Attached is information you may find helpful in preparing for your clinical rotation in Companion Animal Surgery (CAS). Please read it before your first rotation in SAS. Many of the topics mentioned in the outline will be expanded on during the rotation orientation. We look forward to working you.

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COURSE MATERIALS:

Moodle:
Please view additional materials via login to Moodle by login to your myLSU account: http://itsweb.lsu.edu/Moodle/

COURSE DESCRIPTION:

The general teaching objective of the companion animal surgery rotation is to provide you with the opportunity to apply your basic medical and surgical knowledge in a clinical situation. The primary teaching goal of this rotation is to assist you in the development of your skills in surgical case management. Emphasis will be on the following components of overall case management: client communication, case record keeping, obtaining a complete case history, performing thorough physical, orthopedic and neurologic examinations, developing an appropriate diagnostic plan, interpreting clinical information, identifying sources of additional information, developing a therapeutic plan including appropriate pre-operative patient care needs, developing short and long term post-operative therapeutic plans, developing post-operative patient care instructions for pet owners, and developing confidence in the verbal presentation of case material to colleagues. Due to the referral nature and complexity of cases seen by the surgery service, the students should recognize that primary surgical experience will be limited with clinical cases. However, the spay/neuter laboratories on Mondays will give you an opportunity to perform surgery.

Faculty, residents, and technicians will collectively evaluate each student's performance in the following categories: surgical knowledge; participation in rounds; problem solving skills; record keeping; surgical skills; patient management and clinical proficiency; dependability and ethical conduct; and communication and interaction.

Students will be assigned to groups and will give a case presentation in week 3 or 4. This presentation will be evaluated and will count towards 20% of your final grade in the rotation.

COURSE OBJECTIVES:

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<th>After this rotation, you should be able to</th>
<th>List keywords for each objective</th>
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Louisiana State University School of Veterinary Medicine Syllabus
1. Be able to describe and explain preoperative, intraoperative and postoperative considerations for case management and be able to outline an appropriate pain management plan for all types of surgical patients (e.g., healthy, septic, geriatric, pediatric).

2. Be able to perform complete physical, orthopedic and neurologic examinations.

3. Be able to formulate an appropriate diagnostic plan for a given patient.

4. Be able to formulate an appropriate therapeutic plan for a given patient.

5. Be able to describe the principles of aseptic surgery and be able to apply them in the operating room.

6. Be able to explain the role of a surgical referral center in the management and treatment of small animal surgical disease.

7. Be able to generate and maintain a complete medical record with a thorough but concise daily SOAP, comprehensive surgical report, treatment plan/orders and discharge instructions that will aid the primary veterinarian in caring for our mutual patient.

8. Be able to recognize and describe relevant perioperative and postoperative complications that may occur with a surgical disease or procedure.

9. Be able to effectively communicate with clients regarding common surgical procedures and complications as well as ongoing case management.

10. Be able to use current scientific literature to enhance surgical care of small animal patients.

COURSE POLICIES:

APPROVED/EXCUSED ABSENCE

ANY REQUEST FOR TIME AWAY FROM THE ROTATION MUST BE SUBMITTED TO THE COURSE COORDINATOR VIA EMAIL OR IN PERSON ON OR BEFORE THE FIRST DAY OF THE ROTATION.

Examples of excused absences that may be allowed are: job interviews, state board examinations, family emergencies, illness, and attendance of professional meetings. The Course Coordinator may request documentation. The Course Coordinator, in consultation with the Faculty on service shall have the final authority on granting an excused absence.

A maximum of two excused absences will be allowed per four week block and one excused absence per two week block. If the Course Coordinator grants a number of days in excess of the number allowed, remediation will be required. The Course Coordinator in consultation with the Faculty on service will determine the form of remediation. Any unexcused absence will require remediation and/or possible failure of the block.

Specific Situations/Guidelines:
These are examples to help you plan but as noted above and in the student handbook, the final decision for granting an excused absence is at the discretion of the Course Coordinator.
A student who is beginning an externship on the Monday following a block on Companion Animal Surgery will only be excused from treatments on the last Saturday and Sunday of the block.
Family vacation, birthday, or other non-academic/professional events will NOT generally be considered acceptable reasons for an excused absence.

LSU SCHOOL OF VETERINARY MEDICINE ACADEMIC MISCONDUCT POLICY:
The LSU Code of Student Conduct applies to the School of Veterinary Medicine within the Code is the Academic Misconduct Policy, which outlines the School of Veterinary Medicine expectations for the integrity of students’ academic work, the procedures for resolving alleged violations of those expectations, and the rights and responsibilities of students and faculty members throughout the process. Students are responsible for reading the LSU Code of Student Conduct Policy and for living up to their pledge not to violate the Code.

I. It shall be a violation of this Code for a student to cheat.

II. It shall be a violation of this Code for a student to knowingly circumvent any course requirement.

III. It shall be a violation of this Code for a student to steal.

IV. It shall be a violation of this Code for a student to purposely impair another student’s educational opportunity.

V. It shall be a violation to act in a manner which is detrimental to the moral and ethical standards of the veterinary medical profession.

VI. It shall be a violation for a student to knowingly deceive another student, faculty member, or professional associate with the intent to gain advantage, academic or otherwise, for said student or for any other student.

VII. It shall be a violation for any student to fail to report any infraction of the LSU Code of Student Conduct Policy to an appropriate representative.

