ICU ORIENTATION PACKET

1. **SCHEDULE**
    a. Mon-Fri, 06:00-18:00
    b. Multidisciplinary rounds are daily at 09:30. Your daily notes should be finished prior to rounds, so you are prepared to talk about your pt and the plan of care for the day. There are 2 note templates for cc: "ccnote" which is a daily progress note and "ccconsult" which is for new consults. Be prepared to present your pts in a clear and concise manner during rounds.
    c. Please attend noon conference as long as there is not something requiring immediate attention in the ICU
    d. Other then when at conferences or in clinic, you should be available in the ICU managing and learning from your pts
    e. Brief notes are done in the afternoon with any changes in status, test results, or new plans
    f. If you have clinic, return to the ICU after completing your clinic work to round on ICU patients

2. **LEARNING OBJECTIVES**
    a. Respiratory Failure, hypoxic vs hypercapnic
    b. "Rapid Sequence Intubation" and the approach to Intubation
    c. Vent Modes and Management
    d. Sedation Strategies for the Ventilated Patients
    e. Delirium Assessment and Treatment in the ICU
    f. ARDS
    g. Treatment of Pneumonia; HCAP, VAP, CAP
    h. Management of Sepsis
    i. Management of Shock, Types and treatment
    j. Management and Indications for different pressors
    k. Management of GI Bleeds
    l. Management of STEMI
    m. DKA vs HHS
    n. Diagnosis and Management of PE
    o. Procedures including Intubation, Central lines, Arterial lines, Chest tubes

3. **PROTOCOLS.** There are several protocols/order sets which are used on EVERY ICU pt.
    a. **bactroban** (mupirocin) 2% ointment BID x 5 days on EVERY patient (write order for 10 doses total so that it will be completed if patient leaves the ICU
    b. **CAM ASSESSMENT** for delirium every shift on every pt.
    c. **PUD** and **DVT prophylaxis** on all pts. IF there is a contraindication, it must be documented in your note.
    d. **GLUCOSE CONTROL.**
        i. All pts get **q4 SSI** (unless eating and then AC/HS). If glucose is

greater then 150, they should be started on an Insulin gtt.

ii. We have an Insulin gtt just for the ICU; **Intravenous ICU Glycemic Management** Ask someone to show you how to order the correct one.

iii. We also treat **hypoglycemia** different then the standard SS protocol "subcutaneous ICU Glycemic Management" (Blood glucose 61-79, 12.5 ml of D50, and Glucose <60 with 25 ml of D50).

e. **RESTRAINTS** need to be renewed every 24 hrs (not daily). So if restraints are ordered at 10:00 on Monday, on Tuesday they need to be ordered by 9:59.

f. **SCIP Measures.** All post-op pts. need documentation re: resuming pre-op BB (if applicable), necessity of foley, peri-operative antibiotics, DVT prophylaxis and necessity of central line.

g. **VENTILATOR BUNDLE Order Set**. Should be ordered on all ventilated pts. The components are designed to reduce VAP and facilitate the weaning process.

h. **ICU SEDATION/ANALGESIA Order Set**. Again on all ventilated pts. The focus is on decreasing delirium and decreasing the time on the vent.

i. **CRITICAL CARE PNEUMONIA Order Set**. Should be ordered on all ICU pts with pneumonia.

j. **SEPSIS-THD Order Set.** Should be ordered on all ICU pts with sepsis or suspected sepsis. Key components include CVP, SVO2, and lactic acid monitoring.

k. **ICU Electrolyte Sliding Scale**

l. **TRANSFER ORDERS** should be written ASAP but MUST be entered by noon. Please make sure to clean up orders prior to transfer (remove pressors, change SSI or d/c if not needed, duplicate orders, etc.)

m. If you have any questions re: the above order sets or need a smart phrase assigned to you, please ask.

4. **PEARLS**
   a. Critical care medicine takes a team of providers. There are opportunities to learn from every member of that team; nutrition, nursing, chaplain, pharmacy, respiratory therapist.
   b. NEVER be afraid to ask a question.

5. **RESOURCES/REFERENCES-** can be found in "Intensivists Articles" binder
   a. ARDS/ALI
      i. Ventilation with Lower Tidal Volumes as Compared with Traditional Tidal Volume. NEJM 2000; 342: 1301-1308. May 4, 2000.
      ii. Comparison of Two Fluid-Management Strategies in Acute Lung Injury. NEJM 2006; 354: 2564-2575. June 15, 2006.
      iii. www.ardsnet.org

b. Shock
    i. Vasopressors for hypotensive shock. Cochrane Database Review 2011. May 11; (5):CD003709
    ii. Inotropes and Vasopressors: Review of Physiology and Clinical Use in Cardiovascular Disease. Circulation. 2008; 118: 1047-1056.
    iii. Vasopressor Support in Septic Shock. CHEST 2007; 132: 1678-1687.
    iv. Comparison of Dopamine and Norepinephrine in the Treatment of Shock. NEJM 2010; 362: 779-789. March 4, 2010.

c. Delirium in ICU pts.
    i. Clinical Practice Guidelines for Management of Pain, Agitation, and Delirium in Adult Patients in the ICU. Critical Care Medicine. 2013; 41: 263-306.
    ii. www.icudelirium.org

d. Glucose Control
    i. Intensive versus Conventional Glucose Control in Critically Ill Patients. NEJM 2009; 360: 1283-197. March 26, 2009.

e. Steroids in sepsis
    i. Hydrocortisone Therapy for Patients with Septic Shock. NEJM 2008; 358: 111-124. January 10, 2008.

f. DKA
    i. The Metabolic Derangements and Treatment of DKA. NEJM 1983; 309: 159-169. July 21, 1983.

g. Sepsis
    i. Early Goal-Directed Therapy in the Treatment of Severe Sepsis and Septic Shock. NEJM 2001; 345: 1368-1377. November 8, 2001.
    ii. Management of Sepsis. NEJM 2006; 355: 1699-1713. October 19, 2006.
    iii. http://www.sccm.org/Documents/SSC-Guidelines.pdf
    iv. www.survivingsepsis.org

h. NEJM Videos on Intubation, CVC
    i. http://www.nejm.org/multimedia/medical-videos