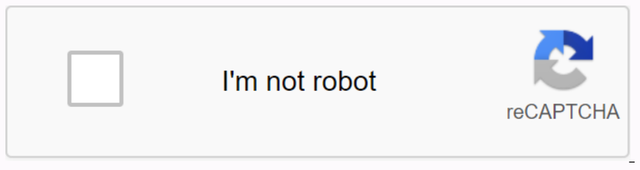

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Micu survival guide for residents

July is just around the corner. For hospitals, it's a dynamic time. Changing the guard. Graduating residents move on and new trainees who have just run out of medical school with their clean and sharp long white coats are moving in. Out with the old one, in with the new one. The ICU cycle for medical residents and medical students is stressful in the best of circumstances, but always an additional challenge in early July. As a resident, I remember trying to pick up from peers who had already completed their tipping cycles by choosing their brain tips and tricks on how to survive and thrive. But often what we are looking for is not what we need most. Acid base disorders and ventilators seemed so frightening. But in hindsight, it was not a difficult part to learn how to manage and treat certain diseases and conditions. Learning to survive mentally and physically, ICU ducks and growing up as a doctor were much bigger challenges. Start your day early. This is easy to do for your first week at the ICU when you're full of nervous energy. But what about #22 when you're desperate for an extra five minutes of sleep in the morning? Unfortunately, a 10-minute delay at 5 a.m. means an extra hour at the end of the day. At 5:00, you have unfettered access to patients and computers. You have time to talk to the nurses at night and listen to their impressions and worries. Take the time to think about patients before the rounds, rather than just accepting the role of the praised data collection tools. Escape emr. Nowadays, it's easy to bury our faces and get lost in electronic medical records. We present on tours looking at the screen, stating laboratories and data. But that's all it is. I'll say and read. Does not process and synthesize. EMR can be an excellent knowledge base. But it's terrible to make it easier to think independently about your complex patients. Learn how to introduce your patient while looking into your team's eyes. Just don't do anything. Just stand there. This was one of the most useful sentences I learned during my residency. There's often so much pressure to do something. Hakurisi constantly alerts nurses and therapists with requests to do something to reduce urine output or drop oxygen saturation or increasing heart rate. You're tempted to respond with action. Order an X-ray. Push iv-beta. But don't replace reflexive action with thoughtful reflection. Take the time to process and integrate new data. Go check on your patient again. And then... Make decisions. Make a considered decision as best you can and take decisive action. What do you really think's going on? What do you want to do? Do you think new infiltration into X-rays is swelling or pneumonia? Whether the patient's blood pressure is low for sepsis or Make a hypothesis and test it. I think he has low urine output because he's hypovolesmic. That's why I give three liters of saline in 30 minutes and reassess his blood pressure and urine output. After half an hour, either you know: A) The urine outlet is better and the hypothesis was correct. B) He is now worse and in pulmonary oedema and your hypothesis is wrong. C) There has been no change in the patient and you need more information or help or both. The more decisions you make, the more confidence you gain in your evolving clinical judgment. Whether it's right or wrong, you'll learn and grow as a doctor. Just make sure you're thoughtfully wrong. Don't give good news to the families. This is a tough one. You're working hard. A critically ill patient or blue code is transferred to the ICU. Put a breathing tube. You set up venous and arterial lines. You're upsetting the heart back to normal rhythm. You have blood pressure now. Your patient is now pink instead of blue. In the last hour, you and your team have not left this small room, doing everything you can to prevent this patient from dying. And now you go and tell the family that blood pressure is stable with new intra-vein drugs, his breathing is better with a tube and machine, and he rests calmly soothing. We know what we mean. The patient no longer deteriorates rapidly in relation to the äss. But terrified and distressed families hear stable and better and resting. These words are best reserved for patients moving away from the rescue home. Families need to know that their loved one is still critically ill. Life tests. They're the sickest sick. They could die. We must bear in mind our own human nature. The desire to convey the positive. We want our patients and their families to trust us. We want them to know that we work hard and think about the patient all the time. However, we must be careful not to give false hope or to feed overly optimistic expectations. Participate in all end-of-life discussions and the goals of care conferences. Don't miss these. They're easy to miss. I know you have notes to write and scut to do and put to sleep. But you have to get involved in as many as you can. As a medical student or first-year resident, you don't lead