

**Intern Orientation Packet:
Inpatient Medicine
Harbor-UCLA Medical Center
2010-2011
Caroline Kim, MD and Charles Lanks, MD
Updated 06/2010**

Purpose

This rotation is designed to provide clinical experience with patients having a variety of acute illnesses requiring inpatient hospitalization. Patients will be followed from admission (largely from the emergency department), through the ward and/or ICU, and through discharge. Medical, psychosocial, and other aspects of acute illness will be discussed. At the conclusion of this rotation, residents will have gained insight into the diagnosis and management of acute inpatient medical problems, the role of subspecialty consultation, diagnostic methods, the natural history of disease, and strategies for efficient workup and treatment.

Clinical Experience (may include the following patients):

1. Acute respiratory failure (ARDS, COPD, asthma)
2. Acute and chronic renal failure
3. Gastrointestinal bleeding
4. Complications of cancer
5. Sepsis
6. Pneumonia, tuberculosis, empyema
7. Congestive heart failure
8. Acute myocardial infarction
9. Bacterial endocarditis
10. Complications of AIDS and other immune compromised states
11. Electrolyte disturbances
12. Hypertension
13. Cirrhosis, hepatitis, biliary disease, pancreatitis
14. Altered mental status, cerebrovascular disease, meningitis
15. Medical diagnostic problems, including fever of unknown origin
16. Diabetic ketoacidosis
17. Drug overdose or toxicity, drug/alcohol withdrawal

Reading, discussion, and other educational activities should be directed at understanding the pathophysiology, clinical course, and management of the disorders listed.

Procedures (exposure to the following procedures, including indications, contraindications, and complications, is likely on this rotation):

1. Paracentesis
2. Thoracentesis
3. Lumbar puncture
4. Phlebotomy
5. Urinalysis
6. Examination of peripheral blood smear
7. Arterial puncture
8. Central line placement

In addition, this rotation will provide exposure to and experience with the indications and decisions regarding: hemodialysis, fine needle aspiration, bone marrow aspiration and biopsy, gastrointestinal endoscopy, fiberoptic bronchoscopy, cardiac catheterization, echocardiography, pulmonary function testing, exercise tests.

To see what number of each procedure is required for you to complete during internship and to log in procedures you have completed, check the verinform online web site. <http://rm.verinform.com/lac>

EDUCATIONAL RESOURCES

Remember, **this is a learning institution and you should make learning a high priority, even when you are busy on the wards.** In addition to learning from direct patient care, here are other educational resources:

1. Work rounds with resident and/or attending physician
2. Attending physician rounds (work/teaching)
3. Subspecialty residents, fellows, and attending physicians
4. ICU Rounds, daily if patients admitted to these areas
5. Department of Medicine conferences

Weekday Schedule

Monday	Tuesday	Wednesday	Thursday	Friday
6:00 Pre-round 7:30 - 9:00 Walk Rounds 9:00-10:00 AM Report	6:00 Pre-round 7:30 – 8:30 Walk Rounds 8:30 Grand Rounds (Parlow Library)	6:00 Pre-round 7:30 -9:00 Walk Rounds 9:00-10:00 AM Report	6:00 Pre-round 7:30 -9:00 Walk Rounds 9:00-10:00 AM Report	6:00 Pre-round 7:30 -9:00 Walk Rounds 9:00-10:00 AM Report
12:00P Evidence-Based Lecture/ Rotating Lecture (5W-11)	12:00P Journal Club/Rotating Lecture (1 East Surgical Conf. Room)	12:00P Primary Care Lecture Series (D-9)	12:00P Morbidity & Mortality Conference (Parlow Library)	12:00P Intern Report (5W-11)

Supervision:

1. Ward Attending Physician
2. Ward Resident (R2 or R3)
3. Ward Call (R2) for overnight cross-coverage issues
4. ICU Fellow for 5EICU patients

Evaluation:

Evaluations of your performance by residents and attendings, as well as your evaluation of them are to be completed on <http://rm.verinform.com/lac> at the end of every rotation.

Arrange a time with your residents at the midway point of the rotation for feedback as well.

ADMISSION POLICIES

1) General

- a. Each team consists of 2 residents (typically one R2 and one R3) and 3 interns.

