

## Appendix B: Inpatient Rotations

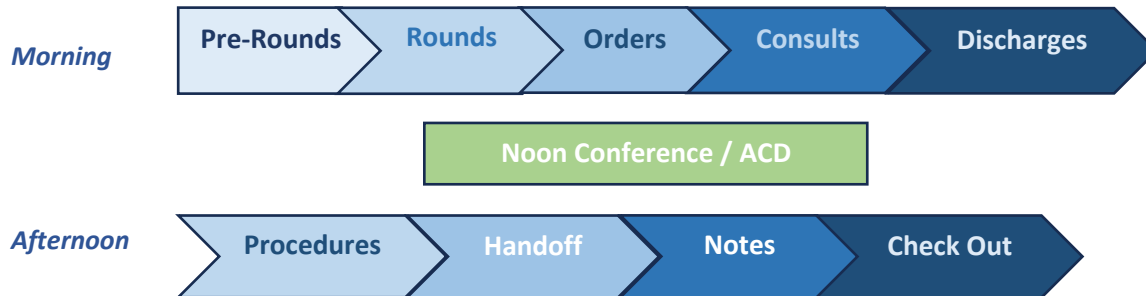
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## Inpatient - Resident Responsibilities:

### Hospital Arrival:

- All residents should arrive no later than 0630/1830 for their respective shift to receive check out from the call team. Residents may arrive earlier if they need additional time to complete pre-rounding before rounds.

### Expected workflow:



<b>Pre-Rounding</b>	<ul style="list-style-type: none"> <li>The team should chart review their assigned patients (which is up to the team to divide), see each of their patients, and have a plan before rounds.</li> <li>The attending on service should be informed before rounds if any of the patients are seriously ill, unstable, or otherwise need attention before rounds.</li> <li>At the VA, there will be a social work meeting that the upper level should attend via teams at either 8:30 or 8:45 depending on the team assigned.</li> </ul>
<b>Rounds</b>	<ul style="list-style-type: none"> <li>Interns are responsible for presentation of all patients unless assigned to a medical student to present.</li> <li>Attending rounds typically start between 8:00-9:00 and finish by 10:00-11:00</li> </ul>
<b>Discharges</b>	<ul style="list-style-type: none"> <li>To expedite patient admissions, discharges should be as early as possible.</li> <li>Discharge orders should be placed before noon.</li> <li>Discharge summaries should be completed before discharge.</li> <li>If there are questions about whether to discharge a patient, the attending should be called for direction.</li> <li>Detailed information on discharge summaries is discussed in the "Clinical Documentation -&gt; Discharge summary" section.</li> </ul>
<b>Complete Procedures</b>	<ul style="list-style-type: none"> <li>PROCEDURES ARE NOT TO BE 'CHECKED OUT' no matter how late the admission. Passing this off to the on-call service is both inappropriate and inconsiderate. If in the ICU and multiple procedures need to be performed seek help from the fellow.</li> </ul>
<b>Update Handoff</b>	<ul style="list-style-type: none"> <li>In EPIC using the handoff tab, using the dot phrase, ".medicineco" at UH or in the word document at the VA. The VA word document 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 in to locked HIPAA compliant shred bins since they contain protected health information.               <ul style="list-style-type: none"> <li>Should be comprehensive and <b>accurate</b>, but brief.</li> <li>Document should contain: Patients' name, medical record number/last four, room number, diagnosis, brief history/reason</li> </ul> </li> </ul>

	<p>for admission, code status, anticipated issues overnight and pending tests that need to be checked.</p> <ul style="list-style-type: none"> <li>▪ Additional important information should also be included, i.e. patient has religious preferences or private medical conditions, etc.</li> <li>▪ Handoff must contain a list of all expected patients (from ICU, clinic, or another facility)</li> </ul>
<b>Checkout</b>	<ul style="list-style-type: none"> <li>- Must occur face-to-face.</li> <li>- Every team should check out to the short call resident and interns, who will then check out to the night float resident and interns.</li> <li>- Should use an updated, printed copy of the team list.</li> <li>- It is the outgoing resident’s responsibility to contact the on-call resident for check-out.</li> <li>- Check- out should be done using the I-PASS structure (Illness severity, patient summary, action list, situation awareness &amp; contingency planning, synthesis by Receiver). Please see end of appendix A for visual depiction. <ul style="list-style-type: none"> <li>▪ Brief verbal description of each patient and major reason(s) why they are currently in the hospital.</li> <li>▪ Any significant events over the past 24 hours.</li> <li>▪ Anticipated events.</li> <li>▪ Next steps of what to do when pending test results return.</li> </ul> </li> <li>- If a resident does not check-out to the on-call team, the Chief Resident should be notified immediately.</li> </ul>

- If you get called with an ICU transfer on call for a team you are covering at the VA it is imperative to add the patient immediately to the word document and save it, otherwise the primary team will not know this patient is on their list the following day.

<b>General Responsibilities by PGY Level</b>	
PGY-1	PGY-2/PGY-3
The day before coming onto a new service, you are expected to receive a verbal checkout from the existing intern about the patients you will be covering to smoothly transfer care from the existing intern to yourself.	The day before coming onto a new service, you are expected to receive a verbal checkout from the existing resident about the patients you will be covering to smoothly transfer care from the existing resident to yourself.
Split the list with the other intern on the team. Every patient should be covered by an intern. You are expected to see all your patients before rounds	If another upper level is on service, split the list with the other upper level. If you are the only upper level on the team, you will carry the whole list.
You will present your patients if not being presented by a medical student.	Be prepared on rounds to enter time sensitive orders, fill in information gaps in presentations, show pertinent imaging, etc.
When the second intern of the team is off, the remaining intern is expected to pick up some of their co-interns’ patients.	Run the list with the team after rounds and fairly split the remaining tasks among the team. Include the medical students in this process.
Assist medical students as outlined in the “Resident teaching responsibilities and expectations” section.	Oversee the interns and ensure patient safety.
Interns will assist with admissions. Please see “Resident Inpatient Responsibilities -> Admissions” section for further expectations regarding admissions.	Upper levels are primarily responsible for admissions; however, interns are expected to assist with them, and medical students should be involved as well. Please see “Resident Inpatient Responsibilities -> Admissions” and

