Department of Medicine

VA Hospital Policies: Internal Medicine

VA Services

Four (4) General Medicine Teams
One (1) ICU Team
One (1) Med Consult Resident
One (1) Day MAR
One (1) Day MAI
One (1) Night Float Resident
One (1) Night Float Intern
Two (2) VA PACT/Quality Residents
One (1) Procedure Team

ACGME Rules Applied to the VA

- **ACGME Rules Regarding Supervision**
  - *Level 1/Direct Supervision*, defined by immediate, in-person supervision, is required for all procedures performed by non-credentialed housestaff regardless of the time of day. The supervisor may be a credentialed house officer or faculty member; if the former, the responsible faculty member must be immediately available either on/off site (this is defined as Indirect Supervision depending on the time of day as is described below).
  - *Level 2A/Indirect Supervision*, defined as immediate on-site availability, is required of faculty between 7AM-4PM daily for housestaff clinical responsibilities and is required of senior housestaff 24 hours a day for PGY-1s.
  - *Level 2B/Indirect Supervision*, defined as immediate availability from off-site faculty, is required of faculty between 4PM-7AM daily for housestaff clinical responsibilities.
- **ACGME Rules Regarding Duty Hours**
  - The Work Day
    - No shift can be longer than twenty-four (24) hours for PGY-2/3s (16 hours maximum for PGY-1s).
      - An additional three (3) hours can be utilized to finish work that does not relate to direct patient care.
    - There must be ten (10) hours off between shifts.
  - The Work Week
    - No work week (Sunday through Saturday) can exceed eighty (80) hours under any circumstance.
      - Moonlighting (for fellows and chief residents) counts toward the eighty (80) hours; PGY1s-PGY3s may not moonlight.
    - There must be a continuous twenty-four (24) hours off per week.
- **ACGME Rules Regarding Patient Numbers per Intern and Resident**
  - Interns (PGY-1)
    - *Interns can follow no more than ten (10) patients at any one time*.
    - No more than five (5) new patients + two (2) transfers can be assigned to an intern during a routine day of work.
    - No more than eight (8) total patients (news + transfers) can be assigned to an intern over a 2-day period.

- Senior Residents (PGY-2/PGY-3)
    - *With one (1) intern on the team, the supervising resident can follow no more than fourteen (14) patients at any one time (this means the intern can follow up to ten (10) patients and the resident, without the intern, can follow an additional four (4) patients).*
        - With one (1) intern on the team, the supervising resident can only have five (5) new patients + two (2) transfers assigned to the team during a routine work day.
        - No more than eight (8) total patients (news + transfers) can be assigned to the team over a 2-day period.
    - *With two (2) interns on the team, the supervising resident can follow no more than twenty (20) patients at any one time.*
        - With two (2) interns on the team, the supervising resident can only have ten (10) new patients + four (4) transfers assigned to the team during a routine work day.
        - No more than sixteen (16) total patients (news + transfers) can be assigned to the team over a 2-day period.

With these rules serving as our guide, our own policy will be that any team with two interns can have no more than 16 patients total for the resident (with no more than 8 for either intern). When patient demand exceeds our total inpatient capacity, teams can flex to no more than 20 patients (10 per intern), but this should be the exception rather than the rule. At no time will any covered team be responsible more than 20 patients. Overnight coverage will be provided by the housestaff night services with a nocturnist attending providing supervision. The Chief Residents will keep track of numbers daily to the best of their ability. Ultimately, though, it is your responsibility to immediately report an infraction of the above rules to the Chief Residents. Failure to do so could lead to loss of program accreditation (which ultimately will affect your residency training).

Remember, however, no rule nor regulation should ever come before urgent patient care.

