**Intern Survival Guide**



**2017**

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**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 your 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.
* Work life balance is important. Find a way to designate a portion of your weekend to go out and do something fun. For example; some people make a point to go out on the night before their day off no matter how tired they are. It ensures you get out and enjoy life after a hard week.
* 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.*

***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.
  + 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.
  + 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)
  + 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.
  + 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.
* If you have a concern about patient care, let your senior resident know so they can help; they are there for exactly that.

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**](http://www.youtube.com/watch?v=bFEoMO0pc7k)**,” BUT, remember…**

***“Even when it seems there are not enough hours in a day…***

***in the end, it’ll ALL get done.”***

**Continuity Clinic**

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
* Rotations without clinic sessions: 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. Ensure you leave at 12 noon to give yourself enough time to grab lunch and account for traffic/driving time.
* You may occasionally be assigned to alternate clinic sites/days depending on the schedules of other team members to minimize understaffing. Check your email frequently for these updates.
* When someone else has clinic on the Ward, the other intern(s) on their team need to cover for that person. Pay attention in AM sign out and during rounds so you are well equipped to manage your co- intern’s patient that day.

**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)
* When the attending also sees your patient, enter modifier “GC” while billing. If the attending does not see the patient which can occur after the first six months of intern year, enter modifier “GE” while billing.
* You can save auto texts for several clinical scenarios you may encounter. It becomes useful for template layouts for well visits and certain common sick visits. To do so, highlight the text you want and right click it to save it as auto text.
* You can also save Macros which may help you with notes. Ex Negative Review of Systems, Normal Physical Exam.

**Clinic duties**

* For the first six months of intern year, you will present all patients to your attending, who will also need to see the patient. After that, you will be able to see patients on your own.
* In addition to the patient’s on your schedule, you will have messages in the “Pool” that you and the other residents at clinic will have to reply to. You can right click, assign the message to you and work on it before seeing, patients, while waiting to present to the attending or while waiting for your next clinic patient to arrive.
* There is a basket of school physicals/ forms that accrue, ensure you check for this and fill out as many forms as you can.

**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!

**Development/Behavioral**

**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.
* Be engaged and ask questions. Remember that many of the chronic care patients that come through 11N have needs in this area, and the more you understand them, the better care you will provide
* 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:
  + ADHD, Autism, Cerebral Palsy, Major genetic disorders like Down syndrome and Turner Syndrome

**Scheduling**

* Obtain your schedule from Janet Ruggiero (in the 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.

**Documentation Guidelines**

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 ASAP. There are certain situations that may prevent you from getting to it in a timely fashion, however you must ensure it is completed by the end of your shift.
* Physician’s orders should be entered on admission and reviewed daily. In the event of a busy day on the floor, ensure the admission orders and home medication orders are placed before doing the H&P.
* *Medication reconciliation is to be done – correctly and accurately - on admission, transfer and discharge. These should always be reviewed by your senior.*
* 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.

**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 – 8pm, 3pm - 3am, or 9pm - 9am. You may work with other Peds or ED residents.
* You may occasionally work short call shifts from 5pm -10pm during the week, 10am - 3pm or 3pm - 8pm or during elective blocks.
  + 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. However, during busy shifts where there are many charts waiting you should take charts (perhaps less complicated/”quick” ones) until the end of your 12 hour shift and then write your notes afterwards. If you are not sure, ask a senior in the ED with you!
  + You should be out the door (no longer providing direct patient care) at the 12-hour mark. Note: writing notes does not constitute providing direct patient care.
* 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.
* Full Continuity clinic will be once per week (half days for med-peds).
* You may be post-call on days after you’ve worked 3pm to 2am, but you can work multiple night shifts in a row and likely will be scheduled for another 3pm-2am shift or a 9pm to 8am shift.
* If you are post-call on a Wednesday (i.e. have worked the 3pm - 3am or 9pm – 9am Tuesday shift), or your Wednesday shift starts at 3pm or 9pm, you do not need to attend Wednesday lectures.
* If possible, chiefs will schedule shifts so that you will have two entire weekends off for every month you work.
* You will have days off during the week, this is the perfect time to schedule personal appointments that have “9-5” hours.

**Firstnet**

* Firstnet is our electronic ED board. Take an hour or two 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.
* When writing notes on Firstnet, be sure to save the document type as “ED note physician” and choose a reason for visit. All ED notes have a template. Most ED physicians prefer if you fill out those templates as it helps with billing. However, for completeness and your own learning, you should write a complete HPI and Assessment and Plan.

**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

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

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.
* Newly added per request the residents, portable otoscopes and ophthalmoscopes are now available in the area where the residents and attendings work. This was requested because certain rooms have equipment which is not optimal to patient care and also because it is more convenient when examining patients situated in the hallway.

**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 any patient whom you have been providing care for that has not yet been discharged to another resident still in the ED 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.
* When they are ready to be seen, their name and room location 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 want to 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, all orders are “STAT” and “x1” in frequency.
* Chem-8s must be ordered as “ED Whole Blood Panel”
* Order UA without microscopic, if + then stat lab will reflex cell count
* Images (XR, CT, MRI) can be ordered through the “Emergency Department”→”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:
  + Cardiology c/s (Tip): Before calling a Cardiology consult, you should obtain an EKG. 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 / service will be.
  + A patient with a private attending who admits to the hospital will be admitted under that PVT attending (see Appendix).
  + A patient with no PMD or a PMD without admitting privileges will be admitted under the hospitalist service (SVC).
  + A patient going to a subspecialty/surgical service will get admitted under their on-call attending.
* Page the admitting physician and discuss/formulate a plan. Make sure they accept the admission/patient and let your ED attending know they have accepted.
  + Call the patient’s destination service (11N, PICU) and talk to the senior resident who will be accepting the admission. They will notify the charge nurse of the admission.
* Place the admission orders. Type in “Bridge” to the search box in orders, select the result, and fill in the required fields (you will need to know the name of the resident you spoke with and the name of the attending who accepted 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.
  + 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.
* Once the discharge is prepped and printed, have the attending sign the discharge. 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.

* 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 are required to attend Grand Rounds and Conference on Wednesdays
* While on your elective rotation, you will also be required to work short calls in either the ED, the Ward, or the Nursery.
  + ED Weekday short calls are typically 5-10pm after your work day.
  + Make sure you get orientation in the Nursery before your first short call if you haven’t had your Nursery rotation yet. Short calls are 6am-11am

**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 correct attending so they can addend/sign your note.
* Developing your own set of macros can be a huge time saver. Be sure to make your own!
* Developing your own set of auto-text can be a huge time saver. Be sure to make your own!
* Always remember to have the appropriate timeframe selected in Powerchart 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”).
  + 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.
  + 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.
  + 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.
    - 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**. **A list of the commonly used chemotherapies and side effects are listed on the cork board over the computers.**

**Where Things Are**

Charts

* Red Charts are usually found in the chart rack. In them are:
  + Patient stickers
  + ED and outside records
  + Completed consults
  + **Chemotherapy orders (in “Orders” section)**
  + 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: IHI/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)
* Tumor Board: Every other Monday at 4pm
* Radiology Rounds: Thursdays at 11am
* Interdisciplinary Meeting: Every Tuesday at 12pm in the Morning Report room. **You will prepare 2 presentations 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 at 6:30a 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..

**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.
  + Tip: When presenting vitals, include ranges and UOP in cc/kg/day.
  + 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. H&Ps are due ASAP. 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).
  + 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. 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, Radiology, 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.
* Print copies of the Heme/Onc list for the night team 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.
  + Report by systems, including most recent vitals.
  + Briefly list important medications and their side effects **(list chemotherapy side effects on the sign out so night team is aware)**
  + 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:
  + **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?
  + **What to do for abnormal urine dips** – What are acceptable parameters for urine dips? How should we adjust fluids for abnormal parameters?
  + **If you need methotrexate levels done overnigh**t– 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 Encountered 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

* 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).
  + Diet: Regular pediatric vs. Neutropenic. Write a neutropenic diet for a patients with an ANC<500.
* **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 -(hyroxyzine)
* 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 attend Morning Report every Mon-Tue-Thurs-Fri from 8:30 – 9AM, 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, to focus on resident education, especially high-yield topics and discuss presentation, management/workup and treatment. 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.
* 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 with an email confirmation if there is a case they would like you to present

**Case Selection/Preparation**

* Cases are to be decided upon by chiefs who will allow for ample preparation time. Attendings relevant to the case will be asked to attend.
* Cases should be well-structured and succinct with clear discussion points incorporated throughout the presentation. Focus the discussion on either building a differential diagnosis or management of your case.
* There is NICU morning report once a month led by the current NICU residents.

