General Surgery Section
Raymond G. Murphy VA Medical Center

Resident Guide
2016-2017
RESIDENT GUIDE
GENERAL SURGERY SERVICE
RAYMOND G. MURPHY ALBUQUERQUE VA MEDICAL CENTER

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I. GENERAL SURGERY ROTATION GOALS AND OBJECTIVES

It is a privilege for the Attending General Surgeons and staff in the General Surgery Section to teach and to be educated by the medical students and residents on our service. Our mission is unique---to provide first class care to our Nation's veterans. We take that responsibility seriously and we have the expectation that you will do the same. We trust that this handbook will be helpful to you as you expand your knowledge of surgical diseases and its management as well as provide you with useful information that will enhance your experience at the Raymond G. Murphy VA Medical Center.

A. MISSIONS OF THE SECTION

- To provide comprehensive medical, non-operative, minimally invasive (laparoscopic), and open surgical treatment to Veterans with surgical diseases of the skin, soft tissue, breast, abdomen and extremities.
- To educate our Veterans and their families about treatments to prevent and reduce the risk factors associated with surgical diseases and to implement care plans that focus on the quality of life for each Veteran with surgical diseases.
- To educate, train, and mentor medical students and residents in the evaluation, treatment, and management of Veterans with surgical diseases. N.B. The priorities of Medical Students are 1. Tutorials/Lectures and 2. Get into operating room. They can see 2 to 4 inpatients. Issues? Page Dr. Vigil...
- To perform evidenced-based clinical research that advances the evaluation and treatment of Veterans with surgical diseases.

B. OBJECTIVES for PGY I Level
<table>
<thead>
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<th>Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health</th>
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<td>The resident should attend morning rounds daily on ALL service and consult patients. The resident should be able to summarize the care plan and hospitalization course for ALL service and consult patients.</td>
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<td>The resident should perform examination and evaluation of new patients, peri-operative and postoperative care of established patients, and surgical consultations under the supervision of attending surgeons. This care should occur in the inpatient and outpatient settings, including at least ½ day of weekly clinics.</td>
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<td>The resident should demonstrate responsibility for the care of all service patients, including admission history and physical examination, daily progress notes, and discharge summaries.</td>
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<td>Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care</td>
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<td>The resident should be able to recognize and diagnose common general surgery problems and emergencies.</td>
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<td>The resident should be able to demonstrate accurate interpretation of common radiographic abnormalities as they pertain to General Surgery.</td>
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<td>The resident should be able to discuss the indications and outcomes for common operations and demonstrate informed consent.</td>
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<td>Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care</td>
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<td>Demonstrate use of textbook and other resources to supplement the learning obtained in the clinical and conference setting.</td>
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<td>The resident should refer to the VA General Surgery Rotation Objectives for the Senior Resident and reflect on an individual learning plan to achieve gradual competency in more senior objectives.</td>
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<td>Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals</td>
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<td>Communicate information to co-workers, faculty and consultants to ensure continuity of care.</td>
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<td>Discuss medical errors or professional mistakes honestly and openly within the context of quality improvement to promote patients safety, trust, and self-learning.</td>
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<td>The resident should clearly, accurately, and respectfully communicate with patients and appropriate members of their families, nurses and other hospital employees, referring and consulting physicians, including residents.</td>
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<td>Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.</td>
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<td>The resident must attend required conferences on time.</td>
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<td>The resident must enter all procedures and operative cases in which he/she is the surgeon of record into the ACGME Case Log System within 24 hours of completing the procedure or operation or no later than weekly by Tuesdays at 7 AM.</td>
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<td>The resident must dictate an accurate and descriptive narration of the operative procedure in which he/she is the primary surgeon within 24 hours. If the Attending was not scrubbed for entire case please say (if relevant) “for key and critical portions of the case.”</td>
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<td>The resident must maintain compliance with the ACGME Duty Hours requirements and must insure that members of his or her team maintain compliance. The resident must document his or her duty hours in the New-Innovations System within 24 hours of completing the shift or no later than weekly by Tuesdays at 7 AM.</td>
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<td>Systems-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.</td>
</tr>
<tr>
<td>The resident should be able to apply the appropriate documentation needed for coding and billing.</td>
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The resident should demonstrate appropriate use of institutional resources, such as social service, home health care, outpatient services, etc. for effective discharge planning; and to be able to begin this process well in advance for efficient and patient-oriented discharge.

These goals will be met by performing the following:

1. Read and understand the Resident Guide.
2. Manage all General patients on the service under the direction of the Chief Resident/Attending Surgeons.
3. Attend daily ward rounds with the team.
4. Attend all General Surgery Clinics as required (see Outpatient Clinic for details).
5. Attend and participate in the bimonthly VA Department of Surgery Morbidity and Mortality Conference and the monthly UNM Department of Surgery Conferences (see Weekly Schedule for details)
6. Attend and participate in weekly General Surgery Conferences (see Weekly Schedule for details).
7. Scrub in on all operative cases as patient care allows.
8. Read assigned materials as distributed.

C. OBJECTIVES for PGY II Level

The General Surgery rotation is designed to prepare the Senior Surgical Resident (PGY IV/V) to independently evaluate and safely treat patients with surgical diseases. The PGY II level resident should use the rotation as an opportunity to develop leadership and delegation skills in the management of patients with surgical disease. The Chief Resident/PGY IV/V is responsible for the day-to-day operation of the General Surgery Service: performing rounds twice daily, supervising and directing junior residents and medical students, preparing for Morbidity and Mortality and General Surgery Conferences, and informing the Attending
Surgeons of major changes in a patient’s status or therapy (transfer to ICU, need for transfusions, changes in antibiotics, consultations to other services, etc). The PGY II level resident should consider him/herself as an extension of the PGY IV/V resident in insuring that these activities occur. While the Chief Resident is to assume directorship of the service and is ultimately responsible for the delegation/assignment/completion of work, the PGY II level resident should use the Chief level resident as a model to develop efficiency and communication skills. All of the clinical functions will be performed under the guidance and direct supervision of the Attending General Surgeons. Just as the PGY IV/V level resident, the PGY II level resident will see Emergency Room patients, new patient consults, and outpatients in the General Surgery clinics. All patients requiring admission by the Attending Surgeon will also be seen by the PGY II level resident when the PGY II level resident is the most senior resident available. When the PGY II level resident is the most senior resident available, e.g. during weekend coverage, he/she is responsible for the roles as noted above. In this setting the PGY II level resident should formulate a detailed and comprehensive management plan on all patients admitted to the service and review the plan with the Attending General Surgeon. The PGY II level resident will perform assigned operations under the direct supervision of the Attending General Surgeon. Upon completion of the rotation, the PGY II level resident will have a more complete working knowledge of surgical diseases and their medical, non-operative and surgical management.

*PLEASE EMAIL DR. VIGIL AT ANTHONY.VIGIL@VA.GOV EVERY TWO WEEKS OR SO WITH EVALUATIONS OF STUDENTS AND INTERNS.*
Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

(These items match the SCORE Curriculum Outline)

Disease/Conditions: BROAD = a graduate should be able to care for all aspects of disease and provide comprehensive management; FOCUSED = a graduate should be able to make the diagnosis, provide initial management/stabilization, but will not be expected to be able to provide comprehensive management.

Operations/Procedures: ESSENTIAL (Common) = frequently performed operations in general surgery; specific procedure competency is required by end of training (and should be attainable primarily by case volume); ESSENTIAL (Uncommon) = rare, often urgent, operations seen in general surgery practice and not typically done in significant numbers required by end of training (but cannot be attained by case volume alone.); COMPLEX = not consistently performed by general surgeon in training and not typically performed in general surgery practice.

The resident should lead morning rounds daily on all service and consult patients when the PGY-5 resident is on leave and on call weekends. The resident should be able to summarize the care plan and hospitalization course for all service and consult patients.

