BUMCP INTERNAL MEDICINE WARD ORIENTATION

KENDALL NOVOA-TAKARA AY 19-20

REVISED 12/13/19

IMPORTANT CONTACTS

- Site director Kendall Novoa-Takara
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- Student Coordinator: Fran Harvey
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STUDENT RESPONSIBILITIES

- Work up and follow patients assigned by resident
- Patient load MS 3 1-3 , MS 4 3-5
- Preround on all patients before attending rounds
- Review charts thoroughly at beginning and end of each day
- Staff all patients with intern or resident before attending rounds-you must reach out to them
- Present patients on rounds
- Write H&P
- Write daily SOAP notes and SIGN BEFORE attending rounds
- Personally follow up on every study ordered on your patient
- Personally review all plain X ray and CT imaging
- See patients again in the afternoon
- Keep pager on person during duty hours
- Read on your patients
- Call your resident if someone doesn't look good or with questions

PHONE SYSTEM

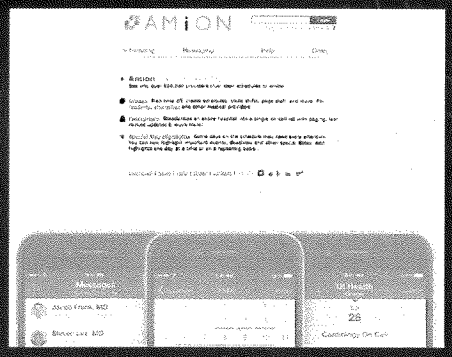
- Area code 602, hospital prefix 839-XXXX
- To call anywhere inside and outside of the hospital dial 9+phone
- For area codes 480 and 623 do NOT dial the usual "1" before the area code and phone number
- Most phones in the nurses stations can be used to directly dial US phone numbers; if call can't be placed from phone you are using ,dial 0 for the operator for assistance dialing

CELL PHONE USE

- Cell phones: don't work in the basement unless you have verizon
- Avoid texting patient names

PAGING SYSTEM

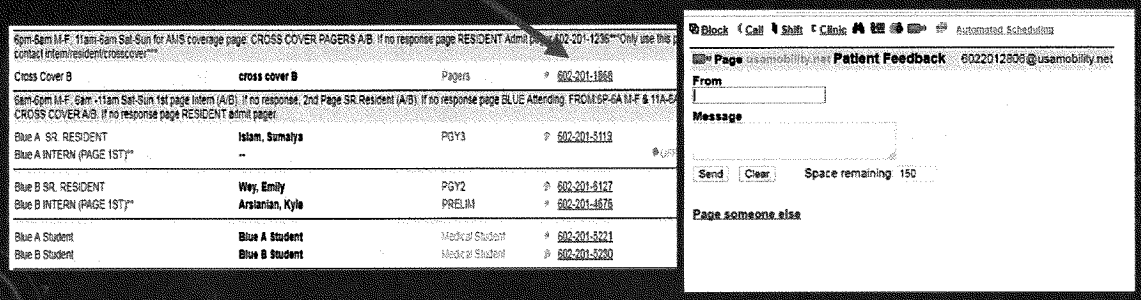
- Amion.com
- Password: bgsmcim all
- Most reliable way to page is to send numeric page using the phone number
- Paging system works everywhere in the hospital



USING AMION

Click on the pager number

Sign your page using 'From' field—if you don't the receiver has no idea you sent the page



Cross Cover B	**cross cover B**	Pagers	602-201-1868
Blue A SR. RESIDENT	**Islam, Sumaiya**	PGY3	602-201-5119
Blue A INTERN (PAGE 1ST)**	--		
Blue B SR. RESIDENT	**Wey, Emily**	PGY2	602-201-5127
Blue B INTERN (PAGE 1ST)**	**Arsianian, Kyle**	PRELIM	602-201-4676
Blue A Student	**Blue A Student**	Medical Student	602-201-5221
Blue B Student	**Blue B Student**	Medical Student	602-201-5230

