VA ICU

**The schedule**: There are two interns in the ICU. One covers CT and vascular surgery patients. The other covers general, urology, neurosurgery, ENT, and ortho patients. The interns switch schedules after two weeks, so you get to experience both sides.

**The team**: Dr. Chuck Hobson has a general surgery background. Dr. Sasha Grek has an anesthesia background. They switch off weeks. Both are happy to let you be as autonomous as you want, but are also available to answer any questions you have. They are eager to get you procedures and like to teach. We also have had a 3rd year med student. You can co-sign the notes they write on patients and not have to write your own note.

**The work**: At 6:00am (5:30 am on Wednesdays), you try to round in the unit with the primary services you are covering. The CT service does not have an intern so we make it a priority to round with the CT surgery service. Sometimes CT and vascular round at the same time, so you can’t get to both, which means you follow up with the intern on the vascular service to find out the plan for their ICU patients. You then work on writing the orders and preparing to do ICU attending rounds, which usually starts between 8:30 and 9:30am, depending on the attending. The attendings like presentations in the following format (with examples of the types of things talked about in each category):

**Patient summary**: Mr. Jones, 65 yo m POD#3 s/p 3 vessel CABG

**Neuro**: mental status, pain control, withdrawal prophylaxis, psych meds

**Cardiovascular**: HR, BP, cardiovascular medications

**Respiratory**: RR, SpO2, vent settings, ABG

**GI/Nutrition**: diet, bowel regimen

**Fluids/Electrolytes/Renal**: Ins and Outs, BMP (especially BUN/Cr for Dr. Hobson, mention it every time on every patient), urine output

**Heme**: Hgb/Hct/Plts

**ID**: temperature, WBC, antibiotics (treating what, stop date), cultures

**Endocrine**: blood glucose, insulin regimen

**Integument/Wound**: general appearance, dressings, skin, distal pulses as appropriate

**ICU Prophylaxis**: DVT prophylaxis, PPI for stress ulcer prophylaxis in the intubated, VAP prophylaxis if indicated,

**Lines/Drains**: what they have, what can come out

**Disposition**: stay in the ICU or transfer to the floor

After rounds, you write more orders, work on writing your notes, and deal with issues as they come up. You can also walk over to the ORs and see what patients are headed your way that day. The day should end at 6pm when the Surgical Critical Care team rounds with and signs out to the night float resident.

**Notes:** All patients, every day, even floor boarders get a note every day. All notes use the Surgical Critical Care note title. The format is system-based, just like the presentation. Note the **important** past medical history for every patient – a big part of the complexity of our patients derives from their long list of co-morbidities.

To save time and to foster consistent communication we would like everybody on the ICU service to use the same CPRS note template for every note:

Surgical Critical Care

ID:

PMHx:

|ACTIVE PROBLEMS|

ALLERGIES: |ALLERGIES/ADR|

CODE STATUS: Full

Prior MEDICATIONS have been reviewed

INVASIVE HARDWARE:

 []Arterial []PAC []CVC

 []Epidural []Ventriculostomy

 []NGT/FT []PEG/J []Drain

 []ETT []ChestTube

 []Foley - if needed past POD1, document the reason here:

ICU PROTOCOLS:

 BETA BLOCKADE []Yes []N/A

 STRESS ULCER PROPHYLAXIS []PPI []H2B []N/A

 DVT PROPHYLAXIS []SCDs []SQH/LMWH []Full A/C []N/A

 ELECTROLYTE REPLACEMENT [] []N/A

 GLUCOSE CONTROL []Infusion []ISS []Oral []N/A

GTT: None

ABX: None

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

~ ACTIVE PROBLEMS // PLAN: ~

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

INTEGUMENT--CDI.

ENT---------None.

NEUR/PSYCH--Alert/exam nonfocal.

CARDIOVASC--SR //

RESPIR------Sats //

RENAL/F/E---None.

GI/NUTR-----None.

INFECTIOUS--None.

HEMATOLOGY--None.

ENDOCRINE---None.

DISPO/SOC---ICU care.

All notes MUST have one of the ICU attendings **AND** one of the primary surgery attendings as co-signers on the note. There should be a one line note at the end documenting that the patient was seen, and plan formulated, with the ICU and surgery attendings:

“Patient seen and plan formulated with Dr.Hobson and Dr. Bercelli”

Medical student notes count as official notes – there is no need for duplicate notes. Additions/corrections can always be done as an addendum to the original note. Medical student notes should have the resident **AND** the ICU attending **AND** the surgical attending as co-signers.

Patients on ICU status should have a full systems-based note. Patients who are stepdown or floor status generally require a much less detailed note.