Intern Survival Guide

17th Edition

Department of Internal Medicine

Parking:

1) Parking structure #1"E" lot by VA entrance, open for parking for residents 24 hours a day, 7 days a week.
2) Parking structure #6 on Virginia Ave- great if you are going to clinic. You are not supposed to leave your car overnight
3) Parking Structure #8 across from new hospital- only controlled Mon-Fr 8a-4:30pm, (but have to pay until 11pm) so OK to park on the weekends
4) Commonwealth Stadium **ORANGE "E" lot** - can shuttle or walk
5) Parking Structure #3 Kentucky Clinic. Do not park at the Kentucky Clinic Parking Garage unless it is a weekend

Shuttles: Takes employees from front of hospital to Stadium parking lot and to Limestone ST. garage. Shuttles leave every 5-15 minutes from front of HSRB or employee entrance at Pav A.

Cafeterias (hours subject to change)

Wildcat Deli (KY Clinic) M–F 7:30am–3:00pm	**Cafés** Pavilion CC • Whitney Henderickson Bldg: M-F 7:30 a– 3:00 p Pavilion A • Courtyard café (ground floor): M-F 6:30a-3p • Terrace café (1st floor): M-F 11a-2p
Coffee Shops- **Pavilion H** M-F 10:00am-2:00pm Daily 11:00p-6:30a **KY CLINIC** Starbuck's M-F 6:30a-6:00pm	**Cafeteria- Pavilion A** Open 22 hours a day: Closed from 5am-6am and 10am-11am.

ATMs

1. Main hospital north of information desk.
2. Hallway between medical school library and dental school.
3. 1st Floor of KY Clinic across from pharmacy.
4. Big Blue Deli during business hours.

Vending Machines

Located across from main cafeteria. Accessible 24/7.

Employee Health: First floor of UHS building. Performs TB screening

Post Office: Basement of Medical school. Open M-F 8 a.m. – 4 p.m.

Hospital Address
A.B. Chandler Medical Center
800 Rose Street
Lexington, KY 40536

Your Professional Mailing Address
Your Name
900 S. Limestone
306 Charles T Wethington Building
Lexington, KY 40536-0200

General Layout:

Pavilion H: "original hospital"; divided in to 4 wings: North, South, East, West. Critical Care Center (Pavilion HA) on south end of building.

Floor	Contents
8th	Medical/ surgical wards
7th	Medical/surgical wards
6th	Medical wards, Internal Medicine Resident Lounge (BS room), noon conference room, resident library, Grand rounds auditorium, medical records, progressive care units (6S/6W), clinical laboratory, microbiology
5th	Medical/surgical wards (isolation ward 5E), dialysis (code 6353#), clinical research center (5N), vascular lab
4th	Children's hospital, Peds Conference Room, Transplant Center, Pathology Lab, NICU, PICU, cytopathology.
3rd	OB/GYN, L&D, endoscopy, radiology film library, IR, angiography, specialty pharmacy
2nd	Radiology, OR materials, surgical pathology, 2ACT, 2MED, CT scanner, UK SIM lab
1st	Administration, GME, gift shop, chapel, call rooms, coffee shop, MRI
Basement	Post office, Central supply, EEG, Nuclear medicine (V/Q scans, stress tests), pager replacement, radiation oncology

Markey Cancer Center (Pavilion CC) – Inpatient Hospice, Heme-Onc fellow and attending offices 4th floor, Heme clinics 1st floor

Whitney Hendrickson Building (Pavilion WH): Multi-D Oncology clinics on 1st and 2nd floor

Gill Heart Building (Pavilion G): Contains cath labs, ECHO, GXT, ECG, Cardiac MRI, Cardiology clinics, outpt minimally invasive surgery

Pavilion A – "new hospital"

General layout of patient floors is two towers—100 (S. Limestone side) and 200 (VA side)—with connecting corridor between that is location for elevators and waiting rooms.

Floor	Contents
Ground	ED, Pediatric ED, Radiology department (off lobby), courtyard, coffee shop, atrium, auditorium
1st	Cafeteria, Concourse/atrium, terrace/ patient library/ resource center
2nd	PACU and ORs, cath lab, walkway from old hospital
3rd	Pharmacy
6th	Neurosciences—ICU, progressive, acute care
7th	Trauma & Surgical Services—ICU, progressive, acute care
8th	CCU, CTICU, Cards floor service
9th	MICU 1 and 3, Private Hospitalist Teams,
10th	MICU 2, Private Hospitalist Teams
11th	Markey Cancer Center Inpatient

*****9 and 10 can have patients on teaching teams as well

Room numbers:

- **Alpha prefix designates pavilion**
- **Next two digits indicate floor**
- **Next digit indicates tower**
- **Last two digits indicate room number**

Example: A.06.124

→ A = Pavilion A
→06 = 6th floor
→1 = Tower 100 (i.e. S. Limestone side)
→24 = room 24

Connections to Pavilion A from Pavilions H& HA ("How do I get to the *new* hospital from the *old* hospital?"): *hint: wear comfortable shoes!*

- Ground floor: Walk through employee hallway past the ER
- Floor 1 concourse: Many signs with directions on the main concourse
- Floor 2 concourse: from old surgery/OR desk to Pavilion A staff elevators, also connects with Gill heart

Other Connections between various pavillions:

1. KY Clinic bridge – 3rd floor of KY Clinic to 2nd Floor of Pavilion H
2. Markey CC – north end of 2nd Floor Pavilion H to 2nd floor MCC
3. VA – beautiful first floor walkway; Requires PIV access
4. Gill Heart Institute – connections on 1st via concourse from Pavilion HA to A (front of hospital) and 2nd via double doors near 2 ACT Also connects from 3rd floor to 3rd floor CTW

Key Locations

Radiology

1. Reading rooms are located on the ground floor of Pavilion A next to the lobby and the auditorium (just past the main entrance)
2. ER reading room - on the hallway between the adult/pediatric ER
3. CT/MRI/ultrasound – 7-5829
4. Weekend/nights. Hint: It is good form to look at films yourself prior to asking rad resident to help. It may be easier to call resident in the ER reading room (3-5338)
5. Film library – 2nd floor rad by US
6. Dx Rad pager – 0663

Supply (So you want to do an LP. You can order supplies and wait for the runner or get it yourself (much faster). Most of this can be found in each floor's supply closet.)

