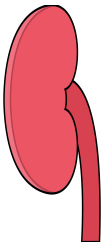
SENIOR HANDBOOK

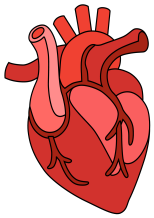
RONALD REAGAN (+ SANTA MONICA)

BLUE TEAM



+ HOSPITALIST

YELLOW TEAM



+ HOSPITALIST

BLUE TEAM → Nephrology is a consult service, round with only the hospitalist attending

YELLOW TEAM → Cardiology is a primary service, round separately with both cardiology and hospitalist attendings

Contents

DAILY SCHEDULE AND WORKFLOW

Team structure: Each team is composed of 1 senior and 2 interns. Team cap is 16 (8 per intern).

0600: AM sign out
0700 – 0730: Case management will call for updates (see below)
0730 – 0745: Interpreter calls to see which rooms require an interpreter and what time to meet
0745: Check in with rounding attending about start time and where you would like to start (typically discharges / sickest first)
0800: Start rounding
1030/11: Finish rounding, page consults, make sure TPN orders are in before 12, run the list
12 - 1300: Noon conference (protected time, forward pager to attendings)
1300 → : Check all orders from rounds, consults etc, run the list with attending and interns PRN, see new admits and PICU downgrades
- Update handoffs throughout the day, go over contingency plans for the night team
1700 - 1830: PM sign out
Rotating team order for sign out (Yellow, Blue, GI), daily schedule posted in work room
Senior signs out
Interns can leave when: 1. Tasks are done / patients tucked in
2. Notes completed
3. Families updated + Qs answered

Senior Responsibilities

- Pre-round on all patients. See in person any unstable / watcher patients before rounds.
- Res-intern for the interns on their day off
- Go over plans with interns prior to rounds as needed
- Ensure orders are in/correct and plans are carried through
- Discharge planning / orders
- Facilitating medical student teaching
- Help interns with responsibilities to make sure they get to leave by sign out
- If possible, pend orders and start H&Ps for pending admits that will come during night shift
- Stay for sign out
- Yellow and Blue seniors should sign into the code pagers during the day!
  Yellow: 30071
  Blue: 30072

Case management calls [0700 – 0730]:

You will typically get called by multiple case managers. They will tell you which patients they cover. They want to know:
Very brief one liner
Anticipated discharge date
Any needs for discharge you foresee like home O2, TPN, GT supplies, central line care, equipment (walker, wheelchair, commode), nebulizers, IV antibiotics

Pre-rounding:

Prioritize sick vs stable
Find an organizational style for use on rounds that works best for you, options include:
    Print entire handoff
    Annotate the patient list
    Write sticky notes in the chart and print with patient list

Focus on the big picture:
    Major problems, what's keeping them admitted, discharge needs, your plan
Note major meds / doses / timing
Abnormal vitals
Renew expiring orders / meds (if necessary)
Pend TPN
Prep DC med rec, orders and instructions
You won't know everything about your patients on the first day !!! (and this is ok)

Responding to a rapid:

Typically nurses will call the rapid and you will be paged or called
Yellow and Blue seniors should sign into the code pagers during the day!
    Yellow: 30071
    Blue: 30072
Inform attending of rapid if not already aware
PICU arrives quickly
When intern is comfortable they should present to PICU when they arrive
PICU presentation:

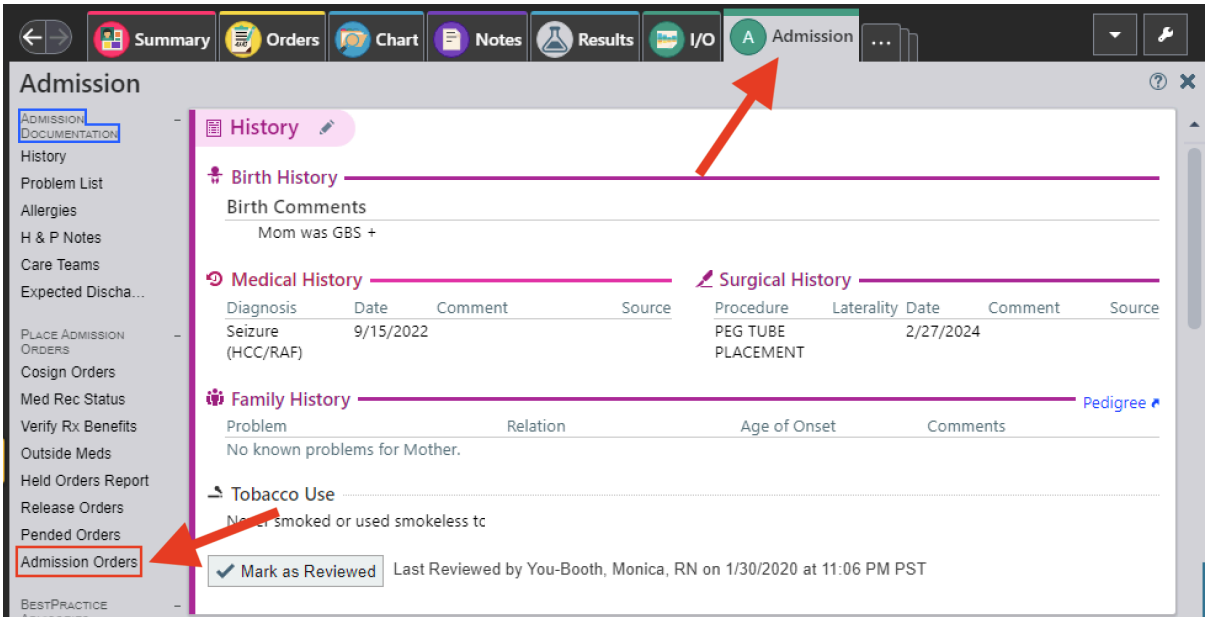
- Identify who called the rapid and why it was called.
    Some reasons to call a rapid
        Neurological changes: AMS/concern for stroke, seizure
        Respiratory: increased WOB, maxed out respiratory support, hypoxic/desats
        Cardiac: tachycardic, bradycardic, hypertensive, hypotensive, arrhythmia
        Bad Feeling
- Proceed with patient one-liner, say what XYZ interventions have been done or are in process. If decompensation was so rapid that no interventions have been possible, communicate that.
- Need to write transfer note, put in transfer order, update the DC summary and give verbal sign out to PICU resident

ADMISSION PROCESS

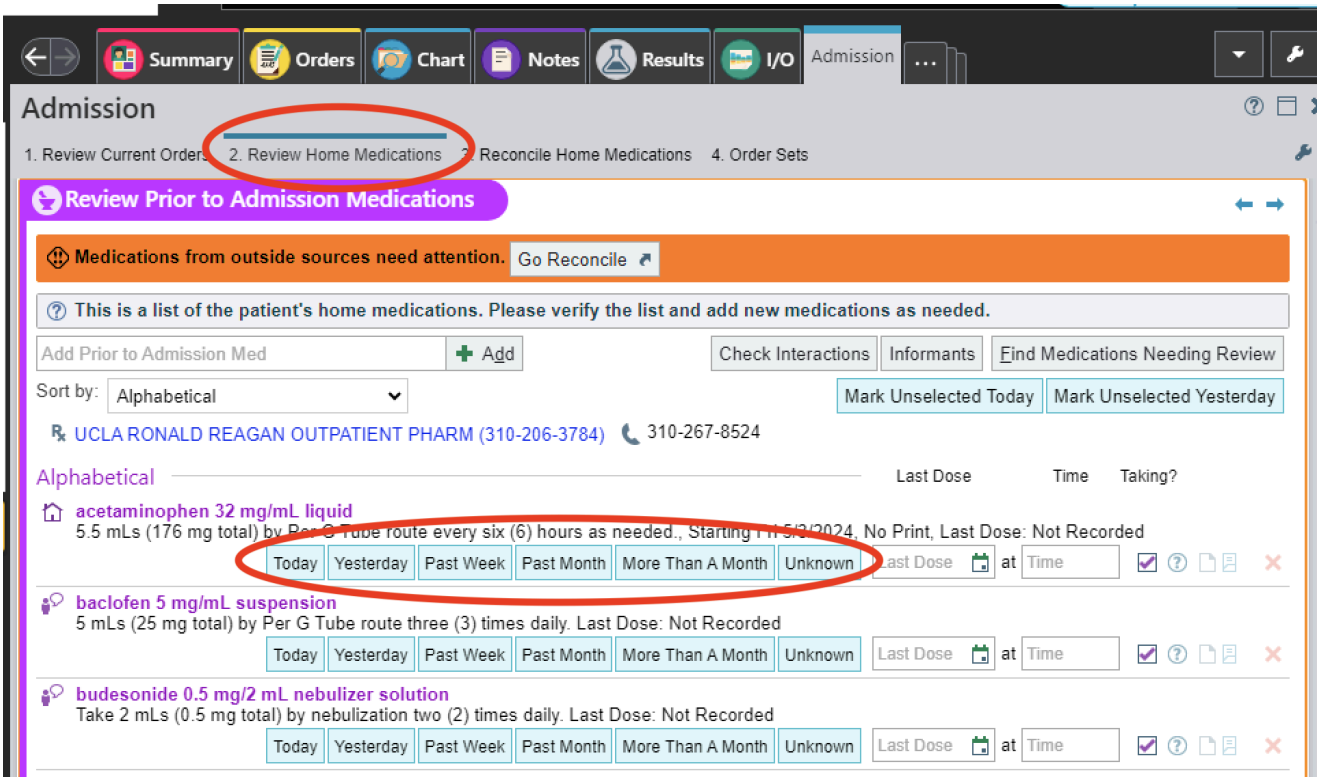
Adding a patient to the Blue or Yellow team list:

- Need to assign teams for a patient to be visible to all viewing the list. If you add a patient to the list and don't assign teams the patient will only show up on your list in EPIC
  → right click on patient, choose "assign teams" and choose either "pediatric – blue", "pediatric – yellow" or "pediatric – cardiology". If they are transferred off the service (ie to PICU) you can choose "remove teams" after right clicking on the patient. They will then fall off the list.

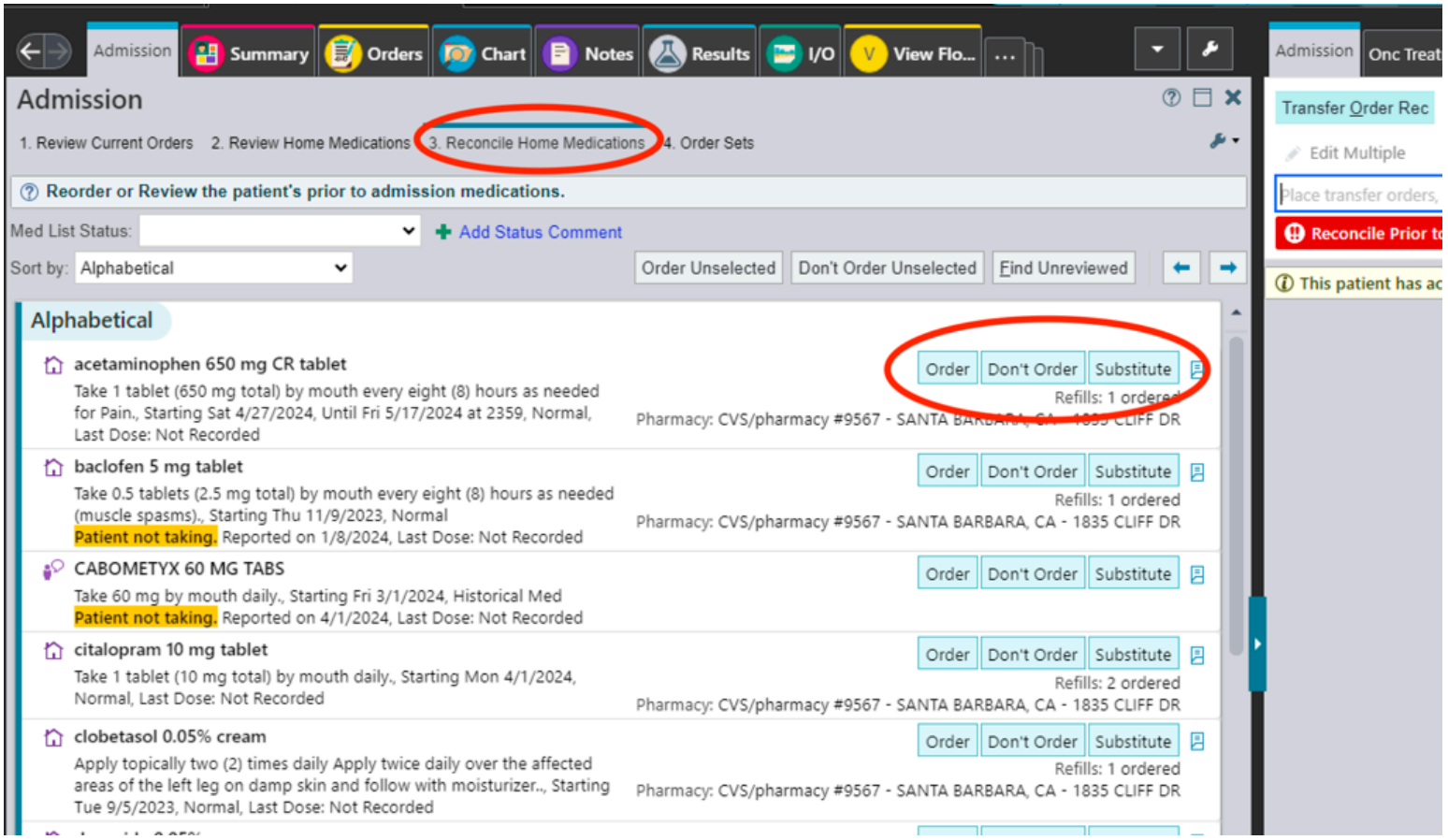
To start the admission process click on the admission tab then on the left menu bar choose "admission orders." This will bring you to the admission med rec.



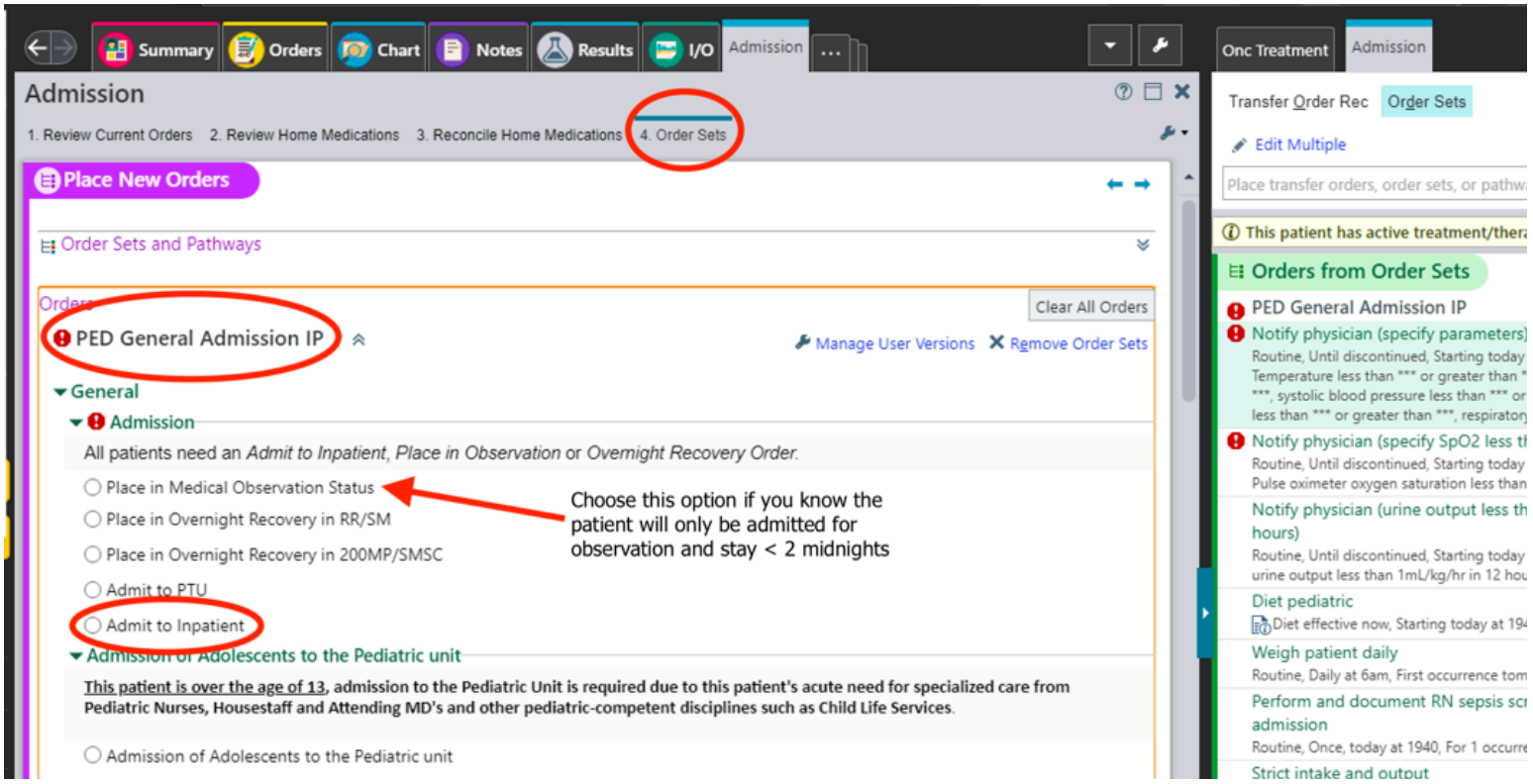
Click review home medications on the top. It will show all their home medications that appear in the system. Go over each one with the patient and choose when they last took the medication. You can remove a medication the patient is no longer taking by choosing the little red "x" on the far right.



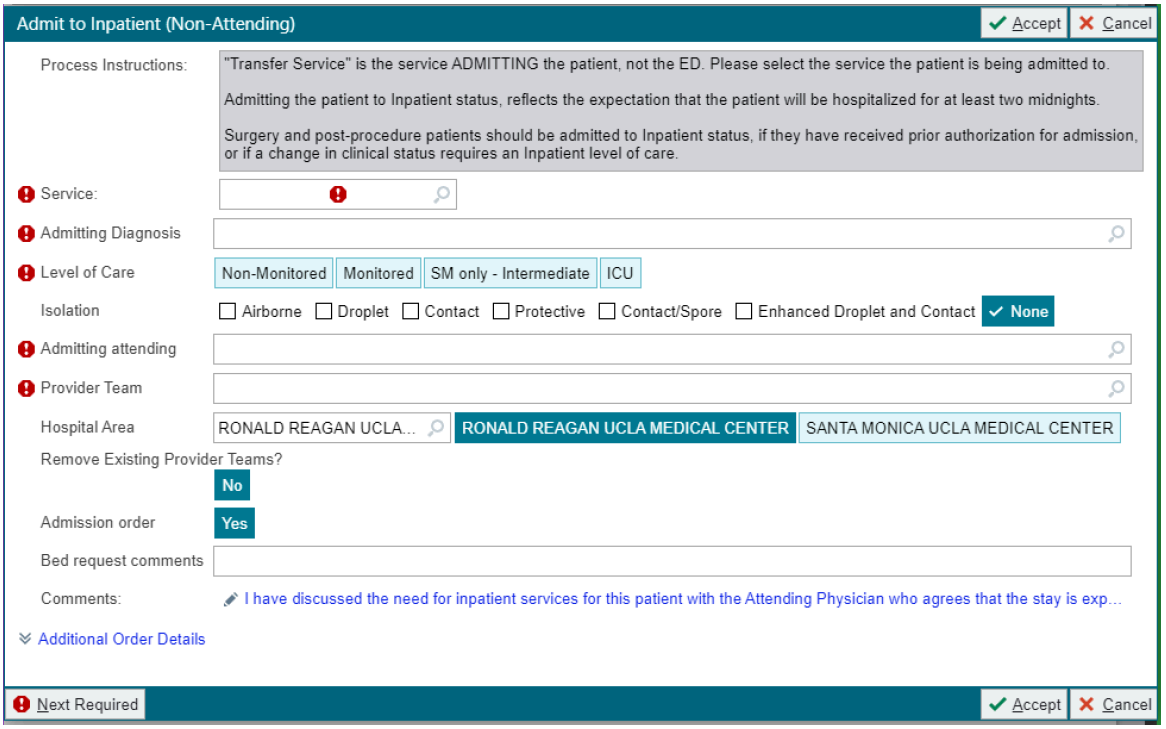
Next choose “reconcile home medications.” This will allow you to order their home medications.



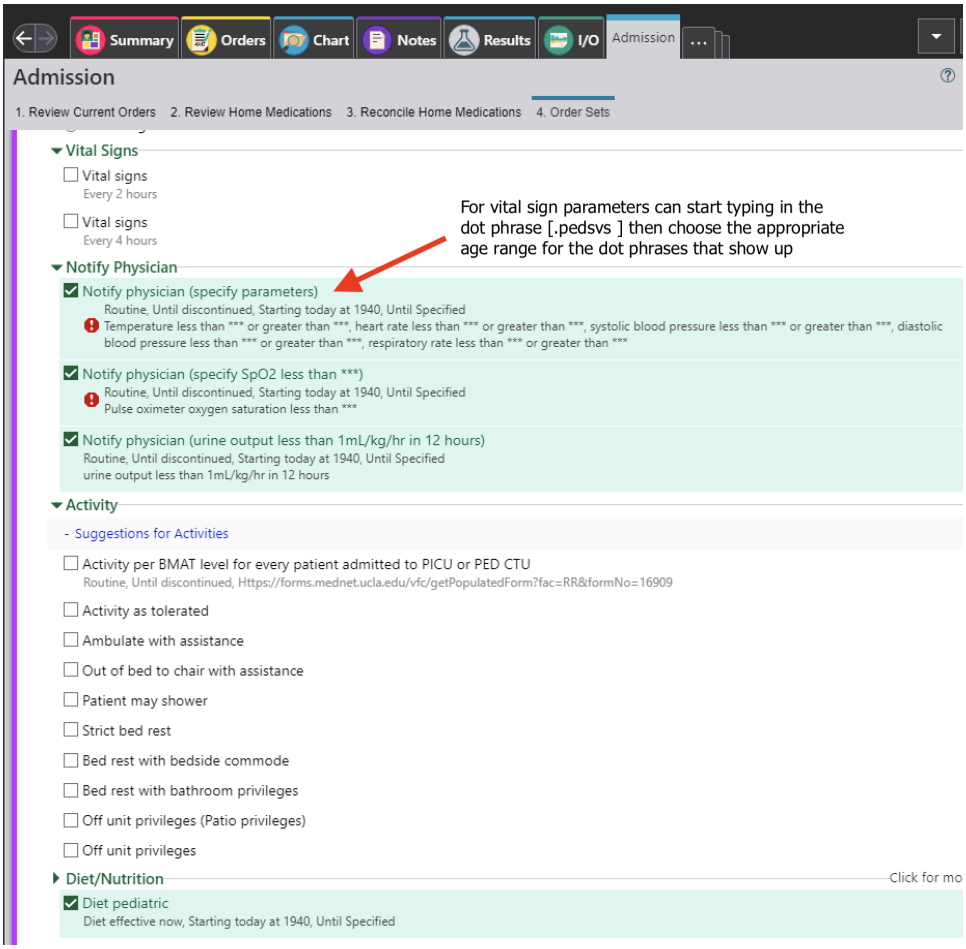
The admission order set will automatically populate once you click on “order sets.” Click on “admit to inpatient.” You can also choose to admit to observation if you know they will only be inpatient for <2 midnights.



