INTERNAL MEDICINE HOUSE STAFF

Handbook and Policies 2021-2022

Welcome to Little Rock and to our Internal Medicine program at the University of Arkansas for Medical Sciences. Relevant policies and guidelines for working at UAMS and CAVHS are included in this document.

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Introduction

Welcome to Little Rock and to our Internal Medicine Residency Program at the University of Arkansas for Medical Sciences. Our mission is to provide you excellent education, and we are committed to helping you become a confident and competent internist. Our program utilizes a block schedule with a 4+1 layout for all years of training that consists of 4 weeks of inpatient care and 1 week of ambulatory medicine.

UAMS (University Hospital)

Ward Services

There are six teams comprising the teaching services. Two general medicine and four subspecialty teams. There are also four direct care hospitalist teams (3C-F) and one hematology/oncology team (2C) staffed by hospitalists to which residents are not assigned.

Team 1	Cardiology
Team 2A	Oncology
Team 2B	Hematology
Team 3A	General Internal Medicine
Team 3B	General Internal Medicine
Team 6	Abernathy Infectious Diseases Team

Team 1: Cardiology

Staffing: 2 upper level residents, cardiology attending

Patients: Inpatients with primary cardiovascular disease diagnosis

Cap: 10 patient semi-real time: real time cap of 10 until 11:00. At 11:00, if team 1 is at 10 patients, but there are planned discharges, then the resident shall text the triage hospitalist their numbers after discharges, and they will be open for new admissions as available.

Responsibilities: Direct patient care.

Admissions: Triaged by Triage Hospitalist, sometimes recommended by the cardiology fellow

Team 2A: Oncology

Staffing: 1 upper level resident, APRNs, hematology/oncology attending, medical students

Patients: Inpatients with primarily solid organ malignancies.

Cap: 14 patients

Responsibilities: Direct patient care. Weekdays: APRNs are responsible for daily notes and discharge summaries. Residents are responsible for everything else, i.e. consults, orders, patient care. Weekends: Residents are responsible for 10 daily notes, while APRNs remain responsible for discharge summaries.

Team 2B: Hematology

Staffing: 1 upper level resident, APRNs, 1 fellow, hematology/oncology attending, medical students

Patients: Inpatients with primarily hematologic malignancies and stem cell transplants.

Cap: 14 patients

Responsibilities: See Team 2A: Oncology

Team 3A: General Internal Medicine

Staffing: 2 upper level residents, 1 intern, Internal Medicine attending, medical students

Patients: Inpatients

Cap: 16 patients

Responsibilities: Direct patient care

Team 3B: General Internal Medicine

Staffing: 1 upper level resident, 2 interns, Internal Medicine attending, pharmacist, medical students

Patients: Inpatients

Cap: 14 patients

Responsibilities: Direct patient care

Team 6: Abernathy Infectious Diseases Team

Staffing: 1 upper level resident, 1 intern, Infectious Diseases Attending, medical students

Patients: Inpatients with unique infectious diseases

Cap: 10 patients

Responsibilities: Direct patient care

Admissions

All admissions are assigned to a team by the triage hospitalist as follows—this includes admissions from the Emergency Department, direct admissions, and outside facility transfers:

- Team 1 Cardiology: primary cardiovascular diagnosis (chest pain, heart failure, syncope, arrhythmias, etc.) are assigned by the triage hospitalist. If the team is capped, high-priority cardiology patients may be admitted to team 1 with a balanced shift of a patient with less

cardiovascular disease specialty needs to a general medicine teams. Any transfers must be discussed with the cardiology attending.

- Team 2A: Patients with cancer actively followed by UAMS Oncology Clinic with solid organ tumors are assigned to Team 2A. Other patients may be assigned to 2C or general internal medicine.
- Team 2B: Patients with cancer actively followed by UAMS Hematology Clinic with hematologic malignancies will be assigned to Team 2B. Other patients may be assigned to 2C or general internal medicine.
- More on Hem/Onc admissions
  - **Daytime admissions, 7am-4pm weekdays, 7am-12pm weekends:** Admissions will be distributed in round robin fashion, 1:1:1, between the 2c hospitalist, APRN and the residents (2A/2B) between **7am and 4pm on weekdays** and 1:1, between the 2C hospitalist and residents from **7am to 12pm on weekends**. This is regardless of the team the patient is going to end up on. But, whenever there is an opportunity to admit the patient you are going to see the next day, try to do that admission (as long as this does not disrupt the round robin).
  - APRNs hold the H/O admission pager and are responsible for keeping track of who is next in the round robin.
  - In the round robin, the residents on 2A/2B will alternate and do the admissions (For example, if the third admission was done by 2A resident, the sixth will be done by 2B resident, first and second by the 2C hospitalist and APRN respectively).
  - APRNs can do admissions up until 4 pm on weekdays. APRNs do not do admissions on weekends.
  - Residents never admit directly to 2C
  - No such thing as a bounce back. EG If a lung cancer patient was on 2C last admission and now they are back less than 30 days later and there is room on 2A for them, they will be admitted to 2A.
  - **Call shift admissions, 4 pm and 7 pm on weekdays** and **12pm to 7 pm on weekends** and **holidays:** all the Hem/Onc admissions will be done in a round robin fashion 1:1, between the admitting resident and 2C hospitalist.
- General Internal Medicine patients are assigned in a round robin fashion to 3A, 3B, 3C, 3D, 3E, and 3F.
- Team 6: Patients with HIV/AIDs followed by our Infectious Diseases Service and patients admitted for primarily (usually complex) infectious diseases will be assigned to the Abernathy Infectious Diseases Team 6. If Team 6 is capped, then admissions will be assigned to general internal medicine, unless a transfer is approved by the ID attending.

Each team is responsible for admissions to their team until short call starts at 16:00. When the resident on Team 6 is off, the intern on Team 6 is responsible for admissions with direct supervision from the ward resident on-call.

Call

Weekdays 16:00 – 19:00

Weekends/Holidays 12:00 – 19:00

Staffing: 2 upper level residents, 1 intern

Responsibilities:

- Code Blue Team: The on-call resident and interns must respond **immediately** to all code pages and start appropriate triage and resuscitation efforts. A resident should quickly identify and verbally announce himself/herself as the code team leader upon entering the room. The rest of the code team should assist with obtaining information from the EMR, calling family or the patient's primary team, providing chest compressions, etc.
- Ward Resident: Supervise the care of patients on the floor and new admissions. Upper level residents are ultimately responsible for all admissions during their call shift, but should allow interns to complete orders, H&Ps, etc. Maintain accurate log of all admissions. Reconcile EPIC team lists prior to the end of every shift. Clearly communicate any team re-assignments with both the teaching and non-teaching services. Wise use of any free-time for intern and medical student orientation.
- Cover Resident: Cross-coverage: respond to pages promptly and professionally, document any significant interventions, and admitting patients assigned to their respective teams; wise use of any free-time encouraged.
- Intern: Cross-coverage: respond to pages promptly and professionally, document any significant interventions, and admitting patients assigned to their respective teams; wise use of any free-time encouraged.
- Patient Handoffs: Face-to-face handoff with an acute, concise patient list *must* occur for every team at every level (PGY-1, 2, & 3) utilizing I-PASS method.

Admissions:

- At 16:00, team censuses will be reconciled. Any team that has reached its cap will no longer be assigned admissions. Exception: Team 1 Cardiology, which has a semi/rolling-cap throughout the day as team census is reconciled and patients are admitted/discharged.
- The call team is responsible for all admissions to the teaching services from 16:00-19:00.
- After 16:00, admissions are assigned in a round-robin fashion with 2:2 ratio with the non-teaching teams (includes cardiology and hematology/oncology teams)

ACR Weekend Shift

Each upper level resident will be assigned a number of weekend ACR shifts in the UAMS MICU, either Saturday or Sunday during elective weeks to be determined by the chiefs. Assignments will be posted in the call schedule.

Responsibilities: Assist the on-call team with admissions, transfers, and procedures. Residents must check their schedules to make note of when they are assigned.

Night Float

19:00 – 07:00

Arrive at 18:45 to receive handoff.

Staffing: 1 upper level resident, 2 interns

Responsibilities: Direct patient care, all admissions to teaching services, face-to-face handoff for admissions after 16:00 to the appropriate teams in addition to handoff about other patients; and all duties outlined in "Call" section.

Medical Intensive Care Unit (MICU) at UAMS

2 Teams: MICU 1 and MICU 2

Staffing:

- Each team: 2 upper level residents, 2 interns, pulmonary/critical care attending
- 1 pulmonary/critical care fellow for both teams
- 1 Acute Care Resident (ACR): admissions, transfers on weekdays (no weekends/holidays)
- Medical students (M4)

Admissions:

- 07:00-16:00: ACR +/- APRN
- 16:00-19:00: Upper level resident on call
- 19:00-07:00: Upper level on MICU Night Float; must staff patients with fellow and/or attending

Call: MICU 1 takes short call on ODD days, MICU 2 takes short call on EVEN days; responsibilities: cross-coverage for other MICU Team and all admissions/transfers.

MICU Night Float: 1 upper level resident, 1 intern

The MICU curriculum includes MICU-specific conferences. These are ***mandatory*** unless a resident or intern has a previously scheduled off-day.

Transferring patients out of MICU

Contact the triage hospitalist to choose appropriate team for transfer when a patient is stable for the floor. All accepting teams must be called with a handoff prior to the patient transferring (resident-to-resident/attending, intern-to-intern). Family medicine patients and bounce-backs should be triaged appropriately.

Code Blue Team

The most senior MICU resident is the leader of the Code Blue Team and should respond *immediately* to all code pages. The ward resident should defer to the MICU resident once they arrive at a code on the floor. Regardless of the outcome (transfer to ED or MICU), a member of the code team shall remain at bedside of a living patient until final disposition is reached.

Central Arkansas Veterans Healthcare System (CAVHS): VA Hospital

All residents and interns are required to maintain active VA computer and CPRS access.

