Welcome to the Emergency Department!

The ED can be a daunting place, but also can be a lot of fun. There are a lot of opportunities for procedures and learning and I can promise you that you will see a lot of different pathology in just one short month.

Our ED is a level 1 trauma center, which, in addition to CMC Main having Chest Pain Center accreditation and Primary Stroke Certification, means we stay constantly busy.

With that being said, we want you to have the best experience possible and begin to start to feel more comfortable with acutely ill patients by the end of the month.

In this orientation document you'll find, in order:

- Shift Overview
- Department Overview
- Documentation Expectations
- Sign- Out
- Consults/admissions
- On-Shift References
- TLDR

Shift Overview:

Schedule Interpretation: As an intern, you will be working in all areas of the ED. Your shifts will be 10 hours. Below are the current shifts. The earliest start time is 9am! Everyone's schedules can be seen on ShiftAdmin, and you can also trade shifts through this website. Trades will be approved by chiefs. Please overcommunicate any changes in schedules.

- AEC Intern 1 (AEC) 11:00-21:00
- AEC Intern 2 (AEC) 21:00-07:00

- Med1 Intern (Med 1 Trailer) 15:00-01:00

- MI1(Major) 11:00-21:00
- MI2(Major) 21:00-07:00

- P tern 1 (Peds) 09:00-19:00
- P tern 2(Peds) 19:00-05:00

- Ped Pod2 I (Peds, Sun – Wed) 15:00-01:00

Departments:

- ***AEC****: Physically located in the AEC area, however the patient population is that which used to be seen in "Diagnostics" and you may here some people call it this.* Lives under Pod3 on EPIC Trackboard. Patients that are stable (mostly) but have a lot of co-morbidities, old people, people who are immunocompromised and stable but require a room for isolation etc. In general, the most challenging

patients will be found here. Once Med1 shuts down at 1am, low acuity complaints will also be seen in AEC.
You can pick up any patient here.

- ***Med 1****: Physically located in the Trailer exterior to the hospital.* Lives under SURGE on EPIC. Includes B and BB rooms (B is main trailer v. BB which is the "yurt - the small snowglobe looking structure just outside the trailer).
Ambulatory patients, usually stable vital signs, not a lot of co-morbid conditions, low acuity complaints. Pregnant patients<20weeks(>20weeks goes to OB triage upstairs as long as they are stable & the complaint seems OB-related). You will still admit patients from here, even to the ICU. On weekdays there is a 3rd year resident working 5p-1am as a teaching shift, on the weekends from 5PM-12AM; you staff patients with them as well as the attending. There is also a PGY2/3 during the day on the weekends moonlighting.
You can pick up any patient here.

- ***Major*****:** Lives under POD1 on EPIC. Anything life threatening, requiring immediate intervention, trauma; on the opposite end of acuity, this is also where you see the intoxicated and psychiatrically afflicted patients. Front rooms 1-5 are for the critically ill, traumas in 1 and 2 usually, patients who need to sober up (metabolize to freedom) or be psychiatrically observed go in 16-18 or in the hallways when it's busy.

- Generally, the upper levels see the patients in rooms 1-5. Patients in 6-10 can also be fairly sick, it's always safe to ask before seeing one of these patients.
- Room 11 and on are fair game for you to pick up and see.
- *If you ever walk into a room of a patient and find they're much sicker than anticipated, do not hesitate to go find an upper level or attending*

- ***CED (aka Peds):*** Fully autonomous Children's ED which will treat all pediatric patients. Pediatric trauma alerts as well as code 1 and 2s are seen in the CED. Acute medical resuscitations will be placed in either room 7 or 8 of the CED. The Peds ED has 12 rooms and can stretch with 3 hallway beds. Our child life specialists are awesome and are there to distract/play with the child during procedures. Peds POD2 is a mix of higher and lower acuity patient's. Rooms 12-15 are "fast track" rooms that should generally be seen by an APP or attending only, as the goal is for these patient's to be discharged in less than 90 min from arrival. You'll often have a PEM fellow who you will staff your patients with, who will then staff with the attending.

- ***You can pick up any patient in POD1 with the exception of traumas****, which will need to be seen by ATLS certified providers.*
- ***Other than rooms 12-15, you can pick up any patient in POD2****. Speak with your attending before signing up for a "fast track" child in those rooms.*

The ED gets very busy, but if you are worried about a patient or just need to catch the ear of an Attending, make sure you speak up. They may appear very busy or distracted but if you say "I'm worried about the man in room 8...not sure what's going on with him, but I think he may be really sick" it will get their attention. We want you to feel comfortable doing this and the attendings like to know about sick patients sooner rather than later. Plus...we have a pretty approachable set of leaders here!

