

# Overview of Goals and Objectives of Rotation: Good Samaritan Intensive Care Service

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Legacy Good Samaritan Hospital (LGSB) is a major tertiary care center in Portland, OR, with an independent medical residency program, and active full service patient care activities, including a renal transplant and cardiac surgery program.

The Kern Critical Care Unit (the Kern) is a state of the art medical-surgical intensive care unit, at Legacy Good Samaritan Hospital. It was the recipient of the 1996 Society of Critical Care Medicine Award for Best Designed ICU. The multidisciplinary unit houses 28 beds with an average occupancy of about 20. Fellows have the opportunity to participate in direct patient care, along with co-management and consultative practice models. In this setting, fellows will be responsible for communication and interaction with private practice physicians and should learn the vital role of the intensivist in providing multidisciplinary care of patients in this setting. The service also has a large post-operative surgery population providing fellows the opportunity to gain experience in post-surgical pain, respiratory insufficiency, hemodynamic instability and peri-operative nutrition.

**Medical Knowledge:** *Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.*

- Review the role that 1) peri-operative fluid 2) pain control 3) heat loss and 4) residual anesthetic/paralytic agents play in immediate post-operative complications
- Understand the common complications and temporal profile of events occurring during the perioperative period
- Recognize how post-operative pain contributes to peri-operative complications  
Understand the basic tenets of acute post-operative pain management as expressed in the ASA Practice Guidelines document
- Review the role of post-operative NIV to improve pulmonary outcomes
- Describe the etiology and treatment of cardiac complications of noncardiac thoracic and general surgery
- Understand the risk factors, prevalence, treatment and outcome of post-pneumonectomy ARDS
- Demonstrate familiarity with classification of hemodynamic instability and principles of assessment
- Describe the common peri-operative rhythm disturbances and their management
- Review the laboratory and clinical tools for nutritional assessment
- Describe the common peri-operative complications and/or critical care needs of the following: Geriatric patients, Orthopedic patients, Vascular Surgery patients, ENT patients, Opioid-dependent patients

**Patient Care:** *Residents are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life.*

- Review history and physical findings with Junior Housestaff and confirm key elements
- Develop a primary, patient-specific management plan, with a reasonable alternate plan
- Use information technology to support patient care decisions and patient education
- Use data from appropriate invasive and non-invasive monitoring devices to diagnose, treat & titrate patient therapy

- Identify and manage complications of surgery including 1) surgical bleeding 2) hemodynamic instability 3) post-operative ventilatory failure
- Provide appropriate levels of post-operative sedation and analgesia
- Identify patients with ARDS/ALI and initiate appropriate ARDSnet strategies
- Identify patients with early sepsis, severe sepsis, septic shock and institute key components of the IHI sepsis & ventilator “bundles”
- Insure that all patients in the ICU receive appropriate prophylactic therapy based on perceived risk of developing complications associate with medical illness
- Promote timely convalescence through early ambulation, appropriate nutrition, and scrupulous wound care
- Recognize potentially futile care based on available evidence and individual patient goals
- With assistance, lead discussions regarding withdrawal or withholding of care

**Practice based Learning: Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.**

- Maintain a list of patients experiencing untoward events (morbidity and mortality) during their ICU stay
- Provide limited “root cause” analysis of significant errors and developing relevant action plans
- Contribute to and support process improvements in the ICU by meeting with nursing or physician staff to assess current practice
- Participate in development of protocols and guidelines pertinent to ICU care
- Contribute to and support process improvements in the ICU by meeting with nursing or physician staff to assess current practice
- Participate in Multi-disciplinary rounds and be responsible for completion of daily goal sheets
- Understand the goals of and adhere to pathways developed for unique patient populations

