VA GM WARDS ORIENTATION

DEPARTMENT OF HOSPITAL & SPECIALTY MEDICINE
PORTLAND VA MEDICAL CENTER
– updated March 2017 –

Orientation materials are also available online:
VA DHSM Sharepoint IMResPDX OHSU MedHub

GM ATTENDING ROTATION LEADERS:

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IMPORTANT LOCATIONS:
Morning and evening sign-out rounds:
8D-104
Team rooms:

		Code:
GM1	8D-111	4215*
GM2	6D-107	8641*
GM3	8D-112	4125*
GM4	6D-125	1357*
GM5	5D-124	5124*

Call rooms:
5D-148c
7C-101

IMPORTANT NUMBERS:

Bed control/AOD	5-5424 or 5-5425
ED	5-5438
Triage/CHS On-Call	*41-2810

Admitting Cycle and Daily Schedule

	Sa	Su	M	T	W	Th	F
GM1	RON/RS/RS	IS/DW/LW	L2	D1	D2	IS	L1
admits	0	4	3	4	4	2	3
duties		*CODE				AM S/O	CODE
day off	interns/MS3s	resident/-/-				resident	
GM2	RS/RON/RS	LW/IS/DW	D1	D2	IS	L1	L2
admits	0	4	4	4	2	3	3
duties		*CODE			AM S/O	CODE	
day off	interns/MS3s	-/resident/-			resident		
GM3	RS/RS/RON	DW/LW/IS	D2	IS	L1	L2	D1
admits	0	4	4	2	3	3	4
duties		*CODE		AM S/O	CODE		
day off	interns/MS3s	-/-/resident		resident			
GM4	DW/LW	RS	L1	L2	D1	D2	IS
admits	4	0	3	3	4	4	2
duties			CODE				AM S/O
day off		interns/MS3s					resident
GM5	LW/DW	RS	IS	L1	C/L2	D1	D2
admits	4	0	2	3	3	4	4
duties	CODE		AM S/O	CODE			
day off		interns/MS3s	resident				

Legend: (details below)

D or DW	Day Call or Day Weekend
L or LW	Late Call or Late Weekend
RS	Resident Solo (MS3s and interns off)
IS	Interns Solo (resident off)
RON	Resident Overnight (rotates every third week among GM1-3)
C/L2	Providence resident goes to clinic in the morning then comes back for Late Call
NF	Night Float
CODE	Team that carries the code pager (on Sunday this rotates among GM1-3)
AM S/O	The attending who is present at the AM sign-out rounds

Recent Updates

- Late Call admissions cut-off (3/1/2017)
- Observation admissions
- Transitions of care
- Triage
- Conferences

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ORDER OF THE DAY: MONDAY – FRIDAY

Time	Activity
7:15 am	Day Call & Intern Solo teams arrive, receive signout from Night Float in 8D-104; finish by 7:45 am Late Call teams arrive at 7:45 am – finish signout by 8 am
7:15 am	Day Call admitting teams begin to take admissions
8:00 am	TUES – Dept of Medicine Grand Rounds (OHSU 8B60) – ALL RESIDENTS/INTERNS/STUDENTS
9:15 am (9:30 am)	Multidisciplinary Rounds w/ SWS, OT/PT, nursing, pharmacy, nutrition (~15 minutes) for GM1/4/5 o GM2 and GM3 start instead at 9:30.
9:30 am (9:45 am)	Attending Rounds begin immediately after multidisc rounds end – MUST FINISH BY 11:15!
12:00 pm	Noon Conference begins – attendance is MANDATORY o MON/WED – Noon Case Report (Bldg 101-201) o TUES/THURS – Noon Conference (Bldg 101-201) o FRI – Dept of Medicine Friday Conference Series (OHSU 8B60) (Morbidity & Mortality, Autopsy, CPC, Senior Resident Talks, etc) Students have separate conferences from ~12pm-2pm on Monday-Friday.
1:15 pm	THURS – Resident Report (OHSU 11D03 1st/3rd/5th Thurs, VA 101-335 2nd/4th) – RESIDENTS ONLY FRI – Intern Report (101-335) – INTERNS ONLY
3:00 pm	Day Call ends and Late Call begins
5:00 pm	If work is done, Day Call teams may sign out internally to one designated team member. Interns on Intern Solo day may also sign out to their counterparts on L2 call if all work is done (Mon: GM5→GM1, Tues: GM3→GM4, Wed: GM2→GM5, Thurs: GM1→GM3, Fri: GM4→GM2)
7:00 pm	Late Call teams stop taking admissions. Night Float team arrives, all teams sign out in 8D-104.
9:15 pm	ALL TEAMS (except night float) MUST BE OUT OF THE HOSPITAL

ORDER OF THE DAY: SATURDAY – SUNDAY

Time	Activity
7:15 am	Admitting teams arrive, receive signout from Night Float/RON in rm 8D-104 (no staff present) o SAT – Non-admitting teams (GM1/2/3) arrive at 7:45 o SUN – All teams, including non-admitting teams, must arrive by 7:15 to take signout from RON
7:15 am	Day Call team open to admissions
7:30 – 8:30 am	SUN – RON rounds on newly admitted patients with attending and interns RON departs after new patients are seen/discussed; attending/interns round on established pts
Morning, tbd	Attending rounds timing at discretion of other teams
2:00 pm	Day Call team stops taking admissions and Late Call team begins
3:00 pm	SAT – All other teams may sign out to RON if work is done and patients are stable. SUN – All other teams may sign out to Late Call team if work is done and patients are stable.
7:00 pm	Late Call teams stop taking admissions. SAT – RON takes sign-out from Late Call team and begins taking admissions. SUN – Night Float team arrives, Late Call team signs out in 8D-104 (or NF finds Late Call team in office).
9:15 pm	ALL TEAMS (except night float or overnight resident) MUST BE OUT OF THE HOSPITAL

Shift and Role Descriptions:

D = Day Call
Day Call teams arrive for sign-out at 07:25 (D1) and 07:35 (D2) and each admit up to 4 patients until 15:00, including patients from Night Float. NF patients will be distributed first to the Intern Solo teams (on Monday-Friday), then across the D teams, in the order of IS→IS→D1→D2→D1→D2. New admissions during the Day Call shift will then be distributed among the D1, D2 and CHS teams as determined by Triage. Teams are responsible for admitting any patient signed out (from the ED, ICU or POPS) by 15:00, even if the patient does not arrive to the floor until after 15:00. When work is done teams may sign out internally, leaving one designated team member to cover their patients until 19:00 and sign out to Night Float. All teams are required to maintain a presence in the hospital until 19:00.

If there are extenuating circumstances that might warrant straying from the typical admissions distribution (absences, very busy service, other team difficulties, etc.) please discuss with Triage as well as the Chief Residents or any of the GM Attending Rotation leaders and we will work through these on a case-by-case basis.

L = Late Call
Late Call teams arrive at 07:45 for cross-cover sign-out. Teams begin admitting when both Day Call teams have filled or at 15:00, whichever is first, and are open for up to 3 admissions. When on Late Call the team should arrange the day to allow most work regarding established patients to be done (e.g. progress notes completed, orders entered) well before 15:00 (preferably by 12:00) so that they can focus solely on new admissions after that time.

Admissions will be distributed among the L1, L2 and CHS teams as determined by Triage. Teams are responsible for admitting any patient signed out (from the ED, ICU or POPS) by 19:00, even if the patient does not arrive to the floor until after 19:00. The admitting team should see the patient in their current location (ED, ICU or POPS) and then enter DELAYED – ADMIT TO GENERAL MEDICINE orders. Patients still "belong" to their current location until they are physically moved so for any urgent orders that need to be executed prior to transfer please discuss directly with the ED/ICU/POPS care team. If the patient still has not arrived on the floor by sign-out rounds make sure to manually add him or her to the Shift Handoff Tool and inform NF of their bed assignment.

Teams are expected to be ready to sign out established patients at 19:00 sign-out rounds, then to find NF to update them on new admissions before leaving for the night. It is vital that teams be done and out of the hospital BY 21:15 AT THE LATEST to allow for an ACGME-mandated 10-hour duty free period between shifts. If/when there are violations of the 10-hour rule, PLEASE keep Dr. Papak and the Chief Residents informed of the factors that led up to this in order to help us tweak the system accordingly.

C/L = Clinic/Late Shift — for Providence Residents only.
Providence residents will still have a half-day of continuity clinic each week. To accommodate this, he/she will have a morning clinic every Wednesday. On these days, the attending and interns will round in the morning and formulate the plan of the day on established patients. When the resident returns from clinic (by 1300), there should be time to "run the list" to catch up on events before Late Shift admissions begin at 1500. This team will be assigned to "L2" to offer a little extra breathing room.

RS = Resident Solo.
This will always fall on Saturday or Sunday. Both interns and the students will have the day off together. There will be no new patients on this day. Each team can decide how this day runs (i.e. timing of rounds etc). Residents must be available to nursing and to their patients and their families until 1500. In the event of downtime, there is plenty that can be done: finishing D/C summaries, calling families, keeping track of clinic patients, catching up on reading, etc. See "Order of the Day" for information about which team to sign out to. Residents may sign out at 1500 if all patients are clinically stable and all clinical care is wrapped up thoroughly. See the schedule above for information about which team to sign out to. Sign out should be to the resident of that team, not the interns.

Once per rotation, the resident from GM1-3 will stay after a Resident Solo shift and spend Saturday night in the hospital (see below).

IS = Intern Solo.
This will fall on a different weekday for each team. The resident will have the day off but students will be present. Intern Solo interns come at 0715 for cross-cover and new patient sign-out. The first two patients admitted by Night Float will go to the Intern Solo team (one each per intern); if Night Float admits no patients or only one, the Intern Solo team will NOT be open to admit additional patients during the day. Interns may sign out at 1700 if all patients are clinically stable and all clinical care is wrapped up thoroughly. See the schedule above for information about which team to sign out to. Sign out should be to the corresponding intern (A or B) for that team. If there are tenuous patients, we recommend a phone call to the NF intern at 1900 to provide direct sign-out.

For GM1-3, there will be a second Intern Solo day on Sunday following the RON shift (see below). On that day, the team resident will leave after rounding formally on the new overnight admissions, and the day will carry on like an Intern Solo day otherwise: attending and interns will write all notes and manage the patients for the day. Interns may sign out at 1500 if all patients are clinically stable and all clinical care is wrapped up thoroughly. See the schedule above for information about which team to sign out to. Sign out should be to corresponding intern (A or B).

DW = Weekend Day Shift.
On Saturdays, GM4 and GM5 will alternate Day and Late Shifts every other week (see amion for the assignment). On Sunday, GM1-3 will rotate through this assignment once every 3 weeks (after the IS and before the LW shift; again, check amion). The team on DW shift will arrive at 0715 for sign-out from Night Float (Saturday) or RON (Sunday) and will be open for admissions until 1400. There are some differences between Saturday and Sunday on DW shift:

- *Saturday*: DW team will take up to 4 overnight admissions from Night Float. If it fills all 4 admissions slots, there are no more admissions for the day. If not, the DW team will continue admitting until it has a total of 4 new patients or it is 1400. Any patient signed out to the DW team by 1400 is their responsibility, even if the patient does not arrive to the floor then.
- *Sunday*: DW team will not start the day with any overnight admissions, since these will stay on the RON's team. The team will be open for up to 4 admissions until 1400. Any patient signed out by 1400 is the DW team's responsibility, even if the patient does not arrive to the floor then.

The DW team may sign out to the RON (Saturday) or LW team (Sunday) as early as 1500 (NO EARLIER) if all patients are clinically stable and all clinical care is wrapped up thoroughly for the day.

LW = Weekend Late Shift.
On Saturdays, GM4 and GM5 will alternate Day and Late Shifts every other week (see amion for the assignment). On Sunday, GM1-3 will rotate through this assignment once every 3 weeks (after the DW and before the IS shift; again, check amion). The LW team will start taking admissions at 14:00 or after the DW team has taken 4 new admissions, whichever is first. They can receive up to 4 new admissions up until 19:00. Teams are responsible for admitting any patient signed out (from the ED, ICU or POPS) by 19:00, even if the patient does not arrive to the floor until after 19:00. The admitting team should see the patient in their current location (ED, ICU or POPS) and then enter DELAYED – ADMIT TO GENERAL MEDICINE ORDERS. Patients still "belong" to their current location until they are physically moved so for any urgent orders that need to be executed prior to transfer please discuss directly with the ED/ICU/POPS care team. If the patient still has not arrived on the floor by sign-out rounds make sure to manually add him or her to the Shift Handoff Tool and inform NF of their bed assignment. The LW team should finish work and leave BY 21:15 AT THE LATEST.

There are some differences between Saturday and Sunday on DW shift:

- *Saturday*: LW team arrives at 07:45 for sign-out from Night Float. Be aware that the LW team is at risk for one overnight admission if NF has admitted 5 patients, and for immediate new admits if DW has already filled from NF admissions.
- *Sunday*: LW team arrives at 07:15 for sign-out of cross-cover RON. There will not be any admissions to hand off.

Non-admitting teams may sign out their patients to the LW team on Sunday at 15:00 BUT NO EARLIER. Sign-out on Saturday will be to the RON, not the LW team. See "Order of the Day" above for instructions about who signs out to whom. Attending rounds timing is at the discretion of each team.

