# Anesthesiology Intern Survival Guide

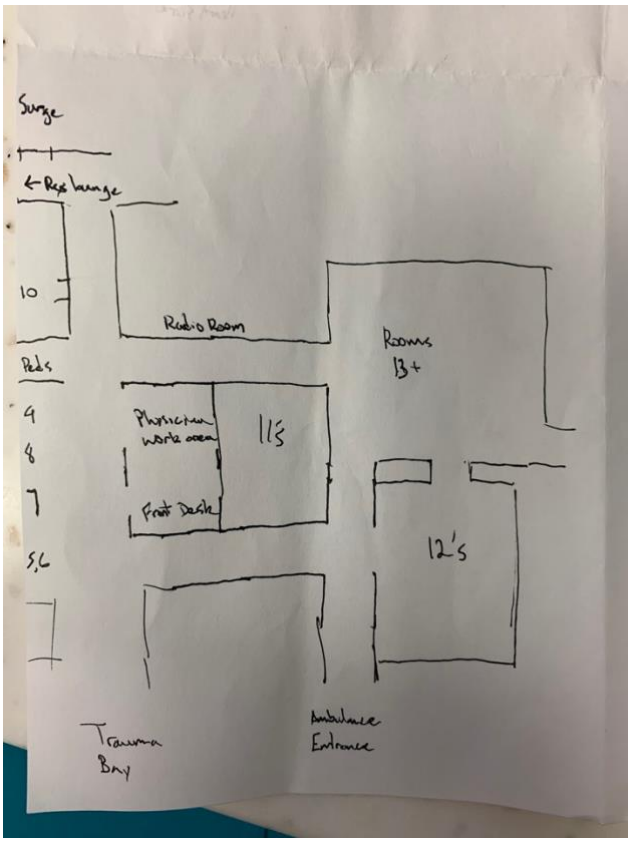
**Emergency Medicine**

The orientation website is super helpful for most of what you need to know
Emergency room is on A level.

On your first day go to the physician work area right by the front desk and rooms 5-9
Introduce yourself to the seniors. They are great resources for putting in orders and questions about patient treatment. All super nice

See any patients that are on the board and in red color. See the dark blue patients if they have been waiting 30+ minutes or if it's after 2 am (these patients are usually seen by mid-levels)
Rooms: P-X is adults in the peds area. SH-X is surge area (across the hall from the ED).
Assign the patient to you, review their chart, go see them, staff with the attending for plan, put in orders. Some attendings will put in orders during the presentation.
The techs (in grey) are good resources for finding equipment or rooms.
If you need to do a procedure let the nurse know. Most of them are really good about getting you the supplies you need.

Consults: always put in the order for consult on epic. For MOD consults you do not need to call them. FOR ALL OTHER CONSULTS have the front desk page them for you. Tell them you have a consult for them, give them the MRN, then the story.
Sign out: ask the senior that you are signing out to how to do it, they'll show you.
Sepsis protocol: there is an order set. Also notify the front desk when you use it.



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**NMCCS**
Workroom 8700H, Go Left from the elevators straight through the unit 8200 down the hall by the dialysis center. Door on the Right.

Scrubs every day. Unless you want to wear business casual, your choice. Attendings all wore scrubs.

Sign out is at 6am every day, no need to show up any earlier than that. You will be assigned patients on a white board in the office. Short call 6am-2pm, long call 6am-6pm. They added a swing shift since there will be so many people for August 2pm-10pm. Otherwise I was never assigned night call (you would be alone so I doubt that will ever be assigned for us interns) There will be a fellow for August as well as at least 1 NP every day. Rounds begin anywhere between 9:30-11am depending on the Attending.

