

## **Supervisor Inpatient Orientation**

1. **CALL YOUR ATTENDING!** For any issues, don't fight the fight alone!! At the very least, call your chiefs if you have any questions/concerns. Any direct admits that get called to you that you are not comfortable with need to be discussed with your attending to determine if they should be accepted for direct admit or sent to the ED to be seen. There is no "eye-balling" of patients, even though they may enter the hospital through the ED.
2. Intake rounds are at 7:30 AM every weekday morning in the Education Classroom conference room. Everyone should be on time and the post call residents should be able to discuss any admission from the previous night. Please know results of all pertinent labs and films.
3. Work rounds should occur at/around 8:00 AM every weekday with your team. If it is more feasible for your team to have work rounds at a different time, make sure they are before your scheduled service rounds. This should be a quick run through of the patients on your service, including (especially) private patients, so the team is aware of potential problems and the plans for each patient for the day.
4. **Conference daily at noon.** If lunch is provided, it will be on the calendars on the door to the conference room, the lounge & online. Conference is mandatory. That means get your lunch at 11:45. Grand rounds every Wednesday at 8:00 am **BE ON TIME**—it's unprofessional and disrespectful to our speakers when you're late.
5. **PRIVATE PATIENTS:** Make sure Interns communicate with the private physicians in some way on a daily basis. When a patient is from out of town, their private physician should be notified after admission, every few days, and upon discharge. A copy of the discharge summary should be sent to that physician. (They need to request a copy be sent to the PCP when dictating the summary). Private physicians should be notified if transferred in or out of the ICU. If there is no documentation that the ICU team notified the pvt MD, it is the accepting Intern/Resident's responsibility to do so. You should be aware of the progress of private patients daily. You do not need to write daily notes on private patients, EXCEPT on patients in the SCU or those who are complicated require your attention in their care.
6. **STUDENTS:** You have to write notes on all patients followed by M4s and cosign their orders. They should not be following more than 10 patients at a time. M4s can admit private (and subspecialty) as well as service patients, but keep in mind their attending will only have exposure to them with the service pts. The M3s need to carry at least 5 patients, preferably service, but may also have privates and subspecialty pts. On weekends, M3s can take call with the subspecialty intern. If they need to pick up pts everyday, that's fine. They're purpose here is to learn and they need to be following pts to do that. If there are not enough intern pts for the M3s to follow, they may follow the M4's pts.
7. **DAYS OFF:** Ideally, interns should try to take their days off during weekends. Supervisor days off can be weekend or weekdays, and should be on days were there is adequate coverage of the patients on the service. It is still the job of the intern(s) to see all of the patients on the service on the weekends. The supervisors should help, but interns are still primarily responsible.
8. When private or out of town attendings call to admit patients, please accept those patients willingly. If there is any question, call the chiefs.

9. The most important part of your RAN is the differential diagnosis and plan. You may refer to the intern H & P for all other information unless there is new information to add. Remember, asthma H&Ps and orders are for patients older than 2 years and those with a known diagnosis of asthma.
10. Supervise intern check-out (for the first few days) of patients to make sure the patients are being adequately covered overnight and afternoons after the post call intern has left.
12. Sidhu, Warnick, Algae, Gandhi, Levine, Sailors, and Sudheedran DO NOT admit. Their patients go on service. Patients of Dr. Kassees are admitted to Pediatrics Consultants (Dr. Frizzell's group). Drs. Nicole Sheffield admits. Monica Wright (pager 533-5500) is now with Cordova Pediatrics, and also admits. Tiffany Hall (Southwind Medical Specialists) is now admitting, off 367-9001, pgr 477-4755.
13. There is not a hospital policy stating that consults have to be called to you by the requesting physician. If you are called for a consult by a ward clerk or nurse, go see the patient and then call the requesting physician regarding your recommendations. If the patient you are seeing as a consult has a private physician in town that has admitting privileges, you staff the patient with that attending or his/her partner. Otherwise, the patient is staffed by your service attending. If an attending of a D team pt requests a general Peds consult, the intern already following that pt needs to address the question of the consult and call either the pvt. PCP to staff it or call one of the service attendings to do so.
14. Neurosurgery patients admitted to Special Care should be admitted to service or to the patient's private doctor if that patient will be staying overnight. If the patient is being admitted and discharged in the same day, you do not have to admit them. We will consult on all ophthalmology patients in SCU regardless of length of stay (consult ONLY not admit/discharge.)
15. DIRECT ADMITS from local pediatricians are admitted to the floor. The DA nurse will call you when the pt arrives. Transfers from OSH &/or ERs still come in through the ER (but are not seen, nor "eye-balled"). DA Nurse 572-3113, cells: 647-8384, 647-8383. After 9 pm/weekends, Duty will be handling the direct admits (Pager 418-9095).
16. Referral & Resource Center: If you need any physicians' number or are having difficulty contacting a physician in town or out of town, call them 24 hours a day. #572-6733
17. The LeBonheur NICU is at x4800 and you can call them for consults or if you think a patient from an OSH (or our ICU) would be better served by the NICU.
18. If you admit a PCC patient, please let the Outpt residents know about the patient. They can also have the outpatient chart pulled to assist you...and then they know about them when they follow up.
19. For all new IV/IM antibiotic orders (including admission orders) use the "Intravenous Antimicrobial Order" Form.
20. After all notes and orders please use your stamp or print your name, Cerner number, pager number.

21. You may get called by the EMU (seizure monitoring unit). Be aware of those patients in case they Harvey, but you do not have to write H & P or daily notes. If you are already seeing a pt on the floor & they get sent to the EMU, continue to follow. We do not do H & P's for heart cath patients either, but the floor may call. If it is a seriously ill pt is expected to stay or Cards specifically ask you to follow—then do so. We still do CRC *if* there is *NO FELLOW* on.
22. If you're seeing a pt in the ED and their room is ready, please let them go and continue your H&P upstairs.
23. A very important part of your job is managing the list. Things to keep in mind: a good rule of thumb is "even by morning", meaning the interns on call don't necessarily have to admit an even number of pts, but the important thing is to look at the number of service pts the teams have, the overall number of pts the teams have and also the number each intern has. If in the morning, the post call interns and/or teams look fairly even, (service, overall number) that's a good thing. While subspecialty pts should preferentially go to the D intern, shifting them to the other teams when D is getting killed is a GOOD idea. Start with Heme and non-UT neuro/cards, but in the end, any TEAM can get subspecialty pts.
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25. Corrections to pager cards: Al Hamda 418-4510, Linda Lazar 269-4012, Lutterman 392-3324, Heather Thompson 418-6005, Marion Hare 418-2025, Cath Lab on call pager 418-9158 (for questions re: CVLs)