

## General Medicine Wards Orientation for Housestaff

Revised 9/18/2024

### GOALS

The General Medicine Ward rotation is the core inpatient experience for the Olive View Program and rotators to Olive View. As interns and residents, you are integral members of the teaching medical team with the goals to provide excellent patient care to county patients in a collaborative and educational environment.

Interns function as the primary providers for their patients, evaluating and managing medical disease, coordinating care of the patient with other healthcare providers, and educating patients. Residents have the added responsibility of supervising the medical team and coordinating the transitions of care for their patients. All team members including medical students and attending physicians are responsible for promoting learning and teaching in an educational environment.

### HIGHLIGHTS

#### Call Cycle & Schedule

Long Call	Post-Long Call	Non-call	Short Call	Non-call	Medium Call	Non-call	Non-call
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- Long Call team: Admits 10 patients, 8am-10pm. Resident stays overnight to finish admissions and cross-cover.
- Medium Call team: Admits 6 patients, 7:45am-4pm.
- Short Call team: Admits 4 patients (on overflow days, can admit up to 6 patients), 7:30am-12pm.
- Patients are cross-covered by the Night Float (NF) intern overnight, except patients on the Long Call team.
- Sign-out about overnight events from NF starts at 6:30 am in the call suite (5B-106, code 747210). The NF rooms are 5B-104 (blue NF) and 5B-105 (red NF) inside of the suite.
- Sign-out to NF starts at 4:00pm in the NF intern call room in 5B-104 (blue NF) and 5B-105 (red NF), please see the sign out section below for further information on priority list.
- Use the AMION schedule for ward team assignment, call and day-off schedules, and text paging.

### STARTING THE ROTATION

- Find out what team you are on by going to AMION at [www.amion.com](http://www.amion.com) (password: ov im). Search your schedule by clicking the schedule icon or advance through the "Who's on-call" schedule until you see yourself on call.
- Make sure to complete training for ORCHID PowerChart, the electronic health record for LA County DHS. Online training can be completed at [www.oliveviewucla.org/orchidtraining/](http://www.oliveviewucla.org/orchidtraining/). **You must complete PowerChart training a few days in advance of starting the rotation in order to obtain access by the time you start. No training means no access.**
- Get sign-out the day prior to starting from the outgoing intern/resident. For interns taking over post-Long Call teams, get sign-out on as many NEW patients as possible. You will receive the rest of the new patients in the morning.
- **For outside rotators or first-time ward interns:** On your first day, stop by the call suites (5B-106, code 747-210) to pick up your pager. There will be a cloth bin on the table that has these items labeled with your name. Do not forget to return your pager on the last day of your rotation (either in the Chief's Office or in the cloth bin). If you lose or do not return it, you are responsible for the costs of replacement: pager \$50.
- **For residents on call:** Start picking up patients by going to the Call suites (5B-106, code 747-210) to get sign-out on overnight holdovers. Pick-up time depends on the call day (see above for start times).
- **For interns:** Pick up sign-out from the Night Float intern at 6:30-7:00 AM in the Resident Lounge (2C-160, code 325)

#### Hospital Layout

- 2F: Med/Surg/Tele/SDU/Isolation Units
- 4A/4D: Med/Surg wards
- 5A: Med/Surg + Hem/Onc wards
- 5C: Med/Surg + Telemetry wards
- 5D/4BN/4BS: Step Down units
- 5BN/5BS: ICU
- Call Rooms:
  - 5B-106: Long Call (or 4B-106 if 5B-106 under fire alarm construction) – door code 747-210 for both
- Res lounge: 4B118 - door code 118118

## WARD TEAMS

### Team Structure

- There are 8 Medicine Ward teams. Each team is comprised of 1 attending, 1 resident, 2 interns, and additional rotators, including additional interns, sub-interns, and medical students.
- Each intern is responsible for the care of up to 10 patients (“hard cap”) at a time, and up to 5 new admissions (“soft cap”).
- Each resident is responsible for the care of up to 20 patients (“hard cap”) at a time, and up to 10 new admissions.

