Detailed info about the Who/What/How of the CNMC ED

**NOTE: Please see the CNMC ED Orientation Module (on Blackboard or Residentbook) for essential orientation info NOT covered in this document.**

**Overview:**

* Sheikh Zayed "Main" Campus - About 90,000 pts/ year, Level 1 trauma center
* United Medical Center (UMC) Children's ED - Satellite ED located within a general hospital in SE DC. About 36,000 patients/ year, higher proportion of low acuity patients, but also sees codes.

**Who works here?**

* **Attendings** - about 45 total in the department
* **Front End Attending** – 1 working in triage, will see some patients and start plans on them prior to coming back to the main ED. These patients still need a resident and to be staffed with an attending or fellow!
* **Charge Doctor**- Doctor in charge. Manages flow, traumas and medical alerts that come in.
* **Associates** - General pediatricians who work in the ED.
* **Fellows** – 10 fellows. Function as attendings in ED, with oversight from faculty
* **Residents** - Residents from 7 different programs rotate here: CNMC and Walter Reed Pediatrics, Georgetown Family Medicine, Howard Family Medicine and 3 EM residencies: GWU, MedStar Georgetown/WHC, and University of Maryland (
* **Medical Students** - Primarily GW students in their 3rd/ 4th years
* **Nurse Practitioners** - mostly work on “D” side and “RTU” (see below)
* **Physician Assistants** - similar position to NPs
* **Nurses** - There is a charge nurse that sits by the end computer on “B” side (x8195). A/B and C/D have a team leader (‘TL’) nurse. Nurses change roles ~every 4 hours. Many are highly experienced and can be especially helpful teaching how things typically run at CNMC.
* **Respiratory Therapists** - 1-2 usually sit in the C side. Give nebs/MDIs, help with airway in codes, do EKGs.
* **Techs** - incredibly helpful at IVs, splints, holding during lacerations/ procedures, etc. In past some (trauma techs) were able to perform more procedures on their own and this is being explored again. Assigned to a side per shift, carry an Ascom.
* **Trauma Techs** – Perform wound management and other procedures, mainly on D side. A wonderful resource for laceration repair.
* **Spanish Interpreters** - available in person many hours of the day (usually 9a-3a), often sit in the work area behind B side. Other languages and hours available with the 2 sets of cordless phones that sit by the Unit Clerks and another set on the D side. Phone interpreters can also be called from any phone (dial x7100, code 1000).
* **Unit Clerks** - amazing at placing and making any type of phone call (consulting services, PCPs, etc.). **Make sure to let them help you.**
* **Child Life** - available many hours of the day (x8878)
* **ED and General Social Workers** - at certain hours we have an ED specific social worker and at other times we share with the hospital. (x8746 or via page)
* **Psychiatry Social Worker** - They initiate the psychiatry consult for any patient we request (after we medically clear them). They then discuss with their psychiatry attending the disposition (admit or not). Their office is located to the right of B-side room 18. (Note: there are no MD psychiatrists that routinely see patients in the ED).
* **ED Concierge** - currently Chris Lombardi, and he is an amazing resource. Some of his many tasks include advocating for patients with long wait times, helping families obtain food/ books/ crayons/ phone chargers/ blankets, helping make us aware of families with a stressful experience, and in certain situations providing meal coupons or other items to families who have had a very difficult visit.
* **ECIC** - the coordinators of all transports, physically located upstairs- the **"**Med Control Room**"** in the ED is sometimes called the “old ECIC”.

**Promoting a culture of safety and communication**

* **Shared mental model** – The ED is rapidly changing and sometimes chaotic. The goal is to take safe and excellent care of our patients. Communicate frequently with the bedside nurse- in person or by phone- especially regarding changed orders, patient status changes, and plan.
* **Questioning attitude** – be prepared to be questioned by nurses and other team members regarding clarifications of orders, plans, and your thought processes.
* **Updating Families** – Be sure to update families on their plan after you discuss with the attending, and include what specifically they are waiting for (I.e. “the nurse will come and draw your blood shortly, and from the time the blood is sent it will be about 1.5 hours for results. Then we will need to speak with the hematologist.”). Update them as information becomes available and if there is a change in plans or an unexpected delay.
* **200% accountability**/peer checking (you are responsible for the safe conduct of yourself and your coworkers)
* **STAR** (Stop, Think, Act, and Review) before performing a critical task
* **SBAR** (Situation, Background, Assessment, Recommendation) for escalation and for handoffs
* **The 2-challenge rule** and escalation to question a decision that doesn’t sound right