LONG CALL	POST CALL	SHORT CALL	SHORT CALL	COVER
----------------------	----------------------	-----------------------	-----------------------	--------------

2) Long call

- a. The superteam cap is 15 admissions and each intern caps at 5 patients on long call.
- b. Sub-interns: The team will still take 15 admissions but at least 2-3 of these admissions will be assigned to the sub-intern, so each intern will take on average 4 admissions.
- c. Long call
 - i. On weekdays, long call begins at 2:00 p.m., or when short call caps, and ends at 12:00 a.m.
 - ii. On weekends, long call begins at 12:00 p.m. or after short call has capped, and ends at 12:00am

3) Short call

- a. Each intern caps at 2 patients on short call.
- b. Short call ends when the teams have capped or at 2:00 p.m. on weekdays, 12:00 p.m. on resident clinic day and weekends.
- c. Patients that are to be admitted on short call must be available for evaluation by the ward resident before short call ends. Patients that arrive late from outside clinics will be reassigned to a long call team.

4) C team

- a. Call cycle: To be determined by C-team resident and fellow. Will include the following:
 - i. Long Call – Admit until 5:00 AM with enough time to pre-round in the mornings.
 - ii. Post-Call
 - iii. Cover day – No admissions, but helps out other interns, especially post-call intern.
 - iv. Short Call – Takes admissions after rounds and until 2:00 PM. Generally takes about 2 patients.

5) Bounce backs - Patients who are re-admitted within 10 days of prior discharge can be bounced back to the original team; if the discharge summary is not dictated within 10 days then the patient may bounce back indefinitely until the discharge summary is completed. There are some important caveats:

- a. Sickle cell patients and chronic pancreatitis patients only bounce within 5 days
- b. No bounces to post call teams until the following day.
- c. No bounces on non-admitting days. These patients will remain in your care until the next day.
- d. Bounces do happen on long call
- e. Bounces follow residents not interns
- f. No bounces on the same day that you admit the patient. (i.e., if you admit a patient on short call, you cannot bounce it to the long call team that same day.)
- g. If the dictation is completed within 10days of discharge and not yet transcribed onto Affinity, then provide the dictation number to the Chiefs to verify completion
- h. If the dictation has been completed after 10days of discharge (delinquent) but has not yet been transcribed onto Affinity, then the patient may still bounce back to the original team.
- i. Patients admitted for complications from chemotherapy within 10 days of discharge may bounce back to the original team.
- j. If there are any questions or disputes, contact the Chiefs

PRE-ROUNDS

Interns are expected to round on their patients prior to meeting with the residents in the morning. Plan to give yourself enough time to round on all your patients and for any potential problems or issues that may arise. Depending on the complexity of the patient, this process may take five to twenty minutes per patient.

For each patient, you should:

1. Please review and verify the vitals on your printed progress notes for PCU and ward patients. If there are any outliers, please note the timing of these events and if they are associated with any other significant factors (i.e. high blood pressure with episode of chest pain or hypoglycemia after p.m. insulin dose). Blood sugar values, daily weights, I/O's should also be noted and recorded. Vital signs for ICU patients can be found at bedside.
2. Check for overnight events – these may be documented in the chart by your cross cover or noted in nursing notes. When you arrive to pre-round, please page your cross-cover intern to determine if there were any overnight events.
3. Check the chart for any subspecialty consultation recommendations.
4. Assess patient status – determine if the patient has any new complaints or comments about their progress. A physical exam with particular attention to areas noted to be abnormal previously should be performed **daily**.
5. Check overnight labs – for example, it is helpful to know if your patient's cardiac enzymes are negative, etc.
6. Sign any overnight telephone orders left by your cross coverage.
7. Review the need for restraints on any patient with them. Also note when the restraints will expire –make sure they expire during work hours (i.e. 8am-5pm).
8. **If you are pre-rounding on your patient in the morning and are concerned they are doing poorly, PLEASE call your resident right away rather than waiting for rounds.**

DOCUMENTATION

Documentation is a vital responsibility of interns, serving several important functions:

