Intern Survival Guide

Stony Brook Children’s

2014
Topics Included

USE SEARCH FEATURE IN PDF TO FIND RELEVANT TOPICS

Being Good to Yourself and Others
Continuity Clinic
Development/Behavioral
Documentation Guidelines
Emergency Department
Electives
EMR Tips
Heme/Onc (aka PONC)
Morning Report
Newborn Nursery

NICU

Nights

Signing Out

Step 3 Process

Wards

Ways to Shine On Your Rotations

What to See and Do in Long Island

Resident Recommendations

Appendix: Frequently Called Phone Numbers
Being Good to Yourself and Others

Taking care of others requires taking care of #1 first...YOU!

- Getting into residency is a valuable reward after a long road in medical school, but residency can be very hard work with little rest or routine. The schedule of intern year especially can be exhausting, tiring and stressful. All told, it can really test our limits physically and mentally.
- We all know the schedule is difficult. There will be many days that seem stressful, so it is important to take things a day at a time, and when you have a hard day find effective and efficient ways to get back up and keep going when you return.
- You work hard. So, Eat when you can, Sleep when you can (Use the restroom when you can).
- Remember, all of your seniors have gone through this and your fellow interns are going through it with you. Reach out to others, share some humor, check in on how others are handling things or take a moment to vent during a hard day. The chief office number is 4-7711 or 4-3103 and you can always contact them if you just need a confidential space to let things out or have specific concerns in or out of the hospital.
- Take a short break every day to relax. Many times it can be hard to leave work behind even when you have physically left the hospital. This can make it harder to rest effectively, be fully “present” at home if you need to be or to perform other tasks you need to do after you leave. To counter this, create a “transition” habit. When you leave the hospital after a long day or night, listen to music or the news, make a phone call to someone close to you, watch something on TV, go workout, or do something else short, interesting, enjoyable and distracting to help your mind “transition” away from the hospital.
- Keep in touch with the things that you value and enjoy: family and friends, religious or spiritual affiliation, exercise, hobbies, etc.
- Get enough sleep. Mental alertness and problem solving capacity are greatly reduced with sleep deprivation. Set an appropriate bedtime and set alarms – even backup alarms - for your mornings. If you have a long night shift and do not feel safe to drive home, it may be ok to nap in the call room until you are ready.
- Try to schedule routine Doctor/Dentist appointments when you have electives, nights, or ER, you will have more normal “9-5” hours available outside the hospital during that time. Otherwise, give the chiefs as much notice as you can of upcoming schedule conflicts and they will try to work things out on a case by case basis.
- If you are ever unable to work a scheduled shift due to major illness or other emergency, page the pediatric chief on-call to notify them. Give as much notice as you are reasonably able. While there is a
backup system in place for these situations, remember: if you aren’t working it means someone else has to do it.

- **Remember, doctors are human too.**
  
  o **So… “Be Kind to One Another.”** —Ellen DeGeneres

**Being a Team Player**

- Throughout the course of the year, you will be working, speaking, consulting with nurses, phlebotomists, social workers, clerks, administrators, laboratory workers, child life specialists, pharmacists, residents and attendings. While there will be many different personalities to deal with, remember that you are working for your patient, so maintaining professional relationships is very important.
  
  o Always speak with others with R-E-S-P-E-C-T. Everyone has gone through some level of training to work in their position. While their area/level of expertise may not match your own, always know that they may have something to add.

  o Make sure you are on the same page. When speaking with other services, let it be known what your concerns are, what your specific questions area and how you would like them to help. Be sure to mention time sensitive aspects of care or other factors that may influence priority or preparation (e.g. Patient will need sedation for procedure, requires NPO status, has significant co-morbidities, will need parental consent, has social or protection issues pending)

  o Get people involved early, when applicable. Avoid the situation where the disposition of your patient is held up by other services out of your control. A nervous or distracted child may need child life sooner. If you anticipate home care needs, insurance issues, or are concerned about social issues, do not hesitate to voice those concerns with our social worker. A potential consult is better served if you call them early in the day rather than around sign-out time, or earlier in the week rather than Friday afternoon. If you may need help sending reference labs or have a question on dosing, try to call the respective departments before they close or the pediatric-experienced members leave.

  o Keep people updated. This applies more with nursing. Whenever something changes with the plan, especially if it differs from what was discussed on rounds. Of course, you will be informing your nurse of any new labs or procedures required, of any changes in monitoring (more frequent vitals, change in respiratory checks, urine dips,
fingersticks, etc.) Confirm specialty suggestions with the nurse once the attending approves.

Of course if you are facing difficulty or resistance regarding patient care or communication, do not hesitate to escalate the level of involvement.

- When calling hospital services, especially if confirming/scheduling time-specific events, always write down the name and extension of the person with whom you have spoken. Also ask for any supervisor name and number should things change.
- If you are paging a fellow intern on specialty and are not getting a response within reasonable time and number of attempts, page the next listed resident. Let your own senior resident know about your difficulty in reaching the service.

Ok so maybe we are a hungry bunch. The most important advice your PGY-2’s can give you as a class is: There will be a lot of times where you will think to yourself, “Ain’t nobody got time for that,” BUT, remember...

“Even when it seems there are not enough hours in a day... in the end, it’ll ALL get done.”
On a weekly basis, each resident is assigned to either a full or half day of outpatient general pediatric clinic, with the exception of certain rotations (NICU, Night Intern). Med-Peds residents may have two clinic days per week.

**GENERAL CLINIC DAY SCHEDULING**

- You will find out your clinic assignment during orientation. You will remain at this clinic throughout your residency.
- The clinic schedule is emailed out monthly by the chiefs periodically for all of the Stony Brook pediatric clinics.
- No clinic: NICU, night intern
- Full day clinic: Electives, ED, Development
- Half day clinic: Wards, Heme/Onc, Newborn Nursery
- Before leaving for clinic from an inpatient setting, sign out your patients to another team member (i.e. intern or senior), finish your notes, and prep discharges. Team members will cover each other’s patients on clinic days.
- You may occasionally be assigned to alternate clinic sites/days depending on the schedules of other team members to minimize understaffing.
- When someone else has clinic on the Ward, the other intern(s) on their team need to cover for that person.

**AMBULATORY EMR**

- All outpatient SB clinic sites utilize EMR.
- Note templates can be accessed in Powerchart under “Catalog.” If you search for Well Child for example you will find well child note templates for each major age group. Save your favorites.
- GPV = Well Child Visit (General Patient Visit), ACV = Sick Visit (Acute Patient Visit)
- All orders, prescriptions, and follow up visits should be scheduled through the EMR.
- Patient billing can also be completed through EMR and will link to PatientKeeper (which logs your patients and their billing).

**CLINIC DUTIES**

- For the first six months of intern year, you will present patients to your attending, who will also need to see the patient. After that, you will be able to see patients on your own.
Establishing continuity

- Try to schedule your patients for follow ups on your clinic days to maintain continuity.
- Recruit infants from the Newborn Nursery or during your inpatient rotations. If a family doesn’t have a primary pediatrician, offer your card and recruit them to your clinic to build your continuity population. Carry a few cards in your wallet/bag!
So You’re Starting Your Development Block…

▪ Your Development/Behavioral rotation will incorporate a number of outpatient experiences geared to expand your understanding of normal vs abnormal child development and behavior, and the management of common developmental issues.
▪ Bring reading materials to clinic as there may be downtime.
▪ There is a paper to write and an oral exam at the end with one of the faculty, so keep up on the assigned readings. There is A LOT of assigned reading, just FYI.
▪ By the end of this rotation your goal should be to have a better grasp on developmental milestones, diagnosing, and managing common developmental disorders such as:
  o ADHD, Autism, Cerebral Palsy, Major genetic disorders like Down syndrome and Turner Syndrome

Scheduling

▪ Obtain your schedule from Janet Ruggerio (in same office as Jean)on the Monday afternoon prior to starting your Development block. She will also provide you with the Development books/readings for the block.
▪ If you are sick, page the chief on call and notify Janet Ruggerio so that she can contact the appropriate person for where you were scheduled for the day.
Medical documentation is part of a medical-legal record. For this reason, it is imperative that all medical documentation be consistently high-quality and up to date.

- Another medical care provider should be able to continue quality medical care at any time based on objective, complete, accurate entries.
- H&P’s must be documented within 24 hours of admission.
- Physician’s orders should be entered on admission and reviewed daily.
- Medication reconciliation is to be done – correctly and accurately - on admission, transfer and discharge.
- Inpatient progress notes must be electronically documented daily at the time of observation. They should give a pertinent, chronological report of the patient’s course in the hospital and should reflect any change in the patient’s condition and the results of treatment.
- Event notes and SBAR notes must be electronically documented as soon as possible after the event. The nurse should be notified as soon as the event note is completed to allow for nurse review and additional information to be added, if necessary.
- Discharge summaries, or clinical resumes, should be dictated upon discharge.
Emergency Department

So You’re Starting the ED…

- The Pediatric ED is located on the 4th floor of the main hospital building.
- Yay for scrubs!
- During your ED rotation, you may work 8am – 7pm, 3pm - 2am, or 9pm - 8am. You may work with other Peds or ED residents. You may occasionally work short call shifts from 5pm -10p.
  - Note that the shifts are 11 hours to give you one hour at the end to sign out and dispo your remaining patients if possible.
  - You should be out the door at the 12-hour mark. You should try to help out with “quick” patients during the last hour of your shift if there are charts on the rack and the ED remains busy.
  - The Pediatric ED is now open 24 hours/day.
- This goes without saying - please practice general safety when leaving late from the ER. While the area around SB is generally safe, if you are parked far away, do not hesitate to ask a fellow resident or a security guard to come with you.

Scheduling

- For every 14 days of ED, you will usually work at least seven 12-hour shifts.
- Continuity clinic will be once per week and full days (half days for med-peds residents).
- You will be post-call on days after you’ve worked 3pm to 2am, but you can work multiple night shifts in a row.
- If you are post-call on a Wednesday, you do not need to attend lectures.
- If possible, chiefs will schedule shifts so that you will have two entire weekends off for every month you work.

Firstnet

- Firstnet is our electronic ED board.
- Take an hour or two just to surf around Firstnet and see how things work. The first thing you should do is set yourself up as a provider:
  - Hit the “provider” tab
  - Pick a nice nickname for yourself and a representative color
  - Select “mid-level provider” as provider role.
- For more information regarding Firstnet, please refer to your Powerchart orientation/training.
When writing notes on Firstnet, be sure to save the document as ED note physician and choose a reason for visit.

**Where Things Are**

**Charts**

- When you walk into the ED, chart racks will be directly in front of you and will house:
  - Patients waiting to be discharged
  - New charts
  - Charts in process
  - Familiarize yourself with the locations of each type of chart!

Green supply carts (in each patient room) – ask someone for the code on the first day

- Blood/IV/Urine supplies
- Diapers, Pedialyte
- Yellow – ED wear (gloves, masks, gowns, etc)
- Blue – Casting supplies

**Triage Board**

- Our electronic board is projected in HD behind you as you walk in.
- Work stations
- Behind the clerk sits a very long desk with 5 computers. This is where you’ll work.
- There are lockers where you can stash your things behind the long desk.
**When Things Happen**

- The ED is pretty straightforward in that you come in when your shift starts, see patients, and signout when your shift ends.
- If your shift ends at 8 pm, you should sign out to another resident seeing pediatric patients.

**Patient Arrival**

- When patients arrive in the ED, they are seen by triage, assigned a level of acuity, vitaled and sent to the Pediatric Emergency Room with their chart.
- Their name will pop up on the electronic board, and their chart will be placed in the new patient rack. Grab a chart and try to see patients as they arrive because they can stack up quickly.

**Procedures**

- Make sure to log all your procedures in New Innovations at the end of each shift. It can be easy to forget to do so, but you don't wanna be scrounging for procedures to log at the end of your year.
- To log a procedure you will need the patient's MRN, the date of the procedure, and the certified person (senior resident or attending) who is signing off on the procedure log.
- You should do all of the procedures possible during your rotation. Practice makes perfect!

**Contents of an ED Chart**

- Triage Form – can be seen by clicking the “T” next to a patient’s name on Firstnet
  - Level of acuity (assigned by nurse in triage), dependent on patient age, chief complaint, initial VS. Determines how quickly the patient is seen. Always see the higher acuity patients first.

**Orders**

- Use Power Orders through Firstnet
- Notify the patient’s nurse of any new orders, especially if the order is written as STAT.
- Use Lexi-Comp (accessed through Firstnet or Powerchart) as medication reference.
- In the ED, place orders as STAT and x1 in frequency.
- Chem-8s must be ordered as “ED Whole Panel”
- Order UA without microscopic, if + then stat lab will reflex cell count
• Images (XR, CT, MRI) can be ordered through the “Emergency Department” or “ED Radiology” to get images not only STAT but with most of the order information filled out for you

CONSULTS

• Consults are arranged via Firstnet. A physician-to-physician consult order should be placed.

• There are a few exceptions:
  o Cardiology c/s: Tip: Before calling a Cardiology consult, you should obtain an EKG. They are always helpful! For infants, also consider pre-/post-ductal sats.

• Never call a consult without attending approval and never initiate a plan proposed by a consultant without attending approval.

ADMISSIONS

• If a patient needs to be admitted, you first must determine who the admitting physician will be.
  o A patient with a private attending who admits to the hospital will be admitted under that attending (see Appendix).
  o A patient with no PMD or a PMD without admitting privileges will be admitted under the hospitalist service.
  o A patient going to a subspecialty/surgical service will get admitted under their on-call attending.

• Present to the admitting physician and formulate a plan.

• Call the patient’s destination service and talk to:
  o The on-call resident who will be accepting the admission. They will notify the charge nurse of the admission.

DISCHARGES

Patient Information and Follow Up

• To discharge a patient, in your ED note, select a diagnosis, order prescriptions, and select patient education and provide follow up recommendations.
  o Tip: “Form for School/Work Excuse” can be added on in the patient education section and completed to give the patient a note for school or work

• Follow-up is generally with their PMD in 1-2 days.

• Check the box that states that the patient verbalizes an understanding of these instructions.

• Once the discharge is prepped, print and have attending sign. The forms can then be attached to the patient clipboard, and placed in the rack for discharge.

• You may discharge patients yourself. This can be particularly helpful if the ED is busy
Electives

So You’re Starting an Elective

Electives are available in a number of subspecialty fields and about 8 weeks of your year will be dedicated to electives depending on the preferences you made during scheduling.

- Days before your elective, CONTACT the fellow/attending on service to find out where you should be on your first day.
- If your schedule permits you to attend Morning Report from 8:30-9am you are expected to do so, check with the chiefs
- You should still attend Grand Rounds and Conference on Wednesdays
- While on your elective rotation, you may also be required to work short calls in either the ED, the Ward, or the Nursery.
  - Weekday short calls are typically 5-10pm, and you may present after your elective duties wrap up for the day.
  - Make sure you get orientation to the Nursery before your first short call if you haven’t had your Nursery rotation yet.

EMR Tips

You will receive a thorough orientation on how to use Cerner Powerchart, our EMR, during your orientation, but here are some specific tips that your seniors have found practical and helpful.

- Save common note pathways on to your ‘Favorites’ list (H&P, Progress, Event, etc). Encounter pathway (see next page) is where you would find these. Each pathway has slightly different fields and comes with some auto-populating information. This is particularly the case when it comes to subspecialties and electives.
- “Note type” is simply a label for the note and does not change what it looks like.
- Be sure to forward signed notes to the attending responsible for the patient in question.
- Developing your own set of macros can be a huge time saver. Be sure to make your own!
- Always remember to have the appropriate timeframe selected in Powerchart for when browsing in your ‘Results’ and ‘Clinical Notes’ sections
- If you are unable to find old patient documents/information, try searching through Eclipsys.
- Rounds List. For any patient list you view or make, you can also view this on a ‘Rounds List’, which can be very helpful when carrying a large load of patients (NICU, Newborn, or covering for your co-intern on ward).
The rounds list simply display patients names and info, but importantly, has icons that display whenever a new lab, radiology, orders (and customizable to display any other result) returns. You can even set the timeframe for which this applies. Having this list open and refreshing can keep you on top of events for your patients without having to open their individual charts. Try it out and see if it helps your workflow!

