SICU primer

Welcome to the SICU. This rotation is regarded as one of the most rewarding and best learning opportunities in anesthesiology and surgical residency training. You will have the opportunity to care for some of the sickest patients in the hospital with some of the most unique and interesting pathophysiology. There will be many opportunities to hone your procedural skills and to further develop your clinical reasoning.

You will be the primary point of contact for some of the sickest patients in the hospital. Being trusted with their care can be a daunting but rewarding experience. Don't worry. You will not be alone. You will be surrounded by a wealth of experience and knowledge.

Patient care in the ICU is very much a team endeavor. Every member of the team adds value and brings a unique skill set to the group. Surgical, ED and anesthesia residents, fellows, APPs, consultants, respiratory therapists, speech language pathologists, occupational therapists, physical therapists, dieticians, pharmacists, and nurses all have valuable knowledge to share and are available to help. I encourage you to engage in dialogue, ask questions, get to know what each team member can offer and to fully utilize the resources available. The team is there to help care for patients and to teach. Have a low threshold to take advantage of that help.

You will sign in for and act as the covering provider for your portion of the list during the day and for all of either the SICU Green side (Campus 11) or the SICU Gold side (Center 11) in the HUP Pavilion when on night float or call. The expectation is that you or one of your co-residents be immediately available. Nurses or other staff should be able to find you or reach you by phone. If leaving the unit, let your fellow, co-resident and /or charge nurse know that you will be off the unit and how you can be reached.

Please show up on time and ready to care for your patients. Be available and take ownership of your patients. You are the primary point of contact for each of your patients.

Structure of Surgical Critical Care Service:

The SICU is divided into two teams, now both in the HUP Pavilion

- Campus 11 SICU beds 1125-1136
- Center 11 (Perelman) Pavilion beds 1113-1124
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Each team functions independently during the day. Overnight, ICUs are covered by one fellow. The fellow covers the junior resident and patients on both the Gold and Green sides.

The schedule:

You will do 1 week of night float, 3 weeks of days, 1 24 hr. Saturday call, and have 2 weekends completely off during your rotation.

Day Floats: You will have 3 weeks of days during your rotation. Day shift is from 6am – 6pm. You should be on time to receive sign-out from the night float resident at 6am. You are expected to stay the entire shift and then sign-out your patients to the night float resident at 6pm.

Night Float: You will take one week of night float during your rotation. Night float is 6pm – 6am. You are expected to be present on the floor of the unit throughout your shift. There is no need to go to the call room as you are expected to be awake caring for your patients at the bedside.

You will take one 24 hr. Saturday call during your rotation. You will be relieved after rounds the Friday before you are scheduled for your Saturday call in order to give you an opportunity to get extra rest prior to this call shift. A call room on the Green and Gold side is available for you during this shift; however, the expectation is that you are checking in and re-evaluating your patients frequently throughout the day and night.

On Sundays, there will be one resident on 6a-6p and one resident on 6p-6a. This allows you to have 2 weekends completely off during your rotation.

Sign-out:
Sign-out at 6am each morning. The overnight resident will update and print a copy of carelign for each member of the team prior to sign-out.

Pre-rounding:
Review carelign, notes, labs, ins and outs, the critical care flowsheet and any other pertinent information from the day prior. Check in with your patients' nurses. Often, they can identify issues that will need attention during your shift and update you on the night's events. Examine your patient, check vent settings, drips, drains, surgical sites, mental/neuro status, etc. Formulate your plan for the day. See appendix 2 for the system based approach to assessing your patient.

Rounds:
Rounds kick off with board rounds at 8:00am. These are led by the fellow(s). The charge nurse will want to get a sense of the expected disposition for each patient. They will also want to know if any patient will be leaving the floor for any reason, radiology studies, surgery, procedures, etc. Also raise any potential issues that may affect staffing, e.g., an anticipated need for CRRT. (Another important element of board rounds is to address level of sedation and weaning readiness of ventilated patients. Addressing this on board rounds gets everyone on the same page so that respiratory can start challenging to wean early in the day rather than waiting for the plan to set on team ICU rounds)

Morning rounds will begin in earnest after board rounds. Typically, rounding will start with new admissions or with any particularly sick patients who need prioritized attention. Rounds are systems based, rather than problem based. It is important to include the nurse when rounding. Make every effort to have the patient's nurse present. Plan to present without a computer. Residents who are not presenting will use the computer(s) to update carelign (see appendix 1: carelign) and to put in orders while rounding on the patient. It may be helpful to bring a personal computer to use during rounds. Workstations on wheels may not be available for all team members. New consults should be called as soon as possible (during rounds, not after). A resident or med student will be responsible for scribing the to do list on the outside of the patient's window with a dry erase marker.

