



FREE SAMPLE

ICU Survival Book

You are reading 5 pages of a 204-page guide.
These are real pages, not a mock-up.

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1. WHAT MAKES THE ICU DIFFERENT

The ICU is not just a floor with sicker patients. It operates on fundamentally different principles that shape every decision you make.

ICU VS. MEDICAL-SURGICAL FLOOR

ASPECT	MED-SURG FLOOR	ICU
Patient Ratio	4-6 patients per nurse	1-2 patients per nurse
Monitoring Type	Intermittent vital signs Q4H	Continuous cardiac/hemodynamic monitoring
Assessment Frequency	Every 4-8 hours routine	Every 1-2 hours minimum
Interventions	Scheduled meds, basic wound care, ambulation	Titrated vasoactive drips, mechanical ventilation, CRRT
Response Time	Minutes to hours acceptable	Seconds to minutes critical
Clinical Judgment	Protocol-driven, MD orders followed	Real-time autonomous decision making within scope
Documentation	Every 4-8 hours, narrative notes	Q1-2H vitals, continuous flowsheets, detailed trending
Family Presence	Open visiting hours	Often restricted, family meetings scheduled
End-of-Life	Less frequent, often transfer to hospice	Common, complex goals-of-care discussions

THE ICU MINDSET: SHIFTING YOUR THINKING

Working in the ICU requires a mental shift from task completion to **continuous clinical reasoning**. You are not checking boxes. You are constantly asking:

- WHAT IS THE CURRENT CLINICAL PICTURE? WHAT DO I SEE, HEAR, FEEL, AND MEASURE?
- WHAT COULD CHANGE IN THE NEXT 30 MINUTES TO 2 HOURS? WHAT ARE THE LIKELY TRAJECTORIES?
- WHAT WOULD I DO IF IT DOES CHANGE? AM I PREPARED FOR EACH SCENARIO?
- WHAT AM I MISSING? WHAT QUESTIONS SHOULD I BE ASKING?



Before you leave any ICU patient's room, pause for 5 seconds: What is the most likely thing to go wrong with this patient in the next hour? This habit builds anticipatory thinking that becomes automatic with practice.

7. YOUR FIRST 6 MONTHS: WHAT TO EXPECT

Practical wisdom from experienced ICU nurses. This is what we wish we knew starting out.

THE LEARNING CURVE: WHAT'S NORMAL

TIMEFRAME	WHAT YOU'LL EXPERIENCE	WHAT'S EXPECTED OF YOU
Weeks 1-2	Overwhelming, everything is new, relying heavily on preceptor	Focus on safety basics, ask many questions, observe patterns
Weeks 3-4	Starting to recognize patterns, still slow, frequent preceptor check-ins	Begin managing 1 patient with supervision, document accurately
Months 2-3	Building confidence with routine care, still need help with complex situations	Manage 1-2 patients, recognize when to escalate, improve efficiency
Months 4-6	Developing clinical intuition, can handle most situations, know when to ask	Full assignment with backup available, mentor newer nurses
Month 6+	Comfortable with routine, still learning nuances, less anxiety	Independent practice, continuing education, specialty development

COMMON NEW ICU NURSE MISTAKES TO AVOID

MISTAKE	WHY IT MATTERS	BETTER APPROACH
Silencing alarms without investigating	Alarms are there for a reason	Identify cause before silencing
Not trending vital signs	One value is a snapshot; trends tell the story	Always look at the last 4-6 hours
Waiting too long to call the MD	Delays worsen outcomes	Call early with specific concerns
Not asking for help	You can't do it alone	ICU is a team sport—ask early
Skipping documentation	Legal protection and continuity of care	Document in real-time when possible
Forgetting to eat/hydrate	You can't pour from an empty cup	Take your breaks—it's not optional
Trying to know everything immediately	Learning takes time	Focus on safety first, depth comes later



1. If something feels wrong, it probably is. Trust your gut and escalate.
2. You don't have to know everything—but you DO need to know who to call.
3. Ask questions. No one expects you to know it all on day one.
4. Document everything. If it's not documented, it didn't happen.
5. Take care of yourself so you can take care of others.



3. LINES, TUBES & DRAINS

ICU patients often look like they are connected to everything. Your job is to know what each line does, what it should look like, what should be coming out, and what would concern you.



KEY CONCEPT

**FOR EVERY LINE, TUBE, OR DRAIN ON YOUR PATIENT,
ASK YOURSELF THESE 5 QUESTIONS:**

- **PURPOSE** – why used? when can it come out?
- **POSITION** – where should it be? how to verify placement?
- **OUTPUT CATHETER** – what color/consistency is normal vs. concerning?
- **OUTPUT VOLUME** – how much is expected? what is the trend?
- **RED FLAGS** – what are immediate red flags? know the signs before they happen

**WHEN DOCUMENTING DRAIN OUTPUT,
INCLUDE ALL OF THE FOLLOWING:**

→ AMOUNT, COLOR, CONSISTENCY, TREND, ODOR

NOTIFY PROVIDER IMMEDIATELY:

- FRANK BLOOD FROM ANY DRAIN
- FECULENT MATERIAL FROM ABDOMINAL DRAINS
- PURULENT DRAINAGE WITH FEVER
- SUDDEN LARGE INCREASE IN VOLUME
- ABRUPT CESSATION OF EXPECTED DRAINAGE.