The resident should perform examination and evaluation of new patients, peri-operative and postoperative care of established patients, and surgical consultations under the supervision of attending surgeons. This care should occur in the inpatient and outpatient settings, including at least ½ day of weekly clinics.
**Disease/Conditions: BROAD**

By the completion of the culmination of (VA and UNM) General Surgery rotations, the resident should be able to care for all aspects of disease and provide comprehensive management for the following conditions:

- **Abdomen-General:** acute abdominal pain, intra-abdominal abscess, rectus sheath hematoma, mesenteric cyst;
- **Abdomen-Hernia:** inguinal hernia, umbilical hernia, ventral hernia, miscellaneous hernias;
- **Abdomen-Biliary:** jaundice, cholangitis, gallstone disease (acute cholecystitis, chronic cholecystitis, choledolithiasis, biliary pancreatitis, gallstone ileus), acalculous cholecystitis and biliary dyskinesia, gallbladder neoplasms (polyps, cancer), iatrogenic bile duct injury;
- **Alimentary tract-Esophagus:** dysphagia, gastroesophageal reflux and Barrett’s esophagus, hiatal hernia, esophageal perforation (spontaneous/iatrogenic), Mallory-Weiss syndrome;
- **Alimentary tract-Stomach:** upper GI bleeding, peptic ulcer disease (H. pylori infection, duodenal ulcer, gastric ulcer, bleeding, perforation, obstruction), gastric neoplasms (polyps, carcinoma, lymphoma, carcinoid), stress gastritis;
- **Alimentary tract-Small Intestine:** small bowel obstruction and ileus, Meckel’s diverticulum, Crohn’s disease (emergency management), radiation enteritis, small bowel neoplasms (polyps, adenocarcinoma, lymphoma, carcinoid, GIST), intussusception, malrotation, pneumatisos, acute mesenteric ischemia (arterial/venous/nonocclusive);
- **Alimentary tract-Large Intestine:** lower GI bleeding, large bowel obstruction, acute appendicitis, diverticular disease (diverticulitis, diverticular bleeding, fistulae), volvulus, colonic neoplasms (polyps, colorectal cancer, miscellaneous), neoplasms of the appendix, inflammatory bowel disease, (emergent management of ulcerative/indeterminate colitis), ischemic colitis, antibiotic-induced colitis;
- **Alimentary tract-Anorectal:** hemorrhoids, anal fissure, anorectal abscess and fistulae, anal cancer, rectal cancer;
- **Skin and Soft Tissue:** nevi, melanoma, squamous cell carcinoma, basal cell carcinoma, evaluation of soft tissue masses, epidermal cyst, tumors of dermal adnexae (apocrine, eccrine sebaceous, Merkel cell), dermatofibrosarcoma, skin and soft tissue infections (hidradenitis, cellulitis, necrotizing fasciitis), hand infections (paronychia, felon), wound infections, pilonidal cyst/sinus, intravenous and enteral access.
Disease/Conditions: FOCUSED

By the completion of the culmination of (VA and UNM) General Surgery rotations, the resident should be able to make the diagnosis, provide initial management/stabilization, but will not be expected to be able to provide comprehensive management for the following conditions:

**Abdomen-General:** chronic abdominal pain, peritoneal neoplasms (carcinomatosis, pseudomyxoma peritoneii), spontaneous bacterial peritonitis, desmoids tumors, chylous ascites, retroperitoneal fibrosis; **Abdomen-Biliary:** gallbladder cancer, cancer of the bile ducts, choledochal cyst, sclerosis cholangitis, **Alimentary tract-Esophagus:** achalasia, diverticula (Zenker’s, epiphrenic), foreign bodies, Schatzki’s ring, chemical burns (ingestion), benign neoplasms, malignant neoplasms (adenocarcinoma, squamous cell carcinoma), other motility disorders (diffuse esophageal spasm, nutcracker esophagus, presbyesophagus, scleroderma connective tissue disorders); **Alimentary tract-Stomach:** morbid obesity, bezoars and foreign bodies, gastroparesis, postgastrectomy syndromes; **Alimentary tract-Small Intestine:** short bowel syndrome, enteric infections and blind loop syndrome; **Alimentary tract-Large Intestine:** endometriosis, irritable bowel syndrome, functional constipation, infectious colitis; **Alimentary tract-Anorectal:** pelvic floor dysfunction, incontinence, anal dysplasia/sexually-transmitted disease, rectal prolapse; **Skin and Soft Tissue:** decubitus ulcer, soft tissue sarcomas (extremity, retroperitoneal), lymphedema; **Plastic Surgery:** aesthetic surgery (abdomen), abdominal wall reconstruction.
Operations/Procedures: ESSENTIAL (Common) -- By the completion of the culmination of General Surgery rotations, the resident should achieve specific procedure competency (attainable primarily by case volume alone) for the following procedures: Abdomen-General: exploratory laparotomy (open/laparoscopic); Abdomen-Hernia: repair inguinal/femoral hernia (open/laparoscopic), repair ventral hernia (open/laparoscopic); Abdomen-Biliary: cholecystectomy with/without cholangiogram (open/laparoscopic); Abdomen-Liver: needle/wedge biopsy (open/laparoscopic); Abdomen-Spleen: splenectomy for disease (open/laparoscopic); Alimentary tract-Esophagus: laparoscopic antireflux procedure; Alimentary tract-Stomach: percutaneous endoscopic gastrostomy, open gastrostomy; Alimentary tract-Small Intestine: small bowel resection (open), adhesiolysis (open/laparoscopic), ileostomy, ileostomy closure, feeding jejunostomy (open/laparoscopic); Alimentary tract-Large Intestine: appendectomy (open/laparoscopic), partial colectomy (open/laparoscopic), colostomy, colostomy closure; Endoscopy: esophagogastroduodenoscopy, proctoscopy, colonoscopy with or without biopsy/polypectomy, bronchoscopy, laryngoscopy; Skin and Soft Tissue: biopsy (excisional and incisional skin/soft tissue lesions), incision, drainage, debridement for soft tissue infection, pilonidal cystectomy; Plastic Surgery: skin grafting, intravenous and enteral access, nasogastric tube placement, central line placement, and arterial line placement.

Operations/Procedures: ESSENTIAL (Uncommon) 

By the completion of the culmination of General Surgery rotations, the resident should achieve specific procedure competency (NOT usually attainable primarily by case volume alone) for the following procedures: Abdomen-General: open drainage abdominal abscess; Abdomen-Hernia: repair miscellaneous hernias; Abdomen-biliary: cholecystostomy, common bile duct exploration (open), choledochoscopy, choledochoenteric anastomosis; operation for gallbladder cancer, repair acute common bile duct injury; Alimentary tract-Esophagus: open antireflux operation, open/laparoscopic repair of paraesophageal hernia, repair/resection of perforated esophagus; Alimentary tract-Stomach: partial/total gastrectomy, repair duodenal perforation, truncal vagotomy and drainage; Alimentary tract-Small Intestine: superior mesenteric artery embolectomy/thrombectomy; Alimentary tract-Large Intestine: subtotal colectomy with ileorectal anastomosis/ileostomy; Alimentary tract-Anorectal: excision of anal cancer; Skin and Soft Tissue: wide local excision melanoma, sentinel lymph node biopsy for melanoma, intubation, tracheostomy.

Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care


Operations/Procedures: COMPLEX

By the completion of the culmination of General Surgery rotations, the resident should attain knowledge in, but not specific procedural competency (most likely requiring the assistance of a reading or other educational program) for the following procedures:
Abdomen-General: retroperitoneal lymph node dissection (open/laparoscopic), operation for pseudomyxoma; Abdomen-Hernia: component separation abdominal wall reconstruction; Abdomen-Biliary: laparoscopic common bile duct exploration, operation for gallbladder cancer (planned), operation for bile duct cancer, excision of choledochal cyst, transduodenal sphincteroplasty; Alimentary tract-Esophagus: esophagectomy (total), esophagogastroectomy, cricopharyngeal myotomy with excision of Zenker’s diverticulum, Heller myotomy (open/laparoscopic), laparoscopic gastric resection, proximal gastric vagotomy, revisional procedures of postgastrectomy syndromes; Alimentary tract-Small Intestine: stricturoplasty for Crohn’s disease; Alimentary tract-Large Intestine: total proctocolectomy and ileoanal pull-through; Alimentary tract-Anorectal: stapled hemorrhoidectomy, repair complex anorectal fistulae, operation for incontinence/constipation, transabdominal operation for rectal prolase (open/laparoscopic), perineal operation for rectal prolapse, operations for rectal cancer (transanal resection, abdominoperineal resection, pelvic exoneration); Endoscopy: mediastinoscopy, cystoscopy, ERCP; Endocrine: adrenalectomy (open/laparoscopic); Skin and Soft Tissue: ileoinguinal-femoral lymphadenectomy, major resection for soft tissue sarcoma.

The resident should be able to demonstrate accurate interpretation of common radiographic abnormalities as they pertain to General Surgery.

The resident should be able to discuss the indications and outcomes for common operations and demonstrate informed consent.

Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

Demonstrate the ability to access, analyze, and use the scientific literature during discussion for the General Surgery VA Indications Conference (This occurs weekly on Thursday mornings at 7am.) and General Surgery VA Attending Rounds (This occurs weekly on Fridays at noon.)

Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals.
<table>
<thead>
<tr>
<th>Review with your Attendings and present clear and concise information monthly to the surgery faculty and residents at the VA Department of Surgery Morbidity and Mortality Conference and the monthly UNM Department of Surgery Conferences.</th>
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<tr>
<td>Present clear and concise information weekly to the multidisciplinary Tumor Board. (This occurs weekly on Tuesdays at 1230.) Be aware of the patient’s performance status, living locale, and tumor markers.</td>
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<td>Communicate information to co-workers, faculty and consultants to ensure continuity of care.</td>
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Systems-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

The resident should be able to describe the risks, benefits and alternatives for treating patients with surgical disease.

The resident should be able to apply the appropriate documentation needed for coding and billing.

The resident should demonstrate appropriate use of institutional resources, such as social service, home health care, outpatient services, etc. for effective discharge planning; and to be able to begin this process well in advance for efficient and patient-oriented discharge.