Documentation:

- In addition to this orientation document, you should have also received a video orientation to Epic since the ED view may be a little different than the Epic you're used to
- We generally try to use the CMCEDNOTE or CMCEDNOTE2 as our main note in the Emergency Department, please reference the Epic video to see how to find this and save this template
- Dot phrase/dragon phrases will save you SO MUCH TIME. Please do not waste your time writing out your physical exam word for word. At the top of Epic, there's a "Personalization" tab where you can find the "Smart Phrase Manager", you can search for anyone in the "search" bar and steal their dot phrases (see separate word doc with step by step pictures)
    - Feel free to steal my dot phrase for physical exams ".hdpe" ".hdneuro" and ".hdpeds"

- **PATIENT CARE TAKES PRIORITY OVER DOING NOTES**
  I cannot emphasize this enough. If there are patients that need to be seen, it is our duty in the ED to see them in as timely a manner as possible. This may mean you have not started a note on the last patient you saw yet. That's okay. Our goal is to see patients quickly once they're back in a treatment area. There's no way to know how sick a patient may be until you actually see them. Additionally, you can chart review after your initial assessment.
- In general, it is reasonable to attempt to at least finish the HPI of your charting after seeing each patient. You may find it works better for you to see the patient, dictate the H&P then talk to your attending - if, while dictating, you can tell your attending is in a good place to hear about the patient, jump on that opportunity.
- Do not expect to completely finish a note before picking up a new patient
- Notes should be completed before you leave the hospital. Priority is completion of notes for patients that you signed out. You do not need to stay in the ED to finish notes but notes need to be done as soon as you can, especially if admitted or if you signed the patient out at the end of your shift.

Sign-Out:

- You will find yourself signing out patients at the end of your shift. Often to the oncoming intern, but sometimes to the upper level resident. You will sign-out at the end of your shift to your replacement.
- We also have sign-out as a large group when a new attending takes over. Try to be mindful of what time it is since we will "Board Round" at the times listed below and everyone needs to be present
- In Major and AEC, attending sign-out is at 7am, 3pm, and 11pm. In Med1, attending sign-out is at 5pm and 1am

General format for Signout:

- Is this patient a signout or have they already been dispositioned?
- What are they pending?
- Anticipated disposition
- BRIEF presentation / one liner / pertinent workup
- Dispo option: if this, then that

Consults/Admissions:

- FIRST ALWAYS ASK: WHO IS THEIR DOCTOR? Consults will be very upset if they come in to see someone and it is not their patient. If they have seen a doctor within the past 2 years then that person is their doctor. If you haven't heard of their doctor, look them up in the computer, call their office, and find out if they admit to CMC (or just google them). This is important because we work with a lot of private physicians.

- ***General Rules for Medicine Admissions*:** (please see the spreadsheet on the compendium)
  - Recently, we switched to **single call medicine** from 7a-7p M-F. Basically, this means you just go to the secretary and ask them to page medicine and they'll figure it out. It's amazing
  - OTHERWISE:
    - Patient has a PCP that is associated with Atrium Health (i.e. tree-of-life practice): CHG admits.
    - Patient has a PCP of Myers Park Internal Medicine OR the Medicine Faculty clinic (Charlotte Internal Medicine and Specialty or CLT Dowd): Staff admits
    - Patient has a PCP with Charlotte Medical Clinic: CHG admits
    - Otherwise, patient is unassigned. This may be a patient with a PCP not in CHS, or a patient with no PCP
    - IF MRN ends with 1,2,3,4,5: Staff admits.
    - IF MRN ends with 6,7,8,9,0: CHG admits.
  - CHG will admit most "pure" psychiatric patients (i.e. no real active other medical issues). Patients being primarily admitted for a medical issue (i.e. overdose that can't be monitored on 6B) can be split by the above policy. Staff medicine will admit ALL Myers Park Internal Medicine patients regardless of diagnosis, including psych.
  - In the case of aliases, i.e. fake names like Trauma Whisper or MR Xanadu, the ED will make every attempt to determine the patient's name and have the medical record changed to it if possible. Otherwise, the number IN EFFECT at the time of the call from the ED to the admitting service will take priority regardless of the "real" medical record. Similarly, a patient's PCP will be attempted to be determined prior to the call. If a patient is later determined to have a PCP that would have led to admission by the other Medicine team, the patient may be transferred to the appropriate team after a discussion between the on-call physicians.
  - Fragility Fracture patients will all be admitted to CHG or Orthopedics; see compendium for details.
  - Staff Medicine caps are still mandated by accrediting bodies. CHG will admit all unassigned patients after the teaching service is capped. Patients with Myers Park IM PCP will always be admitted by Staff Medicine, regardless of cap.
  - CHG has coverage for a large number of primary care practices who do not have admitting privileges, including but not limited to North Park and Mecklenburg Medical Group. CHG also admits all psychiatric patients and ICH patients, unless they need acute neurosurgery intervention. (These policies change all the time, so look out for emails.)
  - The CHG coverage list is available on the Compendium; keep this handy
    - If admitting psych patient to CHG and awaiting tele-psych (psych is not in house 24 hours), then you need to commit the patient so that they are not allowed to leave. The ERIC form is the involuntary commitment form we use and is on the Compendium. This is a whole thing unto itself. The telepsych navigator can usually help you here, as can your attendings and co-residents if the navigators aren't available.

