Welcome to the George Washington University ICU
Your rotation

- will be a great experience
- very different from your usual duties

You will learn a great deal

You will become comfortable with caring for critically ill patients
Our ICU is multidisciplinary
- Patients are under the care of the ICU housestaff, usually in collaboration with the admitting service
- Medical, Surgical, Neuro and Neurosurgical Patients

Communicate with the admitting service
- Coordinate care, avoid duplication of efforts
- Essential when significant changes in clinical status occur

Only ICU Team and occasionally admitting service are allowed to write orders
ICU TEAM COMPONENTS

- Attending (Monday switch)
  - ICU 5 Attending
  - ICU 4 Attending

- Critical Care Fellow (Thursday switch)

- 4-5 Residents
  - Anesthesia, Surgery, Medicine

- 4-6 Interns
  - Anesthesia, ER, OB, Medicine, Surgery

- ICU Physician Assistants

- 4th year medical students

- Night Fellow

- Night Attending
Intern Schedule

- **Dayfloat:** 6a-8p
- **Nightfloat:** 8p-6a Sun-Thur
  - Friday night and Saturday night intern must stay until they finish rounds on Sat/Sun (16 hour limit)
  - As the night intern you will not be on call on consecutive Friday/Saturday nights to avoid 2 16 hour shifts back to back
Intern schedule continued

- If it is M-F and you are not listed as day or night, you work a regular day
  - Come in for rounds, leave after afternoon signout
  - Details on daily routine later in this presentation
- Off days weekends (if not on day/night shift /weekend rounder you do not come in)
  - Occasionally you will be given a weekday off in order to have enough weekend coverage
Weekend Rounder

- Comes in only for rounds and to write notes on Sat/Sun
- We try to have one both days but don’t always have enough staff
- The role of this person is to dec the number of notes the post-call resident and night intern write so that we can get them out on time.
- This person is usually an intern but may be a resident as well
Resident Schedule

- Generally Q4 overnight
- 28 hour limit now
- Come in at 8am all days except Sunday**
  - No prerounding except for Sunday
  - **If there is a weekend rounder on Sunday the on call resident does not preround
- Stay until noon the next day
  - When post-call on Monday, must leave after 28 hours (roughly 10AM) which means you must round on the 5th floor patients only
DAILY SCHEDULE

0630-0800 – Housestaff pre-round

- Review overnight events
- Patient exams and review of pertinent data
  - labs, consults, X-rays, ventilator adjustments, medication changes, extubations, transfusions, etc..
- MUST document:
  - Cultures
  - Antibiotics
  - Line day #
DAILY SCHEDULE

- **0800-1130 – Rounds (08:30 on Sat-Sun)**
  - Interns/students transport barge
  - Interns not presenting are responsible for finding the chart for the next patient, ask the nurse to join rounds
  - Order writing is done by anyone not presenting
    - If you have any questions about what to order or you missed something, **ASK**
  - Everyone assists in calling in tests, consults, gathering additional information, keeping rounds moving

- **YOU MUST PAY ATTENTION, even when it's not your patient**

- New admissions are presented in H&P format
- All others in ICU Standard Progress note format
DAILY SCHEDULE

- **1130 – 1200**
  - Signout then post-call resident is sent home

- **1200 – 1300 Lunch**

- **Conference Tu, Wed, Friday 8-9 am, Rm 6121 Rounds begin afterwards.**
  - Tuesday/Wednesday – Fellow lecture
  - Friday – Attending Case Conference
DAILY SCHEDULE

- 1300 – 1630
  - Work time

- 1600-1700 – Evening signout
  - Review events of afternoon, lab studies, radiology
  - Establish plan for overnight
  - Non-call housestaff leave

- The goal is to get non-call housestaff out before 1700, but *the patients come first*
  - Help each other! If the fellow and on call residents are busy with admissions, it may delay signout…
Admissions

- All admissions go through ICU (DUCK) Pager 741-1234

- Duck Pager
  - Carried by the ICUPA 7:00am - noon
  - Carried by the fellow noon to 7:00 am

