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WARDS

Structure

2 ward services: Vascular Neurology & General Neurology

Vascular

- Based on Bridge Bldg 7 (BB7). Overflow to Main 7B (7B) followed by 9A
- 7 days/week there is 1 Attending, 1 PGY2 Neurology Resident, 1-2 APPs, 1 PGY1 Medicine Intern
- Mon-Fri there is also either a stroke fellow or a chief resident year-round (excluding holidays)

General

- Based on Main 7B (7B) with the work room on 6B. Overflow to 9A
- 1 Attending, 1 PGY2 Neurology Resident, 1 PGY1 Medicine Intern 7 days/week
- Mon-Fri there is a chief resident when the stroke fellow is on wards (excluding holidays). In other words, the wards chief resident defaults to the vascular team unless the stroke fellow is there (about 5 months of the year) at which point the wards chief will be on general instead

Schedule

- 6am-8am
  - receive sign-out from the overnight resident
  - ensure the white board and epic lists are updated
  - Help the interns and APPs divide up the patients
  - Give the secretary on any floor you have patients on a print out of the census and the names and pager of who’s taking care of them that day and until what time. You can usually give print this out for your primary floor and ask that secretary to fax the form to the secretaries on the other floors where you have additional patients
  - Pre-round by looking though your patient’s charts and checking a brief and pertinent neuro exam on all of them. The PGY2 should do this for all the patients on their service, but prioritize the new and sick patients on busy days
- 8am-9am: Morning report, APC 5 – Attendance REQUIRED
- 9am-9:15am: Multidisciplinary rounds. Say the patient’s diagnosis, whether they need PT, OT, speech, social work, and what their estimated length of stay is.
- 9:15am-11:45am: Attending Rounds. If you are not done discussing and seeing all the new admissions at least (ideally the whole service on a good day) there is likely a flow issue. Please discuss with the chief/fellow/attending or the program directors to address this
• 12pm-1pm: Noon Conference, APC 5 – Attendance REQUIRED
• 1pm-4:30pm: Afternoon work
• 4:30pm: group signout on BB7. Neurology residents and APPs sign out their patients to the on-call resident or Consult 2/3 resident. Give FYI on intern patients as they will be primarily covered by Med a night float. The non on call medicine intern signs out their patients to the on call medicine intern
• 7pm: On call medicine intern signs out to Med A nightfloat.
• 9pm: On call neurology wards resident signs out to nightfloat

Census
• Intern caps at 10 patients; can take up to 3 new patients per day
• APPs cap at 10 patients each; can take up to 3 new patients per day unless the service is very busy at which point they can take more than 3 news but still cap at 10
• Neurology PGY2 resident is responsible for over-the-cap (OTC) patients on either service
• If the total census is above 15 on general or above 20 on vascular, residents can admit patients to the less busy service after clearing it with the attending, chief, or fellow on the service they want to transfer to. If the total census is at or above 35 patients, we will go on diversion. See Diversion Protocol under Policies section (this is on hold as of July 1st 2017 pending further discussion with the hospital)

Roles
PGY1
• Interns rotate through neurology ward to learn neurology, have their neuro exam skills and reasoning assessed by the team
• Inters should have received a neuro wards guide by email from the intern that just came off of their neurology rotation. If not, they should ask for it
• Make sure to have someone on the team observe you do a neurological exam
• May carry up to 10 patients
• May take on up to 3 “new” patients per day. This means any over-the-cap patients covered by the resident would be considered “new” when transitioned to the intern’s census.
• Every wards patient must be examined daily and have the vitals and new results reviewed
• Not responsible for LTM (long term EEG monitoring) patients on the general team at any time
• all ER patients are admitted by the neuro consult residents. Floor to floor or icu to floor transfers should default to neurology resident. The neurology resident may delegate to the intern if they feel they have adequate experience
• the intern writes progress/transfer notes on their own patients and should include the following
  • overnight events
  • 2 relevant ROS
  • vitals
  • meds
  • new results from the last 24 hours, not an exhaustive list of all work up since admission (that goes in the hospital course of the discharge summary)
  • neuro exam with a minimum of 5 components relevant to the patient's problem. you are not expected to do a full neuro exam on each patient as that is inefficient and often irrelevant to the patient's chief complaint. a full neuro exam is always done by the admitting neurology resident before you've seen them and should serve as a reference for your own to see if the patient's better or worse the next day. if you're not sure what the most important things to check on someone's exam are, check what was abnormal on the admitting H/P or ask someone on the team. the most important components are usually level of alertness, pupil size and reactivity, face droop, aphasia, strength in limbs, visual fields
  • assessment/plan organized by problem, be sure to update daily

• discharge summaries are a lot more efficient if you update the hospital course daily or at least periodically. use the stroke discharge template for all strokes but the usual paragraph form is sufficient for non stroke patients. be sure to check with the team as to who the patient should see in neuro clinic if at all as not everyone needs follow up

APP
• Only rotates on the vascular neurology team
• If an APP wants to rotate on general neurology for personal experience, they should check with the stroke fellow or chief first. If they join general neuro that day, they must stay with them for the whole day and not carry patients on both services simultaneously and sign their patients out to the whoever will be taking care of them on general the next day
• Please see intern and PGY2 sections for more info

PGY2
• Direct supervision of intern. Review the intern patients’ chart as if they were your own. This includes the neurological exam, vitals, labs, overnight events, notes, orders, discharge summaries. Use your judgement to determine when you can transition from direct to indirect supervision of your intern in part or completely. This will depend on your
own level of comfort and that of your intern. Please let them know when you are comfortable making that transition and to what degree to set expectations. Remember that when an intern makes a mistake, it is because they are not adequately supervised

- Please be aware of the APP patients to the same level of detail as those of the intern’s. This is important because the PGY2 is on for the entirety of the rotation and the APPs rotate every few days so the PGY2 ensures continuity of care. It is also important in case the APP needs to occasionally leave for a code stroke or interventional case. APPs should be viewed as colleagues rather than subordinates, please do not manage their patients. They will make decisions regarding their patients appropriate to their level of comfort. However you should be available for any questions they may have.

- Ensure that every patient has a daily progress note unless they already have an admission or transfer note

- If the H&P was electronically signed after midnight on the day of admission, a new note is **not** necessary unless there are major clinical changes

- Touch base with your intern several times a day, and always return their pages promptly, run the list multiple times during the day

- Not responsible for admitting any patients during the day with the exception of Epilepsy Monitoring Unit/LTM patients or outside hospital floor to floor transfers if you are not busy (otherwise will default to one of the consult residents)

- Patients newly admitted during the day by consult residents are usually managed by them until sign-out

- When the service is busy and the PGY2 is carrying several over the caps, they should discuss with the chief/fellow about focusing on their own patients while the chief supervises the intern and is available as a resource to the APPs. In such instances, the PGY2 should get sign out regarding those patients from the chief/fellow at the end of the day to ensure continuity of care

- Ensure your intern’s notes are complete, accurate, and timely

- Please review ALL intern discharge summaries prior to the patient leaving. This ensures quality control and accurate exam findings.