Personalized Patient List. You can make a patient list of your own to use by going to the Patient List tab and then clicking on the picture of the wrench (“setup”).
  o Create a name for your patient list, this is not a list that will show up on anyone else’s EMR, this is for you. Click the arrow that points to the right to add it to the “lists you want to have shown up on your screen.
  o Once the tab with the personal list show’s up, click the picture of the person with the yellow asterisk to add patients to your list. You can remove patients from that list by clicking the picture of the person with the red X.
  o You can scroll through your patient list in the order you have saved it while performing any function (such as intake/output or labs or MAR) by clicking the forward or backward arrows on the top right of the Patient List screen.
    i Tip: alphabetize your list on Newborn Nursery and crank out your intake/output numbers this way!

For patient privacy and safety purposes, NEVER leave your computer console on with the EMR logged in when you need to step away.

EMR is a great tool but there are still ways to make errors and glitches to work out, so check and double check your orders and documentation. (See Documentation section).

Call 4-4357 for the IT Help Desk if you are ever having trouble with the EMR.
Heme/Onc (aka PONC)

SO YOU’RE STARTING PEDIATRIC HEME/ONC...

- The Heme/Onc ward is located on 11S, to the right of the elevators.
- The resident call room is in the shared PICU/Heme-Onc core.
- The team will consist of 1-2 medical students, 1 intern and 1 senior.
- You and your medical student will be responsible for all of the patients on the floor. The census will be smaller than 11N, but patients will likely be more complicated, so be prepared to have a heavy workload.

SCHEDULING

- As the Heme/Onc intern, your work hours are from 6:30am–6pm.
- Because there are only two residents on the rotation at a time, you will end up doing 4 weekend calls. Despite what the schedule technically reads, the weekend call schedule will be determined by you and your senior resident.
- The chiefs need to know who will be on if it is different from the printed schedule. If you are schedule-shuffling, send the chiefs an email with your final decision and cc your rotating H/O co-residents. This formalizes the process and decreases scheduling memory lapses.

PREPARATION

- As with the wards, before you start, familiarize yourself with where everything is.
- The day before you start, the Heme/Onc intern will sign out the patients to you. Make sure that you know everything about each one of those patients: take notes during the verbal signout, comb the chart for pertinent information (H&P and off-service notes are key, if the latter is applicable) and go through the computer for current orders, latest labs and previous discharge summaries, if there are any.
- READ about the diagnosis and management. **Make sure you know the side effects and mechanism of action of any chemotherapeutic medications the patient is on**

WHERE THINGS ARE

Charts

- Red Charts are usually found in the chart rack. In them are:
o Patient stickers
o ED and outside records
o Completed consults
  o **Chemotherapy orders (in “Orders” section)**
  o Chemotherapy binder is found on the chart rack.

- **Powerchart:** Go there for all admission and progress notes, orders, Meds/MAR, vitals, etc.
- **Eclypsis:** Go there for old completed dictations that summarize a previous hospitalization

**Forms/Paperwork**

- Most paperwork can be found on a rack by the clerk.
- There is also a gray cabinet in the 11S core that has a lot of the pertinent paperwork.
- If you need paperwork and cannot find it, ask someone! The NP’s can be particularly helpful.

**Chemotherapy Binder:**

- In the chemo binder, you will find the paper orders for chemotherapy that the nurses will fax to pharmacy. You are not responsible ever for any chemotherapy orders, but you should review the orders before and after they are entered into powerchart.
- There is also usually a copy of chemo orders in the chart during an admission for chemo.
- Benny, the chemo pharmacist, will transcribe all the orders into the computer.
- **You are responsible only for fluid orders (which you should keep an eye on, as they can change with each stage or day of chemotherapy).**

**WHEN THINGS HAPPEN**

**Daily**

- 6:30 to 7am: Obtain signout from night senior in 11N conference room
- 7am – 8am: Pre-round
- 8:30am – 9am: Morning Report (except Wednesday, Grand Rounds at 8am)
- 9am – Midmorning: IHII/Attending Rounds
- Midmorning – 5pm: Work
- 5pm: Evening Rounds (depending on attending and census)
- 6pm: PM Signout
Weekly
- Heme/Onc Clinics: Daily in the afternoons (you and your senior must each attend once a week)
- Port access: AM Mon or Fri (this is your opportunity to become credentialed in accessing ports – you must access 2 in order to become credentialed; go early in the month because it can involve a lot of waiting and trial/error; call the Heme/Onc clinic in advance to let them know when you are coming for this)
- Tumor Board: Every other Monday at 4pm
- Radiology Rounds: Thursdays at 11am
- Interdisciplinary Meeting: Every Tuesday at 12pm in the Morning Report room. **You should present two talks on a subject related to Hematology or Oncology (one each).**
- You and your senior will also have your usual continuity clinic day(s) each week

**AM Signout**
- Because there is no formal AM signout for Heme/Onc, just make your way over to the 11N conference room sometime before 7am to get signout from the night residents.
- Tip: The earlier you can get there the better or you might have to wait for some Ward signout to take place.

**The Heme/Onc List**
- The signout list is located under the Medicine Physician’s Worklist as it is on 11N.

**Pre-Rounding**
- Ask the nurses about overnight events (that you should know about from the night team already, but you never know).
- Review vitals (including ALL ranges), ins and outs (including reporting UOP in cc/kg/day), new labs or films, etc.
- Check the MAR to note the time of chemotherapy, PRN pain medicine, etc.
- See as many kids as possible if they’re awake. If the patient is sleeping, let them sleep. Finish notes before rounds.
- Get to Morning Report by 8:30am.

**Attending Rounds**
- Attending rounds are bedside and family-centered with presentations outside of the patient’s room.
• For established patients, presentations should be short, with a brief introduction to the patient, any overnight events, ROS by system, vital signs, pertinent physical exam findings, new labs, assessment and plan for the day.
  o Tip: When presenting vitals, include ranges and UOP in cc/kg/day.
  o Tip: When presenting labs, include pertinent indices (i.e., corrected reticulocyte count in sickle cell patients or ANC in chemotherapy patients).
• If the patient is a new patient, you will have to present the entire H&P.
• You should defer all presentations to your medical students if they are following a patient. Make sure to go over with them the correct format and help them in their areas of weakness.
• On Wednesdays, everyone goes to Grand Rounds. One resident (you or your senior) will then man the ward while the other goes to lecture. This should switch off every week.

**Admissions**

• Admissions are the same as on 11N. Patients who are admitted will need a complete history and physical written on Powerchart, growth chart and BMI, admission orders, PMD notification (if necessary) and medication reconciliation (if not done by nurses).
  o Tip – Use past notes/labs from Powerchart and completed dictations from Eclypsis to fill in as much history as possible before the patient arrives on the floor.
• Unlike patients on 11N, patients on Heme/Onc have done the same song and dance over and over.
  o We usually like to spare them as much history regurgitation as possible.

**How to Access Eclipsys**

• Under desired patient’s menu, hit the Eclipsys tab on the left.
• A window will open that will provide you with Eclipsys links. You can double-click any of those for results.
• Hit “Image” at the bottom of window (or click the little green icon with the landscape in the toolbar).
• The Eclipsys manager will come up. A starred visit means that parts of the chart have been scanned; an “I” means that there should be a discharge summary
• Here you will find a wealth of information from previous hospitalizations.
ORDERS, RADILOGY, PRESCRIPTIONS, CONSULTS, DISCHARGES, DICTATIONS, TRANSFERS, OFF-SERVICE NOTES, MEDICAL STUDENTS

- Please see the Intern Survival Guide: [Wards section](#) for in depth details about the above.

**Heme/Onc Consults**

- Other services will frequently consult the Heme/Onc service for Hematology and Oncology issues.
- Either you or your senior will be responsible for doing a complete H&P for consulted patients as well as formulating your own assessment and plan.
- Keep track of them and write notes daily, unless the attending specifies otherwise.
- Frequent reasons for consultation:
  - Thrombocytopenia/elevated coags/bleeding
  - Anemia
  - Neutropenia
  - Thromboemboli/anti-coagulation needed

**Running the List/Updating your senior**

- During the course of the day, update your senior (and your patients/families) frequently.
- Make sure to also update the list frequently, double and triple-checking correct medications and doses.
  - Don’t let any vital medications (i.e. Antibiotics) fall off the MAR on your watch!
  - Check your medications orders twice daily
- You and your senior will take turns staying until 6pm to sign out. Everyone else stays until evening rounds with the attending around 5pm.
- Before evening signout, you should have reviewed the most recent vitals (including ranges) for your patients and have a good idea of what the night team should expect overnight.
- Try to print 2 copies of the Heme/Onc list and get to the 11N conference room at 5:45pm to be ready for signout.

**PM Signout**

- Evening signout begins at 6PM in the 11N conference room.
- Confirm which attending will be on call that evening at rounds and whether they would prefer to be contacted via pager or cell/home phone.
• Presentations to the night team should be brief, but they should also include any and all pertinent information about your patients that would be important to know overnight.
  o Report by systems, including most recent vitals.
  o Briefly list important medications and their side effects (list chemotherapy side effects on the sign out so night team is aware)
  o Finish with a summary of night issues/things to look out for or accomplish overnight, as well as labs expected in the AM if there is a value that needs to be watched for. (see Signing Out for more information)

• Common Heme/Onc issues to sign out:
  o **What to do for a fever** – What is the temperature cutoff for each patient/what counts as a fever? Do we need a blood culture with fever? To a max of how many/day? Has patient already reached max? Does max restart at midnight? Should we start antibiotics if the patient is febrile?
  o **What to do for abnormal urine dips** – What are acceptable parameters for urine dips? How should we adjust fluids for abnormal parameters?
  o **If you need methotrexate levels done overnight** – Usually not run after hours unless approved by Pathology resident on call (you can get prior approval during the day). If you need this done, page pathology resident on call during the day and tell them patient’s name, DOB, MRN and the time the sample will be drawn. They should approve it with no problem, but be prepared to explain why we need it done overnight (it will change our management).

FROM “FREQUENTLY ENCONTERED H/O PATIENTS” - Dr. Suzanne Van Benthuysen

*Sickle Cell Disease and Routine Chemotherapy Visit*

**SICKLE CELL DISEASE**

• Patients with SCD will often present with pain crises and/or fever.

**HPI**

• Normal pain questions: Onset, location, duration, severity (0-10) before and after intervention, what do they have at home and what usually works? Quality? Associated sx?
• Any chest pain, cough or SOB? RUQ pain (think about gallstones)?
• Febrile at home/in ED?
PMHx

- What kind of hemoglobin disease is it? (SC, SS, SB-thal). You can look back in the labs on the computer to find out old electrophoresis results if they don't remember.
- Any hospitalizations, surgeries (GB out?), last transfusion, any exchange transfusions or PICU admissions, any acute chest/stroke/priapism/osteomyelitis events?
- Home meds and compliance? Were they on PCN until 5?
- Immunizations (pneumococcal vaccines and flu vaccines)
- Look back in the computer and get an idea of their hemoglobin/hematocrit, what are their normal values? What are their normal reticulocyte values?
- Check Eclipsys for previous admissions and surgeries

Orders

- FEN:
- IVF: Hydrate aggressively 1.5 maintenance except in cases of acute chest, when fluid overload can be an issue (in that case 1M is sufficient)
- Regular diet if tolerated, strict Is/Os
- Respiratory
- Supplemental O₂ as needed to keep oxygen saturation greater than 92%
- Pulse oximetry protocol (continuous not always necessary!)
- Incentive spirometer at bedside, encourage frequent use (suggest during commercial breaks if watching TV)

Pain

- Whatever works for them around the clock and PRN for breakthrough (if they don't know, morphine is usually a good place to start).
- PCA can be started by acute pain service. Call them to come see the patient if you deem it necessary.
- Motrin or Toradol around the clock always!

Other Meds

- Antibiotics: If febrile, start ceftriaxone. If you're also worried about pulmonary involvement, also start azithromycin to cover atypicals.
- Hydroxyurea
  - Increases hemoglobin F production
  - If not taking at home, ask why
- **Folate**
  - Sicklers have inherent folate deficiency because of high RBC turnover
  - Also if not taking at home, ask why
- **Pepcid** – Prophylaxis for NSAID gastritis
- **Bowel regimen** – Constipation from opiates.

**Labs**

- Usually get a CBC and differential with reticulocyte count (probably done in ED)
- CXR if any suspicion of pulmonary involvement (probably also done in ED)
- Hb electrophoresis if concerned about compliance.
- Blood culture for T > 101 up to 3/day if febrile

**Hospital Course**

- If patient is febrile, they do not necessarily need to be admitted (but cultures need to be drawn and antibiotics should be administered within one hour of arrival). Can give CTX IM x 2 days as outpatient.
- Admit if poorly compliant pt/family, WBC <5 or >30 or patient is very ill-appearing/there is concern for acute chest syndrome
- Follow blood cultures.
  - When afebrile and cultures are negative 48 hrs, patient can go home (if on PO pain meds and not requiring oxygen)
- For pain crises, goal is to get patient off of IV pain meds.
  - Once tolerating PO pain meds, they too can be discharged.
- On discharge, make sure all sicklers have H/O follow-up in clinic, adequate home meds and pain meds.
  - Common home meds: Folate, Hydroxyurea, Exjade (iron chelator)
  - **For po narcotic pain meds, make sure you have the attending write the prescription in advance of discharge**

**Routine Chemotherapy Visit**

- Patients coming for chemotherapy have usually been in clinic that day or the day before and have already had their labs drawn. They have probably already answered a bunch of questions about how
they were feeling since the last round, but unfortunately we have to ask them again.

HPI

- Make sure to be thorough in ROS: fever/appetite/energy/pain/rash/bleeding/nausea/vomiting/diarrhea/constipation/cough/sniffles/blood in stool or urine/pain on swallowing/pooping/peeing (all mucous membranes = possible mucositis).
- Are they neutropenic? Are they tolerating neutropenic diet?

PMHx

- You can find a lot of the pmhx on Eclipsys, so before the patients come up, try to fill in history you can.
- When they were diagnosed
- How many cycles of chemo/radiation and when was the last one
- Past surgical history
- Home meds and compliance issues
- Immunizations

Chemo Orders

- You do not have to figure out a structure for a chemo protocol or order chemotherapy yourself. The protocol will be provided to you when a patient is admitted.
  - Your job is to order anything in the protocol other than the chemotherapy medication itself (including fluids, medications for nausea, antibiotics, etc).
- Preprinted chemotherapy orders live in the red binder. Go through them carefully.
- Make sure to know the side effects of each of the chemotherapies. Check the document in the resident drive named “chemo side effects.” There is also a binder of medication side effects as well as the Internet at large.
  - Always know side effects! The Chemotherapy medication section of Harriet Lane has a great summary of these that is easy to Xerox and carry around (just a couple of pages long).
- Chemo orders often include PCP prophylaxis but not necessarily mouth care and will not include Motrin/Tylenol for fever. Make sure they have mouth care, some antifungal for the mouth, PCP prophylaxis.

Admission Orders

- Admission orders should include:
  - A communication order to the nurse detailing that you want to know exactly when a patient has a fever > 100.4,
and whether you want blood cultures with new fever spikes.

- Also include a communication order with urine parameters (ph, blood, and specific gravity, state “Notify MD when” for any abnormalities).

