

## Inpatient Medicine Rotation Guidelines

### I. Overview

- A. Inpatient medicine is a core, required rotation for all residents. Overall goals of the rotation include the following:
1. Residents will provide patient care in the inpatient setting that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
  2. Residents will develop knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care in the inpatient setting.
  3. Residents will investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
  4. Residents will demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates.
  5. Residents will demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
  6. Residents will develop an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
  7. Residents will deliver patient care in ways that promote patient safety, and will continually reflect on risks to patient safety and ways to mitigate those risks.
  8. Residents will develop an awareness that while providing safe, effective and timely care to patients, care of the provider is also essential.

Rotation goals and objectives specific for PGY-1 and upper level residents can be found on New Innovations ([www.new-innov.com](http://www.new-innov.com)).

### II. ACGME and UAFMR-T Requirements for Inpatient Service

- A. Residents must have at least 600 hours (or six months) and 750 patient encounters dedicated to the care of hospitalized adult patients with a broad range of ages and medical conditions. The encounters below, with the exception of ICU patients, are tracked by a report capturing interns' and supervising residents' signatures on relevant documents.
1. Residents must have at least 100 hours (or one month) and a minimum of 15 encounters dedicated to the care of ICU patients.
    - i. ICU encounters must be logged in New Innovations (NI). One patient per admission per log, with a brief description of the problems and care delivered.
  2. Residents must provide care to hospitalized adults during all years of the program.
  3. Residents must have at least 200 hours (or two months) and 250 patient encounters dedicated to the care of ill child patients in the hospital and/or emergency setting.
    - a. This experience should include a minimum of 75 inpatient encounters with children.
    - b. This experience should include should include a minimum of 75 emergency department patient encounters with children.
  - ii. Residents must receive training to perform clinical procedures required for their future practices in ambulatory and hospital environments.
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### III. Well-being, Fatigue Mitigation, and Monitoring

- A. The practice of medicine can be very fulfilling, but can also be taxing on a provider's mental, physical, and emotional well-being. It is important that residents and faculty physicians alike learn how to perform their clinical duties effectively, but in a way that fosters their well-being.
- B. Fatigue, which can be physical or mental, can influence the quality and safety of the care provided the one's patients.
- C. It is important that residents and faculty physicians learn to recognize fatigue as a threat to their judgment and may lead yield untoward outcomes for their patients and themselves. They should learn to mitigate their fatigue and take advantage of the processes set in place to support them.
- D. Similarly, resident and faculty physicians need to be alert to signs of fatigue in their colleagues, and to assist in mitigation efforts provided by CCHS.
- E. Residency programs need to provide education on well-being, signs and symptoms of fatigue and mitigation thereof, and to monitor these among the resident cohort.

Refer to the CCHS Policy on Well-bring, Fatigue Mitigation and Monitoring under PolicyStat at <https://cchs.policystat.com/policy/7317555/latest/>

### IV. Supervision

- A. In graduate medical education, interns and resident physicians are to provide safe and effective medical care with levels of supervision to their level and duration of training, their ability, and each patient's complexity and acuity.
- B. The attending physician is ultimately responsible for the care of the patients assigned to their team. The attending physician will delegate increasing responsibility of their patient's care to the resident's on their team to allow for professional growth toward independent practice.
- C. It is imperative that interns and residents fully understand and abide by the required supervision, and abide by the relevant policies set forth by the ACGME and the individual residency program.
- D. Residents/fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.
- E. An attending physician must see all inpatients for each day of care, though the attending may not be present during all episodes of care.
- F. Supervision takes many forms and is generally outlined by the following:
  - 1. Direct Supervision: the supervising attending physician (or resident) is physically present with the resident(s)/intern(s) and the patient
  - 2. Indirect Supervision with Direct Supervision Immediately Available: the supervising physician is physically in the hospital or other site of patient care and is immediately available to provide direct supervision
  - 3. Indirect Supervision with Direct Supervision Available: the supervising physician is not physically present in the hospital or other site of patient care, but is immediately available by the means of telephonic and/or electronic modalities, and is available to provide direct supervision within 30 minutes.
- G. In addition to indirect faculty supervision, upper level residents serve in a supervisory role to interns, who have only a limited medical license. Upper level residents will oversee all care provided by interns and presentations to attending physicians. Upper level residents document their supervision by creating a Review Note on the notes entered on all patients seen and examined by interns.

- H. On inpatient medicine service, interns must be directly supervised for all patient care they provide until they have successfully completed and passed one four-week block of daytime inpatient medicine service.
- I. Thereafter, on either the daytime inpatient medicine service or the night float rotation, interns must have indirect supervision with direct supervision immediately available.

Refer to the CCHS Policy on Supervision and Accountability under PolicyStat at <https://cchs.policystat.com/policy/7317521/latest/>.

## V. Schedules

- A. The inpatient medicine teaching service of the UAFMR-T and CCHS teaching faculty at DCH Regional Medical Center is covered 24/7 by residents.
- B. Please consult the CCHS intranet for the most up-to-date call and back-up call schedules.
- C. At the start of the inpatient medicine rotation, a faculty member will review with the teams the key elements of this handbook and expectations for the month.
- D. On Fridays, the inpatient medicine teams will be joined by a CCHS Behavioral Medicine faculty member to assist with common psycho-social issues that may arise while patients are in the hospital.
- E. Near the end of each block, a Morbidity and Mortality (M&M) Conference will be led by each of the resident teams.
  - 1. The purpose of M&M Conference is to promote engagement across all of the departments in discussing examples we encounter to promote education and to foster improvements in communication, patient safety, and quality improvement.
  - 2. Cases should be presented succinctly, emphasizing areas relevant to the teaching points.
  - 3. Each team will present one case, with the upper level resident overseeing the interns(s) preparation of and presentation of the case.
  - 4. The upper level resident will also summarize the main points of the case and will field questions and lead discussion about the case.
  - 5. The upper level resident should be a timekeeper to make sure the conference stays on schedule, with a 15-minute time limit for the entire case review.
  - 6. Except for those on approved leave, attendance is mandatory for the M&M conference, whether in person or by video conferencing.
  - 7. Faculty from all departments are invited and encouraged to come.

