GENERAL SURGERY
RESIDENT MANUAL

James J. Peters Veteran Affairs Medical Center
130 West Kingsbridge Road
Bronx, NY 10468

2ND Edition – May, 2019

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VETERAN HEALTH SYSTEM

Welcome to the James J. Peters VA Medical Center in the Bronx, the oldest VA facility in New York City, celebrating over 75 years of service to veterans. The James J. Peters VAMC is a tertiary care facility classified as a Clinical Referral Level 1 Facility. Department of Surgery is designated as a high complexity surgical program. It is a teaching hospital, providing a full range of patient care services, with state-of-the-art technology as well as education and research. Comprehensive health care is provided through primary care, tertiary care, and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. This medical center has 378 authorized hospital beds with 75 beds on the Medical/Surgical floors and 20 beds in the Intensive Care Unit, as well as 120 nursing home beds.

The Bronx VA operates several regional referral points including Spinal Cord Injury (SCI) and Veterans Integrated Service Network (VISN) referrals for Medical/Surgical subspecialties. The medical center is the VISN Bariatric Surgery Referral Program where the team performs laparoscopic sleeve gastrectomy. The first operation was done in February 2010. Since that time, the team has successfully performed over 350 surgeries with an average excess weight loss of 50% at one year.

The JJP VA Medical Center is also an approved member of the American College of Surgeons Commission on Cancer. In addition to providing the surgical treatment for esophageal, gastrointestinal, liver and pancreas cancers, the medical center also provides up to date advances in radiation therapy and chemotherapy. Weekly Surgical Tumor Board provides a forum to develop treatment plans for patients by a truly multidisciplinary team. The Cancer Committee also meets quarterly to review outcomes and management of patients.

In 2010, JJP VA was designated as the first VA medical center within the VISN to acquire the da Vinci Robotic Surgical System produced by Intuitive Surgical Systems since 2000. The da Vinci robot is used for a number of surgical procedures with the largest volume being Robotic Assisted Laparoscopic Radical Prostatectomy (RALP) to treat prostate cancer. In General Surgery, the da Vinci is utilized for colon resections and other bowel surgery.

The Vascular Surgery service at JJP VA is a robust service offering our veterans the best in open and endovascular techniques. Vascular pathology is rampant among the Veteran population allowing for a wide range of complex surgical cases.

In 2016, the JJP VA Medical Center became the 7th VA Renal Transplant Program nationally and the VISN Renal Transplant Referral Program to serve veterans living in the Northeast US and beyond. The medical center has one of the largest renal medicine

and dialysis programs in the VA system. Now we offer the preferred renal treatment option, transplantation, to veterans who are candidates.

GENERAL SURGERY SERVICE GOALS & OBJECTIVES

Introduction

The general surgery service at the James J. Peters Veterans Affairs Medical Center admits patients with a wide variety of problems. These include general surgical problems, vascular surgery, hepatobiliary surgery, bariatric surgery, colorectal surgery, thoracic surgery, and oncology. One Chief resident (PGY5), one senior resident (PGY3) and 3 junior residents (PGY 1) rotate to this service. The goals and objectives for this service include all of those previously mentioned for general surgery (see Team IV, MSH). In addition to the Department Educational Goals & Objectives, the following objectives pertain specifically to this rotation:

Medical Knowledge

Residents must demonstrate 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.
Residents rotating on the James J. Peters VA Surgery Service will:

Be able to treat a large number of patients with complex problems that often have much co-morbidity frequently related to smoking and increased alcohol intake. Chronic diseases including arteriosclerotic heart disease, vascular disease, and cancer are also common in this hospital.

PGY-1 residents rotating on the James J. Peters VA Surgery Service will learn to:

Vascular Surgery

- Recognize the anatomy, physiology and pathophysiology of the vascular system.
- Diagnose and manage patients with clinical problems relating to the arterial, venous, and lymphatic systems
- Know and understand the pathophysiology of various vascular disorders, including obstructive arterial disease, aneurysmal arterial disease, thromboembolic disease (arterial and venous), vascular trauma, venous insufficiency and lymphatic obstruction. Other important areas that must be studied include the management of cerebrovascular problems, mesenteric angina, and renovascular hypertension.
- Understanding and familiarity with common diagnostic modalities, including angiography, CT scanning, MRI, MRA, duplex scanning, and the non-invasive vascular laboratory.

Surgical Oncology

- Obtain a good knowledge of the anatomy, physiology and pathophysiology of the liver, biliary tract and pancreas.

- Increase their knowledge of the clinical disorders and pathology of diseases of the hepatobiliary system and learn advanced techniques in the diagnosis and management of problems in this area.
- Gain expertise in evaluating CT scans, ultrasound, ERCP, PTC and arteriography. • Understand the management, surgical and non-surgical, of malignant and benign problems of the common bile duct and pancreas

Transplant Surgery
- Obtain a good knowledge of the anatomy, physiology and pathophysiology of the native and transplanted kidney.
- Increase their knowledge of the clinical disorders and pathology of diseases of the renal system and learn advanced techniques in the diagnosis and management of problems in this area.
- Gain expertise in evaluating CT scans, nuclear medicine and ultrasound Doppler imaging of transplanted kidneys.
- Understand the management, surgical and non-surgical, of complications after renal transplantation.

PGY 3 & 5 residents rotating on the James J. Peters VA Surgery Services will learn to:

Vascular Surgery
- Participate in and perform more complex operations including aortoiliac bypasses, femoropopliteal bypasses, carotid endarterectomies and aneurysm repairs.
- Participate and acquire competence (PGY4) in various surgical procedures using endovascular techniques and learn to deal with the care of these patients pre and post operatively ***Surgical Oncology***
- Perform liver resections, robotic colon resections, gastrectomies and Whipple procedures. ***Thoracic Surgery***
- Perform VATS procedures, open thoracotomies and esophagogastrectomies

Transplant Surgery
- Obtain a good knowledge of the anatomy, physiology and pathophysiology of the native and transplanted kidney.
- Increase their knowledge of the clinical disorders and pathology of diseases of the renal system and learn advanced techniques in the diagnosis and management of problems in this area.
- Gain expertise in evaluating CT scans, nuclear medicine and ultrasound Doppler imaging of transplanted kidneys.
- Understand the management, surgical and non-surgical, of complications after renal transplantation.
- Participate in and perform aspects of renal transplant surgery, transplant nephrectomy and complex general surgery on listed and transplanted patients.

Bariatric Surgery
- Perform laparoscopic bariatric surgery such as Sleeve Gastrectomy

Patient Care
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. As such:

Residents rotating on the James J. Peters VA Surgery Service will learn to:
- Gain a better understanding of establishing an independent plan of management. Although an attending supervises the care of each patient, the residents have a greater ability to exercise their own judgment. The care and treatment of this group of patients, with a different attending staff from the other hospitals, helps to round out the education of the surgical resident in our program. ***Surgical Oncology***
- Manage patients both operatively and non-operatively with cancer, liver disease and liver failure, cirrhosis and portal hypertension.
- Play an integral role on the service and participate in all major arenas of patient care—in preoperative evaluation of new patients as well as long-term management of patients seen in the outpatient setting.
- Responsible for the surgical and non-operative management of patients with hepatocellular carcinoma which includes: radiofrequency ablations, ethanol injections and chemoembolization procedures.

Transplant Surgery
Manage patients both operatively and non-operatively with renal failure and transplant rejection.
Play an integral role on the service and participate in all major arenas of patient care.
Thoracic Surgery
- Understand the preoperative evaluation and postoperative care of these patients, including a detailed assessment of the ability of a patient to undergo extensive esophageal and pulmonary surgery.
- Manage the care of the patient after chest tube insertion
- Develop and carry out patient management plans
- Counsel and educate patients and their families on the state of the patient's disease, necessary diagnostic tests, operative procedures medical management
- Ensure that the needs of the patient and team supersede individual preferences when managing patient care; incorporate evidence-based medicine into patient care whenever possible; comply with changes in clinical practice and standards given by the senior Thoracic Surgery resident and/or attending

PGY-1 residents rotating on the James J. Peters VA Surgery Service will learn to:
Vascular Surgery
- Manage the preoperative and postoperative care of patients with vascular disease, including a comprehensive understanding of the assessment of risk factors in patients needing vascular surgery.
- Participate in and perform some of the simpler vascular surgical procedures. These include: amputations, varicose vein surgery and A-V fistulas. • Know and understand the indications for endovascular techniques.

Transplant Surgery

- Manage the preoperative and postoperative care of patients with renal failure including a comprehensive understanding of the assessment of risk factors in patients needing kidney transplant.

PGY-3 & 5 residents rotating on the James J. Peters VA Surgery Services will learn to:

Vascular Surgery

- Know & understand the preoperative & postoperative management of patients with clinical problems that are amenable to surgery. This includes familiarity with the various monitoring devices and drugs used in the perioperative care of the patient.
- Demonstrate competence in obtaining history & physical examination as they apply to vascular problems. ***Transplant Surgery***
- Know & understand the preoperative and postoperative management of patients with clinical problems related to kidney transplant surgery

Practice-Based learning and improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. As such, residents rotating on the James J. Peters VA Surgery Service will learn to:

- Learn to utilize a variety of educational resources, library or web-based learning, to examine and improve their patient care practices based on scientific evidence.
- Attendance and active participation in department and team conferences where they learn how to critically review the current literature.
- Participate in Performance Improvement programs of the department to identify areas of deficiency.
- Contribute and participate in the Near Miss Program reporting system to help avoid medical errors.
- If possible, carry out and participate in retrospective studies to examine practice patterns in the institution.

Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective information exchange and teaming with patients, their families, and health professionals. As such, a resident rotating on the James J. Peters VA Surgery Service will learn to:

- Communicate with patients and their families regarding surgical procedure & medical status of the patient
- Participate in the process of obtaining informed consent.
- Inform patients and their families of the risks and benefits of the procedure.
- Interact with hospital staff, peers and attending in a collegial, professional manner.
- Participate in the education of medical student and junior residents.
- Participate in discussions and resolution of ethical issues that affect patient care
- Attendance and participation in Departmental and team conferences; activities aimed at developing skills in public speaking

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. As such, a resident rotating on the James J. Peters VA Surgery Service will learn to:

- Strong work ethic, personal integrity, and commitment to the highest standards of patient care.
- Demonstrate sensitivity and respect for age, sex, race and culture of patients • Conform to the highest standards of professional hygiene and dress professionally
- Commitment to providing equal health care to all patients.
- Maintain a professional atmosphere in their relationship with their peers, medical students and other associates.

Systems-Based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on system resources in the system to provide optimal health care. As such, a resident rotating on the James J. Peters VA Surgery Service will learn to:

- Understand and practice high quality, cost effective patient care.
- Choose appropriate treatment options for patients based on risk-benefit analysis
- Know the roles of the different specialties and services in the institution and how and when to incorporate their services I the care of the patient.
- Learn the basics of coding for diagnoses and services.
- Learn how to arrange for surgeries (elective & emergent), tests and admissions.

AGENDA & CONFERENCES

WEEKLY – Clinic

All residents who are not scrubbed in the OR, including Chief and Senior Residents, are expected to attend clinic. Where indicated, there are clinics that do not require resident coverage but have been added here for your knowledge. PLEASE BE ON TIME FOR CLINIC. All clinics are located on 2G except where noted.

Monday	8:00 am	Transplant Surgery 4C-18 (no residents)
	10:00 am	General Surgery
	9:30 am	Rectal Surgery – Dr. Freed
	1:00 pm	Thoracic Surgery–Dr. Lee (no residents)
Tuesday	8:00 am	Transplant Surgery 4C-18 (no residents)
	8:30 am	Vascular Surgery - Dr. Changer
	10:00 am	Bariatric Surgery (no residents)
	1:00 pm	Vascular Surgery - Dr. Schanzer
	1:00 pm	Plastic Surgery - Dr. Meisner
Wednesday	8:00 am	Transplant Surgery 4C-18 (no residents)
	10:00 am	General Surgery
	9:00 am	Vascular Lab
Thursday	8:00 am	Transplant Surgery 4C-18 (no residents)
	9:00 am	Vascular Lab
	1:00 pm	Plastic Surgery – Dr. Ko
Friday	9:00 pm	Vascular Lab
	9:30 pm	Bariatric Surgery (no residents)
	1:00 pm	General Surgery (Attending Rotation)
	1:00 pm	Plastic Surgery – Dr. Fang

Conference -LECTURES ARE MANDATORY INCLUDING TUMOR BOARD

Monday	2:00 pm	Attending rounds (Surgery Conference Room, 2G)
Wednesday	8:30 am	Vascular Conference
Thursday	7:00 am	Basic Science at Mount Sinai

	8:45 am	GI/Surgery Conference (8C-20)

Presentations alternate weekly between Surgery and GI. Please contact GI fellow at the beginning of the month to arrange schedule. A senior or Chief resident should be presenting. Topics will be distributed.

	9:30 am	Surgery Grand Rounds (M&M/Journal Club/Presentation – see monthly)
	11:15 am	8B Multidisciplinary/Social Work Rounds (8C-20)

To follow: Attending walk rounds (start in SICU)

	1:30 pm	Tumor Board (5C-02)
Friday	7-9:00 am	Mandatory conference at Mount Sinai

MONTHLY - Conference

ALL LECTURES ARE MANDATORY

Wednesdays - 4th of month Vascular Access Conference (4C-13)

Thursdays (8C-20)

1st of month	9:30 pm Surgery Grand Rounds presentation by resident/intern
2nd of month	9:30 pm Journal Club
3rd of month	9:30 pm Surgery Grand Rounds presentation by resident/intern OR Specialty M&M
4th of month	9:30 pm M&M All M&Ms must be written up to include patient name, last four, diagnosis, procedure, complication and case summary. These must all be emailed to Dr. Heimann.

MOUNT SINAI HOSPITAL SHUTTLE SCHEDULE

Departs JJPVA	Departs Mt. Sinai Hospital
6:00am (bus)	6:45am (bus)
7:30am (bus)	8:15am (bus)
9:00am (passenger van)	9:45am (passenger van)
10:30am (passenger van)	11:15am (passenger van)
2:30pm (bus)	3:15pm (bus)
4:00pm (bus)	4:45pm (bus)
5:30pm (bus)	6:15pm (bus)

Mt. Sinai Shuttle makes trips during weekdays between the JJPVA at 130 W Kingsbridge Rd & Mt. Sinai Medical Center at the front of the parking lot at the ICAHN Building at 99th St. & Madison Ave. Valid VA or Mount Sinai ID required. There is no service to/from the JJPVA & Mt. Sinai on weekends or holidays.

