**MICU**

**Overview**: This is a great rotation: lots of learning, relaxed, time to read, and less responsibility as an intern. You function as an "extra hand", seeing a few patients every morning and performing procedures that need to be done. Awesomely, your pager doesn't go on any charts, so you essentially never get called. The upper level will take pages on all the patients on your team. There are two resident “teaching” teams, MICU A and B, and two attending only services, MICU C and MICU N. You will be on A or B, which consists of 1 or 2 upper-level residents (either EM, IM, FP), 1 or 2 interns, one attending, and possibly 1-2 medical students. The format of your team will vary and depends on how many people are scheduled in the MICU for that month. The attending changes every week starting Monday; be prepared to give a fairly thorough presentation on your patients when a new attending comes on. Each attending has specific preferences. Your EM upper level will probably be on the other team, this is to allow you to do your nights with the EM upper level, and prevents a single team from being left with one resident for several days at a time.

**Cerner Notes for Day 1: (**from chart for “patient” named: ZZPowerPlanCMCLCH, CritCare)

* MICU Progress Note
* PCC ICU Admission Note
* PCC ICU Consult Note

You are also allowed to use the dictation service to write H&P, consults notes, and death summaries.

**Cerner Order sets for Day 1:**

* CRIT Admission ICU
* CRIT Sedation and Analgesia of Mechanically Ventilated Patient
* ADULT PHARM Subcutaneous Insulin Non-pregnant
* ADULT PHARM VTE Prophylaxis

**Service List**: Helps to have two separate lists for this rotation (as you cover both lists on night call) Provider Group → Consult MICU A + Consult MICU B , Discharged Criteria → Only not discharged

**Schedule:**

*In General*: Expect to work 8-10 hours on short days, 13-14 hours on long days, and 13-16 hours on night shifts.

*Life Planning*:

* You get 4 days off during the month in addition to 2 post-call days.
* If you need a particular day off, email Mary early and ask to be forwarded to the MICU scheduler.
* You can request your 2 days off in a row if you request early
* You can also switch shifts with the other interns, including interns on the other team

*Schedule Interpretation*

* 6-8 day (long) shifts, 12-14 short shifts
* They will select 4 night shifts (in groups of 2 nights)
* All interns will receive a total of 4 days off
* 1 day off after each group of 2 night shifts
* 2 days assigned randomly
* Arrive at approximately 6am each morning to complete pre-rounds
* Rounds typically start at 8am each morning, but attending dependent

**General Tips and Hints**:

For months where there are three upper levels there will be a gap period of 3.5 hours in the evening from when the long resident leaves at 5:30pm and the night resident comes on at 9pm. This is in place because to keep all the nights covered and prevent the upper levels from violating duty hours. As an intern, if you are long, you leave with the long resident at 5:30pm. If you are scheduled for nights, you come in at 7pm. When you are short, if everything is wrapped up on your patients, you can leave as early as 4:30-5 pm.

You will be assigned (typically) between 2-3 patients every morning, usually the same you saw the day before. As interns, they do not want you seeing more than 3 patients, but this is dependent on the amount of patient load. In theory, they do not want upper levels seeing any more than 5 patients. Try to finish your notes before 8AM, when walking rounds generally begin. The attendings would prefer for notes to be finished and signed by at least lunchtime, when they generally start to write their addendums (as you may round all morning, this is why it is easiest for you if your notes are mostly finished prior to starting rounds). The post-night upper level (depending which system is being used) and the post-night-intern present first and then can go home.

You are expected to talk to the family members of your patients at least once per day. Building rapport becomes crucial in the event you need to discuss end-of-life issues with the family. This can be the most rewarding and the most frustrating part of the month.

Take advantage of the nurses - they know a lot about their patients and may express specific needs or concerns to improve patient care. They are experienced and their requests deserve consideration at the very least. The nicer you are to the nurses the more they help you out. ALWAYS ask the nurse every morning what happened overnight with your patient. They only have 2 patients at a time, so they know everything that goes on and will have updates about drips etc