**Things to arrange in advance**

* Know your case well! Comb through the EMR and read the H&P, progress notes, pertinent physical exam findings, lab trends, radiology, consults, etc.
* Review useful resources such as Uptodate, Pubmed, Peds in Review, etc to help you understand the case and lead the discussion
* Photos of physical findings and pertinent Radiology can be used. Everything else (labs, etc) will be verbally stated during your presentation.
* Try to meet with a chief resident and/or with a faculty member a couple of days before you present to review your presentation and pertinent information to include.

**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.
  + The chiefs will be the ones to invite pertinent morning report attendings and will let you know generally who they are expecting.
  + 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, ROS, full past histories and physical exam. Ask your Chiefs or a senior resident for a sample outline of Morning Report, or how to structure your case. This is a learning process we all go through!
* Major teaching points should be included in discussion of differential diagnoses and management. Here are some ways to incorporate teaching points into the discussion:
  + 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?”
  + For each differential diagnosis, ask the group how they would rule in/out that particular 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?”
  + 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?”
  + Save the true diagnosis until last, even if someone guesses it first, to allow creation of a broader differential.
  + Try to come up with about 4-6 teaching points. Don’t forget to include the medical students!

**General Structure of a Morning Report**

* + Initial “one-liner” should contain the following patient information: Age, Sex, and Race/Ethnicity, chief complaint
  + 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.
  + Review of Systems with pertinent positives and negatives
  + Physical Exam – Initial vital signs, growth percentiles (weight, height/length and head circumference)
  + 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 differential 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 given throughout the presentation during the differential and/or management section.
  + Hospital Course/Follow Up - The end of the case should include the relevant hospital course, follow-up including social issues, outpatient appointments with subspecialties or PMDs. This is a great time to incorporate faculty to teach management/prognosis of your case
  + 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” (by senior residents on the Ward and Heme/Onc) will be done at the discretion of the chiefs and faculty. This reviews recently admitted cases for learning purposes

**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.
  + Tip: You’ll need your ID at practically every entrance, so don’t forget it!
* The nursery itself is about halfway down the hallway in the enclosed core.
* 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. The layout is exactly the same on both floors.
* The Dress code is business attire, no white coat. Wash your hands before and after examining each baby. Use an alcohol swab to clean your stethoscope before placing on the baby.
* As the newborn resident, you’ll be working from 6am until 5pm. You will work one weekend day for three weekends and have a golden weekend during your block.
* There are also Nursery call shifts on a weekend day for people on electives or Development so you may work in the nursery before your actual rotation.
* A few days before your first day of Newborn Nursery, contact the Nursery resident and set up a time to visit/orient the Nursery. The goal is to familiarize yourself with the day to day activities of the nursery before your first day as the census can get very high and you can easily feel time constrained.
* Tip: **The key to success on this rotation are high efficiency and organizational skills.** Also, you will see a lot of “normal” well babies so it is important to be able to detect and note any abnormalities.

**Where Things Are**

There is a resident computer station that you will do most of your work at in the nursery core. There are also extra Nursery Laptops stored in the Circumcision room for attendings, medical students, etc. 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 (Girls) and Blue (Boys): Every new baby needs a card filled out. You can find the information via Cerner under the baby’s delivery record or the OBGYN H&P in the mother’s chart. These cards are your lifeline during rounds and will also help you keep track as you care for the baby and prepare them for discharge (ie Hep B vaccine, hearing screen, CCHD, anticipatory guidance) Update the cards frequently during the day. Remember to fill in the ins/outs and weights per day on the back of the card.

Babies and Accessories:

* 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).**
* Bassinettes are stocked with pretty much everything you need: diapers, wipes that you wet with water, receiving blankets, etc. Check the drawers.
* Ophthalmoscopes on wheels to check the red reflexes are located in the nursery core.
  + Tip: All new babies need red reflex checked so wheel the scope with you in the morning.It is helpful and quicker to carry your own portable ophthalmoscope if you have one.

Hard/Paper Charts: Located in the nursery during the early morning hours or out by the nursing stations near the baby’s mother’s room. Blue folders= Baby’s and the Maroon/Red folders=Mother’s. These folders contain:

* **Stickers** with the patient’s name and MRN number for you to put on your baby cards. It is helpful to have the MRN on your cards in case you need to call a phone translator.
* Consents – HepB and circumcision
* **Prenatal Records** located inthe mother’s folder –clipped to front of the chart or in the H&P sections. Review these if questionable prenatal findings, to review sufficient prenatal visits, etc.
* 9-10 prenatal visits is considered “adequate” or “routine” prenatal care.

Notes: Every baby needs two notes at admission. One is an admission H&P and the other is a “Newborn History” note, there are templates in Powerchart.

* TIP: You can automatically pull in the delivery record information into the Newborn History note to save you massive amounts of time!
* TIP: 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 also “Patient is a newborn” under ROS.

**When Things Happen**

* 6am: Arrive, call NICU for overnight events
* Until 9:30am: update the cards, pre-round, write a minimum of 10 notes. Discharge notes takes precedence followed by admission notes, and Newborn history 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.”
* If there is only one resident on, you will also need to divide the patients so that there are 2/3rd of the patients on your team and 1/3rd of the patients on the non-teaching service. Less medically complicated patients should go to the non-teaching service.
* 9:30am-noon: Attending rounds (time may vary).
* Afternoons: see new admissions, give anticipatory guidance and prep discharges for the following day, Check in with moms and babies,
* 5pm: Signout to the NICU (x4-2000), see section below.
* 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 compared to other days. All discharge prep, completed newborn cards and documentation for rounds must still be complete before rounds on Wednesday.**

**Pre-rounding**

* 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 arrive is do a 3min surgical scrub 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!
* An anticipated discharge list (with T/D bili 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”. http://Bilitool.org can be a great tool for evaluating bilis.
* Compare the anticipated discharges with patients you think should be discharged home (day 2 for NSVD, day 3-4 C/S). Sometimes, parents request to be discharged home early while NAS babies typically stay longer.
* Call the NICU (4-2000 for NICU front desk, ask to speak to the resident) for signout of any overnight transfers or events.
* 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.
* Begin updating your cards with the I&Os, weights, hearing/CCHD/bili, etc.
  + TIP: Utilize Medical students to help you fill out the cards!

Begin writing your notes using the information from the cards and save the note without the physical exam (you will sign notes after you preround and insert the physical exam, see below)

* **TIP: Make templates** **for the physical exam and plan since they are almost the same for every baby.**
* Examine all of the babies, discharges first, 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 and a rolling computer onto the floor and see the babies in their mothers’ rooms. Once you exit the room, open up your saved note, insert your physical exam, sign the note and move on.**

**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.
* Double check by asking the nurse, reviewing the charts or asking the mother if the pediatrician is staff or private. If it’s private, it’s not your admission. Make sure staff is not covering for any private attending.
  + Along those lines, if nurses ever have a question on a private 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 while you begin filling out the newborn baby card.
* You must insert Admission Orders on all babies, staff and private.
  + Under “orders,” search for “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”.) It is helpful if you save these Powerplans to your favorites.
* Unless you are unsure about a plan of action, there is no need to notify an attending about an admission.Otherwise, staff attendings will see new babies the next morning.
* Examine the baby and write your admission H&P and Newborn history note.
* The OB/GYN H&P located in the mother’s EMR chart under “documentation” has most of the pertinent prenatal info needed for your cards. If the mother was GBS+, check the mother’s MAR to see if she was adequately treated. The Baby’s delivery record will have the rest of the info.

**Discharges**

* **Discharges are the number one priority in the morning.**
* To be eligible for discharge, all babies need:
* Total/Direct bili levels. Graph every level based on hours of life. If the

level is abnormal, page the attending and begin phototherapy as

indicated.