1. Basement of the new hospital is main materials office
2. Check list:
    a. procedure tray (eg LP, paracentesis, etc.),
    b. gloves for you and upper level,
    c. betadine, box of 4x4s, extra towels,
    d. gown, mask, hair net, glasses,
    e. ?extra tray (just in case), ?extra lidocaine,
    f. med student to help carry.
3. To be sure your sample makes it to lab, ALWAYS deliver it yourself to 6th floor far south end. If you don't, it may mysteriously disappear and you will have to repeat the procedure—that would be bad

Pager batteries: GME, info desk HA main lobby, basement pager office, clerk on your floor

Medical Library: first floor of medical school

Pager replacement/loaner for day (if you forgot yours): basement – MIS office

Parking: 5 level garage located southeast of hospital**.** Free with an "E" parking permit.

Cafeterias

Main cafeteria on 1st floor:
24/7; closed 10a-11a
Starbucks Coffee Shop located in the Main lobby
M-F 7:00 a.m. to 3:00 p.m.
Does not take badge money

Vending Machines

Near main cafeteria and multiple floors.

VA Auxiliary Store (AKA "Canteen")

Located in basement. Snacks, drinks, personal items, clothing, electronics. You can find some really random stuff here! M-F 9a.m. – 3p.m.

Main Telephone Number

(859) 233-4511

Call room

4th floor, north side, past Endo
Free food and water when on call
Code 4578#

Admin and Tech support

4th floor North side, opposite chapel

VAMC

General Layout: Original Hospital divided in to 4 wings: North, South, East, West.

Main hospital

Floor	Departments or Services
6th	SICU/MICU, OR, PACU
5th	Medical / surgical ward, medicine team rooms
4th	Endoscopy, psychiatric ward(4S), dialysis, Hem/Onc Office, call rooms, and your ADPAC, Greg Hazlett
3rd	medical/surgical wards- non tele, PFT, respiratory
2nd	Progressive care unit, outpatient specialty clinics, heart station, ECG, exercise stress tests, cath lab, warfarin clinic, Morning Report Room (2N)
1st	clinical laboratory, inpatient and outpatient pharmacy, nuclear medicine, radiology, MRI, ER- an always exciting place- Badge access needed from VA police
Basement	cafeteria, morgue, physical therapy, VA auxiliary store

Ambulatory Care Center

(Attached to the VA Hospital, immediately south.)

3rd and 4th Floors: Basic Research

2nd Floor: auditorium, medical library, optometry, dentistry, ophthalmology, prosthetics, medical records, vending machines.

1st Floor: ED, Urgent Care Center, outpatient pharmacy, radiology, CT scanner, MRI.

Key Locations

MICU: 6th floor (Door Code 4567#)

Endoscopy: 4th floor (Door Code 4511#)

Heart station: 2nd floor near PCU

Morning report: North outpatient clinics conference room 2nd floor

ECHO: Heart station, 2nd Floor

Purple Medicine Office: 5 right hallway B512; Ph 4786,4755,4777

Blue Medicine Office: 5 right hallway B518; Ph: 4331,4334,4336

Red Medicine Office: 5 right hallway B514; Ph 4412,4485,5521

Orange Medicine Office: 5 right hallway B 515; Ph 5168, 4732, 4738

Nuclear Medicine: 1st Floor across from inpatient pharmacy

Radiology: 1st floor

Attending/Hospitalist Room: 2nd floor just inside entrance to 2-PCU- code 3453#

ACGME Hot Topics

1. **Hours**: It is the responsibility of both the program and the residents to be compliant with these national rules:

a**. 80 hour rule**: No more the 80 hours per week
(AVERAGED over four week period)

b. **24+4 hour rule**: No resident will work a shift longer than 28 hours.
- 24 hours with new patients
- 4 hours to complete work with no new patients

- if you stay later than that it should be for one of the following reasons:
1. Continuity for a severely ill or unstable pt
2. Academic importance of the events transpiring
3. Humanistic attention to a pt or family

c. **Days off**: Each resident will get one day off in seven
(AVERAGED over a one month period)

d. Graduated responsibility: interns should not work more than 16 straight hours

e. Time off between shifts: must be 10 hours unless coming off a night float or overnight call

*To verify compliance we must log hours. We are using Medhub Uky.medhub.com-need to log weekly or you will be locked out!

2. **Core Competencies**: These are the six areas in which you will be evaluated:

- Patient Care
- Medical Knowledge
- Systems Based Practice
- Practice based learning and improvement
- Communication and Interpersonal skills
- Professionalism

IM Residency Program

Program Leadership

Kristy Deep, M.D (Program Director)	323-1946
Sarah Schuetz, MD (PC Director)	562-2467
Sarah Vick, M.D (Associate Program Director)	323-7641
Joseph Sweigart, MD (Associate Program Director)	
Devin Oller, MD (Associate Program Director)	323-3872
Sean Lockwood, M.D (VA Site Director)	330-4526

Core Faculty

Jacqueline Gibson, M.D
Vedant Gupta, MD
Kristen Fletcher, MD
Angela Webb, MD
John Romond, MD

Residency Program Coordinator

Kristi Lovell 218-2834

Med/Peds Program Directors

John Stewart, M.D. (Program Director)
Kelli Trent, M.D. (Associate Program Director)

Med/Peds Residency Program Coordinator

Leann Jacobs 323-6561

Education Specialist

Jamie Taylor 323-1388

Data Coordinator

Carl Broaddus 323-1180

Program Assistant

Holly Elkins 218-2834

Clerkship Coordinator Jon Gent 323-6540

Chief Residents (CTW 306E)	Pager	Office	Cell
Megan Wolak, MD	0850	80896	(586)-719-4142
Chris Thomas , MD	0470	80837	(859)-382-3297
Sara Klinger, MD	1360	80891	(336)-671-6706
Neil Backer, MD			(314)-971-7281

UK numbers begin with 257, 218, 562 or 323. To call UK from VA dial 9 then number.

