Virginia Commonwealth University
Medical Center
Medical College of Virginia Campus

Department of Surgery

Resident Handbook

2009 - 2010

A guide to services, procedures and policies at Virginia Commonwealth University Health Systems and Medical College of Virginia Hospitals
We are pleased that you have chosen the Virginia Commonwealth University Health System for your graduate surgical education and look forward to providing you a rewarding and educational experience. The staff in the Surgical Education Office looks forward to working with you and is available to assist you.

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# INDEX

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman’s Message</td>
<td>6</td>
</tr>
<tr>
<td>Program Director’s Message</td>
<td>6</td>
</tr>
<tr>
<td>Affirmative Action Statement</td>
<td>7</td>
</tr>
<tr>
<td>Mission Statement</td>
<td>7</td>
</tr>
<tr>
<td>Department of Surgery Residency Policies and Procedures</td>
<td>8</td>
</tr>
<tr>
<td>Selection Process</td>
<td>8</td>
</tr>
<tr>
<td>Eligibility Requirements</td>
<td>8</td>
</tr>
<tr>
<td>Surgery Resident Expectations</td>
<td>10</td>
</tr>
<tr>
<td>Policy on Clinical Education and Supervision of Housestaff</td>
<td>10</td>
</tr>
<tr>
<td>General Principles</td>
<td>10</td>
</tr>
<tr>
<td>Site Specific (Inpatient, ED, Clinics, Consult Service, ICU, and OR)</td>
<td>10</td>
</tr>
<tr>
<td>Housestaff Clinical Duties and Privileges – Lines of Supervision</td>
<td>14</td>
</tr>
<tr>
<td>Policy on Duty Hours</td>
<td>19</td>
</tr>
<tr>
<td>Introduction</td>
<td>19</td>
</tr>
<tr>
<td>Monitoring</td>
<td>19</td>
</tr>
<tr>
<td>Duty Hours</td>
<td>19</td>
</tr>
<tr>
<td>Oversight</td>
<td>19</td>
</tr>
<tr>
<td>Duty Hours Exception</td>
<td>19</td>
</tr>
<tr>
<td>Supervision of Residents</td>
<td>20</td>
</tr>
<tr>
<td>On-Call Activities</td>
<td>20</td>
</tr>
<tr>
<td>Moonlighting</td>
<td>20</td>
</tr>
<tr>
<td>Fitness for Duty</td>
<td>20</td>
</tr>
<tr>
<td>Resident Assessment of Performance</td>
<td>22</td>
</tr>
<tr>
<td>Mentor Program</td>
<td>22</td>
</tr>
<tr>
<td>Surgery Education Committee</td>
<td>22</td>
</tr>
<tr>
<td>Academic Review Committee</td>
<td>22</td>
</tr>
<tr>
<td>Probationary Status</td>
<td>22</td>
</tr>
<tr>
<td>Suspension</td>
<td>22</td>
</tr>
<tr>
<td>Dismissal During or at the Conclusion of Probation</td>
<td>22</td>
</tr>
<tr>
<td>Summary Dismissal</td>
<td>22</td>
</tr>
<tr>
<td>Resident Information</td>
<td>23</td>
</tr>
<tr>
<td>Grievance Policy and Procedures</td>
<td>23</td>
</tr>
<tr>
<td>Promotion</td>
<td>23</td>
</tr>
<tr>
<td>Call Rooms</td>
<td>23</td>
</tr>
<tr>
<td>Resident Conferences</td>
<td>23</td>
</tr>
<tr>
<td>Evaluation Process</td>
<td>23</td>
</tr>
<tr>
<td>Meal Tickets</td>
<td>23</td>
</tr>
<tr>
<td>Operative Log</td>
<td>23</td>
</tr>
<tr>
<td>Resident as Teachers</td>
<td>23</td>
</tr>
</tbody>
</table>
Vacation Policy
Travel Policy
Sick Leave Policy and Notification Policy
Maternity Leave Policy
Family Medical Leave
Call Schedule
ABSITE

Telephone Directories
VCUHS/MCVH Surgery Resident Pager Numbers
VCUHS/MCVH Surgery Faculty Pager Numbers
Department of Surgery Administration/Division Chiefs
Departmental Numbers
Hospital/Clinic/Laboratory Numbers
McGuire VA Medical Center
Local Area Hospitals

Medical Records
Policy
Medical Record Content
Tips for Dictation
Instructions for Dictation
Discharge Summary Content Guidelines
Operative Report Content Guidelines
Delinquent Medical Records

Pharmacy Services (MCVH)
Formulary
Drug Information and Consultative Services
Pharmacy Services Clinic
Prescribing
Nutritional Support Team
Prescriber Identification
NOW, STAT, and EMERGENCY
Emergency Medications
Drug Sample Policy

General Information
Organ, Tissue, and Eye Donation
Autopsies
Advanced Directives
Services Available to Family Members

Department of Radiology
Diagnostic Radiology
Portable Exams
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordering Special Studies</td>
<td>34</td>
</tr>
<tr>
<td>Ordering Inpatient Studies</td>
<td>35</td>
</tr>
<tr>
<td>Computed Tomography (CT)</td>
<td>35</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>35</td>
</tr>
<tr>
<td>CT and US Interventional Procedures</td>
<td>35</td>
</tr>
<tr>
<td>MRI</td>
<td>35</td>
</tr>
<tr>
<td>Myelography</td>
<td>36</td>
</tr>
<tr>
<td>Angiography</td>
<td>36</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>36</td>
</tr>
<tr>
<td>Review of Studies and Film Sign out Policies</td>
<td>36</td>
</tr>
<tr>
<td>Get Results (8-7827)</td>
<td>36</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>37</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>37</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>37</td>
</tr>
<tr>
<td>Patient Education</td>
<td>37</td>
</tr>
<tr>
<td>Patient Education Center</td>
<td>37</td>
</tr>
<tr>
<td>Patient Education TV</td>
<td>37</td>
</tr>
<tr>
<td>Teaching Materials</td>
<td>38</td>
</tr>
<tr>
<td>Nursing Support Team</td>
<td>38</td>
</tr>
<tr>
<td>Care at Home</td>
<td>38</td>
</tr>
<tr>
<td>Hospital Hospitality House</td>
<td>38</td>
</tr>
<tr>
<td>Security</td>
<td>38</td>
</tr>
<tr>
<td>Sexual Harassment</td>
<td>38</td>
</tr>
<tr>
<td>Cafeteria</td>
<td>38</td>
</tr>
<tr>
<td>Hours</td>
<td>38</td>
</tr>
<tr>
<td>Vending</td>
<td>39</td>
</tr>
<tr>
<td>A La Cart</td>
<td>39</td>
</tr>
<tr>
<td>Catering</td>
<td>39</td>
</tr>
<tr>
<td>Child Care</td>
<td>39</td>
</tr>
<tr>
<td>Physician Services</td>
<td>39</td>
</tr>
<tr>
<td>Telege</td>
<td>39</td>
</tr>
<tr>
<td>Paging</td>
<td>39</td>
</tr>
<tr>
<td>Consult Service 828-6369</td>
<td>40</td>
</tr>
<tr>
<td>Physician Services 828-7929</td>
<td>40</td>
</tr>
<tr>
<td>HealthLine 828-6284</td>
<td>40</td>
</tr>
<tr>
<td>Statements of Professional Attire</td>
<td>40</td>
</tr>
<tr>
<td>Universal Precautions</td>
<td>40</td>
</tr>
<tr>
<td>Airborne Precautions</td>
<td>40</td>
</tr>
<tr>
<td>HIV/AIDS Services</td>
<td>41</td>
</tr>
</tbody>
</table>

C:\DOCUME~1\enelson\LOCALS~1\Temp\Handbook 2009 2010.doc; 10/9/2009
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious Diseases</td>
<td>41</td>
</tr>
<tr>
<td>HIV Antibody Testing</td>
<td>41</td>
</tr>
<tr>
<td>Occupational Exposures</td>
<td>42</td>
</tr>
</tbody>
</table>
Chairman’s Message

Welcome to the Department of Surgery at the Virginia Commonwealth University Health System and Medical College of Virginia Hospitals. Your life as a house officer will offer you many opportunities for growth educationally, socially, and in maturity. The Department of Surgery has prepared this handbook to try to put useful information in a compact, readily accessible format; we hope that this information will save you time and aid you in your work. As Chairman of the Department of Surgery, I look forward to working with you and helping you to learn, teach, and to attain your potential.

Sincerely,

James P. Neifeld, MD
Stuart McGuire Professor and
Chairman, Department of Surgery

Program Director’s Message

Welcome to the Virginia Commonwealth University Health System, Medical College of Virginia Hospitals General Surgery Residency Program. Because the Department of Surgery will be your home for the next several years, we’ve developed this manual to help make your lives a little easier. This manual contains our expectations of residents in the program and also provides a quick reference for the multitude of services that you will need to make use of during your residency years.

In our program you will have the opportunity to work with clinicians who are at the forefront of their professions and to participate in operations that are performed at few other medical centers in the country. While the acquisition of clinical knowledge and technical skills are vital in patient care, compassion and genuine concern also have a profound impact upon patients and their families. As you enter into the senior years of your residency, you will be called upon to teach junior residents and medical students; we hope that you will impact well what you learn here.

Brian J. Kaplan, MD
Associate Professor of Surgery and
Program Director in General Surgery
AFFIRMATIVE ACTION/EQUAL EMPLOYMENT POLICY

The agreement with the policies of the Virginia Commonwealth University and the Medical College of Virginia, the Department of Surgery is committed to basing judgment concerning the admission, education, and employment of individuals upon their qualifications and abilities and affirmatively seeks to attract to its faculty, staff and study body qualified individuals of diverse backgrounds. In accordance with this policy and as delineated by federal and Virginia law, the Medical College of Virginia does not discriminate in admissions, educational programs, or employment against any individual on account of that individual’s sex, race, color, religion, age, handicap national or ethnic origin, or sexual orientation.

Our policy is committed to affirmative action under the law in employment of women, minority group members, handicapped individuals, special disabled veterans, and veterans of the Vietnam era.

For information write to

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Program Director
Department of Surgery
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P.O. Box 980135
Richmond, VA 23298-0135

MISSION STATEMENT

The Department of Surgery at the Medical College of Virginia of Virginia Commonwealth University will serve the people of Virginia through national leadership in surgical science, patient care and education. The Department will identify critical questions in surgical biology and systematically address those questions in its laboratories and programs. The Department is committed to exemplary clinical care and clinical investigation. The Department will be steward of our traditions of compassionate and competent care. The Department will equip a talented cadre of young physicians with the skills of inquiry, analysis and communication to achieve roles of leadership as lifelong scholars and clinicians. The Department will accomplish its mission in an atmosphere of collegial mutual respect and support for all elements of the University, its faculty and staff. The Department will manage its affairs in conscious recognition of our mission and its relation to a changing world and continuously seek ways to improve the quality of work, our processes and our people.
DEPARTMENT OF SURGERY POLICIES AND PROCEDURES

Selection Process

All applications and other supporting material for the residency program must be submitted using the ERAS system. The VCU Department of Surgery deadline for receipt of applications is (TBD). The following information is required:

- Completed Application
- Three (3) letters of recommendation from U.S. or Canadian physicians, including the Chair of Surgery or designee
- Dean's letter (or equivalent), IMG's must have letters of recommendation which clearly document U.S. or Canadian clinical experience
- Medical school transcript
- Personal statement
- Results of standardized tests: USMLE, NBME, FLEX, FMGEMS or equivalent; all in-service exams
- ECFMG certificate (IMG applicants)

Interviews for categorical positions are held during three weekend sessions. Applicants begin the interview process on Friday by attending a tour of VCU's Medical Center, the Medical College of Virginia Hospitals and presentations by our faculty. On Friday evening, the department hosts a reception at a local hotel where applicants have the opportunity to visit informally with our residents and faculty. Interviews are held on Saturday morning. Applicants have a continental breakfast with residents and faculty. Applicants will interview with at least three faculty members throughout the morning. An informal luncheon is provided to the candidates giving them the opportunity to meet with faculty and current residents.

The faculty meet after interviewing candidates each interview session to rank candidates interviewed. Candidates are ranked based on their application, letters of recommendations, dean's letter, transcript, personal statement, standardized test scores and the faculty interview score. After the three weekend interview sessions, faculty compile the final rank list for submission to the match.

Eligibility Requirements

Applicants are expected to display commitment to a career in surgery, strong analytical ability, good judgment, proven academic skill and be of sound moral character: In addition:

- All applicants must be within four years of graduation from medical/dental school or direct patient care activity (either independent or ACGME, AOA, or ADA accredited residency)
- Non-clinical graduate work in the US or Canada does not meet this requirement
- All applicants must have a minimum of three months of U.S. or Canadian direct patient care activity. For U.S. and Canadian Medical and Dental students, their clinical rotations during medical or dental school will meet this requirement. For IMG's, externships of direct patient care will meet this requirement, observerships do not qualify
- All residents must have passed Step 1 of USMLE or equivalent
• Prior to the first day of employment, all residents must have passed Steps 1 and 2 of the USMLE
• There is no minimum board score requirement
• Any ECFMG certified applicant who has not been enrolled in a United States or Canadian residency program within eighteen months of being issued his/her ECFMG certificate must take the Test of English as a Foreign Language Exam (TOEFL) and obtain a score of at least 600 before beginning their residency. The Test of Spoken English (TSE) and Test of Written English (TWE) are also required. ECFMG certification is required before you will be accepted into the program; however, an interview can be granted without a certificate
• **All applicants must have sufficient written and spoken English language skills**
• Current and appropriate Visa or equivalent, if not US citizen *(VCU ONLY ACCEPTS J-1)*
• Licensed to practice medicine in Virginia (or eligible)

For additional information please go to the VCU GME policies webpage.

