Welcome to the Crouse ICU!!!

This email is a guide for Crouse. Please read it in completion as the information here has been collected for your benefit based on feedback from previous classes of residents as well as current IM and EM Chief Residents. These documents can also be accessed here: Resident Resources Drive.

THE MOST IMPORTANT GUIDANCE FOR THE CROUSE ICU ROATION IS: PLEASE CALL THE CROUSE ON-CALL ATTENDING ASAP AND 24 * 7 WITH ANY CONCERNS, QUESTIONS, PATIENT RELATED MATTERS, CONFLICTS, AND ACUTE/SEVERE PATIENT DECOMPENSATIONS

- **Put in the new call structure**
- **Explain short and long call**
- **Update the night-time structure guidance**
- **Clarify role of Upstate fellows**
- **Infographic on clinicians on Crouse ICU team**
- **Infographic on Who's Who at Crouse ICU (Seating/Contact)**
- **Anatomy of Crouse Hospital: Jennifer**

Announcements:

- **If you have any concerns, you *must* reach out to the attending on call and/or the IM Chief Resident on call in real time based on urgency**

Schedule:

Daily Workflow Guide:

- **7:00 – 7:30 am: Daily sign-out @ the ICU (3rd floor Irving Building) conference room**
- **7:30 – 8:30 am: Pre-round on your assigned patients**
- **8:30 am: May start later but please be prepared to round with the attending at 8:30 am and have the 4 large screen WOWs available**
- **During rounds, the pre-call resident & intern will input orders and pull up imaging studies/labs, unless they are presenting patients**
- **After rounds conclude, call consults, finish inputting orders, and follow-up on pending work-up**
- **12 pm – 1 pm: Noon Didactics (For all IM interns). Seniors will manage the ICU/grab lunch during this time**
- **1:00 – 2:00 pm: Wednesday and Thursday: Crouse ICU conference (see details below)**
- **2:00 – 3:30 pm: Re-evaluate your patients, follow-up on pending work-up/consult notes, ensure all pending tasks for the day are addressed**
- **3:30 or 4 pm (depending on service acuity): Afternoon *bedside rounds* with On-Call Attending and/or the PCCM/CCM Fellow**
- **Post PM rounds: Whomever is not on call may leave after confirming with the fellow and the long call senior resident. Prior to leaving, give a verbal sign-out to long call team**

Call and Overnight Workflow:

- **Two Crouse NF residents (PGY2 and/or PGY3) will serve on-site as night-time coverage from 7:00 pm – 7:00 am**
- **7:00 – 7:30 pm: Sign-out between the long call team and the 2-night float seniors**
- **9 pm (or when feasible): Night float team should meet with the overnight PA (if covering that night) and go over the patient care plans for the day, ideally at bedside. Feel free to call the on-call attending at this time to clarify plans**
- **6 am: Run the list as a team (both seniors + PA) to ensure details are communicated about care of all patients overnight, so they can be shared with the morning team**

***** INFOGRAPHIC**
***** SIGNING OUT OVERNIGHT WORK AND ADMISSIONS**

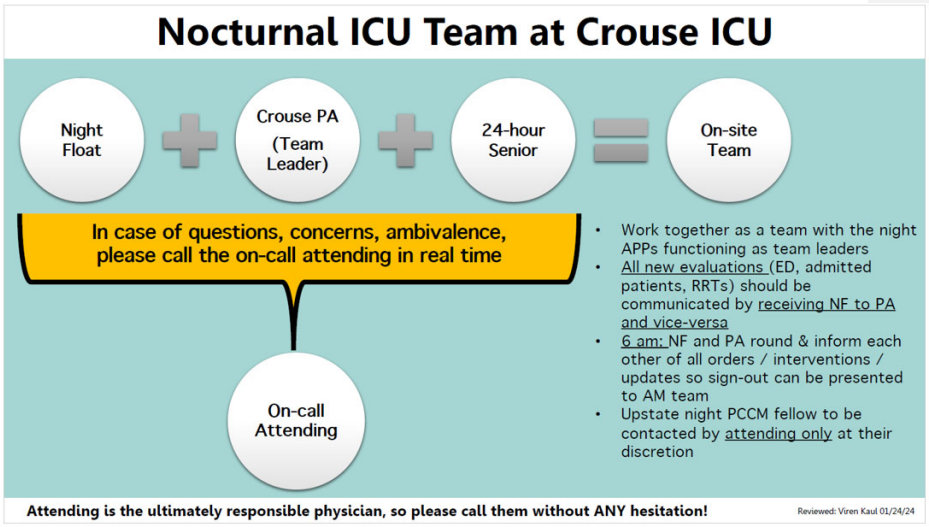
Patient ownership, admissions, and consulting on patients:

