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CRITICAL INFORMATION

Phone Numbers:

Code Blue or Code Green ext. 15555

Computer Help Desk 15519
Bed Flow Coordinators:
7am-4:30 pm, M-F 14233, 13143, 15184
4:30pm-7am, Weekends, Holidays: AOD x15162
Transcription/Dictation: See attached page.
MICU 16075; CCU 14640; PCU 16729;
4A 14501; 6B 14602; 5A 18878; BMTU 16337;
SICU: 14573; 2W 14402, and Telemetry (for 5A, 6B,
2W) 14628
OR desk: 15103; Outpt. Surgery: 16266
PACU: 16265
Surg Residents' Workroom (2W): 14424 and 14418
On Call Roster: Audie Home Page, L column.
Login is "Audie0 (pick 1 through 9)
Password is "Murphy0 (pick 1 through 9)

CPRS training: log into TMS (the system where you completed the Mandatory Training for Trainees) and type code 35795 into search window. Excellent program where you pick/choose your modules.

(or, not in TMS, an older but excellent interactive training behind Resident + Student Portal, Homepage on I)

House Staff Manual: STVHCS Intranet home page, left column, in "Resident and Student Portal".

Library: robust, online resources. STVHCS Intranet home page, "Resident and Student Portal"; or in "Tools" drop down from any patient's CPRS cover sheet, you can access UpToDate resources.

To Link Encounters & Consults, or to Retract Progress or other Notes entered in error: Addend note: "request this note be hidden or deleted due to _____", and send email to STXHIMHelpdesk@va.gov to request note be "hidden" or deleted. Need help? Call ext. 15608.

COMPUTER CONDUCT

- Always lock your screen or logout when away from the computer.
- Do not give anyone your User ID and Password, PIV PIN, or Vista Access Code and Verify Code!
- Do not share your dictation code, or use anyone else's.
- Do not plug anything into a USB port, including your cell phone for charging.
- Confirm you are in the correct patient's chart before writing orders, notes, etc. (Yes, this happens!)

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FOUR CODES YOU SHOULD ALWAYS KNOW

- Network User ID & Password * / PIV PIN
- VISTA/CPRS/IMED Access Code & Verify Code
- Electronic Signature Code
- Dictation ID Number (see Dictation Instructions, under "Residents and Students" on Home Page)

*** The Network User ID & Password are required if/when you have a PIV Exemption, e.g., Dragon dictation).** This Password changes every 90 days; can't use previous ones; must be complex)

Dragon: you can add to your desktop computer (see page 24 of Housestaff Manual); get headphones from Education Service.

GENERAL GUIDELINES

NOTE TITLES

Selecting Frequent Note Titles

You may add and remove service specific note titles during your rotations, as needed).

Sign in to CPRS, select any patient. Select TOOLS, then OPTIONS. Under OPTIONS, select the NOTES tab.

Suggested Document Titles:

10-10M/Physician (admit from clinic)
History & Physical Note/Surgery, or Medicine, or H&P/Psychiatry
Physician Progress note
(XXXX) Surgery, Bedside Procedure Note
(XXXX) Clinic, Procedure Note
Preliminary Operative Report
Medicine Reconciliation Note (or your "After Visit Summary" includes the Med Rec)
Med Rec & DC Note, Surgery
Physician Against Medical Advice
DNR (Life Sustaining Treatment [LST]) Note
Physician Code Blue
Physician Death Note
GEC Physician Referral/LIP note
When finished click *Apply* and *OK* boxes; edit PRN.

MEDICATION RECONCILIATION

TJC and VA have mandated the performance of med reconciliation at every outpatient episode of care, at admission, at transfer of care and at discharge. This is a reasonable expectation and improves patient safety and compliance. Please add OTC meds and meds prescribed at other VA locations as "Non-VA Meds".

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Review all ordered medications, including OTC and non-VA Meds at admission, transfer, prior surgery and at discharge. You may review and edit med orders, and/or lists embedded in admit/transfer notes with patient and/or family. Document med review with attestation embedded in notes, or using note titled "Medication Reconciliation", or "After Visit Summary", or (at discharge) "Med Rec & DC Note". Order any medications, tests or consults *prior* to completing the After Visit Summary, as these will populate the document. Review for completeness. If you take the time to do this correctly, you will find it easier to reconcile medications at discharge. Medication reconciliation is an essential process for patient safety, and a standard measure of quality of care.

