Maternal Child Teaching Service (MCTS) at Meriter Unity Point

Revised Mar 2023

For questions about this document, please contact Ally Couture, Jensi Carlson, Tom Hahn, or Ildi Martonffy

Basic Information

Overview: A team of four family medicine residents, two R2s, one R1, and one "floating" R3 provide around-the-clock coverage of the low risk patients on Meriter OB floors (Labor and Delivery, Postpartum Suites, Antepartum). Residents round as a team on all low-risk postpartum patients. They take turns covering the labor and delivery floor in 12-13 -hour shifts.

- Weekdays: R1 and/or R2 during the day (R1 without senior on W/F), R2 in the evenings
    - *Starting July 1 2019, R1/R2 during the day on M/T/Th/F, R1 without senior on Wed only
- Weekends
    - Saturday: floating R3
    - Sunday: R2

Some notes on rotation scheduling: Clinic educational afternoons, In-Training exams, DO Workshops, critical care courses, and other unique events affect the schedule in atypical ways. Katy Bixby will try to arrange the schedule so that residents can attend such events. This may mean occasionally splitting a work shift between two residents. These situations are less than ideal and will be avoided when possible.

What is different about the Meriter rotation from the one at St Marys?

This rotation is structured to focus on delivery of obstetric and newborn care in the family medicine model. You are responsible for both the mother and the baby on this rotation. The NICU team may be involved in resuscitations however you are still the primary manager of the baby in conjunction with the attending.

MCTS Google Drive: Up-to-date policies, logistics, and care resources are available on the MCTS Google Drive. You can access this by logging in to Google Drive with username: Madres.obnewborn and password: obnewborn

Key People

Who will you work with at Meriter?

1. **Nurses and staff** (unit clerks, OR techs, and other occasional administration people)

2. **Attendings:**

--*Family Physicians:* Most of your deliveries will be with an attending from one of the groups below. The community attending physicians are generally not in house and should be contacted promptly with admissions.

- Our Residency Family Physicians (includes patients managed by resident-only, resident and faculty co-managed, faculty only): You will provide back-up for your resident colleagues if they are unable

to be present (for duty hours, rotation, call or personal reasons) for the admission and management of their patients.
    - GHC Family Physicians
    - DFMCH Community Physicians
    - Wildwood Family Physicians
    - ***To find out who is on-call for each group, you can look at the "on-call" Meriter website (found by going to the Citrix launch screen and clicking on "on-call"). You can also call the operator or looking at the InsideDFMCH page under the faculty call schedules. ***

--*Obstetricians:* You will not generally work with the OB groups on this rotation
    - *UW Obstetricians:* One of their physicians is always in-house 24 hours a day and will often be the consultant group if need is determined by the attending physician
    - *Other Obstetricians:* Generally, you will not work with these groups unless they are the hospitalist covering for the day. Includes Madison Women's Health (Dickmeyer, Sample, Sharma, Stoffel, Widel, Yanke, Schoenecker) and Melius, Cardwell, and Schurr.

--*Pediatricians:* Generally, you will not work with this group, however you may participate in joint lectures with the pediatrics residents. The UW pediatric hospitalist is Dr. Goetz and the Unity Point hospitalist is Dr. Baumann-Blackmore.

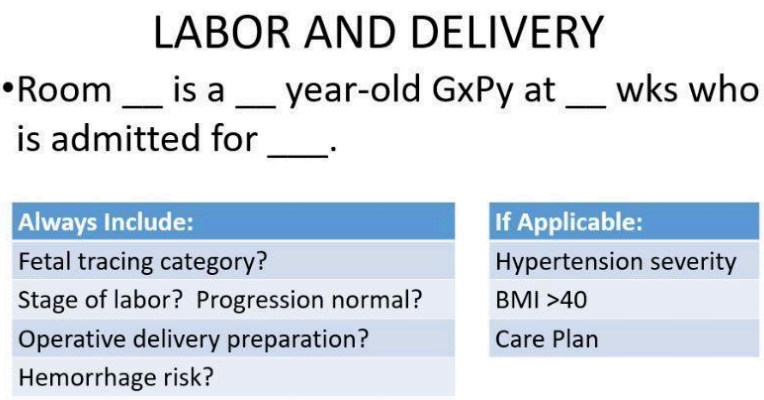
3. **Anesthesiologists:** Contact is limited to discussions about epidurals.
4. **OB residents**: Meriter is the primary location for OB resident rotations so there are several different residents on service with multiple functions. They always have a resident in-house. They are expected to have a collegial relationship with FM residents and can be excellent teachers. You can ask them a lot of things, but do not ask them to make management decisions on patients that are not on their service. For the obvious medical - legal reasons, they cannot make treatment decisions on somebody else's patient. If you are unsure about the safety/treatment/management of a patient, you must communicate this directly to the patient's attending and s/he must come in to evaluate the patient. The Senior OB resident becomes involved directly only if an OB consult is made by the attending or the patient develops an acute high-risk condition. So please respect their role on the floor. Again, they are generally a smart and wonderful group of people and can be very helpful.

