VA Wards Orientation Guide 2017-2018

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Team room door codes:

- Team 1: 3E- 239, code 3+4, 1
- Team 2: 3E- 105, code 3+4, 1
- Team 3: 3E 141, code 3+4, 1
- Team 4: 4E- 239, code 3+4, 1
- Team 5: 4C-194, code 1, 3, 5
- Team 6: 4C- 135, code 1, 3,5

Team Phone Numbers:

- Team 1: 55027 / 55028
- Team 2: 57714 / 55054
- Team 3: 57138 / 57139
- Team 4: 57036 / 56993
- Team 5: 57037 / 54179
- Team 6: 58738

Administrators: Evangeline Kokkinos, evangeline.kokkinos@va.gov x58121

For password issues or IT issues: call 5-8129 for the IT Help Desk. At night or on weekends, for Windows and computer issues 1-855-673-4357, press 2 (VHA), press 4 (region 4)

Wards structure

Team structure:

- There are 6 day ward teams and a night float team for admitting and cross-cover.
- Each team consists of one resident (either PGY-2 or 3) and two interns. You will work with residents and interns from Georgetown University, George Washington University, Walter Reed and Howard University.
- Each team will have between one and four students (MS3/MS4/PA/Podiatry).
- One team will have an additional resident as the "Teaching Resident" or TR, who will be a PGY3 selected for additional teaching responsibilities.

Call Schedule:

- Every team admits patients each day (including weekends) from 7am to 3pm, with overnight admitted patients distributed based on census.
- Two teams are designated the "Late Call Team" each day, which means that they also admit from 3pm to 6pm (in addition to getting admissions from 7am to 3pm). This rotates amongst all 6 wards teams every 3 days.

Distribution of Admissions:

- 7:00 AM – 3:00 PM: All team admits patients every day (including weekends), with distribution based on census.
- 3:00 PM – 6:00 PM: Designated "Late Teams" admit patients (one team per floor).
- 6:00 PM – 7:00 AM: Two Night Teams (Mon-Fri) or weekend Moonlighters admit and cross-cover
- The daytime "Late Teams" will each have a set of code blue and RRT pagers which they should hold all day
    - If the Medicine Consult resident has clinic in the afternoon, one of the Late Team Residents will also be responsible for holding this pager and seeing any urgent consults (work this out with your co-resident)
- Night Team admissions are distributed in the morning to all teams by the Chief Residents based on team census and call schedule
- All overnight admissions distributed by the Chief Residents need to be seen by the day resident prior to rounds.
- In the morning, please change CPRS admission order to reflect the day team number, resident and intern, and attending.

Weekends:

- All housestaff have one day off per weekend. There are no golden or black weekends.
- The interns from each team work one day and the resident work the other day. Interns from the post-call teams should be assigned to work Saturday.
- Each team is paired with a "Sister Team." The interns partner with the resident of their "sister team," and vice versa. The two "Sister Teams" form a "Super Team" on the weekend. **They round together and complete admissions together.**
    - Sister Teams: Teams 1 & 2; Teams 3 & 4; Teams 5 & 6
- All teams can get overflow patients (admitted by the night team) in the morning.

- All teams are eligible for admissions from 7 AM – 3 PM, just like a weekday.
- The "Late Teams" (each composed of one resident and two interns from "sister" teams) are responsible for all admissions to their floor from 3 PM **–** 6 PM, just like a weekday.
- Sign-out: Teams may sign out to the "Late Teams" at 3 PM, if all work is completed. Teams 1, 2, 3 sign out to each other; Teams 4, 5, 6, sign out to each other. Otherwise, all teams may sign out to the moonlighter for their designated floor at **6 PM.**
- There are two moonlighters overnight on weekends, with one moonlighter designated for the 3rd floor teams (Teams 1-3) and one moonlighter designated for the 4th floor teams (Teams 4-6) for cross-coverage. The moonlighters are also responsible for overnight admissions.

Night float team:

- **Hours:** Monday – Friday, 6 PM – 7 AM (last shift ends at 7AM on Saturday morning).
- After the night team completes its five-night stretch (Monday-Friday night), the team will be post-nights on Saturday (not counted as an ACGME day off) and off on Sunday.
- The night float team consists of 2 residents and 3 interns. The residents supervise cross-coverage and all admissions in the same manner as they do during daytime hours.
    - Intern A covers Teams 1, 2, 3; Intern B covers Teams 4, 5, 6
- All CPRS admission orders should be assigned to "Medicine Night Team A or B" on CPRS with the night resident and intern names, the night attending, and the appropriate Night Team pager number for staff to contact the correct admitting team.
- Pagers held by the night team:
    - MAR A = 9516-3822
    - Xcover A = 9516-0151
    - Admitting Intern A = **9259**-3283
    - MAR B = 9516-3284
    - Xcover B = 9516-0035
    - Admitting Intern B = **9259**-3278
    - Med consult = **9259**-3286
- PM Sign Out, **6 PM** in **Team 2 room** to receive sign out and call pagers

- **AM Sign out**: **6:45am** outside the Chief's Office
    - The 2 overnight residents should **ONE e-mail** the Chief Residents (**dcvamcchiefs@gmail.com**) by 6:30am with the following information:
        1) List of overnight admissions (LastNameInitial, Last4, and floor unit assignment ie 3E, 4E/4C, 2D)
        2) Note if any patient is a bounceback and to which team or resident
        3) Current census for each of the 6 Medicine Teams from the overnight sign-out (exclude discharges)
    - The overnight residents present a brief teaching point (2 min) about a patient admitted overnight on weekday mornings.
    - On **Weekend mornings**, the Chief residents will **email you back** about team assignments for the patients and sign out will occur **outside** the Chief's Office.

