LAC+USC Medical Center
Internal Medicine Wards Orientation
2021-2022

Faculty in Charge of Rotation:
Patrick Sarte, MD
323-409-6630
psarte@med.usc.edu

First Day of Rotation:
Report to Conference Room B for sign-out at 6:30 AM.

GOALS

The General Medicine Ward rotation is the core inpatient medicine experience. The purpose of the rotation on the inpatient general medicine service is to gain experience in management of acute medical illness across a wide spectrum of patient ages and diagnoses.

As interns and residents, you are integral members of the teaching medical team with the goals to provide excellent patient care to county patients in a collaborative and educational environment. Interns function as the primary providers for their patients, evaluating and managing medical disease, coordinating care of the patient with other healthcare providers, and educating patients. Residents have the added responsibility supervising the medical team and coordinating the transitions of care for their patients. All medical team members including medical students and attending physicians are responsible for promoting learning and teaching in an educational environment.

In addition to fostering competence in the areas of patient care and medical knowledge, the service provides critical experience in collaborating with other members of the healthcare team, including care coordinators, social workers, and pharmacists, as well as students and fellow residents, which builds skill in interpersonal communication and professionalism. Exposure to the intricacies of daily hospital care, including discharge planning and triage to higher or lower levels of care, builds competency in systems-based practice, provides opportunities to learn from mistakes, and builds patterns of practice-based learning.

ROTATION STRUCTURE

STARTING THE ROTATION

Before the first day on service, sign-out should occur from the outgoing member to the appropriate oncoming team member (resident to resident, intern to intern).

WEEKLY SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8AM – 9AM	Goldstein Morning Report	Journal Club / Chief Morning Report	Palliative Care / Humanities Morning Report	Goldstein Morning Report	Intern Morning Report
12PM – 1PM			Noon Conference		Noon Conference

DAILY SCHEDULE

6:30 AM – 8:00 AM	Sign-out, Pre-rounds, and Resident Rounds
8:00 AM – 9:00 AM	Morning Report/Intern Report
9:00 AM – 9:30 AM	Work Rounds
9:30 AM – 11:30 AM	Attending Bedside Rounds
11:30 AM – 12:00 PM	Work Rounds
12:00 PM – 1:00 PM	Lunch/Conference (Grand Rounds, M&M, CPC)
1:00 PM – 5:30 PM	Patient Care and Management / Afternoon Didactics
5:30 PM – 6:00 PM	Sign-out to Night Float resident

Resident Rounds

Pre-rounds and Resident Rounds on all of the team's established patients must be conducted with all the team members present every morning from 7AM – 8AM. All team members, therefore, will become familiar with all of the patients on the team. These rounds are led by the resident without the attending. The goal is to ensure that a management plan for the day as well as the overarching plan for each patient is established daily. Care coordinators should be present at these rounds to review patients slated for discharge. Priorities for work rounds include addressing patients for discharge (as well as placing discharge orders), addressing sick/unstable patients, entering orders for diagnostic testing early, and calling in consultations early in the day.

The team should strive to see all patients during this hour, but should prioritize sick/unstable patients, patients pending discharge, and new patients.

Attending Bedside Rounds

Attending Bedside Rounds are performed from 9:30 AM – 11:30 AM every Monday through Friday. The attending should review all of the team's new admissions from the previous twenty-four hours and discuss all of the team's established patients with new, significant developments. Any new patient must be seen by and discussed with the attending with the team at the bedside. Faculty are expected to perform bedside teaching, discussion of pathophysiology, and should use current available studies to aid in diagnostic and therapeutic decisions.

Faculty must perform discharge planning and management rounds daily. Discharge planning and management rounds are afternoon rounds whereby the faculty discusses and briefly visits with the team's established patients not seen during teaching rounds. Faculty must evaluate all of their

team's patients each day and must co-sign all necessary notes. All documentation, including the initial history and physical must be signed within 24 hours. Each faculty attending is available for their team at all times when they are on service.

