# Sample daily routine on the ICU

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| Example time | Activity |  |
| 0800 | Handover |  |
| 0830-1200 | Ward round | Format depends on unit and consultant |
| Patient review |
| 1200 | Radiography round | Depends on unit whether these happen at all |
| 1230 | Microbiology round |
| 1300 | Lunch | Whenever you can |
| 1330 | Post-ICU clinic etc | Timing likely to depend on unit activity |
| Teaching/audit/research |
| 0900-1700 | Own-team reviews |  |
| Scans – potential transfers |
| Ward reviews |
| New admissions |
| Additional results from morning tests |
| Family updates/meetings |
| Outreach/Follow-up |
| Transfer to other hospital/unit |
| 1600-1800 | Afternoon/evening round | Ensure day’s plans have been achieved and put in place plan for night |
| 1800-2000 | Management changes from ward round | Line changes etc. |
| 2000-2100 | Night shift handover +/- round |  |

# **Reviewing the ICU patient**

Know the history and progress first. Acknowledge any limitations on movement (eg spinal injury restrictions, known or suspected high ICP recent history of desaturation on rolling etc.) and removing dressings.

#### **Stand back and observe**

* Mental state, GCS, sedation score
* Monitors
* Equipment attached
* Infusions
* Drains

#### **Speak to the patient**

* Symptoms, trends, pain score etc.
* Gain consent to examine.

# **Use your unit’s proforma review sheet or follow this:**

#### **Airway**

Mouth – perioral skin, lips, tongue, Candida?, dental hygiene, bleeding, cyanosis

                Tubes/devices – ETT length at teeth, other airway device, oesophageal Doppler, OG tube,

Nose – airway device, NG tube (secure?), discharge, bleeding.

Standard respiratory exam (probably can’t sit them forward, worth auscultating after suction/cough, as anteriorly and posteriorly as possible (often only axillae)

Look at tidal/minute volume.

Note settings (FiO­2, mode and pressures) and doses of bronchodilator nebulizers or  infusions.

#### **CVS**

Peripheries – colour, perfusion, pulses, skin changes, anaemia

Standard examination

CVS parameters and infusion rates of pressors, dilators, chrono/inotropes.

#### **Abdomen**

Wounds. Feeding regimen. Palpate, ascultate. Stoma output. Drain output. Rectal tube output / stool type. Drain/catheter sites, integrity, output.

#### **Neurology and mental state**

Eyes – erythema, oedema, pupil size and function,

Agitation score and delirium assessment. Ask about hallucinations, anxiety.

Focal neurology if appropriate

#### **Fluid balance and kidneys**

Last 24hr and whole stay

Diuretics used?

Renal function results.

Urine sample required?

#### **Skin and lines**

Lines in date and site ok

Skin survey

## Then continue with the notes/chart/computer

#### **Haematology**

Hb, platelet and coagulation values.

Consider blood products if lines/procedures planned

#### **Microbiology**

New results – inflammatory markers and specimens. Known colonizers.

New cultures required?

Drugs, day and reason for doses and levels.

#### **Drug chart review**

Anything to stop.

Interaction/allergy check.

#### **Treatment limitations**

Therapeutic ‘ceilings’ or DNAR orders etc.?

Jehovah’s witness re blood products

Advance directives

#### **Next of kin or advocate**

Updated and in agreement with the plans.

# Document all the above

Start with the current main issues, and indicate whether they are improving or deteriorating.Then:

## Your review findings

In the order as above

## Your impression

A summary line, likely to conclude with 'deteriorating', 'improving', 'weaning' etc!

## Your plan

Address the current issues in turn

# Sample ward Round Structure

Decision re who gets seen first – potential discharges ‘v’ most unwell ‘v’ just sticking to the order.

## At each patient

**Admission diagnosis and background** (PMH)

Clarify if necessary

**Progress summary**

The stage of their critical illness

The general trend

**Systems reviewed** – as per above structure

**Results reviewed**

**Imaging reviewed**

View, compare, view report, discuss with radiologist or specialist, ?repeat, opinions in notes

Echo?

**Drug review**

For each drug, check: still required, not contraindicated, level checked, dose adjustment, convert route or convert to alternative, interactions.

Pre-admission drugs restarted where appropriate.

**Referral**

Speciality review (?other hospital).

Palliative care

Pain team

**Family and home team update**

**Instructions in notes and for nurses clearly written**

**Then:**

**Final rapid-fire cross-check – eg FAST HUG or adapted version eg ‘FLAST HUG DRIFT’:**

1. Fluids/feeding/faeces (ie aperients)
2. Lines - still required, VIP, correctly sited
3. Analgesia/Sedation started/stopped/altered
4. Thromboprophylaxis started/stopped(for procedures/bleeding)/HIT,
5. Head-up/rolling/spinal precautions,
6. Ulcer prophylaxis started/stopped/correct,
7. Glucose control - ?alter scale or change feeding regimen or restart long-acting insulin etc
8. Drugs stopped/adjusted/restarted (inc pre-admission drugs)
9. Referrals made/done and home team updated
10. Imaging needed/reviewed/referred
11. Family updated
12. Team up to date and in agreement (nurses instructions etc)