I worked with Dr. Guth, Dr. Hou, and Dr. McCluskey. Hou and McCluskey are both anesthesiology trained. Guth is neuro trained. Guth is more laid back with rounds and for the most part just told me what orders to change/add. Hou and McCluskey like full presentations. Before rounds the NPs and sometimes attendings will ask about plan for SIBR (multidisciplinary rounds with the nursing staff, PT, pharmacy, and social work Monday-Friday) They started having us pre-write the SIBR notes and pend/share them so they can take it over during SIBR. Basically it's why are they still requiring ICU care and what is the plan for today and the NPs will ask you for that before rounds (totally okay if you have no idea why/ whats going on, the first week I had no clue and no one cared).

**PSH**
Dr. Stier 909-844-2116
Dr. Chang 951-347-5934
Dr. Tone 949-306-7926
Dr. Pasca?

Dr. Gary Stier is the head of PSH, but you may also work with Dr. Chang, Tone or Pasca. Be flexible during this rotation because every day is a little different. Also note it may change as the year progresses. Right now we are still being consulted on urology (which will remain) and neurosurgery (which may change to vascular and/or ortho at some point).
Usually plan to meet at 8:30 am at Surgical Home off Barton across the street from Barton Vinyards Apartments. Just get the attendings contact and be in touch each morning about what time to meet in case things change or there are no patients. You and attending will round with the Urology NP (Janelle) on patients that may be medically complex or just needing a little tune up before discharge. After rounds you decide who to write notes on of the patients you rounded on. Then you may or may not get a neurosurgery consult at the MC, so you can head over there after you are done at SH. Sometimes the consults come in later in the afternoon...but sometimes they don't at all. Usually our cut off is at 5pm-ish, but you could be done as early as you finish rounding and writing notes on your urology patients. Lately, we've also been seeing patients at East campus too.

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When you sign on to epic sign in under "Pb Surgical Home" department. These notes are consult notes and there are dot phrases on epic. They start with psh, and some say "pshinitial/pshnote" but try them out and see which one you like or ask the attending. You can organize how you want, but typically the note has a brief HPI at the top. Followed by important chart review or interval history. Then you jump to your assessment and recommendations section this way the surgery team consulting us sees the recs near the top. The attendings are super helpful and will often walk through all the recommendations with you.

**Pain**
Chronic pain clinic. It's at East campus in one of outpatient buildings. Attending are anesthesia or PM&R trained. Can do some in clinic procedures like trigger point injections or steroid injections. Can also go to surgical hospital some afternoons to do procedures with fluro. Document the new chronic pain consults in ACGME case log-> group-> pain consult
**ACS**

**MOD LLU**
Schedules are at lluimresidency.com. Under the "resources database" tab there are helpful links for the most common medical issues you're going to see (click on the MOD one). These are super helpful!! They have 15-minute mini lectures that cover these topics on your inpatient week, but you can't always make it.
The first and third Tuesday of the month are intern academic half-day. These are for medicine interns, so as anesthesia interns you don't need to go to these if you have something better to do.

Inpatient week (Monday-Sunday):
Go to the resident lounge on A level to get sign-out from night float in the morning (nice to get there around 6:45 or earlier). Use. MODHP and. MODPROG for note templates (grab these from someone who already did medicine or Jasmine Bains (MOD chief). It's fine to use copy forward for patients who already have a progress note.
Teams typically consist of an attending to one senior resident and one intern. Patient cap is 14 (plus two attending-only patients). The general goal is for the intern to carry 8 patients so the senior can do more supervising/teaching. At LLU admissions come by a drip system, so discharging a bunch of patients on one day means you'll be admitting a bunch the following day. Rounds generally start at 9:00. Attendings and/or seniors break off for Case Manager rounds st 10:30 to discuss dispo issues. Rounds break again at 12:00 on weekdays for required noon conference. You're technically supposed to forward pages to your attending during noon conference.

Use smart web to find specialty services to page.
See the list of useful contacts below for phone numbers/pagers of frequently contacted services.