<u>**GENERAL SURGERY TEAM MEMBERS & IMPORTANT NUMBERS**</u>

SURGERY

Attending	Specialty	Cell	Pager	Office
Jorge Camunas	Thoracic	646-241-5860	917-389-4187	
Rajiv Chander	Vascular	732-221-0287		
George Deitrick	Gen Surg	516-384-4255 917-205-3965	**035	5410
Dong-Seok Lee	Thoracic	646-438-5395		212-241-4325
Jeffrey Freed	Gen Surg	917-355-0108		212-396-0050
Tomas Heimann	Gen Surg (Chief)	914-645-4986	800-329-1543 212 241-9281	5052
John Ko	Plastics	917-887-1583		718-898-3090
Robert Kurtz	Gen Surg	646-842-2681	**528	5155
Marie Le	Transplant	347-668-4507		6623
Chung Loh	Thoracic	201-568-8411	201-296-2438	
Glenn McWilliams	Urology	917-968-5176		
Jay Meisner	Plastics	212-794-1500		
N. Roberson-Jasper	Gynecology	646-532-7410		
Harry Schanzer	Vascular	917-797-4153		
Steve Siegel	Podiatry	917-868-1435	**259	5181
Daniel Stephens	Bariatric/Gen Surg	917-991-8958		
Albert Thomas	Gynecology	347-723-6209		

Nurse Practitioner

Marcel Kaganovskaya 347-835-9379

Practice Manager

Lisahia Horton, x5908

INTERVENTIONAL RADIOLOGY

Attending	Cell	Pager	Office	Home
Bruce Reiter	917-205-1871	**003	6552	212-861-5498

ANESTHESIOLOGY (p)214**

Attending	Cell
Andrew Schwartz	808-349-3553
James Chien	646-522-7573
Deepali Dhar	973-2041745
Adrienne Gleit	860-912-3361
Andrew Goldberg	914-582-0045
Craig Mattison	415-205-9876
Moshe Wagh	914-882-9295
Mark Trentalange	480-620-6506

ICU (p) 7-805

Attending	Cell	Pager	Office
Robert Siegel (Chief)	917-842-6975	**008	6723
Bindu Raju	917-952-8831	**162	6696
Roberta Lenner	516-482-2048	**174	6682
Joon W. Kim	718-344-2299	877-365-8107	5597
Gregory Schilero	914-374-0811	**222	6701
Sharif Latef	201-920-6213	**111	
Zinobia Khan	718-496-9531	**405	5099
Moses Bachan	718-496-9854	877-568-0649	5037
David Shaz	404-769-8720	**493	6716
Maciej Walczysyn	860-748-5361		

JJPVA Medical Center

Main Number 718-584-9000
HAC (c) 917-282-9593 (p) 7-853 or **393 in house
(Hospital Administrative Coordinator)
Interpreter 800-481-3293 Acct #501019506, Pin #0592
Help Desk 5441
Human Resources 6584
GME office (7B) 6753
Employee Health 5356/5357
VA Police 5377

Surgery Resident Team Room – 8B-69

Code 7874#
Extension 5031/1567
Bathroom Code 234

Resident pager 7-842

Supply Rooms

1D	1533#
7B	6820#
7C	0012#
8B Supply Room	1234#
8B Med Room	1472#
SICU	5689#

OCC/Holding 6205/6206/5277
PACU 6210/6211/6208
Admitting (2A-10) 5277
Bed Board 6880
Hoptel 5473/5475/4212 fax 4641
Telephone Consents (Taniesha Richardson) 5630

Operating Room

Inner core	6230/6231
OR Scheduler	6216
Rm1	Storage
Rm2	Storage
Rm3	Nurse 6223/wall 6256
Rm4	Nurse 6224/wall 6277
Rm5	wall 1191/nurse 6225
Rm6	wall 1190/nurse 6226
Rm7	wall 6227/nurse 6234
Rm8	wall 6228/nurse 1640
Rm 9	wall 6229/nurse 1641
Rm10	wall 6230/nurse 1642

General Surgery Clinic – 2G

Extension	5041/5021
Clinic Fax	718-741-4621
Room 1 (2C178 – nurses)	5957 or 3716
Room 2 (2C177)	5035
Room 3 (2C176 - Rectal)	5034
Room 4 (2C175 – Vasc Lab)	5033
Room 5 (2C188)	5008
Room 6 (2C189)	5072

Head Nurses: Nickesha Johnson, RN x3716; Marie Walters, RN x5957
Medical Assistants: Marie Rainey x5021; Arthur Dace x5041
Medical Support Assistant: Anique Lyne x3721, Setha Kao x3822

Floors

Emergency Room	5255/5256
1C-07 Urology Clinic	5359/5360
1D SCI	5392/5393/5394
1E	5433
NH1A	3446
NH2A	3426
2C-Suite E/Coumadin Clinic	6776/5276
4C PD	5822
4C-Kidney Dialysis	6670/6633
Nurse Manager	6640
Faye	6324
Renal Clinic	6608
6B	5429/5250
7B	6828/6829
7B Med Team	6825/6775
7C	6742/6743
7C Med Team	5855
8B	5026/5027/5024/5003
8B SDU	1440
8C-ICU	6715/5068 6727/5071

Radiology

Main Extension	6533/6534/6357
VETMED	(Dial 0)
CT Scans	5792/6555
IR Suite	1550/1560
MRI	5584/5935
Ultrasound	6347/6859/6354
Nuclear Medicine	1550/1560/1311 Dr. Lynn p**215
CARDIO	1539
ECHO	6770
ABI/PVR	5021/5041
PET	6349
X-ray Tech	6533

Laboratory/Pathology

Pathology	6307/6308
Microbiology	6320/6321
Chemistry	6269/6264

Hematology	6263
Hematology Clinic	3600/6669
Blood Bank	6250/6251
Histology	6318

VAC/Wound Care

SPD/Vac Sponges		5528	
Wound Care RN:	Carmel	6142	(p)**543
	Thureiyya	646-667-3921	
	Andrea Smith	(p)**092	
KCI Repair		1-877-485-0343	
KCI Order		1-800-275-4524	

Consults

Book Res (TR)	7-851, x6775
ID	5842
Derm	5289
Pulmonary	5842
GI/GASTRO	3600
Kapra	**0527
Heme/Onc	5696
Colonoscopy/GI	5342
Endoscopy	6687
Renal	6636
Renal Transplant	4444
Resp	5842
Endocrine	6729
PT	5089/5090
OT	5102/5101
Ortho	**171
Prosthetics	5557
Pain Mgmt	5080
Neurology	6803/6804

Nutrition:

Lisa	3447/7487
Ilza	6844
Margie	5047
Pam	6682/ **070

Pall Care	**306, **165
Nikki	608-692-6540
Physical Therapy (Janice)	7240
Speech and Swallow	3613, 6504, 7-237

Procedures

ECHO	6770
EEG	6842
Endoscopy	6687
Cytology	5921

Social Workers

Sandy (SW 7C)	5709, 7-796
Terrance (7B)	6751, 7023
Doris Purnell (7C/8C)	5065, 7087
Sean (8B)	5044
Evette Morales (7B)	6751
Prosthetic	5555/5556
VNS Reinstate	800-675-0391
Laura	5044
Carl Frazier	7187, 5618
Daphne Quality Assurance	5624
Charmaine	(c)347-920-1331

Pharmacy

8B (Lilian)	7100
7B	7678
7C	7547
ID (Kirsten)	5487
DC Rx (Ray)	7258
IV Room	5486/5487/5490

Tumor Board

Jeanne Chartier	3785

INSTITUTIONAL POLICIES

HANDWASHING

The National VA system has a very strict infection control policy. All patients are cultured for MRSA on admission and again at discharge.

The policy at this institution is that BEFORE and AFTER every patient encounter, hands must be washed, preferably with the hand sanitizer. This includes when you use gloves. There are dispensers located throughout every ward---please use them.

There are patients who may be under isolation. Please check the signs and follow the instructions (ie. need for gowns or mask, need to wash hands with soap and water).

Again, this is a federal facility that takes Infection Control very seriously. There are nurses who monitor this and this must be complied with.

IDs/COMPUTER ACCESS

In order to get computer access, a valid VA ID is required. If you don't already have these things, you should report to the GME office on 7B. They will instruct you as to the correct steps you must go through. You will need to be fingerprinted, have your picture taken and take computer and privacy training. The process does take several days so please try to come before your rotation start date in order to ensure everything is in place.

IMPORTANT: DO NOT SHARE YOUR PASSWORD/COMPUTER ACCESS WITH ANYONE ELSE. DO NOT WRITE NOTES USING SOMEONE ELSE'S ACCESS. While you may have someone else write a note for you (ie asking someone who has access to write an immediate operative note), do not use their access as your own. This is a federal facility and the federal government is VERY strict about this. USING SOMEONE ELSE'S COMPUTER ACCESS IS A FEDERAL CRIME.

MEDICAL LIBRARY

Located on 5th floor, Room 5A-14
Hours 8am to 4:30 pm Monday through Friday
Available: current print subscriptions, Bronx's PubMed Linkout, circulating book and video collections, computer room for online access, quiet seating and work space available

RESIDENT HOURS

If you are going to be absent from the rotation for conferences or interviews, please let Dr. Heimann know ASAP.

There has been a night float system implemented where one intern at night will arrive in the afternoon and stay until 7 am.

When there are only 3 interns on the service, there will be nights where the ICU attending will cover AT NIGHT after 11 pm. There will be an on-call intern who will leave at 11pm on during those days.

Night call

Please make sure to give the resident on call schedule to Dr. Kurtz the first day of the rotation so he may post the schedule on the intranet. On the home page of Internet Explorer, there is a link to call schedules on the right hand column. All call schedules for all services are posted here including the surgery attending and resident call schedule.

Senior resident is second call to the intern when there is an intern in house. The intern in house is assigned a call room on the 4th floor by the VA Police.

On nights when the ICU attending is on call, that ICU attending should be given a proper sign out of the service every evening.

Please realize that the ICU attendings are covering in cases of urgent/emergent consults and floor emergencies. Routine floor matters such as pain med orders, medication renewals and whatnot should be dealt with prior to the intern leaving for the night. That also means that if any patients are being discharged over the weekend, all the prescriptions that that patient needs, especially narcotics, should be written in advance of that weekend.

The ICU attending will contact the senior resident as needed for telephone consultation or if s/he feels that the senior resident needs to evaluate the patient directly. Please work with the ICU attending in a collegial fashion and remember that they are not surgeons. For major surgical issues, the surgery service is responsible and the senior resident on call may have to come in to deal with the problem.

Safe Transportation

The Mount Sinai UBER account can be used for rides between the hours of 9:00 pm and 5:00am daily.

- Make sure you are active on the ISMMS GME account (contact Mount Sinai GME office for instructions)
- Enter brief free-text details in Expense Code/Memo (example: Code-BVA; Memo-Call)
- Uber app will track where you are picked up and dropped off.
- Can use Expense Memo section to add details related to your trip.
- Toggle between any personal Uber account you may have and this ISMMS GME account

ROUNDS

Surgery rounds are made in the morning DAILY on 8B and the ICU. Surgery rounds are made in the afternoon at the end of the day.

Daily notes must be written on all the patients by the residents and countersigned by the attending. Patients being followed as a consult should have a note written every other day to update the primary team.

Notes on patients in the ICU should be written by the senior resident.

The appropriate on call attending should be notified of all admissions.

ALL patients MUST have a post op check and note, including the SICU patients.

Daily follow-up of preoperative clearances for scheduled OR cases should be carried out to ensure cases proceed.

Calls should be made to patients scheduled for OR 24 hours prior to ensure cases proceed and documented in the patient's chart.

MISCELLANEOUS

On occasion, the GYN service will call you to let you know about a case to ask you to scrub with them. The senior surgical resident should scrub on all GYN cases. They will also be admitting the patient to General Surgery as there is no GYN inpatient service. The GYN attending will instruct you on the care of the patient.

On the rare occasion that there are plastic surgery admissions and consults, please be aware that the general surgery service is required to cover these patients when there is no plastic surgery resident in house. Any questions about these patients by the interns should be directed to the plastic surgery resident and /or the plastic surgery attendings (Drs. Ko, Fang and Meisner). This includes hand consults directed to plastic surgery.

VASCULAR SURGERY GUIDE

Vascular Lab Studies done by 2G Medical Assistants:

Wednesday	9:00-11:30
Thursday	9:00-11:30
Friday	9:00-11:30

Check list for post-operative management:

1. See the patient (evening after surgery).
2. Assure proper medications ordered. ASA beta blocker statins, antibiotics.
3. Make sure antibiotics stopped within 24 hours of surgery unless active infection and Foley removed (NSQIP guidelines).
4. Check all cultures daily and narrow antibiotics when indicated.
5. Must check pulses and incisions daily for signs and symptoms of complications, i.e. hematoma, infections, etc. Unless a pervena Vac is on.
6. Order and check labs pertinent to specific interventions, i.e. creatinine following contrast-based procedures.
7. Assess for development of surgery specific complications, i.e. neuro deficit, hematoma/hyperperfusion syndrome following CEA.
8. Update family of discharge planning, if none available then CALL. Most importantly Update Dr. Chander. He will call the family and update.
9. Confirm plan for antiplatelet and or anticoagulation regimen: ASA/clopidogrel/Warfarin.
10. Signout with on call staff pending laboratory evaluations/tests inform on call house staff if this/then what (transfusion triggers, etc.).

Common medications in Vascular Surgery:

Anticoagulants

Unfractionated Heparin:

- *Dosing:*
  - Bolus — 60–80 units/kg, depending on diagnosis
  - Infusion —18 units/kg/hr., adjusted to keep a PTT of 50 to 80 sec
- *Half-life:* 1 to 1.5 hours
- *Complications:* Major concerns are bleeding and heparin induced thrombocytopenia (HIT). Watch the Plts every day.

Low molecular weight heparin (LMWH): i.e. Lovenox R (enoxaparin sodium injection). Factor X inhibitor.

- No monitoring of the PTT coagulation parameter.
- *Treatment dose:* 1 mg/kg subq q12 hours or 1 . mg/kg subq daily. Prophylaxis is 40 mg subQ daily, or 30 mg subq bid daily.

- Must be renal adjusted if creatinine clearance is less than 30. For dialysis patients Lovenox R (enoxaparin sodium injection) has not been approved and is not recommended.

Pain Management Protocol for Vascular Patients:

1. Consider IV Tylenol/PCA pump for AKA/BKA
2. Include IV Pain Medication for Breakthrough pain
3. Include in orders prn pain medication
4. At 5:30 am, make sure pain med is administered prior dressing changes.
5. **Include in orders colace/senna, for constipation related to narcotics.**
6. **Include order for anti-nausea medication**
7. Consult Pain Service for *acute/chronic* pain not well controlled after 8 hours
8. Pain management of these patients are case by case basis
9. IV Breakthrough Medication include 0.4mg Dilaudid or 4mg Morphine
10. PO Pain medication include 1-2 Percocet q4h — or —Dilaudid 2mg/4mg/6mg q3h

Premedication of Patients with Known or Suspected Contrast Allergy:

Prednisone: 50 mg po at 13 hours, 7 hours, and 1 hour before contrast media injection, and Benadryl R (diphenhydramine): 50 mg IV/IM/po 1 hr., before contrast medium.

Urgent medication if can't do above:

Solu-Medrol R (methylprednisolone sodium succinate) 40 mg or Solu-Cortef R (hydrocortisone sodium succinate) 200 mg IV (q4h) until contrast study required and diphenhydramine 50 mg IV 1hr prior to contrast .

• Data suggest steroids of limited effect if not given more than 4 hours pre-contrast load

Reversal of Coumadin® (warfarin sodium) in patients requiring surgery in 24–48 hours:

1. INR : < 2.0 : Vitamin K 1.0 mg po
2. INR: 2–5: Vitamin K 1–2.5 mg po
3. INR: 5–9: Vitamin K 2.5–5.0 mg po, repeat 1–2 mg in 24 hours

if still elevated

For patients requiring emergent surgery use FFP and Vitamin K intravenous from 1–5 mg slowly depending on degree of INR elevation.

