After Rounds: Inpatient Work

This is the least structured part of the morning when efficiency is most likely to falter. Prioritize and focus!

Tasks

- **Work with the rest of the team to divide and conquer** tasks. Most of this should be accomplished during rounds.
- Prioritize care of acutely ill patients, discharges and calling consultants
- **Carry out patient plans discussed during rounds:** new medication orders, labs, radiology studies, etc. Most of the orders should have already been entered on rounds
- **Call consultants** (see below on the nuances of doing this). You want the consultant to start thinking about your patient as soon as possible!
- **Update families regarding care plans for the day.** This is especially important if the family was asleep when you pre-rounded, if the team did sit-down or non-family centered walk rounds, and if there were significant changes in plans since you last talked to them. Your primary physician role is undermined when families have to hear about important updates from supervising physicians.
- **Finalize (should start before rounds) your medical documentation.** Be sure to include update with any changes discussed during rounds! If you sign off on the note without doing that we start to seriously wonder whether you were actually listening
- **Attend Large Group Didactics while at CG**
    - Core pediatric student lecture series
    - Resident noon conference (residents and AIs)
- **Check in with your patients and families again.** You are expected to do this at least twice a day: when pre-rounding and again in the afternoon. Do this soon after rounds for any families with whom the plan was not discussed during rounds (Eg. table rooms, family not physically in the room, etc). If a patient has a lot of things going on that day, you are expected to update them more often. Remember, you are their primary contact with the medical world!
- **Individual Study.** Always have something to read/work on
- **Admit new patients.** This is a team effort
- **Redistributed team patients.** Clerkship students are asked to preferably "pick up" patients who are brand new to allow them to be involved in their care right from the beginning. However, with the overall rapid turnover in patient census, some students might find themselves with few "old" patients and no new admissions during a particular day. You can always "pick up" one of the "old" team patients. Interns are typically more than happy to share!
- **Work ahead and "tuck patients in" as much as possible.** Inpatient service is unpredictable when it comes to admissions and acuity. Go with the premise both the census and the acuity will double overnight! They really do on occasion. And if they do not…. you'll end up with bonus time. In addition, you KNOW the time between AM sign-out and rounds is packed and that "decompressing" that time is helpful. "Tucking in" is especially important for (1) patients expected to leave soon to make the discharge process go smoother (2) prior to your own day off to make cross cover smoother.

    - **Anticipate.** This is an ongoing process. What will your patient need tomorrow? Can you get started on that task now? For instance if you think that you might want to change from IV to oral antibiotics tomorrow, look up what antibiotic and what dose you might want to use. If a patient will likely be going home in the morning, check with family whether they will need a school or work excuse, write prescription, call PCP, etc.

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- Prep your PN for the following day. You can start doing this as soon as you finalize today's note. Update the clinical course with any events since the morning, leave a placeholder for anticipated labs, update the problem list, assessment, and plan if needed
- **Update "hospital course."** It is used as the basis for the d/c summary.
- **Update "resident handoff."** This is the "go to sheet" for the night team.
- Read any new clinical notes, review any new orders.

Admitting Patients

Where do patients come from?

- You may receive the gift of a new patient from one of several places
- **New Admissions**
  - The ER
  - Direct Admissions. Direct admissions are a streamlined way of getting patients from clinics, outside ED's, and (on occasion) home to the hospital floor. A physician determines if a child needs to be admitted/transferred, but does not need to be formally seen in the ED. These patients need to be seen as soon as possible and definitely within 30 minutes of arriving to the floor.
  - OR
- **Patient Transfers**
  - Patients should have a transfer summary written by the transferring team describing the hospital course up until the point of transfer as well as plans for further care. The transferring service is also responsible for writing transfer orders. Your job is to use the transfer note as a basis for your accept note. Your job is also to review all of the transfer orders to ensure that they are really what you want to happen with the patient
  - Outside Hospital
  - Different acuity level: Eg. transfers between floor and the intensive care unit (PICU or NICU)
  - Different service: Eg. transfers between medical and surgical services

How many patients can third year students carry?

- As a general guideline 2-4 patients per an MS3 at a time BUT with much flexibility depending on overall census, patient complexity, acuity, as well as patient turn-over.
- It is preferable for you to carry fewer patients, know them really well, and contribute in a meaningful way to their care than to carry many patients but know each only superficially.
- Prior to AM rounds clerkship students should "pick" up 1 (at MOST 2) patients who had been admitted by the night team without your involvement. Your time to get to know these patients between sign-out and needing to present them during rounds is pretty short. You can, however, ask to "pick up" the same patient after rounds, present them during rounds the following morning, and take care of them throughout the hospitalization.
- We will try to provide you with a good mix of pediatric inpatient diagnoses during your rotation. If there are specific patients you would like to admit during the month, let the team senior know.

