Duke Regional Hospital
General Internal Medicine Orientation

General Overview
The general internal medicine rotation at Duke Regional Hospital trains housestaff to practice medicine in a community-based setting. Unlike the tertiary referral centers at Duke and VA Hospitals, Duke Regional provides residents with the experience of taking care of patients in a secondary care level facility. Through daily interactions with DRH hospitalists and consulting physicians, the housestaff will gain insight into the daily demands faced by community-based physicians. There is structured teaching on the rotation, but patient-based independent learning is critical.

Educational Objectives
During the general medicine rotation, interns and residents will have the opportunity to develop a variety of skills in delivering patient care.

The goals for interns include:
1. To develop proficiency in obtaining a comprehensive history and performing a thorough physical exam.
2. To provide safe and effective health care with compassion, consideration, professionalism, and courtesy.
3. To formulate, in conjunction with the resident, a thoughtful assessment and plan for the patient.
4. To gain proficiency in the basic procedures of internal medicine, including but not limited to phlebotomy, arterial blood gas, nasogastric tube placement, central venous line placement, thoracentesis, arthrocentesis, paracentesis, and lumbar puncture.
5. To record daily notes on patient’s condition.
6. To follow-up on studies and tests performed on patients.
7. To become proficient in the art of verbal patient presentations.

The goals for residents include:
1. To formulate a thorough assessment and plan using the medical literature as references.
2. To ensure the delivery of safe, compassionate, and effective health care to all patients.
3. To acquire the skills for independent, life-long learning.
4. To lead the medical team in the daily ward round.
5. To take an active role in the medical education of both interns and students.
6. To increase understanding of systems based practice required in complete coordination of patient care within the hospital and upon discharge.

Daily Work Schedule
The Duke Regional General Medicine Service has four teams, GM-1, GM-2, GM-3 and GM-4. Each team is comprised of one PGY3 resident, one intern, and a variable number of medical students and PA students. There will be one week during each block during which the intern leaves the team and becomes the night-intern. During this week, the team is comprised of one PGY3 resident and a variable number of medical students and PA students.

Gen Med teams admit on a Q4 long call/post-call/short call/pre-call schedule. The on-call general medicine team takes admissions from the Duke Regional ER or transfers from the MICU; the patients admitted are generally DGIM patients, DOC patients, John Umstead Hospital patients, or Butner Prison patients. Additional “unassigned patients” may also be admitted.

When the team intern is on days, teams may take up to 7 patients on a long-call day (with the caveat that there is a real time hard cap of 14 patients, which will not be exceeded). Patients discharged earlier in the day do not count.

Version February 2015
towards the cap. Teams may take up to 2-3 patients before 3PM on a short-call day (Mon-Fri) depending on the number of overflow patients and on scheduling issues including days off and clinic.

When the team intern is on nights, teams may take up to 5 patients on a long-call day (with the caveat that there is a hard cap of 10 patients, which will not be exceeded). Teams may take up to 2 patients before 3PM on a short-call day (Mon-Fri).

Morning report begins Monday-Thursday at 7:15am. Either before or after MR, the senior resident leads work rounds with his/her team. General medicine teams round with their attending at times specified below (differs based on where in the call cycle the team is). Noon conferences are teleconferenced from Duke at 12:00 every weekday.

**Principal Teaching Methods at DRH**
The residency program has traditionally focused teaching from the patient’s bedside. Essentially, the patients are our curriculum and the educational experiences are generated from this patient-centered approach. The residents, interns, and students also receive formal, dedicated teaching from the following sources:

1. **Morning Report**
   Every Monday through Thursday from 7:15-8:15am, residents, interns, and students attend morning report in the Private Dining Room E (PDR-E). A case is presented or an outpatient curriculum topic is covered. For the case presentations, the housestaff are expected to prepare 5 minutes of teaching on a topic that is related to the case. Gen Med teams on pre-call days may have the opportunity to present a “real-time” case with the focus on evaluation and management as opposed to diagnosis and “zebras”. The ACR and DRH chief can help the teams select an appropriate case and will help pull appropriate literature for discussion. Of note, the post-call team is not required to attend morning report (see next section), and the short call team is also excused if already receiving new admissions by that time (which is not unusual).

