OUR TEAM CONSISTS OF....

- **Attending Physician**
  - Critical care intensivist responsible for *24 hour coverage*

- **Critical Care Fellows**

- **Anesthesia, Surgery, & OB/Gyn Residents**

- **Pharmacist**
  - Often able to round with the team

- **4th Year Medical Students**
  - Students do not generate orders

- **CRNA Students**
  - Students do not generate orders
Attending Physicians

- Melody Chang MD
- Dana Darwish MD
- Scott Gaspard MD
- David Hecht DO
- Karen O’Bosky MD
- Ronak Raval MD
- Nitin Shah MD
- Gary Shih MD
- Gary Stier MD
- Mark Wittman MD
- Kaushik Mukerjee MD
- Ioana Pasca MD
- Ed McClusky MD

Critical Care Fellows

- Ali Mehdizadeh MD
- Kelsi Froom DO
- Oliver Small MD
- Matthew Kushner MD

CCC Administrator

- Bekki Wharton

CCC QI NP

- Alex Bandy ACNP

WHO’S WHO?

Ihab Dorotta MB ChB
SICU Medical Director

David Turay MD, PhD
SICU Associate Medical Director
MANDATORY EDUCATION

- **Journal Club**
  - Every Tuesday 1300-1330 Coleman Pavilion 2nd Floor, Room 21109

- **M&M Presentations**
  - Every Tuesday 1330-1400 Coleman Pavilion 2nd Floor, Room 21109

- **Resident ICU (RICU) Lecture**
  - Tuesdays and Thursdays 1430-1530 by SICU attending (Location TBD)

- **Critical Care Grand Rounds**
  - 1st Wednesday of the month 1300-1400 A-level Amphitheatre

- **Respiratory Lecture**
  - 1st Wednesday of the month 1400-1530 by RT (Location TBD)

- **Fellow Chapter Review**
  - Every other Wednesday 1500-1600 Anesthesia Library

***If you are scheduled off or post-call you are excused from the mandatory educational requirements***
Objective: To provide an opportunity for scholarly evaluation of current research articles and evaluate how it could potentially affect the practice of the SICU team.

- Please bring your own lunch as it will not be provided
- Articles can be found at [www.ccforum.com](http://www.ccforum.com) and [www.nejm.org](http://www.nejm.org), among others. *Please avoid nutrition articles since these tend to be over-presented.*
- When presenting:
  - Please check your proposed article Dr. Shih @ gshih@llu.edu for approval
  - Bring formatted flash drive to presentation (PC) as you will not be able to open any email version for presentation
  - Email your article to Bekki @ rnwharton@llu.edu ahead of time to print copies
Objective: To evaluate patient outcomes that deviated from the expected and were associated with morbidity and/or mortality. This includes sentinel or never-events, events triggering reduced reimbursement, and errors that may or may not have caused harm to the patient.

- You will be assigned a case by Carissa Cianci or Hala Hebeish in the PSR department. Please contact Alex @ abandy@llu.edu for any assistance you might need in reviewing the case.

- Checklists for chart review are available on the MC8100 Resident Folder for the following:
  - CLABSI
  - CAUTI
  - Self-extubation
  - Reintubation <48 hours
  - Return to ICU <48 hours
  - Death

- Other events you may have to investigate include:
  - Peri-procedural complications
  - Ventilator-associated events
  - PE or DVT
DAILY ROUNDS/PATIENT ASSIGNMENTS

- Check your assignments daily as they are subject to change
- Rounds begin @ **08:00 SHARP**
  - You should be prepared @ 08:00.
  - Plan to arrive between 0500-0600 daily, and earlier if you think you need more time to be ready (i.e. high census)
- Please have 4 computers ready @ 0800: (1) attending, (2) resident presenting, (3) resident placing orders, (4) resident uploading images and updating problem list
- Next-day labs and imaging should be ordered during rounds but it is the responsibility of the assigned resident to ensure this is done
- Rounds should include the bedside nurse
  - This process is called SIBR
- The on-call physician is responsible for patient assignments
  - Post-call resident should evenly distribute patients, especially if they admitted a large number of patients
  - Please distribute new admissions evenly as well to ensure that on-call residents can leave on time
  - The SICU resident desk is reserved for the post call resident to complete their notes in the AM
  - Our goal is to facilitate the post-call resident leaving by 1000
- On-call residents should discuss planned admissions with charge nurse who goes to bed meeting each morning and distribute H&Ps for new arrivals among day residents
EVENING ROUNDS

