

**UTMCK
INTERN SURVIVAL
GUIDE**

**Internal Medicine
2010 – 2011**

Name/Pager

UTMCK Intern Survival Guide

Internal Medicine

2010

Contributing Staff: Past and Present

John Hoskins

Ben Helms

Samer Hodroge

Jeremiah Bivins

Ed Cladera

Edgar Diaz

Jenney Headrick

Christopher Parrish

Mark Rasnake

Mark Smith

Laura Sullivan

Resources:

-Duke Internal Medicine Survival Guide 2006

-Maxwell Quick Medical Reference

-Internship Survival Guide-Washington Manual

-Everything You Wanted to Know About Being a
Medicine Resident at UT-5/2007

-Helpful Hints for Intern Year-Jenney Headrick

-CDI "Golden Rules"-Trey LeCharite

-“On Doctoring-stories poems, essays”-Reynolds and Stone

Important Websites

Morning Report Blog: <http://utkmedicine.blogspot.com/>

Summary of MR and other topics with links to additional reading as well as links to helpful IM related blogs and websites.

Preston Library Full Text Books/Journals: http://gsm.utmck.edu/med_library/main.cfm

Collection of full text journals, uptodate, and online texts through MD consult

New Innovations: <https://www.new-innov.com/Login/Login.aspx>

Evaluations and online curriculum documents

GSM Pulse Intranet: <http://pulse/medicine/main.cfm>

Dept of Medicine intranet – available on campus only. Links to conference schedules, handbook, etc

Internal Medicine Dept Public Website: <http://gsm.utmck.edu/internalmed/main.cfm>

Links to faculty roster, curriculum documents, and general dept information.

Online Medical Calculator: <http://www.mdcalc.com/>

Extensive collection of online calculators and risk scores. Works best in Firefox or Safari browsers.

Table of Contents

Section 1

Admit Orders	5
H&P/Consult/Transfer Note	6
Discharge Orders	7
Discharge Summary	9
The Death Note/The Death Summary	10
Extended Care Facility (ECF Forms)	12
Critical Care Medicine	14
Critical Care Daily Note	17
Outpatient Clinic	18
Medical Records	20
CDI “Golden Rules”	21
TOP 10 Workups: CP, Abd pain, AMS, ARF, Headache High/Low BP, Arrhythmias, Fever, SOB, GIB	23
Middle of the Night Floor Calls	26
Pain Management, Narcotics, and acetaminophen toxicity	30
Wound Care	33
Favorite Scripts	36
Favorite Orders(CSF fluid, thoracentesis, paracentesis)	38
Disease Risk/Severity Tools (CHADS,Ranson,TIMI, etc)	39
Policies	41
Intern Sign Out/Conference Policies	43
USMLE Step 3	44
Parting Words from Sir William Osler M.D.	46
My Notes	47

Admit Orders

ADC-VAAN-DISMLO-Orders for Admission/Transfers (Separate from your H&P/Transfer Note)

Admission: HSM Team (1,2,3), Attending/Resident/Intern/Student with pager numbers!

Diagnosis: Primary admission diagnosis and major comorbid conditions (refer to page:.....<CDI Golden Rules>

Condition: Good, Stable, Fair, Critical

Vitals: routine, q _ Hours, notify house officer if: __)

Activity: Bed rest, as tolerated, out to chair/toilet, etc.

Allergies: NKDA, list them

Nursing: dressing changes, elevate bed, spirometry, accuchecks

Diet: Regular, Cardiac, ADA, Low sodium

IV Fluids: NS @ __/Hr,

I's and O's: Strict/routine, daily weights

Studies: Xray, CT, U/S etc (give reason: ex-look for nephrolithiasis)

Monitor: Telemetry, continuous pulse oximetry

Meds: List em-scheduled and PRN and Prophylaxis (GI/DVT)
(Print out Medicine Reconciliation form in ED to Restart/DC Home Meds)

Labs: Today's and AM labs

Other: Consults, Chaplain ect.

Sign your orders at the bottom(print last name and pager # in BIG numbers!)

(AND FINALLY-DON'T FORGET THE CODE STATUS)

H&P/Consult/Transfer Note

H&P/Transfer Note/Consult Note-(Don't have to dictate the transfer note, must dictate the H&P/Consult notes within 24 hours of being admitted.)

Note-when a patient is transferred to the Unit, a Critical Care consult note must be dictated by the 'accepting' CCM team

CC: chief complaint (in patient's words: ex "I can't breathe well"-not SOB)

HPI: put 'relevant' past med hx/ROS/and tx prior to admission

(If transfer note-for rest of hx may put 'see dictated H&P')

PMH/PSH: put dates if you can-ex. CAD-sp cath in '02/CABG '06

MEDS/ALLERGIES: put 'reaction' if known

SOC/FAM: More the better-minimal is 'triad'-smoking, booze, and drugs(now and past)

ROS: may put 'remainder of 13 point ROS neg except per HPI'

VITALS: O2 sat @ __, I/O if transfer pt/known

PE: give more detail on the organ systems of interest

LABS:(important!) at minimum you get labs/CX/imaging on current admission, however-it's better to have dates/imp of last ECHO, baseline Cr, last MPS/Cath report, prior hx of MRSA/infections, last CT/MRI if relevant
-we don't want to re-invent the wheel at each admission
-don't be afraid to check the HPF/'drop by' the resident clinic to get more info

A/P:(most important-lifetime to perfect)

-explain your rationales

-'Do no harm'

-If putting in a consult: Call the team/service you are planning to consult (it is polite/appropriate and it gives them a heads up)

Discharge Orders

Discharge Orders-

(Separate from your D/C summary-which is more thorough)

D/C Date:

D/C DX: List all the patient has(just like the admit diagnosis)-if discover something new (ex-CHF by ECHO), put 'likely present at admission'

Service: HSM-Team (1,2,3), Attending/Resident/Intern/Student

D/C Condition: Good, Stable, Fair, Guarded, Critical

Disposition: D/C to Home, SNF(skilled nursing facility), ect.

Meds: "See D/C MAR"* (you have to print it off, check off the meds you're keeping, and write in meds that you're adding. Remember, if your're changing a home dose or adding a new med-need to write out the scripts:

ex. Lisinopril 10mg
one tab PO qday

Instructions: Diet, activity, and follow up labs/imaging-ex: Will need BMP in one week (also write this out on script pad for patient to take to the outpatient lab)

Follow-up (most important): Physician's name, specialty/PCP, location if known, time period (ex.in 1-2 weeks), and indicate whether the nursing secretary needs to schedule the appointment prior to discharge (some patients like this/others prefer to do this on there own)

Final Order: Please fax a copy of this page and D/C MAR to the following physicians (list them, including specialties, locations, and fax #'s-if known)

*Printing a D/C MAR: (Go to screen where you see the red/blue clock icon on top bar, click on it, click on 'transfer MAR', enter entire med rec #(every number on the sticker-including the zero's, click 'Go')
(if trouble-politely ask the nursing secretary to print one off for you)

Discharge Orders Cont...
Words to the Wise

1. Write a “very brief”...meaning 3-4 sentence hospital summary in the right hand column of your D/C orders. It is hard to tell how long it will take for your D/C Summary to be transcribed, and this page (and D/C MAR) may be all that the outpatient physicians have in hand when the patient presents for follow-up. Nothing is worse than seeing a patient for “hospital follow-up” and NOT KNOWING what needs to be ‘followed-up’ on.

