Welcome to UWMC Wards -- a core rotation of the residency program! You’ll see complicated pathology, subspecialty medicine, complications of solid organ transplant, and tertiary/advanced care; however, now you’ll also find there is a substantial amount of bread-and-butter medicine within this patient population.

Team Rooms/Call Rooms
Team A+B: Room 6121 (code 3627*)
Team C: Room 6233 (code 1234*)
Team D: Room 6244 (code 2007*) (located across the hall from patient room 6254)

Senior call room: 7SE Room 7119 (code 6317*)
Intern call room: 7SE Room 7123 (code 6317*)

Note: Please let the chief resident know if daily linen changes in the call rooms are not happening. If the room is dirty off hours, call x86181 to request an urgent linen change.

Crow’s Nest: 6th floor mezzanine level up from 5th floor on B wing (door code 325) (location of scrubs, MS3 sleep rooms, lounge, miscellaneous exercise equipment)

UWMC Inpatient Medicine Services
- Medicine A, B, C, D: Daytime teaching service teams
- Day Medicine: Senior resident (usually R3) – assumes care of post-call team patients and cross-covers other ward teams’ patients when the work of the day is done. In house 7:30am-7:30pm.
- Night Medicine: Nocturnist (8pm-8am) and intern (7pm-9am).
- Medicine Swing: Hospitalist, accepts all admission phone calls and distributes to admitting teams. Serves as backup for procedure supervision if senior or ward attending is unavailable.
- Medicine E: Daytime hospitalist, often with sub-I.
- Medicine M: Non-teaching hospital medicine service
- Medicine O: Non-teaching hospital medicine service for oncology patients remote from chemotherapy who are admitted for non-oncologic, medical issues.

UWMC Wards Team:
Attending
1 Senior resident (usually an R3)
1 Intern
Usually 2 MS3s (occasionally a PA student)
Ancillary staff available but not usually rounding: Social Worker, Pharmacist, Discharge Coordinator

Rotation Structure for Primary Team R1 and R3
The admitting schedule for this rotation is a 4-day cycle structured around an overnight (24+3 hour) Long Call day. The census cap for each team is 10 patients, with no touch rule. The 4-day call cycle occurs in the following order: 1) Long Call; 2) Post-call; 3) Non-admit (usually R1 alone); 4) Overflow (usually R3 alone). To comply with ACGME duty hour regulations suggested bedside rounding start times are as follows: 8 am on “senior alone” and “intern alone” days, 7:30am on postcall days, and may begin between 8-8:30 on call days (as census allows). Please ensure clear communication to all team members about the following day’s planned start time.
• Long Call
  o ~7 am: Intern arrives for pre-rounding (obtain signout from night medicine intern no later than ~7:15 am)
  o 7:30-8:00am: Senior arrives
  o 8-8:30am: Bedside rounds begin with Attending
  o 10am: Break rounds if not completed to attend Morning Report
  o Admit from 11am-11pm. Cap: maximum of 7 total patients, with cap of 5 new admissions (ED, clinic, direct admissions) with remainder being ICU or other intrahospital transfers (eg Cardiology, Surgery).

• Post-call
  o 6-7:30am: Resident pre-rounding, work rounds with R1+R3, daily note prep
  o 7:30-9 am: Bedside rounds begin with Attending and Day Medicine utilizing SIBR. New patients, patients who are unstable or requiring active medical decisions, and discharging patients should be prioritized.
  o 9 am: Bedside rounds must stop (even if all patients have not yet been seen)
  o 9-9:30 am: return to team room and card-flip on remaining patients and finalize daily plans/create day’s To-Do list
  o 9:30-10 am: Complete time-sensitive work; eg call consults, sign notes, tie up loose ends, complete signout
  o 10am: R1 must leave the hospital. (R1 may attend Morning Report if felt to be a learning experience of extraordinary value--this is generally discouraged but at the discretion of the R1)
  o 10-11am: Senior presents at Morning Report, leaves hospital immediately following conference
  o 11-12pm: Attending and Day Medicine complete bedside rounds utilizing SIBR on patients that were card-flipped, and attend discharge rounds as scheduled

