University of Washington Medical Center

Cardiology A

ONSITE PROGRAM SUPPORT:
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Team Room: 5 NE (just behind the nursing station on the right)

The goal of the Cardiology A service at UWMC is to provide both excellent patient care and outstanding teaching, while providing an introduction to both basic inpatient cardiology and exposure to advanced cardiac care. On the first day of the rotation (Monday 11-12 pm), residents will have an additional 30-minute orientation session with pharmacy, nursing, care coordinator, team assistant, social work, and the Fellow. Our Cardiology A Pocket Book includes the team members, daily schedules, and other key information helpful for residents, and is updated quarterly. Any suggestions for revision or additions are greatly appreciated – please send to Heather Ruit (hruiter@u.washington.edu). An online educational curriculum is in development.

Call room:
Crow’s Nest: 6th floor mezzanine level – go up stairs from 5th floor on B wing (code 325) (also location of scrubs, MS3 sleep rooms, lounge)

Cardiology A Team Structure:
Attending
1 first-year Cardiology Fellow
4 Internal Medicine R2s (divided in 2 sub-teams: A1 and A2 as below)
1 Preliminary Medicine R1
Ancillary support: Social Worker, Pharmacist, Nurse Care Coordinator
Cardiology Nocturnist

The 4 R2s are divided into 2 sub-teams (with the goal of improving continuity of patient care) as detailed in the table below. The goal is for patients to stay within each resident sub-team for their entire hospital course; however, there may be circumstances when patients must be transitioned between teams in order to rebalance the service.

<table>
<thead>
<tr>
<th>Weekday of first call shift</th>
<th>Sub-team</th>
<th>Subteam label in ORCA</th>
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</thead>
<tbody>
<tr>
<td>Monday</td>
<td>A2</td>
<td>“intern 5”</td>
</tr>
<tr>
<td>Tuesday</td>
<td>A1</td>
<td>“intern 1”</td>
</tr>
<tr>
<td>Wednesday</td>
<td>A1</td>
<td>“intern 1”</td>
</tr>
<tr>
<td>Thursday</td>
<td>A2</td>
<td>“intern 5”</td>
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Note: patients listed as “intern 4” subteam label in ORCA are those for whom the Preliminary Medicine R1 (or Cardiology ARNP) is the primary provider/contact.
In order to comply with new ACGME work-hour regulations on overnight call, it is critical that the teammate of the Post-Call R2 play an active role on rounds to facilitate the work of the day (complete notes, place orders, call consults, sign into CORES) so that the Post-Call R2 can leave immediately after rounding on their patients.

**Caps**
- The Cards A service total census cap is 15
- Daily encounter (“touch”) cap is 10 patients for an individual R2
- Daily encounter (“touch”) cap is 6 patients for an individual R1, with a maximum census of 5 at any given time (i.e. if intern has 5 patients, he/she must discharge 1 patient prior to admitting another)
- Long Call R2: Up to 5 admissions (any combination of new patients and ICU transfers), until the time cut-off of 4 am the next morning or until service/personal census cap has been reached
- Short Call R2: Admit a maximum of 2 patients (maximum 1 new admission, 1-2 ICU transfers)
- Intern daily admission cap: 1 patient per day (preferably new patients)

**Daily Schedule (by day in call cycle)**

**Long Call:** Arrange around 7 am, leave by 10 am the next morning (Post-Call)
- Admit from 8 am - 4 am (Post-Call morning): Complete admission notes/orders and obtain outside records/hard copies of cath/echo reports, EKGs, rhythm strips, stress test results
- Supervise R1 all admissions and discharges, supervise R1 “old” patients as needed
- Receive sign-out from other members of the service and cross-cover these patients overnight
- Start/complete discharge paperwork and medication reconciliation for anticipated AM discharges the day prior
- Start/template daily progress notes and other Post-Call day work overnight for the following day

**Post-Call:** Leave hospital by 10 am (24+3 hour overnight call)
- 6:00 am: Pre-round on patients, prep notes and other work of the day in preparation for rounds
- 7:30-8:00am: Provide sign-out on overnight events to all other team members (including Fellow)
- Work rounds at 8:30am: present new admissions with update on overnight events
- Rounds on the Post-Call resident’s patients should be completed by 10 am. At this point, the post-call R2 should leave the hospital (his/her R2 teammate should be playing an active role on rounds to facilitate the care of the day for the Post-Call R2’s patients to allow timely departure)

**Short Call:** Arrange before 7 am
- Receive sign-out from overnight R2 and pre-round on all patients before rounds
- Start admitting at 7 am, up to 2 patients (maximum 1 new admission, remainder transfers). This may also include overnight admissions from the Cards A nocturnist (which would count as a transfer)
- Teaching rounds 8:00-8:30 am (Monday and Tuesday)
- Work rounds at 8:30 am
- Admit until 3 pm. Complete work of day and sign-out to Long Call R2 no earlier than 4 pm

**Off/Clinic**
- Patients should be redistributed his/her R2 teammate. If necessary, patients may also need to be transitioned to the other R2 team

**R1 work overview**
- **R1 supervision:**
  - Overall philosophy: The R1 should NEVER be expected to do management that he/she feels uncomfortable with. If at any time the R1 is feeling uncertain about what to do, he/she should
reach out to one of the R2s for guidance. Although the go-to R2 will generally be the long-call R2, any R2 who is available to help is welcome to do so.

