Parkland MICU Rotation Guide

A. Team structure/schedule:

1. **Superteams:** The MICU consists of two Superteams (MICU I / III and MICU II / IV). The MICU I / III Superteam, for example, consists of the following:
   - 1 attending
   - 2 residents (e.g. MICU I resident / MICU III resident)
   - 3 interns (shared between MICU I / MICU III)
   - 1 float resident (IM or ED)
   - 1 night resident (shared by the two Superteams)
   - 1 night intern (shared by the two Superteams)

2. **Days off**
   - Interns: Take every 6th day off (day before "Call A").
   - Upper levels: Days off are not scheduled in Amion and are taken at the discretion of the resident. Each resident should have 4 days off averaged over the 4 weeks, with the transitions to nights and back to days each counted as a day off as long as there is a 24-hour break between shifts. Residents need to coordinate days off with the float residents. *Every effort should be made to avoid taking the same day off as the ED float (having 2 residents present all day on each mega-team is the main function of the float).*

3. **Arrival/departure times:**
   - Day interns:
     - Call days: Arrive no earlier than 5:00am (can arrive later if census is low, latest by 7am), admit until 5:00pm, sign out to night resident and depart around 7:00pm (latest 9pm!)
     - Non-call days: Arrive no earlier than 5:00am (can arrive later if census is low, latest by 7am), sign out to night resident and depart by 7:00pm.
   - MICU I-IV residents:
     - Call days: Arrive no earlier than 7:00am
     - Post call: Depart no later than 11:00am.
     - Other days: Arrive no earlier than 5:00am, depart by 7:00pm.
   - Night intern: Arrives at 8:30pm, departs by 10:30am (or whenever he/she has finished presenting overnight admissions). On their last night, must leave by 5:30am to have 24 hours off before returning to day shift.
   - Night resident: Arrives at 6:30pm and leaves at 7am, but may stay later for safe handoff particularly if major cross-cover issues occurred overnight or patients still require stabilization/ active management while the day teams arrive in the morning).

4. **Sample call cycle (for MICU I):**
   Day 1:
   - MICU I resident takes 28 hour call. Arrives no earlier than 7am. Admits new patients 7am-5am the following day.
   - All three interns on the super team are present today. Two of the three interns are taking admissions.
     - On call interns arrive no earlier than 5:00am and see their old patients. Admit 7am-5pm, departs no later than 9pm.
     - Non-call intern arrives no earlier than 5:00am, sees old patients. Assists call team in whatever ways are needed (procedures, etc.). Will be off the following day, so must provide signout to float resident with a "to do" list for the next day. Departs no later than 7:00pm.
   - From 5pm-8:30pm (when the night intern arrives), the on call resident admits without an intern. Once the night intern arrives, they admit together.
   - MICU III resident (the buddy resident) might be off this day.

Day 2:

- Interns arrive no earlier than 5:00am.
- MICU I resident and night intern present overnight admissions at 8am. The overnight patients are distributed to the 2 post call interns. (MICU I resident should be sure to let the interns know which overnight patients they'll be taking before that patient is presented.)
- MICU I resident rounds until 10:30am, departs no later than 11am.
- The intern who wasn't on call on day 1 is off. This intern has some patients on MICU I (resident will be leaving post call) and some on MICU III (resident present all day).
    - The float resident will cover the MICU I patients. (The intern should have provided the float with signout and a "to do" list on these patients the day before.)
    - The MICU III resident (the buddy resident) will cover their own patients.
- MICU III resident and the float resident assist w/ procedures and mop up.

Day 3:

- MICU I resident might have the day off today. All three interns should be in house and will come in earliest at 5:00am. They will cover all of the old patients on MICU I.
- MICU III resident is on call. Arrives at 7am and admits from 7am-5am the following day. Just like on day 1, two of the interns will be admitted w/ MICU III and covering their old patients. These interns will leave at 7pm. The other intern will have a regular day with their old patients and help out the on call interns, then leave by 7pm (or whenever his/her work is complete).