## VI. Clinical Responsibilities

### A. Day Team PGY-1 Duties

- 1. Admission H&Ps and Consultations – Created in Meditech after discussion with the upper level resident and Attending (see section XIII.H. for further details).
- 2. Discharge Summaries – Dictated or created in Meditech within 24 hours of discharge. (see section XIII.K. for further details)
- 3. Daily Progress Notes (see section XIII.I. for further details)
- 4. Addendums to progress notes to update any needed changes after team rounds.
- 5. Check out to the Attending
  - i. All PGY-1s must review all patients to their upper level resident prior to calling the Attending.
  - ii. Residents will discuss with their attending all newly admitted patients, Emergency Department (ED) patients seen and all in-patients who undergo significant clinical changes during the shift.
- 6. Take care of up to eight (8) patients on one's team. All ICU patients are included in the cap of eight

patients (1 ICU patient = 1 patient).

7. Enter orders
8. Manage floor calls; immediately notify upper level resident of any patient status change
9. Involve medical students in all aspects of patient care, including assigning each student at least 2 patients to follow. Medical student notes should be discussed with the student prior to patient presentation to the upper level and/or Attending.
10. Arrive on time and be prepared for morning report.
11. Present and discuss cases when assigned to do so in morning report.
12. Participate in all transitions of care
13. Notify the upper level resident when notes are complete, as the resident must edit and create a review note on each patient seen by the intern.
14. Study and thoroughly learn the core topics listed in the "Inpatient Medicine Guidelines Supplemental Information in New Innovations"

**B. Day Team PGY-2 and PGY-3 Duties**

1. See ALL patients on the team
2. Teach and supervise PGY-1s and medical students
3. See all ED patients with the PGY-1 and review the assessment, plan of care, and orders before the PGY-1 calls the Attending
4. Review all orders
5. Notes – Round and create complete progress notes on all patients above eight (8) for each intern on one's team
6. "Review" notes on PGY-1 notes – Edit intern notes as needed to update diagnoses and plans and create "review" notes on all PGY-1 H&Ps, daily progress notes, ICU notes, and discharge summaries after seeing the patient and reviewing the documentation and plans. These "review" note signatures are captured in the annual report of each resident's cumulative required inpatient patient numbers.
7. Contact the PCP via a "telephone message" within NextGen as notification whenever his/her patient has been admitted and discharged.
8. Code and bill all inpatient encounters
9. Oversee and participate in all transitions of care/handoffs
10. Prepare and oversee presentations and lead discussion in Morning Report
11. Study and thoroughly learn the core topics listed in the "Inpatient Medicine Guidelines Supplemental Information in New Innovations"
12. On Sunday afternoon, write orders to change to the Attending who will be seeing the patient on Monday and update the Patient Tracker Board.

**C. Night Float**

1. Hours – Night Team call coverage is from 4:15 pm to 6:15 am.
  - i. The Night Team should arrive by 4:15 pm for the formal transition of care meeting between Day and Night Teams
  - ii. The Day Team should arrive by 6:15 am for the formal transition of care meeting
  - iii. Transition of care meetings are mandatory and allow for the respective residents finishing their shifts to leave on time.
2. Though reading time on this rotation is limited, as time permits study and thoroughly learn the core topics listed in the "Inpatient Medicine Guidelines Supplemental Information in New Innovations"

**3. PGY-1 Duties**

- i. Admission H&Ps – Created in Meditech after discussion with the upper level resident and

Attending. Dictation is NOT permitted for H&Ps due to delays in the availability of the transcribed H&P.

- ii. Check-out to the Attendings
  - a. All PGY-1s must discuss all patients to their upper level resident prior to calling the Attending.
  - b. Interns or residents will discuss all ED patients, new admissions and all inpatients who undergo significant clinical changes during the shift with their Attending.
- iii. ICU Notes
  - a. At a time after midnight until no later than 4:00 am, the Night Float PGY-1 will pre-round and write progress notes on a maximum of two intensive care unit patients from each team (including Medical, Surgical, Stroke, and Cardiac critical care units).
  - b. All progress notes for critical care patients should include adequate interval history, data review, physical exam and a comprehensive update of assessments and plans.
  - c. ICU notes should be completed and submitted to the Day Team Attending unless interaction is needed with the on-call attending.
- iv. Enter orders
- v. Manage floor calls; immediately notify upper level resident of any patient status change.
- vi. If available, involve medical students in all aspects of patient care.
- vii. Notify the upper level resident when notes (all types) are completed as the resident must edit and create a review note on each patient seen by the intern.

#### **4. PGY-2 and PGY-3 Duties**

- i. Supervise and teach medical students and PGY-1s:
  - a. On inpatient medicine service, interns must be directly supervised for all patient care they provide until they have successfully completed and passed one four-week block of daytime inpatient medicine service.
  - b. Thereafter, on either daytime inpatient medicine service or night float rotation, interns must have indirect supervision with direct supervision immediately available.
- ii. ICU Notes
  - a. Oversee the acute care, assessment, and plan on ALL ICU patients (including Medical, Surgical and Cardiac critical care units) with PGY-1.
  - b. Create a Review Note on ALL ICU notes written by PGY-1:
    - 1. Specifying direct or indirect supervision as given.
    - 2. Direct supervision when required due to patient severity/instability and/or until the intern's first daytime inpatient medicine block is successfully passed.
- iii. H&Ps
  - a. Edit notes and create a Review Note on ALL intern H&Ps after seeing the patient and reviewing the documentation and orders.
- iv. Assist PGY-1s or acting interns with new admissions, floor calls, or further duties while ICU patients are being seen.

#### **VII. Patient Safety**

- A. Providing patient care safely is an essential component of providing quality care for patients. There are numerous threats to patient safety in the health care environment and the risks thereof cannot be overstated.

1. Residents receive presentations and participate in workshops to learn principles of patient safety, including Root Cause Analysis and Fishbone Diagramming. Residents are instructed about ranges of patient safety from potential threats to fatal errors.
2. Residents learn to recognize and mitigate threats to patient safety on a continuing basis. Residents are expected to follow safety protocols, to call out safety concerns, including those that have occurred and circumstances that may create a risk to patient safety.
3. Residents incorporate these principles in individual patient care, in team rounds, in presentations they do during morning report (daily and especially on “Bounce Back Fridays” discussions on readmissions and safety issues), and in the monthly Morbidity and Mortality Conferences.
4. Residents are expected to submit their concerns while on inpatient service through the Meditech “QA Referral for Safety Concerns Icon” on the Meditech Desktop located on the bottom right of the screen. This is only active on DCH desktops and not on UMC owned desktops in the education tower.
5. If during the care of inpatients it is noted that there are potential or existing safety concerns in the processes of transitioning back to outpatient care, these should be submitted through the outpatient safety reporting process. This can be accessed through the CCHS Intranet. Visit [cchs.ua.edu](http://cchs.ua.edu) and scroll to the bottom of the page. The link to the Intranet is located on the far right. Once logged in, the Safety Learning Report link is at the bottom right of the options shown.
6. Residents should notify their attending of safety concerns but should not delay in acting to protect patients when necessary.
7. Residents should submit their concerns through the hospital reporting system and not rely on their upper level or attending to do it for them. These submissions are reviewed and addressed, as appropriate, by DCH Quality and Safety staff members and committees. Follow up on a submission is given to the resident if possible and appropriate.
8. Lastly, to positively impact resident evaluations on the patient safety subcompetency, residents should log these submissions in New Innovations and ask their attending to comment on their patient safety performance in their rotation evaluation.

