VA MEDICAL CENTER HOUSESTAFF ORIENTATION  
(Revised 9/22/2014)

People and places

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Wards structure

Team structure:  
There are 7 ward teams at the VA. You will work with residents and interns from Georgetown University, Walter Reed, and George Washington University. Each team consists of one resident (either PGY-2 or 3) with two interns. GW interns will rotate with a Georgetown resident and GW residents will rotate with two Georgetown interns. The other two teams are composed of residents and interns from Walter Reed. Each team will have between one and four students (MS3/MS4), including Physician Assistant students.

Distribution of Admissions:

- 7:00 AM – 1:00 PM: Early admitting team (alternating between teams 1 & 2)  
- 1:00 PM – 4:00 PM: Mid admitting team (rotating between teams 3, 4, 5, 6)  
- 4:00 PM – 7:00 PM: Late admitting team (rotating between teams 3, 4, 5, 6)  
- 7:00 PM – 7:00 AM: Night admitting team (Monday through Friday)

“Early Admitting” teams:  
Teams 1 and 2 (each led by one Georgetown residents with two GW interns) will not take any overnight call or night admission duties.  
- These teams will admit from 7am-1pm every weekday, alternating every other day.  
- These teams will be responsible for admitting any direct admissions (such as IR patients) or outside hospital transfers until 2PM.  
- Depending on the census of the various medicine teams, these teams may also pick up patients that were admitted by the night team.  
- Typically, members of these teams will have one day off each weekend. Either the resident will be on by themselves or the two interns will be on together.  
- The resident from the “sister team” will supervise the interns on weekends when their resident is off.  
- Golden weekends can be addressed on a case by case basis if you are able to arrange switches within your team and your sister team.

Schedule template

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
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<tbody>
<tr>
<td>Week 1</td>
<td>Early call: Team 1</td>
<td>Early call: Team 2</td>
<td>Early call: Team 1</td>
<td>Early call: Team 2</td>
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<tr>
<td>Week 2</td>
<td>Early call: Team 2</td>
<td>Early call: Team 1</td>
<td>Early call: Team 2</td>
<td>Early call: Team 1</td>
</tr>
</tbody>
</table>
**“Mid/Late Admitting”/Night admitting teams:**

Five teams (resident + 2 interns) will participate in a 5-week rotation. Four teams will alternate admitting in the afternoon/evening. The fifth team will be admitting overnight. Two teams are led by a GW resident with two Georgetown interns; one team is led by a Georgetown resident with two GW interns; and two teams are led by a Walter Reed resident with two Walter Reed interns.

- In this system, during your four week block, there is a 4/5 chance that you will rotate with your entire team through a four-night stretch of night admissions.

**“Mid/Late Admitting” weeks:**

- Monday through Thursday, the late call teams will be admitting every other day, from either 1-4 PM (MID CALL) or 4-7 PM (LATE ADMITTING) - alternating mid-afternoon and late-afternoon admitting every two days.
- The LATE ADMITTING team (4-7 PM) should sign-out all of their new admissions to the night admitting team (instead of the moonlighter). They should sign out their old patients to the moonlighter as usual.
- On Fridays, the “LATE ADMITTING” team resident will stay overnight and continue admitting until 7 AM. The interns will admit with the resident until 7 PM, and they must leave the hospital by 9 PM to comply with duty hours. Residents must leave the hospital by 11 AM to comply with duty hours.
- On Saturdays and Sundays, the “late admitting” resident admits from 7 AM – 7 AM. The interns will admit with the resident until 7 PM, and they must leave the hospital by 9 PM to comply with duty hours. Residents must leave by 11 AM to comply with duty hours.
- Weekend coverage is variable from team to team.

**Night admitting week:**

This is an admitting service with no cross-coverage responsibilities. The resident will supervise the interns’ admissions in the same manner as they would during a normal daytime wards rotation.

- **Hours:** 7 PM-8 AM, with an hour built in for supervised hand-off in the chiefs’ office from 7-8 AM.
  
  - The team should arrive at 7 PM and pick up the admission pager from the “late call” team.
  - Each team will perform five nights of night admissions.
  - When you finish your five-night stretch (Monday-Friday night), you will have Saturday as a post-call day (not counted as an ACGME day off) and Sunday off.
  - **Saturday morning:**
    
    - Night resident should email a list of overnight admissions with a brief description to the Chief Residents ([dcvamcchiefs@gmail.com](mailto:dcvamcchiefs@gmail.com)) by 6:30 am. The admin chief will assign each admission to a day team. The night resident will sign out the admissions to the day team residents around 7:30 am. Then the night resident will join the wards team that they will be taking over for rounds to allow for a smooth transition of care. The night resident should leave at 11:00 am.
    
