Emory Family Medicine Inpatient Service Guide

2013

**BASIC EXPECTATIONS**

-Sign out is at 7:30 AM Monday-Friday, 8:30 AM Saturday & Sundays (and designated holidays).

PM sign out is at 6:30 pm everyday

-For AM, meet in conference room on 6th floor of hospital. To open door, push 2 and 4 together, then push 3

-For PM, meet in residents’ lounge on 5th floor of MOT. Code is 1234#

-Interns are ALWAYS present at sign out, both AM and PM

-Interns will print sign out sheet for afternoon sign out

-Night resident will print sign out sheet for morning sign out

-The night resident or upper level day resident will prepare a brief teaching presentation for morning report

-All residents must see new patients together, preferably with attending

**PGY-1**

-Interns will carry AT LEAST 5 patients on service

-You MUST see your patients, know their labs and vitals and overnight issues BEFORE morning report

- You will do all admissions with the help of your senior residents

**PGY-2**

-You will carry the leftover patients after the intern patients are assigned

-You should see your patients, know their labs and vitals and overnight issues BEFORE morning report.

- Your patients may change daily because of your clinic schedule. Please coordinate this with your PGY-3 or fellow PGY-2 so that you are able to see your patients before morning report.

**PGY-3**

-You will supervise all residents and assist with their patient care as needed

- You will see each patient every day

-You MUST know all dispositions and direct the plan of care

**IMPORTANT HOSPITAL INFORMATION**

-Free breakfast in cafeteria from 6:30-7:30AM each day

-Free dinner in cafeteria from 4:30-7:30 PM on weekdays and Saturdays and 4:30-6:30 on Sundays

-There is a snack bar located on the 1st floor of the inpatient tower that is open 24/7

-Cafeteria is open from 2-3 AM during the weekdays for snacks/drinks

-Call Room Codes: Front room= 541, Back room=531

-Gym/Employee Lounge located on 1st floor of inpatient tower

**\*Codes are not audible in the call room. If you hear a voice over the speaker, open your door to hear the announcement\***

**SIGN-OUT TEMPLATE**

-**HPI**: This should be ONE LINE containing the person’s age, gender, chronic medical problems and the reason they are admitted.

\*Include patient’s PCP and specialists in this box

\*Include code status, NOK/POA and contact phone numbers here

-**Active Issues**: ACTIVE ISSUES ONLY. DO NOT copy and paste your H&P into this box.

\*Each active problem stated in numeric order of importance and followed by brief but complete plan of care

\*This should be limited to 1 line per problem as much as possible

-**Overnight Tasks**: include only what you need the overnight person to do before morning report

\*See sample sign-out below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Info | HPI | Active Meds | Active Issues | Overnight Tasks |
| Smith, Billy | 32 yo male with HTN, DHF, ESRD on HD & NIDDM a/w abdominal pain | 1. Dilaudid 2. Morphine 3. Xanax 4. Percocet 5. Multivitamin | 1. **Abd pain**: severe, acute abdomen, gen surg consult 2. **ESRD**: HD MWF 3. **DHF**: BNP above baseline, echo in AM 4. **NIDDM**-SSI | [ ] BNP  [ ] Monitor resp status  [ ] Serial abdominal exams |

-Please print on single-sided paper when possible, unless double-sided is preferred by receiving team

-Print patient list sheet in order of ascending location, as well as sign-out sheet and STAPLE

**GOALS OF SIGN OUT**

-There should be no confusion on behalf of the residents or attending s after sign out. It is your job to provide the oncoming team with a thorough but concise sign out so that their knowledge of the patients is as good as yours is when your shift is ending

-Every member of the team should know 1) why the patient was admitted 2) the plan of care for the day 3) any acute issues 4) the disposition. NO EXCEPTIONS

**NIGHT FLOAT**

-The intern or covering resident should print the sign-out for the night resident by 6:30 PM

-Meet in residents’ lounge for sign out

-The day team should cover all admissions and issues UP UNTIL 6:00 PM. Anything after that time will be handled by the night resident unless there is an acute/emergent problem

**Expectations for the night resident:**

-**During the week:** On arrival, once you have received sign-out from the day team, you should make rounds and see all patients. Communicate with the nurses when possible regarding plan of care for the night. This will cut down SIGNIFICANTLY on the number of phone calls you get throughout the night

\*Check orders, vitals and resulted labs on all patients

\*Update the sign-out as necessary and especially after overnight tasks are completed

\*Print the sign out sheets in AM for day team

\*Prepare a very brief presentation on a topic relevant to service if the night allows

-**Weekends**: Round on all patients at night

\*Check orders, vitals and resulted labs on all patients

\*Update the sign out as necessary and especially after overnight tasks are completed

\*Print sign-out for day team

\*No teaching required on weekends

-Be sure that anything you order STAT in the middle of the night will impact your management of the patient. For example, do not call for a consult at this time unless the problem is urgent and requires immediate attention. Most consults can wait until the morning.