TEAM STRUCTURE

There are 12 teams that make up the General Medicine Service. Eleven teams are comprised of one faculty attending, one senior resident, and two interns. One team, the Hospitalist team, is made up of one faculty attending and 2-3 senior residents. The purpose of the Hospitalist team is to prepare senior residents for independent, unsupervised practice as these senior residents come close to completing residency training. Additionally, depending on the time of year there can be 2 third year medical students and a fourth year medical student (sub-intern). Each medicine team is responsible for the care of up to 16 patients and each intern on the team is responsible for the care of up to 8 patients.

An attending will be available to the house officers at all times of the day. Each attending will perform teaching rounds five days per week with their individual teams and will cover the weekends within each firm. The housestaff are expected to use this attending as the primary resource for issues regarding patient care.

ADMISSION SCHEDULE

General Medicine Ward Teams accept new admissions daily. The resident must see and evaluate all admissions assigned to the intern and medical students who they supervise. The team's attending is always responsible for all activities no matter the time of day.

SIGN-OUT

Each medicine night float resident is responsible for cross-covering and admitting for two medicine teams overnight. Each medicine team signing out to the night float should provide a written handoff ("Physician Handoff") in addition to preparing for a verbal sign-out. Sign-out should take place in a protected, quiet space, and follow the I-PASS format. It is the responsibility of the team member signing out patients to update the Physician Handoff. The medicine team should arrive promptly to receive sign-out on their patients at 6:30 AM and the night float should arrive promptly to receive sign-out at 5:30 PM.

DAYS OFF

All house officers on the General Internal Medicine Service will get an average of one day off per week across the duration of the rotation. Days off will be designated by the Chief Residents and is available on AMION. Predetermining everyone's days off will ensure that days off are distributed fairly and that the appropriate complement of residents and interns are in the hospital at all times.

EXPECTED OR UNEXPECTED ABSENCES

If you are unable to perform your clinical duties on any given day, please notify both the Chief Resident on call and your fellow team members as early as possible.

CURRICULUM

EDUCATIONAL PLAN

The purpose of this rotation is to train residents to competently care for patients with a broad range of medical problems who require hospital admission to the general medicine ward service. The rotation is designed to increase diagnostic skills, reasoning ability, therapeutic acumen, objective knowledge, overall patient care skills and team management skills. Additionally, residents will acquire the skills to perform basic procedures including but not limited to: lumbar puncture, thoracentesis, paracentesis, arterial blood gas, and venipuncture.

CONFERENCES

Morning Report

Morning report starts promptly at 8:00 AM. Please make sure that you arrive on time for all conferences. There are four different formats that are employed:

Goldstein Morning Report

Mondays and Thursdays, the Program Leadership moderates Morning Report. Medicine ward residents present established patients for discussion. A panel of subspecialists help guide the entire group of residents to identify problems, build a differential diagnosis, and formulate patient care and management plans.

Humanities Morning Report

On some Wednesdays, Dr. Panush moderates morning report with a humanities perspective on cases, applying the art and history of medicine as it pertains to specific cases.

Palliative Care Morning Report

On some Wednesdays, Drs. Van Zyl or Storms will discuss the complexities of managing and caring for patients at the end of life. Topics are wide-ranging from pain or nausea management to approach to a Goals of Care discussion. Residents are often invited to discuss difficult cases.

Program Directors & Chief Residents' Morning Report

On Tuesdays, the Program Directors and Chief Residents lead Morning Report. This session is designed to be more intimate and more informal. Residents present cases which are discussed by the group with a particular emphasis on building a differential diagnosis and patient work-up and management.

Intern Report

Intern report is every Friday starting promptly at 8:00 AM on Zoom.

Intern Morning Report

This conference is mandatory to all interns on the medicine ward rotation and open to all interns on other services. It serves as an opportunity to work through challenging cases in a systematic manner that focuses on differential diagnosis, critical thinking, and management. The Chief Residents and the Program Directors moderate intern report.

CXR and EKG Conferences
On select Fridays at 8:00 AM, faculty from the divisions of Pulmonary and Cardiology will lead a conference teaching interns EKG and CXR interpretation skills, differential and approach to management

EDUCATIONAL METHODS

Direct observation of patient care and bedside teaching occur in the setting of daily inpatient rounds with the attending. Residents evaluate and treat patients both in the capacity of follow-up as well as initial evaluation. The supervising attending reviews and critiques the resident's interpretation of diagnostic studies and formulation of assessments and plans. Residents additionally attend didactic conferences as indicated above.

