RESIDENT EXPECTATIONS

1. **PREOP**
    a. You are expected to check the patient in, and be available to observe markings performed in the Preoperative area
    b. You are expected to be in the OR prior to attending to help facilitate care, communicate reasons for any delays and position patient etc.
        i. Please discuss with attending of record if clinical obligations preclude you from doing this (exception not rule)
2. **OPERATING ROOM**
    a. Residents will be expected to be prepared for assigned cases including knowledge of patient and knowledge of pathophysiology and relevant anatomy.
    b. Residents will be prepared to discuss an operative plan for the patient
    c. Brief post-operative note will be placed before the patient leaves OR. In the plan section, include information that a future team member may need to know, e.g. "remove sutures 7-10 days" or "ok to shower after 48 hours."
    d. If PRS is not primary team, please communicate with the primary team to sign out patient before the patient leaves PACU
    e. A post-operative check will be performed, ideally by the resident who performed the case, though for cases ends after 3pm these can reasonably be signed out. If you were the resident in the case and cannot perform the post-operative check yourself, it is your responsibility to determine who will be performing the post-op check and give an appropriate sign out to that person on what specifically needs to be evaluated beyond the general clinical status. Communicate this plan to the attending so he/she knows who to contact in case of questions.
    f. Post-operative check note—this can be a brief SOAP note format but must be done for every <u>inpatient</u> operated on. Any concerns should immediately be communicated directly to the operating attending.
    g. If any pages regarding flap concerns please see the patient. This will be important as we get the flap ward off the ground and will ultimately pay dividends in the future.
3. **ROUNDING**
    a. Rounding should be performed at a time, and in a manner that allows residents to be available for any assigned case – including preoperative check in, marking, and being available in OR <u>prior</u> to case start
    b. Please communicate with attendings of record regarding their patients on the ward (ideally prior to first case)
        i. This should include a general update of patient and proposed plan for the day. Please include a text or call in the morning outlining/confirming plan for the day including the junior resident/PA who will be available throughout the day for additional follow-up. This will allow us to communicate directly with junior provider when the seniors are in the OR.
        ii. Confirm discharge planning with attending – this should be something that is worked on daily to prevent delays
    c. Free Flap Rounding:

i. POD 0 – Resident/PA should see flap around 6 hours after anastomosis and text attendings of record an update

ii. POD 1 – Flap should be seen <u>first</u> (by overnight call team or day team), early in the AM (latest 6-6:30am) and a brief update sent (flap doing ok, etc). This is important because if there is an issue with the flap, we have to get patient into OR before the cases of the day are started

iii. POD 1 – Flap should be seen 2-3 times throughout the day as a quick check by any member of the team (I.e. when DIEP gets OOB, etc).

d. Wound vacs & wound care:

i. All wound vac changes must be documented in the progress note. You must record the number and color of sponges removed and placed for every vac change. Retained vac sponge is an event reportable to the state medical board and should be considered a "never" event.

ii. If we are assuming care of a wound with a vac placed by another service, their documentation must specify number and color of sponges placed, otherwise we cannot assume responsibility for the vac.

iii. Pre-medication, if indicated, should be ordered for wound vac changes the day prior and communicated to nursing staff so they can administer oral medication one hour before the planned vac change.

iv. Prior to performing a vac change, communicate with the attending to ensure that he/she does not need to be present to evaluate the wound.

v. A photo should be taken of the wound, uploaded to the patient chart, and included in the progress note.

vi. Patient with a wound vac should have an order for the wound vac specifying pressure. Non-vac wound care orders should have clear orders and instructions for the nurses.

e. Splints:

i. Splints are a common source of preventable pressure injury. All splints should be checked daily for possible pressure injury and changed as needed.

ii. Any patient with a splint or cast should have nursing order place that specify if nursing is allowed to remove the splint for skin checks and who to contact if there is splint concern.

4. CONSULTS

a. Consults should be communicated with the attending on call in a timely fashion per the chart below.

b. All consult notes should include a full history and physical, with details of past medical history, surgical history, medications, and social history confirmed with the patient and thoroughly documented. It is unacceptable for a consult note to simply say "No history on file" for any of these fields.

c. Definitive plans should not be finalized prior to confirming with attending.

i. We want you to push yourselves to come up with plans but these should always be confirmed

ii. If a preliminary plan is enacted overnight (e.g non-op max sinus fracture) the patient should not be discharged prior to confirming that plan with the attending physician.

If the patient will stay until morning, can wait until that time to discuss with attending.

d. If you have not confirmed a plan with an attending the language should NEVER be “Patient was discussed with Dr. X who is in agreement with the plan” but rather should be “Attending of record is Dr. X, definitive and final plan to follow in AM.”

5. BOUNCE BACKS AND ADMISSIONS

a. Regardless of who is on call, please always communicate with the attending of record regarding any readmissions or ED bounce backs

b. For new admissions – these should never occur under an attendings name without first confirming with that attending

Ultimately we want to create an environment in which we as attending physicians are available to maximize your education however possible while also optimizing patient care and reducing liability. As always thank you for all your hard work in helping us care for patients.

Attending Communication Preferences and Documentation Guidelines

UC Davis Department of Surgery, Division of Plastic and Reconstructive Surgery

<table>
<tr><th></th><th>How would you like to be contacted?</th><th>Who would you like to be contacted by?</th><th>When would you like to be contacted for non-urgent consults?</th><th>If my post-operative patient presents to the ED:</th></tr>
<tr><td>Clifford Pereira</td><td rowspan="3">Text first, then phone, then pager if no answer</td><td rowspan="5">Senior resident</td><td rowspan="6">The next morning</td><td rowspan="3">Staff with the attending on call. That person will contact me if needed.

For post-op hand patients presenting on Ortho hand call days, contact the PRS Hand attending on call that week.</td></tr>
<tr><td>Andrew Li</td></tr>
<tr><td>Ravi Sood</td></tr>
<tr><td>Granger Wong</td><td rowspan="2">Phone or text</td></tr>
<tr><td>Lee Pu</td></tr>
<tr><td>Ara Salibian</td><td rowspan="2">Text first, then phone, then pager if no answer</td><td rowspan="3">Contact me first. If I am unavailable, please staff with the attending on call.</td></tr>
<tr><td>Michelle Zaldana-Flynn</td></tr>
<tr><td>Ian Powelson</td><td>Group text with in-house provider and senior resident. Phone call if no answer.</td><td>Any resident or PA who actually saw the patient</td><td>At the time of the consult, <u>prior to discharge from ED</u></td></tr>
</table>

Consult notes should describe what communication *actually took place or the plan for future communication* with the attending physician:

“The patient was discussed with the senior resident on call, Dr. _____, who agrees with the assessment and plan and will discuss the patient’s care with the attending physician on call.”

The senior resident should determine which attending the note should be sent to in the case of post-operative patients, according to the guidelines above, and communicate this to the provider doing the documentation so that the note is assigned appropriately.