The Drip System, est. 9/1/2018
OVERVIEW

- 8 pods of resident/2 interns, divided into day teams, late shift, and night shift, rotates weekly
- 6 medicine teams (A-F)
- Team cap is 14 pts
  - Max **5 new patients** from late+night to walk into the following day
  - Max of **8 total new patients** between day+late+night shifts (24 hour period)
OVERVIEW

- Teams admit from 7A-4P every day EXCEPT for the short and off team exceptions:
  - Off team - resident is off, can get overnight patients and team admits up to 4 pts with the triage resident from 7A-2P on weekdays
    - No admissions from 7A-2P and no overnight admissions on weekends b/c no triage resident
  - Short team - resident is present, can get overnight patients every day, does not admit from 7A-2P ever

- Late team admits for the short and off teams - if capped, can admit for any team after 4P.

- Night team admits for all teams except off team on the weekend
Admission Flow

07:00: Triage picks up pager from night team and starts accepting patients from bed management
  - Start with team with FEWEST # of pts then go in alphabetical order
  - If team <7 pts, fill them up to 7 before next team gets a patient
  - Bed management assigns to teams based on cohort - but it should follow drip

14:00: Late team arrives
  - Late takes the next 4 pts and admits for short/off team (2 each)
  - If it’s not yet 4PM, each day team with an open spot can admit 1 more pt themselves
  - Late team then takes the rest for short/off team
  - If short/off cap, late team can admit for any team after 4PM

16:00: Day teams stop admitting

17:30: Float intern arrives and can start getting check out from day teams

19:00: Nocturnist and night interns arrive and start accepting patients from bed management
  - Late stops admitting and calls team attending to discuss pts and get feedback
  - Late checks out their patients to nocturnist/night intern
  - Nocturnist admit for all teams except “off tomorrow” team on weekends
Normal Day

**Admit 7A – 4P**, only 1 admission between 3P-4P.
- Interns admit up to 4 new pts each
- No more than 8 new patients in 24 hours
- Check out to float intern at 5:30P

Weekends

**Admit 7A – 3P**, only 1 admission between 2P-3P.
- One intern stays to give check out to the float intern at 5:30P
Late Shift

Admit 2P – 7P, only 2 admissions between 6P-7P

- 2 residents and 2 interns, have a dedicated phone and a pager
  - Interns can admit up to 4 new pts/day
  - Late shift team can admit up to 8 new pts/day
  - If only 1 resident is present, the team only admits up to **6 patients**

- After 7P, call the team attending to discuss the patients -- get feedback
  - Text the team resident # admitted for them and offer a check out
- Late resident/intern **check out** patients to nocturnist/night intern who covers the patient until AM
  - Late/Night share a pager -- make sure correct pager # is listed!!

- New:
  - If the short and off cap, the **late team can admit to any team** after 4P
  - Max of 5 patients to one team from the late/nocturnist shift
Night Shift

Admit 7P – 3A

● 2 interns and the 2 LBJ nocturnists, have a dedicated phone and a pager

● Each nocturnist team can admit 5 new patients for a total of 10 overnight
  ● Max of 5 new patients per intern
  ● If there is only 1 intern at night, the 2 nocturnists can still accept a total of 10 patients, but they will see the last 5 patients on their own (2 for one nocturnist, 3 for the other).

● There will be no extra patients given to the resident like in the previous system
AM Check Out

6:30 AM - team interns receive check out from float intern on overnight events

*Night residents/interns will also go to this check out to update team interns on overnight events for late patients*
Triage Resident

- Monday-Friday
- Holds admission pager and receives call from BM 7A-2P
- BM assigns team, but make sure they follow drip
- Process:
  - BM pages → tells triage MRN and what team going to → triage calls ER for check out/sees pt make sure stable for floor → places admit order within 30 mins (inpt/obs) → places any urgent orders (fluids/IV abx) → calls team and tells about pt
  - If pt stable, triage can tell team they don’t have to see until after rounds; if pt unstable, triage tells team to see immediately

- Communication is key - if triage busy and can’t see pt, tell team to go see immediately and place admission orders

- Triage also admits up to 4 pts with Off team when their resident is off
Bounce Backs