<u>Logistics</u>

Overview of the Typical L&D Shift:

- Shifts last either 12-13 hours and change over at 6:00 AM and 6:00 PM daily ("day" and "night" resident, except Wed when the night resident stays until 7 AM) or 6 hours from 6:00 AM to 12:00 PM daily ("morning" resident).
- Resident Work Room code is 2-5-8. The code to get into the OB work room next door is 3-5-2. The codes for all other rooms in the hospital is 3-5-7
- At change of shift in the morning, residents should be changed into scrubs and ready to get sign out at 6 AM sharp.
- The resident coming off a labor and delivery shift signs out the board of actively laboring patients to the resident coming onto labor and delivery at the change of shift (6:00 AM and 6:00 PM).

- Attend board rounds at 8am and 8pm. Format of presentation:



- The residents should aim to round on patients with the family medicine attending. If this is not possible, the residents may round prior to the arrival of the family medicine attending. If the Family Medicine attending has already written a note on the patient, the resident does not have to see that patient and write a duplicate note. However, if you delivered the patient or were involved in post-partum care you are encouraged see the patient and write a social rounding note in this case.
- In order to facilitate rounding with potentially multiple attendings in the morning, residents are encouraged to call/text the attendings at 7am to coordinate the morning rounding with as many attendings as possible.
- The goal of this service is to round on the mother-baby dyads delivered by family medicine residents Priority for rounding should be given to the following groups:
    - Residency patients: Continuity DFMCH patients will usually be seen by continuity residents and the MCTS attending. The postpartum/newborn rounder does not have to round on these patients unless they delivered them, and the continuity resident is not rounding.
    - Access family medicine patients, regardless of whether they were delivered by family medicine, OB, or midwives. *The only exception is if the newborn is going to the Access East Clinic (Evjue on E. Washington)--in that case the newborn will be seen by the peds hospitalist. We only round on newborns going to the Access West clinic (Erdmann on S. Park St)
    - DFMCH community/Wildwood/GHC patients delivered by family medicine residents.
    - **NOTE: Residents are NOT expected to round on non-Access and non-residency babies that they did not deliver (AKA: do not have to round on UW community, GHC, Wildwood babies they did not deliver).**
- Teaching on this service will be primarily conducted by the in-house MCTS Family Medicine Attending. The goal is to cover a teaching topic around 11 am every day to allow the day and morning resident to participate in the session.
- Other didactics that you are expected to attend (if patient care allows):
    - Mon/Tues/Wed/Fri: OB does teaching topics around 7:30am every day in the 5th floor sim lab which the residents are welcome to attend. I would encourage the senior to ask the OB residents/MCTS attending for the topics early in the week as they often have materials to review

- Thursday: peds didactic in the mornings in the 3E conference room. Residents should page Liz Goetz sometime that morning (between 7-9am) to determine what time to meet that day.

*ACGME clinical and educational work hour requirements and residency standards dictate that residents may not be scheduled to see clinic patients following an overnight inpatient shift. Work hour requirements recognize and support the collective responsibility of residents and faculty for the safety and welfare of patients. It is the responsibility of each resident, therefore, to proofread carefully her/his clinic and inpatient schedules early and often to make sure that s/he is not scheduled in clinic following an overnight shift. To protect both yourself and your clinic patients from a post-shift scheduling problem, it is imperative that you check your schedules with great care. In the event of an immediate scheduling issue, contact your clinic manager and the family medicine faculty staffer for the day ASAP; for less immediate scheduling problems contact the acting chief.

