Overview

General Structure

Day Team

- Hours **6 AM-6 PM**
- Please arrive on time for sign out from the respective day or night team
- Day residents will be assigned to either the orange or the blue team
- Interns can expect to be responsible for 4-5 patients daily, based on the number of members on the team
- On days with only 1 intern when the senior is writing at least 5 progress notes, the maximum number of admissions will be capped at two for a maximum of 12 patients
- On days with 2 interns, the maximum number of admissions will be capped at four for a maximum of 14 patients
- If medical students are present, they should take 1-2 patients from the senior resident's list
- Sign in to your patients daily utilizing the sign in tab

Night Team

- Hours **6 PM-6 AM**
- Review all hand-offs upon arrival after sign-out
- Please check in with daytime nursing staff to ensure that all daytime needs have been met for each patient. This can be achieved by completing walking rounds at the start of each night shift.
- Keep a tab of all orders/clinical status changes that occur to present at sign-out
- If any significant events happen (code, family meetings), please document this with a progress note in SOAP format. This does not need to be co-signed by an attending.
- **All admissions brought in overnight are considered teaching patients** until they are redistributed in the morning by the attending.
- If you are paged by nursing, the best strategy is to GO TO BEDSIDE and assess.
- If there is an emergency in the ICU, regardless of if the patient is teaching v non-teaching, residents must respond to this
- Ensure to update the attending and fellow about any major changes that occur overnight. This includes but is not limited to addition of vasopressors, major increase in vasopressor dosing (notify senior of any pressor changes overnight, if don't hear back in reasonable timeline follow chain of command, i.e dose increase of 5 mcg of levo), addition of HFNC or NIV, difficulty with sedation/agitation, and change in mental status or new neurologic deficits
- Attendings/fellows need to be notified and involved in code status change discussions

Sign-out structure

- Sign-out starts promptly at 6 AM and 6 PM
- Interns are responsible for leading sign-out on their respective patients

I-PASS: Verbal Handoff Tool

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading to admission • Hospital Course • Ongoing assessment • Plan
A	Action List	• To do list • Timeline and ownership
S	Situation Awareness & Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

- Start sign out with a brief 1-liner regarding the reason the patient is currently in the ICU
- Briefly summarize the significant events that occurred during the day or overnight (e.g. i.e. significant neurologic changes, starting pressors, change in code status, code blue)
- Discuss things that the night or day team needs to follow up on (i.e. labs, imaging, code status)
- Include things that need to be followed up or potential anticipated calls/events with options for management in the written hand-off
- All written hand-offs should be updated daily

Pre-Charting

- Ensure you are logged in under the critical care context
- Review all vital signs, labs, I/Os, lines/drains/airways, micro, imaging, specialist notes, orders
- Attempt to look at all imaging before reading the radiologist's report
- Review and clean up orders
- Ensure all electrolytes are replaced
- Review DVT ppx, GI ppx, and nutrition

Pre-Rounding

- Try to talk to the night nurses before shift change at 7 AM. They are incredibly knowledgeable and helpful! They will give you insight into the patient's pressor needs, current clinical status, I/Os, bowel movements etc…
- Assess current drips (vasopressors, sedation/analgesia, antibiotics etc…). This is best done at the bedside, as the flowsheet is not always up to date
- Assess vent settings (FiO2, PEEP, tidal volume, respiratory rate). If the patient has concern for ARDS, calculate a P/F ratio.
- Assess tube feeds. Rate? Are they at goal? Are free water flushes ordered? Is the dietitian consulted?
- Check chart or discuss with respiratory therapy to determine if your patient passed a SAT/SBT (spontaneous awakening trial/spontaneous breathing trial)
- Complete detailed physical exam. In the ICU, use tools available to you! Don't be afraid to use an ultrasound to guide your volume assessment!

Notes

- Utilize template (.ccprogressnote1), please ask your senior resident for access to the template
- All notes should be co-signed to your team's attending
- If a medical student is writing a progress note, the note should be assigned to the senior resident who will then co-sign the note to the attending
- Try to keep notes concise and please update relevant information DAILY
- Make sure that you are updating your assessment and plan. The admitting diagnosis may not be the current or primary diagnosis!
- Update hospital summary at the top of the note as events occur. Avoid copying/pasting the same summary daily.
- Families should be updated daily. Utilize the template (.familycommunication) template to document this

Rounds

- Timing based on attending preference. Your senior will coordinate when rounds will start (typically between 8:30-9:00)
- Interdisciplinary rounds are common in the ICU. You may round with nephrology, infectious disease, pharmacy, ethics etc…
- At least 1 intern from each team should ensure that a WOW is brought to rounds. The person presenting should also not be entering orders as it disrupts the flow of rounds
- During rounds, be prepared to show relevant imaging for the team to review
- Presentations (unless the patient is new/new to the attending) should start with overnight events, followed by SOAP format
- Be prepared to discuss your assessment and plan in detail, including changes/reasoning behind changes you want to make that day. The ICU is constantly changing, and your assessment and plan should as well. **Take ownership of your patients!**
- After rounds, make sure to run the patient by your senior to confirm that all orders discussed have been placed appropriately

- Review medication and active orders list. Update appropriately (discontinue duplicate ordered, drips that are no longer being utilized, old vent orders)

Family Communication

- All families should be updated daily for every patient. If a family member is present at the bedside, this is sufficient.
- If the family is not at bedside, a phone call should be made.
- Please document all phone calls even if the NOK does not answer and use the dot phrase (.familycommunication)
- Phone consent for procedures and blood will require a witness (this can be a co-resident or nurse). These forms can be found by the ICU secretary. Note these are different consent forms than Procedure consent forms. Patient labels should be attached to the physical form and document should be placed in physical chart outside patient room.

