

## SICU INTERN GUIDE

- ALWAYS ASK and NEVER HESITATE IF YOU HAVE ANY QUESTIONS!!
- On call trauma resident x23754, trauma chief x23755, trauma attending x23756 (dial x3900 before spectra number)
- Arrive 10-15 minutes BEFORE rounds to help overnight intern print list (anticipate printer issues 😞)
- On rounds one intern is responsible for the orders and other intern is responsible for pulling up CXR/imaging (determine roles before rounds begin, each should have their dedicated WOW)
- SYSTEMS BASED APPROACH is very important to ensuring nothing is missed
- **Antibiotics**
  - Check culture results every day and adjust per sensitivities, de-escalate antibiotics if possible
  - If patient is on vanc, ensure there is a vanc trough showing therapeutic dosing (if not please order to collect 30 minutes before 4<sup>th</sup> dose, trough goal is usually 10-15) – call pharmacy to adjust dose if not at goal
- **Bowel regimen**
  - Adjust bowel regimen as needed – colace 100mg BID, miralax, senna, Dulcolax suppository, fiber in tube feeds
  - Check MAR/order to ensure it is scheduled NOT PRN
- **DVT Prophylaxis**
  - Lovenox 30mg SubQ q12 hrs (if Cr Clearance > 30)
  - Check AntiXa level every week EXACTLY 4 hours after 3<sup>rd</sup> dose of lovenox (prophylactic goal 0.2-0.6, therapeutic goal 0.6-1.2)
  - Recheck AntiXa level after each 3<sup>rd</sup> dose if dose is changed until you are at goal
  - Recheck level every week (usually qMonday) for all patients
  - If renal dysfunction order heparin 5000 Units SubQ q8 hrs (search “SURG DVT/VTE prophylaxis” order set)
- **Lines**
  - Ask yourself EVERYDAY – “does my patient still need this arterial line, central line, PICC line or foley?”
  - Consider giving nurse option of calling vascular team to place PIV and remove central line if “hard stick”
  - Double check your line list with the nurses EVERYDAY because you don’t know what you don’t know
- **Nutrition/Glucose checks**
  - Tube feed per nutrition recs (search “Tube feeds continuous – HAR” vs. “Tube feeds bolus – HAR”) – need to specify type, starting rate, advancement per hour, goal rate, and flush amount per SICU team/nutrition recs
  - No evidence behind checking residuals
  - TPN – call x8823 to renew daily TPN before noon, can adjust lytes and also add regular insulin if needed
  - Glucose checks q6 hrs on tube feeds or TPN, adjust low/moderate/high dose sliding scale to achieve goal glucose 140-180 (NICE trial)
- **Restraints** – usually soft restraints on bilateral wrists for intubated patients
  - If new order then search “restraint non-violent initiate”
  - If renewing then search “restraint renewal non-violent” – need to renew everyday if indicated
- **Sedation**
  - Search “ICU pain and sedation management subphase”
  - Usual sedation of choice is fentanyl at 25mcg/hr and propofol 5mcg/kg/min starting rates for intubated patients (other options include precede gtt and versed gtt used in selective circumstances)
- **Vasopressor**
  - Search “ICU vasopressors subphase”
  - Parameters must be specified (MAP or SBP goals) in order comments, starting rates listed under each drip
- **Ventilator settings**
  - Search “ICU ventilator management subphase”
  - Vent Settings - AC PRVC is most common, input appropriate values (RR, TV, Fio2, PEEP) as changed on rounds
  - Decrease FIO2 if possible to 40%, maximize oxygenation w/ PEEP if needed
  - Adjust ventilation with RR and TV per ABG
  - Order set preselects chlorhexidine BID and ocular lubricant q4 hrs
- **Ulcer Prophylaxis**
  - IV protonix 40mg daily or IV famotidine 20mg BID
  - Indications – coagulopathy (Plts<50,000, INR>1.5, PTT>2x normal), mechanical vent >48 hrs, hx GI bleed in last yr, traumatic brain or spine injury
- **Labs**

