RESIDENTS' GUIDE

Department of Internal Medicine
Lincoln Medical Center

These guidelines were compiled from several resources at the time of review, however are not a substitute for good clinical knowledge, judgment and expertise for individual patients.

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RESPONSIBILTIES BY POST-GRADUATE YEAR

Role of CMR:

In our institution, this is a PGY-3 year focused on administrative and academic responsibilities. It it's a year to enhance leadership, management and teaching skills.
The chief residents act as the liaison between the department of medicine and the residents. They are advocates for residents' issues and are the first ones with whom residents should discuss any complaints or suggestions regarding the residency program or institution in a confidential and respectful manner. They are the direct supervisors to whom residents should report to.

Duties of the chief residents are:

- Yearly and monthly schedules
- Organizing didactics for residents and students (morning report, noon conference)
- Teaching residents and students by bedside, SIM lab, etc.
- Conflict resolution
- Counseling
- Coordinate mentoring program along with Attendings
- Promote and coordinate scholarly activities together with research assistants, IRB and attendings in the RST (research stewardship team) motivating residents to publish in journals as well as to compete in different meetings.
- Participate in quality improvement projects
- Be a source of institutional and departmental information
- Assist to GMEC meeting, GME CIR meetings and dept. of Medicine meeting
- Coordinate with other departments Chiefs rotators as well as address any issues involving residents from other specialties

Role of PGY3:

- The PGY3's are the most senior residents in our internal medicine program and their role is mostly as leaders of the team they are working with. PGY3's will mostly cover the floors in the first 2 rotations and some will act as junior attending of a team.
- PGY3's rotate in all medical specialties. They are the medical admitting residents (MAR - a rotation where they receive admission for the internal medicine department) and the leader of the MICU teams.

Role of PGY2:

The PGY2's are senior residents on the floors.
Remember:

- Leadership: Backup intern's presentation/work. Teach them and discuss/ admission/ daily/discharge plan for each patient
- Know the orders: Reason for every medication, be aware of days of antibiotics, titrate antihypertensives and diabetes meds
- Make a plan
- Review/correct PGY1 notes: HPI/ DC summaries
- Ensure admission and discharge medication reconciliations
- Review & follow-up consults and attending notes
- Update problem list, only current diagnosis

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- Communicate with specialist
- Interaction, ask questions. *Speak up!*
- Supervise sign-outs
- Supervise bed-side procedures
- Build up team spirit and resolve minor conflicts within team
- Watch out possible sings of interns' burn-out and address in time (There is no harm of over-precaution)

Role of PGY1: The PGY1 is the primary care physician responsible for the care of the patient in the inpatient or outpatient setting.

- H&P
- Discharge summaries
- Examine patients daily
- Progress Notes: quality not quantity, to reflect the plan. Required 6 days/week; 9B patients 7 days/week
- Plan should be written/finalized after discussion with the Attending
- Prepare to have own plans for the patients ready for discussion with attendings during rounds
- Patient's morning and/or admission presentations with relevant history, physical examination and Laboratory/ Radiological results. Give your own "Assessment and plan"
- Know your patients every morning for "SOAP" oral presentation during rounds
- Avoid unauthorized abbreviations in your notes
- Reflect education to patient
- Early SW notification. Home Care forms before noon.
- Communicate with patients and staff
- Discharge script
- Notify and get information from PCP, please document on patient info field: Name, information, next appointment
- Document your call to PCP
- Know all your team patients, not only your patients
- If it is not documented it did not happen!
- Don't leave notes partial. Notes have to be complete and accepted in 24 hours
- Students will be assigned to a PGY1 who is directly responsible of his/her notes and education.

Pricinpal Objectives For Floor Rotation

- PRIORITIZE PATIENT'S SAFETY.
- Team work, Caring, Organization, Communication
- Examine patients everyday as often as needed. Status can change quickly
- All the patients are everybody's patients!!
- Reconcile medications on discharge prescriptions & contact PCP

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FLOOR SCHEDULE

Regular Schedule:

- 7am to 4pm
- Morning report: 8AM to 9AM (Mon & Tues – to be presented by night PGY2s and Thursday by 2 floor teams for each week, MICU report on Wednesdays)
- Grand rounds: Friday 8AM to 9AM, in the main auditorium
- Noon conference or Simulation sessions 12PM to 1PM
- Sign out: 4PM

Floor teams:

Regular floor team:

- 1 attending physician, 1 second year, 3 interns, medical students vary (usually 2-3), and PGY3 Junior attending occasionally
- Team is on call every day. Second year of the team will be on call till 8:00PM
- Regular intern admits every third day from 7:00 AM to 7:00PM

Night float team:

- Consists of 2 second years and 4 interns
- Schedule: 8:00PM to 9AM, 6 nights a week, is off from 9AM on Saturday till 8:00PM on Sunday
- Admits from 8:00PM to 5:30AM
- Night float second years present the admissions in the morning report 8 AM-9AM (Monday and Tuesday, occasionally Friday)
- Night float residents should leave the hospital by 9AM after proper sign out to the day teams

Weekend coverage:

- Weekend floor call timings are from 7 am to 8 pm and 8 pm to 7 am
- The intern will round with the primary attending if he/she is here. If not, the intern will discuss the old patients with the primary attending by phone, will round with the on-call attending for 9B patients, and will round with the “paired attending” for the new admissions from previous call.
- Each patient should have 6 notes in a week, notes for half of the patients in regular floors to be done by the intern on Saturday and notes for the other half of the patients to be done by the intern on Sunday
- All 9B patients need to have daily notes.
- The intern will start admitting by 12 noon. All admissions before 12 noon will be written and admitted by PGY2s. Two of the PGY2 will be on long call; one will be on short call until 12 noon.
- Short-call PGY2 gives sign out to on-call PGY1 after 12 PM.

Backup Sick calls:

- There will be a schedule for backup calls every month
- Residents oncall as a backup are expected to come to work within 60 minutes of being called by the CMR

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- If a resident who is scheduled for a backup and was called for coverage but didn't show up, the resident will receive a memo from the program director and will be considered as absent and has one extra negative credit
- Residents are eligible to receive monetary reimbursement when they cover sick residents call by filing the proper forms IF they have no negative credit

Holidays Coverage:

- Any resident who works on hospital/CIR recognized holidays will be eligible to receive monetary compensation as per CIR/hospital protocol. This include calls of floor coverage shifts
- During established holidays, residents on electives are not expected to work. ICU residents will work full shifts and receive money reimbursement. Floor residents will work a half day if not on call and still receive monetary reimbursement.

Sign-out at 4PM:

- The sign out must start at 4PM, not before!
- For the PGY-1s and PGY-2's that are in the afternoon clinic, they must sign out to the oncall PGY1 before going to their clinics
- The intern will sign out all patients to the on call interns
- PGY-2 will be physically present and supervise sign-out with interns.

Sign-out at 8PM:

- The sign out must start at 8PM sharp.
- Seniors (On-call PGY-2, Hospitalist or Attending) supervise each intern's sign out.

