EPIC specific considerations for ICU rotations at St. Michael's Hospital

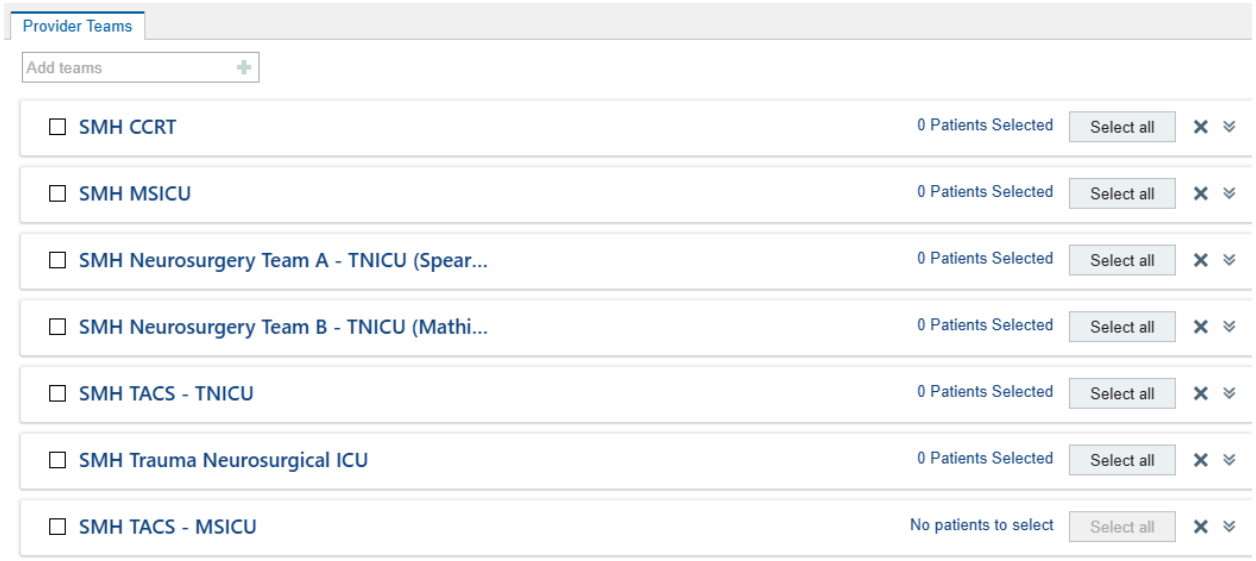
This is a working document and may be updated, so please refer to document sent by rotation coordinator

Many of you have likely used and are quite familiar with EPIC from other hospitals/rotations. We have adopted a few conventions in the ICUs at SMH that are detailed below.

1. Treatment teams and EPIC chat
2. Admitting provider, attending provider and service
3. Problem list and past medical history
4. Notes and ICU course
5. ICU best practices
6. Nursing care orders, confirmation of lines, tubes
7. Sign and hold orders

Using treatment teams and 1st contact function in EPIC

Step 1 - when you come in the morning - click on the correct team and sign in



Depending on the unit you are in you will need to pick **TWO** treatments teams:

For MSICU:

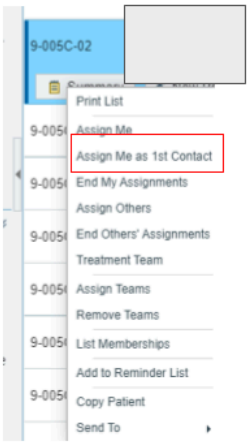
1. SMH MSICU
2. SMH TACS- MSICU - for non-urgent communication with TACS

For TNICU:

1. SMH Trauma Neurosurgical ICU
2. SMH TACS-TNICU - for non-urgent communication with TACS

Step 2 - go back to the normal patient list

Step 3 - for patients assigned to you - right click on the patient and click Assign me as 1st call