* Newborn screen sent. Results take 2-3 weeks to return.
* Hearing Screen passed bilaterally. The results can be found under

“Results review” OR there will be a green sticker dot on the baby’s bassinet

* Critical Congenital Heart Disease (CCHD): results also found under

“results review.” This is just a pulse ox sat comparing the right arm to either right leg/leftarm/left leg. A positive result is <90% or a greater than 3% difference between the two readings. Notify the attending immediately for positive results.

* hepatitis B vaccination if parents consented. If it was given, look under

the MAR Summary OR Immunizations tab

* anticipatory guidance given (see below)
* PMD followup established
* Weight <10% below birth weight
* feeding, voiding and stooling appropriately
* All premature babies <37 weeks will need a car seat test
* The Depart and everything required for discharge should be completed and signed before rounds therefore the baby can be discharged immediately during rounds after the attending has examined the baby.
* Bring a computer with you on rounds so you can put in discharge orders. go to “Order” search for “Discharge

orders home.” Insert your name for dictations however there are no dictations for <48hour admissions. All NICU

transfers and NAS babies require dictations.

**Interim Babies**

* You will write a daily Nursery progress note in Powerchart.
* 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.

**Night Sign**o**ut**

* Call the NICU x4-2000 and sign out to the night NICU resident at 5pm
* Only signout babies that have active issues, pending labs (CBC, T/D bili, etc) or babies that you predict may have issues overnight (hypoglycemia). All NAS babies need to be signed out. Don’t forget to sign out a plan if labs are abnormal.

**Transfers to/from NICU**

Transfers to NICU can be done at any time a baby is ill. If you are especially worried about a baby, discuss the situation with the service attending or the PVT attending first then call the NICU and speak with the fellow. The fellow will come evaluate the baby and may/may not transfer to the NICU. If they decide to transfer, you:

* + Always go with the baby to NICU.
  + When you get there, sign out to the resident (and fellow, if necessary).
  + As with any transfer, write a thorough transfer note.
* Transfers from NICU – check the census every morning to make sure there were no new transfers overnight.
  + Babies who are 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.
  + Be sure to put in the Newborn Nursery Admission 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 onto a baby card.

**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. The protocol is printed on the bulletin board in the nursery core AND on the SB curriculum website.**
* This is complicated and its best to make sure everyone is on the same page. Lisa is our expert on this topic.

**Attending Rounds**

* 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 (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/Discharge Rounds**

* In the afternoon, you and your medical students will have free time to do work. You should use this time to round and prepare discharges for the next day.
* General questions to ask:
* Do they have any questions or concerns?
* Breast/bottle feeding? Any problems with breastfeeding? If so, you can order a breastfeeding consult.
* Who will be the baby’s pediatrician? If they do not have one, recruit them to SB Peds and give them your business card! Its great continuity to pick up a newborn and follow them through residency.
* Give anticipatory guidance. See next section for details.
* Update your newborn cards with the PMD, anticipatory guidance, etc. Once you get back to the nursery after your discharge rounds, update/sign your depart so it will be done for the following morning. The depart includes the medication reconciliation (all babies are discharged with NO meds), patient education, and PMD follow up.

**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 in first 2 months of life. Any temperature below 97 or greater than or equal to 100.4 is an emergency and they need to be seen in an ED.
* 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. This reduces the risk of SIDS. If family does not have a crib, can use a laundry basket with a towel on the bottom.
* Have everyone wash their hands prior to handling the baby. Advise not to let other touch/kiss the baby’s hands/lips, since they can get their hands to their mouths and ingest germs.
* 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. The safest position is in the middle of the back seat otherwise passenger seat if it cannot fit.
* 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. This protects the baby who is unimmunized until 2 months.
* Ask about HepB vaccine if the mom has refused. Many times they have questions or other concerns or it is because they prefer to get it later with the pediatrician. Clarify the reason for refusal and document the refusal. If needed, reorder the vaccine (the original order will fall off after 12 hours if not given).
* Umbilical cord falls off around 7-10days old. Leave it out to dry, no alcohol needed. No first full bath until the cord has fallen off and the area is healed.
* For females, there may be some bloody discharge the first few days. This is a mini-period as the baby is clearing maternal hormones from the delivery.

**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 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. You should make arrangements with Kathy early in your rotation to complete breastfeeding training/education with her at a time that works for both of you. Prior to meeting with her make sure to complete the breastfeeding modules on the curriculum website (this will all help you feel more comfortable with and proved better patient care to the babies and their mothers while you give anticipatory guidance and address their concerns).
* 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**

* There will be 1-2 third yr medical students and will carry 2-3 patients
* All students help fill out the I&Os and weights on the cards, examine, and write notes.
* It can get busy but try to make the student’s nursery week worthwhile. Teach as much as you can, even if it’s only pearls of wisdom here and there. They’ll appreciate it.

**Recommended Readings**

* Just like the Wards, there are weekly reading topics that you should read and be ready to discuss with the attending. The curriculum schedule and articles are on the Peds curriculum site: <http://medicine.stonybrookmedicine.edu/pedrescurriculum>
* There is also a breastfeeding course that you should go through, also located on the SB Peds curriculum site.

**Weekend Call**

* Weekends are structured exactly like weekdays except there will be a senior resident there for short-call. They mostly help with discharges and some interim/additional babies until 11am.
* 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**

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!).

You must wear the blue scrubs ONLY that are provided in the scrub machine outside the NICU. You should return them at the end of the day and grab new scrubs each morning. Do not take them home and wash them yourselves.

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 – The Red team is the resident team and the Green team is the Nurse Practitioner team (the NNPs). The NNPs are amazing and are very helpful teachers so be really nice to them…they like chocolate.

Just like wards, when you’re on call at night and over the weekend, you’re responsible for all the resident babies.

**Where Things Are**

* Red Chart/Folder: sit behind the clerk in the cubbies under the counter. These contain patient stickers,

consents

* Blue Chart/Folder: located in each baby’s room. These contain daily IHI forms, newborn screens (pink slip)

Consents

* Mom is the consenting parental unit always unless there is a CPS issue. Dad can give consent ONLY if he and mom are legally married.
* When a baby is first admitted, the consents you should get are:
* NICU – give permission to be in the NICU
* JHACO – acknowledges we gave her info on privacy
* HepB – if baby is >2kg
* Circumcision– if mom is interested and baby is a boy
* Consent forms will either be clipped in the blue chart 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 a good chance to update them/ask questions/get consents signed.
* If you have admitted a new admission and for any reason cannot complete the consenting process on your shift, make sure to notify the next shift that they still need to be done. Make every effort to complete them on your shift.

**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. You will be given a list of babies who need ophtho exams – make sure to place the orders for them and hold onto the list.
* TPN renewal – Every day
  + TPN must be ordered before 11am every day.
  + Fellows like to order TPN before rounding.
* Weight adjusted medications- Thursdays, for all babies >7days old

**A Day in the Life**

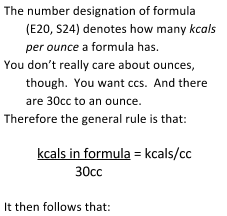
* 7am-7:10- NICU Brief: Pre and Post-call Residents Join NICU staff around the charge nurses’ desk in the NICU for announcements
* 7:10-7:45- Resident Sign Out in the NICU call room
* 7:45-8am- Examine Sick Patients ( Ventilator, Surgical )
* 8am -12:00ish-Attending rounds
* 11am-11:30- IHI Rounds Tuesdays and Fridays ( Attending and Fellows Only)
* 2pm-3pm- Attending /Fellow teaching Rounds with Residents (Tues/Thurs)\*
* 3-4pm- Social Service/Discharge Sit Down Rounds (Tuesday) Residents are required to Present Red Team
* 4pm- Sign out by Red Team and L&D Fellow, residents NNPs, and Attending to Medical Team
* 7pm-7:10pm-Brief (Pre and Post Call residents attend)
* 7:10-8pm: Resident sign out
* 9pm: “Lightening rounds” on all patients
* Progress Notes: write 4 notes daily (includes weekends).
* Simulation sessions will be held at SIM LAB on 1st and 3rd Thursday during their rotation month.