2. Write the D/C dictation number beneath your signature (proof that it was done)

3. Finally,
DICTATE THE D/C SUMMARY ON THE DAY OF DISCHARGE!

Discharge Summary

Discharge Summary-(Dial 6900→ Personal Four Digit Code→ work type #4 for DC summary code → Pt. med-rec number, and finally #2 to get started)

-You ‘dictate’ this-ideally (see page 7) on THE DAY OF DISCHARGE (but must be dictated within 2 wks)-reason is so that you can end the dictation by saying “Please have this dictated D/C summary faxed to the following physicians: ___”-that way they’ll get it fast and know what’s going on when the patient shows up in their office in a week or two

Same as the D/C orders with the following additions:

Admit date/Diagnosis (list them all)

Consults: List each physician and their specialty

Procedures: List each procedure/date performed (and a brief statement-(one sentence max)-of the result:

ex).ECHO-9/18/2009-EF55%, mild AS

History and Physical: You can just say “Please see dictated H&P”, which should always be dictated

Hospital Course: The meat of the D/C Summary-(try to be as concise as you can without leaving any important info out)

Medications: List EVERY medicine, dose and frequency-(if you provided a script then state the number of tablets/refills)

-Do NOT say “See D/C MAR” when dictating a D/C Summary

(Remember, like your discharge orders-‘follow-up’ instructions should be included in the D/C Summary: ex. Pt instructed to follow-up within 1 week for PT/INR and call it in to PCP)

The Death Note

(This is to be written in patient's chart like a progress note)

"I was called to patient's bedside to pronounce that patient-_____ has died."

"Patient laying motionless. Patient is unresponsive to verbal/tactile stimuli. Pupils fixed and dilated. No spontaneous breath sounds. Absent peripheral pulses. No heartbeat on auscultation."

Family in room?

Family aware of death?

Post-Mortem Services (autopsy) offered?

Chaplain services offered?

"Patient's 'major' medical illness:_____"

"Time of Death:_____ " (get with nurses-agree on time)

Death Summary

You need to also dictate a Discharge/Death Summary. This follows the basic outline of a discharge summary but you need to include the items from the death note as well, especially the points about an autopsy and chaplain services being offered. According to Joint Commission and CMS guidelines, the medical death summary content must contain the following at a minimum:

- a. Final diagnosis
- b. Reason for hospitalization
- c. Pertinent history, physical examination and laboratory findings.
- d. Procedures performed
- e. Treatment provided
- f. Death counseling given to families in a timely manner.

***ORDERS:**

“D/C to Morgue”

“Please notify attending ***in AM (after 0800)***: __ (name of attending) __ that pt has expired and death certificate will need to be signed. Please provide/fax a copy of this page along with death certificate to above physician”.

***EXTRA: AUTOPSY (need two things)**

1. Permission from family (in descending order)

Spouse-adult child-parent-sibling-other blood relative

(if family away-fax to funeral home-have family sign/notary at funeral home-fax back)

2. Autopsy Permit

(Go to “Insite”-“Med Record Forms”-“Consent Forms”-“autopsy”)

***Families are NOT charged for autopsies (make sure you communicate this)**

The Extended Care Facility **(ECF ORDERS)**

-Whenever a patient is going somewhere besides home, they will usually need to have the ECF Order Form filled out. The ECF forms help communicate the needs/logistics of discharging a patient out of UTMCK/admitting to the ECF(SNF, Rehab, NH etc..)

-The ECF form usually comes as a packet of papers that the Case manager will get for you. Usually it is blank and the case managers fill in the gaps after you're finished with it

1. Code Status Form: If nobody has yet addressed/ completed a code status form-it needs to be done with the patient and signed/dated by you

2. Ambulance Form: Usually, an ambulance company will come and pick the patient up. Generally, all you need to do is sign and date the bottom of this one (the case manager will *usually* fill out the rest)

3. Psych Form: A page which asks whether the patient has a 'major' mental illness or retardation. In general, one line drawn down all the "No's" and a signature/date is all you need (unless otherwise)

4. Page 1/2 of ECF 'Orders': A carbon copy packet that communicates to the accepting physician/facility what is going on/needs to be accomplished. (two columns-left column is the only one that you really need to address) Write out all diagnosis (PMH), re-emphasize code status, indicate if restraints are necessary, under PT/OT-may write "PT/OT to eval and treat", put all follow-up info at bottom (names/dates/phone #'s if you got em of the doctors they will need to see when the patient gets out)

The ECF Forms cont...

5. Page 2/2 of ECF 'Orders': Under meds: write "See D/C MAR" (and go print/fill out D/C MAR and attach it). The next section (bottom half of left column) is perhaps the most important-blank lines where you can communicate any additional concerns/follow-up/advice etc. (remember to put yourself in the shoes of the accepting physician-when this patient is unloaded off the ambulance-all he/she is going to have is this packet, a copy of the MAR, a copy of the H&P-and that's about it)-The more info that you can give the better.

*You will also have to dictate a D/C Summary which you will end the dictation by asking that it be faxed to all the Attendings involved in the patient's care at UTMCK, the PCP, the patient's outpt. Specialists (if nec.), and to the accepting ECF

**THE CASE MANAGER IS THE INTERN'S BEST FRIEND

Be extremely kind and appreciative. Touch base with he/her daily. Stay up-to-date on the 'Forms'. Case Managers help us discharge the patient.

Critical Care Medicine

Do not be afraid (but it is appropriate to be a little nervous)

***Typical Day:**

0600 sharp

-Arrive at MCC-1 nursing station shortly before 6am (while you may be tempted to arrive earlier-please do not. Reason: the CCM rotation is already very demanding of your time. Arriving before 6am may put you over your duty hours).

-Meet with your team and divide the patients-old/new (that came in overnight). The seniors should do this for you.

0600-0900

-You have three hours to see your patients. Patients may be located in any of the ICU's (MICU-1/2, SICU-1/2/3, CVICU in the new Heart Hospital, and occasionally in the ED as well as 'Holding')

0900- 'however long it takes'

-Round with your team/Attending. Attendings switch every Monday (so be prepared to present an abbreviated HPI on all of your patients on Mondays). Monday is NOT a good day to have off. If you find that you have been scheduled 'off' on Monday, talk to your Senior about changing it.

-Perform procedures, take care of 'transfers, and help your comrades (just because your team finished rounding early AND you're not 'on-call'... does NOT mean that your expertise is not needed. Talk to your fellow interns and see what you can do to help make EVERYBODY'S day a little less stressful. 'Spread the wealth')

*Call is 24 hours (0600-0600) carry pager

**Post-Call is 6 hours (0600-1200) don't carry pager

Critical Care Medicine Cont...

*Admissions:

-Patients are placed in critical care, NOT because they are the sickest (though many of them are), but because they require additional monitoring/interventions that cannot be provided on the floor.