The Presentation:
Complete and high-quality presentations allow for development of comprehensive treatment plans, and are also a platform for teaching and assessing progress. During your presentation- DO NOT read aloud from sign-out- this does not demonstrate that you have assessed your own patients. Also- DO NOT say that you performed an assessment that you did not do! It is never ok to fabricate information.

There is a lot of data to sift through when preparing your presentation- it is very easy to feel 'lost'. If you ever feel this way, think about the 'big picture'- why is this patient here? What is currently their biggest threat to life? What needs to happen in order for them to leave the ICU? Always ask questions if you don't understand something- it is ok to not know an answer!

The format and order for the presentation may vary slightly per attending preference; however, the basic components include overnight events, physical exam, assessment and plan.

Assessment is presented by organ system- discuss each problem under the relevant organ system, and provide the most likely etiology/diagnosis for each problem (see Appendix 2 for common diagnoses by system in the ICU). If a diagnosis is unclear, provide a few differentials and present any data which supports your diagnosis.

Just like assessment, the plan is also presented by system. Use specific goals (titrate pressors to MAP goal of ___, titrate ionotropes to cardiac output goal of ___, SpO2 goal > ___, titrate sedation to RASS goal of ___). Use specific time intervals (Goal (-) 1 L over next 24 hours, advance tube feeds to goal by 20 mL q6 hrs). Avoid general phrases such as "wean pressors" or "decrease vent settings".

Sample Assessment and Plan:

- **Neuro**
  - Assessment: Postoperative back pain- poorly controlled requiring several doses of IV breakthrough narcotics; History of grand-mal seizures- no evidence of seizure activity since admission
  - Plan: Increase Oxycodone dosing to 10 mg q3 hrs and add standing Tylenol; continue home anti-epileptic therapy and monitor for signs of seizure activity

- **Pulm**
  - Assessment: Acute hypoxemic respiratory failure due to hospital acquired PNA- currently on volume-control ventilation, secretion burden improved, BAL growing pan-sensitive GNRs
  - Plan: Wean ventilator settings to pressure support today, consider SBT and extubation if patient tolerates. Continue antibiotics for PNA and continue with aggressive pulmonary toilet to aid with secretion burden

After Rounds:
Following rounds, the team will gather to run the list. The covering provider will run through tasks on the to do list for each patient.

The time between running the list and afternoon rounds is your time to accomplish tasks on the to do list, follow up with consultants, perform procedures, talk with patients, update family/ designated decision makers, etc. and to continuously check in and re-evaluate your patients as they are dynamic.

Timing of afternoon rounds is typically at around 4:00pm but may vary at the discretion of the fellow or attending. The patient's nurse will lead rounds. This is a good time to review and to update the list of things to do for each patient.

The day residents will sign out the patients to the night float resident at 6pm.

PM/Overnight rounds:
The night resident will round at least one time in the late evening, ~10PM with the call fellow. These rounds are less formal and may be led by the patient's nurse.

Overnight call:
A key to overnight call is to be available, which means being present on the unit. You will inevitably be needed as unexpected issues will arise. You are the primary point of contact for all patients on your 12-bed service overnight. When contacted by a nurse with a concern, it is expected to go to the patient's bedside to assess and treat the patient in the most expeditious manner possible. Going to see the patient will provide better care and will, ultimately, save you time, effort, and additional calls throughout the night. **Have a low threshold to call the fellow with questions or concerns.**

Update carelign with significant events throughout the night. This will save you time in the morning and will make sign-out more efficient and complete.

Call your fellow with any questions. A fellow is always immediately available to help.