- Review DVT prophylaxis daily

**Chief/Fellow**

- Acts as the attending in that all patients are presented to them, they go over imaging, teach, and lead rounds (examination and counseling of patients/families). The attending leads rounds on days when the chief/fellow has clinic, on weekends, or at the attending’s discretion at any time

- When meeting a patient/family, the chief/fellow should acknowledge the presence of the attending to ensure they know that the attending is providing direct supervision
• Remain on the team you are assigned to the entire week except for assisting the general wards residents with LPs at the beginning of the academic year until they comfortable doing them on their own
• Directly responsible for overseeing the PGY2’s management for the first 2 weeks they rotate on the wards. After that, they should be available as a resource to the PGY2 and all them to act as the “assistant manager” for the team
• Use your judgement depending on the complexity of the case and how busy the day is to allow the PGY2 to lead part or all of rounds
• Teach interns, students, and residents
• Provide feedback on juniors to the attending
• Ensure the PGY2 makes it to all didactics. If they must do something that can’t wait till after didactics, please do it yourself for the sake of their education

Overnight wards coverage
• Both general and vascular wards teams meet the NCCU, peds neuro, and consult residents for group signout at 4:30pm in BB7 workroom
• Intern patients covered by Med A
• Neurology resident and APP patients covered by Neurology consult 2 and 3 and on call resident until night float arrives

Long-term monitoring patients (LTM)
• Most weeks (typically Monday AM), 1-2 patients are directly admitted to the LTM unit on 6A
• General ward neurology PGY2 is solely responsible for all LTM patients
• A full H&P must be written on admission and progress notes on subsequent days, which cannot be copied from the attending’s note.
• These patients are staffed daily with set attendings from the epilepsy group rather than the on call general wards attending
• PGY2 residents will sign these patients out to the neurology on-call resident who will sign out to the nightfloat.
• **Medicine interns have no role in caring for these patients**

Tips
• While a person is presenting their patients on rounds, another person should be helping them out by putting in orders in real time. This saves times so that all the orders don’t have to be put in after rounds
• The intern patients should be presented first on weekdays as the APPs may still be looking up their patients and because the intern needs to be done early and leave for clinic some days. On weekends, the APP patient should be done first in case they need to break away for NIR cases/code strokes.

• Case managers are your best friends. Keep them informed and happy to ensure smooth flow of patients.

• Even if you know someone won’t be discharged that day when you discuss them at interdisciplinary rounds, let the case managers know when you expect them to be discharged so they can start working on them

• Don’t order tests unless they will change management

• Always discuss use, type, and timing of blood thinners with the chief, fellow, or attending

• Ask yourself if tests need to be done in house or whether they can be done as an outpatient

• Always set expectations regarding length of stay and inpatient treatment goals with patients and families to minimize issues down the road

• Ensure PT/OT evals have been completed and case manager knows their recommendations

• Case management needs to talk to the patient/family to obtain rehab choices

• Speak with your interns, APPs, and med students regarding the schedule for the week and weekend so you can anticipate and possibly rearrange scanty coverage during clinic and other times of anticipated absences

• On Mondays, ask what orientation your med students have already received and set expectations regarding presentation on rounds and patient care

• The PGY2 or chief should have the med student practice presenting patients to them before rounds when time permits
Consults

Structure

- 1 neurology attending, 1 chief resident, 3 neurology residents staggered throughout the day, 1-2 Medicine Residents, med students. Additionally, there are sometimes PA students, psych residents, and medicine residents from Memorial Hospital
- Chief resident obtains the consult pager from night float resident at 7:45am and assigns consults and follow-ups to the team throughout the day
- The on call chief resident is available for questions day or night at all times except Sat (24 hours) and Sun until 4:30. At these times, the chief is off and the junior residents must call the attending directly with any consults
- Code strokes are only seen by neurology residents
- Consults are only seen at RIH and Women & Infants. Hasbro consults are done by the peds neuro resident. Please see the peds neuro rotation for details
- Pager is handed off by the chief to the call resident at 4:30pm
- 3 neurology resident shifts (either PGY2 or PGY3):
  - Consult 1: 8am - 6pm
  - Consult 2: 11am - 9pm
  - Consult 3: 2pm - 12am

Schedule

- 8am-9am: Morning Report
- 9am-9:30am: run consult list with chief resident in noon conference room on APC 5
- 9:30am-12pm: see consults
- 12pm-1pm: Noon Conference
- 1pm-4:30pm: Attending rounds

Expectations for all team members

- All consults should be seen in a timely manner with the most acute patients being seen first
- All residents MUST leave the hospital at the end of their shift. Do not take new consults that you do not think you can finish by the end of your shift. Time to wrap up notes and orders should be accounted for. Passing on consults to the incoming resident is an expectation and should not be something that only happens when things are busy.
- PGY2s must call the chief/attending to discuss every consult
- PGY3s must call the chief/attending for all code strokes and send outs from the ED. They only need to call for other things if they have questions/concerns
- If you are asked to see a consult that you think is not necessary, you can explain your reasoning to the consulting team and offer another plan such as a clinic appointment if applicable. However if the team still wants the consult, you may not refuse it
• If you receive a code stroke or other emergency near the end of your shift, please go make sure the patient is stable and initiate any time sensitive management. On your way down, let the chief or incoming consult resident know of your situation so they can relieve you once they get there. You must not stay beyond your shift to wrap up urgent consults provided there is a resident available to relieve you. It’s ok to start these consults and have someone else wrap them up. However please avoid starting nonurgent consults that you will not have time to finish before the end of your shift
• If time permits, ask the attending to observe you perform a consult in its entirety and/or the neuro exam on a patient at least once during the week
• Always set the consulting team’s expectations regarding when the consult will be seen to avoid call backs and frustration on both ends
• After the attending has seen the patient, be sure to document whether this patient needs in house or outpatient follow up. If so, note which clinic and the time frame
• If peds calls with a consult or question, direct them to the peds neuro consult resident from 8:00am-4:30pm Mon-Fri. Outside of those times they must call the peds neuro attending directly who may then ask you to see that patient. You cannot see a peds patient or curbside without a minimum of indirect supervision from the peds neuro attending who is informed about that case

Chief role
• Return all pages promptly
• At the beginning of attending rounds, go over all send outs from the ED that the attending didn’t hear about to get feedback on your indirect supervision of junior residents
• Lead rounds including demonstrating exams on patients, counseling, and imaging interpretation. This is your service and the attending is there to guide you
• It is ALWAYS okay to call the attending 24/7. However at the PGY4 level, you should have a preliminary plan when calling to discuss
• Know the important details of every consult you delegate to a resident or student
• Consults given to students should be paired with a resident so the resident can write the billable note for the attending to sign and appropriately supervise the student. The student should write their own separate note
• Do not pull residents out of didactics for nonurgent consults
• Delegate consults appropriate to a resident’s/student’s proficiency and efficiency
• Provide constructive feedback to every team member at the end of the rotation and report it to the attending so they can fill out their evaluations
• Leave “TO Dos” and “FYIs” on BB7 Whiteboard for overnight and weekends

Tips
• When there are multiple consults pending and you have no help, identify who the sickest patients are and evaluate them as efficiently as possible. Triaging is a skill that takes time to build. Talk to a senior resident or attending if you are having trouble
• If time permits, write the HPI and exam prior to presenting your consult case to the chief or attending - this will help to make your presentation clear and concise.

