the resident to document duty hours monthly in order to assure compliance with this requirement.

**SMOKING AND EATING POLICY**

Smoking is prohibited throughout the hospital and the grounds. Eating is prohibited in all storage and dispensing areas of the Pharmacy Department. These include all satellites where drugs are prepared and dispensed, all Pharmacy Stores spaces, Pharmacy Manufacturing and Packaging, and the Pharmacy Vault.

**DISMISSAL POLICY**

The conditions for dismissal are outlined in a departmental policy online in Policystat and will be reviewed during orientation.
Appendix A: PGY2 Critical Care Program

Didactic discussions, reading assignments, case presentations, written assignments, and direct patient care experience will allow the critical care resident to understand and appreciate the implications of medication therapy on the following areas of emphasis as listed below.

Re: Core areas or types of patient care experiences

It is expected that all PGY2 CC residents will acquire new knowledge and understanding related to core areas or types of patients for graduates of PGY2 critical care program. However, the primary method for PGY2 critical care programs to help residents to achieve patient care competence in providing comprehensive medication management is to provide residents with sufficient clinical experience providing patient care for common disease states and conditions.

For this purpose, residents are required to have direct patient care in the designated sections (*). Residents will be able to elect other areas to develop patient care competence. In addition, resident may further develop knowledge and understanding to help them become competent providers of comprehensive medication management by case-based application through didactic discussion(s), reading assignments, case presentations, or written assignments. However, patient care competence cannot be achieved solely through these methods without actual patient care experience in providing comprehensive medication management.

The PGY2 CC resident is provided this spreadsheet to ensure the topics listed are covered throughout the PGY2 CC residency year. After completion of a topic, the resident and preceptor need to sign off the date of completion.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Type</th>
<th>Preceptor</th>
<th>Date</th>
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<tbody>
<tr>
<td>*Direct Patient Care Required</td>
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<tr>
<td>Pulmonary</td>
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<tr>
<td>Acute Respiratory Distress Syndrome*</td>
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<tr>
<td>Severe Asthma Exacerbation*</td>
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<tr>
<td>Acute COPD Exacerbation*</td>
<td></td>
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<tr>
<td>Acute Pulmonary Embolism*</td>
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<tr>
<td>Acute Pulmonary Hypertension*</td>
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<tr>
<td>Drug Induced Pulmonary Disease*</td>
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<tr>
<td>Mechanical Ventilation*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Severe Pulmonary Hypertension</td>
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<td>Advanced Cardiovascular Life Support*</td>
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<td>Arrhythmias (atrial and ventricular)*</td>
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<td>Acid-Base Imbalance*</td>
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<td>Fluid and Electrolyte Disorders*</td>
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<td>Contrast Induced Nephropathy*</td>
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<td>Drug-Induced Liver Toxicity*</td>
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**Immunology**

- Acute Transplant Rejection
- GVHD
- Management of the Immunocompromised Patient
- Acute Management of SOT or BMT Patients
- Medication Allergies/Desensitization

**Endocrine**

- Relative Adrenal Insufficiency*
- Hyperglycemic Crisis*
- Glycemic Control*
- Thyroid Storm/ICU Hypothyroid States

**Hematology**

- Acute Venothromboembolism*
- Coagulopathies*
- Drug Induced Thrombocytopenia*
- Blood Loss and Blood Component Replacement*
- Anemia of Critical Illness
- Drug Induced Hematologic Disorders
- Sickle Cell Crisis
- Methemoglobinemia

**Toxicology**

- Toxidromes*
- Withdrawal Syndromes*
- Drug Overdose
- Antidotes/Decontamination Strategies

**Infectious Diseases**

- CNS Infections*
- Complicated intra-abdominal infections*
- Pneumonia*
- Endocarditis*
- Sepsis*
- Fever*
- Antimicrobial Stewardship*
- Clostridium Difficile Associated Diarrhea*
- Skin and Soft Tissue Infections
- Wound Infection
- Catheter Related Infection
- Infections of the Immunocompromised Host
- Pandemic Diseases
- Febrile Neutropenia
- Acute Osteomyelitis

**Supportive Care**

- PK/PD Alterations in Critically Ill*
- Nutrition (enteral, parenteral, special populations)*
- Analgesia*
- Sedation*
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<td>Delirium *</td>
<td>Sleep Disturbance*</td>
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<td>Stress Ulcer Prophylaxis*</td>
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<td>Pharmacogenomic Implications</td>
<td>Oncologic Emergencies</td>
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<td>Other Devices (intravascular, peripheral nerve stimulators, IV pumps)</td>
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