Frequently Used Numbers

BS Room	3-5889 / 7-8153	UK ER	3-5902
Medicine	3-8691		
Paging office	3-5321		
UK MDs	7-5522		

Service Pagers

Cardiology Fellow	330-2700	Pulmonary Fellow	330-1885
Pharm-D on call	330-1875	Trauma Surg-Jr resident	330-0912
PICC nurse	330-7447	Rapid Response	330-6860
HOA	330-6855		

Medicine Staff

Kristi Lovell	218-2834
Carl Broaddus	
Holly Elkins	8-2834
Leann Jacobs	3-6561

General

Capacity Command	3-2233
Med Records	7-3591
Risk Mgmt	7-6212
Patient rep.	7-2178
IT Help desk	3-8586
Housekeeping	3-5133
OR front desk	3-5631
Security	3-6152
UK Police	3-6156
Employee Health	3-5823

Therapeutic Services

Dental emerg.	3-9707-day 3-5321 -eve	Dialysis	3-6353/ 3-6115
Physical Therapy	3-5841/ 7-8001	Nutrition	7-4347
		Home Health	3-5501
Pharm inpt	3-5641	Pharm outpt.	3-5854
Social service	3-5501	Audiology	7-3390
Chaplain	3-5301		

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IMAGING DEPARTMENTS

(for scheduling and ordering questions)

CT Pav A	39730
CT ED	36167
Cardiac CT/MRI	86315
Echo	84277
EEG	35472
MRI	31138
Nuclear medicine	37852
Ultrasound	35072
Vascular lab	35119
X-ray/Fluoro Pav H	35075
X-ray Pav A	71698/33055
PET request	(Fax 32171)
Image Library	32131

RADIOLOGY READING ROOMS

(To speak with a radiologist)

ED reading	35338
Abd/fluoro	35551
CT Abdomen	30826
MRI Abdomen	76762
US Abdomen	36089
Chest	86308
Echo	36947
Fluoro	35582
IR	35890
Musculoskeletal	73399
Neuro	70112/30441

PROCEDURE DEPARTMENTS

Cath Lab	36035
Endoscopy	32680
IR	30348/330-1729

PHARMACY

Central Pharmacy	80001
Pharmacy	35641
Meds To Beds	83360 (fax 35622)

CLINICAL SUPPORT SERVICES

Nutrition	36987
PT	35842
RT	36923
Speech	87884
Weekend social work	330-1077

MISCELLANEOUS

Anticoagulation	330-2093
Blood Bank	35401
Brace Company	866-661-5500
Chaplain	330-1520/35301
Coroner	252-5691
Dialysis	36115
Hospice	330-7440/31140
Infusion Center	218-2769/37027 (fax 82770)
Lab	35431
Materials	35645
Medical Records	38930/73591
Micro	35411
Patient Relations	72178
Pathology	35425/75089
Path- FNA	73640
PFT Lab	36111
PICC	330-7447
Spanish M-F	330-6692

UK numbers begin with 257 or 323. To call UK from VA dial 67 then number.

Paging Operator	35321
Admit/Reg	35062
Code Blue	35200 Option 1
Rapid Response	32872/330-6860
Central Mon.	30643
CDU office fax	323-3386
Computer Help	38586
Utilization Review	35316
Risk Management	76212
Hosp. Workroom	70084 (code 6097#)
VA hospital	233-4511
(For transfer to VA ext 4969)	
MESA pager	330-3896

CAPACITY COMMAND

Bed Assignment	32233
Pt transfer facil.	73014

RESIDENTS

Lounge/BS room	35889/78163
MT1	330-2611
MT2	330-2612
MT3	330-2613

EMERGENCY DEPARTMENT

ER	35901/226-7191
ED Obs	85568/85592
ED Fax	35682
Vocera	39700

MARKEY

Markey 1	87850/87863
Markey 2 (BMT)	87936/87974
(fax 257-0652)	

PAVILION H

2TU	30821/30822
3 North	35397
5 Main	36053
5 North	75033
5 East	35517
5 South	36267
5 West	36833
6 Main	36863 (fax 38935)
6 North	36478
6 South	36826
6 West	33746
6 Monitoring	30641
7 Main	35100
7 East	35213/39115
7 South	35214
7 West	39621
8 Main	36212
8 East	39702
8 South	39704
8 West	39705

PAVILION A

Pav A 6-100	33385
Pav A 6-200	33491
Pav A 7-100	33570
Pav A 7-200	33760
Pav A 8-100	84254/84240
Pav A 9-100	39073
Pav A 9-200	39153
Pav A 10-100	39297
Pav A 10-200	39392
Pav A 11-100	87863/87850
Pav A 11-200	87974/87936

UK numbers begin with 257, 218 or 323. To call UK from VA dial 9 then number.

Emergency

Fire/police	911	Risk Management	7-6212
Security	3-6156		
Code 500	3-5200	Poison Control	1-800-722-5725
Safety Officer	259-6690	Chemical spill	3-6280

UK MD's 7-5522 (for outside doctor's numbers and faxes)

Computer

Help desk	3-8586
College of med	3-3580
TASC Center	7-8272

Miscellaneous

Emp. health	3-5823	Housekeeping	3-5133
Home health	3-5501	HR	7-9519
Infection	3-6337	KODA	800-525-3456
Parking	7-5757	Physical plant	3-6281
Public Affairs	36363	Sexual Harass	7-3100
UK Workers	800-440-6285		

Fax numbers

5 Main: 3-5924
6 Main: 3-8935
6 North: 3-1933
7 Main: 7-5211
8 Main: 7-1863

VAMC Phone list: From outside 233-4511 or 281 and then the extension.

General

Admitting/ Bed control	4360/4969	AOD	4950
		Transcription	4393
med records	4379	Risk mgmt.	4904
Code 500	4500	IT help	5550

Floors

ED	4966/4660	2 South PCU	4932
3 North	4934	Hospitalist office	4171
4 South	4931	Dialysis	4938
5 Main	4933	Recovery/PACU	4782
6S MICU/SICU	4942	OR	4619
NP office	4746	5 Main Fax	281-4881

Laboratories

Clinical Add.	4503	Blood Bank	5937
Bone Marrow	4432	Chemistry	4529
Hematology	4516	Micro	4522
Histology	4530	Gen. Pathology	4508
Surg Rpts.	4509	Cytology	4519

Radiology

CT Scan	4567	Neuro rad	4469/5327
Vascular/dupl	4261	MRI	4560/4569
Reception/ gen	4267	Ultrasound	4566
Angio/IR	4254		

Diagnostics

Audiology	4972	Card cath lab	4417/4468
ECHO	4458	EEG	4463
EKG/Heart Station	4414	EMG/NCV	4461
		Holter monitor	4454
Endoscopy	4735	Exercise stress	4419
Nuclear results	4921		
Pulmonary Lab	4441		

From outside call 233-4511 or 281 and enter the extension.