Working Nights:

- Working nights can be difficult physically and emotionally. Try to limit sleep deprivation.
- Limit caffeine late in the shift because you may have trouble falling asleep when you get home.
- Stick to a regular sleep-wake schedule as much as you can.
- Limit phone calls and visitors during your sleep hours.
- Use blackout blinds or heavy curtains to block sunlight when you sleep during the day.
- Try to arrange things in your life around the 2 weeks of nights. Don't stop to run errands, make a lot of plans during the day, etc.
- Focus on getting enough sleep

Caps for Admissions:

- PGY-1 will admit 5 NEW patients excluding ICU transfers
- PGY-2 will supervise 10 admissions
- After an intern has admitted 5 new patients with PGY-2 supervision, the sixth and seventh admissions will be admitted by PGY-2 and directly supervised by the hospitalist on call
- Additional patients will be admitted by the MAR with the hospitalist on call until they can be assigned to the day teams. It will be the responsibility of the MAR to initiate the above rule for the night float.

Cap on the patients cared for on the inpatient unit:

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- PGY1 can be responsible for the care of up to 10 patients on daily basis, excluding cross coverage (other interns in clinics) and calls
- PGY2 can be responsible for the care of up to 20 patients on daily basis. Beyond 20 patients, interns will communicate directly with the hospitalist.

WELLNESS AND TIME OFF:

As per ABIM, residents need 33 months of clinical training to be eligible for ABIM exam. Any shorter duration needs to be approved by the program director and ABIM after meeting certain criteria as per the guidelines. This process is not guaranteed.

- Wellness days:
    - Every resident has up to 3 days per year
    - Resdients should notify the CMR 30 days in advance
    - Personal days are not allowed more than one at a time, before and after vacation, the first day of rotation, before and after a holiday, and during night rotation
    - Resident should inform the primary team including the attending for their upcoming scheduled personal days at the beginning of the rotation
    - Resident can use 2 days of their unused personal days as sick days payback

- Sick/absence days:
    - Resident have unlimited sick days. All have to be paid back
    - If sick days can't be paid backfor any reason, resident training will be extended accordingly
    - A note from medical provider is needed for more than 2 consecutive sick days
    - Resident needs to inform the CMR, primary team and primary attending on their day of absence
    - Sick days will be paid back by doing extra calls as scheduled by the CMRs
    - Residents with the highest negative credits will be the first to be as a backup call
    - Residents should have Zero balance by march 31st of every year

- Conferences:
    - All conferences have to be preapproved by the CMR and program director
    - Conferences days are exempted from payback if the resident is to present
    - Conferences expenses can be reimbursed after following the proper procedures
    - PGY3 residents have 3 GMe days which can be used for conferences, interviews or board review ocurse

- Interviews:
    - There are unlimited number of interview days allowed. All have to be paid back
    - All interview days have to be preapproved by the CMR
    - Residents have to inform the primary team and attending in advance regarding their interview days
    - Residents who are conducting virtual interviews on the hospital premises and lasts half a day or less, don't need to be paidback as long as there is no need for service coverage

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CHART REVIEW

- Prior to seeing the patient, the EMR has to be reviewed to have a general idea of the patient's condition. Try to develop your own differentials.
- Review the following:
  - Triage ED MD notes, EMS report in the media section.
  - Vitals
  - Labs (check if any other labs that will need to be sent after examining the patient)
  - Last HIV test
  - EKG (if not uploaded, check in the chart)
  - Radiology: chest x-ray, CT, US
  - Other related ancillary tests: GI, pulmonary, cardiology
  - Problem list
  - Clinic note
  - Previous H&P, discharge summary
  - Advance directives
  - Home meds (if patient follows up in medicine clinic or has a recent discharge, check in prescriptions or discharging)
  - Previous consults and current consults
  - Medications received in the ER by the patient
  - Contact precautions (check microbiology for C.diff or abnormal cultures)
  - Allergies
  - EMS sheet in the paper chart/ scanned into EMR (in scanned charts #80)

DOCUMENTATION

Do not copy and paste!!

Other hospitals, health workers, patients, and families are able to see everything you write in the medical record

History and Physical:

A) Documenting H&P: History and physical documentation should be completed within 24 hours of starting the note

- Informant: Choose appropriate entry
- Method of communication:
  - Preferred Language
  - If cyracom used, note the interpreter ID
- Chief complaint: Mention the patient's chief complaint for admission
- HPI:
  - Describe each symptom in detail
  - Pertinent negative

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- PMH/ Surgical/ Psychiatric:
  - List all past medical and surgical history
  - Compliance with diet and medications must be mentioned
  - List out all the home medications with doses and frequency (optional)
- Social/ Family history
  - Describe the relevant social history in detail
  - Activities of daily living (ADLs), including baseline functional status
  - Home services including the number of hours should be mentioned
  - Always address substance/EtOH abuse to anticipate possible withdrawal during the hospital stay.
- Advance directives:
  - Always to initiate the conversation if patient is in the state to discuss or with the family member if patient does not have capacity.
  - Choose if the patient has advance directives or not
  - Choose the type of advance directives: Full code, DNR/DNI, DNR only with trial of intubation, HCP/Surrogate decision makers) (There is no DNI only.)
  - If code status is DNR, make sure DNR form is signed and uploaded to the Epic.
- Allergies:
  - Needs physician verification (Always ask for severity and document in the EPIC)
- Medication reconciliation: **It must be done for every patient, no exceptions!**
  - Changes made as compared to home meds
  - Document medication started/ held/ discontinued, dosage changes, give reason for the changes made
- Review of systems (10 fields required)
  - Document all complaints
  - Free text is preferred. Don't write it if you didn't do it…It is a fraud
  - Type 'Unable to obtain' in all fields if patient is unconscious/ delirious/ demented
- Physical examination (9 fields required)
  - All fields to be typed
  - If normal exam is chosen for a particular system, review whether the findings are appropriate
  - Write 'not performed' if a certain examination is not performed (rectal, breast, ears)
  - Monofilament test required in Diabetes mellitus
  - Decubiti/ Pressure ulcers to be documented on admission
- HIV screening:
  - Testing required every 6-12 months for every patient, even older patients if indicated
  - Verbal consent to be obtained during history taking and test to be ordered as add-on
- DVT assessment:
  - To be done for every patient, choose all appropriate conditions applicable to the patient
  - Order DVT prophylaxis based on the recommendations and mention whether ordered or not
  - Don't overuse DVT prophylaxis if the score is low
- Tobacco use: Choose if plan to stop. Always offer the patient nicotine patch during hospital stay.
- Lab, radiology and EKG:
  - Interpretation of labs, radiology and EKG relevant to the diagnosis
  - Do not click "reviewed"

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- No numbers to be placed, interpretation required

- Diagnosis/ Problem list:
  - Needs revision and clearing up of old issues, only current issues should be present
- Assessment and Plan:
  - Brief description of the patient
  - Give the most accurate diagnosis (Not Complaints) with reasoning and management
  - Avoid broad differential diagnosis
  - Address each abnormal investigation
  - Each problem should have etiology, duration, supporting labs and radiology, treatment plan
  - Do not copy and paste the HPI
  - Health management: diet, immunization
  - If the patient's current admission is a re-admission within the last 30 days, address the issue further
  - Code status
- Education:
  - Who was educated: patient/ family
  - Method: if unable- explain why, indicate if cyracom used
  - Learning evaluation
  - Need to enter what patient was educated about

B) Additional documentation for H&P for MICU:

"AFASTHUGER" must be addressed

- Advance directives: appropriate field to be chosen, important to have surrogate information in case patient is unable to make decisions
- Feeding: Choose appropriate choice based on the patient's current nutritional status
- Analgesia: If patient is started on analgesics
- Sedation: choose the appropriate answer, sedation vacation is not valid on admission but has to be done every day to assess neurological status of the patient, write the names of the medication that was started for sedation
- Thromboembolic treatment: Choose appropriate options
- Head end elevation: Choose whether ordered or not, if not ordered, explain the reason
- Ulcer prophylaxis: choose appropriate prophylaxis (H2 blocker if there is no specific indication to use PPI), if not required, choose 3 and explain the reason
- Always address I/O and bowel movement.
- Glycemic control: Choose appropriate options for the patient
- Education: Choose whether the patient's condition was discussed with family or the patient
- Restraints: Choose whether patient is on restraints or not and if on restraints, explain the reason

APACHE II score must be calculated for every patient admitted to MICU and it should be mentioned in the assessment and plan

C) Supplementing/ correcting:

- Additional information can to be supplemented or corrections can to be made to a completed H&P (H&P reviewed and accepted by the attending)

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- Go to 'Note Edit Previous/ Partial'
- Press 'Expand' at the bottom of the page, click on the appropriate document to be edited, press correct/ supplement and choose whether to correct or supplement and edit the appropriate field before accepting the note.