## **VIII. Morning Report and Rounds**

### **A. Timing and Participation**

1. Morning report occurs Monday-Friday at 8:00 am in Conference Room A or as otherwise designated.
2. Residents will meet with the day's Attending (as well as pharmacy students, clinical pharmacist faculty, and medical students if available) for Morning Report.
3. The length of Morning Report may vary, but rounds should start no later than 9:30 am.
4. Medical students should be released from rounds when scheduled for daily lectures or workshops.

### **B. Structure and Content**

1. The upper level residents will create a calendar at the beginning of the block indicating when each team will present a topic for Morning Report. This will typically be Teams 3,1,2 on Tuesday, Wednesday and Thursdays, adjusted if needed.
2. The patient presented should represent a core Family Medicine subject that will yield high value learning for medical students and interns.
3. After the morning report topic and discussion conclude, team “table” rounds and discussion of the previous night's admissions may occur at each attending’s direction.
4. Each team’s upper level resident will direct and alternate the PGY-1(s) and medical student(s) roles in presenting the case.
5. Friday morning report sessions are typically focused on patient safety. This may include a

presentation about patient safety principles, (a.k.a. “Bounce Back and Patient Safety” presentations about readmitted patients or those with patient safety concerns). These mimic the presentation style of M&M conferences. (see section V. E.)

#### IX. Admissions and ED Consults

- A. Unless otherwise noted, only patients of UMC Family Medicine, UMC Internal Medicine, Faculty/Staff Clinic, and patients under the care of Pickens County Primary Care (PCMC), including their nursing home patients, are admitted to the inpatient medicine service.
- B. If the ER calls with an “unattached” or “un-referred” patient, please discuss this with the Attending on call.
- C. The upper level resident will be notified by the ED physician when there is a UMC patient they deem as needing admission or, on rare occasions, for consultations for possible discharge.
- D. Upon being called about an obvious admission, the upper level resident, under the direct or indirect supervision of the attending physician, must:
  1. Promptly place both:
    - i. Admission orders specifying the major diagnoses, the attending to whom the patient is being admitted, and the status of the admission (inpatient vs. observation)
    - ii. Basic transfer orders, so as not to delay room assignment or disposition out of the ED.
  2. If unable to see the patient and/or enter admission orders promptly, then notify the ED physician and relay the above pertinent information and request that the EDP enter:
    - i. Admission orders
    - ii. Bridge orders

As soon as possible thereafter, the resident must enter new admission orders and cancel the bridge orders (which expire at 24 hours)
  3. The admitting team members may see the patient in the ED *if* the patient remains in the ED, or should see the patient upon arrival to their room. Disposition out of the ED **must not** be delayed to complete student or intern evaluations.
  4. If the resident determines that urgent treatment or diagnostic evaluation needs to occur before transfer out of the ED to their floor or ICU bed, they should discuss this with the ED physician and the attending physician.
  5. The PGY-1 will review the assessment and plan with the upper level resident prior to calling the on-call Attending.
  6. An H&P will be completed in Meditech (no dictations allowed for H&Ps) as soon as possible and prior to the end of shift.
  7. If the patient does not require admission but can be sent home as determined by the ED physician, a Short Stay Summary (i.e., an abbreviated H&P with History of Present Illness, Physical Exam, Assessment and Plan, follow-up instructions, and upper level review note) must be documented before the end of shift. (See section XIII.L. for further details.)
  8. After the resident discusses the patient with the on-call attending, if the attending does not think that the patient requires admission, the resident (and if needed the attending) must discuss case with ED physician. Thereafter, if they agree, discharge the patient from the ED with close follow up scheduled and document Short Stay Summary.
  9. If the ED physician does not agree that the patient can be safely discharged, then the admitting attending must:
    - i. Agree to admit the patient.
    - ii. Physically come and assume care, evaluate the patient and discharge the patient if that be their final

recommendation.

- E. Team designations (e.g. 1, 2, 3) are determined internally by the Inpatient Medicine Service and are not designated in Meditech. They should be listed on the Patient Tracker Board or similar product. (see section XV.A. for further details)

**F. General Weekly Admission Call Schedule**

	<b>On call Attending (8am-8am)</b>	<b>Admitting Team</b>	<b>Rule</b>
<b>Monday</b>	Attending A	Team 1	Admit to Team 1
<b>Tuesday</b>	Attending B	Rotates based on PGY-1 who covers in the afternoon (will also do weekend nights)	Admit to covering PGY-1's team (if PGY-1 is from Team 4, then even out the teams)
<b>Wednesday</b>	Attending A	Team 2	Admit to Team 2
<b>Thursday</b>	Attending B	Team 3	Admit to Team 3
<b>Friday</b>	Attending C	Rotates based on team that stays till 9 pm; other two teams leave at 12 noon	Admit to covering PGY-1's team (if PGY-1 is from Team 4, then even out the teams)
<b>Saturday/Sunday (Holiday)</b>	Attending C (Rotate for Holidays)	Rotates	Even out the teams
<b>ALL NIGHTS</b>	Per upper level discretion	Even out the teams	Even out the teams

**G. Patient Assignment Teams**

1. Weekday admissions called between 6:00 am and 4:00 pm are to be admitted by the daytime on-call team, as specified by the PGY-1 on-call schedule.
  - i. Urgent or unstable admission calls between 4:00 pm – 4:15 pm and 6:00 am – 6:15 am should be immediately assessed by the leaving team until the arriving team can assume care.
  - ii. Checkout is given to the PGY-1's team attending, and typically, the patient is assigned to the on-call PGY-1 team for care. This is to promote intern continuity as a priority.
2. Weeknight admissions, between 4:00 pm and 6:00 am, are distributed under the direction of the upper level night float resident to:
  - i. Promote continuity with the PCP resident or attending if they are on service
  - ii. Readmit back to the team that cared for the patient if readmitted within 30 days of discharge if

a resident or attending member of the original discharging team is still on service (aka "Bounce Back).

