Boston Children’s Hospital – Division of Infectious Diseases
Overview for Fellows on the Inpatient ID Clinical Services

General Overview
- Philosophy: To optimize patient care by using our expertise to provide guidance on the diagnosis and management of infectious diseases in the pediatric population.
- Role: We are a consultation-only service. We do not admit primary patients and do not write orders for patients. We care for patients indirectly by providing a service to the primary team, which drives our interaction with patients and families differently than if we were the primary care provider.

Supervision
- Your attending physician is available to you 24 hours a day, seven days a week. Contact him or her to discuss any clinical issue at any time. If in doubt, CALL!

Daily Workflow
Morning Procedures
- Pre-rounding: Talk with the patient and family, nurse, and teams for updates on the clinical course and team plans for the day. Review labs, notes, and overnight events in the patient's chart (but do not feel compelled to write everything down as you will have access to PowerChart during rounds).
- Touch-base: Connect with your attending briefly by phone or in person in the morning before rounds; this is required for the General ID service unless early rounds are planned.
  - Quickly review new consults and consult questions; this helps the attending to prepare ahead of rounds.
  - Discuss curbside questions. The attending will help decide whether curbsides should become full consults.
  - Review quick questions from primary teams on existing patients (e.g., Based on new culture results, do we need to change antibiotics? Should any further labs be obtained or medications be changed as this patient is prepared for discharge?). This will enable you to provide a timely response before rounds.
- If time permits, start notes for those patients whom you anticipate will require one for the day.

Rounds
- Rounds on the General ID service generally start at 1pm, however as the fellow you are the team leader and should communicate with your attending if the day is especially busy or there are many patients which may necessitate rounding earlier. On the general service, morning touch-base between 10 and 11am is required unless early rounds are planned. Rounds on the ICH ID service start at 11am.
  - Sit-down rounds: Most of the time the team starts with sit-down rounds; at times it may be feasible or preferable to start directly with walk rounds. Address curbsides or team questions that have arisen since the morning touch-base as the first thing during sit rounds.
  - Review data together in PowerChart for existing and new patients.
  - Review new and evolving issues for existing patients and formulate preliminary recommendations.
  - The ID pharmacist will be available to participate in both general ID and ICH ID rounds on most days. If rounding times or location change on a given day, the fellow must notify the pharmacist early in the day.
- Walk rounds:
  - Review radiology imaging.
  - See new patients:
    - Always see new patients with your attending. This enables the attending to model how to discuss recommendations with the family and team and how to negotiate toward the best patient care when opinions on the best plan differ.
    - Introduce the attending and other members of the team to the patient and family.
- Lead communication about the assessment and recommendations with the patient and family; the attending will chime in as needed.
- Answer the family’s questions as a team together with the attending.
- In some situations (e.g., delicate social situations, extremely complex patients being followed by multiple teams), rather than talking directly with the family, it works better for our service to make recommendations to the primary team and allow them to manage communication with the family.
  - See existing patients:
    - In general, we should aim to see patients as a team so that we can talk with the primary teams and address unexpected issues as the need arises.
    - You should always see existing patients with the attending if they are unstable or there are new issues to discuss with the family or team.
    - On occasion, the attending may see existing patients who are stable with no new issues on his or her own if you already examined them earlier in the day and the service is especially busy. This approach, however, should be the exception and not the rule.

**Team Communication**

- Always discuss assessments and recommendations for new and existing patients with the primary team before speaking with the patient and family.
- For patients for whom there are new recommendations, talk with the primary team face-to-face or by phone to verbally review the recommendations. Communication with the primary team must take place before they sign out to the overnight team (generally prior to 4:30pm). This enables the primary team to start implementing our recommendations before they sign out and optimizes timely patient care. This is especially important because our notes are often not finalized until later in the evening. If our services are busy and rounds take longer than expected, a break must be planned so that team communication can occur before 4:30pm.

**Signing off on Patients**

- To optimize patient care, we support and advise the primary team for as long as they feel our input is helpful.
- Generally, when the final diagnosis, treatment course, and follow-up plan have been established or at the time of discharge, our service can sign off if the primary team agrees that the timing is appropriate.
- We may delay signing off on patients in the ICU or on the ICH service whose course is evolving, even if the diagnostic work-up has been negative and we are not writing daily notes or making new recommendations.
- We do not sign off just because a team disagrees with our recommendations. Our job is to find common ground and negotiate an optimal plan for the patient.
- Keep a dedicated list in PowerChart of patients who have pending studies when we sign off.

**Fielding Consults**

- Addressing a question as a curbside is appropriate if the answer can be provided as general advice without requiring knowledge of the specific patient’s case.
- Conversely, any question that requires review of a patient case should ideally be addressed through a full consult (this can be a one-time consult, if appropriate).
  - This approach ensures that patients receive optimal care because it allows us to complete our own review and assessment and enables us to document our recommendations. This also enables us to bill for the work that we do.
- In general, all consults requested before the start of rounds should be seen the same day.
- Discuss with the attending whether consults requested after the start of rounds should be seen the same day or deferred to the next day.
  - In general, if possible, see unstable patients and those in the ICU even if the consult is requested late in the day.
  - Stable/floor patients can be seen the next day, BUT
  - Facilitate timely patient care by offering provisional recommendations for testing and empiric treatment that the primary team can begin to implement while awaiting more definitive
recommendations. Emphasize that recommendations are preliminary until our service has thoroughly reviewed the case and examined the patient.

