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Introduction

Welcome to CMC Emergency Medicine! You’re in for a great 3 years. Ask your upper levels for guidance and encouragement. Remember, you are here to learn, not to already know everything. You should have already received (or will be soon) the name and contact info of a 2nd year EM resident who will be your Big Sib for the next 3 years. Use them for advice and support. We are happy to help and we’ve already been through this!

Procedure Logs:
You will need to keep a log of all of your procedures for the RRC (the Residency Review Committee within our accreditation board – the ACGME). You will need the patient’s medical record number and age, the date of the procedure, and the name of the supervising attending. You will log procedures online in MedHub (under the Procedures tab, then click on Log New Procedure/Case). Definitely do these as you go! Some employers ask to see your residency procedure log when evaluating you for potential employment. After you log a procedure, you should send a procedure evaluation to the supervising attending for evaluation both for procedures in the ED and performed while off service. We also do many of these procedures during Sim, so be sure to log procedures done by anyone in your Sim group as well!

Required Procedures:
● Adult Medical Resuscitations (45): anyone requiring critical care time, including off service months
● Adult Trauma Resuscitations (35): trauma month as well as those in the ED
● Bedside Ultrasound (40): you will log these on SonixHub; log any off service ultrasounds on Medhub
● Cardiac Pacing (6)
● Central Venous Access (20)
● Chest Tubes (10)
● Conscious Sedation (15)
● Cricothyrotomy (3)
● Dislocation/Fracture reductions (10)
● Endotracheal Intubations (35)
● Lumbar puncture (15): easy way to get these is jump on any patient under 1 month old who is presenting with fever; all get a LP
● Pediatric Medical Resuscitations (15): includes ANY child under 18y/o who needs a procedure
● Pediatric Trauma Resuscitations (10)
● Pericardiocentesis (3)
● Vaginal deliveries (10): you will get these ALL on OB/GYN, most get 15-20

Additional memos about procedure logging:
● Logging procedures is important for two main reasons; first, it helps with credentialing and showing your future employers that you have seen lots of patients. Second, if our residency applies to increase the residency class size, part of the evaluation process
involves how many procedures each resident has recorded. That is why it is important to keep logging once you reach the required number.

- Suturing is now required by our residency program to log.
- Abscess I&D’s, and many other minor procedures, aren’t recorded for graduation requirements; however, you may want to keep track of them for credentialing after residency. Log these under “Add Custom Procedure Type” in MedHub.
- Ultrasounds will be recorded in SonixHub (Dr. Tayal keeps track of these). However, all ultrasound done outside of the ED need to be recorded in MedHub in order to receive credit; this is especially important for central line placement and DVTs (all central lines in the ED need to have a saved image of the guidewire in the vein, which is a hassle to do while sterile, however, no images are required to be saved outside of the ED). So when you are placing central lines in the MICU, be sure to log this as both a central line and an ultrasound procedure.
- We are in the process of switching from SonixHub to QPath. Stay tuned.
- Record adult and pediatric medical and trauma resuscitations from day one.
- Every primary survey you do on your trauma month should be recorded as a trauma resuscitation.
- If you see a patient who is acutely ill and requires critical care time then log it as a medical/trauma resuscitation (including MICU and trauma patients).
- Try to log at least one medical resuscitation for every major shift; even if you do not actually see any patients in the front rooms, pick your most complicated patient and make that your MR for the day. Also, log every patient you admit on your MICU months as a MR.
- Log your procedures the day you do them. Going back through stickers or discern report is a pain, and you will forget procedures to log. Waiting until your 3rd year to type in the hundreds of procedures will be painful.
- Record all simulation cases as medical/trauma resuscitation. Simulated procedures count! Especially every time you do pacing, pericardiocentesis, or cricothyrotomy (ones that you may not get on actual patients).
- The more procedures you log the better – for you and the program.

Evaluations:

At the end of each rotation, you are required to fill out an evaluation on MedHub. You will also be evaluated by that rotation and will receive an email asking you to select your attendings. Mary will have your evaluations on file. Review these evaluations as you please.

Electronic Signatures/Charting:

All medical records and orders are electronic. Documents you have not yet completed will be in the inbox of your Message Center to sign. “Phone orders” put in by nurses under your name will also be sent to your mailbox for confirmation. Be aware that documents “to be dictated” in your inbox should be completed as soon as possible. If you become delinquent in your charts your CME money can be decreased, and your name will be sent to our program directors. Our goal for our residency is to have no EM resident on the delinquent charting list. Complete all of your ED charting ASAP (ideally before you leave the hospital). While it’s tempting to go home after a long day you will quickly fall behind, and the patients we see are
often admitted or return quickly to the ED. It is required to finish documentation on all admitted patients prior to leaving the hospital. Ideally, patients discharged from the ED will have a note finished prior to you leaving but can be completed within 24 hours. You can also refuse orders and documents that appear in your inbox. The easiest way to do this is select the order/document that you do not approve, select forward only, and then type “refuse” for the signature box. Use “refuse, order” for orders and “refuse, HIM” for documents. This is important to remember when you get random discharge notes to be written sent to your inbox; if you write a discharge order on rounds but never actually saw the patient, the chart auditors will still automatically send you a discharge summary to write if no one else completes it.

Dragon: Take time to train your Dragon. It will be worth it when you are getting crushed in the Emergency Department (and while off service) both to help you get your charting done efficiently and in terms of charting accuracy. Review of ED charting recently revealed multiple mistakes in multiple charts rendering the chart incomprehensible. Admitting teams read and rely on our charting for information. REVIEW YOUR CHARTING before signing them to ensure they are accurate and make sense. Dragon can come up with some pretty silly things, don’t let your chart be the one that flashes “I obviously didn’t read this!” There are some helpful dragon tips included in the documents under intern orientation month.

In addition to training your Dragon, creating macros (dot phrases) can be very helpful when you want to put something in your chart that you write in many charts. To create one, type out the phrase you want to say, highlight it, right click, press “save macro as”, and then type a period followed by whatever word you associate with this phrase. For example, if you wanted to save a sentence saying that discharge instructions were discussed, you might title it “.discharge”. To insert this sentence/paragraph into your chart in the future, just type “.discharge” & press enter.

Faculty Advisor/Mentor:
In late July or August, you will be matched with your faculty advisor/mentor. You select 5 potential advisors and will be matched with one of them. Immediately begin thinking about an ED Attending you might want as your advisor. Try to think about where you want to go with your career; identify an attending who has similar interests and rank them highly. Our Attendings are fantastic and you can’t go wrong with any one of them. Review their background and interests on the CMC EM webpage (see link below) or just ask them! Once you are paired up you should meet at least twice a year. Utilize them as much as you can for advice, direction, and assistance, and consider working with them on your academic research project.

EM Faculty Profiles:
http://www.carolinashealthcare.org/emergency-medicine-faculty-medical-education

Conference:
Conference is block conference every Thursday from 8am to 12pm. The RRC requires a 70% attendance rate, which is very high, especially because of overnight shifts. Make sure to sign in at the beginning of each conference to get credit for attending. If you are paged out of conference while on call you still get credit for attending.

You are responsible for logging an average of one hour of asynchronous learning each week, which is now called Individualized Interactive Instruction: 4 hours of lecture plus one hour of self learning equals the required five hours of learning each week (this total number
equals your 70% attendance rate). So if you find that you miss a lot of lectures, then it is especially important for you to log your asynchronous learning. Examples of this include journal club, podcasts, ROSH review questions, simulation center, 4C’s, etc. For the podcasts and practice tests, you must discuss what you learned with an attending to receive your hour of credit. Reading textbooks, journals, or review books does not count. Attending off service lectures also does not count; except for trauma M&M does. The lectures must be emergency medicine as the main topic in order to receive credit. **It is up to you individually to remind your teams/upper-level residents when you are off service that you are required to attend conference.** You will be able to attend all conferences while off-service, even in the ICU, if you take charge and make it happen. They will not remember to send you to conference. It is also up to you to ask your attending/team how they want to handle your conference days. Some attendings will simply expect you to show up early and have your notes finished prior to leaving so your peers can read your notes during rounds. Other attendings will meet with you individually prior to rounds to discuss only your patients.

**Computer Resources:**
- **Cerner:** FirstNet and Power Chart link to the same patient database. This dates back to 2005-2006.
  - First Net is the ED Greaseboard, and your window to patient information while in the ED.
  - Power Chart is used by every other service in the hospital.
- **Stentor:** Radiology image viewer. There is a link from Cerner, but a different password. If you look at an image and there isn’t a radiology read yet, be sure to put your own interpretation in the “memo” section. You can access this by clicking on the white clipboard to the left of the image.
- **Dragon:** Dictation system, separate password from FirstNet.
- **MicroMedX:** Can be accessed from Synapse. Helpful for drug doses.
- **IPad/IPhone/Android Access:**
  - Create a new Wi-Fi account
  - Network name: vlan5o4 (you need to be in the hospital for this to work)
  - Under Security choose WPA2 Enterprise.
  - Enter your username and password.
  - Download the Citrix client for your respective smart phone/IPad through the respective app markets. The Citrix app for iPad/iPhone is marginally useful for rounding on off service rotations. It is not ideal but it works for reviewing labs/vitals and entering orders.
  - Set up a new connection
  - Address = 10.250.130.148
  - Username and password
  - Domain is Carolinas.
  - Access gateway = turn to off.

**Books:**
- Most of these books are available for free on AHEC library website; you will get login information during orientation. Don’t waste your CME money on hardcopies unless you
really like to ride on paper

- Rosen: Emergency Medicine: Concepts and Clinical Practice
- Harwood-Nuss: The Clinical Practice of Emergency Medicine
- Roberts and Hedges: Clinical Procedures in Emergency Medicine
- Schwartz and Reisdoff: Emergency Radiology
- Trauma Management: An Emergency Medicine Approach - Ferrera, Colucciello, Marx, Verdile, Gibbs
- Clinical Toxicology: Ford, Delaney, Ling, Erickson
- The Handbook of Fractures, 2nd Ed.: Perry and Elstrom
- Radiology of Emergency Medicine: Harris and Harris
- There is a large list of useful resources available in the “admin” section of the compendium
- Check with Mary before ordering. Since many faculty members are authors, they can sometimes get a reduced rate if you do decide to buy.

Websites:

- MedHub: chs.medhub.com
  - Your portal to schedule, documents, evaluations, procedure logging
  - Many links to useful EM blogs and resources
- Off Campus WebApps Access: goremote.carolinas.org
  - You will be given info about this at orientation computer training – use this to set up WebApps on your home computer (different instructions depending on whether you have a PC or a Mac)
- Shift Admin: www.shiftadmin.com
  - Use this website to look at the ED shift schedules
  - It can also help you request shift trades
- Webmail: webmail.carolinas.org
- Access emergency medicine; has personalized practice test questions, available for free with AHEC library access
- Also ask one of the upper levels to email you access to the Peer VIII review question bank if you want additional practice tests
- CORD Database: www.cordtests.org
- Carolinas Electronic Compendium: www.cmcedmasters.com
  - Password is Carolinas76
  - This includes all the educational resources you could need in one website. It is being updated continuously.
  - Also has helpful information about schedules, Sim, and much more.

Email: CHS has moved to Outlook for management of email on your personal device. The app is called “Microsoft Intune” and is available in the app store of your choosing. This will download Outlook, Skype and OneDrive on your device. Corporate IT will likely send you more information about this, but make sure you have access to your email on your phone and check and respond to it daily. There are lots of emails that require timely responses, don’t ignore them.
**Vacation:** You get two weeks during 1st and 2nd years, and 3 weeks during your 3rd year. You also get 1 week of CME to take an educational trip. In addition, you get either five days in a row during Christmas or New Years; you get this every year no matter what rotation you are on. You can take vacation on Orthopedics, OB/GYN (most months), Cards, Pediatrics (if on team C/DX), and ED. It is not recommended to take vacation during ED months because it will not result in a shift reduction. If your schedule allows, try to use your vacation on the harder vacation-eligible rotations; cardiology, pediatrics and Ob/Gyn. For life planning, you cannot take vacation during the last two weeks of June, first two weeks of July, during December, or any month you take CME trips. Vacation is five days long, Monday through Friday. You can usually request for your weekend off to be taken along with your vacation. Be sure to make vacation requests as early as possible.

**CME Money:** Every resident gets $1900 in CME each year. You can pay for EMRA or SAEM membership, Step 3, books, Danskos, &/or Intern Conference registration, housing, flights, & food. If you plan on taking STEP 3 during your intern year and are out of CME money, you can apply those receipts to your 2nd year CME money. Half of the class takes STEP 3 during intern year, and the remainder take it during 2nd or 3rd year. Each class will make class jackets, but it is difficult to impossible to use CME money for this. Most buy whatever thin/lightweight jacket they like the most; then one of you can take everyone’s jackets to an embroiderer for about $10 per jacket.

**Intern Conference:** The entire intern class takes a CME trip together in February. The majority of 2nd years and 3rd years go to SAEM and ACEP respectively; however, a few PGY2 & PGY3 residents do have to stay behind to work in the department. Residents that are unable to attend during 2nd and 3rd year get to go to a conference of their choosing. Many prior intern classes have gone to the Wilderness Medicine Society Winter Conference in Bozeman, MT in past years, although other Emergency Medicine conferences can be chosen as well. Each intern is allotted $1,900 in CME money. This can be used towards conference registration, flights, housing, rental cars, and food. Be sure to book your conference registration through the CHS Travel Department. You can reach them through the CHS Operator for more information. Mary Fiorillo will be your contact for making this happen. Start planning early and ask Mary how to make her life easier, as she does a lot of work helping plan this.

Significant others are encouraged to attend all CME trips; however, the GME office understandably will not pay for spouses to attend; this means SO’s must pay for their own airfare. Typically, the intern class will rent a large house that fits 20-25 people and split the cost between the 14 of them with the CME money. The residents bringing SO’s tend to help pay for rental cars, food, etc. Each resident will get $55 per day for food; this will be refunded to you after the trip. YOU MUST SUBMIT ITEMIZED RECEIPTS TO MARY FOR FOOD IN ORDER TO GET REIMBURSED (alcohol is not reimbursed but can be on the receipt).

Try to decide which conference your class wants to attend as soon as possible, so you all can submit your schedule requests for time off. One resident will need to take charge of organizing this so everything gets done on time.

Although this is largely a trip about bonding with your co-residents, the GME office is providing significant funds in paying for your conference and flights, in addition to giving you a paid week off. Make sure you actually attend the conference! We have to balance the fun,
team-building part with being responsible and using the time off and money for its intended purpose. Some mistakes we’ve made in past years: (1) Accidentally signing up for the attending rate instead of the resident rate, incurring higher registration fee. (2) Attending few or none of the educational sessions – despite very generous time allowed for recreational activities – so much so that the conference providers actually call our faculty because they’ve never seen certain residents that were registered as attending. (3) Adding days on to either end of the 5 allotted days & seeking reimbursement for food these days.

**Orientation**: Orientation will be the last 2 weeks of June. For life planning, expect to be at orientation every day during these two weeks. You will complete BLS, ACLS, PALS, and ATLS, and NRP during this time. You will also complete the hospital required orientation during this time. The days are long and boring, with lots of sitting in a classroom. But you will have time at night to go out and get to know your fellow interns better. We strongly suggest creating a GroupMe account to keep entertained.

**Food Money**: Your food money gets reset every 3 months. Your food money will not start until July 1st. Most of the orientation days during June will have food provided, so don’t worry about not having food money during that time. The amount of food money you receive is dependent on how many hours you will work during those three months. You get more during TEGS, trauma, OB, and MICU (months where you work more hours). Expect between $700-1000.

**Salary**: You can expect to receive your first paycheck approximately 3-4 weeks after starting orientation. If you elect for the retirement plan deduction; your paycheck will be around $1350.

**Money**: CHS will match up to 4% if you contribute 6% to your 401k, take advantage of this (free money). This will not kick in until you have been an employee of the hospital for 90 days. You will receive a raise each year, roughly $2000 a year. You will receive a bonus in December if the hospital reaches certain goals; this is usually $600 intern year and $1000 second and third year. This can be deposited directly in your HSA tax-free, or into your regular paycheck after taxes, your choice. You can get a $250-300 credit for healthy weight once per year, as well as an additional several hundred dollars for completing goals such as having your blood drawn, watching a finance video online, and having a 10 min phone conversation about your health. This money goes into your health savings account. You should definitely take advantage of the extra money opportunities for HSA, such as fully matching up to $750 if you’re married and $300 if you’re single. This can pad your HSA to as much as $2250 a year, tax free. More information about how to reach these goals can be found on the Total Health Portal on PeopleConnect.

**Health Care**: Your health care will start on the day of orientation, however you can access your health insurance card online through the company’s website. Dental is included for free. Vision care is extra and you must elect to pay for this, $10/month for individuals, $20/month for couples. Includes an eye exam each year and $200 towards contacts or glasses, worth it if you need it. Links provided below if you need access to your insurance before your cards arrive with your name and SSN. Disability insurance also available, you can increase the amount you’re covered with a small cost per paycheck.
Med Cost (Health Insurance)
Delta Dental
Vision Your ID for this is your employee ID plus the last 4 of your SSN

Driver License/License Plates: You are required to obtain a NC driver's license and license plate by law. Many residents elect not to do this; fail to do this at your own risk. The driver's license requires a short pictures-only test. They show you photos of street signs without writing, such as a red octagon, and want you to know it’s a stop sign. You have to wait 7-10 days to receive your driver’s license in the mail before you can get your license plate. You do not have to get your car inspected until you renew your license plate the following year.