- iii. Reasonably balance teams
3. Weekend admissions should be placed on the team (in order of priority):
  - i. The PCP (intern, resident or attending) if on service
  - ii. The PGY-1 who admitted the patient
  - iii. The upper level resident who admitted the patient (if the geriatrics intern was cross covering)
  - iv. And under the name of the Attending who will see them first, as determined by the most senior resident on service at the time
- H. **Pediatric Admissions (age <18)**
  1. On weekdays when an internist is the Inpatient Medicine on-call physician, pediatric patients will be admitted to a Family Medicine Attending on "Pediatric Backup call." The call schedule should reflect which Family Medicine attending is on Pediatric back-up call
  2. On weekends, if an Internal Medicine Attending is on-call, *new* pediatric patients will be admitted to the Pediatric Attending on call and rounded on by residents on the Pediatric service. They will remain on Pediatrics service until discharged for care continuity.
  3. On such weekends, existing Family Medicine pediatric patients transition to the Pediatrics Service. In this setting, these patients transition back to a Family Medicine team on Monday.
- I. Residents may NOT accept a patient in transfer from another hospital or institution. All transfer calls from the ER or the DCH Health System operator should be immediately referred to the on-call Attending. The resident should assist the ER staff or outside facility in how to contact the appropriate Attending.
- J. The on-call team residents and on-call Attending should be notified when a resident and/or attending admits a patient from UMC to the hospital.
- K. Patients who are readmitted within 30 days of discharge are assigned to the team that originally cared for the patient, if any of the last admission team members (intern, resident or attending at discharge) are currently on service.

## X. Consultations

- A. All consultations should be approved by the Attending and ideally should be communicated personally to the consultant to clarify the questions/services being requested and the time frame that it is needed, consistent with DCH bylaws.
- B. All urgent and stat consults must be ordered as such and require direct communication to the consultant.
- C. The PGY-1 may contact the consulting physician, but the upper level resident should ensure that the intern has a clear understanding of: 1) the patient's clinical diagnostic situation and prognostic status; 2) what the consultant is being asked to help with; and 3) how to efficiently communicate this to a specialist attending.
- D. The upper level resident should monitor the first few phone consultation calls completed by the intern.

## XI. Inpatient Procedures

- A. The following hospital procedures must always be directly supervised by an attending or supervising physician with credentialing privileges to perform that procedure until the requirements for credentialing are met. Thereafter, the resident credentialed to perform a procedure must have indirect supervision with direct supervision available (see section IV. "Supervision" for definitions) from an attending or other provider with credentialing privileges for that procedure. See the CCHS Handbook for credentialing requirements.
  1. Endotracheal and Supraglottic Airway Intubation

2. Central Venous Line Placement (all sites)
  3. Tube Thoracostomy (Chest tube) placement
  4. Lumbar Puncture (Adult and/ or Children)
  5. Newborn Circumcision
- B. Residents may become credentialed to perform the above procedures as outlined by DCH. The resident must first submit a request for approval to the Program Director for each procedure. Once approved, the resident submits a request through the DCH Medical Staff Office. The request will then be presented to the DCH Physicians Activity Committee (PAC) for approval. Once approved, the resident may perform the specific procedure(s) with indirect faculty supervision.
- C. Residents credentialed to perform these procedures may teach the procedures to other residents, as outlined by DCH.
- D. The following items performed by any residents should be indirectly supervised by the attending or on-call physician. Specifically, the intern or resident should discuss such management or intervention as soon as possible with the attending or supervising physician.
1. ACLS/Code Blue on a UMC patient
  2. New ICU admissions or transfers for any cause
  3. Any UMC patient requiring SWAT intervention or Code Sepsis or Code Stroke
  4. Patients requiring initial invasive or non-invasive ventilation or significant changes in such patients
  5. Any patients requiring urgent consultations / procedures
- E. The attending supervising a resident's procedure must have been granted privileges for the procedures he/she teaches and supervises. The attending is responsible for any procedure performed by a resident.
- F. DCH Medical Center bylaws permit any physician in an emergency to perform any procedure necessary to save a patient's life. Residents are obligated to notify the attending physician as soon as they are aware that a life-threatening situation exists.

## **XII. Communication**

### **A. Attending On-Call Line**

1. The Inpatient Medicine Attending line is (205) 348-0829. This provides 24/7 access to the Attending physician on-call.

### **B. Pagers**

1. The beeper/pager is the primary means of communication for nurses and staff in the hospital.
2. Residents must have their pager on and carry it with them at all times when on- call or on-duty for the inpatient medicine rotation.
3. All pages should be returned within 15 minutes. If for reasons of involvement of urgent clinical issues or procedures the resident cannot return a page within this time-frame, he/she is to have another team member answer the page for them.
4. If a resident is paged in error, it is that resident's responsibility to help the person contact the correct resident or other correct recipient.
5. If the resident forgets his/her pager or if the pager stops working, the appropriate personnel (attendings, upper levels, Residency Office, etc.) must be notified and given alternate contact information.
6. Should reasonable response time to pages become a recurring issue, the program director will respond and request a personal meeting with the resident. Thereafter, any ongoing or repeated instances will be considered unprofessional behavior and disciplinary action may follow.

### **C. Email**

1. Residents are expected to check their ua.edu email account at least daily while on all rotations, including while on the inpatient medicine rotation or night float rotations as this is an important means of communication for UAFMR-T.
2. All emails regarding patient care must remain HIPAA-compliant. Please have an attending review the message prior to it being sent if there is any question regarding compliance.

**D. Text Messages**

1. Patient care information (Protected Health Information (PHI) should not be sent via non-secure means.
2. Text messages are considered a non-secure / HIPAA-noncompliant form of communication.
3. Patient care information / PHI may be sent via a HIPAA-compliant application means such as HIPAABridge or Ingenious Med messaging.

**E. PCP Notification**

1. For every UMC or Pickens County Primary Care (PCPC) patient admitted to the hospital, the primary or covering upper level resident is responsible for sending the PCP a task within NextGen (UMC) or through Ingenious Med (PCMC) as notification that their patient has been admitted. This should be done the day of discharge
2. Likewise, for every UMC and PCPC patient discharged from the hospital or sent home from a short stay in the ED, the primary or covering upper level resident is responsible for notification of the PCP of such information. This should be done the day of discharge.

