**MICU Intern Survival Guide 2024-2025**

**Schedule:**

* There are three daytime call teams and one night float team:
  + Short call (x2): 630a – 3p
    - Admits from 630a until noon
    - Goes to RRT and code blue until 3p
  + Long call 7a- 8p
    - Admits from noon until 7p
    - Goes to RRT and code blue until 8p
  + Night float 8p – after rounds
    - The expectation is you are present for rounds for your teaching opportunity (per ACGME policy)
    - You **must** ask either the attending or the fellow before leaving before rounds
* Your days off are when you are “short call” on the weekend
* You are expected to show up for **every shift** regardless of census unless specified by the fellow or attending

**Pre-Rounds:**

* **Arrive at the latest at 630 am, but if you have complicated patients and need more time come earlier**
* Sign out starts at 0630, do not be late that’s not fair to the long call team
* **You are expected to know everything about your patients:**
  + There is a lot of data in the ICU. Organization is key
    - Some people write on stacks of note cards, some use rounding sheets. Find the system that works for you
    - DO NOT PRINT OUT OLD NOTES THEY CONTAIN OLD INFORMATION
* Overnight Events (Senior sign out and ask the nurse)
* Vitals, Intakes & Outputs, Ventilator Settings with ABG
  + ABG format: pH/CO2/O2/HCO3 + lactate
  + Ventilator settings format: Mode/Tidal Volume/ FiO2/Set Respiratory Rate/ PEEP
  + Other values to record are the true respiratory rate (is patient over breathing a set rate) and Minute Ventilation (MVe = TVxRR)
* Hemodynamics if has pulmonary artery catheter. Some intensivists follow CVP if patient has central line.
* ALL Medications/ antibiotics / Drips and dosing (or trend)
  + - Sedation
    - Vasopressors/Inotropes
    - Antiarrhythmics
* Pertinent Exam Findings
* Labs / Imaging / Microbiology Data
* 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
    - Within each system you should have a problem/diagnosis organized by the most pertinent/active problem first
      * Neuro
        + Most acute issue
        + Sedation/RASS goal
        + Pain
* Cardiovascular
  + Shock (Distributive, Hypovolemic/Hemorrhagic etc.)
  + Vasopressors OR antihypertensives
  + Anything on tele?
* Respiratory
  + Intubated /ventilated?
  + O2 delivery system
  + Look at chest imaging
* GI
* Bowel regimen
* GI Prophylaxis
* ID
* Culture results
* Antibiotic day/ duration
* Imaging
* Endo
* Glycemic control
* Heme
* H&H trend
* DVT PPx
* FASTHUGS BIDD also known as the ICU Checklist
  + Feeding/fluids
  + Analgesia
  + Sedation
* RASS goals
  + Thromboembolism PPX
  + Head of bed
  + Ulcer PPX
  + Glycemic control
  + Spontaneous breathing trial
  + Bowel regimen
  + Indwelling catheters
  + Disposition
* PT/OT speech
* Downgrade?
  + De-escalation of Antibiotics
* Know antibiotic day/duration
* Look at cultures/sensitivity
* CODE STATUS
  + EVERYONE MUST HAVE A CODE STATUS
  + Your senior will help with these discussions
* Decision Making Capacity
  + Can they make their own decisions are not
  + If patients cannot make their own decision, they HAVE TO have a POA or surrogate
* Discuss your patients with your seniors before rounds. They will help guide you and create the assessment and plan with you

**Rounds:**

* Rounds start at 0800 daily
* **Discuss your patients BEFORE ROUNDS**
* Start with a formal presentation, unless the attending indicates otherwise
  + When the patient’s **new**:
    - Name, gender, age
    - Relevant HPI, plus events prior to coming to ICU
    - Relevant allergies
    - Physical exam
    - Labs and Imaging
    - Assessment and plan (below)
* When the patient’s a **follow up**:
  + SOAP format
  + 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 FASTHUGS
    - We will be implementing an evidence based, ICU patient care checklist. Familiarize yourself with the information you will need to collect, however your senior or the patient’s nurse will be going through the checklist every day.
* Following a structure will help make all of this second nature
* Communication
  + Patient’s nurse must be present during rounds
  + 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.
    - Any major changes to the plan or imaging
    - Urgent/STAT orders MUST be communicated verbally

