

## **ATTENDINGS**

Shintaro Chiba, MD  
Nina Cohen, MD  
K. Conley Coleman, DO  
Lauren Dudas, MD  
Brett Floyd, MD  
Daniel Grabo, MD  
Cynthia Graves, MD  
Katherine Hill, MD  
Brone Lobichusky, MD  
Melissa LoPinto, MD  
Amanda Palmer, MD  
Alice Race, MD  
Gregory Schaefer, DO  
Nova Szoka, MD  
Alison Wilson, MD

## **MIDLEVELS**

Trell Stowell, PAC ..... 79458/79029  
Kylie Armstrong, PAC..... 70488  
Olivia Naylor, PAC..... 75126

## **NURSE COORDINATOR**

Kristen Amato, RN..... 79940  
  
Heather Brunett..... 293-5169  
Sherry Davenport ..... 293-0668  
Ronda Fike..... 293-1272  
Jennifer Hanning ..... 293-8266  
  
HSC Office Fax ..... 293-1106

## **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



- 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:

<b>Penny Culley, APRN</b>	<b>ACS Clinic</b>
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 <b>physician</b> 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

ACUTE CARE SURGERY (ACS) - PHYSICIAN OFFICE CNTR - MORGANTOWN, WV - PANEL Accept

FOLLOW UP: ACUTE CARE SURGERY (ACS) - PHYSICIAN OFFICE CNTR - MORGANTOWN, WV Accept Cancel

Order details

Reason for visit: HOSPITAL DISCHARGE ED FOLLOW-UP POST-OP VISIT RETURN VISIT OTHER

Follow-up With: Penny Culley, APRN Provider, Acute Care Surgery POC

Follow-up in:  FIRST AVAILABLE TOMORROW 3 DAYS 1 WEEK 2 WEEKS 1 MONTH  
6 WEEKS OTHER

Scheduling Instructions: [+ Add Scheduling Instructions](#)

Comments: [+ Add Comments](#)

Ref to Department: ACUTE CARE SURGERY...

Priority: Routine  Routine STAT

Status: Normal Standing **Future**

Expected Date:  Today Tomorrow 1 Week 2 Weeks 1 Month 2 Months  Approx.  
3 Months 6 Months 1 Year

Expires: 2/8/2026  1 Month 2 Months 3 Months 4 Months 6 Months 1 Year 18 Months

PLEASE KEEP FOLLOW-UP APPT ALREADY SCHEDULED IN - ACUTE CARE SURGERY - PHYSICIAN OFFICE CNTR - MORGANTOWN, WV Accept Cancel

**Next Required** Accept

- For **Specific Surgeon Followup**:  
 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.
- **Pre-Rounds**: 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).
- **During Rounds**: 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.
- **After Rounds**: 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, 4<sup>th</sup> 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