PAGER: 'HOME' SCREEN

Press to stop pager from beeping/buzzing etc, to read through messages

Press to switch to control screen

PAGER:'CONTROL' SCREEN

Set an alarm

Set time

Set 'tone' or to vibrate

turn pager off

Use arrow keys on bottom to navigate right and left

To turn pager on: hold down until it comes on

PAGER: READ AND DELETE MESSAGES

Press to go to screen to delete messages

delete ALL

delete selected

LOCK (can't be erased unless unlocked)

Press once desired option is selected

STUDENT TEAM ASSIGNMENTS

- MS 3 student carries the B pager
- MS 4 student carries the A pager
- If more than one MS3 or MS4 on team, MS 3 may carry the A pager and MS 4 may carry B pager
- Student should stay on one side of the team (work with one resident only)
- MS 4 A team, MS 3 B team—OK if attending decides MS 4 B team and MS 3 A team

TEAM ROOMS

- 10: Green
- 11: Red
- 12: White
- 14: Blue
- 17: Orange

MEDICAL STUDENT DOCUMENTATION FOR BILLING

- Write in regular note section—NOT student note section
- Title note " Internal Medicine Teach H&P or PN"
- Your entire patient interaction (obtaining history/interim history and physical exam) MUST be supervised and confirmed by the intern/resident cosigning your note
- You must be proactive to make arrangements with your resident
- MS 3 one H&P/day, MS 4 two H&P/day

H&P/INITIAL CONSULT DOCUMENTATION

- Must have a chief complaint
- No BUMCP ER course in HPI: outside ER/hospital/ICU course does belong in HPI
- 10 organ ROS and Physical exam ** DO NOT SAY NEGATIVE UNLESS OTHERWISE INDICATED
- Must include allergies, past medical, surgical, social, and family histories
- Formulate a complete problem list with differential diagnosis on active problems
- Write up assessment and plan by problem
- Consult notes must say "patient seen at the request of Dr. _____(attending's name)

WRITING PROGRESS NOTES

- Use SOAP format (most widely used here at BUMCP)
- S=subjective, do not include vitals, labs etc. OK to include over night events but keep brief as if significant will be discussed in assessment and plan
- O=objective, start with vitals, I/O, weights then PE, labs, and studies
- Do not pull in the whole radiology report-use impression only and keep report only for ONE day; if important will be part of your assessment and plan
- Start assessment and plan section with a brief summary of why patient is admitted (1-3 sentences—keep it brief, you shouldn't be discussing your whole assessment and plan here)
- Discuss assessment and plan by problem-what is going on, why, what you think about it (sometimes implied by your actions), and what you want to do

CLINICAL ILLNESS STATEMENT (H&P) VS SUMMARY (PN)

Clinical illness statement***use this on H&P before your A/P→build DDX off this

- 42 y/o female w/ PMHx of Crohn's disease with hx of colon resection x2 (most recent 2008), anxiety, insomnia , HTN who presents with intractable nausea/vomiting, abdominal pain, and elevated Lactate level.

Summary: use this on progress note→already know DDX, focusing on workup and tx AKA ID STATEMENT

- 42 y/o female w/ PMHx of Crohn's disease with hx of colon resection x2 (most recent 2008), anxiety, insomnia , HTN who presents with intractable nausea/vomiting, abdominal pain, and elevated Lactate level with concern for Crohn's flare.