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**Expectations of Surgery Residents**

It is expected that all residents:

- Answer pages promptly
- Respond courteously and appropriately to hospital staff and consulting physicians/house staff
- Handle patient problems expediently
- Consults to the ER must be completed within one hour
- Arrive to the clinics on time
- Be present in the operating room whenever possible.

Patients must be seen and evaluated by the operating resident (and intern if possible) before the case begins. The operating resident should document this by placing a pre-op note on the chart explaining why the patient is undergoing surgery, the risks/benefits, and that these have been explained to the patient who understands. Patients must also be evaluated by the operating resident postoperatively/prior to discharge for all inpatient and outpatient surgery. This is critical to maintaining continuity of care and a sound educational process.

It is expected that all residents participating in a procedure:

- Read about the case ahead of time and understand the indications
- Technical anatomy and possible complications for all elective cases.

As the operative schedule is available at least 24 hours in advance, and textbooks are available in the OR surgeons lounge, this should be an attainable goal and responsibility. Residents should make their best attempt to meet this same standard for urgent and emergency cases for the good of their patients as well as their own education. It is also expected that residents read about the illness/conditions of those on their inpatient service.

Operative reports must be dictated immediately after the case is completed. Discharge summaries should be dictated at the time of or prior to patient discharge from the hospital. Dictations should be concise and accurate, including all relevant information only.

In order to expedite patient discharge and facilitate attendance in the OR, orders for patient discharge including discharge medications and dictation should be entered/written the evening before the discharge is anticipated. These orders may be changed or cancelled in the morning if necessary.
It is the responsibility of each resident to keep an up-to-date log of all cases in which you were the operating surgeon, teaching assistant or first assistant. This log should include the patient's name, MR#, age, diagnosis, date of procedure, procedure performed, CPT code and complications. This information must be entered into the ACGME's Surgery Operative Log System (SOL) (www.ACGME.org). Each resident will be given a log-in and password. **Do not rely on the operating room or medical record for this data as it is often incorrect or incomplete.** Residents are expected to enter their cases on a weekly basis. The Program Director will review case entry information weekly. This log is required in order for you to successfully complete the program and be allowed to take your board examination.

Residents will be asked to anonymously evaluate each attending, chief resident and the service in general at the end of each rotation. Residents will be evaluated at the end of each rotation by faculty, nurses, and patients. Each year residents will evaluate the services they rotated on for a cumulative service evaluation to evaluate the educational value of each service. Chief residents are additionally asked to evaluate the program in writing anonymously prior to their departure.

**Call Schedule**
The monthly call schedule will be placed by your mailbox. Residents will be on call no more than every third night and will have one day in seven free of clinical responsibilities averaged over a four week period

**ABSITE**
All Categorical General Surgery Residents are expected to take the American Board of Surgery In-Service Exam (ABSITE) each January. The expectation is that residents will receive a test score of 50% or higher. Any resident with a score of 35% or lower will be discussed at the Surgery Education Committee meeting and possibly placed in a structured tutoring program with a faculty member.

**Conferences**
On time **attendance is required** at the following conferences. Attendance is taken the first 10 minutes of the conference. If you are more than **10 minutes late** to conference you are **not counted** as in attendance. Attendance is monitored and reported to the Program Director and Chairman. Repeated absence from conferences may lead to disciplinary actions. The Departmental Grand Rounds and Resident Basic Science Conference is Teleconferenced to the VA weekly. There are sign-in sheets for you to sign at the VA. Please remember to sign in so your attendance can be counted.

**Departmental Conferences**

- **Surgical Grand Rounds**
  (weekly – Thursday 7-8 am, GBJ Auditorium) – Teleconferenced to the VA.

- **D&C Conference (Quality Assurance)**
  (weekly – Thursday 4-5 pm, Sanger 8-036 Bigger Auditorium)

- **Resident Basic Science Conference**
  (weekly – Thursday 8-10 am, GBJ Auditorium for juniors – Teleconferenced to the VA and the Learning Center for senior residents).

- **VAMC Grand Rounds (when assigned to the VA)**
  (weekly – Friday 7:30-9 am, 2L Conference Room)
Divisional Conferences

**Cardiothoracic Surgery**
- Thoracic Surgery Weekly – Wednesday 4:30-5:30 pm, Main 3 Radiology Conference Rm.
- Cardiac Cath Weekly – Friday 8-9 am, Main 1 Cafeteria Conference Rm.
- Cardiac Surgery Weekly – Saturday 7-9 am, Main 4 ICU Conference Rm.

**General Surgery**
- GI Conference Weekly – Monday 4:30-6:00 pm, Main 3 Radiology Conference Rm.
- General Surgery Weekly – Tuesday 7:30-9:00 am, Main 9 Central Conference Rm.

**Surgical Oncology**
- Surgical Oncology Weekly – Tuesday 7:30 – 8:30 am MCC Demonstration Rm.
- Breast Weekly – Tuesday 8:30 am MCC Demonstration Rm.
- GI Tumor Center Weekly – Thursday 1:30 pm, MCC Demonstration Rm.

**Pediatric Surgery**
- Pediatric Surgery Weekly – Tuesday 4-5 pm, Main 7 Conference Rm.

**Transplant Surgery**
- Transplant Weekly – Thursday 12:00-2:00 pm, TBA

**Trauma & Critical Care Surgery**
- Trauma Weekly – Wednesday 7:30 – 9:30 am, Main 9 Central Conference Rm.

**Vascular Surgery (MCV & VA)**
- Vascular Weekly – Tuesday 7:15 – 8:15 am – Main 3-201

**VA Conferences** (When assigned to the VA service)
- Cardiothoracic Weekly Cath Conference Location to be announced
  Weekly Thoracic Conference Location to be announced
- General Surgery GI Conference Friday 7:30 – 9:00 am, 2K Conference Rm.
- Tumor Conference Wednesday 3:30-4:30 pm, 2L Conference Rm.

**CONFERENCE PRESENTATIONS**

Residents presenting cases in departmental or divisional conferences should research the most recent data available on the topic of discussion. They should have pertinent laboratory data, x-ray films, and pathology results of educational benefit.

**D&C Conference** is held weekly where the most senior level resident on the service will present a patient list and complications. The presentation must include:
- Service and time frame covered
- Number of cases done by each level resident on the service
- Total number of cases
- Patient age, MR number, and patient initials
- Attending and residents on case
- List of complications and/or deaths
 Residents should be prepared to discuss complications and/or deaths and answer questions regarding the cases.

**Interesting Case Presentation for D&C Conference**
- Residents will give a 3-5 minute presentation on an interesting patient, whether a complication, operation, disease or other interesting facet of care.
- A brief literature discussion should be prepared
- Discuss complications
- Give 2 to 8 teaching points appropriate for that particular case.

The **Resident Basic Science Conference** schedule is prepared for the year. It is the resident’s responsibility to prepare the presentation with the faculty facilitator and present to the residents. The following week faculty will review, with the residents, the previous week presentation. Residents are expected to have read ahead of time and be prepared to answer questions. There are several General Surgery Textbooks available in the department where you can find information on the topic being discussed.

Textbooks are located in the Program Director’s Office on West 7, the Resident Library on Main 9, and some are in the OR Faculty Lounge on Main 5. In addition, there are online resources as indicated on the Surgery Website. This conference is required and attendance is taken and monitored. The conference is Teleconferenced to the VA. Residents at the VA should also prepare for the conference and be prepared to answer questions.
POLICY ON CLINICAL EDUCATION AND SUPERVISION OF HOUSESTAFF

General Principles

As outlined in the Joint Statement on Resident Supervision issued by the Virginia Commonwealth University School of Medicine, the Department of Surgery subscribes to the philosophy that the most effective learning environment for post-graduate medical trainees is one that allows sufficient freedom for housestaff to share responsibility for decision making in patient care, yet provides adequate faculty supervision and involvement to provide feedback to trainees about their actions and to address the quality and safety of the care rendered to patients. Housestaff are individuals with an M.D., D.O., D.D.S., or equivalent degree who meet the qualifications for graduate education/training in the specialties or subspecialties of surgery or dentistry. In order to preserve this type of learning environment for its teaching program, the Department advocates the following principles as elements of its policy on housestaff clinical education and supervision:

1. Housestaff are regarded as primary physicians for all patients admitted to the teaching inpatient services, emergency rooms and clinics, and, as such, are responsible for the writing of orders, for the maintenance of records and for the execution of diagnostic, therapeutic and discharge plans.

2. Depending on their respective levels of training, it is appropriate and essential that junior housestaff be supervised by more senior housestaff in accordance with site-specific guidelines stated elsewhere in this document.

3. All spheres of housestaff activity will be supervised by attending faculty members who will share responsibility with houseofficers for patient care rendered and who will have ultimate authority for final decision making. The nature and extent of attending physician involvement will vary according to site as outlined below.

Operating surgeon, education and trust

One of the main tenets of adult education is that the adult learner must take responsibility for, and be actively involved in, their own education. Every day, it is your responsibility to ensure that you are prepared to optimize your learning for that day. It is your responsibility to find out what elective cases you are scheduled to cover the evening before the operations are scheduled. We expect you to read about the operation(s) you are scheduled to perform, unless you are on call in-house. Areas that should be covered include the pertinent anatomy, the normal physiology of that area of the body, the pathophysiology of the disease process requiring operation, the details of the operation itself, the recovery from the operation, and the nature and incidence of complications associated with the operation. As you progress, you should also become familiar with the significance of co-morbid diseases and their impact on the disease process, the operation and the recovery from surgery. Over time, your reading should cover not just the clinical details of patient care, but should also encompass the basic science material that is relevant to the clinical care provided. As you progress you should be able to discuss recent publications about clinical and basic science research being performed on the disease and the surgical management of the disease.
Our clinical expectations are similarly high. You should make a reasonable effort to meet every patient you are scheduled to operate upon prior to the operation. It is understood that at times you will not be able to meet with every patient prior to the operation because of mandatory lecture attendance or other demands, we all realize that at times we fall short of ideal due to multiple extenuating circumstances. At those times you should meet with the patient after surgery. For all elective operations, you must know the patient’s history, physical exam findings, lab test results and diagnostic imaging results prior to operating upon them.

The next area that requires education and trust is the operative note itself. The note is not just a narrative, often filled with unimportant details, but an important source of information for financial purposes, quality of care, risk management and decision making. Proper coding affects surgeon and hospital reimbursement. Precise terminology must be used. Outlining decision making in the note can be the difference between an expected occurrence, such as enterotomy during lysis of adhesions, and an adverse event that must be reported to the State – and a malpractice suit. Decision-making and unusual or complex maneuvers should be carefully described to provide information for future surgeons, who may have to re-operate – and again to forestall lawsuits because necessary information to understand the clinical situation was missing. Attending surgeons today understand these complexities of dictation: residents must learn them–they are as important as the actual technical procedures themselves.

When patients are admitted after hours, on weekends or holidays; the residents on call must see them in a timely fashion. You are responsible for making sure that the patients you are tasked with caring for receive high quality care. This means that residents with adequate levels of skill, knowledge and experience see ill patients. If you are covering the service, you will see them. If it is not possible for you to see them because of conflicting demands, it is your responsibility to ensure that someone with an adequate level of skill, knowledge and experience sees them. If you see a patient and are not confident that you are able to adequately assess and manage the patient, you must contact the appropriate higher-level person in the chain of command and arrange for them to see the patient.

The changes occurring in resident education, in particular the work hours limitations, must not be allowed to compromise patient safety or your education. The response to the regulation changes is complex and is everyone’s responsibility. The faculty and the administration are responsible for ensuring that the system responds to the changes enough to ensure that patients are safe and that you have ample opportunity to learn. You are responsible for ensuring that you learn from the opportunities provided to you. You are also responsible for making sure that the patients you are covering are properly evaluated and managed. If you have patient care questions that you cannot answer confidently, then you should involve individuals with the requisite knowledge, skill and experience.

**Site-Specific Housestaff Supervision**

The structure of housestaff-attending interactions and the form that faculty supervision of housestaff takes will vary according to site and type of patient care setting and are summarized below. In general, these rules are uniform for the University hospital, the Veteran’s Affairs Medical Center and other affiliated institutions unless otherwise noted.

**Inpatient Teaching Services**

1. All patients admitted to the service will be cared for by a patient care team which may include medical students, interns, residents and fellows under the direction of faculty attending physicians.
2. Although decisions regarding diagnostic tests and therapeutics may be initiated by the housestaff, these decisions will be reviewed with the attending surgeons.

3. All patients will usually be seen by the attending and discussed daily with housestaff. Stable patients may not be discussed and/or seen daily.

4. The attending will review the medical record and document his/her involvement in the care of the patient.

5. All transfers to another service and discharges will be approved by the attending in advance.

6. Housestaff are required to notify the patient’s attending, in a timely fashion, independent of the time of day, of any substantial controversy regarding patient care, any serious change in the patient’s course including unexpected death, need for surgery or transfer to an intensive care unit or to another service for treatment of an acute problem, or for any other significant change in condition.