Carotid Artery

Routine components of vascular imaging include gray-scale and Doppler US interpretation of the ICA[2]*:*

Duplex Velocity Criteria for Native Carotid Artery [3]

PSV = Peak systolic velocity (cm/sec)

EDV = End diastolic velocity (cm/sec)

< 125 none < 2 < 40 normal

> 125 < 50% < 2 < 40 < 50%

125–230 > 50% 2–4 40–100 “50–69” >
230 > 50% > 4 > 100 “> 70”
• Low velocities in CCA < 50 cm/sec? Ostial carotid stenosis.
Subclavian artery:
Asymmetry in brachial blood pressures > 20 mmHg with reversal of blood flow in the vertebral arteries demonstrate anatomic subclavian steal.

Postoperative Complications:

1. Most common is hypertension/hypotension: Medical management. Meaning please see the patient in the ICU few times over night. SBP 160 to 120 Hypertension—Increases hematoma frequency.
2. Expanding hematoma: Requires emergent re-exploration, symptoms may include dysphagia, difficulty breathing, and stridor.
3. Neurologic deficit in operating room: re-explore to rule out carotid thrombosis. If in recovery room, may get stat CT or duplex, and if abnormal the patient should be explored urgently.
4. Cranial nerve injury occurs in up to 15% with most resolving within six months. Dysphagia (vagal nerve), paresthesia in the marginal mandibular branch of the facial nerve distribution, hoarseness (recurrent laryngeal nerve).
5. Myocardial infarction (MI) — up to 1–2% of patients.
6. Death (< 1%).
7. Combined stroke/MI/death should be less than 3% in asymptomatic patients and < 5% in symptomatic patients.

Neurological deficit After CEA vary with the timing of the deficit.

- General anesthesia and awakens with a neurologic deficit, an intraoperative hypoperfusion injury or an embolic event is likely.
- In a patient with a transient period of normal neurologic status who develops a deficit, a technical cause is the most common cause (intimal flap, kink, hematoma) which can cause thrombosis.
- Riles found that symptomatic carotid thrombosis occurs in only 0.8% of patients but it caused 40% of the strokes.
- In patients that have a neurologic deficit after 1 to 2 days, cerebral hemorrhage or edema from hyperperfusion may be the cause.

Hyperperfusion Syndrome HPS and Cerebral hemorrhage after CEA

- Cerebral hemorrhage **0.2% to 0.8%** after CEA mostly due to HPS
- After CEA, the blood flow to ipsilateral hemisphere increase by as much as 57%. Given the fact the cerebral vasculature is **dilated** secondary to chronic carotid occlusive disease, there is an increase in cerebral perfusion pressure that results in reactive hyperemia and can cause edema and vessel rupture.
- The initial management is blood pressure control and close monitoring. Seizures may occur and anticonvulsants can be given as prophylaxis.

FMD of carotid. more distal extracranial internal carotid artery rather than at the bifurcation.

- Most commonly seen in **white women** in their fourth or fifth decades, carotid FMD **is bilateral in 50-60%** of instances and can be associated **with multiple intracranial aneurysms and vertebral artery** involvement.
- MCC artery **renal** w/ FMD , **carotid second** MCC.
- MCC distal internal carotid artery, frequently sparing the carotid bifurcation.
- Of the four histologic types, carotid artery FMD is most frequently of the **medial fibroplastic type**. The lesions are frequently multifocal, with a string of beads appearance on angiography, but are **only rarely symptomatic**.
- Treatment is reserved for symptomatic lesions and includes either graduated dilation through a standard neck incision or, more recently, percutaneous balloon angioplasty.

The **Asymptomatic Carotid Atherosclerosis (ACAS**) Study randomized 1662 patients with a > 60% asymptomatic carotid stenosis into a surgical (carotid endarterectomy) arm and a medical management arm (aspirin therapy).

- After a mean of 2.7 years of follow up, the 5-year Kaplan-Meier projected risk for any stroke or death with medical management alone was 11% compared to a 5.1% risk of endarterectomy. For good surgical risk

Recurrent carotid stenosis, **5-20%** of cases open surgery.

- Lesions occurring **less than two years** after carotid endarterectomy are typically due to **intimal hyperplasia**, with older lesions having characteristics of atheromatous plaques

Cranial nerve injuries 5-20% of carotid endarterectomies.

- The hypoglossal nerve is most frequently affected, resulting in ipsilateral tongue deviation.
- Vagus nerve injury is associated with unilateral vocal cord paralysis and hoarseness. **Most common nerve injured.**
- Injury to the **marginal mandibular** branch of the facial nerve results in ipsilateral drooping of the corner of the mouth. This is typically the result of cephalad retraction on the mandible rather than a clamp injury and is usually transient.

Post-intervention Imaging

- Routinely we have performed carotid duplex examination within 30 days of intervention to document a new patient baseline.

- Subsequent imaging should be at 6 months and then again at 12 months, assuming no critical abnormalities are detected after interventions or in de novo lesions.

- As a group we have continued to recommend surveillance at the following intervals:
    - < 50% stenosis with disease present 1–2 years. If B-mode: no disease and velocities less than 50% can evaluate prn.
    - 50 to < 70% at 6 month–12 month intervals
    - 70% recommend secondary imaging with possible repeat intervention

Peripheral Vascular Disease:

An ankle brachial index (ABI) should be performed as an initial screening exam for peripheral arterial occlusive disease and asthe AHA recommended examination following lower extremity revascularization procedures.

Ankle Brachial Index (ABI)

Best predictor of long-term limb loss and survival in patients with PAD.

- ≥ 1.3 signifies poor/noncompressible tibial arteries
- **0.9 to < 1.3 normal**
- < 0.9 to 0.7 mild PAD
- < 0.7 to 0.4 moderate PAD
- < 0.4 severe PAD

If the patient is diabetic and the arteries are non-compressible, i.e. pressure > 250 mmHg, then toe pressures are recommended as a baseline examination.

Toe Brachial Index (TBI) Normal
TBI > 0.75.

- Toe pressures > 50 mmHg in diabetic patient should permit healing of a digit amputation.
- Toe pressures < 30 mmHg unlikely to heal in either a diabetic or nondiabetic patient.

Segmental Pressures

Classic examination includes four cuffs: high thigh, low thigh, calf, and ankle. A 20 mm drop in blood pressure between two cuffs is considered significant. The high thigh should be at least the same as the brachial pressure, if less than brachial blood pressure, then consider inflow disease.

Treatment: Pharmacologic treatment of claudication (i.e., **cilostazol**) Cilostazol (Pletal) is a phophodiesterase III inhibitor which increases cyclic adenosine monophosphate (cAMP) and results in a series of physiologic effects, including inhibition of smooth muscle cell proliferation, decrease in serum triglycerides, and increased HDL.

Critical ischemia with tissue loss:

- Gold standard is inline flow from common femoral to distal. Angioplasty considered for focal tibial vessel lesions in CLI
- Inadequate length of autologous conduit can use angioplasty of the SFA lesion to allow a more distal bypass graft origin, or to sequential bypass grafting with PTFE above the knee and an autologous bypass below.
- Angioplasty for CLI or DM patient has poor outcome. Good for focal, non calcified.
- Rutherford Classification 6 categories are: ○ 0 asymptomatic ○ 1 mild claudication ○ 2 - moderate claudication ○ 3 severe claudication
    - 4 - ischemia rest pain without tissue loss
    - 5- minor tissue loss; ischemic ulceration not exceeding ulcer of the digits of the foot ○ 6 - major tissue loss; severe ischemic ulcers or frank gangrene

Bypass graft surveillance should include a clinical exam, ankle and brachial pressure determinations, and duplex scanning of the bypass graft and immediate inflow and outflow vessels.

- The frequency of post-operative evaluation is somewhat physician specific but generally consists of reevaluation every 3-6 months in the first 2 years. After this, if there is no evidence of stenosis, yearly follow up is usually adequate.
- However, surveillance should be more frequent if claudication worsens, the ABI drops by more than 0.1, and/or velocities on duplex scanning suggest a developing stenosis.
- Current criteria for intervention for severe (>70%) stenosis are peak systolic velocity of >300 cm/sec or peak systolic velocity ration of >3.5.
- Moreover, a low graft velocity distal to the area of stenosis with PSVs less than 45cm/s is suggestive of imminent graft failure.

Dialysis

The National Kidney Foundation-Dialysis Outcomes Quality Initiative (NKFKDOQI 1997 in an effort to increase the placement and prolong the use of autogenous arteriovenous (AV) access. The guidelines recommended that autogenous access should be constructed in at least 50% of all new AV access placements and, ultimately, 40% of prevalent dialysis patients should have an autogenous AV access. As a response to these guidelines, the Centers for Medicare and Medicaid Services (CMS), the ESRD Network, and the Institute for Healthcare Improvement (IHI) formed the "Fistula First Breakthrough Initiative" (FFBI). Through the work of the FFBI, the national rate of autogenous access reached 40% prevalence by August 2005. The most recent data indicates that more than half (55%) of all renal patients currently obtain hemodialysis through autogenous arteriovenous access.

AVF take 4 to 8 weeks for mature**,** early use can cause failure.

AV access monitor monthly determinations of access flow by ultrasound dilution, conductance dilution, thermal dilution, or Doppler technique.

Access flow less than **600 mL/min or access flow less than 1000 mL/min** decreased by 25% over 4 months should be further evaluated with duplex surveillance followed by fistulography.

Arterial steal secondary to low access tract resistance, creating a **reversa**l of blood flow in the arterial outflow tract **towards** the access and away from the hand.

- In 90% of all AV accesses, less than 10% w/ symptoms.
- Arterial steal should evaluate w/ **arteriogram** to identify any proximal arterial stenosis, **tx** w/ endo or open

Ischemic monomelic neuropathy (IMN) a subtype of arterial steal that occurs secondary to arterial steal leading to ischemia of the **nerves only**, producing neurologic deficits of the median, radial, and ulnar nerves. not severe enough to cause muscle or skin necrosis. IMN presents almost immediately

To avoid permanent paralysis, IMN should be treated definitively and immediately with **ligation** of the AV access. Attempting to revise time consuming, and lead to permanent neurologic deficit.

Venous disease

- Low clinical probability DVT, neg D-dimer rules out a DVT (99% predictive value)
- D-dimer sensitive test to detect DVT, not useful for diagnosis of DVT, since there are so many false positives.
- Reflux superficial/deep veins has been defined as a retrograde flow of > 500 ms
- High risk (age, obesity, abdominal surgery, active cancer) for DVT. PPX w/ mechanical and pharmacological methods is recommended.
- Current consensus recommends malignancy undergoing major surgery or those undergoing major orthopedic surgery should receive pharmacological prophylaxis in hospital and for a **month after dischar**ge.

Ruptured AAA

Background

- *50% rule:* 50% make it to hospital alive. Of those alive on arrival, only 50% survive operation.
- There is an overall 75% mortality.
- 15,000 patients die annually of rupture. 13th leading cause of death in United States.
- *Predictors of mortality in ED:* Increasing age, Hgb < 10, elevated creatinine, syncope, cardiac arrest > 90% mortality.

History and Physical Examination

Classic triad of: **Abdominal pain, pulsatile abdominal mass and hypotension.**
*Most common misdiagnosis —Renal colic -third of patients.

Treatment

Permissive hypotension: Massive fluid resuscitation will actually result in more bleeding and worse outcome.
While waiting for anesthesia team or angio suite staff, place Foley catheter, vascular sheath in jugular and radial arterial line if possible
to expedite the case once in the operating theater.
Predictors of mortality following ruptured AAA:

- *Bleeding:* 90%—Either coagulopathy from massive blood loss or iatrogenic venous injury during dissection.
- *Renal failure:* > 70%
- *Ischemic colitis:* > 60%
- *Respiratory failure*

Intervention:

- *Open:* Should be reserved for unstable and non-endovascular candidates.
- *Endovascular:* If hypotensive, rapidly place balloon to occlude thoracic aorta. If difficulties cannulating the contralateral gate, then be prepared to convert to aortouniiliac repair with contralateral iliac occlusion and femoral-femoral bypass. Some centers advocate initial AUI placement.

* Dramatic improvement in morbidity and mortality when comparing endovascular vs. open repair.

Amputations

Preoperative Considerations

- *Healing potential:* Overall nutritional status, immune status, as well as other conditions contributing to skin healing, (i.e. lymphedema and chronic venous changes).
- *Functional status:* Patients non-ambulatory prior to amputation will still be non-ambulatory after the amputation and this should factor into level of amputation.
- *Risk of anesthesia:* Most patients can have regional anesthetic if moderate- to high-risk with general anesthetic.

Level of Amputation Clinical Evaluation

- Patients will generally heal below a palpable pulse, i.e. palpable popliteal pulse > 90% healing of BKA.
- Knee contractures > 30 degrees will often develop stump complications and poor healing secondary to pressure necrosis — AKA recommended.
- Severe edema and cellulitis of below-knee skin from severe lymphedema or venous stasis are unlikely to heal below knee.

Testing

- Ankle pressure > 50 mmHg will permit healing most BKAs.
- Toe pressure > 50 mmHg will permit healing with digital or foot amputations.
- Transcutaneous oxygen— considered by some to be best predictor of healing. TcO_2 > 20 mm Hg allow healing at tested area.

Preprocedural Counseling and Consent

1. Understand the expected mortality and functional outcomes.
2. Frequency of subsequent revisions.
3. Potential peri-operative complications unrelated to procedure.

Postoperative Care

- Patient should be placed in intermediate care unit following procedure, since perioperative mortality exceeds that of distal revascularization procedures.
- Administer beta blocker unless contraindicated.
- DVT prophylaxis: second most common cause of death related to thromboembolic complications.
- *Cardioprotective meds:* ASA/Beta-blocker/Statin
- *Antibiotics:* Length of therapy should be 24–48 hours unless ongoing infection at remote location.
- *Fluid management:* Careful attention since significant number of patients with reduced ventricular function.
- *Early mobilization:* Physical therapy and rehabilitation consult— helpful to have rehab. Team to see patient prior to the procedure for further amputation education.
- No weight bearing activity unless immediately casted or apops placed.

Perioperative Complications

- Death should be < 5% following digit or foot amputations, expected mortality is up to 10/15% for BKA/AKA respectively.
- Most common cause of mortality is cardiovascular related.
- *DVT/PE:* Patients at high risk with most series reporting thromboembolic complications as second leading cause of death.
- *Wound infection and nonhealing:* Depending on how aggressive attempts are at preserving the knee joint the frequency of this complication will vary. Typically quoted as 20% of BKA's and < 10% of AKAs requiring revision.
- Wound infection occurs up to 30% of patients with MRSA the leading cause of infection.
- *Non-surgical site infections:* Secondary to patients' reduction in mobility this cohort is at high risk for pneumonia, UTI from indwelling catheters and venous line related infections from prolonged hospitalizations.
-

Long-Term Functional Outcomes

- **10–20%** will subsequently undergo a contralateral amputation.

- Energy expenditure is not significantly increased in toe and foot amputations, however great toe amputations including the first metatarsal head may have considerable changes in balance.
- Increase energy expenditure following BKA/AKA is 30%/60%.
- Expected ambulation with a prosthesis is up to 75% with BKA and 40% after AKA.

Long-Term Survival

- One-year survival is 50% and three-year survival is as low as 30%.