- Elizabeth Family Medicine & Biddlepoint patients belong to our Family Med residents and will be transferred to CMC Mercy if admitted. Some chief complaints aren't appropriate for Mercy, though, so think critically.
- There is also a protocol to transfer CHG patients to CMC Mercy. There is an algorithm posted in the compendium with specifics on transferring to Mercy. Essentially, try to transfer any patient to Mercy that is stable and does not require a specialist that is not available at Mercy. A criterion for Mercy transfer created by Dr. Drew Kitchen; if the patient can survive being tied down in a garage can for 12 hours, they are safe to be transferred to Mercy, otherwise, admit to CMC Main. CMC Main operates at over 95% capacity year round and Mercy is only 5 minutes down the road and always under capacity. Patients have to agree to be transferred to Mercy; we cannot make them. To help with the "sell", tell patients that they will be taken to a room faster, that there are less patients at Mercy so their doctors can spend more time on them, the rooms are all private (some double rooms at Main), and the ambulance ride is free.
- If patient needs dialysis, make sure to find out who their dialysis center is and then call Metrolina Nephrology / or CMC Nephrology and Hypertension Consultants if a patient of Dr. Doman specifically.
- Every patient you admit needs a diagnosis added.

Who to Call:

- Generally, the unit secretary will make all calls for you through the Haiku app. Ask to be added to all chats sent on your behalf.
- If consulting Ortho, please message them yourself with the patient attached, injury, neurovascular exam, anticipated medications needed for intervention, and any pending imaging studies.

***Admitting/Bed Requests*:**

- Once the patient has been accepted for admission, put a bed in for them on the computer. To do this, go to the Dispo tab. Click "Admit" as the disposition, or "Observation" if indicated by the admitting team. Add your diagnoses. Then under "Admit to IP Bed Request Orders" select "ED to Observation Bed Request" or "ED to Floor Bed Request (Acute)" / "Prog" / "ICU" depending on the type of bed they need. To complete this order, you MUST know the name of the admitting physician. You will need to ask what the name of the attending is when you speak to the accepting team. You also need to know the type of bed (regular, med tele, cardiac tele, progressive, ICU, etc). Be sure to ask your consultants these things before you hang up the phone.
- If admitting to a medicine, under "Consult Orders" additionally select "Inpatient consult to Hospitalist" for CHG/Staff Medicine and enter attending and the team accepting under "Consulting Group." For Staff Medicine this will be "CMC Medicine A-F" or for CHG it will be "CHG Service Hospitalist CMC."
- For PEDS admissions, you will place "Inpatient consult to Pediatrics" and the consulting group will be "LCH CHIPS ADMIT" or "LCH CHIPS A" / "B" depending on the accepting team.

***Bunny Hop Orders*:**

- Stable patients can be sent to an inpatient bed ("bunny hop") without someone seeing them in the emergency department first. In order to do this, the patient must be stable, not going to Progressive or the ICU. These patients should be seen within an hour of arriving to the floor, but this doesn't always happen, so if you think a patient may not be stable, DON'T bunny hop them. In

order to put in holding orders so the patient can go to the floor, go to the orders section and type in “ED Adult MED Holding Orders”. Click what you want (I almost never click anything other than diet if able, pain meds if needed, and hypoglycemia order set – required), then sign these orders. The floor nurses will initiate the orders once the patient goes to their hospital bed.

