Inpatient Care Responsibilities

1. ***Junior residents*** will report to their assigned hospitals early enough each day to complete the prerounds, take signout from the on-call physician, write orders and progress notes, discharge patients, and dictate discharge summaries *prior to beginning assignments in the operating room or the clinic*. Except for the rare circumstance when a ward patient unexpectedly becomes seriously ill, being late for the O.R. or clinic is unacceptable. The junior resident should also be prepared to adequately assess and care for patients on rounds. This requires the appropriate equipment to be readily available. Lab coat essentials include such items as: extra pens, tongue blades, cotton swabs, pen light, prescription pads (for both standard & controlled substances), stethoscope, tuning fork (512Hz), head mirror, current patient list, scissors, drug handbook, and contact phone numbers.

2. ***Working Rounds*** will be conducted under the supervision of senior residents at least once daily, and all patients will be seen twice daily, once in the morning and once on the evening. All post-op patients will be seen the night of surgery and a Night-of-Surgery note will be written, updating their condition postoperatively. Ideally, all residents and faculty assigned to the service will make rounds together on all patients (consults included) at least once daily. If a resident is uncertain about orders or disposition of the patient, the chief resident or attending physician must be contacted.

3. ***Notes for patients*** should be written prior to rounds for review on rounds with the attending staff. ICU patient notes should be written in a system format and include events since the preceding rounds including a summary of all relevant labwork, cultures, pathology, radiology or other tests, medications, and consults. Floor notes should be written in a SOAP format with the vital signs, relevant labwork and any updates included.

4. ***Chief residents*** share responsibility for seeing that their services run smoothly and that patient care is appropriate. Management decisions are ultimately the responsibility of the faculty and chief resident, and he or she must monitor the performance of junior residents at all times.

5. ***Assignments of junior residents to participate in surgical cases*** will be made at the discretion of the chief resident and should be performed at minimum one day prior in order for the resident to be able to prepare for the case appropriately. The chief resident also has the authority to delegate responsibilities for ward-work, clinics, and other activities.

6. ***A designated attending staff physician*** makes rounds at each hospital, each day. The responsible resident is expected to make arrangements with the designated attending physician to round together each day.

7. ***Non-emergency consults*** must be seen promptly, preferably on the same day that the call

for consultation is made. If the call comes after 5 pm, and the requesting service indicates that it is a non-urgent consult, then the patient may be seen the following morning. As a general rule, however, even routine consults should be seen within 12-24 hours, and a disposition made regarding management at that time.

8. ***Emergency room calls or urgent consults*** must be answered immediately. The first-call resident should never hesitate to call the second-call resident for assistance in the event of a difficult emergency, or in the unusual circumstance of concurrent emergencies. If the team has to take an emergency case to the operating room, other residents and/or staff should be notified if necessary to cover emergencies that may arise while the first team is in surgery.

9. ***The chief resident must be notified of all admissions, emergency room consults, and urgent inpatient consults*** as soon as they occur, day or night. The attending physician on-call should be notified similarly.

10. ***A written log of phone calls, ER visits, and all patient evaluations that transpire over the call night will be kept.*** This list will be discussed the following day on rounds with the chief resident and/or the on-call attending physician. Non-emergent and routine issues will be discussed with the appropriate staff the following day in person or by leaving a voice message on his/her paging system. A copy of the written log will be given to the appropriate attending physician as well. The purpose of this log –thorough patient follow-up—mandates that information be transferred accurately, timely, and completely. Thus, the log must include patient contact information (name and numbers), reason for the call, a brief summary of the advice or disposition rendered, and any prescriptions given.

11. ***Daily sign-out of on-call responsibilities is mandatory.*** The two physicians will discuss all in-house patients and potential problems in sufficient detail to provide continuity of care. The resident on call must notify the appropriate resident assigned to the service of any untoward developments or complications with his/her patients before the on-call resident assumes his/her regular daytime duties.

12. ***On-call physicians are responsible as above for consults, phone calls and inpatient care issues.*** Their duties also include carrying the on call pager and sign outs with the appropriate service residents both the evening of call and the morning after call. Call hours are from 7pm until 7am the following morning.

13. When a resident is assigned to take in-house/emergency call, he or she ***must not leave the premises of the hospital*** without the approval of the chief resident of that service. If the on-call resident must leave the hospital, arrangements must be made to provide coverage in his/her absence.

14. ***During the month of July***, emergency first call will be covered by a junior resident along with a more senior resident in house.

15. Lists of ***institution-specific responsibilities*** will be appended to this manual as needed, and distributed to each resident upon arrival for rotations at those institutions.