MICCU Intern Survival Guide 2017-2018

If you have any questions or concerns about anything always feel free to contact your Senior Resident or Chief Resident

Pre-Rounds:

- **Please show up on time for sign-out:**
  - **Arrive at 6 am, earlier if you think you need time to learn your patients**
  - **Your seniors will be signing out during this time. Listen in**
  - Start gathering data to present
- **You are EXPECTED to know everything about your patients:**
  - There is a LOT of data in the ICU. Organization will be your savior
    - Some people write on stacks of note cards
    - Some people have rounding sheets
    - Some people have photographic
    - Just find the system that works for you.
  - Overnight Events (Senior sign out and ask the nurse)
  - Vitals, I&Os, Ventilator Settings **with ABG**
    - ABG format: pH/CO2/O2/HCO3 + a lactate if available
    - Ventilator settings format: Mode/Tidal Volume/ FiO2/Set Respiratory Rate and PEEP
    - Other values to record True respiratory rate (is patient over breathing a set rate) and Minute Ventilation (MVe = TVxRR)
  - Pertinent Exam Findings
  - Medications / Drips, Sedation, Antibiotics, Pressors
  - Labs / X- Ray findings
  - Lines, tubes, drains
  - DVT prophylaxis, GI prophylaxis
  - Impression/Plan:
    - Review this with your senior prior to rounds
    - Organize your thoughts and presentation in a systems based approach: Head to Toe
      - Neuro
        - Most acute issue
        - Sedation
      - HEENT
        - No issues
      - Cardiovascular
        - Cardiogenic shock
      - Pulm
        - Intubated and ventilated
      - Etc.

Rounds:

- **Rounds start time depends on the Attending**
  - Refer to your senior, some attendings will start at around 8 am, others won't start until 9:30. This will be the case until the optimal workflow has been agreed upon by the intensivists
  - Regardless of when rounds start, your seniors will be expected at Interdisciplinary rounds at 9 am, so if you started early rounding there will be a temporary interruption
- Start with a **formal presentation**, unless the attending indicates otherwise
  - When the patient's new:
    - Name, gender, age
    - HPI, plus events prior to coming to ICU
    - PMHx and any home medications
    - Pertinent social and family history
    - Relevant allergies
    - Physical exam
    - Labs and Imaging
    - Assessment and plan (below)
  - When the patient's a follow up:
    - SOAP
    - Start with a brief 1-2 line of why the patient is in the ICU
    - Review overnight Events
    - Subjective, patient's experience (if they are alert)
    - Objective: all chart, nursing, and physical exam data you have gathered
    - Assessment and plan (below)
  - Always remember the "Housekeeping", as Dr. Jamilla puts it
    - **Dr. Barounis is piloting an evidence based, ICU patient care checklist**. This will be found at the end of this document. Familiarize yourself, however your senior or the patient's nurse will be going through the checklist every day.
- **Organization and maintaining a consistent presentation structure will be key.**
  - For example don't bring your physical exam into the HPI, don't bring assessment and plan into your objective section
  - The exception is this: if it's something that was found prior to admission to the ICU, sure put it with the HPI since those are part of the events that led up to ICU admission. Same for any data that supported ICU admission, however use judgment here to determine what better serves the narrative.
- **Communication**
  - Ideally, the patient's nurse will be present during your presentation so they can help present any new data, and get up-to-date on the plan for the day.
  - **If that is not the case it is the responsibility of your senior and you to communicate the plan to the nurse in a timely manner.**
    - In the ICU, the nurses cannot be tied down to the computer, so simply entering an order into the computer is not good enough.

        - Urgent orders MUST be communicated verbally as well, it is also a courtesy to verbally communicate all other orders
        - Be careful about heparin drip orders, clarify whether it is High intensity, Moderate intensity, or reduced intensity and whether a bolus is given or not.
- **Do not worry if you do not know an answer or make a mistake.** Your first month of ICU will be a steep learning curve, and you will spend the entirety of it getting your bearings. That is the point.
- **Where you don't know your senior will, or know how to find out.** They will be a constant presence to back you up, so breathe easy.
- Rounds Should conclude by 11, but you will learn this varies widely