Fellow Call Triggers-MUST call fellow for the following:

- New admission
- Patient requires intubation
- Decisions to extubate
- Change in ventilator mode or need for increased support (i.e. FiO2, PEEP)
- Greater than 2L fluid resuscitation
- Transfusion decisions
- Hypotension unresolved by 2L fluid resuscitation
- Addition of vasopressors or titration to upper drug limit
- Oliguria greater than 2-hours or anuria
- Addition of antibiotics

Admissions

New patients that arrive to the unit before 5pm will be admitted by the APP. The APP will receive the patient. It is a good idea to be present when the patient is dropped off to listen to sign out. The APP will get the patient settled, review their chart, formulate a plan, write a note, perform necessary procedures and place orders. If you have interest in or a need for training in a particular procedure let the APPs and Physician Fellows know so that they may facilitate those opportunities. Please be helpful by offering assistance when you are able, especially when very sick patients are being admitted. When the patient is in a good place, the APP will sign the patient out to the resident who will be covering. They will not typically update carelign. It is also a good idea to confirm that ICU consent has been obtained. If consent has not been obtained, it is the resident's responsibility to obtain ICU consent either from the patient or the patient's medical decision maker.

You are responsible for admitting patients to the unit after 5pm. Be sure that your fellow is aware that a new patient is arriving on the unit. Admitting a patient includes taking sign-out, examining and assessing the patient, ensuring the patient is stable and resuscitating as necessary. You can and should ask your fellow for help. Once the patient is stable, you can finish chart review, place remaining orders, obtain ICU consent, write an admission note, and update carelign. Be sure to discuss your plan, necessary procedures, studies, and medications with your fellow. Expect to present patients you admit on morning rounds. (see appendix 3: ICU admission checklist)

ICU consent

An ICU consent should be obtained for each patient in the ICU. It is the resident's responsibility to obtain consent on arrival to the ICU. If the patient is not consentable and a decision maker is not available to provide consent, emergent procedures may be performed without consent. Every effort should be made to obtain consent as soon as possible, however. If unable to obtain consent, it should be signed out to the next shift that the patient has not been consented so that they know to obtain consent.

Procedures:

- **MUST** be certified to perform each procedure independently
    - If you aren't certified, you cannot perform independently
- **Dobhoff tubes-** Providers **MUST** have completed training at SIM center before placing
    - **There is a new technology called IRIS that is being introduced to the system. For now, only APPs are receiving training on this equipment. From a hospital standpoint we are working out a process for residents.**
- **Ensure procedure notes are completed for ALL procedures-** in PennChart, steal procedure templates from Ashley Geller, CRNP's SmartPhrase list (use the. SCCS notes only)

Transfer process

- **Communication with primary service**
- **Assess patient for readiness to transfer**
- **Discuss transfer with Physician Fellow, APP, and or Attending**
- **Notify charge RN of impending transfer (They will place a bed request)**
- **Review and make epic orders floor appropriate**
- **Sign the patient out to the floor covering provider**
- **Use the. SCCS template to complete a brief transfer note**
- **Place a transfer order**

Call rooms

The Gold service resident call room is Room #H11317, across from room #1153 on the museum side of Center 11. The Green service resident call room is in the off stage space in Campus 11, room 11386.

Lockers

There are six day-lockers assigned to each of the Green and Gold service residents. You may lock your belongings in any of them through their own locks or bring your own lock from home. Unfortunately, these are not for overnight storage and they must be vacated every evening. If you do not have a locker available, please contact Tina Taylor at Tina.Taylor2@pennmedicine.upenn.edu.

Appendix 1: Carelign

ICU CARELIGN TIP SHEET

CREATING A NEW SICU GOLD CARELIGN:
- Under the Care Plan tab, "Click here to add new problem"
Name it "SICU Gold or Green", and choose "surgical critical care" under the Service drop-down,
then click Save In that new box that you created, click "Add consultant notes", and choose "surgical critical care" under the "Choose Consulting Service" drop-down

- In the blank box below, type ".sicu", update the respective systems

- Update the Assessment section: HPI, PSH/PMH, OR dates, to do's.

UPDATING THE CARELIGN DAILY:
- Update the "one liner" to ensure it is still accurate/ relevant

- Update significant daily/nightly events

- Update the head to toe! This should be as current as possible.

COVID/MICU OVERFLOW CAVEAT:

- If patient is MICU overflow, and SICU Gold or Green is the primary team, the carelign will not print out correctly if done in the usual way Do NOT add SICU Gold consult

- Instead, use the "Summary (one-liner)" as your space to do the usual SICU Gold or Green carelign

Other Carelign tips:

- If patient is in the SICU for a long time, please condense the daily events. Keep 3-5 days of daily events at a time. Move daily events that are older than 3 – 5 days to the HPI section

- Do not delete older events. Instead, copy and paste them under the "Hospital Course" tab (below the "Summary (one-liner)" tab. Then add something like "See Hospital Course for prior events" just above the daily events that you are keeping in the current sign-out.