- Follow Discharge Resident (use judgment)
- Senior to senior *verbal* check-out

- Can get a bounce back at any time and even if your team is capped - can hold up to 16 pts & no new pts until <14
  - If upper level is off, talk to team attending if they are OK accepting patient still

- Admitting senior's responsibility to **add the patient** to the "Bounce Back" team's list & put **brief note** stating, “Pt admitted to Team _X_. Discussed with Senior Resident, ______, on Team _Y_, and patient will be a bounce back and under care of Team _Y_, starting on __Date__.”
Other points

- Each team will have a phone and a pager including the late and the night teams.
  - Turn off SPECTRA phones during noon conference

- Add all new admissions to the “LBJ New IM Admissions” list

- ALL pts should have a sticky note with info on who the team is and pager/spectra #
  - Late/Night - say late/night covering and give the pager/spectra - make sure it’s correct!
  - Day teams - update each morning, make sure it is clear to only PAGE after 5:30

- Every time you see a patient, you are the patient’s doctor and in charge of their care -- take ownership! Never think of yourself as just covering for a team or a patient.

- Please help each other, the nurses, SW, CM, and BM out - if they call for a patient you do not know, help them find who is taking care of that patient.
Off days

- Resident days off are preassigned

- Interns can take any day off except
  - Off - resident is off
  - Post-short - busiest days

- Interns can take off during late/night shifts
  - Must clear with upper level first
  - There must be at least 3 people on each shift (1 resident/2 interns or 2 residents/1 intern)
Multi-Disciplinary Rounds

- Each unit is working on how to incorporate nursing and case management into rounds

- On Day 1 for Attending & Senior Resident: you should introduce yourself to the clerk/charge RN

- Goal will be for Clerk to announce “Team * Starting Bedside Rounds Now” - to prompt everyone to be available and potentially round with you to be up to date on plans
Discharges

- Discharge before 11!
- Should have discharges pended for morning rounds
- Pharmacy stops taking prescriptions at 4:30 pm
- You can order prescriptions the day before discharge
- Please “eprescribe” and click on “to fill today”
- Don’t Cancel DC order b/c “nurse said so” ← notify chiefs
- *** Please write comment in the DC order itself if patient is not to be immediately discharged (eg. Please DC Pt in afternoon when ride here, Please DC after Vancomycin completed).
ID Clinic Follow ups after LBJ Discharge

ID patients from **LBJ** should go to **LBJ ID clinic**. (Please **DO NOT** schedule at Smith ID Clinic.)

**HIV patients** should go to Thomas Street or follow up with their private HIV providers.
Orders

- Midlines are an option
- REMOVE PICC lines once treatment is complete
- Consolidate lab draws (no more phlebotomy)
- Review telemetry orders daily
Tricky Orders

- 6MWT - nurses, physical therapist, or respiratory therapists can do it - if you want the RT to do it, the order is a Respiratory Communication and in the comments put 6 minute walk test
Family Medicine Admits

- Admits every day to unit 2B
- They accept their bounce backs if there is room on their service.
- If they are full, these patients go to the admitting medicine team and stays on that team until discharge.
  - This is because there is a slight difference in billing between FM and IM.
- If a FM team admits one of our bounce backs, the patient stays on FM until discharge.
- If there is ever a disagreement about this, it must be an attending to attending conversation to figure out what team the patient goes to.

EXCEPTION:
- FM patients that are transferred to the MICU will return to FM team when they leave the unit, even if there is not a bed in their unit
- The patient will sit on a medicine floor until a FM bed opens, but FM will be primary on the patient.
- This is the one exception to the rule that FM has all of their patients in one unit, 2B.
Trauma Admissions

- 24 hours – trauma service
Special Patients

- Orthopedic surgery
  - We help them.
- OB
  - Medicine can admit up to **20 weeks**
Sick?