<u>Admitting Schedule and Man-Power at the VA</u>

Please see section "The Upstate IM Residency-An Overview"

1. Weekdays
    a. 8AM-12PM
        i. The MAR will distribute overnight admissions to all four (4) teams fairly based on team numbers that morning.
            1. Bounce-backs, defined as a patient cared for by a team's current intern or resident, will be assigned to that team.
        ii. The MAR is responsible for assigning and completing all admissions to the non-ICU medicine services during this time; the MAR may also provide emergency/urgent care to patients in the ER if they are awaiting medicine admission.
        iii. The ICU resident is responsible for admitting ICU patients.
        iv. If help is needed, the MAR or the ED attending may contact the Chief Resident who will then be responsible for finding additional manpower (for example, jeopardy).
    b. 12PM-4PM

i. The MAR will be responsible for distributing admissions to all services; all services are responsible for completing their own admissions.
    1. Assignment of admissions:
        a. Bounce-backs, defined as a patient cared for by a team's current resident, will be assigned to that team.
        b. Team numbers at the time of the admission (not in the morning as discharges may have occurred) will determine team assignment otherwise.

c. 4PM-8PM
    i. The MAR and on-call resident (and intern, if available) take all medicine admissions (including ICU admissions) during this time.
        1. Bounce-backs, defined as a patient cared for by a team's current resident, will be assigned to that team.
        2. The on-call resident can receive no more than 2 admissions between 6-6:30PM and 1 admission between 6:30-7PM to their own team; additional admissions during that time and anytime between 7-8PM will be distributed among all teams.
            a. Until 7PM, the on-call resident will present admissions to their team to their team attending.
            b. From 7-8PM, all admissions will be presented to the Nocturnist.
        3. The on-call resident can only receive one (1) additional admission (not counting ICU transfers to the floor, but counting floor transfers to the ICU) from 7PM onward with the last admission at 7:30PM and may sign out anytime after 8PM (when work is complete).
            a. Additional admissions will become the responsibility of the VA Night Service (at 8PM).
            b. The only exception to this is if a patient is unstable and requires urgent attention.

d. 8PM-8AM
    i. The VA Night Service (Attending and Resident) will admit all patients.
        1. Bounce-backs, defined as a patient cared for by a team's current resident, will be assigned to that team.
        2. The on-call resident can only receive one (1) additional admission (not counting ICU transfers to the floor, but counting floor transfers to the ICU) from 7AM onward.
            a. Additional admissions will become the responsibility of the MAR (at 8AM).
            b. The only exception to this is if a patient is unstable and requires urgent attention.
            c. Until 7AM, admissions will be presented to the Nocturnist.
            d. From 7-8AM, admissions will be presented to the team attending.

2. Weekends
    a. 7AM-2PM
        i. The MAR and will fairly distribute overnight admissions to his/her own team and the off-call team based on team numbers that morning.

1. Bounce-backs, defined as a patient cared for by a team's current resident, will be assigned to that team.

ii. The on-call resident will fairly distribute admissions during 7AM-2PM between his/her own team and the off-call team; ICU admissions are assigned to the ICU team.

1. Bounce-backs, defined as a patient cared for by a team's current resident, will be assigned to that team.

b. 2PM-8PM

i. The on-call resident (and intern, if available) takes all medicine admissions (including ICU admissions) during this time.

1. Bounce-backs, defined as a patient cared for by a team's current resident, will be assigned to that team.
2. The on-call resident can receive no more than 2 admissions between 6-6:30PM and 1 admission between 6:30-7PM to their own team; additional admissions during that time and anytime between 7-8PM will be distributed among all teams.
    a. Until 7PM, the on-call resident will present admissions to their team to their team attending.
    b. From 7-8PM, all admissions will be presented to the Nocturnist.
3. The on-call resident can only receive one (1) additional admission (not counting ICU transfers to the floor, but counting floor transfers to the ICU) from 7PM onward with the last admission at 7:30PM and may sign out anytime after 8PM (when work is complete).
    a. Additional admissions will become the responsibility of the VA Nocturnist/VA Night MAR.
    b. The only exception to this is if a patient is unstable and requires urgent attention.

ii. If help is needed, do not hesitate to call the on-call Chief Resident who will coordinate extra man-power.

c. 8PM-8AM

i. The VA Night Service (Attending and Resident) will admit all patients.

1. Bounce-backs, defined as a patient cared for by a team's current resident, will be assigned to that team.
2. The on-call resident can only receive one (1) additional admission (not counting ICU transfers to the floor, but counting floor transfers to the ICU) from 7AM onward.
    a. Additional admissions will become the responsibility of the MAR (at 8AM).
    b. The only exception to this is if a patient is unstable and requires urgent attention.
    c. Until 7AM, admissions will be presented to the Nocturnist.
    d. From 7-8AM, admissions will be presented to the team attending.