Therapeutic Services

SATP (LD)	3756	Chaplain	4910
Dialysis	4938	Dietetics	4330
Pharmacy	5631	Phlebo	7609
Outpt		Prosthetics	4952
Pharmacy Inpt	5202	Home O2	4641
Disch Pharmac	5218/5365	PT	4573
ID Pharm	4240	OT	4577
CHF Pharm	2357		
Heme Pharm	5241	Speech/ Dysphagia	4154
Palliative	4116		

Team Rooms

Red	4421/ 4485	Blue	4331/4334
Purple	4786/ 4755	Green	4229
Orange	5168/ 4732		

Miscellaneous Access Codes

ER	Badge access	CALL ROOMS
Team Rooms	1234 #	A425B 4755#
Supply Closets	4511 #	A425C 4412#
ICU Stairwell	4500 #	A425D 4732#
ICU entrance	4567#	A425G 4563#
3rd Floor	4511#	

Computers

Greg Hazlett, IM business manager: 4790

Regional Help desk: 5550

To page a VA pager from the VA dial 66, wait for the prompt, and then enter 3 digit pager number.

GS numbers begin with 226. Not all lines are accessible from an outside line, so if you page someone at Chandler, page them to the main floor number.

Operator – 226-7000

Laboratory	7090 / 8566	PT	7026 / 7095
Lab Pager	330-1945	Speech Therapy	330-7624
Pathology	7094	Respiratory	330-8637
Blood Bank	323-9694	Wound Care	7050
Materials	257-9211		
Admitting	7100	2nd floor surgery	7139
Medical Records	7033 / 3-6624	3rd floor – select	7321
Pharmacy	8135 / 7038	4th Floor ICU	7364
Security	8524	4th Floor Med/Surg	7075
Housekeeping	330-1011	5th Floor Med/Surg	7165
Help Desk	7500	5th Floor Surg	7065
PICC nurse	330-7447	6th Floor Ortho	6700
Meds-to-beds	218-4775	7th Floor Med/Surg	7030
		ER	7070

Diagnostics

EEG	7009	Sleep Lab	7006
ECHO (Peta)	230-1586	Radiology resident	1755
ECG stat	7025 / 2740	Nuclear Medicine	2532
Dialysis	4620	Radiology	2505
Endoscopy	7067	CT	7013
Reading room	7214	MRI	7200 / 8269
		Ultrasound	7016 / 2874

Phone in the resident work room: 226-7129

-Begins at admission!
-Keep hospital course updated in snapshot daily, or at least when having off to another resident.
-Discuss issues at daily DC meeting.
-Important questions to address daily

*What is keeping them in the hospital?
*Where will the patient go?
*What needs will they have after discharge?

TIPS

-Nursing home patients:

*Usually return to where they came from
*MUST HAVE DC SUMMARY PRIOR TO DC
*Scripts for controlled substances must be provided, even if it was a prior med (few days)
*Other meds do not need scripts, but must be detailed in the DC summary
*Ensure NH knows days in advance when you anticipate DC. The social worker will help with this.

-Veterans:

*Many different options, SW can provide a lot of help with this
*If the patient is admitted for placement it is important the SW know early

TIPS FOR DISCHARGE PLANNING

1. Discuss plan with the patient and clarify any questions.
2. Complete hospital course in the designated box in the snapshot tab.
3. Head to the **discharge tab** and follow the the various sub tabs,
   - **Care providers-** Enter your attending and list all services consulted during hospitalization.
   - **Diagnosis-** Enter discharge diagnoses, Reason for Hospitalization: should be a one liner explaining why patient presented. Hospital course: problem based summary of events. Do not paste in assessment and plan
   - **Medication:** Will prompt you to complete med rec; prompted – very important to clarify new meds, changes made, and ensure accuracy
   - **Disposition:** Where they are going and list any pending test
   - **Appointments:** List all appointment details in Schedule For* box for all appts for follow up. On some floors, clerks will schedule appts based on what you enter on this part of discharge tab in advance
4. Click discharge patient > Discharge note will populate details from this tab. Please put physical exam, check mark on order rec and select attending co-signer for the note.
5. **Discharge order** will pop up when you save note.

**If DC summary is dated the day of discharge and has physical exam it will also count as a progress note for the day.*

**Stuff sometimes disappears if you leave the discharge tab alone for too long, save any long hospital courses elsewhere.*

Pre-rounds at UK (06:30 – 07:00)
You should start your day with the following:
1. Night Float – Discuss any issues the night float intern may have had with any of your patients first thing in the morning.
2. Check SCM for new orders and nursing communication.
-physician rounding reports are a good for a quick summary and taking notes
3. **Medications**
- Check Medication Administration Record (E-MAR) DAILY. Found in SCM. Always know what meds your patient is on .
- Day #/# for antibiotics
- Usage of PRNs
- If patient refuses or nurse does not actually give a scheduled med
4. **Telemetry** if applicable. Check for overnight alarms and print strip if necessary. Found in Nursing stations or central tele on 6.
5. **Vitals** (Tmax, I&Os, etc.) Found in SCM
6**. Labs and test results.** Review all pertinent labs and check on cultures.
7. Enter any **orders** you know need to be done.
8. Head to **Morning Report** at 07:30 if there is time. If you are worried about any patient, go see them **BEFORE** morning report
9. 8:15-9: go see your patients and get a brief overnight **history and physical**
10. Start electronic notes if there is time

Rounds (09:00 - 11:40):
1. **Communicate**. Be sure your upper level knows of any urgent or unexpected findings from your pre-rounds prior to starting official rounds with the attending, preferably before morning report. NO DISCOVERY ROUNDS.
2. **Learn**
3. **Teamwork**. Enter orders, etc. while other intern presents.
4. **Multitask**. Review all consultant notes. Look for a chance to call that consultant or arrange that test during a lull in rounds. Your upper level may help you spot a good time.