• Non-admit: Usually R1 only (R2/3 “off” or clinic day)
  o No new patients received (obtain signout from night medicine intern no later than ~7:15 am)
  o May sign out to Day Medicine resident when work of day is done, no sooner than 2pm

• Accept/Overflow: Usually R2/3 only (R1 “off” or clinic day)
  o Accept up to 2 overnight admissions
  o Night Medicine R1 presents new admissions bedside with Senior and Attending at 8am
  o May sign out to Day Medicine when work of day is done, no sooner than 2pm

You will have 4 days off distributed throughout the month, as well as clinic days on either Accept or non-admit days). Please check Amion to make sure you are aware of your schedule, and which days you are expected in continuity clinic. Please review your schedule with your senior at the beginning of your rotation to confirm that you are not scheduled for days “off” or clinic on the same day!

Rotation Structure for Day Medicine R3
Schedule: 5 days on / 5 days off + clinic, 12-hour shifts: 7:30-7:30pm.

Typical workflow:
  o Arrive by 7:30am to round with post-call team
  o Consider bringing computer workstation and spectralink team phone on rounds to facilitate real-time work on rounds
  o During rounds: update notes during bedside presentations, place orders, provide input on patient care
  o Sign in as the primary contact on CORES (and otherwise assume role of primary provider for post-call team’s patients in real-time during rounds)
  o After rounds: call/communicate with consultants, update patients and families, perform independent patient assessment and initiate care as felt necessary, complete documentation, complete medication reconciliation, DC readiness forms, discharge preparation
o Play a primary role in facilitating post-call team departure from hospital in timely manner. Both the post-call R1 and post-call senior resident must be done with ALL work by 10am (in order to leave the hospital and present at morning report respectively).

o Day Medicine resident is expected to attend Morning Report and Senior Report

o You may occasionally be asked to perform one medicine consult on holidays/weekends between 1-5 pm (see Medicine Consult section below for details)

o Accept signout from ward teams when their work of day is done, between 2pm-6pm

o Sign out to Night Medicine R1 starting at 7pm, leave when signout is complete

**Day Medicine & Postcall team workflow expectations**

On the postcall morning, the postcall primary team is expected to do the following for all patients (including “old” patients, new patients staffed by the primary team attending, new patients staffed by the nocturnist overnight):

- at least one resident (usually the intern but can be intern and/or senior) from the primary team should physically see each of these patients. (although it is NOT necessary to routinely see a patient immediately before rounds if providers have examined the patient overnight after midnight in the course of the admission management and no other significant changes in medical condition are anticipated since the most recent evaluation)

- begin a progress note with an updated subjective and physical exam (NOTE: all patients require a full progress note, ie it does not matter what time the admission note was signed).

- develop a comprehensive medical plan for the day and begin enacting as appropriate. There are rare occasions when it is reasonable not to physically preround on an “old” patient (eg a patient with dementia/falls awaiting placement for whom early morning rounding may be deliriogenic), in which case the postcall senior should clearly communicate this to the Day Medicine senior and make explicit what documentation remains to be completed.

When the primary team R1 leaves the hospital and the primary team senior resident goes to morning report at 10 AM, the Day Medicine senior takes over responsibility for any documentation that is not complete.

In general, it is preferred for the postcall team to do as much of the documentation as feasible due to the unpredictable nature of the Day Medicine role (who is eventually responsible for the care of up to 30 patients). While this expectation should be “the rule”, there will also be occasional call shifts which are so busy that immediate patient care is prioritized over this and the above documentation cannot be completed before rounds. In these occasions, the Day Medicine senior should assist with any documentation necessary to facilitate the postcall team leaving the hospital on time at 10 AM. In summary, the postcall team and Day Medicine should strive to be kind to each other and improve each other’s workflow.