Simulation Center: You will have simulation during orientation month and will also have 5 days of simulation spread throughout the year; the schedule for these is available on the compendium. Simulation will have 1-2 residents from each class level. After each case, you will discuss how you did with the other residents and attendings (about 2-3 ED attendings usually attend). You do not need to study or prepare for simulation center; these cases are designed to be difficult and you are expected to make mistakes. You personally do 1-2 cases at each session and observe the other cases. The day will last approximately 4 hours. If you are late to simulation or miss your date, you will be required to write a case series for the simulation department. You will also have 3 additional sim sessions in the spring titled 4-Cs. These are critical care based simulation cases that all interns from every department are required to attend. If you need to reschedule 4-Cs, you must find another intern to switch dates with you. Both 4-Cs and simulation are mandatory. Make sure to include any simulation or 4-Cs dates on your schedule requests.

Moonlighting: You can begin to moonlight internally in AEC starting 2nd year, you do not have to have completed STEP 3 to moonlight. Pay is $85/hour. You can also moonlight at the cardiac rehab clinic starting 2nd year; this is for 2 hours in the morning. Pay is $80/hour. You are only required to be there in case someone codes (you have ACLS nurses for assistance and a code cart). You are allowed to workout at the gym, sleep, or do whatever you want as long as you can respond to codes.

Back up shifts: During ultrasound and cardiology months you will have back up shifts. Expect to have 11 backup shifts during these months. You are on backup from 9am to 7am. You must stay sober and within 30 minutes of the hospital. If called in because of an EM intern, they will work one of your shifts in the future. You are on back up for any intern (EM or off-service) that calls out for a shift.
Anesthesia

Overview: This is one of the easier rotations from a time commitment standpoint and is combined with ultrasound. This rotation requires you to take initiative, and you essentially get out of it what you put in. If you want tubes, be aggressive and ask to intubate as many patients as you can. Concentrate on getting direct intubations during this month; you will get plenty of video guided tubes while in the ED and now is the time to practice on the real stuff in a controlled environment. Most importantly, let the CRNAs and anesthesiologists know you want to learn advanced techniques and act interested; now is the perfect time to practice using bougie and other various techniques that you haven’t tried out before.

This rotation can be frustrating when you’re not able to get tubes. It is highly recommend showing up around 645 to stalk the board and try to scope out which rooms do not have students. As an alternative, hang out where all the beds roll by and if you see someone rolling a patient by themselves, introduce yourself and ask if they mind if you intubate. You may also attempt to find an anesthesiologist to attach on to. Most of the CRNAs are willing to let you intubate, but not all.

Cerner Notes to have on Day 1:

None. You do not have to write notes for intubations done in the OR. However, this is a good time to make sure you have good dragon templates or macros for intubations. Procedure notes for intubations will be required for intubations done in the ER and ICUs. Try to make separate templates for intubations by Mac blade direct, Miller blade direct, CMAC, glidescope, and fiberoptic guided. You can also ask your upper levels to import their macros for procedures.

Cerner Order Sets to have on Day 1:
None, you will not be placing orders

Schedule:

In General: Expect to work from 2 to 6 hours per shift (depends how many tubes you get and when you want to leave)

Life Planning: Reasonable to request a specific weekend or consecutive days off

- You will not have your schedule shortly before the month starts. Dr. Tayal makes the schedule for both US and Anesthesia, though in reality you can switch your anesthesia schedule around as long as it doesn’t interfere with US shifts. Try to find out which days the CRNA students will not be there and work those days so you aren’t competing for tubes.
- You will be scheduled for backup shifts during Anesthesia/ Ultrasound and cardiology months. Expect to be on back up approximately 7 days out of the month, including one weekend.
- While on backup; you are on call from 9am-7am for any intern in the ED who calls out sick; you are not allowed to be intoxicated and must be within 30 minutes of the hospital

Schedule Interpretation
- Expect to work 4-6 anesthesia shifts during this month, so essentially 1-2 mornings per week
Where to go:
Our anesthesia shifts are scheduled at CMC Main. Show up to the 5th floor OR front desk. The OR schedule is displayed on several monitors. Generally the CRNA’s and Anesthesiologist hang around in this area. If you get a chance, swing by the anesthesiologists and let them know who you are; otherwise, start finding some rooms to intubate. Often you can hang out near the monitors or in pre-op and catch the CRNA as they wheel the patient past. Introduce yourself and ask to perform the intubation; answers will vary, but are almost always yes. See below for tips to maximize intubations.

What to bring: Stethoscope, and pen and paper to track MRN's of patients you've tubed. Cover your hair before entering the OR area and put on a mask before entering an OR. Eye shield is optional, but recommended. Many ER attendings will require eye protection during trauma intubations so this is a good time to get used to wearing it.

Who to Find:
CRNA working with each patient you plan to intubate: The name can be found in the CRNA lounge on their board and each person wears a CHS nametag exactly like ours. They are generally friendly and can teach you a lot.
The anesthesiologists: You may not meet the anesthesiologist until you are in the OR with the patient, but simply introduce yourself as they expect us each week. They are very good at showing you their techniques if you are willing to learn.
What you have to do: 20-30 intubations over the month (this can be very hard to obtain if you are not aggressive). Enter your intubations in MedHub under “Endotracheal Intubation”.

Getting Intubations:
Find the electronic greaseboard next to the OR nursing desk on the 5th floor, hard to miss, it is four huge monitors. There is a whiteboard greaseboard in the hall to the left of the electronic greaseboard; look at this so you don’t go into a room with a CRNA student (rooms with two nametags). You are also not allowed to intubate in pediatric ORs as a first year, although this is flexible depending on the CRNA and anesthesiologist. There are over 40 rooms to pick from with little number of students. Best option is to find an anesthesiologist with multiple rooms with no students with rooms all going off about ten minutes apart. Introduce yourself to the CRNA of the room that is going off first, you can find them next to the patient in the preop area. You will meet the anesthesiologist in the OR; quickly introduce yourself as a resident and tell them that you are on an anesthesia month and would like to work with them on their additional cases that day and if it is ok to bounce from room to room with them. This is an easy way to get 3-4 intubations in less than 30 minutes. And if you nail your first few intubations with them, it’s a good time to ask to try using a bougie. Also, give the CRNA your cell phone number and ask them to call you when their next case is going back; 2nd cases often go back early and this keeps you from having to stay in preop waiting around with nothing to do.

Now go back to the pre-op area prepare for your case. Say you are going to pre-op room 3 for a
case that will be taking place in OR 6. You now have to (a) meet the CRNA and ask if you can
do the tube and (b) introduce yourself to the patient. (It’s not always possible to introduce
yourself to the patient before you enter the OR).

Check the pre-op room for the CRNA first. If he/she is not there, check in the appropriate OR to
see if he/she is setting up (optimal). Introduce and ask if you can do the tube. If you don't know
how to intubate or haven't done it before, now is a good time to tell them.

After you meet the CRNA, go introduce yourself to the patient: "Hi Mr. Smith, my name is Dr.
Dude. I'm one of the resident docs on the anesthesia team. I'll be going back with you at the start
of the procedure and helping to get you comfortable and get things started." Also, now would be
a good time to do a basic airway exam. Some anesthesiologists will expect you to know their
Mallampati score:

To do the Mallampati correctly: You will need the patient to sit up in the bed and open his/her
mouth without phonating.

Also assess the patient’s neck extension and flexion.

When you get back to the room, set-up your gear and help get the patient situated:

- You can help attach the patient to the monitor:
  - EKG Leads: Snow over grass (white on R shoulder, green is on R hip); Smoke over
    fire (black on L shoulder, red on L hip); brown in R 4th intercostal space near
    midline.
  - BP cuff (non-IV arm)
  - Pulse-ox (IV arm)
  - Make sure you have suction available
- If the plan is to place an LMA, stick around to get the practice, but these do NOT count
toward our RRC requirement. You can log these under “Other” in MedHub if you wish.
- Check your blade to make sure the light works (the CRNA will usually have everything out
  and ready to go)
- Pre-oxygenate with at least 9L O2 or so (just gently place the mask on the pt's face, and do
  not bag-mask until the patient is out and they lack an eyelash reflex)
- Tube 'em
- Give your name to the CRNA or anesthesiologist to put in the EMR
- When you're done, offer to tape the tube. Ask if there is anything else to do, and BOUNCE!

Go right back to pre-op and prepare for your next case in the same way. Rinse and repeat.

After noon there are fewer ORs running, but if you want to continue to intubate the CRNAs can
be very helpful in finding additional intubations. By 3pm all the scheduled cases have usually
finished. Enjoy the hours of the rotation! Don't forget to record your intubations in your
procedure log in MedHub.
Ultrasound

Overview: Ultrasound combined with anesthesia is one of the more relaxing and fun rotations you will do. You will have lots of free time to enjoy Charlotte, study time is minimal, and you will learn tons during your shifts. Dr. Tayal, Dr. Lewis, and Dr. Weekes supervise this rotation. They spend a ton of time on residents and go out of their way to teach you. You will always be assigned to work with at least one of the many ultrasound attendings or fellow. There is a test that you must pass at the end of the rotation, so there is some required studying. You will also be required to complete at least 25 exams in all of the ACEP recommended ultrasound scans in order to graduate. The good news is that this will make all of you that much better at ultrasound and all of you will be fully credentialed to perform all ED ultrasounds when you graduate. This is also a great month to get better at various procedures; make sure to let the upper levels know you would like to perform them.

Cerner Notes for Day 1:
None. However, some residents will ask you to write a short addendum to their note about your findings. This is completely optional. If you tell the resident/attending about your findings then it is actually completely up to them to document. But, if you would like to help out or practice, all you have to do is write 1-2 sentences about what your findings were and always conclude with the statement: “further details available in SonixHub”. Templates for each of these procedure notes are at the end of this section. Making macros for these will save you time, and this is a great month to get them down and into Dragon.

Cerner Order Sets for Day 1:
None. You are not expected to write any orders during this rotation. However, if you place a central line, it would be helpful for you to enter the CXR order once you finish.

Schedule:
In General: Expect to work 8 hour shifts. You will be working attending shifts so that you can be paired up with an ultrasound attending. Image review meetings are every Wednesday morning at 11am and are mandatory.

Life Planning:
• Dr Tayal will email you about making your schedule about 1-2 weeks prior to your rotation.
• Dr. Tayal for the most part will grant you any schedule request you have, and is also great about letting you tweak your schedule as needed.
• If you have any big requests for short vacations, you can usually email Dr. Tayal months in advance and secure a few days off to make travel arrangements early.

Schedule Interpretation
• Expect to work from 13-17 ultrasound shifts. The number of shifts varies depending on if you are the lone intern during the month or if there are two interns
• Remember, you will also have ~5 anesthesia shifts in addition to your ultrasound shifts
• Expect to have approximately 7-10 back-up shifts during the month
Key Points:

- Ultrasounds performed on off service rotations also count towards graduation numbers; no images will be saved, just record the ultrasound in Medhub under procedures with Dr Tayal as your supervisor.
- Make creative signs for each area of the ER at the start of each shift with your contact info and let everyone know that you are there; you won’t get calls unless people know you are there because of how varying the ultrasound shifts are.
- Signs should be funny, but try not to cross the line as they are visible to patients in some areas of the department
- Pick up the US Ascom at the start of every shift (if you are the lone intern on that month then you can keep the ascom with you all month; nurses tend to borrow the phone often). If you can’t find it, try giving it a call as someone is likely borrowing it.
- Store it in the charge nurse office and pick it up at the beginning of your shift there. This rule is often not followed, and the phone can usually be found dead in the US supply closet above the consultant computers in Major.
- Try to get a lot of procedures this month; central lines, ultrasound guided PIVs, chest tubes, LP’s etc. The best way to get lines is to go to every code sepsis you hear. Another good way to get procedures is to hang out in Major while you are waiting for your next scan, so you are close to the resuscitation rooms. Let all the upper levels know you are looking for procedures.
- Dr. Tayal will get angry if he constantly sees you in traumas getting FAST exams, as you will get a ridiculous number of these during residency and should aim for the harder to get exams this month. Along the same lines, you will get a huge number of pregnancy and cardiac ultrasounds in residency, so don’t prioritize these scans if you have multiple scans pending.
- **Try to maximize your DVT, Biliary, Renal, and Ocular ultrasounds** even if you get the required 10 for the month as these are not performed very often outside of this month. Remember you will need 25 of these scans in order to graduate.
- DVT, Biliary, and Renal exams require confirmatory studies to count.
- If you see someone getting a CT abdomen, try to complete biliary, renal, and aorta all at once if possible. You can split them on Sonixhub afterwards and credit for 3 ultrasounds at once.
- If you do a cardiac US, also be sure to get a thoracic at the same time. Again, split the exam on Sonixhub afterwards.
- Make sure to split your DVT exams for each leg. Each leg counts as one scan. This helps tremendously. See below for instructions.

**Splitting exams:** Splitting exams allows you to perform multiple different scans on one single patient without having to re-setup the computer between each exam. Dr. Tayal will explain this in more detail during orientation, but you will perform this in SonixHub after you complete the exam. Example of when to split exams: If a patient has an abdominal CT ordered, then you can get a renal, biliary, and aortic exam off that one patient (and by splitting the exam you don’t have to repeat some of the images obtained). If you do a FAST exam, always do a thoracic scan (E-FAST to check for lung sliding) and remember to split them afterwards as a FAST exam and a thoracic exam. It’s important not to submit the exam for “QA” until after splitting them.
because the submission process will lock you out of further editing or splitting.

*Take care of the machines at the beginning of every shift.* This includes stocking clean cloths, which can be found in plastic bags in the blue canvas clean linen bins in each treatment area. Replace empty gel bottles and make sure there is cleaner spray with each machine. Stock each machine with several pairs of sterile gloves (to cover the endocavitary probes during exams), sterile probe covers (for performing sterile procedures like central lines), and 18-gauge IV catheters for US-guided peripheral lines. Also restart each machine at the beginning of each shift.

*Clean all probes after use.* Try to wipe down probes with sani-wipes after each use. In particular, RETURN USED VAGINAL PROBES TO THE STERILE PROCESSING machine in Diag and tell one of the Diag techs there is a dirty probe there that needs to be cleaned. Prior to dropping off the probe, remove the glove from the probe, wipe off the gel, then place it in the red biohazard bag provided in the original box.

*Enter the patient’s MRN# or Accession# (The number that is auto-populated when you scan a wrist band on the machine prior to each exam).* Dr. Tayal would prefer that you use the Accession# as it makes it easier for him to keep track of exams on SonixHub. If doing FAST exams during traumas, you often will only have a MRN# to enter. It’s possible to go back and do this later in Sonixhub after you’ve gotten your images if need be. To enter usernames for yourself and the attending that is supervising, type in your initials (VT for Vivek Tayal) and hit tab down until found.

There is a quota on how many scans you need to get and what types (total of 100 exams, although you will likely do more). The current requirements are listed below. You normally will not have any difficulty getting these numbers. These numbers, as well as lots of other information, are available in the ultrasound orientation guide you receive. **Remember that you will need 25 exams from each of these categories in order to graduate; so go beyond the required amounts for this rotation if possible.** It’s highly recommended you try to obtain **25 exams in Biliary, DVT, Renal, and Ocular as it’s difficult to get these completed later.**

- **Trauma US**: 10 exams
- **Pregnancy**: 10 exams
- **Abdominal Aorta**: 10 exams
- **Cardiac**: 10 exams
- **Biliary**: 10 exams (needs formal radiology study also)
- **Renal**: 10 exams (needs formal radiology study also)
- **DVT**: 10 exams (needs formal radiology study also)
- **Soft-tissue/MSK**: 10 exams
- **Thoracic**: 10 exams
- **Ocular**: 10 exams (need both eyes to count)
- **Procedure**: 5 exams (includes one central line and one peripheral IV)
- **Nerve Identification**: 10 exams (you will not have to do a nerve block, you will only be required to ID nerves and save the images)
- **Bowel**: 5 exams (SBO, appendicitis)
Airway: 2 exams

You can also check out who has imaging studies ordered and find potential ultrasounds that way. An easy way to do this is keep checking the ED boards on FirstNet to see which patients are getting CT abdominal scans or radiology ultrasounds.

**Education:**
The attendings are great at teaching during shifts. However, there is a test at the end of rotation that you must pass. In order to pass, do the practice test located on the compendium, which is very similar to the real thing. Critical to the rotation are the online digital lectures. Tayal will provide access to these at the beginning of the month. Also use Sonoguide for quick reference: www.sonoguide.com. There are many other electronic resources available to you for free as well as more traditional texts. Many additional resources are listed in the US orientation materials you will receive prior to your month, as well as on the Compendium. Additional learning will be obtained at the weekly Image review—usually Wednesday mornings in the MEB. You will go over noteworthy scans from the prior week. You’ll often be asked to review these images and point out important structures and pathology. This is done in a very low stress atmosphere with the ultrasound faculty without any pimping.