	“Resident Teaching responsibilities and expectations -> PGY-2/PGY-3” for further direction on admission process and what is expected when interacting with medical students.
The upper level will run the list with the team after rounds and the team will split up the remaining afternoon responsibilities.	Even if interns enter in some of the orders, as the upper level, it is your primary responsibility to ensure everything that was discussed on rounds is completed by the end of the day. Having a checklist and marking off tasks as they are completed throughout the day can help you keep track, and prevent you from repetitive checking, therefore improving your efficiency.
Write a note for every patient (see the “clinical documentation” section for details on note writing).	Make sure the handoff is accurate and complete
Carry the team pager and answer pages. You can seek help from your upper level if you do not know the answer to the question.	Expectations are that the upper-level will see all patients before rounds. At minimum, make sure to see the sick patients, discharges, and new admissions before rounds.
If at the VA you will need to order morning labs daily for each one of your patients.	

### Admissions:

- All admissions are assigned to a team by the triage hospitalist as follows. This includes admissions from the emergency department, direct admissions, and transfers from outside facilities.
- Each team is responsible for admissions to their team until short call starts at 4 p.m. 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.
- Upper levels have the primary responsibility of admitting patients, however interns should help with admissions as well.
- Each intern is expected to do at least one admission per night when on night float.
- By month three of residency, interns should be doing admissions regularly, including initial evaluation/orders/initial plan/and H&P with the assistance and oversight of the upper-level resident.
- Upper-level residents should evaluate each patient the intern is admitting, review the plan and orders with them and write a resident attestation note to their H&P.

### 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 the Computerized Patient Record System (CPRS).
- Both EMRs can be used from home with remote laptop access. EPIC also has a smart phone app with limited features.

Residents and faculty must comply with each hospital’s requirements for timely and accurate completion of medical records. It is the resident’s responsibility 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 but not limited to a verbal warning from the Program Director, and/or a written warning from the Program Director that becomes a permanent part of the resident’s file.

## UAMS – Inpatient Team Structure:

### Ward Services at UAMS:

There are six inpatient ward teams—two general medicine and four subspecialty teams—which comprise the teaching services:

<b>Team 1</b> Cardiology	<b>Team 2A</b> Oncology	<b>Team 2B</b> Hematology	<b>Team 3A</b> General IM	<b>Team 3B</b> General IM	<b>Team 6</b> Abernathy ID
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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.

<b>Team 1</b> <b>Cardiology</b>	
<b>Team Structure</b>	Two upper-level residents, two or three interns, medical students, and a cardiology attending.
<b>Patients</b>	Inpatients whose primary diagnosis is a cardiovascular disease requiring medical management
<b>Cap</b>	Twenty patients. The cap takes effect at 4 p.m. on weekdays and at noon on weekends and holidays. If the team list exceeds twenty patients at the time the cap takes effect, all patients will remain on the team until 6 a.m. the next day, at which time the triage hospitalist will reassign patients to other teams until the team has only twenty patients.
<b>Responsibilities</b>	Direct patient care, including but not limited to rounding, calling consultants, writing progress notes, admitting patients, and discharging patients.
<b>Admissions</b>	The emergency department will call the triage hospitalist who will notify the residents of patients to admit. If a patient was admitted to team 1 in the last 30 days and needs re-admission the patient will “bounce back” to team 1.
<b>Admission Details</b>	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, that would result in the balanced shift of a patient with less need for cardiovascular disease specialty to a general medicine team. Any transfers must be discussed with the cardiology attending.

<b>Team 2A</b> <b>Oncology</b>	
<b>Team Structure</b>	One upper-level resident, APRNs, PAs, medical students, a pharmacist, and a hematology/oncology attending
<b>Patients</b>	Inpatients with solid-organ malignancies who are followed in the UAMS Oncology Clinic
<b>Cap</b>	Fourteen patients. The cap takes effect at 4 p.m. on weekdays and at noon on weekends and holidays. If the team list exceeds fourteen patients at the time the cap takes effect, all patients will remain on the team until 6 a.m. the next day, at which time excess patients will be reassigned to Team 2C until the team has only fourteen patients. After the team is capped, the admissions will be directed to 2C, which the residents do not cover.
<b>Responsibilities</b>	On weekdays, APRNs and physician assistants write progress notes, discharge patients, and admit some patients. The resident on the team is responsible for all other patient care including but not limited to rounding, calling consultants, and admitting some

	patients. On weekends and holidays, the resident is responsible for writing some progress notes in addition to their other clinical duties as listed above. APRNs on the weekends remain responsible for discharging patients.
<b>Admissions</b>	From 7 a.m. to 4 p.m. on weekdays, patients triaged for admission to a hematology/oncology team (i.e. 2A, 2B, or 2C) will be admitted by the following people in this order: a 2C hospitalist, an APRN/physician assistant, and either the 2A or 2B resident. This cycle will repeat until 4 p.m. From 4 p.m. to 7 p.m., the on-call ward resident will alternate hematology/oncology admissions with the on-call 2C hospitalist. From 7 p.m. to 7 a.m. all oncology patients will be admitted to 2A until the team is capped. Once the team is capped, the remainder of oncology admissions for the night will be admitted to team 2C by the 2C hospitalist.
<b>Admission Details</b>	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**  
**Hematology**

