OLIVE VIEW-UCLA MEDICAL CENTER

General Medicine Ward Orientation

GOALS

The General Medicine Ward rotation is the core inpatient experience for the Olive View Program and rotators to Olive View. As interns and residents, you are integral members of the teaching medical team with the goals to provide excellent patient care to county patients in a collaborative and educational environment.

Interns function as the primary providers for their patients, evaluating and managing medical disease, coordinating care of the patient with other healthcare providers, and educating patients. Residents have the added responsibility supervising the medical team and coordinating the transitions of care for their patients. All medical team members including medical students and attending physicians are responsible for promoting learning and teaching in an educational environment.

HIGHLIGHTS

- Use AMION.com for ward team assignment, call and day-off schedules, and text paging.

Call Cycle & Schedule

Long Call	Post-Long Call	Non-call	**Short Call**	Non-call	**Medium Call**	Non-call	Non-call

  - Long Call team: Admits 10 patients, 8am-10pm. Resident stays overnight to finish admissions and cross-cover.
  - Medium Call team: Admits 6 patients, 8am-4pm.
  - Short Call team: Admits 4 patients, 8am-12pm.
- Patients are cross-covered by the Night Float (NF) intern overnight.
- Sign-out about overnight events from NF starts at 6:30am (or earlier) in the Housestaff Lounge (2C-160).
- Sign-out to NF starts at 4:00pm in the NF intern call room.

STARTING THE ROTATION

- Find out what team you are on by going to www.amion.com (password: ov im). Search your schedule by clicking the schedule icon or advance through the "Who's on-call" schedule until you see yourself on call.
- Make sure to complete training for ORCHID PowerChart, the electronic health record for LA County DHS. Online training can be completed at www.oliveviewucla.org/orchidtraining/. You must complete PowerChart training a few days in advance of starting the rotation in order to obtain access by the time you start. No training means no access.
- Get sign-out the day prior from the outgoing intern/resident. For interns taking over post-Long Call teams, get sign-out on as many NEW patients as possible. You will receive the rest of the new patients in the morning.
- **For outside rotators or first-time ward interns:** On your first day, report to the Chief's Office (5D-103) for an inpatient orientation at 7:30 AM. You will be given a pager, a parking pass, and a parking hangtag. Do not forget to return all 3 on the last day of your rotation (either in the Chief's Office or in the Housestaff Lounge). If you lose or do not return it, you are responsible for the costs of replacement: pager $50, parking pass $10, parking hangtag $5). Remember to go to the cafeteria office (1C-115) to get a meal card.
- **For residents on call:** Start picking up patients by going to the ED OBS unit (2E-257) to get sign-out on overnight holdovers. Pick-up time depends on the call day.
- **For interns:** Pick up sign-out from the Night Float intern at 6:00-6:30 AM in the Resident Lounge 2C-160 (code 3-2-5).

HOSPITAL LAYOUT

- 4A/4D: Med/Surg wards
- 5A: Med/Surg + Hem/Onc wards
- 5C: Med/Surg + Telemetry wards
- 5D/4BN/4BS: Step Down units
- 5BN/5BS: ICU
- Call Rooms:
  - 5B Call Suite: code 3-2-5
  - Housestaff Lounge: 2C-160, code 3-2-5 (can leave personal items here)

WARD TEAMS

Team Structure

- There are 8 Medicine Ward teams. Each team is comprised of 1 attending, 1 resident, 2 interns, and additional rotators, including additional interns, sub-interns, and medical students.
- Each intern is responsible for the care of up to 10 patients ("hard cap") at a time, and up to 5 new admissions ("soft cap").
- Each resident is responsible for the care of up to 20 patients ("hard cap") at a time, and up to 10 new admissions.

Preferred Rounding Rooms

- The 8 Teams on Wards (A though H) will be divided into 4 pairs of "sister teams."
- Each pair of "sister teams" will be sharing a workroom and assignment of the workroom is arranged so that the pair "sister teams" will never be on call on the same day.
  - Teams A and B: 4D 107 Workroom
  - Teams C and D: 4D 127 Workroom
  - Teams E and F: 5C 106 Workroom
  - Teams G and H: 5D 107 Workroom

WARD SCHEDULE

General

- Ward teams admit patients on Long Call, Medium Call, and Short Call.
- The general daily routine consists of picking up sign-out from the Night Float cross-cover intern (7am), pre-rounding on patients (7am-9am), attending Morning Report (8:15am-8:45am), rounding with the attending (9am-11:30am), Noon Conference (12pm-1pm), patient care activities (afternoon), and sign-out to the Night Float intern.