BARIATRIC SURGERY GUIDE

Laparoscopic Sleeve Gastrectomy Post-op Order Form

Admit to SICU
Diagnosis – s/p laparoscopic sleeve gastrectomy
Condition – Stable
ALLERGIES: _______________
Vitals – q3hr, call MD for HR > 110
SaO2 < 93%
SBP < 100
Activity – OUT OF BED to chair 6 HOURS AFTER SURGERY, AMBULATE as tolerated TONIGHT
Compression boots B/L LE while in bed
Incentive spirometer 10 times/hr while awake

IVF – Day of surgery: LR at 150 ml/hr
POD#1: LR at 100 ml/hr

Diet – Day of surgery: NPO

POD#1: Bariatric stage I liquids 1-2 oz/hr

Once patient tolerates 1-2 oz/hr of liquids, can advance to 3-4 oz/hr (still stage I diet)

PATIENT STAYS ON BARIATRIC LIQUIDS WHILE IN HOSPITAL AND IS DISCHARGED ON THIS DIET

If patient is diabetic: Fingersticks q6hr with RISS as per ICU protocol

Portable CXR in AM of POD#1
D/C Foley POD#1 if UOP is adequate

Meds:

Zofran 4 mg IV q4hr PRN nausea
Lovenox 40 mg sq q12hr, start 12 hours post-op
Day of surgery: PCA or Dilaudid IV PRN pain or Morphine 4 mg IV q 4hr PRN
POD#1: D/C morphine, add Tylenol #3 elixir 5 ml q4hr PRN pain or Percocet

Restart patient's home meds on POD#1 EXCEPT diabetic medications and diuretics

Labs:
CBC, BMP in AM POD#1

D/C patient home on POD#2 after patient is tolerating 3-4 oz. of bariatric liquids per hour, and after attending surgeon has seen patient.

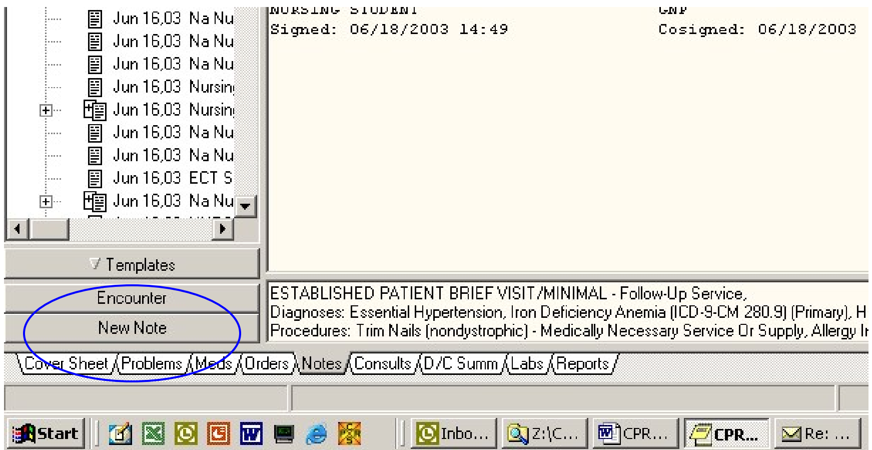
Discharge prescriptions: Tylenol #3/Percocet, chewable multivitamin BID, calcium citrate/Vit D 2 pills PO BID, and patient's home medications EXCEPT DIURETICS. If patient is on combination lisinopril/HCTZ discharge on plain lisinopril WITHOUT HCTZ. Diabetes meds as per endocrinologist, but in general, if on oral meds, dose should be cut in half. If on insulin, it should be cut in half and patient needs to check FS frequently.

HOW TO WRITE A DAILY INPATIENT FLOOR/PROGRESS NOTE

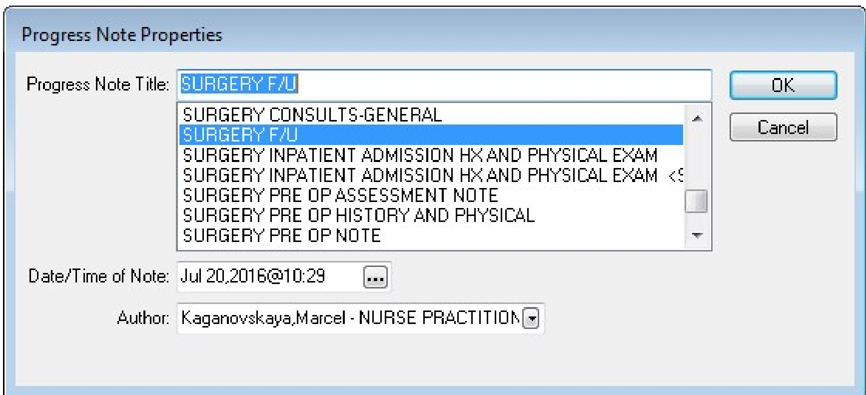
Click on the Visit Location box. Encounter provider is your name. Choose "New Visit" tab – The visit location is the BRX SURG Bedside visit.

Confirm that encounter is changed to the bedside visit and not the floor the patient is located.

Click on the "New Note" button.

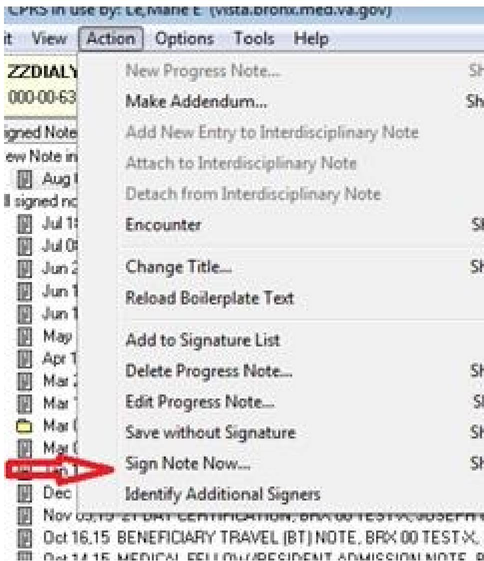


Select the proper note title – "Surgery F/U". You will have to select the proper co-signer.

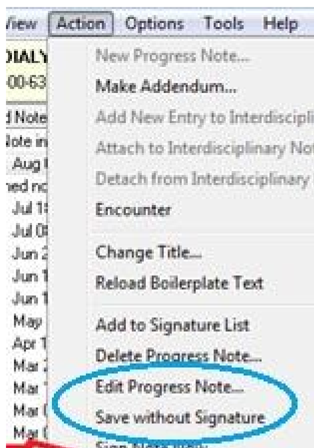


Notes may be written using templates or free text. Click in the body of your note, type your note. When you are finished, go up to the menu bar, select

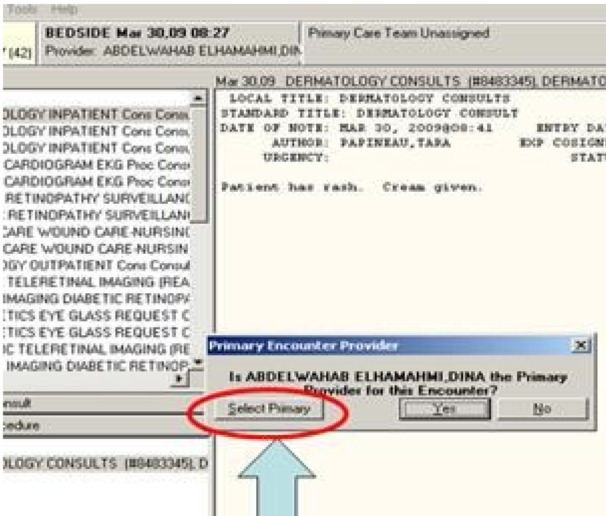
ACTION, then SIGN NOTE NOW.



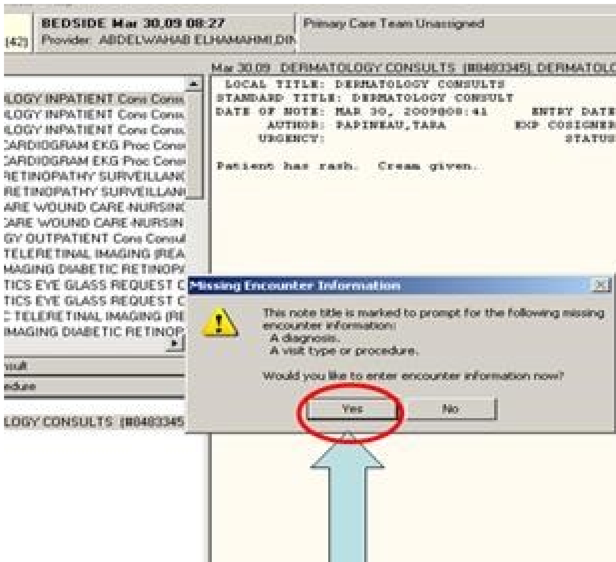
If you are unable to finish the note at the time you started it, go up to the menu bar, select ACTION, then SAVE WITHOUT SIGNATURE. When you are ready to finish the note you can click on the unfinished note, go up to the menu bar selection ACTION then EDIT PROGRESS NOTE.



The primary provider is the attending physician. Select the “Select Primary” tab.



Enter the encounter information if it is the FIRST service visit for the day.

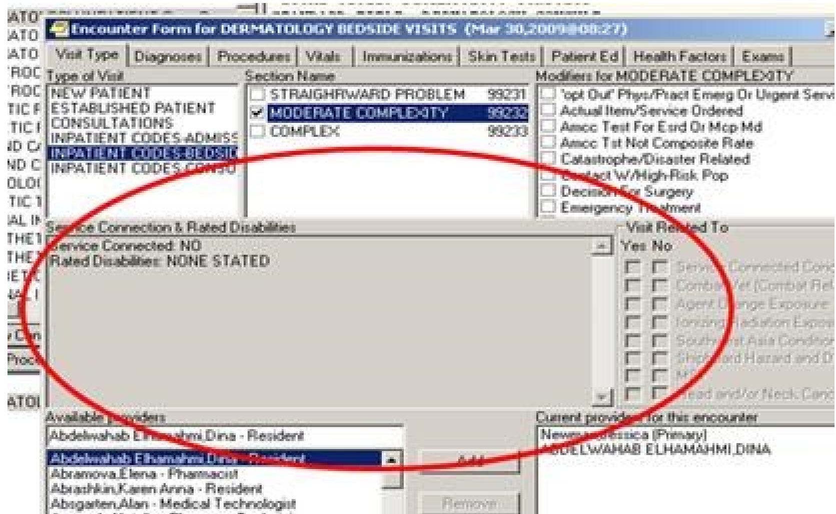


A full encounter requires 4 elements. All 4 elements must be answered to close the encounter.

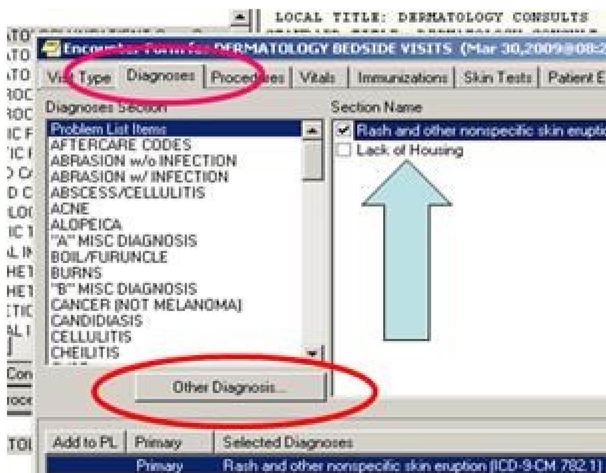
*Visit Type with CPT
*Diagnosis
*Answer Service Connected Condition
*Provider's names (attending must be primary)

Type of Visit is “Inpatient Bedside”.

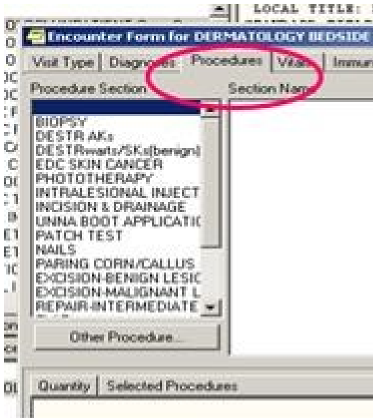
Always answer service connected condition questions if there are white boxes – Is your consultation related to the service connected condition of the Veteran?



Provide the diagnosis. Select the diagnosis related to your visit. If diagnosis does not appear in the diagnosis section you can select "Other Diagnosis" and search.



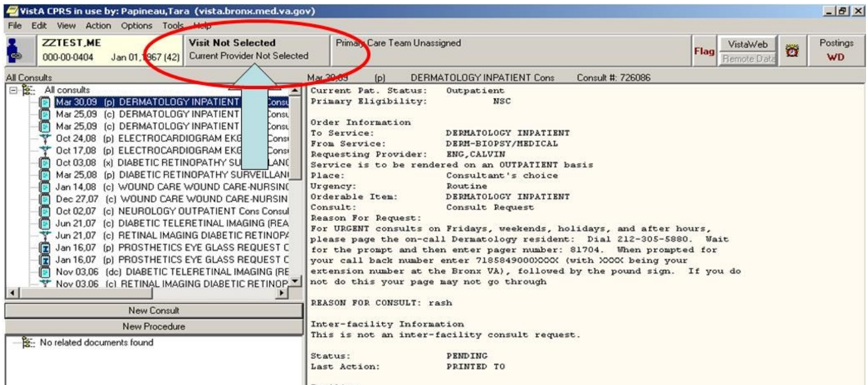
The Procedure tab is used when there are other professional procedures being performed at the time of consult ie Biopsy.



Click “OK” and sign with your pin.

HOW TO ANSWER AN INPATIENT CONSULT

Click on Visit Location Box.



