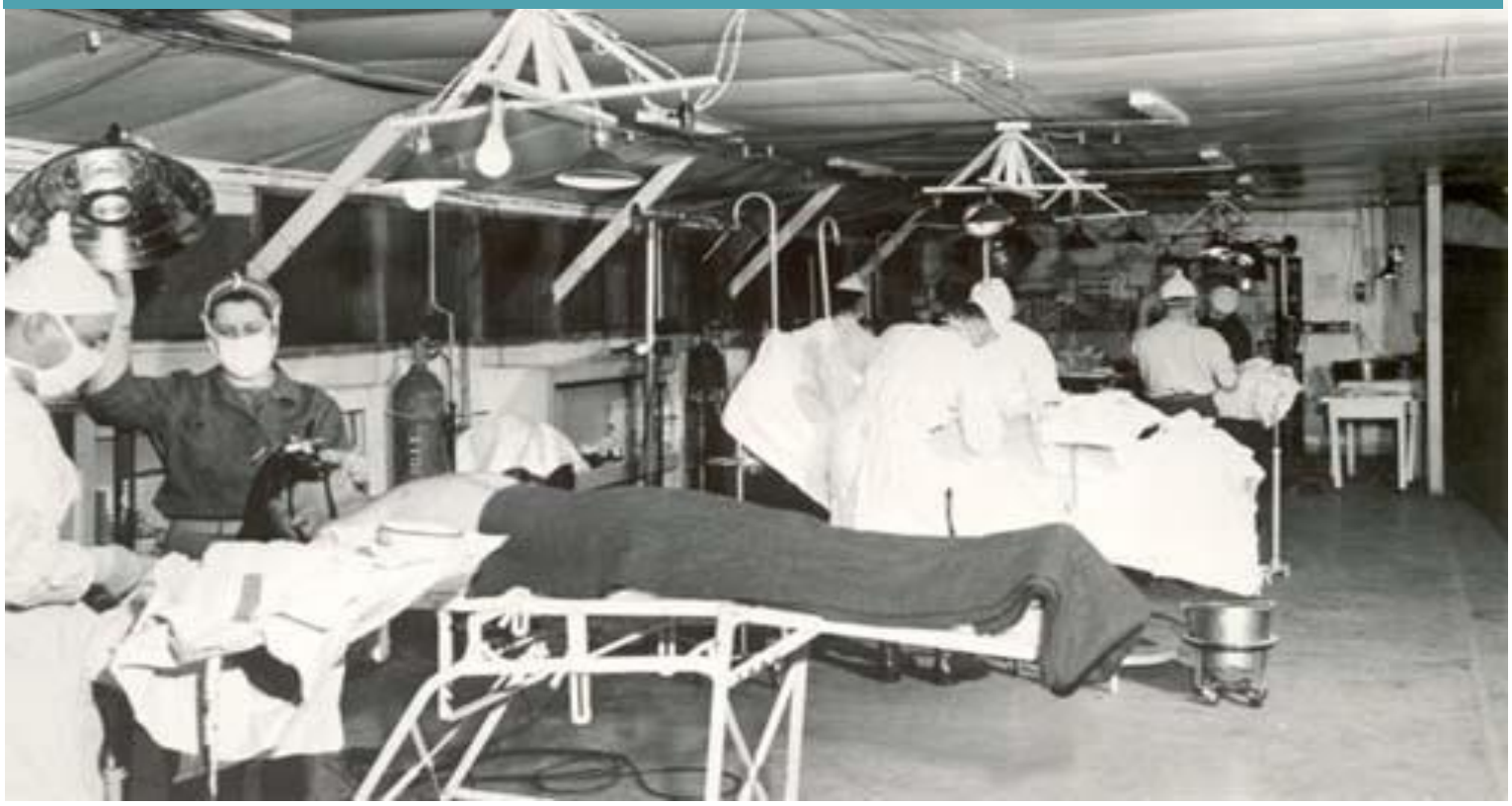


Surgery Resident Survival Guide

Updated June 2021

Edit by the Trauma & Acute Care Surgery Service

ZSFG & Trauma Center, 1001 Potrero Avenue, Suite 3A
San Francisco, CA 94110

The Resident Survival Guide to Trauma & Acute Care Surgery

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

Door Codes, Phones, and Pagers:

3A: Door Code 5757 ***7A Resident Area: 7418**** ***7A36 INTERN/R2 Shared workroom: 2001***

2nd-floor resident room: 35131 3M Clinic Door: 8201

ZSFG phones: Dial 6, then the 4-digit number of the unit you're trying to reach

ZSFG pagers: Dial 61877, then enter the 4-digit pager number… UCSF pagers: Dial 9 then 415-443-….

NEW HOSPITAL PHONE AREA CODE: 628

Intern Locker #67 in Building 25, B-level – 14-28-06
Intern Locker #48 in Building 25, B-level – 06-28-18
Intern Locker #49 in Building 25, B-level – 26-00-30

7A open computer workspace: This area is a QUIET ZONE! If you are taking a number of phone calls, please relocate to the R2 Shared office space. Please be mindful of limiting noise during business hours. We WILL still perform sign-out in this area in the AM & PM. COVID MEASURES = Masks on in general areas please; Maintain social distancing.

Introduction

Welcome to Trauma Surgery at the ZSFG! This guide is intended to orient you to the basics of how the rotation works, expectations for interns, responsibilities on days versus nights, and provide some basics on how to survive what can be a very busy month.

Communication:

We want you to communicate with us ***a lot***. Text messages are fine for many things, but when we are scrubbed in the OR ***or*** do not respond quickly, please page us (If in the OR, just come into the OR to discuss issues in-person). ***DO NOT communicate HIPPA information via text message.*** Text messages are not secure methods of communicating. ***Assume if we did not reply to your text message, we did not receive it***. Information about a change in patient status should be communicated early. We don't want to be surprised on AM rounds or PM sign out that a patient has had a change that we were not aware of. Communicate questions for ICU patients at night. They are complex patients and we don't expect you to understand each nuance of caring for them at this point in the year, though we do expect you to try.

As with all information you present to us, we rely on you to be **accurate**. If you do not know something for sure, please just say you ***don't know***. It can be hard to admit you haven't followed up on something, but it is much better to do that then to present incorrect information, which we will use to make decisions about patient care.

SIGN INTO EPIC patient team when you FIRST log in so nursing and other staff can EPIC CHAT NON-URGENT ISSUES

There are key similarities and differences between the inpatient and outpatient communication strategies that I want to highlight:

- Regardless of setting, *if an urgent/immediate response is needed, then numeric paging or a phone call should be used.*
- *In the inpatient setting, Secure Chat within Epic is strongly encouraged for most communications*. For this to be successful, providers need to sign into Epic.
- *In the outpatient setting*, Secure Chat can be used liberally within an individual service/department. However, Secure Chat should not be used regularly to communicate between services/departments. Secure Chat may be appropriate when an immediate action is needed; however, you must page/call if there is no answer after 10 minutes. Secure chat should never be used for results notification. Note that Secure Chat messages linked to a patient are purged at 72 hours and are not part of the legal medical record.
- *More communication tools can be leveraged in the outpatient setting* such as Telephone encounters (available in the medical chart) and staff messages (not visible in the medical chart) to discuss non-urgent patient care issues.
- *Trust the system:* Epic results routing to the authorizing provider is robust, has flags that identify abnormal results, and is easily seen by cross-covering providers

Category	Response required	Timeframe	Communication Mode
Inpatient			
Urgent	Yes	≤ 5 minutes	Numeric paging Phone
Advise/ Important	Yes	≤ 30 minutes	Secure Chat (Epic) UCSF Webpaging Portal
FYI/Routine	No	N/A	Secure Chat (Epic)
Outpatient (between services/departments)			
Urgent	Yes	≤ 1 hour	Numeric paging Phone (Secure Chat to a provider may be appropriate when an immediate action is needed; must page/call if no answer after 10 minutes)
Subacute	Yes/No	≤ 48 hours	Numeric paging Phone
Priority	No	≤ 1 week	Telephone encounter (Epic)
FYI/Routine	No	N/A	Clinical encounter (Epic) Staff message (Epic)
Outpatient (regarding diagnostic studies including laboratory and radiology results)			
Urgent	Yes	≤ 5 minutes (Lab) < 1 hour (Radiology)	Numeric paging Phone
Subacute	Yes	≤ 12 hours	Numeric paging Phone
Priority	No	≤ 1 week	Epic result with abnormal flag as automated in the system (Secure email is optional additional communication)
FYI/Routine	No	N/A	Epic result with abnormal flag as automated in the system (Secure email is optional additional communication)

We are all here to help you, and share the goal of taking excellent care of our patients. You are an essential part of providing that care. Please let us know if anything is not clear.

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

The Teams

Currently, the Trauma ACS Service comprises four teams: Trauma A, B, C & D (Elective Surgery/Flex). During day shifts, you'll cover either Trauma C or D, while the NPs cover Trauma A & B and the ICU patients. On night shifts, you'll cover Trauma A & D (including ICU patients), or Trauma B & C (including ICU patients). There is always a SURGERY R4 or R5 in house (24 hours), an R2 who responds to all traumas and consults, as well, during the day there isan R3 who attends surgical theater and/or helps out with traumas and consults.