7. Attendings or their designee are expected to be available and responsive, either by phone or pager, for housestaff consultation, 24 hours a day for their term on service, their on-call day, for their specific patients.

**Emergency Department**

1. Supervision in the Emergency Department will be provided 24 hours a day by Emergency Room physicians.

2. All patient admissions to the service will be discussed with an ER physician or the appropriate attending physician unless delay would result in harm to the patient.

3. All patient admission to inpatient units will be discussed with the attending (or his designee) assuming responsibility, as well as notifying the resident team assigned.

4. Housestaff is responsible for receiving all referral calls and for securing approval for activation of the MedFlight Helicopter.

5. All patients evaluated by an intern (PGY-1) will be presented to a more senior resident or attending.

**Clinics and Consult Services**

1. A faculty attending should be present on clinic site or in unique circumstance available by phone. His/her responsibility will be the supervision of housestaff working in the clinic.

2. All inpatient consultations written by a houseofficer will be presented to an attending, countersigned by that attending, and amended or supplemented by the attending as necessary, in accordance with the MCV Consultation Policy.

**Intensive Care Units**

Housestaff decisions, including senior resident decisions, regarding admission and discharge of patients from the intensive care units, and regarding the performance of specified invasive procedures, may be subject to review by subspecialty fellows and attendings depending on the
specific procedural rules for that unit. However, the attending physicians ultimately are responsible for all major patient care decisions.

Operating Rooms
1. The faculty is responsible for direct supervision of all operative cases. At a minimum, this means being in the operating room with the housestaff during critical parts of the procedure. For less critical parts of the procedure, the faculty must be immediately available for direct participation.

2. A PGY-4 or PGY-5 may act as a “teaching assistant” on appropriate cases and supervise operative procedures performed by a junior resident, although the attending surgeon retains ultimate responsibility and will be present for the critical portion of the surgical procedure.
HOUSESTAFF CLINICAL DUTIES AND PRIVILEGES LINES OF SUPERVISION
(CUMULATIVE, BY YEAR)

PGY 1
1. Care of the surgical patient including preoperative evaluation, postoperative care, writing pre and postoperative orders.
2. Basic pathophysiology of surgical disease.
3. ACLS and ATLS certification.
4. Basic procedures: start IV, placement of central lines, swan ganz catheters, chest tubes.
5. Surgery: basic techniques, sterile technique, surgeon in simple procedures, excision subcutaneous lesions, breast biopsies, hernia repair. First, assist on larger procedures.
6. Communicate as a professional with patients, hospital staff, students, fellow residents and attending staff.

PGY 2
1. Care of more complex or severely ill patients including critical care, trauma and burns.
2. Expand basic surgical knowledge and learn to apply it during evaluation and care of patients with more complex surgical problems. Gain an understanding of surgical specialties while caring for patients with multiple injuries.
4. Surgery: be able to perform more advanced procedures under supervision and first assist on more complex surgical procedures.
5. Communicate more effectively with patient care team; begin to assume leadership position within the team, show foresight and planning in regards to patient care, concise and effective presentations.

PGY 3
1. “Leader/supervisor” on a smaller surgical team with close attending supervision.
2. “Mid-level/sub leader” on larger surgical teams with supervision and input from more senior residents and attendings. Coordinate patient care to include appropriate evaluation and treatment by other health care professionals and consultants.
3. Mastery of basic surgical pathophysiology and patient care (ward and ICU), basic understanding of surgical alternatives.
4. Procedure: teach and supervise basic procedures including line placement, chest tubes, etc.
5. Surgery: teach and supervise junior residents in the performance of basic surgeries including excision of subcutaneous masses, breast biopsies, and hernia repairs. Perform as surgeon on more complex surgical procedures. Focused exposure to general, trauma surgery, and transplant.
6. Develop teaching and supervision skills.
7. Improve communication with patient care team and function more effectively as team leader. Communicate effectively with other health care professionals. Begin to address issues of problem solving and dispute resolution. Demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.
8. Improve mastery of adult learning skills.

PGY 4
1. Function in the role of senior resident with its associated increase in responsibility in an affiliated hospital.
2. Assume leadership of larger surgical teams and supervise care of surgical patients at various levels of acuity with input from surgical attendings, consultants and other health care professionals.
4. Surgery: teach and supervise some more advanced surgeries.
5. Mastery of general surgical knowledge.
6. Advanced understanding of subspecialties including surgical oncology, vascular surgery, and head and neck surgery.
7. Further develop skills in problem solving and dispute resolution.
8. Continue to improve the mastery of adult learning skills.

PGY-5
1. Provide clinical and administrative leadership of residents and students assigned to the surgical services of the affiliated hospitals.
2. Begin to function as a responsible surgeon under appropriate supervision.
3. Master surgical skills.
4. Provide oversight of all aspects of pre, peri and postoperative care. Coordinate evaluation, input, and care from consultants and other health care professionals.
5. Achieve the full competence (knowledge, skills and attitudes) of a board eligible general surgeon.

SUPERVISION OF RESIDENTS
1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
3. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.
**POLICY ON DUTY HOURS**

**Introduction** – The ACGME policy on duty hours, was implemented into all residencies and fellowships effective July 1, 2003. This policy ensures that each residency training program establishes formal policies governing resident duty hours consistent with the institutional and program requirements that apply to each program.

a. **Scope**: This policy applies to all residency and fellowship programs at the VCU medical center and its affiliates.
b. **Responsibility**: It is the responsibility of all residency and fellowship program directors, residents, fellows, and faculty and hospital staff to assure compliance with this policy.

**Monitoring**

Duty hours and call schedules will be monitored by the program director and other program faculty.

Adjustments will be made as necessary to address excessive service demands and/or resident fatigue.

Services must ensure that residents are provided appropriate backup support when patient care responsibilities are especially difficult or prolonged.

There is a hotline **827-LIFE** that is available to residents to report problems with duty hour compliance.

**Duty Hours**

Resident duty hours and on-call periods must be in compliance with the requirements listed below. The structuring of duty hours and on-call schedules must focus on quality and safe patient care, continuity of care and educational needs of the residents.

a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
d. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call. Residents must not exceed 24 continuous hours. Residents may remain on duty up to 6 additional hours to participate in didactic activities, transfer patients, and maintain continuity of surgical care. No new patients may be accepted after the 24 hours of continuous duty.
e. Residents are required to enter their hours weekly into a software program used to track resident hours. [www.gmeone.com](http://www.gmeone.com)
f. Taxi Vouchers are available for post call residents. These vouchers may be used to obtain taxi service from the hospital to the resident’s home and back to the hospital the next day. Any resident who is hesitant to drive home due to fatigue and/or lack of sleep should contact either the GME Office or the Educational Administrator, Susan Haynes (828-1141)
Oversight

a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.
RESIDENT ASSESSMENT OF PERFORMANCE

Mentor Program
Each resident will be asked to select a mentor for the duration of their training. Residents are required to meet with their mentor at least twice annually or as often as needed to review their progress and discuss strengths and weaknesses. The mentor will complete an evaluation after review of your file and discussions with the resident. These evaluations will suffice as a semiannual review to assess your progress in the program. Should remediation be necessary the mentor plays a key role in developing a plan for the resident whereby improvement can be assessed and measured. Mentors also help residents prepare for presentations for local, regional and/or national meetings. It is the residents’ responsibility to set up meetings with their mentor throughout the year.

Evaluations: Written evaluations are solicited from faculty members at the conclusion of each resident rotation. Should an evaluation of a resident indicate that the resident’s performance be discussed by the Surgery Education Committee (SEC), a copy of that evaluation is forwarded to the Program Director. Upon review of the evaluation, the Program Director may request additional documentation or provide this documentation at the next SEC meeting and the resident’s performance will be discussed. The SEC may recommend the following.

1) The resident will be carefully monitored in the upcoming months due to recent evaluations. This discussion will be documented in the minutes of the SEC meeting.
2) Review of the resident by the Academic Review Sub-Committee.

Evaluation Process: All residents will be expected to evaluate the faculty on their service and the rotation itself. Evaluations are conducted at the end of each rotation by faculty and upper level residents. All evaluations should be completed in a timely fashion. It is important that residents evaluate the rotations in order to maintain quality in the educational program. In addition to faculty evaluating the residents the nursing staff and OR staff also complete evaluations on residents during their rotations. Throughout the year random patient evaluations of residents are completed.

All evaluations of residents and faculty are managed through an electronic software program New Innovations. Residents are given a user ID and password to sign in to record their evaluations of faculty and to review their evaluations from the faculty. The web-site is www.new-innov.com.
Surgery Education Committee and Academic Review Sub-Committee

The Surgery Education Committee (SEC) is the departmental committee charged with assisting the Chairman and Program Director with oversight of all issues related to the education. Specifically, the committee is responsible to advise on the planning, implementation and performance of education programs for pre-doctoral, postdoctoral and resident trainees. The committee shall review and approve curriculum for pre-doctoral students in the third year clerkship and will serve as advisors on the curriculum of the General Surgery Residency Program. The committee will discuss issues pertaining to resident performance and may recommend that action be taken by the Academic Review Committee. The committee shall meet monthly and is comprised of the Department Chairman, who serves as committee chair, the Program Director, who serves as co-chair, 7 other faculty representatives (including the Program Directors of the Urology Residency Program, the Vascular Fellowship Program, the Plastic Surgery Residency Program, the Laparoscopic Surgery Fellowship Program, and the Surgical Oncology Fellowship Program or their representatives), the Clerkship Director and one resident representative.

The Academic Review Committee (ARC) shall review resident complaints and the academic records of residents whose performances have initially come to the attention of the SEC. Discussion of resident performance by the ARC is at the recommendation of the SEC. The sub-committee is comprised of six faculty representations, the Program Director and one resident representative. The Program Director is NOT a voting member. Upon discussion and review of a resident’s academic record, the sub-committee will make a recommendation, in writing, to the Program Director regarding what, if any, action is deemed necessary. In accordance with VCUHS Institutional Policies, the Department may make the following recommendations:

A Resident may request to appear before the Academic Review Committee (ARC) to defend and/or appeal recommendations made to the ARC by the Surgical Educational Committee (SEC). The resident must submit written notice requesting to appear before the ARC one (1) week prior to the ARC meeting designated to discuss the resident.

1) **Warning** - The resident may be issued a warning, in writing, which should include the specific behaviors, performance issues and/or incidents which warrant the warning and measures that can be taken to improve performance. The letter should also include notice that failure to establish improved performance may result in probation and establish a timeframe in which the resident will be re-evaluated. The resident’s performance will be re-evaluated at the end of 3 months.

Upon notification of warning, the resident must sign the written notice and return it to the Program Director.

2) **Probation** - The resident may be placed on probation and will receive notification in writing and verbally in a meeting with the Program Director, the Department Chairman, or both. The written documentation of probation must contain the following.

   a) A statement of the grounds for the probation, including identified deficiencies, issues or problem behaviors;
   b) The duration of probation and a time-frame in which the resident will be re-evaluated by means of written documentation which is ordinarily 3 months;
   c) A plan for remediation and criteria by which successful remediation will be judged;
   d) Notice that failure to meet the conditions of probation could result in extended probation, additional training time, and/or suspension or dismissal from the program during or at the conclusion of the probationary period; and
e) Written acknowledgement by the resident in the form of a signature to verify receipt of the probation document.

f) Upon notification of probation, the resident must sign the written notice and return it to the Program Director.

**Probationary Status**
If, at the end of the initial period of probation, the resident’s performance remains unsatisfactory, probation may be extended or the resident may be suspended or dismissed from the program. Probationary actions must be reported to the Graduate Medical Education Office and probation documents must be forwarded to the GME Office for review prior to being issued. Probationary status must be reported to inquiries for verification of residency training after completing your residency.

**Suspension**
A resident may be suspended from **clinical activities** by his or her Program Director and Department Chair, pending documentation from the clinical faculty of continued unsatisfactory performance during a probationary period. Unless otherwise directed, a resident suspended from clinical activities may participate in other program activities. A decision involving suspension of clinical activities of a resident must be reviewed within three working days by the Program Director and Department Chairman (or his or her designee) to determine if the resident may return to clinical activities or whether further action is warranted (including, but not limited, counseling, probation, fitness for duty evaluation, or summary dismissal).

A resident may be suspended from **all program activities** and duties by his or her Program Director, Department Chair, The Associate Dean of Clinical Activities or Graduate Medical Education, or the Dean of the School of Medicine. Suspension from all program activities may be imposed for conduct that is deemed to be grossly unprofessional, incompetent, erratic, potentially criminal, or threatening to the well being of patients, staff, or the resident. A decision involving full program suspension of a resident must be reviewed within three working days by the Program Director and Department Chair (or his or her designee) to determine if the resident may be allowed to return to some or all program activities and duties and/or whether further action is warranted (including, but not limited to, counseling, probation, fitness of duty evaluation, or dismissal).

**Dismissal During or at the Conclusion of Probation**
Probationary status in a residency program constitutes notification to the resident that dismissal from the program can occur at any time (i.e. during or at the conclusion of probation). Dismissal prior to the conclusion of a probationary period may occur if conduct, which gave rise to probation, is repeated or if grounds for program suspension or summary dismissal exist. Dismissal at the end of a probationary period may occur if the resident’s performance remains unsatisfactory or for any of the foregoing reasons. Prior to dismissal, the GME Office must be notified of any dismissal of any resident during or after the conclusion of a probationary period.