RON = Resident Overnight.
The Night Float team is off on Saturday night. Instead, the residents from GM1-3 will rotate to cover Saturday night every 3rd week (i.e., once each per rotation). On this weekend, the resident works on Saturday as usual (Resident Solo shift, with no new patients). However, at 1500 the other Resident Solo teams, and potentially the DW team, can sign out to the RON and leave. At 1900, the LW team will also sign out, and the RON will then be responsible for cross-cover on all GM patients as well as admission of up to 4 new patients between 1900-0630. The RON will keep all patients admitted on his/her own team and sign out cross-cover at 0715. He/she will then round with the rest of his/her own team on Sunday morning on all new overnight admissions. The RON should then leave, and the attending and interns will stay for the rest of the day to manage the new patients and round on established patients. There will be no additional admissions to this team. The resident's own team attending will provide support for new admissions as needed for the night.

NF = Night Float.
Night Float arrives at 1900 and leaves by 0800. Please see separate section of this document for Night Float orientation.

AM S/O Rounds.
The attending assigned this role will be present at the 0715 sign-out rounds Monday-Friday. He/she will provide structured feedback on sign-out and is also expected to dispense the occasional pearl of wisdom and keep things running smoothly. You may also receive an email with feedback. Expectations for these rounds are in a separate document. Please bear in mind that this is a work in progress. Attendings may swap shifts, provided there is coverage continuously on Monday-Friday.

Additional Guidance Regarding Admissions and Sign-Out:

Bounce Back Policy.
If a patient is readmitted shortly after discharge or comes out of the ICU after a brief stay, we strongly encourage the team that cared for the patient previously to assume care again, provided the involved team: 1) is admitting that day; 2) has not taken their 3-4 admissions yet (this counts as an admission); and 3) receives sign-out on the patient by the end of their scheduled admitting shift (i.e. before 1500 on D shifts and before 1900 on L shifts). For patients in the ICU, it is best to communicate with the ICU team and help facilitate transfer back to the original team. IM residents working in the ED should also try to direct readmitting patients back to the original team. Keep in mind that this may require shuffling of patients and will require communication with Triage, the AOD and the other admitting teams to ensure all understand the change. Bounce backs may also be accepted outside of the admission cycle if this is deemed best for patient care and duty hours will not be violated.

Patient Distribution.
Triage will determine the order of admissions each day, including the distribution of patients between GM and CHS. Again, if there are extenuating circumstances that may warrant changes to the typical admissions distribution please discuss with Triage as well as the Chief Residents or any of the GM Attending Rotation leaders.

Caps.
Each team should have no more than 14 patients at end of day. The team can flex up to 16 patients during the day if there are pending discharges. Of course, it is more than team census that determines how busy each team is. Anytime a team is stretched to the point that patient care or mental health is at risk, they can/should close to admissions. If such a situation arises, the team attending should work Triage to develop a plan for diverting admissions to other teams.

Sign-Out and Pager Status.
To ensure nursing staff, ward secretaries, and consulting teams can always reach someone responsible for the care of each patient, it is important to have a uniform policy regarding sign-out and pager status. The VA policy is consistent with the one in use at OHSU. Always leave your pager on, status "In hospital, on page." Whenever you leave for the day, use SmartWeb to forward all pages to the covering resident or intern. Most often this will be the night float intern, but there may be situations where there will be more than one hand-off before your return (e.g., handing off to your team co-intern at 1700 on Day Call, then to Night Float at 1900, then to your team resident the next morning if it is your day off). On those occasions, make certain you set coverage for all of those transitions.
SmartWeb instructions:

- Click "Personal Profile"
- Login (use your usual computer login)
- Click "exception", then "Coverage" and hit "new"
- Type in the pager of whomever you signed out to and what time you want to stop coverage
- If you have a day off, forward to the night intern (RON resident on Saturday), and then set a second coverage to your resident/intern for the day off

Holiday Schedule.

We will operate on a holiday schedule for all federal holidays except Columbus Day and Veterans Day:

New Year's Day	January 1
Martin Luther King, Jr. Day	Third Monday in January
George Washington's Birthday	Third Monday in February
Memorial Day	Last Monday in May
Independence Day	July 4
Labor Day	First Monday in September
~~Columbus Day~~	~~Second Monday in October~~
~~Veterans Day~~	~~November 11~~
Thanksgiving Day	4th Thursday in November
Christmas Day	December 25

When a federal holiday falls on a Saturday, it is usually observed on the preceding Friday. When the holiday falls on a Sunday, it is usually observed on the following Monday.

- Day Shift teams take a max of 3 patients signed out by 13:00 and can leave at 15:00 if all work is done. D1 signs out to L1, and D2 signs out to L2.
- Intern Solo teams may leave at 15:00 if all work is done. They still take 2 patients in the morning from Night Float. IS interns sign out to L2.
- Late Shift teams have no change except to start taking admissions at 13:00 instead of 15:00. Thanks for taking one for the team, Late Call teams!
- Night Float is unchanged.

Night Float

Roles:

- Intern:
    - Priority is to provide excellent cross-cover, including leaving notes where appropriate. Hint: If you saw the patient or made a significant clinical maneuver (such as starting antibiotics), write a note.
    - Admit new patients under the guidance of the resident.
    - Either intern or resident may present new patients, provided they are done in a succinct fashion. The focus is to explain what you think is going on and why, major diagnostic considerations, what actions you took, and what results may be pending vs what actions you considered but did not actually take. Practice this with your resident.
    - Carry code pager, respond to codes.
- Resident:
    - Direct the admission of new patients.
    - Assist the intern with cross-cover issues.
    - Role model succinct "executive summary" patient presentations
    - Carry code pager, respond to codes.

Supervision:

- The team attending for each patient is available at all times you are on service. Indications to contact the attending: any ICU transfers, AMA discharges, unexpected deaths, and procedures. If the thought occurs to you to call the attending, you should call the attending.
- For questions regarding new admissions call or page the attending on the team who will be receiving that patient.
- The CHS hospitalist is also available on-site during night hours to answer any questions.

Admissions:

- The night float team is open for 6 admissions alternating with the CHS nocturnist.
- The intern can admit 5 patients, and the resident will complete the 6th admission. The AOD will alert the accepting resident of the team assignment for each patient. Document this team assignment in the admission navigator. If extenuating circumstances make you believe assignments should be changed, please call the chief resident on call.
- If it is a chaotic cross-cover night, the resident may elect to do more admissions “solo”

Schedule

- Arrival Time: 1900
- Departure Time: 0800
- When you first arrive: Go to the 8D 104 classroom for sign-out from the day teams. There are late teams which may sign-out to you after this time, as they may be still admitting. If you do not hear from them by 2100, FIND THEM. Please notify the chief residents if any house-staff are not leaving on time.

Night School:

- In progress. (The CHS night attending is available for any questions.)
    -

In the wee hours of the morning:

- Residents should review with the intern any interventions the intern has made on cross-cover patients or other concerns that they have. You will be providing feedback to the day teams (see below) so please review any problems/concerns/congratulations the intern has regarding day care.
- Take a moment to reflect on the shift and provide brief, specific feedback to one another. If either party feels things should go differently the next night, discuss.
- New admissions after 0615 will be "tuck-in" only. This means:
    - SEE the patient and TALK to him, ensure stability.
    - Place a set of basic holding orders to include diet (if appropriate), morning meds, vitals/activity, AM labs you think should be drawn.
    - Leave a brief SOAP note summarizing your discussion, findings, general impression, and pending labwork.
    - If a patient is admitted after 0615 and is quite sick, spend more time with them and stabilize as much as possible. Alter your AM sign-out rounds such that the receiving team hears about them promptly.
- Attend morning sign-out rounds (see below)

Morning Sign-out Rounds:

- *Time*: 0715-0800 *Location*: 8D-104
- In attendance: day residents, night resident, night intern, an attending
- Teams will arrive in a staggered fashion for sign-out:
    - 0715 Intern Solo
    - 0725 Day 1
    - 0735 Day 2
    - 0745 Late 1
    - 0750 Late 2
- Keep in mind the main goal of sign-out rounds: Primarily to provide structured sign-out—given data that patient care is improved when sign-out is formalized (i.e., sign-out new patients from night float to day teams, then day teams to night teams). Secondarily, provide some education to night.
- Night float resident should hand teams a paper copy of admission note (do this before/during intern sign-out so resident can peruse)
- Sign-out to each team should take no more than ~10 minutes for discussion of cross-cover issues and up to 2 new patients
- Sign-out to each team should start with cross-cover
    - NF intern should write down everything that he/she is called about on cross-cover patients overnight on sign-out sheet and hand it back. That way there is no need to verbalize routine things like "gave bowel regimen," "made NPO," etc.
    - Verbal sign-out should only consist of major issues:
        - "hypotensive to 80s, considered sending to unit but didn't because sustained response to fluid bolus"
        - "gave IV BB bc was in Afib again, BP stable, increased PO dose of metop,"
        - "went to bedside, evaluated chest pain, EKG normal, trop sent, considered heparin drip, but gave GI cocktail instead."
    - Attending and residents should ask questions about the major cross-cover issues, highlight learning points.
- Then move on to new admissions; resident or intern can do this, but prefer the intern.
    - Start with the sickest patient.

    - New patients are presented quickly – in style of the shorter resident note or "executive summary" style. i.e.,: Reason for admission, sick/not sick, few sentences of HPI, most pertinent PMH/meds/vitals/exam/labs only, assessment/plan. Highlight outstanding labs, other already ordered but pending tests, decisions that need to be made
    - Attending and residents will ask question about management, and attending may highlight a learning point
- Late teams arrive at 0745 – cross-cover signout should take no more than 5 minutes
- **Everyone leaves by 0800.**
- **Attending may provide verbal feedback during/after rounds and will add both NF resident and intern as additional signers to the attending H+P.**

Documentation requirements:

- **For the first 5 admission**s, interns will write the H+P, with an adjunctive resident addendum or brief note that highlights the assessment and plan.
- For the 6th admission, the resident will complete a single H+P with no additional addendum.
- iMed Consent needs to be completed prior to any transfusion or procedure (e.g. LP, paracentesis).
- A procedure note must be on the chart before leaving the hospital; please use the procedure template.
- Leave cross-cover notes on any patient that requires in-person evaluation. The note should include a f/u plan, even if that plan is to wait for the AM team to f/u on issues.
- Please add the PCP onto any admission notes as an additional signer.

Code and STEMI coverage:

- The night float and ICU teams are responsible for all codes in the hospital. The ICU resident has primary responsibility for codes but can choose to delegate control if someone else is already running a code at the time they arrive.
- Code pagers will be handed to both of you by the long-call team when you arrive.
- **Please see RRT, CODES, STEMI, and Stroke coverage on Pages 15-16.**

Tips for Night Float Success:

- An outstanding doctor has a sense of his/her limits and is not hesitant to call for help.
- Attending*s consistently* want to know about any patient that will be "leaving the list", such as deaths, ICU transfers, AMA discharges, or transfers to a different service.
- Feel free to call for help with decision making ("should I make the MRI tech come in?") or difficulty getting through red tape (a consultant will not see your patient). Your attending will be gracious and at least try to help.

Anticipate. Identify patients as "sick" or "not sick". Always alert team members at the time of sign-out if a patient is "sick." Get to know the names of the nursing staff. Remember the closed-loop communication skills when effecting plans that require action from multiple members of the patient care team.

RESIDENT SURVIVAL GUIDE

Documentation/Charting:

H&Ps: There should be both an intern H&P and a brief resident note on each patient at the time of admission. The resident note should focus on the assessment and plan.

- If the intern is unable to write all of their complete admission H&Ps, a complete resident H&P can be substituted for the intern's H&P; however, an expectation is that the interns become efficient enough to complete five admission H&Ps.
- Medical students may write their own H&Ps in the chart, but these do not "count" as the team's official H&P (i.e., the intern or resident must still write a full H&P).
- Attending notes MUST BE on the chart within 24 hours of admission.

Progress notes: One progress note per day is required on every patient.

- Notes should also be written if the patient's condition worsens, when a complication of diagnosis or therapy occurs, or when the patient is transferred to another service (ICU, surgery, etc.).
- An addendum should be made if there have been changes in the team's thinking over the course of the day.
- Medical students can write daily progress notes which count as the daily note as long as there is a brief intern/ resident addendum that includes some basic exam elements and a brief assessment/plan, and the standard blurb about attending supervision.
- Patients discharging should have either a progress note for day of discharge or a completed discharge summary

Code Status: Remember that DNR/DNI is a decision not a condition.

- When you have a discussion with a patient that chooses DNR/DNI status, include in your note a very brief synopsis of the discussion with the patient or the patient's decision-maker (this can be as short as one line).
- Patients who choose DNR/DNI also need a Code Status note entered under the CPRS template titled "Code Status Note." This can be completed by the intern, resident or attending.