**Make SURE that you order all labs outlined by the protocol.**

**Hospital Course**

- Patients will likely get nauseated. Do what you can to keep their appetite stimulated and nausea at a minimum.
- Most chemo protocols are uncomplicated, and patients finish them and go home uneventfully. (The exception is AML patients – we wait for their counts to drop and recover before they’re allowed to go home due to high risk for developing gram negative bacteremia.)
- If patients develop a fever and are NOT neutropenic, they are usually cultured and started on a cephalosporin like ceftriaxone until cx are negative 48 hours.
- If they ARE neutropenic, they have to get started on antibiotics that cover gram positive, negative, and pseudomonas.
- Cefepime and nafcillin are standard starting antibiotics and are continued until patient is afebrile, cultures are negative 48 hours, and ANC > 500.
- In this case we also get daily CBC/diff (to trend ANC, make sure it’s starting to go up--you can go home neutropenic, but not febrile and neutropenic, and we want to make sure the ANC is at least trending in a better direction) and blood culture, along with blood cultures with febrile episodes as above.
- Make sure that on discharge, patients have enough home meds (you may have to write Rx or call in to the pharmacy).
Common Home Meds after Chemo

1. Prophylaxis

Prophylaxis for PCP pneumonia
- Bactrim (trimethoprim/sulfamethoxazole): Taken 2-3 days/wk, may cause bone marrow depression
- Mepron (atovaquone): 2nd line coverage, only comes as liquid, some patients won't tolerate it. Daily drug, less bone marrow depression
- Dapsone: 3rd line coverage, not as good coverage but less bone marrow depression
- Pentamidine: 1 IV dose Qmonth, good for sulfa-allergic pts
- Prophylactic antiseptic mouth care
- Peridex (chlorhexidine): 1-2 teaspoons (5cc=1tsp) PO TID, swish/spit

Prophylactic Antifungal mouth care
- Nystatin (100,000 units/ml) 1-2 tsp (5-10cc) PO TID, swish/swallow (sw/sw)
- Mycelex 1 troche PO TID

2. Antiemetics

Selective 5-HT3 Receptor Antagonist
- Zofran (ondansetron) ODS, pills, or IV
- Kytril (granisetron) IV only
- Aloxi (palonosetron) IV only

Antihistamine antiemetics
- Benadryl (diphenhydramine) - good antiemetic, IV or PO. Patients can develop addiction to IV push.
- Atarax -(hydroxyzine)
- Ativan
- Emend (aprepitant): antagonizes substance P/neurokinin-1 receptors, usually only given once per protocol on first day as premedication
- Marinol: active component of marijuana, good appetite stimulant/antiemetic
- Reglan (metoclopramide)/ Benadryl (addition of antihistamine reduces extrapyramidal side effects)
- Phenergan (promethazine) phenothiazine derivative, sedating (use cautiously, don't use in children under age 2 or with seizures)

3. Other Meds
**Neutrophil stimulators**

- GCSF (Neupogen) 5micrograms/kg, SQ qday until ANC adequate (usually 2 week cycle)
- GCSF (Neulasta) 1 shot SQ usually good for a month, 6mg if >45 kg, 100mcg/kg if <45kg *because it LASTS, get it!* it's easy to mix the two up but neulasta is crazy expensive and neupogen is a bit more affordable. Usually neulasta is given at home (cheaper for the hospital)

**Antibiotics**

- Cefepime and nafcillin are standard starting antibiotics and are continued until patient is afebrile, cultures are negative 48 hours, and ANC > 500.
- When running them through a central line (PICC, mediport (underneath the skin, accessed by a needle), or broviac (tubes hanging out all the time)), make sure that they are being run through ALL LINES of double lumen mediport (accessed by 2 needles), double or triple lumen PICC, or broviac with 2 lines. That way any possible infection in the line is being treated as the antibiotics run through. Also remember to draw blood cultures from both lumens if a patient is febrile.
- Write two (or three) separate orders, splitting the dose between multiple ports. If patient needs 800mg Nafcillin, for instance:
  - 400mg IV Nafcillin Q6H, comments: red port
  - 400mg IV Nafcillin Q6H, comments: white port
Morning Report

ALL House Staff and anyone on electives that are scheduled to attend must be present BY 8:30am every Mon-Tue-Thurs-Fri.

- BE ON TIME. Page the chiefs asap if there is a patient care emergency that precludes you from coming on time
- The goal of morning report is two-fold. First, the focus is on resident education, especially high-yield topics. Second, it is an opportunity to hone presentation skills.
- If you are presenting, be prepared to be interactive with the audience and teach about your case.
- If you are in the audience, be prepared to participate in the discussion.
- Morning report is 30 minutes long, from 8:30am (promptly) until 9:00am. It is facilitated by the chief residents.
  - Senior residents will present cases for the first 6 months.
  - Interns are expected to start presenting cases in January.
  - The chiefs will notify you if there is a case they would like you to present
- BE ON TIME.

Case Selection/Preparation

- Cases are to be decided upon within the week prior by chiefs, which will allow for ample preparation time. Attendings relevant to the case will be asked to attend.
- Cases should be well-structured and succinct, with NO extraneous information, with clear discussion points, with a focus on either differential diagnosis or management.
- Once a month, one of the morning reports will be led by the current NICU residents.

Things to arrange in advance

- The presenting resident is to email the general topic of the morning report out to the “SOM Pediatric Resident” list serve the day prior to their presentation. For instance, “I will be presenting my morning report tomorrow on the management of abdominal pain.” Do not give away the diagnosis!
- Photos of physical findings can be used, assuming the proper consent has been obtained and placed in the chart, and that the photos are erased from e-mail/computer immediately after morning report.
- Radiology images can be used from the EMR if pertinent.
- Scheduling of morning report – In order to discuss fresher cases, the chiefs will be scheduling cases to be presented within a few days of admission.

- Try to run your first presentation by a chief resident and/or with a faculty member a couple of days before you present.

**Faculty/Teaching at Morning Report**

- Faculty are encouraged to contribute to the discussion at the appropriate times, but are asked to refrain from interrupting the presentation or from redirecting the discussion away from the main area of focus.
  
  o The chiefs will be the ones to invite morning report attendings to your morning report and will let you know generally who they are expecting.

  o If you know who is coming, try to communicate with attendings that will be present at your morning report ahead of time. Let them know if there is a specific part of the history, diagnosis, management, or follow up that you want them to try to answer more in-depth, then give them an opportunity at that point in your presentation to address those areas.

- Tip: Presentations should be concise but complete and include the chief complaint, HPI, full past history and physical exam.

- Major teaching points should be included in discussion of differential diagnosis and management. Here are some ways to incorporate teaching points/discussion:
  
  o Ask the group for differentials, give ten seconds before asking again (gives them a chance to think and respond). I.e. “What might be causing this abdominal pain?”

  o For each differential diagnosis, ask the group how they would determine IF that were the diagnosis (which lab, imaging, test, etc) and/or how they would manage it. I.e. “What testing might support a diagnosis of appendicitis? “ Or “What might you do next if this diagnosis were confirmed?”

  o Offer a teaching point relevant to the case about that testing or management. Try to be interactive! I.e. “In this case, the abdominal CT failed to visualize the appendix and the white count was high, but the physical exam was not a classic presentation. Because the patient was a toddler another consideration might be Meckel’s diverticulitis. Does anyone remember the Rule of 2’s?”

  o Save the true diagnosis until last, even if someone guesses it first, to allow creation of a broader differential.

  o Try to come up with about 4-6 teaching points.
GENERAL STRUCTURE OF A MORNING REPORT

- Initial “one-liner” should contain the following patient information: Age, Sex, and Race/Ethnicity
- Histories – The residents are expected to know the patient very well. The history should be presented freely without directly reading word for word from their paper.
  - Residents should be able to answer ALL pertinent questions regarding the HPI and PMH.
  - The entire HEADSS exam should be stated.
- Physical Exam – Initial vital signs, weight, height/length and head circumference should be stated.
  - "If the patient is an infant, the term “length” should be used instead of “height.”
- Images – Residents should know the images well and be able to explain them. Images should be reviewed with the radiologist and/or neuroradiologist prior to the presentation.
  - Powerpoints – PPT should only be used to show pertinent images ex. Rash.
- Discussion – All relevant diagnoses should be included. Zebras are welcome, but only if they are truly a possible diagnosis.
  - The discussion should be led primarily by the resident.
  - The discussion should be interactive and should include the appropriate faculty members.
    Residents should engage the faculty for discussion points.
  - There should NOT be a formal lecture discussion at the end of the presentation. Any teaching points should be mentioned during the differential and/or management section.
- Hospital Course/Follow Up - The end of the case should include the relevant follow-up, including social issues, CPS follow up, outpatient appointments with subspecialties or PMDs. This is a great time to incorporate faculty!
- Audience: Please refrain from clapping at the end... House rules.

THE AFTERMATH

- Ask for feedback from the chiefs or other senior residents and attendings following your presentation.
- “Running the list” (senior residents on the Ward do this) will be done at the discretion of the chiefs and faculty.
Newborn Nursery

SO YOU’RE STARTING THE NEWBORN NURSERY…

▪ The newborn nursery is located in the mother-baby ward of the hospital. To get there, hang a right at Starbucks and take the elevator to the 6th floor.
  o Tip: You’ll need your ID at practically every entrance, so don’t forget it!
▪ The nursery itself is located about halfway down the hallway. The front door is on the north side (higher numbers). The door closest to where the resident hangs out is on the south side (lower numbers).
▪ When the census is low, most moms (and babies) reside on the 6th floor. There is, however, overflow to the 5th floor so pay attention to where your patients actually are.
▪ Dress code is business attire, no white coat. If you’re on over the weekend, you may wear scrubs.
▪ As the newborn resident, you’ll be working from whenever you arrive in the morning (more on that later) until 5pm.
▪ You will work one weekend day for three weekends during your block. Before or after your assigned Newborn Nursery block, you may do a weekend day of Newborn Nursery during elective or Development blocks.
▪ A few days before your first day of Newborn Nursery, contact the Nursery resident and set up a time to visit the Nursery. The goal is to make sure that you are very familiar with the day to day activities of the nursery. Thoroughly read this section before going.
▪ Tip: The big keys to being a success on this rotation are high efficiency and organizational skills. Also, you will see a lot of normal babies, so it is important to be able to detect and note any abnormalities.

WHERE THINGS ARE

Nursery Laptops

▪ When you come to the nursery, go to the Circumcision room. Face the cabinets and the leftmost drawer has a small gold key that unlocks the leftmost upper cabinets. The laptops and chargers are in there. Make sure two laptops always charge through the night (to “survive” rounds). You can also lock purses/bags up there during the day.

Newborn Nursery Cards – Pink and Blue
Located near the table in the back of the nursery where you can sit.

For every new baby you need to fill out a card as completely as possible. It will also help you keep track as you care for the baby about things they might need to have done, like Hep B vaccine, hearing screen or anticipatory guidance. Update the cards frequently during the day. Make sure the ins/outs and weights are completed per day of admission on the back of the card. See guide below.

Babies and Accessories

- We are a baby friendly hospital, so all babies will be in the mother's room and should be examined in their room. **(Always wear gloves when examining as new babies are not washed for the first 8 hours of life).**
  - Families often have questions, so know your anticipatory guidance
  - Budget your time wisely.
- Bassinettes are stocked with pretty much everything you need: diapers, wipes, receiving blankets, etc. Check the drawers.
- Ophthalmoscopes on wheels are located within the two nurseries for easy access. There is also one on floor 5 near the nursing station.
  - Tip: All new babies need red reflex checked so wheel the scope with you in the morning. **It can be helpful and quicker to carry your own portable ophthalmoscope with you.**

Blue Baby Charts

- Located in the nursery during the early morning hours and out to the appropriate nursing stations after rounds. If you can't find a chart, look at the nursing station near that baby's mother's room. Important things you will need from the chart are:
  - **NBN report sheet** – A white form filled out with handwriting, when the nurse from L&D delivers the baby to the nursery, the newborn nurse takes notes on this sheet, provides a summary. **(Can be a helpful form for completing cards on new babies in the AM)**
  - Inpatient Admitting Face Sheet – with insurance information, sometimes states PMD (Check to be sure the PMD selected is not an admitting physician)
  - Admission/Delivery Summary – is printed from the CIS system, has some more history and birth information.
  - Birth Report (a carbon copy yellow page)
  - Physician Orders – discharge orders (every baby has a stickered one in this section, save them in the morning, fill them out when it is quieter in the afternoon but don't sign until sending the baby out).
- Consents – HepB and circumcision.
- Report of Operation – Birth report will be found here if not in the H&P section
- Nursing Records – NICU/NBN nursing admission sheet

Red Mom Charts

- Located in L&D with mom immediately after delivery. Comes over with mom when she is taken to her room. Use these in the mother-baby nursing stations, do not take them back to the resident area!
  **There are 2 things in this chart important to you:**
  - Prenatal Records – clipped to front of the chart or in the H&P sections.
  - Admission Note – in the H&P section. Will provide a wealth of info, including the number of prenatal visits. 9-10 prenatal visits is considered “adequate” or “routine” prenatal care (PNC).
  - Be sure to note any unusual conditions/complications that are relevant to the baby. (e.g., if mom had HSV or was on Valtrex and delivered vaginally, it will be important to ask mom if she had any lesions.)
  - HIV, GBS, HepB and blood type will be written in a number of places. RPR are usually done when the mom is admitted, so check mom’s Powerchart for those. Using an RPR from early pregnancy is not helpful because mom can contract it after that point.

Tan Bedside Charts

- Clipped to the baby’s bassinette.
- Record of day of life, birth weight, daily weight and change, vital signs, voids and stools, feedings and NAS scoring.
- If you witness a void or stool, check it off in the bedside chart
- This chart usually comes up with the baby before the baby even has a blue baby chart so you can use it to get a head start if the birth report is inside.
Newborn Nursery Admission Notes

- Write Your Admission History Note (“Newborn History” template) and Admission H&P (“Newborn History and Physical” template) in Powerchart. Do not fill all of the history out a second time in the H&P note, click the option “Refer to History Note” at the beginning of History and then continue on.

When Things Happen

Daily

- 6am: Arrive, call NICU (4-2000 for NICU front desk) to get overnight sign out from the resident that covered.
- Make sure you have checked the bilirubin levels on the discharge list and made sure the list is accurate (sometimes NAS babies are on the list but should not be, or they miss a baby that actually is able to go home). Have all the to-do items done for these babies and their discharge paperwork completed and in their charts. Order any pending DC bilirubins if needed.
- Prior to 9:30am: See all babies, write minimum 10 notes. Discharge notes takes precedence followed by admission notes, then interim baby notes. You should be able to easily manage about 15-20 babies but the census can be higher than that. Keep open communication with your attending as to expectations if the census “blows up.”
- 9:30am: Attending rounds (time may vary)
- Afternoon: Admissions, Check in with moms and babies, Pending discharge orders
- 5pm: Signout any issues that need overnight monitoring or follow up to NICU resident on call. These include pending labs, babies on NAS protocol, or babies you are worried about.
- Tip: When you are on newborn, you do not go to morning report but you do attend Grand Rounds and Wednesday lectures.
  - Come earlier on Wednesdays because you will need to be done and sitting in Grand Rounds at 8am and then onward to Wednesday lectures, so you have 90 less minutes to work on average than on other days. All discharge prep (i.e. completed newborn cards) and documentation for rounds must still be complete before rounds on Wednesday.
**Prerounding**

- Your arrival time each day to the nursery should be based upon how many patients are on your census, how comfortable you are with the paperwork and how well you can manage your time. **In general, you should arrive no later than 6 AM.**
- The first thing you should do when you hit the nursery is **scrub, surgical style, at one of the sinks.** Stay on the good side of the nurses. Trust us.
- Next, **print two copies of the census from Powerchart.** One is for you, one is for the attending. Take a big, black marker and **cross off any babies who aren’t on the hospitalist service** i.e. “staff babies.” (see **Appendix** for list of admitting private PMDs). Always double-check if staff is covering for a PMD.
  - Tip: Ask parents for their chosen PMD when you see any new babies, sometimes the family intends to see an admitting PMD but doesn’t realize that the PMD admits, in that case the baby can be transferred from service to private attending even before our attending comes. But you have to ask!
- Note on your census which babies need to be admitted, which ones you think should be discharged, and which ones are interim.
- An anticipated discharge list (with T/D bill levels) will be hanging up on a clipboard by the charge nurse. The bilis are drawn at 0400 everyday, but sometimes slightly later, always plot the bili based on the “hours of life” between birth and the time the bili was drawn. **Bilitool.org can be a great tool for evaluating bilis.**
- Compare the anticipated discharges with patients you think should be discharged home (day 2 NSVD, day 3-4 C/S). Sometimes, babies can be discharged but don’t get on the list so it is important to double check. Other times the babies that are not being discharged such as for NAS or social hold do get on the list but you should keep them. Check with the floor nurses or moms themselves.
- Organize yourself using the baby cards. Find an order that helps you locate a particular baby’s card easily, such as alphabetical or by the order of priority (discharges, admissions, interims). Sometimes, it is also helpful to use your copy of the census as a to-do list.
- **Examine all of the babies, first the discharges, then the admissions, then interims. You should see every baby. If the census is overflowing, your goal should be 15-20 a day and then address the remainder over rounds.**
  - Tip: Try to see any babies in the nursery first. Then, take your ophthalmoscope onto the floor and see the babies in their mothers’ rooms.
Every baby in the nursery that is a staff baby should have a Newborn Card. The cards from the night before are kept on the resident table in the box. Try to keep them clipped or rubber-banded together.
- Newborn cards: pink for girls and blue for boys, blank ones are located in the resident area of the nursery.
- Begin filling out a newborn card for every admitted baby, then update as you get more information or complete further tasks. By the time of discharge, all necessary checkboxes should be complete, there should be a D/C bili and CCHD result recorded and you should know the result of any pending social issues.