**What is the setup of the ED?**

* Divided into different sections/ sides, A, B, C, D, O, ETU, RTU, Sub Waiting (SW), and Code Rooms
* **Code Rooms** - two connected rooms, typically use Code Room 1 for resuscitations. Make sure to gown, glove, get a sticker (ED resident), and write your name on the white board outside. Often Code Room 2 will be used to examine and/ or treat patients when rooms are very full.
* **Rooms 1-4:** A multipurpose portion of the ED with isolation rooms, often housing the pelvic bed, rooms for Sub-waiting pts to be seen, some patients who need to stay for observation and various other purposes (formerly called ETU). Pts usually assigned to A or B teams
* **A side (Rm 7-15)** - Typically the busiest side as two of the rooms have 3 beds each. Other than lacerations/ I&Ds, just about anything can end up on this side. Staffed by a PEM attending
* **“Med Control”/“Work room”** (historically was called "ECIC", which itself is now located upstairs)- area between A/B where phone doc often sits and takes transport/ EMS calls. Also has a station to teach LPs “just in time”. The US machine usually is located here. You can eat in here and place your bag/coat here.
* **B side (Rm 16-19)** - Similar to A and also sees many of the “Sub Waiting” (SW) patients. Rooms right near the charge nurse (like 18 & 19) tend to have the highest acuity patients so that they can be monitored closely. Usually this side is staffed by a PEM fellow or associate.
* **Sub Waiting** - a waiting area within the ED itself (after pts have gone through the main waiting). Here pts sit on chairs and can be examined in the small consult room nearby or in rooms #1 and #2 or in the Code Bay (if these are not in use). After using the exam room pts are returned to the chairs while waiting for x-ray, PO trial etc. Sub Waiting patients can be assigned to A,B,C or D sides.
* **C side** **(Rm 20-30)** - focus on respiratory (wheezing/ asthma) and psych. 1-2 respiratory therapists sit here.
* Psych rooms (also called “Decon” as it’s near the decon showers): this is a secure, security-staffed area for psych patients, mostly with SI or aggression. Police clearance patients are often seen here also (even if no psych c/o). If patients present an acute danger to themselves or others, the psych SW can help with disposition. It is your job to medically clear them prior to psych SW seeing the patient, and to address any acute needs.
* **D side (Rm 31-38)** - procedures and anything else. Lots of lacerations, I&Ds, g-tube replacements. The other rooms can be filled with any patients (similar to A/B sides). Usually there will be an NP or PA working with you on this side. Rooms at the end of the hall, 35/38 are for laceration repairs (no I+Ds –“dirty”- should go on in those rooms)
* **RTU** – (a.k.a Rapid Treatment Unit) a separate “fast track” area to see low triage acuity (office visit type) patients. Open from 7am-2am
* **“O Team”** – Most evenings from ~7pm-1am the ED uses the Orthopedic clinic rooms across the hall for an attending to see moderate acuity, low complexity patients

**Patient Triage Acuity Levels**

* Patients are assigned a triage acuity level, which corresponds to a color
* RED = Critical: trauma stat, needs active resuscitation of some sort
* YELLOW = Emergent: needs rapid MD assessment, goal in <20 minutes. Significant resp distress, metabolic pt with crisis, sickle cell or immunodeficiency w fever, severe pain, VP shunt w sx of failure.
* GREEN = Urgent: most ED patients. Abd pain, asthma, s/p seizure, migraine.
* BLUE= Not acutely ill but may need resources/testing. Extremity injuries, fever in healthy child, vaginal discharge w/o other complaints in teen.
* PURPLE= Not acutely ill, unlikely to need resources/testing. URI sx without fever, rash without systemic sx. Most of these are seen in RTU (when open).

**Patient Perspective of ED Visit:**

* Arrive at welcome desk and obtain a security sticker
* Triage - an approximate 2 minute nurse triage is done and a Level 1-5 is assigned and main ED vs. RTU is determined. May go wait at this point.
* Assessment - a more in depth initial nurse evaluation, vitals, history. May wait again or this may take place in the ED room itself.
* Note some of the above is being adjusted due to new "Lean" efforts
* MD portion, dispo: admit vs. discharge
* After the MD says “you are being discharged” they will still have to wait for an RN to come, remove IV, repeat VS PRN, and go over discharge instructions

**Common Patient Non-Medical Questions:**

* Is parking covered? No (patients should push the call button when exiting the garage if any issues)
* Do you give cab vouchers? No [note that some Medicaid plans provide transportation which nurses can call to arrange, and in *rare cases* a social worker can provide public transit assistance]
* What are inpt visiting hours? 8am-8pm, Parents/legal guardians welcome to come and go 24/7
* How many adults can be in the ED/inpatient room at a time? 2
* How many adults can stay overnight in the room with an admitted patient? 1
* Can other children stay overnight with the parent and admitted child? No
* Food options – You can provide sandwiches/ snacks from ED nourishment room. Vending machines (including coffee) in ED waiting room, Cafeteria (2nd floor ~7am-7pm- varies), Café (7th floor, 24/7).