The MICU day/long call team is responsible for responding to in-hospital codes during the day. The night team responds to codes at night. The short call team is not responsible for codes, but you should also go. Your role during these codes can be to do procedures, lines, intubations, CPR, or running the code. Your upper level has the code pager which will go off for all codes. Before any code pagers go off, however, the code will be announced overhead, and it’s hard to miss, “code blue, 7 tower”. Listen for it and go immediately if you hear it. Otherwise your upper level will try to let you know when something goes down. There will usually be an upper level with you and they are generally responsible for “running” the code but may dole out responsibilities. If you want, ask the upper level on the way to the code if you can run it (assuming no one else already is). This is a great time to practice this skill outside of the well-organized major resuscitations in the ED. Be aware that the respiratory therapists will intubate the patient unless you tell them you’re there to do it; codes on the floor are the holy grail of respiratory therapy, and the only chance they ever get to tube someone. They’ll do it unless you step up. As a general rule, codes on the floor are disasters, there are 50 people around and nobody is doing anything useful for the patient, so you’ve got to be assertive in these situations in order to get in position to do anything (goes for lines, intubations, etc). Generally, these patients that code on the floor will come to your MICU team as transfers if they are resuscitated.

New admissions (transfers or admissions via ED) are assigned by the attending carrying the MICU pager that day. When you get an admission, you are expected to go with the upper level to evaluate the patient, come up with an assessment and plan, and begin to work on the consultation report and orders. Occasionally, you will be doing urgent procedures at these times as well.

**Call days:** Interns will take “call” or shifts with the upper levels,. You may want to switch your call days around to get certain days and weekends off, and to work with the EM residents (usually EM interns take call with EM residents and our internal medicine colleagues follow suit).

**Didactics**: On Tuesday, Wednesday and Thursday, one of the attendings will lecture from 7:30am-8am before rounds start. On these days, you have a little less time to see your patients and do notes. On these days, you may have to work on notes after rounds, but as the month goes on, you will become more efficient and should be able to complete them before rounds start.

**Source of Patients:**

* From the ED.
* Transfers from other hospitals (ICU to ICU for higher level of care).
* Staff medicine team needs a higher level of care for a patient.
* Private attending (usually CHG) consult the ICU team.

**Sign-out:**

Because we are doing complete shift work now, sign out is essential. The sign-out is located as a Microsoft Word document on the right-most computer on the MICU low-side (outside room 10602). Some months you will and some months you will not utilize this tool. The medicine teams prefer a verbal sign out on everyone. If your team elects to use this sign out document, open the document and update the sign-out on your patient’s daily. It is especially important to remember to do this prior to leaving in the morning if you were on the night before.

**Important Numbers:**

* MICU A
  + Resident pager: 8831
  + Ascom: 6-7072
* MICU B
  + Resident pager: 8832
  + Ascom: 6-7073

**Pearls:**

* On MedHub and the Compendium under ICU documents there are multiple handouts about Ventilation, Blood Gases, Pressors, etc. All the lectures they cover in the month generally have a guideline already on MedHub.
* CMC has an open ICU policy – Patients requiring an ICU bed may be in any of the four main ICUs: Dickson Cardiac ICU – (7th floor), Neuro ICU (9th floor), Medical ICU (10th floor), and Surgery ICU (11th floor). Patients may also freely move from the floor or progressive to ICU and vice versa without necessarily needing to consult the critical care team.
* There are 2 sides to the MICU (10th floor)—Low Side, comprised of bed numbers 10601 to 10615, and High Side, comprised of beds 10616 to 10630. The same is true of the 9th floor NSICU and the 11th floor STICU.
* There are two supply rooms in the MICU, one at each end of the hall. The code for both doors is 2-4-1-\*. There is a procedure cart in each room that can be taken to the patient room and houses most, if not all, of the supplies you will need. The ultrasound is located in the "fishbowl" between the Low Side and the High Side.
* Jump in on procedures. Procedures within your scope include all varieties of central lines, intubations, arterial lines, lumbar punctures, chest tubes, para-and thoracentesis. Offer your services, as many of the IM and FP residents simply don't want procedures. Pipe up to do chest tubes too as not even MICU attendings do them often and many times they get CT surgery to do them. Also, you can do procedures for the other MICU services (namely MICU C, an attending-only service), the attendings are by themselves, and if you offer they will more than likely take you up on your offer. And don't forget about Dickson ICU, an ED 2nd yr is there and if you let them know, they will call you to help place lines.
* A good basic ICU book is Marino. There are multiple copies in the library. Some chapters are outdated, but the pulmonary section in particular is good. Make sure you leave the MICU understanding the basics about ventilators.
* Although you are not the one in charge, ask to run codes to practice, etc. Ask lots of questions – its helps you learn, stay focused and prepares you for next year.
* Pay attention! You will be there next year as the upper level!