Noon Conference: Eat and learn from 12:00 – 1:00
Work: Procedures, test results, etc. Admit new patients
Check on your patients one last time before you head out.
Let your upper level know when you are ready to go.
Checkout: at 17:00, Make sure all orders for the next day are entered. Go over your checkout list with the Resident and check out to cross cover intern.

Your Morning Plan at the VAMC:

1. Get checkout from the intern on overnight.
2. In your **team office**, log into CPRS and check vitals and new orders from overnight. Record significant findings, vitals, etc. on your prerounding sheet. Look for trends in BP, Pulse, Resp, Pulse Ox, O2 requirements, Temp. (Tmax in particular). Notes: review all notes written since you last looked Look for cross cover notes, nursing notes, consults notes, etc. In the Labs Section, look for any new results, review micro to see if culture results have been update. In the Procedures/Imaging section, check to see if official or prelim results are in the computer. Vitals are in Philips system for the PCU and MICU (Use you initial VA login to log on)
3. Go to **Morning report** on 2N (7:30 am- 8:15am) on Thursday
4. Make one circuit of the floor, examining each **patient** in turn, and recording all findings on your prerounding sheet. Ask patient about any events, problems, symptoms, etc. Record I's and O's on prerounding sheet (Found on bedside board, NOT located in computer; In the PCU data is located on Clinicomp U: & P: your CPRS ID & password; Clinicomp1! For first time users password). Do focused physical exam.
5. Check **telemetry** on 5 & 3 for any overnight events.
6. Prioritize patients to expedite discharge of patients prior to noon.
7. Enter orders for any new meds, labs, tests as indicated based on prerounds. If orders need to be done STAT, you should call the nurse taking care of the patient or radiology as needed or your test will not be done in a timely manner.
8. Write SOAP notes
9. Round with team and take notes during discussions on each patient regarding med changes, new tests or consults.
10. After rounds, enter any new changes as needed. Call consults early. Enter new labs, tests, procedures, meds. Prioritize order entry in order to get to conference at noon.
11. Go to Noon Conference
12. Check on patients again after noon conference, complete notes, and perform procedures as needed.
13. Check out to on call team after all work is completed and all patients are stable.

The First Day of the Rotation

As teams finish their rotation and move to the next, the handoff of patients to the new teams needs to be seamless. From a patient safety standpoint, the patient is vulnerable to less than adequate care during this transition. This is the main reason that interns switch service on the 1st of each month and the residents switch on the 4th of the month. Even though it will be impossible to know your patients as well as the intern who just left the team, the entire medical staff along with the patient and family will be looking to you like you know everything. To hit the ground running and complete a good handoff, the following tips will be helpful.

Beginning a Service:

1. Call your new resident the day before you begin.
2. Discuss the patients with the off going intern to get a feel for what needs to be done.
3. Briefly review the chart of each patient the day before you start. You may want to write down previous culture results and imaging studies. Take notes re: plan of care
4. **Arrive early** to preround on your patients the morning of your first day on the service.

When Leaving a Service:

1. Write s succinct email check out with family dynamics not present in note. **Complete hospital course in Snapshot** tab for all patients, especially those close to discharge so that the incoming intern is able to better understand the details of the hospitalization.
2. The responsibility of the discharge summary(especially hospital course and meds) will go to the off going intern if the discharge is within 24 hours of leaving the service.

UKMC: How Do I Order a……?

Transthoracic ECHO: Order complete Study
Transesophageal ECHO: TEE order. Call the TEE Cardiology Fellow.
Carotid duplex: type carotid and select cerebrovasc study. Results in SCM documents.
Venous duplex: type venous and you will find it. Best study is with vascular lab but they are only here M-F 8-5 If weekend or afterhours be sure to select the non vascular lab one.
Nuclear stress tests: Go to Browse then cardiology then Gill Nuclear Med
Stress ECHO: under stress ECHO and assoc EKG is in the order set.
Exercise stress tests: type Stress and you will find it.
ECG: type ECG. Make sure to pick the inpatient one. Hardcopy in chart. Results in SCM imaging.
Angiography(IR): Enter order- Consult interventional radiology. Call interventional Radiology 30348 or page 1729 or sub-specialty listed on Provider on call. Talk with them first about if they will do the procedure. Make sure patient has recent coags and platelets and is NPO the night prior.
X-rays: Search with part of body. 'Foot'. Order with Indication for test and timing (stat vs. am, etc)
CT: order 'CT____' with Indication and technique, i.e. with contrast, without contrast, pancreas protocol, PE protocol, etc. Consider prehydration fluids.
MRI: order under 'MR___'
MRCP: order. Call MRI station to schedule.
Ultrasounds: order US. Specify indication.
Ultrasound guided tap*: order U/S and specify area to be marked, if you want radiology (IR) to do the procedure you need to call them first
CT guided biopsies: Call Interventional Radiology.
EEG: Order EEG routine or EEG and video. Results in SCM documents.
EMG: EMG/ NCV. Specify limb. Call EMG for results.
Bone Marrow Biopsy: Consult Hem/Onc fellow
Hemodialysis: consult Renal fellow to schedule. They put in the orders.
ABG: ABG order set. Have the nurse page respiratory if emergency.
PFT: PFT- specify full or screening
Respiratory Therapy: order nebs with instructions on dosage and frequency. The neb orders automatically expire in 3 days so make sure to review meds and renew these if needed
PT/OT: order PT/OT evaluation order and reason. They are separate orders.
Who needs to be NPO?: EGD, colonoscopy, surgery, PEG , IR, tube placement, abdominal ultrasound, ERCP, stress tests.
Heart cath in AM (except EP procedures)- Clears from MN, NPO from 7AM.

VAMC: How Do I Order a……?

For all testing at VAMC, put an order in CPRS first. It is always important to notify people of the order at the VA to ensure that orders get done. STAT may mean tomorrow to someone else…

Follow the steps below:

Transthoracic ECHO: listed under common procedures

Transesophageal ECHO: Call TEE Fellow on Cardiology to schedule.

