

*Texas Tech University  
Health Sciences Center  
School of Medicine*

*Urology Resident Handbook*



***Academic Year***

***2011-2012***

*8/31/2011*

### **Purpose of this Manual**

In order to allow compliance with expectations the resident's manual contain essential information for the daily operations of the department. The manual is available in "hard copy" in the departmental office and online at:

<http://www.ttuhsct.edu/som/urology/Residency.aspx>

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**WELCOME TO THE UROLOGY DEPARTMENT  
TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER**

On behalf of the faculty and staff of the Urology Department at Texas Tech University Health Sciences Center I would like to welcome you to Lubbock, to Texas Tech and to our Department. You are about to engage in the most challenging and rewarding phase of your medical training. You have worked hard and have accomplished much to get here, and we are proud to have you represent us.

Over the next five years you will learn the art and science of urology and it is our goal that you leave our program with the knowledge and skill to be a confident, competent urologist, and most importantly, a compassionate and ethical physician. It is our responsibility that you receive all the resources and help necessary to achieve those goals. If you have need of additional support during your residency, we are available to help you in whatever way we can.

We are also concerned about your personal development and the welfare of your family and your relationships with your friends, and your community. It is vital that you balance your work and study with your other personal commitments. If you have any problems or requests with these aspects of your life, we are also available to assist you in whatever way we can.

This handbook outlines the organization of the program, our policies and procedures, and provides you with the contact information for individuals and services you will need during your residency. You are responsible for knowing the information in this handbook. Should you have questions about the content of this handbook, or if you have suggestions or improvements for this handbook please let us know.

Best wishes for your continued success,

A handwritten signature in blue ink, appearing to read 'C. Smith MD', is placed over a light blue rectangular background.

Cynthia K. Smith, MD  
Urology Program Director

# **MISSION STATEMENT**

**Texas Tech University Health Sciences Center  
School of Medicine - Department of Urology  
Lubbock, Texas**

- Provide the highest standard of urological care in a compassionate and ethical manner.
- Pursue academic, clinical, and technical excellence.
- Foster an environment of intellectual curiosity.
- Promote leadership and mentorship at all levels.

## **Departmental Policy for Resident Supervision**

Residents are supervised by the responsible attending based on their level of competence and years of training. Close supervision is appropriate in the beginning of training for teaching the core competencies and progressive autonomy is important towards the end of residency to foster independent, well-prepared graduates.

Residents will promptly contact the Chief Resident and the attending on call with any admissions, new consults, or significant changes in a patient's status. Each patient on the Urology Service will be seen by a resident and an attending on a daily basis. The patient's case will be discussed and appropriate documentation reviewed and signed by both the resident and attending. All surgical cases will be supervised by an attending and the case performed based on the resident's level of training and preparation. A resident may not start a case without prior consultation and authorization by the attending of record. This authorization must include a discussion of how far the resident may proceed before the faculty member's physical presence in the operating room.

Resident Acknowledgment  
Texas Tech University Health Sciences Center  
Department of Urology  
Resident Handbook

I have been provided a copy of the Residency Handbook for the Urology Department at Texas Tech University Health Sciences Center - Lubbock, Texas.

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Signature of Resident

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Name (printed)

---

Date

Resident Acknowledgment  
Texas Tech University Health Sciences Center  
Department of Urology  
Departmental Policy for Resident Supervision

I have read and understand the Department Policy for Resident Supervision.

\_\_\_\_\_  
Signature of Resident

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Date

Resident Acknowledgment  
Texas Tech University Health Sciences Center  
Department of Urology  
Present Academic Year - Goals

I have been provided the Texas Tech University HSC Urology Residency Program goals for my academic year beginning 7/1 \_\_\_\_\_ (Specify year level).

I have read and understand these goals and have been given the opportunity to discuss the goals with the Program Director or Site Director.

\_\_\_\_\_  
Signature of Resident

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Date

This form needs to be completed at the beginning of each academic year by the resident (PGY II – V).

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER  
DEPARTMENT OF UROLOGY

UROLOGY CLERKSHIP & ROTATION AGREEMENT

I have discussed the goals and objectives for the \_\_\_\_\_  
rotation with \_\_\_\_\_.

My individual goals for this rotation are:

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I propose to meet these goals in the following manner:  
(Attach additional sheets if necessary)

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---

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---

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
RESIDENT/MEDICAL STUDENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
FACULTY SUPERVISOR

\_\_\_\_\_  
DATE

*Return completed – signed form to Residency Coordinator – Judy Pierson 3B163*

# I. UROLOGY DEPARTMENT GUIDELINES FOR ALL HOUSEOFFICERS

THE FOLLOWING GUIDELINES PROVIDE THE STANDARD OPERATING POLICIES FOR UROLOGY RESIDENTS, NON-UROLOGY RESIDENTS, AND MEDICAL STUDENTS ROTATING ON THE UROLOGY SERVICE.

All residents must familiarize themselves with these policies and refer back to them as often as needed during the time they are on the service.

## A. General Guidelines

1. **All residents** are strongly encouraged to purchase Urology for the House Officer by Michael T. Macfarlane, or Pocket Guide to Urology by Jeff A. Wieder, or a similar guide to urology prior to their rotation. These books are reasonably priced and are generally available in the HSC bookstore. These guides are small enough to fit in your lab coat pocket. They are a useful addition to your library even if you are not going into urology or a surgical specialty.
2. **Dress:** All residents are expected to be well groomed at all times. Clean lab coats are expected at all times. 3 lab coats are provided by the department. Cleaning is available through the department and coats should be cleaned on a weekly basis. Street clothes should be worn on clinic days when possible. If in OR, clean scrubs should be worn. Strong perfumes, colognes, excessive jewelry or body piercings are inappropriate.
3. Phones receiving business e-mails should be pass code protected. If phone is lost/stolen, IT MUST be notified immediately. Communication regarding patients should be held verbally between providers as much as possible. Texting PHI is not allowed. Patient information may be e-mailed within the system to appropriate providers.
4. The Department of Urology has a limited library available for the house staff. **BOOKS CANNOT BE REMOVED FROM THE DEPARTMENT.** (see pages 52-54 for list of books in Library)
5. **Beepers:** Each resident is expected to carry his/her personal pager at all times while on duty or on call. Communication by cell phone is acceptable, but is not an alternative to a pager.
6. All issues regarding communication and residency operations are to be brought to the Program Director or Assistant Program Director.
7. The residency Program Coordinator, Mrs. Judy Pierson, is available to answer many questions residents might have about

the operations and administrative policies of the Urology Department. Judy can be reached at 743-3400 extension 262.

8. Residents cannot take vacation without prior approval from the Urology Program Director.

## **B. Medical Students & Other Residents on Service**

1. All efforts should be made to make medical students and visiting residents feel **welcome and a part of the team. They are our guests.** Residents are responsible for teaching medical students to the maximum extent when the students are on our service.
2. All efforts will be made to incorporate medical students, PGY I house staff and visiting residents into the activities of the Department to include sharing of surgical procedures, didactics, and rounds.
3. Medical students & residents should be introduced to the AUA National Medical Student Core Curriculum ([www.AUAnet.org/core](http://www.AUAnet.org/core)).
4. Dress codes and availability for clinics, rounds and surgery apply to medical students as well.

## **C. On-Call and Admission Responsibilities**

1. Every patient admitted to the urology service is assigned one attending surgeon. At all times, and for all types of patients, participating residents will act under the supervision and direction of the responsible attending surgeon.
2. Patients admitted during the day and after hours are generally admitted to the attending on call.
3. Faculty physicians generally take call one week at a time (Friday-Thursday).
4. Consults must be completed in a timely fashion but unless designated an emergency and the resident has 24 hours in which to complete them. The emergency room consult must be completed within a 2 hour time frame. All consults and admissions must be discussed with the appropriate attending.
5. All residents are to round together and rounds are to be completed in time to start morning surgery.
6. All house staff will round with the attending on call on a daily basis. The time for rounding will be determined by each attending.
7. All trauma consultations will be seen immediately if only to perform a quick assessment and recommend appropriate imaging studies prior to providing a complete consult.
8. **Always check with patients to ensure that they have not previously established care with a community urologist. If the resident have already seen the patient and gathered information. It is appropriate to contact the community**

**urologist or their on call and notify them of the patients status.**

9. Admissions after hours: All admissions after hours need to be discussed with the attending on call or the Chief Resident.
10. All patients who may require surgery (for example, stone patients who may need a stent) should be placed n.p.o. These patients should also be posted for surgery the next day at the time of admission and the responsible attending notified that the case has been posted.
11. The attending must be notified immediately if surgery is anticipated or if any patient has an urgent or critical problem.
12. The urology resident is responsible for keeping the patient list on Power Chart up to date.
13. Follow-up appointments for patients seen in the Emergency Department or inpatients should generally be scheduled with the attending of record with the exception of pediatric patients who should be scheduled with Dr. Vordermark or Dr. Smith. Do not schedule follow-up appointments for adult patients with Dr. Vordermark or Dr. Smith without talking to them first. Patients should be given the date and time of their follow-up appointment at the time of discharge whenever possible.
14. Appointments for cystoscopy, urodynamics, or other clinic procedures can be made by calling the clinic and speaking with one of the nursing staff at 743-1851. **PLEASE NOTE THAT THIS NUMBER IS A PRIVATE NUMBER AND SHOULD NOT BE GIVEN OUT TO ANYONE!**

## **D. Sign-Outs**

Effective communication regarding patient status and needs to the next shift is essential to quality patient care. Attention to detail and a careful and complete sign-out at each stage will greatly reduce the likelihood of errors.

Sign-out should take place on three levels:

1. The Chief Resident on call should receive sign-out from the senior resident, with particular attention to potential "problems" on each individual service.
2. The on-call resident will sign-out with off-call resident. A detailed sign-out is imperative. Sign-out between residents is to contain the following information:
  - a) Pertinent problems for each patient
  - b) Labs to be checked upon during the night
  - c) Radiographic studies to be reviewed during the night
  - d) Basic trouble shooting.  
If patient spikes, does he need to be cultured or has it already been done, etc.
  - e) Vital signs

- f) Daily I/O's
- g) Current medications
- h) Current diet
- i) Current IV fluid administration

## **E. Ward Rounds**

- 1. Rounds must be finished by 0715 to allow the resident in the operating room to be in the OR in a timely fashion.** This is especially important on Friday mornings so that residents and students can attend tumor board if a urology case is to be presented.
2. The Chief Resident is responsible for organizing ward rounds each morning. This includes dividing the service as he or she sees fit for maximum efficiency.
3. All residents must report any significant developments on active patients, post-operative patients, and patients on the consult service to the Chief Resident each morning.
4. The Chief Resident is responsible for insuring that the faculty are given timely, current updates for each of their patients on the service.
5. Post-operative patients and patients admitted directly to a specific attending are to be followed by the attending of record during the week. The attending on call will round on all other patients. All active in-patients must be seen by an attending every day.
6. A written note using a pre-printed hospital daily progress note form must be placed on each patient chart at the time of morning rounds. Those notes need to be co-signed by the responsible faculty member at some time during the day.
7. Resident schedules take precedence over rounding with faculty. Residents must be available for their assigned duties and not pulled out for rounding or surgery except for exceptional circumstances, and then only with the concurrence of the attending supervising them at that time.
8. Faculty who desire to round with a resident will make rounds in the evening after clinic or surgery to avoid creating a conflict with the resident's schedule.
9. If the on call resident is not available to see a consult (this pertains especially to Emergency Department consults), he or she must notify the Chief Resident of the problem so that arrangements can be made to have the consultation answered as quickly as possible. If no resident is available the Chief Resident is to notify the attending on call of the need for a consult.
- 10. Residents are not to be pulled away from the clinic except for emergencies.**

11. A copy of all consults should be given to Jan Jones in our billing office so that we can bill appropriately and also start a chart for new patients. The resident who is conducting rounds needs to **provide Jan a copy of the patient list from power charts daily.**

## **F. Documentation**

*Complete documentation is necessary for medical, legal, & billing purposes.*

**1. Notes & dictation should include the following information listed below.**

- a) *Medical students can only enter review of systems social & family history. (this is for billing purposes)*
- b) *Residents **must** document the chief complaint, HPI, medication, allergies, past medical history, physical examination, plan and diagnosis.*
- c) *Attending's **must** document their presence and involvement separately to include their involvement in surgical procedures.*

**2. Residents **cannot** co-sign any notes for junior residents or medical students.**

### **a) Preoperative Note**

- 1) Planned procedure with indication
- 2) Attending surgeon
- 3) Laboratory data:
  - CBC
  - Chemistries
  - Coagulation Studies
  - Liver Function Tests (if applicable)
  - Urinalysis
  - Arterial Blood Gas (if indicated)
- 4) X-ray studies (CXR, CT scan, arteriogram)
- 5) EKG
- 6) Medications (antibiotics)
- 7) Blood products available
- 8) Consent – Must specify side (“left” or “right”, not “L” or “R”) if surgery is site specific

### **b) Operative Note**

- 1) Preoperative Diagnosis
- 2) Findings – to include significant normal & abnormal findings
- 3) Procedure
- 4) Surgeon
- 5) Estimated Blood Loss
- 6) Fluid Replacement
- 7) Drains

- 8) Complications
- 9) Disposition – Should include basic plans for postoperative care (i.e. steroid wean, diet plans, dressing changes, and bathing)

**c) Postoperative Note**

Note should follow a standard SOAP-note format. Specific details to include: urine output over a given period of time, results of postoperative studies (laboratories, x-rays), pain control.

**d) Operative Dictation– Needs to be done at completion of operative case. Record dictation number on brief operative note and give yellow copy to Jan Jones.**

- 1) Patient's name and medical record number
- 2) Date
- 3) Preoperative Diagnosis
- 4) Procedure
- 5) Postoperative Diagnosis
- 6) Findings
- 7) Surgeon
- 8) Assistants
- 9) Anesthesia
- 10) Operative Findings
- 11) Operative Procedure

**e) Discharge Summaries – Should be dictated at the time of patient discharge**

- 1) Date of Admissions
- 2) Date of Discharge
- 3) Resident Physician
- 4) Attending Physician
- 5) Dictating Clinician
- 6) Admission Diagnosis
- 7) Discharge Diagnosis
- 8) Operation/Procedure
- 9) Consultations
- 10) Reason for Admission
- 11) Hospital Course
- 12) Condition on Discharge
- 13) Discharge Instructions
- 14) Discharge Medications
- 15) Diet
- 16) Physical Activity
- 17) Follow-up Plan

**f) Patient Lists**

***(The importance of an accurate, up-to-date patient list cannot be overemphasized)***. Information provided on the list should include a patient's full name, location, medical record number, age, date of birth, attending

surgeon and a brief description of his or her surgical issues. Lists are generated and stored in the computers located in the call room (location being determined). An adequate number of copies should be prepared for the primary team as well as attending.

**Patient lists contain confidential information and are not to be left anywhere in the hospital. Please be cognizant of discussion of patients in public areas. Sign-outs should not take place in areas such as the cafeteria where discussions may be overheard. Patient lists should be discarded only in a protected health information bin or shredded.**

The ACGME common program requirement changes, effective July 1, 2011, include an institutional and program requirement to “ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety (C.P.R. VI.B.2).” The ACGME stipulates that transitions of care must be organized such that complete and accurate clinical information on all involved patients is transmitted between outgoing and incoming teams/individuals. Pertinent elements include exam findings, laboratory data, any clinical changes, family contacts, and any change in responsible attending physician.

Check list for Urology

- 1) Residents give verbal checkout on each patient at each shift change.
- 2) Attendings are on for one whole week and on Friday the attending sit down and review each patient verbally.

## **G. Surgery**

1. All surgical procedures to include after-hours procedures are performed under the direct supervision of an attending faculty member.
2. Residents are to be present in the Operating Room and ready for the start of surgery by 0715 hrs. Monday through Thursday and 10 am on Friday.
3. Residents are expected to have, whenever possible, studied the patient’s medical record and be able to discuss the condition necessitating surgery, procedure planned and performance of the procedure.
4. Residents must be **present at the time of induction and participate in positioning the patient and otherwise helping with insuring timely start of the procedure.**

5. **Residents must stay with the patient after the procedure and accompany the patient to the Recovery Room.**
6. The following guidelines apply to the start of cases:  
PGY 1 – 3: Attending must be physically present before the start of any case. The resident cannot begin any portion of the procedure to include positioning of the patient.  
PGY 4 – 5: Resident may begin actual instrumentation, but may not begin a critical portion of the procedure. The resident can start a case only after explicit discussion and approval by the attending of record as to what he/she may do prior to the physical presence of the attending.

