WELCOME TO YOUR CRITICAL CARE ROTATION AT LAKERIDGE HEALTH OSHAWA

WELCOME

- Lakeridge Health Oshawa: Tertiary academic affiliated 38-bed medical/surgical ICU
- Our ICU is a major referral site for critically ill patients from Durham region and our affiliated hospitals in Ajax/Pickering, Bowmanville, Port Perry and Whitby
- This is a big and busy ICU!
- The ICU is a multidisciplinary team including learners, nurses, pharmacists, RTs, PTs, dieticians, social workers, ethicists and many others
- You are an integral part of our team, and the skills you will learn during this rotation will help you take better care of your patients, regardless of where your career takes you!

SCHEDULE FOR ORIENTATION DAY

- Morning sign over in ICU conference room
- Orientation presentation / PPE training / tour of ICU
- Meet Brandi McLaughlin for further orientation: Computer training and hospital tour
- Airway sim session in LHEARN centre
- When not at orientation join your team in ICU

CONTACTS

List of physicians on call each day posted at each nursing station

- Locating: 33200 (to page people) – pre-fix 3 is for all Oshawa numbers
- Operator: 0 (e.g. for long distance calls)
- Main ICU number: 905-576-8711
- Charge RN, CCOT nurse and on-call residents all carry portable phones

- Education Lead: **Dr. Kavita Sridhar** – page via locating or ksridhar@lh.ca
- Specialty Disciplines Site coordinator: **Katelyn Barker** x32308, lhregional@queensu.ca
  - Issues like absences, call schedule, OR/RT days, time off requests, teaching schedule
- Medical Ed. Coordinator / academic affairs coordinator: **Brandi McLaughlin** x36037, bmclaughlin@lh.ca
  - Issues like badge access, IT access, orientation modules

EPIC INSTRUCTION DOCUMENT

tinyurl.com/epicccu

EPIC INSTRUCTION VIDEOS

https://youtube.com/playlist?list=PL_mhibFB33QNdV1iLAJav7UOUByhgvHcO

STRUCTURE OF THE ICU

- 3 PODs in main unit on 2N, satellite unit on F6
- During weekdays we function as 3 ICU teams
  - Team 1 and 2 each have an ICU staff and residents, rounding in the main unit
  - Team 3 is led by the Critical Care Outreach Team ICU staff who rounds on F6 satellite unit and reviews new consults
- On the weekend there are two ICU staff and a CCCA (licensed physicians or senior trainees from various base specialties)

TYPICAL ICU DAILY SCHEDULE

- 8:00-8:30: sign over rounds in ICU conference room
- 8:30-9:15: Scheduled teaching for residents +/- fellows
- 9:15-12:00: rounding on patients in the ICU
  - Concurrently see new admissions, consults, procedures
- ~12:00: lunch
- ~1:00-4:00: see new admissions, consults, f/u investigations, procedures, update families
- ~4:00-4:30: team sign out to on call team

TEACHING SCHEDULE

- Formal teaching
  - Morning lecture series – Fundamentals in Critical Care + guest lectures
  - Simulation sessions Monday afternoons in LHEARN centre
  - Procedural sim sessions during the block
  - Queen's CCM Grand Rounds Thursdays 12:00pm
- Residents here for 2 months are expected to give one teaching session to the ICU team at morning handover – interesting topic, case based, etc.
- Informal teaching on rounds and during procedures. Senior residents and fellows are encouraged to teach junior colleagues when appropriate

ROUNDING IN THE ICU

- You will be assigned patients that you will be responsible for
- Please physically examine each patient each day before rounds and try to get familiar with their "main" ICU issues
- **You** will give the "one line" for the patient when it is time to round
  - e.g. "Mr. Smith is a 55M admitted with respiratory failure secondary to pneumonia, intubated last night"
- The bedside **nurse** will provide a "head-to-toe" update of the patient's main systems, relevant details of which should be captured in the rounding note being concurrently completed by one of your team-mates
- The team will review the labs, micro, imaging and any other investigations
- Medication review with the team pharmacist

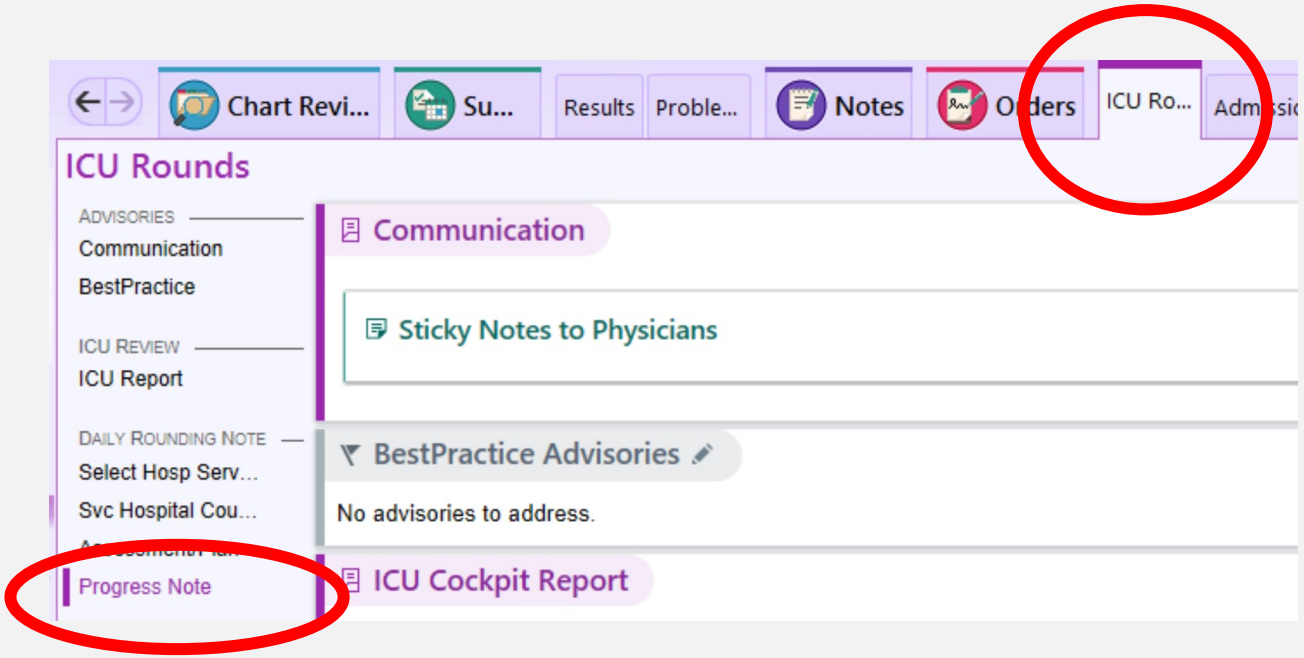
ROUNDING IN THE ICU

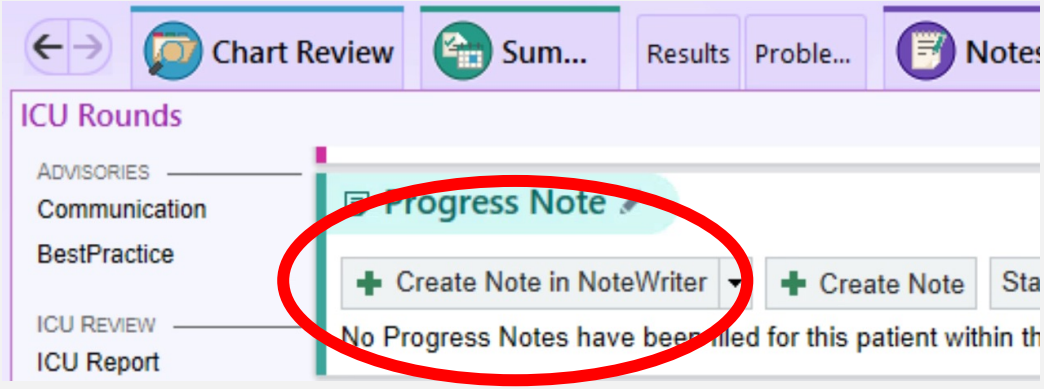
- Back to **you** for your issue-based plan
  - Issue 1: Pneumonia complicated by ARDS: I would like to obtain sputum cultures and legionella antigen, broaden coverage to include atypicals with azithromycin. I would like to obtain another blood gas at 1pm to see if ventilation is adequate.
  - Issue 2: Acute kidney injury: This is likely pre-renal, I would like to rule out post renal causes with an ultrasound and give a 500cc bolus.
  - Best practices: I would like to initiate feeds, and start stress ulcer and DVT prophylaxis. I will call the family for an update this afternoon.

ROUNDING IN THE ICU

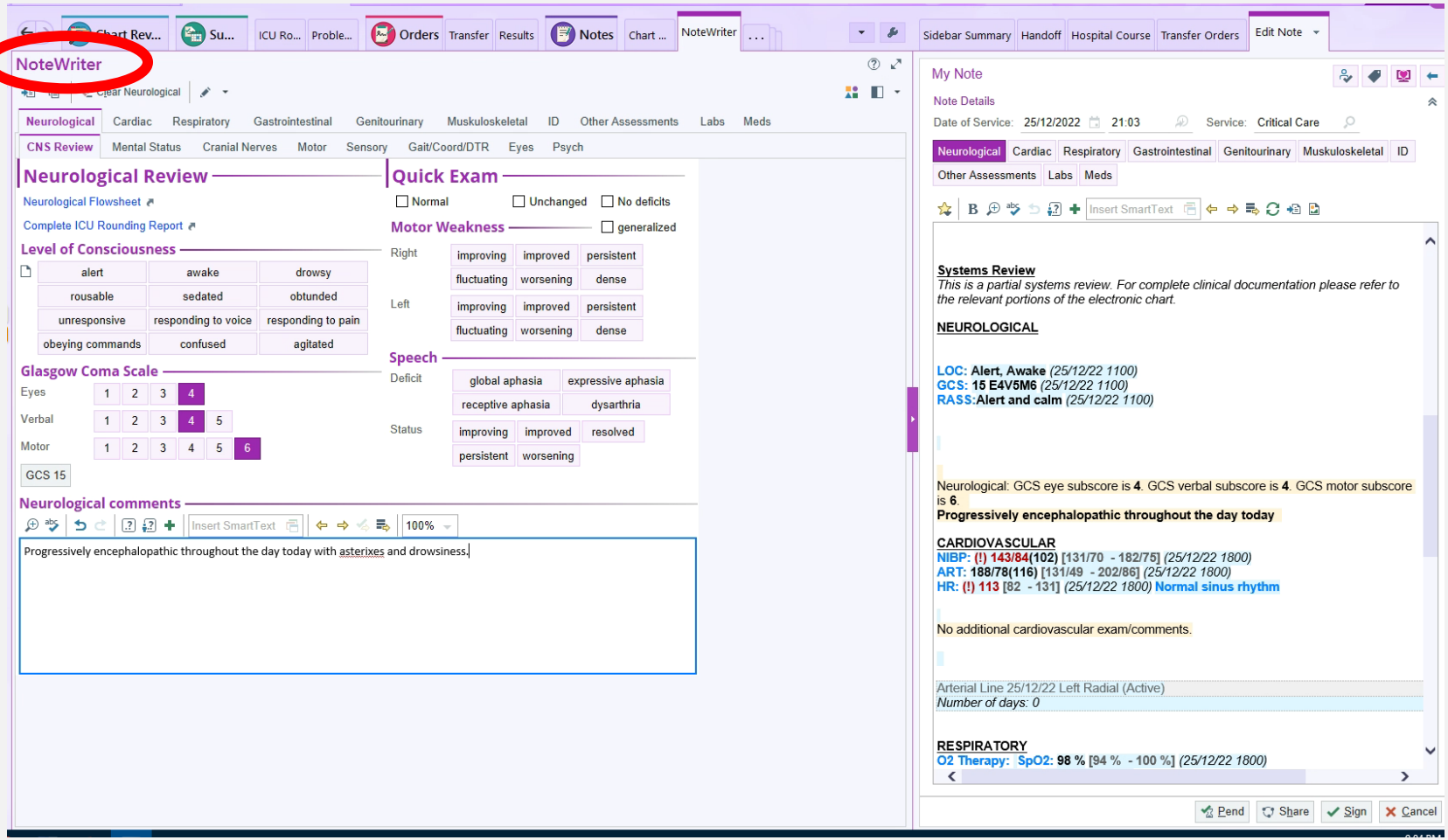
- Don't worry if your plan is adjusted by the staff!
- Remember, we work as a team, you are here to learn, and patients in the ICU can be quite complex
- Make note of specific tasks or issues for your patients that you will need to follow-up or address after rounds