Carotid duplex: Under Radiology/Nuclear Medicine from main screen, Then, order #29- vascular lab. Then #1

Venous duplex: Under Radiology/Nuclear Medicine from main screen, Then, then order #29- vascular lab, then order #3

Nuclear stress tests: listed under common procedures (myocardial spec)

ECG: listed under common procedures

Angiography/ CT guided bx: Call interventional Radiology to make sure they are willing to do the procedure then: Radiology/CT orders and pick CT guided bx , angiography etc.

X-rays: Listed Under Radiology/Nuclear menu, Then under Radiology Quick Orders

CT: Listed under Radiology/CAT. If you need it STAT then call down to CT, as often times they prioritize the outpts over the inpt so let them know you need it now.

MRI: Listed under Radiology/MRI. Usually this will happen at night so warn the pt—they do outpt during the day, so don't count on a STAT MRI

Ultrasounds: Listed under radiology/Nuclear, Then U/S #28

Hemodialysis: consult Renal they will schedule the pt and put in the orders

ABG: order under labs menu

Respiratory Therapy: Under Respiratory, Then Respiratory Care Orders. Here is where order CPAP/ BiPAP

PT/OT: Under Consult menu, then PM&R, then PT/ OT inpt (the RIGHT colum). Same menu for PMNR consult

Home supplies: To order BP cuff, bed/ mattress other things at home go to consult menu, under prosthetics consult, then pick what you need

Home O2 : consult menu, then Home oxygen request order

Pharmacy Consult: Consult menu, then pharmacy. Where can place non-formulary consult or warfarin consult

Tip: if you do a procedure like paracentesis, LP, etc there is a lab fluid tests order under then Lab menu that has useful order sets. A Urine lytes order set is here too

VAMC Discharge Summary

Note: discharge summaries are required prior to discharge to a nursing home or a VA facility.
Donna Miller at 4379 will let you know which Discharge Summaries are yours and that you haven't done yet.
Make a list in your workroom of outstanding d/c's for other pt

The discharge summary serves as an overview of the events of the hospitalization and provides the PCP and subsequent providers with medication changes, follow-up plan and significant events. Since the VA operates an electronic medical record, with easy access to all notes, diagnostics, and labs, an extensive summary is unnecessary. The main focus should be on the hospital course based upon the assessment and plan, discharge medications, and follow-up plan. **DO NOT SIMPLY CUT AND PASTE LARGE SECTIONS OF PREVIOUS NOTES INTO A DISCHARGE SUMMARY!!
** Don't forget to always **flag the PCP** as an additional cosigner on the discharge day progress note

VAMC Discharge Summary Format

Identifying data: included as part of CPRS including patient name, SS, admit date, discharge date.
Service: Red, Purple, Orange, Blue
Attending
Discharge Diagnosis (list all diagnoses)
Reason for Hospitalization/HPI (1-2 lines)
Past Medical History
Hospital course (problem by problem is easiest to read)
Discharge meds
Procedures
Discharge instructions
Follow up instructions

Death Note

Things to Do When Called for a Patient Death

1. See patient and assess for signs of life: listen for heartbeat, feel for pulse, check for pupil reactivity, do a sternal rub. If patient found and NOT a DNR, initiate a code and ACLS algorithm.
2. Check telemetry if patient is being monitored.
3. Inform next of kin of the death of their family member – face to face is much preferred.
4. Ask family if they want an autopsy and name of funeral home.
5. Call KODA, the organ and tissue transplant organization. You will have to record the name of the KODA rep you talk to so write it down! If at the VA you are not supposed to give the name of the pt to the KODA rep unless they are a possible donor. This does not apply at UK.
6. Documents for pronouncing MD (these include numbers for step 5):
   a. Notification of Death from in SCM at UK
   b. Death procedure note at VA.
7. Work for primary intern – Death Summary (Abbreviated version of a discharge summary, choose d/c summary in SCM)
8. Many attendings want to be informed immediately, even at 3am. Ask at the beginning of the month.

Death Summary Format

COMPETE -

Patient ID: patient's full name and MR #.

Attending : they will be the one to sign the official death certificate

Service

Date of Admission

Time and date of death

Cause of death

Complete name and address of referring physician or PCP

Admitting diagnosis

Final Diagnoses at time of death

Procedures

Brief History: reason for hospitalization

Hospital course: procedures and treatments with focus on events leading to death. Be brief.

Physician pronouncing.

What we have here is . . . (failure to communicate)

UK:

1. Lightning Bolt – paging / on-call system
2. LifeImage (radiology images including CT,MR, XR, US)
3. Sunrise Clinical Manager (home access from https://medconnectplus.mc.uky.edu)
4. Up to Date (hospital & from https://medconnectplus.mc.uky.edu via SCM)

VA:

1. CPRS (available at home. See Medicine ADPAC, VA computer support for how to set this up) - IF YOU GO LONGER THAN 90 DAYS WITHOUT LOGGING INTO THE COMPUTER YOU WILL BE LOCKED OUT. If that happens make sure you get your codes updated several days before you have to go back to the VA and be on service.

Some men you just can't reach . . .

Lightning Bolt –Our on-call system

To Report Mistakes in on call pager #s - phone the Paging/Communications operators at 7-3700. During daytime hours, also report the mistake to person in that department who enters the information.

Remember to always have your pager on SCM next to the patients you are taking care of on your list under the On-call tab.

Voalte

What is it? A HIPPAA-compliant messaging system used by UK Healthcare system. It is a secure way to communicate with nurses and other members of patient care team as well as a directory of users. You will be instructed on how to download to your mobile device.

Expectations:
1. Sign in to Voalte every shift if on rotation utilizing Voalte (GSH, MT, Consults, ICU/CCU, CA-3)
2. Assign yourself to appropriate role.
3. Respond in timely manner to all messages.
4. Sign out at the end of shift.

Note: As of now, you are still required to carry your pagers.

Tip: Lightning Bolt is available under “Menu”→”On-Call Schedule”

Resource for additional questions: https://bit.ly/3d2MHZ9

Paging 101

How To Place A Page At UK Hospital

• For 7-digit pager numbers - 330-xxxx
- dial 9 + the pager number.
•Can also page via www.usamobility.net
• You can text msg to a 330-xxxx pager from your cell phone- have to use 859 first
• If at VA dial -6-6 and then the 3-digit pager number when prompted.
• For older four-digit pager numbers (not many left), dial 3-3000 (or 323-3000 from outside), and then follow the prompts ("Enter the display digits" refers to the phone number you want the person being paged to call).