Outpatient week:
Monday's are off, clinic is Tuesday-Thursday or Friday. Night float is 7-7 Friday or Saturday of your outpatient week. Be sure to check the SACHS schedule to know where to be for your outpatient week. You usually only have a half day of clinic each day. Most clinics have multiple residents so it's not uncommon to only see 2 patients for the day. All subspecialty clinics are on the second floor of the Sachs building (250 G street in San Bernadino). Just have the front desk

staff buzz you in from the waiting area on the second floor. Most clinic schedules are found under SAC SBC INTERNAL MEDICINE, but a few (like cardiology) have their own context in epic (SAC SBC "specialty name"). Talk to your attending/senior resident to know which note template to use for that particular day.

**MOD VA**

There is no outpatient week inpatient week like LLU. It's all inpatient. Each team is one senior and two interns. On call every 4th day. Only admit on call day so when you discharge patients there's aren't new ones the next day. Can admit up to 10 new patients throughout the 24 hour call. The senior does the full 24 hours while one intern works the day and the other overnight. VA charting is it's own system to get used to.

**Night float**

Work Sunday-Thursday night from 7pm to 7am. They are changing it to add a Senior for 2021 but used to be just two interns and an attending. One intern would admit 5 patients. The other intern did cross cover of the 45 MOD patients and up to 3 admissions ( depending on the attending sometimes cross cover didn't do any admits).

**CCU**

- Unfortunately, this is very service heavy rotation, interesting patients, great learning opportunities but the teaching is rather lacking. Cardiologists they only care about the heart, non-heart problems you do bring them up but mostly will be up to you and the senior to manage them
- When you are on day: Short call 6am to whenever you are done with round, orders, consults, notes and floor stuff you can sign out to the other team intern and go home. However, you are still responsible for the pages you get so try to tuck them in well to minimize these pages.
- On day, 1 short call, 1 long call (6am-7pm when the night intern gets in), 1 short call then day off. The cycle repeats. Long call carries the intern code blue pager during the day
- Night:
    - You come in at 645pm, get sign out from both team- get the general story of why they are here, if they are on any drips, what the team did for them during the day, plan for tomorrow, what to look out for, stable/unstable?- hypotension, hypertension, afib RVR, VT/VF, evening labs to follow, transfusion etc. Ask and press the day team to tell you their contingency plans if they anticipate anything happening overnight to their patients (e.g. if they go back into Afib with RVR what you want me to do?). It's their job to anticipate these things and check with their attending, attendings sometimes want specific things done for their patients too. If patient sounds sick, don't take 'nothing to do overnight,' you will get burned. Know which one is DNR\DNI. Know the sick ones on each team to keep an eye out for. Your role as a night intern is to put out fires not to make drastic changes to their management. Anything you can safely defer to the day team, defer away. Get the fellow number, make sure to ask if it's ok for the intern to text the fellow for issues (most are cool, just a few that are iffy), go through your senior first. If family asking