Transfers

- Check the covering provider for the patient on the Summa@work page
- Contact the admitting service that covers the patient via EPIC chat and provide a brief overview of the patient's course to facilitate transfer
- Once the patient is accepted, then place transfer orders under the "**Transfer" tab** and cancel ALL ICU specific orders (this includes all vasopressors, sedation, drips, etc.). Please initially have your senior review the transfer orders
- Remove all unnecessary lines (central lines, arterial lines), and foley catheters
- Complete the ICU transfer checklist note in chart (.cctransferchecklist) - ensure you are under the critical care context
- If a patient was transferred from a med team to the ICU from the floor, they will go back to that same team.
- If a patient is a med team patient and was directly admitted to the ICU, contact the team who was admitting on the same day the patient was admitted
    - To find out who was admitting that day go to Summalearner.com and click on schedules found under the drop-down column using the blue column icon. Click on med team schedule for corresponding month, reference the date of admit and which team (i.e. A/B/C/D) is listed directly underneath the numerical date
- Complex care patients will go to USACS
- Prior to transfer, please clarify if patient will need telemetry
- If patient is on PAP, please ensure the correct form of PAP is ordered/continued

Discharges

- ICU discharges are rare, but may occur
- Please use the dot phrase (.ccdischargesummary)
- Route discharge summary to patient's PCP

- If discharging to a SNF/rehab/LTAC, will need to complete COC which can be found under the discharge tab (only complete the physician section)
- Regarding discharge orders, this will also be under the discharge tab. Please closely review ALL medications. Most ICU medications will NOT be continued on discharge. Review your discharge medication orders with your senior prior to signing.
- If discharging home, and the patient is an IMC patient, will need to set up IMC hospital follow up appointment and create TCM encounter (.imctcmnote) which will be routed to Nate Conway
- If patient requires outpatient IV antibiotics on discharge ensure ID has filled out OPAT for antibiotics at correct dose, frequency, and duration. Found under "Chart Review" tab in the top column under subtab "Media"

Patient Death

- If a patient expires, please ensure that a death exam is completed and a death note (.deathnote) is documented in the chart
- Ensure the attending and fellow are notified the patient has expired
- After the death exam is completed, the Summit County coroner's office will need to be called and notified of the patient's death (330-643-2101)
- After speaking with the coroner, they will let you know whether or not the body can be released to the morgue. Please update the nurse regarding this.
- A discharge summary will need to be completed for expired patients using same discharge template as above

Code Blue

- During the day the admitting team will be holding the pagers and will be responsible for responding to Code Blues called overhead. At night the senior and intern respond to all codes
- Residents respond to all Codes in all areas of the hospital, except for Team 4's
- If you are the first person responding to a Code and you aren't sure what to do, attempt to gather as much information as possible. If the patient is truly pulseless just ensure that someone is doing compressions until back-up (senior resident, fellow, or attending arrive). If possible, have the patient's chart pulled up with all relevant most recent labs, figure out why the patient is admitted, verify code status, any relevant surgeries/procedures that occurred that day
- If a floor code and the patient is being transferred to the ICU, you must follow the patient while being transported to the ICU if ROSC is obtained.
- If code called on a non-patient, you must follow them to the ED, and update the ED team so that they can take over
- To call a code, the extension is *757
- If you are the resident that calls and speaks to family, please be sure to document the conversation
- Important Dotphrase (.familycommunication, .codeblue)

Consent

- Consent must be obtained for all procedures that are performed in the ICU as well as for administration of blood products. Ideally, we obtain consent from the patient. If not able to consent, we must obtain it from next of kin (NOK)
- Familiarize yourself with the most common risks and benefits of the procedures that are performed in the ICU as this is information that must be provided when obtaining consent
- Consent forms and patient labels are typically located by the secretary's station in the ICU. If phone consent is obtained, 2-person consent is required (one person obtains consent, the other acts as a witness)
- Document conversations regarding consent via phone using the .familycommunication dotphrase

Procedures

- All procedures performed are documented using the .procdoc dotpharase which then opens a selection window for various procedures that you can then click through
- All procedures performed by residents must be supervised by fellow/attending

Navigating Epic

- ICU lists are located under the physician/group patients and then you must scroll down to the respective ICU Blue and Orange Resident lists. There are labeled at ACH SHMG ICU Blue/Orange Resident
- Sign in to your respective patients daily utilizing the sign-in tab

Smart Phrase Guide

H&P/Consult: .CCINITIALNOTE

Progress: .CCPROGRESSNOTE1

Transfer note: .CCTRANSFERCHECKLIST

Discharge: .CCDISCHARGESSUMMARYANDPROGRESSNOTE or .CCDISCHARGESUMMARY

Sepsis note: .SEPSISCOREMEASURESUMMA

Code blue: .CODEBLUESUMMA

Death note: .DEATHNOTE

Sign-out

- **.IMICUHANDOFF**
- **.IMICUMEDNOTES**
- **.IMICUTODO**

Procedures: .Procdoc