How many patients can AIs carry

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How are Patients Divided Among Students?

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- Talk with your senior as well as your fellow students. Different methods have worked with different groups. In some cases the senior resident assigns patients to the students during morning sign-out. In other cases the students divide the patients among themselves.
- We ask third year students to preferentially pick patients assigned to interns over those assigned to AIs. Given often the lower pediatric census during the "AI season" however, at times you will share patients with the AI especially towards the later part of his/her month when the AI assumes more of a supervisory role.
- Work with your team on patient assignments. Typically the MS3 who is staying late would "pick up" any patients admitted after ~3PM. Earlier admissions should be assigned to other students. Some things to consider is everyone's primary census (number, acuity, service distribution) as well as which MS3 has yet to complete their written H&P assignment.

What exactly is a "Bounce-back" ?

- A "bounce-back" is a patient who is well known to you who was either discharged and then readmitted for the same (or closely related issue) OR who was admitted to the floor, transferred to critical care and is now coming back. The idea is to maintain continuity of care by "bouncing" him or her back to the original team and student. You might want to keep a list of your team patients who had been transferred to the PICU

I heard about a new admission. What do I do now?

- **Set some mental time goals while** recognizing that some admissions are more complicated than others…. (approx 1-2 hours for a typical admission from start to finish)
  - **20 min-1 hr** = Chart review, History and Physical
  - **5-10 min=** orders
  - **10-30 min**= staffing
  - **10 min=** update orders and family, call consults
  - **10-30 min**= note
- **Start "working" on the admission ASAP.** A common misconception is that you are not supposed to start working on a patient until they are physically on the floor. **WRONG.** Start working on an admission as soon as the pt is assigned to you. They don't even need to be physically in the hospital! The sooner you do that, the sooner you can develop and institute your care plan and the sooner the patient can start to get better!
- **Chart Wrangling.** A general guideline is to try to collect as much preliminary information as possible before actually initiating patient contact. This means reading the ED chart, PICU chart, looking at labs, x-rays, past discharge summaries etc. We assure you that this is the most efficient and considerate way to complete an admission. This advice is especially true for medically complex patients. Also remember that the purpose of chart wrangling is not gathering information "just because," but thoughtful collection information that will help you formulate your patient assessment and plan.
- **Review your patients' past medical history and problem list**. Both part of the shared electronic health record, which unfortunately often means no one takes the time to update it. Reviewing and "cleaning up" is a great way to review your patient's medical history AND an opportunity to do a huge favor to current and future providers!

I'm ready to see the patient. What now?

- As always, try to go together with your supervising physician/s. Clerkship students should typically be the primary person obtaining the history. When you have finished, others might ask have

additional or clarifying questions. You should also be the primary person performing the physical exam

- Occasional instances of the supervising physician being the primary team "talker" and "examiner" are okay. Actively observe and learn. If the active observer role is more frequent, speak up.
- Introduce yourself and clearly explain your role in the child's care. You are a student doctor x working with the general pediatric (or nephrology, GI, cardiology, critical care, etc) team who will be taking care of this patient during the hospitalization. Introduce your supervising physicians.
- Obtain a history. See the pediatric history taking document for detail
- Perform a full physical exam. During subsequent days you will perform a brief and more focused exam. The admission physical exam is a full one. See pediatric PE document for details

I've finished seeing the patient. What now?

Remember that you've been formulating your differential diagnosis from the time you initially heard about the patient. Chart wrangling, history, and physical exam have all helped you narrow that differential down. They also allowed you to start formulating your treatment plan. If you feel quite comfortable and sure about the assessment and plan, feel free to discuss them with the family. If you are not quite sure, tell the family that now that you have all this information, you will discuss the case with the team and get back to them. Be sure you do!

Tasks after you finish seeing the patient

- Admission orders. The earlier you write orders the earlier the patient receives treatment and gets better! . Yes medical students can and should write orders. Until you have an MD, however, you "pend" instead of signing them. Student orders need to be co-signed by a physician.
- Staff the admission. If you are really unsure about what to do with a patient, do this EARLY before writing orders
- Update your orders with any changes in plan obtained from staffing
- Update patients and families with any changes in the assessment and plan obtained from staffing. This is really important! The family is waiting to hear from you and appreciates knowing the final plan.
- Write the H&P.
- Read up on your patients

Staffing Admissions

This is the time you present patient history, physical, labs, radiology studies and most importantly your assessment and plan to intern, senior resident and/or attending. They will add their input. At the conclusion of staffing, everyone should be on the same page regarding pt's diagnosis (or diagnoses) as well as the treatment plan. Don't make the mistake of being simply a reporter and stopping after summarizing all of the history, physical exams, and labs! The assessment and plan are still the most vital parts!