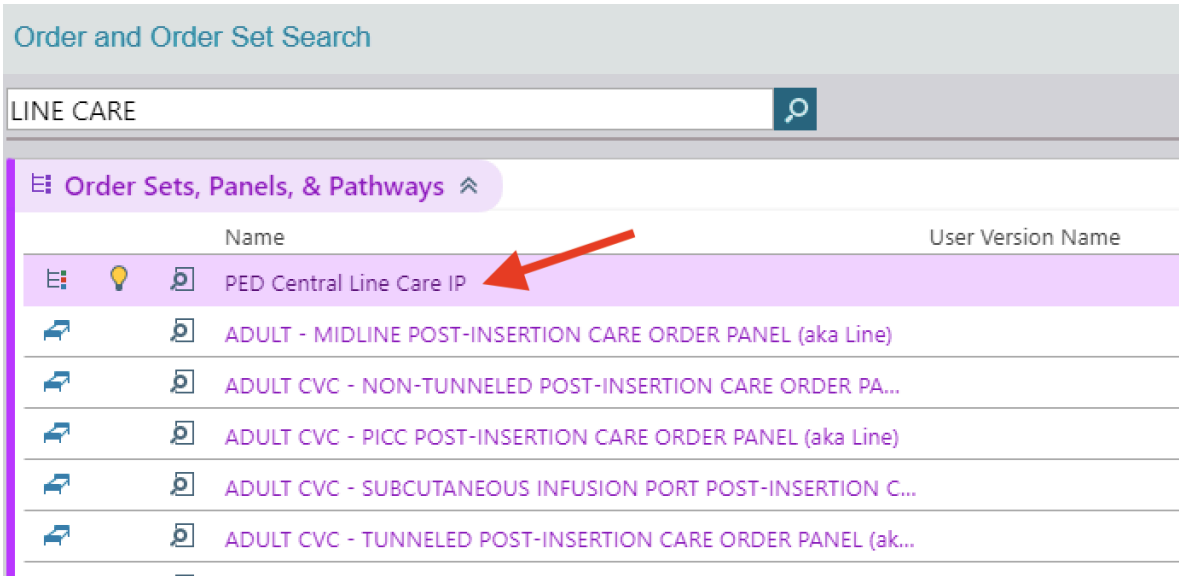
The admit to inpatient window will pop-up. The “service” and “provider team” is the hospitalist team. The level of care can be “monitored” if you plan to have them on continuous cardiac or pulse ox, otherwise choose “non-monitored.”

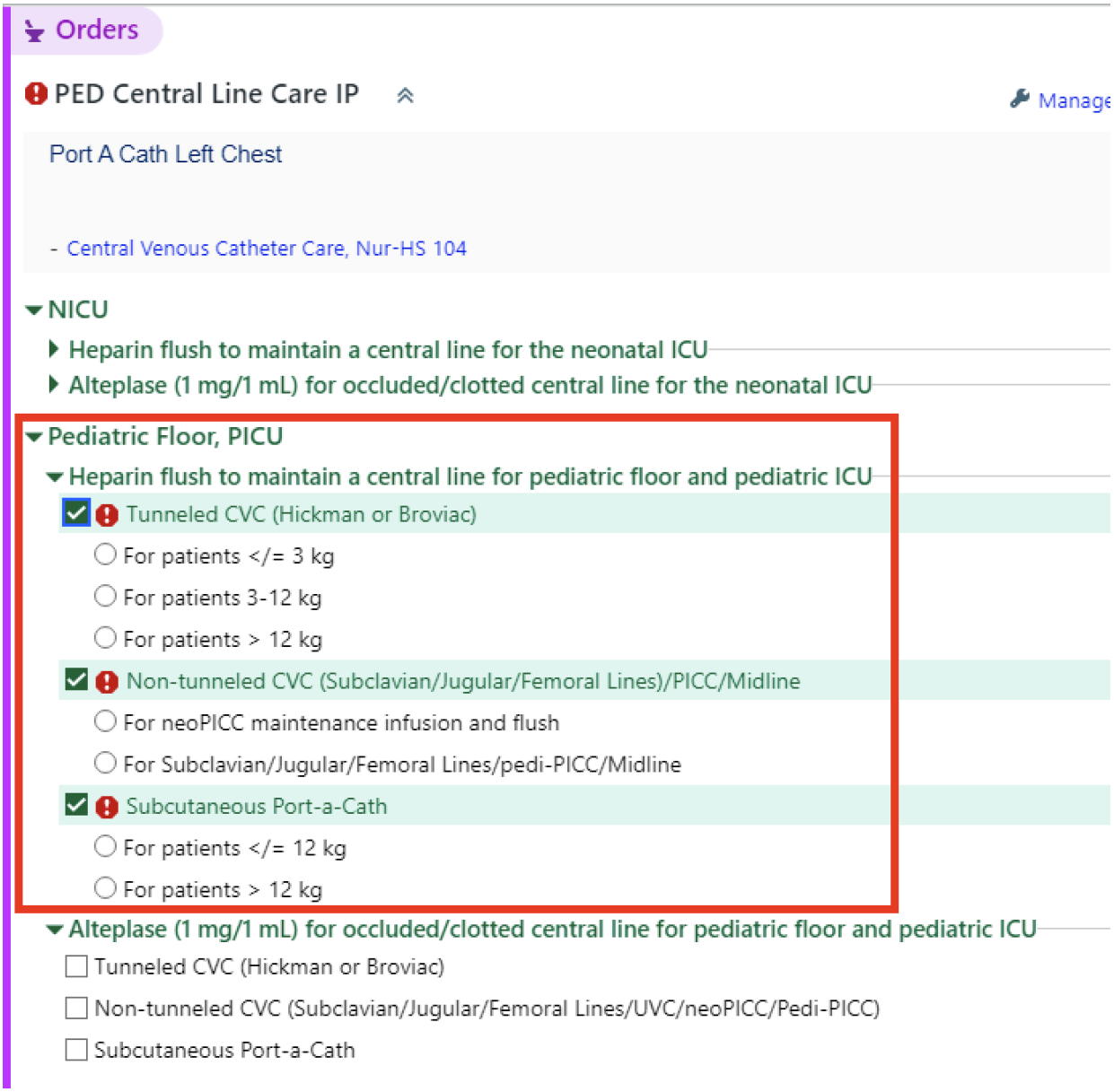


You can scroll through the remainder of the admission order-set and order what’s appropriate. For the vital sign parameters you can use the dot phrase [.pedsvs] and choose the correct age range for the patient.



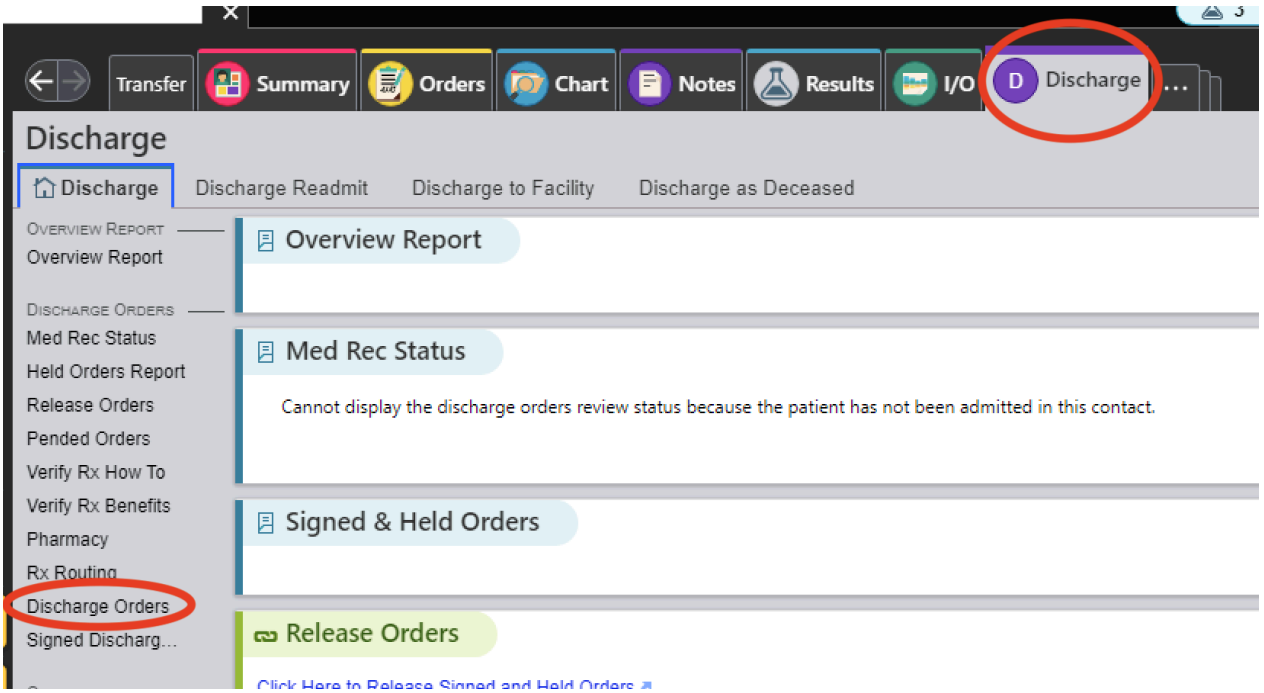
The order for pediatric central line care is at the bottom of the admission order set. You can also search for it separately. Make sure to order appropriate line care for anyone being admitted with a central line. The orders for alteplase for a clotted line is also in this order set.



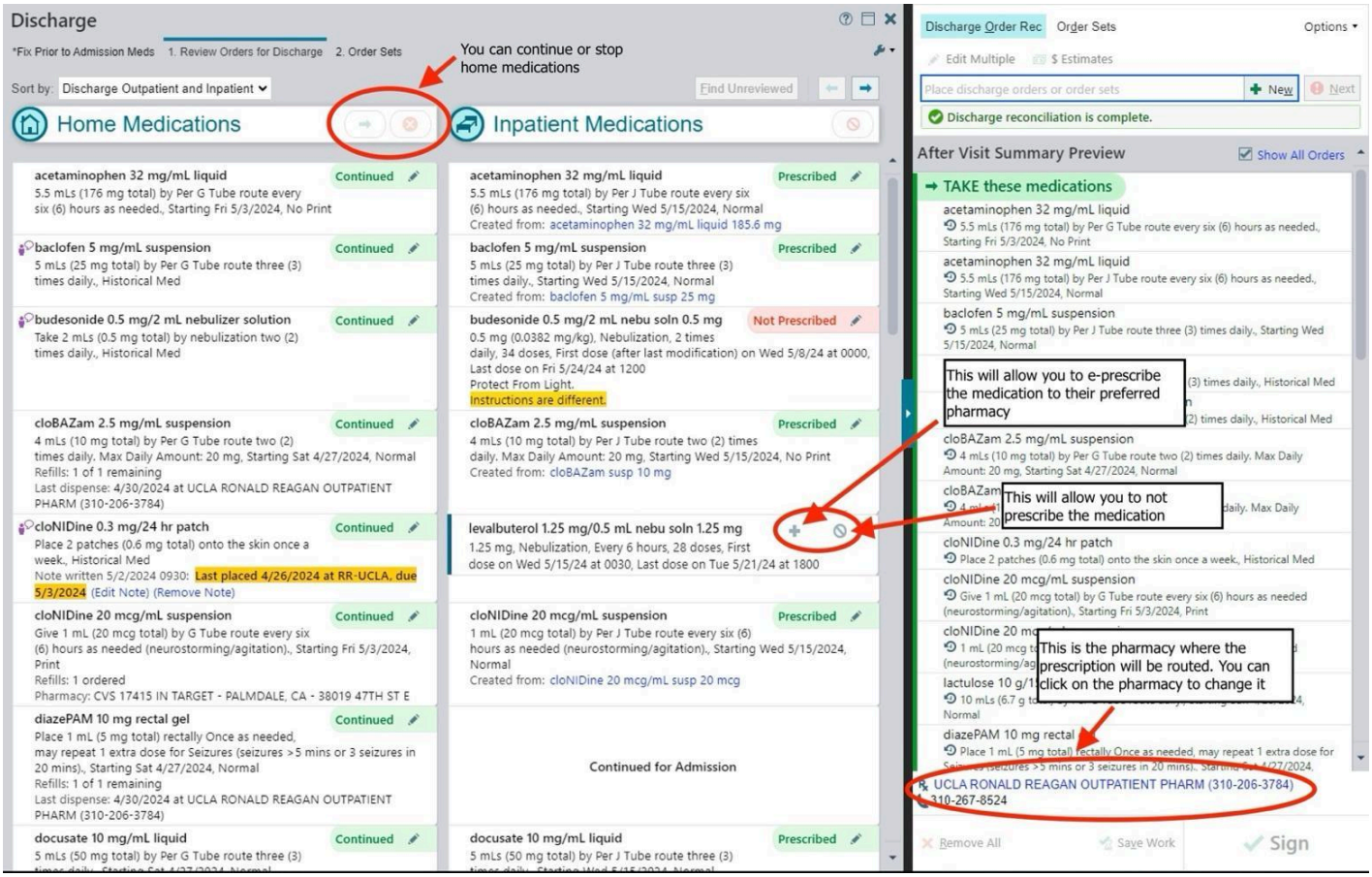


DISCHARGE PROCESS

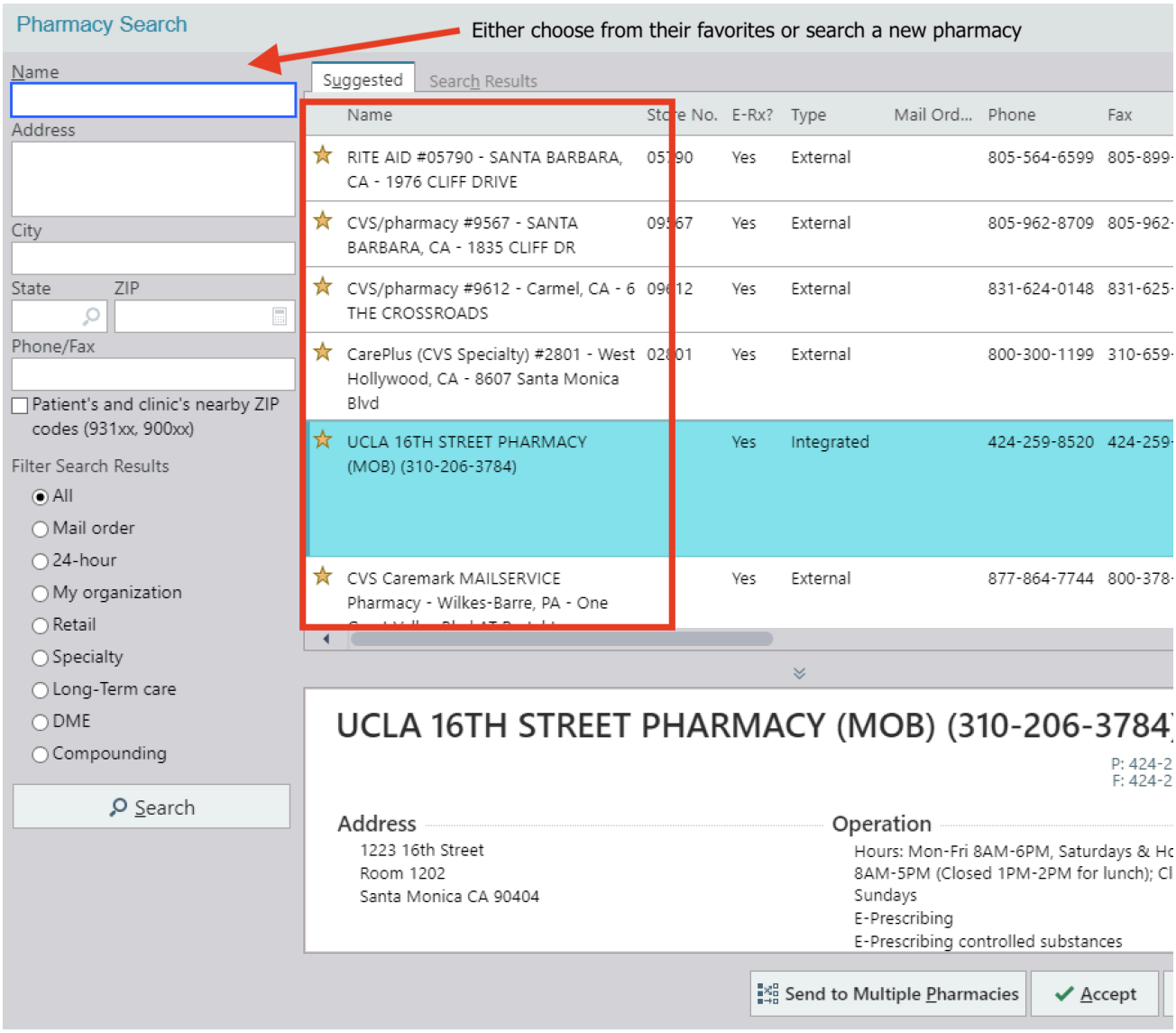
To discharge a patient, start with the discharge tab and then click on “discharge orders” on the left sided menu. Of note if a patient is being discharged, who was “admitted to inpatient”, and was only admitted for <2 midnights you must order “place in medical observation status” PRIOR to signing the discharge order.



Once you click discharge orders it will take you to the discharge medications page. Here you can continue/stop home meds and prescribe inpatient meds to their outpatient pharmacy. You can click the pharmacy to change it.

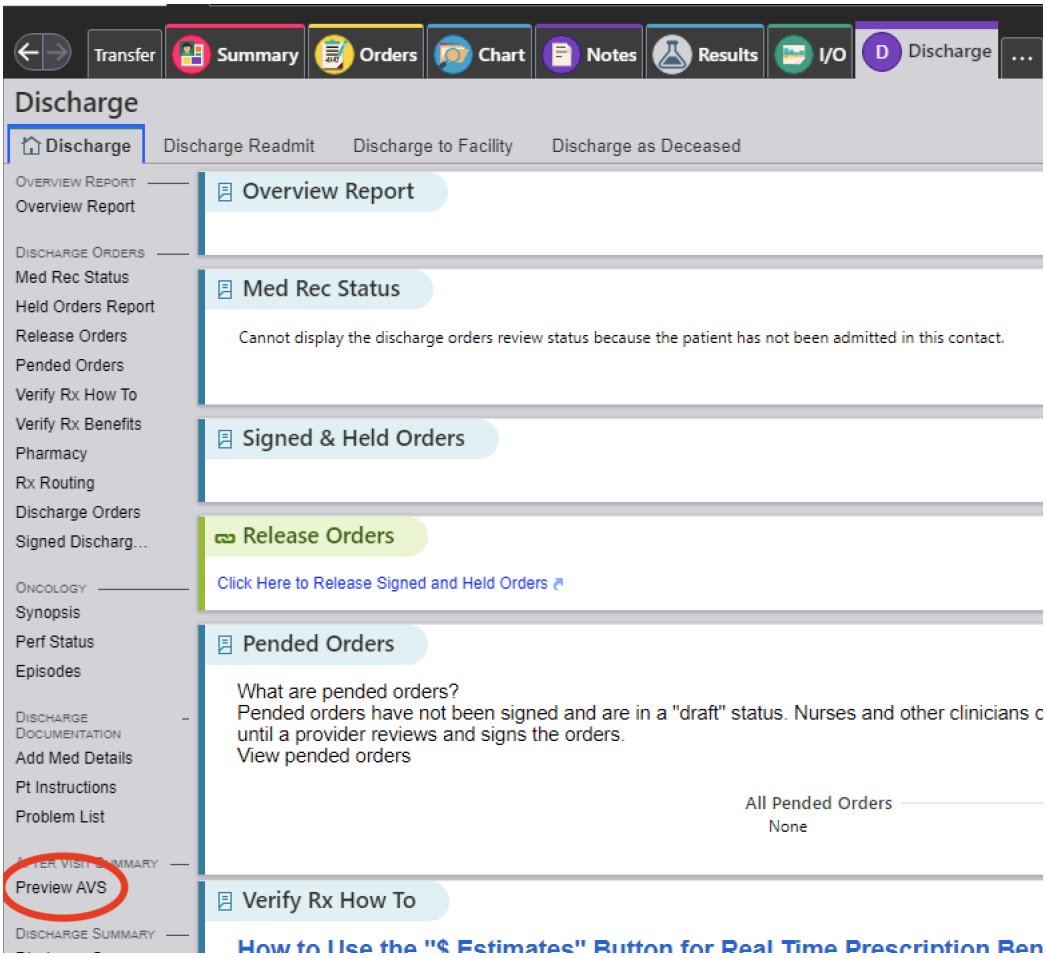


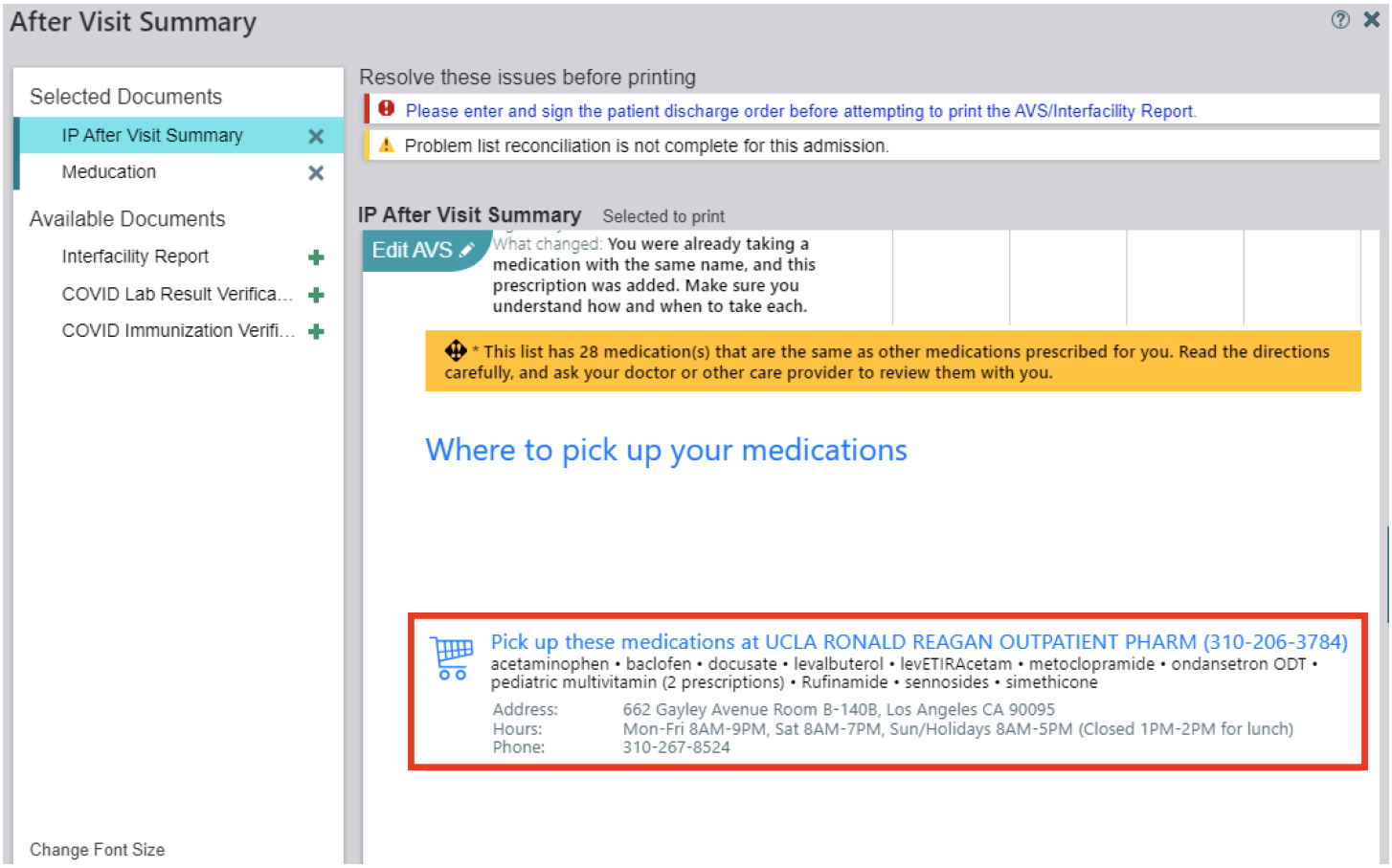
If you click on the patient's pharmacy, this window pops up. You can choose another pharmacy from their favorites list or search for a new pharmacy.