**Summary Dismissal**
For serious acts of incompetence, impairment, or unprofessional behavior, a Department Chair or Program Director may immediately suspend a resident from all program activities and duties for a minimum of three days and, concurrently, issue a notice of dismissal effective at the end of the suspension period. The resident does not need to be on probation, nor at the end of a probationary period, for this action to be taken. The resident must be notified, in writing, of the reason for suspension and dismissal, have an opportunity to respond to the action before the dismissal is effective and be given a copy of the GME Appeals Process. Prior to dismissal, the GME Office must be notified of any dismissal of any resident.
**Grievance Policy & Procedure**

The grievance policy and procedure is to provide a mechanism for resolving disputes and complaints which may arise between residents and their program director or other faculty members.

Step I: Informal Resolution: A good faith effort will be made by an aggrieved resident and the Program Director to resolve a grievance at an informal level which will begin with the aggrieved resident notifying the Program Director, in writing, of the grievance. The notification should include all pertinent information and evidence which supports the grievance. Within seven (7) calendar days after notice is given to the Program Director, the resident and the Program Director will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Step I of the informal process will be deemed complete with the Program Director informs the aggrieved resident in writing of the final decision. A copy of the Program Director’s final decision will be sent to the Department Chair and to the Director of Graduate Medical Education.

Step II: Informal Resolution: If the Program Director’s final decision is not acceptable to the aggrieved resident, the resident may choose to proceed to a second informal resolution step, which will begin with the aggrieved resident notifying the Department Chairman of the grievance in writing. Such notification must occur within 10 working days of receipt of the Program Director’s final decision. This notification should include pertinent information, including a copy of the Program Director’s final written decision, and evidence which supports the grievance. Within seven (7) calendar days of receipt of the grievance, the resident and the Department Chairman will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Step II of the grievance process will be deemed complete when the Department Chairman informs the aggrieved resident in writing of the final decision. Copies of this decision will be kept on file in the Chairman’s office and sent to the Director of GME.

Formal Resolution: If the resident disagrees with the Department Chairman, he/she may pursue formal resolution. The aggrieved resident must initiate the formal process by presenting their grievance in writing along with copies of all other final decisions, and pertinent information to the office of the Associate Dean for Graduate Medical Education within 15 days of receipt of the Department Chairman’s final decision. Failure to do so will waive his or her right to proceed further. Upon timely receipt of the written grievance, the Associate Dean of Graduate Medical Education will appoint a Grievance Committee and will contact the resident to set a mutually convenient time to meet. The Committee will review and carefully consider all material presented by the resident. The Grievance Committee will provide the aggrieved resident with a written decision within five (5) days of the meeting and a copy will be placed on file in the GME office. The decision of the Grievance Committee will be final.
RESIDENT INFORMATION

ON-CALL ACTIVITIES
The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

a. In-house call must occur no more frequently than every third night, averaged over a four-week period.

b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.

c. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.

d. At-home call (pager call) is defined as call taken from outside the assigned institution.

1. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

2. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

3. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

MOONLIGHTING
Because residency education is a full-time endeavor, the program director does not allow moonlighting so as not to interfere with the ability of the resident to achieve the goals and objectives of the educational program.

Residents who have chosen one or two years in a research laboratory may moonlight, while they are in the laboratory, with the written authority of the program director.

FITNESS FOR DUTY
It is the responsibility of each resident to manage their behavior and conduct outside of duty hours in such a way as to avoid excessive fatigue or mental impairment while on duty. If a resident is identified by a faculty member as not fit for duty due to impairment or fatigue, the Program Director is authorized to suspend the resident from all clinical duties until further notice. Any action on the part of the resident to disregard the instruction of the Program Director may result in personal liability to the resident, extended suspension and/or possible termination from the program.
Call Rooms

<table>
<thead>
<tr>
<th>Department</th>
<th>Location</th>
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<tbody>
<tr>
<td>Cardiac Surgery</td>
<td>M-4 - 318</td>
</tr>
<tr>
<td>General Surgery</td>
<td>M-9 - 247</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>M-4 ICU</td>
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<tr>
<td>Oncology</td>
<td>W-3 West</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>M-11 East</td>
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<td>Pediatrics</td>
<td>M-7</td>
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<tr>
<td>Plastic Surgery</td>
<td>West-3 - 328A</td>
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<td>Thoracic Surgery</td>
<td>M-10 - 216</td>
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<td>Transplant Surgery</td>
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<td>Trauma Surgery</td>
<td>M-9 - 247</td>
</tr>
<tr>
<td>Urology</td>
<td>W-3 West</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>M-11 - 238</td>
</tr>
</tbody>
</table>

Resident Conferences
Residents are required to maintain conference attendance of 75% or greater for all conferences in the basic clinical sciences fundamental to General Surgery. Attendance is taken and monitored at the principal conferences for general surgery residents, which are: Death and Complications (D&C) teaching conference (Thursdays, 4:00 PM). Surgical Didactic Conference includes Surgical Grand Rounds (Thursday, 7:00 AM). Basic Science/Skills Lab (Thursday, 8:00 am). Department of Surgery faculty or distinguished visiting faculty give lectures on topics that address clinical to basic science issues in surgery.

At the D&C teaching conferences, the chief resident presents complications and deaths for their service. Residents rotating through the surgical subspecialties are required to attend conference given by faculty and senior residents in those subspecialties.

Meal Tickets
Each resident will receive a monthly stipend for meals. This stipend will be credited to their University ID card via the Graduate Medical Education Office.

Operative Log
Every resident is expected to enter his/her cases in the ACGME’s Operative Log System. (www.ACGME.org) Each resident will be assigned a logon and password. Residents must update their operative logs weekly, as they will be reviewed by the program director and the chairman. All cases must be entered each week. Any resident not up to date with entering cases may be removed from service and the OR until cases are entered.

Residents as Teachers
You are expected to teach junior residents and students on your service. Below are a few tips to help you be a better teacher:

- Give constructive feedback immediately
- Make everyone feel a part of the team and a contributor
- Don’t give students “busy work” just to keep them out of the way
- Give them assignments that are needed for patient care that you or your junior residents do not have time to track down or do
- The success of your junior residents and students is directly related to your success
- You are evaluated on your teaching abilities and effectiveness
- Remember you were a junior resident and student eager to learn
Travel
Resident travel is available only to residents presenting research and/or publications at national, regional and/or local meetings. Poster presentations are not funded by the department.

- All resident travel must be approved in advance. A “Request for Travel Authorization Form” must be completed and approved by the chairman prior to travel. (Forms are available on the Surgery website.)
- University Policy outlining Travel Reimbursement Allowable Expenses will be followed for In-State and Out-of-State travel.
- Original receipts (including receipts for airline tickets purchased online) must be submitted for reimbursement (except for meals). Please note the Out-of-State standard lodging reimbursement excluding taxes and surcharges is $88 per day. Meals and Incidental Expenses, including tips, taxi, personal phone calls, and other transportation is $44 per day.
- The maximum reimbursement for any trip is $1200 and residents agree to be personally responsible for all expenses in excess of $1200. Travel is limited to 3 trips per year per resident.
- Residents will not be reimbursed for travel taken without prior approval by the chairman.

Chief Residents will be allowed one trip in their chief year. The maximum reimbursement is $1200. Original receipts must be submitted and the trip must be approved in advance.

Residents invited to present papers must obtain approval prior to travel. Papers presented as a result of your research with a faculty should be paid for by the grant which funded your research work. If the faculty have no travel funds you may request approval from the department chair.
Leave Policy for General Surgery Residents

Board Requirements for Time in Training
Based on the requirements set forth by the American Board of Surgery (ABS) for Board Eligibility, the number of weeks of full-time surgical experience needed to complete residency training is as follows:

1. First three clinical years; 144 weeks completed of 156 calendar weeks.
   Vacation permitted: 3 weeks/year (21 days). This allows an additional 7 days/year available for academic leave (meetings, interviews, etc.)
2. Fourth and Fifth clinical years; 96 weeks completed of 104 calendar weeks.
   Vacation permitted: 3 weeks/year. This allows an additional 7 days/year available for academic leave (meetings, interviews, etc.)
3. The ABS endorses one additional 2-week period within the first three clinical years for documented medical or family leave. The American Board of Surgery (ABS) will accept 46 weeks of surgical training in one of the first three years, for a total of 142 weeks during the first three years. The ABS will accept a total of 46 weeks of training in one of the last two years for a total of 94 weeks during the last two years. Any additional time taken will require additional training time in order to meet the ABS requirements for certification.

Academic Leave requests must be submitted in writing and will be approved if the Resident has leave days available and the service and on-call schedule is covered. Academic Leave includes but is not limited to: fellowship interviews, meetings, etc.

Vacation Leave Interns are given one month of vacation. All other residents will receive three weeks vacation which will be scheduled according to seniority. Once vacation times have been approved by the Program Director and the Administrative Chief Resident notification must be sent in writing (email is sufficient) to Fonda Heath and Susan Haynes.

Leave requests for the Academic Year may be submitted in advance. Available 1-week vacation blocks will be spread evenly throughout the year and evenly across all rotations. Requests submitted by the due date will be granted according to seniority. Remaining vacation blocks will be granted on a first come, first serve basis with consideration to service coverage and by rotation call schedule. At a minimum, vacation requests must be submitted by the last working day of August. We encourage Residents to plan ahead and spread Vacations throughout the year so as not to lose allowed days. For compliance of the Duty Hour Restrictions as outlined by the ACGME, our program will maintain a minimum of one-in-four call for all residents. These criteria may result in leave request denials. Any exception to this policy will be reviewed on an individual basis.
Family Medical Leave Policy/Childbirth or Adoption
A leave of absence for serious illness of the resident/fellow, serious health condition of a spouse, parent, or child, or birth or adoption of a child, shall be granted through formal request to the program director. Eligibility guidelines for Family Medical Leave are detailed in the institutional policies as outlined on the GME website. The length of the leave will be determined by the program director based upon an individual’s particular circumstances and the need of the department, not to exceed 12 weeks in any 12-month period. The resident/fellow shall be granted upon request up to 6 weeks paid maternity leave for birth or 2 weeks paid leave for adoption. After using paid maternity leave and all unused vacation, any additional leave will be without pay. Two weeks paid paternity leave will be granted upon request to the program director. Estimated periods for Family Leave must be submitted to the Surgical Education Office at the time the circumstances necessitating leave arise.

Sick Leave Policy
In the event of illness, the affected resident/fellow is personally responsible for notifying the faculty member of the affected clinic(s)/service(s) and the Surgical Education Office or Fellowship Director’s Office as soon as the resident/fellow knows that the illness will cause an absence from clinical responsibilities. Sick leave will be approved only for legitimate illness. A physician’s note may be requested to support the resident/fellow’s request for sick leave. If the above policy is not followed, the absence will be counted as vacation time. It is the responsibility of the resident and the program director to ensure that Board eligibility requirements are met within the original residency period or alternative arrangements are made.

Bereavement, Extended Illness/Injury, Jury/Witness Duty, Military, and Personal Leave
Guidelines for leave are outlined in the Institution Policy Manual.

Notifying Program of Sick Time
It is the resident’s responsibility to notify the department if you are going to be out sick. The following is required:

- Call the administrative chief resident so coverage can be arranged.
- Call Susan Haynes at 828-1141 or Fonda Heath at 828-2755 and leave a message or send an email.

Maternity Leave Policy
It is the resident’s responsibility to notify the program director (in confidence) of her pregnant status as soon as it is known so that coverage issues can be mapped out well in advance. In most instances the resident should schedule her vacation around the time of delivery.

The affected parties (i.e., the pregnant resident, or the resident taking leave, and the residents who will be affected by an absence) will work out a solution for coverage (with the administrative chief resident) for the allowed six weeks of medical leave. A contingency plan will be implemented only in an emergency which may require the pregnant resident to go out early due
to complications. All affected residents will be aware of the plan for coverage while the resident is
out and the resident and the Program Director will generate a plan to make up time off service,
should that be necessary.

**Paternity Leave**
Fathers desiring to take time Family Medical Leave when their wives deliver should notify the
program director as soon as possible so that arrangements can be made to schedule vacation
close to the due date. Residents may take up to 12 weeks of paid or unpaid family and medical
leave. If prolonged leave is taken, timely promotion to the next level may be affected and is
governed by specialty requirements. Please refer to the VCUHS House staff Handbook for specific
details on Family Medical Leave.