**Crunching Numbers**

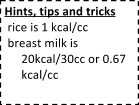
* The night resident will calculate numbers on all of the red team patients. They will write the numbers in the blue folder for rounds.
* For the first week of life (days 1 through 7), all numbers are based on birth weight. Starting day 8, you begin using daily weights.
* It’s important to keep meds and lab levels updated. Even if a 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/pertinent.
* 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**

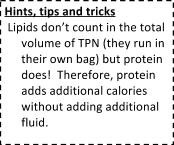
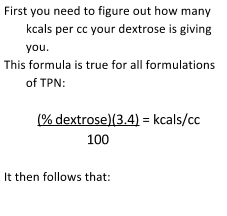






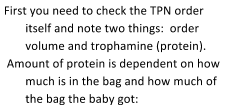
**Calculating TPN: Dextrose**











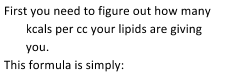
**Calculating TPN: Protein**





**Calculating TPN: Lipids**







Another quick way to crunch the numbers is to plug it into this website: **http://www.medcalc.com/nicufen.html**

**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

**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.
* 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.

**The Delivery and Operating Rooms**

* Go to lots of deliveries! You need to go to 3 with the fellow/NP in order to become certified to go by yourself with a DR nurse for uncomplicated deliveries. If you’re uncomfortable attending a delivery by yourself, someone will always be there to go with you. You’re never truly alone. Our staff is very eager to teach.
* On the weekdays, there is a fellow and an attending assigned to deliveries while you are rounding.
* You’ll never go to complicated deliveries on your own. These include meconium aspiration, twins/multiple gestations, premature babies, etc,
* If you’re the one catching the baby in the OR, you’ll have to surgically scrub. 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!
* You also will need to assign the APGAR score and resuscitation measures in the EMR.

**Med dose Rounding**

* The NICU has standardized drug dosing policy in which you round each dose based on the medication itself. Example, gentamycin is rounded to 0.52mg/ dose while ampicillin is 1mg/dose. The chart 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 351/7 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
* Persistent Hypoglycemia
* Maternal temp >100.4 and/or any documented diagnosis of

chorioamnionitis prompts NICU admission for rule out sepsis in the newborn

* 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 respiratory therapists will be around to show you how they like to do respiratory orders. Every change in vent settings or mode of support, requires 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

* There is a template in the shared resident drive that will highlight the baby’s major NICU events and hospital course by systems. This is SO useful for your dictations later.
* Fill in ALL follow-up appointments with the name of the physician, phone number and time-frame.
* The discharge physical exam can be taken from the discharge note

Discharge Orders

* If the baby is going home, Discharge the baby to home as you would in Newborn Nursery via the “Discharge Orders home” order.
* If the baby is going to Newborn Nursery, you need “Transfer Orders” to Newborn Nursery. Call the Nursery resident to give signout on the transfer. Initiate the Newborn Nursery or Late Preterm admission Powerplan so the baby has what he or she needs when they get to the nursery.

Dictation and Beyond

* All NICU discharges require a dictation unless they are transferred to the Nursery. Create a list of discharged babies throughout your month and distribute the dictations amongst all the residents on for the month. Once the discharge summary is completed, you can read it for your dictation (x4-6191).
* Don’t forget to complete the discharge summaries before your last day for the oncoming residents.

**Signing Out**

* Make sure to sign out anything pending overnight and for the AM.
* There is 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 red team babies and concerning nursery babies
* The newborn resident will call at 5pm and signout concerning babies, all NAS babies, and any babies

with pending labs (CBC, T/D bili, etc). It is your job to follow up these labs just as if they are your NICU babies.

* Anytime during the night, you may get called to the nursery about any acute nursery events.

Examine the baby then call either the service or PVT attending on call. Remember to write an event note and sign out the event to the Nursery resident when they call at 6am.

* There will be an attending, an NNP, and a fellow on call 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 for enough time to follow up all pending labs, update the list, and crunch all of your numbers before 7am.
* 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.

**Night Intern**

* The night intern rotation consists of two 2-week blocks of nights from Sun night-Friday night (your night off will be Saturday night).
* Your night starts with 6PM signout. Make sure to listen carefully about anything pending overnight, taking notes on the signout sheets if necessary. You are covering the 11N floor and heme/onc. 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 and tending to the acute overnight events.
* Be sure to help keep the list updated through the night as admissions can occurs at any time.

**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.
  + A brief HPI including what was done for them, if anything, at outside hospitals, the ED, and on the floor
  + Pmhx pertinent to HPI
  + Significant labs/radiographs
  + Pertinent physical exam findings
  + 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)

**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, ward interns are not permitted to accept sign-out on a patient being transferred 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**

* + Rambling/commentary – Try to stay focused on getting key points across
  + Disorganization – Try to use a problem or systems based approach for more complex patients, do not jump around
  + Oversimplification - Try to not leave out critical information the next person will need to continue managing the patient
  + 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)**

* + 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 antibotics 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**

It is probably best to take step 3 as early during intern year as your schedule allows while some adult specific material is relatively fresh in your mind (for both DOs and MDs). Intern year is very tiring and you won’t get numerous full study days like step 1&2. Good study rotations are electives, development-behavioral, and nursery. Don’t forget, you can use your educational money to pay for books and Q banks however not the test itself. Just keep your receipts and give it to Lorenza Swany (x4-6706). Make every effort to consider when you will take Step 3 early in the year and talk to the Chiefs about your intent. Do not leave this until the last minute. Ask your seniors for their input if you want, this is something that they can offer insight in. Bottom line: you will be fine.

**COMLEX**

* Your study habits and time will vary, but the exam is very similar to the computer based COMLEX Level II CE so your preparation will probably be similar. The exam itself is one 8-hr day and NOW INCLUDES a clinical cases portion. Per the NBOME Bulletin, a 2-day exam will take effect in 2018.
* For most residents, studying typically involves about 2-4 weeks of studying/questions. It is ideal to start this process on a lighter rotation (listed above). Remember to let the chiefs know when you are taking the exam, and email Jean with your exam results.
* Scheduling is the same process as for Level II via the NBOME website (https://www.nbome.org/online.html). The nearest Prometric testing center is in Melville which is about 30mins west of Stony Brook via the LI Expressway.
* As there is significant overlap with step 2, some of the same review books you used for Level II may suffice. It is recommended that you use a Level III question bank (ComQuest, Combank, UWorld, etc). 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 to review 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. The green OMT Review by Severese is very good!

**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.
  + [WWW.FSMB.ORG](http://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.
  + 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.
  + 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.
  + 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.
  + You can peruse the Prometric site before you apply or get your Scheduling Permit to get a sense of testing date availability.
  + In rare cases, a Saturday/Monday split is allowed with a break on the Sunday (but you have to call Prometric).
* Usmleworld 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 right in front of the entrance to the playroom. Please ask one of the seniors or the chiefs for the code. Keep the code private between residents (not med students) since everyone keeps their personal belongings here.
* The dress code is business attire ± white coat based on your personal preference. Nights are scrubs ☺
* Handwashing is our best defense against the spread of infection. It is expected that hands will be washed with soap and water or foam before entering a patient’s room and immediately after exiting the room.
  + You must adhere to all instructions on the isolation cards……NO EXCEPTIONS!
* There are two floor teams. Each team will have 1 senior, 2 interns and 3-4 medical students.
* 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. There is no cap on the number of patients each person carries.
  + 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. Since time will be limited, try to learn/read as much as you can while you have the patient otherwise you will be very exhausted in the evenings to catch up.
  + 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 (intern signout) – 6pm (signout). Your schedule will be found in New Innovations.
* All notes have to be completed by rounds so plan ahead and come in earlier if you know you need extra time learning the EMR/pre-rounding or if there is a high census
* For every four weeks that you’re on the floor, you’ll work a Saturday daytime shift, a Saturday overnight shift, and a Sunday daytime shift. Weekend daytime shifts start at 7am, and signout on Saturdays and Sundays is at 7pm.
* Weekends are a skeleton crew with 1 intern and 1 senior so be prepared to cover all the patients for both floor teams. Since you can access Cerner from home, it is helpful to skim over patients the evening before your shift so you are familiar with the patients.
* If you’re the Saturday night intern, it is your job to write the daily notes for the day team. Focus on the service notes first then work on the others. You should aim to write half of the notes for the day team (Write notes after midnight of course!).
* 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.
* The day before you start, you will get a senior supervised signout on your patients from the previous intern. 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 (this will also be useful for your dictation which are required for patients admitted longer than 48hours.)