Discharge Summaries: Use the discharge summary template in CPRS

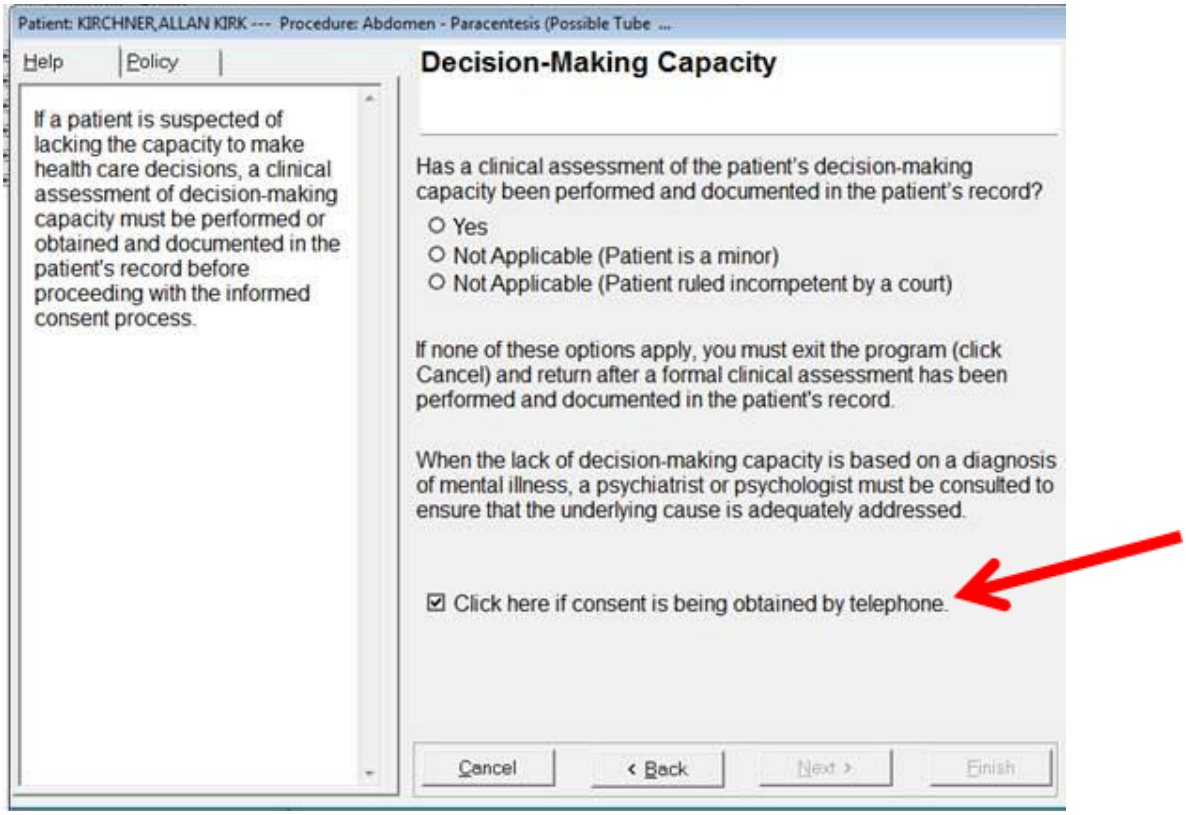
- These should be completed on the day of discharge most of the time, and MUST be completed within 24 hours of discharge. Every patient discharging to a nursing home MUST have a completed discharge summary prior to transport. It is printed out and faxed to the facility as part of the discharge packet. Every patient being assigned a new PVAMC PCP MUST have a completed discharge summary at the time of discharge.
- Intern and resident share this task but resident should be writing at least 50% of D/C summaries

Procedures:

Consent:

- Written consent should be obtained prior to performing procedures (e.g. LP, paracentesis, thoracentesis, central lines, intubation, joint aspirations/injections) and blood transfusions. Consents are good for 60 days.
- All consents are done electronically through a system called iMedConsent. Training for the use of this system will be covered during the ward orientation. If the patient cannot consent due to mental status issues, go to the next of kin or other legal decision maker. If that person is not at the bedside, you will need to complete a telephone consent. This can be done in iMED and will require a nurse to serve as a witness. If iMED is down, you will need to contact the AOD (55425) to do a telephone monitored consent. To complete telephone consent in iMED, open up the appropriate consent. On the next screen you should click the box hidden at the bottom that

says, “Click here if consent is being obtained by telephone.” It will walk you through the process from there.



Procedure Supervision:

- Attending should be involved in all decisions to perform procedures (you may call the CHS noturnist or NFS attending at night for new admissions).
- In general, all efforts should be made to perform procedures during daytime hours with direct attending supervision.
- All central venous catheters (besides PICC lines) must be placed under ultrasound guidance, in a monitored setting (POPS Unit, ICU, dialysis suite). You should speak with the ICU fellow to arrange for this.
- Thoracenteses must also be done in a monitored setting (ICU, POPS Unit, bronch suite). Determine with your attending who will supervise the procedure (pulmonary consult attending or the GM team attending). If pulmonary consult attending will supervise, ask for a formal pulmonary consult, and they will arrange it and perform it (assuming they agree on the indication). If the GM team attending will supervise, he/she must be present for the procedure. You will need to work with ICU fellow and charge nurse to coordinate a room and use of an ultrasound machine.

Time Outs:

- All invasive procedures (anything that punctures the skin) require a pre-procedure Time Out which will be led by a ward nurse. DO NOT proceed without the Time Out.
- The nurse will ask the patient questions to verify their identity and the planned procedure. They will verify that the consent is correct.
- You will be asked to mark the procedure site with your initials.
- If your patient’s nurse is busy when you are ready to perform a procedure, the charge nurse will lead the Time Out.

LVPs:

- LVPs at the VA are performed using wall suction, a 12 L jug container, and the Safe-T-Centesis catheter over needle kit.
- If your attending is not comfortable with this kit, contact a chief resident or CHS consult (CHS5) attending to assist you in this procedure.
- Information on the kit and set up is available here.

Procedure notes:

- Document all procedures (even failed attempts) under a templated procedure note in CPRS. Look for templates under "Procedure" note title.
- As above, you need to perform and then document a "Time Out" in each procedure note. (So don't forget to find a nurse to lead the Time Out!)
- You must document the level of attending supervision with one of the following:
    1) Attending was in the room
    2) Attending was in the hospital and aware of procedure
    3) Attending was available by phone and aware of procedure

Transfers:

To/From the ICU:

You (the resident) can make the decision to transfer a patient to ICU at any time you are uncomfortable with caring for that patient on the floor. An ICU resident may not refuse acceptance of a patient to the ICU. If the patient is deemed stable for the ward and is not accepted to the ICU, this MUST BE THE DECISION OF THE ICU STAFF PHYSICIAN. If necessary, a staff-to-staff conversation should occur to clarify the situation.

In order to transfer a patient to the ICU:

- Call the ICU resident to discuss the patient and sign-out
- Talk to the charge nurse on the patient's ward (they will then talk to ICU charge nurse)
- Inform bed control 5-5425
- Call your attending or the attending responsible for the patient in the case of cross-cover
- Enter transfer orders
- Complete brief transfer note (summarize clinical status, indication for ICU transfer)
- Accompany nurse to escort patient down to ICU

From other services within the hospital: As the resident, DO NOT accept transfer patients; refer the transferring team to the CHS consult (CHS5) attending.

From outside hospitals/direct admissions from clinic: These patients are accepted by the DATA attending at all times. You may receive them for admission after their acceptance. The DATA attending will try to notify you, but often it isn't clear which team will be getting the patient, so your first knowledge of the patient may come when you get the call about arrival. There should ALWAYS be a note, and you can feel free to contact the DATA attending or provider who requested admission (contact info should be in the accept note).

From VAPORHCS to an outside hospital: On occasion, a patient will have to transfer from our hospital to another hospital, because ICU-level care is necessary when our ICU is full, or specialty care is indicated that cannot be provided here (e.g., plastic surgery evaluation when there is no consultant on the schedule, or urgent ERCP is indicated on the weekend and can only be done at OHSU). The patient may

go to OHSU by prior arrangement (e.g., for ERCP or orthopedic oncological surgery); if not, the AOD should call community hospitals to locate an accepting facility. After an accepting facility is found, you will be responsible for doing the following:

- Providing verbal sign-out to the accepting provider at the non-VA facility
- Completing a template inter-facility transfer note ("INTERFACILITY TRANSFER FORM (VA FORM 10-2649A")
- Using iMedConsent to complete a patient consent for transfer (VA form 10-2649B, Physician Certification and Patient Consent for Transfer).
- Completing a discharge summary
- Printing out relevant records to go with the patient to the outside facility

Discharge Process/Efficiency*:*

- Anticipate discharges. Complete paperwork the night before whenever possible, you can leave orders unsigned until moment of discharge. Inform your attending about patients you think may leave prior to rounds and that do not need to be presented.
- Remember transportation: Some travel arrangements may take a day or at least need a "travel order." Your social worker can help if he/she knows it is an issue ahead of time.
- Prepare the UAP and page your team pharmacist to let him/her know they can review the discharge medications with the patient
- Complete the "Discharge Instructions" note
- Make follow-up appointments. For patients without a VA PCP you can help arrange for them to get a new VA PCP. The process is initiated from the discharge order menu or consult menu and is fairly self-explanatory. You <u>should always call the new PCP (if known)</u> to provide a verbal handoff, especially for any new patient who requires urgent follow-up.
- Arrange indicated subspecialist follow-up. If the inpatient team has not seen the patient but you believe specialty care is indicated but is not urgent, please call the inpatient consult team to discuss this. They may elect to push evaluation to the outpatient setting, but many times it is easier to complete the evaluation during the inpatient stay (as clinic access can be difficult).
- If you do place a new consult at discharge, please be thoughtful about the timing of requested follow-up. If urgent follow-up is truly necessary, you should note this, but blanket requests for an appt in 1-2 weeks should be avoided, as clinic access can be quite restricted. Enter a "clinically-indicated date" that is appropriate to the patient's situation, but not sooner.

Rapid Response:

- **Have a low threshold to call rapid response (RRT) for an unstable patient.** The rapid response team can provide timely additional resources that would not otherwise be available on the floor. Ask a nurse to activate this. You can also dial *47 to activate it yourself.
- Rapid response team = respiratory therapist, rapid response nurse, ICU fellow (daytime), ICU resident.
- Patients and their families are also able to initiate a mini-RRT. This will summon the Family-Activated Safety Team (FAST), made up of a member of the nursing staff and an RT. They will involve MDs as indicated.

Codes:

- Internal Medicine covers all VA hospital codes including: Buildings 100, 101, 103 and 104. This includes wards, patient lodging, specialty clinic areas, radiology, cafeteria etc. Building 103 and 104 are the outpatient clinic building; someone will meet you at the indoor bridge to the

outpatient building to direct you. The code team also covers the parking levels, P1, 2,3,4,5, the sky-bridge, T51 and mobile MRI units.

- **Directions to T51 Lodging (Two possible routes):**
  1) Take the parking garage elevators (across from Blg 104 primary care) and go to P3, then exit to the right following the corridor and going around the trailers, T51 will be in front of you.
  2) Go to the 2nd floor of Blg 101, go to the end of the hallway and take the stairs out to 1st level which exit outside on the side of the building, go across the road and down a set of stairs on your left, and you will see T51 in front of you.
- **Directions to mobile MRI machine**: Take the back (WEST) patient/staff elevators to B2, when you get off turn right, and the doors to the outside are on your LEFT. Go through the two sets of double doors and the trailer is right outside the second set of doors (back of VA hospital on west side of OHSU, under the canopy).
- **Codes on visitors (not a VA patient):** Age >12 goes to the VA ED (look for physical signs of puberty). Age <12 call 911.
- **Code leader**: By default this is the MICU resident. However, whoever arrives on the scene first should take control and control can be delegated from the ICU resident to the ward resident based on familiarity with the patient.
- **Code roles/tasks:**
  - Upon arrival announce LOUDLY who you are and ask who is running the code
  - If no code code leader present, assume this role (ok to transition later if more appropriate leader arrives)
  - ASCERTAIN CODE STATUS Designate tasks (recorder, medication administrator, CPR performer etc) Crowd control (if enough helping hands are present, ask bystanders to leave)
  - If you are not the code leader:
    - Help with CPR, offer to start a central line, get an ABG, get the chart, volunteer to talk to the family, inform the primary team/attending, ask the code leader what else needs to be done. You should be notified if one of you patients codes, and if you are in house (but not carrying The code pager) you should still go to the code to offer assistance including calling family members, etc.
    - If no assistance is needed at the code, then leave. Too many people at a code increase the confusion, chaos and potentially the errors.

STEMI:

- For the VA ICU and floors if you a reasonably sure that this is an ST elevation MI (which usually equates to a combination of typical symptoms and ECG changes) then call the AOD and call a 'STEMI code' giving the patient's floor and name and your name and contact number. The ninety minutes between when the first ECG demonstrating ST elevation is recorded and when reperfusion must occur disappears fast – do not waste time.
- Initiating a STEMI Code Page will automatically activate the entire team (Interventional cardiologists/nurses/technologists). There is no 'on call' person to consult as the team members physically swap pagers. Disconcertingly, there will be a delay of about five minutes before your call is returned as the interventional cardiologist will not be contacting you until they are on the road. In the meantime call the OHSU cardiology fellow on call via the OHSU switchboard and enlist their assistance.
- For less certain cases call the OHSU cardiology fellow direct making sure that they understand that this is a STEMI code situation.

- Remember to warn the ICU that a bed will be required. However, in general it saves time to transfer the patient to cardiac cath directly once the STEMI team arrives as opposed to transferring from the floor to the unit and then to the cath lab.

