

**UT Southwestern- Austin
Internal Medicine**

**Resident Handbook
2011 - 2012**

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ROTATION SCHEDULE

PGY-1 Categorical Year

Wards	5 blocks	q 5 night call
Clinic	2 blocks	no call
ICU	2 blocks	q 3-5 night call
GI or Heme/Onc	1 block	no call
Emergency Department	1 block	15-10 hr shifts and 1-12hr EMS ride-out
Behavioral Med/Psychiatry	1 block	1 weekend call
Nightfloat	1 block	6 nights per week;no daytime call

PGY-1 Preliminary Year

Wards	5 blocks	q 5 night call
Clinic	2 blocks	no call
ICU	1 block	q 3-5 night call
Neurology	1 block	rotating pager call, weekends off
Emergency Department	1 block	15-10 hr shifts and 1-12hr EMS ride-out
Elective	1 block	no call
Behavioral Med/Psychiatry	1 block	no call
Nightfloat	1 block	6 nights per week;no daytime call

PGY-2 Year

Wards	3 blocks	q 5 night call
Clinic	2 blocks	no call
ICU	2 block	q 3-5 night call
Medicine Consults	1 block	2 weekends/month
Hospitalist	1 block	2 weekends/month
Elective	1 block	no call
GI or Heme/Onc or Renal	1 block	no call
Pulmonary	1 block	no call
Cardiology	1 block	no call

PGY-3 Year

Wards	2 block	q 5 night call
Hospitalist	1 block	2 weekends/month
Ambulatory Care Block	2 blocks	no call
ICU	1 block	q 3-5 night call
Elective	1 block	no call
Infectious Diseases	1 block	no call
Nightfloat	1 block	6 nights per wk: no daytime
Neurology	1 blocks	2-3 weekends per month
Geriatric Medicine	1 block	no call
Admitting Resident	1 block	5 days per week, 2 weekends/month
Endocrinology	1 block	no call

RESIDENT WORK/ON-CALL HOURS

DUTY HOURS

1. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
2. Residents must not work in excess of 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods, and after in-house call.

ON-CALL

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 14 hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

1. In-house call must occur no more frequently than every third night.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Resident may remain on duty for up to 4 additional hours to participate in didactic activities, transfer care of patients, and maintain continuity of medical care.
3. No new patients may be accepted after 24 continuous hours on duty. A new patient is defined as any patient for whom the resident has not previously provided care.
4. At-home call (pager call) is defined as call taken from outside the assigned institution.
 - a. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 - b. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
5. Residents must inform and obtain permission from the Program Director of any and all moonlighting activity.
6. Moonlighting activities should not cause residents to work in excess of 80 hours per week when added to the program responsibilities.

7. At no time should any of the above policies compromise the care of patients assigned to residents.

WARD DUTY

The housestaff is on weekday ward duty from at least 7:00 am until 5:00 pm. Weekend hours are 7:00 am until afternoon checkout. These hours will vary with the individual patient load. During each month of ward duty, there will be five ward teams consisting of an attending, upper level resident, and two or three interns. A third year medical student will also be assigned to each team. Fourth year medical students will act as interns on the team.

CALL SCHEDULE

The call schedule is arranged with a short call A/short call B(hand-off)/long call pattern. Short call A consists of 2 hand-offs or ICU transfers and admitting up to 3 new patients from the ER from 1:00 pm to 9:00 pm. Short call A occurs two days following the long call. Short Call B consists of up to 3 hand-offs and up to 4 admissions from the ER from 7:00 am to 12:00 pm on the weekends instead of hand-offs. Short Call B occurs the day after Short Call A. Long call is every fifth day from 1:00 until 9:00 pm with no overnight call. Long call teams admit to a maximum of 8 new patients and ICU transfers.

A typical call schedule for a ward team would be:

Day 1	Day 2	Day 3	Day 4	Day 5
Long-call	Post-call	Short-call A	Short-call B	No call

Hospitalist/Resident teams provide ER coverage from 7:00AM-12:00pm from Monday through Friday. Following this time either short-call teams or long-call will admit.

The Hospitalist of the Day (HOD) will receive phone calls from ER MD for admissions from 7:00 am to 9:00 pm and distribute patients to the hospitalist team, short-call team and long-call team. From 9:00 pm to 7:00 am the Hospitalist of the Night will perform this duty. From 1:00pm and on, every 5th unassigned patient goes to the family medicine service.

If the teams become overwhelmed by the amount of admissions, then backup can be called to help.

ADMISSIONS

The majority of admissions occur through the ED. The patient is usually seen first by one of the ED physicians unless otherwise specified by an Internal Medicine Faculty. If the ED physician thinks the patient needs admission, the Hospitalist of the Day (HOD) on call will be contacted. Patients may be directly admitted to the hospital from Brackenridge clinic if the HOD has been contacted by the referring physician and the HOD agrees with the direct admit to the floor. Direct admissions from physicians other than those at Brackenridge need to be called to the HOD for approval for the direct admission.

Once a decision has been made to admit a patient, the intern enters the admission orders. There should be a full history and physical exam on the chart by the intern. A holding note by the resident or intern may suffice to accompany the patient to the ward if there is urgency to move the patient from the ED.

Other sources of admissions include transfers from the ICU, from the outpatient Brackenridge Clinic, and from local health department clinics (as stated above). Rarely patients will be transferred from other hospital services or private physicians.

DAYS OFF AND UNANTICIPATED/PLANNED ABSENCES

All residents who are off duty for any reason at any time, are responsible for transferring care of their patients to the “on-call” or covering resident. If a resident is taking a day off, it is the responsibility of THAT resident to notify the page operator and the Internal Medicine program office. Any other unanticipated absences must be discussed and handled by the Chief Resident. Simply notifying one’s attending is not adequate for an unanticipated absence. Planned absences must also be coordinated and arranged through the Program Office and the Chief Resident. You must complete the leave of absence form prior to leave. Sick call must be accompanied by a physician’s letter.

