Rounding in the RACC

We want to formalize the transition rounds between the morning and afternoon shift in order to ensure comprehensive handoffs and bolster teaching. Please follow these steps:

1. At 8am, 4pm, and 12am have the clerk overhead announce that rounds will be starting at bed 1 (this is to allow the nurses to participate—we want the nurses!). **Please start rounds on time!**
2. The patient's nurse, the docs, the incoming scribe, and the ED Pharmacist should be present
3. Get at least one Computer-On-Wheels; two are preferable. One resident should pull up labs and radiology, the 2nd resident should put in orders as they are discussed.
4. The senior resident should know **ALL** of the patients and should present each patient on rounds. The junior resident and the outgoing attending should fill in any additional details
5. For non-critical patients, there should be a brief description of the situation that brought the patient to the ED, **followed by** pertinent PMH/PSH/background, and then a problem list and what is being done about each item.
6. For Critically Ill patients, the presentation should follow ICU-systems based approach (See Page 2)
7. If a new patient arrives during rounds, the junior resident should break off and assess the patient, place initial orders and then return to rounds. Only if the patient requires immediate resuscitation, should rounds be paused and the entire team should go and stabilize the patient.
8. Non-emergent issues and requests for orders by nursing should wait for the team to arrive at that patient during rounds. This is one of many reasons that nursing should be involved in this multi-disciplinary rounding.
9. For some reason the attending taking over is always much smarter than the attending signing out. Oh, wait, that's not it; it's that when rounding in a 25 bed unit, there are bound to be things that are discovered on rounds—in fact that is one of the main benefits of rounds. If you are taking over, be kind and judicious when asking about, "Why has BLANK not been addressed or acted upon. These are discovery rounds. The outgoing attending should not feel they have somehow failed if the lab they have been waiting-for for the past 3 hours finally comes back during rounds and changes the disposition—this is why we are comprehensively rounding.
10. At the end of each patient, a closed-loop summary should be reiterated of plan, orders, and disposition.

RACC Critically Ill Patient Rounding Sheet

1. Summarize **Why the patient is here**
2. Discuss *Pertinent* **PMH/PSH/MEDs**
3. Assessment and Plan by System (discuss pertinent exam findings and labs in each system as well) and FAST Bullets

BY SYSTEM

Neuro

- Neuro Exam
- Neurological Issues / Review Neuro Imaging
- **Analgesia/Sedation**/Delirium (RASS Scale)

Cardiovascular (CV)

- ECHO
- Cardiac Function
- Lactate/ScvO2
- Vasopressors/Inotropes/Vasodilators

Pulmonary

- Vent Settings
- Blood Gases & Chest Radiograph
- Pulm Toilet

Renal/Electrolytes

- Urine Output and I/Os
- Acid/Base Status (Review Gases for Acid/Base)
- Chemistries
- Fluids Administered
- HD Issues. If ESRD, what is HD access, schedule, last HD

Gastrointestinal

- NPO Status
- Hepatic Status and Labs

Hematology/Oncology

- CBC
- Bleeding?

Infectious Disease

- Suspected Source
- Cultures Sent
- Antibiotics (are they written continuously?)

Endocrinology

- Sugar/**Continuous insulin for IDDM Diabetics**
- Stress Dose Steroids (ask if pt has been on steroids in past 3 months)
- Can this be an Endocrine Issue, Thyroid?

Oncology (if applicable)

- Diagnosis
- Metastasis?
- Chemo/Rads

Tox (if applicable)

- Ingestion
- Timing
- Has Tox Been Called

Trauma/Orthopedics (if applicable)

- Injury List
- Clear Collar or Replace with Philly

FAST BULLETS

A bulleted approach to avoid missing iatrogenesis/less than ideal care

- ☐ Head-Up Position (30 degrees) if intubated
- ☐ Skin/Eye Care/**Contact Lens**
- ☐ **Indwelling Catheters**-Where, how, sterile/non-sterile, checked for location?
- ☐ Nasogastric tube
- ☐ **Code Status**/should we be changing it?
- ☐ Psychosocial support (for patient, family and staff)

4. Check all **Labs and Radiology**, that have not been seen
5. Look at **Vital Signs and Trends**
6. **Disposition** and what criteria could cause a downgrade to a lower bed