- 1) **Communication:** Appropriate documentation is an effective way to communicate to consult services significant history, clinical events, test results, and treatment plans for a patient. Please put notes in the chart in a timely manner.
- 2) **Billing:** It is very important for appropriate hospital billing for all services rendered. Harbor loses a significant amount of money because of inadequate documentation. When interns began using computerized progress notes, we lost approximately 25% of Medi-Cal payments because of inadequate documentation.
- 3) **Litigation/M&M Review:** Careful, complete and LEGIBLE documentation is critical in today's world of medical litigation. While you may find the ongoing need for documentation to be cumbersome at times, it is important to remember that the medical record is a legal document. One rule of thumb is to simply assume that each patient you admit will end up as a case presented at M&M, so optimal documentation is vital, to outline thought processes and rationale for diagnostic work up, management decisions, interpretation of test results.

Admission H&P

- The intern must write a full H&P.
- The H&P must be placed in the chart within 24 hours of admission.
- All notes must have the following wording at the beginning of the note: "Discussed with Dr. X at (insert time)" or "Case will be discussed with Dr. X at (insert time)".

Progress notes

- Begin each note with the appropriate statement: "Discussed with Dr. X at (insert time)" or "Case will be discussed with Dr. X at (insert time)".
- **Every day, at the end of the progress note, there must be a justification as to why the patient is still in the hospital.** This is important because Medi-cal will choose to pay the hospital or not based on this justification. It is also good practice as it forces you to think about why the patient needs ongoing hospitalization. **"Awaiting studies" or "awaiting placement" is NOT a sufficient justification for hospitalization.** Even if placement is an issue, it is crucial that justification for ongoing hospitalization be stated, such as "needs IV antibiotics for treatment of cellulitis."
- No computerized notes until further notice.
- **There must be a FULL progress note written for every day.** When you admit a patient after midnight on long call, you still need to write a new, complete progress note for the post call day. The note can be relatively short, but it must be complete. Brief addenda on post call days are not sufficient documentation.
- Do NOT intentionally post-time notes in an attempt to escape having to write a progress note post call.
- **Your name, signature and physician ID should be put on every note you write.**

Addenda

- Whenever there is a major change in a patient's hospital course, an addendum should be added in the chart with important data, such as vitals, physical exam changes, labs, study results.
- It is NOT appropriate to document administrative problems in the chart (ie. I can't reach social work or I disagree with the consult service)
- Avoid chart wars (talk to your consultants if you have contradictory plans). Do not insult, disparage consulting services in the chart.

Discharges

- Discharge triplicate forms should be filled out completely on all patients at the time of discharge.
- On the day of discharge, a full progress note must still be written in the chart.
- All prescriptions must be completed using prescription writer on Quantim CW Live. Please ask your resident or the Chief Residents how to discharge a patient using the prescription writer.

Discharge Summaries

- This is the only documentation of hospitalization that your patients will have upon discharge; the goal is to provide the next MD with all of the pertinent information
- Include all clinical diagnoses
- Include all medications and doses that the patient should be on after discharge (“continue outpatient/home meds” is NOT acceptable)
- Include all studies, pertinent labs with dates and results
- Allergies
- Discharge weight (especially important for CHF patients)
- Check the boxes for nutrition and smoking counseling boxes
- Special instructions on every patient should be specific to their condition and should begin with “Return to ED with . . .” and end with “. . . or any other concerns”
- Include any limitations (e.g. lifting limitations, weight bearing, wound care)
- **Follow up should have the correct clinic**, date and time as well as any labs that should be ordered or followed up. To book the clinic appointment, please write the clinic appointment date and time with any labs that need to be ordered as an outpatient in the order section with “d/c iv and d/c home”.
- Please make sure that the correct resident is listed on the discharge summary.
- Review the discharge summary and medications with your resident before placing it in the chart.
- Remove the pink copy and give it to your resident before the chart is sent to medical records.

Medical Student notes

- All medical student notes (MS III and MS IV) should be reviewed and cosigned daily by the resident and the intern. A MSIII note that is co-signed by the resident and intern can substitute for an intern note; this does not include ICU patients. MS III can follow patients along with interns, while MS IV can have their own patients independent of interns.