Admissions

- To keep on top of admissions, keep your EMR patient list ordered by “length of stay” (shortest first), and refresh your census frequently. Note if the baby is a staff baby or a private attending's baby.
- When the baby first gets here, try to listen to the L&D nurse sign out to the nursery nurse. All that initial information goes on the first sheet in the chart, the Newborn Nursery Report Sheet.
- Double check which pediatrician is written on the green Newborn Physician Information sheet that comes with the baby. If it’s not staff, it’s not your admission. Make sure staff is not covering for any private attendings though as this sometimes happens – the charge nurse will know.
  - Along those lines, if nurses ever have a question on any baby, first ask what the question is and find out if its emergent. Suggest that they call the appropriate private attending if it is not emergent but you should evaluate the baby if they are concerned or if you are after you hear their questions. You are the nearest doctor to all the babies and saying “it’s not a staff baby” is a pet peeve of the nursing staff.
- The nurse will take the baby to the warmer and do her admission. Let her chart everything and bathe the baby. Her vitals and physical will go in the Nursing Records section.

Admission Orders
- Some orders will be put in by the L&D nurse.
- Admission orders are found in your pediatric folder under “Newborn Nursery Admission Power Plan.” Initiate and sign. (For babies who are less than 37 weeks gestation, enter the “Late Preterm Newborn Nursery Admission Power Plan”.)

Notifying the Attending

- Unless you are unsure about a plan of action, there is no need to notify an attending about an admission.
- Attendings will see new babies the next morning.
- The H&P must be filled out within 24 hours of birth time.

**Mom’s Arrival to Mother-Baby Unit (Floors 5E and 6E)**

- As you might have noticed, some things are missing from your admit flow sheet/summary sheet. All of those things will be neatly filled in once mom arrives at postpartum.
- Mom will give consent/refuse HepB vaccine.
- Mom’s chart is a wealth of information:
  - Her medical history
  - Her prenatal labs

**Interim Babies**

- Write a progress note in Powerchart.
- The attending will co-sign your note.
- Because the attending must write a note on all of the interim babies, they are last on your priority list. If there is a huge number on the census and you don’t get to them, don’t worry.

**Discharges**

- **Discharges are the number one priority in the morning. Double-check the anticipated discharge list.**
- Fill out the discharge orders (located in the “physician orders” section of the baby’s chart). Note the date and time of their follow-up appointment and what the baby should be feeding.
- You can prewrite these!
- Feeding instructions: Breastfeed 10-15 min/side or 30 min total every 2-3 hours. OR Formula feed 1-2 oz every 3-4 hours.
- Other instructions: Fever is >100.4F or <97F via rectal thermometer. Call a doctor if baby is not feeding, voiding or stooling well. Baby should sleep alone on his/her back.
- Take a chart rack and put only the discharge baby charts on it for rounds.

**Transfers to/from NICU**

- Transfers to NICU can be done at any time.
  - If you are especially worried about a baby, call the NICU.
  - Always notify the attending, even if it is a private baby.
  - Always go with the baby to NICU.
  - When you get there, sign out to the resident (and fellow, if necessary).
If you just want the baby looked at and assessed by a NICU fellow, have one paged.

As with any transfer, write a thorough transfer note.

- Transfers from NICU – check the list every morning to make sure there were no new transfers, these babies may be older (longer length of stay) than other admissions, so check the whole list.
  - Babies admitted with gestations 35-36 weeks may be transferred to NBN after 24 hours of monitoring and determined to be stable. Babies must weigh > 2000g at the time of transfer.
  - Term newborns with any type of physiologic instability/delayed transition may be transferred to NBN after consultation with the accepting physician.
  - Make sure transfer orders are correct.
  - Be sure to put in the Newborn Nursery Power Plan (or Late Preterm Power Plan) if needed.
  - On admission to Newborn, write an accept note. Gather all the information that you would with any other admission.

Orders

- All order writing is done electronically through our Powerchart system, but, as always, you should notify the patient’s nurse of any new orders, especially if the order is written as STAT.

- The nurse for the babies physically located in the nursery are also physically located in the nursery, and for those babies out in mom's room, the nurses are out at those nursing stations.
  - Tip: Admission orders are found in the “Pediatric” folder. The “Newborn Nursery Admission Power Plan” will have everything you need to admit a baby. There is also a “Late Preterm Admission Power Plan” for babies who are 35.0 to 36.6 weeks of gestation when they are born.

- Admission orders need to go in for every baby, not just service babies. Private attendings will try to do their own, but it is ok to help them out.

- If HepB was given, it should be found in baby’s MAR.

- To find out if the mom was given appropriate antibiotics for GBS positive or unknown, check her MAR.

Opiate Orders

- If you have a withdrawal baby on morphine and it is time for a dose change, remember that the pharmacy sometimes takes forever and a day to get drugs where they need to be.
• For example, if you are going from 0.12mg to 0.09mg Q4H, and the baby is due to receive a 0.12mg dose at 8am, let the baby get it.
• After the baby receives that dose, cancel the order in Powerchart and put in the new dose (0.09mg), first dose to be given at 12pm.
• Make sure to call the pharmacy and let them know you’ve made this change. You should get the new dose in time for the 12pm administration, but no promises.
• **Always check with the nurse practitioner Lisa Clark and the attending’s note to determine plans for opiate weaning.**
• This is complicated and its best to make sure everyone is on the same page. Lisa is our expert on this area.

**Attending Rounds**

• Generally occur at the bedside, family-centered style and incorporating presentations with teaching.
  - Tip: You can give anticipatory guidance while the attending examines the baby if you can keep it short (2-3 minutes).
• Rounds usually begin at around 9:30am but is attending dependent. Most will call the nursery in the morning to give you a heads up when they are coming.
• Each attending will let you know their rounding preferences and their expectations of you and your medical students.
• Length of rounds is obviously dependent on the census. When the census ranges from 10-15, you will likely be done by noon, with plenty of time for lunch, new admissions, and mommy rounds.
• Generally, a good goal is to try to easily handle 15-20 babies on the staff census by the end of your nursery rotation.

**Mommy Rounds**

• In the afternoon, you and your medical students should make rounds to see all of the families on the floor.
• General questions to ask:
• Do they have any questions or concerns?
• Breast/bottle feeding? Any problems with breastfeeding?
• Who will be the baby’s pediatrician? If they do not have one, are they interested in one of our clinic pediatricians? Its ok to refer to your own clinic and to yourself! Its great continuity to pick up a newborn and follow them through residency.
• Take care of anticipatory guidance on the first day of admission if at all possible. See next section for details.
• Note the patient's PMD on your newborn cards
• Address any and all concerns the parents have. Reassure them that there is a pediatrician on at all times and their baby will be looked at every day.
**ANTICIPATORY GUIDANCE**

Everything is important. But since new moms are also patients and recovering, it is important to try to get a few key things across that might be helpful once they get home. So these are a few things that are so important and easy to remember that these need to verbally stated as well as written on the discharge form too:

- Rectal thermometers only in first 2 months of life. Any temperature below 97 or greater than or equal to 100.4 is an emergency.
- Any change in feeding, peeing or pooping, especially if decreased, need to be evaluated by the pediatrician.
- Back to Sleep (SIDS campaign). Baby sleeps alone in the crib on his/her back, no pillows or stuffed animals, reducing the risk of SIDS. If family does not have a crib, can use a laundry basket with a towel on the bottom.

These next things are important too. Definitely state these verbally, write them if you have time, but not required for discharge form:

- Handwashing. Especially young siblings. Advise not to let other kids touch babies hands, since they can get their hands to their mouths.
- Carseats: Parents must have one before leaving the hospital. Current AAP recommendations as of April 2009 are to be rear-facing until age 2 or 20 lbs, usually 2 yrs supercedes.
- Smoking? Offer Opt to Quit (NY Quitline contacts the family after the hospitalization to initiate a plan) for any family members who are present and interested in quitting. You will need their full name, DOB, phone number and address. You or the nurse can enter the information into the Ad Hoc section of Powerchart (top of the screen).
- Tdap booster for all family members/caregivers. Flu vaccine for all >6 months old in the home during October-March.
- Ask about HepB vaccine if the mom has refused. Many times they have questions or other concerns and other times it is because they prefer to get it later with the pediatrician. Clarify the reason for refusal. If needed, reorder the vaccine (the original order will fall off after 12 hours if not given).
- Tip: Make sure to check off that you've given anticipatory guidance on your newborn card!

**IMPORTANT PEOPLE TO KNOW**

Lisa Clark (beeper 4-5859)

- Newborn Nurse Practitioner
Lisa helps to “run” the nursery by assisting the team with any number of tasks. She spends considerable amount of time with the many psychosocial issues as well as with any NAS scored babies.
- It should not be assumed that Lisa will be available to assist with morning rounds or pre-rounding work.
- Lisa has 25 years of newborn experience and is also our resident neonatal withdrawal expert.

Kathy Vanderventer – lactation consultant.
Darlene – social worker, keep her up to date on babies that are getting close to discharge but might need CPS clearance, especially on Fridays in preparation for the weekend. Darlene leaves after 4:30 pm on weekdays so make sure you catch her when she is there.

**Medical Students**

- All students assigned are to collect information, examine, and write notes.
- **Depending on the ability, the average assignment is 3-5 patients.**
- Medical students should also assist with new afternoon admissions.
- All assigned patients are under the supervision of the residents and nursery attending. All admission/ discharge chart notes must be completed in time to attend AM rounds.
- It can get busy, but try to make the time that the students spend in the nursery worthwhile. Teach as much as you can, even if it’s only pearls of wisdom here and there. They’ll appreciate it.

**Resident Assignments**

- Newborn Nursery Exam
  - [https://ezexam.som.sunysb.edu/q4/perception.dll](https://ezexam.som.sunysb.edu/q4/perception.dll)
- As part of your newborn nursery rotation, all interns must take and pass the online exam. Questions are based on the required readings on the curriculum website.
- The test will contain approximately 13 random questions from a large bank of board style questions. If you do not achieve 85% or better, you will need to retake the exam until you pass. You will not pass the rotation if you do not pass the exam.
- You will need an access code that will only work for a limited period of time after your rotation ends; therefore it is critical that you take the exam in a timely fashion during the last week of your rotation.
- Please e-mail or see Jean for your individual access code.
RECOMMENDED READINGS

- See the Peds curriculum site
  - http://medicine.stonybrookmedicine.edu/pedrescurriculum

WEEKEND CALL

- Weekends are structured exactly like weekdays except there will be a senior resident there for short-call.
- Time your arrival depending on the census and take into consideration that neither Lisa nor the medical students are available over the weekend, you must arrive by 6am at the latest.
- Most attendings will get in early, see babies by themselves, then sit down to round. (However, this is extremely attending-dependent, so stay flexible!) Make sure that you have all your paperwork done.
  - Tip: On Fridays, make sure to round and remind mothers going home on the weekend to make their pediatrician follow-up appointments on Friday.
- If another resident is covering a weekend day, sign out any pending issues to them as well as to NICU on-call Friday evening. Since the other resident is covering, it is nice to make them a list with the service babies, each with a one liner, major exam findings and to-do’s on it, as well as leave the pink and blue cards for them.

NICU

SO YOU’RE STARTING THE NICU...

The resident call room is across from the locker rooms. The code is 2011.

You wear scrubs every day, but if you’re wearing long sleeves under your scrub top, make sure you can push them above your elbows easily (or the OR nurse will yell at you!).

No eating or drinking at all on the unit. There’s a break room as well as a fridge in the call room.

PREPARATION
If it’s July and NICU is your first rotation, you’ll have a nice orientation during orientation week, and you can get signout from the departing intern then.

If it’s not July, the day before the rotation starts, make your way to the NICU and get signout from one of the interns. If they’re really nice, they’ll show you around and teach you how to do numbers.

**DIVISION OF LABOR**

NICU patients are divided into two teams – Babies on the Red Team are cared for by the residents; and babies on the Green Team are cared for by the Nurse Practitioner team (the NNPs).

The NNPs are amazing so be really nice to them…they like chocolate.

When you’re on call at night and over the weekend, you’re responsible for all the resident babies.

**WHERE THINGS ARE**

**Big Red Charts**
- The big red charts sit behind the clerk

**Consents**

- Mom is the consenting parental unit always unless there is a CPS issue. Dad can only give consent if he and mom are legally married.
- When a baby is first admitted, you should get:
  - NICU – give permission to be in the NICU
  - JHACO – acknowledges we gave her info on privacy
  - HepB – if baby is >2kg
  - Circ – if mom is interested and baby is a boy
  - They will either be clipped in the blue chart (usually when patient is first admitted) or in the “consent” section of the red chart. You can also ask the clerk to print them for you.
  - Moms will usually visit when they recover. If they don’t, grab the forms and head over to L&D. It’s good chance to update them/ask questions/get consents signed.

**Daily Signout – use the Medicine Physician’s Worklist**

**WHEN THINGS HAPPEN**

- Weekly Labs (H&H, retic) – Order on Tuesday for AM Wednesday
- Weekly length, head circumference
  - Order on Tuesday for AM Wednesday
  - Don’t forget to plot these!
• Ophtho exams – Wednesdays, performed weekly
• TPN renewal – Every day
  o TPN must be ordered before 11 every day.
  o Fellows like to order TPN before rounding.

A Day in the Life

• 0700-0710: NICU Brief: Pre and Post-call Residents Join NICU staff, Attending, Fellow and NNP, meet around the clerk’s desk in the NICU
• 0710-7.45: Resident Sign Out
• 0745-0800: Examine Sick Patients (Ventilator, Surgical)
• 0800-1100: Attending/Fellow/Resident work rounds and bedside teaching, tpons and orders during rounds
• 0800-0900: Pediatric Grand Rounds (Weds)
• 1100-1130: IHI Rounds Tuesdays and Fridays (Attending and Fellows Only)
• 1200: Neonatal Division Academic Conference (Optional for residents)
• 1400-1500: Attending/Fellow teaching Rounds with Residents (Tues/Thurs)*
• 1500-1600: Social Service/Discharge Sit Down Rounds (Tuesday) Residents are required to Present Red Team
• 1600 Sign out by Red Team and L&D Fellow, residents NNPs, and Attending to Medical Team
• 1900-1910: Brief (Pre and Post Call residents attend)
• 1910-1930: Resident sign out
• 2100: “Lightening rounds” on all patients

progress Notes: Limit to 4 notes daily (includes weekends).
• Simulation sessions will be held at SIM LAB on 1st and 3rd Thursday during their rotation month.

Crunching Numbers

• The night resident will calculate numbers on all of your patients. They will put the numbers on the Medicine Physician’s Worklist.
• For the first week of life (days 1 through 7), all numbers are based on birth weight. Starting day 8, you can use actual weight.
• It’s important to keep meds and levels updated. Be sure, even if your baby has been off caffeine for a week, a covering attending will want to know the last caffeine level. You don’t have to list ALL of the result as you make sheets, just the most recent.
• Little kids need fluids. Their total fluids will vary with their gestational age and issues. Most kids will either start with 100cc/kg/day (little kids) or 80cc/kg/day (bigger), and we’ll work up from there.
- You care about two things
  - How many cc/kg/day the baby is getting
  - How many kcal/kg/day the baby is getting
- Kids get fluids in 2 ways: parenteral and enteral. Enteral is easy so we'll do that first.
CALCULATING PO FLUIDS

**Total fluid volume**

\[
cc/\text{kg/day} = \frac{\text{total ccs PO}}{\text{weight in kg}}
\]

**Hints, tips and tricks**

- Rice is 1 kcal/cc
- Breast milk is 20 kcal/30 cc or 0.67 kcal/cc

**Total fluid volume**

\[
cc/\text{kg/day} = \frac{\text{total ccs TPN}}{\text{weight in kg}}
\]

**Total calories**

The number designation of formula (E20, S24) denotes how many kcal\text{ s per ounce} a formula has. You don’t really care about ounces, though. You want ccs. And there are 30cc to an ounce. Therefore the general rule is that:

\[
\text{kcal s in formula} = \frac{\text{kcal s/cc}}{30 \text{cc}}
\]

It then follows that:

\[
\text{kcal s/cc/day} = \frac{\text{kcal s/cc} \times \text{total cc PO}}{\text{weight in kg}}
\]

**Total calories**

First you need to figure out how many kcal\text{ s per cc} your dextrose is giving you. This formula is true for all formulations of TPN:

\[
\left(\% \text{ dextrose}\right) \times 3.4 = \frac{\text{kcal s/cc}}{100}
\]

\[
\text{kcal s/cc/day} = \frac{\left(\text{kcal s/cc} \times \text{total cc TPN}\right)}{\text{weight in kg}}
\]

**Hints, tips and tricks**

- Lipids don’t count in the total volume of TPN (they run in their own bag) but protein does! Therefore, protein adds additional calories without adding additional fluid.
CALCULATING TPN: PROTEIN

Total fluid volume

0

Total calories

First you need to check the TPN order itself and note two things: order volume and trophamine (protein). Amount of protein is dependent on how much is in the bag and how much of the bag the baby got:

\[
\text{Total kcals/kg/day} = \frac{\text{Trophamine}}{\text{order volume}} \times \frac{\text{Total cc TPN}}{\text{weight in kg}} \times 4
\]
CALCULATING TPN: LIPIDS

\[
\text{Total fluid volume} \quad \frac{cc}{kg/day} = \frac{\text{total ccs lipids}}{\text{weight in kg}}
\]

\[
\text{Total calories} \quad \text{First you need to figure out how many kcals per cc your lipids are giving you.}
\]

\[
\text{This formula is simply:} \quad \frac{\text{kcals/kg/day}}{\text{weight in kg}} = (2)\left(\frac{\text{total cc lipids}}{\text{weight in kg}}\right)
\]

CRUNCHING NUMBERS: OTHER FLUIDS

- Anything dripping in (morphine, sodium acetate, etc.) Counts for cc/kg/day but provides no calories.
- Anything being put out (i.e. OG, Replogle) must be subtracted from cc/kg/day
- For those who are a little more high-tech, check out the NICU calculator (Peds drive à NICU folder à NICU documents). There are also apps for that.

