

### Office cases:

- 1) Read the information and look at the vitals
- 2) Form DDx along with which tests to order.
- 3) Do complete physical exam unless not stable or need to transfer the patient to the ED etc.
1. Order routine tests because office cases can take 30 min so send the patient home. But do treat patients current CC.
  - a. So order: CBC, BMP, UA, CXR, pulse ox, LFTs,
2. If patient need immediate symptomatic treatment do so.
3. So you ordered test and sent the patient home. While the patient is at home, results come back. As you read the results (patient still at home), you can stop the clock if you want.
4. Clock stoppage when patient is at home
  - a. To address abnormal labs
  - b. To order additional tests based on your previous results
  - c. Abnormal lab? Must address it.
5. Patient comes back to the office on their next appointment
  - a. Do a focus PE along with interval history.
6. Then continue with management. If need to order more specific test then do so. If need to admit the patient then first send them to the ER and then to the ward/ICU.
  - a. Only move the ER patient to the ward once patient is stable and when the ordered procedure has been completed and the report is back. So if you ordered pericardiocentesis then order this and WAIT to have this procedure done. Then move the patient to the appropriate location if need it.
7. If need to admit patient to ICU, patient should go the ER first and then to the ICU
8. After reading the basic order report, order more specific, chief complaint related orders.
9. Get consult if needed.

### @2 minute screen order things in this order:

1. 2 minute screen (possible options)
  - a. Diet orders, bedrest, activity, safe sex, seat belt, screening test (for future), council, etoh, smoking, seat belt.
2. Things need to be done now
  - a. If your case ended before you can order the surgical procedure then add surgical procedure FIRST thing in the 2 minute screen.
3. Things need to be done at a later date
4. Monitoring (ie. Synthroid), statins (check lipid, LFTs)
5. Counseling
  - a. Case specific
    - i. Patient had Trichomonas. So need to council the patient regarding their partners treatment
    - ii. Anaplyxis

1. Patient need to know about epinephrine
- iii. Child with asthma
  1. Tell the mother
- iv. Diabetic patient
  1. Tell them to monitor blood glucose etc
- b. Routine council (Not important for ER cases. Important for Office cases)
  - i. Routine screening
    1. Colonscopy at age of 50 etc

## **ER cases:**

### **Simple approach for ER cases:**

1. If vitals are unstable and you have NO clue about the diagnosis from history then:
    - a. Do a quick PE (cardio + abd)
  2. Vitals are unstable and you have a clue from the history then:
    - a. Go to order sheet first and write stabilizing orders, basic orders, and symptom relieving orders. Also write specific diagnostic tests and specific treatment
  3. Vitals are stable and patient has no pain then:
    - a. Perform full PE and then order your tests
  4. Vitals are stable and patient has pain:
    - a. Address patient's pain first and then do PE. If pain is abdominal then do PE first and then address pain
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- 1) Look at the vitals first and determine whether patient is HEMODYNAMICALLY STABLE OR UNSTABLE.
    - a. UNSTABLE
      - i. Stabilize the patient if hemodynamically unstable (IVA, Pulse ox, oxygen, normal saline, cardiac monitor, bp monitor, pain management)
      - ii. Form your DDx along with which specific tests you will order.
      - iii. Do not perform complete physical exam but rather do a quick physical exam. Focused physical exam
      - iv. Now go ahead and order LIFE SAVING orders such as Head ct or pericardiocentesis.
      - v. Also order basic orders such as: CBC, bmp, ua, chest xray, ekg, lft's etc.

- vi. Now you can go back and finish the PE exam if you did focused exam earlier. Since clock has to be advanced might as well finish your PE and this will move the clock as well.
- b. **Should always order basic tests like UA, CBC, bmp, cxray and order on the first order sheet along with stabilizing orders.** That will keep simulated time low. For example: in the er case you ordered EKG and didn't order bmp because this isn't needed and now after advancing the clock to get EKG results, you are like fuck now I need bmp and you ordered. That's ADDITIONAL 15 minutes of wasted simulated time.
- c. **Basic ER orders (without specific orders)**
  - i. Vitals (choose 1 hr)
  - ii. Oxygen (pulse ox, oxy)
  - iii. IVA
  - iv. EKG
  - v. Cardiac monitor
  - vi. UA
  - vii. BMP
  - viii. Cxr portable
  - ix. CBC
  - x. Check interval history often
  - xi. Don't order Blood cultures and ABx together. Order Blood cultures first then move the clock and then order ABx

**@2 minute screen order things in this order:**

- **2 minute screen (possible options)**
  - Diet orders, bedrest, activity, safe sex, seat belt, screening test (for future), council, etoh, smoking, seat belt.
  -

**6. Things need to be done now**

- a. If your case ended before you can order the surgical procedure then add surgical procedure FIRST thing in the 2 minute screen.