## WARD SCHEDULE

### General

- Ward teams admit patients on Long Call, Medium Call, and Short Call.
- The general daily routine on a non-call day consists of picking up sign-out from the Night Float cross-cover intern (6:30am), pre-rounding on patients (6:30am-8:15am), rounding with the attending (9am-11:30am), Noon Conference (12pm-1pm), patient care activities (afternoon), and sign-out to the Night Float intern.

Typical Daily Routine		<b>LONG CALL</b>	Post-Long Call	Non-call	<b>SHORT CALL</b>	Non-call	<b>MEDIUM CALL</b>	Non-call	Non-call
Sign-out from NF	<i>6:30am</i>								
Pre-round	<i>7:00am</i>								
Morning Report	<i>8:15am</i>	10 Admissions			4 (up to 6) Admissions		6 Admissions		
Attending Rounds	<i>9:00am</i>	8:00 am to 10:00 pm			7:30 am to 12:00 pm		7:45am to 4:00 pm		
Noon Conference	<i>12:00pm</i>								
Patient Care and Education	<i>1:00pm</i>								
Sign-out to NF									

## Long Call

- Each team will be on long-call every 8th day.
- For residents, Long Call starts at 8:00am and ends 11:30am the next day (24 hours + 4 hours). Residents pick up overnight admissions in the Call suites (5B-106, code 747-210) at 8am.
- For interns, Long Call starts with sign-out at 6:30am and ends no later than 10pm.
- Each Long Call team can admit up to 10 new patients provided that does not violate their “hard cap.”
- ICU transfers will go to the Long Call team as a part of the 10 new patients.
- Each intern can admit up to 5 new patients (intern “soft cap”).
- Interns cannot care for more than 10 patients at any given time (intern “hard cap”).
- Team can admit patients until 10pm.
- Interns should not admit new patients after 7pm. Exception: If an intern has not admitted 3 patients by 7pm, then the time cutoff for intern admissions is 8pm.
- If the team has received less than 6 patients by 7pm the admission cap will decrease to a total of 8.
- The intern History and Physical document needs to be completed and signed within 24 hours of the time of admission. It can be completed on the post-call day. The date/time of admission starts at the time “Request for Admit” was ordered.
- The resident will complete admissions on all new patients that the interns have not had a chance to evaluate before the interns leave for the night (this includes admission orders and H&P).
- The resident will be responsible for cross-coverage on their team’s patients overnight on Long Call. The interns will be responsible for providing the resident with a thorough and complete sign-out before they leave.
- Interns return on their post Long Call day, at which point they will get sign-out on old and new patients from their resident. They should see their patients before attending rounds begin.
- Interns will stay to complete their work under the supervision of the attending after the resident leaves at 11:30am on the post-Long Call day.
- On post call days, interns will be responsible for writing progress notes on all old and new patients.
- Interns’ H&P, if written on a post-call day, also counts as that day’s note, but should reflect changes in management from that day.

## Medium Call

- Team will admit up to 6 patients.
- For interns, medium call starts with sign-out at 6:30am and ends no later than 10pm.
- Residents pick up overnight admissions in the Call suites (5B-106, code 747-210) at 7:45am, and their day should end no later than 10 PM.
- In most situations, each intern on Medium Call will admit up to 3 new patients.
- The time cap for admissions to the Medium Call team is 4pm.
- Intern H&P’s must be signed before sign-out.

## Short Call

- Team will admit up to 4 patients, which can flex to 6 patients if the hospital is in overflow.
- For interns, short call starts with sign-out at 6:30am and ends no later than 10pm.
- Residents pick up overnight admissions in the Call suites (5B-106, code 747-210) at 7:30am, and their day should end no later than 10pm.
- The time cap for admissions to the Short Call team is 12pm.
- In most situations, each intern on Short Call will admit up to 2 new patients.
- Intern H&P’s must be signed before sign-out.

