



THE GEORGE
WASHINGTON
UNIVERSITY

WASHINGTON, DC

Jack Zimmerman ICU

Resident Orientation

Updated January 2025

We hope you learn and enjoy your rotation!

Questions? ICU fellow 6141

Please email or Tiger Text Dr. Daniel King (daking@mfa.gwu.edu) for any issue regarding schedules or the rotation in general.

If you are sick and can't come into work, please contact the fellow, attendings, or Dr. King to arrange coverage.

- Multidisciplinary 60 bed ICU
- ICU team is the primary team
- ICU 5 & 6 Floor.
 - ICU 2 and 4 Floor (APP service/CT surgery)



10 RULES TO ICU SUCCESS

1. Be responsive to changes immediately
2. Talk to the bedside nurse
3. Know your drips and rates
4. Know your ventilator settings
5. Always look to simplify care (daily med-rec is mandatory)

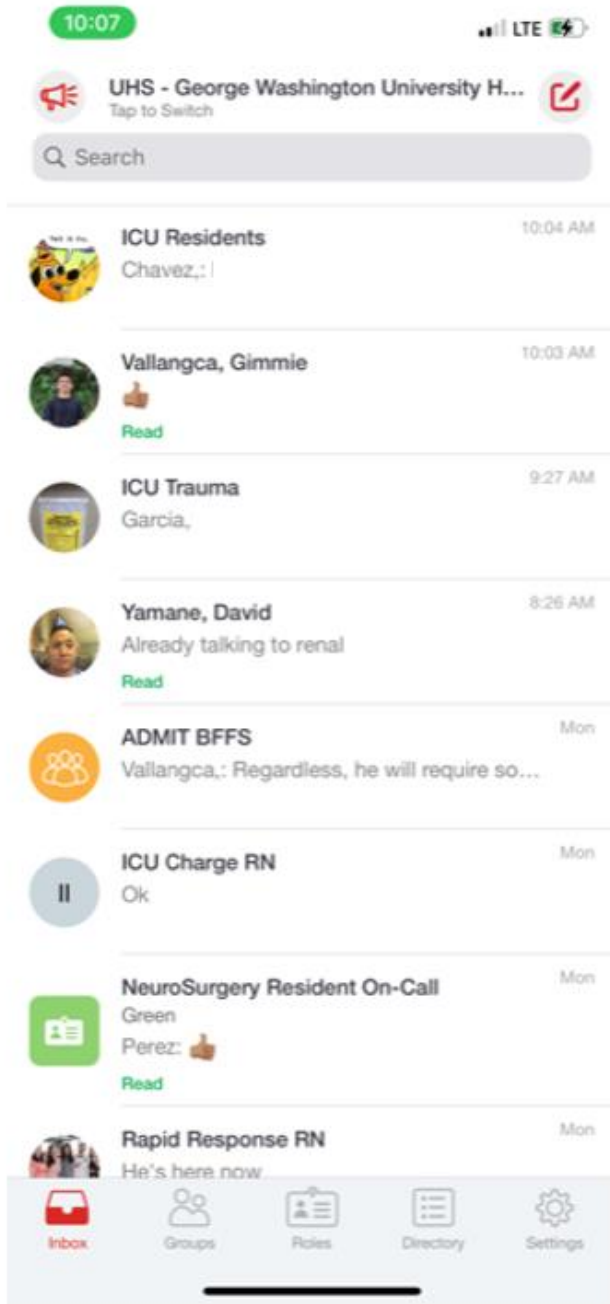
6. Know your patients neurological exam
7. Appropriate order sets
8. Be vigilant about antibiotics/nutrition/mobility/DVT ppx
9. Don't culture without discussing with fellow
10. Always over communicate

