**Rotations**

**Hospital Medicine 1A/1B:**

You’ll probably want to arrive no later than 5:30, especially in the beginning. Get updates on your patients from the house officer and start pre-rounding.

From 8 to 9 you’ll have didactics, usually in the conference room near the patient elevators on the 4th floor.

At 9, go to multidisciplinary rounds in the 4B workroom to discuss potential barriers to discharge, PT/OT or social work needs, and so on.

Then meet up with your attending for rounds!

You will usually be on for admits unless you have clinic in the afternoon. If you get a 5973 page, it’s probably the ED with an admit.

Try to sign out as close to 5 pm as you can. It helps to start updating your sign-off notes at 4:30pm no matter what -- you can always finish your H&P and any last to-do’s after but you’ll never leave if you never sign out. Also, the SHO will start to get pages on your patient at 5pm anyway, so they’ll want to know what is going on with them and will want updated notes to refer to! First update all your written sign-off notes. If boarding in ED, write your sign-out note as a cross cover note in chart because if you put it in the sign-off section, it gets lost when they get a bed. For floor patients you sign out to the house officer. Verbally sign out every to-do you have and every patient with more acute illness. For ED boarders and IMCU patients, you need to sign them all out verbally to IMCU resident. Make sure to update your signout note for all your patients, as well.

Family practice clinics are (usually) Tuesday and Friday afternoons. Some attendings are around in the afternoon and are happy to help out with things that need doing. Otherwise, you can sign out to the wards attending or else field pages from clinic. This is one of the trickiest aspects of the rotation. Just remember that your preceptors and attendings are there to help you and support you, and don’t feel like you have to do everything yourself.

**BM:**

**Schedule**

* to find the schedule, go to www.ccrmc.wikispaces.com-->Residency Stuff-->BM/CODA-->Schedules
* Patty Hennigan is in charge of the rotation. You may want to contact her prior to starting to ensure the schedule is correct.

Patty Hennigan

Pager 504

***patty.hennigan@gmail.com***

* The schedule is pretty mellow and you get a lot of free time. Quite a few things are out in the community.
* **“Meet the doctor” on Wed AM is cool at Casa Ujima. Is drug/Etoh addicted mothers. They like to ask you questions but equally you are able to ask them questions as well.** 
  + **This is usually on the first day of the rotation, so make sure to sign out to the person following you. You can’t be late or the group will leave (they have pretty strict time rules)**
  + They’ll likely have questions about their (usually multiple) health problems. Though they’re all relatively young, they’ve probably done some serious damage to their bodies, so be quick to say, “If you have any concerns, go to your doctor/the ED.” One lady mentioned she’d woken up with some numbness in her fingers and toes. (Lots of EtOH or drug-related neuropathy in this population) I said to see a doctor if it persists. The next week, she reported that she’d gone to the ED and had had a small stroke. Scary. All of them should have doctors.
* Wednesday evening buprenorphine clinic with Dr. Saffier is amazing. It helps to ask for no SHO shifts on wednesday evenings so you don’t have to switch them later.
* There is a required assignment, called a Toolkit. The idea is to make a quick reference document on a BM related topic, such as a specific disease or topic (nutrition, for example) that residents can use in the clinic to help assess, treat, educate and empower the patient.
  + You present your Toolbox during the last Wednesday of the rotation.
  + On the BM/CODA website on the wiki:
    - Recommended topics and specific directions for the asigment can be found under “Directions and Contact Information” link
    - Examples of previous Toolkits can be found under the “Behavioral Medicine Case Conference Readings” link
* Some people find the afternoons in PES boring, but if you are proactive and ask to see patients yourself you can learn a lot. You can also learn a lot about meds for handling agitation which we have to do all the time on the floor. Drs. Niclas, Adler (or something like that), and Saldana are very nice and generous teachers, so stick with them.