## Non-call day

- Sign-in (from Night Float) is from 6:30 - 7:00am in the call suite (5B-106, code 747210).
- Attendings are expected to conduct rounds with the team from 9am to 11am.
- Interdisciplinary rounds occur on non-call days over Teams
- Resident discusses potential discharges for the next day sometime between 3:30-4:00pm to prepare morning workflow.

## Days Off

- Every intern and resident will get 1 day off per week averaged over 4 weeks.
- On intern days off, the resident is responsible for daily progress notes and follow up of all of the team's patients.
- MS3's have days off with the resident (MS3's cannot be off on Mon/Wed/Fri)
- MS4's take days off with interns, not the same day as the resident.

## SIGN-OUT

- 2 Night Float interns will be responsible for cross-cover overnight of patients on the General Medicine and Hem/Onc wards (except for patients on the Long Call teams). Hospitalist service patients will be covered by the Night Hospitalist residents.
- Sign-out consists of the electronic, printed "Physician Handoff" PLUS verbal phone sign-out.
- Electronic sign-out is accessed from the "Physician Handoff" in ORCHID and makes use of the IPASS model. To print, select print from the top-right menu and select the "detailed" printout option.
  - Sign-outs can be printed and placed on the respective night float desk starting at 3:30pm (the lists have a timestamp).
  - Ensure your printed sign-out includes your name, team name, and call-back extension.
  - Please note your team color on AMION and sign out to the night float corresponding to this color.
- Verbal phone sign-out will occur starting at 4pm with prior given to specific teams based on their position in the call-cycle (see order below). If one team has not placed their sign-out before 4:00pm the night float will move down the list.
  1. Pre-Long Call
  2. Heme/Onc Resident
  3. Post-Short Call
  4. Pre-Short Call
  5. Post (1 day) Medium Call
  6. Short Call
  7. Post-Long Call Interns
  8. Medium Call

## How to Sign Out:

- Review sign-out with your resident or attending.
- Interns on regular working days, Short Call, or Medium Call can sign out to the Night Float intern after their arrival at 4pm.
- On weekends and holidays, interns can drop off their patient list in the respective Night Float intern call rooms at 12pm. The intern/resident leaving the hospital will remain on pager until telephone sign-out to the Night Float intern after 4pm. If any acute issues arise prior to sign-out, the intern/resident is to return to the hospital to manage the patient.
- Long-call interns sign out to their resident for the night rather than the Night Float interns.
- To retrieve sign-out on patients managed overnight by the Night Float interns, go to the call suite (5B106). Night Float interns leave promptly at 7:00am. Interns may page Night Float directly if they arrive early.
- Residents will follow the same procedures for sign-out when the interns are off.

## ADMISSIONS, TRANSFERS, AND DISCHARGES

### About Admissions to the Medicine Service

- Admissions are first called to the Medicine On-Call pager and tracked on an admission list, which are usually managed by the Hospitalist attending. The time of admission starts at the time the "Request for Admit" or "Place in Observation" order was placed.
- On the morning of call days, the admitting team resident is expected to pick-up new admissions from overnight by coming to the Call suites (5B-106, code 747-210). The accepting resident will receive sign-out of patients from the overnight resident.
- During the call day, the admitting team resident will be paged about admissions. The resident should receive verbal sign-out from the admitting provider (e.g. the ED provider) to accept the patient.
- The admitting team should evaluate the patient in the ER or clinic, place orders electronically in ORCHID, and document a History & Physical. These patients must be placed on the intern's sign-out.
- The resident should notify the triaging Hospitalist if the team will reach the hard cap. This is a rolling cap, so if there are discharges, transfers, or deaths, this will decrease the census, allowing for more admissions until the hard cap is reached.

## About MEDICAL OBSERVATION

- Upon hospitalization, patients will be either placed under **observation** or admitted to **inpatient**. The triaging hospitalist will identify this status when patients are assigned.
- Observation requires a "Place in Observation" order. If observed patients require full inpatient admission due to severity of illness and intensity of services, they can be converted to admission at any time, but no later than 72 hours into observation.
- All upgrades from "observation status" to full admissions require a "Consult to UR" order with subsequent approval for the admission. Once the admission is approved by UR, place the "Request for Admission" and "Admit to Inpatient" orders.
- Otherwise, orders, documentation, and bed assignments are similar for observation and admitted patients.