D. OBJECTIVES for PGY IV/V Level

The General Surgery rotation is designed to prepare the Senior Surgical Resident (PGY IV/V) to independently evaluate and safely treat patients with surgical diseases. The Chief Resident/PGY V is responsible for the day-to-day operation of the General Surgery Service: performing rounds twice daily, supervising and directing junior residents and medical students, preparing for Morbidity and Mortality and General Surgery Conferences, and informing the Attending Surgeons of major changes in a patient’s status or therapy (transfer to ICU, need for transfusions, changes in antibiotics, consultations to other services, etc). The Chief Resident/PGY IV/V is will assume directorship of the service and he/she is ultimately responsible for the delegation/assignment/completion of work. All of these functions will be performed under the guidance and direct supervision of the Attending General Surgeons. The Chief Resident/PGY V will see all Emergency Room patients, all new patient consults, and outpatients in the General Surgery clinics. All patients requiring admission by the Attending Surgeon will also be seen by the The Chief Resident/PGY IV/V. The Chief Resident should formulate a detailed and comprehensive management plan on all patients admitted to the service and review the plan with the Attending General Surgeon. The Chief Resident will perform assigned operations under the direct supervision of the Attending General Surgeon. Upon completion of the rotation, the Senior Surgical Resident (PGY IV/V) should have a complete and thorough working knowledge of surgical diseases and
their medical, non-operative and surgical management. The PGY IV/V resident is responsible for the roles as noted above when cross-covering on the General Surgery Service.

PLEASE EMAIL DR. VIGIL AT ANTHONY.VIGIL@VA.GOV EVERY TWO WEEKS OR SO WITH EVALUATIONS OF STUDENTS AND JUNIOR RESIDENTS AND INTERNS.

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Disease/Conditions: FOCUSED

By the completion of the culmination of General Surgery rotations, the resident should be able to make the diagnosis, provide initial management/stabilization, but will not be expected to be able to provide comprehensive management for the following conditions:

Abdomen-General: chronic abdominal pain, peritoneal neoplasms (carcinomatosis, pseudomyxoma peritoneii), spontaneous bacterial peritonitis, desmoids tumors, chylous ascites, retroperitoneal fibrosis; Abdomen-Biliary: gallbladder cancer, cancer of the bile ducts, choledochal cyst, sclerosis cholangitis, Alimentary tract-Esophagus: achalasia, diverticula (Zenker’s, epiphrenic), foreign bodies, Schatzki’s ring, chemical burns (ingestion), benign neoplasms, malignant neoplasms (adenocarcinoma, squamous cell carcinoma), other motility disorders (diffuse esophageal spasm, nutcracker esophagus, presbyesophagus, scleroderma connective tissue disorders); Alimentary tract-Stomach: morbid obesity, bezoars and foreign bodies, gastroparesis, postgastrectomy syndromes; Alimentary tract-Small Intestine: short bowel syndrome, enteric infections and blind loop syndrome; Alimentary tract-Large Intestine: endometriosis, irritable bowel syndrome, functional constipation, infectious colitis; Alimentary tract-Anorectal: pelvic floor dysfunction, incontinence, anal dysplasia/sexually-transmitted disease, rectal prolapse; , intravenous and enteral access, nasogastric tube placement, central line placement, and arterial line placement, Skin and Soft Tissue: decubitus ulcer, soft tissue sarcomas (extremity, retroperitoneal), lymphedema; Plastic Surgery: aesthetic surgery (abdomen), abdominal wall reconstruction.
Operations/Procedures: ESSENTIAL (Common) -- By the completion of the culmination of General Surgery rotations, the resident should achieve specific procedure competency (attainable primarily by case volume alone) for the following procedures: Abdomen-General: exploratory laparotomy (open/laparoscopic); Abdomen-Hernia: repair inguinal/femoral hernia (open/laparoscopic), repair ventral hernia (open/laparoscopic); Abdomen-Biliary: cholecystectomy with/without cholangiogram (open/laparoscopic); Abdomen-Liver: needle/wedge biopsy (open/laparoscopic); Abdomen-Spleen: splenectomy for disease (open/laparoscopic); Alimentary tract-Esophagus: laparoscopic antireflux procedure; Alimentary tract-Stomach: percutaneous endoscopic gastrostomy, open gastrostomy; Alimentary tract-Small Intestine: small bowel resection (open), adhesiolysis (open/laparoscopic), ileostomy, ileostomy closure, feeding jejunostomy (open/laparoscopic); Alimentary tract-Large Intestine: appendectomy (open/laparoscopic), partial colectomy (open/laparoscopic), colostomy, colostomy closure; Endoscopy: esophagogastrroduodenoscopy, proctoscopy, colonoscopy with or without biopsy/polypectomy, bronchoscopy, laryngoscopy; Skin and Soft Tissue: biopsy (excisional and incisional skin/soft tissue lesions), incision, drainage, debridement for soft tissue infection, pilonidal cystectomy; Plastic Surgery: skin grafting intravenous and enteral access, nasogastric tube placement, central line placement, and arterial line placement.

Operations/Procedures: ESSENTIAL (Uncommon)

By the completion of the culmination of General Surgery rotations, the resident should achieve specific procedure competency (NOT usually attainable primarily by case volume alone) for the following procedures: Abdomen-General: open drainage abdominal abscess; Abdomen-Hernia: repair miscellaneous hernias; Abdomen-biliary: cholecystostomy, common bile duct exploration (open), chodoschoscopy, choledochoenteric anastomosis; operation for gallbladder cancer, repair acute common bile duct injury; Alimentary tract-Esophagus: open antireflux operation, open/laparoscopic repair of paraesophageal hernia, repair/resection of perforated esophagus; Alimentary tract-Stomach: partial/total gastrectomy, repair duodenal perforation, truncal vagotomy and drainage; Alimentary tract-Small Intestine: superior mesenteric artery embolectomy/thrombectomy; Alimentary tract-Large Intestine: subtotal colectomy with ileorectal anastomosis/ileostomy; Alimentary tract-Anorectal: excision of anal cancer; Skin and Soft Tissue: wide local excision melanoma, sentinel lymph node biopsy for melanoma. intubation, tracheostomy, Swan Ganz Catheterization
Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

Operations/Procedures: COMPLEX

By the completion of the culmination of General Surgery rotations, the resident should attain knowledge in, but not specific procedural competency (most likely requiring the assistance of a reading or other educational program) for the following procedures:
Abdomen-General: retroperitoneal lymph node dissection (open/laparoscopic), operation for pseudomyxoma; Abdomen-Hernia: component separation abdominal wall reconstruction; Abdomen-Biliary: laparoscopic common bile duct exploration, operation for gallbladder cancer (planned), operation for bile duct cancer, excision of choledochal cyst, transduodenal sphincteroplasty; Alimentary tract-Esophagus: esophagectomy (total), esophagogastronomy, cricopharyngeal myotomy with excision of Zenker’s diverticulum, Heller myotomy (open/laparoscopic), laparoscopic gastric resection, proximal gastric vagotomy, revisional procedures of postgastrectomy syndromes; Alimentary tract-Small Intestine: stricturoplasty for Crohn’s disease; Alimentary tract-Large Intestine: total proctocolectomy and ileoanal pull-through; Alimentary tract-Anorectal: stapled hemorrhoidectomy, repair complex anorectal fistulae, operation for incontinence/constipation, transabdominal operation for rectal prolapse (open/laparoscopic), perineal operation for rectal prolapse, operations for rectal cancer (transanal resection, abdominoperineal resection, pelvic exoneration); Endoscopy: mediastinoscopy, cystoscopy, ERCP; Endocrine: adrenalectomy (open/laparoscopic); Skin and Soft Tissue: ileoinguinal-femoral lymphadenectomy, major resection for soft tissue sarcoma.

The resident should be able to demonstrate accurate interpretation of common radiographic abnormalities as they pertain to General Surgery.

The resident should be able to discuss the indications and outcomes for common operations and demonstrate informed consent.

Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

Demonstrate the ability to access, analyze, and use the scientific literature during discussion for the General Surgery VA Indications Conference (This occurs weekly on Thursday mornings at 7am.) and General Surgery VA Attending Rounds (This occurs weekly on Fridays at noon.)
Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals

<table>
<thead>
<tr>
<th>Review with your Attendings and present clear and concise information monthly to the surgery faculty and residents at the VA Department of Surgery Morbidity and Mortality Conference and the monthly UNM Department of Surgery Conferences.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present clear and concise information weekly to the multidisciplinary Tumor Board. (This occurs weekly on Tuesdays at 12:30.) Be aware of the patient’s performance status, living locale, and tumor markers.</td>
</tr>
<tr>
<td>Communicate information to co-workers, faculty and consultants to ensure continuity of care.</td>
</tr>
<tr>
<td>Discuss medical errors or professional mistakes honestly and openly within the context of quality improvement to promote patients safety, trust, and self-learning.</td>
</tr>
<tr>
<td>The resident should clearly, accurately, and respectfully communicate with patients and appropriate members of their families, nurses and other hospital employees, referring and consulting physicians, including residents.</td>
</tr>
<tr>
<td>The resident should maintain clear, concise, accurate, and timely medical records including (but not limited to) consultation notes, progress notes, written and verbal orders, operative notes, and discharge summaries.</td>
</tr>
<tr>
<td>The resident should be able to teach medical students and junior residents about the procedures performed on this rotation. They should be able to counsel patients and appropriate members of their families in order to obtain informed consent.</td>
</tr>
</tbody>
</table>

Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

| The resident must attend required conferences on time and insure that members of his or her team attend required conferences in a timely fashion. |
| The resident must enter all procedures and operative cases in which he/she is the surgeon of record into the ACGME Case Log System within 24 hours of completing the procedure or operation or no later than weekly by Tuesdays at 7 AM. |
The resident must dictate an accurate and descriptive narration of the operative procedure in which he/she is the primary surgeon within 24 hours. If the Attending was not scrubbed for entire case please say (if relevant) “for key and critical portions of the case.”