- **Calling overnight attendings**
    - There is an attending on call (AOC) available by phone each night.
    - The AOC will call you between 9 and 10pm touch base with the residents and discuss admission and concerns.
    - **Residents, please call the attending at 10 PM if you have not heard from them.**
    - Attending contact information is on the VA intranet site → On call schedules → Medicine attending contacts.
    - Night attending assignments are below.
        - Monday: Team 1 attending
        - Tuesday: Team 2 attending
        - Wednesday (attending switch day): Team 3 attending
        - Thursday: Team 4 attending
        - Friday: Team 5 attending
    - Must call events include:
        1. Code Blue or significant Rapid Response
        2. Transfer to the ICU or significant change in clinical status
        3. Patient leaves AMA
        4. Death of a patient that is unexpected (inform overnight attending and make sure primary team informs their attending in the AM.)
        5. Significant hemodynamic instability requiring intervention
        6. New onset neurologic finding

7. Medication or treatment errors resulting in increased patient monitoring, intervention, or patient harm
8. Challenges determining level of care (floor, tele, PCU, MICU) for new admissions
9. Anytime you are unsure of the next step in work up or management
10. Any other clinical management or difficult system question you might have

Team Caps:

- **Team Cap:** Each medicine team has a cap of 20 patients total. When the total medicine census is less than 84 (average of 14 patients per team), the team cap drops to 18 patients total.
- **Personal Cap:**

  Interns:
  - Can receive a maximum of 7 new patients on any given day (5 admissions + 2 transfers)
  - Can carry no more than 10 patients at a time (including weekends – this means that an intern can only pre-round and write progress notes on a maximum of 10 patients per day).

  Residents:
  - Can supervise a maximum of 14 new patients on any given day (10 admissions + 4 transfers).
  - Can carry no more than 20 patients at a time.

Sign-out to a new team:

- When you are rotating off of VA wards, starting a week of nights, or off on a weekend, you are required to give the house staff caring for your patients an adequate written and verbal sign-out. Written sign-out should be sent using your institution-specific email addresses (GW, Georgetown, Howard, or Walter Reed - this is the only HIPAA-compliant way to do so). Do NOT use personal email accounts like gmail or yahoo. If the house staff covering your patients are not physically at the VA, the email sign-out should include your phone number so that you can be called by the person picking up your patients.

Duty Hours:

- If you are approaching your duty hour limits, please let us know so that we can identify system issues and correct it.
  - All residents and interns may work for 80 hours per week averaged over the month.
  - All residents and interns *must* have 8 hours out of the hospital between shifts and *should* have 10 hours.
  - All residents and interns must have 1 day off in 7, averaged over the month.

Conferences

Attendance to conference is mandatory. Please be punctual. You must maintain at least a 70% attendance at your educational conferences to graduate from residency per ACGME requirements.

Afternoon Report: Mon, Tues, Thursday at 12pm

- All interns and residents are expected to attend.
- Residents will present a case and teaching session (usually Report on Thurs) once during their rotation

Grand Rounds: Wed 12:00 pm – Freedom Auditorium, 4th floor (Across from the Department of Medicine)- **with food**

- All interns, residents, and medical students are expected to attend.

Life Conference: Fri 12:00 pm – Freedom Auditorium, 4th floor (Across from the Department of Medicine)- **with food**

- All interns, residents, and medical students are expected to attend.

Contacting people

Vocera: Please log in to your team Vocera when you arrive in the morning, and remain logged in until you sign out. Replacement batteries are located in the Medical Service Office on the front desk.

Vocera Log-in Names

Team 1: Obi-Wan Kenobi
Team 2: Deuce Bigelow & Napoleon Dynamite
Team 3: Three Amigos
Team 4: Fantastic Four
Team 5: Captain Planet
Team 6: Kevin Bacon

To contact someone on their Vocera using a phone, dial 5-8899 and you will hear the Vocera prompt.

Paging:

- **VA pagers: Dial 9516, then 4-digit pager number** (If calling a VA pager from outside the hospital: 202-516-pin #).
- **GW pagers: Dial 7777, wait for the beep, then enter 7-digit PIN** (If calling a METROCALL pager from outside the hospital: 1-800-946-4646, wait for prompt, then enter 7-digit pin #).
- **GT pagers: Dial 9, 202-405-XXX/259-XXXX**
- **Navy pager: Dial 369, then pager number**

- VA Call back number: 202-745-8000 & 5-digit extension.
- Calling outside phone numbers: Dial 9 + 10 digit number.

Radiology:

When placing a radiology consult/order, in the "reason for study" section, please conclude with your "TEAM #" so that radiology knows how to reach you in a timely manner.
If you leave a voice mail for a technologist, leave your "TEAM #" so that they know how to contact you to confirm that they received the message.

Who to call and how to get radiology studies done		
Type of study	**Hours**	**What to do**
CT scans	24/7	Vocera "CT technologist" OR Call 5-5774 (CT room) OR call 5-5771 (Front room) for STAT studies. A voicemail is set up so that you can leave a message WITH A CALL BACK NUMBER where the CT tech can reach the team to confirm receipt of request.
MRI	Mon-Fri, 7:30AM-8PM	Call 5-6424 OR 5-5215 OR 5-8361 OR 5-2333 OR 5-6917 for STAT studies.
X-rays – bedside studies	24/7	Vocera "X-ray tech" OR call 5-2325 OR 5-5771
X-rays – non-bedside studies	Mon-Fri, 7:30AM-8PM	Vocera the patient's nurse to get the patient ready, then send the patient down. You can also call the escort (Vocera "Escort") to bring the patient down.
	Off hours	There is only one technologist in-house. Try the receptionist desk first at 5-2325 or 5-4985. If no answer, Vocera "X-ray tech." A voicemail is set up so that you can leave a message WITH A CALL BACK NUMBER where the tech can reach the team to confirm receipt of request.
Ultrasound	Mon-Fri 7AM-4PM	Vocera "Ultrasound technologist" OR call 5-5006 (front desk of Ultrasound).
	Mon-Fri 4PM-MN	Vocera "Ultrasound technologist" OR call 5-5693.
Nuclear medicine	Mon-Fri 7AM-4PM	Call 5-8390 (front desk of Nuclear Medicine) .
MRI, nuclear, ultrasound	Off hours	Call the technologist on call, who will have to come in from home. Their contact information can be found on the VA intranet on-call schedules. If you have trouble, call the CT tech OR call the technologist supervisor (contact info in the same schedule).
Interventional radiology	Mon-Fri, 7AM-4PM	Call 5-8647 OR 5-4251 to schedule.
	Off hours	Page the interventional radiologist on call using the IR call schedule on the intranet.