## Admissions FROM THE EMERGENCY DEPARTMENT

- Most patients are admitted from the ED, located on the 2nd Floor.
- The medicine team is responsible for care of the patient as soon as the accepting resident receives verbal sign-out from the ED, even if the patient is still located (*i.e.* boarding) in the ED. Patients admitted from the ED will be converted to "ED Boarder" status in ORCHID, after which the ED bed functions as a ward bed and Internal Medicine becomes the primary service.
- Admission orders must be signed within 2 hours of receiving sign-out from the ED.
- Prior ED orders and home medications must be reconciled through the Admission Reconciliation in ORCHID.

## Direct Admissions FROM URGENT CARE OR CLINIC

- Some patients are admitted from outpatient clinics, Urgent Care, or outpatient procedure areas, which are located on the 2nd Floor. Their evaluation may start in clinic.
- These patients require a new inpatient FIN (or encounter) generated for the admission. Admission orders must be signed and "initiated" under the **new FIN** in ORCHID once the patient arrives in an inpatient care area. The H&P must also be started and signed under the new FIN.

## Transfers FROM THE ICU

- The ICU team continues all clinical responsibility for a patient while in the unit or on the medicine floor until completion of a formal sign-out with the accepting medicine team. This includes all written orders and documentation.
- The ICU resident will give a direct sign-out to the accepting resident. The ICU team will also sign a Transfer Note that details the patient's clinical course.
- Ward interns are responsible for writing an "accept note" (use the "Internal Med Inpt Progress Note" note type) and adding that patient to their sign-out. Don't forget to review and reconcile all transfer orders and medications (written by the ICU) as part of the initial evaluation.
- ICU transfers are treated like new admission and must be worked-up as such.
- ICU transfers count towards the admission cap on call days.

## Transfers TO THE ICU

- If a patient requires acute critical management you must call a "Rapid Response" or "Code Blue." Please have the patient's nurse or clerk call the rapid response/code. If not, you can do so yourself by dialing 114. Do not page the resident as this will delay needed treatment.
- Please note that the ICU team is not a consultant and that any call to the ICU is considered a notification for admission/transfer to the ICU. Any disagreements or uncertainty about the proper level of care should be discussed with the ICU fellow and/or attending.
- All transfers to the ICU must be accompanied by a Transfer Note from the ward team. The intern is responsible for this document unless he/she is off.
- The ICU team is expected to write transfer orders and reconcile all prior active orders.
- If a ward patient is transferred to the ICU, that patient will be transferred back to the same intern if within 14 days. This does count as a "bounceback" (Please see bouncebacks below).

## Bouncebacks

- A bounceback is defined as a readmission to a medicine INTERN that is still on service within 14 days of discharge.
- Bouncebacks are accepted by the primary team:
  - On a non-call day;
  - On a call day, which counts toward the admission cap if the team has not yet capped or as a bounceback re-admission if the team has already reached their admission cap;
  - On the post-Long Call day only if there were less than 10 patients during the Long Call and the total number of admissions to the resident does not exceed 10 in a 24 hour period;
  - On a resident's day off

- On an intern's day off, except if the intern is off on the last day of the rotation.
- Bouncebacks go to the primary team on the same day if called to the list before 2:30pm Mon-Fri and before 12:00pm on Sat/Sun/holidays. After these times, the patient will be held over by the NAR (if patient is a new admission) or ICU team (if patient transferring from ICU) and transferred to the team the following morning.
- All bouncebacks must be staffed with an attending within 24 hours of admission.
- Hem/Onc patients who get re-admitted for scheduled chemo do not bounce back. Those admitted for other reasons/complications do.

