Due to the complexity of your patients in the MICU, you will have an incredible amount of data on each patient, and it can be challenging to organize and present all that information in a way that is easy to follow for everyone on rounds. Here are our suggestions to help.

**PRESENT BY ORGAN SYSTEM** - What we mean by this is to abandon your typical SOAP note format for presentations. Lump together hemodynamic data with CV and volume assessment; pulmonary data with vent settings and blood gas results; neurologic data with wake-up assessment, etc. For a typical follow-up patient on rounds, this means stating the patient’s major events overnight (if any) and then launching in to assessment as below. Except in rare instances, the 1st systems addressed should be hemodynamics, pulmonary or neuro. Both an outline format and sample narratives are below.

1. **Hemodynamics** - BP has remained X/Y on the following vasoactive drugs and doses. She appears to be (wet/dry/evolemic) based on a CVP of X (with/without) respiratory variation. A-line (does/does not) show respiratory variation. Pulse pressure variation is X. Central venous sat (SVO2) is X. UOP has remained (good vs oliguric) and the patient feels (warm with good cap refill vs cold with thread pulses). Tips: ok to give vitals as either a representative sample or as ranges, but if giving ranges, report blood pressure as X/Y - A/B – not as a systolic range and diastolic range – to allow us to hear the pulse pressure.
   - **Blood pressure**
   - **Vasoactive meds and doses**
   - **Volume status (with data – CVP, SVO2, I/Os, UOP, PPV)**
   - **Heart rate/rhythm**
   - **Ischemia or heart function**

2. **Pulmonary**: Pt remains intubated on the following vent settings: XXXX. By convention, we report vent settings as Mode (AC vs PC vs PS) / Rate/ Tidal Volume/ PEEP/FiO2 – and on these settings the ABG is (report as pH/ CO2/ paO2/ sat –ok to round up to the nearest whole number). Patient’s oxygenation is (improving vs worsening) and the CXR is (better vs worse). We plan a SBT today but are concerned that pt’s (oxygenation/ventilation/neuro status/airway) may prevent extubation. Patient’s acid-base status is …. and the respiratory alkalosis we are observing might be explained by …...
   - **Vent or oxygen status and effort**
   - **ABG**
   - **Plan for SBT/extubation**

3. **Neurologic**: Pt remains sedated on the ventilator. Awoke when sedation held yesterday, followed all commands. Still requires sedation because… For comatose patients off sedation in whom we are trying to prognosticate, the 3 most helpful parameters are papillary response, doll’s eyes (oculocephalic reflex) and corneal reflex.
   - **Exam**
   - **Sedation**
   - **Radiographic studies**

4. **ID**: Pt is febrile with a rising WBC despite antibiotics (X,Y, and Z). We think the source of infection is …. because....
   - **Temp, WBC, Culture data**
   - **Antibiotics**
   - **Source of infection**

5. **Heme/Onc**: Hb dropped from X to Z with 400cc of coffee grounds from OGT. Plan for an EGD today. She required X units PRBCs, Y platelets, and Z FFP overnight
   - **CBC**
   - **Onc issues**

6. **Renal**: Only necessary if this pertinent information is not already addressed in hemodynamics. **UOP, Creatinine trends probably belong under hemodynamic data**. Patient tolerated intermittent dialysis yesterday and needs more volume off today.
RESOURCES

Listen to nurses - They are extremely experienced and have very important information to tell you. If they are paging you, it is because they REALLY need you to come evaluate the patient.

Use your pharmacist – Great resource for information about meds (dosing, interactions, etc)

Ask your residents, fellows, attending and APNs for help – You will learn a lot on this rotation. This will be enhanced if you ask when you don’t completely understand something. If you are ever in a situation where you are writing an order without knowing why you are doing so, ask your residents, fellows, attending or APN.

THE DAILY GRIND

When pre-rounding – Come in at 6am. Look at the orders written overnight and ask your cross cover why they made a change. What prompted them to change the vent/start pressors/extubate etc. The expectation is that you have seen all of your patients and reviewed their information PRIOR to morning rounds.

Sign outs and cross-cover are critical- The MICU is an around the clock endeavor. Thus, our mentality is that each MICU patient is a communal patient. Your sign out and presentations on rounds are ways you communicate your plan and anticipated problems to the cross-covering team. High quality sign out and presentations are the only way to deliver quality around the clock critical care.