Telepsych:
When an ED patient needs to be seen by psych, they will be seen by “telepsych,” which is a psychiatrist that speaks through the patient via a webcam on an Orwellian telepsych cart. It can be a bit complicated going through all of the steps for this.

1. Order “ED Adult BH Observation”
    - Generally, you can leave all the prechecked boxes selected. This gets them changed into green paper scrubs and orders labs they need to be seen by the psychiatrist.
    - Most psych patients need an UDS, ETOH level (can be breathalyzer), and UPT if female
    - You will also need to indicate if you’re keeping the patient here to see psychiatry on an “Involuntary” basis (a 72-hour hold that does not let them leave the hospital even if they want to) or “Voluntary” basis
    - At the very bottom of this order set you MUST click “Consult Telepsych”
2. *If patient is involuntarily staying* Fill out & print the ERIC form (involuntary commitment form)
    - This can be found on the Top 20 Page of the compendium
    - You must complete the ENTIRE top section so the magistrate will not reject the form. This includes patient name, age, DOB, address, phone number, and your name. Of note, there is a movement now toward having the telepsych navigators fill out the demographics, so you can try just putting in name and DOB, but most of us find it's just as fast to fill this out ourselves (especially since the navigator may not be working when you are, or may be at lunch).
    - In the large boxes, you should use quotations. Don’t say “patient suicidal.” Instead say: Patient said “I’m planning to jump in front of a car.” It helps to use actual quotes from the patients and use plain language such as “Mr. / Ms.” rather than patient, and “thoughts of death by suicide” rather than “suicidal ideation.”
    - Do not use abbreviations (SI, HI), or the magistrate will throw the form out
    - After you fill out the form on the computer, print it. Do NOT close the form on the computer, in case you goofed and have to make changes. Call the telepsych navigator, tell them about the patient, and ask if they can notarize it. Most are notaries, but not all. If not, ask the secretary to call the notary
    - The notary will come watch you sign the form, and it will then be placed in the patient’s chart or given to the telepsych navigator for the next steps
    - Patient eventually gets seen by telepsych
      a. Many hours later, the patient will be seen by telepsych. On Epic, it is hard to tell whether or not they have been seen already unless you add the Telepsych consult note tab to your dashboard. If you do not have this, or do not want this tab, make sure to check periodically to see if a Telepsych note has been added. The nurses are also pretty good at telling you if telepsych has been completed but do not rely on this. You can now look for psych’s note, where they will recommend either admission or discharge for your patient

Helpful References:

- Carolinas Electronic Compendium: www.cmcedmasters.com
  - **Password is Carolinas76**
  - This is likely going to be one of your most helpful resources
  - This includes all the educational resources you could need in one website. It is being updated continuously
  - It is where you will find ERIC forms for psych patients, admission rules for staff v. CHG, our pathways for chest pain, a.fib, heart failure, etc.
- Life in The Fast Lane
  - Australian ED/Critical care website with multiple posts about various emergency medicine topics, as well as easy to digest literature evaluations/reviews.
  - Also has a KILLER A-Z EKG database
- PedEMMorsels.com
  - Pull this up every time you are working in the pediatric ED
  - A look into the vast pediatric emergency medical knowledge that is swirling around Dr. Fox's head at all times
  - Updated weekly, can subscribe for email as well

<u>Too Long Didn't Read</u>

- The top 20 page on cmcedmasters.com will be your friend, please use it (password Carolinas76)
- The Major treatment area is where we see our sickest patients. Rooms 1-5 are our resuscitation rooms and generally those patients are seen by upper level residents. This is also often the case for Major rooms 6-10. Feel free to ask an upper level resident if you are unsure whether or not a patient is too sick to be seen primarily by an intern
- You have been sent an Epic Overview video, please review this
- PATIENT CARE TAKES PRORITY OVER NOTES. It is reasonable to try to do the HPI after you see a patient but please do not let not being finished with a note stop you from picking up another patient. It is or duty in the ED to see patients once they are placed in the treatment area.
- Never hesitate to ask anyone for help! We all remember what it was like our first month in the ED as an intern. We are happy to help navigate notes, orders, dragon phrases, etc. Whatever you need, we want you to feel comfortable asking for!