**Physician Handoff**

* On Powerchart, there is a ‘Physician Handoff’ that can be accessed through Cerner and is used as our signout/daily list. It is updated by all
* For each patient, this medications and our comments/plan (which include the team, the intern assigned to the patient, the PMD, a 1 line description of the patient, and to-do’s for the day and night teams).

**Charts**

Cerner Powerchart: our electronic medical record

* Orders
* Meds/MAR Summary
* All vitals (including height, weight and HC) and I/Os.
* Lab results and 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/ Paper Charts are usually found next to the clerk in the chart cart.

* Patient stickers
* ED and outside records
* EKGs, consents, pathology/special IR handwritten reports

Forms/Consents/Paperwork:

* Ask a clerk or your senior. The clerk will print consents or special forms
* Empty letter heads are also available at the nurses’ station

Other Items in the Core:

* Crash cart
* Oto/ophthalmoscope cart and tongue depressors however they may be stored in the Med room
* A quick reference of Frequently called phone numbers (also see Appendix section of this document) is written on the marker board on the right
* Printer (11na)/Fax machine 444-1355. The Fax Machine also copies.
  + Tip: For larger copying orders, go to Jean’s office, its free.

**A Typical Day**

* 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: Finalize before rounds- ie. sign notes, follow up labs, call consults, finish seeing patients and sign your notes, prep discharges, etc
* 9:30am-noon : Attending Rounds
* Noon – 6pm: Work
* 6pm: PM signout in 11N Conference Room
* *Throughout the day: Update your senior! Bring your medical students around with you to teach/show them!*

**AM Ward Signout**

* Intern signout begins at 6:30am in the 11N conference room. It’s extremely important to be on time.
* This is when overnight events are communicated from the night to day team. New overnight admissions are also signed out during this time. Interns may leave the room quietly and begin their prerounding/notes once they have received signout on all their patients.
* Senior signout begins at 7AM after intern signout. Touch base with your senior resident after their signout with updates, to clarify the day’s plan for each of your patients or ask any questions/help.

**Pre-rounding**

* After sign out, begin seeing all of your patients. See patients with acute issues/concerns first. 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. Write down labs, radiology, etc on your daily worklist and begin a checklist of what you foresee to be the day’s plans.
  + Tip: Senior signout and Nurse signouts both occur from 7-7:30am. Try to see as many of your patients during this window as you can and unless truly necessary, do not interrupt others’ signouts.
  + Tip: Prepare your families and ask for their permission to involve them in family centered rounds while prerounding.

**Attending Rounds**

* Attending rounds begin around 9:30am at the attending’s discretion. Rounds are family-centered at the bed-side with the team, pharmacist, nurse. The attending 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 a new admission, 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, especially the beginning 3rd year medical students. You will learn more strategies for this during your “Residents As Teachers” retreat in the fall.

**Teaching Curriculum**

* There is ward curriculum with readings over preselected topics. Your service attending will serve as “teaching attending” for the week and will review and discuss any articles or relevant topics with the ward teams and medical students. If discussing articles,
* Access the articles on the SB Pediatric curriculum webpage under the ‘Wards’ link.
* Username=sbp and the Password=sbpediatrics
* Access the curriculum schedule on the SB Pediatric curriculum webpage under ‘Resident’s corner’ link. Username=sbp and the Password=sbpediatrics

**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.
* Most private attendings come in to round between 7am and 8am, but some come during morning report. Be sure to catch them while you can to discuss the daily plan on your patient otherwise you will have to call them later and discuss it over the phone while they are in their clinics.
  + 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: Call to Update the PMD at least once daily before evening signout
  + 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 otherwise it may be missed/drawn late.
* Lexi-Comp online (http://online.lexi.com/crlonline) is our hospital-approved reference for medication dosages. There is a direct link to Lexi-Comp 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 that hasn’t automatically fallen off of the MAR.
* Tip: IV Tylenol/Ofirmev, 1:1 safety watches, restraint orders only last 24hours unless renewed
* Compare active orders to what the patient should be getting to exactly what the patient is getting (MAR) every day.
* Orders for phlebotomy/Lab collect need to be put in for the exact times of 6:00am and 11:00am Routine (no STAT orders). 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, esp if they need to be NPO.
* If contrast is to be given, obtain parental consent and place it in the chart.
* In general: Patients who need studies under anesthesia or 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 directly to pharmacies via “E-scripts.” Thus, you will not need to hand write paper prescriptions 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 which medications they will need a script for once at home. This includes any new medications prescribed while admitted, continuation of chronic meds that they may need a refill on, etc
* 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 Med “Reconciliation” → drop down “Discharge”
* For the inpatient medications that the patient should continue at home that they do not need a refill for, select the green arrow icon. To prescribe an inpatient medication prescription, select the middle column. To prescribe a new medication that is not listed, select “+Add”. To discontinue an inpatient order/medication, select the red square icon.
* Double check the appropriate formulation, 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 patient’s pharmacy, 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.
* 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.
* For Spanish-speaking only patients, you can write “Spanish speaking only” in the pharmacy special comments so the prescription will print in Spanish.

**Controlled Substances**

Residents have the ability to prescribe controlled substances. When patients need to go home on rectal diastat for seizures or oxycodone for pain management, we need to send these controlled medications to the pharmacy. As with any other medication that will be prescribed, the order is completed through PowerChart. Instructions to follow as below:

* Select the medication you want to order and ensure all the details are correct before you hit sign
* A window will pop up with “WARNING” and will provide a link to the NY State Prescription Monitoring Program (PMP). This link will lead you to the NYS Health Commerce System (HCS). After logging in, you will be able to look into the patient’s history of prescribed controlled substances. Ensure that the last prescription was performed 1 month or more ago before prescribing another course of controlled medication.
* Once this is done, return to the “WARNING” pop up and select okay which will return you to the previous screen. Double check the order and if correct, hit sign.
* Another window will pop up at this point with an empty box next to the name of the medication. Check the box and hit sign if the prescription is correct.
* Another screen will appear (“imprivata”). For User Name, you use your PowerChart username.
* On the bottom, select ID token and enter the 6-digit code from the DIGIPASS App on your work phone.
* The User name portion at this point will gray out. Proceed to enter your PowerChart password and hit enter, this will be the final step before the controlled substance is sent to the pharmacy. Congrats, you just did it!

**Consults**

* When arranging for a consult, page the resident or fellow for that service. If there are no residents or fellows, page the attending directly. Use the “On call directory” via Cerner to access who is on call and to directly page them.
* 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 via “Pediatric admission Powerplan”
* PMD notification. Also, notify subspecialists if your patient has a chronic illness and follows with one frequently.
* Document the PMD notification either in the Admission H&P Note or a separate free text note.
* Don’t forget to complete the Admission Medication Reconciliation to resume your patient’s home meds (this is tracked by the department)

The H&P

* New admissions are split between the two teams. The seniors assign them try to keep the two teams balanced. You are responsible for doing admissions with the senior resident and your medical student. Obtain a full H&P. After your medical student has watched you do this once or twice, you should pass the baton to him or her.
* Don’t forget to ask for the PMDs and obtain a HEADSS exam (indicated).

**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.

Orthopedics, Neurosurgery, Colorectal Surgery , ENT, Burn

* We co-manage these patients which mean we write daily notes that are sent to the service attending.
* The primary surgical team will write all of the orders for the patient and ultimately make all decisions regarding their care. They will also do the discharge paperwork, write prescriptions, and be responsible for dictations.
* Patient issues or questions about plan of care should be deferred the primary surgical team.
* We co-manage these patients to ensure things don’t get lost between the cracks while the surgical residents are off the floor. Thus, check orders and if an order needs to be changed, check with your senior and service attending and the primary surgical team.

Pediatric Surgery, Urology, Plastic Surgery, OMFS

* We are involved with surgical patients as we are on the floor 24/7 while 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 or notes on these patients unless it is an emergency!
* You are still required to notify PMDs and complete HEADSS exams as indicated.

**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 after midnight, a SOAP note is not required for that day.) Complete daily progress notes prior to attending rounds at 9:30am.

**The SOAP format: a Refresher Course**

* One liner of your patient to refresh the reader of whom this patient is
* S (subjective): How the patient did overnight, any events, any complaints.
* O (objective): Vitals, weight, Physical exam, I/Os, labs, radiology.
* A (assessment): Summary of status.
* P (plan): either by systems or problem-based
* All notes by medical students should be reviewed, discussed and co-signed. The medical student’s note does not count as an official note and does not take the place of your daily progress note.