**Interpersonal and Communication Skills: Residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.**

- Provide effective and professional consultation to other physicians and health care professionals and sustain therapeutic and ethically sound professional relationships with patients, their families, and colleagues.
- Use effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families
- Counsel and educate patients and families
- Communicate effectively in times of dynamically changing conditions
- Interact with consultants in a respectful, appropriate manner
- Communicates clearly, correctly, and concisely in a written report, stressing the important issues and an articulate plan.
- Maintain comprehensive, timely, and legible medical records
- Use nomenclature and writing standards consistent with that of the institution
- Transfer care of the patient in a manner that ensures patients safety, comfort and continuity of care
- Display support & empathy to patients and their families, as witnessed by attending staff or reported to staff
- Demonstrate respect for and recognition of particular skill sets possessed by other CC practitioners, such as CC nurses, RT, PT, OT, dieticians, pharmacists.
- Considers ethical issues and patient wishes in treatment decisions

**Professionalism:** *Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.*

- Demonstrate respect, compassion, integrity, and altruism in relationships with patients, families, and colleagues
- Demonstrate sensitivity and responsiveness to the gender, age, culture, religion, sexual preference, socioeconomic status, beliefs, behaviors and disabilities of patients and professional colleagues
- Adhere to principles of confidentiality, scientific/academic integrity, and informed consent
- Recognize and identify deficiencies in peer performance
- Teach junior colleagues or peers
- Admit to and seek help in remedying errors
- Interact with nursing staff and other professionals as two-way educational opportunities when current approach does not appear to be effective

**Systems-Based Practice:** *Residents are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.*

- Apply evidence-based, cost-conscious strategies to prevention, diagnosis, and disease management
- Collaborate with other members of the health care team to assist patients in dealing effectively with complex systems and to improve systematic processes of care
- Demonstrate the Critical Care Practitioner's role as patient/quality care advocate
- Utilize established quality management procedures to facilitate care
- Discuss the issues of patient safety including the medical systems that put patients at risk, medication, operations, transfusions & nursing ratios.
- Recognize, describe and ensure compliance with institutional and unit policies and procedures as well as regulatory policies from accreditation agencies, regulators, and payers

### **Instructional Methods:**

Introductory Lecture Series, Web-Based Curriculum (RICU), ATS Hemodynamics Primer, structured conferences, teaching rounds

### **Methods of Assessment:**

- Competency-based staff evaluations
- Critical incident reporting
- Conference attendance and participation
- Completion of PACEP / ATS Primer on Hemodynamic Monitoring

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Healthcare Improvement Skills Center  
<http://www.improvementskills.org/>

Agency for Healthcare Research and Quality  
<http://www.ahrq.gov/>

Institute of Healthcare Improvement  
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Joint Commission on Accreditation of Healthcare Organization  
<http://www.jointcommission.org/>

The Leapfrog Group  
<http://www.leapfroggroup.org/>

Centers for Medicare and Medicaid Services  
<http://www.cms.hhs.gov/home/medicare.asp>

# **Duties and Responsibilities of the Critical Care Fellow, at the Kern Critical Care Unit, at Legacy Good Samaritan Hospital and Legacy Health System.**

## **Daily rounds**

1. The Critical Care Fellow (Fellow) actively participates in daily rounds, including X-ray and bedside rounds. Daily rounds are to be led by the intensivist, with proactive input from the Fellow.
2. Daily rounds start at 8 30 am on Mondays, Tuesdays, Thursdays, Saturday and Sunday; 9 am on Fridays. There are no formal ICU rounds on Wednesdays, but both the attending and fellow are expected to meet with the residents to consolidate the plan for the day.
3. The Fellow is expected to be involved in teaching during rounds and present evidence – based medicine practice parameters whenever possible.
4. Daily rounds begin with review of all relevant radiological studies, followed by bedside rounds.
5. Bedside rounds include the participation of residents, pharmacist, nurse, and respiratory therapist. Issues pertaining to patient care takes priority. Teaching is encouraged during bedside rounds as part of the discussion of patient care.