**XIII. Transitions of Care**

**A. Transition to Another Facility**

1. The decision to transfer a patient to another facility must be made in consultation with the attending.
2. All transfers require an attending to attending call for transfer of care.
3. Once the decision to transfer the patient is made and the patient is ready for transport, an EMR template discharge summary must be completed immediately to accompany the patient to the new facility. (see section XIII.K. for further details)

**B. Shift Change and Team Handoff Rules**

1. Per ACGME Family Medicine Guidelines (VI.B.1-4), transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is communicated between the outgoing and incoming individuals and/or teams responsible for that specific patient or group of patients. Programs and institutions are expected to have a documented process in place for ensuring the effectiveness of transitions. Pertinent elements evaluated should include exam findings, laboratory data, any clinical changes, family contacts, and any change in supervising Attending physician.
2. Transitions of care create high risk or medical errors. In addition to the processes defined below, promotion of patient safety is further ensured by:
  - i. Provision of complete and accurate rotation schedules in New Innovations;
  - ii. Presence of backup call schedule for those cases when a residents is unable to complete their duties;
  - iii. The ability of any resident to be able to freely and without fear of retribution report their inability to carry out their clinical responsibilities due to fatigue or other causes.
3. Residents receive educational material on Transitions of Care/Handoffs during Intern Orientation and periodically thereafter.
4. A formal checkout must happen between the Night Float Team and the Day Team at each shift transition. It is expected that each handoff be face-to-face and substantive, without exception.
5. The medical students and PGY-1s must communicate with the upper level residents regarding patient

status and plans prior to morning rounds.

6. Any resident seeing a continuity patient must communicate about that patient to the team caring for the patient.
7. Residents are to familiarize themselves with and routinely use the I-Pass Handoff System. (see Inpatient Medicine Guidelines Supplemental Information in New Innovations)

**C. Specific Shift Change and Team Handoff Rules (Transitions of Care/TOC)**

1. In any instance where care of a patient is transferred to another member of the health care team, an adequate transition must be used. Although transitions may require additional reporting than this process, a minimum standard for transitions must include the following information:
  - i. Demographics
    - a. Patient Name
    - b. Unit/Room Number
    - c. Age
    - d. Attending Physician
    - e. Date of Birth
    - f. Gender
    - g. Other Unique Identifier
    - h. Admit Date
    - i. Allergies
  - ii. History and Problem List
    - a. Primary diagnosis(es)
    - b. Chronic Problems (Pertinent to this Admission/Shift)
  - iii. Current Condition/Status
  - iv. System Based
    - a. Pertinent Medications and Treatments
    - b. IV Fluids
    - c. Blood Products
    - d. Oxygen
    - e. Respiratory Therapy Interventions
  - v. Pertinent Lab Data
  - vi. To Do List: Check x-ray, labs, wean treatments, etc. – rationale
  - vii. Contingency Planning – What may go wrong and what to do
  - viii. ANTICIPATE what will happen to your patient,
    - a. Ex: “If patient seizes > 5 minutes, give him Ativan 0.05mg/kg. If he still seizes give a loading dose of 5mg/kg of fosphenytoin.”
  - ix. Family or Psychosocial Situations
  - x. Code Status (especially recent changes or family discussions)
2. The process by which information is distributed is via Intern Orientation presentations to residents and is found on pocket cards delivered to each resident. In addition, this information is presented in program/departmental meetings.
3. The UA Family Medicine Residency Program regularly monitors transitions, including a sample of a patients chart and interview of incoming team to ensure that key elements are transmitted and have been understood.
  - i. An attending will participate in the evening transition from Day Team to Night Float on a weekly

basis. Milestone-based evaluations are completed on participating residents.

- ii. The entire team must be present and participate in transitions of care. The upper level residents are responsible for monitoring the transitions.
- iii. Any deviations are to be reported to the attending on call that day.
- iv. It is the responsibility of the attending physicians on service each day to ensure that adequate TOC occurs.

**D. Outpatient to Inpatient to Outpatient Transitions of Care**

1. On admission, the patient's PCP is to be recorded within the H&P.
  - i. For those few patients with an inactive or soon graduating PCP listed, the attending will assign a new PCP, or the hospital resident can assume PCP care if desired.
2. The primary or covering upper level resident is responsible to contact the PCP by a NextGen task with a brief description of the admission and who will be the residents taking care of the patient. The PCP may be called to discuss care if needed.
3. The PCP, if not on a primary inpatient service, should make every effort to see the patient as a meaningful encounter(s), but generally may/will leave the bulk of the care to the inpatient team. Any suggestions from PCP regarding patient care in the hospital should be communicated clearly to the caring team.
4. When discharged, the name of the PCP should be included on the Discharge Summary and a copy sent to the outpatient office.
5. The upper level resident is to send a telephone message it NextGen to the PCP notifying them of the following: reason for hospitalization, medication changes, and follow-up instructions.
  - i. Ex: "Your patient was admitted for pneumonia and hypokalemia. We increased the potassium to 20mEq daily. Needs a repeat BMP in 1 week."
6. The discharging intern must complete the discharge summary within 24 hours of discharge.
7. If the discharging intern is covering for the primary service intern, the discharging intern must notify the primary service intern to do the discharge summary within 24 hours, or must do the discharge summary his or herself.
8. At UMC-FM, the staff receiving the paper copies of the discharge summary and med lists will send them to medical records to be scanned and then to the PCP's PAQ for review.
9. The patient should be scheduled for hospital follow-up with the PCP. If the PCP is not available, one of the inpatient team members are to see them in clinic for that hospital follow-up visit. The resident may need to approve the patient as a work-in if at all possible.

**E. Meditech** is considered the active patient chart and is the EMR used for daily notes, orders, etc. All attendings for UMC Family Medicine & Internal Medicine are listed within Meditech as rounding group #19.

**F. ChartMaxx** is considered the archived patient chart. Notes are officially "signed off" in ChartMaxx, therefore it must be checked on a regular basis.

**G. Hospital Orders**

1. Attendings generally leave writing or entering orders to residents.
2. Orders should be entered electronically in Meditech. If Meditech is not functioning, then written orders will be accepted.
3. Admission orders must be sent to the Day Team Attending who will be seeing the patient, not the Attending on-call at night if not the one assigned to see the patient.
4. If orders are needed from the Attending, the resident should communicate this during rounds or in the progress note.
5. Admission orders (including admission orders from observation status) should be signed by the

attending as soon as possible and MUST be signed before the patient is discharged. Notify the attending if this needed.