Shift Responsibilities Summary:

1. Evaluate and manage all family medicine managed obstetrical patients from presentation/admission until discharge.
   - MEWS (maternal early warning system)--activated by nursing staff if maternal patients meet the criteria below on the postpartum, antepartum, or triage units

Maternal Early Warning Criteria

Maternal Signs & Symptoms	ACTIVATE MATERNAL EARLY WARNING SYSTEM (MEWS) Response Team = OB Hospitalist, Senior Resident, Charge Nurses 4N and 5N
Systolic BP	< 90 or > 160 mm Hg
Diastolic BP	>100 mm Hg
Heart Rate	<50 or >120 bpm
Respiratory Rate	<10 or >30
SpO2 on room air	<95%
Oliguria	<35 cc/hour x 2 hours
Neurologic	Maternal agitation, confusion or unresponsiveness; Patient reporting a non-remitting headache
Other	Shortness of breath; other concerning symptoms/behaviors

   - Service pager will go off if this system is activated for maternal issues. You are expected to go to the room as soon as possible (within 10 minutes or less). If you are an intern and receive this page, you need to either bring your senior or attending to the room to assess the patient. After assessment, call the primary OB to discuss the plan (or FMOB on call for that patient) to formulate and execute a plan. You can get the UW OB hospitalist involved if needed. You will need to write a note documenting the event and plan in the EMR. Please see the powerpoint in the Google Drive folder regarding more details about MEWS

2. Assess patients in triage and determine an appropriate treatment plan -- admission, further observation or discharge -- in consultation with the attending. Residents will complete progress notes, orders and communicate with patients, nurses, and attendings in a timely fashion. Residents will perform the delivery and repair and round on all postpartum patients. May participate in operative vaginal delivery or c-section of a patient that the resident has been managing at the discretion of the OB attending.

3. ALL family medicine patients are admitted to the "teaching service" regardless of the attending's clinic/call group. This includes all scheduled admissions for cervical ripening or admission for low-to moderate risk

reasons like post-dates and other conditions at the discretion of the attending (like IUGR at 37 weeks, gestational hypertension, diet-controlled gestational diabetes, etc).

Note: The rare exception in which the FM resident is not involved with a family medicine patient is usually when the patient is a member of or married into the Family Medicine Department and expresses discomfort with the association. Pregnant people in the department are encouraged to discuss their feelings early in the pregnancy with their individual attending, as most attendings expect that a resident will always be involved with a delivery.

4. Give thorough sign-out on all patients on L&D and any postpartum patients with complications requiring active management.

5. Assist in resuscitation of the infant after delivery and continue to manage this infant until discharge. Residents will round on the infant in the setting of the maternal-child dyad completing progress notes, orders, and procedures (circumcision, clip tongue-tie, etc) and communicate with patients, nurses, and attendings in a timely fashion.

- If nursing has any concerns about newborns overnight, they should be paging the appropriate on-call attending. During the daytime, the first call goes to the resident, who can then assess and call the attending as needed.
- Babies needing bilirubin checks over the weekend should be directed to West Towne or Union Corners on weekends (a chart can be created for newborn at urgent care--parents can call in advance to register the newborn prior to arrival). The resident/attending should call urgent care in advance to give them a heads up and give them the contact info for the person who will follow up the lab result (PCP or MCTS team).

6. You may be contacted by an attending to follow a patient admitted to postpartum suites for late postpartum complications. These are important learning opportunities and you should plan to follow all of these patients.

7. You may be contacted by an attending to follow a patient admitted to antepartum suites for an antepartum complication (pyelonephritis, preterm labor, etc) if > 20 weeks gestation. You are expected to manage these patients with close communication with the appropriate family medicine attending.

8. Maintain accurate notes for procedure logs and complete rotation evaluations.
    - Residents must log 40 newborn encounters throughout residency. Do this through New Innovations or the Peds Tracker App (one or the other, not both). Contact Jenny White if you have questions.

9. Be courteous, attentive, collegial/respectful and efficient in your interactions with patients, nursing staff and physicians.

10. Assure there has been a change name/pager number on L&D and Family Care suites call boards at the change of shift and carry the resident phone and pager.

11. Stay clean. Be fastidious with sharps. Wear protective eye, shoe, and hair gear. Always. Wear scrubs at all times (if you're not in scrubs, you're not working on the L&D floor). Change scrubs as needed to prevent spread of contamination through exposure to bodily fluids. Should you be exposed to bodily fluids or a needle

stick and are treated in the ER, please report this incident as soon as possible to Jenny White, the Residency Education Coordinator, to file a worker's compensation report.