3. ICU admissions

a. Weekdays

i. 7AM-4PM

1. The ICU resident takes all admissions/transfers to the ICU.
2. All ICU admissions must be presented to ICU fellow.

ii. 4PM-7AM
    1. ICU admissions are done by the MAR or on-call resident.
    2. All ICU admissions must be presented to ICU fellow.

b. Saturdays
    i. 7AM-2PM
        1. The ICU resident takes all admissions/transfers to the ICU.
        2. All ICU admissions must be presented to ICU fellow.
    ii. 2PM-7AM
        1. ICU admissions are done by the on-call resident.
        2. All ICU admissions must be presented to ICU fellow.

c. Sundays
    i. 7AM-8PM
        1. All ICU admissions are done by the on-call resident.
        2. All ICU admissions must be presented to ICU fellow.
        3. The on-call resident will round on all patients in the ICU, but is not responsible for writing notes.
    ii. 8PM-7AM
        1. ICU admissions are done by the on-call resident.
        2. All ICU admissions must be presented to ICU fellow.

4. What About Overflow or Above-the-Cap?
    a. Unless there is an urgent/emergent patient safety issue, the ACGME rules outlined above may not be violated under any circumstance.
    b. Overflow patients are the responsibility of the on-service attendings (or other VA-appointed health-care providers); housestaff are not to be involved in the care of these patients unless team numbers allow for transfer to a housestaff-covered service or if an urgent/emergent issue requires immediate medical attention.

<u>Medicine Consult at the VA</u>

-Medicine Consult

- Weekdays
    - 7AM-5PM
        - In hospital
    - 5PM-8PM
        - Home Call (may be UH or VA Med Consult Resident)
    - 8PM-7AM, VA Night Service (not the intern) covers all urgent consults.
- Weekends (1st Sat-UH; 1st Sun-VA / 2nd Sat-VA; 2nd Sun-UH)
    - Saturdays and Sundays
        - 7AM-4PM (or later until work is done)
        - 4PM-8PM (Home Call)
            - 4PM-8PM, you are first call for medicine consults and, after 2PM, back-up for admissions.
        - 8PM-7AM, VA Night Service covers all urgent consults.

<u>Admission Notes</u>

Admission Notes may be typed or dictated and must include the following information:

1. Chief Complaint
2. History of Present Illness

3. Past Medical/Surgical History
4. Allergies (drug and reaction)
5. Current Medications (drug, dose, and schedule)
6. Social History
7. Family History
8. Review of Systems
9. Physical Exam
10. Labwork/Diagnostics
11. Assessment
12. Problem List
13. Plan
14. The last line should indicate that the patient has been discussed with your attending; don't forget to designate the attending as the co-signer of your note.
15. CC List

Daily Progress Notes

Daily Progress Notes must be completed using the SOAP (Subjective, Objective, Assessment, Plan) format.

1. Clerkship student notes are a vital part of the record and must be reviewed by the intern or resident; however, clerkship student notes alone do not legally suffice and, thus, a full daily progress note must be completed by the intern or resident.

2. Acting-Intern student notes are a vital part of the record and must be reviewed by the resident (not the intern); however, Acting-Intern student notes alone do not legally suffice and, thus, a full daily progress note must be completed by resident (not the intern).

Discharge Summaries

Discharge Summaries must be completed within 48 hours of discharge and must include the following information:

1. Date of Admission
2. Date of Discharge
3. Primary Discharge Diagnosis
4. Secondary Discharge Diagnoses
5. Significant Procedures Performed During Hospitalization
6. Brief Summary of Hospitalization
7. Discharge Allergy List (drug and reaction)
8. Discharge Medication List (drug, dose, and schedule)
9. Disposition/Code Status/Proxy Status/Follow-Up Requirements
10. CC List

Signout/Handoffs

Signout or Handoffs are, unfortunately, an opportunity for error. As such, it is imperative that great care be taken in preparing these documents. We utilize CPRS's signout/handoff feature. The policy is as follows:

1)The senior resident (PGY-2, PGY-3) on each service will be responsible for ensuring that the signout/handoff is accurate and up to date on a daily basis. This does not mean these are the individuals responsible for inputting the information (this can be done by any team member), but the senior resident, as the team leader, will be responsible for what is contained within the signout/handoff.