**Notes**

- **Consult notes on new patients:**
  - Write a full consult note if our service has not seen the patient previously during the current hospitalization.
  - For patients whom our service has seen previously during the current hospitalization, write a full consult note if the new consult deals with a different issue than the previous consult. Otherwise, write a more targeted consult note in which you focus on interim developments since the prior consult; instruct the reader to refer to the initial consult note (provide the authors and date of the consult) for full details of the patient's history and prior hospital course.

- **Daily progress notes:**
  - In general, we should write notes daily for patients whom we are following, even if we are simply awaiting culture results or response to therapy and not making interim changes to the management plan. This allows us to maintain communication with the team and document our ongoing recommendations, as well as bill for the care that we provide. Daily progress notes can be brief “SOAP” notes and should not repeat the patient’s course from the initial consult note. Please be aware, however, that to support billing at a minimum level, a follow-up note must contain at least two of the following three elements: (1) interval history (with at least 1 detail such as location, timing, or associated symptoms of a problem), (2) physical exam (can be problem-focused), and (3) medical decision making (i.e., assessment and recommendations). On rare occasions, we may not write notes for all patients on the team, particularly if there are many new consults. The attending will help to guide this decision, and may also write his/her own notes for the patient if fellows are especially busy.
  - A daily progress note MUST be written for existing patients if:
    - There are new recommendations, changes in status (e.g., transfer to the ICU), new data driving a change in diagnosis or management, or new data about which the primary team has questions for us to address, even if no changes in diagnosis or management are required.
    - A note has not been written for three or more days but we are continuing to follow the patient.
    - The team requests a note.
    - The ID team participates in a team meeting, consults with outside experts, or is otherwise working to optimize the care of a patient, even if you were unable to examine the patient that day. It is important to document the care we are providing for patients even if the care is behind the scenes.

- **Sign-off notes:**
  - A separate sign-off note is not required for one-time consults, but the consult note should state that the consult is a one-time consult so that the team is aware we will not continue to follow the patient.
  - On the day the sign-off occurs, a daily progress note is not required in addition to the sign-off note.

**Care Transitions/Sign-out**

- Update the sign-out in PowerChart at all times of transition:
  - Fellow switch day
  - Attending switch day
  - On Friday afternoon before the weekend and Sunday afternoon at the end of the weekend
  - Whenever there is change in coverage (e.g., a fellow's covering while another is taking SITE)

- Face-to-face sign out is required on switch days and at the beginning and end of weekends.

**Consult Attending**

- At times, when there is no co-fellow or visiting fellow on a team, an additional attending, referred to as the “consult” attending, will be on service along with the traditional “service” attending. The service attending will remain your primary supervising attending and see patients with you/review your notes. The role of the consult attending is to help support the work of the team and ease the fellow's and service attending's workload on
days with high consult volume. He or she will see some new consults on his or her own, formulate the assessment and recommendations, write the note for these patients, and communicate with the primary team.

- The consult attending is typically on service for a week at a time, Monday – Friday. Whenever a consult attending is on the team, the fellow remains the team leader and is responsible for dividing new consults among him/herself, the consult attending, and (if present) other team members such as medical students or residents. The consult attending is considered to be an integral member of the team and is expected to participate actively each day in the care of patients followed by the team.

- The consult attending should be assigned to new consults as the consults come in. There may be days when there are only two new consults; one may be assigned to the consult attending and the other to the fellow.

- The consult attending is expected to join the touch-base with the fellow and service attending every morning to hear about new consults and any other patient care needs for the team for the day. The consult attending can be especially helpful for the team if the fellow is in clinic in the morning, if there are patients to be seen at BIDMC or BWH, and many other aspects of patient care. The role of the consult attending is not limited to only seeing new consults or one-time consults. The consult attending will continue to follow patients daily until he or she decides to sign off on the patient or until he or she goes off service. The consult attending will write daily progress notes and sign-off notes for his or her own patients.

- Although the consult attending is seeing patients independently, he or she is welcome, and when feasible is expected, to join the service attending and fellow for rounds to discuss the patients and provide additional teaching about the work-up and management of these patients so that the fellow continues to gain educational benefit from these consults. In addition, discussion of all patients as a team during rounds helps to maintain continuity when the consult attending goes off service.

- When going off service, the consult attending will sign out patients to the weekend fellow/service attending.

**Education**

- Be a proactive learner: education is your primary purpose for pursuing fellowship training. Let your attending know if there are topics about which you would particularly like to learn.

- On the inpatient services, teaching most often occurs in the context of clinical case discussions rather than in formal teaching sessions. For example, teaching may occur as clinical pearls, by observing physical exams, or by watching how an attending communicates with a team. On less busy days, teaching may be more structured and accomplished through discussions led by you, the attending, or rotating students or residents.

- Ask questions and request clarification when you do not completely understand a patient recommendation or a point made in case discussions.

- Take the opportunity to learn about aspects of being a consultant beyond clinical content, such as
  - How to present information to families
  - How to negotiate management plans with teams, particularly when the primary team’s plan for managing their patient differs from the recommendations of the ID team
  - How to write a collegial consult note
  - How to conduct an effective literature search

**Feedback**

- The service attending should provide informal feedback at the midpoint of the service block and throughout the block as needed, thus giving you the chance to work together with him or her on developing and strengthening clinical skills and expertise.

- At the end of the service block, the service attending should provide more formal verbal feedback that reflects what will be included in his or her written evaluation. Use this opportunity to ask for suggestions for getting to the next level in milestones for achieving clinical competency.

- If your service attending does not offer to give you formal feedback, ask for it.

- Provide feedback to your service attending about teaching and daily workflow, both during and at the end of the block. This helps him or her to become a more effective teacher and clinical supervisor.