

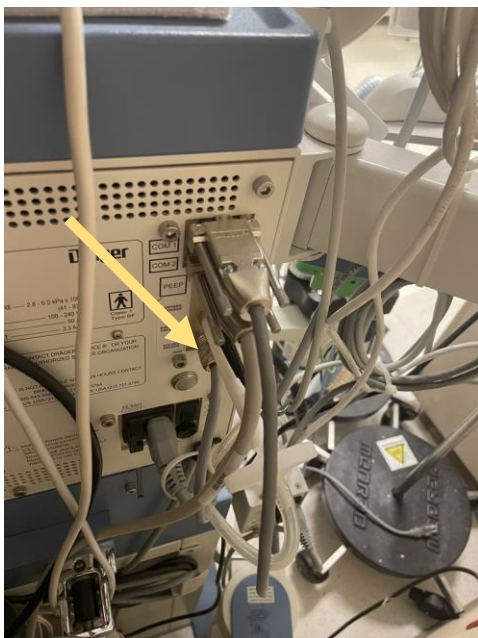
Buyer Beware:

Check supply for ETTs, LMAs, medications you *may* need, temp probes/cables, IV setups, extra suction supplies, circuits, nitrous supply, oxygen supply, BVM, etc as you are remote and something is usually not set up correctly or not stocked. Ensure connectivity to network and gas line hookups.

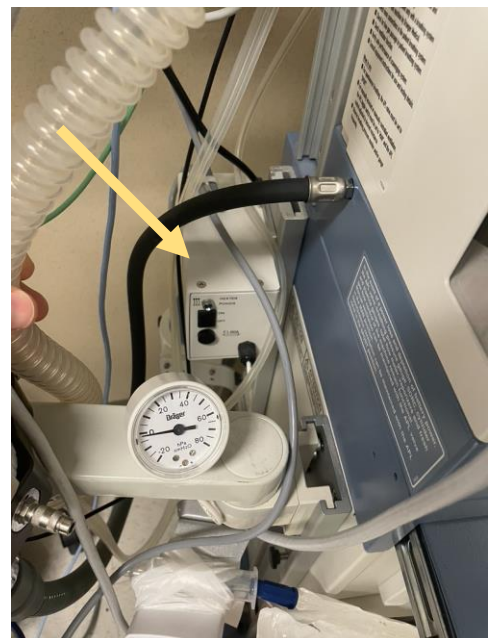
Need wish lists submitted every day to ensure machines/carts are set up in locations.

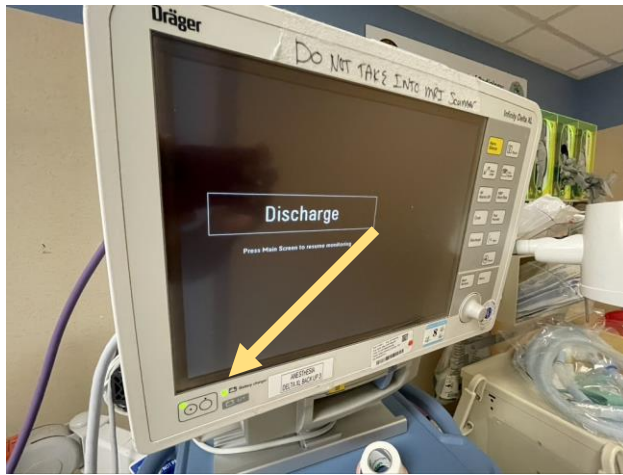
MRI:

1. Upon arrival to MRI control room, fill out MRI screening form from MRI techs to be allowed access to MRI suite (or you can do this before your first day down there).
2. Remove ALL metal
3. 2 machines exist. Do not move them. One is MR safe, the other is not. Test inside machine first with circuit + extenders, then move that circuit to outside machine and test. Ensure MRI machine has tape and accordions available. MRI machine does not have CO2 monitoring line. End tidal will appear on MRI vitals monitor.
4. The outside vitals machine will only be used for pulse ox. MRI has another vitals machine that will be connected for induction.
5. Depending on staff, some will set up med cart by machine vs control room. See pictures below.
6. In general, mask induction>IV>LMA>ensure 100% O2>disconnect from machine, carry circuit/bag into MRI>reconnect to machine.
7. Pt usually starts in PICU, and they will bring them down. Consent patient/parents in the zone before entering
8. No need for post op orders unless going through PACU.



