

How to Good Sam

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Updated 3/2026 by Max Chou

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Paperwork

Since Good Sam is part of TriHealth, you need to go through their own onboarding process.

Pre-arrival checklist

Donna will send you a "Visiting Residents/Fellows Prerequisite Checklist" before you start that contains a list of things you will need to submit online. Refer to that checklist for the details; here are some tips:

- **eLearn online modules:** You view them, take a quiz, and download a certificate of completion for each one. You then send them all to the GME email address on the checklist. The required "COVID-19 Self-Assessment Screening" eModule

didn't actually produce a certificate for me; I just sent a screenshot of the last screen and that worked.

- **Immunization records:** You can simply download your UC immunization records from UC ReadySet (<https://uhealth.readysetsecure.com/>); go to ReadySet, click on "Results" on the left, then click on "Complete Medical Records" at the bottom. This will generate a PDF with a list of all the vaccinations you've already reported to UC, including COVID-19 vaccines. You can then send this PDF along with your eModule certificates to the GME address on the checklist.
- **Epic:** You should have done Epic Training as a class at the beginning of CA-2 year. An email with your name and password should have been sent to you UC email.
- **Badging:** You sign-up for a badging appointment online at <https://signup.com/go/EGHhOBz>. You must then physically go to the TriHealth badging office at 4750 Wesley Avenue, 1A, Norwood, OH for your appointment. They'll want a photo ID, make/model/license plate of your car, and addresses of the last 3 places you've lived. Like above – most available appointments are during business hours, so you'll likely need to work with the AOD to get you time to do this. -- They may ask you where you will be working or who you will be following. The magic word for this is "7 Hills anesthesia". It will help them know how to make your badge work.
- **Armstrong Cart:** It's the same blue carts that we have filled with anesthesia supplies. Your badge will open all drawers except for the top drawer, which is assigned when you onboard.
- **Scrubs:** Good Sam has new scrub machines on the 6th and 8th floor. You may need to email Alex @alexander_rahe@trihealth.com to get access, but it may be part of the formal onboarding process.

Voalte

"Voalte" is a communications app that everyone uses to text & call one another. It's vital to have this, since everyone relies on being able to look everyone else up in Voalte; without this, it will be difficult to coordinate you doing epidurals & procedures since people don't really have a way to look up your phone number. You might not be able to log in until you get to Good Sam, but you can prepare by downloading & setting up the Voalte app before you arrive:

- **Download Voalte:** You want the "Voalte Me" (not "Voalte One") app. For iPhones it's on the [App Store](#), and for Android it's on [Google Play](#).

- **Set up Voalte:** You will be prompted for a “Site Code.” It is “tricvg”.
- **Try to log in:** Your username/password are the same as your TriHealth Epic credentials. If you can’t log in, your account wasn’t set up properly; email Dr. Michael Stein (michael.stein@7hillsanesthesia.com; he is involved with both Epic and the UC/TriHealth residency collaboration) and Kim Brothers (kim.brothers@7hillsanesthesia.com; she is admin at TriHealth) letting them know you got the app and put in the site code, but still can’t log in.
- You will be asked to click a role, select “GSH OB Anesthesia Resident”
- You will be asked to select units. Go to Add Units -> Good Sam -> Select GSH Labor & Delivery, GSH OB Triage, and GSH Q Labor and Delivery.
- Lastly you will assign yourself to GSH OB Anesthesia Team
- **Dial “0” via Voalte if you ever need the operator for anything**

Omnicell Access

- TriHealth used to use Pyxis
- Donna now fills out the Omnicell access forms for us