ORDERS

- During rounds, while you’re presenting, another resident (or fellow) will usually put in orders for you depending on what is being discussed. Make sure the nurse is aware, especially STAT orders.
- Even though orders are written on the computer, you have to show all (virtual) math. When ordering Zantac, you should pick the “2mg/kg” option so the computer does the math for you.
- All fluids have to be re-ordered daily, and every time TPN is sent from pharmacy (usually 3pm) you’ll need to set a rate.
- On Thursday, Medication orders should be re-written based on patient’s weight.

THE DELIVERY AND OPERATING ROOMS

- Go to lots of deliveries. Our staff is very eager to teach.
- At first, you’ll attend all deliveries with someone more experienced like a fellow or senior resident. After attending three deliveries with supervision, you’re certified to go to uncomplicated deliveries alone with the DR nurse. However, if you’re uncomfortable attending a delivery by yourself, someone will always be there to go with you. You’re never truly alone. On the weekdays, there is a fellow and an attending assigned to deliveries.
- You’ll never go to complicated deliveries on your own.
When you go to the OR and you’re the one catching the baby, you’ll have to scrub in surgical style. Don’t forget your hat and mask.

The attendings, nps, and fellows will go over DR/OR proceedings in more depth. However, be aware that your primary role is airway – which puts you at the head of the radiant warmer. Review your neonatal resuscitation handbook – it helps.

Every other Thursday you will also participate in neonatal mock codes.

You also will need to assign the APGAR score and resuscitation measures in the EMR.

**MED Rounding**

The NICU has standardized drug dosing by instituting rounding policies on specific drugs. This can be found hanging in NICU

**NICU Admission Criteria** *(FROM NICU MANUAL, KATHY GILSBACH, RN, MS)*

- The following babies must be admitted to NICU:
  - Babies less than 35\(\frac{1}{7}\) weeks as documented on the yellow “Birth Record” and less than 2000 grams. These babies must come to the NICU for a period of observation to ensure normal transition.
  - Infants >35 weeks have no specific length of time they must stay in the NICU. In general, the transition period should be no less than 4 hours.
  - Infants <35 weeks must stay for a minimum of 24 hours of cardiopulmonary monitoring.
  - Any baby who shows signs of delayed transition/physiologic instability, including tachypnea, grunting, flaring, etc., should come to NICU for observation and monitoring, but as above, do not have to stay once normal transition is ensured. Keep in mind that normal newborn nursery has limited ability to monitor babies, both in terms of equipment and staff.
  - 5-minute APGAR total of 6 or less
  - Hypoglycemia
  - Maternal temp >100.4 and/or any documented diagnosis of chorioamnionitis
  - Infants who receive naloxone (Narcan) at delivery (for 24 hrs of monitoring)

**NICU Admission Orders**

- When a baby is admitted to the NICU, after he or she is stabilized, the most important thing to do is write the admission orders. Use the NICU admission power plan.
- One of the fellows or one of the fabulous respiratory therapists will be on hand to show you how they like to do respiratory orders. For
every change in vent settings or mode of support, you’ll have to write a new order.
  ▪ Ask the attending that is on if they would like you to write an admission note.
  ▪ Obtain consents from the mother (or father if married).

**DISCHARGE CHECKLIST**

Discharge Summary

  ▪ Use template in shared resident drive.
  ▪ Fill in ALL follow-up appointments with the name of the physician, phone number and time-frame.

Discharge Physical

  ▪ Will be noted in your discharge note on Powerchart.
  ▪ If any significant findings, add to the discharge summary list.
  ▪ Informing the PMD
    o The pediatricians appreciate a heads up about the patients before they are seen.
    o Call the PMD and give a brief history.

Discharge Orders

  ▪ If the baby is going home, Discharge the baby to home as you would in Newborn Nursery (see Newborn Nursery section)
  ▪ If the baby is going to Newborn Nursery, you need “Transfer Orders” to Newborn Nursery and you also need to initiate the Newborn Nursery or Late Preterm admission Powerplan so the baby has what he or she needs ready when they get to the nursery.

Dictation and Beyond

  ▪ When discharging a baby, discuss with other residents who will be assigned to the dictation.
  ▪ Try to distribute dictations equally during your NICU month.

**SIGNING OUT**

  ▪ Update the list and give the on-call resident a copy. Make sure to sign out anything pending overnight and for the AM.
  ▪ There is now a “brief” at 7 AM and 7 PM each day. Sign out will follow the brief.
  ▪ Focus mostly on the sick infants when signing out. It is ok to spend a bit less time on “feeder-grower” baby signouts if they are stable.
OVERNIGHT

- You’re in charge of all the resident babies from signout until 7am the next morning.
- There will be an attending, an NNP, and a fellow on with you at night. However, you’re first in line if there’s an issue with a resident baby – the call will come to you.
- You should wake up early enough in the morning to get all of the pending labs, update the list, and do all of your numbers before the rest of the team gets there at 7am.
- Some attendings will also want to review AM Chest X-rays.
- Don’t forget to follow up anything signed out to you from Newborn Nursery and to give an update on these items when the nursery resident calls you in the morning.
Nights

So You’re the Night Intern...

- The night intern rotation consists of two two-week blocks of nights.
- Your night will start with PM signout. Make sure to listen carefully about anything pending overnight, taking notes on the signout sheets if necessary. Both the floor team and Heme/Onc will sign out to you. Feel free to ask for clarification if something is unclear.
- Depending on the night senior and number of pending admissions, many night teams will do night rounds, which consist mainly of introducing yourself to the patients and families and asking if they have any problems or concerns.
- Depending on the census and the number of admissions, there may also be evening rounds with the hospitalist.
- For the rest of the night, your job is admissions.
- Be sure to help keep the list updated through the night.

Overnight

- Check vitals and labs frequently. If something looks suspicious or impossible (respiratory rate of 0, for example), get clarification! Make sure to have the nurses or CNA repeat any abnormal looking vital signs.
- If you are called to the bedside for whatever reason, write a 2-3 line event note in the chart stating why you were called, what you did, and what the resolution of the event was.
- Eat (Starbucks is open until 12am and Cafeteria opens at 12am), sleep (seriously) and go to the bathroom when you can.
- Before signing out in the morning, review the vitals and labs on all of your new admissions, listen to your respiratory kids and put all your paperwork together.

Admissions, Orders, ETC (See Wards Section)

AM Signout and Beyond

- Intern signout begins at 6:30am. Your night senior is there to supervise this process, but it is up to you to sign out in an efficient and complete manner.
- You will sign out to the day interns. Tell them about any overnight events for each patient they signed out to you the night before and the outcome of anything that they asked you to follow up on for them.
• The night senior will have already let you know which day intern is assigned to your overnight admissions. Present the overnight admissions in the following format. It will take a while to finesse, but these presentations should only be 2-3 minutes long.
  o A brief HPI including what was done for them, if anything, at outside hospitals, the ED, and on the floor
  o Pmhx pertinent to HPI
  o Significant labs/radiographs
  o Pertinent physical exam findings
  o Brief assessment/plan.
• It is always good practice to ask for feedback from your seniors about how your presentations are going and what you can do to improve.
• For more information, see the Signing Out section.
• You should leave after AM Intern signout, as close to 7am as possible.

Signing Out

Hand-offs, or “signing out” are a critical part of health care and requires, above all, excellent communication. You will get better at it as the year progresses but here are some general tips and sign-out structures that incorporate the key information for each type of sign-out.
• As a general rule, on the ward, interns are not permitted to accept sign-out on a patient being transferred over from the ED or PICU, the senior resident needs to do that.
• Interns may not sign out a patient to one another in the morning or evening without both the day team and night team senior resident for that patient present

Things to avoid in a sign-out

  o Rambling/commentary – Try to stay focused on getting key points across
  o Disorganization – Try to use a problem or systems based approach for more complex patients, do not jump around
  o Oversimplification - Try to not leave out critical information the next person will need to continue managing the patient
  o Assuming things have remained the same – Always provide the basic one liner and current status on every patient, and always update on changes

General structure of a sign-out (From Dr. Blair’s All-Resident Meeting, “Resident Hand-Offs” 2013)

  o Demographic (age, sex)
- One liner
- How sick? (stable, guarded, worsening, improving, etc)
- PMHx (only significant and relevant)
- Why was the patient admitted?
- Current status, recent interventions, new results, active problems
- **TO-DO LIST with relevant contingency plan** (e.g., “Please continue the IV antibiotics overnight, but if the patient loses his IV again, you can change the antibiotic to oral for the time being.” e.g., “Please check the blood sugar at 10pm, and if the sugar is higher than 250, call the Endo fellow on-call first, otherwise continue our current plan.”)
- Ask if there are any questions and answer them
Step 3 Process

For Step 3, whether you are a DO or MD, it is probably best to take it as early as your schedule allows. Especially for categorical pediatrics residents, this will allow for some adult specific material to be relatively fresh in your mind.

COMLEX

- **Timing.** Your study habits and time will vary, but the exam is very similar in material as Level II, so your preparation will probably be similar. For most residents, this typically involves about 2-4 weeks of studying/questions. It is ideal to start this process on a rotation that has some free time (i.e. Non-Ward, Heme-Onc or NICU).

- **Scheduling.** Same process as for Level II. The nearest Prometric testing center is in Melville which is about 30mins west of Stony Brook.

- **Material.** As there is significant overlap, some of the same review books you used for Level II may suffice, along with a Level III question bank. Differing opinions exist on which question bank is better, but the bottom line depends on which one you are comfortable with and how many questions you will be able to finish.
  - Do not forget about OMT! Again, the same material you used for Level II should suffice, along with question bank. The most high-yield information remains innervations, Chapman points and muscle energy techniques.

USMLE

- **Start planning early in the year once you have your Block schedule.** You might not have a specific date in mind, but you may be able to determine a good block in which to schedule your test.

- **Let the chiefs know as soon as you have a block in mind and they can help you arrange your schedule to accommodate your exam dates.**

- **Blocks that are not recommended for taking Step 3 are: Ward or Night float, Heme/Onc, NICU, Nursery, and ER.** Vacation is meant to be a time to rest and relax so try to avoid taking your exam then unless you are finding it difficult otherwise. This leaves electives, which are the preferred time.

- **Structure of USMLE Step 3:** Day 1 is 8 hours and Day 2 is 8 hours. One day will be multiple choice questions on management of medical conditions and the other day will be part multiple choice questions and part CCS (clinical cases in “real time” where you
order things and address outcomes as you are notified). The two
days can be in either order – questions first or questions/cases first.
If you call Prometric to schedule, they can often tell you which one is
being given on the first day.

- Taking and passing USMLE Step 3 is an expectation for all interns
  by the end of intern year

HOW TO REGISTER ONLINE FOR USMLE STEP 3

- First go to the Federation of State Medical Boards page.
  o WWW.FSMB.ORG Here you will find the state-by-state
criteria for submitting an application to take USMLE Step
3. Follow the link for Licensure Examination and then
“individual licensing authority” to choose a state medical
board to be your licensing authority. Once you choose
that state medical board that works for you, go to “begin
the USMLE Step 3 application,” create an account and
complete the application. Remember that Certificate of
Identity form must be prepared and faxed/mailed before
your application is complete.
  o You do not have to register in the state of NY. In fact
  most of your senior residents did not do so. NY requires
  you to apply for your license first, which is a longer
  process and is not a program requirement until you take
  your pediatric boards during your last year.
  o States that have “sponsored” previous residents include
  CT, NJ and PA but really any state that fits your
  academic/residency training background is ok. You do not
  have to take your test in the state whose medical board is
  “sponsoring” your step 3 exam. You can take it anywhere
  there is an available Prometric testing facility – the closest
  one to Stony Brook is in Melville, NY.

- Choose the state medical board that you want to have sponsor you
  and make sure that you fit all of their criteria.
  o BE CAREFUL: Once you accept the terms of application,
even if you do not pay the fee yet, your application is not
reversible. If you do not fit the criteria for the state medical
board you choose, your application may be rejected and
you will have to start over. The average fee for 2012-2013
was $780 for the application. This is not reimbursable
through our education stipend so plan ahead fiscally.

- Print off the Certificate of Identity form and any other form that the
  specific state requires with your application. Jean Segall in the
  Pediatric Department Office is a notary for any documents that need
  notarized signatures. You will need a passport-style printed photo to
  attach.
• Once your application is accepted, you will receive a Scheduling Permit as with the step 1 and 2. Use this to schedule two dates at a Prometric center that work for you. The dates must be consecutive so that you can have both the questions and the CCS portion of the test included.
  o You can peruse the Prometric site before you apply or get your Scheduling Permit to get a sense of testing date availability.
  o In rare cases, a Saturday/Monday split is allowed with a break on the Sunday (but you have to call Prometric).

• Usmlworld and First Aid for Step 3 are great study tools. The cost of these preparation materials can be reimbursed from your educational stipend.
Wards

So you’re starting the pediatric floor…

- The pediatric ward is located on 11N, to the left of the elevators.
- The resident call room is in the corridor between the PICU and PONC on 11S. Please ask one of the seniors or the chiefs for the code.
- Dress code is business attire ± white coat. If you’re on over the weekend, it’s all scrubs, all the time.
  - Handwashing is our best defense against the spread of infection. It is expected that hands will be washed with foam before entering a patient’s room and washed with soap and water or foam after leaving the patient.
  - You must adhere to all instructions on the isolation cards……NO EXCEPTIONS!
- The floor team will consist of medical students, 3-4 interns (usually 3 or 4 pediatric interns) and 2 seniors.
- Patients will be split as evenly as possible, but expect to carry at least 4-5 per day on average. During the busier months, this number can easily double.
  - Tip: Time management will likely be the most important thing you learn your intern year.
- Remember – you play an active role in your education, of which the inpatient rotation is an important piece.
  - Please feel free to ask ANY AND ALL questions you may have.

Scheduling

- During each month of floor rotation, your work hours are officially 6:30am (AM intern signout) – 6pm (PM signout). Your schedule will be found in New Innovations.
- For every four weeks that you’re on the floor, you’ll work a Saturday daytime shift, a Saturday night shift, and a Sunday daytime shift. Weekend daytime shifts start at 7am, and signout on Saturdays and Sundays is at 7pm.
- If you’re the Saturday night intern, you should aim to write half of the notes for the day team (after midnight of course!). Focus on the service notes, but if you can do more than that, that is great!
- Be prepared to push the 80-hour work week limits. Sleep when you can, eat when you can, and don’t forget to keep yourself hydrated.
PREPARATION

- Before you start the floor, familiarize yourself with where everything is.
- Get a sturdy binder or clipboard, black and colored pens, highlighters, and a small calculator. A pen light is also helpful.
  - Tip: STAPLES has cute keychain calculators and mini-flashlights you can hook onto your badge.
- The day before you start, one of the other interns will sign out their patients to you. Make sure that you know everything about each one of those patients: take notes during the verbal signout, comb the chart for pertinent information (H&P and off-service notes are key, if the latter is applicable), and go through the computer for current orders, latest labs and previous discharge summaries.
- Off-service notes should be written by the outgoing intern for any patient that has been hospitalized for more than 48 hours.

MEDICINE PHYSICIAN’S WORKLIST

- On Powerchart, there is a Medicine Physician’s Worklist for 11N that can be accessed and updated by all residents, and this is our sign out. (At first, the senior resident will likely update the sign out, but as you become more comfortable on the floor, you should feel free to update it as well.)
- For each patient, this includes the most recent vital signs, as well as the ranges for the last 24 hours, medications, and our comments (which include the team, the intern assigned to the patient, the PMD, a description of the patient, and to-do’s for the day and night teams).