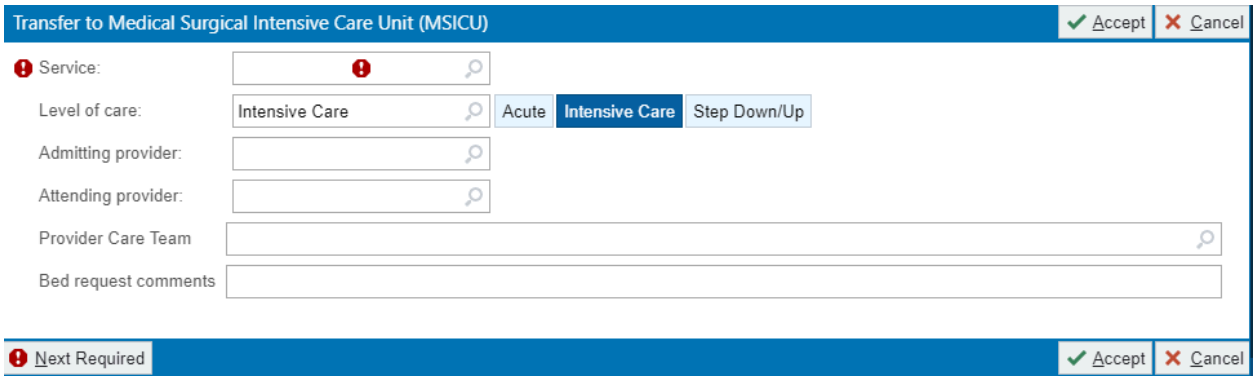
Step 4 - at end of day - please click sign out

On call team

1. Follow step 1 and sign into the correct team
2. Go back to patient list and ctrl A to select all patients
3. Right click - Assign me as 1st contact

Using treatment teams also enhances ease of communication with EPIC chat

Admitting provider, attending provider and service



When a patient is admitted to the ICU, as part of the admission orders there will be a box that pops up as above.

As an example, let's admit a neurosurgical patient.

We have adopted the following conventions:

1. Admitting provider is the staff **SURGEON**
2. Attending provider is the staff **INTENSIVIST**
3. Service is **Neurosurgery**
4. Level of care is **Intensive care**

As an example, let's admit a hematology patient.

1. Admitting provider is the staff **HEMATOLOGIST**
2. Attending provider is the staff **INTENSIVIST**
3. Service is **Hematology**
4. Level of care is **Intensive care**

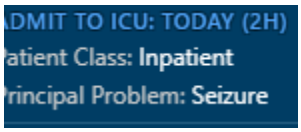
If it's a medical patient we are admitting from the ED then admitting and attending will both be the staff intensivist and service will be ICU.

Problem list and Past medical history

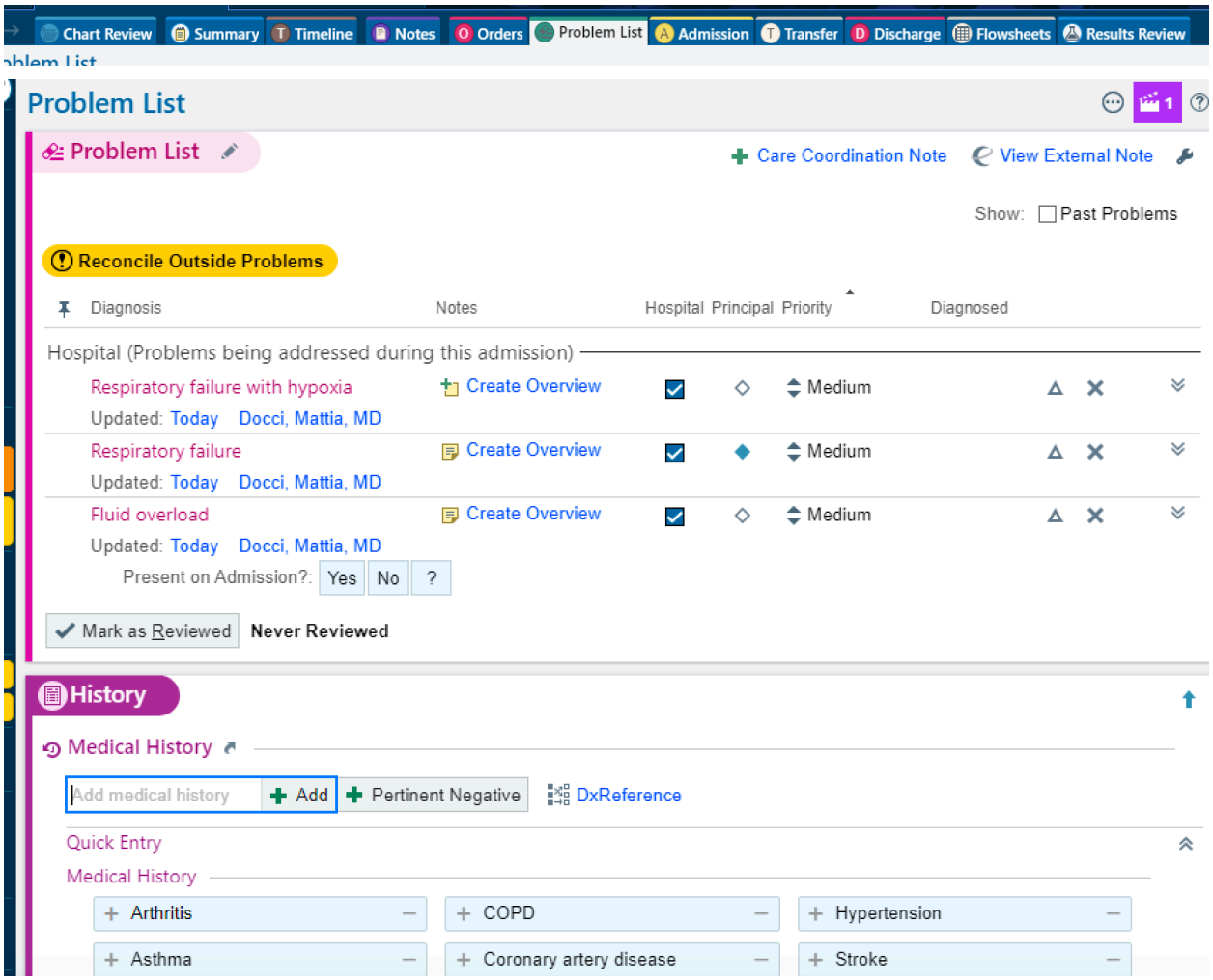
We use problem-oriented charting in the ICUs, so all consults and progress notes that we have customized will have the problem list appear so that issues can be documented on here directly. Updating the problem list is therefore essential for consistent charting in our ICUs. When a patient is admitted it is important to fill out both the problem list and the past medical history.