them. But one day you will. Watch. Not only a caring or older resident, but also families. How are they doing and how are they doing? Listen to the way things are said. It can be clumsy and awkward, natural and comfortable or something in between. Listen. Watch. Observe. Remember what works. Steal it, adopt it, shape it into your own words. Get rid of what doesn't. It's never going to be easy, but it's going to get easier. Self-care. No chocolate bar. Meal. Something that contains protein as well as ordinary and fat. Make some time. In the ICU, everything affects Start learning what can and can't wait. Drink liquids, keep hydrated. Pee, a lot. The urine output should not be lower than the patient's. Sleep. Get some sunlight when you can. Contact us, although briefly, to the outside world via audio, not text. Stay in touch. Identify the winnings. Learn how to retrain your brain. As doctors, we tend to focus and think about what went wrong. Challenging families. Frustration from missing labs. The hours that lasted across the line. Complications of our interventions. Poor results. Deaths. This is where our brains go when we are the most tired and beaten after an exhausting and unstoppable 24 hours. But in doing so, we will lose the celebration of our victories. We successfully herd so many patients through the treacherous and complex world of critical disease. We'll browse them through the rescue home. However, we do not appreciate our role in this as a victory and instead see it as a basic expectation. We have to learn that nothing is given about the patient's course. If we blame ourselves for evil, we must take credit for the good. On a long tired journey home, we must open our eyes and celebrate the numerous victories and successes to which we have become immune. Check yourself. Check on your colleagues. Everyone's nervous at the rescue home. Even your involvement. I'm so tell you. Many projected the façade of self-confidence. But behind that mask are often fears, anxiety, self-doubt and deep sadness. Take the time to check your own mental reserve. Share your thoughts. Those around you probably have the same feeling. If you have a problem, talk to someone. Senior resident. Your participation. Your program director. Your family. Someone. But don't keep quiet and run alone. Share your journey. Don't think of it as yourself. Write about it, write it. Deal with other residents. Share your excitement and winnings with your spouse or partner or family. They may not always understand exactly what you're going through, but they'll help make them part of your journey. Then read your words again. Listen to your nervous voice and recognize how you've grown. Let your family point out that you no longer comment on sleepless nights and annoying EMR, but now make important decisions in the middle of the night. Often we can see real growth in ourselves through the eyes of others. There are no mistakes. The events we bring to ourselves, however unpleasant, are necessary in order to learn what we need to learn. Whatever steps we take, they are necessary to get us to the places we have decided to go. Richard Bach Housestaff's rough guide MICU Updated 7/19/2019- by MICU Participates in MICU due to the complexity of patients you have an incredible amount of information about each patient, and it can be challenging to organize and present all this information in a way is easy to follow for everyone on tours. Here's our proposal to help. PRESENT WITH THE ORGAN SYSTEM - By this we mean that we reject the typical SOAP note format for presentations. Hemodynamic data are lumped together with cv and volume assessment; lung data with ventilation settings and blood gas results; neurological data with wake-up assessment, etc. For a typical follow-up patient in rounds, this means reporting significant events to the patient overnight (if any) and then initiating the assessment as described below. Except in rare cases, the systems of the first treated should be hemodynamics, lungs or neuros. Below are both the structure format and the example overtellings. Hemodynamics and doses have remained X/ Y in the following vasoactive medicines and doses. He appears to be (wet/dry/euvoleminen) based on X's CVP (with or without respiratory variability). Line A (no/does not) show respiratory variability. The pulse pressure variation is X. Central(SVO2) is X. UOP is preserved (good vs oliguric) and the patient feels (warm good cap filling vs cold with wire pulse). Tips: ok to provide vital functions either as a representative sample or as a range, but if you give variability, indicate blood pressure X/ Y - A / B - not systolic range and diastolic range – so that we can hear the pulse pressure. Assessment of heart function, myocardicular ischemistry, dysrhythmia, etc. Blood pressure Vasoactive doses And doses Volume status (data – CVP, SVO2, I/Os, UOP, PPV) Heart rate/rhythm Ischemia or heart function Lung: Pt remains intubated in the following ventilation settings: XXXX. According to our policy, we report the ventilation settings as (AC vs PC vs PS) / Syke / Tidal volume / PEEP / FiO2 - and with