Common Questions and Answers for Flow Changes Updated 2/6/2024

QUESTION: How do I know which patients are assigned to my Team?
ANSWER: The patient is assigned by round robin to Teams A, B, and C. This assignment will be written in the "comment" column in the tracking shell of Cerner during triage.

QUESTION: A patient has been assigned to my Team, but my Team does not have a resident, or APC, or I am way behind. Can I just change the color in the tracker?
ANSWER: NO. Please, do not do this. This leads to redundant work, delays in care, lost patients, and unequal work distribution. It is a dangerous practice and unprofessional. The appropriate response to this situation would be a request for help. The Team B physician is the designated "physician on duty" and can facilitate aligning work loads with available resources in coordination with the Charge Nurse.

QUESTION: I don't have a resident assigned to my Team. Can I request or grab one from another Team?
ANSWER: NO. Please, do not do this.
If changes in the schedule have resulted in a less than optimal distribution of residents, APCs or Attendings, the physician on duty (Team B Attending) can help reallocate existing providers.
If there is a conflict or a resolution is not agreed upon, please contact Dr Wood for resident related scheduling concerns or Dr Ammon or Dr Wiederhold for physician or APC staffing issues.

QUESTION: I am on top of my game today! Other Teams are falling behind. Should I help out or wait for the cyclone to touch down in my area?
ANSWER: Please help as appropriate and your availability allows. The care of the entire emergency department rests on all of us. Play your position well. Also recognize that when random variability has found favor upon your Team it is incumbent that reasonable professionals compensate/correct by assisting those who have become encumbered.

QUESTION: What happens if there are no beds/spaces available in a POD for the patient's chief complaint?
ANSWER: Patients will continue to be assigned to PODs based on chief complaint, but may be placed in an adjacent location if a bed is needed (please see vertical vs horizontal matrix). The goal is to place patients in pods based on chief complaint. If this is not possible, the patient will be placed in a location where they can receive care without delay.

QUESTION: Where do boarded/admitted/social services patients go?
ANSWER: ICU patients will preferentially board in beds 59-62. The remainder of admitted boarded patients will preferentially board in the radiology beds followed by the "other/general" (GREY POD) area. If there is more demand that these areas can accommodate the Team B (previously identified as "RED POD") Attending and Charge Nurse will huddle to identify the next locations to be used. If this does not easily resolve the issue, Cheryl and/or Ben (text or call) will be contacted to allocate resources.

QUESTION: Where are the Physician/APC care team charting areas?
ANSWER:
Team A: previous “North doc box” adjacent to north charge nurse area
Team C: previous “South doc box” across from beds 59-62
TeamB: South desk area adjacent to beds 52-54

QUESTION: How is the round robin run? Are there multiple round robin cycles?
ANSWER: There are two triage areas using round robin cycling. Ambulatory patients arriving by private vehicle are round robin cycled by the waiting room triage nurse. EMS patients arriving through the ambulance bay are also cycled using round robin. They are independent. The degree and frequency of communication that would be required to synchronize these two is prohibitive and the volume of ambulatory patients to EMS arrivals is 2.5:1. Meaning, these two independent cycles have a variance in frequency that are statistically unlikely to align often enough to create undue load to one Team or another.

QUESTION: Are “codes” cycled round robin style?
ANSWER: Codes are cycled in the same way all other ambulatory and EMS traffic are cycled. Meaning, a stroke that walks in the front door would be cycled through the ambulatory round robin assignment. The expectation is that an overhead announcement would include the TEAM assignment. For example, “Nurse Activated Stroke Alert, Lobby, Team A”. EMS codes are typically given pre-arrival notification by paramedic ring down. These will be assigned a TEAM at the time of the ring down to give sufficient time for the team to prepare. For example, the overhead announcement would be “CODE-3, Room XX, ETA XX minutes, Team A”.