## **H. Conferences and Didactics**

1. All case conferences will be conducted to the highest standards. All conferences will be held and will start in a timely fashion.
2. Conference attendance is mandatory and residents can be excused only with prior permission of the Program Director or because of an active patient care emergency.
3. The Chief Resident is responsible for maintaining an up to date conference log and insuring that the log is present for conferences.
4. Interruptions during conferences should be kept to a minimum and **cell phones and pagers of residents not on call turned off.**

## **I. Procedural Skills/Case Logs**

The ABU requires documentation of cases performed. This log is maintained on the ACGME web-site. These logs must be submitted for review by the Program Director quarterly. (see pages 47-47 for complete guidelines)

## **J. Discipline:**

All residents must become familiar with the TTUHSC policies for disciplinary actions. (Adverse Actions page 13) These policies can be found at:

[http://www.ttuhschool.edu/som/gme/documents/HS\\_PandP\\_s\\_062011.pdf](http://www.ttuhschool.edu/som/gme/documents/HS_PandP_s_062011.pdf)

[http://www.ttuhschool.edu/som/gme/documents/Dismissal\\_of\\_Residents\\_050510.pdf](http://www.ttuhschool.edu/som/gme/documents/Dismissal_of_Residents_050510.pdf)

## II. PHYSICIAN AND RESIDENT LISTINGS

<b>Physicians Name</b>	<b>Pagers</b>	<b>Home &amp; Cell Phone #'s</b>
<b>Faculty</b>		
Werner deRiese, MD Chairman, Professor Urology	741-7746	H: 791-1167 C: 790-8648
Michael R. Crone, MD Assistant Professor Urology	721-3093	H: 853-9988 C: 707-514-5081
Allan Haynes, MD Professor of Clinical Urology	721-0490	H: 796-0183 C: 470-6231
Bernhard Mitemeyer, MD Professor of Urology		C: 790-1523
Thomas Nelius, MD Assistant Professor of Urology	721-0489	H: 792-0169 C: 252-7436
Cynthia K. Smith, MD Associate Professor of Urology Program Director	721-3047	C: 970-417-1057
Jonathan S. Vordermark, MD Professor, Urology & Pediatrics	743-8781	H: 795-1002 C: 790-0879
Stephanie Filleur, PhD Assistant Professor Urology & Dept. of Microbiology & Immunology	N/A	H: 792-0169
J. Thomas Cammack, MD Assistant Professor	721-3133	C: 830-370-3107
<b>Residents</b>		
Jessica Paonessa, MD Resident Physician	721-3214	C: 789-5437
Katherine Rinard, MD Resident Physician	721-2309	H: 702-4958 C: 368-1158
Johnny "Trey" Hickson, MD Resident Physician	721-3607	C: 405-206-5106
Natalie Gaines, M.D. Resident Physician	721-1982	C: 543-3545

### **III. ADMINISTRATION AND FACULTY LISTINGS**

#### **A. Office of the Chairman**

Bowie McGinnis: Department Administrator  
E-mail address: [bowie.mcginnis@ttuhsc.edu](mailto:bowie.mcginnis@ttuhsc.edu)

Werner deRiese, M.D.: Department Chairman  
E-mail address: [werner.deriese@ttuhsc.edu](mailto:werner.deriese@ttuhsc.edu)

Andrea Patterson: Coordinator for administrative & business matters – Andrea prepares all check requests, purchase orders and expense reimbursements. Andrea provides academic and administrative support for Dr. Werner deRiese, Dr. Allan Haynes, Dr. David Van Buren, Dr. Bernhard Mittemeyer, Dr. Thomas Nelius, Dr. Stephanie Filleur, and Dr. Thomas Cammack.  
E-mail address: [andrea.patterson@ttuhsc.edu](mailto:andrea.patterson@ttuhsc.edu)

#### **B. Academic Offices.**

The Urology academic office is located Texas Tech University Health Sciences Center, 3601 4<sup>th</sup>, 3B163 (Judy Pierson).  
Office number: 743-3400 x 262.  
E-mail address: [judy.pierson@ttuhsc.edu](mailto:judy.pierson@ttuhsc.edu).

#### **Program Director**

Cynthia K. Smith: Director of the Urology Residency Program and Associate Professor of Urology. Dr. Smith oversees the evaluation, guidance, and activities of the urology residents. Dr. Smith maintains an open door policy for problems, issues external to the program that are impacting on your training, or if you need feedback on any aspect of the program.  
E-mail address: [cynthia.k.smith@ttuhsc.edu](mailto:cynthia.k.smith@ttuhsc.edu)

#### **Vice Program Director**

Dr. Jonathan S. Vordermark is the Vice Program Director. He is also available for all resident concerns and problems if Dr. Smith is not available.  
E-mail address: [jonathan.vordermark@ttuhsc.edu](mailto:jonathan.vordermark@ttuhsc.edu)

#### **Residency Coordinator**

Judy Pierson: Judy oversees the on-call and rotation schedules with the residents, lectureships schedules, and resident vacation schedules. Judy is in charge of maintaining conference data/distributing conference calendars/schedules with the residents and all aspects of the residency program.  
Office number: 806-743-3400 ext.262  
E-mail address: [judy.pierson@ttuhsc.edu](mailto:judy.pierson@ttuhsc.edu)

Nurse Manager - Linda Payne, RN	743-1851 ext 235
Clinic Charge Nurse – Melissia Tomblin, RN	743-1851 ext 245
Urodynamics	743-1851
Clinic/Follow-up Appointments	743-3400 ext 224, 221, 222, 223, or 225
Clinic Supervisor – Deborah Ortiz	743-1851 ext 226
Schedule Office Procedures	743-1851
Billing – Jan Jones	743-3400 ext 230

#### **IV. Curriculum**

The Urology Residency Program at the Texas Tech University Health Sciences Center School of Medicine is a five year long program that includes a PGY I year in the Department of Surgery at Texas Tech and four years in the Department of Urology at Texas Tech.

The PGY I year is spent with the Department of Surgery, but is designed by the Urology Program Director to give the resident a firm foundation in the principles of surgery to include pre- and post-operative management, and the diagnosis and management of common surgical problems. A strong exposure to the management of surgical emergencies, trauma and intensive care medicine is provided. We feel that an exposure to these disciplines is a fundamental part of the education of the urologist and necessary for the resident to understand the principles of urology that the resident will be exposed to during the remainder of his or her residency.

The next four years are devoted to learning the scientific and clinical basis of the specialty of urology to include a thorough exposure to the principles of research relevant to the specialty and the anatomy, physiology and path-physiology of the renal, genito-urinary, and male reproductive systems. Residents have the opportunity to participate in on-going urological research and are required to contribute to the body of urological knowledge in the form of basic science or clinically orientated research or case reports, literature reviews, or clinical studies.

During the course of the residency, residents participate in a comprehensive didactic program that includes thorough review of the foundational textbooks of urology and the current urological literature. Instruction in fields necessary to the urologist to include urological imaging and urological pathology is also provided. The didactic portion of the residency is conducted in weekly conferences, assigned reading and independent study. Emphasis is given throughout the residency to performing well on the annual Urology In-Service examination and the certification examinations given by the American Board of Urology. AUA Core Curriculum is followed and can be accessed at [www.auanet.org](http://www.auanet.org) Judy Pierson initiates AUA membership.

The focus of this program is primarily clinical, with a robust and broad exposure to and participation in all aspects of clinical urology. Residents participate directly in all phases of the clinical care of urological patients to include performing or assisting in all urological surgical procedures performed at University Medical

Center Hospital and supporting institutions. Residents are closely supervised at all times and decisions regarding patient management are discussed with the responsible faculty member. At the completion of the training program, residents are expected to be able to perform as an independent practitioner able to conduct the medical and surgical management of the complete spectrum of routine urological disorders.

At graduation, residents should have the necessary background to practice urology in the environment of their choice to include general (sub-specialty) training, or an academic or research oriented career.

#### **A. EDUCATIONAL PHILOSOPHY**

**Residents are first and foremost, here to learn the science and art of urology. Participation in didactic activities and scholarly endeavors including conferences and meaningful clinical and surgical experiences take precedence over service obligations and repetitive or menial clinical duties.**

Educational and patient care activities are conducted with continuous attention to the six core competencies as described by the Outcomes Study endorsed by the ACGME. [www.acgme.org](http://www.acgme.org)

Our program seeks to integrate all resources of the Health Sciences Center at Texas Tech University, the University Medical Center Hospital, the Southwest Cancer center, Covenant Health System, and the Lubbock Veteran's Center Outpatient Clinic. Our program is committed to providing an opportunity for residents to perform progressively more independent decision-making and clinical activity in a culture of strong and committed mentorship.

Residents should have a broad exposure to all aspects of medical, surgical and other interventional modalities. Residents should be exposed to the greatest variety of pathology and surgical techniques possible, but should also have a strong sense of the limitations of medical and surgical intervention based on their skills, the resources and limitations of their particular work environment, and most importantly the social, cultural and personal concerns and desires of the individual patient.

#### **B. EDUCATIONAL GOALS**

1. The primary goal of this residency program is to produce urologists able to practice urology in an environment or geographic location of their choice.

2. Graduates will have the necessary didactic, technical, and clinical exposure to meet the requirements for certification by the American Board of Urology.
3. Graduates interested in pursuing a career in academic medicine, medical research, or fellowship training within a sub-specialty of urology will have the appropriate preparation for additional training or successful entry into their chosen career path.
4. All graduates will have a broad exposure to and understanding of the moral, ethical, and regulatory aspects of establishing and conducting a successful urologic practice. This includes education in medical administration leadership, interpersonal-communication skills, the tenants of lifelong professional development, and the ability to function successfully in today's medical environment.

### **C. DESCRIPTION OF EACH ROTATION SITE**

1. **Texas Tech (Adult & pediatric):** The urology clinic has the capability to perform flexible cystoscopy; bladder, renal testicular and prostate ultrasound and urodynamics. Minor procedures such as vasectomies and prostate biopsies are performed in the clinic. Residents participate in their own continuity clinic and learn the outpatient management of urologic disease and clinic based diagnostic and minor surgical procedures. This clinic provides continuity of care for patients seen in hospital. A faculty member is always present and all patients are seen by the resident and the attending physicians.
2. **Lubbock VA Clinic:** This clinic provides outpatient care for veterans in our immediate region. This clinic is held every other Tuesday and Thursday and is covered by the PGY-3 resident.
3. **Fundamentals of Research Course:** This course takes place during the PGY 2 year. The course director is Stephanie Filleur, PhD provides instruction in areas ranging from current technologies in basic sciences research, principles of animal and human research, biostatistics, and current research initiatives in the departments of Urology, Microbiology and Immunology, and Physiology.
4. **Research:** (PGY 2 All day research on Wednesdays). All residents are expected to be involved in a clinical or basic science research project throughout their residency. Residents are required to prepare a minimum of one project for publication or presentation during their residency and ideally one project per year. Residents must include their plans for research in their annual written goals and discuss their needs for time and support with the Program Director. If at all possible, funding will be provided to allow residents to travel to present papers accepted at scientific programs.

- 5. Uro-gynecology:** (July – Sept) The PGY II resident spends one morning a week with Dr. Cornelia deRiese, MD, PhD in the Uro-gynecology Clinic learning to evaluate women with symptoms and disorders referable to the lower genital and urinary tracts. Whenever possible, the resident should be present for any scheduled surgical procedures that result from this clinic. If desired, the resident can request to continue participation in this clinic.
- 6. Urodynamics:** The PGY II resident attends the urodynamic clinics held weekly under the direction of Dr. Cynthia Smith. These clinics include performance of standard and video-urodynamic studies. Residents are involved in all phases of the procedures to include performance and interpretation of the results. These studies include adult and pediatric patients.
- 7. Skills Enhancement:** During the second half of the PGY II year the resident works with the Director of the Surgical Skills Center in the Department of Surgery to develop basic laparoscopic skills. At the end of these sessions the resident is expected to become “Fundamentals of Laparoscopic Surgery” certified. The resident also works with Dr. Michael Crone to learn basic microsurgical skills. The residents also completes an online based course on Coding Basics: “Fundamentals of Coding Instruction for Beginning Urology Coders,” provided by the American Urological Association (AUA), and on-line courses to include “Evidence Based Reviews in Urology,” and “Clinical Ethics for Urologists” available from the AUA ([www.AUA.net.org/core](http://www.AUA.net.org/core)).
- 8. Community Urology:** Resident works with private urologists who are on the clinical faculty beginning in their PGY VI year. The residents spend their entire PGY IV year with Covenant Health System Urologists operating at Covenant Health System. Dr. Thomas Nicholson is the site Director for Urology. During the 4<sup>th</sup> year the resident learns about private urology. They experience private practice office management, introduction to hospital protocol, exposure to female and oncologic surgeries. Ability to have exposure to robotic procedures in urology.
- 9. Transition to Practice:** This course is designed to prepare the resident for managing a medical practice. The resident at the end of the course shall have a good understanding of the models of practice, requirements, legal issues, and ethical issues of practice such as office management, contacts analysis (personal, insurance, business), coding issues (CPT, ICD-9, CCI), and where to obtain further resources and advice. The course may also include site visits to successful local practices for the evaluation of EMR accounting systems, employee systems, equipment needs, building arrangements, etc. The course is supervised by Dr. Haynes. The course is conducted addressed during the AUA Core Curriculum.

## **V. PRIMARY RESPONSIBILITIES FOR EACH YEAR LEVEL**

### **A. PGY I**

1. This resident is under the supervision of the Department of Surgery, but is expected to attend all urology conferences within the constraints of duty hour restrictions and other duties.

### **B. PGY II**

#### **1. General:**

- a. Responsible for the daily care of assigned in-patients. This includes prompt attendance at ward rounds, a thorough physical examination of each patient including recording of vital signs and other pertinent information, and ensuring that all daily notes are completed.
- b. Attends assigned Texas Tech adult and pediatric clinics, performing and performing history and physical examinations, etc. as required, & arranging diagnostic procedures, other relevant studies, and admissions if necessary.
- c. Participates in Adult and Pediatric OR as assigned.
- d. Participates in the Uro-gynecology Clinic Monday morning and the Urodynamic Clinic Monday afternoon for 3 months then Continuity Clinic for remaining 9 months.
- e. Participates Wednesday all day in Research lab. Supervisor Stephanie Filleur, Ph.D. At the end of year, the resident will give a report to group on research activities during the year.
- f. Participates in the "Surgical Skills Laboratory" and becomes eligible for "Fundamentals of Laparoscopic Surgery" certification provided by the Department of Surgery. Completes the "Ethics for Urological Residents" module provided by the American Urological Association (AUA).
- g. Completes the "Basics of Urology Coding module provided by the AUA. Attends the Basic Science course at the University of Virginia, Charlottesville, Virginia.
- h. The department initiates candidate membership for each incoming in the American Urological Association.
- i. Grand Rounds presentation one per year.

### **C. PGY III**

- a. Responsible for the daily care of assigned in-patients. This includes prompt attendance at ward rounds, a thorough physical examination of each patient including recording of vital signs and other pertinent information, and ensuring that all daily notes are completed and signed.
- b. Attends assigned Texas Tech clinics, performing and performing history and physical examinations, etc. as required, the & arranging admissions if necessary.

- c. Participates in Adult and Pediatric Urology OR cases at appropriate level and supervision.
- d. Attends VA outpatient clinic two days per week every other week. Supervised by Dr. Mittemeyer.
- e. Continues with on-going research activities and has at least one manuscript completed for publication or presentation.
- f. Expected to teach medical students and junior house staff and non-urology residents rotating on the service.

**D. PGY IV**

- a. Attends clinic, rounds, conferences and surgical procedures as directed by Covenant Health System supervised by Dr. Nicholson.
- b. Attends Urology conferences at TTUHSC.
- c. Completes one manuscript for publication or presentation.
- d. Attends the AUA Annual meeting during 4<sup>th</sup> year.

**E. PGY V**

- a. Responsible for the administration of the urology service to include case scheduling, distribution of workload amongst residents, resident call schedules, and assignment of cases.
- b. Responsible for directing day-to-day activities of each service and distributing in-patient care duties between junior residents.
- c. Oversees care of critically ill patients admitted to the hospital.
- d. Insures all consults are promptly evaluated and patients on consult service seen on a regular basis. The chief resident is also responsible for notifying the attending on-call for seriously ill patients.
- e. Responsible for organizing and conducting all didactic and recurring conferences in collaboration with the Program Director.
- f. Responsible for assigning case presentations involving the adult urology service, teaching medical students to include insuring that they successfully complete the study guide given to all medical students on the urology service.
- g. Participates as the Urology Department representative to the House Staff Council.
- h. Completes one manuscript for presentation or publication.
- i. Develops a written personal plan to prepare for the written and oral portion of the AUA Board Certification Examination to be discussed with the Program Director not later than December of their PGY V year.

## **VI. Resident Evaluations**

### **A. Resident Evaluation Process**

1. Residents are evaluated in a variety of ways and intervals. Evaluations are generated from patients, nursing staff, urology faculty and others. These evaluations monitor the resident's progress in all six of the Core Competencies. Some evaluations are just a snapshot of an individual encounter or procedure and some are a summation of performance over time. The residents also have the opportunity to evaluate the faculty and the training program. All evaluations are confidential and used exclusively to improve the training program and insure that each resident is making appropriate progress. Evaluations the residents complete are anonymous and residents should not hesitate to give honest, pertinent feedback when asked to evaluate the faculty or the program.
2. It is mandatory that residents take the responsibility to have evaluations completed and submitted in a timely fashion. Evaluations such as observed patient encounters and surgical evaluations are meant as a teaching vehicle and should be discussed with the attending filling out the form so that the resident can get maximum teaching benefit from the encounter.
3. All forms are included in the appendices of this handbook. Residents are responsible for providing the forms for observed assessments by the faculty to the faculty member.
4. The results of evaluations will be reviewed individually with residents at least semi-annually.
5. Evaluation forms are included in the appendix.

<b>Annual &amp; Bi-Annual Program Evaluation</b>	<b>Annually (Nov/May)</b>	<b>Faculty – Residents</b>
<b>Faculty Evaluation</b>	<b>Quarterly (Sept/Dec/March/June)</b>	<b>Residents</b>
<b>Global Evaluation – Residents</b>	<b>Quarterly (Sept/Dec/March/June)</b>	<b>Faculty</b>
<b>Operative Performance Evaluation</b>	<b>Weekly – 1 evaluation per resident/per week</b>	<b>Faculty</b>
<b>Observed Patient Encounter Form</b>	<b>Weekly – 1 evaluation per resident/per week</b>	<b>Faculty</b>
<b>Patient Evaluation</b>	<b>Weekly</b>	<b>Random Patients</b>
<b>360 Evaluation</b>	<b>Q 6 mos (Nov/May)</b>	
<b>Urology Service Evaluation</b>	<b>End of Rotation</b>	<b>Medical Students – Rotating Residents</b>
<b>Faculty Evaluation</b>	<b>End of Rotation</b>	<b>Medical Students – Rotating Residents</b>
<b>Self-Assessment</b>	<b>Q 6 mos (Nov/June)</b>	<b>Residents</b>

## **B. OPERATIVE SKILLS ASSESSMENT**

Residents must keep a record of cases done as the surgeon and as an assistant /primary surgeon (all cases). These cases are log on the ACGME website: Data Collection Systems – Resident Case Log System – Login <https://www.acgme.org/residentdatacollection/>

It is imperative that the chief residents review their index cases with the Program Director on at least a quarterly basis. This is to ensure that the surgical experience of the chief resident is well rounded and that there will be no deficiencies in their training.

The guidelines for filling out the SOL pertaining to each case are reviewed with the residents on a yearly basis at the beginning of the year. The following are generic guidelines:

1. One should be considered the operative surgeon, as opposed to the assistant, in a case if the resident does at least 50% of the case. If there is any question, ask the appropriate attending.
2. For multiple procedures on the same patient, it is allowed that multiple residents may be primary surgeons. For instance, if one resident does a cystectomy and the other resident does the diversion, each can be counted as a surgeon for that particular procedure.

A completed and signed SOL must be given to the Program Director prior to graduation. All cases must indicate resident as primary surgeon or assistant surgeon.