these settings ABG is (indicate pH /CO2/paO2/sat - ok round up to the nearest integer). The oxidized number of patients (healing vs. worsening) and CXR are (better vs. worse). We plan SBT today, but we are concerned that pt (oxidation/ventilation/neuro mode/airways) may prevent exhalation. The patient's acid base status is .... and the respiratory alkalosis we observe may be explained ..... Ventilation or oxygen status and effort ABG CXR plan for SBT/extubation Neurology: Pt remains sedated on a ventilator. I woke up yesterday, when the sedation was being held, following all orders. Still requires sedation because... For the coma patient we are trying to predict, the 3 most useful parameters are papillary response, dummy eyes (oculocephal reflex) and corneal reflex. Exam Sedation Radiographic Studies ID: Pt is febrile with rising WBC despite antibiotics (X, Y and Z). We believe the source of infection is .... Because.... Temp, WBC, Culture data Antibiotics Source of Infection Heme/Onc: Hb From X to Z with 400cc ground coffee from OGT. Design EGD today. He needed X-units of PRBC, Y platelets and Z FFP overnight this essential information has not already been addressed in haemodynamitics. UOP, creatinine trends are likely to be part of the hemodynamic data. The patient tolerated intermite dialysis yesterday and needs more volume off today. RESOURCES Listen to the nurses – they are very experienced and have very important information to share. If they call you, it's because they really need you to evaluate the patient. Use your pharmacist – An excellent resource for information, etc. This will get better if you ask when you don't fully understand something. If you're ever in a situation where you're writing an order without knowing why you're doing so, ask your residents, colleagues, attending or apn. DAILY GRINDING During pre-rounding – Come in at 6:00 a.m. Take a look at the orders written overnight and ask your cross cover why they made the change. What made them switch ventilation/start cleaners/extubate etc. It is assumed that you have seen all your patients and checked their data before the morning rounds. Check-out and cross cover are critical – MICU is a round-the-clock effort. Therefore, our mentality is that every MICU patient is a community patient. Sign-out and touring tours are ways you can pass on your plans and anticipated issues to the cross-sectional team. High-quality check-out and presentations are the only way to provide quality 24/7 critical care. Everyone should know every MICU patient for the mail call team APN/ED dayfloat is named as a helper, especially for procedures, roadtrips, etc. Call consult early - you know your patient's best Complete nighttime activities EARLYà, which means GET CONSENT and OPTIMIZE COAGS for procedures early Maintain active type and displays and put blood consent on the chart for patients who need blood products There are family contact information and possible treatment limits (code status) when lying out of an X-cover patient going out to the ward should be given appropriate service (GENS, HONC, etc.) ASK if the X-cover spoke to the ward team about your patients who went on overnight transfers away from MICU: All orders must have complete team information (attg ,res/intern/pager) although the ward teams are full and MICU covers overnight Be sure to perform order reconciliation before transfer EXPLICITLY DISCUSS which residents assumed they were treating your patients on ward Buff family qD! So much can happen in MICU day and ICU patients are relatively more likely to experience major condition changes than floor patients. You will find that the family is more prepared for adverse events/need for procedures/changes in status if you keep them up to date at all times. To do this, the family must identify the only person who: point person and you can update him or her, then he will update the family. Be sure to also ask for a CODE (last 4 SS #) before providing information by phone or in person. Keep your workspaces clean – We share these spaces, which are almost continuously available 24/7. Be aware of your belongings. Hang up your coats. Store the bags in cabinets/ on top of cabinets. Restore medical records. DO NOT bring supplies into the study. The unlocked needle violates the requirements of the Illinois Department of Public Health. CONFERENCES at 07:00 – Multidisciplinary rounds Bedside patient care rounds are carried out outside the patient's room. If you don't see the patient's RN taking part in the rounds, let them know that the rounds are taking place. The resident introduces the patient within 7 minutes. All team members are expected to listen and learn from these presentations. RN introduces FASTHUGS. Pharmacy needs will be met. 9:00 a.m. - Lung morning report If your attendees and friends go to the lung morning report, then you should. This is not an opportunity to break laps to get other work done. 15:00 – Afternoon lecture A large series of lectures. You have to participate every day unless the patient is actively falling over. By the end of the month, you should understand 4 types of respiratory failure, mechanisms of hypoxyemia, shock types, knowledge of vasoactive diseases, forms of mechanical ventilation and the multidisciplinary daily routine process of sepsis MICU Participants Targets 7:00 AM to 7:30AM Nursing report Night and day shift RNS Patient donation. From 07:00 to 09:00 Multidisciplinary tours participate, fellows, residents, APNs, RNs, Pharmacist Patient presentation. Draw up a multidisciplinary management plan for the day. Training. 