Day 4:

- MICU III resident presents overnight admissions and distributes patients to the two post call interns.
- The non-post call intern is off. The MICU I resident is present today and will cover this intern's old MICU I patients. The float resident will cover all of this intern's old MICU III patients. (Again, intern should give signout and "to do" list to float resident the prior evening.)
- MICU I and float residents help the post call interns w/ mop up and procedures.

B. Daily routine

1. **Treatment teams: <u>FIRST THING EVERY MORNING,</u>** assign a 1st call and a 2nd call provider to your patients & remove the off-going person.

2. **Daily notes:**
   - **General expectations:**
     - We have numerous consultants seeing our patients and your progress note is where they look for information. Notes should be completed before 8am rounds. **There are two exceptions to this rule:**
       1) **Note writing is a tool for thinking. When given appropriate attention, you will find that note writing helps you organize your thoughts. As such, they are extremely important to your development and to patient care, but you are not allowed to violate your duty hours to complete them by 8am.** Part of your training is learning to be efficient and effective. This is not tested on your boards, but it is an extremely important skill to learn. They need not be perfect. You can circle back after rounds and addend as needed.
       2) The post long call intern cannot arrive before 7am. This intern can submit notes after rounds.
     - Notes should be written using one of the MICU smart phrases (.newmicuhp, .newmicuprog, .newmicutransfer). These templates make very clear what information should be included in your daily note. Additionally, if everyone uses the same templates, it should become easier to cover for one another on days off, etc.
     - Do not autopopulate labs. Rather, review the data and make mention of pertinents. Keep a running list in your note of pending and resulted cultures, ID workup, and sendout labs. Everyday, review the chart to see if more of these have resulted.
     - Copy forward is great. However, keep notes up to date and clean of resolved issues that no longer are relevant to ongoing care. I understand that keeping some resolved issues on the list is helpful for transfer notes/discharge summaries, but everything else needs to be removed once no longer relevant.
   - **LAST STAND:** The final portion of your progress note should be structured as follows. Use the mnemonic "LAST STAND".

     e**L**evate the head of the bed to 30 degrees (VAP prevention)

     Analgesia: Do we have adequate pain control regimen? Can it be simplified? Is it appropriate for pt?

     Sedation: Do we have adequate sedation? Excessive? Can we transition to prn? Are we doing a daily SAT (Spontaneous Awakening Trial) for patients on the vent?

     Tissue/skin integrity: Make sure that we do full skin assessment on admission to document skin issues that were "Present On Admission" aka POA. What are we doing to reduce new injuries? Do not write "do not turn" order without discussing with faculty first. We can usually do mini-turns as opposed to no turns at all. (This is usually an issue for our patients that have ARDS and desaturate with full body shifts.)

     Stress ulcer prophylaxis

     Thromboembolic prophylaxis : VTE prophylaxis type and why

     Antibiotics and **A**nti-inflammatory medications: Need to document thoroughly and daily with abx name, indication, number of days received, and total number of days planned). The anti-inflammatory (i.e. immunosuppressants, not

NSAIDs) portion should be handled similarly. Ex. prednisone, rituximab, cyclophosphamide, etc. State your plan for deescalating or stopping these meds here.

Nutrition and glycemic control: Is the patient being fed? At goal? If not, why and what are our plans for addressing it? Are we struggling with glycemic control → low threshold for using insulin gtt to clarify needs and achieve glycemic control quickly/reliably. The absence of a diabetes history does not mean scheduled CBGs are unnecessary. Our patients are critically ill and often require vigilance with respect to CBGs +/- insulin (septic patients and cirrhotics in particular). Unrecognized hypoglycemia can be neurologically devastating.

Devices and **D** ispo: List lines/drains/tubes and include number of days present as well as plans for removal. State whether or not the patient is to remain in the ICU, be transferred to floor, or be evaluated for transfer to alternate facility (LTAC, SNF, home, etc.). If being transferred out of ICU, document that you have discussed this with faculty.