DNR documentation

- Only the ward resident (not intern) can document any DNR discussion and write the actual order. Write a DNR note documenting who the conversation was with, what circumstances were involved (i.e. disease entity, prognosis, etc.), and the outcome of the discussion, followed by specific instructions for the DNR order.
- You must discuss with your attending any conversation that you have had with the patient and/or the patient's family members as well as the outcome of the conversation.
- Your attending must sign the DNR paper **within 24 hours** of writing the order.
- Finally, you must fill out the appropriate paper work and write the order specifically listing the individual resuscitation instructions (patient is DNR including no intubation, no CPR, no cardioversion, OK pressors, etc).

Telephone orders

- Telephone orders are favors done by nurses; **do not forget to sign** your telephone orders and the telephone orders of your cross-covering intern in an expeditious manner.

Change of Service

- When starting on the wards write an order in the chart indicating “**Change R1 to__**” and include your pager number. This allows the nurses to correctly identify who to page.
- Similarly, please write an order when your resident or attending changes

CROSS-COVER

1. How to Sign Out Your Patients to the Cross-Coverage Intern/Resident

- a. On the monthly ward resident/intern assignment sheet, find the intern cross cover list. This is often posted at various nursing stations.
- b. Maintain an up-to-date sign-out.
- c. On weekdays, you may not sign out before 4 PM; on weekends and holidays, not before noon.
- d. Sign out **3WICU, 5WRTU, 6W ICU, CCU, Emergency Room, DNR, and any other patients that you are particularly worried about to the Ward Call Resident.**
- e. For patients in the emergency room, please inform Ward call when the patient may be downgraded (if stable, if rules out... etc
- f. Include code status, need for cultures if patient spikes, allergy status and any other relevant info on your sign-out. (Neutropenic, etc)
- g. Be appropriate and reasonable in what you sign out to do. Routine tasks should be completed before leaving (i.e. follow up on daily routine labs).
- h. Regarding blood cultures, a general rule is that patients who spike do not need to be cultured if they have been cultured within the previous 48 hours. This is however dependent on the patient and clinical scenario (e.g., patient is neutropenic, or is spiking temps despite a recent change in antibiotics); when in doubt, ask your resident or Ward Call. Nurses in the ER and in the ICUs can draw blood cultures; on all other floors, there are phlebotomy services available for blood cultures between 2PM-6AM.
- i. If a patient spikes between 6AM and 2PM when blood culture services are not available, then it is the intern's responsibility to culture the patient if warranted. Do not wait for phlebotomy services to become available.
- j. **Your sign out should appropriately anticipate overnight issues and provide a tentative plan for you cross-covering intern.**
 - a. Renew Narcotics every 48 hours
 - b. Soft restraints require renewal every 24 hours.
 - c. Hard restraints require renewal every 4 hours.

2. How to Provide Cross-Coverage

- a. When called, respond appropriately and timely. Remember, the nurse is calling because they are concerned for the patient.
- b. **SEE THE PATIENT YOURSELF.** Key rule of cross-coverage: **Never trust anyone's judgment that a problem is minor, but always trust someone's judgment if they think a problem is severe.**
- c. When you have multiple cross cover patients, prioritize who you see first by who is potentially more ill.
- d. After evaluating a patient, make your own assessment of the problem and a plan. Start your diagnostic or treatment plan. Discuss the patient with the Ward Call Resident (or your own resident, if convenient). Don't hesitate to have them see the patient if you are unsure or would like another opinion. Remember that Ward Call may have a very different insight or think that a much more or less active approach is called for.
- e. Document **in the Progress Notes.** Write down the DATE AND TIME you saw the patient (this is always extremely important, but even more important for cross-coverage). Indicate that you have seen the patient, why you were called, features of your history and examination, appropriate vital signs. Write down an assessment/diagnosis and your plan. Don't forget to check up on results that will be back while you are still cross covering. **Reassess the patient after your therapeutic intervention and document in the chart.**
- f. In the morning, sign out any overnight events or issues to the primary intern or resident.
- g. Oncology Patients. When signing out the patient, make sure you mention if the patient is neutropenic or not (ANC < 500 or <1000 and dropping). Explain what you would like done if these patients have a fever.
- h. Please be courteous. If you think a patient may need a blood transfusion or a CT with IV contrast, please fill out the consent form before you leave and put it in the front of the chart.
- i. Patients with respiratory distress often require ABGs. Emergent/Urgent ABGs are to be done by the intern and not by the respiratory therapist.