D) Patient's contact information:

- Patient's PCP with contact information, patient's family information and pharmacy information (if possible) must be obtained on admission and the patient's contact information field must be completed on admission

Progress note:

- It should be short and meaningful. Explain why the patient is still here. Address the primary issue and any other new complaints. Don't repeat all details from the H&P.
- **It should be written in a diagnosis based style, not system based.**

Discharge summary:

- 24 hour discharge notice to the patient
- Do discharge prescriptions first then discharge orders before starting the discharge summary
- Do not put 'Discharge Patient' order until patient is physically ready to leave.
- If the discharge summary is needed for the social worker prior to patient's discharge, do it and accept the note as "pending"
- On the day of discharge, complete the discharge prescriptions and orders first and then complete rest of the fields in the discharge summary
- Discharge summaries need to be started (can be pending) the day before the anticipated discharge so that the patient can be discharged before 12 noon on the day of discharge
- DC summary visit should be completed within 24 hours of patient discharge
- DC Script: Discuss with the patient all relevant diagnoses and information including medications, appointments and needed tests on the day of discharge
- Always write important education in the patient's instruction section so that will appear in AVS (After Visit Summary) and patient can see.
- Include palliative discharge summary.

- **Documenting the discharge summary:**
  - Admitting problem: same as in H&P
  - Please choose the right diagnosis, it is extremely important
  - Hospital course: **Do not repeat H&P**
  - DNR/ DNI status should be mentioned in bold in the beginning of the hospital course
  - Document primary and secondary diagnosis and the relevant hospital course for each diagnosis, be concise
  - Discharge medications: Include a list of all discharge medication with doses, frequency and special instructions. In case of discharge to nursing home, include all current orders to be followed in the nursing home
  - Medication reconciliation: Mention changes in medications as compared to home medications

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- Update the DC summary after each revision of medication reconcillioation or new developments related to patient care
- PCP and follow up: Mention whether the patient's PCP was contacted or not. Document all the follow up appointments given to the patient
- Disposition- discharge to where and with whom
- Education, including diagnosis, follow up plan, activity, lifestyle modifications, care-plan notes given
- Compliance review: All fields have to be completed, if not present, choose NO.
- Final diagnosis: Primary diagnosis
- Medical student: Write the name of the medical student if the discharge summary is done by the medical student
- Must be completed by the resident if the discharge summary is done by a medical student

Transfer to other services:

- Discharge summary must be written for patients who are transferred to psychiatry but ensure to write DC orders to Psych floor, not to home. For other services, a transfer note will suffice.

Transfer from other services:

- H&P is required for transfer of patients from Psychiatry. For transfer from all other services, a transfer note will suffice.

Transfers and acceptance from floors to MICU and vice-versa:

- For transfers, use transfer/ off service notes
- In the assessment and plan, document the entire hospital course with the assessment and plan
- Complete the rest of the note
- For acceptance notes, start a progress note and document the entire hospital course and the plan.

Off-service note:

- At the end of the rotation, write an off-service note instead of a regular progress note on the last day of the rotation
- It should include the hospital course and plan for the patient and any follow up issues for the next team to follow

Short on-call note:

- Use SBAR format for the note
- Document Situation, Background of the patient, Assessment, Recommendation and plan for the patient

Abbreviations:

- A list of approved abbreviations and do-not-use abbreviations are available at:
- http://intranet.genplus.nychhc.org/abbreviations/abbrev_listing_2012_Lin.pdf

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- http://intranet.genplus.nychhc.org/abbreviations/Do_Not_Use_Abbreviations.pdf

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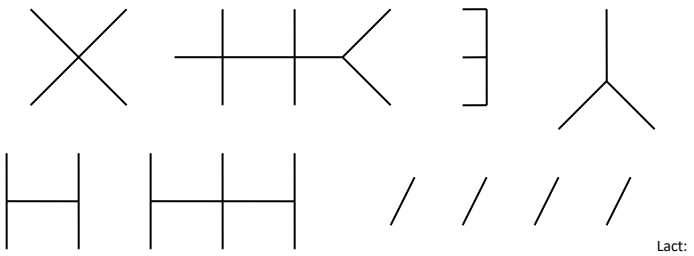
H&P Template

Date: Nº: Attending: Location:

Name: MR# Age/Sex: M/F EMS: CC: VS: T PR BP RR OSat FS Triage: VS: T PR BP RR OSat FS ED MD notes: ED Meds:	Labs MCV: Agap: - - -  Lact: UA: Trop: Amylase/Lipase: CPK: BCx/UCx:
HPI: VS: T PR BP RR OSat FS T /Alc / ID HIV: HAART: CD4: Lives with: HS:	Imaging/Procedures/EKG's CXR: PF: CT: MRI: USG/Echo: EKG's: Cardiac Cath: Stress test: EGD: Colonoscopy: FOBT: Mammogram: Dexa: PFT: PCP:

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PMH: Allergy:

- Meds:

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-

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FH/SH/Vaccines:

Review of systems:

Physical exam:

General:

Psy:

Head:

Neuro:

Respiratory:

Cardiovascular:

Abdomen:

GU:

Extremities:

A/P:

-

-

-

-

-

-

Fluids/Meds:

Advance directive/DNR/DNI:

Telemetry:

Diet: VS/Accucheck/Neurockeck/1:1

Isolation: Fall/Seizure precaution/ Visual impairment

DVT prophylaxis: Hep/Venodyne/Early ambulation

Labs/Imaging/Procedure/EKG:

Previous/future consults:

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Assessment and Plan	

jcfr/Lincoln Hospital/10/03/2010

Discharge planning:

- Primary diagnosis and care
- Secondary diagnosis and care
- Meds to continue
- Changes in medications
- Follow up appointments
- Supplies (i.e. BP kit, glucometer)
- Diet
- Activity and lifestyle modifications
- Education/Patient information (from up to date)
- Does the patient need prescriptions?