**NHO:**

Schedule:

Sun - Wed 8pm-8am

Thurs 8pm-7am

Friday 5pm-8am (you come in early on friday so that no one on outpatient has to do SHO on fridays, and you get off an hour early on friday morning to make that easier to do)

**Logistics**

* Go to IMCU workroom 5-8PM for Short House Officer (SHO) and 8PM-8AM for Night House Officer (NHO)
* Pick up the HO pager (901). Keep your own pager on as well.
* Responsibilities:
  + Get sign-out from primary teams. While you do not have to track people down, if they have any to-do’s they MUST verbally sign them out to you. Every patient *should*be verbally signed out but ***requires*** a standardized floor sign-out note – if there is no note, feel free to point this out to the resident/attending and/or write a passive aggressive note in the signout section.
  + As soon after 8pm as you can, page the pediatrician at 733 for sign-out
  + Answer pages for all 4A (telemetry), 4B (medical ward), 4C (psychiatry), 5B (nursery) and 5D (med/surg) patients. [ Gyn patients, L&D patients, and post-partum patients are covered by the Ob resident on call and IMCU/ICU and ED boarders are covered by the ICU resident]
  + Assist with admissions

**How to approach pages**

* Look at the page. Respond to numeric pages, especially 5615 (nursery) quickly
* Is this patient stable? Is the situation the nurse is paging me about potentially life threatening? If so, go immediately to bedside. If possible, while en route, grab a cow and notify your senior of the situation. Consider calling an RRT or a code
* IIf patient is stable and you have some time, call the nurse back and ask him or her to explain the situation. Sometimes they just want a technicality about an order fixed, sometimes they need to document that MD is aware of xyz, sometimes they are conveying a request/need from the patient regarding pain/anxiety/insomnia, and sometimes they are actually worried about the patient, and it is important to ask lots of questions to find out which. It is also important to think critically about whether or not you are concerned regardless of whether the nurse is.
* While talking to the nurse, look at the sign off note -- is this situation addressed there? Who is this patient, why is he in the hospital, and what are his comorbidities? Look at old/relevant records -- did the dilaudid or heparin expire or were they cancelled on purpose? Is this a new BP or has the patient gone down to 88/55 every single night while sleeping? Was the potassium already replaced this morning?
* Think: is this better dealt with now, or in the morning by the primary team? Do not wake patients up to change their IVs (unless the patient lost IV access & needs it) or replace K (as long as the K isn't dangerously low). Don't make major changes to the plan unless they will impact the patient's well-being overnight, and if you do, it should likely be run by a senior.
* Unsure what to do? Talking through the situation out loud with the nurses can be helpful. Always call your senior resident for help, and if still unsure, call the Medicine for FMS attending.

**Documentation**

* Small stuff (pain, insomnia, anxiety, replacing electrolytes) – make a smart phrase saying date/time/who you are and then put this in the sign-out note under “communication to primary team” with what you did
* Routine but more involved things (post-op checks, resp checks) – write a cross-cover note in chart in SOAP format
* Complex issues (high fevers, chest pain, SOB, hemodynamic instability) – write a ‘significant event’

**Resources**

* **RRT** = rapid response team = ICU nurse and respiratory therapist. Nurses can call them for significant change in vitals, concern about patient, altered LOC, lactate>4. MD is supposed to be informed but doesn’t always happen.
  + RRT nurse is a great resource especially for thinking about whether someone needs to move to IMCU/ICU. It can be very helpful for you to call an RRT to get them to bedside along with a RT.
  + It’s always good to be in communication with RRT nurse – they have a ‘worry list’ of patients at night and it is great to make sure you’ve got the same patients on your radar.
* **Code Blue** = all hands on deck , obviously call if someone is not breathing or doesn’t have a pulse, but can also call if someone is critically ill and you need a lot of help fast
* **After hours pharmacists** 866-503-4443
* **VRAD** = after hours radiology for CT and Ultrasounds. You read your own plain films overnight but can review with ICU resident or ED attendings, or call and ask VRAD to read a plain film
* **ICU resident** – your go-to for questions and support
* **FMS / Medicine Attending** – often you want to talk to ICU resident first but you can always call them directly; if something big is happening with a patient they want to know anyway

**Things to do before your first shift:**

* Make patient lists in EPIC, generally nice to have:
  + **HO List** with all patients you are covering: 4A tele , 4B medicine, 4C psych, 5B nursery, 5D med/surg, operating room
  + **To Do** – where you can drag patients when you get to-do’s from primary teams or for you to remember to follow up labs/imaging you order on your shift
  + **To Done** – you can drag patients here once the to-do is finished, but this lists enables you to find them again if you remember something later
  + **To be aware of** – sometimes you get important verbal sign-out that is not a to-do but is important to know if called on this patient and important to sign-out to NHO
  + **To sign-out** – if something major happens on a patient you want to be sure to verbally sign out to resident in the AM, put them in this list and erase them as you sign-out these thing
  + Columns: Room/Bed; Patient Name/Age/Sex; MRN; Problem; Provider Team; Service; Code Status; CrCl
* Think about what you want to have on you:
  + Stethoscope and Scoop for sure
  + Code cards (although main algorithms are in Scoop)
  + Nice to have a penlight
  + Consider having pocket references, reflex hammer, etc available if not always on you

