ATTENDINGS

James Bardes, MD
Shintaro Chiba, MD
Nina Cohen, MD
K. Conley Coleman, MD
Lauren Dudas, MD – Program Director
Daniel Grabo, MD
Cynthia Graves, MD
Katherine Hill, MD
Melissa LoPinto, MD
Amanda Palmer, MD
Alice Race, MD
Gregory Schaefer, DO
Nova Szoka, MD
Alison Wilson, MD

MIDLEVELS

Trell Stowell, PA 79458
Kylie Winchester
Olivia Naylor

NURSE COORDINATOR

Michael Krueger, RN 79940

USEFUL PHONE #S

Service Phone: Blue 73374
SICU Intern 78743
SICU Chief 78620
SICU Attending 71899
Inpatient Pharmacy 70724
ACS Dietician 73606

OR front desk 74150
OR Charge Nurse 76212
OR Room 3 74203
PACU 74135

Supply Chain/Materials 74189
Sterile Supply 72042

Blood Gas Lab - Respiratory 74023
CT Scan 74257
X-Ray 74258
Radiology 79729

7 East 74072
7 West 74071
8NE 74620
MICU 75454
IR Resident 71907

Wound and Ostomy Team 74337
PICCTeam 75215
Weekend Care Manager 76101

Helpful Information:

General Info:

- ACS encompasses all urgent/emergent general surgery admissions as well as inpatient general surgery consults.
- General surgery attending will cover Blue for a one-week duration during the day (Monday-Sunday). Overnight attending rotates daily.
- Home base is 5th floor workroom.
- APPs office is on 9E.

Note templates:

Inpatient:

- .GSBprogress
- .GSBconsult
- .GSBHandP

Clinic:

- .acsfollowup
- .acsh&p

Order Sets/Common Checklists:

- SURG ONC/SURG GEN: ROUTINE ADMISSION POST-OP: IP
- SURG ONC/SURG GEN: ROUTINE PRE OP: IP
- GENERAL SURGERY: DISCHARGE ORDER SET

- *Admission Checklist:*
    - Manage Orders > Order Sets > SURG ONC/SURG GEN ROUTINE ADMISSION
        - Confirm code status
        - Diet order
        - IVF
        - Antibiotics
            - See Epic for Web Link: Enterprise Antimicrobial Stewardship Services | WVU Medicine Connect
                - *This link provides a wide variety of antimicrobial information specific to hospital policy including dosing, administration, monitoring, duration of therapy, and current restrictions.*
        - Nursing Orders
            - *Vitals, I&Os, activity, POCT, IS*
        - Labs
            - *Baseline CBC, BMP, Mag, and Phos*
        - DVT prophylaxis
            - *Most GSB patients are medium risk and require Lovenox 40qd*
        - Pain regimen
            - *Most common: Tylenol scheduled, oxycodone 5mg (PRN moderate pain), oxycodone 10mg (PRN severe pain), dilaudid 0.2mg (PRN breakthrough)*
        - PT and OT evaluations

- *With the exception of patients who would otherwise be a day-surgery patient (ex. 23-year-old appendectomy), ALL patients need physical therapy and occupational therapy assessment order. This evaluation decides the most appropriate location for discharge.*
- Restart appropriate home medications – (See RESTART HOME MED instructions for walkthrough of how to do this properly)
  - *Important to note, other than insulin, all long acting diabetes medications should be held in the inpatient setting.*
  - *Most surgical patients will need anticoagulation held. We do not routinely continue regularly prescribed oral anticoagulation unless patient is being transitioned back to PO before discharge. Be sure to order alternative according to indication – i.e. Heparin gtt, weight-based Lovenox.*
- Admit Order
  - *An admit order specific to admitting service and location is needed for proper billing. If you do not place an admit order at time of admission, you will surely receive messages about it until done.*