EVALUATION TOOLS

The attending physician is responsible for providing verbal feedback and must submit evaluations of the resident physicians in MyEvaluations. The attending must meet face-to-face to provide mid-point and end-of-rotation feedback with all of the house officers they evaluate and indicate that discussion on the evaluation form. Evaluations must be completed within one week of completing a rotation. Peer evaluations for other trainees on the team should be completed in a timely manner.

PATIENT CARE

LOCATION & PATIENT CHARACTERISTICS

The Wards Service is entirely at the LAC-USC hospital and comprises of floor patients only. Of note, the ICU and CCU are separate services and closed units.

- 1E: Jail Ward
- 2E: Behavioral Health Unit
- 3C: OBGyn & Med/Surg Ward
- 4M/5F/8B: Progressive Care Unit (PCU)
- 6A/6B/6C/6D/7A/7C: Med/Surg Wards
- 7B: Hematology Ward
- 7D: Hemodialysis Unit
- 8A: Telemetry Unit

The patient population at LAC+USC Medical Center is very diverse, with multiple ethnic and socioeconomic groups represented. The spectrum of these encounters will be from primary presentation of new disease processes to the tertiary care for the patient who is referred for subspecialty care. We also receive transfers from outside hospitals needing acute hospitalization for higher levels of care. The care for these patients will occur on either general medicine floors or telemetry floors. Any patient requiring ICU or CCU level care will be transferred to the respective team who will assume care of the patient. Once the patient is stabilized and can be transitioned out of the ICU or CCU, the care for this patient can be reassumed by the general medicine ward service.

COHORTING

Medicine teams will be cohorted to specific wards to foster interprofessional communication and multidisciplinary care.

ADMISSIONS

All potential patient admissions are screened using Interqual criteria, and some undergo a secondary physician review regarding medical necessity for admission. Bed control is first informed of the admission, and once an assignment to a team is made, this is communicated to the primary team. If the patient is in the ED, or an intensive care setting, physician sign-out to the accepting team will occur.

Day Team Admissions: 5:00 AM – 5:00 PM
Night Team Admissions: 5:00 PM – 5:00 AM

TRANSFERS

If a patient is sick or unstable, the patient can be moved from a Med/Surg floor to the Telemetry Unit (8A), to a PCU (4M, 5F, or 8B), or to the ICU.

Transfers to the ICU

Patients that a medicine team deems to require a transfer to a higher level of care will have the care of the patient assumed by the ICU team. To initiate an ICU transfer, first notify Med Consult that there is a patient who necessitates transfer. Med Consult will then evaluate the patient and discuss the case with the ICU Fellow. If determined to be an appropriate ICU transfer, Med Consult will notify the team to place orders and to give sign-out to the ICU team. All transfers to the ICU must be

accompanied by a Transfer Summary from the ward team. The ICU team is expected to write transfer orders and reconcile all prior active orders.

Transfers from the ICU
When the ICU team deems a patient stable for transfer to a lower level of care, the medicine team will be notified by Bed Control that a patient has been assigned to the medicine team. The medicine team should call the ICU team to receive sign-out. A Transfer Summary will accompany all patients being transferred out of the ICU. The medicine team should addend the Transfer Summary upon transfer of care.

DISCHARGES

The decision to discharge a patient and the discharge plan must be discussed with the attending each day. This discharge plan should also be discussed with the patients. All hospital discharges require Discharge Instructions and educational material for the patient, appropriate medication reconciliation and prescriptions, appropriate follow-up referrals or appointments, an electronic discharge order, and a Discharge Summary (please see below).

Transfers to other healthcare facilities (another hospital, long-term acute care (LTAC), skilled nursing facility (SNF), rehab, etc.) require a Discharge Summary (please see below). Additionally, a triplicate form, which can be obtained at each nursing station, will need to be filled out and signed by a licensed physician prior to transfer.