There are several ways to access the problem list:

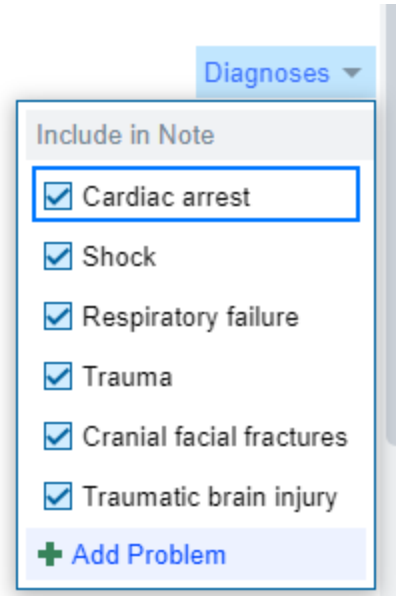
1. Click on the principal problem



2. Find it along the activities tab



3. In our templated notes you can access the problem list by clicking on diagnoses and then add problem



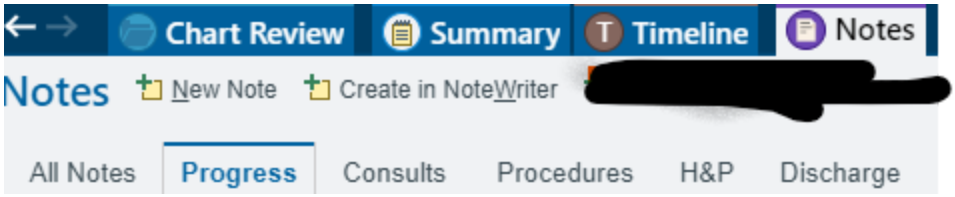
Notes

In general, please avoid excessively long and copied and pasted reports in notes. ICU notes should be focused.