**7. Things need to be done at a later date**

- 8. Monitoring (ie. Synthroid), statins (check lipid, LFTs)
- 9. Counseling

- a. **Case specific**

- i. Patient had Trichomonas. So need to council the patient regarding their partners treatment
- ii. Anaplyxis
  - 1. Patient need to know about epinephrine
- iii. Child with asthma
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- b. Routine council (Not important for ER cases. Important for Office cases)
  - i. Routine screening
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## Pearls:

- **Need to move patient?**

- Stabilize them first
- If patients needs catheterization or surgery and patient is in the ER?
  - **Schedule it while the patient is in the ER and wait UNTIL procedure is done. Then MOVE the patient after to ICU or to the ward.**
- Patient needs needle thoracos and chest tube?
  - Order it in the ER and then MOVE. DON'T MOVE the patient from ER (i.e) until the procedure is done. Once procedure is complete then move the patient

Archer video 1: this video includes strategy clip. So 2 hr and 45 minute of this video is strategy clip from video 4

- If you think that patient needs surgery and you order it. Consult comes and sees and says, surgery is not needed then that means you haven't met the criteria for surgery. Meaning, you haven't ordered or haven't seen the results on your imaging and or labs to confirm the need for surgery. After doing so, re order surgery and this time, consult will come and will accept the patient.

Discharge the patient:

If you admitted the patient, then keep the patient in the hospital for 24 hours. So lets say, you admitted the patient and patient is doing well. As you advance the clock to get to day 2 so that you can discharge the patient..If the case ends before that then **in the 2 min screen write DISCHARGE patient because** you are seeing the 2 min screen BEFORE 24 hours have elapsed.

You scheduled an appointment and then you stopped the clock. You need to re schedule the appointment and if you don't then the patient will show up randomly because there isn't scheduled appointment. Which can canceled when you stopped the clock.]]

- **If the software doesn't end the case within 24 hours and lets the case run for more than 24 hours then it probably means that software wants you to discharge the patient before it ends**

**the case for you.** So be a normal doc on day 2 as well. So do a focused exam, with focused labs to see how the patient is doing.

- Recommendations regarding moving clock:
  - Look at your most important ordered test and its return time. And move the clock to that particular point in time.

Example: In your office case if the patient doesn't warrant admission (very sick looking, unstable vitals etc these patients need admission) if patient isn't very sick looking or have stable vitals these patients should be sent home after ordering appropriate tests AND treating her CC. Give her something for her chief complaint and send her home. But do treat her present symptoms. If she's really sick etc then do PE and send her to the ER. In the ER, just do focus exam.

As you are advancing the clock, if an abnormal lab/test pops up then stop the clock and address the problem. But remember, stopping the clock will cancel all the pending orders so have to re-order them

Move the patient from ER to ICU?

- Have presumptive diagnosis so that you can have some idea about the diagnosis and that's because of labs/imaging ordered.
- Patient is stable
  - Then transfer the patient.

When looking at the vitals think critically. If has fever then think about source of infection. Then it could sepsis, bacteremia so that would require CBC and or UA to find the source of infection. Also need to order central line and ABGs. If hypotensive then think about the cause and how you can find out the reasoning?? Sepsis guidelines need to be implemented in 2 hours...

### **10 min case expectation:**

They just want you to realize the problem and quickly reverse it with a life saving step. They are just testing you on FAST management. So clues will be obvious. And requires fast life saving management

### **20 min case expectation:**

Here, they are expecting you to go one step at home and be thorough and keep your differentials broad. Be comprehensive in your orders and be broad.

Whenever you think about IV medications then they might have to be admitted.]

- Whenever patient comes back for a f/u, just do focused PE and no need to do full PE.
- Start MTX, then add folic acid.
- Steroids?...add Ca and vit d
- When you order a follow up. lets say, its pneumothorax and you ordered needle. Pay attention to needle report time and only ordered follow up once the report time has passed.

### **Strategy Video:**

1. Note location
  - a. ER or office
2. Look at CC
  - a. ER are usually severe and require admission. Rarely has to DC patient.
    - i. Pt will have pain. Pain will be severe so need to address this first.
      1. IF abdominal case then do PE first and then pain management because if you did pain management first then your PE might not be accurate. So PE then pain management
      2. Other cases except abdominal
        - a. Pain management then PE
3. Pulse by itself is not abnormal unless it's hemodynamic unstable.
  - a. Important vitals are: BP and RR
4. When you get patients history it can be complete (indicating that don't need to go back over n over to ask for interval history). If incomplete then have to go back.
  - a. Remember history is part of the exam. It's your job to stabilize the patient and then get more history (remember pneumothorax practice case). So if you only got part of history then lose points
5. General systems of PE must be done even in ER cases. While you are waiting for orders to come back, and advancing clock passively. Go and finish rest of your PE. Doesn't have to do absolutely every single physical but do at least the major systems.
6. **Check the time of your report. For example if you ordered CBC and EKG and whichever is more important to move forward then move the clock to the time when this particular report comes back.**

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General Notes from UW CCS interactive cases:

- 1) Memory problem patient needs:
  - a. Council, cognitive rehab, occupational therapy, ensuring good nutrition, no driving, medic alert bracelet.

Counseling:

No smoking

No alcohol

Medication compliance

VACCINES