LSU Code of Student Conduct can be found at: http://saa.lsu.edu/code-student-conduct

SEXUAL HARASSMENT POLICY:

The University reaffirms and emphasizes its commitment to provide an educational and work environment free from sexual harassment and to provide a means to remedy sexual harassment that employees may have experienced. (PS-73 Sexual Harassment and PS-95 Sexual Harassment of Students)

The intent of this policy is to express the University’s commitment and responsibility to protect its students from sexual harassment and from retaliation for participating in a sexual harassment complaint. It is not intended to infringe upon constitutionally guaranteed rights nor upon academic freedom. In considering allegations of sexual harassment, the University must be concerned with the rights of both the complainant and the accused.

All proven cases of sexual harassment shall result in appropriate disciplinary action. The severity of the disciplinary action shall be consistent with the seriousness of the act of sexual harassment. Additionally, under appropriate circumstances, the University may take action to protect its students from sexual harassment by individuals who are not students of the University. If the alleged harasser is a student, the Dean of Students Office must be notified of the complaint.

Student Advocacy & Accountability, Office of the Dean of Students, LSU Student Life & Enrollment, 340 LSU Student Union 747-8330 Fax: (225) 578-5637 dossaa@lsu.edu

GENERAL STATEMENT ON ACADEMIC INTEGRITY:

Louisiana State University adopted the Commitment to Community in 1995 to set forth guidelines for student behavior both inside and outside of the classroom. The Commitment to Community charges students to maintain high standards of academic and personal integrity. All students are expected to read and be familiar with the LSU Code of Student Conduct and Commitment to Community, found online at www.lsu.edu/saa. It is your responsibility as a student at LSU to know and understand the academic standards for our community.

Students who are suspected of violating the Code of Conduct will be referred to the office of Student Advocacy & Accountability. For undergraduate students, a first academic violation could result in a zero grade on the assignment or failing the class and disciplinary probation until graduation. For a second academic violation, the result could be suspension from LSU. For graduate students, suspension is the appropriate outcome for the first offense.

AMERICANS WITH DISABILITIES ACT:
Louisiana State University is committed to providing reasonable accommodations for all persons with disabilities. The syllabus is available in alternate formats upon request.

Students with disabilities: If you are seeking classroom accommodations under the Americans with Disabilities Act, you are required to register with Disability Services (DS). DS is located in 115 Johnston Hall. Phone is 225-578-5919. To receive academic accommodations for this class, please obtain the proper DS forms and meet with me at the beginning of the class. The Office of Veterinary Education and Student Affairs can help you if you have questions as well. http://disability.lsu.edu/students

SYLLABUS CHANGE POLICY:

Except for changes that substantially affect implementation of the evaluation (grading) statement, this syllabus is a guide for the course and is subject to change with advanced notice.

COPY STATEMENT:

Some of the materials in this course are possibly copyrighted. They are intended for use only by students registered and enrolled in this course and only for instructional activities associated with and for the duration of the course. They may not be retained in another medium or disseminated further. They are provided in compliance with the provisions of the Teach Act (Section 110(1) of the Copyright Act) http://www.copyright.gov/docs/regstat031301.html.

COURSE DESCRIPTION:

Morning Case Rounds
These rounds take place separately for each service. Your punctual attendance at rounds is mandatory for successful completion of this rotation. In the morning rounds will take place at 7:45 am, the Orthopedic Service will meet in the Bandage Room and the Soft Tissue Service will meet in room 1840. Please be as prepared as possible for rounds. Be ready to start on time, with inations and AM treatments completed, bring APRs that need signing, surgery reports from the previous day, discharge instructions completed for all patients that might go home that day, orders written for all inpatients for the day, clients called for routine cases, SOAPs completed, and the knowledge to discuss all of your cases. The length of the discussion for each case will depend on time but in general, discussions are fairly in depth. We will discuss radiographs and other diagnostic findings, differential diagnoses, and treatment plans (medical & surgical). Consideration must be given to potential complications of surgery, postoperative therapy, prognosis, and client communication. It is expected that you review materials about the condition(s) of each assigned case before the presentation. You have the opportunity to learn from every case that is seen during your rotation whether or not they've been assigned to you!

For new patients, each student will present their assigned case by stating the signalment, brief pertinent history, physical exam findings, differential diagnoses, diagnostic test results, working diagnoses, and plan. For patients that have been previously presented at rounds, you can give a briefer presentation to include signalment, diagnosis, update on condition, and any changes to the plan. Make sure you bring all lab results to rounds so the clinicians can review them. The length of the discussion for each case will depend on time but in general, discussions are fairly in depth. We will discuss radiographs and other diagnostic findings, differential diagnoses, and treatment plans (medical & surgical). Consideration must be given to potential complications of surgery, postoperative therapy, prognosis, and client communication. It is expected that you review materials about the condition(s) of each assigned case before the presentation. You have the opportunity to learn from every case that is seen during your rotation whether or not they've been assigned to you!

After Receiving/Preoperative Rounds
Again be prepared for rounds. Be ready to discuss all cases currently in the hospital. The goals of these rounds are to get updates and revised plans for inpatients, to introduce new patients, and to learn about the surgical diseases our patients have and their treatment options. Generally these are not as thorough as the morning rounds. For new patients, the student will present each case by stating the signalment, brief pertinent history, physical exam findings, differential diagnoses, diagnostic test results, working diagnosis, and plan. For patients that have been previously presented at rounds, you can be briefer giving signalment, diagnosis, update of the condition, and current plans. The location for these rounds will be determined at the time and an overhead page will usually be made.
Postoperative Rounds
These may be “walk-through-the-wards” rounds or they may occur in a location determined at the time. Listen for an overhead page. Be prepared. Before rounds, make sure treatment sheets are filled out, medications have been ordered, etc. For new patients, the student will present each case by stating the signalment, brief pertinent history, physical exam findings, differential diagnoses, diagnostic test results, working diagnosis, and plan. For patients that have been previously presented at rounds, you can be briefer giving signalment, diagnosis, update of the condition, and current plans.