## C. RESIDENT EVALUATIONS CORE COMPETENCY MATRIX

	Eval. Times	Patient Care	Medical Knowledge	Practice-Based Learning & Improvement	Interpersonal & Communication Skills	Professionalism	System-Based Practice
Observed Patient Encounter	Weekly	X	X	X	X	X	X
Operative Performance Evaluation	Weekly	X	X	X	X	X	X
Patient Resident Evaluation	Weekly (random)	X			X	X	X
Didactic Presentation Evaluation	As needed		X	X	X	X	X
End of Rotation Evaluation (paper-students and residents)	Wk, bi-mo, monthly	X	X	X	X	X	X
Global Evaluation (Faculty & Resident) (electronic on new innovations)	Quarterly	X	X	X	X	X	X
Semi-Annual Evaluation - Resident	Dec	X	X	X	X	X	X
360 Evaluation	Every 6mos – Nov & May	X			X	X	X
Self-Assessment	Every 6mos – Dec & June	X	X	X	X	X	X
Case Logs (ACGME system)	Reviewed Semi-Annually	X	X				
In-Service Exam	Annual		X	X			X
Annual Evaluation - Resident	Annual – June	X	X	X	X	X	X
Annual Evaluation - Faculty	Annual – June	X	X	X	X	X	X
End of Year Program Evaluation (electronic on new innovations)	Annual – June	X	X	X	X	X	X

## VII. CLINIC AND SURGERY SCHEDULES

LEVEL	PGY 2				
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	OB/GYN (July, Aug, Sept) Res Clinic - Adult	Pediatric Clinic	Research (Principles of Research -am) (Expanded Research -pm)	OR	7:30 - 9 Conf
PM	Urodynamics				OR - Peds

LEVEL	PGY 3				
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Res Clinic - Adult	VA /// OR	OR	VA /// OR	7:30 - 9 Conf
PM					OR - Peds

LEVEL	PGY 4				
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Covenant	Covenant	Covenant	Covenant	7:30 - 9 Conf
PM					Admin/Research

LEVEL	PGY 5				
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Res Clinic - Adult	OR	Admin	OR	7:30 - 9 Conf - Res Clinic
PM					Res Clinic - Procedure

## **VIII. Conference Schedule**

A minimum of four hours are devoted to conferences each week. This does not include the time residents spend in the course "Introduction to Research" during the PGY II year. The Tumor Board conference is held weekly every Friday morning at 0700 in the Southwest Cancer Center conference room, resident attend if Urology cases are to be presented. The majority of conferences are held Friday morning in a designated room (4AB100 or 3B125). The uro-pathology conference is held in room 1A115 in anatomic pathology. The uro-gynecology conference (2 per year) is in the OB/GYN conference room 3B214. The urology/nephrology/radiology conference is held quarterly in 4AB100. AUA updates are done at the combined monthly resident meeting at a location TBA.

### MASTER CONFERENCE SCHEDULE

	Required Attendance	TIME	1 <sup>ST</sup> WEEK	2 <sup>ND</sup> WEEK	3 <sup>RD</sup> WEEK	4 <sup>TH</sup> WEEK	5 <sup>TH</sup> WEEK
Weekly – Tuesday	All Residents	5-6:30 PM	Urology Core Curriculum	Urology Core Curriculum	Urology Core Curriculum	Urology Core Curriculum	Urology Core Curriculum
Weekly - Friday	Urology Cases to be presented only - All Residents (except PGY 4 except PGY3 on Renal Transplant rotation and PGY 4 and Trans. M&M)	7-8 AM	Tumor Board	Tumor Board	Tumor Board	Tumor Board	Tumor Board
Weekly Friday	All Residents	7:30-9 AM	Uro-Path	Case Conference	Morbidity & Mortality	Case Conference	Case Conference
Monthly – Friday (Qrtly)	All Residents – week depending on schedule	7:30-9 AM		Neph/Uro/Radiology			
Monthly – Friday(2 times year – Oct & April)	All Residents	11:30 – 1pm		UroGyn			

## FACULTY CONFERENCE LEADERS

Conference	Site	R /O	Frequency	Conference Leader
AUA Core Curriculum	TTUHSC	R	Weekly	Dr. C. Smith & Dr. Cammack
Urology Grand Rounds	TTUHSC	R	Monthly – 4times per year	Dr. C. Smith
Morbidity & Mortality	TTUHSC	R	Monthly	Dr. C. Smith & Dr. Cammack
Uro-Pathology	TTUHSC	R	Monthly	Dr. Suzanne Graham (Pathology)
Case Conference	TTUHSC	R	Monthly	Dr. C. Smith & Dr. Cammack
Nephrology/Urology / Radiology	TTUHSC	R	Quarterly	Drs. S. Prabhakar (Nephrology), Dr. C. Smith
Uro-Gynecology	TTUHSC	R	2 times year (Oct & Apr)	Drs. C. deRiese & Dr. C. Smith
Journal Club	TTUHSC / TBA	R	Quarterly	Assigned – Annually a Faculty Mentor

### A. Conference Descriptions

**1. AUA Core Curriculum:** This conference is conducted weekly. The AUA's Urology Core Curriculum is the most comprehensive reference guide available detailing the knowledge necessary to deliver quality urological care. There are 14 categories and 51 sub-sections, which contain additional content sections, of the core curriculum. They will be divided weekly. A list will be generated and distributed to all Faculty, Residents, and Community Urologist. Faculty and Community Urologists will be asked to sign-up to (lead) a review and discussion.

The Faculty Leader is asked to facilitate the curriculum and to add any additional experience or resources to that conference. This curriculum will be covered within a two year time frame. Each Faculty leader will be asked to generate 5 board-formatted multiple choice questions prior to their assigned week. The questions and answers need to be turned into the residency coordinator who will keep them in a data file for future use. Please give Q&A to the residency coordinator no later than Friday prior to the assigned conference. The questions will also be given to the residents at the end of the weekly discussion for scoring.

A resident will be assigned as the lead resident for each conference. They will be asked to lead the review and discussion. They will need to contact the lead faculty for their week in advance to cover any concerns, questions, and to discuss the flow of the conference.

**2. Tumor Board:** (if Urology Cases presented) This weekly conference is held every Friday morning. It is supervised by the Director of the Southwest Cancer Center, Dr. Everardo Cobos, (Chief, Oncology/ Hematology Division, Department of Internal Medicine at Texas Tech), and Dr. Werner de Riese. During this conference patients with newly diagnosed tumors and patients who are established patients who have developed multi-disciplinary issues that require review of their status are presented to the medical, radiological and surgical specialists dealing with tumors at UMC and TTUHSC. Their clinical presentation is correlated with the relevant imaging and histopathology studies and a course of treatment is developed. This conference exposes the residents to an excellent forum in which to learn Uro-pathology and Uro-radiology as well as the management of urological malignancies. Residents also learn to interact with their peers in other disciplines as well as the selection of appropriate imaging and diagnostic studies for patients with malignant diseases. The participation of non-clinical support personnel (social work, chaplains, etc.) also provides an exposure to the humanistic and ethical issues involved in the care of the patient with cancer.

**3. Morbidity and Mortality:** The M & M conference is conducted by the Department Chairman on a monthly basis and is designed to provide a forum to present complications, untoward outcomes and deaths on the service. The resident involved in the care of the patient presents a concise summary of the patient's hospital course and the nature of the complication or death. The resident who was most intimately involved with the patient is responsible for discussing how the incident could have been handled differently and the management of complications to include review of the recommended literature of each case. The impact of all six core competencies are discussed and documented by using a standardized form. This conference gives the residents and faculty an opportunity to improve patient care and our practice environment by initiating, if appropriate, a performance improvement initiative.

**4. Uro-pathology:** This monthly conference is conducted jointly with the department of pathology faculty and residents. It provides a forum to correlate the clinical aspects of selected cases with the histo-pathological and laboratory findings. Residents present the clinical history for each case and the histo-pathological material available is reviewed by the pathology staff. When appropriate, a more formal didactic format gives the urology residents a deeper understanding and knowledge of the pathology of genito-urinary disorders. In addition, residents are expected to review any biopsy or other tissue samples with a member of the pathology department prior to presenting the patient at a pre-op conference or tumor board. This conference helps prepare the residents for their board examinations in urology as well as their clinical practice.

**5. Case conference:** This conference, held 2 to 3 times per month) allows the residents to discuss, in depth, selected complex urological patients with Dr. C. Smith and the urological faculty. The chief resident is responsible for selecting cases for in-depth review. The discussion can be centered on the clinical presentation and management of a problem (patient care & medical knowledge), ethical, social or outpatient management issues (interpersonal and communication skills, professionalism, system based practice), or other

relevant aspects of caring for the patient. The relevant basic science and published literature (medical knowledge, practice based learning and improvement) may also be the focus of the conference. Pediatric cases include discussion of aspects relating to all of the General Competencies as they apply to the management of children, their families, and the health care system.

**6. Nephrology/Urology/Radiology Conference:** This quarterly conference is supervised by Dr. Sharma Prabhakar, Chief, Nephrology Division, and Department of Internal Medicine and Dr. C. Smith and Dr. Cammack (Urology). Patients from the Urology, Nephrology, or Transplant services are chosen for presentation and discussion based on joint involvement or joint interest. The conference is also attended by radiology attending who presents pertinent radiographs. The pathology service also attends whenever relevant histopathology is available. Generally, the Chief Resident chooses the Urological cases to be presented.

**7. Uro-Gynecology:** This conference is held 2 times per year in October and April at 11:30 am in the Gynecology Conference Room adjacent to the Urology Clinic. The conference is attended by the OB/GYN and Urology Department members and residents and topics referable to Urological and Gynecological disorders of interest to both groups are presented. Strong emphasis is given to providing didactic lectures in anatomy, physiology, clinical and urodynamic evaluation of bladder and pelvic floor disorders in women.

**8. Grand Rounds:** Quarterly, residents are assigned dates for a formal grand rounds presentation covering a specific topic relevant to recent clinical problems. Subjects for the grand rounds are determined annually based on topics suggested by community and faculty urologists, and residents. Subjects are determined by performance on in-service examinations, unusual or complex cases seen by the service, reviews of a particular subject required by the Specialty Specific Requirements or Urology (geriatrics, radiation safety, fatigue and stress, etc).

**9. Journal Club Conference:** This quarterly conference is conducted off campus at various sites. Community urologists are invited to participate. Residents participate by presenting cases from our institution and interpreting x-rays and analyzing cases. A few highly selected articles are chosen for the residents to present and to be discussed. This forum allows the residents to apply the knowledge they gained in their "Principles of Research" course. The articles are reviewed from the standpoint of study design and validity as well as the practical and scientific knowledge provided. This forum gives the residents an opportunity to develop a deeper understanding of the role of peer-reviewed literature both for purposes of applying that information to patients they currently care for and also a method for developing the habits necessary for their continuing education once they leave their residency.

**10. Other Resources:**

**AUA Updates:** This is done monthly along with the monthly resident meeting at a location TBD. Residents review weekly AUA Updates from the AUA website.

**AUA SASP:** The AUA SASP are reviewed periodically and available for all residents in the resident library.

## IX. POLICIES AND PROCEDURES

### A. General Policies and Procedures

#### GME Policy & Procedures (Institutional)

<http://www.ttuhscc.edu/som/gme/policies.aspx>

#### HouseStaff

[http://www.ttuhscc.edu/som/gme/documents/housestaff\\_policies\\_and\\_procedures2008-2009.pdf](http://www.ttuhscc.edu/som/gme/documents/housestaff_policies_and_procedures2008-2009.pdf)

#### Department of Urology Policy & Procedures

<http://www.ttuhscc.edu/som/Urology/>

#### ACGME Program Requirements & Common Program Requirements

[http://www.acgme.org/acWebsite/navPages/nav\\_480.asp](http://www.acgme.org/acWebsite/navPages/nav_480.asp)

#### ACGME Urology Program Requirements & Pediatric Program Requirements

[http://www.acgme.org/acWebsite/RRC\\_480/480\\_prIndex.asp](http://www.acgme.org/acWebsite/RRC_480/480_prIndex.asp)

### B. The following sections are policies and procedures specific to the Texas Tech University Health Sciences Center Department of Urology.

#### 1. Administrative Issues

All problems regarding scheduling or personnel (both House Staff and Ancillary) should be referred to the program director. With regard to requests for changes in the published rotational schedule, a written change request form must be signed by the program director and the resident(s) involved in the change.

#### 2. DUTY HOURS & FATIGUE

##### DUTY HOURS

Urology residents take call from home. Home call is not subject to the every third night limitation. However home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking home call are provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

Continuous on-site duty must not exceed 24 consecutive hours. If a resident has been on duty in excess of 24 hours, they may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care. No new patients may be accepted after 24 hours of continuous duty.

- a) When averaged over a four-week period, total hospital, and clinic activities should not exceed 80 hours per week. In-house call can occur no more frequent than once every 4 nights, averaged over a 4 week period.
- b) Residents must have 1 full (24 hr) day without duty per week averaged over a 4 week period.
- c) Residents should not work more than 30 consecutive hours. After 24 hours, resident cannot be scheduled for a duty which sees new patients.
- d) Residents must have at least 10 hours off for rest and personal activities between all daily duty periods.

### **FATIGUE**

The program director and faculty monitor the demands of home call and insure that scheduling adjustments are made to mitigate excessive service demands and/or fatigue. The PGY IV and V level residents back up the junior level residents for major cases or complex problems. They are not expected to respond to routine urologic consultations or problems.

Back-up support will be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. The request for back-up support will be directed to the Program Director, Assistant Program Director, or Department Chairman.

### **Weather and Disaster Situations**

All residents will follow the Graduate Medical Education Policy and Procedures regarding their duties and location to report to for weather or disaster situations.

### **3. Moonlighting**

**Urology Residency training requires significant and prolonged efforts to develop clinical skills and to master a large fund of medical knowledge. Outside activities such as moonlighting should not interfere with the residents' training responsibilities. The Department of Urology has the following guidelines for moonlighting.**

Completion of a urology residency is a full-time endeavor. This program **does not permit** resident moonlighting.

### **4. Charts**

The medical chart is essential to quality patient care. Notes should be thorough, accurate and clearly legible. As a legal record, the dating

and timing of entries is mandatory. Under no circumstances should charts be altered, i.e., addition or deletion of backdated notes or orders. All notes written by medical students are limited to history and recording of laboratory results. They must be cosigned by a resident. Charts should effectively convey a patient's course, not only to the primary service but also to consulting services. Importantly, the medical chart permits reimbursement by third party payers. (See section XI for document standards)

Prior to the anticipated day of discharge, consider the potential need to consult necessary ancillary services (Social Services, Physical Therapy, etc.), which may render follow-up care on an outpatient basis. All necessary paperwork should be completed at this time.

## **5. Discharge Summaries**

As part of a complete medical record, the discharge summary should accurately portray the notable events of a patient's hospital course. This document serves to inform subsequent providers of surgeries, complications, and discharge instructions. All discharge summaries are to be dictated within forty-eight hours of discharge. Dictation prior to discharge is optimal and strongly encouraged. Maintaining medical records is the responsibility of all residents. In order to remain current and avoid accruing delinquent charts, residents must check the power chart system and requests charts to be brought to the department on a weekly assigned day. Failure to remain current results in notification to the involved attending surgeon and automatic suspension of the attendings admitting and booking privileges. Should the resident's delinquency reach this stage, operative privileges will be immediately suspended until all records are current. (See section XI for the mandatory elements of a discharge summary)

## **6. Operative Notes**

Notes must be dictated within 24 hours of procedure. See section XI-D for components of the operative note.

## **7. Clinic notes:** Clinic notes in EMR must be completed within 7 days

## **8. Dress Code**

Urology residents should appear professional and well-groomed at all times. Such behavior reflects attention to detail and inspires confidence in patients and families. White coats, if worn, must be clean. Operating room attire is restricted to the operating room, and overnight/weekend call. When dressed in scrubs, a clean white coat should always be worn outside of the operating room.

## **9. Benefits**

**1<sup>ST</sup> YR (PGY 2) RESIDENTS:** AUA Membership dues paid annually.  
Paid support for the Charlottesville Basic Science Course

**2<sup>nd</sup> YR (PGY 3) RESIDENTS:** AUA Membership dues paid annually

**3<sup>rd</sup> YR (PGY 4) RESIDENTS:** AUA Membership dues paid annually.  
\$1,000 allowance for the AUA Annual Meeting

**4<sup>th</sup> YR (PGY 5) RESIDENTS:** AUA Membership dues paid annually.

**ACLS COURSE:** Paid renewal every 2 years. Residents are required to take the initial course before beginning their PGY 2 year.

**ATLS COURSE:** Initial Course is given in the PGY I year only (During Surgery Prelim year at TTUHSC)

**LAB COATS:** 3 coats per PGY II residents, thereafter replaced on an **AS NEEDED** basis

**MEALS:** \$40 month (no accrual) - Urology Residents

**PHOTO COPYING PRIVILEGES:** Copies & transparencies for conferences as long as cost is not excessive, otherwise issued copy card is to be used

**TRAVEL:** For **APPROVED** additional educational and scientific meetings ONLY. You have to notify Program Director and Residency Coordinator 1 ½ month in advance of travel in order for it to be approved. Also, you pay your own way then submit receipts for reimbursement – if approved. Travel & accommodations will be reimbursed for one approved meeting per year to present a manuscript/poster.

**10. Leave: Vacation-Sick-Educational**

*Approved by the Program Director, residents' vacation schedules will be complete at the beginning of each year.*

**FOR APPROVAL OF ALL LEAVE REQUESTS**

You must go to Residency Coordinator, Judy Pierson and fill out leave form/clinic cancellation form (it will be sent to Patient Services Supervisor - allowing her to block your clinic time). Vacations must be approved by the Program Director. Applications must be submitted at least 60 days in advance. You must provide the name of the doctor that will provide clinic call coverage for you.

a. **VACATION:**

PGY II, III, IV, & V - 15 working days per year – non-accruable

b. **SICK:**

PGY II, III, IV, & V - 12 working days per year – accruable

c. **EDUCATIONAL LEAVE:**

1). Residents will be granted additional Educational Leave for essential examinations, such as Step III of the USMLE (if necessary).

2). Residents may attend professional meetings up to 5 working days per year.