LEAVING AGAINST MEDICAL ADVICE (AMA) & ABSENT WITHOUT LEAVE (AWOL) & ELOPING

Patients have the right to leave AMA if they have the capacity to make their own medical decisions. This means that they know their diagnosis, prognosis, the risks of leaving the hospital, the benefits to staying in the hospital, and alternatives to hospitalization. If your patient can verbalize all of the above, is deemed to have capacity to make medical decisions, and still insists on leaving, the patient should sign the AMA form and the incident should be documented thoroughly in the chart.

Patients who leave the hospital for more than 2 hours are considered to have left AWOL from the hospital. Patients are considered to have eloped only if they are on a psychiatric hold. This is different from leaving AMA.

Patients who AWOL, elope, and who leave AMA still require discharge orders and a discharge summary.

RAPID RESPONSE & CODE BLUES

If a patient appears acutely unstable, do not hesitate to call the Rapid Response Team. If your patient is decompensating rapidly and requires intubation or resuscitation, call a Code Blue.

Always document goals of care discussions, even if the decision is to remain full code. Keep in mind that the code status obtained during the hospitalization is dynamic and only relevant to the current hospitalization. It does not necessarily hold true for the next hospitalization unless the patient has a signed a POLST or on discussion with your patient, he/she reiterates his/her desired code status. Upon discharge, a POLST form should be completed in an effort document goals of care. The pink original goes with the patient and a copy should be placed in the chart for scanning into ORCHID.

PLACING CONSULTS

Decisions to consult a different service should always be discussed with the attending of the team. The consultant can be reached either through the operator (dial "0" from any hospital phone) or through AMION. Remember to be courteous when calling the consult and have a well-defined question for your consultants. Please give your consults enough time to see your patients, so try placing consults as early in the day as possible.

PROCEDURES

Prior to performing any procedure, an informed consent must be obtained and placed in the patient chart. If a translator is used to obtain consent, this must be documented. For any procedure, residents must be supervised by an attending physician or a senior resident until they have logged 5 instances of performing said procedure in MyEvaluations. Procedures may be supervised by the attending on service or the Attending of the Day (AMION: lacusc / IM Attendings).

DEATH

Deaths must be pronounced by a licensed provider on the primary team. All in-hospital deaths require a Death Summary to be written by the primary team. If a death is pronounced by the overnight cross-covering resident, he/she may write a brief Death Note to document the circumstances and death exam; however, a Death Summary still needs to be completed by the primary team.

Deaths in the hospital are not uncommon and may be an emotionally challenging experience. Housestaff are encouraged to discuss the experience of caring for a patient who has died with the team and/or chief residents.

DOCUMENTATION

All documentation must be completed electronically in ORCHID. Each note needs to end with "Discussed with Attending Dr. [Name]" and be forwarded to the attending on service for the day for review.

History & Physical

H&Ps must be written and signed by the attending within 24 hours of admission. In ORCHID, the note type, "History and Physical" should be used.

Daily Progress Note

A daily progress note must be completed for each patient unless an H&P or Discharge Summary will be written for the day of admission or day of discharge. Daily progress notes must be forwarded for evaluation to the attending of the team. In ORCHID, the note type, "Internal Med Inpatient Progress Note" should be used.

Discharge Summary

Discharge Summaries are required for any discharge from the hospital and should be completed within 24-48 hours of discharge. This includes discharges against medical advice or elopements. In ORCHID, the note type, "Discharge summary" should be used. Discharge summaries should include the following:

- Admission date

- Discharge date
- Procedures or surgeries
- Consulting services
- Summary of hospital course
- Discharge diagnoses and medication
- Follow-up plan

Transfer Summary
A Transfer Summary is required when the patient is being transferred to another service (ICU, surgical service, Blue team) or to another facility. The transfer summary should follow the format of the Discharge Summary above. In ORCHID, the note type, "Transfer Summary" should be used.

Death Summary
A Death Summary is required when a patient expires in the hospital. The Death Summary should follow the format of the Discharge Summary above. In ORCHID, the note type, "Death Summary" should be used.

MEDICAL RECORD DOCUMENTATION QUERIES

You may receive a message in your ORCHID inbox from Medical Records inquiring about specific diagnoses. Please make sure to respond to all messages in a timely fashion as it affects hospital funding.

