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ABCs of the ICUs for Juniors

ICU patient = floor patient?

- Treat all the same…

- **Think proactively = prevent codes**
- Elective intubation better than PEA arrest

- Floor patient going to ICU? Treat if you are waiting!
- Rapid Response if Needed

Transfer: Think Proactively

- Does this patient need to be in the ICU?
- This *can* be an intern-level decision…
  - As a suggestion… gestalt
  - Bump it up for the ultimate decision

- Criteria for the ICU:
  - Pressors
  - Vent
  - Monitoring

Concerns About a Patient?

- Resources– avoid rapid response internally
  - VU: **consult resident**, chief
  - VA: chief, **anesthesia**
  - St. Thomas: **CVA**, chief
- Stabilize… get the ball rolling
  - Airway: oxygen, NRB, etc
  - Sepsis: fluids, culture, ?antibiotics?

The Actual Transfer

- TALK to appropriate people
  - Rapid Response: easy-- done
  - No rapid response:
    - SICU fellow: 479-4082
    - SICU midlevel: 752-6234
    - SICU charge nurse: 414-7201
  - VA (charge nurse, resident/fellow)
  - STH (transfer orders, CVA attending)
- Travel with Patient
- Next Step: Review orders
  - Times to review:
    - Transfer of care
    - NPO status
    - Airway status (intubate, extubate)

WhenYou are IN the ICU…

Roles of the Resident in the ICU:

- Joint Plan: Primary and ICU
- Communication is KEY…

- Beyond that, it is the resident's role to recognize when a patient is not "following the plan…"

- And then **COMMUNICATE…**

Frustrations

- Very easy to get discouraged

- Easy to be frustrated with *the patient*…
- Easy to be frustrated with *the primary team…*
- Easy to be frustrated with *the ICU…*

- Not necessary.

ABCs of the ICU…

Assume the worst.

- In the box or out of the box?
- If out, be able to explain it…

- Least reserve of all patients.
- Sign out what "could go wrong" with a patient.

Be available.

- Be in the ICU. Ward off disasters.
- Extended breaks?

Communicate

- Work with… not against.
- Effective communication makes for better care.
- Closed unit doesn't mean to sign off…

- 1) Run the list daily.
- 2) Round with the team (show interest)
- 3) Call early if there is any **change in direction.**

- **MUST CALLS: transfusion, pressors, airway**

Diets, Tubes, Wounds:

- Per the PRIMARY TEAM
- Communicate.

- Diets, tubes and wounds.

- *AND FOLEYS ARE TUBES!!!*

Early antibiotics save lives.

- Seems non-urgent… BUT
- Starting abx within an hour of suspected sepsis makes a difference in outcomes
- Get cultures first!
- ICU patients need all orders placed immediately, all orders STAT

Follow up everything.

- Make boxes, check boxes
- Write EVERYTHING down.

- On your on-call day, **USE "new results"** in StarPanel
- (clear it in the morning when you arrive…)

Go see.

- If there is a change in neuro exam reported, go see the patient.
- If the nurse says that there is a cuff-leak, go see the patient.
- If there is any change at all reported, go see the patient.

Hyperglycemia is bad.

- HYPO-glycemia is WORSE.
- On an insulin drip
  - Do they have a sugar source? **Fluids, TPN, feeds**
- Being made NPO for an operation
  - Are they on an insulin drip? Give them a sugar source
- Example: pt made NPO for OR– add IV source of glucose if on insulin drip

Ignore something…

- And you will regret it.
- Spidey-sense… listen to patients, nurses
- If a lab doesn't seem right (high potassium when all have been normal)
  - It's OK to recheck
  - But make sure to follow it up

J-tubes are NOT for meds.

- Liquids only – tube feeds and elixirs
- Flush regularly
- G-tubes are for crushed meds