How to talk to a radiologist about a study	
Main reading room	5-5013
General/CT scans	5-6420
Neuroradiology	5-7598, 5-5499
Body/MSK radiology	5-6430
After hours radiology service Mon-Thurs 9PM-8AM, Fri 9PM-Mon 8AM, Holidays (24 hours)	877-780-5559
Dictated reports (24/7)	5-8677, 5-8678 or 5-8888 THEN dial #199 THEN dial 1 plus the patient's social security number. The most recent report will be played first. Press 5 for an earlier report.

Cytology:

General

- All specimens need to be labeled with 2 identifiers (**FULL name and FULL SSN**) **and the source of the specimen**. A Tissue Examination Request Form (SF515) must accompany the specimen. That form also needs to be labeled and clinical data should be indicated. **There is no electronic alternative to this form.** A form can be downloaded from the intranet – see departmental listings.

- Please write your name, team and availability **legibly** on the form.
- Physician/Department will be notified if a specimen is received without proper labeling the specimen will be held for 5 business days; **if no corrections are made, the specimen will be discarded**.
- Never add formalin or other fixative to the specimen. Submit the specimen ASAP for proper refrigeration prior to processing.

Paracentesis

- **All serous fluid** specimens are to be submitted for cytopathologic evaluation.
- Submit all the fluid you obtained.
- Collect specimens for cultures separately – we cannot take a sample without risk of contamination.

CSF

- Please indicate if the patient has suspected CJD.

Useful numbers

- Anatomic Pathology Resident GB x8608
- Histopathology Lab: GB116; x7508
- Cytopathology Lab: GB114 x6986
- Microbiology Lab GB x7502

Admissions, discharges and transfers

Admissions:

- All new hospital admissions should have an "Admission History & Physical" note written.
- Add the primary care doctor as a **co-signer** to your admission H&P.

ER admissions:

- **The order to admit a patient (A/D/T order) from the ER should be placed immediately after hearing about the patient (within 15 minutes at the latest).**
- If you disagree with the ED physician's disposition for the patient (e.g. you think the patient should be on telemetry and the ED physician put in a request for a non-telemetry bed), you must discuss this with your attending immediately. Update the ER and AOD know what kind of bed the patient needs.
- The patient's status should be changed to "inpatient" with a bed and/or floor assignment. Place orders as active.
- If you need to write orders to be completed while the patient is in the ED, notify the patient's nurse.

Direct admissions from clinic/interventional radiology/CLC:

- You will receive pages from clinic attendings, IR, GI suite, and the CLC (nursing home) for direct admissions.
- If you think the patient is potentially unstable (i.e. does not meet the definition above), please ask the referring physician to send the patient to the ED. In the case of the CLC, these patients may be transferred directly to the PCU/MICU.

CHF admissions:

- Please use the **CHF admission order set** for all patients admitted with CHF.
- Document the patient's NYHA classification.
- Please ensure that the patients get **1:1 bedside teaching with the RNs**. This is in the order set.
- Make an accurate medication reconciliation at discharge: classify each medication for the specific medical condition it treats (for your heart failure: lisinopril 20mg orally daily, carvedilol 25mg orally twice daily, etc).

Telemetry beds: * see section near end of packet titled "Telemetry & PCU Indications"**

- The decision to admit to telemetry (or not) is made by the ED attending. If the house staff disagrees with the ED attending's decision, they should discuss with the ER attending ASAP, and with medicine attending as needed

Med-tele beds (see indications near end of packet):

- Write the admission order in CPRS "Admit to telemetry".
- To discontinue telemetry, complete "d/c tele" order, change status to Acute Medicine and inform charge nurse.

PCU beds: Beds available in the step-down unit on 4BW for patients who require a higher level of nursing care, Bipap or Continuous pulse ox, but do not meet criteria for ICU/CCU admission. (again, see "telemetry &PCU indications" section)

- Call the MICU charge nurse at extension **58112** to ask if there is a PCU bed available and inform them of incoming patient.
- Then write the order "Admit to tele/PCU."
- To transfer out of the PCU, inform the MICU clerk and write the patient's name on the board in the MICU.

Bounce-back policy: if a patient is readmitted within 30 days, they return under the care of the same team if the resident or either intern remains on the team for the same rotation i.e. a patient cannot bounce back to a new resident/intern team.

Transfers:

Transfers to MICU:

- If you are concerned that your patient requires a higher level of care, page the ICU team at 9-516-**3801**. The ICU resident will assess the patient and determine whether the patient is appropriate for transfer.
- If your patient is accepted for transfer to the ICU, please write a Transfer Note summarizing the patient's hospital course and current plan. The MICU team will place all of the transfer orders and arrange for a bed assignment.

Transfers from MICU team:

- Patients can be transferred from the MICU **only if they have a bed assignment**.
- The patient must be seen within 1 hour of being called by the MICU team.
- The MICU team must write a transfer summary for all patients in the MICU > 24 hours.
- The medicine team must also write a transfer note. This **should not** be a copy of the MICU transfer summary.
- Patients physically in the PCU **should not** be transferred from the MICU team to the medicine team. The only exception is if the patient is only in the PCU because they require home CPAP/BiPap i.e. if they will not be able to leave the PCU at any time prior to discharge from the hospital. Other exceptions can be made on a case-by-case basis after discussion with the medicine attending.

Transfers from other services (except the Nursing Home 2K):

- Facilitated by the medicine consult service. The consult service will evaluate the patient and call the admitting resident to write transfer orders.
- The admitting resident should write the "transfer to medicine" order.
- If a bed is unavailable, but the patient needs immediate medical care, they should be transferred to the ED.

Death: If you are called to pronounce a patient (your patient or a cross-cover patient)…

Notify your attending.