- On call team sees admissions in the ER and Floor
- PACU admits seen by anyone

- OVERALL GOAL: Take care of patients
DAILY SCHEDULE

Night Call Intern / Student

- Responsible for DAILY updates of cultures and antibiotics
- Final list update by 6am
- Please have new patients added to the list in the evening by 6pm as well
Admissions

- The charge nurse (Ext 6130) must be notified ASAP when an admission is likely
  - Usually notified by the fellow

- The fellow must be notified for every admission

- Admitting intern or resident is responsible for ensuring the patient's primary care physician and family are aware of the ICU admission
**Notes**

- H&P for all patients admitted through ED or outside hospital
- ICU accept note for PACU patients or floor transfers
- Don’t forget to assign notes to an attending.
  - Any notes done in the afternoon should be assigned to the night attending.
Labs

- Do not assume that every patient needs every lab test every day
  - AVOID MEDICAL VAMPIRISM
  - If you're not sure on rounds…ask

- Not every patient needs a daily chest X-ray

- Very few vent changes require an ABG

- Not all patients need arterial and / or central lines
Procedures

- Safety is the primary concern

- Do not attempt a procedure that you are not familiar with or certain about

  GET HELP

- All invasive procedures require a standard procedure note in SALAR

- No intern is to be doing procedures unsupervised by a resident, fellow or PA!!!!
Infection Control
Wash your hands before you start!

5 steps to clean hands

1. Use soap and running water
2. Rub your hands vigorously for 10-15 seconds
3. Wash all surfaces: backs of hands, wrists between fingers under nails
4. Rinse well
5. Dry hands with a disposable paper towel

Germ Farm

Scrub'em!
Preferred practices
Preferred practices
Clean up your mess
Bad form
Antibiotic rotation

- Broad spectrum for empiric sepsis
  - Changes every 3 months
    - cefipime (Maxipime)
    - imipenem/cilastatin (Primaxin)
    - piperacillin/tazobactam (Zosyn)
    - If you want one that is not on rotation you must get ID approval

- Broad spectrum Gram +
  - No rotation
  - Vancomycin
  - Linezolid
  - Daptomycin (remember no lung penetration)
  - Tigecycline
Discharges

- **Transfer notes - Medicine ONLY**
  - When pt has been here OVER 48 hrs
  - summarize important events and ongoing issues
  - provide information essential for continuity of care

- Transfers to surgical services do not need transfer notes
Dress Code

- You are doctors and adults, dress professionally.
  - Scrubs are appropriate
  - Not mixed with street clothes
  - White coat not mandatory

- Nose, lip, and tongue piercings must be discrete and tasteful
Nursing

- ICU nurses work here permanently
- You are the visitor
- If a nurse questions an order, always reconsider it
- There is a charge nurse for every shift x6130
  - They are chosen for their experience, and are a valuable resource for both in unit operations and specific patient difficulties
Nursing

- Nursing shift changes occur at 0700-0730 and 1900-1930
- An important time to relay patient information
- Do not interrupt the nurses or take charts at this time
- The entire report on a particular patient takes about 10 minutes if the nurses are not interrupted
Nursing

- Provide valuable information about patients
- Usually present on rounds
- Keep nurses informed
- Tell them about any new orders
- Make room for the nurse on the barge!
Relations with other services

- Keep the primary service informed of status

- Do not engage in prolonged controversies with consultants

- Involve the fellows, who can mediate and facilitate a spectrum of clinical and personal issues.
Relations with families

- Be careful about the information you provide to families, especially concerning prognosis.
- When families are frustrated or hostile, allow the fellow or attending to speak with them to avoid mixed messages whenever possible.
- Keep the case manager informed about family dynamics.
- If you are uncomfortable or unsure about discussions involving prognosis.
- On your patients... please update family daily with a quick phone call.
Ventilators

- Respiratory therapists are in charge of all ventilators and O2 equipment 24/7
- They assist with treatment decisions, assist with intubations, extubations, and codes

- Only the ICU attending and fellow may make ventilator changes
- All others must inform the respiratory therapist
- Make sure that the nurse is aware of all ventilator changes.
- Write orders for all vent setting changes
Code Blue