- All residents are to remain available to manage their assigned patients until 1600
- Sign out is from 1615-1645
- Sign out to on-call resident must be completed prior to departure
- Residents should ensure they have done the following:
  - Order management
  - Follow up consults
  - Complete shared patient list
- Log-In to drive MC8100 via password “circle”
- Found on MC8100 drive in the SICU Resident folder
- Update daily on your assigned patients
  - Cultures
  - History
  - Lines (start/end date)
  - Abx therapy (start/end date)
  - Vasopressors/medications
- Please leave “Doe” names on the list as well as the real/alias names given to patients
- Please do not leave the list open... Be sure to close the list after you have updated it.
- Update the Shared Discharge List by copy/pasting off patient list for all discharged patients
GENERATING NOTES

- When signing on to LLEAP and writing notes designate the department of record as the CCC (Critical Care Center) and the team as either SICU, ECICU or NMCCS. Please remember it is not your home department.

- Use the CCC daily progress note template (.ccc***). You can also utilize the other CCC templates for brain death, code blue, death note, bronchoscopy, limitation of treatment, etc.

- Do not copy/paste notes, as not all pre-populated sections will update. Moreover, the note should reflect your assessment.

- Delete irrelevant pre-populated material (i.e. weaning mechanics on a patient who is not intubated).

- Important historical facts should not be carried forward in the assessment and plan but can be included in HPI to understand the patient timeline especially for patients who have been admitted for long periods of time.

- The actsives diagnoses being addressed in your daily note should be reflected in the patient problem list; please review and update this tab each day.

- The QI section of the note should be updated each day. Indicate N/A, the measure taken, or a specific indication for why best practices were not followed.

- NPs should document critical care time on all pertinent patients by using the .cccattestation at the time cc time met, regardless of whether or not she/he will bill. Charges for CC vs. E&M are reviewed elsewhere.

- Avoid describing any aspect of the patient’s status as “stable” – “acceptable” is preferred (“hemodynamically acceptable” or “neuro exam acceptable”) as it describes a finding as unchanged but does not negate the need for ICU level of care, which is inherently unstable.
RATHER THAN STATING “NO ACTIVE PROBLEMS” CONSIDER THE FOLLOWING STATEMENTS WHICH DESCRIBE DIAGNOSES THAT HAVE BEEN TIED TO INCREASED LOS, COST, MORBIDITY & MORTALITY:

# At risk for skin breakdown and deconditioning 2/2 decreased mobility
   I Plan: PT/OT, Mipelex to sacrum, skin check by nursing per unit routine

# At risk for CAUTI 2/2 indwelling urinary catheter
   I Plan: FTG, pericare per unit routine, daily discussion of Foley removal

# At risk for CLABSI 2/2 CVC use
   I Plan: daily discussion of line removal, line maintenance per unit routine

# At risk for ICU delirium 2/2 sleep disturbance
   I Plan: CAM-ICU scores by nursing, Benadryl 25mg HS PRN for sleep

# At risk for malnutrition 2/2 NPO status despite obesity AEB BMI of x
   I Plan: nutrition consult, TTR/albunin levels Q Monday

# At risk for VTE 2/2 bedrest
   I Plan: SQH or Lovenox, BLE SCDs

# At risk for stress ulcer development 2/2 interrupted nutrition/MV/etc
   I Plan: PPI vs. H2B
SBAR & PLAN OF CARE COMMUNICATION

AT LLUMC, SBAR IS A WRITTEN DOCUMENTATION OF PHYSICIAN-TO-PHYSICIAN HANDOFF

- **FOR NEW ADMITS:** After you receive verbal report you should notify the charge nurse to verify bed space and nurse staffing available.