PROVISION OF CARE BY RESIDENTS TO NON-TEACHING PATIENTS

Residents provide CPR, ACLS, and Medicine consultation to private patients who are not assigned to ward teams or the consult service. Otherwise, residents are not available for histories, physicals, or emergency evaluation of non-teaching service patients. Non-Teaching service patients are patients on services without internal medicine residents and attendings giving direct care. Unless formally consulted by the attending physician, histories, physicals and emergency evaluations are the responsibilities of the attending physicians for patients not assigned to the teaching service. However, residents may also be asked to become involved in the care of patients at the request of critical response team. It is the responsibility of the most senior resident performing “code” services for non-teaching patients to communicate directly with the patient’s Attending or covering physician after the code is complete and the patient requires further disposition, thereby transferring the care of the patient to the appropriate physician or service.

ADMISSION CAPS AND CENSUS CAPS—CONTINUITY CLINIC QUOTAS

Ward Teams:

- Interns (R1) may admit only 5 new patients during any long call day.
- ICU transfers and handoffs from the night float resident count as full admissions.
- 2 Intern teams will be responsible for 8 admissions. R2 or R3 Residents will not be responsible for more than 8 admissions during a long call period.
- All admissions over 8 should be managed by the Admitting, Backup, or Night Float resident and officially admitted to the next call or short call team.
- Interns (R1 residents) are responsible for the ongoing care of no more than 10 patients. Progress notes must be written by the upper level resident if an R1s census exceeds 10 patients.
- The upper level resident cannot be responsible for supervising the ongoing care of more than 20 patients.

ICU Teams

- R1, R2, or R3 residents may not admit more than 5 patients during any on call period.
- R1 residents may not care for more than 5 patients on an on-going basis.
- R2 or R3 residents may not supervise the care of more than 14 ICU patients.

Hospitalist/Consult teams:

- Residents may admit up to 5 patients per day. Some of these patients will be Night-Float hand-offs and will not be admissions from the ER.
- One-resident teams will not carry a census beyond 15 patients on the Hospitalist service.
- The consult team takes new consults from 7am-5pm daily.
- If a new consult comes in between 5pm-7am the AR or NF resident will admit for the team and they will assume care in the morning

BOUNCE-BACK PATIENTS

Bounce-backs are patients who are re-admitted to the hospital at any time during the block during which they were discharged. These patients will “bounce-back” to the upper-level resident who originally admitted them. Patients who return after discharge from the ED within the same week will go to the team that originally evaluated that patient in the ED.

All bounce-backs are counted as admissions if the receiving team is on short or long call team and writes a full admission history and physical. If not, they count as admissions to the team that admitted them and that team will hand them back to the original team the following morning in which case the original team CANNOT count them as a handoff.

Patients who return from the ICU to the ward within same resident month of the initial ICU transfer go back to the original team. These ICU bounce-backs are counted as a bounce-back to the original or on-call team.

PATIENT FOLLOW-UP

Revised 12/8/2011

Residents should attempt to contact their patients' primary care physicians during a patients' hospital stay. All patients admitted to the medicine service should have outpatient follow-up scheduled at the time of discharge. Ideally the patient's primary care doctor has been informed of the admission, has the appropriate information and discharge paperwork, and has agreed to follow the patient after discharge. This must be documented in the discharge note and discharge dictation.

Patients from the Paul Bass Clinic and David Powell Clinic may be sent directly back to them for follow-up if the above procedures of clear communication have been followed.

ROUNDS

Daily work rounds commence after morning report. All patients should be seen and/or discussed by the resident and intern. Pertinent new data should be reviewed. The intern should write progress notes as early as possible during the day. The organization of work rounds is the responsibility of the ward resident. Interns should pre-round on patients before work rounds in order to present the patients to the resident in a problem oriented format. Residents should use this opportunity to teach, interact with patients, and supervise the order writing skills of the intern.

Attending rounds are generally at 9:30 am until noon. These rounds combine management and teaching. Rounding times may vary according to the schedule of the team's attending. Work rounds should be conducted prior to attending rounds. During rounds the intern should present all new admissions to the attending. Each patient on the team should be discussed and seen. A particular patient may be the focus of the teaching aspect of attending rounds. The attending is responsible for writing a note on each patient and signing all progress and procedure notes. Procedures must be supervised by an attending to be billed.

Weekend rounds usually begin at 8:00 am and last until all patients on the team have been seen and evaluated, and a progress note has been written. Rounds are expected to occur every day. Attending rounds on weekends will be scheduled in the morning between 8:00 and noon.

CHECK OUT

At the end of each day, before leaving the hospital, each team must check out their patients to the team on call with a list of names, locations, problems that may arise, pending labs, etc. All critically ill patients should be carefully discussed. The NF should receive 8 check-out lists every night. The Chief Resident should be notified the next morning if a team did not check out the previous night. Residents must notify the page operators when going off duty. There will be formal check out at 4:00pm in the residents' room in the ER.

MORNING REPORT

Attendance at morning report is mandatory during the ward rotations with the exception of days off and late AM start times. Morning report begins at 9:00am and is held Monday through Friday mornings. Residents are expected to be on time. The residents are responsible for presenting cases and providing a brief discussion on a pre-determined subject following presentation and discussion of the case. The presentations should be **brief but informative. They should be no more than ten**

minutes. Pertinent x-rays, EKGs, CT-scans and other data should be available. The ward team resident will choose the patient to be presented.

CODE BEEPERS

The medicine call team responds to all arrests in the hospital these are announced as **“ATTENTION, ATTENTION, Code Blue <then the location>”**.

The page operator will announce a Code Blue overhead, and about 30-60 seconds later, the code beeper will go off as well. The resident runs the code while the intern assists. The ED attending will be available for consultation if needed. It is the responsibility of the call team to pass on the code beepers to the next team. Someone should carry the code beeper at all times. If there is a conflict, the intern passing off the beeper must find another intern to carry the beeper. Each resident must be ACLS certified and must maintain his or her certification.

Ancillary Support for Patient Care

Residents are not routinely responsible for performing venipuncture, drawing labs and transporting patients.

