Durham Regional Hospital
General Internal Medicine Orientation
Nicole Greyshock, DRH/Ambulatory Chief Resident

General Overview
The general internal medicine rotation at Durham Regional Hospital trains housestaff to practice medicine in a community based setting. Unlike the tertiary referral centers at Duke and VA Hospitals, Durham 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 Durham 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.

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 Durham 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 hard cap of 14 patients, which will not be exceeded). Teams may take up to 2-3 patients before 11A 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 11A on a short-call day (Mon-Fri).

Morning report begins Monday-Thursday at 7:15 am (Grand Rounds are at Duke North Room 2002 at 8:00am Fridays). Either before or after MR or GR, 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 day.

**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, which interns and residents rotating on DRH Gen Med or the Ambulatory Block present to a teaching attending. 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 but is encouraged to attend morning report (see next section).

2. **Attending Rounds**
   - On days when you are short-call and on-call, attending rounds begin at 9:30am and end at 11:30am. 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**
   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 12:00-12:45. During the Intern Emergency Lecture series (July and August), residents should cover the intern’s pager. Food tickets ($6.00) 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 Chairman’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 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 CPOE helps the nurses know which team to call about issues on that patient. Please fill out the Team Contact Information at the time of admission also to facilitate triage of nursing questions.**

We recognize that sometimes you are hit with 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. A direct admit from an attending in the Duke Health System satisfies this requirement. Requests for outside hospital transfers, however, must go through the on-call hospitalist and should not be accepted or declined by the on-call resident. If you are called about a direct admission, generally it is just best to direct them to the chief resident.

1. **Short Call (Team Intern on days)**

   Short call may take up to 2-3 patients by no later than 11 am 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 11A; 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 11A; max 2 patients (max team census = 14)
   3) No short call on weekends

2. **Short Call (Team Intern on nights)**

   Short call may take up to 2 patients by no later than 11 am Monday through Friday (except on holidays). 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 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.**

3. **Long Call (Team Intern on days)**
   Long call occurs every fourth night. Team cap is 7 patients on call (3 patients admitted by day-intern and resident from 11A-5P, 1 patient admitted by resident from 5P-7P, and 3 patients admitted by night-intern and resident from 7P-3A). There are hard caps of 14 patients per team, 7 patients per team/24 hours, and 3AM while on long call. 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 one new patient to the attending from 7:30A-8A but MUST leave by 8A.

4. **Long Call (Team Intern on nights)**
   Long call occurs every fourth night. Team cap is 5 patients on call (2 patients admitted by resident from 11A-5P and 3 patients admitted by night-intern and resident from 7P-3A). 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 night, there is no night-intern. When the night-intern is present, he/she will present one new patient to the attending from 7:30A-8A but MUST leave by 8A. A senior day float will cover the post-call team.

5. **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.

6. **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 dictate for patients who have been admitted < 72 hours and residents dictate discharge summaries for those who have been hospitalized > 72 hours. The DRH Medical Staff Office assigns dictation code numbers – this is the same as your NetAccess 5 digit code. **Please communicate with the patient’s primary care physician prior to discharge as both a courtesy and an attempt to ensure the continuity of care. Dictations should be completed within 24 hours of discharge; please dictate discharge summaries as “STAT.”** Prior to hanging up, remember to obtain the report number of your dictation to facilitate tracking of the discharge summary. You may write this in the chart. 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 dictate if the original order said to “admit” the patient, even if the patient was in house < 23 hours. Dictations cannot be edited by the resident, only by the attending. If you need to correct a discharge summary quickly, it is best to dictate an addendum update unless your attending is immediately available to correct the document.

**Documentation**

A Hospital History and Physical Form must be completed on every patient by the intern (or resident, if the intern is capped) and should be on the chart by 7:30 AM the post-call day. (Student H&Ps are not acceptable and should not be placed on the chart.) Every section should be completed, including pain score and functional status. Resident admission notes should be dictated and should include a differential diagnosis and the most appropriate management plan. The attending H&P must be in the chart within 24 hours of admission. Each Gen Med team is expected to write daily progress notes. Online progress notes can be completed in NetAccess; residents/interns should anticipate completing training for this prior to starting on service. These notes must be printed each day and put in the chart.

Students should do full admission work-ups and the attending and the resident should review these. Again, student admission notes do NOT go into the chart, however students can write daily notes. These must have a substantive intern or resident addendum (i.e. not just “Agree with above” and a signature).