    - Night interns should pair up with the interns from the wards team that they will be taking over on Monday. Night interns should pre-round with the day intern (see the patient, review patient history, etc) to learn about their new patients. The night team is not responsible for presenting patients during rounds or writing progress notes. The night interns should leave at 11 am.
    
    - Monday you will arrive as a team to start caring for the patients from the team that is transitioning to nights. You will also take the team room previously used by the team whose patients you are taking.

- **Admitting specifications:**
  
  - All admissions should be admitted to “Medicine Night Team” on CPRS with the night resident’s and intern’s names.
  - The admitting attending Monday through Friday nights is the “early call” attending for that day (either Team 1 or Team 2 attending).
  - After the 7-8 AM hand-off, the team receiving the overnight admissions should change the CPRS admission order to reflect the new team number, resident, intern, and attending.

- **Educational requirement:** The night resident should present teaching points or pearls from one of the admissions during the morning hand-off (for example – reviewing Wells Criteria or reviewing evidence/guidelines behind a management decision). Please aim for a 5-10 minute discussion with the Chief Resident and the other day residents. A formal presentation is not necessary (no slides).
Sample template

<table>
<thead>
<tr>
<th>WEEK</th>
<th>MONDAY</th>
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<th>THURSDAY</th>
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<th>SATURDAY</th>
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<tbody>
<tr>
<td>1</td>
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<td>Mid call: Team 5</td>
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<td>Mid call: Team 3</td>
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<td>5</td>
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Caps:

**Team Cap:** Each medicine team has a cap of 20 patients total.

**Personal Cap:**
- Interns:
  - Can receive a maximum of 7 new patients on any given day (5 admissions + 2 transfers)
  - Can carry no more than 10 patients at a time (including weekends – this means that an intern can only pre-round and write progress notes on a maximum of 10 patients per day).
- Residents:
  - Can supervise a maximum of 14 new patients on any given day (10 admissions + 4 transfers).
  - Can carry no more than 20 patients at a time.

Sign-out:
- The wards patients are covered from 7PM-6:45AM by an attending moonlighter.
  - Evening sign-out: 7PM in the Medicine Team 5 room (4E-147). One intern or resident from each team must stay until sign-out at 7PM.
  - Morning sign-out: 6:45AM in the Chief Resident’s office.

Morning Hand-off (Distribution of night admissions):
- The resident from each team should meet in the medicine conference room at 7am Tuesday through Friday to receive distribution of overnight admissions. The night admitting resident will present teaching points for the first 5-10 minutes. Then the night admissions will be distributed amongst the teams. Please change the CPRS admission order to reflect the day team number, resident and intern, and attending.

Weekend coverage:
- The long-call team will cover the pre-call team’s patients.
- Red and blue teams will cover each other.
- Interns cannot write more than 10 notes on the weekend. Residents will write the remainder of the notes for the patients their team is covering.
Signout to a new team:
When you are rotating off of VA wards, starting a week of nights, or off on a weekend with another team covering your patients, you are required to give the housestaff caring for your patients an adequate written and verbal signout. Written signout should be sent using your institution-specific email addresses (GW, Georgetown or Walter Reed - this is the only HIPAA-compliant way to do so). Do NOT use personal email accounts like gmail or yahoo. If the housestaff covering your patients are not physically at the VA so that you can sign out in person, the email signout should include your phone number so that you can be called by the person picking up your patients.

Wards Schedule

Conferences:
- **Afternoon Report**: Mon-Wed, Fri 2:00 pm, Thurs 1:00 pm – Medicine conference room, 4th floor
  - All interns, residents, and medical students are expected to attend.
- **Noon Conference**: Tues 12:00 pm – Medicine conference room, 4th floor
  - All interns, residents, and medical students are expected to attend.
- **Grand Rounds**: Wed 12:00 pm – Freedom Auditorium, 4th floor (Across from the Department of Medicine)
  - All interns, residents, and medical students are expected to attend.
- **Life Conference**: Fri 12:00 pm – Freedom Auditorium, 4th floor (Across from the Department of Medicine)
  - All interns, residents, and medical students are expected to attend.

Attendance to conference is mandatory. Please be punctual.
- You must maintain at least a 70% attendance at your educational conferences to graduate from residency per ACGME requirements.

Exemptions from conference:
- If you have an acutely sick patient, your patient takes priority. Please notify the chief residents if this is the reason for your absence from conference
- If you are admitting patients during conference, please triage the admissions (briefly evaluate them, decide their level of care, and place admission order). You should complete the orders and finish the H&P after conference.
- If you have afternoon clinic, you are excused from conference obligations.