**Seeing a Patient:**

* New patients will be indicated in Cerner by a patient assigned to a room and no provider assigned yet. The physical charts (outside documents, demographic stickers, signed consent forms etc.) are placed in a bin which correlates to the room number.
* Some patients may have been seen by the Front End doctor prior to coming to their room or subwaiting. You are welcome to go see those patients as well, unless the Front End doctor has indicated that they are keeping the patient. All patients seen by the Front End doc will have a brief note in the chart detailing the initial plan.
* Introduce self to pt, clearly stating name and role: “Hi, I’m Dr. Awesome. I am the resident doctor caring for your child today.”
* Order labs/ xrays etc. as needed, try to verbally notify nurses of orders (this will help catch a lot of mistakes). Medical students, make sure to tell the doctor you are working with to co-sign the order or it will not get done!

**Only order labs out of “ED Common Meds” folder or an ED PowerPlan to avoid mistakes.**

* If you order an XR, it will not get done until the comment field on the main board says “ready for XR @ time”. Before you write this, check with the RN to make sure patient is actually ready (in a gown, not in middle of a blood draw, HCG is done etc.). The XR techs check that column to see who to call for XR.
* Update families and nursing staff of all changes and what is determining dispo. Update free text columns in Cerner as appropriate.

**Discharging:**

* Consider a PCP phone call or order to call at this stage. PCP notification is **expected** for all triage levels 1-3, admissions, and “pre-arrivals” (pts who were called in as a referral by PCP).
* Notify/ check with any consultants as appropriate
* Complete discharge process in Cerner and ensure “house” symbol appears
* E-prescribe (or print) scripts (often includes OTC meds) and discharge instructions. Med students cannot complete this step. **Please get all prescriptions (including e-prescriptions) checked by an attending or fellow prior to discharging the patient.**
* Liberally give school/ work notes – most people want them
* Notify nurse to discharge patient when papers printed and on chart.

**Admitting:**

* First step, determine PICU vs. NICU vs. floor. Then determine which service to admit to.
* ICU admissions
* Most go to PICU- call fellow directly re admissions.
* CICU: Consult cardiology, they will determine if a cardiac pt needs CICU.
* NICU: Rare to admit to NICU from ED, consider in ALTE/ROS especially in <44wks corrected gestational age or recently discharged preemies. Contact NICU fellow.
* Floor admissions (Acute Care)
	+ Surgery - All trauma of any kind, burn, NAT patients will default to trauma surgery (unless isolated ortho injury)
	+ Ortho – Admits ortho injuries if needed. Pts with concurrent medical needs (i.e. osteo) go to a medical service w Ortho consult
	+ Kaiser - any Kaiser patient (can see in Patient Information section in Cerner or ask family) should be discussed with the Kaiser hospitalist and then will be seen by the admitting resident
	+ General Medicine/Hospitalist - coordinated by an admitting attending or resident (depending on time of day) also called “bed czar” or HAR (hospital admitting resident) who determines which team (a color, or “PHAST”) a pt goes to. *You cannot place a Gen Med admission order until you are given a team assignment from the Bed Czar.*
	+ Gen Med also admits for smaller subspecialty services such as ENT, Urology, Rheum, ID, Special Immunology (=HIV, though some are followed by Adolescent), and Metabolic/Genetics.
	+ PHAST - hospitalist (no resident) only service, target patients are those who are less educational for residents and often <48hr admissions, e.g. a wheezing patient on room air and q2h albuterol, simple gastro, simple cellulitis.
	+ Neurology - will admit most first time afebrile seizure patient for EEG/ possible MRI
	+ Pulmonary - will admit asthma patients if they follow in clinic
	+ Heme/ Onc (sickle pts, cancer), Cardiology, GI/IR (Intestinal Rehab), Renal, Endocrine, Adolescent admit to their own services- call specialist fellow/attending directly, don’t need Bed czar
* All admissions require an “ED inpatient bed request” order which does not require the attending’s name, just diagnosis, team, and isolation needs. Some teams (general medicine, medical subspecialty services) require “holding orders” which are just very basic admission orders like vitals, fluids, meds to be given in next few hours.
* Why are holding orders important? They allow nurses to provide pain meds, albuterol nebs, or other medications in the first 2 hours, even before the full evaluation by the floor resident. Holding orders: these are needed for all hospitalist and subspecialist admissions. Holding order are *not needed* for any surgical admission (Trauma, Neurosurgery, Ortho), for any ICU (PICU, NICU, CICU), or for PHAST (the short-stay unit upstairs staffed by Hospitalists only).
* Unit Clerks will call all PCPs regarding admissions, no need to specially request it or place an order.
* Once an order is placed a series of beds will be displaced on tracking board, starting with 1 bed and progressing to 3 beds (a clean bed is ready).

**Evaluations**

* Each shift, please make sure to have an attending, associate or fellow fill out an evaluation card for you
	+ GW Medical students: You will use the form on Blackboard
	+ Everyone else: You will use the yellow cards located on the desk in between A and B sides.
* Don’t forget to take a purple card and evaluate the attending, associate or fellow you worked with
* Some of you will receive an electronic request for feedback soon after your rotation ends. Please fill this out so we can improve the rotation.