Inova Fairfax Medical Campus
Internal Medicine Residency Program
Inpatient Ward Rotation - Admitting
Competency Based Curriculum, Goals and Objectives

I. Educational Purpose and Goals

a. This rotation allows residents to refine history taking, physical examination skills, differential diagnosis, and treatment strategies. Residents will focus on creating a comprehensive synthesis, assessment, differential diagnosis, problem list and management plan for an undifferentiated illness or with an acute exacerbation of a chronic disease requiring inpatient management. Residents will learn to become competent in diagnostic testing and management of common and complex acute medical problems, using evidence based practice. Residents will also get exposure to uncommon medical conditions and will interact with subspecialty consultants as part of ongoing care of their patients. Residents will learn how to prioritize management of both acute and chronic problems in hospitalized patients. Residents will become comfortable with managing transitions of care, both within the hospital and also out of the hospital. Residents will learn to initiate care plans based on patients' medical problems, social situation, and economic status and collaborate with other members of the health care team.

II. Principal Teaching Methods

a. Supervised direct patient care: Resident teams will present for daily admitting shifts where they will work directly with hospitalist attendings. They may work with multiple attending providers during the course of their shift as well as work with one medical student at either M3 or acting intern level. Residents will be assigned patients by a triage hospitalist. Patients will be seen and examined by the resident, who will formulate a hypothesis and a treatment plan and present it to the assigned attending faculty. Both the resident and attending will examine the patient and discuss the plan of care. Subspecialty consultation may be requested at time of admission and an appropriate, specific clinical question is expected to be asked. The resident will assume primary care for the management and coordination of care for their patients, including performance of any necessary procedures under direct supervision of their attending faculty, all of who are board certified Internal Medicine and/or subspecialty certified physicians. Residents are expected to be first point of contact for all matters related to patient care and should be placing all orders on their patients unless there are specialty specific needs (ex. Chemotherapy, Dialysis orders).

b. Didactics and small group sessions: Residents may (but are not required to) attend noon conference didactic sessions during their admitting rotation. Noon conferences include but are not limited to the following sessions: Journal club, Resident Report/Evidence Based Practice Case presentation, Internal Medicine

Grand Rounds, Educational Grand Rounds, attending lecture series, Residents as teachers/Faculty Development sessions, Medicine-Pathology-Radiology conference, Morbidity and Mortality Conference, Cost-conscious curriculum, rapid response curriculum and administrative morning reports.

c. Self-Study: Residents are expected to perform directed reading based on their patient's problems and disease states**.** This will be a primary method of learning during the admitting rotation as residents spend more time independently. Access to articles and electronic resources will be made available to residents from any computer with an internet access, both inside and outside the hospital.

III. Educational Content

a. Disease mix: Patients with a wide variety of medical illnesses will be seen by residents on the internal medicine service.

b. Patient characteristics: Inpatients at Inova Fairfax Hospital of 18 years of age or older provide an ethnically diverse patient population with a broad array of common and rare diseases. Patients will primarily be admitted through the Inova Fairfax Medical Campus Emergency Department or as direct admissions from surrounding health care facilities.

c. Learning Venues: Inova Fairfax Hospital

d. **Structure:**

- i. The rotation is a two-week block with all clinical time spent in the hospital. The admitting team will consist of a resident and one medical student. An attending physician is always available for questions and support. In the event that the dedicated ward attending is not available, a hospitalist provider may always be reached at the general hospitalist pager (pager #84677)
    1. A PGY-1 admitter will have a cap of 4 new patients per shift.
    2. A PGY-2 or PGY-3 admitter will have a cap of 6 new patients per shift.
- ii. Each shift will be 9 hours in length. The last admission should be assigned at least 1.5 hours prior to the end of the shift.
- iii. Residents will continue to attend their continuity clinic during this rotation for one half-day per week in the afternoon. Residents will not come to hospital for admitting on days that they have continuity clinic.
- iv. The chief resident will orient the resident to the rotation at the beginning of the block and will review the specific schedule at that time. Residents will always have four days off in a month, will not work more than 80 hours on average per week and will not work more than 28 hours (24+4) consecutively. All level residents will have 10 hours free of clinical duty between working shifts. Interns will not work more than 16 hours consecutively.