- If a patient goes to the OR multiple times during their SICU stay, it is helpful to add "OR" just above the Daily Events, to have a quick guide to their operative/IR/bedside OR history without

having to scan through all of the daily events Here, add the dates, procedure, and anything else significant. (keep it brief!)

- SICU Gold or Green should be the primary team ONLY when the patient is MICU overflow. If the patient has a surgical team following (not just a surgical consult for a trach, for example), the surgical team should be the primary team.

- To ensure patient has correct primary team, go to the "Treatment Team" section in their EPIC. Make sure SICU Gold or Green is added as a team

- Make sure the correct surgical team is clicked as primary. A blue diamond will appear next to the primary team.

- Keep things succinct. This is your sign-out, not a note in the chart! Ex: "HFNC 40L/40%" instead of "acute respiratory failure requiring positive airway pressure with high flow nasal cannula"

- Routine things that we do/think about for every patient every day do not need to be in carelign. (Ex: educate and reinforce IS 10x/hr when awake, chlorhexidine for VAP prophylaxis, reassess daily need for foley)

Appendix 2: System Based Approach to Patient Assessment

This framework is useful for assessing your patient on admission to the unit, prior to rounds, during rounds, and for documentation. A few key points for each system are included. These points are not comprehensive.

Neuro: mental status, CAM: positive, negative, unable to assess, RASS, sedation plan
Cardiovascular: hemodynamics – stable or unstable, MAPs, vasoactive infusions
Pulm: oxygen support, vent settings to include tidal volumes in ml/kg, vent mode, set tidal volume, respiratory rate (actual and set), pressure support, PEEP
ID: fever curve, WBC, cultures, antibiotic therapy
GI/nutrition: PO status, TEN?, TPN?, bowel movements, bowel regimen
Renal: I/Os, urine in ml/kg/hr, electrolytes, renal replacement therapy
Heme: CBC, coags, transfusions, VTE ppx, SCDs, active type and screen
Endocrine: glucose, insulin requirement
MSK: PT/OT, out of bed
Tubes, lines, drains:

Common SICU Diagnoses Organized by System

This outline is to help you frame your data and assessments for rounds into high-quality presentations.

- Neuro: delirium, sedation for ventilator synchrony, altered mental status, post-operative pain, risk of EtOH withdrawal, risk of spinal cord ischemia, seizures
- CV: hypotension (due to various forms of shock, hypovolemia, vasodilation, etc), risk of MI, arrythmia, need to maintain flap perfusion, paroxysmal Afib history
- Pulmonary: post-operative mechanical ventilation, respiratory failure (acute vs chronic, hypoxemic vs hypercarbic), respiratory acidosis or alkalosis, pneumonia, COPD, atelectasis, pulmonary edema, pleural effusion, ARDS
- GI: perforated duodenal or gastric ulcer, gastritis, peritonitis, recent bowel anastomosis, transaminitis, malnutrition
- Renal: AKI (pre-renal vs intrinsic vs post-renal), rhabdomyolysis, CKD
- Electrolytes/Fluids: volume overload, metabolic acidosis/alkalosis, hyper/hypokalemia, hyper/hyponatremia, etc.
- Heme: anemia (due to chronic illness, acute blood loss, phlebotomy) without evidence of active bleed, acute blood loss, pulmonary embolus or DVT, at risk for DVT
- ID: sepsis, septic shock, bacteremia, peritonitis, at risk for hospital acquired infection, post-op leukocytosis
- Endo: hyperglycemia, adrenal insufficiency, DM

Appendix 3: ICU new admission checklist 5pm - 7am

Pre arrival (time permitting):

- Chart biopsy
- Start admission note (Steal note template from Ashley Geller, CRNP's SmartPhrase list, use the .SCCSGENERAL note, or another appropriate ".SCCS..." admission note)
- Start carelign (see appendix 1)
- Start orders (recommend Ashley Geller, CRNP, admission order set, see below)