ICU TEAM

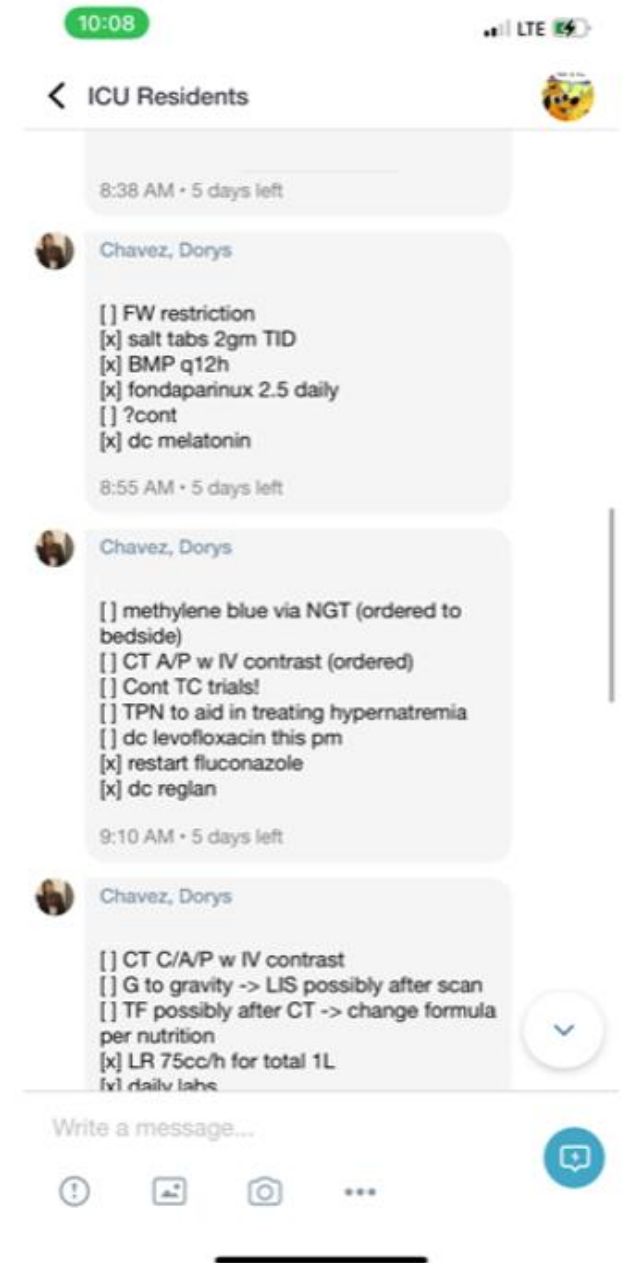
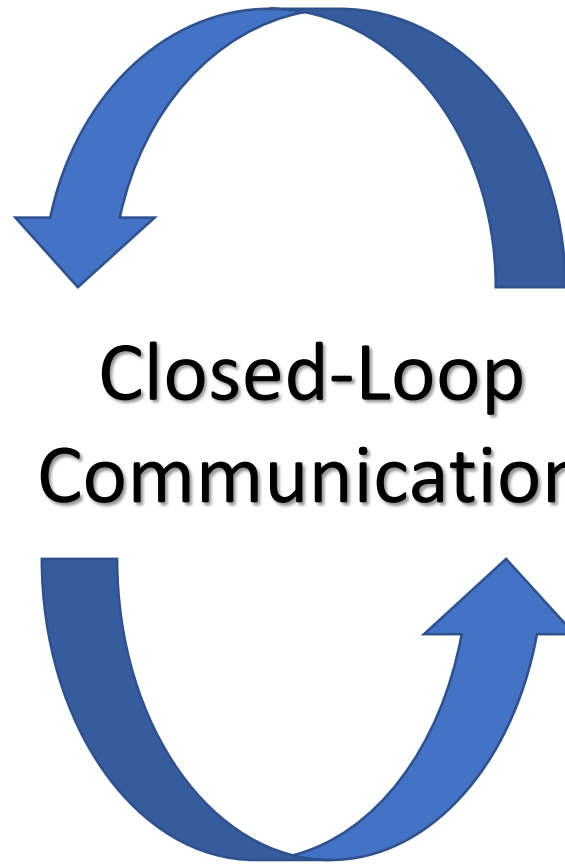
- Every ICU floor has an attending
- Two fellows
 - Main Service ICU Fellow: covers all admitted patients
 - Admitting ICU Fellow “Swing”: covers all admissions 7am-7pm
 - Rare weekends may be missing the swing fellow and admissions will be covered by the rounding fellow and resident(s)
- Senior residents
- Junior residents
- ICU APPs

Residents' roles

- Rounders: Assigned patients of their own (needs to pre-round)
- Call resident: Assigned patients of their own, and covers the service as the rounders sign out until the night crew arrives (needs to pre-round)
- Swing resident: NEW ROLE: Not assigned any patient, but will join the admitting ICU fellow taking care of new admissions and emergencies (7 am till 7 pm role)
- Night residents (7 **pm** till 7 am role)



Tiger Text



CORES Primary Contact Daily Assignment

To improve interdisciplinary communication, **all** ICU residents, fellows, and APPs must assign themselves as the primary contact for their patients in CORES. The following steps review how to set up CORES with TigerText and assign yourself to a patient's care team.

Enabling TigerText in CORES

1. From CORES, select “+More” then “My Preferences”
2. Select “TigerText” from the dropdown carrier options
3. Enter your phone number associated with TigerText
4. Check the box to allow text messaging.