Duty Hours:
If you are approaching your duty hour limits, please let us know so that we can identify system issues and correct it.
- All housestaff may work for 80 hours per week averaged over the month.
- Interns may work a maximum of 16 consecutive hours.
- Residents may admit for 24 hours with 4 additional hours for transitions of care.
- All housestaff must have 8 hours out of the hospital between shifts and should have 10 hours. (This means that if you leave at 8 PM on a call day, you can still come in at 4 AM if needed to pre-round, but should try to be in after 6 AM.
- All housestaff must have 1 day off in 7, averaged over the month.

Contacting people

Vocera:
Please log in to your team Vocera when you arrive in the morning, and remain logged in until you sign out. Replacement batteries are in the Medical Service Office on the front desk.

Vocera Log-in Names
- Team 1: Obi-Wan Kenobi
- Team 2: Deuce Bigalow
- Team 3: Three Amigos
- Team 4: Fantastic Four
- Team 5: Captain Planet
- Team 6: Kevin Bacon
To contact someone on their Vocera using a phone, dial 5-8899 and you will hear the Vocera prompt.

If you are having trouble with your Vocera, want information about how to use it, or need other support, call Suleimon Bello at 5-4924 or Vocera him.

Paging:
- **VA pagers:** Dial 9516, then dial 4-digit pager number (If calling a VA pager from outside the hospital: 202-516-pin #).
- **GW pagers:** Dial 7777, wait for the beep, then enter 7-digit PIN (If calling a METROCALL pager from outside the hospital: 1-800-946-4646, wait for prompt, then enter 7-digit pin #).
- **GT pagers:** Dial 9, 202-405-XXX/259-XXXX
- **Navy pager:** Dial 369, then pager number
- **VA Call back number:** 202-745-8000 & 5-digit extension.
- **Calling outside phone numbers:** Dial 9 + 10 digit number.

Radiology:
- A radiologist is on-call at all times. The operator can give you the number.
- **You can listen to radiology report dictations by calling x58677 or 58678 or 58888, dial #199, then 1+ social security number.** The most recent dictated report will be played. Press 5 for an earlier report.
- If a reading is unavailable one hour after completion of the image, call the CT technologist: ext. 56938 or Vocera “CT Tech”.
- For questions about interpretation of an image after-hours or on weekends or holidays, call the NTP clinical service at: 1-877-780-5559.
- **For overnight radiological studies that must be followed up, order these as STAT so that the night hawk will read them. Include your team number in the comments section of the order.**
- MRI reading room 8AM - 4PM (202-745-8000 x55499)

**Admissions, discharges and transfers**

**Admissions:**

**ER admissions:**
- Obtain as much information from ED physician before accepting the patient.
- The patient must be seen within 1 hour of being called by the ED physician.
- Once you decide to admit the patient, please place the admission order (including resident/intern names, pager/Vocera, diagnosis) as soon as possible.
- Place orders as “delayed orders,” which means the orders will become active only when the patient is transferred from the ED to the floor (otherwise the orders will be active in the ED).
- If the patient is boarding in the ED (while awaiting a bed), your team is responsible for following the patient.
- If you need to write orders to be completed while the patient is in the ED, notify the patient’s nurse. Of note, when placing orders in the ED, a pop-up asks if you would like to enter encounter information – just say “No.”

**Direct admissions from clinic/interventional radiology:**
- You will receive calls from clinic attendings and interventional radiology for direct admissions. Please evaluate the patient. If the patient is unstable, please inform clinic attending/interventional radiologist that the patient must be sent to the ED. Additionally, you must make an addendum to the admission transfer note documenting that you have spoken with the attending who has agreed with plan. If this happens during short call, the short call team is still responsible for admitting the patient.

**CHF admissions:**
- Please use the [CHF admission order set](#) for all patients admitted with CHF.
- Document the patient’s NYHA classification.
- Add the primary care doctor as a [co-signer](#) to your admission H&P.
- Please ensure that the patients get **1:1 bedside teaching with the RNs**. This is in the order set. You should also talk to the nurse champion on the floor (3E Elaine Sherman, 4E Julia Garrety).
- Please ensure that the patient receives the discharge educational packet (also be arranged by the nurse champion).
- Make an accurate medication reconciliation at discharge: classify each medication for the specific medical condition it treats (for your heart failure: lisinopril 20mg orally daily, carvedilol 25mg orally twice daily, etc).

**Telemetry beds:**
**Med-tele beds:** 4 beds available on 4E and 3E for patients requiring rhythm monitoring.
- Write the admission order in CPRS “Admit to tele/4E”.
- To discontinue telemetry, complete “d/c tele” order and inform the charge nurse.