<b>Team Structure</b>	One upper-level resident, APRNs, PAs, medical students, a pharmacist, a hematology/oncology fellow, and a hematology/oncology attending.
<b>Patients</b>	Inpatients with hematologic malignancies who are followed in the UAMS Hematology Clinic
<b>Cap</b>	Fourteen patients. The cap takes effect at 4 p.m. on weekdays and at noon on weekends and holidays. If the team list exceeds fourteen patients at the time the cap takes effect, all patients will remain on the team until 6 a.m. the next day, at which time excess patients will be reassigned to Team 2C until the team has only fourteen patients.
<b>Responsibilities</b>	On weekdays, APRNs and physician assistants write progress notes, discharge patients, and admit some patients. The resident on the team is responsible for all other patient care including but not limited to rounding, calling consultants, and admitting some patients. On weekends and holidays, the resident is responsible for writing some progress notes in addition to their other clinical duties as listed above. APRNs on the weekends remain responsible for discharging patients.
<b>Admissions</b>	From 7 a.m. to 4 p.m. on weekdays, patients triaged for admission to a hematology/oncology team (i.e. 2A, 2B, or 2C) will be admitted by the following people in this order: a 2C hospitalist, an APRN/physician assistant, and either the 2A or 2B resident. This cycle will repeat until 4 p.m. From 4 p.m. to 7 p.m., the on-call ward resident will alternate hematology/oncology admissions with the on-call 2C hospitalist. From 7 pm to 7 am all hematology patients will be admitted to 2A until the team is capped. Once the team is capped, the remainder of oncology admissions for the night will be admitted to team 2C by the 2C hospitalist. The only exception to this is all sickle cell crisis patients will be admitted directly to 2C by the 2C hospitalist regardless of round robin or caps.
<b>Admission Details</b>	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**

- **7 a.m. to 4 p.m. on weekdays:** Admissions will be distributed in round robin fashion, 1:1:1, between the 2c hospitalist, APRN and the residents (2A/2B).

- **7 a.m. to 12 p.m. on weekends:** Admissions will be distributed in round robin fashion, 1:1, between the 2C hospitalist and residents. 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 to 2C. Only 2A and 2B are staffed by residents.
- 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 p.m. to 7 p.m. 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.

**Night shift admissions 7 p.m. to 7 a.m.:** The night resident will admit all hematology patients to 2B until capped and all oncology patients to 2A until capped. After a team is capped the remainder of the oncology or hematology patients (depending on which team is capped) will be admitted to 2C by the 2C hospitalists.

<b>Team 3A</b> <b>General IM</b>	
<b>Team Structure</b>	Two upper-level residents, one intern, medical students, physician assistant students, and a general internal medicine attending.
<b>Patients</b>	Inpatients with primarily medical (i.e. non-surgical) diagnoses
<b>Cap</b>	Sixteen patients. The cap takes effect at 4 p.m. on weekdays and at noon on weekends and holidays. If the team list exceeds sixteen patients at the time the cap takes effect, all patients will remain on the team until 6 a.m. the next day, at which time excess patients will be reassigned to other teams until the team has only sixteen patients.
<b>Responsibilities</b>	Direct patient care, including but not limited to rounding, calling consultants, writing progress notes, admitting patients, discharging patients, and performing some procedures
<b>Admissions</b>	After 7 a.m. on odd dates, team 3A receives the first admission. After 7 a.m. on even dates, team 3A receives the second admission. Team 3A can receive additional admissions after all other eligible teams have also received an admission. If a patient was admitted to 3A in the last 30 days and needs re-admission the patient will “bounce back” to 3A regardless of the round robin.
<b>Admission Details</b>	General Internal Medicine patients are assigned in a round robin fashion to 3A, 3B, 3C, 3D, 3E, and 3F.

<b>Team 3B</b> <b>General IM</b>	
<b>Team Structure</b>	One upper-level resident, two interns, medical students, a pharmacist, and a general internal medicine attending.

<b>Patients</b>	Inpatients with primarily medical (i.e. non-surgical) diagnoses
<b>Cap</b>	Fourteen patients. The cap takes effect at 4 p.m. on weekdays and at noon on weekends and holidays. If the team list exceeds fourteen patients at the time the cap takes effect, all patients will remain on the team until 6 a.m. the next day, at which time excess patients will be reassigned to other teams until the team has only fourteen patients.
<b>Responsibilities</b>	Direct patient care, including but not limited to rounding, calling consultants, writing progress notes, admitting patients, discharging patients, and some procedures.
<b>Admissions</b>	After 7 a.m. on even dates, team 3B receives the first admission. After 7 a.m. on odd dates, team 3B receives the second admission. Team 3B can receive additional admissions after all other eligible teams have also received an admission. Team 3B can receive additional admissions after all other eligible teams have also received an admission. If a patient was admitted to 3A in the last 30 days and needs re-admission the patient will “bounce back” to 3B regardless of the round robin.
<b>Admission Details</b>	General Internal Medicine patients are assigned in a round robin fashion to 3A, 3B, 3C, 3D, 3E, and 3F.

**Team 6**  
**Abernathy ID**

<b>Team Structure</b>	One upper-level resident, one intern, medical students, and an infectious diseases attending
<b>Patients</b>	Inpatients whose primary diagnosis is an infectious disease
<b>Cap</b>	Ten patients. The cap takes effect at 4 p.m. on weekdays and at noon on weekends and holidays. If the team list exceeds ten patients at the time the cap takes effect, all patients will remain on the team until 6 a.m. the next day, at which time excess patients will be reassigned to other teams until the team has only ten patients.
<b>Responsibilities</b>	Direct patient care, including but not limited to rounding, calling consultants, writing progress notes, admitting patients, discharging patients, and some procedures.
<b>Admissions</b>	The triage hospitalist determines when a patient meets criteria for admission to team 6 and will inform the team of patients to be admitted to their service.
<b>Admission Details</b>	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.