*** Note: The components of LAST STAND are often unimportant for any one patient on any one day. However, when these items are not followed systematically and continuously, these items can suddenly become the patient's most important issue (line infection, UTI, GIB, fungal sepsis from an unnecessarily long abx course, etc)

3. **Morning rounds:**

- **Post call presentations, "Table Rounds":** Everyone should attend. The post call resident and night intern will present their overnight admissions at 8am. Be on time and sit at, not in the vicinity of, the main table. [Exception: The "buddy" resident should be logged into a computer to assist with looking up data and placing new orders.] Morning rounds are an active process. Expect to be called upon to answer questions about potential diagnoses, treatment plans, ABG interpretation, ECGs, CXRs, CTs (make sure you have looked at the CTs of your patients→ not just the formal read). Ask questions when you have them… questions are encouraged.

  Note: This is the primary time for teaching/learning. Do not use this time to type notes or work on other non-emergent tasks. If you are paged out of rounds for something emergent, you should leave to handle the situation and then return. If you are on call, at least one member of the team should be present for the post-call team's presentations. We are a team. Everyone will, at some point, cross cover on or help out with everyone else's patients. Learn about all ICU patients, not just those belonging to your side. This is better for patient care, and it will substantially augment your learning experience.

- **CXR rounds:** After post call presentations, we will read and interpret CXRs every day as a group. This is not a time to disappear and go get started on work. This is your opportunity to update the teams on your patient's events and then read the CXR. You should become much more proficient with CXR interpretation by the end of the month. Be sure someone follows up on the formal read for every imaging study ordered to make sure there is not a crucial finding in the interpretation (i.e. CNS blood, pneumothorax, ETT malposition).

4. **Bedside Rounds**

- **Presentations:** The success of daily rounds in the MICU depends upon clear and concise bedside presentations. In your presentations and in your notes, focus on the relevant facts. Adhere to the template below for your presentations. This essentially mimics the order of your daily progress note, but you should not merely read the entire note. For the interns, your ability to discern what is relevant will improve greatly during this rotation.

- **Overnight events:** You need to be able to state what has developed since the previous day. This should include important facts such as hypotensive episodes, fevers, HCT drops, changes in urine output, etc.
- **Current vital signs:** Know the ranges and the current numbers. **If the patient is on a pressor, please include that information (e.g. 88/50 on levo 10) .** Please include ins and outs here. **The ventilator settings are also considered part of the vital signs, followed by the blood gas.**
- **Brief summary of physical exam findings:** Pay particular attention to level of arousal (if on sedation, what is the RASS goal and what is their current RASS score), changes in breath sounds, worsening or improving peripheral edema, skin rashes, abdominal distention, and erythema at IV line insertion sites.
- **Pertinent labs:** You do not need to state every single lab study that has returned since the previous day. Which labs are being followed closely? → HCT in a GI bleeder, Cr in a patient with ARF, Na in a hypo/hypernatremia. Are there any surprising lab findings—values that suddenly changed (or normalized)? Finally, are there any new culture results that need to be discussed? Alternatively you might need to relay that the cultures remain negative at 48 hours, etc. Certain labs warrant mention daily: **Cr, Hct, WBC**, **HCO3, anion gap.**
- **Assessment/Plan: THIS IS THE MOST IMPORTANT PART OF YOUR NOTE AND YOUR PRESENTATION**. Consultants and other providers will rarely read any information beyond your A/P. This portion of the presentation needs to be direct and meaningful. Organize your assessment by problems and **not** by organ system. "Respiratory" is not a problem. "Pneumonia with respiratory failure" is a problem. For problems that don't have an answer → this is the section that should include you differential diagnosis (somewhat different from the initial H+P where it is customary that your problems be listed in order of severity and it is expected that the majority of the problems will be accompanied by a differential diagnosis). Remember that the differential diagnosis often evolves during the hospital stay and your daily note should reflect that. Further, the priority status also may change during the hospital stay (resolved septic shock is no longer the most important issue and should changed to "sepsis" and perhaps moved down the priority list as a new GI Bleed, ARF, MI may be more important). For your presentation, you should name the problem, its etiology, and current plan. If additional tests are part of the plan then say so.
- **Conclude your presentation by running through the components of LAST STAND.**
- **Other information to have available:** Medications, radiology results (make sure to follow up on formal reads), consultant recs (regardless if we are following them)

- **Orders:** While rounding at the bedside, the buddy resident should log into a computer to place orders. Many of the orders you might want to place can be found in the "MICU Rounding" order set. Restraints should be renewed at this time everyday.