Typical Daily Routine		**LONG CALL**	Post-Long Call	Non-call	**SHORT CALL**	Non-call	**MEDIUM CALL**	Non-call	Non-call
Sign-out from NF	*6:00am*								
	6:30am								
Pre-round		10 Admissions 8:00 am to 10:00 pm			4 (up to 6) Admissions 8:00 am to 12:00 pm		6 Admissions 8:00 am to 4:00 pm		
	8:15am								
Morning Report									
	8:45am								
Attending Rounds									
	12:00pm								
Noon Conference									
	1:00pm								
Patient Care and Education									
Sign-out to NF									

Long Call

- Each team will be on long-call every 8th day.
- For residents, Long Call starts at 8:00am and ends 12:00pm Noon the next day (24 hours + 4 hours). Residents pick up overnight admissions in the ED OBS Room (2E-257) at 8am.
- For interns, Long Call starts with sign-out at 6:30am and interns should leave no later than 10pm.
- Each Long Call team can admit up to 10 new patients provided that does not violate their "hard cap."
- ICU transfers will go to the Long Call team as a part of the 10 new patients.
- Each intern can admit up to 5 new patients (intern "soft cap").
- Interns cannot care for more than 10 patients at any given time (intern "hard cap").
- Teams can admit patients until 10pm.
- Interns should not admit new patients after 8pm
- If the team has not received at least 6 patients ("on the list") by 7pm the admission cap will decrease to a total of 8.
- The intern History and Physical document needs to be completed and signed within 24 hours of a patient being admitted. It can be completed on the post-call day.
- The resident will complete admissions on all new patients that the interns have not had a chance to evaluate before the interns leave for the night (this includes admission orders and H&P).
- The resident will be responsible for cross-coverage on their team's patients overnight on Long Call nights. The interns will be responsible for providing the resident with a thorough and complete sign-out before they leave.
- Interns return on their post Long Call day at 8am, at which point they will get sign-out on old and new patients from their resident. They should see their patients before rounds begin.
- Interns will stay to complete their work under the supervision of the attending after the resident leaves at 12:00pm noon on the post-Long Call day.
- On post call days, interns will be responsible for writing progress notes on all old and new patients.
- Interns' H&P if written on a post call day also counts as that day's note, but should reflect changes in management from that day.

Medium Call

- Teams will admit a total of 6 patients.
- For interns, medium call starts with sign-out at 6:30am and ends no later than 10pm.
- Resident pick up overnight admissions in the ED OBS Room (2E-257) at 7:30am, and their day should end no later than 10 PM.
- The time cap for admissions to the Medium Call team is 4pm.
- In most situations, each intern on Medium Call will admit up to 3 new patients.
- Intern H&P's should be signed before sign-out.

Short Call

- Teams will admit a total of 4 patients, which can flex to 6 patients if the hospital is in overflow.
- For interns, short call starts with sign-out at 6:30am and ends no later than 7pm.
- Resident pick up overnight admissions in the ED OBS Room (2E-257) at 7:30am, and their day should end no later than 10pm.
- The time cap for admissions to the Short Call team is 12pm ("on the list").
- In most situations, each intern on Short Call will admit up to 2 new patients.
- Intern H&P's should be signed before sign-out.

Non-call day

- Sign-out is from 6-6:30am in the Resident Lounge 2C-160 (code 325).
- Pre-round and discuss patients with your resident prior to morning report at 8:15am.
- Attendings are expected to conduct bedside rounds with the team from 9am to 11:30am. If attendings are not performing bedside rounds or if rounds go beyond 12pm consistently, please let your chief residents know.

Days Off

- Every intern and resident will get 4 days off averaged over 4 weeks.
- On intern days off, the resident and attending are responsible for daily progress notes and follow up of all of the team's patients.
- MS3's have days off with the resident (MS3's cannot be off on Mon/Wed/Fri)
- MS4's take days off with interns, not the same day as the resident.