Stroke (see full protocol) **:**

- If you suspect your patient is having a stroke, ask the ward secretary to activate the Rapid Response Team (RRT).
- RRT (this may be you!) will assess the patient. Use the BEFAST Stroke Assessment:
    - B: Balance. Is there a sudden loss of balance or coordination? (To check, ask the person to walk a straight line or touch each finger to his nose.)
    - E: Eyes. Are there sudden vision changes? (To check, ask if the person has double vision or cannot see out of one eye.)
    - F: Face. Does one side of the face droop? (To check, ask the person to smile.)
    - A: Arm. Does one arm drift downward? (To check, ask the person to raise both arms.)
    - S: Speech. Are the words slurred? Is speech confused? (To check, ask the person to repeat a sentence.)
    - T: Time the symptoms began. When was the person last seen looking or acting normally? Write down the exact time symptoms began.
- If you suspect a stroke:
    - **Activate the Stroke Code Team** by calling the OHSU Operator (*45-4700) and asking them to page; they request that you stay on the line. Response time is supposed to be < 10 minutes. The answering neurologist will triage your call and either a) activate the stroke team b) defer to on-call neurologist. If the Stroke Team is activated, the neurologist should be at the bedside within 30 minutes.
    - Order a STAT non-contrast head CT. Ask the ward secretary to call Imaging (57065/56535) to expedite the study.
    - Notify Pharmacy of potential t-PA order (55535)
    - Ensure 2 18g IVs are in place.
    - Obtain labs, ECG, and CXR if indicated.

Supervision/When to call an attending:

- Residents are supervised by an attending physician who should be available by telephone/pager at all times. Your responsibility as a resident is to be aware of your limitations and to ask for assistance when you need it.
- Call your attending for:
    - Uncertainty about how to proceed with diagnostic/therapeutic evaluation
    - Procedure awareness/supervision
    - New patient who is critically ill or unstable
    - Major change in clinical condition for the worse of a patient who has already been seen by staff
    - Any patient requiring transfer to the ICU
    - Patient leaving AMA or missing
    - Patient deaths, even if it is expected UNLESS you were explicitly told not to
    - Frustration with consultant
    - Frustration about perceived administrative barriers (i.e., conflict with nursing service, chart availability, discharge planning problems - your attending can often help).
    - Patient or family request to see attending/need for family meeting

Helpful Hints:

Finding out who is on call

- Residents (and some staff) have expressed frustration at not being able to find who is on a particular consult service at the VA, especially on the weekends. While the first reaction may be to call the VA operators, the following alternative approach will be more efficient:
- Open CPRS →Tools menu→ MD webpages (Links calculators and references)
- Under "Logistical Resources" listing click on "On-Call Schedules (ALL)"
- If your consultant service is not listed consider calling OHSU operator to ask who's on call (some consultants cover both sides of the bridge, for example Radiation Oncology)
- Internal medicine subspecialties (such as GI, pulmonary, renal) are under "Medicine Subspecialty Consults"; Cardiology is listed by itself.

Sign-out

- Use "Shift Hand Off Tool" in CPRS

Quality of Life

- Inpatient rotations are stressful and exhausting. Seek help as needed - talk to your fellow residents, your ward team, your attending, your chiefs, your linked associate program director or other mentors you find. You can also seek confidential free counseling with Mary Moffitt, PhD psychologist through the Resident Wellness Program (moffitm@ohsu.edu).
- If you find yourself fatigued to the point it is affecting patient care, talk to your attending and contact the Chief Resident to discuss options.
- Jeopardy: If you are ill and cannot work, we have a backup system for coverage. Call the chief resident on call and we'll help arrange it. You are not helping anyone by coming to work sick.

Hot spots

- Let your chiefs and attendings know early if you have an intern or medical student in trouble. The sooner we can help, the better!
- Communicating with nursing, social work, the ED, surgery, etc: Dr. Kagen meets regularly with leaders from each of these groups. If you have questions, frustrations, or other feedback to share, please keep a list in your team room with specific details and medical records numbers and pass this along to the chiefs, or give this directly to Dr. Kagen.

Additional Resources

- Non-urgent CPRS help or feedback: Blake Lesselroth, MD (Informatics) or in CPRS Tools-->CPRS feedback (about midway down)
- Other administrative issues: Miguel Celis (ext 59822)

DETAILED POLICIES AND PROCEDURES – FOR ATTENDINGS & RESIDENTS

ADMISSIONS

Admissions will come from the emergency department or outpatient clinics, or as transfers (in-house from the MICU/CCU or non-medical services [surgery specialties, neurology, or psychiatry], or from outside hospitals). All patients should have their primary provider identified at time of admission, via phone or addition as a signer to admission notes. This applies to all PCPs, not only those at VAPORHCS.

See Admissions & Transfers Policy for details of processes.

See Admissions Distribution Policy for details of how patients are distributed among all potential medical admitting teams.

RESOURCES AVAILABLE AT DISCHARGE (besides PCP clinic follow-up):

Nursing Home Care:
If a patient has substantial physical/occupational therapy rehab needs or requires continued extensive nursing care (for IV complex IV antibiotics, wound care, etc), skilled nursing facility (SNF) referral is indicated. If you believe a patient may require SNF care, you should initiate PT and OT consults, which are imperative to confirm need for SNF-level rehab. Otherwise, Social Work Services is your link to obtaining all post-discharge resources, including SNF, for patients who need it. There is a 72-bed VA long-term and rehab care facility in Vancouver, WA, which is referred to as the "Community Living Center" (CLC). This provides step-down care to a number of discharging veterans. Patients are referred by SWS through a CPRS consult and are reviewed each day, with decisions made about acceptance at that time.

If a patient prefers non-VA community nursing home placement (e.g., because he/she lives far from Portland/Vancouver), there are no available beds at the CLC, or the patient is deemed more appropriate for a community SNF, SWS can refer patients to other facilities under the patient's Medicare benefit. In some circumstances, funding for short-term placement can be obtained for patients without Medicare or Medicaid ("contract exception"). The Complex Discharge Committee handles these requests, which come through SWS.

Program @ Home: NOT AVAILABLE CURRENTLY
Providers and their veteran patients can make use of Program @ Home as an alternative to hospital days of care. Eligible patients can be admitted to Program at Home directly from the ED or clinic, or they can be discharged early from the hospital to complete their hospital stay at home. Patients can be admitted from 8 am to 4:30 pm 7 days a week. Eligible patients include individuals of any age who have CHF, COPD, community acquired pneumonia, or cellulitis who can safely receive care at home within our service area (generally within a 15 mile radius of the medical center). Program at Home can provide O2, nebulizers, IV therapy, and daily nursing visits (including day of hospital discharge if needed). There is also an MD visit either the day of or day after admission, along with daily MD oversight.

To initiate a referral to Program @ Home, place an electronic consult, which can be found off of the Inpatient Consult Menu, under Home and Community Based Services, about ¾ of the way down the second column. You must call the answering service at 503-412-2306 for weekend/holiday referrals (and it may help to call during the week as well to ensure the consult is seen early).

Questions can also be referred during the daytime to: Kay Jenkins (x54136) or a community health coordinator at extension 31740.

Home Health:
Coordinators: Jill Poole, Janelle Bodenner, and Karen McWhorter x31739
Social Work Services must be involved to set up any home health referral.

Criteria for referral:

1. Patient must require skilled care: i.e. need the services of a licensed professional.
   Definitions:
   a. Unskilled care: If a neighbor can do it, it is not skilled care. Patient safety assessments are not skilled. Medication management (filling a pill box) is not skilled.
   b. Skilled care: Home IV therapy, wound care, monitoring unstable disease process or response to medication change are all skilled.
2. There must be an MD order for the service (electronic consult available from the Inpatient Consult Menu, under "Community Health," at the bottom of the second column). This order is cumbersome and not fully intuitive; you can find instructions about filling it out at: New Home Health, Hospice, HBPC orders.ppsx
3. An MD must be willing to follow the pt and be available over the time of the home based service. When you make a referral, you are responsible for ensuring that there is a physician who will be available to the community agency (usually will be the PCP – just contact him/her).

There are several options for home health care; generally, the coordinator will determine which service to use. Resources include:

1. **Home-based Primary Care (HBPC)** – VA nursing, as long as necessary, usually 1-2 visits/week or less. Must live within HBPC catchment area (which will be expanding). First visit usually within 48 hrs of referral. Mental health is available, and it can involve PT/OT, SLP, or SW care.
2. **Contract Home Health** – Provided by outside resources. Patient must be home-bound. Can see pt >=3 times per week, but usually sees for no more than a few weeks. First visit can be delayed up to a week (but at other times next day). This can involve PT/OT, SLP, and/or SW care.
3. **Home health aide/homemaker** – Unskilled, institutional-level care. Previously only available to highly service-connected patients, now limited only by budget. Talk to Jill Poole or your social worker for more information.

Hospice:
Home hospice can be initiated via an electronic consult available from the Inpatient Consult Menu, under "Community Health," at the bottom of the second column. Patients discharged to hospice care must have a physician who has agreed to manage their care. This is often the patient's PCP, but may be an oncologist or other clinician (VA or community) that has been involved in their care. It is mandatory that the physician who is to manage the patient's hospice care be contacted prior to discharge and agree to manage care prior to that physician's name being entered as the physician responsible for hospice care. Unless you can respond to requests with orders signed etc within one day, you should generally not serve as hospice provider.

Home IV antibiotics :
If you anticipate discharging a patient on home IV antibiotics, please promptly notify your social worker and place an electronic consult for home antibiotics (first column, about 1/3 down on the Inpatient Consult Menu under "Infectious Disease Home Infusion"). CORAM (our home antibiotic infusion contractor) usually requires 24 hours notice prior to discharge and is not available on weekends. While

the ID consult team is involved in the care of many patients who go home on IV antibiotics, they do not coordinate home care with CORAM; you or your team must still do this.

DISCHARGE EFFICIENCY

Discharged patients frequently do not leaving the hospital until late in the day. This often results in large "boluses" of evening admissions as beds open up. We have set a goal of 50% of discharges before noon. Please prioritize planned discharges to early in the day as much as possible. It is quite helpful to touch bases as a team early in the morning (~8am) to confirm discharges so that the intern/resident aren't waiting for attending rounds to proceed with discharge orders. For patients to be able to discharge by noon, it is most helpful for the discharge orders (including the UAP – see below) to be completed by 9am. This will account for pharmacy delays and limit interruptions to Attending Rounds. You should also consider completing discharge work on the afternoon/evening prior to planned discharge. It is recognized that some discharges will inevitably occur later in the day due to procedures, consultant input, etc.

DISCHARGE PROCESS

All discharge orders (including follow-up appointment requests, medication orders) and discharge instructions are placed electronically.

All orders necessary for discharge are clustered in an order set in CPRS. The most complex part of the electronic discharge process is the Discharge Medications Reconciliation, or eUAP. Instructions can be found **here** or in CPRS → Tools → UAP.

After signing the UAP, if you have changes to make, you will notice that you cannot click on "View UAP" again. It is greyed out and not available. To make further changes, click "write delayed orders" again, then click cancel. Now you can click on "view UAP" again and bring up your prior UAP. If you sign the UAP and then later make changes, remember to page your team pharmacist to let him/her know. If there are complex medication changes, it is best to speak directly to the pharmacist regardless.

In general, to complete a discharge, you should:

1. Complete UAP as described (see above).
2. Return to the Orders tab, and select "Active Orders" View.
3. Select Orders: Medicine Service from menu on left.
4. Click on "Discharge Orders/Instructions" at the upper right corner, and complete all sections.
    a. You must make PCP notification/follow-up. This will happen automatically for patients who already have a PCP in the Portland catchment (including surrounding CBOCs). If a patient does not have a PCP and needs one, use the "No PCP" option. If the patient receives non-local VA care, use the "Outside VA" option; this will generate notification to the outside VA PCP, with the DC summary sent to him/her.
    b. Place appropriate non-PCP consultations off of the menu available under #3. You should do this for every appt you would like the patient to have after discharge (see below).
    c. Click on the text under #4 Discharge Orders. If appropriate, discontinue IVs and Foleys with separate orders from the available list.
    d. Write travel orders as indicated. If you fill this out, the ward secretary will arrange for transport for the patient to his/her home or to nursing facility, if the patient is eligible for travel arrangements.
5. Write a discharge instructions note in CPRS:
    a. Go to Notes tab and start a new note using the title, "Discharge Instructions – Medicine"

b. Follow the prompts. If your patient has heart failure or ACS, be sure to choose those options, as they incorporate certain language that meets standard educational requirements regarding weight monitoring, salt restriction, etc. Likewise, if your patient is going to a nursing home, be sure to choose this option. There will be standard SNF orders generated (House MD to follow, PT/OT eval and treat, diet orders, etc).
c. After you have finished this, a note will be generated to reflect your entries. You can (and should) edit this to add necessary content and reformat as indicated.
d. Be sure to educate your patient! Write down important information about his/her diagnosis and treatments, including recommended follow-up, and do it in lay terms, at a level appropriate for your patient.
e. After you have finished with your edits, sign it.

6. Complete the DC summary (see below).

DISCHARGE SUMMARIES

DC summaries should be in the chart and signed preferably on the day of discharge, definitely within 24 hours after discharge. This summary should include careful delineation of medications changes, planned follow-up appointments, and planned labs/imaging (or outstanding results from tests already performed). These sections are templated into the note. Discharge diagnoses should be as specific as possible to allow for optimal coding and reimbursement, and abbreviations of diagnoses are discouraged.

