Lake Cumberland Regional Hospital
Internal Medicine Handbook

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1 Introduction
This document has been developed by the Internal Medicine Residency Program in order to familiarize residents with Lake Cumberland Regional Hospital and provide information about working conditions, key policies, procedures, and benefits affecting residency at Lake Cumberland Regional Hospital.

1.1 Welcome
Welcome to Lake Cumberland Regional Hospital! We are happy to have you as a new member of our family!

Abbreviations used in the Manual:
American College of Osteopathic Internists – ACOIM
American Osteopathic Association – AOA
National Match Service – NMS
Electronic Residency Application Service – ERAS
Osteopathic Graduate Medical Education – OGME
Osteopathic Postdoctoral Training Institution – OPTI
Post Graduate Year – PGY
Osteopathic Manipulative Medicine – OMM
Osteopathic Manipulative Treatment - OMT
Lake Cumberland Regional Hospital – LCRH
Council on Postdoctoral Training – COPT
Program Trainee Review Council - PTRC

1.2 Change in Policies
This manual supersedes all previous Internal Medicine Residency manuals and memos. While every effort is made to keep the contents of this document current Lake Cumberland Regional Hospital reserves the right to modify, suspend, or terminate any of the policies, procedures, and/or benefits described in the manual with or without prior notice to employees.

1.3 Orientation Schedule
All new residents are required to attend a New Resident Orientation prior to the start of residency training. Residents’ off-cycle will be scheduled to meet with individuals prior to their first rotation. New second and third year residents will meet with the program director prior to the start of the new academic year to review their goals and expectations for the upcoming year.

1.4 Educational Purpose
The Internal Medicine Residency is structured to provide the osteopathic Internal Medicine Resident with properly organized training programs that provide progressive primary responsibility for patient care in a family environment through continuity of didactic and clinical experiences. The training in the application of osteopathic principles and practice is an integral part of the program.

1.5 General Goals and Objectives
The specialty of Internal Medicine consists of the prevention, diagnosis and treatment of diseases with emphasis on internal organs of the body in the adult patient. The major goal of the osteopathic Internal Medicine Program is to achieve mastery of the following core competencies:

1. Osteopathic Philosophy and Osteopathic Manipulative Medicine
   a. Integrate osteopathic principles into the diagnosis and management of patients.
   b. Apply osteopathic manipulative therapy to patient management where applicable.

2. Medical Knowledge
   a. Demonstrate competency in the understanding and application of clinical medicine as it relates to patient care.
      i. Demonstrate a thorough knowledge of the complex differential diagnoses and treatment options of the Internal medicine patient.
      ii. Integrate the sciences applicable in family medicine experiences scientific applications of Internal medicine to clinical practice.
   b. Understand and apply the foundations of behavioral medicine as it relates to Internal Medicine.
      i. Demonstrate an ability to provide end of life care.
      ii. Identify and address the socioeconomic, ethnic, religious, and cultural aspects of illness and their impact on a patient’s clinical presentation and subsequent management.

3. Patient Care
a. Demonstrate an ability to rapidly evaluate, initiate and provide appropriate treatment for patients who are critically ill.

b. Demonstrate an ability to thoroughly evaluate, initiate treatment and provide appropriate long-term therapeutic recommendations to patients with chronic medical problems in both hospital and ambulatory settings.

c. Demonstrate an ability to make appropriate recommendations to promote health maintenance and disease prevention.

d. Demonstrate an ability to gather appropriate essential medical information from patient interviews, relevant medical records, examinations and testing.

4. Interpersonal and Communication Skills
   a. Exercise effective patient interview skills
   b. Demonstrate appropriate verbal communication with clarity, sensitivity, and respect,
   c. Create well organized, clear, succinct but thorough and legible medical records.
   d. Demonstrate an ability to interact with support staff in the hospital and ambulatory settings in a constructive, positive and effective manner.
   e. Identify methods to communicate with non-English speaking patients, and with those having sensory deficits (verbal, visual, and auditory).

5. Professionalism
   a. Identify the role of Internal Medicine as it relates to other medical disciplines.
   b. Develop the principles of appropriate ethical conduct and integrity in dealing with patients and the medical community.
      i. Identify potential areas of conflict of interest inherent in medical practice.
      ii. Demonstrate appropriate, judicious and efficient utilization of medical therapies, procedures, and testing without consideration of personal gain.
      iii. Demonstrate understanding of the implicit position of trust and authority into which patients often place the physician; recognize the ethical requirement to avoid exploitation of this trust either intentionally or unintentionally.
   c. Complete training in personal health information protection policies, and recognize their application in daily medical practice.
   d. Recognize the elements of religion, race, ethnicity, or cultural background in individual patients, and address them properly.
   e. Recognize the need for continuous quality of care in all patient populations, and demonstrate lack of discrimination.
   f. Provide medical care to those seeking it regardless of age, race, physical handicap or religious affiliation.

6. Practice-Based Learning and Improvement
   a. Develop professional leadership and practice management skills.
   b. Evaluate the progress of the training of the resident by using continuous assessment tools.
      i. Utilize systematic evaluation to include self study and assessment, individual trainee assessment, and outcomes analysis.
      ii. Participate in quality improvement programs and assessment activities in the hospital and ambulatory setting.
   c. Expose the resident to research methodology in Internal Medicine.
   d. Identify information technology applicable to the practice of medicine and research.
      Demonstrate the ability to effectively utilize such technology.
   e. Develop teaching skills in the Internal Medicine resident.
   f. Promote the development of commitment to habits of lifelong learning and scholarly pursuit in Internal Medicine.
   g. Prepare the resident to meet the eligibility requirements of the AOA to take the certification examination administered by the American Osteopathic Board of Internal Medicine.

7. Systems-Based Practice
   a. Develop in the resident the skills needed to practice within a system-based health care environment and to use the resources to deliver quality care.
   b. Understand the national and local health care delivery systems and how they impact on patient care and professional practice.
   c. Develop and promote advocacy for quality patient centered health care in complex systems.

1.6 Expected Outcome
   • To produce outstanding clinicians in the field of osteopathic Internal Medicine
   • To produce clinicians who are grounded in the “whole” patient.
Internal Medicine Residency Handbook

- To produce clinicians who are compassionate and embody what it means to be an osteopathic Internal physician
- To view the patient in their entirety, mind, body, and spirit.
- To produce clinicians who are proficient in all seven AOA Core Competencies
- To have a program that is compliant with all AOA basic standards and the standards of the ACOIM.
- To create an environment that fosters research opportunities as well as other scholarly pursuits.
- To train osteopathic Internal medicine physicians & prepare individuals for career goals in hospital based medicine.

1.7 Appointment

Appointments to the Internal Medicine residency program are made on the recommendation of the Medical Education Committee, the Program Director and the Director of Medical Education. Lake Cumberland Regional Hospital is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, national origin or handicapped persons who, with reasonable accommodation, can perform the essential functions of the job.

The residency application process at Lake Cumberland Regional Hospital is as follows:

a. Interested osteopathic medical school students must apply through the National Match Service (NMS) via ERAS;
b. Upon receipt of information requested on the NMS and available on ERAS, (i.e. three letters of professional reference, letter from your medical school Dean stating you are a student in good standing, board scores, and transcripts, the Resident Coordinators will contact applicants to arrange an appointment for an interview;
c. Resident applicants are interviewed by the Program Director, Administrative Staff, the Resident Coordinators;
d. Applicants are discussed at either the December or January Medical Education Committee Executive Session and either accepted or denied and a rank order list is generated;
e. Lake Cumberland Regional Hospital completes the National Intern Registration Match forms that are returned within the appropriate timeframe, usually in January;
f. Results of the Match are returned, usually in February. Resident contracts are mailed out within the time allotted by the AOA/NMS

g. Match regulations.

1.8 Advanced Placement

The Internal Medicine Residency Training Program follows the guidelines for residents requesting advanced placement of the AOA. A request for advanced placement must be received from both the resident and the program director at the advanced placement institution. This request must include the program director's assessment of the resident's academic status/equivalency and the resident's academic level in comparison to other residents at the training level if advanced placement were to occur. Determination of advanced placement within these guidelines shall be made by the Council on Education and Evaluation of the ACOIM and reported to the COPT. These guidelines are as follows: (Reference AOA Basic Standards for Residency Training in Osteopathic Internal Medicine).

1. The Program Director of the accepting program has the authority to determine which, if any, rotations from the previous program(s) will qualify for a request for advanced standing.
2. An AOA-approved internship or its equivalent is the prerequisite for acceptance into all ACOI OGME-2 and OGME-3 approved training.
3. Post graduate medical education training will be considered on an individual basis for advanced credit in osteopathic Internal medicine residency programs.
4. Residents entering osteopathic Internal Medicine residency programs who have taken previous residency training in accredited osteopathic or allopathic residency programs may request advanced placement of the Program Director.
5. The request for advanced standing will be reviewed by the Program Director, who shall forward requests to the ACOI Committee on Evaluation and Education. The ACOI Committee on Evaluation and Education shall report to the AOA PTRC all approvals for advanced placement. In no instance is the Program Director compelled to recommend advanced standing to the ACOI Committee on Evaluation and Education. Recommendations will be forwarded to the AOA PTRC.