### Discharge Planning

- Discharge planning should start upon initial evaluation during admission.
- Discharge needs should be coordinated during Collaborative Care Rounds (CCR; aka interdisciplinary rounds, IDR).
- IDR is held daily Monday through Friday in the team workroom on non-call days. The CCR includes the primary medical team, utilization management (UM) nurse, social worker (SW), therapist, dietitian, and pharmacist. The CCR should identify outpatient resources for the patient, including primary care and pharmacy. Look for the "Discharge Planning" note in the chart for additional information.
- Your team's assigned UR nurse and SW will be available on Microsoft Teams in a dedicated Teams channel. Discuss discharge planning for each patient on your team to facilitate timely discharges and to address any barriers to discharge. During IDR, where all teams will present, the attending or the senior resident should be leading this discussion. Ideally, the entire team is present during this call.
- Patients needing outpatient follow-up fall under these categories:
  - **Has insurance and empaneled with outside primary care physician (PCP):** All follow-up should be arranged with the outside (PCP), including subspecialty follow-up. The UM nurse should assist with this.
  - **Has DHS insurance and empaneled at a DHS site (e.g., OVMC, MVHC, SFHC):** Follow-up may be arranged by calling these individual clinics or as a "Discharge Request for Hospital Follow Up in Primary Care (DHS)" order through the discharge order set.
  - **Has no insurance:** Temporary follow-up for active medical issues (e.g. new dx of DM, complete resolution of infection, etc.) can be arranged with CCC (Continuity Care clinics) located in Urgent Care (x74312). To schedule this, send an Orchid Message to the CCC clinic. You can do this by typing "OVM CCC" under the "Pool" tab. You should be able to select the "OVM CCC PDC Urgent Request". Write a brief message requesting the post-discharge appointment along with the timeframe and brief patient.
    - Patients can go to the outpatient financial office on weekdays at 2D-141 (7AM-5PM) to explore insurance options.
  - **Subspecialty follow-up:** If a patient has been evaluated by a subspecialty service during the admission and needs follow-up, that service will arrange follow-up. If the patient needs an initial subspecialty evaluation as an outpatient after discharge (was not seen by the subspecialty during admission), this must be arranged by their primary care physician. If the patient does not have a primary care physician, you can arrange a CCC Clinic follow up as above to have an eConsult submitted. **eConsults generated by the inpatient team will not be accepted.**

### Discharges & Interfacility Transfers

- The decision to discharge a patient and the discharge plan should always be discussed with the attending.
- The discharge plan should always be discussed with patients.
- All hospital discharges require:
  - **Discharge Instructions** and educational materials for the patient
  - Appropriate **prescriptions** and **medication reconciliation**
  - Appropriate **follow-up** referral or appointments
  - Discharge orders
  - Discharge Summary
- Transfers to other healthcare facilities (hospital, long-term acute care (LTAC), post-acute, SNF, etc.) additionally require the following:
  - Reconciliation of medications and orders
  - Completion of the Discharge or Transfer Summary prior to transfer
  - Chart copy

### Patients Leaving Against Medical Advice (AMA)

- Patients have the right to leave AMA if they have the capacity to decide their disposition (i.e. they know their diagnosis, prognosis, the benefits of staying in the hospital and the risks of leaving the hospital, alternatives to hospitalization)
- To care for patients wishing to leave AMA:
  - First, de-escalate the situation. Listen to the patient's concerns, explain why it would be dangerous to leave AMA. Assess for decision-making capacity. Discuss the situation with the attending.

- If the patient has dispositional capacity and still insists on leaving, provide them with the necessary prescriptions and follow-up. Leaving AMA does not mean abandoning all medical care.
- Have the patient sign the AMA form (located in nursing stations).
- Document the incident thoroughly.
- If a patient becomes aggressive or threatening, call for a “Code Gold” (De-escalation team composed of inpatient psychiatric nursing staff and security).