**This will prompt a verification code to be sent to TigerText. You will be asked to enter the verification code to finalize setup.*

The screenshot shows the 'MY PREFERENCES' settings page in the CORES interface. The page is titled 'MY PREFERENCES: SAVE CHANGES'. Below the title is the 'PERSONAL CONTACT INFORMATION:' section. The 'App/Provider/Carrier:' dropdown menu is set to 'TigerText', with a blue arrow pointing to it labeled 'Step 2'. The 'Device Identifier/Number:' field is empty, with a blue arrow pointing to it labeled 'Step 3'. Below this field is the text 'Valid format: 10 characters/digits'. The 'Allow text message/paging?' checkbox is checked, with a blue arrow pointing to it labeled 'Step 4'. Below this is the 'Additional Contact Info:' text area, which is empty, with a blue arrow pointing to it labeled 'Step 4'. Below the text area is the text 'Characters remaining: 250'. Below the 'PERSONAL CONTACT INFORMATION:' section is the 'Help Info:' section, which contains the text: 'Your 'Pager Number' and 'Additional Contact Info' will be published to the chart and will be accessible by other users. When text paging is enabled, users will be able to send you text pages directly from PowerChart.' Below the 'Help Info:' section is the 'DEFAULT SETTINGS:' section, which contains the 'Default View:' dropdown menu, which is set to 'Team Patient List', with the text '(which page you will open to first)' to its right. Below the 'DEFAULT SETTINGS:' section is the 'MOBILE APP ACTIVATION:' section, which contains the 'Start Using the Mobile App:' section, which contains the text: 'Using the Core Workflows mobile app, now you can manage your patient list, handoff coverage, clinical data easily and conveniently from your own mobile device.' On the right side of the page, there is a 'MORE' button, which is circled in orange. Below the 'MORE' button is a dropdown menu with the following items: 'RECENT HISTORY', 'OTHER VIEWS', 'MY SETTINGS', 'TEAM SETTINGS', and 'NOTIFY SETTINGS'. The 'MY SETTINGS' item is circled in orange. Below the 'MY SETTINGS' item is the 'My Preferences' item, which is also circled in orange. Below the 'MY SETTINGS' item is the 'TEAM SETTINGS' section, which contains the items: 'Team Communication Setup', 'Manage Contacts', and 'Team Members'. Below the 'TEAM SETTINGS' section is the 'NOTIFY SETTINGS' section. Below the 'NOTIFY SETTINGS' section is the 'OTHER' section, which contains the items: 'Announcements', 'Patient List Activity', and 'Assign Patient Relationships'. Below the 'OTHER' section is the 'LINKS' section.

Assigning Primary Contacts in CORES

- 1. From CORES, find the column labeled "Primary Contact" under the "On Call" tab. You may need to collapse other sections to view more easily
- 2. Click on the pencil icon under "Primary Contact" to edit

The screenshot shows the CORES interface. At the top, the 'On-Call' tab is active, and the 'PRIMARY CONTACT' column is circled in yellow. A blue arrow labeled 'Step 2' points to the pencil icon in the 'PRIMARY CONTACT' column of the first row. Below this, the 'Patient List' section is visible, with a blue arrow pointing to the 'Handoff Info' section header, accompanied by the text 'Click these arrows to collapse columns'. The 'Patient List' table has columns for ACUITY, PATIENT NAME, MRN, AGE, GE, LOCATION, ADMIT, LOS, TEAM, SUB-TEAM, PRIMARY TEAM, CONS, CODE, REASON FOR ADMIT, and DAILY INPT. PRB/SUMMARY. The 'PRIMARY TEAM' column contains 'Critical Care - C...' for all rows.

Assigning Primary Contacts in CORES

3. Select your name under “Select A Provider”

You have the option to mark “Yes” for temporary handoff timed to remove your name as point of contact at the end of your shift

PROVIDER/DEVICE SEARCH: ✕

Use the form below to search for a provider:

Name:

Show Advanced Options

SELECT A PROVIDER: ✕ NONE/REMOVE PROVIDER

- [Walker, Alexandra K PA-C](#) ←
- None/Remove Provider

COVERAGE HANDOFF FOR 'GWU ✕

Please confirm coverage handoff from **None** to **Walker, Alexandra K PA-C** for patient **GWU** :

Is this a short-term or temporary handoff? **Yes.**

Until when should this temporary coverage last?

✕ ex. 08/12/2012 13:45

WORKFLOW

- Pre-rounds – 6-8 AM (Read H&P/*Progress notes, exam, drips, nurse...*)
- Fellow or Attending Lecture – 8-8:30 AM
- Rounds – 8:30-12:00 PM
 - Place orders during rounds!
 - Don't sign notes before rounds!
 - Call team takes over admissions. Non-call team can also help !
- Lunch
- Task completion
 - Clinical work, Procedures, Family (daily call, meetings..), CORES (update)
- Afternoon sign-out ~3:30pm
 - Variable time!
- Day fellow and residents sign out to night fellow and residents together **7:00 pm in ICU 4 Nursing Break Room.**

Where do I put my bag?