- Write a death note - Type in "Death" and choose DEATH <SUMMARY OF DEATH NOTE>.
- You or the nurse should contact the AOD who will coordinate with Decedent Affairs to prepare the appropriate paperwork. They will also coordinate transferring the body to the funeral home with the family.
-

Discharges:

1. Notify Case Manager of appointments needed
2. **Medication Reconciliation:**
    a. Type all the new medications, which medications were stopped, and which medication doses were changed during admission
    b. List all medications by Medical Problem at the bottom. Although the medications will auto-populate, group them by medical issue. For example, a good Med Rec should look like this:
        i. "For Hypertension:
            1. Amlodipine 10 mg each day by mouth
            2. Lisinopril 40 mg each day"
        ii. Items like "plastic gloves" and insulin lancets often auto-populate in this section, make sure you delete them
3. **Prescriptions for new medications**
    a. Click "Add new order" → "**Outpatient Medications**" (#46 on the menu) → type the medication name, # of pills needed, if refills are needed
    b. Click on "**Window**" to have the medication sent to Outpatient pharmacy
    c. Call outpatient pharmacy and tell them to prepare the medication ASAP. Their number is **5-8235**
    d. Speak to your patient and review new medications or medication changes with them
    e. Let the nurse know so they can call pharmacy to make sure the medications are handed to the patient prior to discharge.
    f. **Narcotics: When discharging a patient with narcotics, you must complete a paper prescription.** Controlled substance prescriptions can be obtained from the chief resident's office. You must use your **VA DEA number**, which can be obtained at the chief resident's office or from the pharmacy.
4. Click "note" → "new note" → Type "**Discharge Instructions Part A**"
    a. Go through prompts
    b. To find immunization history, click on the "**Cover Sheet**" at the bottom left of the screen, and look at the "**Immunization History**" on the bottom left
5. Click "note" → "new note" → Type "**Discharge Instructions Part B**"
    a. Click through the boxes, making sure to click each bubble. Know the patient's tobacco, alcohol, and heart failure history in advance to fill out each section appropriately

b. Write a few sentences, in terms the patient can understand about what happened in the hospital

6. Put in **Discharge Order**
    a. Click "Add new order" → "Discharge Patient" (#95 on the menu)
    b. Be sure to write in the comments to the nurse which medications the patient should have at discharge
    c. Call the nurse and tell him/her that you are putting in the discharge order and which medications the patient will need
    d. Make sure the patient knows that he/she is leaving and has a ride home or if the patient needs to take a shuttle to another VA. Contact your team's case manager if help with transportation is needed.
7. **Write Discharge Summary** within 24 hours
    a. Click "D/C summary" tab → "New summary"
    b. Select "Discharge Summary: Medical"
    c. Select Admission Date
    d. Add attending as co-signer and click "okay"

Nursing Home Discharges

- If the patient is being discharged to a nursing home, Soldier's home, or sub acute rehab, check with SW/CM if the patient needs medications filled by the VA
- When discharging to a facility, rather than listing "non-VA med"- please enter each outpatient/discharge medication under "Meds, Outpatient" with Quantity 1, Day Supply 30, Refill 1.
- Add comment: "Nursing home discharge. For profile only. Please process, but do not fill".

Discharges to the CLC- Community Living Center (H/K wing)

- **DO NOT** order medications for patients being discharged to the K/H wing. Carefully write out medications on Part B and Discharge Summary

Multidisciplinary Rounding

Multidisciplinary meetings:

- Every Monday between 9:30 to 10:30am, the case managers will call your team via Vocera and ask you to meet in the 3E-S Conference room for discharge planning for about 10 minutes per team.
- On all weekdays except Mondays, the case manager and social worker for your team will Vocera you to ask where they can meet you for discharge planning.

Bed Huddles:

- Bed huddles occur daily at **9 am and 3 pm in the 4th floor conference room #4E231**. Each team will be contacted by the bed huddle team to review/address the following:
- Anticipated discharges for today and tomorrow – Provide patient's name, last 4, bed location.
- Studies needed for planned discharges (transport, imaging, labs).
- Need for telemetry or PCU level care for patients on your team.

Weekends:

Please be aware of the following social work resources for the inpatient medicine ward teams on weekends and holidays:

- Saturdays - Coverage is through Lea Anderson. She typically checks in with all teams to check for SW and/or discharge needs and is available to assist any team.
- Sundays and holidays – There is a social worker assigned to the emergency department from 8am –midnight, 365 days/year who will be able to help with transportation, assessments, etc. Their number is x 56031. SW is working on filling 2 open positions on the wards, but in the meantime will ensure the ED SW can assist teams if needed.

How to get stuff done

Ordering Labs:

Regular labs:

- Collected by the main lab during routine collection times.
- Place the order as "lab collect" and select collection time.
- Labs should be drawn by the phlebotomy team between 5 am and 10 pm.

STAT LABS:

- Place the order as "STAT".
- Print lab requisition: highlight lab order, under file and print menu, change the requisition to print to "BB94."
- Contact the phlebotomy team: by pager (9, 516-3144) or vocera "phlebotomy."

Labs from PICC/central lines or new PIV:

- Place the order as “lab collect.” Labs should be drawn by the IV team.
- If ordering after midnight the night before for a morning lab draw, call the IV team.
- IV team can be contacted by phone (ext 57296 or 55032) or vocera “IV nurse.”

To add on a test to a specimen already in the lab:

- Enter the order as “ward collect” and time as “Now.”
- Call the lab to let them know that the order has been placed (x 5-7493).
- *Note* - this will only work if the lab already has the correct color phlebotomy tube for the specific test.

Ordering PICC line placement:

- Complete electronic patient consent for PICC line.
- Confirm recent PT/PTT/INR is in CPRS.
- Contact IV nurse via Vocera “IV nurse”.

Night time (10p- 5a) Emergent Labs and Peripheral IV Access

- Vocera “nursing supervisor” to explain the situation of why a patient needs emergent labs, nursing supervisor will advise if RN from ER or MICU should be pulled to assist.