Arrows = main power buttons for machine





Arrows for power buttons for machine and monitor (After main power is turned on)



In these two pictures, the med cart can be configured either by the machine (code cart must be moved, ask MRI tech) or it can be placed across the room as seen in the R picture by the MRI bulk cart and glidescope.
*Staff preference. R picture makes more sense if you are not alone.



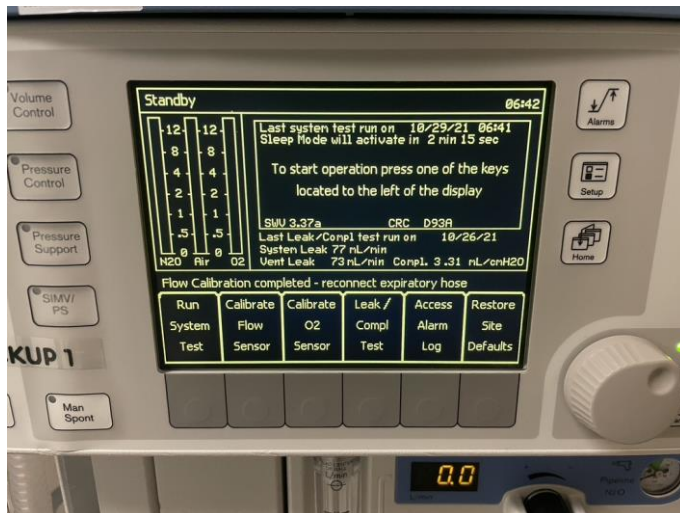
Below is vitals monitor in MRI control room. Turn on prior to trending in Innovian



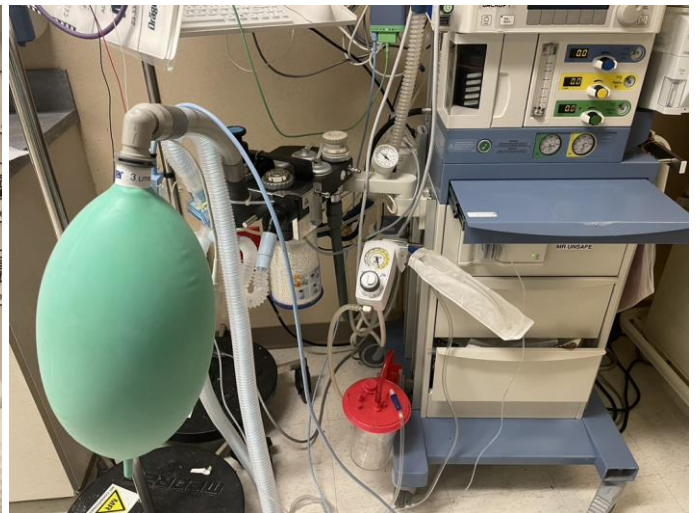
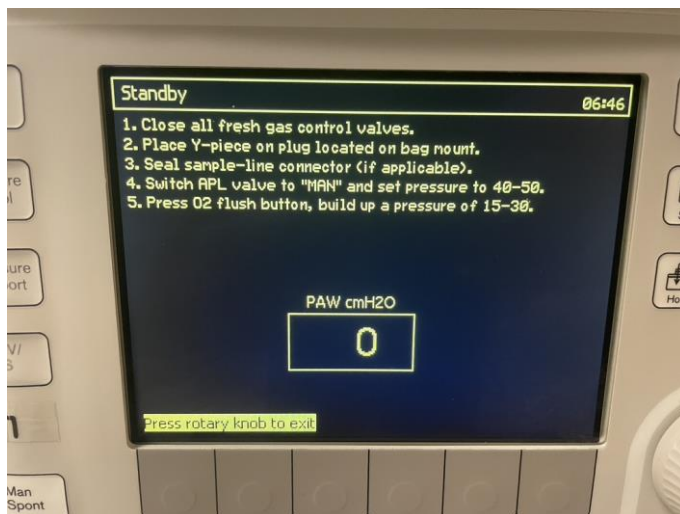
Testing MRI Machine.

Begin Left to Right. Follow prompts.

1. Run System Test (watch Matrix happen on machine)
2. Calibrate Flow Sensor (remove expiratory hose on circuit and proceed)
3. Calibrate O2 Sensor (remove O2 sensor and replace when prompted. It's blue and labeled)



4. Leak/Comp test (Close APL to 40 and slowly use purge valve to increase bag pressure until ~ 20cm H2O attained and machine will take over and begin test). Ensure seals are tight and extensions are extended as troubleshooting tips. May need to replace circuit if failing.



