

## VA Cardiology Ward (VCW) - Telemetry

Admits and cares for floor and PCU level cardiac patients. Each Team (2 teams) consists of one intern and one resident. The service cap is 20 patients (10 per intern).

### Team Overview

- 1 Attending, 1 fellow, 2 residents, 2 interns
- Intern cap of 10 patients, service cap of 20 patients.
- Each res/intern pair admits on an every other day schedule.

### General Schedule

- 7AM:
  - Both teams receive signout from NAR and handoff on any holdovers admitted overnight.
  - Holdover patients should be distributed to the team beginning their call cycle, however the fellow/attending can re-distribute patients to help balance the census
  - On-call resident signs onto virtual admissions pager (**p89084**) and picks up code pager.
  - On-call intern signs onto virtual tele cross-cover pager (**p89078**)
- 8:30-10:30AM: Team Rounds.
- 12-1PM: Attend noon conference
- 4PM: NAR arrives and receives sign out from day admitting team, signs on to admissions pager.
- Note: The non-admitting intern/resident can signout to the day admitting team after noon conference when their work is completed/patients are tucked in. If the admitting team is preoccupied with admissions, the non-call team should wait to sign out. Please use this extra time for teaching or independent study

### Admissions

- Each team (1 res/intern pair) admits Q2 days until 4pm.
- On admitting days, intern caps at 5 admissions. After 5 admissions, the resident will admit solo up to 10 admissions. This cap resets when the night team arrives.
- Residents are required to write brief MRANs on all patients admitted by the intern (H&P by intern is still required).

- Non-urgent (not RRT) transfers to tele from VA-wards (GMED/GERI) or non-ICU services (TCU, psych, ortho, etc) must be approved by cardiology consult service during regular business hours, after hours at the discretion of the admitting resident (the MOD has final say and is available 24/7). Transfers between MICU and Cardiology should be mediated by fellows/attendings.
- Holdovers to the oncoming call team start at 6AM (all patients should be seen and preliminary orders placed).
- General Admission Criteria (not exhaustive):
  - Chest pain/ACS in hemodynamically stable patients
  - Congestive heart failure: New onset, exacerbation, requiring close cardiac monitoring, any EF
  - Hemodynamically Stable Arrhythmias: heart block, bradycardia, Afib with RVR
  - Symptomatic valvular heart disease
  - Syncope with strong suspicion of cardiac etiology
  - Bacterial endocarditis in patients with prosthetic valves
- Please note that the VCW team only has capacity for 2 ICU level patients. Further ICU level admissions will be admitted by the MICU team with **mandatory** cardiology consult. Ultimate triage decision for the CCU lies with the Hospitalist MOD (who must be notified of any CCU upgrades/admissions).
- Examples of ICU level patients on the telemetry team are, but not limited to, the following conditions:
  - Hemodynamically Stable Arrhythmias:
    - Atrial fibrillation / flutter requiring titratable gtts for rate control
    - Ventricular tachycardia/VF electrical storm/multiple ICD shocks
    - High degree/complete heart block (with or without temporary pacing wire)
  - Acute Coronary Syndrome
    - Unstable angina/NSTEMI that requires a continuous nitroglycerin drip
    - STEMI
  - Cardiogenic Shock without evidence of end organ damage
- ICU level patients with the following conditions will require transfer to the MICU service with a **mandatory** cardiology consult
  - Undifferentiated shock
  - Multi-organ failure (e.g. hypoxia, severe renal injury, lactic acidosis, encephalopathy)

**Transfers:**

- **Transferring a patient from Tele VA-wards (GMED/Geri):** All transfers from telemetry **MUST** be approved by the MOD (p99511) to ensure appropriateness of transfer. Once approved, place delayed transfer orders in CPRS and call the nursing supervisor (extension 53568). Patients can only be signed out to VA-wards once they have been **assigned a GMED ward bed**.

## Notes

- Admission H&P: Use the "**History and Physical - Cardiology**" note title for all new admissions to the telemetry service
- Daily progress notes can be written as "Medical Intern Note" or "Medical Resident Note"
- For discharge summaries, no specific note title is required. However, you should use the **Cardiology discharge summary template**, which can be found under **Shared Templates | CARDIOLOGY | Cardiology Discharge Summary**. This note template has the necessary elements for cardiology service discharges.
- Medical student notes:
  - Both MS3s and MS4s should have their **notes cosigned by the senior resident or the attending**.
  - For patients followed by the MS3, the intern is still responsible for reviewing the note with the medical student (making sure that it is appropriate documentation for the medical record, as other services will use their note to get information); **the intern** is also responsible for writing an addendum to their note. This could be a brief addendum, but should include at the very least the plan for the day in addition to any pertinent subjective or objective data.
  - For patients followed by the MS4 (sub-intern), **the senior resident** is responsible for reviewing the note and writing the addendum, in addition to cosigning their orders; sub-interns function like interns but with a lower patient load and with closer oversight from the senior resident.