for update, you can tell them how they are doing right now but overall management, defer to the day team
    - If they anticipate transfusion, make sure to get consent.
    - Most of the time, you are the only one on the floor at night. The senior will be busy doing admissions
    - 7ish-8pm: come to the unit secretary 7200, 7300 ask them to give you the list of any telemetry order that needs renewal, any restraint renewal. Do them early to cut down the late-night pages later. Skim through everyone's lab, replete them so you won't get 'Doc, K is 3.8, you want to cover?' pages at 3 am.
    - Pick the call room on the right, the light switch is inside the room. The left room is bigger, but the switch is outside.
    - In the morning, when the day teams come in, sign out to them and go home. It's also a nice gesture if you could get all the teles for all the patients on the list: what's their current rhythm, anything bizzare happened overnight, print them out. Tele for 7300 is on 7100, Tele for 7200 is on 7200.
- Day:
    - 2 teams: Red/Yellow and Blue/Green
    - Short phrase .CCUPROG1, you could use .DRVPHYS for the physical exam part if you want, stolen from Dr. Varadarajan
    - Very rarely, you have to do a full presentation. New admissions are done by the on-call senior and present by them to the attending the next day. You pick up the patient for the next day and the attending already know their story at that point. Presentation mostly just: a 1 liner, reason why they here, what are we doing for them, acute events overnight, pertinent labs/physical exams (crackly lungs, JVD, edema etc) and assessment and plan. However, this may be senior-dependent. The only time you might have to present the full HPI is when there's a different attending covering the weekend or new attending coming in for the new week
    - Red/Yellow is the main Heart Failure team, patients are sicker and more complicated. Stolenyi, Sakr, Abramov are the 3 main attendings for this team.
        - Sakr wants all notes signed by 8am. Table round on all the patients on the WOW, he will add the plan to your signed notes and co-sign them on the spot then go see all the patients at once. This makes your early morning very rushed and chaotic but you get all your notes done early, put all orders in during round and consults/phone call done by 11am.
        - Stolenyi, table round on 2 patients go see them then come back do 2 more. Notes can be done later. She rounds early, earliest was 630 am. Don't have to see all your patients beforehand but do look at and write down pertinent labs. Round is just sit around and talk it through with her.
        - Abramov, the most chaotic. Stand up round on the WOW on 2 patients, go see their teles, then see the 2 patients, then come back and repeat for 2 more patients.
    - Blue/Green: patients are relatively less sick than Red/Yellow but very fast turnover, you could be discharging 4-5 patients a day on that team. Abudayyeh, Varadarajan, Isaeff (Dr. Stier was his medical student) and Mamdani are the main attendings on this team.

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- Abuddayeh- minimize round interruption or you'll get chewed out. Get a call back number and call them back later if you get a phone call during table round with him. Table round on all the patients then see them all at once later.

- **MISC: (disclaimer: this is my own notes, so fact check them for yourself)**
  - Useful to have your Butterlfy handy to check for IVC collapsibility, pericardial effusion and stuff at bedside. You'll be the coolest kid on the floor
  - 44372/44373 on the phone get u to nursing station on 7200/7300 respectively
  - Chris the pharmacist x48509, very helpful. Call him if you need help with dosing.
  - During a code, unless there is no-one else around to run it. The most useful thing we could do at this stage is to grab a WOW and put orders in for them.
  - Pain meds: Start with Tylenol, Lidocaine patch, Tramadol, Norco 5. I have never gone beyond Norco 5. NEVER TORADOL on this floor.
  - Antiemetic: be mindful of QTC, patients on this floor on a lot of stuff that prolong their qtc. Tigan 200mg IM doesn't prolong qtc if you ran out of options.
  - Inpatient blood sugar goal is 140-180, NICE-SUGAR trial. Tell the nurse to chill if they page you
  - Impella, LVAD settings- that's fellow level stuff, dont touch it.
  - Post-cath, ablation etc. Patient keeps legs straight for 6 hours, if the sheaths are out and just the figure of 8 stitch, the nurse can remove it after bed rest. If the sheaths are still in, fellow will remove it in the am, and keep legs straight the entire time
  - Everyone gets daily BMP, Mg, Phos. Keep Mg>1, K>4
  - Post-PCI patient with stents and you plan to discharge them the next day: send a script of Plavix/Brilinta down to the downstairs pharmacy to make sure their insurance covers them. In the DC interface, send to Loma Linda University Pharmacy on Campus st etc.
  - Deborah and Maureen the 2 case managers are your best friends, if you plan to DC someone, let them know ASAP so they can help with the social bs.
  - Omeprazole lowers Plavix plasma level, switch them to Famotidine.
  - Change code status:
    - Note type: Limitation of treatment, smart phrase 'CCCLimit'
    - Change code status by ordering POLST in the order window
  - Patient SBP is usually their EF+75-80. e.g . EF of 5% their SBP would be 80-85, that's where they usually live. Look at the vital sign trend though. If nurses bug you about blood pressure tell them as long as MAP 60-65ish it's cool.
  - Post pacemaker patient: they get a 2nd dose of 1g of Vanc 12 hours after the 1st dose. Also 2 view CXR.
  - On the weekend, if you need NORA for TEE/Cardioversion, call them at 7am otherwise, it will not happen