- **Admissions:**
  - **Residents are responsible for all H&Ps overnight. In case of multiple admissions at same time, please work with overnight PAs and each other for timely order placement**
  - **ED admissions are called directly to the on-call attending. These admissions should be assessed and managed. If there are questions regarding the admission or care, please call the attending**
  - **Consults from floors / RRTs / Codes: These are primarily the responsibility of the responding ICU resident. Please make expeditious decisions regarding their care, disposition, and discuss ASAP with fellow during the day.**
    - **At night, work closely with the PA to admit to ICU as necessary and provide care**
    - **Use discretion regarding discussing with the on-call attending, with low threshold to inform the on-call attending in case of severely/rapidly decompensating patients**
    - **If you decide to refuse an ICU consult for admission, take note of the patient's name, MR#, write a note in the chart and inform the attending in the morning so they can review your decision. Please also follow up in on the patient to ensure they are stable**
    - **If you have a concern for a neurological issue, call a code B (stroke code)**
    - **If there is a code M (RRT) that needs ICU care, alert the ICU charge nurse ASAP (Ext: 7037 or call 315.470.7037)**

- **Ownership of patients:**
  - **Medical and neurology patients are typically admitted to the ICU with the on-call intensivist as the primary with the ICU team serving as primary service**
  - **Surgical/neurosurgical (and sometimes cardiology) patients: Are typically admitted to the ICU with the surgery service as primary service with ICU providing close consultative management (vent management, pressors, management of post op care, or multiple medical issues)**
  - **If unsure about who the primary service is or should be: Call on-call ICU attending immediately. In the meantime, provide all necessary care to ensure patient stability and safety**

- **Escalating care:**
  - **Day shift: Discuss patient care matters in an ongoing manner with the PCCM/CCM fellow or the attending, depending on patient severity or urgency of the question**
  - **Night shift: Please see the following infographic for night team care structure**
    - **Work closely with night-time PAs (when present): They will provide clinical experience and Crouse specific expertise**
    - **If PA is not available, please call the on-call attending**
  - **Call the attending with any significant acute decompensations: i.e. intubations, codes, patient deaths, change in code status, significant changes in hemodynamics without improvements**

Commented [VK1]: Insert the delineation b/w PGY2 and PGY 3



Code/Consult Responsibilities:

- **Short-call resident and intern: Hold the Code/Consult pager during rounds and respond to all pages until the conclusion of rounds**
- **Short-call group will hand off the pager to the long-call team after rounds and they will assume the same responsibilities**
- **Resident carrying the Code Pager responds to ALL Code M/RRT and Code B/Stroke Code (unless in ambulance bay)**

Documentation responsibilities:

- **Please sign all orders in the left pane and sign all your notes every single day at the end of the day**

AMION On-Call Page:

- **Resident Schedule accessible via Amion.com with password (upstate). The CICU schedule is found at the bottom of the page**
- **CICU attending schedule accessible with different password (crouse) → Look under Critical Care Associates and not Medicine**

Calling out Sick:

- **If for any reason you are sick or something comes up and you are not able to make it to work please contact the IM Chief Resident on Call (Listed on AMION as Chief On-Call) to arrange appropriate jeopardy coverage**
- **EM Residents should also inform EM Chief Resident**

Designated Spaces for Residents:

- **Utilize the locked call room opposite the Critical Care office in the 3rd floor corridor, adjacent to the elevators (Code: 2-1-4-3): All your bags and belongings must be kept in this safe room and not in the ICU or the conference room**
- **The work room on the right of the elevators is for ALL residents at Crouse, not just Surgery residents**

Conference Schedule for Crouse Hospital:

Wednesday's PM Conference is a didactic from 1 pm-2 pm presented by the CICU On-Call

Attending. Thursday's PM Conference is located in the Cardiac Cath Conference Room and is a combined presentation by the Senior Resident & Intern who are pre-call (meaning that they are the Call Residents for FRIDAY with the weekend off). Please make every effort to be there on time, however, we completely understand that urgent patient care issues take precedence. You are allowed to answer your pages during the conference. Inform the Crouse chief if you will be late for the conference.