**PCU beds:** 4 beds available in the step-down unit on 4BW for patients who require a higher level of nursing care, but do not meet criteria for ICU/CCU admission.
- Call the MICU charge nurse at extension 58112 to ask if there is a PCU bed available and inform them of incoming patient.
- Then write the order “Admit to tele/PCU.”
- To transfer out of the PCU, inform the MICU clerk and write the patient’s name on the board in the MICU.
- If there are no med/tele beds and the patient needs telemetry, call the MICU resident to evaluate the patient and admit them to the MICU team.

**Bounce-back policy:** within the last 4 weeks to the intern or resident (If any member of the team has taken care of the patient earlier that block).

**Transfers:**

**Transfers from MICU/PCU:**
- Patients can be transferred from the MICU **only if they have a bed assignment**.
- The patient must be seen within 1 hour of being called by the MICU team.
- The MICU team must write a transfer summary for all patients in the MICU > 24 hours.
- The medicine team must also write a transfer note. This **should not** be a copy of the MICU transfer summary.

**Transfers from other services (except the Nursing Home 2K):**
- Facilitated by the medicine consult service. The consult service will evaluate the patient and call the admitting resident to write transfer orders.
- The admitting resident should write the “transfer to medicine” order.
- If a bed is unavailable, but the patient needs immediate medical care, they should be transferred to the ED.

**Discharges:**

**Step 1:** Complete **“Discharge Instructions Part A.”**
- Please complete Part A at least one day prior to discharge, if a discharge is anticipated.
- These instructions expedite pharmacy, nursing, and social work coordination. They are not given to the patient.

**Step 2:** Review and **reconcile outpatient medications** (discontinue, change, or prescribe any medications).

**Step 3:** Complete **“Discharge Instructions Part B.”**
- These instructions are given to the patient. This should be completed on the morning of discharge. Please include a brief summary of the hospitalization, written so that the patient can understand it. Please review the outpatient medication list and classify each medication for the specific medical condition it treats.

**Step 4:** Notify inpatient pharmacists of pending discharge and add the pharmacist as an additional cosigner (in addition to your attending) to “Discharge Instructions Part B” (during weekdays).
- **4EA pharmacist:** Ayne Adenew, Pharm D, pager 9, 516-3409.
- **3EA pharmacist:** Alex Sumana, Pharm D, pager 9, 516-3055.
- **During weekdays by 3:00 pm,** the pharmacist will retrieve the medications from pharmacy, formulate a medication reconciliation form, and review the discharge medications with the patient.
- **During weekdays after 3:00 pm and during weekends,** the intern should review the discharge medications with the patient and ensure that the patient receives his or her medications prior to discharge.
- Narcotics: When discharging a patient with narcotics, you must complete a paper prescription. Controlled substance prescriptions can be obtained from the chief resident’s office. You must use your VA DEA number, which can be obtained at the chief resident’s office. Alternatively, your attending can place the order electronically in CPRS. Residents do not yet have controlled substance e-prescribing capabilities at the VAMC.

Step 5: MRSA swabs:
- MRSA swabs must be ordered on admission, discharge, and transfer. The order will pop up automatically - click “yes”.

Discharge Summaries:
- All discharge summaries should be completed by the interns within 48 hours of discharge.
- If a discharge summary is not completed in time, the responsibility will ultimately fall on the resident.
- All admissions require a discharge summary - even if the patient leaves AMA, even if the patient is admitted less than 24 hours.

Throughput

Multidisciplinary meetings:
- Held Monday mornings in 3E-S Conference room with case managers, nursing supervisor, etc to discuss discharge planning. Your team will be notified by Vocera when they are ready for your team.
- Approximate times: Team 1: 9:30-9:40 am; Team 2: 9:40-9:50 am; Team 3: 9:50-10:00 am; Team 4: 10:00-10:10 am; Team 5: 10:10-10:20 am; Team 6: 10:20-10:30 am

Bed Huddles:
Bed huddles occur daily at 9 am and 3 pm in the 4th floor conference room #4E231. Each team will be contacted by the bed huddle team to review/address the following:
- Anticipated discharges for today and tomorrow – Provide patient’s name, last 4, bed location.
- Studies needed for planned discharges (transport, imaging, labs).
- Need for telemetry or PCU level care for patients on your team.

How to get stuff done

Ordering Labs:

Regular labs:
- Collected by the main lab during routine collection times.
- Place the order as “lab collect” and select collection time.
- Labs should be drawn by the phlebotomy team between 5 am and 10 pm.