- The admitting surgical service (including IR) must complete a SBAR form in LLEAP known as .CCC SBAR admit TO ICU

- **FOR DISCHARGES:** When the patient is transferred from ICU to another service, you give verbal report and fill out .CCC SBAR discharge from ICU

SITUATION – BACKGROUND – ASSESSMENT – PLAN
PROFESSIONAL ETIQUETTE

Encouraged 😊

• Wear your lab coat with either LeCeil colored scrubs or professional attire
• EAT BREAKFAST BEFORE ROUNDS!
• Show attentiveness during rounds & mandatory education
• Maintain serious tone during rounds since family members are often watching and judge us based on our attitude during rounds

Discouraged 😞

• You are not to wear hoodies or sweatshirts
• There is no eating on the unit
• Limit non-clinical cell phone/computer use
Family satisfaction often centers around perceived involvement in the care of their loved ones and the level of communication rather than the medical team’s competent care. The following is the recommended guideline for family conferences especially in end of life situations:

- **ALL** families with patients with expected Length of stay (LOS) > 48 hrs. in the ICU should be scheduled for a family conference with the attending intensivist or a critical care fellow.

- The family conference is to include the patient’s diagnosis, hospital course and prognosis.

- LLEAP documentation of these conferences is highly recommended.

- Social work can assist in organizing these events.

- Residents and nurse practitioners can do daily family updates.

- **ALL planned** conferences discussing level of care including DNR and withdrawal should again include the attending intensivist. This should not preclude the ability of residents and nurse practitioners to engage in these type of discussions when it is unplanned or in off hours.

- There should be agreement between all the services covering the specific patient before a discussion about prognosis is initiated.

- It is highly recommended not to engage in any type of withdrawal of care discussion in the initial 24 hours following admission.
LLUMC Guidelines for Reporting Potential Organ & Tissue Donation
(800) 338-6112

In accordance with laws and regulations governing organ/tissue donation, all patients whose death is imminent or who have died in the hospital will be reported to OneLegacy. Please do not mention organ/tissue donation to the family until a OneLegacy Clinical Coordinator has determined the patient to be medically suitable for donation. Notify the attending physician of the referral. Remember, a timely referral will assure that families can donate all suitable organs and tissues.

Potential Organ Donation

Clinical Trigger: Imminent Death

1. Mechanical Ventilation
   - Yes
2. Neurological Injury/Insult
   - Yes
3. GCS Score ≤5*
   - Yes
   - with two or more clinical signs of Brain Death
   - Pupils fixed & dilated
   - No Cough or Gag
   - No spontaneous respiration
   - No purposeful movement to painful stimuli

Potential Tissue Donation

Clinical Trigger: Cardiopulmonary Death

Call Within 1 Hour of Clinical Trigger

All Deaths
(Not on Ventilator)

*Glasgow Coma Scale

<table>
<thead>
<tr>
<th>Eyes Open</th>
<th>Best Verbal Response</th>
<th>Best Motor Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneously 4</td>
<td>Oriented (to time, person, place) 5</td>
<td>Obeys commands 6</td>
</tr>
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<td>To speech 3</td>
<td>Confused speech 4</td>
<td>Localizes pain 5</td>
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<tr>
<td>To pain 2</td>
<td>Inappropriate 3</td>
<td>Withdrawal 4</td>
</tr>
<tr>
<td>Never 1</td>
<td>Incomprehensible sounds 2</td>
<td>Abnormal flexion 3</td>
</tr>
</tbody>
</table>

onelegacy
a transplant donor network
bridging lives
CONSENT FORMS

- Consider obtaining consents from patient or family upon admission for all potential events including CVC, PICC, a-line, intubation, and blood products.
- Each consent has 2 separate forms that must be signed, witnessed, and kept in the chart.
- Any consents obtained over the phone require 2 nurse signatures as verification.
- As a safety check, the bedside nurse will check the paper chart and stop you from proceeding if the consent is not present.
- HOWEVER each time a procedure is done a new consent form must be obtained (i.e. the patient was consented for an a-line placed day#2, but it fell out day#8 and she needs a new one).
- Only “CODES” are considered emergent circumstances where not obtaining consent for the procedure is reasonable given the time-sensitive and life-saving nature of the events.
- 1 blood transfusion consent is sufficient for the whole LOS.
PROCEDURES

→ All procedures are supervised by an attending physician

→ Remember to change the authorizing attending physician as appropriate when generating your note
QUALITY PERFORMANCE IN THE ICU
PROGRESS NOTE QI INDICATORS

+ VENTILATOR BUNDLE

1. Date of last trach change
2. HOB elevation greater than 30 degrees / Reverse trendelenburg
3. Spontaneous breathing trial
4. Sedation interruption trial
5. Chlorhexidine / Oral care
6. Thrombosis prophylaxis
7. Ulcer (GI) prophylaxis