CHARTS

Powerchart: our electronic medical record

- Orders
- Meds/MAR
- All vitals (including height, weight and HC) and I/Os.
- All patient results including radiology (PACS) and old records (Eclipsys)
- Power Notes (admission, progress, and event notes are written electronically for all service, Pediatric subspecialty, Orthopedic Surgery, Neurosurgery, and Colorectal Surgery patients)
- Discharge Summary

Red Charts are usually found next to the clerk. In them:

- Patient stickers
- ED and outside records

Forms/Paperwork:

- Letterhead is available for writing patient letters, but it is elusive so ask the clerk
- If for any reason the EMR is down, there are paper forms for admissions, etc in the gray cabinets also
- Can't find something? Ask a clerk or your senior.

Other Items in the Core:

- Assignments for the weekly team symposium (discussion of a relevant topic, your senior resident and attending will schedule these)
- Crash cart
- Oto/ophthalmoscope cart and tongue depressors
- Frequently called phone numbers (also see Appendix section of this document)
- Printer (11na)/Fax machine 444-1355. The Fax Machine also copies.
  - Tip: For larger copying orders, go to Jean's office, it's free.

When Things Happen

- Daily
- 6:30am: Intern signout in 11N Conference Room
- 7am – 8:30am: pre-rounding, work, touch base with senior
- 8:30am – 9am: Morning Report (except Wed, Grand Rounds at 8am, do NOT be late!)
- 9am – 9:30am: Work
- 9:30am-midmorning: Attending Rounds
- Midmorning – 6pm: Work
- 6pm: PM signout
- Throughout the day: Update your senior!

AM Ward Signout

- Intern signout begins at 6:30am in the 11N conference room. It’s extremely important to be on time for every scheduled event, including this one.
- What happens: The day interns receive signout on their patients from the night intern. This is also the time that the day interns hear about new admissions from overnight. Prior to AM signout, the night senior assigns the new admissions to the day interns.
After intern AM signout, the day seniors receive signout from the night senior while the day interns see patients, do work, start their daily notes, and prepare for attending rounds.

- Tip: Touch base with your senior resident after senior signout with updates and to clarify the day’s plan for each of your patients.

Pre-rounding

- Following intern sign out, begin seeing all of your patients. Patients with acute issues should have priority. If the patient is sleeping, you do not have to wake him/her for a full physical, but when pertinent, do a focused exam.
- Review vitals (which are on your sign out), ins and outs, asthma scores, new labs, etc. Look at radiology studies done overnight (don’t just read the report).
- Try to see all of your patients prior to morning report. Again, patients with acute issues take priority.
  - Tip: Organize yourself while pre-rounding in order to prepare for attending rounds. Either on your sign out or your own sheet, write labs and begin a checklist of what you foresee to be the day’s plans.
  - Tip: Senior signout starts at 7am and goes until 7:30am. This is also when nurses sign out to each other in the core. Try to see as many of your patients during this window as you can and unless truly necessary, do not interrupt others’ signouts.

Morning Report (All House Staff)

- See Morning Report section
- BE ON TIME.

Attending Rounds

- After morning report, you should get all time-sensitive work done: discharge paperwork for any patients you anticipate going home that day, calling consults, and seeing any patients you didn’t have a chance to see before morning report.
- Attending rounds begin around 9:30am at the attending’s discretion. Rounds are family-centered at the bed-side.
- The floor residents are split into two teams, with two interns, one senior, and one hospitalist on each team. The hospitalist rounds on service patients and orthopedics patients, but family-centered
rounds are done with every patient on the floor with the senior resident leading.

- If the patient is established (i.e. Not a new admission from overnight), your presentation will be brief and follow the SOAP format. Try to present your plan in either a problem-based or systems-based format to demonstrate your organized thinking to the attending.
- If the patient is new, you will have to present the entire H&P.
  - Tip: You can print out the admission note from overnight to help you in your presentation.
- You should defer all presentations to your medical students if they are following a patient with you. Make sure to go over with them the correct format and help them in their areas of weakness. You will learn more strategies for this during your “Residents As Teachers” retreat in the fall.

**Teaching Attending**

- One of the service attendings serves as “teaching attending” for the week.
- The teaching attending may meet with residents and medical students following rounds for a “wrap up” session to discuss interesting cases or topics encountered on the floor.
- Once weekly, there is a symposium in which each intern will present part of a topic.

**Private PMDs**

- Some community pediatricians have admitting privileges. If a patient is admitted under a private PMD, he or she is the attending in charge of that patient.
- The physician “on-call” to the hospital will usually round in the morning. Most private attendings come in to round between 7am and 8am, but some come during morning report.
  - Tip: Check for an EMR note from the PMD after morning report in case you missed them. Follow up their plan.
- Because there are no formal attending rounds, you should have a low threshold for calling them during the day for any situation.
- For a list of pmds and their contact information, see the Appendix section.
  - Tip: Most will appreciate being updated at least twice during the day – once in late morning and once in late afternoon.
  - Tip: If the PMD has multiple patients on the floor, try to batch phone calls.
ORDERS

- All order writing is done electronically through Powerchart. You should notify the patient’s nurse of ANY new or discontinued orders, especially if the order is written as STAT.
- Lexi-Comp online (http://online.lexi.com/crlonline) is our hospital-approved reference for medication. There are links to Lexi-Comp directly from Powerchart and also from the main hospital intranet page.
- It is prudent and necessary to check every order every day to make sure that you haven’t hit a soft stop or fallen off of the MAR.
- Compare active orders to what the patient should be getting to exactly what the patient is getting (MAR) every day.
- Orders that need to be renewed daily: Restraints, 1:1 orders.
- Orders for phlebotomy need to be put in for the exact times of 6:00am and 11:00am. These orders should ideally be put in the night before, but if that is not possible, make sure to give the phlebotomists enough time to see your order. If you want the phlebotomy team to draw the labs, make sure you select “Nurse collect” -> “No” when placing the order in Powerchart.
- If you are too late for phlebotomy or would rather have the nurses collect blood for you, put in the order as a “Nurse collect” and tell that patient’s nurse. Our nurses are very professional and will place ivs, draw blood and place catheters for urine when necessary.
- If the patient has a central line or is an especially “hard stick,” labs will always be drawn as “Nurse collect”.

RADIOLOGY

- After putting in orders, call the appropriate department to make them aware. Get an estimated time that the study will be done.
- If contrast is to be given, obtain parental consent and place it in the chart. In general:
- Patients who need studies under anesthesia and patients who need CTs with contrast will need to be NPO for a certain amount of time before the study.
- MRIs without sedation usually do not require a patient to be NPO.
- If a patient requires anesthesia, call the Anesthesia Coordinator (Pam 4-2464) and she will help you arrange the study. This can be a complicated process, so if it is your first time arranging a
procedure with sedation, enlist the help of your senior or another intern who has done it before.

**Electronic Prescriptions**

Powerchart allows electronically transmitted prescriptions, aka “E-scripts.” Therefore, in most settings you will not need to write out prescriptions on a prescription pad as often as your seniors did. To write your patient’s E-scripts at the time of discharge, follow these steps.

- Confirm your patient is going home and what medications they will need at home that they need a prescription for (i.e. if it’s a home med and they have enough or someone else usually manages it, you don’t need to resend it)
- Ask the parent for the name of the patient’s preferred pharmacy – most local pharmacies, including several “mom and pop” pharmacies in the area are included in our electronic pharmacy list.
- Go to Power Orders and click on “Reconciliation” ▶ “Discharge”
- Select the medications on the list that the patient should continue at home, the ones you want to create a new prescription for, and the ones they should not continue. Click “+Add” to add any medications to the list that were not on the list for any reason
- For each medication, complete the web-form by selecting the appropriate formulation and specifying the dose, frequency, duration, number of doses, and number of refills to be ordered.
- It is often helpful to fill out the “special instructions” section with a set of clear instructions for the patient/family to see on their discharge paperwork also so there is no confusion as to what you intended for them to do “Please take 2 tabs with food every 8 hours for the next 7 days.”
- To assign the medication to the pharmacy, once you have completed the information for a medication, click the yellow box that says “Route to..” in the middle right corner of the page and then click “Find Pharmacy.”
- Within “Find Pharmacy,” search for the pharmacy your patient will go to and select it.
- Once you have selected all medications, completed their prescribing information, and assigned the pharmacy, click the bottom right button that says “Reconcile & Sign.”
  - Tip: Do not click “Reconcile & Sign” until you are ready to send the prescriptions to the pharmacy!
- Your prescriptions are sent! Let your patient/family know they are being prepared.
  - Tip: Until you are sure that E-scripts is working for you, it may be helpful to call the pharmacy after your first few attempts to be sure that the prescriptions sent properly and are in process to be picked up.
- If your patient/family is not sure which pharmacy they will go to, you can still use E-scripts. In the “Route to..” box, select “Print and Give to Patient” and print a prescription with the 11N Rx printer (in the gray cabinet under the 11NA printer).
- If you make a mistake printing a prescription, make sure you put the incorrect one in the special bin in that same gray cabinet for prescription shredding.

**Written Prescription Basics (Just in Case)**
- Jean Segall dispenses the prescription pads and keeps track of the numbers on the bottom right. Keep your prescription pad and stamp in a safe place!
- For every prescription include the following: Name, DOB, date, patient weight, and signature.
  - Tip: Make sure to stamp/date/time and sign every written prescription!
- Residents are not permitted to write prescriptions for controlled substances. The attending physician for that patient must do so.
- Your prescription needs to be reviewed by a senior resident or attending on the floor as well as in continuity clinic. Written prescriptions need the senior or attending’s initials.
- Prescriptions do not need to contain any math but they do need to specify what the concentration is of any suspension or tab/pill you write for:
  - Amoxicillin 400mg/5ml oral suspension
  - Sig: 6ml PO BID for 10 days
  - Disp: QS

**Consults**
- When arranging for a consult, page the resident or fellow covering for that service. If there are no residents or fellows, page the attending directly. You can find out who is on call for a given service by going to the online paging directory.
- Never call a consult without attending approval.
- Never initiate a plan proposed by a consultant without attending approval.

**Admissions: General Pediatric Services**
- Patients who are admitted to a general pediatric service (service, private PMD, non-surgical subspecialties) will require:
  - A complete history and physical
Admission orders
PMD notification
PMDs need to be notified of admission both when they are the attending and when they are not.
Any private pediatrician of a service patient or patient from another service (i.e. Surgery, Ortho) should be notified of admission.
Document in the Admission H&P Note and in the Medicine Physician’s Worklist that the PMD has been notified. Document who the PMD is and if you have any trouble reaching them.
Document Medications by History and do Admission Medication Reconciliation (this is tracked by the department)

The H&P

- You are responsible for doing admissions with the senior resident and medical student (if you are assigned one).
- At that time, you will ask the questions regarding the history. (After your medical student has watched you do this once or twice, you should pass the baton to him or her.)
- You will all complete the physical together.
  - Tip: Don’t forget the oto-ophthalmoscope to examine the ears and the pharynx. Check to see if there are pediatric otoscopic specula (the smaller ones) and tongue depressors with the scope before you go in.

Admissions: Surgical Services

Depending on the surgical service, we have different duties in patient care. Regardless, we always are responsible for notifying the patient’s PMD, for remaining in contact with the primary team and for any emergency management if it is required.

Orthopedics, Neurosurgery, Colorectal Surgery, ENT

- We co-manage these patients.
- These are the ONLY surgical services for whose patients we write notes; an admission H&P and daily progress notes should be sent to your service attending.
- The primary surgical team will write all of the orders for the patient and ultimately make all decisions regarding their care. The primary team also does the discharge paperwork, writes prescriptions, and is responsible for dictations.
- Patient issues or questions about plan of care should be discussed with the primary team.
• Orders should not be written on their patients without their approval, but you should check to make sure they are correct.

ENT

• New for 2014-2015 Academic Year - Pediatric residents comanage ENT patients. They will require H+P notes, progress notes. They are to be treated like ortho patients.

Pediatric Surgery, Urology, Plastic Surgery, OMFS

• We are involved with surgical patients as we are on the floor 24/7, and the surgery residents are often in the OR when situations arise. You should know your surgery patients as well as all of your other patients.
• DO NOT write orders on these patients unless it is an emergency!

Progress (SOAP) Notes

• There should be a progress note in the electronic/paper chart for each patient every day. (Exception: If the H&P of a new patient admitted overnight is dated after midnight, a SOAP note is not required.) Daily progress notes for service patients need to be completed prior to hospitalist attending rounds at 9:30am.
• In the first line of the note, remind the reader why the patient was admitted: “7-year-old with reactive airway disease exacerbation and hypoxia.”

The SOAP Format: A Refresher Course

• S (subjective): How the patient did overnight, any events, any complaints.
• O (objective): Physical exam including ALL vitals (weight, I/Os), labs, radiology.
• A (assessment): Summary of status.
• P (plan): Goals by systems.
• Date, time, stamp, and sign every page of your progress note.
• All notes by medical students should be reviewed, discussed and co-signed before being placed in the patient’s chart. The medical student’s note may not take the place of your daily progress note.
**Discharges**

- All patients are discharged electronically.
- In order to discharge a patient, you must complete the discharge process in Powerchart, write all necessary prescriptions, and include follow up information with PMD and any consulting services (contact consultants prior to discharge and ask if they would like follow up if not addressed in their note).
- You can access the Discharge Summary by going to “Inpatient Viewpoint,” then clicking the “Discharge/Depart Process” tab, and clicking “Discharge Process.”
- Discharge paperwork should be started as soon as the patient is admitted so that completion does not delay discharge.
- We write the discharges for all service and Pediatric subspecialty patients (surgical services do their own discharges).
- Make sure there is enough information on each summary so that a resident covering for you could discharge the patient successfully.
- Make sure to write the responsible intern’s name under “responsible dictating resident” on the discharge order or else the dictation will get sent to you.
- If the patient has been hospitalized for less than 48 hours, no dictation is required (you may write “no dictation required, <48 hours” in the comments and special instructions on the discharge order).
- Remember to let the patient’s nurse know that the patient is going home!

**Unusual Medications**

- If a patient is going home on an unusual medication, call the outside pharmacy and make sure they will have it available in a timely manner.
- If the pharmacy is closed or will not have the medicine in an acceptable period of time, see if there is a spare dose in the patient's drawer to get them through the day and/or the next morning. The pharmacy supervisor is also sympathetic to the realities of these situations and will sometimes agree to send up an extra dose or two before discharge.
- Magical pharmacies that seem to have very unusual medications are Stony Brook Pharmacy (no affiliation) and Fairview Pharmacy.

**Dictations**

- All patients admitted for more than 48 hours will require a dictation.
- Guidelines for a Quality Dictation
Clearly state:

- Your name
- Attending physician’s name
- Patient’s name
- Medical record number
- Type of report

Speak slowly, clearly and directly into the receiver.

- Spell names and difficult medical terminology
- Dictate names and addresses (if available) of individuals and referral sources whom you want to receive copies of the report.
- To start a new dictation, dial 4-6191, plug in your 6 digit physician ID, select “Discharge Summary” and provide the initial information it requests (name of patient with spelling, attending responsible for signing, this is usually the attending who discharged the patient).
- Then begin the dictation which should include the main summary of the patient’s visit (usually identical or similar to your discharge summary in the EMR). See TIP below on editing in Eclipsys.
- Patients being transferred to another facility will require a STAT dictation, which is like any other dictation except you will select the “Transfer summary” option when you call 4-6191. You also need to call 4-1417 once you are done and then pick up the dictated printout on the MR floor in Medical Records (it will be included among other stat dictations in the basket on the shelf along the wall when you go in).
- You should be listed as the dictating physician for any patient you discharge. If there is confusion, like on weekends or holidays, check with your senior.
  - Tip: Dictate patients in a timely fashion. The longer you wait, the more difficult it will be to remember all the details. Following discharge, the patient’s chart is scanned into Eclipsys.
- If dictations are delinquent, you will receive reminder emails and notices in your mailbox until they are done, and there are major consequences if they do not get done in time.
- You can no longer copy-and-paste already written summaries into Eclipsys. Unfortunately, the entire dictation must be read into the phone even if already typed.

**Transfers**

**Accepting a Transfer**

- Usually from the PICU
- Read through chart thoroughly. PICU admission and progress notes are also found on Powerchart under “Documentation.”
- Talk to the patient, get history, do physical.
Double-check already written orders. Twice. Discontinue any orders that pertain only to the ICU – i.e. Cardiac monitor, etc.
Write an accept note. Make sure to include the hospital course until the time the patient is transferred.