Triage:

The resident covering labor and delivery is responsible for evaluating all low-risk family medicine OB patients who present to triage. Most patients present for evaluation of labor, rupture of membranes, fetal well-being and other complaints like vaginal bleeding or cystitis. The resident will examine and develop an appropriate treatment plan for all triage patients in consultation with the triage nurse and the assigned attending physician. The L&D floor has a policy of contacting the attending physician within 30 minutes of the patient's arrival to triage. Ideally, the resident will complete their initial assessment in that window of time. If the resident is occupied by other duties on the floor (like a delivery), he/she will work closely with the triage nurse to delegate this initial phone call. When appropriate the resident will coordinate the discharge of triage patients, discussing the case with the attending prior to discharge and thoroughly documenting the evaluation and treatment plan in a triage note. The resident will admit and manage the labor of all low-risk obstetrical patients. Residents will complete admission orders and a concise history and physical in a timely fashion. Residents will continue to monitor patients throughout their labor, completing exams and documenting their assessments in progress notes.

Ordering an ultrasound:

- If in triage call perinatology clinic and ask for them to schedule patient
- If antepartum order "Schedule Perinatal Ultrasound while inpatient"

Antepartum Admissions

For UW DFMCH antepartum patients who are > 20 weeks, if you or the continuity attending for the patient are comfortable managing the patient, they will be admitted to our service. Otherwise, you would need to call OB/MFM for admission (or co-management). If they are admitted to our service, please ensure that the patient is added to the MCTS system list by asking the HUC to do this.

For patients < 20 weeks, UW OB is contacted and determines if these patients are appropriate for antepartum admission to the OB service. If it is primarily a non-OB issue, the patient will be admitted to the internal medicine hospitalist team. MCTS does NOT admit these patients to our service.

Wildwood patients > 20 weeks are admitted to MCTS, if appropriate. Otherwise, they are admitted to OB vs MFM depending on the clinical situation. The resident will see the patient in triage and call the Wildwood attending who will make the decision about which service the patient should go to, and then the Wildwood attending should have an attending-to-attending conversation for the admission if they are admitted to OB or MFM. If the patient is admitted to MCTS, the patient is followed by the Wildwood attending and the resident can also follow for educational purposes.

GHC currently does not admit antepartum patients. The policy for any of their patients is as follows:
For < 20 weeks gestation, the ER contacts UW OB for an consult, assessment, admission needs.
For >20 week concerns, the DFM resident calls the GHC provider from Triage. Based on the acuity of the situation, they determine if the admission should go to MFM or UWOB. Then, there should be an attending-to-attending call based on that determination.

Communication with Attendings:

Residents will work with the nursing staff to ensure that attendings receive timely updates and are in-house at the appropriate time (when primigravidas start to push, when nulliparous patients are 6cm, when multiparous patients are 5cm, or when any patient develops a complication or for whom the general standard of care assumes that an attending should be present, such as a patient on an epidural or trial of labor after cesarean section.). At the time of admission for a patient, discuss with the attending how frequently they would like to be contacted and how they prefer to be contacted (phone vs pager). Make sure to also communicate frequently with nurses to keep them updated, and they can also be a good resource for you to help facilitate communication with the attending if you are very busy.

Delivery and Postpartum:

Residents will perform the delivery and immediate postpartum management (including repair of perineal lacerations and management of postpartum hemorrhage) under the direct supervision of an attending.

Following the delivery, residents will help clean up the patient. The resident will dispose of all delivery table sharps however an OB tech will clean the rest of the delivery table and perform a count of sponges with the patient's nurse.

Residents write a delivery note and write postpartum orders. A computerized nursing record will be available shortly after the delivery that will provide many of the details needed for the traditional delivery note (like time of delivery, birth weight and APGARS). Patients will be transferred to the postpartum floor (Family Care Suites) about 2 hours after a routine delivery.

Residents are responsible for daily rounding on these patients and should place a high priority on seeing patients they delivered. The resident covering labor and delivery will also take phone calls from the floor and manage postpartum complications.

Residents are also responsible for assessing the newborn and completing the newborn H&P. Nursing enters the newborn admission orders; however, the resident should continue to follow the newborn through discharge. This includes daily rounding, completion of procedures, and responding to emergent situations during the day.

Planned admissions:

All scheduled admissions and procedures are recorded in the Snapboard available in Epic. The L&D resident is responsible for checking this schedule at the beginning of his/her morning shift and being available for all scheduled inductions and completing admissions for inductions/cervical ripening in a timely fashion. This work can be done in advance of the patient arrival if time allows.