2. **Attending Rounds**
   On days when you are short-call and on-call, attending rounds begin at 9:00am and end at 11:00am. On days when you are post-call or pre-call, the post-call team should begin attending rounds at an early enough time to complete rounds by 10am. This may mean starting rounds as early as 7am depending on the attending and your needs. The pre-call team should then begin at 10:00am and last until no later than 11:30am. The pre-call team should join rounds with the post-call team after morning report if at all possible in order to benefit from the attending’s teaching about the sister team’s new admissions. As has always been the case, urgent patient care needs, including time-sensitive discharge issues, supersede all else. However, all pre-call resident/intern absences from post-call attending rounds should be cleared by the attending.

   This schedule has been implemented because our program has a zero-tolerance policy towards duty hour infractions. Aiming for a 10AM completion of post-call rounds should allow for appropriate time to complete necessary documentation, hand-off and leave the hospital well before the end of the 24+4 hr shift. **POST CALL RESIDENTS MUST LEAVE THE HOSPITAL NO LATER THEN 11 AM.** We will continue to modify the post-call day schedule as needed to achieve an optimal balance between education and duty-hour compliance.

   The resident area is located in the Watts Building on the 3rd floor. The Watts Building is connected to the hospital via the 2nd floor of the hospital, near Radiation Oncology. As you enter the Watts Building (1st floor of Watts = 2nd floor of DRH), the elevators will be on the right. Go to the 3rd floor. Go left out of the elevator, through the door, and take the hallway to the left, then to the right. The Chief Resident’s office is on the left. The next door on the left will be the Resident Room. The code is 1-5-1. The workroom will also be the conference room used for rounding by GM 1 and 2. GM 3 and 4 round in the Watts Building in the DRH Hospitalist Conference Room just down the hall from the resident workroom **(the key for this room is in the Resident workroom – please make sure this is clean and locked up after use!).**

3. **Noon Conferences**

Version February 2015
DRH noon conferences are the same as the Duke noon conferences. They are teleconferenced to DRH. This will be held in PDR-E on the 1st floor Monday-Friday from 12-1. During the Intern Emergency Lecture series (July and August), residents should cover the intern’s pager. Food tickets ($6.00) for the cafeteria are provided to all residents and students Mon-Fri.

4. Medical Grand Rounds
Every Friday at 8:00am, a member of the faculty or a distinguished visiting professor presents original research or a clinically important topic in internal medicine at Duke North 2002. While everyone has the option to attend, at least one Gen Med team must remain at DRH during this time.

5. Required Lectures and Conferences for Students
All students rotating at DRH are required to attend DRH Morning Report and DRH Noon Conference. Additionally, all second year students are required to attend Chair’s Conference on Friday (12:00 to 1:00) (teleconferenced to DRH) and the student lecture series held by the DRH/Ambulatory ACR (also teleconferenced). Any absences from these conferences must be approved by the Chief Resident in advance.

6. Radiology
Radiologists are available M-F to review films with the team. This is an informal opportunity to review interesting films of patients on the service. All films can be accessed online via PACS.

Admissions
When admitting patients from the DRH ER, the team is expected to evaluate the patient in the ER within 30 minutes of receiving the admission call to determine appropriate disposition (i.e. floor, telemetry, or intensive care unit). Orders must be initiated before the patient is permitted to leave the Emergency Department. These should be completed within 60 minutes of the admission call. Please note that putting the correct Gen Med team number in Maestro helps the nurses know which team to call about issues on that patient.

We recognize that sometimes you receive many admissions in a short time. This makes it difficult to fully evaluate and complete orders within the 60 minutes preferred. In this instance, we suggest that you “eyeball” the patient, confirm their stability and appropriateness for GenMed. If you agree they would be appropriate for your team, complete a basic admission order with a team assignment, diet plan, and basic additional nursing care orders. This may include pain meds, antiemetics, or insulin – anything you can imagine the initial care nurse needs to take immediate care of the patient. This allows the ER to move them out of the ER to a floor bed without holding up patient flow. You can complete additional lab, studies, and med orders later as you are able, though still in a timely fashion.