ROUNDING IN THE ICU – EPIC NOTES



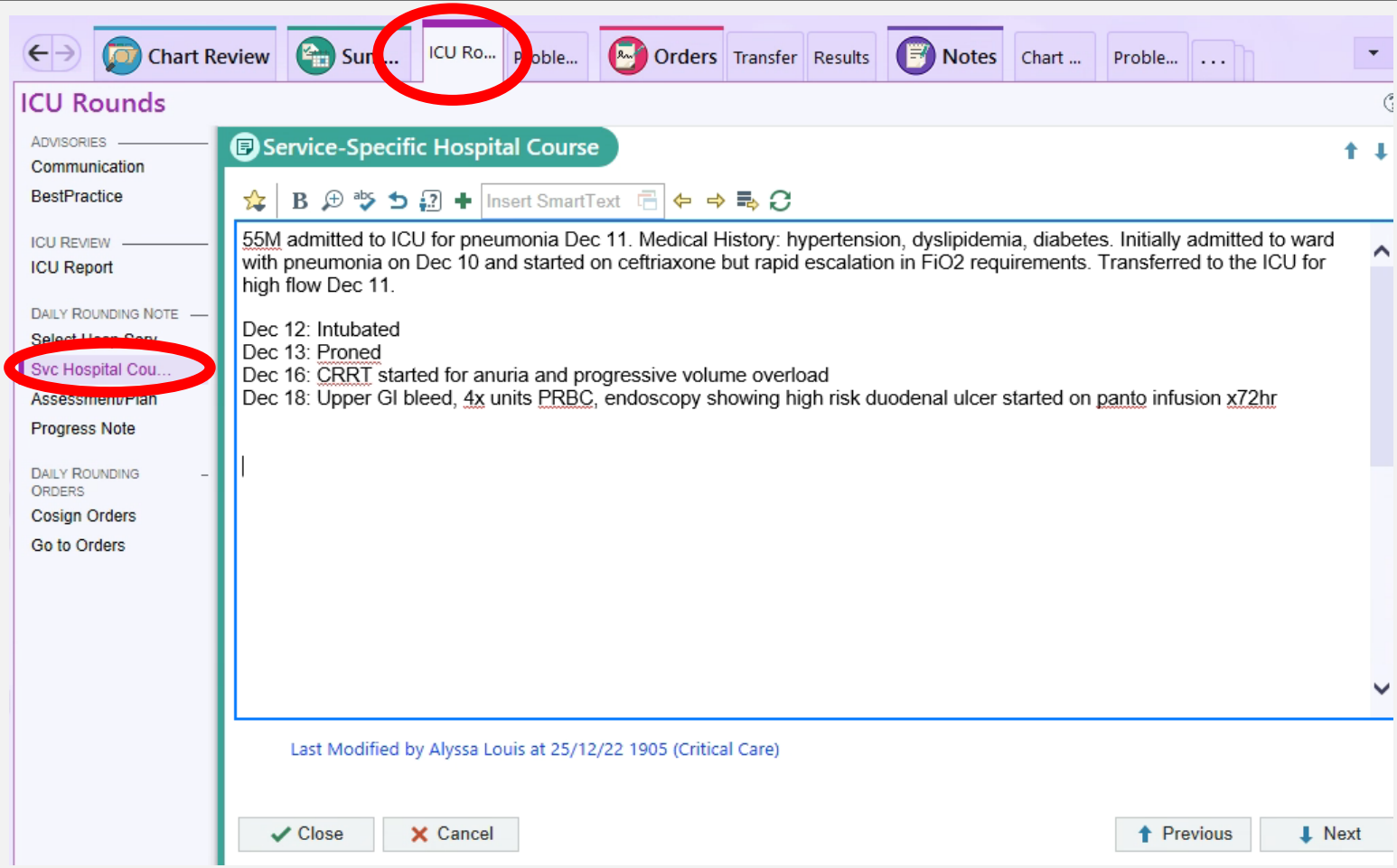


ROUNDING IN THE ICU – EPIC NOTES



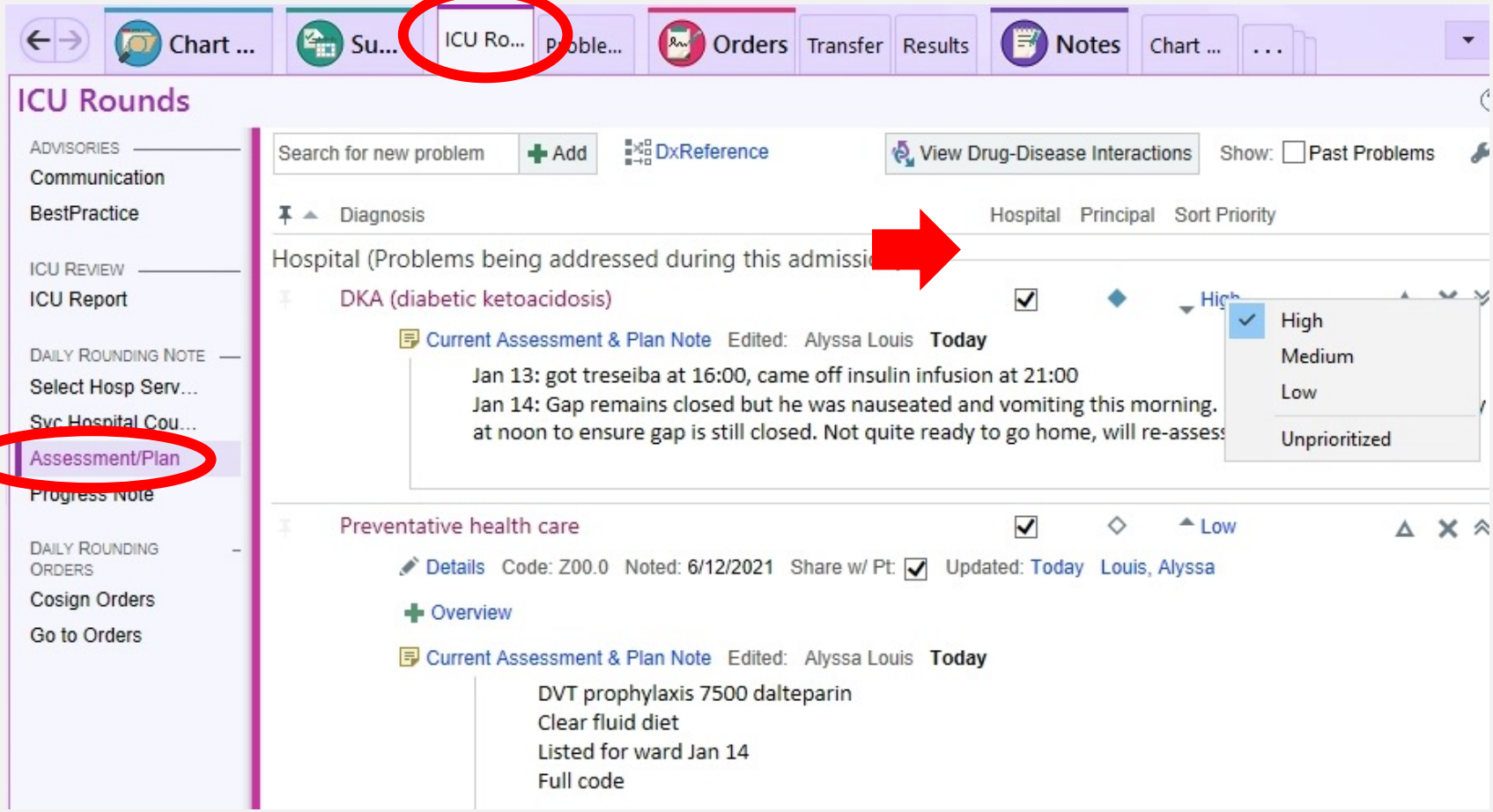
Go through each system (neurological, cardiac, respiratory, etc.) as nurse is giving head-to-toe and fill in the relevant details from this information, as well as your own assessment. It is not necessary to have every single domain from each system completed.

ROUNDING IN THE ICU – HOSPITAL COURSE



Update the ICU service-specific hospital course - this should be done at the time of admission **and** populated daily with clinical events!

ROUNDING IN THE ICU – EPIC NOTES

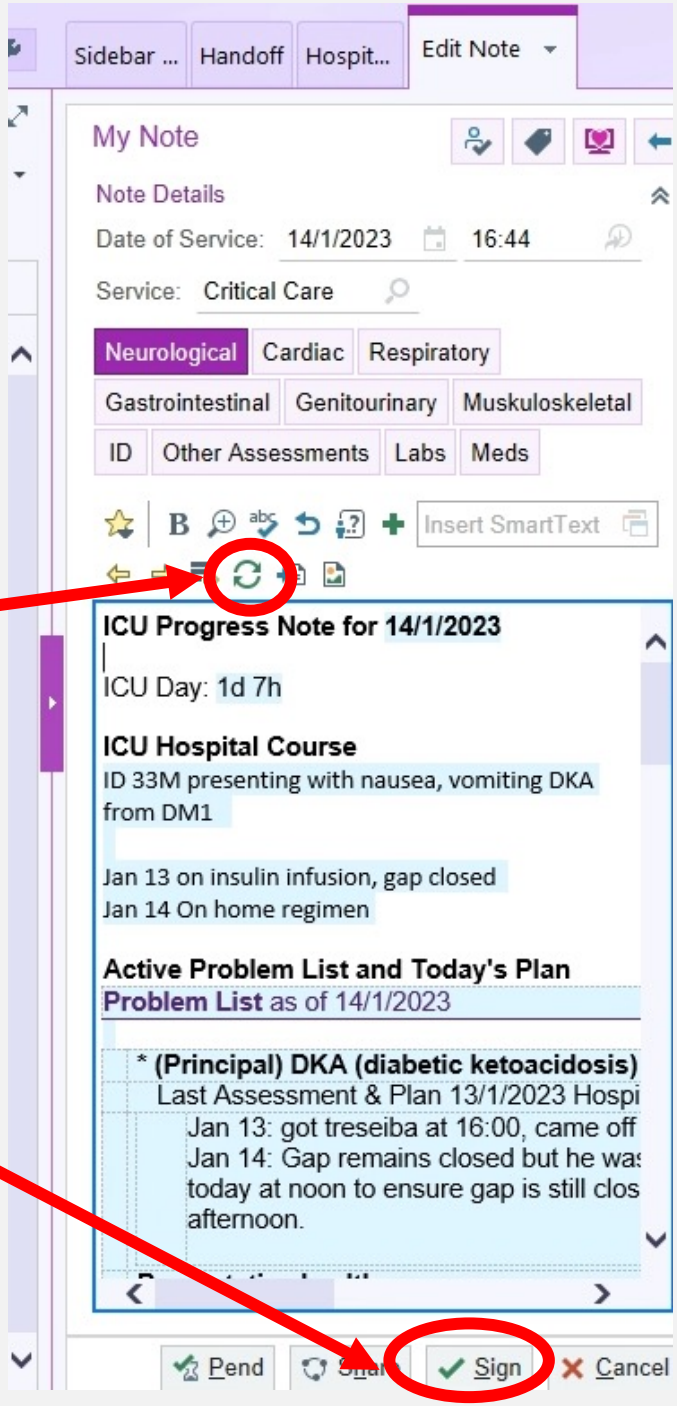


Update the patient's active problem list and ensure that any new problems you add have a "priority" assigned, as "unprioritized" issues will **not** end up in the note!

ROUNDING IN THE ICU – EPIC NOTES

Refresh the smart-links so that your updated problem list, course and vitals populate

Sign off on the progress note! The note does not exist in the medical record until it is signed!