**Structured Interprofessional Bedside Rounds (SIBR)**

Please watch these short videos prior to your first day to familiarize yourself with SIBR (the term for bedside rounding at UWMC):

Ideal Rounds: [https://www.youtube.com/watch?v=qK9lBF0b-Ns&feature=youtu.be](https://www.youtube.com/watch?v=qK9lBF0b-Ns&feature=youtu.be)

Roles and Responsibilities: [https://www.youtube.com/watch?v=RUoKqCnvnqA&feature=youtu.be](https://www.youtube.com/watch?v=RUoKqCnvnqA&feature=youtu.be)

Nurse Rounding: [https://www.youtube.com/watch?v=mcCtYjkK9rbg](https://www.youtube.com/watch?v=mcCtYjkK9rbg)

YOU play a leading role in incorporating SIBR into daily rounds, which facilitates both improved team communication/patient care as well as reduces primary contact paging burden. The key responsibility of the primary team is to call the bedside nurse as you travel to the patient’s room to request the nurse to join you for rounds in real-time. Then round together with the nurse at the patient bedside using the standardized format.

**Multidisciplinary “Discharge” Rounds**

- When/where: daily Monday-Friday in the 6NE Nursing Conference room (see specific times below)
  - **Med A**: 11:10 am
  - **Med B**: 11:20 am
- **Med C:** 11:30 am  
- **Med D:** ***currently piloting earlier time – 9:45 am***

- **Who:** ward team (on postcall days: should only be attending + day medicine), social workers, other care providers (eg pharmacist), and nurse care coordinator (aka CCN)

- **Process overview:** The CCN will present the patient’s one-liner and ask probing questions focused on discharge planning/barriers (NOTE: this is led by the CCN, NOT the primary team providers whose role is to be present and to help answer questions). The goal is for this to be a highly-efficient process of <1 min/patient. This is NOT the time for nuanced discussion of medical plan or medical teaching not directly related to discharge barriers.

**Noncall Team Resident Signout to Day Medicine**

Often, the two teams not on call (the non-admit “intern alone” and overflow “senior alone”) will have completed the work of the day prior to the 7pm arrival of the Night Medicine intern. These residents may sign out to the Day Medicine senior between 2-6 pm provided all of the following: *work of the day is done, all patients are stable, and there are NO major active issues or pending tasks to be done.* Signout may not be requested prior to 2pm (as the Day Medicine senior is often still wrapping up issues from the post-call team and can be quite busy until early afternoon), and may not be requested later than 6pm as this would necessitate a rapid second immediate handoff to Night Medicine. It is acceptable for primary team residents to prepare and execute signout before completing progress notes.

**Discharges**

You should begin to anticipate discharge needs and date on admission. Medication reconciliation for discharging patients and all discharge paperwork are best completed *the day prior to anticipated discharge.* Counsel patients to plan for early or mid-morning transportation ahead of time. Altogether this will facilitate morning patient departures and bed turnover - preventing a late afternoon bolus of admits (that results from delayed bed turnover when these items have not been completed ahead of time!).

**Medicine Consults**

Consults are completed by a medicine consult team (staffed by hospitalists) during business hours, and at night by the nocturnist. However, **senior residents may be asked to see a consult patient on weekends and holidays between 1-8 pm as follows:**

- **1-5 PM:** Day Medicine is first call (Senior resident from call team is the backup if Day Medicine is unable)
- **5-8 PM:** Senior resident is first call (the Day Medicine senior resident should NOT be involved with consults at this time)

You will be notified of a new consult by the Swing or Consult attending, who will also instruct you on the appropriate attending with whom to staff. If you are extremely busy at the time you are asked and do not feel you can perform the consult in a timely manner without compromising other patient care, it is appropriate to communicate this to the Swing/Consult attending, and the consult can be re-triaged.

