Guide to Navigating PCMC Wards (without sinking)

1st edition
Starting Wards
Many of the patients you will care for on the ward teams at PCMC are quite complicated. It will benefit you, at least on your first ward rotation, to come to the hospital the evening before and familiarize yourself with the patients you will be picking up. Otherwise you may find it difficult to complete your pre-rounds in the a.m. prior to team rounds.

Pre-rounding
As a med student, you may have used some sort of system for pre-rounding such as cards or tables to keep track of patient information. The most efficient way to pre-round is to carry around daily notes and record the information in a skeleton form. If using this system to pre-round, you do not have to record the information in 2 places. The skeleton can be used to present patients at rounds and can be later filled in as your daily note. There is a skeleton note template on the shared drive (W:) at PCMC. Look in the folder labeled “SHARED” then the folder “residents”. The file is called “SOAP5”, and there is also a “bronchiolitisPN” that is helpful for respiratory patients. These notes can be printed or copied onto progress note paper (orange border). A sample skeleton is included in this packet. You may also make your own skeleton note.

Many interns write their tentative plans on post-it notes attached to their skeleton notes and fill in the final plan later. The post-its essentially serve as “to-do” lists for after rounds. Some others use an entirely separate sheet with multiple patients listed with check boxes under each patient name. Find the best system for you, but use a system.

It is helpful to have some sort of ongoing record of labs/studies for chronic or complicated patients outside of the progress notes. A helpful place to put this information is in patient tracker (the senior residents on the team frequently do this already). You may also want to have your own table/record of this information in whatever format you choose.

Steps in pre-rounding (loosely in this order)
1. Get checkout from the intern covering the night before (usually around 6 am).
2. When you arrive at a nursing pod to pre-round, find the bedside nurse for the patient and ask about any concerns or important updates about the patient. Reviewing nursing notes can be especially helpful if the bedside nurse is unavailable for verbal updates.
3. Obtain ranges of VS from flow sheets. Note times of fevers. Obtain fluid balance and calculate input in cc/kg/d and kcal/kg/d in selected cases (ex, FTT). UOP should be in cc/kg/hr. Stool in cc or grams/kg/d. Record output from all drains. Obtain daily weight and determine if the patient gained or lost weight. For respiratory patients, record frequency of NP (nasopharyngeal), BBG (baby booger grabber), or bulb suctioning and albuterol treatments, resp assessment scores or bronchiolitis scores and supplemental O2 need.
4. Read consult notes, including notes from nutrition and respiratory therapy (which are usually in the progress note section).
5. Review any orders that were written overnight as well as any cross cover notes. Sign verbal orders given to nursing by your cross-covering colleagues (yes, you may sign verbal orders given by someone else).
6. Review and record any labs from the computer lab databases. Don’t forget outstanding send out labs. Call the lab if necessary (x3100).
7. Obtain results of radiographic studies.
8. Review the MAR on a daily basis. Note frequency of prn med use and times antibiotics were started. D/c any prn meds that aren’t being used.
9. Examine the patient. Daily exams should be focused (heart, lungs, abdomen). Further exam should be directed based on the patient’s illness (neuro if the patient is admitted for mental status changes, skin if the patient is admitted for rash, etc.)
10. Talk with the patient/parent (if they are awake) about their concerns or observations. Introduce yourself; make sure they know you’re a doctor and your role on the team. Avoid yourself; make sure they know you’re a doctor and your role on the team. Avoid medical jargon when talking with families.

**Formal Rounds**

*Presenting a new patient*

H&P components: chief complaint, history of the present illness, medications and allergies, past medical, family, social, developmental, and immunization histories, review of systems, vital signs, oxygen saturation, weight, height, head circumference (all with percentiles), physical exam, labs, medical imaging, assessment, plan, discharge criteria.

Being concise is key in any presentation. Concise is not synonymous with brief. Concise means providing the important or key information without being verbose. Avoid editorializing. There is no need to provide information like the name of the child’s hamster (unless it’s humorous). It is important to note that there is a dog or cat in the home, however, if the child is having an asthma exacerbation. Events that occurred in the emergency department should be included in the HPI. Vitals should be interpreted, not just stated. Presentation of the physical examination should be limited to pertinent positives and negatives. Lab studies should be interpreted, not just stated. The goal of your presentation is to guide your listeners to the assessment at which you had already arrived.

You should not make a pause before presenting your assessment. A pause only gives your attending or senior resident the opportunity to interrupt you and steal your thunder. You should provide a list of differential diagnoses if the diagnosis is unclear, but this is not necessary if the diagnosis is certain. Your plan should be presented by systems, particularly in complicated patients. The plan can be the most difficult and intimidating part to present; you may not know what to do, or you may think that what you would like to do sounds stupid or is wrong. It is ok to say that you don’t know what to do as long as you have thought critically about the patient and come to that conclusion. Don’t worry about sounding stupid…we all do at times. Your plan may actually be very sound, and you’re just being paranoid, or better yet, you may have a great idea that no one else thought of that will save the patient. In that case, you also look like a genius.
**Presenting an old patient**

1.) The “one-liner”: this does not refer to a witty joke, but is actually a brief patient identification that reminds your listener who your patient is before you start talking about his/her stool output. Ex: “Brayden is a 4 month old boy with complex congenital heart disease admitted with respiratory distress.”