**Notes types and Forwarding to the proper attending**

* Service (SVC), Ortho, Neurosurgery (NSG), Burn, ENT= Send to the Service attending on for the week
* Peds subspecialists (Neuro, Pulm, GI, Endo, ID, etc) = Send to the Subspecialist attending on for the week. To determine the attending, click the “on call” button in the Cerner Powerchart menu. Select the 2nd “on call” tab then scroll until you find the proper service (ie, Peds neuro, Peds pulm, etc)
* Do not write daily notes/H&Ps on Pediatric Surgery, Urology, Plastic Surgery, OMFS.

P**MD Notifications**

* To provide complete patient care and maintain proper communication with community Pediatricians, we must notify every child’s PMD when they are admitted to Stony Brook Children’s. Simply ask whom the PMD is during your H&P then call their office (there is a list of popular PMD’s in the area with the contact info in the core on the bulletin board or google the office number) and leave a message notifying the PMD of their patient’s current admission.
* Don’t forget to document this either in your H&P or a separate free text note otherwise your effort doesn’t count.
* TIP: This is a good medical student task if you have a huge workload.

**Discharges**

* In order to discharge a patient, you must complete the discharge process in Powerchart under “Depart”. This is where you e-prescribe necessary prescriptions, 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) and patient education.
* Begin the Discharge paperwork and process as soon as possible, especially if you anticipate social work involvement to prevent delaying 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 discharge 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. Everyone admitted for 48hours or longer requires a dictation.
* 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).
* Let the patient’s nurse know that the patient is going home and you put in the discharge order so they can print/prepare the paperwork!

**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.
* This is particularly important when discharging on holidays when numerous places are closed!

**Discharge Summaries**

* All patients admitted for more than 48 hours will require a dictation.
* Discharge summaries need to be completed in a timely fashion.
* Under message center on PowerChart, you can look under the Work Items section which contains the “Documents to Dictate” to see if you have any discharge summaries to complete.
* To complete a discharge summary, begin a new note with the note type “Discharge Summary” and under Encounter pathway, search for the note template “Discharge Summary (Standard).”
* Complete all parts highlighted in yellow and send the discharge summary to the attending responsible at the time of discharge.
* It is vital to include all significant events and changes that took place while the patient was hospitalized as this document is seen by PMDs who need to know what happened with their patient.
* Discharge summaries are also necessary prior to sending a patient back to Angela’s house and Brookside Multicare Nursing Center (formerly known as Avalon Gardens).

**Transfers**

Accepting a Transfer

* This includes PICU downgrades or direct transfers from an outside hospital
* Read through chart thoroughly. PICU transfer notes are generally very helpful with an overview of the hospital/PICU course and are also found on Powerchart under “Documentation” with the regular admission H&P and progress notes.
* Talk to the patient, get history, do physical.
* You write an “11N accept note” which is SOAP note format that includes the hospital course until the time the patient arrives to 11N.
* Don’t forget to do the medication reconciliation→”Transfers”. Discontinue any orders that pertain only to the ICU – i.e. Cardiac monitor, 1hour vitals, etc.

Transferring to Another Service (PICU)

* You MUST write a transfer note, which is SOAP note format with more detail and include a brief HPI and hospital course.
* Write transfer orders in Powerchart under “Documentation”
* 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.
* 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 need to be completed before the new team begins so they have it to refer to.

**Running the List**

* Throughout 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 before signing out to the night team.
* 3pm is when your senior will meet with the charge nurse for Discharge Rounds. You should update your senior on potential discharges BEFORE this time
* At 5pm, you should be updating the Physician Handoff, giving your senior final updates and preparing to signout. You should review the most recent vitals for your patients, complete respiratory checks, etc and have a good idea of what the night team should expect overnight. This is key to leaving the hospital on time.

**Discharge Process**

* The discharge process begins as soon at the patient is admitted and should be as complete as possible. The goal is to be able to discharge patients during rounds therefore it is important to begin/complete the “Depart” prior to rounds if you are planning on discharging your patient that day. This includes sending prescriptions to the pharmacy, follow up appts with PMD and subspecialists, patient education, reviewing the asthma action plan, etc.
* The day team should identify areas where the night team can help with discharge and let them know during PM sign-out. For example, sign out to the night team to wean IV fluids or space asthmatics to q4hours overnight if they can. That way, they will be ready for discharge during morning rounds rather than later that day.
* Also, anticipate if your families will need services that required coordination with social work, etc and begin obtaining these services as early as possible.  For example, an ALTE’s family may need CPR training or an asthmatic who needs a nebulizer machine obtained through social work.

**Medical Students & Teaching**

* There will be 3-4 third yr medical students assigned each team. Typically, they will co-follow 2-4 of your patients. Help them pick good bread and butter cases, particularly service patients so they have a chance to interact with the attending. They should take ownership of their patients (pre-rounding, seeing their patients, writing notes and following up labs.) 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. Remember, medical students notes do not count as your daily note.

**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.
  + Start with a one-liner
  + Report pertinent daytime events and pertinent plan for the night team, including your updated vitals.
  + Briefly list important medications.
  + 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 and what to do with that lab if abnormal.
* If necessary, also sign out if anyone needs to be called for a specific parameter (i.e., page the Endo fellow with D-sticks at 10PM if >250)
* See Signing Out section for more information.

**Completing an Asthma Action Plan**

Because childhood Asthma/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.

* Minimum goals asthmatics must reach for home-going are:
  + Tolerating q4h albuterol (preferably on MDI for older kids),
  + Keeping sats >92% on RA both day and night (no supplemental O2)
  + No longer requiring IV access (good po and UOP, no abx)
  + Completed a Pulmonology consult if warranted
  + Plans to follow-up closely with PMD +/- Pulm
  + Family has completed Asthma Education and has a completed and reviewed Asthma Action Plan.
  + Every patient with an asthma/RAD diagnosis requiring albuterol MUST have an Asthma Action Plan (AAP) filled out in Cerner and reviewed with the family prior to discharge!!
  + To create an AAP:
* Click “Ad hoc” located in the top menu bars in CernerPower

Chart. Check “Asthma Action Plan” then hit “Chart.”

* Fill out the form using the check boxes or dropdown menu options, particularly any required yellow areas. At the bottom, select “yes” for Follow up with SB Affiliated Physician then search for their PMD’s name in Follow Up with: \_\_. Type in the Provider’s phone number and type “1-2 days” in the Follow Up Appointment. Once you have finalized the AAP and are ready to review the AAP and discharge the patient, click “yes” for AAP reviewed with and copy given to the patient/family. When you are done, click the green check mark in the top left. If you are not ready, do not click yes and instead, click the disk icon to save the AAP.
  + To print the AAP:
    - Click “Task” in the top left in Cerner PowerChart. You will see a popup menu, Select “Reports” then check “Asthma Action Plan.” At the bottom under Printer Destination, scroll to “asthma” then click “Print.” The asthma printer will print the AAP in color and is located by the main 11N Clerk station.
  + Once you’re done and have your AAP in hand, review it with your medical student and your patient/family prior to discharge.

**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 orders. Pay attention to time-limited orders such as 1:1 or IV Tylenol that will automatically fall off after 24hours.
* 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.
* New admissions, transports, transfers or post-op patients should be discussed with the charge nurse as soon as the senior 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 of the new patient.

**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. They are a great resource for our kids and are available on the Wards, ED, Heme/Onc and PICU.

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 Sucrose built into our Power Orders to ensure that our patients receive proper measures to decrease the amount of discomfort during procedures such as: phlebotomy and PIVs.
* We also utilize Child Life Services for diversion during procedures that a child is fearful of such as PIVs, MRI/CT scans, 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, the nurses may be busy so you can help out by providing extra anticipatory guidance and discharging patients yourself is always viewed as a positive by staff.

