Tips & Tricks for Intern Year

Kent Garber
Chris Childers
UCLA General Surgery (soon to be) R2s
Quick Run Down...

• Top 10 Pages
• The Digits
• Your Little Black Box
• The Nitty Gritty
• Call
• Help Is On the Way
• Your Turn!!
Top 10 Intern Pages & How to Respond
09:55555, xx,
doctor, pt very
nauseous and
vomiting, but i see↓

no orders, please
call ASAP, he’s
vomiting everywhere!
7:42PM 06/16/14
1. Nausea

- **Medications**
  - Zofran (odansetron)
    - Typical Dose: 4mg IVP q8h prn
    - Max 32mg/24 hours
  - Reglan (metoclopramide)
    - Typical dose: 10mg q6h prn
    - Avoid in all patient with new bowel anastomoses
  - Compazine (prochlorperazine)
    - Only available PO and PR making it somewhat useless
  - Phenergan (promethazine)
    - Typical dose: 12.5 or 25mg IVPB (please don’t give this IM despite it being an option)
    - Start with single doses (6h apart)
    - Not a first line agent
    - Contraindicated in children <2y (respiratory depression)

- **Vomiting?**
  - What color is it? How much? Is their belly “blowing up like a balloon”?
  - Make patient NPO
  - Consider NGT and KUB, talk to chief
08:55 AM, XX, PT
complains of 10/10
Pain, screaming oxy
Prn not enough,

wants BTP med.
Please advise. thank
you.

7:20PM 06/16/14
2. Pain

Typical UCLA pain regimens

- **PCEA**
  - Managed by Acute Pain Service only
  - If issues overnight with epidural (i.e. believe patient is hypotensive, epidural not working, epidural site reactions etc.) the RN should contact the acute pain team directly
  - Common epidural side effects: Hypotension, numbness, somnolence, itching—let pain team know

- **IV**
  - PCA: no basal, 0.2mg dilaudid q10 mins (6/hour), allow incr by 0.1 up to 0.4 for unrelieved pain
  - Dilaudid sliding scale: 0.2/0.4/(0.6) mg dilaudid q2-4h prn
  - Morphine (2-4mg q2-4h prn)
  - Toradol: always ask permission, not used when high risk for bleeding or elevated Cr (or elderly), when do give, typically either 1x dose or ATC for up to 72 hours
  - Tylenol: PACU, ICU only
How to Write for a PCA

Pain - Patient Controlled Analgesia

Reminder: MD to discontinue all opioids (narcotics) after initiating PCA (to be done on the ward).

1. Nurse should instruct patient on the use of PCA pump until patient demonstrates understanding. Patient and family to be instructed that the PCA is to be used by the patient only. 2. Maintain at least one IV site throughout therapy. If no continuous IV run Normal Saline OR IV at 20 mL/h. 3. DISCONTINUE all narcotics after initiating PCA. No other narcotics to be given without contacting ordering physician. 4. Record vital signs (BP and RR) and assess pain prior to initiating PCA, then Q15 mins x4, and then Q4 hr until PCA discontinued. Repeat VS (BP and RR) Q15 mins x 4 if PCA dose or basal dose increased, and then Q4 hrs. 5. Call ordering physician if RR < 10, Modified Alert Sedation Agitation Scale (SAS) score < 1 EXCESSIVE SOMNOLENCE (sedation score >3), or if pain unrelied.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Prompt</th>
<th>Answer</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Loading Dose (mg)</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Basal Continuous Rate (mg/hr)</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Patient Bolus (mg)</td>
<td>0.2</td>
<td></td>
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<tr>
<td>4. Bolus Interval (min)</td>
<td>10</td>
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<tr>
<td>5. Max # of boluses/hour</td>
<td>6</td>
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<tr>
<td>6. If pain unrelied for 30 minutes, increase patient bolus dose by</td>
<td>0.1</td>
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<tr>
<td>7. May repeat this dosage increase every 30 minutes x 2 doses. Maximum patient dose (mg):</td>
<td>0.4</td>
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</tbody>
</table>
2. Pain Cont.