5. **Sign out:** Every written signout should be reviewed by the primary or buddy resident. Every verbal signout should be supervised by the primary or buddy resident. What labs, studies, consults are you waiting for? Leave instructions for what to do if a lab or study returns with a particular finding. **Anticipate the problems and provide guidance before it happens.** Every sign out should include any patients on your list that can be transferred out of the ICU if there is a "bed crunch".

   In general, the day team should sign out directly to the night resident at 6:00pm. If you finish early, there is likely someone else on the MICU team who would need and appreciate your help. If there is truly no work left to do, take some time to teach, learn about a new procedure, pick your fellow's brain about a complicated patient, etc. If the service is very light and everyone is done with their work, you can leave early. **But remember this: We are a team. We will pitch in and tackle everyone else's "to do" lists with the same commitment with which we tackle our own lists. When the work is done, we will walk out as a team.**

C. Call days

1. Admission/team caps:

- **Definitions:**
  - "New Patient": A patient for whom you write the initial H+P and admit orders. Most commonly, patients coming from the ED.
  - "Transfer": A patient for whom you do not write the original H+P and admit orders. Most commonly, these are transfers from the wards. Also includes the patients handed-off by MICU night resident when the previous day's team exceeded its cap.
- **Caps:**
  - **Individual Caps:**
    - **Interns:** Most days, it is expected that interns will carry 4-6 patients. An intern should not be 1st call provider for more than 10 patients during the day. **Residents:** In general, no single MICU resident should have primary daytime responsibility for more than 10 patients.
  - **De-escalation on call and post call days:** Call days can be quite busy, and new admissions will need both your mental focus and your physical presence at the bedside. As such, the on call resident should de-escalate involvement in the management of most of their "old" patients during the day. Specifically, the resident should pick 3 old patients to see and actively manage. This decision should be made at the end of the resident's precall day and conveyed to the rest of the team. You are always free to chart check old patients or to discuss them with the rest of the team when time allows, but you will not be held responsible for knowing every detail or checking off all the boxes on the "to do" list for these particular patients on the call day. If one of these patients needs to be stabilized, needs a procedure, etc. on the call day, the intern will have ample assistance and supervision from the float, fellow, and attending. When the day interns sign out, the resident can assign themselves as first call provider for these patients and assist in their cross cover.
  - **Admission caps:** The on call resident should expect to admit up to 7 new patients. Anything after that should be admitted by the night resident. The night resident is expected to admit up to an additional 5 patients. Excess patients will be handed off to the other teams in the morning (primarily, the "buddy" team). Patients admitted after 5am are stabilized and handed off to the next day's call team.
  - **Team caps:** Each Superteam should be responsible for the care of no more than 20 patients. If this number is exceeded, it will trigger the redistribution of the stable/inactive patients to the other Superteam. (This will be determined in coordination with the ICU fellow and attending). Generally, the entire service carries 25-35 patients. Theoretically, we could go up to 40 between the 2 Superteams. As such, our MICU service as a whole (interns, residents, fellow, and faculty) should be able to manage the MICU patients properly and safely, maintain a great learning experience, and stay well within the ACGME guidelines. We need to increasingly think of ourselves as the MICU service rather than discrete MICU teams.
  - **Example:** MICU IV is precall. MICU IV currently has 9 patients. At signout this evening, the MICU IV resident will select 3 old patients to see and actively manage tomorrow. The other 6 patients will be seen by the 3 interns, who will manage the patients with assistance from the float resident. Supervision of the interns/float resident in the management of these 6 old patients will be provided by the fellow/faculty. The following day, the MICU IV resident admits 7 new patients. 3 more patients are then admitted by the night resident and intern. On the post-call day, the MICU IV resident sees the 7 patients they admitted the previous day and a few old patients. We will evaluate the service census and determine the need for redistribution during post call rounds.