Residents must login to CPRS and a VA PC to maintain active access at least once every 90 calendar days. If a resident fails to login, their account may be terminated. If a resident is unable to place orders or document, they are unable to fulfill their duties. Failure to fulfill duty will result in making up shifts, call, etc. at the discretion of the Chiefs and/or Program Director.

Ward Services

The general internal medicine service at the VA is composed of three teaching teams, one cardiology team, and several non-teaching teams.

GM 1	General Medicine Team 1
GM 2	General Medicine Team 2
GM 3	General Medicine Team 3
Team 7	Cardiology

GM1, GM2, and GM3

Staffing: 1 upper level resident, 2 interns, 1 attending physician, medical students

Patients: Inpatients

Cap: 14 patients

Responsibilities: Direct patient care

Team 7 Cardiology

Staffing: 3 upper level residents, 2 interns, 1 attending physician, 1 fellow (for CCU)

Patients: Inpatients (Floor and CCU)

Cap: 16 patients

Responsibilities: Direct patient care

Admissions

General Medicine Admissions

The Medicine On-Duty (MOD) attending is responsible for assigning all admissions to the general medicine service including admissions from the ED, clinic, NLR VA, and other facilities.

- 07:00-16:00 Weekdays and 07:00-12:00 Weekends and Holidays

- Admissions will be distributed in a round robin fashion with a 3:2 ratio between the teaching teams and direct care teams. The first, third, and fifth admissions of the day go to teaching teams, the second and fourth to direct care; the cycle then repeats. The cardiology admissions do not count in the round robin.
- From 1145-1300, all admissions will go to the direct care service to provide protected education time for the residents. Distribution of patients will be maintained however and a "catch-up" period will occur starting at 1300 to ensure teams remain balanced.
- At 1445, the MOD will go to the ED and meet with the ED docs to see about upcoming admission and provide a disposition for any patients that have a completed work-up. Admissions will continue to be called prior to that time. At 1500, the MOD will meet with all gen med team residents in GM1 workroom to divide up these admissions.
- "Bounce-backs" within 30 days go back to the team from which they originated unless that team is capped or goes to cardiology team. "Bounce-backs" **DO** count in the round robin.
- During this time, no team caps will be observed. The team numbers will be reconciled at 1600 and 1900.
- Direct admissions will be assigned at the time of arrival and will be distributed per the round robin.
- Admissions to the cardiology service will be communicated to the MOD for screening to medicine team vs cardiology team. The MOD communicates to the team 7 resident.
- When a resident is off from a general medicine team, the team remains in the round robin and the interns will staff the patient with their attending or the resident on call.
- If any team has a disproportionate number of patients, social admissions, or is in need of high value teaching cases, patients may be re-distributed among teaching teams per an attending to attending discussion. If that process is not satisfactory to balance the teams, an MOD to attending conversation may occur and admissions will be temporarily assigned outside of the usual fashion for balancing purposes
- MICU transfers are to be called to the MOD to track patient flow. "Bounce-backs" will be returned to the appropriate team. All unassigned patients will be distributed to the gen med teams in a 3:2 fashion between the teaching and direct care teams but are not counted in the admission round robin. The patient's do not count in the census until they have arrived on the floor. **IT IS STILL THE RESPONSIBILITY OF THE MICU RESIDENT TO CALL EACH TEAM AND GIVE A PROPER HAND-OFF.**

- 16:00-07:00 Weekdays and 12:00-07:00 Weekends and Holidays
  - MOD will assign admissions to teaching services in a round-robin 1:1 fashion (teaching:hospitalist). Short-call upper level resident and 2 interns will be responsible for all admissions assigned to the teaching teams. Once a teaching team reaches a cap of 14, they are excluded from the round-robin. Once all general medicine teaching teams are capped, all admissions are the responsibility of the direct-care hospitalists.
  - Direct-care/hospitalist teams should accept admissions with low educational opportunities, including acute alcohol intoxication, post-procedural observation, social admit, etc.
  - Admissions will be distributed 1:1 between the teaching teams and hospitalist teams. The heme-onc, palliative care, and cardiology admissions do not count in the round robin.

- Starting at noon for weekends and holidays, the teams will initially soft cap at a census of 10. Once a team reaches this initial cap, it is removed from the rotation until all teams reach 10. The academic teams have a hard cap of 14 and direct care teams have a soft cap of 14.
- "Bounce-backs" within 30 days go back to the team from which they originated unless that team is capped or goes to cardiology team. Bounce backs **DO** count in the round robin.
- Direct admissions will be assigned at the time of arrival and will be distributed per the round robin.
- Any patient with a surgical intervention planned for next day who requires pre-op clearance will be preferentially admitted to the direct care service unless team numbers necessitate admission to a general medicine team. If the general medicine team admits the patient, the general medicine team will place a medicine consult and notify by phone the direct care attending on-call of the consult and reason for consult.
- Admissions to the cardiology service will be communicated to the MOD who will contact the resident-on-call.
- All heme-onc admissions will be performed by the direct care service from 1630-0700 weekdays and 1200-0700 weekends and holidays.
- If a large "bolus" of patients is admitted from 4PM to 7AM to either the teaching teams or the nocturnist, then all providers will admit patients to optimize care and avoid clustering admissions to one physician (e.g., 1 patient going to teaching teams and 7+ patients going to the nocturnist).
- From 4PM to 7AM, if Team 7 is capped, cardiology admissions will be distributed round robin to all teams (direct care and teaching teams).
- Once the overnight (1900-0700) resident-on-call reaches a total of 10 admissions or all teaching teams are capped, the on call direct care physician will admit all patients, including cardiology, to the respective services.
- MICU transfers are to be called to the MOD to track patient flow. "Bounce-backs" will be returned to the appropriate team. All unassigned patients will be distributed to the gen med teams in a 3:2 fashion between the teaching and direct care teams but are not counted in the admission round robin. The patient's do not count in the census until they have arrived on the floor. **IT IS STILL THE RESPONSIBILITY OF THE MICU RESIDENT TO CALL EACH TEAM AND GIVE A PROPER HAND-OFF.**

Team 7 Cardiology Admissions

- 07:00-16:00 Weekdays and 07:00-12:00 Weekends and Holidays: MOD will assign admissions to cardiology and CCU if they have primarily cardiovascular diseases. All admissions assigned to Team 7 are the responsibility of the residents and interns on Team 7.
- 16:00-19:00 Weekdays and 12:00-19:00 Weekends and Holidays: Admissions assigned to Team 7 Floor are the responsibility of the short call resident and interns. Admissions assigned to the CCU are the responsibility of the ICU resident and intern on short call. The ICU resident and VA Floor Short Call resident should communicate regarding admissions to Team 7 floor and CCU.
- 19:00-07:00: Admissions assigned to Team 7 are the responsibility of the night float resident and interns. Admissions assigned to the CCU are the responsibility of the VA ICU Night Float resident and intern.

Disease categories appropriate for non-Cardiology team admission

- Low-intermediate risk chest pain (normal ECG, normal troponins); can be managed by internist.
- Cor pulmonale with right heart failure symptoms
- Chronic atrial fibrillation with uncontrolled rates in the setting of a cute systemic, non-cardiac disease: should be managed by MICU/medicine teams
- Syncope with normal ECG

Disease categories that should be admitted to Cardiology

- Unstable angina/chest pain with elevated Troponin
- Patient with known CAD admitted with chest pain (high risk)
- Acute on chronic systolic or biventricular heart failure
- New-onset symptomatic brady- or tachy-arrhythmias

Any patient who has a non-cardiac medical reason for admission in addition to a cardiac issue should be admitted to a general medicine team (GM and Direct Care).

HEART SCORE

- Risk Factors: DM, Current or recent (< 1 month), Smoker, HTN, HLP, Family History of CAD, Obesity. MACE = AMI, PCI, CABG, and Death
- **Score 0-3: 2.5% MACE over next 6 weeks -> Discharge home**
- **Score 4-6: 20.3% MACE over next 6 weeks-> Admit for Clinical Observation (medicine teams)**
- **Score 7-10: 72.7% MACE over next 6 weeks -> Early Invasive Strategies (cardiology team)**
    - Results of Validation Study
        - Low HEART Score (0 -3) = 1.7% MACE Rate
        - Intermediate HEART Score (4 – 6) = 16.6% MACE Rate
        - High HEART Score (7 – 10) = 50.1% MACE Rate
        - C-statistic of HEART Score (0.83) > TIMI (0.75) > GRACE (0.70)

Note: the ED will be looking at this same sheet to determine who goes home and who is admitted. For any patient that ED sends home, they will order a stress test and outpatient follow-up with pcp. You should not be asked to do this.

Team 7/CCU has a cap of 16 patients. However, during the day the team continues to receive admissions until 16:00 at which time patients are transferred to general medicine team to maintain at census ≤ 16. High-priority cardiology patients may be admitted to Team 7/CCU during call, but lower-priority patients must be moved to general internal medicine teams to maintain the cap of 16.

Patients admitted after an EP procedure are admitted by the cardiology APRN from 07:00-16:00. After 16:00, these patients are the responsibility of the resident on call. These patients count in the team cap of 16.

Patients admitted post PCI after outpatient cath are admitted and cared for by the Interventional Cardiology team (staffed by fellows and the interventional cardiology attending). These patients do not count in the Team 7 census.

Patients admitted solely for pre-cath hydration are to be admitted by the Interventional Cardiology team (fellows) and staffed with the interventional cardiology attending. These patients do not count in the Team 7 census.

Hematology/Oncology Admissions

Admissions to the hematology/oncology service are the responsibility of the hematology/oncology team from 07:00-16:00.

16:00-07:00: the MOD/hospitalist is responsible for admissions to the hematology/oncology service, and these count in the overall round-robin.

Night Float System

Staffing: 1 upper level resident, 2 interns

Responsibilities: direct patient care, all admissions to GM1, GM2, GM3, and Team 7, cross-coverage for teaching teams.