**Triaging**

* Things that should be evaluated in person:
  + Anytime a nurse is concerned about a patient, you need to see them in person, period.
  + Chest pain (even if it is 99.9% GERD)
  + New onset SIRS
  + Rashes (r/o drug reaction, especially to antibiotics, or scabies which requires isolation)
  + SOB (top 3 things on your differential should be PE, PE, PE. You will miss a PE at some point in residency. Also ACS, pneumonia, volume overload, atelectasis, anxiety, asthma/COPD, etc.
* If you are signed out “nothing to do, but I’m worried about this person” call the nurse and make sure they know to have a low threshold to contact you. Consider ordering frequent vitals so they will get eyeballed regularly.
* Always consider the worse possible scenario and disprove it before considering anything else (ie every chest pain you are disproving ACS or PE, every abdominal pain you are disproving acute abdomen, etc)

**Work-flow**

* One of the hardest parts of being HO is prioritizing your work. Patients you are concerned about come first, fixing orders and ordering a sleeping pill can wait. There are times when you will be back 10 pages if you are handling something acute, and that is OK as long as you have looked at the pages and they are not urgent
* IIt often works well to physically see and evaluate people you are concerned about, then, once you have a plan and have ordered appropriate tests, you can hang out in the vicinity and take some time to handle the back-log of lower priority things while you are waiting for results to come back and re-evaluate the patient.
* It can be helpful to politely request that nurses send text-pages whenever possible and use numeric paging only for something urgent so that it is easier for you to triage.
* You may be asked to help with admissions but keeping floor patients safe is your #1 priority, it is OK to say that you cannot take an admission, and is always a good idea to makes sure any admits you do are stable patients in case you get called away
* It is important to go to OB-responses in case the baby needs resuscitation so you can help the peds attending

**Communication**

* Keep your ICU resident in the loop – they ALWAYS like hearing about sick patients earlier rather than later
* Always be polite and positive with nurses. Their training and perspective is different and you may find that what seems pertinent to them doesn’t always coincide with what is pertinent to you. Always be polite and explain your thought process so that everyone on the team is on the same page.

**Sign-off notes**

* Being HO helps you write better sign-off notes
* See page 9 of your Scoop, but briefly: Use dotphrase .floorsignout or .icusignout and give brief one liner. It is helpful to update each day with any major events/plans. Leave lots of if-thens for anything you are likely to be called about (pain, anxiety, insomnia, fever)

**General Surgery:**

Schedule: No later than 6 AM unless you’re a total stud/speedster. Typical inpt hours (i.e. 12ish). You should have a designated OR day (check that it’s not the same day as your clinic and tell an attending if it is).

Surgeries: try to get to 1-2 cases on your OR. Look at the schedule with your attending the day before “Under All Areas in Epic” because sometimes the coolest case is in the morning and you might be able to coordinate with them to go to the case and round afterward.

Most surgeons, regardless of specialty, are happy to have you in on the case. If you’re there early enough, most anesthesiologists will also let you intubate.

Etiquette: Leave your pager and write your full name on OR the white board. Always ask if the tech needs your gown and/or gloves. Leave your white coat in the locker room or break room.

Dr. Weiss will page you when he goes to the OR. This is really nice, but if you’re swamped, don’t feel pressure to go. He does “pimp” but not maliciously. Make sure to give pts 1 refill on their pain meds cuz he doesn’t like it if they’ve run out by the time they see him.

Dr. Gynn usually pages you if you ask him ahead of time (sometimes he will let you know a few days ahead of time what his schedule is). He is super nice, so always feel free to ask him any questions about post-op management, follow up, etc. If he doesn’t have any cases, Dr. Weiss is happy to have you in his cases!