2. **Closed unit:** The MICU is a closed unit. This means that only the MICU team (residents, MICU fellow, or MICU attending) can approve admission to the MICU from the ER or Gen Med services. **Transfers from non Gen-med services (CCU, Surgery/SICU/Burns, Ortho, Urology, etc.) must be evaluated by the Pulmonary Consult service for approval of transfer to MICU team.** For example, a patient on the SICU service that they would like to transfer to the MICU team requires pulmonary consult to evaluate and decide whether or not the patient needs to be transferred to MICU team (most often the patient does not need to be transferred to MICU team, but rather can be followed by pulmonary consult service while remaining on surgical team's service).

3. **What to do after you are called on a new patient:** You are expected to assess the patient and **make a triage decision.**

   - **Patients who do not require MICU:**
     - After you have made a decision and are ready to present the patient, contact the fellow/attending (during the day) or the attending (overnight). You are not calling to "run it by" them. **Be prepared to make a case for your decision.** Learning how to triage patients is one of the most important things you will do this month. The fellow/attending may disagree with you and decide that the patient needs the MICU, but you need to make your decision and be prepared to defend it.
     - Call the ED or hospitalist and relay your decision. Leave a brief note doing the same.
     - **Never refuse an admission from the ED or a transfer from a gen med service without first going over the case with the fellow or the attending.** Your note should make mention of the fellow or attending with whom you discussed the case. If there is ever a difference of opinion about a triage decision, this should be escalated to the fellow/faculty level.
   - **Patients who do require MICU:**
     - **Admission orders:** Use the "MICU Rounding" order set to place your admission orders. There is a section in the order set that will allow you to place recurring labs without changing each one individually.
     - **Staffing:** Once you have orders in and have organized your thoughts on how you would like to manage the patient, call and run your plan with the fellow and/or attending. Overnight admissions should be staffed with the overnight attending.
     - **Admission notes:** Use the smart phrase .newmicuhp to write your admission note. Your attending will addend your H&P. The ROS must be completed for ALL patients. If unable to obtain from the patient, ask a family member/care-giver. If not available, be certain to document the reason for not obtaining the ROS.
     - **ICU consent:** As a general rule, the majority of patients admitted to the MICU service should have an ICU consent obtained. The ICU consent covers most procedures you might need to do this month on one form and can be completed on paper or in iMed. While not every patient needs to be consented for thoracentesis, paracentesis, LP, etc., the majority should be consented for blood transfusion, central access, art line, and intubation. It is best to do this at the time of admission as it is more likely that there will be a family member available (as opposed to during an unanticipated decline in the middle of the night). If you have ever had to consent a patient on cross-cover after an unexpected decline, you know how difficult and time consuming it can be. Please be courteous to your colleagues.
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4. **Code team:**
   - **Roles and responsibilities:** The code team is massive. Everyone has defined roles. Know yours and expect the others to know theirs. The nurses know to get the patient on the monitor, on a backboard, IV access, etc. You need to focus on your job.
     1. **MICU resident:** Code team leader
        MICU faculty will attend all codes to provide supervision and redirection, but you are the

code team leader. Calmly and clearly announce to the code team members that you are running the code. You should stand at the foot of the bed. (We are using predetermined stations to help the rest of the rest of the code team recognize individuals.) Anesthesia will come to all codes to intubate. While waiting for their arrival, ask that the head of the bed be cleared and that suction be set up.

