Internal Medicine Teaching Service Policies and Procedures

PURPOSE: To define the policies and procedures for the Internal Medicine Teaching Inpatient Service.

SCOPE: Applies to all interns and residents (hereafter referred to as trainees in the Internal Medicine training program at Texas Health Presbyterian Hospital Dallas.

POLICIES AND PROCEDURES:

I. The Role of the Teaching Service

A. All patients admitted to the Teaching Service have a private attending, usually a hospitalist, and the private attending has the ultimate responsibility for these patients.

B. However, by admitting to the Teaching Service the private attending agrees to allow the trainee to manage patients under his/her supervision. Thus, the trainee will play an active role in all decisions about diagnosis and treatment; will write all orders (with the exception of restraints and DNR orders, which must be written by the attending); will implement the diagnostic workup and treatment plan, including appropriate diagnostic and therapeutic procedures; will write or dictate the admission history and physical, progress notes and discharge summary; and will be responsible for all aspects of patient care during the hospitalization.

C. Good communication between trainee and attendings is of vital importance for a number of reasons including ensuring patient safety and providing an optimal educational experience for trainees. Communication is enhanced markedly by the attending calling the trainee directly at the time of admission and by the trainee calling the attendings at least **daily** to discuss the patient's progress and to revise the care plan.

II. Admissions to the Teaching Service

Admitting physicians-

A. The teaching faculty are encouraged to admit patients to the Teaching Service, provided the physicians believe the patients in question would be of educational value to the trainees.

B. Attendings who admit to the Teaching Service are expected to do so on a regular basis and not only for convenience on nights, weekends or other busy times.

C. Physicians who should not admit their patients to the Teaching Service include those who:

1. Do not adhere to the spirit and letter of these Policies and Procedures. Physicians who repeatedly admit to the Teaching Service and do not follow these guidelines will have their teaching privileges revoked.

2. Object to the teaching attending seeing and examining the patient on teaching rounds. Bedside teaching by the teaching attending is an indispensable aspect of the training program.

D. To initiate an admission to the Teaching Service, the attending physician must always contact the upper level resident on call personally. This establishes a clear line of communication that is important in the care of the patient, especially during the first and often critical few hours.

E. The attending physician should call the on call upper level resident and discuss the purpose of the admission. It is important during the initial handoff/acceptance of the patient from attending to resident that appropriate communication be maintained. The attending and resident must have **verbal communication** for handoff/acceptance of a patient. Texting alone is not acceptable. During this verbal communication, the attending should tell the upper level resident whether he/she has already seen/examined the patient.

F. A brief check list of the information the on-call resident should receive from an attending includes but is not limited to the following:

- name of patient
- medical record number
- room number
- location/destination
- chief complaint and reason for admission
- Any urgent concerns (i.e., is the patient medically stable?)
- Whether the patient needs to be seen immediately

G. The trainee should see the patient within one hour of admission to conduct an initial assessment to ensure that any critical issues are recognized and addressed in a timely fashion. Initial admission orders should be placed at this time, if appropriate.

H. The teaching team is expected to *check out the patient with the attending within 2 hours of accepting the patient*. However, if the upper level resident believes that a detailed intern checkout will take longer than 2 hours after acceptance, then the upper level resident must commit to the following:

- Provide an update to the attending with a preliminary plan within 2 hours
- Propose a time for a detailed checkout, being mindful of the attending's duty hours (If the attending finds this proposed time of checkout to be unacceptable, s/he can then choose not to admit the patient to the teaching service after all)

- If the intern is unable to check out by the committed time, the upper level resident must check out directly with the attending within the previously established time frame.

I. In order to meet this 2-hour check-out requirement patient acceptances before 10:00 a.m. will be capped at 4 patients. After 10:00 a.m. every effort should be made to reach the admission cap limits for the day. It is the resident's responsibility to admit the appropriate quota of patients. *Not reaching the daily admission cap limits while refusing patients in the morning is unacceptable.*

J. If the patient is admitted through ED, house staff is encouraged to directly communicate with the ED physician also.

K. On the day of admission, the resident will write or dictate a brief admission history and physical and discuss the patient with the intern. The intern will write or dictate a complete admission history and physical and write admission orders. In addition, the intern must call the attending to discuss the patient's diagnosis and treatment plan within an appropriate time frame (see H above).

L. Ultimately it is the upper level resident's responsibility to run his/her service efficiently and with timelines.

M. Criteria for a "full" Teaching Service:
   1. The on-call resident on a one intern team **may** choose to close his/her Service as **soft cap** if the day float intern has admitted 2 patients and on-call intern has admitted 5 patients (i.e. a total of 7 patients). However, the upper level resident will still admit patient(s) that are active in the residents clinic until the hard cap is met.
   2. The on-call resident on a one intern team **will** close his/her Service as **a hard cap** if s/he has admitted enough patients that the team will have 10 patients on the next post call day. If the on-call resident is called to admit a resident clinic patient after they have hard capped, s/he may not accept such patients but instead will inform the on-call team for the next day to take in this patient as an in-house transfer the next day.
   3. The on-call resident on a two-intern team **may temporarily** close his/her Service if each of the 2 interns has admitted 5 new patients
   4. The on-call resident on a two-intern team **must temporarily** close his/her Service if a total patient census of 20 has been reached.

The resident may decline an admission to the Teaching Service in **one** of the following situations:

1. The service is "full" as defined above. In this case the resident should inform the attending politely that the Service has been temporarily closed for the relevant reason.