Rarely, the on call resident may be contacted regarding a hospital transfer or direct admission from a clinic. Only attendings and the Chief Resident can accept admissions at DRH. Should you receive a request for direct admission or transfer, refer these to the lead hospitalist covering the “9050” admissions pager. This pager is the equivalent of “1010” at Duke University hospital, but is always covered by hospital medicine at DRH.

1. Short Call (Team Intern on days) 10A-3PM
Short call may take up to 2-3 patients by no later than 3PM Monday through Friday (except on holidays). This is a variable target depending on intern days off, team caps (max of 14), and intern/resident clinics. Please see below for the rules regarding short call. The short call team may be asked to pick up unassigned/DOC/DGIM patients who were admitted by the hospitalist service overnight, after the Duke long-call team capped. These patients will have been seen and admitted by the hospitalists but they likely came in late at night, so the work-up may not be complete. They count toward your cap. The resident or intern is expected to write a resident accept note in addition to the hospitalist H&P (in the style of a MICU transfer note) documenting your acceptance of these patients and the major issues at hand.

1) If intern on and resident does not have clinic: 2 new admissions or 2 overflows + 1 new admission; no new admissions after 3PM; max 3 admissions (max team census = 14)
2) If intern off or resident/intern has PM clinic: 2 new admissions or overflows; no new admissions after 3PM; max 2 patients (max team census = 14)
3) No short call on weekends

*Short call resident, please sign onto admissions pager (1933) at 10AM.

2. Long Call (Team Intern on days)
Long call occurs every fourth night. Team cap is 7 patients on call. Generally, admissions workflow includes 3-5 patients admitted by day-intern and resident from 11A-7P and 3 patients admitted by night-intern and resident from 7P-3A. Please note these numbers are guidelines, NOT rules. There are no caps within these time intervals. There are hard caps of 14 patients total per team (real time census cap) and 7 admissions on a long call day. Long call ends at 3am, 7 new admissions or total team census of 14 patients, whichever comes first. The hospitalist service admits patients after teams cap and between 3-7AM. Overflow patients will be distributed to short call teams Mon-Fri and long call teams on the weekend. Day-intern and resident receive sign out from gen med teams together. Day-intern is responsible for cross-cover until 7P, at which time day-intern gives sign-out to the night-intern under the supervision of the on-call resident. The night-intern is responsible for cross cover from 7P-7A. The day-intern leaves after admission work is completed but MUST leave by 9P. The night-intern presents 1-2 new patients to the attending from 7:30A-8A but MUST leave by 8A.

3. Long Call (Team Intern on nights)
Long call occurs every fourth night. When the team intern is on nights, the long call team caps at 3AM, 5 new admissions, or total team census of 10 patients. Ideally, 2-5 patients are admitted by the resident from 11A-7P and 3 patients are admitted by night-intern and resident from 7P-3A. These are guidelines only. There are no time interval specific caps or rules. There are hard caps of 10 patients per team, 5 patients per team/24 hours, and 3AM while on long call. The hospitalist service admits patients after teams cap and between 3-7AM and overflow patients will be distributed to short call teams Mon-Fri and long call teams on the weekend. Resident receives sign out from gen med teams and is responsible for cross-cover until 7P, at which time resident gives sign-out to the night-intern. The night-intern is then responsible for cross cover from 7P-7A. EXCEPTION: On Saturday and Sunday nights, there is no night-intern. The resident is responsible for ALL 5 admissions and ALL cross cover on Saturday and Sunday. When the night-intern is present, he/she will present 1-2 new patients to the attending from 7:30A-8A but MUST leave by 8A. A senior day float will cover the post-call team.

4. Bounce-back rules
Patients discharged within 72 hours for any problem and one week for the problem(s) that led to their previous admission will be transferred to the general medicine team that provided care during their most recent hospitalization. Bounce backs follow any member of the team that was involved with their prior hospitalization. Bounce backs do NOT count toward the admission cap but do count toward total team cap.

5. Intensive Care Unit
The ICUs at DRH are closed units, so Gen Med residents do not follow patients while in the ICU. However, patients may be transferred out of the ICU onto your service. If the patient was not previously on your service, the patient counts toward an admission. If the patient was previously on your service prior to ICU transfer, the patient does NOT count as an admission, but does count toward the total team cap of 14. There are medicine interns rotating through the ICU at DRH. Please use this as a line of communication for patient care.