#### MAC (Medical Alert Center) Transfers

- MAC is a Los Angeles County inpatient referral and transfer system, whereby patients are transferred out to other hospitals for services that are unavailable at Olive View such as neurosurgery, certain orthopedic cases, and certain cardiothoracic surgery cases (e.g. CABG).
- To initiate a MAC consultation/transfer:
  - Call MAC at 866-940-4401. Request a consult service and specify if routine or emergent. MAC will ask you a few questions about the patient and initiate the process. Or, fill out the MAC paper work and fax to 562-906-4300. For the patient’s facesheet, request the unit clerk to print this for you.
  - MAC will contact other hospitals to identify an accepting physician and bed availability.
  - MAC may call/page you to discuss the case in real-time with a consulting provider. All communication with the outside provider or consultant should go through MAC. Communication is recorded and part of the medical record.
  - You may call MAC periodically to check on a patient’s status.
- To complete a MAC transfer
  - Anticipate patient transfer once you have started the MAC paperwork.
  - You will need to complete medical reconciliation, a Transfer Summary, and discharge orders. You can prepare notes and orders ahead of time, and forward unsigned notes to another team member who will cover you when you are off.
  - You will need to request a chart copy. Use the “Medical Record Request” order from the Discharge order set.
  - If radiographic images are needed, you may request a CD with relevant radiology from the Radiology Film Library during business hours or from ED Radiology after hours.
  - Once a patient is accepted for transfer and transportation is arranged, place an order to discharge to another hospital.
- Patients requiring cardiac surgery that is recommended by the Cardiology consult service are usually coordinated by Cardiology (usually to LAC+USC or Harbor), but the ward team is still responsible for the orders and Transfer Summary.

## PATIENT CARE

#### Calling Consultations

- Locate the consultant you want to reach on AMION on the “Who’s on Call” page or on the paging list under Subspecialty Consult. If the particular service is not listed, please call the Operator (dial ‘0’) and ask for the specific subspecialty on call. Oftentimes, their pagers can be found on AMION for text paging.
- Always see your patient first and complete a full exam before calling a consult. Be ready to answer all questions.
- Please have a well-defined question for your consultants. For instance, you may call cardiology because your patient with a history coronary artery disease is having chest pain consistent with unstable angina and you want to know if they need a coronary angiogram. Do not call cardiology simply because your patient without any risk factors is having chest pain.
- Remember to be courteous, including leaving a return extension and allowing at least 5 minutes for the consultant to call you back.
- Please give your consultants enough time to see your patients, so try requesting all new consultations before 1 PM.

#### Holds & Restraints

- Medical Hold = Patient is delirious (e.g. pulling at IVs, not oriented). Any physician can initiate, renew, and discontinue a medical hold. This is the “**non-violent**” **restraint** in ORCHID. The medical hold lasts up to 24 hours and includes soft restraints. The necessity for medical restraints must be re-evaluated with a face-to-face visit within 24 hours and renewed every 24 hours.
- Violent/Hard restraints are rarely needed in medical patients. Indications include physical attacks towards others. To initiate, order “violent” restraints in ORCHID and complete a face-to-face evaluation to document necessity within 1 hour of the order. Violent restrain orders are only valid for 4 hours and require a face-to-face evaluation to be documented q4h.
- 5150 Hold = Patient is suicidal, homicidal, of gravely disabled (unable to take care of self). This hold can only be initiated and discontinued by Psychiatry and lasts up to 72 hours. 5250 lasts up to 2 weeks.
- To get a hold of psychiatry from 8:00 AM to 4:00 PM Mon-Fri: Call or page the Psych Consult Liaison (C&L) x74024. After hours and on weekends: Psych ER: (x74341 & x74340).

- If a patient becomes aggressive or threatening, call for a “Code Gold” (de-escalation team composed of inpatient psychiatric nursing staff and security).