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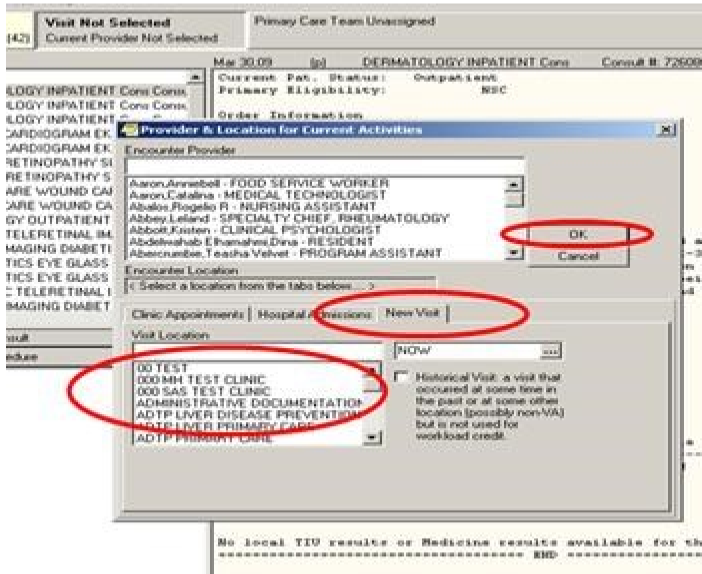

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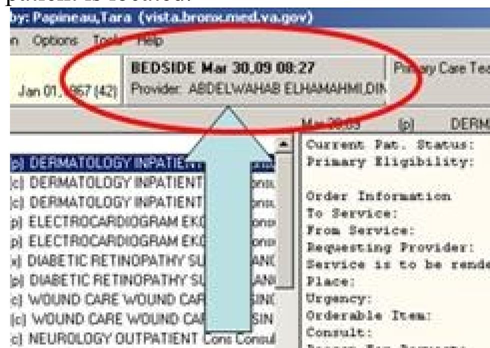
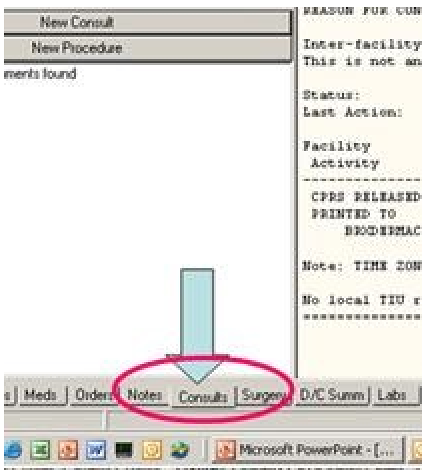
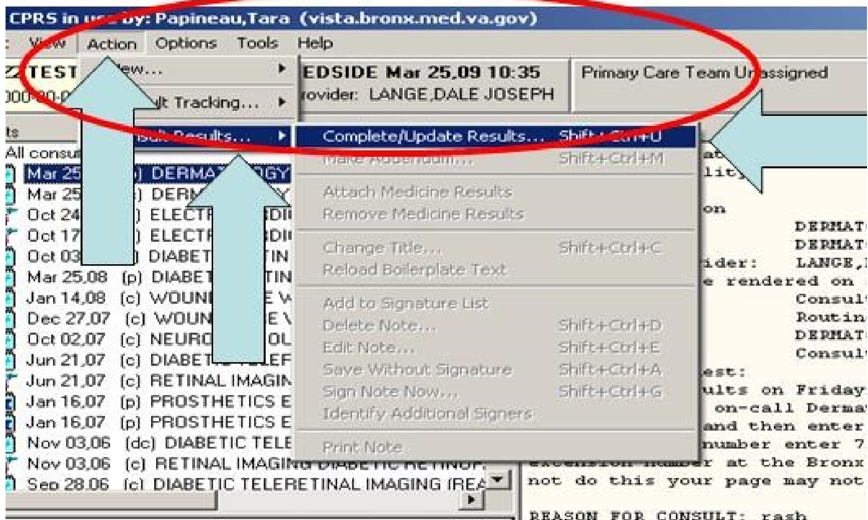


Click on "Consults" tab.

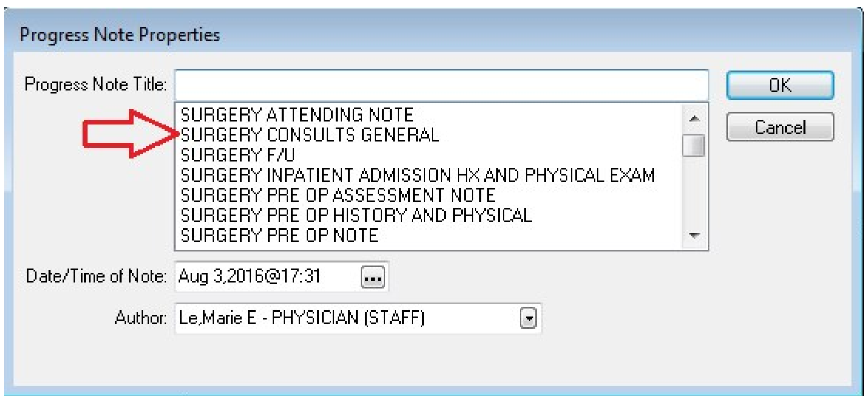


Highlight the Surgery consult to address.

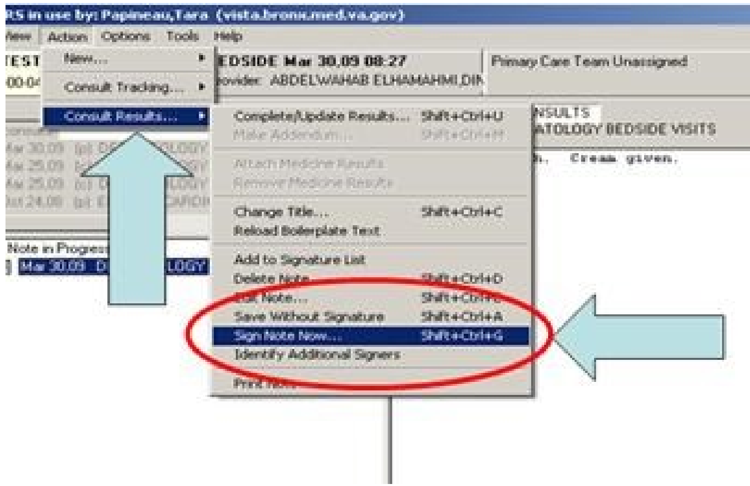
Click on **Action | Consult Results | Complete/Update Results**.



Select proper note title "Surgery – Consults General". Type your note.



Click on **Action | Consult Results | Sign Note Now.**



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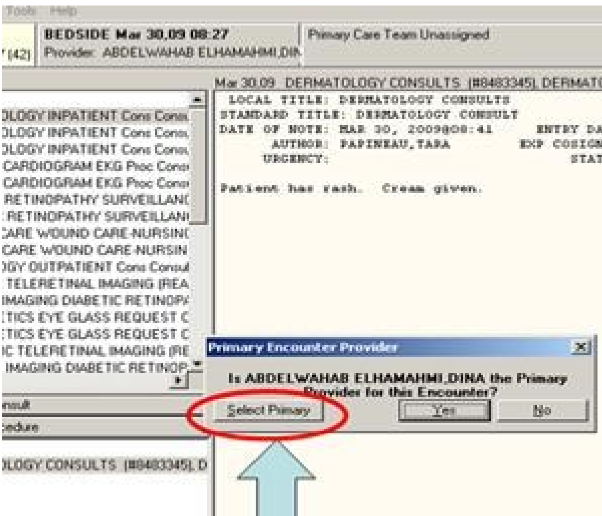
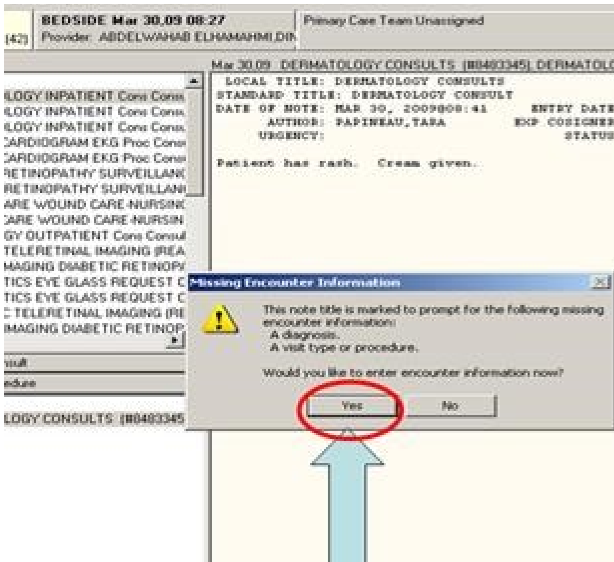
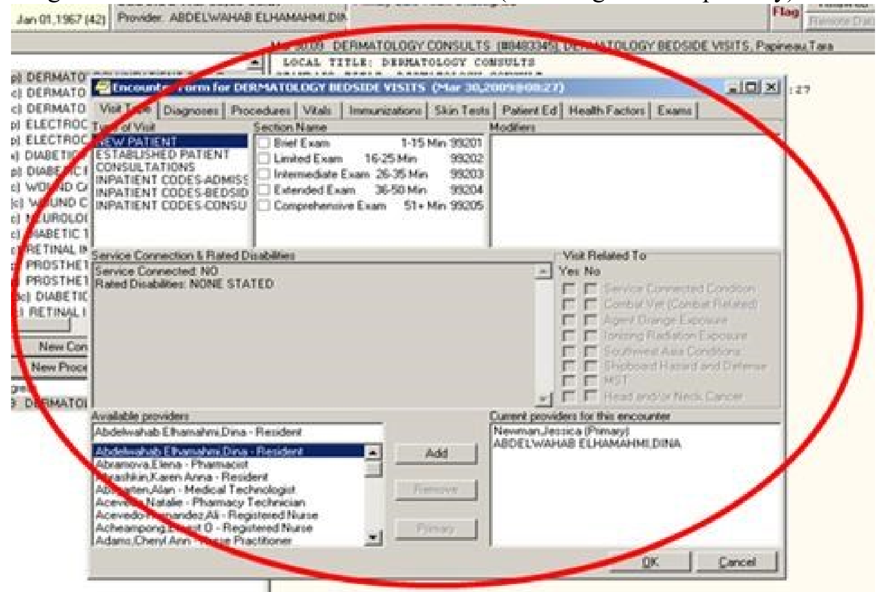


Enter the encounter information if it is the FIRST service visit for the day.



A full encounter requires 4 elements. All 4 elements must be answered to close the encounter.

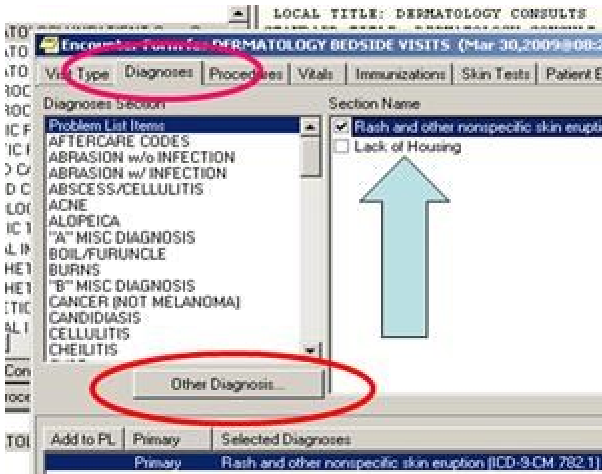
*Visit Type with CPT *Answer Service Connected Condition
*Diagnosis *Provider's names (attending must be primary)



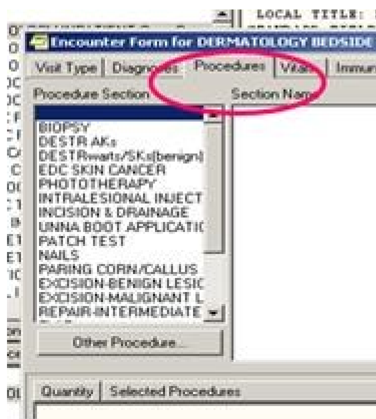
Bedside Visits used to answer inpatient consult must use “Inpatient Consult Codes” in the visit type tab.

Always answer service connected condition questions if there are white boxes – Is your consultation related to the service connected condition of the Veteran?

Provide the diagnosis. Select the diagnosis related to your visit. If diagnosis does not appear in the diagnosis section you can select “Other Diagnosis” and search.



The Procedure tab is used when there are other professional procedures being performed at the time of consult ie Biopsy.



Click “OK” and sign with your pin.

HOW TO ANSWER A CLINIC/OUTPATIENT CONSULT

Every patient seen in clinic should have a completed encounter form with the attending as the primary provider. In addition, if the patient is sent as a consult, the note should be linked to the consult.

Completing a Consult from the Consults tab

Make sure Visit Tab is selected for the clinic appointment with you as the encounter provider.

Provider & Location for Current Activities

Encounter Provider

Le,Marie E - PHYSICIAN (STAFF)

Le,Marie E - PHYSICIAN (STAFF)
Leak,Lee
Leandre,Leloutie - NURSING ASSISTANT
Leblanc,Linda A - IT SPECIALIST
Lebo,Debra
Ledesma,Javier - RADIOLOGY TECHNOLOGIST
Lee,Chang Mee - REGISTERED NURSE

OK

Cancel

Encounter Location

Brx General Surgery Aug 03,16 15:15

Date Range...

Clinic Appointments | Hospital Admissions | New Visit

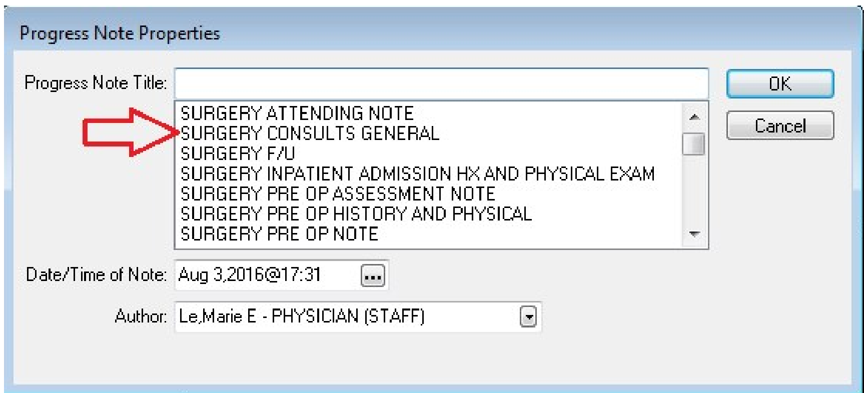
Clinic Appointments / Visits (T-90 thru T+90)

Brx Rehab Pain-Dr. Davidescu	Sep 20,2016 14:00	
Brx Podiatry Dr. Klein	Sep 09,2016 09:20	
Recall (fol) Brx Pact Team 5a	Sep 07,2016 00:00	
Recall (fol) Zzzbrx Podiatry	Aug 26,2016 00:00	
Brx Mh Opd Schimming	Aug 09,2016 09:30	
Brx General Surgery	Aug 03,2016 15:15	Checked Out
Brx Emergency Room	Jul 28,2016 14:26	Checked Out
Brx Emergency Room	Jul 27,2016 14:33	Checked Out
Brx Tele/Visn Triage	Jul 21,2016 15:30	Checked Out
Brx Magnetic Resonance Clinic	Jun 03,2016 11:30	Non-Count
Zzzbrx Podiatry	May 26,2016 09:00	Checked Out
Brx Pact Tele Med	May 24,2016 07:16	Checked Out
Brx Pact Tele Med	May 20,2016 16:11	Checked Out
Brx Magnetic Resonance Clinic	May 20,2016 09:30	Cancelled By Patient

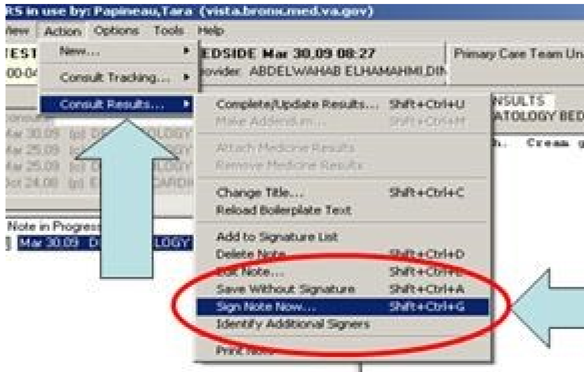
Click the **Consults** tab.

Click on **Action | Consult Results | Complete/Update Results**.

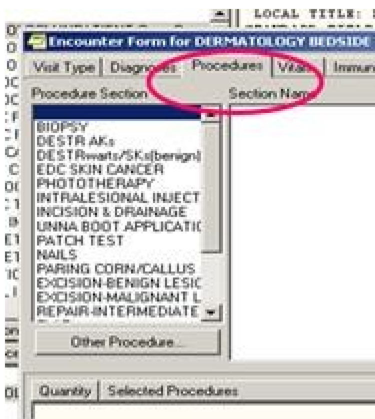
Select proper note title “Surgery – Consults General”. Type your note.