• When performing chart review prior to seeing a consult, it is helpful to start pre-writing your note and incorporating pertinent history and hospital course thus far prior to your evaluation.

• After seeing patient, jot the exam into your incomplete note or on a paper before you forget it.

• You should finish writing each note before moving on to the next patient assuming your next patient is stable. Otherwise you may be writing 10 consult notes at the end of a 24 hour shift and it will take you twice as long to do when you’re tried.

• Goal should be to read about patient, evaluate them, place orders and finish the note in 1-1.5 hours.
Neurocritical Care Unit (NCCU)

Structure

- 2 teams each covering 9 patients each for a total of 18 patients
- each team has: 1 neurocritical care attending and 1 PGY2 neurology resident + 1 NCCU-APP or 2 NCCU-APPs. This is the schedule 7 days per week. On Sundays, the NCCU PGY2 has the day off and an off service PGY2 or 3 covers for them
- each resident or NCCU-APP carries up to 4-5 patients regardless of whether the problem is primarily neurological or neurosurgical
- overnight, the NCCU is covered directly by the NCCU-APPs. The neurology consult residents or nightfloat are contacted with neurological questions but this is rare and usually involves interpreting an EEG

Workflow

- 6am-8am: Get signout from overnight APP and Pre-round
- 8am-9am: Morning report - REQUIRED
- 9am-11:45am: attending rounds
- 12pm-1pm: Noon Conference - REQUIRED
- 1pm-4:30pm: Afternoon work
- 4:30pm: signout in BB7 work room to consult or on call resident and update the BB7 white board with to dos

Expectations

- If you didn’t do so when you transferred the patient out earlier in the day, make sure to give verbal sign-out to the wards team at 4:30 sign-out
- Direct admissions to NCCU from outside hospitals are admitted by the NCCU during the day; new admissions from the consult resident should be signed out to the NCCU resident or APP taking care of them, who will subsequently help manage them
- Sign out all patients who are going to a service other than neurology to the Consult Chief so they will be followed on the consult team – transfer patient to consult list on Epic
- Do not hesitate to ask questions or bring clinical concerns to your attending or the NP/PA
- Know your patients extremely well to round efficiently and effectively
- Present in the following order: HPI (new patients only), 24 hour events, vitals, home and current meds, infusions, I/O, labs, imaging, exam, organ systems based plan
- You are the direct liaison with the family and will be expected to eventually lead family meetings in conjunction with the attending
- If you want to learn to do lines and intubations, you should let the attending/APP know. As they are not ACGME requirements, you are not obligated to learn these skills

Admitting to the NCCU
• If no beds, discuss with APP or attending about possibility of putting patient in a different ICU or moving someone out of the NCCU to make room
• Admitting note needs to be completed before patient arrives to the NCCU
• Inform NCCU PGY2 resident and APP about patient if during day. After 4:30pm, sign out directly to consult 2, consult 3, or nightfloat resident and the NCCU-APP
• Important orders not to miss:
  • For ICHs: Repeat head CT at 6 hours, INRs post-reversal, troponins, Blood pressure parameters
  • Vent and sedation orders, precedex
  • When appropriate, notify neurosurgery if not notified by the ED

Transferring out of the NCCU
• Flag patient for transfer, notify NCCU secretary and BB7/7B charge nurse. alert if they need q2h or q4h vitals
• Write a transfer note
• Write the name on the BB7 or 7B whiteboard depending on where they’re going and sign out directly to the wards team taking the patient over. This should be done at 4:30 group sing out at the latest
• These patients are managed by neurology residents only until rounded on the next day (if assigned to an intern)
• In rare instances, the NCCU attending and NCCU PGY2 will be the primary neurology consultants for NCCU patients boarding in other ICUs due to lack of beds in the NCCU. This will be determined by the NCCU attending
Pediatric Neurology

Structure

- 1 attending, 1-2 Neurology residents, medical students at times
- this is a daytime Mon-Fri rotation. Overnight and weekend consults typically wait till a weekday. If a consult is urgent, the peds team must call the peds neuro attending directly. The peds neuro attending will either provide recommendations over the phone or ask the in house neurology consult resident to see the patient and then discuss with them

Schedule

- 8am-8:15am: receive pages from peds teams regarding patients that came in overnight and need to be seen that day
- 8:15am-9am: Morning Report
- 9am-11:45am: see consults and follows, attending may round with you in the morning or afternoon depending their schedule
- 12pm-1pm: Noon Conference
- 1pm-4:30pm: see consults and follows, attending may round with you in the morning or afternoon depending their schedule
- 4:30pm: sign out in BB7 work room

Expectations

- Resident carries the pediatric neurology pager from 8am-4:30pm and is responsible for Hasbro ED, Hasbro floor consults along with W&I NICU consults (do residents go independently to NICU or do they always go with the attending?)
- When in Thursday resident clinic, call operator and sign pager out to the attending during your clinic hours (only when you don’t have 2 residents on peds)
- All consults must be staffed directly with the peds neuro attending the same day
- Disposition: discharged, admitted to pediatric neurology (yellow team), other pediatric team or PICU
- The peds team manages ALL orders, day-to-day management, daily progress notes, and discharges patients. The neuro resident only acts as a consultant
- You are not expected to physically pre-round on follow up patients, but you should know their history and current presentation
- Peds writes H&P’s for admitted patients; you must still write a consult note unless told otherwise by the attending
• The need for follow up consult notes for a particular patient should be discussed with the peds neuro attending
• Calls from outside pediatricians need to be discussed with the attending before providing advice/recommendations
• When you discuss a patient with the peds neuro attending, anticipate questions specific to that case and create contingency plans as the peds team will call often. You should include contingency plans in your note. Common questions include
  • Are we continuing EEG overnight/over the weekend?
  • What should we do if the EEG leads fall off? Keep them off or call in techs to put them back on?
  • What should we do if they have another seizure?
  • When can they be discharged and does the peds neuro team need to be notified?
  • When will you be available to answer the family’s questions?
  • When are you going to round on the patient?
  • When do they need clinic follow up (if at all)?
  • What neurological changes can be expected to develop and should not be concerning?
  • Do we need to get antiepileptic levels
  • Do we need daily labs
  • What clinical changes require acute brain imaging and should it be a CT or MRI?
  • Should we call acutely if the patient has a seizure?
Night Float

Structure
- Saturday – Thursday (Fri night is off and covered by an off service resident)
- PGY3 Neurology resident for 1st half of the year
- PGY2 Neurology resident for 2nd half of the year
- Arrive at 8:45pm. Receive sign out from call resident, Consult 2 and/or Consult 3 in BB7 work room
- carry pager until 7:45am at which point you pass it on to the chief on weekdays or the on call resident on weekends
- Go to morning report from 8am-9am

Expectations & Tips
- Please see consults rotation

Additional Tips
- Overnight, staff with Chief Resident except for Saturday nights where you call the neurology attending specific to a case (NCCU, vascular, or general neurology)
- It’s more efficient for both you and your senior to “bunch” calls to chief/attending for nonurgent consults. For all code strokes and neurological emergencies be sure to call immediately
Resident Continuity Clinic

Structure

• One half day every Thursday during one of these slots:
  ▫ AM Clinic: 9am – 12pm
  ▫ PM Clinic: 1pm – 4:30pm
• Up to 6 patients per clinic (PGY2s start with 4)
• 1 new (1 hour), 1 ED/inpatient new (30 min) and 4 follow up’s (15 min). Despite the short
time for follow ups, the no show rate is high and co residents can help each other out if
things can busy
• If you are on wards or NCCU, your clinic will be in the afternoon
• Consult 2 (11am-9pm) has clinic on Thursday morning (starting at 9am)
• Consult 3 (2 pm -12: 00 am) will have clinic on Thursday afternoon
• If you are the wards resident, sign out your patients to the neuro resident on the other
wards team i.e general if you’re on vascular or vice versa
• There will be several occasions throughout the year when a full day clinic (both morning
and afternoon sessions) is scheduled. This is to satisfy the required number of clinics per
year.