Transferring Patients to a Higher Acuity Setting

Some patients who are getting sicker on the floor might need more intensive care. This decision is made usually via a critical care (NICU or PICU) consult, rapid response, or a code. There are a lot of tasks to be completed with a transfer.

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- **Update the family either in person or via phone** as to why the child needs to be transferred and what this transfer means (new bed on a different floor, new team of doctors, etc)
- **Notify the attending.** The primary hospital attending should be notified whenever you are concerned about the patient! Needing higher acuity care definitely qualifies!
- **Orders:** the transferring team is responsible for writing the transfer orders
- **Transfer Note.** History of present illness (including hospitalization course all the way to events leading to the transfer), exam, pertinent labs, problem list with assessment and plan.
- **Walking the patient over.** If a patient is ill enough to need critical care, an MD (and/or student) should walk with the bedside nurse/tech transferring the patient. This will also give you the opportunity to directly sign the patient out to the team taking over and (if the family is present) introduce them to their new team.
- **Notify the PMD (if different from the primary hospital attending).** The PMD should be notified with any major changes in the patient's condition and a PICU transfer definitely qualifies! Depending on the time of day or night the transfer happens, this might occur right after the transfer or the following morning. When signing the patient out to the PICU team make sure there is a definite plan in place as to who is going to notify the PMD and when.
- **Debrief.** Escalation of care is stressful. Talk with your intern and senior about the transfer, what led up to it, what went well, what could have been done better. There is usually something to learn from the experience that can be improved on next time

Medical Communication

- Medical communication is a skill and an entrustable professional activity for entering residency (EPA 6. Provide an oral presentation of a clinical encounter). Much of your work as both a trainee and as a physician involves communicating with various other multidisciplinary team members regarding patient care issues. If you have questions about how to approach a communication challenge please talk to your senior or attending.

Communicating with Nurses

- Checking in with your patient's night nurse when pre-rounding
- When walk rounding, make sure one of the students (NOT the student whose pt it is) is contacting the bedside nurse (number written outside the room)
- Discuss any new orders with the nurse

Supervising Physicians

- Third year students share all patients with an intern or AI. The senior is responsible for all the patients on the team. The team attending +/- fellow are responsible for the patients on a given service.
- Keep everyone in the loop regarding patient updates.
- Third year students are expected to touch base with the intern prior to rounds regarding shared patients.

Hospital Attendings

- It is your responsibility to speak with each of your patients' attendings every day. This is usually done during rounds.
- You are expected to notify the attending with any important patient updates (those that change the assessment and plan) as well as worsening in patients' condition. If you have doubts whether to

call the attending or not, run it by the intern or senior. Definitely if you are considering a transfer to the PICU, the child's attending needs to know!

Calling Primary Care Physicians and Consultants

- We ask that third year students practice with the intern or senior resident. Pretend the intern or senior is the PCP or consultant and run through what you would say
- IF your supervising intern or resident believes you are ready, call and have him/her nearby to both provide feedback regarding the conversation AND be ready to take over the phone if needed.
- IF your supervising intern or resident states you are ready to do calls independently at this point, do so.
- IF your supervising intern or senior does not think you are ready, continue practicing and listening to others calling

Calling PCPs

- Confirm the PCP identity with the caregiver. Ideally information about the PCP as well as last well child visit is obtained during admission…. But sometimes missed. If there had been a change in the PCP, be sure to make the change in EPIC!
- Contact the PCP on admission and clarify how often they would like to be contacted
- Contact patient's primary care physicians when appropriate: significant change in patient's condition, close to discharge.
- Document doing so in EPIC under PCP communication

Calling Consultants

- On occasion we might need a consultants' expertise regarding patient care. If it is decided on admission or during rounds that a consultant's opinion is required, call them as early in the day as possible (but not before 8AM). This gives the consultant more time and flexibility in seeing your patient—and usually allows you and the patient the benefit of their opinion earlier on.
- NEVER page a consultant without having a specific question or worse yet without knowing why exactly you want to get them involved.
- You should **NOT** present the entire H&P to the consultant. You should provide the consultant with enough information so that he feels the consult is justified. He will be able to sort through the details when he does the consult. S/he might also ask you for more information about the patient—for instance a cardiologist might ask for the most recent echo report, or most recent vitals, current medications, etc. It is your patient and you are expected to know all this information.
- Never page a consultant (or anyone else) and have nothing to do while waiting for the call back. This is the time to work on your notes, enter prescriptions, look up papers, etc

Heading home

- Check in with the late stay team. Offer to help and mean it. If possible, commit to a specific task. They will appreciate it! (Yes, every resident knows that the question "Is there anything else you need help with?" is really code for "Can I go home now?")
- Check in with the senior
- Go home! There intentionally is no designated end time for team members who are not staying late.
- **Individual study.** Easier in home vs. hospital