+ LINES/CATHETERS

+ NUTRITION

+ CORNEAL CARE

+ SPINE IMMOBILIZATION

+ ANTIBIOTIC DE-ESCALATION

EVALUATE & UPDATE DAILY! If any of the quality indicators are not performed, you must list a reason why EACH AND EVERY DAY!
Example: No SAT (2/2 increased ICPs)/ No SBT (2/2 FIO2 >60%)
ACCEPTABLE RATIONALES FOR NOT MEETING QI STANDARDS

CENTRAL LINES
✓ Vasopressors
✓ Hypertonic saline or other vasocautic medications
✓ TPN
✓ Difficult peripheral vascular access (following failed attempt by VATs team)
✓ HD monitoring

FOLEY CATHETERS
✓ Large volume incontinence risking skin breakdown
✓ Encephalopathy (RASS < -2)
✓ Spine immobilization
✓ Active diuresis with strict I&O monitoring
✓ Urinary obstruction or irrigation
✓ Placed by urology
NOTE: “Bedrest” is not acceptable

DVT PROPHYLAXIS
✓ Ongoing bleeding
✓ High risk for bleeding
✓ Concurrent coagulopathy
✓ Low risk for DVT 2/2 lack of the following risk factors:
  - ICU status
  - mechanical ventilation
  - multiple trauma
  - neurological deficit
  - H/O any VTE
  - morbid obesity
  - cancer

NOTE: “Bedrest” is not acceptable
Patients must meet criteria for sedation vacation, spontaneous breathing trials, & extubation.

SICU must generate a order for SAT/SBT under the sedation order.
Both boxes for sedation interruption & weaning trial-sedation interruption must be checked!

Please be aware that this order covers Versed/ Fentanyl/ Propofol only. If you want the patient off Precedex, please over-write the order’s language.
RT will help you assess your wean mechanics. Values should populate in your CCC progress note. However, be aware of this flowsheet available through VIP online.

Similar info about what parameters constitutes safe to wean/ extubate are listed in the M&M checklist for re-intubation.
EXTUBATION ORDERS

- There must be an order to extubate the patient → the RT will not perform the task without an order

- Do NOT write the order as a nursing communication → there is an order

- Please remember to discontinue the vent/sedation/medication orders under order management → this is important in calculating ventilator days
CULTURES

*IF YOU CULTURE, DO SO WITH ATTENDING APPROVAL!*

* Blood cultures should be 2 peripheral sticks, 10 minutes apart (please “time” them as such in the orders)
  
  → NEVER draw BCx from the A-line, as these typically result in a false positive w/ S. epidermis
  
  → Avoid drawing off CVCs as results can reflect line colonization rather than true bacteremia
  
  → The only exception is that the CVC should be cultured when arriving from an OSH before pulling the line and replacing with a new, in-house line
  
  → We do not culture the cath tip, regardless of circumstance

* UA w/ reflex should only be performed when urinary source is suspected, after ATTENDING APPROVAL

* Respiratory cultures can be obtained by deep tracheal suctioning by RT (avoid expectorated sputum), after ATTENDING APPROVAL
NURSE-DRIVEN SEPSIS PROTOCOL:

RNs are empowered on clinical suspicion to activate a standing order set of labs, cultures, IVFs, and antibiotics when best-practice advisories are triggered in LLEAP on patients with SIRS criteria.

诜 Sepsis Alert Algorithm (3 SIRS criteria)

诜 Severe Sepsis Alert Algorithm (3 SIRS criteria + s/s organ dysfunction)

Don’t suspect sepsis? Respond to the RN page. Communicate your concerns!
CAUTI & CLABSI are costly and serious conditions that are unique in that they are reportable to CMS and as such any outcomes associated with their presence are not reimbursable. They are a major focus of the QI bundle not only due to their un-recouped cost to the hospital but also because of their correlation to increased LOS and adverse outcomes such as morbidity and mortality.
Upon Admission

Obtain UA w/ reflexology then change the Foley for patients that:

1) Admitted from the Emergency Room or other units with no documentation of sterility. If documentation exists catheters can be left in place.
2) Admitted from an outside hospital/ facility
3) Come from another unit with suspected sepsis/SIRS

No Foley change but obtain UA on all unit-to-unit transfers that are not sepsis/SIRS

Evaluate need for Foley daily!
D/C ASAP!