Expectations

• Interns also have weekly clinic, and they should sign out their patients to the other intern
as well as you on the wards. Ensure that the covering intern has an updated paper copy
of your team’s signout.
• When starting on wards – talk with your intern the first day to find out when their clinic
day is to ensure there is no mix up about coverage
• Take patient from waiting room and bring them to room when they arrive, and walk them
to check out when you are done. Let the medical assistant at the front know when they
need follow up and what tests have to be ordered if any to make the plan clear to them
and your patient
• Staff with clinic attendings to devise a plan. They may or may not see every patient with
you depending on the complexity
• Ask that an attending observe one of your clinic encounters from start finish on days
where it’s not busy
• Check your clinic schedule routinely at the beginning of the wee to ensure there are no
errors
• When switching calls or rotation assignments or taking days off, please be mindful of your Thursday clinic commitments. You should ask the clinic chief resident if you have questions.
• Send a copy of your note to the primary care. The easiest way to do this is highlight your note in epic and click the route button. Make sure the medical assistants update the patient’s primary care in Epic with their fax number so that this is possible
• If you receive correspondence from lawyers or others seeking medical records, please pass these on to the clinic nurse or clinic manager.
• If you receive other paperwork such as disability questionaires, discuss with your preceptors how to fill out (or not fill out) these forms for the particular patient.
• The Neurology Clinic does not routinely endorse the State of RI medical marijuana applications
• The Neurology Clinic does not have a mechanism to prescribe and monitor long term opioids for pain management.

Tips
• You can look your patients and pre write your notes in your email which can then be copy/pasted during clinic. Do not open the encounter note in Epic prior to the patient’s arrival at the appointment. When patients no-show (which happens frequently) open encounters creates a problem for the staff.
• Not every patient needs an in person follow up. Many patients can be given your card and asked to call as needed to discuss issues with you and then you can ask that an appointment be scheduled for them depending on the issue
• Pick one day in the week to routinely follow up on your clinic patients’ results and clear your Epic inbox. This prevents build up of material in your inbox and ensures timely communications with your patients
• When you see a patient, set expectations about:
  ▪ Goals of today’s appointment
  ▪ Whether they need a follow up appointment and why
  ▪ When they should come to the ER. This is especially important for people with migraine or epilepsy
  ▪ When you will be calling them with results
  ▪ Whether they need a follow up appointment, when it should happen, and what you will accomplish at that visit
• Be sure to document everything for your patients in the after visit summary that will be printed for them. This is important as patients often will come alone and may not
remember or be unable to communicate your recommendations to their family members/care takers

• If someone comes from a nursing home, rehab, or other facility with a carbon copy paper asking for your recommendations to be written down, you can simply print out your entire clinic note instead. This is more legible, professional, and avoids the redundancy of having to repeat your recommendations from your note.
EEG

Structure

- 1 EEG attending, 1 fellow, 1 resident
- EEG techs come intermittently and update the list of inpatient/outpatient for review
- Attempt to read EEGs in the AM and review your attempts with fellow. If adequate, present to attending in the afternoon.

Schedule

- 8am-9 AM: morning report, APC 5
- 9am-12pm: review EEGs with fellow, EEG lab at APC 6
- 12pm-1pm: Noon conference, APC 5
- 1pm-4:30pm: review EEGs with attending, EEG lab at APC 6
- Thursdays: ½ day resident continuity clinic

Goals (ACGME Milestones)

- Describe EEG in objective and standardized terms
- Recognize normal EEG and its variants
- Describe normal EEG features of wake and sleep state
- Recognize common EEG artifacts
- Interprets common EEG abnormalities
- Interpret uncommon EEG abnormalities
- Recognize EEG patterns of status epilepticus
- Describe normal and some abnormal EEG features of wake and sleep states in children

Resource

- AAN - Interpretation of the Normal Adult EEG: Normal Patterns and Common Artifacts (Free)
EMG

Structure
- Mon-Thu
  APC 6 EMG lab
  0900-1200, 1300-end (usually 1700)

- Friday
  APC 5 Clinic – MDA and/or ALS clinic with the fellow and attending
  0830 - 0500

- Break from rotation for the usual didactics: morning report, noon conference, grand rounds

What
- 8 week continuous rotation during which the resident learns to interpret and perform routine nerve conduction studies and EMG under the supervision of the neuromuscular techs, fellows, and attendings

- During the rotation the resident is expected to present at least once at the neuromuscular conference on a topic of their choosing

- Recommended reading (both hardcopy and PDF copies available):
  Electromyography and Neuromuscular Disorders: Clinical Electrophysiologic Correlations. Preston, D., and Shapiro, B.

Goals (ACGME Milestones):
- Explains an NCS/EMG procedure in nontechnical terms
- Uses appropriate terminology related to NCS/EMG Pathology
- Describes NCS/EMG data
- Lists NCS/EMG findings in common disorders
- Interprets NCS/EMG data in common disorders
- Describes common pitfalls of NCS/EMG
- Formulates basic NCS/EMG plan for specific, common clinical presentations
- Performs, interprets, and creates a report for NCS/EMG
Psychiatry Consults
Neuropathology
Neurology Outpatient Clinic (NOC)
ELECTIVE
-HOW TO...-
Do weekday call

Structure

- Monday-Thursday, 4:30pm – 9pm
- Meet for signout on BB7 at 4:30pm
- The day call resident will hold the pager and return all calls until 8pm, at which time they pass off the pager to the consult 3 resident (who holds it until nightfloat arrives at 9pm)

Expectations

- If you have a sign patient on the floor, you should defer consults to Consult 2 or 3 residents
- The call person should ideally see ER consults or floor patients that they think are going to be admitted to their service and assign other consults to the consult 2 or 3 person. This allows them to present them to the attending on rounds the next day and provide continuity of care. Of course this is not always possible.
- The Wards resident MUST be out by 9pm!
- Be cognizant of when someone’s shift is finishing up so they can get out on time
- Be aware of who is available to do consults and what their current work load is in order to distribute work equitably

*Please see consults rotation for additional expectations and tips
Do Friday Call

Structure

• Done by a PGY2 or 3 resident
• Carries consult pager from 4:30pm on Friday until 7:45am on Saturday
• Generally is scheduled for ICU rotation on Sunday
• Consult 2 resident helps until 9pm
• Consult 3 resident helps until 12am