**Expectations:**
You are not expected to be a pro when you start the rotation. The faculty completely understand this is possibly the first time you have ever performed an ultrasound. Try your best to have viewed some of the exams on the AHEC website or compendium so that you have an idea of what you are looking for. There are also guidelines for what measurements constitute a positive scan that are posted on the compendium and are included in the orientation material and will be helpful to have with you on your initial shifts. During the first few shifts the attending will usually do the scan with you, but by the end of the month you’ll improve significantly and feel comfortable scanning on your own and then reporting back to your attending to show them the images afterwards. Also, it’s always best to let your attending know prior to performing a pelvic US because it’s difficult to stop part way through to call in your attending if you are having any concerns with the scan.

**US Macros:** save these to your Dragon!

**Preliminary Emergency Ultrasound Report – Soft-tissue**
A limited soft-tissue ultrasound was performed over 2 planes for detection of abscess. Findings: Sonographic abscess.

Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.

**Preliminary Emergency Ultrasound Report – Abd Aorta**
A limited retroperitoneal ultrasound was performed over the anterior abdomen to evaluate the abdominal aorta. Findings: No AAA. Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.
Preliminary Emergency Ultrasound Report – Cardiac
A limited cardiac ultrasound was performed over the left chest. Findings: There is no pericardial fluid, there is normal ventricular function and size, and there are normal IVC dynamics.
Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.

Preliminary Emergency Ultrasound Report – FAST
A limited trauma US was performed over lower torso. Findings showed no significant peritoneal or pericardial fluid.
Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.

Preliminary Emergency Ultrasound Report – IUP
A limited pelvic ultrasound was performed over the uterus in two planes. Findings: IUP with fundal GS with FP or YS at _ weeks with FHR of _.
Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.

Preliminary Emergency Ultrasound Report – MSK
A limited musculoskeletal ultrasound was performed over the joint/tendon/muscle/bone in 2 planes. Findings: No abnormality.
Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.

Preliminary Emergency Ultrasound Report – Procedural
Ultrasound guidance was used to dynamically guide the following procedure: _
Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.

Preliminary Emergency Ultrasound Report – EFAST
A trauma ultrasound was performed over the torso. Findings showed no significant peritoneal fluid, pericardial fluid, pleural fluid, or pneumothorax.
Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.

Preliminary Emergency Ultrasound Report – Ocular
A limited ocular ultrasound was performed over the eye in two planes. Findings: There is no retinal detachment or vitreous bleed.
Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.

Preliminary Emergency Ultrasound Report – Indeterminate
A limited pelvic ultrasound was performed over the uterus in two planes. Findings: Indeterminate based on no sonographic evidence of fundal GS with FP or YS.
Please see complete Emergency Medicine Ultrasound report sent from Sonixhub.
Emergency Medicine

Overview: The reason why you chose to come here. You get to do four emergency medicine months your first year in addition to your orientation month. Medical students rotate through the ED throughout the year, but they report directly to attendings. However, if you enjoy teaching then you are free to help out the medical students as you have time. We also have mid-level providers (NP’s and PA’s) working in pediatrics, diag, and AEC. The MLPs are a great source of information when you need help during shifts. The MLPs cover major while we are in conference on Thursday, but otherwise you will not work with them during major shifts. The department is very fast paced and will take some time to get used to, but always take some time for yourself. There will always be patients on the board and in the waiting room. We don’t expect you to starve or not take bathroom breaks during your shift. Do plan to grab snacks/food from the cafeteria before your shift; there is not always time to leave for food during a shift.

Notes/templates for Day 1: All of your notes for the ED will be written through FirstNet. You will have a chance to set up macros and dragon templates during your orientation month and computer training. To start a note, use the ED View section of LaunchPoint. There will be boxes for you to add your HPI, ROS, Exam, MDM and Procedures. FH, SH, PMH, PSH can all be added through the EMR and they will autopopulate.

Order sets for Day 1: There is a 90% page on FirstNet that contains the 90% most frequently used orders, all located on one page. You will also be able to save your personal favorite order sets and medications. This list is so long and differs by personal preference that it is best to find an upper level and have them help set up your favorites.

- Use “ED ADULT” or “ED PEDS” for most order sets.
- ED Holding/Transition Orders (for bunny hops)
- Use ADULT PHARM for medication bundles (like code sepsis, PCA, etc.)

Schedule:
In General: All shifts are ten hours in duration your intern year. Expect to stay after your shift 1 to 4 hours charting.

Life Planning: Reasonable to request a specific weekend or consecutive days off, possible Vacation Month

- You are strongly encouraged not to use your vacation while in the ED; it will guarantee your time off, but will not result in a shift reduction
- Each intern gets two schedule requests per month; a primary and secondary request. Most people will get both of their requests
- Chiefs will send out schedule requests emails approximately 2-3 months prior to the rotation. Your requests are time stamped for priority, so plan ahead and have your requests ready to be submitted right when you receive the schedule request email
Schedule Interpretation
As an intern you will be working primarily in the AEC and the Peds ED, and will also spend a little time in Diag and Major. Your shifts will be 10 hours. Below are the current shifts. Please note that in the A3 shift you start in AEC and move to Diag when AEC shuts down at 1am, for a total of a 10 hour shift. Everyone’s schedules can be seen on ShiftAdmin, and you can also trade shifts through this website.

- P1 (Peds): 09:00-19:00
- A1 (AEC): 11:00-21:00
- M1 (Major): 13:00-23:00
- A2 (AEC): 15:00-01:00
- P2 (Peds): 19:00-05:00
- D3 (Diag): Diag 21:00-0700

- Bump shifts: During your last month of ED as an intern, you will be assigned shifts where you switch with an upper level and take their shift. Expect to have 2-5 bump shifts to help you prepare for being a 2nd year. These are generally Diag shifts. During this month you are expected to perform all 2nd year responsibilities, including stocking the ultrasound machines prior to starting your shift. You are also expected to run traumas, front rooms, and answer medic calls during your last month.

Departments:

Ambulatory Emergency Center (AEC): Ambulatory, usually stable vital signs, not a lot of co-morbid conditions, low acuity complaints. Pregnant patients < 20 weeks (>20 weeks goes to OB triage upstairs as long as they are stable & the complaint seems OB-related). You will still admit patients from here, even to the ICU. On weekdays there is a 3rd year resident working 5p-3am as a teaching shift; you staff patients with them as well as the attending. There is also a PGY2/3 during the day on the weekends moonlighting.

Diagnostics: Patients that are stable but have a lot of co-morbidities, old people, etc. In general, the most challenging patients will be found here. Once AEC shuts down at 1am, low acuity complaints will also be seen in Diag.

Major: Anything life threatening, requiring immediate intervention, trauma, drunk/disorderly, and psych patients. Front rooms 1-5 are for the critically ill, traumas in 1 and 2 usually, patients who need to sober up (metabolize) or be psychiatrically observed go in 16-18 or in the hallways when it’s busy. You will be expected to see front rooms during your last ED month, but try to see one or two each shift once you feel comfortable.

CED (aka Peds): Fully autonomous Children’s ED which will treat all pediatric patients with the exception of major trauma (go to rooms 1 and 2 in major). Pediatric trauma alerts seen in the CED. Medical resuscitations will be placed in either room 42 or 43 of the CED. The Peds ED has 12 rooms. Our child life specialists are awesome and are there to distract/play with the child during procedures. There is also the Peds AEC that is run by NPs starting at 3pm to decompress the main peds ED during peak hours by taking the priority 4s and 5s.
Pearls:

- Ask lots of questions. You will learn faster the more stupid questions you ask, and it’s better to ask them early.
- Be nice to nurses and secretaries and LEARN THEIR NAMES. If you are good to them, they will be good to you.
- Attendings will probably be pretty diligent in seeing your patients in your earlier months. Everyone is different, so ask how they want you to present.
- Record your procedures (history number, date, attending who supervised you) - you will need to enter procedures in medhub - try to keep the online log up to date, ie enter procedures the same day.
- Don’t forget to log pediatric and adult traumatic and medical resuscitations. Anytime you are directing the care of a patient that requires invasive monitoring, significant IV fluids and medications, or airway management counts.
- Help with patient flow when nurses are busy or there is not a tech; change the sheets, bring patients back, and keep things moving.
- The ED gets very busy, but if you are worried about a patient or just need to catch the ear of an Attending, make sure you speak up. They may appear very busy or distracted but if you say “I’m worried about the man in room 8...not sure what’s going on with him, but I think he may be really sick” it will get their attention. We want you to feel comfortable doing this and the attendings like to know about sick patients sooner rather than later.
- Figure out a way to keep up with your documentation. Expect to stay back after a shift to complete your charts. You will get more efficient as the year progresses, but certainly do not expect to finish a patient’s chart before picking up the next patient. Everyone has their own method, and you will figure out what works best for you.
- In general, try to at least finish the HPI of your charting and then sign your chart. It should take you no more than 1-2 minutes to dragon dictate your HPI. Signing your chart allows the attending to write an addendum to your chart; some attendings prefer to start their charting before they leave their shifts.
- After signing your chart, you can “correct” the note as many times as needed until you are done with your charting. Do not hit “modify” note, this will place a true addendum on the note and prevent you from changing previous documentation.
- Try to stop seeing new patients 30 minutes before the end of your shift. However, if the department is slammed with new patients you are expected to continue to see new patients and can check out your patients to the oncoming resident.

Follow-up:

Follow-up can be a problem for emergency patients. Giving the appropriate numbers on the discharge instructions will NOT result in an appointment. Patients MAY (very rarely) be able to get in at one of the clinics if they are diligent and call more than once. If someone REALLY needs to be seen by a PCP soon, the “fast track scheduler” is in the ED from 11am-9pm Monday through Thursday, and can help patients get follow-up for some established Myers Park, North
Park, and Biddle Point patients (please see the guidelines in the ED), as well as for uninsured people or those without a primary care physician with acute serious illness (the list of diagnoses that warrant fast track scheduling can be found on the form that is filled out and given to the scheduler). They can also help with Orthopedic, OB/GYN and Dental clinic appointments. If it is after hours for the scheduler, the form can be filled out and placed in a folder that the scheduler picks up daily. Be sure you have 2 current phone numbers for the patient (ask the patient, as the number they give is not often the number where they can be reached). Our main Fast Track scheduler is Josie and you will work with her on almost every shift.

For Peds Myers Park follow-up, there is a folder in the Peds ED. You write their info and COPY THEIR FACESHEET from the ED and put it in the folder beside that day’s sheets. Use this only for urgent follow-up or people you think need to be seen within one week who are established at Myers Park or who live in Mecklenburg County and have no pediatrician.

OB/GYN follow-up is usually available (ED follow-up clinic is on Thursday). Typically call the OB residents to schedule patients for follow up, especially those requiring 48 hr beta-hCG checks.

Surgery clinic is a little slower but patients WILL get an appointment; if you think it needs to be urgent, call the intern on call.

**Consults/Admissions:**

FIRST ALWAYS ASK: WHO IS THEIR DOCTOR? Consults will be very upset if they come in to see someone and it is not their patient. If they have seen a doctor within the past 2 years then that person is their doctor. If you haven’t heard of their doctor, look them up in the computer, call their office, and find out if they admit to CMC (or just google them). This is important because we work with a lot of private physicians.

**General Rules for Medicine Admissions:** (please see the spreadsheet on the compendium)

IF:
- Patient has a PCP that is associated with Carolinas Healthcare System (i.e. tree-of-life practice): **CHG admits.**
- Patient has a PCP of Myers Park Internal Medicine OR the Medicine Faculty clinic (Charlotte Internal Medicine and Specialty): **Staff admits.**
- Patient has a PCP with Charlotte Medical Clinic: **CHG admits.**
- Otherwise, patient is **unassigned.** This may be a patient with a PCP not in CHS, or a patient with no PCP.
  - IF MRN ends with 1,2,3,4,5: **Staff admits.**
  - IF MRN ends with 6,7,8,9,0: **CHG admits.**

CHG will admit most “pure” psychiatric patients (i.e. no real active other medical issues). Patients being primarily admitted for a medical issue (i.e. overdose that can’t be monitored on 6B) can be split by the above policy. Staff medicine will admit ALL Myers Park Internal Medicine patients regardless of diagnosis.
In the case of aliases, i.e. Trauma Atlas, the ED will make every attempt to determine the patient’s name and have the medical record changed to it if possible. Otherwise, the number IN EFFECT at the time of the call from the ED to the admitting service will take priority regardless of the “real” medical record. Similarly, a patient’s PCP will be attempted to be determined prior to the call. If a patient is later determined to have a PCP that would have led to admission by the other Medicine team, the patient may be transferred to the appropriate team after a discussion between the on-call physicians.

Fragility Fracture patients will all be admitted to CHG or Orthopedics; see compendium for details.

Staff Medicine caps are still mandated by accrediting bodies. CHG will admit all unassigned patients after the teaching service is capped. Patients with Myers Park IM PCP will always be admitted by Staff Medicine, regardless of cap.

- CHG has coverage for a large number of primary care practices who do not have admitting privileges, including but not limited to North Park, Biddle Point, and Mecklenburg Medical Group. CHG also admits all psychiatric patients and ICH patients, unless they need acute neurosurgery intervention. (These policies change all the time, so look out for emails.)
  - The CHG coverage list is available on the Compendium; keep this handy
- If admitting psych patient to CHG and awaiting tele-psych (psych is not in house 24 hours), then you need to commit the patient so that they are not allowed to leave
- Charlotte Medical Clinic has admitting privileges, but they only admit up until 7pm, at which point CHG takes over. Between 7a to 7p, call their PCP or on-call attending immediately after evaluating the patient, and before starting your work-up. They like to know about their patients and can provide you with valuable information.
- Elizabeth Family Medicine & Biddlepoint patients will be transferred to CMC Mercy if admitted
- **There is also a new protocol to transfer CHG patients to CMC Mercy.** There is an algorithm posted in the compendium with specifics on transferring to Mercy. Essentially, try to transfer any patient to Mercy that is stable and does not require a specialist that is not available at Mercy. CMC Main operates at over 95% capacity year round and Mercy is only 5 minutes down the road and always under capacity. Patients have to agree to be transferred to Mercy; we cannot make them. To help with the “sell”, tell patients that they will be taken to a room faster, that there are less patients at Mercy so their doctors can spend more time on them, the rooms are all private (some double rooms at Main), and the ambulance ride is free.
- If patient needs dialysis, make sure to call Metrolina Nephrology
- Every patient you admit needs a diagnosis added. The secretaries will hunt you down the second you put in a bed request without a diagnosis.
- This information can also be found online in addition to other useful ED documents (there is also a copy of this list in all sections of the ED):
  - go to Synapse
  - click on “Team and Department Links”
  - click on “CMC Emergency Department”
Who to Call (generally the unit secretary will make all calls for you; ask nicely, but remember this is their job and do not take push back if they try to make you do your own phone calls): numbers not listed here are listed on a sheet of paper posted in each section of the emergency department with the attending schedule

- CHG – pager 8889 for admissions, 8888 for questions (text page)
- Staff Medicine – pager 0494
- General Surgery – pager 6868 for all surgery patients regardless of service
- Pediatrics – 704-512-7888 (through PCL)
- Ortho – pager 2591
- Trauma – pager 1165
- OBGYN – pager 4790

If you want to page consults yourself, there are updated pager numbers posted around the computers daily. To page dial 5-4088, and then the 4 digit pager numbers. However, this may slow you down as you have to stay until they call back. You have the option of dialing the secretary’s number as the call back number, then letting them know (nicely) that you have paged “so and so,” and you are now going to room “blank,” or find an Ascom so you can be called back directly.

Admitting/Bed Requests:
Once the patient has been accepted for admission, put a bed in for them on the computer. To do this, go on the 90% order page and click on “Bed Request”. To complete this order, you MUST know the name of the admitting physician (for CHG, it’s the name of the admitting provider and for Staff Med, it’s “CMC, Medicine (letter of team, A-F)” as well as the type of bed (regular, med tele, cardiac tele, progressive, ICU, etc). Be sure to ask your consultants these things before you hang up the phone. This is especially important when admitting to some of the private groups (Charlotte Medical Clinic, Surgical Specialists of the Carolinas)

Bunny Hop Orders:
Stable patients can be sent to an inpatient bed (“bunny hop”) without someone seeing them in the emergency department first. Ask every admitting physician you speak with if the patient is ok for bunny hop orders. In order to do this, the patient must be stable, not going to Progressive or the ICU, and meet a few other requirements. These patients should be seen within an hour of arriving to the floor, but this doesn’t always happen, so if you think a patient may not be stable, DON’T bunny hop them. In order to put in holding orders so the patient can go to the floor, go to the orders section and type in “ED Holding/Transition Orders”. Click what you want, then sign these orders, but DO NOT initiate them. The floor nurses will initiate the orders once the patient goes to their hospital bed.

Telepsych:
When an ED patient needs to be seen by psych, they will be seen by “telepsych,” which is a psychiatrist that speaks through the patient via an iPad. It can be a bit complicated going through
all of the steps for this.

1. Order “ED Adult Standing Behavioral Health Assessment”
   a. Wait for the icon of a bed with a P over it to turn green on the ED tracking board

2. Fill out & print the ERIC form (involuntary commitment form)
   a. This can be found on the Top 20 Page of the compendium
   b. You must complete the ENTIRE top section so the magistrate will not reject the form. This includes patient name, age, DOB, address, phone number, & young name
   c. In the large boxes, you need to use quotations. Don’t say “patient suicidal.” Instead say: Patient said “I’m planning to jump in front of a car.” It helps to use actual quotes from the patients
   d. Do not use abbreviations (SI, HI), or the magistrate will throw the form out
   e. There are red boxes around the sections that need to be filled out
   f. After you fill out the form on the computer, print it and ask the secretary to call the notary
   g. The notary will come watch you sign the form, and it will then be placed in the patient’s chart

3. Order “Consult telepsych”
   a. Many hours later, the patient will be seen by telepsych. You will know this has happened when the letters BH turn green on the tracking board. You can now look for psych’s note, where they will recommend either admission or discharge for your patient

**Charting:**

To start a note, go to the patient’s chart and click on “Doc Viewer and Power Note”, and then click “Add”. Make sure the type is “ED Physician Documentation”, then find a note applicable to the patient’s complaint. You can change the title of the note just under the note type.