IV. Principal Educational Materials

a. Educational materials and expectations will be available electronically through MedHub.

b. Residents will have 24/7 electronic access to journals, uptodate and other library materials both at the hospital and at home through remote access applications (citrix)

V. Methods of Evaluation

a. Feedback will be given to the resident throughout the rotation as appropriate. At the end of the rotation, the attending teaching faculty will complete a web-based evaluation (MedHub) of each team member and review it with the team members.

b. The residents will also evaluate faculty and the rotation in an anonymous fashion (summarized annually in a composite form).

c. In-training examination aggregate results as well as Internal Medicine Board examination results for the program.

d. All written feedback will be reviewed with program director twice yearly during semi-annual meetings.

VI. Resource List

a. Harrison's Principles of Internal Medicine

b. Core journals in internal medicine and it's subspecialties

c. Up-to-Date

d. Reading list: please refer to Ward Goals and Objectives for Complete List

VII. Learning Venues

1. Supervised patient care/Attending rounds
2. Small group and Didactic sessions
3. Independent reading

VIII. Evaluation Methods

a. Attending evaluation
b. Direct observation with feedback
c. Peer evaluation (ex. Feedback from rounding team)
d. Student evaluation
e. In-training exam for the program level evaluation of the rotation

Competency: Patient Care	**Learning Venue**	**Evaluation Method**
Demonstrate the ability to interview a patient, gaining pertinent facts in an efficient and complete manner	1	ABCD
Perform a complete and accurate History and Physical Exam	1	ABCD
Be able to judiciously order and rationally interpret diagnostic tests	1	ABCD
Approach patient management with compassion.	1	ABCD
Teach junior learners/team members how to perform a complete, sensitive, and accurate physical exam	1,2	CD

Teach the indications and interpretation of diagnostic tests to various levels of learners on the team		C,D
Competency: Medical Knowledge	**Learning Venue**	**Evaluation Method**
Articulate the pathophysiology, evaluation, diagnostic work up and treatment of common medical problems	1,2,3	ABCDE
Identify and prioritize active medical problems in an acutely ill patient	1,2,3	ABCDE
Rationally approach differential diagnosis and management	1,2,3	ABCDE
Be able to manage multiple concurrent admissions within your team by triaging acute and non-acute issues	1,2,3	ABCDE
Competency: Interpersonal and Communication Skills	**Learning Venue**	**Evaluation Method**
Understand the role of different members of the health care team	1,2	ABCD
Show understanding of cultural and gender differences as they relate to patient preferences of treatment and evaluation	1,2	ABCD
Interact in an effective way with members of the health care team	1,2,3	ABCD
Concisely and completely present a case to supervising provider and consultant team when indicated	1	AB
Complete timely, throughout documentation of a newly admitted case such that the accepting team can easily follow thought process and determine next step	1	ABC
Competency: Professionalism	**Learning Venue**	**Evaluation Method**
Consistently update team contact information in Epic	1	ABC
Treat team members with respect	1	ABCD
Treat all patients with respect and altruism	1	ABCD
Understand the problem with/avoiding arrogance toward colleagues and patients	1	ABCD
Show honesty, integrity and compassion toward colleagues and patients	1	ABCD
Demonstrate acceptance of the responsibilities of your role on the team and toward your peers and ensure prompt completion of duties	1	ABCD
Competency: Practice-Based Learning	**Learning Venue**	**Evaluation Method**
Acknowledge the “gaps” in medical knowledge	1,2,3	ABCD
Identify errors in medical care and utilize medical literature, information systems, and teachers to address those errors	1,2,3	ABCD
Understand and utilize the information technology available to you at the hospital	1	ABCD

Use an evidenced based approach to patient care	1,2,3	AB
Accept feedback and work to improve deficiencies	1,2,3,4,5	ABCD
Competency: Systems Based Practice	**Learning Venue**	**Evaluation Method**
Understand and acknowledge the barriers to health care and adherence in your patients	1,2,3	ABCD
Use evidence based, cost conscious strategies in the care of medical patients to prioritize what should be completed acutely in the inpatient setting	1,2,3	ABCD
Utilize the resources available to you to optimize medical care of your patient	1,2,3	ABCD