STAT LABS:
- Place the order as “STAT”.
- Print lab requisition: under file and print menu, change the requisition to print to “BB94.”
- Contact the phlebotomy team: by pager (9, 516-3144) or vocera “phlebotomy.”

Labs from PICC/central lines or new PIV:
- Place the order as “lab collect.” Labs should be drawn by the IV team.
- If ordering after midnight the night before for a morning lab draw, call the IV team.
- IV team can be contacted by phone (ext 57296) or vocera “IV nurse.”

To add on a test to a specimen already in the lab:
- Enter the order as “ward collect” and time as “Now.”
- Call the lab to let them know that the order has been placed (x 5-7493).
- *Note* - this will only work if the lab already has the correct color phlebotomy tube for the specific test.

Ordering PICC line placement:
- Complete electronic patient consent for PICC line.
- Confirm recent PT/PTT/INR is in CPRS.
- Contact IV nurse via Vocera “IV nurse”.

Ordering EKGs:
- Daytime: Place order and call x55783 (stat RF phone) or x58429 (office).
- Overnight, Weekends: Place order and contact PCT (patient care tech) via Vocera (P-C-T).
Order renewals:
- Patient restraints need to be renewed every 24 hours with a daily order and a daily note (Physician Restraint Seclusion note).
- Narcotics expire after 72 hours.
- Fingerstick orders and antibiotics expire after 1 week.
- All other medication orders expire after 30 days.

Ordering all radiology studies:
In the “Clinical History” box, we highly recommend that you include your name and contact information (pager, Vocera), so that the interpreting radiologist can easily reach you with results as needed.

Ordering X-rays:
For bedside X-rays, order it as “Portable” under the “Transport” box.
- If it is needed STAT, call the portable X-ray technician on Vocera – “X-ray Tech.”
For multi-view X-rays, order it as “Stretcher” or “Wheelchair” under the “Transport box.
- Call the main radiology X-ray technician (5-846) and let them know that you are sending the patient down.
- Ask the nurse to send the patient to radiology. (S)he will arrange for Patient Transport to come get the patient.

Ordering CT scans:
If you need a STAT CT scan, or when ordering on nights/weekends, call the CT tech to let them know you are sending the patient down (x 56940, 56417, or 55013.
- Ask the nurse to send the patient to radiology. (S)he will arrange for Patient Transport to come get the patient.

Ordering MRIs:
Weekdays 8AM – 4PM
1) Call Neuro-Radiologist for approval (Dr. Khan; 202-745-8000 x57598)
2) Call MRI tech (202-745-8000 x56424). They are in house from 7:30AM to 8PM.

Weekends/Nights
1) Call radiologist on call for approval (refer to Radiologist on call schedule on DCVAMC webpage)
2) Call MRI tech on call (refer to Radiologist on call schedule on DCVAMC webpage)
   a. B. Mesgun (202-516-3306)
   b. Posy (202-516-3222)
   c. Oliver (202-516-3202)

Procedures

Supervision:
All procedures should be supervised by the senior resident or the attending. If the senior resident is unavailable, the intern should ask the residents on other teams for supervision. Chief residents may supervise if other residents are unavailable.

Consent:
The iMed Consent application is the preferred method.
- Choose a laptop with an attached signature pad to bring to the patient/designee.
- In CPRS, click the “Tools” menu, then “iMed Consent.”

If paper consents must be used due to computer malfunction, you must physically take the consent form to the ward clerk and ensure they scan it into CPRS before proceeding.
When the patient is unable to give consent, consent from the legal next of kin/healthcare surrogate can be obtained via telephone. The AOD should be called, and they will call the family member for a three-way call with the physician. If the AOD is not available, a paper telephone witness form must be completed.

**Documentation:**
A procedure note must be filled out for any procedure that is done or attempted using the “Procedure Note” template.

**Consults**

**Calling consults:**
Any consultation request to another physician service must both include the CPRS request AND a call to the provider within an hour of putting the order into CPRS.
- If you experience a delay in callback from the service, please notify the chiefs.
- Evaluations by MICU/CCU count as consults. Please place a CPRS order, in addition to calling the MICU/CCU resident.
- PT, OT, Speech, Nutrition, SARP and other ancillary staff consults do not require a phone call, but it is always a good idea to call them to facilitate the best care for your patient.

**Psychiatry consults:**
- Monday–Friday from 8:00am to 4:30pm:
  - Patients <65 years old, please page 202-516-3963
  - Patients 65 years and older, please page 202-516-3956
- After hours, weekends and holidays: please contact the psychiatrist on duty by paging 202-516-3526

**Medicine consults:**
- All inpatient medicine consults will be followed by the consult resident from 8am–4pm on weekdays.
- The night call resident is responsible for the consult service on nights, weekends, holidays, and when the consult resident is in clinic. On weekends, holidays and overnight, the medicine consults will be staffed by the on-call team’s attending if the patient is acutely ill or if there are any questions or concerns.
- Any medicine consult that is staffed immediately should be counted as a transfer on the on call team admission census. If a patient is transferred from the H/K-wings to the floor, it is considered a new admission.