Press * and your pager # after call back # to let them know who is paging.

How to read between the numbers when paged

- Four digit number – someone at VA or GS is paging
- Five digit number – someone at UK is paging
- Ten digit number – A patient in Hazard got your pager number.
- Don't forget to push *67 if you are calling a patient back on your cell phone, otherwise they will seriously call you for years… seriously

Crosscover calls

Your will receive calls on ALL of the following topics at some point during your intern year. The key questions are "What do I do first?", "Do I need to see the patient on every call?", "At what point do I call my upper level?" When in doubt **go see the patient**! On your way to the room go ahead and think through possible situations and what you will do for each.

Chest pain This is a must see patient scenario. Have nurse get a stat ECG and give NTG SL if the CP sounds like ischemia. Check vital signs. Do a chest, CV, and lower extremity exam. Obtain ABG, cardiac enzymes, and portable CXR if necessary. You could try a GI cocktail if the story supports. If this is typical cardiac pain and the patient has already received NTG x 3 with continued pain or EKG changes, call your upper level for additional recs or the cardiology fellow. Consider ASA and starting heparin therapy.

SOA This is a must see patient scenario. Have nurse get a stat ABG and portable CXR if appropriate. Exam: heart, lung, JVD, lower extremities. Check O2 sat. Deep NT suction when appropriate (Order these before leaving your bed). Differential could be ischemic heart disease, CHF, pneumonia, pleural effusion, pericardial effusion, mucous plug or PE. Stat EKG. Consider lasix if history appropriate. Nebs Tx by RT if COPD or asthma.

Fall: This is a must see patient scenario. Musculoskeletal exam; if hip hurts get Stat x-ray to r/o fracture, do neuro exam to r/o CVA, check FSBG to r/o hypoglycemia. CT of head without contrast if head injury or acute CNS bleed is suspected as the cause of the fall. DDx = syncope vs. gait abnormality vs. simple fall. Nurse will have an incident report for you to complete and sign.

Low BP: Go see patient. Review meds and hold anti-hypertensives as necessary. Look at vitals trend. This **may be normal** for some patients. Recheck manually; if truly hypotensive can give healthy young patients a 1Liter NS bolus. If appropriate (mild cardiac dysfunction) try a 500 cc NS bolus. If severe systolic/diastolic dysfunction or renal failure patient then try 250 cc bolus. Remember, if the cause of the hypotension is cardiogenic shock, fluids may make things worse. If BP not really too low and asymptomatic (i.e. urine output and mental status ok) then can try a little fluid or nothing at all. Take history and see why low: new meds, heart failure, or sepsis.

High BP: Check meds, other vital signs. Look at MAR- previous nurse may have held a med. Consider pain, accelerated HTN, or CVA. Also, a markedly elevated BP may be caused by pain, distended bladder, or hypoxia. Rule out these causes before giving anti-hypertensives. Consider giving a dose early or an extra dose. You don't need to be too aggressive if asymptomatic. Don't give a dialysis pt a bunch of antihypertensives if they will be going for HD soon or they will bottom out in dialysis.

Cross Cover calls

Tachycardia: Order an ECG and rhythm strip on way to see patient. Review VS and oxygen sats. Determine rhythm with the help of upper level or CCU resident. Usually secondary to fever or dehydration or underlying arrhythmia. Can give fluids (1 liter or 500 cc), check temp, if febrile give Tylenol, pain control if necessary. If sinus tach, treat the underlying cause. Ask for help if considering IV rate control metoprolol IV or dilt drip.

Bradycardia: Hold any contributing meds. Are they symptomatic, asymptomatic, asleep? If asymptomatic just be sure to r/o heart block with ECG. If symptomatic you will need atropine (0.5 to 1 mg Q3-5 minutes PRN IV, max 2 mg total dose). If you're giving atropine you probably need to ask an upper level or cards fellow for help and get pacing pads ready just in case.

Constipation: If obstruction is suspected, it would be better to give something from "below" before stimulating the bowels from above. Consider PR Dulcolax or enema first. DOSS for prophylaxis (but does nothing once already constipated). Miralax 17gm daily is great for prevention but won't relieve the patient right away. Lactulose or Mag citrate usually do the trick.

Decreased urine output: If Foley catheter is in place check for obstruction first. (flush or replace with new Foley). If no Foley, then can do a bladder scan or do I/O cath. Can give fluids if you think they are hypovolemic. If renal patient may simply be oliguric/anuric. If hematuria, change Foley. Never treat low UOP with Lasix.

Hyperglycemia: Use the insulin protocol in SCM. Can give more sliding scale. Make sure they don't have dextrose in their IVF. Then adjust their insulin regimen so this does not happen again.

Fever: Have nurse recheck. if > 101 F orally or > 100.4 F orally and neutropenic, then get UA, urine culture, blood cultures x 2, CXR, sputum gram stain and culture (Don't forget to follow up UA, CXR). You don't have to start antibiotics right now if they are not neutropenic or looking especially bad. Check all lines for signs of infection. Check for decubitus ulcers. Consider sinusitis if NG tube in place or intubated. A thorough review of systems and physical examination is mandatory. If they are neutropenic or look like they are declining fast, begin empiric/directed antibiotics. Schedule Tylenol/ibuprofen if indicated.

Diarrhea: Send C. diff PCR. If newly admitted, consider comprehensive GI panel. Maybe hemoccult check. In ICU, could start empiric Flagyl or PO vanc until C. diff tox comes back.

Crosscover calls

Hypoglycemia: if in 50's and awake, give 4 ounces of orange juice and recheck. If 30's to 40's or dizzy/very symptomatic, give 1/2 amp of D50 (especially prefer 1/2 amp if pt. diabetic) or 1 AMP of D50. Then make sure you or the team adjusts their insulin regimen so this doesn't happen again.

Anxiety: Try to figure out why they are so anxious first. You can give ativan 0.5 to 1 or even 2 mg if it is a young person with a functioning liver. The elderly do much better with haldol, risperdal, or seroquel. Sometimes a pt just needs to talk and to hear that things are ok. You can also give hugs!