Expectations

• Discuss all cases with attendings Saturday morning and see as many cases with them as you can. Usually one service will have more overnight admission than the other. The service with more admission should round with that attending while you see your consults and discuss your admission with the other attending. You then interrupt rounds on the other service to present your consults and admission to the other attending and leave.
  ▪ You should not round with the attending on patients who were consulted on by other residents
  ▪ Do not stay to help with follow ups or addition consults after 8am
  ▪ Write all admission and consults on the BB7 white board
    ▪ Put G next to general consult and V next to vascular consult patients so the attendings know who they need to round on
    ▪ Put all new admission on the white board
    ▪ Add all new admission and consults to the appropriate lists on Epic

*Please see consults rotation for additional expectations and tips
Survive the weekend

Structure

- Team members
  - House staff/APPs
    - 1 On Call Consult resident (7:45am – 9pm)
    - 1 Ward Resident (6:00am – 9:00pm). Can help with consults after they finish wards but must leave after 9:00 pm signout. The week’s vascular wards PGY2 takes one weekend day and the general wards PGY2 takes the other day
    - 1 NCCU Resident (6:00am – 4:30pm). Can help with consults after they finish NCCU. Must leave after 4:30pm sign out to nightfloat
    - 2 PGY1 medicine interns (1 on vascular and 1 on general both Sat and Sun)
    - 1 Friday Call (starting 4:30pm) or Nightfloat (starting 9pm Sat and Sun) until 7:45am the following morning
  - Sat - 1 APP for code stroke/interventional cases and 1 APP for vascular wards (7am-7pm)
  - Sun - 1 APP for vascular wards that may get temporarily called away for code strokes and interventional cases (7am-7pm)
- There is no chief resident
- Attendings
  - 1 General wards attending that also staffs general consults
  - 1 Vascular wards attending that also staffs vascular consults
  - 1 NCCU attending
  - there is no dedicated consult attending, consults are divided between the in house general and vascular attendings

On Call Consult Resident

- Receive and triage all new consults and calls
- See consults yourself until the wards and NCCU residents are free (typically around noon)
- If outside hospitals call for transfers, please direct them to express care (the transfer center) 401-444-3000. Please do not accept outside hospital transfers, this should only be done by attendings
- If you receive outpatient phone calls from patients or the operator, please direct them to the on call general neurology attending
Friday call/Saturday overnight Resident

- Signout to On Call resident at 7:45 am
- Discuss all cases with attendings Saturday and Sunday morning and see as many cases with them as you can. Usually one service will have more overnight admission than the other. The service with more admissions should round with that attending while you see your consults and discuss your admissions with the other attending. You then interrupt rounds on the other service to present your consults and admission to the other attending and leave
  - You should not round with the attending on patients who were consulted on by other residents
  - Do not stay to help with follow ups or additional consults

Wards Resident

- 6am – 8am: Pre-round
- 8am – 8:30am: Wards attendings arrive for rounds on BB7 to check out the white board
- Start rounds with the attending responsible for the sicker/busier/service with more new admissions (use your judgement). Meanwhile the other attending should be seeing their consults with the nightfloat person. Then switch. The goal is to get the overnight resident out. The PGY2 should be rounding with the attending on each service sequentially
- When rounding on your wards patients, start with the APP patients since they need to free up first and be available for endovascular cases and code strokes while the intern is going to be around all day and just responsible for the wards
- If the APP has to go to a stroke/endovascular case you should be covering their patients in the interim
- **You do not need to see every wards patient since you are the senior for both wards services on the weekend. Focus on new/active patients and those the intern requests help with**
- After both attendings round on their respective wards services, all residents, interns, and APPs from all services typically migrate to the BB7 work room to keep everyone centralized and stay on top distributing work

NCCU resident

- Runs just like a weekday except rounds tend to be quicker and you will be staying till 9pm to help the on call consult resident

*Please see consults rotation for additional expectations and tips*
ORDER EEGS

• EEG techs normal hours are 7AM-3:30PM. So, plan ahead.
• Routine (20 min) are done in the EEG lab (APC 6) during the week
• Prolonged/portable routine are done at the bedside
  o ICU patients, wards patients who need longer monitoring or challenging to move off the floor
  o Please page the EEG tech (350-4040) to inform them about these patients
• Concern for status epilepticus (convulsive or nonconvulsive) is the only reason to call in EEG tech during off hours.
• If emergent EEG needed, only neurology residents or neurology attendings may call in tech. Pager is 350-4040.
• ***EEG techs are unreachable from midnight to 6am. You must treat clinically during these times.***
• EEG tech is in house during the day
• They need to know who can be taken off entirely, or who needs to stay on (and turn over the machine). It’s good to habitually let them know after you round with your attending, otherwise they will call you
• The overnight resident and wards residents should be aware who needs to stay on
  o Consult Chief resident should communicate to the weekend residents who needs to stay on as well as criteria for discontinuing EEGs
• EEGs must be interpreted by us on the spot!
  o EEG attending is available by phone for emergencies and will call with emergent findings. The attending will routinely put the reports in Epic in the afternoon 7 days a week
RUN CODE STROKES

*IF IN DOUBT OR IF THERE IS A DISAGREEMENT BETWEEN YOU AND ANOTHER PROVIDER, CONSULT THE STROKE PROTOCOLS ON THE LIFESPAN INTRANET. THE PROTOCOLS ARE ALWAYS CHANGING AND THIS IS WHERE THE MOST UPDATED INFORMATION IS. IF A DISAGREEMENT REMAINS, BYPASS THE CHIEF RESIDENT AND CONTACT THE ON CALL STROKE ATTENDING IMMEDIATELY

Some facts about code strokes

- Neurological emergencies
- Can be initiated by anyone in the hospital
- There are 3 criteria for activation:
  - Clinical suspicion for stroke
  - Ongoing neurological symptoms (cannot be resolved)
  - Last known well (LKW) within 16 hours
- ED and EMS code stroke pages are sent out by medcomm (the little desk inside the entryway in the ER)
- Floor code strokes are sent out by the operator who is contacted by that unit’s clerk or nurse
- Floor code strokes are overhead everywhere in the hospital, but ER code strokes are only overheaded in the ER. All code strokes are sent to the consult pager regardless of location
- If you would like to receive code strokes on your personal pager all the time, just ask the operator
- tPA can be given to patients up to 4.5 hours of LKW. At our institution, we do not exclude patients between the 3-4.5 hour window based on ECASS 3 criteria
- An NVC-APP will accompany you to all code strokes from 7am-7pm, but not overnight. The 2 of you will parallel process to ensure timely treatment. Resident focuses on tPA and APP focuses on endovascular
- Remember a code stroke consult is NOT a fast neuro consult. It happens in 2 stages, getting an abbreviated neuro exam and asking the 4 screening questions to make acute decisions on endovascular and tpa. After these acute decision are made, the non urgent portions of the H/P are done i.e. reflexes, gait, family and social history
- As soon as you determine the patient is not a candidate for tPA, notify the patient’s nurse to cancel the code stroke immediately. This does several things:
  - Frees up the ER CT scanner for other cases
o Makes the nurse your best friend because they don’t have to document the stuff in the code stroke flow sheet

o If they are stable, moves the patient out of the critical care bay and makes them a non time sensitive consult