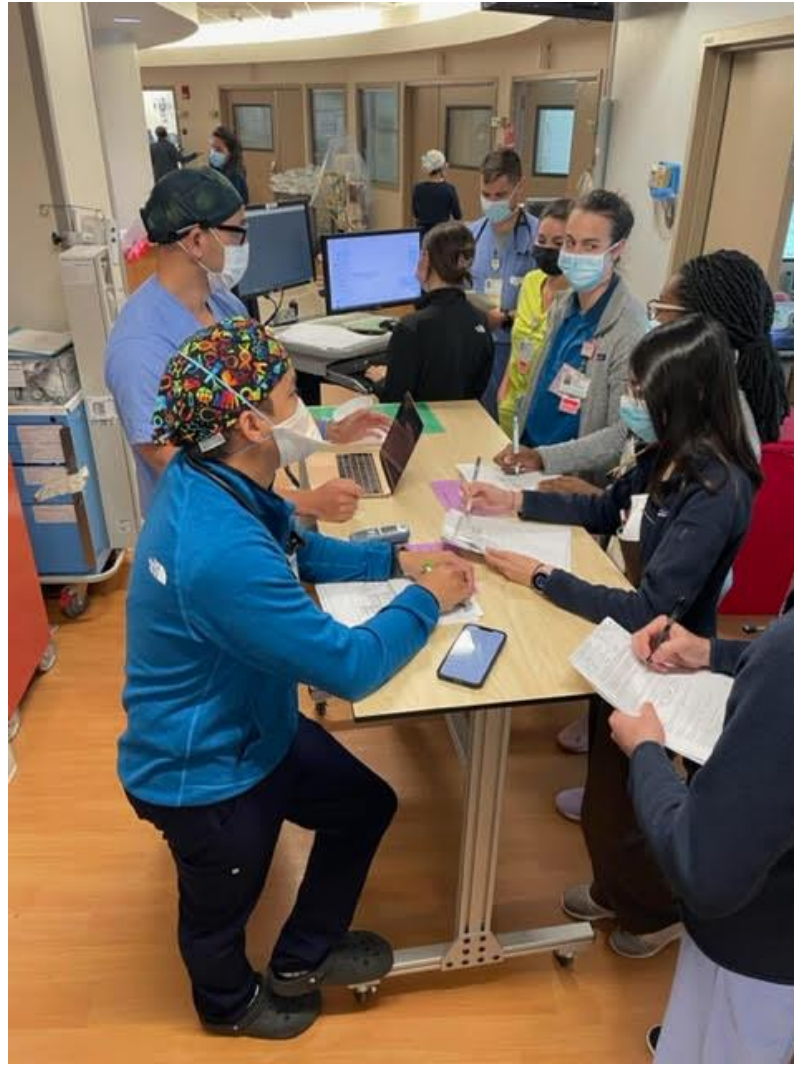
- Please do not put bags around ICU 6 workstation.
- Please store bags and personal items in ICU 5 call room or in the ICU 6/5/4 Nursing Lounge.



ICU 5 Call Room Code:6060



ROUNDING



ICU Rounding Checklist

Sedation

- Pain addressed?
- SAT?
- Delirium present? * Consider lab/CXR holiday and sleep hygiene

Ventilation

- Vent/sedation Cerner order set present? (VAP bundle included in this orderset)
- SBT?
- DART? Blue band?

Nutrition

- TF's at goal?/Diet ordered?
- Stress ulcer ppx indicated?

Lines/Tubes/Drains

- Central line?
 - # of days present ____
 - Still Indicated?
 - Order with indication present?
- Foley?
 - # of days present ____
 - Still Indicated?
 - Order with indication present in Cerner?

Antibiotics

- Deescalate?

DVTp?

Skin

- Breakdown? Documentation?
- Wound care consult indicated?

Mobility- PT/OT?

Family/code status

- Need family meeting?
- Code status?

ORDER CLEAN-UP!!

ICU Research Candidate?