**Ward Night Float - UAMS**

<b>Team Structure</b>	1 upper-level resident, 2 interns
<b>Patients</b>	Cross coverage and admissions to of all the inpatient ward teams – Team 1, 2A, 2B, 3A, 3B, and Team 6.
<b>Work Hours &amp; Days</b>	19:00 – 07:00 Residents and interns work 6 nights (Monday-Saturday night) with Sunday night off. Sunday night will be covered by 1 resident and 2 interns on call from the ward teams.
<b>Arrival</b>	Arrive by 18:45 to receive handoff.
<b>Responsibilities</b>	Direct patient care, all admissions to teaching services, face-to-face handoff in the morning for admissions after 16:00 to the appropriate teams in addition to handoff about other existing patients; and all duties outlined in “Call Structure.” Interns will split cross coverage of the inpatient ward teams. The upper level is primarily responsible for all

	admissions to inpatient ward teams. Once the overnight resident reaches a total of 10 admissions or all teaching teams are capped, the on-call hospitalists will admit all patients, to the respective services. The Night Float resident will also be responsible for seeing the general medicine consults overnight which will then be staffed with the triage hospitalist. These patients will need to be checked out to the general medicine consult resident in the morning.
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**Medical Intensive Care Unit (MICU) at UAMS:**

MICU 1	MICU 2
<b>Team Structure</b>	-Each team: 2 upper-level residents, 2 interns, pulmonary/critical care attending, 1 pulmonary/critical care fellow (only 1 fellow for both teams on the weekends/holidays). May have an M4 student. -1 Acute Care Resident (ACR): admissions, transfers on weekdays (no weekends/holidays)
<b>Patients</b>	Critically ill patients with a primary non-surgical medical diagnosis.
<b>Cap</b>	14 per team
<b>Responsibilities</b>	Direct patient care, including but not limited to rounding, calling consultants, writing progress notes, admitting patients, transferring patients, and some procedures.
<b>Admissions</b>	-07:00-16:00: ACR -16:00-19:00: Upper-level resident on call -19:00-07:00: Upper-level on MICU Night Float -Weekends 07:00-12:00: Since there is not an ACR on the weekends, the first admission of the morning will go to the upper-level resident on call. The other upper levels present on both teams will then alternate admissions. Each upper-level present that day should do an admission before the upper-level on call does a second admission. -Weekends 12:00-19:00: Upper-level resident on call -All admissions must be staffed with the fellow on call and/or the attending.
<b>Call</b>	MICU 1 takes short call on ODD days MICU 2 takes short call on EVEN days Responsibilities: cross-coverage for other MICU Team, all admissions/transfers, and procedures
<b>Transferring patients out of MICU</b>	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.

MICU Night Float	
<b>Team Structure</b>	-1 upper-level resident, 1 intern -1 fellow (except for Saturday night) and 1 attending are in house. The fellow on call also covers the VA ICU overnight.
<b>Patients</b>	Cross coverage of all patients assigned to MICU 1 and MICU 2. All admissions to the MICU, up to 10 patients in one shift. The fellow or attending on call will assist with any admissions if this 10-patient cap is reached.

<b>Work Hours &amp; Days</b>	19:00 – 07:00 Residents and interns work 6 nights (Monday-Saturday night) with Sunday night off. Sunday night will be covered by 1 resident and 14 intern on call from the MICU teams.
<b>Arrival</b>	Arrive at 18:45 to receive handoff.
<b>Responsibilities</b>	Cross-coverage for both MICU Teams, all admissions/transfers, and procedures.
<b>Admissions</b>	Must be staffed with fellow and/or attending. On Saturday night, all admissions will be staffed with the attending.
<b>Reminders</b>	Any patients that are decompensating or requiring increase in pressors should be communicated to the fellow and/or attending immediately.

**CVICU**  
**UAMS**

<b>Team Structure</b>	1 IM upper-level resident, 2 anesthesia residents, 1 APRN, 1 critical care attending, 1 cardiac surgeon, 1 cardiology attending, and 1 cardiology fellow.
<b>Hours</b>	6:00-18:00, Monday-Sunday with one day off.
<b>Patients</b>	Post-operative cardiovascular surgery patients or inpatients requiring critical care due to a primary cardiovascular cause.
<b>Responsibilities</b>	The patient list should be split evenly among the 3 residents and 1 APRN. You are responsible for all the patient care of your assigned patient, including but not limited to, rounds, orders, notes, transfers, and procedures (if the procedure is normally performed by an internal medicine resident – CVLs, arterial lines, paracenteses, lumbar punctures; other procedures will need direct supervision of an attending).
<b>Admissions</b>	The ED will call the team phone to request CVICU admission. The admission should be cleared by the attending before accepting. Once accepted it is up to the team to decide who is up for admission out of the residents and APRN. Admissions should be split up and shared amongst the group. All admissions should be staffed with the critical care attending
<b>Transferring Patients out of CVICU</b>	Most patients will either go to Team 1 or cardiothoracic surgery, however if there is any question about this confirm with your attending before transfer. It is required that verbal handoff be given to the accepting team for all patients transferring out of the CVICU.
<b>Night Float</b>	This service is covered by APRNs and anesthesia residents. IM residents do not cover any nights in the CVICU.

**Inpatient Call at UAMS**

<b>Call Hours</b>	Weekdays 16:00-19:00 Weekends/Holidays 12:00-19:00
<b>Staffing</b>	2 upper-level residents, 1 intern
<b>Admissions</b>	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. After 16:00, admissions are assigned in a round-robin fashion with a 1:1 ratio with the non-teaching teams (includes cardiology and hematology/oncology teams)
<b>Responsibilities</b>	All admissions to the teaching services from 16:00-19:00