### Code/Rapid Response and Code Status

- CODE BLUE or RAPID RESPONSE TEAM are announced by the Operator. Long Call ward teams and ICU teams are the Code Blue responders around the clock. The primary team is also expected to respond if in-hospital, otherwise the Night Float interns and residents will respond after-hours.
  - If during normal day hours, the primary attending needs to be notified within 30 minutes of the Code/RRT ending.
  - If during the night or after the day team has left, the on-call hospitalist needs to be notified within 30 minutes of the Code/RRT ending.
- If a patient looks very ill, is decompensating, or you feel you need immediate urgent support, *DO NOT HESITATE TO CALL THE RAPID RESPONSE TEAM (RRT)* at x114. The team includes an ICU nurse, a respiratory therapist, and ICU team. They can initiate antibiotics, fluids, venous access, etc.
- Residents/interns may write a DNR/DNI order. Resident orders must be co-signed by an attending within 24 hours or the order is invalid. Attending orders last for the duration of the admission.
- Always document goals of care discussions in ORCHID, even if the decision is full code. Make sure to update the code status on the IPASS sign-out.
- The code status obtained during the hospitalization is only relevant during the hospitalization and does not necessarily hold true for the next hospitalization unless the patient has signed a POLST. Please make sure to discuss code status with every patient admitted to your service.
- Upon discharge, a POLST form should be completed in an effort to document goals of care. The pink original goes to the patient and a copy given to the unit clerk to send to HIM for scanning into ORCHID.

### Death in the Hospital

- Deaths in the hospital are an unfortunate but real aspect of medical care. Housestaff are encouraged to discuss the experience of caring for a patient who has died with the team and/or Chief Residents.
- Death should be pronounced and documented by a provider on the primary team or cross-covering intern.
- All in-hospital deaths require a “Death Summary” written by the primary team. If a death is pronounced by a cross-covering housestaff, he/she may write a brief “Death Note” to document the circumstances and death exam but the Death Summary should still be completed by the primary team.

### Pharmacy

- Inpatient Pharmacy Hours: 24/7
- Outpatient Pharmacy Hours: Mon-Fri 8:00 AM - 8:00 PM, Sat 8:30 AM - 5:00 PM
- Check the DHS Pharmaceutical Formulary (on OVMC Intranet home page) for current guidelines and restrictions at DHS.

### Multidisciplinary Care

- Collaboration with additional health services and coordinating care is essential for providing excellent care to patients.
- Attend Collaborative Care Rounds (CCR) to coordinate disposition and discharge with a multidisciplinary team. Details should be discussed with your team and Chief Residents (see Discharge Planning above).
- Ancillary services include:
  - Clinical Social Work
  - Physical, Occupational, and Speech Therapy
  - Phlebotomy
  - Wound Care
  - Dietitian
  - Pastoral Care
  - Utilization Management (UM)
  - Patient Financial Services (PFS)

### Electronic Systems

- **ORCHID:** LA County DHS uses ORCHID, a Cerner EHR. Use this system for patient data, writing notes, orders, and electronic prescriptions.
- **Affinity Legacy/Clinical Workstation:** We formerly used Clinical Workstation until 10/31/2015 for documentation and labs/studies, which was retired on July 1, 2019. All data (patient notes, results, etc.) that resided in Clinical Workstation can be viewed in the Affinity Legacy System. Please see separate how-to guide posted on oliveviewim.org website for how to view results in Affinity.



- **Synapse:** Our PACS system is Synapse. You may access this as a stand-alone application from your desktop or launch it from ORCHID.
- **Microsoft Teams:** Teams is HIPAA-compliant. Use this to message care team members about protected health information.
- **Housestaff Website:** Please visit [www.oliveviewim.org](http://www.oliveviewim.org) for educational materials and additional resources including smartphrase templates for documentation.
- **Help Desk:** For IT or EHR questions, you can call extension x74522 or (323) 409-8000 to reach the DHS Enterprise Help Desk.
- **E-mail:** Everyone is expected to use their @dhs.lacounty.gov emails.

## EDUCATION

### Morning Report/Noon Conference

- Morning Report has been resumed. Please check the Switch Day email for details on this, under the “Didactics” section
- Noon Conference takes place from 12:00 to 1:00 PM on weekdays. The Chief Residents will message about the location and topic on MS Teams.
  - Attendance is mandatory unless you are on a day off or post-long call.