EXAMPLES OF DOCUMENTING COMMON PROBLEMS

PATIENTS WITH DIABETES

Components

- DM 1 or 2
- A1c with date(if not done in last 90 days, order one)
- BS range in past 24 hours or previous day
- Current insulin regimen
- What you think about BS control
- What you want to do

Examples

- DM2-A1c 9.0 on admission, BS 215-419, Lantus 10, lispro 5 with meals + ssi, total insulin yesterday 40 units, change lantus to 23 and lispro to 7 tid ac
- DM2-A1c pending, BS 40-160, Lantus 80, lispro ssi, total insulin yesterday 80 units, change lantus to 20, no scheduled lispro, cont ssi
- DM1-A1c 8, DKA resolved, new diagnosis, BS 160-180, on insulin drip 2 units/hour average, calculated 24 hour insulin need 40 units, start lantus 20 units daily, lispro 6 units tid ac, and low resistance ssi

INFECTIONS

Components

- What infection (location/organism)
- Current antibiotic regimen and day of treatment
- How is patient doing on abx? (better/worse/same)
- Tolerating abx?
- What do you think? What do you want to do?

Examples

- HAP-RLL infiltrate, concern for gram negative infection, sputum and blood cx pending, afebrile, O2 2L NC, vanc/zosyn day 2, tolerating, await culture results to deescalate
- MRSA bacteremia-from skin abscess/cellulitis, TTE neg, blood cultures neg x 7 days, day 7/15 vancomycin, tolerating, PICC line placed, anticipate dc to SNF

ALCOHOL WITHDRAWAL

Components

- Specify type (etoh withdrawal seizure, withdrawal, delirium tremens)
- Current treatment regimen (CIWA or MSAS +/- scheduled benzo)
- HOW MUCH benzo required in 24 hours/previous day
- How is patient doing? What are your plans?

Examples

- Etoh withdrawal-currently on CIWA, got 20 mg of diazepam yesterday, 50 mg day before, improving, continue CIWA
- Etoh withdrawal-blood alcohol on admission .2 and symptoms of withdrawal, hx of etoh withdrawal sz, on scheduled diazepam 20 mg q 8 hours and CIWA, got 60mg yesterday compared to 100mg day before, sx improving, dec diazepam to 10mg q8 hours and cont CIWA

PAIN

Components

- Location of pain and acuity
- Severity of pain (pain scale)
- Current pain regimen
- HOW MUCH medication was given in 24 hours/previous day
- What you think about their pain control
- What your plan is

Examples

- Acute on chronic abdominal pain-pt with CML blast crisis, CT abdomen shows no perforation or obstruction, appendix not visualized,+ peritoneal fluid, pain 15/10, exam with peritoneal signs, on fentanyl patch 100mcg/hr and taking oxycodone 20mg qid prn, got 80 of scheduled oxy and additional 40mg, pain uncontrolled, can't r/o appendicitis, surgery has seen, not operative candidate even with peritoneal signs, second opinion pending, continue fentanyl patch, add dilaudid pca .2mg q 15 minutes, no basal, stop oxycodone

DOCUMENTING ON COMPLEX PATIENTS

- Consider organizing assessment and plan by organ system then go into individual problems
- Prioritize by severity of illness in overall organ system
- OK to keep housekeeping things at the end (DVT prophy, Code status, Nutrition, etc)
- Example: 67 year old female with ANCA positive RPGN s/p rituxin, TPE and temporary HD presents for nausea, vomiting, and pruritis and is admitted when labs show hyponatremia, higher BUN, higher creatinine, and metabolic acidosis
- 67 year old female with ANCA positive RPGN s/p rituxin, TPE and temporary HD presents for n/v/pruritis
  a. RPGN-creatinine and BUN improved with hydration overnight, appreciate nephrology consultation, no need for HD at this time
  b. Hyponatremia-worse overnight, fluid restrict per nephrology to 1 liter/day, monitor BMP Q 6
  c. Metabolic acidosis due to renal failure-no need for renal replacement therapy, continue sodium bicarbonate per nephrology