- PO

  - Oxycodone 5/10/15mg q4h prn mild/mod/severe pain
    - Elixir form available
  - Norco/Percocet 1-2 tabs q6h
    - Max tylenol dose 3g/24h
  - Tylenol 650mg q6 (prn or ATC)
    - Elixir form available
  - Motrin 600mg q6 (prn or ATC)
    - Elixir form available
  - Tramadol 50-100mg q6 prn
3. Low UOP

• Is it low?
  – UOP goal: 0.5-1cc/kg/hr
  – Baseline kidney function? HD? Meds?
• Verify I/Os
• Assess overall picture: pre-renal (“dry”), renal, vs post-renal (foley)
• Foley?
  – Is it working? Flush it
• Are they retaining?
  – Bladder scan
• Placing a foley vs straight cath
  – Fresh post op or several days post op?
  – Epidural still in place?
  – Male or female? How old?
  – Were they started on their home flomax?
• Low UOP troubleshooting: bolus, urine lytes (FeNa), renal US
Low UOP

**Do the cross cover intern a favor and remove foleys in the morning so voiding is not an issue overnight; if you do want to remove it at night... try ordering foley removal for midnight, that way the void check will be first thing in the morning
4. H&Ps and SCIPs

- Before each elective (Blue) & urgent (Green Line) case, patient must have:
  - H&P within 30 days
    - If there isn’t one, do one the day of the procedure
    - Clinic progress notes count as long as they have all the relevant info
  - SCIP Pre-Op Note
    - Complete the day of surgery (do not enter until patient has been seen/is in pre-op)
  - Procedure Consent
    - Valid for 1 year
    - Sometimes done in clinic, so check CareConnect (consent tab, media tab)
  - Blood Consent
    - New consent required for every visit to OR, not required in Surg Center
    - Separate consent than if transfusion received on the floor
SURGICAL REQUIRED ELEMENTS
Ronald Reagan UCLA Medical Center and Santa Monica
UCLA Medical Center and Orthopaedic Hospital

SCIP Pre-op Note
*the SCIP Pre-op note must be completed within 24 hours of surgery, in the pre-operative area or as an in-patient*
*the SCIP Pre-op note must be completed by an MD, NP or PA on the surgical team

1. What is the status of the patient’s most current History and Physical?
   - {SCIP PRE-OP 1:26011}

2. Does the patient have a suspected pre-operative acute infection?
   (if YES, Update Problem List with suspected pre-operative acute infection.
   1. Chronic infections do not meet SCIP definitions for pre-op infection
   2. Pre-op infection must be considered an ACUTE infection)
   - {SCIP PRE-OP2:21947}

3. Has vancomycin been ordered pre-operatively for the patient?
   - {SCIP PRE-OP3:21948}

4. Will antibiotics be administered prior to surgery?
   - {SCIP PRE-OP4:21949}
### Consents

A screenshot of a chart review section showing various consents and documents. The image highlights a table with columns for Enc Date, Display Date, Document Name, Description, and Doc ID. The table lists several consent forms, including:

- Consent Blood Transfusion
- Consent Surgery

The table also contains other entries related to medical records and procedures.
Don’t Stop Your Patient from Getting to the OR…

• **H&P**
  – Within 30 days
  – Include: HPI, PMH, PSxH, Soc History, ROS, PE, A/P

• **SCIP note**
  – Must be signed the day of surgery, AFTER patient arrives

• **Operation Consent**
  – Check OR schedule request, H&P, clarify with resident
  – No abbreviations
  – Must write out “Right” and “Left”
  – Sign as witness

• **Blood Consent**
  – Require new blood consent for every visit to OR

• **Marked for laterality**

• **For in-house/consult patients:**
  – T&S within 24 hours
  – Complete set of labs
  – Cardiac clearance (by medicine, cardiology or anesthesia)
16:55555, Sally, PACU. Pt is ready to go to floor, but can’t transfer.