CONSENTS

- Use pre-printed consent forms only
- Use English forms for English-speaking patients and Spanish forms for Spanish speaking patients.
- All consent forms will be available in the nurses station and online
- Patient's label must be pasted on the consent forms
- The risks and side-effects, benefits, alternatives, risks related to not receiving the procedure must be explained to the patient in the patient's primary requested language only
- Interpreter or cyracom could be used, signature of the interpreter must be documented
- The consents have to be witnessed by the nurse and the name, signature, date and time to be documented on the consent by the nurse. The nurse has to be informed before the patient is approached for a consent.
- Patient has to sign, date and time the consent
- If the patient cannot sign, health care agent can sign the consent (copy of the authorizing document for health care agent or legal guardian should be placed in the paper chart)
- If the patient cannot makes decisions for himself/herself and does not have a health care proxy, consent should be obtained from a surrogate

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- Telephone consents from health care agents or surrogates can be obtained if the patient is unable to consent. Telephone consent must be witnessed by the nurse and the person consenting should be verified by the nurse.
- The attending's and resident's name and signature must be present on the consent
- If the patient is unable to make decisions for himself, an additional signature by the attending is required on the form
- Consents are to be taken by the resident doing the procedure only (Ex: an intern cannot take a consent if the procedure is being done by PGY2)
- Consents for procedures done by other services cannot be taken by residents unless the resident is assisting in the procedure or is rotating in that service
- CTs with contrast do not need consents, the consent is implied in the general consent for treatment that's is completed on admission.
- MRIs need metal assessment questionnaires completed in the work list section.

ADVANCE DIRECTIVES

- Advance directives have to addressed at every admission
- Necessary forms have to be completed every admission

- Health care proxy:
  - If a patient has health care proxy, documentation has to be brought by the HCP and has to be put in the paper chart and scanned into EMR by clerk
  - If the patient wants to assign a health care proxy, guest relations has to be notified so that the necessary documentation can be completed

- DNR/ DNI:
  - Once the DNR/ DNI form is completed, Out-of-hospital DNR form also has to be completed
  - Orders are to be placed for DNR and out-of-hospital DNR
  - DNR forms should have patient's label pasted on the form

- Forms:

  - 'No emergency CPR adult patient with decisional capacity' form: It has to be signed by an attending and witnessed by another attending and resident/ nurse.
  - Everything else goes on one extra form
  - 'Out-of-hospital DNR' form has to be signed by an attending
  - Copy of the out-of-hospital DNR form has to be given to the patient or family members on discharge

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SIM LAB

- All residents will have regular activities in the simlab including procedures and scenarios. Residents will do multiple procedures on mannequins before doing procedures on live patients.

PROCEDURES

- The American Board of Internal Medicine requires a credentialing process for approval of procedures performed.
- Procedures must be performed under direct supervision of a physician privileged to do the procedure until certified as clinically competent to perform them under general supervision.
- Please note that the only way to certify that you are credentialed to perform a certain procedure is to have documentation for that in EMR - in the form of procedure note.
- Document your procedures in New Innovation with the correct supervising attending, the best way to track all procedures.
- All procedures except ABG/NGT/Foley/IV lines, require a procedure note regardless of how many you have done.
- POCUS: All studies have to be ordered in EPIC, read in QPath by the performing residents and attested by the supervising attendings.
- Upon graduating, residents will receive an attestation of all procedures they performed including POCUS. They will also receive an attestation of training in Hospitalst POCUS after meeting the criteria set by the program

- Procedures available:

  1. ABGs
  2. NGT/OGT
  3. Foleys
  4. IV lines
  5. LP
  6. Central Lines
  7. Intubations
  8. Arthrocentesis of knee
  9. Paracentesis
  10. Thoracentesis
  11. Bone marrow
  12. PAP smears
  13. Midline insertion
  14. Arterial lines

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TRANSFER TO BELLEVUE OR ANY OTHER H+H FACILITY: Call 1-844-HHC-BEDS

- Complete the discharge summary with a detailed hospital course and current orders
- Prepare discharge package and place all the documents in a yellow envelope with the patient's label attested
- Discharge package includes the following:
  - Discharge summary
  - History and physical
  - Attending's note on admission and discharge
  - All labs (trend them)
  - All consult notes
  - Vitals including FS
  - All radiology reports
  - Print outs of EKGs and relevant telemetry strips
  - Medication screen to be printed on a word document
  - Inter-institutional transportation form and Ambulette form

- Flag the discharge package with the transportation forms and discharge papers
- Place orders for discharge

DISCHARGE TO NURSING HOME

- PRI(Patient Review Instrument) should be requested by the social worker once the plan to send the patient to nursing home is confirmed
- Once the PRI is completed by the utilization nurse, it will be sent to all the nursing homes by the social worker
- The nursing homes will review the PRI and will inform the social worker on whether the patient is accepted by the nursing home or not
- Once the patient is accepted, insurance approval must be received
- Patient can be discharged to the nursing home once the patient's insurance approves of the transfer
- Discharge package has to be prepared prior to discharge
- The discharge summary must contain a detailed hospital course and must specify the orders to be followed once patient goes to the nursing home
- The patient is not seen by a physician in the nursing home every day and the management is done by the nurses, so orders must be clearly specified
- The current medications with the doses and frequencies must be mentioned in the discharge summary
- Discharge package contains the following (All done by the clerk and interns)
  - Discharge summary
  - H&P
  - Recent labs
  - Last chest x-ray

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- Medication screen to be printed on a word document
- Ambulette and inter-institutional transfer form must be prepared unless the patient's insurance will set up the transportation, confirm with social worker if the transportation will be set up by the insurance company or not

- Place all the documents in a yellow envelope with the patient's label attested
- Flag the discharge package with the transportation forms and discharge papers
- Place orders for discharge
- Make sure out-of-hospital DNR form is completed and is placed in the chart if the patient is DNR

SOCIAL WORK

- Interdisciplinary round with social worker, charge nurse and utilization manager occurs everyday on every floor after rounding on patients on that floor.
- Every floor will have two social worker assigned; as an intern you need to work closely with this person to arrange home services, nursing home and acute rehab placement.
- In addition our hospital has a group of social workers different to this one assigned to the floor who work with patients with substance abuse problem and will assist with counseling the patient and placement of the patient in acute detoxification program (this social worker will be identify as PASA)

Home care Forms:

- Face-to-face forms (can be done online) must be submitted to the social worker in the morning, immediately after the rounds.
- Most of the home care agencies will need at least 24 hours to re-activate home services.
- Discharge summaries should be completed when the forms are submitted to the social worker so that the social workers can fax the forms as well as the discharge summary.
- The forms have to be signed by the attending

Shelter package:

- If a patient comes from a shelter, find out from the social worker if the patient needs a shelter package to be filled.
- If a patient is being discharged to a shelter for the first time, a shelter package has to be filled out and submitted to the social worker
- Shelter package can be obtained from the social worker.

PROCEDURE POST PATIENT'S DEATH

I. Death Pronouncement:

When called to pronounce a patient's death, identify the patient, examine patient, document the legal time of death, notify supervising resident and attending physician, print out the rhythm strip, obtain yellow card from clerk. This card must be filled out by the MD and brought with you to admitting by the clerk

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II. Family Notification:

Family has to be notified as soon as possible. Body can stay on floor for a long time. Discuss with nurse/charge nurse if there are any problems. Try not to tell the family about the death over the phone, just tell them that the patient is “very sick”

III. Notification of the Organ Donor Network:

Organ Donor Network must be called within one hour of all deaths. In case of Brain death, ODN is to be notified before brain death is declared by the neurologist or intensivist. Note the name of the ODN, reference number and the time ODN was informed

IV. Notification of the New York Medical examiner:

ME call is not mandatory for all deaths unless if the case is reportable such as: unexpected death within 24 hrs of admissions, post op death, post procedures death, trauma related death, death related to public hazards, suicides related death, prisoners, child birth related death, and drug over dose among others. Autopsy must be requested for all patient deaths. Consent must be obtained from the next of kin. Consent form must be filled out with next of kin information. Forms should be at nurses station or obtained from admitting
Medical examiner doesn’t have to be called for all deaths. If case is accepted, case number must be noted. Name of the medical examiner and notification time must be noted.