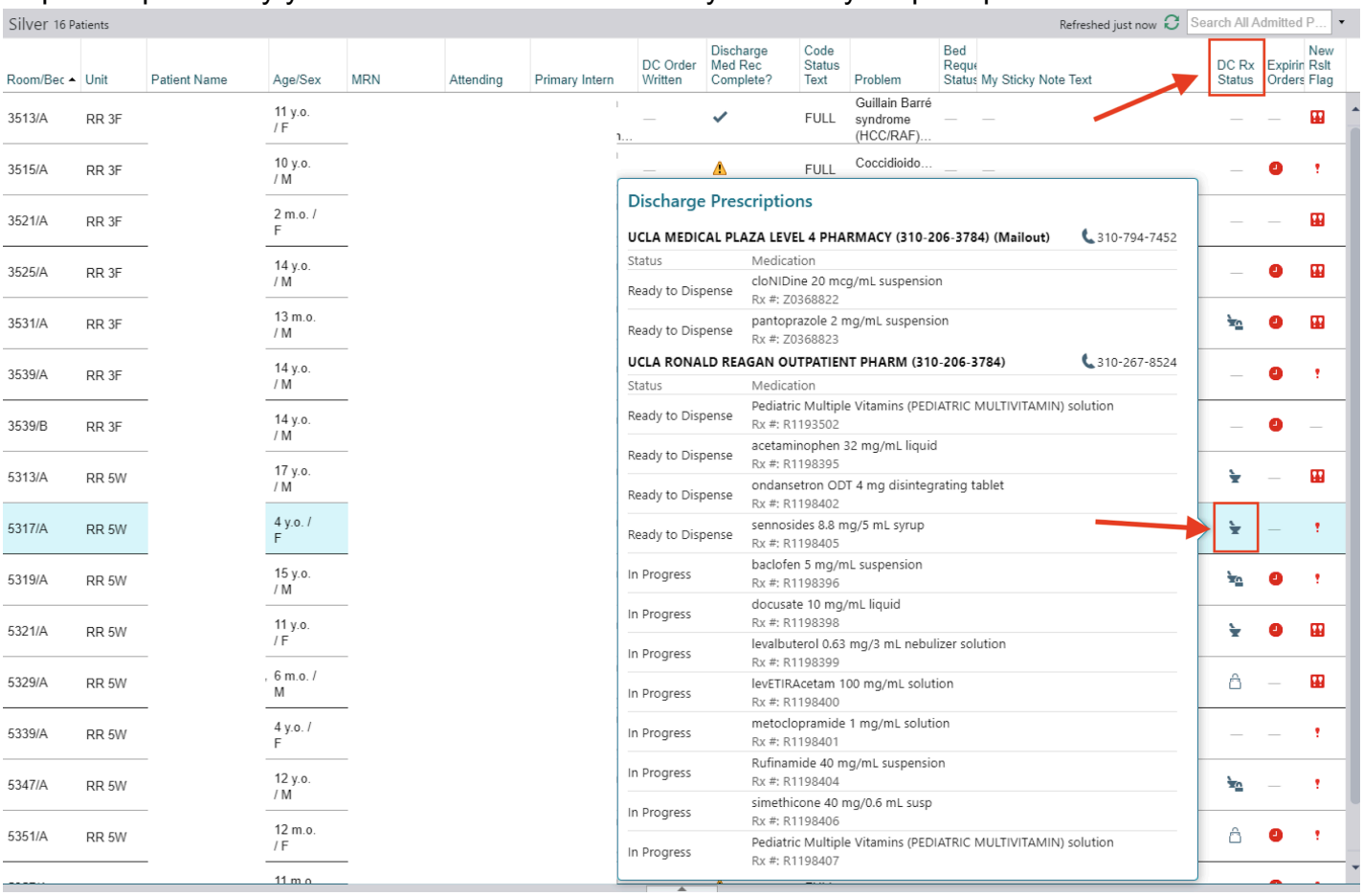
<u>If you want to change the pharmacy the meds are sent to, but already signed the discharge meds:</u>
Click on the meds and edit them click the pencil icon for each med you want re-routed then close the window (you don't actually have to make any changes to meds). This makes the system think the med has been changed and a new script needs to be sent. Then re-sign the discharge med orders and it should re-route the meds. You should then contact the previous pharmacy and let them know the meds have been re-routed so they can stop the prescriptions from being sent to the patient's insurance. If you don't do this the medications can be denied by insurance at the new pharmacy since it looks like they have already been filled.

To ensure you sent the medications to the right pharmacy you can choose “preview AVS” from the discharge tab and it will list the medications and the pharmacy they have been sent to.

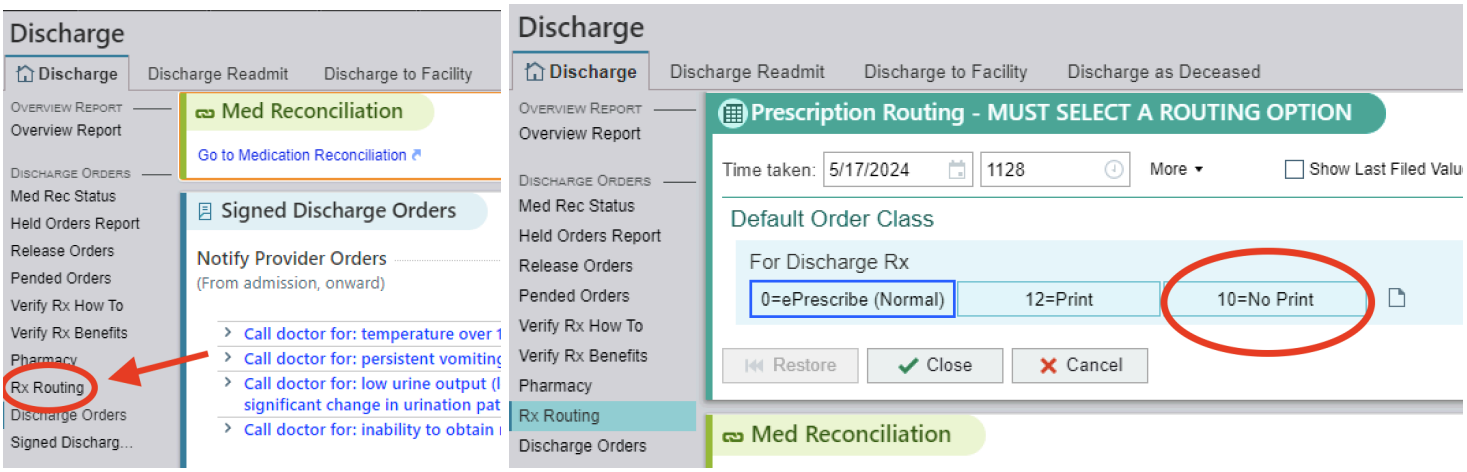




Also helpful: Have the “DC Rx Status” as a column on your patient list. If the medications are sent to our outpatient pharmacy you can see whether or not they are ready for pickup.



If a patient is being transferred to an outside facility and you don't want to send their medications to a pharmacy, you can choose the "no print" option. This will allow their medication list to be printed, but no meds will be routed to a pharmacy when you sign the discharge med orders.



Discharge Medication Overview

This document describes the discharge medication workflow and provides tips and best practices to help patients receive their medications on time.

For questions call the UCLA RONALD REAGAON OUTPATIENT PHARMACY (RR) prescriber line at **78531**.
For time sensitive questions call the Meds-to-Beds/Discharge pharmacist at **79990**.

Workflow

Provider orders discharge medication(s) in CareConnect

- Select med with house icon
- Choose/confirm UCLA RONALD REAGAN OUTPATIENT PHARMACY

UCLA RONALD REAGAN OUTPATIENT PHARMACY receives prescription

Runs eligibility claim with insurance. Notified immediately if Prior Authorization (PA) required. If PA is required:

- Pharmacy staff submit PA documentation to the insurance company.
- Pharmacy staff notify provider and send MyChart message to patient.

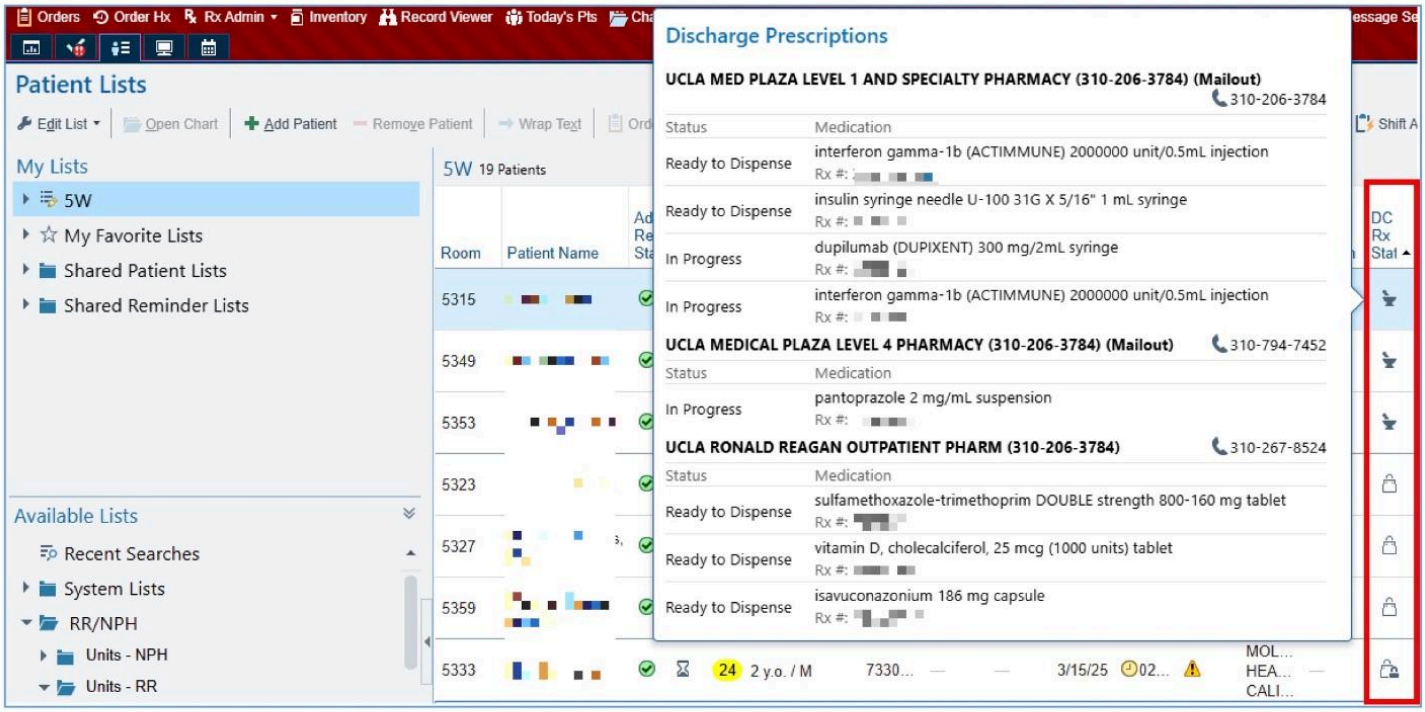
Check to make sure they have the medication in stock. If medication out of stock:

- Pharmacy staff order medication.
- Pharmacy staff notify provider and send MyChart message to patient.

If no PA required, and medication in stock, pharmacy fill prescription. DC Rx Status updates in CareConnect

Viewing Prescription Fill Status in CareConnect

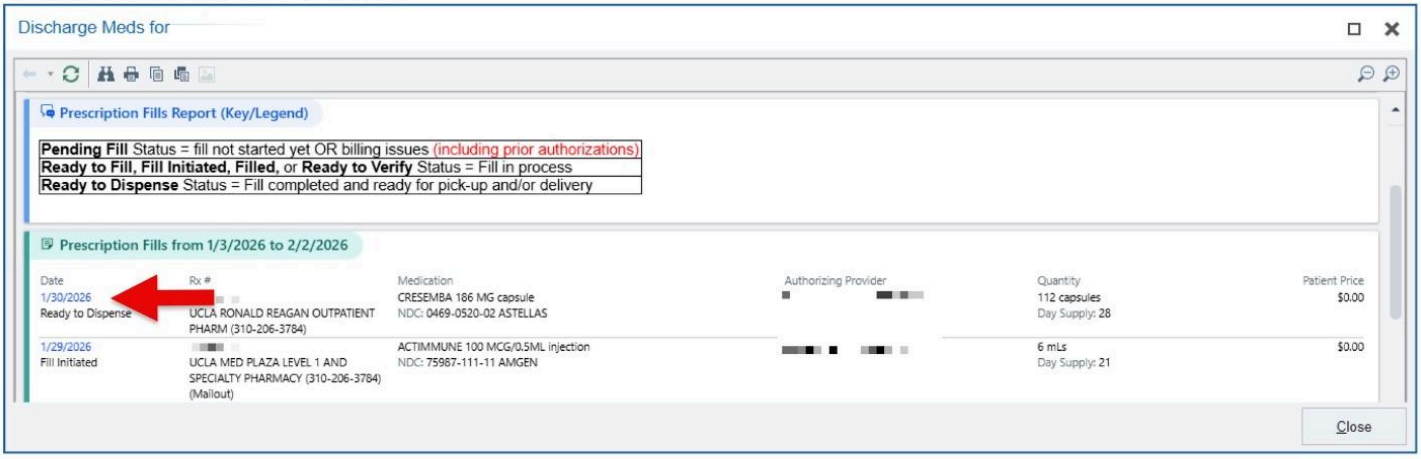
Use the **DC Rx Status** column in Patient Lists to view fill status, cost, and the receiving pharmacy. Hover over the icon for details, or double-click the icon to open a report with additional information, including prior authorization (PA) status.

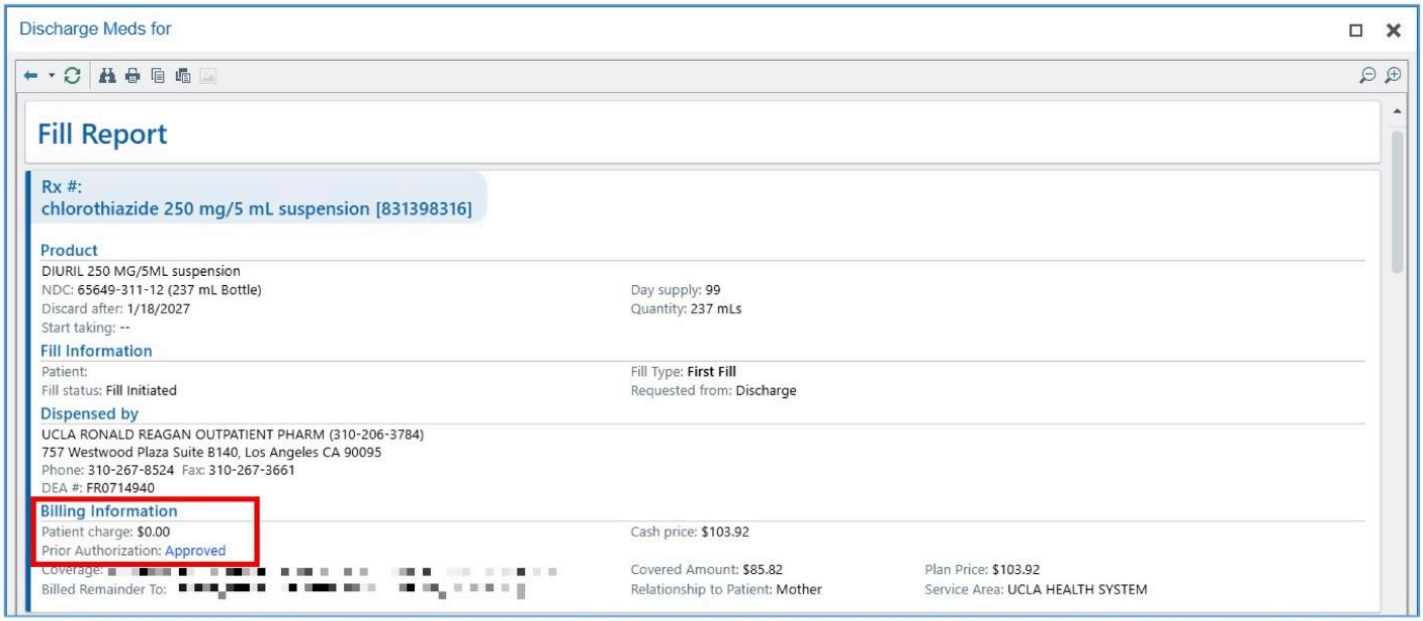


Icon meanings:

- (🫙) Mortar and pestle — Fill in progress
- (👜) Carry bag — Ready for pickup
- Checkmark — Filled and picked up
- Lock icon — Controlled medications present

Double-click the icon to open Discharge Meds report.
Click the date to see the PA status.

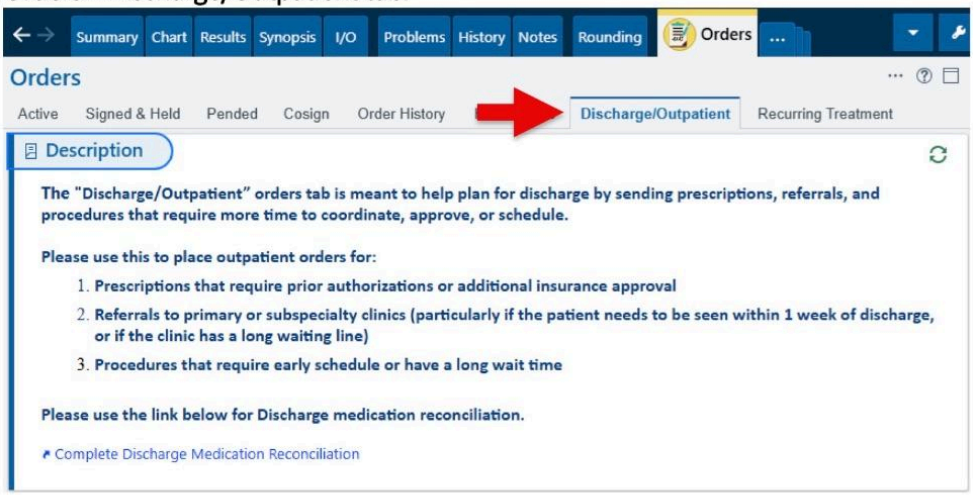




Best Practices

- Send new prescriptions at least **2 days before** the expected discharge date to RR pharmacy.
- Send previous (not-new) prescriptions to the patient's preferred pharmacy, or RR pharmacy if none is listed.
- Hazardous compounds (e.g., tacrolimus suspension) must be routed to **Walgreens Specialty Pharmacy** at 1399 S Roxbury Dr #200, Los Angeles, CA 90035.
- For urgent issues on discharge day, call the Meds-to-Beds pharmacist at **79990**.
- PA-required medications (e.g., **Neulasta**, **Cresemba**) often cause delays—send prescription as early as possible.
- The day before discharge, call the RR prescriber line (**78531**) to check prescription status. You may also call the Meds-to-Beds/Discharge pharmacist (**79990**) for help troubleshooting.
- Use the Discharge/Outpatient orders tab to order prescriptions that require PA.

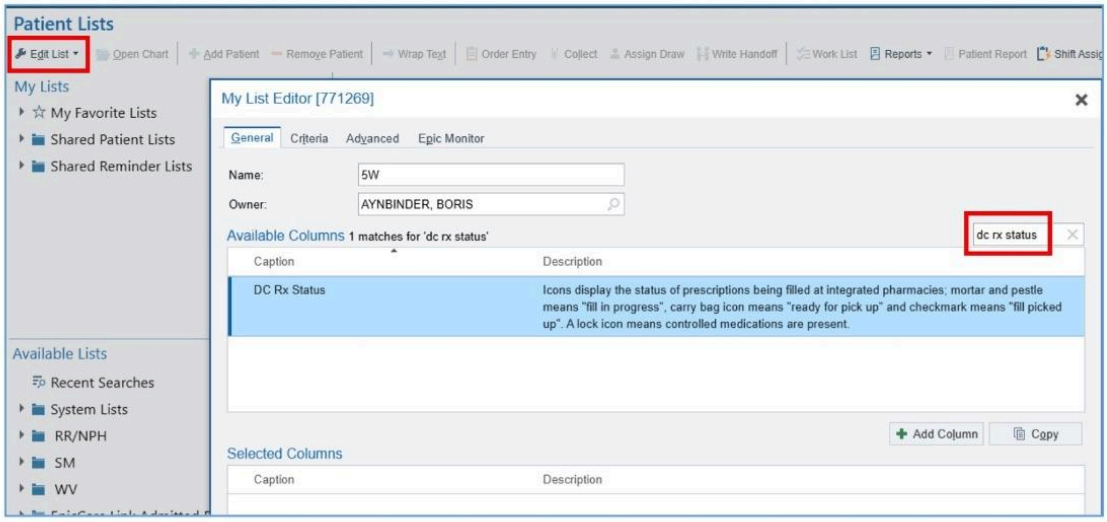
Orders > Discharge/Outpatient tab.



Tips

- PA status can be viewed in the Discharge meds report.

- Typical turnaround time for urgent prior authorizations is **24 business hours**.
- Usual turnaround time for medications that need to be ordered is **24 hours Monday–Thursday**. Friday orders are recevied on Monday.
- The RR pharmacists can internally transfer any prescriptions (e.g. compounded Pharm Tech lab (PTL) items to Med Plaza Level 4 or specialty prescriptions to Med Plaza Level 1. *Exception*: **Tacrolimus suspension and other hazardous compounds** must be sent directly to Walgreens Specialty on Roxbury.
- The RR staff will notify the RN/CSW for any insurance or funding issues.
- Add the **DC Rx Status** column to your patient lists.