17:55555, Jenny, Pts call re: pt Sanders, 8734. Pt ready to go home. I can’t print.

Orders are not showing up. Pts call. 8:28AM 06/18/14

8734. Pt ready to go home. I can’t print AVS. 8:30AM 06/18/14
5. Unreconciled Orders

- Transfer Orders from OR
- Discharge Orders
# Reconciling Orders

For medications you want the patient to take after discharge that have both a prior to admission entry (Person icon) and a hospital entry (Bed icon), make sure to choose "Refill/Modify" or "Resume" for the prior to admission medication and "Do Not Prescribe" for the hospital medication. This will prevent errors on the After Visit Summary (AVS). Please check the AVS in the discharge navigator after completing medication reconciliation to ensure that the instructions to patients are clear.

One or more inpatient medications needing review were originally ordered as part of a linked order group. Linked order information is shown for reference only. Discharge orders will not be linked.

<table>
<thead>
<tr>
<th>Orders Needing Review</th>
<th>Refill/Modify</th>
<th>Resume Taking (No Script)</th>
<th>Stop Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol) 325 mg tablet</td>
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<tr>
<td>Acyclovir 50 mg/mL in sodium chloride 0.9% 250 mL IVPB</td>
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<td>Clonidine 0.1 mg/24 hr patch 0.1 mg</td>
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<tr>
<td>Dextrose 5%/0.45% NaCl 20 mL KCL IV soln</td>
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<tr>
<td>Dicyclomine (Bentyl) 10 mg capsule</td>
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<tr>
<td>Diphenhydramine 12.5 mg</td>
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<tr>
<td>Esomeprazole 50 mg</td>
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<tr>
<td>Fat Emulsion (Intralipid) 20% Infusion 250 mL</td>
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<tr>
<td>Ketorolac 30 mg</td>
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<tr>
<td>Metoclopramide 10 mg</td>
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<tr>
<td>Methylphenidate 15 mg</td>
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<td></td>
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<tr>
<td>Morphine 10 mg</td>
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<td></td>
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<tr>
<td>Naloxone 0.4 mg/mL</td>
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<td></td>
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<tr>
<td>Nortriptyline 10 mg</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Omeprazole 20 mg</td>
<td></td>
<td></td>
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<tr>
<td>Oxycodone 5 mg</td>
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<td></td>
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<tr>
<td>propofol 200 ug/mL</td>
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<td></td>
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<tr>
<td>Prednisone 10 mg</td>
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<tr>
<td>TPN Adult</td>
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6. Hypertension

General Pearls:
- What is the etiology? (pain, anxiety, hypoxia...)
- Does it make sense? (have the last 4 been normal)
- Was it re-checked? On the opposite arm? Manually?

Chronic
- What are patient’s home meds? Have you restarted them?
- Often don’t treat unless SBP > 160
- Hx aortic stenosis? Don’t give hydralazine or ACEi
HTN

Acute

– Neuro status? CP/SOB/anxiety?

– Meds:
  
  • PO meds can be given anywhere
  • IVPB on most floors, but must be on monitor
  • IVP in ICU and PACU only
  • Example meds: Metoprolol, labetalol, hydralazine, nitroprusside, nitro paste
04:55555, xx,
patient would like
off unit privileges
and analgesic balm

for baik. FYI,
patient BP 75/30.
Pls call. ty. ;)
7. Hypotension

- **Sepsis**
  - SIRS: tachycardia, febrile, leukocytosis, tachypnea
  - Hypotension $\rightarrow$ treat aggressively with fluids, CBC, BMP, Lactate, Cultures (blood – all lines, urine), CXR

- **Hypovolemia**
  - Bleeding – tachycardic? Low UOP? Latest CBC + coags?
  - Post-op under resuscitation – how much fluid/products in OR?