The resident must maintain compliance with the ACGME Duty Hours requirements and must insure that members of his or her team maintain compliance. The resident must document his or her duty hours in the New-Innovations System within 24 hours of completing the shift or no later than weekly by Tuesdays at 7 AM.

Systems-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

The resident should be able to describe the risks, benefits and alternatives for treating patients with surgical disease.

The resident should be able to summarize the financial costs, potential complications, and long-term expectations for planned procedures.

The resident should be able to apply the appropriate documentation needed for coding and billing.

The resident should demonstrate appropriate use of institutional resources, such as social service, home health care, outpatient services, etc. for effective discharge planning; and to be able to begin this process well in advance for efficient and patient-oriented discharge.

E. Initial and Final Rotation Evaluations

All surgical trainees on the service will have an initial and final rotation evaluation with the Attending Surgeons. The purpose of the initial meeting with the Attending Surgeons is to review the section goals and objectives and to determine the needs of the individual trainee and set personal goals for the rotation. Final rotation evaluations will be completed via New Innovations and provided to the residents through that
system. Residents on the service may request an evaluation at any time to review their progress, particularly when deficiencies have been noted.

II. GENERAL

A. POLICIES AND PRINCIPLES

1. Patient care is the first priority.

Our goal is that all patients on the General Surgery Section are provided the best possible care. The welfare of our veterans and the quality of the medical services provided are the combined responsibility of the residents, medical students, the support staff, and the attending General surgeons.

2. Education is a vital part of the everyday operation of the service.

Medical schools and surgical residencies exist for the purpose of providing medical education and professional training. As physicians and physicians-in-training, each of us is responsible for the education of other medical and paramedical personnel, our patients, and their families. Please provide a good example to medical students by not cutting and pasting notes from the prior note: this is annoying to read and a waste of time for the reader.

For survey purposes and best practices:

- be reminded that we have 4 regularly scheduled educational conferences here at the VA for general surgery learners.

- Feel free to remind learners when you are giving them feedback or teaching them.

- Reading this handbook is a huge part of your ‘goals and expectations’.

3. Research opportunities are available to any interested medical student or resident.
The commitment of the Attending General Surgeons is for the trainee to develop and be mentored through a research project to produce a paper suitable for presentation at a local, regional, or national meeting and suitable for publication in a peer-reviewed journal.

B. ORGANIZATION AND ADMINISTRATION

An Attending General Surgeon supervises all patient care. The Chief Resident/PGY V has general responsibility for the service including inpatient preoperative and postoperative care as well as outpatient care in the General Surgery Clinic. The junior residents, in conjunction with non-physician providers assigned to the service, are the primary physicians responsible for all aspects of General Surgery patients’ evaluation and treatment. Junior residents are expected to take an active role in all patient care activities. The general rule is that independent thought, not independent action, is encouraged. Once you make a management plan or change a current plan, protect yourself and your patients by discussing it with someone more senior to you before you put your plan into action. It may mean going into the OR, Gastroenterology suite, or other locale, to discuss as soon as possible. The resident team should meet in person for patient care coordination among all involved. Residents are to carry the General Surgery pager (251-0120) at all times (When possible the pager should remain out of the OR if another responsible provider is available to carry the pager.)

C. ADMISSIONS

All admissions must be scheduled, coordinated, and approved by an Attending General Surgeon. This includes admissions from the clinic, telephone referrals, hospital transfers, and admissions from the Emergency Department. Residents may NOT take outside/transfer calls. Outside/transfer providers should be referred to the Administrator on Duty (AOD) so that VA process for transfers can be followed the appropriate Attending provider contacted. Admissions from the clinic are facilitated through our section nurse, Ms. Stacey Schneider -5867. Outpatient consultations, ASU preoperative appointments, and follow-up appointments are coordinated with Ms. Schneider or our secretary at ext 2776. Patients are not placed on the operative schedule until all of the necessary preoperative evaluations and consultations are completed.

Consultations from the Emergency Department, both during duty hours and after hours, should be seen by the resident within 30 minutes of the consult request. Be sure or gently remind the consulting to provider to put the consult request in the CPRS computer chart. After the patient has been seen and evaluated, the on-call Attending General Surgeon should be notified and plan of care developed.
USE ‘STANDARD’ H AND P FOR ANY PATIENT TO BE ADMITTED-FILL OUT ALL REQUIRED BOXES, WHETHER WITH N/A OR WHATEVER APPROPRIATE.

Use ACUTE CARE HOSPICE SERVICE as your admitting service for any patient that is unlikely to survive, for any reason, the next 6 months. Use the surgical attending of record as the attending.

D. DISCHARGES

All patient discharges need the approval of an Attending General Surgeon. Arrangements for patient follow-up should be completed before the time of discharge. Planning for discharge includes:

1. Completing discharge prescriptions and patient instruction regarding required medications. Most will automatically need a stool softener for one month.
2. Diet and activity instructions.
3. Wound care instructions and provisions of dressing supplies
4. Assuring that patients’ social needs have been addressed. (e.g. travel and home care arranged, instructions to family, etc.)
5. Making follow-up appointments for the General Surgery Clinic. If the patient is being discharged at night or on a weekend, please make sure that the patient information is placed at the bottom of the Patient List so that an appropriate follow-up appointment can be arranged the first work day back (usually Monday).
6. Institution policy is that above be completed the day prior so the patient can meet the discharge time of 11:00 AM the following day.
7. Any patient getting a transfusion that we ordered will need a transfusion episode note. The note must have the indications and the CLINICAL response to the transfusion. Any transfusion order must be discussed with the attending.

At the time of discharge, all appropriate discharge paperwork (1-outpatient/discharge medications or supplies Rx, 2-"Discharge Instructions" note in CPRS, which will auto-generate a 3-"Discharge" order and a 4-"Discharge Summary") must be completed in CPRS and the discharging resident MUST dictate a discharge summary in
24hrs. If there are any questions with regard to the administrative requirements at the VA for patient discharge, please direct them to the appropriate Attending General Surgeon.

Dc note needs to be completed prior to pt dc.

Discharge progress note element must include: 1. Condition of patient at dc to include wound, if applicable 2. Pt readiness for dc appropriate

Discharge summaries must have: operations, procedures, treatments rendered with the dates

E. WARD SERVICE RESPONSIBILITIES

1. The history and physical examination must be recorded in CPRS at the VA upon admission. If a medical student performs the history and physical, it must be reviewed and countersigned by a supervising resident or attending. The history and physical examination must be completed within 24 hrs of admission to the ward and is a requirement before transfer to the operating room. If the patient has had a history and physical in the clinic prior to elective/preoperative admission (and within 30 days of the admission), a "General Surgery Inpatient" note or an addendum should be made to the history and physical to reflect the patient's current status at admission.

2. Patient rounds should be conducted at least twice daily. A physician should review each patient’s course, problems, and needs-- morning and evening. The Chief Resident/PGY V is responsible for coordinating work rounds in the morning and in the evening. The Chief Resident/PGY V or delegate should discuss the daily care plan with the supervising attending(s) following morning rounds. If there are changes to the patient’s status or test/study results to report, the supervising attending should be notified. In the afternoon, the Chief Resident should touch base with each of the supervising attendings, so that appropriate attending-to-attending check-out can occur.
3. All patients require appropriate daily progress notes recorded in the medical record. These notes should be concise and describe only significant complaints, findings, investigations or developments. The most important entries are those that explain what decisions were made about the patient’s management and why. The General Surgery Attending assigned to the patient should usually be the co-signer for these notes. On the weekends and holidays the General Surgery Attending assigned for call should be the co-signer. Please communicate this to the interns, students, and off-service residents.

4. All progress notes and orders written by medical students must be countersigned by a supervising resident as soon as possible. This is particularly important for orders, as policy prohibits nurses from carrying out medical students' orders that have not been countersigned.