<b>Code Blue Team</b>	The on-call resident and interns will carry a code pager when their shift starts at 7 a.m. to when their shift ends at 7 p.m. All three must respond <b>immediately</b> 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.
<b>Ward Resident</b>	Will be responsible for most of the admissions on call. Typically, admissions are done in a 2:1 fashion with the ward resident doing the first two, the cover resident doing the next one, then the next 2 will go to the ward resident and so on. Will also supervise the care of at least one patient team. Upper -level residents are ultimately responsible for all admissions during their call shift, but should allow interns to complete orders, H&Ps, etc. Please see “admission” section of Appendix A for further direction on expectations surrounding admissions. The admitting resident is responsible for maintaining an accurate log of all admissions and reconciling EPIC team lists prior to the end of every shift. Clearly communicate any team re-assignments with both the teaching and non-teaching services.
<b>Cover Resident/Cross Coverage</b>	Will be responsible for some of the admissions on call, as stated above. The cover resident will typically assist/supervise the intern more than the ward resident as the ward resident will be doing more admissions. The cover resident should also respond to pages promptly and professionally and document any significant interventions they performed.
<b>Intern/Cross Coverage</b>	Respond to pages promptly and professionally, document any significant interventions, and assist upper levels with admissions if needed.
<b>Patient Handoffs</b>	Face-to-face handoff with an acute, concise patient list <i>must</i> occur for every team at every level (PGY-1, 2, & 3) utilizing I-PASS method. Any patient that was admitted on call <b>MUST</b> have an updated handoff in EPIC and be verbally checked out to the night team.
<b>Code Blue Team</b>	The most senior MICU resident is the leader of the Code Blue Team and should respond <i>immediately</i> 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 and should accompany the patient to the new level of care.

**VA – Inpatient Team Structure:**

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 at the VA:**

	<b>GM1</b> General Medicine Team 1	<b>GM2</b> General Medicine Team 2	<b>GM3</b> General Medicine Team 3
<b>Team structure</b>	2 upper-level residents, 2 interns, 1 attending physician, a pharmacist, +/- pharmacy resident, and medical students		
<b>Patients</b>	Inpatients with primarily medical (i.e., non-surgical) diagnoses		
<b>Cap</b>	Soft cap of fourteen patients and hard cap of sixteen patients. The cap takes effect at 4 p.m. on weekdays and at noon on weekends and holidays. If the team list exceeds sixteen patients at the time the cap takes effect, all patients will remain on the team until 6 a.m.		

	the next day, at which time excess patients will be reassigned to other teams until the team has only sixteen patients.
<b>Responsibilities</b>	Direct patient care, including but not limited to rounding, calling consultants, writing progress notes, admitting patients, discharging patients, and some procedures
<b>Admissions</b>	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. Direct admissions will be assigned at the time of arrival and will be distributed per the round robin. If a patient was admitted to one of the general medicine teams in the last 15 days and needs re-admission the patient will “bounce back” to the team in which they were previously admitted regardless of the round robin, however the bounce back will count as an admission for that team in the round robin.
<b>Admission Details</b>	General Internal Medicine patients are assigned in a round robin fashion to GM1, GM2, GM3, Hospitalist A, Hospitalist B, and Hospitalist C. The round robin continues from call/overnight and does not reset at 7AM. There is a “soft cap” for teaching teams in which all teaching teams will first have 14 patients. For example, if GM3 had 14 patients but GM1 and GM2 have only 12 patients each, GM3 would be taken out of the round robin until GM1 and GM2 have reached 14 patients. Once all teaching teams have 14 patients the round robin is reinstated until all teaching teams have 16 patients. Once each teaching team has 16 patients, the remainder of the admissions will go to the hospitalist teams.

**Ward Night Float - VA**

<b>Team Structure</b>	1 upper-level resident, 2 interns
<b>Patients</b>	Cross coverage and admissions to of all the inpatient ward teams – GM1, GM2, GM3
<b>Work Hours &amp; Days</b>	19:00 – 07:00 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.
<b>Arrival</b>	Arrive at 18:45 to receive handoff.
<b>Responsibilities</b>	Direct patient care, all admissions to teaching services, face-to-face handoff in the morning for all admissions after 16:00 to the appropriate teams in addition to handoff about other existing patients; and all duties outlined in “Call Structure.” Interns will split cross coverage of the inpatient ward teams. The upper level is primarily responsible for all admissions to inpatient ward teams. Once the overnight resident reaches a total of 10 admissions or all teaching teams are capped, the on call direct care physician will admit all patients, to the respective services.

**Medical Intensive Care Unit (MICU) at the VA:**

**MICU VA**

<b>Team Structure</b>	- 1 upper-level resident, 3-4 interns, 1 pulmonary/critical care attending, 1 pulmonary/critical care fellow, 1 pharmacist - 1 VA Acute Care Resident (VCR): Admissions, transfers on weekdays (no weekends/holidays)
<b>Patients</b>	Critically ill patients with a primary non-surgical medical diagnosis.

<b>Cap</b>	
<b>Responsibilities</b>	Direct patient care, including but not limited to rounding, calling consultants, writing progress notes, admitting patients, transferring patients, and some procedures.
<b>Admissions</b>	-07:00-16:00: VCR -16:00-19:00: Upper-level resident on call -19:00-07:00: Upper-level on VA MICU Night Float -Weekends 07:00-12:00: Upper-level resident on VA MICU service. If the upper level is off, the interns are responsible for all MICU admissions/transfers with direct supervision by the MICU fellow. -Weekends 12:00-19:00: Upper-level resident on call -All admissions must be staffed with the fellow on call
<b>Call</b>	Admissions as above Responsibilities: cross-coverage for the entire MICU Team, all admissions/transfers, and procedures
<b>Transferring patients out of MICU</b>	Contact the MOD to choose the appropriate team for transfer when a patient is stable for the floor. "Bounce-backs" will be returned to the appropriate team. All unassigned patients will be distributed to the gen med teams in a 3:3 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. All accepting teams must be called with a handoff prior to the patient transferring (resident-to-resident/attending, intern-to-intern).

**VA MICU  
Night Float**

<b>Team Structure</b>	-1 upper-level resident, 1 intern -1 fellow is in house every night except for Saturday, however they also cover UAMS MICU at night. On Saturday night there is a fellow on home call. All admissions should be staffed with them over the phone, and they should be called with any deteriorating patients, intubations, and increased pressor requirements. If the fellow does not answer and there is a deteriorating patient, the attending on call should be called
<b>Patients</b>	Cross coverage of all MICU patients. All admissions to the MICU, up to 10 patients in one shift. The fellow on call will assist with any admissions if this 10-patient cap is reached.
<b>Work Hours &amp; Days</b>	19:00 – 07:00 Residents and interns work 6 nights (Monday-Saturday night) with Sunday night off. Sunday night will be covered by 1 resident and 2 interns on call from the ward teams.
<b>Arrival</b>	Arrive at 18:45 to receive handoff.
<b>Responsibilities</b>	Cross-coverage for the entire MICU Team, all admissions/transfers, and procedures.
<b>Admissions</b>	Must be staffed with fellow and/or attending.
<b>Reminders</b>	Any patients that are decompensating or requiring increase in pressors should be communicated to the fellow and/or attending.