COMMON ICU LINES/ TUBES: QUICK REFERENCE

LINE/TUBE	PURPOSE	NORMAL FINDINGS	RED FLAGS
Arterial Line	Continuous BP monitoring, frequent ABG access	Pulsatile waveform with dicrotic notch, site clean/dry	Dampened/flat waveform, bleeding, distal limb pallor/pain/pulselessness, air in tubing
Central Line (CVC)	Large-bore IV access, CVP monitoring, vasoactive infusions	All lumens flush easily with blood return, dressing clean/dry/dated	Signs of infection, no blood return, resistance to flush, air embolism
ETT/Tracheostomy	Secure airway, mechanical ventilation	Bilateral equal breath sounds, stable cm marking, cuff pressure 20-30 cmH ₂ O	Unilateral breath sounds, depth change, air leak around cuff, sudden desaturation
NG/OG Tube	Gastric decompression, enteral feeding, medications	Placement verified, secured, cm marking documented	Tube displacement, bloody drainage (not pink-tinged), abdominal distension
Foley Catheter	Accurate urine output monitoring	Clear to yellow urine, output >0.5 mL/kg/hr, bag below bladder	Gross hematuria, sudden output drop, cloudy/foul urine, leaking around catheter
Chest Tube	Drain air or fluid from pleural space	Tidaling in water seal, expected air leak pattern, drainage <100-200 mL/hr	New/continuous air leak, >200 mL/hr bloody output, subcutaneous emphysema
Surgical Drains	Remove fluid/blood from surgical site	Suction maintained, serosanguinous drainage decreasing	Bright red blood >100 mL/hr, purulent drainage, drain dislodgement

3. THE ICU HEAD-TO-TOE ASSESSMENT

The ICU head-to-toe is more detailed and more frequent than a floor assessment. You will perform a comprehensive assessment at shift start and then focused reassessments Q1-2 hours or with any change in condition.

THE ASSESSMENT FLOW: ROOM ENTRY TO EXIT

DOORWAY	First Impression (5 seconds)	Before touching anything—LOOK. Does the patient look comfortable or distressed? What is the overall color/appearance? Is the room calm or chaotic? Trust your gut—if something feels wrong, it probably is.
MONITOR	Read the Numbers (30 seconds)	Check vital signs on the monitor. Compare to baseline. Note any alarms or trends. Are parameters appropriate for this patient?
PUMPS & DRIPS	Verify Infusions (1-2 minutes)	Trace each line from pump to patient. Verify rates match orders. Check IV site patency. Confirm high-alert drips (vasopressors, sedation, insulin).
AIRWAY & BREATHING	Top Priority (1-2 minutes)	ETT/trach security and position. Ventilator settings and alarms. Breath sounds and respiratory effort. SpO2 and oxygen delivery.
HEAD-TO-TOE	Systematic Body Assessment (5-10 minutes)	Neuro → Cardiac → Respiratory → GI → GU → Skin. Use the detailed tables below.
LINES & ACCESS	Complete Inventory (1-2 minutes)	All IV access points, arterial lines, central lines. All drains and tubes. Document position and function of each.
ENVIRONMENT	Safety Check (30sec - 1 minute)	Bed position and alarms. Call light within reach. Suction and emergency equipment. Room organized for emergency access.

➔ **MONITOR ASSESSMENT** The bedside monitor is your real-time window into patient physiology. Know what each number means and what is normal for YOUR patient.

PARAMETER	NORMAL RANGE	WHAT TO LOOK FOR	ACTION TRIGGERS
HEART RATE	60-100 bpm	Rhythm regularity, sudden changes, compare to baseline	<50 or >130, new irregularity, symptomatic
BLOOD PRESSURE	SBP 90-140, MAP >65	Trend direction, response to interventions, compare to goal	MAP <65, SBP <90 or >180, rapid changes
SPO2	>92-94% (varies)	Trend, response to O2 changes, waveform quality	<90%, downward trend, need for increased O2
RESPIRATORY RATE	12-20/min	Pattern, depth, synchrony with vent if applicable	<8 or >30, labored, paradoxical
TEMPERATURE	36.0-38.0°C	Trend, response to interventions	>38.3°C (fever workup), <36°C (sepsis concern)
CVP (IF AVAILABLE)	2-8 mmHg	Trend with fluids, respiratory variation	High (>12) or low (<2), not responding to fluids
ETCO2 (IF AVAILABLE)	35-45 mmHg	Trend, waveform shape, correlation with ABG	<20 or >60, flat waveform, sudden change





THAT WAS THE SAMPLE

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