PRESENTING H&P/INITIAL CONSULT

- Start with chief complaint
- HPI focuses on history related to CC and focus on pertinent positives and negatives (refer to DDX & Clinical Illness Summary talk for details)
- Do NOT include ER course, OK to include ICU course/outside facility course
- When going through HPI pertinent positives/negatives start with your working diagnosis then the rest
- Clinical illness statement goes after PE/labs/studies
- State DDX
- Go through your assessment and plan by problem starting with your working diagnosis
- You can say less on rounds but be prepared to answer any question your resident or attending may have
- Written documentation must be complete (10 organ ROS/PE etc)

PRESENTING ESTABLISHED PATIENTS ON ROUNDS

- Students present their patients on rounds unless time constraints prevent
- Start with one liner on who the patient is and why they are admitted
- Clear organization: Subjective, Objective, Assessment and Plan by problem
- Don't mix S-O-A-P components up
- Practice, practice, practice

TIPS ON PRESENTING : SUBJECTIVE

- If your listener is new to the patient, state why the patient is admitted and when they were admitted (a couple of sentences) OR give the problem list of the active issues (if they have already reviewed chart, give less detail)
- The subjective is HOW the patient feels, this is where your FOCUSED ROS (pertaining to active medical problems) goes
- Keep things organized: subjective is subjective, objective is objective, etc.
- Do not include consultation, studies, etc unless it relates to HOW patient feels (e.g. had colonoscopy yesterday, tolerated well, no abdominal pain—don't tell me the results of the colonoscopy here)
- What if something happened overnight? Keep the report brief…A/P is later
- Don't repeat things in multiple places—we'll hear about your interventions etc in A/P

TIPS ON PRESENTING: OBJECTIVE

- Start with vital signs, include I/O and weights if pertinent
- Focused physical exam, related to WHY patient is in the hospital
- Labs -only the abnormal ones or those with significant changes, do not go into detail on what is being done about it here
- Studies-all of them (in past 24 hours), do not go into detail of what is being done as result of study
- Usually NOT consults—usually better served in assessment and plan, but could be briefly alluded to (e.g. CT abdomen/pelvis with and without contrast done per surgery recommendations…then list findings)

TIPS ON PRESENTING: ASESSMENT AND PLAN

- Present assessment and plan by problem
- Reprioritize problem list daily (what is keeping patient in the hospital gets higher priority)
- **For each problem talk about: what is going on, why it is happening, what you think, how the patient is doing, what you want to do**
- More active and complex issues get more time
- Problem list must be complete
- Be concise, telegraphic is OK (don't have to use full sentences)
- Recall my examples for writing a progress note for diabetes, pain, etoh withdrawal, and infection—that is exactly what I would say when presenting

MS 3 REQUIRED EVALUATION FORMS

- CEX (direct observation), H&P, presentation on rounds
- Must be filled out by attendings
- Attendings will complete one evaluation a week per student
- Dr. Novoa-Takara available to assist, one evaluation a week per student
- ***Banner specific MS 3 form: AHD rounding report

TYPICAL WARD SCHEDULE

TYPICAL day

- 6:00 preround
- Rounds: 8 ish on Tuesday, 9 on Friday, and 8:30 or 9 ROW
- Conferences
- Leave when short/long call duties completed

CONFERENCES

- Academic Half Day Tuesday 9:15-12:30 am (amphitheater)- MS 3 exempt, MS 3 stays with attending and completes form weekly
- Tues PM student didactics
- Morning report: Mon, Wed, Thur 11 am (classroom C)
- Grand rounds: Fri 8-9 (amphitheater)

CALL

- Short call M-F 7am-4pm all types of patients
- Weekend short call until 11 am (NF holdovers, bounce backs)
- Long call until 6pm
- Get your last patient at 3:59 pm or 5:59 pm not that you can leave the hospital at that time
- Must come back to BUMCP after didactics (lecture, simulation, longitudinal care) if on long call
- Attending rounds are mandatory

NIGHT FLOAT

- Starts at 5 pm and goes until 8 am the next morning
- Meet in your team's room at 5 pm
- Attending rounds 6-7 am Mon-Sat, 6-10 am on Sundays
- Follow intern all night
- Perform H&Ps on new patients
- Participate on cross cover and write cross cover notes
- MS 4 must work 4 nights for UACOMP credit for rotation
- Number of H&Ps to write: MS 3 one MS 4 two