**Inpatient Call at the VA**

<b>Call Hours</b>	Weekdays 16:00-19:00 Weekends/Holidays 12:00-19:00 Sundays (24 hour): 12:00-7:00
<b>Staffing</b>	1 upper-level resident, 2 intern

<b>Admissions</b>	At 16:00, team censuses will be reconciled. Any team that has reached its cap will no longer be assigned admissions. After 16:00, admissions are assigned in a round-robin fashion with 3:3 ratio with the non-teaching teams
<b>Responsibilities</b>	All admissions to the teaching services from 16:00-19:00
<b>Code Blue Team</b>	The on-call resident and interns will carry a code pager when their shift starts at 7 a.m. to when their shift ends at 7 p.m. All three must respond <b>immediately</b> 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 CPRS, calling family or the patient’s primary team, providing chest compressions, etc.
<b>Upper-Level Resident</b>	Upper-level residents are ultimately responsible for all admissions during their call shift, but should allow interns to complete orders, H&Ps, etc. Please see “admission” section of Appendix A for further direction on expectations surrounding admissions. The admitting resident is responsible for maintaining an accurate log of all admissions and reconciling all team lists on word prior to the end of every shift. It is crucial that each patient is added to their respective team’s word documents as they are admitted ensuring they do not “get lost” in the system. Clearly communicate any team re-assignments with both the teaching and non-teaching services.
<b>Intern/Cross Coverage</b>	Respond to pages promptly and professionally, document any significant interventions, and assist upper levels with admissions if needed.
<b>Patient Handoffs</b>	Face-to-face handoff with an acute, concise patient list <i>must</i> occur for every team at every level (PGY-1, 2, & 3) utilizing I-PASS method. Any patient that was admitted on call <b>MUST</b> have an updated handoff in EPIC and be verbally checked out to the night team.
<b>Code Blue Team</b>	The most senior MICU resident is the leader of the Code Blue Team and should respond <i>immediately</i> 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 and should accompany the patient to the location of final deposition.
<b>VA Code Orange Stroke Weekends</b>	<ul style="list-style-type: none"> <li>The first weekend of each month, the VA MICU upper-level on call and VA ward upper-level on call will each carry stroke pagers and respond to provide care accordingly.</li> <li>Stroke pagers are kept in the MICU workroom.</li> <li>Residents are NOT expected to respond to code strokes in the ED.</li> <li>Telehealth will follow patients for 24 hours after stroke activation.</li> <li>If the patient is on the Urology, Orthopedic or ENT service, they will go to the MICU. All other surgery patients will go to the SICU. If a Neurology, Ortho, or ENT patient comes to the MICU, their former primary teams will continue to follow as a consultant.</li> <li>Please see the “VA Code Orange Stroke Weekend” power point on teams for further instructions and visual aids on how to enter acute stroke orders.</li> </ul>

**Hematology/Oncology Admissions:**

- This is a non-teaching service and residents should not be admitting to this team.
- The hematology/oncology service is the responsibility of the hematology/oncology team from 07:00-16:00. From 16:00-07:00, the MOD/hospitalist is responsible for cross-coverage and admissions to the hematology/oncology service, and these count in the overall round-robin.

## ***Resident Teaching Responsibilities and Expectations:***

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.

<b>PGY-1</b>	<b>PGY-2/PGY-3</b>	<b>Acting Interns</b>
Assist the medical students with the EMR.	Meet with the medical students at least 10 minutes before rounds to help prepare their presentations/answer any questions (barring any urgent patient needs).	One week, they will instead take a MICU overnight call. They'll have the day before and the day after their night call as an off day, in addition to their four regular days off during the month.
Assist the acting intern in answering pages.	Have at least 1-2 clinical pearls to share with the medical students each day.	Expected to take short call once per week with one of their upper levels.
Work with the acting intern to delegate patients to the third-year medical students. The primary focus for the medical students is education, so make sure they are assigned patients with active medical problems. It is encouraged to retire previous patients in which the workup is complete or are only inpatient for social reasons/placement and assign new ones with a higher educational value.	Run the list after rounds with your interns to ensure everyone understands their assigned duties for the afternoon and have the medical students listen in. Assess their understanding of the plan and answer any questions.	For their patients, please have them enter orders (for you to co-sign), call consults; write handoffs, discharge summaries and hospital courses. They can also do MRI screenings, patient education, family calls, help with procedures, and guide the third-year medical students.
Ensure the acting intern is presenting at least one of the active/new patients on rounds each day.	Pick a topic relating to one of the patients on your service or to the organ system they are to be tested on that week and give a brief educational talk (does not have to be formal).	They should work toward presenting 5-6 patients each day and should write daily notes on each one.
Teach the medical students at least one thing per day	Attend all noon conferences and ACDs.	They should go to all noon conferences and ACDs.
Attend all noon conferences and Intern ACDs.	Take a student with you to every admission. Let them see how you take a history and perform a physical the first time you take them. On subsequent admissions, it is encouraged for the medical student to obtain the initial history and present to you.	
	Take a student with you to every educational experience – procedures, family discussions, clinical deterioration/MICU evaluation, etc.	

Resident Duties to junior clerks and senior student acting interns:	
<b>Assign the students patients as they are admitted</b>	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. In general, M3 students should see 3 patients per day and Acting Interns should see 5.
<b>Conduct daily teaching rounds for the students</b>	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.
<b>Select patients to work up and present to the attending on rounds.</b>	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.