## **Call Coverage**

1. The Fellow is the first line call for all matters pertaining to intensive care issues, including new consults, problems related to unstable patients and staffing residents on admissions. The attending shall staff all new patients and consults within the 24 hour period.
2. The Fellow shall be on first line night call twice a week, on Mondays and Fridays, during each week they are on rotation at LHS.
3. There shall always be an ICU Attending on back up call with the Fellow.
4. Call coverage shall include both Legacy Good Samaritan and Legacy Emanuel Hospitals.
5. If the Fellow has to return to the Intensive Care Unit during the call, the intensivist on call has to be notified at all times. The attending intensivist will ALWAYS return to the ICU, with the fellow, for any new consultation or as patient care requires. If the fellow returns afterhours to see a patient admitted to the ICU service (not a consult), the Fellow will notify the attending intensivist.
6. Direct admissions from another facility can be handled by the Fellow on call. Bed control shall call the Fellow on call and have the physician discuss the case with the Fellow. The intensivist on call is then notified of the case. In general, we always accept transfers if ICU beds are available.

## **Teaching**

1. As mentioned above, the Fellow is expected to lead rounds and provide leadership in patient care at all times.
2. Evidence based medicine in Critical Care Medicine is the standard of practice whenever possible.
3. Didactic lectures are presented to the residents once a week by the Fellow, and this can include any topic in critical care medicine, including journal article appraisals.

4. The Fellow may give a talk on a specific topic on prearranged dates for the teaching program for the residents in the ICU  
Teaching and supervision of residents is an important component of the Fellow's rotation in the ICU.

### ***Daily responsibilities of patient care***

1. The Fellow is responsible for all the cases under the residents' team care, and this includes coordinating all subspecialties involved and communicating in a timely manner any problems that may arise.
2. The Fellow is responsible for all daily notes and dictations by the end of the day. The attending can assist in this process.
3. The Fellow should supervise the housestaff on all procedures, including lumbar puncture, thoracentesis, central line placement, arterial cannulation, paracentesis and chest tube placement. Bronchoscopies should be performed in the attending's presence only. Intubations should be performed in the presence of the intensivist or anaesthesiologist.
4. The Fellow interacts in a collegial manner with the RT's and nurses daily and ensures communication of goals with them.
5. The Fellow shall attend daily Multidisciplinary rounds at the Kern ICU, starting at 1 30 pm daily and provide input even in non – team care cases.
6. The Fellow is responsible for smooth transition for discharge of patient's to the wards, and timely communication with the hospitalists.
7. Time off for Fellows falls on every Sunday.

### ***BILLING RESPONSIBILITIES***

1. The intensivist is ultimately responsible for the billing procedure and submission of billing slips.
2. The Fellow is encouraged to learn the billing process during their stint at Legacy.
3. The intensivist can assist in this process.

### **Legacy Inpatient Medicine Service**

### ***Intensivists Rules & Guidelines***

July 1, 2006

### **Mission Statement**

The Legacy Inpatient Medicine Service will:

- Provide the finest patient care available.
- Be as cost and resource efficient as possible.
- Make it as easy as possible for the medical staff to practice at Legacy Health System.
- Make communication with physicians and patients the cornerstone of our practice.

- Function as a team in the practice of inpatient medicine.
- Provide comprehensive bedside and didactic training for residents and students.
- Provide education to the nurses and ancillary personnel of Legacy Health System.
- Provide a challenging and satisfying practice of inpatient medicine for physicians.
- Provide for professional growth and satisfaction through opportunities in research, administration, and in professional societies.
- Reach out to physicians in the community, to educate them about the services available at Legacy Health System, and to assist them in the growth of their own practices.

### **Approach to Critical Care Medicine for Intensivists**

The Intensivist Service at Legacy Portland Hospitals provides full service attending and consultative critical care for critically ill patients at Good Samaritan and Emanuel Hospitals. We operate in a semi-closed ICU environment. Therefore, we see patients referred to our service in a formal manner, but follow the progress of all patients in the ICU. This allows for the efficient functioning of the ICU and to be ready to assist in patient care emergencies. Lastly, through our support and development of unit protocols, we aim to reduce the variability of practice and ensure, to the best of our abilities, that best practices are available to all patients.