2.) 24 hour events: This includes “subjective” information as well as consults, procedures, med changes, trips to the ICU, etc. For respiratory patients include frequency and type (nasopharyngeal, BBG, bulb) of suctioning and bronchodilator administration. Report respiratory assessment/bronchiolitis scores.

3.) Vital signs. You may eventually be able to skim over this section in patients with normal or stable vitals, but you must prove your trustworthiness first. Interpret vitals and report ranges. Include O2 sats and amount of supplemental O2.

4.) Intake: Can be reported as total volume, cc/kg/day and kcal/kg/day, or even just as “adequate” in some patients (once again you have to prove yourself first). Kcal/kg/day is very important in failure to thrive/feeder grower type patients. Route (% po, IV, NG or NJ) should be reported.

5.) Output: UOP should be stated in cc/kg/hour (<1 cc/kg/hr is abnormal for a small child, < 0.5 cc/kg/hr is abnormal for an adolescent). Stool output in grams (cc)/kg/day (>20 g/kg/d is diarrhea for most patients). Total volume of emesis. Output from all drains.

6.) Fluid balance: Ins minus outs, reported as positive or negative. Very important for cardiac and renal patients.

7.) Weight: Crucial to report for feeder/grower or failure to thrive patients. Report gain or loss and how much (in grams).

8.) Physical exam: Usually limited and only pertinent findings should be presented. Present important findings related to the patients diagnosis like the appearance of the surgical wound in post-op patients, change in the murmur/liver size in cardiac patients, worsening or improving respiratory distress in an asthmatic, improving mental status or focal neuro findings in a seizure patient.

9.) Labs: Interpret them. For example, “blood gas: he has a mild uncompensated respiratory acidosis.” “CBC: he has a normocytic anemia.” You, of course, then must state the abnormal values, but at least you got your listener’s attention rather than having them zone during a string of meaningless numbers.

10.) Radiographic images: Report results of all imaging. You can also look at the films on the computers in the team room if they are interesting.

11.) Assessment: Not just a reiteration of the one-liner, but an assessment of how the patient is progressing. Ex: “Brayden’s respiratory distress is not due to CHF, but to RSV infection. He is improving with suctioning and supplemental O2.”

12.) Plan: By systems. Begin with the most greatly deranged system. For Brayden this would be respiratory not neurologic. Be brave and state your plan!
After rounds
This is the time to finish your daily work. Carry out tasks on patients discussed during rounds, call attendings you haven’t yet had the opportunity to talk with yet, have a donut and a second, third or fourth cup of coffee.

Unfortunately, this is the part of the morning when efficiency is most likely to falter, since it is the least structured; therefore:

Your tasks should be prioritized:

1. Get urgent matters regarding patient care taken care of (write orders for those antibiotics or that blood transfusion.)
2. Call consults (see later section on the nuances of doing this.)
3. Less urgent patient care matters (go by and see what color that baby’s poo really is).
4. Pee or other bodily functions prn (this could move to #1).
5. Donut and coffee; try not to get too distracted by the Caddyshack video playing in the lounge.
6. Contact attendings ASAP.
7. Finish notes (the skeletons should already exist from pre-rounding).
8. Multitask as much as possible.

Numbers 5, 6, 7 and 8 of these tasks can sometimes be carried out together from the comfort of the resident’s lounge or your team room. One important point to remember is to never page an attending and have nothing to do while waiting for the attending to call back (especially a GI doc). This is the time to complete your note skeletons, complete your checkout sheet, check your email, or catch up on Caddyshack trivia.

One fine day, you will become efficient enough, have few enough patients, or have come to the hospital way too early, that you will have some or all of your progress notes completed prior to rounds. If this ever happens to you, photocopy your note to bring to rounds and leave the real note in the chart with your pager number boldly emblazoned at the bottom by your legible name. This amazing feat of documentation may prompt the attending to page you instead of your having to page him or her.

Regarding Orders
When you write an order in the chart, make sure it is legible to other people besides yourself. Orders for medications should be written in total dose and milligrams per kilogram (ex. Cefuroxime 50 mg/kg = 200 mg IV q 8 hours). PRN meds must have an indication (ex. Tylenol 15 mg/kg = 60 mg po q 4 hrs prn fever). Radiographic studies must have a reason (ex. AP and lateral CXR—reason: hypoxia and respiratory distress). Sign your name (including MD) legibly and put your pager number after it. New orders should be shown to the bedside nurse and then taken to the clerk’s desk. There is a special place at each clerk’s desk to put charts with new orders (usually denoted by a small sign made from tape). Don’t let med students write orders without your immediate
signature or verbal order to an RN; sometimes the clerks will enter med student orders without an MD signature—very bad.