1.9 Promotion Criteria

8
Intern:

**Patient Care:**
1) Prioritizes a patient’s problem
2) Prioritizes a day of work
3) Monitors and follows up patients appropriately
4) Demonstrates caring and respectful behaviors with patients and families
5) Gathers essential/accurate information via interviews and physical exams and reviews other data
6) Provides services aimed at preventing or maintaining health
7) Works with all health care professionals to provide patient-focused care
8) Knows indications, contraindications, and risks of some invasive procedures
9) Competently performs some invasive procedures

**Medical Knowledge:**
1) Uses written and electronic reference and literature sources to learn about patients’ diseases
2) Demonstrates knowledge of basic and clinical sciences
3) Applies knowledge to therapy

**Practice-Based Learning Improvement:**
1) Understands his/her limitations of knowledge
2) Asks for help when needed
3) Is self motivated to acquire knowledge
4) Uses PowerPoint, Word, Internet and other computerized sources of results and information; such as, “Up-to-Date” to enhance patient care
5) Accepts feedback and develops self-improvement plans

**Interpersonal and Communication Skills:**
1) Writes pertinent and organized notes
2) Has timely and legible medical records
3) Uses effective listening, narrative and non-verbal skills to elicit and provide information
4) Works effectively as a member of the health care team

**Professionalism:**
1) Establishes trust with patients and staff
2) Does not refuse to treat patients
3) Is honest, reliable, cooperative and accepts responsibility
4) Shows regard for opinions and skills of colleagues
5) Is free from substance abuse or satisfactorily undergoing rehabilitation
6) Demonstrates respect, compassion and integrity
7) Is responsive to the needs of patients and society, which supersedes self-interest

**Systems-Based Practice:**
1) Is a patient advocate
2) Makes constructive comments
3) Advocates for high quality patient care and assists patients in dealing with system complexity

Second Year Resident:

**Patient Care:**
1) 1 through 7 of PGY 1; and,
2) Understands and weights alternatives for diagnosis and treatment
3) Uses diagnostic procedures and therapies appropriately
4) Elicits subtle findings on physical examination
5) Obtains a precise, logical and efficient history
6) Interprets results of procedures properly
7) Is able to manage multiple problems at once
8) Makes informed decisions about diagnosis and therapy after analyzing clinical data
9) Develops and carries out management plans
10) Considers patient preferences when making medical decisions
11) Triages patients to appropriate location
12) Competently performs an increasing number of invasive procedures
13) Knows indications, contraindications and risks of an increasing number of invasive procedures

**Medical Knowledge:**
1) 1 through 3 of PGY 1; and,
2) Is aware of indications, contraindications and risks of commonly used medications and procedures
3) Demonstrates knowledge of epidemiological and social-behavioral sciences
4) Complete and Pass COMLEX III

Practice-Based Learning Improvement:
1) 1 through 5 of PGY 1; and,
2) Undertakes self-evaluation with insight and initiative
3) Facilitates the learning of students and other health care professionals

Interpersonal and Communication Skills:
1) 1 through 3 of PGY 1; and,
2) Creates and sustains therapeutic and ethically sound relationships with patients and families
3) Provides education and counseling to patients, families and colleagues
4) Is able to discuss end of life care with patient/families
5) Works effectively as a member or leader of the health care team

Professionalism:
1) 1 through 7 of PGY 1; and,
2) Displays initiative and leadership
3) Is able to delegate responsibility to others
4) Demonstrates commitment to on-going professional development
5) Demonstrates commitment to ethical principles pertaining to the provision or withholding of care, patient confidentiality, informed consent and business practices
6) Demonstrates sensitivity to patient culture, gender, age, preferences and disabilities
7) Acknowledges errors and works to minimize them

Systems-Based Practice:
1) 1 through 3 of PGY 1; and,
2) Applies knowledge of how to partner with health care providers to assess, coordinate and improve patient care
3) Uses systematic approaches to reduce errors
4) Participates in developing ways to improve systems of practice and health management

Third Year Resident:

Patient Care:
1) 1 through 11 of PGY 2; and,
2) Competently performs AOBIM required invasive procedures
3) Knows indications, contraindications and risks of all AOBIM required invasive procedures
4) Spends time appropriate to the complexity of the problem

Medical Knowledge:
1) 1 through 6 of PGY 2; and,
2) Demonstrates an investigatory and analytic approach to clinical situations

Practice-Based Learning Improvement:
1) 1 through 7 of PGY 2; and,
2) Analyzes personal practice patterns systematically, and looks to improve
3) Compares personal practice patterns to larger populations
4) Locates, appraises and assimilates scientific literature appropriate to specialty
5) Applies knowledge of study design and statistics

Interpersonal and Communication Skills:
1) 1 through 4 of PGY 2
2) Works effectively as a leader of the health care team

Professionalism:
1) 1 through 7 of PGY 2; and,
2) Is effective as a consultant

Systems-Based Practice:
1) 1 through 4 of PGY 2; and,
2) Demonstrates ability to adapt to change
3) Provides cost effective care
4) Understands how individual practices affect other health care professionals, organizations and society
5) Demonstrates knowledge of types of medical practice and delivery systems
6) Practices effective allocation of health care resources that does not compromise the quality of care

1.10 Qualifications

All residents shall be graduates of an approved college of osteopathic medicine and shall make application on the forms provided by the NMS for prospective candidates. Residents must be members of the American Osteopathic Association (AOA) and American College of Osteopathic Internal Medicine (ACOI), and maintain membership throughout residency.

The residency training program in Internal Medicine is thirty-six (36) months in duration, with the first year consisting of an AOA-approved internship or its equivalent in an institution in which an AOA-approved internal medicine residency exists and which meets the criteria for approval by the ACOI and the AOA. Prior to starting residency, all residents must pass Comlex Step II, including the clinical skills portion of this exam. Residents must pass Comlex Step III, prior to the start of their post-graduate year two. Residents must be appropriately licensed in the state in which the training is conducted.

1.11 Terms of Service

Internal Medicine Residency training is thirty-six (36) months. The contract will be issued for a period of one year. Contracts for the next year of training will be issued in February of each year upon satisfactory performance during the current year. The Program Director, Director of Medical Education and the Graduate Medical Education Committee will determine if continuation in the training program will be granted.

Under qualifying circumstances, residencies may be extended through the Family Medical Leave Act. All leaves must be reported to the Program Director and the Director of Medical Education, the Graduate Medical Education Committee, Human Resources and the subcommittee on Residency Training of the American Osteopathic Association. All additional time taken off during residency must be made up at the end of the contract year and prior to the next level of training. Refer to Resident Manual for contract contents.

1.12 Status

You are an employee of the hospital. As a resident employee, you are responsible to the Board of Trustees through the Director of Medical Education. The hospital is liable for your acts. Remember – during your first year of training, you do not have a license to practice medicine outside of the institution unless on a rotation approved by the Program Director and the Department of Medical Education. You will not be covered by malpractice insurance unless you are on an approved rotation. Under no circumstances may the resident engage in moonlighting, i.e. employment outside of the hospital. Moonlighting is grounds for immediate termination.

1.13 Educational Stipend

Each resident will be allocated a specific dollar amount as outlined in the letter of appointment to be used for educational expenses during each year of training. These dollars will not carry over into the next academic year. Funds will be available July 1st of each academic year. The following is a list of acceptable items that can be counted toward these educational dollars:

<table>
<thead>
<tr>
<th>Will be Approved:</th>
<th>Will NOT be Approved:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Textbooks</td>
<td>Digital Camera</td>
</tr>
<tr>
<td>Medical Journal Subscriptions</td>
<td>CD Burner</td>
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<tr>
<td>Computer</td>
<td>Office Supplies</td>
</tr>
<tr>
<td>PDA (Palm Pilot)</td>
<td>Lab coat altering/dry cleaning</td>
</tr>
<tr>
<td>Medical computer software</td>
<td>Flash drives</td>
</tr>
<tr>
<td>Computer printer</td>
<td>Computer/Palm batteries</td>
</tr>
</tbody>
</table>
Computer scanner
Medical conference registration
*Airfare, hotel, meals (medical conference related)
State licensing fees
Board application fees
AOA/ACOI dues
Board review audio/video tapes
Gas mileage (rotations, meetings)

*****Educational stipends may be subject to applicable taxation*****

*All conferences must be approved in advance by the Director of Medical Education and all travel arrangements must be made by the GME Office after approval is obtained. If the resident is unsure whether an expense can be counted toward these educational dollars, they are responsible for speaking with the Administrative Director or Director of Medical Education prior to the purchase of such item.

To be reimbursed for educational expenses, the resident must complete an “Employee Expense Form” (Appendix 9.9), sign and attach the original receipt(s). Return completed form and receipts to the Administrative Director for further processing and tracking of educational expenses. Note: Educational stipends may be subject to applicable taxation.

1.14 Time Away
Residents are allocated twenty (20) paid time off for personal reasons during each academic year of training. The following is a list of acceptable personal days:

<table>
<thead>
<tr>
<th>To be used for:</th>
<th>Do not need to be used for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacation/Personal Days/Illness/holidays</td>
<td>Holidays – when on call</td>
</tr>
<tr>
<td>Medical conferences</td>
<td>Boards – preceptor excused – exam days only</td>
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<tr>
<td>Interviews</td>
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- All requests for time off must be submitted two weeks prior to the requested time off or within 24 hours of returning from a sick day. Failure to comply will result in these days being made up during the weekend. All notification of time away must be communicated in writing.
- If you request time off on a day when you are scheduled for call – you are NOT excused from call. You must find someone to take your call and make that day up at another time. TIME AWAY DOES NOT EXCUSE YOU FROM CALL.
- You may not take more than one week vacation at a time.
- You may not take time off after June 15th of each academic year, unless prior arrangements are made with the Program Director.
- If a resident is assigned an outpatient clinic, notification of time off must be reported to the Clinic one (1) month prior to the requested leave.

1.15 Absences
(Refer to the Residency Manual, Section 8 – Time-Off Benefits)

The resident will not be permitted to leave the hospital premises other than during off-duty hours without the permission of the Program Director, Director or Administrative Director of Medical Education or Administration.

If it becomes necessary for a resident to leave the premises during duty hours, permission must be first obtained as stated above. The resident must arrange for another resident to cover the service, notify the switchboard and nursing station involved that you will be off the premises, and the name of the resident covering the service.
Upon returning to the hospital, the resident is to notify the switchboard, the Department of Medical Education and the nursing station, that you are back on duty.