Click on **Action | Consult Results | Sign Note Now.**



Complete the Encounter documentation as with other notes.
The Procedure tab in this instance is used when there are other professional procedures being performed at the time of consult ie Biopsy as well as to capture the time you spent with the patient in clinic.

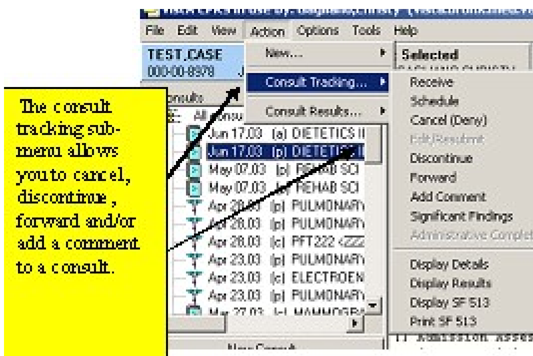


New patients:
99201 Office or other outpatient visit; self-limited or minor problem, 10 min.
99202 low to moderate severity problem, 20 min.
99203 moderate severity problem, 30 min.
99204 moderate to high severity problem, 45 min.
99205 high severity problem, 60 min.
Established patients:

99211 Office or other outpatient visit, minimal problem, 5 min.
99212 self-limited or minor problem, 10 min.
99213 low to moderate severity problem, 15 min.
99214 moderate severity problem, 25 min.
99215 moderate to high severity problem, 40 min.

Click “OK” and sign with your pin.
The note will be visible both attached to the consult under the consults tab AND listed chronologically under the notes tab.

Consult Tracking drop-down menu



<u>Discontinuing Consults</u>:
Consults may be discontinued if the patient does not respond to the minimum scheduling effort of 2 phone calls, 1 letter, followed by a 14 day wait of no response from the patient. Consults may be discontinued if the patient refuses the service, has multiple cancellations or no shows, if the patient is deceased or when an in-house consult is superseded by a Non-VA care consult or Veteran’s Choice.

<u>Cancelling Consults</u>: Consults should only be cancelled under the limited circumstances where the ordering provider did not ask an appropriate consult question or if the Clinically Indicated Date field needs to be corrected. The ordering provider may then resubmit the consult with appropriate information without having to start over.

HOW TO WRITE A CLINIC NOTE WHEN NO CONSULT TO ANSWER

Make sure Visit Tab is selected for the clinic appointment with you as the encounter provider.

Provider & Location for Current Activities

Encounter Provider

Le,Marie E - PHYSICIAN (STAFF)

Le,Marie E - PHYSICIAN (STAFF)
Leak,Lee
Leandre,Leloutie - NURSING ASSISTANT
Leblanc,Linda A - IT SPECIALIST
Lebo,Debra
Ledesma,Javier - RADIOLOGY TECHNOLOGIST
Lee,Chang Mee - REGISTERED NURSE

OK

Cancel

Encounter Location

Brx General Surgery Aug 03,16 15:15

Date Range...

Clinic Appointments | Hospital Admissions | New Visit

Clinic Appointments / Visits (T-90 thru T+90)

Brx Rehab Pain-Dr. Davidescu	Sep 20,2016 14:00	
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Brx Mh Opd Schimming	Aug 09,2016 09:30	
Brx General Surgery	Aug 03,2016 15:15	Checked Out
Brx Emergency Room	Jul 28,2016 14:26	Checked Out
Brx Emergency Room	Jul 27,2016 14:33	Checked Out
Brx Tele/Visn Triage	Jul 21,2016 15:30	Checked Out
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Zzzbrx Podiatry	May 26,2016 09:00	Checked Out
Brx Pact Tele Med	May 24,2016 07:16	Checked Out
Brx Pact Tele Med	May 20,2016 16:11	Checked Out
Brx Magnetic Resonance Clinic	May 20,2016 09:30	Cancelled By Patient

Click on “New Note” tab. Select “Surgery F/U” note.

Progress Note Properties

Progress Note Title: SURGERY F/U

SURGERY CONSULTS-GENERAL
SURGERY F/U
SURGERY INPATIENT ADMISSION HX AND PHYSICAL EXAM
SURGERY INPATIENT ADMISSION HX AND PHYSICAL EXAM <S
SURGERY PRE OP ASSESSMENT NOTE
SURGERY PRE OP HISTORY AND PHYSICAL
SURGERY PRE OP NOTE

OK

Cancel

Date/Time of Note: Jul 20,2016@10:29

Author: Kaganovskaya,Marcel - NURSE PRACTITION

Complete the Encounter documentation as with the correct outpatient procedure codes and sign your note.

HOW TO WRITE IMMEDIATE OP NOTES

Immediate Operative Reports MUST be done after every case. All immediate op notes, even on **inpatient**, must have their visits changed to **Ambulatory Surgery** prior to writing the note. The tab next to the patient's name tab on the home page should be clicked before choosing the immediate op note option and a new visit to "**brx ambulatory surgery**" should be entered if this tab doesn't already say ambulatory surgery. It doesn't matter if the patient is coming from the **ICU**, it has to be under ambulatory surgery.

Then click on "New Note" and select the proper Immediate Operative Report.

Progress Note Properties

Progress Note Title: IMMEDIATE OPERATIVE REPORT

IMMEDIATE <IMMEDIATE OPERATIVE REPORT >
IMMEDIATE OPERATIVE REPORT
IMMEDIATE OPERATIVE REPORT <IMMEDIATE OPERATIVE RE
IMMINENT <DEATH/IMMINENT DEATH OF PATIENT NOTE (T)>
IMMUNIZATION <IMMUNIZATION/SKIN TEST NOTE>
IMMUNIZATION/SKIN TEST NOTE
IMPAIRMENT <VIS VISUAL IMPAIRMENT SERVICES>

OK
Cancel

Date/Time of Note: Aug 10,2016@13:17

Author: Le,Marie E - PHYSICIAN (STAFF)

The attending is the Primary provider. Complete the Encounter documentation as with other notes. The Procedures tab should be completed with the proper CPT/OR procedure done.

Lookup Procedure

Search for Procedure:

repair inguinal hernia

Select from one of the following items:

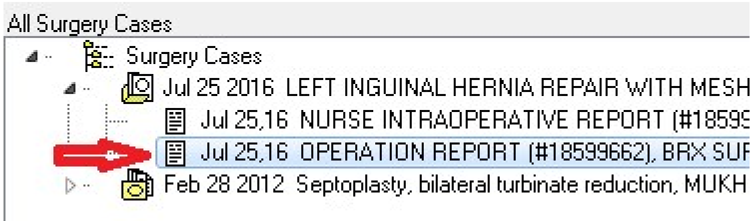
Term

- Laparoscopy, Surgical; Repair Initial Inguinal Hernia
- Laparoscopy, Surgical; Repair Recurrent Inguinal Hernia
- Orchiopexy by Inguinal Approach
- Repair Initial Incarcerated or Strangulated Inguinal Hernia (Age 5
- Repair Initial Incarcerated or Strangulated Inguinal Hernia (Age 6
- Repair Initial Reducible Inguinal Hernia (Age 5 Years or over)
- Repair Initial Reducible Inguinal Hernia (Age 6 Months to Under 5
- Repair Recurrent Incarcerated or Strangulated Inguinal Hernia (a
- Repair Recurrent Reducible Inguinal Hernia (any Age)
- Repair Sliding Inguinal Hernia (any Age)
- Repair, Initial Inguinal Hernia, Full Term Infant Under Age 6 Mont
- Repair, Initial Inguinal Hernia, Full Term Infant Under Age 6 Mont
- Repair, Initial Inguinal Hernia, Preterm Infant (less than 37 Weeks
- Repair, Initial Inguinal Hernia, Preterm Infant (less than 37 Weeks

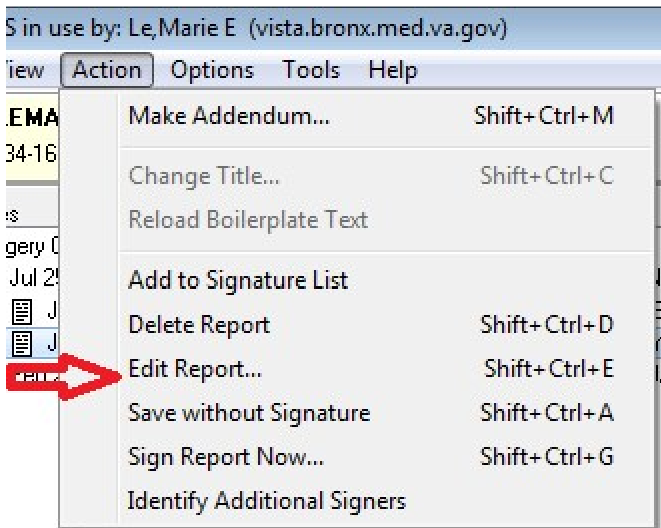
Sign your note.

HOW TO COMPLETE THE FULL OPERATIVE DICTATION

Click on the Surgery Tab. Find your surgery date folder. Click on the Operation Report document.



Click on "Action" then "Edit Report".



Complete the operative report with the proper format. Then sign the note after completing the proper encounter documentation.

DATE:
PATIENT:
MRN:
DOB:
PRE-OP DIAGNOSIS:
POST-OP DIAGNOSIS:
SURGEON: ASSISTANT:
YOU ANESTHESIA:
OPERATION:
ESTIMATED BLOOD LOSS:
IV FLUIDS:
URINE OUTPUT:
SPECIMEN:
STENTS/DRAINS/IMPLANTS:
COMPLICATIONS:
POSTOPERATIVE CONDITION:
FINDINGS:

INDICATION:

DESCRIPTION OF OPERATION:

HOW TO DO TELEPHONE DICATATIONS

If you plan on using the telephone dictation service, please request a phone ID # from Tracee Sawyer via email Tracee.Sawyer@va.gov or phone 718.584.9000 x:5605.

Dictation Instructions:

1. DIAL – 1-800-592-6949 (Or Facility Set Up Extension)
2. ENTER ASSIGNED PHONE ID #
3. ENTER GROUP ID (4314)
4. THE SYSTEM WILL ASK THE PROVIDER TO ENTER THE WORK TYPE (PRESS THE NUMBER 2 FOR OPERATION REPORT)

Keypad Functionality:

1. Pause
2. Record Over
3. Rewind
4. Fast Forward
5. Disconnect
6. Set Priority
7. No function
8. End Job
9. Speak Info

HOW TO SCHEDULE AN OR CASE

At the beginning of the rotation, contact Dr. Kurtz (Robert.Kurtz@va.gov) to receive access to the Outlook calendar for the surgery OR schedule.

General Surgery, Bariatric, Rectal, Vascular, Transplant and Thoracic cases are scheduled by their respective clinics.

Every patient booked from the clinic needs **5** things done on the day they are seen:

[1] Surgery F/U note or Outpatient consult note. Remember to change the visit location tab.

[2] Surgery Pre-procedure orders under the “New Note” tab.

Progress Note Properties

Progress Note Title: SURGERY PRE-PROCEDURE ORDERS <MANDATORY PREOPERA

SURGERY INPATIENT ADMISSION HX AND PHYSICAL EXAM
SURGERY INPATIENT ADMISSION HX AND PHYSICAL EXAM <S
SURGERY PRE OP ASSESSMENT NOTE
SURGERY PRE OP HISTORY AND PHYSICAL
SURGERY PRE OP NOTE
SURGERY PRE-PROCEDURE ORDERS <MANDATORY PREOPE
SURGERY PROCEDURE NOTE

OK | Cancel

Date/Time of Note: Aug 12,2016@11:13

Author: Le,Marie E - PHYSICIAN (STAFF)

The Surgery pre-procedure orders must include the ICD-10 code and the CPT code as well. Frequently used ICD-10 and CPT code documents can be accessed on the Surgery Share Drive. Please make sure patient has all orders for a proper pre-operative workup. Preop workup is good for 60 days.

Reminder Dialog Template: MANDATORY PREOPERATIVE TEMPLATE

Expected LOS:

Elective Urgent Emergent

Hoptel arrangements needed

Diagnosis:
Requested admission date:
Procedure date:
Procedure:

**INDICATE THE DIAGNOSIS CODES USED FOR THIS PROCEDURE*

ICD-10 Codes:

INDICATE THE CPT CODES USED FOR THIS PROCEDURE

CPT Codes:

Special Requests:

Equipment(SPD Trays):
(All trays must be delivered to SPS 48 busine
day of procedure.)

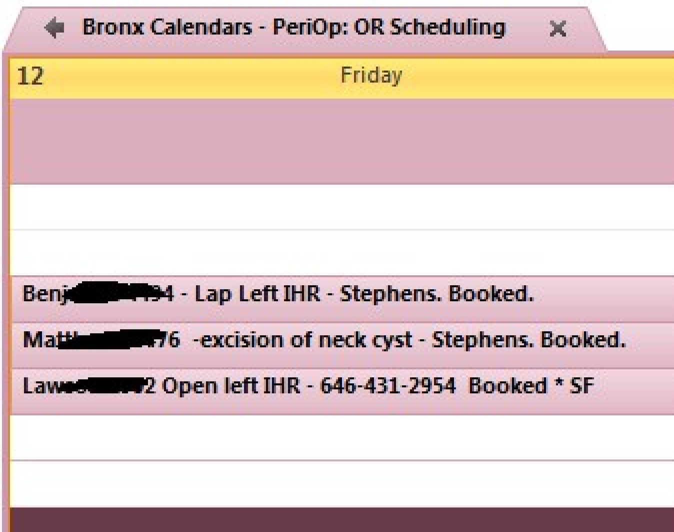
Instruments:

[3] Instruct patient to report to 2A-10 for Preoperative appointment. This must be done or the case will not happen.

Tell Ms. Rodriguez (clinic nurse) or NP Marcel to schedule the case in VISTA. **If the surgery is scheduled less than 2 business days away (WEEKENDS DO NOT COUNT), then the case must be pink slipped to the OR.**

[4] Consent done in iMED (if procedure done within less than 30 days)

[5] Enter case in the SharePoint Outlook calendar with patient information, case, attending, booked or not booked in VISTA, and pending clearances.



Inpatient and add-on cases are to be scheduled onto the SharePoint Outlook calendar and into VISTA by the senior surgery resident. The senior resident should also review the Outlook OR schedule daily for any outpatient cases that might have been missed, as well as to make sure patients are ready for surgery.

IF CASES ARE CANCELLED BEFORE DAY OF SURGERY, PLEASE NOTIFY NP MARCEL TO CANCEL THE CASE IN VISTA. IF THE DATE OF SURGERY IS CHANGED, VISTA AND THE SHAREPOINT NEED TO BE UPDATED ACCORDINGLY.