To comply with the American Board of Surgery rules for eligibility, all residents must complete 48
clinical weeks of full-time surgical experience each year of training. The board does make
allowances for documented medical leave and maternity leave. *See ABS statement below*

**American Board of Surgery Requirements**

“For documented medical problems or maternity leave, the American Board of Surgery will accept 46 weeks of surgical training in *one* of the first three years, for a total of 142 weeks during the first three years, and 46 weeks of training in *one* of the last two years, for a total of 94 weeks during the last two years.” Any resident taking leave that results in less than 46 weeks of clinical training, as stated previously, will be required to make up the time before being advanced to the next level of training.
## Resident Pager Numbers
### 2009/2010

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(P) Plastic Surgery Preliminary
## Faculty Pager Numbers

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* Professor Emeritus
Department of Surgery

Administration

Dr. James P. Neifeld, Chairman 827-1033
Donna Hensel, Assistant to Chair 827-1033
Susie Beirne, Business Administrator 828-9665
Susan Haynes, Educational Administrator 828-1141
Fonda Heath, Residency Coordinator 828-2755
Diane Hundley, Clerkship Coordinator 827-1032
Debbie Nicholals, Faculty Support Coordinator 828-8290
Aja Chambers, Administrative Assistant 828-3031

Divisional Chiefs

Dr. James P. Neifeld  Chairman  827-1033
Dr. Vig Kasirajan  Cardiothoracic 828-2774
Dr. James Maher  General Surgery  828-9516
Dr. Harry Bear  Oncology  828-9325
Dr. Omar Abubaker  Oral Surgery  828-0602
Dr. Charles Bagwell  Pediatric  828-3500
Dr. Andrea Pozez  Plastic  828-3033
Dr. Marc Posner  Transplant  828-9298
Dr. Rao Ivaturity  Trauma  828-7748
Dr. Harry Koo  Urology  828-5318
Dr. Mark Levy  Vascular  828-7749
Dr. Thomas Miller  VA Hospital  675-5112
Dr. Jeannie Savas  Third Year Clerkship Director  675-5112
Dr. Brian J. Kaplan  Residency Program Director  828-3250
# FREQUENTLY CALLED NUMBERS

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MEDICAL RECORDS

PURPOSE
To ensure that medical records are completed within established institutional guidelines to facilitate data for continuity of patient care, financial reimbursement, and to meet the standards of the Joint Commission on the Accreditation of Healthcare Organizations.

POLICY
Appropriate actions will be taken with respect to both attending and house staff physicians who become delinquent in completing medical records within specific time frames. The value of a quality medical record does not lessen when a patient is discharged from the hospital. The medical record is a permanent legal document and must reflect the quality of care given. A complete medical record will protect the physician or dentist from medico legal affairs and aid in research studies. It is the basis for reimbursement.

MEDICAL RECORD CONTENT
It is stated in the By-Laws, Rules, and Regulations of the Medical Staff of MCV Hospitals that patients shall be discharged only on the authorization of the attending physician or dentist, and on a written order of a physician or dentist. The rule states that no patient shall be considered for discharge until the Final Diagnosis Sheet has been filled in and the diagnosis section completed and signed. Since the principal diagnosis stated on the Final Diagnosis Sheet is the basis for assigning a Diagnosis Related Group (DRG), the physician must take special care when listing the principal diagnosis and principal procedure.

Principal Diagnosis
The condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.

Principal Procedure
Procedure that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. It is the procedure most related to the principal diagnosis.

Secondary Diagnosis
Conditions that coexist at the time of admission or develop subsequently, which affect the treatment received and/or length of stay. It is very important to list all secondary diagnoses. Diagnoses that relate to an earlier episode which have no bearing on the present admission are not to be listed. Abbreviations are not to be used for recording of diagnoses or procedures.

Referring Physician/Family MD
The Referring and/or Primary Care Physician of the patient MUST be identified to enhance communication between MCV and outside Physicians. Physicians should be identified by first AND last name, if possible.

Follow Up
Any future appointments with MCV, Referring, or Primary Care Physicians that have been scheduled should be listed as well as any appointments that should be scheduled, by either patient or MCV Clerk.
**Discharge Condition**
The patient’s condition upon discharge as compared to admission condition (unchanged, stable, improved, etc.).

**Discharge Summary**
The Discharge Summary and/or letter to Referring or Primary Care Physician or Dentist should be completed on the day of discharge. Timeliness of completion is extremely important. The Discharge Summary is in reality a final progress note. It should briefly recapitulate the significant findings and events in the patient’s course during the hospitalization, describe the condition and treatment on discharge, and include the recommendations and arrangement made for the patient’s future care. Discharge Summaries should be completed at time of discharge.

**TIPS FOR DICTATION**
A dictated Discharge Summary is required for:
1) any hospital stay that exceeds 23 hours to include Cesarean Section
2) normal deliveries and newborns that exceed a stay of three days.

**INSTRUCTIONS FOR DICTATION**

How to Get into the System
Dial 9, 1-888-304-0349 and listen for the Prompting Message:
- ID Number. Please respond as follows:
- Enter your MCV Physician ID Number followed by the # key.

For Assistance
Call the transcription supervisor at Incomplete Record Section at 828-9021.

**DEFINITIONS OF TERMS**

**DELINQUENT MEDICAL RECORD DEFICIENCIES**
Delinquent Medical Record Deficiencies include either of the following:
1. A Discharge Summary not dictated within 16 days of an inpatient discharge.
2. An Operative Report, which is not dictated immediately after a surgical procedure.

**Suspension of Clinical Privileges**
All clinical privileges involving patients not already hospitalized, or formally scheduled with the Admissions Department, will cease until the physician’s delinquent medical record deficiencies have been completed and that completion is certified in writing by the Director of Health Information Management or his or her designee. “Clinical privileges” shall mean admitting privileges and all inpatient care activities.

**Readily Available Medical Records**
Records located by the Department of Health Information Management within 24 hours of the physician’s request (The physician may specify when within the 24 hour period he or she would like to return to complete the records.)

**Responsible Physician**
Attending physician of record at patient discharge is ultimately responsible for the dictation of Discharge Summary and completion of Final Diagnosis Sheet if not accomplished by the house staff physician who discharged the patient.
**Responsible Surgeon**
Attending surgeon in attendance at the surgical procedure is ultimately responsible for dictation of the surgical procedure if not accomplished by the house staff physician who is normally the first assistant during the procedure.

**Chronic Offender**
If a house staff physician goes on probation three times during their tenure, they will be deemed a chronic offender. If an attending physician is suspended three times in a 36-month period or is suspended one time for greater than 60 days, they will be deemed a chronic offender.

**Personnel File Letter**
A letter in the house staff physician’s personnel file or the attending physician’s credential file documenting disciplinary action taken will be provided to accrediting licensure and certifying bodies that request character reference.
PHARMACY SERVICES

The following information is a brief introduction to Pharmacy Services; a more detailed description of policies, procedures, and ordering guidelines can be found in the preface of the latest edition of the MCV Hospitals Formulary.

Inpatient Pharmacy
The Inpatient Pharmacy (8-0364) is located in B-300 of the Main Hospital. It is open 24 hours a day and provides services for most inpatients.

A.D. Williams Clinic Pharmacy
The A.D. Williams Clinic Pharmacy (8-0756) that fills prescriptions for A.D. Williams Clinic patients is located in the basement of the A.D. Williams Clinic Building. This pharmacy is open 9:00 am to 5:30 pm, Monday through Friday.

Ambulatory Care Center Pharmacy
The Ambulatory Care Center Pharmacy (8-7730) that fills prescriptions for Ambulatory Center and Nelson Clinic patients is located on the ground floor of the Ambulatory Care Center Building. This pharmacy is open from 9:00 am to 5:30 pm, Monday through Friday.

Patient Care Area Pharmacy Services
Patient care area pharmacy services are provided by pharmacists who are assigned to specific patient care teams in the Main and North Hospitals.

Intensive Care Unit Pharmacy
The ICU Pharmacy (8-5023) is located on the Fourth floor of the Main Hospital and provides service to all Main 4 adult Critical Care patients, 24 hours a day.

Operating Room Pharmacy
The OR Pharmacy (8-4685) provides services to patients undergoing surgery and recovering in the PACU. This pharmacy is open 6:30 am to 3:00 pm, Monday through Friday.

Maternal/Child Pharmacy
The Maternal/Child Pharmacy (8-5918) is located on the sixth floor of the Main Hospital and provides services to all pediatric and labor/delivery patients, Monday through Friday from 8:30 am to 4:00 pm. Services at all other times for this patient population are provided by the Inpatient Pharmacy (8-0364).

Emergency Room Pharmacy
The ER Pharmacy (8-9261) is located on the ground floor (G-105) of the Main Hospital. It provides pharmacy services for Emergency Room patients, Episodic Care Clinic patients, and discharge patients. The ER Pharmacy is open from 9:00 am to 5:30 pm, daily.

Dalton Oncology Clinic Pharmacy
The Dalton Oncology Clinic Pharmacy (8-9952) is located on the ground floor of North Hospital. Cancer chemotherapeutic agents for all inpatients and outpatients are prepared in this location. Outpatient prescription services are also provided to patients receiving care in the Nelson Oncology Clinic and the Infectious Diseases Clinic through this pharmacy.

Investigational Drug Pharmacy
The Investigational Drug Pharmacy (8-9952) provides all investigational drugs used at MCV Hospitals and Clinics. A copy of all protocols, a list of authorized prescribers, and a record of each
prescription is maintained. Procedures for submitting protocols to the Committee on Conduct of Human Research and prescribing policies are available in the Formulary preface under Investigational Drugs.

**MCV Care at Home Infusion Pharmacy**
The MCV Care at Home Infusion Pharmacy (8-7733) is located offsite at 3600 West Broad Street. This pharmacy provides IVs and other drug-related therapies to patients for administration at home. The pharmacy is open from 8:00 am to 5:30 pm, Monday through Friday. A pharmacist is on call 24 hours a day, 7 days a week.

**Student Health Services Pharmacy**
The Student Health Services Pharmacy (8-8828) provides pharmacy services to students on the VCU academic campus from Gladding Residence Hall. The hours are 9:00 am to 5:30 pm, Monday through Friday. Pharmacy services are also available to students on the MCV campus from the Emergency Room Pharmacy. The hours are 9:00 am to 5:30 pm, daily.

**MCVH Pharmaceutical Care at South Richmond**
MCVH Pharmaceutical Care at SRHC (230-7768) is the pharmacy located in the Hayes E. Willis Health Center of South Richmond at 4730 N. Southside Plaza (corner of Hull Street and Belt Blvd.). This pharmacy fills prescriptions for patients of Hayes E. Willis Health Center. In addition, the pharmacists are involved with monitoring and assessing patients’ therapy between provider visits (on a referral basis). This pharmacy is open 9:00 am to 5:00 pm, Monday through Friday.

**MCVH Pharmaceutical Care at Stony Point**
MCVH Pharmaceutical Care at Stony Point (323-2155) is the pharmacy located in MCV Physicians at Stony Point Medical Office Building located at 9000 Stony Point Parkway (off Chippenham Parkway). This pharmacy fills prescriptions for patients of MCVH Physicians at Stony Point. In addition, the pharmacists are involved with monitoring and assessing patients’ therapy between provider visits (on a referral basis). This pharmacy is open 9:00 am to 5:00 pm, Monday through Friday.

**FORMULARY**

The Pharmacy and Therapeutics Committee has established a formulary for use at MCV Hospitals. It is a continually revised compilation of pharmaceuticals which reflect the current clinical judgment of the medical staff, and lists the drugs and dosage forms approved for use at MCV Hospitals. Formulary drugs are stocked by the Department of Pharmacy Services. Non-formulary drugs are not stocked in the Pharmacy, but may be obtained for inpatients when no formulary alternative is available, if the order is accompanied by a complete non-formulary Drug Request Form. Non-formulary preparations will generally not be obtained for outpatients or discharge patients. Specific patient care needs will be evaluated for exceptions to this policy (e.g., a different formulary is used by the ambulatory patient’s prescription insurance plan). For specific details and procedures concerning the ordering of a non-formulary drug, please refer to the current edition of the MCV Hospitals Formulary or call the Drug Information Service, 8-INFO.
DRUG INFORMATION AND CONSULTATIVE SERVICES

A variety of drug information and consultative services are available through the Department of Pharmacy Services and are directed toward meeting the information needs of health care professionals at MCV Hospitals. These services are available 24 hours a day and may be accessed in-house by calling the appropriate telephone or pager and requesting specific information or a consultation from any of the following services: Drug Information Service. The Drug Information Service of the Department of Pharmacy Services provides therapeutic and product-specific information regarding medications. MCVH physicians, pharmacists, dentists, and nurses may use the service. Pharmacists staffing the service have general references and textbooks, indexing, and abstracting services, online database access, article files, and leading journals available to meet their needs. The telephone number is 8-INFO.

Clinical Pharmacokinetic Consultation Service. The clinical pharmacokinetic consultation service is offered by the Department of Pharmacy Services on the request of a physician and at no additional charge to the patient. The service is provided to individualize drug therapy by evaluating and interpreting drug serum concentrations in relation to drug absorption, distribution, metabolism, and excretion characteristics; improve patient outcomes; educate health professionals about pharmacokinetics; and facilitate pharmacokinetic research. Any physician may request this consultative service by initiating a request via the MIS.

Discharge Medication Counseling. This service is performed by pharmacists upon request and involves one or more instructional sessions with the patient on the day preceding discharge. Each session entails the provision of verbal instruction about the patient’s discharge medications, supplemented with written drug information. Additionally, a medication calendar is completed with dosage regimens tailored to the patient’s daily routine. Pharmacists will consult and be documented in the patient’s medical record. Formal requests for discharge medication counseling should be generated by 12:00 noon on the day prior to discharge by contacting the appropriate patient care area pharmacist or initiating a request via the MIS.

Medication History. Upon request of a physician, a pharmacist will conduct a thorough post-admission interview to identify and properly document the patient’s preadmission use of prescription and nonprescription medications. Additionally, drug allergies and other pertinent information about the patient’s drug use habits will be documented. Requests for a pharmacist-conducted medication history may be generated by contacting the respective patient care area pharmacist or initiating a request via the MIS.