Our nurses here at PCMC are very gracious in accepting verbal orders. It is a JCHAO requirement that nurses read verbal orders back to you verbatim and then document that they have done so; please be patient while they do this. All verbal orders must be signed within 24 hours. You should make a point to sign all unsigned verbal orders in the chart during prerounding. It is perfectly acceptable to sign another physician’s verbal order.

### New Patients
You may receive the gift of a new patient from one of several places:

1. The ER—located on the first floor posterior to the glass elevator doors.
2. The PICU—located on the second floor. Too cryptic to explain location—follow signs.
3. Direct admission from “the outside” (they just mysteriously appear on the ward—the admitting resident will tell you what to do).
4. The NICU—4th floor near the Infant Unit. I, however, would recommend waiting until the patient comes out to the floor unless you’re accustomed to hanging around in a NICU. The oscillators can be scary and I’ve heard they can suck you in. **Never touch a baby in a NICU without asking permission from the bedside nurse!**
5. Subspecialty clinic—Mostly on the 1st floor on the “south end” which, if you have a compass, you will discover is actually east.
6. The RTU (Rapid treatment Unit)—24 hour observation unit located adjacent to the ED. The patients you will be accepting were not-so-rapidly treated and therefore failed 24 hour obs.

The admitting resident (pager number #6642) has the coveted job of assigning patients to interns. The admitting resident will call you to give you some brief yet crucial information about your new patient. After you find the patient (which you can do by using the trusty maps included in this packet) try to collect as much preliminary information as possible before actually initiating patient contact. This means reading the ED chart, PICU chart, looking at labs, x-rays etc. This advice goes against everything you were taught as a medical student…and it will not be the first time you will receive such advice. I assure you that this is the most efficient and considerate way to complete an admission. Sometimes the reason the child is being admitted has more to do with a test result rather than something you will find on H&P anyway. Parents frequently have little clue as to the details of happenings in the ICU’s; this info is better obtained from the chart. (Don’t worry, you will have an opportunity to play detective during your ED rotation.)

Also, by the time you see the patient and his/her family, you are likely the third, possibly even fourth or fifth person that has tried to extract the story in the same grueling fashion.
Confirm the story you obtained from your colleagues in a concise way with the family and ask them to fill in any missing details.

Exceptions to above advice:
1.) If the patient is very ill or likely to have acutely decompensated (a frequent occurrence in your most common admission in winter, the bronchiolitic) you should at least “eyeball” the patient prior to chart wrangling.
2.) The patient is a diagnostic dilemma or the story you heard from your colleagues was “fishy”. You should then try to extract your own story, since it may be very different from what you heard.

After you have completed information collection, talking with the family and examining the patient, discuss the plan with the family. If you don’t know the plan or feel uncomfortable discussing it, tell the family that you will discuss the case with the team and get back with them.

You now need to complete a written H&P. PCMC has a standardized green bordered form for H&P’s. They can be found at the clerk’s desks and in a cabinet above the resident work area in the ED. The form consists of 3 pages bound together at the bottom by carbon paper. The carbon facilitates name plate stamping on all 3 pages at once and should be removed before you begin writing on the form. The supervisory note section should be reserved for your senior resident who will be “staffing” the admission with you.

When you are nearing completion of your H&P and you have thoughtfully considered the patient problems and possible solutions, you should contact the admitting resident (#6642) who will be staffing the patient with you. After you discuss the patient with the admitting resident and the two of you have formulated a plan, you should contact the attending (see later section on contacting the elusive attending). Always introduce yourself to the attending using your full name and state your role (pediatric intern, family practice intern). Refrain from introducing yourself to an attending as “doctor” since this is annoying. The attending may or may not know important details about the patient when you call. In order to keep from annoying the attending at 3 am when you awaken them, after you introduce yourself, you should politely ask how much information they would like to know about the patient.

Your conversation should go something like (insert names in blanks)…..

“Hello Dr. ___________ this is _________ ___________ one of the pediatric interns. I’m calling regarding patient __________ __________ whom I am admitting from the ED at PCMC. I know that you have already spoken with the ED staff regarding this patient. How much information would you like to hear from me at this time?”

If the attending is a hospitalist and you are admitting the patient during the hours that most normal humans are not working or are sleeping, you may not need to call the attending at all. Check with the admitting resident to see if the hospitalist wants a call.
You should begin your admission orders after talking with the admitting resident. For the first few weeks of your internship (at least) you should not put admitting orders in the chart without first reviewing them with the senior resident.

More on admitting orders...
You can always use ADC VAN DIML...or you can use standardized admitting orders (the latter is the right choice).

PCMC has standardized admitting orders for a number of conditions including:
- Bronchiolitis
- Cystic Fibrosis
- Anorexia nervosa
- A variety of Heme/Onc problems

The standard admitting orders for the specific condition should be used when admitting a patient with that condition. There are an additional set of orders called “medical/surgical services admission/transfer order sheet” that should be used for all other admitting orders. This sheet can be used for patients admitted to Infant Unit, Med/surg or Neuroscience trauma regardless of its title. The order sheets can be obtained in the resident work area in the ED or at the ward clerk desks.