**OB-1A:**

This rotation is relatively chill and you definitely get a good amount of time off. The schedule may change a bit this year as there is no longer a Women’s Health rotation and some of those experiences may get integrated into OB 1A. You should get an e-mail with the correct schedule a few days before the start of the rotation, and you’ll also get all this during orientation on the first day, but this should give you a bit of an idea:

On Tuesdays through Fridays, meet on the 5th Fl on L&D at 6:30 to do sign-out and then 7am lecture in the resident lounge on the 5th Fl.

After that, on Tuesdays you’ll do post-partum rounding and be back-up on L&D until noon or so. Take your time and spend some time with each woman discussing breastfeeding and pp contraception. There are on most days 2 other attendings rounding (who, as everyone repeats to me, are paid to be there). When you’ve seen your share of the postpartum patients, or earlier if it’s super busy on L&D, head over to L&D to see if they need help with triages, etc. In the afternoon you’ll have your continuity family practice clinic.

On Wednesdays you’ll go to prenatal clinic all day with Dr. Cavallaro in Pittsburg. They will explain it at orientation but basically you still go to L&D at 6:30, do lecture and PP rounding, and then get to Pittsburg by 9:15-ish. On some days you’ll get to work with the perinatologists, Dr. Goldman or Dr. Marinoff.

Thursdays are L&D all day until 8pm or so; depending on how busy it is I would sometimes leave earlier or later. I would introduce yourself to the nurses at the start of each shift. They will be your best resource during L&D, though some of them have particular belief/practices that may be contrary to the way we’ve learned to do things. If you’re friendly and ask them questions they’ll ultimately help you a ton!

Friday is PP rounding from 8-9 and then PBL and clinic.

Sat night you do a 8pm-8am shift on L&D.

L&D is really fun and you’ll get to deliver a ton of babies. Go to the OR whenever there is a section. You’ll get to do everything even if you know nothing and everything on the floor will be taken care of while you’re gone.

Other things to know:

You’ll be writing delivery summaries and op notes for all babies delivered. Make sure to explain the indications for the section in the op note (briefly explain the course in L&D up to the decision to section, similar to what you would do for a vaginal delivery note).

You need to write a progress note on every L&D patient q4hrs

Be sure to discuss every triage patient with your attending. I sent a couple obvious r/o labor patients home without discussing with my attending and apparently that isn’t ok (haha, I mean, it was fine, but just let them know your plan, sometimes it seem like you can do most things without discussing them with your attending, but in that case you ought to discuss with them)

Each attending has a different style that is very distinct from others. You’ll feel confused about what the evidence supports and what the standard of care is, just go with what each attending does and check out the wiki page under ob/gyn for some good info on evidence based practice.

The team structure on OB can be very amorphous and non-hierarchical, which can be one of the biggest challenges. In general, you can consider your shadow as almost like a senior resident and your first go-to person for questions/help/supervision. Sometimes there are many attendings around and some of them will be actively involved in managing patients as well so you will work directly with them.

It can be helpful to make a template piece of paper similar to the white board and jot down the most important info on each laboring patient at the beginning of shifts and keep it updated so when you are called / asked a question about a patient you can refer to it.

The wiki page is a great resource for everything you might want to know about- pp rounding, contraception, dictations, etc.

Have fun and enjoy your saturDAY, sunday post call AND monday off every week!

**OB-1B:**

This is the more intense OB rotation where you have 4 OB calls per week and only one of your FMC clinis to make that happen. It is actually great to have more concentrated learning and most of us felt that we got much more comfortable much quicker on this rotation than on OB-1A. Generally you go to board sign-out at 6:30am and lecture at 7pm on weekdays unless you pre/postcall.

L&D is really fun and you’ll get to deliver a ton of babies. Go to the OR whenever there is a section. You’ll get to do everything even if you know nothing and everything on the floor will be taken care of while you’re gone. The expectation is that you will be primary on all c-sections. All of the attendings who have been around for a while know and honor this, with some of the newer attendings you will have to ask to be primary. You may get push-back from one or two on this, I would advise to be respectful and ask to do as much as they feel comfortable allowing you to do and then tactfully giving some feedback to Judy Bliss if any attendings aren’t letting you do much on the sections.

Other things to know:

You’ll be writing delivery summaries and op notes for all babies delivered. Make sure to explain the indications for the section in the op note (briefly explain the course in L&D up to the decision to section, similar to what you would do for a vaginal delivery note).