The keys to our practice of critical care medicine are to be available, affable, and able. Availability will be manifested by a visible daytime presence in the ICUs. We will meet or exceed Leapfrog and IHI guidelines for intensivist presence and we will continually titrate the care of our patients in order to provide for optimal outcomes and efficiencies. At night, we will readily be available by pager and will return to the ICU, without hesitation, to care for our patients. Affability will be derived from our personal relationships with our physician and nursing colleagues. We will treat them as valued colleagues and customers. We will always present a “can do,” highly responsive attitude. We will always welcome a request for our assistance in caring for critically ill patients. Finally, ability will be demonstrated by providing high quality, proactive critical care. We will assume responsibility for the total patient, while working with our other colleagues. In areas where our subspecialist colleagues are also involved, we will continue to be up-to-date and communicate to develop a treatment plan. In essence, we will be all knowing on every patient and leave nothing to someone else. We will also function as the coordinator of the patient’s care, acting as a central communication focus to ensure that the care is coordinated.

Proactive critical care is a crucial concept in our philosophy. Proactive care is care that seeks to prevent and actively reverse ongoing injury. It does not just react to results and occurrences but rather seeks to prevent events through aggressive patient care plans, coordination of care with the multidisciplinary team, and frequent evaluation of a patient’s progress. Always asking, “What problem will occur next?” This will result in optimal patient outcomes and efficiency.

We should aggressively pursue doing invasive procedures that are appropriate for a patient and within the scope of our abilities and practice. However we will operate under the “right of first refusal,” meaning that any qualified physician, participating in the patient’s care, will have priority over us to do a procedure.

Whenever we become involved in a patient’s care, a dictated history and physical or consultation will be completed. This can be done by the housestaff on our behalf. This will provide an easily assessable summary of our involvement, both during the present and for any future admissions. Initially, and throughout the course of the patient’s ICU stay, we will communicate closely and

frequently with the patient, their family, and the other physicians. This will allow us to ensure that the plan of care is clear. We will not rely on chart communication. We will remain involved in the patient's care until the point that transfer orders to the acute care ward are written. At that time, if the patient requires ongoing internal medicine involvement or if we are the patient's attending; we will notify the hospitalist of the patient.

The Key Points are:

- Communicate, communicate, communicate
- Assume that if you do not follow-up on a patient care issue, no one will.
- Residents and students are our future referring physicians.
- Nurses can be our biggest supporters or our greatest foes.
- The entire medical staff is our customers. Treat each with respect and communicate.
- Critical care is a fellowship trained, board certified subspecialty with a distinct body of knowledge and expertise for the patient. Act as an expert in critical care.
- Head off crises and maximize patient outcomes efficiently.

LEH: Patients transferred out of the ICU: If on team care, will be picked up by the attending for the team. The residents will notify the hospitalist attending of the patient. If not on team care, the patient will be assigned to the next hospitalist up for a non-team care admission. The intensivist will notify and give appropriate sign out to the accepting hospitalist (see sign-out policy). If notification of a transfer from the ICU to the floor occurs after 8 am, the intensivist will be responsible for the day's visit and note.

The intensivist will meet in person (if unable due to patient care needs, he will call the central pager) with the hospitalists by 7:30 am to clarify who will cover any new ICU admissions. In general, if a new patient can transfer out of the ICU that same day, he/she should be covered by the hospitalist that will see the patient on the floor. If the patient will be in the ICU longer than that day, the intensivist will be responsible for the patient. This will improve patient continuity and efficiency.

LGSH: Patients transferred out of the ICU: If the patient requires ongoing internal medicine involvement the patient will be assigned to the next hospitalist up for an admission. The intensivist will notify and give appropriate sign out to the accepting hospitalist (see sign-out policy). If notification of a transfer from the ICU to the floor occurs after 8 am, the intensivist will be responsible for the day's visit and note.