Patient Controlled Analgesia / Acute Pain Service. The acute pain service is a multidisciplinary team with representation from the Departments of Anesthesiology, Pharmacy, Nursing, Physical Therapy, and Pastoral Care. The team provides services, devices, and medication to patients at MCV Hospitals requiring patient-controlled analgesia (PCA), administration of narcotics, and/or local anesthetics via the epidural or IV route. Consultative services are available for other types of acute pain management therapy. Consultation may be requested by the patient’s physician or nurse by calling either 8-PAIN or Telepage.

PHARMACY SERVICES CLINIC

The Pharmacy Services Clinic (8-038I) is a combined service component of Primary Care Associates and the Department of Pharmacy Services. It was established to detect and help resolve patient drug therapy problems; assist in monitoring drug response; support and encourage the safe and compliant use of drugs by patients; and provide a mechanism for prescriptions to be refilled. Services are provided either on the request of referring physicians or at the discretion of the staff. Patients followed by Primary Care Associates may be referred to the Pharmacy Service Clinic by their primary physician for monitoring and assessment between physician visits. The Pharmacy Service Clinic meets every morning. Monday through Friday from
8:30 am to 12:00 Noon on the second floor of the A.D. Williams Clinic Building. The mechanism for referral of patients and further details about services are listed in the Formulary.

**PRESCRIBING**
All drugs should be ordered or prescribed by generic (nonproprietary) names. All drugs will be dispensed and labeled by nonproprietary nomenclature. Specific guidelines pertaining to inpatient and outpatient prescribing is available in the MCV Hospitals Formulary. Discharge prescriptions to be filled at MCV Hospitals should be ordered as early as possible before discharge. Although the MCV Hospitals Emergency Room Pharmacy will fill discharge prescriptions, all patients should be given the opportunity to choose the pharmacy where they would like their prescriptions filled. Many insurance plans do not allow for reimbursement of discharge prescriptions, and those that do may specify where the prescriptions must be filled. Patients and/or their representatives will be responsible for picking up discharge medication from the Emergency Room Pharmacy and providing cash payment in accordance with hospital outpatient payment policies. Patients with discharge prescriptions will wait for their medication along with other outpatients served in the Emergency Room Pharmacy. A 30-day supply of drugs is the maximum that will be dispensed on discharge prescriptions.

**NUTRITIONAL SUPPORT TEAM**
MCV Hospitals has a Nutritional Support Team (NST) consisting of physicians, nurse-specialists, dietitians, and pharmacists who are available for consultation via the MIS. Patients who are at risk or conform to two or more of the following criteria should be referred for consultation as a routine part of the diagnostic workup:
- Body weight 85% or less of Ideal Weight (from chart or MIS).
- Weight loss of more than 10% in the preceding 3 months.
- Serum albumin level below 3.0 g/dl.
- Peripheral blood lymphocyte count below 100/mm3. Hospital protocols for Total Parenteral Nutrition (TPN) are available in the form of a manual. The Department of Pharmacy Services provides TPN solutions after the order is validated by a physician member of the Nutrition Support Team. It is important to initiate a consultation if TPN is contemplated. This can be accomplished via the MIS using the Diet Screen. Questions pertaining to TPN solution ordering or formulation for a specific patient should be directed to the Department of Pharmacy Services at 8-0851.

**PRESCRIBER IDENTIFICATION**
In accordance with the Virginia Board of Pharmacy regulations, all outpatient prescriptions and handwritten inpatient prescriptions must clearly show the printed or lettered name of the prescribing physician, in addition to the physician’s signature and assigned MCV number. The purpose of the printed name and number is intended to reduce the incidence of prescription forgeries and to expedite the identification and validation of prescriber.

**NOW, STAT, AND EMERGENCY**
The terms “Now,” “Stat,” and “Emergency” indicate the relative degree of urgency of the completion of drug orders. Basic interpretations follow. Inappropriate use of these terms slows the delivery of those doses that are needed in a short period of time.

**NOW**
Degree of urgency—**moderate**. In appropriate circumstances, Now doses will be dispensed by the Pharmacy within 45 minutes.

**STAT**
Degree of urgency—**high**. In appropriate circumstances, Stat doses will be dispensed by the Pharmacy within 15 minutes.
**EMERGENCY** Degree of urgency—complete. A life dependent Stat.

**EMERGENCY MEDICATIONS**
Since no method of ordering or drug delivery can be rapid enough to meet some emergency needs, a stock of drugs most commonly required in emergencies is maintained in limited quantities on Nursing Units, as a “CODE” tray. A tray is stored in all “CODE” carts located throughout MCV Hospitals. A list of these medications can be found in the latest edition of the Formulary.

**DRUG SAMPLE POLICY**
Uncontrolled drug samples constitute a potential therapeutic hazard to patients at MCV Hospitals. Therefore, except as described in the procedural guidelines (see Formulary under Drug Sample Policy), no drug samples will be stored, dispensed, or administered in MCV Hospitals. ADVERSE DRUG REACTION REPORTING PROGRAM MCV Hospitals participates in the adverse drug reaction reporting system of the Food and Drug Administration. Notification, suspicion, and confirmation of adverse drug reactions should be reported to the Drug Information Service (8-INFO) or via MIS.
GENERAL INFORMATION

ORGAN, TISSUE, AND EYE DONATION
A PROFESSIONAL APPROACH
MCVH is recognized for its leadership role in the health care community. Consistent with that role is the hospital’s commitment to organ, tissue, and eye transplantation as a life-saving/enhancing therapy and as a method of providing hope for the donor’s family. MCV Hospitals is committed to an overall bereavement approach to handling the issue of death and the support of patients and their families. New Health Care Finance Administration guidelines require that anyone approaching families about donation be trained as a designated requestor by the Organ Procurement Organization. It is recognized that the approach of the family for organ/tissue and eye donation will be the responsibility of the designated requestor or organ procurement specialist. To support the donation process, coordination and cooperation is necessitated between the Organ Procurement Organization (LifeNet Transplant Services) and the Eye Bank (Old Dominion Eye Bank). MCVH has adopted a protocol with specific medical triggers to be used for assessing potential organ donors. When there is a GCS of less than or equal to 4, or the patient is not moving or is extending, the cues are in place to contact the Family Communications Coordinator (FCC) through the telepage operator pager #6194. The FCC will remain with the family throughout the course of the event and will facilitate communication between the family, the medical staff and LifeNet. The FCC will be responsible for contacting LifeNet. MCVH is a partner with LifeNet supporting a policy of routine referral for every death. As a professional at MCVH, your responsibility for compliance with the Commonwealth of Virginia Law related to Routine Referral is to contact LifeNet on every death. With patients who die a cardiorespiratory death, a coordinator from LifeNet will decide whether or not someone is a suitable candidate for tissue and/or eye donation and will follow-up with families where appropriate to provide them this opportunity. Your responsibility related to patient deaths is to make certain that LifeNet is contacted. Experience has shown that many grieving persons are comforted or are able to find some meaning in the death of a loved one by donation of organs, tissues, and eyes. The decision to receive information about donation is a very personal decision there are no right or wrong responses. Do support family bereavement care by calling the Chaplains and LifeNet and providing the family or legal designee the opportunity to donate.

AUTOPSIES
Request for autopsies is legally mandated in the Commonwealth of Virginia. If the request for an autopsy is decoupled from the death telling, the chances of consent escalate dramatically. When approaching a family about an autopsy, if you approach it from the perspective of what the family has to learn to protect themselves or others that they love and care about versus what we might be able to learn about their loved one’s disease, you will have a much more successful request rate. Again, the objective in situations of death is to care about/for the family.

ADVANCE DIRECTIVES
Advance Directives are defined as wishes that someone expresses about their care prior to an event occurring. The Federal Law related to Advance Directives is The Patient Self-Determination Act (PSDA). This Act was passed by the U.S. Congress in 1990 and became effective December 1, 1991. The PSDA is a law that promotes education and communication between individuals about the kind of end-of-life treatment one would desire. Under the PSDA, patients are asked during an admission if they have either a living will or a medical durable power of attorney. At MCVH, this
responsibility falls to each of us to ascertain patients’ wishes and to make certain that it gets documented in the chart and entered into the Permanent Patient Record. The two Advance Directives most often talked about in the law are a Living Will and a Medical Durable Power of Attorney. The Health Care Decisions Act of 1992 is the law in the Commonwealth of Virginia that addresses surrogate decision making. If you need assistance with either completing an Advance Directive, education of patient or family about Advance Directives, or help in answering questions related to Advance Directives, please contact the Chaplain’s office at 8-0928, the department of social work at 8-0212, or the Patient Representatives at 8-0958.

FAMILIES
Please remember that most families that are present in the environment of MCVH are grieving the losses of many things; i.e., independence, role, status, and relationships. Because of this, their stress levels and coping abilities are probably dramatically diminished. Be patient with families and use other resources within the environment to assist them in their coping and to assist you in your communication with them; i.e., Chaplains, Patient Representatives, and Social Workers. One of the benefits in being at MCVH is that there are many individual services with a multitude of available resources. You do have the opportunity to ask for assistance for you and your patients and families!

THE DEPARTMENT OF RADIOLOGY
DIVISION OF DIAGNOSTIC RADIOLOGY
The Department of Radiology plays an important role in helping care for our patients. Diagnostic Radiology services incorporate all radiographic examinations including computerized tomography, magnetic resonance imaging, ultra sonography, angiography, and interventional procedures. Radiologic consultation services are available 24 hours a day to assist you in selecting the appropriate study or procedure to aid you in the clinical decision-making process. Consultant radiologists are available from 7:30 am until approximately 7:00 pm daily on Main 3. During usual workdays, call 8- 6831 and ask for a radiologist in the area of which you have concern. The emergency room radiology section (8-3656) is staffed by radiologists 24 hours per day. After 11:00 pm and on weekends, an in house diagnostic radiology imaging resident is on duty in the hospital and can be contacted on pager 6354. Pursuant to Joint Commission on the Accreditation of Health Care Organizations (JCAHO) requirements and policies of the Division of Diagnostic Radiology, all radiographic services, studies, and procedures will be performed only after submission of a completed radiology request form. An examination will not be performed, nor will patient transport be effected until the appropriate order has been written or entered and the properly completed radiology request has been received. The request should include all patient identification information, referring physician’s name and address, the examination requested, and pertinent history and physical findings. It is extremely important that appropriate clinical information be provided to ensure that the proper studies are obtained. Providing an admission diagnosis or some other current diagnosis may not be sufficient. The referring physician should always ask the question, “What do I wish to learn from the study?”, and should keep this in mind when providing information. It is more helpful to indicate what happened to the patient as a result of an auto accident rather than just to indicate “MVA.” Specific requests for special views present a particular problem unless the appropriate history, physical findings, and clinical questions to be addressed are provided. It is preferable to provide the appropriate clinical data and allow the radiologist to design the study in the most effective manner. Most plain film radiography can be obtained by placing the appropriate order in the computer. Check the first computer menu under Diagnostic Radiology in the Medical Information System (MIS) for specific, helpful instructions to assure your request is complete and accepted. The first computer screen lists studies that require prior scheduling. These studies should be scheduled with Radiology prior to entry of the order in MIS to allow the scheduled date/time to be entered as part of the order. Routine repetitive or daily examination of patients (even when in intensive care units) are not
always necessary. Please keep in mind the cost of such examinations to the patient and the institution, as well as the labor demands involved.

**PORTABLE EXAMS**
While portable exams are available, and are sometimes necessary, please order these examinations sparingly. There is an extra patient charge associated with portable examinations and they usually give less information than examinations performed in the radiology department. If patients can be up and out of bed, they can usually be transported to the radiology department. Portable examinations do not necessarily expedite obtaining a quality study. Please remember there is a limit to the speed and number of exams that can be completed by the portable radiography staff in any given period of time. Portable chest radiography will be ordered and performed based upon a universally agreed-upon priority system graduated to address clinical circumstances. For clinical priority levels, “am portables,” and routine services are available for portable chest radiography. Non-chest portable studies should be ordered according to the patient’s clinical status with options available in the ordering pathway.

**ORDERING SPECIAL STUDIES**
If a patient has a history of previous allergy or reaction to IV contrast agents, please discuss the situation with a radiologist. Patients on Glucophage (Metformin) for diabetes will need to be taken off the medication for 48 hours following their study. When your patient is undergoing an emergency CT, angiogram, ultrasound, or nuclear medicine study after hours (and sometimes during regular working hours), the presence of a clinical physician with the patient may be required. The need for a physician’s presence is based upon the patient’s clinical status. If your patient requires monitoring or supervision, you must either provide for or arrange such services. Alternatively, you may place a note in the patient’s chart clearly stating that your patient may undergo radiologic studies without clinical supervision. After 11:00 pm, the physician ordering the exam (or his or her designate) will be the person to obtain/provide transportation for the patient. To schedule outpatient CT, US, MRI, or Mammography, call 225-3580 from 8:00 am to 4:30 pm. To schedule angiograms or vascular interventional procedures, call 8-6985. To schedule pediatric and adult fluoroscopic studies (IVU and contrast GI studies) call 8-1459. When ordering contrast studies (IVU and contrast GI studies), please ensure that standing prep orders are fulfilled. If a GI study or IVU is needed the same day, call 8-5498 and ask to speak to the radiologist performing that study. Percutaneous transhepatic cholangiograms, biliary drainages, and biliary stone extractions must be scheduled directly with the GI radiologist (8-5498).