The HANDOFFS mnemonic

Hospital location: wing, room number
Allergies/adverse reactions/medications
Name (age, gender)/number (medical record)
DNAR?/Diet/DVT prophylaxis
Ongoing medical/surgical problems
Facts about this hospitalization
Follow-up on...
Scenarios

DNAR = do not attempt resuscitation; DVT = deep-vein thrombosis.

DAY FLOAT

Goal: The Day Float position is to be held by a 2nd or 3rd year medicine resident whose main function is to facilitate getting ALL members of the post call team home by 1pm.

Duty Hours: Day float is a resident who is currently on either a subspecialty consult or elective month. When the resident is assigned as day float, he/she is excused from all responsibilities on the consult service or elective for that day. **Day float will meet you after at 8 am. Day float duties end at 5 pm.**

DAY FLOAT PAGER 1350

Day Float Responsibilities:

- 1) **Post call rounds:** Day float will meet the post call team at **8AM** to round with the team.
 - a. The ward residents should provide day float with a list of patients for the entire team before rounds.
 - b. During rounds, the ward residents (not interns) should assign day float **specific tasks** to help the interns with their work.
- 2) **Appropriate Day Float tasks:**
 - a. Getting studies approved and forms dropped off
 - b. Following up on studies that have immediate relevance, ie. P-MIBI results, CT scan results
 - c. Following up on consult recommendations (the primary resident or intern should call in the consult since they know the patient best)
 - d. Discharging patients home after relevant studies or consults are completed (ward interns/residents should complete discharge forms before they leave so that appropriate medications and follow up appointments are given)
 - e. Managing an unstable patient
 - f. Performing urgent procedures if the primary team is unable to do them
 - g. Checking in with the team at intervals to see what work still needs to be done
 - h. Dropping off completed progress notes in the charts and writing any necessary orders
 - i. Responding to nurse pages for the post call team from 12 pm – 5pm
- 3) **NOT appropriate Day Float tasks:**
 - a. Withdrawal of care/code status discussions, or any family discussions
 - b. Completion of daily progress notes
 - c. Non-emergent procedures
- 4) **Sign Out to Cross-Cover Intern and Ward Call**
 - a. Before they leave, the ward team is still responsible for signing out to the appropriate cross-cover interns and ward call, if needed.
 - b. Day float will update the cross-cover intern or ward call if anything changes during the day.

****THE KEY TO WARDS IS TO ORGANIZE & PRIORITIZE****

1. When pre-rounding, make notes to yourself including the vitals, and any significant abnormalities on exam.
2. Prioritize time sensitive issues like ordering studies, discharging patients, dropping off consults, etc. above writing progress notes early in the day. Get study requests, such as CT forms, and consults done early in morning to facilitate a more expedient hospital course and to minimize wasted hospital days.
3. On the day of discharge, prescriptions should be dropped off as early as possible. Notify the nurse that the patient is to be discharged and the prescriptions will be in the pharmacy. Get your resident to sign the prescription in the AM during work rounds so you don't have to chase them down later in the day.
4. **Carry forms with you!** It makes your life easier if you stockpile the forms you will need on a routine basis rather than hunting for them every time. This includes radiology forms, heart station forms, contrast consents, discharge summaries, and prescriptions. Consider carrying a binder for all of your forms.
5. Consider starting a discharge summary on the day of admission. Keep it updated with important study results during the hospitalization to minimize the amount of information which must be added on the day of discharge. Don't forget to pull the pink copy for your resident and include the patient medical record number on the form.
6. **Plan ahead!** Make to-do lists in the morning with your residents and prioritize them. If possible, try to group tasks by location (i.e. get P-MIBI reading, and get U/S approval when you are in the basement). Also, start the day with a clear game plan of what you want to accomplish for the patient that day.

If you feel overwhelmed or are having difficulty prioritizing/organizing yourself, please ask your residents or the chief residents for help.