5. All patients scheduled for surgery MUST have a preoperative note annotated in the chart. In most cases, this note will be written by the individual expected to perform the operation. This note should briefly describe the planned procedure and the rationale for it. The note should clearly state that the risks of the procedure have been explained, as well as the alternative treatment options, and that the patient indicated that he/she understood and gave consent. The preoperative note should also indicate which Attending General Surgeon has reviewed the case and approved the plan. A preoperative review should be done to ensure that all necessary preoperative evaluations are complete and that the patient is adequately prepared for the operation.

6. Procedural consent forms for operation should be completed by the individual expected to act as the surgeon. All General Surgery Attendings are to be listed on the consent form. To obtain an informed consent, the resident must be sufficiently familiar with the operation planned (and its potential complications) to answer the patient’s questions. Consent forms at the VA are completed electronically in CPRS under iMED Consent. The consent forms specific to General Surgery can either be found under the General Surgery or Gastroenterology procedure lists. The iMedConsent (not paper consent) is expected to be completed prior to any scheduled procedure (within 60 days of the planned operation) so that appropriate questions/concerns of the veteran and his/her family can be addressed. If iMed Consent is not available, a paper consent can be completed (forms are available on 3A and in the SICU) with a note indicating the reason that the iMed Consent could not be completed annotated in CPRS.

F. OPERATING ROOM
Elective surgical and general must be completed electronically 3 business days prior to the day of surgery by 10:00 AM—please note holidays. If the case is not ‘highlighted’ it is not listed in the computer. Emergency and add on case scheduling is completed by filling out a paper request available at the Operating Room front desk and delivered to the charge nurse in the Operating Room or another responsible party at the Operating Room front desk.

Because Operating Room time and resources are at a premium, it is paramount that everything possible be done to assure efficiency. Both the patient and the surgeon should be prepared for the operation before entering the Operating Room. All patients must be appropriately site marked pre-operatively by a member of the operative team who will be participating in the operating room (not a medical student) in the ASU or PACU or in the Emergency Department or SICU/etc. First cases of the day must be marked by 7:10 AM by the attending! Any special requirements should be addressed ahead of time. The Operating Room staff should be briefed about unusual equipment, supplies, positioning or technical considerations both verbally and in writing when the case is scheduled. No opportunity to safely expedite procedures and to speed room turnover should be missed.

Emergency cases that are expected to end up in the operating room (lap appy) that come in after midnight should be discussed asap with the attending so that a 0600 O.R. slot can be negotiated with anesthesia. This is critical in avoiding ‘bumping’ of elective cases and may best utilize an over-extended O.R. staff. O.R. ‘CARDS’ must be filled out and placed on anesthesia office and a CPT code MUST be added! (doesn’t have to be exact/enough to get case pulled...)

H&Ps are valid for 30 calendar days prior to an operation; if the patient has been an inpatient (especially on another service), please be sure the H&P is within 30 days and/or has an addendum to update it. Consents are good for 60 calendar days prior to an operation.

Please discuss with each General Surgery Attending the specific needs required in the iMed Consents in General Surgery. Avoid paper consents unless cleared to do so by the Attending General Surgeon.

1. A resident from the General Surgery Section must be present in the operating room no later than 7:30 AM. A resident’s late arrival could result in the loss of that resident's ability to perform/assist on that case. The resident will assist in positioning the patient, insertion of Foley catheters, and the preparation of the operative field. A resident unprepared for an elective case may be relegated to performing less or none of the case.

2. All surgical patients (inpatient and outpatient) should have a brief operative note completed electronically in CPRS immediately following the operation. This must be completed prior to the patient moving to the next care location. This note may be written in the PACU if the resident or attending surgeon is continuous attendance with the patient during transport from the OR to the PACU. This is a templated note that can be found by selecting the Notes tab and writing “Brief Operative Note” in the menu box. It is the responsibility of
the operating resident to complete this note and identify as an additional cosigner the Attending General Surgeon of record for the case. The brief operative note should be as complete as possible as it is the sole documentation of the operative procedure for the first 24 hrs following surgery and can greatly assist in postoperative care/coordination. It is recommended that residents add an addendum to the brief operative note documenting the dictation of the procedure.

3. Operative Notes should be dictated by the surgery resident immediately following the procedure. Dictation is required prior to the close of that day. Mark the Dictation STAT 6 ON THE KEYPAD!

4. All inpatient surgical patients should have delayed transfer orders entered immediately following the operation. This duty is usually the requirement of the surgical resident who performed/assisted on the case in order to insure appropriate continuity.

5. Outpatient surgical procedures require ASU Postoperative orders as well as Discharge Instructions. Please refer to II.D.

6. Following each case the operative resident should confirm with the attending that will be responsible for the above items, e.g. brief operative note, orders, discharge instructions, dictation and addressing the patient’s family. It is appropriate to ‘divide and conquer’ these duties with your attending.

G. CONSULTATION SERVICE

All consultations to the General Surgery Section from the Emergency Department, or Inpatient Service, should be seen as soon as possible by the responsible resident and the Chief Resident/PGY IV. The Chief Resident/PGY IV should present their plan to the Attending General Surgeon on call. On nights or weekends, the PGY II may substitute for the Chief Resident/PGY IV as assigned. If the Chief Resident/PGY IV is not available due to leave or other circumstance, the responsible resident should discuss their assessment and plan with the Attending General Surgeon on call. At the very least, a brief note is to be written as soon as possible after seeing the patient and making the plan. Junior resident will discuss the consult with the chief resident ASAP, including going into the operating room. On occasion (not the norm), depending on resident and attending availability, and time of day (with a view to consideration of operating room availability or IR availability), a junior resident may staff a consult with the attending without going through the chief resident.
Every effort will be made to keep the chief resident in the loop. Also note that, on occasion, attendings will be notified of consults directly from other attendings.

All hospitalized consult patients must be followed until discharged or until resolution of their General Surgery problem. If appropriate, follow-up can be arranged in the General Surgery clinic. Remember, there are no "curbside consults." If you are requested to see a patient, a formal consult must be completed and discussed with the Attending General Surgeon on call. You may need to provide a friendly reminder to the consulting service to place the consult into CPRS so that it can be appropriately completed. You may also need to enter the consult order yourself to expedite documentation of your assessment and plan in the chart. Also remind consultants about NPO and anticoagulation status. With the exception of “necrotizing soft tissue” infections, we, in general, do not see urgent/emergent forearm, wrist, hand, foot, or head and neck infections. Since we have clinic daily, non-urgent consults should instead be referred to the next available clinic slot asap.

At the NMVAHCS, providers asking for a consult must have an appropriate question for general surgery to answer, whether provider to patient or via e-consult:

Example of a Consult that is CANCELLED because the ordering provider did not ask an appropriate question

“Please see this patient” is not a sufficient consult question and the receiving service can CANCEL/DENY the consult with instructions to the ordering provider RESUBMIT the consult with an appropriate consult question.

BILIARY NOTE: Any biliary system consult needs a ‘biliary note’ within one hour!

***Intra-facility patient transfers cannot be accepted by residents. If you receive an outside call (or a call from our VA AOD) requesting a patient transfer, notify the caller that you as a resident are not allowed to accept transfers and have them notify the Administrator on Duty (AOD.) Do not engage in any conversation/opinion
as this may be misconstrued as an ‘acceptance.’ Insist the caller talk with the AOD or General Surgeon on-call directly.***

**LANGUAGE/NARRATIVES**

Please try to incorporate recent developments in language and technology in consults and progress notes and H and P’s. Specifically, need to start using ‘performance status’ for cancers and tumor board consults; use ‘END OF LIFE’ and ‘palliative care’ words when talking with patients with severely limited life expectancy; use the ACS surgery risk calculator as much as possible (especially for M and M); use METS > 4 in H and P’s to document exercise tolerance.

**H. GENERAL SURGERY CLINIC**

Your supervising attending for a clinic patient must be an Attending General Surgeon who is physically present in the clinic with you. Every patient evaluated in the clinic must be discussed with an Attending General Surgeon. All new patient consultations must be seen by an Attending General Surgeon. Discussion of the treatment plan should be directed to the appropriate Attending General Surgeon. Because of the large number of patients that are accommodated each week, these clinic evaluations must proceed expeditiously and efficiently. Examinations must be directed to the referral problem. Clinic notes should be brief, with emphasis on pertinent findings, any interval changes in the patient’s status, therapeutic regimen, and plans for further follow-up.

Finally, many patients or other family members will call with questions regarding their care, wounds, or other problems. If you are asked by the nursing or physician staff to return a call, please call the patient/family back and discuss the problem or situation. Don’t hesitate to contact an Attending General Surgeon if you have questions.

**I. WEEKLY CONFERENCES FOR RESIDENTS**

Residents rotating on the General Surgery Service at the VA will attend the VA Morbidity and Mortality Conference, held at 7:00 AM on the 2nd and 4th Tuesdays in the Performance Improvement Conference Room on the 4th floor next to the Director’s Suite. Residents may present cases when General Surgery is ‘up’ for presentation.
Tumor Board is held weekly at 12:30 PM, Tuesday, in Pathology. The PGY II level resident is expected to prepare and present the patients on the Tumor Board Schedule. A copy of this schedule is distributed to the Resident Office and to Ms. Sauve on the preceding Friday.