**ADMISSIONS FROM THE ED**

-You MUST see the patient before placing orders for admission. It is not uncommon for the ED to attempt to admit someone to the floor that is ICU appropriate

- All admits must be cleared through attending first. Please ask the caller to call the attending to discuss possible admission. If accepted, the attending will then call you with details

-Do not forget to do the admission medication reconciliation. Confirm with the patient which meds they are taking and reconcile appropriately.

-The ED physician MUST notify renal team if the patient is ESRD admitted for dialysis or dialysis-related complications

-The patient’s BP and vitals must be stable before admitting the patient to the floor. If in the ED, your patient has a BP qualifying for HTN urgency, order IV meds in the ED and wait until the BP has come down before putting in admission orders

**COMMON SCENARIOS: TIPS & PEARLS**

**Fever:**

-Blood cultures x 2 (power set), Urine cultures, and empiric antibiotics

-Assess SIRS criteria

**HCAP**: start vanc, zosyn and levaquin. Also place pharm consult for dosing if the patient has kidney disease or ARF

**Chest Pain**: trend cardiac enzymes, EKG q8hr, telemetry, BNP and if concern for ACS/MI remember MONA. Call cardiology AT ANY TIME. They are very helpful

**PE**: D-dimer ONLY if low risk for PE and your clinical suspicion is low but present

-Do not order d-dimer in ESRD or pregnant women

-If ESRD, order a VQ if possible. For all others, CT PE Protocol

-Use Wells’ score to determine likelihood of PE

**Stroke:** head CT without contrast and aspirin

-Call neuro at ANY TIME if you suspect stroke

-If speech/swallowing is impaired, you MUST get a speech/swallow evaluation before giving food or PO meds. Put patient on IV meds as possible and wait for consult to give PO

**SIRS criteria**: if 2/4 positive, pt is at high risk for sepsis. Get lactic acid, start aggressive hydration and consider ICU transfer

-HR > 90

-Temp>38.3 or <36.0

- Resp > 20

-WBC > 12,00 or <4,000

**Suspected Line/Catheter Infection:** cultures from the line and peripheral. Always get two sets of cultures, 1 minute apart (in power set). Start empiric antibiotics (vanc) after cultures are drawn

**Alcohol Intoxication/Withdrawal**: place pt on withdrawal protocol

**Agitation:** use the least dangerous meds first, preferably haldol or benzos. If the patient is elderly, use 0.5 mg haldol. Do NOT give Benadryl, ambien or benzos to elderly unless this is part of their regular regimen

-Avoid restraints as much as possible

-Look for underlying cause of agitation remembering that this is a hallmark of delirium

**Hypertensive Urgency**: use IV hydralazine for SBP>180 or DBP>100 in ***renal patients only***

-Labetalol IV if not renal and HR supports this therapy

-Amlodipine IV

**Pain**: always start with Tylenol, unless pt has liver disease

-In ESRD, pain medications can have toxic metabolites

-Give PO 1st if possible, then IV if pain not controlled or patient is vomiting medication

-Dilaudid should be last resort unless the patient has cancer pain or another legitimate indication. Start with 1mg IV

**CLINIC CALLS**

-Indicate to the caller that they have called the “Emory Family Medicine after hours emergency line”.

-This is not a medication refill line. Unless there is a pressing need for a medication to be refilled after hours, this should be done during clinic hours only.

-As the resident on call, you are responsible for handling all after-hours clinic calls. It is not appropriate to call the resident/attending who regularly cares for the patient to ask them to assist the patient. It is your responsibility to assist the patient to the best of your ability, document the encounter and forward your note to the appropriate provider if desired to inform them of the event

-A caller with a potentially serious problem should always be referred to the emergency department

**NOTES**

-Make sure you are using the correct format for your hospital notes. H&P’s and progress notes require different note templates. DO NOT copy your H&P note forward as a progress note

-Progress notes should discuss ***active issues only***. While the H&P might mention controlled hyperlipidemia, there is no reason to discuss this in a daily progress note

-All progress notes must include a disposition

-When transferring a patient out of the ICU, you must write a transfer or acceptance note. This is a template in PowerChart. If you are transferring a patient TO the ICU, you can write a freehanded event note to document your decision and that the patient was accepted (note accepting physician/team)

-Anytime you respond to a nurse’s call by going to see a patient, you must write a brief event note to document the encounter and your decision-making. If the event is a code MET or Doctor 99, please indicate this as well and describe the event as thoroughly as possible