MISCELLANEOUS

- 1) **Autopsies** – Remember to offer post-mortems for patients who died with unknown or unclear causes. They are a great learning experience and are a necessity for a teaching hospital. In addition, try to make autopsy conference from time to time on your cases.
- 2) **Follow-up Appointments**
 - a. The care we give in the hospital is not sufficient if we cannot provide adequate follow up care.
 - b. Discharged patients must all have specific follow up appointments.
 - c. Patients with Medi-Cal (MCL imprinted on the lower left of the patient's Harbor Card) should be recruited into **CHP** during their hospitalization. Please call a marketing representative at x5350. However, it may take as long as 6wks for the patient to get a CHP. Thus CHC or CCC until then is appropriate.
 - d. Patients with **Medi-Cal and Medi-Care (MCL/MCR)** are usually accepted by outside physicians. Patient may schedule with an outside private MD or may follow-up in the Professional Office Building, staffed by Harbor-UCLA faculty. This can be arranged by calling x5101.
 - e. Patients without complex medical problems can be referred to **Community Health Clinics**.

The Harbor Roadmap: Hints for Surviving the Wards!!

How to Order Studies

***** ALL PATIENTS MUST HAVE ATTENDING READS PRIOR TO DISCHARGE*****

CT Scans – CT scans can be requested over Affinity. Contrast consent form must be signed by the patient or next of kin (if patient does not have capacity) if the patient is to receive IV contrast. A copy of the consent should be in the front of the chart. All approvals after hours (after 5pm on weekdays and all-day weekend) should be done by on-call radiologist (p5814). After obtaining approval take the form to the CT scanner (Basement or ER).

CT scans – Head and Neck

- **Approval:** Write an order for the CT scan in the chart and indicate whether the study requires contrast. Order the CT scan in Affinity under “Chart Assessment,” after the CT scan has been ordered in the computer by the clerk. Click on “Record” and select CT scan. Complete the required portions of the CT request online and then print to either the “CT Basement” or “CT ER.” Call x2808 to obtain approval. Make sure to ask the approving physician his/her name or initials. Then, call the CT scanner in the basement (x3600) or in the ER (x2189) and notify the technician of the approving radiologist’s name/initials.
- **Reading:** Go to 2nd floor neuro-angio reading room (2w-42) or check Synapse for a read.

CT-scans – Chest & Abdomen/Pelvis and CT guided procedures

- **Approval:** Write an order for the CT scan in the chart and indicate whether the study requires contrast. Order the CT scan in Affinity under “Chart Assessment,” after the CT scan has been ordered in the computer by the clerk. Click on “Record” and select CT scan. Complete the required portions of the CT request online and then print to either the “CT Basement” or “CT ER.” Call x3079 to obtain approval. Make sure to ask the approving physician his/her name or initials. Then, call the CT scanner in the basement (x3600) or in the ER (x2189) and notify the technician of the approving radiologist’s name/initials.
- If the patient is to take PO contrast, arrange a time for the CT and note in the order the timing for the po contrast (usually omnipaque 10 mL in 250 ml of water po q 1 hr x 3).
- In order to obtain approval for CT-guided biopsies, go to the CT body reading room (B-252) and speak with a radiology resident.
- **Procedures:** If specimen needs to be sent for laboratory studies, have labels printed in advance. For CT-guided biopsies, you must fill out the appropriate pathology and cytology form and bring them to the basement when obtaining approval.
- **Reading:** Go to basement CT body reading room (B-252). Preliminary resident reads may be found on Synapse.

Echocardiogram/Dobutamine Echo/Stress Echo

- **Approval:** No approval needed. **Write order for procedure in the chart.** Complete study request information under “Chart Assessment” in Affinity and save as final. After completed, print to “Heart.” To check on the status of a procedure (when it will be done) you can call the Heart Station at x2527. Transesophageal echocardiograms require discussion with and approval from the heart station fellow.
- **Results:** For all standard echos, prelim results by the echo tech will be in the chart. Results of stress echos or final readings on standard echos will be dictated and available on the affinity system. If results are not dictated, go to the heart station on the 8th floor and ask the clerk.

EEG: Yellow EEG Form

- **Approval:** Fill out EEG request form (found on 6 West nursing stations). Bring to 8E-12.
- **Results:** Call x2492 for results.