3). Residents may present information at professional meetings regardless of their current clinical responsibility

**provided they identify adequate coverage. In these cases, the resident should limit his/her absence from his/her clinical responsibility to the shortest time necessary to travel to the meeting, make the presentation, and return to Lubbock. If the presentation is at the request of the department, it will not be counted against the allotted educational leave. If the conference is at the request by the resident, it will be counted against their allotted educational leave or none is available, it will be counted towards their vacation leave.**

**4). Residents in the PGY-IV and V year applying for fellowships positions may have 7 days of Educational Leave for both professional meetings and fellowship interviews. Time required beyond 7 days should be taken from vacation. Residents will need to find coverage when on in-patient services**

### **11. Patient Load**

Residents must balance the need for patient care responsibilities with their own educational responsibilities and their own needs for good mental and physical health. Patient loads will clearly depend on the complexity and severity of the medical problems in hospitalized patients. If patient load is excessive, the attending faculty will be responsible for additional patients. In the event the resident is confronted with an unmanageable patient load, the attending on service will provide patient care if patient load increases and becomes unmanageable. Residents who are concerned about their patient load should first discuss the problem with the Chief Resident who will then immediately notify the Program Director. If the problem is not satisfactorily resolved, the resident must immediately inform the Program Director or Assistant Program Director.

### **12. Order Writing**

- a. Residents with appropriate supervision of faculty should write all the orders on all their patients.
- b. Upper level residents should write orders on their patients when PGY - II residents are unavailable or when the patient load prevents the PGY - II residents for providing timely orders.
- c. The attending faculty may write orders in the following circumstances.
  - 1) Urgent patient care considerations preclude the use of the usual line of responsibility.
  - 2) The pharmacy requires faculty signatures for certain classes of medication, such as chemotherapeutic agents.
  - 3) The faculty writes brief orders on clinic patients to initiate the admitting process.

### **13. Non-Teaching Patients**

Residents are not expected to provide physician services to non-teaching patients except in emergencies. However, when time permits, residents may be expected to provide minor services to these patients or to their physicians when such service does not require significant patient assessment and when such services are requested by the attending physician.

### **14. Performance Standards**

#### **a. OBJECTIVE**

All residents completing Urological Residency Training should have the clinical skills and overall medical competence necessary for certification of their clinical competence to the American Board of Urology, should demonstrate moral and ethical behavior, and should have a reasonable expectation of passing the certifying examination of the American Board of Urology

#### **b. STANDARDS**

##### **1) Satisfactory ratings on all evaluations**

###### **Rationale**

- a) The Board will not admit residents with unsatisfactory evaluations to the qualifying examination.
- b) An unsatisfactory rating usually indicates significant performance problems.

###### **Process**

- a) Any unsatisfactory rating by a faculty member on a resident's evaluation form will trigger a review of the problem with the program director, the chief resident, the resident, and the faculty member. If the rating is correct, then corrective measures will be identified and instituted. Future evaluations will be critically reviewed to determine whether or not this problem has been corrected.
- b) A second unsatisfactory rating will trigger a repeat review and analysis of the problem. The resident will be issued a written warning regarding his performance. Corrective measures will be identified and instituted. Future evaluation will be reviewed monthly with the program director for the next three months.
- c) A third unsatisfactory rating will trigger a repeat review and analysis of the performance problem. The resident will be placed on probation (see 3). Corrective measures will be identified and instituted. Future evaluations will be reviewed monthly with the program director for six months.

##### **2) Clinical Skills**

###### **Rationale**

Residents must demonstrate expertise in patient assessment, including thorough and well documented histories and physical examinations.

### **Process**

- a) Each PGY II resident will perform a directly observed history and physical on a new patient annually. It is the resident's responsibility to notify the designated faculty member of this requirement and insure that the faculty member provides a written evaluation of the residents history & physical exam to the residency coordinator.
- b) Written records (histories, physical examinations, clinic notes, and progress notes) must steadily improve during the 3-year program and ultimately reflect high quality and thorough patient evaluation and assessment.

### **3) Advanced Cardiac Life Support and Advanced Trauma Life Support**

#### **Rationale**

The American Board of Urology requires proficiency in advanced trauma life support. The Texas Tech University Health Sciences Center institution requires basic life support, advanced cardiac life support, and cardiac defibrillation. Certification documents are required in these areas.

#### **Process**

- a) Residents must maintain ACLS certification. ACLS certification is renewed every 2 years.
- b) Residents without up-to-date certification will have 30 days to obtain certification.

### **4) Educational Responsibilities**

#### **Rationale**

The American Board of Urology requires each resident to have a significant fund of knowledge and to develop methods for maintaining this fund of knowledge. Urology residency Training implies participation in as many educational activities as possible. Failure to participate in on-going departmental activities cannot be justified.

#### **Process**

- a) Residents will attend at least 60% of the required conferences (after correction for vacation and special rotations).
- b) Residents who do not maintain a 60% meeting average over 3-month periods will be issued a written warning.
- c) After two written warnings, residents with persistent attendance problems will be placed on probation (see 3).

### **5) Medical Records**

#### **Rationale**

The American Board of Urology, UMC, and TTUHSC require timely and legible records as one indicator of professional attitude and behavior. Proper records are essential for patient care.

#### **Process**

- a) Residents will maintain records, including all dictations and signatures, on a timely basis.
- b) Attending physicians are ultimately responsible for record completion.
- c) Residents with persistent delinquencies resulting in faculty suspension by Medical Records will receive two written warnings and then probation (see 3).

## **6) In-Service Examination**

### **Rationale**

The in-service examination allows residents to identify areas of strengths and weaknesses and allows the resident to compare his/her overall performance with other residents at similar levels of training.

### **Process**

- a) Residents at all levels will take the in-service examination in November of each year. All residents will review their in-service scores with the program director.
- b) PGY IV residents below the 50th percentile for all PGY IV residents will review their test results with the Program Director to identify areas of weakness. They must then develop a plan which has a reasonable expectation for correcting these weaknesses. This plan should involve individual faculty members who will serve as mentors and advisor.
- c) PGY IV residents below the 30th percentile may have a serious deficiency in their fund of knowledge. These residents must review their areas of weakness and present a detailed plan for improvement. PGY III or IV residents who have scores below the 20th percentile probably cannot pass the American Board of Urology, given their current fund of knowledge. These residents will need intensive and prolonged preparation for the American Board of Urology. These residents must increase their performance over the 30th percentile on the in-training exam taken during the PGY V year to assure approval for taking the ABU certifying examination.

## **7) Ethical and Moral Behavior**

### **Rationale**

The ABU expects all candidates to exhibit appropriate moral and ethical behavior in the clinical setting.

### **Process**

- a) Each resident should demonstrate integrity, respect, and compassion when providing medical care. These attitudes will be assessed by the resident's action and behavior at work. Input will come from patients, nurses, other residents, and faculty.

- b) Residents' appearance shall be of professional standards in physical and verbal expression to include appropriate dress and grooming. Interaction with other residents, faculty, students, staff, and hospital personnel will be of the utmost professional standards.
- c) Residents with unacceptable behavior patterns will receive counseling, written warnings and eventually probation if problems persist. This evaluation is admittedly subjective and will utilize all resources available to make proper decisions.

**8) Resident Files and Portfolio's**

The master resident's notebook will be maintained in the Department of Urology Residency office by the residency coordinator.

All residents will maintain a portfolio on the New Innovations online web system. Hard copies will also be updated in the master resident notebook.

**c. Case Logs**

As part of your development as a surgeon, we expect you to become competent in certain basic urologic procedures. You must request an attending physician to assess your competency in these procedures by completing an Operative Performance Evaluation. The core procedures listed below and divided into Pediatric and Adult cases.

<b><u>PEDIATRIC:</u></b>	Hydrocelectomy/ herniorrhaphy	Ureteroneocystostomy
	Orchiopexy/Orchidopexy	Circumcision
<b><u>ADULT:</u></b>	Circumcision	Prostatectomy, radical
	Cystoscopy	Renal surgery, partial or total nephrectomy
	ESWL	Hydrocele repair
	Female incontinence, sling	Transrectal ultrasound/prostate biopsy
	Lymphadenectomy, pelvic	Transurethral prostate surgery
	Penile prosthesis implantation	Transurethral resection bladder tumor
	Percutaneous renal surgery	Ureteroscopy

Competency to perform each category a case must be demonstrated for promotion and graduation. (Competency is determined by the

Faculty who observes/ assists with the type of case in question and submits a completed Surgical Evaluation form to Judy.

These certifications for individual procedures can be done at any time that a resident feels comfortable with his/her abilities to perform and understands a particular case. The resident will be assessed on their knowledge of anatomy, technique, their choice of instruments and handling, their behavior and demeanor in the operating room, and their use and respect for ancillary OR support staff.

The Surgical Operative Logs (SOL) is an integral part of the Residency Program. They are required to be filled out on a regular basis in order to comply with the guidelines set forth by the Residency Review Committee. It is expected that a completed operative log be updated at least monthly.

- 1) Failure to keep logs up to date may result in suspension of operative privileges.
- 2) Residents will review their case logs with the Program Director every six months as a part of their formal semi-annual evaluation.
- 3) At the conclusion of the residency, each chief resident must provide the Program Director with the **SIGNED** surgical log documenting his/her 48 months of clinical urology operative experience. It is the resident's responsibility to keep copies of dictated operating room reports on all cases in which he/she is listed as the responsible surgeon. The operative log submitted to the RRC must be countersigned by the Program Director who will attest to the accuracy of the data submitted. Logs without **BOTH** the resident and Program Director signatures will be returned.
- 4) In most cases a resident cannot obtain credit as surgeon for more than one operation unless the procedure is a multi-component operation. For example, the resident who performs a radical nephrectomy cannot take credit for a nephrectomy, adrenalectomy, and a retroperitoneal lymphadenectomy. Some multi-component operations that incorporate individual procedures that are commonly performed as individual operations such as pelvic lymphadenectomy can be credited as separate procedures.

Approved Examples of Exceptions:

Operations	Report
Radical Retropubic Prostatectomy	1 Radical prostatectomy <u>and</u>
	1 Pelvic lymphadenectomy
Radical Cystectomy with urinary continent diversion or reconstruction	1 Radical cystectomy and:
	1 Pelvic lymphadenectomy
	and either: a.) conduit, ileal or colonic;
	b.) any continent cutaneous diversion
	c.) orthotopic neobladder, any type
Urinary Diversion with Transureteroureterostomy	1 Transureteroureterostomy and
	1 Ureteroneocystostomy with bladder flap

- 5) In certain circumstances two residents can claim credit for separate portions of a procedure. For example, when one resident is performing a radical prostatectomy, he can permit another resident to make the incision and perform the pelvic lymphadenectomy before performing the radical prostatectomy. In this case, one resident is the assistant on the lymphadenectomy and the surgeon on the prostatectomy, and the other resident is the surgeon on the lymphadenectomy and the assistant on the prostatectomy.

In cases where a bilateral operation is performed, two residents can obtain credit for unilateral procedures, e.g. bilateral orchiopexy, adrenalectomy, simple nephrectomy, ureteral re-implantation. The resident who performs 50% or more of a case is considered the surgeon. Assistant refers only to first assistant

- 6) If you have any questions about entering cases please check with Dr. Smith.

**d. Probation**

**Rationale**

Residents who are placed on probation have a serious performance problem and have a high likelihood of not being certified as clinically competent to the American Board of Urology.

**Process**

- a) Residents may be placed on probation after they have received a written warning(s) regarding a deficiency in performance but fail to correct this deficiency. At the time

of probation, measures for corrections will be identified and instituted.

Follow-up evaluation and reassessment will occur monthly for three months by the Program Director.

- b) Residents may be placed on a second probationary period if the same deficiency persists after the initial probationary period, or if a new deficiency which has been preceded by written warning(s) occurs during or after the initial probationary period. They may be asked to leave the program at the end of the annual contract if satisfactory progress has not been made. They may be asked to extend their training for six to twelve months, depending on the deficiency and evidence for progress and improvement.
- c) Department policies will be consistent with institution policies.

## **15. Reading List**

### **General Urology**

Urology for the House Officer, Michale T. MacFarlane, 4<sup>th</sup> Edition, Lippincott, Williams and Wilkins, 4<sup>th</sup> Edition, ISBN # 0781799333

1. Smith's General Urology, Tanago, 16<sup>th</sup> Edition, McGraw Hill ISBN #0071396489
2. Campbell's Urology, 4 Volume Set, Walsh Retik, Vaughn, 9<sup>th</sup> Edition, Elsevier, ISBN #0721690580
3. Campbell's Urology Study Guide, Walsh Retik, Vaughn, 9<sup>th</sup> Edition, Elsevier, ISBN #0721695884

### **Pediatric Urology**

1. Pediatric Urology, John P. Gearhart, ISBN: #1588291103

### **Uro-gynecology**

1. Textbook of Urology & Gynecology 2<sup>nd</sup> edition, L Cardozo, D. Staskin
2. Urogynecology & Reconstructive Pelvic Surgery, MD Walters, MM Karrow
3. Urodynamics, Paul Abrams
4. Female Urology, Urogynecology, and Voiding Dysfunction, SP Vasavada, RA Appell et al
5. Functional Reconstruction of the Urinary Tract & Gynecology-Urology, Richard, Turner-Warwick, Blackwell.

## Additional Suggested Reading

- a. Adult and Pediatric Urology, 2002, 4th Edition - J. Gillenwater, J. Grayhack, S. Howards, M. Mitchell, \*4<sup>th</sup> edition - available in print and online (through Books@OVID) at the TTUHSC Library
- b. 2. CT Urography: an atlas., 2007, S. Silverman, R. Cohan, \*2007 edition - available in print and online (through Books@OVID) at the TTUHSC Library
- c. Comprehensive Textbook of Genitourinary Oncology, 2005, 3rd Edition, N. Vogelzang, P. Scardino, W. Shipley, F. Debruyen, W. Linehan, \*2000 edition - available in print in the TTUHSC Library
- d. Genital Dermatology Atlas, April 2004, L. Edwards, \*2004 edition - available in print in the TTUHSC Library - \*New edition found in NLM Catalog: Genital Dermatology Atlas, 2<sup>nd</sup> edition, 2011, L. Edwards, P. Lynch, S. Neil
- e. Glenn's Urologic Surgery, 2004, 6th Edition, S. Graham, T. Keane, J. Glenn, \*6<sup>th</sup> edition - available in print and online (through Books@OVID) at the TTUHSC Library \*New edition found in NLM's Catalog: Glenn's Urologic Surgery, 2010, 7th Edition, S. Graham, T. Keane, J. Glenn
- f. Handbook of Pediatric Urology 2nd Edition, February 2005, L. Baskin, B. Kogan, \*2nd edition - available in print in the TTUHSC Library
- g. Handbook of Urology: Diagnosis and Therapy, 3rd Edition, March 2004, M. Siroky, R. Oates, R. Babayan, \*3<sup>rd</sup> edition - available in print and online (through Books@OVID) at the TTUHSC Library
- h. Mastery of Endoscopic and Laparoscopic Surgery, 2nd Edition, 2005, N. Soper, L. Swanstrom, W. Eubanks, \*2<sup>nd</sup> edition - only available in print in the TTUHSC Library \*New edition found in NLM's Catalog: Mastery of Endoscopic and Laparoscopic Surgery, 3<sup>rd</sup> Edition, 2009, N. Soper, L. Swanstrom, W. Eubanks
- i. The 5-Minute Urology Consult, April 2000, L. Gomella, \*2000 edition - available in print and online (through Books@OVID) at the TTUHSC Library \*New edition found in NLM's Catalog: The 5-Minute Urology Consult, 2nd edition, 2010, L. Gomell
- j. Urologic Pathology, 3rd Edition, March 2009, R. Petersen, I. Sesterhenn, C. Davis, \*1992 edition - available in print in the TTUHSC Library
- k. Urology, 4th Edition, June 2006, M. Macfarlane, \* 4<sup>th</sup> edition - available in print and online (through Books@OVID) at the TTUHSC Library
- l. Multidisciplinary Management of Female Pelvic Floor Disorders, 1st edition, 2006, Chapple, Zimmern, Brubaker, Smith & Bo, \* 1<sup>st</sup> edition - available in print in the TTUHSC Library
- m. Urologic Oncology, 1st edition, 2005, Richie & D'Amico, \* 1<sup>st</sup> edition - available in print in the TTUHSC Library
- n. Genitourinary Imaging, 2nd Edition: Case Review Series, 2007, Zagoria, Mayo-Smith & Fielding, \*2000 edition - available in print in the TTUHSC Library
- o. Genitourinary US, An Issue of Ultrasound Clinics, 2007, 1st edition, Dogra, \* 2005 edition - available in print in the TTUHSC Library
- p. Prostate Imaging, An Issue of Radiologic Clinics, 1st edition, 2006, Ramchandani, \*not available in the TTUHSC Library
- q. Kidney Transplantation, 5th Edition: Principles and Practice, 2001, Morris, \* 5<sup>th</sup> edition - available in print in the TTUHSC Library, also have 2008 edition in print in Library \*New edition found in NLM's Catalog: Kidney Transplantation: Principles and Practice, 6th Edition, 2008, P. Morris, S. Knechtle
- r. Handbook of Urology, 2004, 3rd edition, Siroky, Oates, Babayan, \* 3<sup>rd</sup> edition - available in print and online (through Books@OVID) at the TTUHSC Library
- s. Comprehensive Textbook of Genitourinary Oncology, 3rd edition, 2005, Vogelzang, Scardino, Shipley, Debruyne, Linehan, \*2000 edition - available in print in the TTUHSC Library

## **UROLOGY - RESIDENT LIBRARY**

### **ADULT & GENERAL UROLOGY**

Adult & Pediatric Urology – 3<sup>rd</sup> Edition – 3 vol. set – Gillenwater, Grayhack, Howards, Duckett

Smith's General Urology 15<sup>th</sup> Edition – Tanago

Urology Pearls – 2000 – Resnick, Schaeffer (3 in Library a/b/c)

20 Common Problems in Urology – 2001 – Teichman

Campbell-Walsh Urology 9<sup>th</sup> Edition – 4 Vol. set

Handbook of Urology 3<sup>rd</sup> Edition – Siroky, Oates, Babayan

Urology – An Illustrated Color Text – Bullock, Doble, Turner, Cuckow

Smith's General Urology – 17<sup>th</sup> Edition – Tanago, McAninch

Sauer's Manual of Skin Diseases – 9<sup>th</sup> Edition – Hall

Handbook of Urology 3<sup>rd</sup> Edition – Oates

Penn Clinical Manual of Urology – Hanno, Malkowicz, Wein

The Washington Manual of Medical Therapy – 32<sup>nd</sup> Edition

Urology Secrets – 3<sup>rd</sup> Edition – Martin I. Resnick, MD & Andrew C. Novick, MD

Gray's Anatomy – The Anatomical Basis of Clinical Practice – 14<sup>th</sup> Edition – Susan Standring