- **PCEA**
  - Hypotension without tachycardia
  - 1st bolus 500 NS $\rightarrow$ no response $\rightarrow$ call Pain to decr PCEA
  - Very concerned about hypotension $\rightarrow$ turn off PCEA
8. Chest Pain

- Things to think about
  - Nature of symptoms: onset, location, quality
  - Cardiac history, cardiac meds
- DDX: heartburn, MI, incisional pain, anxiety, costochondritis

- Heartburn
  - Tums
  - Pantoprazole!
  - Pepcid

- MI
  - EKG, Troponin
  - ALWAYS LOOK FOR PRIOR EKG FOR COMPARISON

- Incisional pain
  - Press on it
05:55555, xx,
Patient HR 110-150s,
complaining of
Palpitations. EKG

done; i think you
should order ltyes.
pls come assess.
thank you.
9. A Fib

- Hemodynamically stable? Symptomatic?
  - Full set of vitals
  - Formal EKG, BMP/Mg/Ca, TSH; consider troponins
  - GO SEE THE PATIENT
- HD Unstable & Symptomatic → ACLS
- HD Stable
  - Metoprolol
    - IVP 5mg q15 min to max of 15mg
    - On floor patients - MD must push meds and confirm dose prior to injection
    - Greater effect on BP vs dilt
  - Diltiazem
    - IVP 5mg q5 min to max of 25mg
- Amiodarone, Digoxin
  - Service/attending specific
  - Amio gtt can be started on the floor but given hemodynamic changes are probably better served in the ICU
10. Desaturation

• <92% → Go see patient
• Think about differential and medical history? OSA, BMI, COPD, Home O2, Fluid overload
• Full set of vitals, make sure the O2 probe has a good waveform, listen to lungs
• Has O2 been titrated? Crank it up (see below)
• STAT portable CXR
• Consider ABG (done by MD on floor)
• Modes of O2 Administration
  – Nasal cannula: Flow 1-6L, FiO2 28-44%
  – Face mask: Flow 6-15L, FiO2 28-44%
  – Non-rebreather: Flow 10-15L, FiO2 100%
  – Any additional needs → Call RT
A Few Horror Stories to Make a Point....

• Stroke code
  – Call page operator (x66766) ask for stroke pager, stroke phone
  – While waiting for neurology
    • Will the patient be able to go in the MRI?
      – Do they have any metal in their body?
      – Do they have a PCEA?
    • Get a history for possible tPA?

• STEMI
  – Order EKG, troponin, full set of labs, CXR
  – Pain medication, O2, nitroglycerin, aspirin
  – Ask page operator for CCU Resident on Call & Cardiology Consult (covered by an attending)
  – Notify your senior
Phone Numbers

x66766

(310) 206-6766

And your nifty phone cards...
How to manage your new best Frienemy...

• Setting up your own pager
  – Most helpful if password is your pager ID #

• Services Pagers
  – Listed on phone card
  – *Always give your service pager #*

• Logging on to a Pager
  – Login & PW are both the pager number

• Calling to change pager coverage
  – Page operator x66766

• Batteries available in supply room on every floor
UCLA Website

• https://amcomwbsm.ad.medctr.ucla.edu/smartweb/
Paging Etiquette

- Always include:
  - Call back extension
  - Pager number (Service > Personal)
  - Patient last name
  - MRN
  - Brief reason for paging
  - Level of urgency
- ALWAYS return pages promptly
A Day in the Life…

• Prep for Rounds
  – Get sign-out from overnight/NF intern
  – Print the list
  – Chart pre-round
  – Think about dressing changes, etc.
• Lead the team on rounds
• Present patients
• Assist with pre-op
• BrEaKfAsT
• Get final plans from seniors
• Order entry!!
  – Enter orders they told you to... and the ones they didn’t
    • Lytes, Modify IVFs
    • DVT ppx – should it be held? continued?
    • Dressing change orders
    • PT/OT, Ambulate, IS
    • Check home meds**
    • Clean up nursing communications**
• Follow up with Consultants, Radiology, Nursing
• Check in with Social Work and Case Managers
• Keep seniors updated throughout the day
• Keep your patients updated throughout the day
• OR
• PM Rounds
• Prep for Sign Out
A Day in the Life...