2. **CCU resident:** Assessment and access
   The CCU resident should be at the patient's bedside doing the assessment (pulses, breath sounds, crepitus, etc). That resident will also be responsible for line placement (or supervising an intern doing a line) if this is needed.
3. **MICU intern:** History
   Log into the computer in the corner of the patient's room and start looking the patient up. Be prepared to answer relevant questions (reason for hospitalization, recent interventions, most recent labs, etc.).
4. **CCU intern:** CPR / assisting with line placement
5. **RAT nurse 1:** Nurse leader / recorder
6. **RAT nurse 2:** Assist with crash cart & iSTAT labs
   All patients should get the following: 1) Glucose POC, 2) iSTAT BMP, 3) iSTAT Hct, and 4) blood gas (if they have a PICC or CVC, a central VBG is fine). The RAT nurses should be doing this automatically now, but it is a new addition to the code team, so there may not be 100% adherence initially. If it is not getting done, please ask that they run it.
7. **MICU nurse:** Administer drugs / IV access
8. **CPICU Nurse:** Runs crash cart
9. **RT Team leader:** Bag mask ventilation / supplemental O_2 / vent
10. **Anesthesia:** Anesthesia will come to all codes to intubate the patient if instructed by MICU resident/fellow/faculty.
11. **Nurse admin:** Crowd control and infection control (at door)
    We have asked that the nurse admin for the floor assist with crowd control (clearing the hallways and preventing unnecessary personnel from entering the room). DO NOT BE OFFENDED if you are asked about your relevance when trying to enter the room. Simply state your role on the code team. They are there to help keep things under control so that you can run a smoother code.
12. **Primary RN/PCA:** Runner for needed supplies (should be stationed outside the room)

- **Tips for running a successful code:** The goal is to use minimal verbal communication. There is absolutely no need for shouting and absolutely no need for extraneous chatter. Codes at Parkland should be very low stress. Often, our greatest challenge is too many people. Ideally, only the resident running the code is speaking, with the person performing a task repeating and confirming that the task is understood and complete. Codes are to be run like an operating room, not a plane crash. When not doing CPR or a line, or performing some other necessary function, please step out of the room. All communication should be direct, calm, and using minimal volume needed to get the message heard.
- **Codes on surgery patients**: When a surgery patient codes, surgical residents, fellows, or faculty will often respond and want to manage their patient. The decision to relinquish the running of the code to the surgery service will be at the discretion of the MICU faculty and surgery faculty. Even when we relinquish the running of the code to the surgery team, please offer your ongoing assistance.

D. Nights:

1. **Night intern:** There is always an intern overnight on the MICU service. The intern arrives at 8:30 PM and leaves by 10:30 AM. The overnight intern is expected to perform procedures, evaluate and manage new patients, and assist with cross-cover. Assist means that they will help out the resident as necessary but very rarely will they be first call providers.

2. **Night rounds:** The night intern and resident will alternate making face-to-face rounds on our patients, both in the SICU and in the MICU. Rounds should occur roughly every 2 hours starting at 8 PM. (This means the resident will make walk rounds 3 times over the course of the night and the intern will do the same. They will generally alternate.) When done properly, this has been extremely successful in terms of limiting low and intermediate priority pages. In addition, the nurses and house staff have found that it leads to an overall improvement in team functionality and satisfaction. These walk rounds should be quick.
   *** Finding individual nurses in the unit at New Parkland can sometimes be a challenge. The night rounds tend to go more smoothly if you use the Engage app to send out a group text to the MICU informing that that you will be rounding in X minutes. Anyone who needs you will know to keep an eye out for you. Anyone who doesn't will continue to go about their business but will know that you made the effort to come around. If your Engage app is not working, you can ask the charge nurse to send out the group text for you.

3. **When to call overnight faculty:**
   - When there is a new admission (after you have seen the patient and decided to admit).
   - When there is a new consult that you feel does not need MICU (after you have seen the patient and decided to send to the floor). As stated earlier, you are not calling the faculty to have them make a triage decision for you. You are calling to let them know about the patient and make the case for **your** triage decision. Again, the faculty may disagree with your decision and you may end up taking the patient. Never send a patient to the floor without first discussing with the overnight faculty.
   - When you want to do a procedure (lines, thora, para, LP, ETT, DCCV, intubation).
   - When someone is unexpectedly deteriorating.
   - When there is anything that you need help managing.

E. Transferring patients out of the ICU: Prior to transferring a patient out of the MICU and onto another service, notify the MICU fellow or faculty and clarify appropriateness. The intern or resident should call and give verbal sign out to the accepting service. Use the MICU transfer note template (.newmicutransfer) to write your transfer note. It should include a summary of the ICU course, overnight events, a physical exam for that day, an assessment/plan, and a list of pending issues. If the HOD refuses to take the patient, simply give the HOD the name and pager of the MICU faculty for that patient and they will resolve the issue.