Six locations

- CHS Pharmacy
- Specialty Pharmacy
- 200 Medical Plaza Pharmacy, 4th floor
- Santa Monica 16th Street Pharmacy
- Ronald Reagan UCLA Medical Center Outpatient Pharmacy
- West Valley Outpatient Pharmacy (*Opening April 2026*)

More About UCLA pharmacies

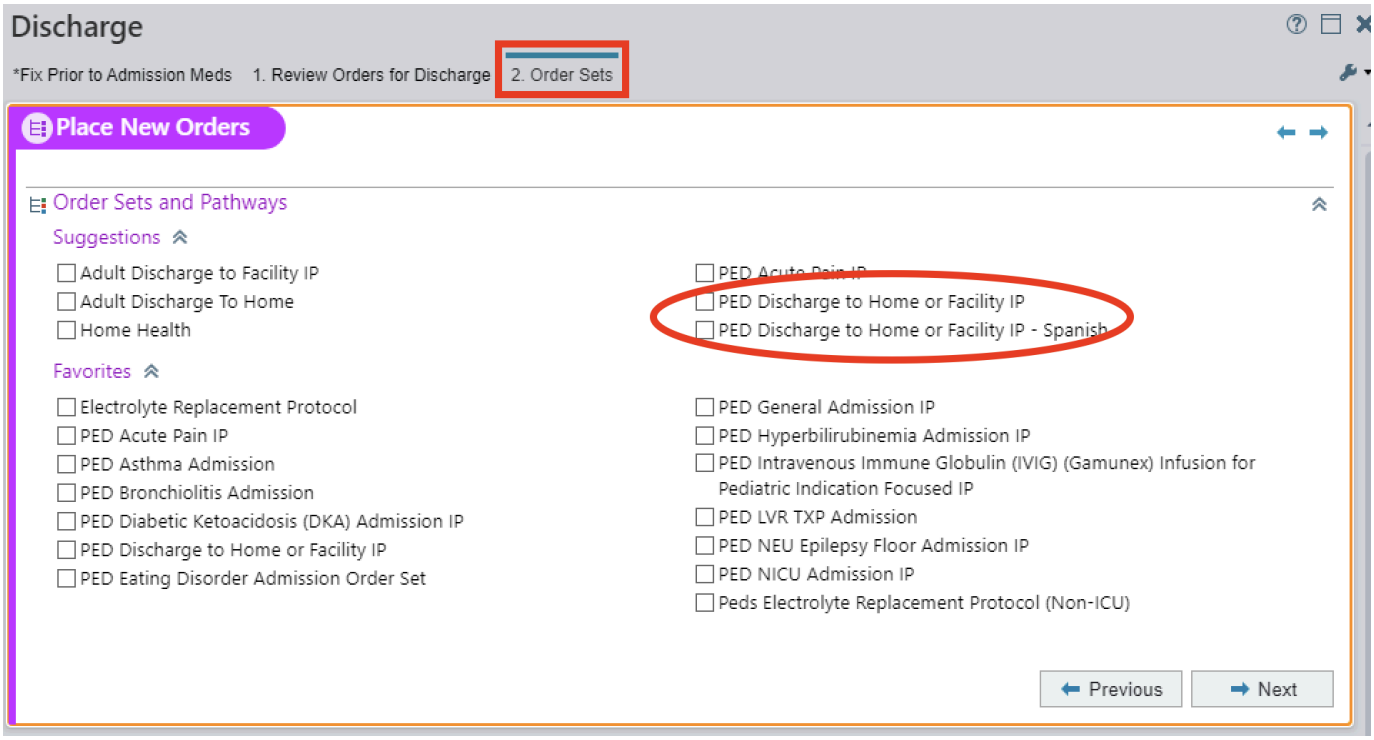
Prior Authorization

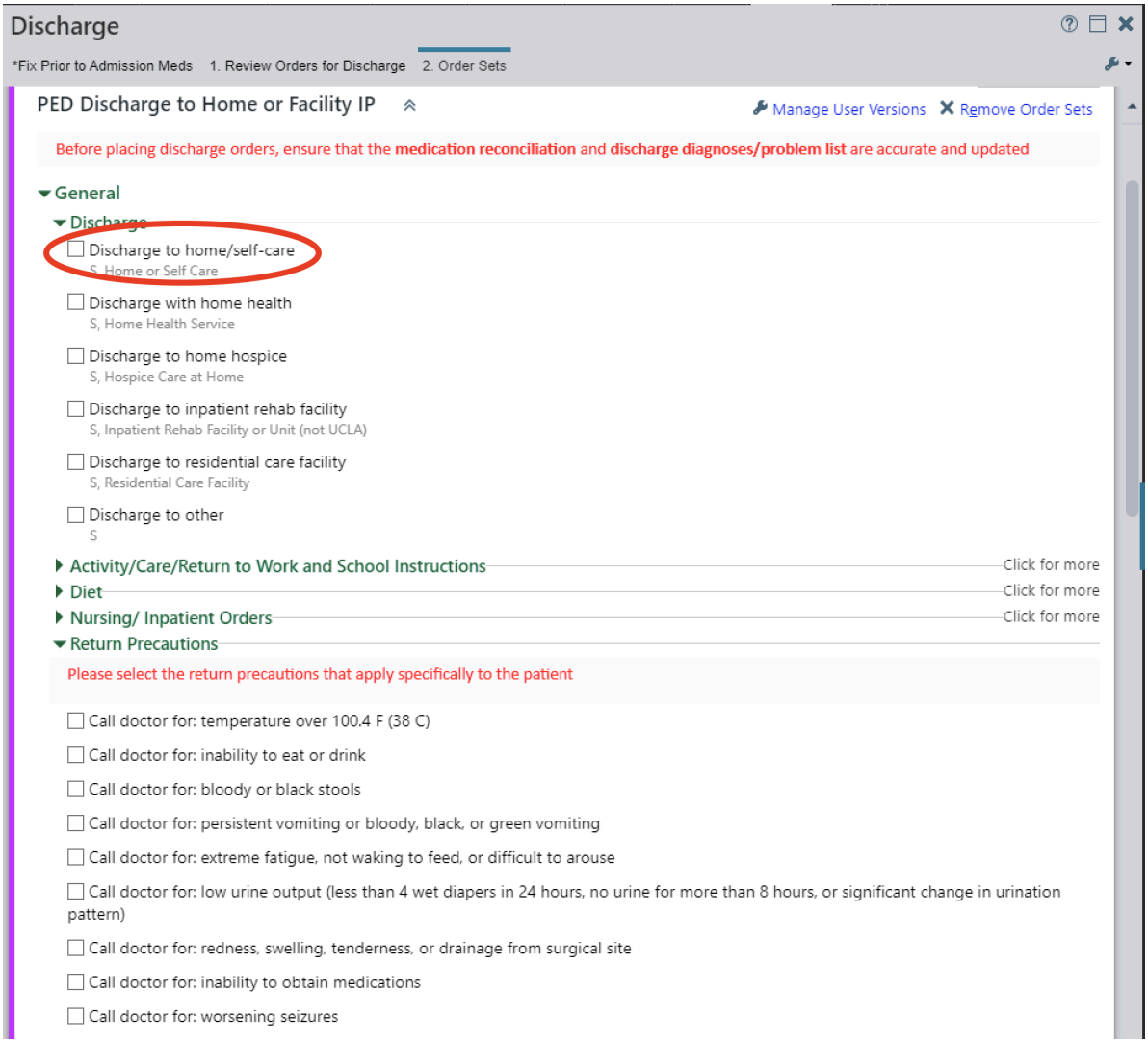
Prior authorization (PA) is when your health insurance requires additional documentation before they will pay for a prescription. It's essentially the insurer asking: "Is this medication really necessary, and does it meet our coverage criteria?"

Common reasons a medication requires PA:

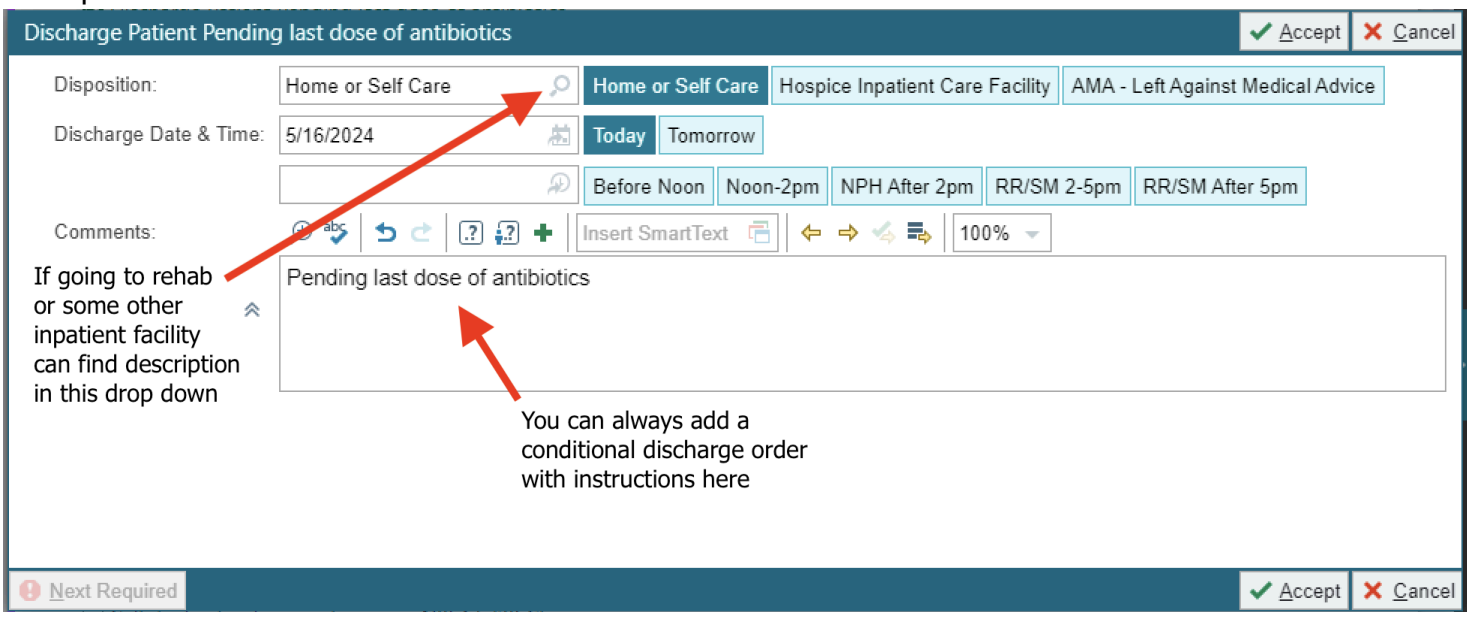
- High cost
- Brand-name ordered when a lower-cost generic is available
- Safety risks
- Commonly mis prescribed

Find the discharge order set by clicking the order set tab or searching “ped discharge” in the DC orders. This is where you will find the actual “discharge to home” order along with patient return precautions and the order for follow up appointments.

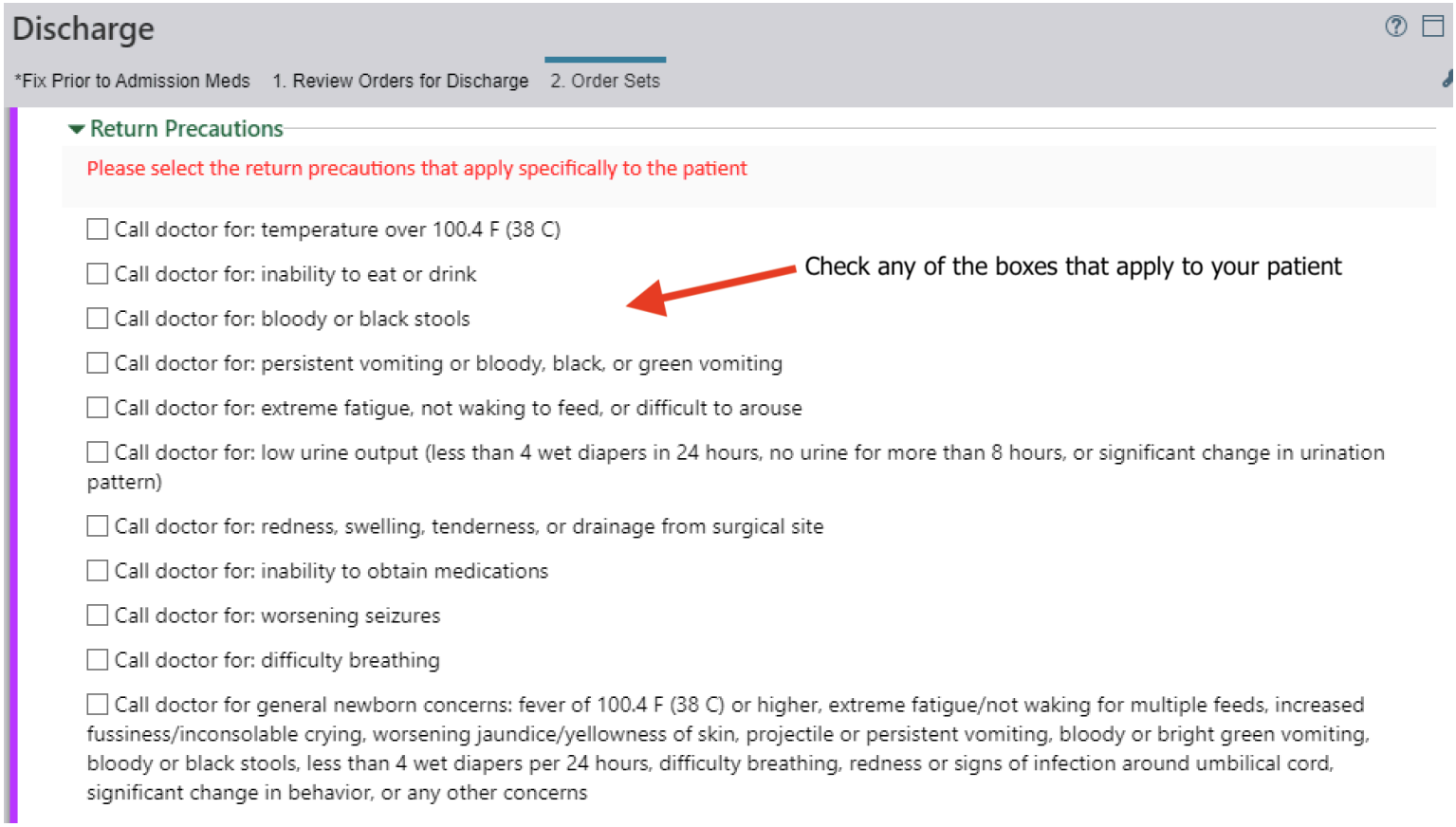




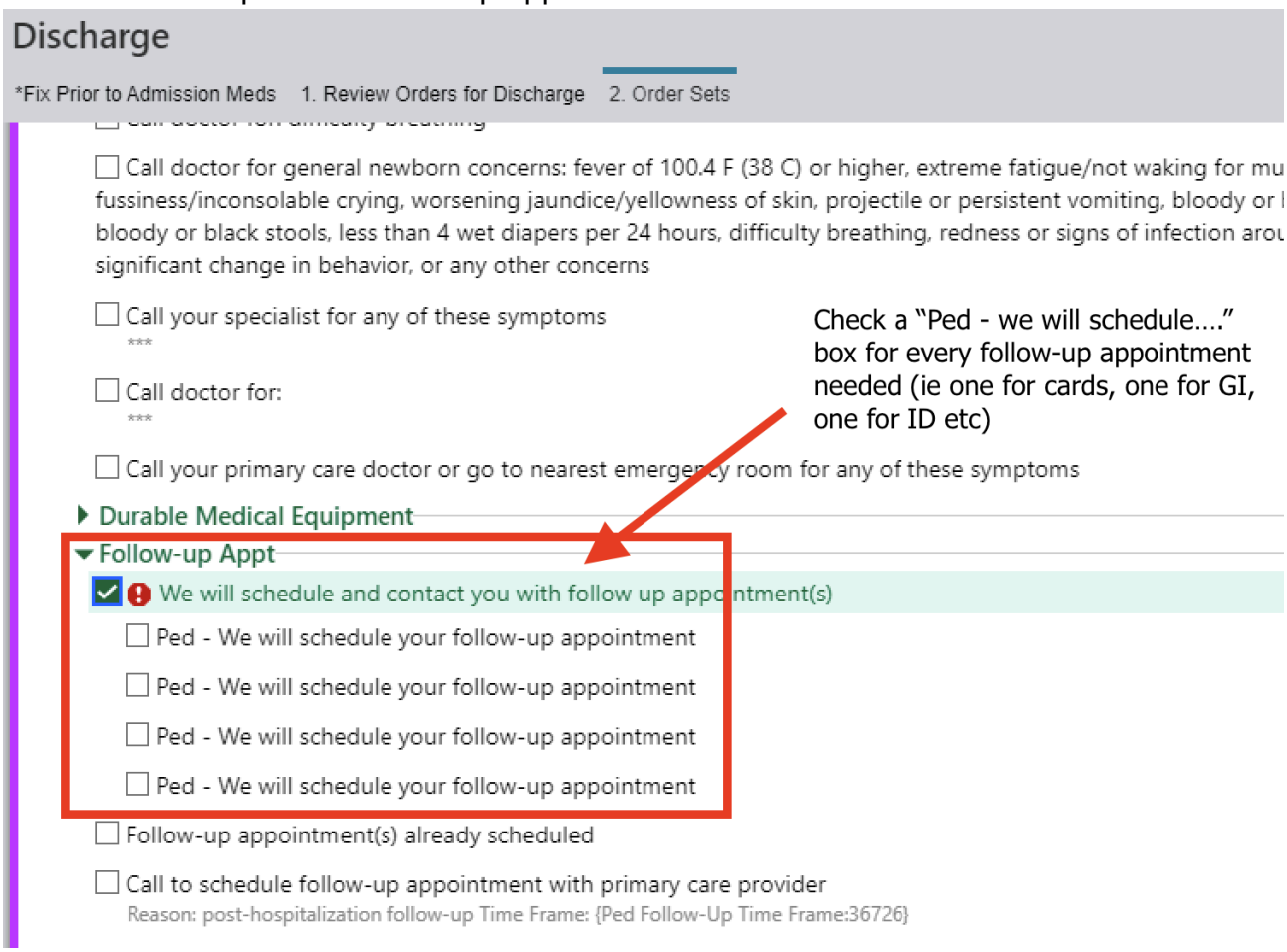
In the discharge to home order you can write instructions to make it a conditional discharge, if applicable. Example below.



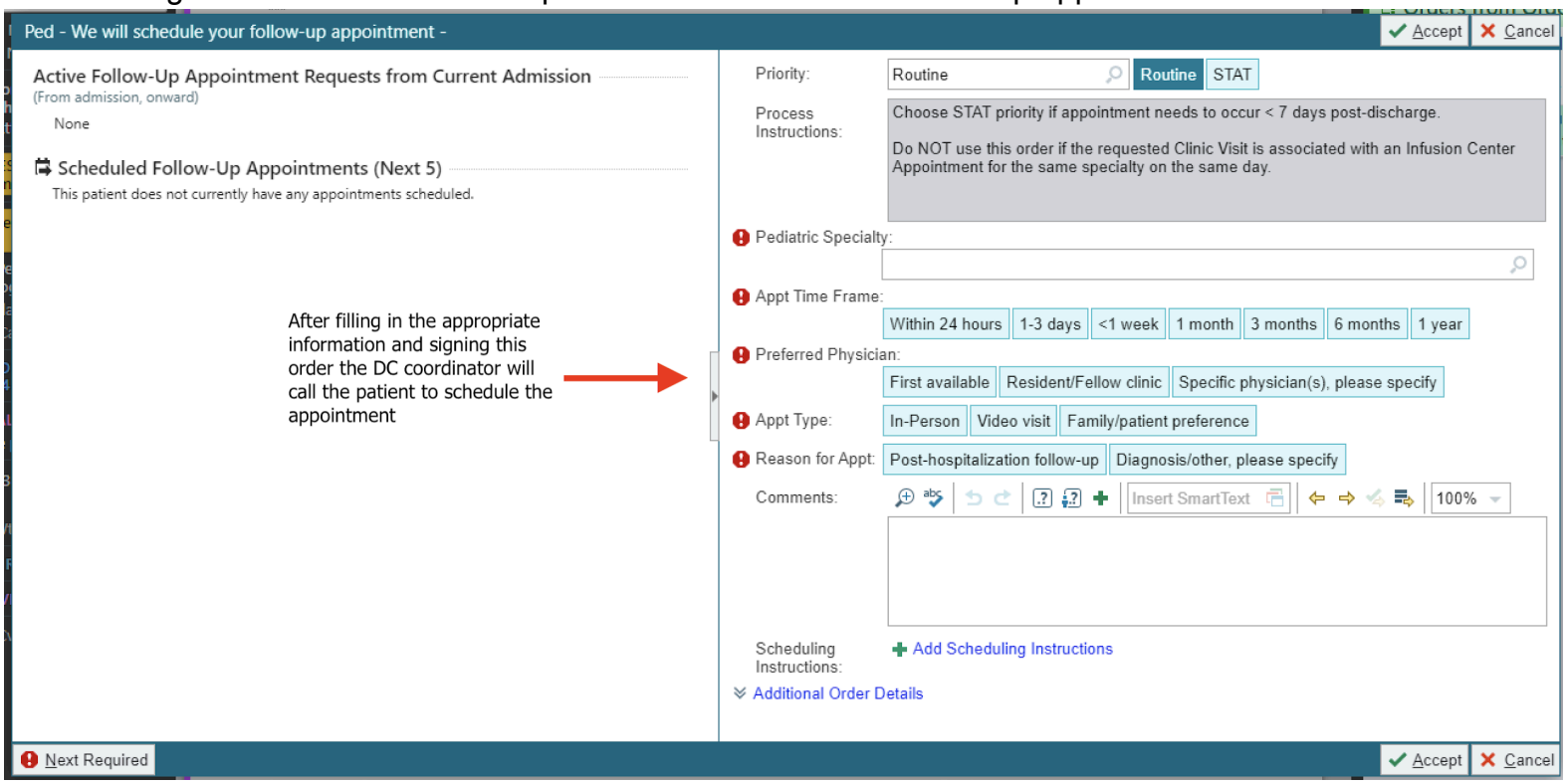
The return precautions you choose will show up on the patient's AVS



To schedule a patient a follow up appointment:



The discharge coordinator will call the patient to schedule these follow up appointments



Does your patient qualify for the Medical Home Program at UCLA?

ENROLLMENT ELIGIBILITY CRITERIA

- Willingness to transfer primary care to UCLA Children's Health Center (200 Med Plaza)
- Medi-Cal insurance accepted at UCLA Children's Health Center for primary care
- Condition for which patient receives CCS
- At least one other chronic condition requiring subspecialty services
- If heme/onc patient: off chemo at least 6 months
- If transplant patient: post-transplant at least 12 months
-

HOW TO REFER A PATIENT TO MEDICAL HOME PROGRAM

- Send email *(pedsmedicalhome@mednet.ucla.edu)* or CareConnect Staff *message (Peds Medical Home Pool)* with pt name/MRN and diagnoses
- Please note that until the patient is enrolled by us in clinic, we can't do care coordination (i.e. we can't do discharge planning)

If your patient is already enrolled in the Medical Home

WHEN A MEDICAL HOME PATIENT IS ADMITTED

- Anyone from inpatient team contact Siem by e-mail, Careconnect staff message, or phone
- Agree on plan for further communication during hospitalization and how we can help

WHEN A MEDICAL HOME PATIENT IS READY FOR DISCHARGE (24-48 HOURS PRIOR)

- Brief handoff - hospital course, status changes, pending issues, follow-up plan

MEDICAL HOME CONTACT INFO

Office Phone: 310-825-0867 ext 171924

Program E-mail: pedsmedicalhome@mednet.ucla.edu

Program Website: www.uclahealth.org/medicalhome

Program Clinical Structure: **Attendings** (Anderson, Lee, Lerner, Peralta, Yazdani), **PCC Residents**

Nurse Practitioner (Siem Ia), **Family Coordinators** (Danika Pineda, Ana Morales, Mitzya Duran, Vanessa Alvarado)

All patients are assigned to a primary Medical Home Attending and primary Medical Home Family Coordinator

Medical Director
Carlos Lerner, M.D., M.Phil.

Medical Home Attending Doctors
Martin Anderson, M.D., M.P.H.
James Lee, M.D.
Jennifer Peralta, M.D.
Shahram Yazdani, M.D.