Directions

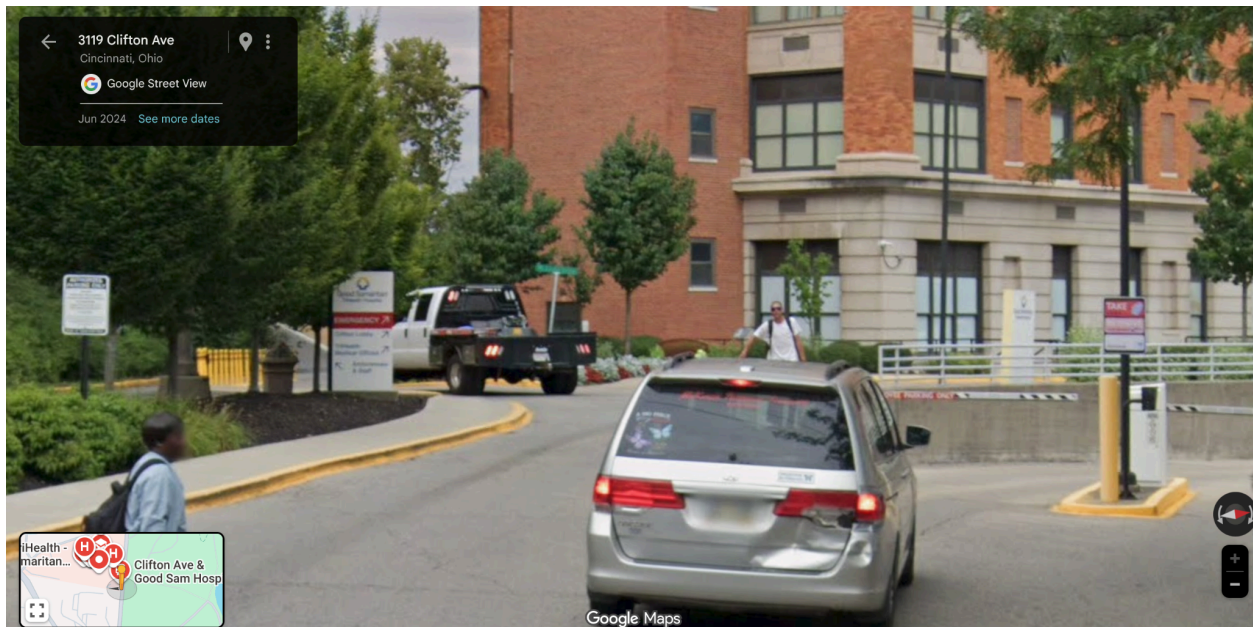
- Map your way to 3119 Clifton Ave, you should see the following (in daylight)
- Going south on Clifton Ave



- Going North on Clifton Ave



- Take a left towards ambulance and staff, basically where that truck is going



- Not picture is an incline going up to the garage. Your badge should swipe you in if the gate is closed. You will start on the top floor, which is the 5th floor
- The entrance to the Hospital is on the second floor, I usually park somewhere there
- Follow the signs and take the stairs down to the hospital
- You will end up on the 4th floor of the hospital

- Take Dyxmyth Elevators to L&D on the 9th floor. Below will be a map layout of the floor, but seriously you should be able to just follow signs.
- An alternative way to get to the garage is by turning into the driveway of the Hebrew Union College - Jewish Institute of Religion and heading straight towards the stop sign in the picture. Take a slight left down the hill towards the garage. That Gate is always open in the morning; it will spit you out on the 3rd floor of the garage



OB Workflow

Day 1 nuts and bolts - go to the 9th floor via Dyxmyth Elevators, meet at the nurses station at 7AM. Vickie Hau (OB anesthesia) should give you an orientation, where to get scrubs, logistics etc. You'll do CSEs for labor and C-sections, your first day. The key to your call room will be in locker 24 (25-45-15) in the locker room located near the attending on-call room; Vickie should show you where that is.

Your shifts always start at 0700 and typically end at 1600-1700 depending on your attending. Vickie Hau is the OB trained attending who should be orienting you on your first day (scrubs, daily flow, basics of neuraxial, etc.). She's thorough and your first day will be a whirlwind. The OB attending is typically on 24-hour call.