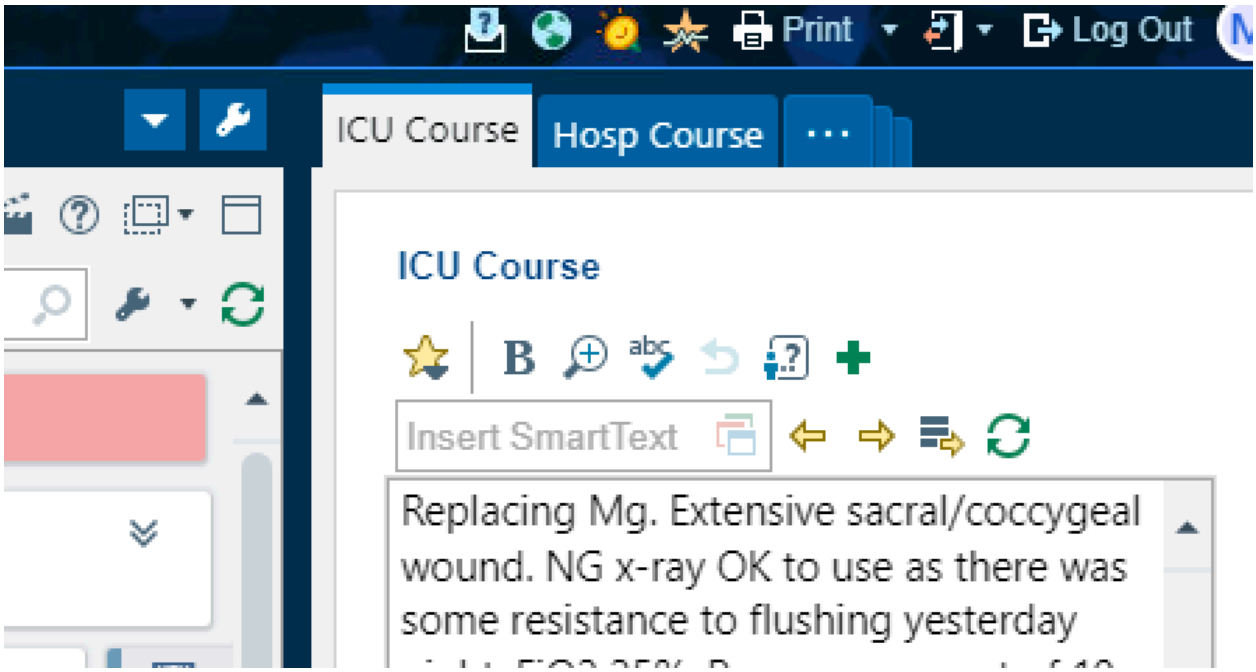
For consults and progress notes, you may have templates/notes saved from other rotations which you may want to use. In general this is ok as long as you have the problem list in your note. The smartphrase .diagpoc will bring in the problem-oriented charting problem list.

However, we have created consult and progress note templates that have everything required for an ICU consult and progress note. They can be accessed in the following way.

1. Go to notes tab
2. If you then click on the progress note sub tab and click “new note” it will bring up automatically our ICU progress note
3. The same is true for consults



The sidebar ICU course must be updated daily and can be pulled into notes for a summary of patient stay in the ICU. It should be brief and include pertinent updates.



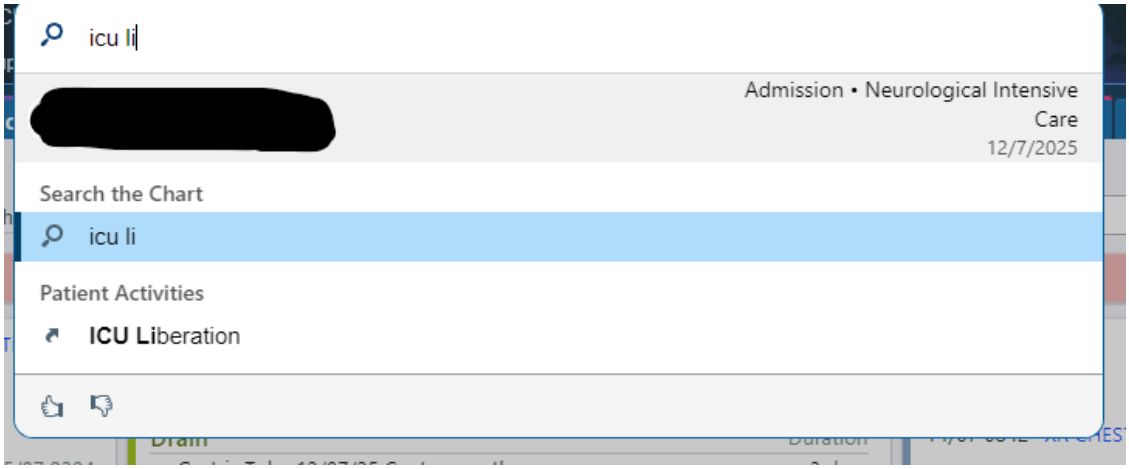
A few other conventions about notes in the ICU. Please try to avoid copying and pasting entire imaging reports, these are readily accessible in the chart. This contributes to note bloat and makes documentation un-readable. Please ensure that copy and pasted information is accurate, this is critical.