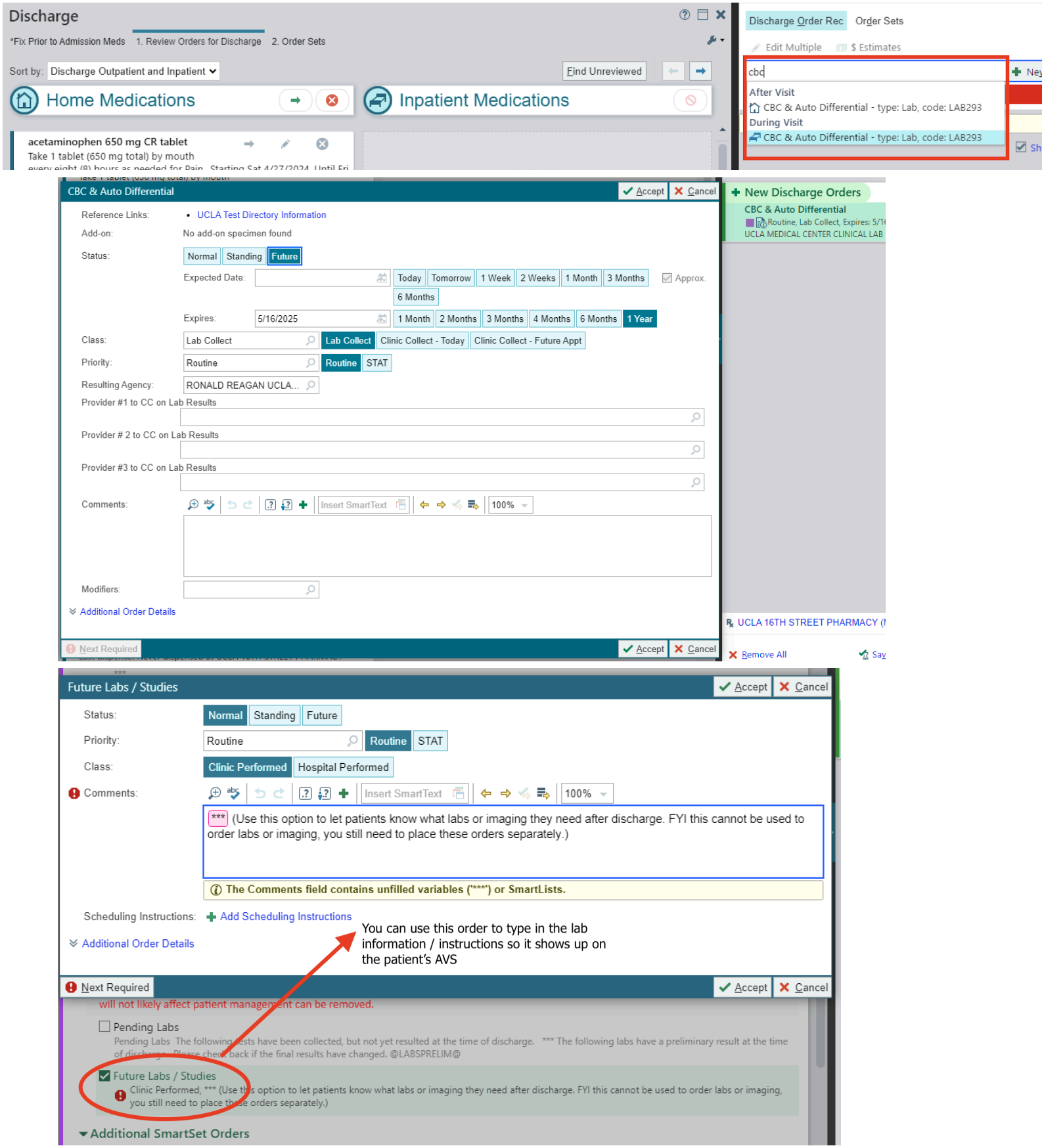
Nurse Practitioner
Siem Ia, MS, RN, CPNP-PC

Social Worker
Lilia Castillo, MSW

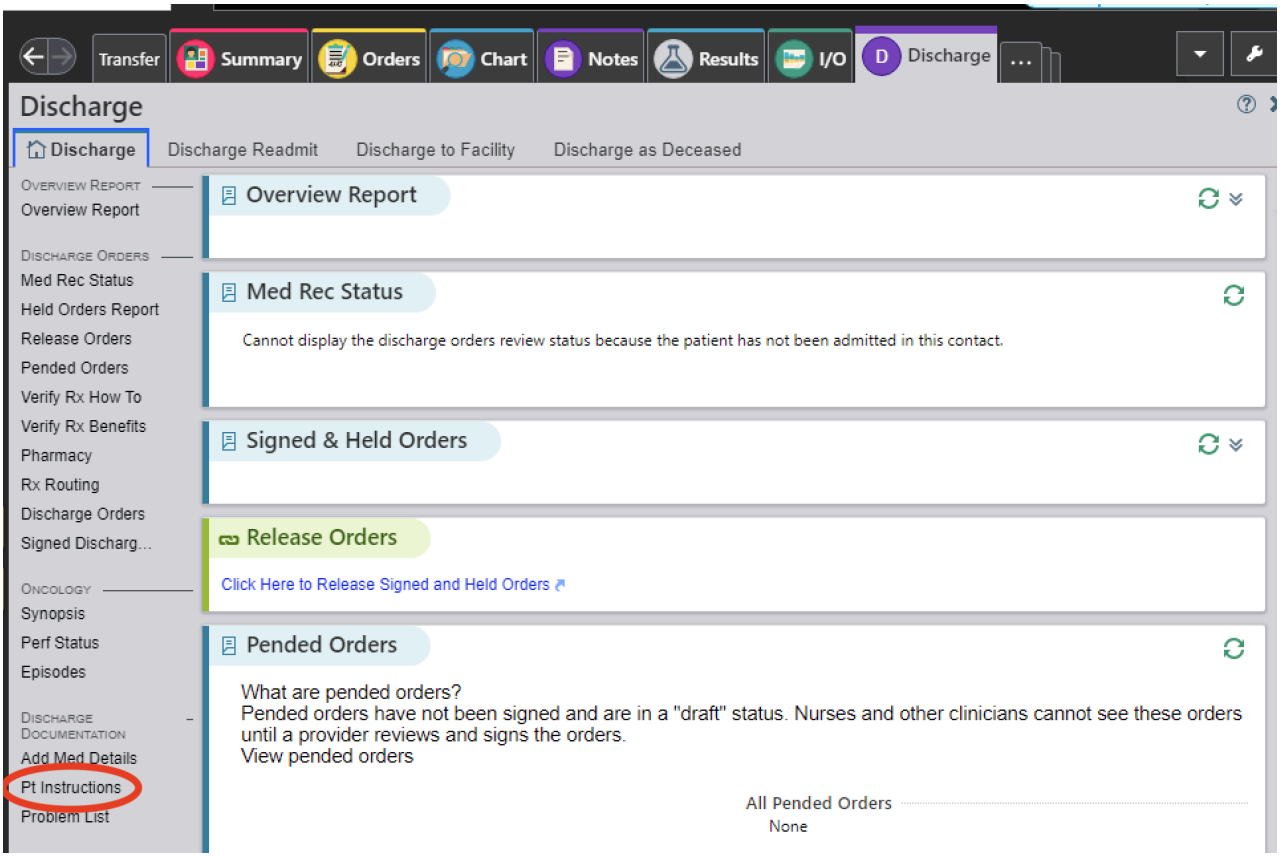
Family Coordinators
Vanessa Alvarado
Mityza Duran
Ana Morales
Danika Pineda

200 Medical Plaza Ste 265, Los Angeles, California 90095-1743
Office: (310) 825-0867 Ext. 171924 • Fax: (310) 267-0261

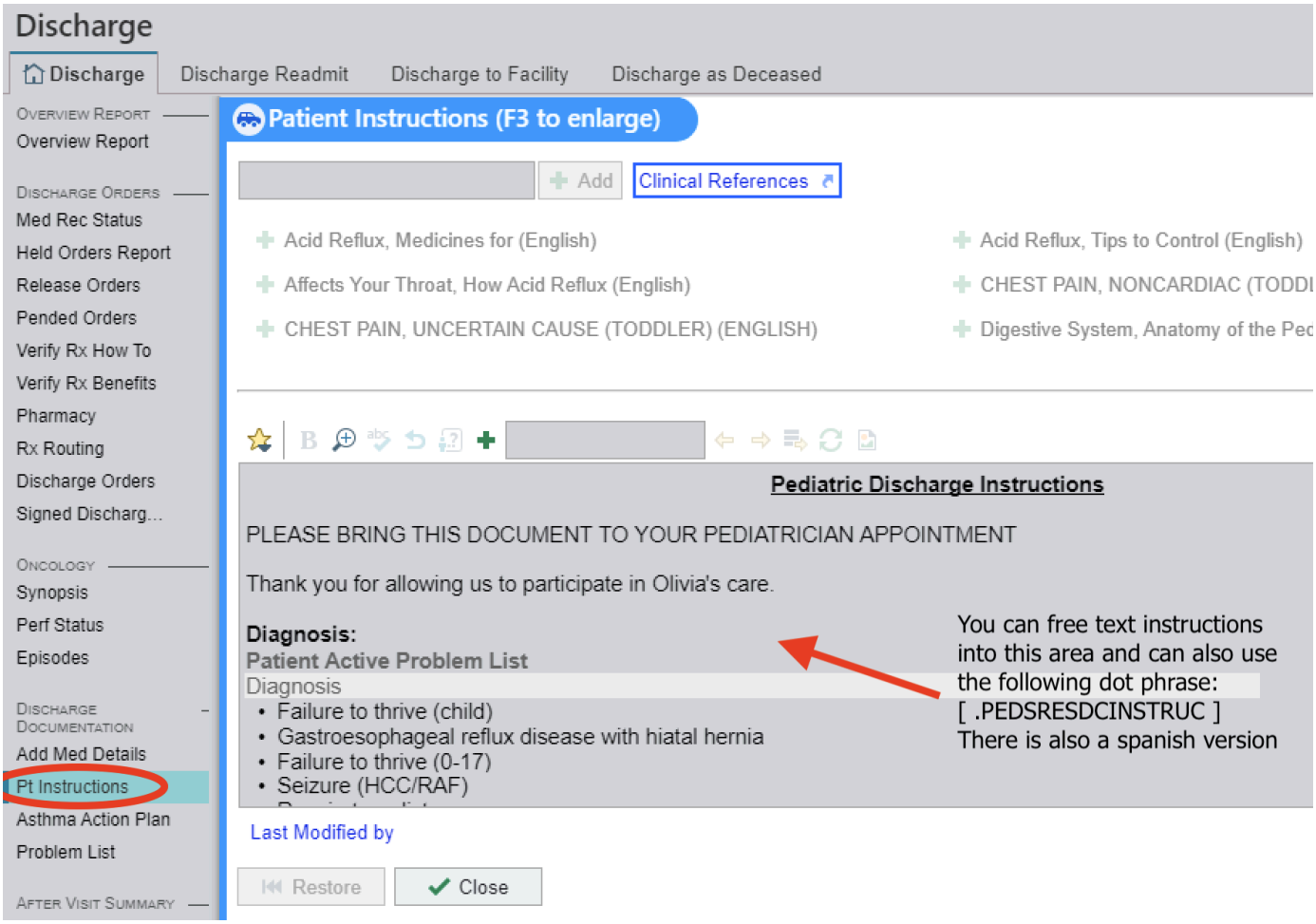
If your patient will be getting outpatient labs after discharge you can order them through the discharge orders tab. An example for a CBC is below. This will allow them to go to any UCLA lab to get them drawn and the lab requisition will already be in the system. You can also order these labs through the home health order set.



Add specific instructions for the patient under the “Pt instructions” tab.



You can add free text instructions and/or use the dot phrase [.pedsresdcinstruc], there is a Spanish version of this dot phrase as well.

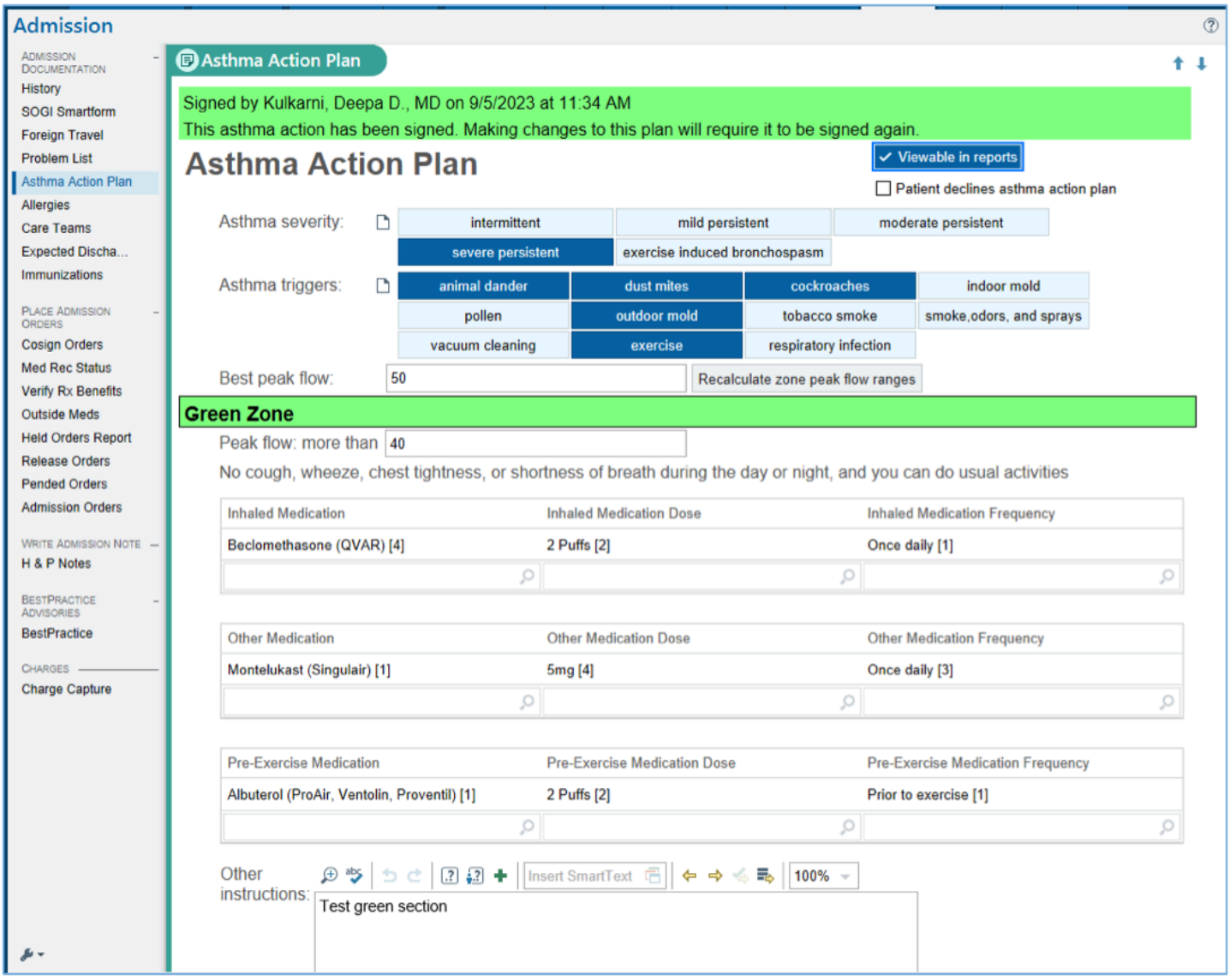

Discharge
Discharge
Discharge Readmit
Discharge to Facility
Discharge as Deceased
Overview Report
Overview Report
Discharge Orders
Med Rec Status
Held Orders Report
Release Orders
Pended Orders
Verify Rx How To
Verify Rx Benefits
Pharmacy
Rx Routing
Discharge Orders
Signed Discharg...
Oncology
Synopsis
Perf Status
Episodes
Discharge Documentation
Add Med Details
Pt Instructions
Asthma Action Plan
Problem List
After Visit Summary
Patient Instructions (F3 to enlarge)
Add
Clinical References
Acid Reflux, Medicines for (English)
Acid Reflux, Tips to Control (English)
Affects Your Throat, How Acid Reflux (English)
CHEST PAIN, NONCARDIAC (TODDI
CHEST PAIN, UNCERTAIN CAUSE (TODDLER) (ENGLISH)
Digestive System, Anatomy of the Pec
Pediatric Discharge Instructions
PLEASE BRING THIS DOCUMENT TO YOUR PEDIATRICIAN APPOINTMENT
Thank you for allowing us to participate in Olivia's care.
Diagnosis:
Patient Active Problem List
Diagnosis
• Failure to thrive (child)
• Gastroesophageal reflux disease with hiatal hernia
• Failure to thrive (0-17)
• Seizure (HCC/RAF)
You can free text instructions into this area and can also use the following dot phrase: [.PEDSRESDCINSTRUC] There is also a spanish version
Last Modified by
Restore
Close

Asthma Action Plan Workflow for Providers

The following Tip Sheet details where and when providers will see the dynamic Asthma Action Plan link in the Admission and Discharge Navigators.

Asthma Action Plan upon Admission

If an existing Asthma Action Plan exists for a patient, providers will see the Asthma Action Plan link in the Admission navigator. Providers should review / update / complete documentation as needed at this time.

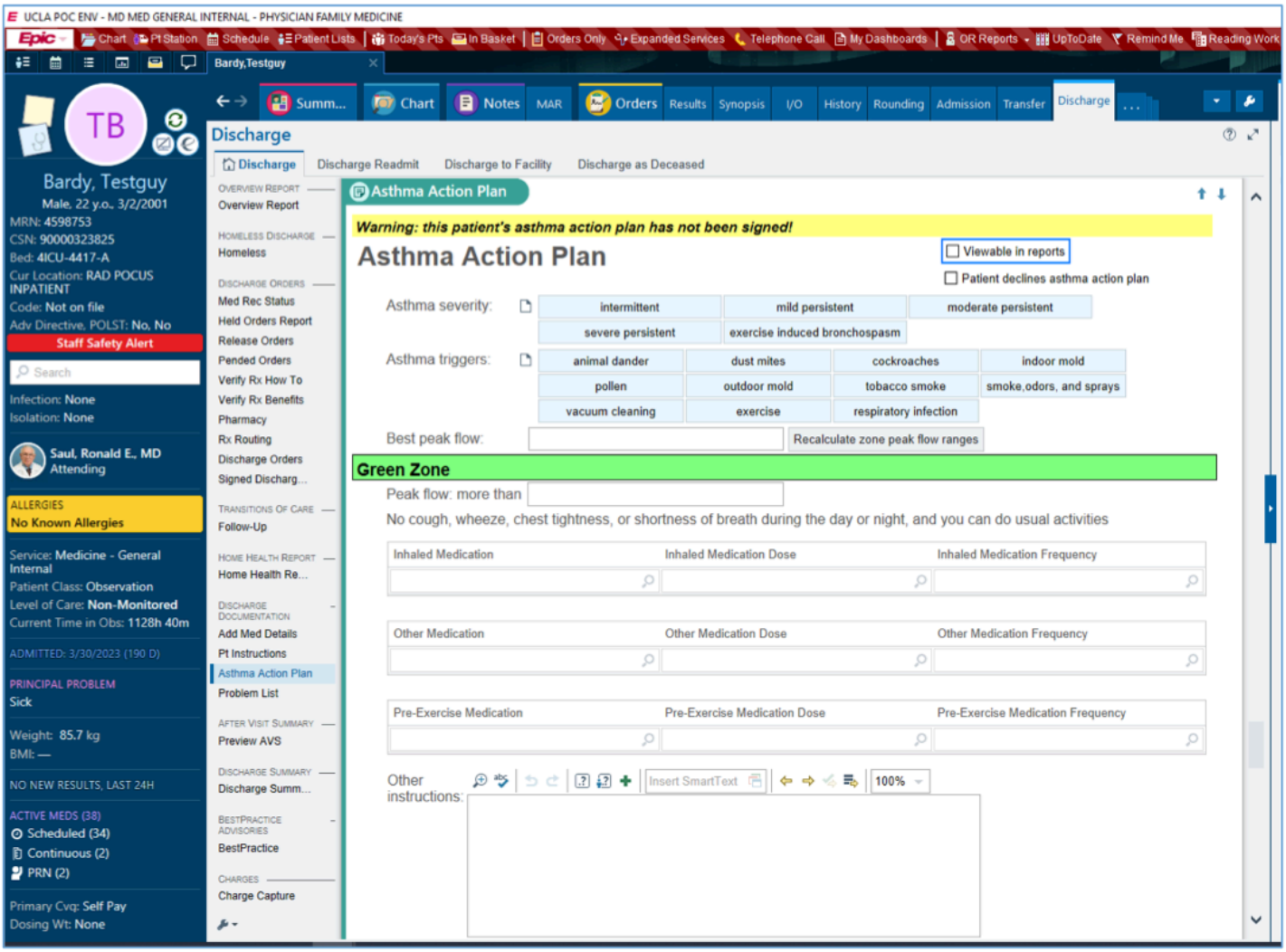


Asthma Action Plan Upon Discharge

The Asthma Action Plan link will also show up in the Discharhe Navigator if certain asthma medications were given during the patient's ED or admission encounter. These medications include: **Albuterol** or **Levalbuterol.**

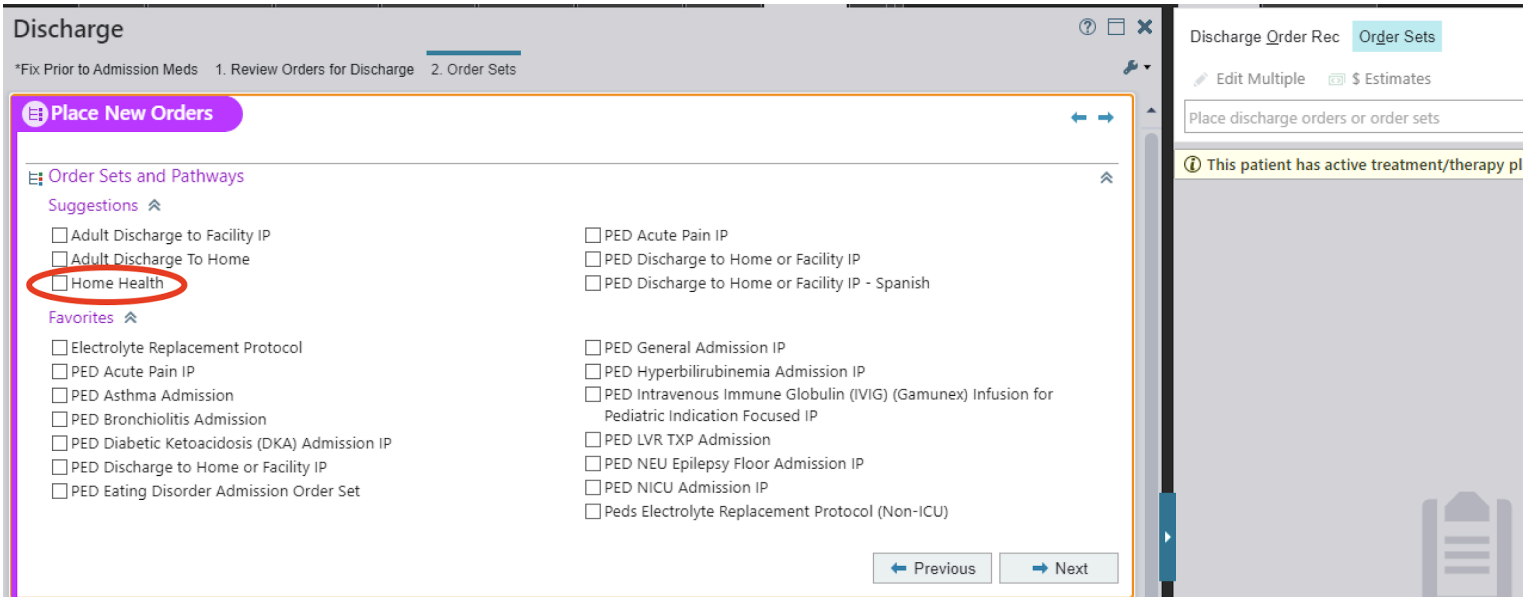
Providers should once again update / complete documentation as needed at this time.

Once signed, the Asthma Action Plan will automatically appear in the After Visit Summary. The updated SmartForm will also be available for review / modification by future providers across encounters.

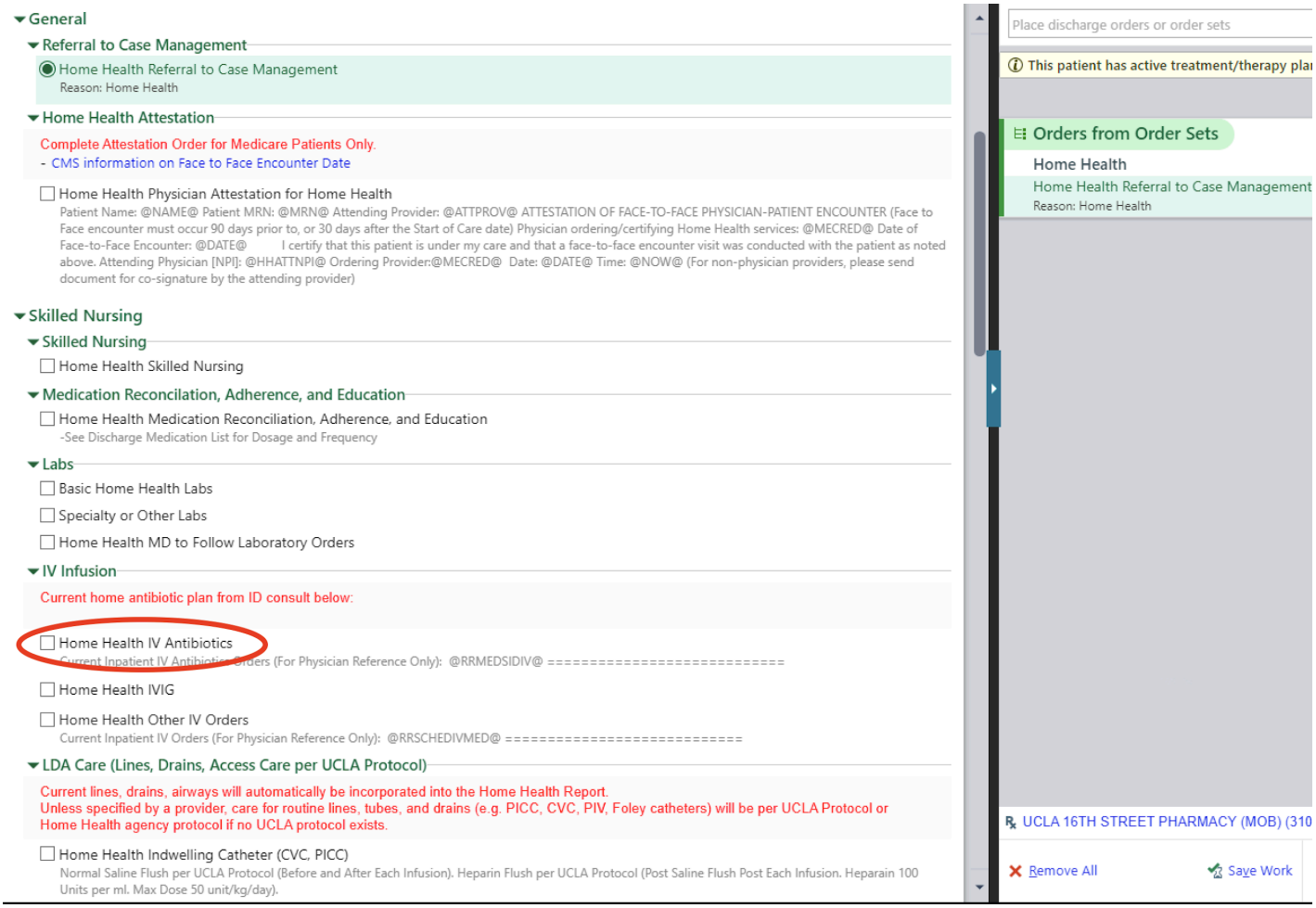


DME and HOME HEALTH orders: If you have a patient admitted that you anticipate will need home health orders / and or DME prior to discharge, order them AS SOON AS POSSIBLE. Often these orders need prior authorization from insurance and if ordered too late this process can hold up discharge.