## 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.

<b>History and Physical (H&amp;P)</b>	<p>The H&amp;P is an essential component of a patient's complete care while on an inpatient service. Both residents and interns will write H&amp;P. If an intern does write the H&amp;P, the resident should follow this with an attestation note as stated above. This is a brief account of the history and physical and a well outlined assessment and plan. The H&amp;P must include the following elements:</p> <ul style="list-style-type: none"> <li>• Date, time, title: Should be all listed at the top of the H&amp;P.</li> <li>• Chief Complaint: in patient's own words.</li> <li>• HPI</li> <li>• Past Medical History: listing of all chronic medical conditions with timeline if necessary</li> <li>• Surgical History: listing of all surgical procedures with timeline if necessary</li> <li>• Medications: listing of all current medications.</li> <li>• Allergies: listing of all medication allergies and reaction from each.</li> </ul>
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	<ul style="list-style-type: none"> <li>• 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/are pertinent to presenting complaint.</li> <li>• Family History: listing of all major diagnoses in family members with timeline if necessary.</li> <li>• Review of systems: 12 system review is required (can be included in HPI)</li> <li>• Vitals: on presentation</li> <li>• Physical Exam: 2 points on each of 10 systems</li> <li>• Lab: listing of significant lab findings.</li> <li>• Imaging listing of significant imaging.</li> <li>• Assessment and Plan: problem-based approach for non-ICU patients, system-based approach for ICU patients</li> <li>• Emergency contact</li> <li>• Code status</li> </ul>
<b>Progress Notes</b>	<p>SOAP note format.</p> <ul style="list-style-type: none"> <li>• Brief subjective overview of patient’s status</li> <li>• Vitals and PE: important that PE is accurate from day to day and not simply copied forward so call team can accurately assess for changes</li> <li>• Pertinent laboratory and imaging studies</li> <li>• Assessment and plan: Important that this is updated every day and not simply copied forward. Call team should be able to read your A&amp;P and understand exactly what is being done for the patient and what changed that day.</li> <li>• Student notes are required to have a resident or attending addendum and signature. Student notes do not substitute for physician notes under any circumstance.</li> </ul>
<b>Discharge Summary</b>	<p>The discharge summary is vital for continuity of patient care once the patient is discharged from the hospital. It should contain the following elements:</p> <ul style="list-style-type: none"> <li>• Patient’s name and MRN/SSN</li> <li>• Date of admission</li> <li>• Date of discharge</li> <li>• Service and attending physician at discharge</li> <li>• Primary diagnosis which was the cause of the admission</li> <li>• Secondary diagnosis: any other diagnoses that were addressed while patient was in the hospital</li> <li>• Consultations</li> <li>• Procedures performed</li> <li>• Hospital course should include the following: <ul style="list-style-type: none"> <li>○ One liner of pertinent prior medical history.</li> <li>○ Two-three sentences about the patient’s presenting complaint and reason for admission to the hospital, including any abnormal labs or imaging that were pertinent to the admission.</li> <li>○ Summary of the patient’s clinical course, treatments, procedures, and any other interventions performed in the hospital. Include pertinent vitals, imaging and labs that changed or improved during the hospitalization.</li> <li>○ Instructions for the PCP of specific follow up that needs to be done – imaging, labs, medication changes, etc.</li> </ul> </li> <li>• Physical Exam</li> </ul>

	<ul style="list-style-type: none"> <li>Discharge medications: <b>Essential</b> that these medication lists are accurate and match the medications you place in the computer for patient discharge.</li> <li>Discharge instructions for the patient: list of special instructions including dietary, activity level/return to work, monitoring symptoms at home, when to return to ED with problems, when to follow up with PCP or another specialist.</li> <li>Name of referring physician: Discharge summary should be sent to patient's PCP through Epic OR you can print it off and give it to patient for them to hand to their physician at their hospital follow up appointment. Telephone calls to referring physicians to notify them of a patient's discharge may be made as well.</li> </ul>
<b>Transfer Notes</b>	<p>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:</p> <ul style="list-style-type: none"> <li>Admission date</li> <li>Admission service: list attending and resident</li> <li>Transfer date:</li> <li>Transfer service: list attending and resident</li> <li>Admission diagnosis</li> <li>Secondary diagnosis</li> <li>Consultations</li> <li>Procedures</li> <li>Hospital Course: <ul style="list-style-type: none"> <li>When transferring to ICU: Summary of why patient was admitted, what has been done thus far, summary of event that required ICU transfer, pertinent imaging and labs</li> <li>When transferring out of ICU to wards: All of the above, plus what was done in the ICU for the patient, how they improved and their current clinical status</li> </ul> </li> <li>Physical exam</li> <li>Assessment and Plan: System based</li> </ul>
<b>Off-Service Notes</b>	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.

**Death Documentation, Reporting, Certification and Autopsy**

**Death Documentation**

All deaths occurring in any UAMS or VA patient care setting, either inpatient or outpatient, must be documented in the patient's medical record. In certain circumstances, the coroner or law enforcement officials may need to be notified.



Call ARORA: have the patient's chart pulled up as they will ask you a series of questions. They 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.

Log the death on ERAVE through <https://adherave.arkansas.gov/erave/do/login>. This will create the death certificate. It must be completed 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), otherwise 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 an 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 death appears to be a result of a motor vehicle accident, or the body was found in or near a roadway or railroad.

The death appears to be a result of a motor vehicle accident and there is no obvious trauma to the body.

The death occurs while the person is in a state mental institution or hospital and there is no previous medical history to explain the death.

While the person is in police custody or jail other than a jail operated by the Department of Correction.

Physical abuse is suspected.

The death appears to be a result of fire or explosion or drowning.

There is no previous medical history or apparent cause of the death.

The death is sudden or unexplained or appears to be due something 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.