The Interstitial Cystitis Survival Guide – 2000 – Moldwin

Smith's General Urology 16<sup>th</sup> Edition – Tanago, McAninch

The Little Black Book of Urology – 2<sup>nd</sup> edition- Daniel K. Onion

### **CONSULTS**

The 5-Minute Urology Consult – April 2000 – Gomella

The 5-Minute Urology Consult – April 2000 – Gomella

### **FEMALE & GYNECOLOGY**

Female Urology, Urogynecology, and Voiding Dysfunction – 2005 – Vasavada, Appell, Sand, Raz

Female Urology – 3<sup>rd</sup> Edition – Shlomo Raz and Larissa V. Rodriguez

Textbook of Female Urology and Urogynecology – 2<sup>nd</sup> Edition 2 volume set – Linda Cardozo & David Staskin

### **GENERAL SURGERY**

Current Surgical Therapy – 9<sup>th</sup> Edition – Cameron

### **HOUSE OFFICER - MacFARLANE**

Urology – House Officer Series 4<sup>th</sup> Edition – Macfarlane

### **KIDNEY / RENAL TRANSPLANT / DIALYSIS**

A Clinician's Guide to Donation and Transplantation – 2006 NATCO

Clinical Transplants 2007 – J. Michael Cecka and Paul I. Terasaki

Handbook of Kidney Transplantation – 4<sup>th</sup> Edition – Gabriel M. Danovitch

Handbook of Dialysis – 4<sup>th</sup> Edition – John T. Daugirdas, Peter G. Blake, & Todd S. Ing

**Handbook of Nephrology & Hypertension – 5<sup>th</sup> Edition – Christopher S. Wilcox & C. Craig Tisher**

**Handbook of Nutrition & the Kidney – 5<sup>th</sup> Edition – William E. Mitch & Saulo Klahr**

**Kidney & Urinary Tract 8<sup>th</sup> Edition 3 volume set – Robert W. Schrier**

### **PATHOLOGY**

**Atlas of Nontumor Pathology – Non-Neoplastic Kidney Diseases – D’Agati, Jennette, & Silva**

**AFIP Atlas of Tumor Pathology Series 4 – Tumors of the Kidney, Bladder, and Related Urinary Structures – Murphy, Grignon, & Perlman**

**AFIP Atlas of Tumor Pathology Series 4 – Tumors of the Adrenal Glands & Extraadrenal**

**Paraganglia – Ernest E. Lack, M.D.**

**Atlas of Tumor Pathology 3<sup>rd</sup> Series – Tumors of the Testis, Adnexa, Spermatic Cord, & Scrotum – Ulbright, Amin, & Young**

**Atlas of Tumor Pathology 3<sup>rd</sup> Series – Tumors of the Prostate Gland, Seminal Vesicles, Male Urethra, & Penis – Young, Srigley, Amin, Ulbright, and Cubilla**

### **PEDIATRIC**

**Handbook of Pediatric Urology – Baskin, Kogan, Duckett**

**Handbook of Pediatric Urology – 2<sup>nd</sup> Edition – Baskin, Kogan**

**Hinman’s Atlas of Pediatric Urologic Surgery 2<sup>nd</sup> edition – Frank Hinman, Jr., & Laurence S. Baskin**

**The Kelalis-King-Belman Textbook of Clinical Pediatric Urology – 5<sup>th</sup> Edition – Editor-In-Chief, Steven G. Docimo, Asso. Editors, Douglas A. Canning & Antoine E. Khoury**

### **PROSTATE**

**The Prostatitis Manual – 2002 – Nickel**

**An Atlas of Prostatic Diseases – 2<sup>nd</sup> Edition – Kirby**

**The ABC’s of Advanced Prostate Cancer – 2000 – Moyad, Pienta**

**100 Questions & Answers about Prostate Cancer – Pamela Ellsworth, M.D., John Heaney, MD, & Cliff Gill**

**Contemporary Issues in Prostate Cancer/a Nursing Perspective – Held-Warmkessel**

**Guide to Surviving Prostate Cancer 2<sup>nd</sup> edition – Dr. Patrick Walsh**

### **RADIOLOGY**

**Textbook of UroRadiology – 4<sup>th</sup> Edition – N. Reed Dunnick, Carl M. Sandler, Jeffrey H. Newhouse, & E. Stephen Amis, Jr.**

### **URODYNAMICS**

**Urodynamics Made Easy – Chapple, MacDiarmid**

**Managing and Treating Urinary Incontinence 2<sup>nd</sup> edition – Diane Kaschak Newman, RNC, MSN, CRNP, FAAN & Alan J. Wein, MD, PhD**

## **16. Standardized Tests and Certifications**

- a) USMLE Step 3 is an institutional requirement and must be passed by the end of the PGY I year.
- b) IRB Certification  
PGY I residents must complete the human research training requirements for IRB certification during the PGY I year.
- c) BLS/ACLS Institutional Requirement  
Must be obtained prior to beginning their PGY I and must be maintained throughout their training.
- d) In-Service Examination  
All residents are required to take the annual Urology in-service examination which is given in November. Performance on this examination is discussed with the Program Director to identify areas of weakness and develop a plan to correct any deficiencies.
- e) American Board of Urology: Board Certification  
<http://www.abu.org/certification.aspx>

Residents are responsible for becoming familiar with the eligibility criteria and processes for obtaining Board Certification from the AUA. The Program Director is available to discuss this process and assist with preparing for the examination. Residents need to include a plan for preparing for their Board Certification examination as a part of their PGY V goals.

## **X. Security**

Prevention of theft and vandalism is the responsibility of everyone. Personal belongings brought to the hospital, including coats, bags, books, etc., should be securely stored.

## **XI. Appendices**

- A. Campbell-Walsh (online access)
- B. Uro-Gynecology Rotation – Goals
- C. Covenant Medical Center/Lakeside – Delinquent Charts
- D. Surgical Patients seen in the ER – Letter from Dr. Allan Haynes
- E. DVT Prophylaxis
- F. Antimicrobial Prophylaxis for Urologic Procedures – Chart  
[www.auanet.org](http://www.auanet.org) antibiotic prophylaxis-pocket table – revises 7/2008  
(also available on Urology website:  
<http://www.ttuhsc.edu/som/urology/Residency.aspx>)
- G. Dept. Operating Policies – Procedures

- H. Instructions to New Innovations – Completing Evals, Duty Hours, and Portfolio**
- I. Evaluation forms**
- J. Leave form**
- K. New Innovations Instructions**
  - Logging Duty Hours**
  - Completing Evaluations**
  - What is a Portfolio?**
  - Scholarly Activity**
  - What is Journaling?**

## **Uro-Gynecology Rotation – Goals**

1. To review and understand primary historical and current published literature related to pelvic organ prolapse and urinary incontinence.
2. Be able to describe the normal anatomic supports of the vagina, rectum, bladder, urethra, and uterus (or vaginal cuff in the setting of prior hysterectomy), including the bony pelvic floor nerves and musculature, and connective tissue.
3. Describe the static and dynamic interrelationships and function of the pelvic organs and support mechanisms.
4. Describe the function of the normal lower urinary tract during the filling and voiding phases, and the mechanisms responsible for urinary continence.
5. Summarize the potential psychological, social, and sexual consequences of uro-gynecologic disorders.
6. Describe the principle etiologies of pelvic support defects, urinary incontinence, and fecal incontinence, including effects of pregnancy and delivery.
7. Identify the anatomic defects associated with various aspects of pelvic support disorders.
8. Characterize the major types of urinary incontinence.
9. Characterize and explain various types of urinary voiding disorders.
10. Describe the possible etiologies, diagnostic strategies, and treatment approaches for interstitial cystitis and other chronic conditions of the female bladder.
11. Describe the etiologies, prevention, diagnostic techniques, and approaches to repairing various fistulae that may involve the pelvic organs.
12. Describe the symptoms that may be experienced by a patient with pelvic support defects, urinary incontinence, or fecal incontinence.
13. Elicit an in depth focused history in a patient with a suspected pelvic support defect, urinary incontinence, or fecal incontinence.
14. Perform a focused physical examination to identify and characterize specific pelvic support defects, including:
  - a. Anterior compartment
  - b. Urethral hypermobility
  - c. Posterior compartment
  - d. Apical compartment (cervix/uterus or vaginal cuff)
  - e. Neurological examination
15. Perform a focused physical exam in a patient with urinary and/or fecal incontinence, including assessment of:
  - a. Bladder and urethral support
  - b. Perineal, levator, and anal sphincter strength
  - c. Neurologic examination

16. Perform and interpret the results of selected tests to characterize urinary incontinence disorders, including:
  - a. Assessment of residual urine volume
  - b. Simple cystometry
  - c. Q-tip test
17. Describe the indication for, perform, and interpret the results of other diagnostic tests, such as:
  - a. Urinalysis
  - b. Urine culture
  - c. Cystourethroscopy
  - d. Multichannel cystometry
  - e. Urethral profilometry
  - f. Uroflowmetry
  - g. Video urodynamics
  - h. Electromyography
  - i. Assessment of anal sphincter integrity (e.g., manometry, radiologic imaging studies, neurologic testing)
18. Become familiar with imaging studies available to evaluate the lower urinary tract. Be able to discuss indications for each study and advantages and limitations of each study. Provide a differential diagnosis of incontinence in women.
19. Treat uro-gynecologic disorders by both nonsurgical (e.g., pelvic floor exercise regimens, physical therapy, pessary) and surgical methods (vaginal, abdominal and laparoscopic, to include the use of biological and manufactured grafts).
20. Describe the types of injuries or complications that may occur related to medical and surgical treatments of uro-gynecologic disorders and the approaches to managing them.
21. Describe the appropriate follow-up for a patient who has been treated for an uro-gynecologic disorder.
22. Summarize and counsel patients regarding risks, benefits, and expected outcomes of surgical and non-surgical approaches to management of pelvic support and incontinence disorders.

**Excerpt from Section 8: Rules and Regulations - Covenant Medical Center/ Covenant Lakeside**

9. Any chart will be delinquent when:
  - a) The history and physical are not present within twenty-four (24) hours of admission.
  - b) Any portion of the chart is incomplete fifteen (15) days after the date of discharge.
10. A delinquent record that lacks a history and physical will be handled separately from all other records. The Director of Medical Records, or his designee, will notify the physician of his suspension from the Hospital. A written notification from the Chief of Staff will follow. The Director of Medical Records will notify the appropriate departments.
11. Any Practitioner with a delinquent chart will be notified by letter from the Quality Review Committee liaison physician. If those records are not completed within seven (7) days, a letter will be faxed from the Chief of Staff notifying the Practitioner of automatic suspension of all Hospital privileges, except for the care of patients presently hospitalized under his care at the time of the suspension and the responsibilities for emergency call as assigned on the call schedule.
12. In extenuating circumstances, as determined by the Chief of Staff, suspension may be deferred until the next meeting of the Medical Executive Committee, at which time a decision as to the disposition of the suspension will be made.  
Rules and Regulations - Covenant Medical Center/ Covenant Lakeside
13. Each practitioner will be prompted to review and complete their patient's medical records in an electronic format Horizon Patient Folder. All Charts that require completion, correction, or a final electronic signature will be 'flagged' automatically upon 'log in'. If the Medical Records HPF staff cannot make a record available to a Practitioner, a new available date will be entered into the computer for that record, giving the Practitioner an additional seven (7) days to complete the record.
14. When Medical Records determines that the record has not been satisfactorily completed, the physician will have (7) days to complete the records. If the physician fails to complete the records within the (7) day period, the physician's name will automatically be re-posted to the suspension list.
15. When a Practitioner has been on the suspension list for thirty (30) consecutive days, he will receive a one-month reminder letter from the Chief of Staff.
16. After forty-five days of continuous suspension, the Chief of Staff will notify the suspended Practitioner that failure to complete the delinquent records within sixty (60) days of continuous suspension will result in referral of the matter to the MEC.
17. If a physician does not complete all delinquent medical records within sixty (60) days of continuous suspension, his Medical Staff membership and clinical privileges will be terminated, unless he can provide evidence that extenuating circumstances have prevented completion of the record(s). Such termination will entitle the Member to his procedural rights under the Fair Hearing Plan of these Rules and Regulations.



TEXAS TECH UNIVERSITY  
HEALTH SCIENCES CENTER  
School of Medicine

Department of Urology

April 9, 2009

Joe Sasin, M.D.  
Emergency Medicine  
602 Indiana Avenue  
Lubbock, TX 79415

Dear Dr. Sasin:

I am writing this letter with the support of the entire faculty of the Department of Urology. As you are aware there has been some concerns regarding surgery patients that have had recent surgical procedures by the Urologic Service and their follow-up care in terms of when they returned to the ER. Briefly, we would like to advise you that the policy of the Department of Urology is that any patient that has had surgical procedures performed within the previous 90 days and presents to the Emergency Room at UMC should have a consultation with the Urologic Service. It may well be that there is nothing we need to do but we feel this would insure that patients would not be admitted and a potential complication arise because we were unaware of the problems or unaware of the admission and therefore unable to provide appropriate urologic services to prevent problems related to the surgery that had occurred.

In summary, our policy would be that any time a patient who has had surgery by the Urologic Service within the previous 90 days is seen in the emergency room, the Urologic Service should be called or the urologic resident on call with the attending backing him should be called. We would appreciate very much if we could accomplish this and if there are any questions feel free to contact me.

Sincerely,

A handwritten signature in blue ink, appearing to read "Allan L. Haynes, Jr.".

Allan L. Haynes, Jr., M.D. FACS  
Chief Adult and General Urology

ALH:rrf

## DVT Prophylaxis

**September 11, 2009**  
**DVT Prophylaxis Discussion**

**Concern:** Urologic patients are a unique subset of surgical patients regarding DVT prophylaxis in that they undergo different procedures than other surgical patients (i.e. orthopedics or general surgery patients) and have unique problems concerning DVT prophylaxis. They are at higher risk of having complications from the prophylaxis concerning bleeding due to the vascular nature of the kidney and prostate and the abrasive effects of urine crossing the surgical site.


**Area of conflict:** The UMC Guidelines promote more aggressive DVT therapies that could be detrimental to urologic patients. Residents from other specialties who may be on rotation or are the primary service for the patient may not be aware of the special needs of urologic patients.

**Area of discussion:** What is the proper DVT prophylaxis for urologic surgical patients? Are there guidelines specifically for Urologists?

**Discussion:** The AUA Best Practice Statement concerning DVT's was discussed at length as well as the UMC Guidelines.

**Resolution:** The AUA Best Practice Statement provides guidelines for DVT prophylaxis, but still relies on the decision making skills of the surgeon. It is our duty to provide education to the nursing staff and other residents who may be rotating on our service or providing joint care to our patients our specific guidelines concerning DVT prophylaxis.

WEBSITE : AUA Best Practice Statement – Prevention of Deep Vein Thrombosis in Patients Undergoing Urologic Surgery  
<http://www.auanet.org/content/media/dvt.pdf?CFID=1503271&CFTOKEN=57455969&jsessionid=8430a973f091e432f1b36e35791652f2d514>

	<h2 style="margin:0;">Adult DVT Prophylaxis Guidelines and Orders</h2>	<p>PATIENT LABEL</p>	
<b>CLINICAL RISK FACTORS FOR VTE</b>		<b>POSSIBLE EXCLUSION CRITERIA FOR PHARMACOLOGICAL VTE PROPHYLAXIS</b>	
<p>Each risk factor has a value of 1 unless otherwise noted</p>			
<input type="checkbox"/> Age > 40 yrs <input type="checkbox"/> ICU admission <input type="checkbox"/> History of VTE/PE (4) <input type="checkbox"/> Obesity <input type="checkbox"/> Stroke (ischemic) or Paralysis (4) <input type="checkbox"/> Heart failure <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> Respiratory Failure <input type="checkbox"/> Pneumonia <input type="checkbox"/> Serious Infections <input type="checkbox"/> Malignancy (4) <input type="checkbox"/> Prolonged immobility (>3 days)	<input type="checkbox"/> Active collagen-vascular disorder <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Central venous line/catheter <input type="checkbox"/> Varicose veins <input type="checkbox"/> Estrogen use <input type="checkbox"/> Trauma (4) <input type="checkbox"/> Pregnancy <input type="checkbox"/> Hypercoagulability (4) <input type="checkbox"/> Spinal cord injury (4)	<input type="checkbox"/> Active bleeding <input type="checkbox"/> Hypersensitivity to heparin or LMWH <input type="checkbox"/> Uncontrolled hypertension <input type="checkbox"/> Coagulopathy <input type="checkbox"/> Heparin Induced Thrombocytopenia (HIT) <input type="checkbox"/> Recent intra-ocular or intra-cranial surgery <input type="checkbox"/> Spinal tap or epidural anesthesia within 24hr <input type="checkbox"/> Surgical procedures placing the patient at high risk for bleeding. Assess risk vs benefit	
<p><b>Total =</b> _____</p>			
<b>LEVEL OF RISK</b>		<b>RISK FACTOR STRATIFICATION</b>	
<p>Low Risk</p>	<ul style="list-style-type: none"> <li>• Any patient with &lt; 2 risk factors</li> <li>• Minor surgery in patients &lt; 40 yr with no additional risk factors</li> </ul>		
<p>Moderate Risk</p>	<ul style="list-style-type: none"> <li>• Any patient with 2 risk factors</li> <li>• Minor surgery in patients with additional risk factors</li> <li>• Non major surgery in patients aged 40-60 yr with no additional risk factors</li> <li>• Major surgery in patients &lt;40 yr with no additional risk factors</li> </ul>		
<p>High Risk</p>	<ul style="list-style-type: none"> <li>• Any patient with 3 risk factors</li> <li>• Non major surgery in patients &gt; 60 yrs with additional risk factors</li> <li>• Major surgery in patients &gt; 40 yrs with additional risk factors</li> </ul>		
<p>Very High Risk</p>	<ul style="list-style-type: none"> <li>• Any patient with ≥ 4 risk factors</li> <li>• Major surgery patients &gt; 40 yrs with history of VTE, CA or molecular hypercoagulable state</li> <li>• Hip or knee arthroplasty</li> <li>• Surgical repair of hip fracture</li> </ul>		
<b>THERAPEUTIC RECOMMENDATIONS</b>			
<input type="checkbox"/> LOW RISK	<input type="checkbox"/> MODERATE RISK	<input type="checkbox"/> HIGH RISK	<input type="checkbox"/> VERY HIGH RISK
Early ambulation Consider elastic stockings	Low dose unfractionated heparin 5,000 units q12h OR SCD	Low dose unfractionated heparin 5,000 units q8h OR Enoxaparin OR SCD	Enoxaparin AND SCD

- Elastic stockings:  Both legs  Right leg  Left leg
- Sequential compression device (SCD) for the leg/calf:  Both legs  Right leg  Left leg
- Unfractionated heparin 5,000 units SC q12h
- Unfractionated heparin 5,000 units SC q8h
- Enoxaparin 40 mg SC q24h
- Enoxaparin 30 mg SC q12h (knee replacement, hip replacement/fracture, trauma)
- Enoxaparin 30 mg SC q24h (creatinine clearance < 30 ml/min)
- Other: \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date/Time \_\_\_\_\_

\*These recommendations are intended as a guideline only and may not be appropriate for all clinical situations. Clinicians should use professional judgment when making decisions.