THE ADMISSION PROCESS

- * Requires completion of Admission Orders, H&P
- * Staff must enter note by 24 hours after admission
- * Use "History & Physical/Surgery" or specific service note titles (see suggestions, page 2).
- * Enter Admission orders as "Delayed Orders". When prompted, select delayed pending "Admission to X" where X is your service. Each Med ward, or Surgical or Psych Service, etc., has pre-written Order Sets; see "Add new orders" in CPRS.
- Admit To (your service); identify Attending and Primary Physician names.
- Diagnosis: Do not use abbreviations.
- Condition: "Stable" for ward patients, "Critical", "Unstable", "Seriously Ill", for ICU patients.
- Code Status: Full, Limited (with explanation), DNR. If DNR, orders and note must both be completed; staff must sign by 24 hours).
- Surgery Date: (if applicable).
- Planned Procedure: (if applicable).
- Vital signs, nursing assessment and care orders: (Intake/Output, Daily weight, Accuchecks, etc.) Telemetry orders are renewed q 24 hrs.
- Activity: (See options) Restraint orders if necessary.
- Patient Care: Specific nursing care, e.g.: dressing changes, traction, etc.
- Diet: enter diet orders. Request diet consult if indicated. Don't just "DC NPO" status; must replace NPO with a diet order.
- Medications: You may highlight Outpatient meds in the meds tab, and use the "Action", "Transfer to Inpatient" options, or write new inpt. med orders. Don't forget IV fluids, IV medications.

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Respiratory Therapy Consult (if applicable): order set allows you to request treatments and write for meds.

Laboratory Orders: Pay attention to the “collect:” options. **Ward collect** means that the ward personnel or you will draw and send. **Lab collect** means that lab personnel will draw at scheduled times (0400 and 1100).

Send Patient to Lab means the patient must be able to walk down to the lab and wait for personnel to draw the studies (not for use on inpatients).

Special Studies: Complete radiology requests, ECG requests, or appropriate consults to obtain any special studies you may require. Inpatient consults require that you page and discuss them with the on-call person for that service.

Anticipated Discharge: Identifies a target date and expected discharge location. Notifies ward clerk to schedule outpatient clinic follow up appt, notifies bed flow of bed status. Order can be updated/changed.

FOR SURGEONS: THE SURGICAL PROCESS

- * Prophylactic antibiotics are service/procedure specific, are ordered by the surgery team, and administered within one hour of incision time by anesthesia. Check patient allergies prior to ordering.
- * Postoperatively, prophylactic antibiotics are continued for no more than 24 hours. After 24 hours, document the indication for use in the chart.
- * Patients on β -blockers: continue pre-and post-op.
- * Keep postop blood glucose levels to below 200.
- * Keep postop patient temp >96.8 .
- * DVT prophylaxis ordered postop.

Informed Consent.

Find and use the I-MED Consent - on "Tools" drop down in CPRS. If CPRS or IMED are not available, ward clerks have written consent forms. Informed consent can be obtained days to weeks prior to surgery. A signed form is good for 30 calendar days. To open a new or previously saved consent form go to the Tools tab in CPRS, drop down to IMED consent, and double click to open. See previously written consents on the left (“saved forms without signatures”). Click to open the appropriate form. If opening a new consent, click on the + sign next to the appropriate specialty. For most procedures, select “Consents-Basic”, then select all procedures that apply. Next, select Begin Consent in the lower right corner. Verify/complete the info on the Verification page. Complete the Condition or Diagnosis page.

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Identify anatomical location and side/laterality in clear language. Note anesthesia’s involvement.

Blood Consents.

Find in "basic" menu for almost any specialty. There are 3 options (all included within surgery consent too); pick one. If veteran refuses blood products, best to ask staff for guidance.

List yourself as the signing practitioner. Identify any attending staff and all additional individuals who may be involved with the case (i.e. surgical team members).

After clicking OK, the computer will present you with a consent form for review.

Best Practice: You may print the form for patient review and have them read it until your attending has had a chance to meet with them.

Patient may “sign” now, or “hold for signature”.

When all discussions are completed, obtain appropriate signatures, then click “Save to Chart.” If you don’t do this, your consent form goes away!

