DVT Prophylaxis	YES Unless: - Hemorrhage - PLT <30,000 or <50,000 and dropping - Need for LP or proceduralist preference (hold and restart asap) * Cirrhosis and elevated INR still need DVT proph *GFR < 30* - *Enoxaparin* *GFR < 30* - *Heparin*
GI Prophylaxis	Hold ASA if not necessary Avoid NSAIDS PO route preferred Order of preference generally: - Famotidine 20 mg PO q12 (reduce to q24 for CrCl < 50) - Famotidine 20 mg IV q12 (reduce to q24 for CrCl < 50) - Pantoprazole 40 mg/day PO (can't put down tube) - Lansoprazole 30 mg/day per tube - Pantoprazole 40 mg IV daily Intubated: - Sepsis/Stroke pts - Mech vent >48h, coagulopathy with INR >1.5 and PLT <50 Non-intubated: - If risk factors (high dose steroids, GIB, profound shock, stroke) REMOVE when TF/eating, on D/C from ICU
Glycemic Control	Endotool: - Difficult to maintain once on TF - Change to basal/bolus once TF or stable on endotool HYPOGLYCEMIA KILLS (pts can’t tell you when symptomatic) - Goal blood glucose 140-180, maybe higher in poorly controlled diabetics Monitor: - Enteral nutrition - Dextrose in fluids/abx - Steroid dosing
Nutrition	Start enteral nutrition early - Dietician consult for TF rec and order - Even trophic/”trickle” prevents villous atrophy and bacterial translocation Contraindications: - GI catastrophe (perf, obstruction, major UGIB, mesenteric ischemia) Doesn’t need to be post-pyloric

	Don’t check residuals unless pt starts vomiting/significant abdominal distension

Volume Status	Follow:
	- I&O daily
	- Weight daily
	Avoid maintenance fluids, they get enough from:
	- Medications/drips
	- Tube feeds
	  - adjust free water flushes
	Unless indicated - rhabdo, pancreatitis, ketoacidosis
	USE LR, NOT NS (? lower AKI risk, no need to worry about high K as only 4meq/L)
	Lactate, low UOP, and low CVP aren’t good indicators of low volume
	Utilize bedside US (call your residents, intensivists, hospitalist colleagues for help)
	Diuresis:
	- Furosemide can lead to hypernatremia
	  - Use thiazide to counter this
	  - Needs close K and Mg monitoring (protocols for replacement)

Electrolytes	Hypernatremia
	- Calculate free water deficit and replace (prefer via NG, otherwise D5W)
	- Tx because causes agitation (thirsty but can't drink)
	Hyponatremia
	- 125-135 common in critical illness, monitor
	- UpToDate has great hyponatremia workup algorithm or curbside Nephrology
	Hyperkalemia
	- Shift if EKG changes
	- If dry and acidosis → D5W Bicarb
	- If dry and alkalotic → LR
	- If fluid resuscitated → furosemide
	  - Consult nephrology if doesn’t resolve for emergent dialysis
	  - Replace UOP with LR (not NS)
	Hypokalemia AND hypomagnesemia
	- Replacement protocols
	Hypophosphatemia
	- Start enteral nutrition early
	- Check in alcoholism, replace per protocol if necessary

Delirium Prevention	Schedule melatonin at 6pm - Can add quetiapine 25-50 mg early evening (otherwise will have grogginess in AM) Order PT/OT, early mobilization

Information sourced from emcrit.com/pulmcrit.com

ICU courses available online:

- Critical Care for the Non-ICU Clinician
- Modified BASIC ICU Course - 13-03-20 : UCC COVID-19 Resource Centre