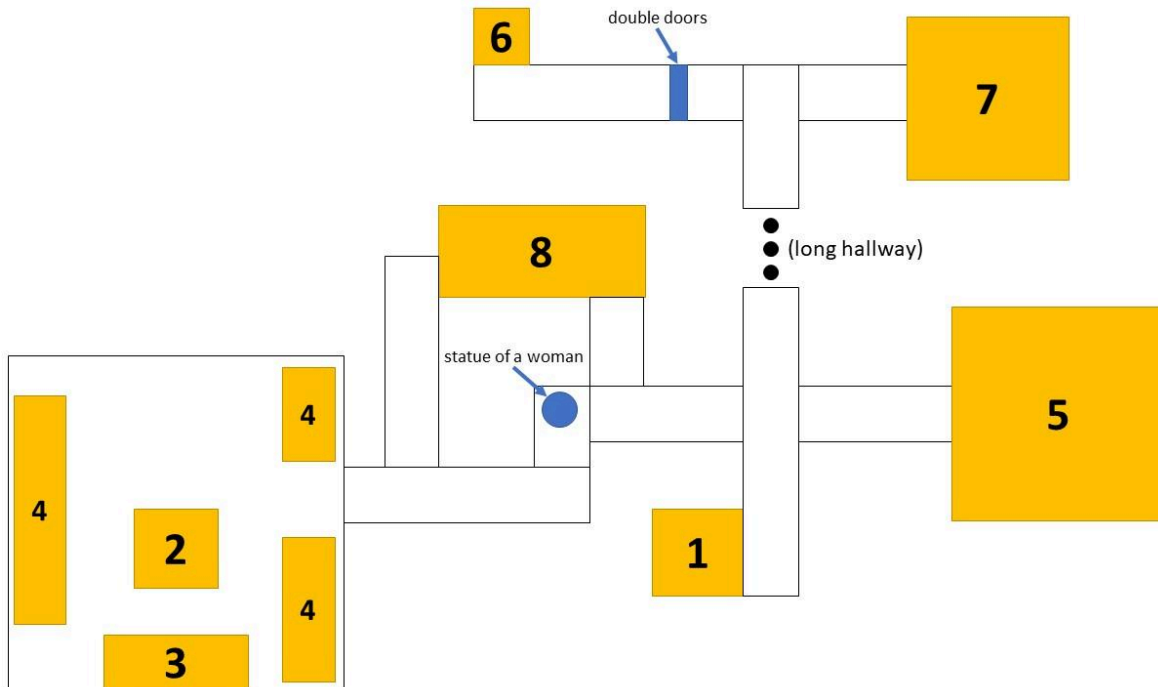
OB does a verbal sign-out at the nurse's station at 0700 and again at 1900; you should be present and in scrubs in time to make the 0700 sign-out if you are on days. It's important to

hear about the L&D patients & planned procedures during sign-out, but we do not personally present during sign-out.

Floor layout, map, & call room location

The areas you need to know are:

- The “Q:” This is the L&D floor on the 9th floor; it contains L&D rooms 1-12 and ORs 1 & 2. This is where you will do labor CSEs on the floor. ORs 1 & 2 are generally used for emergency cases and weekend cases. There is a locker room right next to the OR; they no longer contain clean scrubs. There is a med room across from the nurse’s station where you can grab meds fentanyl for CSEs I do not know why the floor is called the “Q.”
- ORs 3, 4, & 5 (the “main” ORs): These are down the hallway from the L&D floor. ORs 3 & 5 are the “main” C-section rooms; they will generally do the first C-section of the day in 5, then flip-flop between 3 and 5 for remaining sections. OR 4 is preferred for cerclages and D&Cs. **The OR listed in Epic is not necessarily the OR that will be used; ask the patient’s nurse to determine which OR will actually be used for a case.**
- Between section 7&5 is a hallway called “FG” where overflow laboring patients go, there is also a med room and epidural cart with a computer there. At the end of that hallway is another locker room where we are given a locker; locker 24 code 25-45-15. The attending on call room is also around there.
- Triage: This is between the L&D floor and the main ORs; this is the “ED” of L&D, where outpatients will come in for OB evaluation. Triage will also often be used as a holding area for patients scheduled for C-sections.