General Surgery Indications/Educational (Preoperative) Conference is held weekly at 7:00 AM, Thursday, in the 3B-125 Conference Room. The senior resident on service is expected to prepare and present the patients on the operative schedule for the week that starts 10 days from the Thursday conference. It is expected that the case will be completely prepared for presentation to include all pertinent studies.

General Surgery Pathology Conference is held weekly at 7:30 AM, Thursday, in Pathology.

General Surgery Attending/Teaching Rounds are held weekly at noon, Friday, starting in 3B-SICU. The medical students or interns are expected to prepare and present their own patients along with pertinent educational topics. Alternatively, we can use some of this time to go over questions pertinent to the Surgery In-Service exam, e.g. SESAP, depending on the Chief Resident’s interest.

J. DUTY HOURS

Dr. Ketteler is the on-site General and Vascular Surgery Resident Coordinator at the VA for administrative issues related to your rotation at the VA. All requests for time off (vacations, time away to interview, family emergencies, etc.) should be coordinated through her. (Dr. Vigil in her absence.)

All surgical trainees who rotate on the service are required to place their duty hours into New Innovations no later than the close of business each Monday for the preceding week. We insist upon accurate and honest duty hour documentation so we can effectively assess rotation obligations and be able to make adjustments and changes appropriate for duty hour requirements and to avoid fatigue and exhaustion. Additionally, if you or another surgical trainee on the service is approaching the duty hour limits as prescribed by the General Surgery Program Director, please notify Dr. Ketteler immediately so that corrective action can be taken. If there are any questions about work hours, please direct them to Dr. Ketteler (Dr. Vigil in her absence).

K. CALL RESPONSIBILITIES

WEEKDAY NIGHT HOME-CALL: Due to PGY1 residents being unable to participate in night call beginning July 2011, the VA home call schedule during the weeknights is a rotating cross-coverage schedule among: the PGY4 on Vascular, the PGY2 on ENDO, the PGY4/5 on General, and the PGY2 on General. This schedule was decided upon in August 2011 in a joint VA resident/faculty committee meeting (initiated by Dr. Nelson, then the UNM Surgery Program Resident Program Director). In this meeting, home call was deemed educational by both the residents and the faculty---but the every other night call as separate services was creating fatigue.
and exhaustion, even if not violating duty hours. Thus, a rotating call schedule was initiated in September 2011. This schedule will try to assign residents to a single night of cross-coverage call Monday thru Thursday. The weeknights will attempt to be chosen so that if the resident is up all night (or is fatigued or exhausted), the resident can be sent home the next morning without missing cases and/or educational opportunities.

Knowing the above, the general and vascular cross-coverage home-call senior resident schedule is as follows (assuming a full resident complement):

**Monday and Wednesday nights:** General Surg PGY4/5 or General Surg PGY2  
**Tuesday nights:** Vascular Surg PGY4  
**Thursday nights:** Endo PGY2 resident

Each service’s PGY1 (or PA/NP/senior resident) will hold their individual service pagers (Gen= 251-0120, Vasc= 251-0808) from 0630 until 2000. Each service is responsible for their own services’ obligations from 0630 thru 2000 via the 251-pagers unless proper check-out has occurred (see below.)

The senior home-call resident may begin taking cross-coverage for the other service at 1500----with a proper checkout from the other service. [The senior home-call resident is not required to take cross-coverage for the other service if the other service is still at the VA in-house seeing consults, operating, rounding, etc.] However, from 2000 to 0630, the assigned senior home-call resident will begin general and vascular cross-coverage via his/her individual UNM resident pager number. (This avoids the senior resident having to return to the VA to get the service 251-pager if he/she was able to leave prior to 2000.) **The VA call-schedule thru the operator is set to reflect the above pager assignments and any changes needed in the call schedule need to be approved by Dr. Ketteler at least 3 days in advance (Dr. Vigil in Dr. Ketteler’s absence).**

During Friday morning UNM mandatory educational conferences, the Gen Surgery NP will take primary call from 0700-1100 and the Vascular Surgery PA will take primary call from 0600-1100. Residents will resume responsibility for service calls at 1100. (Residents are expected to find each NP/PA/Attd to give them the pager).

**Weekend-CALL:** Two residents will be on-call (preferably one senior resident from each service) for Friday at 2000 thru Monday at 0630. The residents can decide to split the calls each night or share the calls each night. Both residents are expected to round each day—unless there are prior night/day duty hour concerns. The goals for weekend call are the same as for weekday call: to avoid fatigue, exhaustion.
and duty hour violations. Thus, the weekend call residents need to be in close contact and communication with each other and also with the weekend faculty to avoid hour issues so appropriate coverage (even via the faculty) can be anticipated and arranged.

Reviewing the above brings these thoughts to mind:

- Maintenance of continuity of care is paramount for our patients.
- Avoiding unnecessary calls and/or returns to the hospital at night are paramount for our residents
  - Expected to pro-actively call at 2100 to wards, ICU
  - Residents are encouraged to contact faculty during the night for questionable requests and consults (prior to returning to VA to see such)
- Meticulous communication and check-out between faculty, residents, and ward providers (RN, LPN, HT, MSA, NP, PA) is vital to make the system work safely and effectively for our patients and our residents!

III: WEEKLY SCHEDULE

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<tr>
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<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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</thead>
<tbody>
<tr>
<td>PGY I</td>
<td>7:30 am Operating Room or 9:00 am Minor Procedure Room</td>
<td>7:00 am VA M&amp;M 2nd and 4th Tuesdays</td>
<td>7:30 am Operating Room or 8:00 am to 11:30 am CLINIC</td>
<td>7:00 am VA Indications, Education, &amp; Pathology Conferences 3B-125</td>
<td>7:00 am UNM Grand Rounds, M&amp;M &amp; Resident Education Conference</td>
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<tr>
<td>am</td>
<td>1:00 pm-3:30 pm CLINIC</td>
<td></td>
<td>1:00 pm-3:30 pm CLINIC</td>
<td>NOON General Surgery Attending/Teaching Rounds</td>
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<tr>
<td>pm</td>
<td>12:30 pm to 1:30 pm Tumor Board</td>
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</tr>
<tr>
<td>Time</td>
<td>PGY II am</td>
<td>PGY II pm</td>
<td>PGY V am</td>
<td>PGY V pm</td>
<td></td>
</tr>
<tr>
<td>-------</td>
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<td>-----------</td>
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<td>----------</td>
<td></td>
</tr>
<tr>
<td>7:30 am</td>
<td>7:30 am Operating Room or 1:00 pm-3:30 pm CLINIC</td>
<td>12:30 pm to 1:30 pm Tumor Board</td>
<td>7:00 am VA M&amp;M 2nd and 4th Tuesdays or 8:00 am to 11:30 am CLINIC</td>
<td>12:30 pm to 1:30 pm Tumor Board (when possible)</td>
<td></td>
</tr>
<tr>
<td>7:30 am</td>
<td>ENDOSCOPY-all day Vigil/VB/Ford in am Lopez/Last in pm</td>
<td>Operating Room or 8:00 am to 11:30 am CLINIC</td>
<td>7:30 am Operating Room or 8:00 am to 11:30 am CLINIC</td>
<td>Operating Room or 1:00 pm-3:30 pm CLINIC</td>
<td></td>
</tr>
<tr>
<td>7:00 am</td>
<td>7:00 am VA Indications &amp; Pathology Conferences in pm after noon ENDOSCOPY Dr. Kingsley</td>
<td>Operating Room</td>
<td>7:00 am UNM Grand Rounds, M&amp;M &amp; Resident Education Conference</td>
<td>NOON General Surgery Attending/Teaching Rounds</td>
<td></td>
</tr>
<tr>
<td>12:30 pm</td>
<td>12:30 pm to 1:30 pm Tumor Board</td>
<td>Operating Room</td>
<td>7:00 am</td>
<td>NOON General Surgery Attending/Teaching Rounds</td>
<td></td>
</tr>
</tbody>
</table>
IV. ATTENDING SPECIFIC INFORMATION

A. FORD

B. KINGSLEY

1. Dr. Kingsley prefers to do her own brief operative notes, orders and discharge instructions, just ask her at the end of each case.

2. Dr. Kingsley prefers to use SQ Heparin for DVT prophylaxis instead of Lovenox.

C. LAST

Dr. Last prefers to do his own brief operative notes; He will often do the post op orders. (This will agreed upon at the end of the case.) He prefers to use SQ Heparin for DVT prophylaxis instead of Lovenox. Anal cases are given 10 oz Mag citrated and clears the evening before surgery and a fleets enema x 2 in the am at home and or in the ASU. Golytely bowel preps are done for colon. Almivopam on call to OR and post op for elective colon resections. Hassan cut down for laparoscopic access and routine IOC on all gall bladder cases. Repeat close review of CT just before bowel cases (*know where the ureters are expected to be and what will be the window in which we access the abdomen). Inguinal hernias get UA’s preop. Foley Catheters are frequently used and orders to D/C must be written with additional orders to prevent urinary retention episodes.