CALL ROOMS

- 17th floor reserved for med students on nights
- Code: 1928*

CROSS COVER NOTES

- CC: why you were called
- Identify patient, list pertinent PMH and reason for admission
- TARGETED history and physical
- Assessment and plan
- Write notes as you go along and addend if necessary
- Notes are critical so all participating in the care of the patient can read
- Do not need to use progress note template, free text is fine
- longer≠better
- MS4 turn in at least one cross cover note to Dr. Novoa

NIGHT FLOAT TO DAY TEAM TRANSITION

- Sat PM-Sun AM
- Sat pm: get names of patients you will be taking over/following after the transition and read their charts and go see them
- Sun am: 4:30-5am go see the patients you picked up
- Sun am: write progress notes
- Sun 6-10am attending rounds
- Team signs out to day senior
- Leave hospital by Sun 10 am
- Return to hospital Monday am

ROUNDS

- Mandatory
- Prepare for rounds by reviewing charts, seeing patients, discussing patients with intern/resident
- Take care of personal business (eating, drinking, restroom) before rounds
- No food/drink on rounds (outside of team room)
- Stay off phone and computer during rounds unless specifically asked to look something up
- Focus on patients being presented, whether on your side or not

DAYS OFF

- 3-4 days off per month-1 day off for a 7 day week
- When on night float, students typically have Monday night off (to participate in Tuesday afternoon didactics) and Friday night
- ***When on nights if additional curriculum (LPC, hospice, simulation etc), leave by midnight the night before scheduled activity

ABSENCES (ILLNESS AND EMERGENCY)

- If you are sick, please don't come in
- Notify your school
- Notify your team
- Notify Dr. Novoa-Takara and your attending
- Additional absences may require alternate experiences/work extra shifts after rotation ends OR remediate rotation

HOSPITAL POLICIES

- Introduce yourself by name and explain your role
- Wear name tag at all times
- Address patient by surname preceded by Mr., Mrs. etc
- Dress code: no sleeveless shirts, bare midriffs, open toed shoes
- Scrubs-per attending preference

SAFETY

- In case exposure, notify your attending and site director immediately and seek appropriate medical care (occ health or ER), follow any procedures/policies of your school
- If you feel threatened at anytime by a patient, excuse yourself from the room immediately and notify your senior resident and attending

Security Tip of the Week

PRISONER PATIENT

May 1, 2019

A prisoner patient is any patient in Law Enforcement (LE) or Correctional custody

This patient population presents unique safety challenges because the potential of the patient attempting to escape custody A study of prisoner escapes from hospitals show 62% of escapes occurred when restraints were partially or completely removed, 29% took place in restrooms and 39% took place most frequently in the clinical treatment areas

It is important to know what to do and what security measures to take when caring for the patient. These security measures include, but not limited to

- Notify Security anytime a prisoner patient is declared, or LE/Corrections is present guarding a patient. Banner Security will assist with establishing security measures
- Security must be notified of any patient movement from room (ambulation, procedures, etc.)
- Patient must always be accompanied and restrained by LE/Corrections, including transportation of the patient anywhere in the building and monitoring during all examinations, treatments tests, surgeries, and procedures
- At a minimum, two (2) limbs shall always be secured to the bed
- Restroom privileges are not allowed, provide alternatives such as urinal, bedpan. Keep the bathroom door locked to avoid unauthorized use or access
- List patient as NINP
- No visitation or telephone privileges
- No mail, packages, flowers, or other gifts
- Remove items from room that could be used as weapons
- All meals served with disposable utensils
- Do not discuss discharge times with the patient
- Do not indulge in undue familiarity with the patient. Employees will not
  - Discuss their personal lives with the patient
  - Sit on the patient's bed
  - Correspond or assist in conducting correspondence for the patient with persons outside the facility
  - Discuss rules/regulations or other issues relating to patient incarceration or detention