1.16 Illness
If a resident is unable to report to duty due to illness, he/she is to notify the Program Director, Department of Medical Education, the attending physician that the resident is rotating with and the switchboard. The resident may be required to go to the Emergency Room for an examination. (Refer to the Residency Manual, Section 8)

1.17 Unauthorized Absence
An unauthorized absence from duty will result in disciplinary action. Any unauthorized absence of three or more consecutive business days will constitute a voluntary resignation from the program.

1.18 Revocation of Off-Duty Hours
In the case of delinquent medical records, or other incomplete work, the resident may be assigned extra call by the Program Director, Director of Medical Education or the Medical Education Committee Chairman, pending the completion of work

1.19 Internal Medicine Residency Training Program Director
The Internal Medicine Residency Training Program Director must be qualified to manage and direct residents in a graduate medical education program within the residency training requirements of the American Osteopathic Association and applicable laws and regulations.

The Clinical Program Director is directly responsible for the overall program administration of the Internal Medicine Residency Program.

**Qualifications:**

1. The Program Director must be licensed to practice medicine in the state in which the training site is located.
2. The Program Director must be certified in Osteopathic Internal Medicine and Osteopathic Manipulative Treatment by the American Osteopathic Board of Internal Medicine Physicians.
3. Due to the necessity for continuing interaction with osteopathic Internal Medicine colleagues in order to keep abreast of developments within the specialty, the Program Director must be a member in good standing of the American College of Osteopathic Internal Medicine.
4. The Program Director must be an active member of the department of Internal Medicine or its equivalent, and engaged in patient care.
5. The Program Director must demonstrate experience and/or interest in the field of medical education as well as administrative ability and sufficient expertise to implement educational programs.
6. The Program Director must meet the standards of the position as formulated in the AOA Accreditation Document for Osteopathic Training Institutions (OPTI) and the Basic Documents for Postdoctoral Training Programs.
7. The Program Director shall have no less than three (3) years Internal Medicine experience (not including time as a resident), prior to becoming a Program Director.
8. A new Program Director of a residency with more than twelve approved slots shall fulfill one of the following:
   a. Have served as Program Director of another residency for no less than three (3) years.
   b. Have served as Associate Program Director of a residency for no less than three (3) years.
9. A new Program Director must be approved by the ACOI Committee on Evaluation and Education prior to assuming the position.

10. Exceptions to the requirements for Program Director may be approved by an ad hoc committee of the ACOI Committee on Evaluation and Education.

Responsibilities:

1. The Program Director must have sole responsibility and authority for the educational content and conduct of the residency. The Program Director’s authority in directing the residency program must be defined in the program documents of the institution. The Program Director must fully implement the basic standards for residency training in osteopathic Internal Medicine and osteopathic manipulative treatment as outlined in this document.

2. The Program Director and Director of Medical Education shall provide for the proper supervision and clinical teaching of all training assignments in the continuity of care clinic. Continuity of the faculty is to be encouraged.

3. The Program Director shall assure the arrangement of affiliations and/or outside rotations necessary to meet the program objectives.

4. The Program Director will maintain the ratio of qualified full time employee supervisors to the total number of residents in the program at a minimum of 1:6.

5. The Program Director shall, in cooperation with the AOA Department of Education, prepare required materials for inspection in advance of each inspection, and be available for the scheduled review.

6. The Program Director shall provide each resident with a resident manual, which shall contain all documents pertaining to the training program as well as the requirements for the satisfactory completion of the program.

7. The Program Director must report annually by August 1 to the ACOI Committee on Evaluation and Education. This report shall contain documentation of all residents in the program along with other information as specified on a form furnished by ACOI.

8. The Program Director must verify that the resident demonstrates competency in meeting or exceeding the minimum standards for quality patient care utilizing the competency-based evaluation.

9. The Program Director must report to the ACOI Committee on Evaluation and Education deficiencies in the residency or internal problems in the parent institution that could adversely affect the educational component of the residency.

10. The Program Director must devote a minimum of 400 hours per year to teaching and administrative activities exclusive of patient care.

11. The Program Director must assure that he/she and/or the Internal Medicine faculty is qualified to perform and teach all the required procedures listed in the ACOIM and AOA Basic Standards for Residency Training in Osteopathic Internal Medicine and Manipulative Treatment, Article V, Program Requirements, Section F, Procedures.

12. The Program Director must assume leadership for the coordination of inspections as required by the AOA.

13. The Program Director or physician designee:
   a. Must attend a residency director’s workshop sponsored by the American College of Osteopathic Internal Medicine Physicians every year in order to qualify the residency program for approval. Each Program Director must personally attend at least every two (2) years.
   b. Must attend a regional or national procedural institute, sponsored by the ACOI every two (2) years.
   c. Must documented travel and other expenses related to (a) and (b), above, not to exceed $2,500 each residency training year, will be reimbursed directly to the physician attending the event upon submission of a properly completed expense report.
1.20 Internal Medicine Residency Training Supervisor

The Training Supervisor of the continuity of care site of the osteopathic Internal Medicine residency must:

1. be an osteopathic physician;
2. a member of the ACOI;
3. be certified by the American Osteopathic board of Internal Medicine Physicians;
4. have been in active osteopathic Internal Medicine for at least six (6) years, or a graduate of an ACOI approved osteopathic Internal Medicine residency program;
5. be able to teach procedures incorporated in the specific continuity of care site;
6. be certified in osteopathic Internal Medicine and manipulative treatment by the American Osteopathic Board of Internal Medicine Physicians (AOBIM);
7. will report to the Director of Medical Education (DME) at Lake Cumberland Regional Hospital;
8. is responsible for reviewing all resident notes and writing an attending note on all patients;
9. will perform monthly chart reviews with the residents to ensure that the clinic charts are in compliance with AOA and ACOI guidelines;
10. will review resident charts to ensure that each chart has a current medicine list, problem list, yearly history and physical with osteopathic structural exam and documentation of OMT when performed;
11. must be licensed to practice medicine in the state in which the training site is located;
12. must be an active member in good standing in the Department of Internal Medicine at Lake Cumberland Regional Hospital;
13. must be present at the Internal Medicine clinic at all times when residents are seeing patients, i.e. when resident clinics are in session;
14. is responsible for clinical teaching during clinic sessions as well as at least one lecture per month to Internal Medicine residents on selected Internal Medicine topics;
15. must maintain adequate records at the Internal Medicine training site so that each resident is provided quarterly with his/her gross billings, diagnosis distribution, net income and procedure distribution;
16. must be willing to precept medical students, interns and residents on IM clinical rotations as IM training supervisor schedule permits;
17. must complete all paperwork as dictated by the ACOI (annual reports, quarterly evaluations, etc.).

2 Didactic Programs

2.1 Meeting and Lecture Requirements

Residents are required to attend a minimum of 80% of all meetings/lectures as directed by the program director and participate in major committee meetings, in addition to participation in institution intern/student education programs.

An attendance record of 80% at all such programs is required for successful completion of the Internship/Residency program. Disciplinary action and/or additional training may be required if interns are found delinquent. Attendance is a requirement of your employment. Failure to attend violates your contractual relationship with the Hospital.

All in-house Residents will attend the following didactic sessions. Residents on out-of-house rotations will attend (M W,F) educational programming as their rotation schedule permits unless excused by program director. Residents on out-of-house rotations must then attend didactic sessions at host site and submit logs of educational activities.

You are also required to attend your assigned committee meetings such as, Quality Assurance, Pharmacy and Therapeutics, etc. You will receive this assignment during orientation or at the start of each academic year. (Special Pathology Conferences). Grand Rounds and Morning Lectures:

Monday through Friday 7 a.m. Noon and Midday Lectures: Per Residency Training Requirements. CME Programs: Medical Section, Clinical Pathology Conference, Department Journal Club, On-service X-ray Conference,
Tumor Conference, General Medical Staff Meetings and Department Meetings.

Failure to comply may result in incomplete credit for the training year and failure to receive a certificate. Residents with less than 80% attendance at lectures will not be allowed to do outside elective rotations.

Attendance will be recorded for the following lectures – all lectures will be held in the Classroom unless otherwise noted on the Lecture Schedule.

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Journal Club</td>
<td>2nd &amp; 4th Friday Afternoon</td>
</tr>
<tr>
<td>SAM’s Club</td>
<td>Every Friday Afternoon</td>
</tr>
<tr>
<td>MKSAP Board Review</td>
<td>1st &amp; 3rd Friday</td>
</tr>
<tr>
<td>Regional Grand Rounds</td>
<td>Once Monthly</td>
</tr>
<tr>
<td>Morning Report/Case Presentations</td>
<td>Tuesday, Wednesday Thursday, mornings</td>
</tr>
<tr>
<td>EKG Conference</td>
<td>Third Monday of every month</td>
</tr>
<tr>
<td>Osteopathic Manipulative Medicine Lecture</td>
<td>Second and Fourth Thursday of every month</td>
</tr>
<tr>
<td>Medical Topic Lectures</td>
<td>Monday, Thursday 12:00 – 1:00</td>
</tr>
<tr>
<td>House staff Meetings</td>
<td>Third Wednesday of every month</td>
</tr>
</tbody>
</table>

➢ To be excused from required lectures, please leave a message for the Department of Medical Education.
➢ If you have an emergency and cannot attend a lecture, please notify the Department of Medical Education by noon for missed morning lectures and by 4 p.m. for missed noon lectures.

2.2 Attendance Rosters

Attendance rosters will be prepared for each meeting, conference, and lecture, etc., which the resident is required to attend. These are specifically designed for the residency-training program. In order to document your training for the American Osteopathic Association, it is mandatory that these rosters be completed and personally signed by those residents who are in attendance.

2.3 Journal Club

Journal Club is an integral element in any medical training center. It directs education to externs and interns, as well as attending physicians and reviews current literature on specific medical problems. Journal Club is held in multiple departments, and attendance is mandatory when the intern is on service.