ICU CONSULTS

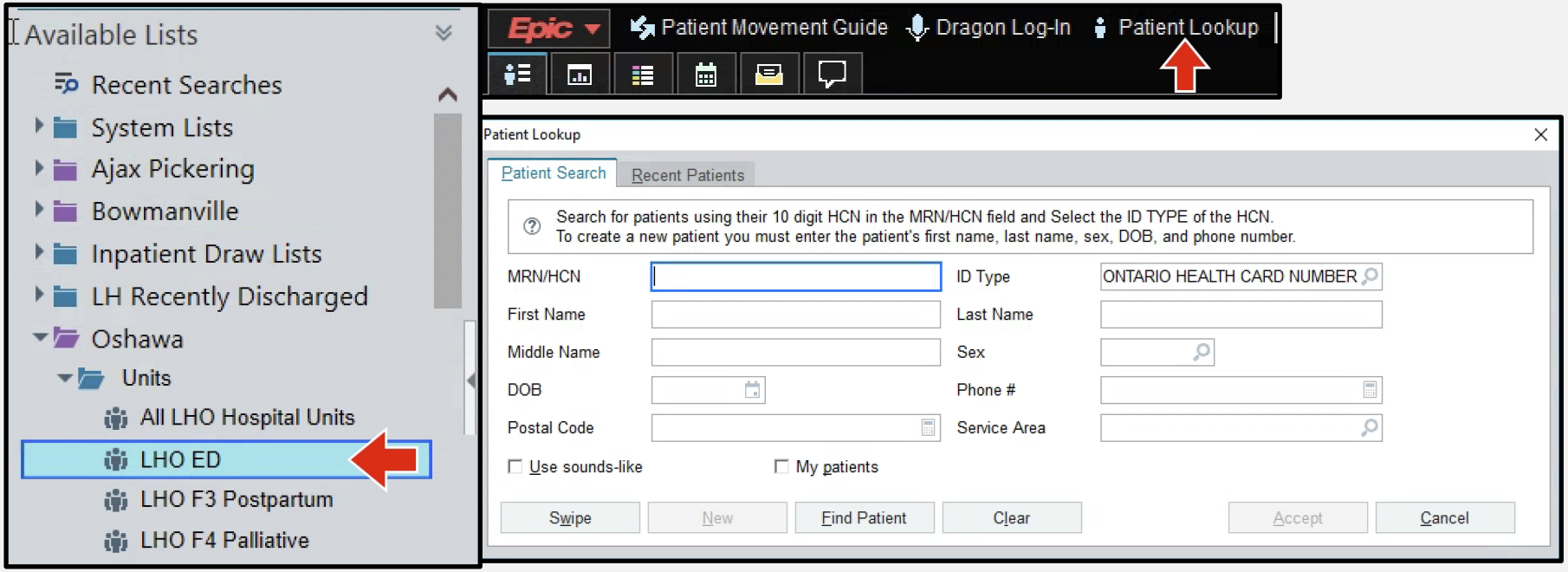
- During the day, and on call, you will be notified by your staff or your CCCA about patients that require an ICU consult (in ED, post-op, inter-hospital transfer, patient on the ward, etc.)
- Consults are an excellent learning opportunity!
- This may require you to leave your rounding team, in which case it is your responsibility to ensure any time-sensitive tasks are handed over (i.e. if you were going to call a consulting service after rounds, or your patient needs transfer orders, etc.)

ADMISSION NOTES/DOCUMENTATION

- Admissions/Consults come from: ER, ward, scheduled post op (eg. Thoracic patients), Criticall, code stroke service, etc
  - All new consults are supposed to go through attending (if you are called directly, redirect to your staff)
  - **If you feel uncomfortable or don't know the process, procedure or management, please reach out to attending at any time**

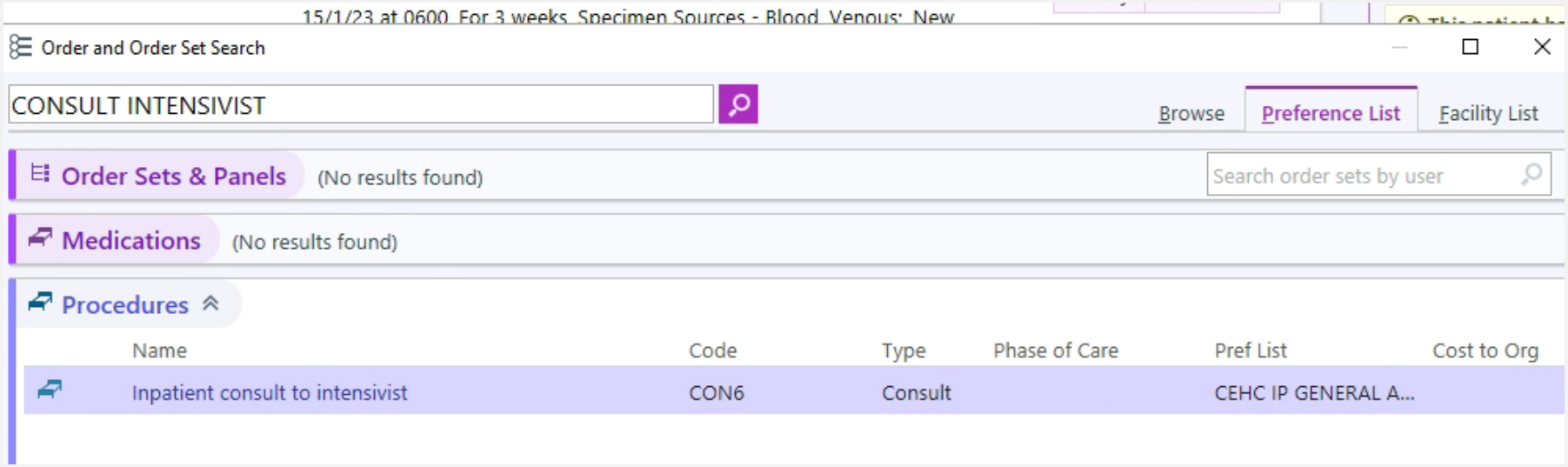
- Patients admitted to ICU will need
  - A full consult note + Full set of admission orders in EPIC
- Once you have seen the consult, you **review with staff** – plan for admission, management plans, and orders

ICU CONSULTS



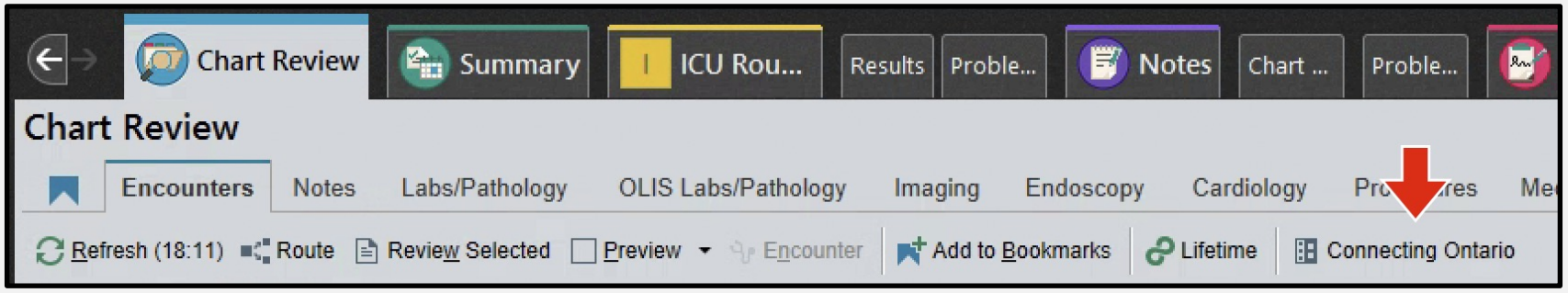
- To find the patient in epic, you can look them up based on location, or perform a manual search

ICU CONSULTS



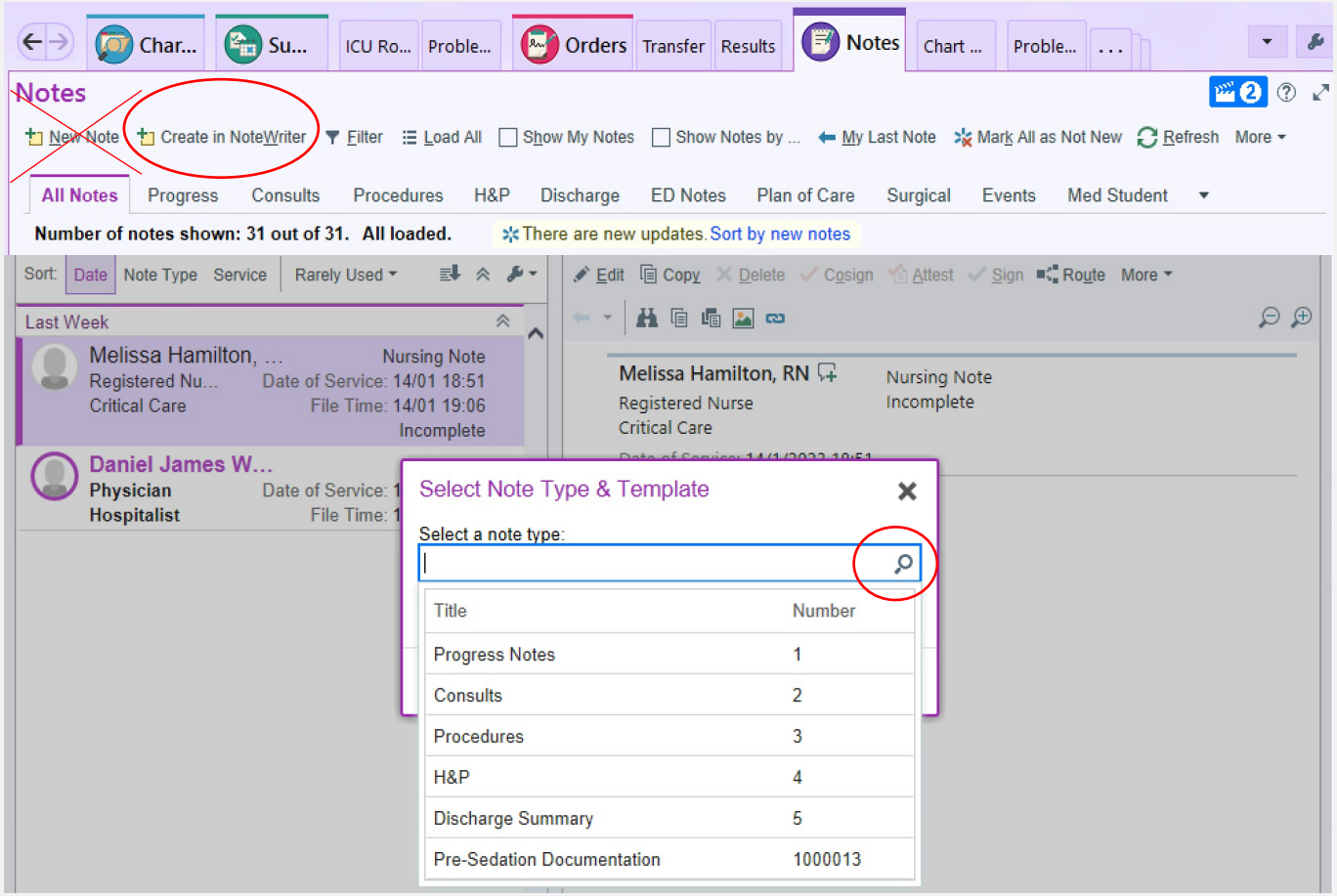
- When there is an ICU consult, the consulting service is supposed to place an ICU consult order in epic
- If you do not see an ICU consult order, you must place one so that your note is associated with the order (this is very important)