Transfusion issues: It is common for people to have a slight fever. A hemolytic reaction is uncommon but can cause abdominal, back, or chest pain, fever, chills, HTN, hemoglobinuria. Stop transfusion, send blood bag and serum specimen to blood bank. Use vigorous hydration, mannitol, benadryl, and solumedrol.

-***Antigen/antibody reaction***s are from WBC contaminants and cause fever, chills, urticaria. Always r/o hemolysis. Tx with benadryl 50 mg IV and use WBC filter with future transfusions.

-*Anaphylaxis* rare, but need epinephrine, fluids, H1 & H2 blockers, steroids

Mental status changes: Go see patient. Get Hx and VS. Do a quick neuro exam. Check pulse ox, finger stick, and EKG. Review meds and look at the MAR to see what they have gotten. Administer D50 if hypoglycemic or narcan if receiving narcotics. Always think about infection! As well as hypoxia, CO2 retention or renal failure/ electrolyte disturbance.

Seizure: Go see patient. En route can give ativan 1 or 2 mg IV. You can do this several times. If does not stop with first or second dose call your upper level or neuro resident. Consider withdrawal, meningitis, electrolytes, hypoxia, HTN, brain mass. Maintain airway- if still seizing may need intubation. You also may have to load with Phenytoin or Fosphenytoin

High potassium: For lab values under 6.0 then give 60gram kayexalate (PO or enema if necessary); patient must be having regular BM's for this to work. If > 6.0, obtain an ECG. If the ECG is normal, repeat the lab value. If there are loss of P waves, new prolonged R interval, or a widened QRS complex, call your resident and give calcium gluconate 2 gm IV. Next reduce the serum K by giving sodium bicarbonate, glucose, and insulin with 1/2 amp of D50 and 8 units regular insulin if diabetic. If not diabetic, give 1 AMP of D50 and 10 units of regular insulin IV. Repeat BMP in 30 minutes to 1 hour. The total body potassium needs to be reduced by kayexalate, or hemodialysis. – there is an order set in SCM under PUL-hyperkalemia with all the orders you may need and you can just click the boxes

Code Blue - What Do I Do Now?

As an intern, it helps to have perspective well before you arrive at your first code on the floor. Excluding trauma, a coding patient likely represents very advanced disease and poor likelihood of survival. With that in mind, take the advice found in *The House of God* and check your own pulse first. If it is present, even though a little tachy, chances are you are going to do more good than harm for the patient in extremis, no matter what you choose to do.

UKMC code team:

-Consists of wards senior resident on call, MICU resident, CCU resident, ER resident, rapid response nurses, MICU nurses, and respiratory therapy.
-The first physician to arrive will assume control of the code until the MICU resident arrives. MICU resident has priority and may assume code leader role.
-ER resident is responsible for securing airway

VAMC code team: The code team consists of the on-call floor resident and on call interns or the night float team. At night the MOD will also respond.

If you are the first one on the scene: **ABC's before all else!**

Airway: eliminate airway obstruction and get an airway (not necessarily intubation). If you can oxygenate the patient with a bag-valve-mask there is no emergent need for intubation. Oral airways can be helpful. Get someone to hook up suction!

Breathing: give oxygen, bag valve mask patient. Have someone check for breath sounds. If breath sounds are present and you feel you are adequately ventilating the patient (O_2 sat coming up), there is no reason to immediately intubate.

Circulation: check for pulse, if you don't feel one have someone start chest compressions if necessary. Fast and Hard is key…

Do Not: simply pronounce; initiate code unless patient is a known DNR

Get Pads on the patient quickly because the **most important thing** you can do after you have gone through the ABC's is check for a **shockable rhythm**. Look for v-fib or pulseless v-tach and shock if that is the rhythm. Each minute a patient spends in v-fib, the likelihood of recovering to sinus rhythm decreases 10%. Do whatever it takes to determine the rhythm early. Defibrillate or cardiovert immediately if indicated.

Also, Remember the 5 B's:

Bedboard: remove and start compressions
Box: get code cart, monitor, lead placement
Bucket: suction
Blood: CMP, coags, Mg, phos, ABG, type and cross, CBC, cardiac enzymes
Backup: have a nurse or tech call the upper level of the patient for background information

ACLS protocols form the basis for codes: So know it!

The Checkout

What a long day!. Time to go home…..not so fast Doctor.

Your patients expect and deserve good continuity of care while you are out of the hospital. So…a good checkout helps ensure that excellent care continues. The patient must be stable without pending procedures when you leave.

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Time line and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

Important Points

When constructing your checkout list, put yourself in your colleagues place. Be sure to: provide if/then solutions for the labs or results you are asking them to check! Bad: BMP due at 6 pm. Good: BMP due at 6 pm; if potassium still above 6, give another dose of kayexalate.

Be sure to update the Handover tool with above IPASS information

Needlesticks

Avoid it by:
1. Universal precautions
2. DON'T RUSH- SLOW DOWN whether you are experienced or not!

If it happens:
1. Take comfort that you aren't the only one
2. Wash with soap and water. Don't "milk"/massage/press wound to help them bleed freely; this can increase risk of transmission of blood borne illnesses
3. Find the Charge Nurse on the floor and she will give you a red packet with forms to fill out and instructions.
4. It will instruct you to call 1-800-440-6285 to report to workers comp (who will pay for tests)
5. They will ask you if you want care for it. Say yes (This gets you and patient tested)
6. If it is normal business hours they will then schedule you an appt at Employee Health. If it is at night or a weekend, they will connect you with an on-call physician and they will advise you on the risk and decide if it can wait until employee health opens.
7. Fill out the rest of the forms in the packet.

* This is tedious to make all these calls and go to the lab multiple times, but worth it. Do NOT ignore this protocol if you have an exposure. Seriously!

Other info:
Sanford Guide
National Clinicians Postexposure Hotline (PEPline)
http://www.ucsf.edu/hivcntr (888) 448-4911
NEEDLESTICK!
http://www.needlestick.mednet.ucla.edu
CDC
http://www.cdc.gov/niosh/topics/bbp/emrgnedl.html

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