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER:	4.1															
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE:																
TITLE: <b>WET PREP - OBTAINING SPECIMEN</b>		PAGE: 1 OF 2																
<p><b>A: PURPOSE:</b> To obtain specimen from vaginal secretions for examination to identify yeast or trichomonas. Also to obtain semen for examination for the presence of sperm.</p> <p><b>B: GENERAL INSTRUCTIONS:</b> This procedure is to be performed by either a physician or a trained nurse. Usually, this test is performed when obtaining a pap smear and smear for G.C. (gonorrheal culture). This is not a sterile procedure.</p> <p><b>C: EQUIPMENT:</b></p> <table border="1" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>If sent to the lab:</b> Hematology tube (large or small) 1 ml sodium chloride (placed inside test tube) 1 sterile applicator</p> </td> <td style="width: 50%; vertical-align: top;"> <p><b>If checked in the clinic:</b> Slide Cover plate Potassium hydroxide 20% (change yearly) 1 sterile applicator</p> </td> </tr> </table> <p><b>D: PROCEDURE:</b></p> <table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 35%; text-align: center;">STEPS</th> <th style="width: 35%; text-align: center;">POINTS TO REMEMBER</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td>Explain procedure to patient</td> <td>Explain that a pelvic examination will be done. To do this test, a swab will be inserted into the vagina to obtain specimen of vaginal secretion.</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Assist the patient in preparation for the examination by removal of necessary clothing and positioning the patient for the pelvic exam.</td> <td>Drape the patient to provide as little exposure as possible.</td> </tr> <tr> <td style="text-align: center;">3</td> <td>Assist the physician with the exam.</td> <td>Check with the physician as to where the specimen will be examined and prepare as indicated. The nurse will open the sterile applicator for the physician; hold the removal of the applicator (usually the specimen for the G.C. will be obtained with one of the applicators first then the second applicator used for the wet prep. If specimen sent to the lab, remove the stopper from the test tube with normal saline for the applicator to be placed in the solution. The physician may wish to break the applicator and leave it in the tube. Replace the cap on the tube. If examined in the clinic, hold slide for smear.</td> </tr> </tbody> </table>					<p><b>If sent to the lab:</b> Hematology tube (large or small) 1 ml sodium chloride (placed inside test tube) 1 sterile applicator</p>	<p><b>If checked in the clinic:</b> Slide Cover plate Potassium hydroxide 20% (change yearly) 1 sterile applicator</p>		STEPS	POINTS TO REMEMBER	1	Explain procedure to patient	Explain that a pelvic examination will be done. To do this test, a swab will be inserted into the vagina to obtain specimen of vaginal secretion.	2	Assist the patient in preparation for the examination by removal of necessary clothing and positioning the patient for the pelvic exam.	Drape the patient to provide as little exposure as possible.	3	Assist the physician with the exam.	Check with the physician as to where the specimen will be examined and prepare as indicated. The nurse will open the sterile applicator for the physician; hold the removal of the applicator (usually the specimen for the G.C. will be obtained with one of the applicators first then the second applicator used for the wet prep. If specimen sent to the lab, remove the stopper from the test tube with normal saline for the applicator to be placed in the solution. The physician may wish to break the applicator and leave it in the tube. Replace the cap on the tube. If examined in the clinic, hold slide for smear.
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TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER: 4.1	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE:	
TITLE: <b>Wet Prep - Obtaining Specimen</b>		PAGE: 2 OF 2	
<b>STEPS</b>		<b>POINTS TO REMEMBER</b>	
4	Label test tube or slide. Fill out request on laboratory slip if specimen goes to laboratory.	The slide must be labeled on frosted side with pencil; a stick - on label must be used for test tube.	
5	Assist patient in getting dressed.	Giving patient tissues for drying perineum.	
6	If the specimen is to be sent to the laboratory, continue as for any specimen which goes to the clinical laboratory.		

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER:	4.2	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: EFFECTIVE DATE: 7/1/2006		
TITLE: <b>RENAL ULTRASOUND</b>		PAGE: 1 OF 1		
<p><b>A: PURPOSE:</b> Abdominal mass, urinary calculi, recurrent urinary tract infections, febrile urinary tract infections, blood in urine.</p> <p><b>B: PERSONNEL:</b> It is the policy of the Urology Clinic for the urology tech and nurses to assist with the performance of renal ultrasound when deemed necessary by the physician.</p> <p><b>C: EQUIPMENT:</b> High - frequency sound waves (varying from 5,000 t 20,000 hertz) are used to image the organs of the urinary and reproductive systems. These organs include kidneys, ureters, bladder, prostate, and testes. Ultrasonography offers distinct advantages, since radiation exposure is avoided, several images can be obtained and repeated over a short period of time.</p> <p><b>D: PROCEDURE:</b> <b>STEPS</b></p> <ol style="list-style-type: none"> <li>1 Explain procedure</li> <li>2 Position patient appropriately.</li> <li>3 Prepare ultrasound machine by entering patient name and medical record number.</li> <li>4 Prepare probe with KY jelly.</li> <li>5 Conducting jelly is spread on the patient's abdomen or back, and axial (transverse) and longitudinal (saggital) images are obtained. A renal scan will image renal parenchyma, including the pyramids, calyccs, and renal pelvis. Longitudinal and sagittal measurements of the kidneys may be obtained.</li> <li>6 Hydronephrosis can be detected, as well as dilated renal pelvis and ureters, calculi produce a shadow below the stone as they block sound waves; tumors and cyst can also be seen.</li> </ol> <p><b>E: CONTRAINDICTIONS:</b> None</p>				

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER:	4.3	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: EFFECTIVE DATE: 7/1/2006		
TITLE:		<b>PROSTATE ULTRASOUND/BIOPSY</b>		PAGE: 1 OF 1
<p><b>A: PURPOSE:</b></p> <p>To obtain material for microscopic examination of tissue suspect for malignant cells. Abnormal Digital Rectal Exam. Elevated prostatic specific antigen.</p> <p><b>B: PERSONNEL:</b></p> <p>It is the policy of the Urology Clinic for the urology tech and nurses to assist with the performance of renal ultrasound when deemed necessary by the physician.</p> <p><b>POLICY AND GENERAL</b></p> <p><b>C: INSTRUCTIONS:</b></p> <p>Prostate tissue is obtained by a hollow needle guided by ultrasound. A transrectal route is used, and a biopsy "gun" is inserted into a holder attached to the ultrasonic probe. Several specimens from the area of interest are obtained.</p> <p><b>D: PROCEDURE:</b></p> <p style="padding-left: 40px;"><b>STEPS</b></p> <ol style="list-style-type: none"> <li>1 Obtain signed consent.</li> <li>2 Explain procedure.</li> <li>3 Assist patient to left lateral knee chest position.</li> <li>4 Prepare ultrasound machine by entering patient Medical Record Number.</li> <li>5 Prepare rectal probe with ultra sound cover.</li> <li>6 Familiarize patient with sound of biopsy instrument</li> <li>7 Have at least 10 containers of 10% formalin</li> <li>8 When biopsy is obtained, place in 10% formalin. Rinse needle in sterile water</li> <li>9 Label specimens with exact site, patient's name, date, physician's name, and medical record number.</li> <li>10 Complete lab requisition, place specimen in appropriate bags and place in pick up box or carry to the lab.</li> <li>11 Patient is instructed to have family member or friend available to drive him home.</li> <li>12 Instruct patient to "force fluids" for next 6 - 8 hours to reduce bleeding.</li> <li>13 Call the clinic or go to ER if unable to void, or fever of 101.</li> <li>14 Keep follow-up appointment for results of biopsy.</li> </ol> <p><b>E: CONTRAINDICATIONS:</b></p> <p>Inability of patient to cooperate. Abnormal clotting factors.</p>				

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE	NUMBER: 4.4	
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PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: EFFECTIVE DATE: 7/1/2006
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TITLE: <b>INCISION AND DRAINAGE OF ANY ABSCESS</b>	PAGE: 1 OF 1
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**A: PURPOSE:**

To drain abscess formation either from a spontaneously or mechanically formed abscess.

**B: PERSONNEL:**

Trained nursing personnel.

**POLICY AND GENERAL**

**C: INSTRUCTIONS:**

- 1 This is a sterile procedure performed by the physician.
- 2 Cultures are taken
- 3 A special form is filled out on all hospital dismissals that have an infection. This is called a UMC Report of Post Discharge Infection, kept with the laboratory.

**C: EQUIPMENT:**

Xylocain 1% Minor Tray Knife Blades #15 Cultures Tube (anna. & aerob.) H2O2 Iodoform Gauze Penrose Drains	Sterlie Gloves Small Plastic Garbage Bags 10 ml. Syringe 25 G. 5/8" Needle Plastic Pad Skin Prep Solutions Sterile H2O2 Label
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**NOTE: FOR POST – OPERATIVE ABSCESS:  
COMPLETE REPORT TO INFECTIOUS CONTROL**

**D: PROCEDURE:**

**STEPS**

- 1 Obtain signed consent.
- 2 Explain procedure.
- 3 Open minor tray.
- 4 Scrub & Glove.
- 5 Take supplies offered by nurse.
- 6 Remove amount of iodoform gauze that will be necessary for packing wound to prevent contaminating the remaining gauze.
- 7
  - (A) Position patient on procedure table plastic pad beneath drainage site.
  - (B) Check that patient's position is comfortable and caution patient that he/she must lie still until procedure is completed.
- 8
  - (A) Assist physician in procedure.
  - (B) Culture is to be taken immediately upon sight of purulent drainage.
- 9 Clean wound and dress as directed.
- 10 Instruct patient to call clinic or go to ER if fever of 101.
- 11 Keep follow-up appointment.

**\*LABEL AND SEND SPECIMEN TO LAB.**

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER		NUMBER:	4.5	
DEPARTMENT OF UROLOGY POLICY AND PROCEDURE				
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: EFFECTIVE DATE: 7/1/2006		
TITLE: <b>SKIN TEST FOR CONTINGENT/COLLAGEN IMPLANT</b>		PAGE: 1 OF 1		

**A: PURPOSE:**

The skin test Contigen implant is administered intradermally into the forearm and evaluated over a four week period to screen out individuals who might develop hypersensitivity to injectable bovine dermal collagen devices.

**B: PERSONNEL:**

All trained nursing personnel, RN, LVN

**POLICY AND GENERAL**

**C: INSTRUCTIONS:**

This procedure is performed by a trained nurse.

**D: EQUIPMENT:**

Alcohol swab  
Pre-filled syringe containing Contigen

**E PROCEDURE:**

	STEPS	POINTS TO REMEMBER
1	Explain the procedure to the patient.	Give patient the Contigen Patient Information booklet.
2	Clean injection site with alcohol swab	
3	Inject contents of syringe intradermally into forearm.	
4	Instruct the patient to observe the injection site carefully and periodically over a four week period, beginning six hours following administration of the skin test.	
5	Dispose of syringe and needle in Sharps container.	
6	Instruct patient to report any signs or symptoms of adverse reactions to the device.	Review skin test card with patient, going over S/S of adverse reaction.
7	Schedule follow - up in five to six weeks for evaluation of skin test site.	

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER:	4.6	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: 5/8/2009		
TITLE: <b>FLEXIBLE CYSTOSCOPY</b>		PAGE: 1 OF 1		
<p><b>A: PURPOSE:</b> To permit visualization of the urethra and the bladder for diagnostic and Therapeutic procedures with minimal trauma or discomfort to the patient.</p> <p><b>B: PERSONNEL:</b> Physician, nurse (to assist with procedure).</p> <p><b>C: POLICY AND GENERAL INSTRUCTIONS:</b> A procedure performed by the physician.</p> <p><b>C: EQUIPMENT:</b> Flexible Cystoscope Light source 500ml 500 ml 0.9% sodium chloride Cysto pack Sterile 4x4 tray and prep solution. Use alternative antiseptic solution if patient has allergy to Betadine, KY jelly; lidocaine uro-jet sterile gloves, face shield (optional), cysto tubing, and drainage pan.</p> <p><b>D: PROCEDURE:</b></p> <ol style="list-style-type: none"> <li>1 Explain procedure to patient.</li> <li>2 Obtain signed consent.</li> <li>3 Female patients are placed in lithomy position, sterile drapes positioned, perineum is prepped with Betadine solution (Hibiclens if patient is allergic to Betadine).</li> <li>4 Male patients may lie flat, sterile drapes positioned, perineum prepped with Betadine (Hibiclens if patient is allergic to Betadine).</li> <li>5 Prepare a sterile field on a cart; place supplies on sterile field using sterile technique.</li> <li>6 Administer uro-jet, wait approximately 10 minutes before starting procedure.</li> <li>7 Assist physician by handling equipment.</li> </ol> <p><b>*ASK ALL PATIENTS IF THEY NEED SBE PROPHYLAXIS</b> <b>INDICATION:</b> Recurrent urinary tract infections, dysuria, urinary incontinence, hematuria, BPH, history of bladder cancer, and as directed by physician.</p>				

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER:	4.10	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: EFFECTIVE DATE: 7/1/2006		
TITLE:		<b>PENILE INJECTION TEST</b>		PAGE: 1 OF 1
<p><b>A: PURPOSE:</b> Assessment of erectile dysfunction</p> <p><b>B: PERSONNEL:</b> Physicians</p> <p><b>C: POLICY AND GENERAL INSTRUCTIONS:</b> Diagnostic test performed by physician.</p> <p><b>D: EQUIPMENT:</b> Medication, syringe with 26g ½ ‘ needle</p> <p><b>E: PROCEDURE:</b></p> <ol style="list-style-type: none"> <li>1 Explain the procedure to the patient.</li> <li>2 The penis is placed or stretched by holding the head with the fingers of the left hand.</li> <li>3</li> <li>4 The injection site is selected thoroughly cleansed with an alcohol sponge. Any location in the upper outer portion of either side of the penis can be used as an injection site. If one looks at the cross section of the penis as the face of a clock, this would be the 10 o’clock position (right side) or the 2 o’clock position (left side).</li> <li>5 The injection should not be given into the head of the penis and enough room should be left at the base near the body to constrict that area between 2 fingers.</li> <li>6 The needle, with syringe attached and filled with proper dose of medication, is quickly placed through the skin at 45 degree angle as far in as the needle will go, using the right hand.</li> <li>7 Prior to injection of the solution, the base where the penis joins the body is gently squeezed between the middle and index fingers of the left hand.</li> <li>8</li> <li>9 The medicine is slowly injected and during injection a mild tingling sensation may be noted in the penile shaft.</li> <li>10 After the medicine is injected, the needle is quickly removed and the injection site compressed with an alcohol pad, using the right hand while construction at the base is maintained between the middle and index finger of the left hand. Little, if any, bleeding is usually encountered after removing the needle.</li> <li>11 A circular rubbing motion of the alcohol pad will help distribute the medicine through the erectile bodies.</li> <li>12 This rubbing motion and constriction of the base between 2 fingers should be continuous for about 30 sec. There is communication between the erectile bodies and medicine injected into one will easily gain access to the other. (Monitoring of vital signs is advised for approximately 30 minutes.</li> <li>13 Observation for erection is observed for 30 minutes.</li> <li>14 Second injection may be given at Physician’s direction.</li> <li>15 Instruct patient to observe for prolonged erection, which is fully hard beyond 4 hours. This should be reversed. Contact Physician immediately, if after clinic hours go to UMC ER.</li> </ol>				

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER:	4.15	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE:		
TITLE:		<b>BLADDER TREATMENT (BCG)</b>		PAGE: 1 OF 1
<p><b>A: PURPOSE:</b></p> <p>BCG bladder treatment is indicated for intravesical use in the treatment of primary and relapsed carcinoma in-situ of the urinary bladder to eliminate residual tumor cells and to reduce the frequency of tumor recurrence. It is indicated for the treatment of carcinoma in-situ with or without associated papillary tumors.</p> <p><b>POLICIES &amp; GENERAL</b></p> <p><b>B: INSTRUCTIONS:</b></p> <ol style="list-style-type: none"> <li>1 Explain procedure to patient.</li> <li>2 Patient is to empty bladder completely. Obtain a voided urine specimen to rule out possibility of urinary tract infection.</li> <li>3 Catheterize patient using sterile technique. Drain bladder completely.</li> <li>4 Instill drug intravesically by gravity via the catheter.</li> <li>5 Slowly withdraw catheter.</li> <li>6 Double red – bag all products from procedure for proper disposal.</li> <li>7 <b>DO NOT INSTILL BCG IF PATIENT REPORTS BLOOD IN URINE OR HEMATURIA IS NOTED.</b> Call Physician for orders.</li> <li>8 Medication should be retained for 2 hours, changing patient’s position every 15 minutes to ensure all areas of bladder are coated with drug.</li> <li>9 After patient has retained medication for 2 hours, instruct patient to sit down on the commode and empty bladder.</li> <li>10 After patient has urinated, pour 2 cups bleach into the commode; let mixture stand for 15-20 minutes before flushing.</li> <li>11 Instruct the patient to repeat this process for the first 6 hours after treatment. Wash hands and genital area thoroughly after urination.</li> <li>12 Instruct patient to increase fluids.</li> <li>13 Instruct patient to <b>CALL PHYSICIAN</b> if he/she experiences urgency, frequency, bright red blood or blood clots, joint pain, coughing, skin rash, fever, chills, fatigue, or flu-like symptoms.</li> </ol> <p><b>C: CONTRAINDICATIONS:</b></p> <p>Patients on immunosuppressive therapy or with compromise immune systems should not receive this treatment due to overwhelming systematic mycobacterial sepsis.</p> <p>Should not be given to patients with fever unless fever is determined and evaluated. If fever is due to an infection, treatment should be held until patient is afebrile.</p> <p>Patients with urinary tract infections should not receive BCG treatments because administration may result in the risk of disseminated BCG infection or severity of bladder irritation.</p>				