Topic Rounds
Topic rounds take place daily from Tuesday-Thursday in Room 1840 unless well tell you otherwise. These rounds are for your benefit and are an opportunity for discussions about topics you are unfamiliar with or those you would like to learn more about. The topics for these rounds will be chosen from the following: Orthopedic exam, Neurologic exam, Wounds, Acute abdomen, Surgical Oncology, Cruciate disease, Hip dysplasia, Fractures, Intervertebral Disc Disease, Portosystemic shunts, Reproductive emergencies, Splenectomy, Urogenital surgeries, and Laryngeal paralysis. If you are provided reading material you are expected to have read it before rounds.

RECEIVING
The list of cases to be seen will be posted on the notice board by the cashiers desk the evening before receiving, it is strongly recommended that as a group you review this list the evening before receiving and divide the cases among yourselves. This will allow you to make sure that you all get to see an equal number of new appointments and rechecks and will allow you to review the pertinent information on the case prior to the appointment.

When seeing appointments always introduce yourself clearly to the client, take them to a consulting room and explain how the appointment will work (i.e. once you have taken the history about their pet, you will bring the pet to the treatment room for evaluation while they return to the waiting area; once their pet has been evaluated you will return with the house officer/faculty to discuss the case and the next steps). You should start with a thorough history this should focus on the presenting complaint (symptoms, onset, duration, effect of any medications, diagnostics performed & results) but not to the exclusion of all else. You must also gather information about the vaccination status of the animal, any previous or concurrent medical conditions and the name and dosage of any medications the animal is currently receiving. When you have completed your history you should confirm you have the correct phone numbers for the client then return them to the waiting room, do not leave clients in the consulting rooms. The patient should then be taken back to the treatment room and you should perform a thorough physical examination. Examinations should not be performed in front of the clients. If an owner is reluctant to have you take their pet to the back for the examination, page a clinician to speak with them.

If it is an orthopedic or neurologic case you should also complete an orthopedic and/or neurologic examination. When you have completed your history and physical examination before you talk to a clinician you should formulate a problem list, differential diagnosis and plan for the patient. You should then find a clinician and present the case following the format of the rounds presentations. In general you will present to both a faculty member and house officer. If the animal is aggressive or overly nervous, discuss the case with one of the technicians or clinicians as we may just do one exam together. If the patient is staying in the hospital the file should stay with them. A cage card should also be stamped and filled out and put on the patient’s cage. If the patient is on any medications we can accept these from the client as long as they are properly packaged and labeled, otherwise we will have to prescribe the medications for the patient’s stay from pharmacy.

Under no circumstances should a client be allowed to leave their pet until a clinician has been consulted and in most cases talked to the owners.

Dress Code
You must wear appropriate professional/business casual attire when seeing clients. Appropriate attire includes tucked in button down dress shirt, polo or fitted shirt for men, blouse, sweater or dress shirt for women, closed toe shoes, trousers for men and women, and appropriate length skirts for women (ladies, please remember that you will potentially have to crouch and sit on the floor to do orthopedic and neuro exams on large dogs). A white lab coat should be worn when seeing clients and must always be worn over scrubs. You should also have a name badge on your lab coat at all times. Examples of inappropriate attire included, but is not limited to, jeans, t-shirts, hooded sweatshirts, sweat pants, shorts. Your lab coat MUST be clean. Clean scrubs that have not been worn from home can be worn under a
lab coat on surgery days. Failure to follow this dress code will be that you will not be allowed to see
appointments and this will be reflected in your grade.

**When admitting a patient to the hospital:**
- Leave the collar, leash, carrier, and any personal items with the owner (We cannot guarantee that
  personal items will be returned if left with the pet).
- Place a completed ID collar on the animal.
- Record any client questions for the clinician in the medical record.
- Check the phone numbers for the owners to insure they are correct.
- Please fill out treatment sheets and cage card and attach them to the animal’s cage.

**DAILY PATIENT CARE/TREATMENTS**
You are responsible for each of your patients and their care. This includes daily patient assessment,
attention to bandages, collars, dressings, keeping the patient dry and comfortable, making sure the
urinary bladder is emptied with appropriate frequency, and the administration of medications. Please
work to assist your colleagues. The technicians are available to assist with patient care, but they are not
responsible for these duties during the hours listed below.

*Students are responsible for ALL WARD TREATMENTS.*

*Students are responsible for all 8AM treatments in ICU.*

***Give yourself at least 30 minutes every morning for each ward patient and 60 minutes for each ICU
patient until you know your abilities***

All cases must be assessed and treated by 7:45 AM (even patients having surgery that day). ANY
concerns should be brought to the attention of a clinician immediately. When scheduling treatments in
the ICU q8hour (TID) treatments are scheduled at 8:00 AM, 4:00 PM and 12:00 AM. q12hour (BID)
treatments are scheduled at 8:00 AM and 8:00 PM. The number and frequency of treatments determines
what the client is charged so make sure you check with a clinician before making changes to the number
of walks, ice-packing, etc.

On receiving days you are required to wear professional attire and have personal equipment/instruments
available. You will also need to have a clean pair of scrubs available each day as you may be required to
go into surgery. You also need to have a clean lab coat available at all times.