- If you are sick:
  - Do NOT Call/text/email a chief resident
  - **Page** the chief resident pager (top pager on amion)
    - We do not check our emails and texts in our sleep
    - If CMR is not paged, you will receive night float
  - We will set up coverage for you and help you with contacting them
Calling Consults

- Construct a clinical question (this is an educational experience)
  - If calling about a status update, make sure you have checked the chart first
  - eg. Check for HD orders before calling to ask if HD being done today
AFB order set for Pulmonary tuberculosis

If any doubt, please order.
EKG ORDERS

- There must be an order for every EKG performed.
Call Rooms

- There are call rooms. They should be cleaned daily. If they are not, call housekeeping and let the chiefs know - call rooms getting renovated!
GERIATRIC/PALLIATIVE CONSULT

- Palliative care needs
- Prescriptions for controlled substances
- “Goals of care discussion”

- If you are discharging to bridge program, you have to put the order in yourself - this is not palliative’s duty
Simple Frameworks for Daily Work: Innovative Strategies to Coach Residents Struggling With Time Management, Organization, and Efficiency

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ABSTRACT

Background Organization and efficiency are central to success on busy inpatient services and may be relevant to demonstrating certain milestones. Most residents adopt these skills by observing supervisors and peers. For some, this method of emulation and adaptation does not occur, with the potential for a negative effect on patient care and team morale. Information on effective strategies for remediating organization and efficiency deficits is lacking.

Objective We explored the major themes of organization and efficiency referred to the University of Pennsylvania Department of Medicine Early Intervention and Remediation Committee (EIRC), and developed tools for their remediation.

Methods Assessments of residents and fellows referred to the EIRC between July 2014 and October 2016 were reviewed for organization and efficiency deficits. Common areas were identified, and an iterative process of learner observations and expert input was used to develop remediation tools.

Results Over a 2-year period, the EIRC developed remediation plans for 4% of residents (13 of 342 total residents), and for 1 internal medicine subspecialty fellow. Organization and efficiency was the primary or secondary deficit in more than half of those assessed. Most common deficits involved admitting a patient efficiently, performing effective prerounding, and composing daily progress notes/presentations. Remediation tools that provided deconstruction of tasks to their most granular and reproducible components were effective in improving performance.

Conclusions Deficits in organization and efficiency can disproportionately affect resident performance and delay milestone achievement. Many residents would benefit from detailed frameworks and assistance with new approaches to basic elements of daily work.

Introduction

First-year residents are not typically given explicit instructions about how to organize their day or complete their work efficiently. Program directors assume that, with experience, they will learn to manage a task list and triage it appropriately, often by modeling the behavior of their supervising complete their daily to-do list. These residents may be mislabeled with deficits in clinical reasoning or professionalism, and there are implications for patient care and team morale when a member of the team struggles.

Organization and efficiency is not a recognized clinical competency, and there is little information on how to address or remediate deficits. If the problem is isolated to the examining residents, this article offers a framework for remediation. If the problem is widespread throughout the training program, the authors propose including organization and efficiency training in the early curriculum.
NEW ULTRASOUND MACHINE


2. Clean with **purple top** after each use (do not use orange top).

3. **ALWAYS** place probes in appropriate holders!! (~$15,000 per probe).

4. Be **gentle** and do not BUMP

5. Keep **plugged** in when off.

*Notify unit Clerk immediately for any issues & they can place **work order**.*
Conferences
Monthly Conference Calendar

- If you still don’t know how to find this, let me know.
- Google “Chiefs corner”….
Resident/intern report

- Please check to see when you are presenting!
  - no more intern report on Monday - everyone comes to noon conference at 12 PM now!

- New structure of conferences
  - More thorough HPI
  - Audience only asks a few questions to fill in any holes
  - Focus on differential/work up more than history
  - Teaching point related to diagnostic modalities or comparing treatment options - evidence based
Resident/intern/consult report

- Send in your topic/summary/patient MRN a couple days before the presentation

- Interns must practice with the CMRs before presentation if 1st time (Residents optional)
Attendance sign in sheet

- Sign in sheet will be taken up after 7 mins of starting conference

→ Rewards for 100%

→ Consideration of Night Float for < 70%
Conferences and Pages

- Turn off your spectralink
  - Nurses should be aware of protected time
- Pagers can remain on for emergencies
  - Consider if you have sick patients
  - Consider responding to back-back pages
- Notify Chiefs ASAP if this becomes an issue!
Scholarly Brainstorming