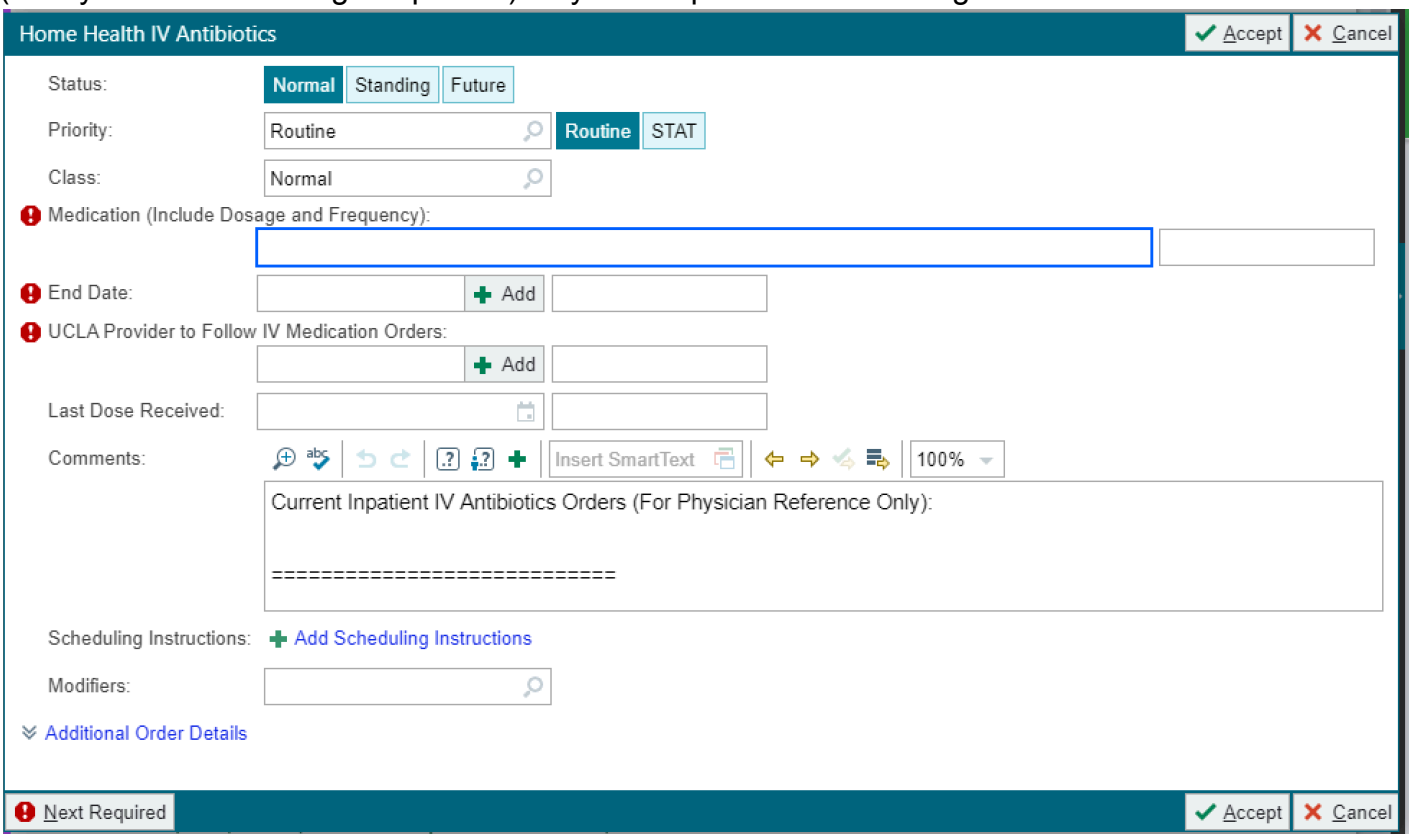
You can find the Home Health order set under the order set tab or by searching in the discharge orders. This is where you will find most of the home health orders for discharge including PICC/CVC line care supplies, GT/NGT supplies, IV antibiotics, formula feeds, TPN, outpatient labs etc. Case managers can also help with these orders and their specifics.



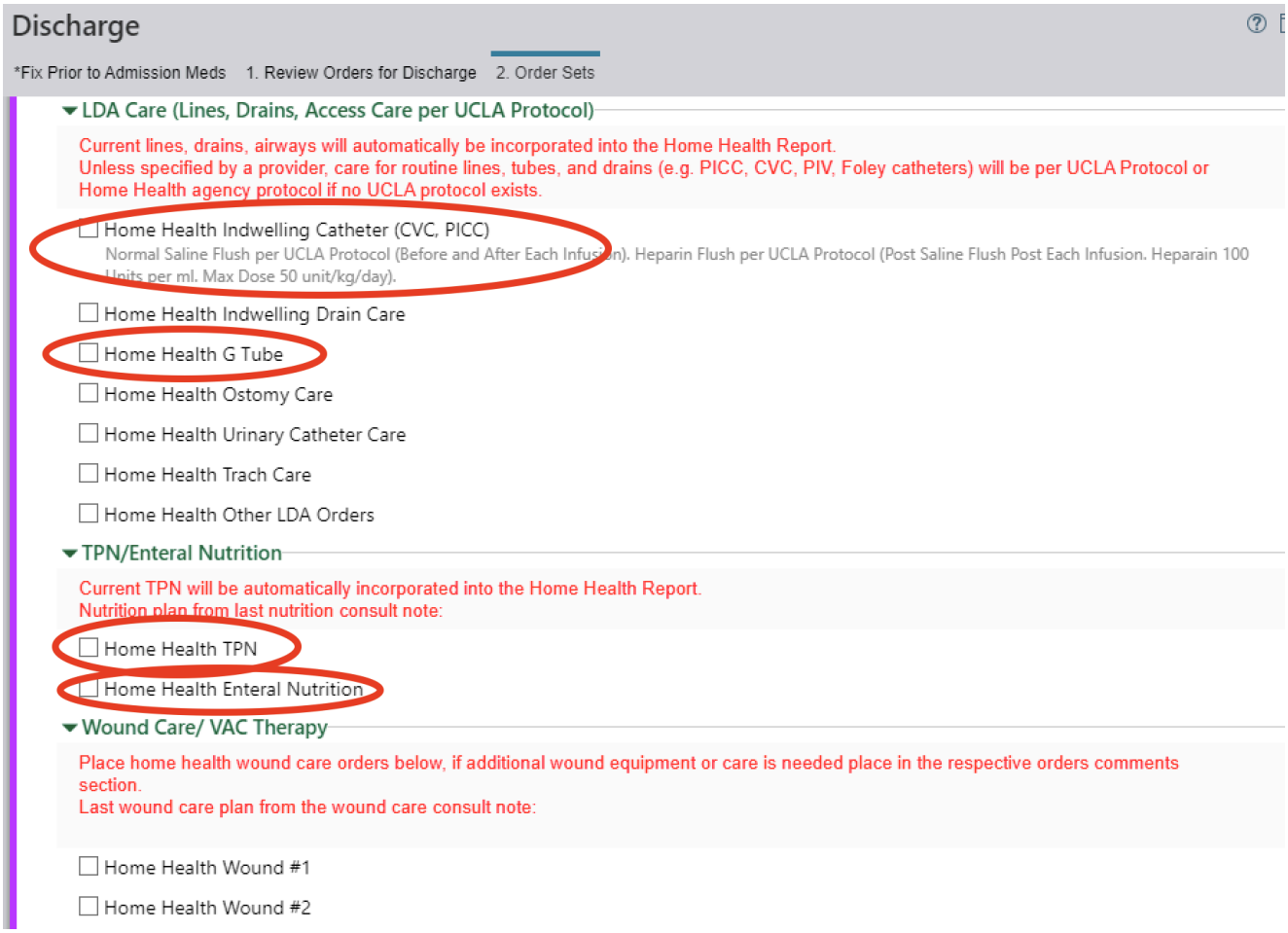
The following are examples of various home health orders



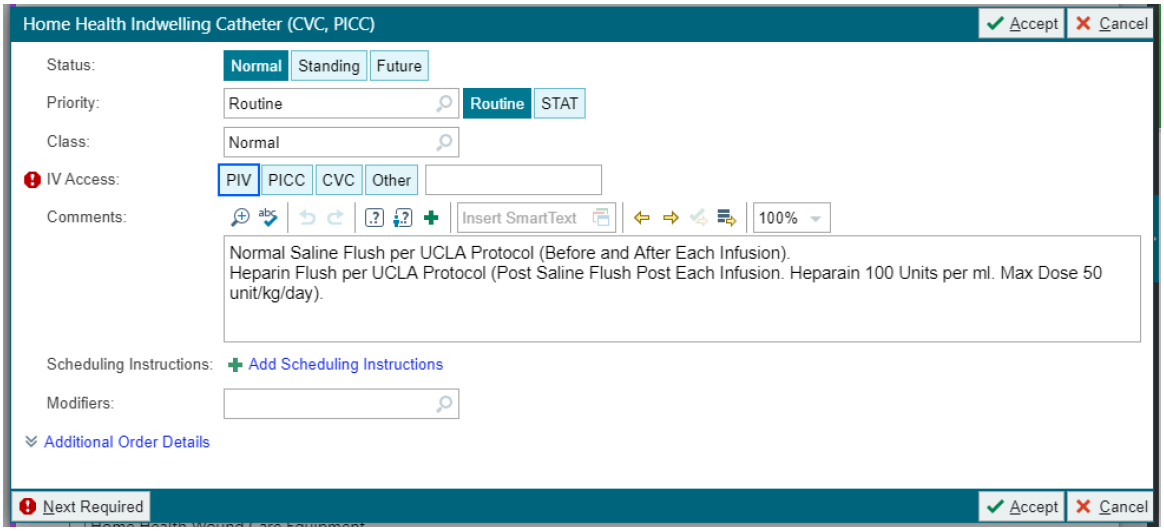
Put in the med dose and frequency and end date. The provider to follow IV antibiotics is typically peds ID (if they've been following the patient) so you can put the ID attending on service.



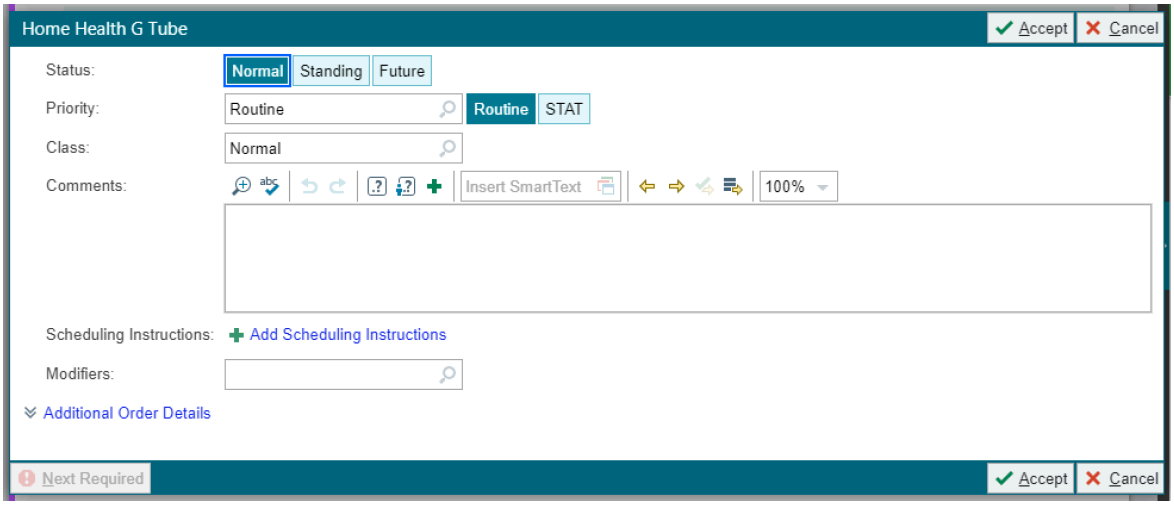
For patients who come in with long term GT, lines etc. Can write "resume home health" in the comments section of the specific home health order.



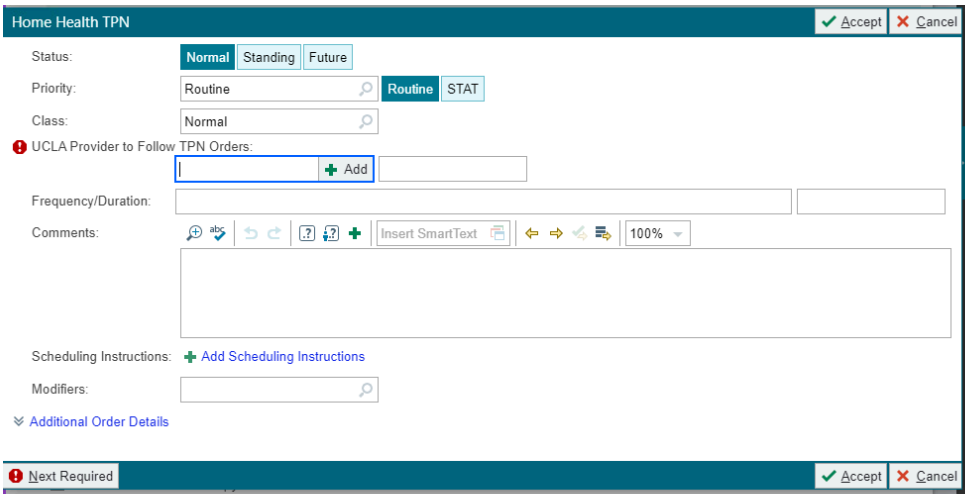
The instructions in the box are auto-populated when you open the order. After choosing the type of line the case manager will reach out to you if they need any more specifics written in the comments.



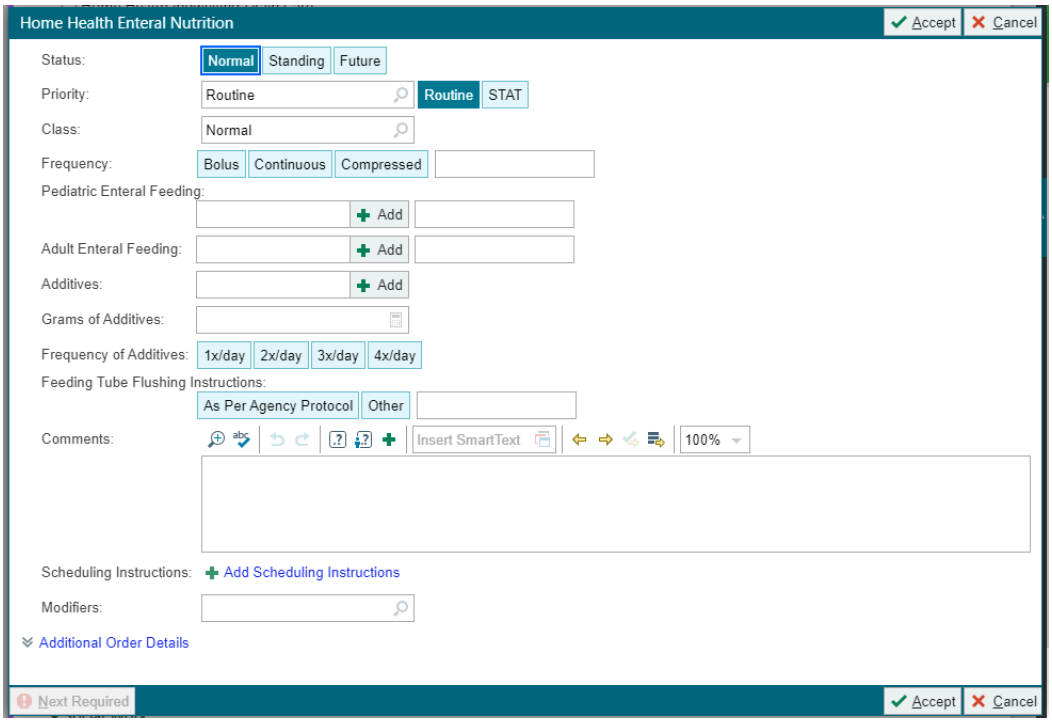
In the comments section of the GT you can add which type of tube it is, french size, etc (this can typically be found in the procedure note from original placement). The case manager can tell you other details like types of flushes and other care items that need to be included in the comments. You can also use resident Young Bo Sim's dot phrase (.ystubesupplies). This dot phrase has a larger text of all the options that residents can copy and paste for DME when needed.



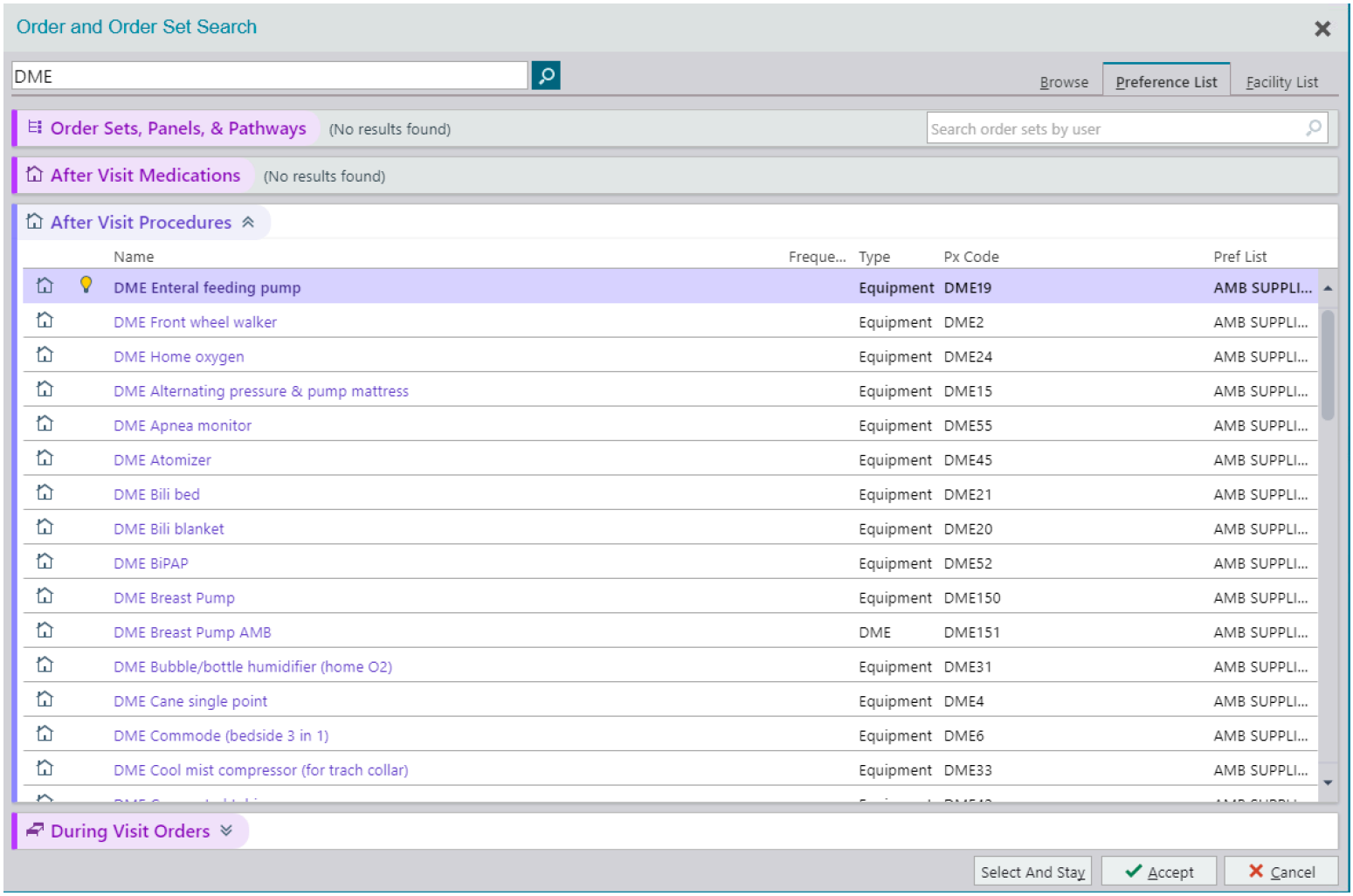
The case manager will be able to see the current inpatient TPN recipe/order, which they can send to the vendor. You can choose the GI attending on service to follow the TPN orders if they will be following up with them outpatient.



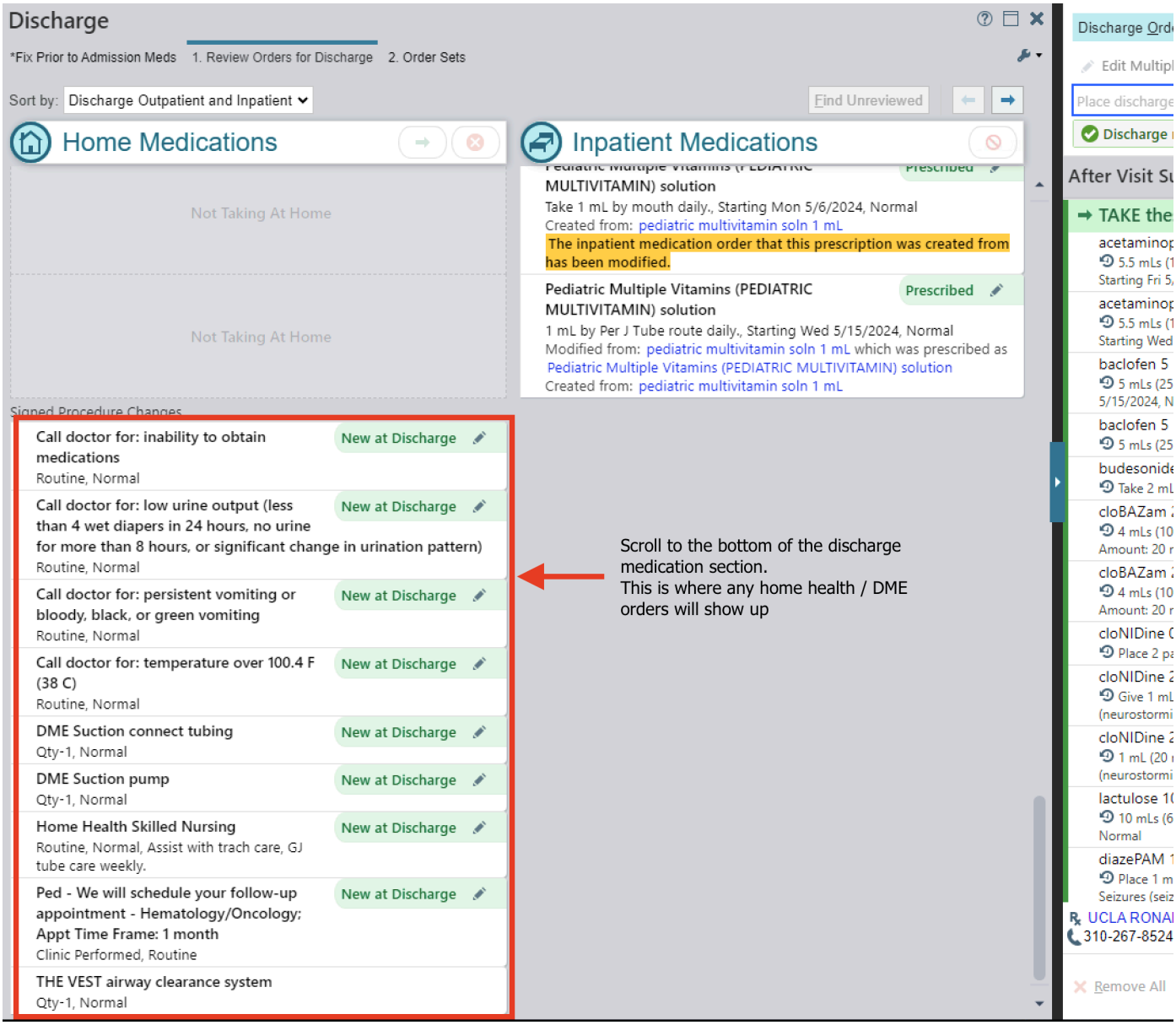
You can copy all the info from the inpatient feeding orders here



For DME items that aren't included in the Home Health order set such as an enteral feeding pump, walkers, wheelchairs, oxygen etc you can search for them in the discharge orders tab. Search "DME" and then the item you are looking for.