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- Acute on chronic HF comes in been taking beta blocker, continue it. Been off for a while, put them back on it at discharge. Everyone HF gets a beta blocker and an ACEi/ARB, try to start them a day before DC see if they tolerate, you don't want your DC to be delayed by them developing symptomatic hypotension d/t the new meds on the day of DC
- Consult: put the order into Epic order and also page them via smartweb. You need to do both. You could either 1. Give them the story and question in the page and a call back number OR 2. Sit by the phone, page them just the call back number, 10/10 they would call you immediately. Know your patient well and have a clear clinical question to ask the consultant.
- Notes: keep a CCU course section in your daily progress note and update them daily. Copy and paste this into the Hospital Course for discharge summary for a quick and painless DC.
- For Discharge, med rec them, put the orders in to DC them, you can write the DC summary later (within 24 hours I think), unless they are going to a SNF/LTAC then the DC summary needs to be in.
- If they are going to a SNF, needs an order 'Supplemental SNF' put in
- Discharge: if patient needs home health- Order Ambulatory Referral to Home Health in the regular ordering window. If patient needs referral to Cardiology, HF clinic etc. order 'Ambulatory Referral to Cardiology/Gastroenterology etc' in the DC ordering window.
- NGT- lots of end-stage HF patients also have cirrhosis liver disease, d/t congestive hepatopathy, with ascites and stuff, be wary of esophageal varices.
- Nurses will ask you to put in order for 'OK to use line.' PICC/Trialysis/Central Line terminates in the atriocaval junction. Lots of these patients also have ICD/pacemaker with multiple leads so it looks very busy. It's ok to call Radiology Reading Room to have them confirm it for you. STAT CXR after lines, KUB after NGT, make sure to click portable.
- NPO order, click 1. Ok to take meds 2. With sips.
- Bradycardia patient without a pacemaker and you feel like they could go south quickly, keep pacing pads at bedside.
- Hold Eliquis for 24 hours before procedure.
- Afib RVR, most of the patients on this floor have HF: avoid negative inotropes- **never CCB**, BB maybe if good HR and pressure (Esmolol gtt is great), almost always Amiodarone, Dig is iffy. Make sure they are anticoagulated before rhythm control
- If you are aggressively diuresing people do BMP, Mg q12 hours. Also remember to restrict their fluid 1.2-1.5L/day
- Patient extubated after less than 24 hours of intubation, bedside RN dysphagia screening is good enough. Otherwise Speech Eval Consult before diet
- It's ok to run pressors via peripheral lines for 24 hours in the diluted bag.
- 2 g of IV Magnesium for all arrhythmias. Sustained VTach/VFib, start with Amio 1st line IVP 150, 2nd line is Lidocaine 100mg IVP. Call Senior/Fellow first.

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- If fluid overloaded patients not responsive to already high dose IV diuretics, consider adding Metolazone 5mg qd or bid
- IV Bumex 1mg = 40 mg IV Lasix. 20 IV Lasix = 40 PO Lasix (50% BA), Bumex 1mg IV = Bumex 1mg PO (100% BA)
- Dobutamine gtt max at 7.5, Dopamine gtt keep below 3 at renal dose, Lasix gtt max at 15 (typically titrate to UOP 100-120cc/hour) , Bumex gtt 0.5-1. Levophed I have seen it as high as 44. Amio gtt bolus 150mg then follow the built in instruction.
- NOAC is under DOAC order set
- If there are 2 drips for sedation, make one fixed rate the other one titratable to a goal RAS, nurse cant have 2 titratable drips toward 1 goal.
- Intubated, sedated patients, before consulting NEUROLOGY, all sedation must be turned off for at least 48 hours otherwise they won't be able to exam
- It's almost never cool to give fluid bolus for patients on this floor.
- If patient has ascites, and you suspect urinary retention, bladder scan is not useful. Order Bladder US.
- Some useful order sets to set favorite (Right click- Favorite)
    - Blood Product Orders
    - Cardiology CCU Orders-ADULT
    - ACS Intermediate/Observation Orders-ADULT
    - Critical Care Continuous IV Medications-ADULT
    - Electrolyte Replacement Adult Module
    - Subcutaneous Insulin: Target Blood Glucose is 140-180mg/dL Orders- ADULT
- I will keep updating this as things start coming back to me