Transferring to Another Service

- You MUST write a transfer note, which is SOAP note format with more detail. Include a brief HPI and hospital course.
- Write transfer orders in powerchart
- Reconcile meds using the “transfer” option.
- Sign out to the resident accepting the patient.

Off-Service Notes

- Off-service notes should be written for complicated/chronic patients, as well as patients who have been on the floor for more than 48 hours with no discharge plans.
- The off-service note is a more comprehensive SOAP note, including problem list, brief HPI and hospital course since admission. Be very detailed in physical exam and assessment/plan.
- Save a copy of the off-service note in the shared drive or in the patient’s chart (title it “off-service note”)
- Make sure to let the resident you are signing out to know where the off-service note can be found.
- ALL off-service notes are to be written before they new team begins so that they have it to refer to. Should not be done 1-2 days after the switch occurs.

Running the List

- During the course of the day, update your senior (and your patients/families) frequently.
  - Tip: Parents should not be asking the night team about long-term plans! If they are, that is a clue that you should be more on top of updating your families.
- 3pm is when your senior will meet with the charge nurse for Discharge Rounds, as much as possible, you should update your senior on potential discharges BEFORE this time
- At 5pm, you should be prepared to give your senior final updates. This is key to leaving the hospital on time.
- Before evening signout at 6PM, you should have reviewed the most recent vitals for your patients and have a good idea of what the night team should expect overnight.
DISCHARGE PROCESS

- The discharge process must be started at least the day prior to discharge and should be as complete as possible. The goal is to be able to discharge patients during rounds. Ideally, the day team should be completing the majority of this process.
- Discharge rounds at 3pm must occur daily between the senior resident(s) and the charge nurse to help everyone prepare for the next day on the floor.
- However, IF the night team is not that busy with admissions/patient care and the day team was too busy to complete discharges for the next day, the night team can and should help with discharge preparation overnight so that our patients can be discharged as early as possible the next day. Priority should be given to patients that will definitely be discharged the following day ex. An asthmatic spaced to Q4 on room air.
- The day team should identify areas where the night team can help with this process and let them know during PM sign-out. IF the night team is very busy and is not able to get to the discharge process, this is understandable.
- The day and night teams should work together as a unified team to provide the best patient care.
- Also, if families need services that are difficult to coordinate, these services should be identified and acted upon early in the hospital stay. For example, ALTE whose family needs CPR training.

MEDICAL STUDENTS & TEACHING

- Medical students will be assigned to you when they come on service. Typically, they will follow 2-4 of your patients during the course of the week, after which they will follow a different intern and a different student will follow you.
- Med students should be seeing patients and writing notes. They should also be presenting during attending rounds.
- Be sure to take time to teach, even if it's only pearls here and there, or tips and tricks for internship.
- Constructive criticism is especially important in history taking, physical exam skills and note writing. Before co-signing medical student notes, they should be reviewed and discussed.

PM SIGNOUT

- Evening signout begins at 6PM in the 11N conference room.
• Presentations to the night team should be brief, but they should also include any and all pertinent information about your patients that would be important to know overnight.
  o Start with a one-liner
  o Report by systems, including your updated vitals.
  o Briefly list important medications.
  o Finish with a summary of night issues/things to look out for or accomplish overnight, as well as labwork expected in the AM if there is a value that needs to be watched for.
• If necessary, also sign out if anyone needs to be called for a specific parameter (i.e., calling the Endo fellow with urine ketones and D-sticks at 10PM.)
• See Signing Out section for more information.

**Completing an Asthma Action Plan**

Because childhood Asthma (and its relative Reactive Airway Disease) are such common and often difficult-to-manage diagnoses, it is critical that a strategic “going home” plan be in place for the patient to follow once they have met their goals for discharge from the inpatient ward.
  o Minimum goals asthmatics must reach for home-going are:
    o Tolerating q4h albuterol (preferably on MDI for older kids),
    o Keeping sats >92% on RA both day and night (no supplemental O2)
    o No longer requiring IV access (good po and UOP, no abx)
    o Completed a Pulmonology consult if warranted
    o Plans to follow-up closely with PMD
    o Family has completed Asthma Education and has a completed and reviewed Asthma Action Plan (see next page for the form).
Asthma Action Plans are now DIGITAL in CERNER! They appear as above. Ask your senior to show you how to complete!

**Patient and Family Centered Care**

Patient and Family Centered Rounds on the unit begin between 930am and 1000am. These rounds are walking rounds room to room with the inclusion of the Nurse who will document on the IHI daily goal sheet. At this time orders can be discontinued or entered into the computer, as needed, based on the plan of the day.

- Residents should review orders daily to assess for renewal or discontinuation of restraints or 1:1s
- Evaluation of foley, central line and/or peripheral IV catheter continuation should be reviewed daily during rounds.
- Medication orders should also be reviewed to ensure that medications are being renewed, if needed, or converted to oral administration. Medication reconciliation is done at admission, transfer and discharge. The discharge process starts on the day of admission and continues throughout the stay.
- The senior resident will meet with the clinician/charge nurse at 3pm daily to discuss the planned discharges for the following day.
o Ideally, the discharge process should be finalized by 3pm discharge rounds to simplify the process of discharge the next morning.

o While it is not always possible, the goal is to be ready to discharge patients ON rounds as often as possible

- New admissions, transports, transfers or post-op patients should be discussed with the charge nurse as soon as the resident has knowledge of such patient. This will allow for timely communication to the receiving nurse to prepare the room and organize her workload in preparation to receive the patient in a timely fashion.

**CHILD LIFE SPECIALISTS**

Certified Child Life Specialists are trained in child development and are equipped to deal with the effects of hospitalization on children. They work closely with the healthcare team to assess and address the individual needs of young patients and their families. Their goals include:

- Minimizing overall stress and anxiety
- Providing normal play opportunities
- Enhancing normal living patterns and experiences within the hospital environment
- Promoting normal growth and development during hospitalization
- Lessening the emotional impact of illness and hospitalization
- Advocating and supporting the patient’s and family’s roles in the healthcare team

**WE ARE AN OUCHLESS CHILDREN’S HOSPITAL**

- We have LMX or Toot Sweet built into our Power Orders to ensure that our patients receive proper measures to decrease the amount of discomfort during painful procedures; such as: phlebotomy and PIVs.
- We also utilize Child Life Services for diversion during painful procedures or procedures that a child is fearful of.
- Child Life Services is available on the Wards but also in the ED, Heme/Onc, PICU, etc.
Ways to Shine On Your Rotations

There are some things on each rotation beyond the general requirements that will help you stand out, improve workflow, and improve patient care. Some are mentioned throughout this guide, but here are some specific tips for doing well on your rotations.

Presenting in the ED

Aside from medical/surgical/social considerations, start thinking about the disposition of the patient with your initial assessment. Will this patient need to be admitted (PVT vs SVC)? Are you going to observe after treatment? Consults? Social work? CPS? Will a CT read influence your decision? Will the patient need sedation for a procedure? NPO?

- While not part of the textbook/board management, this is real life. Setting these things into motion will not only make your life easier, it will help the inpatient team accepting your patient, allow nurses to maximize their patient contacts, and ultimately improve patient care.

Discharging Patients in the ED

When in a bed crunch, nurses are busy or just to personally provide extra anticipatory guidance, discharging patients yourself is always viewed as a positive by staff.

- After you and your attending sign the discharge form and you have printed appropriate patient education, have the patient's parent sign and provide a phone number (should any labs need to be followed).
- Before the patient physically leaves, make sure they have seen registration, else guide them to the registration clerk, who sits by the Scud machine.
- Take the rest of the chart and place it in the 'Discharge' bin, at the clerk's desk. Inform the clerk and nurse that the patient is gone so that they may remove the patient from the board and turn the bed for the next patient.
**Communication in the ED**

Often, you and the staff are constantly walking between patients and rooms, so stopping to provide updates may be difficult. Always seek your attending’s attention for any new labs or radiology (especially if disposition dependent).

- You can leave comment in the tracking board for the staff to let everyone know what is pending. (This should never supplant actual communication, just as a reminder!). There is a comment section which is visible on the public tracking board and a ‘Pvt Comment’ section, which only staff can see on their workstations. Choose carefully what to list. (e.g Keep CPS or psych private)

**Teamwork on the Ward**

This is where teamwork can really play a significant factor. Remember, you are no longer competing for that elusive Honors grade or ranking.

- You and your colleagues are evaluated on your own merit and part of your competencies includes interpersonal communication and ability to work in a team.
- Your patient’s team includes not just the physician team but medical students, nurses, and other staff (CAs, social workers, consultants, etc), so treat everyone as an equal member of the team. Have patience, communicate clearly, and speak with respect.
- Focus this year on improving your management plans, identifying patients who are sicker than others, and learning how to anticipate and prepare for discharging patients in a safe and appropriate manner.

**Heme/Onc Tips**

This is an emotionally draining rotation – much more than others intern year – so make sure to get your rest and have fun when you do have time off. (See [Being good to yourself and others](#) section)

- Know your side effects of the chemotherapeutic medications or other medications you are using when you present for rounds.
- Know what you are looking for or worried about for each patient’s day to day management, and what you are going to do about it if it happens (i.e. Oral mucositis, increase mouth care).
- Be nice to the nurses. Keep them updated. Many have a wealth of experience and can help teach you about the complex care involved with Heme/Onc (and really all) patients.
LEAVING SMOOTHLY ON CLINIC DAYS

When you are leaving in the afternoon for clinic, try your best to have as many things prepared for your covering intern. This includes any discharge preparation that you can anticipate (medications, follow-ups, home care), any consults to call, etc.

▪ Give your co-intern a detailed sign-out of updates since rounds, what you have done, what is left to follow-up and any pertinent information for the rest of the evening.
▪ Don’t be late to clinic even if there is a lot going on. Budget time for your commute and a quick bite to eat. Everyone has clinic days and it is expected you fulfill your requirements for clinic as well as the services you rotate on.

MAKING THE MOST OF “DOWN” TIME

Often, interns are busy with one patient when something occurs with another, making it difficult for nurses to find him/her.

▪ For common issues (fever, fingerstick, nausea, diet orders), it would be considerate to assist if you are available, especially if there is some time sensitivity (e.g., a new order of insulin).
▪ Notify a senior or fellow, put in orders after confirmation, take down labs values. Update your co-intern when they become available.

WEDNESDAY CRUNCH

While interns all attend Grand Rounds and conference/lectures, seniors and medical students present and manage the ward.

▪ Arrive earlier than usual for signout or pre-rounding on Wednesdays. All of your notes should be done by 8am Grand Rounds.
▪ DO NOT be late to Grand Rounds, but if you will be due to patient care issues, text the chiefs.
▪ This is where your medical student should act as an extension of your coaching/teaching and detailed sign-out given to your senior for rounds.
▪ Also, if there is lunch during lecture, everyone appreciates if you bring back an extra plate for your senior!

SOCIAL WORK/CARE MANAGEMENT

You may not realize until this year how invaluable this team is on any service you rotate on.

▪ They can help you with things like calling CPS to address concerns for abuse/neglect, obtaining prior authorizations for medications, arranging for placement at a separate facility
Because most of the social workers are in high demand and work weekdays 9-5, it is imperative that any concerns that need to be assessed by social work be communicated to them as soon as reasonably possible.

• There are weekend social workers on call to help with pending discharge concerns, but they are usually not able to take time to address routine matters.

• So consult social work early and keep tabs on the progress of your patient’s needs!

• Also, their notes are in the “Clinical Notes” tab on Powerchart and will not show up under “Documentation.”

• Follow up the social work/Care management note daily if you have consulted them to see what the situation is. Always check if there is a CPS Hold on a patient before discharging them home.

What to See and Do in Long Island

Dining

• Long Island is rapidly becoming well-known all around the country both for the cuisine it is presenting as well as producing (hey, Food Network’s Ina Garten, aka the Barefoot Contessa, makes her home in East Hampton)! The North Fork is well-known and well-renowned for its wineries and has too many to count (there are a few wineries on the South Fork but go figure, the climate and soil is just different enough that it makes growing almost all varieties of grapes impossible). In addition, the forks and even parts of central Long Island are dotted with amazing farm stands that produce and sell many fresh fruits and vegetables, as well as great flowers. You will become well-acquainted with Briermere farms during your tour around Long Island. Remember where it is and go back often.

• Long Island restaurants are some of the finest around and some rival many experiences you will have in New York City. Many restaurants now are starting to offer some sort of prix fixe menus either all the time or on certain days of the week and are usually a great way to experience fantastic dining on the cheap or at least at a bargain. In addition, twice a year Long Island has its own “Restaurant Week” where numerous spots on the Island have set per-person menus and a great opportunity to experience local flare. Last year as a bonus the Smithtown Chamber of Commerce did
their own restaurant week as well in addition to the 2 previous ones. Get a Zagat; you'll be surprised at how many amazing restaurants are in Suffolk County alone.

In close proximity to Stony Brook:

- Sushi- Kotobuki in Hauppauge, Nisen in Commack or Kimi in Port Jefferson. Hoshi in Stony Brook is close by and will deliver to the hospital! Kumo near Smith Haven Mall is great for both sushi and hibachi and happy hour.
- Seafood- H2O. They also have sushi that is better than can be had in some Japanese restaurants
- American- Oscar's in St James, John Harvard's in Lake Grove, Bliss (the caterers of our recruitment dinners) in Stony Brook
- French- Mirabelle's in Stony Brook (at the Three Village Inn), Kitchen a Bistro in St. James
- Italian- Umberto's in Lake Grove, Pasta Pasta in Port Jefferson
- American/Bar: John Harvard’s is a common watering hole for people from the hospital There is also a trivia night every week, and some of our residents participate!

There are also many of the casual dining franchises to feast on including Cheesecake Factory, California Pizza Kitchen, Friday’s, etc. Bobby’s Burger Palace, owned by Bobby Flay also has great burgers. It is in Smith Haven mall.

**Entertainment**

- Long Island has plenty to offer in the way of entertainment be it from movies, concerts, plays, etc. It isn't hard to find the local movie theatres so we'll skip those. (If interested, the nearest is on 347 & Hallock Rd.)
- The Long Island Philharmonic Orchestra is an excellent group that performs many times a year and often gives at least one free concert a year outdoors. Theater Three in Port Jefferson is a quaint, local playhouse that puts on 5 or 6 productions a year, in addition to small local productions that run in and out of the playhouse all the time. There is an outdoor amphitheater in Oakdale that presents numerous concerts all throughout the summer. However, by far the biggest concert day on Long Island is the day that the Jones Beach summer schedule is announced.

- The theatre at Jones Beach has roughly 25 different acts every summer and is an outdoor amphitheatre right on the Atlantic Ocean. You should avoid seats in the very top section but otherwise there
generally is not a bad seat in the house. It is usually a popular stopping spot for any big groups touring during the summer. If you search for the theatre online it is located in Wantagh, NY and is just over half an hour from Stony Brook.

**EXPLORATION**

- Do not forget to take time to EXPLORE! Every week toward the end of the week Newsday (LI’s newspaper) publishes things to do over the weekend on Long Island and usually comes out with weekly top-ten lists or best of lists to help navigate you throughout LI life. Look them up at [www.newsday.com](http://www.newsday.com).
- Don’t forget that we have great downtown areas on Long Island too. The top three downtowns in Long island are: Huntington (about 30 minutes from Stonybrook), Port Jefferson (about 10 minutes from Stonybrook) and Northport (about 45 minutes from Stonybrook). And within an hour’s drive are Bridgehampton, Southampton, and Easthampton (i.e. The Hamptons), a great area to shop, eat, and go searching for local celebrities!
- And remember, you are still only 1.5 hours by train from New York City! You can get service on the Port Jefferson branch or the Ronkonkoma branch into NYC, though the PJ branch is a little longer. Park and ride stations are available to these and other LIRR lines all over Long Island – the parking is free and you can pay $10-15 at the machines to buy your train fare. The Ronkonkoma line has expresses at various times during the day that make fewer stops and can get to Penn Station in NYC in a little over an hour. You can take the NYC MTA subway from Penn Station to anywhere in the city.
- If you would like to really get away from the area for a weekend, do not forget that the two ferries to Connecticut leave at multiple times each day from Port Jefferson (5-10 minutes from Stony Brook depending on traffic, CT terminus Bridgeport) and Orient Point (on the very end of the North Fork, roughly 45 minutes from SB, CT terminus New London).

