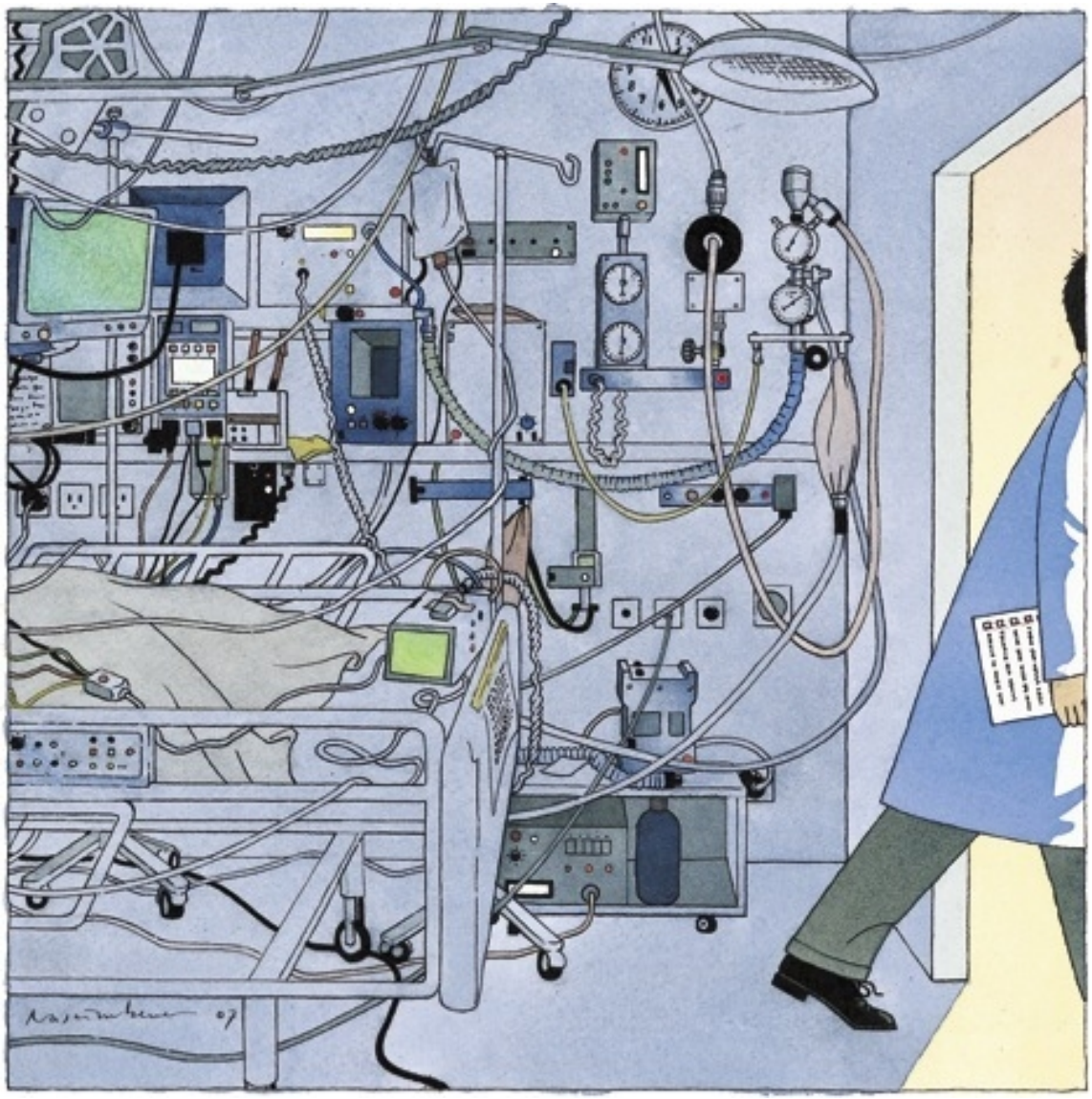


9. Daily patient checklists & prescribing

D A S H E M F F U G B T T

Drug chart: legible and clear? Appropriate dose / frequency? Missed doses? Restart chronic drugs? Stop anything? IV to enteral? Therapeutic monitoring required?

Analgesia: Regular simple analgesia + / - opiates. What is the quality of pain control?

Sedation: Is there a need for sedation over and above analgesia? If so, when was it last stopped and what happened? What is the sedation plan for today? Does the patient have features of delirium e.g. inattention or disorganised thinking?

Head of bed up 30 – 45 degrees: Can the patient be sat out of bed or even mobilised?

Eye care: Simple eye ointment qds for all patients receiving mask or invasive ventilation (unless long term tracheostomy and awake).

Mouthcare: Chlorhexadine mouthwash + / - nystatin 4-6 hourly? Is there any peri-oral pressure injury from the endotracheal or other tubes?

D A S H E M F F U G B T T

Feeding: Is the patient successfully being fed? Are they receiving prokinetics? Do they still need them (not if 4hrly gastric aspirates are <200mls for >24hours)?

Fluid balance: What is the fluid balance target for today? Have any maintenance IV fluids been stopped? What is the sodium balance?

Ulcer prophylaxis: Patients who are intubated and/or coagulopathic should receive ranitidine prophylaxis 150mg NG bd (unless on PPI).

Glycaemic control: Is the blood sugar ≤8.0 mmol/l over the last 24 hours?

Bowels: Are they working? If not, senna 15mg NG od-bd and sodium docusate 200mg bd?

Thromboembolic prophylaxis: dalteparin 5,000 iu prescribed? TEDs? Calf pumps?