ICU CONSULTS



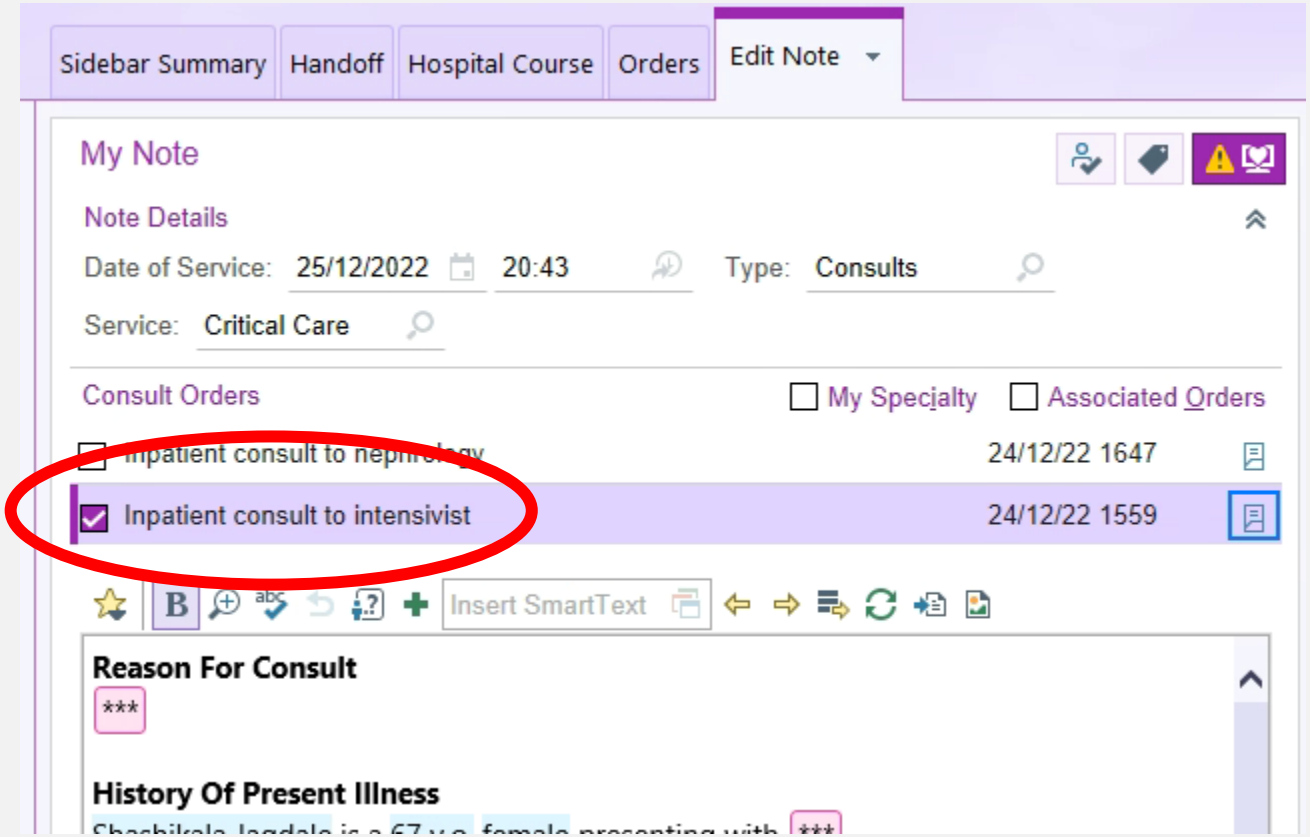
- Review all relevant details of the patient's chart, including review of Connecting Ontario, labs, imaging, current orders

ICU CONSULTS



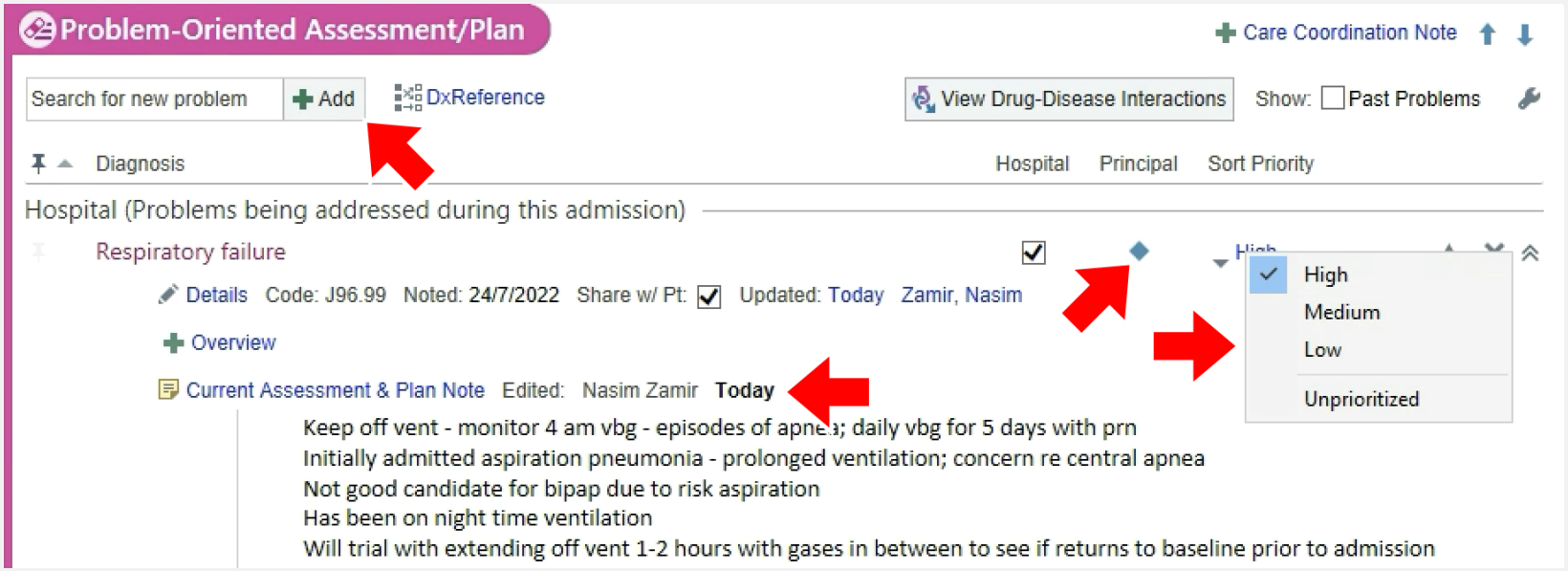
- When you are ready to make your note, select "Create in Note Writer" And label it as an "**H+P" if the patient is not yet admitted** (i.e. referred from the ED doc) or a **"consult" if the patient is being transferred from the ward**

ICU CONSULTS



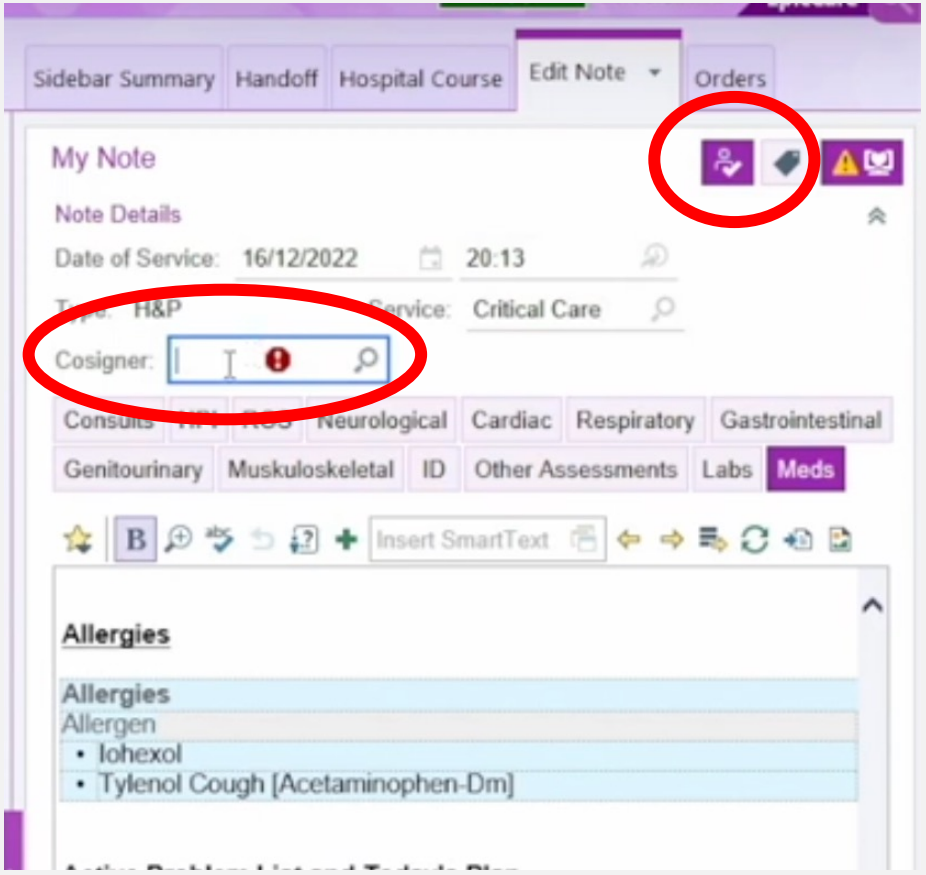
- It is very important to select the associated consult order! If there is no consult order to intensivist, you must place an order and associate it with the note

ICU CONSULTS



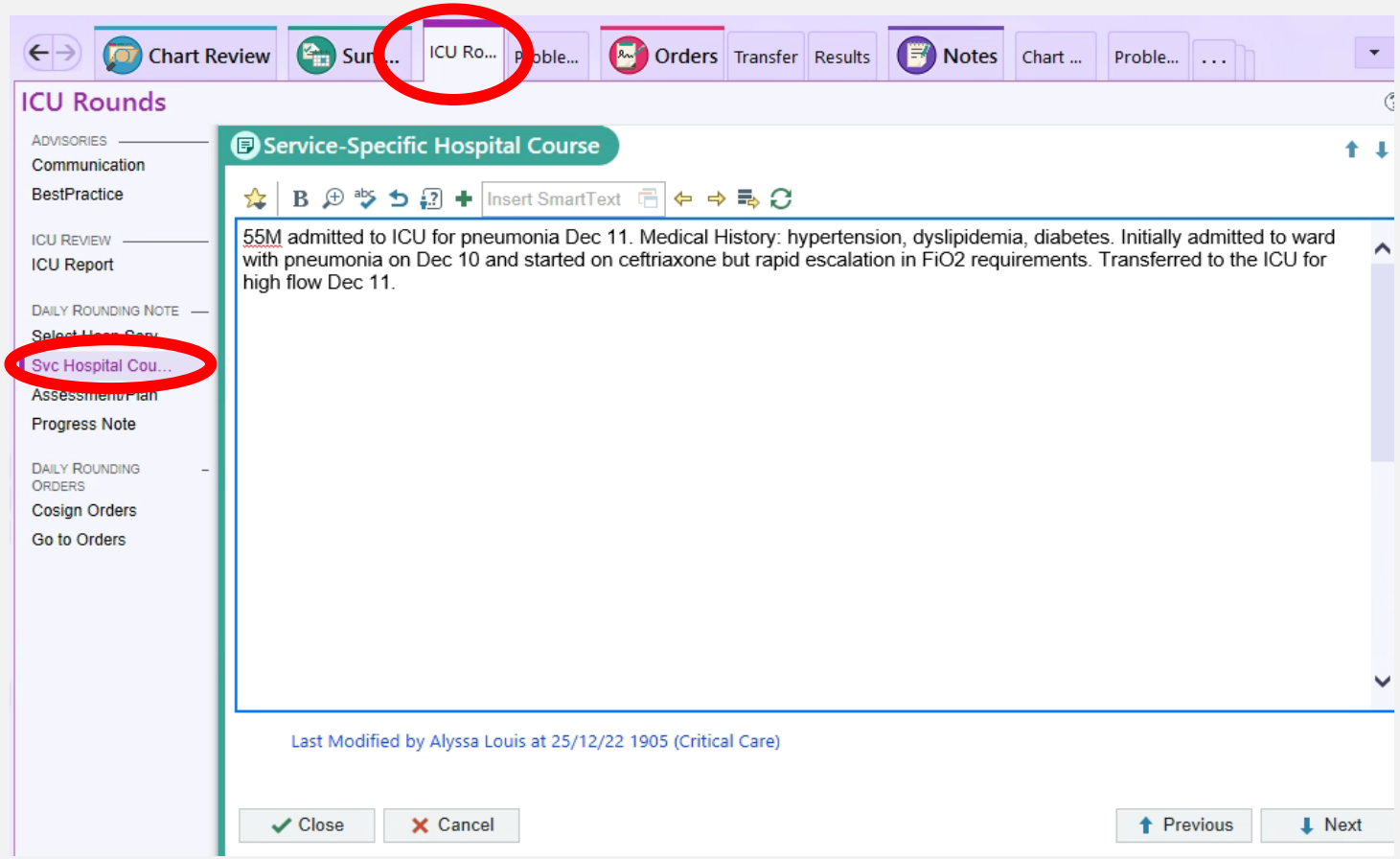
- Create the problem list ensuring that all issues have an assigned priority
- The diamond icon indicates the "principal" problem