Admitting Guidelines

1pm/3pm Admitting to do list:

At 10pm, meet with the other admitter to complete the distro which includes the following:

- Log onto amion.com **ffxmed** to check cap and attending, and enter into tracker
  - 2 intern team cap is 16
  - 1 intern + resident or 1 resident only cap is 12
  - 1 intern only cap is 10
- Look at the resident team list and find out how many patients there are on each team list at 10pm. Enter this info into the tracker.
- Distribute your newly admitted patients to resident teams. Enter the new patients into the tracker and add the treatment team (also remove admitting team before leaving) and the new attending to each patient. If the patient will not be distributed to a resident team, state so in the tracker. Try to prioritize Tower 10 patients going to tower 10 teams (A first, B second).
- If there is NO bed assignment at the time of sign out – particularly for team A, please pass off the responsibility of assigning to a teaching to the NF MAR and the cross cover resident. Please place an "uncovered" sticky note that can be updated at the time of team assignment at 4:30am.
- You can assign team B patients anywhere in the tower or the Women's and Children's Building.
- We should try to limit IHVI team to IHVI building; but understand that may not always be possible or if it is an interesting patient, do give to the team.
- Resident teams may not be assigned patients in the observation unit on NPT6 (beds 25-48)
- If all resident admitted patients have been assigned and there are still spots on the resident team, please reach out to the distro hospitalist (Nocturnist 1) to obtain additional patients to assign to teams along with a brief signout about the patient
  - ICU stepdowns that have not been evaluated by a hospitalist or a resident (i.e. no patient accept note) may NOT be assigned to resident teams as handovers
- After you have completed the tracker, email it to the medicine chiefs, the 1pm/3pm and 9pm admitters, and the ED triage/PM triage hospitalist, nocturnist1 and night APP (find out who these hospitalists are by logging into QGenda (https://app.qgenda.com/landingpage/inovahospitalmed)
- After you have emailed the tracker, call **Nocturnist 1 hospitalist** to let him/her know that distro is done and email is sent out and to discuss distro.

At the end of your shift:

- After you are done with all of your work and you have signed out to cross cover, change the sticky note and treatment team. If your patient is going to a resident team, change sticky note and treatment team to resident team **(.medteamIHVI, .medteamA, or**

.medteamB). If going to be *__unassigned OR uncovered__* the following day, change sticky note to .medteamuncovered.

- *Call the nurse for each of your patients and let them know that they need to call or page 65751 overnight as you are leaving.* **(Nice to do but not required)**
- Forward your personal pager to 65751.
- Turn off the admitter spectra.

Intern Admitting Rules (specific to their rotation):

- Cap of 4 admissions per shift
- When you are the 1pm/3pm admitter, distribution of patients as outlined above IS your responsibility. There is no resident supervising your admissions.
- You will staff each patient directly with the attending who is your supervisor for the shift.
- If unsure at any time, reach out to the chief resident on call.
- Apply and follow all of the outlines above when you are the 1pm or 3pm admitter.

Crosscover to do list:

- At the end of your shift, double check to make sure the sticky note for each patient on the team AM admitter and team PM admitter lists is updated. If the new patient is assigned to a resident team, sticky needs to be changed to **.medteamIHVI, .medteamA, or .medteamB**. If going to be uncovered, remove the sticky note all together.
- For each of the newly admitted patient, remove the admitter team from the treatment team before leaving
- Turn off the cross cover pager and spectra.
- **__On Monday at 4:30 am__**, touch base with distro hospitalist and let know how many spots are available for the teams. (Requires reviewing tracker sent by day admitter). Will have to manually add patients to the team list. Will need verbal sign-out from the hospitalist.
- **__You can assist the 9 pm admitter resident with the distro by working together.__**

Distro Rules to Keep in Mind

1. Team A should preferentially get Tower 10 patients
2. If team A is capped, then Team B can get Tower ten patients if interesting or needed to keep team capped. Otherwise can leave uncovered.
3. Teams should only receive four new patients each morning, and all teams should be appropriately capped with admissions each day.
4. Goal is to have only a very few teaching service patients in APU.
5. All Obs Unit patients should remain uncovered.
6. You do NOT need to finish team assignments on all of your patients *if waiting for bed assignment* before leaving and can pass to the 9pm admitter – this should only be for a select few with regards to team A being limited to IMC or tower 10 geographically.
7. **__All admissions have some learning value__**
8. The 9pm admitter and cross cover intern should be communicating and working closely and should know about teaching service patients admitted to ICU, patient deaths and AMA – thus factor those into the final distro at 4am.

