**ICU rounding:** Pretty much all your fellow cares about...

Please note that you do not need to present all of this in great detail each day depending on your fellow or attending but you should know it all! That way, if they ask a question about any of these things you’ll know it right away and won’t have to fumble through your notes or the chart. It’s a way to stay on top of things for yourself and your pt but also to look good while doing it!

**VS** (not just 24 hour ranges but TRENDS, like BP went down but then normalized, it doesn’t help me to know a range of systolic 60-120 if I have no idea where it’s headed or if we did something about it)

**On what vent settings?** (MODE: variables) – for details of vents see separate vent basics sheet

AC/VC (Assist Control/Volume Control): Tidal Volume/Respiratory Rate/PEEP/FiO2; know minute ventilation!

AC/PC (Assist Control/Pressure Control): Pressure Control (PC)/PEEP/Respiratory Rate/FiO2; know what volumes you’re pulling and your minute ventilation!

PSV (Pressure Support Ventilation): PS/PEEP, pt’s own RR, set FiO2; this is a weaning mode, know RSBI!

**And what pressors/drips?** Again, I can’t stress enough, know the trends!!! Know how long a drip has been on or off, when it is increased or decreased, and what the pressures or whatever you’re controlling have done in response to the drip (pressor know BPs, HR, UOP; insulin know sugars, gap, ketones; heparin know PTTs or hep assay; etc).

**Through what lines?** Please know your pt’s access daily, if you don’t it makes me question how good of a physical exam you really did. If there are peripheral IVs you must know the gauge and location – a 22 in the hand is NOT a 16 in the AC!

**And input/output through what tubes and drains?** This should include total AND net for the 24 hours as well as for the hospitalization. Again, you’ve got to know trends. It doesn’t help me to know that in 24 hours the pt peed 1L when all of it was in the 1st 18 hours but in the past 6 hours the pt peed zero. Same goes for chest tubes, post op drains, etc. Know the indications for when you should suggest removing a drain (will depend on what the drain is placed for, and how surgery feels). If there is a chest tube you need to know if it is to water seal or suction and if suction how much? Air leak? Ask RT! Also, is your Foley necessary? Reassess daily!!! Prevent CAUTIs!

**Abx?** Day ?/total days in course?

**Steroids?** Day ?/total? Taper?

**Prophylaxis?** DVT, GI, abx ppx if on indicated.

**Exam and labs**. Most important is changes in exam or labs, and trends, and then new **imaging finding or studies**. Please do not act on labs and imaging results in this section, you will address this in your plan.

**Problem list and plan** (or systems based with plan if that's how you do it – **see “How to Present in Systems”**). Just like on wards, to make a problem list name the main issue first followed by other active issues. Ilike to list out all of the problems while I am reviewing the chart from vitals to ABG to labs to imaging. Do that first and you’ll have about 15-20 problems, but you’ll notice that some go together, for example: hypotension, tachycardia, tachypnea, leukocytosis, lactic acidosis, acute kidney injury, hyperbilirubinemia, +blood cultures – that can all be from one problem, ie septic shock! That’s how you begin to manage both the details and the big picture simultaneously. It takes practice, but a good repeatable method will help you along the way. Don’t worry if your ICU rotation asks you to present in systems, I’ll show you in the doc titled ICU presentations – systems-based, we got you!