SPECIFIC INTERN WARD DUTIES

1. Interns should pre-round on all patients before morning report. This may entail a 6:00 am hospital arrival so that all patients can be seen.
2. The intern is responsible for maintaining the daily census, with the help of their resident. The updated census will be ready before attending rounds and will be updated prior to checkout before the intern leaves for the day. This census will be maintained on the G drive in an excel sheet. Copies should be made for the team prior to rounds.

A census entry should include the following information:

Room Number	Admit Date
Patient Name	Age/Sex
MR #	Diagnosis

The intern should not adjust or change the billing line in the census. The census must reflect all patients seen by the attending for any particular day.

3. Attendance at morning report is MANDATORY. Morning report begins promptly at 9:00 am Monday through Friday, with some exceptions such as Grand Rounds, Cardiology, GI, or outside reports. The resident is responsible for the presentation of patients.
4. A resident may be asked at any time to present a patient from their team.
5. Noon conference is held daily from 12:00 to 1:00 pm. Attendance at noon conference is mandatory.
6. A 50% attendance rate is the minimum allowable rate for all conferences. Failure to meet this minimum will result in an automatic "4" or lower in problem-based-learning with the possibility of lowering other evaluations, as well as a permanent letter the resident's file.
7. Afternoons should be spent completing progress notes, checking on pending tests, talking with family members, etc. On the days of outlying clinics, an intern may have to return to the hospital to complete their work.
8. At day's end, the intern should contact his/her resident before leaving the hospital. The intern must then check out with the intern on-call/nightfloat intern. Check out must include clear verbal expression of concerns about unstable patients, and a written list with possible problems and suggestions and category status for each patient.
9. If work is finished before 5:00 pm, the intern may leave the hospital while remaining on beeper call until 5:00 pm.

10. During on-call days, the interns are responsible for the intern code beeper. The beeper is passed from long call to nightfloat interns.
11. The intern is responsible for a complete and thorough admission history and physical on each patient within 24 hours of admission. In the beginning, the resident will assist the intern with ED evaluation of patients and discuss management/disposition issues. Admitting orders should be entered by the intern and supervised by the resident. As the year progresses, the intern may go alone to the ED to evaluate the patient before presenting the case to the resident. The intern should not discharge a patient from the ED before the resident has evaluated the patient. The intern is also responsible for the cross-coverage of the other teams' patients with the assistance of their upper-level resident when needed.
12. On-service notes are to be written for each patient at the beginning of a new ward rotation. It is best to call the intern leaving the service a day or two in advance to discuss briefly the patients whose care you will be assuming. The on-service note should contain a brief summary of the patient's hospital course, a physical exam for that day, and current management issues. Off-service notes are to be written by the intern rotating off the service and should describe the patient's presentation to the hospital, the hospital course, a physical exam, medications, and a complete problem list with appropriate plans. Transfer notes are needed if a patient is being transferred from the wards to the ICU or to another service. The transfer note should contain similar information while also explaining why the patient is being transferred and what plans for management are in effect.
13. All notes should be titled, dated and **timed**.
14. Discharge progress notes and orders should be written/entered by the intern and faxed or cc'ed to the primary care doctor.
15. Discharge summaries and death notes should be dictated by the intern. All patients (including 23hr observations) should have a discharge summary.
16. An intern should not take more than 5 patients (new admissions and transfer/handovers) per call day.
17. Interns must review the indications and contraindications for the internal medicine ward procedures, including lumbar puncture, thoracentesis, paracentesis and arthrocentesis. Procedures should be observed prior to being attempted. It is desirable to have a skilled resident or attending assist in all intern-performed procedures until the intern has gained proficiency and performed an adequate number.
18. Interns need to write a note in addition to medical student's notes that outlines the patient's progress, management plan and progress every day.
19. When an intern or resident is off, the other intern is responsible for rounding and writing notes on no more than 10 patients.

20. The intern and the attending are responsible for the daily completion of the billing sheets.
21. Verbal orders from a cross cover intern or other resident may be co-signed by the primary intern if in agreement with the order. It is mandatory that all verbal orders be signed within 24 hours.

SPECIFIC RESIDENT WARD DUTIES

1. The resident should be present at morning report promptly at 9:00 am. Attendance is mandatory. Ward residents are responsible for presenting patients per a pre-arranged schedule at morning report.
2. The resident is responsible for the organization of work rounds after morning report. This time should be spent teaching the interns and students on the team. The resident should provide literature related to patient problems currently being observed on the team.
3. Resident admit notes on patients admitted by the intern should be comparatively brief with pertinent additions or changes in history and physical exam findings with a complete assessment and plan.
4. Ward resident will alternate patients between the 2 interns during call day.
5. The intern's orders should always be reviewed with discussion of any changes, deletions, or additions.
6. The resident is responsible for obtaining sub-specialty consults. As the academic year progresses and the interns become more acquainted with the various sub-specialists, the intern can assume this responsibility.
7. A 50% attendance rate at conferences is required.
8. The resident is responsible for directing all codes with the advice of the attending ED physicians.
9. The resident must be careful to document each patient's category status in the progress notes. Specific interventions for category II, a clear description of family discussions.
10. In the case of any unstable or complicated patient, the resident needs to write a note in addition to the intern's daily note that outlines the patient's progress, management plan, and prognosis. If both interns are off or there are >10 patients, the resident needs to write a note on the patient.
11. Ward residents should always check out to the on call resident.
12. Ward residents, if certified in internal medicine procedures, must supervise the intern's performance of procedures on ward patients. If the resident is not yet certified in internal medicine procedures, the resident must perform the indicated procedure under direct supervision of a certified resident or attending.