- Everyone should know each patient in the MICU
- For the post call team, the APN/ED dayfloat are designated “helpers”, especially for procedures, roadtrips, etc
- Call consults early – you know your patients the best
- Complete bedside procedures EARLY which means OBTAIN CONSENT and OPTIMIZE COAGS for procedures early
- Maintain active type and screens and put blood consents in the CHART for patients who require blood products
- Have family contact information and any limits of care (code status) on sign out
- X-cover patients going to the ward should be given to appropriate service (GENS, HONC, etc)
- ASK whether X-cover spoke to ward team about your patients who went out overnight

Transfers out of the MICU: All orders must have complete team info (attg,res/intern/pager) even if ward teams are full and the MICU is covering overnight

- Remember to complete the order reconciliation prior to transfer
- EXPLICITLY discuss which residents assumed care for your patients on the ward

Buff family qD! – So much can happen in a MICU day and the ICU patients are relatively more likely to have major condition changes compared to floor patients. You will find the family is more prepared for adverse events / need for procedures /status changes, if you keep them in the loop all along. To do this, have the family identify the one person who will be the point person and you can update him/her, then he/she will update the family. Also please remember to ask for the CODE (last 4 SS#) before giving info via phone or in person.

Keep the work rooms clean – We share these spaces that are almost continually in use 24/7. Please be cognizant of your belongings. Hang up coats. Store bags in/on top of cabinets. Return medical records to the patient’s chart. DO NOT bring supplies into workroom. Unlocked needles are in violation of Illinois Department of Public Health requirements.
CONFERENCES

7:00am – Multidisciplinary Rounds
- Bedside patient care rounds are performed outside of the patient’s room. If you do not see the patient’s RN participating in rounds, please notify them that rounds are taking place.
- Resident presents patient within 7 minutes. All members of the team are expected to listen and learn from these presentations.
- RN presents FASTHUGS.
- Pharmacy needs are addressed.

9:00 am – Pulmonary Morning Report
- If your attending and fellow go to pulmonary morning report, so should you. This is not an opportunity to break from rounds to get other work done.

3:00pm – Afternoon Lecture
- Great lecture series. Must attend every day unless a patient is actively crashing. By the end of the month, you should understand the 4 types of respiratory failure, mechanisms of hypoxemia, types of shock, familiarity with vasoactive meds, modes of mechanical ventilation, and sepsis

<table>
<thead>
<tr>
<th>Time</th>
<th>Process</th>
<th>Participants</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 AM - 7:30 AM</td>
<td>Nursing Report</td>
<td>Night and day shift RNs</td>
<td>Patient handoff.</td>
</tr>
<tr>
<td>7:00 AM - 9:00 AM</td>
<td>Multidisciplinary Rounds</td>
<td>Attendings, Fellows, Residents, APNs, RNs, Pharmacist</td>
<td>Patient presentation. Establish multidisciplinary plan of care for the day. Education.</td>
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<tr>
<td>9:00 AM - 9:30 AM</td>
<td>Pulmonary Morning Report</td>
<td>Attendings, Fellows, Residents, APNs</td>
<td>Case presentations. Education.</td>
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<tr>
<td>10:00 AM - 10:15 AM</td>
<td>Post-Rounds Multidisciplinary Huddle</td>
<td>Charge RN, Fellows, PT, OT, SW, CM, Dietician</td>
<td>Brief outline of daily patient goals. Address geography of MICU service patients. Address social work needs, and barriers. Identify patients ready for PT/OT and nutrition.</td>
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<tr>
<td>2:00 PM - 2:45 PM</td>
<td>Afternoon Rounds</td>
<td>Attendings, Fellows, On-Call Resident, Bridge Resident, APNs, Charge RN</td>
<td>Present patient to on-call resident. Address progress on daily patient goals. Charge RN to identify patient throughput and staffing issues.</td>
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<tr>
<td>3:00 PM - 4:00 PM</td>
<td>Afternoon Lecture</td>
<td>Attendings, Fellows, Residents, APNs, RNs, Pharmacist</td>
<td>Education</td>
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<tr>
<td>3:00 PM - 3:05 PM</td>
<td>Measuring for Daily Improvement Huddle</td>
<td>Charge RN, RNs</td>
<td>Quality improvement</td>
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<td>5:00 PM</td>
<td>Resident Sign out</td>
<td>Residents</td>
<td>Patient handoff</td>
</tr>
<tr>
<td>7:00 PM - 7:30 PM</td>
<td>Nursing Report</td>
<td>Night and day shift RNs</td>
<td>Patient handoff</td>
</tr>
<tr>
<td>7:30 PM</td>
<td>Long call Resident Signs Out to Night Float</td>
<td>Residents</td>
<td>Admitting pager handoff so that Long call resident can focus on getting intern out by 9pm</td>
</tr>
<tr>
<td>10pm</td>
<td>Bridge resident signs out Cross-Cover to Long Call resident</td>
<td>Residents</td>
<td>Updates on what has been done and needs to be done for active management of cross-cover patients</td>
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