**Code stroke protocol**

*The following division of labor between the neurology resident and APP is a suggestion for what seems to be the most efficient way to run most code strokes. However, as you will see every code stroke is different and the most efficient flow will vary with each case. Be in constant communication with each other so you help each other parallel process and do not repeat each other’s work*

- NEVER send a student or rotator to see a code stroke on their own. If you want them to practice running one, it should be under your direct supervision and should not affect the time to treatment
- Do not waste time calling the ED/floor – go directly to the bedside
- Arrive ASAP - expected time is within 5 minutes, but the sooner the better
  - Walk, don’t run, as it scares people in the hospital
  - No place takes >5 minutes to walk to in the hospital
- Upon arrival, ensure the patient is the correct patient
- Identify yourself as the neurology resident running this code to the patient and other providers – people will be happy to see you as strokes scare everyone (except us)
- If you happen to get to the patient before they are in CT, get an abbreviated exam (aphasia, drift in 4 limbs) and go over the 4 exclusion criteria in your stroke cards en route to ED. If there is a family member there, grab them and ask them to stay put right outside the scanner so they can accompany you and the patient to the critical care room after the scan
- Most of the time the patient will already be on the CT table. You can continue to examining/speaking with them until the techs are ready to run the scan. The techs will sometimes stop when you touch the patient or talk to them. Politely remind them to please keep doing what they’re doing, you will work around them, and get out of their way once they’re ready to run the scan
- While the patient is getting scanned, use your time efficiently
  - Find EMD, ED team, or family for more collateral info
  - The APP can stay in the scanner and ensure there is no bleed and put in an order for the CT/CTA if the ED hasn’t already
- Look up the patient’s medical record on Epic or in nursing home paperwork
  - Often the contact information can be found in here– start calling to get collateral if necessary
  - Focus on exclusion criteria (anticoagulant use, recent surgery, prior ICH, etc.) and history of prior strokes/baseline exam
- The non con CT head is always done before the CTA. If it shows a bleed, it will be obvious and you should ask for labetalol and a cardene drip to be prepared. It is a judgement call as to whether you want to add on a CT/CTA at the time.
- If the non CT head doesn’t show a bleed and you haven’t encountered any exclusion criteria thus far, the tPA should be mixed by the ER nurse. This determination can be made by the neuro resident or APP in the scanner, bleeds are usually obvious and can be seen on the control room monitors. If there is any question ask the ER radiologist in the reading room next door. The neuro resident or APP should make sure the tPA gets mixed by asking for a verbal confirmation (Who is this person’s nurse? -> I am -> Would you please mix the Tpa? -> Yes). If there is resistance, refer them to the stroke protocol on the intranet. If there is further resistance, call the stroke attending immediately
- While the patient is getting their CTA head and neck, the ER nurse should be mixing the tPA, the APP should go to the ER radiology reading room to confirm the CT and CTA read and the neuro resident should be getting further collateral or can accompany the APP to the reading room. Do not go back to the reading room a second time after the APP has already gotten the read unless there is a discrepancy you need to clarify. This is an inefficient use of precious code stroke time and irritates the radiologists (understandably). You are not responsible for checking the APP’s information, you are a team and must trust each other and parallel process
- Once the patient comes out of the scanner, they get weighed
- They then get parked in critical care rooms 1 through 6
- At the point the APP will be back with a read as to whether there is a LVO (large vessel occlusion) or not. If there is not, the APP can check to see if you still need their help with getting meds from pharmacy, tracking down family, arranging for a hyperacute MRI et. Otherwise they can leave. If there is and LVO, the APP will contact the on call neurointerventional (NIR) attending and send out an LVO page.
- While the APP is figuring out the LVO stuff, make sure to complete the NIHSS. If your 4 screening questions for tPA were negative, call your Chief Resident (Wards Chief during 8a-4p M-F; Consult Chief after 4pm) or Vascular Attending ASAP to discuss in 2 lines and give the tpa
- DO NOT ASK PATIENT/FAMILY IF IT’S “OK” TO GIVE TPA. This presents it as an option and introduces uncertainty. tPA should be an assent, not a consent. When someone refuses tPA, it is usually because you are not selling it properly. Please see the code stroke lecture on the resident drive on how to sell it.
• PGY2s should never administer tPA without discussing with the on call chief or attending first. PGY3s may administer tPA while or shortly after discussing with the attending or chief.

• Shout out the time that tPA is given so the nurse can record it. “tPA bolus going in at 9:45am!” The neurology resident or APP will give the bolus and the ED nurse will hook up the drip.

• If the patient is ready to go up to endovascular, do not hold them up in the ED to get tPA. tPA is available in the NIR suits and can be given by staff there.

• Although you must trust the APP to obtain the correct read of the CTA and appropriately call the NIR attending for an LVO, you should always look at the CTA yourself at some point for your own education. A good time to do this is once you have given or excluded the possibility of tPA. This can be done on any of the ED bay/critical care computers.

• Once tPA is given or the patient starts getting transported up to VIR (or both treatment options are excluded), announce that the code stroke is completed and thank everyone.

• Call BB7 to inform the charge nurse a patient is being admitted to the stroke unit and has been given IV tPA. If they didn’t call the appropriate charge nurse for the unit they should go to.

• After tPA is given, wrap up the non-urgent portions of your neuro exam and history then go complete your note if you don’t have another urgent consult pending. Again, do not hold up endovascular for it, you can do this on the way or after endovascular. You can go up to the NIR suite and watch the procedure if you don’t have other consults pending. Document the time you did your stroke scale as 5 minutes before the tPA was given in your note (Joint Commission requirement of NIHSS being done before tPA administration). If the patient didn’t get tpa or endovascular document the reason as it is the standard of care. i.e. out of window for tpa and endovascular or large area of established infarct on CT correlating with clinical exam excludes tpa and endovascular.

• Give the ED the dispo (attending and floor), BP parameters, any other orders, and whether you’ve already called the charge nurse on that floor requesting a bed otherwise you will be paged about these questions after you’ve already left the patient’s bedside and will be interrupted during another consult.

What to do about faulty activations

• STAY CALM AND BE POLITE

• If a patient does not meet all 3 code stroke criteria:
  o Clinical suspicion for stroke
  o ongoing neurological symptoms (cannot be resolved)
  o last known well (LKW) within 16 hours
they should not be a code stroke activation and you should cancel it immediately. This is important as the CT scanner and NIR suites stop their normal work flow waiting for this patient. If you receive frequent inappropriate activations, please let the lead NVC-APP, Gino Paolucci, know.

- If the team that activated the code stroke disagrees with your cancelling it despite your explanation of the reasoning, have them speak with the on call stroke attending immediately
- Always be polite and ask if the team would still like a regular neurology consult which you can perform now or later depending on whether you have a sicker patient to see at that time. If they do not want a regular consult, just write a 2 line (literally 2 lines) significant event note explaining the reasoning for code stroke activation, cancellation, and why a neuro consult was not needed.

