**UAMS Emergency General Surgery Service Guide**

Welcome to the Emergency General Surgery (EGS) service at UAMS. We handle emergent, urgent, and elective general surgical needs at UAMS, which makes our days unpredictable and exciting. This service will challenge you, however with hard work, efficiency, and help you can thrive and own the service. This document is meant to help you on the service and it changes frequently. If you would like to add edits, please send them to [kevin.sexton@uams.edu](mailto:kevin.sexton@uams.edu) and I will include after approval from the Acute Care Surgery Faculty.

**Team**

1. Advance Practice Nurse
   1. Michelle Jupin
2. Clinic RN
   1. Kimberly Minnie
   2. Stephanie Rohrer
3. Staff
   1. William Beck
   2. Avi Bhavaraju
   3. Ben Davis
   4. Joseph Jensen
   5. Katie Kimbrough
   6. Ron Robertson
   7. Kevin Sexton
   8. J.R. Taylor
4. Clinical Instructor
   1. Anna Privratsky

So that personal information is not online, please email Mary Appleby in the UAMS system to get a list of all contact information. **Mandatory** orientation is on the first weekday of service and led by Michelle Jupin and Kim Minnie, it is your responsibility to talk with them about timing.

**Expectations:**

1. Everything on the service is the responsibility of the staff surgeon of the week. If something goes wrong, or you even think something might have went wrong, tell the attending. This service depends on absolute honesty. The only way you will be hung out to dry is if you make unreasonable decisions independently.
2. No one is above any task. If you need help with anything, if you ask your team will do it. If you don’t ask it is assumed that you are doing it. Staff will see consults and deal with issues independently if they are informed. The key is we must be informed.
3. Staff will show you how to function as part of a team.
4. We will all teach each other something.
5. You will read all clinical guidelines at <https://surgery.uams.edu/divisions/trauma/guidelines/> prior to starting the rotation.
6. Required reading can be found at
   1. <https://www.east.org/education/publications/landmark-papers-in-trauma-and-acute-care-surgery/emergency-general-surgery>
      1. Interns and students: appendicitis, choledocholithiasis, cholecystitis, damage control laparotomy, and necrotizing soft tissue infection
      2. Midlevel: all above plus small bowel obstruction, cholangitis, diverticulitis, and pancreatitis
      3. Chief Resident: all articles.
7. Treat the Nurses, APN’s and patient care techs as colleagues. All of these people work hard and if you treat them with courtesy and respect they will be willing to help you whenever you need it. They are also part of this team, you are a guest. Membership is earned.
8. You must be willing to learn. Respiratory Therapists, Nurses, APN’s, and patient care techs can all teach you something.
9. You must be willing to teach (medical students, Nurses, your senior residents and attendings). You should learn the job of the person above you in case they are unavailable and teach your job to the person below you.
10. Integrity: Integrity is the qualifications of being honest and having strong moral principles; moral uprightness. It is generally a personal choice to hold oneself to consistent moral and ethical standards. In ethics, integrity is regarded by many as the honesty and truthfulness or accuracy of one's actions.

**Schedule**

**Conferences: All are mandatory except trauma division meeting.**

1. **Third Friday @ 0600 Trauma Operational Committee Surgery Library**
2. **Second Wednesday @ 0700 Trauma/EM Education (M&M) Conference Ed II G137**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Weekly events | Monday | Tuesday | Wed | Thursday | Friday | Saturday | Sunday |
| Morning Rounds | 0500 | 0500 | 0500 | 0500 | 0500 | 0500 | 0500 |
| Morning Report | 0630 | 0615 | 0630 | 0630 | 0630 | 0700 | 0700 |
| M and M |  | 0700 |  |  |  |  |  |
| Grand Rounds |  | 0800 |  |  |  |  |  |
| Resident Teaching Conference |  | 0900 |  |  |  |  |  |
| Clinic |  | Immediately  After Conference |  |  |  |  |  |
| Research Meeting |  |  |  | 1500 |  |  |  |
| Trauma Division |  |  |  | 1600 |  |  |  |
| PM rounds | 1700 | 1700 | 1700 | 1700 | 1700 | 1700 | 1700 |
| Sign out | 1800 | 1800 | 1800 | 1800 | 1800 | 1800 | 1800 |