ICU CONSULTS



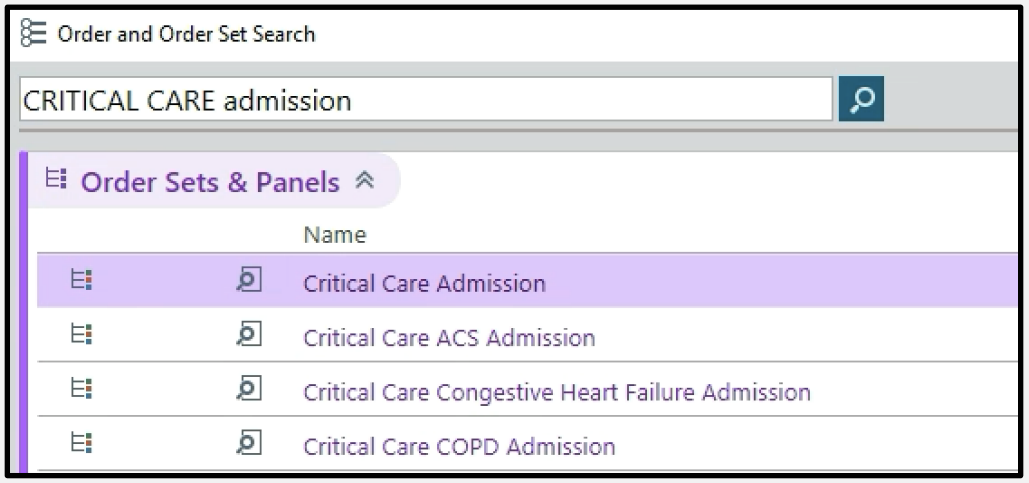
- When you are done the consult note, make sure to refresh the problem list area so that it is updated
- Request cosign from the attending you have reviewed with and sign off on the note

ICU CONSULTS



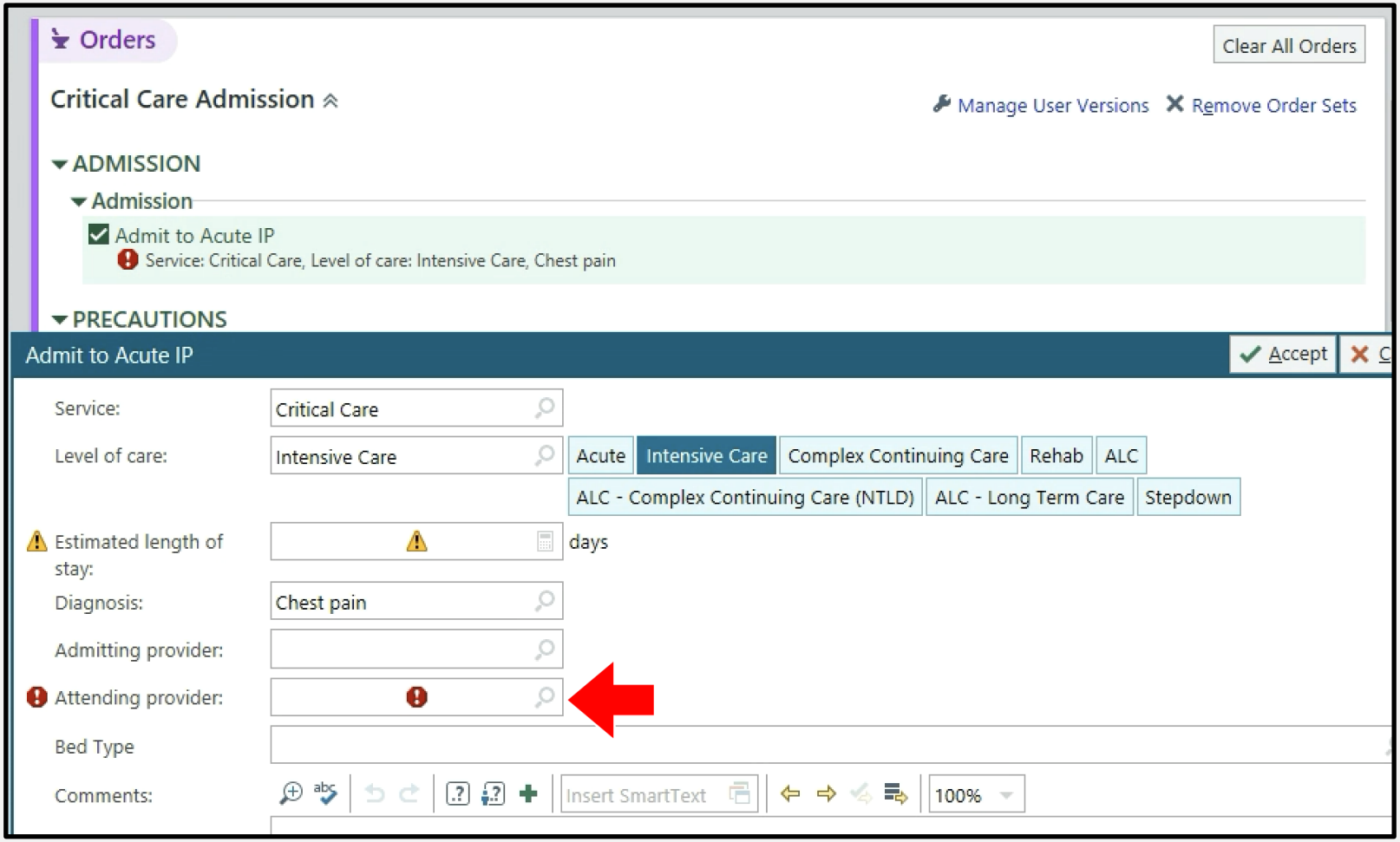
- Add the brief story to the ICU service specific hospital course

ADMITTING PATIENTS TO THE ICU FROM THE ED



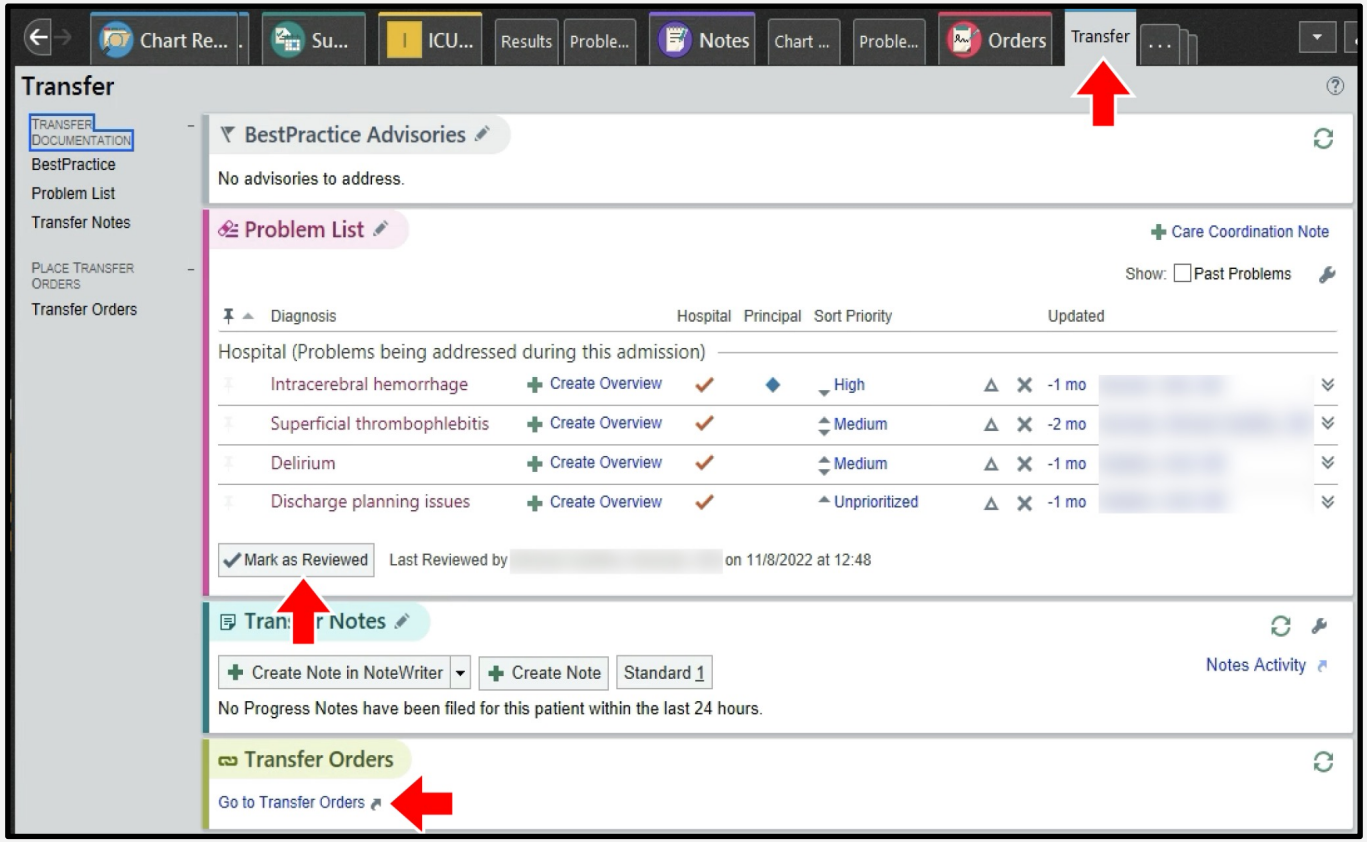
- All orders are done via epic, and there are specific order sets for a variety of common presentations – select the one most appropriate for your patient