Tips

- LAST KNOWN WELL (LKW)
  - This is NOT the time the symptom was discovered unless it was acutely witnessed by someone (i.e. they were talking normally and then stopped mid-sentence)
  - Always confirm LKN with a reliable patient or eye witness—DO NOT simply take the word of another provider
  - Identify contact information by going through EPIC and talk directly with family members for aphasic, elderly or non-English speaking patients who seem unreliable
  - If LKN >4.5hrs, the patient is not a IV tPA candidate but may still be VIR eligible. DO NOT STOP THE CODE STROKE UNTIL IT IS CLEAR THE PATIENT IS NOT ELIGIBLE FOR THROMBOLYICS OR INTERVENTION
  - Do not delay tPA for a foley, another IV to be put in, EKG, gown. Politely remind the nurse or tech that the tpa is the priority as per the code stroke protocol
ADMIT PATIENTS

Rule 6

- This is a hospital wide rule that enables the ED to decide which service is most appropriate for a patient and improve their flow
- If that service disagrees, the attending of that service has 1 hour to contact the attending of a different service which they think is a better disposition for them.
- If a different service is not identified after 1 hour, the patient is admitted to the service initially identified by the ED

Note: just because the ED calls a neurology consult, this does not mean they intend to admit to our service. IMIS cannot use this to state that our attending needs to call them.

Expectations

- Verify medications – if unable to, please document in your note and sign-out for the day team to do this!
- Use the appropriate order set
- Ensure all imaging and tests are ordered
- Fill out MRI Screening form yourself, do not leave this for the day team except if extremely busy or unable to complete due to lack of family. This delays imaging for our patients and ultimately discharge!
- It is YOUR responsibility to inform the NCCU resident, ward resident, call resident or nightfloat about this patient
- Drag patient onto the appropriate group list in Epic
- Write name on the BB7 white board
  - Write important follow up or FYIs on the white board for the evening and/or nightfloat residents to do or be aware of. For example, “f/u 6 hr HCT at 2am to r/o ICH”
- Set expectations with family/patient:
  - Working diagnosis
  - What tests will happen and when
  - Which doctors/APPs will be taking care of them
  - Day time rounds between 9:30am-12pm – they should be there to ask their questions if possible
  - Estimated length of stay in the ED (if there are not free beds)

Tips on writing an admission note
• Chief complaint should be an actual complaint: right sided numbness & tingling. Not “stroke.” And NEVER CVA. Cerebrovascular accident is a ludicrous term, it is almost never an accident
• HPI: Concise, but enough detail to understand the story. Pertinent components of the PMH, but not every element of PMH. For example, gout is almost never relevant. Some HPIs require significant background information to be conveyed
• A lot of neurology is detective work. It’s often necessary to dig through the chart and document relevant history in a concise fashion
• Prior imaging/stroke details or EEGs are important to mention!
• Medication: All currently known, list how you obtained list (i.e. confirmed with family, CVS).
• Social Hx: Includes habits, occupation. Level of independence (ADLs) and ambulatory status are very important to know for baseline and dispo
• A full neurological exam must be documented on every initial consult/admission seen
• Make a template of a normal neurological exam adapted from macros used by attendings/senior residents
• Please provide at least 3 differentials for each assessment.
  • Even when the DDx is seizure, seizure, seizure... it is often worth addressing why it is not another Dx.
  • Additionally, provide a DDx for etiology or mechanism (i.e. seizure due to medication non-compliance, substance abuse/withdrawal, infection decreasing seizure threshold or acute R MCA cardioembolic stroke due to afib)

What does a full neuro exam include?

• **Mental Status:**
  • Level of alertness
  • oriented to person, place, time. Person means another person, not one’s self
  • fluency. Dysarthria is different from aphasia. it does not belong in mental status, it is a cranial nerve finding
  • Attention
  • Fund of knowledge
  • 3/3 registration and recall
• **Cranial Nerves**
  • II: Discs sharp, intraocular vessels appear normal, Visual fields full to confrontation. PERRL
  • III/IV/VI: EOM intact, no nystagmus noted
  • V: V1-V3 sensation in tact to LT/temp
  • VII: Face symmetric.
• VIII: Hearing intact to conversation
• IX/X: Absent dysarthria, normal palatal elevation
• XI: Traps/SCM 5/5.
• XII: Tongue midline. If you notice a tongue deviation it’s usually due to a face droop and not a true tongue deviation. You can lift the side of the person’s face up at the cheek or have them push their tongue against your hand while their tongue is in their mouth to check

• **Motor:**
  • Tone and bulk normal for age. No fasciculations or atrophy noted.
  • Strength in 4 limbs

• **Reflexes**
  • In 4 limbs; No clonus

• **Sensory:**
  • Intact to LT, temperature and vibration throughout. No extinction.

• **Coordination**
  • no dysmetria in 4 limbs. The Romberg is a test of proprioception and belongs under sensation, not coordination

• **Gait:**
  • Normal stride and cadence. +Toe/heel/tandem walking.
DISCHARGE PATIENTS

The discharge summary includes the following components. It is the resident’s job to review all intern discharge summaries before the patient leaves:

- **Medications**
  - Ensure the comments section includes the start and stop time for any new or scheduled blood thinners. i.e. Aspirin 81mg. stop once INR is 2 or greater.

- **HPI** – generally copy from H&P unless inaccurate.

- **Hospital Course:** essential – ensure this is accurate and detailed
  - There is now a shared discharge summary to be used for strokes "strokedisc". Fill out every field in this template and if not applicable, write why that it
  - In addition to the strokedisc, you must include a brief paragraph outlining hospital course and reasoning of medical and dispo decision making
  - If a patient’s primary diagnosis if not stroke, do not use the strokedisc template and just use the usual paragraph form used by internal medicine

- **Neurologic exam at discharge:** This is very important and should be complete and accurate since patients may bounce back and you’ll want to know their most recent baseline exam
  - DOUBLE CHECK ALL DISCHARGE EXAMS DOCUMENTED BY THE INTERN

- **Follow up**
  - On the day of discharge, check with the attending whether the patient needs a follow up, with whom, and approximately when
  - Contact Vascular Neurology for follow ups – call or email information to the stroke secretaries
  - Ensure this is not automatic 2 week follow ups for any service. Epic will sometimes default to this it sets wrong expectations of patients, families, and primary cares

- **Diets**
  - especially if modified diet or TFs (type and rate)

- **Activity level**

- **After Visit Summary**
  - Explain in plain language what happened during their stay
  - Spell out diagnosis, appointments/times, med changes, outpatient tests and labs
HANDLE TRANSFERS

• **Outside hospital transfers**
  - Responsibility of the accepting attending to notify the person carrying the consult pager of the details

• **Floor to Floor transfers**
  - Responsibility of the resident/APP taking care of the patient to notify the resident/APP taking over care of the patient

• **Outside stroke transfers**
  - The consult pager would receive a page notifying them patient is on the way or arrived and where they will be arriving (usually the ED)
  - Essential to find out if IV tPA was given or not; and if a CTA was done. if not it will require extra work on our part to figure this out
  - Ideal to examine before intervention, but this should not delay groin puncture
  - Coordinate with BB7 charge nurse early to ensure open bed; if patient is intubated, work to make a NCCU bed ASAP

• **Tips**
  - If you know a transfer is en route and don’t feel you’ve received adequate information, you can call express care for family or outside hospital contact to collateral
  - Check the BB7 or 7B white boards to see which patients can be bumped to other units and make room for the transfer. You or the nurse should explain the reasoning to the patient as to why they’re being bumped. If the patient is encephalopathic and it’s not too late, notify the family member/care taker. But please do not wake them up in the middle of the night to let them know they’re moving to a new bed
-Policies-