6. Verbal orders must be signed within 24 hours, either in the chart or in Meditech.
7. When a patient is being admitted to Inpatient Medicine (not Pediatrics or OBGYN), then a “Y” should be checked in the box labeled “Is this an admission for a UA Physician?” on the Admissions Order template in Meditech.
8. When giving a verbal order, the resident must ask that the order be read back to him/her to ensure accuracy.
9. Orders written by medical students are invalid until countersigned by a physician.

#### **H. History and Physicals (H&Ps)**

1. Templates for H&Ps are available in Meditech.
2. H&Ps should be sent to the attending on-call who received the admission presentation, and the Day Team attending who will see the patient, if different.
3. H&Ps should be created in Meditech after discussion with the upper level resident and attending, as soon as possible and by the end of the shift.
4. All H&Ps must be completed by the end of the shift. If the admitting resident is unable to complete the H&P due to committing a duty hour violation, he/she will appoint another resident to complete it. PGY-1s stop seeing new patients 30 minutes before the end of the shift, except for emergencies and code blues.
5. H&Ps should incorporate not only information from the current visit, but also pertinent information from previous visits/notes in Meditech and in NextGen, pertinent past diagnostic studies, lab values and historical trends, All available resources should be utilized (PCI, ChartMaxx, and scanned documents in the Categories tab of NextGen) to obtain the whole clinical picture.
6. For Medicare patients, inpatient status vs outpatient with observation status designation is required. For any patient admitted under inpatient status, statement along these lines MUST be present in the H&P: “Care for this patient is expected to surpass at least two midnights, or the patient is at risk of an adverse event, such as (sepsis, respiratory failure, death, etc.)”
7. The decision to order a specialist consultation for any patient must be discussed with the upper level resident and approved by the attending prior to the order/request being entered, except in the case of an emergency.
8. ICU H&P templates are available and optional for use for complex patients with multiple organ system involvement, and for those whose stay in the ICU is not anticipated to be brief.

#### **I. Progress Notes**

1. Templates for daily progress notes are available in Meditech.
2. Progress notes should be created daily according to the SOAP method. Notes should be clear and accurate. These should be signed and submitted to that day’s attending before rounds. Draft forms are not acceptable. It is expected that the plan for that patient may change during rounds from what was written. The progress note may then be updated with an addendum, or the resident may edit it before completing the review note.
3. Every patient needs a progress note on the day of discharge in addition to a discharge summary.
4. Every note by an intern must be reviewed, edited and a review note placed and signed by the supervising upper level resident.
5. Attendings will review, edit and attest the notes and write comments if appropriate.
6. The assessment and plan section of the progress note should account for all active and/or significant inactive or resolved problems.

7. For non-ICU patients, the assessment and plan should be organized by problems, with the most pertinent problems listed first.
8. No extraneous material should be carried forward in daily notes. The assessment and plan from the previous day will carry forward but must be reorganized and prioritized for that day's work/patient status prior to finalizing the note. As diagnoses are updated, they should replace the initial problem (e.g. "NSTEMI" must replace the earlier entry of "Chest Pain").
  - i. When inserting lab results, insert only the results most pertinent to the active problems, using the fishbone entry method. You may simply document "lab results reviewed." Avoid inserting large data sets.
  - ii. If inserting radiology results, do not insert the interpreting physician's name as this may cause signature errors in Meditech. Do not include information from the report other than the impression. You may simply document "radiology reports reviewed."
  - iii. Symptom diagnoses are acceptable before a diagnosis is established, but do not need to be continued thereafter (May discontinue "Shortness of Breath" when "Pulmonary Embolism" is diagnoses, or "Leukocytosis" and "Cough" when "Community Acquired Pneumonia" is confirmed.
9. On the day of discharge, especially for Medicare patients, at least one progress note timed before the time of the discharge order must give a follow-up plan for the patient. Ex: "Pt is to follow up with Dr. S--- at [date and time and location".
10. Interns should discuss the quality of progress notes with the upper level resident and attending by requesting regular feedback on documentation content and accuracy.
  - i. All patient encounters must documented in Meditech. This includes, but is not limited to, calls to the floor to evaluate a patient, family conferences, medication changes, and/or conversations with consultants. The encounter must be documented in the patient's chart as an addendum to that day's progress note. If done by an intern, the supervising upper level should put a review note, specifying their direct or indirect supervision.

#### **J. ICU Progress Notes**

1. The UMC ICU note template is available in Meditech for daily ICU notes, which allows for organization according to the organ-system method.
2. The ICU note templates are an option for complex patients with multiple organ system involvement, especially for those whose ICU stay it not expected to be brief.
3. Resident pre-rounds should start in the ICU. It is standard of care in the medical community is to see an ICU patient and document that visit at least twice a day.
4. At afternoon checkout, the Day Team should decide and assign to the Night Team which ICU patients will need routine and comprehensive ICU notes.
5. Night float interns and residents must write complete progress notes (usual or ICU notes) on a maximum of two ICU patients per team (see section on Night Float). ICU notes should be completed and submitted to the Day Team Attending, unless seen by the on-call attending. These should be completed between midnight and 4 pm.
6. ICU or floor patients needing intervention or updates before midnight should have documentation entered in a brief revisit note. The routine and more comprehensive ICU patient note should be completed after midnight.
7. Day Team residents must write a daily revisit note or addendum to the Night Float ICU patient note after rounds in order to update the plan of care.
8. All progress notes for critical care patients should include adequate assessments and plans, and should

be edited by and review note entered by the supervising upper level resident.

