

**LSU HEALTH SCIENCES CENTER IN SHREVEPORT
DEPARTMENT OF MEDICINE**

WARD POLICIES 2009 – 2010

General

1. The purpose of these policies is to set forth the expectations of residents and attending faculty assigned to all ward rotations on the Medicine Service at LSUHSC-S. Any changes must represent the consensus of all residents and faculty in the program. Changes cannot be made monthly, based on the preferences of those rotating on inpatient services that month.
2. It is impossible to establish policies that cover every situation that arises on the Medicine Service. Issues that are not covered explicitly in written policies should be discussed with the chief resident, a program director, or the department chairman. The leadership of the department will attempt to resolve all questions equitably.
3. The program director will ordinarily refer major questions, concerns, and requests for changes in policies to the Department of Medicine Resident Council for study and recommendations. When circumstances arise that require an immediate change or suspension of policies, the program director and department chairman will always seek input from the chief resident.
4. The educational needs of residents and the best interests of patients and their families will be the overriding consideration in all policy decisions, provided that no regulation of the hospital, an accrediting agency, or a third-party payer is violated.
5. It is expected that all physicians in the department will exhibit the highest professional standards in dealing with any administrative issue that arises in the course of patient care.

Limits on Team Census

1. In accordance with ACGME policies, a team with one PGY-1 resident and one upper level resident may not exceed 14 patients at any time. A team with one upper-level resident and two PGY-1 residents may not exceed 20 patients at any time. These caps must not be exceeded even if discharges are pending.
2. Ordinarily, the cardiology and nephrology teams will not exceed 16 patients. The purpose of these lower caps is to expedite the management and disposition of patients with problems in these disciplines. However, the caps may be exceeded if the general medicine teams in rotation on a given day have reached their caps. The decision to raise the caps on these teams will be made by the program

director or department chairman, in consultation with the chief resident and the respective section chief and/or ward attending.

3. The hematology/oncology team will ordinarily not exceed 20 patients. However, this cap may be exceeded if the fellow and/or physician's assistant on the team assume responsibility, with the faculty attending, for the additional patients.

Admission Numbers and Sequence

1. In accordance with ACGME policies, a team with two PGY-1 residents may not admit more than 10 new patients (5 per PGY-1 resident) in 24 hours or 16 in 48 hours. Up to 4 transfers (two per PGY-1 resident) from the Medicine Service (MICU or another medicine team) may be accepted beyond these limits. On-call teams may not work-up more than 10 new patients, exclusive of transfer patients, in 24 hours, even if the additional patients are assigned to other teams. Admissions above this number must be worked-up by another resident, under the established back-up system.
2. Patients admitted by the night float team are considered transfers (see above) to the team assuming their care the next morning, in accordance with written policies of the Internal Medicine Residency Review Committee (IM-RRC) of the ACGME.
3. The upper-level night float resident may work up or supervise the work-up of a maximum of 10 patients per night. Any admissions beyond that number must be worked-up by a back-up resident. A PGY-1 resident assigned to the night float team is limited to working up 5 patients per night.
4. Under ACGME standards, the post-call team cannot work-up any new patients after 24 hours on duty. The post-call team each day is exempt from admissions until the call team for the day assumes responsibility for all admissions. Weekends and holidays, the post-call team may be assigned patients beyond the sixth admission regardless of the time of day. However, the call team for that day will work-up and care for those patients until the next day.

"Bounce-Back" Patients

1. Patients who are readmitted to the Medicine Service within a calendar month will be assigned to the team that cared for them previously. Patients readmitted after discharge from a subspecialty team may be admitted to a general medicine team if the reason for the second admission is not within the scope of the subspecialty team.

2. When patients are readmitted, the admission sequence will not be altered (i.e., the team will not receive “credit” for an admission. However, the patient will be considered a “transfer” for purposes of the number of patients admitted within 24 or 48 hours.
3. A patient who is transferred to the MICU and then back to a floor team will be assigned to the team that cared for him/her previously. The admission sequence will not be altered (i.e., there will be no “credit” for an admission), but the patient will be considered a “transfer” for purposes of the number of patients admitted within 24 or 48 hours.
4. If a patient is readmitted to the team that is post-call, the workup will be completed by the resident covering the team Monday through Friday, or the call team on weekends and holidays.