*HPI:* Free text or use the click boxes for this; the click boxes are helpful for quick and easy documents like lacerations, dental pain, etc. (the click phrases also help with billing). Most people just Dragon the entire HPI.

*PMH/PSH/FH/SH:* Complete as much of these as possible in each box. Look at the info that is populated in the note previously, and add as necessary. Delete extraneous information.

*ROS/Exam:* DO NOT check things you haven’t specifically examined, and for pertinent findings, type it out. Be sure to look at the vitals that populate, and please include only the vitals for this visit. For ROS, check as least TWO in each box, do NOT place negative except for HPI for every system. And ask patients if they have any other symptoms, then check the box for “All Other ROS negative.” For PE, check at least TWO in each box that you did. Check everything that you review (triage notes, EMS notes, prior records, etc.)

* Labs/Imaging:* These will populate in the appropriate column if you open the “other” box and then click “[]”, and a list of results options will populate. Select the appropriate option (Lab
Results, CT Results, etc). Be sure to look at the ACTUAL film as well as the read…radiologists aren’t perfect! If labs/imaging prepopulate, be sure that you check “Labs Reviewed”, etc.

Vital Signs: Be very wary of sending someone with abnormal vital signs home unless you have a good reason for the abnormality. Don’t forget you can always ask the techs/RNs to repeat vitals, but beware they will not always tell you if vitals are abnormal at time of discharge.

Procedures: Check the appropriate boxes for procedures. Also document ultrasounds and include the statement “please refer to images and full report in SonixHub”. Write separate procedure notes on anything you DO to the patient (and be sure to write the time the procedure was completed).

Addendums: Anytime you re-examine a patient or add orders, you should add documentation and timestamp when you completed the re-exam. If you re-exam a patient five times, then you need to document it; otherwise it never happened in court. This includes walking by the intoxicated patient and just saying hello to see if they are alive and if they have sobered up.

Medical Decision Making: **This is the most important portion of your documentation.** Include what you thought about and what you ruled out, reasons for not doing additional tests – anything you need to explain such as why you stopped a work-up or canceled a test (i.e. family arrived and provided additional information). This will be beneficial to you and the patient if they come back with a different diagnosis than what you thought.

Impressions: Don’t forget to put your diagnoses on the last page of the chart. Patients can’t go upstairs without a diagnosis.

Macros: A great way to increase efficiency when charting. You can save things like normal physical exams, C-spine clearance, or other items you commonly click or chart, so you don’t have to repeat these each time. You can make these yourself, or you can use macros others have created. For example, if you were going to create a standard “normal physical exam”, you would click or chart everything you would want to include for that exam. You then right click on “Physical Exam”, and then “Save Macro As”. Then name your macro. When you go to another chart, an “M” will appear next to “Physical Exam” and you can click on that to access your macro in another chart. If you want to save text rather than part of the clicked chart, type something out, highlight the phrase, click “save as autotext”, and give it a title that begins with a period, such as “.macro.” In the future, if you want to add that phrase type “.macro” and the macro will be automatically inserted into your chart.

Orders:
Options for entering orders:
- 90% page (on the left sided taskbar of FirstNet). You can click the orders for the patient and then submit. Be sure you are doing this on the correct patient. Most common orders are on this page.
- Go to orders, click “Add”, and then type in the order.
- Order Sets – listed under “ED Adult - **” or “ED Peds - **. Available for things like DKA,
sickle cell, neonatal fever.

**Pearls:**
- Tell the patient’s nurse if it’s a time sensitive order (like transfusions, blood, etc) or if it’s a nursing communication (like you want the patient in restraints, or it’s ok to eat) to improve communication.
- Communicate with the unit secretary and nurse if you order an imaging study and then cancel it-for some reason; these don’t leave the transport people’s list of things to do, and you don’t want someone going up for a CT you don’t want.
- If giving more than one IV antibiotic, be sure to tell the nurse the order you want them administered. Don’t give an antibiotic that takes an hour to hang first.
- Use the tracking board to communicate

**Pharmacy:**
Think about whether your patient will actually fill their prescription when you write it – ask how they’ll pay for it before you write for expensive antibiotics. There are financial aid programs available at Myers Park – BUT they are not open on the weekend. If it’s the weekend or late at night, you can give a “mercy script” that will get them JUST ENOUGH medications to get them through to business hours. The prescription needs to be tubed to pharmacy. Do this as soon as you realize your patient will need it because it can take a while.

*Few prescription pearls:*
- Use the $4 or $7 prescription medication lists. You can frequently find this list hanging on the wall somewhere, but you can always look it up online as well.
- Get the NC Drug database access early. Helps with drug seekers. This allows you to see what controlled substance prescriptions have been filled by a patient in North Carolina. Remember not to be fooled, we are close to the border and drugs filled in South Carolina do not show up on the website; and not all pharmacies participate.

**Discharge Instructions:**
We have an electronic system for discharge instructions, which will allow you to select a diagnosis, discharge medications, follow-up, and any special instructions (including wound care, how to use crutches, smoke cessation, etc). Before you start you will go through a tutorial to help you become familiar with the system. Instructions can print in Spanish or English (select “English and Spanish” for Spanish speaking patients—this makes sure the official chart has an English copy). This system is a huge time saver but remember it isn’t perfect. Sometime patients have an unusual diagnosis, or something very specific you are concerned about. There is a custom form you can fill out in these situations which takes a little more time and will remind you how nice it is to have ready-made instructions.

**Important Numbers:**
Lidocaine cabinet (diag, major, AEC) 3240#
Lidocaine cabinet (peds) 1234
Supply closet 3240#

Major 52157
Diag 53271
AEC 58683
E Hold 53276
Triage 52167
PEDS 56579
LAB 59350
Radiology 52270
Psych 60238
Pharm 52434
Josie 54001
Overhead 71009
Dental 4165
Paging 54088
Operator 52000

How to call from outside hospital
Phone # 704-35 then last five numbers (if starts with 5)
Ascom # 704-44 last five (if starts with 6)
Cardiology

Overview: Historically this has been one of the interns’ favorite months, with 1 on 1 instruction from one of the best teachers at CMC, Dr. Littmann. Though Dr. Littmann retired from clinical duties in June of 2016, he has agreed to continue to give his incredible lectures to the interns. As a result, the rotation will now be a mix of Littmann’s didactics and bedside teaching by the Dixon attendings on the Sanger General service. As before, the rotation is M-F banker’s hours, so it’s a good time to get caught up on life, and spend time with friends and significant others that don’t work a crazy ED schedule.

Cerner Notes for Day 1: (from chart for “patient” named: ZZPowerPlanCMCLCH, Card)
- Staff Cardiology Progress Note
- Staff Cardiology Consult

Cerner Order sets for Day 1:
None for now. Check with your attending and/or NP on day 1 to find out what orders would be most helpful.

Service List: To be determined

Schedule:
In General: Expect to be at the hospital 4-5 hours per day (7-8 hours if you are the one taking consults). You can expect to be the resident taking consults 1-2 times per week.

Life Planning:
- You can take vacation during this month. If possible, try to take vacation during one of your more time-intensive months instead. This month is essentially like a month long vacation already.
- You have every weekend off during this month
- You will have approximately 10 back-up shifts during this month, including 1-2 weekends of back-up (most people do not get called in for back-up shifts, however, it is completely luck of the draw; so stay sober and within 30 minutes of CMC)

Schedule Interpretation (anticipated, subject to change pending your feedback):
- The day technically lasts from 7am to 5pm, Monday through Friday
- 7am-9am: Preround
- 9am-12am: Round with Sanger attendings
- 12-1pm: Set lectures
- 1-4pm: Follow-up on AM stress tests/echos etc. Intermittently will have half-days in sub-specialties such as stress testing, cath, EP, etc. Dr. Littmann will give lectures on random afternoons.

Pre-rounding: List averages about 20 people. Right now, plan would be for over half of the list to be covered by the PA. Thus remaining 5-10 or so would be covered by 2-3 residents (1-2 EM residents + IM resident). These patients are all in house cardiology consults. Ask to take the
more interesting cases, not just the pre-op clearances. Look for a-fib, SVT, ACS - anything you would find useful to know more about in the ED.

**Didactics:** Dr. Littmann’s lectures have historically been the highlight of the rotation, and we are extremely lucky to have his continued involvement in this rotation. The majority of these involve learning how to read EKGs. No need to read up on anything brush up on anything before his lectures; he will go through each part of the EKG and teach you how to read it in a methodic fashion.

**Clinic:** You will attend and see patients in the General Cardiology Clinic, which is Monday afternoons at Myers Park on the 3rd floor at 1:30pm. Save the cards clinic note template.
**Overview**: This is a great rotation: lots of learning, relaxed, time to read, and less responsibility as an intern. It is frequently considered the “best” rotation of intern year outside of the department. You have your own patients, but ultimately there is at least one upper level if not two on the team. You see a few patients every morning (ideally no more than 3, but some people saw 5 or 6 a morning depending on the number of providers on the team), and perform procedures that need to be done. Your pager doesn’t go on any charts, and each team has their own pager and ASCOM. You may carry these if you’re on long call, but while your team is still there, you can always ask them these questions. There are two resident “teaching” teams, MICU A and B, and two attending only services, MICU C and MICU N. You will be on A or B, which consists of 1 or 2 upper-level residents (either EM, IM, or FP), 1 or 2 interns, one attending, and possibly 1-2 medical students. There may be an ACP fellow as well. The format of your team will vary and depends on how many people are scheduled in the MICU for that month. The attending changes every week starting Monday; be prepared to give a fairly thorough presentation on your patients when a new attending comes on. Each attending has specific preferences. If there is one EM intern and one EM upper level on for the month, the EM upper level is probably on the other team so as to allow you to do your nights with the EM upper level, and prevents a single team from being left with one resident for several days at a time. Some months will have two EM interns or two EM upper levels on, so you may get paired on the same team if that is the case.

**Nights**: Currently, the interns have stopped doing MICU nights to help out scheduling with the IM residents. This is currently in flux. Those of us who did MICU before this change felt that nights were when we got most of our procedures, and usually got to work with the EM upper level as interns, which was really fun. We are continuing to advocate for EM interns to work nights, but know this decision may not be fully made until later your intern year.

**Cerner Notes for Day 1**: (from chart for “patient” named: ZZPowerPlanCMCLCH, CritCare)
- MICU Progress Note
- PCC ICU Admission Note
- PCC ICU Consult Note

You are also allowed to use the dictation service to write H&P, consults notes, and death summaries.

**Cerner Order sets for Day 1**:  
- CRIT Admission ICU (contains many of the below PowerPlans)  
- ADULT CRIT Pain and Agitation Management of Mechanically Ventilated Patient  
- ADULT PHARM Subcutaneous Insulin Non-Pregnant  
- ADULT PHARM Subcutaneous Insulin Patient NOT Eating Discrete Meals  
- ADULT PHARM VTE Prophylaxis  
- CRIT Vasopressor Infusion – Norepinephrine 16 mg – NS 250 mL Drip  
- CRIT Vasopressor Infusion – Vasopressin 40 units – NS 250 mL Drip  
- CRIT Vasopressor Infusion – Epinephrine 4 mg – NS 250 mL Drip
**Service List:** You can set up one, two or three lists. Some people combine both A and B into one list, some people have a Consult A and Consult B list, and some have an A, B, and combined list.

Provider Group → Consult MICU A ± Consult MICU B, Discharged Criteria → Only not discharged

**Schedule:**

*In General:* Expect to work 8-10 hours on short days, 13-14 hours on long days, and 13-16 hours on night shifts.

**Life Planning:**
- You get 4 (sometimes 5) days off during the month in addition to 2 post-call days (assuming interns are doing nights).
- If you need a particular day off, email Mary early and ask to be forwarded to the MICU scheduler.
- You can request your 2 days off in a row if you request early
- You can also switch shifts with the other interns

**Schedule Interpretation**
- 6-8 day (long) shifts, 12-14 short shifts
- 4 night shifts (in 2 groups of 2 nights, pending, see above)
- All interns will receive a total of 4 days off
- 1 day off after each group of 2 night shifts
- 2 days off assigned randomly
- Arrive at approximately 6am each morning to complete pre-rounds and receive sign out from the night team.
- Rounds typically start at 0730-0800 each morning, but this is attending dependent

**General Tips and Hints:**
On months where there are 4 upper levels, long call intern/residents stay until 1900 when the night team comes in. Short call intern/residents can leave when rounds are over and all your work is finished, usually around 1600-1700. Some days, this is as early as 1400 hrs (depending on the attending, you might be able to leave by noon on weekends if the list is short and the attending is cool).

For months where there are three upper levels there will be a gap period of 3.5 hours in the evening from when the long resident leaves at 5:30pm and the night resident comes on at 9pm. This is in place because to keep all the nights covered and prevent the upper levels from violating duty hours. As an intern, if you are long, you leave with the long resident at 5:30pm. If you are scheduled for nights, you come in at 7pm. This can vary month to month, so be sure to check the schedule in Medhub to know exactly what is expected your month.
You will be assigned (typically) between 2-3 patients every morning, usually the same you saw the day before. As interns, they do not want you seeing more than 3 patients, but this is dependent on the patient load. In theory, they do not want upper levels seeing any more than 5 patients. Try to finish your notes before 8AM, when walking rounds generally begin. The attendings would prefer for notes to be finished and signed by at least lunchtime, when they generally start to write their addendums (as you may round all morning, this is why it is easiest for you if your notes are mostly finished prior to starting rounds). The post-night upper level (depending which system is being used) and the post-night-intern present first, and then can go home.

You are expected to talk to the family members of your patients at least once per day. Sometimes this is hard when the families don’t visit. Call the power of attorney or decision maker to give them an update and answer any questions. Building rapport becomes crucial in the event you need to discuss end-of-life issues with the family. This can be the most rewarding and the most frustrating part of the month.

Take advantage of the nurses - they know a lot about their patients and may express specific needs or concerns to improve patient care. They are experienced and their requests deserve consideration at the very least. Trust us when we say they frequently know more than we do as interns. The nicer you are to the nurses the more they help you out. ALWAYS ask the nurse every morning what happened overnight with your patient. They only have 2 patients at a time, so they know everything that goes on and will have updates about drips, etc.

Nursing sign out is at 0700 every morning. Try to talk to the nurses before this, as interrupting their sign out won’t make you any friends.

The MICU day/long call team is responsible for responding to in-hospital codes during the day. The night team responds to codes at night. The short call team is not responsible for codes, but you should also go. Your role during these codes can be to do procedures, lines, intubations, CPR, or running the code. The team pager will go off for all codes. Before any code pagers go off, however, the code will be announced overhead, and it’s hard to miss, “code blue, 7 tower”. Listen for it and go immediately if you hear it. Otherwise your upper level will try to let you know when something goes down. There will usually be an upper level with you and they are generally responsible for “running” the code, but may dole out responsibilities. If you want, ask the upper level on the way to the code if you can run it (assuming no one else already is). This is a great time to practice this skill outside of the well-organized major resuscitations in the ED. Be aware that the respiratory therapists will intubate the patient unless you tell them you’re there to do it; codes on the floor are the holy grail of respiratory therapy, and the only chance they ever get to tube someone. They’ll do it unless you step up. Get in there, pick up the laryngoscope, and start asking for your intubation equipment. As a general rule, codes on the floor are disasters; there are 50 people around and nobody is doing anything useful for the patient, so you’ve got to be assertive in these situations in order to get in position to do anything (goes for lines, intubations, etc). Generally, these patients that code on the floor will come to your MICU team as transfers if they are resuscitated.
New admissions (transfers or admissions via ED) are assigned by the attending carrying the MICU pager that day. They usually try to keep things somewhat balanced with respect to each team’s list. When you get an admission, you are expected to go with the upper level to evaluate the patient, come up with an assessment and plan, and begin to work on the consultation report and orders. Occasionally, you will be doing urgent procedures at these times as well. If there isn’t a lot going on, you and the rest of the team can do this together: one person do orders, one do the note, one do procedures. Sometimes, only one person will be available to go, so you may have to do it all yourself.

**Call days:** Interns will take “call” or shifts with the upper levels. Usually it’s one intern from one team and one upper level from the other team. This means that you are responsible for admitting patients and dealing with issues that arise. Typically, your short call teammates are there until about 1600 or 1700 and will help you out until then. After that, they will sign their patients out to you ± the upper level that’s on call that day. From then until 1900, you are responsible for handling issues and taking new admission. You may want to switch your call days around to get certain days and weekends off. Some people try to switch so that the EM intern/upper levels work together on call shifts.

**Didactics:** Frequently, on Tuesday, Wednesday and Thursday, one of the attendings will lecture from 7:30am-8am before rounds start. On these days, you have a little less time to see your patients and do notes. You may have to work on notes after rounds, but as the month goes on, you will become more efficient and should be able to complete them before rounds start.

