Table of Contents:

A.) Medical ICU Resident Responsibility.
   - Documentation
   - Patient Care
   - Communication with ICU Staff
   - Night Time Communication
   - Withdrawal of Care
   - Daily Rounds
   - Admissions to ICU
   - 2500 Calls to ICU Resident (During the day)
   - Transfer out of the ICU

B.) ICU Call Policy.
   - Residents
   - Call Shifts
   - Call Team
   - Admissions
   - Sign out List
   - Assignment of paid ICU shifts
   - Policies
MEDICAL ICU RESIDENT RESPONSIBILITY:

a. Documentation:

i. Residents must complete all 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 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. Calvo 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 back to evaluate the patient. This is very important. It is your responsibility to know what you are dealing with when you accept a patient. Same thing goes for post-operative patients. Instruct them to call you once patient is actually 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 ATMO and request the appropriate ICU/SDU bed and inform the ICU charge nurse (either 2500 or 3500). During night, 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 has to 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 needs to be placed either by the ICU residents or the intensivist, to ensure patient safety.
vii. **With 2 intern teams during the day, there will be maximum of 6 patients per intern and 8 for the senior(s).** 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. APP are available to take patients when present. Intensivist and APP are responsible for patient care on unit 2500. Again, help out when needed. Consult resident is to cover unit 2500 during the day if the intensivist is gone to clinic and no midlevel is available.

viii. With 3 intern teams during the day, there will be a maximum of 6 patients per intern. This will leave the total cap of 20 patients for the team. Additional patients will go to the intensivist as described above. It is up to the discretion of senior how many patients, he/she should personally be responsible for if the interns are capped at 6 each.

ix. 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.

x. **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. Inform the Intensivist of the additional consults.

xi. During night coverage, there will be a maximum of 8 patients for the team. Any additional admission should still be seen by the senior with orders placed and a brief note in the chart (ex. septic shock, start pressors, hcap, start abx, etc.) The full h&p should be signed out to the incoming morning team/consult resident/attending. If there are more than 8 new patients, please take care of them to your full capacity to address the urgent/emergent needs (i.e. placing lines etc.). Calls at night are covered but the midlevel on unit 2500. The ICU senior is there for assistance. Night team is to cover unit 2500 when no midlevel is available.

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. Night Time Communication:
   i. Every patient needs to be staffed with the ICU physician on call and document the ICU attending name. Patients admitted at night are staffed with the Intensivist at West Bloomfield. At night, the name of the ICU attending at West Bloomfield must be documented in the H&P note.
   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 at HF West Bloomfield – (248) 325-3001.
      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. Perfect serve 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 staff. (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.

j. **Didactics.**
   i) The ICU team will have mandatory didactic sessions every Tuesday and Thursday of the week. This will be given by the attending. Didactics are scheduled from 1:30 pm to 2:00 pm. Wednesday afternoons are available at the discretion of the intensivist and ICU team. If a emergency occurs the ICU senior is to step out and manage the situation. If a consult occurs the consult resident is to leave didactics to evaluate the patient.
### ICU Schedule

ii) Teams will be consistent of one intern and one senior.

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ICU Call Policies

Residents

- Two residents on call, admissions to the unit are alternated between the two residents, unless other arrangements are agreed upon.
- 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 4th 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.
- Shifts will be paid at $75/hour
- Vacations and prior plans will be taken into account when assigning shifts.
- Should the resident violate this expectation, 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.