ICU best practices - AKA The best practice checklist, FASTHUGSBID, ICU liberation

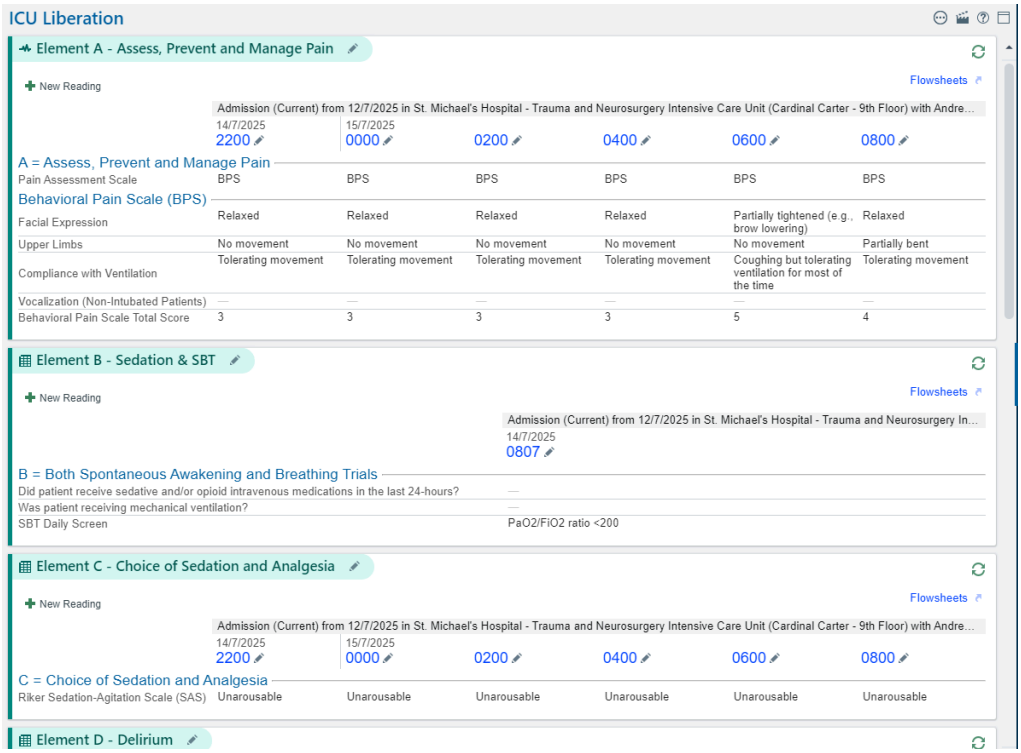
In the ICU, there are evidence based best practices that, when implemented, markedly improve outcomes in patients in the ICU. In order to maximize uptake, consistency and accuracy, we have built a best practice activity in EPIC. This activity is a shared document and therefore shared responsibility and can be accessed and documented on by physicians, nurses etc.

The overarching idea is that everyday, the elements contained in the best practice navigator are reviewed by the team. Many teams may do this during rounds, it may be reasonable before the whole team rounds to review this before rounds. As you will see in the screenshots below, many (if not all) of the elements have data which is automatically pulled from the chart.