SIGN-OUT

- 2 Night Float interns will be responsible for cross-cover overnight of patients on the General Medicine and Hem/Onc wards (except for patients on the Long Call teams). Hospitalist/Observation patients will be covered by the Night Float residents.
- Sign-out consists of the electronic, written handoff PLUS direct verbal sign-out.
- Electronic sign-out is accessed from the "Physician Handoff" in ORCHID and makes use of the IPASS model. To print, select print from the top-right menu and select the "detailed" printout option.
- Verbal sign-out will occur in the following night float intern call rooms (5B call suite, code 3-2-5):

How to Sign Out:

- Review sign-out with your attending. The in-hospital Hospitalist attending is available for back-up until midnight.
- Interns on regular working days, Short Call, or Medium Call can sign out to the Night Float intern after their arrival at 4pm.
- On weekends and holidays, interns can drop off their patient list in the respective Night Float intern call rooms at 12pm. The intern leaving the hospital will remain on pager until telephone sign-out to the Night Float intern after 4pm. The long call intern can be called with any urgent patient issues but there should be no items "to do" prior to night float sign-out, and if any acute issues arise prior to 4pm sign-out the intern/resident should return to the hospital to manage the patient.
- Long-call interns do not sign out to the Night Float interns. Their patients are cared for by their Long-call resident.
- To retrieve sign-out on patients managed overnight by the Night Float interns, go to the Resident Lounge (2C-160) from 6-6:30am. Night Float interns leave promptly at 7:00am. Interns may page Night Float directly if they arrive early.

ADMISSIONS, TRANSFERS, AND DISCHARGES

About Admissions to the Medicine Service

- Admissions are first called to the Medicine On-Call hospitalist attending and tracked on an admission list. Time of admission is, when a request for admission is ordered by the ER.
- On the morning of call days, the admitting team resident is expected to pick-up new admissions from overnight by coming to the Observation Unit in the Emergency Department. The accepting resident will receive sign-out of patients from the overnight resident.
- During the call day, the admitting team resident will be paged about admissions. The resident should receive verbal sign-out from the admitting provider to accept the patient.
- The admitting team should evaluate the patient in the ER or clinic, place orders electronically in ORCHID, and document a History & Physical. These patients must be placed on the intern's sign-out.

Admissions FROM THE EMERGENCY DEPARTMENT

- Most patients are admitted from the ED, located on the 2nd Floor.
- The medicine team is responsible for care of the patient as soon as the accepting resident receives verbal sign-out from the ED, even if the patient is boarding (i.e. still located) in the ED. Patients admitted from the ER will be converted to "ED Boarder" status in ORCHID, after which the ER bed functions as a ward bed and Internal Medicine becomes the primary service.
- Admission orders should be signed within 2 hours. Prior ED orders must be reconciled.

Direct Admissions FROM URGENT CARE OR CLINIC

- Some patients are admitted from outpatient clinics, Urgent Care, or outpatient procedures, which are located on the 2nd Floor. Their evaluation may start in clinic.
- These patients should have a new inpatient FIN (or encounter) generated for the admission. Admission orders must be signed and "initiated" under the new FIN in ORCHID once the patient is in an inpatient care area. The H&P must also be started and signed under the new FIN.

Transfers FROM THE ICU

- The ICU team continues all clinical responsibility for a patient while in the unit or on the medicine floor until completion of a formal sign-out with the accepting medicine team. This includes all written orders and documentation.
- The ICU resident will give a direct sign-out to the admitting resident. The ICU team will also sign a Transfer Summary that details the patient's clinical course.
- Ward interns are responsible for writing an "accept note" (use the "Internal Med Inpt Progress Note" note type) and adding that patient to their sign-out. Don't forget to review and reconcile all transfer orders and medications (written by the ICU) as part of the initial evaluation.
- ICU transfers are treated like new admission and must worked-up as such.
- ICU transfers count towards the admission cap on call days.

Transfers TO THE ICU

- If a patient requires acute critical management you must call a "Rapid Response" or "Code Blue." Do not page the resident as this will delay needed treatment.
- Please note that the ICU team is not a consultant. The determination of whether the patient needs a higher level of care is determined by the ward team.
- All transfers to the ICU must be accompanied by a Transfer Summary from the ward team. The intern is responsible for this document unless he/she is off.
- The ICU team is expected write transfer orders and reconcile all prior active orders.
- If a ward patient is transferred to the ICU, that patient will be transferred back to the same intern if within 14 days. This does count as a "bounceback" (Please see bouncebacks below).