Residents and interns work 6 nights (Monday-Saturday night) with Sunday night off. Sunday night will be covered by the resident and interns on call for Sunday 24-hour call.

Call

Weekdays: 16:00-19:00

Saturday/Holidays: 12:00-19:00

Sunday (24h): 12:00-07:00

Staffing: 1 upper level, 2 interns

Responsibilities: direct patient care, all admissions to GM1, GM2, GM3, and Team 7, cross-coverage for teaching teams, code blue team.

Stroke Weekends

The first weekend of each month, the upper level in the MICU and Floor will carry stroke pagers and respond to provide care accordingly.***

Medical Intensive Care Unit (MICU) at the VA

Staffing: 1 upper level resident, 3-4 interns, pulmonary/critical care attending, pulmonary/critical care fellow, 1 upper level on MICU night float.

Admissions

- 07:00-16:00 Weekdays: MICU upper level resident is responsible for all MICU admissions/transfers. If the resident is off, the interns are responsible for all MICU admissions/transfers with direct supervision by the MICU fellow.
- 16:00-19:00 weekdays and 12:00-19:00 Saturday/holidays: MICU/CCU resident on call is responsible for all admissions/transfers.
- 19:00-07:00: MICU night float resident is responsible for all admissions.
- The interns in the MICU/CCU rotate in a "mole" system where each intern works night shifts from 19:00-07:00 for up to six nights at a time. This allows interns to participate in educational opportunities that arise from taking care of patients while on call.
- For all admissions, the resident must call the pulmonary/critical care fellow on-call for acceptance to MICU or the cardiology fellow on-call for acceptance to the CCU.

Duty Hours

When averaged over a 4-week period, residents must not spend more than 80 hours per week in patient care duties, inclusive of all in-house, on-call activities, and all moonlighting.

Residents must have at least 1 day in 7 free of patient care duties averaged over a 4-week period.

PGY-1 Residents (Interns) must not have patient care duties more than 24 hours at a time and should have 10 hours, but must have 8 hours off between duty periods.

PGY-2/3 Residents may be scheduled to a maximum of 24 hours of continuous duty (with 4 additional hours to ensure effective transitions of care, education). They should have 10 hours, but must have 8 hours off between duty periods.

Residents are encouraged to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 18:00-08:00, is strongly encouraged.

Duty hours will be tracked by each resident in New Innovations.

New-Innovations

Duty hours will be tracked by each resident in New Innovations. <new-innov.com>

Any transition of care and educational activities done after 24 continuous hours of in-house duty must

Post-Call

- Any transition of care and educational activities done after 24 continuous hours of in-house duty must be logged with the correct duty type ("Transition of Care," "Hand-offs," "Conference," or "Educational"). Hours logged past 24 as any other duty type, will create a duty hour violation, even if the resident was engaged in appropriate activities.

- The "Justifications" feature in New Innovations should only be used for those times when a resident stays past 24 hours "on their own initiative" for the reasons outlined in the ACGME Common Program Requirements [VI.G.4.b). (3)-*In unusual circumstances, residents, on their own*

initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family], not when they have stayed past 24 hours to perform transition-of-care activities. If transition-of-care activities are logged correctly, these hours will not cause a violation; thus, no need for a justification.

Days Off

- It is not necessary to log "Days Off". New Innovations will recognize any period of 24 hours without any time logged as the 24-hour period free of duty that the ACGME requires. This does not apply to vacation or other leave time. Residents can continue to log leave time in the designated area.

Other Issues

- Residents need to avoid leaving short periods of time during their day without any hours logged (meal break, time between call and conference, drive time between sites, etc.). These gaps cause short-break violations (less than 8-10 hours off between duty assignments). Once a resident reports for duty and until they get another 8-10 (or more) hours off, his or her hours should count toward the 24 hours maximum of continuous duty.
- When a resident is scheduled on a rotation that "belongs" to another program, he or she needs to use that program's duty types. (When residents log hours while on another program's rotation, the department option on the duty hour log screen will default to the department that owns the rotation.) It will not check for violations if a resident records a duty type that is not active in the other program's basic configuration.

Communication

With Attending Physicians

For both education and optimal patient care, the House Staff must communicate freely with attending physicians on all services. If there are questions or problems, the resident or intern should feel free to contact the subspecialty service at any time. Attending physicians want and need to be contacted regarding patients; if there are problems, contact the Chief Resident, Residency Program Director or Department Chairman. Residents must call the attending of record whenever a patient dies or when a change in the patient's clinical status necessitates transfer to another team or a higher level of care (i.e. transfer from the floor to the MICU or CCU).

With Residents

Communication between residents is imperative for safe and successful patient care.

- *Team Residents/Interns to On-Call Residents/Interns*: There is a mandatory checkout list to be given to the on-call team. This list is to be up-to-date and must include all the current patients and all the expected patients from outside hospital admissions, clinic admissions, or transfers from different services. Verbal face-to-face checkout is required.

- *On-Call Residents/Interns to Night Float Residents/Interns to Team Residents/Interns*: Communication between the On-call Team and the Night Float Team must be efficient as to ensure patient continuity of care. Night Float Resident to Team Resident communication must happen in a timely manner first thing in the morning so that the Night Float Resident can leave on time. Night Float Interns to Team Interns must communicate essential events overnight so that the team will be aware of any potential problems.
- *Transferring Patients*: Communication between residents when a patient is transferred from one service to another is essential. It is the responsibility of the Transferring Team Resident to contact the Accepting Team Resident any time a patient is transferred between services. As a secondary safeguard, the transferring intern will also contact the accepting intern. A transfer note must accompany the patient to the accepting team and must include the accepting team's attending physician and resident.
- *Accepting Patients*: An accept note is required for all patients accepted to a team regardless of patient origination. If the patient is accepted and transferred during the day, one of the accepting team members must complete the accept note. If the transfer occurs during on-call hours, the patient's name must be added to the list of new admissions for the evening so that this patient is passed off to the team the next morning. If an on-call intern accepts a patient transfer and writes the accept note, the intern must communicate with the on-call resident so that the accepting patient can be placed on the list of admissions.
- *Off-Service Notes*: At the end of each rotation, a summary of patient's hospital course must be written in the progress note to help facilitate transfer of care to the oncoming team.

With Nursing and Other Ancillary Staff

- When a resident is contacted in error about an IM admission or a transfer, he or she should take the time to find out who does need to be called. We do not want the Emergency Department or the floor staff to call multiple persons with each person denying responsibilities. Our call schedule can be intimidating and we should be willing to find the appropriate resident or intern.
- If a resident has an issue with the nursing staff or other ancillary staff, the resident should document what the event was, who was involved and a brief description of what happened. This should then be taken to the Chief Resident as soon as possible. If the resident needs immediate assistance, the Chief Resident is to be called.
- Professionalism is one of the key competencies to master while in residency. Part of professionalism is being able to communicate effectively and resolve conflicts in patient care.

Supervising Residents, Interns On-Call

- Every decision made by an intern about a deteriorating patient must be discussed with the supervising resident on short call, overnight call or float rotations. This resident can be a PGY-2 or 3 who is on call with an intern. This would include telephone calls and person-to-person communication to show ECG tracings, CXRs, or other results. Documentation of the discussion in the patient record is required.
- In addition, interns must call for any patient, even if not in a deteriorating status, when there is any question or discomfort about the diagnosis or management of a patient.

- Subspecialty fellows and attending physicians must be called when there is an unexpected and dramatic change in the condition of their patient (including death) or if there is a question regarding the diagnosis or management of a patient, or if there is a change in level of care.
- Any patient accepted to the floor by the intern from the MICU/CCU service must be communicated to the supervising resident so that this patient may be placed on the admission list to ensure check-out to the accepting team the following morning.

Handoffs and Check-Out: Standard Operating Procedure for Internal Medicine Services

All teams must maintain an updated version of their team check-out list. The list should be updated at a minimum in the morning and again at the end of the work day. UAMS team lists are stored within Epic. VA lists are typically stored within a Word document, which must be stored in a protected location on the hospital server's hard drive. Printed copies of the list should be safeguarded closely and discarded into locked HIPAA compliant shred bins since they contain protected health information. Check-out lists should include at a minimum the patient's name, location, age, brief history/reason for admission, working diagnosis, code status, and things to check. If there are other important issues (i.e. patient is a Jehovah's witness and will not accept blood products or the family is not to be told of the patient's HIV status, etc.), they should be included on the check-out list. Lists should also include contact information for the responsible attending. Check-outs must occur face-to-face between residents. Telephone check-out is not acceptable. Every team should check-out to the short-call resident and interns, who will then check-out to the night float resident and interns. Each House Staff should check-out using an updated, printed copy of their team list. It is the outgoing resident's responsibility to contact the on-call resident for check-out. If a resident does not check-out to the on-call team, the Chief Resident should be notified immediately.

Check-out should include a brief verbal description of each patient and the major reason(s) why they are currently in the hospital. Any significant events over the past 24 hours should be mentioned as well as any potentially anticipated events. If there are test results pending that are on your "to check" list, you should also include what to do with the results (i.e., [ ] CBC at 19:00, if hemoglobin less than 7.0 give 1 unit of packed RBCs).

Check-out should be formatted with the dot phrase ".medicineco" and utilize the I-PASS structure for standardized handoffs to ensure patient safety.

In general, you should NOT check-out pending ECGs, procedures, or post-procedure imaging. Lab results, consults, and radiology exams that could potentially change a patient's management can be checked out in most cases. If a patient arrives while you are still on duty, the responsibility for admitting that patient is yours (although it is acceptable to ask the oncoming resident to help with admissions so that you can leave the hospital at a reasonable time in order to avoid violating duty hour regulations).