Admissions by Subspecialty Services and Other Departments

1. Subspecialty sections of the Department of Medicine other than cardiology, nephrology, and hematology/oncology may admit patients to the general medicine teams with a faculty member of that section as the attending. Except as discussed below, the ward team will care for that patient as they would any other patient, but with the oversight of the subspecialty service, not the attending faculty of the team. The subspecialty section will determine the extent of their responsibilities for the medical records, including the initial history and physical examination, daily progress notes, and discharge summary.
2. Patients admitted by a subspecialty section solely for short-term therapy, such as Remicade® or radioactive iodine, will be assigned to a general medicine team but cared for entirely by the residents, fellows, and faculty of the subspecialty service. However, if significant complications of the therapy or other medical problems requiring inpatient therapy are identified, the care may be transferred to the general medicine team.
3. Any contingency related to a subspecialty service that would necessitate oversight of the short-term therapy by the general medicine team must be discussed with the program director and/or department chairman before the policy is violated.

Patients Transferred from Other Services or Hospitals

1. Upper-level residents responsible for admissions must be familiar with both the hospital and Department of Medicine policies related to transfer of patients from outside hospitals.

2. Generally, outside physicians seeking to refer patients for tertiary care services should be referred to the appropriate subspecialty service. The on-call fellow or a faculty member of that service should make the decision to accept the patient in transfer, and at the same time may offer suggestions for the management of the patient until the transfer of care takes place.
3. Patients may be transferred to an inpatient bed at LSUHSC from the emergency department of another hospital. The general medicine consult resident or the on-call upper-level resident may accept these patients if they would ordinarily be admitted to a general medicine team from the LSU Emergency Department (ED). If there is any question concerning the appropriate place for admission (general ward, telemetry, ICU), the resident may, with concurrence of the ED faculty, request that the patient be evaluated there first. However, the medicine resident, not the ED physicians, is responsible for the evaluation.
4. Patients transferred from other inpatient services of LSUHSC to the Medicine Service will be assigned to teams under the same policies as patients admitted from the ED or an outpatient clinic.
5. Transfer patients from other facilities who are accepted by the cardiology, nephrology, or hematology/oncology service should ordinarily be admitted to the respective subspecialty ward service, even at night and on weekends, unless that service's team has exceeded their admission cap. See section on "Admissions to Subspecialty Teams" for more details.

On Call Policies

1. The on-call team assumes responsibilities for admissions at 3:30 p.m. weekdays, and at 8 a.m. weekends and holidays.
2. Patients identified for admission in the afternoon, or early morning on weekends, must not be "held" until the on-call team assumes responsibilities. This practice can result in a call team or the night float team exceeding the limits for admissions.
3. Ordinarily, the first 6 patients admitted by the on-call team will be assigned to that team. Thereafter, patients admitted will be assigned to the other general medicine teams in rotation, regardless of the time of day. Exceptions include "bounce-back" patients (see above), patients transferred from the MICU back to a ward team, and transfer patients accepted by Cardiology, Hematology/Oncology, or Nephrology (see above). However, if the on-call team exceeds any admission or census cap, patients will be admitted to other teams even before the limit of six is reached.