Drips	Usual Concentration in Cerner	Titration Instructions per Cerner	GWUH Titrations Changes	Special Instructions
Epinephrine	<ul style="list-style-type: none"> 4 mg/250 mL D5W 8 mg/250 mL D5W 	Initial rate: 1 mcg/min Change rate: 1 mcg/min every 10 minutes. Max: 15 mcg/min Titrate to keep MAP >=65, HR < 125, SBP > 90 High Alert Medication Look Alike - Sound Alike Medication ***Infusion through central line optimal***	Change rate: 1 mcg/min every 5 minutes. Max: 10 mcg/min	
Norepinephrine	<ul style="list-style-type: none"> 4 mg/250 mL D5W (or NS) 8 mg/250 mL D5W (or NS) 	Initial Rate: 4 mcg/min Change rate: 2 mcg/min every 5 minutes. Hard Max: 47 mcg/min Titrate to keep MAP greater than or equal to 65. ***Infusion through central line optimal***	Hard Max: 30 mcg/min	MD order needed for >30mcg/min
Vasopressin	<ul style="list-style-type: none"> 40 units/100 mL NS 100 units/ 100 mL NS 	<u>Septic Shock</u> SEPTIC SHOCK; Adjunct: 0.03 units/min, no dose titration ***Infusion through central line optimal*** <u>Vasodilatory Shock</u> SHOCK, VASODILATORY: Initial Rate 0.03 units/min Titrate by 0.01 units/min every 30 min to Max of 0.1 units/min Titrate to MAP >=65 HR < 125 High Alert Medication ***Infusion through central line optimal***	<u>Septic Shock</u> Adjunct: 0.04 units/min, no dose titration	USE SEPTIC SHOCK ONLY
Phenylephrine	20 mg/250 mL D5W (or NS) 10mg/250 mL D5W(or NS)	Initial Rate: 100 mcg/min Change rate: 20 mcg/min every 5 minutes Max rate: 360 mcg/min Map >=65 ***Infusion through central line optimal***	Initial Rate: 30 mcg/min Change rate: 20 mcg/min every 5 minutes Max rate: 180 mcg/min Map >=65	
Angiotensin II	<ul style="list-style-type: none"> 2.5 mg/500 mL NS (not fluid restricted) 2.5 mg/250 mL NS (fluid restricted) 	Initial: 10 to 20 ng/kg/minute; monitor response and titrate as frequently as every 5 minutes by increments of up to 15 ng/kg/minute as needed. Once the underlying shock has sufficiently improved, down-titrate every 5 to 15 minutes by increments of up to 15 ng/kg/minute based on response. Doses as low as 1.25 ng/kg/minute may be used. <ul style="list-style-type: none"> Maximum initial dose: 80 ng/kg/minute during the first 3 hours of treatment. Maximum maintenance dose: 40 ng/kg/minute. <i>Titration parameters per Lexicomp; these do not pre-populate in Cerner. Usually added by pharmacy</i>		
Dobutamine	<ul style="list-style-type: none"> 500 mg/250 mL D5W 1000 mg/250 mL D5W 	Initial rate: 1 mcg/kg/min Change rate: 2.5 mcg/kg/min every 10 minutes Max: 40 mcg/kg/min Titrate to: <ul style="list-style-type: none"> MAP > 65 <ul style="list-style-type: none"> CVP: 8-12 mm/Hg HR < 125 ***Infusion through central line optimal***	NO TITRATIONS UNLESS ORDERED BY MD	
Dopamine	400mg/250 mL D5W 800mg/500mL D5W	Initial Rate: 2 mcg/kg/min Change rate: 2 mcg/kg/min every 10 minutes Max: 20 mcg/kg/min MAP >=65, HR < 125. Titrate to: MAP of >= 65 mmHg and HR < 125. If dosages > 20 to 30 mcg/kg/min are needed, a more direct-acting vasopressor may be needed. ***Infusion through central line optimal***		
Milrinone	40 mg/200 mL D5W	Initial rate: 0.375 mcg/kg/min Change rate: 0.15 mcg/kg/min every 10 minutes Max rate: 0.75 mcg/kg/min Adjust to increase Cardiac Output and decrease PCWP	Initial rate: 0.125mcg/kg/min Titrate per MD order	

PRESENTATION

Patient XXXX:

1. He/she is admitted to ICU for _____ (+PMhx if relevant)

2. Overnight events _____

3. Systems presentation

Neuro

CV

Pulm

GI

Nephro

ID

Hem

MSK

CORES

Plan / Signout
Small Bowel Obstruction

90yF hx HTN, CKD stage V, who was previously Independent Admitted for SBO now post op lysis of adhesions and small bowel resection. Admitted to ICU for closer monitoring post op.

If looking worse or continues to have bandemia consider broadening antibiotics
 possible downgrade

Next of Kin: Donna Williams (202-297-2936)



Concise



Very brief summary even manages to identify pertinent independence status. No mention of pre-hospital symptoms, drips, how sick she was on arrival and hospital narrative → all generally belongs in progress notes and H&P



Appropriate sign-out of tasks. Although potentially could make better by being more specific (e.g. if/then statements – “if febrile then broaden antibiotics)



Decision maker with accurate phone number

G
O
O
D

Plan / Signout

Ms. [REDACTED] is a 71F w/PMH of HTN, DM, COPD, ESRD on dialysis every Tue, Thurs, Sat, recent lacunar stroke in March 2020 with residual RUE weakness. Transferred from UMC as a concern for lumbar osteomyelitis seen on CT. On imaging she was found to have cervical myelopathy and is now s/p ACDF 6/12, and is s/p L5-S1 disc biopsy by neuro-IR 6/22. Of note, she had a rapid response called on her yesterday (6/18) for similar presentation though this was much more transient. Rapid response was changed to a brain attack and CTH showed no acute findings. Another rapid response was called around 530 pm today for unresponsiveness. Noted to be hypotensive, altered, minimally responsive - only to painful stimuli. Not to sternal rub or voice. Had RR ~5 breaths per minute. Code blue called for airway and pt subsequently intubated. Intubation was difficult and concern for airway edema vs hematoma in neck suspected for obscuring DL view. has been failing SBT last 3 days

6/21. completed dexamethasone for airway edema

6/22: tolerated PS. try SBT again in the AM

Daughter, [REDACTED] (last called 6/21)



Missing bolded admission diagnosis → Respiratory failure

It needs to have only pertinent problems



Simple enough to say transferred for cervical myelopathy with concurrent lumbar osteomyelitis

Avoid words like “yesterday”.