Accepting Patient Transfers
PICU and NICU transfers are done somewhat differently. For both types of these patients, nearly all of your information about the patient will be obtained from the chart. Prior to transfer, both PICU and NICU transfers should have transfer notes written by their care providers in those units describing the hospital course up until that point and any active issues. Transfer orders essentially serve as floor admission orders and should be written by the transferring, not the accepting, physician.

PICU transfer notes are handwritten by the transferring housestaff/practitioner. NICU transfer notes are printed notes from Clinical Workstation (an electronic medical record used by some groups within IHC) and can be somewhat difficult to decipher; usually the key information is found in these notes, however.

As the accepting intern, you are responsible for writing an accept note, which is a more concise version of the transfer note, and amending the transfer orders if needed. An accept note written on progress note paper and placed in this section of the chart. You should perform a full exam on PICU and NICU transfers.

Transition to the less intensive environment of the floor from an ICU setting can be difficult for some families. Chatting with them about what to expect in the new environment can be helpful.

RTU transfers are handled similarly to direct admissions and admissions from the ED. They need both a green-bordered H&P and admission orders. Some information for an
RTU transfer can be obtained from the chart, but it is important to confirm historical information with the patient/parent.

All types of transfers must also be staffed with a senior resident.

**Direct Admissions**
Direct admissions take precedence over other types of admissions since they arrive on the floor without being first evaluated in the emergency department. They usually come from their primary physician’s offices, but are sometimes transferred from another hospital. They have usually had little or no work-up or therapy initiated and can be more ill than reported. After evaluating a direct admission, try to complete admission orders ASAP in order to be helpful to the nursing staff and expedite care.

**Discharging a Patient**
A standardized discharge order form is placed in the patient’s chart on admission in the “discharge planning” section. The form has a purple border. This is the only form that may be used to write discharge orders. It has self-explanatory blanks to be filled in.

When writing out medication instructions on the discharge form, the instructions should be in a form understandable to patients. For example:

Amoxicillin (400 mg/ 5 ml) Take 5 ml by mouth 2 times per day

**NOT** Amoxicillin (400/5) 400 mg po bid.

If you write the instructions in the latter way, the nurses have to rewrite the instructions for the patient and the discharge sheet becomes very messy and difficult for the patient to read.

If the patient is admitted to the hospitalist on your team, a follow-up physician must be identified and contacted prior to discharge. This is your responsibility unless the hospitalist or your senior resident volunteers to perform this task. If the patient is discharged on a Saturday or Sunday, the follow-up physician’s answering service should be contacted and information given to the physician on call.

If your patient is somewhat complex or has home health needs such as oxygen or home IV antibiotics, the patient’s discharge planner will need to be involved. A d/c planner is an RN who specializes in arranging home health needs. The d/c planner name and contact number can be found on a sticker on the front of the chart. Each team usually has its own d/c planner and some special groups, like cystic fibrosis patients, have their own. Many times the d/c planner comes to rounds and is almost always very on top of things; s/he will usually identify d/c needs before the physicians do. It is best to involve the discharge planner ASAP as some home health needs may take an entire day or more to arrange.
If a patient has medical equipment needs such as supplemental O2, a nebulizer or pulse oximeter, a medical equipment prescription form must be filled out. These can be obtained from the clerk. The follow-up physician must be specified on the form as s/he will be responsible for managing the medical equipment once the patient is discharged.

The Discharge Summary
If a patient is hospitalized for 48 hours or greater, a discharge summary must be dictated on the hospital dictation system by the intern who primarily cared for the patient. If you are cross-covering for the weekend on a patient who was followed for 3 weeks by one of your colleagues, that colleague is responsible for dictating the discharge summary. Unfortunately medical records does not know this; you therefore must specify who will be dictating the discharge summary in the appointed blank on the discharge orders. Otherwise, you will be asked to dictate the summary merely because you signed the discharge orders.

A discharge summary should be dictated ASAP after the patient’s discharge. It is often not possible to do the dictation the same day due to other pressing matters weighing on you, and you may have a long list of delinquent dictations to complete after you finish your ward rotation. This is obviously not ideal; if you can bring yourself to dictate the summary closer to the time of d/c, it will not only be easier, since the details will be fresh in your mind, you will also not have to waste a perfectly good day off hanging out in the dictation room in medical records. It may also be more useful for posterity if the summary is completed in a timely fashion.