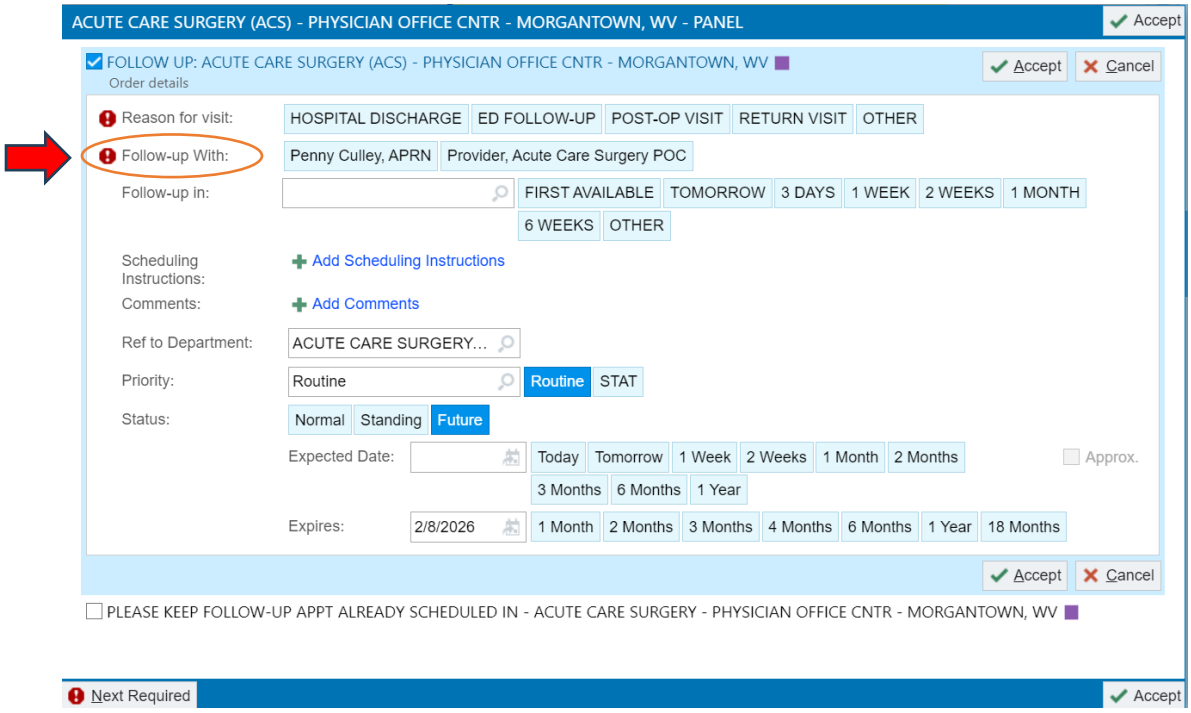
- *Home Meds Restart:*
  - Direct Admit Tab > Order Reconciliation > 3. Reconcile Home Meds
    - At this point, you will have the option of selecting from a list of reported home medications. Your options are ORDER, REPLACE, DISCONTINUE, or ORDER AND HOLD
    - ORDER: This medication will be ordered immediately.
    - You will never need to REPLACE or DISCONTINUE any medications.
    - ORDER AND HOLD: This should be used if you want it to be apparent that this patient is taking the home med and that it should be restarted, however not at the time of admission.

      For example, it is appropriate to ORDER AND HOLD medications such as anticoagulation or antihypertensives. That way they can be restarted as appropriate during their admission and prevents that patient from being started on new medications by accident – (For example, you wouldn't want to continually give a patient PRN hydralazine or start a new antihypertensive when they could just be restarted on their home dose of Losartan)

- *Discharge Checklist:*
  - Call the Care Manager – this number can be found as a separate column on the GSB patient list next to each corresponding patient. Many factors can affect patient discharge: PT/OT recommendations, home situation, need for home health, rehab/SNF placement, insurance coverage, etc. Unless patient is a 'day surgery' type of patient, there should be a phone call made to the patient's care manager to determine whether or not any further steps need to be taken before discharge.
  - Discharge Tab > Order Reconciliation
    - 1. Reconcile Medications for Discharge
      - Left Column 'Home Medications'
        - Generally, all home medications can be restarted.