**Gear**

* All
  + Hospital dress code calls for scrubs covered by a white lab coat. Do that.
  + Some people even carry a stethoscope.
* Students
  + Make sure all dressing supplies for daily dressing changes are present in patient rooms by 0500 so that all non vac dressings may be changed on am rounds.
  + Bandage scissors: you can use suture removal kits for these.
* Interns
  + Make sure students have completed their responsibilities
  + Vacuum dressing supplies are in room by 0500 of morning for dressing change

**Texting**

SMS text messaging is not HIPAA compliant. UAMS provides Impravata Cortext© for secure messaging for patient information. You have to put in a help desk ticket to get this activated. This is the recommended workflow for protected health information.

**Daily workflow**

AM Rounds

* Students
  + You will interview your patients in front of the chief on rounds. You will have at least 2 patients every day, selected by you. If 2 folks want the same patient the resident with the smallest shoe size picks for you.
  + You are required to write notes on these patients every day. Compare your documentation to that of the resident and attending.
  + Every afternoon you will print patient lists at 1630 and record daily intake and output values prior to 1700 rounds.
* Interns
  + Every morning you will print patient lists at 0450. The list should be the [trauma rounding summary](http://surgery.uams.edu/wp-content/uploads/sites/37/2018/01/Trauma-Handoff.pdf). The list used will be a cover sheet including the following columns followed by the surgical sign out list
    - Be sure it is the surgical sign out list. If nursing is checked you have killed a lot of trees.
  + You will round with the chief starting with the first patient on F4. Meet there at 0500.
* Midlevel
  + You will round in the ICU starting at 0500 and upon completion you will start on H9 and gravity round.
* Chief
  + The service is your responsibility, take as much as you’d like.
  + Review significant events from overnight prior to rounds.
  + Meet intern at 0500 on F4, after completing F4 see any patients in the ED and then coordinate with midlevel to ensure all patients seen by 0630.

Morning Report

* Chief
  + At 0630 you start talking.
  + Present all consults from your last day call.
    - XY is a \_\_ year old man/woman with \_\_\_\_ diagnosis. Significant history includes\_\_. Exam significant for \_\_\_. Plan is \_\_\_.
  + After presentations are completed you present the operative cases for the day with your plan for each. Which resident is with which staff and salient points of the case should be presented.
* Midlevel
  + Present any consults as designated by the chief.
  + Run the computer. Every image is reviewed by the team.
* Intern
  + Additional orders called out during morning report should be entered immediately.
  + You should grab a computer and enter orders from morning rounds during morning report as you are able.
  + All case requests should be entered **immediately** and the OR board should be called. Think of it as reserving a spot in line!
* **Immediately** following morning report the staff will run the list and confirm plans for the day.
  + Medical students are expected to present their patients during the list run in under 60 seconds.

Orders

* Weekdays Michelle will coordinate entering of all orders with the interns.
  + Michelle will usually do discharge related orders
  + Interns will usually do all others
  + Change is at Michelle’s discretion. Trust me, she will not abuse you and will make your life easier. Just do what she asks.
  + All consult orders should be placed and called as soon as possible.
  + If a patient has an order for IR, make sure a team member calls to make sure the patient is on their radar. It is common for a patient to remain in IR purgatory for several days before they are taken down for the procedure. Bonus points if you walk to IR and discuss the patient face-to-face.
  + All patients should have each home medication reconciled at the time of admission. If you have not had time to do this, please tell the oncoming resident so that it can get done.
  + If the patient was independently ambulatory prior to admission and you are not concerned about a change in their physical capabilities, it is the nurse's responsibility to make sure the patient ambulates. Do not order physical therapy just to make sure the patients get out of bed. Let them use their time on a patient that could benefit from therapy.