Medical records will provide you with a template that contains the requirements for dictating a discharge summary. They will also assign you an ID number and instructions on using the dictation system. One important thing to remember is that the hospital course should not be a daily blow-by-blow of every little thing that happened to the patient. It should truly be a summary of significant events. Complicated hospital courses should be arranged by system. When dictating the final discharge plan, names and dosages of discharge medications should be included (you will understand why the first time you use a discharge summary to help admit a frequent flyer with a laundry list of meds). The full name of the follow-up physician should be dictated as well as his or her phone number if available. The summary may be dictated “STAT” if necessary; stat dictations should turn around the same day. If you need a d/c summary particularly fast (ex. to send with the patient for his PMD) call medical records and let them know; they can sometimes get the transcription back in just under an hour. Don’t abuse the stat system.
Sign-out
Starting this academic year, interns will be using the web-based program “Patient Tracker” for sign-out. Patient tracker was a brilliant invention that allows residents and interns to keep an updated patient list that can be accessed from any computer in the hospital. Patient tracker is an efficient tool to organize and share important patient care information. You can log on to patient tracker using your internet/Help username and password. Patient tracker is found on the PCMC Intranet under the “Reference Library” Section. It is organized into a resident view and an intern view. This enables you and your senior resident to each create your own unique patient list with information that each of you needs to care for the patient. This is particularly important for the “to do” list, since yours will be more detailed than that of your senior.

The key to good sign-out is anticipation. Anticipate specific problems that could occur on your patient overnight and devise a concrete solution to share with your colleague. “_______ could happen. If it does, do __________.” If you ask a colleague to check a lab or an x-ray study, tell him or her what to do with the result.

In the era of work-hour restrictions, it is key to have a low threshold for signing-out patient care tasks which you have not had time to complete. This may (or may not) make you feel guilty; nonetheless, you must remain within your work hour restrictions and timely sign-out is key to achieving this. It is unacceptable to sign-out daily attending contact, documentation such as progress notes, and patient/family communication about sensitive care issues. Most other things can be signed out if necessary.

Going off-service
Prior to going off ward service, you must write, type or dictate an off-service note on the patients that you will pass off to your colleagues who are coming on to wards. This document should contain relatively detailed information about the patient’s hospital course up to the off-service date as well as ongoing problems/issues. It should be similar in content to a PICU transfer note. Dictating this note is kind to your colleagues as your off-service note (called an interim summary when dictating) will serve as the discharge summary for the time that you cared for the patient. If you dictate an interim summary, your colleague will only need to dictate the summary of the hospital course during the time that s/he cared for the patient. The interim summary will need to be dictated in a timely enough fashion so that it will be available for your colleagues to use when they come on service. The transcription turn around time is approximately 24 hours during weekdays and at least 48 hours on weekends. The summary may be dictated “STAT” if necessary to be available to your colleagues sooner.

What to do when the meconium hits the fan……
Sometimes patients crump. As an intern, you are not expected, nor should you try, to deal with a crumping patient independently. Call your senior resident, the admitting resident or the hospitalist to help you. If the patient is crumping hard and fast, call a code and help will descend upon you like a swarm of bees. (Usually the nurse one-ups you on the code. They have lightening-fast code-pushing fingers.).
You should also call your senior if you and a nurse have differing opinions regarding whether a patient is indeed crumping or not. Such disagreements almost always need an independent third party to resolve.

On occasion, you will hear the operator call a “code” over the hospital intercom. The word “code” will be followed by a color. “Blue” denotes a crashing patient and is the one you should be most concerned about. “Red” is a fire; you can generally ignore this one unless the building is burning down. “Pink” means someone stole a baby. You may generally ignore this one as well unless you see someone running down the hall with a baby; you can be a hero, or at least not hold the elevator door for them. “Yellow” is a disaster, and is usually a drill. Every able bodied pediatric doctor should go to the ED to help with mass casualties. Code yellow drills were common before the Olympics. Code brown will never be called overhead, but can be readily detected with the nose.

When a code blue is called, you should go, regardless of whether you’re wearing the code pager. If the patient is yours, you should stay and provide necessary information to the resuscitating team and do whatever else the code leader tells you to do (you may be the only person there who really knows anything about the patient). If the patient is not yours, there is another intern present to whom the patient belongs, and your presence is clearly adding to the chaos, then you should leave. You should always stay, however, if your assistance is required. If the code is a “mock code”, an exercise designed by the code committee to improve your code proficiency, you should stay to learn things. If you are the first responder to a code, you should do the ABC’s you learned in PALS or ACLS until a more experienced provider arrives, but do not stop your resuscitative measures until someone takes them over.

**How to Contact the Elusive Attending**

It is your responsibility to personally speak with the attending of each of your patients every day. This is a small sentence, but a big pain in the buttocks. If each of your patients has a different attending (not uncommon), contacting the attendings will be the most time-consuming portion of your workday. Best-case scenario: you have the names and phone numbers of all the attendings. You call or page them all once and they respond immediately. This requires perfect alignment of all the planets.

Reality: some of the attendings don’t call back right away because they’re busy with patients in their offices or because they’re skiing and aren’t getting good cell phone service in the canyon. Sometimes the name of the attending you have listed isn’t the attending who will be rounding that day. Large practices often have different people covering inpatients on random days of the week. How do you find that elusive attending?

There is no easy answer to this question, but there are some tricks. The primary operator (0 or ext. 2000) has office and answering service numbers for most of the community physicians that have admitting privileges at PCMC. They also have some pager numbers. If you call the office of the MD of record, the office staff or answering service can usually tell you who is rounding at primary on a given day and tell you how to contact
that person or put you directly in contact with them. Private attendings also frequently round early in the am and leave a note with their name and pager number at the bottom. Always contact the person who left the note, as this is your best chance of actually contacting the right person.

If the primary operator does not have the number of an outside attending, the ED clerks frequently will. They are usually willing to share this information with a polite resident. The ED extension is 2293.

The Medical Staff Office keeps a list of all the attendings that have privileges at PCMC with their contact numbers listed. This list is updated monthly. The senior residents sometimes keep a copy of this list in their call room.

You can also use the Qwest Dex Yellow Pages. There is a link on the PCMC Intranet.

I wish I knew a good trick to contacting an elusive GI doc…if you devise one, share it.

Subspecialists sometimes change service in the middle of the week, so you can’t assume that the same cardiologist that you talked to on Wednesday will be on service Thursday. Look on the call sheet or ask the operator for the doc on service that day.

**Calling Consults Unscathed**

Subspecialty consultants are notoriously intimidating (some more than others). When speaking with a subspecialist on the phone or in person, the consult requestee fears the snide comment, the reprimand, and the blow-off. Fortunately in pediatrics, most consultants are very nice. They are occasionally stressed due to excessive or intense clinical demands, and will be a little testy; a few are just like this by nature. Both of these statements particularly apply to cardiologists. Remember that when you are calling them to evaluate the murmur of your otherwise healthy patient, they may be struggling with an infant crashing in the ICU.

A call to a consultant requires a degree of mental preparation. Never page a consultant without thinking about what you will say to him or her first. You should not present the entire H&P to the consultant. S/he will be able to sort through the details when s/he does the consult. You should provide the consultant with enough information so that s/he feels the consult is justified. Always have a specific question to ask the consultant.

As an example, let’s call a cardiology consult for our patient Brayden:

“Hello Dr. Orsmond, I’m __________ _________, one of the pediatric/family practice interns. I’m calling to request a consult on a patient named Brayden ___________. He is a 4 month old with a history of truncus arteriosus status post repair. He was admitted last night due to respiratory distress and hypoxia. He has had some nasal congestion and cough for several days. He is not on any diuretics or other cardiac medications. He has been slightly tachycardic and quite tachypneic, but has normal blood pressures. On exam, he has a 3/6 systolic murmur and diffuse coarse crackles and wheezes in the lung fields. His liver is palpable 3 centimeters below the costal margin. He has good
perfusion. His CXR shows perihilar infiltrates and post-operative changes with borderline cardiomegaly. We have a viral respiratory panel pending, but were concerned that some of his respiratory distress could be due to a cardiac cause. Could you come by and evaluate him for heart failure? He is in room _______."

You can ask if they would like any studies ordered pending their evaluation. Many times cardiologists would like an EKG and CXR done before they do the consult, but not always, so it’s best to ask.

Try to call consults as early as possible, but after 8 am. Don’t call a consult without talking to the attending first. Hospitalist attendings in particular usually prefer to do some preliminary work-up before requesting a consult. Requesting a consult on the weekend is o.k., but should only be done if the patient would be harmed by waiting until a weekday, or if the discharge would be delayed. If a consult is requested late in the afternoon, it will likely not be done until the next day, unless the problem is urgent. Only urgent consults should be requested after 5 pm.

**Dealing with Stress**
1. Exercise regularly. (Ultimate Frisbee every Tuesday 6:30 pm Sunnyside park)
2. Don’t give up your hobbies.
3. Eat meals.
4. Stay well hydrated—you live in the desert; your brain will not be adequately perfused with diet coke.
5. Get to know the members of your ward team on a personal basis.
6. Sometimes be the complainer, sometimes be the listener, sometimes be the optimist.
7. Remember that even if it’s hard, the work you do is important and valuable.
8. Others have survived.
9. If someone is mean to you, make a small voodoo doll and...you know what to do.
10. Never blame the chief residents or the hospitalists.

**Physician/Nurse Communication**
Physicians and nurses share a common goal, the health and well being of their patient. Nonetheless, there are sometimes disagreements amongst health care professionals about the best way to meet this goal. Professionals should always be civil in trying to solve their disagreements, and when needed, involve a third party (as above).

Much of your work as an intern will be directly communicating with nurses regarding patient care issues; you, therefore, would like this part of your work to be enjoyable. The best way to make this enjoyable is to always be nice. Nurses only call for 2 reasons: they are concerned about their patient and need something from you in order to alleviate their concern or because you asked them to call if certain things happened to the patient (fever, low urine output, oxygen requirement). Sometimes you are not as concerned when they are; despite your apparent lack of concern they keep calling you. You find this frustrating, but you have to remember that it is a nurse’s job to advocate for the patient. If this situation occurs (and it will) ask yourself 2 questions: 1. Am I wrong? 2. Did I explain the reasoning for my actions adequately?
Charge nurses are special nurses with more experience who supervise the other nurses. At this stage of the game, they probably know more pediatrics than you do, so take their input seriously.

Since we often don’t do bedside rounds at PCMC, the nurses are often left out of the loop regarding the plan of care. Make a point to talk with them about it; you will likely receive fewer calls if you have their buy in or a stupid plan may be thwarted thanks to their input. Also make a point during pre rounds to ask the nurse about any overnight events or concerns they have.

The most important thing, though, is to be nice.

**Random Telecommunications Tips**
Whenever you page someone, always put your pager number in after you enter the call back number. (Enter the call back number, then *, then your pager number.) If you have a pager number that begins with 339, enter the entire pager number. Entering you pager number allows the person to know that an MD is calling them, and will also allow them to page you later if they are unable to return the call right away.

If you page an attending or consultant who does not work inside PCMC or who works at multiple hospitals (ex. community attendings, geneticists, or many surgical residents), always enter the entire call back number including 588 and not just the last 4 digits.

*Never* page someone to your pager number. This is very rude.

Wait for 5 minutes for someone to return a call after you page, then page again. If they don’t return your call after another 5 minutes, you may need to seek an alternative solution to your problem.

All the phones at PCMC are equipped with speaker phones. Most of the phones do not allow you to communicate into the phone through the speaker, but you can hear what’s on the line (there are special phones that secretary and administrator types have that allow you to speak into the phone; they are larger than the usual phones). The speaker is activated merely by pressing the button beside the extension number. This is extremely useful when you are paging someone, since you don’t have to use the receiver, and when you are put on hold, since you may hang up the receiver and still listen. You may also hang up by pressing the button beside the extension number. If you would like to learn to use the phone system expertly, sit with the admitting resident for a while during a busy afternoon and just watch.

Most phones at PCMC have at least 2 extensions. Only the number listed on the phone at the bottom actually rings to that particular phone. Make sure you know which phone will ring before you page someone to an extension.
All PCMC extensions have a prefix of “588”. You need only enter the last 4 digits to call inside the hospital. Extensions which have the last 4 digits beginning with 5 may not be called from outside the hospital (ex. 588-5874, the extension outside classroom C). Do not page an attending (or anyone) that may be outside the hospital to one of these numbers. You may have the operator page the attending (with you holding) if you need to use one of these extensions. Likewise do not page anyone to a forwarded extension; these extensions have rapidly flashing lights beside the extension number and ring some other place.

To place a call on hold, press the “hold” button and hang up the receiver.

To pick an extension other than the one listed at the bottom, you may either press the button beside the extension number, or you may use the “pick” button if the extension is not listed. Pick up the receiver, hit “pick” and then the last 4 digits of the extension. If someone is on hold for you there, say hello.

There is a button on each phone called “camp”. If you call an extension that is busy, press the camp button and hang up the receiver. When the extension is no longer busy, both that extension and yours will ring. Using camp prevents you from needing to call a busy extension over and over again until it’s no longer busy.

It’s best to let nurses transfer calls; trust me. It’s also best to not answer a ringing phone at a nursing pod unless you paged someone or a nurse asks you to.

The operators are your friends and great resources. Be nice to them and they’ll help you out.

**Text Paging**

Text paging can be accomplished most easily by using [www.myairmail.com](http://www.myairmail.com). If you are paging a peds resident, a list of names in alphabetical order by first name, can be obtained by entering `uuped` into both the username and password box. A list of hospitalists can be obtained by entering `uupimps` into both. Anyone with a Verizon Wireless alpha-numeric pager can be text paged by entering the area code and pager number (without dashes) in the “To” box. Text pages are acceptable ways to communicate as long as you are certain that the individual possesses an alpha-numeric pager. Text-pages should not be used to communicate urgent matters, since you cannot be sure that the individual received the page unless you receive a call back. Text pages should not be used to request consults or as your only form of daily communication with an attending.

An alternative text paging method is by e-mail. Enter the area code and pager number (no dashes) followed by `@myairmail.com` into the “To” box. Enter the text as the body of the message and then hit send. Practice text paging on your own pager before you try to communicate important information by this method.
**Computer Stuff**

There are several computer programs that will be helpful to you while you are on wards. A detailed description of the how-to’s is beyond the scope of this already too-long document. Most of the programs are self-explanatory, or get someone to help you:

1. **Help system (previously known as Tandem)**—Web based program for finding labs, radiology reports, dictated summaries, inpatient medications, and some other things. Nursing staff and clerks can enter orders through this system. Overall, it’s a little less self explanatory than Help 2, but once you learn to use it, it offers some efficiency benefits over Help 2.