9:00 a.m. to 9:30 a.m. Training. 10:00 – 10:15 After-rounds Multidisciplinic Huddle Charge RN, Fellows, PT, OT, SW, CM, Dietician Short Outline of Daily Patient Goals. Address the geography of MICU service patients. Let us respond to the needs and obstacles of social work. Identify patients who are ready for PT/OT and nutrition. 14:00 – 15:00 Afternoon readings, friends, residents, APNs, RNs, Pharmaceutical training from 15:00 to 15:30 Afternoon tours Participating, Fellows, On-Call Resident, Bridge Resident (or Short Call Resident on Bridge Day off), APNs, Charge RN Present patient for the occupant of the snout. Process the progress of daily patient goals. Charge RN to identify patient through and staffing issues. 15:00 – 15:05 Measuring daily improvement Huddle Charge RN, RNs Quality improvement From ~ 17:00 Resident Log out Residents Patient donation 19.00 – 19.30 Nursing Report Night and day shift RNS Patient donation 19:30 Long call Resident registers when accepting a pager for Night Float residents The Long Call resident can focus on getting the trainee out by 9:30pm Bridge resident to sign Cross-Cover NF Intern and Long Call resident updates on what has been done and need to do active care for cross-cover patients MICU Procedure Guidance Expectations Start planning and preparation procedures immediately after the rounds. The aim is to carry out the procedures before lunch/lectures. Get consent. Collect the accessories before the procedure begins. Return all excess supplies to the service room (not the study!) Report the procedure to the RN. Run the Procedure timeout as a group. Ask RN to complete the time batch documentation. Ask the RN to place the induction supplies on the arterial lines. Perform the procedure by participating in the +/- fellow. Pearls Order lidococin 1% injection (without epinephrine) 20ml bottle Use order kits to order diagnostics XYZ: IP Lumbar Punctions(#1947) XYZ: IP Thoracentesis/Paracentesis (#1101) Make sure the samples are marked. Ask RN to release the system's labs. Deliver the samples to Mitchell's laboratory The process should collect and dispose of all blades. Clean up all the supplies and debris. Order and monitor CXR after central line placement and thoracentesis. Positioning the centerline of a document Click the Procedure tab to the left. Document under CL Insert Part 1. Ask the RN to complete the observer's documents. Set ok to use the order after CXR scanning NEJM procedural resources VASCULAR ACCESS Consult center line/PICC placement. Centreline: Standard line used for long-term (>5 days) medication for non-vesikants medicines. Considered a short PICC that does not cross the midline. No CXR is required to confirm the placement. Ordered under the name PICC in Epic. PICC: The catheter tip ends with a distal third of the superior vena cava. For chemotherapy, TPN and vasoactive drugs. CXR must confirm the location. RN requires an ok use order. Network Cleansing: Get approval from nephrology before the GFR Consultation Procedure Service <45. Tip: Order as few lumens as possible to minimize the risk of infection and in-snow clotting. Troubleshooting: Bleeding: Press manual pressure at the installation site for at least 5 minutes. Do not use external pressure sauce or leave next to the bed until hemostasis is reached. Slow/No Blood Return: Order alteplase 2mg for each non-functioning bone. Let the drugs live for up to 2 hours. If no blood is returned, repeat the second 2 mg dose and outfit for x2 hours. Leaking: Tell Doppler to rule out the clot. ACCESSORIES Center line Chux Sterile gloves Additional protectors (masks, gloves, bouffants, suits) additional for proceduralists Center line accessory pack Center line 2inch 16g angiocath Scalpel (not included snow cooker sheets) Lye pisto Sterile gloves Mask 1 Chux Betadine Gauze pack LP kit Specimen bag Consider ordering an extra lidocane Arterial line sterile sterile Mask Chux Chlorhexidine OR sterile towel pack Gauze pack Arterial line arrow Tegaderm Thoracentesis Lidokain: Order epically. Ask RN to leave your original before the procedure Sterile gloves Mask Skin marking pen 1 Chux Chlorhexidine Thoracentesis kit 60 cc syringe 19g needle or pink vacutainer liquid for transfer to diagnostic samples ABG syringe Anaerobic culture flask Aerobic culture flask Lavender top tube Gold top tube Sterile sample cup Sample bag Paracentesis Lidocaine: Order epically. Ask RN to leave your original pre-procedure Sterile gloves Mask Skin marking pen 2 Chux: 1 patient's lap, 1 floor chlorhexidin OR towel pack 14 g angiocat 10 ml syringe 5ml syringe 19g needle 25g needle 19g needle or pink vacutainer liquid transfer