Consultations

The Department of Medicine receives many consultation requests, both for subspecialty as well as general medicine evaluations. The department views these consultations as an important part of resident education; they should be seen quickly and diplomatically—as we hope other departments will do for us. Several points concerning consultations deserve emphasis:

- Subspecialty consultations will usually be evaluated by the resident and/or intern on the subspecialty consult service first and then presented to the subspecialty attending. An exception to this generalization might be a private patient of a faculty member. In that case, the faculty member may care for the patient initially and bypass the subspecialty house staff.
- A General Internal Medicine Consult service is established at the VA Hospital. This team will be staffed by the hospitalist team attending. It is not the responsibility of the residents to see General Medicine Consults at the VA. If the resident gets called by other specialties about a consult, then they should direct them to the appropriate person to contact.
- General Internal Medicine consultations at UAMS will be the responsibility of the resident or intern and faculty assigned to the General Medicine Consultation (GMC) Service. If the resident on the consultation service cannot see the patient in a timely manner, it is the responsibility of

that resident to contact the Chief Resident to discuss the problem. The Chief Resident will see the patient or ask a subspecialty resident to see the patient. After 16:00 on weekdays and on weekends and holidays, the ward resident on call will provide coverage for IM consults at UAMS and contact the faculty who is on call for General Internal Medicine. For the VA hospital, the non-teaching hospitalists will still be staffing those consults.

- The Night Float resident at UAMS will notify the appropriate consultation service the next morning about any patient seen at night. This communication is important to ensure follow-up.

Discharges

In order to expedite patient admissions to the hospital, *early discharges are mandatory*. Discharge orders on patients known to be ready for discharge should be entered prior to noon. If there are questions about whether or not to discharge a patient, the attending should be called for direction. Discharge summaries at the University Hospital and the VA Hospital are the responsibility of the resident or the intern on the team. At UAMS, Discharge Summaries are due a maximum of 7 days after the date of discharge. If not completed after 7 days, disciplinary actions including, but not limited to, monetary fines may be taken at UAMS. At the VA, discharge summaries are due prior to discharge.

The VA requires that if a patient's status is advanced from outpatient to inpatient a Discharge Summary must be written. This occurs when a patient is admitted as Observation (Outpatient designation) to a Full Admission (Inpatient designation). The patient must also have a regular Discharge Summary (Transition of Care Document) at their discharge from the VA Hospital.

Transfers

The general policy of the Internal Medicine services is that if an outside hospital physician calls wishing to transfer a patient to UAMS, we accept the patient unless we cannot offer services different from the transferring hospital. It is not appropriate for us to accept a transfer from another hospital simply because the patient cannot pay. The University Hospital has instituted an administrative transfer team to evaluate the financial status and obtain a transfer-back agreement. The UAMS transfer team will then determine further eligibility for transfer and initiate the timing of the transfer. Direct care hospitalists at UAMS and MOD at VA will be contacted for general medicine transfers and also for designating team assignments of patients once they have arrived, and will notify the assigned team of the patient's arrival.

If a patient is in the emergency department in the outside hospital and the physician wants to transfer the patient, the patient may be accepted directly if stable and an initial workup is done. If the patient is on a floor, they must be accepted to the same level bed as the outside facility. Therefore, if patients are on telemetry, they come to a telemetry bed; if they are in the outside facility's stepdown unit, they will be accepted to our ICU. Patients cannot be accepted directly to stepdown from transferring facilities.

Residents DO NOT accept MICU or CCU patients at either hospital and these must go through the direct-care hospitalists for the VA hospital who will communicate with the on-call pulmonary/critical care fellow for MICU or the on-call cardiology fellow for CCU transfer. Patients must be out of the unit for 24

hours prior to being transferred to the floor at UAMS. This can be negotiated at the VA. We do not have the right to refuse transfer to the VA unless the patient is unstable for transfer. The direct-care hospitalist accepts patients at the VA and recommends level of care and will contact bed control and leave the appropriate documentation in CPRS. If no beds are available, the patient will be accepted "pending bed availability."

Conferences

The National Residency Review Committee-Internal Medicine requires attendance by residents at conferences. Our Education Cabinet considers Core Curriculum, Grand Rounds, and M&M mandatory and requires attendance.

Monday

12:00 Core Curriculum

13:00 Board Review

Tuesday

12:00 Medicine-Pathology Conference – 1st Tuesday of every month

12:00 Systems Conference – 4th Tuesday of every month

12:00 Core Curriculum

13:00 Afternoon Case Discussion (ACD)

Wednesday

12:00 Core Curriculum

13:00 Board Review

Thursday

07:15-08:20 Morbidity and Mortality Conference (M&M) 4th Thursday of the month

12:00 Internal Medicine Grand Rounds

13:00 Intern ACD

Friday

12:00 Resident Presentation / Journal Club

13:00 ACD

Morbidity and Mortality Conference

All medical students, interns, residents, and attending physicians working at UAMS and the VA are required to attend with few exceptions. Residents are exempt if they are carrying a code pager at VA, tending to an acutely decompensating patient, or have a patient at VA clinic at 08:00. Night float

residents are not exempt from mandatory attendance. The conference is held the 4th Thursday of the month.

No off-service interns are to attend this conference.

All cases (deaths, complications, or selected cases requested by the Chairman, Chiefs, Faculty, Adverse Events Committee (AEC) or Residents) are reviewed by the Chief Residents. Cases are selected for presentation based upon educational value and/or Department of Medicine quality and safety issues. Cases involving quality issues relevant to other departments may also be reviewed. All participants understand that medical information regarding patient health is personal and confidential and are committed to protecting the confidentiality of patient medical information. This Conference is understood by all participants to be for the improvement in the quality of care for our patients. It is not a venue for placing blame or finger-pointing. Such activities will not be tolerated.

Intern Afternoon Case Discussion (ACD)

A selected intern will present a case for discussion on Thursdays at 13:00. Attendance is mandatory for interns unless they have a scheduled day off, night float, or emergent patient care responsibilities. Residents are encouraged, but not required, to attend intern ACD. Supervising residents should hold the intern team pagers during Intern ACD. The format of the conference is basic HPI with specific questions from the intern audience, differential diagnoses formulation, and the rest of the case presentation with teaching points at the end of the presentation. ACD is facilitated by the Chief and a faculty member.

Afternoon Case Discussion (ACD)

ACD is presented by an upper level resident on Tuesday and Friday at 13:00. Attendance is mandatory for residents unless they have a scheduled day off, night float, or emergent patient care responsibilities. Interns are encouraged, but not required, to attend intern ACD. Supervising residents should hold the intern team pagers during Intern ACD. The format of the conference is basic HPI with specific questions from the intern audience, differential diagnoses formulation, and the rest of the case presentation with teaching points at the end of the presentation. ACD is facilitated by the Chief and a faculty member.

In-Training Examination

All PGY-1 and PGY-2 residents must take the ACP's In-Training exam (ITE). PGY-3 residents must take the exam, unless determined otherwise by the Program Director. The results are used to identify areas of strength, areas for improvement, and to help predict success or failure on the American Board of Internal Medicine Certifying Exam (ABIM-CE). Published data indicates that PGY-2 residents whose national percentile on the ITE is above the 30th are very likely to pass the ABIM-CE. If a resident scores below the 30th percentile on the ITE, he/she will not qualify for a research rotation, and further remediation will be decided as directed by the Program Director. The Department assumes the cost of the ITE for all 3 years.

Addressing Resident Concerns in Internal Medicine

At times, various issues resulting from miscommunication, stress, or inappropriate behavior may arise. In compliance with the UAMS College of Medicine GME Committee Policy on Addressing Concerns in a Confidential and Protected Manner, the resident should follow these guidelines to raise and resolve issues of concern in a confidential and protected manner:

- A resident should discuss the concern with either the supervising-senior level resident or attending physician or the Chief Resident or the resident's assigned faculty advisor.
- If the above discussion does not resolve the concern, the resident should meet with the Program Director or his designee.
- If the issue cannot be resolved by the Program Director, the resident should contact at least two members of the Resident Council (contact list found on the GME webpage) and/or the Associate Dean for Graduate Medical Education to discuss the issue confidentially. Members of the Resident Council can meet with the resident and offer advice on how to resolve or handle the problem and decide whether further steps are necessary. Based on the discussion and advice of this meeting, the resident may resolve the problem, and no further action is necessary.
- If the resident desires further discussion, or for serious issues for which confidentiality is of the utmost importance, the resident may seek assistance directly from his Chairman and/or the Associate Dean for GME.

Jeopardy

Our mission is to train our residents and provide high-quality patient care services in furtherance of the mission of UAMS and CAVHS. In order to fulfill our missions and maintain our responsibilities to our patients, we have the responsibility to provide back-up coverage in the event the assigned staff member cannot work.

In the absence of a resident or intern who is scheduled on an essential service (ward/ICU rotations) for reasons of unforeseen illness or death of a family member, jeopardy is available for coverage. The jeopardy schedule is comprised of residents on consult rotations. Each resident is assigned blocks of "call" during which he/she will be available for emergency coverage. There are 5 residents and 1 intern assigned on call for jeopardy for each day. Either resident can be called depending on need. The Jeopardy system will not be used for non-essential service coverage such as subspecialty electives. It is also not used for scheduled absences. If a resident or intern must be away from the hospital other than vacation time, he or she must arrange his or her own coverage. (This does not apply to clinic coverage. Residents are **not** permitted to make their own arrangements to cover for each other in clinic). The Residency Medicine Office and Chief Resident must be notified of all changes. Jeopardy coverage must be assigned by the Chiefs (residents are not permitted to directly call the jeopardy resident).

We have 5 upper level jeopardy slots each week, in increments of 7 days. Everyone will have 5-6 weeks of jeopardy throughout the year (exception: med-peds has 2-3 as they only spend half the year with us). As a guideline, Chiefs will attempt to schedule residents to only have one week of Jeopardy 1 and one week of Jeopardy 2, the remaining 3-4 weeks of Jeopardy you will be farther down the list.