4. The order that the on-call team is notified about patients (by the ED or a clinic) must determine the admission sequence to teams. If the ED notifies the team about multiple admissions at the same time, the patients should be admitted in alphabetic sequence according to last name. Any suspicion that the admission rotation has been “manipulated” to the advantage of the on-call team should be discussed with the chief resident.
5. On weekends and holidays, the on-call team is responsible for working up new admissions to any team, even if the residents of the team are still in the hospital.
6. The on-call team is responsible for the management of all acute problems and administrative issues for patients already in the hospital. The PGY-1 residents will be called initially for such problems and issues, according to the team coverage list on the monthly call schedule. ***The on-call team’s attending faculty is responsible for the care of all patients in the hospital at night, including those admitted by the float resident.*** However, on-call residents are encouraged to contact the upper-level resident and/or attending faculty of another team if a difficult problem or management issue arises on one of that team’s patients. This will facilitate patient management, but also represents appropriate professional courtesy.
7. Late afternoons, weekends, and holidays, the team to which a patient is assigned should be asked to manage problems that arise in their own patients, if a member of the team is still in the hospital. There is no rigid “cut-off” time for the on-call team to assume responsibility for these problems. However, problems that will potentially involve diagnostic evaluation and therapy over a period of time may be passed on to the on-call team after initial assessment and orders.
8. Currently, the Department of Medicine does not have a formal process to check-out patients to the on-call team. However, it is the responsibility of each team to inform the on-call residents of any problems that are anticipated (including deaths), and any pending laboratory or radiologic tests that may require intervention.
9. It is the responsibility of the on-call team to handle all matters related to a patient death, including pronouncing death, notifying the family and dealing with their needs, requesting autopsy, and completing all forms. A death note, documenting the circumstances of the death, should be written. However, the dictated discharge/death summary will be completed by the team responsible for the on-going care of the patient.
10. Each morning, the on-call team and float resident are responsible for informing teams of any admissions worked-up overnight. The on-call team must also report any problems that occurred with other teams’ patients. Notes in the medical records do not preclude the need for a “verbal hand-off.”

11. Each morning, it is the responsibility of the float resident to post a list of admissions the past 24 hours in the 7G-West team room, or other location designated by the chief resident. A photocopy of the appropriate pages in the admission book will suffice.
12. Management of problems by telephone is discouraged unless you have sufficient information to make appropriate decisions. Significant problems such as fever, pain, shortness or breath, gastrointestinal symptoms, or mental status changes must be evaluated at the patient's bedside. The findings, assessment, and management plan should be documented in the progress notes.

Consultations

1. After 3:30 p.m. and on weekends and holidays, the upper-level resident of the on-call team is responsible for all general medicine consultations to other services. If admissions and cross-cover emergencies preclude prompt attention to requests for consultations, the float resident is expected to assist with this, provided that his/her responsibilities permit.
2. The acuity of the situation dictates the rapidity with which the patient is seen in consultation, but in all cases it must be within 24 hours. If other responsibilities make this impossible, the back-up system must be activated.
3. Sunday through Thursday, consultations may be deferred to the General Medicine consultation service the next day, unless there is a problem which requires acute intervention. However, caution must be exercised in determining that a consultation can be deferred. The decision may require some degree of hands-on evaluation.
4. On Fridays, Saturdays, and holidays, consultations may be deferred to the on-call team the next day, *if* the work-load precludes seeing the patient, the float resident is unable to assist, and there is no other justification for activating the back-up system (i.e., admission limits exceeded or an emergency consultation). Under ACGME regulations, the on-call team cannot evaluate new patients, including consultations, after being on duty for 24 hours. However, # 2 above still applies in all cases.
5. Consultations that are deferred for any reason must be discussed with the chief resident on the next regular duty day.
6. On weekends and holidays, when the general medicine consultation service is not active, on-call residents should present all consultations from the previous day to an attending on a general medicine team (either their own attending or the attending for the team on call the previous evening). The attending may choose to evaluate the patient at the bedside.

7. On-call residents are responsible for passing on information to the general medicine consultation service or the on-call residents the next regular duty day, if it appears that the patient will need further evaluation or follow-up by the Medicine Service. These should be logged into the general medicine consult list in the Invision system (team number 99508).