For additional information and procedures on prisoner patients read Patients in Law Enforcement or Correctional Custody Policy #806

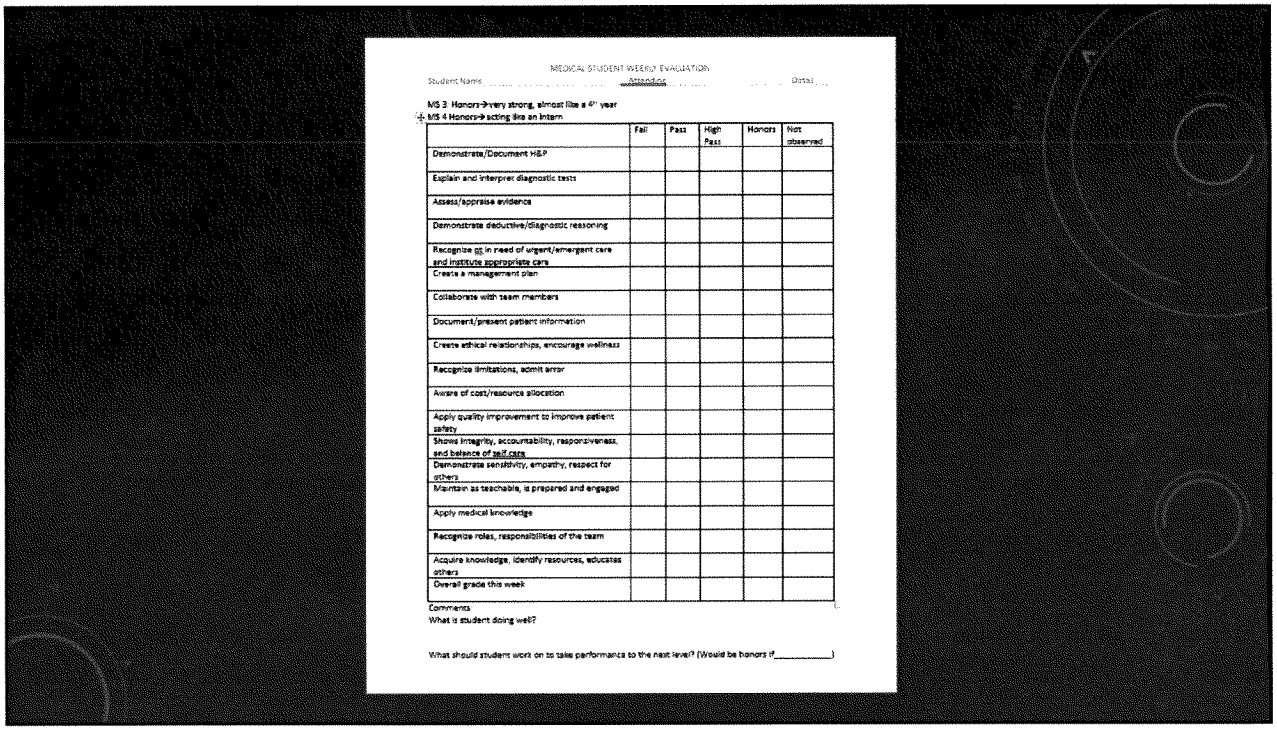
Never attempt to stop an escaping prisoner!