The format consists of house staff members presenting interesting cases to their peers. Residents review articles in the four journals recently released the month preceding the review. These journals are the JAMA, American Journal of Internal Medicine and the New England Journal of Medicine. In addition, subspecialty journals are reviewed by all IM residents and formally presented to the IM Director and invited subspecialty physicians. Each resident is assigned a journal to read and determine which articles are pertinent to the IM program. This review is opened to all house staff. In this format, review articles are evaluated as well as original articles critiqued for their significance in information, their type of set up for research, the number of people evaluated, and how well their tables and graphs correlate to their conclusion. The article should be critiqued on its content, as well as how information was gathered and techniques involved. The case presented should be first discussed with the attending physician and, if possible, have the attending physician or active physician in the case be present at the Journal Club.

Attendance sheets are to be signed and completed with date, time, topic, and presenter’s name and then sent to the Department of Medical Education for CME credit.

2.4 Morbidity/Mortality
Morbidity & Mortality conference will be faculty lead chart reviews from cases provided by the Utilization Management/Quality Counsel committee and conducted under peer review protocols with Risk Management and Utilization/Quality staff also in attendance.

2.5 Morning Report/Case Presentations

Case Presentations

1. The presenting intern with the junior/senior resident should choose a topic at least fourteen (14) days prior to the scheduled presentation.
2. The topic should pertain to a recent case.
3. The topic should reflect that intern’s clinical exposure.
4. The topic should be very narrow and precise.
5. Upon choosing a topic, prior to proceeding with preparation, it should be reviewed and accepted by the Program Director.
6. Each accepted topic will then be given to the Medical Education Office for announcement purposes at least five (5) days prior to the scheduled presentation.
7. The presenting intern/resident should have pertinent materials available on the day of the lecture (projectors, x-rays, scans, etc.).
8. A written bibliography is to be distributed at the lecture.
9. It is encouraged, but not required, to have handouts including graphs, outlines and diagrams.
10. Each prepared topic should have been reviewed in the recent literature as available from Index Medicus.

Morning Report

Interns, residents and students coming on duty at 7:00 a.m. are to assemble in the designated meeting room for morning report at 7:00 a.m. daily. Residents are expected to be present. The intern coming off of night call will write the name of admissions (patient initials) on the dry erase board at the front of the classroom, and review pertinent symptoms with the interns coming on duty.

Scheduled educational session occurs at 7:30 a.m. daily. This will include presentations by residents, interns, students and staff physicians on practical medical and surgical problems. After this, the interns and students should all go to their respective floors and make rounds on their patients, spending time as needed to evaluate changes or see new patients. Progress notes should be written on all of the assigned patients in preparation for teaching rounds with the trainers.

2.6 Grand Rounds

Grand Rounds will be simulcast via teleconference/closed circuit TV from UPIKE. Topics vary annually but include local, regional and worldwide medical experts, who will discuss topics, review cases and share research results. Residents assigned to in-house rotations are required to attend.

2.7 Tumor Board/IM Lecture Series

Tumor Board occurs on the first and third Wednesday of each month with residents and faculty presenting and reviewing complex oncology cases. The residents will present the clinical case and faculty from LCRH, UPIKE and staff physicians will lead a multi-disciplinary discussion including review of literature, therapeutic options for treatment including medical, radiation and surgical oncology options.

The IM Lecture series occurs on Friday mornings from 7-8 am. The focus is on “the physician as teacher”. Resident or faculty lecturers will review a medical topic with PowerPoint presentation. Topics are selected in advance from the required curriculum and approved by the program director. Alternate topics may be assigned in discussion with the program director. Presenters will review the medical literature as related to their topic; major studies and scientific advances in treatment will also be presented as appropriate. Handouts and bibliography will be included. Residents will be evaluated on PowerPoint slides, time utilization, and Q/A sessions with the audience and public speaking in addition to review of medical literature, accuracy and completeness of presentation. Formal evaluations will be maintained by the resident as part of their portfolio and by the Medical Education Department.
2.8 OMM Lecture

Twice monthly, the Medical Education Department and Internal Medicine Department will provide formal lecture and hands-on laboratory to review basic and advanced osteopathic techniques. All G-1 IM residents are required to attend unless excused by the Medical Education Department. G-2/G-3 residents may attend and may also serve as faculty for the purposes of review and technique review with their G-1 colleagues. All IM residents will also attend regional OMM/OPP reviews as selected and approved by the program director in order to meet their OMM/OPP training requirements.

2.9 Admissions Rounds

The admission rounds are an integral element in any training center. It is to inform the intern staff of current, interesting cases presenting to the hospital on the floor, as well as problem cases. Included should be a case presentation, differential diagnosis, current work-up and future work-up with prognosis. Discussion should occur with these cases to have everyone learning from the case.

The attending physician should be notified in advance when their case is to be presented so they may attend and contribute in the teaching.

Attendance sheets should be signed and dated; topic and presenter should also be noted and forwarded to the Department of Medical Education.

The guidelines for Admission Rounds may be summarized as follows:

1) Scheduled in accordance with the monthly lecture schedule.
2) Multi-disciplinary approach (medicine, surgery, etc.)
3) Student and intern discussion of differential diagnosis and management plan.
4) Brief presentation by the intern reviewing the salient features of the case.
5) Four to five cases should be presented.

3 Comportment

3.1 Area of Responsibility

1. Residents are responsible for their respective service between 7 a.m. – 5 p.m. daily.
2. Residents are responsible for making sure orders are written and reviewed if written by an intern for patients admitted to their service during the day and while on call for all unit patients on IM/FM services or co-managed by IM/FM physicians.
3. History and physical forms are not the responsibility of the resident.
4. Residents are required to review the admit notes of all admissions to their service and discuss them with the interns and students. Residents will have a note written to supplement the admit note on all unit patients on IM/FM service or co-managed by an IM/FM physician with a plan or recommendations when on call.
5. Residents are to round on their service patients daily, unless scheduled off and either review the note written by interns/students or write the daily progress note.
6. Residents when on an in-house rotation are to actively participate in morning report.
7. Residents are to attend all in-house lectures, unless a patient’s well-being is at risk.
8. Residents are not to work more than 80 hours per week. They cannot exceed 32 hours on call/work without 12 hours off. Residents are to have one complete weekend off per month.
9. Coverage of new residents by Jr./Sr. residents shall be for a period initially of 3 months.
10. When a resident is called to admit a patient, the attending must be called to go over the admission by that resident.
11. It is not the responsibility of the resident to review ER’s, EKGs, or lab work on patients not admitted.
12. Medicine residents are not responsible for pediatric patient care unless it is a “Code Blue”.
13. It is not the resident’s responsibility to obtain DNR’s on patients unless they are admitting the patient or it is a new change of the family’s thinking or the patient’s wishes. The resident is not to discuss the DNR with families of patients that they are not acquainted with their progress. This is the responsibility of the attending physician.
14. Residents cannot take verbal orders from Internal Medicine physicians that have patients in the unit. They must discuss the case with the physician or subspecialist who is managing the patient in the unit.
15. The residents are to assume the role assigned by the attending physician when on service and to notify the attending or any acute change in the patient’s condition.
16. Residents are to respond to all Codes within the hospital.

3.2 Call Responsibility
1. 1st, 2nd and 3rd year residents will provide unit coverage from 5 p.m. – 7 a.m. daily. This includes admissions, as well as, complications that develop. 1st year residents are not responsible for consults unless specified by the attending.

2. Residents must see and enter an admit note on all admissions while they are on call.

3. The emergency room physicians will discuss the patient with the attending first before the resident is to be involved in that patient’s care.

4. Residents are not responsible for consultations (medical) at night (5 p.m. – 7 a.m.) unless it is urgent.

5. Residents are not to have call more frequently than once every five days.

6. Attendings are to be second on call for all residents.

7. Residents call is between 5 p.m. – 7 a.m. on Monday through Friday and 7 a.m. – 7 a.m. on Saturday and Sunday. On designated holidays (i.e. 4th of July, Labor Day, Thanksgiving, Christmas, New Years Day, and Memorial Day) call will be 7 a.m. – 7 a.m.

8. On weekends the residents will evaluate all unit patients under IM service or with co-manage with the IM service and conduct daily care under the supervision and wishes of the respective attending.

9. If an internist has a patient in the unit who is critical, they may sign out to the evening resident if that particular internist does not have a resident or intern on their service. However, if a student/intern is on the service, they are also responsible to sign out to the evening resident.

10. It is the duty of the medical resident on call to evaluate all the patients in the unit who have an acute change, enter a note, and notify the attending if warranted between 5 p.m. – 7 a.m. on call.

11. If an acute situation in the unit occurs and supervision or input is needed and the attending is unable to be reached, then either the Chairman of Medicine or the Director of the unit are to be called for that input or supervision until the attending has responded.

12. No patient is to be admitted to the unit unless verified or approved by the patient’s respective attending (managing the patient in the unit).

13. Residents are not to be called to order routine lab work, x-rays, or EKGs on patients when on call.

14. If a patient is directly admitted to the unit, orders are to be entered by the attending or the attending is to call the resident with a history and preliminary diagnosis and the resident will enter the orders.