**Night Medicine**

- **Night Medicine:** Intern hours are 7pm-9am. Their job is to *assist daytime teams to allow them to leave the hospital expeditiously.* They should be an active presence in team rooms – encourage them to coordinate care, do procedures, write orders, etc.
- **Please ensure a team member arrives at an early enough hour (no later than 7:15am) to allow completion of AM signout in order for the night medicine intern to round with the Accept team**
- **Night Medicine R1 is asked to present on rounds to allow opportunity to receive feedback on workup and oral presentation from an additional attending, to improve communication and provide a more seamless transition of patient care. Exceptions are:**
  - **Tuesdays:** Night Medicine R1 presents at 8:15am following Senior Report
  - **Thursdays:** if primary team is attending Grand Rounds at 8 am, it is acceptable to forgo bedside presentations on stable patients and for seniors to obtain verbal signout only before 8am
ICU Handoffs
There is now a standardized medicine floor to MICU handoff process, which includes a bedside handoff between the two teams in the MICU.

1. CORES floor intern will be paged to patient bedside on 6SA after patient is moved
2. CORES intern + senior/attending should arrive at that room within 10 minutes to meet the MICU team
3. Medicine floor team will give a short presentation on patient to MICU Team (similar to rounds: 1-2 liner, recent problems, key events from past day)
4. ICU intern/resident will complete ICU handoff packet and checklist

Code Blue
Overview of Code Blues at UWMC:

- Code Blues are not called overhead; instead, your code pager will alert you to the location of the code (if this doesn’t happen, for whatever reason, call the operator to request the location) – leave whatever you are doing to get to the code expeditiously. If you have any difficulty finding the location of a code, go to the elevators on the floor and tower you were paged to. A UW Public Safety Officer will find your team and direct you to the correct location.
- The traditional code team (with the Medicine R3 as Code Team Leader and Medicine intern as Assistant MD), will respond to all codes other than on 5SE, 5SA and 5NE. There is an alternate code team response for patients on 5SE, 5SA and 5NE (aka the “Cardiac Code” team). This team was created to support our increasing mechanical circulatory (MCS) population as well as to put into effect some modifications of ACLS for patients who are s/p sternotomy. For the codes on these three units, advanced practice providers from the CCU and CT ICU will serve in these roles as part of the Cardiac Code Team.

Traditional Code Blue Team Roles:

- Senior resident role: The long-call senior is the code team leader (NOTE: you are the only code team leader at UWMC! You lead all of the codes)
- Intern role: The long-call R1 is on the code team during the day, but will hand off the code pager to the Night Medicine R1 when they arrive. As the intern, it is not your role to run codes, and if anyone asks you to do so, simply supervise chest compressions; a senior WILL arrive soon. Discuss with your senior what your role should be during a code blue.
- Supervising MD (aka “code whisperer”): the MICU/SICU fellows and nocturnists supervise the traditional code team

Medical Students
Residents are still ultimately responsible for all MS3 patients, but the student should be viewed as the primary inpatient provider and be signed into CORES as the primary contact. MS3s have multiple teaching sessions throughout the week that they are required to attend. It is their responsibility to let you know when these sessions occur. Please remind students to sign out of CORES when attending teaching sessions as this is protected time, or when leaving for the day. The primary team members responsible for the supervising and teaching of MS3s are the attending and senior resident. MS3s should be encouraged to direct most of their questions to the senior resident in order to give the R1 space to complete work.

Documentation Expectations
NOTE: these expectations differ from the VA and HMC (and even other services at UWMC). When in doubt, ask your attending questions regarding billing/documentation expectations.

- Admission notes: The intern is expected to write a complete H&P (separate from any medical student H&P). On exceptionally busy call nights, the senior resident may help with this. A complete H&P is NOT required (although it is billable if you do write one) for intrahospital transfers (eg from the MICU, Surgery, etc). If you choose not to write a complete H&P for intrahospital transfers, please write a detailed progress note that clearly shows your changes to the assessment/plan.
- Progress notes:
  - Daily progress notes must be completed for each patient, even if no significant changes. Intern, senior, or attending must write either a separate daily progress note or a complete
SOAP note as an addendum to student note. This must include an MD’s own interval history (including minimum 2-point patient ROS), exam, and A/P. Discuss with your attending who is expected to complete this addendum.