-You can write a freehand note by following these steps:

Clinical Notes🡪Add🡪Progress Note Hospital🡪 Change title to “event note”

**DISCHARGING PATIENTS/DISCHARGE SUMMARIES**

-When you discharge a patient, place them on the “discharge list”. If possible, please attach a sticky note indicating who is responsible for the DC summary

-DC summaries MUST be done within 24 hours of patient discharge. NO EXCEPTIONS. You will receive an email from the responsible attending indicating your delinquency if you don’t comply with this. This is very important to maintaining our privileges at this hospital

-The person who discharges the patient is responsible for the discharge summary unless the patient has been in the hospital for **MORE THAN 5 DAYS!** In that case, the provider who was following the patient most closely will be responsible

-If you are not writing the DC summary, place the patient on the DC list and send a message via EMR to the person responsible indicating the patient’s name

**BACK-UP POLICY**

-There is ALWAYS someone on back-up on the schedule. If you feel that you need back-up, it will be available to you. The back-up person is intended to help out in the event that the on-call resident has an emergency requiring them to leave the hospital or the workload is excessive for one resident

-Please follow this order of operations: 1) Call chiefs or attending on service BEFORE calling the back-up person themselves

-The back-up person is REQUIRED to respond to the request and present to the hospital ASAP to assist. Once the workload is manageable or the emergency has been handled, the back-up resident is able to leave if no longer needed

**OB PATIENTS IN HOSPITAL**

-If a FM OB patient presents to triage, let the primary physician know the patient is in triage and the reason they are there

-During the day, if there is a FM resident on EUHM OB, that resident will triage all FM patients. If there is no FM resident on EUHM OB, the in-house resident will triage the patient. At night, the resident on call will triage all FM OB patients

-Once you have triaged, please call the attending to discuss the plan of care

-Once a decision has been made about a plan of care, the on call resident should call the PCP and advise them of the plan. The PCP and secondary resident will decide with the on call resident when they should come to the hospital

-Read the sticky note to find out information relevant to the delivery/infant

-The delivering resident and/or the assisting resident are responsible for seeing the mother and the baby each day during their hospital stay and for providing circumcision (with the help of an attending) if required. The mother gets a note in EMR while the baby has a paper chart. Discharge summaries are to be completed on both with mother in EMR and baby on paper

-On discharge, please give the mother a 6 week follow-up appointment In the clinic and make plans to see the baby within the first week and again at 2 weeks of age

-To admit an OB patient to labor and delivery:

Orders🡪OB L&D Admission🡪modify the admit order as we typically do🡪On left column, select “Labor and delivery Admission”🡪Leave checked boxes alone🡪Add LR for IVF🡪No VTE prophy🡪check ondansetron🡪If GBS positive, choose appropriate antibiotics🡪add fentanyl🡪add the communication order for epidural at 4cm if desired🡪select CBC, RPR, Blood type and screen🡪Initiate🡪orders for signature

-To admit an OB patient to the postpartum unit following delivery:

On left column, you will see “Immediate Postpartum”🡪leave checked boxes alone🡪add LR for IVF🡪add pitocin🡪select Percocet and ibuprofen and ondansetron🡪Initiate🡪Orders for signature

On left column, select “postpartum vaginal delivery”🡪select “delay initiation of power plan”🡪leave checked boxes alone🡪add “out of bed” and “general diet”🡪add “notify MD if HCT<25%”🡪Add sitz bath🡪add pitocin🡪No VTE prophylaxis unless indicated🡪add “Percocet, ibuprofen and Tylenol”🡪add “glycerin topical, dibucaine and lanolin”🡪add “Tdap” if necessary and all other necessary items based on patient🡪add “CBC +8 hrs”🡪 DO NOT INITIATE🡪”Orders for signature”

\*\***If you have an OB patient pending delivery and you will not be able to attend the delivery, you MUST designate a proxy who can cover the delivery in your place. This person should have met the patient before they present to L&D if at all possible\*\***

**SOCIAL ISSUES IN HOSPITAL**

-Always place a social services consult first, and be specific in your request

-If the request requires a powerform, please fill it out thoroughly. The requests cannot be processed without specific information (medication dosage and frequency, the type of home health equipment needed, etc). Not doing this will greatly delay any placement for the patient

-Call Case manager, Kim Whittaker (number is in all phones) if needed to assist with social issues

**CONTACTS**

Resident Phone #1: 404-293-3776

Resident Phone #2: 404-293-2976

OB Phone/Resident Phone #3: 404-293-3593

Attending Phone: 678-687-1540

EUHM Operator: 404-686-1000 or 6-1000

Jenn Burkmar: 404-908-4183

Katie Humphries: 704-807-6022

\*You can call either Jenn or Katie at any time