The ICU consult

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James talks to Dr Oliver Flower about the ICU consult. This particular consult is a task that many junior doctors may find daunting.

For example, the ICU consult requires recognition of the sick patient, formulation of an issues list within a complicated and acute scenario, and communication of management priorities to the ICU team. In this podcast, we'll run you through an example case for how to go through the consult.

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About Dr Oliver Flower

Oliver Flower, known as Oli, is a staff specialist in Intensive Care Medicine at Royal North Shore Hospital, Sydney.

He is a believer in the power of the big crit care community in addition to Cadogan's FOAMed ethos. Moreover, he runs the educational and networking crit care website Intensive Care Network.

As an undergraduate in the UK he attained a 1st class BMedSci from Nottingham University, from where he subsequently received his MBBS. In Australia, he has worked in a variety of critical care areas in New South Wales and the Northern Territory. He completed his intensive care training and was awarded the Don Harrison medal for exam performance in 2009. During a fellowship year concentrating on neuro-intensive care he worked in acute spinal medicine at Prince of Wales Hospital, Sydney, and at Queen Square Intensive Care in London. Furthermore, he has a particular interest in e-learning initiatives. For example, he created the websites www.neuro-icu.com, www.rnshicu.org, Oli Flower's ICU Podcasts, and the College of Intensive Care Medicine's online journal club. Oli is a co-creator for www.intensivecarenetwork.com and a guest lecturer for www.lifeinthefastlane.com.

The ICU Consult

With Dr Oliver Flower, Staff Specialist Intensivist, Royal North Shore Hospital

Introduction

The ICU consult can be a daunting task for junior doctors in the hospital and requires recognition of the sick patient, formulation of an issues list within a complicated and acute scenario and communication of management priorities to the ICU team.

Case

You are the Orthopaedic Intern and have been asked to review a 75-year-old patient on the ward who is 48 hours post-NOF repair. The patient has become confused. On arrival at the bedside you note the patient is disoriented, agitated and is trying to get out of bed.

Review of observations at the bedside

Pulse rate 125/min in Atrial fibrillation
Borderline blood pressure of 95/50
Oxygen saturations on low side, 88% on 6L Hudson mask
Tachypnoeic
Febrile

Your Registrar asks you to make an ICU consult.

1. What is your approach to this case?

- This is an unwell patient who needs to be reviewed urgentlyto determine if additional help is needed. If you decide you do need ICU support, start some initial resuscitation before calling ICU.
- **Start some initial resuscitation**
    - Oxygen therapy – start by ensuring the patient has a patent airway (ABCs)
    - IV access and fluid rehydration
    - Blood tests (full basic panel) and blood cultures
    - Ask for increased nursing support
- **Call the ICU Registrar**
    - The aim is to communicate your concern regarding the patient's clinical condition
    - *ISBAR* is a helpful tool to give structure to your ICU consult:
        - *Introduce yourself*
        - *Situation:*you are a junior doctor reviewing a patient post-op with acute deterioration
        - *Background of the patient:* detail the patient's co-morbidities and post-op status
        - *Assessment:* examination findings (succinct – to point towards your differential diagnosis)
        - *Recommendations:* what you have done and a basic resuscitation plan, the recommendation should convey why you are concerned about this patient's condition

2. What are the key points for the ICU Registrar to know?

- Identification of organ failure is the key point
- How have they responded to initial resuscitation?

- Response to oxygen therapy: have their saturations improved, is there a good trace?
    - What does the patient look like: well or unwell? The gestalt impression is difficult to quantify but very important (this is something that improves with clinical experience)
- A high respiratory rate and respiratory failure will be of concern to the ICU team – indicating the patient may require an increased level of respiratory support, whichmay not be possible on the ward

3. What co-morbidities are important for the ICU to be aware of?

- Any life-threatening/limiting co-morbidities are important as they may direct ceilings of care/appropriate level of escalation of care:
    - Terminal cancer in those for whom palliative care is the approach of care
    - Anything leading to limitation on resuscitation status

4. The ICU Registrar will review the patient. What other actions are important prior to the ICU Registrar arriving to see the patient?

- IDC insertion: measuring fluid balance is important
- It is important to take blood cultures prior to antibiotic commencement, this will help identify the causative organism if this is sepsis
- A blood gas may be helpful: aVBG may be sufficient if you are happy with the patient's oxygenation and respiratory status
- Blood glucose: this may be deranged and easily amenable to treatment

5. You decide to do an arterial blood gas. Should the patient be taken off oxygen to perform this?

- No! Do not take the patient off oxygen if they are hypoxic or in respiratory distress
    - This increases the risk of hypoxia to the patient and potential cardiac arrest
    - By knowing the fraction of inspired oxygen, it is possible to take this into account when interpreting the blood gas

6. You order a CXR. Should this be performed on the ward or can the patient go to Radiology?

- A patient requiring resuscitation should not be taken off the ward to an area where it will be more difficult to resuscitate the patient or where there are fewer resources
- As a CXR can easily be performed on the ward, the patient should remain here and resuscitation continued

Do not leave the patient to go and do other ward jobs at this point. The unwell patient needs ongoing care and assessment of response to resuscitation.

Whilst waiting for ICU, the patient deteriorates. Although saturations increase to 92% on a non-rebreathermask, the patient is increasingly agitated and is trying to take off the oxygen mask. You call the ICU registrar who will be there in 15 minutes. The nurses ask you to consider sedation.

- This is a critical situation and the patient is extremely unwell
- Sedation may decrease the patient's level of agitation but could potentially worsen the patient's condition
- At this point it may be advisable to press the arrest buzzer to increase supports at the bedside as expediently as possible
- With regards to sedation, although this patient's symptoms may be distressing, sedation may be worse for the patient and lead to a decrease in respiratory drive, obstructed airway and hypotension
- Any sedatives should be used with caution and only by those with experience in their use and airway management

Take home messages

- Try to be succinct: Why are you calling the ICU and what do you feel you need?
- Direction of patient care including aims of treatment: Are there any limitations on care of this patient?
- Why are you worried about the patient: A brief list of issues (e.g. Rapid AF with haemodynamic instability and fluctuating GCS that cannot be managed on the ward)
- Where do junior doctors commonly fall down during the ICU consult?
    - If the message is not clear, it is difficult to elucidate in what way the junior doctor needs help on the ward

Reference

- www.intensivecarenetwork.com

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