MS 3 EVALUATIONS

- UACOMP evaluations will be done in One45
- MS 3 will select evaluators
- Attending will be notified no later than TUESDAY during the week that they are working with you that they are responsible for the evaluation
- Student is responsible for sending eval to attending by WEDNESDAY of the week you work together
- Attendings notified/selected after going off service are not obligated to complete evaluation
- Evaluation cannot be done during night float week

M4 EVALUATION

- Attendings will give weekly evaluations to Dr. Novoa
- Dr. Novoa will be compile all evaluations to compose the final evaluation
- Paper evaluations will not be given back to students, they will be given to the student coordinator and then submitted to your school



MEDICAL STUDENT WEEKLY EVALUATION

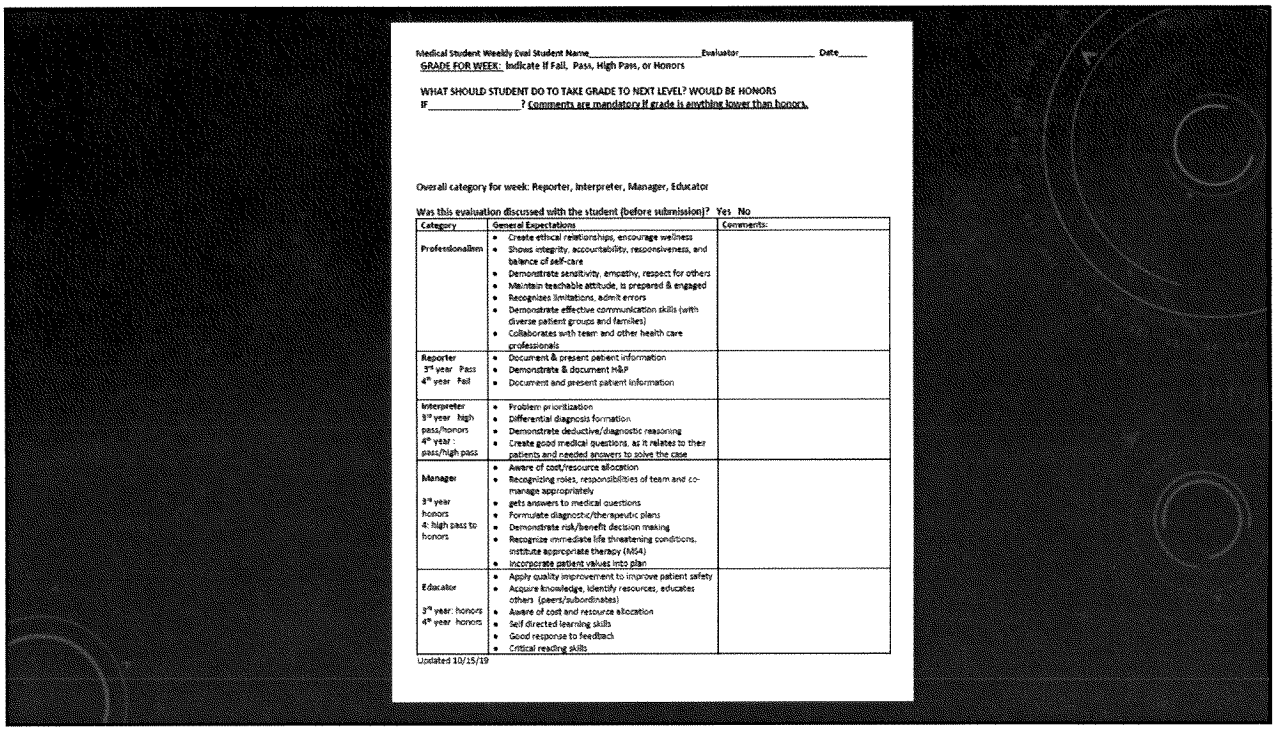
Student Name _____ Attending _____ Dates _____

MS 3 Honors→very strong, almost like a 4th year
MS 4 Honors→ acting like an intern

	Fail	Pass	High Pass	Honors	Not observed
Demonstrate/Document H&P					
Explain and interpret diagnostic tests					
Assess/appraise evidence					
Demonstrate deductive/diagnostic reasoning					
Recognize pt in need of urgent/emergent care and institute appropriate care					
Create a management plan					
Collaborate with team members					
Document/present patient information					
Create ethical relationships, encourage wellness					
Recognize limitations, admit error					
Aware of cost/resource allocation					
Apply quality improvement to improve patient safety					
Shows integrity, accountability, responsiveness, and balance of self care					
Demonstrate sensitivity, empathy, respect for others					
Maintain as teachable, is prepared and engaged					
Apply medical knowledge					
Recognize roles, responsibilities of the team					
Acquire knowledge, identify resources, educates others					
Overall grade this week					

Comments
What is student doing well?