Of note, sometimes patients are ready for transfer from the MICU but may not have a floor bed assignment. If these patients are communicated and accepted by gen med, they are considered floor status, boarding in the MICU. The GenMed team and attending (ie you) are the team of record and should be coordinating their care, writing their orders, etc. just as if they were on the regular floor.

Discharges
Discharge summaries are a shared responsibility. Interns are asked to complete d/c summaries for patients who have been admitted <72 hours and residents enter discharge summaries for those who have been hospitalized >72 hours. All discharge summaries should be entered in Maestro care. Dictation is no longer allowed. Please

Version February 2015
communicate with the patient’s primary care physician prior to discharge as both a courtesy and an attempt to ensure the continuity of care. You do not have to do a discharge summary for admissions that were originally entered as “23 hour obs” status, but you will have to enter a summary if the original order said to “admit” the patient, even if the patient was in house < 23 hours.

**Documentation**

All documentation must be entered into Maestro care. The record and functionality are identical to that used at Duke University hospital and clinics. Attendings must cosign your admission notes within 24h.

Students should do full admission work-ups and the attending and the resident should review these. Again, student admission or daily notes do NOT become part of the permanent record and cannot be used in place of a physician’s note. Any student documentation must have a substantive intern or resident addendum (i.e. not just “Agree with above” and a signature).

**Days Off**

The General Medicine rotation is designed to require an average of < 80 hours of work per week over 4 weeks for interns and residents. Each house officer should have an average of 1 day off per week. *Days off and clinics will be denoted on your monthly schedule and are largely pro-scripted in order to allow residents to remain in compliance with 80 hr weeks. If the teams desire to make a change in the schedule, this must be discussed with the chief resident in advance.*

If the resident takes a day off on short call days (which should only happen if there is no feasible alternative), be sure that the day float/teaching resident and the CR know in advance, as the intern will need back-up with new admissions.

The medical student days off are arranged by the course director prior to the rotation and we ask the teams to adhere to this schedule. The medical school and PA school have asked that we follow the basic RRC duty hour guidelines for student work hours and days off.

**Miscellaneous**

1. **Day Float Resident:** As of January 5, 2015 there will no longer be a daily day float resident. Coverage for the resident only team (i.e team intern is on nights) will be available on Post Call (Wednesdays/Sundays) and OFF days (Fridays). Coverage will be provided by the DRH SAR.

2. **Orders**
   Maestro care is used for all orders and documentation. If you must give a verbal order, make sure you sign the verbal orders at the next earliest opportunity. Admission orders should be entered from the ER. If the patient is still in the ER and you need an order completed urgently (before they make it to the floor), then the order should be written on the paper order sheet that the ER utilizes. You can ask the ER secretary or nurse for assistance with this if needed.

3. **Meals**
   Meal passes for dinner (on-call residents, not students) are obtained from Kevin Fallon in Medical Staff Services on the 2nd floor. He will usually distribute these to each team on the first day of the rotation. Meal passes for lunch Monday through Friday (all residents/students) are obtained from the DRH ACR. Please make every effort to obtain your lunch prior to conference so that you may be on-time for conference. Lunch meal tickets MAY NOT be used for dinner tickets and may not be used in the evenings. Please do not abuse this. We have a fixed number of on-call (dinner) tickets allotted each month. If you use more than one on your call night or give them to students, we will exhaust our monthly allotment prematurely and there will be no free food for your last call dates.

4. **Students**
   Teaching is one of your main goals on General Medicine. Discuss this with the students at the beginning of the rotation and clearly outline what you expect of them. Give feedback often. Review admission and daily
progress notes. Make sure they get to all their required teaching conferences. You will also complete on-line evaluations for them and you should discuss evaluations with the attendings.