**K. Discharge and Discharge Summaries**

1. Per hospital policy, discharge summaries must be created in Meditech or dictated at the time of the patient's release or within 24 hours. Every patient needs a progress note on the day of discharge in addition to a discharge summary.
2. When creating or dictating a Discharge Summary specify the names of the intern, upper level resident and attending on the day of discharge as well as the PCP. Copies of the Discharge Summary should be sent to the PCP and relevant consultants:
  - i. Discharge Summaries created in Meditech: Selecting the "CC" button opens a drop down of names to select to whom the discharge summary should be copied to.
  - ii. Discharge Summaries that are dictated: Specify at the beginning of the dictation to whom a copy should be sent. If requesting it to be sent to a non-DCH physician, please specify the physician's name, address and fax number.
3. Discharge summaries should be concise yet thorough. All diagnoses should be listed as part of summary, including all diagnoses (evolved to the highest specificity) for which the patient received treatment in the hospital as well as the patient's chronic conditions.
4. If dictating, abbreviations and initials for diseases, procedures, etc. are common sources of error in transcription. Dictation of whole words rather than abbreviations is preferable. Residents are to familiarize themselves with the "Do Not Use Abbreviations" on the DCH Regional Health System intranet.
5. Do NOT list discharge medications in the Discharge Summary. Instead, refer to the "discharge medication list".
6. At discharge, all new or changed medications must have printed and signed prescriptions, or when possible, transmitted electronically (e-Rx).
7. At discharge, the intern will have completed and reviewed the "discharge information card" for patients, noting the team members that cared for them, their primary care physician's (PCP) name, any follow up plans and appointments specifically noted, along with any needed follow up tests / test results. (see Inpatient Medicine Guidelines Supplemental Information in New Innovations)
8. If a patient who was originally thought to be stable for discharge is not discharged, the on-call attending must be notified as to the situation. Also, if a discharge summary was dictated, DCH medical records must be notified of the change in status/situation.
9. Discharge summaries should be sent to the attending who saw the patient last.
10. Interns/Residents may start a draft Discharge Summary before the day of discharge for complex patients with a longer anticipated length of stay, to keep track of key elements of the hospital course.
11. Ideally, the discharging resident should update the problem list and medication list in NextGen.

**L. Short Stay Summaries**

1. If a patient is seen and sent home from the ED, a Short Stay Summary must be documented before end of shift.
2. The summary should be an abbreviated H&P with history of present illness, physical exam, assessment and plan, and follow-up instructions.
3. All documentation done by interns must have a supervising resident review note before end of shift.

**M. Procedures**

1. A signed consent form must be documented in the chart prior to the performance of any procedure.
2. The discussion of risks, benefits, and alternatives to the particular procedure must be documented in the medical record.

3. A procedure note should follow and include the indication, the procedure note itself, any complications or limitations, estimated blood loss, and follow-up instructions.
4. All procedure notes must be signed off by the Attending.

**N. Inpatient Deaths, Death Summaries, and Death Certificates**

1. For patient who die while in the hospital, the covering attending should be notified promptly, especially if an unexpected death. Additionally, the patient's PCP should be notified as soon as possible.
2. For patients who die while in the hospital, a death summary note must be typed or dictated by the end of shift. This can be encompassed within a discharge summary for brief hospitalizations, or as a separate note from a more detailed discharge summary.
3. The death summary should be sent to the Attending who saw them last and to the on-call attending, if different.
4. The certifying intern or resident must complete the death certificate promptly. These should ideally be done online through the EVERS system within the Alabama Department of Public Health (ADPH) site. If it cannot be done online, the resident or intern should proactively seek out a paper death certificate to complete.
5. The death certificate is the permanent legal record of the patient's death and is important in court, epidemiological studies, and to the family. Death certificates are important legal documents, which may not be spindled, folded, mutilated, erased, stapled, or have lines struck through.
6. Death certificates must be completed and mailed to the Health Department (or completed online) within five days. They are never given to the family.
7. Residents must consult with an Attending, who will check for accuracy before online submission or mailing.
8. If a patient admitted to a non-UMC physician dies after a code blue response led by a resident, the admitting or covering physician who cared for the patient in the hospital should complete the death certificate. Residents who responded to the code blue should notify the PCP or the covering physician of the death as soon as possible and ask them to complete the death certificate. There may be rare circumstances where it is acceptable for the resident to complete the death certificate. In the case of an ED death of a UMC, the death certificate will typically be directed to the UMC PCP to complete.

**O. Signatures**

1. All handwritten signatures should be followed with one's legibly printed first and last name with DCH Physician ID/Dictation Number.

**P. Delinquent Hospital Charts**

1. Delinquency is defined as any hospital H&P or discharge summary not dictated or completed within the EMR within 24 hours of admission or discharge.
2. Any resident found to have a significant number of delinquent charts and/or a repetitive pattern of delinquency is subject to disciplinary action.
3. All charts are to be completed prior to taking annual leave.

**XIV. "401 Calls"**

- A. These are "after-hours" telephone calls from the UMC answering service.
- B. The upper level resident on call for Pediatrics receives these from 5:00 pm – 8:30 am on weeknights, and from 5:00 pm on Friday until 8:30 am on Monday
- C. The upper level resident on inpatient medicine may be asked to assist with returning these calls if the other teams are busy.
- D. All of these encounters must be documented with the "Telephone Call" template in NextGen and may be

tasked to the appropriate PCP.

- E. The on call attending for the appropriate service should be available for questions and discussions about the proper advice and recommendation for care.

## **XV. Miscellaneous Inpatient Processes**

### **A. Patient Tracking – The Board**

1. The Patient Tracker Board is one of the monitors in the residency lounge. It is color coordinated:
  - i. Blue = New Patient
  - ii. Black = Current Patient
  - iii. Red = Discharge Complete/Pending Transport
  - iv. Red with Strikeout = Deceased Patient
  - v. Yellow Highlight = Contagion Risk (e.g. Covid +)
  - vi. Orange Highlight = Person Under Investigation (PUI) for Contagion Risk
2. The team is responsible to keep the Board as accurate and up-to-date as possible since it can be viewed by other residents and Attendings who are coming on shift.

### **B. Physical Findings Board**

1. Team members asked to record any interesting or abnormal physical findings on the small white board in the resident lounge.
2. These will be used teaching other residents or students, with each patient's permission.

### **C. Continuity Clinic**

1. All residents will have at least one continuity clinic session per week while on this rotation.
2. Before leaving for clinic, all patients must be transitioned to the resident who will be covering. This transition must be face-to-face.

### **D. Continuity Inpatients**

1. Every effort should be made to ascertain the patient's PCP and the upper level resident must notify him/her that the patient has been admitted to the hospital.
2. If a difficult situation occurs after-hours requiring a call to the PCP for patient information, such a call should be made after consultation with the upper level resident and/or Attending on call.
3. Patients expect that their PCP will be aware of their admission, so please notify the PCP as soon as possible of their admission.

### **E. Outside Learners**

1. At times, there may be outside learners on rounds. These may include pharmacy students and/or residents (PharmDs), social work or psychology students.
2. Residents are encouraged to utilize them for this unique collaborative learning experience.