Team D INTERN Rounding Responsibilities:

- **Weekdays**
  - **AM:**
    - **6AM: Rounds with R5 on Elective General Surgery Patients prior to morning report**
    - **6:45 AM: Attends morning report with R5 & R3**
    - **Post Morning report:**
      - **Attend 2 3M Clinics per week (Mon / Fri)**
      - **Attend OR 2 days per week (Tues / Thur)**
        - **Responsible for Clinical management of Team D patients**
      - **Attend Educational conferences on Wednesdays**
        - **Clinical Coverage of Team D during educational conference by NP / Chief Resident**
  - **PM:**
    - **Checks in with Senior Trauma Resident: to be assigned additional afternoon duties pending Trauma/ACS service needs and needs of the Team D patients**
      - **12:30 Clinic Days**
      - **2 pm OR days**
      - **Wednesdays: after completion of educational conferences**
        - **Assigned duties may include:**
          - **Assistance to Team A/B/C or ICU NP with acute inpatient care tasks.**
          - **Assistance to R2 with trauma resuscitation / consultation**
- **Weekends**
  - **Attends resident sign out & morning report**
  - **Rounds with Senior resident on Elective General Surgery Patients and select Vascular Patients during Trauma / ACS rounds**
    - **Vascular ICU Patients: Will be given time to round on prior to start of ACS ICU Rounds**
    - **General Surgery ICU Patients: Will be rounded on by Trauma/ACS Faculty**
    - **Elective General Surgery & Vascular Floor Patients: Senior Resident / Intern allowed to round on patients during Trauma/ACS Rounds**
  - **Assists with service needs at the discretion of the Senior Trauma Resident**

Traumas (See Attached for Trauma Activation Criteria)

Your pager will alert you when a trauma comes in. You will respond to the ***SHOCK TRAUMA & 900 (Major Activations)*** ***Trauma activations*** for the learning opportunity during the day. You should make yourself available during the day for 900s, but these rooms are crowded and the aim is to have only the mid-level, the senior and the attending at the patient bedside.

Night-time hours you will play more of an active role in the resuscitation (RE**: Accurate Documentation**, assisting as directed by the Senior Resident/Attending Surgeon). A 911 is a trauma where the initial report suggests the patient is hemodynamically stable. It is helpful to respond to multiple 911 Activations to assist with patient care flow in the emergency department.

The Schedule

INTERN Days:

- START ***(7A WARD, BUILDING 5)*** at 6am on weekdays, 6:30am on weekends or holidays.
- The entire team including the R4/R5, Fellow, & Attending meet in 3A at 6:45am on weekdays (Wed 630A) and 7am on weekends/holidays to do formal morning report. The night interns are expected to sign out their Trauma & Acute Care Surgery patients to the oncoming Interns/NP prior to morning report. ***The morning report is both for communication & education purposes***. Pay attention and stay engaged!

NEW ROOM FOR AM ROUNDS: **(HG904)**, **it should accommodate our whole team in person, but we will also be holding the Zoom meeting for those that prefer it.**

Directions: From 7A Bld 5: Take elevators to the ground floor. Head towards the main hospital, Bld 25. After passing the blood bank, the conference room is the second door on the left-hand side of hallway.

From Main Hospital Bld 25: Take elevators to the ground floor. Head towards Bld 5. Look for the scrub machine sign on the right-hand side of hallway, the conference room is the first door on the right after the scrub sign.

- Morning rounds are targeted to be complete by 10 am. You should grab breakfast before hand. Your day finishes at **5:45pm (SHARP)** in ***7A*** for ONE-ONE ward sign-out then Group ICU sign-out (R4 bunker) until approximately 6:30pm.

NOTE: TUESDAYS you will arrive at 4:45pm prior to Journal Club Conference/M&M for Ward sign-out. ICU sign-out will occur after Journal Club Conference/M&M

Grand Rounds/ Teaching/ Skills Lab WEDNESDAYS:

Wednesdays AM = GRAND ROUNDS for general surgery on ZOOM. Attend your teaching and skills lab (if assigned that day) & ***immediately*** after and head to the OR for your late morning/afternoon case **(ONLY the residents who have *Skills Labs* will return between 1130am & 12pm)**. You will still arrive for AM sign-out & one of the NPs with cross-cover your Trauma Ward team until you return.

INTERN Nights:

- START ***(7A WARD, BUILDING 5)*** at 5:45pm where you'll receive sign-out from the day WARD interns and NPs (Trauma A&D combined and Trauma B&C combined).
- ICU SIGNOUT will be in the R4/R5 BUNKER with the OFF going NP from 6PM – 630PM. This is an opportunity for you to ask questions regarding complex patients THEN review a plan for the night with the R4/R5.
- Your night ends at 6am (or 6:30am weekends/holidays) when you'll meet the day interns/NPs in ***7A*** main area and sign-out. You then stay for the beginning of morning report or new patients and teaching.
- Interns covering at night are expected to see all of their patients (trauma and acute care surgery) at least once in the night/morning. You are expected to update the list with overnight events and new patients by sign out time in the morning. We will usually request a list by 5:30. We expect updates to be done by then and that all new patients will be on the list. **All attendings, medication lists, labs, microbiology, abx, and surgeries should be checked when you update the list each day.** With a largeservice we rely on the list. Please include the last imaging dates/findings if there is space in the diagnosis space.

ICU Notes should be prepared, SIGNED & assigned to the oncoming ATTENDING Surgeon. (Physical exams, Updated EPIC populated notes).

The workflow of nights:

1) Receive sign-out
2) Swing through the ICU to enter orders, check in on patients
3) Enter orders for floor patients/round on floor patients
4) Check in on ICU patients around midnight; record new labs, I/O's, interval events, and report to your senior
5) Complete rounding and ICU Progress Notes -> sign and assign to oncoming Attending by 630AM

PRINT HANDOFFS with CENSUS SHEET: ALL X3, ICU X1, Tra A, B, C, D X1 each

OTHER Members of the TRAUMA & ACUTE CARE SURGERY TEAM:

SOCIAL WORKERS: We have TWO social workers covering all four Tr. Service Lines. You will speak with them in person and EPIC CHAT group on patients.

EPIC INPATIENT ORDERS = Consult for Social Services with intake reason

UTILIZATION MANAGEMENT RNs: There will be one assigned to each service line. They will join the MSW on the call to discuss patients (What is keeping a patient in the hospital, anticipated DC, DC Needs Home VS SNF for example). UM RNs help with placement of pts with referrals and home health referrals once placed. There is NO EPIC order to be placed for their involvement.

PATIENT NAVIGATOR: Alex McConnell-Hill is our Pt Navigator who supports our workflow with obtaining Primary Care Follow-up appt; Off-service appointments; Disability paperwork; Patient/Family letters; Follow up phone calls to patients. Some appointments are not given at the time of DC from hospital, Alex contacts patients at home. NO EPIC order needed.

PHYSICAL & OCCUPATION THERAPY: We have one of each assigned to our service each month (they rotate). Typical referrals include injured patient's needing a recovery treatment plan, including HOME versus FACILITY for REHAB. No every patient needs a referral = they have mobilized on their own with deficits. Some medical causes for trauma such as syncope is helpful to evaluate for coordination safety. PRO TIP: Make sure any weight bearing limitations are updated in the orders AND Bedrest is discontinued in Activity (if Appropriate).

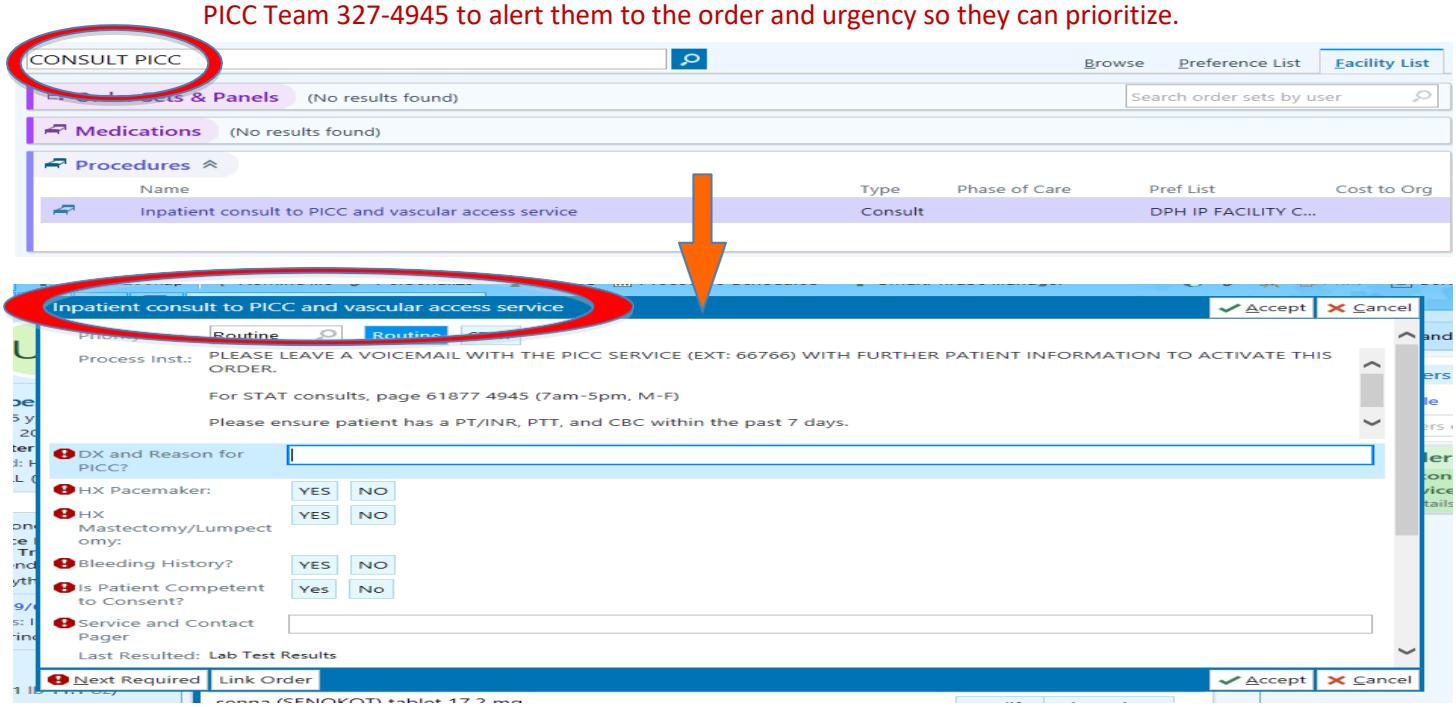
EPIC INPATIENT ORDERS = Consult PHYSCIAL THERAPY +/- OCCUPATIONAL THERAPY