**ORDERING INPATIENT STUDIES**
There are MIS pathways for ordering CT, US, and fluoroscopic radiology studies. The pathways require that a priority be assigned based on the indication for the examination. This will allow studies to be triaged appropriately once the order is received. It will not be necessary to call and schedule inpatient and emergency room patients for most plain film, CT, US, and fluoroscopic (IVU, UGI, BE) exams. Entry of an order will result in performance of these studies. Without an order, these examinations will not be performed.

Priority 1 and 2 exams require a call to the exam area to ensure that the study is expedited. The phone numbers are listed in the order pathway. Angiography, CT biopsies and drainages, all interventional procedures, and MRI studies need to be scheduled. The phone numbers are listed in the order pathway.
For outpatients, continue to call and schedule an appointment. If an order is entered for an outpatient, select Priority 4 and enter the scheduled appointment date.

It is our hope that these pathways make it easier to order studies, decrease time on the telephone, and enhance patient care. Please call the Radiology System Manager at 8-7762 if you have any questions or suggestions.

**COMPUTED TOMOGRAPHY (CT)**
For after-hours emergency CT studies, contact the in-house night diagnostic imaging resident on pager 6354. That physician will return your call and provide consultation. Abdominal and pelvic CT studies require both a computer generated request and an oral contrast preparation (test prep #82). Either the unit clerk or nurse must take the prep #82 order off the computer in order for it to print on the Pharmacy Meds List and be sent to the nursing unit via tube or messenger. If a computer generated radiology request is not entered or if the patient has not received oral contrast material, the CT will be canceled and must be rescheduled through the system by the referring physician. Patients should have a recent BUN and Creatinine determination. An “abdominal CT” incorporates the area from the diaphragm to the iliac crests. A “pelvic CT” includes the area from the iliac crests to the pubic symphysis. A separate request is necessary for each anatomic region: head, neck, chest, abdomen, pelvis, extremity, etc. Do not “bundle” studies on one request. A separate request is also necessary if an intervention (e.g., abscess drainage) is requested.

**ULTRASOUND**
To request inpatient sonography, enter the request in the MIS system and assign the proper priority when prompted. To schedule emergency studies, outpatients that need to be done on the same day or for consultation between 7:30 am and 5:00 pm, call 8-3180. To schedule outpatients in the future, call 225-3580. After normal working hours or on holidays, contact the in-house diagnostic radiology imaging resident on pager 6354. That physician will return your call and provide consultation.

**Ultrasound Patient Preparation.** For an abdominal sonography, except kidneys and retroperitoneum, six-eight hours NPO minimum (especially gallbladder, right upper quadrant, and pancreas). For pelvic sonography, encourage fluids, with a distended urinary bladder ideal. Prohibit voiding for two hours prior to the study. For infants, leave off the last feeding before the study.

**CT AND US INTERVENTIONAL PROCEDURES**
CT and US interventional procedures will only be performed after consultation with the appropriate radiologist. In general, you must have informed consent, a coagulation screen, a request form, and all pertinent previous outside studies. These procedures also presume that the proper preparations have been made (as described above). Outpatients will need to remain for a two-hour minimum period of observation post procedure, and an individual must accompany the patient to provide transportation.

**MAGNETIC RESONANCE IMAGING (MRI)**
To schedule a non-emergent MRI study call 225-3580. Sedation or anesthesia may be necessary for some patients. For Cardiac MR, you will be contacted for additional clinical information so the MR study can be tailored to address specific questions. Please keep in mind that Cardiac MR techniques are applicable to the heart, great vessels, pulmonary and coronary circulations, and para- or pericardiac structures. Functional data is available as well. For abdominal and pelvic MR, call 8-3482 to speak with an abdominal imaging radiologist to discuss the indication for the study and provide clinical information. For after-hours emergency MRI studies, contact the in-house night diagnostic imaging resident on pager 6354. That physician will return your call and provide consultation.
**MYELOGRAPHY**

To schedule non-emergent myelography, call 8-1459. For after-hours emergent myelography, contact the imaging resident on pager 6354. All myelograms are routinely followed by CT. Two requests must therefore be entered, one for myelography, the other for CT.

**ANGIOGRAPHY / INTERVENTIONAL RADIOLOGY**

To schedule angiography during regular working hours, call 8-6985 and speak with the appropriate attending Radiologist. After hours, call the diagnostic imaging resident on pager 6354. Patients undergoing angiographic studies require basic laboratory studies: Hb, Hct, BUN, Cr, and a coagulation profile. In general, the patients should have a good IV line running when they are sent to the Radiology Department. The patient should not eat anything solid for six to eight hours prior to the procedure. Clear liquids may be given until two hours prior to the study. All routine medications should be continued. If the patients are receiving anticoagulant therapy, consult the radiologist for instructions.

**MUSCULOSKELETAL**

The following studies must be approved by a Musculoskeletal Radiologist before they are scheduled (call 8-6831):

- All emergent musculoskeletal MRIs and CTs (i.e. those needing to be performed on the same day)
- All inpatient arthrogram
- All percutaneous bone biopsies

To schedule arthrography, call 8-1459.

**REVIEW OF STUDIES / FILM SIGN-OUT POLICIES**

Every radiograph or film jacket that leaves the Radiology Film Room on Main 3 or any satellite area (Nelson Clinic, Emergency Department, and ACC) must be signed out regardless of the borrower, the ultimate destination of the radiographic file or the intended use. There will be no exceptions to this policy. Accountability for each radiographic file must be maintained. Films that are signed out to the Operating Room are the responsibility of the person signing out the file or the primary operating physician requesting them, even though the Radiology Department transports those studies to the Operating Room. These films must be returned to the Radiology File Room on the day of surgery. This promotes enhanced interpretation of post-operative studies when the preoperative studies are readily available. Radiographic files that are signed out to major clinics must be returned by 6:00 pm of the day of clinic. Radiographic files will only be signed out to those conferences that have a Radiologist in attendance or have been prearranged through the office of the Chairman of Diagnostic Radiology. These files also need to be returned by 6:00 pm on the day of the conference. When requesting radiographic files for conferences, the pull lists must be submitted according to the film request policy. Inpatient files will no longer be signed out to any location other than the film file room area (staff viewing room or reading rooms). The most frequent cause of lost, misplaced, and delinquently returned files is signing out film for physician convenience, such as taking a study to the floor to be viewed by a fellow, house officer, or attending. Violations of this policy will result in individuals losing their borrower privileges. Unread radiographs may not be signed out. If unusual circumstances demand that unread radiographs be removed from the file room before official interpretation, a preliminary interpretation must be obtained. Interpretation services are available 24 hours a day. Film jackets for those patients having radiographic services that same day will not be released to clinics, conferences, or for any other purpose until after the patient’s exam has been completed and an interpretation rendered. Individual borrowers, according to radiology film file records, are
responsible for delinquent film jackets may not sign out additional studies until the delinquent jacket is returned. Special film sign-out privileges, such as those for research and media services, must be arranged through the film room supervisor so that their responsible and timely return can be accomplished. Examinations obtained after 11:00 pm and before 8:00 am on inpatients are performed by the radiology technologists in the ER and then taken to the third floor. Examinations obtained on ER patients are collected and taken to the third floor at approximately 10:00 am and 5:00 pm on weekdays, and 10:00 am weekends and holidays. Radiologists are available 24 hours per day, 7 days per week, on Main 3 and in the Emergency Room to review films with you as needed. Please confer with the appropriate radiologist regarding the final interpretation if there is any question or lack of correlation between clinical findings and film interpretation.

**TO GET RESULTS**

Exam reports are available via touch-tone phone at 8-RTAS or 8-7827.
EMERGENCY MEDICINE
The Department of Emergency Medicine of the Medical College of Virginia Hospitals is one of the Largest Emergency Departments on the East Coast. It is a Level I Trauma Center and MCVH Trauma Services are initiated in the Emergency Department. The Emergency Department also is a starting point for MCVH unique Chest Pain Program that is nationally recognized. In the Emergency Department rotation, house staff provide Medical services through a well-coordinated team Approach consisting of pre-hospital care providers, faculty Physicians, nurses, clerks, and social workers. Faculty physicians supervise residents in all treatment Areas and most physicians in clinical training programs At MCV will rotate through the Emergency Department during their internship and/or residency. At the beginning of each emergency department Rotation, an orientation will be given to the house staff. Attendance at this orientation is mandatory. During the Orientation, the house staff will be introduced to the Emergency Department’s state-of-the-art patient tracking System that incorporates such features as printed Discharge instructions and printed medication prescriptions. Patients’ preexisting relationships with primary Care physicians will be respected and reaffirmed.

NURSING SERVICES
Nursing Services at MCV Hospitals is committed to Promoting patient-focused, high-quality care for patients and families. Patient care units are organized into Clinical Divisions Reporting to the Executive Director of Nursing and Patient Care Services. There is a Nursing Director for each Division with nurse managers reporting to them who are Responsible for the daily operations of his or her unit. The divisions are Medical-Surgical, Cardiovascular, Transplant, Neuro-Psych, Rehab, Ortho, Women’s and Children’s, And Oncology. Primary Nursing is the professional practice model At MCV Hospitals. Each patient has one identified RN, The Primary Nurse, who coordinates and provides direct Patient care for the patient from admission to discharge. Associate nurses care for the patients when the primary Nurse is not working. A patient’s primary nurse is listed on the unit “bed” board. Registered Nurses at MCV Hospitals are recognized for their clinical expertise through the Professional Advancement Program. This is a peer review system which identifies four levels of practice. Clinical Nurse I am Novice to advanced beginner level. Clinical Nurse II practice at the competent level and Clinical Nurse III and IV are at the proficient and expert level of bedside practice.

ADVANCED PRACTICE NURSES
Advance Practice RNs are accountable for patient Care outcomes across the care continuum from admission to discharge. They coordinate care for patients in the hospital clinics and actively work with members of The health care team to design and enhance clinical Pathways. Currently there are case managers in the following clinical areas: Spinal Cord, Gynecology, Asthma, and Neurosurgery. Case managers are available through telepage.

CLINICAL NURSE SPECIALISTS
Master’s prepared Clinical Nurse Specialists are available To support the management of complex patient Care problems. They are available in the following clinical Areas: Psychiatry, Substance Abuse, Gynecology, Oncology/Pain, Neurosciences, Vascular, Breast Oncology, Cardiovascular, and Chest GI/CU/CNS Oncology. Clinical Nurse Specialists are available through Telepage. In addition, Enterostomal Therapists and Nutrition Support Nurses are available for consultation.
**DISCHARGE PLANNING**
Nursing and other disciplines share the responsibility of discharge planning. Community Health Nurses Review and coordinate services that a patient may need In the home. They are available Monday through Friday From 7:00 am to 5:00 pm by calling 8-0205 or Telepage. A message may be left at 8-0205 during other hours. The Utilization Management Nurses assist with discharge Planning and can be reached at 8-0490. Other Professions such as social workers, physical therapists, Respiratory therapists, and occupational therapists also play an active role in discharge planning.

**PATIENT EDUCATION**
A network of resources is available for patient and Family education. These include:

**PATIENT EDUCATION CENTER**
The Patient Education Center located in North B-067 Provides a variety of printed materials (8-2139)

**PATIENT EDUCATION TV**
Patient Education TV has two channels available. Channel 2 plays a regular schedule of videotapes. Channel 3 is designated to play tapes requested by hospital Staff. Tapes may be requested by calling the Hospital Learning Resource Center at 8-0810. (See the Nursing Information Pathway on MIS for a complete listing).

**TEACHING MATERIALS**
Teaching materials and protocols are accessible on each unit. Group classes are available for cardiac and diabetic patients, as well as expectant and new mothers. The Patient Education Coordinator is also available for Consultation (8-0418).

**THE NURSING SUPPORT TEAM**
The Nursing Support Team provides orientation to The TDS Medical Information System (M IS) and is available 24 hours a day as resource personnel. Call 8-5111 for scheduling orientation. Contact the NST via Telepage for user assistance.

**CARE AT HOME**
MCV Care at Home is a Medicare/Medicaid certified, JCAHO-accredited homecare agency providing Skilled Care and IV/Pharmaceutical services to residents of the Greater Richmond metropolitan area. For further information, Call 8-HOME (4663); fax 8-5560.

**HOSPITAL HOSPITALITY HOUSE**
The Hospitality House provides lodging for patients And families being served at MCV Hospitals, Veterans Affairs Medical Center, Sheltering Arms Physical Rehabilitation Hospital, HEALTHSOUTH Medical Center, Richmond Eye and Ear Hospital, Bon Secours Stuart Circle Hospital, And Capitol Medical Center. Guests must be at least 14 Years of age. All outpatients must have an adult caregiver with them. The suggested donation is $10 per person, per night, for those who can afford it. Since the Hospitality House is a nonprofit organization, families should be encouraged to
make the donation. There is a refundable $20 key and linen deposit required at check-in. Fifteen-
minute parking is available for check-in. Daily parking is available at the MCV parking deck. Free
MCV Shuttle and Escort transportation are available. A completed and signed referral form must
be sent to the Hospitality House prior to guest check-in. Doctors, 154 Nurses, social workers,
patient representatives or chaplains are authorized to refer patients and/or families of patients.
Referral forms may be obtained by calling 828-6901. Limit four guests per room.