### **F. Code Blue and Trauma Calls**

1. The in-house medical team is required to attend and manage all Code Blue situations, under the supervision of the Attending (if still in-house) or the ER physician (if available).
2. The upper level resident is expected to supervise or "run" the code.
3. The PGY-1 is expected to participate and assist in the code, as directed by the upper level resident
4. The team should attend and assist in all trauma alerts, unless patient care issues prevent this.

### **G. Code Sepsis**

1. The upper level resident on-call for Inpatient Medicine is responsible to respond to code sepsis alerts on weekdays (daytime) and weekends.
2. The upper level resident on Pediatrics Night Float (Sunday through Thursday nights) is responsible to respond to code sepsis alerts during those times.

3. The responsibility of the resident is to quickly assess the patient to verify if signs of sepsis are indeed present and to initiate urgent treatment orders. If the patient is not a UMC patient, the responding nurse on the Code Sepsis Team should notify the admitting or covering attending who should assume care thereafter. Failure of the nurse to do so should be reported to the Inpatient Medicine Director on weekdays and the Attending on call, if different. These instances should then be reported to the Multidisciplinary Peer Review Committee.

#### H. Moonlighting

1. See the [Sponsoring Institution Policy](#).

#### I. Leave

##### 1. Annual Leave

- i. Annual leave is not allowed while on the inpatient medicine rotation.
- ii. In extraordinary circumstances, the resident must provide written justification as to why the leave should be approved as far in advance as possible to the Program Director.

##### 2. Sick Leave

- i. If a resident becomes ill, the resident must notify via phone or email his/her team and Attending, his/her suite, and the Residency Office as soon as possible. Residents should arrange coverage for responsibilities as able. Sick leave occurring on the weekends must be submitted by the Monday following leave. Any sick leave in excess of 72 hours must be accompanied by a physician's statement and release to return to work.

#### XVI. Third-Year Medical Students

- A. Third-year Internal Medicine students will be working with residents on the Inpatient Medicine service. It is the resident's responsibility to assist in the education of these students.
- B. Student Requirements
  1. Lectures and other learning sessions (weekly schedule is emailed)
  2. Attendance at Morning Report, pre-rounding, attending rounds
  3. Following patients and writing notes
    - i. Students should be involved as early as possible in the admission process
    - ii. Upper level residents, and interns as possible, should review the student's progress notes and give feedback for any needed improvement.
    - iii. Upper level residents, and interns as possible, should assist in the student's preparation of and presentation of patients and give feedback for any needed improvement.
    - iv. The students should follow a minimum of two, and no more than four, patients at a time.
    - v. Students are **not** to follow children during this clerkship.
  4. Observed H&Ps – Can be observed by the Attending or resident. Please be strict, but fair, in the review and complete the form for the student.
  5. Students should be present for and involved in all transitions of care (TOC) (Team checkouts) morning and afternoon, unless formally scheduled to be elsewhere.
  6. When not on-call, students should be available until 5:00 pm or until the TOC is completed, whichever is later.
  7. When on-call, medical students should stay in-house and work with the night float team until at least 7:00 pm, but not longer than allowed by current LCME duty hour rules. Students are expected to perform H&Ps on new patients, including at least one directly observed H&P and to attend to assigned continuity patient follow-up and duties.

#### C. Resident Supervision of Students

1. Meet with students before rounds and review patients with them.
2. Assist with patient assignments and continuity.
  - i. Direct students to see new patients when on-call in such a way that they will be able to follow the patients in-house. We try to place students on-call with their intern whenever possible.
  - ii. On weekend call, the students are assigned to be on with their Attending, intern and/or resident, if possible.
    - a. Oversee that the student is rounding on his/her usual patients.
    - b. Students on night call should round with the Night Team and students on daytime call should round with the Day Team.
    - c. Students must follow current LCME duty hours rules, including a maximum of 16 hours per shift.
  - iii. Meet with students at other times and review patient care, pertinent knowledge or patient-care topics, or other important learning topics. The students enjoy learning from you. Remember that the students have required reading and studying to do during this clerkship so avoid assigning them excessive mundane tasks.
  - iv. MedHub Grading – Please complete online grading form when link is emailed to you. Resident grades do count. Please contact the IM clerkship coordinator for any technical problems.
  - v. The resident, and intern as possible, should give the students feedback on any of the core competencies. Feedback is an essential part of learning and should occur regularly. Negative feedback should be given respectfully and privately.
  - vi. Report student problems promptly to the attending and to the IM clerkship director. Whether knowledge, patient care or professionalism issues, please report and problems to the clerkship director as soon as the concern arises. Do not wait until evaluations.
  - vii. Entrustable Professional Activities. Residents should evaluate each student on service once per week on a history or physical EPA. This will be done with the student’s phone app.

#### **XVII. Fourth-Year Medical Students**

- A. Fourth-year medical students will often be part of the medicine teams as Acting Interns (AIs). These guidelines should be followed:
  1. AI should not be following a patient with an intern.
  2. As patient numbers allow, AI should follow at least two, and up to five (5) patients (at resident’s discretion and comfort)
  3. Patient distribution among teams should take into account the extra “intern” on the service.
  4. AI will be matched with his/her upper level resident at all times. Keep in mind that patients admitted by AI will be on AI’s team.
  5. Assigning third-year students to an AI’s patients is at the discretion of the resident. Please be sure that AI has at least one patient to present on rounds, if possible.
  6. AI should write notes on all patients on AI note templates. These notes should be promptly reviewed and confirmed by the upper level resident. Exam elements must be performed by the resident.
  7. Attestation statements have been created in Meditech. They are labeled “AI Attestation for Resident” and “AI Attestation for Attending”.
  8. AI should write orders on his/her patients. We do not currently have a system to do this in Meditech. It is up to the resident to decide how to do this. One suggestion is allowing AI to hand write orders on patients that can then be reviewed and transcribed by the resident.
  9. AI should participate in all “checkouts”/transitions like interns. Since AI is matched with residents, if resident is in clinic for the afternoon, AI should checkout patients at noon to his/her cross-cover.

Approved by GMEC on 06.2020

10. Call schedule for AI will be distributed. AI should be in the hospital most, if not all, times when his/her resident is. Ordinarily, AI will have one weekend call assigned with his/her resident.
11. The AI *may* attend third-year lectures if he/she wishes. AI *should* attend weekly EKG workshop.
12. Students will comply with all duty hour requirements as set forth by the LCME.