The intensivist will meet in person (if unable due to patient care needs, he will call the central pager) with the hospitalists by 7:30 am to clarify who will cover any new ICU admissions. In general, if a new patient can transfer out of the ICU that same day, he/she should be covered by the hospitalist that will see the patient on the floor. If the patient will be in the ICU longer than that day, the intensivist will be responsible for the patient. This will improve patient continuity and efficiency.

#### **Notifying a Primary Care Physician about an Admission**

1. See new policy

#### **Description of Shifts**

The intensivist will arrive in the ICU by 7 am. He will remain in-house until 5 pm on weekdays and 3 pm on weekend and holidays. During this time he must be available to return to the patient's bedside within 5 minutes, 95% of the time. Under no circumstances will he be further from the ICU than the distance and time between Good Samaritan and Emanuel Hospitals. Between 5 – 7 pm on weekdays, the intensivist may not be in-house, but is responsible for seeing any patient admitted to the service during this period and any ongoing care of established patients.

Upon arrival in the morning, the intensivist reviews the course and overall management of all ICU status patients with the bedside nurses. He will meet with the resident teams and other

hospitalists/ intensivists to review and assign new admissions and determine which patients are on- or off-housestaff. Teaching will occur according to the guidelines above. The intensivist will attend or consult on all patients on ICU status that are referred to LIMS. He will see patients and perform procedures as indicated. Each assigned patient will have a daily progress notes written in accordance with CMS documentation requirements, and a charge form will be completed for every encounter. He will ensure that a dictated interim summary, in addition to a verbal sign out, will be done for any patient transferred to the floor after a prolonged or complex ICU course. The intensivist will be readily available to the ICU for emergencies, new patients, resident or staff questions/problems, and for the reevaluation of existing patients during regular working hours. He will be available on call and answer pages within 5 minutes, 95% of the time until 7 am the next morning. He will readily return to the ICUs at night, as needed, to ensure patient care.

The intensivist will also participate in training program faculty and administrative meetings, committees and other administrative functions as requested by chief of medicine and the medical director of LIMS. The on call intensivist is available for both informal and formal consultation from LIMS physicians, 24 hours a day.

### **Night Call**

Night call responsibilities begin from at 7 pm at both GSH and EH, on weekdays. On weekends it begins at both GSH and EH at 3:00 pm. In all cases, night call lasts until 7:00 am the next morning. You must be available on your personal pager at all times during this period. You should expect to receive calls for cross coverage of patients, requests for questions/assistance from residents, staffing of patients admitted to the Intensivist service (as needed), requests for transfer of patients from outside hospitals. During this time you must return 95% of your calls within 5 minutes and be able to return to the ICUs, within 30 minutes. Patient information is available per the Sign-out Policy.

### **Sign-out**

#### **When Leaving a Service or Transferring a Patient to Another Level of Care**

Both written and verbal sign-out is mandatory when signing off a service. In JCAHO's 2006 National Safety Goals, effective January 1, 2006, Goal 2E states that we must, "implement a standardized approach to hand-off communications, including an opportunity to ask and respond to questions."

The written component will give basic information, while the verbal conversation should ensure that the physicians on both ends understand the situation, plans, and rationale. This policy also pertains to patients being transferred to another LIMS physician because of a change in the level of care, such as to the ICU or from the ICU to the acute care ward.

Therefore, LIMS requires that each physician that signs off a service must update a written web based computer database. Between 6 and 7 pm the last night on service, the physician signing out must initiate contact with the physician signing on. It is the responsibility of the signing out physician to contact the signing on person. If for some reason, the signing on person is not available, it is that person's responsibility to notify the signing out person and arrange for an alternate time or phone number. When transferring to or from the ICU, the patient's computer database will be transferred to the receiving physician AND verbal communication will occur. Whenever possible the verbal sign-out will occur while the physicians are reading the written computer information. In all cases, if contact does not occur, then the signing out person remains responsible for the patients until sign-out does occur. Patients being transferred to a different level of care will have the written data transferred and verbal communication will occur.