PICU:

1. Set up machine in second room on left. First is patient arrival and consent room.
2. No need for post op orders as don't go through PACU
3. Perform own turnovers, load intraop chart, postop note. Quick turnovers. As such, prep IV kits/bags, meds, supplies for each case in the morning unless you have slow cases (i.e. ABR)
4. In general, +/-premed >mask induction>IV>LMA. Charting staff may complete if rapid case. US is available for IVs, just ask PICU.

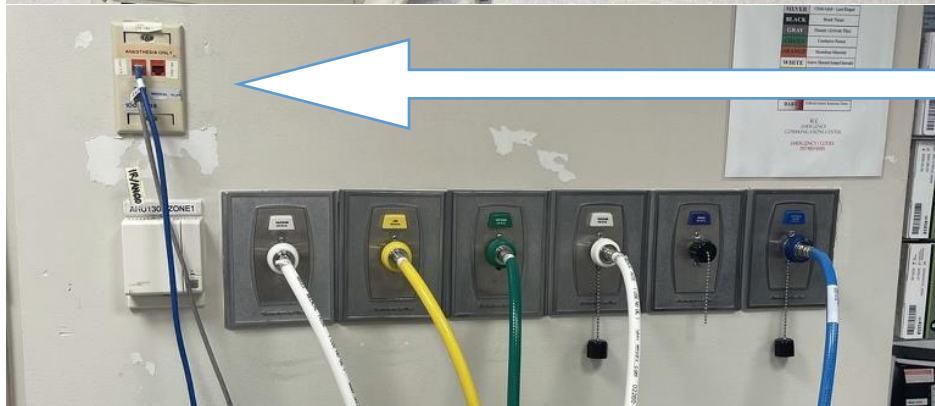
>Internet port is on wall behind med cart (arrow)

>Can usually place bulk cart by trash can in below picture



IR:

1. Patient starts in pre-op. Can consent/IV in main OR preop or in IR preop bay.
2. See pictures for setup.
3. IR suite is on right when entering IR. Avoid entering through double doors to IR suite after they start opening kits. Buddy up to IR support staff. They will take care of you.



<Internet port. May need to switch ports on computer/wall in order to find one that works.

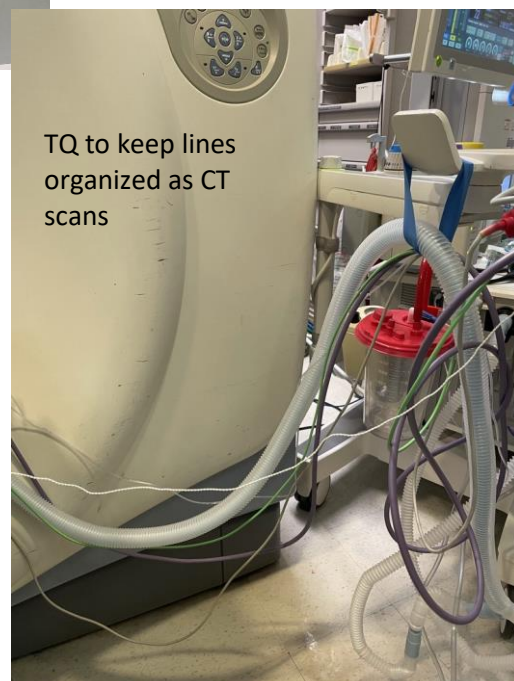
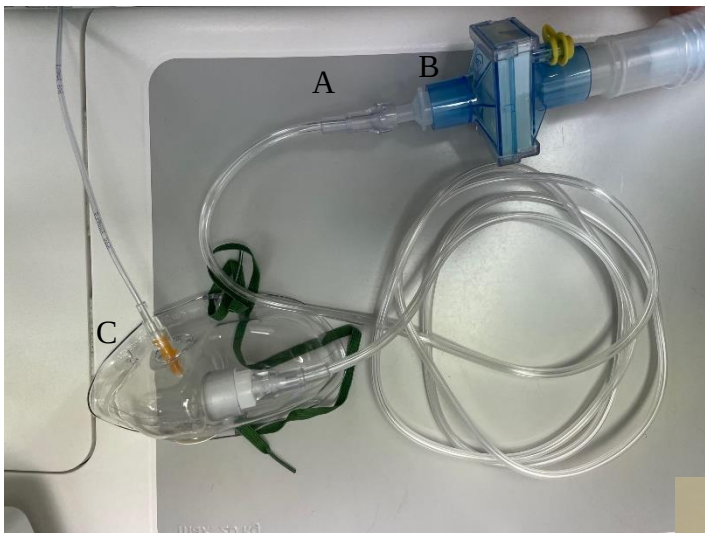
CT:

1. The first door on R is the CT you use, next to IR, not the ED CT machine.
2. Machine is pinned to R side of CT machine due to gas line stretch to wall behind. There really is only one way for the techs to set it up.
3. Will need extensions to circuit if doing general. Extensions to oxygen supply if doing MAC. Oxygen line can be extended via below picture as one option:

A>6.0 ETT connector shoved into end of non-rebreather mask oxygen line (The end you would normally connect to auxiliary oxygen port on machine)

B>Connect regular circuit to ETT piece to marry machine to oxygen line to provide oxygen flow via normal flow valves on machine.

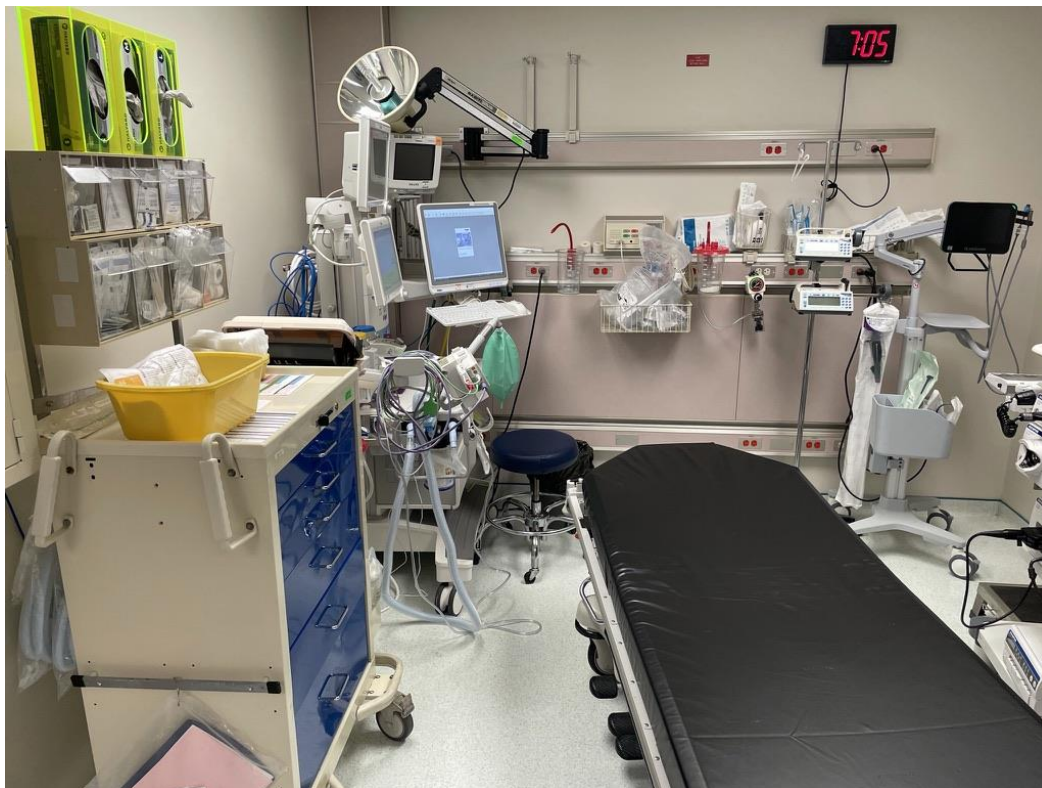
C>Connect CO2 sampling line from machine to face mask using 14G catheter hub



TQ to keep lines
organized as CT
scans

PULM:

1. Rarely used. Machine is present. Supplies/connections double check
2. Will need bronchoscope adapter for LMA. Found on airway cart top clear bin. Pulm has extra
3. See pictures for room set-up.
4. Located down main hallway of pulm clinic on R side in negative pressure room.