You need to write a progress note on every L&D patient q4hrs

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It can be helpful to make a template piece of paper similar to the white board and jot down the most important info on each laboring patient at the beginning of shifts and keep it updated so when you are called / asked a question about a patient you can refer to it.

The wiki page is a great resource for everything you might want to know about- pp rounding, contraception, dictations, etc.

**Newborn:**

* Generally a nice, uplifting rotation with a lighter schedule than most inpatient rotations.
* Pre-rounding starts at 7am on postpartum (might want to get there a little earlier on first day)
* Pre-rounding data: term/preterm, appropriate for gest age vs LGA/SGA, Apgars, type of delivery, complications, GBS status, vitals, birth weight, today’s weight and % lost.
* Well babies need admit and discharge physical; nursery babies need daily exam and note. Attire: scrubs. Food: eat breakfast before you get there. They will encourage you to go to noon conference/eat lunch.
* You will work with a Travis resident (second year) who is usually very helpful.
* You generally get out at 5pm or shortly thereafter reliably, which is wonderful.

**Clinics:**

- Jim Walls is supervisor (jwalls@ccfamilymed.com)

Monday

-AM: Derm 8am-noon, Martinez (MTZ) clinic 3North: all the attendings work together, so you see patients on your own then present to one of them, whoever is available. Dr. Lee will give you a quick orientation. Dr. Lee does the most teaching when you present to him, and Dr. Paige is brilliant. Those are the two attendings that I tried to present to the most.

-PM: High risk preop clinic

Tues:

-AM: Minor procedures clinic: 8:00-12:00 MTZ 1 South: On the schedule it says Dr. Cominos, but there a few different attendings who take turns at this clinic. Common procedures include cyst removal, cryotherapy, excisional biopsies, keloid injections, etc. You work very closely with the attending who walks you through everything. If things are slow you can always ask for teaching about suturing, pathology, etc. You write the procedure note after each procedure (ask for templates). Don't forget to log them in New Innovations.

-PM: your own FPC

Wed:

-AM:

- Radiology teaching with Dr. Liebig 8:30-10:30: go to the radiology room where Liebig works and he talks about various topics. It is absolutely amazing.

- Behavior Med Conference: 10:30-12:00 in the 2nd floor conferene room of 331 C street, (where we had PPD the first time). Sit and talk about various topics with Patty Hennigan and Jessica Sullivan

-PM: Renal / internal medicine

Thurs:

-AM: Neurology with Van Handel who is really nice and a great teacher.

-PM: Rheumatology with Dr. Stone

Evening: 4th week of calendar month IUD/nexplanon clinic with Dr. Robello

Fri:

- AM: PBL at 9:00-12:00 in 5th floor resident's lounge. Usually two topics are presented.

- PM: your own FPC

Call responsibilities:

- four short HOs

- two Saturday NHOs with Sunday AM rounding. You split the 4 saturdays with whoever is on BM, so if you have a preference talk to that person. Hope for good sign out from whoever you are rounding for. You can find out who it is on friday in the ICU work room.

Other helpful hints:

- door codes for all Martinez clinics: 6380

- When things are cancelled or not scheduled, this is a great time to explore your own interests:

- The OR is usually pretty welcoming.

- I spent a good amount of time stalking the Endoscopy room to learn colonoscopies. Some GI attendings are more interested in teaching residents than others. The FM GI registrars are the best: Dr. Forman, Dr. Roberts, Dr. Slauson (not sure if she is FM or not?). Dr. Hauck will let you watch but he is adamant that he will NOT teach residents to scope. Dr. Kogan let me do a couple, but doesn't really know what to do with residents.

- Dr. Klinerman is rumored to do one vasectomy on Friday mornings at 7:45 in MTZ 1 South, which you could do before PBL. He didn't actually have any scheduled during my month, but you might keep an eye out if you're interested. But be aware there are some R2s who are also interested and try to go to those too.

- Regarding Minor Procedures clinic: it is only held Tues mornings and Wed afternoons. There is always an intern scheduled for Tues AM and a 3rd year for Wed PM, however the 3rd year often takes at least one week of vacation. So if you can figure out when that person is taking time off you could go to their minor procedure clinic that week if you want more experience.