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER: 4.16	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: 5/11/2009	
TITLE: <b>SUTURE REMOVAL AND SKIN CLIP REMOVAL</b>		PAGE: 1 OF 1	
<p><b>A: PURPOSE:</b> To provide proper technique with suture removal or skin clip removal.</p> <p><b>B: PERSONNEL:</b> Trained nursing staff.</p> <p><b>C: POLICY AND GENERAL INSTRUCTIONS:</b> This is a clean procedure to remove suture skinclips or staples.</p> <p><b>D: PROCEDURE:</b></p> <p><b>Suture removal equipment</b></p> <ol style="list-style-type: none"> <li>1. Scissors, forceps</li> <li>2. (or) disposable suture removal kit</li> <li>3. sterile 4x4s</li> <li>4. tincture of benzoin swabs</li> <li>5. steri-strips</li> </ol> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. Explain procedure to patient.</li> <li>2. Pull suture up with forceps and clip the stitch under the knot and remove from patient</li> <li>3. Apply tincture of benzoin to skin along incision-do not apply directly to incision. Place steri - strips across incision.</li> </ol> <p><b>Skin clip removal equipment</b></p> <ol style="list-style-type: none"> <li>1. Skin clip remover</li> <li>2. Sterile 4x4s</li> <li>3. Steri-strips</li> <li>4. Tincture of benzoin</li> </ol> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. Place skin clip remover under the skin clip and remove from patient.</li> <li>2. Apply tincture of benzoin to skin.</li> <li>3 Place steri-strips across incision.</li> <li>4. Keep follow-up appointment.</li> </ol>			

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER:	4.18	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: 5/11/2009		
TITLE:		ULTRASOUND BLADDER & KIDNEYS, URETERS, PROSTATE TESTES		PAGE: 1 OF 1
<p><b>A: PURPOSE:</b></p> <p>Bladder stones, frequent urinary tract infections, postvoid residuals, testicular mass, post-hydrocele aspiration.</p> <p><b>B: PERSONNEL:</b></p> <p>Physician and trained nursing staff</p> <p><b>C: POLICY AND GENERAL INSTRUCTIONS:</b></p> <p>Ultrasound machine // High - frequency sound waves (varying from 5,000 to 20,000hertz) are used to image the organs of the urinary and reproductive structures. These organs include kidneys, ureters, bladder, prostate and testes. Ultrasound offers a distinct advantage; since radiation exposure is avoided, several images can be obtained, and repeated over a short period of time.</p> <p><b>D: PROCEDURE:</b></p> <ol style="list-style-type: none"> <li>1 Explain procedure.</li> <li>2 The patient is placed supine position. Sonolucent bladder images are obtained when urine is present in the lower urinary tract.</li> <li>3 The relative thickness of the bladder and some of its architectural features also are noted. Dilated ureters are visible, although a normal ureter can not be distinguished. Comparison of full and postvoid bladder volumes allows evaluation of micturition. A quantitative estimation of bladder of volume may be obtained.</li> <li>4 Imaging of the testicular parenchyma is used to detect masses, and fluid collection.</li> </ol>				

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER: 4.19	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: 5/11/2009	
TITLE: <b>UROFLOWMETRY</b>		PAGE: 1 OF 1	

**A: PURPOSE:**

Urinary incontinence, recurrent urinary tract infection, dysuria, BPH.

**B: PERSONNEL:**

Trained nursing staff.

**C: POLICY AND GENERAL INSTRUCTIONS:**

- 1 The urinary flow or uroflowmetry reflects the final result of the micturition process consisting of:

Detrusor function, bladder neck opening and urethral conductivity. An abnormal flow rate indicates impaired voiding, but does not permit exact localization of the suspected dysfunction.

- 2 Patient cooperation is essential and psychological discomfort has to be minimized in order to obtain a voiding representative of the habitual pattern during flow measurement.
- 3 The procedure is non-invasive and the patient can be left in privacy.
- 4 Under acute conditions and after instrumentation of the lower urinary tract, voiding may be non-representative and flow measurements therefore unreliable. Both too high and too low flow rates may be recorded; therefore, uroflowmetry should be performed as the initial procedure.

**D: EQUIPMENT:** Flow transducer and Commode chair (for females only)

- 1 Explain procedure to patient.
- 2 The patient should be instructed to hydrate himself/herself well before the procedure to guarantee a full bladder and a strong urge to void.
- 3 The patient should be instructed to relax.
- 4 Male patients should stand if possible and female patients should sit on the commode chair.
- 5 The patient should be instructed to refrain from having a bowel movement during the procedure.
- 6 The nurse should explain the procedure to the patient.
- 7

In some patients it will be necessary to do a fill-pull-flow; a foley catheter or a urodynamic catheter is inserted, using sterile catheterization technique, and the patient's bladder is filled to maximum capacity with sterile H<sub>2</sub>O or a 9% sodium chloride solution and the catheter is then removed. The patient is instructed to void in a normal manner.

**E: CONTRAINDICATIONS:**

Patients on medications that affect urinary tract.

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER:	4.20	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: 5/11/2009		
TITLE:		<b>URODYNAMICS</b>		PAGE: 1 OF 1
<p><b>A: PURPOSE:</b> Assess bladder function.</p> <p><b>B: PERSONNEL:</b> Trained nursing staff.</p> <p><b>C: EQUIPMENT:</b> Urodynamic Machine, urodynamic catheters, transducers, tubing 1000 ml bag sterile water, sterile gloves, Iodine swabs, tape, syringes of various sizes.</p> <p><b>E: PROCEDURE:</b></p> <ol style="list-style-type: none"> <li>1 Obtain signed consent.</li> <li>2 Explain the procedure to patient (if infected do not continue, notify physician and send urine for C&amp;S and treat accordingly).</li> <li>3 Instruct patient to void into "flow machine" check specimen to rule out infection.</li> <li>4 Cleanse urethra with iodine.</li> <li>5 Catheterize patient with straight catheter to ensure bladder is empty.</li> <li>6 Introduce vaginal and rectal catheters and connect to urodynamic tubing and transducers. Tape securely in place.</li> <li>7 Proceed with bladder filling asking patient to respond when patient has first sensation to urinate, normal sensations to urinate and urges, marking each with event marker on control unit.</li> <li>8 Patient will be asked to cough several times during the procedure to check for proper catheter placement and abdominal pressures and urine leakage.</li> <li>9 When filling phase of the procedure is complete patient will be asked to empty their bladder again. At this time the urine is measured to determine if any "residual" urine is left in the bladder.</li> <li>10 When study is completed the patient will be scheduled to see the doctor for discussion of the results.</li> <li>11 Clean urodynamic equipment according to manufacturers' instruction.</li> </ol>				

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER:	4.21	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: 5/11/2009		
TITLE: <b>VASECTOMY</b>			PAGE: 1 OF 1	

**A: PURPOSE:**

For purpose of sterility in the male.

**B: PERSONNEL:**

Trained nursing personnel & physicians.

**C: POLICY AND GENERAL INSTRUCTIONS:**

This is a sterile procedure performed by the physician which consists of resection of a segment of the vas deferens and ligating each end.

**D: EQUIPMENT:**

Betadine scrub tray	2 specimen bottles of 10% formalin 2
Vas tray	tissue request forms
Sterile gloves	2 labels for bottles
Lidocaine w/o epinephrine	4 extra mosquito forceps
Bovie with spatula tip	Neosporin ointment
Sterile drape sheet	4-0 Chromic
#15 knife blade	2-0 silk ties

**E: PROCEDURE:**

	STEPS	POINTS TO REMEMBER
1	Explain procedure.	
2	Have patient sign operative permit. (If Medicaid, the patient is to sign the permit for sterilization 31 days prior to the operation).	Explain to patient that this is a permanent procedure.
3	Position patient on table and prep patient for operation.	Be careful to have patient dry following the prep.
4	Apply the grounding pad for Bovie.	Take special precautions that pad is making good contact with the skin. If necessary, shave the area.
5	Prepare the instruments and supplies for the procedure.	
6	Assist the physician as necessary.	
7	Prepare and label 2 specimen containers, labeled right and left respectfully.	This is very important for identification of each vas in case sperm is still present following vasectomy.
8	Instruct patient as to care of scrotum and to wear the scrotal support.	Patient is cautioned to wear a scrotal support or tight fitting shorts. Patient is cautioned to refrain from any strenuous exercise the remainder of day to prevent hemorrhage.
9	Instruct patient regarding precautions during sexual relations as directed by physician.	Patient is to refrain from unprotected intercourse for 1 month and until report of semen returns negative.
10	Give patient a request for semen count to be done at a designed date.	Instruct patient in the procedure for obtaining specimen. It must be a fresh specimen obtained after arriving in laboratory; sperm live only a few minutes.

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER: 4.22			
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: 5/11/2009			
TITLE: <b>HEMOCULT SCREENING</b>		PAGE: 1 OF 1			
<p><b>A: PURPOSE:</b> To provide a rapid, convenient and qualitative method for detecting fecal occult blood.</p> <p><b>B: PERSONNEL:</b> This procedure is performed by physician, resident, or trained nursing staff.</p> <p><b>C: EQUIPMENT:</b> Exam gloves Hemocult slides Hemocult developer K-Y jell</p> <p><b>E: PROCEDURE:</b></p> <ol style="list-style-type: none"> <li>1 Explain procedure to patient.</li> <li>2 Obtain thin smear of stool inside Box A.</li> <li>3 Obtain thin smear inside of Box B.</li> <li>4 Close cover flap. (Wait 3 to 5 minutes before developing. *Rational: to allow for sample to penetrate test paper.</li> <li>5 To develop the test, open the back of the slide and apply two drops of developer to guaiac paper directly over each smear.) Read test results within 60 seconds. Any tracer of blue on or at the edge of the smear is a positive result for occult blood.</li> <li>6 Developing the performance monitor feature. Apply one drop of developer between the positive (+) and negative (-) performance monitor area. Read the results within 10 seconds.</li> <li>7 After reading, discard in the in the trash.</li> <li>8 For quality check, the physician must document in the progress note that the control is (+), in addition to the results.</li> </ol> <p style="text-align: center;"><b>POINTS TO REMEMBER</b></p> <ol style="list-style-type: none"> <li>1 If the slide and developer are functional, a blue color will appear in the performance monitor area.</li> <li>2 If the performance monitor area does not react after applying the developer, the test results should be regarded as INVALID.</li> </ol> <p><b>NOTES</b></p> <table border="1" style="width: 100%;"> <tr> <td>           Substances which can cause false positive (+) test:           <ol style="list-style-type: none"> <li>1. Red meat, processed meat</li> <li>2. raw vegetables and fruits like horseradish, turnips, melons, and radishes</li> <li>3. application of antiseptic with iodine to anal areas</li> </ol> </td> </tr> <tr> <td>           Substances which can cause false negative (-) test:           <ol style="list-style-type: none"> <li>1. vitamin C taken in excess 250 mg per day</li> <li>2. excessive amounts of vitamin C enriched foods (citrus fruits and juices)</li> <li>3. iron supplements with vitamin C &gt; 250 mg per day</li> </ol> </td> </tr> </table>				Substances which can cause false positive (+) test: <ol style="list-style-type: none"> <li>1. Red meat, processed meat</li> <li>2. raw vegetables and fruits like horseradish, turnips, melons, and radishes</li> <li>3. application of antiseptic with iodine to anal areas</li> </ol>	Substances which can cause false negative (-) test: <ol style="list-style-type: none"> <li>1. vitamin C taken in excess 250 mg per day</li> <li>2. excessive amounts of vitamin C enriched foods (citrus fruits and juices)</li> <li>3. iron supplements with vitamin C &gt; 250 mg per day</li> </ol>
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TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF UROLOGY POLICY AND PROCEDURE		NUMBER: 4.23	
PREPARED BY: Bowie McGinnis Administrator	APPROVED BY: Werner deRiese, M.D. Chairman	ESTABLISHED DATE: 7/1/06 REVISION DATE: EFFECTIVE DATE: 7/1/2006	
TITLE: <b>MICROSCOPIC EXAMINATION OF URINARY SEDIMENT</b>		PAGE: 1 OF 1	
<p><b>A: PURPOSE:</b> Examine urine cells if dip stick urine is abnormal or as directed by the physician.</p> <p><b>B: PERSONNEL:</b> Slide prepared by nursing staff and read by physician.</p> <p><b>C: EQUIPMENT:</b></p> <ul style="list-style-type: none"> <li>Test Tubes</li> <li>Centrifuge</li> <li>Slides</li> <li>Cover Slips</li> </ul> <p><b>E: PROCEDURE:</b></p> <ol style="list-style-type: none"> <li>1 Gloves are to be worn.</li> <li>2 Take 10-15 ml of urine, place it in a test tube and spin for 5 minutes in the centrifuge.</li> <li>3 Pour off all fluid, tap tube against counter to loosen cells.</li> <li>4 Place one drop of fluid on slide, place cover slip over fluid.</li> <li>5 Slide is ready to be examined by physician.</li> </ol>			



## TTUHSC - Urology Faculty Evaluation by Residents and Students

Evaluator:      Subject:

Status:

Rotation:

Please rate the program faculty member in the following areas.

**Unsatisfactory** = Several behaviors performed inadequately or missed (ratings 1,2, or 3)

**Satisfactory** = Most behaviors performed acceptably (ratings 4,5,or 6)

**Superior**= All behaviors performed very well (ratings 7,8, or 9)

1) Interest in Teaching

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2) Ability to teach surgical Technique

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3) Ability to teach Research Technique

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4) Commitment to the educational program

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5) Ability to motivate

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6) Approachability / Availability

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7) Receptiveness to questions

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8) Medical Knowledge

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9) Scholarly and research activities

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



6) Communicates effectively with patients and their families

Allows patient to tell his/her own story; listens attentively; uses non-technical language when explaining & counseling; involves patient or family in decision-making; encourages questions & checks for understanding

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7) Communicates effectively with other healthcare professionals

Maintains complete & legible medical records; writes clear & concise consultation reports & referral letters; makes organized & concise presentations of patient information; gives clear & well-prepared presentations at conferences

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8) Works effectively with other members of the healthcare team

Demonstrates courtesy to and consideration of consultants, therapists, & other team members; invites others to share their knowledge & opinions; makes requests not demands; negotiates & compromises when disagreements occur; handles conflict constructively

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**MEDICAL KNOWLEDGE**

9) Demonstrates basic science and clinical knowledge

Is able to identify & discuss pathophysiology of urologic disease processes; can intelligently discuss diagnosis; evaluation & treatment of common urologic disorders; applies knowledge to solve clinical dilemmas; understands rationale for varied approaches to clinical problems

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10) Demonstrates up-to-date knowledge

Seek new information by searching the literature & asking questions; cites recent literature when appropriate; asks knowledgeable & well-informed questions

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11) Uses knowledge and analytical thinking to address clinical questions

Uses effective problem solving techniques; demonstrates sound clinical judgment; applies analytical approach to clinical situations

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**PRACTICE BASED LEARNING & IMPROVEMENT**

12)

Tracks and analyzes practice to identify areas for improvement

Uses systematic approach such as chart or case analysis, or surgical log review to track own practice; compares own outcomes to accepted guidelines & national or peer data; reflects on critical incidents to identify strengths & weaknesses; monitors effects of practice changed & improvements

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13)

Engages in ongoing learning

Determines how learning deficits or weaknesses can be addressed; seeks feedback; does extra reading & surgical practice when needed; seeks information from the literature; critically appraises research evidence for applicability to patient care; uses information technology (IT) resources to aid learning

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14)

Implements improvement activities

Changes practice patterns & other behaviors in response to feedback; applies new skills or knowledge to patient care; tailors research evidence to care of individual patients; uses IT to improve patient care

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15)

Facilitates the learning of others

Explains clinical reasoning & procedures to junior colleagues & medical students; provides clinically useful information in response to learner questions; directs learners to useful resources; provides coaching

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**PATIENT CARE**

16)

Demonstrates outpatient assessment and management

Obtains complete & accurate patient histories; performs thorough & appropriate physical exams; orders appropriate laboratory & radiological tests; integrates information meaningfully & coherently; generates appropriate differential dx

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17) **Manages hospital inpatients**

Develops appropriate evaluation & treatment plan for preoperative & postoperative patients; anticipates patient needs in the hospital setting; effectively identifies & manages postoperative clinical problems; writes clear & appropriate orders; plans outpatient follow-up visits as needed

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18) **Prepares for surgical cases**

Can discuss rationale & risks of commonly performed surgical cases; reads about surgical procedures in advance; demonstrates knowledge of important steps & instruments in specific surgical cases

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19) **Demonstrates surgical skill in performing endoscopic procedures**

Demonstrates surgical proficiency & technical ability during endoscopic procedures such as cystoscopy, ureteroscopy, & percutaneous renal surgery

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20) **Demonstrates surgical skill in performing open surgical cases**

Demonstrates surgical proficiency & technical ability during commonly performed open surgical procedures

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21) **Demonstrates surgical skill in performing laparoscopic procedures**

Demonstrates surgical proficiency & technical ability during laparoscopic procedures

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**SYSTEM BASED PRACTICE**

22) **Provides cost-conscious medical care**

Considers costs and benefits of tests & treatments; adheres to established patient care pathways; does not order unnecessary tests; uses appropriate billing codes for outpatient visits & surgical procedures

UNSATISFACTORY			SATISFACTORY			SUPERIOR			N/A
1	2	3	4	5	6	7	8	9	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

23) **Identifies system causes of medical error; anticipates & responds to patient care problems; adheres to surgical**

Works to promote patient safety

protocols that ensure patient safety; accepts input from the patient care team

1      UNSATISFACTORY      2      3      SATISFACTORY      4      5      6

7      SUPERIOR      8      9      N/A

24) Coordinates care with other healthcare providers

Obtains consultation when needed; communicates with other providers; resolves differences in treatment plans; reconciles contradictory advice

1      UNSATISFACTORY      2      3      SATISFACTORY      4      5      6

7      SUPERIOR      8      9      N/A

25) Facilitates patient care in the larger healthcare community

Understands different healthcare delivery systems & medical practices; assures patient awareness of available care options; makes appropriate referrals; assists with arrangements & follow-up to ensure appropriate care

1      UNSATISFACTORY      2      3      SATISFACTORY      4      5      6

7      SUPERIOR      8      9      N/A

**Comments and/or Observations**

26) Comments

Comments

Remaining Characters: 5000

[Return to Questionnaire](#)