- On postcall days, ALL patients require a progress note (i.e., it does not matter what time they were admitted, what matters is the attending physician’s date of service which is almost always day 1 of the call day).
- On overflow/“senior alone” days, the best documentation practice for patient care is to write a full progress note for the overnight admissions (although this is only required for billing purposes if the nocturnist’s date of service was the previous day).

- **Medical student progress notes on postcall days:** There is no universal expectation for whether medical students should write any notes on postcall mornings. However, it is discouraged to have medical students write postcall progress note on multiple patients. A reasonable expectation (depending on the level of the medical student) is to have the medical student write 1 postcall progress note on a newly admitted patient (as these are likely to be the most dynamic/have the most educational value). Medical students should be strongly encouraged to leave the hospital at 10 AM regardless of the state of their notes.

- **Discharge summaries:** are the responsibility of the senior resident and must be completed within 48 hours of discharge. If the senior is off or in clinic and a patient requires a discharge summary (e.g., for SNF placement), then the attending or Day Medicine senior should complete it.
Conferences/Teaching

**Morning Report:** M/W/F at 10:00 am (RR-110). Post-call R2/3 presents. *Attendance expected of all ward teams.* RNs have been asked to hold non-urgent pages during this time, tell chief resident if not happening.

**Senior Report:** Tuesday at 7:30am (BB-514). For R2/3s only - cold case presentation from overnight.

**Imaging Rounds:** Tuesdays after Senior Report, 8:20-8:50 (2nd floor Chest Reading Room). *All ward teams except post-call team expected to attend.* Please bring cases you’d like to review.

**Core Teaching Conference:** Monday at 12:30-1:30pm (RR-110). Core Internal Medicine topics that are presented at all three hospitals during the month. Lunch provided.

**Chief of Medicine:** Tuesday from 12-1pm (D-209). Conferences rotate among Inpatient cases, Outpatient cases, Autopsy conference, and M&M. Lunch provided. RNs are requested to hold non-urgent pages.

**UWMC Teaching Conference:** Wednesday at 12:30-1:30 pm (RR-110). Guest lectures from attendings and other educators, with emphasis on topics that are more specific to the UWMC patient. Lunch provided.

**Grand Rounds:** Thursday at 8am (T-625), except during the first 8 weeks of summer. Light snacks and coffee provided.

**Intern Teaching Conference:** Thursday 7-8am first 8 weeks of summer. Required of all R1s - *if ITC falls on a post-call day R1s should NOT attend.* If ITC falls on a Long Call day the R1 should attend and R2/3 responsible for prerounding that day. If ITC falls on an Intern Alone/Nonadmit day, the attending should coordinate with the R1 to accept signout from the night intern and hold the R1’s pager.

**Intern Report:** Thursday from 11:30am-12:30pm (RR-110), except during the first 8 weeks of summer (due to Intern Teaching Conference). *Required for inpatient R1s. Seniors hold intern pagers.*

**Attending rounds** (structured teaching by your attending) should happen at least 3 times weekly. Please work with your attending to find the most appropriate times for this.

**Medical Student Teaching Sessions** (medical student attendance is expected at all of the following sessions, except for afternoon sessions for the post-call students. They should keep track of their schedule, but please excuse them from clinical duties during this protected learning time.)

- Monday: 3-4:30 pm, MS3 teaching with Dr. Paauw
- Tuesday: 11 am-12 pm, MS3 teaching with Dr. Paauw. 3-4 pm, MS3 teaching with Chief Resident
- Wednesday: 3-4 pm, MS3 teaching with Chief Resident
- Thursday: 9-11:30 am, MS3 Didactics with Dr. Paauw
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<td><strong>MS3 didactic with chief resident (3:00-4:00)</strong></td>
<td><strong>MS3 exam rounds with chief resident (3:00-4:00)</strong></td>
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* Once per month, Intern Core Conference will take place from 11:00-11:45 a.m. in place of the regularly scheduled Intern Report. The Chief Resident will remind you of this time change earlier in the week when this occurs.