1: Dixmyth elevator (this is the closest to the Dixmyth garage, where you'll likely park), **2:** Nurse's station (signout location), **3:** ORs 1 & 2 (plus scrubs), **4:** L&D rooms, **5:** ORs 3, 4, & 5, **6:** Resident call room (sign says "0976.23"), **7:** "AOC" ("floor" for OB patients who aren't in L&D), **8:** Triage.

Here is a picture of the entrance to your call room (#6 above):



Scrub Machine

- Located on the 6th and 8th floors.
- I don't know if they're phasing out the old scrub cart system, which can be found in the locker rooms by OR 1 and 2

Take Dyxmyth elevators to the 6th floor, go through the wooden double doors and take a right down to the intersection. Take a left and walk to the next intersection towards surgicare. Swipe your badge and go through the left double doors.



A note on supervision

It's a good idea to know the rules regarding resident supervision at Good Sam since having anesthesia residents is a new thing and not all the attendings/CRNAs may know all the subtleties.

When a resident (you) is doing a procedure, the attending must be physically present for the "critical portions." For a CSE, this would be while you are finding LOR with your Tuohy. For a case under general, this would be while you are establishing the airway. Attendings will likely stay with you for more than the "critical moments" of a case, but those are the parts that they absolutely must be in the room for. One strategy is to send a Voalte message to your attending when the patient enters the OR; they will likely be there by the time you've finished with patient positioning & prep. If not and your hands are sterile, you can ask a nurse to call them via Voalte.

CRNAs cannot "supervise" you; if your hand is on the Tuohy, the attending needs to be with you.

Residents & CRNAs cannot both be involved in a case. In short – this negatively affects billing. You cannot relieve a CRNA or pass off a case to a CRNA. On your first few days you may spend some time just watching a CRNA do a case so you can get oriented – your name shouldn't go on the chart, and you shouldn't be performing any procedures in these situations.

You cannot be in an OR case if the attending is already running 2 rooms. These are the same rules as at UC: attendings can run 4 rooms with CRNAs (since any SRNAs are supervised by CRNAs) but can only supervise 2 rooms if one of them has a resident. Normally this is not an issue since they try to only give the OB attending one main OR room at most - but if the main OR is busy, you may be locked out of OB OR cases for a period of time. *(Stein actually says you can, but it reduces billing revenue, IDK*)

Procedures

Neuraxial techniques

Good Sam typically perform CSEs for women in labor or receiving C-sections (as opposed to UC, where most attendings will just have you do either an epidural or a spinal).