**RESIDENCY COMPETENCY EVALUATION SYSTEM - UROLOGY**

**Operative Performance Rating Form**

Resident: \_\_\_\_\_ Staff: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_ Procedure: \_\_\_\_\_ CPT Code: \_\_\_\_\_

Please circle the number corresponding to the resident's performance in each area, irrespective of training level

**Knowledge of Operative Steps**

1	2	3	4	5
Unfamiliar with the steps of the operation; Unable to recall or describe many operative steps		Knows and can explain most of the operative steps but unsure of some without hesitation		Obvious knowledge of all operative steps; Able to give details of steps

**Instrument Handling**

1	2	3	4	5
Makes tentative or awkward moves by inappropriate use of instruments		Competent use of instruments but occasionally appears stiff or awkward		Fluid moves with instruments and no awkwardness

**Knowledge of Instruments**

1	2	3	4	5
Frequently asks for wrong instrument or uses inappropriate instrument		Knows names of most instruments and uses appropriate instruments		Obviously familiar with the instruments and their names

**Flow of the Operation**

1	2	3	4	5
Frequently stopped operating and seemed unsure of next move		Demonstrated some forward planning with reasonable progression of procedure		Obviously planned course of operation with effortless flow from one move to next

**Respect For Tissue**

1	2	3	4	5
Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments		Careful handling of tissue, but occasionally caused inadvertent damage		Consistently handled tissues appropriately with minimal damage

**Resident has demonstrated sufficient competence to perform this procedure independently without supervision upon completion of his/her residency training.**

**YES**  
**NO**


**Comments:**

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

Staff Signature: \_\_\_\_\_

**Texas Tech University Health Sciences Center – Dept. of Urology  
RESIDENCY COMPETENCY EVALUATION SYSTEM - UROLOGY  
Observed Patient Encounter Rating Form**

Resident: \_\_\_\_\_

Rotation: \_\_\_\_\_

Faculty: \_\_\_\_\_

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

Please circle the number corresponding to the resident's performance in each area, **irrespective of training level**

*Unsatisfactory = Several behaviors performed inadequately or missea (ratings 1, 2, or 3)*

*Satisfactory = Most behaviors performed acceptably (ratings 4, 5, or 6); satisfactory performance is described below*

*Superior = All behaviors performed very well (ratings 7, 8, or 9)*

	UNSATISFACTORY			SATISFACTORY			SUPERIOR		
<b>Medical Interview</b>									
1. Initiating interview	1	2	3	4	5	6	7	8	9
	Greets patient; introduces self clearly; begins process of building rapport through appropriate eye contact, relaxed body language & pleasant affect								
2. Taking history - content	1	2	3	4	5	6	7	8	9
	Elicits description of symptoms and sequence of events; obtains relevant background information such as past medical history, relevant social & occupational information; elicits patient's concerns/ worries; identifies, confirms, & characterizes patient problem								
3. Taking history - process	1	2	3	4	5	6	7	8	9
	Listens attentively; allows patient to complete statements without interruption; uses concise, easily understood questions & comments; appropriately uses open & closed questioning techniques; facilitates patient's responses verbally & nonverbally; redirects patient as needed								
<b>Physical Examination</b>									
4. Preparing for exam	1	2	3	4	5	6	7	8	9
	Explains exam before beginning it; has necessary equipment/material at hand								
5. Conducting exam -content	1	2	3	4	5	6	7	8	9
	Conducts an appropriate & complete genitourinary exam; conducts an appropriate non-genitourinary exam								
6. Conducting exam - process	1	2	3	4	5	6	7	8	9
	Conducts exam in a logical and efficient sequence; is sensitive to patient comfort; is respectful of patient's privacy								
<b>Clinical Judgment</b>									
7. Assessing the information	1	2	3	4	5	6	7	8	9
	Obtains sufficient information from interview & exam to include or exclude likely, relevant, significant conditions; electively orders or performs appropriate diagnostic studies as needed								
8. Identifying the problem	1	2	3	4	5	6	7	8	9
	Synthesizes information to make a clinically appropriate working diagnosis								
9. Addressing the problem	1	2	3	4	5	6	7	8	9
	Develops a plan that is appropriate for the working diagnosis & reflects a good understanding of current accepted practice; addresses patient's concerns & preferences								
<b>Explanation &amp; Planning</b>									
10. Explaining the problem	1	2	3	4	5	6	7	8	9
	Explains assessment clearly & uses non-technical language; provides the correct amount & type of information; checks for patient understanding; responds to patient emotion & reassures patient as appropriate								
11. Discussing the plan	1	2	3	4	5	6	7	8	9
	Describes plan clearly & uses non-technical language gives reasons for plan; discusses relevant benefits & risks; checks for patient receptiveness to plan; explores possible compliance issues; negotiates, educates & counsels as needed								
12. Closing the session	1	2	3	4	5	6	7	8	9
	Summarizes assessment & plan; discusses next steps								

**PLEASE RETURN FORM TO RESIDENCY COORDINATOR – Judy Pierson 3B163**



Name \_\_\_\_\_

# Urology Clinic & Floor Patients Patient Resident Evaluation

Dear Patient:

To improve our services to you, we are requesting that you provide us feedback regarding your visit with us. This evaluation is for our resident physicians. Our residents are enrolled in a five year long training program in Urology. Your evaluation will help us monitor their progress. Your responses are confidential.

Please rate the following services:

	Agree	Not Sure	Disagree
1. The doctor treated me with respect and courtesy.	3	2	1
2. I was able to explain my problem to the doctor as fully as I needed to.	3	2	1
3. The doctor explained things so now I know what might be the matter with me.	3	2	1
4. The doctor explained what treatment, tests, or other follow-up is going to happen.	3	2	1
5. The doctor gave me the opportunity to ask questions and express my opinion.	3	2	1
6. The doctor used understandable and non-technical language	3	2	1
7. I feel satisfied with the medical care that I received.	3	2	1

Comments (describe good or bad experience) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please give this form to one of our office staff to be sent to office below. Please feel free to ask any questions you might have about our resident training program or your care.  
 (Return form to TTUHSC-Urology, Attn Residency Program Coordinator, MS 7260)**

*Thank you for your time  
 Urology Residency Program*



TEXAS TECH UNIVERSITY  
HEALTH SCIENCES CENTER  
Department of Urology  
School of Medicine



Name, M.D.

# Resident Physician Evaluation

## SECURE 360° Rating Form

Rate this physician on the following performance statements. This form can be used by nursing staff, pharmacists, social workers or other ancillary personnel. Therefore, some items may not be relevant to you. If you are unable to assess a particular area, please circle "DK".

PROFESSIONALISM (1-10) INTERPERSONAL & COMMUNICATION SKILLS (11-20)	Not at all Characteristic			Highly Characteristic		Don't Know
	1	2	3	4	5	
1. Follows through on tasks he/she agreed to perform	1	2	3	4	5	DK
2. Responds to requests, including pages, in a helpful and prompt manner	1	2	3	4	5	DK
3. Knows the limits of his/her abilities and asks for help when needed	1	2	3	4	5	DK
4. Takes responsibility for actions, admits mistakes and does not blame others	1	2	3	4	5	DK
5. Makes patient care and well-being a priority	1	2	3	4	5	DK
6. Provides equitable care regardless of patient culture and socioeconomic status	1	2	3	4	5	DK
7. Is willing to act on feedback or other information to improve patient care	1	2	3	4	5	DK
8. Maintains respectful demeanor in demanding and stressful situations	1	2	3	4	5	DK
9. Is honest in interactions with others	1	2	3	4	5	DK
10. Takes on extra responsibilities when the need arises	1	2	3	4	5	DK
11. Easily establishes rapport with patients and their families	1	2	3	4	5	DK
12. Is respectful and considerate in interactions with patients	1	2	3	4	5	DK
13. Responds to patients' needs, feelings, or wishes	1	2	3	4	5	DK
14. Uses non-technical language when explaining and counseling	1	2	3	4	5	DK
15. Spends adequate amount of time with patients	1	2	3	4	5	DK
16. Is willing to answer questions and provide explanations	1	2	3	4	5	DK
17. Is courteous to and considerate of nurses and other staff	1	2	3	4	5	DK
18. Discusses patient issues clearly with staff and faculty	1	2	3	4	5	DK
19. Listens to and considers what others have to say about relevant issues	1	2	3	4	5	DK
20. Maintains complete and legible medical records	1	2	3	4	5	DK

Comments: \_\_\_\_\_

**Please return completed evaluation to Judy Pierson, TTUHSC-Dept. of Urology, MS 7260**



TEXAS TECH UNIVERSITY  
HEALTH SCIENCES CENTER™

# Urology Service Evaluation

Students and Residents - please rate the following services:

	Strongly Agree	Agree	Probably Agree	Not Sure	Probably Disagree	Disagree	Strongly Disagree
1. My urology rotation was a good use of my time.	7	6	5	4	3	2	1
2. I was treated with respect and consideration.	7	6	5	4	3	2	1
3. The attending(s) were good teachers.	7	6	5	4	3	2	1
4. The resident(s) were good teachers.	7	6	5	4	3	2	1
5. I would recommend this rotation to other students or PGY I residents.	7	6	5	4	3	2	1
6. The conferences were useful.	7	6	5	4	3	2	1
7. There was good balance of clinic and operating room experience.	7	6	5	4	3	2	1

8. I would like to see more of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. I would like to see less of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Suggestions for improving this rotation. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

As a result of this rotation, would you consider urology as a career? Explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**UROLOGY RESIDENCY PROGRAM  
RESIDENT SELF-ASSESSMENT**

**Please complete this self-assessment for the preceding six-month time period. It is designed to help you identify your strengths and weaknesses and subsequently establish goals on how to improve your learning and patient care. The self-assessment will be discussed with the Program Director at your upcoming semi-annual review. Negative self-assessments will not reflect poorly upon your formal evaluation and for this reason, your honest answers are expected.**

**Name:** \_\_\_\_\_

**Year in Training:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**For each of the following ACGME core competencies, please rate yourself using the following scale:**

- 1 = Area where I know that I need improvement**
- 2 = Area where I think that I need improvement**
- 3 = Area where I think that I perform adequately**
- 4 = Area where I think that I am above average**
- 5 = Area where I think that I am very skilled**

**PATIENT CARE** – Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

***“I always.....”***

- \_\_\_\_\_ Obtain a complete medical database via history and physical examination
- \_\_\_\_\_ Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences
- \_\_\_\_\_ Make informed decisions about diagnostic and therapeutic interventions based on up to date scientific evidence
- \_\_\_\_\_ Work with other health care professionals, including those from other disciplines, to provide patient-focused care
- \_\_\_\_\_ Involve the patient and patient’s family in decisions regarding care
- \_\_\_\_\_ Communicate clearly with the patient and the patient’s family
- \_\_\_\_\_ Teach the patient and their family about their diagnosis, treatment, and discharge plans
- \_\_\_\_\_ Demonstrate empathetic and caring behavior to the patient and patient’s family
- \_\_\_\_\_ Triage patient effectively and efficiently
- \_\_\_\_\_ Respond responsibly and appropriately to emergencies
- \_\_\_\_\_ Reassess and evaluate ongoing treatment

**MEDICAL KNOWLEDGE** – Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

***“I am comfortable with...”***

- \_\_\_\_\_ My knowledge about relevant medical illnesses
- \_\_\_\_\_ My ability to generate a complete differential diagnosis
- \_\_\_\_\_ My understanding of basic epidemiologic principles and their application to clinical medicine

***“I recognize...”***

- \_\_\_\_\_ My own limitations in medical knowledge and seek consultation when appropriate
- \_\_\_\_\_ My own limitations in procedural skills and seek consultation when appropriate

Are these specific disease states or syndromes (Breast Cancer, CHF, Asthma, etc...) where you are less comfortable with diagnosis and treatment?

**PRACTICE-BASED LEARNING AND IMPROVEMENT** – Residents must be able to investigate and evaluate their patient care practices and appraise and assimilate scientific evidence to improve their patient care practices.

***“I am able to, and frequently do...”***

- \_\_\_\_\_ Analyze feedback and my patient care experiences to make improvements in patient care
- \_\_\_\_\_ Use evidence-based medicine as it relates to my patients condition and diagnosis
- \_\_\_\_\_ Consult the medical literature (web-based resources and reference materials) to support my education and improve patient care
- \_\_\_\_\_ Assist in the education of medical students
- \_\_\_\_\_ Assist in the education of my physician colleagues
- \_\_\_\_\_ Assist in the education of other health care professionals (nursing, ancillary staff, etc...)
- \_\_\_\_\_ Apply knowledge of study designs and statistical methods when reviewing scientific studies

**INTERPERSONAL AND COMMUNICATION SKILLS** – Residents must be able to demonstrate interpersonal and communication skills that result in the effective exchange of information between patients, their families, and professional associates.

***“I make a concerted effort to...”***

- \_\_\_\_\_ Create a personal relationship with every patient
- \_\_\_\_\_ Communicate the diagnosis, treatment outcomes, and expected course at each patient encounter
- \_\_\_\_\_ Use effective non-verbal and listening skills in every patient encounter
- \_\_\_\_\_ Communicate with patients and their families in a timely manner
- \_\_\_\_\_ Communicate in a respectful manner to all professional colleagues, ancillary staff, and hospital/clinic personnel
- \_\_\_\_\_ Complete written and electronic communication that is comprehensive, timely, legible, and easy to follow

**PROFESSIONALISM** – Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population while maintaining a professional relationship with all members of the patient care team.

***“At all times I demonstrate...”***

- \_\_\_\_\_ Respect, compassion, and integrity for my patients
- \_\_\_\_\_ Commitment to ethical principles
- \_\_\_\_\_ Responsiveness to the needs of my patients and their families
- \_\_\_\_\_ Commitment to maintaining confidentiality and obtaining informed consent
- \_\_\_\_\_ Sensitivity and responsiveness to patients’ culture, age, gender, and disabilities
- \_\_\_\_\_ Accountability to the needs of society
- \_\_\_\_\_ Accountability to the needs of the profession
- \_\_\_\_\_ Commitment to excellence

***“At all times I...”***

- \_\_\_\_\_ Identify myself to patients and their families
- \_\_\_\_\_ Am well-groomed and wear professional attire (including name badge)
- \_\_\_\_\_ Respond to pages and inquiries in a timely manner
- \_\_\_\_\_ Complete duties necessary to my training and patient care (evaluations, time sheets, dictations, signatures, medical records, etc) in an honest and timely manner

**SYSTEMS-BASED PRACTICE** – Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

***“At every opportunity, I...”***

- \_\_\_\_\_ Consider how my practices affect other health care professionals and the hospital system
- \_\_\_\_\_ Consider how my practices affect the society as a whole
- \_\_\_\_\_ Practice cost-effective care and resource allocation (including my own time) that does not compromise quality of care
- \_\_\_\_\_ Assist patients in managing the complexities of the health care system
- \_\_\_\_\_ Look for ways to improve our system of health care

**IDENTIFICATION OF STRENGTHS**

After having completed the self-assessment, what would you identify as your strengths?

- 1.
- 2.
- 3.

**IDENTIFICATION OF AREAS FOR IMPROVEMENT**

What would you identify as your areas for improvement?

- 1.
- 2.
- 3.

**IDENTIFICATION OF LEARNING OBJECTIVES**

Please list three specific learning objectives and goals to work over the next six months:

- 1.
- 2.
- 3.

Comments:

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

**TEXAS TECH UNIVERSITY HSC  
DEPARTMENT OF UROLOGY**

**EVALUATION FOR RESIDENT CONFERENCES**

Conference Name \_\_\_\_\_

Conference Date \_\_\_\_\_

Resident Presenter \_\_\_\_\_

	Not at All	2	Reasonably Well	3	4	Extremely Well	5
<b>Use of Literature was:</b>							
A. Recent sources from current evidence	1	2	3	4	5		
B. Used well formulated statistical concepts and/or relevant study design/methodology for this presentation	1	2	3	4	5		
C. Well referenced	1	2	3	4	5		
<b>Audiovisual Materials:</b>							
A. Effective use of slides/video/handouts	1	2	3	4	5		
<b>Presentation was:</b>							
A. Organized	1	2	3	4	5		
B. Effective	1	2	3	4	5		
C. Diction/audibility of presentation	1	2	3	4	5		
D. Effective use of time	1	2	3	4	5		
E. Major points summarized	1	2	3	4	5		
F. At appropriate level	1	2	3	4	5		
<b>Response to Audience Questions:</b>							
A. Appropriate	1	2	3	4	5		
B. Successful in ability to answer	1	2	3	4	5		
<b>Overall Quality of Presentation:</b>							
A. Met Expectations	1	2	3	4	5		

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SCHOOL OF MEDICINE  
DEPARTMENT OF UROLOGY  
FACULTY / RESIDENT LEAVE REQUEST**

**A.** Faculty/Resident requesting Leave: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Print)

**B.** Date: \_\_\_\_\_ Prepared by: \_\_\_\_\_  
Coordinator

**C.** Period of Leave:

<b>Out</b>		<b>a.m.</b> <b>p.m.</b>
<b>Return</b>		<b>a.m.</b> <b>p.m.</b>

**D.** Purpose of Leave:  Educational  Vacation  Other \_\_\_\_\_

Meeting/conference info. \_\_\_\_\_

Internal COMP Days used \_\_\_\_\_ # days used

**E.** Cancel Clinic?  Yes  No      Cancel Surgery Day?  Yes  No

**F.** Chairman Approval: \_\_\_\_\_  
Signature

**Program Director Approval:** \_\_\_\_\_  
(For Residents only) Signature

•ADD TO DEPT. CALENDARS

•SEND TO CLINIC

•SECURE COVERAGE  
(if needed)

**H.** Coverage during leave: (if applicable)

Printed name	Signature

**Office Procedure**

Office Use Only:  
**Coordinator – Andrea Patterson - Judy Pierson**  
 Leave recorded to Outlook/Dept. Calendars: \_\_\_\_\_ Date copy to PSS: \_\_\_\_\_  
 Date copy to Nurse supervisor: \_\_\_\_\_ Date copy to Dr. Haynes(Call Schedule purposes): \_\_\_\_\_  
 Final – Date copy to Adm.: \_\_\_\_\_  
**PSS – Supervisor** \_\_\_\_\_  
 Clinic Bumped: \_\_\_\_\_ By: \_\_\_\_\_ # Pts. cancelled: \_\_\_\_\_  
 Copy to Coordinators (after pts. cancelled): \_\_\_\_\_