Medical Records

1. The general policy of the Department of Medicine is that the initial full history and physical exam of **all** patients should be completed and recorded by a PGY-1 resident. However, days off, clinic assignments, and the overall work load of the team may necessitate that some initial evaluations be completed by the upper-level resident.
2. When the full history and exam is recorded by a PGY-1 resident, the upper-level resident should complete a “resident’s admit note” that summarizes the key points of the history, exam, and available diagnostic evaluation, and outlines the general management plan. This note will indicate the team leader’s insight into the inter-relationship of medical problems, discuss diagnostic and therapeutic dilemmas, and document anticipated complications.
3. Discharge summaries may be dictated by any member of the team. For patients that are discharged when the PGY-1 resident caring for the patient is off-duty, the discharge summary should not be “saved” for that resident to complete the next day. This is contrary to the spirit of having days off. Often, the insight of the upper-level resident is valuable in completing the discharge process. The discharge summary is a critical document for the ongoing care of the patient and for medicolegal documentation. Discretion must be exercised in assigning the discharge summary of a complicated patient to an inexperienced resident, particularly residents from other services who are assigned to Medicine for a limited time.
4. Daily progress notes are required on all patients. While these may be recorded by residents at any level or medical students, accuracy and thoroughness of the information, assessment, and clinical logic must be the overriding principle. Notes written by medical students must be amended and countersigned by a resident. Students should not write notes early in the day before lab and diagnostic studies are available, and before discussion during attending rounds.
5. Progress notes must reflect the input of the attending faculty into the patient care process. In general, the sole note for the day should not be written prior to attending rounds, unless it is later amended. The notation “will discuss with team” or “will discuss with attending” requires a follow-up amendment.

6. Under Medicare guidelines, teaching physicians cannot use documentation of medical students, other than past medical history, family history, and social history, to justify the level of care for billing purposes. Accordingly, attendings may require that residents write the progress notes for Medicare patients.

Patients Leaving the Hospital Against Medical Advice (AMA)

1. If a team or on-call resident becomes aware of a patient's intention to leave AMA, the patient should be counseled and the counseling documented in the progress notes. The patient should be asked to sign the appropriate AMA form.
2. If leaving AMA imposes significant risk to the patient's well-being and there is any question about the patient's capacity to make the decision, consider instituting an Order of Protective Custody (OPC).
3. Use discretion in providing these patients with prescriptions for medications. Generally, if the need for the medication is established and there is no significant risk in the patient taking it, a prescription should be provided. Prescriptions for controlled substances should not be written under these circumstances.
4. If the patient later returns to the hospital, he/she should be managed administratively as any "bounce-back" patient.

Admissions to Subspecialty Teams

1. Appropriate patients may be admitted to subspecialty ward teams seven days a week. Provided that admission caps are not exceeded, on-call and float residents may admit to these teams if the patient's major problems are clearly within the scope of the subspecialty. However, patients with multiple co-morbid conditions that will require active investigation or adjustment of therapy during the hospital stay are more appropriate for admission to a general medicine team. If there is any question about the most appropriate team, the issue should be addressed with the on-call faculty or fellow of the subspecialty service. Any concern about the admission philosophy and practice of a subspecialty service should be discussed with the chief resident, program director, and/or department chairman.
2. Patients admitted by the on-call team to a subspecialty team are counted in the on-call team's six admissions for the evening or day (weekends, holidays). If, after evaluation by the subspecialty team attending faculty the next day, it is determined that the problem should be managed on a general medicine team, the patient will be transferred back to the team that admitted the patient. Since that team worked-up the patient and counted him/her in their admission numbers, there should be no "credit" or adjustment of the admission sequence.

3. A resident assigned to the subspecialty team must be notified of all admissions the next day. If no resident is on duty, the on-call/covering fellow of the service should be notified.
4. Patients with end-stage renal disease on hemodialysis or peritoneal dialysis generally should be admitted to the nephrology service when possible, unless the primary reason for admission clearly is more appropriately managed by a general medicine team.
5. Patients who are accepted in transfer by a subspecialty service generally should be admitted to that service's ward team if the team is under the admission cap and the initial evaluation does not reveal problems that are better managed on general medicine.
6. The priorities for admission to the Hematology/Oncology team are (per Drs. Glenn Mills and Gary Burton):
 - a. Inpatient chemotherapy
 - b. Acute leukemia
 - c. Thrombotic thrombocytopenia purpura requiring plasmapheresis
 - d. Research protocol patient
 - e. Oncologic emergency (cord compression, hypercalcemia, SVC syndrome, etc) in a patient with a tissue-diagnosed malignancy
 - f. Febrile neutropenia and other complications of chemotherapy
 - g. Pain control and terminal care
 - h. Patients who are strongly suspected of having malignant disease but do not have a tissue diagnosis and patients with metastatic cancer with unknown primary site should generally be admitted to the general medicine service