Tubes: for each tube (nasogastric, all vascular access, urinary catheter, drains etc) consider, is it still needed, is it working, is the exit site inflamed (look especially for pressure injury from NG tubes)?

or failing that…FAST HUG(S BID)

Feeding

Analgesia (adequate)

and

Sedation (daily cessation)

Thromboprophylaxis

Head of the bed elevation

Ulcer (stress) prophylaxis

Glycaemic control

Spontaneous breathing trial

Bowel regimen

Indwelling catheter removal

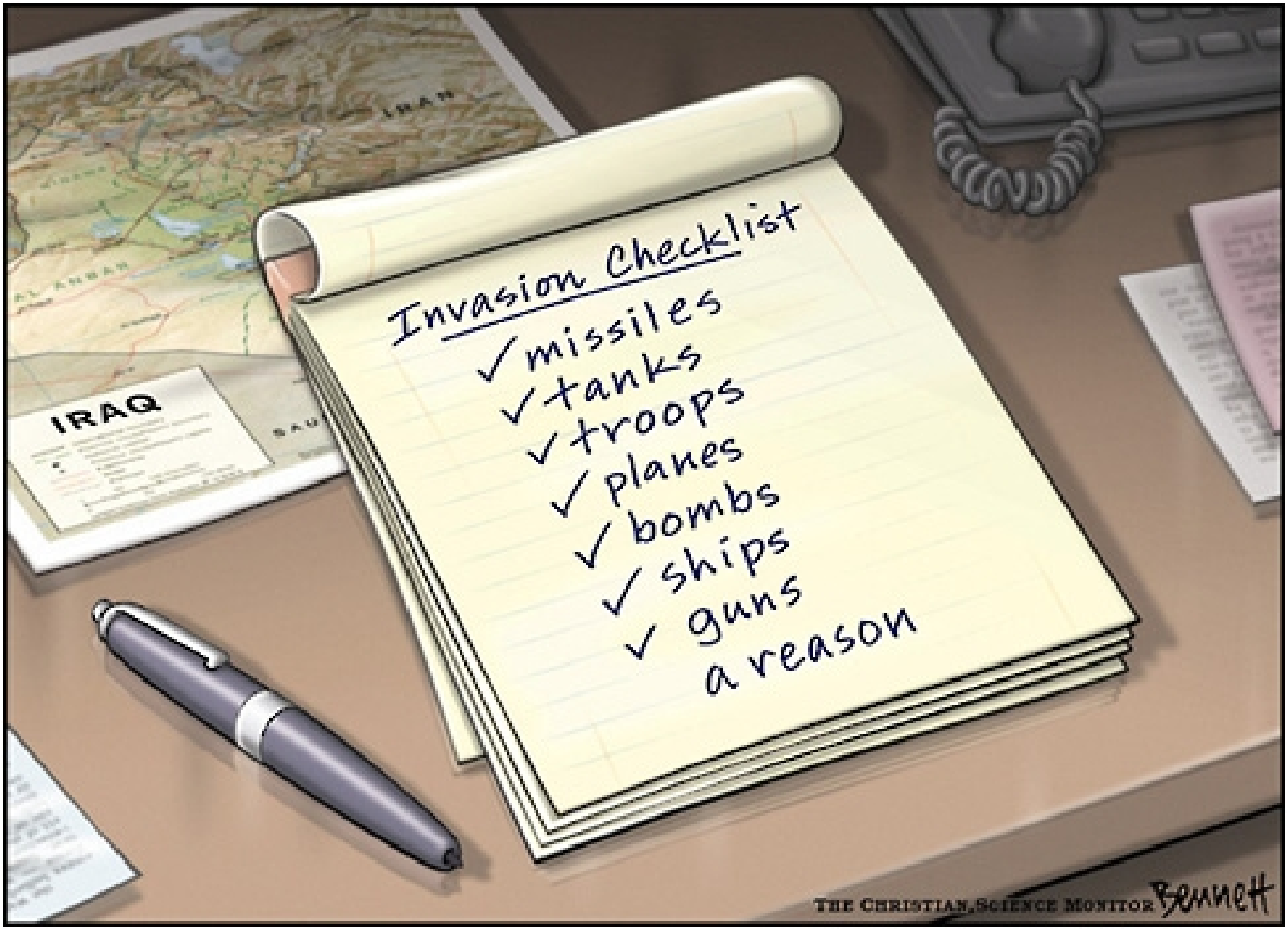
De-escalation of antibiotics

Prescribing

- Short term elective admissions – ward charts
- All others – ICU charts
- Clear and legible especially timings
- All IV fluids / blood products / RRT fluids
- NG whenever possible (except phenytoin)
- AVOID concentrated IV potassium
- All infusions

Empirical antibiotic therapy

- CHAOS book page 91 (or thereabouts)
- Empirical antibiotics must be stopped after 72hrs unless there is clear clinical and microbiological evidence to continue treatment.
- All doses are IV unless otherwise stated. Switch to enteral route at earliest opportunity. Usual criteria for switch are:
  - Temperature less than 38°C for 48hours
  - Oral food/fluids tolerated, with no evidence of impaired absorption
  - No unexplained tachycardia (>90bpm for 48hrs)
  - Patient is clinically stable and improving clinical parameters such as WCC, CRP
  - Not treating infections that require high antibiotic tissue concentration such as endocarditis, meningitis, necrotising fascitis, mediastinitis, brain abscess etc.
- Patients discharged from ITU on antibiotics should have the intended duration of treatment written in the notes and medicine chart.
- Clindamycin, cefotaxime, ceftazidime and ciprofloxacin- switch to appropriate oral agents that are less likely to cause C.difficile diarrhoea prior to discharge Treatment should be discussed with microbiology on a daily basis.


IRAQ
Invasion Checklist
✓ missiles
✓ tanks
✓ troops
✓ planes
✓ bombs
✓ ships
✓ guns
a reason
THE CHRISTIAN SCIENCE MONITOR
Bennett