What should student work on to take performance to the next level? (Would be honors if_____)



Medical Student Weekly Eval Student Name_____Evaluator_____ Date_____

GRADE FOR WEEK: Indicate If Fail, Pass, High Pass, or Honors

WHAT SHOULD STUDENT DO TO TAKE GRADE TO NEXT LEVEL? WOULD BE HONORS IF_____? Comments are mandatory if grade is anything lower than honors.

Overall category for week: Reporter, Interpreter, Manager, Educator

Was this evaluation discussed with the student (before submission)? Yes No

Category	General Expectations	Comments:
Professionalism	• Create ethical relationships, encourage wellness • Shows integrity, accountability, responsiveness, and balance of self-care • Demonstrate sensitivity, empathy, respect for others • Maintain teachable attitude, is prepared & engaged • Recognizes limitations, admit errors • Demonstrate effective communication skills (with diverse patient groups and families) • Collaborates with team and other health care professionals	
Reporter 3rd year Pass 4th year Fail	• Document & present patient information • Demonstrate & document H&P • Document and present patient information	
Interpreter 3rd year high pass/honors 4th year : pass/high pass	• Problem prioritization • Differential diagnosis formation • Demonstrate deductive/diagnostic reasoning • Create good medical questions, as it relates to their patients and needed answers to solve the case	
Manager 3rd year honors 4: high pass to honors	• Aware of cost/resource allocation • Recognizing roles, responsibilities of team and co-manage appropriately • gets answers to medical questions • Formulate diagnostic/therapeutic plans • Demonstrate risk/benefit decision making • Recognize immediate life threatening conditions, institute appropriate therapy (MSA) • Incorporate patient values into plan	
Educator 3rd year: honors 4th year honors	• Apply quality improvement to improve patient safety • Acquire knowledge, identify resources, educates others (peers/subordinates) • Aware of cost and resource allocation • Self directed learning skills • Good response to feedback • Critical reading skills	

Updated 10/15/19

MEETINGS WITH DR. NOVOA

- To review documentation submitted (MS 3 H&P or MS 4 cross cover notes)
- For every document you submit, you should have a meeting with Dr. Novoa to review BEFORE your next one is due
- MS H&P are submitted in weeks 1-3, no submission during week 4
- Documents are submitted on paper unless otherwise instructed by Dr. Novoa
- Electronic submissions must be deidentified, SCANNED, and preferentially sent encrypted (internal medicine department staff can send it encrypted)
- MS 4 Mid-rotation feedback
- MS 4 End of rotation
- As needed for coaching etc if desired by student
- Please check schedule for exact dates and time
- Meetings are in Internal Medicine Department unless otherwise indicated

CHECKOUT

- MS 3: A block check out Friday afternoon, B block Thursday noon.
- MS 4: check out on Friday afternoon
- MS 3 If night float on last week of rotation of B block, check out Wednesday by 4 pm, last shift is Wednesday 5-10pm

FIRST DAY ASSIGNMENTS

- Make sure your computer codes work
- Ask residents to help you get to team list in cerner
- MS 3 pick up at LEAST one patient if you are on a DAY team—'new' to you, not necessarily new to the team.
- Critical for you to pick up a patient so you have someone to present and can get feedback from your attending this week
- Sub I pick up TWO patients if you are on a day team
- Email a one liner to Dr. Novoa about your patient—age, sex, and reason for admission—do not email the patient name or MRN