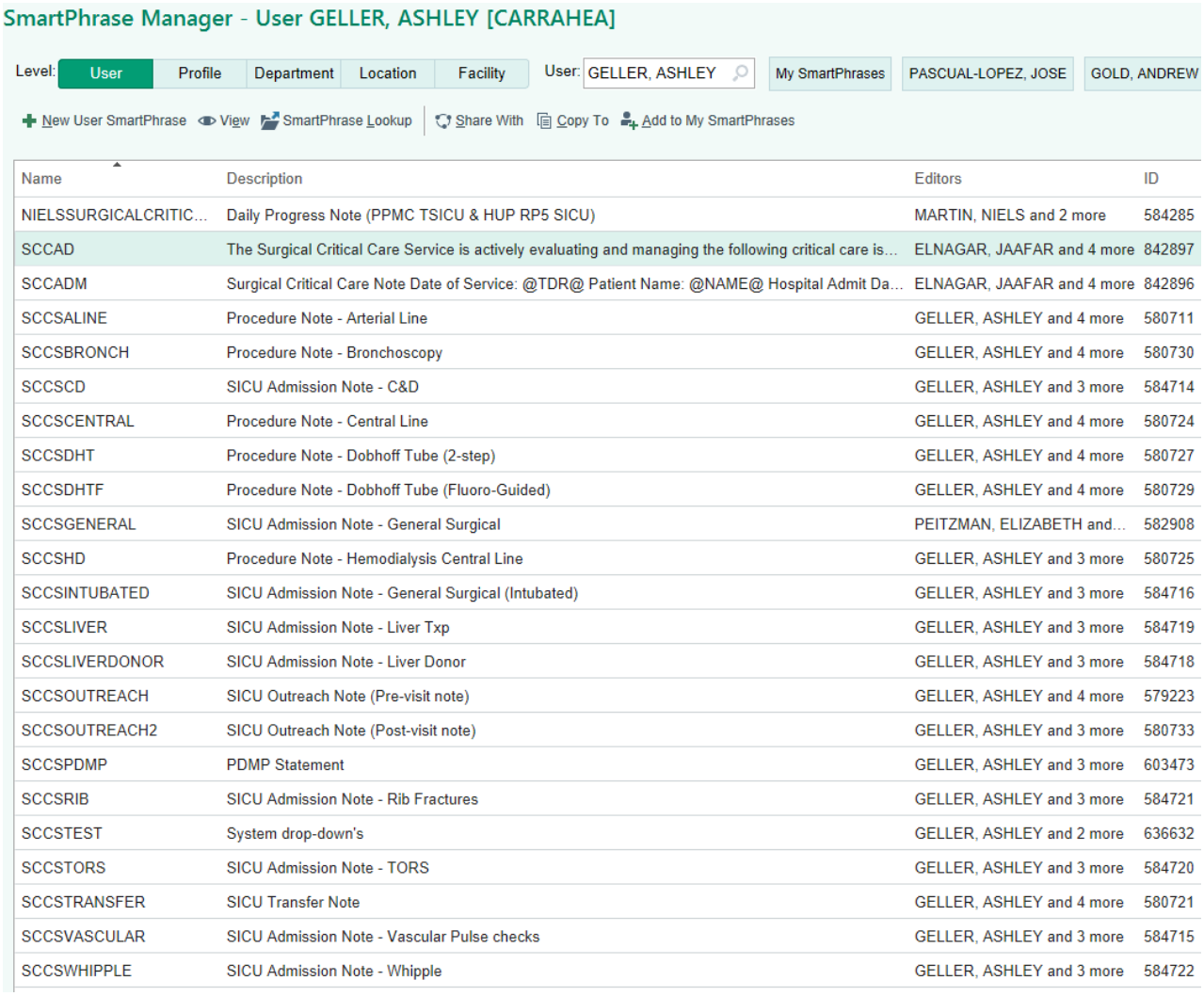
On arrival:

- Take sign-out
- Examine and assess patient
- Formulate plan with focus on immediate needs (circulation, airway, breathing, necessary procedures, antibiotics, etc.)
- Discuss your plan with your fellow
- Ensure the plan is communicated to nursing and other pertinent members of the team
- Implement urgent/emergent portions of agreed upon plan, to include finishing orders

After the patient is settled:

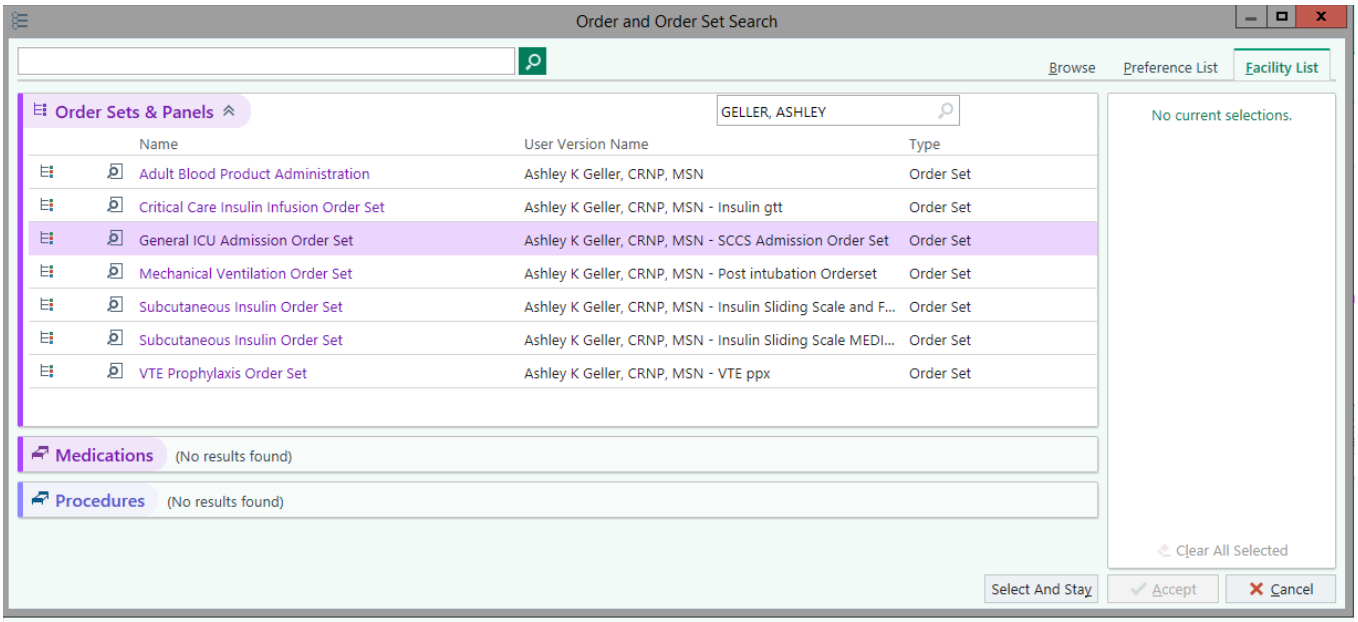
- Confirm ICU consent has been obtained
- Accomplish non-urgent portions of plan
- Complete admission note
- Update carelign
- In Pennchart, add SICU green/gold to pt Treatment Team

Helpful dot phrases:



Name	Description	Editors	ID
NIELSSURGICALCRITIC...	Daily Progress Note (PPMC TSICU & HUP RP5 SICU)	MARTIN, NIELS and 2 more	584285
SCCAD	The Surgical Critical Care Service is actively evaluating and managing the following critical care is...	ELNAGAR, JAAFAR and 4 more	842897
SCCADM	Surgical Critical Care Note Date of Service: @TDR@ Patient Name: @NAME@ Hospital Admit Da...	ELNAGAR, JAAFAR and 4 more	842896
SCCSALINE	Procedure Note - Arterial Line	GELLER, ASHLEY and 4 more	580711
SCCSBRONCH	Procedure Note - Bronchoscopy	GELLER, ASHLEY and 4 more	580730
SCCSCD	SICU Admission Note - C&D	GELLER, ASHLEY and 3 more	584714
SCCSCENTRAL	Procedure Note - Central Line	GELLER, ASHLEY and 4 more	580724
SCCSDHT	Procedure Note - Dobhoff Tube (2-step)	GELLER, ASHLEY and 4 more	580727
SCCSDHTF	Procedure Note - Dobhoff Tube (Fluoro-Guided)	GELLER, ASHLEY and 4 more	580729
SCCSGENERAL	SICU Admission Note - General Surgical	PEITZMAN, ELIZABETH and...	582908
SCCSHD	Procedure Note - Hemodialysis Central Line	GELLER, ASHLEY and 3 more	580725
SCCSINTUBATED	SICU Admission Note - General Surgical (Intubated)	GELLER, ASHLEY and 3 more	584716
SCCSLIVER	SICU Admission Note - Liver Txp	GELLER, ASHLEY and 3 more	584719
SCCSLIVERDONOR	SICU Admission Note - Liver Donor	GELLER, ASHLEY and 3 more	584718
SCCSOUTREACH	SICU Outreach Note (Pre-visit note)	GELLER, ASHLEY and 4 more	579223
SCCSOUTREACH2	SICU Outreach Note (Post-visit note)	GELLER, ASHLEY and 3 more	580733
SCCSPDMP	PDMP Statement	GELLER, ASHLEY and 3 more	603473
SCCSRIB	SICU Admission Note - Rib Fractures	GELLER, ASHLEY and 3 more	584721
SCCSTEST	System drop-down's	GELLER, ASHLEY and 2 more	636632
SCCSTORS	SICU Admission Note - TORS	GELLER, ASHLEY and 3 more	584720
SCCSTRANSFER	SICU Transfer Note	GELLER, ASHLEY and 4 more	580721
SCCSVASCULAR	SICU Admission Note - Vascular Pulse checks	GELLER, ASHLEY and 3 more	584715
SCCSWHIPPLE	SICU Admission Note - Whipple	GELLER, ASHLEY and 3 more	584722