ADMITTING PATIENTS TO THE ICU



- Populate the required fields

ADMITTING PATIENTS TO THE ICU FROM THE WARD

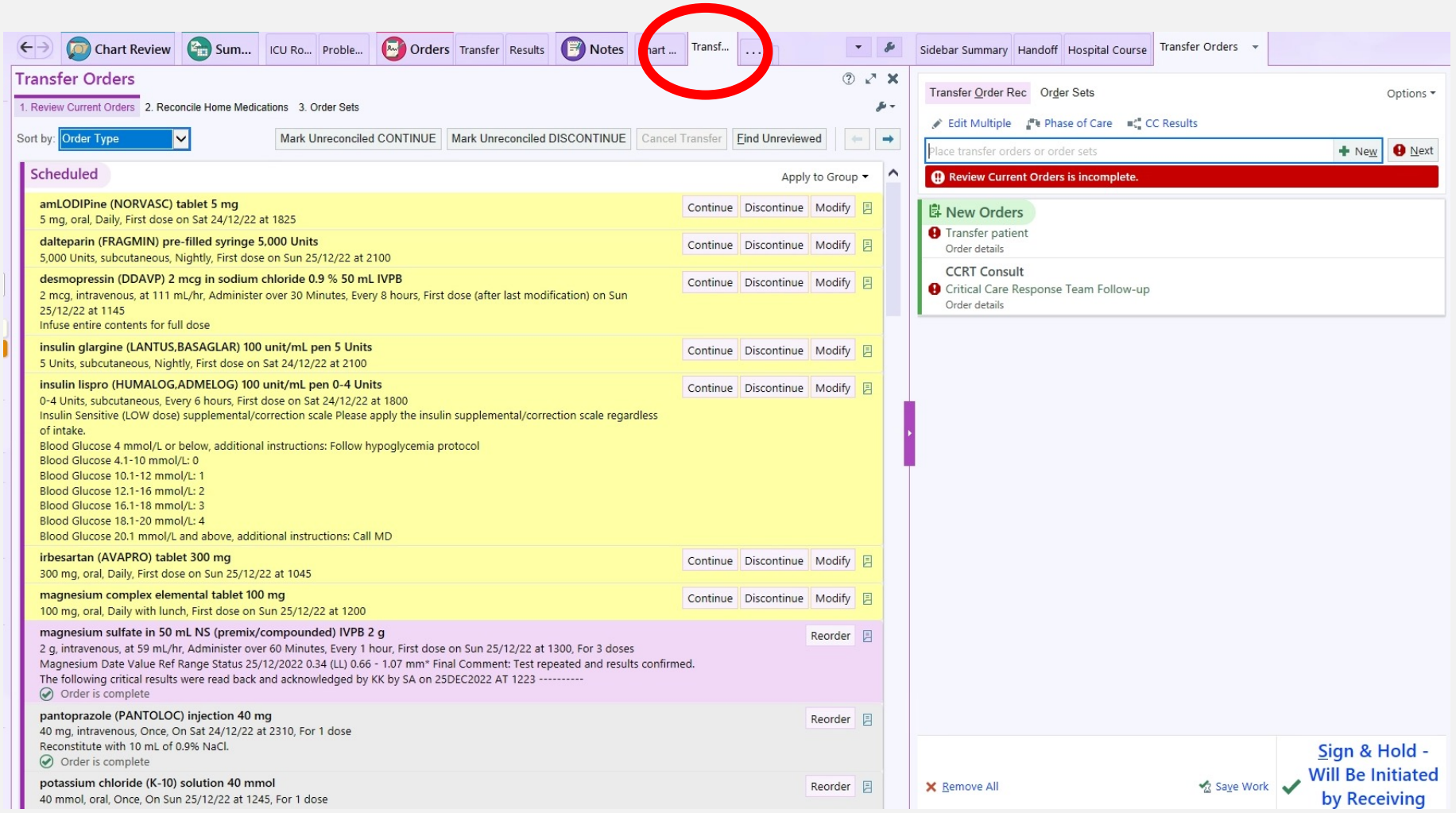


- When transferring a patient to the ICU from the ward, use the transfer tab first to reconcile and clean up orders that are no longer relevant (e.g. your patient who is in hemorrhagic shock will still have their amlodipine ordered if you don't reconcile their prior orders)

TRANSFERS OUT OF ICU

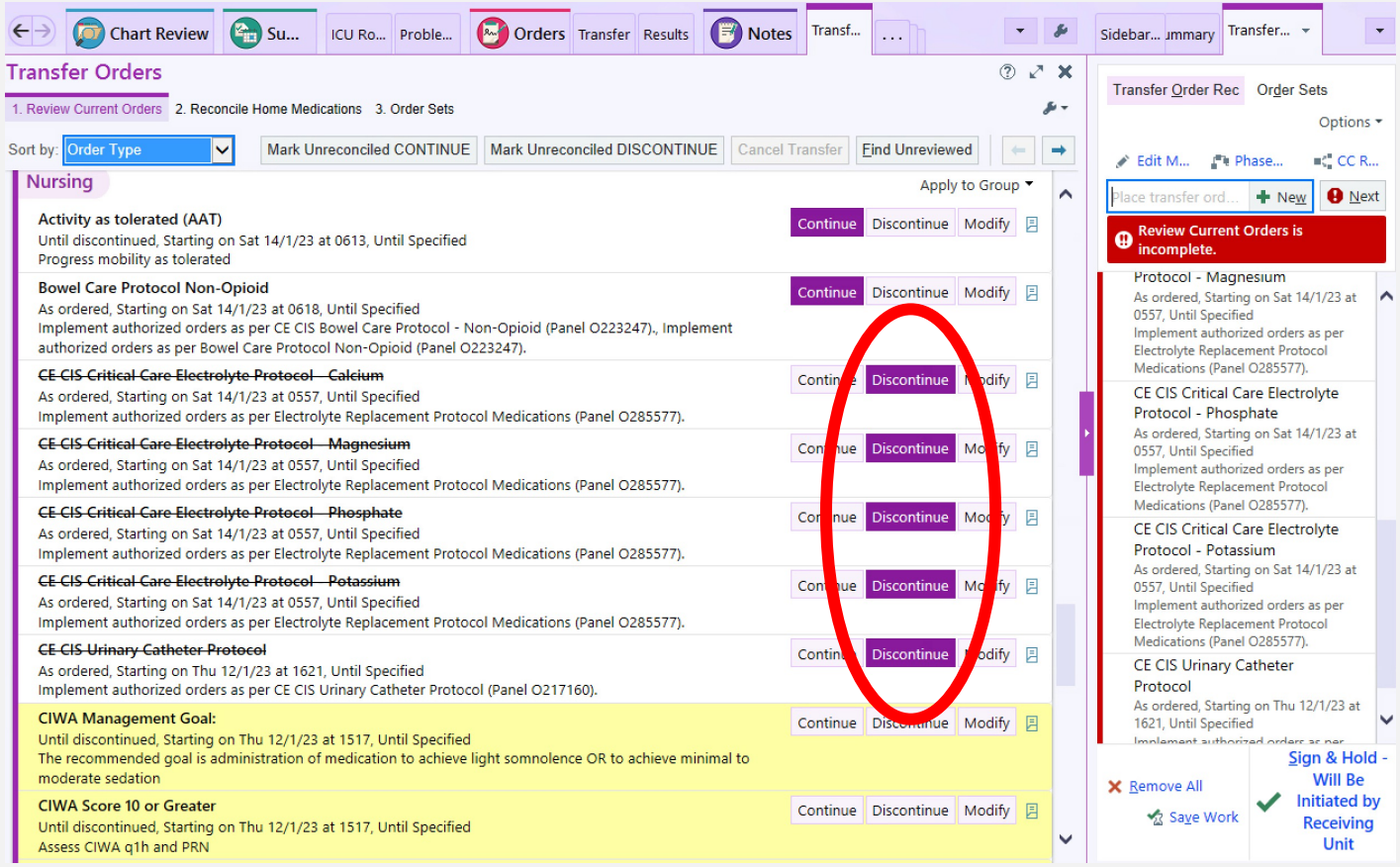
- ICU transfers can occur at any time of day
- When you identify that your patient is stable to be transferred to the ward, place an order and notify the patient's nurse or charge
- Complete and initiate the transfer orders ASAP (it is bad for the patients to have the on-call doing this for patients they are less familiar with – transfers are a big source of medical error)
- When a bed is available, and transfer is imminent the nurse will notify you of the ward the patient is going to
  - double check the transfer orders to ensure no new meds/orders require reconciliation – sometimes the original transfer orders were done *days* prior to transfer
  - Page the hospitalist staff covering the ward they are going to to provide verbal handover "doc to doc" before the patient leaves the ICU **EXCEPT** post op thoracic patients, **DO NOT** call the thoracic surgeons

TRANSFERS OUT OF THE ICU



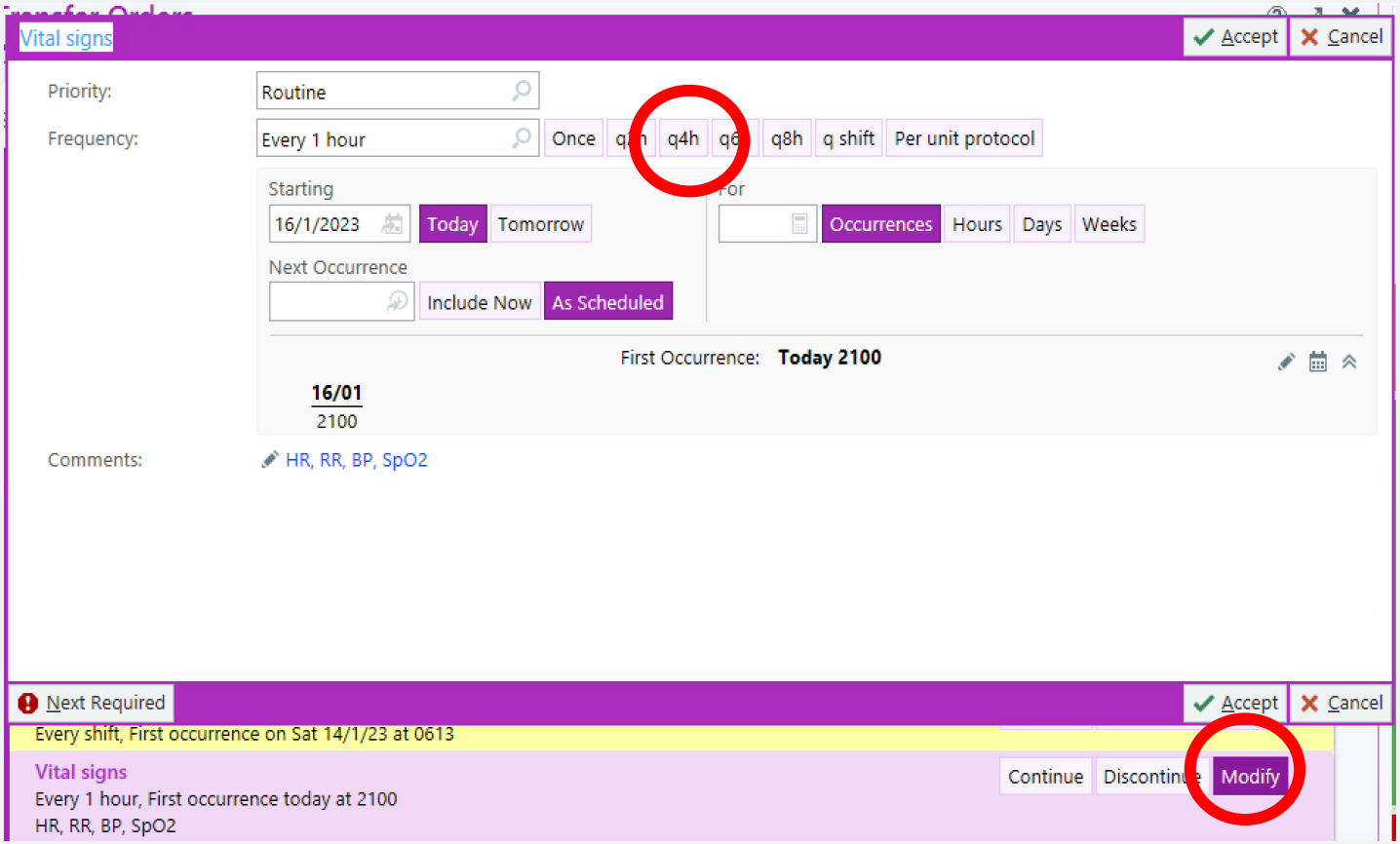
- Please use the transfer tab and reconcile all orders

ICU TRANSFERS



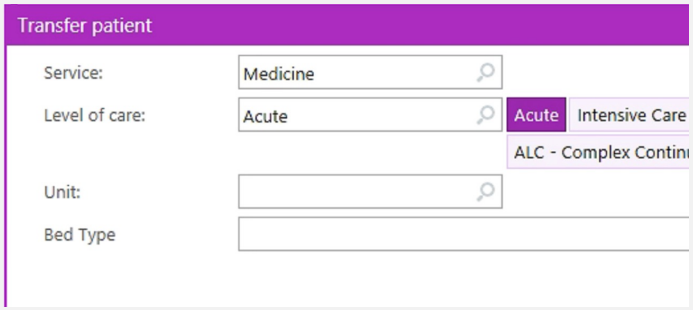
- Ensure to discontinue orders that are labelled "critical care" including electrolyte replacement as well as sedative infusions, PRN fentanyl orders, electrolyte replacement protocols and vasopressors

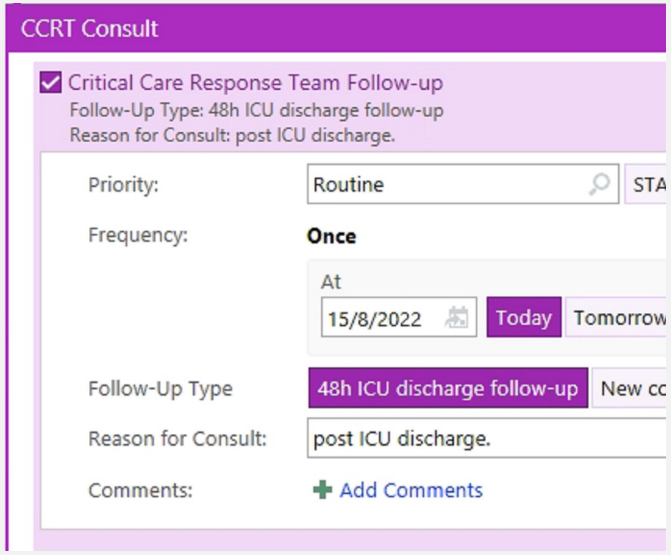
ICU TRANSFERS



- Change vital signs to Q4h
- Discontinue continuous cardiac monitoring (unless your patient actually needs telemetry on the ward)