ACGME MILESTONES 2.0

LEARNING OBJECTIVES

	PGY 1	PGY 2	PGY 3
Patient Care	• Residents can consistently elicit and report an accurate and thorough history for common and complex patient presentations • Residents can consistently perform a thorough physical exam for common and complex patient presentations • Residents can consistently organize, summarize and reason through information from the patient evaluation to develop a differential diagnosis for common patient presentations • Residents can consistently formulate management plans for common patient presentations with minimal guidance	• Residents can consistently elicit and report a hypothesis-driven history for common and complex patient presentations • Residents can consistently perform a hypothesis-driven physical exam for common and complex patient presentations • Residents can consistently organize, summarize and reason through information from the patient evaluation to develop a prioritized differential diagnosis for common and complex patient presentations • Residents can consistently formulate and implement management plans for common patient presentations and modifies the plan based on clinical course and acuity	• Residents will consistently elicit and report a hypothesis-driven history for common and complex patient presentations that incorporates psychosocial and other determinants of health, including secondary data • Residents will consistently perform a hypothesis-driven physical exam for common and complex patient presentations and use advanced maneuvers to elicit subtle exam findings to guide diagnosis and management • Residents can consistently organize, summarize and reason through information from the patient evaluation to develop a prioritized differential diagnosis for common and complex patient presentations, accounting for unusual, or conflicting findings • Residents can consistently formulate and implement value-based management plans for common and complex patient presentations and modifies the plan based on clinical course, acuity, and shared decision making • Residents will be able to coach and teach others through the workup and development of a management plan
Medical Knowledge	• Resident has basic understanding and is able to briefly describe the epidemiology, pathophysiology, and treatment of common diseases including pneumonia, DVT, chest pain, preoperative care, COPD & asthma exacerbations, DM and management, CHF exacerbation, non surgical abdomen, acute GI bleeds	• Resident demonstrates broad differential diagnosis skills • Resident demonstrates appropriate diagnostic and therapeutic planning. • Resident is able to describe in detail and teach the pathophysiology, epidemiology, diagnosis and treatment of common diseases on the medicine inpatient service	• Develop an analytic approach to clinical scenarios • Resident demonstrates independence in decision making • Resident is proficient in the common disorders seen on medicine inpatient and is able to teach students and junior residents effectively
Practice Based Learning and Improvement	• Resident prioritizes diagnosis and treatment decisions based on patient's severity of illness • Resident refers to evidence to make decisions with respect to clinical care • Resident accepts responsibility and is open to feedback	• Resident prioritizes diagnosis and treatment decisions based on patient's severity of illness • Develop clinical judgment in the strategies used to match treatment protocols with illness • Resident refers to evidence, appraises best available evidence, and incorporates it into making decisions with respect to clinical care • Resident accepts responsibility and asks for feedback	• Resident prioritizes diagnosis and treatment decisions based on patient's severity of illness. • Resident will develop clinical judgment in the strategies used to match treatment protocols with illness. • Resident applies evidence in the face of uncertainty and conflicting evidence to guide clinical decision making • Resident accepts responsibility and identifies owns limitations between ideal and actual performance

Interpersonal and Communication Skills	• Resident communicates regularly with patient and his/her family. • Resident provides feedback to junior team members.	• Resident function as an effective team leader.	• Resident is concerned about the patient's comfort. • Able to deal with challenging patients and families. • Resident addresses end of life decisions with minimal faculty input
Professionalism	• Resident recognizes and takes steps to correct his/her deficiencies. • Resident treats team members with respect, including nurses and other health care providers. • Resident adheres to all ACGME mandated duty hour restrictions. Resident completes medical records on time.	• Resident will counsel junior team member on issues of professionalism including personal reactions to the morbidity and mortality associated with the care of medical disease. • Able to delegate responsibility to others	• Set a tone of respect and collegiality for the team. • Identifies ethical issues and employs available resources to solve them.
Systems Based Practice	• Resident can effectively initiate the appropriate use of other consultants in the care of patients with various diseases.	• Resident serves as a consultant to other services with moderate faculty input.	• Understands and develop cost effective care • Demonstrates expertise in Medical practice knowledge and delivery systems