Daily Activities

* Michelle will discuss discharge plans with the social workers and follow up on all discharge needs. Please let Michelle know if you anticipate special discharge needs. If you need an update regarding the progress of discharge needs, including status of placement, check for social work or case management notes in the consult tab in Epic.
* Medical students are expected to change simple dressings and help ambulate patients when not in the OR. This will make the nursing staff happy and ensure that our patients are getting out of bed more often. This will also help the students learn proper mobility techniques.
* Wound vac dressings may be done by residents or Michelle. The assignment of this task should be delegated during morning report.
* It is everyone’s responsibility to make sure orders are being carried out. It is helpful to utilize the group text and take ownership for the task you are doing so it is not carried out twice. Keep everyone on the team informed of medical complications and patient/family frustrations because poor communication between our team members is the typical complaint from patients and their families.
* Interns are to email Kim at [KAminnie@uams.edu](mailto:KAminnie@uams.edu) and copy Stephanie [SRohrer@uams.edu](mailto:SRohrer@uams.edu) with any discharges for the day. They will coordinate the follow up for our patients in clinic.
* Notes are the responsibility of **everyone**. Divide the work to accomplish notes as early in the day as possible. That being said, the intern will do most of the daily floor notes. The mid-level will do most of the ICU notes and the majority of consultation notes. The chief will help as needed.
* Use the [trauma rounding navigator](http://surgery.uams.edu/wp-content/uploads/sites/37/2018/01/Trauma-Rounding-Navigator-Copy.pdf) to add all patients to the appropriate service registry (trauma, EGS, SICU, or a combination of trauma/SICU or EGS/SICU).
* In order for Kim and Stephanie to see discharges, you must use the internal referral order ambulatory referral to general surgery. A screen shot is found [here](http://surgery.uams.edu/wp-content/uploads/sites/37/2018/01/Amb-Ref-to-Surgery.png).
* Documentation is key. There are subtle things to know about documentation that will make your lives easier. The outline for postoperative documentation below is sufficient for postoperative inpatients. For inpatient consults, documentation should approximate the clinic follow up visits.
* Preoperative and postoperative check note templates are available and should be used on all patients needing or having undergone an operation.
  + SmartText: Preoperative Check - UAMS and Postoperative Check- UAMS

Cases

* All are welcome in the OR.
* Each case at a minimum should have one resident and one student.
  + For laparoscopic cases all are welcome, but only one should scrub.
* Expectations are that you have met the patient prior to the OR, reviewed their chart, the pertinent anatomy, and know the overall technical steps of the procedure.

Follow up

* Chief: it is everyone’s job to make sure orders are carried out and followed up. You have to delegate specifically and effectively.
* Other residents: the chief is ultimately responsible for it all, but you have to help.
* Midlevel: primary consult resident, but delegate consults as appropriate to junior residents
* Medical students: between cases you should check on your patients. You should also participate in vacuum dressing changes. Prior to completion of the service you should be able to change this dressing independently.

PM Rounds

* Medical students will have seen and present their patients on rounds.
* Medical students will make the list when available.

Sign out

* Medical students present patients in sign out to the intern to practice handoffs.

**Clinic**

Clinic Day Outlined

Clinic will start immediately after conference. **ALL** residents are expected to attend clinic. As the patients are roomed Stephanie and Kim will bring a card with the room number and a patient sticker to the clinic work-room. Once done seeing the patient present them to the attending. After the attending has seen the patient we may need to redress a dressing, suture/staple removal, place a binder, remove drains etc. Please do not let the patient leave until Stephanie or Kim take them their discharge slip. This slip contains any tests they may need and when their next follow-up needs to be scheduled.

Kim is your main contact for clinic. She is there to teach and/or assist you with these things and help you gather supplies. Please just let her know what you need and what you are doing. Kim will also need to know if they need a follow up, diagnostic tests, referrals, etc. so that she can verify all of these things are done and ordered. Kim has copies of pre/post surgery teaching, preferred bowel prep, new Surgical consent, and Release of Information. If needing any of these please see her. Each patient will receive an ACS After Clinic Visit Follow Up once visit is complete with the Attending who saw the patient in clinic. Please do not let the patient leave until Stephanie or Kim take them the ACS After Clinic Visit Follow Up. This slip contains any tests they may need and when their next follow up needs to be scheduled. Every patient that comes through the ACS clinic will be given a hand washing survey when the check in. They are asked to assess the entire clinic visit from triage to check out. Please remember to wash your hands. Whether it be with soap and water or the foam gel. Make sure our patients are seeing you wash our hands.