**UNDER NO CIRCUMSTANCES SHOULD YOU WEAR YOUR SCRUBS FROM HOME AND INTO THE
HOSPITAL. IF YOU DO, YOU WILL BE SENT HOME TO GET A CLEAN PAIR AND THIS WILL BE
REFLECTED IN YOUR GRADE.**

You are responsible for all medications and treatment to be given to your patient if it is not in the ICU. If
there is a treatment to be given at 10:00 PM this can be done by the on call student. If the on call student
is busy with an emergency or the treatment requires more than one person, you will need to come in at
10:00 PM for the treatment. **If there are more than 5 cases that need treatments at 10pm, the beeper
student AND the backup student will come in to do the treatments.**

You are responsible for calling the clients at least once daily (minimum of once if the patient is in the
wards, twice if they are in ICU). There is a long distance code to be used. Make sure you fill out a Client
Communication form and place it in the medical record. You do not have to discuss anything you are not
comfortable with (e.g. costs, prognosis) and should tell the client you will have the clinician call to discuss
these matters.

**Recovery**
Patients that have received a general anesthetic or heavy sedation for a procedure are recovered in the
ICU. You are responsible for monitoring your patient during the recovery period and following extubation.
During this time you should monitor the temperature, pulse, respiration and other indicated parameters.
Be cognizant of the effects of monitoring and if an alternative method needs to be used (e.g. repeated
rectal temperature measurement can cause irritation, a patient that has had rectal surgery should not
have a rectal temperature taken). Some patients may be move to wards once they have recovered
sufficiently but this will be at the discretion of the clinician(s) on the case.

**Client Visits**
No visits are allowed on the day of surgery unless previously approved by the primary clinician. A student
or clinician must be present during owner visits so it is important to schedule these appropriately. It is
often useful to discuss a visiting time with the clinician so they can help determine the best time. Client visits are limited to 60 minutes for ward patients and 30 minutes for ICU patients.

**Hospital Closure Emergency Receiving**
If the Veterinary Teaching Hospital cancels normal receiving due to weather related or other condition and where larger than normal small animal emergency case load will be anticipated, students will be asked to help with receiving and managing these emergency cases.

**RECORDS**
Every piece of paper or document related to a case MUST have the case number and patient name on it. If you make an error, place a single line through the error and initial it. DO NOT scribble over any errors or mistakes on any of the records.

**History and Physical Exam Forms:**
Use the forms to guide your data collection. If a system is not examined, mark it as "not examined". If there is something that is not applicable, indicate that as well. These are legal documents and should be treated as such. They are also important pieces of information to be used by future students, staff and clinicians that may see the case. The paper documents will also be used to create the digital discharge instructions. Remember to collect ALL the necessary information regardless of why the pet has come to the clinic.

**Progress Notes:**
A progress note should be completed every day for every inpatient (regardless of why they are in the hospital). In the progress note you need to provide the **Subjective** (patient demeanor, attitude) and **Objective** (temperature, pulse, respiration, laboratory data) data. In the **Assessment** section you will then list each problem and provide a list of differential diagnoses for the problem. In the **Plan** section you will then list what steps are to be taken in working through the problem list (i.e. diagnostic or therapeutic procedures). This section can also include information about consultations with other services, when you believe the animal will go home, any necessary steps that are needed in order to educate the client, etc. This may seem like a tedious exercise but it will help you work through a case and process your thoughts. It is also an excellent method for you to learn how to record your observations and relevant data regarding your case.

Each afternoon/evening (one SOAP per 24 hr period) a progress noted should be completed, printed, signed by you and given to the house officer on the case for their review. The SOAP for the previous day should be given to the house officer in rounds each morning. For example, a dog is admitted on orthopedics on Tuesday afternoon. Tuesday evening, complete a SOAP for admission to evening treatments. Give this SOAP to the HO on Wed morning in rounds. Wednesday evening, complete a SOAP for the 24 hours from Tues evening until Wed evening. This SOAP is due Thurs AM.

**Telephone Communication:**
This form should be completed EVERY time you speak to an owner, rDVM or other external entity regarding the case. Even if you speak to an owner in person during a visit, complete one of these forms. Remember to sign the bottom and place the form in the record.

There is an online record system that you are required to use for your patient records. This is inaddition to the hand written forms. The system can be found at [http://130.39.48.9/DischargeSummary/](http://130.39.48.9/DischargeSummary/) and instructions can be found [http://130.39.48.9/DischargeSummary/DischargeSummaryHelp.pdf](http://130.39.48.9/DischargeSummary/DischargeSummaryHelp.pdf).

**Treatment Sheets**

**ICU**
The ICU treatment sheets should be completed and ready to be reviewed by the clinicians before rounds each morning. A clinician MUST sign the treatment sheet before the treatment can be performed so if you do not have it ready on time your patient will not receive its treatments.

If you are not sure if things will change, new medications will be added, etc. you can leave some areas blank but the basic information (e.g. patient information, clinician information) should be completed.

We expect you to think about your cases and treat them as your own. You should have a treatment plan ready for your patient to be discussed and this should be complete with dosages, frequency and route of administration. It is not acceptable for you to blindly copy the treatment sheet from one day to the next.
Remember details like taking your patient outside to urinate and defecate as well as feeding frequency, what can be fed and the amount. These are very important details that are often overlooked. The treatment sheet is a way for you to communicate with the rest of the students, staff and clinicians what needs to be done with your case. Think of it from the point of view of someone who is walking up to the cage and knows absolutely nothing about your case. What you put on the treatment sheet should allow them to perform the treatments safely and correctly with minimal to no risk to the patient.

**Wards**

The Wards treatment sheets should be completed and ready to be reviewed by the clinicians before rounds. If you are not sure if things will change, new medications will be added, etc. you can leave some areas blank but the basic (e.g. patient information, clinician information) should be completed.

We expect you to think about your cases and treat them as your own. You should have a treatment plan ready for your patient to be discussed and this should be complete with dosages, frequency and route of administration. It is not acceptable for you to blindly copy the treatment sheet from one day to the next. Remember details like taking your patient outside to urinate and defecate as well as feeding frequency, what can be feed and the amount. These are very important details that are often overlooked.