D. LOPEZ
E. VIGIL: fleets enema x 2 in asu for anal cases. Golytely, neomycin and flagyl bowel prep for colon. SQ Hep for DVT prophylaxis. Routine IOC.

In general, does not get ‘routine’ post op labs. Should have a reason for every lab.

Almivopam for colon resections.

Schedule postop clinic appointment from clinic visit rather than from ASU orders.

Inguinal hernias get UA’s preop.

Lap teps need both arms tucked. Lappy’s don’t need arms tucked.

Does not do forearm/hand/wrist/feet I and D’s.

Portacaths not seen post op>go to Hem/Onc

Please see feeding tube policy in our own consult request form

F. VALDEZ-BOYLE
V. CONTACT INFORMATION

Questions or comments regarding this manual or any other section issues should be directed to the General Surgery Attending Staff.

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Associate Chief of Staff for Education
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Email: Janice.schwartz@va.gov

On Call General Surgery Resident Pager
(505) 251-0120
Blood Transfusion Guidelines

As noted above in discharge section, the attending must be notified if resident is considering giving blood products!

TYPE AND CROSS ONLY FOR CASES WHERE YOU ARE SURE TO USE THE PRODUCTS. T & S FOR CASES WHERE NO ONE WOULD BE SURPRISED IF BLOOD WERE GIVEN.

If you or nurse thinks there is a transfusion reaction, immediately stop the transfusion, call blood bank and Call Dr. Vigil and write a note!

Platelets

- Apheresis platelet units (1 unit equivalent to ~6 pooled whole blood-derived platelet units)
- Prophylactic transfusion when platelet count < 5,000 – 10,000/μL (spontaneous bleeding does not occur until platelet count falls below 5,000 – 10,000/μL)
- Platelet count < 50,000/μL in a bleeding patient
- Platelet count < 50,000/μL in patient undergoing major surgery or invasive procedures, including liver and transbronchial biopsy. Platelet counts between 30,000 and 50,000/μL are generally adequate for hemostasis;
- Platelet count < 100,000/μl in a patient undergoing neurologic or ophthalmologic surgeries/procedures

RBCS

<table>
<thead>
<tr>
<th>RBCs may be indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hemoglobin ≤7 g/dl</strong> in patients</td>
</tr>
<tr>
<td>• Stable non-bleeding patients with no clinical symptoms attributable to anemia</td>
</tr>
<tr>
<td>• On a ventilator</td>
</tr>
<tr>
<td>• With stable cardiovascular disease</td>
</tr>
<tr>
<td>• Who are postoperative (higher hemoglobin if risk of end-organ ischemia)</td>
</tr>
<tr>
<td><strong>Hemoglobin ≤8 g/dl</strong> in patients</td>
</tr>
<tr>
<td>• With acute hemorrhage (≥ 30% TBV) &amp; hemodynamic instability or inadequate O2 delivery</td>
</tr>
<tr>
<td>• With acute myocardial infarction, ST changes on EKG, and/or unstable angina</td>
</tr>
</tbody>
</table>
Hemoglobin \(< 10 \text{ g/dl}\) in patients

- With symptoms attributable to anemia (e.g., tachycardia, dyspnea, hypotension, altered mental status)

**RBCs are almost never indicated when**

- Hemoglobin is \(> 10\)
- **Do Not Transfuse** based solely on Hemoglobin trigger. Transfuse based on patient’s intravascular volume status, evidence of shock, acuity of anemia & cardiopulmonary physiologic parameter
- In the absence of acute hemorrhage, transfuse RBCs in single unit increments followed by clinical laboratory assessment

---

**Plasma Transfusion Guidelines – Adults**

_**Clinical practice guidelines and recommendations are not considered to be standards or absolute requirements. They do not apply to all individual transfusion decisions. Clinical judgment is critical in the decision to transfuse; therefore, plasma transfusion above or below the specified INR threshold may be dictated by the clinical context**_

<table>
<thead>
<tr>
<th>Patient description</th>
<th>INR requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient with active bleeding or pre-invasive procedure</strong></td>
<td><strong>INR (&gt; 2.0)</strong></td>
</tr>
<tr>
<td>CNS/spinal trauma, CNS/spinal surgery, ocular trauma/surgery, CNS hemorrhage, or invasive neurologic procedure</td>
<td><strong>INR (&gt; 1.5)</strong></td>
</tr>
<tr>
<td>Inherited deficiency of single clotting factors (factors II, V, X, XI, and XIII)</td>
<td>If specific factor is not available in concentrate form. Plasma to be given for active bleeding or in preparation for invasive procedure/surgery.</td>
</tr>
<tr>
<td>Thrombotic Thrombocytopenic Purpura (TTP)</td>
<td>During plasma exchange. Can also be used for simple transfusion in these patients while awaiting vascular access for plasma exchange.</td>
</tr>
<tr>
<td>Hemorrhage Protocol/ Massive</td>
<td>Give at least 1 Plasma for every 3 RBCs. Refer to</td>
</tr>
</tbody>
</table>
Transfusion Protocol

<table>
<thead>
<tr>
<th>Institution specific protocols.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replacement fluid in therapeutic plasmapheresis</td>
</tr>
</tbody>
</table>

Contraindications

- For bleeding in the absence of clotting factor deficiencies.
- For supratherapeutic INR due to warfarin without bleeding or without an imminent invasive procedure.
- For replacement of immunoglobulin in patients with immunoglobulin deficiency.
- For patients with one or more coagulation factor deficiencies who are not bleeding and who are not anticipating an invasive procedure.
- As a volume expander.
- As a nutritional supplement.

References


RESIDENTS’ CODES FOR VA

**Residents coming TO the VA**

Be sure your computer codes are ready to go the day you start! *(This is a professionalism issue.)*

Call Jerry Casteel at 265-1711 ext. 4946 stat!

**Residents LEAVING the VA:**

43
1) you are required to complete all your CPRS alerts prior to leaving the VA

AND

2) when you leave the VA you must assign the resident taking your role to be your SURROGATE for future alerts in CPRS

For questions regarding how to do such please see Dr. Ketteler or Dr. Vigil.

Resident CPRS

Quick Reference Guide

New Mexico VA Health Care System

Log-on to the Network
1. Press and hold, Control, Alt keys + and press Delete key.
2. Type your Network User Name (vhaabq_ _ _ _)
3. Press Tab key (or use the mouse to move to the cursor to the password field).
4. Type in your Network Password
5. Press the Enter key or Click OK.

Log-on to CPRS
1. Double-click the CPRS icon.
2. Type in your Access Code.
3. Press the Tab key.
4. Type in your Verify Code.
5. Press the Enter key.

Patient Selection
After you sign in to CPRS, the Patient Selection screen appears that enables you to choose which patient record you want to open and process notifications you have received.

- To select a patient, type their name or social security number. (You can also use the mouse to select a clinic, ward, or specialty and then click on the patient's name.)
- When you click a patient name, CPRS brings up the demographic information under the OK and Cancel buttons so that you can verify that you have selected the correct patient.
- Click OK.

**The Cover Sheet**
The Cover Sheet is the first screen you see after opening a patient record. It summarizes important information about the patient, such as current orders, recent lab tests, medications, demographic information, and so on. Click on any item to get more detailed information.
The CPRS Windows interface mimics the paper chart of a patient's record. To go to a different part of the patient chart, Click on the appropriate tab at the bottom of the chart. For example, click on the NOTES TAB to read or write a progress note.

**Selecting Multiple Orders for Processing on the Same Patient**
To select non-consecutive orders, press and hold the “Control” key and left-click on the desired orders.

To select a block set of orders, press and hold the “Shift” key left-click on the first order, then the last order you wish to select.

**Changing the Orders View**
To change the view of the orders:
The user may select “Active”, “Expiring” or “Unsigned” by selecting “View” on the toolbar.
For a more specific view of the orders:
- Select “View” on the toolbar.
- Select “Custom Order List”.
- Select Service – from all to individual.
- Select Status – from all to specific
You can create a custom order list for the selected patient. (With this command, you can quickly sort the orders list to isolate specific types of orders by choosing the necessary criteria.

**Create a Custom Order List**
1. Under the Orders tab, change your view.
2. Under the View menu choose Custom Order List…
3. In the Custom Order View dialog, click the desired grouper or individual service.
4. Click the desired type of order.
5. If desired, set a date range:
   a. Click the box in front of Only List Orders Placed During the Time Period
   b. Enter the beginning date in the From field
   c. Enter the ending date for the custom view in the Through field
6. Choose whether you want the entries in reverse chronological sequence.
7. Choose whether you want the orders grouped by service.
8. Click OK.
After you customize your view of the orders list, you can save the view as your default view. You will then see that default view when you go to the Orders tab. You can still change the view or make a custom order list, but you will have the default view. You can save any view of the orders list as a default view.