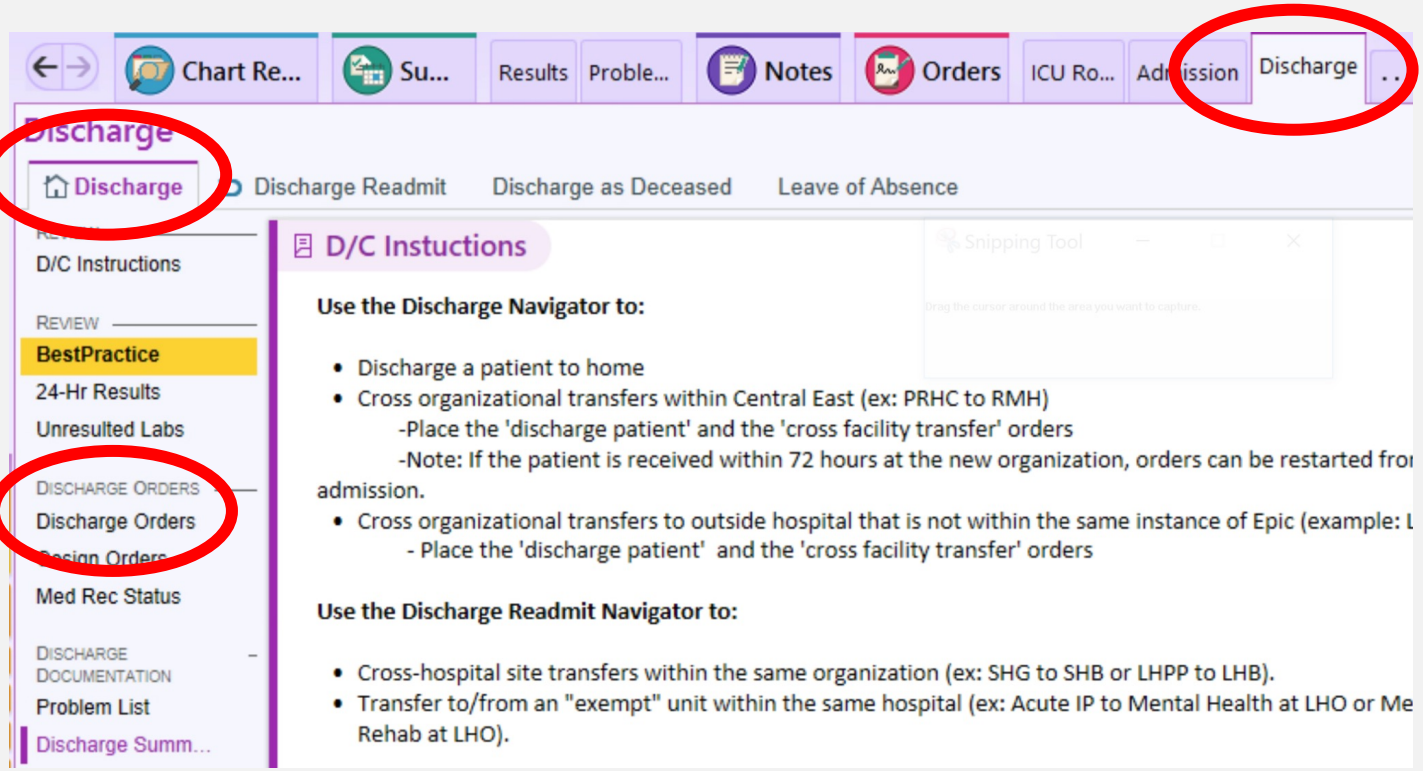
ICU TRANSFERS





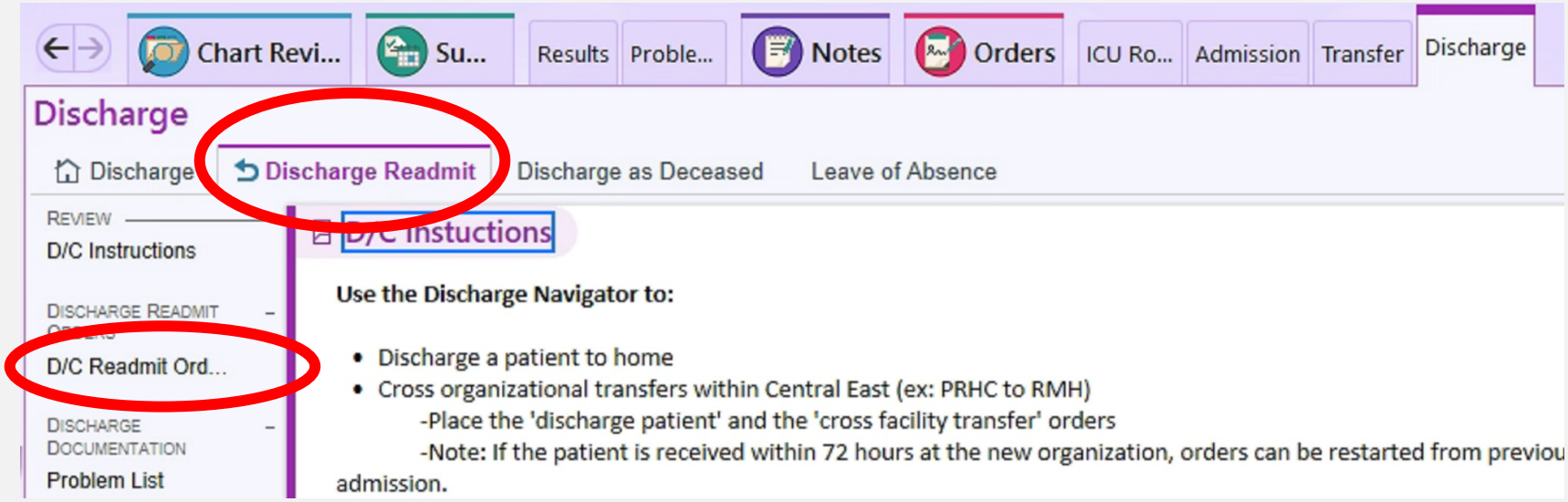
- Complete all relevant fields, and then click sign and hold so that the nurse receiving the patient can initiate them when they arrive at their new unit

ICU DISCHARGES HOME



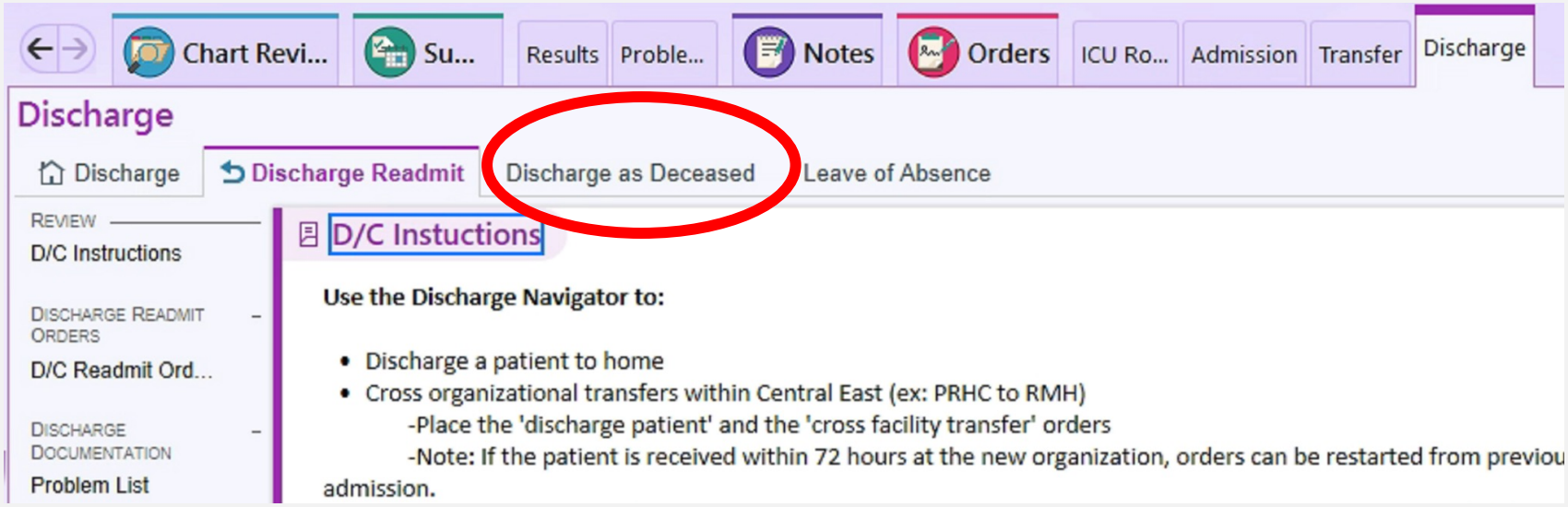
- Please use the discharge tab and discharge orders

ICU DISCHARGES – TO ANOTHER LAKERIDGE HOSPITAL, PSYCHIATRY OR PALLIATIVE



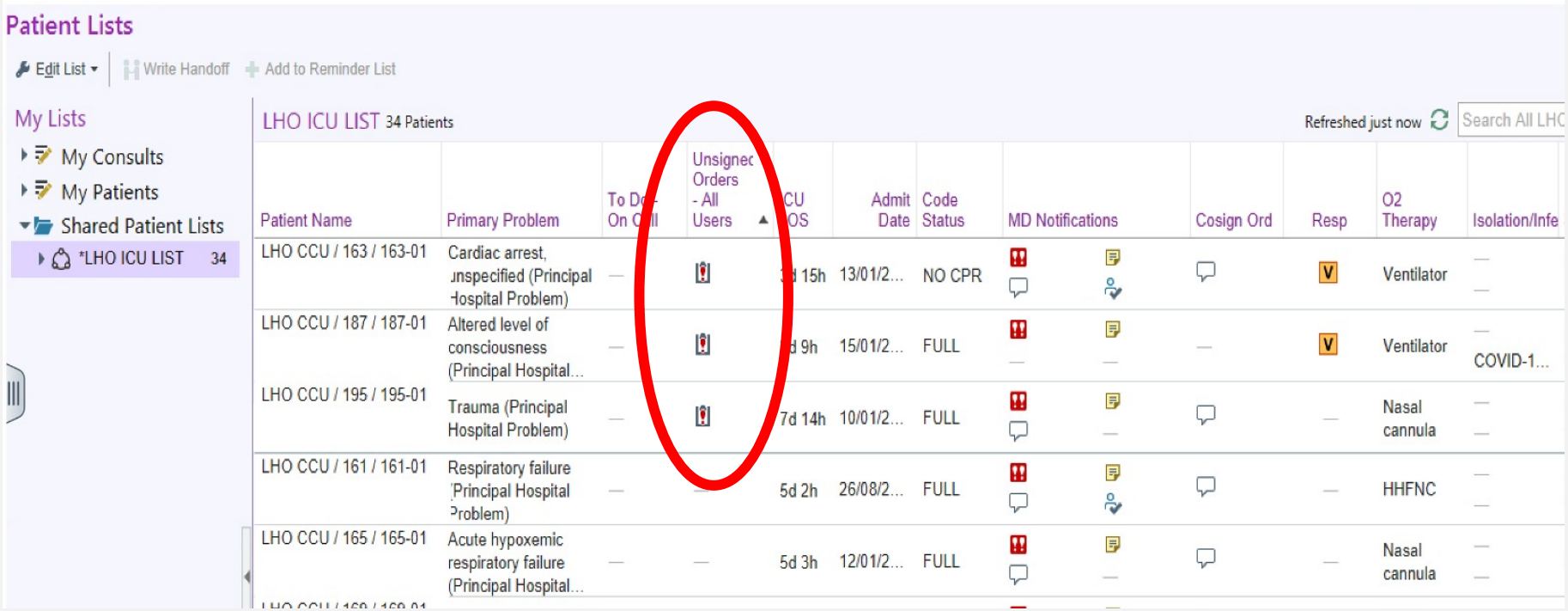
- Use the ”discharge readmit” for transfers to another lakeridge affiliated hospital/ICU, psychiatry or palliative care unit