Documentation:

It is worth noting that concise, accurate and timely notes and orders are a crucial part of providing obstetrical care. Guidelines for documentation including sample notes will be posted on New Innovations for you to review and download. It is essential that you document your discussions with attendings and patients accurately.

Notes should be written every day for all patients that residents are following. For inductions or patients in latent labor, notes should be written every 4 hours or sooner if there are any interventions or complications. For laboring patients, a note should be written every 2 hours. This does NOT mean that the patient needs a cervical check every 2-4 hours. You can do just a strip review if they do not need a cervical exam.

Note templates (share, do NOT copy)
.DFMNBHP
.DFMNBPROGRESS
.DFMNBDISCHARGE
.DFMNBSIGNOUT

.DFMOBHP
.DFMOBPROGRESS
.DFMOBDISCHARGE
.DFMOBTRIAGE
.DFMOBSIGNOUT

.DFMPPPROGRESS
.DFMPPSIGNOUT

Evaluation:

At the end of the rotation you will receive an evaluation in New Innovations from the UW Family medicine attendings that you worked with during the rotation. During the rotation you should ask other attendings you work with (GHC, community DFM, and Wildwood) to complete a "card" which is available on the L&D floor to facilitate evaluation. At the end of the rotation you will also receive an evaluation form from the L&D Nursing Council and collated feedback from the attendings who you asked to complete cards. You will be asked to evaluate the rotation as a whole. At any point during the rotation, please contact Priya Kalapurayil or Ronni Hayon if you have feedback or want to discuss a problem with the rotation. Other members of the faculty, chief residents, and your senior residents are also good people to talk with about the rotation.

Continuity OB Patients:

Residents should arrange coverage for their continuity or personal OB patients as they would for any other inpatient rotation. Due to duty-hours restrictions and fatigue, it is usually impossible to attend your own continuity OB patient after completion of a 12-hour shift. Residents may not leave the hospital while covering labor and delivery in order to cover their own laboring patients at St Mary's Hospital. The designated backup for all resident patients laboring at St Mary's is the resident on the L&D floor. If you are unavailable (due to work or duty hour restrictions or personal reasons), the designated back-up resident and the faculty member on OB call for the day will manage the patient. At St. Mary's, the resident working on L&D is the designated backup for all resident patients laboring there and as above the resident on L&D at Meriter is the backup there. If you admit one of your own continuity patients to Meriter during your L&D shift, you will follow her (as you would other residency clinic patients) with help and supervision of the residency faculty member on OB call.

It is expected that you see your continuity patients prenatally, during their labor course, and postpartum in order for that patient to be "counted" as one of your continuity patients. In order for you to be able to count a patient as a continuity, you must see the patient in 2 out of 3 of those settings.

Readmissions

Postpartum mothers (up to 6 weeks postpartum)

-If patient was seen in the clinic that day and you determine that she needs to be admitted due to a postpartum issue, you can call Meriter and have her directly admitted. She cannot be sent to OB triage- if you think she needs further work prior to admission she will need to be sent to the ED.

-If the patient was not seen in clinic and you are concerned about a postpartum issue, direct her to go to the ER. If the ER determines that she needs to be admitted, they will page/call the MCTS attending. The MCTS attending should ask the resident on service to go and see the patient in the ER to determine if she is an appropriate admission to the MCTS service (e.g. endometritis) or if she should go to OB (e.g. pre-eclampsia with severe features requiring magensium). If you are uncertain about whether she should go to OB, you can call the hospitalist to discuss the case to determine this and/or if the patient can be co-managed by MCTS and OB

Newborns

-MCTS does NOT admit for any newborn issues after initial discharge

-If a newborn was seen in clinic that day and you determine s/he needs to be admitted, you can call SMH or UW to get directly admitted onto the family medicine service (as long as they do not need to go to the NICU)

-Any newborns should be directed to be taken to the SMH/UW ER if they had not been evaluated in clinic that day and you are concerned that they might need to be admitted. The family medicine service will then be notified if admission is deemed appropriate after ER workup/evaluation.

-If an infant just needs a bilirubin blanket on the weekend and was discharged from Meriter, you can call the operator at Meriter and ask them to connect you with the Unity Home Health on-call person. You will then need to put in an order for phototherapy into the Meriter system and have this faxed to Unity Home Health at 608-417-3747.