SPEECH & COGNITIVE THERAPY: We typically consult SPEECH when there is a question of dysphagia/risk of aspiration. In addition, we consult for persons with TBIs with related deficits (ST Memory, high level cognitive functioning deficits). So important as baseline and follow with a TBI recovery.

EPIC INPATIENT ORDERS: Consult SPEECH & COGNITIVE THERAPY = complete the data collection screen.

PICC LINE (VASCULAR ACCESS SERVICE): For TPN or longer term ABx we will obtain PICC typically.

Two step process: INPATIENT Orders = CONSULT PICC Service & complete the order collection screen -> Then ***Page*** the PICC Team 327-4945 to alert them to the order and urgency so they can prioritize.



Notes Workflow:

ALL Admissions must have an ***INITIAL ENCOUNTER*** ***.TRAUMAHPNEW***

ICU Pts: ***EPIC: .TRAUMASICUPROGRESSNOTE***

WARD Pts: EPIC Daily Progress note ***unless*** Lower Level of Care (LLOC) = ONLY THURS rounding.

EPIC: TRAUMAWARDPROGRESSNOTEMAY2021

.ACUTECARESURGERYWARDPRGRESSNOTEMAY2021

Post op Check ***.POSTOPCHECK2021***

If injury patient recent admission, then start a ***Trauma Tertiary Survey (TTS)*** in lieu of daily progress note.

NOTE: TTS MUST BE COMPLETED WITHIN 36 hours of ADMISSION

EPIC: .TERTIARYTRAUMAIPVSCREEN

Discharge/Transfer Summary: Doubles as progress note for the day of transfer from our service. ***If short stay may use as a TTS as well (Place a NOTATION "This services as the TTS")***

EPIC: .TRAUMATTSDISCHARGE

Procedure Notes: ***.CHESTUBEREMOVAL .DRAINREMOVAL .TRACHEOSTOMYDOWNSIZE***

.DECANNULATIONPROCEDURE .ASPLENICVACCINESCHEDULE

Advanced Care Planning Note: ***.ACP***

TQIP PC Surrogate & ACP Information: ***.TQIPSURROGATE***

Surrogate Decision Maker: ***.TQIPSURROGATE2***

Goals of Care: .goalsofcare

Incidental Findings: .incidentalfindings

Check Daily HAND-OFF FACE Page for updated dot phrases for use. You have ALL been assigned the dot phrases.

PRO TIPS

Emergency Department Admitted Pts awaiting Bed

NOTE EPIC Admitted pts boarding in ED form order time to 8 hours will only have Antibiotics, Anti-coagulation & Pain Meds initiated. If you need other orders write them as ONE TIME or STAT depending on urgency and discuss with RN

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

TRAUMA TERTIARY SURVEY (TTS)

TTS is to be performed once the ***final*** reads of radiological imaging are available within 24 to 36 hours of presentation. The completed **Initial Encounter Note** information will *carry forward* into the TTS note.
The TTS ***must*** address spinal clearance (C-spine, and/or T+L spine) for all patients not admitted to a spine service (a medicine should not have to call a separate spine consult to get the 80-year-old syncopal woman out of a C-collar).
Please coordinate all recommended trauma consults when appropriate and continue to follow (on the consult list) any TTS with ongoing injury discovery or whose 'other' injuries are not fully attended to.
Please watch the TTS lecture: https://www.youtube.com/watch?v=oxIC6unoAwc

The R2/R3 is responsible for ALL TTS on ***injured*** patients admitted to another service in the hospital. *(Hint: the most commonly 'missed injuries' in trauma are orthopedic and axial spine).*

Trauma Tertiary Survey (TTS) CHECKLIST:

- Complete ***full*** Head to Toe Examination (See Below)
- Obtain complete medical history and current medication list including look in CURES
- Review ***all final reads*** of radiologic studies completed (Note any additions or corrections or INCIDENTAL FINDINDGS to wet reads)
- Order any imaging/testing for new suspected injuries
- Call any consults needed for injury disposition
- Address disposition of C Spine & T/L Spine and document mechanism used to clear (Nexus, radiologic imaging etc); clear if able or document why unable with recommendations- eg pain on exam despite normal imaging
- Compile Injury List and PLAN for injury care
- List and address all ***current medical issues*** with relevant plan of care for each (eg when to resume meds safely)
- ***LIST all INCIDENTAL FINDINGS*** with follow up recommendations for PCP

NOTE: EPIC DOT PHRASE = .TERTIARYTRAUMA

NORMAL PHYSICAL EXAM COMPONENTS FOR TTS

NEURO: Alert & Oriented X3 Cranial nerves II – XII intact Moves all ext. strength symmetrical, no sensory deficits

Head: No lacerations or abrasions; No bony step offs ; Midface stable to palpation.

Eyes: PERRL Conjunctiva/corneas without lesions EOM intact.

Ears: Canals without blood or CSF drainage TMs clear External ears without lacerations.

Nose: Septum midline No crepitus with motion.

Throat: Oral mucosa without lacerations Teeth in place Tongue without lacerations.

NECK: No midline pain with palpation No pain with active ROM No lacerations / wounds Trachea midline No JVD.

RESPIRATORY: No crepitus No TTP Equal excursion No abrasions/contusions Lungs: Breath sounds clear & symmetrical No wheezes or rales

CARDIOVASCULAR: Heart rhythm regular rate S1S2 No R/M/G

ABDOMEN: Appearance: Non-distended no scar/ lacerations Palpation: Non-tenderness or peritoneal signs, no masses/organomegaly.

PELVIC / PERINEAL: Normal male / female genitalia pelvis No TTP on Palpation or Leg lift no blood noted at urethra meatus. **Rectal exam:** (+) tone (-) for blood Male: normal riding prostate

BACK / SPINE: Thoracolumbar spinal column non-tender no step off or deformity no external injury noted

EXTREMITIES: Checking normal box means all joints are freely mobile & without pain, No lacerations, abrasions or swelling. IV sites are clean without erythema. Document pulse exam & ABI if penetratin injury to limb (or vasc compromise)

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

Trauma & Acute Care Surgery Service
Policy: Application of the Trauma Tertiary Survey (TTS)

Definition: The Trauma Tertiary Survey (TTS) is a comprehensive assessment for injury performed by a Nurse Practitioner (NP) or MD (including residents rotating on the surgical service) to identify or exclude suspected injuries, and the plan of care for each.

Objective: To list/confirm all known & evolving injuries based on mechanism of injury or co-morbidities, and to identify those which have not yet been discovered or documented during the *Primary & Secondary Survey.*

Indications:

- All patients admitted to a Critical Care & Med/Surg Wards who have or are suspected of having sustained blunt or penetrating traumatic injuries will have a TTS initiated within 24 hours of hospitalization. TTS will be completed prior to discharge or transfer to another service or facility.

Application:

- When completing a TTS, providers will perform and document a complete physical examination (head to toe), review of all final interpretations of radiological imaging/investigations, and identification of all consultation services. All TTS will include a disposition of the Cervical Spine, a complete ('final') list of injuries and known active diagnoses (eg 'intoxication', 'seizure', 'hyperglycemia', 'DVT/VTE'), and recommendations for the management of each.
- Patients admitted to the Trauma Surgery Service at ZSFG will undergo a TTS within the time frames specified above. TTS will be documented in Salar on the TTS form.
- Patients admitted directly to another medical or surgical service after suspected or known trauma will have a TTS performed by the R2/R3 or designate (MD or NP).
- All findings and recommendations will be documented in the chart using the TTS form and communicated within the primary provider team
- Based on the findings of the TTS, the primary provider may initiate consults to specialty service groups, further investigations for evaluation of potential/identified injuries, and/or a treatment/surveillance plan for the management of identified injuries.