ICU DISCHARGES – DECEASED



- Please complete your death pronouncement note as a progress note
- Complete a death certificate (unless it is a coroner's case)
- Discharge as deceased for patients who died

PATIENT LIST



- Please regularly check the patient list to see if there are notifications about new or suggested orders (i.e. from consulting services, nursing staff, etc.)
- This is especially important to check during your call shifts

ON CALL

- You are never "alone" there are many layers of backup to support you!
- Usually 2 residents and CCCA on per night (in house), along with one ICU staff (at home, or in-house if no CCCA)
  - Your call schedule was finalized weeks before start of the block
  - Further changes need pre-approval by Dr. Sridhar/Katelyn Barker
  - Notify Dr. Sridhar/ Katelyn Barker of any potential changes ASAP

ON CALL

- 4pm : Sign out in conference room
  - Cover the main issues for each patient
- See all new consults from ER/ward/OR
  - Consults called will be screened by staff → residents then asked to see consult
  - Review all consults with the CCCA or attending staff on call prior to making admission decisions
- ~9pm: Tuck-in rounds with Charge RN
  - Walk bed to bed in main unit and satellite on F6 and address issues, order bloodwork
  - Then review w/ staff via phone if necessary
  - If significant change to patient status/management plan – write a quick progress note in chart
- Call rooms are located outside the main ICU (room 220 and room 222)
- 8am post call morning in conference room
  - Bring the set of new patient lists (from POD 3 clerk's desk) to the conference room

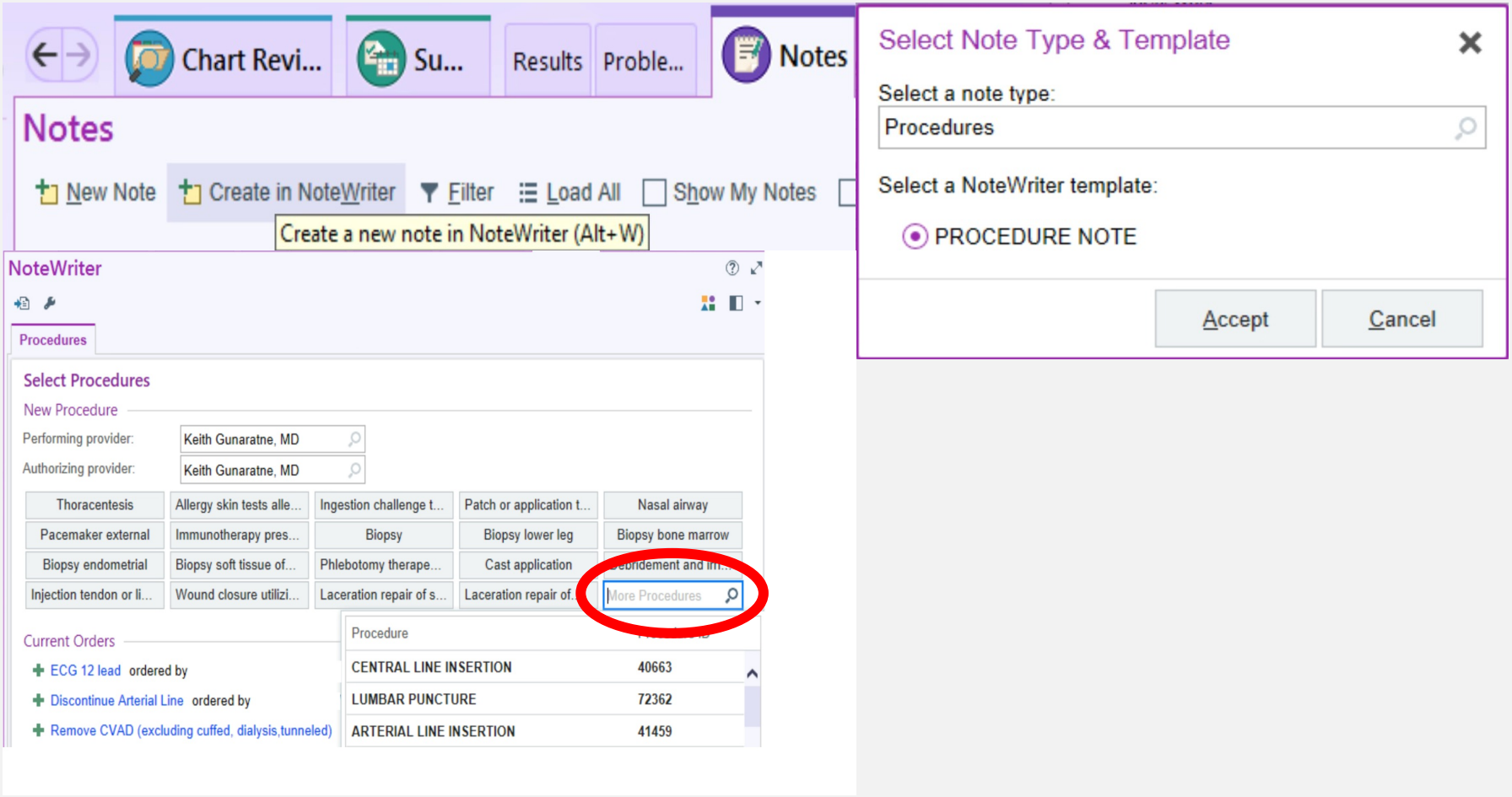
ON CALL

- Carry your pager at all times – this is how you will be contacted via locating
- At night, page CCCA/staff with any concerns and to review new patients (locating also has our cellphone #s if needed)
- Your staff is available 24/7, you can contact them directly as required for support, even on nights when there is a CCCA (and if there are any issues or conflicts that arise that you feel need additional review, reach out to Dr. Sridhar)
- If you are paged directly for a new consult, please direct the call to your attending. He/she will then call you to give you details
- If there are any "big changes" in a patient's status overnight, please write a brief note in EPIC (i.e. new GI bleed, unplanned extubation, seizure, etc.)
- If you are planning to page a subspecialist for a consult overnight, please discuss this with your staff

CODE BLUE

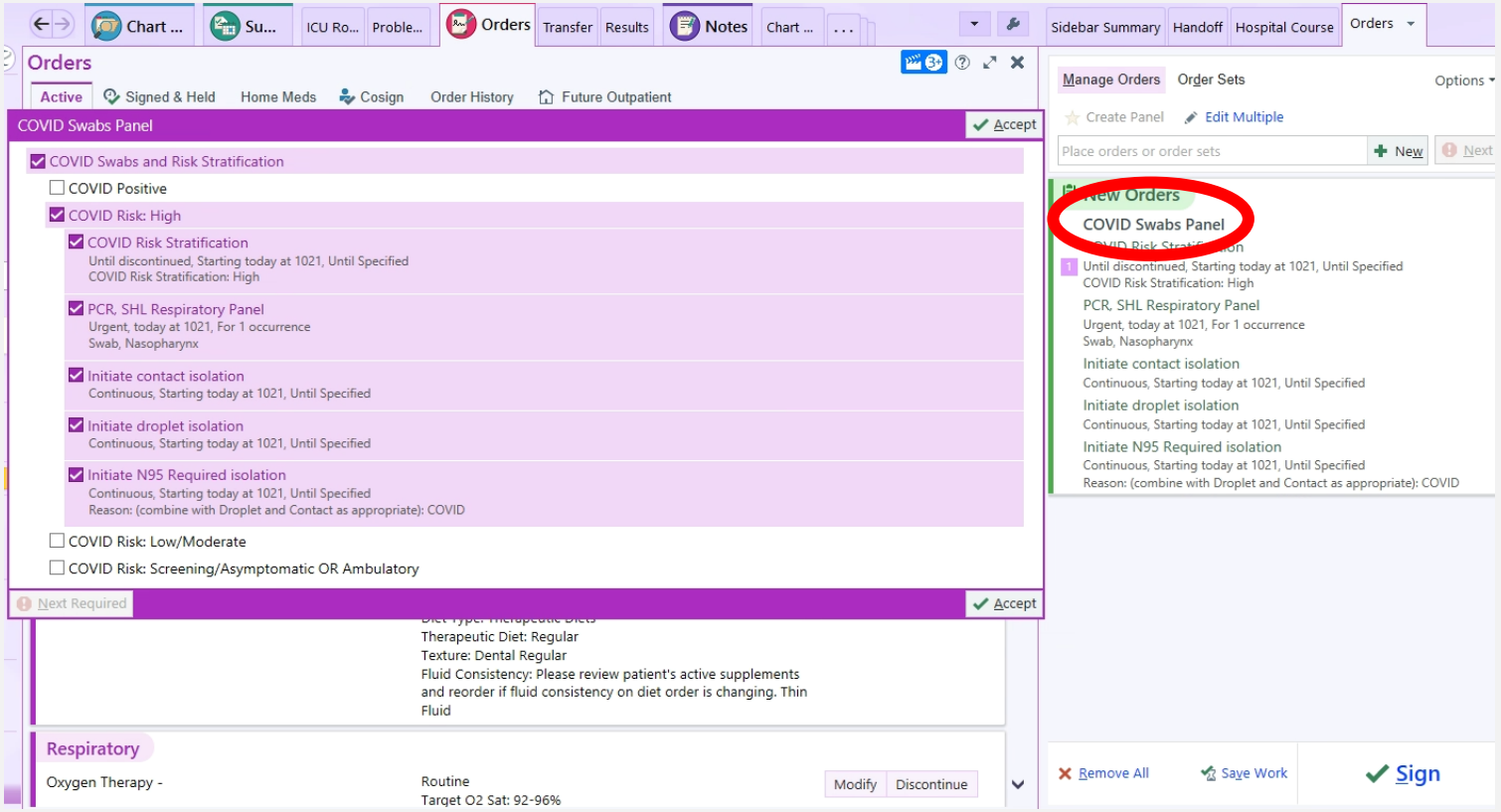
- The CCCA is the code blue team leader outside of the ICU, and the ED staff is the code blue team leader for any 1st floor codes
- As the resident, you are **not** responsible for "CODE BLUE" coverage on wards/ER but will have to take the patient in transfer to the ICU if resuscitation is successful on the wards – so attend them if free (this is a good learning opportunity!)
- You **are responsible** to attend to Code Blue calls in the ICU

PROCEDURE NOTE



- You must document all procedures in EPIC – use the search to find the correct template for central line, arterial line, etc.

COVID



- Every patient being admitted to the ICU needs a "COVID swabs Panel" and a risk level ordered
- Surgical masks must be **<u>worn at all times</u>** in the hospital and we cannot eat or drink coffee in the conference room
- Follow Lakeridge Health IPAC guidelines/PPE signage for all patient interactions/procedures

WHAT TO DO IF YOU ARE SICK

- If you develop any symptoms of illness or become aware you have had a high-risk exposure to COVID-19 **do not come to work**
- Notify your staff, as well as:
  - Education Lead Dr. K. Sridhar: ksridhar@lh.ca
  - Site Coordinator Katelyn Barker: lhregional@queensu.ca
  - Occupational Health: OHnurses@lh.ca

PGY1 IM – AIRWAY / ICU ROTATION

- Scheduled for 2 OR days and 1 RT day
- OR days
  - Must wear lakeridge hospital issued scrubs (if you need access to the scrubs/changeroom, ask at the OR desk)
  - You must be changed and ready to go by 7:15am
  - Goal is to rotate between multiple ORs to maximize airway management experience
  - You are not expected to come to the ICU on your OR day (if you are on call that night, please come for handover at 4pm)
  - Coordinator is Dr. Sam Walsh
- RT day
  - Meet at the ICU RT office room 2-207 outside of POD 1 entrance after handover/morning lecture
  - Knock on the door and let them know you are the resident doing your RT day and they will buddy you with an RT

HAVE A GREAT ROTATION!

- We look forward to having you on our team this block and genuinely hope you have an amazing experience here
- We are happy to complete EPAS (please send them within the week you worked with the staff and remind us if incomplete!)
- Please contact your staff or Dr. Sridhar (ksridhar@lh.ca) with any concerns, questions or feedback