Floor CSEs

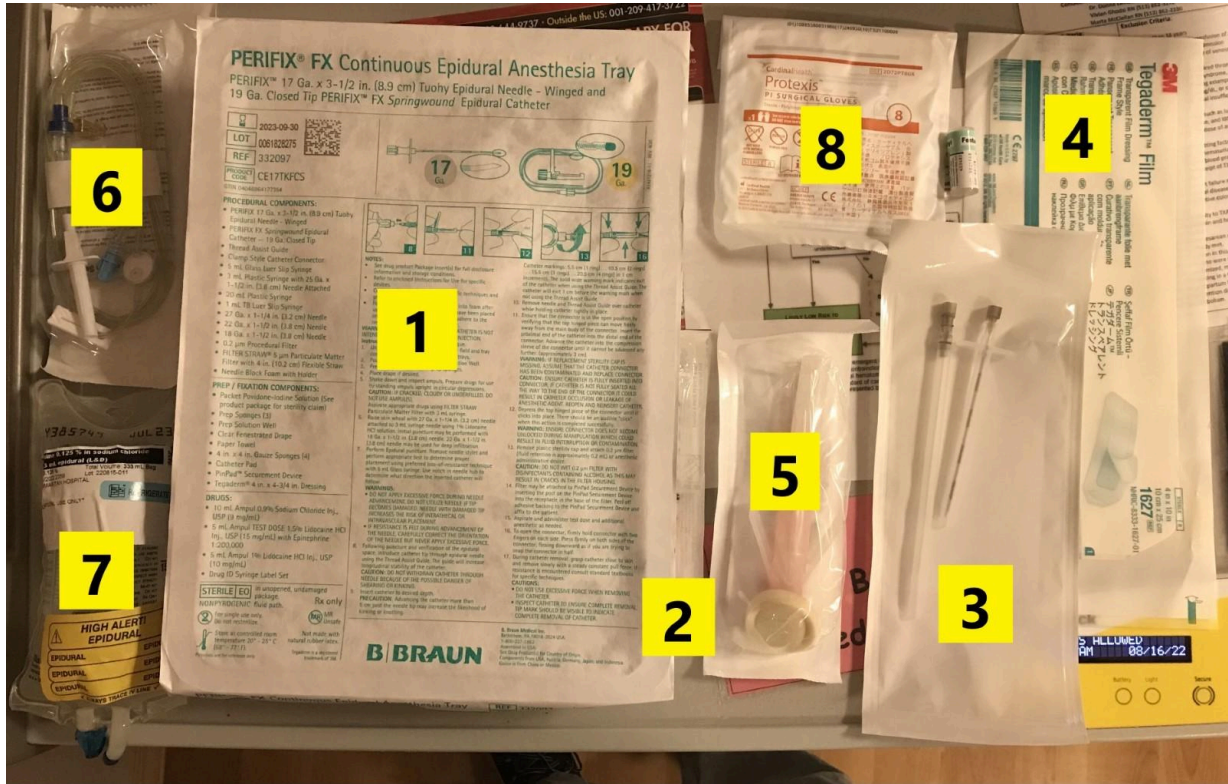
If you are doing a CSE on the floor, you'll use one of the three carts with CSE supplies in them just inside the doors into the L&D floor. Two of them have laptops on them. Two of the carts can be opened with the code "1-2-3-4."

Floor CSE set up:

- Get your 1cc vial of fentanyl and a bag of 0.125% bupivacaine + 2mcg/ml of fentanyl from the med room on the L&D floor.
- Go to an epidural cart with a laptop on it. Unlock the cart, and grab an epidural tray, a 3 mL Luer-lock syringe (to draw up fentanyl), a spinal needle/Tuohy package, a long Tegaderm, a Chloraprep, epidural pump tubing (see pic below).
 - Optional: You can also grab a stick of Mastisol (similar to benzoin) from the cart and "paint" this on the patient's skin around the epidural entry site to make your tape stick better. Some will instead use the spray-on adhesive available in a spray bottle on the top of each cart.
- Open the patient's chart and start a pre-op evaluation note BEFORE hitting anesthesia start.
- Enter the room, do a quick pre-op H&P, and consent the patient for the CSE (**verbal consent is all you need at Good Sam**, unlike the written consents we do at UC).
- Get patient into position, expose back, prep back with Chloraprep, and do a quick timeout (I do name, DOB, allergies, blood-thinning meds, and procedure name).
- On Epic, go to Intraprocedure and go to Macro -> Public -> Epidural/CSE. Click the "Anesthesia Start" event, then the "Out of OR Borrow Device" event. This triggers the datacaptor to send the patient's vital signs to Epic instead of the nurse's monitor; otherwise, you will not get vital signs automatically piped into your intraprocedure record. For billing purposes, your "Anesthesia Start" time should be as close to your timeout as possible (and cannot include time spent doing your preop eval).
- Glove up & proceed with CSE placement.
- Connect your epidural to the pump (see dosing below).
- Wait for at least ~2-3 BPs to be collected to ensure normotension.
- Remember to click the "Out of OR Return Device" event as you leave so that vitals flow back to the nurse's monitors.
- Finish your pre-op note if there are new things to add, finish charting.