The conferences have typically been a brief case description by the senior resident of an interesting case in CICU followed by a topic discussion by their intern peer. However, this structure may be adjusted based on the preferences of this pre-call team.

If you are ever uncertain about anything at Crouse ICU, please discuss with your medicine peers or reach out to us for clarification.

We hope you enjoy the rotation!

Crouse ICU Night Float Curriculum

Introduction

The use of night float systems and cross coverage is is an established method to balance patient care issues with need for time off. Night float rotations offer both unique learning opportunities as well as pose challenges in providing appropriate supervision and evaluation. Night float does test a resident's skills in certain areas. Specifically, residents are asked to evaluate patients with whom they are unfamiliar for both acute medical issues as well as pharmacologic decision-making. Night float tests a resident's judgment. Night float also tests a resident's ability to prioritize patient care issues and to juggle multiple tasks concurrently. Because it occurs at night often residents feel additional stress related to change in the sleep-wake cycle. The night float rotation at Crouse Hospital additionally provides an opportunity for residents to work in a multidisciplinary environment as they work hand-in-hand with experienced dedicated night-time Advance Practice Providers (APPs). The following curriculum is intended to offer guidance and description of how the residents will be supervised and evaluated with the use of a resident portfolio.

I. Educational Purpose

The general internist should be competent to evaluate and assess a wide range of common and acute medical issues that arise in hospitalized patients. So often in modern complex inpatient medicine the resident's involvement in the care of patients is directed by multiple specialists and by large teams of physicians. Night float rotations offer the resident a higher degree of autonomy in clinical decision-making and patient care. Equally as important is the demonstration that the resident has the knowledge and desire to use evidence-based solutions in the approach to patient care while maintaining an interest in learning variations in care.

II. Learning Venue

A. Rotation Description: The night float rotation is a 1-week block that primarily involves cross-covering and admitting patients to the Crouse ICU. The PGY-2 and PGY-3 will arrive at 7:00 PM and receive sign-out from the long call team along with the nighttime APP. The sign-out is expected to be complete and to be reviewed between the sign-out team and the covering night float done bed to bed walking the unit. Much of the 12-hour shift is going to be spent on evaluating new patient problems that come up, renewing medications or patient care orders, following through on tests that are ordered but not yet back at the time the long call team signs out, and handling any new ICU admissions. The NFs are expected to work integrally with the night time PAs and each other with duties delineated in following sections. On nights where PAs are not available, the Crouse fellow will be available on home call to discuss new consults/decompensating clinical situations.

As demonstrated in the included infographic (Figure 1), the night float resident will work in real time with the APP to address new and ongoing issues, especially issues that are time sensitive. The night float resident should precent all new admissions with the Pulmonary and Critical Care Medicine Fellow how is on shift at University Hospital. The night float will also coordinate with the long call resident in case of multiple acute issues that arise in a short period of time to ensure effective and timely delivery of care (eg. Multiple ongoing RRT/codes, admissions, or decompensating patients). Ultimately, in case of any significant concerns, especially with decompensating patients or in situations where consensus of care is not reached, the on-call attending must be involved overnight.

Expectations of NF: The night float is expected to interview and examine all patients that they are called about on night float. They are also expected to document succinctly their findings and their plan of action. Any significant change in a patient's condition should prompt a phone call to the attending of record. The NFs are expected to be timely in their evaluation of patient issues. If there will be a delay in evaluating a patient, there should be clearly conveyed information for the nurse who calls the night float resident, and available support structure (APP, on-call resident, Upstate PCCM fellow, and the on-call attending) must be engaged by the resident depending on clinical scenario.

NF team responsibility: Work with PA as team lead / home call fellow (the Crouse fellow) when PA not on (see following graphic)

*** PGY-2 NF:**

- ❑ Cross-cover all patients admitted to the service
- ❑ Perform new admissions from ED (already approved by attending)

*** PGY-3 NF:**

- ❑ Respond to stroke codes (code B), RRTs (code M), and code blues
- ❑ ICU consults on admitted patients
- ❑ Perform admissions arising from either of the above

B. Teaching Methods:

The education that occurs on night float is arises from the opportunity of evaluating acute complaints, assessing a patient, and formulating a plan and then learning from that experience as the actions are reviewed on AM sign-out by the fellow with further specific feedback from rounding attending when NF return to service the following night. All night floats are expected to review the following day the outcomes of patients that they were significantly involved with the night before. In addition, documentation for the resident's portfolio of cases that were involved in will be an important learning opportunity for the night float resident.