V. Death note:

The entire hospital course must be written, cause of death must be mentioned in the field provided. (There is online training for how to complete death certificates from NY DOH). Death note is not a substitute for a discharge summary.

VI. Death certificate:

Death certificate must be completed by the resident who pronounced the death. It must be done in the admitting office on the 1st floor.

VII. Notify MAR:

MAR has to be informed of all deaths

Ordering Consults:

Emergent:

Any request made for the evaluation of patients with acute or life threatening problem must be answered within one hour. **Emergent consults cannot be placed online without contacting the respective service and informing them of the nature of the consult**. The name of the responding physician and time notified must be noted in the request.

Urgent:

Urgent consults cannot be placed online without contacting the respective service and informing them of the nature of the consult. Consult will be answered within 6-8 hours.

Routine:

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Any non-emergency consult shall be answered within one full working day. Routine consult must be placed before 12 Noon for the consulting service to answer the same day

Ordering a consult in EPIC:

- Go to order entry, search for the particular consult, choose routine or urgent
- Choose the relevant diagnosis
- Referring provider is your attending
- Reason for consultation must include:
  - Present illness and pertinent past medical history
  - Pertinent physical exam and lab findings.
  - Specific problem to be addressed by the consultant-i.e., specific diagnostic question you want the consultant to answer. Never write: Evaluate for CHF!

Special circumstances:

- **Emergent Renal Consults** are typically for ESRD or AKI. Please have the following patient information ready prior to calling the Renal Attending on call:
  - Reason for emergent consult, patient's name, MRN, major co-morbidities, reason for admission, dialysis access type and presence of inflammation, good thrill or bruit, vital signs, cardiovascular exam, pulmonary exam, presence of edema and relevant investigations (Na, K, bicarb, BUN, Cr, Phos, Calcium, AGap, Hgb, wbc, platelets, Hep B and C status, ABG, troponins, EKG and CXR).
  - If AKI requiring dialysis, in addition to above, you'll want to have the input/output and, presence of a Foley catheter, urinalysis, CPK, uric acid and hx of nephrotoxins.
- Don't delay calling because you don't have all the above information: just get as much as you can to help the consult go smoothly. See Hemodialysis orders in the next section.

ORDERS

Reactivating orders:

- Reactivating orders is necessary when patient gets transferred from MICU to the floors, ER to the floors or from one location to another
- Check to make sure all orders are correct, be aware of STAT/Now order

Orders for blood components:

- Consent for blood transfusion and 2 type and screens if patient had none in our system (the last one within the last 72 hours) must be present before orders for blood can be placed
- There are two orders required, one for blood bank to request for the blood product; another for the Nurse to administer it on the floor.
- Go to ORDER ENTRY, select appropriate blood product such as RED BLOOD CELL, FRESH FROZEN PLASMA, etc. You need to answer the appropriate and required fields, including the amount of units of blood product, informed consent if needed, and the indications.

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- In addition to the order for blood products, “Blood components – RN instructions” order must be placed and it has to indicate the type of blood product, the amount needed, when to give, rate of transfusion and the route
- Time required for transfusion:
  - PRBCs: 3-4 hours/ Unit
  - FFPs: 30 minutes/ Unit
  - Platelets: 30 minutes/ Unit

Insulin Orders:

- Oral hypoglycemic drugs are usually avoided in the inpatient setting
- For patients with diabetes mellitus, total daily dose is split into basal and pre-meal insulin with supplemental scale as needed
- Basal insulin (Levemir/Detemir) can be ordered as night time or morning dose subcutaneous
- For pre-meal insulin type “Insulin Lispro” in orders and order required dose as TID subcutaneous before meals
- For supplemental scale, type “Sliding scale” in orders, it directs you to order set “General inpatient diabetes management”, choose insulin corrective scales from the menu and select appropriate sliding scale dosing
- Make sure you place an order for POC glucose capillary check “4 times daily before meals and at bedtime” for all patients on basal and pre-meal insulin regimen
- All diabetic patients must have“Hypoglycemia management” ordered from order set (includes prn dextrose, prn glucagon, prn oral glucose)

Ordering EKGs:

- When an EKG is ordered, choose ‘now STAT’
- Once the order is placed in the computer, an EKG requisition order will be printed out.
- Tell the RN or the clerk to communicate with the PCA responsible for it on the ward.
- In case you need to get an EKG and there is no Nurse in Charge or PCA, please order the EKG as now, and then page ADN (Associate-Director of Nursing) who will find a certificated PCT in the hospital for you.
- In case you need an urgent EKG and there is no PCT available, please order it as now and get it yourself if you cannot wait.

Orders for contrast for CT/ MRI:

- Order the contrast from the same drop down menu while ordering the CT or MRI test

Orders for mechanical ventilation:

- Once a patient is intubated, promptly place an order for mechanical ventilation, enter the ventilator settings that were selected at time of intubation (FiO2, Tidal volume, RR, PEEP) and sign the order.

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Hemodialysis Orders

- The Renal Attending on call may ask you to place hemodialysis orders and will guide you over the phone
- Send HCV antibodies, Hepatitis B Surf Ab, Quant and Hepatitis B surface Antigen if no tests within the last 2 months

Electrolytes Replacement Orders

POTASSIUM REPLACEMENT – INTRAVENOUS

- Recommended rate of infusion is 10 mEq/h
- Maximum rate of intravenous replacement is 20 mEq/h with *continuous ECG monitoring. Try to avoid it*
- Standard Concentrations: 10 mEq/500 mL, 20 mEq/100 mL, 20mEq/ 250ml and 20 mEq/500 mL
- Maximum Concentration for Central IV administration = 20 mEq/50 mL
- Maximum Concentration for Peripheral IV administration = 10 mEq/50 mL
- Don't give oral and IV at the same time
- If the initial value is critically low, always repeat after replacement.

POTASSIUM REPLACEMENT– ORAL or ENTERAL

- Standard dosage forms: KCl 10mEq, 20mEQ, 40mEq tablet or KCl solution 10 mEq/120 ml

MAGNESIUM REPLACEMENT:

- Infusions should be no faster than 1gm of magnesium sulfate every 15 minutes.
- Standard Concentrations: 4 gm/100 mL and 2 gm/50 mL

PHOSPHORUS REPLACEMENT:

- Replacement must be ordered in mmol of phosphorus.
- Recommended rate = 3mmol/hr (= 4.4 mEq/h of K)
- Maximum rate = 10 mmol/hr (= 15 mEq/h of K)
- Use **SODIUM** phosphate for patients with serum potassium > 4.5 mEq/L and serum sodium < 145
- mEq/L
- Standard Concentrations:
- Potassium Phosphate: 15 mmol/100 mL and 15mmol/500 ml
- Sodium Phosphate: 15 mmol/250 ml

CALCIUM REPLACEMENT:

- You must specify the salt form (gluconate or chloride)
- Calcium *chloride*:
  - Reserved for ICU/telemetry units only
  - Must be administered via a central line
  - Maximum rate = 1 gm IV over 10 minutes
- Calcium *gluconate:*
  - May be used in all levels of care
  - Administration via a central line is *preferred*; however, it may be given peripherally with adequate IV access.
  - Maximum rate = 3 gm IV over 10 minutes
- Standard concentrations:
  - Calcium *chloride*: 1 gm/50 mL, 2 gm/100 mL, 3 gm/150 mL
  - Calcium *gluconate:* 1 gm/50 Ml

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DISCHARGE PROCEDURE

- 24 hour discharge notice must be ordered at least 24 hour prior to patient's discharge.
- Type “Nursing Communication”in orders, once order opens type “Give 24 hours discharge notice” in comments and sign the order
- This will start the discharge process and will notify the social workers, clerks and nurses of the discharge plan.