If you perform a treatment on a patient in the wards, initial beside the treatment. If you CANNOT perform a treatment for whatever reason, write the reason on the treatment sheet. By doing this it will be clear why the treatment was not performed.

**Surgery/Anesthesia Request Packets**

All forms in the packet must be completed for EVERY case that is undergoing an anesthetic/surgical procedure. In some cases, only an Anesthesia Packet is needed (e.g. a patient that is going to CT or MRI only). These packets MUST be submitted by 3:30PM each day. These forms/packets are also used to schedule the procedure. It is your responsibility to return the completed forms to anesthesia/surgery. Make sure that the patient information can be read clearly after you have stamped it with the blue card. If there is any doubt, write the patient name and number on the form. Most cases will need to have a complete blood count (CBC) and serum biochemical profile performed on them. Be sure to check with the clinician in case extra or additional tests are required BEFORE drawing any blood samples. The forms for these procedures are in the treatment room and they should be stamped and completed and turned in to the Clinical Pathology lab with the samples. At the same time you need to record an EKG for your patient using the EKG machine in the Treatment room. The technicians can help you with these procedures.

**Surgery Request form**

It is very important for you to complete this form with as much detail as possible. Under the clinician name put the Faculty surgeon and House Officer on the case. Be clear about the procedure to be performed. Do NOT just write fracture repair. Instead write fracture repair of the left femur and if we have discussed the method of repair you can also add that. In some cases the c-arm may be needed so you should also indicate that on the form. If you have any questions about what to write please ask a clinician. The goal of this form is to help the OR technicians prepare for the procedure as much as possible.

**Anesthesia Request and Data Form**

Like the Surgery Request Form, you should complete this form with as much detail as possible. One of the key pieces of information on this form is the Preferred surgery time – if we have discussed that, be sure to include it on the form. If the laboratory data is available, enter it on this form. The EKG should also be attached to this form.

**Anesthesia Record and Anesthesia Student SOAP Forms**

The only part of these forms that is your responsibility is to stamp the blue card, record the clinician and proposed procedure.

**Small Animal Recovery Room**

This orange sheet should be stamped with the blue card and the date, procedure, clinician and your name recorded on it. The form is then placed on the recovery cage in ICU. When you place the form on the cage you should also place bedding, etc. in the cage so it is ready for when your patient comes out of surgery.
Prior to surgery you should have an idea if there is going to be a sample submitted for histopathology, stone analysis, etc. With this in mind you should have all the appropriate forms started so that you are not trying to complete all the basic information after surgery. It is your responsibility to take the samples to the Diagnostic Lab submission area regardless of the time of day. Fill these forms out with as much information at possible. For histopathology samples it is sometimes helpful to draw a diagram of the mass or sample. The more information you provide the better the result will be.

**Medical Imaging**

**Be sure to put the Faculty AND House Officer names on these forms.**

A radiograph request should be completed with as much detail as possible. It is your responsibility to make sure these requests are submitted. Many of the orthopedic cases will require both pre-operative and post-operative radiographs. This will require you to submit two separate requests – one for pre-op and one for post-op.

Ultrasound, CT and MRI require their own individual request. When submitting these requests be sure to check with your clinician as there are often specific requests/areas to be imaged and this needs to be indicated on the request.

**Peri-operative cefazolin**

You will complete an APR to be signed by the clinician. The APR will indicate the dose, total amount (i.e. total mg) to be given, timing of administration (i.e. prior to start of surgery or wait for culture). The yellow portion of the signed APR will be given to the OR technician or placed in the folder on/near the fridge. The white portion will be placed in the record. You will go to the fridge in surgery and draw up the appropriate dose and amount of cefazolin from the vial. You will then give the syringe of cefazolin to the anesthesia student/technician and inform them if it is to be given or if we are waiting to collect samples for culture. The anesthesia student/technician will make a record of the amount (in mg), time and route of administration of the cefazolin administrated to the patient. If a subsequent does of cefazolin is needed an available CAS student (usually one that is observing the surgery) will obtain the drug from the fridge in surgery. If there is not a CAS student available an OR technician will be asked. If an OR technician is not available a member of the anesthesia team will obtain the drug. Anesthesia will ONLY be asked to do this if no other person is available.

**Surgery Report:**

The online system should be used to complete the surgery report. The surgery report should be completed as soon as possible after the surgery so that you do not forget the important details. It MUST be completed and given to the house officer on the case within 24 hours of the surgery. The house officer will provide feedback/corrections that must be made prior to having the report signed by the house officer. The completed, signed surgery report should be placed in the medical record.

It is necessary to list all implants that are used. For orthopedics you should provide the type of plate, number of holes it has (i.e. a 9 hole limited contact dynamic compression plate). You also need to list how the plate was applied (i.e. in compression, bridging or buttress). For screws you should provide the type and size (i.e. 3.5mm self-tapping cortical screw) but do not need to provide the length of every screw. For soft tissue list any implants or materials that are being left in the patient (i.e. mesh, cellophane band, ameroid constrictor) and where appropriate the size. For suture material you should list the name, this is NOT the trade name but the material name, size, location and pattern. You do not need to provide the size/type of needle.

Many groups find it helpful to have a rotation mate be a scribe and take notes during surgery.

**DISCHARGES**

DO NOT under any circumstances discharge a patient without the attending clinician’s knowledge. A discharge summary should be completed no later than 7:30 AM on the day the patient is to be discharged. This allows time for the clinician(s) to review and sign the discharge. There are templates (separate ones for Orthopedics and Soft Tissue) on the computers that should be used to write the discharge. You can start the instructions the day the patient is admitted and then add to them as the case progresses. There is a section that is for the owner and one for the primary veterinarian. Remember that the owner section needs to be written so that they will understand the instructions (i.e. avoid medical terms). The primary veterinarian section should provide enough detail so that they know what happened.
with the patient and will be able to assist the client when they present to their clinic. Think about what you would want if you were on their end. What information would be necessary/helpful so that they can provide adequate care to our mutual patient?

When arranging discharges with the owner it is imperative that you check with the clinician(s). We will often want to be present for discharge. These should be arranged during “non-scheduled” hours (when no receiving or surgery is scheduled).

**When discharging a patient from the hospital please:**
- Be sure the discharge instructions are complete and have been approved by the clinician in charge of the case.
- Be sure the animal is clean.
- Be sure all catheters have been removed.
- Be sure any medications to accompany the animal are available and are sent home with the client.
- Be sure all "Personal belongings" of the animal are clean and ready to go with the animal.
- When releasing the pet be sure to clean the kennel in the wards.

*All animals scheduled to go home should have a completed discharge.*

You are responsible to be available for patient discharges between 8AM and 8 PM.

**CHANGING FROM ONE SERVICE TO THE OTHER**

Midway through the block (usually the Monday of Week 3) you will change from one service to the other (i.e. from Orthopedics to Soft Tissue or vice versa).

On this morning:
- You are responsible for 8 am treatments for any cases you had on service or received over the weekend.
- ALL paperwork MUST be completed for any cases you had on service. This includes SOAPs, surgery reports and treatment sheets. The Discharge should be written as completely as possible so that the student taking over the case will be able to pick up where you left off.
- You are EXPECTED to review the cases on the service to which you are transferring, this includes in hospital cases and transfers, and be ready to discuss/present these cases at rounds at 7:45 am.

**EMERGENCY DUTY**

The surgery students will establish an emergency schedule the first day of the block. An emergency duty protocol will be available during orientation. All students will personally perform their emergency duties. Failure to do so will result in an *Incomplete* and you will be required to repeat the rotation.

The schedule for ER duty and ICU is:
- Saturday, Sunday and Holidays ICU 12:00 AM – 8:00 AM
- Saturday, Sunday and Holidays ER 3:00 PM – 10:00 PM
- A back-up student should also be assigned for each shift.

* Surgery On Call:
  - One student must be available/on call every night, on weekends and holidays for surgical emergencies.
  - A duty roster will be completed on the first day of the rotation. It is your responsibility to ensure this list has the correct names and phone numbers. A back-up student must also be available for each shift.
  - The on call student MUST write their name on the laminated sheet beside the white board across from the wards by 12:00 (noon) each day.
  - A pager is available for you to carry if you would prefer to be contact in that manner. All students MUST respond to a phone call/page within 20 minutes and MUST be available to come in for surgeries when called. *Failure to respond or come in will result in an Incomplete and you will be required to repeat the rotation.* Any student presenting for an on call shift under the influence of alcohol or other substance will be sent home and will receive an F on the rotation.
  - The surgery student on call for emergencies will be responsible for the treatment of cases on the surgery service between 10:00 PM – 12:00 AM (midnight). *Failure to come in for these treatments will result in an Incomplete or F on the rotation.* Each student is responsible for filling in details of the required treatment for their case and clearly noting the location of the animal. This information MUST be placed on the white board opposite ward 1 by 6:00 PM. Any treatments written on the board after this time are the responsibility of the student on the case.
  - If there are more than 5 cases that need treatments at 10pm, the beeper student AND the backup
student will come in to do the treatments. If the on call student is busy with an emergency case they will call in the back up student AND/OR student(s) on the case to do the treatments. Examples of treatments are medication administration, urinary bladder expression, walking, removing food, hot/ice packing, checking bandages.
The on call schedule is:
Monday – Friday 5:00 PM – 8:00 AM
Saturday, Sunday and Holidays 8:00 AM – 8:00 PM

PREPARATION OF THE PATIENT FOR SURGERY
It is your responsibility to make sure your patient is ready for surgery. This includes making sure that they have been off food for an appropriate period of time (since 10pm the evening before except for young animals and other special cases) that they are clipped and cleaned prior to moving in to the OR. Many of the orthopedic cases will need a purse string suture placed in the anus so be sure to ask if this is required. The technicians and clinicians are available to help and a clinician should check the surgery clip prior to doing the “Dirty prep”.

Dirty Prep
Once the patient is anesthetized they can be clipped and the initial prep can be performed.

1. Be sure to check with the clinician regarding the area(s) to be clipped and prepped.

2. Clippers are available in the prep area:

Clippers can cause significant irritation to the skin of the patient when/if they are not used properly. If you are not sure how to use them, ask for help.

   a. Make sure you have your lab coat on and that it is buttoned up to protect your scrubs.
   b. Check the clippers to make sure they are clean.
   c. There are disinfecting sprays/solutions available and the clippers should be cleaned with these prior to use on your patient.
   d. We use a #40 blade to clip the hair.
   e. If you notice that the clippers are not working they may need to be cleaned or a new blade may be needed. The Surgery technicians are available to help trouble shoot clipper problems.
   f. The area around the proposed incision should be liberally clipped. If you are not sure how much to clip, ask.
   g. In male dogs that are undergoing abdominal surgery or when the incision will be near the prepuce, the prepuce it must also be clipped.

3. A vacuum is then used to remove clipped hair from the patient and surrounding area.

4. For procedures involving the limb or some other areas of the body, a hanging prep will need to be performed. A clinician or technician will help you with this.

   a. The distal limb/foot will be covered with an examination glove and secured to the limb with white tape. The glove is then wrapped in tap as the limb/ear/etc. is hung from an IV pole.

5. The clipped area is then scrubbed with chlorhexidene scrub and alcohol. These supplies are available in the prep area.

   a. Remove your lab coat and don a cap, mask and examination gloves.
   b. Start with clean gauze and the chlorhexidine. Using the gauze start at the intended incision and work your way out from that site. (See diagram) You NEVER want to go from the outside back in to the intended incision site and you want to keep the outer edge of the gauze on the outer edge of the area (notice how the white area of the square is ALWAYS towards the outside in the diagram). Once you reach the outer area throw the gauze away and get a new one. This is repeated until the area is covered with chlorhexidene. Wait 3 minutes.
c. Now the process is repeated with gauze soaked in alcohol.

d. Repeat step b and c until the area is clean (i.e. the gauze does not have any dirt on it when you are done scrubbing the area).

e. You should then help move the patient into the OR area.

**Sterile Prep**

This is done by the OR technicians once the patient is positioned on the surgery table.

**Operating Room**

*Attire*

- A clean pair of scrubs is required for entry in to the operating rooms.
- UNDER NO CIRCUMSTANCES SHOULD YOU WEAR YOUR SCRUBS FROM HOME AND INTO THE HOSPITAL. IF YOU DO, YOU WILL BE SENT HOME TO GET A CLEAN PAIR AND THIS WILL BE REFLECTED IN YOUR GRADE.
- The scrub top should be tucked into the bottoms.
- Undergarments should not exceed the length of the scrub sleeves.
- When wearing your scubs outside of the OR a laboratory coat MUST be worn to cover your scrubs.
- IF your scrubs become visibly soiled, contaminated and/or penetrated by blood or other materials they should be changed.
- Any external jewelry that will be exposed (i.e. rings, dangling ear rings) should be removed.
- A cap, mask and shoe covers must be donned before entering the operating room area (this includes the area of the scrub sinks just inside the doors from anesthesia prep).
- Remove nail polish or acrylic or gel nails

*Etiquette*

- Traffic in the operating rooms MUST be kept to a minimum.
- ALL students on the rotation are expected to be present in the OR observing the procedures. The best way for you to get the most out of this rotation is to be involved with every case even if it’s not yours. Students who have patients recovering or undergoing other procedures (i.e. ultrasound) will be excused.
- Conversation should be kept to a minimum within the OR.
- ALL students are encouraged to ask questions about the procedure, even if it is not your case.
- When asking questions be cognizant of what is happening with the procedure and that it is an appropriate time to distract the surgeons.

**TECHNICIANS AND SUPPORT STAFF**

The surgery (those that help with receiving and those in the OR), treatment room and ICU technicians are here to help us with the operation of the hospital and care of our patients. The front desk and other support staff also play important roles in client services and care of our patients. Please be respectful and courteous when working with them. If you have a problem or concern with one of the technicians or support staff, please bring it to the attention of the faculty member on your service.

The hospital is a very busy place. We ask that everyone pitch in to keep it clean and orderly. The technicians are not here to clean up after you. We all need to do our part and clean up after ourselves during anesthesia but you may be asked to help with induction. You will be required to clip and aseptically prepare your patient for surgery, move them to the surgery area and position them for the procedure.

The Companion Animal Surgery Fellow will supervise the lab. He or she must approve each major step in the procedure before you move on to the next step. For the surgery labs on Monday a surgery report detailing the procedure(s) that you will be performing must be written and turned in to the Surgery Fellow on arrival at the lab. Failure to do so will result in you not being allowed to participate and will be reflected in your grade.

You are also required to turn in a surgery report for the actual surgery you do in lab. This is turned in to the Fellow by **Wednesday of that week**. They will be corrected and returned to you. The due date of the corrected version will be indicated on what is returned to you.
STUDENT EVALUATION

Indirect Assessment
Students taking the full 4 week block will spend 2 weeks on the Soft Tissue service and 2 weeks on the Orthopedic/Neurosurgery service. Students will be divided and assigned to each service by the course coordinator and these assignments will be provided during orientation if not before.

Student evaluations will be based on the forms attached below. The evaluation for the first half of the block will count towards 35% of your final grade. A second evaluation for the second half of the block will count towards 45% of your final grade. The seminar will count towards 20% of your final grade.

GRADING/EVALUATION:

Grading scale used for determination of course grades (fractions will be rounded up):

<table>
<thead>
<tr>
<th>Grade</th>
<th>Vet Med grading scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>A+</td>
<td>97-100</td>
</tr>
<tr>
<td>A</td>
<td>93-96</td>
</tr>
<tr>
<td>A-</td>
<td>90-92</td>
</tr>
<tr>
<td>B+</td>
<td>87-89</td>
</tr>
<tr>
<td>B</td>
<td>83-86</td>
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<tr>
<td>B-</td>
<td>80-82</td>
</tr>
<tr>
<td>C+</td>
<td>77-79</td>
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<tr>
<td>C</td>
<td>73-76</td>
</tr>
<tr>
<td>C-</td>
<td>70-72</td>
</tr>
<tr>
<td>D+</td>
<td>67-69</td>
</tr>
<tr>
<td>D</td>
<td>63-66</td>
</tr>
<tr>
<td>D-</td>
<td>60-62</td>
</tr>
<tr>
<td>F</td>
<td>&lt;60</td>
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</table>

Direct Assessment
At the end of each week the students will be evaluated on each of the following Clinical Competencies.

Competency one: comprehensive patient diagnosis (problem solving skills), appropriate use of clinical laboratory testing, and record management

1.1 History/Physical Examination
1.2 Patient Assessment/Clinical Thinking Skills
1.3 Knowledge Base/Basic Pathophysiology
1.4 Diagnostic Skills/Clinical Laboratory Assessment
1.5 Participation in Patient Discussions
1.6 Medical Records

Competency two: comprehensive treatment planning including patient referral when indicated

2.1 Treatment planning

Competency three: anesthesia and pain management, patient welfare

3.2 Pain Management/Patient Welfare/Empathy

Competency four: basic surgery skills, experience, and case management

4.1 Basic surgical skills
4.2 Surgical experience gained through rotation
4.3 Case Management

Competency six: emergency and intensive care case management

6.1 Emergency Care Management
Competency eight: client communications and ethical conduct
  8.1 Client Communication/Client Education/Discharge Summary
  8.2 Working with Health Care Team
  8.5 Reliability/Thoroughness/Punctuality/Appearance

Competency nine: critical analysis of new information and research findings relevant to veterinary medicine
  9.1 Critical Analysis of New Information and Research Findings Relevant to Veterinary Medicine

The assessment scale for the clinical competencies is the following:
  Exemplary performance
  Expected performance
  Acceptable performance
  Below expectation

During the final assessment (at the end of week 4) any student that receives a below expectation on any of the competencies will be asked to meet with Dr. Taboada to discuss the deficiency. Specific descriptions for each of the competencies and what constitutes an Exemplary performance, Expected performance, Acceptable performance and Below expectation are available from Student Affairs.

**SVM INSTITUTIONAL LEARNING GOALS/OBJECTIVES:**

<table>
<thead>
<tr>
<th>AVMA - COE Competency</th>
<th>VMED 5454 &amp; 5463 Course Objective</th>
<th>Assessment Method</th>
<th>Teaching Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competency One:</strong> Comprehensive patient diagnosis (problem solving skills), appropriate use of clinical laboratory testing, and record management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 History/Physical Examination</td>
<td>2</td>
<td>Oral patient presentation; Participation</td>
<td>Case based instruction/learning; Discussion, Small group</td>
</tr>
<tr>
<td>1.2 Patient Assessment/Clinical Thinking Skills</td>
<td>1, 2, 3, 4, 7, 8, 10</td>
<td>Oral patient presentation; Participation</td>
<td>Case based instruction/learning; Discussion, Small group</td>
</tr>
<tr>
<td>1.3 Knowledge Base/Basic Pathophysiology</td>
<td>1-10</td>
<td>Oral patient presentation; Participation</td>
<td>Case based instruction/learning; Discussion, Small group</td>
</tr>
<tr>
<td>1.5 Participation in Patient Discussions</td>
<td>1, 3, 4, 5, 6, 7, 8, 9, 10</td>
<td>Oral patient presentation; Participation</td>
<td>Case based instruction/learning; Discussion, Small group</td>
</tr>
<tr>
<td>1.6 Medical Records</td>
<td>7</td>
<td>Multisource assessment</td>
<td>Case based instruction/learning</td>
</tr>
<tr>
<td><strong>Competency Two:</strong> Comprehensive treatment planning including patient referral when indicated</td>
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<tr>
<td>2.1 Treatment Planning</td>
<td>1, 4</td>
<td>Oral patient presentation, participation</td>
<td>Case based instruction/learning; Discussion, Small group</td>
</tr>
<tr>
<td>2.2 Understanding Therapeutic Modalities and Availability (would include knowledge of referral services available)</td>
<td>1, 4, 6, 8, 10</td>
<td>Oral patient presentation; Participation</td>
<td>Case based instruction/learning; Discussion, Small group</td>
</tr>
<tr>
<td>Competency Three:</td>
<td>Anesthesia and pain management, patient welfare</td>
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<tr>
<td>3.2 Pain Management/Patient Welfare/Empathy</td>
<td>1, 4, 7, 8</td>
<td>Oral patient presentation; Participation</td>
<td>Case based instruction/learning; Discussion, Small group</td>
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<tr>
<th>Competency Four:</th>
<th>Basic surgery skills, experience, and case management</th>
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<tbody>
<tr>
<td>4.1 Basic surgical skills</td>
<td>1-10</td>
</tr>
<tr>
<td>4.2 Surgical experience gained through rotation</td>
<td>1-10</td>
</tr>
<tr>
<td>4.3 Case Management</td>
<td>1-10</td>
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<table>
<thead>
<tr>
<th>Competency Six:</th>
<th>Emergency and intensive care case management</th>
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<tbody>
<tr>
<td>6.1 Emergency Care Management</td>
<td>1, 2, 3, 4, 6, 8</td>
</tr>
<tr>
<td>6.2 Intensive Care Management</td>
<td>1, 2, 3, 4, 6, 8</td>
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<tr>
<th>Competency Eight:</th>
<th>Client communications and ethical conduct</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 Client Communication/Client Education/Discharge Summary</td>
<td>1, 9</td>
</tr>
<tr>
<td>8.2 Working with Health Care Team</td>
<td>3, 4, 5, 6, 9</td>
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<tr>
<td>8.3 Ethical Conduct</td>
<td>1-10</td>
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<td>8.4 Emotional Stability</td>
<td>1-10</td>
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<tr>
<td>8.5 Reliability/Thoroughness/Punctuality/ Appearance</td>
<td>1-10</td>
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<tr>
<td>Competency Nine:</td>
<td></td>
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<tr>
<td><strong>Critical analysis of new information and research findings relevant to veterinary medicine</strong></td>
<td></td>
</tr>
<tr>
<td>9.1 Critical Analysis of New Information and Research Findings Relevant to Veterinary Medicine</td>
<td></td>
</tr>
<tr>
<td>9.2 Demonstrate effective use of literature, references and informational technology in support of diagnosis, case management, and continuing medical education.</td>
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<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Oral patient presentation; Participation; Multisource assessment</td>
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<tr>
<td></td>
<td>Case based instruction/learning; Discussion, Small group</td>
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