"Obligation" Call for Upper-Level Residents

1. Post-call team coverage weekdays:
 - *Who:* ICU "short-call" resident; any resident assigned to the General Medicine Ambulatory and Consultative Care rotation (GMACC), or a subspecialty consult or elective rotation except geriatrics, neurology, cardiology, and Willis-Knighton. This resident may also be assigned daytime admitting resident responsibilities the same day.
 - *Usual frequency:* Usually no more than twice a month for residents assigned to subspecialties; more frequently for ICU short-call and GMACC residents.
 - *Responsibilities:* Round with post-call team and the attending and be available after 1 p.m. to cover any patient care activities on the post-call team's patients, including discharges, follow-up of diagnostic studies, management of acute problems, and answering inquiries from nurses; work

closely with the attending of the post-call team; enter appropriate progress notes reflecting work on post-call team; when not needed for post-call team responsibilities, may continue to function as part of regular rotation for the month.

- ***There must be a “face-to-face” handoff of responsibilities from the post-call upper-level resident to the cover resident prior to 1 p.m. each day.***
- *If possible, the post-call team should complete routine progress notes prior to leaving the hospital.*

2. Call Back Schedule:

- *Needs:* one resident on weekdays; two on weekends and holidays
- *Who:* Residents assigned to the GMACC and all subspecialty consultation services and electives; residents assigned to geriatrics, cardiology, and Willis-Knighton are exempt Sunday through Thursday.
- *Responsibilities:* coverage of any essential duties, including, but not limited to night call, supervision of PGY-1 residents on wards, stress tests.
- *Frequency:* variable

3. Weekend Ward Coverage:

- *Needs:* one or two residents per weekend; each upper-level resident assigned to a General Medicine team at the LSUHSC and VAMC, and to the VA MICU will be provided coverage for one weekend out of the month.
- *Who:* all residents not assigned to an inpatient rotation
- *Responsibilities:* cover all upper-level resident duties for the team, including but not limited to rounds with the PGY-1 residents and attending, evaluating admissions from the previous evening, and discharging patients

4. Night float:

- PGY-1 residents assigned to night float at LSU will typically be from the General Medicine Ambulatory and Consultative Care (GMACC) rotation. However, interns that have two weeks of vacation scheduled in month may be assigned to one week of night float and one week of another responsibility, such as the procedure service or coverage for a vacationing intern at the VA.
- Upper level categorical medicine residents may be assigned to night float at LSU or the VA from the GMACC; months combined with vacation, the procedure service, general medicine consults and/or admitting; or, for VA night float, from neurology or dermatology rotations at that hospital.
- The length and specific days of a night float rotation may vary from month to month depending on the residents availability and how the days fall within the month.

5. Residents assigned to geriatrics, cardiology consultations (“stress tests”), and Willis-Knighton:

- One weekend ward coverage during the month
- One call-back assignment
- No post-call team coverage

6. General policies:

- Call-back and float resident schedules will be developed so that each resident will have at least two weekends during the month without any obligations.
- During any one month, some inequality in assignments is inevitable. However, the chief resident will make every effort to equalize these assignments over the entire year to the extent possible.
- The ACGME's 30-hour maximum rule and 10-hour break rule will be observed by residents assigned to any of these obligations. If either would be violated, the resident will be allowed time off either before or after the assignment.
- Residents who are unavailable because of sick leave, annual leave, educational leave, or leave without pay may be assigned additional call in the months they are available in order to equalize the work over the year.
- Assignments will be made to avoid interference with residents' general medicine continuity clinic days.
- If additional residents beyond those on the call-back schedule are needed to cover essential responsibilities, the chief resident at the respective hospital will be contacted to arrange coverage.
- Ordinarily, the call-back schedule will not be activated to cover essential responsibilities during regular duty hours. The chief resident will arrange coverage from among available residents.