

Medical Intensive Care Unit Rotation Objectives

The primary roles of the PGY-2 and 3 residents are supervision and education. This includes:

1. Initial evaluation of all patients, including assimilation of old records and outside information.
2. Seeing every patient immediately upon admission with the intern and dividing the admissions equitably, commensurate with experience level.
3. Review and approve diagnostic and treatment plans with the intern *every day prior to Attending Rounds*
4. Review patients' progress daily, giving feedback to the intern on progress notes, order writing, transfer notes and orders and discharge planning
5. It is expected that the resident and intern will divide up progress note writing responsibility equitably.
6. Creating an atmosphere such that the intern is encouraged to ask for help when appropriate
7. Supervising procedures
8. Interacting with nurses and other personnel in a way that respects all members of the healthcare team and encourages their input
9. Being certain all members of the team are familiar with the current literature regarding their patients
10. Resident will not supervise more than 10 new admissions including in-house transfers
11. Actively attempt to perform required procedures under direct observation if you have performed less than 5
12. Communicating with the patient and family about treatment plans, consultations, risks and benefits of procedures and medications, and other aspects of care
13. Discussion of "Do-Not-Resuscitate (DNR)" orders and other end-of-life issues when appropriate
14. Asking surviving family members for permission to perform an autopsy.
15. If not completed by the PGY-1, Dictating all outside hospital transfers, discharges from the ICU, death summaries and history and physicals

PGY-1 residents, otherwise known as interns, have the following major responsibilities:

1. Initial evaluation of all patients, including assimilation of old records and outside information.
2. Developing a plan for each patient to present to the resident.
3. Communicating with the patient and family about treatment plans, consultations, risks and benefits of procedures and medications, and other aspects of care.
4. Getting write-ups on the chart no later than 8:00 a.m. following a call day.
5. Discussion of "Do-Not-Resuscitate (DNR)" orders and other end-of-life issues when appropriate.
6. Asking surviving family members for permission to perform an autopsy.
7. Working on discharge planning from day one.
8. Writing daily progress notes.
9. Interns work closely with medical students and assist with their education.
10. An Intern will not admit more than 5 new patients in a 24 hour period
11. An Intern will not be responsible for the ongoing care of more than 10 patients
12. Dictating all outside hospital transfers, discharges from the ICU, death summaries and history and physicals

The primary roles of the Attending Faculty:

1. The faculty must regularly participate in organized clinical discussions. Teaching Faculty on ward services are expected to attend Case Conference.
2. Patient based teaching must include direct interaction between resident and attending, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions.
3. Residents have protected educational time for their Conferences per the conference schedule.
4. Faculty may need to rearrange their clinic schedules during their on-service months.
5. Teaching attendings will be held responsible for enforcing the duty hour rules
-10 hour time period free from all duties must be provided between all daily duty periods
6. Teaching Faculty must clearly state their expectations at the beginning of the rotation to the housestaff and students
7. The faculty are expected to provide a verbal mid-month evaluation to all Housestaff on the team
8. The faculty are expected to provide a verbal and written end-of-month evaluation to all Housestaff on the team

Daily Work/Conferences:

Residents, Interns, and Students are expected to attend Morning Report at 1pm and Noon Conference at 12pm

- a. Rotation specific conferences that interfere with this schedule are the only accepted reasons for excused absence from Case Conference or Noon Conference
- b. Rotation specific conferences that interfere with this schedule along with necessity for travel to an alternate location are the only accepted reasons for excused absence from Noon conference

Any Housestaff with <70% attendance rate at Conferences (tallied throughout the month and finalized on the last day of the month) will meet the following:

1st Violation: meet with their Associate Program Director, have a letter placed in their file, be assigned and complete a Core Curriculum Program (CCP) Exam, and be assigned Holiday Jeopardy

2nd violation: Housestaff will be required to repeat the month

Evaluations

1. A verbal mid-month evaluation will be given by the attending to Housestaff
2. An end of month verbal and written evaluation will be given by the Attending to Housestaff
3. All Housestaff will be expected to give a written evaluation of the rotation and of their Attending

Poor Performance on a specific rotation or in a particular Subspecialty on the October Inservice Training Exam will render assignment to that subject's Core Curriculum Program (CCP) Exam.

If the Resident fails the CCP or is a No-Show to take the assigned CCP, then the Resident must meet with their Associate Program Director for an Oral Exam

Learning Objectives

By the completion of this month, the Resident and intern will be able to:

1. Describe the indications for and performance of orotracheal intubation.
2. Describe the algorithm for management of severe sepsis in the ICU.
3. Describe the complications of central line placement.
4. Describe how to choose initial settings on a ventilator.
5. Describe the evaluation of Carbon Monoxide poisoning.
6. Describe the management of Diabetic Ketoacidosis.
7. Describe the management of COPD exacerbation.
8. Describe the evaluation of a suspected drug overdose/intoxication.
9. Describe the treatment of status asthmaticus.
10. Describe the management of status epilepticus.
11. Describe the evaluation and management of Acute Liver Failure.
12. Describe Critical illness myopathy and neuropathy.
13. Describe the use of hemodynamic monitoring in critical care.
14. Learn how to perform central line placement
15. Learn how to perform arterial line placement
16. Evaluate Altered mental status/meningitis
17. Evaluate hypercapnic/hypoxic respiratory failure including management of ARDS
18. Recognize indications for ventilator weaning
19. Adhere to clinical practice guidelines for ICU: stress ulcer prophylaxis, DVT prophylaxis, Ventilatory-associated pneumonia prevention, line day documentation
20. Learn management of End-of life issues
21. Learn basic antibiotic uses and principles
22. Identify and differentiate community acquired pneumonia versus hospital acquired pneumonia
23. Management of Hypertensive urgency and emergency
24. Learn evaluation and management of acute GI bleed and resuscitation techniques

25. Learn basic understanding of ABG interpretation and acid/base principles
26. Evaluation and management of acute renal failure and indications for hemodialysis
27. Recognition and management of cardiac arrhythmias
28. Basic electrolytes replacement skills and nutrition requirements
29. Evaluation and management of cardiac arrhythmias
30. Indications for placement and removal of central lines
31. Management of chest tubes
32. Basic understanding of infection control measures.
33. Evaluation and treatment of anemia including indications and complication of blood product transfusions
34. Evaluation and management of ischemic strokes