**Ortho:**

- Attending in charge is Jose Yasul ( jiy3@yahoo.com)

- Ortho & MSK clinic are in 3 north

- Radiology is in Radiology dept on 3rd floor in the hospital

- Injection with Beaton is in 2N of Building 1

- your schedule is flexible, the only attending that knows you are coming and will look for you is Yasul. Otherwise, you can have some options, e.g. going to the OR instead of the 2nd casting clinic

- casting techs are Pat and Phil. Pat will let you do everything, so he’s a good one to stick with

- most ortho clinics are great - you go see patients, do your exam, present & go in with attending. you learn a lot about knee exams, it’s an easy 8-5 schedule

- injection clinic is great

**NA:**

* A challenging rotation, but amazing learning because you get to initial workup and management for so many patients and talk them through directly with an attending.
* Schedule: 8pm-8am Sun-Friday, saturday night off
* You are responsible for doing the bulk of the admissions overnight, but the ICU resident and house officer also usually help, and if there are tons of admits then callback comes in and helps as well.
* I was told to strive to get up to an admit every 2 hours, or 6 admits in a shift, but it is to be expected that it will take several days to ramp up to this pace.
* Come to IMCU workroom at 8pm and you will get sign-out about pending admits.
* Come up with a system for doing H&Ps. What worked for me was:
  + Start H&P and dig through the chart, put in important labs/ imaging / PMH, but limit myself to around 10min just looking at stuff from this ED visit and then scanning any recent H&Ps and Discharge summaries.
  + See the patient and took notes on HPI on paper, then used a WOW to type the rest of the history directly into H&P while talking to patient.
  + Put in basic admit orders. While doing med-rec i listed those meds i was continuing vs stopping under relevant problems.
  + Depending on flow, i’d then either finish all of the H&P before paging the attending, or page the attending, finalize plan, and then write the rest of the H&P afterwards.
  + Make sure you have a system for keeping track of orders that you have and haven’t actually put into the chart (i put \*\*\*). (I once forgot to put in the antibiotics for a patient who was pregnant with cholecystitis and we were doing non-operative management with antibiotics and she was in the hospital for 3 days without actually getting antibiotics because I wrote in my H&P that i ordered them but didn’t and no one else caught it)
* If you can stack admissions and present more than one at once, attendings appreciate it, but if someone is sick definitely staff them right away so they get what they need soon.

**EM-1:**

Here is the schedule:

Monday: ER shift from 1-8 pm

Tuesday: AM Anesthesia (6:30-8:30 am)

Afternoon clinic at respective site (1-5 pm)

Wednesday: AM anesthesia (6:30-8:30 am)

Radiology Rounds with Dr. Liebig in his office (8:30-10:30 am)

Behavioral Med Rounds at C Street (10:30 am - 12:00 pm)

Thursday: AM Anesthesia (6:30-8:30 am)

ER shift from 1-8 pm

Friday: AM Anesthesia (6:30-8 am)

ER teaching rounds in resident lounge (8-9 am)

PBL in resident lounge (9 am - 12 pm)

Afternoon clinic at respective site (1-5 pm)

Saturday: OFF

Sunday: ER shift from 1-9 pm

\*\* Anesthesia shifts are for your benefit to practice airway management and learn how to intubate. You don’t have to go every morning if you want to sleep in or have something else planned, but it is good practice. Some of the anesthesiologists are better than others in terms of teaching and most want you to meet the pts and do a brief verbal H&P and PE in the pre-op area before they will let you intubate in the OR.

\*\* I discovered partway through that it was really helpful to look the day before to see what the 7:30 cases were so i didn’t show up at 6:30 only to discover that there were just two cases both getting LMAs. Generally bigger cases, intrabdominal cases, laparoscopic cases, all postpartum cases get ET tubes.

\*\* You can go early (around 6:30 am) any morning and help start IVs for the pts going into surgery in the pre-op area next to PACU if you would like. You can also scrub into surgeries if you are interested too! Most mornings are free for your learning.

\*\* You will work with different faculty members each ER shift. You can find the teaching attending listed on Amion. You will need to print off an evaluation form to take with you so your faculty member can evaluate you at the end of each shift. The contact person is Estela Hernandez and she should forward you all the info you need, as well as the evaluation form.

\*\* You do not have short HO call or weekend rounding responsibilities on this rotation, so take advantage of it!!