**Sources of Patients:**
- From the ED.
- Transfers from other hospitals (ICU to ICU for higher level of care).
- Staff medicine team needs a higher level of care for a patient.
- Private attendings (usually CHG) consult the ICU team.
- Sometimes, you will be consulted just for a procedure (Vas-Cath placement for plasmapheresis, etc), other times you will be consulted to offer assistance (intubated patient on pressors in the bone marrow unit) or just take over a sick patient. Any time someone goes on pressors in the MICU, that is supposed to trigger a MICU consult.

**Sign-out:**
Because we are doing complete shift work now, sign out is essential. The sign-out is often located as a Microsoft Word document on the right-most computer on the MICU low-side (outside room 10602); however, this may change throughout the year. Some months the A and B teams split between the high and low side (A on low, B on high, etc) and the sign outs will be on one of those computers. Some months you will and some months you will not utilize this tool. The medicine teams prefer a verbal sign out on everyone, but make sure to update the paper handoff too. If your team elects to use this sign out document, open the document and update the sign-out on your patient’s daily. It is especially important to remember to do this prior to leaving in the morning if you were on the night before.

**Important Numbers:**
- MICU A
  - Resident pager: 8831
  - Ascom: 67072
- MICU B
  - Resident pager: 8832
  - Ascom: 67073

**Pearls:**
- On MedHub and the Compendium under ICU documents there are multiple handouts about Ventilation, Blood Gases, Pressors, etc. These are very helpful broad reviews. The ICU Book by Paul Marino is a good reference with copies in the EM resident lounge. All the lectures they cover in the month generally have a guideline already on MedHub.
- CMC has an open ICU policy – Patients requiring an ICU bed may be in any of the four main ICUs: Dickson Cardiac ICU – (7th floor), Neuro ICU (9th floor), Medical ICU (10th floor), and Surgery ICU (11th floor). Patients may also freely move from the floor or progressive to ICU and vice versa without necessarily needing to consult the critical care team.
- There are 2 sides to the MICU (10th floor)—Low Side, comprised of bed numbers 10601 to 10615, and High Side, comprised of beds 10616 to 10630. The same is true of the 9th floor NSICU and the 11th floor STICU.
- There are two supply rooms in the MICU, one at each end of the hall. The code for both doors is 2-4-1-* (you can remember this by “2 for 1 sale”). There is a procedure cart in each room that can be taken to the patient room and houses most, if not all, of the supplies you will need. **DO NOT TAKE THIS CART OR ITS DRAWERS INTO ROOMS OF PATIENTS ON MRSA/CRE/CDIFF ISOLATION!** The whole cart has to be deconned afterwards and any drawers taken out/opened in the room have their contents discarded. It’s a stupid rule, but the nurses, especially the charge nurses, will make sure you don’t forget that you just wasted several thousand dollars of supplies. The ultrasound is located in the "fishbowl" between the Low Side and the High Side. You can also steal the NSICU US on the 9th floor.
- Jump in on procedures. Procedures within your scope include all varieties of central lines, intubations, arterial lines, lumbar punctures, chest tubes, para- and thoracentesis. Offer your services, as many of the IM and FP residents simply don't want procedures. Pipe up to do chest tubes too as not even MICU attendings do them often and many times they get CT surgery to do them. Also, you can do procedures for the other MICU services (namely MICU C, an attending-only service); the attendings are by themselves, and if you offer they will more than likely take you up on your offer. And don’t forget about Dickson ICU, an ED 2nd yr is there and if you let them know, they will call you to help place lines.
- A good basic ICU book is Marino. There are multiple copies in the library. Some chapters are outdated, but the pulmonary section in particular is good. Make sure you leave the MICU understanding the basics about ventilators.
- Although you are not the one in charge, ask to run codes to practice, etc. Ask lots of questions – it helps you learn, stay focused and prepares you for next year.
- Pay attention! You will be there next year as the upper level!
OB/GYN

This is one of the more time-intensive months of the year. Your time will be divided between OB-Triage days/nights as well as clinic. You work with attendings, residents, ACPs, nurse midwives, and nurses. There is a lot of ice breaking. Humility, in particular, will allow you to establish an excellent working relationship with the many nurses with whom you will be working very closely. The nurses in OB Triage function independently for the private patients. Therefore it is wise to seek out their advice and expertise. If they are worried a woman is about to deliver, she probably is!

The OB service has a great “intern survival guide” that is detailed, outlines exactly what you should know, and includes the workups for each patient. It is your cookbook and lifeline. Read this before the rotation. Keep a copy of this handy, by paper or electronically, to help make decisions. Often you are the primary doc working in OB triage without an attending like we have in the ED.

Notes to Have on Day 1: (from chart for “patient” named: ZZPowerPlanCMCLCH, OB)

*** It is helpful if your H&P template is an exact template of Karen Helms, CNM, or another resident’s. You spend a lot of time populating data into these notes and if they match you can copy forward more easily

- OB History and Physical
- OB Post Partum Progress Note
- OB Delivery Summary
- OB Discharge Summary
- OB Rounding Template
  - This is a template which helps with prerounding in the AM. It is paper rather than a Cerner note. It can be found on the compendium, and is often in the 8A nurses station if you ask someone there for a copy. Often, the OB interns have a copy they will send you.

Order Sets to Have on Day 1:

- OB STANDING Triage Orders (Ask Karen to go over the presets to save, like removing PRN adapter, adding POC glucose, adding POC Urine dip, etc)
- OB Intrapartum (Admission orders, add a STS and CBC to everyone you bring in)
- OB Vaginal Delivery Post Partum
- OB Discharge Vaginal -> Steal from an OB resident’s favorites
- OB Discharge C/S -> Steal from an OB resident’s favorites
Service List: Provider Group → CMC OB, Discharged Criteria → Only not discharged

Schedule:

In General: Expect to be working from 5:00 am until 5:00 pm. 4 days off for the month

Life Planning:

- Reasonable to request a specific weekend off.
- Possible vacation eligible month (usually 3-4 months per year are eligible).
- Email the OB scheduling chief as soon as possible if you have specific day requests; they require schedule requests very far in advance.

Schedule Interpretation

- Triage: 5:00 am - 5:30 pm, you are there until sign out at 5:30 pm ends
  - Deliver the low-risk babies
  - Work as the Triage doc
  - Write delivery summaries & place postpartum orders
- Board (“Bored”): 5:00 am, staying until 5:30 pm sign out ends
  - You cover floor issues for postpartum patients, make sure the charge nurses know about discharges, and may have to see consults. An easy day.
  - Carry the Mommy Line Pager
  - If there are GYN consults you may be asked to see them; there may be 1-2
  - Try to follow up on anything the rounding team left unresolved
  - You can make the next morning significantly better if you start entering discharge follow-ups and meds in the downtime, anticipating discharges.
  - The board intern should try to write discharge summaries on all postpartum patients that are going home soon. These are easy to do in downtime and help your team out in the morning immensely.
- Clinic: Starts at 8:30/9am. You still have to be at the hospital pre-rounding at 5:00am. Day ends anywhere from 4-6pm
- Nights: 5:30 pm (or whenever PM check out occurs—see OB’s intern survival guide, timing varies by weekend vs weekday) until 7:00 am morning check out
  - You cover the post partum floor, delivery low-risk babies, and are the triage doc. Also covering the mommy line—everything but consults
  - If you work a night that ends on Saturday or Sunday morning, you will unfortunately post partum round as there is only one other intern. This can be rather taxing so start seeing patients in the early morning hours if triage is slow

Note that PM sign out changes based on the day of the week, see the OB schedule/guide for specifics

Detailed Daily Schedule:

- Arrive anywhere from 4:15-5:30 AM (depends on patient load), hopefully the overnight intern texted everyone with the number of postpartum patients around 4/430am - this will help you gauge how early to start
- Cherry picking—generally, he who arrives earliest gets to pick easiest. Depending on what your co-interns do that month, if you arrive first, you may sign up for whomever on
the postpartum packet up at 8 tower. Depending on how helpful you want to be to your team, you can decide if you want hard interpreter (Nepali, Burmese, French) patients or former high risk patients on 8 DE vs. relatively straightforward 8 tower patients, many of whom speak Spanish. Of course, sign up for your fair share (if there’s 24 patients and 3 interns, choose 8—duh)

- The interns all round on the post partum patients. A list is made by the upper level overnight residents to help guide you on which patients to see—on overnight, find that upper level at around 2am to make the list for you so that you can text your friends the list size.
- AM board checkout is at 7:00 AM in the conference room (one of the first doors on the left of 8A; has badge access panel to enter). You are expected to have seen, rounded, written your notes, and placed any orders/discharges that need to be done on your folks.
- During the week, you will have multiple interns to help with morning rounds, but on the weekends there is only one call intern and one overnight intern, so you likely need to arrive earlier on the weekends to make sure everyone is seen on time. While you should try to complete as many notes and orders as possible before AM checkout, it is difficult to accomplish when you may have 20+ postpartum patients to see.
- ~730-830am. After board checkout on the laboring patients, the attending will stay and interns will discuss the low risk postpartum patients.
- There is a pre-rounding tool made by prior ED interns that outlines all of the information you need to collect for these presentations on the Compendium
- After rounds, one intern presents a topic. A random and rather unorganized schedule will be emailed to you, probably right before the rotation begins. It’s about 10 minutes, do your best to find an ACOG guideline / UpToDate something and make a one page handout. Expect a lot of attending correction. If you’re scheduled for a talk while on nights, don’t bother and don’t even mention it, you leave right after board checkout.
- Finish floorwork, clinic interns go to Myers Park, day call intern prepares for a day of deliveries in OB triage.
- Board intern will check in with the charge nurses from the post partum floors (8T, 8D) to let them know which patients are going home, and what needs to happen on each low-risk patient for the day. After this, follow up on things clinic interns didn’t finish, and answer floor pages. If there is an ED consult you may be deployed—rare.
- Remember, AM and PM board checkout are at different times during the late week and weekend! Double check with the upper levels so you’re not caught off guard!

General Tips and Hints:

- The OB/GYN residents have made a comprehensive intern survival guide that outlines how they would like patients worked up, labs, and general management strategies. You
should have a version of this available when you’re in triage, and read it before your rotation

● Because of the above, we have elected to not include tons of patient workups here; because OB changes this guide year-to-year and it is in your best interest to perform the workups they expect

On-Call Tips and Hints:

● Your workstation is in Triage. You can sit with the nurses or at the mid-level desk
● Shoe covers are essential. Consider keeping sterile gloves in your back pocket. The delivery calls come right before the delivery and you walk quickly to them.
● Mommy line calls are irritating. Don’t let PCL direct connect you to the patient. Obtain from operator and write down:
  ● MRN
  ● Patient call back number
  ● Chief complaint
  ● Hang up, look up patient’s stuff, personally call them back
  ● **You do this for two reasons. 1, so it isn’t recorded. 2, you have time to look up the patient’s dates, PMH, medications, etc
● Follow the OB survival guide procedures and if you have questions call the patient back after you talk about it with your upper level
● Remember, after a delivery you need to write the delivery note (baby’s sex, weight, APGARs, and any lacs you repaired. Because it’s a pain to find, it’s nice to steal a sticker and write these numbers on the edges.
● Placing postpartum orders is rare, usually covered by a multiphase PowerPlan orderset at admission to L/D
● Know how to one handed knot tie in case you’re asked to repair a vag lac—rare
● When you are on call it is your job to remember to bring the master list (that you find on 8T in the AM while you preround) to the conference room for the attending during table rounds.

Triage Tips and Hints:

● M-F 7 am until 11 pm there is a mid-level in triage. You will staff patients with them—usually Monica Murdock PA or Karen Helms CNM (Certified Nurse Midwife)
● 11 pm - 7 AM and at all times on the weekends you staff with the on call R2
● In either case, have completed or initiated your workup before speaking with them; again, follow the guide they provide you—it’s a cookbook
● Ask the nurses about reading FHR strips; they are all pros. Let the R2 know what kind of strip they’re dealing with for admissions, as well as contraction frequency. Just look for
decels and variability

- If you have concerns somebody may deliver in triage, obviously let them know sooner. If you have concerns about a strip, let them know sooner as well
- Triage can get hectic at times, especially on the weekends. Try to figure out dispo and keep people moving. Many times you will be told to send women home that you think need to stay; this is part of the rotation, but difficult to explain to the patients and their families.

**Post-Partum Rounding Tips**

- Ask the overnight person to text out the number of patients and number of rounders; this may buy you additional sleep. Usually you’re in around 5:00-5:30 AM
- Gestational diabetics will usually be seen by endo, but their recommendations will be as a corner sticky note (on the patient list screen by their name, right click to view).
  - There is also a discharge sheet you must fill out for GDM women; ask for help the first time but you basically put in what the endo team recommends
  - Usually we see these women back in 8 weeks for a post partum check and OGTT visit
- Lactation consults are placed for you automatically
- If you have any concerns about the patient, their ability to care for the child, any h/o domestic violence, teen pregnancy, or late prenatal care, order a social work consult before D/C
- Rubella nonimmune women will need a MMR at discharge
- Consider making a Conditional Discharge order your favorite that says “EPDS needs to be completed prior to discharge.” The d/c summaries require that the Edinburgh Depression Scale score is recorded. It’s hard to find, it’s under Flowsheets, Assessments tab, then click Psychosocial on the left sided tabs
- If a patient’s EPDS score is high, you must personally (the nurses will not) perform a MADRI score on them; though time consuming, it may save a psych consult for you. Especially in the Spanish-speaking patients, the EPDS score is often questionable
- C-sections usually go home on POD#2/3; staples can often be removed before they leave. Sutures dissolve and do not need to be removed usually.
- Vaginal deliveries CAN go home as soon as 36 hours, but usually more around 48 hours. It is helpful to discharge those that can go at 36 hours to keep your list small, but remember GBS+ women need 48 hour monitoring for the infant, so they’re staying
- Offer everyone some form of contraception. Most of the attendings like to at least call in an OCP for the patient in case they change their minds from abstinence after discharge. Often you can at least prescribe Plan-B
- Print your narcotic rx and drop them off at the patient’s hard chart. You can call in all the
scripts except for narcotics; it’s poor form to leave this for the board intern
  ○ Postpartum vaginal delivery usually does not get narcotics, except for lac’s
● Be sure to tell the board intern any labs or things you have pending on people

Clinic Tips and Hints:
● Clinic is hard. Breathe and accept that you’re going to be bad at it. Much of it is logistics you’ll never quite grasp, and it involves lots of paperwork. Just keep a good attitude and the nurses can help you.
● After postpartum rounds head over to Myers Park; clinic is located on the 2nd floor, but difficult to find. Try to go with one of the seasoned family or OB interns on day one
● Each type of visit has a specific form to fill out; it begins with new OB and then they add progress note sheets. Make sure you touch on each problem at each visit, because when you’re in triage seeing a patient & you look everything up it helps if whoever saw them last made a concise list on the last progress note with the active plans
● Check the back sheets for labs; it tells you what and when to order things. The OB clinic nurses will help you fill out the forms to order the labs and ultrasounds
● You may also have to see GYN patients in clinic, or well-woman annuals

Board Intern Tips and Hints:
● Your main duty is to discuss discharges with the 8T and 8D charge nurses, and to make sure the team’s plans get completed with regards to labs, consults, and pending discharges.
● Be a team player and tee up patients for D/C if you have PPD#1 or 2 patients who are staying.
● WRITE DISCHARGE SUMMARIES. This is an easy no-brain activity that will save your team so much time and work. Write them for anyone going home the next day.
● This is a good day for reading, projects, and catching up on things, but you do need to be in the hospital and have your pager on. You can help out in triage if they’re getting swamped.

Important Numbers:
● Nursing Stations:
  ○ 4B/4B Nursery: 56540  8T: 52052  8T Nursery: 56118  8APC: 54055
  ○ 11B: 56312
● MP OB/GYN Clinic: 61544
  ○ After hours: 61978  Triage RN: 61518  Fax: 61550
● Labor and Delivery
  ○ OB triage: 54053  8A: 56281  8B: 56282  8L: 54005
● OB Ascom Phones
● Interpreter
  ○ Day: 53131  Night: pager 1726
- Misc
  - Lab: 59350
  - Pharmacy: 52434
  - Bed Management: 52123
  - Paging System: 54088
  - Paging Operator: 52443
  - Radiology: 54614
  - Dictation: 36600/704-358-6788
### Pediatrics – CHIPS Team A/B

**Overview:** In general, the business in Peds varies drastically with the time of year (i.e. If you're on the docket for Oct-Feb, prepare to be slammed) but regardless, you can expect to put in 65-80 hours/wk. This is a typical resident style ward month similar to those you had in medical school. You will round with the resident team and are expected to confirm orders with the upper level residents. The peds folks are very nice but they are big-time hand-holders, sometimes. Warning: Depending on your team, do not attempt to make any decisions, great or small, by yourself. There are also “teaching patients” on this service, which are patients covered by the cardiology, pulmonary, and endocrine services. If you have a teaching service patient, you will round and present your patient with both the peds team and the other service. You have less autonomy on this service compared to the C/D/X teams. You cao at 8 regular patient and can have up to an additional 2 teaching patients.