Instead of providing a narrative; better to summarize → multiple rapid responses and was ultimately found to be altered and hypotensive leading to a code blue and difficult intubation. Subsequently has failed ventilator liberation trials



Avoid a daily narrative. Intent is to summarize

B

A

D

SCHEDULES

The Jack Zimmerman Intensive Care Unit



You are here: [Home](#) / Schedules 2021-2022

- HOME
- SCHEDULES**
- FACULTY
- PUBLISHED RESEARCH
- RESIDENT INFORMATION
- FELLOWSHIP PROGRAM
- ICU EDUCATION & ORDER SETS
- TRAUMA PAGE

Schedules 2021-2022

- [ICU Events Calendar](#)
- [Housestaff Schedule](#)
- [ICU Fellow Schedule](#)
- [ICU APP Schedule](#)
- [Attending Clinical Schedule](#)
- [Pre-lecture schedule](#)

Google Search:
"GW ICU schedules"

This will take you here



- ✓ Monday through Friday.
- ✓ There are assignments during the weekend
- ✓ Night team makes assignments for day team with fellow supervision.
 - Goal is continuity
 - Ensure assignments match resident training
 - Complex patients to seniors; less complex to junior
- ✓ Outliers need to be evaluated before rounds. Admitting fellow/APP will help with these as well.
- ✓ If any personal emergency/schedule change, communicate with fellow and Dr. Daniel King (Tiger text or daking@mfa.gwu.edu)

SIGNOUT

Highly critical process with the shift work in the ICU !

- Early morning sign-out of the night float team to the rounders
- Afternoon sign-out around ~3-3:30 pm (rounders to the day call senior and junior)
- Day call signout to night shift– 7:00pm in ICU 4 Nursing Break Room.
 - CORES updated/concise !
 - All pending tasks listed for night team !

PROCEDURES

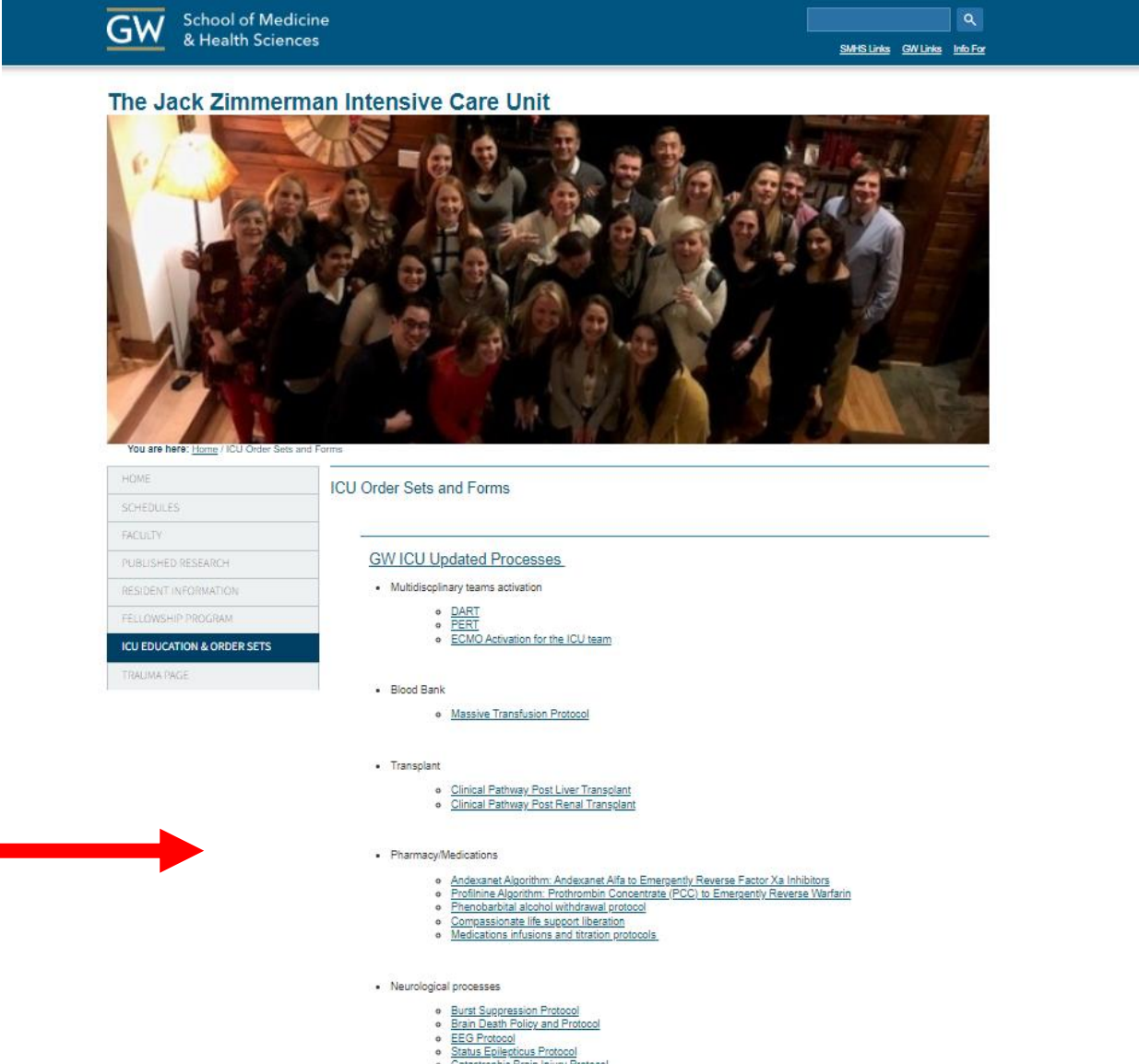
- All procedures require consent
 - Consent needs to be obtained from patient or legal decision maker
 - Provider AND witness (usually a nurse) is required
 - Two physician consent ONLY for emergencies (Ask fellow)
- Interns/residents DO NOT perform procedures until approved by fellow and/or attending
- For any procedure, Time out flow chart is required (see next)