Once completed, the IMED Consent form will be viewable in the note section of CPRS.

Telephonic Consent

On occasion, the patient can’t provide consent for themselves due to illness, injury, intubation, or altered mental status. The surrogate may only be available via telephone. The process for obtaining telephonic consent is framed in the IMED consent form.

1. Go to your selected IMED consent form.
2. On **Verification** page, **“Does patient have decision making capacity?” answer: No.**
3. On **Decision Making Capacity** page, click box indicating consent being obtained by telephone.
4. Complete the consent form, save for signature.
5. Identify two individuals (nurse, staff, student, or others) in proximity to serve as telephonic witnesses.
6. Call the next-of-kin/guardian or surrogate. Discuss the details of the proposed procedure; read appropriate sections, answer their questions, and explain consent will need to be confirmed with you and two witnesses. Once the individual agrees to the procedure, he/she must verbalize that to each of the witnesses.
7. Write in the Signature Box “Telephone Consent obtained.”
8. Complete consent with your own, then witnesses’ signatures.

Emergencies

If the patient can’t give consent, and the party who has the authority to grant consent is not available or

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nonexistent, authority may be granted by the Chief of Service or two staff physicians for emergency procedures. A written progress note must note patient’s inability and the urgent indication for surgery procedure. Notify the Service Chief to review and sign.

Preoperative Assessment

Regardless of the location of the preoperative assessment, inpatient or outpatient, certain components must be completed prior to taking a patient to the operating room.

First, all patients must have active orders, which include a diagnosis, the proposed surgical procedure and date, and any prophylactic antibiotics that should be administered.

Second, all patients must have a valid consent for surgery, and for blood products. This consent must have been signed within the previous 30 days.

All patients must have a complete history and physical exam, less than 30 days old.

DOSA & OPS patients with an Admission note from more than 24 hours prior, must have a Day of Admission/Surgery note.

The attending surgeon, who will be performing the operation, must have a recent staff note in the chart before surgery.

Appropriate preoperative studies (will vary by procedure) must have been completed, reviewed and have results noted in the chart.

Patients who normally take metformin should have that stopped at least 48 hours prior to undergoing general anesthesia.

Other pre-surgical medication instructions vary by service.

On the day of surgery: the *staff surgeon* will verify the identification of the patient, complete the Day of Admission/Surgery note and mark the surgical site.

Procedures outside the Operating Room

Any invasive procedure performed outside of the operating room should be consented in the same manner used for operative procedures.

Once informed consent is obtained, the patient should be identified, and the correct side and/or site verified and marked.

Bedside and Clinic procedures are documented by completing a Procedure Note, XXXX (Surgery, Medicine, etc.), or just a Procedure Note, or the XXXX Bedside Procedure Note in CPRS.

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This note should include: identifying the surgical attending, an indication of the presence (and name) of the supervisor if you are not yet “approved” for independent performance, verification of identification of the patient, documentation of informed consent, and correct site marking. The procedure should be briefly described, and comment made on how well the procedure was tolerated and the outcome. Identify specimens sent to the lab.

Documenting Surgical Procedures

Nationally, the standard of care requires a written surgical report be included in the patient’s chart immediately after surgery.

The Immediate Post-Op Note allows the surgeon to communicate the essential intraoperative information as part of a hand-off process to the next level of care. It should be completed prior to leaving the OR, but **must be done at Audie Murphy within 30 minutes of the patient leaving the OR and must contain:** 1. Pre-op dx; 2. Pos-op dx; 3. Technical procedures used; 4. Surgeons; 5. Anesthesia; 6. Blood loss; 7. Findings; 8. Specimens removed; 9. Complications; 10. Plan. If appropriate, add: 11. Drains; 12. Tourniquet time.

The surgeon of record may dictate the op report using dictation services. You will receive an alert when the report is available; review the report, make corrections, and then sign the report. Once signed, no one can make corrections to the text. Should you or your staff want to change anything, you may enter as an addendum. Your staff surgeon will then cosign the report.

Postoperative Care

Remember that post op orders must be written as delayed, or written as active after the stop time for the procedure is entered by the nurse in the OR.

Pay attention to maintaining normothermia, tight glucose control, deep venous thrombosis prophylaxis, the evaluation of skin integrity, and the appropriate use of prophylactic antibiotics (see column 4).