**Before you show up on day 1:**
- Complete iPASS orientation *MUST*
  - iPASS is a system you will be expected to know for the sign out process while on CHIPS. They will send you an email with required orientation info and a "test". Don't fight the man. Just do it. Because of this system, your signouts will be thorough but at times extremely redundant and lengthy when you listen to others. Be prepared to be exasperated. At times one of the attendings will observe the team checking out in order to give feedback on how appropriately or inappropriately they are utilizing the iPASS system. *sigh*
- Call for sign out on your patients from the outgoing intern *MUST*
- Download templates

**Cerner Notes for Day 1:**
Look under ZZPowerPlanCMCLCH, Pedsmed or under ZZPowerPlanCMCLCH, ED
- Pediatric Progress Note
- Chips H&P Template
- Pediatric Discharge Summary

**Cerner Order sets for Day 1:**
- Peds MED General Admission
- Peds Endo Diabetic Ketoacidosis Admission
- Peds MED Psychiatric Management Orders
- Peds PULMO Asthma Exacerbation
- Peds PULMO Bronchiolitis
- Peds MED Fever under 28 days old

**Service List:** You need three lists for this rotation
- Provider Group → CHIPS A, Discharged Criteria → Only not discharged
- Provider Group → CHIPS B, Discharged Criteria → Only not discharged
Schedule:

*In General*: You work 6 nights in the month, are on call about 1-2 times per week, and have 2 weekends (Sat/Sun) off. Expect to work M-F every single week and Sat-Sun for 1-2 weekends in the month.

*Life Planning:*

- You get assigned 2-3 Saturday/Sunday combinations off for the month. Whether or not you get to choose depends on the chiefs for that year. This year the answer was no.
- Absolutely no week days or vacation off this month. This includes trying to schedule Step 3
- In general, you get out on time each day and are rarely stuck late, so you can plan your evenings.
- Regular days you sign out when your work is done, usually around 4-4:30pm. Call days you stay until 7pm signout and leave around 7:30pm. On nights you work from 7pm through morning report and leave after you round on your patients first, usually you get out at 8:30am.

*Schedule Interpretation*

Regular day: Every day shift starts with group checkout at 6am. 6:30a-8am is pre-rounding on your patients. 8a-8:30am is morning report. 8:30am-9am is radiology rounds with the team. 9-11:30am is team rounds. 11:30-11:45am is cardiology rounds. 11:45am-12pm is pulmonology rounds. Finish rounding at noon and do your work from noon to 4pm. Tuesday and Thursday have extra teaching at 2pm. ED residents don't have to go to the 12:30-1:30 peds conference daily. Check-out around 4-4:30pm.

Long call: Same as regular day except that you stay and admit patients for both teams until 7pm. You have a supplementary that helps you admit from 5-7pm so that you don't get stuck with a late admission. The interns leaving at 4p will sign out to you and you will cover their patients until 7p.

Nights: Starts with checkout at 7pm. You cover both teams at night and admit all new patients. You signout to the team at 6am and have to stay until 8:30am morning report ends. Occasionally you get an admission between 6:30 and 8am. You often have time to watch a movie on nights so be sure to bring some. There are also call rooms to sleep. You leave after morning report. Except on weekends or your last night call, when you have to round with the team and leave by around 10am. Again, supplemental intern will be there from 5p-10p to help.

Weekends- There will be 1 intern from either the A or B team to cover on the weekend. When you are that intern the list of patients will be divided between you and the overnight intern. After rounding and floor work you will take admissions and cover the floor for the rest of the day. Supplemental will be there to help and are crucial while you are trying to round.

*General Info:*

ED residents have no clinic responsibilities but you are expected to wear “clinic clothes” all days except when you are on call. Additionally, when the other intern on your team is in clinic you cover their patients for the afternoon.
You should get checkout from one of the current month’s interns. You should call 11363 to find out which intern you will be getting checkout from, and arrange a time you can meet up before the start of your month.

Room 9036 (door code 7337*) is your home base for the month. Take the main elevators in Levine's (called the Marble elevators) to 9th floor, and look for 9036 in the vestibule area outside the main ward. Team and patient assignments are posted on the board in the rounding room (room 9036) the night before the new month. Check out is here at 6AM every day, after which you have time to pre-round on your patients.

**Team Composition for A/B:**

*Organization:* CHIPS A and CHIPS B each have 2-3 interns (see figure), as well as one mid-level peds/FP resident and one attending. That's the group you will round with each morning. There is also a 3rd year "Ward Chief" that oversees both A and B and rounds with the post-call team.

*Weekday Schedule:*

- **0600: Morning Checkout and Pre-rounds (LCH 9036)**
  - Night team distributes workload evenly between A/B Teams, students and interns.
  - Night team intern, PL2 and PL3 update the Day team interns, PL2s, PL3 and students on all patients. Begin with the team who is on long call. Review all established and new patients.
  - For new patients, Night Team hands the accepting Day intern a copy of the H&P and highlights only pertinent issues.
  - Begin progress notes for all CHIPS A/B patients and review in detail pertinent vital signs, I/Os and patient status.
    - If you can finish your notes prior to rounding, print these off to help you round on your patients. Most days you will not be able to finish notes until after rounding so write down pertinent info to present at rounds with a good assessment and plan.
  - Prepare prescriptions and discharge paperwork for patients likely to be discharged on rounds – this often involves sending prescriptions to Med Center Plaza Pharmacy to then be delivered to the patient’s room prior to discharge.
    - Your PL2 will often do this for you while you are prerounding but make sure to confirm
  - Overnight intern does admissions between 0600 – 0800 unless supervising resident delegates to another person.
- **Wednesdays:** Grand Rounds 0730, Radiology 0830, Attending Rounds 0900.
- **0800: Morning Report (LCH 1st Floor**
  - Led by the Day and Night PL3s. All team members are expected to attend. Night Team leaves at 0830.
- **0830: Radiology Rounds (LCH 3067**
  - Have a ready list of patients with studies to be reviewed; include PICU transfers with old studies.
  - Primary student/intern provides MR#, studies to be reviewed, and brief history (6mo with T103, RR 60, wheezing).
0900: Attending Rounds
  o Get a laptop to assist with presentations, viewing results / films, and entering orders.
  o Bedside “family-centered” presentations; PL2 will call nurses for each patient.
  o You are expected to discuss/negotiate the plan with the family, including goals for the day, and identifying goals for when the patient will be able to be discharged.
  o If it is not your patient, you write goals for the day on the whiteboard for the family.
  o PL2 will enter orders (that you haven’t already entered) and update your hand-off tool for each patient on their laptop.
  o If unable to see all patients as a team, discuss and have a plan for every patient by 1130.

1130: Cardiology Teaching Rounds (LCH 9036)
  o Each intern following a Cardiology patient will round with the Cardiology attending (max 3 patients).

1145: Mid-day Checkout (LCH 9036) only for patients followed by interns who will be leaving for Continuity Clinic.

1230: Lunchtime Conference (MEB-4) – **Our conference is at 12, so speak up!**

1330: Resume patient care
  o Admit and staff new patients; read and discuss topics of interest with supervising residents and attending.
  o Reassess patient progress; follow up studies and consults; update families; complete d/c summaries, call PCPs.

1400: Thursdays: Cardiology attending didactic session in LCH 9036 (30 minutes).

1600: Afternoon Checkout by interns, PL2 and PL3 to the long call intern and PL2.
  o Cardiology attending will page #1361 to provide checkout to the short call intern (max 3 patients).

1700: Supplemental Intern works ~1700 – 2200. This is a Peds intern to assist with admissions.

1900: Evening Checkout (LCH 9036) by short call intern and PL2 to the Night team (intern, PL2).
Weekend Schedule:

- **0600: Morning Checkout and Pre-rounds (LCH 9036)**
  - Night Team updates Day Team & supplemental intern on established patients.
  - Day Team evaluates established patients. Night Team re-evaluates new patients as needed.

- **0730: Attending rounds**
  - Night Team intern and PL2 divide new patients between Teams A and B. One rounds with Team A, the other with B.
  - Night Team intern and PL2 present new patients, then leave by 0900. (No mid-morning checkout)
  - The Day Team intern rounds with her/his usual team, while the visiting PL2 rounds with the other team.
  - Supplemental intern admits A/B patients from 0630 – 1200. Rounds with both attendings on established pts.
  - Night PL3 provides checkout for Subspecialist attendings (Heme/Onc, GI and Renal), then leaves.

- **1130: Cardiology Teaching Rounds (LCH 9036)**
  - Cardiology attending integrates checkout to the short call intern into teaching rounds (max 3 patients).

- **1200: Supplemental intern begins to admit new patients for Heme/Onc, GI and Renal; staff directly with Subspecialist attending.

- **1900: Evening Checkout by Day intern and PL3 to Night Team (intern, PL2 and PL3)**

- **2000: Night PL3 calls Subspecialist attendings (Heme/Onc, GI and Renal) to request checkout.

- **2200: Evening discussion between Night Team and the on-call CHIPS attending (Team A on odd nights, Team B on even nights).**
Daily Routine Pearls:

Overall, this rotation is very rounding-oriented so prepare yourself. It is easiest if you can pre-write your notes and “save and close”, then finish them with any updates from rounds. You do, however, need to have numbers (i.e. vital signs, I/O's, etc.) and a brief plan on all your patients. You need to finish pre-rounding before 8:00 am.

Staff / Attending team rounds: Format will vary depending on your attending; some do sit-rounds first, some gravity rounds, some in Progressive first, etc. If you are post-call they usually round on all your patients first. Some attendings will give mini-lectures at random points throughout the day, just roll with whatever the team wants to do.

"Teaching" patient rounds: This is very confusing; you will not figure it by the end of your rotation so just go with the flow. If you have a teaching patient assigned to you, you will pre-round on them before 8am. If there are major issues, you should call the attending for that patient on either heme-onc, renal or GI. Otherwise (minor issues or pulmonary pts), just try to leave your note early on the chart so that when that attending rounds they have your note. Most of the time you have no idea what the plans are for these sub-specialty patients so just call that attending when in doubt or have questions. For the renal patients, you will be expected to know all of the details and should plan on calling the renal attending (Dr. Massengill or Dr. McKay) for ALL management questions and to discuss the plan on a daily basis. You are required to dictate discharges on everyone except heme-onc and pulmonary patients. Be quick to call the sub-specialty attendings with any questions overnight. They want to be in the loop on all of their patients.

Check Outs: All team members gather and give sign-out to everyone about the patients from both teams. One-liner, then systems-based presentation. Keep your patients updated in the hand-off tool, including tasks to do. Usually you’re taking care of your own kids, but if someone is post-call/gone to continuity clinic/slammed, there is a TON of overlapping help/work.

Most days you will have plenty of work (i.e. discharges to dictate, orders to write, PCP's to update, renal patients to discuss with the attending, etc) to keep you busy until it is time to go
home. If you are not busy, you can help the on-call intern admit a patient or find a place to hide and read.

**Admissions:**

There is NO CAP, and you can anticipate 2-20 admissions per night (this is now split between the short call intern and the night intern).

Staff patients: These are Myers Park Peds patients or private patients that you will admit, work-up, and manage until they are discharged. Consider yourself their primary physician.

Teaching patients: These are either heme-onc/renal/GI/pulmonary patients/cardiology. For heme-onc patients, you have no role in managing these patients on a daily basis and are not responsible for discharge summaries. (The privates will write notes and orders everyday.) You will, however, be responsible for H&P's, and cross cover issues (though the privates will want to be informed of anything serious). For the renal patients, essentially you should treat them like your staff patients (except that you discuss them with the renal attendings).

Bunny-Hop: Peds loves the bunny-hop (sending the patient directly up with holding orders from the ED). Once you hear about a patient coming you can pre-write much, if not all, of the admission order set. After you see the person, you can change the occasional order and then tell the nurse to initiate it. You can also pre-write much of your H&P. And, if you just want to knock it out, just go see them in the ED. BE SURE to not initiate your orders if they are coming from the ED, otherwise the floor nurses won’t see your orders. These patients usually need to be seen soon after they hit the floor.

Med Rec: Don’t forget to complete this on each admission.

Staffing: This will vary depending on the attending/day. Sometimes you will staff with the attending and upper level together, sometimes just one or the other. At night it’s never with the attending (not in house). Print out the H&P or have a computer to reference your note labs.

Be prepared to be bombarded with pages from the floor, as the peds nurses will page you about every issue imaginable. If the nurse wants you to see the kid, just do it. Also, call your second year with anything beyond giving Tylenol. Seriously. Even if you handle a situation correctly, everyone will be all frowny-face the next morning if you don't call and give a heads-up.

The call rooms are on the hall of what would be 7A in the main hospital where the children's hospital was. Intern use RM 7123, code is 3154. There is a restroom as well as a shower in the room with a TV and DVD. You are lucky if you see that room during call -- a quicker option is to pull chairs together in the rounding room and grab Z's there.

**Discharges:**

Discharges can be prepped prior to rounds and discharge power-plans initiated on rounds. Have prescriptions prepped (either ask the family which pharmacy they use or call and have the nurse check), and sent to the pharmacy. Peds REALLY likes using the Med Center Plaza Pharmacy (across the street) since they will fill the scripts and deliver them to the patient’s rooms. This can happen at 3 times throughout the day (1100, 1300, and 1600 I think). Expect to do this for ALL asthmatics (you will get several lectures about how it improves compliance, etc.), but it’s a good
option for many people, especially without insurance. Plan to call all PCPs (except Myers Park) to let them know the patient’s been seen and discharged – doesn’t mean you need to speak with the doc, nurses are often ok.

Discharge summaries are done in PowerChart like everything else. Some people will start them early in the admission, then “Save & Close” and avoid signing until they are done. If you start a discharge summary early during the admission, MAKE sure to change the date when you actually sign the note and change it to the day of discharge. When you hit sign and the box with co-signers pops up, this is where you can change the date. After you have discharged a patient, be sure to put their name, MRN, diagnosis, your name, and any follow up items in the discharge booklet. For most patients, you are expected to call the child’s pediatrician to give them a quick report of their admission and that you will be forwarding their discharge summary to him/her. When you have called and completed the discharge summary, check off the appropriate boxes in the discharge booklet.
Overview: Most of the residents come away from the hospitalist service surprised with how much they like the rotation. You are working directly with an attending on this service; this is not a staff ward team. The attendings give you a lot of autonomy, and expect you to pretty much run the service. Currently this rotation is changing slightly. You will be on team C, and while you are rounding and getting work done in the morning the D/X team usually admits patients. D/X is run by the same group of attendings as Team C, so your attendings will rotate on that service throughout the month. The team D/X attending will usually call you with the first afternoon admission if you are short call, and if you are long they will usually admit the first one or two and give you a later afternoon admission. You may get a few admissions in a day if the service is very busy. The highlight of team C is that you deal with sick patients, but expect to keep some of your patients for the whole month. The highlight of Team D/X is that you get to do a lot of pediatric admissions. This is a very chill rotation, and you typically have plenty of downtime during the day after finishing notes to do whatever you want. It is a great time for reading, as you are probably already behind in Tintinalli’s.

Cerner Notes for Day 1:
Look under ZZPowerPlanCMCLCH, Pedsmed or under ZZPowerPlanCMCLCH, ED
- Pediatric Progress Note
- Chips H&P Template
- Pediatric Discharge Summary

Cerner Order sets for Day 1:
- Peds MED General Admission
- Peds Endo Diabetic Ketoacidosis Admission
- Peds MED Psychiatric Management Orders
- Peds PULMO Asthma Exacerbation
- Peds PULMO Bronchiolitis
- Peds MED Fever under 28 days old

Service List: You need three lists for this rotation
- Provider Group → CHIPS C, Discharged Criteria → Only not discharged
- Provider Group → CHIPS D, Discharged Criteria → Only not discharged

* You should make a mixed C/D list for when you work nights and cover both services

Important Phone Numbers
- Admitting/Night Attending - 19090
- CHIPS C Attending - 19091
- CHIPS D Attending - 19092
- CHIPS ACP Ascoms - 19096 and 19097
- Banner Burleson - 14316
- Your phone - 15308

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Schedule:

*In General*: Expect to alternate long call and short call every other day. Long call is from 6am to 7pm. Short call is from 6am until you get your work done or are discharged (usually leave around 4:30pm, but they will let you go early on occasion). The attending will call you at the end of the day and ask you for signout, but you can speed this along if you call them throughout the day with updates on your patients.

*Life Planning*:
- You can take vacation during this rotation and are highly advised to. This rotation is the best about giving you the weekend before and weekend after your five day vacation (for most people).
- You typically will get either Saturday OR Sunday off each weekend. The only days you have off are weekend days when you're not on call.