A person is admitted to a hospital emergency room unconscious and is unresponsive, with cardiopulmonary resuscitative measures being performed, and dies within twenty-four (24) hours of admission without regaining consciousness or responsiveness, unless a physician was in attendance within thirty-six (36) hours preceding presentation to the hospital, or, in cases in which the decedent had a pre-diagnosed terminal or bedfast condition, unless a physician was in attendance within thirty (30) days preceding presentation to the hospital.

The patient was DOA or died in the emergency room.

The death poses a potential threat to public health or safety.

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. You can find the formal guidelines of when to contact the coroner per AR state law at

<https://www.cdc.gov/php/publications/coroner/arkansas.html>.

## 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 especially 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

The following will be the responsibility of the resident if autopsy is performed as determined by the coroner OR requested by the family:

- Obtain consent from the proper authority. The priority list for next of kin is listed on the website below.
- You need the physician's signature (first witness), the closest next of kin's signature, and that of another UAMS employee (second witness).
- Before obtaining consent for autopsy, notify the pathology resident on call
  - [501-686-6414](tel:501-686-6414)
  - Morgue attendant on call can be reached through the UAMS operator.

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. You can also find further instructions, including a priority list of next of kin, at <https://medicine.uams.edu/pathology/divisions/anatomic-pathology/autopsy-service/>.

## Clinical Communication

### Communication with Attending Physicians

For both education and optimal patient care, the House Staff must communicate freely with attending physicians on all services.

The resident or intern should feel free to contact the attending at any time. The attendings should be informed whenever a patient dies or when a change in the patient's clinical status necessitates transfer to another team/higher level of care (MICU or CVICU).

If there are any problems contacting your attending, contact the Chief Resident, Residency Program Director, or Department Chairperson.

Upper-level residents should be in contact with the attending before the attending's first day on service to inquire about when the attending prefers to round and relay this to the rest of your team to ensure everyone is prepared for rounds in a timely manner.

Residents should also be aware of how their attending likes to staff admissions during the day.

<b>Communication with Residents</b>	
<b>Team Residents/Interns to On-Call Residents/Interns</b>	<ul style="list-style-type: none"> <li>• There is a mandatory checkout list to be given to the on-call team as discussed in detail in the “afternoon responsibilities” section of the handbook. 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.</li> <li>• Verbal face-to-face checkout is required.</li> <li>• Checkout to the on-call team can begin at 1545.</li> </ul>
<b>Team Residents/Interns to Night Float Residents/Interns to Team Residents/Interns</b>	<ul style="list-style-type: none"> <li>• Communication between the on-call Team and the Night Float Team must be efficient and concise as to ensure patient continuity of care.</li> <li>• Night float resident to team resident communication pertaining to admissions or seriously ill patients overnight must happen in a timely manner, beginning at 0645, so that the night float resident can leave on time.</li> <li>• Night float interns to team interns must communicate essential events and any important findings on studies performed overnight, so that the team will be aware of any potential problems/changes in the patient’s clinical status.</li> </ul>
<b>Supervising Residents, Interns on Call</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Interns must call for ANY patient when there is any question or discomfort about the diagnosis or management of a patient. If there is any uncertainty, the intern should call the upper level on call with them.</li> </ul>
<b>Transferring Patients</b>	<ul style="list-style-type: none"> <li>• Communication between residents when a patient is transferred from one service to another is essential.</li> <li>• It is the responsibility of the Transferring Team Resident to contact the Accepting Team Resident any time a patient is transferred between services.</li> <li>• As a secondary safeguard, the transferring intern will also contact the accepting intern.</li> <li>• A transfer note must accompany the patient to the accepting team and must include the accepting team’s attending physician and resident.</li> </ul>
<b>Accepting Patients</b>	<ul style="list-style-type: none"> <li>• An accept note is required for all patients accepted to a team regardless of patient origination and time of day the patient is transferred. This will be completed once the patient is out of the ICU and has made it to a floor bed. You should see the patient promptly once notified that the patient is on the floor, ensure they are still stable for the floor and write an accept note.</li> <li>• 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.</li> <li>• If an on-call intern accepts a patient transfer and writes the accept note, the intern <b>must</b> communicate with the on-call resident so that the accepting patient can be placed on the list of admissions. This is especially important at the VA – the patient needs to be immediately added to the word document as to not “become lost.”</li> </ul>

## Communication with Nursing and Other Ancillary Staff

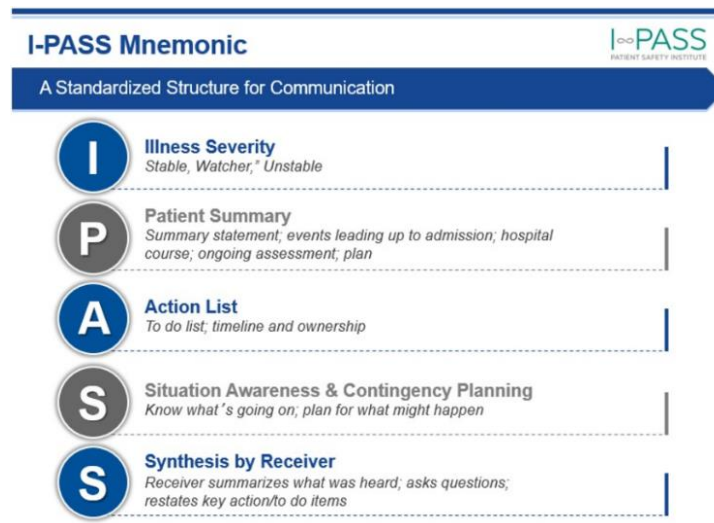
When a resident is contacted in error about an IM admission or a transfer, he or she should take the time to find out who does need to be called. We do not want the Emergency Department or the floor staff to call multiple persons with each person denying responsibilities. Our call schedule can be intimidating, 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.

## Handoffs and Check-Out: Standard Operating Procedure

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



## Handoff and Check-Out: FAQs

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 HIPPA compliant shred bins since they contain protected health information.

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.

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.

In general, you should NOT check-out pending ECGs, procedures, or post-procedure imaging. Lab results, consults, and radiology exams that could potentially change the patient's management can be checked out in most cases.