Bouncebacks

- A bounceback is defined as a readmission to a medicine INTERN that is still on service within 14 days of discharge.
- Bouncebacks are accepted by the primary team:
  - On a non-call day
  - On a call day, in which case the bounceback counts toward the admission cap;
  - On the post-Long Call day only if there were less than 10 patients during the Long Call and the total number of admissions to the resident does not exceed 10;
  - On a resident's day off
  - On an intern's day off, except on the intern's last day of the rotation.
- Bouncebacks go to the primary team on the same day if called to the list before 2:30pm Mon-Fri and before 12:00pm on Sat/Sun/holidays. If the intern/resident has left the hospital, then the patient will be held over by Night Float and admitted to the team the following morning.
- All bouncebacks must be staffed with an attending within 24 hours of admission.
- Hem/Onc patients who get re-admitted for scheduled chemo do not bounce back. Those admitted for other reasons/complications do.

Discharge Planning

- Patients being discharged needing outpatient follow-up fall under these categories:
  - **Has insurance and empaneled with outside primary care physician (PCP):** All follow-up should be arranged with the outside (PCP), including subspecialty follow-up.
  - **Has DHS insurance and empaneled at a DHS site (e.g., OVMC, MVHC, SFHC):** Follow-up may be arranged by calling these individual clinics.
  - **Has no insurance:** Temporary follow-up for active medical issues requiring a **face-to-face visit** (e.g., new dx of DM, complete resolution of infection, etc.) can be arranged with CCC (Continuity Care clinics) located in Clinic A (x3126). Patients needing **non-face-to-face follow-up** such as lab follow-up may be referred to the nurse practitioners' office (5D104, x4568). Patients can go to the outpatient financial office on weekdays at 2D-141 (7AM-5PM) to explore insurance options.

- **Subspecialty follow-up:** If a patient has been evaluated by a subspecialty service during the admission and needs follow-up, that service will arrange follow-up. If the patient needs an initial subspecialty evaluation as an outpatient after discharge, this must be arranged by their primary care physician. If the patient does not have a primary care physician, you can arrange a CCC Clinic follow up for them (call Clinic A x3126) to have an eConsult submitted. eConsults generate by the inpatient primary team will not be accepted.
- There is a discharge planning team that will identify outpatient resources for the patient, including primary care and pharmacy. Please look under the "Discharge Planning" note for each of your patients on ORCHID for more information.

Discharges & Interfacility Transfers

- The decision to discharge a patient and the discharge plan should always be discussed with the attending.
- The discharge plan should always be discussed with patients.
- All hospital discharges require:
  - Discharge Instructions and educational materials for the patient
  - Appropriate prescriptions and medication reconciliation
  - Appropriate follow-up referral or appointments
  - Electronic discharge orders
  - Discharge Summary
- Transfers to other healthcare facilities (hospital, long-term acute care (LTAC), post-acute, SNF, etc.) additionally require the following:
  - a **VNA form** signed by a licensed physician prior to transfer
  - completion of the Discharge Summary prior to transfer
  - chart copy

Patients Leaving Against Medical Advice (AMA)

- Patients have the right to leave AMA if they have the capacity to make their own medical decisions (i.e. they know their diagnosis, prognosis, the benefits of staying in the hospital and the risks of leaving the hospital, alternatives to hospitalization)
- To care for patients wishing to leave AMA:
  - First, de-escalate the situation. Listen to the patient's concerns, explain why it would be dangerous to leave AMA. Assess for decision-making capacity. Discuss the situation with the attending.
  - If the patient has dispositional capacity and still insists on leaving, provide them with the necessary prescriptions and follow-up. Leaving AMA does not mean abandoning all medical care.
  - Have the patient sign the AMA form.
  - Document the incident thoroughly.
- If a patient becomes aggressive or threatening, call for a "Code Gold" (De-escalation team composed of inpatient psychiatric nursing staff and security).

MAC (Medical Alert Center) Transfers

- MAC is a Los Angeles County inpatient referral and transfer system, whereby patients are transferred out to other hospitals for services that are unavailable at Olive View such as neurosurgery, certain orthopedic cases, and certain cardiothoracic surgery cases (e.g. CABG).
- To initiate a MAC consultation/transfer:
  - Call MAC at 866-940-4401. MAC will ask you a few questions about the patient and initiate the process. Or, fill out the MAC paper work and fax to 562-906-4300.
  - MAC will contact other hospitals to identify an accepting physician and bed availability.
  - MAC may call/page you to discuss the case in real-time with a consulting provider. All communication with the outside provider or consultant should go through MAC. Communication is recorded and part of the medical record.
  - You may call MAC frequently to check on a patient's status.
- To complete a MAC transfer
  - Anticipate patient transfer once you have started the MAC paperwork.
  - You will need to complete a Transfer Summary, VNA form, discharge paperwork. Place all paperwork in the physical chart in case the patient is transferred when you are off.
  - You will need to request a chart copy. Use the "Medical Record Request" order from the Discharge order set.
  - If radiographic images are needed, you may request a CD with relevant radiology from the Radiology Film Library during business hours or from ED Radiology after hours.
  - Once a patient is accepted for transfer and transportation is arranged, place an order to discharge to another hospital.