**HOLIDAYS AROUND LONG ISLAND**

- The winter on Long Island has much to offer in the way of both traditional as well as modern celebrations. In Port Jefferson, one particular event for people regardless of religion/denomination/faith is the Dickens Festival in December. Main Street in PJ is transformed into a Dickensian village complete with horse rides and
chimney sweeps roaming the street greeting people as they go into shops or sit down for meals at the restaurants. It is a lot of fun and always is hallmarked by Theatre Three’s production of A Christmas Carol. There are multiple tree lightings around the local towns as well as festivals and celebrations for all faiths and denominations.

- In the summer Long Island holds its annual Strawberry Festival, which is pretty much exactly how it sounds.
- The Long Island Balloon Festival is an annual show in August that spans 3 days of a weekend and has a carnival, shopping, lots and lots of food-cart eating, and of course, many, many hot air balloons that take off into the sky for dazzling displays. Do not miss the nighttime balloon glow where the balloons go up and all glow under their fiery canopies.
- Check out Sagamore Hill, the home of 26th US President Theodore “Teddy” Roosevelt. TR was the only President to make his permanent home on Long Island.
- Of course, not to be left out, are Long Island’s amusement park and waterpark. Splish Splash is located about 30 minutes from Stony Brook (exit 72, LIE) and is annually rated one of the ten best water parks in the US. Travel Channel recently named it #5 on its list. Go toward the end of summer and the lines are much shorter. Labor Day weekend is actually the last weekend the park is open and, weather permitting, is the ideal time to go. But it’s enjoyable any time of the year.
- Adventureland is in Farmingdale (about 30 minutes from Stony Brook). It is not exactly Six Flags, but is a very fun place to go (and admission is free) to spend a cool evening. They have their own log flume, roller coaster, [lame] haunted house, bumper cars, etc. It is also the inspiration for the recent movie of the same name, since the writer of the movie worked at the amusement park when he was a teenager. If you go expecting a quaint, campy, fun amusement park you will not be disappointed.
- During the summer almost every town has a fair, like Northport’s Cow Harbor Day, or Freeport’s Nautical Mile which has multiple events throughout the summer. Basically search any town name and “festival 2009” and you’re bound to get something fun.

**Seasonal**

- Memorial Day Weekend there is a great Air Show at Jones Beach that is free admission (you only have to pay to park). Each year the show is traditionally ended by the US Air Force Thunderbirds and they should not be missed if you feel the Need for Speed.
- Every Autumn the farms around the area get ready for the seasons with Pumpkin/Apple picking. Prices are very reasonable and some places only charge by the bag rather than the pound. So you can
stuff 30 apples in a bag and make apple pie for all your friends and third year residents who are on call.

**Shopping**

- Everyone has their favorite places to shop, and of course Long Islanders are no exception. The two big players are the Smithaven Mall and Roosevelt Field. Smithaven is 10 minutes from the hospital and boasts stores such as Williams Sonoma, Apple, Build-A-Bear (this is Pediatrics after all), and Coach. Right next to the Smithaven Mall is a Barnes & Noble that welcomes many authors for frequent talks and signing, and a Dick’s Sporting Goods where you can by the Frisbee that you are going to take to the many State Parks around Long Island.
- Roosevelt Field is a mall that is so big that you need a compass to navigate it. It has all the stores you would expect in a mall and then some including Armani-Exchange, Bose, Tourneau, the Franklin Mint, just to name a few. It is about 45 minutes from Stony Brook.
- The other 2 shopping megaspots not be missed on Long Island are the two huge Tanger Outlets, one in Riverhead and the newer one in Deer Park, the “Arches” (accessible by train on the Ronkonkoma line). Both also have ample parking if you want to drive out there, about 45 minutes to either one from Stonybrook.

**Sports/Recreation**

- Long Island is home to only one professional sports team and one minor league baseball team. New York City similarly is home to one professional baseball team, the New York Mets, and one minor league team, the New York Yankees. Both ballparks are easily accessible by train (Citi Field, home of the Mets, also accessible by car). On LI itself there are the Long Island Ducks who play in Central Islip at Citibank Park and are a great value at $8 a game. The New York Islanders are the aforementioned only LI pro team and play hockey at the Nassau Coliseum in Uniondale, about 45 minutes from Stony Brook. There are many local leagues anyone can join as well as intramurals on campus.
- The US Open Tennis Tournament is held every August/September in Flushing Meadows, between 45-60 minutes from Stony Brook.
- The US Open Golf Tournament has been held on Long Island 3 times in the last 10 years, once at Shinnecock Hills and twice at the Bethpage State Park Black Course. The Barclays will be held at Bethpage Black this August.
- Don’t forget about Stony Brook Seawolves Athletics. The Men’s Basketball team has made it to the NCAA tournament the past two years and the Baseball team made the NCAA College World Series for the first time in June 2012.
State Parks

- Long Island is home to one National Seashore (Fire Island), numerous beaches (over 1000 miles all-told), and many, many parks. The State Parks on LI are beautiful and many even have events in the winter. Some are pet friendly and some have exquisite hiking trails and fishing, among other activities. [Http://nysparks.state.ny.us/regions/long_island.asp](http://nysparks.state.ny.us/regions/long_island.asp) has a listing of all the parks in the region. Long Island is an absolutely beautiful place to be outdoors any time of year. Many of the beaches on the South Shore of Long Island are incorporated into the State Park system meaning they generally are well taken care of and looked after.
Resident Recommendations

RESTAURANTS

American

- Toast Coffeehouse - 242 E Main St, Port Jefferson
- Bliss - 766 Route 25A, East Setauket
- California Pizza Kitchen – Smithhaven Mall, Lake Grove
- John Harvard’s - 2093 Smithhaven Plaza, Lake Grove
- Chili’s - 280 Pond Path, S. Setauket
- Tiger Lily Café (Vegetarian) - 156 East Main Street, Port Jeff

Italian

- Pentimentos – 93 Main Street, Stony Brook
- Brothers Four Pizzeria - 310 Main St., Center Moriches
- Il Porto Bello - 1090 Route 112, Port Jeffrsn Sta.
- Ruvo Restaurant East - 105 Wynn Ln, Port Jefferson
- Pasta Pasta - 234 E Main St, Port Jefferson

Japanese

- Kimi - 115 Main Street, Port Jefferson
- Middle Eastern
- Pita House - 100 S Jersey Ave # 27, East Setauket

Thai

- Thai Gourmet - 4747 Nesconset Hwy # 24, Port Jeffrsn Sta
- Lemonleaf Grill - 208 Route 112, Port Jefferson Station

Indian

- Raga – 130 Old Town Road, Stony Brook
- Curry Club - 766 Route 25A, East Setauket
Mexican

- Salsa Salsa – 142 Main Street, Port Jefferson
- Green Cactus Grill - 1099 Route 25A, Stony Brook
<table>
<thead>
<tr>
<th><strong>SUPERMARKETS</strong></th>
<th><strong>PHARMACY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop &amp; Shop</td>
<td>CVS</td>
</tr>
<tr>
<td>Waldbaum's</td>
<td>Rite Aid</td>
</tr>
<tr>
<td>Wild By Nature</td>
<td>Walgreens</td>
</tr>
<tr>
<td>Trader Joe's</td>
<td></td>
</tr>
<tr>
<td>Meat Farms</td>
<td></td>
</tr>
<tr>
<td>King Kullen</td>
<td></td>
</tr>
<tr>
<td>Whole Foods</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>GYMS</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Powerhouse</td>
</tr>
<tr>
<td></td>
<td>World Gym</td>
</tr>
<tr>
<td></td>
<td>Synergy</td>
</tr>
<tr>
<td></td>
<td>Planet Fitness</td>
</tr>
<tr>
<td></td>
<td>LA Fitness</td>
</tr>
</tbody>
</table>
**Banks**
- Bank of America
- Chase
- Capital One
- Wells Fargo
- TFCU
- HSBC
- Citibank

**Cell Phone Provider**
- Verizon
- AT&T
- T-Mobile

**Internet/Cable/Phone**
- Cablevision/Optimum
- Time Warner
- Verizon

**Movie Theater**
- AMC Lowes on 347
- Cinema De Lux Island 16
- Port Jeff Cinemas

**Mechanic**
- Bruno’s Garage, St. James
- Mike’s Mechanics, Port Jeff

**Primary Care**
- Stonybrook Family Medicine – Dr. Soliman
- Stonybrook Internal Medicine – Dr. Lane

**Dentist**
- Dr. Schwartz, Shirley
- Cool Smiles
- Joseph lacarrubba
- Gentle Dental
- Stonybrook Dentistry

**Optometrist**
- Stonybrook Tech Park
- Davis Vision

**OB/GYN**
- Dr. Pilliteri, Deer Park
- Dr. Lochner
- Three Village Women’s
- Stonybrook OB/Gyn

**VERY IMPORTANT WEBSITES**
- Pediatric Curriculum Site (has links to New Innovations, AAP, Amion scheduler, Outlook email, Patientkeeper, and much more information about all of our rotations!) - http://medicine.stonybrookmedicine.edu/pedrescurriculum
- Prep Questions (Do 20 per month!) - https://www.pedialink.org/
- Remote Access – https://vdi.uhmc.sunysb.edu/
- SOLAR - http://www.sunysb.edu/it/solar.shtml
- HSC Library - http://www.hsclib.sunysb.edu/
### APPENDIX: FREQUENTLY CALLED PHONE NUMBERS

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Numbers</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 NORTH</td>
<td>4-1152 (FAX: 4-1355)</td>
<td>PEDIATRIC PHARMACY</td>
</tr>
<tr>
<td>11 NORTH CORE</td>
<td>4-1169, 4-8148, 4-1154</td>
<td>ADULT PHARMACY</td>
</tr>
<tr>
<td>11 SOUTH PICU</td>
<td>4-1102, 4-8084 (FAX: 4-8983)</td>
<td>TPN PHARMACY</td>
</tr>
<tr>
<td>11 SOUTH HEME/Onc</td>
<td>4-1101, 5-7433</td>
<td>SB PHARMACY</td>
</tr>
<tr>
<td>11 NORTH CALL ROOM</td>
<td>4-7984, 8-2156</td>
<td>FAIRVIEW PHARMACY</td>
</tr>
<tr>
<td>11 NORTH CONFERENCE ROOM</td>
<td>5-7432</td>
<td>DIETARY</td>
</tr>
<tr>
<td>NICU</td>
<td>4-2001</td>
<td>COMPUTER HELP</td>
</tr>
<tr>
<td>NEWBORN NURSERY</td>
<td>4-2110</td>
<td>JEAN SEGALL</td>
</tr>
<tr>
<td>Peds ED</td>
<td>8-3500</td>
<td>NB SCREEN</td>
</tr>
<tr>
<td>OR</td>
<td>4-2444</td>
<td></td>
</tr>
<tr>
<td>Admitting</td>
<td>4-2591, FAX: 4-1355?</td>
<td>AMERICAN RED CROSS</td>
</tr>
<tr>
<td>Poison Control</td>
<td>516-542-2323</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-222-1222</td>
<td></td>
</tr>
<tr>
<td><strong>CLINICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment Line</td>
<td>444-KIDS (444-DOCS IF MOVING TO ADULT LEVEL CARE)</td>
<td>PSYCH</td>
</tr>
<tr>
<td>Tech Park</td>
<td>4-0651, 4-4601 (FAX: 4-4990)</td>
<td>APNEA TEAM</td>
</tr>
<tr>
<td>Patchogue</td>
<td>4-6319, 4-6314 (FAX: 4-6327)</td>
<td>RADIOLOGY</td>
</tr>
<tr>
<td>Islip</td>
<td>581-9330 (FAX: 581-9561)</td>
<td>CT</td>
</tr>
<tr>
<td>East Moriches</td>
<td>638-2900 (FAX: 878-8084)</td>
<td>CT ER</td>
</tr>
<tr>
<td><strong>LABS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>4-2222</td>
<td>NEURORADIOLOGY</td>
</tr>
<tr>
<td>Blood Bank</td>
<td>4-2626</td>
<td>Peds Radiology</td>
</tr>
<tr>
<td>Chemistry</td>
<td>4-2365</td>
<td>Radiology JR</td>
</tr>
<tr>
<td>Cytogenetics</td>
<td>4-2749</td>
<td>Radiology SR</td>
</tr>
<tr>
<td>Department</td>
<td>Phone</td>
<td>Services</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Cytology</td>
<td>4-2216</td>
<td>RadioLOGY Supervisor</td>
</tr>
<tr>
<td>Hematology</td>
<td>4-2375</td>
<td>Anesthesia Backup</td>
</tr>
<tr>
<td>Histology</td>
<td>4-2236</td>
<td>Ultrasound</td>
</tr>
<tr>
<td>Immunology</td>
<td>4-2231</td>
<td>Reading Room</td>
</tr>
<tr>
<td>Microbiology</td>
<td>4-2370</td>
<td>X-Ray</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>4-7626</td>
<td>X-Ray Technician</td>
</tr>
<tr>
<td>Virology</td>
<td>4-2374</td>
<td>IR Fax</td>
</tr>
<tr>
<td>Coag Lab</td>
<td>4-2379</td>
<td>IR</td>
</tr>
<tr>
<td>Specimen Receiving</td>
<td>4-2616</td>
<td>MRI with sedation</td>
</tr>
<tr>
<td>Other Labs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFT</td>
<td>4-8137</td>
<td>Child Life</td>
</tr>
<tr>
<td>EEG</td>
<td>4-2260</td>
<td>Dietician</td>
</tr>
<tr>
<td>EKG</td>
<td>4-1760, 4-5481</td>
<td>PT</td>
</tr>
<tr>
<td>Echo</td>
<td>4-1770, 4-3769</td>
<td>OT</td>
</tr>
<tr>
<td>Operator</td>
<td></td>
<td>Transport</td>
</tr>
<tr>
<td>Chiefs</td>
<td>4-7711, 4-3103</td>
<td>Child Psych</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient Relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>JERRI</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>4-1273 (to see who is on call)</td>
<td>Michelle Kelly, NP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr. Shreya Nagula</td>
</tr>
<tr>
<td>Family Counseling Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Service League</td>
<td>(631) 288-1954</td>
<td>Suicide Hotline</td>
</tr>
<tr>
<td>Pederson- Krag Counseling</td>
<td>(631) 427-3700 ext 221</td>
<td>Domestic Violence or Sexual Abuse</td>
</tr>
<tr>
<td>Service</td>
<td>(631) 920-8000</td>
<td>(1-800) 942-6906</td>
</tr>
<tr>
<td>11N Charge Nurse Phone</td>
<td>(631) 560-8248</td>
<td></td>
</tr>
<tr>
<td>Pediatric Cardiology</td>
<td></td>
<td>Peds ENT/Dr. Szeremata</td>
</tr>
<tr>
<td></td>
<td>Fax EKG (1-866) 858-4985</td>
<td></td>
</tr>
<tr>
<td>Pharmacies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compounding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belle Mead Pharmacy</td>
<td>(631) 689-2209 (FAX)</td>
<td>Fairview Pharmacy (631) 474-7828/ (631) 474-75</td>
</tr>
<tr>
<td>Individual Pediatric Physician Numbers (don’t admit but have privileges = underline)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Narain</td>
<td>(631) 476-7456; Backup # (631) 473-1111/ (631) 241-4444</td>
<td></td>
</tr>
<tr>
<td>Dr. Irwin Schwartz</td>
<td>(631) 698-0600</td>
<td>*NOT KIDS Care Pediatrics</td>
</tr>
<tr>
<td>Dr. Masakayan</td>
<td>(631) 209-2827</td>
<td>*Has privileges</td>
</tr>
<tr>
<td>Dr. Amy Goldberg</td>
<td>(631) 585-4440</td>
<td></td>
</tr>
</tbody>
</table>

**Private Pediatric Groups**
- **Adolescent and Pediatric Medicine, formerly known as “Freed Group”**
- **Branch Pediatrics**
- **Friendly Medical Group**
- **Kids Care Pediatrics**
- **Kids First Pediatrics**
- **Mid-Suffolk Pediatrics**
- **Nataloni Pediatrics**
- **Smithtown Pediatrics**
- **Southhampton Pediatrics**

**Suffolk County Health Centers**
- These PMD’s do not admit or have privileges here

### Brentwood HC
- (631) 853-3400
- [Website](#) (for complete list of county clinics and staff pediatricians)

### Coram HC
- (631) 320-2220

### Patchogue HC
- (631) 854-1300

### Riverhead HC
- (631) 852-1800

### Shirley HC
- (631) 852-1000

---

Don’t forget to refer to this guide as you change rotations during the year!
ANY QUESTIONS? PLEASE ask!

CONGRATULATIONS &

BEST Wishes PGY-1’s!