- For calling jeopardy in the event of an emergency, you must CALL the Chief-On-Call as designated on AMION. Emails/Texts are not appropriate.
- After the 3rd call-out of the year, jeopardy circumstances will automatically be reviewed by the Program Director to ensure optimal support of our residents. We also want to ensure that educational goals are met; thus, in some cases, a resident may be required to make up an equivalent educational experience.
- Availability Policy
  - You must be *immediately* reachable by phone or pager during the entire time on Jeopardy (24 hours/day). This means you have a maximum 15 minutes to answer/return a call or respond to a page.
  - You must be able to arrive for the shift within one hour of being contacted.
  - If you do not respond within 15 minutes, repercussions include
    - 1 day of coverage to the resident who covers in your place
    - 1 additional Jeopardy day
- If you are Jeopardy 1-5, you must be able to work at UAMS/VA within 1 hour of notification.
- Regardless of your position on the Jeopardy list, if you are informed you are “on-deck” (the next resident to call in the schedule), you must be able to get to work at UAMS/VA within 1 hour of notification.
- Residents cannot do an ACR weekend shift if they are on Jeopardy 1-3.
- Residents may elect to trade days of Jeopardy coverage or weekend ACR, but the switch must be approved by one of the Chiefs. For Jeopardy, residents should switch a whole week at a time to preserve continuity, but this may not always be possible. The Jeopardy schedule should be published for the entire year.
- *Residents who switch Jeopardy are responsible for the schedule swap. For example, if one trades a single day with someone, they are responsible for coverage if they are needed—even if they had a previous day off, were on nights before.*
- *Residents may not be on Jeopardy if they are on an essential service.*
- If a resident uses jeopardy improperly, he/she will be expected to pay time back into the system (i.e., a day for a day). Legitimate use for jeopardy is illness or emergency, taking an extra day of vacation is not.
- If House Staff utilizes jeopardy for illness, then he or she will be expected to see a physician. If a physician is not available, House Staff will be seen in medicine clinic at UAMS.
- Excuses: There are very few legitimate excuses for missing a jeopardy call. It is your responsibility to check the schedule to assure you are not on call and make prior arrangements if you are unable to cover.

Fellowship and Job Interviews

We are excited to help support you through fellowship and job application process. When possible, residents are expected to schedule interview as follows

1. Vacation
2. Consults

3. NOT on Jeopardy or essential services

USMLE STEP 3

Interns/residents are expected to take Step 3 during a vacation, elective, or on a weekend. If this is not possible, residents can use a clinic day only with prior approval from Dr. Alexander.

Leave for Residents

ABIM Policies and Procedures of Certification

Up to one month per academic year is permitted for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities. Training must be extended to make up any absences exceeding one month per year of training. Vacation leave is essential and should not be forfeited or postponed in any year of training and cannot be used to reduce the total required training period.

Leave for Exams

All leave requests must be submitted in writing to the Chief Residents and the Residents House Staff office for approval for leave taken for exams (USMLE, ACLS, etc.). This must be done **31 days in advance** of the leave requested. It is the resident's responsibility to arrange coverage. It is the responsibility of the resident to arrange coverage for elective exams taken during ward, unit, float, or IM consult rotations. Exams should be scheduled during elective rotations only.

Educational Leave

Educational leave can be taken, with **31 days advance notice,** to attend a medical conference with the approval of the Program Director. It is the responsibility of the resident to arrange coverage of any duties or clinics. The exception is if a resident is presenting a paper, poster, or abstract at the meeting, in which case the Chief Residents will help find coverage, up to 2 conferences. After 2 conferences, it is up to the resident to find their own coverage. The resident must submit proof of the meeting along with an educational leave request from the Residency Office.

Vacation Leave

Vacation leave for each house staff member consists of 21 days (three-7 day weeks). If the service to which you are assigned rounds on weekends or holidays, you are expected to be in attendance for work, even if you had vacation the day before or after that weekend or holiday.

Interns and residents are permitted to use up to 1 ambulatory week per year for vacation. Med-Peds residents are expected to choose most of their vacation weeks from ambulatory weeks.

It is absolutely necessary for you to submit your vacation requests for the entire three weeks to the Chief Residents to enable coverage plans and proper billing for your vacation time. Only with special approval can your original requests be changed. To make changes from your original requests, you **MUST** submit a written request to the Chief Residents and the Residents House Staff office at least **90 days in advance**.

- PGY1: Vacation may be taken during elective rotations (except Neurology), the ED rotation (with prior approval from the ED), and up to 1 ambulatory week. General Medicine Consult is eligible for vacation, provided there is another intern/upper level resident scheduled at the same time. Med-Peds interns may take vacation during the Geriatrics / neurology rotation and/or their other elective rotation.
- PGY2 and PGY3: In order to attend interviews, a resident may elect to use his/her days off, whether from the monthly ones (4 days off a month) or from the yearly vacation (21 days). If not, the resident is expected to arrange coverage for the days when he or she will be off to interview. It is mandatory to inform the Chief Residents and the Residency Office of every interview/coverage that will take place to be able to keep track of the time off taken by the resident. **This policy only applies to residents attending interviews.**
- Prior to traveling out of state or abroad, you must submit a copy of your itinerary to the Residency Office. When a delay occurs, problems develop in scheduling. The delay often results in time being extended beyond the approved requested vacation dates. It will be up to the discretion of the Program Director, Associate Program Director and/or Chief Residents to decide whether you will have to pay back any extended time due to travel delays.
- You cannot carry vacation time over from one year to the next.
- No vacation time can come from the Wards, ACR, MICU, or float rotations.
- Time to attend meetings is vacation unless you are presenting a paper or unless you have made prior arrangements through the Medicine Residency Office.
- **No vacations except officially recognized vacation days will be allowed during the "Holiday Schedule/Mental Health Days".**

Sick Leave

Sick leave for unforeseen medical reasons will be granted with pay for a maximum of 12 days during each year of the residency program. Weekdays and weekend days during which the resident is assigned to work will be charged as sick leave if the resident is unable to work due to illness. Residents will not be charged sick leave for days on which they were not assigned to duty (i.e. scheduled days off). Sick leave cannot be carried over from one year to the next, nor will residents receive payment for unused sick leave at the completion of the program. To access sick leave a resident must notify the Chief Resident at their respective work location as well as the Residency Office. A resident may be placed on sick leave for extended periods of time (generally in excess of one consecutive week only) with the approval of the Program Director, according to the following:

Procedure for extended sick leave

The resident submits a written request to the Program Director stating the nature of the illness or injury and the reason for the requested extension of sick leave.

The request is reviewed by the Program Director who determines the effect of extended leave on continued participation in the residency program and the possible need for and availability of remedial training. This information must be provided to the resident in writing. The Program Director may require a statement from the resident's treating physician to help in these determinations.

The Program Director must notify the Assistant Dean for House Staff Affairs about the planned leave period.

Unused vacation time must be used after the exhaustion of sick leave. When maximum sick leave and vacation time have been exhausted, the resident is placed on leave without pay.

The Program Director shall decide whether the resident may return to full duties upon consideration of all circumstances involved. The Program Director may require a statement from the resident's treating physician to help determine if the resident is medically qualified to return to duty and if any restrictions are necessary in the resident's clinical activities because of the illness.

Under special circumstances, the resident may request permission to start and complete one year of residency program over a two-year period. Such requests must be made in writing and in advance to the Program Director. Approval will be based upon the educational curriculum of the program, the requirements of the clinical service, and the Residency Review requirements of the residency program.

Special Provisions for Pregnancy

In recognition of the physical demands of the residency program and to ensure optimum consideration for both the mother and the unborn child, the following procedures should be followed.

1. When the pregnancy is confirmed, the resident should notify her Program Director promptly.
2. The Program Director will be sensitive to the confidential nature of this information during the early part of pregnancy.
3. By the end of the sixth month of pregnancy, the resident must provide the Program Director with a written statement about the expected date of delivery, and the intended dates of leave. Any subsequent change in medical condition that might alter this information should be submitted in a revised statement.
4. The Program Director may request a statement from the treating physician, especially in the case of extended leave.
5. See UAMS Administrative Guide No. 4.6.11, Family and Medical Leave Act (FMLA) if leave is without pay or if she elects to take a leave of absence without pay before exhausting her unused sick and vacation time.
6. FMLA paperwork will need to be completed regardless of paid or unpaid time off taken, and it is the responsibility of the resident to ensure that this is completed.

Parental Leave

1. The maximum period of parental leave with pay is 33 days (12 days of unused sick leave plus 21 days of unused vacation time). Time off-duty beyond that amount is without compensation. Parental leave must be taken at the time of the birth and all of the time will be taken together and cannot be split up.

2. Time off for parental leave must be requested in writing to the Program Director as soon as it is known, preferably at least four (4) months before the date of the leave.
3. The Program Director will consider all aspects of the residency program in granting or denying permission for leave.
4. See UAMS Administrative Guide No. 4.6.11, Family and Medical Leave Act (FMLA) if leave is without compensation.

Bereavement Leave

Residents may request leave of one (1) to three (3) days due to death of an immediate family member. Requests for this leave or extension of this leave beyond three days must be approved by the Program Director.

Moonlighting

The institutional policies regarding moonlighting can be found on the GME office website: http://gme.uams.edu/wp-content/uploads/sites/24/2017/06/UAMS-GME-Moonlighting-Policy_10-2-17.pdf

Schedule Changes

All schedule changes must be submitted in email to the Chief Residents.