Postoperative patients will recover in the PACU or in the SICU. From the PACU they may return to outpatient surgery for discharge, or they may be moved to the surgical ward on 2W as observation or inpatient admission. The prudent physician will reassess his written orders following patient movement to that unit.

Make sure your postoperative orders include several options for pain management. You should provide something for moderate to severe pain and something for mild to moderate pain, at the very least.

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Physician notes are required daily on all inpatients. All progress notes on patients located in the SICU require a statement indicating collaboration of care with the Critical Care Intensivist Team (it’s in your ICU note template).

The Discharge Process

Identify family members, significant others or friends who are willing to support and/or care for this patient. Document contact info.

Explain how illness or surgery will affect ability to function. Ask patient’s wishes about advanced directives and organ donation.

Consider PM&R consult for physical therapy, occupational therapy or to determine appropriate level of rehabilitation. Order any prosthetic equipment via a Prosthetic consult.

Consult with the Social Worker assigned to your Service for placement options, and necessary documentation.

Enter a GEC Referral Physician/LIP note to request patient care services, if needed, at CLC, Kerrville Short Stay Rehab Unit, Inpatient Hospice or Home Health.

Home IV medications. Requires discussion with IV Pharmacist, Social Work, possible ID consult if for antibiotics. Patient needs PICC or appropriate IV access. The GEC/LIP consult requires you know approved drug, dose, duration, admin access, and Home Health services needed prior to completion.

Home oxygen. Place Home Oxygen consult at least 24 hours prior to discharge, and prior to a weekend or holiday.

Discharge orders

1. Use the **Anticipate Discharge** Order Set. Complete when discharge date determined. Can be changed. Fill in required fields, including request for follow up. *This order set alerts bedflow for patient bed mgmt., and alerts MAS/ clerks to schedule follow up appt.*

2. **Order medications.** Go to Meds tab. Review Non-VA and Outpatient meds, discontinue meds no longer needed, hold meds patient may restart in near future, change medication doses as appropriate. Go to Inpatient Meds, select any new meds to continue after discharge, transfer the order (under “Action” tab) or write as new Outpatient orders. DC med orders may be written as early as 2-3 days prior to discharge. Can enter the **fill and hold order** in the order set. This will tell the pharmacy to fill this order, but hold release until the patient is discharged.

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3. **Complete the Med Rec & DC Note (Surgery, Medicine, etc.** From the notes tab, choose Med Rec & DC Note title (which becomes the first part of the DC Summary). Enter the date of patient’s hospital admission (include any observation days) and discharge date. You must write out all admission and discharge *diagnoses without abbreviations* in this note. All DC meds should be determined and ordered prior to creating this note, as ordered outpt meds will populate the Active Outpatient Meds field. If meds are changed/added, make a note addendum.

4. **Complete the Med Rec & Discharge Summary** (yes, separate from “Note”, but TJC requires). Go to the D/C Summary tab. Choose New Summary. Identify the attending physician, and select Med Rec & Discharge Summary. Copy and paste in your Med Rec & DC Note, without any signature lines or headers. Complete the DC Summary template. Use no abbreviations in either admit or discharge diagnoses sections.

5. Use the **Discharge Order Set**, filling out the first three fields, then any special instructions. *A nursing text order should not be used to discharge the patient as it does not notify bedflow of bed availability.*

Special Situations

Clinics: Close your encounters the same day!

Medical or Surgical Observation: Patients who may be safely sent home within 47 hours may be “admitted” to Medical or Surgical Observation. These patients are housed and cared for on the Wards, but do not have official Inpatient status. To use this, you must admit the patient to Medical or Surgical Observation, write orders and an H&P, anticipate discharge at the time of admission and write all discharge meds, discharge the patient within 47 hours of their assignment to this status, and complete a Med Rec & DC note, and Discharge Summary & DC note.

Death: The physician involved in a Code Blue should complete the Physician Code Blue Note. The physician present at a death should complete the Physician Death Note in the Progress Notes tab (2 different notes, may be same doc). The intern or resident on the patient’s primary service will still have to complete a Discharge Summary on the decedent. The attending physician on the inpatient service will be the one to sign the on-line Texas Death Certificate (if an ED death, it’ll be the PCP “out there”).