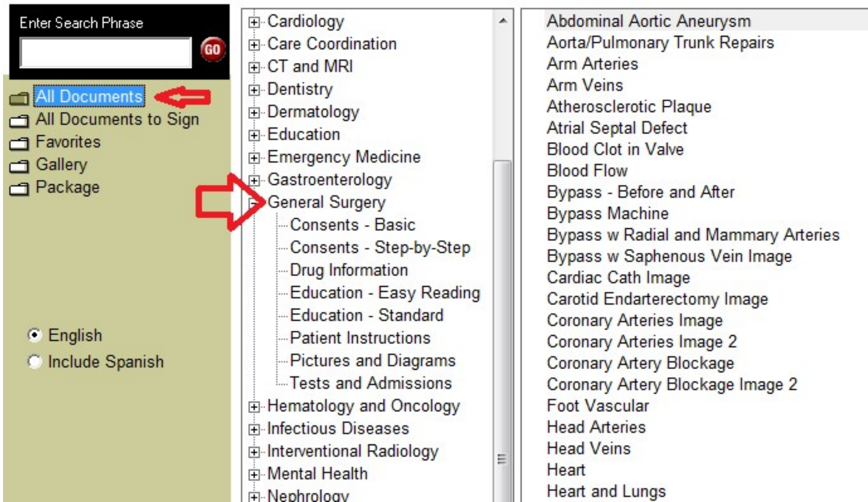
HOW TO DO iMED CONSENT

1. Log into CPRS
2. Select a patient
3. Go to Tools → iMedConsent

4. Log in again (if applicable)

5. iMedConsent opens, Look for patient name on top

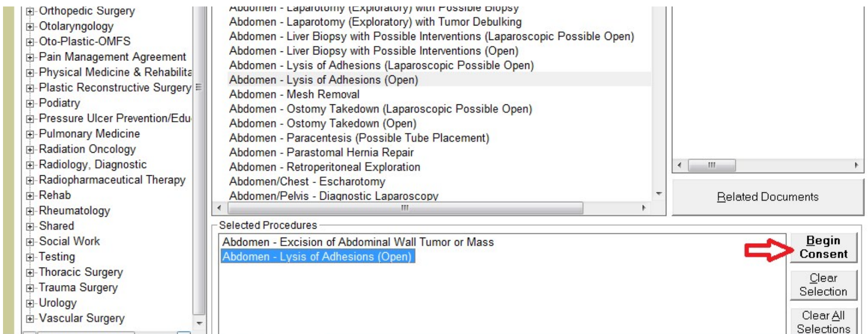
6. Click the (+) next to your specialty “General Surgery”



7. Click on **Consents-Basic** or **Consents-Step-by-Step**

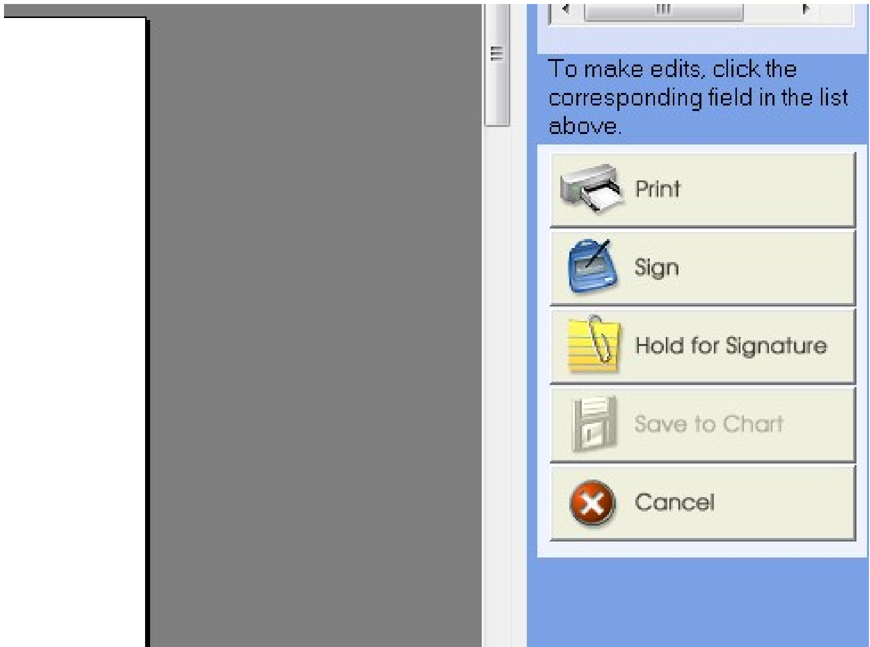
8. Click on the procedure(s) from the list on the right

9. Click on **Begin Consent**



10. Follow instructions on each screen

11. Obtain all signatures by clicking **Sign** or click **Hold for Signature**



12. Once you have all signatures, click **Save to Chart**

13. Progress note automatically created in CPRS

14. Go to Vista Imaging if you want to view copy of signed consent

HOW TO SCHEDULE A CASE IN VISTA

Please follow up that cases are booked in VISTA a week in advance.

Log into Vista Access

You may have to select "Service Packages" if you do not see the "Surgery Menu" option immediately.

```
PATIENT INFORMATION
MAILMAN MENU ...
TELEPHONE BOOK
FACILITY ADMINISTRAT
SERVICE PACKAGES
USER HELP/SETUP/TOOL
Unsigned orders sear
All MY UNSIGNED Docu
CONNECT TO OTHER VA
HALT
```

Select Surgery Menu

```
6      Request Operatio
7      Schedule an Admi
8      Schedule of Oper
9      Schedule Operati
10     Scheduled Admiss
11     Surgery Menu
CHOOSE 1-11:
```

Select Request Operation

```
   2     Cancel a Scheduled Admi
   3     Clinicomp DSIHF VistaGa
   4     CPRSChart version 1.0.3
   5     Operation Menu
   6     Request Operations
   7     Schedule an Admission
   8     Schedule of Operations
   9     Schedule Operations
   10    Scheduled Admissions Li
```

Select Make Operation Request

```
   A       Display Availability
   R       Make Operation Requests
   D       Delete or Update Operation Req
   W       Make a Request from the Waitin
   CC      Make a Request for Concurrent
   V       Review Request Information
```

Enter the patient name and date of surgery.

```
Select Patient: zzztest,patient,PATIENT   ZZZ
424       NO      NSC VETERAN
                               ** NON-VESTED
WARNING : You may have selected a test patie
 Enrollment Priority:            Category: N
 Enrollment Status: NOT ELIGIBLE; INELIGIBLE

Make a Request for which Date ?
```

Enter Primary Surgeon, Attending Surgeon and Surgical Specialty.   General Surgery is code 50; Transplantation is code 49.

```
Primary Surgeon: le,marie  LE,MARIE E      MEL
P-GENERAL SURGERY     PHYSICIAN (STAFF)
Attending Surgeon: le,marie  LE,MARIE E      MEL
 CP-GENERAL SURGERY     PHYSICIAN (STAFF)
Surgical Specialty: transplantATION  49     TRANS
 49
Principal Operative Procedure: renal transplant
Principal Preoperative Diagnosis: esrd
```

Laterality: 1 = N/A; 2 = Left; 3 = Right
Admission: 1 = Ambulatory; 2 = Admit postop; 3 = Hospitalized/Inpatient
Planned principle procedure code is the CPT code.
Planned principle diagnosis code is the ICD-10 code.
Again the documents with frequently used CPT and ICD-10 codes for surgery are on the Share Drive.

```
Laterality Of Procedure:1  NA
Planned Admission Status:2  ADMITTED
Planned Principal Procedure Code:50360      TRANSPL
 RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; W
 NEPHRECTOMY
 Modifier:
Planned Principal Procedure Code (CPT): 50360  RENAL
TATION OF GRAFT; WITHOUT RECIPIENT NEPHRECTOMY   //
TION, IMPLANTATION OF GRAFT; WITHOUT RECIPIENT NEPHR

Planned Principal Diagnosis Code (ICD10):n18.6

 One code found

 N18.6     End Stage Renal Disease
```

Enter the estimated case length.

```
Principal Procedure:      renal transplant
Planned Principal Procedure Code (CPT): 5036
TATION OF GRAFT; WITHOUT RECIPIENT NEPHRECTO
          //
Select OTHER PROCEDURE:
Estimated Case Length (HOURS:MINUTES): 3:00
Brief Clinical History:
  1>esrd secondary to type II dm
```

Enter blood requests as appropriate.

```
Request Blood Availability (Y/N): N// y  YES

Type and Crossmatch, Screen, or Autologous: TYPE & CROSSMATCH//
H
Select REQ BLOOD KIND: prbc
CHOOSE 1-0:2

     RED BLOOD CELLS  -  RBC
     FRESH FROZEN PLASMA  -  FFP
     CRYOPRECIPITATE  -  CRYO
     PLATELETS  -  PLT
     OTHER  -  OTHER
     WHOLE BLOOD  -  WB
```

Always answer yes to "preadmission testing" Case type is either elective or emergency.

```
            ** REQUESTS **    CASE #189614   ZZZTE
1     PRINCIPAL PROCEDURE:      renal transplant
2     OTHER PROCEDURES:         (MULTIPLE)
3     PLANNED PRIN PROCEDURE CODE : 50360
4     LATERALITY OF PROCEDURE: NA
5     PRINCIPAL PRE-OP DIAGNOSIS: esrd
6     PRIN PRE-OP ICD DIAGNOSIS CODE (ICD10):
7     OTHER PREOP DIAGNOSIS:    (MULTIPLE)
8     PALLIATION:
9     PLANNED ADMISSION STATUS:  ADMITTED
10    PRE-ADMISSION TESTING:    YES
11    CASE SCHEDULE TYPE:       ELECTIVE
12    SURGERY SPECIALTY:        TRANSPLANTATION
13    PRIMARY SURGEON:          LE,MARIE E
14    FIRST ASST:
15    SECOND ASST:
```

All the other details for the case can be omitted if not vital to preparing for the case. However if there is special equipment requested ie Bookwalter, Ligasure please be sure to include details in appropriate slot.

```
1     ATTENDING SURGEON:        LE,MARIE E
2     PLANNED POSTOP CARE:
3     CASE SCHEDULE ORDER:
4     SURGERY POSITION:         (MULTIPLE)(DATA)
5     REQ ANESTHESIA TECHNIQUE:
6     REQ FROZ SECT:
7     REQ PREOP X-RAY:
8     INTRAOPERATIVE X-RAYS:
9     REQUEST BLOOD AVAILABILITY: YES
10    CROSSMATCH, SCREEN, AUTOLOGOUS: TYPE & CR
11    REQ BLOOD KIND:           (MULTIPLE)
12    SPECIAL EQUIPMENT:        (MULTIPLE)
13    PLANNED IMPLANTS:         (MULTIPLE)
14    SPECIAL SUPPLIES:         (MULTIPLE)
15    SPECIAL INSTRUMENTS:      (MULTIPLE)
```

These options can be left empty by hitting the return key.

```
1       PHARMACY ITEMS:                (MULTIPLE)
2       REQ PHOTO:
3       PREOPERATIVE INFECTION:
4       REFERRING PHYSICIAN:           (MULTIPLE)
5       GENERAL COMMENTS:              (WORD PROCESSING)
6       INDICATIONS FOR OPERATIONS:  (WORD PROCESSIN
7       BRIEF CLIN HISTORY:            (WORD PROCESSING)(
8       SPD COMMENTS:                  (WORD PROCESSING)
```

The case is not booked until you get a confirmation screen seen below with the case # which should be recorded to the Shared surgery calendar as confirmation of booking.

```
No classification information is required for this patient.

A request has been made for ZZZTEST,PATIENT on 09/23/16.

Sending a Notification of Appointment Modification for case #189614

  Press RETURN to continue.
```

HOW TO LOOK AT SCHEDULE OF BOOKED CASES IN VISTA

Under the Surgery Menu there are two ways to check the schedule for booked cases.

```
R       Request Operations ...
LR      List Operation Requests
S       Schedule Operations ...
LS      List Scheduled Operations
O       Operation Menu ...
NON     Non-O.R. Procedures ...
C       Comments
SR      Surgery Reports ...
L       Laboratory Interim Report
```

LR –list does not show next day surgeries. This option is good to check for surgeries a few days in advance.
You want to list by specialty (General Surgery 50).

```
List requests by SPECIALTY or WARD ?  SPECIALTY//

Do you want requests for all surgical specialties ? YES// no

List Requests for which Specialty ? genERAL SURGERY  50      GENE
     1    50   GENERAL(OR WHEN NOT DEFINED BELOW)      50
     2    50   PSYCHIATRY      50
CHOOSE 1-2: 1   GENERAL(OR WHEN NOT DEFINED BELOW)      50

Print the Report on which Device: HOME//
```

LS – will show tomorrow's surgeries.
Again remember to list by specialty (General Surgery 50)

```
List of Scheduled Operations:

List Scheduled Operations for which date ? 8/31/16 (AUG 31, 2016)

Do you want to sort by OPERATING ROOM, SPECIALTY or WARD LOCATION ? spec

Do you want a list of scheduled operations for a specific specialty ? YES//

Print the list for which Specialty: genERAL SURGERY  50     GENERAL SURGERY
     1   50  GENERAL(OR WHEN NOT DEFINED BELOW)      50
     2   50  PSYCHIATRY     50
CHOOSE 1-2: 1  GENERAL(OR WHEN NOT DEFINED BELOW)      50

Print the list on which device: HOME//
```

HOW TO CANCEL A CASE IN VISTA

Select Request Operation

```
    2     Cancel a Scheduled Admi
    3     Clinicomp DSIHF VistaGa
    4     CPRSChart version 1.0.3
    5     Operation Menu
    6     Request Operations
    7     Schedule an Admission
    8     Schedule of Operations
    9     Schedule Operations
    10    Scheduled Admissions Li
```

Then select "Delete or Update"

```
   A       Display Availability
   R       Make Operation Requests
   D       Delete or Update Operati
   W       Make a Request from the
   CC      Make a Request for Concu
   V       Review Request Informati
   OR      Operation Requests for a
   WR      Requests by Ward
```

If surgery date is changed then OCC should be notified as well in order to close the loop.

HOW TO TELEPHONE CONTACT NOTE 24 H BEFORE SURGERY

Click on the Visit Location box. Encounter provider is your name. Choose “New Visit” tab – The visit location is the BRX SURG Bedside visit.

Click on the “New Note” button.

Select the proper note title – “Telephone Contact”. You will have to select the proper co-signer.

Progress Note Properties

Progress Note Title: TELE <C&P TELE PROVIDER>

TELEPHONE <RESPIRATORY TELEPHONE APPOINTMENT NO

TELEPHONE <SCI TELEPHONE ANNUAL PHYSICAL>

TELEPHONE <SCI TELEPHONE CONTACT NOTE>

TELEPHONE <TELEPHONE CONSENT>

TELEPHONE <TELEPHONE CONTACT>

TELEPHONE <UROLOGY TELEPHONE CONTACT>

TELEPHONE <WOMEN'S HEALTH/GYNECOLOGY TELEPHONE:

OK

Cancel

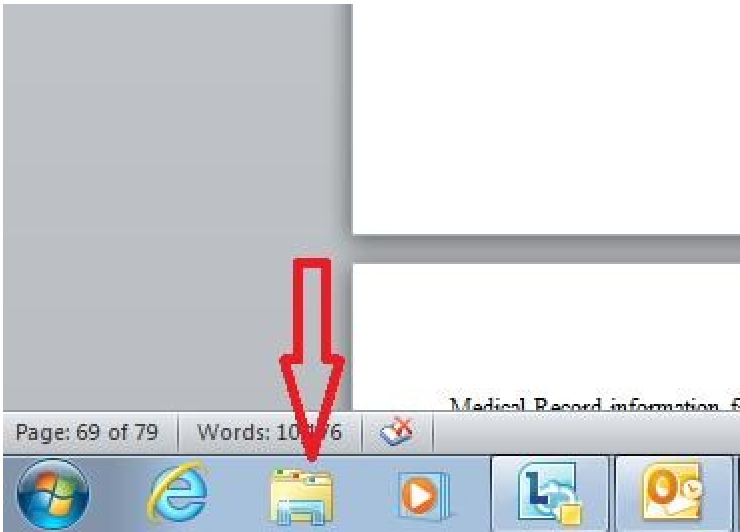
Date/Time of Note: Oct 31,2016@14:09

Author: Le,Marie E - PHYSICIAN (STAFF)

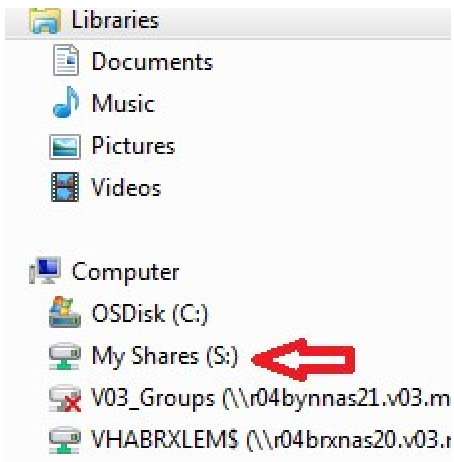
Document your conversation with the patient and if ready for OR.