Discharge prescriptions:

- The prescriptions have to be done first before orders or summary can be done
- Discharge medications have to be reconciled in “discharge reconciliation”, where medications can be continued, discontinued or new medications added

Discharge communication:

- Inform the patient and primary nurse about planned discharge preferably during team rounds

Discharge instructions:

- Clear discharge instructions mentioning follow up visits with PCP or specialty clinics
- Give clear instructions on new medications added or old medications discontinued at the time of discharge

Discharge summary:

- Complete your discharge summary followings the instructions provided earlier in the guide

Placing discharge orders:

- Once discharge medications have been reconciled and discharge instructions given, place “discharge patient” order, and specify the time of discharge

PHLEBOTOMY: No need for routine daily labs for every patients

- Phlebotomy teams on floor perform morning labs at 5 AM
- Emergent labs should be drawn by residents. Don’t wait for nurses

Ordering labs:

- All labs to be ordered as STAT
- Order non-urgent labs for 5 AM (done by phlebotomy team)
- ** Troponin is NOT a routine lab. **

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- For emergent labs, place order for STAT labs and inform the primary RN about need for STAT labs

Re-printing specimen labels:

- Specimen labels can be re-printed using “Cerner Reprint Label” icon on EPIC workstation

Phlebotomy tubes:

- Identify the patient before drawing blood; the labels have to be affixed to the tubes at the patient’s bedside after collection of blood.
- Note that all “outside/send out” labs should be sent in separate tubes so that they can be transported out of the hospital.
- Generally 2ml of blood is needed in SST for 1 test, but if you need more tests, or anticipate add on labs later, it would be advisable to obtain more blood on the initial attempt.
- Blood cultures have to be collected using sterile precautions. They have to be collected prior to administration of antibiotics.

  - Blue (Na Citrate) - PT, PTT, Fibrinogen, D-dimer, Factor assays
  - Lavender (K2 EDTA) - CBC, HIV, CD4 Count, HBA1C, Reticulocyte count, RBC Folate
  - Pink (K2 EDTA)- Type & Screen
  - Green (Lithium)- Ammonia (ice)
  - Green (Heparin)- Ionized Calcium(ice), Homocysteine, Lead
  - Yellow (SST)- Most of the Chemistry, Immunology, Hepatitis screen
  - Grey (Na Floride) – Glucose, lactate
  - White (K2 EDTA)-PCR (mostly viral)
  - Red (Plain bottles)- for bodily fluids, send out test to other laboratory
  - Black- ESR
  - Royal Blue- Copper, Metals
  - Quantiferon- 3 tubes in a kit, need to obtain from Lab Central

Transporting specimens:

- Specimens should not be transported by a resident or medical student unless the labs are deemed urgent. The floor PCA/PCT/messenger service will transport labs on daily schedule
- In the event that the specimens need to be dropped to the lab immediately, the specimen bag should be held with a glove and the other hand should be free to open doors
- The regular visitor elevator should not be used to transport specimen
- For all other non-urgent labs, the specimens have to be placed in the designated areas for the transporter to collect
- For emergent specimens, residents can and probably should transport specimens to the lab
- Chute to the lab is present only in the ER. Blood culture bottles cannot be sent via the chute.

PATIENT LEAVING AGAINST MEDICAL ADVICE/ABSCONDING

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- If patient wants to leave Against Medical Advice, please approach patient, assess their mental capacity and capability of understanding the risks and address their concerns, often times this is due to a misunderstanding. Explain the risk involved if patient wants to leave AMA.
- We do not need Psychiatry consult to assess mental capacity for every patient, except in selected cases.
- If the patient insists on leaving, notify your senior resident and attending or the attending on call.
- You will need the patient to sign an AMA form, with all the risks documented, and witnessed by staff nurse.
- The attending in charge will have to sign the form before you can discharge the patient.
- Complete the discharge summary, give the appropriate discharge prescriptions and follow up appointments.
- Give a copy of the discharge summary if the patient follows up with a PCP outside.
- Complete an occurrence report which will be provided to you by the nurse.
- **Absconding means patient with psychiatric issues who left the hospital. It doesn't mean patients who wanted to sign AMA and left before signing the form or patients who simply left the hospital but not high risks.** Complete an occurrence report which will be provided by the nurse. Discharge summary needs to be written.

FALLS ON THE FLOORS

Identification of High Risk Fall Patients:

- Visual identification with Yellow clip, Yellow socks, and Falling star signs
- Impaired Gait and Mental status e.g. Confusion; order fall monitoring/ Constant Observation
- Place an order for "Fall precautions" in EPIC

Post Fall procedure:

- Fill out incident forms on the VOICE
- Inform Attending oncall
- Examine and document in the EMR
- Review medications
- Order appropriate tests if required
- Order "constant observation" if needed
- Inform the family
- Write a short note

PRESSURE ULCERS

- Document ulcers in the daily progress note
- Update Problem list
- Contact Wound care Nurse and follow their suggestions
- Order Wound Dressing

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STROKE CENTER

- The Department of Health designates Stroke Centers statewide to improve the standard of quality and access to care for patients with a presumptive diagnosis of stroke
- LHC is an award winning stroke center
- Stroke Protocol packets are available in the ED and ICUs

Within 10 minutes of arrival

- Immediate general assessment by a stroke team member or emergency physician, or other expert, including the order for an urgent non-contrast CT head scan
- Perform and document NIHSS within 15 minutes
- Use Stroke admission order set.
- All patients need dysphagia screening by nursing

Within 24 Hours window from symptom onset or wake-up stroke

- Page stroke team through the operator **immediately**

Greater than 24 hour symptom onset

- Standard work-up including CT head

MEDICAL ALERTS

- Pager is held by senior resident in MICU
- Medicine on call teams are required to answer cardiac arrest/RRT 2nd floor and above.
- RRT team (or Cardiac arrest team) = MICU attending on-call, ICU PGY-2/3, MAR, CMR, on-call PGY2s and PGY1s.
  - Crowd control. Leave if there are enough people as deemed by the team leader
  - Always discuss with attending and document in EMR
  - Answer RRT test page at 730AM
- Stroke Team: MICU attending on call and ICU senor resident
- BEST Team Call: Behavioral team (psychiatry attending + resident), on call medicine PGY-1/2 (from patient's team), and hospital police

ESCALATION POLICY

Patient issues:

For acute life threatening situation residents MUST notify the in-house attending immediately.

- Hypotension or hypotensive episode
- New onset seizure
- Significant or symptomatic tachycardia/bradycardia (i.e. Heart rate > 125/min or < 45/min) and/or symptoms.

