Intensive Care Unit
Resident Service Policy
Manual

Henry Ford Macomb Hospital

Academic Year

2021-2022

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MEDICAL ICU RESIDENT RESPONSIBILITY:

a. Documentation:

i. Residents must complete all documentation either by using MModal or typing the consults, H&Ps, progress notes, and discharge summaries for timely documentation per hospital policy. Using ICU templates or attending approved format. Residents need to use the "problem list" to list the up to date diagnosis daily and this should be populated into your assessment and plan. Rounding box should be populated with plan to help with handoff between residents.

ii. Document: time and date when the patient was seen.

iii. Document the name of the rounding ICU attending for the patient. (Example: "*case was discussed with Dr. Osobamiro via phone on 7/1/14 at 1500"* or "*the patient was seen and examined with Dr. Huda on 7/1/14 at 1500*", or that *"the case will be discussed with Dr. Huda"*).

iv. Document a note in the chart of any significant overnight events. (i.e. change in code status, family discussions, patient decompensation).

v. Document names of family members who have been updated

vi. The resident should update "handoff notes" section in epic. Include all important sign out information, limit extraneous information in the sign-out.

vii. Rectify/update VTE/best practice advisory on every new admission.

viii. Daily progress notes should include, (see the MICU progress note template) :

1. Time and date, you examined the patient
2. Intubation and extubation dates (and re-intubation date if applicable)
3. Date antibiotics were started and why.
4. Dates central lines, PICC line, arterial lines, Foley catheters were placed.
5. "FAST HUG BID" (Feeding, antibiotics, sedation, thromboembolism prophylaxis, Head of bed, ulcer prevention, glucose level, bowel regimen, indwelling Foley, de-escalation (abx, lines, drips, vent, etc)).

6. ICU attending that staffed the patient.

ix. Daily progress notes should not be signed out to the night team

b. Patient Care:

i. It is the responsibility of the ICU resident/consult resident to triage all ICU admissions. When you are called for a consult from ER or the floor, have a person to person discussion regarding the availability of work-up information. You can kindly request that they call you back at the availability of the results when pertinent. For example; if a patient is **not intubated** and ER calls to tell you they will need a bed but all the labs are not back yet, kindly inform them to give you call when the work up is complete and you will come to down to evaluate the patient once you get a call back with the values. Please place a one-two liner in the chart saying you got a call from the ER to evaluate, but are awaiting a call back once "x-ray, abg, lab work, etc." are available to evaluate the patient. This is very important. It is your responsibility to be aware of all the information when you accept a patient. Same thing goes for post-operative patients. Instruct them to call you once patient is in post-op area so you may evaluate them and decide if they need ICU care or not.

ii. If the ICU resident deems a patient needs to come to the ICU, he/she should call central bed at 2350 (then click 7). Request the appropriate ICU/SDU bed and inform the ICU charge nurse (either 2500 or 3500). During nights, inform charge nurse or nurse manager (#5007) of the need for bed.

iii. If you get called on a patient, take care of the patient! All patients, if possible, should be seen within 30 minutes and decision for placement made within 60 minutes. **Refusal of accepting a patient to the unit, must be made after discussing with the intensivist.** If the ICU team is attending to an urgent patient issue, such as placement of lines, please kindly let the consulting physician be aware you will be there as soon as possible, and they should continue managing the patient.

iv. ICU residents are not responsible for CABG patients or Trauma patients; but if you get called to help, please assist.

v. If a patient needs consult/consults to a specialist, it should be addressed with the rounding Intensivist before being placed. However, overnight consults maybe placed at your own discretion, if unsure, you may call the on-call intensivist. Be sure to sign out to the day team any consults placed overnight.

vi. We have a closed unit, please be aware of orders that may "sneak in" to patient's chart. Gently remind consultants that all orders need to be placed either by the ICU residents or the intensivist, to ensure patient safety.

vii. The patient load is assessed at the beginning of the ICU shift. If one intern had 6 patients at beginning of day but discharged one patient in the morning/afternoon, they can still pick up a patient later in the day. If the team is at the maximum of 6-6-8 in the morning, yet night team has more admissions, they need to speak with intensivists as the overflow patients will be seen by the consult resident and intensivist alone.

viii. It will be up to the discretion of the ICU senior if a new consult should assigned to the ICU consult person or an intern. If things are wrapped up after rounds and interns are free, they should ideally be performing new consults since they will be taking care of patients the following day. The person in charge of doing a consult will be doing the note and orders. If the ICU senior is busy, ICU consult person should supervise the intern performing the consult.

ix. **ICU consult person must be present from 7am - 7pm**. ICU consult person is expected to be rounding with the team, if they are not seeing a new consult. This will allow the entire team to be aware of the plan as we are moving forward with the rotating schedule. A maximum of new consults per day shift including both the ICU consult person and ICU day team. Inform the Intensivist of the additional consults.

x. During night coverage, the senior resident and intern may work as a team with the 2500 NP/PA in cases where there are a high-volume of admissions or help is needed with placing lines. Admissions as always should be staffed with the on-call attending and the H&P should be signed out to the incoming morning team/2500 day PA/NP.