Ordering EKGs:

- Daytime: Place order and call x55783 (stat RF phone) or x58429 (office).
- Overnight, Weekends: Place order and contact PCT (patient care tech) via Vocera (P-C-T).

Order renewals:

- Patient restraints need to be renewed every 24 hours with a daily order and a daily note (Physician Restraint Seclusion note).
- All IV antibiotic orders expire after 7days – if you are not using empiric therapy and would like a specific end date, you can add that to notation section when orders.
- Narcotics expire after 72 hours.
- Fingerstick orders and antibiotics expire after 1 week.
- All other medication orders expire after 30 days.

Ordering all radiology studies:

In the “Clinical History” box, we highly recommend that you include your name and contact information (pager, Vocera), so that the interpreting radiologist can easily reach you with results as needed.

Ordering fine needle aspiration or abdominal fat pad aspirate:

- The Pathology Department runs an FNA clinic on Tuesdays 12-3pm and Thursdays 9am to 1pm. Any **palpable** lesion >1cm is a good candidate for FNA.
- The Clinic is located on the second floor in the ENT suite.
- Additionally, abdominal fat pad aspirates to rule out amyloidosis are performed by the cytology service. We prefer performing the procedure in our clinic, but in case the patient is unable to ambulate, we are able to do it at the bedside.
- **To schedule an FNA or fat pad aspirate or with any question, call 4719 (Dr. Paal), 8280 (Dr. Chauhan) or 6986 (Cytopathology lab)**

Procedures

Supervision:

All procedures should be supervised by the senior resident or the attending. If the senior resident is unavailable, the intern should ask the residents on other teams for supervision. Chief residents may supervise if other residents are unavailable.

Consent:

- All consents must be electronic through iMed Consent application in CPRS. Go to CPRS → Tools → iMed Consent. You can do phone consents via iMed as well if there is a second witness.
- If paper consents must be used due to computer malfunction, you must physically take the consent form to the ward clerk and ensure they scan it into CPRS before proceeding.

Documentation:

A procedure note must be filled out for any procedure that is done or attempted using the “Procedure Note” template.

Consults

Calling consults:

- **Any consultation request to another physician service must both include the CPRS request AND a call to the provider within an hour of putting the order into CPRS.**
- If you experience a delay in callback from the service, please notify the chiefs.
- PT, OT, Speech, Nutrition, SARP and other ancillary staff consults do not require a phone call

MICU/CCU consult

- For MICU/CCU evaluations, please place a CPRS order as well.
- When asking the MICU/CCU to evaluate a patient, patient should be evaluated within 30 mins or less. They are expected to write a "MICU evaluation note" if patient is not accepted to the MICU service.

Palliative Care consults:

- Monday-Friday from 8:00am to 5:00 pm: Call ext 58240.
- After hours, weekends, or anytime you have trouble reaching the Palliative Care Team: Call Dr. Blackstone's cell 202-213-1042.

Psychiatry consults:

- Monday- Friday from 8:00am to 4:30pm:
    - Patients <65 years old, please page 202-516-0003
    - Patients 65 years and older, please page 202-516-3956
- After hours, weekends and holidays: please contact the psychiatrist on duty by paging 202-516-3526

Medicine consults:

- All inpatient medicine consults will be followed by the consult resident from 8am– 4 pm on weekdays.
- The night call resident is responsible for the consult service on nights, weekends, holidays, and when the consult resident is in clinic. On weekends, holidays and overnight, the medicine consults will be staffed by the on-call team's attending if the patient is acutely ill of if there are any questions or concerns.
- Any medicine consult that is staffed immediately should be counted as a transfer on the on call team admission census. If a patient is transferred from the H/K-wings to the floor, it is considered a new admission.

Obtaining Approval for Home Intravenous Antibiotics:

- Start the request for evaluation of an approval **48H before** planned date of discharge
- Antibiotics at home can be given intravenously through certain types of catheters and may allow patients to go home under the right conditions. *Nursing in the home is short-term and only intermittent (1-2x week at most on average).* Carefully consider the risk for complications.
- All Home IV patients need ID approval by an ID Attending according to the call schedule. Even if the patient has an ID consult or is on service with ID attending only Drs Kan, Gordin, Benator, Gibert, Liappis or Weintrob can approve.
- All home IV patients must have a primary care provider assignment + an appointment with them within 2wk of D/C.
- If you are unsure if the patient needs/requires continuation of therapy with IV antibiotics – ask for formal ID consult
- Case managers on your team can help you figure out who is the right person to call for the approval

Other Resources:

Antibiotic Stewardship Team (AST)

The AST is available to help discuss selection and modification for optimal antimicrobial drug regimens that avoid excess toxicity and can help you to address dosing/duration issues. *What can you do?* Narrow your therapy once you have additional clinical and/or laboratory data and ask for help if you are unsure. The ID consult service is available to you for antibiotic-issues requiring clinical evaluation and assessment. **For AST questions**, please contact: Dr. Liappis (x56328) or Dr. Ayne Adenew (vocera). For assistance with urgent clinical issues or questions after hours, please call the ID fellow on call.

The DCVAMC antibiogram can be found on the Intranet DCVAMC home page -> Departments-> Infectious Diseases -> Antibiotic Information Card. LINK: https://vaww.visn5.portal.va.gov/sites/WAS/ID/ID/Antibiogram.pdf

*A few antibiotic-associated reminders:

- All intravenous antibiotics have an ***automatic stop date***. Empiric regimens need to be assessed and renewed if continued *longer* than 7 days. Once you have a specific diagnosis, you may enter a specific stop date for a specific therapeutic course under the comment section. Do not enter prolonged courses or large number of days on your initial or continuation orders for empiric regimens (where you are not sure of diagnosis).
- A number of antibiotics are on ***restriction*** – the antibiogram lists which drugs need ID approval and the pharmacists will be calling to remind you that continued use requires speaking to the ID fellow on call or a member of the AST. Certain doses are also restricted due to toxicity. When you call, please document who you talked to in the text box option of the order for the antibiotic. The fellows will ask for a consult if they disapprove your choice or think the clinical situation warrants further investigation.
- ***Vancomycin levels***

Vancomycin is a drug which needs careful adjustment – some patients may only need daily dosing or intermittent dosing based on levels. The level most helpful is the "trough" or level in the blood prior to the next dose. If you are unsure about what trough you should use for your patient's indication, please consult the ID team.