#### **Signing off for night call**

On the date of admission, a written component, giving basic patient information, will be created on a computer database that is kept on the Legacy Web Portal. At the completion of each day,

each physician will update this database for each of their patients. This information is not discoverable. When a patient is no longer on the LIMS service, their information should be deleted. Each physician, when on call, should review this data. If there are questions, they should directly contact the LIMS physician of record. Up to date contact information for each LIMS physician is available for this purpose on the web portal. This should ensure that the physicians on both ends understand the situation, plans and rationale.

### **Delineating Intensivist Involvement in Patient Care**

This is a critical patient safety issue. Hospital staff must be able to rapidly determine which physician is attending to a patient. From 7 pm – 7 am each weekday (3 pm to 7 am on weekends and holidays), staff are instructed to call the on call intensivist. From 7 am to 7 pm (3 pm on weekends and holidays), they should contact the intensivist assigned to the hospital by personal pager.

E-Chart Designation - It is required that each LIMS physician, as soon as they are able to, changes the designation in the attending or consultant field (as appropriate) to reflect their involvement in the patient's care. This is critical for assisting the hospital staff in determining who the responsible LIMS physician is. This can be done as follows:

1. On the main echart page, select a patient, then click on Add Consult in the right upper corner.
2. Click on Change Attending or Add Consult, as appropriate
3. Select the current date
4. Change the physician field in the lower left corner to reflect your name.
5. Check under the admitting physician field. If it lists one of our names, change this to "Misc, doctor"
6. Click on Save, then exit
7. The next physician to take over care will sign you off.

Signatures/P-Numbers – JCAHO and Legacy require that all signatures be accompanied by a P-number for identification. Each LIMS physician has been issued a name stamper with their P-number. You are required to use this stamper along with your signature for all clinical signatures. As an alternative, you may write your P-number beside your signature. This is mandatory and will be looked at for your evaluation.

### **Teaching Responsibilities**

The intensivist is responsible for the critical care education of the residents and fellows rotating through the Legacy Portland Hospitals. This is an integral part of the duties of the intensivist and should be woven into all aspects of patient care. The Kern Critical Care Unit is the designated ICU rotation for the program and will have a critical care fellow from OHSU, and three resident teams made up of 1 senior resident and 1 intern. In addition, up to two medical students at a time may be rotating on the service. At Emanuel, the resident ward teams will manage their patients in the ICU most often with the intensivist as their attending. Bedside and patient specific teaching will occur as a routine at both hospitals. Because of the nature of the resident coverage at the two sites, formal teaching responsibilities will differ. The intensivist provides mid-month performance feedback to residents and completes written evaluations at the end of the month.

#### **Kern Critical Care Unit**

Teaching Rounds – 8:30 am – 10:00 am on Mondays, Tuesdays, Thursdays, Saturdays, & Sundays. Friday at 9 am – 10:30 am. Rounds done by Jones and Patrick, on Wednesday, at 9 am.

Didactics – By schedule at 10:30 am Tuesday, Wednesday, and Thursday.

Multidisciplinary Rounds – With the team at 1:30 pm – 2 pm each weekday.

Sign-out rounds – Prior to the end of the day departure of the intensivist.

Emanuel

Teaching Rounds – 10:30 am – 11:00 am Seven days per week.  
Multidisciplinary Rounds -  
Sign-out rounds – Prior to the end of the day departure of the intensivist.

**Mandatory Meetings:**

Intensivist Staff Meeting: Quarterly at times and sites to be determined.

Department of Medicine Full Faculty Meeting – First Wednesday of every month, 7:30 am – 8:30 am, Andrews Conference Room, EH