## Cardiac Consult

### Useful contacts:

ACS 51165/55143/55144/ pgr 1890
Cancer Cntr ACS 51165/55143/55144/ pgr 1890
Cancer Cntr 51300
ED Xerox Code 8230
Florence Rehab 87081

Anesthesia (NORA) 50141 /50131/44410/51352/55619

Cardiac Lab / Stress testing: 42603
Cardiology Consult NP – Cheryl Fish 5744

Case Manager

- 49476 – Manager of Case Management Jennifer Willecke
- 45769 – 6200 CM Arlene
- 42246 – 7300 CM Debbie
- Pgr 6226 – weekend CM

CNS 52389 52436 50189

- Lucy Sistoza 50096

DART 44642 / Charge RN 55040

Echo 42455/42414
- Yvette 42699 (schedules TEE w/ GA)

ED Case Manager 87141
ED Front Desk 42828
ED Surge Desk 50650

Epidemiology 66115

GI 42674, pgr 3195
GI scheduler 45884

Heme/Onc
Tumor Board Coordinator
Janet Arias ext 15432

HIM 14191

HBO schedule 88097

Housekeeping/EVS 44326

ID Line 81025/43667

Interventional Radiology
Ext: 45060/47821 (Karen)/45061/46365 (angio lab)
Pgr: 3195 / irteam
NeuroIR
- Georgy Liljedahl pgr 5247/46355

Lab 43290
Lab Micro 86040
Lab/send out 46161/46133

Lab TB/mycology 86043

Language/Interpreter
Ext 42245/ Pgr 3715
ID 201208
Cost Center 7079

Legal 951-317-9001/909-226-1451

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MICU
Yellow Sr 1 50027
Yellow Sr 2 50028
Black Sr 1 50026
Black Sr 2 50012
NF 52074
Fellow 52061

MOD
Red
- Sr 55023 / workroom 83109

Yellow
- Sr 55022 / workroom 52881 52882

Green
- Sr 55045 / workroom 42541

Nephrology
9029 / neph1@my2way.com
22794 clinic back line (appointments)

Neurology
6190 / neurocall@my2way.com

Nutrition
TPN pgr 8755
Oncology 41152

Orthopedics
- Ortho Library – 49794

Outpatient HD 48989

Pathology 44398/45356

Pharmacy 8th Floor 43681
Pharmacy, outpatient 47693
Pharm pgr 8957
- Discharge Pharmacist 51375
- Pgr 1807

PICC Team 51041/5111 pgr

Patient Placement 87511/87554

Physical Therapy

- Senior PT/Shift Coordinator pgr 8595 / 45324

Pulmonology Consult
3955 / pulmconsults@my2way.com

Rad: Chest 47617
Rad: Neuro 47752
Rad Reading Room: 82520 82511
Rad: CT Body 46375/82518/46050
Rad: General 44691
Rad: US 43352
Rad: MRI 44010/47755/47750
Rad: Nuc Med 81338 / 87056

Rheumatology
- Fellows Workroom 53707

SLP 1547

Toxicology
- 4506 / toxic@my2way.com

TPN/Tube Feeds pgr 6929 / nstrd@my2way.com

Transfer Center 43915 / 83111

VAT: 42543 (office)/51041 / Pgr 5111