- If you have a patient on BID dosing (9am/9pm) consider ordering level as a morning routine blood draw rather than a ward collect . The routine morning blood draw (430am order) is drawn between 5am and 7am generally and this is a good approximation of a trough level.
- If you forget to order it, it can generally be added to the morning labs if you ordered a chemistry lab (serum tube) just call the lab and request it be added!
- If your patient is not on a scheduled dose, use the ward collect system planning for an hour before dose is given.

Always communicate in person with the nurse so they know the phlebotomists are coming up to draw a level that morning.
When interpreting the level: the lab enters a "specimen was drawn at XXX" comment when result is put in CPRS; use that time along with the nursing administration time documented in CPRS to determine if the level was appropriately drawn before changing or holding dose.

CPRS tips and tricks:

Notifications:

When you first sign into CPRS, you will see a box of notifications. These will include medications that are about to expire, radiology results that have returned, consults that have been completed, and notes that remain unsigned. These are very helpful in finding out what has been done for your patients!

Setting a default cosigner:

Under the "Tools" Menu, click "Options," then the "Notes" tab. Click the "Notes" button. Select your attending's name as your default cosigner.

Medications that require justification:

There are a number of medications that are on the VA's formulary list, but require justification in order to be prescribed. These include:

- Atypical antipsychotics: aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone
- Angiotensin receptor blockers: losartan, valsartan
- High-risk drugs: amiodarone, varenicline
- High-cost drugs: clopidogrel, erythropoietin stimulating agents, extended release metoprolol

To order these drugs, you must write a Medical Use Exception (MUE) note. Once you have completed the worksheet, you will be able to order the drug.

Requesting a non-formulary medication:

To request a non-formulary medication, you must place a consult to the pharmacy service.

- In your consult, make sure to include if the patient is already taking and tolerating the medication.
- If the patient is able to take their own supply of medication from home, make sure to include that as well.

Favorite note types:

Under the "Tools" Menu, click "Options," then the "Notes" tab. Click the "Document Titles" button. We recommend the following frequently used note types:

- Admission History and Physical
- Med: Inpatient Progress Note
- Med: Inpatient Cross Cover Note
- Med: Discharge Progress Note (can be used on the patient's last day if being discharged in the morning)
- Universal Protocol Note – Physician
- Universal Protocol Note – Time Out
- Central Line Insertion Note
- Discharge Instructions Part A
- Discharge Instructions Part B
- HIV Verbal Consent Note
- Code Blue: Medicine Note

Creating and editing your electronic signature

Under the "Tools" Menu, click "Utilities," then "Create e-signature."

- To change your title or signature line, click "Edit User Characteristics."

- We highly recommend you include your pager number in your Signature Block: Title so that consultants, radiologists, etc. can get in touch with you more easily.
- To change your electronic signature code (used to sign orders and notes), click "Check/Edit Electronic Signature Code."

Finding documentation of medications given off the floor

If your patient receives a medication in the ED, it will not be documented in the BCMA. You will find it documented under the name "Emergency Department Medication Note."

- Often, all of the notes from a given Emergency Department visit will be bundled together – click on the plus sign next to the Emergency Department note and all of the notes will appear.

If your patient receives a medication in dialysis, it will also not be documented in the BCMA. You will find it documented under the name "AKC Monitoring Sheet."

- Often, all of the notes from a given dialysis session will be bundled together – click on the plus sign next to the AKC_Team note and all of the notes will appear.

Documentation

General rules:

DO NOT cut and paste notes. This is a medical-legal liability issues and a billing issue. If it is noted that this is happening repeatedly, a letter will be sent to your program director reflecting a lapse in professional behavior.

Special notes:

HIV Consent Note:

- You are encouraged to routinely consider screening for HIV in *all patients* admitted to your service
- <u>You must obtain and document verbal consent for in veterans for an HIV antibody test</u>
- In CPRS use note titled HIV Verbal Consent – this is a template with nothing to type; then order HIV-1/2 antibody in orders tab
- Be sure to give a verbal result to patient and document with an addendum to the consent note. If your patient leaves hospital before result is available – please make sure follow-up with PC is assured
- To assure linkage to care - <u>always consult</u> Infectious Diseases for any new positive or known positive, or anyone who is known positive but who is not taking HIV meds!!

DNR/DNI documentation:

- Place a DNR/DNI order in CPRS.
- Write an "Advanced Directive Discussion" note.
- Document code status in your daily progress note.

Fall Note: If you are called about a patient who had a fall…

- Write a "Med:Fall Medical Assessment and Intervention Note."

Death Note: If you are called to pronounce a patient (your patient or a cross-cover patient)…

- Write a death note - Type in "Death" and choose DEATH <SUMMARY OF DEATH NOTE>.

Student Notes:

3rd year students are expected to write and sign a progress note for their patients each day. A 3rd year student note should NOT be used by an intern as the daily progress note; interns are expected to write their own daily progress note.
4th year students (Acting Interns) notes may be used by the resident as daily progress note with an addenda to include the residents independent physical exam, assessment and plan. Every patient also needs to have a full H&P by an MD (Not an addendum to a student H&P).

Nursing home patients (CLC)

Nighttime/weekend coverage:

- During nights and weekends, the on-call Geriatric Medicine physicians may ask the medicine admitting resident to evaluate nursing home patients with urgent medical concerns. Please evaluate the patient, communicate recommendations to the on-call Geriatric Medicine physician, transfer the patient if necessary, and write a note in CPRS.
- The night team is responsible for cross-coverage of the H/K-wing patients, including fall evaluations and death pronouncements, from 6PM to 7AM.
- From 5PM to 6PM and 7AM to 8AM, the medicine admitting resident is responsible for fall evaluations.

- Patients should be transferred directly to the floor and do not need to go through the ED. If a patient is unstable, they should be transferred directly to the PCU/MICU.
- If the admitting resident does not think that the patient warrants admission but may require some simple tests, the PCT can be asked to draw labs on that patient. They may also be sent to radiology without an admission.

Facilities info

Door codes:

- Team rooms 1-4: 3+4, 1
- Team 5, 6 rooms: 1, 3, 5
- 3E clean utility room: 1, 2, 4
- 4E clean utility room: 1+5, 3
- Medicine call room 4D205: 2+3, 4
- Medicine call room 4D207: 2+3, 5
- Medicine call room 4D106: 2, 3, 4
- Medicine call room 4D208: 2+3, 1

Security:

You may arrange for a police escort to the parking lot (ext 58189).

Meals on-call:

The patient cafeteria (Room 1C101) is open to housestaff as follows:

- Mon-Fri: Breakfast 7:30-9:00 am, Dinner 4:30-6:30 pm
- Sat-Sun, Holidays: Breakfast 7:30-9:00 am, Lunch 11:30 am-1:00 pm, dinner 4:30-6:30 pm
- If you will be unable to go to the cafeteria before closing, you can call the supervisor (ext 58269) and ask them to hold a meal for you (which you can pick up until 8:00 pm).

Washington Hospital Center also has a cafeteria.

Wireless internet: Available throughout the hospital.

Library and online resources:

The library is located on the first floor (L134). Hours: 8:30 am-4:30 pm. The staff librarian is available to help you look up articles **(ext. 5-7423)**. The VA home page also has a link to the library resources.

Professionalism:

As part of a professional environment, professional attire is expected and all physicians must wear a white coat when seeing patients. Scrubs are permitted only for those staying overnight in the hospital and on weekends. Please keep your white coat clean.

Reporting Medical Errors & "Near Miss" Events

It is very important that we report medical errors and "near miss" events to improve patient safety and health care quality at the VA. From the VA intranet, click on "VA quick links" (listed in the menu on the left). Click on "Electronic Incident Reporting." Fill out the information related to the medical error or near miss. Please write the attending's name as the "Physician notified" (not the resident's name).

Telemetry & PCU indications

Medical Telemetry (4EA, 4C and 3EA)

Indications for patients admitted for medical telemetry monitoring include:

1. Evaluation of chest pain
    a. Patients with risk factors for coronary artery disease, but initial ECG and cardiac biomarkers are negative.
    b. Telemetry monitoring required if serial cardiac enzymes are being checked
2. Syncope
    a. Unexplained syncope, near syncope or episodic dizziness with no clear cause
    b. Not attributable to life threatening cardiac disease
3. Stable Arrhythmias requiring monitoring
    a. Hemodynamically stable atrial fibrillation or atrial flutter requiring PO rate control, PO drug loading to convert, or new onset atrial fibrillation or atrial flutter
    b. New, aymptomatic bradycardia that is not life threatening, not requiring external/temporary transvenous pacing
    c. Hemodynamically stable nonsustained ventricular tachycardia

4. Hyper/hypoklaemia
    a. Without ECG changes (if ECG changes, admit to 4BW or consult MICU)
    b. K<7.0 and unlikely to rapidly worsen
5. Alcohol withdrawal with CIWA score of 15-20 and requiring use of intravenous medications.

PCU Telemetry (4BW)- can be under Medicine, CCU or MICU service. See below for further direction

Possible indications for patients to be discontinued from medical telemetry

1. Stabilization or resolution of chest pain and/or arrhythmias
2. Negative cardiac markers ("Ruled out" for myocardial infarction)
3. Resolution of syncopal episodes and completion of arrhythmia evaluation
4. Normalization of electrolyte levels
5. Stabilization of congestive heart failure symptoms
6. Stabilization of respiratory status
7. Stabilization of alcohol withdrawal symptoms
8. Adequate control of blood sugars not requiring frequent blood sugar monitoring
9. Stabilization post CVA

PCU Telemetry Under CCU Service

1. Patients with acute coronary syndrome, or a high suspicion of acute coronary syndrome in patients with significant cardiac risk factors for coronary artery disease (such as prior myocardial infarction, diabetes) or those ER admissions already evaluated by CCU to require emergent or urgent catheterization.
2. Supraventricular tachycardia (SVT) not controlled by initial therapy
3. Decompensated congestive heart failure
    a. Hemodynamically stable patients receiving continuous IV diuresis
    b. Fixed dose of Dobutamine (i.e. 2-3 mcg/kg/min) after therapeutic goal is achieved; Amiodarone IV after the initial 6-hour dose (or once titrated to 0.5mg/min over 18 hours). Other IV inotropes must be in the ICU.
4. Patient transferred out of the ICU under the CCU Service who continue to have active cardiac issues.
5. Patients admitted after device implantation (pacemaker/defibrillator)
6. Patients admitted after electrophysiology procedure such as ablation
7. Patients with presumed device malfunction, patients with ICD and syncope.

PCU Telemetry Under MICU Service

1. Patients with escalating oxygen requirements who are not candidates for ICU transfer (Excluding comfort care).
2. Patients requiring **initiation** of bipap for acute or acute-on-chronic hypercapnic respiratory failure (pH<7.3 with pCO2 of greater than 45) or severe pulmonary edema not meeting ICU admission criteria. Bipap is limited to the front half of the PCU only (beds 14-19).
3. Patients presenting with sepsis, with initial systolic hypotension ≤ 90, requiring >2 liters of fluid resuscitation for stabilization.
4. Patient transferred out of the ICU under the MICU Service.