- ICU team attends all codes
- Call the team if anyone is missing
- If no one else has taken charge – you do it
- On the floor – attendance will depend on time of day
  - Critical care nurse always present to help you out
  - An anesthesiologist will arrive quickly
  - Eventually you will likely take the patient to the ICU so stick around
- In ICU – the attending, fellow, or resident is in charge
ICUPA Service

- In house 7am-7pm, daily, 365 days/year
- Sees new consults and admissions 7AM-12PM
- Admissions to ICU2 will be followed by PA Service during the day and the PA or ICU2 moonlighter at night.
  - If you are called about an ICU2 patient first ask if it is an urgent/emergent problem. If so…go help. If not, direct the nurse politely to the PA phone (6137)
- PA Service may admit patients to ICU5 or ICU4 during rounds, will hand patients off to main team
GOLD Team Consults

- All Gold Team patients on a ventilator are required to have an ICU consult
- Overnight consults should be seen by the Night fellow
- Resident DOES NOT do the official consult
- Consult notes should be done by the fellow or PA (Depending on floor)
- Please add/ensure consults are on the census
Deaths

- The death packet MUST be filled out (Pink papers)
- The physician section NEEDS to be filled out by the person pronouncing death = YOU
  - Time of death recorded in progress notes
  - Family notified – do not forget to ask about autopsy so we can avoid repeat calls
  - Attending notified – document once you tell the fellow
  - Autopsy ? – Ask the family
  - Call medical examiner if appropriate – LIST in packet
  - ANY death from trauma, ICH or ETOH MUST be reported to medical examiner
- Fellows / Attendings are responsible for signing death certificate and causes of death
- The intern or resident on for the day will usually be assigned the discharge summary
# DEATH CHECKLIST AND INFORMATION SHEET

<table>
<thead>
<tr>
<th>RN RESPONSIBILITY</th>
<th>DATE</th>
<th>TIME</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admitting Dept notified.</td>
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<tr>
<td>3. House Operations Supervisor or Director/designee notified</td>
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<tr>
<td>5. Body to morgue</td>
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<table>
<thead>
<tr>
<th>PHYSICIAN PRONOUNCING DEATH RESPONSIBILITY</th>
<th>DATE</th>
<th>TIME</th>
<th>SIGNATURE</th>
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<tbody>
<tr>
<td>1. PRINT NAME OF PRONOUNCER:</td>
<td></td>
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<tr>
<td>2. DC License Number if applicable:</td>
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<tr>
<td>3. Time of death recorded in progress note:</td>
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<tr>
<td>Time of death:</td>
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<td>4. Attending physician notified</td>
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<tr>
<td>5. Family notified (or verification that family will be notified by another physician i.e. attending)</td>
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<tr>
<td>6. FOR EVERY PATIENT, Medical Examiner (OCME)* sheet (pg 3 of death packet) must be reviewed and OCME notified when appropriate. Medical Examiner = 202-698-9000</td>
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<tr>
<td>7. FOR EVERY PATIENT, autopsy requested if not a Medical Examiner’s case (form “Disposition of Remains”)</td>
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<tr>
<td>8. DO NOT SIGN THE ACTUAL DEATH CERTIFICATE UNLESS YOU ARE A PHYSICIAN LICENSED IN DC</td>
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<thead>
<tr>
<th>ATTENDING PHYSICIAN OR PHYSICIAN WITH CURRENT D.C. LICENSE RESPONSIBILITY</th>
<th>DATE</th>
<th>TIME</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ON OFFICIAL DEATH CERTIFICATE:</td>
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<tr>
<td>SIGN NAME ONLY ON LINE 45 – ALL OTHER INFORMATION MUST BE TYPED</td>
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<tr>
<td>2. Complete CAUSE OF DEATH information on page 2 of GWUH death packet</td>
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*If patient meets Medical Examiner acceptance criteria, please inform family that they will be called by the Medical Examiner’s office and that someone will need to identify the body at their office. The person identifying the body can be anyone who can definitively identify the body and give patient’s full name. The person identifying the body, also, must have identification of their own.