The PCP must be contacted at the time of discharge and be made aware of all the above, and any anticipated future clinical problems and critical elements to monitor. This can be accomplished by adding the PCP as an additional signer of the discharge summary, or in the case of non-VA PCPs, forwarding a copy of the discharge summary to the PCP after appropriate release of information is signed. **Direct telephone contact should be made with PCP regarding discharge plans when dictated by clinical circumstances.** This should include anytime you recommend follow-up by the PCP within a few days, and anytime you are discharging a patient with a new PCP assignment.

For patients whose primary care is received through VISN20 VA's outside of Portland (e.g. Roseburg/Eugene, Walla Walla, Boise, Puget Sound, Spokane, Anchorage, etc), such communication is accomplished through the use of the Inter-Facility Consult (IFC Discharge). This consult is generated automatically if you choose "Outside VA" in the PCP notification section of the DC orders. You can also find this under "Consults." It is a requirement for all discharges to these facilities.

POST-HOSPITAL FOLLOW-UP APPOINTMENTS

Primary Care:

For patients without VA Primary Care who desire it, there is an administrative order available from the Discharge Order Set, also available shortly from the inpatient consult menu, to arrange a new PCP appointment. There are options for routine follow-up (within 30 days) or urgent follow-up (can be seen as quickly as necessary). If you expect a newly assigned PCP to take responsibility for a patient's care immediately at discharge, you must talk with him/her. VA PCPs outside of Portland are notified to arrange follow-up through the same IFC consult noted above.

For all other patients established w/ VA Primary Care in the Portland catchment, follow-up can only be arranged through Primary Care (i.e. no direct scheduling). Primary Care controls access to their clinic appointments, so no appointment can be made at the time of discharge. Each patient discharged who has a PVAMC PCP is scheduled for a 1-2-day phone follow-up appointment with the PCP's Nurse Care

Manager. PCP and NCM are supposed to review the DC summary at this time and decide about appropriate timing for follow-up. It is very important that the DC summary be complete by this time, and it should make note of the discharging providers' recommendations regarding timing of follow-up. When rapid follow-up is absolutely essential, direct communication with the PCP or NCM should occur at the time of discharge.

You can find contact information for each PCP and his/her NCM, facilitator, social worker, and MA/LPN here.

Specialty Care:
If they saw the patient during his/her hospitalization, specialty follow-up is often arranged by the inpatient consult team. Appropriate electronic consults should be placed at the time of discharge if it is not clear that follow-up has otherwise been arranged. In cases where you believe a patient should be seen by a medicine subspecialist but this is not urgent (i.e., would be safe and reasonable to wait for a clinic appt), please call the inpatient consult team to discuss this. While they may elect to push evaluation to the outpatient setting, it is often simpler for consulting services to see the patient during the inpatient stay (as clinic access can be difficult). In most cases, this evaluation can be completed within a few hours, without significant delay of discharge, and saves the veteran another trip to the medical center.

When you do place a consult at discharge, you will be prompted to enter a "Clinically-Indicated Date" (CID). Please be thoughtful about the timing of requested follow-up. If urgent follow-up is truly necessary, you should note this, but blanket requests for an appt in 1-2 weeks should be avoided, as clinic access can be quite restricted. Enter a CID that is appropriate to the patient's situation, but not sooner.

You can find information about each clinic, including when and where it is held and the names and contact information for the facilitator and/or care coordinator **here.** This menu is also available off of the Clinical Tools menu from the CPRS Tools tab (bottom right, under "Logistical Resources – Provider/Clinic/Specialty Contacts).

There is a **Hospitalist CHF Clinic** on Thursday afternoons in which patients discharged from medicine teams with a primary diagnosis of CHF can be scheduled. Because of limited capacity, patients with a new diagnosis of CHF or those with brittle disease felt to be high risk for readmission should have priority for referral. Those patients already established with cardiology providers for their CHF should return to their usual provider for follow-up, not the Hospitalist Clinic. Patients can be referred to this clinic via the usual discharge appointment process, with the consult listed under specialty medicine clinics → Hospitalist CHF clinic.

Anticoagulation clinic follow-up:
Patients may only be followed in our anticoagulation clinic if they have a PVAMC PCP (includes Portland, Vancouver, Salem, Camp Rilea, Bend Clinics) or specialty managing provider (for example cardiologist or hematologist) willing to oversee their care. If patients new to PVAMC have been assigned to a PCP, but have not yet seen that PCP, they may be followed in anticoagulation clinic. Other arrangements will need to be made for patients without a PVAMC PCP or specialist managing provider.

Anticoagulation clinic staff will follow patients meeting above criteria and newly started on anticoagulation on an urgent basis as outpatients. Clear communication with anticoagulation clinic staff

(phone: 52565) as early in the hospital course as feasible is essential; this can often be accomplished through the team pharmacist.

It is imperative that a CPRS anticoagulation consult be completed prior to discharge of a patient new to anticoagulation clinic. This should be completed as early in hospital course as possible and the need for outpatient management specified. This is the only way that anticoagulation personnel know that they are to follow a patient. The team pharmacist will help coordinate outpatient follow up with the anticoagulation clinic. For patients already enrolled in anticoagulation clinic, you can find the most up-to-date plans in CPRS (and ensure follow-up is set) under the Reports tab → Flowsheets → Anticoag Flowsheet.

OTHER IMPORTANT INFORMATION

CONSULTS

Specialty Physician Care:
We have full physician consultative services, including all medicine subspecialties (except for allergy/immunology) as well as surgical specialties, psychiatry, neurology, and radiation oncology. Most provide consultations in teams that include residents, and at times students. With the exception of palliative care, psychiatry, and radiation medicine (who have electronic consult processes – see CPRS inpt consult menu), all consults are requested by phone. You will need to contact the on-call resident or fellow for the relevant service.

On-Call schedules are available here. You can find a link to this menu from the Clinical Tools menu (bottom right, under "Logistical Resources"), which is itself available from the Tools tab on CPRS (top option).

You can also obtain the name of the consulting resident or fellow (and/or attending) from the VA operator. At times, even if you use the operator or the on-line schedules, it can still be difficult to find the right person to call.

****CURRENT SURGICAL SPECIALTY CARE LIMITATIONS:**

Plastic Surgery: There have been significant coverage gaps for plastic surgery, the result being that on some days the hospital will not have anyone to handle urgent plastics issues.

The ED is aware of these gaps and should NOT be asking you to admit any patient with an issue that may warrant an evaluation by a plastic surgeon when there is a gap or a gap is about to start. It is possible someone may forget, so all medicine teams should be aware and should remind the ED anytime you hear of a patient who may need such care. We have an agreement about the care of patients presenting with hand infections available here.

You should also be aware that, should a need for plastic surgery arise in someone already on your team, you will have to transfer the patient to another hospital to receive the service. Likewise, you should look at the call schedule to ensure necessary specialty care is available before you accept anyone in transfer or as a direct admission on a day you are handling DATA calls.

Cardiac Surgery: As of September 1, VAPORHCS has no full-time cardiac surgeon. Dr. Ravichandran will continue to operate on Tuesdays, and the cardiac surgery group from OHSU will be operating at VAPORHCS on Thursdays. Any patients who cannot be scheduled during available Tuesday/Thursday slots, either because of clinical urgency or limited capacity, will be outsourced to OHSU. The cardiology consult team will serve as liaison in arranging this, but you/your team will be responsible for the work of the transfer. If questions/issues arise, you can contact the cardiac surgery nurse coordinator:

Joan Cummings – office 57709, pager *41-3513

Substance Use Care:
We have a Substance Abuse Treatment Program (SATP) consult team available to meet with patients presenting with active substance use problems and interested in discussing their issues and treatment

options. Consults to SATP are requested electronically from the CPRS inpt consult menu. A clinician from SATP will attempt to see the veteran within 24-48 hours of consult placement. If discharge occurs prior to their seeing the patient, they will attempt to reach out by phone.

Interdisciplinary Care:
We also have fully staffed Physical and Occupational, (PT/OT), Dietetics, Speech and Language Pathology, Social Work, and Audiology services available on Monday-Friday, and in some cases Saturday (PT, SW). In addition, Pharmacy, Respiratory Therapy and Chaplain services are available 24/7. You will meet daily (Mon-Fri) with a social worker, clinical pharmacist, RN, and intermittently other team members in interdisciplinary rounds (discussed above). All can be consulted electronically from the Inpatient Consult Menu; PT and OT are listed under Rehab Medicine. If you believe a patient may require inpatient rehabilitation, you should use the initiate PT and OT consults, which are imperative to confirm need for SNF-level rehab, and if they concur, you can engage Social Work Services for placement assistance. In general, Social Work Services is your link to obtaining home health services and nursing home placement for patients who need it.

TRANSFERS OUT FROM VAPORHCS TO ANOTHER HOSPITAL
On occasion, a veteran will have to transfer from our hospital to another hospital, because ICU-level care is necessary when our ICU is full, or specialty care is indicated that cannot be provided here (e.g., plastic surgery evaluation when there is no consultant on the schedule, or urgent ERCP is indicated on the weekend and can only be done at OHSU). The patient may go to OHSU by prior arrangement (e.g., for ERCP or orthopedic oncological surgery); if not, the AOD should call community hospitals to locate an accepting facility. After an accepting facility is found, you will be responsible for doing the following:

- Placing a purchased care consult (Inpatient Consults → Purchased Care under "Ancillary Services" → Non VA Care Inpatient Medical under "Inpatient")
- Providing verbal sign-out to the accepting provider at the non-VA facility
- Completing a templated inter-facility transfer note ("INTERFACILITY TRANSFER FORM (VA FORM 10-2649A")
- Using iMedConsent to complete a patient consent for transfer (VA form 10-2649B, Physician Certification and Patient Consent for Transfer).
- Completing a discharge summary
- Printing out relevant records to go with the patient to the outside facility

MED-PSYCH BED
There are 2 designated beds in the 5C unit (psych unit with locked door) that have been set aside for the care of patients with acute medical illnesses and concomitant significant suicidal ideation or, more often, elopement risk in the setting of delirium/dementia with loss of decision-making capacity. The ED, the medicine team, or nursing may make the decision to utilize these beds, but **ALL PATIENTS IN THE MED-PSYCH BED MUST HAVE AN ACTIVE PSYCHIATRY CONSULT.**

RADIOLOGY
Routine MRIs and nuclear imaging/PET scans may take several days, but all other tests should be performed within 24 hours of order placement (except for weekends/holidays). Routine/less urgent tests will generally be delayed until regular working hours, but emergent imaging should be available 24/7**.** Images should be officially read and available in CPRS on the day of completion (except on Sunday). **On weekends or holidays, you must speak with the on-call radiologist** in order to get imaging beyond plain films or head CTs. If you are having difficulty getting an imaging procedure done you may call the following imaging numbers for assistance: day: 56536 or 56545; after hours: 50255 or 50273.

The radiology division chief, Ron Boucher, and assistant chief, Tim Duncan, are also available to discuss these issues by phone or email.

Dr. Boucher: office 56670, pager 503-936-9314, email Ronald.Boucher@va.gov
Dr. Duncan: office 56514, pager 503-729-0341, email Timothy.Duncan@va.gov

If you would like to speak with a radiologist to order a study on the weekend, request advice on appropriate imaging modality, seek clarification regarding a read, etc, you can find the appropriate person to contact **here.** You may also find the Radiology On Call schedule as a link off of the Clinical Tools Menu (bottom right, under "Logistical Resources"), which is itself available from the Tools tab on CPRS (top option).

Teleradiology:
Recently, our hospital has begun piloting use of teleradiology services for more timely preliminary reads of CTs completed after hours from the ED. The company used is called US Radiology On-Call (USROC). The plan is for this to expand to other modalities, and to other locations (i.e., to images ordered on the wards), but this has not begun yet. The on-call radiology resident is still providing preliminary reads for CTs and other images ordered from the wards.

Regardless of who is reading the images, they are always available for our review on AGFA and Vista – Imaging Display. However, the USROC read is not available directly on CPRS. You can find the preliminary reports in one of 3 ways:

1. Log onto the USROC website:
   www.Usroc.com/go
   username: vhapormed
   password: 123
2. Progress note, "Radiology – Teleradiology" (USROC website read copy/pasted by ED provider).
3. In the comment box on AGFA (CT techs should copy it there).

When USROC does the preliminary review, a VA/OHSU staff radiologist will review and make a final interpretation the following morning, which will be dictated in CPRS and available as usual in CPRS Reports. Any significant discrepancies from the preliminary read will be communicated to the ordering provider.

ATTENDING GUIDE:
SUPERVISION, DOCUMENTATION AND EDUCATIONAL RESPONSIBILITIES

DAYS OFF

Residents are scheduled to be off on Intern Solo day (always Monday-Friday). Interns are off on Resident Solo day (always Saturday or Sunday, same day for each particular team).

CLINIC

No OHSU interns or residents have clinic while on wards. However, they are responsible for daily "in-box rounds" to ensure their patient's needs are being met while they are unavailable. Residents from Providence, who work on the GM5 team from August-May, still have clinic. This is scheduled for Wednesday morning. Thus GM5 will have interns only until mid-day on each Wednesday for the bulk of the year; the resident will arrive by 1pm, and admissions can begin thereafter (Late Call).