PCU Telemetry Under Medicine Service

1. Hyperglycemia/Hypoglycemia
    a. Hyperglycemia requiring Q2h blood sugar checks (limited to 8-hour time frame before disposition re-evaluated for ICU admission)
    b. Hypoglycemia requiring Q2h blood sugar monitoring (limited to 8-hour time frame before disposition re-evaluated for ICU admission)
2. Patients requiring suctioning more frequently than every 4 hours, particularly those with a tracheostomy or altered mental status.
3. Patients who meet SIRS criteria initially, currently normotensive, after resuscitation with 2 liters or less of fluids.
4. Patients requiring neuro checks more frequently than every 4 hours
5. Patients requiring scheduled nebulizer treatments more frequently than q4 hours. Does NOT include prn nebs.
6. Patients with peritoneal dialysis catheters in situ (needs a private room)
7. Hemodynamically stable lower GI bleeds
8. Patients requiring hemodialysis not in the dialysis unit **ONLY when determined necessary by nephrology.**

3EA/4EA Telemetry Beds under Medical Service

1. Patients admitted for evaluation of syncope, without evidence of heart block or recurrent VT in the ED.
2. Patients with atrial fibrillation that is poorly rate controlled but stable hemodynamics.
3. Patients admitted with atypical chest pain, and negative cardiac markers.

Emergencies

STEMI:

Call the operator and ask for Cardiology Team 1. This will activate the cardiologist, cath lab, etc.

Code Blue:

The MICU resident runs the code, assisted by the medicine admitting resident. The admitting interns should also be present at the code to assist the residents.

Rapid Response:

The rapid response team consists of an ICU nurse, Respiratory Therapist and MAR (during the day) or Moonlighter (at night). The medicine admitting resident or moonlighter runs the rapid response. Patients should be stabilized at their current location then moved to a bed with increased monitoring if needed (they should NOT be sent to the ED). If you go to a rapid response as the on-call resident, please write a note under the rapid response template note (Rapid Response Team (RRT) physician). The primary team will also write a Medicine Cross Cover note, but there must be an RRT note for each rapid response written by the on-call resident.

Occupational exposure:

Call a chief resident immediately. If any delay, you may contact an ID Fellow or ID Attending directly. Contact information is located on the Medical Center Web Site / On-Call Schedules / Infectious Diseases.

- Mon-Fri during business hours, go to Occupational Health (Ground floor, room 1C118 - located next to the vending machines; phone number ext 58254) or the ED after hours/weekends. DO NOT wait. Then go to Occupational Health the following day. VAMC Occupational Health contact is George Giannakos, NP and you can reach them at ext. **58254**
- DO NOT ORDER AN ID CONSULT
- For all exposures, you will also need to report to your own university occupational health department
- * GWU Occupational Health: 202-715-4275. * GTU Occupational Health: 202-444-3680
- Consent from the patient will be obtained for HIV/Hepatitis lab work.

- **Team Phone Numbers:**
- Team 1: 55027 / 55028
- Team 2: 57714/ 55054
- Team 3: 57138 / 57139
- Team 4: 57036 / 56993
- Team 5: 57037 / 54179
- Team 6: 58738

- **Vocera Log-Ins:**
- Team 1: Obi-Wan Kenobi or "Team 1"
- Team 2: Deuce Bigelow & Napoleon Dynamite or "Team 2"
- Team 3: Three Amigos or "Team 3"
- Team 4: Fantastic Four or "Team 4"
- Team 5: Captain Planet or "Team 5"
- Team 6: Kevin Bacon or "Team 6"

- **Chief Resident Phone Numbers:**
- Dianne Thompson ext 58392
- Justin Beckett ext 54521
- Kanika Gupta ext 56821
- Shaheer Khan ext 55464

- **Transfer Coordinators:**
- Edith Mansaray, Pamela McKenna
- ext 57887, Fax: (202) 745-2278

- **Bed Board:** Michelle Gaines (vocera)

- **Pharmacists**
- Teams 1, 5: Sumana Alex ext 58761, 54919
- Teams 2, 6: Ayne Adenew ext 58759, 55941
- Teams 3, 4: Albert Ly ext 58760

- **Case Managers:**

Teams 1: Bernadine Ekeh (ext 54193)

Teams 2: Sharon Tapp (ext 57073, VA pgr 3170)

Team 3: Gloria Washington (202-745-8439)

Team 4: Olu Gisanrin (ext 57362)

Team 5: Jeanette Lee (202-745-8709, VA pgr 3745)

Team 6: Laura McNeil (ext 58708)

PCU/MICU: Jose Rodriguez (ext 55423, pgr 3565)

- **Social Workers:**

Team 1: Janel Thompson (ext 54056)

Team 2: Erica Friedman (ext 57486)

Team 3: Leah Anderson (ext 54725)

Team 4: Kimeola Cato (ext 57062)

Team 5: Vashta Thompson (ext 57797)

Team 6: Heidi Hartz (ext 56958)

PCU/MICU: Kimeola Cato (ext 57062)

Important Pagers:
MAR A pager 9516-3822; MAR B pager 9516- 3284
MICU pager 9516-3801
Med Consult pager 9259- 3286
XCover A pager 9516-0151, XCover B pager 9516- 0053

How to page:
1. To page VA: 9516 + 4-digit PIN → wait for tone → enter call-back number #
2. To page WR: 9 + 1-800-759-8352 → wait for tone → 7 digit PIN → enter call-back number#
3. To page GW: 7777 → wait for tone → 7 digit PIN → enter call-back number #
4. To page GT: 9 + 10 digit PIN → wait for tone → enter call-back number #

Radiology
CT: vocera "CT technologist" or call 5-5774 or 5-5771 for STAT
MRI: 5-6424 or 5-5215
Xrays for bedside: vocera "xray tech"
Ultrasound: vocera "ultrasound technologist" or call 55006/55693/5-2327
Nuclear Medicine: call 5-8390
IR: call 5-8647 or 5-4251; off hours – page the on call IR doctor (found on intranet)

Team and Call room door codes:
Team 1: 3E- 239, code 3+4, 1
Team 2: 3E- 105, code 3+4, 1
Team 3: 3E 141, code 3+4, 1
Team 4: 4E- 239, code 3+4, 1
Team 5: 4C-194, code 1, 3, 5
Team 6: 4C- 135, code 1, 3,5
3E clean utility room: 1, 2, 4
4E clean utility room: 1+5, 3
Medicine call room 4D205: 2+3, 4
Medicine call room 4D207: 2+3, 5
Medicine call room 4D106: 2, 3, 4
Medicine call room 4D208: 2+3, 1