Procedure Documentation Logs

For certification in Internal Medicine, ABIM has identified a limited set of procedures in which it expects all candidates to be competent with regard to their knowledge and understanding. Upon completion of your residency it will be essential for you to have a log of the procedures you have performed to ensure technical competence and in obtaining hospital privileges. Procedures include: abdominal paracentesis, advanced cardiac life support, arterial line placement, arthrocentesis, central venous line placement, drawing venous blood, drawing arterial blood, incision and drainage of an abscess, lumbar puncture, nasogastric intubation, pap smear and endocervical culture, placing a peripheral venous line. After you have done a given procedure several times, you no longer need a supervisor's approval but you should continue to record the procedure in New Innovations

All residents (except preliminary interns) are to enter procedures in New Innovations, the same program used for completion of evaluations. These procedures are to be entered as they are completed so that an updated list will be available during faculty advisor meetings and so that they are not lost

To enter procedures go to the website: https://www.new-innov.com/login/

Institution's Login: UAMS (all caps)

Username: first initial and last name (no space in between and in lower case)

Password: same as username (unless you changed it when doing evaluations)

Click on Logger, click on Procedures

Resident Teaching Responsibilities

Your choice of a University Hospital for training in Internal Medicine indicates your desire for active supervision and teaching during your training. Your choice also implies a commitment to providing supervision and teaching to those less experienced than you, and we expect this of you. Residents play a vital role in the instruction of medical students—on ward rounds, informal discussions, scheduled ward conferences, and by example. We believe your teaching responsibilities are an important part of your training. There is no better way to insure your understanding of a subject than to prepare to teach others what you know of it.

The ward resident has the potential for a major and lasting impression on the junior and senior students. They provide a direct model of a clinician, and students will emulate their traits. To set an example of a hurried, sloppy approach to a patient's problem or a rude, inconsiderate attitude toward a sick patient is intolerable.

The specific duties of the resident to the junior clerks and the senior student acting interns on the service are:

- Assign the students patients as they are admitted. Usually this is done in rotation, but a strict rotation schedule should not be allowed to interfere with a balanced patient experience for a student. Patients should be assigned as soon as possible after their admission if they are not already involved in the admission process—a priority. This is particularly important in patients who are acutely ill. For example, the major teaching value of a patient with gastrointestinal bleeding, acute pulmonary edema, or sepsis, resides in the first few hours of his hospitalization. Students should follow a limited number of patients – they should be able to focus on understanding the patient's disease process and not be overloaded with a large volume of patients.
- Residents should conduct daily teaching rounds for the students. Attendance at these rounds may be limited to the student, or they may be combined with the interns for afternoon "work rounds." Rounds with the students provide an opportunity to find out if they understand the changes and developments in their patient's course and treatment, and give them a chance to ask questions concerning therapy, laboratory tests, etc. These discussions of immediate clinical problems in patients that students know and have examined are of tremendous importance in their clinical training. Their value is not limited to the student; explaining an illness and the reason for a proposed or established therapeutic regimen aids the resident and intern in crystallizing their concepts of the patient and his disease. We look on the resident's rounds with the students as a major part of the student teaching program and will insist that you give it the time and effort that it deserves.

- Residents should select patients for the senior acting interns to work up and to present to the attending physician on rounds. In choosing patients from the wards, a primary consideration should be given to the teaching value of the patient chosen. The resident should not feel bound to adhere to a strict rotation of students. It is the resident's responsibility to be certain that students grasp the fundamental nature of the patient's problem and to advise him or her in their reading and preparation for the presentation.

Evaluations

Resident and Intern Evaluations (by Attending Physicians)

At the end of each rotation, attending physicians submit evaluations of their residents and interns based on the goals and objectives for the rotation (see Residency Education Clinical Curriculum for details.)

Resident Evaluations (by Interns)

At the end of each rotation, interns submit evaluations of their supervising residents.

Intern Evaluations (by Residents)

At the end of each rotation, upper level residents submit evaluations of their interns. Residents should provide direct and timely feedback regarding their intern's performance during the course of the rotation.

Attending Evaluations (by Interns and Residents)

At the end of each rotation, interns and residents submit evaluations of their attending physicians. These evaluations are aggregated in large time blocks and are completely anonymous. These evaluations are directly considered for faculty advancement and/or development.

Continuity Clinic Evaluations

These evaluations are completed by faculty members to give the training program feedback regarding the intern/resident's performance in the continuity clinic.

Multi-Rater Evaluations

Periodically evaluations may be completed for interns and residents by non-MD, non-student healthcare professionals to give the training program feedback on their interpersonal communication and skills and professionalism.

Patient/Family Evaluations

Periodically evaluations may be completed by patients and/or family members for interns and residents to give the training program feedback on interpersonal communication and skills and professionalism.

Resident Self-Evaluations

These evaluations may be requested from interns/residents annually to promote practice-based learning and improvement.

Training Program Evaluations

All residents evaluate the program, the institution, and the hospitals via the ACGME survey each year. This is an anonymous survey, the results of which are reviewed during the Annual Program Review with the goal of improving the program.

Student Evaluations

Residents will be asked to submit an evaluation of medical students on their team. If you feel that the student is doing unsatisfactory work, you should discuss it with the attending before the middle of the rotation so they can notify the student with room for improvement. The student works with the resident every day, and the resident should provide constant feedback to the student. This feedback to be most effective should include what the student is doing right as well as areas for improvement. The performance of the student on the ward rotation counts for 50% of the final grade so this evaluation is a very important one.

End-of-Year Evaluations

At the end of each year, the ABIM requests from the Program Director a summative evaluation of each intern/resident.

Expectations

Hospital Arrival

- Arrive no later than 06:30 and contact night float resident for check-out of new admissions and events overnight.
- Work Rounds: The team should run the list and make a plan for the day for each patient before attending rounds. All discharge planning and orders should be placed before noon on day of discharge. If there are any questions by the team about discharges, the team should contact the attending.

Afternoon Case Discussion

- Attendance and participation are mandatory with few exceptions as noted above.

Rounds

- Interns are responsible for presentation of all patients unless assigned to medical student to present.
- The attending rounds are from approximately 08:30-10:30 at UH and 09:00-11:00 at VA.
- Expected workflow: Pre-Rounds, Rounds (with COW for essential orders), Discharges, Consults, Orders, Procedures, Conference, and then Notes.

Noon Conference

Mandatory attendance and participation of at least 80% of eligible conferences. Repercussions at the discretion of the Chiefs and Program Director.

Afternoon Responsibilities

For inpatient services, residents are expected to complete procedures and update check-out as noted above using I-PASS.

- Create accurate, updated check-out list: A comprehensive, yet brief, list should be given to the appropriate resident and intern on call. This document should contain the patients' name, medical record number, room number, diagnosis, brief history, code status, and pending tests that need to be checked. Check-out list must contain a list of all expected patients (from ICU, clinic, or another facility). If resident or intern is off, the remaining members of the team need to check-out to all levels.
- PROCEDURES ARE NOT TO BE 'CHECKED OUT.' If a patient admitted at 15:30 needs an LP, the primary team needs to do this before leaving. Passing this off to the on-call service is both inappropriate and inconsiderate.

Medical Records

EPIC is available on all computers at UAMS and is both an inpatient and outpatient computerized medical record system.

The CAVHS facility uses a Computerized Patient Record System (CPRS).

Residents and faculty must comply with each hospital's requirements for timely and accurate completion of medical records. It is the resident's responsible to check their email regularly and respond in word and deed to alerts regarding medical record delinquencies. Failure to complete delinquent records as required could lead to disciplinary measures, including by not limited to: a verbal warning from the Program Director, and a written warning from the Program Director that becomes a permanent part of the resident's file.

Dress Code

- All residents at the VA and UAMS are expected to be appropriately dressed and well-groomed at all times. This means khakis or dress trousers, shirt & tie for the men, and skirts/pants & blouse or dresses for the women.
- Scrubs are only appropriate in the following circumstances:
    - MICU/CCU Rotations
    - Night Float
    - On-Call
    - Weekends
    - S/P 24 hr call: even if a resident is s/p 24 hour call, he or she is still expected to take the time to make himself/herself look presentable.
    - Global pandemics
- If a resident is found improperly dressed or groomed, they may be sent home to change clothes or "clean up," and will be expected to be back in time for rounds that day.

Cross-Coverage for Upper Levels

Upper level residents are expected to help interns on other teams when their upper levels are off, i.e. admissions, procedures.

Unexplained Absence

Residents must notify the Chiefs and the House Staff Office via appropriate methods for EVERY absence. To ensure communication is open, all arrangements for absence must be emailed to ALL the Chiefs. Unexplained absences will be investigated and appropriate steps taken at the discretion of the Chiefs and Program Director.

Ambulatory/Resident Clinic

Contacts

UAMS: Dr. Alice Alexander

VA: Dr. Shagufta Siddiqui

Overview

One of the most important skills to be obtained during your residency in Internal Medicine is the efficient and effective handling of outpatient encounters. Resident Clinic is structured to offer you a varied clinical experience in acute and chronic outpatient disorders in the adult patient.

- Residents are expected to be on time to clinic. Our schedule is designed to eliminate conflicts between outpatient and inpatient duties, so you are free to focus on your clinic duties during your clinic sessions.
- Residents are expected to work in a timely and efficient manner in clinic. (i.e., if a resident sends a patient from clinic for a CXR or ECG, they should still continue seeing other patients while awaiting the results).

Clinic swaps are strictly limited. Please see the policy for clinic changes below

Goals

- Evaluate acute health concerns in an ambulatory setting, including appropriately triaging patients to the emergency department or hospital;
- Deliver high quality, evidence based care for chronic diseases;
- Deliver high quality preventative health care;
- Coordinate care with other health professionals such as specialists, inpatient physician teams, nurses, and other non-physician professionals;
- Use an electronic health record (EPIC/CPRS) to care for a panel of patients.

Scheduling

- **House Staff Schedules:** In accordance with requirements of the Internal Medicine RRC, all residents will have ≥ 130 clinic sessions over 3 years. Internal Medicine residents will be assigned their ambulatory experience at either the University Hospital or Veterans Administration Hospital. Medicine/Pediatrics residents will have clinics at both University Hospital and Arkansas Children's Hospital.
- **Categorical internal medicine PGY1s PGY2s and PGY3s** will have clinic one week out of every five. During your "ambulatory week", you will have five, half-day sessions of continuity clinic. These continuity clinic sessions will be on the same half-days every time you have an ambulatory

week. PGY1s are permitted 2 vacation weeks during ambulatory weeks; PGY2/3 residents cannot take vacation during an ambulatory week. Med-Peds residents are not permitted to use ambulatory weeks for vacation.

