VA Inpatient PGY1 Expectations

Please read *Department of Medicine Expectations for Floor/ACS/ICU faculty* for comprehensive overview. Below is to highlight VA expectations.

Patient Care

1. Daily rounds
    - Pre-round: prioritize seeing sickest patient first and any patient with overnight event. Escalate any issue/concern/question to your senior resident/attending.
    - Prioritize and plan your morning so that you're done seeing patients before Multidisciplinary Discharge Rounds begins (Team 1 8:30; Team 2 8:40; Team 3 8:50; Team 4 9:00 am).
    - If unsure of plan for your patient, discuss with your senior resident prior to rounds.
    - When seeing patients, pay attention to devices on a patient such as Indwelling catheter/SPT/nephrostomy, ostomy, telemetry, O2 supplementation, IV/central lines.

2. Presentation
    - Use SOAP format for follow-up presentations. Full H&P for new overnight admissions.
    - You are expected to have an assessment and a working plan and not just report subjective and objective findings.

3. Notes
    - Daily progress notes should **NOT** be copy pasted from prior notes. You can paraphrase and update each assessment entry. It's not necessarily to list all information in the assessment section. Notes should include:
        - Tobacco/substance/ETOH
        - Family update (every other day)
        - DVT PPX
        - Life Sustaining Treatment
        - Disposition plan

      Progress note is not needed on the day of discharge as long as physical exam on the day of discharge is included in DC Summary.
    - H&P needs to be completed and signed before leaving for the day. Include all components of H&P such as family and social history. If wound/ulcer is present, it should be included in your physical exam. All neurological/spine/back pain symptomatology need full neurological exam.
    - Discharge Summary
        - Don't copy paste the HPI, paraphrase the HPI.
        - For Secondary discharge diagnosis, remove auto-populated problem list, only include actively managed medical conditions.
    - Do not auto-populate images from previous hospitalization or outpatient unless relevant to why patient is currently admitted. If image is auto-populated, condense to remove unnecessary information to only include pertinent finding.
    - Reformat auto-populate labs so that it's not one long list. You can group as CBC, BMP, LFTs, Cultures, Images, etc.

4. Admissions
    - Utilize clinical pathways that are available to ensure we meet standard of care
      Below are available clinical pathways
        - Acute Coronary Syndrome
        - Alcohol Readmission reduction
        - Stroke/TIA
        - Cellulitis
        - CHF
        - Comfort Care
        - COPD
        - Delirium
        - GI bleed
        - Pneumonia
        - Sepsis
        - Syncope

5. Discharges
    - Accurate and appropriate discharge is critical to patient care.
    - Utilize ***Anticipate Discharge*** a day prior (if discharge is known in advance).
        - Medication Reconciliation (including WOUND care supplies, Nutrition supplements)
        - Anticipatory discharge (under administrative order)
        - Discharge instruction: Use Care Transition Portal or CHF discharge instruction (CHF patients)
            1. This is for the patient, avoid medical jargon.
            2. Include medication changes and instruction for the patient.
            3. Include CPAP/BIPAP/Oxygen if prescribed for patient.
            4. Wound care instruction must be included.
            5. Include f/u laboratory or image testing if recommended for patient.
            6. Tobacco/Substance/Alcohol use– must be accurately selected that matches admission nursing documentation (*Vaaes Acute Inpatient Nsg Admission Screen*). If agreed for cessation, order cessation medication and Quit Smart or STS consult must be placed.
    - D/C summary must be completed prior to discharge for patients going to SNF/assisted living.
    - For patient discharged to home, D/C summary must be completed within 24 hours.
    - Review Discharge Timeout for each patient that's anticipated or on the day of discharge w/ resident/attending.

Communication

1. Pages/Pager
    a. Pages should be answered within 5 minutes.
    b. On-call intern should carry Code-pager starting at 7AM.
    c. Cross-cover intern should pick up cross-cover pager at 7AM.

2. Handoff
    a. Proper handoff to another resident is critical.
    b. Handoff sheet should be updated daily, succinctly, and accurately.
    c. Include anticipatory guidance for cross-cover/NF team in "if" and "then" format.
3. Keep nursing staff informed of plan for patient. Urgent labs, tests, medication should be verbally communicated.

Professionalism

- Be on time for multi-disciplinary discharge rounds and rounds with attending.
- Be on time for educational conferences.
- Work as a team with your co-intern; ex. when one presents, one can place orders.

Didactics/Teaching

- Noon conference is mandatory 12:00 -1:00 pm.
    - This is a protected hour from patient care and you are expected to be on time
        - Exception is if you're on call and there is a *code* or *rapid response*
- Independent reading on topics is an essential aspect of your education during your rotation.
- You are expected to teach and guide 3rd year medical students who will mutually follow 1-2 patients.
- Suggested Reading Resources
    a. Harrison's Principles of Internal Medicine, 21th Edition
    b. Up-To-Date Online
    c. ACP/Annals of Internal Medicine, www.acponline.org
    d. NEJM – Interactive Medical cases; Videos in Clinical Medicine
    e. Stanford Antimicrobial guide
    f. Phone app: Journal Club: Medicine (quick reference for landmark trials)

Evaluations

- Attendings and Residents will provide verbal and written feedback using MedHub.
- You are evaluated by medical residents using MedHub.
- You are encourage to seek for feedback as well as direct observation to complete MiniCEX.
- Your evaluation is based on **6 Core Competencies**: Patient care, Medical knowledge, Professionalism, Interpersonal communication skill, Practice based learning, & Systems based practice.

Reviewed and Revised by: Iyerus Tariku, MD

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