**Time Delay Orders for Admissions/Transfers**
1. Write Delayed Orders button.
2. Pick the event that will release the orders — ie. 
   Medical ICU Admit for M ICU pts or 
   Medicine Ward Admit for Ward or Tele pts; Trans 
   Care Unit ward transfer for ward pts.
3. Enter transfer information. Specify Attending Doc 
   & Primary Care Giver & Dx click OK
4. Highlight orders to copy. Click OK
5. Add new orders using Medicine Order Sets
6. Sign the orders then click active orders again

View an Order
1. Double click on any order for detailed display.
2. To sort by status/service click View menu on orders tab

Discontinuing Order
1. Select the Orders tab.
2. Select the order or orders you want to discontinue
4. Select the name of the clinician (you may need to 
   scroll through the list), select the encounter 
   location, and then select OK
5. Select the appropriate reason from the box in the 
   lower left of the dialog and select OK.
6. If the order you are discontinuing is a pending 
   renewal of another order, CPRS needs to know 
   how to deal with the order you are discontinuing, 
   and the original order. Choose the appropriate 
   action from the dialog that displays: o DC Both, o 
   DC Pending, and o Cancel – No Action Taken

Write a New Progress Note
1. On the Notes tab, click New Note.
2. In the Progress Note Properties dialog, select the following:
   a. Progress Note Title (e.g., Nursing Note, Monthly 
      Summary, etc. Note titles are designated by your 
      Clinical Center 
   b. If necessary, change the note date by clicking 
      the button next to the date and entering a new 
      date. 
   c. Click OK.
3. In the main text box, type in your note and /or 
   insert predefined text from desired templates.
   Note: Spell checking and grammar checking are 
   available in the CPRS GUI.

Using Templates
1. Click the Templates drawer.
2. Locate the template you need.
3. Double-click the template, drag-and-drop the 
   template into the document, or right-click and 
   select Insert Template. (It will be placed where 
   the cursor is.)

Signing Your Note
1. Select Action | Sign Note Now (or Sign 
   Discharge Summary Now).
2. To sign orders or documents and stay in this 
   patient record, select File | Review / Sign
Changes:
3. To sign and move on to another patient, choose File | Select New Patient
4. In the dialog that appears, enter your electronic signature code.
5. Click OK.

Adding an Addendum to Progress Notes
CPRS enables you to make addenda to Progress Notes.
1. Click the Notes tab.
2. From the index of Progress Notes on the left of the dialog, click the Note to which you want to add an addendum.
4. Enter the text of the addendum.
5. Select the Action menu and choose Sign “Note Now”.
You can create multiple addenda to a single Progress Note if you choose and identify additional signers.

Identifying Additional Signers
1. After you have signed the note, select Action | Identify Additional Signers.
2. To identify a signer, locate the person's name (scroll or type in the first few letters of the last name) and click it.
3. Repeat step 2 as needed.
4. (Optional) To remove a name, click the name under Current Additional Signers and click Remove.
5. When finished, click OK.

Completion of an Unsigned Note
You can process your unsigned notes from the alert dialog box when you sign onto CPRS GUI. If you remove an alert for an unsigned note and you do not remember the patient's name, you can look up "ALL MY UNSIGNED progress notes" in VISTA TIU menu. If you know the patient's name you can go to the notes tab.
- Select “View” from toolbar.
- Select “Unsigned Notes”.
- Select appropriate note.
- Select “Edit” from toolbar.
- Select “Edit Progress Note”.
- Make edits as appropriate.

Viewing Progress Notes
By selecting “View” the user may view:
- Signed Notes (All)
- Signed Notes by Author
- Signed Notes by Date Range
- Unsigned Notes
- Custom View

Finding Specific Text in a Note
If you want to find results of a prostate exam search "prostate" or "DRE" using the Search for Text function on the Notes Tab.
1. Right click on all signed notes will give you the option for “Search text”.
2. Select the “Search for text (within current view)
3. To find the results of a prostate exam search “prostate” or “DRE” using the Search for Text.
4. Select Ok.

Note: the “Search for Text” can also be found on the View Menu”.

**Progress Note Entered In Error**

If you enter a Progress Note in error or on the wrong patient and it has already been signed, by NMVAHCS Medical Policy, this note will be retracted and will not be available for clinician viewing.

Guidance on what to do if you have signed the progress note on the wrong patient:
1. First make an addendum to the note stating that the note was "Entered in Error" and electronically sign the progress note.
2. Next, identify either "Martines, Rebecca" or “Janel Sams” as an Additional Signer of the note. Once one of them is identified they will retract the progress note once they receive the view alerts.

**Notifications and Alerts**

Notifications are messages that provide information or prompt you to act on a clinical event. Clinical events, such as a critical lab value or a change in orders trigger a notification to be sent to all recipients identified by the triggering package. “Notifications” are located on the lower third of the screen. The user has the choice of:
- “Process Info”.
- “Process All” – If selected the user may move from one notification to another beginning with the first listed.
- “Process Selected” – If selected the user may process just the notification selected. The user will be given the choice to continue through the remainder of the notifications if desired.
- Reason for notification with opportunity to act on “action” notifications and to view “information” notifications.
- “Next” - To proceed to the next notification.

**Surrogate Settings**

1. Click on the Menu Bar and select “Tools”
2. Go to the “Options” menu and select
3. Click on the “Notification” Tab
4. Select the “Surrogate Settings”
5. Choose a Surrogate from the drop down bar.
6. Click the “Surrogate Date Range” to specify a specific date range.

**Reports**

**Cumulative and All Tests by Date**

Can be sorted by heading and/or date range

**Available Reports**

1. Click on any of the available reports
2. Click on + to expand tree view
3. Click on Selected Date Range (if available).

**Adhoc Report**

A patient at a site can have multiple procedures performed. Over a certain period of time, this would make it difficult for the physician to search through the Clinical Reports for Medicine/CP Reports in CPRS. The site can setup an Ad Hoc Health Summary component for a specific procedure. This way, the physician can just look through the reports for a specific procedure.

1. Go to the reports tab
2. Click on + Health Summary to Expand tree View
3. Click on Adhoc Report
Find the Health Summary component that you want and select it. Enter the Occurrence Limit and Time Limit that you want. Once you clicked the “OK” button, you should generate only the reports found for that occurrence and time limit.

**Imaging**

1. Click on a specific image on the list
   View as directed in Notes section.
2. Click on Tools Menu, Imaging to view images

**VistAWeb**

To access VistAWeb, you must first log into CPRS using your access/verify codes, select a patient, and select VistAWeb from the Tools menu. VistAWeb will maintain context with the selected patient and retrieve data for that patient from all sites where the patient has records. When you select a different patient from the CPRS File menu, VistAWeb will maintain context with the new selection.

1. Click on VistAWeb (top left) when Blue
2. Your Internet Explore will open a new window
3. The patient’s name, SSN, and DOB will be viewed in the new window
4. You will be asked to “Proceed” or “Cancel”

**CPRS HELP**

Whenever you need more information about anything in CPRS, click on Help on the menu bar at the top of the Window, and choose Contents.

**CAC Support for CPRS GUI**

Daily CPRS Issues – Call Ext. 2490

Any new or changes to existing templates, consults, or progress notes, see your service ADPAC to submit a project request form

**TIME OUTS MUST BE RECORDED BY RN PRIOR TO ANY INVASIVE PROCEDURE WHERE AN INFORMED CONSENT WAS OBTAINED.**

**PROCEDURE VERIFICATION PROCEDURE**
Active ID of Correct Pt

**STEP 1**

1. Ask pt to state their **FULL NAME, FULL SSI#, and DOB**
2. Actively verify info stated by pt with pt’s ID band and informed consent to ensure you have the right pt

*NOTE: Patient ID band must be in place and chart with informed consent at bedside to complete verification*

Active Verification of Correct Procedure and Site/Laterality

**STEP 2**

1. Ask pt to state **PROCEDURE being done**
2. Ask pt to state **SIDE or LOCATION of PROCEDURE**
3. Actively verify procedure and site/laterality as stated by pt **WITH INFORMED CONSENT**

*NOTE: The chart and informed consent must be at pt’s bedside to complete verification*
Site Mark
Surgeon/Trainee/Mid-Level

STEP 3

1. Use SINGLE USE disposable marker
2. Mark must be UNAMBIGUOUS
3. MARKED BY ATTENDING performing procedure or MEMBER (Resident/Mid-Level) of operating team assigned to be present in the OR during procedure
4. If unable to site mark skin, place orange wrist band on pt with name of procedure and your initials
5. Must be marked prior to anesthesia placing regional nerve block

NOTE: STEP 1 and STEP 2 must be completed by surgeon, trainee, or mid-level prior to proceeding to site marking

Complete Pre-Procedure Verification Checklist

STEP 4

- INITIAL each item under your assigned section as you are verifying and addressing each line item
How to chart a telephone note for General Surgery scopes:

Click on NEW VISIT

Visit location ABQ GEN SURG/TELEPHONE-X
Document your note, and then encounter:

Select note title
GENERAL SURGERY TELEPHONE NOTE

Mark service connection and your name as the provider
Diagnosis tab

Pre op or post op call
Code for the amount of time you spent on the phone

You did it! Yeah!