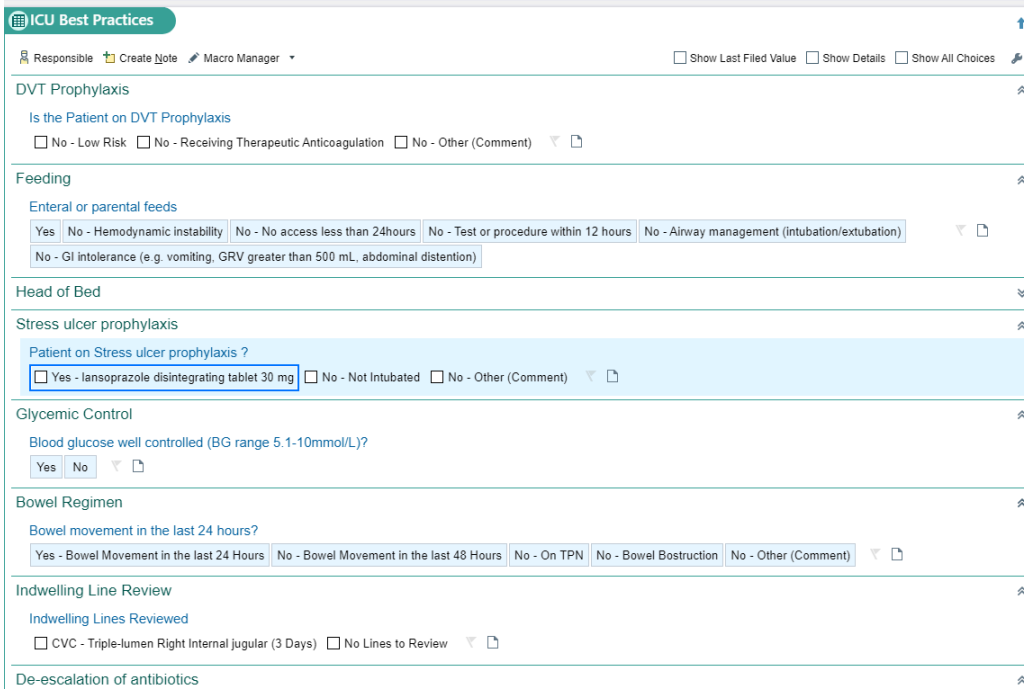
To access, open a patient's chart. Press ctrl+Space to get you into the search bar at the top and search ICU liberation



Once clicked on, you will be taken to the elements of the best practice checklist. There are two parts - the A-F bundle that is recommended by the Society of Critical Care Medicine:



The second component is the St. Michael's specific ICU best practices:



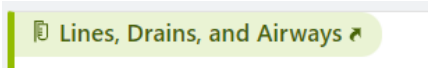
Nursing care orders, confirmation of lines, tubes

In general, there is an order for everything you can think of in EPIC and therefore, we strongly want to avoid nursing care or nursing communication orders. The typical offenders for these are things like “keep MAP >65” - there is a map target order on your monitoring or vasopressor orders. “Clamp chest tube” - there is a chest tube order set, same for EVD’s etc, tubes, flushes. **Please find these orders in EPIC - if they do not exist, please let one of us know so we can build a correct order.**

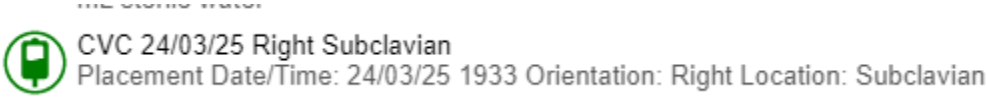
As it relates particularly to confirmation of lines and tubes, in the Sorian-era we would often write a nursing care order “ng ok to use”. The obvious problem is that this “ng ok to use” order has no link to the actual NG that has been inserted. So which NG is ok to use? The 4th one that was pulled out? For these reasons, we have decided to use the lines, drains, airway (LDA) Avatar to confirm placement of lines and tubes in EPIC.

The avatar can be accessed by both nursing and MDs.

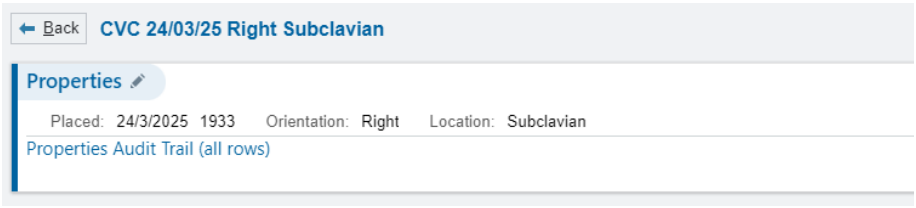
1. In the summary tab click on:



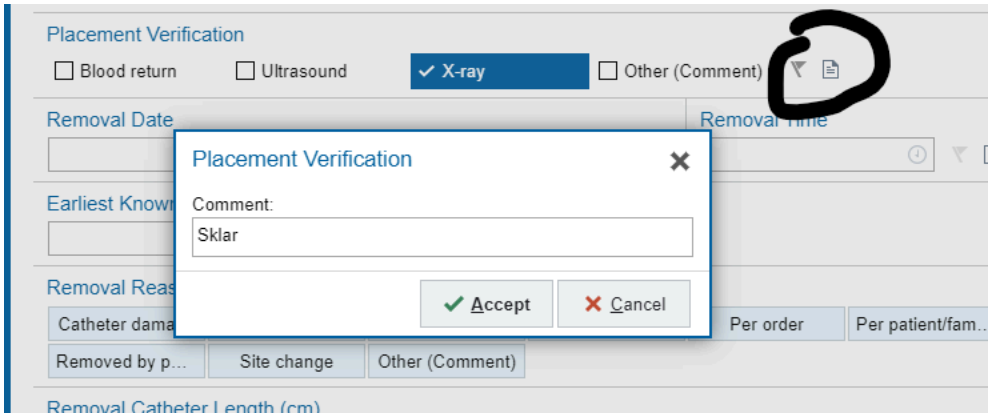
2. Click on the line or tube you would like to document on



3. Click on properties

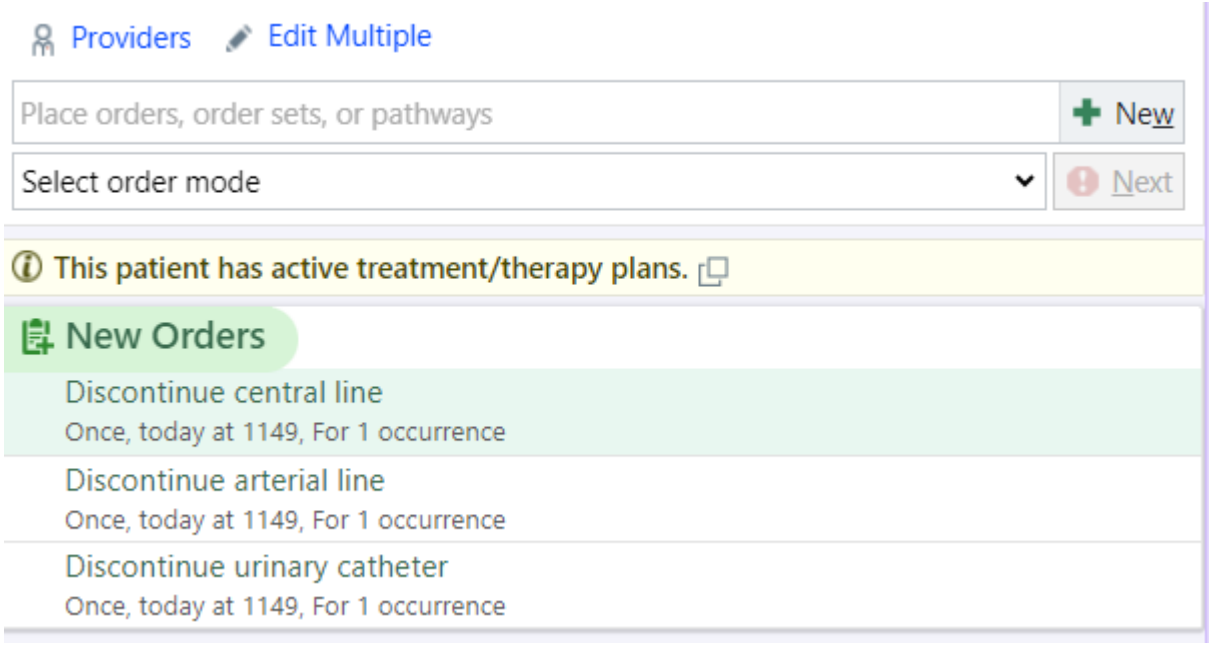


4. Scroll down to placement verification - click on x-ray and then on the small comment box and add name



Line discontinuation

To dc lines place an order, do not use the avatar:
One an order is placed the nursing team will remove the line from the avatar



Sign and hold orders

In Epic, **"Sign and Hold"** is a feature that allows you to **prepare orders in advance** but **delay their release** until a later time. In the ICU, you will see this mainly in patients from the ORs. When you see sign and hold orders please review them, accept them or discontinue them as necessary. Surgeons may put antibiotic orders and APS may have pain orders here.