2. **Help 2 (aka Results Review)**—Web based program for finding labs, radiology reports, and dictated summaries. The main benefits of this system include access to reports from all IHC hospitals. If your patient was seen at McKaydee hospital and you need lab reports from that visit, they will be available on Results Review. You can also view actual radiology images rather than just the reports as long as the appropriate software is installed on the computer. Results Review can be used from facilities outside IHC as long as you have a token that gives you a continuously changing PIN number required in addition to your password for increased security. This system also does other exciting things for IT minded individuals, but most people will just use it for the above reasons.

3. **PCMC Intranet/Internet**—When you click on the Internet Explorer icon at PCMC, the PCMC intranet page comes up as the home page. There are many helpful links which you can explore. The one that you will use most commonly is the Reference Library. There are a few links listed under the Reference library heading that are helpful electronic resources, but if you actually click on the purple reference library bar, there are lots of other helpful links within. Try exploring the reference library at your leisure. Resident rotation resources (within ref library) contains educational information hand picked by the course directors of the various subspecialties. There is also a PCMC phone directory that may be helpful at times, but does not contain pager numbers of faculty or subspecialists.

   The intranet can unfortunately, not be accessed from outside of PCMC.

   Inside PCMC, the internet is accessed from the intranet home page. In order to access the internet, you need a login and password to get past the firewall.

4. **Web Server (Xray)**—Web based program to visualize radiology images. Denoted by a little skull on the desktop. There are large monitors located in the team rooms for the purposes of effectively looking at these images. This program requires a separate password that needs to be obtained from Darin Day in radiology (x2507).

5. **Folio**—Folio is a program installed on all the computers at the nursing stations that contains all clinical protocols used at PCMC. This program can be somewhat difficult to navigate, but most of the nursing staff are trained to use Folio and can help you. You will need this program infrequently and possibly never, but it’s helpful to know that it exists.
Information such as how quickly a potassium infusion can be run on the floor and the details of the bronchiolitis CPAP protocol can be found here. This program does not need a password.

6. Email—If you are a pediatric or University family practice intern, you have been assigned a University Groupwise email account that has its own unique username and password. Try to establish a habit of checking this email on a regular basis even if you have some other type of account. The chiefs and residency coordinators like to communicate by email and you will miss lots of important announcements if you do not check your email. Your university email account cannot be accessed by clicking on the groupwise icon on the PCMC computers as this is a separate groupwise system. You must use Novell Web Access, which is already listed as a link under favorites on all the team room and resident lounge computers. It can also be accessed through the following two URLs: umed.med.utah.edu or remote.med.utah.edu. Click on the links for either groupwise web access or web email access.

7. Patient Tracker—A web based program that organizes patients by teams and contains information interns, residents and attendings find useful in caring for patients. The interns and residents are responsible for maintaining the information in patient tracker. This information is used by the residents and interns for their signout (see Sign-Out section above). Since patient tracker is web-based, it can be accessed from any computer in the hospital. Patient tracker, like the PCMC intranet, cannot be accessed from outside the hospital. Patient tracker also assists in nurse/physician communication, since the nursing staff can also log on to patient tracker and see what you’ve been thinking. The nursing staff are responsible for entering a patient assessment in patient tracker every 12 hours. The housestaff are responsible for entering discharge criteria into patient tracker. If, during a nursing assessment, the nurse feels that the patient has met discharge criteria, s/he flags the patient as “awaiting team response” regarding appropriateness of discharge. This system is designed to expedite discharge, as a physician is theoretically alerted to the patient’s condition more frequently than every 24 hours during rounds. Drs. Clark and Maloney frequently peruse Patient Tracker information, so be careful what you enter.

Computer problems? Call PCMC Computer support (x3456). This includes log-in problems for any program that uses “pc”, your first initial and your last name. This does not include Web-server (the x-ray program). The computer guys live on the 4th floor fairly close to the resident’s lounge if you need to speak to them in person. This Information Technology area is also where you fill out requests for passwords (except for Web Server).

About logging in.....your login/password for Help, Results Review, Patient tracker and the internet (IHC proxy) are all the same (the “pc” one). Web server and University logins are different. Contact the University computer support regarding University computer logins.
Things to Ponder…

Sir William Osler 1849—1919

Take the sum of human achievement in action, in science, in art, in literature—subtract the work of the men above forty, and while we should miss great treasures, even priceless treasures, we would practically be where we are today….The effective, moving, vitalizing work of the world is done between the ages of twenty-five and forty.

Things cannot always go your way. Learn to accept in silence the minor aggravations, cultivate the gift of taciturnity and consume your own smoke with an extra draught of hard work, so that those about you may not be annoyed with the dust and soot of your complaints.

Hippocrates 460—377 B.C.

Life is short, the art long, opportunity fleeting, experiment treacherous, judgment difficult.

Herodotus 485—425 B.C.

If a man insisted always on being serious, and never allowed himself a bit of fun and relaxation, he would go mad or become unstable without knowing it.

Not snow, no, nor rain, nor heat, nor night keeps them from accomplishing their appointed courses with all speed. (regarding interns and mailmen)

Jay Berry, recent grad, still alive

Dude.