**General Expectations, Schedule, Tips, How to Take Ownership of Your Patients:**

* Hours: 6am-5pm (morning signout until afternoon signout)
* Prerounding time 6am-7:30am (8am on M, W, F)
* See your patients and have notes signed by rounds
	+ med students should have notes signed by 7:30 so you can edit/addend)
* you can still edit a note after you’ve signed it, always choose sign/submit
* 7:30/8 - 8:30: teaching
* 8:30 - 10:45: family centered rounds
	+ Your time to shine! Presentations should be in SOAP format, take no longer than 2-3 minutes, and mostly focus on assessment/plan. Feel free to confirm the plan with senior before rounds!
	+ Direct your presentation to the patient/parent
* 10:45 - 12: highest priority tasks
	+ Call consults, discharge patients who are ready, update families
	+ O.C.D. 🡪 Orders, Consults, Discharges!
* 12-1: Noon conference + lunch
* 1-5: Patient care
	+ Update families
	+ Hospital summaries: start a hospital summary or update on each of your patients
	+ New admissions, more discharges
	+ Update sign out

**Hospital Tips:**

Important numbers (you can use any phone anytime to make calls)

* Operator: 5000
* In-hospital calls: 4 digit number, no other code
* In/out of the hospital: to dial out, code is 2711#. To dial in, all numbers are 202-476-xxxx
* Nurses: 602-xxxx
* 7E: front desk 5120, fax 202-476-7360
* Pharmacy: 8035 (7E unit pharmacy); 4080 (general pharmacy)
* Lab: 2600 (chemistry 5354, hematology 5676, micro 5359).
	+ Labs that are not yet in process/where are the labs(?): 2229

How to get outside images uploaded into Cerner:

* Get disc and put patient label on it, take to radiology on 2nd floor (counter right next to elevator). There is a form to fill out at the desk with patient info
* Remember to put an order in Cerner: “second read of outside hospital film” –be specific!

**A system for prerounding so you don’t miss anything!**

**Orders**

* Scan through and especially look at diet, continuous infusions, medications (PRN vs scheduled), labs to see if anything is different from how you left the plan the day before

**Results Review**

* Vitals
	+ Temp: look for fevers >38.5. Note if temp was axillary or oral/rectal
	+ HR, RR, BP: range from last 24 hours
	+ SpO2: note any recorded desats and how much oxygen the patient is on
	+ Pain score: if this is something we are following, what is the range of the pain score (ex- 6-8/10).
	+ If any of the vitals were abnormal in the last 24 hours, note the time and abnormal vital and determine the reason (or differential) for why the vital was abnormal and if anything was done about it (PRN medication, lab workup, cultures sent, etc)
		- Ex- HR 160 at 8pm, likely due to the fever patient had at the time. Blood cultures sent, tylenol given, HR back to 120 at next check
* Labs
	+ Morning lab results, if any, but may result during or right before rounds
* Micro
	+ Check on any pending cultures daily (ex- blood cx NGTD x36hrs)
* Radiology/Cardiology
	+ Check if any new imaging or EKGs were done overnight (may be in the chart or look in MUSE)

**I-View** → Intake and Output: *recorded from 7am to 7am so this will be up to date at 7am*

* Total Intake
	+ Note the total amount in from IV fluids and total amount of PO taken (ex- 1100mL total intake, 1000mL from IVF, 100mL PO)
	+ This is the only place in the chart that blood products are recorded by mL (if relevant)
* Total Output
	+ Calculate the urine output in mL/kg/hr over the 24 hours
		- If the patient has not been admitted over 24 hours, calculate urine output in ml/kg/hr for however many hours the patient has been there (ex- UOP was 2 ml/kg/hr over the last 6 hours)
	+ Number of stools, emesis, drain output, chest tube output if this is pertinent
* Balance over the last 24 hours
	+ A moderately positive balance is normal, accounts for insensible losses

**MAR Summary**

* Scheduled meds
	+ Check what day of antibiotics we are on (ex day 3/7). If you don’t know the expected length of antibiotics, suggest a course!
		- Update the day of antibiotics in your note daily, so you won’t have to keep counting individual doses day after day!
* PRN meds
	+ Often meds like pain meds or respiratory treatments
	+ Note when given (ex- morphine at 0100) and how many (ex- tylenol x3 in the last 24 hours)

**How to turn this into the best SOAP note + Presentation!**

Notes and presentations are both in SOAP format. The note needs to be complete in all of these sections but the presentation should focus on the pertinent findings that inform your plan for the day.