**Post Rounds**

* Run the list with your senior
* Place any outstanding orders as soon as possible
* Communicate with consultants/ new consults

**Orders**

* To increase efficiency, your senior be putting orders in during rounds
* During rounds you should be diligently writing down the plan. After rounds you can help verify that all the proper orders have been 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 if critically ill. If patient is stable we can order less, refer to your senior
  + Daily chest X-rays if:
    - Swan/PA catheter, balloon pump, transvenous pacer wires
    - Patient is intubated (ATTENDING DEPENDENT, ASK)
  + ABG if ventilated (tube or BiPAP) and critically ill
* Nurses may ask for miscellaneous routine labs and imaging (i.e. abdominal x ray after NG tube placement). Please ask your seniors to teach you how to place these orders. Learning how to place them correctly is a huge help to your seniors and the team.

**Communication**

* Towards the beginning, your seniors will likely be placing pages/calls to the consultants
* As you learn to have a good grasp on your patients and the course of management, you will start to become the ones to make these pages/call
* Every consultation should have **specific questions** for the consultants
* Communication is key. Coordinate with your seniors**. You should share with each other and the intensivist the recommendations of the consultant**

THERE NEEDS TO BE A RESIDENT PHYSICALLY IN THE ICU AT ALL TIMES WHILE A FELLOW IS IN HOUSE

* + These are your patients, you should be the ones speaking with consultants, and bedside nurses for the minute-to-minute changes
  + If your patient decompensated you should be the FIRST to know and intervene NOT the last to know the plan

**Notes**

* This is a duty of the interns but the last on your to-do list
* New admissions need a full H&P
* Follow ups need a SOAP note
* Your seniors will review the notes with you, especially at the beginning of the year

**Admissions/ Admission Notes:**

* Your senior should have an idea if new patients are coming from the ED, the floors, or transfers from outside hospital when they get assigned a bed. Check in with them or charge nurse periodically to see if you are expecting a patient.
* 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 10–15-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/outside hospital for more information.
* Staff the plan with the senior and attending, and write the H&P.

**Consultants and PCPs:**

* This is a “Closed Unit”
* The intensivist is the primary physician while the patient is in the unit and decides the management, orders, consults, and when the patient is to be transferred
* If you notice orders placed on your patients from outside the team please say something
* All recommendations by consultants are just recommendations- they need to be run by the fellow and intensivist before becoming an order

**Codes:**

* Before 12 the short senior and intern go. After 12 the long senior and intern.
* The ICU cannot be empty when there is a code, someone needs to watch our current patients

**Procedures:**

* **All Procedures require Consent (ask your senior and nurse to help you), a TIME OUT and Procedure Note**
* Consent forms are online on CPRS under the “Tools” tab 🡪 iMedConsent
* Arterial/Central Lines:
  + ASK to DO YOUR OWN LINES SO YOU CAN LEARN AND BECOME CERTIFIED
  + Not every procedure is good for teaching. Do not be discouraged if your fellow decides to do a procedure, observe and learn.
  + You need 5 of each procedure in order to become certified
    - Central lines in the left and right IJ will count towards your 5 IJ’s
    - Central lines placed in other locations (i.e femoral vein or subclavian) require 5 separate placements before you can become certified (you have to do 5 femoral central lines before you have conditional independence)
  + Equipment can be found in the procedure cart or supply rooms and Find ICU U/S machine
  + Watch and assist your fellow/senior through one first, then your fellow/senior will assist you through future lines
  + Check CXR after placement of internal jugular or subclavian lines
  + ALWAYS TALK TO THE FELLOW BEFORE PLACING CENTRAL LINES

**\*\*If you have any immediate concerns about your patient (hypotensive, hypoxic, labored breathing, tachy/brady, looks worse) do not hesitate to go to your fellow\*\***

Enjoy your time in the ICU and always ask your Senior Resident or Fellow if you have questions or have concerns!!