- Complete the “yellow card” corresponding to the patient’s room in the cubbies above the “Anesthesia Work Zone” in the nurse’s station.

Here is a picture of all the supplies you need to do a CSE:



1: epidural tray, **2:** 3 mL Luer-lock syringe; (hiding behind epidural tray), **3:** Tuohy + spinal needle, **4:** long Tegaderm, **5:** Chloraprep, **6:** epidural pump tubing, **7:** 0.125% bupivacaine, **8:** gloves. Note 100 mL vial of fentanyl between 4 & 8.

Dosing:

These are only broad tips on “usual” CSE doses; discuss with your attending as preferences may differ and circumstances may change your dosing strategy.

Spinal: The “standard” dosing is 10-20 mcg of intrathecal fentanyl followed by 3 mL of epidural lidocaine-epinephrine 1.5%-1:200000 as your test dose. Many people will mix the remaining fentanyl over from your spinal into the 3 mL test dose for some extra effect. Some will wait to give the remaining fentanyl epidurally until the test dose is confirmed negative. Others will simply waste it.

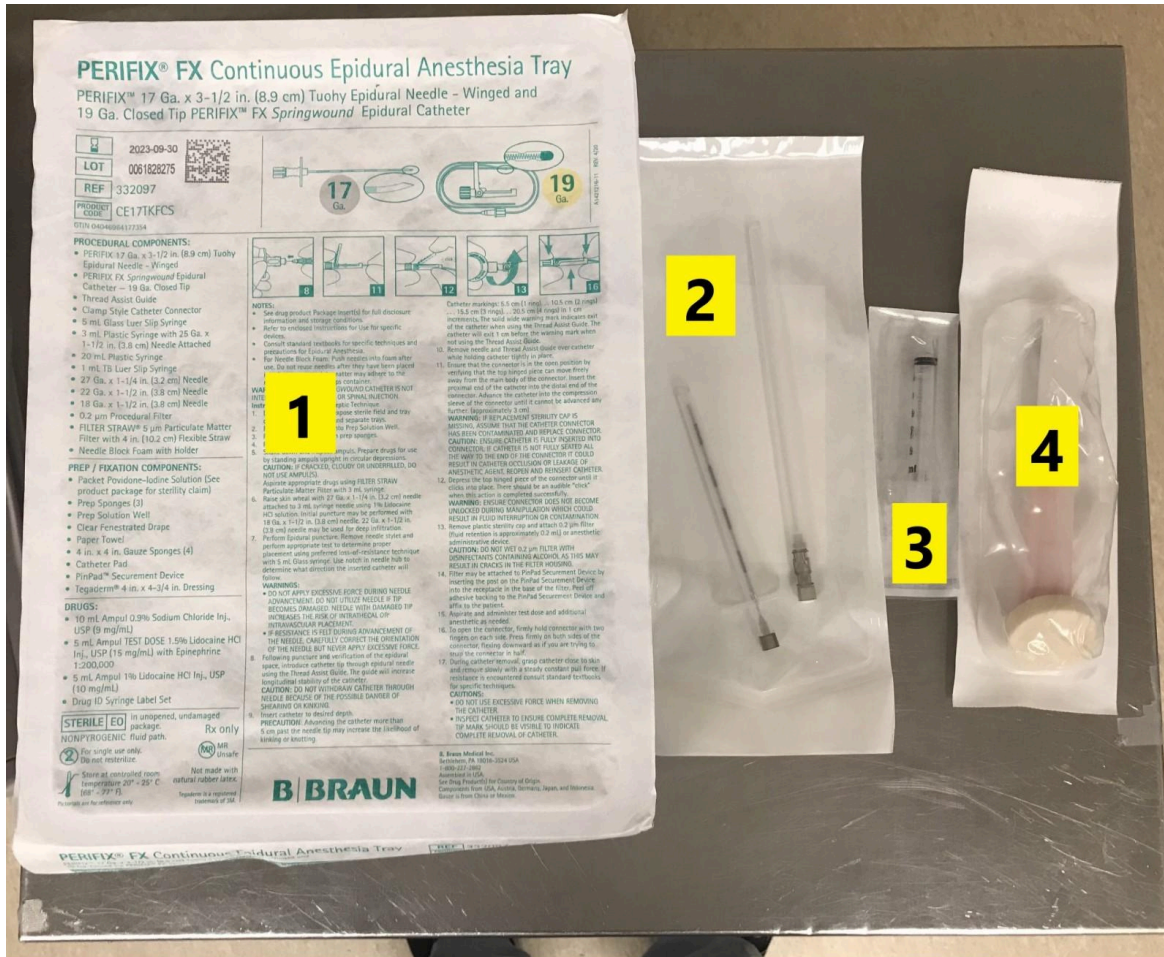
Good Sam is moving away from intrathecal bupivacaine use in floor CSEs. There are concerns that this causes excess hypotension, so the “standard” is now becoming to only use intrathecal fentanyl.