diagnostic samples 60cc syringe Suction tube Orange tanks Gauze pack Tegaderm Anaerobic culture bottle Aerobic culture bottle Lavender top tube Gold top tube Sterile sample cup Sample bag Gold top tube Sterile sample cup Sample bag MICU MULTIDISCIPLINARY TEAM Advanced Practice Nurses (APNs) Contact: Stefanie Blummer, #4039 Kelly Coudron. #9823 Megan Mattingly, #6011 Role: Assist in the post-call team. Rotate through the procedure service. Enter procedural control procedures. Provide lung consultations for CCU patients on mechanical ventilation. Tips: Get back-up to the goals of treatment meetings. Use ICU order kits. Case Management Contact: Jessica Torres,# 6683; Melanie Boyd, #6692 Consult: Help with home health, home appliances, medication authorization treatment night nurse Tips: Do not adjust IV pumps and/or ventilators without a nurse in the room. If you give a STAT order, talk to the RN next to the bed. Restraining orders shall be entered on the EPIC form within one hour of the submission of the application and every 24 hours. DON'T LET THE RESTRICTIONS EXPIRE!! Check/new rounds. When the drugs are OG / NG, type EPIC Per Tube . Try to group the labs together. If the labs have just been shipped, place an order for more. Charge nurse, x61504 Nursing management Marisol Arellano, #6309 Amber Turi, #5825 (nights) Nutrition contact: Christine Boesdorfer,# 6185, x22450. On weekends, use call-in searcher 8406 from 9 am to 6 pm Consultant: Epic is recommended. Also available orally, sideways and during MICU Multidisciplinic huddle Role: Evaluate patients (laboratory data, medical/surgical history, physical research focusing on nutrition, anthropometric data, dietary history, medical treatment plan), diagnose malnutrition (if necessary) and make recommendations: feeding tubes to patients with enteral tubes (OG, NG, DHT, PEG/PEJ), standard peripheral or standard medium parenteral nutrition (PPN/ TPN), nutritional oral supplements, diet to be taken through, supplementing vitamins/minerals, nutritional medicinal products (intestinal medicines, appetite stimulants), etc., monitor progress towards goals and reassess Appropriate. Tips: I don't follow transplant surgery

service patients or GI nutrition patients. ASPEN/SCCM guidelines for feeding critically ill patients are: 1. Early entero-feeding (within the first 24-48 hours) reduces infectious morbidity, mortality and duration of stay. 2. We do not routinely check the residual amounts of the stomach as they are poorly correlated with aspiration events. 3. Serum protein markers (albumin, transferrin, prealbumin, retinol binding protein) ARE NOT a good description of the nutritional status of critically ill patients. 4. DO NOT change the tube feeding formula without talking to a nutritionist (changing the formula can increase/reduce calories/protein or certain vitamins/minerals, significantly). Occupational therapy contact person: Brittanie Blaber #1962 Consult: Make sure you make two consultation orders (one for evaluation and one for treatment). Role: Assists in early mobilisation with PT, as well as assess/treat cognitive impairments; prolonged periods of immobility lead to an increase in delirium and bone muscle breakdown, leading to weakness in the intensive care unit. Occupational therapists also make the production of the child in order to prevent joint immobility. Tips: Talk to CAM ICU sooner rather than later. Occupational therapy can help family members understand delirium and provide interventions to prevent this in the ICU. Pharmacy physiotherapy contact: Jen Ryan, #6089 Role: Facilitate early mobility for all hemodynamically stable patients, regardless of their level of alertness. Consult: When consulting pt and OT, place two consultation orders (one for evaluation and one for treatment). Tips: Contact us as soon as possible and consider MICU admission. Pt also provides wound care, especially negative pressure therapy and debridement. Respiratory contact: 9N RT x 61889, 9S RT x61898 Tips: Make sure all your intubated patients have a Mechanical Ventilation subscription that includes ventilation settings. Notify RT of any changes to the vent. Social work contact person: Lauren Hall, social worker for all MICU services EXCEPT patients receiving robust transplants - MICU SW virtual search engine: #1009 Consult: Epic consultations, page, discussion, interdisciplinological daily rounds with fellow human beings Role: Investing (LTACH, rehabilitation, hospice, etc.), Health care credentials, psychosocial pt/family needs, participation in family meetings and objectives of care discussions, assisting PT/families with financial needs such as UCM financial support/SSDI/etc., substance abuse treatment resources, identification of unidentified PT's and/or location of families, and varying selection of other interesting (I may not know the answer, but I'm happy to work as a team to figure it out!). Tips: Don't ask me (I don't scream, just direct ☺) home health care or home appliances needs (CM), making follow-up visits (MD), hotel (patient experience), diabetes supplies (CM and diabetes educator) trainer)