2018-2019- DUKE GENERAL MEDICINE SENIOR RESIDENT ORIENTATION

Your responsibilities and goals as the supervising resident on the Duke General Medicine Service will focus on leadership, decision-making, and teaching. Over this rotation, you will have the opportunity to develop your clinical, communication, and leadership skills as you oversee the care of acutely ill medical patients at our largest teaching service and manage a multidisciplinary team of providers and students.

GENERAL MEDICINE SERVICES:
There are seventeen general medicine (GM) teams:

- GM1-7: Resident General Medicine services
- GM 8-11, 13-16: Hospital Medicine Faculty service, including an inpatient procedure service (GM10)
- GM 12: Medicine/Psychiatry service

You will rotate on one of up to seven intern/resident services (GM 1-7 A and B).

Each GM resident team is comprised of the following:

- 1 Attending physician
- 1 Daytime Supervising Resident (usually a SAR)
- 2 Interns (or 1 intern and 1 sub-intern)
- 1 Night Resident
- 1-2 Students (2nd year Medical Student or Physician Assistant student)
- Pharmacist and/or PharmD resident or student

DESIGNATED WORK AREAS:

GM1 and GM 6	8300
GM2 and GM 7	8270 (old patient waiting room outside of 8200)
GM3	8100
GM4	8200
GM5	4300

DEFINITIONS OF DAILY ASSIGNED ROLE:

REGULAR and ADMIT DAYS: The regular and admit days you can accept overflows and admit new patients during the day. Team is expected to meet the night resident for handoff of old patients and presentation of new (overflow) patients at 7:00am. The number of overflows are assigned based on overnight team census with caps as below. On regular days, admissions will stop by 4 PM (with sign out by 6:30 PM), and, on admit days, admissions will stop by 6 PM (with sign out at 6:30 and team members leaving by 9 PM at the latest). *The ADMIT senior resident will also be back up for the interns on the protected teams if a patient on their team becomes unstable or urgent questions arise.*

PROTECTED DAY: The protected day is the day of the week in which you can accept overflows, but not have any new admissions. The goal of the protected day is to focus on the care of established patients, focus on discharge and transitions of care, and to focus day on teaching and learning – led by both SAR and attending. On the PROTECTED day, the SAR can leave at 5:00pm if patients are stable and clinical duties are near completion for the day. The intern on the protected team will remain until the handoff with the night float resident at 6:30pm.

WEEKENDS: All teams can accept rollovers on weekends with caps as below. The teams will receive morning hand off from the night residents at 7am and can receive overflow admissions based on team census. Interns can sign EARLY to early night JARs or their resident (at 5 PM) when two interns are on a service together. Residents will sign out by 6:30pm.

Caps for Teams with Sub-Is				
WEEKDAYS			WEEKENDS	
Admit	**Regular**	**Protected**	**Resident On**	**Intern On**

- Up to 2 rollovers - Admit until **6:00PM** - Cap of 3 NEW admissions *(not counting rollovers)*	- Up to 2 rollovers - Admit until **4:00PM** - Cap of 3 NEW admissions *(not counting rollovers)*	- Up to 2 rollovers - No new admissions	- Rollovers: up to 2 - Admit until **5:00PM** Cap of 2 NEW admissions *(not counting rollovers)*	- Rollovers: up to 2 - Admit until **3:00PM** - Cap of 2 NEW admissions *(not counting rollovers)*

Caps for Two Intern Teams					
WEEKDAYS			**WEEKENDS**		
Admit	**Regular**	**Protected**	**Resident On**	**Intern On**	**Res and Intern On**
- Up to 3 rollovers - Admit until **6:00PM** - Cap of 4 NEW admissions *(not counting rollovers)*	- Up to 3 rollovers - Admit until **4:00PM** - Cap of 4 NEW admissions *(not counting rollovers)*	- Up to 2 rollovers - No new admissions	- Rollovers: up to 3 - Admit until **5:00PM** Cap of 3 NEW admissions *(not counting rollovers)*	- Rollovers: up to 3 - Admit until **3:00PM** - Cap of 2 NEW admissions per intern *(not counting rollovers)*	- Rollovers: up to 3 - Intern Admits util **3:00 PM**, Resident until **5:00 PM** - Cap of 2 NEW admissions per intern and 2 NEW per resident

SCHEDULE:

As Senior Resident, you will have responsibility in working with your attending to develop a model of rounding that works best for your team. Ideally, all members of the team (Attending, SAR, intern and subintern, MS2s) will begin at 7:00am to receive handoff from the night residents about cross cover patients. Ideally any overflow patients to the team are presented by the night float resident to the teams. Over time, one model of rounding has not been more effective than another. Rather, attending and resident preferences tend to guide efficient morning workflow. Please discuss this with your attending early in the rotation to determine which rounding structure works best for your team.

A NOTE ABOUT SUB-INTERN NOTES:

Medical student (MS2 and MS4s) and Physician Assistant student notes are not part of the official medical record. Both PA-S/MS2 and MS4/Sub-I notes must be reviewed and cosigned by either the SAR or attending. Because the Sub-I or MS2/PA notes are not part of the medical record, a separate note is needed for the patient. Senior resident and Attending will be responsible for the documentation (H&P, progress notes, discharge note) of Sub-I patients, not the intern.