- Patients requiring cardiac surgery that is recommended by the Cardiology consult service are usually coordinated by Cardiology (usually to LAC+USC or Harbor), but the ward team is still responsible for the Transfer summary, VNA form, and discharge orders.

PATIENT CARE

Calling Consultations

- Locate the consultant you want to reach on AMION.com under the "Fellows" Tab. If the particular service is not listed, please call the Operator (dial '0') and ask for the specific subspecialty fellow on call. Oftentimes, their pagers can be found on amion.com for text paging.
- Remember to be courteous, including leaving a return extension and allowing at least 5 minutes for the consultant to call you back.
- Always see your patient first and complete a full exam before calling a consult. Be ready to answer all questions.
- Please have a well-defined question for your consultants. For instance, you may call cardiology because your patient with a history coronary artery disease is having chest pain consistent with unstable angina and you want to know if they need a coronary angiogram. Do not call cardiology simply because your patient without any risk factors is having chest pain.
- Please give your consultants enough time to see your patients, so try requesting all new consultations before 1 PM.

Medical & Psychiatric Holds

- Medical Hold = Patient is delirious (e.g. pulling at IVs, not oriented). Any physician can initiate, renew, and discontinue a medical hold. This is the "non-violent" restrain in ORCHID. The medical hold lasts up to 24 hours and includes soft restraints. The necessity for medical restraints must be re-evaluated with a face-to-face visit and renewed every 24 hours.
- 5150 Hold = Patient is suicidal, homicidal, of gravely disabled (unable to take care of self). This hold can only be initiated and discontinued by Psychiatry and lasts up to 72 hours.
- To get a hold of psychiatry from 8:00 AM to 4:00 PM Mon-Fri: Call or page the Psych Consult Liaison (C&L) x74024. After hours and on weekends: Psych ER: (x74341 & x74340).
- If a patient becomes aggressive or threatening, call for a "Code Gold" (de-escalation team composed of inpatient psychiatric nursing staff and security).

Code/Rapid Response and Code Status

- CODE BLUE or the RAPID RESPONSE TEAM are announced by the Operator. Long Call ward teams and ICU teams are the Code Blue responders.
- If a patient looks bad, *DO NOT HESITATE TO CALL THE RAPID RESPONSE TEAM (RRT)* at x113. The team includes an ICU nurse, a respiratory therapist, and ICU team. They have antibiotics, fluids, can start lines, etc.
- Only residents (not interns) may write a DNR/DNI order. Resident orders must be co-signed by an attending within 24 hours or the order is invalid. Attending orders last for the duration of the admission.
- Always document goals of care discussions in ORCHID, even if the decision is full code. Make sure to update the code status on the intern sign-out.
- The code status obtained during the hospitalization is only relevant during the hospitalization and does not necessarily hold true for the next hospitalization unless the patient has signed a POLST. Please make sure to discuss code status with every patient admitted to your service.
- Upon discharge, a POLST form should be completed in an effort to document goals of care. The pink original goes to the patient and a copy given to the unit clerk to send to HIM for scanning into ORCHID.

Death in the Hospital

- Deaths in the hospital are not uncommon but neither easy to grapple. Housestaff are encouraged to discuss the experience of caring for a patient who has died with the team and/or chief residents.
- Death should be pronounced by a provider on the primary team or cross-covering intern.
- All in-hospital deaths require a "Death Summary" written by the primary team. If a death is pronounced by a cross-covering housestaff, he/she may write a brief "Death Note" to document the circumstances and death exam.

Pharmacy

- Inpatient Pharmacy Hours: 24/7
- Outpatient Pharmacy Hours: Mon-Fri 8:30 AM - 6:00 PM, Sat 8:30 AM - 4:30 PM
- Check the DHS Pharmaceutical Formulary (on OVMC Intranet home page) for current guidelines and restrictions at DHS.

Multidisciplinary Care

- Collaboration with additional health services and coordinating care is essential for providing excellent care to patients.