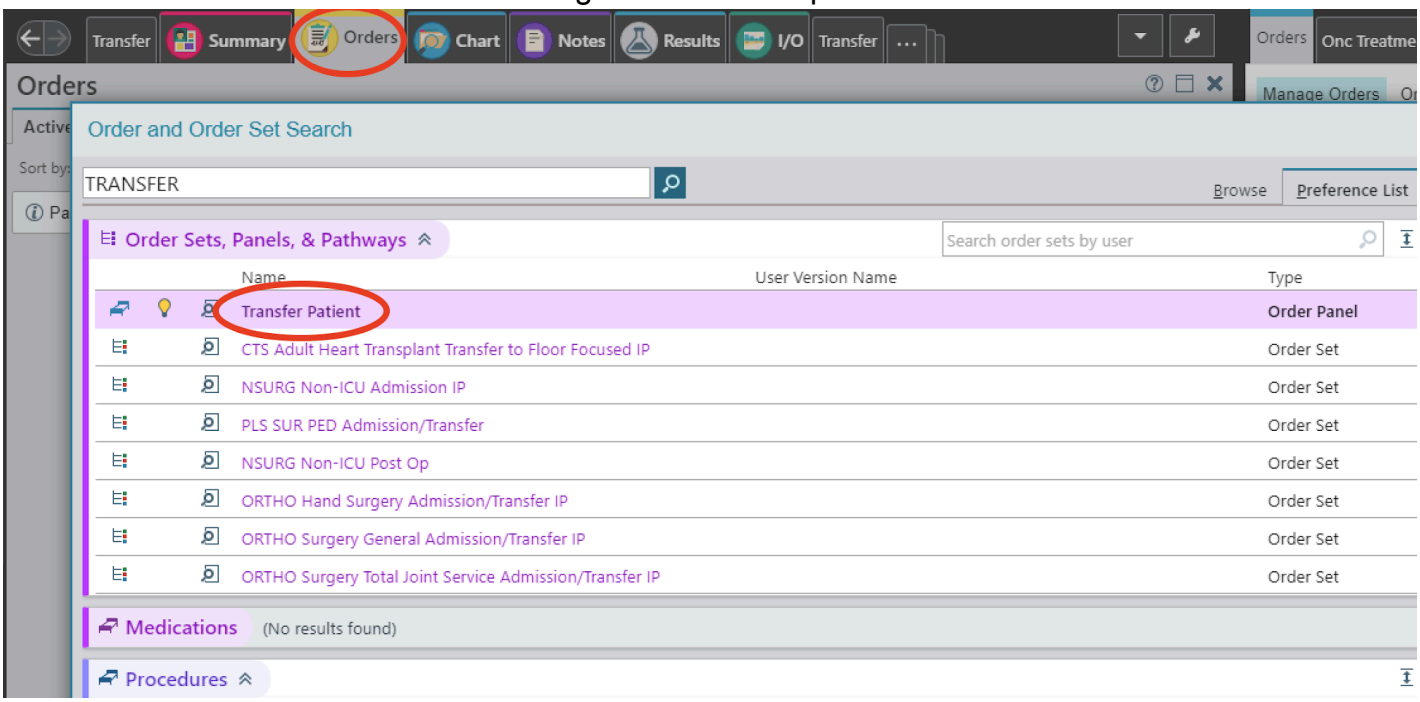


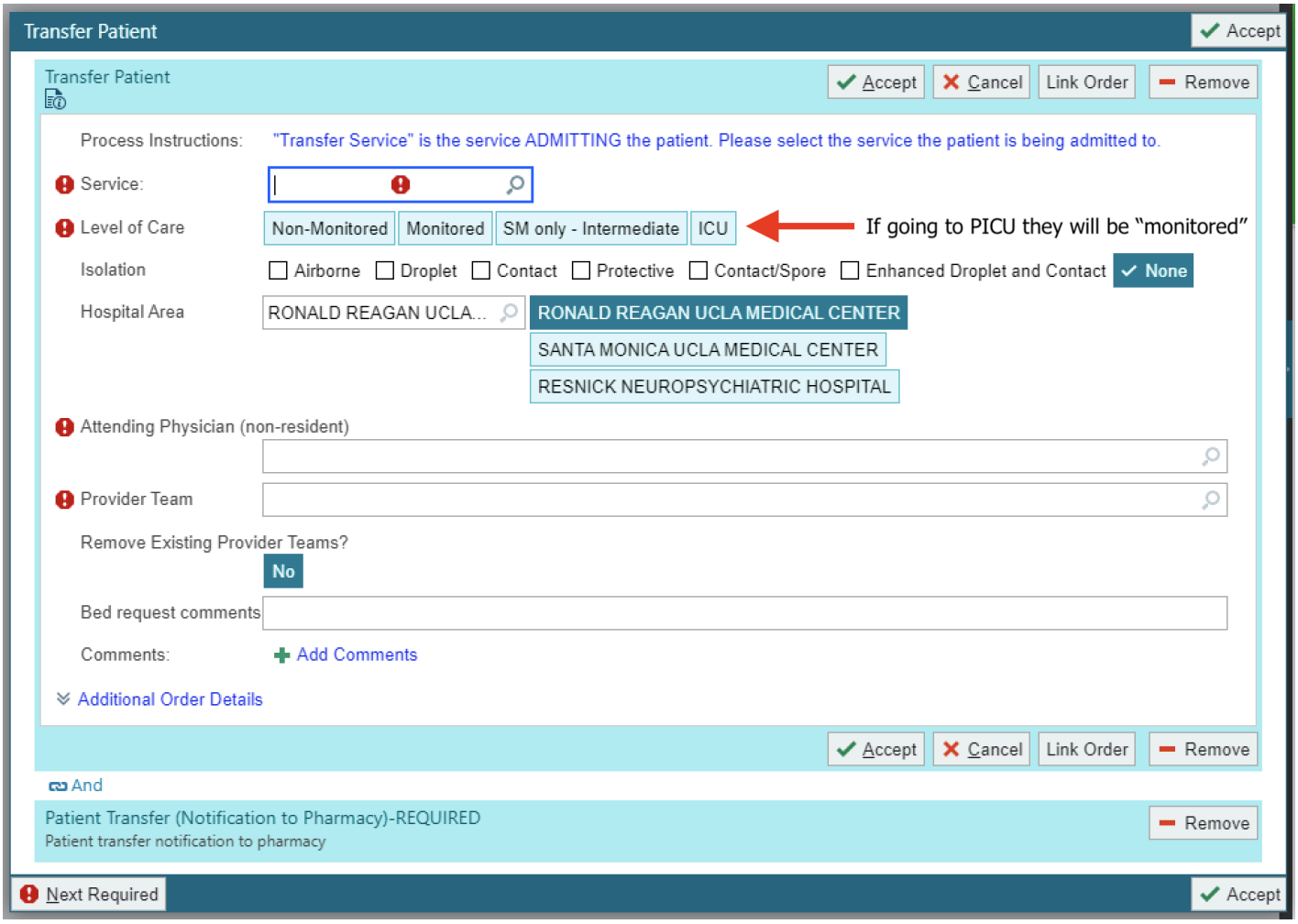
Once you're done with your DME / Home Health orders you can see them all at the very bottom left of the discharge home medications section.



TRANSFER ORDERS (To/from another service (ie PICU))

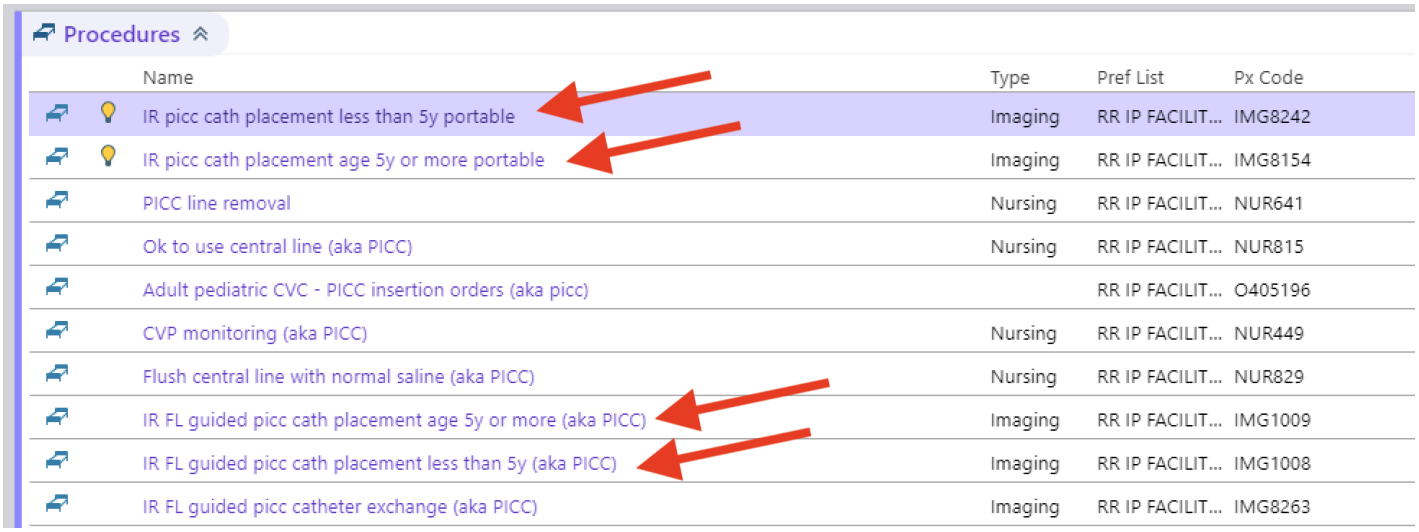
Place a “Transfer Patient” order, which looks very similar to the admission order. Once you place a transfer order bed control can start finding a room for the patient.





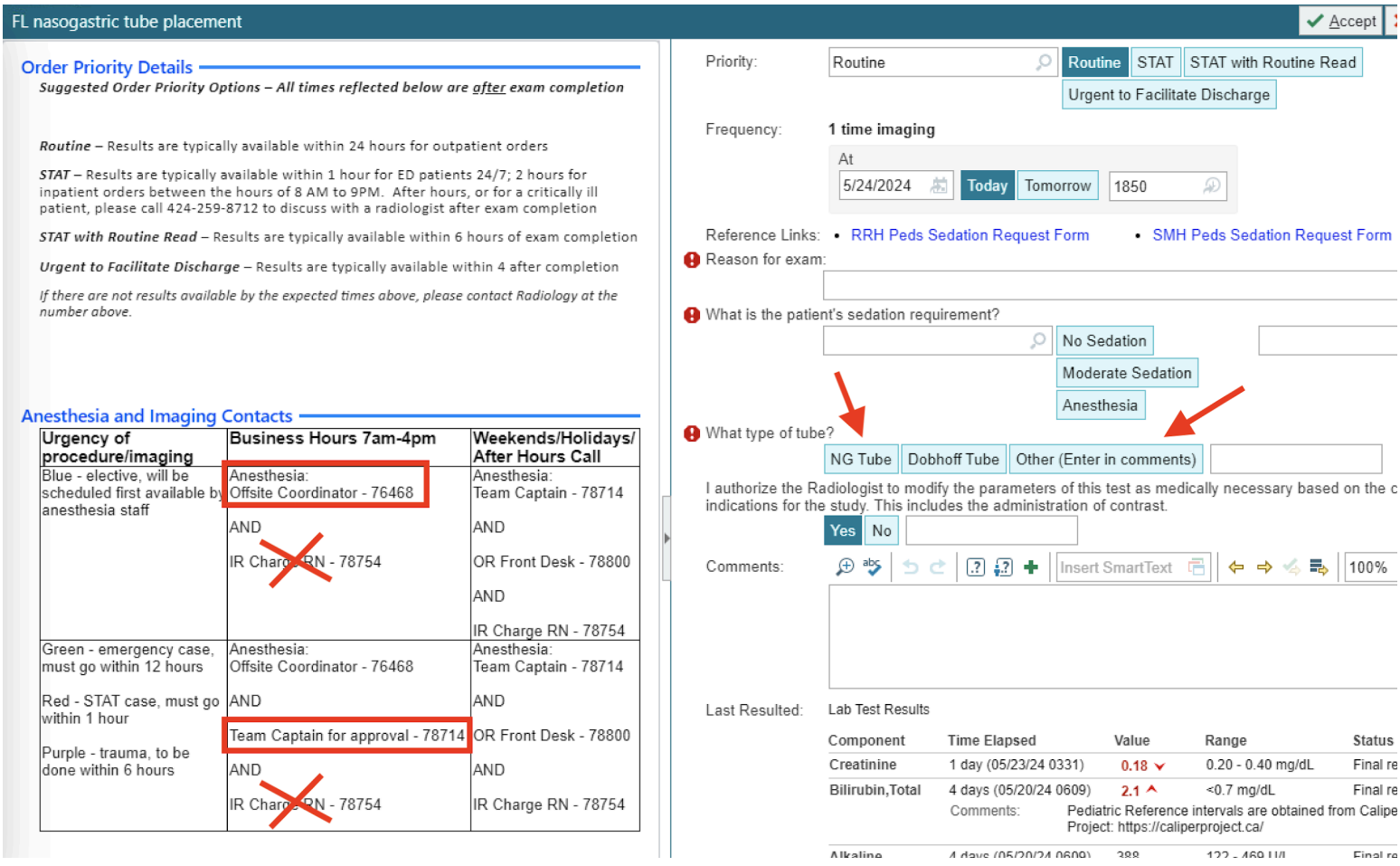
PICC Line Placement

Most PICCs can be placed bedside by the PICC NP. Choose the order that says “portable.” If the insertion is deemed too complicated by the NP then IR can place. To be placed by IR choose one of the orders that say “IR FL guided.”



NG or ND/NJ placement with rads

If your patient requires an NG or ND/NJ tube to be placed under sedation, it’s completed by peds diagnostic radiology (NOT interventional radiology) using the ‘FL nasogastric tube placement” order. You then call the anesthesia offsite / team captain and they will help coordinate with the radiology technicians. You do NOT need to call the IR NP since IR does not place NG tubes. It’s the same order even if you need an ND or NJ placed, but you specify in the comments which tube you need.



LPs in the OR (sedated)

If you need to complete an LP in the OR / procedure room for a patient:

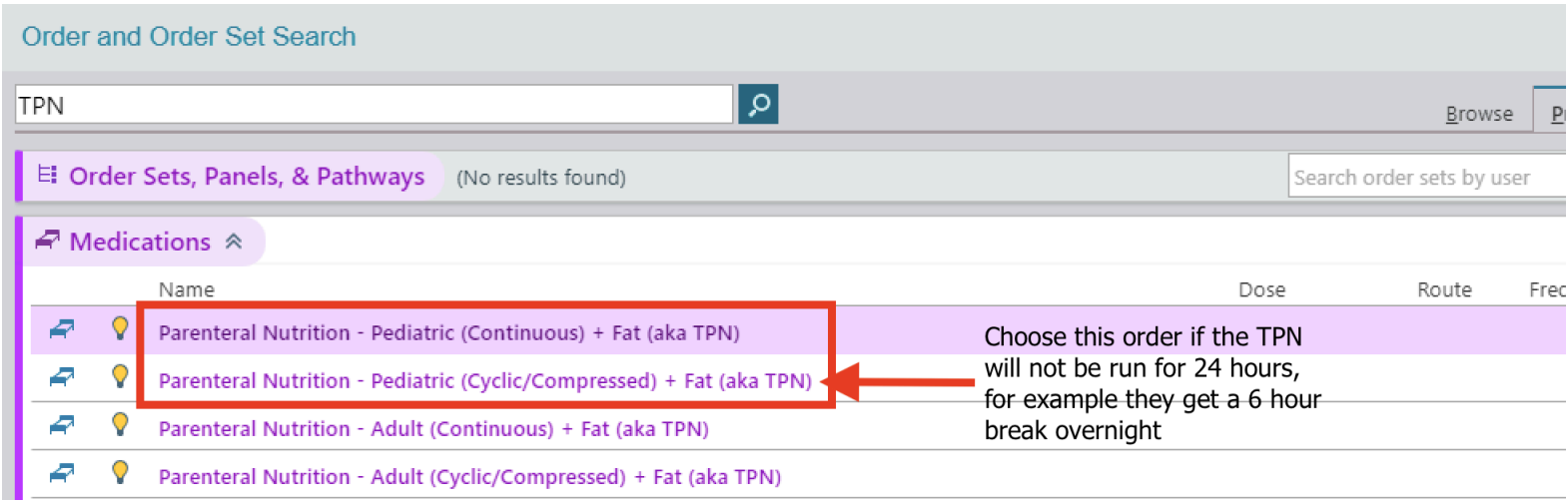
- Coordinate a time for a procedure room with the OR
- Patent needs an H&P in the last 30 days, and a SCIP note attesting that nothing has changed since that last H&P (SCIP note type)
- Patient needs a SURGICAL consent for OR procedures (different than normal LP consent). Form can be found in the forms portal. OR should also have physical copies.
- Consent needs to be obtained and go down with the patients so place in their physical chart.
- Order all CSF studies before going down to the procedure room and have nurses print labels for labs to be sent down with patient
- Bring to the OR: LP kit tray with extra needles / sizes
- Where to go if you can't find supplies - 5W/3F supply rooms -> central supply request -> PICU supply rooms (look in both sides) -> NICU
- Before you go into the procedure room you need to obtain a white "bunny suit" from the OR front desk or already be wearing the official UCLA light blue scrubs
- Procedure rooms are located on the 2nd floor (get to them via the interior elevators not the patient elevators)
- Once you are done with the procedure the labeled CSF specimens need to be walked and dropped off at the lab

Please see OR/Procedure Room Map →
https://drive.google.com/file/d/1cUbtE4HiymPhQzRgoM1z20NCPFz7DUpi/view?usp=sharing

TPN

If a patient is admitted with prior TPN (and followed by UCLA GI) you can call the TPN nurse (x79574) and they can email you the patients most updated formula for you to order.

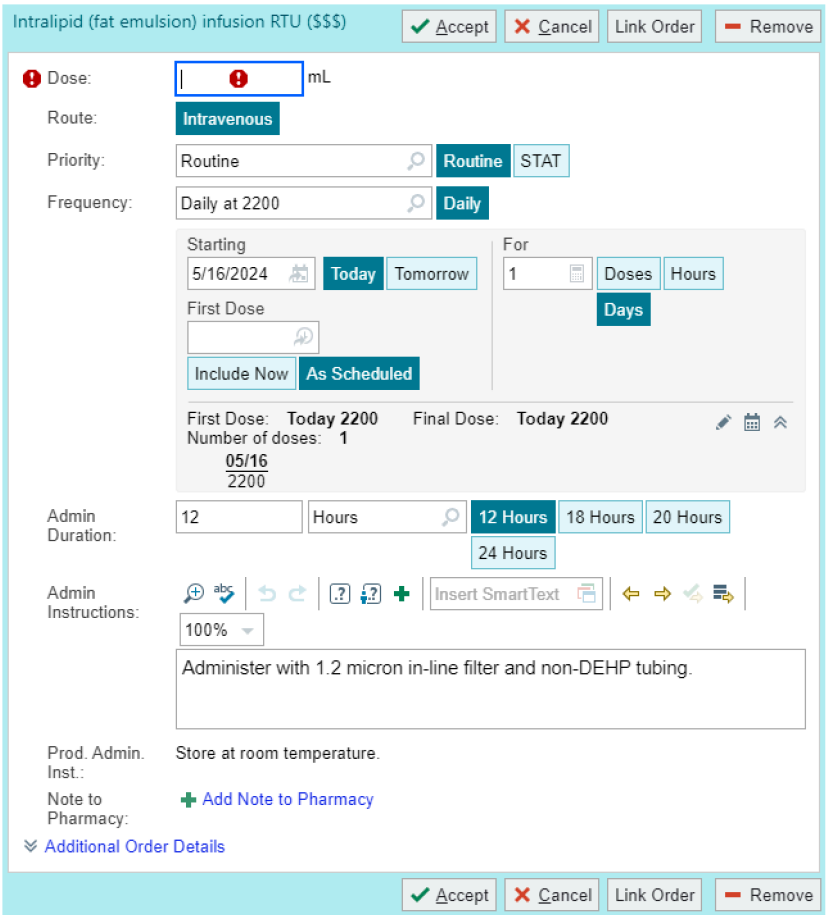
There are 2 different TPN/Lipid orders, one for continuous (24 hours a day) and one for compressed (<24 hours a day)



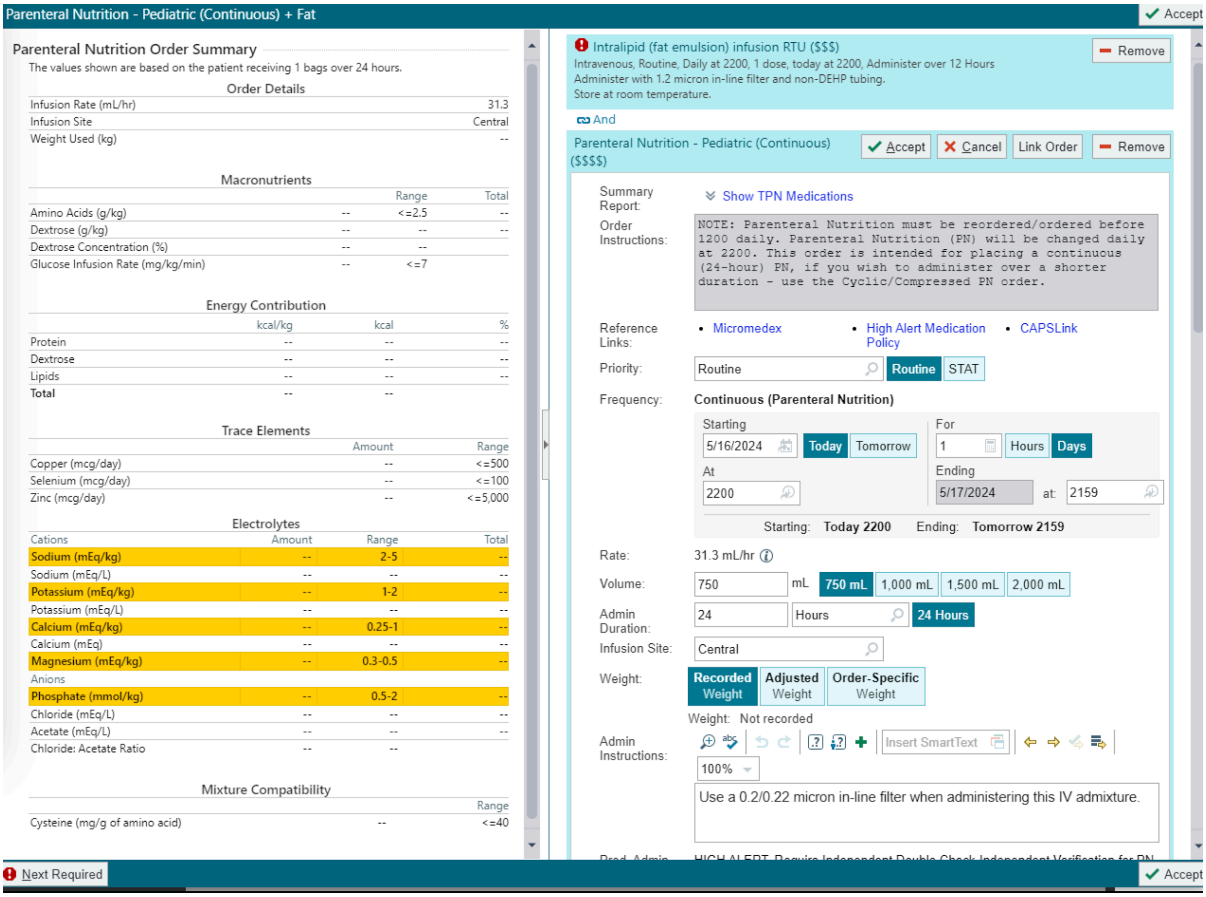
The first part of the order set is ordering lipids. To calculate the mL of lipid you need you can use the equation in the pink box. You typically start with 2gm/kg of lipid a day.