A note from the staff surgeons:

Welcome to Acute Care Surgery clinic. We expect you to participate fully in today’s clinic. This means seeing patients, helping with procedures, and completing documentation in a timely fashion. We want you to see every patient you can in clinic and have the best learning experience, however do NOT do a sensitive physical exam (groin, rectal, breast, etc) without an attending present. It is uncomfortable for the patients to have these repeated and we would like to do these together. As a rule, asking permission is better than asking forgiveness. When in doubt, ask!

There will be 3 main types of patients seen in clinic:

1. Postoperative patients are here following their procedure.

2. Follow up patients are usually coming back after hospital discharge, completion of a test, or for repeat evaluation of symptoms after medical therapy

3. New Patients are patients that we have never seen before and these are usually consultations.

Each patient requires a different level of documentation and unfortunately student documentation is not billable, however students may function as a scribe. To do this well, for each type of patient we have created a documentation form. Please grab a form, place a patient sticker on the form and complete the documentation to the best of your ability on the form. The new patient form is front and back. The post op and follow up patient forms are just one page. After the encounter, we expect you to document a note that same day, preferably in clinic. If you can’t get them done in clinic. Copy your form and take it with you to complete it later the same day. I send all letters out the following day so I need everything done ASAP.

For this clinic, we want all of your efforts to be problem based. If someone has an inguinal hernia, asking them if they wear seatbelts while driving (although important) is not relevant.

The patients requiring the least amount of documentation are postoperative patients. They are usually in a global period for 90 days after their operation. This means that their operation and all postoperative care for 90 days are billed at the time of surgery. For these patients, we are not getting paid in clinic. They require the least amount of documentation. We expect you to know what their operative indications were, what did their pathology show, and present a focused history and exam based on common complications and problems after surgery. Ideal time for this encounter is < 5 minutes.

Follow up patients are billable and require additional documentation than postoperative patients. The elements are outlined on the follow up form. Prior to seeing these patients, ascertain from the chart (or clinic list) why they are coming back so that you can focus your history. Ideal time for this encounter is < 10 minutes.

New patients are the longest encounters and require the most documentation. As with follow patients, determine the reason for referral prior to entering the room. These patients will usually have outside studies and imaging. Check the chart to see if any is available prior to seeing the patients. Sometimes the patients come with a disc and you need to find this out first thing. Once you have the disk, take the disk to one of the clinic nurses to have it scanned in ASAP. This way we can look at the images together with the patients in clinic and scanning can be underway while you are completing the encounter. As you focus on the problem in these encounters think of 3 things on your differential and ask questions related to these 3 things. For example, if someone comes in with right upper quadrant pain, immediately I think of gallstones, ulcer disease, and reflux. I will ask questions in the history to help me delineate which I think is most likely and I will broaden my differential as needed if there symptoms do not fit with these conditions. It helps keep me focused and efficient. The ideal time for this encounter is < 20 minutes.

**Admitting Patients from Clinic:**

Please see the link below for instructions.

<https://drive.google.com/open?id=1ZVdEhC7bsHaMLkUmAk8iferJSnjiYun9>

**Pearls**:

1. It is not illegal to read about patients beforehand!
2. One of the most common omissions from documentation is the patient’s primary care doctor. This is extremely important for me because I send letters to all of these doctors so they are up to speed on the progress of their patients.
3. For every patient at the end of your exam I want you to answer the following and write it on the documentation form
   1. What do I think is going on?
   2. What do I want to do next?
4. Nurses are your friend. They can help you find everything.
5. Residents are your friend. Ask them for help and guidance.
6. When it comes to doing exams or anything to a patient, ask permission not forgiveness.
7. When it comes to documentation (filling out operative consents, return to work forms, etc) ask forgiveness, not permission. This is my way of saying try to fill them out and then let me check your work.
8. Kim is our clinic nurse and the most familiar with how we do things. Use her as a resource.
9. Patients that need follow up, you should email Kim with name, MRN, and follow up needed. These creep up on folks discharged at night and on the weekend.
10. We will ask you questions, you will not know all of the answers. Our goal is to assess the limitations of your knowledge. It is OK to say I don’t know.
11. Have fun.