* After your attending has signed the discharge form with printed patient education, filled out the follow-up appts, sent prescriptions, have the patient’s parent sign and provide a phone number (should they need to be contacted regarding any labs, imaging, etc )
* Before the patient physically leaves, make sure they have seen registration, otherwise guide them to the registration clerk who sits by the Scud machine. Also, make sure to remove their IV!
* 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 as 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 the side effects of the chemotherapeutic medications or other medications you are using when you present for rounds.
* Try and think one step ahead (ie. Plan for what to do if your patient has a fever, know which antibiotics they are on and which ones you would add to broaden coverage, if the attending wants to be notified, which labs needs to be sent with the fever spike, etc.)
* Be nice to the nurses and keep them updated about changes in the plan or new labs that you ordered. Many have a wealth of experience and can help teach you about the complex care involved with Heme/Onc (and really all) patients.

**Leaving The Ward smoothly on Clinic days**

When you are leaving the wards 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 and update on the plan from 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. If you’re on wards, let the attending and senior know before rounds that it is your clinic day so they are aware you need to leave by noon. 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 to be given). Notify the resident/senior.

**Wednesday morning Crunch**

All interns attend Grand Rounds (Wednesdays at 8am, breakfast included!) and conference/lectures on Wednesday mornings while seniors and medical students round and manage the ward until the interns return.

* Arrive earlier than usual for signout and pre-rounding on Wednesdays. Manage your time appropriately especially since all of your notes should be done by about 7:45am before you head to Grand Rounds.
* DO NOT be late to Grand Rounds. Text the chiefs if you will be late due to patient care issues.
* Update your medical student on the plan for the patient’s they are following so they can be prepared for rounds without you. They should act as an extension of your coaching/teaching and plan which will also help your senior manage rounds while you are gone.
* Also, remember to bring back an extra plate of lunch for your senior covering for you!

**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 (physical rehab, substance use rehab, skilled nursing, etc), and arranging home health care services and equipment for your patients.
* 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. Especially if it is a Friday, anticipate needs and notify social work in the morning otherwise very little will get done Friday afternoon through the weekend.
* 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.
* *Bottom line: Consult social work early and keep tabs on the progress of your patient’s needs otherwise SW issues may hold up discharge!*
* Find their notes in the “Clinical Notes” tab in Powerchart. It 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.

**Mobile Apps**

There are a wealth of available resources to advance your knowledge and clinical skills, available through the Stony Brook University Library website. Follow the link below to check them all out.

Guides.library.stonybrook.edu/mobile/health\_sciences

AND

Guides.library.stonybrook.edu/mobile/mobilemedicine

**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.
* 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.

**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 about 45minutes 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 Stony Brook), Port Jefferson (about 10 minutes from Stony Brook) and Northport (about 45 minutes from Stony Brook). 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, Stony Brook is about 1.5 hours by train from New York City! The closest Long Island Rail Road (LIRR) station is Stony brook or Port Jefferson (train runs ~every 1.5-2hours), Ronkonkoma (hourly trains), or Hicksville which is about a 40minute drive from SB (q15minute trains). Parking is free at these stations and the LIRR will take your directly to Penn Station in Manhattan. Depending on the station, the fare ranges $10-18 one way. Be sure to buy your ticket at the machine before you board the train otherwise it’ll cost a few dollars more once boarded. From Penn station, you can then connect to any NYC MTA subway via a Metrocard to go anywhere in the city.
* If you would like to get away for a weekend and head to the Northeast, there are two ferries to Connecticut that leaves multiple times each day year round. The first ferry is from Port Jefferson (5-10 min from SB) and ends in Bridgeport, CT. The other leaves from Orient Point on the very east end of the North Fork (~45min from SB) and connects to New London, CT. Both ferry rides take about 1 hour 20 minutes and costs ~$27 per walking passenger or $56 per car with driver.

**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 season 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 Stony Brook.

**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. For tennis fans, the qualifier matches are free and are typically a few days before the actual tournament.
* 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/Beaches**

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, and kayaking 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 highly acclaimed and are incorporated into the State Park system meaning they generally are well taken care of and looked after. The closest beach to Stony Brook is West Meadow Beach which is 5 miles from the SB hospital and the larger, soft sandy beaches are Robert Moses Beach, Jones Beach, Hamptons, etc (all are about 45 minutes-1 hour drive from the hospital).

**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
* Maureen’s Kitchen- 108 Terry Rd, Smithtown
* SE-Port Deli- 301 Maint St, East Setauket (cash only)

Italian

* Pentimentos – 93 Main Street, Stony Brook
* Brothers Four Pizzeria - 310 Main St., Center Moriches
* Il Porto Bello - 1090 Route 112, Port Jefferson Sta.
* Ruvo Restaurant East - 105 Wynn Ln, Port Jefferson
* Pasta Pasta - 234 E Main St, Port Jefferson
* O Sole Mio- 2194 Nesconset Hwy, Stony Brook

Asian/Sushi

* Ssambap Korean BBQ- 2350 Nesconset Hwy, Stony Brook
* Kumo- 2548 Nesconset Hwy, Stony Brook
* Ten 89 Noodle House- 1089 Rte 25A, Stony Brook

Middle Eastern/ Greek

* Pita House - 100 S Jersey Ave # 27, East Setauket
* Z Pita- 217 Main St, Port Jeff
* SpiceTown Café & Eatery- 1245 Middle Country Rd, Selden
* Istanbul Café- 2139 Middle Country Rd, Centereach

Thai

* Thai Gourmet - 4747 Nesconset Hwy # 24, Port Jefferson Sta
* Grill - 208 Route 112, Port Jefferson Station
* Raan Thai- 203 Terry Rd, Smithtown
* Phayathai- 735 Hawkins Ave, Ronkonkoma

Indian

* Raga – 130 Old Town Road, Stony Brook
* Curry Club - 766 Route 25A, East Setauket
* Hicksville, NY (~35min drive) has numerous places!

Mexican

* Salsa Salsa – 142 Main Street, Port Jefferson
* Green Cactus Grill - 1099 Route 25A, Stony Brook

**SUPERMARKETS**

* Stop & Shop (multiple locations)
* Waldbaum’s (multiple locations)
* King Kullen (multiple locations)
* Shop Rite (Patchogue & Selden)
* Wild by Nature (E. Setauket)
* Trader Joe’s (Lake Grove)
* Fairway Market (Lake Grove)
* Whole Foods (Lake Grove)
* Uncle Giuseppe's (Smithtown & Port Jeff Station)
* Target (S. Setauket, Medford, Central Islip, Commack)
* Walmart
* Costco

**PHARMACY**

* 24 hr CVS in Port Jeff Station
* 24hr Rite Aid in Selden
* 24hr Walgreens in Selden
* Fairview Pharmacy, Port Jeff

**BANKS**

* Bank of America
* Chase
* Capital One
* Wells Fargo
* HSBC
* Citibank

**MECHANIC/AUTO**

* Bruno’s Garage, St James
* Mike’s Mechanics, Port Jeff
* Setauket Auto Body, E. Setauket
* Firestone
* PepBoys

**GYMS**

* LA Fitness
* Planet Fitness
* World Gym
* Stony Brook Campus
* Numerous Crossfit gyms
* Retro Fitness

**MOVIE THEATERS**

* AMC Loews, Stony Brook on 347
* Cinema De Lux Island 16
* Port Jeff Cinemas

**PRIMARY CARE**

* SB Family Medicine-Dr. Soliman
* SB Internal Medicine- Dr Lane

**Optometrist**

* SB Tech Park
* Davis Vision

**DENTIST**

* Dr Schwartz, Shirley
* Cool Smiles
* Joseph Lacarribba
* Gentle Dental
* SB Dental
* Port Jefferson Dental Group

**OB/GYN**

* Dr Pilliteri, Deer Park
* Dr Lochner
* Three Village Women’s
* SB OB/GYN

**CELLPHONE PROVIDERS**

* Verizon
* AT&T
* T-mobile
* \*Poor Sprint service in the area

**INTERNET/CABLE/PHONE**

* Optimum/Cablevision
* Time Warner
* Verizon

**VERY Important Websites**

* Pediatric Curriculum Site: <http://medicine.stonybrookmedicine.edu/pedrescurriculum>
  + Username: sbp
  + Password: sbpediatrics
  + Has links to the readings for each rotation, new innovations, amion, Patient Keeper, outlook email, etc.
* AAP Pedialink Prep Questions (Do 20 per month!) - [https://www.pedialink.org/https://www.pedialink.org/](https://www.pedialink.org/)
* Remote Access from home– <https://vdi.uhmc.sunysb.edu/>
* SOLAR - [http://www.sunysb.edu/it/solar.shtmlhttp://www.sunysb.edu/it/solar.shtml](http://www.sunysb.edu/it/solar.shtml)
* HSC Library to access databases, journals, etc- [http://www.hsclib.sunysb.edu/http://www.hsclib.sunysb.edu/](http://www.hsclib.sunysb.edu/)