### 3.3 Procedures

Residents are provided the opportunity to perform procedures as they arise. Residents are expected to become proficient in the following procedures:

1) Sufficient experience and training to ensure proficiency in the following procedures, including indications, contraindications, complications, limitations and interpretation:
   a. Osteopathic manipulative treatments
   b. Incision and drainage of abscess
   c. Biopsy of skin
   d. Cryosurgery of skin
   e. Curettage of skin lesion
   f. Laceration repair
   g. Injection of shoulder joint
   h. Injection/aspiration of knee joint
   i. Office microscopy
   j. EKG interpretation
   k. Office Spirometry
   l. Defibrillation
   m. Removal of cerumen from ear canal
   n. Insertion of urethral catheter
   o. Endotracheal Intubation
   p. Central Venous Line Placement
   q. PICC line Placement

2) Optional Procedures:
   a. Vasectomy
   b. Vaginal delivery
   c. Episiotomy repair
   d. Flexible sigmoidoscopy
   e. Colonoscopy
   f. Lumbar puncture
   g. IUD insertion
   h. Breast Cyst Aspiration
   i. Epistaxis Management (Nasal Packing/anterior cautery)
   j. Trigger point injections
Formal lectures, hands-on labs and videotape procedure demonstrations are used to introduce the procedure and review anatomy and indications/contraindications of the procedure. Residents are assigned or designated as the “procedure resident” on the in-patient service rotation. This arrangement rotates on a monthly basis and residents are directly supervised by attending staff until proficiency develops.

Residents will develop procedural skills on elective rotations; such as, cardiology, pulmonary, nephrology, gastroenterology, radiology and hematology under the direct tutelage of the attending physicians. Additional skills in intubation and central lines are obtained, if needed, with the assistance of the anesthesiology department, by assigning the resident to the department in the morning hours from 0700-1000 to perform intubations, central lines and peripheral IV access.

Mastery of skills is demonstrated during the second residency year on ICU and Hospitalist services, resident logs are reviewed and the resident is signed off as independent in the procedure and the medical staff office will be notified in writing.

- All procedures are done under the supervision of an attending physician who is responsible for the care of that patient. This supervision can be direct or indirect, depending on the experience of the resident.
- Do not start any non-emergency procedure until you obtain permission from the responsible attending physician.
- Interns should have first opportunity to do procedures on patients assigned to their care.
- Informed consent must be obtained before starting unless it is an emergency.
- Procedure notes must be entered immediately after the procedure.
- Procedure logs must be completed by the resident and signed by the supervising resident/attending.
- Each time a procedure log is reviewed, the program director will assign a privilege status as follows:
  - Level I = Direct supervision only – PGY 1
  - Level II = Perform and teach with indirect supervision – PGY 2
  - Level III = Perform with indirect supervision; can teach and certify others – PGY 3

Residents unable to master their skill level as indicated above will be assigned additional procedure assignments until such time that the level is mastered. Those residents in their PGY 3 level will not be eligible for graduation. Individual adjustments and accommodations are made on a case-by-case basis for those residents unable to master the skills as indicated above and additional training options are constantly evaluated.

### 3.4 Moonlighting

Members of the intern staff are expected to devote themselves entirely to the service of the Hospital and its training program. During their period of service they CANNOT participate in any outside activities of a professional nature except educational, and that only with the permission the Director of Medical Education.

They shall not be permitted to participate in private, professional, or clinical practice wherein they or others collect compensation for an intern’s services. Moonlighting will be considered just cause for termination of the intern’s contract.

Interns operate under a restricted training license that allows their practice of medicine only within the approved Intern Training Program of Lake Cumberland Regional Hospital.

Residents may Moonlight provided they have obtained a full, unrestricted medical license and DEA number and only with the expressed, written consent of their Program Director provided such activities do not interfere with their training obligations. House Officers who moonlight are responsible for their own medical malpractice insurance coverage while engaged in moonlighting activities.

### 3.5 Chief Resident Job Description

The Chief Resident for the Internal Medicine Residency Program will be nominated by the Program Director upon consultation and advice from the Graduate Medical Education Committee, Director of Medical Education and the Administrative DME (ADME). It contains both a leadership and administrative position meant to improve and facilitate the training programs for medical students, interns and residents at Lake Cumberland Regional Hospital.

Qualifications:

1. Resident in good standing at Lake Cumberland Regional Hospital preferably in their senior year of training.
3. Demonstrates an interest and participation in the educational programs at Lake Cumberland Regional Hospital. Demonstration of excellent rapport with peers.
4. Approval for acceptance of the position of Chief Resident by the applicant’s Program Director.
5. Demonstrates and participates in scholarly activity, as well as possessing the work habits appropriate and consistent with the mentoring responsibilities of the position.
6. Willingness and ability to attend training and skill development courses or CME as suggested by the DME/ADME to prepare and guide the applicant in performing their duties as Chief Resident.

Responsibilities: (Inclusive of but not limited to)
1. Assist in development of the Resident rotation schedule.
2. Is responsible for scheduling topics for IM lectures, journal club and board review.
3. Assist in development of and supervision of the Resident on-call schedule.
4. Act as liaison between the Department of Medical Education and all House Staff Officers, Medical Students and Allied Health Students.
5. Act as liaison between House Staff Physicians and Nursing Staff.
6. Attend all Graduate Medical Education Committee meetings (usually the 3rd Friday of the month).
7. Must keep all logs and inpatient and outpatient charts current.
8. Actively mentor the House Staff, Medical Students and Allied Health Students in the areas of scholarly activity, professional/ethical behavior and work habits. The Chief Resident(s) is/are directly responsible to the Director of Medical Education (DME). In the absence of the DME, the Chief resident is responsible to the Program Director, Administrative DME, the Chairperson of the Graduate Medical Education Committee, and the Vice President of Medical Affairs, in this order.
8. Introduce all Guest Lecturers/Presenters at Morning and Noon lectures.
9. Serve as member of Peer Review Committee, subcommittee of the GME Committee as needed.
10. Assist with development and procurement of resources to support Medical Education Activities at Lake Cumberland Regional Hospital.
11. Attend House Staff meetings monthly.

Compensation:
Chief Resident Stipend: $1,000 annually
Terms of appointment: July 1, 20__ through June 30, 20__

3.6 Research Responsibility
Residents may meet the requirement by demonstration and documentation (via Portfolio) of any of the following:

1. Resident research projects within the department of Internal medicine.
2. Institutional research programs in which the department of Internal medicine is actively involved.
3. Area-wide or multi-centered research projects involving the teaching institution and its department of Internal medicine.
5. Presentation at a state, regional or national meeting.
6. Authoring a grant.

Goal:
To provide the resident with research opportunities that will provide an awareness of the basic principles of study design, performance, analysis, and reporting, as well as of the relevance of research to patient care.

Objective:
The resident will demonstrate competency in his/her ability to:
1. Understand the concepts and principles behind evidence based medicine.
2. Critically evaluate medical literature and its applicability to clinical practice.
3. Participate in scholarly activities and convey findings to his/her peers.

4 Continuity Clinic
**Goals:** To create an Internal Medicine Clinic experience designed to prepare Internal Medicine Residents for osteopathic practice. The Clinic will facilitate the diagnostic and therapeutic skills of physicians in training utilizing patients representing the full spectrum of Internal Medicine.

### 4.1 Overview

Internal Medicine Residents are required to attend continuity clinic forty-four (44) weeks per academic year. The residents will be supervised by an attending internist. Cases will be discussed and all electronic charts will be reviewed. The resident will be exposed to a broad spectrum of medical diagnoses and will be taught to apply the concepts of disease prevention and health maintenance.

Residents are required to maintain an ambulatory log that will be maintained in each resident's personnel file. These logs must contain the patient's medical record number, diagnosis and the activity and/or procedure performed on each visit.

Number of patients seen per half day period, will be as follows:

- PGY 1 = 2 new patient; 2 existing patients
- PGY 2 = 2 new patients; 4 existing patients
- PGY 3 = 2 new patients; 5 existing patients

Residents will maintain approximately fifty (50) patients per year in their patient panel.

Residents will be evaluated on a semi-annual basis using the 360° evaluation process. Residents will be evaluated by their attending physician, clinic staff and their patients.

The resident will be exposed to osteopathic concepts, behavioral and psycho-social aspects of medical care, medical ethics, medical-legal implications and practice management throughout the course of their training through lectures and discussions.

Residents will be notified of the patient's admission and will follow their patient's admission throughout the course of the patient's stay.

Residents will be evaluated by the attending physician on their ability to perform a comprehensive history and physical examination, including structural examination for somatic dysfunction, pelvic exam, rectal exam, breast exam and male genital exam.

### 4.2 Teaching Objectives

Residents will learn skills required to:

1) Provide continuity primary and consultative care
2) Office procedural skills
3) Understanding and proficiency in proper documentation
4) Understanding and proficiency in coding and billing for services
5) Weekly didactics with focus on general ambulatory Internal medicine

### 4.3 Resident Patient Schedules

Residents are expected to progressively expand their patient base and clinical skills with advancing academic year. As such, their individual clinic schedules will vary by post graduate year as follows:

<Note these represent approximate Schedules and may vary on individual resident and patient needs>

<table>
<thead>
<tr>
<th>Time</th>
<th>PG-1 (1 – ½ day/wk)</th>
<th>PG-2 (3 – ½ days/wk)</th>
<th>PG-3 (3 – ½ days/wk)</th>
<th>Medical Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00-1:15</td>
<td>Overview</td>
<td>Overview</td>
<td>Overview</td>
<td>Overview</td>
</tr>
<tr>
<td>1:15</td>
<td>New Patient / Consult</td>
<td>Recheck</td>
<td>Recheck</td>
<td>Recheck</td>
</tr>
<tr>
<td>1:30</td>
<td>#</td>
<td>Recheck</td>
<td>Recheck</td>
<td>#</td>
</tr>
<tr>
<td>1:45</td>
<td>#</td>
<td>Recheck</td>
<td>New Patient/ Consult</td>
<td>#</td>
</tr>
<tr>
<td>2:00</td>
<td>#</td>
<td>Recheck</td>
<td>#</td>
<td>Recheck</td>
</tr>
</tbody>
</table>
2:15 # New Patient / Consult # #
2:30 New Patient / Consult # Recheck #
2:45 # # New Patient / Consult Recheck
3:00 # New Patient / Consult # #
3:15 # # # #
3:30 # # Recheck
3:45 Recheck # Recheck
3:45-4:15 Charting Completion Charting Completion Charting Completion Charting Completion
4:00-5:00 Didactic Preparation Didactic Preparation Didactic Preparation Friday Didactics 07:30-08:30 AM

<table>
<thead>
<tr>
<th>Time Allotments</th>
<th>New Patient/Consult</th>
<th>Recheck</th>
<th>Procedures</th>
<th>Annual Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>PG-1</td>
<td>60 Minutes</td>
<td>20 Minutes</td>
<td>30 Minutes</td>
<td>60 Minutes</td>
</tr>
<tr>
<td>PG-2</td>
<td>45 Minutes</td>
<td>15 Minutes</td>
<td>30 Minutes</td>
<td>45 Minutes</td>
</tr>
<tr>
<td>PG-3</td>
<td>30 Minutes</td>
<td>15 Minutes</td>
<td>30 Minutes</td>
<td>30 Minutes</td>
</tr>
</tbody>
</table>

For Years 2 and 3, there will be documented a minimum of 312 – ½ days in the continuity care clinic during the final twenty-four months of residency. Residents on vacation or on out-rotations must schedule additional clinic days prior to or upon the resident’s return. NO CLINIC DAYS WILL BE CANCELLED WITHOUT A 30-DAY WRITTEN NOTICE SIGNED BY THE PROGRAM DIRECTOR. Residents unable to document these clinic days will not be eligible for graduation.