**CPRS tips and tricks:**

**Notifications:**
When you first sign into CPRS, you will see a box of notifications. These will include medications that are about to expire, radiology results that have returned, consults that have been completed, and notes that remain unsigned. These are very helpful in finding out what has been done for your patients!

**Setting a default cosigner:**
Under the “Tools” Menu, click “Options,” then the “Notes” tab. Click the “Notes” button. Select your attending’s name as your default cosigner.

**Medications that require justification:**
There are a number of medications that are on the VA’s formulary list, but require justification in order to be prescribed. These include:
- Atypical antipsychotics: aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone
- Angiotensin receptor blockers: losartan, valsartan
- High-risk drugs: amiodarone, varenicline
- High-cost drugs: clopidogrel, erythropoietin stimulating agents, extended release metoprolol
To order these drugs, you must write a Medical Use Exception (MUE) note. Once you have completed the worksheet, you will be able to order the drug.
Requesting a non-formulary medication:

To request a non-formulary medication, you must place a consult to the pharmacy service.
- In your consult, make sure to include if the patient is already taking and tolerating the medication.
- If the patient is able to take their own supply of medication from home, make sure to include that as well.

Favorite note types:

Under the “Tools” Menu, click “Options,” then the “Notes” tab. Click the “Document Titles” button. We recommend the following frequently used note types:
- Admission History and Physical
- Med: Inpatient Progress Note
- Med: Inpatient Cross Cover Note
- Med: Discharge Progress Note (can be used on the patient’s last day if being discharged in the morning)
- Universal Protocol Note – Physician
- Universal Protocol Note – Time Out
- Central Line Insertion Note
- Discharge Instructions Part A
- Discharge Instructions Part B
- HIV Verbal Consent Note
- Code Blue: Medicine Note

Creating and editing your electronic signature

Under the “Tools” Menu, click “Utilities,” then “Create e-signature.”
- To change your title or signature line, click “Edit User Characteristics.”
  o We highly recommend you include your pager number in your Signature Block: Title so that consultants, radiologists, etc. can get in touch with you more easily.
- To change your electronic signature code (used to sign orders and notes), click “Check/Edit Electronic Signature Code.”

Documentation

General rules:

DO NOT cut and paste notes. This is a medical-legal liability issues and a billing issue. If it is noted that this is happening repeatedly, a letter will be sent to your program director reflecting a lapse in professional behavior.

Special notes:

DNR/DNI documentation:
- Place a DNR/DNI order in CPRS.
- Write an “Advanced Directive Discussion” note.
- Document code status in your daily progress note.

Fall Note: If you are called about a patient who had a fall...
- Write a “Med:Fall Medical Assessment and Intervention Note.”

Death Note: If you are called to pronounce a patient (your patient or a cross-cover patient)...
- Write a death note - Type in “Death” and choose DEATH <SUMMARY OF DEATH NOTE>.

Student Notes:

EVERY medical student note needs to be addended by either an intern (for 3rd years) or resident (4th years). The addendum needs to include physical exam, assessment and plan. Every patient also needs to have a full H&P by an MD (Not an addendum to a student H&P).
Nursing home patients

Nighttime/weekend coverage:
- During nights and weekends, the on-call Geriatric Medicine physicians may ask the medicine admitting resident to evaluate nursing home patients with urgent medical concerns. Please evaluate the patient, communicate recommendations to the on-call Geriatric Medicine physician, transfer the patient if necessary, and write a note in CPRS.
- The Moonlighter is responsible for cross-coverage of the H/K-wing patients, including fall evaluations and death pronouncements, from 7PM to 7AM.
- From 5PM to 7PM and 7AM to 8AM, the medicine admitting resident is responsible for fall evaluations.
- Patients should be transferred directly to the floor and do not need to go through the ED. If a patient is unstable, they should be transferred directly to the PCU/MICU.
- If the admitting resident does not think that the patient warrants admission but may require some simple tests, the PCT can be asked to draw labs on that patient. They may also be sent to radiology without an admission.

Facilities info

Door codes:
- Team rooms 1-5: 3+4, 1
- Team 6 room: 2+3, 5
- 3E clean utility room: 1, 2, 4
- 4E clean utility room: 1+5, 3
- Medicine call room 4D205: 2+3, 4
- Medicine call room 4D207: 2+3, 5
- Medicine call room 4D106: 2, 3, 4
- Medicine call room 4D208: 2+3, 1

Security:
You may arrange for a police escort to the parking lot (ext 58189).