Patient Disposition: *Start discharge planning early*

Work with social work to arrange for respite bed, SNF beds and rehab. Please keep your senior resident informed if there are things preventing discharge, and be sure that each sign out includes information to your co-interns about the status of discharge planning.

Appointments: Every patient should have post hospitalization follow up with PCP: If new PCP is needed for SF City & Co residents then call 415-364-7942; If Kaiser UM care coordinator will arrange. If other private insurance then call provider directly and fax records. POST OP patients are allowed ONE clinic visit in 3M for follow up as part of global fee. Follow up appointments usually fall between 1 and 3 weeks after discharge with the surgeon or attending in charge of their care. Please be sure to check with the senior resident about when a patient should be seen in follow up.

We have a PATIENT NAVIGATOR (Alex McConnell-Hill) Mon -Fri to assist with theappointments and return authorizations if needed.

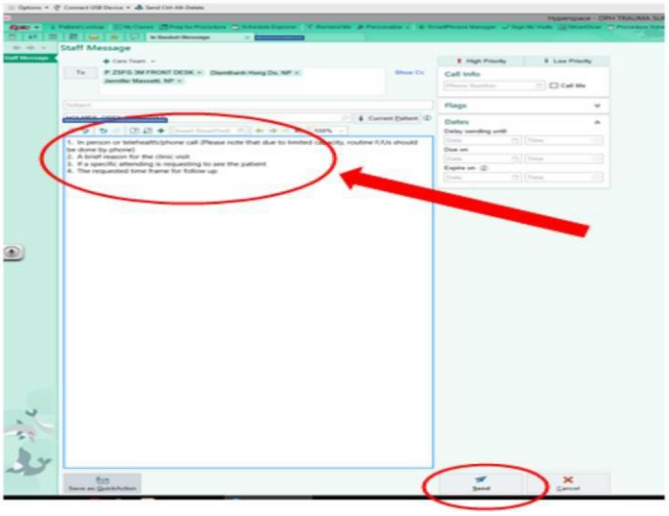
Be sure that any referral for follow up with the patient's primary MD or other specialist (cardiology, renal etc) are submitted and that the patient knows about the appointment and how to contact the clinic if needed.

Making a 3M appt request in (Epic-Confirmed to be working)

Go to your EPIC IN BASKET

1. Click on NEW MESSAGE
2. Click on the TO: button
3. Under the POOL search option type 3M
4. Choose 3M FRONT DESK, JENNIFER MASSETTI & DIEMTHANH DO
5. In the notes section leave your appt request (Ex. Post op follow up 2 weeks. s/p OR for lap appy. If questions call: LEAVE CALL BACK NUMBER in case they need to ask you a question about the appointment.)
6. **NOTE: Routine LAP APPYS & LAP CHOLE will have a telehealth follow up**

APPOINTMENTS will be triaged after chart review & Patient Contacted on CURRENT Mobile number (Make sure it is updated in EPIC)



Type into the box

1. In person or telehealth/phone call (Please note that due to limited capacity, routine follow ups should be done by phone)
2. A brief reason for the clinic visit
3. If a specific attending is requesting to see the patient
4. The requested time frame for follow up

Then click "send"

Medications:

Trauma Pharmacists are on service M-Fr 6A – 3P. They are fantastic about looking up "active medications" on patients for admissions, medication updates (weight based, DVT prophylaxis etc) while inpatient & outpatient teaching prior to discharge. If patient's require TPN, they will complete based on labs etc and PEND it in the ORDERS for you to sign.

Addiction Care Team: The team consists of an Attending, +/- Fellow, Social worker, Pt Navigator for people with substance use addictions (including alcohol). CO-manage withdrawal and offer enrollment in outpt treatment / long term management.

Anesthesia Pain Service: Contacted for epidural insertion for pain control from injury or acute care surgery (RE: Rib fractures not responsive to PO/IV regimens, Complex ABD surgeries with NPO status etc). They then manage their acute pain meds until the Epidural is DC. They will also work with Addiction Care Team when approp. NOTE: DVT prophylaxis is Enox 40mg Bedtime for all patients with an epidural cath NORMAL renal function OTHERWISE Heparin SQ 5000 units BID (Hold AM dose day of insertion or removal).

OVERALL, we FOCUS on multi-modal pain control to reduce unnecessary opioid use for patients. ASK questions about pain control for your patients! This is important LEARNING!!!!
(Example: Routine post-operative lap appy & lap chole patients should not be going home on narcotics).

Think about:
- Preoperative medications - Have all home medications been restarted & is that appropriate? Is there a plan for when to restart them?
- Will the patient need to see their primary MD about medication changes or new medical problems diagnosed in the hospital? (See Above)
- Does the patient need anticoagulation as an Outpt? Are the correct teaching and appointments done?
- Have you weaned Narcotics to "as needed". Limit the script for <5 days until PCP FU

Opioid (controlled medications): Interns & Junior residents should get a Controlled paper script from the R4/R5/Fellow or Attending (the day before or morning of DISCHARGE to submit to Pharmacy). The NPs can ONLY perform this duty if the Senior Staff are all occupied in OR (as an EMERGENCY back-up)

MOST instances we can ONLY dispense a 10-day supply of medications at time of discharge unless we can justify/get approval = Trauma Pharmacists can assist during the weekdays.

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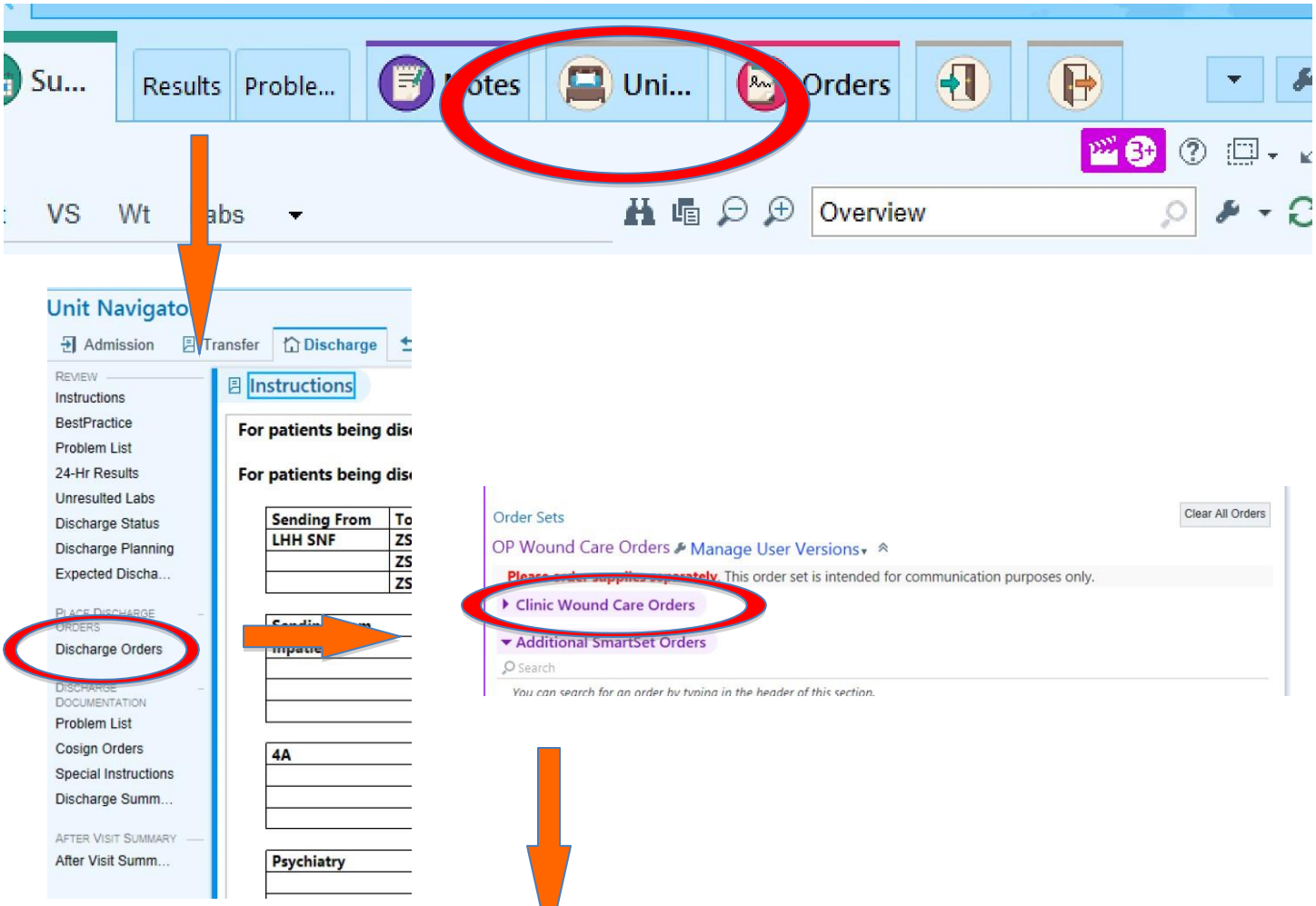
Wound care:

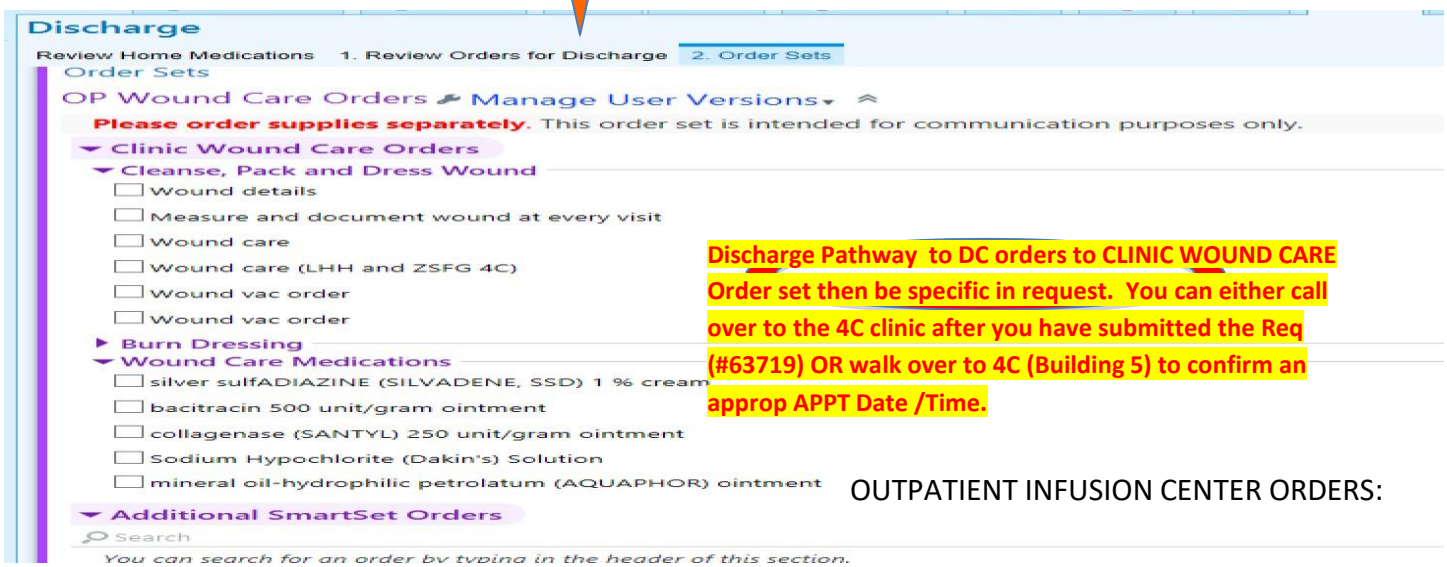
WOUND RN CNS is Ossie on the 4th floor. We refer COMPLEX, long-term wounds & OSTOMY care to her. She is super helpful for any wound care questions you have.

- Inpatient "real-time" wound care resources are the R4/R5, Fellow, Attending & NP.
- Has the patient received wound care instructions/ teaching? Have the family members received the instructions/teaching?

Preparing for Discharge:

- Will they need a 4C clinic appointment for wound care before they are seen in the 3M clinic VS PCP?

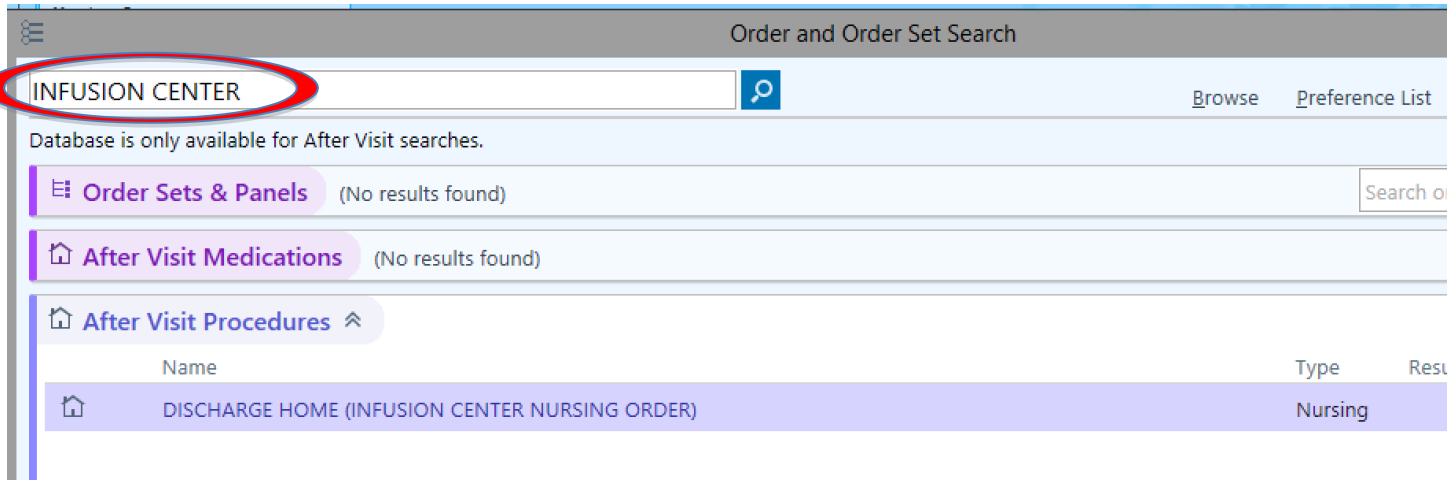




Discharge Pathway to DC orders to CLINIC WOUND CARE Order set then be specific in request. You can either call over to the 4C clinic after you have submitted the Req (#63719) OR walk over to 4C (Building 5) to confirm an approp APPT Date /Time.

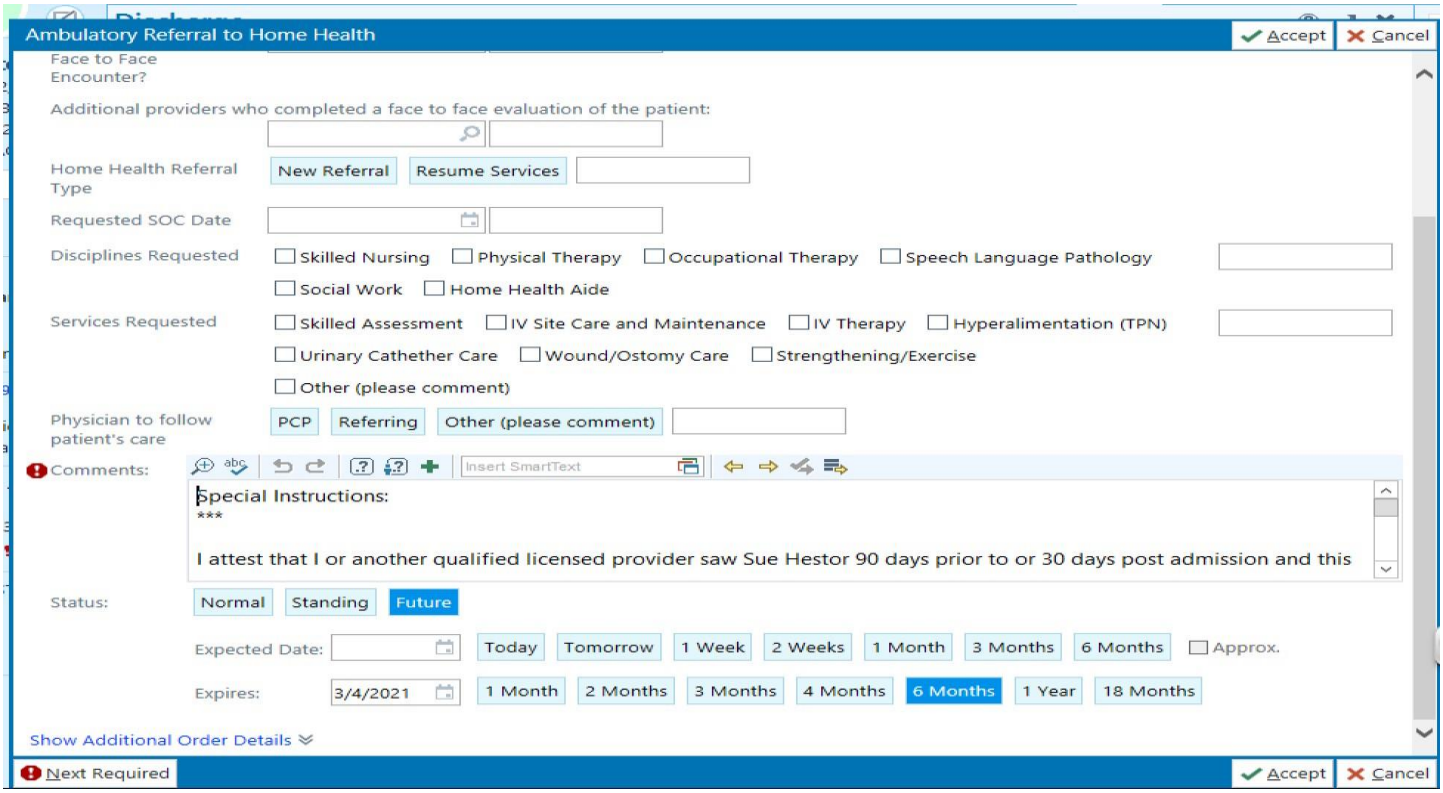
OUTPATIENT INFUSION CENTER ORDERS:

These are not common on the service. Infusions can either be done with a home health order (See Next Section) OR 4C Infusion center order (See below) in the DISCHARGE NAVIGATOR. Once you have PLACED the 4C INFUSION REQUEST (Let the Trauma Pharmacist know) they can assist in the logistics



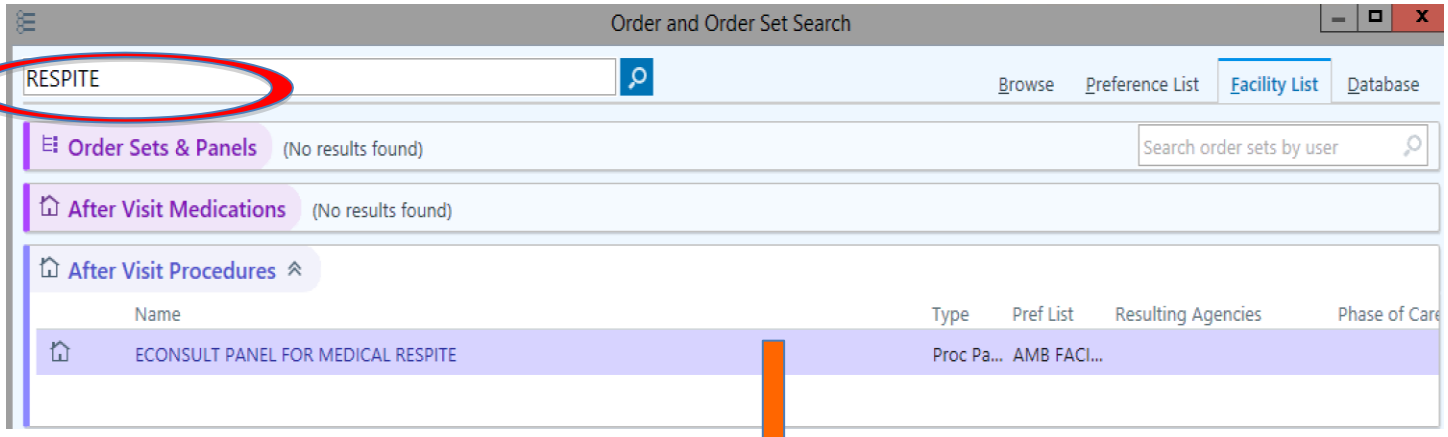
- HOME HEALTH: Will they need a nurse to come to their home and help with wound care?

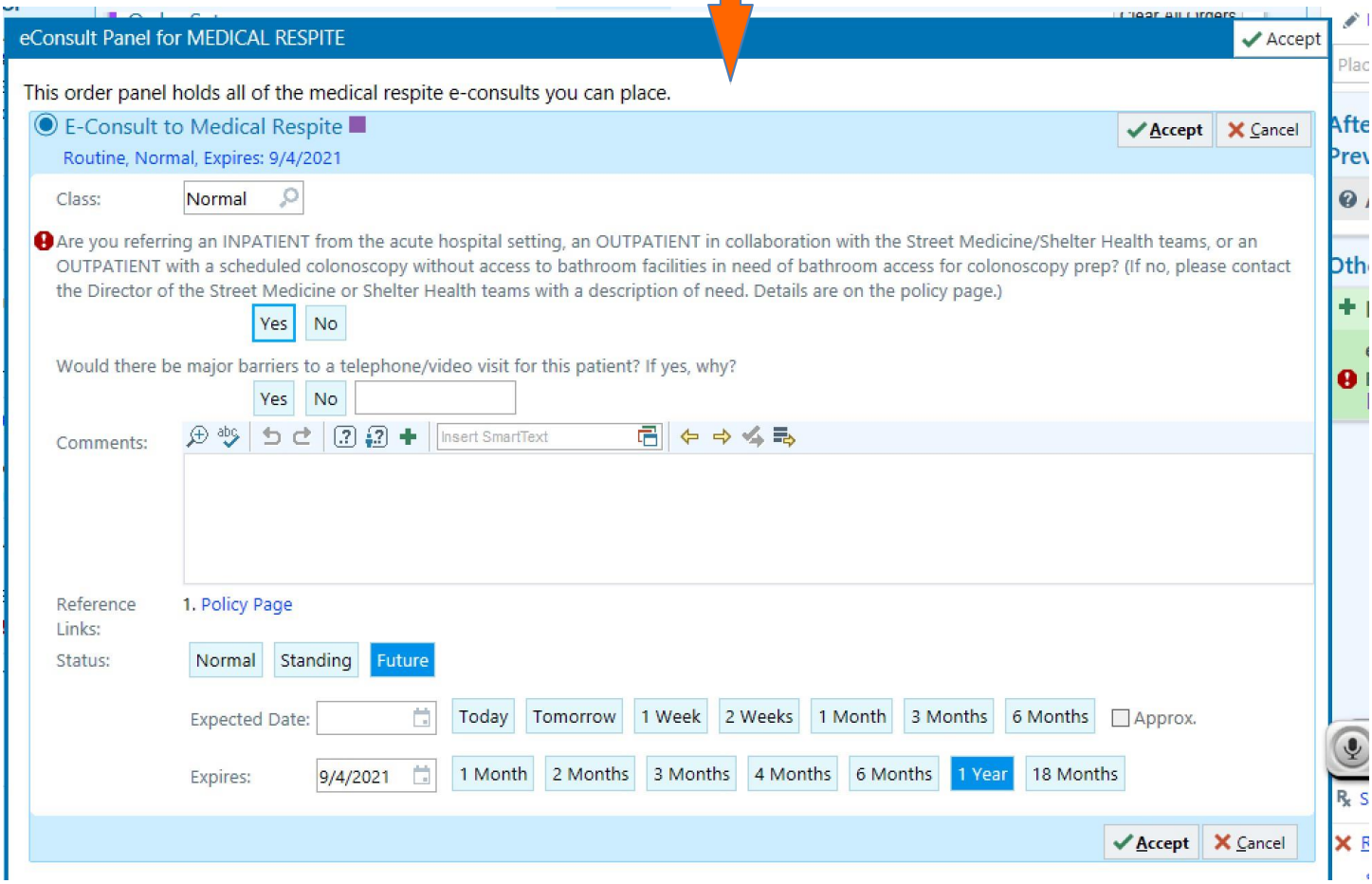
Use the UNIT Navigator to DISCHARGE. Follow DC Orders (previous page) and TYPE in HOME HEALTH. An orderset will pop up. You will need to use this for home wound acre, PT, OT Speech therapy, Social work and home health aide. You can complete this days before DC if this is KNOWN. The social worker can help you is this is approp or not AND timing of request.



RESPITE REFERRALS: This provides a temporary residence to recover from injury & illness. The health staff assist with wound care and medication dispensing.

DISCHARGE Navigator to the DC Order SETS (as on previous DC Examples). ENTER RESPITE. An e-consult order set will be generated to complete. The Medical Respite intake will contact you. AT THE SAME TIME when you place the order, also put an inpatient order in for: TB Skin Test (PPD); COVID PCR if not within 7 days surviellence & HEP A Vaccine if never received. AS Flu Season approaches, a FLU VACCINE.





Drains/tubes:

- Will the patient be going home with a JP, foley, or other drain? Have they gotten teaching to care for that drain?

If the patient isn't independent with existing drains then we typically submit a HOME HEALTH REFERRAL for the RN to reinforce teaching and monitor. See previous HOME HEALTH ordering instructions

Staples and sutures:

- Does the patient have stitches or staples? Should they be removed before discharge?

Nutrition:

- Is the patient on a regular diet or a new special diet? Did you give them verbal instructions about the diet?
- Will they need a feeding pump for tube feeds?

Nutrition will assist with the logistics. This will NEED pre-authorization via UM RN and they will complete the paperwork and submit it for approval.