- Attend Collaborative Care Rounds (CCR to coordinate disposition and discharge with a multidisciplinary team. Details should be discussed with your team and Chief Residents.
- Ancillary services include:
  - Clinical Social Work
  - Physical, Occupational, and Speech Therapy
  - Wound Care
  - Dietician
  - Pastoral Care
  - Utilization Management (UM)
  - Patient Financial Services (PFS)

Electronic Systems

- **ORCHID:** LA County DHS uses ORCHID, a Cerner EHR. Use this system for patient data, writing notes, orders, and electronic prescriptions.
- **Clinical Workstation (CWS):** We formerly used Clinical Workstation until 10/31/2015 for documentation and labs/studies. You may need to access this system to review previous notes and results.
- **Synapse:** Our PACS system is Synapse. You may access this as a stand-alone application from your desktop or launch it from ORCHID.
- **Housestaff Website:** Please visit www.oliveviewim.org for educational materials and additional resources including procedure smartphrase templates.
- **Help Desk:** For IT or EHR questions, you can call extension x74522 or (323) 409-8000 to reach the DHS Enterprise Help Desk.
- **E-mail:** Everyone is expected to use their @dhs.lacounty.gov emails

EDUCATION

Morning Report

- Morning Report takes place at 8:15 AM on Mondays, Tuesday, and Fridays, often in the Conference Dining Room in the Cafeteria.
- Morning Reports will be presented by interns and residents from ward and consultation rotations. The Chief Residents will schedule the hosuestaff and post it on AMION.
- Attendance is expected every day expect when post-Long Call or off.

Noon Conference

- Noon Conference takes place from 12:00 to 1:00 PM on weekdays, usually in the Main Auditorium on the First Floor.
- Attendance is mandatory unless you are on a day off.

Medical Students

- **MS3's:** Interns are responsible for teaching and overseeing MS3's. This means reviewing notes, plans, and all orders.
- **MS4's:** MS4's are sub-interns and should be treated similarly to interns. They operate under the supervision of the residents.
- Remember that you are a teacher. DO NOT give your medical students scut work.

Other Rotators

- **International Medical Graduates (IMG's):** Function as MS3. Can interview, examine, assist in writing orders and notes. Cannot do invasive physical exam (like breast and rectal) or procedures. They are expected to follow and present patients.
- **Japanese rotators:** Shadowing experience only. Should not examine, write notes, etc. They do not work on weekends.

DOCUMENTATION

- All documentation should be done electronically in ORCHID.

History & Physical

- The intern or sub-intern must complete and sign the H&P for each patient within 24 hours of admission. The resident does not need to write a resident admission note.
- In ORCHID: Use the "History and Physical" note type.

Daily Progress Notes

- In ORCHID: You must document Required Provider Note Details first. Then use the "Internal Med Inpt Progress Note" note type.

Discharge / Transfer / Death Summaries

- The Summary is required for any discharges from the hospital (including discharge against medical advice), transfer to another facility (including MAC transfer or to the Psychiatric Ward), or death in the hospital.
- All summaries must include:
  - Admission date
  - Discharge/Transfer date
  - All diagnoses and invasive procedures
  - Summary of hospital course
  - Discharge medications and follow-up plans
- In ORCHID: Use the "Discharge Summary," "Transfer Summary," or "Death Summary" note type.
- Discharge Summaries must be completed within 48 hours, and preferably within 24 hours.
- Residents are expected to complete the Summary except when the patient is discharged while the resident was off.
- The signed Discharge Summary may count as the daily note (must include physical exam).
- All notes should end with "Discussed with Attending Dr. [name]" and be forwarded to the attending for co-signature.
- Leaving the medical record incomplete is a mark of unprofessionalism. If documentation is incomplete, housestaff will be called to complete the medical record. After the rotation, outside rotations will be called to return to complete the medical record, and deficiencies can result in "no credit" for the rotation along with a formal letter to the home institution and program director.

PROFESSIONALISM

Illness

- Please notify the Chief Resident on call (can be found on AMION.com) if you are ill or have an emergency preventing you from coming to work.

Deficiencies

- Occasionally you will be called by Medical Records (a "query") with a question regarding the medical record of a patient you cared for. This information is vital for hospital funding. If a query is not answered in 7 days a letter of unprofessionalism may be placed in your file.

Evaluations

- You must complete evaluations of your medical students, interns, residents, and attendings in a timely manner. This is done through MedHub.
- For rotators, there is a separate MedHub account for Olive View. Please contact Gus Chavez (gchavez@dhs.lacounty.gov) for access.

Work Hour Documentation

- Please complete your work hour documentation on MedHub. For rotators, you will need to complete this on your own program's site.