MICU ORIENTATION JUNE 2017

Structure of the MICU:

-Three F wings (9F, 10F, 11F), 10C

- 10C – an ongoing project. Stable patients, some who may need mechanical ventilation. Chronic patients. Staffed by MICU attendings.
- Occasionally an F-wing patient transfers over to 10C
  - This is an internal transfer, so no need to call sign-out, but it is still important to make sure the orders are reviewed up
    Example: medications reconciled and outdated orders removed.

MICU Leadership:

- Medical Director – Phillip Lamberty, MD
  - 412-310-1160
- Associate Medical Director – Bryan McVerry, MD
- Rotation Director – Phillip Lamberty, MD
- MICU AI course Director—Phillip Lamberty, MD
- Unit Director – Shauna Campbell, RN
- Nurse Clinicians – Sue Svec, RN, Sue Marshall, RN, Paula Kramer, RN, Mary Louise Meyers, RN
- Clinical Resource Specialists – Michele Sebelia, RN, Dana Romah, RN, Renee Hernandez, RN
- Case Managers – Anita Lovell, RN, Val Tappe, RN

Schedule:

Day starts at 7am – work hour restrictions preclude early arrival for pre-rounding

-7-7:30am - Lecture

-7:30-~8:30am - Sign-out/teaching session

-8:30-9:30am – Pre-round on patients

Consideration: Resident and Intern should split patients up when both there to improve efficiency of pre-rounding.

- should be familiar with and involved with decision making for all patients on the floor despite primary documentation and order entry responsibility for half

-9:30-~12:00am– Bedside Work Rounds

- GO INTO THE ROOM TOGETHER—AT THE DOORWAY IS NOT THE BEDSIDE
- Evening signout occurs at 7:00PM

Rounding:

Bedside work rounds occur in the room at the bedside

Structure

- Fellow calls to order
  - two line summary
- Bedside RN presents current data and nursing needs

(see “MICU Nurse Lead Rounds” document)

- House Officer synthesizes data and presents plan for diagnostic evaluation and therapeutics

- Problem based
  - may be structured in systems as long as problem is identified
- Address detailed checklist in room
- Enter orders before leaving bedside
  i. House officer not presenting should be following discussion and entering orders on the fly
  ii. When house officer is solo, fellow may enter or team will wait before progressing to next patient
- Fellow summarize plan and add thoughts
- Attending contribution/teaching

- Order entry tricks/policies:
  i. Labs one day in advance – we don’t do daily labs x a week
  ii. Drips need rates and titration parameters (EXAMPLE SEDATION-RIKER SCORE)
  iii. Route of delivery must match patient’s access
     i. e.g po vs per tube
  iv. Sign verbal restraint orders (without question)
  v. Order drugs by the clock: q12 vs. BID
     i. avoids double dose and adverse events
  vi. Medication reconciliation is required within 48 hrs
     i. CRS will update list – please revisit after 48 hrs to reconcile

Where patients come from:

1. ED – should get sign-out from ED resident
2. Referral (REF-COM 412-647-7001)– the attending taking
   a. You may not hear about the patient because we often don't know where they will end up. YOU CAN CALL REF-COM AND HERE SOME NOTES FROM THE FACILITATOR.
3. Transfer from floor or other ICU – this is usually from a resource intensivist or the floor team. Generally, they will call.

Transfer out process:

1. Decide with team needed bed type (telemetry, step down, non-monitored)
2. Contact charge nurse (647-4122)
3. Order Transfer In house power plan (no attending yet)- unclick this, make vitals q 6hrs,
4. Clean up orders—MUST DO
   a. Remove outdated orders or orders not compatible with floor administration (EXAMPLE—IV SEDATION)
   b. Ensure med reconciliation completed
5. Order next day labs/orders IF NEEDED
6. When the patient is assigned a bed, call sign out, THEN CHANGE

ATTENDING-- we have 60 minutes (per hospital policy) to: ALL OTHER DUTIES GET SUSPENDED FOR THIS

Deaths:

- Ask for autopsy in every patient (required as a training program)
- Notify organ procurement (CORE)
    - PA state law
    - Note: legally cannot ask about organ donation
- Call coroner
    - every death so we don't forget
    - report adverse event
- Complete the death pronouncement at the time of pronouncement
    - pronouncer should complete
- Death summary
    - can go to house officer taking care of patient