

General Surgery

Guidelines for The Queen's Medical Center General Surgery Rotation (Formulated by a previous Chief Surgical Resident; revised 6/28/07)

AM Rounds

All Residents are expected to pre-round on their patients prior to meeting in the SICU (Tower 4C) for morning rounds with the General Surgery Team.

For post-call Residents, if it is anticipated that work duties will interfere with completing am pre-rounding (i.e. admissions, assisting in OR, exceptional circumstances on the wards), it is expected that fellow Residents be contacted at a reasonable time (1 hour before am Team rounds) to assist in ensuring all patients are seen.

Never be late for am rounds. Being late prevents the Service as a whole from functioning efficiently and effectively.

For patients with scheduled am x-rays (all thoracic patients usually have CXRs taken by 5 am), films should be reviewed before rounds, if available.

It is expected that all Team members be present for the entire duration of morning rounds so that everyone is familiar with the on-going management issues of all patients on the General Surgery Team Care Service. This is the only time that the full Team formally meets and systematically reviews all patients on the Service.

Breakfast during am rounds is optional, and is dependent on the efficiency of the Team to complete a comprehensive review of all patients on the Service.

Pre-Rounds

It is expected that a progress note be written in every patient chart prior to am Team rounds. Only the Chief Surgical Resident will determine exceptions to this rule.

The progress note should be a documentation of the patient's input, objective data, an assessment (problem list), and a treatment plan, i.e. "SOAP" note. As an example:

- S:** Issues over the last 24hrs. GI: nausea/vomiting, bowel movement, flatus, diet; CV: chest pain, palpitations, shortness of breath, wheezing; Pain: adequate analgesia; Activity: chair, ambulation, endurance PT/OT; D/C planning
- O:** Vitals, 24hr I/O's, 24hr & 8hr urinary output, type of IV fluids/rate, IV site/peripheral/central, #days of line, TPN, Tube feeds, 24hr nasogastric tube drainage, drains, chest tube output – air leak, ostomy function; level of

consciousness (A&O x3); heart (rhythm, murmurs), lungs (breath sounds, Incentive Spirometry, air leak in chest tube, **water seal vs suction, O2/vent, CXR**); abdomen (girth, palpation, bowel sounds, **drains (JP/NG/Penrose), location and age of drains, feeding tube, wound**); extremities (venodynes, tactile temperature, pulses, edema) *usually for vascular patients*; wounds (**check after 48hrs post op**, 5 days if vascular wound, do dressing changes for open wounds, wound VAC can be seen later in the day if it is scheduled for change). **You should document everything attached to the patient starting from the toes up to the head.**

A: There should be a problem list of ongoing care issues: S/P procedure POD#, ileus, DM, HTN, asthma, fever, nutritional status, physical deconditioning, etc.

P: Actions to be taken to rectify the listed problems.

Medical Student notes are for educational purposes only. Please try to make an effort in reviewing their notes and provide feedback. Co-sign the note if it is reviewed. Co-signing does not excuse a Resident from entering an individual progress note.

Care of the Patient

Residents should be proactive in the care of patients. If the Resident is unsure in taking the initiative in implementing a treatment plan/decision, discuss this with the Chief Surgical Resident first.

Time permitting, any patient care issues discussed during am Team rounds should be taken care of immediately after am rounds.

Patients are to be seen later in the day to evaluate the progress of the patient, re-assess any changes in care, review notes from Attendings, consults, or ancillary services.

A formal signing out round will be done in the afternoon. This allows the on-call person to obtain relevant data for all the patients so as to make the right decisions over night.

If it is anticipated that the patient will be discharged soon, fill out the discharge order form, but do not place a date. This allows the Attending the flexibility to delay discharge if warranted.

Reviewing pathology, prognosis, and/or treatment decisions discussed with the patient and family should be reserved for the Attending, Chief Surgical Resident (PGY-5) or Senior Surgical Resident (PGY-4).

Update the patient list before going home.

SICU Patients

The SICU Team will provide a more comprehensive note on the management of ICU patients. However, this does not excuse Residents from writing am progress notes. A brief systems based note highlighting ongoing treatment issues is acceptable. Being informed of each SICU patient's hospital course is essential.