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- Tachypnea > 30/min
- Altered mental status
- New neurologic deficit
- Patients who abscond, patients who want to sign out AMA.
- Falls
- Suicide attempt/Disruptive behavior
- Any recommendation(s) from a consultant requiring intervention change in medication, STAT labs, imaging studies).
- When you feel you need help!!!
- Presence of: Examples
  - Critical Value Notification (microbiology, radiology, chemistry, pathology etc.)
  - Meningeal signs
  - Delirium/Psychoses/DTs
  - Peritoneal inflammation / Free air in abdominal cavity
  - Typical Chest pain, Excruciating Headache
  - Stridor, Angioedema
  - Loss of previously present pulses, Limb ischemia
  - Bleeding, Melena
  - Hypoxemia (PaO_2 <90%), Hypocapnea ($PaCO_2$ < 35 mmHg), Hypercapnia ($PaCO_2$ > 40 with tachypnea
  - Positive cardiac enzymes/ New EKG changes
  - Pneumothorax

Staff issues:

- Occurrence report must be filled for the following: workplace violence, needlesticks, and exposure to hazardous materials.
- Any disruptive or unacceptable behavior from staff to patients, other staff or unprofessionalism should be reported to authorities in the following order:
  - Senior Resident
  - Head nurse or ADN if indicated
  - Attendings on call
  - Administrator on Duty off hours
  - Program Director, anytime
  - Department Chair, anytime
  - Institutional GME **(EXT 3433)**
  - **Pulse Anonymous**
  - **The VOICE**
  - CIR

All complaints shall be documented in writing and must include:

- Date, location and time of incident
- Name and MR number if patient was affected
- Name and title of employee(s) involved
- Circumstances of situation

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- Description of behavior
- Description of intervention/ remedy if any
- Witnesses.

The appropriate authorities (program director, GME, CIR) will track and trend the complaints, and if substantiated disciplinary action will take place which ranges from informal discussion to suspension or termination of contract. All information about reporting, documenting, investigating and managing disruptive behavior will be kept confidential.

Sexual Harassment:

- There is zero tolerance for any sexual misconduct in our institution.
- Sexual harassment includes but is not limited to: **unwelcomed** sexual advances, request for sexual favors and other verbal and physical conduct of sexual nature which creates an intimidating, hostile or offensive work environment. The key work is unwelcomed indicating that such conduct is not wanted or solicited. Once the person makes it known that is unwelcome then it must stop immediately.
- We promote awareness, training prompt and swift investigation of allegations. Our institution policies apply to all staff and patients.
- Allegations should be reported immediately to the respective supervisor AND the Program Director
- If such is not feasible it should be reported to the Equal Employment Opportunity/Affirmative Action officer (at the "EEO office") at our institution usually on Human Resources dept.
- When filing a complaint with the EEO office should be in writing and includes: name, address and signature of complainant, brief description of alleged action.
- Forms should be directed to the EEO office. EEO officer is responsible to make timely and comprehensive investigation that may include interviewing complainant, respondent and witnesses. Once completed, determination should be communicated to the complaining party upon closing file. If it is probable that a cause exists, an action will be taken to address the alleged misconduct (ranges from disciplinary action to termination).
- Complainants have the right to pursue formal complaint with an outside agency (i.e. Civil Rights Enforcement Agency)
- This matter is dealt with in utmost confidentiality and no retaliation will be permitted against any employee who files any type of complain.
- In patients case, situation should be reported to the attending or program director.

Social Media Policy:

- It is absolutely prohibited to use social media at work or home to post or discuss anything related to patients or colleagues. This policy is strictly enforced. Breech of the policy will result in termination.
- The program maintains its website and other social media platfroms regularly. It is expected to post pictures of residents on those platforms for academic or wellness purposes. If a resident doesn't want his/her pictures posted on social media, the resident should inform the department leadership.

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LEARNING GOALS AND OBJECTIVES

- Learning goals and objectives for every rotation can be found on the department's "Shared Drive"

IMPORTANT TELEPHONE NUMBERS

- Lincoln hospital operator: 718-579-5000
- Department of Medicine 5278, 4739, 5874
- Department of Medicine Fax 718-579-4836
- 8-14 resident's lounge 6242, 3807, 3806, 1937
- 8B: 5118, 5103
- 8C: 5290, 5102, 4573, 3013
- 6B: 5181, 5182, 4511
- 6C: 5184, 5185, 4512
- 9B: 4571, 5155, 3202, 3201, 3207, 3208
- On call attending room 5104
- Admitting office 3400/5400

- Social workers:
  - Social work department 5657

- MICU/ CCU
  - MICU: 5941, 5944, 4878, 6097
  - CCU: 4617, 4619, 4485, 4440
  - X-ray room in CCU 3828
  - Computers in CCU 4341
  - MICU Fax: 718-579-4623

- Radiology/ Ancillary
  - US: 5748, 3691, 5558
  - X-ray 5218
  - CT in ER 1122
  - CT 2nd floor 5207, 5750, 3148
  - MRI 6250
  - Virtual Radiology (night reads) 5369/1-866-9414341
  - CXR Portable 3692, Portable X-ray beeper 27847
  - ECHO 4868, 4236, 4869
  - Nuclear medicine 5970
  - EEG 3705

- Lab
  - Central Receiving 5841
  - Blood Bank 5661
  - Phlebotomy 5332 (8AM-5PM), 5841 (5PM-8AM) 3282, 5842, 3667
  - Heme Lab 5846
  - Chem Lab 5836
  - NY Blood Bank 914-784-4545

- Bellevue

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- Bellevue Fellow 917-884-0216/5901
- Bellevue CCU 212-562-3271/8444,
- Bellevue Cath Lab 212-562-6357
- Bellevue Dept. of Cardiology 212-562-6365
- Bellevue Transfer 212-562-6458/10 Bellevue Transfer (Nafia) 917-884-0216. If no response, then try (917) 884-3630 (her personal pager).
- Bellevue Consult pager 917-884-0216
- Bellevue Fax 646-414-1497 and 212-562-3274

- Others:
  - ER Radiology 5369
  - ER 5784/3235/5200
  - ENT 5093, 5695
  - Recovery room 5841
  - Dialysis 5715, 5548
  - Transporter 5763
  - Respiratory 3465
  - Rehab 5651
  - Pharmacy 5523
  - Outpatient pharmacy 5631
  - Medicine clinic 5580
  - Infection control 5774
  - Housekeeping 5955
  - Computer MIS 5260/ 5308

HOW TO SET UP BELLEVUE ROTATION

- 2 months prior to the rotation, you will receive an email with access to the "Checklist" from Florence Centeno (Bellevue Program Coordinator)
- Complete all the FOCUS modules
- Complete the forms assigned on checklist prior to the deadline
- "Letter of good standing" will be uploaded by Gisele Cordero
- Once you are approved and credentialed to rotate at Bellevue hospital, you will receive another email with instructions on how to obtain your Bellevue ID (An ID Badge as a House Staff Officer limited to the dates indicated (NYU Security at Tisch Hospital HCC-102D: 212-263-5038. M-F 8:30am – 3:30pm).
- You will also need to get a Bellevue ID from security. To get Bellevue ID, you need your NYU ID and fill out the Bellevue ID request Form (form will be attached in email, you are NYU affiliate). Take the form to Bellevue Hospital Building H, ME 20 (take the local elevator to Mezzanine level, room E20) to have it signed. Then you can take the signed form to the security office to get your Bellevue ID. Their office is located in building D on the ground floor
- Same H+H username and password to access your windows and Epic account at Bellevue
- You can check your call schedule at www.amion.com , password is 'nyu,medoncall'. You will be listed as 'Lincoln'

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PROTOCOLS

All of the following protocols available in the "lin-dept" shared folder→Medicine→Sign out→ Protocolized medicine. MICU protocols in "lin-dept" shared folder→Medicine→ sign out→MICU material. Keep in mind these are extremely useful and easily accessible folders!!