- **Med/Peds residents**: Med-Peds residents will have 6 weeks of inpatient/elective/ICU services followed by 2 ambulatory weeks. Each ambulatory week will have 3 Internal Medicine sessions, 3 Pediatric sessions, and 1 Adolescent session. Residents will join IM and Peds clinic didactics during ambulatory week.
- It is ultimately the resident's responsibility to make sure that his/her clinic patients are rescheduled when he/she has a clinic day change or cancellation. Clinic schedules are easily viewable in advance through CPRS or EPIC. If you have clinic patients scheduled on a day when you will not be there, notify the Chief Residents and the appropriate clinic medical director.
- Trades of clinic days are strictly limited (clinic trades impair the ability to develop and maintain patient care continuity). See policy on Page 25.
- The electronic chart is available at UAMS, VHA & ACH. It is **your responsibility** for follow-up of laboratory or imaging tests that you have ordered while in clinic. If you order a test, **you are responsible** to take appropriate action. If you need assistance in making a further plan, contact the attending who saw the patient with you in clinic.
- The electronic medical record is designed to allow timely communication between you and the clinic staff, even during times when you are not in clinic. In fact, it is an Internal Medicine program requirement that residents retain responsibility for their panel of continuity patients between clinic visits. You are expected to check your EPIC In-basket at least three times a week and to reply to all documents in a timely manner. Access to EPIC is available off-campus by going through UAMS MyDesk (mydesk.uams.edu).
- At the VA Hospital, limited ancillary services are available after 17:00, and our check-out clerk will usually not be available after 16:30. Ensure that any patient who checks out after 16:00 has appropriate follow-up instructions incorporated in the clinic note. The clinic nurse and clerk should be named as co-signers of the note to make sure they see and act on your instructions the next business day.
- All patients must be checked out to an attending physician and this must be documented in your note.

Location

- The UAMS clinic is located in the outpatient building on the first floor. The workroom is equipped with several computer terminals and each patient room has its own computer terminal for convenient access to facilitate efficient patient care.
- The VA clinics for General Internal Medicine are located at Fort Roots in North Little Rock.

Patient Scheduling

- The clinics will operate as a group practice. You will be assigned a panel of patients but if one of your colleagues is not in clinic or if we have a walk-in to the clinic, other patients may be assigned to you. At the beginning of every clinic session all clinic slots convert to same-day appointments – you must not leave early because you may have a patient added to your schedule at any time.

- The outpatient scheduling center at UAMS or the VAH clinic clerks schedule all patients. You should make a note of when you want your patient to return to your clinic and at UAMS place an order for this in EPIC. At the VA, the clerks will schedule patients according to the time frame that is in your note.
- Overbooks are occasionally necessary depending on patient care needs and clinic staffing. The involved resident or the clinic attending must approve overbooked patients.

Ambulatory Education

- The program has subscribed to the Johns Hopkins online ambulatory curriculum. The online modules are available through www.hopkinsilc.org – we will provide you more information about logging in and which modules you will need to do.
- All categorical Internal Medicine residents have didactic sessions, including QI, during each ambulatory week on Tuesday at 11:00 in the Abernathy classroom and Wednesday at 9:00 in Ebert library. Simulation lab is Tuesday at 08:00 at the Simulation Center. Attendance is required for both UAMS and VA clinic residents. If you must be absent, you must notify Dr. Alexander and chief residents. There will be assigned pre-readings before the didactic sessions that will be emailed to your group.
- Unexcused absences from didactic sessions and/or failure to complete assigned educational modules may result in assignment of additional clinical duties or other consequences as determined by the Program Director and Chief Residents.

Patient Load

Resident patient load will increase gradually as you advance in your skills. PGY1 residents will initially be assigned 3-4 patients per clinic ½ day and this will increase to 5 patients by the end of the first year. PGY2 and PGY3 residents will be assigned 5-7 patients per clinic ½ day. You are required to be in clinic even if you do not have patients scheduled for a particular day. Remember this is a Group practice. You may be assigned other patients.

Documentation

- Every patient encounter must be documented in the patient's medical record.
- The VA uses a computerized record system called CPRS. You will receive training in the use of this system prior to your first patient encounter. If this system is nonfunctional, hardcopy backup procedures will be used. At the VA Hospital, electronic encounter forms must be completed on every patient in CPRS.
- UAMS uses a computerized record system called EPIC. You will also receive training for this prior to your clinic experience. Clinic notes must be complete within 24 hours after the end of the encounter.

Clinic Changes

Policy for UAMS Resident Clinic changes that occur within 90 days of the scheduled clinic.

- The only acceptable reason for a resident to not be present as scheduled in his/her clinic is the occurrence of a *true emergency* (e.g. accident, illness, birth of a child, illness/death of a family member).

- When such an emergency occurs and the resident believes that he cannot be present in clinic as scheduled, he must immediately contact a Chief Resident who will then find a suitable substitute from the pool of residents on Jeopardy, preferably a resident who is on the same clinic team as the resident for whom he is going to cover.
- Under NO circumstances should a resident directly contact another resident to ask for clinic coverage in the form of a trade or favor unless this has been approved by the Chief Residents or clinic medical director.
- A resident who cannot be in clinic as scheduled due to an emergency pays back the resident who was “jeopardized” to cover for him. Payback is preferred to be in the form of a short call, not by covering the other’s clinic because clinic-for-clinic swaps or trades hurt continuity of care twice.
- Because clinics may be cancelled during vacations (for PGY1s who must take a vacation during an ambulatory week), it is essential that we have advance notice about any changes in vacation time. Any change in vacation must be communicated to the House Staff Office more than 90 days beforehand and the appropriate form must be completed. This allows sufficient time for the Appointment Center to reschedule the patients.
- Any anticipated absences such as a late-notice vacation change or educational leave should be communicated to the clinic medical director as soon as possible so that this change can be accommodated. Depending on the time frame, a cancellation or coverage by a colleague (see below) may be requested. Late cancellations for any reasons are required to have approval by the department chairman, Dr. Marsh, and he will only approve these on a very limited basis.
- If a resident needs to be absent from clinic for other University or educational business that is not scheduled >30 days ahead of time (for example, a project meeting, committee meeting, etc.), it is acceptable to ask a colleague to cover his or her clinic; this coverage arrangement must be approved by the Chief Residents and appropriate clinic medical director. Payback is expected.
- For residents interviewing for fellowship or jobs: Because our clinic at UAMS is booked up weeks in advance and because cancellations affect our ability to see patients (that is, unlike the VA system, we don't have an attending who can take care of those patients), cancellations for interviews should be avoided whenever possible. However, we understand that subspecialty interview times are limited and programs may only give residents one or two possibilities for interview days. We will cancel up to two sessions per ambulatory week for interviews/travel IF we have at least 30 days' notice. (This represents a difference from our usual 90 day vacation change policy because we understand that specialty interviews aren't generally scheduled 90 days in advance.) Cancellations beyond 2 sessions per week or with less than 30 days' notice have more significant impacts on patient care; therefore, we are asking 3rd or 4th years whose absences fall under those criteria to find a fellow upper level resident who is willing to provide clinic coverage. It is expected that this switch should be paid back in some way - it doesn't have to be with another continuity clinic (since that impacts continuity x2). The covering resident should be an upper level who is familiar with how to do clinic notes in Epic.

Clinical Documentation

Timely entry of patient notes is critical to ensure medical information is available for review by other caregivers and to ensure salient details pertaining to patient care are recorded before they are forgotten. All notes should be completed and signed on the day of service.

History and Physical (H&P)

The H&P is an essential component of a patient's complete care while on an inpatient service. Both residents and interns will write H&P. If an intern does write the H&P, the resident should follow this with a RAN (resident admit note). The RAN is a brief account of the history and physical and a well outlined assessment and plan. The H&P must include the following elements:

- DATE, TIME, TITLE, PRIMARY CARE PHYSICIAN: should be all listed at the top of the H&P.
- CHIEF COMPLAINT: in patient's own words, the cause of the hospitalization.
- HPI: description of the CC including timeline of the complaint, aggravating/alleviating factors, associated symptoms.
- PMH: listing of all chronic medical conditions and if necessary a timeline of diagnosis.
- PSH: listing of all surgical procedures and if necessary a timeline of procedures.
- MEDS: listing of all current medications.
- ALL: listing of all medical allergies and the reaction from each.
- SOCIAL HISTORY: listing of tobacco/ETOH/IDU status, occupation status, social support status, and any other lifestyle elements that could directly affect patient's health.
- FAMILY HISTORY: listing of all major diagnoses in family members with timeline if necessary.
- REVIEW OF SYSTEMS: 14 system review is required.
- PHYSICAL EXAM: 2 points on each of 10 systems
- LAB: listing of significant lab findings.
- IMAGING: listing of significant imaging.
- ASSESSMENT AND PLAN: problem-based approach for non-ICU patients, system-based approach for ICU patients and complicated non-ICU patients

Progress Notes

- SOAP note format with brief subjective overview of patient's status, objective overview of PE, laboratory, and imaging studies followed by an assessment and plan by pertinent system outlining a plan for the day.
- Student notes are required to have a resident or attending addendum and signature. Note that student notes do not substitute for physician notes under any circumstance.