Helpful admission order set from Ashley Geller:


Order and Order Set Search
Browse
Preference List
Facility List
Order Sets & Panels
GELLER, ASHLEY
No current selections.
Name
User Version Name
Type
Adult Blood Product Administration
Ashley K Geller, CRNP, MSN
Order Set
Critical Care Insulin Infusion Order Set
Ashley K Geller, CRNP, MSN - Insulin gtt
Order Set
General ICU Admission Order Set
Ashley K Geller, CRNP, MSN - SCCS Admission Order Set
Order Set
Mechanical Ventilation Order Set
Ashley K Geller, CRNP, MSN - Post intubation Orderset
Order Set
Subcutaneous Insulin Order Set
Ashley K Geller, CRNP, MSN - Insulin Sliding Scale and F...
Order Set
Subcutaneous Insulin Order Set
Ashley K Geller, CRNP, MSN - Insulin Sliding Scale MEDI...
Order Set
VTE Prophylaxis Order Set
Ashley K Geller, CRNP, MSN - VTE ppx
Order Set
Medications
(No results found)
Procedures
(No results found)
Clear All Selected
Select And Stay
Accept
Cancel

Appendix 4: roles and responsibilities

Daytime resident responsibilities:

- Obtain sign out
- Pre round – perform chart review, physical exam, discuss nursing concerns
- present patients during rounds
- Enter orders and call consults **while rounding** (don't wait until after)
- Update patient doors with daily "to-do's" and antibiotics regimen w/dates
- Contact Primary service covering provider to update on patients' plans of care
    - Attending to attending communications for discrepancies
- Enter labs/CXR/TPN orders during rounds for following day
- Obtain ICU consent on **ALL** patients when they arrive
- Ensure Carelign is up to date: (see appendix 1)

Resident Nighttime responsibilities:

- Be available
- Contact primary service covering provider with any significant changes in patient condition
- Complete physical exam and update documentation/Carelign as indicated
- Patient discharges/transfers 5pm-7am:
    - Assess patient for appropriateness of transfer, give verbal sign-out to primary team, clean up orders (remove any ICU specific orders), write transfer note in PennChart (steal procedure templates from Ashley Geller, CRNP's SmartPhrase list-use the .SCCSTRANSFER), place transfer order
    - If overnight transfer is unplanned ("bump") for emergent bed needs, and if patient is transferring to Rhoads 4 or Silverstein 12, communicate with SICU RN that patient must be designated as a "Green Sheet" & place order for "Inpatient Consult to Respiratory Care" (type "Green Sheet" in comments of order)

Advanced Practice Provider responsibilities:

- Admit/Transfer/Discharge patients between 7 am – 5 pm
- 1+ APP per side during weekdays plus 1 "admitter" APP, 1 APP for entire SICU during weekends on the side opposite the on call physician fellow
- 1 overnight APP on side opposite fellow
- Maintain SCCS Database
- Ensure compliance with SCCS Clinical Practice Guidelines (CPGs)
- Cover VISICU PACU beds (admissions, transfers and ICU care)
- Communicate plan of care with primary service (APP/Fellow/Chief)
- Assist/train or perform ICU procedures
- Outreach (see at-risk patients on floor who have transferred from SICU)