9. Also, please update the admitter sticky notes each week with your personal pager to be included. We no longer use the admitter pagers per your request.
10. Utilize new Adult Hospitalist Order set, to minimize unnecessary calls/pages

Tracker

Attending	Team	EOD	Goal	Attending Census	Patients
	A				1. 2. 3. 4.
	B				1. 2. 3. 4.
	IHVI				1. 2. 3. 4.

Uncovered:

COVID-19 Addendum

Patient Care

- Residents admitting patients who have COVID-19 or are under suspicion for having COVID-19 should have an initial exam with the attending or resident (only one needs to go into the room).
- You will need to contact your attending to figure out who will physically see the patient.
- If you will not be physically seeing the patient then you may call their room to obtain history or call their cellphone.
- Subsequent encounters do not require that the resident go into the room. This is to both reduce the chance of exposure and to reduce PPE use.
- **Even in Code situations all resident must wear appropriate PPE (airborne precautions/ N95 mask/ PAPR or P100 respirator) as CPR will aerosolize COVID-19**

PPE

- Please wear your respirator or on your first day on the unit please ask the charge nurse about access to N95 mask (you must know your size and style of mask prior to starting the rotation). All patient interactions require a minimum of face shield, simple face mask (for droplet precautions) and gown.
- Aerosol generating procedures include the list below. For any of these procedures please wear N95/PAPR/P100 Respirator
- For the most current INOVA specific protocols for COVID-19 patients please visit https://www.inova.org/tmcovid19

INOVA **Aerosol Generating Procedures (AGP) Guidelines**
May 12, 2020

OVERVIEW

- Inova defines the following as Aerosol Generating Procedures (AGP), and they should be performed in an airborne infection isolation room (AIIR, aka negative pressure) when possible for rule-out/confirmed COVID-19 patients

GUIDELINES

Aerosol Generating Procedures (AGP):	
▪ Bronchopulmonary Hygiene, excluding VEST Therapy	▪ Manual Ventilation/Open Suctioning
▪ Bronchoscopy	▪ Nasogastric/Orogastric (NG/OG) Placement
▪ Cardiopulmonary Resuscitation	▪ Non-Invasive Ventilation (BiPAP, CPAP)
▪ Chest Tube Insertion or Removal	▪ Nebulizer Therapy
▪ High Flow Nasal Cannula (see table below)	▪ Sputum Induction
▪ High Frequency Oscillating Ventilation	▪ Tracheostomy
▪ Intubation/Extubation	▪ Transesophageal Echocardiography (TEE)
▪ Invasive Mechanical Ventilation with Circuit Disruptions	▪ Upper GI Endoscopy

Aerosol Generating Procedures (AGP) High Flow Nasal Cannula Flow Rates *(Requiring Airborne Isolation & AIIR for COVID-19 Patients)*	
Patient Weight:	**Flow Rate**
< 9 kg	>12 lpm
9-15 kg	>15 lpm
15-25 kg	>20 lpm
>25 kg	≥30 lpm

Oxygen Reservoir Therapy (ORT) *The following oxygen administration devices are NOT Aerosol Generating Procedures*
▪ Nasal Cannula
▪ Non-Rebreather
▪ Oxygen Reservoir Cannula
▪ Simple Mask
▪ Venturi mask

Note: In the event that an AIIR (negative pressure room) is not available and an AGP must be performed, place patient in a normal patient care room with a closed door and continue to use N95s or PAPRs. Normal patient care rooms are neutral pressure and performing an AGP in a non-AIIR does *not* contaminate the air in the area outside the room. Ensure that the door to the room remains closed for a full 60 minutes after the AGP was performed.