**FMC-1:**

Supervisor: Lisa Quinones

* This is a new rotation. The goal is to have some dedicated time to focus on your family medicine clinic as the main priority. You will have outpatient didactics, supervised admin/inbasket time, as well as some extra specialty clinics.
* Try to invest some time in this rotation in creating systems to help make your clinic more efficient - smart phrases, order preferences, building relationships with your care team. Some attendings have amazing smart phrases and order preferences to quickly find all the labs they need for working up common conditions (anemia, LFT abnormalities), etc. Make dot phrases to send to your LVN / resource for common lab abnormalities / diagnoses they can deal with (hypokalemia, vit D deficiency, BV, yeast infections, etc).
* Mon AM: FMC
* Mon PM: urology
* Tues AM: Minor procedures / Cards / adult medicine core topics
* Tues PM: FMC
* Wed AM: Radiology rounds and supervised inbasket management
* Wed PM: GI clinic
* Thurs AM: FMC didactics, inbasket/admin time, PCMH lab (get help on challenging patient cases with an interdisciplinary team)
* Thurs PM: flex sig: Flex sig clinic 1-5 MTZ 1 South. Different attending each week, they usually have you watch one then you do them all yourself! The nurses here are your best friends, they are very helpful in assisting. You consent the patient before the procedure - the major risks the attendings like you to mention are bloating/cramping, bowel perforation (rate 1/10,000 to 1/50,000), lightheadedness, bleeding, missed findings. Find out what kind of risk they are: family history, FOBs, anemia. If any of those are positive they should really be getting a colonoscopy. These can also be logged in New Innovations.
* Friday AM: PBL and one friday home visit with Natasha Pinto
* Friday PM: FMC

**CHO:**

When you first get to CHO, park or store your bike in the parking garage (your badge gets you in), walk into the main entrance across the street. There is a CHO/McArthur BART shuttle that runs Monday-Friday, 5:50 AM to 12:10 AM. Meet it outside the ED doors after work. Meet it under the BART overpass before work (there are usually many shuttles there, hard to miss).

You can get to most places using Stair 5. To get to stair 5, walk in the main/ED entrance à walk straight, between the two security desks à Take first hallway on the R à Go to the end of this hallway. You will walk past the ED on your right and Urgent Care on your left. à When you get to the end of that hallway, turn L and walk until you see stair 5 on the R.

Take Stair 5 to the 2nd floor. When you exit stair 5, turn L for cafeteria (money is on your card to pay for food) or turn R for GME office (you will need to go here on day #1). As you’re walking towards GME office, there is a sign that says Children’s Playcourt, turn R down this hallway and on your R will be the case conference room where you will go M/W/F @ 8:30 for case conference.

Take Stair 5 to the 3rd floor. When you exit stair 5, turn R for the resident’s lounge, which will be on your R. Your CHO badge will get you into the resident’s lounge, but if it doesn’t work, just knock. You can use the comps in the resident’s lounge, or you can go to the medical library (see below), if all of the resident lounge computers are in use. There is a CCRMC locker on the wall to the left of the door, on the bottom right, sort of behind the mini fridge and blue recycling bin. If you turn L when exiting stair 5 on the 3rd floor, you will find the 3SURG unit at the end of the hallway on your left.

Take stair 5 to the 4th floor. When you exit stair 5, turn L. On the R will be the medical library, which you need to badge into. There are computers and a printer in there, and usually some computers are open (unlike the resident lounge computers). This is where your Epic test out is at 8am on the first day. After passing the medical library, keep walking to your L through double doors. On the other side of the double doors, you will see some kids’ books, a small staircase or a ramp, you can take either, which will put you out near the 4th floor wards.

Once on the 4th floor, you can walk straight, on your R will be the 4th floor nursery (rooms 4D and 4E). If you keep walking straight, turn to your L and you will end up at 4MED unit (rooms 4300-4309). If you continue to walk past 4MED, the hallway will curve to your L and you will end up on 4SOUTH (rooms 4310-4323, also known as Rehab). Between 4MED and 4SOUTH there is a conference room on the left called the “4SOUTH conference room” (contains 2 computers, some tables and many cabinets). This is where you meet every morning at 6:45am for sign-out. The door next to the 4SOUTH conference room is the clean hold where you can go for supplies, including but not limited to otoscope tips and tongue depressors.