c. Communication with ICU/medical staff/family:

i. Inform the 2500-unit ICU staff when you know a patient will be going to that unit. H&P and orders ideally to be completed by the midlevel covering 2500 at night. The senior should still evaluate these patients.
ii. Attempts should be made to inform the attending from the GPU if a patient is transferred.
iii. Attempts should be made to inform family of patient transfer. **Keep in mind HIPAA policies.**

iv. All communication should be documented in a timely manner.

d. Nighttime Communication:

i. **Every patient needs to be staffed with the ICU physician on call** and document the ICU attending name.
ii. Please note that critically ill patients (code blue, cardiac arrest) should be staffed in a more urgent manner and use your common sense to decide which patient should be staffed more urgently also.

iii. To reach the ICU attending on call:

1. For night consults, call intensivist on call
2. Day consults are to be staffed with daytime rounder
3. Pager or cell phone (contact information for all intensivists are on the white board in unit 35 resident area)
4. Operator
5. HALO text application

e. Withdrawal of Care:

i. Withdrawal of care cannot be done without speaking with an ICU attending (unless there is written documentation that withdrawal of care was pending). Discussion regarding withdrawal of care and/or changes in code status are required to be documented in chart as well as an order placed in Epic.

f. Daily Rounds:

i. Be prepared to round with the ICU staff by 9:30am (this time will vary based on ICU staff)

ii. Please discuss with your ICU staff who will be staffing the new admissions or new consults in the afternoon, attending clinic afternoons will vary based on rounder

iii.Notes are ideally completed before rounds to best of the ability of the intern/resident.

iv. There is a schedule posted for the on-call intensivist for that night located in the resident work area in 3500.

iv. After rounds nursing staff should be made aware of potential transfers and orders should be placed as early as possible in order to facilitate transfer.
v. It is advisable that the night team perform rounds at the beginning of the shift in order to place eyes on all patients.

g. Admissions to ICU:

i. Please place a new **"consult" to a medicine service** at the beginning of the admission for "Post-ICU care". If the patient was transferred to the ICU and was being followed by an attending prior to ICU transfer, place a new consult to the same attending. (Otherwise, they will not appear on their list).

ii. Use **"Medical intensive care unit" order set**, appropriate electrolyte, glucose protocols in Epic.

iii. Admission/transfer reconciliation must be performed. Pharmacy to verify home medications, though the responsibility of medication history ultimately falls on the resident. Orders should be released by the nursing staff once patient arrives on the unit. Orders should be released immediately if the patient has an expected prolonged course in the ER.

iv. If there is a rapid response on the floor, it is the responsibility of the senior IM resident to take care of any patient until the patient is physically in the ICU or the ICU Consult resident states that they will be taking full responsibility (which means the nurse may call their phone with any questions and pertinent orders placed by ICU team while patient is on floor.) Keep in mind this scenario is for patients whom the rapid team believes needs ICU care and they themselves are putting in ICU consults. If the rapid response team treats a patient and do not believe patient needs ICU care, yet private attending says consult ICU, then IM resident should be called if there are any change in hemodynamics until ICU team performs a proper disposition on the patient.

h. 2500 calls to the ICU resident (during the day):

i. Please direct calls from the 2500-unit RN and pharmacy to the 2500-unit MLP or Attending (Please use common sense when called about patient care from 2500).

ii. 2500 is covered by midlevels most evenings. Calls to the ICU resident (at night): handle all problems and questions in which Dr. Osobamiro, Dr. Huda or other intensivist from the HF Medical Group are the admitting service. If the NP (5030) is working at night, they are also available to triage general phone calls for issues on 2500. They are also available to help the night team with admission. It is important that the residents and NP/PAs work as a team when caring for the patients on 3500 and 2500. This excludes trauma patients and Dr. Harrington patients in general.

i. Transfer out of the ICU:

i. Consult Dr. Osobamiro for "ICU-follow up." If he was the attending following the patient.

ii. Please discuss with intensivist which patients they want to follow on medical floor.

iii. Stop tight glucose control, transition to GPU glycemic protocol if needed.

iv. You may continue electrolyte control.

v. Place "bed request" order with future admitting internal medicine provider.

vi. Modify vital checks from q1 hour to q4 hours.

vii. Do transfer medication reconciliation, order pertinent labs for next am as a courtesy to accepting physician.

viii. Call medicine/surgery service that will be assuming primary service on the medical/surgery floor (if physician not reachable, place a communication order for the floor RN to contact primary service when the patient arrives to the floor.)

ix. Please re-evaluate the need for bipap/cpap on GPU. Per policy foley catheter and central/arterial line should be removed prior to transfer unless still required. If a central line is kept in place and the patient is transferred to the floor, it is the house officer's responsibility to remove the central line when needed.