- Dr. Aisenberg
- Happens every month
Medical Records

- Check your EPIC inbox regularly.
- Complete required tasks or risk being pulled off service.
Documentation

- Only document “severe sepsis” or “septic shock” if the patient meets criteria
  - Once you write severe sepsis or septic shock, CMS (Centers for Medicare and Medicaid Services) reviews the chart for compliance with the sepsis bundle which affects $$$ and statistics
- If someone else wrote it (like in ED) but you do not agree it is severe sepsis, clearly document that it is NOT that and you will be fine
Severe Sepsis

1. Documentation of suspected source of infection
2. 2 or more manifestations of SIRS
   a. Temp >101 or <96.8
   b. HR >90
   c. RR >20
   d. WBC >12 or <4 or >10% bands
3. Organ Dysfunction
   a. SBP <90, MAP <65, or a decrease SBP of >40 pts
   b. Cr >2.0 or UOP < 0.5 cc/kg/hr x 2 hours
   c. Bilirubin >2 mg/dL
   d. Platelet <100
   e. INR >1.5 or PTT >60
   f. Lactate > 2 mmol/L
4. Or if a provider documents severe sepsis, r/o sepsis, or possible sepsis, or septic shock

Septic Shock

1. There must be documentation of septic shock present and
2. Tissue hypoperfusion persisting in the hour after crystalloid fluid administration, evidenced by
   a. SBP <90
   b. MAP <65
   c. Decrease in SBP by >40 pts from patient’s baseline
   d. Lactate >4
3. Or if the criteria are not met, but there is provider documentation of septic shock or suspected septic shock
Feedback Matters

- QI Project: Astrid Grouls (PGY-3), Dr. Aisenberg, Dr. Krucke
- Take a feedback notecard and fill it out throughout the month based on the feedback you get from your attending (be it on rounds or sit-down feedback)
- Please complete the survey in your inbox at the end of the rotation
HIPAA

Please do not leave any of your team lists, patient information unattended

→ Use Blue HIPPA bins to dispose
Handwashing

Observed that residents are in/out handwashing compliant only 70%/76% and medical students 70%/50%

LBJ goal in/out >95%

Importance of handwashing should be reiterated and made a priority in our “patient safety culture”
Needle Stick

1. Call needle stick hotline to let them know
2. PAGE THE CHIEF (doesn’t matter if its 3am)
3. Go to the MHH ER (ideally within 2 hours) to get labs and prophylaxis. Chief will send resident coverage.
4. Paperwork needed to be filled out is on Canvas/New Innovations
Please utilize the security available at both MHH & LBJ for a vehicle escort if desired.

MHH Security: 713-704-4000  (ask for Security, then for escort)

UTHMS Security: 713-792-2890  (direct number to dispatch escort)

LBJ Security: 713-566-5302  (direct number to dispatch escort)
Alternate #: 713-566-5305
Inclement Weather

- Hurricane season June - November
- Stay up to date on the weather and check your email frequently
- Disaster plan
LBJ Fitness Grand Opening Celebration
March 15, 2018
Join us as we open the BRAND NEW Fitness Center at LBJ!

Date: March 15, 2018
Ribbon Cutting: 9:00am
Location: UT Annex, 2nd Floor, Room 260

Getting access to the LBJ Fitness Center is EASY! Simply complete these 2 steps:
1) Complete the Employee Wellness group exercise liability waiver
2) Complete the LBJ Fitness Center Rules acknowledgement form

Note: Complete the forms by 3/9/18 in order to have access to the fitness center beginning March 15, 2018. After March 9th, please allow 1 week from the date you complete the above steps to be granted badge access to the LBJ fitness center.

Fitness Center Location: LBJ Hospital, UT Annex, 2nd Floor, Room 260
Internal Medicine Office

- Located on the 4th floor, west hall, near ward 4B.
- The ACS Office is also in the Medicine office. The number is x66199 or x64996
- Meal tickets and parking decals are in the chief’s office
Dosing antibiotics

- Remember what medications need to be renally adjusted in CKD or ESRD
- Vanc and Levofloxacin are our most incorrectly ordered medications!
- Read the prompts when ordering and adjust accordingly OR call pharmacy!
THANK YOU