4.4 Continuity Clinic Evaluation
Residents will be evaluated quarterly with respect to participation in didactic sessions, quality of charting, overall progress in clinic, attitude, professionalism and procedural skills. The resident will provide evaluations of preceptors and constructive feedback for the preceptors and staff at this time as well.

The 360° continuity clinic evaluation is conducted at least twice each year by the Internal Medicine Residency Clinic trainer(s). The evaluation form is presented as a model, which utilizes the AOA core competency requirements.

Trainer(s) should discuss the evaluation with the resident, highlighting strengths and weaknesses and pointing out areas that can be improved. The evaluation process should be an opportunity for teaching by the trainers resulting in personal and professional growth by the resident. Serious deficiencies need to be documented along with a plan for improvement.

A scoring grid is provided for those programs that have multiple trainers in their ambulatory clinic who each fill out an evaluation. The grid serves to illustrate to the resident how their performance has been rated by several supervisors and adds some validity to the evaluation when there is agreement in scores.

The AOA has adopted the six core competencies with an additional section for Osteopathic Concepts. This evaluation, along with the Resident Patient Evaluation, groups the questions into categories based on these competencies. While there is considerable overlap between the competencies, this format serves to illustrate how we are evaluating these items while acting as a guideline for shaping our curriculum.

Medical knowledge and patient care issues are still paramount, but a successful physician needs more than good knowledge. Assessment of professionalism and interpersonal communication is often difficult, especially since the evaluating physician sees the resident in only one context.
A 360° evaluation compiles subjective information from several sources to obtain a 'well rounded' view of the resident. Evaluation forms may be filled out by the resident’s patients and peers, as well as by clinic staff. The clinic supervisor may decide how many evaluations to solicit, with the understanding that three (3) or more evaluations from each source will likely provide better data.

The scoring grid may be used to compile the results of all the evaluations and will act as a valuable resource to promote personal growth and change in our trainees. A discussion between the clinic supervisor and the resident concerning these results is an essential part of this process.

4.5 Clinic Didactics
Teaching during clinic sessions occurs informally with discussion of various Internal Medicine topics as they pertain to the diagnoses of the patients seen in the clinic. Resident notes are reviewed by the supervising clinic attendings and teaching points are reviewed with the resident.

4.6 Charting
Charting will be in standard SOAP format, and are dictated, or standard forms. Additionally, clinical trials/research will be conducted from the Internal Medicine Clinic with additional documentation requirements being requested of the participating resident/preceptor. All entered charting by residents are reviewed and countersigned by the resident’s teaching attending and are completed during the assigned clinic. All charting and resident boxes will be completed prior to vacations or graduation.

Feedback regarding the resident’s documentation will occur during the clinic session and a compiled for inclusion in the resident’s annual performance review will be made.

4.7 Clinic “After Hours”
After hours the Chief Internal Medicine Resident in conjunction with the Clinic Director will arrange coverage. Schedules will be created and distributed on a quarterly basis. The hours of Internal Medicine Clinic Call are 5 p.m. – 9 a.m. Documentation of patient calls is mandatory. Call Logs will be distributed to residents for maintaining this documentation with copies placed in the patient’s electronic chart. Calls requiring more detailed documentation will be dictated. If calling from your private phone, remember to first dial *67 to block caller ID.

4.8 Procedures
Residents will develop proficiency in various procedures. The preceptor staffs all procedures performed in Internal Medicine Clinic. The resident is responsible for staffing and performing the procedure under the direct supervision of the attending physician, notification of the attending 24 hours prior to the procedure and dictation of procedure documentation.

4.9 Vacation/Time Off from Clinic
All vacation requests will be filled in compliance with Medical Education Policies with a copy being provided to the Internal Medicine Clinic by the resident at least 4 weeks prior to the requested time. Any canceled clinic days require 2 weeks advanced notice and will be made up by the resident in discussion with the Clinic Director and staff. The only exception is emergencies, which require immediate notification of the Clinic Director.

5 Floor Responsibility

5.1 Electives
Interns (PGY-1) - Elective must be chosen at the beginning of the program year. Electives may be out-of-house, but if so, should be in a specialty area not available in-house. Electives must be within other LCRH Graduate Medical Education Programs. You must be available to take call at 6:30 p.m. if on an outside elective. Out of town electives will not be allowed. The Director of Medical Education must approve all electives at least three months in advance.

Residents (PGY-2 and above) - Elective must be chosen at the beginning of the program year. Electives may be out-of-house, but if so, must be with an affiliated training institution. The Program Director and the Director of Medical Education must approve all electives at least three months in advance.

LCRH requires all rotations to be arranged at the beginning of the academic year.

Prior to any elective rotations, the resident MUST confirm the elective with the Administrative Director of Medical Education to ensure all requirements for the elective have been met, i.e. affiliation agreements, if applicable; resident program requirements are met.
5.2 Floor Coverage
When a nursing floor requires a Physician for a specific patient problem, coverage is as follows:

1. The Intern that is covering Emergent Floor calls as designated in the monthly call schedule packet.
2. The House Staff Physician designated on patient’s chart as following this patient. This includes all services, i.e. Surgery, EENT, IM, and OB etc.
3. The Attending Physician of record.

Emergent coverage is designated in the monthly call schedule.

5.3 Night Coverage
Night coverage is 7 p.m. to 7 a.m. Weekend nights coverage is 7 p.m. to 7 a.m., Friday; and Saturday and Sunday are 24-hour shifts; 7 AM to 7 AM.

Night interns must immediately notify the operator regarding which intern is covering which specific areas, if changes in the printed call coverage have occurred.

Night interns are expected to participate in all a.m. lectures throughout the year.

The Attending physician on call is responsible for the admission, and must be contacted by the resident. Attending physicians are encouraged to call the resident prior to each admission. Interns should participate in admissions and discuss cases with the admitting resident.

Use your discretion, but it is always better to call than NOT call if there are any questions. Attending physicians are responsible for their patients and want to be informed of significant changes in their status.

All procedures are to be performed by a resident who has been “signed off” by their program director to perform the procedure. Prior to being “signed-off”, interns and residents must have attending or senior resident supervisor the procedure.

If you feel uncomfortable and/or feel you are in trouble, DO NOT get in over your head - ANTICIPATE. You should notify the appropriate resident on call in these situations and/or the attending physician for the patient.

5.4 Response to Floor Calls
Residents shall respond as soon as possible during the day or night when called to see a patient.

Instructions for giving medications and treatments may be given over the phone to the nurses only when the resident cannot report in person. Subsequently, he/she must respond when able and enter all orders into the medical record and sign and date. In addition, the resident must enter a progress note on all patients requiring orders and evaluation.

During the hours 7 a.m. to 7 p.m., floor call is directed to the intern/resident directly caring for the patient. In their absence, the attending physician for the patient will be contacted. During the hours 7 p.m. to 7 a.m., floor call is directed to the intern assigned to Nights. Patients will be seen ACCORDING TO HIGHEST PRIORITY FIRST. When handling a floor call, review the chart, pay attention to age, race, why the patient is here, what procedures have been done, vitals, and lab studies, then go see the patient. If indicated, do not be afraid to ask for a set of fresh vital signs. Then it is your responsibility to enter the orders and a progress note (SOAP format). Finally, it is your responsibility to follow-up with the orders until you are sure the problem is solved; keep the attending notified of the patient’s status.

5.5 Rounds
The resident should make rounds on all assigned cases each morning and enter his/her progress notes at that time. The resident will make rounds with the attending staff and specifically with the staff member to whom he/she is assigned, on a daily basis. He/she will receive instruction, information, advice, suggestions and assistance from the staff who thus contributes to his/her bedside teaching. Prior to rounds, the resident should report to the attending physician all patients who present any new or unusual symptoms, unforeseen developments, emergencies or any dissatisfaction expressed by patients in regard to treatment, food, nursing, surroundings, or annoyances. After each patient visit, the resident must enter appropriate notes in the patient’s chart.

Assigned patients are to be visited as soon as possible after admission regardless of the hour. The attending physician is to be called at this time and be notified of the patient’s condition.
5.6 Admission

The admission process is presently set up to:

1. Provide the attending physician with name of the resident who is responsible for the admission at the time the admission is being called to the Hospital. The attending physician can then, prior to the patient getting to the hospital, notify the responsible resident with information that is essential to facilitate the evaluation of the patient; such as labs, X-rays already done, severity of patients condition, consults, or other physicians who need to be notified.
2. Provide a more service-oriented admission process.
3. Provide for residents performing admissions, not just H & P's.
4. Provide more intern and resident supervision of students.
5. Improve communication between the house staff and the attending physician.
6. Improved patient care and avoid untimely evaluation of severely ill patients.