Post Rounds

- Regroup with your seniors and review the plans for each patient
- **Orders**
    - To increase efficiency, your senior will likely be putting orders in during rounds
    - After rounds, you can help your senior put in orders that were not already placed
    - **Daily labs and imaging orders are your responsibility. Put them in during AM or PM, doesn't matter just remember to do it.**
        - Usually: CBC, BMP or CMP, Mag, Phos
        - ABG if ventilated (tube or BiPAP)
        - Sometimes lactate and procalcitonin
        - Morning Chest XR if following a pulmonary issue or they are intubated.
- **Communication**
    - Again, for efficiency's sake, your senior may be already placing calls to consultants during rounds
    - After rounds, divvy up the calls (Consultants, PCP, pharmacy, etc.) that need to be made
        - In the ICU, Physician Link should be used most often. **41-3333**
        - Less urgent communications, like notifying a PCP their patient will be transferred, can be done through PerfectServe
- **Notes**
    - **This is a key duty of the interns**.
    - It is true that resident notes are not billable, but that is not the point of your documentation.
        - A) Note writing will help you learn
        - B) Your documentation is often better, and is critical for patient continuity of care when they are transferred out.
    - New admissions need a full H&P
    - Follow ups need a SOAP note

Noon(ish) Conference

- A lot of learning occurs during rounds and at bedside
- Pharmacy Poorvi and Nutritionist Kelly will have set noon lectures on several topics

- We will strive to give you regular ICU specific lectures on Mon – Thurs, and try to restrict it to half an hour. However, not all topics are conducive to this restriction.

Admissions/ Admission Notes:

- You should have forewarning of a patient coming, because your senior will be monitoring teletracking, the intensivist or charge nurse will tell them, or the ICU pager will alert them
- Use the time prior to the patient's arrival to do a chart review
- When the patient initially comes up to the ICU, there is a 15-20 minute period during which the nurses are preparing/cleaning the new patient.
- That is a great time to examine the patients back, look for rashes or wounds, and listen to lungs.
- As soon as the nurses are done, you can complete the rest of the interview/exam
- Contact family/living facility to glean more information.
- **Always remember to contact the PCP to update them about their patient's transfer to ICU and their condition.**
- Staff the plan with the senior and attending, and write the H&P.

Transferring patient out of MICCU

- Must be cleared by the intensivist
- **"Transfer ICU Patient"** order must be used
    - Specify location, need for telemetry, continuous pulse ox, apnea monitoring
- Notify the patient's nurse and the charge nurse about the transfer
- **Notify PCP that the patient is being put on the transfer list**
    - If it's a resident covered patient, call the DACR to let them know you are putting someone on the DACR/NACR list. **41-8873**
- Note, ordering the transfer does not mean it will happen quickly
- If a patient is well enough to transfer out of the ICU, they likely do not need any central lines or art lines. Make sure these are removed well before transfer
    - Nurses are capable of removing central lines and radial art lines
    - Residents will be asked to remove dialysis catheters or femoral art lines
- The nursing will notify the residents when a patient has a bed to transfer to. Your duties are then:
    - **Notify PCP that patient is now being transferred**
        - If it is resident covered, call the DACR to give them sign out. **41-8873**
    - **"Change Attending"** order must be placed, to change the attending to the PCP
    - **If patient is going to a STEPDOWN unit, "Consult Physician" to place an intensivist on consult**
        - The intensivist on consult may not be the same group as the one caring for the patient in the ICU. Look back on past notes to see which group should be on consult.
    - **Complete Transfer Medication Reconciliation List**

Consultants and PCPs:

- **This is a "Closed Unit"**
- This means the intensivist is the primary physician while the patient is in the unit, and has the privileges of ordering as he or she sees fit.
- The intensivist chooses who to consult and when to transfer.
- You may see the patient's outside PCP come up to check on their patient, please provide them an update of what is going on. If they have any feedback on care, take it into consideration and you may bring it up with the intensivist, but do not immediately accept orders from the PCP

Procedures:

- First, consider the clinical reasoning for the procedure. We are in the business of caring for patients, not assaulting them with needless procedures.
- There are two procedures that an intern has first crack at: **Central lines and Arterial lines**. These are the most common lines and you need to be certified in them to be effective seniors next year.
- Make sure you have reviewed the Central Line training module available on the MICCU section of the website. This will also be sent to you prior to starting in the MICCU.
- All other procedures, the senior has dibs, however feel free to ask your senior if they would allow to take it, especially in the latter half of the year
- **All procedures require:**
    - **A consent. Either directly from the patient, or from a surrogate decision maker in person or over the phone. If it is a phone consent, a second staff member (resident or nurse) will have to listen to the consent on the phone to witness**
    - **Notification to charge nurse about what procedure is being done**
    - **Supervision if you are not certified (5 needed for certification)**
    - **A TIME OUT: confirm patient identity, procedure, location, and verify consent**
    - **A procedure note filed under the procedures folder on Powerchart. Critical components:**
        - **Indication for the procedure:** an actual diagnosis such as cardiogenic shock, respiratory failure, etc.
        - **Date of Service:** date of when the procedure is done.
        - **If an attending monitored you:** indicate that an attending was present for the entire portion of the procedure.
    - **Logging it in New Innovations so you get credit**
- An Internal Jugular line or Subclavian line always needs a CXR to verify placement
- Materials for common lines are found in the procedure cart. Other materials are found in the clean supply rooms

Characters of the ICU

- Dave Barounis: ED/CC. Values early, quick, efficient rounds. Rounds twice a day. Use EBM ICU patient care checklist. Prefers bedside teaching to lectures. Take advantage of his resuscitation experience

- Julia Espel: Pulm/CC. Take care to pay attention to airways and vent settings. Be very organized and know your patients
- Tabassum Hanif: Pulm/CC. Loves to pimp interns, and you'll never be right. Don't take it to heart! Just learn from her, she's a very good teacher
- Francis Jamilla: Pulm/CC. He is a very deliberate rounder, and it may seem he is not listening. He is! Keep presenting in an organized and focused manner, always remember the "housekeeping". It essentially the same stuff on the EBM ICU patient care checklist.
- Kathia Ortiz: Pulm/CC. She round on her own early, she already knows her plans. She wants to see that you know the patient and that you are coming with well thought out plans. Highly organized presentations please.
- Essam Mekhaiel: Pulm/CC/Interventional. Early rounds, round with the ultrasound. Also rounds twice a day, so don't leave before
- Samir Patel: IM/EM/CC. Early rounds, quick and efficient. Rounds in afternoon as well. Values procedure skills. Can be gruff, roll with it, don't take it to heart. Take advantage of his bedside teaching and resuscitation experience.
- Debjit Saha: Pulm/CC. Very evidenced based, fresh out of residency. Take advantage of his enthusiasm! Show eagerness to learn and he will provide a lot!

<u>Enjoy your time in the ICU and always ask your Senior Resident if you have questions or have concerns!!</u>

Time: ____________ Nurse: _____________ Room:___________Date:_______________

STICKER

Attending: _______________ Resident: _______________ Alcatel#____________________

RN UPDATE

Intubated: Y / N _______ SBT Y / N: _______ Sedation Vacation Performed: Y / N _______ Target RASS: _____________

Actual RASS: __________ CAM-ICU: Positive [ ] Negative [ ] N/A [ ]

Ventilator Issues: ____________________________ Suction Freq: _____________ MAP goal: _________________________

Gtts: ____________________ Trend: ____________________ I/O:__________________ Fluids/Blood: ___________________

Nursing Concerns: ____

EVIDENCE BASED ICU CHECKLIST

If the patient is on a ventilator:

Head of Bed > 30 degrees?	[ ] Y	[ ] N
Chlorhexidine oral care ordered?	[ ] Y	[ ] N

[ ] GI prophylaxis addressed
[ ] DVT prophylaxis addressed
[ ] Early Mobility addressed (PT/OT consulted on all patients)
[ ] Restraints addressed
[ ] Nutrition Addressed
[ ] Bowel regimen addressed with adequate output?
[ ] Skin care/pressure ulceration addressed?
[ ] Antibiotics/indications reviewed?
[ ] Informed Consent?

[ ] Unnecessary labs/imaging studies dc'd	[ ] Y	[ ] N
[ ] Can drains, catheters, or lines be removed	[ ] Y	[ ] N
[ ] Has the patient been in ICU >/= 5 days?	[ ] Y	[ ] N

[ ] If >/= 5 days, schedule a family meeting

Time out: _________________ ORDERS READ BACK BY RN/MD

24- hour goals: ____

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