CIRCUMSTANCES UNDER WHICH RESIDENTS MUST NOTIFY ATTENDINGS

1. Attendings should be called (regardless of the time of day) about any admission to the IMC or ICU, or an admission for whom such care is considered or contemplated.
2. Attendings should be called about any change in patient status, regardless of patient location, and regardless of the time of day.
3. Attendings should be called about change in Category Status, request for, contemplation of, or clinical situation that warrants aggressiveness of care decision making.
4. Attendings should be notified of any request for transfer from another hospital.
5. Attendings should be notified of any unresponsiveness of consulting physicians or services or when the advice or action taken is in question.
6. Attendings should be notified of any conflict with another attending, consultant, ED attending, or with nursing or other resident services.
7. Attendings should be notified when there are difficulties in implementing the decided upon care plan.
8. Attendings should be notified of any deaths on the service—expected or otherwise.
9. Attendings should be notified of any risk management events, including family complaints, threats of litigation, departure AMA, or complication or mistake in medical management of patients.
10. Failure to notify attendings reflects poorly in Systems Based Practice and Practice Based Improvement competencies.
11. Failure to notify attendings may result in remedial or disciplinary action.

CATEGORY STATUS

This is a descriptive and prescriptive notation made in the progress notes and order sheets pertaining to the appropriate level of care for each patient. This should be done only after consultation with the patient and family. Proper documentation in the chart is essential. The attending physician will be involved in the assignment of category status and must be notified of Category II or III status as soon as possible. The attending should approve of any category change of a hospitalized patient, and must make the appropriate notation in the chart.

Category I: Unless otherwise stated, this is the presumed appropriate level of care for every patient. This implies that full ACLS resuscitative measures will be used in the event of a cardiopulmonary arrest, and that all measures to prevent morbidity and mortality will be undertaken.

Category II: This level implies that in the event of cardiopulmonary arrest, ACLS measures will not be taken. However, other measures to prevent morbidity and mortality will be taken during hospitalization, such as treating pneumonia, UTI, CHF, etc. This category status does not imply that illness in the patient will not be investigated or treated. It does suggest that every invasive procedure and risk-associated treatment will be carefully evaluated for its benefit to the care of the patient. Specific instructions or wishes should be spelled out clearly in the chart and orders. Example: “Category II – no intubation, CPR or shocks. Cardiac meds only.” Other instructions to limit CPR are acceptable, however full ACLS is required for successful resuscitation.

Category III: This level implies that “comfort only” measures will be employed. ACLS measures such as intubation, chest compressions, shocks, or cardiac meds will not be undertaken. This category is generally reserved for terminally ill patients. Comfort measures usually include Morphine for pain control, Oxygen via nasal canula, face mask, etc. Details of the category status should be discussed with the nurses and on call team. Again, proper documentation in the chart is of utmost importance. Attempt to anticipate which patient may deteriorate so that you can discuss this with the patient or family members before the patient becomes critically ill and crucial decisions need to be made emergently.

ALL PATIENTS ARE CONSIDERED CATEGORY I UNLESS OTHERWISE STATED.
CATEGORY II AND III STATUS NEED TO BE UPDATED **EVERY 3 DAYS**.

TRANSFER POLICY

1. Interns and residents cannot accept transfer patients from other hospitals. Transfers must be approved by the Hospital Administrator and the HOD. **Emergency transfers from other hospitals emergency rooms can only be handled by the ER physician, and ER transfer nurse. EMTALA rules dictated that all patients from other hospitals, who have emergent illness that can not be addressed at the transferring hospital, must be accepted by the general hospital if a bed is available and the hospital possesses the expertise to care for the patient.**
2. Transfers within the hospital from one service to another (ICU to ward medicine, surgery to medicine, etc.) must include a clear order stating a change of nameplate and front sheet to reflect the new attending and resident. These changes should also be made in the event of a patient being passed on to a new medicine team at month's end.
3. Transfers of patients to other services in the hospital require notification of and approval by the attending physician.

ICU DUTIES

1. The ICU attendings are Drs. Deaton/Shapiro/Weingarten/Perret/Clark/Harford/Dvorak/Morrison/Hinze/Dallas/
2. Paul Bass clinic and outlying clinics will be blocked.
3. The team consists of: at least four of the following: internal medicine resident, internal medicine intern, FP resident, Ob/Gyn resident (FP and Ob/Gyn residents will for practical purposes be considered as interns).
4. Each team member is on call every third to fifth day. Call is 24 hours, 8:00 am to 8:00 am for residents only (R2,R3). Interns will be on a 12 hours shift. The post-call resident may go home after rounds. Each team member must have one day off per seven days on average. Residents may admit a maximum of 5 patients on a call day; anything beyond this must be handled by the backup resident.

Sample Call Schedule:

Sunday	Monday	Tuesday	Wednesday
Int #1 7am-9pm Int #2 9pm-7am	Int #3 7am-9pm Int #1 9pm-7am	Int #4 7am-9pm Int #3 9pm-7am	Int #2 7am-9pm Int #4 9pm-7am
Resident#1 8am-8am	Resident#2 8am-8am	Resident#3 8am-8am	Resident#1 8am-8am

5. The ICU resident will supervise the interns from 8:00 am to 8:00 am the next day except on their days off.
6. Patients are primarily admitted from the ED or from floor transfers after ICU team consultations are requested.
7. Conflicts among the ED physician, ward resident, and ICU resident as to where a patient is to be admitted should be resolved by the ICU attending.
8. Cardiac patients with primary problems of a myocardial infarction or unstable angina should be admitted to the ward team.
9. Otherwise, all critical patients should be admitted to the ICU team (including serious overdoses, patients in danger of needing intubation, shock, etc.) with the advice and consent of the ICU attending.
10. ICU patients should have an AM note and a PM note on their chart. The ICU call resident or intern writes the PM note. It should be written in the SOAP format. Problems should be summarized in the assessment portion. The medications should be included in the notes. Lab and microbiologic data should be included daily. The intern should assume most of the patient care and charting responsibilities. The ICU resident should write appropriate addenda to these notes.

11. Attending rounds vary, but always occur in the morning and again in the evening. The ICU attending will be readily available at other times.

12. Transfers out of the ICU.

- A. Phone calls from the upper level ICU resident who is most knowledgeable about the patient should be made as the ICU transfer orders are being written. The ICU resident should be able to summarize verbally the patient's presentation and course.
- B. An ICU transfer note should be written by the ICU intern after the transfer orders are completed and before the patient leaves the ICU.
- C. Ward teams accepting ICU transfers should see these patients as soon as possible. Physical examinations and chart review should preferably occur in the ICU prior to the patient's transfer.
- D. Included in transfer orders should be the change of the patient's nameplate to include the ward team physicians.

13. Triage of Critically Ill Patient to ICU or Floor Teams

- A. All intubated patients will be admitted to the ICU team.
- B. All patients surviving a cardiopulmonary arrest will be transferred or admitted to the ICU.
- C. Patients with a complicated myocardial infarction (hypotension, arrhythmia, shock) will be managed in the ICU by the ward team with cardiology consultation unless the complexity of care is to a degree that critical care would be best delivered by the critical care service. However, the cardiologist will be the attending of record for these complex cardiology patients.
- D. ED physicians will consult the ICU service for admission of critically ill (shock, respiratory failure) patients, but will consult cardiology when patients have significant heart disease that may be responsible for or a major contributor to the critical nature of a patient's illness.

NIGHTFLOAT DUTIES

1. Night Float (NF) hours are from 9:00pm to 7:00am. There are no outpatient clinic duties during this rotation.
2. NF coverage is Saturday through Thursday with Friday off. The major responsibility of the NF resident is the covering of ED admissions from 9 pm to 7:00 am. Fridays will be covered by an assigned 2nd year Resident.
3. At 9 pm, the NF resident should notify the Hospitalist of the Night of his arrival. The NF resident also carries the long-call resident's code beeper after 9 pm.
4. There are no excused absences from NF. If for extreme circumstances a resident is unable to perform his/her duties, the chief resident should be contacted. A Backup or Jeopardy resident may be called in to cover. The resident not performing NF duties will make up this absence by taking a NF call for the covering resident.
5. The NF resident may discharge patients home from the ED only with the consent of the ED attending, or Hospitalist of the Night.
6. The NF resident has the option of calling the Backup resident for assistance if overwhelmed or capped (10 patients)
7. The Chief Residents are assigned to have table rounds with the NF from 7am till 7:30am.

Admitting Residents (AR) Job Description

1. Shifts are from 5:00pm – 3:00am
2. NF coverage is Sunday through Friday with Saturday off. Saturdays will be covered by an assigned 3rd year Resident.
3. The AR has no clinic responsibilities.
4. The AR attending is the assigned Hospitalist of the Day.
5. There are no excused absences from NF. If for extreme circumstances a resident is unable to perform his/her duties, the chief resident should be contacted. A Backup or Jeopardy resident may be called in to cover. The resident not performing NF duties will make up this absence by taking a NF call for the covering resident.
6. The NF resident may discharge patients home from the ED only with the consent of the ED attending, or Hospitalist of the Night.
7. The NF resident has the option of calling the Backup resident for assistance if overwhelmed or capped (10 patients)
8. When ER is clogged up, AR may write skeletal admitting orders for stable patients to go to the floor to be evaluated by the LC team.
9. If the AR/LC or AR/NF are overwhelmed (very rarely), the back-up resident should be notified by the AR or NF, as well as the Chief Resident.

Medicine Consult Duties/Rules

1. Medicine Consult (MC) resident will accept consults from 7am to 5pm, every day of the week. MC will be off two out of four weekends; the Cardiology Resident will take the place of the consult resident during these periods.
2. AR takes consults from 5pm-3am, NF takes consults from 3am-7am.
3. Both AR and NF will turn their consults over to MC the next day with excellent resident-to-resident communication.
4. MC will check out carefully to the cross cover intern.
5. When MC is in clinic the AR will be expected to handle urgent consults (e.g. Pre-op eval.). Non-urgent consults will be seen after clinic.
6. The ICU team should be consulted for patients in the ICU.
7. No vacation is allowed during consult service
8. MC will produce a census list every day.
9. Consults will be billed on the billing sheets which MC and Attending fill out.
10. Outpatient internal medicine follow-up per MC if no other primary care is available.
11. MC will read the syllabus and the readings prescribed in the syllabus.
12. MC will attend morning report every day.
13. MC will call the MC attending with all daytime consults prior to leaving for the day.

CONTINUITY CLINIC DUTIES

Each intern and resident will be assigned to weekly clinics at one of the Austin/ Travis County Health Department clinics, the Paul Bass clinic, or the VA clinic. The intern will have a ½ day clinic per week. The resident will have two ½ day clinics per week. These clinics are ongoing for the full three years of the program. While on the wards, interns and residents will be excused from clinic on post call days. Other excused times are dependent on specific rotations and with Chief Resident approval.

Residents are expected to arrive at the clinic no later than 1:00 pm. Tardiness will be reported to the director and may result in poor evaluations. Residents must comply with the rules and regulations of their clinics. Failure to comply with clinic attendance, supervision requirements, paper documentation, and patient care, will result in counseling and possible disciplinary action by the Resident Evaluation Committee.

Continuity Clinics may occur post-call for R1, R2 or R3 residents

- R1 Residents on average will see at least 3 patients and not more than 5 per half day, and of those 1-2 will be new patients with 2-3 follow up patients.
- R2 and R3 residents will see at least 4 patients on average per half day. Second year residents will see no more than 6 patients per half day and third year residents will see no more than 10 patients per half day. Of these patients, each group will see 1-2 new patients per half day and the rest will be follow-ups.

Interns must have their patient encounters carefully supervised during the first six months of clinic. It is recommended that the attending physician evaluate all patients seen by interns unless the intern demonstrates competence in evaluation and management of specific problems. It is recommended that attending physicians supervise and evaluate the intern's competence in breast, pelvic and the male G.U. and rectal examination. Interns must document the care delivered thoroughly. If appropriate, interns may perform procedures on their patients in clinic with supervision of the procedure by the attending or an upper level resident who is credentialed in the procedure. Interns must demonstrate competence in understanding indications, contraindications and complications for the procedure performed. Interns are not to perform procedures unsupervised unless previously demonstrating competence and being formally credentialed by the training program. R2 and R3 residents are able to independently perform internal medicine procedures if credentialed by the training program in the procedure being performed. R2 and R3 residents may see patients independently if competence in the care of the problem identified has been demonstrated. All residents are expected to seek supervision (and advice if needed) from attending physicians about all patients seen.

CLINIC ROTATION

Interns and 2nd year Residents will complete two months of full-time outpatient clinic rotations each year. During these periods they will rotate through both the Brackenridge subspecialty clinics and their continuity clinics.

The resident and intern will maintain their afternoon continuity clinics.

Clinic hours are 8:00 am to 5:00 pm, Monday through Friday.

I. General Information for Clinic Rotation

- A. All residents will attend all subspecialty clinics. Additional residents on various subspecialty rotations may also be in attendance.
- B. Starting times: 8:00 am and 1:00 pm.
- C. No clinic may be canceled without the approval of the Program Director, Associate Director, or the Chief Resident.
- D. Patients cannot be overbooked in subspecialty clinics without the attending's approval.
- E. Patients may be assigned to the appropriate resident's primary care clinic by an Attending in a specialty clinic.
- F. ER follow-ups will be scheduled under the continuity clinic slots.

II. Senior resident responsibility

The following is a list of responsibilities for the clinic resident at the beginning of the rotation.

- A. Arrange admissions.
 - Notify the admitting call team of the need for admission and enter initial orders along with a brief note.
- B. Arrange for follow up of all patients and communicate either via a phone call or a written note the findings of the specialty clinics to the primary care physician.
- C. Review all laboratory and X-ray data.
 - Request relevant charts and make sure all significant abnormalities have been treated or more thoroughly evaluated.

- Call the primary care physician or Attending of the specialty clinic with any markedly abnormal values or findings. If an abnormality represents an emergency, contact the patient to be evaluated and possibly admitted through the Emergency Department.
- Arrange for follow-up and closure of abnormal laboratory or X-ray findings with appropriate documentation.

III. Intern Responsibility

- A. See as many patients as possible with the supervision of the attending and senior resident.
- B. Document clearly all care provided.
- C. Date, time, and sign all clinic note entrees.
- D. With the help of the Chief Resident, assume the second year resident responsibility when he/she is on vacation.
- E. Problem lists and medication lists should be in all outpatient records. These are the responsibility of any resident seeing the patient.

IV. Clinic After Hours Pagers

- A. This is an after clinic hours pager call from home. Answer questions from patients directly or patient related and phone triage to determine whether the patient needs to come into the ER (if urgent) or else schedule a clinic appointment the following morning.

EMERGENCY DEPARTMENT ROTATION

1. All interns spend one month in the emergency department (E.D.). They are required to complete fifteen 10-hour shifts during this rotation and one EMS ride-out.
2. The shift schedule is determined by the E.D. attending. Residents are required to acquire intubation skills during this time and to spend at least one shift with Emergency Medical Services (EMS).
3. Procedural skills, inclusive of nasogastric intubation, bladder catheterization, arterial and venous punctures, should be acquired during this rotation.
4. Interns will see patients who have not been previously triaged by another physician and will present all patients seen to the assigned E.D. Attending physician.
5. Interns will evaluate and outline the management of adult E.D. patients.

NEUROLOGY CONSULT SERVICE

1. The Neurology resident will not take vacation during this month unless coverage for the service has been arranged.
2. The Neurology attending will make rounds with the resident on weekdays and when emergent consultations require rounding.
3. The Neurology resident will be responsible for doing a history and physical examination on each patient. The attending will then make rounds and write a formal consultation note.
4. At-home call will follow the rules as above. One weekend per month will be covered by an Internal Medicine R3.
5. The resident will make daily rounds on all Neurology patients.
6. The neurology resident will assist the neurology attending in acquiring and submitting billing information for each patient seen. These should be submitted on a weekly basis.

BEHAVIORAL MEDICINE ROTATION

1. First year residents will spend one month on the psychiatry consultations service. They will collaborate with the psychiatry attending and the psychiatry resident and will consult on inpatients with psychiatric problems.
2. First year residents will read and participate in curricular goals as outlined by the Behavioral Medicine curriculum, including morning report case presentations.
3. Residents will attend all lectures and small group discussions designated as learning experiences by the psychiatry faculty.
4. Residents will be excused from these duties to participate in their medicine continuity clinic.

AMBULATORY CARE BLOCK

Third year residents will complete a two-month block in ambulatory primary care. Residents attend clinical sessions in orthopedics, ophthalmology, gynecology, and other specialties. A guide is given to each resident with information about the location, preceptor, goals and objectives for each subject. Residents attend the Internal Medicine noon conference

The Block has these principles:

- Residents learn aspects of ambulatory primary care not otherwise covered in their residency.
- Residents develop new insights into the interface of primary care doctors with non-internist specialists and their relationship to the larger medical community.
- Residents have opportunities to perform procedures not otherwise available.

MEDICAL RECORDS AND MEDICAL DOCUMENTATION

GENERAL RESPONSIBILITIES

1. Each patient on a ward team must have a daily Progress Note. This Progress Note must record the complaints, physical exam findings, laboratory data and medical decision making. The responsibility of the daily Progress Note usually falls to the intern caring for the patient. However, if the intern's census exceeds 10 patients or the intern is unavailable or too busy, the resident for the team will complete the daily progress note.
2. Attending physicians will write a daily note on each ward team patient.
3. Hospital admissions must have a complete history and physical recorded in the chart. An admission Form has been devised for this purpose. All aspects of the form, including the Review of Systems must be completed.
4. All discharged patients who have been admitted whether under full admission to the hospital or admitted under observation) must have a completed Discharge Order Form and a dictated Discharge Summary. It is the responsibility of the first year resident to complete the Discharge documentation, with the help of the upper level resident.
5. Residents are required to date, time and sign all verbal orders within 24 hours of giving the order.
6. Residents are required to date and time all orders. If handwriting is illegible residents should print underneath their cursive signature.
7. Residents must go to the Medical Records Department on a weekly basis. Records are required to be completed on a certain day of the month depending on the first letter of your last name. (See Institutional Resident Manual – Section 5 – SETON Medical Records Suspension Policy – or can also be found on SETON Intranet under Policies and Procedures)
8. RESIDENTS WHO FAIL TO COMPLETE RECORDS BY THE DESIGNATED DAY OF THE MONTH WILL BE IN **VIOLATION**. RESIDENTS WHO RECEIVED THREE VIOLATIONS WITHIN A TWELVE-MONTH PERIOD WILL HAVE AN AUTOMATIC TWO-WEEK SUSPENSION. THIS SUSPENSION WILL BE TAKEN FROM VACATION TIME OR WILL BE CONSIDERED AN UNPAID LEAVE. In-house suspension requires that you report to Medical Records in lieu of assigned responsibilities. If a jeopardy resident is required to work for you during in-house or medical records suspension you will be required to pay back the resident covering you.

OUTPATIENT DOCUMENTATION

1. Residents are required to document the reason for the outpatient visit, the patient's history, physical, laboratory data, and medical decision making. Documentation for the visit will be determined by the complexity of the medical illness and the time given for the visit. In addition, continuity patients should have a Problem List, and Medication Flow Sheet. Some clinics require flow sheets for health maintenance issues and immunizations. Some clinics have a computerized medical record. It is the responsibility of the resident to become facile with the electronic medical record.
2. Residents should understand that all visits require attending documentation. Attendings best document the record in a linking note to the previously written resident note.

PROCEDURES/INTERPRETIVE SKILLS

PROCEDURES

Each resident will be issued a procedures logbook in which to record all procedures performed. All procedures must be supervised by credentialed upper level residents or faculty until competence is achieved.

The following information should be recorded for each procedure:

- a. Date, time
- b. Type of procedure
- c. Name of patient
- d. Medical records #
- e. Signature of individual who supervised.

In addition, carbon copies from the logbook are given directly to the IM Program Coordinator. Procedure information is entered into a computerized database. This database is shared with Brackenridge Hospital for resident procedure credentials. Updates to the Brackenridge database every 6 months.

Procedures available for competency education with numbers required for certification:

- ABG(arterial puncture) (5)*
- Arthrocentesis of knee (3)
- Central venous line placement (5)
- Lumbar puncture (5)
- Abdominal Paracentesis (3)
- Thoracentesis (5)
- NG tube placement (3)
- Pap Smear & Endocervical culture (5) *
- Basic and advanced cardiopulmonary resuscitation (valid certification) *
- Intravenous line placement (3)
- Venous blood sampling (3) *

* ABIM Required

The number in the parenthesis indicates the number of successful, supervised procedures required to be credentialed and able to perform a procedure unsupervised.

Elective procedures include:

- Arterial line (3)
- Bone marrow biopsy and aspiration (3)
- Elective cardioversion (5)
- Endotracheal intubation (10)
- Flexible sigmoidoscopy (10)
- Pulmonary artery balloon flotation catheter placement (5)
- Skin biopsy (3)
- Temporary pacemaker placement (5)
- Holter monitor interpretation (5)
- Exercise treadmill testing (5)
- Cryosurgical removal of skin lesions (3)
- Soft tissue and joint injections (3)

INTERPRETIVE SKILLS

1. All residents must develop competency in interpretation of electrocardiograms.
2. All residents must develop competency in:
 - a. Chest roentgenograms
 - b. Peripheral blood smears
 - c. Gram stains of sputum
 - d. Microscopic examinations of urine
 - e. Spirometry
 - f. KOH and wet prep examinations of vaginal discharge
3. Residents should have the opportunity to achieve competence in additional common interpretive skills required in the residents' expected practice settings. These include but are not limited to:
 - a. Ambulatory electrocardiography
 - b. Ambulatory blood pressure monitoring
 - c. Spirometry

ORAL PRESENTATIONS

Oral presentations are an important part of our daily medical lives. Skill in this arena makes a strong impression on the listener and helps maximize efficient care. Below is a suggested format.

I. Identifying Data and Chief Complaint.

- You may include relevant social and medical history data in this initial sentence.

“Mr. P. is a married white construction worker and longtime smoker who presented yesterday with no prior medical problems but with an acute onset of substernal pressure-like chest pain of two hours duration which awakened him from sleep.”

II. History of Present Illness (HPI).

- This should be brief and succinct, including PERTINENT positive and negative data. Relevant data from the patient’s past medical history, current medication list, family history, and social history may be included in relation to the chief complaint.

III. Physical Exam.

- One should present full vital signs, a description of the general appearance and only pertinent positive and negative physical examination findings.

IV. Laboratory and Procedural Data

- Residents should be consistent in the order of presentation of this data. Suggested order: CBC, lytes, BUN, Cr, Glu, UA, Chemistries, Coagulation panel, Chest X-ray, EKG. If one adheres to an order of labs listed, it facilitates the listener.

V. Assessment/Plan

- Presentations should include a problem list with differential diagnosis for the problems at presentation. This skill is developed over the first year of residency.

CONFERENCES

All residents must attend 60% of conferences each year. During non-ward, non-ICU months, they will be responsible for various presentations.

At the minimum:

First year residents will give

One Clinical Question.

One psychiatric case.

Second year residents will give

One Clinical Question.

One journal club discussion.

One GI case conference.

Third year residents will give

One case conference.

One Clinical Question.

One geriatric conference.

One journal club discussion.

Failure to attend 50% or more conferences over a 6month period will result in:

1. A permanent letter of reprimand in the resident's file.
2. An automatic evaluation score of 4 or less in Problem-Based Learning.
3. The possibility of having other evaluations deducted.

VACATION POLICY

- A. The ABIM requires 36 months of internal medicine residency with at least 24 months at the R2, R3 level. The ABIM allows one month off per year of training (sick & vacation). Therefore training time must equal 33 full months to be Board Eligible.
- B. Vacations can only be taken during certain electives and clinic months.
- C. Vacations are usually taken in one-week blocks; there are a few exceptions.
- D. All residents receive a least 3 blocks of 5 working days each year of their residency.
- E. It is preferable that vacations be taken during the first or last weeks of your electives. This provides a better educational experience and promotes a more accurate evaluation process.
- F. Vacation requests should be turned in to the Chief Residents at the start of each residency year to avoid too many residents being out on vacation at the same time. Each formal vacation request must be completed at least **3 Months** prior to the desired vacation time and signed by the Chief Resident. Request forms may be obtained in the IM office. Vacation requests received after 8 weeks will require that the resident find appropriate Continuity Clinic coverage.
- G. Second and third year residents are allowed one week per year for educational leave in addition to their vacation time. This time should also be taken during an elective month. This extra week is NOT an extra week of vacation. Proof of registration must be provided if attending a conference. Fellowship interviews should be taken from this time. Notification should be given **eight weeks** before the leave. Request forms may be obtained in the IM office.
- H. Vacation time does not roll over to the next academic year.
- I. Any day taken off during normal work time is considered a vacation day. Unauthorized leave is a possible reason for probation.
- J. Leave required beyond vacation (maternity, sick or elective) follow the institution's official leave policy.

Policies & Procedures on Due Process and Grievance

Refer to the AMEP Institutional Housestaff Policies on Due Process and Grievance

MISCELLANEOUS

Mentors

Each resident will be assigned a mentor. The mentor is intended to be an individual who may assist the resident in a variety of ways that may include but not be limited to: adjusting to residency, questions regarding aspects of residency, professional growth and development, career development, problem resolution, concerns regarding monthly evaluations, conflicts with faculty/residents/staff, stress management, etc. If the mentor you are assigned is not a good match for you then you may request the Chief Resident assign you to a new mentor.

Pagers

Pagers will be issued for the duration of the residency. Pagers may be turned off during the daytime period only when a resident is post-call for the ICU and NF rotations, or on a designated day off.

1. Ward team residents need to respond to pages every day from 7:00am – 5:00 pm
2. On off-days, the intern/resident taking off needs to notify the page operator who will be covering for him/her.
3. Interns/Residents on-call (including ICU on-call) should notify the operator which call room they are assigned to each evening before turning in and when they leave house.
4. Page operators and the medicine office should always have a working telephone number for each resident. The medicine office and the pager operators should be informed of days off and time off the pager.

Ancillary Support for Patient Care

Residents are routinely not responsible for performing venipuncture, drawing labs, and transporting patients.

Food

The hospital provides breakfast and lunch Monday – Friday in the Doctor's Dining Room. Meal tickets will be issued on a monthly basis for your weekend and call night shifts.

Paychecks

Paychecks are distributed on a bi-weekly basis. Direct deposit is available.

Book Fund

All residents and interns will receive a yearly book fund. This fund is renewed each year but the previous year's unused balance cannot be added onto the next year.

ATTENDING PHYSICIAN ORDER WRITING

Policy regarding order entry for attending physicians on the ward medical services when patients are primarily cared for by housestaff:

1. Attending, faculty, and consulting physicians should refrain from entering orders on ward medical staff patients. The exceptions to this rule include:
 - a. Chemotherapy orders.
 - b. Procedural or preoperative orders.
 - c. Emergency care.
 - d. Research protocols.
2. Attending must notify the appropriate housestaff when he/she has entered orders on a chart.
3. If an attending physician enters orders which include routine medication, laboratory and nursing care orders, that physician should assume primary care responsibility for the patient and excuse housestaff from this responsibility.
4. Attendings in the ICU are exempted from the above but are encouraged to maximize house staff autonomy while not sacrificing patient safety.

On-Call Telephone Triage Policy

Residents will update the list of doctors responsible for the care of patients so that the care team is accurately reflected in the orders for each patient. If the nameplate is inaccurate, the resident will ask that it be changed to reflect an accurate list of doctors in the orders.

Teams will be color coded to help nurses and page operators identify the proper doctors caring for a patient.

Residents will call in to the page operators to sign in and out for calls for their teams.

R1 residents (interns) will take first call on patients to whom they are assigned. Nurses and other staff will page the intern for order clarification, patient requests and new problems, and lab results as appropriate. Nurses will call the intern for sudden change in status of patients and will also page the upper level (R2 or R3) resident if the intern does not answer promptly or reflects insecurity or uncertainty about the medical decision making. Sudden change in status requires that the intern respond in person. After hours, the on-call or night-float intern will respond to cross-cover calls and will personally evaluate patients with a sudden change in status. If nursing concerns are not addressed by the intern then the nurse will use the "chain of command" rule to insure the best patient care.

ICU Chain of Command

ICU teams usually consist of 2-3 interns and 1-2 upper level residents. One intern (R1) and one upper level resident (R2,R3) will be on-call together.

1. The ICU resident or intern on-call will respond to general concerns and sudden change in status of ICU patients. The Intern on-call will have back-up by the ICU resident. If the ICU intern is unable to address the nursing concerns, then the ICU nurse will page the ICU R2 or R3 assigned to the ICU team.
2. If the nursing concerns are not addressed by either the ICU intern or upper level resident providing Back-up, then the ICU attending will be paged.

The Chain of Command for the Internal Medicine ward teams:

1. The Intern caring for the patient is the first call for nursing concerns unless it is after hours or that intern is "off". The page operator will know whether or not the intern is available and who is taking calls for that patient for the day, if not clarified in the orders.
2. The Intern "on-call" will respond to nursing concerns about floor patients after the team intern has signed out. The page operator will know the status of the sign out for each Intern. This will be important, especially on weekends when sign out times will be variable. If an intern fails to sign out, it will be assumed that he or she is continuing to take beeper calls for his or her patients.
3. If the Intern caring for the patient or covering the patient fails to return pages or responds in a way that does not answer nursing concerns, the Resident (R2 or R3) on the team will be called. After 5pm cross-cover calls will go to the intern on-call; if they are unable to answer questions, the LC resident will assist with calls or issues.
4. If the Team Upper Level Resident (R2 or R3) fails to respond to nursing concerns during the normal workday, the Attending on the team will be called. If the LC or NF residents fail to respond to nursing concerns, then the Hospitalist of the day will be called.