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Questions on that should go to the MAS Details Section. Questions regarding autopsy and/or involvement of the Medical Examiner should be resolved prior to the removal of any lines, drains or other indwelling devices (discuss with faculty). If possible, request “autopsy” or “limited autopsy”, e.g., “only chest and abdomen is entered” (or even just “needled”).

AMA Discharge: Attempt to persuade patient to stay. Use other providers, chaplains, social workers, etc. Order discharge meds & complete Med Rec & DC note, Physician AMA note, & Discharge Summary & DC note.

Do Not Resuscitate: After discussions with family and attending staff, complete Life Sustaining

Treatment Note which generates the DNR order set. See Resident & Student link on home page for brief PPT. This IS transferable (in and out of hospital, or different sites) Communicate clearly with nursing and support staff. *The note and order must be cosigned by staff within 24 hours.*

Transfers Between Facilities

Transfers between other facilities and Audie Murphy are coordinated through a central office. The Bed Flow Coordinators (phones, see page 1) are responsible for contacting clinical services and arranging direct communication between the other facility/physician and the attending physician on the VA service. Regardless of which direction the patient is going, the accepting attending physician must communicate directly with the transferring physician, and agree to accept the patient.

All patients being transferred to another facility require two forms completed: the “Interfacility Transfer Consult” (New Consult; select at bottom), as well as a consent to transfer (IMED consents; “Shared” menu near bottom; “Administrative”, then “Physician Certification and Patient Consent for Transfer”).

Once done, residents may become involved with the actual transfer. Patients leaving our facility must have transfer orders, including a request for transportation (paper form - obtain from unit secretary), a completed discharge summary-signed by the attending physician, and, depending on the accepting facility, filled prescriptions for 0-30 days of all active medications (no meds required for transfer between VA facilities). Patients accepted for transfer *into* this facility are supposed to have a discharge summary with them on arrival.

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Transfers Between Services within Audie Murphy

Patients at this facility may require changes in the team managing their inpatient care (e.g., a cardiology patient may require open-heart surgery). These transfers also require attending concurrence. The transferring/losing team is responsible for communicating a detailed summary of events to the accepting team. The transferring team is also responsible for completing a Transfer/Hand-off note and Med Rec in the CPRS progress notes tab prior to elective transfer, and as soon as possible after an emergent transfer. The accepting team is responsible for writing the transfer orders and for completing an “admission” assessment (H&P).

Problems, questions, or comments?
Contact:

David P. Dooley, M.D.
Associate Chief of Staff for Education
(210) 617-5109

David.dooley2@va.gov

Revised June 2020

VA RESIDENTS' SURVIVAL GUIDE 2020

Computer and Patient Care Guidelines

Audie L. Murphy VA Hospital
South Texas Veterans Health Care System

RESIDENT SUPERVISION

The STVHCS VA Residency Review Committee in compliance with Veterans Health Administration guidance requires that every note written by a resident must demonstrate the level of supervision provided.

EVERY note must indent your staff using with 1 of these 4 options, found in the Resident Note templates, use them!

- (1) Attending writes a separate progress note (OK for their H&P's, new clinic patients)
- (2) Attending writes addendum to your note (OK for their H&P's, new clinic patients)
- (3) Attending Co-signature (Not “additional”) (must use for D/C summaries, initial consults, restraints, DNRs)
- (4) Statement in your note detailing involvement (OK for f/u of consults, OP f/u patients, or daily IP progress notes):
 - (a) “I have seen & discussed this patient with my supervising physician, Dr. X, and Dr. X agrees with my assessment & plan.”
 - (b) “The attending of record for this patient encounter is Dr. X.”

Medical Student Notes: Students are only allowed to write “Medical Student Note”. Pick this title in “New Note” listing, then click “Templates (L hand column), then “All Med Students”, then “Shared”, then pick template you want.

Attending staff MUST:

- * Write admit note/addendum to your note by 24 hours after admission! Alert them!
- * Write note/addendum for team/service transfer.
- * Write note or addendum for Preop note.
- * Co-sign Operative reports.
- * Co-sign D/C Summaries, restraint, DNR (LST) notes
- * For new clinic visits: write note, addendum, or co-sign

This information applies to Attending staff who need your help! By you being aware of these requirements and notifying staff, you help facilitate staff involvement.