<table>
<thead>
<tr>
<th>EMERGENCY DEPARTMENT STAFF</th>
<th>DATE</th>
<th>TIME</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL EXAMINER NOTIFIED</td>
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<tr>
<td>2ND DISTRICT NOTIFIED</td>
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Evaluations

- After 2 weeks on the ICU rotation
  - contact the fellow from first week for informal feedback
  - Attendings complete official evaluation
# ICU Census Example

<p>| | | | | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td><strong>577</strong>&lt;br&gt;Doe, Jane&lt;br&gt;1234567</td>
<td><strong>DNR/DNI</strong>&lt;br&gt;81F&lt;br&gt;9/17</td>
<td><strong>BRBPR; anemic</strong>&lt;br&gt;PMH: Afib, CABG, DM, anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DNR/DNI</strong>&lt;br&gt;81F&lt;br&gt;9/17</td>
<td><strong>BRBPR; anemic</strong>&lt;br&gt;PMH: Afib, CABG, DM, anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>579</strong>&lt;br&gt;Friend, Joe&lt;br&gt;1111111&lt;br&gt;INTUBATED&lt;br&gt;Neurology&lt;br&gt;Surgery-Lee</td>
<td><strong>75 M</strong>&lt;br&gt;9/12</td>
<td><strong>AMS, Sepsis Acute cva on old R mca cva- intubated. POD 33 LOA for sbo, ATN PMH: dvt, htn, dm</strong></td>
<td><strong>Linezolid 9/13</strong>&lt;br&gt;Cefepime 9/13</td>
<td><strong>9/5: urine/bld MRSA Bronch cx: Ecoli</strong>&lt;br&gt;9/13 Bcx: NGTD&lt;br&gt;9/13 Ucx: negative</td>
</tr>
<tr>
<td><strong>580</strong>&lt;br&gt;Smith, Bob&lt;br&gt;2222222&lt;br&gt;Endocrine</td>
<td><strong>46M</strong>&lt;br&gt;9/17</td>
<td><strong>DMI, IDDM, SOB, cough, hyperglycemia PMH: DM, HTN</strong></td>
<td><strong>Ceftriaxone 9/17</strong>&lt;br&gt;Azithro 9/17</td>
<td></td>
</tr>
<tr>
<td><strong>581</strong>&lt;br&gt;Schmoe, Joe&lt;br&gt;3490393&lt;br&gt;Cardiology</td>
<td><strong>63M</strong>&lt;br&gt;DS&lt;br&gt;9/12</td>
<td><strong>ARF, osteo, CHF, c desats (80's) on 100% NRB, poss fluid overload vs PE</strong></td>
<td><strong>Cipro 09/12</strong>&lt;br&gt;PO Vanco 09/03&lt;br&gt;Fluconazole 09/12&lt;br&gt;Cefepime 09/15</td>
<td><strong>BCx 09/13</strong>&lt;br&gt;UA 09/13&lt;br&gt;Ucx 9/13 – serratia marcesens&lt;br&gt;MSSA (+): wound 8/17&lt;br&gt;C.Diff (+)</td>
</tr>
</tbody>
</table>
ICU Census

- On K drive under “ICU census”
- Only one person can work on census at a time.
- Close when finished viewing otherwise cannot be edited elsewhere
- Must put PMD/surgeon name next to MRN number
- Code status below MRN if not full code
- Intubated or trached.
- Update cultures/antibiotics daily
- Update HPI/pt information daily!
ICU census

- Put main reason for admission followed by PMHx
- Update Cx and Abx even if only NGTD
- Night intern’s job if not updated by others throughout day
- Update new diagnosis
- Do not type in “To do” area
- Do not assign complex patients who have had active issues over the weekend to people who have been gone whole weekend
- Complicated patients should go to the residents and not the intern
- Consults seen on the floor that remain there should be placed in italics under the consult section for the PA attending to see in the AM.
Fellows Office- Room 51048

- For Fellows only
- 5 fellows share:
  - One office
  - One small fridge
  - Couch = our bed
- Residents are **not** to be in office without fellow present
- **Clean up after yourselves**
Welcome to the GW ICU!