- Prep for Rounds
  - Get sign-out from overnight/NF intern
  - Print the list
  - Chart pre-round
  - Think about dressing changes, etc.
- Lead the team on rounds
- Present patients
- Assist with pre-op
- Breakfast
- Get final plans from seniors
- Order entry!!
  - Enter orders they told you to... and the ones they didn’t
    - Lytes, Modify IVFs
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- Follow up with Consultants, Radiology, Nursing
- Check in with Social Work and Case Managers
- Keep seniors updated throughout the day
- Keep your patients updated throughout the day
- OR
- PM Rounds
- Prep for Sign Out

Create a system that works for you... I use ROLIN
Replete (them lytes)
Orders (discussed on rounds)
Labs (for tomorrow)
Imaging (today or tomorrow)
Notes (progress notes)
A Day in the Life...

- Prep for Rounds:
  - Get sign-out from overnight/NF intern
  - Print the list
  - Chart pre-round
  - Think about dressing changes, etc.
- Lead the team on rounds
- Present patients
- Assist with pre-op
- Breakfast
- Get final plans from seniors
- Order entry!!
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    - Dressing change orders
    - PT/OT, Ambulate, IS
    - Check home meds**
    - Clean up nursing communications**
- Follow up with Consultants, Radiology, Nursing
- Check in with Social Work and Case Managers
- Keep seniors updated throughout the day
- Keep your patients updated throughout the day
- OR
  - PM Round
  - Prep for Sign Out

Need an MD signature for HH...

Can you drop a slip?

Can you come talk to Mrs. Confused?

Create a system that works for you... I use ROLIN
- Replete (their lytes)
- Orders (discussed on rounds)
- Lab (for tomorrow)
- Imaging (today or tomorrow)
- Notes (progress notes)

Can you cover this case?

Did you replete??

Don’t forget to log your cases...

New consult!

Can you discharge Mr. Ready??

Are you on call tonight?
Presenting on GS Rounds

• Patient name
• POD ___, s/p ____
• Overnight events
• DIAPP
  – Diet
  – Infusions (IVF, drips)
  – Antibiotics (drug, dx/x)
  – Pain
  – PPx
• Vitals
• I&O
• Labs
• Radiology
• Cultures
• Lines/Tubes
Replete those Lytes!

• Potassium (Goal >4)
  – IV/PO: 10 mEQ for every 0.1 increase
  – Can add to IV fluids if persistently low

• Calcium (iCa >1.1, Ca > 8.7)
  – 1.05<Ca<1.09: 1g calcium gluconate IV/calcium carbonate PO
  – 1.00<Ca<1.04: 2g
  – 0.85<Ca<0.99: 3g
  – <0.84: 4g

• Magnesium (Goal >2)
  – IV: 1g for every 0.1 increase
  – PO: 100 mg magnesium oxide for every 0.1 increase (will give diarrhea)

• Phosphorus (Goal >3)
  – IV: Kphos or Naphos
  – PO: sodium/potassium phosphate tablets or packets
Dropping a Slip

- Essential items/info for dropping a slip
  - 2 Patient Label Stickers
  - Attending Name
  - Diagnosis
  - Operation & CPT Code
  - Special Equipment
  - CONTACT INFO

- Go to OR Front Desk on 2nd Floor to drop it off

- Slips can also be printed from Forms Portal
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</table>
How to find CPT codes

• CPTs
  – Code binder by scheduling forms
  – Code book at OR desk
  – GOOGLE
  – OR Scheduling Forms for previous surgeries
Forms Portal