RESIDENT DUTY HOURS REQUIREMENTS

Essentials of ACGME Resident Duty Hours:

1. Limit of 80 hours per week averaged over 4 weeks for all learners.
2. Maximum 16 hours of continuous duty for interns, 24 hrs for residents (with up to 6 hours for transfer of care and didactics). Strategic napping is strongly encouraged for residents working shifts over 16 hours.
3. 1 day in 7 free from all educational and clinical responsibilities, averaged over 4 weeks.
4. Mandatory 10 hour duty-free period between all scheduled shifts.
5. Maximum of 6 consecutive nights of night float.

The work hours requirements are not optional. These requirements are mandated by the ACGME and compliance is an essential component of accreditation. It is imperative that attending and house staff work as a team to provide efficient patient care, an optimal educational experience and positive work environment.

Our entire call system and patient distribution scheme were changed to accommodate the new duty hours standards. Please let us know if there are violations.

Some general practice recommendations:

1. Work distribution:
    a. Notes: See Dept of Medicine Documentation Standards.
    b. Discharge Orders: Completed by intern usually (or resident)
    c. Discharge Summary: Resident ultimately responsible for completion of discharge summaries; however, interns should do these on resident's days off, and when workload allows. Resident is ultimately responsible for tracking completion of summaries assigned to interns and completing them if not done in a timely fashion (done preferably on the day of discharge, not more than 24 hrs after). The attending is encouraged to help with these in especially busy times.
2. Other "best practices":
    a. Attendings should view patient records before attending rounds.
    Rounds should be used to clarify data, review the house staff assessment and formulation of diagnostic and management plan and set a course for the patient.
    b. It is not the job of the resident/intern to educate attendings about the basic medical history and laboratory data for new patients.
    c. Minimize time spent on "card flip" rounds.

d. Get to the bedside when possible. In almost all cases, new patients should be seen together.
e. Finish rounds by 11:30 am, preferably 11:15 am. If there is more to discuss, you can round again in the afternoon.

ATTENDING SUPERVISORY RESPONSIBILITIES/DOCUMENTATION

The Attending Physician is responsible for the care delivered to all patients on the team. You are expected to be involved in all decision-making and available by pager 24 hours/day.

See **MCM 11-03** for full details of PVAMC policies regarding resident/student supervision.

Availability:

Please contact the VA paging operator and be sure that your home telephone number and /or mobile phone number is available to them, even if you keep your pager on overnight. Make sure your resident and the night float team knows how to reach you at night (post your numbers on white board in team room), and ensure your data is correct in the VA phonebook.

Attendings must return to the hospital any time they suspect that a patient is unstable and believe that immediate supervision of the resident team is required. If a patient requires transfer to a critical care unit, and no bed is available, the attending should be directly involved in helping to get the patient transferred to another hospital with an open MICU/CCU bed. The AOD should be contacted to assist.

Attendings are expected to be available to their team and to the cross cover team 24 hours per day. Attendings may arrange to be covered by another attending if they are going to be attending an event during which pager availability would be problematic, and on weekend days when their team is not admitting. If you will be out of pager range it is a good idea to write the hours of your planned unavailability and who is covering for you on your team whiteboard so that covering intern can quickly identify whom to call. It is also a good idea to let the ward secretaries on the floors your patients are on know this information. You should be available to the Night Float team to discuss established patients on your team at any hour. New admissions to Night Float should be discussed with the designated "Night Float Support" attending (see Ward Guide), which you will be once a week. The in-house CHS nocturnist can also help.

Night float supervision:

For discussion of new admissions over the course of the night, there is a designated "Night Float Support" attending (see earlier in this document). The in-house CHS nocturnist is also available to help the resident night float team.

The night float team will present and turn over the patients they have admitted to the appropriate teams in the morning on Night Float Rounds at 7:15 am. An attending is present each morning and is responsible for teaching and feedback about that night's admissions. These rounds should focus on "executive summaries" and communication of crucial information, not fully detailed H&P's. See Night Float Guide (pp 7-9).

We ask that you provide specific feedback to the resident night float team on your Intern Solo day about the 2 admissions your team takes. You can do this free-form, by email. Please try to do this on the same day you receive those patients. Please contact Kerry directly if you have additional feedback to include such as quality or presence of cross cover notes, decision making, etc (after communicating praise or concerns to the NF team itself).

Documentation: In general, this includes:

1. **Attending Admission Note** (CPRS note title should be: "Inpat-Med-Att-Admit"): You must see and examine all new patients and patients transferred from another service within 24 hours of admission and enter an admission note or transfer acceptance within one calendar day of admission (no exceptions). It is essential that your documentation explicitly indicate:
    a. The time you first met the patient (must be within 24 hours of admission).
    b. That you have talked with and examined the patient.
    c. Your concurrence with, or recommended modifications of, residents' initial plan.

    Example of opening statement meeting these requirements:
    "I have seen and examined Mr._____ this morning at 8:30 AM and discussed him w/ Drs. _____ and _____. I have reviewed their admission notes and confirmed pertinent aspects of the history and physical, and I concur w/ initial assessments and plans as documented."
2. **Attending On-Service and Off-Service Notes** (CPRS note title should be: "Inpat-Med-Att-Progress"): There is no formal requirement that these be done, but many attendings enter a brief note in the electronic record of each patient on the team on the day of assumption of attending-level care and the day prior to going off-service. These notes may be brief and need not repeat details of resident and intern notes.
3. **Documentation of attending supervision of ongoing care and discharge plans**: You must be identifiable in the medical record as the supervising practitioner for all patient encounters, and your supervision and concurrence with care plans must be documented regularly in the medical record. This documentation may be accomplished through any of the following:
    a. Co-signature of the resident's note (not the same as being an "identified additional signer").
    b. Addendum to the resident's note.
    c. Entering a separate progress note (title should be "Inpat-Med-Att-Progress")
    d. Resident progress note documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner's oversight responsibility with respect to the assessment or diagnosis and/or the plan for evaluation and/or treatment. The following statement is acceptable: **"I have discussed the patient with my supervising practitioner, Dr. "X", and Dr. "X" agrees with my assessment and plan."** All resident, intern, and medical student notes in CPRS are automatically templated to include a statement similar to this. PLEASE BE AWARE: THIS STATEMENT MUST BE PRESENT IN THE RESIDENT ADDENDUM TO A STUDENT'S PROGRESS NOTE, EVEN IF IT IS ALSO PRESENT IN THE STUDENT'S NOTE.

    In addition, we recommend that supervision and concurrence be documented specifically with a separate progress note or addendum in certain circumstances. This is not an institutional or VA requirement, however. Such situations include: a major change occurs in patient condition, when critical decisions are made involving high risk or technically complicated procedures or therapies, or a patient is transferred from your service to another service. If the discharge summary will not be entered and signed on the day of discharge, it is also good practice to write a short note on the day of discharge.
4. **Procedure Note** (CPRS note title should be: "Procedure - <Name of procedure>"): Such a note must be entered upon completing any procedure. This is generally done by the resident/intern who performed the procedure, but it is your responsibility to see that it is done, and to cosign it, when applicable. The notes are template so all necessary fields are included.
5. **Code Status Note** (CPRS note title should be: "Code Status"): Any time a patient elects DNR/DNI status, the circumstances and discussion must be documented in a note. Again, this is generally

completed by the resident/intern, but it is the attending's responsibility to see that this is completed. Necessary content is templated.

6. **Discharge Summary:** Should be entered by the resident/intern preferably on the day of discharge, certainly within 48 hrs of discharge. The attending is responsible for ensuring the accuracy/quality of the content and cosigning it. The PCP must be added as an additional signer to ALL DC summaries. If this will not be completed on the day of discharge, it is also good practice for someone to write a short summary note prior to discharge.
7. **Discharge Instructions** (CPRS note title should be: "Discharge Instructions – Medicine"): The intern (or occasionally the resident) must complete a set of instructions to be given to the patient at discharge which includes appropriate education, in lay language. There are special requirements regarding content of instructions for CHF and ACS discharges; instructions are template to ensure these instructions are incorporated.

See also Appendix for chart showing documentation requirements, taken from MCM 11-03.

Quality of Medical Records:

Working with the team regarding medical records is crucial with respect to quality of patient care, and trainee education. The advent of the electronic chart has created new challenges with respect to documentation. Indiscriminate copying and pasting of problem lists, histories and physicals, importing massive amounts of lab data, medication lists etc., has resulted in some chart notes that are excessively lengthy, incomprehensible, and often inaccurate.

The Attending Physician should regularly review the quality, structure and content of medical records with all team members.

Principles

1. Each document should contain sufficient information to achieve its purpose, but should be succinct so it remains a useful clinical tool.
2. Observational data (history and physical) should be original with the author, and should only rarely be copied and pasted and then, only if clearly attributed to the author and date/time of that individual's observation clearly stated. For example, it may be appropriate to copy and paste an excerpt from a history one-year previous of a patient's description of headache. Such an excerpt, when clearly identified can have clinical value.
3. Results of data available elsewhere in CPRS should be summarized, not merely imported or copied and pasted. While it is fine to copy, paste and import, all such material should be edited down to a pertinent core of relevant information as opposed to unrefined data. This process is both educational, and facilitates good patient care.
    a. Problem lists and past medical history should not be indiscriminately copied and pasted. These items are fomites for chart lore, and must be critically reviewed and edited for accuracy.
    b. Notes should reflect the thinking of the author, and can be used as an educational and assessment tool.
    c. Documents should be written with the user in mind (example: discharge summary should be useful for the PCP).

Specifics - See Dept of Medicine Documentations Standards document, and MCM 11-55: Patient Health Records.

Code Status:
Adapted from MCM 11-24: Do Not Resuscitate:

1. The resident is responsible for engaging the patient or surrogate in an informed consent discussion about their wishes regarding DNR or full code status. They will discuss the DNR order with the attending physician and document their discussion with the patient and the attending in the patient's medical record.
2. The attending physician assigned primary responsibility for the patient is responsible for reviewing the house officer's initial DNR order and associated progress note, and validating them within 24 hours.
3. This validation should include confirmation with the patient and entrance or countersignature of a "CODE STATUS" progress note as above and placement by the attending physician of an electronic DNR order (to be renewed every 30 days; resident DNR orders expire after 24 hours).

Procedures:
The following procedures are considered elements of routine and standard patient care:

- Placement of peripheral IVs
- Placement of arterial lines
- Thoracentesis
- Paracentesis
- Lumbar puncture
- Arthrocentesis
- Skin biopsy
- Wound debridement
- Drainage of superficial abscesses

However, you should not seek privileges for any procedures you have not performed recently, or in significant quantity. If you do not have privileges for a procedure or would not feel comfortable performing it yourself , you should not supervise a resident in the procedure, and you must find an alternate who has these privileges. Generally, the best option is the appropriate consult service (pulmonary for thoracentesis, hepatology for paracentesis, neurology for LP, rheumatology or orthopedics for arthrocentesis).

All central venous catheters (besides PICC lines) must be placed under ultrasound guidance, in a monitored setting (POPS Unit, ICU, dialysis suite). Unless you have maintained CVC placement competency, the ICU attending and/or fellow should place the line or supervise your resident in doing so. Your resident should call the ICU fellow to arrange this, and it is most appropriate for you to call the ICU attending to request his/her supervision. The renal fellow will usually place any dialysis line in the dialysis suite. In general, PICC lines are the preferred means of acquiring central access in non-emergent situations; use them when reasonable. A dedicated PICC nurse is available 7 days a week; coverage is not available at night, however.

Thoracenteses must also be done in a monitored setting (ICU, POPS Unit, bronch suite). If you have not maintained competency to perform the procedure, you should not supervise it, either. Your resident should ask for a formal pulmonary consult and they will arrange for the procedure (as long as they agree about its indication). If you DO wish to supervise the procedure, you must be present at the bedside for it. Your resident will need to work with the ICU fellow and charge nurse to coordinate ICU room and use of ultrasound machine

Technically complex or high-risk procedures include the following:

- Hemodialysis
- Central line placement
- Intracardiac catheters
- Sternal bone marrow aspiration
- Bronchoscopy
- Cardiac catheterization
- Liver or Kidney biopsy
- Endoscopy excluding flexible sigmoidoscopy

Someone supervises these procedures other than the GM attending. The staff physician supervising the procedure is responsible for the completion of informed consent, and pre/post procedural documentation.

Consent process/procedure notes:
It is the attending physician's responsibility to ensure completion of the following documents for all procedures and for blood transfusions and HIV testing. It should also be noted that informed consent is required for chemotherapy and for use of Antabuse (consent for these should be obtained from prescribing providers).