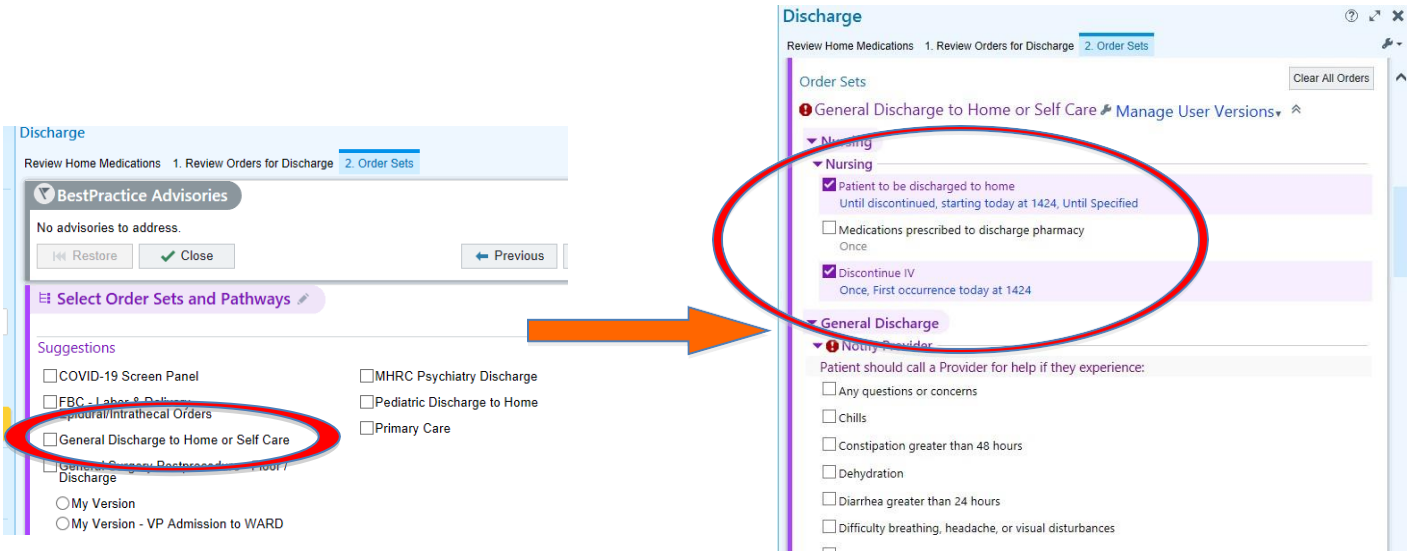
Repeat imaging:

- Will the patients need another CT or MRI or x-ray before to their clinic appointment? Will they need a tube check for an IR drain?

DISCHARGE NAVIGATOR orders section: Enter the specific study request along with the timeframe. They will contact the patient at home. IR TUBE CHECKS will need and OUTPT e-CONSULT IR & contact the department to let them know about the DC home and they will follow the "tubes and drains" they placed.

DISCHARGE INSTRUCTIONS for AFTER VISIT SUMMARY (AVS) (DISCHARGE NAVIGATOR)

We are in the process of developing dot phrases for DC instructions. Some of you may already have standard information for common surgeries (RE: Appendectomy). Below is the GENERAL DC TO HOME data collection field that populates the AVS & provides RN instructions for DC = Communicating DC meds in PHARMACY, DC PIV etc. NOTE: if you have used a dot-phrase in the SPECIAL INSTRUCTIONS then you may just note that under HOSPITAL COURSE "Refer to Special Instructions"



ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

ZSFG 4A SNF TRANSFERS: Patients are ready for transfer at 9AM for the assigned day. The below should be prepared 48 hours prior to transfer to 4A SNF.

- **SCREENING FOR ACTIVE TUBERCULOSIS**
  - Place PPD (or obtain CXR if known positive) (EPIC ORDER = Bedside RN will place)
  - If known neg PPD within past 6 months, document date and result -- no need to repeat and no need for x-ray
  - CXR if PPD positive or PPD not yet ready to interpret at transfer or patient declines PPD
  - we will also accept NEG quantiferon within the past six months if that is available
- **COVID SURVEILLANCE**
  - Negative coronavirus test **within 2 days of transfer** to 4A. No exceptions
- **Influenza vaccine** (or document allergy or date patient declines vaccine)
- **Providers complete discharge readmit pathway**
  - use the correct navigator in order to ensure all orders are carried through safely and correctly
  - indications must be listed for EACH medication to be continued on 4A.
  - behavior to monitor, in addition to indication, must be listed under admin instructions for ALL psychotropic medications, including melatonin (Ex: melatonin 3 mg po at bedtime indication is insomnia behavior to monitor is unable to fall asleep).
  - use the **SNF admission orderset**
  - complete **discharge summary** prior to transfer to 4A
- **Place any outpatient referrals** and schedule all necessary follow-up related to this hospitalization

INTER-FACILITY TRANSFERS (OFF CAMPUS) (SNF, Acute Rehab & Acute Care Hospitals): Out of network patients: typically, patients will be repatriated to their home network if they have continued acute care needs. If rehab needs exist, then SNF rehab VS Acute rehab may be possibilities. Once those decisions are made and SOCIAL WORK & UM are notified perform the following:

ACUTE CARE HOSPITAL TRANSFER: (GO TO DISCHARGE NAVIGATOR)

- Review/confirm **Problem list** & **Cosign Orders**
- Enter any **Special Instructions** (Otherwise the AVS – After Visit Summary *isn't* required)
- Open **DISCHARGE Summary** (serves as the TRANSFER SUMMARY) and complete. (*Sign* if "day of" Transfer). Add the inpatient med list use = **.meds** (**scheduled** and **PRN)** to add to your summary (UM will coordinate ***Provider-Provider sign-out)***
- Reconcile **MEDICATION List** in **DISCHARGE ORDERS**. For all *CONTINUING* meds = make sure each med has "NO PRINT" (so outpatient pharmacy won't dispense). When you have an Ambulance pick-up time, write the final DC Order.

SNF REHAB OR ACUTE REHAB TRANSFERS: (GO TO DISCHARGE NAVIGATOR)

- Review/confirm **Problem list** & **Cosign Orders**
- Enter any **Special Instructions** & complete the AVS (After Visit Summary) along with reconciled medications. NOTE: Some SNF Rehabs will need 48 hours of OPIOIDS = Get that PAPER SAFE SCRIPT from R4/R5 in AM. Otherwise, confirm is other meds need to be dispensed. If not, then "NO PRINT" (so outpatient pharmacy won't dispense).
- FOR SNF TRANSFERS: Some facilities require ADMIT ORDERS are written. These are paper orders found in 7A (SNF Admission orders, PT/OT Speech Rehab orders) = place in chart and alert SOCIAL WORK to fax to facility. Medications will be taken from the DC SUMMARY

- Open **DISCHARGE Summary** (serves as the TRANSFER SUMMARY) and complete & SIGN to fax to facility then ***Provider to Provider sign -out***

JUNIOR RESIDENT:

Trauma Injury (SHOCK TRAUMA, 900, 911 & Non-Trauma Activations) & Acute Care Surgery Consults:
All consults use the appropriate **H&P (Trauma OR ACS)** in **EPIC**. Making sure that this NOTE is filled out completely and accurately (preliminary reads of all radiological imaging, documentation of all consults already called, lab results, FAST results and a detailed clinical examination) is ***essential***. Documentation of limb movement, specific pulse quality & results of rectal exam are often overlooked (especially in the setting of distracting injury & intubation). Please indicate on the form any examinations that were deferred (not performed). These forms ultimately have a long arm, reaching into insurance coverage, legal claims outside the hospital, providing directional guidance for the Trauma Tertiary Survey (TTS), and immediate care decisions.

Perform **your own examination** and document your findings as a clinician performing a consult. This can be done *alongside* the ED's for the sake of the patient-experience; however the ED's [unwitnessed] clinical examination findings shall not be recorded on the **Initial Encounter Note**.

Please ***do not*** document anything un-medically necessary on these forms (or elsewhere). We treat an unusually high volume of victims of violence, crime, or penetrating trauma. Stick to only what you absolutely know from your observations. For example- ***do not*** refer to gunshot wounds as '*entrance wounds*' or '*exit wounds*', we don't know, we weren't there and we are not trained in forensics. Order lab tests you need in order to best treat the patient (eg ETOH level if concerned for TBI, or for possibility of ETOH withdrawal in hospital). Do not re-tell the story of the "two dudes" in the medical record. Once something makes it into a hospital chart, it can be VERY hard to get it out. You want your first deposition experience to go smoothly when reviewing your documentation ☺
Be very careful of what you share with the police (you may be violating a patient's privacy), mostly this should be left to ***attending surgeons***.
Preliminary Reads: All preliminary reads from radiology must be delivered to a ***provider***. MS3s ***are not*** able to receive preliminary reads autonomously. You, or someone else, ***must*** accompany them.

ADMISSIONS TO HOSPITAL & TRANSFERS TO TRAUMA/ACS:

Call ***ALL*** consults from Emergency Department/Inpatient, and document that these consults have been initiated. Complete the Initial Encounter (Trauma VERSUS ACS) Note in EPIC (When complete, ***Finalize*** and ***ASSIGN*** to the appropriate ***ATTENDING SURGEON***). You know the most about this patient at the moment they are being admitted. ***ADD THE PATIENT*** to the ***HAND-OFF*** Tool with the appropriate information.

R4 will designate the Trauma/ACS Service Line open to admissions.