PROTOCOLS

PROTOCOLS

Google Search:
“GW ICU order sets and
forms”

This will take you here



The screenshot shows the website for the Jack Zimmerman Intensive Care Unit at the George Washington University School of Medicine & Health Sciences. The page features a navigation menu on the left with the following items: HOME, SCHEDULES, FACULTY, PUBLISHED RESEARCH, RESIDENT INFORMATION, FELLOWSHIP PROGRAM, **ICU EDUCATION & ORDER SETS**, and TRAUMA PAGE. The main content area is titled "ICU Order Sets and Forms" and lists "GW ICU Updated Processes" under several categories:

- Multidisciplinary teams activation
 - [DART](#)
 - [PERT](#)
 - [ECMO Activation for the ICU team](#)
- Blood Bank
 - [Massive Transfusion Protocol](#)
- Transplant
 - [Clinical Pathway Post Liver Transplant](#)
 - [Clinical Pathway Post Renal Transplant](#)
- Pharmacy/Medications
 - [Andexanet Algorithm: Andexanet Alfa to Emergently Reverse Factor Xa Inhibitors](#)
 - [Profilina Algorithm: Prothrombin Concentrate \(PCC\) to Emergently Reverse Warfarin](#)
 - [Phenobarbital alcohol withdrawal protocol](#)
 - [Compassionate life support liberation](#)
 - [Medications infusions and titration protocols](#)
- Neurological processes
 - [Burst Suppression Protocol](#)
 - [Brain Death Policy and Protocol](#)
 - [EEG Protocol](#)
 - [Status Epilepticus Protocol](#)
 - [Catastrophic Brain Injury Protocol](#)



1. **Google Search:**
“GW ICU order sets and forms”.
2. [Medications infusions and titration protocols](#)

This document shows you how to appropriately order certain medications/infusions in Cerner

PROTOCOLS

- Difficult airway (DART)
- PERT (Pulmonary embolism)
- ECMO
- Massive transfusion (MTP)
- Transplant (renal, liver)
- Anticoagulation reversal
- Alcohol withdrawal (phenobarbital)
- Compassionate extubation
- Appropriate infusion order
- Burst suppression
- Brain death
- Others

Brain Injury Specific Ordersets

Utilize Favorited plans: **Mayor Basto MD, Fernando**

To access: New order entry-Shared- search provider. Then select the applicable orderset & add to your favorite (right click after ordered)

ICU:

1. NEURO Aneurysmal **SAH** Admit to ICU- 2023
2. NEURO **ICH** Admit to ICU- 2023
3. NEURO Ischemic **Stroke non-thrombolytic** Admit to ICU-2023
4. NEURO Ischemic **Stroke post-thrombolytic** Admit to ICU-2023
5. NEURO Ischemic Stroke (CVA) **Thrombolysis** Module
 - a. UHS orderset utilized to order TNK & post monitoring.

ASU (Acute Stroke Unit):

1. NEURO Ischemic Stroke (CVA) **Thrombolysis** Module
 - a. UHS orderset utilized to order TNK & post monitoring
2. NEURO Ischemic **Stroke non-thrombolytic** Admit to ASU-2023
3. NEURO Ischemic **Stroke post-thrombolytic** Admit to ASU-2023
4. NEURO **TIA** Admit to ASU-2023

• Cardene Orders

- Please select the appropriate nicardipine order based on the patient diagnosis & condition
- The applicable diagnoses are listed to the right of the orders in parentheses
- Post TNK= “Ischemic stroke”
- Ischemic stroke, no treatment= “Ischemic stroke w/permissive hypertension”
- If the patient requires a more customized SBP parameter: PLEASE update in the order comment section
- ENSURE that the nursing communication/Notify Provider Vitals order is CONGRUENT