HOW TO ACCESS THE SURGERY SHARE DRIVE

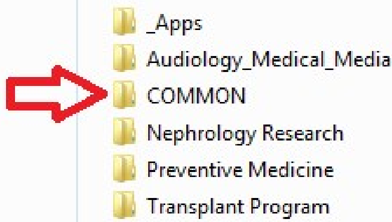
Select on the Files Folder.



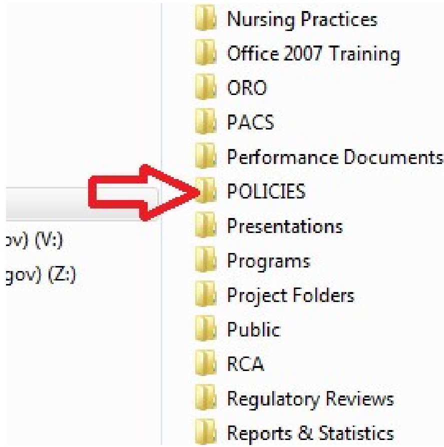
Select My Shares Drive


Libraries
Documents
Music
Pictures
Videos
Computer
OSDisk (C:)
My Shares (S:)
V03_Groups (\\r04bynnas21.v03.m
VHABRXLEM$ (\\r04brxnas20.v03.r

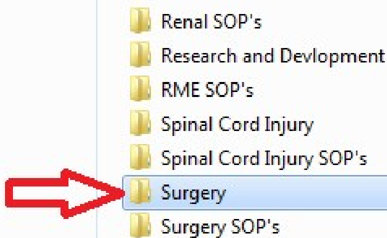
Select the Common folder

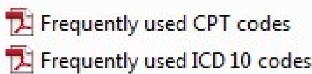


Select the Policies folder



Select the Surgery folder





HOW TO OPEN THE OR AFTER HOURS

Contact the Hospital Administrative Coordinator (HAC):
(c) 917-282-9593
(p) 7-853 or **393 in house

The HAC will then call the on call OR team as well as anesthesia on call. The OR nurse has to come in from home and enter the case into the system to get things rolling.

HOW TO ACCESS PATIENT MEDICAL INFORMATION FROM OTHER VA FACILITIES

Remote Data

Through Remote Data, you can access data generated at other VA Medical Center and Department of Defense (DOD) facilities.

To view a patient's remote data, use these steps:

1. After opening the patient's record, see if the text on the Remote Data button is blue. If the text is blue, the patient has remote data.

2. Click the reports tab

3. Click the Remote Data button to display a list of sites that have remote data for the patient.

4. Select the sites you want to view remote data from by clicking the check box in front of the site name.

5. Select the report you would like to view by double clicking on "Heath Summary" and choosing one of the reports that begin with the word "remote".

Vista Web

Vista Web is another way to access data generated at other VA Medical Center and Department of Defense (DOD) facilities.

Vista Web is found on the TOOLS menu in CPRS.
Open your patient in CPRS, go to TOOLS then select VISTA WEB
The first time you open VISTA WEB you will be prompted to enter an access and verify code. Enter your VISTA/CPRS access and verify codes.

Medical Record information from your local medical center (Bronx) as well as other medical centers visited by your patient will be available for viewing.

HOW TO DO DISCHARGE SUMMARY

Discharge Summary Tab

The Discharge Summary tab gives you quick access to the Discharge Summary for a specific patient. Highlight any discharge summary listed in the left field to view the text of the summary in the right field. Hold the mouse pointer over a listing to see the entire line of the listing. The Discharge Summary that is highlighted is displayed on the right. Right-click in the Discharge Summary text and you may select the “Find in Selected Summary” option from the popup menu. This option allows you to search the displayed text.
Click on the View and Action menus to see the available options.

To write a new discharge summary, click the New Summary button.
If you wish to edit, save, or sign this discharge summary, select an action from the Action menu.

Writing Discharge Summaries

To write a discharge summary, use these steps:

1. Click the D/C Summ tab.

2. Click New Summary or select Action | New Discharge Summary.

3. In the Discharge Summary Properties dialog, select Discharge Summary Title (e.g., General, SOAP, Warning, etc.). Additional items will appear on the dialog for titles that require entry of a cosigner or an associated consult.

4. If necessary, change the note date by clicking the button next to the date and entering a new date.

5. If necessary, change the note author by selecting the author from the Author dropdown list.
6. Enter the attending physician.

7. Click the admission related to this Discharge Summary.

8. Enter any additional information, such as an expected cosigner. Completing these steps will allow the note to be automatically saved.

9. Click OK.

10. Create the summary content by typing in text

11 Sign when discharge summary is complete.

HOW TO DO TRAVEL NOTES FOR DISCHARGE

Travel for NON-INTERFACILITY AMBULANCE:

Reminder Dialog Template: BENEFICIARY TRAVEL (BT) NOTE

☑ SPECIAL MODE TRANSPORTATION/COMMON CARRIER

This template allows request for patient transport by Special M
eligibility, medical need, and administrative approval. Eligi
functional abilities and limitations. Requests must be signed
Psychologist, or other independent licensed practitioner.

Special Mode (SM) includes ambulance, ambulette, air ambulance,
transport disabled persons who cannot otherwise travel safely
owned vehicle (POV). For example, SMT is provided to claimant
at least two people, who require restraints during transport o

SM should not be used for convenience of the patient and/or fam

PLEASE NOTE: Requests with insufficient evidence of functional
clinical evidence or appears intentionally exaggerated to obta
additional information or clarification.

If this patient does not clinically meet requirements for SM tr
the Beneficiary Travel office.

For travel request during the WHEN HOURS, contact the Hospital

Reminder Dialog Template: BENEFICIARY TRAVEL (BT) NOTE

Point of Contact's E-mail:
Phone/Pager/Ext:

Resources

VA Directive 2007-015 - Inter-facility Transfer Policy

INTER-FACILITY TRANSFER:
Is this Special Mode Transport in relation to an Inter-facility

○ [Yes]
● [No]

MEDICAL JUSTIFICATION:

Veteran can safely be transported or transfer in and out
taxi, bus or other common carrier (public transportation)
be on a stretcher during transport; does not require rest
transport; does not require acute medical care during tra

○ [Yes]
● [No]

The clinical condition requiring the use of VA Special

☐ Lower limb Amputation precluding private transporta
☑ Severe deconditioning or functional limitation prec
☐ Orthopedic condition precluding private transportat
☑ Cardiac or hemodynamic instability requiring contin
☐ Dementia/Confusion precluding private vehicle with
☐ Respiratory/Neuro condition requiring ventilator su
☐ Severe COPD/emphysema precluding use of a specially

Reminder Dialog Template: BENEFICIARY TRAVEL (BT) NOTE

Please explain why any other means of transportatio
contraindicated based on the patient's current medi
and/or physical or mental limitations:

Describe: *

TYPE OF TRANSPORT REQUIRED

ADVANCED LIFE SUPPORT: (e.g. High acuity, stret

BASIC LIFE SUPPORT (Stretcher; Medical Attenda

Stretcher: Patient is bed-bound, requires r
unable to maintain static sitting position

Describe functional limitations in detail cl
*

Medical care en route: (e.g. open/infusing I

Describe and clinically justify the required
*

Requires restraint during stretcher transpor

Bariatric Stretcher

DNI

DNR

Foley Catheter

Wearing Halo

Date travel is to commence: *Aug 2,2016

IF THE REQUESTED TIME FRAME IS INCONSISTENT WITH
CONSULT MAY BE RETURNED FOR REVISION.

Estimated time frame Veteran will require transportat

- (•) One Time (Consider requesting longer approval i
- ( ) 3 Months (e.g. - short-term rehab)
- ( ) 6 Months (e.g. - long-term rehab or need through
- ( ) 1 Year (e.g. - long-term impairment expected but

Select one:

- (•) One Way

Visit Info

Travel for NON VA FACILITY AMBULETTE:

Reminder Dialog Template: BENEFICIARY TRAVEL (BT) NOTE

☑ SPECIAL MODE TRANSPORTATION/COMMON CARRIER

This template allows request for patient transport by Special M
eligibility, medical need, and administrative approval. Eligi
functional abilities and limitations. Requests must be signed
Psychologist, or other independent licensed practitioner.

Special Mode (SM) includes ambulance, ambulette, air ambulance,
transport disabled persons who cannot otherwise travel safely
owned vehicle (POV). For example, SMT is provided to claimant
at least two people, who require restraints during transport o

SM should not be used for convenience of the patient and/or fam

PLEASE NOTE: Requests with insufficient evidence of functional
clinical evidence or appears intentionally exaggerated to obta
additional information or clarification.

If this patient does not clinically meet requirements for SM tr
the Beneficiary Travel office.

For travel request during the WHEN HOURS, contact the Hospital

Reminder Dialog Template: BENEFICIARY TRAVEL (BT) NOTE

VA Directive 2007-015 - Inter-facility Transfer Policy

INTER-FACILITY TRANSFER:
Is this Special Mode Transport in relation to an Inter-facility Transfer

[Yes]

[No]

MEDICAL JUSTIFICATION:

Veteran can safely be transported or transfer in and out of a priva
taxi, bus or other common carrier (public transportation); does not
be on a stretcher during transport; does not require restraints dur
transport; does not require acute medical care during transport.

[Yes]

Based on the information provided above, this Veteran does not me
eligible for common carrier mode.

Common Carrier assistance is available to Veterans eligible for b
functional abilities and limitation or the Veterans identified l
Carrier Transportation for the convenience of the Veteran is lim
orders to transport Veteran at VA expense to receive care, treat
administrative eligibility requirements.

Orders must be signed by a Physician, Physician Assistant (PA), N
licensed practitioner.

For assistance in determining Beneficiary Travel eligibility, ple

Transportation assistance is Medically required:
Please describe in detail the Veterans functional abilities/limit

Reminder Dialog Template: BENEFICIARY TRAVEL (BT) NOTE

Suggested Medically appropriate forms of transport

- [ ] Taxi/Hired Car
- [ ] Bus
- [ ] Transit System
- [ ] Train
- [ ] Plane
- [x] Other(VTS Veterans Transportation Service)

Type of care being provided: (Please check all tha

- [ ] Outpatient appointment
- [ ] Inpatient Admission/Discharge
- [ ] Authorized non-VA care Outpatient appointment
- [ ] Authorized non-VA care Inpatient
- [ ] Admission/Discharge
- [ ] Transplant Care
- [ ] Interfacility Transfer/Discharge

Date travel is to commence: *

IF THE REQUESTED TIME FRAME IS INCONSISTENT W
CONSULT MAY BE RETURNED FOR REVISION.

Estimated time frame Veteran will require transpo

- ( ) One Time (Consider requesting longer approva
- ( ) 3 Months (e.g. - short-term rehab)
- ( ) 6 Months (e.g. - long-term rehab or need thr
- ( ) 1 Year (e.g. - long-term impairment expected

Type of care being provided: (Please che

- [ ] Outpatient appointment
- [x] Inpatient Admission/Discharge
- [ ] Authorized non-VA care Outpatient a
- [ ] Authorized non-VA care Inpatient
- [ ] Admission/Discharge
- [ ] Transplant Care
- [ ] Interfacility Transfer/Discharge

Date travel is to commence: *

IF THE REQUESTED TIME FRAME IS INCO
CONSULT MAY BE RETURNED FOR REVISIO

Estimated time frame Veteran will requir

- (•) One Time (Consider requesting longe
- ( ) 3 Months (e.g. - short-term rehab)
- ( ) 6 Months (e.g. - long-term rehab or
- ( ) 1 Year (e.g. - long-term impairment

Does the Veteran have a certified Caregi

( ) [Yes] (•) [No]

Does the Veteran travel with a service a

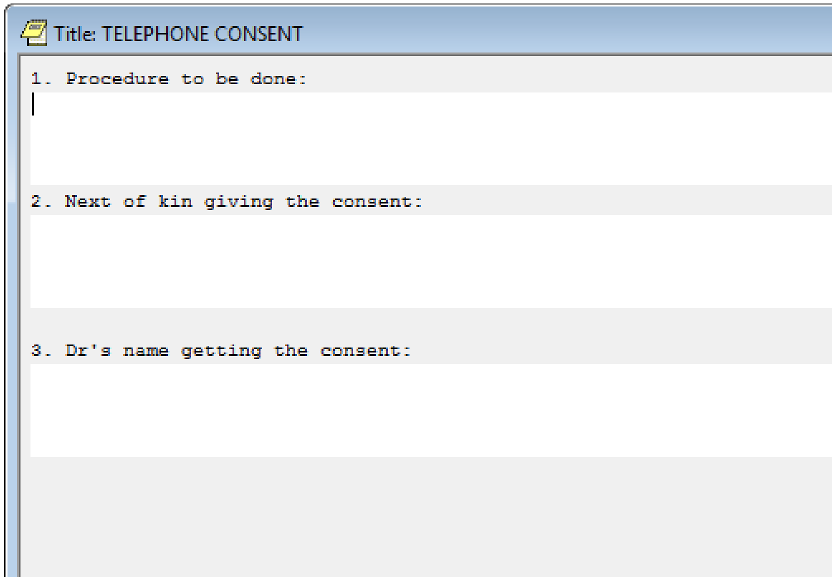
( ) [Yes] (•) [No]

( ) [No]

For VA INTERFACILITY TRANSFER:

```
Special Mode (SM) includes ambulance, ambulette, air a
 transport disabled persons who cannot otherwise trave
 owned vehicle (POV). For example, SMT is provided to
 at least two people, who require restraints during tr

SM should not be used for convenience of the patient a

PLEASE NOTE: Requests with insufficient evidence of fu
 clinical evidence or appears intentionally exaggerate
 additional information or clarification.

If this patient does not clinically meet requirements
 the Beneficiary Travel office.

For travel request during the WHEN HOURS, contact the

WHEN HOURS: [Weekends, Holidays all day, and Weekday E
 Friday]

Point of Contact's E-mail:
Phone/Pager/Ext:

Resources
VA Directive 2007-015 - Inter-facility Transfer Polic

INTER-FACILITY TRANSFER:
Is this Special Mode Transport in relation to an Inter
 (•) [ Yes ]
     Please follow local process for approval of Inter
 ( ) [ No ]
```

To Obtain Telephone Consent: Telephone consent note must be performed, and a nurse must witness this. AFTER the note is signed, go to action add additional signature and include the nurses name into the documentation.


Title: TELEPHONE CONSENT

1. Procedure to be done:

2. Next of kin giving the consent:

3. Dr's name getting the consent: