**House Staff Expectations on the Wards**

**Daily Work Flow**

* Arrive early and pre-round: all information should be obtained by rounds including: relevant overnight events, bedside assessment of each patient, vital sign range, labs, EKG and chart review for consultant recs/PT/nutrition, etc
* Obtain firsthand H&P. Formulate your own differential diagnosis, assessment and plan. Focus on principle diagnosis but must include all secondary diagnoses. Think through the case and don’t anchor on night team’s diagnosis.
* Residents must review labs, meds, orders, & pre-round with interns prior to formal rounds, typically 8-9 AM
* Bedside rounds on all new and sick patients beginning at 9AM
* Active participation on rounds is expected from all members of the team for each patient being discussed
* Create a To-do list on rounds and follow through. Confirm your orders are being completed with the nurses
* Call consults in a timely manner, preferably right after rounds and before noon
* Follow through with the plan discussed on rounds in a timely and efficient manner
* Timely communication with attending physician regarding “Must Call List”(see below) and critical updates
* Teach back: beginning on the day of admission educate patients/families on their diagnosis, new medications and their side effects, signs/symptoms to watch for on discharge. Use methods such as Chunk and Check
* Tip for interns: prior to signing out make sure the following are done for all of your patients: daily note, labs for the next morning, sign out in provider hand off, review all orders, update hospital course for discharge summary
* See your patients more than once a day: provide updates to patient and family, re-enforces patient education as well
* Comprehensive sign out and careful hand-offs are critical to patient care and safety
* Self-directed learning: Knowledge gaps are realistic and questions are encouraged. We should all strive to improve our medical knowledge together

**Presentations**

* For new patients, do not simply read off of the H&P, present without reading and use H&P as a reference

-include pertinent positive and negatives, pertinent history

-obtain additional HPI in the AM

-you must know admitting diagnosis and medications received in the ED

* For established patients, ask overnight RN about overnight events (along with sign out from your colleague)
* Review all vital sign trends, imaging, labs, and orders
* Stay consistent with presentations: overnight events, subjective, exam, labs/imaging, assessment and plan; try not to jump from one part to the other during the presentation
* Think critically about each diagnosis, have plan for each problem, and be able to explain any abnormal findings

**Transitions of Care**

* Ensures better care and treatment for the patient during admissions and once discharged
* Contact patient’s PCP and inform them of admission, obtain collateral history/med list/tests
* Improves patient care and continuity, leads to better outcomes
* Utilize Discharge Referral Coordinator: non-clinical staff member that will make follow up appointments with PCPs and specialty physicians, appointment information should be included in patient’s discharge paperwork
* Most discharged patients should have follow up appointments within 1-2 weeks of discharge
* Notify PCP of pending discharge and any medication adjustments that were made and tests to follow up
* Identify high risk patients that would benefit from a case management follow up visit
* For patient’s without primary care providers, we are able to schedule them with our outpatient ambulatory resident clinic: Lenox Hill Medicine at 85th Street

**Discharges**

* Anticipate discharge needs early such home care, PT, wound care, home infusions and transportation
* Discharge counseling using the teach back protocol should be provided to every patient being discharged home with documentation (in the hospital course of the discharge summary) that the counseling was given. Eligible patients should complete a 4 question survey about their hospitalization and teach back should be given to patients who require further education
* Document concise but comprehensive discharge summaries including essential transitions of care

**Documentation**

* Start your notes early: other specialties and SW/CM depend on them, notes are expected to be completed by 12 PM
* Specific and comprehensive documentation of primary and secondary diagnoses: CKD stage, type of PNA or HF
* Please do not copy and paste or copy forward
* Keep it simple, it is not necessary to copy and paste the whole CT report into your problem list
* For differential diagnoses, explain your thought process and reasoning
* Reshuffle problem lists daily according to most active problem
* All H&Ps should include a full medication reconciliation, PMH, PSH, FHx and ROS and code status
* Daily assessment and documentation for necessity of catheters and lines
* Documentation of pressure ulcers including site and stage, particularly on admission
* Core Measure documentation including: DVT prophylaxis, MI, CHF, TIA/CVA, Sepsis/PNA
* Discharge paperwork is expected to be near-completed the day prior to a patient’s discharge, update the discharge summary daily 🡪 this will save time closer to patient’s discharge date

**Interdisciplinary Rounds**

* Consists of Medicine Attending, Senior Residents, SW, CM, Nurse Manager, RNs, PT, dieticians to review overall care (medical and non-medical) of all patients
* Morning IDRs at 10:30 AM and Afternoon IDRs at 3 PM
* Begin thinking about discharge date and discharge needs from the first day of hospitalization
* Think about what the patient will need to be safely discharged: PT referral for SAR, PICC line, home oxygen, etc
* Speak with your attending(s) prior to IDRs to confirm any patients whom you think will be ready for discharge the next day and any specific labs/imaging/etc. that need to be completed prior to discharge
* PM IDRs primarily focus on patients being discharged the same day who have unresolved issues and those who are planned for likely discharge the next day
* If there are changes to patient’s disposition, please update the social worker or case manager promptly (preferably before 3pm rounds) regarding these changes to ensure timely discharges

**Must Call List to Attendings**

Please note this call does not supersede clinical judgment. If in doubt call your resident or attending.

If any of the below issues occur with private patients overnight, a call must be made to the attending of record as well as to the in-house nocturnist for immediate assistance.

* Deterioration of respiratory status:
  + Significant change in respiratory status RR>25 or RR<10
  + Requires initiation of BIPAP
  + Progression to continuous BIPAP or refusing BIPAP
  + Requires intubation
  + Changes in ABG findings from presumed or known baseline
  + Changes in oxygenation, especially desaturation <90% on >4L of NC
* Deterioration of Hemodynamic Status
  + Lactic Acid level increasing
  + Acute blood loss with or without changes in vital signs
  + New onset hypotension SBP<90
  + Tachy or Brady arrhythmia with change in BP
* Deterioration of Clinical Status
  + Any increased probability of CP that is cardiac in origin
  + Significant new EKG findings
  + Any case that requires ICU/7L or CCU/5L consult regardless if they are accepted
  + Critical new findings on imaging
  + Any acute change in vital signs
* Change in disposition
  + New change in DNR / DNI status
  + Canceled discharges
* Change in Neurologic status
  + New focal deficits
  + Any change in mental status
* Medication error that reaches the patient
  + Incorrect medication that is administered
  + Incorrect dosing of medication that is administered
  + Missed medication dosing of necessary med (ie antibiotics)
* Inform the hospitalist or nocturnist of all new step-down patients immediately after transfer.
* Inform the attending of any rapid responses on his or her patients