2)The attending on a service without a senior resident and attendings for uncovered patients will be responsible for ensuring that the signout/handoff is

accurate and up to date on a daily basis. This does not mean the attending is responsible for inputting the information (this can be done by any team member), but the attending will be responsible for what is contained within CPRS. If no signout is provided for uncovered patients, there will be no housestaff coverage provided and coverage will fall to the Nocturnist.

3)Members of EPO and/or VA Leadership will randomly review patient information in CPRS to ensure that the information contained is accurate and up to date. If information is found to be outdated or inaccurate, the senior resident on that service will be given a warning with some instruction on how to improve. A 2nd and 3rd infraction will be result in Academic Deficiency and Academic Probation, respectively, for an infraction of the Professionalism, Interpersonal and Communication Skills, and Patient Care competencies.

4)If information for uncovered patients is found to be outdated or inaccurate, the attending will need to answer to their respective VA Supervisor. If after instructions on how to improve there are additional infractions noted on future reviews, these services will be at risk for losing housestaff involvement in all aspects of uncovered patient care (except RRT/Code situations).

5)The individual completing the admission history/physical for a patient is responsible for inputting that patient's pertinent information onto the right service in CPRS; this is true regardless of time of day (i.e. overnight admitters are responsible for inputting this information).

6)When a cross-covering service comes across pertinent changes (a new fever, new abx, a new diagnosis, etc.), the cross-covering service is responsible for updating the signout in EPIC.

For questions or clarifications please page the VA Chief Resident weekdays from 7AM-4PM, and the on-call Chief Resident weekdays after 4PM or anytime on weekends.

VA INPATIENT FLOOR CALL SCHEDULE

Week #1						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Team 4	Team 1	Team 2	Team 3	Team 4	LC - 1R,1AI, 2BI	LC - 2R, 2AI, 1BI
					SC - 4R, 4AI, 3BI	SC - 3R, 3AI, 4BI
Week #2						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Team 3	Team 4	Team 1	Team 2	Team 3	LC - 4R, 4AI, 1BI	LC - 1R, 1AI, 4BI
					SC - 3R, 3AI, 2BI	SC - 2R, 2AI, 3BI
Week #3						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Team 2	Team 3	Team 4	Team 1	Team 2	LC - 3R, 3AI, 4BI	LC - 4R, 4AI, 3BI
					SC - 2R, 2AI, 1BI	SC - 1R, 1AI, 2BI
Week #4						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Team 1	Team 2	Team 3	Team 4	Team 1	LC - 2R, 2AI, 3BI	LC - 3R, 3AI, 2BI
					SC - 1R, 1AI, 4BI	SC - 4R, 4AI, 1BI

1R	Team 1 Resident
1AI	Team 1A Intern
1BI	Team 1B Intern
2R	Team 2 Resident
2AI	Team 2A Intern
2BI	Team 2B Intern
3R	Team 3 Resident
3AI	Team 3A Intern
3BI	Team 3B Intern
4R	Team 4 Resident
4AI	Team 4A Intern
4BI	Team 4B Intern

Some Useful Rules:

1) Call Team for given weekend day is called "Long Call"
2) Other Team for given weekend day is called "Short Call"
3) R and AI always work together on weekends (with Attending)
4) BI always works alone on weekends (with Attending)
5) BI's call schedule always mirrors R/AI's call schedule
6) Thursday Long Call is Sunday R/AI Short Call
7) Friday Long Call is Saturday R/AI Short Call

LC	Long Call (until 8PM) R - Day MAR (Admits until 8PM; signs out to Nocturnist at 8PM) AI - Cross-Coverage except for BI Team; Takes over Cross-Coverage of BI Team at 2PM, signs out to Night Float at 8PM) BI - Covers own team until 2PM, then becomes MAI until 8PM
SC	Short Call (until 2PM) R - Helps with Admissions until 2PM AI - Covers own team until 2PM; can take admissions if available BI - Covers own team until 2PM