~~◆ niCARDipine~~
~~◆ niCARDipine (20 mg, Cap, Oral, TID)~~
~~◆ niCARDipine (30 mg, Cap, Oral, TID)~~
 niCARDipine 1 mg/10mL Syringe
 ★ niCARDipine 1 mg/10mL Syringe (1 mg, Syringe, IV Push, Once)
 ★ niCARDipine/0.86% NaCl 20 mg/200 mL (Aortic Dissection)
 ★ niCARDipine/0.86% NaCl 20 mg/200 mL (Hypertensive Emergency)
 niCARDipine/0.86% NaCl 20 mg/200 mL (Intracerebral Hemorrhage)
 niCARDipine/0.86% NaCl 20 mg/200 mL (Ischemic Stroke w/ Permissive Hypertension)
 ★ niCARDipine/0.86% NaCl 20 mg/200 mL (Ischemic Stroke)
 niCARDipine/0.86% NaCl 20 mg/200 mL (Subarachnoid Hemorrhage)

ONLY one “Notify Provider Order”/BP parameter

- **Safety concern!**



Notify Provider Vital Signs Ordered 06/30/24 23:09:00 EDT, Temp greater than 100.4 F or 38 C, HR greater than 120, HR less than 50, SBP greater than 140, SBP less than 90, DBP greater than 110, RR greater than 26, RR less than 12, O2 sat less than 94














Ensure there is only *one* order for vitals/BP parameters

Notify Provider Vital Signs Ordered 06/30/24 22:23:00 EDT, Temp greater than 100.5 F or 38 C, HR greater than 120, HR less than 60, SBP greater than 180, SBP less than 90, RR greater than 26, RR less than 12, O2 sat less than 92

Activity Orders


- Physical and Occupational Therapy is important for all ICU patients!
- It starts with their activity orders placed at admission.
- Early and progressive mobility option is the best choice for most patients
 - Patients requiring strict bedrest could be: spinal cord injuries with “logroll precautions, acute ICH, major surgery, uncontrolled bleeding, hemodynamic instability.
 - Otherwise the goal is to get them out of bed, and PT/OT/bedside nursing/WE can help!

Search:  Type: 

-  Up
-  MED General Admission
-  MED General Admission to ICU
-  Adv  MED General ICU Medications Module
-  Ana  MED General Medications Module
-  Car  MED COVID-19 General Admission
-  Car  General Admit Medicine to Med/Surg
-  Cor  MED Gastrointestinal Bleeding Module

MED General Admission to ICU (Planned Pending)

Admit/Transfer/Discharge

 Admission/Observation/Transfer T;N, Suggested Placement: Critical Care Unit, Admit as Inpatient, Level of Care: Critical Care

Vital Signs


 Vital Signs ▼ Constant order, per Unit Protocol


 Venous Oxygen Saturation


Activity

 Activity ▼ Bedrest, Constant order

Notify/Precautions

 Notify Provider Vital Signs

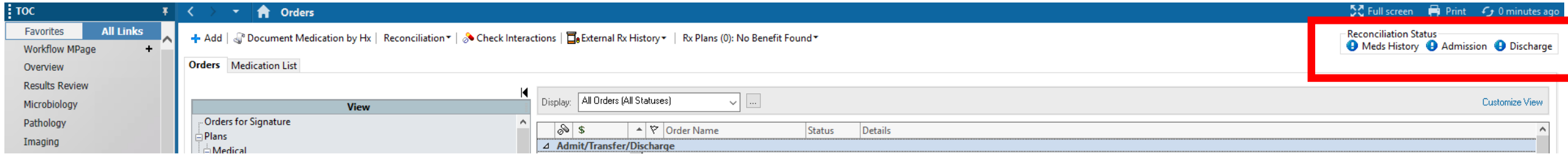
 Isolation ▼

 Nursing Communication (Nurse to order EKG PRN)

- Bedrest, Constant order
- Bedrest with Bathroom Privileges, Constant order
- Up to Chair or Wheelchair, BID
- Up to Chair or Wheelchair, TID
- Early and Progressive Mobilization

Details

Admission Med Reconciliation



Reconciliation Status

! Meds History ! Admission ! Discharge

Make This

Reconciliation Status

✓ Meds History ✓ Admission ! Discharge

Look Like This

By Doing This

+ Add | Document Medication by Hx | Reconciliation

Orders Medication List

Remember!

1. Be responsive to changes immediately
2. Talk to the bedside nurse
3. Know your drips and rates
4. Know your ventilator settings
5. Always look to simplify care (daily med-rec is mandatory)
6. Know your patients neurological exam
7. Appropriate order sets
8. Be vigilant about antibiotics/nutrition/mobility/DVT ppx
9. Don't culture without discussing with fellow
10. Always over communicate

We hope you learn and enjoy your rotation!

Questions? ICU fellow 6141

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