Note: Stair 5 does not go to the 5th floor, but the other stairs & elevators do. There is a conference room on the 5th floor outside room 5303-ish where you have sit down rounds with the team, but you will probably have no difficulty finding this as you will go there with your team on the first day. 5th floor has surgery and heme/onc beds.

*Computer Access and Epic*

Laptops are kept in a locker in a resident lounge, underneath the flat screen TV. (Also any laptop just lying around the resident lounge is up for grabs). When first starting up a laptop, you may encounter a red & grey security screen. The username for this is “resencrypt” and the password is “password”.

If someone has recently logged into the laptop, you won’t see the security screen. Instead you will see a typical CHO login screen. If the username part of this is greyed out (i.e. you can’t type in the username area to change it to your own user name), just click “Cancel” then “Switch User” and log in as yourself!

“Share” your notes instead of pending them while you are working on them. Keep an updated discharge summary going and shared on all your patients. The template for admissions and discharges automatically fills from the Admission or Discharge tab. You may copy Smart Phrases from colleagues for your daily progress notes.

**Paging – Options**

1. Dial 77, wait for the phone to ring once, then it makes a click-click noise. Enter the pager number. Wait for the voice. Enter your call back number \* your pager number #
2. Text page from the iPage phone app. The number is 510-718-\*\*\*\*
3. Text page from Meditech. No idea how to do this, but all the residents know, so just ask one of them.

***Call Schedule***

**\* Q4 call**

**A) Call days** are 6:45am – 10:45pm. Your schedule on call days will be the same as every other day, but after 1pm, you will carry the team pager and as other interns leave for the day (for clinic or at end of work day), they will sign out their patients to you. By the end of the workday, you will be responsible for pages/issues for all patients on the team. The senior helps out a lot, and you can always call/page them with questions, especially when it’s about patients you’re not familiar with. If this day falls on a weekend, show up at 8am. Round on ½ of the team’s patients, then stay til 10:45, admit patients & carry the team pager.

**B) Post-call** you show up @ 6:45, follow normal schedule. They will give you the first admit after lunch, and as soon as you are done with that admit and all other work, you can sign out your patients to the on-call resident & senior and you may leave. They usually get you out on post-call day by 3 or 4pm (this doesn’t happen in the winter -- TOO MUCH RSV -- plan on staying past 5pm). If this day falls on a weekend, you show up at 8am to round on ½ of the team’s patients. As soon as you’re done doing this, you can go home.

**C) Post-post call** is a normal day. 6:45-5ish. If this day falls on a weekend, you get the day OFF!

**D) Pre-call** is a normal day. 6:4505ish. If this day falls on a weekend, you get the day OFF! J

***Daily Schedule***

Weekdays - ***the chiefs page every day to tell you where/when conferences are***

6:45am Meet @ **4SOUTH CONFERENCE ROOM for sign out with the interns** – except on **Tuesday** where sign out is in the **resident lounge with your senior**

6:45-8:30 Pre-round on patients, start and SHARE your notes.

8 or 8:30am 2nd floor in **Children’s Playcourt/GME classroom** or **OP lecture hall** (see below) for conference.

9:05am Meet outside pt’s room to bedside round (they will page about meeting place)

Then Round on pts (some bedside, most @ 5th floor conference room, use stair 1)

11:00-11:30 **Tuesday and Thursday only** - Radiology rounds in radiology conference rm on floor 2 (will go downstairs as a team, so just follow everyone else)

12:00 Go to cafeteria & get lunch

12:00-1:00 Noon Conference in **Outpatient (OP) lecture hall** (near parking garage) à go past front desk in OP building à take stairs behind and to R of front desk to basement à turn L out of stairs à find large conference room/auditorium

1:00 Meet up w/ team outside of noon conference room. This is where you will “run the list” and pick up new admits.

1:00-5:00 Finish up work, file notes, admit patients

4:45-5:15ish Meet in the resident lounge for sign out (they’ll page you to let you know what time to be there)

Saturday

8:00 Meet in **Resident’s lounge** for sign out. Round on ½ team’s patients. If on-call, stay til 10:45. If post-call, leave when notes are done.

Sunday

8:00 Meet in **Resident’s lounge** for sign out. Round on ½ team’s patients. If on-call, stay til 10:45. If post-call, leave when notes are done.