2. The admission is inappropriate as defined by:
    a. Admission for primarily social reasons such as placement.
    b. Admission for a diagnostic survey rather than for evaluation and management of a specific symptom complex or problem.
    c. Some factor inherent to the patient's care prevents the trainee from assuming full responsibility for the patient (e.g., the patient is admitted specifically for surgery).

III. Admission of Trainees' Continuity Clinic Patients to the Teaching Service

A. If the patient is active in the Internal Medicine Residents' Continuity Clinic (hereafter referred to as the Clinic), the following procedures must be followed:

1. A clinic patient is active if they have followed through with the recommendations of the provider as to when to come back for follow up care. If the provider indicated a length of time to follow up in and it has been more than one year since the expected follow up date, the patient is not considered to be actively receiving care in clinic anymore.

2. If a resident sends a clinic patient to ED, S/he must inform the ED physician, IM resident on ED rotation (if applicable) and On–call resident.

3. If there is a categorical IM resident on ED rotation, s/he must evaluate that patient. S/he must inform on-call resident if the patient needs to be admitted.

4. If there is no IM resident on ED rotation then the patient will be evaluated in the Emergency Department attending. S/he must inform on-call resident if the patient needs to be admitted. However, ED Attending may choose to request the on-call resident to evaluate the patient prior to making the decision to admit.

5. If the patient is admitted, the admitting resident will assign the patient to an intern on the Teaching team.

IV. Communication between Trainee, Attendings and Consultants

A. When a resident accepts a patient to the Teaching Service this should be done with enthusiasm and appreciation. The resident should not convey a negative attitude to the attending physician as this may create hostility and will serve no useful purpose.

B. The intern must discuss the patient face-to-face or by phone with the attending physician on at least a daily basis. Progress notes should not be used for personal communication.

C. Since close contact should be maintained between the Trainee and the admitting physician, the attending rarely, if ever, should find it necessary to write orders on the patient. The attending should do his/her best always to work through the Trainee. If the attending does find it absolutely necessary to write urgent orders, a progress note should also be written to explain the reasoning behind the orders that were written.

D. Trainees should always call the attending covering at night to discuss unexpected developments or complications.

E. Trainees should not request formal consultation without approval from the attending. It may be necessary to ignore this guideline in case of an emergency.

F. Consultants should work through the trainee and allow trainee to do or observe all procedures whenever possible. Consultants should not write orders without first discussing them with the trainee. Ideally the trainees should write the orders for the consultant and if there are any concerns about such orders, trainees should discuss with the attending.

G. Attendings should discuss any changes in management plans with the trainee. All orders must be written by the trainee.

H. Attending physicians should inform their patients when they are being admitted to the Teaching Service. Patients who will not allow active trainee participation in their care should not be admitted to the Teaching Service.

I. As often as possible, trainee should round on patients with the attending physician to discuss problems, test results, etc.

J. The success of the Teaching Service requires a highly supportive and collegial relationship between attendings and trainee. Therefore, both trainee and attendings should make every effort to avoid hostility and contentious disagreements. If such situations do arise, the trainee should care for the patient first and report the incident later to the program leadership if indicated. Conflicts and disagreements between trainee and attendings should never interfere with patient care.

K. It is inappropriate and unprofessional for a trainee to cut and paste and then modify an attending's note or vice versa.

V. <u>Signing Off on a Patient on the Teaching Service</u>

A. Residents rarely should sign off of a teaching case. Signing off may be disturbing to the patient and his/her family and is not in the best interests of the patient in most cases. The Teaching Service is committed to providing continuity of care to all patients admitted to the Service.

B. However, at times it may be appropriate to sign off (e.g. the patient is awaiting placement and has no active medical issues) **ONLY IF** the census of the Service is high and Service is unable to accept new admissions on a call day.
C. If the trainee are considering signing off on a patient on the Service, this should be discussed in advance with the attending physician and the program leadership.
D. Trainees must write a sign off note

VI. Hand offs

A. All hand offs should be done in writing (using the teaching template) AND verbally.
B. When an intern rotates off the inpatient teaching service s/he must write a transfer of care note AND give a verbal hand off to incoming intern for all patients.
C. When a upper level resident (PGY2/3) rotates off the inpatient teaching service s/he must give a verbal hand off to the incoming upper level resident for all patients.

VII. Discharge Summaries

A. Unless otherwise instructed by the attending physician, discharge summaries will be dictated/written by the intern.
B. Discharge summaries must be dictated/written within 24 hours of placement of the discharge order and ideally before the patient leaves the hospital.
C. Copies of discharge summaries always should be sent to the patient's health care team including the primary care physician and any consultants.
D. Discharge summaries should be succinct and should summarize the reason for admission, hospital course and discharge disposition. A discharge summary is not a progress note, and cutting and pasting from other notes is not permitted.

VII. Non-Teaching Service Patients

A. Trainees do not have independent staff privileges. When seeing patients in the hospital or its clinics, they do so under the supervision of a staff physician.
B. Trainees are responsible for responding to all Code Blue/MET events. If a Code Blue/MET patient is not on the Teaching Service, the nurse must be asked to inform the patient's attending physician as soon as feasible. The trainee must document in the patient's chart the events of the Code Blue/MET.

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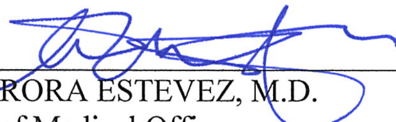

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