- Right Column 'Inpatient Medications'
    - Most orders/medications are discontinued with the exception of a few common meds that may be prescribed to them
        - PO antibiotics (If IV – must be approved and ordered by OPAT)
        - Pain meds – most common Roxicodone 5 mg
        - Bowel regimen – most common Senokot, Miralax
- 2. Order Sets – You will need to select GENERAL SURGERY: DISCHARGE ORDER SET
    - Diet order
    - Activity Instructions
    - Incision/Wound Care – *be sure to adjust this according to wound type*
    - MISC INSTRUCTIONS - *a blank box available for free text. This gets given directly to the patient and is very helpful when describing specific instructions at discharge. Remember, patients need it spelled out for them.*
    - Does the patient need a work/school excuse?
    - Follow-up order (this sends request to scheduler in the office building)
        - SCHEDULE FOLLOW-UP SURG SPEC - GENERAL - PHYSICIAN OFFICE CENTER – PANEL
            - For **ACS CLINIC or PENNY** Followup:
              FOLLOW UP: ACUTE CARE SURGERY (ACS) - PHYSICIAN OFFICE CNTR - MORGANTOWN, WV
                - Then, choose either PENNY (Gen Surg Nurse Practitioner) or ACS PROVIDER
                - Example patients most appropriate for each clinic are listed below:

Penny Culley, APRN	**ACS Clinic**
Routine follow-ups Simple wound check/wound care Subsequent/established wound VAC changes Routine post-op patients: Lap chole Lap appy Uncomplicated hernia repair Perirectal Abscess Feeding tube/PEG placement	Complex patients requiring **physician** guidance Patients with: Need for interval surgery NSTI (with or without a wound VAC) New ostomy (seen in conjunction with ACS RN Coordinator) Any patient discharged with a drain Any patient with scheduled repeat CT imaging Any patient with a cholecystostomy tube Any referral for an ENT PEG to be done at the time of ENT resection Others may include: long and/or complex hospital course, e.g. home TPN, need for further referral or complex follow up planning



- For **<u>Specific Surgeon</u>** <u>Followup</u>:
  FOLLOW-UP: GENERAL SURGERY - PHYSICIAN OFFICE CTR - MORGANTOWN, WV
  - Then, choose specific provider
- Most post-op patients follow-up in 2 WEEKS
- Patient with **no** scheduled follow up: VP Shunt Placement

- Discharge Summary – *if you place the order for discharge, you are responsible for writing the patient's discharge summary. Ideally, this summary should be written at the time of discharge before patient leaves the building.*

Daily Rounds:

- Generally, arrive at 5 am to prepare to round at 6 am.
- Patients having problems should be escalated immediately and chief notified.
- Follow Chief Resident, APP, and team guidance on how to divide up patients that are "yours" to follow for the day.
- <u>Pre-Rounds</u>: gather data (I&Os, vital signs, labs, imaging results, overnight events [e.g., nursing notes]) on floor-level patients (ICU patients are typically the responsibility of the junior on service).
- <u>During Rounds</u>: make sure you are clear on patient care plans – especially diet advancement, IVF, drain management/removal, studies/scans, wound care needs, calling other service consults, antibiotics, anticoagulants, DVT ppx, GI ppx.
- <u>After Rounds</u>: carry out plans while junior/senior go to the OR. Call consults, put in orders, write notes, and update daily handoff (in this order).
- Other components to check daily for primary patients: follow up consultant recommendations, care management updates, PT/OT recommendations

Consults:

- When receiving a new consult, IMMEDIATELY add it to the service list and let your team know. Your team should have a daily group text and you should inform them of this new consult here.
- If a consult comes in while your junior/senior is in the OR: add to service list, text the group you have a new consult, look them up, go see the patient and then go to the OR and present patient.
    - Don't sit on consults – if you accumulate multiple consults that you have seen and not staffed, go to the OR to inform the rest of the team.
    - If you are called that a patient has peritonitis, tachycardia, pneumoperitoneum on imaging, it's acceptable to go to the OR, grab a junior and see the patient ASAP.
    - Vs. if you are consulted for a PEG, it's acceptable to prioritize more urgent things
- Do not attempt to punt or triage consults (this is a senior level decision) no matter how ridiculous, or mind-numbingly-soul-crushingly-excruciatingly-obviously silly they may appear.
- If there is controversy about whether a consult is appropriate for ACS (vs. another service), refer to the ***Triage document*** and discuss with chief resident. It is courteous to inform the other service's resident if you are recommending a consult be re-directed to them (if it's one of the services we cover), even if the attendings have also spoken.
- Be courteous to the service that is calling you for surgical consultation.

Pre-operative Process:

- All pre-ops must have: consent, labs, T&S, any necessary pre-op testing, and family notified
- If you know about a case the day before, then this should be done the day before.
- Place the consent on the paper chart, not in your pocket.
- **How to obtain consent:**
    - Talk to your senior or attending about the procedure and what possible procedures should be included on the consent
    - Ask about any specific risks or rationale that you will need to describe to the patient
    - Ask for questions in an open-ended way: "What questions do you have?"
    - If a patient does not have capacity (if you're not sure about this, talk with your team), then consent will need to be done with the mPOA or healthcare surrogate in the chart.
    - If you are not comfortable describing a procedure, its alternatives, or its risks and benefits, ask your seniors for help. This is how you learn how to describe operations.
- **How to "drop a card":**
    - This is one of the "quaint" charms of our OR, and may also be an occasional source of frustration in your daily life.

  STEPS:
    1. Go to the OR front desk and acquire a "card"
    2. Fill out the following fields:

       Service: ACS
       Consent signed: Yes
       Date of Surgery
       Surgeon Availability: ACS, specify case order
       Faculty/Resident
       Pre-op Diagnosis
       Operation

Additional equipment needed: Consider EGD or sigmoidoscope, lap vs open equipment (or both), feeding tubes, SPY angiography, etc.
Anesthesia: Usually general unless otherwise specified
Patient Identifiers: Name, DOB, MRN#
Blood: T&S or T&C
Position of patient: supine, prone, lateral, lithotomy
In-patient and room number
Operative side (if applicable)
Antibiotics: pre-op Ancef, Clinda, etc., vs. scheduled antibiotics
Latex Precautions/Allergies
Post-op bed (if ICU status post-op)
Resident Name, Pager/Phone #

3. Case Classification
   E1 - stat
   E2 – <2 hrs
   E3 – 2-6 hrs
   E4 – <24 hrs
   E5 – elective
4. Stamp the card with the time submitted – the OR desk staff can demonstrate

Operating Room:

- Double scrubbing is encouraged, interns must still prioritize floor work/consults.
- Ask seniors about intern-level cases - such as PEGs, I&Ds, uncomplicated appendectomies.
- **Do not hesitate** to come to the operating room with new consults, major updates on existing patients, or time-sensitive questions.
- There is such a thing as a stupid question – be aware of operative events and prioritize your communication.

Administrative:

- If you are ill and cannot come to work, if you need to leave early, or go to a meeting or appointment, you must inform the chief as soon as possible in advance and notify your appropriate administrator
- Prior to leaving for the day, individuals must sign out and update the chief or senior resident

Orientation:

- first *Tuesday* of every month,
- at *8:30am* in *Trauma Workroom*
- for *all residents* on service

Weekly ACS Clinic:

- **1-4pm on Tuesday afternoons** every week
- POC, 4th floor general surgery workroom
- Staffed by another general surgery/trauma faculty (*not* the ACS attending of the week)
- All not-currently-operating residents, students, and APPs expected to attend