QUESTION: Who responds to “CODE BLUE TEAM 2” overhead activations?
ANSWER: Team A provider. The Team A physician has the benefit of proximity to most places that “code blue team-2” activations occur. Additionally, this physician has proximity to the charge nurse desk and communication from the desk secretaries. Logistically, the code blue backpack is located in room 10 which also facilitates the Team A physician response. If the Team A physician is encumbered it is their responsibility to communicate this to and solicit another physician (eg Team B or Team C physician) to respond on their behalf.

QUESTION: How do we manage “family packs”?
ANSWER: In most instances, “family pack” patients arrive simultaneously and have very similar complaints. For this reason, they will be treated as one patient in the round robin rotation. Meaning, they should all be assigned to the same TEAM. It would NOT make sense to have three different providers seeing the group.

QUESTION: Who sees psychiatric patients?
ANSWER: Psychiatric patients presenting for care are typically triaged as ESI-2. These patients are seen by the Team A, Team B or Team C physician based on the round robin cycle

QUESTION: Who rounds on and manages the social service and psychiatric patients that are boarding?

ANSWER: Patients that have completed medical evaluation, are deemed as medically stable for further outpatient care, and are boarding for otherwise non-clinical reasons (eg psychiatric holds, social service holds) will be rounded on daily with a progress note recorded in Cerner EMR. It is the expectation that the provider who initiates the social services hold ensures daily medications are ordered, diet is ordered, and appropriate evaluations are requested (eg, PT/OT, psych, etc). Day two begins after midnight of the first day. It is the expectation that the night physician will round on boarded patients after midnight during their shift - to be recorded in the EMR on the calendar day that the night physician is coming off shift. Patients in beds 1-30 and north side hallways are assigned to TEAM A physician. Patients in beds 40-62 and south side hallways are assigned to TEAM B. If the night physician is unable to complete this due to being encumbered, it is the night physician's responsibility to communicate that to the oncoming day shift provider and sign out the pendings tasks.

QUESTION: There is a patient on the tracker without a Team assigned… who sees them?
ANSWER: First look to see if someone has typed a comment in front of the Team assignment… The team assignment might be there, but the writing is too far to the right to see it. If not, ask the triage nurse (lobby nurse or EMS nurse based on mode of arrival) to clarify. If this does not resolve the issue, please discuss with the Charge Nurse.

QUESTION: Who manages admitted patients that are boarding?
ANSWER: The admitting service.

QUESTION: If there is a hole in the physician or APC schedule for any reason… how is that managed?
ANSWER: This happens occasionally. It is impossible to describe every scenario that may occur. The 7a Team B physician is the "physician on duty" and responsible for managing these types of unanticipated events. The Team B physician should review the schedule for the day. If there are significant adjustments needing to be made based on staffing shortages of physicians, APCs or nurses, a plan should be made with the morning charge nurse. If a reasonable solution cannot be determined, the physician and/or charge nurse should contact Dr Wiederhold directly by text or cell phone for resolution. It is important to note that these adjustments should only be made based on staffing shortages. There should not be significant or large adjustments made to the flow based on preferences or subjective perceptions of individual providers.

QUESTION: When are patients no longer assigned to Team-C?
ANSWER: The expectation is to care for patients for the duration of your shift. Team-A and Team-B have adequate overlap to ensure that new patient arrivals should be immediately seen as they arrive. It is reasonable to stop seeing new patients during the last hour of your scheduled shift to facilitate a timely departure. Team-C should not be assigned new patients in the last hour of its scheduled end time.

QUESTION: Who does Team C sign out to?
ANSWER: Any active patients at the time Team C leaves for the day should be signed out to the Team A or B physician using reasonable judgment based on the active loads of each of these

physicians at the time of signout. It would be reasonable in most instances to divide the signout(s) amongst both remaining physicians.

QUESTION: I have a question that is not addressed…
ANSWER: Please ask Cheryl Heaney or Dr Wiederhold - more than likely you are not the only one with the same question… let us clarify this for everyone.