Hospital Hospitality House, Inc.
612 East Marshall Street
P.O. Box 10090
Richmond, Virginia 23240
Phone: (804) 828-6901 • Fax: (804) 828-6913

SECURITY
Security (Emergency Response) 8-1234
Security (MCV) 8-4300

SEXUAL HARASSMENT
“Virginia Commonwealth University shall not tolerate any verbal or physical conduct by any
member of the University community, which constitutes sexual harassment of any other
University community member as outlined in the Federal Civil Rights Act of 1964.” A discussion of
the above stated University policy, explanations of harassing behaviors, and an exposition of
resolution procedures are outlined in the booklet “Policy on Sexual Harassment” published by the
Department of Human Resources, VCU, and is available from the EEO/AA Services at 828-1347.
The provisions of the MCVH policy are applicable to house staff-faculty and all other interpersonal
combinations regardless of the gender of the individual involved. For a copy of the booklet and for
direction to the appropriate division of the University regarding formal and informal complaint
procedures, call 828-1347. The policy is also distributed to each house officer at orientation.

CAFETERIA
The Main Hospital Cafeteria is located on the first floor of Main Hospital and is open to hospital
staff and visitors. House staff will utilize their VCU cards to receive any two meals when on duty
during the week (breakfast or dinner) and any three meals when on duty on week-ends or official
MCVH holidays. The hours of operation are:

**Breakfast**
Weekdays 6:30 am to 10:00 am
Weekends/Holidays 7:00 am to 10:00 am

**Snacks**
Weekdays 10:00 am to 11:00 am

**Lunch**
Hot Line 11:00 am to 2:00 pm
Deli (Monday - Thursday) 11:00 am to 3:00 pm
Specialty Bar (Friday) 11:00 am to 3:00 pm

**Dinner**
Hot Line 4:30 pm to 7:30 pm
Dinners 4:30 pm to 7:00 pm
(Christmas Eve, Christmas and Thanksgiving only)
**VENDING**
All vending machines are available for use 24 hours per day, 7 days per week. Three main vending areas provide food/snacks selections—North Ground Floor, Main Hospital Lobby, and the Main 5 OR. In the event of a machine malfunction, please contact the Department of Food and Nutrition Services at 8-0730. Refunds for hospital machines can be obtained from the cafeteria.

**A LA CARTE**
Main Hospital Lobby and the Main 5 OR. In the event of a machine malfunction, please contact the Department of Food and Nutrition Services at 8-0730. Refunds for hospital machines can be obtained from the cafeteria.

**A LA CARTE**
A mobile cart is situated in the Main 1 Lobby. House staff may not use their meal allowances for this cart.

**Main 1 Cart Serving Hours**
Cookie Cart 11:00 am to 3:30 pm

**CATERING**
Catering Services are provided weekdays from 7:30 am to 3:30 pm by request. After 3:30 pm and on weekends, functions must be approved by the Catering Manager. There will be an extra charge for function requests outside normal operating hours.

**CHILD CARE**
MCV Hospitals’ Child Care Center provides care for children of all MCVH employees in the West Hospital Basement and the Child Center at N Deck from 6:00 am until 12:00 midnight (828-1124). Additional listings of other area centers may be obtained by contacting Work/Life Resources in the Human Resources department at 828-1688.

**PHYSICIANS SERVICES**
The Department of Physician Services handles patient-related communication for you. Our customer service representatives, triage nurses, and the entire staff of Physician Services are dedicated to serving the diverse needs of our customers.

**Telepage (Communications Services)**
- Emergency Dispatch *50
- Overhead Paging and On-Call Schedules
- Pager Supplies (Clips and Pager-doors)
- Locator - (Patient and Employee)
- Pager Director and Assignment of ID’s

Physicians should notify Telepage when:
- is lost or malfunctions
- on-call schedule changes
- home phone number or leased pager number changes
- covering for another physician

**Paging**
Physician dial telephone number *60 (outside 828-4999).
Reply Please dial the ID# to page from the paging directory.
Physician dial ID#. Reply Current status such as available or not.
Physician dial callback extension.
Then hang up.

**Changing Status Code**
Physician Dial telephone number *61 (outside 828-4994).
Reply Please dial the ID#.
Physician Dial ID#.
Reply Please dial your new status as listed in the directory.
Physician Hang up.

**MCV Consult Service 800-628-4141 • 828-6396 (local)**
*(Physicians and Health Care Professionals)* The MCV Consult Service is a toll-free telephone service that provides physicians and other health care providers with easy access to the faculty and staff of MCV Hospitals and VCU School of Medicine. Physicians are available 24 hours a day, seven days a week for consultations, referrals, help with patient problems, or emergency situations. Callers may request a particular physician, specialty service, or assistance regarding a specific disease or disorder.

**MCV Physician Services 800-762-6161 • 828-7929 (local)**
*(Patients and Consumers)*. Our toll-free referral line allows patients to easily access MCV. This service assists with new patient referrals as well as appointment setting for previous patients. Through this line, the department will direct a patient’s call to an MCV Physician’s office or clinic. A triage nurse is available should the caller require a customer service representative with a clinical background.

**MCV HealthLine 828-6284**
MCV HealthLine is a free library of prerecorded messages giving you information on more than 1,200 health care topics. Over 100 services at our medical center offer information on specific topics pertaining to MCV Hospitals.

**PROFESSIONAL ATTIRE**
House staff members, as practicing physicians and dentists in graduate medical education, shall observe the professional dress standards of the School of Medicine and Dentistry. Violations of these standards will be viewed by the administration as evidence that a house officer is not professional in his/her relationship to patients. VCU cards should be worn at all times. “Scrub attire” is allowed only in surgical areas, the emergency rooms, intensive care units, labor-delivery-nursery areas, the burn unit, the cardiac “cathlab,” and other aseptic radiological areas. “Scrub attire” is not allowed outside the hospital, on general medical-surgical floors, or on the first floor (including the dining area) unless covered by a professional coat or jacket. Caps, masks, and “booties” are never appropriate outside the defined areas.

**UNIVERSIAL PRECAUTIONS**
Standard precautions are a revised form of universal precautions. Standard precautions require that gloves be worn when touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and nonintact skin. Fluid resistant gowns should be worn when exposure or splashing from any blood or body fluids is anticipated or can be expected. Goggles with side shields and mask should be worn in any situation where there is an anticipated or potential risk of exposure to any blood or body fluids. Hand washing is required immediately after
glove removal and between patient contacts. Needles should not be recapped, but placed immediately into puncture-resistant containers located in patient rooms. If it is necessary to recap needles, use a scoop technique and carefully cap the sheath against an inanimate object, not your hand. Standard precautions form the base for transmission-based isolation precautions. Airborne, droplet, and contact precautions are in addition to standard precautions.

AIRBORNE PRECAUTIONS
Airborne precautions are designed to prevent diseases transmitted by droplet nuclei or contaminated dust particles. Patients with suspected tuberculosis should remain in isolation until tuberculosis can be ruled out by three negative sputum cultures each on separate days. For those with confirmed tuberculosis in whom effective anti-tuberculosis treatment has been initiated, isolation can be discontinued when the patient is clinically improving, there is noted improvement in the chest X-ray, and three consecutive sputum smears collected on three separate days show no acid-fast bacilli. When entering patient room, an N95 mask must be worn. Fit testing is required prior to wearing the N95 mask. House staff not fit-tested should contact the program director. If the patient has suspected or confirmed measles, varicella or disseminated zoster, non-immune individuals should not enter the room when possible. If entrance is required, a standard mask should be worn. Persons immune to measles or varicella do not need to wear a mask when entering the room. If the patient must be transported from the isolation room to another area of the hospital, a standard surgical mask should be on the patient before leaving the isolation room.

DROPLET PRECAUTIONS
Droplet precautions are designed to prevent the transmission of microorganisms by larger particles. These droplets are produced when the patient talks, coughs, or sneezes. They may also be produced during the performance of procedures. Standard surgical masks should be worn when entering the room.

CONTACT PRECAUTIONS
Contact precautions are implemented to prevent transmission of epidemiologically important organisms from an infected or colonized patient through direct (touching the patient) or indirect (touching surfaces or objects in the patient’s environment) contact. Barrier precautions should be used accordingly, including gloves, gown, and face protection (eyewear and mask).

INSTITUTING EMPIRIC ISOLATION PRECAUTIONS
Frequently, patients are admitted to the hospital without a definitive diagnosis. However they may have an infectious process that may place others at risk. Therefore, certain clinical syndromes should prompt the clinician to place the patient in isolation while a definitive diagnosis is pending. Table 2 in the MCVH Housestaff handbook delineates appropriate empiric isolation precautions for various clinical syndromes based on the potential mechanism of transmission.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>TRANSMISSION-BASED PRECAUTIONS</th>
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<tr>
<td>TABLE 2</td>
<td>CLINICAL SCENARIOS REQUIRING ASSIGNMENT OF EMPIRIC ISOLATION PRECAUTIONS.</td>
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HIV/AIDS SERVICES
MCVH strives to maintain a seamless encounter throughout the continuum of care for the HIV-infected person. The following information is provided in order to more readily achieve this. As
with all chronic medical conditions, communication between the admitting service and the outpatient providers is crucial for the delivery of quality health care; therefore, we insist that the primary care provider of all HIV-positive patients be notified at times of admission and discharge.

OUTPATIENTS: MCVH INFECTIOUS DISEASES CLINIC
The Infectious Disease Clinic located on West 3 was established for the outpatient management of HIV disease; persons with other infectious diseases are seen through the faculty clinic service at Medical Subspecialties Clinic. Patients must be referred to the ID Clinic in order to receive medical care in the clinic. The IDC WILL NOT provide testing results to persons not already enrolled in the Clinic. The ID Clinic provides medical care to children and adults. Services are comprehensive and care is provided by case management. It is encouraged that all persons identified as HIV-infected be referred to the ID Clinic PRIOR to patient discharge, including asymptomatic HIV-positive persons. Until a patient has been engaged in the IDC, the House Staff Team remains responsible for the health and safety of that person. The ID Clinic phone numbers are: 8-6163 8-4418 or 8-5914 for referral.

INPATIENTS WITH HIV INFECTION
In general, patients admitted with HIV complications will be admitted to the house staff services. Because of the highly complicated nature of the anti-retroviral regimen, HIV-associated immuno suppression and the HIV-associated opportunistic infections and/or malignancies, it is strongly encouraged that the Infectious Diseases Consult team be notified and included in any HIV-positive patient’s medical care.

- Call the Page Operator at MCVH (8-9711 or 8-0951) or the VAH for the Consult Team page number.
- Please contact the patient’s primary MD when a patient is admitted. This is necessary for continuity, particularly when a patient presents to the ER. To refer an inpatient to the ID Clinic for out-patient follow-up,
- Call 8-6163, 8-4418, or 8-5914 and discuss the case with a nurse.
- The ID Clinic Nurse will need information on specific testing, diagnoses, and treatment during the patient’s hospitalization.
- Patients will not automatically have an appointment at time of discharge and must be assigned a provider in order to be seen in the ID Clinic.

HIV ANTIBODY TESTING
In order to perform a diagnostic HIV antibody test, a patient consent form must be signed and pre-test and post-test counseling must be performed. The test results are currently not reported in the HIS computer if they are positive. Positive results will be called to the physician-of-record for the test by the Virology Laboratory in the Clinical Support Building. If you are not the physician-of-record, it will be released to a physician, if it is vital for the patient’s care. Regardless of the test result, the ordering physician is obligated to perform post-test counseling as well. Outpatients may be referred to the Anonymous Testing Site (8-2210) in Old City Hall. Free testing is performed anonymously with pre- and post-test counseling. Remember, however, that any test performed at the anonymous test site cannot be linked to any specific individual, and results are not recorded. Therefore, for clinical interventions, another HIV serology must be performed. Individuals may also be referred to their local Health Department for free, confidential, but not anonymous, testing with pre- and post-test counseling. DO NOT refer patients to the local Red Cross or Blood Banks for HIV testing or testing for other blood bone Pathogens (HBV, HCV, syphilis). HIV test results must be given to the patient in person privately. If they are not available at the time of discharge, arrangements must be made for the patient to follow-up in Residents Clinic in Medicine Primary Care or at the VA for the results of testing and counseling. The ID Clinic cannot be used for this service and will not provide test results to non-clients.
**OCCUPATIONAL EXPOSURES**

In order to provide timely assessment of occupational exposures to blood or body fluids, MCVH has a unique post-exposure program. During a regular working day (8:00 a.m. to 4:00 p.m.), the exposure must be reported to the Employee Health department (8-0584 or 8-0585). Determination for the need for prophylaxis will be made at that time. After hours, on weekends or holidays, a phone consult service team (PEP Team) is available (page number 4508). If it is determined that prophylaxis is deemed necessary, the medications will be called into the Inpatient pharmacy in the basement of the Main Hospital. Prophylaxis should be started within two hours after exposure, as directed by the CDC guidelines. In order to perform post-exposure antibody testing on the source patient, the orders must be entered through the HIS Occupational Exposure screen. The *source patient must* be notified the testing will take place because of an occupational exposure. Consent is necessary due to the "Deemed consent" in the state of Virginia.