

The Plastic Surgery QA Conference is held the every 4th Tuesday of the month, at which time complications from the previous month are presented by residents from each of the rotations – UCLA, Hand Service, Harbor-UCLA, OV-UCLA, and the VA.

- o All complications for the UCLA, Harbor-UCLA, VA, and Olive View rotations must be reported.
- o In addition to complications, each resident is expected to come with one interesting case presentation prepared in PowerPoint with pre- and post-operative photos. Case presentations will be used as the bases for discussion and may be used in the Mock Oral Exams.
- o Residents are expected to notify the faculty and clinical faculty of a complication and inform them of when the case will be presented at conference.
- o All participating surgeons (faculty, clinical faculty, and residents) will be required to attend on the night their case is presented.
- o One resident will present the case (according the guidelines below). The faculty will then use that case presentation as a prompt to orally examine another resident. During the course of the conference, each resident will present at least one case and be examined on at least one case.
- o All presentations must be emailed to the UCLA Chief Resident (out-patient) prior to conference. The UCLA Chief Resident (out-patient) will be responsible for loading them onto the computer and setting up all the audio / visual equipment.
- o All QA reports and case presentations must be submitted for review by the 4th Monday of the month. (To conserve conference time, the faculty may ask that complications of a similar nature be grouped together into a single presentation.)
- o Conference should last no more than two hours.

Presentations

The purpose of the QA conference is multifactorial - while it is primarily utilized as a teaching instrument, it is also used to evaluate your breadth and depth of knowledge, and your ability to apply that knowledge to a varied range of similar clinical problems. In an effort to make the conference more educational and time-efficient, please adhere to the guidelines below. This approach will facilitate uniformity, limit cumbersome presentations, and prepare you for both your mock orals and your definitive oral examinations in the future.

1. Each case should be able to be presented in 3 minutes.
2. Only the pertinent positives and negatives should be included.
3. Case presentations should be presented as if they were a board exam case. One suggestion would be to place a small introductory digital photo on the top of a slide, with a summary bullet type paragraph adjacent to the photo so that audience members can get both a visual image and the basic info while you are presenting the case. You should then include important digital photos, showing intra-operative views if available and postoperative results. Include xrays, scans, etc when appropriate.
4. DO NOT then prepare a formal lecture / talk on the complication; rather, the case and complication will be reviewed by the attendings with the resident in a board type format. You should however, be well read and prepared on the case, anatomy, complications, understanding what went wrong, and explaining what you could or would have done differently.

You should remember that your overall presentation / evaluation has several critical components: that the resident -

1. IDENTIFIES the general problem
2. CONSIDERS reasonable goals in case diagnosis and management
3. SELECTS the most appropriate option in case diagnosis and management
4. UNDERSTANDS the risks and benefits of various approaches
5. ADDRESSES complications and unexpected outcomes adequately
6. DEMONSTRATES the ability to structure an alternative plan

Please follow the above guidelines:

- o Limit useless jargon.
- o Speak affirmatively, but without arrogance.
- o Take pride in your appearance, your documentation and your presentation – how you present yourself is as important as what you present.

Explanation of Event Codes:

<u>Technical Unpreventable:</u>	An unpreventable event related to procedure/ surgery performed according to standard protocol by a competent advisor.
Examples:	A routine hematoma postop, an infection postop when appropriate antibiotics were utilized, sterile technique used, an anastomotic failure where there is no identifiable cause for the thrombosis, etc.
<u>Technical Preventable:</u>	A preventable event related to surgery/procedure, due to an error in judgment, a technical error.
Examples:	An infection postop where there was a breach in sterile technique, a wound dehiscence where inadequate technique was utilized, a anastomotic failure where a 180 degree twist in the pedicle is noted on re-exploration, a 'back wall suture', etc.
<u>Medical Unpreventable:</u>	An unpreventable event related to a surgical procedure due to the nature of the disease but where appropriate care was given peri-operatively.
Examples:	Mortality due to nature of patient's disease, bleeding / hematoma postop in patient's with underlying coagulopathies but where appropriate care was given,
<u>Medical Preventable:</u>	A preventable event related to a surgical procedure related to an error in judgment, where routine appropriate perioperative care was NOT given.
Examples:	Inadequate management of a coagulopathy perioperatively, cardiac arrest due to untreated metabolic disorders, etc