- Order needed labs q6hrs, q12hrs or q24 hrs as **TIMED STAT NURSE COLLECT (NOT lab collect)**
- Must be timed to start on cycles of **0000, 0600, 1200, 1800** as those are nursing lab draw times
- DON'T FORGET to order ABG if patient intubated
- **Imaging/diagnostics**
  - EKG – order STAT PORTABLE, page 310-841-7278
  - CXR – order STAT PORTABLE, call x2816 (after 11pm call x1039/2839) --- EVERYDAY ON ROUNDS ORDER CXR FOR NEXT DAY ON ALL PATIENTS WHO NEED A DAILY CXR as ROUTINE 6AM PORTABLE (done by intern assigned to WOW for placing orders)
  - CT scan – order STAT, call radiology for approval (CT head x1760, CT abdomen x7295, afterhours page p5814), call CT scanner (x8279/8289) ask if ready for patient, inform nurse to connect patient to monitor
  - TTE – order STAT PORTABLE, under future order option select NO so that it's not scheduled as outpatient
- **AD HOC FORM – start at the beginning of the evening on call, complete before AM rounds for EVERY PATIENT**
  - ADHOC button on top menu -> ICU progress note required details -> complete questions on VTE ppx, GI ppx, invasive lines, foley, ventilation weaning and sedation holiday
- **Informal walk rounds**
  - Incorporate nursing into the clinical decision-making process as nursing always has updated and critical information on your patient throughout the day and night and of course decades of experience
  - Critical to visualize dressing changes, examine all wounds/incisions every day (coordinate with nursing)
  - **Off sedation exam must be done EVERYDAY at least once (usually by on call resident and intern) for full neuro exam and obtain most accurate/updated GCS on patient**
- **Family at bedside is the perfect time to:**
  - Update family on patient status, ask about advanced directive, goals of care if patient unable to communicate
  - Imedconsent -> Obtain **ICU Bundle consent (“ICU Interventions”) with blood consent** in the event of unforeseen future procedures to be done (i.e. PICC line, bronchoscopy, transfusion, etc) and place in chart
  - Obtain full medical history and medication list if unclear on admission
- **Admission to SICU**
  - “SURG ICU Admit” order set – contains all component of admission discussed above
- **Transfer out of SICU**
  - Sign out patient verbally (page appropriate team) and sign transfer summary **BEFORE** patient leaves the unit
  - Reconcile orders **BEFORE** patient leaves the unit
  - Always remember to sign out what is the patient's baseline GCS/mental status and systems based plan
- **FEVER 38.5C or more**
  - PRN Tylenol BUT also need to work up fever
  - Pan-cultures peripheral blood cultures x 2 at least (if patient has central line need additional x2), sputum culture, UA and reflex urine culture, CXR
  - Evaluate if any lines can be removed – if yes then culture the tip on removal
  - Evaluate wounds, take down dressings, full physical exam for source (question differential – atelectasis? DVT?)
- **HEAD BLEED**
  - Questions to ask trauma team:
    - What is the current GCS? (very important to have a clear baseline to know if mental status changes)
    - Was the patient transfused FFP, platelets or DDAVP? Additional transfusions needed?
    - When is the next CT head due? (usually q4 hours until stable) – once repeat CT head is done page radiology for prelim read and page NSGY informing that CT is done/ask for any additional recs
    - Alcohol use history? Concern for withdrawal?
  - Depending on Na goals, determine if 3% hypertonic saline needs to be ordered
  - Order Q6 hr labs including Na checks, Q1 hr neurochecks, HOB>30 degrees
  - Order Keppra 1g BID scheduled x 7 days (usually IV unless able to tolerate PO), additional agents per NSGY
  - Start DVT prophylaxis 24 hours after last stable CT head
- **REPLETION OF LYTES**
  - K goal 4.0, cardiac goal 4.5 – raise K by 0.1 with 10mEq KCl repletion
  - Mg goal 2.0, cardiac goal 2.5 – raise Mg by 0.1 with 1gm Mg sulfate repletion
  - Phos goal 3.0 – current Na phos shortage, give K phos if appropriate to also replete K