**One-liner/Brief Patient Summary Statement**

* ## is a # year old boy/girl with a history of ## who presented with ##, was found to have ## (or- with working diagnosis of ##) and admitted for ##
	+ Ex: Johnny is a 2 yo boy with a history of asthma who presented with two days of fever and right knee pain, found to have right knee effusion, admitted for workup of septic arthritis vs. transient synovitis.
* Edit one-liner as diagnosis becomes more clear and treatment is defined:
	+ Ex: Johnny is a 2 year old boy with a history of asthma who was found to have right knee MRSA positive septic arthritis and admitted for IV antibiotics

**Subjective**

* Any unexpected events that changed the plan (ex- patient was febrile so cultures sent)
* Anything that is subjectively improving/worsening (cough, swelling), and if any PRN medications were needed to control the symptom (ex- pain medication)
* Subjective can also include anything the parents told you that morning on pre-rounds (ex- mother reports Johnny’s oral intake was much improved overnight)
* Everything that you put in the subjective section is pertinent for the presentation

**Objective**

* Vitals
	+ The note template will automatically pull in a range from the last 24 hours
	+ For your presentation, mention only abnormal vitals
* Ins/Outs
	+ The note doesn’t automatically create a section for this: freetext it!
	+ If a patient doesn’t have a primary FEN/GI concern, ok to list total in/total out and urine output (in mg/kg/hr) only and not mention it in the presentation
	+ What to present depends on what we are following: if the patient is on IV fluids, here for vomiting, diarrhea, failure to thrive, ins and outs are highly pertinent and should be presented in detail
	+ If we are measuring daily weights, include the daily weight and the change from the prior weight (ex- weight overnight 3.43 kg: up 300 grams from prior)
* Physical Exam
	+ In the note, document a complete physical exam daily
	+ In the presentation, present things that are abnormal or changing
* Labs/Microbiology/Radiology/Cardiology
	+ Anything NEW in these sections should go in the note AND presentation

*Most of your presentation time should focus on your assessment and plan - so present what you have written in full!*

**Assessment**

* Same pattern as one-liner, with qualifiers:
	+ Is patient improving, worsening, or no change
	+ Patient continues to require admission for: \_\_\_ (what are they still getting in the hospital that they can’t get at home, eg- oxygen, IV meds, fluids)
		- OR, if you think the patient is ready for discharge, explain why

**Plan** (common things to think about, not a complete list)

* FEN
	+ What is the hydration status? Does the patient need more/less fluids?
	+ What is the PO intake? Can we d/c IV fluids?
* Resp
	+ What is the asthma score? Can we space albuterol?
	+ Is there an oxygen need? Can we wean?
* CV
	+ Is there tachycardia/bradycardia, hypertension/hypotension? What should we do about it?
* ID
	+ If on antibiotics, what are we treating? What is our plan for the expected course (ex day 4/7 of abx for a UTI). Can we switch to PO antibiotics?
* Pain
	+ Is pain controlled on the current regimen? If a lot of PRN use, should we change the scheduled pain control?
* Discharge
	+ When should the patient see the PMD after discharge?
	+ Does the patient need any subspecialty follow ups?
	+ What medications will the patient be discharged on?
	+ Does the patient need any new equipment (neb machine, crutches)
	+ What discharge teaching is needed (eg- asthma action plan)
	+ Any barriers? (insurance, transportation)