C. Mix of Diseases:

All inpatient acute and chronic medical issues are seen on the night float rotation. Common to night float is the opportunity to evaluate chest pain, arrhythmias, dyspnea, delirium, agitation, insomnia, psychosis, abdominal pain, nausea and vomiting, acute and chronic pain, GI bleeding, urinary retention, fever, and the care of acutely decompensated patients and running codes. Patient characteristics are age 18 and older of male and female gender, equal distribution of ethnicities and cultures on all the inpatient Medicine services. Procedures will include any invasive procedure that needs to be done during nighttime hours, including, but not limited to, central lines, thoracentesis, paracentesis, lumbar punctures, arterial punctures, venipunctures, placement of NG tubes, all supervised by senior residents or performed with guidance from the nighttime APPs when appropriate.

III. Methods of Evaluation

A. The learning and competence of the resident's performance during night float rotation will effectively be evaluated in 3 venues:

1. There is 360· evaluation that may be filled out by the night ICU nursing staff. This is primarily intended to evaluate your timeliness in responding to pages and the way that you provide a thoughtful and empathetic care to patients during nighttime hours.

2. Attendings and senior residents who interact with the night float are strongly encouraged to use concern or praise cards in Med Hub as a way of giving feedback for specific interactions during the night. Additionally, the rounding attending will provide structured feedback in Med Hub.

3. Real time feedback on patient care, documentation, quality measures, communication, and other component competencies will be provided by the rounding attending the following morning. This is perhaps the most effective avenue for growth as this feedback is timely, specific, and actionable.

IV. Rotation Specific Competencies

A. **Patient care:** night float rotation allows a great deal of autonomy in patient care decision-making independent assessment. It also uniquely tests a resident's judgment in recognizing acutely decompensating and very sick patients. The patient care experience is best summed up by a residents' experience: "This is the first occasion that a senior resident has in applying his/her clinical skills without direct supervision and this builds confidence and improves his/her ability to handle most of the cases (both serious and trivial issues) with aplomb. This rotation also gives an opportunity to identify what the teams in the morning probably need to be doing and what a patient needs over a period of 24 hrs is." As a learning experience this rotation is second to none and at the end of it, even though the work is challenging, there is a great deal of satisfaction and growth in a controlled manner. Hopefully this rotation will continue to have words like "learning experience", "interesting work" and such associated with it.

B. **Medical knowledge:** the broad nature of medical scenarios encountered on night float, in addition to the frequent downtime, affords the night float resident the opportunity to read on broad topics and improve their medical knowledge.

C. **Professionalism:** Often a sick patient at night will engender a great deal of anxiety with the nursing staff as well as the night float taking care of that patient. These opportunities offer our residents the chance to show good judgment, professionalism, and excellence in interpersonal communication skills with the staff, patients, families, many of whom they do not know. Additionally, as one of the first rotations where APPs are embedded as part of the team, this unique experience will allow the residents to develop the skills needed to function seamlessly in an increasingly complex medical team structure.

D. **Practice-based learning:** As part of the overall evaluation, documentation of the use of evidence-based tools in the application of patient care is tested during this rotation. Additionally, when working in a different medical system with a different EMR, residents will be able to demonstrate adaptability to different practice setting to enhance their learning experience.

E. **Systems-based practice:** This rotation requires the resident to work very closely with a large group of nurses as well as a number of different providers (see Figure 1) of varying skill and level. Often night float residents will spend some time transferring patients between units and in and out of the ICU. Patients will decompensate quickly. Often this exposes problems within our system of cross- coverage, communication between nursing and physicians and answering services, including swat teams. Residents are strongly encouraged to look for opportunities to improve the systems in which we all work.

Figure 1: Infographic detailing team-based approach when working at Crouse Hospital as the night float resident.