Exercise Treadmills / Dobutamine Stress test / Holter / Tilt table test

- **Approval:** No approval needed. Write an order in the chart and complete request in Affinity under “Chart Assessment.” Print request to “Heart.” To expedite study, discuss with Heart Station fellow.
- **Results:** Sometimes results will be in the chart. Otherwise call (x2527) or go to the heart station on the 8th floor and ask for the result at the main office. (8E-21)

Interventional Radiology/Angiography

- *IVC filter, tunnel catheters, angiograms, etc
- Approval: Fill out the **grey** IR/Angio form. Go to the 2nd floor IR suite (2w-40) or the neuro-angio reading room (2W-42, at the end of the hall) to get approval. For the status of a study call x2808.
- Biopsy: Arrange for labels for laboratory studies to be made in advance. Fill out any necessary pathology or cytology forms in advance.

MRI

- *All MRIs are performed at the imaging center on the other side of campus. Pts will be transported there by van.
- Approval for Head, Spine, and Neck: Write an order for the MRI in the chart and indicate whether the study requires contrast. Order the MRI in Affinity under "Chart Assessment." Click on "Record" and select MRI. Complete the required portions of the MRI request online and then print to either the "MRI." Call x2808 to obtain approval.
- Approval for abdomen/pelvis: Write an order for the MRI in the chart and indicate whether the study requires contrast. Order the MRI in Affinity under "Chart Assessment." Click on "Record" and select MRI. Complete the required portions of the MRI request online and then print to either the "MRI." Call x3079 to obtain approval.
- MRI readings: Call 2801 for readings or look in synapse for a prelim read. If urgent, go to the 2nd floor neuro-angio reading room (2w-42), at the end of the hall) to review the images with the neuroradiology attending.
- **Intubated patients requiring transport to MRI must be accompanied by a R2 or R3.
- Patients requiring sedation, need to be accompanied by an intern (ativan, morphine, haldol) or resident (if additional agents are required).

Nuclear Medicine

- *MIBI, V/Q scan, tagged WBC scan
- Approval: Fill out the **gold** nuclear medicine form. Go to the basement nuclear medicine area. Sometimes radiologists can be found in the ultrasound reading room at the end of the hallway. **Must be stamped with patient ID card.**
- Results: Usually nuclear medicine results will be on the computer. Can also call x2841 for results.
- *Remember, for MIBI studies, the patient should be NPO after midnight with no caffeine, no sodas, no chocolate
- *For PET Scans, patient must be on a glucose free diet for the preceding 24 hours.

Pulmonary Function Tests

- Approval: No approval required. No form for inpatient PFT's. Write "PFTs" in the pt order sheet.
- Results: You usually have to call or go to the PFT lab to get results. (204-4; from the elevator go down the hallway marked radiology and make a right at the end. The PFT lab will be on your left). A preliminary report will usually be on the chart.

Ultrasound/Ultrasound guided procedures

- Approval: Complete blue MRI/US form. Go to the basement ultrasound area to obtain approval. Radiologists can be found in the ultrasound reading room at the end of the hallway. For approval after 5 pm or on weekends call radiology on call (p5814).
- Procedures: If procedures are to be sent for laboratory studies have labels printed in advance. For Pathology specimens, have the Cytology and Pathology forms completed in advance.
- Results: Can also call x2831 for results OR look on synapse for a prelim read.

X-rays

- Approval: Write an order for the desired x-ray and how many views in the orders sheet. No form as an inpatient!!!
- Results: Results can be found on the computer, it can often take many days for inpatient studies, and longer for outpatient studies. To look at the x-rays, log onto Synapse. To review films with radiology, locate them on the 2nd floor reading room.

Procedures

All procedures should be supervised by a resident

Procedure Notes

For all procedures, a procedure note is required. Patients should be informed and consented. Use a standard procedure note: physician performing the procedure, name of procedure and location of procedure, technique, findings, complications and labs sent. Don't forget to include the Time out.

ABG

These are done by the physician in urgent/emergent situations. ABG kits can be found on all floors. Ice is found in the kitchen area on the wards. Ask the ward clerk to print an ABG label. Usually, you will need to take the ABG to the blood gas lab on the 2nd floor (room 204-3, from the elevator go down the hallway marked "radiology" and make a right at the end. The blood gas lab will be on your left).

ABGs can be obtained from arterial lines by the nurses.

Non-urgent/emergent ABGs can done by RT.