In order for the Admitting Department to appropriately assign your patient to the correct resident, they need to know:

1. The admitting physician's name.
2. The preliminary diagnosis and unit of admission.
3. Consulting physician(s) and levels of participation.

After seeing the patient, the resident doing the admission is to notify the attending physician of his/her findings and go over the appropriate orders.

PLEASE NOTE: It is our desire to make sure the attending physician knows which resident is in charge of the admission at the time they call the admission in. This is to encourage the attending physician to notify the resident in charge of their admission of any information that may be helpful to him/her in facilitating the admission, i.e. needs to be seen right away, etc.

The Admitting Department needs only to notify the respective resident that they are in charge of the admission, and that name should be on the face sheet.

5.7 Admission Orders

After entering electronic orders, if you have entered any STAT or now orders, notify the unit secretary or appropriate nurse so that undue delays do not occur. Always date, time and sign your orders. Insure there is an electronic signature on your orders at completion.

The American Osteopathic Association allows the attending physician to request consultations for his/her patient. This order must be entered as the following:

a) Consultation only which leaves management to the attending physician and prohibits consultants from writing orders on the chart.

b) Consultation and management of a specific entity or procedure in which the consultant may enter orders to manage the special entity or procedure but overall responsibility remains with the attending physician.

c) Consultation and co-management which permits the attending physician and the named physician to enter orders, however, overall chart responsibility remains with the attending physician.

d) Consultation and full management where the consultant assumes full responsibility for entering orders and management of the patient and prohibits the attending physician from entering orders.

e) Transfer of management to another named physician in which case the patient care responsibilities in the hospital are transferred to the named physician and the admitting physician may no longer enter orders.

6 Logs

Logging your activities is an essential part of any training program. Historically, it has been a challenge for the interns and residents as well as trainers to have the paper work completed in a timely manner. We all tend to procrastinate with paperwork. It is an essential part of practice to adequately document your clinical work. It is a principal adopted
by Medicare, third party carriers, as well as the legal profession that “if it is not documented – it did not happen”. To avoid frustration at the end of the year, and to enhance the satisfaction within a training program, it is extremely important that timely logging of clinical activities take place. Please review the American College of Osteopathic Internists’ requirement on logs.

It is important to realize the essential nature of logging. The principal objectives for this are:

1. Document to certifying agencies that you have accomplished a significant amount of clinical exposure and expertise to have graduated or to be certified and/or credentialed.
2. To document for the Department of Medical Education, the individual program directors and trainers, that the education program is serving their individual educational goals and providing the trainee with adequate opportunity to learn. Outside accrediting inspection agencies do, in the normal course of their review process, examine trainee logs.
3. To document your experience, for the purposes of applying for hospital privileges in the future. This point is the most important and concrete for the individual trainee. It is your personal future! Do not assume that by doing rotations at any particular institution that privileges will automatically flow so that logs need not be kept. Documentation is frequently important when providing letter of reference for future training programs and/or when applying for staff privileges. Frequently, individuals relocate on several occasions, and each new institution requires documentation of prior experiences.
4. Logs are due at the completion of the rotation. Time logs are due on the 1st of every month. Other logs and evaluations are due in within seven (7) days of completing the rotation.

6.1 Important Points to Remember
Responsibility of logs lies exclusively on the shoulders of the individual trainee, and is an American Osteopathic Association requirement for graduation from the program. Log entries should be easily verifiable. It is a normal course of the hospital credentialing process to request patient logs. Patient notes are pulled for verification that the trainee participated in the care of a patient. Therefore, the logs should include some evidence of the level of involvement in the case. The medical record as well should reflect documentation of participation by the intern. Therefore, if multiple people are attending to a particular patient on a day that all parties contribute to the care, it should be noted on the medical record (i.e., attending/resident/intern/MSIV).

The responsibility for archiving the logs falls primarily on the shoulders of the trainee. The fact that the original copies are handed to the Medical Education Office, should not give the trainee a false sense of security that the documentation is safely stowed away. Record catastrophes do happen. It is, therefore, strongly emphasized that all logs and records be copied and retained in the intern’s personal possession. Photocopies are your personal insurance policy. In accordance with AOA policy, Lake Cumberland Regional Hospital is required to retain your logs for only five years.

6.2 What to Log
1. Any continuity clinic encounter should be recorded. Include the patient’s name, identification number, or other indicator as well as the diagnosis or multiple diagnoses and level of involvement.
2. Procedures are particularly important. Institutions when credentialing frequently request documentation of experiences. For this purpose, procedures are the most critical activities to be logged.
3. Any outside educational experience including: Academy meetings, educational seminars, and programs that are not held in-house or recorded in any other manner. We do maintain records internally of lectures, presentations and meetings. All activities out of the institutional walls would be lost unless included in your logs. On-call experiences are often looked upon as secondary activities, but are still a part of your net clinical experience. Therefore, they should be recorded as well.

6.3 How to Log
1. Be as specific as possible. Include name or initials, date, place, preceptor, and level of involvement. This last item is most important for procedures that you may want privileges for (i.e., observed 15 c-sections, participated or assisted in 20, did 2 under observation). All entries supported by hospital medical record number, date, time, location, preceptor, level of participation. You may want to mention complications or other related specifics that you handled.

2. In short, logs help to aid the function of the program, but most directly benefit you. Keep them current, and complete them in an organized manner. Do not procrastinate! The Program Director may call for the logs at any time during the year for spot review. They are your responsibility.
6.4 Policy Statement
To underscore the importance of this activity and to insure timely compliance, the policy on log and evaluation completion will be on the same basis as any medical record within the hospital. The educational objective here exceeds assuring mechanical compliance with submitting logs. It is designed to encourage a physician early in his career, the ability to follow through with the medical record in a timely manner. This is a shared expectation of all institutions that you will be involved with, so that it is appropriate to establish good habits from the beginning.

1. Patient logs and preceptor evaluations are to be in the Medical Education Department within seven (7) days of completion of a rotation. Remember: LATE LOGS = ADDITIONAL NIGHT CALL!
2. Time log is due to the Medical Education Department immediately upon completion of the rotation.
3. For longitudinal experiences that extend over the year period, it is expected that they be completed within fifteen (15) days of the completion of an academic year.
4. If logs are not completed in this timely manner, suspension from the education program may take place immediately upon direction of the Director of Medical Education.
5. Any time lost from the educational program will then be made up with compensatory time at the end of the educational program. A reminder – suspension also means that time off is not compensated time. So, adjustments will be made on the next pay check.

Exception to the rule:
1. Catastrophic illness where the resident is not physically able to complete his/her logs.
2. Catastrophic illness prohibits his/her preceptor from filling out the evaluation form. Consideration will be given to late reports only if an explanation is provided by the preceptor, in writing, and accompanies the log and evaluation.

7 Medical Documentation
The history & physical is a working document and is essential for proper case management. It is a REQUIREMENT to visit the Medical Records Department WEEKLY to make sure your charts are up to date.
Always notify the attending physician regarding the admitted patient regardless if they have seen the patient or not.

If you have to leave the hospital for any reason, notify the attending physician, Department of Medical Education, Chief Residents, Chief Intern and Operators/Admitting Office and have another responsible intern or resident hold your pager and handle any of your floor calls (for day, morning, or afternoon off). If you need to get away for an hour or so, notify your attending physician, and get an intern or resident to handle your calls.

7.1 Patient Workups
Service and trainer: Patient workup assignments, whenever possible, will be in consideration of the service, and the trainers to whom the interns and students are assigned.

Priority of patient workup: Emergency admissions, surgical admissions and medical admissions.

Weekends: Interns and students on weekend duty will pick up all admissions of that weekend. The interns will enter ICU notes. Residents should assist with this.

Nights: The night intern is expected to do patient workups on emergency patients admitted through that department while on duty.

Patient workups are to be dictated within 24 hours of admission: To be completed before a patient is taken to surgery in all cases, and the night before surgery in elective cases.

Progress notes are entered when the patient workup is completed, so stating, (e.g., “patient H&P dictated”) plus working and differential diagnosis.

Extern’s physical workups are the responsibility of the intern on the service and are to be reviewed and countersigned by the intern, in addition to the attending physician. When no intern is assigned to the service, then the attending physician is primarily responsible.
When you enter the progress note “patient workup dictated” add the information to that note. Then the attending physician is responsible and aware.

“Non-contributory”, “essentially negative”, “deferred”, “negative”, and “normal” may NOT be used unless specific to the disease, symptoms, sign or physical finding, (e.g., GI system normal” is not permitted. “Appetite normal” is permitted.)

When dictating, give patient’s name, spelling it if there is any question, sex, age, hospital number, attending physician and date.

Certain items are to be answered by numbers such as OB digit system and blood pressure. Take the blood pressure yourself for your patient workup.

Put patient’s name and hospital number on the top of the physical for identification, in case the sheets are separated.

The musculoskeletal exam is to be done meaningfully, and in narrative form.

The provisional diagnoses are to include all established diagnoses, including obesity and hypertension, when diagnosable. Include diagnoses of the musculoskeletal system when present, whether primary or secondary.

All patient workups are to be signed to be considered complete.

7.2 Emergency Patient Workup

When time does not permit a full patient workup because of the emergency nature of the patient, you may do an emergency patient workup on the patient to expedite surgery. You are obliged to complete the patient workup as soon as possible.

This consists of a chief complaint, onset and course, allergies for the history and a general statement, heart and lungs, and the affected area for the physical in minimum.

7.3 Medical Documentation

Formal communication in medicine is achieved by documentation in the medical record. Since medical documentation is not often addressed in school, we will attempt to provide general guidelines and rules to help maximize the quality of medical care as well as minimizing liability.