RESEARCH: As per ACGME, every resident has to at least complete one scholarly activity during residency

A. Research Rotation and research activities

Research is an essential aspect of Resident formation. We currently have an active Research department lead by **Dr. Menon**, and we recommend you take advantage of it. Interns and senior residents are encouraged to take two weeks rotation for Research purposes, but it is not mandatory. The research block must be approved by Dr. Menon (menonv@nychhc.org) 4 weeks before starting the rotation.

Interns who have been assigned to the Research elective should have their **CITI module** done prior to the rotation (link below).

Instructions for CITI training:

You need to register and then complete the training for **Basic Biomedical Research** and **Good clinical practice.** Remember, none of the training should be paid; make sure you associate your account with **HEALTH AND HOSPITAL CORP (HHC**). Please find the link below:

https://www.citiprogram.org/

Lately, fellowships and job applications have tuned out more competitive. As a resident, you need to understand that one way to make you a competitive applicant is to build the research section of your CV with publications and poster presentations.

As a first-year, we suggest starting looking for case reports during your rotation on floors and discuss with your senior resident/attending about unique characteristics the make the case appealing for publication or presentation. If you identify an interesting case, you must send an email to cmrmedicine@nychhc.org with the following information to lock the case for three months

- MRN
- Patient name and date of birth
- Attending physician supervisor
- Resident's names involved in the case report
- Diagnosis

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After three months, if the resident does not present documentation about the status of the case, it can be reassigned to another resident interested in the case. CMRs can assist you in drafting the case report and help you with the publication process. Also, we recommend you join ongoing clinical research projects from your seniors; you should collaborate with them and learn about designing a protocol, proper data collection, data analysis, and manuscript drafting.

Second and third years need to formulate research questions and design protocols related to the topic you desire; each service (nephrology, endocrinology, pulmonary, etc.) already has one or more Protocols approved by the **IRB office** of our hospital, ready for planning, data collection, statistical analysis, etc. Currently, the Research department has Research proposals and protocols that you can start working with. For information about the Research proposal or Research protocol, you should contact Dr. Menon by email.

CMRs and the research department can connect you with appropriate project mentors based on your interests. Research is considered as a **Scholarship activity** that is part of your evaluation as an IM resident. We consider Research grants, manuscripts, oral presentation, poster presentation, abstract, case reports, Quality improvement projects, Letters to the editor as **Scholarship activities**.

B. Authorship and criteria to be part of the Author list

Authorship implies responsibility and accountability for published work. We want all residents part of the project to make intellectual contributions to Research work to be credit as authors. Residents credited as authors understand their role in taking responsibility and being accountable for what is published. Nowadays, because authorship does not communicate what contributions qualified an individual to be an author, some journals and Conference societies request and publish information about the contributions of each person named as having participated in a submitted study (manuscript, poster presentation, oral presentation, etc.).

Our department follows recommendations done by the ICMJE in terms of authorship.

4 Criteria

- Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
- Drafting the work or revising it critically for important intellectual content; AND
- Final approval of the version to be published; AND
- Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

C. List of venues to apply with your abstract/cases or research

List of Conferences to present abstract:

Generals

NYACP - Open to submit in Nov

ACP - Open to submit in Oct

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SHM – Open to submit in Sep

MSSNY – Open to submit in Jan

SGIM - Open to submit in Nov (Conference: April 21-24, 2021)

Specialty

ATS (Pulm/Crit) – Open to submit Aug- Oct (Conference: May 14-19, 2021)

NYATS (Pulm/Crit) – Open to submit Jan-Feb

CHEST (Pulm/Crit) – Open - Deadline 1 June (Conference: Oct 17-21,2020)

SCCM (Crit) – DL 3 Aug (Conference: Jan 31- Feb 3, 2021, CA)

ENDO – Open to submit Oct (Conference: 20-23 Mar 21)

AACE (Endo) Open to submit Nov (Conference: 27-30 May 21)

NKF (Renal) – Open to submit Oct (Conference: 6-10 April 21)

ASN (Renal) – Open to submit 15 Apr – 1 June 20 (Conference: 22-25 Oct 20)

ACR (Rhemat) – Open to submit 7 Apr to 16 June 20

ACG (GI) – Open - Deadline 1 June 20 (Conference: 25-28 Oct 20)

AAN (Neuro) – Open to submit about Sep (Conference: 17-23 April 21)

AASLD (GI) – Deadline 17 July 20 (Conference: 13-17 Nov 20)

AHA (Cardio) - 15 Apr- 19 June 20 (Conference: 13-15 Nov 21)

Research only

ASCO (Heme/Onco) – Open to submit in Jan

ASH (Heme/Onco) – Deadline August 4, 2020 (San Diego: 5-8 Dec 20) 85$+ member fee

IDWEEK (ID) - Open - Deadline 18 June 20 (Conference: 21-25 Oct 20)

ECCMID (ID) – Open - Deadline 25 Nov 20 (Conference: 10-13 April 21, Austria)

CROI (ID) – Open to submit Oct (Conference: 7-10 March 2021)

ASTMH (ID) – Open - Deadline 22 Apr 20 (Conference: 15-19 Nov 20, Canada)

SHEA (ID) – Open to submit Oct (Conference: 14-16 April 21)

***PS: Conference dates from last year**

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DON'T FORGET TO EAT (RESTAURANTS)

Internship year can be stressful for many reasons. One of the ways to cope with stress, to stay healthy and productive at work is to have good nutrition. In and around the hospital, there are many places where you can find a "quick bite."

Large chain restaurants
Safe and proven. Accepts credit cards

1. Dunkin' Donuts - on 149th, on the right hand side after you cross Morris Ave

Coffee, Open 24-7. They have Ice Cream as well. Tel: (718) 292-1478, note they do delivery.

2. SubWay- on 149th, on the right hand side after you cross Morris Ave

3. McDonalds- on 149th, on the left hand side after you cross Morris Ave. Open 24-7

4. IHOP- 247 east 149th street. They deliver. (718)-713-2912

Sub (gyro, roll) options

1. Lincoln Deli on Morris Ave: Good gyro, rolls, fresh. 24-7, accepts credit cards. Take out.

2. Franco's- on the 149th Street, left hand side after you cross Moriss Ave. Good sandwiches, fruit smoothies, and accepts credit cards. (347)-577-1466

3. Square Food Market- 253 East 149th street. (718)-269-0449. They deliver. Lot of vegan options!

Ethnic food

1. Dragon Yuan-Chinese restaurant (in front of Lincoln), on Moriss Ave Across the street from the hospital building; they do delivery (718) 993-8898.

2. La Perla Mexicana- Mexican restaurant on the 149th Street, left hand side after you cross Moriss Ave. (718)-585-6425.

3. Taco Bell – 249 east, 149th street. They do delivery. (718)-705-0237.

4. Best & Tasty Deli Grocery- Middle eastern and American. 260 East 143rd street. Across the parking lot. They deliver. (718)-402-8888.

5. Julia's Coffee Shop- 232 east 144th street. They deliver. (718)-292-4936 Smoothies, American, middle eastern, Mexican.

Others:

1. Towers café

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Inside hospital building, Cash only, open up to 7pm. Recommend Chicken taco salad-only on Wednesdays, grilled salmon on Thursdays. Can pre-order over phone. Extension: 6140

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