Good Samaritan Wards Rotation Primer

Rotation Overview & Primary Educational Focus

The primary goal of this rotation is the development of **resident autonomy.** This clinical experience is designed to more closely replicate independent practice as a community hospitalist. Residents are expected to take primary ownership of clinical decision-making, patient flow, admission triage, and team coordination while still practicing within an academic teaching environment. Compared to Chandler Wards, patient acuity is generally lower, and there is increased exposure to behavioral health concerns.

Residents are expected to:

- Function with progressive independence, developing and implementing diagnostic and management plans
- Triage and distribute admissions between teams
- Coordinate care with the interdisciplinary team (nursing, pharmacy, case management)
- Ensure safe transitions from admission through discharge and outpatient follow-up
- Effectively supervise medical students, balancing patient care responsibilities with teaching

Team Structure:

- 1 Attending Physician
- 1 Supervising Resident
- 2–3 Medical Students (M4 acting-interns and M3 clerkship students)
- 1 Pharmacist (may include pharmacy resident/students)
- 1 Discharge Planner, Social Worker, or Nurse Case Manager
  There are no interns assigned to this service

Workroom Locations:

- Team 1 (GSH1): A316 (door code 13579#)
- Team 2 (GS2): A316 (door code 13579#)
  Resident workrooms are located on 3rd floor (below the Sleep Clinic on 4th floor)

Scheduling Expectations

1. Start of the Rotation

   Both residents on each team should be present on the first day of the rotation, even if this occurs on a weekend.

2. Days Off

   Residents should receive at least four days off during the rotation.
   When one resident is off, the remaining resident assumes full responsibility for the service.

- Weekend days off are typical. Residents should coordinate with their co-resident to determine whether to:
    - Alternate “Golden Weekends” (Saturday and Sunday off together), or
    - Take one weekend day off per week
- If a resident has a scheduled weekday absence, leaving a single resident to manage the service, that resident should typically work an additional weekend day, with the co-resident receiving that day off.
- If call days are rearranged:
    - Contact the inpatient scheduling chief to update Lightning Bolt
    - If the change occurs same day, contact IT directly

Note templates:
Residents are expected to use the approved IMHP and IMPROG templates while on UK Chandler Wards.
To add templates in Epic:

1. Go to **My Tools**
2. Click **My Smart Phrases**
3. Change user to: *Wolak, Megan*
4. Add:
    - .IMHP
    - .IMPROG

Shift Expectations:
These times reflect expected availability—not exact arrival/departure times. Arrival ≥30 minutes early and departure ≥1 hour late may occur depending on workload.

1. Handoff

There is no in-person sign-out.

- Morning:
    - The Nocturnist updates the “Handoff” tab in Epic to communicate overnight events.
- Evening:
    - Residents must remain in-house until 4:00 PM.
    - If patient care tasks are complete and there are no active issues, non-late residents may leave at 4:00 PM, but must:
        - Ensure the “Handoff” tab is updated in the “Hospital Medicine” context
        - Remain signed in as First Call Provider
        - And be available via Epic secure chat until 7:00 PM
    - If urgent concerns arise after a primary resident leaves (but before 7:00 PM), the resident on late shift should evaluate the patient.
- Update **First Call Provider** at each shift

2. Admissions
   - The triage attending (GS Night) should distribute any remaining overnight admissions between 7:00–7:30 AM.
     - If admissions are being assigned after 7:30 AM routinely, notify the inpatient chief or Dr. Vick.
   - Each team has:
     - Hard cap: 16 total encounters per day (existing + new + discharges)
     - Team cap of 14 total patients
   - All residents (call and non-call) are expected to admit daily.
     - The on-call resident should be designated in Epic as part of the GSH DHM Admissions and is expected to triage and distribute admissions between both teams
     - Early admissions should typically go to the non-call team until:
       - They reach 16 encounters
       - Reach 14 patients
       - Or until 4:00 PM
     - If the non-call team admits a patient, that encounter does not count toward the on-call team's encounter
   - The GS Swing attending should be notified and will assume admissions if:
     - Both resident teams reach 14 patients
     - The on-call team reaches 16 encounters
     - Or it is after 6:30 PM

3. Code Pager: Unlike UK Chandler, the ICU team is the primary responder for inpatient code blues. However, the on-call resident may be designated in Epic to be notified of code blues.

4. Typical Daily Workflow
   - 7:00–8:45 AM: Pre-rounding (chart review, patient interviews, exams)
   - 9:00–11:30 AM: Team rounds
     Rounds should conclude by 11:30 AM to allow residents to attend educational conference (12:00–1:00 PM).
   - After rounds: Enter orders, contact consultants, arrange discharges, perform procedures as indicated, obtain OSH records, update families, complete documentation

Recommended Educational Resources:
- UpToDate
- NIH-NCBI StatPearls
- Harrison's Principles of Internal Medicine

- UK CareWeb Guidelines & Protocols (anticoagulation, antimicrobial stewardship, insulin/glycemic control, PE guidelines, etc.)
- Clinical Practice Guidelines published by specialty specific professional organizations or societies
    - Society of Hospital Medicine (SHM)
    - American Heart Association and American College of Cardiology (AHA/ACC)
    - Global Initiative for Chronic Obstructive Lung Disease (GOLD)
    - American College of Gastroenterology (ACG)
    - American Association for the Study of Liver Diseases (AASLD)
    - National Comprehensive Cancer Network (NCCN)
    - American Society of Clinical Oncology (ASCO)
    - Infectious Disease Society of America (IDSA)