Meals on-call:
The patient cafeteria (Room 1C101) is open to housestaff as follows:
- Mon-Fri: Breakfast 7:30-9:00 am, Dinner 4:30-6:30 pm
- Sat-Sun, Holidays: Breakfast 7:30-9:00 am, Lunch 11:30 am-1:00 pm, dinner 4:30-6:30 pm
- If you will be unable to go to the cafeteria before closing, you can call the supervisor (ext 58269) and ask them to hold a meal for you (which you can pick up until 8:00 pm).
Washington Hospital Center also has a cafeteria.

Wireless internet:
Available throughout the hospital.
- Network: VA Guest Wifi
- Password: FlagshipWifi (case sensitive)

Library and online resources:
The library is located on the first floor (L134). Hours: 8:30 am-4:30 pm. The staff librarian is available to help you look up articles (ext. 5-7423). The VA home page also has a link to the library resources.

Professionalism:
As part of a professional environment professional attire is expected. Scrubs are permitted only for those staying overnight in the hospital and on weekends. Please keep your white coat clean.
Reporting Medical Errors & “Near Miss” Events

It is very important that we report medical errors and “near miss” events to improve patient safety and health care quality at the VA.

From the VA intranet, click on “Quality Management” (listed in the menu on the left). Under “Patient Safety,” click on “Electronic Incident Reporting.” Fill out the information related to the medical error or near miss. Please write the attending’s name as the “Physician notified” (not the resident’s name).
Remote access

SELF SERVICE PORTAL DOCUMENTATION – REQUESTING A VPN ACCOUNT – This must be requested from a VA Network Computer initially, we recommend doing it the first day of your rotation. For issues, contact paul.blose@va.gov, x58375.

Users that access the self-service request portal (https://vpnportal.vansoc.va.gov/selfservice) should login using their Windows domain credentials:

Once logged in, users begin the VPN account application process by clicking the “Request VPN Account” button:

Users are required to complete all steps before submitting their application for a VPN account. Users begin by verifying their Name, phone number, last 4 digits of their SSN (used by VPN Helpdesk to verify identity for support calls), mail code (if known), computer type and reason for account:
Leave mail code blank

Select “personally owned equipment: under type of computer

Under reason for account: “resident physician, need remote CPRS access for patient care”

In the second step, the user must locate their facility. This is done by first selecting the state that the facility is located in, followed by identifying the name of the facility:
Select “Washington DC VA Medical Center”

In the third step, the user selects either “Contractor” or “VA Employee” from the Account Type drop down list. The user then selects their company from the company drop down list. If the user is an employee, the company drop down list will automatically be defaulted to “Department of Veterans Affairs”. Otherwise, contractors must select a company from the list. After a company selection is made, users are then directed to select their supervisor.

**Note – The list of Supervisors is maintained and populated by the Facility ISO. If your supervisor is not listed, you must contact your ISO to have the supervisor added before you can complete the application. In some instances, your facility ISO has chosen to be the only approver of VPN requests. In this case, you will only see “Default Supervisor” in the drop down list and you can leave that selected.

Select “VA Employee”
Once the user identifies their supervisor (select Samantha McIntosh), they will finalize their application in step four by checking the certify box and clicking “Submit Request”.
After your submission, you may come back to the Self Service portal to track the status of your request, as well as, view and download your “Welcome Letter” once the final approval is granted by your ISO.

**To access CPRS remotely:**
2. Enter domain/username. Include `vha05\` before your network access login (ie. `vha05\vhawasXXXXXXX`)
3. Enter your network password.
4. Install Citrix.
5. Open folder “R04- Clinical Applications.”
Telemetry indications

Medical Telemetry (4EA and 3EA)

Indications for patients admitted for medical telemetry monitoring include:

1. Evaluation of chest pain
   a. Patients with risk factors for coronary artery disease, but initial ECG and cardiac biomarkers are negative.
   b. Telemetry monitoring required if serial cardiac enzymes are being checked

2. Syncope
   a. Unexplained syncope, near syncope or episodic dizziness with no clear cause
   b. Not attributable to life threatening cardiac disease

3. Stable Arrhythmias
   a. Hemodynamically stable atrial fibrillation or atrial flutter requiring PO rate control, PO drug loading to convert, or new onset atrial fibrillation or atrial flutter
   b. New, asymptomatic bradycardia that is not life threatening, not requiring external/temporary transvenous pacing
   c. Hemodynamically stable nonsustained ventricular tachycardia

4. Hyper/hypokalaemia
   a. Without ECG changes (if ECG changes, admit to 4BW or consult MICU)
   b. K<7.0 and unlikely to rapidly worsen

5. Alcohol withdrawal with CIWA score of 15-20 and requiring use of intravenous medications.

PCU Telemetry (4BW)

1. Decompensated congestive heart failure requiring fixed-dose drips of inotropes
   a. Hemodynamically stable patients
   b. IV inotropes (eg dobutamine, milrinone) can be administered at fixed rates only, no titration. Otherwise, consider transfer to MICU.