- http://www.mednet.ucla.edu/
Logging Cases

• KEEP the patient labels
• Write the procedure on the label, make sure date and attending are correct
• Don’t lose the labels
• ALL cases/procedures should be logged in the ACGME Case Log
  – You also should log central lines, CTs, etc.
• Log ALL cases where you are the 1st assist as “SURGEON JUNIOR”
• Only log cases under “Major Codes”
• Make a favorites list in the ACGME Log
Mobile logging
Case Entry

Resident
Russell, Tara

Institution
-- Select --

Case ID

Resident Year of Case
1

Case Date
6/17/2014

Resident Role
-- Select --
Computer logging
Call Schedules

It’s ONLY YOUR responsibility to know when you’re on call

– You must email Chi and Desiree if you want to make a change to this schedule
How Does Call Work?

### CALL - General Surgery Pool

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<tbody>
<tr>
<td>U</td>
<td>C</td>
<td>Vasc</td>
<td>OP</td>
<td>Thor</td>
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### CALL - Subspecialty Pool

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<tbody>
<tr>
<td>ENT</td>
<td>Urology</td>
<td>NS1</td>
<td>NS2</td>
<td>Plastic</td>
<td>ENT</td>
<td>N1</td>
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<td>Urology</td>
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<td>NS2</td>
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<td>NS1</td>
<td>NS2</td>
<td>Plastic</td>
<td>Urology</td>
<td>N2</td>
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### Trauma Night Float System

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<tr>
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<th>Monday</th>
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<th>Thursday</th>
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<th>Saturday</th>
<th>Sunday</th>
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<tbody>
<tr>
<td>5a-5p</td>
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<tr>
<td>5p-5a</td>
<td>NF</td>
<td>NF</td>
<td>NF (8pm)</td>
<td>NF</td>
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<td>Ortho</td>
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<tr>
<td>5a-5p</td>
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Ortho/Peds: Fri 5am - Sat 5am  
L1/L2: Sat 5am - Sun 9am  
NF: Sun 9am - Mon 5am
How to Sign Out

• Print out list of patients...
  – Make sure your list has the following: Name, MRN, Rm #, Primary Problem, Attending
• Give On Call Resident’s Name, Phone Number, Pager
• Give a quick one-liner on each patient and what needs to be done
  – POD ___ s/p _____
  – F/U on CT A/P with contrast & get read
• Important things to include:
  – If you are concerned about patient
  – If Chief/On Call wants updates on patient
  – Odd patient exam findings
  – Labs/Imaging to follow-up and when they should be drawn and if On Call needs to know about them
  – Specific components of plan – i.e. Do not give IV pain meds
  – Indicate if patient tolerates abnormal vitals – tachycardia, hypotension
Help your cross cover intern out...

You will have already worked from 5a-5p and now you have to be in house for another 12 hours, covering 5 services and 40 patients....

- The ultimate goal should be to signout nothing
  - PM rounds!!
  - Get the CT scans done for your patients during the day so the night intern doesn’t have to chase down a read at midnight
  - Remove foleys in the AM so no void checks
  - If you want PM labs, check them at 2-3p
  - Clean up orders for your patients:
    - Are the patients home meds ordered?
    - Are there any expiring medications?
    - Are there labs ordered for the AM?
    - Are there unnecessary nursing communication orders?
Helpful Links

• Res.mednet.ucla.edu
  – Antibiotics guide
  – Internal medicine ➔ intern survival guide

• https://atyourserviceonline.ucop.edu/ayso/login.do
There is always someone in house!

• Trauma Junior: x76454, p95550
• Trauma Senior: x76455, p95551
Quick Things

• Big “things” during R1 year... Step 3, ABSITE, Research
  – Step 3: GS/Vasc VA, Peds, OP, SMH, CT/VA
  – ABSITE: Early January
  – Research: Levey award due end of May

• Loupes
  – End of the R1 Year
Questions!?!?!