Operating Room

Residents will be assigned Operating Room cases by the Chief Surgical Resident. Assignments are usually made the evening prior. Due to scheduling changes/conflicts or unforeseen events, last minute changes may be made by the Chief Surgical Resident.

It is the responsibility of the individual Resident to know his/her assignment for the day by checking the printed schedule at the Operating Room front desk and/or assignment board before am Team rounds.

Residents should pre-op patients prior to Operating Room encounters. This visit should include a brief review of the chart, a brief conversation with the patient including introduction, review of the disease process, indications for surgery, past medical history. A brief note should be placed in the chart.

It is the responsibility of the Resident to read ahead of time: the nature of the disease, treatment options, operative procedure, and relevant basic science.

If, for any reason, it is anticipated that the Resident will not be on time for the operative procedure, it is the responsibility of the individual to notify the Chief Surgical Resident and the Surgical Team (usually the circulating RN) that he/she is going to be late. This will allow time to find another Resident or Surgical Assistant to assist.

A written operative note is the responsibility of the Resident. Inquire with the Attending Surgeon at the end of surgery, who will dictate the operative note. Discuss during or after the case, the post-operative management of the patient, i.e. duration of npo status, drain management, wound care, consults, etc.

Post-op orders are the responsibility of the Resident.

Be available to check CXRs for central line placement/chest tubes as indicated.

Update the master list ASAP with the post op admissions.

Admissions

Admissions supercede other daily duties, except for mandatory educational conferences. For any scheduling conflicts (especially assigned Operating Room cases), please contact the Chief Surgical Resident immediately.

Patients should be seen and relevant data reviewed within 30 minutes.

Call the Attending Surgeon and be prepared to present the patient and offer a therapeutic plan.

Notify the Chief Surgical Resident or the Senior Resident on-call if patient management requires operative intervention.

Add new admissions to chief res carelink list as well as main list ASAP.

Morbidity & Mortality

All complications should be listed at the bottom of the patient list and the Chief Surgical Resident appropriately informed.

Kam Auditorium Conferences (Tue 1630-1730)

Mandatory. No exceptions. All Residents are required to be present, unless post-call. If in the Operating Room, Residents must scrub out to attend this conference. If on-call and admitting a patient, call to notify the Chief Surgical Resident immediately.

For the Morbidity & Mortality Conference, Residents will be required to present patients at the discretion of the Chief Surgical Resident.

It is important to discuss the M&M cases before presentation. We want to be well prepared to tackle all the issues before presentation.

Sign in sheets at the conference will be used for tracking attendance.

Ward Rounds (Wed 1130-1200)

Informal meeting in the Radiology Department with Dr. Halford.
Be prepared to present any patient on the Team Care list.

The objective of this encounter is for Residents to practice presenting patients, discuss nature of disease, work up, and management.

Tumor Board (Wed 1200-1300)

Mandatory.

May be required to present. Assignments will be made by the Chief Surgical Resident one week prior.

If presenting:

1. Required to present a relevant article. Find relevant articles the Friday prior and review with the Chief Surgical Resident.

2. Organize a PowerPoint presentation including a brief H&P and summary of Articles.
3. Review presentation with the Chief Surgical Resident prior to presentation.

Queen Emma Clinic (Wed & Fri 1330-1530)

All Residents are required to be present for this Clinic. The only exception is if a Resident is post-call. For any other reason, you must contact the Chief Surgical Resident.

Queen Emma Clinic responsibilities will be reviewed either by the Chief Surgical Resident or by the Resident assigned to that rotation.

Remember, clinic is not scut work. You should learn from it.

On-Call

Residents must obtain verbal sign out for all patients. Written sign out of patients as the only form of communication is unacceptable.

Call is not to exceed 24 hrs (30hrs if the last 6 hrs is dedicated to patient care transfers and continuity of care or educational conferences). There can be no accepting of any new patients during this 6 hr time period. If anticipated to exceed 30hrs, notify Chief Surgical Resident immediately.

No changes in the on-call schedule is allowed once it is finalized and distributed.

Days Off

Residents are given one day off each week. Residents may not have two consecutive days off (combining the last day of one week with the first day of the following week).

It is the responsibility of all Residents to divide up patients to be seen by other Team members when the Resident will be off the following day. The Chief Surgical Resident takes part in this process.