2. Hyperglycemia/Hypoglycemia
   a. Hyperglycemia requiring frequent blood sugar monitoring
   b. Hypoglycemia requiring frequent blood sugar monitoring
   c. Conditions requiring IV insulin drips (eg, DKA) must be treated in the MICU

3. Patients who require scheduled or prn pushes of intravenous vasoactive or rate control medications, such as intravenous calcium channel blockers, beta blockers, and digoxin. Note: intravenous hydralazine MAY be administered by nurses on the medical floor in doses less than 30 mg in 3 hours.

4. Patients requiring suctioning more frequently than every 4 hours, particularly those with a tracheostomy or altered mental status

5. Patients requiring neuro checks more frequently than every 4 hours

6. Patients on ≥40% oxygen by venturi mask who are not candidates for ICU transfer

7. Patients requiring initiation of bipap for acute or acute-on-chronic hypercapnic respiratory failure (pH<7.3 with pCO2 of greater than 45) or severe pulmonary edema not meeting ICU admission criteria. NOTE: bipap cannot be administered in the P3 area of 4BW.
8. Patients requiring scheduled nebulizer treatments more frequently than q4 hours. Does NOT include prn nebs.

9. Patients with severe alcohol withdrawal symptoms requiring intravenous medications more frequently than every 2 hours to maintain CIWA score <20. Note: extreme agitation hemodynamic instability or seizure requires MICU consultation.

10. Electrolyte abnormalities not meeting MICU criteria but requiring emergency management including but not limited to: hyperkalemia with ECG changes, K> 7.0, or K>6.5 and rapidly increasing.

11. Patients with peritoneal dialysis catheters in situ. Note: needs a private room.

12. Patients with who presented with unstable vital signs but have been stabilized may be admitted to the PCU for 24 hours for monitoring purposes if there is suspicion that they may acutely deteriorate in a timeframe that may not be detected by floor nursing policies. Should be transferred to a floor bed if remains stable over 24 hours. Examples include:
   a. Admission with SIRS and hemodynamic instability or GI bleeding who has been stabilized in the ED
   b. Inpatient who became unstable on the medical floor but has been stabilized, such as a Rapid Response event.

13. Patients requiring urgent hemodialysis outside the dialysis unit may board in the PCU for the purpose of hemodialysis if a dialysis-capable bed is available. This may only occur after discussion with the MICU charge nurse and when determined necessary by Nephrology.

Possible indications for patients to be discontinued from medical telemetry
1. Stabilization or resolution of chest pain and/or arrhythmias
2. Negative cardiac markers (“Ruled out” for myocardial infarction)
3. Resolution of syncopal episodes and completion of arrhythmia evaluation
4. Normalization of electrolyte levels
5. Stabilization of congestive heart failure symptoms
6. Stabilization of respiratory status
7. Stabilization of alcohol withdrawal symptoms
8. Adequate control of blood sugars not requiring frequent blood sugar monitoring
9. Stabilization post CVA
Emergencies

STEMI:
Call the operator and ask for Cardiology Team 1. This will activate the cardiologist, cath lab, etc.

Code Blue:
The MICU resident runs the code, assisted by the medicine admitting resident. The admitting interns should also be present at the code to assist the residents.

Rapid Response:
The rapid response team consists of an ICU nurse, Respiratory Therapist and MAR (during the day) or Moonlighter (at night). The medicine admitting resident or moonlighter runs the rapid response. Patients should be stabilized at their current location then moved to a bed with increased monitoring if needed (they should NOT be sent to the ED). If you go to a rapid response, please write a rapid response note.

Occupational exposure:
Call a chief resident immediately. If any delay, you may contact an ID Fellow or ID Attending directly. Contact information is located on the Medical Center Web Site / On-Call Schedules / Infectious Diseases.
- Mon-Fri during business hours, go to Occupational Health (Ground floor, room 1C118 - located next to the vending machines; phone number ext 58254)
- Weekends and after-hours, go to the ED. Then go to Occupational Health the following day.
- Consent from the patient will be obtained for HIV/Hepatitis lab work.