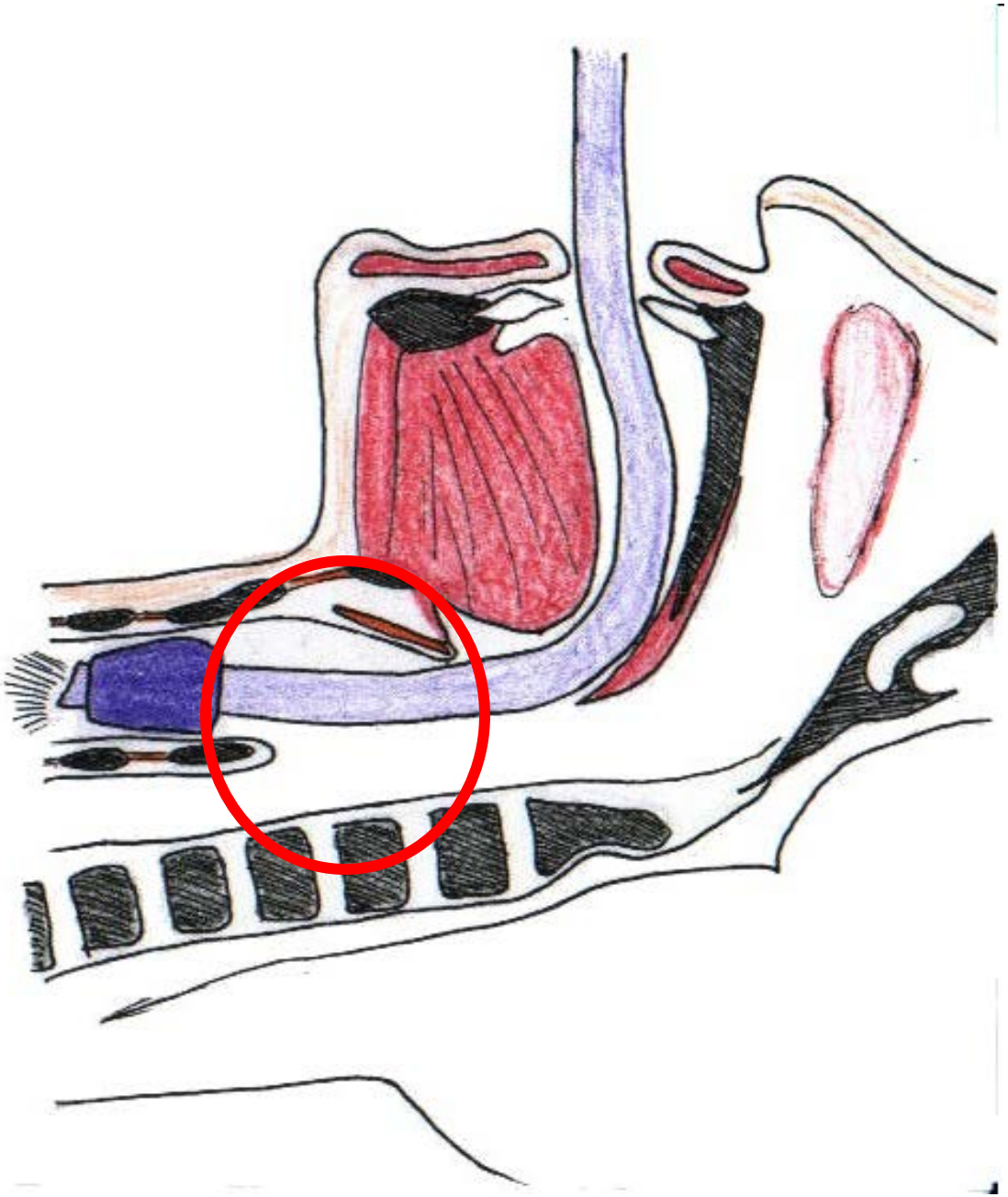
Know a patient's renal function.

- This is pretty much the only organ system for which we redose…
- Multiple meds affected:
  - Antibiotics
  - Potassium
  - Heparin
  - Pain medications
  - Etc…

Leaks are Bad.

- Talking about **cuff-leaks.**
- "RT put some more air in it– it's OK."

- Differential: cuff leak vs…
- About to lose the ET tube!!! (cuff is above cords)
- Actions:
  - Call your midlevel. See prior CXR.
  - Check expired volumes (does it match inspired?)
  - If not, call fellow and consider bronch/tube change/retintub
  - If matches, check another CXR– still consider bronch.



Monitors are on for a reason…

- Look at them. Don't expect the nurses to call you about changes.
- If the numbers are not where you expect them, find out why.
- Tachycardic? Pain? Bleeding?
- Hypotensive? Shock?

- Check monitor, check drips

Nurses are your friends…

- … usually.
- As an intern (and sometimes beyond), ASSUME that the nurse knows more.

- Listen to them.
- Then bump it up the resident ladder (don't just do what they say…).

Organize by systems.

- Think of every ICU patient in terms of systems.

- In the ***morning***, think by systems
- when you round at ***night,*** think by systems
- when something ***"doesn't seem right,"*** think by systems

Prioritize.

- Triage your patients.
- The one that is hypotensive needs attention before the the one with a potassium of 3.8

- Settle in your new admissions before attending to routine work.

Question whether…

- … what you do has potential for harm.
- Check and double-check your orders.

- Everyone makes mistakes, but these patients ***tolerate them the least***.

- Most med errors occur between 3 a.m. and 5 a.m.

Round often.

- After the official rounds…
  - Round again.
- Run the list frequently.
- See all the patients every several hours when on call.

- Makes you more efficient, and makes for better patient care (and **fewer pages!**)

See patients, see monitors, see drips.

- "Between rounds"
- Look at the monitors to make sure numbers are where you expect them.

- "Drip Creep"?
  - Started on 3, now on 15?
  - Vitals can be NORMAL! Monitor the same!

Transfusions…

- Must be bumped up…
- AND discussed with the primary team.

- No surprises.
- Also, it's often a sign that you should look further…

Understand your role.

- As an intern:
  - Get the work done.
  - Bump up anything that was not "in the plan."
  - See warning signs.
- As a midlevel:
  - Know the patients… and know them well.
  - Read their op notes, know their PMH, know their current issues. (helps to keep a running daily list)
  - Communicate with the primary teams.
  - Predict disaster (concerns) EARLY and keep the fellow informed.

View all studies…

- … but don't trust your own reading.

- Use the ER reading room at night.
- Talk to them about studies.

Write it down.

- Don't trust yourself to remember anything… at any level.

X-amine the patient.

- Be at the bedside.

Y: treat electrolytes.

- Don't find out in retrospect that your patient with a potassium of 2.9 went into A-fib.
- Don't find out in retrospect that the one with a potassium of 6.6 went into V-fib.

- Treat and follow up (but know the renal function)

Zzzz's

- … are not for the ICU…

- There are rare times when it is quiet,
- And a short nap is OK…
- But get up in 45 minutes and round again…
- You can always find a way to avert a crisis.