CODE BLACK

When the combined inpatient census reaches 35 or more, the following email will be sent out to the transfer center (express care), the neuro residents, NVC-APPs, and leadership

hello everyone,

Despite taking intra-departmental measures, the inpatient neurology service is now at or above 35 patients and we are on CODE BLACK

The census is as follows
vascular [insert number]
general [insert number]
total [insert number]

We are no longer accepting non-urgent transfers to neurology at Rhode Island Hospital. We will send updates on our status tomorrow morning. I've notified express care

1) please continue to accept all emergent neuro cases including ELVOs and neuro ICU level patients. There is no need for additional calls to any of the on call attendings outside of the calls that are usually made. i.e. calling the vascular neuro attending for floor to floor transfers, calling the NIR attending for ELVOs, and calling the NCCU attending for ICU to ICU transfers

2) for all non-emergent neurology cases from outside hospitals, please let them know we are not accepting non-urgent transfers and direct them to the Miriam IF they have the capacity to accept them. If this is not possible, then direct to hospitals outside of our network. If there is a question as to whether the transfer is necessary, please call either the vascular or general neurology attending on call depending on the type of case. The NIR attending should continue to be called about potential/actual endovascular cases as usual but not non-interventional cases. A transferring hospital “not having a neurologist” is usually not a sufficient reason to transfer as many of these cases can be resolved over the phone when discussing with the on call neurology attending

3) Residents/APPs should discuss with their attending if patients with active medical issues and no/minimal active neurological issues can be transferred to medicine. This should be done by paging 350-0354 as early as possible to determine if the patient is appropriate and they have the capacity to accept them
SCHEDULE CHANGES AND DUTY HOURS

• If a resident needs last minute coverage, it is their responsibility to find coverage and then notify the program directors and chief resident responsible for scheduling. This applies to all rotations, clinics, didactics presentations, grand rounds presentations, and any other assigned responsibility. If the nature of the emergency does not allow them the ability to contact other residents, they should contact the program directors to arrange coverage for them.

• Be cognizant of the impact on duty hours, days off, minimum duration of rotation requirements, and clinic when you change your schedule

• All scheduling changes must be approved by the program director
CONFERENCES AND DIDACTICS

• **Attendance is mandatory**

• Please use the sign in sheet for every morning report and noon conference. Use the evaluation form for grand rounds in lieu of the sign in sheet

• Absences are only excusable for time sensitive emergencies. Having a busy census is not

• Seniors should take on time sensitive emergencies during didactic times to allow juniors to attend

• If a resident is responsible for a didactic session and it unable to give it, they must arrange for a replacement

• The chief resident(s) responsible for the year’s didactics must keep the google calendar for didactics updated for both residents and prospective applicants to view

• All residents must attend at least 66% of didactics by their semiannual reviews. If someone attends less than that, there will be a plan to make it up
FEEDBACK

• Rotation Feedback
  o Make sure to perform 360 feedback with all your team members at the end of a rotation.
  o Do not be afraid to give feedback about negative experiences, if you don’t they will continue to happen. If you’re not comfortable doing it with the attending or team you are working with, speak with your chief or program directors. You can also provide anonymous feedback on your end rotation evaluation form or the internal and ACGME surveys.
  o Be sure to give people recognition and positive feedback!
-Miscellaneous-

EPIC LISTS

• There are lists for all inpatient services
  ◦ General Wards
  ◦ Vascular Wards
  ◦ Pediatrics
  ◦ ICU
  ◦ Consults

• When admitting or seeing a new consult, drag the patient onto the appropriate list

• Write a handoff with pertinent information; update daily if you are directly involved with the patient’s care
  ◦ Also important to communicate information to the Chief (I.e. IMIS attending called about pt X and was curious about Y; I told them Z)
THE WHITE BOARDS

The BB7 White Board
- Essential for collective communication of our dynamic service
- Contains all information for daytime vascular service coverage as well as all nighttime and weekend information for all neurology services in the hospital
- New admissions or transfers (NCCU or other service)
  - Write last name under appropriate team — these will be considered "new patients" for the next day
- Write "old" or "established" patients under the appropriate team, and whether it is covered by the intern or resident
  - Essential for nurses and nightfloat to know who is responsible for cross covering
  - This should be updated by the wards team after rounds every day
- List consults on the right side of the main board
  - This is essential on the weekend so attendings know which consults are new and need to be staffed
  - Place attending's initials (i.e. JC) next to consults needing to be seen on Saturday and Sunday — write down where the patient is located (JB234) and alert the attending in the morning who needs to be seen
- Bottom-Center
  - Used for follow ups and FYIs
  - If writing an EEG follow up, say what to look for and what to do in terms of AED management — writing "check EEG on Pt X" is not appropriate
- Left Side
  - Attending contact info
  - Pending Transfers

6B White Board
- Should contain information specific only to daytime coverage of the general neurology service
- All weekend/overnight coverage belongs on the BB7 white board
WHO ARE THE NVC-APPS?

Inaugurated in September 2016, the Neurovascular Center Advance Practice Provider (NVC-APP) program is a collaboration between the emergency department, interventional neuroradiology, and vascular neurology. The APPs (nurse practitioners and physician assistants) work alongside neurology residents of all levels of training and across systems of care for patients with stroke: code stroke process, interventional neuroradiology, and the vascular neurology inpatient service. Coverage is provided 7 days/week from 7am-7pm.

Code Strokes

The consult resident and APP parallel process with the resident focusing on tPA administration/exclusion and the APP focusing on LVO clot extraction/exclusion. Once the acute imaging is done, the APP discusses the findings with ER radiology. If an LVO is found, the APP contacts the NIR attending and prepares the patient for thrombectomy. The APP also helps in tPA decision making and administration. If there is no LVO, the APP may leave the code stroke if the resident can manage the rest of the code on their own.

If there are multiple simultaneous code strokes, the APP can run a code stroke independently and touch based with the supervising attending about acute decision making. This frees up the consult resident do the other code stroke independently.

Vascular Neurology Wards

1-2 APPs carry their own load of, up to 10 each. When the service is busy, the intern’s list should be capped before the APP’s lists are. On weekends, the ward APPs may also respond to code strokes alongside the consult resident depending on the number of APPs in house that day.

NIR (Neurointerventional Radiology)

When working in NIR, the APP acts as a point person for stroke cases as well as assists in all NIR cases.

The APPs also assist in training junior neurology residents at the beginning of each academic year and are involved in academic projects that are presented at national and regional conferences.
Rhode Island Hospital Neurovascular Center
Stroke / Neurointerventional Radiology NPs/PAs

Gino Paolucci, NP
Lead Provider

Mike Clark, NP

Lindsey Fuller, PA

Lori Oliver, NP

Christina Watkins, NP

Katherine Quinn, PA
Code of Conduct

- Do onto others what you would have them do onto you
- Remember that your primary duty is towards your patient
- Remember that your behavior reflects on your co-residents, department, and specialty
- Except for PGY4s who take home call overnight, all resident must remain in house for the duration of their shift. Temporary leave from in house call for graduation ceremony and other activities must be cleared with the program directors