-If you think that a patient needs a Unit bed, ask yourself the following questions (in addition to talking with your Senior):

1. Is the patient hemo-dynamically stable (vitals)?
2. Does the patient have new onset (multi) organ failure?
 - cardiovascular (MI, Shock)
 - respiratory (BIPAP/Ventilator)
 - Neurologic (CVA, Coma)
 - GI (GIB-upper>lower)
 - Renal (Dialysis, CRRT)
 - Infectious (Septic Shock, BacT Meningitis)
3. Has the patient Over-Dosed?: Do we need to monitor the patient acutely?
4. Can a ward nurse realistically care for the patient while taking care of 4-5 'other patients' on the floor? (this is a particularly difficult scenario when the patient is not all that sick, but may require additional attention/monitoring) Some nurses/floors are more comfortable than others. The charge nurse is generally pretty realistic about what the nursing team can and cannot do. In the ICU, there is generally a 1:1 or 1:2 patient/nurse ratio.

Critical Care Medicine Cont...

*Other Thoughts

A. Going Home (sorry, too bad, can't do it, wish I could help you, etc...)

At any one time, patients are:

-needing to be seen/staffed by the Attending (and Rounding Team)

-needing to be admitted

-needing to be transferred out

-needing procedures

and needing additional TLC (including CODES)

MORAL: Consider 'merely thinking about' going home when you are not needed to help with any of the above.

B. Attendings. They are very passionate, hard working physicians. They will be the individuals that will teach you to be comfortable working with 'sick' patients. In addition, you will find that they will be the physicians that will more than likely oversee the development of the more invasive, technical procedural skills that you will learn. You will learn A LOT from your ICU Attendings.

C. Priorities. Patient care always takes precedence over your "precious notes" (if a patient needs a procedure sooner than later-do it!)

D. Attitude. The work is long, hard, and stressful. Good sleep habits at home, healthy diet (especially in the middle of the night), and occasional walks (or anything else that may raise the heart rate) with your significant other will help you in the 'attitude department'. If you notice yourself or a buddy getting especially down, try to talk about it. We are all working as a team. Don't be like the guy on Office Space that 'was going to burn the building down'. Speak up with concerns. Share your experiences.

The Critical Care Daily Note

ABX: (all antibiotics, Day #, and those that have been D/C'd)

Pressors:

Other: (may include steroids/blood thinners, nutrition)

Lines: (Location, Day#)

S:

Any acute events. Talk with the nurse (they know the patients). Report any changes (pressors, intubation/extubation, ABX-started/stopped). Note any consultant's comments, patient/family concerns etc...

O:

Vital Signs and ranges (including Tc and Tmax)

Vent Settings (mode, TV, PS, Peep, FIO₂, location of ET at the lips)

-comment on Resp Screens/Trials (RSBI, failed b/c of _____)

PE: Bare minimum-Neuro (look at eyes), heart, lungs, abdomen, peripheral pulses (esp if on pressors), and check all line sites

Labs/Imaging: All of them. Go back to date of admission and report all cultures. Be prepared to explain all abnormal labs (ask your Senior if you're not sure why an abnormality is present)

A/P:

-Problem-Based (not System-Based as you may have been taught in medical school). Use the Attending's note from the previous day to determine which problems they thought were pertinent.

-DO NOT BE AFRAID to write down your thought processes and commit yourself to DX and Plans (run it by your Senior before you decide to perform a thoracotomy, amputation ect...just kidding)

-The end of every note should include comments on F/E/N, GI prophylaxis, DVT prophylaxis, and code status

Extra:

*Forms, Forms, Forms (Did you hear that internists have a lot of paperwork?) -Code Status, DVT prophylaxis, EtOH withdrawal, Transfusions, Insulin Sliding Scale, Smoking Cessation, Restraints,

-Take advantage of protocol forms (ex. Surviving Sepsis, CVA etc...)

*Only order what you are comfortable ordering (any doubts/questions-ask your Senior)

*Remember your AM labs for tomorrow

Outpatient Clinic

TWO BIG RULES

*Rule #1-Don't freak out.

Learning outpatient medicine takes time (Dr. Williams/other Attendings understand this)

*Rule #2-Rome was not built in a day.

You have three years to work/develop your style/organizational structure. In addition, you must work hard to address only one or two problems per visit (even if the problem list is 20+ lines long). Unlike inpatient work-the visits are much shorter, labs trickle back over weeks, and follow-ups are your best friend.

YOUR CLINIC DAY

-One afternoon per week for all three years (the only months that you don't work clinic are when you are in ICU)

-Schedule

1300-1330: Teaching time-usually Dr. Williams-brief discussion/clinical pearls about an outpatient teaching objective

1330-16:30: See patients. As a 1st year, you will usually have between 2-4 patients per afternoon (doesn't sound like much, but you'll see)

1630-1700: Wrap things up. It's time to be thinking about going home

-Checking out: After you see each patient, you will need to find one of the two Attendings to discuss diagnosis/treatment plan. (as you will soon see, each Attending has their own style/thoughts/opinions on what to do) The Attending will then go and see the patient with you (after six months of being an intern, the attending does not have to see every single patient with you-only those with Level 4/5 Dx or Medicare)

Outpatient Clinic cont..

THE NURSES

-Each intern will be assigned to a nurse in the clinic

The nurses are responsible for (and this list is not complete):

- bringing the patients back to the rooms
- obtaining vitals (don't hesitate to re-check the vitals yourself-the patients appreciate doctors who touch them)
- assisting with pap smears/urine dipsticks
- cleaning the rooms between patients
- scheduling times for outpatient imaging/specialist appointments
- taking phone calls/messages from patients, copying scripts/discharge info, -
- calling patients at home and relaying messages
- essentially helping you with any concerns/questions you may have about clinical logistics

-You are responsible for writing out your own: diagnosis/codes, 'level' of visits, lab slips, consult forms, imaging forms, and scripts (we have separate scripts from hospital)

EMR

We now have electronic medical records in the clinic. Laptops are available for every resident in Dr. Williams office. Your password to get into the EMR system should initially be the same as your Email password. Our clinic EMR is accessible from any computer in the hospital. We are responsible for daily checking our EMR desktop to address any nursing notes that we might have. Learning how to use the EMR takes time and practice. It's impossible to explain it all in the survival guide but the more you use it the easier it will become.

Medical Records

Located on first floor (behind cafeteria and gift shop)

Two Big Responsibilities (as far as we're concerned)

1. Electronic Signatures

-Every time a nurse takes a verbal order (over the phone and on the floors) the medical order must be signed by a physician. When you log onto powerchart you will be prompted to sign your verbal orders. (click, click, click)

-Medical Records will page you/e-mail you to log into Powerchart and electronically sign these if any of your charts are 'delinquent' (delinquent charts are BAD)

2. Discharge Summaries

-Even more important than the signatures (and takes longer to do)

-Ideally, every time you discharge a patient you are able to dictate the discharge summary on the day of discharge (not always practical/feasible because you may be on-call/post-call...and getting some sleep!)

-The discharge summary must be done ASAP (for reasons described earlier). If the patient has already gone home, then the chart has already been 'broken down and scanned' and you must get on the computer, access the scanned chart, and dictate the discharge summary (there are cubicles in Med Records where you can do this):

a. Go to 'internet explorer' and type 'insite'

b. Go to 'Programs' and click on 'HPF'

c. Type in your code: (two lines)

(and then punch in med record, pull up particular hosp stay, and go to 'Progress notes' to view each page of the chart)

-VERY BAD if these are late. You have 15 days before Med Records calls you and 30 days before Dr. Rasnake is called (don't let this happen)

Dictate your D/C summary on the day of discharge!

(and avoid the **THE PAIN, THE SHAME, and THE HUMILITY**

of disappointing your fellow man (including your Attending) with tardy D/C Summaries)

CDI “Golden Rules” **HIGHLIGHTS**

- Put all discharge diagnosis on D/C summary
 - Use problem specific approach (not organ system approach)
 - Maintain daily/complete problem list
 - Write ‘Present on Admission’ if unrealized problem discovered/realized
(ex .doubtful HF developed on admission)
 - Okay to use “probable, possible, suspect, or likely” before diagnosis
 - Not* Okay to use symbols/arrows
1. Kidney: “Chronic Kidney Dz Stage_” or “ESRD-on HD”
(not CRI/CRF/RI)
 “Acute Renal Failure” if Cr over 0.5 mg/dl over baseline
 (may put ARF on CKD stage 4)
 2. DM: specify type (1 or 2), all complications (nephrosis/foot etc) and
 whether controlled or not (uncontrolled is HgA1C>7.5 or multi BG >250)
 3. CHF: ‘Chronic CHF’-stable or ‘Acute/Acute on Chronic CHF’
(not CHF Exac.)
 Systolic (EF<40%) or Diastolic (nml EF)-always list EF
 4. Anemia: list twice (sep. from cause)
 ex. 1. Anemia secondary to acute GI blood loss and
 2. UGI Bleed-due to varices)
 5. Sepsis = SIRS plus a source
 SIRS (2 of 4): HR>90, R>20, Temp >38.C/<36, and
 WBC’s >12K/<4K/>10%bands

CDI “Golden Rules” cont..
HIGHLIGHTS

6. Resp Failure: acute or chronic

(always acute if on vent/bipap or $pCO_2 > 50$ / $pO_2 < 60$ or resp distress)

7. Malnutrition: check albumin

-(mild:2.8-3.5)/(mod:2.1-2.7)/(severe<2.1)

8. Neuro: Always “Acute Encephalopathy”

NOT :(AMS/Confusion/Delirium/psychosis)

Like anemia-list twice (sep.from cause)-

1. Acute encephalopathy secondary to hypertension

2. Malignant HTN-

9. Others:

-Septicemia-not bacteremia

-Syncope with collapse-not L.O.C.

-HTN-Accelerated (not urgency) and Malignant (not emergency)

-COPD “with” or “without” exacerbation

-Morbid Obesity (BMI>35)

-Electrolyte abnl-“Write Hypo/Hyper_...do not use arrows)

-PNA “(likely) due to causative organism”

-Chest Pain-list cause (angina, GERD, pleuritic)

10. Note about Discharges:

-If the Dx is CHF, must document the date of the most recent ECHO/EF or appt plans for outpatient ECHO as outpatient. If patient is not on an ACE/ARB-then explain why

TOP 10 Workups

#1 Chest Pain

DON'T MISS the BIG 4 (MI, Dissection, PE, and Pneumo)

Nurse calls (while on phone):

Get vitals, stat ECG, O2 to keep sats over 92%, confirm IV access

Labs: ECG, serial troponins, CXR

consider: d-dimer, V/Q, spiral CT, LE Doppler,
(contrast CT/TEE-if dissection)

Tips (meds to consider):

Cardiac-O2, Asa, Nitro, Beta bloker, morphine heparin, or G2b3a inhib
Still CP after Nitro SL-consider Nitro drip

Dissection-labetalol or nitroprusside, BP in both arms/legs

PE-Heparin

Pneumo-needle decompression/chest tube

GI-maalox, H2 blockers, PPI's

Get help (seniors/consults)

#2 Abdominal Pain

Don't Miss: AAA, Bowel Ischemia/Perf, Cholangitis, Appendicitis,
Cholecystitis

W/U (consider): CBC, CMP, Amylase/Lipase, ABG, lactate, BhCG, UA,
abd xrays (flat/upright),

CXR, ECG, Abd CT or U/S

TIPS: Avoid analgesics prior to exam, look for rebound/guarding
keep NPO, IV fluids

#3 Altered Mental Status

Don't Miss: Meningitis, Sepsis, CVA, DT's, or increased ICP

W/U: CBC, CMP, TSH, Ammonia, UA, Blood/Urine CX, ECG, and CXR

Consider: LP, CT-head (always before LP), EEG,

TIPS: DT's-Librium 100mg PO TID or

Ativan 0.5-1mg PO/IM/IV q6-8hrs PRN

-Thiamine>Glucose

Top 10 Workups cont..

#4 Acute Renal Failure

Don't Miss: Hyperkalemia

W/U: UA (cells, casts, protein), BMP, urine lytes (Na, Cr Urea)

Consider: ECG, Renal U/S, ABG

TIPS: Volume status? (orthostatics, I's/O's), Consider bolus

Rectal-check prostate

Put foley in/flush foley/change foley

Check meds: ACEI's, diuretics, NSAID, ABX, Contrast Dye

#5 Headache

Don't Miss: Meningitis, Bleed (epidural/subdural/subarachnoid)

W/U (consider): CBC, ESR, poss CT-head, LP (again:CT>LP)

Tips: mild-tylenol 650mg PO q6/motrin 600mg PO q6

severe-narcs (Demerol/codeine)

migraine-sumatriptan (no triptans with angina/uncontrolled HTN)

#6 Blood Pressure (Too low)

LOW-Don't Miss: Shock (SBP<90 with poor perfusion)

W/U (consider): CE, ECG, ABG, CBC, CMP, and CXR

TIPS: Look at end-organs (AMS, CP, urine output, clammy skin)

Anaphylactic-epinephrine, hydrocortisone, benadryl

HIGH-Hypertensive emergency (encephalopathy, MI, eclampsia, RI, resp failure)

W/U (consider): CE, ECG, ABG, CBC, CMP, U/A and CXR

TIPS: IV hydralazine, labetalol, or nitroprusside

#7 Arrhythmias

Don't Miss: V-TACH/V-FIB!

W/U (consider): CE, ECG, ABG, CBC, CMP, and CXR

TIPS: Use ACLS cards!

In general, if unstable with rate over 150-shock em
(don't forget about the sedation if nec.)

If SVT (narrow/rapid) and stable-carotid massage/adenosine/CCB

Top 10 Workups cont..

#8 Fever

Don't Miss: Meningitis, Sepsis

W/U (consider): CBC, Blood CX (two diff. sites), CMP, UA, Ucx,
Sputum Cx&g/s, CXR, LP (CT>LP)

TIPS: Consider changing out lines/foleys, empiric ABX before LP if
suspect meningitis

#9 Shortness of Breath

Don't Miss: PE, MI, tamponade.....Hypoxia!

W/U (consider): ECG, ABG, CXR, CE, D-dimer, CBC, LE dopplers, V/Q
scan-CT-chest

TIPS: Classic S1, Q3, T3 for PE-if high suspicion..go ahead and anti-
coagulate

Don't forget rescue nebs/diuretics

#10 GI Bleed

Don't Miss: Shock!

W/U: CBC, Coags, CMP

TIPS: Needs at least two 18 gauge IV, Type and Screen/Cross, NG tube
consider Vit.K/FFP if anti-coagulated

If variceal-Octreotide 50 ug bolus and then 50 ug/hr

Consult GI!

Middle of the Night Floor Calls

(Good Rule of Thumb-Go SEE the Patient/write a short note)

Hypotension

- Go see the patient
- Check the BP (manual) yourself
- Check mental status
- Check the pulse/temp...are they septic?
- *NS 500cc bolus, repeat if necessary-evaluate for response
- *Call resident if still in trouble

Low Urine Output

- Go see the patient
- Is bladder distended distended/are they obstructed?
- If there is a foley, ask nurse to flush it
- Check I's and O's, last BUN/CR (are they in renal failure?)
- *If foley was just D/C'd and no UOP-order a straight cath, leave in if more than 300cc's comes out

Diarrhea

- Check stool for C-Diff
- *Give loperamide 4mg PO x1, then 2mg PO after each loose stool
(b/f loperamide-make sure no C-Diff...nurses generally have a good idea)

Constipation

- When was the last stool? Any chance more than simple constipation?
- Consider:
 - Dulcolax supp PR X 1
 - Fleets Enema X 1
 - Miralax 17grams PO qday
 - Milk of Magnesia 30cc PO X 1

Sleep Problems

- Ambien 5mg QHS-PRN
(Do not give benadryl to elderly)

Middle of the Night Floor Calls cont..

Agitation

- Go see the patient
- Haldol 0.5mg PO/IM x 1 or
- Geodon 10mg IM X 1
- Consider restraints

Nausea and Vomiting

- Phenergan 25mg PO/IV q4-6 hrs or
- Zofran 4mg PO/IV q 4-6hrs

Fever (defined as temp>100.4)

- Go see the patient
- Get Blood Cultures X 2, UA/Urine culture, sputum culture
- Tylenol 650mg PO/PR q 6hrs (make sure no liver dz)

Positive Blood Culture Report

- Ask if on antibiotics (if ABX does not cover bug-ex: GNR and currently on Vanc-go see the patient and make adjustments)
- In general:
 - a. Gram Positive: Vancomycin 1 gram IV q 12 hours, peak/trough with 3rd dose
 - b. Gram Negative: Zosyn 3.375 IV q 6 hours AND Cipro 400mg IV q 8hrs
- If coag neg staph (1 out of 2)-likely a contaminant

Pain Meds (step-wise algorithm)

- a. Tylenol 650 mg PO q4-6 hrs P
- b. Lortab (hydrocodone/APAP) 5/500mg 1-2 tabs PO q6
- c. Percocet (oxycodone/APAP) 5/325mg 1-2 tabs PO q6
- d. Morphine 2mg IV q2
- e. Dilauded 1mg IV q3

Middle of the Night Floor Calls cont..

Altered Mental Status

- Go see the patient (absolute must!)
- Do neuro exam/garbeled speech?
- Review lytes/consider CT-head w/o contrast
- Review meds: ambie, darvocet, benadryl, H1/H2 blockers, TCA's, anti-histamines, detrol, narcs,

Lost IV Access

- How many times has nurse tried?
- Did they call house supervisor? (send pt. to holding room so they can try)
- If patient urgently needs ABX-call senior resident for supervision (central line time!)

Chest Pain/SOB

- Go see the patient
- Order stat-EKG, CXR, CE
- Give nitro/Asa-and take it from there pending results

Anxiety

- Ativan 1mg IV/PO q8hrs PRN
- Xanax 0.5mg PO q8hrs-PRN
- *Careful in elderly/pulmonary dz

Hypokalemia

- 1st-check magnesium (order level if you don't know)
- If able to take PO-give 40meq PO (can give liquid if nec.)
- IF IV only-40meq IV over 4 hours

Low Magnesium

- (PO) Magnesium Oxide 400-800mg PO x1
- (IV) Magnesium sulfate 2 grams IV over one hour

Middle of the Night Floor Calls cont..

Hyperkalemia

- 1st-check telemetry/EKG (put on telemetry if not already)
- Re-check chem.-7
- Consider holding ACEI/ARB, potassium in IVF/TF

*Less severe($K < 6.5$ and no EKG findings)

- Kayexalate 30-60 grams PO/PR
(if PO-gotta have BM for kayexalate to work)

*Acute Mgt./more severe($K > 6.5$ or EKG changes)

- Calcium gluconate 1 amp IV
- D50 (1amp-50g) give BEFORE insulin
- Insulin 10 units IV over 15 minutes
- NaHCO₃ 50 mEq IV over 5 min
- Albuterol nebs (20mg nebulized over 15 minutes)
- Also must give Kayexalate (same dose as above)

Respiratory Distress

- Go see the patient (bilat breath sounds?)
- Check O₂ sat, ABG, CXR (stat)
- Consider Increasing O₂, Vent-mask, NRB, AA nebs
- If looks bad/getting worse-call your senior resident

Clogged Feeding Tube

- Consider one Viokase tab with 325 mg of sodium bicarb PT

*Note – Don't forget you are most likely not the primary caretaker for a patient you deal with overnight on cross-cover. Try to avoid starting scheduled meds on a patient, especially pain medicines or sedating medications, because the primary team in the morning may not realize their patient is now on a scheduled narcotic, etc. If you feel the patient needs an increase or addition of a medication, then try to order One Time doses and allow the primary team to address in AM.

Pain Management and Narcotics

First ask yourself-“What is the diagnosis?”-metastatic cancer or ‘back pain’
-if you don’t have a diagnosis-find one (literally-what is causing the pain?)

Start with:

RICE (Rest, Ice, Compression, Elevation)

Heat after sub-acute injuries

Physical Therapy is good

Options for Pain Management (relative equivalent categ: mild, mod, sev)

Mild:

-Acetaminophen 650mg PO q 4 hrs

-Ibuprofen 600mg PO q 6 hrs

Moderate:

Tylenol #3-1 tab PO q 6hrs

Hydrocodone 5mg PO q 6 hrs

Oxycodone 5mg PO q 6 hrs

Severe:

Morphine IR 30mg PO q4 hrs

MS Contin (Morphine sulfate) 30mg PO q 12hrs

Fentanyl Patch 25-50mcg patch q3days

Other:

Neuropathic Pain

-amitriptyline 25mg PO QHS

-Gabapentin 300mg PO BID

Muscle Relaxants

-cyclobenzaprine

-skelaxin

In Clinic-get a pain contract

In Hospital-consider O2 monitor if IV Narc

Opioid Equianalgesic Chart

Opioid	IV/SQ mg	PO/PR mg	Duration of Effect
Morphine	5	15	3-4 hours
Long Acting Morphine		15	8-12 hours
Oxycodone		10	3-4 hours
Long Acting Oxycodone		10	8-12 hours
Hydromorphone	0.75	4	3-4 hours
Codeine	50	100	3-4 hours
Hydrocodone		15	3-4 hours

Fentanyl Transdermal Patch – NOT FOR ACUTE PAIN!

Opioid doses equivalent to 25mcg/hr fentanyl patch

Drug	Oral	IV
Morphine	45mg/24hr	15mg/24hr
Hydromorphone	10mg/24hr	2mg/24hr

Patch duration: 48-72 hours

Onset of effect: 12-24 hours before full analgesic effect of patch occurs

Must prescribe Short acting opioid for breakthrough pain

Opioids use for Liver or Renal Failure

Recommended	Use with caution
Hydromorphone Fentanyl	Codeine * Morphine * Oxycodone *

* These opioid have active metabolites that are renally eliminated

** Meperidine is not recommended b/c the metabolite, normeperidine, may accumulate in patients with poor renal functions causing CNS toxicity.

Meperidine is contraindicated w/ MAOI's

Acetaminophen Toxicity > 3250 mg

Thus, make sure your daily total dose (alone/combo meds) does not exceed 3.25 grams. Safe dose in alcoholics or those with chronic liver disease is much lower, possible <2500mg/day

Examples of combo meds:

- Roxicet (Oxycodone/APAP) 5/325 (5ml-if liquid)
- Percocet (Oxycodone/APAP) 5/325
- Lortab (Hydrocodone/APAP) 7.5/500 (15ml-if liquid)
- Norco 5 (Hydrocodone/APAP) 5/325
- Darvocet (Propoxyphene/APAP) 100/650-avoid this medicine if possible (FDA considering taking off market)

Moral: careful with your PRN acetaminophen/hydrocodone orders

Be specific with the orders (don't write 1-2 tabs PO q 4-6 hrs)

-commit to a specific #tabs and a specific freq

Also, if pt has an infection, you cannot accurately rely on Tc/Tmax for monitoring of ABX therapy if receiving acetaminophen

Powerchart will flag a warning when total acetaminophen dose has exceeded 2600mg for a 24 hour period

Wound Care

Part 1: The Wound Care Consult

- WRITE "Wound Care please Eval & Treat"
(includes Ostomy care/training), sign T.O./V.O. next day whenever possible
- Other:
 - Wound Care for specialty beds (pressure "redistribution" beds)
 - Vascular Surgery for PAD wounds
 - General Surgery if significant debridement required
 - Whirlpool/PT for superficial sharp debridement
- *Consult Wound Care for ALL STAGE III/IV per hospital policy

Part 2: Documentation/Terms to Use

- "Pressure ulcer Stage I, II, III, IV"
(no longer "decubitus ulcer")-only these can be "Staged"
- "Suspected Deep Tissue Injury"
- "Incontinent Associated Dermatitis"
- "Moisture Associated Skin Damage"
- "Eschar/Necrosis C/W Partial (or Full) Thickness Wound"
- *Document if "present on admission" (hospital not penalized; if stage III/IV hospital gets paid more)

Part 3: Do NOT Stage:

Skin tears, eschar/necrotic tissue, tape burns, ischemia from emboli/PAD, excoriations, venous stasis/diabetic ulcers, fungal rash- anything in which pressure is not cause

*UNSTAGEABLE:

- Incontinent Associated Dermatitis (IAD)- skin tears & breakdown due to constant moisture from urine/stool, occurs on buttock/groin/thighs, can have fungal infection
- Moisture Associated Skin Damage- same as IAD but no stool/urine, typically under breasts, skin folds, can have fungal infection
- Eschar/Necrosis C/W Partial/Full Thickness Wound- not stageable until debrided or eschar falls off *Document "C/W Partial/Full Thickness Wound"

Wound Care Cont...

Part 4: Staging of Pressure Ulcers

-DTI= Deep Tissue Injury- purple/maroon/black, SOFT, intact skin/blister, mushy/boggy, painful, may evolve into thin blister, eschar or rapidly progress to Stage II to IV (breakdown occurring from inside out), occurs from pressure, common on foot/heel/sacrum

-Stage I-Intact skin, non-blanching, redness, painful

-Stage II-Partial Thickness, loss of dermis, pink wound bed, ruptured blister, no depth

-Stage III-Full Thickness, subcutaneous fat may be visible, may have tunneling into fat, has depth

-Stage IV-Full Thickness tissue loss with exposure of bone, muscle or supporting structures

Part 5: Tips for Wound Care Options:

-Wet to Dry- is OK on most wounds if you are unsure until Wound Care can eval your patient

-Wet wounds- if lots of moisture/drainage- use "hypertonic" salines in wet to dry dressings- Curasalt/Alginate

-Stage I- Pressure relief, float heels, turn patient

-Stage II- Tegaderm Absorbant, Allevyn Adhesive Foam or ointment (Calmoseptine/Vasolex/Xenaderm)

-Stage III/IV- pack undermining/tunneling- wet to dry or debride necrotic tissue

-Eschar- if on the heel & no sign of infection, leave it alone (the bodies "natural biological cover"); if on the sacrum or has pus underneath, it probably needs debridement

-Venous Stasis Ulcers- Adaptic w/ Kerlix, or non adhesive foams, consider compression (ace wraps)

-IAD (Incontinence Assoc Dermatitis)- moisture barrier ointment such as Calmoseptine, add antifungal (Microguard) if needed

-Friction Rub/Skin tears- Tegaderm Absorbant or Adaptic w/ Kerlix

-Diabetic/Arterial Ulcers that are dry/calloused- SoloSite Wound Gel- adds moisture

-Necrotic tissue- mechanical/chemical debridement (sharp, wet to dry, whirlpool)

-Whirlpool- mechanical debridement, stop when necrotic tissue gone and pink tissue appears

Wound Care Cont...

Part 5: Tips for Wound Care Options-Continued

-Wound Vacs- placed by PT or Wound Care or Surgery- not sterile but can be "protective" if the wound is in a bad location; not billable, comes out of DRG and costs hospital money, rental/sponges are very expensive; difficult to d/c to ECF w/ VAC (it is billable by home health)

Part 6: Products:

- Calmoseptine Ointment- moisture barrier- good for stool incontinence, fungal rash (add antifungal powder), good around PEG tubes, less expensive
- Microguard Powder- Antifungal- mix with Calmoseptine- less expensive & easier to use than Nystatin powder
- Santyl- Chemical debrider (Accuzyme, Panafil no longer available)
- Curasalt/Alginate- hypertonic solutions for wet to dry with absorbent properties
- Tegaderm Absorbent- good for skin tears, Stage II, see through to monitor wound
- Replicare (same as "duoderm")- Stage II, opaque (cannot see through)
- Adaptic & Kerlix- skin tears, weeping, venous stasis ulcers, needs changing daily
- Allevyn Adhesive Foam- absorbent, for moist ulcer/Stage II
- Vasolex/Xenaderm-(UT has Vasolex)- ointment, moisture barrier from urine, more expensive than Calmoseptine
- Sage Barrier Wipes- used to clean pt- has protective moisture barrier ingredients
- SoloSite Wound Gel- adds moisture to dry, calloused areas
- Unna Boot- for compression such as venous stasis wounds- only M,W,F (not daily)- watch for compromised circulation, avoid in PAD

Part 7: Outpatient Options:

- Desitin- for stool type irritation (diaper rash)
- Sween Cream- good OTC moisture barrier, not expensive
- Calmoseptine Samples- call 800-800-3405

QUESTIONS?

Contact Lennis Floyd, RN, Wound Care- pager #1333

Revised 2/09 by Lennis Floyd, RN

Favorite Scripts

1. Diabetes Example
 - Lantus 10 units subq QHS #3 month supply
 - Novolog insulin sliding scale as dir. #one bottle (1000 units)
 - Supplies: (Diabetic supplies #120-PRN refills, Chem strips #120-PRN refills, EtoH wipes #120-PRN refills, Glucometer)
2. Empiric ABX Combo (no renal probs):
(USE YOUR SANFORD GUIDE!-Dr. Rasnake)
3. Pyridium 200mg PO TID max of 3 days
(urinary analgesic-with or without foley)
4. Solumedrol 60mg IV q6 (resp) followed by PO Prednisone taper (Resp)
5. UTI: Macrochantin 100mg BID for 5-10 days (simple cystitis only!)
Cipro 500mg PO BID for 3-7 days
Bactrim DS 1 BID for 3 days
6. Morphine 1 - 2mg IV (conservative dose)
4mg IV (usual~couple of percocet's)
10mg IV (long bone fx)
7. AA nebs: (Albuterol 2.5mg/Atrovent 0.5mg) inhaled q4-6hrs PRN
8. Lovenox (no renal prob): 40mg subq qday (DVT prophylaxis)
1mg/kg IV BID (anti-coag for PE TX)
9. Migraine: Maxalt 5mg PO qday-PRN
10. IV BBBlockers: metoprolol 5mg IV q6 ~ labetalol 5-10mg IV q 4

Favorite Scripts cont..

12. Haldol (Vitamin H): 1mg IV/IM (conservative/old lady dose)
5mg IV/IM (Big Guy)
10-20mg IV/IM (psych patient with prev. tolerance)
13. Ferrous Sulfate 325mg PO BID
14. Captopril 12.5mg PO q8 ~ Lisinopril 10mg PO qday
15. Zosyn (pseudomonal dosing): 4.5g IV q6
(renal dosing) 2.225 g IV q6
16. Cough: Hycodan (codeine) 5 cc PO q4-6 hrs-PRN
Tessalon Pearles 200mg PO TID
18. Meningitis (empiric)
 - Vancomycin 20mg/kg IV 1st dose and then 15mg/kg IV q 12
 - Ceftriaxone 2g IV q 12hrs
 - Acyclovir 10mg/kg IV q 8hrs
 - Ampicillin 2 g IV q 4hrs
 - Dexamethasone 10mg IV q 6hrs (must give with 1st dose or not at all)
19. Hycoamine 0.125 SL q 4-6 hrs or BID (IBS/cramping)
20. Nicotine patch 21mg apply topically qday
21. Delirium Tremens
 - Ativan 2mg IV now
 - Ativan 2mg IV q 8hrs
 - Ativan 1-2mg IV q 2-3 hrs PRN
22. Bicarb Drip ¼ NS with 3 amps of bicarb @ _____/hr
23. Banana Bag Recipe: Thiamine 100mg + Folate 1mg + MVT 1mg
in 1 liter of normal saline

Favorite Orders

1. CSF Orders

- Tube 1: cell count with diff
- Tube 2: protein, glucose
- Tube 3: culture, gram stain, TB stain*, crypto stain*, HSV PCR*
- Tube 4: Hold

* if clinical suspicion for these diagnoses

2. Thoracentesis Orders

1st: Get serum CBC, PTT, PT-INR, LDH, and T. Protein

2nd Do procedure and get fluid

- Tube 1: cell count with diff, cytology
- Tube 2: T. protein, LDH, glucose, amylase, and triglycerides
- Tube 3: gram stain, culture (aerobic/anaerobic), AFB Stain*
- Purple Top: cell count diff
- ABG syringe: pH
- Evacuated container for cytology

3rd Get follow-up CXR (no pneumo)

* low yield test, only if clinically suspect TB

3. Paracentesis

- Indications: Need fluid for diagnosis (suspect SBP) or therapy (chronic ascites from Liver Dz/CHF/etc.)
- Contraindications: Inadequate fluid, coagulopathy (correct 1st-can use FFP)
- 1st: Get serum LDH/albumin
- 2nd: Do procedure and get: cell count and diff, culture, albumin, protein
Consider: glucose/LDH (if thinking perf), amylase (if thinking pancreatitis), cytology, and AFB

4. Home Infusion Orders:

- Consult 'Infusion Partners' for home IV ABX
- (Dose) ex. Acyclovir 770mg IV q 8hrs
- (Monitor) ex. CBC/Chem 7 q Monday and Thursday
- Routine line care
- Report labs to Dr. _____

Disease Risk/Severity Tools

www.mdcalc.com has many of these online
works best with Safari browser

CHADS² Criteria

Should someone with atrial fibrillation be anticoagulated to prevent stroke?

- Congestive Heart Failure = 1 point
- Hypertension = 1 point
- Age >75 = 1 point
- Diabetes Mellitus = 1 point
- Stroke or TIA history = 2 points

<u>Annual Stroke Risk</u>	<u>Anticoagulation Recommendation</u>
0 points = 2%	0 points – ASA
1 point = 3%	1 point – ASA or warfarin
2 points = 4%	2 points or greater - warfarin
3 points = 6%	
4 points = 8.5%	
5 points = 12.5%	
6 points = 18.2%	

Ranson Criteria

Clinical prediction tool for predicting the severity of acute pancreatitis

*All Criteria are worth 1 point. Add up all points from admission and 48hrs.

<u>At Admission</u>
1. Age > 55
2. WBC > 16,000
3. Glucose > 200
4. AST > 250
5. LDH > 350

<u>At 48 Hours</u>
1. HCT drop by >10%
2. BUN increase > 5
3. Base Deficit > 4
4. Calcium < 8
5. PaO ₂ < 60
6. Fluid Sequestraion > 6L

<u># of Criteria</u>	<u>Mortality</u>
2 or less	< 5%
3-4	15%
5-6	40%
7 or more	99%

Disease Risk/Severity Tools

TIMI Risk Score

In patients with Unstable Angina or NSTEMI the TIMI risk score predicts the % chance of all cause mortality, MI, or need for urgent revascularization within 14 days.

*All Criteria are worth 1 point

- Age \geq 65
- Known CAD lesion \geq 50%
- ASA use in last 7 days
- Angina \geq 2 episodes in last 24hr
- ST deviation \geq 0.5mm
- Elevation of cardiac enzymes
- CAD Risk factors \geq 3

<u>Score</u>	<u>% Risk</u>
0-1	5%
2	8%
3	13%
4	20%
5	26%
6-7	41%

ABCD² Score

Predicts the % risk of stroke at 2, 7, and 90 days after a TIA

- Age \geq 60yrs = 1 point
- Blood Pressure SBP $>$ 140 or DBP $>$ 90 = 1 point
- Clinical Presentation
 - Unilateral Weakness = 2 points
 - Speech Impairment without weakness = 1 point
- Duration of symptoms
 - \geq 60 minutes = 2 points
 - 10-59 minutes = 1 point
- Diabetes Mellitus = 1 point

Risk Classification	Stroke Risk at 2 Days (%)	Stroke Risk at 7 days (%)	Stroke Risk at 90 Days (%)
Low (< 4 points)	1.0	1.2	3.1
Mod (4-5 points)	4.1	5.9	9.8
High (>5 points)	8.1	11.7	17.8

Policies (Highlights)

- Internists dress up (scrubs only if on call/ER/ICU)
- Don't do drugs
- Drug Reps are still our friends, but be skeptical ('small' gifts related to pt. care/education only)
- Before each new month-get a hold of your curriculum (usually in your box/online)
- Everybody gets evaluated-keep up with them online (New Innovations)

WORK HOURS:

-no more than 80 hours/week (avg'd over 4), 10 hours off b/w shifts, 30 hours max per shift, one 24 hr period off per week

WORK HOUR EXPECTATIONS:

When on wards

- intern needs to be in hospital by 0730 (even if you only have one pt. to round on), all intern notes on chart by 0800. Interns are required to attend morning report while on housestaff and onsite elective rotations. Home at 1700. (May turn off pager at 1700-after checkout)
- If work is finished before 1700-go read/study until 1630 (check-out time).
- You are responsible for your Team until 1700. You must answer pages and be able to address any problems that arise before 1700.