Schedule Interpretation

*Typical (short call) day*:
- 6:00 am arrival. Pick up your ASCOM from the attending lounge on the third floor (this is just past the ICU elevators if you walk into LCH, and on the immediate left of the LCH main elevators. Call the overnight MD at 19090 or meet them in the attending lounge at 6am to get check out on old patients and pick up new overnight admits. The attendings expect this call at 6am, so don’t be late. A good strategy here is to take 4-5 new patients every morning until you get to 6-8 total. That way you don’t get a call right before rounds asking you to take 1 or two more. Print out the patient list; set up a list of C/D inpatients in PowerChart, press the Explorer Menu icon, choose CHIPS Team C/D and "detailed list" report to print. See your patients and have an idea on a plan. You do not have to go to AM attending signout at 7am like you did on the first day. Ensure that you have updated your pager number on the whiteboards in the MD workrooms on the 8th and 9th floor, which is where most of your patients will be. Go to the secretary on each unit where you have patients and write down the ASCOMs of the nurses taking care of your patients. Most attendings like you to call the nurse for each patient and let them know you are about to round so that they can be there.
- 7:45-8 am: Radiology rounds, where you will go through any readings done on patients on the list. When the service is busy (and this is usually every day on CDX), you will skip this.
- 8:30 am: Morning report in the LCH main auditorium on 1st floor of LCH. You’re encouraged to go, but it is not an issue if you miss this.
- 8:30 am-12 pm: Attending rounds. Note that you don't need to have your notes finished by the time you round. Call the nurse taking care of your patient before you round on that room so he/she can join you. If you're not rounding, work on your consults/orders/notes/discharge summaries in that order.
- 12 pm-4:30 pm: Work on your notes/admissions/discharge summaries. Call consultants early, as it is courteous to them and more efficient for you. Follow-up on your patients at some point, and give the attending a call on their ASCOM with updates. They like to
know before you leave the hospital, and you're generally expected to stay until 4:30pm every day if you are short call. Usually only one of the attendings stays “long call” to sign out to the night attending at 7pm. The other attendings (and you if you are short call) will sign out to the night attending before you leave.

- 4:30pm - 7:30: If you’re long call it is the same as any other day, only they will assign you some admissions they get during the day (admissions and ICU transfers are split between the residents and ACPs) generally starting at about 3pm. New admissions will be staffed with the long call attending who stays until 7pm regardless of when you see the admission or which team he/she ultimately goes to. At 7pm, go down to the attendings' lounge (3rd floor LCH) for evening check out. Sign out your patients and the new admissions, and you’re free to leave.

Typical weekend:
- 6-8:30am: Preround.
- 8:30am-noon: Call and round with attendings.
- If you are not listed short or long you have the day off.

Typical overnight call:
You are usually scheduled a few nights. Meet in the attending lounge a few minutes before 7pm and get checkout on any old patients. You are expected to crossover both C and D. You will admit any patients to either C or D teams overnight. Depending on how busy the service is, you may be asked to pre-round on a few patients overnight for one of the services. You round with the attending immediately after board signout – either walk rounds or table rounds and then leave for the day. This is usually very quick; they know you’re overnight so they try to get you home.

Structure:
There are always two hospitalist attendings on at any given time, one for Team C and one for Team D. The X attending is an extra attending who comes in the afternoon to take admissions but this job is currently in flux and may change. You will either be assigned to team C or D. You alternate nearly everyday between long and short call but will likely have more short call than long. On long call days, you admit till 7pm and are expected to leave by 7:30pm at the latest. On short call days, you admit till 4pm and are expected to leave by 4:30pm at the latest.

This is a busy service. The team caps at 14-16 and you have a personal cap of 8 patients (the remaining 4 are usually seen by the attending alone or by the MLP). You can admit more overnight and they are reassigned in the morning. There have been instances in the past where ED interns have picked up more than 8 patients. Please ensure that you are not compromising the care of your patients if this inadvertently happens and be sure to bring it to the attention of your attending or chief resident if this is a recurring issue.

If there are two interns:
CHIPS C is alternating long call (7a – 7p) every other day with the interns. For example, one of the interns will stay until 7p MWF and the other will stay until 7pm on TTS. The short call intern usually checks out around 4:30p. On Wednesday, there is grand rounds from 7:30a until 8:30a. As far as weekends, one intern works until 7pm, and the other intern will have the day off. You
will have a few nights, starting at 7pm and ending at morning checkout at 7am.

Admitting:
The attending carrying the Ascom phone will get called for admissions. He/she will then call you if they want you to see the new admission. Often patients are “bunny hopped” to their room (skeleton orders placed) meaning they will be sent directly to their floor bed and you will be paged once they arrive. You can also go see the patient in the ED if you don’t have anything else going on. Go see the patient, start or finish the H&P/orders, depending on the attending, and then give them a call to discuss the patient and tweak your plan. As with any attending, it’s a good idea to ask them how much they are comfortable with you doing prior to discussing your plan with them. Once the attending knows you, you can usually finish orders before checking out to them.

Rounding:
There is a huge emphasis on patient and family centered rounds. If you have doubts about the plan, make sure you clarify it with your attending before walking into the patient room. Minimize jargon and educate parents using layman’s terms. You will be expected to answer most questions while in the patient’s rooms with minimal intervention from your attendings; take ownership, but defer to your attending if needed. Call the nurse before entering the patient’s room; he/she will join you to provide their input and they can be involved in discussion of the day’s plan. This whole thing may seem a bit silly to you, but as some of the attendings will tell you, there’s actually a good bit of data to support this rounding method in the pediatric literature. Importantly, if your plan is not the attending’s plan, it’s not a huge deal, as discussion regarding the plan in the room is good for families to see (again, this is evidence based).

Discharging:
There are several steps to discharging a patient. On the day of admission, you can start the discharge summary (this is particularly helpful for patients likely to have prolonged hospitalizations) and save it every day rather than signing it. If you start a discharge summary early during the admission, MAKE SURE TO CHANGE THE DATE when you actually sign the note and change it to the day of discharge. When you hit sign and the box with co-signers pops up, this is where you can change the date. You can also do this when the patient is discharged.

Most attendings will want the patient’s prescriptions delivered to the room before discharge. This requires planning ahead. You must fax or electronically send all prescriptions to the CMC Medical Center Plaza pharmacy the day before or early on the day of discharge (prior to 11:00 AM). Just search for “CMC Med” in the same location where you would change the printer on the Rx window, and you’ll find the right pharmacy (Medical Center Plaza). Failure to do this can cause a delay in your discharges and make your list longer.

Patients need follow-up before leaving. In the ED world, we put something generic like “call your doctor as soon as possible;” this won’t fly on CHIPS most of the time. The attendings expect appointments to be made when possible (during the week when the outpatient office is open). There exists a phenomenal resource and human being named Banner Burleson who assists with making follow-up appointments for the C and D teams. As most of your patients will need
PCP as well as subspecialty follow-up, she will set those appointments up for you. Let her know the day before or early the day of discharge. She only works on weekdays. On weekends, you must simply provide the office’s number from the “Follow Up” section of discharge planning and specify the time frame they need to schedule their follow-up appointment.

On the day of discharge, go to “provider view” then select the discharge tab (top middle of the screen). Then fill out the yellow boxes in the middle: discharge diagnosis, discharge med rec, follow-up, and discharge orders (always these four things to discharge from any service). You can put conditional discharge orders in as well for patients you are certain who will be discharged that day and just need to be rounded on. To do this, check “Conditional Discharge” on the discharge order and write what needs to be done first (such as “when medications are delivered” or “after MDs see patient”).

**CHIPS Tips:**
- There is a C/D intern call room on the 7th floor near the peds dialysis unit; it says "C/D intern" on it. Scan your badge to get in. Nurses from Dickson will sometimes be let in there by environmental services for God-knows-what, so lock the door if you’re in there.
- Banner will save you a ton of time by making appointments for you, let her know early if you have a patient you know will need follow up.
- On the first day, ask for a call list with contact numbers. While not 100% spot on, it will help you get ahold of consultants you need most of the time.
Trauma/TEGS

Overview:

TEGS, the lovechild of Trauma and EGS, will likely be one of the most memorable rotation of your three years of residency for good and bad reasons. It is incredibly busy to the point of being terrifying and overwhelming but will also give you an incredible amount of experience and independence to the point that most other inpatient/off-service rotations will feel like a breeze. The two services of Trauma and Emergency General Surgery were combined this past year to a single service. Still, they do function somewhat independently with residents assigned to either Trauma or EGS for the day as well as having separate attendings for each. On each day of the month, you will be assigned to Trauma Intern, EGS Intern, or Night Intern. Your co-interns for this month might be other EM interns, GS Interns, NSGY, or Ortho.

At the time of writing this guide, there are whisperings that TEGS is getting divorced back into Trauma and EGS as separate services. If this is the case, we will continue to work on Trauma only, and the EGS portion of this guide will be less important.

Trauma Intern: Responsible for rounding on 11A (primary trauma floor/wing) as well as responding to all Trauma codes throughout the day. Will carry the Trauma Intern pager which will both go off for Trauma Codes as well as any floor nursing questions

EGS Intern: Responsible for rounding on “outliers” or patients not on 11A, 11T, or other assorted areas. Some of these patients will still be Trauma patients but, in theory, most should be surgical/post-op patients for emergency surgeries like appendectomies, cholecystectomies, or bowel obstructions. You will also have the opportunity to go into the OR with the surgical team – something you can do as much or as little as you want.

Night Intern: Carry the trauma intern pager and respond to all trauma codes and all floor calls. Can be incredibly busy but also a chance to do a lot of primary/secondary surveys on super sick patients and occasionally get procedures both in the trauma bay or in the ICU.

Never fear, there is some backup available to you during this month. The single best resource, if you can track them down, is the ED second year on STICU that month. They have been through the grind before and can help with any questions you might have. There also are nurse practitioners during the weekdays who can be incredibly helpful with floorwork, but you shouldn’t plan on them doing all (or any) of your discharges. During the times of day that there is no chief present, you will work directly with attendings; they all realize how stressful this can be and are very forgiving and helpful.

**There have been issues with the 80 hour work week on this rotation in the past. Mostly due to whether or not there are 3 or 4 interns and during holidays/vacations. If you are having trouble with this, discuss it with Dr. Craig and the chiefs immediately.

Notes to Have on Day 1: (from chart for “patient” named: ZZPowerPlanCMCLCH, Trauma)

- Trauma ICU Progress Note
- Trauma DC Summary
● Trauma HPI’s are done via dictation; no template needed
● Make notes/macros early on for items you will do often, including chest tube removals, C-collar clearances, etc

**Order Sets to Have on Day 1:**
- ADULT TRAUMA Admission Non-Critical care (floor)
- PEDS TRAUMA Admission Non-Critical care (floor)
- PEDS TRAUMA Admission Critical Care (ICU, in case you have to)
- ADULT TRAUMA Admission Critical care (ICU, in case you have to)
- ADULT PHARM Pain Management

**Service List:** Provider Group → CMC TEGS, Discharged Criteria → Only not discharged

**Important passcodes**
- Trauma rounding room code: 6700*
- Supply room 11a code: 3412
- All ICU supply rooms on all floors: 241* (mnemonic – 2 for 1 sale)

**Schedule:**

*In General:* Expect to be there from 6:00 am until 6:00 pm. Roughly 4 days off for the month

*Life Planning:* Reasonable to request a specific weekend off.
- If you are fortunate you can obtain a post-call Fri-Sat-Sun combination
- Email the surgery scheduling chief as soon as possible if you have specific day requests

**Schedule Interpretation**
- Trauma Intern = 6a – 5p
- EGS Intern = 6a – 5p
- Night = Welcome to the official Night’s Watch. 5 pm until 6 am, expect to stay and chart after (you must leave by 9am for 16hr duty hour restriction)

**Detailed Weekly Schedule:**
- Monday- Quarterback conference, rounds start late (~8:30) because of this.
- Tuesday- Trauma M&M at 11:00 on 6th floor MEB, lunch afterwards.
- Don’t go nuts with this, just know the case and the CMC protocols regarding the injury/procedures performed. These are available on Sharepoint
- A blank M&M trauma template is available on the Compendium and will be emailed to you by the trauma coordinator
- Sometimes this can be a bit of a pimping session, but often it just devolves into the trauma attendings arguing with each other about some policy issue
- Wednesday- Clinic afternoon at Myers Park Clinic - starts at 1pm, scrubs usually, some attendings prefer formal attire
- Thursday- ED Conference day! The surgery team should cover your pager and ASCOM at this time. Usually, one of the ACPs will just take your phone and the pager from you until noon.
- Friday- Sometimes have random conferences (grand rounds, extra M&M if not finished on time on Tuesday). You will be told beforehand if you do. ACPs have clinic in the AM, and so you may have to go to codes between 8:00 and noon those days (see below).
- Saturday and Sunday - If you are working, there is usually less ACP help on the floors that day, so expect to potentially stay longer to finish work/charting.

**Detailed Daily Schedule:**

- **6 am – Signout**
  - Usually night team and incoming day team meet in trauma conference room at 6am
  - If the night team cannot be found (i.e. they are likely down in the ED), call the intern who was on the night before (phone 60562, pager 1165)
  - Make sure to find out at this time which patients the night intern has already seen

- **6:00 am - 8 am: Sign out and prerounds**
  - Start seeing patients. Split up the patients between the interns and start seeing everyone. Write notes after everyone has been seen; start them and save them to get ahead if you have time before rounds.
  - Interns are in charge of 11A. ACPs will usually do outliers/prog, but appreciate help. Ensure that all of 11A is checked off before you move to other floors. If you are alone on 11A and there are not many outliers, don’t hesitate to ask the ACPs for help. It’s a team effort.
  - **You are responsible for responding to codes between 6am and 8am every day.**

- **8am – Start rounds**
  - You start in the trauma conference room going over overnight admissions; then the attending will tell you when and where to meet for floor rounds.
  - If you are on call on a weekday the ACP service will cover codes from 8am-noon to allow for rounding. On weekends there is less staffing, so respond to codes unless you are specifically told otherwise.
  - Generally, the team tries to round together. The intern who saw the patient presents their progress note, another intern enters orders, and the third intern/ACP may be sent to do additional tasks (talk to nurse, discharge a patient, etc.)
  - The case manager and charge nurse from the floor round with the team on all patients, and usually have very valuable information regarding disposition plans or overnight events

**It is critical that you not let labs, imaging, or consults fall through in the night-to-day transition**, this is a serious problem with night rounding. Night intern: make it clear what is pending in your note and sign out to the day team. Consider bolding text in your pending note if you want the day team to notice a “to-do” item. Nothing is worse than a potassium not being noticed until 5 pm!

**After Rounds:**

- Meet with your chief (if you have a daytime chief) and run the list
- Break off and do anything that must be done orders-wise and consultant-wise
- Trauma codes can go off at any time; when they are paged out you should head to Major!
- Very important to divide and conquer; make a to do list to assign people to tasks.
- Try to get all procedures and discharges done before sign out at 5 pm. Nights are very busy and single coverage, so it is difficult to be tied up with a task like suturing that the
day team missed.

Rounding Tips:

● The person who has been on overnight should start rounding at midnight between codes. The best approach is to see a few people, write a few notes, and continue. You never know how the night will go and it is best to not have a ton of progress notes to write because you physically saw every patient.

● This is painful if you’re the person on overnight, but critical to day team success. It allows the day team to focus on discharges, which means less people to cover the next night.

● If you’re not sure of the plan, especially if you’re on nights, write in your plan to ‘discuss with team’ so everyone on rounds (you may not be there) realizes there is an unresolved issue.

● Attendings like overnight events, vitals including I/O, incentive spirometry numbers, ambulation status, and bowel/voiding function

● In general, a brief one line about mechanism and resultant injuries, procedures performed, and current active problems will suffice, then standard SOAP for floor patients.

● Progressive units (the CMC name for step down): these patients need to have ICU style notes written on them when it comes to your assessment and plan. These patients tend to consume more of your time and may be sicker. Same presentation, but with systems based A/P. Most often, the ACPs or the “Lean Team” will see most of these patients.

● System Based Plans-
  ○ Injuries/Plan: listed one by one, with each consultant's plan, disposition
  ○ Neuro: sedation, pain control, GCS, scan results, what neurosurgery is doing
  ○ Respiratory: trach size, vent settings, secretions, why they are still on the vent, and any treatment
  ○ Cardio: the usual RRR, how many days the line has been in, etc
  ○ Renal: I/Os, lytes, foley status
  ○ FEN/GI: what type of feeding, rate, bowel function
  ○ Heme/ID: Tmax, antibiotics and day #, and any culture results
  ○ Prophylaxis: lovenox, coumadin, SCDs, PPIs, ulcers, EtOH withdrawal prophylaxis

Patient Locations

● 11A- Rooms in the 11,100s – The main trauma floor. One or two interns will be assigned to this floor. If there are two interns, one starts at the high side, one at the low, and meet in the middle.

● Progressive “PROG”- Rooms in the 10,400s/10,500s are the Trauma progressive patients and the PICU (LCH 6th floor).

● Pediatric patients are covered by the pediatric trauma team M-F until 4 pm, but by the trauma service overnight and on weekends. These patients can be on any floor in LCH. Expect phone sign out in the evenings and make sure to pass on these details to the night team at signout. On the weekends, you may be expected to preround/round on pediatrics.
patients with the pediatric surgery attending. They should call you in the morning, and you can clarify what they want at that time.