### Medical Students

- **MS2's:** Interns are responsible for teaching and overseeing MS2's. This means reviewing notes, plans, and all orders.
- **MS4's:** MS4's are sub-interns and should be treated similarly to interns. They operate under the supervision of the resident.
- Medical student notes can be used by the intern or resident after thoroughly reviewing and modifying them as needed.
- Remember that you are a teacher. DO NOT give your medical students scut work.

### Other Rotators

- **International Medical Graduates (IMG's):** Function as MS3. Can interview, examine, and assist in writing orders and notes. Cannot do invasive physical exam (like breast and rectal) or procedures. They are expected to follow and present patients.
- **Japanese rotators:** Shadowing experience only. Should not examine, write notes, etc. They do not work on weekends.

## DOCUMENTATION

All documentation should be done electronically in ORCHID.

### History & Physical

- The intern or sub-intern must complete the H&P and have the attending sign it **within 24 hours** of admission. For long call, any admissions that occur after 7pm (if each respective intern has admitted at least 3 patients) or 8pm should be written by the on-call resident. For overnight admissions (outside of long call), the NAR is required to complete the H&P and forward it to the correct call team attending in the morning. The accepting call team is responsible for writing a progress note (if H&P filed prior to 12am) or a post-rounds addendum with an updated physical exam and assessment/plan (if H&P filed after 12am).
- In ORCHID: Use the “**History and Physical**” note type.

### Daily Progress Notes

- In ORCHID: You must document **Required Provider Note Details** before starting your progress note. Then use the “**Internal Med Inpt Progress Note**” note type for your daily progress note.

### Discharge / Transfer / Death Summaries

- The Summary is required for any discharge from the hospital (including discharge against medical advice), transfer to another facility (including MAC transfer or to the Psychiatric Ward), or death in the hospital.
- All summaries must include:
  - Admission date
  - Discharge/Transfer date
  - All diagnoses and invasive procedures
  - Summary of hospital course
  - Relevant studies
  - Discharge medications
  - Follow-up plans
  - Patient condition (e.g. good, fair, guarded, critical)

- Patient disposition (e.g. home, home with home health, skilled nursing facility)
- In ORCHID: Use the “Discharge Summary,” “Transfer Summary,” or “Death Summary” note type.
- Discharge Summaries must be signed within 48 hours, and preferably within 24 hours of discharge.
- Residents are expected to complete the Summary except when the patient is discharged while the resident was off.
- The signed Discharge Summary may count as the daily note (must include physical exam).

#### Additional Information

- All notes should end with “Discussed with Attending Dr. [name]” and be forwarded to the attending for co-signature.
- **OpenNotes:** DHS participates in Open Notes. If patients are enrolled, they are able to view H&P’s and Discharge Summaries within 72 hours of signing. Therefore language in notes should be accurate and professional.
- **Professionalism:** Leaving the medical record incomplete is a mark of unprofessionalism. If documentation is incomplete, housestaff will be called to complete the medical record. After the rotation, outside rotations will be called to return to complete the medical record, and deficiencies can result in “no credit” for the rotation along with a formal letter to the home institution and program director.

<b>PROFESSIONALISM</b>
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#### Illness

- Please notify the Chief Resident on call (can be found on AMION) if you are ill or have an emergency preventing you from coming to work.

#### Deficiencies

- Occasionally you will be messaged by Medical Records (a “query”) with a question regarding the medical record of a patient you cared for. This information is vital for hospital funding. If a query is not answered in 7 days a letter of unprofessionalism may be placed in your file.

#### Evaluations

- You must complete evaluations of your medical students, interns, residents, and attendings in a timely manner. This is done through MedHub.
- For rotators, there is a separate MedHub account for Olive View. Please contact Gus Chavez ([gchavez@dhs.lacounty.gov](mailto:gchavez@dhs.lacounty.gov)) for access.

#### Work Hour Documentation

- Please complete your work hour documentation on MedHub. For rotators, you will need to complete this on your own program’s site.

Updated 9/13/2023