5. **DRH Paging system:**
   - Admitting Resident: Pager: 470-4636 #1933
   - DRH-1 Medicine Intern: Pager: 470-4636 #6101
   - DRH-2 Medicine Intern: Pager: 470-4636 #6102
   - DRH-3 Medicine Intern: Pager: 470-4636 #6103
   - DRH-4 Medicine Intern: Pager: 470-4636 #6104

To sign onto a DRH pager, from a DRH phone, dial 75, wait for the tone, dial pager number (ex. 6101). Then dial *# (there will be no password) and follow the prompts and enter your pager (970-XXXX) as the covering pager. You should then be signed on to your team’s pager.

*Short call resident, please sign onto admissions pager (1933) at 10AM.

**INTERNS:** Always sign your personal pager over to the cross-cover intern when you sign out your patients for the evening. It is easiest to stay signed on to your team’s functional pager for the whole month.

6. **Rapid Response Team:**
   Similar to Duke, there is a Rapid Response Team at DRH. This team consists of multiple team members (nurses, physicians, RTs) from the ICU. When there is a critically ill patient on the floor, the Rapid Response Team can be activated by any health care worker. This was implemented to improve patient safety and facilitate necessary measures to optimize patient care. There is also a Code Blue team (including RT, nursing, vas team, and a hospitalist). There is NOT a stroke code team – in the instance of a stroke code, it is best to call a RRT which gives you additional nursing support in the event TPA is administered and monitoring is needed. All codes/RRTs are activated through the number 222.

7. **Call Rooms:**
   Gen Med call rooms are located on the 1st floor, beyond the cafeteria. You will be shown where these are located on the first day of your rotation.

8. **Security:**
   On day 1, you should make sure your badge works for the 1) parking lot (Stadium lot) 2) hallway from the hospital to the Watts Building (ground floor and 3rd floor), 3) back elevators near the ED, 4) the call room, and 5) the ED. If your badge doesn’t work, contact Kevin Fallon in Medical Staff Services.

9. **Consults:**
   SARS must call all consults, new and follow-up (except on their days off). Please discuss consults with your attending prior to calling. This is a DRH Medical Staff Services Policy. For GI, Monday through Thursday, all procedural consults should be called in to Dr. Poleski directly. Emergent nighttime consults (e.g. food impaction, variceal bleed) and procedural consults Friday through Sunday should be called in to the Duke GI fellow, attending and endoscopy suite. There is no formal liver consultant available, but Dr. Muir may be contacted for informal recommendations.

10. **Key DRH numbers:**
    - Chief’s Office: 4-6515
    - ACR Office: 4-8115
    - Kevin Fallon: 6256 (all purpose go-to guy for equipment needs and security/badge issues)
    - Information Systems (computer): 4187
    - Communications (phone): 4276
    - Engineering (i.e. replace light bulbs, bed issues, lock issues): 4159 (DRH pager 1002 for

Version February 2015
11. Signouts
There is a specific policy regarding signouts at DRH which states that supervising residents must be present during care transitions from intern to intern at night and morning signouts. This helps minimize the impact of the "double handoff" from the day/night intern switch. The residents should also be communicating directly regarding ongoing clinical care needs and helping to maintain their patient lists with pertinent information including active problems, medications (abx), oxygen requirements, code status, etc. Signouts should occur no earlier than 5PM Mon-Fri and upon completion of work on the weekends.

12. Handoff Policy
There is a specific handoff policy regarding AM overflow admissions from the nocturnal hospitalist teams. The short call resident M-F or the long call resident Sat-Sun should be covering the admissions pager at 7am at the latest. This allows a full handoff between the nocturnist and daytime gen med team. Please be on time such that our overnight staff can leave as scheduled at 7AM.

Evaluation Methods
All housestaff are evaluated by attendings on a bi-weekly basis. The attendings should also meet with house staff individually at the end of their block to provide feedback. The residents and interns also have an opportunity to review the written evaluations during regularly scheduled evaluation meetings with their advisor. Residents and interns also are responsible for completing evaluation forms on attendings and on the rotation itself.

Absences
Occasional circumstances necessitate absences and therefore require coverage for the clinical service. All absences from the DRH clinical service require the approval of the DRH Chief Resident in advance. Arranging coverage with other residents without notifying the Chief Resident is not acceptable.

Resources
There is access to the Duke Medical Library website, Ovid, Medline, UptoDate, and other internet services on all computers.