- **Admissions:** R1 should informally “staff” all admissions with the long-call R2. This should include a comprehensive review of the assessment/plan (discuss every medical problem that will involve inpatient management!). The R1/R2 should then generally review the cardiology-specific problems with the fellow. The long-call R2 can use his/her discretion about whether it is necessary for the R2 to physically see the patient or not (acceptable to not see patient when the R1 has no major concerns, the assessment/plan is clear, etc). The long-call R2 should also review the R1’s admission medication reconciliation and admission orders.
  - “old” patients who are not discharging: no formal R2 involvement required (as these patients will be discussed on rounds), BUT the long-call R2 is the go-to person for any questions/changes that occur
  - Discharge summary: can be completed by the short or long call R2. The R1 is NEVER expected to do discharge summaries.

- **R1 schedule and handoff:** R1s are scheduled Thursday through Monday, with days off on Tuesday and Wednesday. At the end of the day on Monday (the last day “On” of the 5-day stretch), the intern will provide sign-out to the Cardiology APP via e-mail (cslack@uw.edu). On Wednesday evening, the intern will receive sign-out via e-mail from the APP. Effective sign-out is mandatory for these transitions of care.

- **R1 caps:**
  - primarily responsible for up to 5 patients, with a total encounter (“touch”) cap of 6 patients daily
  - Admit up to 1 patient daily

- **R1 typical daily schedule:**
  - Arrive ~6:00-6:30 am, depending on time required to pre-round on all patients
  - Start admitting at 7 am: Admit up to 1 patient daily, with preference for a new admission rather than ICU transfer (admission supervised by Long Call R2 as above)
  - Teaching Rounds at 8:00-8:30 on Monday
  - 8:30 am: Work rounds
  - Admitting ends at 3 pm. Leave hospital 4-7 PM (goal by 6 pm)

**Work Rounds**

Sign-out is completed in the Cards A team room 7:30-8:00am daily. Work rounds take place 8:30-11am daily including weekends. Rounds must be efficient and focused, so it is not reasonable to resolve all patient care issues on rounds with the entire team. Work time following rounds is intended to allow members of the team to revisit issues and patients as needed to resolve specific issues. Goals of team rounds include:

- Establish a team approach to patient care
  - New patients seen by all team members, with team aware of diagnosis and plan
  - Diagnosis/treatment initiated early in day (orders placed on rounds, tests scheduled, cath lab cases confirmed and triaged)

- Focused bedside teaching: topics needing in-depth discussion deferred to teaching rounds
  - Key teaching points made during case presentation
  - Review key physical exam findings
  - Brief discussion with patient, with longer discussions deferred to work-time after rounds

**Teaching Rounds**

- Monday: 8:00-8:30 am: AM Teaching Rounds
- Friday: 7:30-8:30: Cardiology Grand Rounds
- Please also see UWMC Conference schedule below. You are invited to all other conferences, as schedule permits
Post-Discharge Cards A Clinic
Each R2 will spend one Tuesday afternoon in the UWMC Post-Discharge Cardiology Clinic seeing patients recently discharged from the Cardiology A service. The clinic is located in the Regional Heart Center at UWMC, located on the third (main) floor just north of the main information desk (across from otolaryngology/head and neck surgery center).

Admission/Discharge Details
- Patients admitted with an acute MI should have the “Acute MI” standardized order set used
- Patients with CAD or CHF should have the respective discharge instructions sheet completed (usually initiated by resident, and finalized by the fellow) prior to discharge

Note-Writing
A daily progress note is required for every patient, including an updated physical exam. A new progress note from the housestaff is not required for patients admitted after midnight and for whom there is an admission note. An addendum or event note must be written for significant changes in the patient’s condition. The Attending daily note for that day will otherwise suffice for the documentation for that day for patients admitted after midnight.

R2s will be responsible for discharge summaries for their patients and the patients cared for by the R1.

Transfers from the Nocturnist or from any other Medicine service, including the CCU, do not require an Admission H&P note. A routine progress note will suffice for documentation purposes.

Code Blue
Cardiology is not currently on the Code Blue team. At UWMC, the Code Blue team leader is the Long Call Medicine R3. If a code occurs on one of your primary patients, you will be notified by page through the UW paging operator, and likely also by nursing or care staff on your floor.

Fellows
- Discuss and determine treatment plan for all new admissions
- Aid in coordination of post-discharge follow up care
- Discuss individual patient plans with residents (overnight, following day) prior to leaving
- Afternoon huddle with charge nurses to review anticipated overnight patient plans
- Sign-out with nocturnist at 8 pm
# UWMC Weekly Conference Schedule

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<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<tbody>
<tr>
<td>7:00-8:00</td>
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<td>Cardiology Grand Rounds○ (7:30-8:30) T-625</td>
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<tr>
<td>8:00-9:00</td>
<td>Attending Teaching Rounds◊ (8:00-8:30) Team Room</td>
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<td></td>
<td>Medical Grand Rounds○ (8:00-9:00) T-625</td>
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<td>9:00-10:00</td>
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<td>10:00-11:00</td>
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<td>11:00-12:00</td>
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<td>Intern Report◊ (11:30-12:30)* RR-110</td>
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<td>12:00-1:00</td>
<td>Core Teaching Conference○ (12:30-1:30) RR-110</td>
<td>Chief of Medicine○ (12:00-1:00) D-209</td>
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<td>UWMC Teaching Conference○ (12:30-1:30) RR-110</td>
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<td>1:00-2:00</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.

◊ Mandatory Conferences: Attendance required, except in case of patient emergencies

○ Attendance is encouraged, unless prevented by workload and patient care