Epidural pump: The “default” pump settings are 6 mL of 0.125% bupivacaine every 30 min, with 3 mL/hr KVO. Often people will select 2 mL/hr KVO or 5 mL boluses for shorter patients. In Epic you chart the pumped bupivacaine in mL/hr units (so for the usual 6 mL q30 min boluses + 3 mL/hr continuous rate you would chart $6 + 6 + 3 = 15$ mL/hr of 0.125% bupivacaine).

C-sections

If you are doing a CSE in the OR (for a C-section or ECV), you’ll find all the supplies you need in the OR. Generally, the last person in the OR will have set out all the supplies (in sterile packaging) on a little silver cart; they consist of an epidural tray, 3 mL slip-tip syringe (for spinal medicine), spinal needle/Tuohy package, and a Chloraprep. Be sure to replace those supplies as you’re finishing the C-section for the next person (it may be you!). **Also please wipe down your Anesthesia station just like at UC.**

Here is the OR set-up for CSEs; this is what the silver cart should have on it by the end of a case:



1: epidural tray, 2: Tuohy + spinal needle, 3: 3 mL slip-tip syringe (for spinal medicine), 4: Chloraprep.

Note: gloves are in the drawer inside this cart.

Dosing: The “standard” dosing is 1.4-1.8 mL of 0.75 spinal bupivacaine (depending on patient height; one rule of thumb is 1.6 mL for heights 5’2”-5’10”, 1.4 mL if <5’2” and 1.8 mL if >5’10”) mixed with 15 mcg of intrathecal fentanyl, followed by 3 mL of epidural lidocaine-epinephrine 1.5%-1:200000 as your test dose (again, many people will mix the left-over fentanyl into the test dose). The spinal dose should last the length of the C-section; however, we almost always give a dose of 2.5-3 mg epidural morphine (Duramorph) toward the end of the procedure to help with post-op pain. Some will inject the remaining 2.5-2 mg of Duramorph into the IV or into the IV fluid bag, others will waste it.

Aspiration pneumonitis prophylaxis: The “standard” is to give 20 mg IV famotidine preoperatively. We generally give this ourselves (e.g., the pre-op nurse does not give this for us). Famotidine is refrigerated, so you can’t get it out of the OR Pyxis units; you need to

go to the Pyxis in the L&D floor or the Pyxis next to the L&D PACU to get it. It's best practice to dilute the famotidine as undiluted use has a rare association with hypotension (and can feel cold in the IV since it's fresh out of the fridge). One strategy is to go to the patient's pre-op room with the 2 mL vial of famotidine & a 10 mL syringe, pull 8 mL of LR off the patient's IV bag, and dilute the 2 mL of famotidine in it to make a 10 mL preparation.