1. Consent forms: The consent process is electronic. There is a link to iMed Consent from the Tools tab on CPRS (about 1/3 down the list). You will find almost all of the procedures you will be performing under "General Medicine – Inpatient." Consent must be fully completed prior to procedure or transfusion. A witness signature is only witnessing that the patient signed the form, nothing more.
2. If a patient lacks decision-making capacity, consent must be obtained through a surrogate. See MCM (below) for surrogacy hierarchy. Assistance identifying the correct surrogate can also be obtained through Social Work Services. If no surrogate exists, or none is available, contact Regional Counsel. See MCM (below) for additional details.
3. Telephone consent: For patients lacking decision-making capacity, and whose surrogate is not available in the hospital, telephone consent can be obtained. When the practitioner obtains consent from a surrogate by phone, a second VA employee must act as a witness. Assistance with the telephone consent process is available from the paging operator or AOD, if needed. You can use iMedConsent or a paper consent in this case. See resident section of this guide (pp 10-12) for additional details.
4. Emergency situations: Attending must document the situation in a progress note, which must be co-signed by the Chief of Staff (or designee).
5. Procedure notes: As above, written by resident or intern, and countersigned by you. If procedure is technically complex or high risk these notes should be addended by you (not simply co-signed).

MCM 11-40: Informed Consent

Suicide Risk Assessment:
Nursing will perform a limited depression/suicide risk screening during all admission intakes. Any patient identified as a possible suicide risk will require a more detailed interview and assessment, to be done immediately by the resident or intern managing his/her care. The same will need to be done for any patient who has made verbal threats or physical attempts to harm him/herself, regardless of the outcome of the initial nursing screen. As attending, you should be notified when a high-risk patient is

identified and should co-sign any such note. Such patients require immediate psychiatric consultation and continuous supervision, and a bed in the locked unit on 5C has been reserved for medical/surgical patients in such situations.

For details, see "Suicide Assessment Tools" under the Tools menu on CPRS, or here.

ATTENDING EDUCATIONAL RESPONSIBILITIES

Expectations, goals, feedback, evaluations

Make an appointment in the first day or two with each trainee. This time should be used to define expectations and goals (both yours and theirs). Make time for regular two-way feedback throughout the rotation. You should notify the appropriate residency program director if there are significant problems with a resident learner. Likewise, for problem student learners, prompt notification of Greg Magarian and/or David Kagen is crucial.

Electronic evaluations of residents, interns, and students should be completed promptly when your rotation is finished. You can obtain username, password, and instructions from Bill Niemeyer at (503) 494-8357. The web site for completion of evaluations is: https://www.e-value.net/index.cfm

Students

Generally there are MS3 clinical clerks on all GM teams. Students should be encouraged to actively participate in the management of their assigned patients, but all of their work must be co-signed by the resident or attending. Third year students may not complete the "official" admission history and physical nor discharge summaries. Fourth year sub-interns may enter the admission history and physical, but there must be a fully-documented senior resident admission note as well. Subinterns may not write discharge summaries.

Rounds

The majority of your "face time" with your team will be spent in rounds. These will begin with multidisciplinary rounds involving the entire medicine team and social work, nursing, and rehab representatives (and pharmacy, nutrition, and speech pathology when feasible), which start at 9:45 or 10:00 (depending on the team) and last for 15 minutes. These rounds provide an excellent opportunity for communication and coordination of care among these disciplines.

The subsequent ~1.5 hrs are spent with the team in a combined teaching/management conference. It is expected that care plans for a portion (or all) of your patients will be arrived at and that there will be teaching – with scheduled didactics or "on-the-fly" discussions relevant to current patients. Students and house staff can also be assigned to present materials.

Attending rounds should end no later than 11:30 to allow for a brief period of work before attendance at Noon Conferences. Unfinished business can be addressed at other times through the day with specific team members. While you must make teaching or management rounds with the team each day, there is room for flexibility in specifics of timing and approach as long as it fits within the rest of the day's schedule.

Type of Service		Documentation Requirements: Resident Supervision	Documentation			
			Progress Note	Addendum	Co-Signature	Statement in Resident Note
INPATIENT	**Admit**	For patients admitted to an inpatient service of the medical center, the supervising practitioner must physically meet, examine, and evaluate the patient within 24 hours of admission including weekends and holidays. The progress note or addendum must be entered by the end of the calendar day following admission. *NOTE: If the specific requirements of the pre-operative notes are included, the admission note (or addendum) may also serve as the pre-operative note*.	✓	✓		
	Night Float Admit	A "night float" resident occasionally will provide care before a patient admitted to an inpatient service is transferred to the inpatient ward team. In these cases, the supervising practitioner must physically meet and examine the patient within 24 hours of admission by the night float to the inpatient service, irrespective of the time the ward team assumes responsibility for the patient. In addition, the supervising practitioner for night float admissions must be clearly designated by local policy.	✓	✓		
	Critical Care Admit	For patients admitted to, or transferred into, the ICU of the medical center, the supervising practitioner must physically meet, examine, and evaluate the patient as soon as possible, but no later than 24 hours after admission or transfer, including weekends and holidays. An admission note or addendum to the resident's admission note is required within one day of admission. Because of the unstable nature of patients in ICUs, frequent evidence of involvement of the supervising practitioner is expected. ***NOTE:*** *Supervising practitioner involvement is expected on a daily or more frequent basis and may be documented using any of the four types of documentation.*	✓	✓		
	Continuing Care *** NOTE: For Critical Care Continuing Care	Supervising practitioners are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the resident. ***NOTE****: Progress notes are entered at a frequency appropriate to the patient's condition. The supervising practitioner must be identifiable for each patient care encounter.* *** Because of the unstable nature of the patient in the intensive care setting, frequent evidence of the supervising practitioner involvement is expected. Documentation of supervising practitioner involvement is expected on a daily or more frequent basis consistent with the patient's clinical condition	✓	✓	✓	✓

Type of Service		Documentation Requirements: Resident Supervision	Documentation			
			Progress Note	Addendum	Co-Signature	Statement in Resident Note
INPATIENT…Continued	**Transfer** Transfer from one inpatient service to another Transfer to a different level of care	**Transferring Service:** The supervising practitioner, in consultation with the resident, ensures that the transfer of the patient from one inpatient service to another or transfer to a different level of care is appropriate and based on the specific circumstances of the patient's diagnoses and condition. The supervising practitioner from the transferring service must be involved in the decision to transfer the patient.	✓	✓	✓	✓
		Receiving Service: The supervising practitioner from the receiving service must treat the patient as a new admission and must write an independent note or an addendum to the resident's transfer acceptance note. This provision covers transfers into and out of intensive care units or transfers to extended care.	✓	✓		
		Same Transferring and Receiving Service: The only exception to the above requirements is whenever the same supervising practitioner is responsible for the patient across different levels of care. A transfer note documenting plan and concurrence by supervising physician will suffice.	✓	✓	✓	✓
	Discharge	The supervising practitioner, in consultation with the resident, ensures that discharge of the patient from an inpatient service is appropriate based on the specific circumstances of the patient's diagnoses & therapeutic regimen; this may include physical activity, medications, diet, functional status, & follow-up plans.	✓	✓	✓	
NON-OR PROCEDURES	**Routine Bedside and Clinic Procedures**	Documentation of Supervision for these activities depends on the setting in which they occur. Standards for documentation must follow the setting-specific guidelines above (i.e. Inpatient, Outpatient, ED, etc). **(e.g., skin biopsies, central and peripheral lines, lumbar punctures, centeses, incision and drainage)**	?	?	?	?
	Non-routine, Non-bedside Diagnostic, or Therapeutic Procedures	These procedures require a high level of expertise in their performance and interpretation. Although gaining experience in doing such procedures is an integral part of resident education, they may be done only by residents with the required knowledge, skill, & judgment and under appropriate supervision by a supervising practitioner. Supervising practitioners are responsible for authorizing the procedure and must be physically present in the procedural area. Appropriate supervision must take into account the complexity and inherent risk of the procedure, the experience of the resident, and assigned graduated levels of responsibility. Documentation of the degree of supervising practitioner involvement is encouraged. For chemotherapy & radiation therapy, the supervising practitioner must be present during treatment planning (i.e., choice of modality/regimen), dosage/dosimetry determinations, and writing of chemo- or radiation therapy orders. Neither the supervising practitioner nor the resident need be present during the administration of chemotherapy or radiation therapy since therapy delivery is a function of associated health personnel. **(e.g., endoscopy, cardiac catheterization, invasive radiology, chemotherapy, radiation therapy)**	?	?	?	?

CPRS - Where to find and how to do a few high yield things

Where to look for past studies	
Biopsy reports	Reports tab > Anatomic Pathology > Cytology or Surgical Pathology OR Labs tab > Anatomic Pathology – all reports
Blood transfusions	Reports tab > Blood bank OR Labs tab > Blood bank
Cardiac catheterization	Reports tab > Procedures
Colonoscopy reports	Reports tab > Procedures
CT or CXR (images)	Vista Vista Imaging (Display) on Toolbar Then find particular image you want to see and double click
CT or CXR (reports)	Reports tab > Imaging (local only)
Echocardiogram	Reports tab > Procedures
EKGs	Vista Vista Imaging (Display) on Toolbar then click on the EKG icon (red PQRST squiggle) on the main window
Exercise tolerance test (ETT)	Reports tab > Procedures Often also in a progress note
Lab status (i.e. is a test drawn? complete?)	Labs tab > Lab status (can quickly see which results are collected, pending, or complete) OR look on orders tab (active vs pending)
PFTs	2006-present: Notes tab > Find note title "PFT Complete" for brief summary Toolbar > Vista Imaging (Display), then find scanned PDF of PFT results Prior to 2006: Reports tab > Procedures

Special Orders/Tools:	
Heparin gtt order	"Heparin MD + RN Tool" located on the toolbar; follow prompts
Blood transfusion orders	Orders tab > Blood bank/Transfusion on INPATIENT orders bar on L side
Insulin gtt start or d/c orders	"Glucotron 5000" from Toolbar; select "Start drip" or "D/C drip" tab
Glycemic control and insulin use summary view	"Glucotron 5000" from Toolbar
Clinical resource links, Med calculators, journal/Ovid links, relevant policies,etc	"Clinical Resources Webpage" on toolbar
On-Call schedules for consults, etc	"Clinical Resources Webpage" on toolbar > Logistical Resources box ½ down will find "On-Call Schedules (ALL)" Can also find this on PVAMC intranet home page, ½ down in green box on right side of the window
Adding a printer	Toolbar > Administrative Tools > Add a Printer Our printers will be in sites "POR" or "MED", building 100

Other tips:	
To find any text within all of the notes	Go to Notes tab, then View menu -> Search for text Can also right click on the list of Notes when in Notes tab
How to get to VA remote access (you have to install Citrix client first)	http://www.varwest.vpn.va.gov
How to get more notes than the 300 you set during orientation	Click on the Notes tab (must do this first) View menu > Custom view (now change the notes number at top left)
Graphing	Just click on the lab of interest Set date range at bottom left of graphing window
Lab worksheets	Labs tab > Worksheet from left-side window If you don't have your own defined test groups, you can choose another "Person with defined Test Groups" (Kagen, Lesselroth,etc). You can make your own as well by choosing up to 7 tests and hitting "New" tab on top right corner of window.

USEFUL LINKS

CPRS online training	http://www.vehu.va.gov/cprstraining/CPRSTabByTab/000000/index_000000.html
VA On-Call Today	http://vaww.portland.med.va.gov/Departments/hospital_wide/OnCall1/index.asp
SharePoint: All inpatient schedules	http://moss.portland.med.va.gov/DHSM/Lists/INPATIENT%20MEDICINE%20Schedules/AllItems.aspx
VA GM wards guide for residents and attendings	file://r01porhsm03/Workgroups/DHSM Web Content/Web/Schedules/Attending/VAMC Ward Guide 6-2015.docx
SharePoint: Medicine policies and procedures	http://moss.portland.med.va.gov/DHSM/Lists/INPATIENT%20MEDICINE%20POLICIES%20and%20PROCEDURES/AllItems.aspx
GM/CHS admissions capacity and flow across teams	file://r01porhsm03/Workgroups/DHSM%20Web%20Content/Web/Schedules/Attending/HSCD%20Policy%20for%20Admissions%20-%207-2014%20update.docx
Admission/transfer procedures	file://r01porhsm03/Workgroups/DHSM%20Web%20Content/Web/Schedules/CHS/transfer%20&%20direct%20admit%20policy%20-%201-3-11.docx
Outpatient provider profiles	http://vaww/Departments/hospital_wide/Provider_Profiles/index.asp
Dept of Medicine notes standards	file://r01porhsm03/Workgroups/DHSM%20Web%20Content/Web/Schedules/Attending/STANDARDIZATION%20OF%20EMR%20DOCUMENTATION%20at%20OHSU%20and%20VAMC%205-27-09.docx
Resident/student supervision MCM	http://moss.portland.med.va.gov/QP/Medical%20Center%20Memorandums/MCM%2011-03%20Resident%20Supervision.docx
Do Not Resuscitate MCM	http://moss.portland.med.va.gov/QP/Medical%20Center%20Memorandums/MCM%2011-24%20Do%20Not%20Resuscitate%20(DNR).docx
Informed Consent MCM	http://moss.portland.med.va.gov/QP/Medical%20Center%20Memorandums/MCM%2011-40%20Informed%20Consent%20and%20Refusal.docx
Missing Patient Search MCM	http://moss.portland.med.va.gov/QP/Medical%20Center%20Memorandums/MCM%2000-70%20Missing%20Patient%20Search.docx
MedHub	https:/ohsu.medhub.com

VA main number		(503) 220-8262		
PVAMC address		3710 SW US Vets Hosp Rd Portland, OR 97239		
Dialing long distance		91 + 10 digit number		
Tie line VA→OHSU	*45 + extension			
OHSU pager extension		4-4799 then pager #		
OHSU operator		4-9000		
Tie line OHSU→VA	095 + extension			
AOD	-	5-5424	5-5425	
ED front desk	-	5-5438		