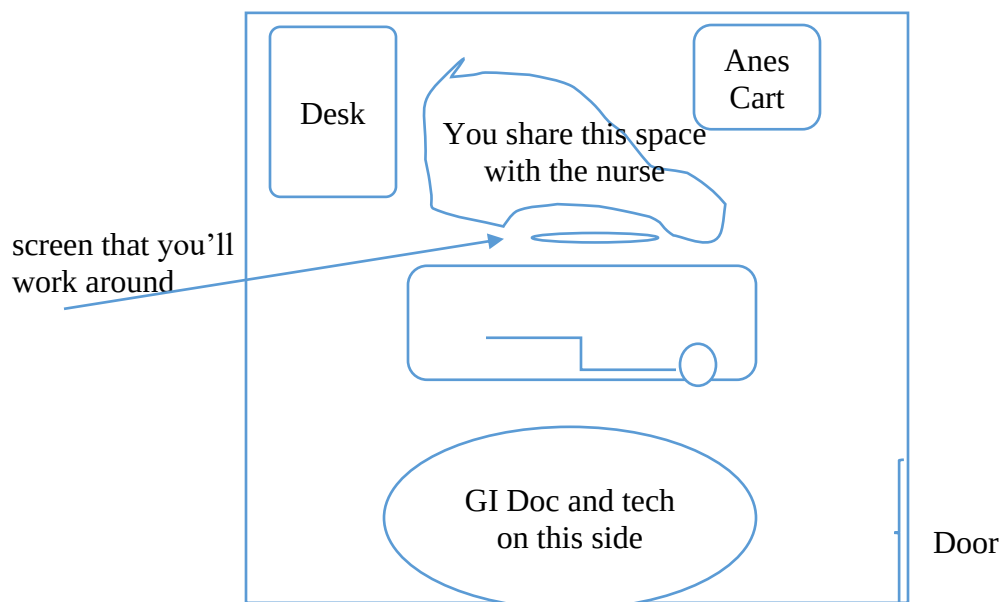
<Bronch adapter

Internet port>



GI:

1. No Anesthesia machine will be in GI! Request a cart, syringe or alaris pump +/- glidescope/FO scope on wishlist (it is never wrong to have the glidescope since you won't really have back up. Propofol +/- Fentanyl/Versed will be the plan *most* of the time. EGDs are more invasive + stimulating than colonoscopy alone.
2. Patients will NOT have Essentris records. Paper charting only in GI. Pick up their records in the normal pre-op filing cabinet and review their records in AHLTA. White chart goes to GI clinic along with consent form, yellow chart is filed in pre-op filing cabinet after case.
3. Use a POM mask for EGD (they will stock them in GI clinic in the cabinet above the nurse computer. Ask if you don't see any and they will get some for you) that allows O2 by facemask with a space for the scope to go in. You can use NC with ETCO2 monitoring for colonoscopy.
4. GI team will usually get IV and recover the patient (no orders necessary), just make sure you fill out and get a staff signature on paper pre-eval, intra-op record + postop eval (with pre and postop vitals).



EP Lab

1. Across from entrance to Ward 3B, in the operating room to the left as you walk through the double doors
2. Put in a wishlist for a machine, cart, glidescope, bair hugger, adjuncts
3. Communicate with Cardiology team as they will hook up their monitors and position before you do anything to the patient. Do not put on monitors preop. Usually wait to give versed until patient is in the lab on the table and getting the cardiac monitors on (they have a lot to hook up and they don't want the patient getting sleepy and falling off the table).
4. Machine goes into the back right corner of room as you walk in. Machine computer should work and trend vitals. You will not be in a position where you could reach the patient with the circuit until after cardiology team is done. Communication is key.
5. Patient goes to preop area and will likely be in a PACU bay (ask up front for the EP lab patient), where you can consent before they head down to EP lab. Preop nurse will get an IV unless you beat them to it or ask to do it.

Rad Onc

1. Go down the stairs nearest to Preop/Resident room to the first floor and go down the hallway to your right, then take the first right. You will see radiation oncology on your left.
2. There are two rooms. An initial room where they do mapping for the treatments that is the first on your left, and one straight down from where you entered for the successive treatments. Both have heavy, slow moving doors and the monitors inside do not communicate with the screens in the room (behind those heavy doors) where you will be during the case. They have a camera trained on the anesthesia machine screen so that you can kind of follow the ETCO2 tracing, and maybe make out the heart rate and blood pressure.
3. These are very quick cases (5-10min) for which the patient CANNOT move. They will have an inflatable mold holding them in place. Anesthesia machine goes to the left of the machine in the first room and in the leftside corner in the second. You will likely run some propofol and ride it out.
4. Pediatric patients come through PICU (upload your own record, do your own post-eval but no orders necessary).