When in Unit

-intern must be in hospital by 0600 (regardless of number of patients). See your patients from 0600-0900.

Policies cont.. (Highlights)

TRANSFERRING FROM ICU TO THE FLOOR:

HSM Does not accept unassigned patients from the ICU. The ICU resident should write some basic transfer orders and a transfer MAR for the UTH physician.

ADMITTING FROM RESIDENT CLINIC: (remember-in general, whoever is going to take care of the patient needs to write the H&P...that said, if it's your patient in the clinic-send along meds/PMH/pertinent info for accepting team) Write some generic admit orders to get the ball rolling

RESIDENT CAPS:

Senior=TWENTY

Intern=TEN

(10 total patient encounters-includes both established and new patients)

Interns can admit 5 new patients and 2 transfers in a 24 hour period

*After your capped-it's your senior's responsibility

**Of course, even if you're capped, you can't go home because you're still responsible for code/intern pagers/floor coverage until next team comes on

READMISSIONS:

-Any patient readmitted to HSM within the same month goes back to the HSM team that admitted/discharged that patient previously in the month.

-Transfers out of the Unit go back to the team that put the patient in the Unit

INTERN CALL (HSM): Every 3rd Day-alt. between day call and night call

Mon-Fri: day call (0800-1700) and night call (1700-0800)

Sat-Sun: day call (0800-2000) and night call (2000-0800)

ORDERING CONSULTS:

-Make sure you specify timeliness (see at convenience, within 24 hours, ASAP/ STAT-better be important)

-If consult is stat-you must physically call and speak with the individual you are consulting. Earlier in day is always better. (It's considered polite/good manners to notify all of the physicians whom you are consulting)

Intern Sign Out and Conferences

INTERN SIGN OUT:

Formal sign out occurs at 4:30pm in the Emergency Department, typically the CDU if its available. The night call intern should be their at 4:30 to receive sign out from other teams. One intern from each team must show up to give the night call intern sign out in person. Our formal sign out should be done through "Pulse."

PULSE:

You must be on a computer within the hospital and...get on Internet Explorer → in the web address type "Pulse" → select Departments and Offices → Department of Medicine → Team Lists → Enter your username and password → then access your team's list to update. You must update the pulse list daily and give it to the night call resident at sign out. Its very important to include any events/calls you might anticipate overnight and let the on call intern know. It is also very important to include any medications you are avoiding in a certain patient, like narcotics.

Morning Report

- Morning report is at 0800 every morning in the grad med conference room
- The second Tuesday of every month is **Grand Rounds** which occurs in Morrison's Conference room. Grand Rounds is **MANDATORY**, even if you are in the ICU. Only exceptions: post call HSM or ICU intern.
- Occasionally, there will be a CPC, Board Review, or another kind of conference that may take place in Morrison's. Check the schedule
- Monday's are "Teaching Rounds" which takes place in grad med conference room

Noon Conference

- Occurs in the grad med conference room except on Wednesdays, which are Cardiology Conference which is in Morisson's Conference Center
- Occasionally there is a Radiology/Pathology conference that will be in Morisson's – check the schedule
- Food is provided for the majority of conferences; however, 4-5 conferences a month there will be NO FOOD. These days are marked by an orange sticker on the conference schedule.

*We are required to go to 70% of Conferences/Morning Reports!!!

USMLE Step 3

Requirement: Sit/Pass Step 3 by Christmas of your PGY-2 year

Best Time: Debatable, though most would agree that you probably want to take it during a month that is NOT ICU/Housestaff (favorite months during intern year have been: derm/optho, ER, GI, or two week elective)

The Goods:

-Phone number of USMLE (M-F 8 to 5): 817-868-4041

-Pick an e-mail that you want to communicate with the USMLE

-Scrounge up your old score report and find out what your USMLE ID # is

-Will need your program director's name, e-mail, & phone number when applying online

-Cost: ~\$700

-You can take it ANYWHERE
(including Knoxville-at Prometric off cedar bluff)

-Apply through USMLE/FSMB website (google it)

-Get your scheduling permit through Prometric
(after your application accepted)

-Takes 3-8 weeks for application to go through

-With application, you will print off a form which will need to be notarized and mailed
(you can go down to medical records to get this done free of charge-we have a notary in the hospital)

-If credit card (visa..no discover)

-Get a photo of yourself-2X2-send it off to them

USMLE Step 3 cont..

-A state (any state) must 'sponsor' you to take Step 3. You can choose 'any state'-regardless of whether you plan to ever practice there or not. The kicker is that each state has either stricter or more lax rules regarding how much GME you need to have under your belt before you sit for the exam (for example, Tenn requires at least either six months or one year-meaning you'd have to wait a little bit to get your application started to sit for the exam) In addition, each state has rules on how many times they will allow you to fail the exam before you may no longer sit for it. **REGARDLESS** of the state you choose, you can still sit for the exam in Knoxville. (One popular state to choose is South Carolina because the rules are more relaxed/able to take during intern year)

-Once application accepted, they will send you a CD with 4 question blocks and 8 computer based clinical cases. Get comfortable with how to use the software.

FCVS: This is a service that the FSMB offers to give you a jump start when you begin applying for individual state medical licenses. Cost~\$400. Note, some states require that you use FCVS. You have the opportunity to put in some of your information ahead of time/coordinate 'official' exam scores ahead of time. Don't worry too much about this right now-just FYI.

Study materials: Crush is the gold-standard. There are plenty of others. Work through either Kaplan Q-Bank or USMLE World for questions. The CCB blue prints book is small but great for the computer based clinical cases. Good luck.

Parting Words
from Sir William Osler M.D.

It is astonishing with how little reading a doctor can practice medicine, but it is not astonishing how badly he may do it.

To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.

The physician needs a clear head and a kind heart; his(her) work is arduous and complex, requiring the exercise of the very highest faculties of the mind, while constantly appealing to the emotions and higher feelings.

He who knows not, and knows not that he knows not, is a fool.
Shun him(her).

He who knows not, and knows that he knows not, is simple. Teach him(her)

While medicine is to be your vocation, see to it that you also have an avocation-some intellectual pastime which may serve to keep you in touch with the world of art, of science, or of letters.

The practice of medicine is an art, based on science.

I desire no other epitaph than the statement that I taught medical students in the wards, as I regard this by far the most useful and important work I have been called upon to do.

AND FINALLY...

I wish I had time to speak of note-taking. You can do nothing as a student ('or intern') in practice without it. Carry a small notebook which will fit into your waistcoat pocket, and never ask a new patient ('or your attending') a question without notebook and pencil in hand.