WEEK 1	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
DATE							
T1	fl	fl	fl	fl	fl	cs	Off
T2	cs	cs	cs	cs	cs	OFF	CALL
T3	PC	OFF	fl	fl	fl	fl	fl
T4	NIGHT	NIGHT	NIGHT	NIGHT	NIGHT	OFF	OFF
WEEK 2	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
DATE							
T1	cs	cs	cs	cs	cs	OFF	CALL
T2	PC	OFF	fl	fl	fl	fl	fl
T3	NIGHT	NIGHT	NIGHT	NIGHT	NIGHT	OFF	OFF
T4	fl	fl	fl	fl	fl	cs	OFF
WEEK 3	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
DATE							
T1	PC	OFF	fl	fl	fl	fl	fl
T2	NIGHT	NIGHT	NIGHT	NIGHT	NIGHT	OFF	OFF
T3	fl	fl	fl	fl	fl	cs	OFF
T4	cs	cs	cs	cs	cs	OFF	CALL
WEEK 4	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
DATE							
T1	NIGHT	NIGHT	NIGHT	NIGHT	NIGHT	OFF	OFF
T2	fl	fl	fl	fl	fl	cs	OFF
T3	cs	cs	cs	cs	cs	OFF	CALL
T4	PC	OFF	fl	fl	fl	fl	fl

ICU Patient Caps

ICU Caps for days

PGY1 : ICU admissions will be 2 less than general medicine due the acuity of illness and need for procedures. Total number of patients no more than 6 per PGY1

PGY2/3 **:**

1 Resident and 2 interns team will not be responsible for no more than 12 patients (6 per intern).

2 Resident and 2 intern team will not be responsible for no more than 18 patients (9 per resident and intern team)

2 resident and 1 intern team will be responsible for 15 patients (9 for 1 resident and 1intern team, 6 for second senior resident)

Consult Senior: 7am -7pm : 6 consults last consult at 6 pm. It will provide adequate time to work up patient, complete notes, place lines if needed, and staff patient with Intensivist

ICU Caps for nights

During night coverage, a maximum of 6 new patients for the team of 1 senior and 1 intern. Last consult 5am. MLP to work with residents for new admissions. If caps present for MLP's per shift, they are to discuss with their Director.

H&P and orders to be completed by the midlevel covering 2500 at night. The senior should still evaluate these patients.

Every patient needs to be staffed with the ICU physician on call and document the ICU attending

name. 2500 MLP (evenings and nights) provide cross coverage and triage of patient issues.

3500 ICU resident (at night) provide cross coverage and triage of patient issues.

If the NP (5030) is working at night, they are to triage general phone calls for issues on 2500. They are to help the night team with admissions. It is important that the residents and NP/PAs work as a team when caring for the patients on 3500 and 2500.

ICU Call Policies

Residents

- Consult resident.
  - This person will carry the 5611 phone.
  - Responsibilities include managing admissions, all ICU patient's pending transfer to the ICU, and 2500 when attending is out of the unit.
  - Consult resident will stay until 5pm at the earliest.
- For senior resident.
  - This person will carry the 5612 phone.
  - Responsibilities include managing both 3500 unit patients, afternoon admissions, and helping the other resident.

24 hour Call Shifts

- Time
  - Saturday 7:00 am – Sunday 7:00 am
  - Call team is responsible for new admissions during the day and evening.
- Both residents will actively participate in the care of and dedicate their designated shift to the patients in the ICU.
- One senior must stay in the ICU for care of the ICU except to see a new consult.
  - Examples: Going into the OR for a surgical case or emergent procedures in the ER not pertaining to a pending ICU patient. Turning off or forwarding ICU phones.

- The resident must staff admissions with West Bloomfield Intensivist or the on call intensivist prior to the end of the shift.

Refused Consults

If a consult is to be refused from the unit, the intensivist must be called prior to refusal. Patients, who were refused overnight, must be signed out to the day team and the consult person along with the intensivist must evaluate the patient. Attending who placed the consult needs to be informed of the refusal.

Sign Out List

- The sign out on “hand off notes” in epic should be updated with any pertinent information. New patients admitted throughout the day should have completed information prior to leaving your shift.

Paid ICU Shifts

- Available to any second year and above in Internal Medicine and ER seniors (3rd year or 4th year) potentially could paid ICU shifts, but will need clearance from Dr Osobamiro and Dr Aravapally first, in edition to their program directors
- If available and interested, submit your order of preference of which shift you would like to work. Paid ICU shifts are available on Friday nights. Slots will be filled as first come first serve.
- **For the first several months of the year, all 2nd year IM resident will be paired with a 3rd year IM resident or 3th year ER resident. 2nd year IM resident and 3rd EM residents will be paired together later in the year.**
- Initial assignment of shifts will be based on preferences and subsequently in rolling order to seniors on electives and seniors with multiple golden weekends.
- Initial ICU schedule, at the latest, will be released by the 10th of the preceding month. The schedule can be released prior.
- If there are any open shifts after the 21st, the mandatory paid ICU shifts policy will be instituted.
- This framework should be followed except when circumstances are extenuating, such as annual schedule availability, etc.
- If paid ICU shifts are not filled by the 21st of each month or per the ICU scheduler, it will be filled based on participation.
- Please review the separate moonlighting policies. Should the residents violate these expectations, they will no longer be considered for future shifts.

Discloser.

- This policy can be changed at any time by the discretion of the program director.
- Schedule template is subject to change on months with more residents than teams and at the discretion of the program director.