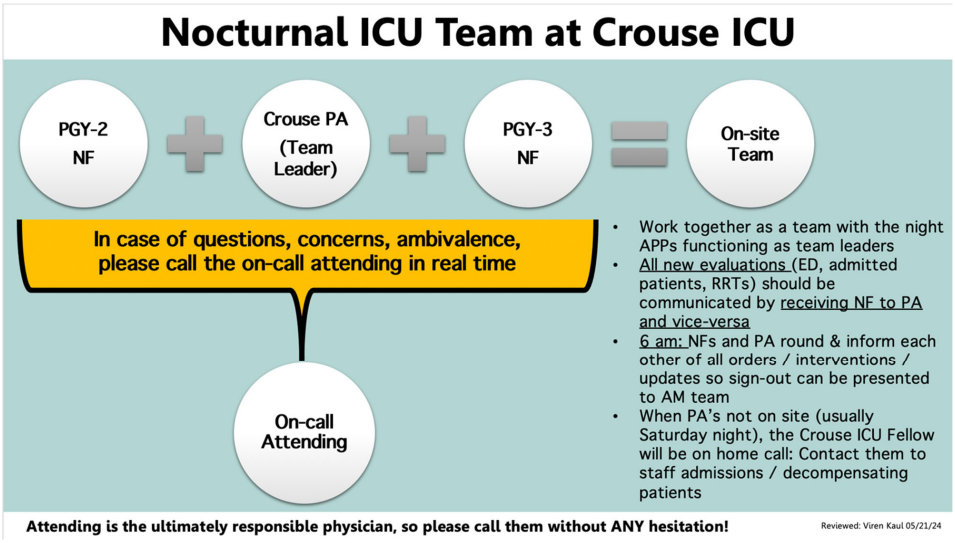
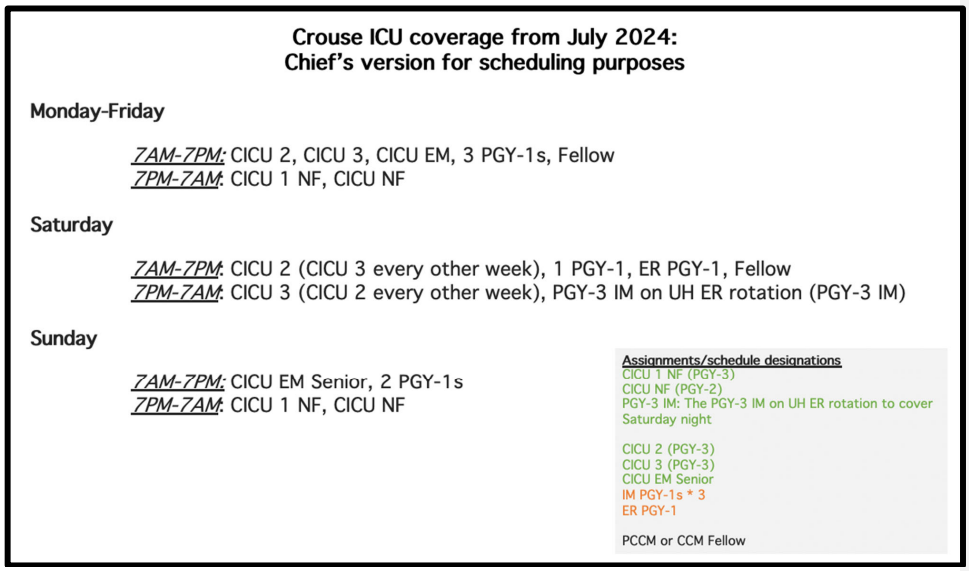
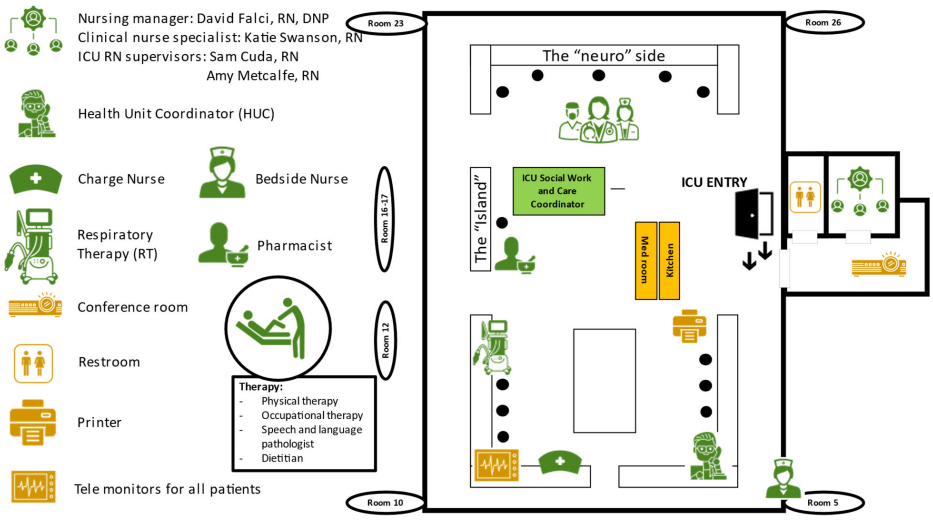
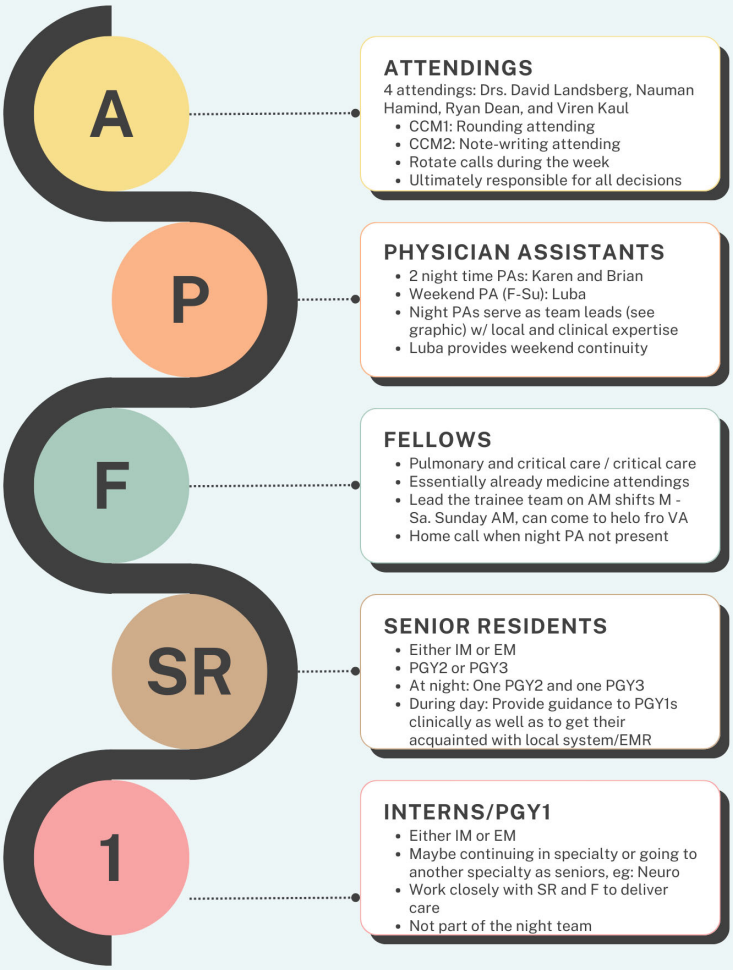


Figure 2: Trainee coverage at Crouse




Nursing manager: David Falci, RN, DNP
Clinical nurse specialist: Katie Swanson, RN
ICU RN supervisors: Sam Cuda, RN
Amy Metcalfe, RN
Health Unit Coordinator (HUC)
Charge Nurse
Bedside Nurse
Respiratory Therapy (RT)
Pharmacist
Conference room
Restroom
Printer
Tele monitors for all patients
Therapy:
- Physical therapy
- Occupational therapy
- Speech and language pathologist
- Dietitian
Room 23
Room 26
Room 16-17
Room 12
Room 10
Room 5
The "neuro" side
The "island"
ICU Social Work and Care Coordinator
ICU ENTRY
Med room
Kitchen

CROUSE ICU CLINICAN TEAM



For patient care issues:

- **Start** with 1 or SR responsible for patient in **AM** or PGY-2 in **PM**
- **Need more help**/time-sensitive matter? Involve F in **AM** or PA in **PM** (or home call fellow if no PA)
- **Call on-call ICU attending at all times if needed as they are ultimately responsible**

Reviewed/revised by: Viren Kaul, MD
Date Revised: 05/21/24