Discharge Summary

The discharge summary is vital for continuity of patient care once the patient is discharged from the hospital. It should contain the following elements:

- PATIENT'S NAME AND FULL MRN OR SSN
- DATE OF ADMISSION
- DATE OF DISCHARGE
- SERVICE AND ATTENDING PHYSICIAN
- PRIMARY DIAGNOSIS: primary diagnosis which was the cause of the admission

- SECONDARY DIAGNOSIS: any other diagnoses that were addressed while patient was in the hospital
- CONSULTATIONS
- PROCEDURES
- HPI, PMH, PSH, admit MEDS, ALL, SOCIAL, FH (from H&P)
- PE
- LAB on admission: any significant lab findings on admission
- IMAGING on admission: any significant imaging findings on admission
- HOSPITAL COURSE: summary of hospital events
- DISCHARGE MEDICATIONS: absolutely ESSENTIAL that these medication lists are accurate and match the medications you place in the computer for patient discharge.
- DISCHARGE INSTRUCTIONS: list of special instructions including dietary, activity level/return to work, monitoring symptoms at home and when to return to ED with problems, etc.
- DISCHARGE FOLLOW-UP: list of follow up appointments, imaging exams, lab evaluation or any other f/u that is necessary.
- NAME OF REFERRING PHYSICIAN: to CC discharge summary to PCP is essential. Discharge summaries may not be mailed to the referring physician until several days after the patient leaves the hospital. Therefore, the discharge summary may not be suitable as an immediate notification to the physician of the patient's diagnosis and treatment. Telephone calls to referring physicians to notify them of a patient's discharge or to inquire of previous medications or events in the hospitalized patient's illness may be made.

Transfer Notes

The transfer note is essential to ensure continuity of care between ward and ICU, and when transfer of specialty occurs (e.g. medicine to surgery). The essential elements are as follows:

- ADMISSION DATE
- ADMISSION SERVICE: list attending and resident
- TRANSFER DATE
- TRANSFER SERVICE: list attending and resident
- ADMISSION DIAGNOSIS
- SECONDARY DIAGNOSIS
- CONSULTATIONS
- PROCEDURES
- HOSPITAL COURSE: summary of why patient was admitted and what has been done thus far
- PE
- LAB: transferring day's lab
- IMAGING: transferring day's imaging
- ASSESSMENT AND PLAN: by system account of what has been discovered, what needs to be followed up and future plans of care.

Death Documentation, Reporting, Certification and Autopsy

All deaths occurring in any UAMS patient care setting, either inpatient or outpatient, must be documented in the patient's medical record. When a death occurs, the resident should work with the

nursing supervisor to complete the death reporting process. The supervisor will guide the resident through the process to ensure that all reports are completed according to UAMS policy and State law. In certain circumstances, the coroner or law enforcement officials may need to be notified. You are required to notify ARORA if a death is anticipated or occurs, who then will talk with the family regarding tissue and organ donation. If ARORA releases the case, they will provide a case number that goes into the Death Note. The Death Note should be entered as soon as possible using the standard template after the patient is pronounced deceased. The Arkansas death certificate must be completed online through https://adherave.arkansas.gov/erave/do/login and printed prior to release of the body to the morgue. You may defer the death certificate until after the provisional autopsy findings are reported (within 48 hours of autopsy), but you must note that you are doing this prior to performance of the autopsy.

Notification of the County Coroner

A rule to live by is, "if in doubt, notify the coroner immediately." Any physician attending the patient may call the coroner or designate another to do so. Basically, you should call them if you suspect death is:

- The death appears caused by violence, homicide, suicide, or accident. Remember, if a person is in an accident, then dies in the hospital six weeks later of a PE, it is still an accidental death and must be reported!!
- You suspect there are drugs or poisons present.
- The dead person was in a mental institution, police custody, or nursing home, or within 5 days of discharge from a nursing home or jail.
- Physical abuse is suspected.
- There is no previous medical history or apparent cause of the death.
- The death is sudden or unexplained, or appears to be due to other than natural causes.
- The death occurs at a place of work.
- No physician was in attendance within the prior 36 hours, or 30 days in the case of terminal or bedfast patients.
- The person was admitted unconscious.
- The patient dies within 24 hours of admission.
- The patient was DOA or died in the emergency room.

Failure to notify the coroner is a Class A misdemeanor. Again, if in doubt, call them at 340-8355. If other officials need to be notified (sheriff, police, medical examiner), the coroner's office will take care of it.

Autopsy

Autopsy requests should be made if a patient's cause of death is not apparent or upon request of patient's family. Autopsies are strongly recommended under the following conditions:

- Unanticipated deaths
- Patients on experimental treatments
- Intraoperative deaths
- Death within 48 hours of surgery or an invasive procedure

- During pregnancy or peri-partum
- Psychiatric inpatients
- Pediatric deaths

Autopsy Process

The following things are necessary in order for an autopsy to begin:

- A properly identified body (toe tag, wrist band, etc.)
- A properly executed autopsy status/consent form signed by next of kin
    - Before obtaining consent for autopsy, notify the pathology resident on-call.
    - 08:00-16:30 Call 501.686.7277 (lab/morgue)
    - 16:30-08:00 Call 501.658.8313 (pathology on call)
    - Pathology residents have been instructed to ensure that all clinical and family questions be clarified, as well as ensure that full consent has been obtained.
- If you are unsure of how to request an autopsy from the next of kin, ask your supervising resident or attending for help. Any physician attending the patient may obtain consent. You need this physician's signature (first witness), the closest next of kin's signature, and that of another UAMS employee (second witness). The case cannot be done without this properly obtained consent. The next of kin who signs this form ideally is the person who assumes funeral responsibilities. Generally, this is the priority list for next of kin (see third page of autopsy consent form): spouse > child > parent > sibling > other first degree relative > other second degree relative > any other relative > friend assuming responsibility for burial. Common Law and other domestic partnerships don't count in Arkansas.

Needle-Stick/Sharps Procedure

It is extremely important for residents to know the policy and procedures for needle stick/sharp injuries and blood/body fluid exposure in order to ensure safety and care of themselves and the students who work with them. The UAMS Medical Center policy http://inside.uams.edu/compliance/uams-policies/ - search for "needlestick" which describes all procedures, in detail, which must be followed if a resident or student sustains a needle stick injury or blood/body fluid exposure. The most important points of that policy are:

Any resident who suffers a needle stick, cut, or mucus membrane (e.g. splash to the eye or mouth) exposure to blood or other body fluids, or who have a cutaneous exposure involving large amounts of blood or prolonged contact with blood regardless of the type of exposure or risk status of the source patient shall:

- Report the incident immediately to their supervisor or instructor.
- Call immediately to Employee Health/Student Preventative Health Services (EH/SPHS), 686-6565 or page 501-405-6734, if it is during regular business hours OR the Emergency Department (ED) 686-6236, if it is after business hours.
- The amount of risk incurred as a result of the exposure must be evaluated and prophylactic treatment must be started within 2 hours to be effective.
- Complete the UAMS Incident and Injury (I&I) Report form: http://www.uams.edu/campusop/depts/ohs/forms/Accident.aspx

- Information about the source patient shall be documented on the Employee Incident and Injury (I&I) report form by the nursing supervisor or his/her designee from which the source patient is receiving care. The I&I form shall accompany the resident to EH/SPHS or the ED at the time of the initial evaluation.

It is the responsibility of the resident's attending physician to make sure that all information relevant to the I&I has been completed and the resident has called either EH/SPHS or the UAMS ED, for triage. It is the responsibility of the Nursing Supervisor or designee to record all information regarding the source patient on the I&I, notify either EH/SPHS or the ED with the risk factors for HIV, and ensure that orders are written for lab work on the source patient's chart.

Residency Office – Department of Internal Medicine

The Department of Medicine Residency Office controls all business functions in the Department of Internal Medicine involving House Staff affairs. The following information should help you identify certain areas in which the Medicine Residency Office can be of help to you.

- **Meal Allowance**: UAMS--The UAMS ID badge will be used to pay your meals when you are on ward and ICU call at the University Hospital. The ID badge is credited electronically for the upcoming month. The cost for replacement of an ID badge is $10. If you encounter any difficulty when purchasing food or if you lose your ID badge, you must notify the Residency office (686-5162). VAH--For those residents with food allergies or who may be vegetarians, the VA Nutrition and Food Service (NFS) has agreed that they will change the menu to accommodate (including the on-call boxed food), if they receive notice ***within 24 hours of the need***. Mail the request to this VA mail group: VHALIT NFS Supervisors or if outside the VA e-mail: VHALITNUTRESIDENTS@va.gov.
- **Paychecks:** Your pay is deposited directly to your specified institution. To view your pay stub, go to: https:\\enterprise.uams.edu\irj\portal
- **Pagers:** An alpha-numeric pager will be assigned to you and will remain with you throughout your training. Batteries will be supplied by the Medicine Residency Office.
- **Mailboxes:** Periodically, check your mailbox located in the resident lounge area. House staff members frequently miss important correspondence because they do not check their mailboxes.
- **E-mails:** All information important to residents will be sent electronically. You have an e-mail address at UAMS. This is on Outlook and is accessible from any internet connected computer in the world. You are responsible for any information sent to you via e-mail. **"I don't check my e-mail" is not a valid excuse!** Residents are expected to check UAMS e-mails on a daily basis and are expected to keep their e-mail boxes cleaned out periodically (if your mailbox is full, you cannot receive e-mail). You will also be assigned a VA e-mail address and this account should be checked periodically.
- **Personal Information Changes:** Please notify the Medicine Residency Office when you have changes in your address, telephone number, marital status, etc.

Book fund: The Department of Medicine furnishes an educational book fund at each level of internship and residency. **Medicine** PGY-1s receive $200, PGY-2s $400, and PGY-3s $400. **Medicine/Pediatric** PGY-1s receive $50, PGY2s $100, PGY3s $125, and PGY4s $125, and will also receive money from ACH. You may not purchase books as an individual and be reimbursed by the Department. UAMS Procurement Services can, on the resident's behalf, purchase books from Amazon and various other book vendors using a P-Card, as well as most subscriptions, dues and journals. If you would like to use this fund for any other educational purposes, such as paying for USMLE exams or ABIM board exam fees, you must have it approved before the fact by the Medicine Residency Office. You may carry book fund money over from year to year. You must use your fund by the last month of your final year of residency.

All elective/discretionary funding is subject to review and/or suspension in exigent circumstances.