It is essential to document all findings that are essential to the support of a diagnosis and rationale for treatment plans. These findings may be positive or negative. All portions of the record should be consistent. That is the admitting note and the history and physical should refer to similar features. Usually the admission note is a more concise summary of what the important features found in the history and physical. The admit note further indicated clinical course and treatment plans. One should not simply refer between documents as “Note H&P”. In the process of the physical examination, it should be clear as to what was and was not examined. In the event an area was not included, it should not be stated that it was “deferred”, but rather an explanation as to why the examination was not performed should be made clear in the record. If a medical form is being filled out, all areas of that respective form should be addressed in one way or another. Continuing progress notes need not necessarily address processes that are unchanged, but should detail an ongoing problem that is evolving. It is often better to make a general statement than to attempt listing the entire possible alternative in a situation because most often it will be incomplete. The generalized statement will suffice for the documentation and not waste effort and time.

One will occasionally come across a difficult situation where an unusual happening or adverse reaction has taken place. It is very important to omit from the record all risk prevention activities in reference to incident reports. Avoid any commentary as to legal implications and restrict your comments only to what is relevant to the patient care and patient’s condition at the time. Keep the statement as factual as possible and do not attempt to misrepresent them or color them either positively or negatively. If a patient or family make legal threats, they may be noted, but in a purely objective way. Use purely professional style in making your record entries. Never attempt to be joking, overly melodramatic, blaming, or judgmental.

The medical record is strictly a forum to note the patient’s medical condition and treatment. It is also not a location to “joust”, that is, to carry on a medical debate between other health care practitioners who may also be writing notes on the document. At all costs avoid any reference to blame, culpability, ability, or carelessness.

The credibility of your records is an important issue. First of all, they must always be legible. A record that is unreadable does not exist. If you refer to other sources of information that may not be reliable, the reasoning behind
your doubts of reliability should be included in the note. This again is where the professionalism and sincerity of your entries are important. If there is ever the occasion to change a medical record, it must be done carefully and in one of two potential ways:

1. It is to place a single line through the deleted material and initial, as well as dating the change. Never, ever destroy, re-write, cross out, obliterate, or make unrecognizable the original entry. The only acceptable motive for altering a medical document is for the protection and safety of the patient as well as assuring the best medical care.
2. The second alternative in making a change in a medical record is to simply make a new note referring to the prior comment and again – date, time and sign it.

If a patient has been injured or a medical complication has occurred, from an untoward event, the appropriate mechanism of documenting that is in an incident report. Therefore, in the medical record – do not state that a risk management activity or an incident report has been filled out. Simply record the facts of the situation, as you know them. If the incident involves any medical equipment, carefully preserve, but in no way alter or destroy it. Sequester it and make it available to the Risk Management authorities.

In dealing with the patient in terms of complication, it is always imperative to show concern for the welfare and comfort of the individual at hand. If no unusual event transpires and there is no patient injury, do not volunteer any admission negligence and avoid any statements that would imply that something has gone wrong until you have notified and discussed the problem with the attending physician.

If an injury has occurred, never give false statements or misleading expressions. Again, examine the patient and notify the attending physician. Although it is appropriate to avoid being overly solicitous, it is equally appropriate to show a reasonable amount of concern and empathy for the patient and family. Never ascribe blame to people, medical equipment, or situations. Doing so is often a reflex response that is given without objectivity and without the ability to consider all the influencing circumstances.

As house staff personnel, it is always proper to refer a patient or concerned family member to the attending physician. They ultimately maintain the responsibility and also usually have the greatest rapport and understanding of the family/patient situation. If you feel uncomfortable in discussing the matter with the patient or family, it is best to avoid doing so. Make an appropriate referral to the attending physician or the individual in charge. Nursing supervisors and personnel often have a high level of experience in these matters and are often valuable resources. It is also very important to take preventive action.

If a recognized potentially dangerous situation exists, take immediate action that would be necessary to protect the patient from potential injury, harm or any adverse effect. It is usually best to warn the attending physician. If you are aware of patient or family dissatisfaction of the health care efforts, bring this to the attention of the attending physician.

7.4 Medical Records

Physical workups must be entered or dictated within 24 hours of assignment or prior to surgery whichever comes first. Surgery workups should be entered so that the medical information is readily available.

When a physical workup is done, always enter a progress note. It is to be entered immediately following the physical workup.

When responsible for an admitting progress note, it is to be entered immediately following the physical workup.

When responsible for interval progress notes, they should be entered every working day. If the condition of the patient changes during the day, extra progress notes are to be entered.

Case summaries, when assigned, are to be done within 48 hours of discharge of the patient.

Everything you enter into the medical record must be signed, timed and dated.

When you enter an order always include the name of the attending physician first, (e.g., James Monroe, D.O./Peter Smith, D.O.)

If done by an extern, or by an intern, in communication with the attending physician, always include the method of communication, preceded by his name, (e.g., V.O. for “voice order” or “verbal order” and P.O. for “phone order”.)

Remember – the admitting physician may not be the attending physician at the time.

Whenever entering orders, always explain the reason in a program note.
All orders and progress notes must be dated, timed and signed.
They may NEVER be taken out of the hospital.
Physical workups may be delegated to an extern, if one is in training at the hospital. However, the intern on service will be directly responsible for the accuracy of such physical workup examinations and must countersign it.
All charts must be completed within fifteen (15) days after the patient is discharged. Therefore, after seven (7) days, you will be considered delinquent in charting unless you are waiting for dictation to be typed. Medical Records will make your incomplete charts available to you at any time.

**CHARTING IS A HABIT – Good or bad it is up to you!**

If you are delinquent repeatedly, disciplinary action will be taken. Remember – the service you are on is no excuse. Go to Medical Records at least twice a week and do all of your charts and you will never be delinquent.

### 7.5 Routine Progress Notes

Before entering progress notes, always identify your service. Conclude your note with your signature, printed name and pager number. Most of the services require daily progress notes, and the SOAP format is usually acceptable. However, an ICU progress note is almost as detailed as a new complete history & physical. Do not over-use abbreviations. When using abbreviations, follow the guidelines from the hospital manual.

On all admissions, please use the following guidelines:

- Progress notes, dated and timed, shall be entered by all participating Physicians or members of the house staff on all phases of a patient’s hospital stay. All progress notes should be in the SOAP format.
- The admitting note (admitting summary) shall briefly state the chief complaint, the symptoms, and the physical findings that led to the working diagnosis, the expected therapy, and the possible consultations.
- All significant physical changes, new signs and symptoms, complications, consultations, and treatment including manipulative therapy shall be recorded.
- Progress notes shall describe in proper continuity, the course, progress, treatment, and disposition of the case.
- Progress notes shall include significant results of tests or x-rays that influence the working diagnosis or therapy. Progress notes are the one place on the chart where the physician’s philosophy of management is displayed. Notes may have to be entered several times a day, if the patient’s changing condition warrants it, or once a day may suffice on assigned cases.
- All progress notes shall be dated, timed and signed by the physician entering them.

Record your OMT on the progress notes. Include the biomechanical diagnosis for which you are treating (e.g., “somatic dysfunction of _____ due to _____”). Date and time as you do for all progress notes. Record the result. If it is a series of treatments, record results after several treatments, but no less than every three days his note must briefly state the chief complaint, the symptoms and physical finding that led to the working diagnosis, the expected diagnostic regimen, therapy and possible consultations; also, the prognosis as of that time.

### 7.6 Admitting Note

This note must briefly state the chief complaint, the symptoms and physical finding that led to the working diagnosis, the expected diagnostic regimen, therapy and possible consultations; also, the prognosis as of that time. Admitting notes will be completed on all hospital admissions in the appropriately designated area of the chart. The admission note is a brief, concise synopsis of the patient’s presentation, chief complaint and reason for admission with documentation of therapeutic interventions indicated for the patient.

### 7.7 Interval Notes

These must cover all significant physical changes, new signs and symptoms, complications, consultations, and treatment given. They shall describe in proper continuity the course, progress, treatment and disposition of the case. They shall include significant results of tests or x-rays that influence the working diagnosis or therapy. Progress notes are the one place on the chart where the physician’s philosophy of management is displayed. Notes may have to be entered several times a day, if the patient’s changing condition warrants it, or once a day may suffice on assigned cases.

All progress notes shall be dated, timed and signed by the physician entering them.
8 Acknowledgment

I acknowledge that I have received a copy of the Lake Cumberland Regional Hospital’s Internal Medicine Residency Manual, and I do commit to read and follow these policies.

I am aware that if, at any time, I have questions regarding Lake Cumberland Regional Hospital’s Internal Medicine Residency policies I should direct them to my Program Director, Director of Medical Education or the Administrative Director of Medical Education.

I know that Lake Cumberland Regional Hospital’s Internal Medicine Residency policies and other related documents do not form a contract of employment and are not a guarantee by Lake Cumberland Regional Hospital of the conditions and benefits that are described within them. Nevertheless, the provisions of such Lake Cumberland Regional Hospital policies are incorporated into the acknowledgment, and I agree that I shall abide by its provisions.

I also am aware that Lake Cumberland Regional Hospital, at any time, may on reasonable notice, change, add to, or delete from the provisions of the company policies.

__________________________________________________________
Resident’s Printed Name

___________________________
OGY Level

__________________________________________________________
Resident’s Signature

________________________________________
Date

__________________________________________________________
9 APPENDICES

9.1 Time Log
9.2 Resident Continuity Patient Log
9.3 Attending Evaluation of Resident Form
9.4 Resident Evaluation of Faculty Form
9.5 Time Away Request Form
9.6 360° Evaluation Forms
9.7 IM Resident End-of-Year Checklist
9.8 Employee Expense Reimbursement Form
9.9 Patient Evaluation of Resident
9.10 Intern Evaluation of Resident
9.11 Resident Exit Questionnaire