Page the NP/R1 to sign-out & transfer care.
Trauma ICU NP 327-8092 (6A -6P)
Trauma A Ward 327-8090
Trauma B Ward 327-8091
Trauma C Ward 327-8080
Trauma D Ward 327-8081

POST OPERATIVE PRO TIPS:

- Come & Stay/Inpatient: Complete ALL ORDERS post-op. Make sure you have ordered ICS, Addressed when ok for diet & DVT prophylaxis.
- SIGN OUT to the receiving TEAM R1/NP
- Complete and documentation and any consults identified that need to be initiated

ADMISSION ORDERSETS & Booking a case

Clinic patient you are booking a case for:
GENERAL SURGERY PREPROCEDURE PLANNING
Vascular Use VASCULAR SURGERY PREPROCEDURE
Pediatrics Use PEDIATRIC SURGERY PREPROCEDURE
Thoracic Use Thoracic Surgery PREPROCEDURE
Pulmonary (This is for bronchoscopy in the OR) Use Pulmonary Pre-procedure

ED Patient ***being admitted*** & is definitely going to the **OR** (i.e acute appendicitis), use **GENERAL SURGERY PREPROCEDURE PLANNING.** This order set will double as the admission order set for these patients.
****USE VASCULAR SURGERY PREPROCEDURE if approp.

ED Patient being admitted to the WARD with ***NO*** surgical procedure planned or decision for surgery still pending, (ie serial abdominal exams or choledocholithiasis needing ERCP first): **use SURGICAL ADMISSION (Adult) or PEDIATRIC SURG ADMISSION**

ED patient being admitted to the ICU use:
CRITICAL CARE ADMISSION (Adult)
CRITICAL CARE TBI ADMISSION
CRITICAL CARE SPINAL CORD INJURY ADMISSION
CRITICAL CARE BURN ADMISSION (Adult)
PEDIATRIC CRITICAL CARE

.
Patient ***ALREADY*** admitted on floor/in ICU, now needing an operative procedure booked. **Use: ADULT INPATIENT PREPROCEDURE** *(this is an abbreviated orderset that only contains the booking form and pertinent preop orders, ie. NPO)*

Other important order sets for our service:
Critical Care Sedation
Critical Care DKA and HHS Insulin Drip and Management
Critical Care Comfort Care Focused
Critical Care Post Arrest Targeted Temperature Management
Sepsis Critical Care Admission
Initial Prone Ventilation Panel
ICU Ventilator Management Focused Adult
ICU Ventilator Management Focused Pediatrics
ICU Adult Insulin Infusion

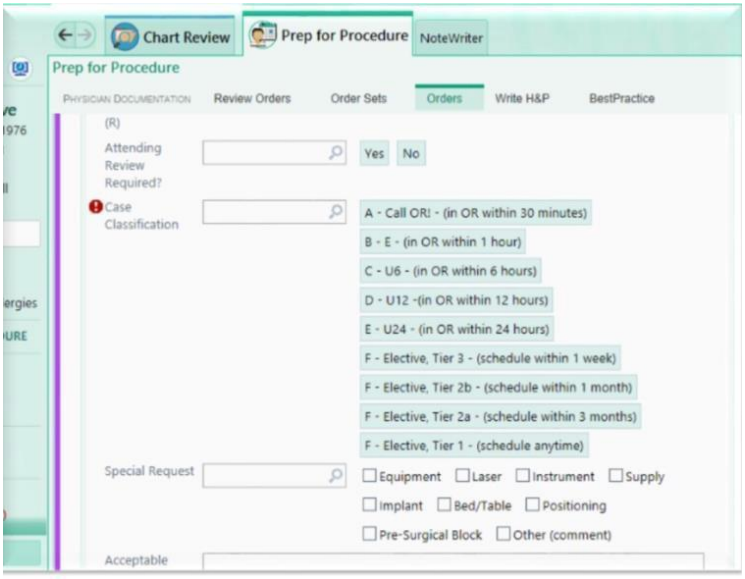
Blood Administration (you must order the blood to be prepared and then order it transfused if you wish for the patient to receive the blood product; if you wish for it to be on hold for the OR, order it as prepared, but not transfused).

Epic: Case Request Field Information for Changes 9/1/2020;
Lang L

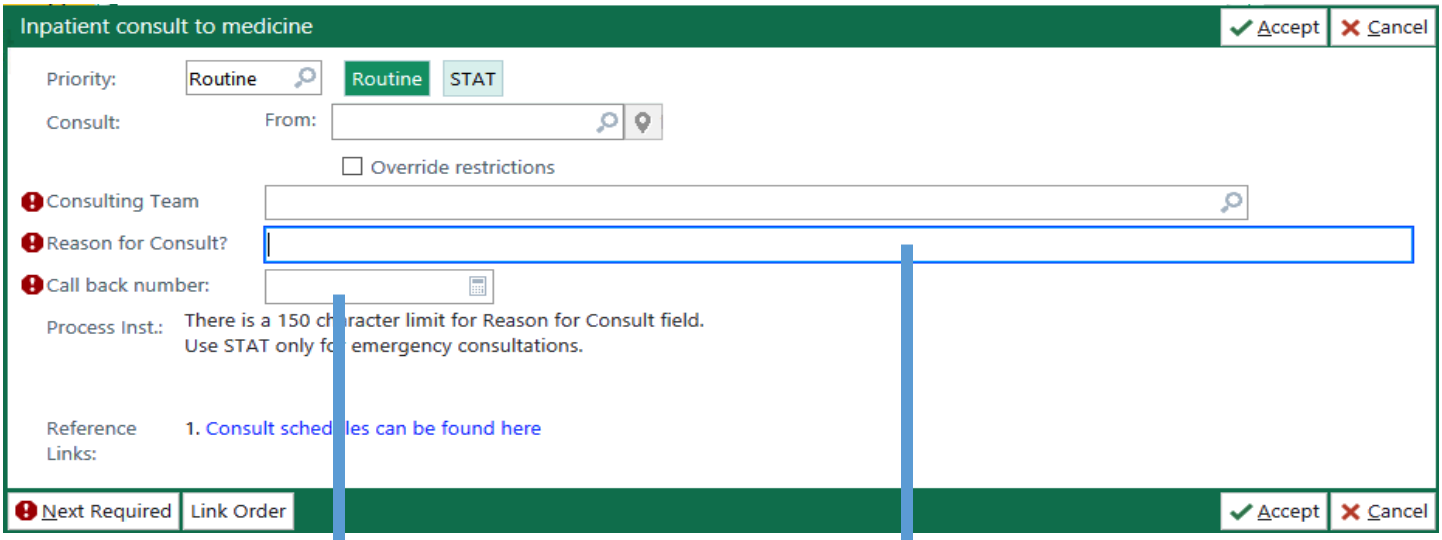
"Patient Class": This is a required field when creating a case request order. Field options are: inpatient, emergency, hospital outpatient surgery (C&G), and surgery admit (C&S); see below screen shot.

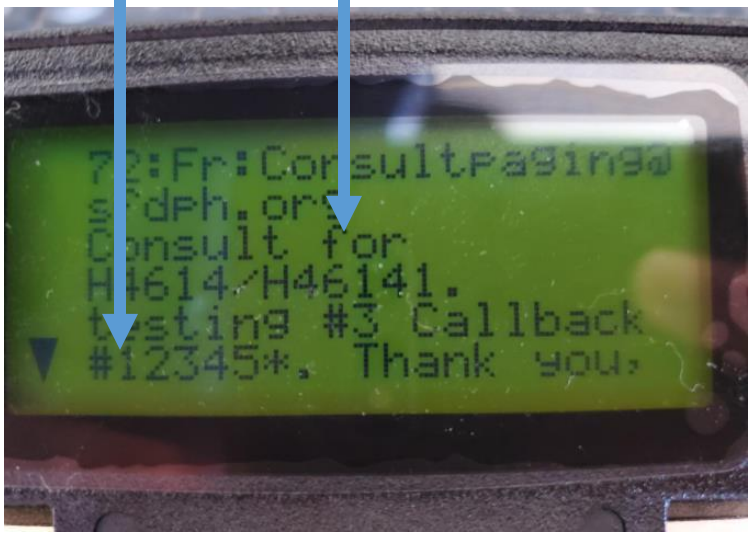
- "Inpatient" should be selected for patients who are admitted to an inpatient unit (wards/ICU) at the time of case request entry.
- "Emergency" should be selected for patients who are located in the emergency room at the time of care request entry.
- "Hospital Outpatient Surgery (C&G)" should be selected for outpatient procedures who will be discharged post-procedure.
- "Surgery Admit (C&S)" should be selected for patients who will be admitted to the hospital post- procedure.

"Case Classification": This field is required when providers complete a case request order. Selection should be made based on medical evaluation of procedure urgency. Field options include A through F with descriptions for urgency; see below screen shot.



INPATIENT CONSULT ORDER IN EPIC REQUESTS:





The text page is delivered to the service pager.
The text page will contain

-> Priority of the consult (if STAT),
-> Patient location (automatically pulled from Epic),
-> Reason for the consult, and the
-> Call back phone number.
-> The order will place the patient onto the consultant's Epic patient list.

If you notice any errors, identify outdated processes, or would like information added to this guide, please contact the following people:

- ***Dr. Ronald Tesoriero, ZSFG Surgery Residency Site Director (Ronald.Tesoriero@ucsf.edu)***
- ***Vagn Petersen, NP, Lean Nurse Practitioner – Surgery Services (Vagn.Petersen@sfdph.org)***
- ***Eric Henderson, ZSFG Surgery Medical Education Coordinator (Eric.Henderson@ucsf.edu)***