Wards

5D	5-6133	5-5059	fax (503) 721-7803
6D	5-6226	5-5065	fax (503) 721-1080
7C	5-6162	5-5061	fax (503) 273-1076
8D	5-8661	5-8662	fax (503) 721-7966
9C	5-1902		fax (503) 721-1437
5C	5-6105	5-6118	
ICU	5-6081	5-5056	

Team Offices

GM1	5-4483	5-6010	5-6011
GM2	5-1941	5-5692	
GM3	5-7089	5-7642	5-5808
GM4	5-7457	5-4116	5-5706
GM5	5-7059	5-7060	
CHS	5-4048	5-4049	5-3007
Night float office		5-6067	5-2250
ICU resident work room		5-4859	5-4858

Support

HIMS Helpdesk	5-5909	
DHSM support staff:		
Rebecca Kurfis (admin assistant)	5-5591	
Joe Sobolewski (admin supervisor)	5-5822	
Miguel Celis (resident coord)	5-5593	
David Kagen	5-4801	*41 2696
Kerry Rhyne	5-3265	*41 3111

Pharmacy

Inpatient pharmacy	5-5535	5-5536
Outpatient pharmacy	5-5559	
Sarah Stearns (GM1)	5-8601	*41 3663
Tom Hutcheson (GM2)	5-8607	*41 3123
Sarah Stender (GM3)	5-9798	*41 3695
Randall Udouj (GM4)	5-8602	*41 2613
Katie Voll (GM5)	5-9784	*41 3184
Kim MacKay (Inf Dz)	5-4505	*41 3234
Domenica McKenna (Txplant)	5-6681	

Social Work

Leif Burton (GM1, GM2)	5-7045	
Bennett Wallace (GM3, GM5)	5-7374	
Don Garner (inpt supervisor)	5-1711	
Saturday SW	*41 3225	
Patient Advocate	5-5308	

Lab

Main	-	5-6724
Chem	-	5-6743
Heme	-	5-6726
Micro	-	5-6768
Path (FNA)	5-6791	*41-3277

Specialty Residents/Fellows

Cards	-	5-5605	5-5640	5-5441
Pulm	-	5-5668		
GI	-	5-1017	5-5179	
Neuro	-	5-5492		

Multidisciplinary

Nutrition 5-5502

Cardiology

Echo	-	5-7970	5-7727	5-5632
Tele	-	5-1935	5-1915	5-4057
Nuc med	-	5-5839	5-7185	
Cath lab	-	5-5658	5-5657	
ETT	-	5-5663		
Heather Perry (echo)			5-2037	
Event mon (Lisa Cogan)			5-5639	

Radiology

CT	5-7065	5-6574	
MRI	5-5833	5-4272	(503) 299-3590
Ultrasound		5-6571	
Vascular U/S		5-5521	
IR		5-6545	
Rad Onc	-	5-8756	
Nuc med reading		5-5839	
Imaging scheduler		5-4732	

CLC/CRU

Administration	-	3-1839
Admissions	-	3-3680
B wing (rehab)	-	3-3683
C wing (hospice)	-	3-3666

Outpatient Coordination

Cardiology		
Fac: Angela Elledge	5-1607	*41-2466
Coord: Hien Block	5-4528	*41- 3580
Infectious Diseases		
Fac: Brian Hawkins	5-4727	
Coord: Mary Clites	5-7755	*41 2844
Pulmonary		
Fac: Juanita Alpuerto	5-4043	*41-3152
Coord: Mary Clites	5-7755	*41 2844
Ann Spencer	5-1184	(971) 533-4930
Multidisc Chest		
Fac: Dave Mindolovich	5-7085	*41-3293
Coord: Ann Spencer	5-1184	(971) 533-4930
Gastroenterology		
Fac: Tonya Boullet	5-2226	*41-2743
Coord: Danielle Kowalski	54658	*41-2357
Liver		
Fac: Rosemarie Trang	5-5676	*41-2840
Coord: Drema Hill	5-6704	*41 2760
Hematology		
Fac: M Rommel-Howell	5-1169	*41-2679
Coord: Bonnie Anderson	51436	*41-2320

Oncology

Fac: Sarah Manuyag	5-6532	
Coord: Andy Schultz	5-3408	*41-2577
Cancer Care Navigation	5-1756	5-1754
RN Jennifer King	5-3117	

Renal

Fac: Liva Lee	5-9857	5-5334
Coord: Loan Pham	5-7825	*41 3366

GENERAL MEDICINE INPATIENT QUALITY CHECKLIST

ADMISSIONS AND PROPHYLAXIS		
Admit medication reconciliation	Look at: 1) **active medications**, 2) recently **expired and discontinued medications**, 3) **remote medications**, 4) **non-VA medications**, 5) **anticoagulation notes (can triage to PharmD)**. Acquire any outside dispensing records from facilities. Encourage family members to bring in meds.	☐
DVT Prophylaxis	IM pts often (but not routinely) require SQ unfractionated heparin – inpt order menus have guidelines	☐
Code status	Is patient: **Full Code** **DNR** (notify attending for note)?	☐
DAILY CHECKS AND PLAN OF CARE		
Medication review and outpatient abx	Prune non-essential medications and critically assess clinical value. Anti-biotics expire automatically at 7d. All medications expire automatically at 14d. Will patient require **home antibiotics**? Consider PICC, CORUM consult, ID svc notification.	☐
Telemetry	Telemetry indicated for when **risk or suspicion of lethal or clinically significant rhythms** exist. Try to stop as soon as possible.	☐
Lines, catheters, drains, restraints	Push to limit any "tethers". **Limit indwelling urinary catheters to 3d** if possible. Place anticipated PICC orders early. Use sitters and focus rooms rather than restraints.	☐
Glycemic control	If patient is insulin dependent, push to **remove SSI** and move to basal/bolus therapy with daily reassessment based on total daily requirements.	☐
Mobility	Is patient: **ambulating independently** **requiring gait assistance** **virtually bedbound** Use this information to determine role of 1) fall precautions, 2) rehab medicine, 3) prosthetics needs such as **wheelchair**, **walker**, **commode**, **hospital bed**, 4) placement needs, or 5) home health care.	☐
Advance care planning	Try to assess patient's expectations of care and likelihood of recurrent needs. Does the patient have a **surrogate decision maker** **completed POLST form** **advance directives**	☐
Oxygen needs	Is the patient hypoxemic or dyspneic and is the patient requiring oxygen? Titrate the oxygen down or determine if home oxygen will be required. Home O2 requires 1) a **formal assessment**, 2) a **consult for oxygen** to pulm, 3) **NORCO referral** for home needs, and 4) **tanks for transfer** from prosthetics. Make certain to notify your social worker and review the oxygen approval criteria in CPRS.	☐
DISCHARGE AND CARE TRANSITIONS		
Destination and safety	Try to assess as soon as possible: 1) where does patient live, 2) how far from Portland, 3) will this be a suitable destination, 4) is a higher level of care needed? Potential care settings include: **home** **retirement ctr** **foster care** **ALF** **Substance tx** **rehab** **SNF/CLC** **hospice**	☐
Transport	How will the patient leave the hospital? Will the patient have a ride and has the ride been notified? Will the patient need: **lifeflight** **ALS ambulance** **BLS ambulance** **wheelchair van** **cab**	☐
Medication reconciliation	When completing the unified action profile (UAP), remember 1) **medications that were held**, 2) **non-VA medications**, 3) **expired medications** or **ones that need renewal**. Special considerations include **CORUM for antibiotics** and pharmacy **consult for anticoagulation**	☐
Follow up appointments and consults	Should communicate directly with most specialty services before requesting follow up appointment. Check with clerk to determine which clinics are "direct schedule". Do not schedule new Cards clinic visits if the patient has not been first seen in-house.	☐
Outstanding diagnostics	What labs, path, or images have been requested or collected? Each outstanding item should be accounted for and a plan documented for follow up or hand-off. **Follow up items include:**_____	☐
DC Summary	The DC summary should be completed within 24 hours of discharge. Most critical issues are 1) documentation of important or complicated therapeutic decisions, 2) discharge medication list, 3) outstanding diagnostics, 4) critical follow up items, 5) forthcoming consults.	☐
Patient education	Has the hospital course and plan of care been communicated with patient and/or family? Has the patient been furnished with any educational materials related to medications, therapies, diets, etc?	☐

PCP Notification	Plan for communication in order of preference: 1) **PCP phone call**, 2) **email**, 3) **additional note signature**, 4) **interfacility consult**, 5) **fax**.	☐

DISPOSITION MANAGEMENT INFORMATION

COMPLEX DISCHARGE NEEDS

Home infusion orders

Home infusion orders must be placed **at least 24 hours prior** to discharge. Infusions are contracted through *Corum Home Infusion Services*. The patient or family must be willing and capable of assisting with the infusion, otherwise the patient should transferred to a skilled nursing facility.

- Place PICC line
- Place consult (Inpt consult → medical services → infx dis home infusion)
- Notify your social worker and the infectious diseases pharmacist
- Enter a nursing text order "Pt to be seen by Corum prior to dc"
- Confirm follow plan for eventual discontinuation

Home and community based services

There are several options available depending upon the duration and intensity of therapy required:

- **Program at Home** offers short term management of complex medical issues. There is an initial MD/RN exam followed by daily RN and as-needed MD visits. Services include phlebotomy and labs, once a day parenteral medication administration, nebulizer training, and evaluative services for diseases such as cellulitis and CHF. ☐
- **Home Based Primary Care** provides homes health visits by nurses, social workers, psychologists, and therapists under the direction of a physician to patients within 25 miles of the Portland facility or the Bend or Salem facilities. ☐
- **Skilled Home Health Care** coordinates with community agencies to provide care to patients that are homebound and in need of skilled services regardless of distance. Services include skilled nursing care, physical therapy and home safety assessment, occupational therapy (e.g. ADL and self care management), speech pathology, and medical social work. ☐
- **Homemaker/Home Health Aid** program provides non-skilled services to patients with significant ADL and IADL deficits and/or severe cognitive impairment. Services may include meal preparation, housework, managing medications, and self-care such as bathing, toileting, and transfers. ☐

PLACEMENT OPTIONS

Community Living Center (CLC)

The Portland VAMC Community Living Center (CLC) is located in Vancouver, Washington. It is a multidisciplinary facility staffed with physicians, nurses, rehabilitation medicine specialists, and ancillary personnel. It includes a **complex rehabilitation unit (CRU)**, a **nursing skilled care unit (NSCU)**, and a **hospice**. The CRU is for patients that need a brief rehabilitation interval for deconditioning. The NSCU is for patient with complex nursing needs and requiring an anticipated long term stay. The hospice unit is typically reserved for patients with less than 2 months of life expectancy. The request for transfer is made by the social worker and is largely dependent upon bed availability. All discharge materials must be completed **prior to the 9:30 am transfer**.

- Notify social worker and secure confirmation of accept ☐
- Place **transfer** orders with delayed release to the designated unit ☐
- Complete a discharge summary ☐
- Call report to the accepting physician ☐

Community Skilled Nursing Facility (SNF)

These are typically residential care facilities contracted by the VA. They are a place of residence for patients requiring constant nursing care and that have significant deficiencies with activities of daily living or that need more complex health care supervision. Nursing aides and skilled nurses are usually available 24 hours a day. To meet payment criteria for placement, patients need to be evaluated and indicated by a physical therapist.

- Notify social worker and secure confirmation of accept ☐
- Complete the electronic Unified Action Profile (eUAP) and notify pharmacist ☐
- Sign the discharge medication list (provided by the pharmacist) ☐
- Complete discharge instructions – be sure to select SNF discharge option (includes house MD, PT/OT, diet/texture orders, etc) ☐
- Complete the discharge summary ☐
- The social worker will place the travel order ☐

Assisting Living Facility (ALF)

Assisted living facilities are housing facilities for patients with disabilities. They provide assistance with activities of daily living, coordination of services by outside healthcare providers, and monitoring of resident activities to help ensure their health, safety and well-being. These facilities tend to be appropriate for patients where independent living is not feasible but the patient does not require 24 hour medical care provided by a nursing facility.

Adult Foster Care

Typically these are residential homes operated by an individual, family, or small business. They provide a monitored and structured environment for a small number of residents that require some help with daily tasks and activities but are not ready or not in need of a nursing home. Licensing requirements for Adult Foster Care Homes dictate that providers supply a limited number of services to residents including meals, assistance with activities of daily living, and basic needs such as toiletries.

Hospice	Hospice patients typically have an expected life expectancy of 6 months or less. Most hospice options are home-based although services can be provided to patients in nursing facilities. The only inpatient hospice facilities in the Portland metropolitan area are *Hopewell House* and the *PVAMC CLC* (listed above). The Hopewell House typically only accepts patients with an expected life expectancy of 1 month or less and who require direct physician oversight. It is recommended that the VA Palliative Consult Service evaluate any patient destined for hospice. • Notify social worker • Place a Palliative Care consult and a Hospice consult • Notify the patient PCP and request they follow patients for home hospice • Place orders for any equipment needs such as a bedside commode, hospital bed, or wheelchair	☐ ☐ ☐ ☐