READMISSION / BOUNCE BACKS:

- Bounce backs follow either the intern or the resident on service. The goal is to preserve continuity of care for the patient as well as continuity of practice and education for the house staff. It is easier to admit a patient who is known to your team than to transfer care to another team so there is no specific timeframe in which a patient cannot bounce back to your team.
- For ICU transfers, your team should follow the progress of patients they had transferred to the ICU and be prepared to have them return to their team at any point.
- Bounce backs can come to your team at any day during your cycle, even a PROTECTED day, in order to preserve the continuity of care.

RESIDENT REPORT – DN8253 MONDAY-THURSDAY AT 1:15 PM:

The resident who is on LONG CALL is responsible for presenting a case on that given day for resident report (example: if you are LONG call on Thursday you are responsible for presenting a patient case during QI report that week). Details about specific resident report days are listed below.

- **Management Discussion** – typically Tuesdays with Dr. Govert/Dr. Rogers, Wednesdays with Dr. Zaas and a rotation of precepting attendings, and may be scheduled on other days based on case selected, faculty discussant

and resident preference. Dr Govert will bring a case of his own for the beginning of report and Dr. Zaas may bring a short case based on a MKSAP or ITE question.
    - The goal is to focus on management of general medicine inpatient scenarios and to hone critical management decision-making skills.
    - Residents will present a recent (within the last 7 days) case to the group.
    - As part of the case presentation, all imaging, EKGs, etc should be displayed and findings reviewed.
    - The case presentation should be fairly brief (15-20 minutes).
    - All residents may then be asked to commit to a management strategy at discrete points during the patient's course.
    - This is always a fun and interactive discussion/debate!
- **Cases** – (Typically Mondays with Dr. McNeill, Dr. Arcasoy, Dr. Hargett, or the Stead Attendings) the usual interactive case presentation, the case should be a patient on your service if possible.
    - If you have a patient with particularly interesting physical findings, please let the ACR or chief resident know beforehand so that we can plan to go see/examine the patient during report.
- **Quality Improvement** – Thursday with Dr. Boggan and the Hospitalist Faculty Presenter should bring a case that demonstrates an adverse event, near miss, etc. that the group will analyze for possible quality improvement /patient safety opportunities.
    - Optimal cases will focus on failures and/or interventions at the systems based level. In other words, how can the system be changed to prevent from happening again?
    - Hospitalist preceptors will often present a case or a small lecture prior to the resident case.
- Please participate, ask questions, join the debate, and have fun learning! This really is one of the most rewarding and enjoyable parts of Gen Med!

RADIOLOGY ROUNDS:
Every Monday and Wednesday, we will have radiology rounds to discuss interesting images in person with a radiologist. These are held in room 8262. All residents should gather interesting radiology images and stop by with your team when you can. Cases can include interesting imaging findings or when management decisions were made based on imaging.

DISCHARGE SUMMARIES:
Discharge summaries are a shared responsibility of the team (Attending, SAR, Interns). Interns are responsible for discharge summaries on patients hospitalized for 3 days or less. Discharge summaries ideally will be completed on the same day as the patient's discharge, however if this is not possible, the summary *must* be completed within 24 hours of discharge. Residents should work with the interns to ensure all patients have a discharge summary. Most attendings will also be able to assist with completion of discharge summaries. Please ask for assistance if needed from the attending.

SOME TIPS FOR GEN MED:
DISCHARGE PLANNING:

- Every day, ask yourself: "Is there an ≥80% likelihood that this patient will be discharged within the next 24-48 hours?" For all patients on service, if the answer to this question is "yes", please enter an "expected date of discharge" (EDD) into Maestro. Please update this if it changes.
- Our goals are for discharge paperwork, follow up appointments, medication reconciliation, and prescriptions to be completed the day prior to anticipated discharge and reviewed the afternoon prior to anticipated discharge by the entire team (intern, resident, attending) to ensure the safest and most appropriate discharge plan.
- Contact PCP (by email, phone, or Maestro) to inform them of admission and discharge. **Remember: you can place an order for the HUC to make follow-up appointments with the PCP.**

STUDENTS:

- **Set expectations:** At the beginning of rotation clarify your expectations for students – this should be the basis of your later evaluation.
- **Take time to teach** particularly on work rounds and in downtime. Gen Med can be a very busy place but we still want our students to have a positive educational experience!
- Student documentation
    - All PA-S/MS2 and MS4/Sub-I progress notes must be reviewed and co-signed by the intern or the resident on the team. Give feedback to your students on their notes. Their note does not count as the primary note for the day. Interns/residents still need to write a separate note.
- **Give feedback often** – weekly is recommended.
- Please make sure that the students get to all their required teaching conferences on time.
- Sub-Intern Note Specifics - sub-interns can document electronic H&Ps in Maestro Care, however residents must still write an electronic H&P as the student note is not considered an official billable part of the medical record.

CONFERENCES:

- **Chairs conference on Friday (12:15) is required for all senior residents on General Medicine.**
- Please tell ACR about good cases, EKGs, CT's, physical findings etc., for gallops, EKG conference, Chair's, M&M.

ATTENDING COMMUNICATION:

- Call your attending for any critical or unexpected changes in clinical status: ICU transfer, urgent/unplanned procedure, AMA discharge, or death.
- Prioritize rounds and let your attending know which patients need to be seen early in the day on rounds
- Call your attending if a patient has a change in advance directives to allow a natural death. The attending ***should optimally enter in DNAR orders. Overnight hospitalists or the chief resident can help put in DNAR orders at night.***