Appendix 5: Recommended Reading

(From "ICU Resident's Guide" by Society of Critical Care Anesthesiologists)
Link: https://www.asahq.org/-/media/sites/asahq/files/public/about-asa/governance-and-committees/caesar-covid/socca-residents-guide-2017.pdf?la=en&hash=E68064D7628D94CBEF659BF3AD35E28F7BC9937D

Month #1: Chapter 1 (Sections 3, 4, 6); Chapter 2 (Sections 1, 2, 4); Chapter 3 (Section 3); Chapter 4 (Sections 1, 2, 3); Chapter 5 (Sections 1, 2, 3); Chapter 6 (Section 2); Chapter 7 (Sections 1, 2, 3, 4); Chapter 8 (Sections 2, 3); Chapter 9 (Sections 1, 2); Chapter 10 (Section 1)

Month # 2: Chapter 1 (Sections 5, 8, 9); Chapter 2 (Section 3); Chapter 3 (Sections 1, 2); Chapter 4 (Sections 4, 5); Chapter 5 (Sections 4, 5, 7); Chapter 6 (Sections 1, 3, 4); Chapter 7 (Section 5); Chapter 8 (Section 1); Chapter 9 (Sections 3, 4, 5); Chapter 10 (Sections 2, 3, 4, 6, 8)

Appendix 6: other helpful tips

Helpful tips:

- When in doubt, ask!
- Only the SICU team is allowed to enter orders (except immunosuppression)
- Review SCCS Clinical Practice Guidelines at: Surgical Critical Care Services - Penn Medicine
- Discuss with and update covering RN re: new orders/tests/plans of care
- **ICU consent** must be obtained on all patients on arrival
- **Med recs** preferably on arrival (must be done within 24 hours of admission)
- Discuss enteral feeding plan with primary team
- Must call for all STAT studies
- Call hematology fellow for approval of HIT panel
- Hemodynamically stable patient transfusion trigger is Hgb<7
- When ordering STAT antibiotics for sepsis, verbally inform RN of order.
- www.uphs.upenn.edu/antibiotics
- Order nutrition labs on Sunday night for every Monday morning
- Ensure type and screen ordered every 3 days
- Think before you "pan culture". Selectively send cultures if you suspect infection. *Obtain urine culture on all direct admissions
- Nutrition- may be signed in to patient chart, if not, main number 662-3223, weekends 215-559-4701
    - Start standard TEN at 20mL/hr while waiting for nutrition TEN recs
- TPN infusions start at night, and TPN orders must be in by 1500 (ask nutrition for help)

A few surgical team preferences: (Unless otherwise specified)

- Transplant –
    - **See transplant guidelines on www.pennsicu.org**
    - Only Albumin for resuscitation, no Crystalloid
    - NO FFP/PLT/Cryo for correction of coagulation unless directed by transplant attending or fellow
    - CBC q4 hours X 24 hours post transplant
    - LFT, LDH, Panel 5, CBC, Coags immediate postop & qAM
    - Transplant team to order immunosuppression
    - CALL transplant team for everything
- ENT-TORS pathway
    - Intubated 48 to 72 hours. Monitored in the ICU 24hrs post extubation
    - Start TEN on POD #1
    - Consult Diabetes if hyperglycemic & requires SSI
- Urology- cystectomy and diversion-
    - IV fluids should be LR
    - NPO until urology team reports otherwise
- Vascular- AAA
    - Q4 CBC for first 24 hours
    - Pulse checks and strict BP goals per vascular team

SICU List:

- print from Carelign site (see Carelign sign-out instructions above).

Nursing issues contact:

Kevin Scesa (RP5 RN manager) 215-490-6209
Megan Michniewicz (RP5 assist. RN Manager) 267-408-2234
Christine Aiello (RP5 Clinical Nurse Specialist) 267-586-3361

Penn-Elert/VISICU: 215-893-7310

- Staffed with critical care Attending from 7 pm to 7 am
- They can look into patient's room to visually assess the patient
- May be able to offer a second perspective, especially useful for acutely decompensating patients late at night