- The PICU team manages the kids in the PICU. Trauma is often a consult on the PICU kids (so don't write orders not directly related to the trauma issue),
- Outliers- Patients that are on our list that are not mentioned above and not in the TICU (11,600s).
- Common floors are 11T, 9T, 5T, 3T, but the patients can be anywhere space allows

Helpful on Shift Stuff:

Electrolytes
- Sodium - if low start with sodium tab 2gm TID and order morning BMP, or order Gatorade instead of water “gatorade restriction”
- Potassium - if low and taking PO, K-Dur (oral potassium) 10 for every 0.1 below 4.0, use IV K if not taking PO. Can also use oral powder potassium replacement
- Magnesium. - if less than 2.0 needs replacement.
  - If 1.7-1.9 and taking PO give oral magnesium; if not taking PO then give 2gm IV
  - If Mg is 1.6 or less then give 4gm IV and order repeat Mg in AM
- Phosphorus - if low then replace oral or IV

Get CBC, BMP, Mg, and Phos level on all patients on initial labs on arrival to unit. If normal then stop checking Mg and Phos

Chest Tubes
- Check daily for air leak - clamp suction and ask patient to cough or take deep breath - if bubbles in blue water then have air leak (air from lung injury going into pleural space). Most of the time, this is because the connector from tube to pleurovac is dislodged or the tube wasn’t sutured tightly enough to the skin and has become dislodged.
- If output is less then 200cc over 24hr and no air leak, order CXR and place to water seal if no pneumo
- Order CXR PA and Lateral in radiology for 4hrs after placing to waterseal - pull CT if no pneumo
- Obtain repeat CXR for 6hrs after pulling CT. (Again a CXR PA and Lateral in radiology)
- Daily CXR on CT patients that are on wall suction need to be Portable only (they can develop a pneumo in the time taken off suction while they transport to radiology)
- Order CT Chest if suspect retained hemothorax - the output is decreasing but the CXR looks worse and increased opacity

Blunt chest trauma (rib fractures/ster nal fractures)
- Do daily incentive spirometer with all patients during your prerounds (they will often exaggerate their numbers if you just ask them)
- Increase pain meds if IS is less then 1500cc

GI
- Ask every patient every day about flatus/BM status
- Give suppository if no BM in 2-3 days, Bisacodyl, etc. Move on to enemas if still no
success.

- Patients with NGT - pull tube if passing flatus! Depending on extent of operation can start clears vs waiting one day then starting clears

**Ppx:** Trauma likes Lovenox 30-40 BID instead of 40 qd

- Be careful and use Heparin 5,000 TID for patients with renal injury or insufficiency.
- If unsure or if iSTATs show elevation in Cr, go with Heparin, then switch over once you have formal labs

**Dispo**

- Check therapy notes daily for PT/OT/rehab recs for placement/dispo
- The only consults you can order in the computer without calling them through the paging system first is PT, rehab, RT, OT
- Social work and CCM help will be critical for placement, especially if to SNF
- If a patient is being transferred (ie to SNF or rehab), you need to have the DC/Transfer summary done and printed out, as well as a printed Med Rec before they can leave. In other words, make this a priority after you finish rounding each day if there are patients going to SNF/rehab.

**Admitting:**

- Admissions will come from either trauma codes or consults. Often Trauma is “last man standing” and will accept admissions that medicine, surgery, and ortho don’t feel are appropriate for their service.
- After you have seen the patient and discussed with your upper level, be sure to place orders before/during your H&P dictation so the nurses know what to do with your admission
- Don’t forget about the admission med rec. If the med history has not been done yet, call the pt’s nurse and politely ask them to do it so you can get the med rec done.

Order sets are again under “ZZPowerPlanCMCLCH, Trauma”:

- **Adult Inpatient Trauma Floor** - You fill out these order sets. Once these patients are admitted they are your responsibility.
- **Adult TICU** - The mid-level will often help you with these - if they don’t still call and run them by your mid-level on the phone since these patients are sick. Once these patients are admitted they are the responsibility of the TICU team, yours when they are transferred to the floor. If you go up to the ICU with these patients, you will often find an opportunity to do some great procedures, just ask your mid-level for help. If you admit someone to the TICU and the TICU resident wasn’t present for the code make sure you call the TICU resident to let them know they are getting a patient. These patients are often ICU admits because they are potentially unstable and the ICU resident needs to know they exist.

**Discharging:**

A trauma discharge needs these things:

- A medication reconciliation.
A discharge summary (not necessary to be done prior to discharge if going home) or a transfer summary (necessary prior to d/c if going to a SNF, LTAC, or another hospital).

A discharge PowerPlan order set.

Follow up appointments with Trauma Clinic (CMC Myers Park, Trauma) and consultants. You may have to call consultants for their preferred scheduling.

Prescriptions. The COWs don’t have printers associated with them.

Patients going to rehab must have a discharge summary to go. They can lose their beds if this is not done. So, if you know a patient may go to rehab soon, you can start the discharge summary early and then simply add an addendum.

If the patient is going home and you are busy/unable to dictate a discharge summary that day, you can let the chart come back to you in the message center mailbox and dictate then. But just make sure you actually do them. These d/c summaries, while not needed prior to departure if the patient is going home, are nice to have at the patient's follow-up appointment in clinic a few weeks later. Often times you will have to dictate a patient who has been in the hospital for weeks and has had a complicated course, and who you had no involvement with other than writing the “d/c home” order. This is not nice or fair, but is part of life. It happens to everyone, so just smile and do it, knowing that others are doing it for you.

Running a Trauma Survey:

- Get on a lead gown, trauma smock, gloves, and tape KY gel and a few paper clips (if GSW) to your chest. It is helpful to double glove your rectal exam hand so you can remove the exterior glove after and keep trucking.
- Get a blue sheet ready to go:
  - These are the H&P form – located in trauma bay one on the right side by the imaging computer or in the paper slots by the PCL phone in Major and put patient stickers on it. Get as much information as you can from the triage call sheet before they arrive.
  - **YOU MUST FILL OUT AND DICTATE THE ENTIRE BLUE SHEET. IT IS YOUR RESPONSIBILITY.**
  - If you have medical students, they can help fill out the blue sheet while you are running the code. However, review it afterwards to make sure it is accurate prior to giving it to the attending or dictating it.
- Stand on the Patient's right side at their head. Listen to Medic report, or just start doing your primary survey (listening to lungs, feeling pulses, checking pupils). You will have to go back and copy information, like meds given in transit, from the nurse’s notes as you will be doing other things when this info is called out.
- Once the patient is transferred to our bed start your primary survey when instructed by whoever is running the trauma code and YELL your findings.
- Be LOUD, and don't stop for other people. You may have to politely wedge yourself in between ED staff getting blood pressures and removing clothes. Remember your voice is the most important.
- If there is a problem, say it LOUDLY. The remainder of the team will begin addressing the problem (put in an airway, decompress a pneumo, etc.), but you should continue your
survey, keeping the pertinent information in your head. Once the issue has been addressed, call out whatever you noted in your survey as you were continuing it.

- If the patient is going to be intubated, try to get a quick neuro exam if possible.
- Do your secondary survey and tell everyone when you are ready to turn the patient and which way you want to roll them.
- If you aren’t sure that you need a rectal, just ask (tactfully) the person running the code. Rectals are sometimes skipped, especially in pediatrics.
- After your primary and secondary survey start filling out the blue sheet. Try to get the attending to sign it in the Trauma bay if possible. The patient cannot go to the OR/IR unless the attending’s signature is on the blue sheet.
- While you were doing your survey several things happened that you need to record on your blue sheet:
  - X-rays were taken, and preliminary reads were made by your attending. If you didn't hear what they were, ask.
  - The FAST was done. Ask the person who did it for the results.
  - Point of care labs were done. They print out on a small, receipt-like, piece of paper.
  - The recording nurse gets this paper first, then you should try to grab it.
  - If you don't have time to write labs down immediately, simply use a sticker to tape this to your blue sheet and write it down later.
  - Vital signs were taken. These will be on the nurse's recording sheet.
  - Most of the things you miss will be on the recording nurse's sheet. This sheet will be on the patient’s chart and eventually gets scanned in to the “Provider Documents” under the ED section. If you need info for your blue sheet later on in your shift, it can often be gathered from this sheet.
- After the Trauma bay the patient often goes to CT.
- If they go to CT, you follow them. One physician must stay in the elevator with the patient.
- If someone else on your team goes in the elevator, you can go up the stairs to the 4th floor and into the CT control room to ask them which CT scanner the trauma patient should go into. By the time the patient gets upstairs you should be able to usher them into the right scanner, it helps to tell the transit team which scanner 1 vs 2
- While the patient is in the scanner you finally have a chance to fill out your blue sheet. You can also enter admission orders during this time if you get the chance.

- Go to the Radiology reading room and ask (very politely) if the radiology team would be willing to give you a quick prelim read on any scans. Give the scan a few minutes to carry over before asking them to do this, they get upset if you ask them before the scan is even electronically available
- After scans the patient will go to the ICU, back to the ED, or occasionally to the OR.
- You can now fill out the problem list on the back of the blue sheet, the plan, and dictate if you can.
- When the official reads are available in Powerchart, write them in on your bluesheet and prepare to dictate. Make sure you have labs and imaging filled in before you start to dictate.
Dictation Line: 704-358-6788. Your dictation number is in medhub->portfolio->training summary-> Physician ID (NOT employee ID)

- To dictate a blue sheet, simply read the whole thing. The transcription department does these constantly and will organize it perfectly, you do not have to specify all punctuation, they are familiar with the sheet format
- Note that you must include each element of the blue sheet, ie do not say “ROS is negative.” Instead, quickly say each category followed by negative. Dumb, but for billing.
- If you cannot obtain any history state that each type is unable to be obtained
- Family history can be bleeding or clotting disorders
- Write the dictation number (automated number given to you after you submit your dictation) on the H&P. Sometimes dictations get 'lost' and this will help medical records track it down and save you from having to do it again weeks later when you can't remember who the patient is.
- At some point the Attending will take your blue sheet to fill out their part of it. So, if you can't find your blue sheet, find your attending. You are not responsible for making sure this part is filled out, so just stick it in the chart if you are done with it. It is nice to call them and ask if they would like the sheet before you do this, then you place it on the chart for consultants to find

Of note:

After all the drama of a trauma is done, you are responsible for the minor things, like making sure abrasions are cleaned and dressed, lacerations are sutured, etc. Finding open lacerations or new injuries during morning rounds is not ideal. If you can, sew any lacerations while the patient is still in ED as supplies are harder to come by on the floor. Also, if you do a procedure, put a note in the chart.

If your patient needs consults, your chief or mid-level will typically call them. Write down consults on the blue sheet.

If you get more than one trauma at a time (and you will) the mid-level (TICU resident) and/or your chief will most likely come down and do the primary and secondary survey. Even if they do the assessment, you are responsible for the blue sheet. So unless they specifically tell you that they will dictate the blue sheet, you must do it.

MAKE SURE YOUR BLUE SHEETS ARE IN THE CHARTS BEFORE 6AM - consultants will want OR clearance, your attending will be leaving, disaster may strike. Now that charts are being scanned, I would keep blue sheets for patient’s you know are going to the OR on you to avoid the document being scanned then lost.  
  **Remember to record your adult and pediatric traumas for your Procedure Log**

Trauma Consults:

While you are on call you will also get trauma consults. You don't get paged for these, as they are approved by your chief first. Your chief will call you and give you a one-liner. You then go to the ED and fill out the same blue sheet for these patients. After your blue sheet is done, call
your chief and discuss the plan.

Trauma consults are difficult, as these patients have at least a partial workup. It is best start over with the ABCs, and then a thorough secondary survey. You can fill out most of the info on the blue sheet from the ED trauma nurse notes (if it was started out as an alert). Sometimes these are patients that had a seemingly innocuous mechanism of injury but end up with a big spleen lac on CT scan or an isolated ortho or neuro injury, but the specialist wants trauma to clear the patient of other injuries. Your upper level may see and admit them on their own if you are busy (and the patients will mysteriously show up on the floor census list the next morning with you not knowing anything about them), or they may page you to see the patient and you will do the H&P, dictation, and admission orders.

Covering the Floor:

We are also responsible for covering the floor patients in the day and overnight. We cover all the Trauma patients that are not in the TICU or PICU. You can give phone orders if you are in the ED at a code (nurses are usually very good about accepting this). If you are called to see a patient for something you feel is significant (ie you intervened), write a note so that the intern/team rounding in the morning knows what happened overnight (very important). If you are concerned about someone on the floor (mental status changes, hypoxia, etc) but you are stuck in the ED due to trauma codes, don’t be afraid to speak up and tell your chief. Sometimes the TICU resident is available to go evaluate the patient or to take over the trauma code so you can get up to the floor yourself. Do not be afraid to ask for help, it is much better to “fill the boat” than sink alone. A good general rule is if you get called twice about something that sounds minor, you should probably go see the patient. Remember, even though young and healthy, trauma patients get floor problems! Suspect compartment syndrome, suspect PE, suspect post-op complication. If it makes you nervous start the workup then call your upper level.

You are also responsible for following up important labs/studies, doing any post-op checks, serial abdominal exams, etc. on your patients overnight. Be sure to document when you see patients. We do post-op checks on all patients, even if we were not the team operating. For example, if our patient had plastic surgery, ortho surgery or neurosurgery, we still check in on them afterwards.

Do not clear a cervical collar without documenting it, just write a quick C-spine note (then save it as a template, you’ll need it!)

Random Phone Calls:

You will get random pages from 704 phone numbers. These are either from pharmacies telling you that somebody on the Trauma service wrote a script wrong, or they are from the physician's paging operator. When patients try to call the clinic after it is closed, or try to call the Trauma team, they will get this service. You call the number and talk to the operator who will tell you the patient's name and DOB. The operator will then connect you to the patient or give you the phone number to call the patient back. It helps to find a computer and look the patient up before calling
them back so you have some background information. When you talk to the patient make a quick note about it. We don't prescribe medications over the phone at night. If they need something that badly, they need to go to the ED. If it isn't urgent, you can tell them to call the clinic in the morning.

Clinic: Wednesday afternoon’s 1-5ish at the Myers Park Clinic (corner of Kings and East, parking lot entrance on East). Formal attire depending on attending. Two interns, one NP, a chief... and only about 20 patients for the afternoon.

Pearls:

- On your first day, get a phone numbers card. You will refer to it constantly.
- You should always have your ASCOM phone, and a charged battery in your pocket for when it dies on you in the middle of a hallway
- Intern on call pager is 1165, and phone is 60562.
- Many phone numbers are in the 'local phonebook' on the Trauma Intern phone. ACPs usually carry the Trauma A, Trauma B, or Float phones
- The attending changes weekly, so rounds work differently every week.
- Find out your dictation number before you begin your rotation: Medhub, portfolio, training summary, physician ID number
- After dictating press “#9” to have it marked STAT, then press “5” to make another dictation or “9” to end the session. Listen for the dictation number and record it on whatever you are dictating. Write it on the blue sheet or somewhere else on the chart.
- For anything you dictate, make sure you mention the Attending's name, later forward it to them once medical records transcribes and sends it to you to sign
- They love the incentive spirometer. Love it. So make sure you make patients do this and write it down as part of your physical. IS should be at least 1000.
- Learn how to pull a chest tube from one of the surgery residents early. You will do a lot of these.
- Make sure to keep the handoff list as updated as possible!! It helps tremendously when you are rounding by yourself with an attending or come in after 1-2 days off and the whole list has changed. Keep it concise.
Ortho

**Overview:** Orthopedics is an awesome, high-yield rotation. It is a very work-light rotation with less than 40 hours of work per week, but the hours are not the best. You will be asked to see consults and occasionally write the consult notes. You never have to write orders. Lots of free time during your shifts. You should be allowed to do all simple reductions, just remember to be aggressive with asking for procedures, or the ortho rotating medical students and ortho interns will take them.

**Cerner Notes for Day 1:** “Ortho Trauma Admission H&P”. Ortho is huge on social history (make sure to ask and document tobacco/alcohol/drugs/phone number, where they live and who with, and what they do for a living). Sample ortho exam can be found below.

**Cerner Orders for Day 1:** None

**Cerner List:** Don’t need one

**Schedule:**

**General:**
- Schedule is Friday-Sunday from 5p-5a
- Arrive at 5pm, stay until 5am
- On the months with two EM interns on ortho, you will split the week. One intern will work Thurs-Saturday nights, one will work Sunday-Tuesday nights. You will never have to work a Wednesday night so you’re always able to come to conference.

**Life Planning:**
- You can take vacation during this month and it is highly advised to take vacation. Remember to ask off Friday-Sunday off on your request (not the usual Mon-Fri request).
- You cannot ask for specific nights off.
- Dr. Craig reminded us several times that she expects us to work every night and not call out sick. If you get called in on backup, make sure your chief knows.
- You will be assigned about 5-6 days of backup and this will include a weekend.

**Schedule Interpretation:**
- Pretty simple. You will work Friday, Saturday and Sunday nights from 5p-5a (Sunday nights it starts at 6:30pm)
- Check with your ortho resident whether they want/need you to stay for AM signout.

**Where to Go:** Meet in surgeon’s lounge at 5pm for ortho check out from day team (6:30pm on Sundays)
**Ortho Exam Template**: (these follow the basic ortho exam that they want performed on all patients)

*Upper extremity*: No deformity. Skin intact with no abrasions or lacerations. Full painless range of motion at glenohumeral joint, elbow joint, and wrist. Good thumb abduction, flex at IP joint, able to make an okay sign, flex/extend wrist, able to adduct and abduct all fingers well against resistance, point index finger, and cross 2nd and 3rd digit. Intact sensation to light touch in ulnar nerve, median nerve, and radial nerve distribution. Strong radial pulse, warm, and cap refill < 2 seconds

*Lower extremity*: No obvious deformity. Intact skin with no abrasions or lacerations. Full painless range of motion at hip joint, knee joint, and ankle. Intact plantar flexion, dorsiflexion, and leg extension. Negative anterior drawer sign. No laxity or pain with valgus or varus stress testing. Patient has intact sensation to light touch in superficial peroneal, deep peroneal, and tibial distributions. Strong DP pulse, warm, and cap refill < 2 seconds.