Blood Cultures

If a patient has a fever, typically >101.4 in a normal patient and > 100.4 in an immunocompromised patient, they may need to draw blood cultures. Between 2pm and 6am these may be drawn by the Blood Culture phlebotomy service. From 6am to 2pm, these must be done by a physician unless the patient is in an ICU or in the ER. Usually 2 sets of blood cultures are drawn. 3 sets should be drawn in suspected cases of endocarditis.

Ideally, blood cultures should be drawn from two separate sites or from the same site at least 5 minutes apart. Skin prep kits are available on all floors and should be used to sterilize the venipuncture site. Try to get about 5 cc of blood in both the aerobic and anaerobic bottles.

Fungal isolator tubes are available from the lab on the second floor. These should be used to send for fungal or AFB cultures in addition to the usual blood cultures. Phlebotomy techs and nurses can draw fungal cultures for you if you have the isolator tube.

Cytology

Fill out and stamp the white cytology form which can be found at any nursing station.

HIV

A verbal consent must be obtained and documented with the HIV order. These CANNOT have 2 physician signatures. ONLY the patient can consent – If the patient is altered, an HIV test CANNOT be ordered.

Pathology

Fill out and stamp the green surgical pathology form which can be found at any nursing station.

Death Notes

A death note must be written for all patients who die on the medicine service.

The basic form of the death note:

"Called by nurses to see patient for.... On physical exam, pupils were fixed and dilated. Patient was pulseless, apneic, and without heart tones. Patient was unresponsive to painful stimuli. Patient pronounced dead at (time) on (day/month/year). Family (notified/at bedside). Family (desires/declines) autopsy."

Blood Products – Call Blood Bank for availability of all blood products (x2252)

Blood Transfusion

Usually no approval required, unless there is a blood shortage. Send a type and cross for the blood. You must consent the patient using the "Authorization for informed consent to surgery" form (HH-209) in addition to the usual "Blood Transfusion Information Sheet" form (HH687). There is also a form for ordering the blood transfusion. Call the blood bank to request the blood products. Typically, patients will receive each unit of PRBCs over 2 hours. In an emergency

you may need to go to the blood bank to get blood more quickly. In cases of transfusion reactions, immediately stop the transfusion and assess the patient. Call your senior resident. Blood bank should also be immediately notified.

Fresh Frozen Plasma

This always requires approval from the blood bank. Call x2252. They will ask for patient details including HH#, PT/PTT. Typically, you will get approval for 2-3 units. No premedication is usually given.

Platelets

This always requires approval from the blood bank. Call x2252. They will ask for patient details including HH#, PT/PTT, platelet count. Typical transfusion thresholds: plts >50k if active bleeding, plts > 20k if febrile, and otherwise plts > 10k. Usually no premedication given.

Consults

Medicine subspecialties/Neurology

Drop a white consult in the consult box. The boxes are located on 5East. For emergent consults, page the fellow.

Dermatology

Page the Dermatology resident (p5856) and leave the white consult form in the front of the chart.

Surgery Consults

Boxes for all surgical subspecialties (GI oncology, cardiothoracic, vascular, colorectal) except trauma, are located in the 3 west ICU. Typically any emergent general surgery consult is done by the trauma service (p4291) and then given to the appropriate subspecialty.

ENT consults

Page ENT at p2665 at night or for urgent consults. Leave white consult form in the front of the chart.

Orthopedic consults

Leave a white consult sheet along with x-rays (they will hassle you if you don't take x-rays) in the consult box in the cast room on the 2nd floor. Page the orthopedic surgery resident on-call for urgent consults.

Urology consults

Page urology at p3821 for urgent consults and leave white consult form in the front of the chart.

Psychiatry Consult

Call the psychiatry consult liaison office at x3128. Leave a message with the appropriate information. Fill out the "Psychiatric Consultation Evaluation Form" which can be found at any nursing station and leave in front of the chart. During nights and weekends call psychiatric ER at x3144 for emergent cases or holds.

Ophthalmology

Page ophthalmology p3303 after hours or for urgent consults. Leave the white consult form in the front of the chart.

Neurosurgery

Page p2701 for consults.

If you do not know how to reach a certain subspecialty, you can always call the ER (ext 3528) and ask for the person on call.

Remember

**You are NOT expected to know everything
You ARE expected to ask for help.**