Bicitra is available if desired, but is rarely used; it will act faster than famotidine (~30 min onset for famotidine vs nearly instant for Bicitra) if timing is important, however.

Anti IONV/PONV strategies: These are highly variable depending on the provider. The most common strategy I've seen CRNAs use is 10 mg metoclopramide around skin incision and 4 mg ondansetron after baby is delivered. I've seen some attendings switch the order of these, +/- add 4 mg dexamethasone after baby is delivered.

My personal approach has become 10 mg metoclopramide as soon as the patient enters the room (pre-neuraxial block), 4 mg ondansetron after delivery, and 4-8 mg dexamethasone after delivery if the patient does not have diabetes. My use of metoclopramide is based on [this meta-analysis in the BJA](#); the theory is that pregnancy causes GERD -> reflux -> nausea, and metoclopramide increases LES tone, decreasing reflux.

Avoiding hypotension is likely the most important part of preventing IONV/PONV. Phenylephrine sticks (100 mcg/mL) are in every OR Pyxis; you can also withdraw 50 mL vials of ephedrine for dilution or IM use.

Uterotonic/PPH agents: Oxytocin is almost always started around the time of cord clamping; some attendings prefer to wait until the placenta is delivered. Oxytocin is stored in 10 unit/1 mL vials in the OR Pyxis units; the usual practice is to inject 30 units into the IV fluid bag, run the remainder of the fluids in (e.g., we do not put the oxytocin on a pump and follow an algorithm like we do at UC).

Surgeons may ask for additional agents:

- **Intrauterine oxytocin:** We facilitate this by grabbing a 1 mL vial of oxytocin and passing off a 3 mL Luer lock syringe and subcutaneous needle to the scrub nurse. They'll assemble the needle & syringe, and we'll hold the vial of oxytocin up for them to sterilely draw out the 1 mL from it.
- **Misoprostol (Cytotec):** We pull this from the Omnicell if it's needed. It comes in 200 mcg tablets; they will usually ask for 800-1,000 mcg, which comes out to 4-5

tablets. You pass it off to either the surgeon or a nurse, who will administer it rectally.

- **Methergine:** A nurse grabs this from outside the OR if it's asked for and administers it IM themselves.
- **Tranexamic acid:** If the surgeon has predicted needing TXA, they may have ordered it pre-op, and the nurse will give you a premixed bag when the patient rolls in. If not, we have 1000 mg vials of TXA in the Omnicell. Administer it when the surgeon asks for it (usually at cord clamp).

External cephalic versions

Patients receiving a version generally receive a CSE with the same dosing as given above for C-sections, as there is a chance that the patient may need a crash C-section if fetal hemodynamics change with the version attempt. You will want to make sure your epidural catheter is taped up well, since the patient may go back to L&D to continue laboring if the version is successful, and you'll then hook up the epidural to a pump for longer-term pain control.

Cerclages

Patients undergoing cerclage generally receive a CSE with 1-1.4 mL intrathecal bupivacaine and 15-20 mcg intrathecal fentanyl followed by the 3 mL lidocaine-epinephrine test dose (most will mix the remaining fentanyl in with the test dose).

D&Cs

Patients receiving D&Cs usually get general anesthesia. LMAs are generally used unless their NPO time is too short or if they are past ~16-20 weeks pregnant, in which case they receive an ETT. The surgeons will often ask for TXA in these cases; make sure your Pyxis has some available.

*Scheduled procedures are listed on the whiteboard by the supply closet with the time, surgeon, and number code corresponding to procedure type: (1) C-section (2) D&C/D&E (3) Cerclage (4) ECV