*Regarding dictations:* Either residents or interns may complete dictated H&Ps or discharge summaries depending on intern level of comfort. Please remember that this is a team effort and sharing of responsibilities is important to ensure safe, efficient patient care that also falls within duty hours. If interns dictate, we ask that residents review dictations to provide feedback and quality control. This is particularly important as ONLY ATTENDINGS MAY EDIT DICTATIONS. If errors/changes needed, please convey this to your attending to change or dictate an addendum.

**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 proscripted 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 resident will still need to dictate a history and physical on each short-call patient the following day.**

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**
   a. **Monday**
      Monday will be the day off for the Day Float. There is no dedicated day float on Monday and on those days the DRH/Ambulatory ACR will be available to assist the post call teams (although he/she will also be needed to help coordinate DRH operations including morning report and noon conference).
   b. **Tuesday, Thursday, Saturday**
      The on call team will admit overnight with resident, day and night interns, and students as a team. The DF resident should function as an active member of the post-call team, starting at 7:30am. The DF will round with the post-call teams and assist the post-call resident in leaving the hospital on time as well as assist the intern with management of the gen med team after the post call resident leaves. The post-call resident will then sign out by 11am; any work that needs to be completed will be handled by the team’s intern and day float. The DF resident will help the post call intern complete needed tasks, follow-up on studies/consults and attend conferences. Communication of the day’s events is a crucial responsibility of the teaching resident/day float. This is most often communicated via email back to the team for which you are covering.
   c. **Wednesday, Sunday**
      The on call team will admit overnight with resident, +/- night intern, and students as a team. The DF resident should function as an active member of the post-call team, starting at 7:30am. The DF will round with the post-call team and assist the post-call resident in leaving the hospital on time as well as assist with management of the gen med team after the post call resident leaves. The post-call resident will then sign out by 11am; any work that needs to be completed will be handled by the day float. Ideally, residents should have all daily notes completed before leaving (usually completed before rounds). The DF resident will help complete needed tasks, follow-up on studies/consults and attend conferences. Communication of the day’s events is a crucial responsibility of the teaching resident/day float. This is most often communicated via email back to the team for which you are covering.
   d. **Friday**
      The resident on the resident-only team (i.e. team intern is on nights) will have a day off on Friday. The DF will cover the team and should receive sign out from the resident, usually via email on Thursday night. The DF will then function as the primary team physician, arriving at 7A to receive overnight sign out, pre-rounding on patients, rounding with the attending, and completing all necessary daily tasks. The DF will sign on to the functional pager and will be responsible for daily notes, completing daily tasks, following up on studies/consults, discharging patients, etc. DF residents will NOT be responsible for any
admissions. The DF may sign out to the on-call team when daily tasks are complete. Communication of the day’s events is a crucial responsibility of the teaching resident/day float. This is most often communicated via email back to the team for which you are covering.

2. **Orders**
   CPOE is active on all floors at DRH. All housestaff and students must be trained on their version of CPOE prior to starting the rotation. If you must give a verbal order, make sure you sign the verbal orders at the next earliest opportunity. Admission orders should be entered in CPOE 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.

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 your team’s pager.

   **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. To get to these rooms, take the main elevator to the first floor. When you get off the elevator, go the opposite direction from the cafeteria. Turn right to go behind the main elevators. Continue to follow that hallway for a quick right and then left. As you walk forward, there will be a Mail/Copy sign. The call rooms are on the left just after that sign. Your security badge will let you in the door. Medicine is assigned to rooms 1 and 2. The code to room 1 is 2-1-4-# and room 2 is 3-1-4-#. The nearest bathroom is next to the vending machines just across from the cafeteria.

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. 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 emergencies – e.g. busted water pipe)

11. Signouts
There is a specific policy regarding signouts at DRH (please see attached) which states that supervising residents must be present during care transitions from intern to intern at night and morning signouts. 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 then 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. Please see attached policy. The short call resident M-F or the long call resident
Sat-Sun should plan to meet the overnight hospitalist from 6:45-7AM in the hospitalist
conference room to ensure safe care transitions. Please be on time such that our
overnight staff can leave as scheduled at 7AM. If this is not happening, please alert the
chief resident.

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, and other internet
services on all computers.

Feel free to contact Nicole Greyshock, DRH/Ambulatory Chief Resident (970-2465)
for any questions.