F. MICU Boarder: This refers to patients that are on the MICU service and physically located in the MICU/SICU, but that no longer require ICU level care and are awaiting a ward bed. These patients may be transferred to ward teams, but ***ONLY*** when that half (team 1+3 or 2+4) is at 15 or more patients. If your side is at less than 15 patients, these patients are to remain on the MICU service. We have a solid clinical team and we need to do our part for the hospital as a whole. The transferring of ICU boarders was put into place as a pop-off valve for the MICU service when it gets busy. It is not to be used otherwise. Be responsible citizens.

G. Other expectations / miscellaneous requests from faculty:

1. **Handwashing:** Wash your hands before entering a room and immediately upon exit. Every time. No exceptions. Even if you touched nothing in the room. We are looking for a Pavlovian behavior on this one. Please do your part. Let us not speak of this again.

2. **Procedures:** Notify the fellow during the day and MICU attending at night prior to performing a procedure. Many of you are "signed off' to perform procedures without direct supervision. However, at the very least we want to review the indications and appropriateness of procedures prior to their performance.

3. **Intubations:** Residents are not permitted to intubate patients without supervision by one of the following: Pulmonary fellow, Pulmonary attending, or anesthesia. Anesthesia responds to CODES and they are responsible for securing definitive airway if indicated (definitive airway means endotracheal tube as opposed to Bag Valve Mask ventilation or BiPAP/CPAP). If you need a patient intubated outside of a code situation → MICU fellow/attending or anesthesia. No exceptions. This does not mean that you are not allowed to intubate… it means that you are not allowed to intubate without appropriate, direct supervision. Be aware that critically ill patients in need of urgent intubation are uncommonly appropriate opportunities for initial exposure to proper/ safe airway management.

4. **Teamwork:** Stay in constant communication with the entire MICU treatment team (nurses, RTs, dietician/PT/OT). Communication is best done face-to-face or over the phone. For example, when there is a significant change in treatment plan, code status, etc we all know it is necessary to change the orders in Epic. However, if you really want to ensure proper patient care and have a rewarding experience while rotating in the MICU, engage the non-physician members of the MICU team. These are the people that make the ICU the Intensive Care Unit. TAKE THIS ADVICE TO HEART…You won't regret it.

5. **Adjusting the vent:** You are expected to become increasingly comfortable with adjusting the ventilator. However, if you make a change to the ventilator (resp rate, tidal volume, FiO2, PEEP), you must do two things → tell the nurse or RT (preferably RT, but they may not be available) and change the order in EPIC before you go onto the next patient. This cannot be over-emphasized, as it is an area of particular scrutiny. If you cannot do those two steps, do not change the ventilator settings.

6. **Other:**
   - If you order a test, know what you are looking for in the result and what to do with the result.
   - Be aggressive with weaning patients from the ventilator.
   - Do not use the phones in the MICU rounding room during table rounds unless absolutely necessary.
   - Do not ignore the family. Compassion cannot be overemphasized when caring for the critically ill.
   - Call your consults first thing in the AM, not late in AM or afternoon. It helps the consultant plan their day, and it increases the likelihood that you will get timely recommendations.
   - Learn to anticipate and intervene as opposed to simply reacting to issues as they arise (i.e. prevent AKI, don't just treat it).
   - Be courteous to the PICC team. The PICC nurses are a great asset and have tremendous experience. Call as soon as you decide you want a PICC, midline, or longPIV. Don't leave calling them until the end of the day. Before asking for PICC, ask yourself: Does the patient need central access? Would a long PIV be better? They have 2.5 inch 18 gauge angiocaths that are perfect for the difficult access patient that just needs 5 or days of blood draws/meds/fluids and has no need for central access. Same holds true for mid-lines, but mid-lines can be left in longer. Remember to ask for single or double lumen).
   - RESIDENTS: If you are scheduled to be off the following day, please let the fellow/attending know if your service is excessively busy/complex such that your intern will be unable to safely manage the service without you. We (the other interns, residents, fellow, and attending) will make arrangements to assist you.