**Appendix: Frequently Called Phone Numbers**

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| --- | --- |
| 11 North 4-1152 (fax: 4-1355) | Pharmacy 4-2680 |
| 11 North Core 4-1169, 4-8148, 4-1154 | TPN Pharmacy 4-1440 |
| 11 South PICU 4-1102, 4-8084  (fax: 4-8983) | SB Pharmacy 751-4477 |
| 11 South Heme/Onc 4-1101, 5-7433 |  |
| 11 North Call Room 4-7984, 8-2156 | Dietary 4-8233 |
| 11N Charge Nurse Phone  (631) 560-8248 | Computer Help 4-HELP |
| 11 North Conference Room 5-7432 | NB Screen 518-474-1753  (LIC 2118550) 1-800-535-3079 |
| NICU 4-2001, 4-2000 |  |
| Newborn Nursery 4-2110 | American Red Cross (CPR) 924-6700 |
| Peds ED 8-3500 | Psych 4-3408, 4-6050  Call 12n for covering attending: 4-1273 |
| OR 4-2444 | Apnea Team 4-3783 |
| Admitting 4-2591 | **Radiology** |
| Poison control 516-542-2323  1-800-222-1222 | CT |
| **Labs** | CT ER 4-2408, 4-3715 (fax: 4-6237) |
| Pathology 4-2222 | MRI4-9002, 4-8150 |
| Blood Bank 4-2626 | Neuroradiology 4-7610.  Scheduling 4-2464  Extremity 8-0706, (fax: 4-8959) |
| Chemistry 4-2365 | Peds Radiology 4-1443 |
| Cytogenetics 4-2749 | Radiology JR 4-7227 |
| Cytology 4-2216 | Radiology SR 4-7450 |
| Hematology 4-2375 | Radiology Supervisor 4-7451 |
| Histology 4-2236 | Anesthesia Backup 4-7453 |
| Immunology 4-2231 | Ultrasound 4-7481 |
| Microbiology 4-2370 | Reading Room 4-7455, 4-2935 |
| Phlebotomy 4-7626 | X-ray 4-2882 |
| Virology 4-2374 | X-ray Technician 4-5056 |
| Coag Lab 4-2379 | IR Fax 4-7453 |
| Specimen & Receiving 4-2616 | IR 4-9282 |
| **Other Labs** | MRI with sedation 4-2413 |
| PFT 4-8137 |  |
| EEG 4-2260 | **Other Services** |
| EKG 4-1760, 4-5481 | Pediatric Cardiology  Fax EKG (1-866) 858-4985 |
| ECHO 4-1770, 4-3769 | Child Life 4-3210 |
|  | Dietician 4-3840 |
| Operator Dial 0, 4-6000, 4-7788 | PT 4-1440 |
|  | OT 4-2620 |
| Chiefs Office 4-7711, 4-3103 | Transport 4-2533 |
| Jean Segall 4-2020 | Medical Records 4-2980, 624-7751 |
| Dictations 4-6191 | Social Work 4-1300 |
| STAT Dictations 4-1417 |  |
| Psychiatry 4-1273 | To call Rapid Response/Code Blue  Dial 321 |
| Child Psych 4-2239, Consult: 4-3408 | Infection Control 4-2552 |
| Family Counseling Services  Family Service League  Pederson- Krag Counseling Service  (631) 288-1954  (631) 427-3700 ext 221  (631) 920-8000 | Patient Relations  4-1250 |
| Suicide Hotline (1-800) 273-8255  Domestic Violence or Sexual Abuse  (1-800) 942-6906 | Jerri  4-2880 |
| Addiction Support (631) 654-1150 AA  (631) 689-6282 NA |  |
|  |  |
| **Compounding Pharmacies:** | **24 hour Pharmacies:** |
| Belle Mead Pharmacy 631-444-0748 (Fax: 631-689-2209) | CVS 631-642-3014  4331 Nesconset Highway, Port Jeff, NY |
| Fairview Pharmacy (631) 474-7828  Fax: 631-474-7571 | CVS 631-422-1912  460 Montauk Hwy, West Islip, NY |
|  | Rite-Aid 631-698-8533  17 College Plaza, Selden, NY |
|  | Walgreens 631-451-6849  655 Middle Country Rd, Selden, NY |

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| **Pediatric Practice**  **\*=admitting PVTs** | **Physicians** | **Phone Number** |
| Mid-Suffolk Pediatrics | Bennett, Manners, Lasner, Peterson, Lawton, Mitsu Kee, Reinitz, Hofilena, Selden, Seritoff, Berman, Cheng | Islandia 631-434-1770  Mt. Sinai 631-331-8350 |
| \*Peds First Pediatrics | Halegoua, Iype, Nastasi, Ng | Medford 631-732-5222 |
| Kids First Pediatrics | Forletti, Oleszak, Visentin, Moore, Husainy, Perera | Port Jeff Station 631-331-7267  Wading River 631-929-0325 |
| \*Branch Pediatrics | Ancona, Mineo, Stern, Murphy, Flynn-Gameng | Smithtown 631-979-6466 |
| Smithtown Pediatrics | Parles, Bernstein, Valmassoi, Inkeles, Baram, Weeker, Ellis | Smithtown 631-979-7222  after hours: 631-689-4275 |
| \*Pediatric and Adolescent Medicine | Klek, Spinnato, Simon-Goldman, Kronberg, Festa, Altschuler, Kleinberg, Nussbaum, Guram, Zwick, Freed, Drago | Holbrook (631) 588-4442 after hours: (516) 759-7838 |
| Friendly Medical Group | Rubin, Bennit, Doughty, Bowers, VanHeyst | 631-689-6226 |
| Kids Care Pediatrics | Anna Schwartz , Leonard, Campfield | 631-698-0600 |
| Nataloni Pediatrics | Nataloni, Aleyas, Santos, Moore, Lorig-Wolf | 631-476-7676 |
| Southampton Pediatrics | Quinn, Cusumano, Gottlieb, Halitsky | Southampton 631-283-7733  after hours: 631-689-4231  Hampton Bays 631-728-5300 |
| \*SV Pediatrics | Narain, Emmett | 631-241-4444  (631) 476-7456  Backup # (631) 473-1111 |
| Dr. Irwin Schwartz |  | 631-698-0600 |
| Dr. Masakayan |  | 631-209-2827 |
| Dr. Carlos Rivera |  | 631-758-6565 |
| \*Lake Grove Pediatrics | Amy Goldberg | 631-585-4440  after hours: 516-729-2393 |
| \*Mona Vani Peds | Vani, Huml, Patel | 631-475-0332 |
| \*Dr Darius Holmes |  | 631- 395-6652 |
| \* Dr David Sanchez |  | (631) 582-2228 |

|  |  |  |
| --- | --- | --- |
| **Health Center** | **Physicians** | **Phone Number** |
| Brentwood |  | 631-853-3400 |
| Coram |  | 631-320-2220 |
| Patchogue |  | 631-866-2030 |
| Riverhead |  | 631-852-1800 |
| South/East Hampton |  | 631-268-1008 |
| Shirley |  | 631-490-3040 |
| MLK at Wayandanch |  | 516-214-8020 |
| Tri Community Amityville |  | 631-716-9026 |

|  |  |  |
| --- | --- | --- |
| **SB Pediatric Offices** | **Physicians** | **Phone Number** |
| Appointment Line |  | 444-KIDS for pediatrics  444-DOCS for adults |
| Hampton Bays |  | 631-723-5000 |
| East Moriches |  | 638-2900 (fax: 878-8084) |
| Islip |  | 581-9330 (fax: 581-9561) |
| Patchogue |  | 4-6319, 4-6314 (fax: 4-6327) |
| Tech Park |  | 4-0651, 4-4601 (fax: 4-4990) |

**Don’t forget to refer to this guide as you change rotations during the year!**

**questions? Please ask!**

**Congratulations & Best Wishes PGY-1’s!**