Read about the presentation of cauda equina vs. sciatica so that you are familiar with the sx and exam findings. IF you ever work in a small hospital without MRI, you will have to decide whether to transfer or not, based on your clinical judgment.

Slow night. Occasionally had to be reminded to check on a pt., but overall very good performance. Consider being more concise when presenting a pt in rounds. Lead with the most important issues, rather than giving a chronological report. This helps the listener to focus on the issues and plan.

Shorten your signout presentations

Remember to use most dangerous potential dx to drive your work up/ed management

Read on alcohol metabolism. Avoid guessing answer to med knowledge questions: if you don’t know, it’s okay to say you are going to look it up. :D

Take a few minutes to organize your presentations before signout. It will help you, the patients, and the person to whom you hand off those patients.

Leah - continue to work on organizing your presentations, particularly with complex and complicated patients. Think about approaching each presentation in the same order.

Think carefully about possible patient limitations when about to discharge someone. Abnormal vital signs, hypoxia with minimal exertion (always roadtest pts with pulmonary issues to detect hypoxia, esp. pts with HIV relaed infections), should not go home unless there is a bullet-proof plan for follow-up and monitoring.

Don’t forget to give tetanus to your pt’s who have unknown vaccination status

Keep working on adding medical decision making to your charts

Re: Pt. with IVDU and PNA - take a look at the online book, "Introduction to bedside Ultrasound." Volume 1, chapter 4 has a good (short) section on diagnosing PNA with U/S. Looks just like what we saw with this pt.

Remember to keep smiling and be as relaxed in demeanor as possible given the situation in resuscitation. Puts the ED staff at ease and facilitates better team work.

Tiffany is not done a lot of the procedural sedations at this point in her residency. She still needs a fair amount of guidance in medication dosages what is comfortable with the pre sedation evaluation and consent process.

Consider time outs for procedures...not commonly done but still a good idea.

Try to see your sign out patients earlier in the shift so you have a clear dispo for them by the next sign out. Avoid assigning the patient as being a pt from the prior team during sign out because that is frequently a cue that you have not thoroughly followed that patient during your shift (even if you have).

I did not realize how altered and agitated one of our patients had become, and that pt ended up getting intubated during the next shift. He was originally seen by the resusc team and had a udm positive for amphetamines. My fault as much as yours, but I think it would help you to 1) slow down a bit to make sure you are thoroughly seeing everyone, and 2) see your sign outs earlier in the shift. I will take my own advice also. :-) Strike a balance between seeing many patients and attention to detail.

Please be careful when talking about pts., especially when you are on the phone or at the desk. Even if your pt. can’t hear you, other pts and their families can. Speaking derogatorily or flippantly about a pt. will not benefit the pt. or you. Try to believe (even though it is VERY HARD to do so) that each pt is doing the best he/she can, with the resources available to him/her (it’s a Zen thing!).

Need to gain more confidence with your U/S skills. If you are handling trauma and resus pts, this is a very important tool that you need to master.

Make sure to complete notes before leaving your shift.

Be careful in your communication style to nurses, techs and clerks. A few have voiced concern that you are unnecessarily sarcastic in stressful situations (i.e. the resusc room).

Make sure to include completed EKG’s and procedures in your notes.