FAT:

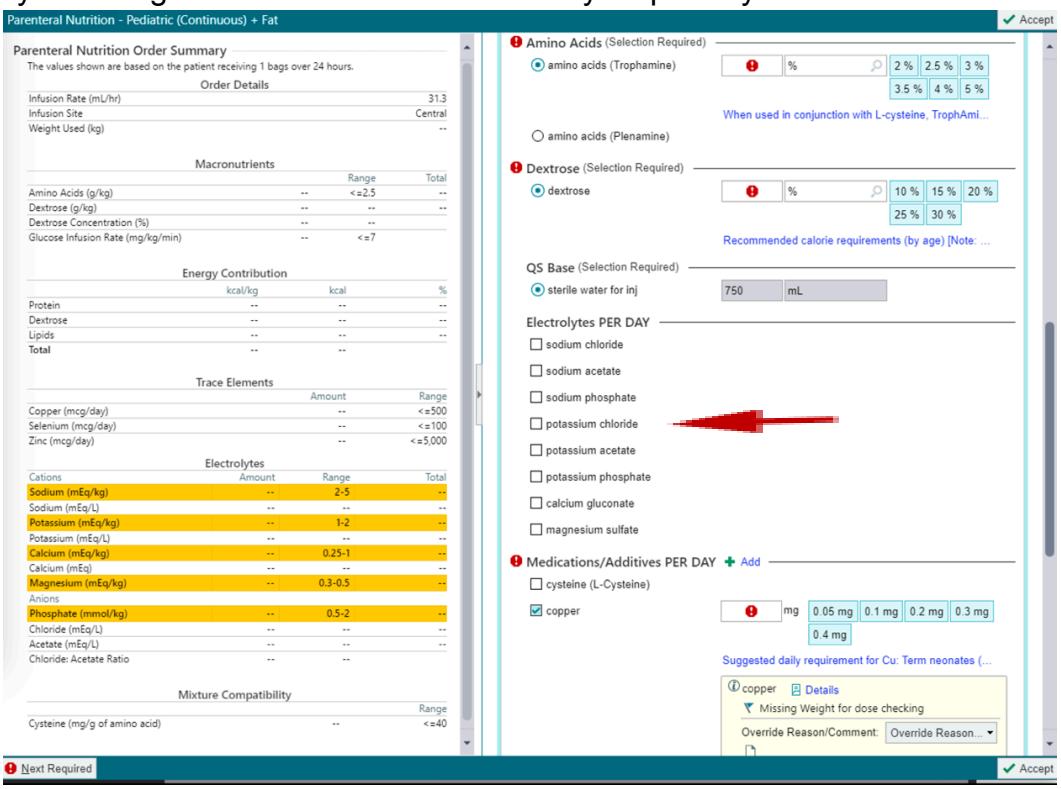
- Lipid ml = gm/kg × kg × 5
- Lipid gm/kg = (total vol × 0.2) / kg
- Lipid kcals: total vol × 2



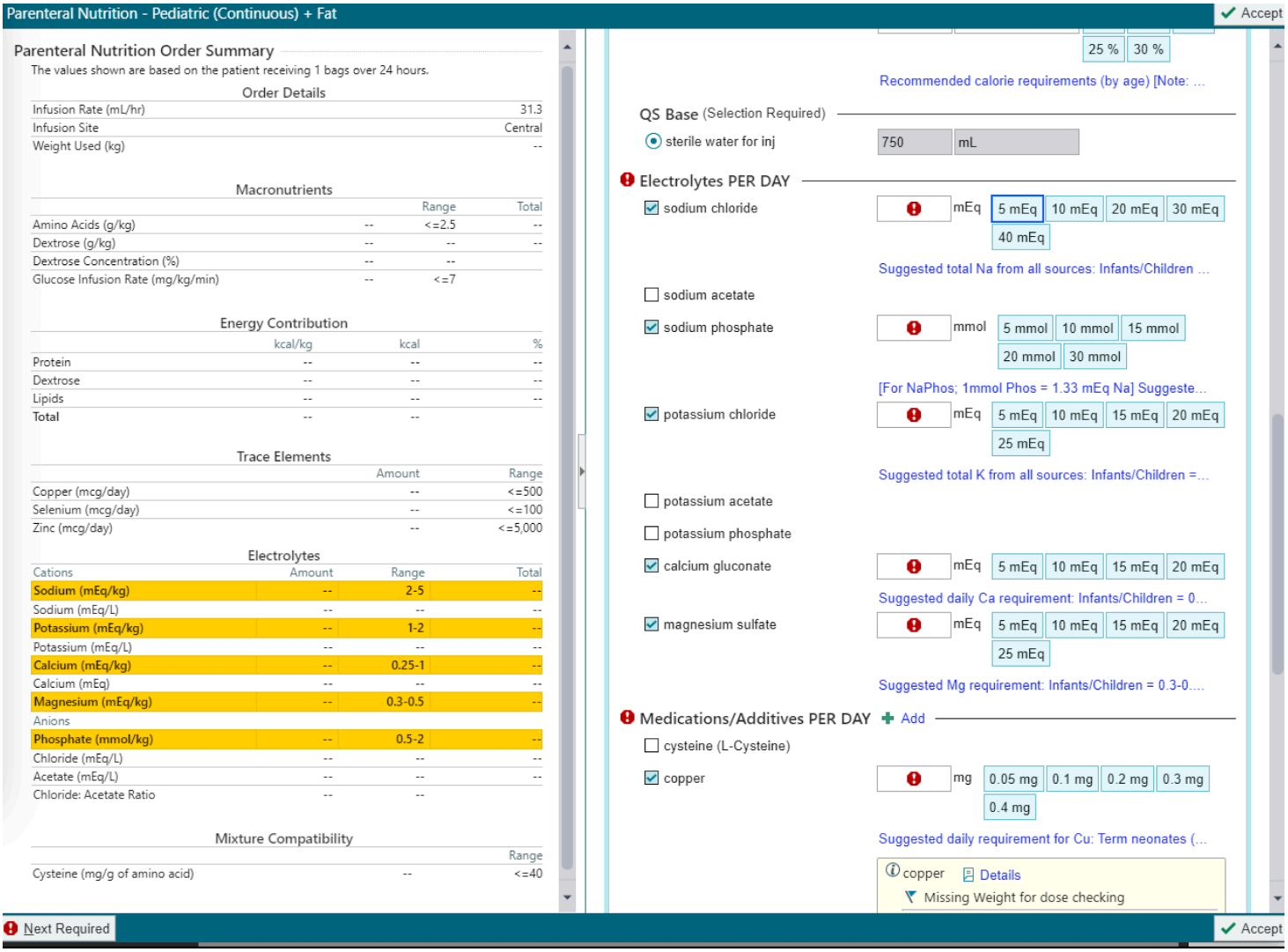
To get the initial mL of TPN discuss with the team what fluid goals you have for the patient. They might not always be getting their full fluid needs with TPN. Below are screen shots of the TPN order to familiarize yourself with what it looks like. On the left you will see typical ranges for most of the nutrients and electrolytes that you can aim for (in yellow). At the end of this TPN section there are nutrient guidelines from ASPEN you can also refer to.



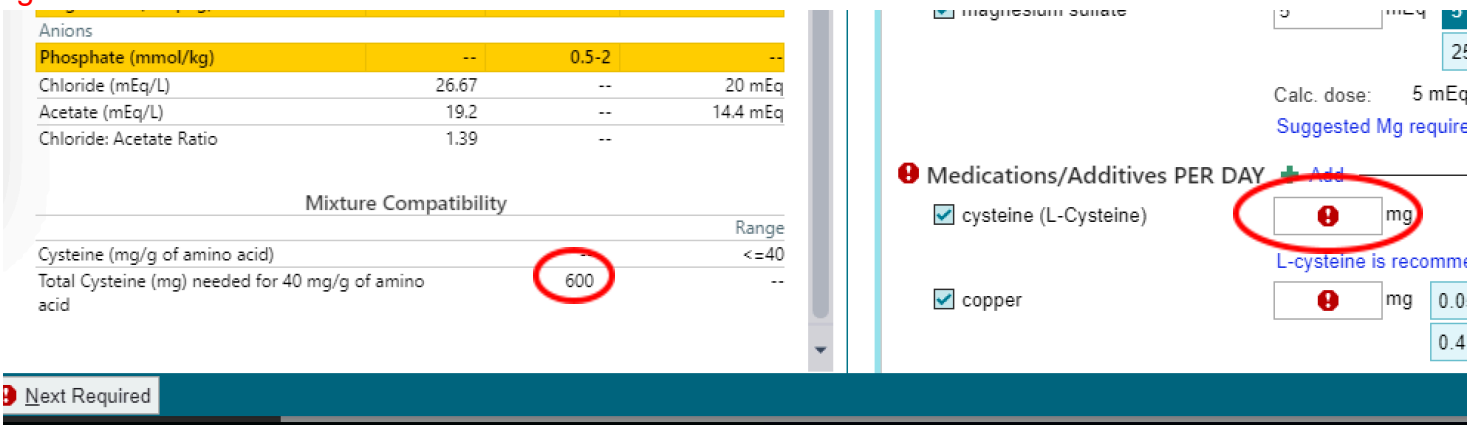
You can choose how you want to distribute your electrolytes via chloride/acetate/phosphate formulations by checking the boxes under the “electrolytes per day” header.



Once you’ve chosen your electrolyte distribution it’s a lot of trial and error in terms of mEq you type in the boxes on the right and the ranges they produce in the left pane. Keep adjusting the mEq until the numbers on the left fall in the desired yellow ranges.



For the cysteine you need to add the number on the left (in this case 600) to the cysteine mg box on the right.



Components of PN - Macronutrient Guidelines

	A.A.P.		A.S.P.E.N.	
	Weight	Daily Recommendation	Weight / Age	Daily Recommendation
Protein	10-20 kg	1-2.5 g/kg	>10 kg or 1-10 yrs	1-2 g/kg
	>20 kg	0.8-2 g/kg	11-17 yrs	0.8-1.5 g/kg
Energy / Caloric	10-20 kg	60-90 kcal/kg	>1-7 yrs	75-90 kcal/kg
	>20 kg	30-75 kcal/kg	>7-12 yrs	50-75 kcal/kg
			>12-18 yrs	30-50 kcal/kg
Fluid	>10-20 kg = 1000 mL + 50 mL/kg >10 kg			
	>20 kg = 1500 mL + 20 mL/kg >20 kg			
Carbohydrates (Dextrose)	10-20 kg	8-28 g/kg	Carbohydrates should comprise 40% to 60% of total caloric intake.	
	>20 kg	5-20 g/kg		
IV Fat Emulsion	>10kg	1-3 g/kg	The minimum fat requirement is determined by essential fatty acid need, and the daily maximum is 50% to 60% of energy.	

Components of PN - Micronutrient Guidelines

	A.A.P.		A.S.P.E.N	
Daily Electrolyte Requirements	Infants & Toddlers / Children	Adolescents	Infants / Children	Adolescents & Children >50 kg
Sodium	2-4 mEq/kg	60-150 mEq	2-5 mEq/kg	1-2 mEq/kg
Potassium	2-4 mEq/kg	70-180 mEq	2-4 mEq/kg	1-2 mEq/kg
Calcium	0.45-4 mEq/kg (infants & toddlers)	10-40 mEq	0.5-4 mEq/kg	10-20 mEq/day
	0.45-3.15 mEq/kg (children)			
Phosphorus	0.5-2 mmol/kg	9-30 mmol/day	0.5-2 mmol/kg	10-40 mmol/day
Magnesium	0.25-1 mEq/kg	8-32 mEq	0.3-0.5 mEq/kg	10-30 mEq/day
Chloride	2-4 mEq/kg	60-150 mEq	Chloride / Acetate – As needed to maintain acid-base balance	

Components of PN - Trace Elements

Mineral	Multitrace®-4 (per mL)	Multitrace®-4 (per mL)	Multitrace®-5 Concentrate (per mL)
	Neonatal	Pediatric	(Adolescent/Adult)
Zinc (as Sulfate)	1.5 mg	1 mg	5 mg
Chromium (as Chloride)	0.85 mcg	1 mcg	10 mcg
Selenium (as Selenious Acid)	none	none	60 mcg
Copper (as Sulfate)	0.1 mg	0.1 mg	1 mg
Manganese (as Sulfate)	25 mcg	25 mcg	0.5 mg

Calculating calories and total fluids (with examples)

Trophic feeds are <20 cc/kg
↳ not included in total fluid (TF) calculations

MBM/EBM = 20 Kcal/oz
fortified MBM/EBM/formula = 22-24 Kcal/oz (can be higher in some cases)

1 oz = 30 cc
Typically feed q3h = 8 feeds/day

1. Calculate how many Kcal/kg (kkd) a baby is getting from feeds
   weight: 3.6 kg
   feeds: 60 cc q3h = 480 cc total/day
   formula: Similac 20 Kcal

$$480\text{ cc} \times \frac{1\text{ oz}}{30\text{ cc}} = 16\text{ oz} \qquad 16\text{ oz} \times \frac{20\text{ kcal}}{1\text{ oz}} = 320\text{ kcal}$$

$$\frac{320\text{ kcal}}{3.6\text{ kg}} = \boxed{89\text{ kkd}}$$

2. Calculate feed volume, q3h
   TF goal = 120 cc/kg/day (ckd)
   weight: 3.6 kg

$$120\text{ cc} \times 3.6\text{ kg} = 432\text{ cc/day}$$

$$\frac{432}{8\text{ feeds}} = \boxed{54\text{ cc q3h}}$$

3. Calculate TF/feed volume
   Caloric goal 115 kkd
   weight: 8 kg
   formula: Similac 20 kcal

$$115\text{ kkd} \times 8\text{ kg} = 920\text{ kcal}$$

$$920\text{ kcal} \times \frac{1\text{ oz}}{20\text{ kcal}} \times \frac{30\text{ cc}}{1\text{ oz}} = 1380\text{ cc}$$

$$\boxed{1380\text{ cc} = 172.5\text{ cc q3h}}$$

Santa Monica Hospital

Team structure: 2 seniors (one rounding and one teaching), 2-3 interns. Family medicine interns often rotate with us at Santa Monica. On the weekend there is only one senior.

0600: AM sign out
0745: Check in with rounding attending about start time and where you would like to start (typically discharges / sickest first)
0800: Start rounding
- Try to page all new consults during rounds since some services only come to SMH on certain days and they need to plan their schedules as early as possible in the day!

0900: Break for adolescent table rounds in the workroom (sometimes these go before floor rounds)
1130: Finish rounding
12 - 1300: Noon conference, chiefs will send an email to seniors with conference schedule
1300 □ : Check all orders from rounds, consults etc, run the list with attending and interns PRN, see new admits
- Update handoffs throughout the day, go over contingency plans for the night team

1700 - 1830: PM sign out
Senior signs out

- Interns rotate being "admit" and "non-admit" □ non-admit interns can help with admits, but shouldn't see new admits that come into the later afternoon. Non-admit interns should aim to leave by 4pm (if not before). Admit interns should stay until sign out.
- Non-admit intern can leave and sign out to admit intern when:
    1. Tasks are done / patients tucked in
    2. Notes completed
    3. Families updated + Qs answered

Team cap: 18 (9 per intern). If the team census is 19+ the extra will go onto overflow and the teaching senior will see with the attending (you can discuss what timing works best to see these patients). Over the weekend the rounding senior will take these patients since there is no teaching senior. Patients that go on to the overflow list should be straight-forward patients and likely discharges (ie neuro EEG admits). No complex or long-term patients on the overflow list! Once the census dips back down to <19 these patients will move back onto the regular list.

Senior Responsibilities

Rounding senior:
- Sign into senior pager: 35507 (this is how the ED will be able to contact you)
- Pre-round on all patients
- Go over plans with interns prior to rounds as needed
- Ensure orders are in/correct and plans are carried through
- Help interns with responsibilities to make sure they get to leave by sign out
- If possible, pend orders and start H&Ps for pending admits that will come during night shift
- Stay for sign out

Teaching senior:
- Facilitating medical student teaching / assigning patients to follow
- Take / round on patients on the overflow list
- Helping with new admissions (typically outside transfers or neuro admits) and ED consults during rounds, putting in orders during rounds
- Prep discharge planning / orders for patients leaving that day

- Prep planned neuro admit orders for the week and if possible pend their H&Ps
- If neuro admits or transfers hit the floor during rounds briefly go see patient for med rec and admit orders. Intern can see the patient after rounds to complete the H&P
- If ED pages for a consult during rounds go see and complete the consult, can discuss the plan with attending after rounds / sign out the patient to the team if they end up being admitted.
- Can leave after noon conference once new admits/consults are tucked in, discharge orders are complete for those being discharged, and the team is in a good place in terms of workload

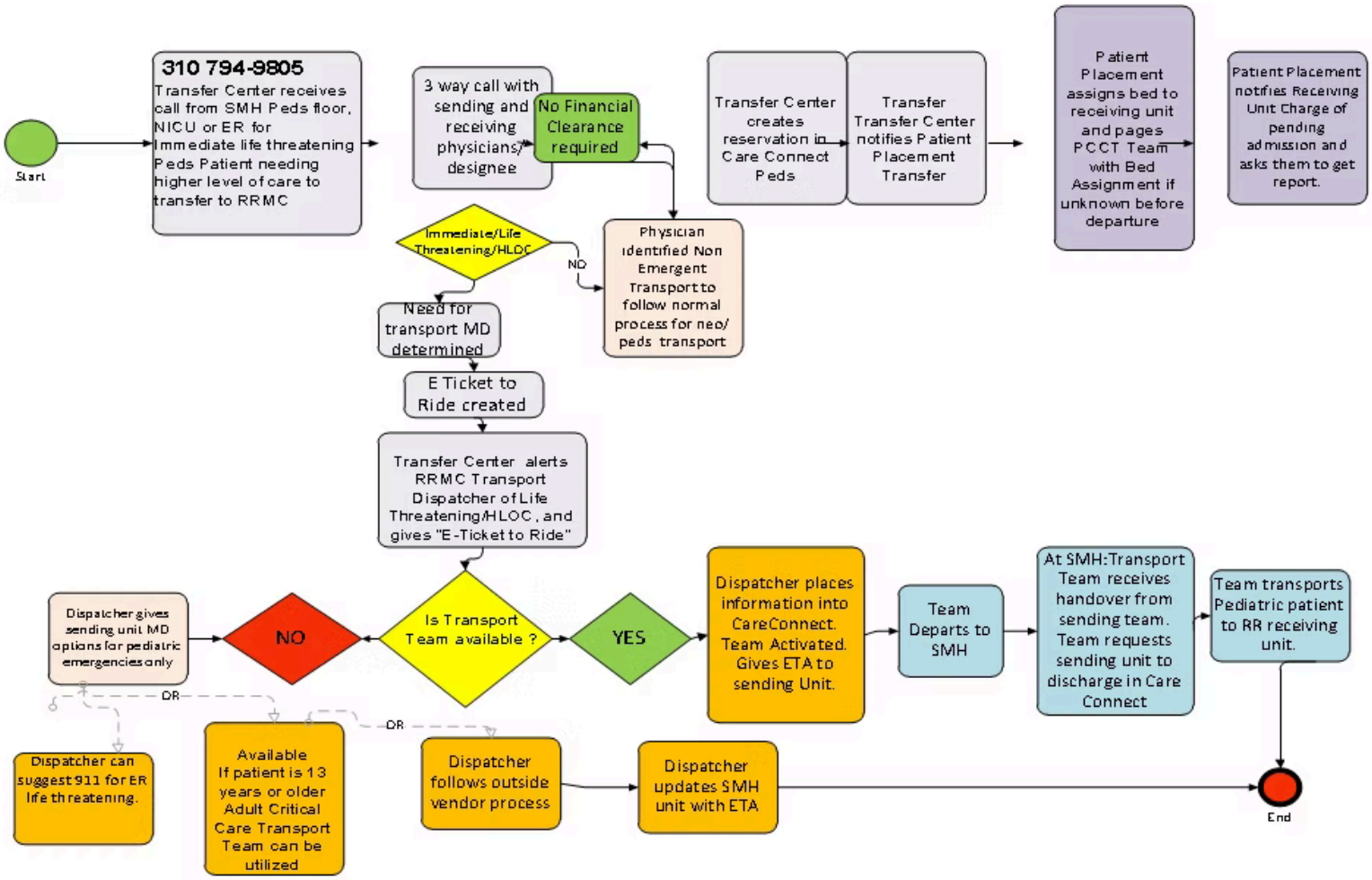
PICU Transfers to RR:

There is no PICU at Santa Monica!! Any patient who needs higher level of care will require a transfer to RR Hospital.

Transfer steps:

1. Notify charge nurse of need for transfer
2. Call transfer center 310-794-9805
3. This will generate an "E-ticket"
4. Transport center will get you in touch with PICU fellow and you will discuss the case with them and they will determine if the patient will be accepted. This is typically done with transfer center on the line via a 3 way call.
5. Transfer center will arrange for transport and call you with periodic updates.
6. Patient will need a discharge summary and DC order signed prior to transfer.
7. Give verbal signout to the PICU resident

Pediatric Immediate Life Threatening / HLOC Transfer From SMH to RRMC
Transfer Center #: 310 794-9805



SM ED Consults

- The ED will page the senior (sign into pager 35507) at any time during the day for new peds consults / admissions. The senior is first page not the attending.
- FYI the attending that you will be seeing a consult and give MRN so they can also look into the patient. Attendings eventually need to see ALL ED consult patients whether or not they end up getting admitted.
- Based on your initial call in the ED you can ask them to add on additional lab/imaging orders or give additional treatments (ie for asthma exacerbations)
- Go down and see the patient as soon as possible
- If based on your initial call with the ED it seems like an admission is likely you can bring the intern with you so an H&P can also be done for efficiency. If the patient doesn't seem like a likely admission or if more workup needs to be completed first then just go down alone so the intern can complete other tasks they may have.
- Senior should write a brief consult note whether or not the patient is admitted and requires an H&P.

Eating Disorder / Adolescent Medicine Info:

- Always use the eating disorder note templates and admission order set, and always UNSHARE your notes.
    - Admission order set: "PED Eating Disorder Admission Order Set"
    - H&P: [.PEDSRESHPEATINGDISORDER]
    - HEADS: [.PEDSRESHEADS]
    - Progress Note: [.PEDSRESPNEATINGDISORDER]
- Table rounds typically start in the workroom at 0900 with the adolescent team (MD, psych, SW, dietician). Sometimes the adolescent team will ask to round first at 0800.
- Interns can take turns being in the workroom to present their patients. The interns not presenting can be outside working on other tasks and will be called in when it's their turn to present.
- You will not round in person on these patients with the adolescent team, they will round on their own
- In the DC summaries be sure to include dispo information from social work notes so their PCP will know
- There is info on the UCLA peds website on the eating disorder protocol and how to present on rounds / preround on these patients (https://www.uclapeds.com/eating-disorder-info)

Parent Calls

- SM takes "mommy calls" from PCC parents after hours (6pm-6am) and all day during the weekend. They will come in as pages from the operator to the night/admitting intern. FM interns DO NOT take parent calls so the senior will take and log these calls instead. Try to return mommy calls as soon as possible.
    - There is a PCC section on the peds website for common parent call topics
    - Create a telephone encounter in the patient's chart for all calls and sign the encounter over to a PCC attending (ideally the last attending to see the patient in clinic).