Senior House Officer (SHO)

This rotation is a hospital based serve that allows a PGY-3 (as a part of admit team with 2 PGY-1s) to both triage patients from the emergency room, admit the patient, accept transfers , and overall send the patient to the appropriate service. You have a very critical role in the transition of care from the emergency room to the inpatient setting. It's a unique opportunity for you as a resident, so make the most of it!

Schedule: Monday to Friday 7:00 AM – 8:00 PM (You will have an early and late intern. The early intern is expected to come in at 7:00 AM (and not roll in at 7:00AM, be prepared and ready at 7:00AM. There can be multiple patients waiting in the morning and they all have to been seen in a timely manner. The late intern will come in at 10:00 AM. As far as when interns leave, the below is what is expected of all interns on admit team, it is up to the SHO if the intern can leave earlier.

Early intern Monday to Saturday or Sunday 7:00 AM -4:00 PM (if everything is tucked in, completed, handed off to the appropriate team or signed out to the call intern)

Late intern: Monday to Saturday or Sunday 10:00AM-8:00PM (The early intern will sign out any admissions that were not distributed to the floor team to the late intern and they will hold the patient until sign out at 8:00pm until the night float time arrives).

As the SHO, you will take admissions from 7:00 AM to 3:30 PM. HOWEVER, you are expected to rotate in if the call team (3:30 – 6:30PM) gets busy. Remember you are part of the team, if everyone does their part, we can all complete our work on time.

Logistics:

1. ED will now directly call you for admission
2. Connect 3 way call with the hospitalist so they can hear the admission
3. While they are signing out to you, look through the chart (focus on hemodynamic stability)
4. Call bed board with the new admission so they have the resident assignment
5. Supervise admission with intern (rotate in with the intern if the day gets busy)
6. Admission orders, H&P, med rec, provider handoff
7. Call hospitalist on call (646-235-5371) or call private attending to confirm the patient is being admitted under their service.
8. If before call and patient already moved from ED to floor, hand off patient to floor team (or sign out next day)
9. Rotate in for admission during call (after each call team has gotten ~2patients)
10. Bed board will also call for transfers or step/downs, hand off patient to the appropriate floor team if before call. If after call, then transfers will go to call team. Try to give transfer to the team that will likely carry them for the next day.

Tips/Tricks from our experts:

- Do NOT blindly accept patients for admission, remember your job is to make sure the patient also goes to the appropriate service. While you are getting sign out, look through everything (Vitals, flow sheets, results, glance at any previous admissions, etc)

- LISTEN closely to everything the ED tells you, this is your sign out! Always try to chart check quickly before hearing the sign out so you can ask whatever questions you have.
- You should also think about why is this patient being admitted, can something be done outpatient? (Do NOT always think this is the case, and even if there is no medical reason for admission, there may be a social reason, needing PT/SAR/etc or if they will have poor outpatient follow up otherwise. What is preventing them from going home? (Ability to tolerate PO, inability to ambulate, safety reason?)
- You are allowed to ask the ED provider questions (it's for the safety of the patient, i.e. 2 sets of blood cultures sent, making sure the patient has adequate IV access before they get up to the floors, repeat labs if needed, COVID swab, etc..)
- Lastly, probably the most important, appropriate triaging the patient requires good clinical judgement. LOOK AT THEIR VITALS, and the trend. If a patient came in with a blood pressure of 140/90, and the most recent blood pressure is 80/50, this is a problem! If a patient is floridly septic, did they get the appropriate amount of fluids, the patient came in with a fall or trauma, did they get a full skeletal survey, FAST exam? Does the patient have a primary cardiac problem, do they need telemetry? If you have a gut feeling a patient may head the wrong direction, talk to the hospitalist and discuss getting an ICU consult for higher level of care.
- Remember you are NOT alone, even as the SHO, there is always a hospitalist, intensivist, cardiology fellow, ICU 3rd year if you need.

<u>Night Senior House Officer (Night SHO)</u>

Responsibilities: SAME AS ABOVE PLUS:

1. **Make the distribution**, start it as early as possible. Your night will get busy as the admissions come in. (If you get more admissions than your team can handle, and there are concurrent rapids/codes, etc, you are allowed to call for back up call, it is not always guaranteed!)
    a. **Try to be fair, cap for 4Ur/7Ur/7Wo = 20, Float = 15 patients**
2. If you are the resident holding the medical consult pager, please NOT refuse or delay a consult. Please discuss to the nocturnist regarding all med consults that come your way. Understandably some nights will be busy, so if a consult can be delayed, this decision should be made in conjunction with the nocturnist. Make sure to ask reason for consult, what surgery (if pre-op), and please do these on a timely manner. Please also make sure to check vitals and assess stability of the patient.
3. Remember there is no phlebotomy at night, so if you need to get repeat labs, see if the ER can do the important ones you need before the patient gets to the floor (lactate, BMP, cardiac enzymes, etc).
4. Obtain the counts from all the teams (4 – 4uris1/4Uris2/Float, 7-7uri1/7Uris2/7Wollman, any remaining Admit team patients will go either one of the night float interns.) Always confirm these counts by checking yourself (You want to account for all new and current patients under the medicine service). Make sure each admission has a resident assignment.
5. Be available to the interns for any major questions. If an intern is coming to you for help with a difficult patient, go see the patient!

6. Document! (This goes for every rotation… any change in status/change in level of care, rapids, major changes in management)
7. Hold the rapid response pager and respond to ALL rapids on the floors.
8. If you feel like the patient may be discharged the next day, you can call bedboard to hold the bed.