Catheter-Associated UTI (CAUTI) Bundle

Weekly Changes

Foleys will be changed weekly on Sundays when:

1) The Foley has been in for >72 hours
2) The patient still requires a Foley

MD Orders

Every Patient with a Foley needs an order!

There is an order panel in Epic that gives the following orders:

1) Insert Foley – includes indication for a foley
2) Daily Foley cares – i.e. Foley to gravity & Q shift pericare
3) Discontinue Foley – automatically after 48 hours to trigger an evaluation at least every 2 days

BE AWARE:
Nursing is empowered to d/c Foleys that do not meet maintenance standards via HOUDINI criteria
CENTRAL LINE INSERTION PROTOCOL

- **Hand hygiene:** ALL house staff/attendings are to wash hands with soap and water before attempting to place central lines.

- **Use of chlorohexidine:** Site prepared with chlorohexidine and allowed to dry.

- **Maximal sterile barriers:** Site to be draped and patient covered fully. Persons placing the line are fully gowned. ALL house staff/attendings are to have a sterile gown, cap, mask and eye protection.
  - **Residents and attendings** that assist with the procedure need to do the same. Anything beyond handling the ultrasound machine needs the assistant to hand wash as well as utilize maximal sterile precautions. Sterile gloves only are not acceptable. Reaching over the sterile field with uncovered arms is also not acceptable.
  - The short end of the drape that comes with the central line kit should go over the patient’s head and the long end should be fully unfolded to cover the patient’s body.
  - The sterile cover for the ultrasound probe should not be allowed to drag over uncovered non-sterile areas. The probe should be allowed to rest on the sterile drape.

- **Avoid the femoral site** unless absolutely necessary or in an emergency situation. These emergency lines need to be replaced within 24 hours.

- Bedside RNs will be empowered to stop the procedure if sterile precautions are breached. He/she will document adherence to the above elements of the CVL insertion bundle. The charge nurses will be asked to document that they have double-checked this process.
CENTRAL LINE MAINTENANCE

- **ALL** femoral lines will be switched to another site within 24 hrs.
- **ALL non-tunneled** central lines placed in an outside facility will be switched to another site within 24 hrs.
- **ALL** newly started central lines must have a bio-patch used at insertion.
- **ALL** lines started in the OR need to have a bio-patch placed within 24 hours of admission to the ICU with the first dressing change.
- **ALL** lines inserted in the ED/other hospital floor with no documentation of sterility should be changed to another site within 24 hrs. If documentation exists then these lines can be left in place.
- **ALL** central line dressings should be changed every seven days and the date and time documented on the dressing.
- **ALL** patients transferred to the ICU from another hospital or floor with an existing non-tunneled central venous catheter and symptoms of **SIRS** (systemic inflammatory response syndrome), including fever, leukocytosis, tachycardia and/or tachypnea will have blood cultures from their central venous catheters on the day of admission. Order should be written as “Draw blood culture from left PICC/CVC.” Unit secretary are to label specimen in comments section as drawn from left PICC/CV.”
- **All** central line catheters shall be maintained by the nursing staff according to the Mosby’s nursing skills for site care, dressing change and blood sampling. This includes scrubbing the hub before sampling or drug injections and routine clave exchange. This process will be double checked by the charge nurse.
UNIT 8100: SURGICAL-TRAUMA ICU
WELCOME TO SICU

**The Unit:** 8100 houses 12 dual-occupancy rooms (24 ICU beds for SICU and overflow NMCCS patients)

**Patient Care Director:** Jennifer Peach-Guzman

**Nurse Managers:** Elisa Cook (AM Shift) and Dan Hubbel (PM Shift)

**Clinical Educator:** Karen Lawson

**Case Manager:** Patty Templeton

**Social Worker:** John Cline
- There is a “Resident Book” for resources that includes protocols for patient care (i.e., liver transplant, ARDSnet…etc.)
- This book is located at the SICU resident desk
- Consider also checking the SICU Resident Resources folder on the 8100 drive
PROCEDURE FOR ADMISSION TO SICU

1. Surgical service requests an ICU bed

2. SICU team agrees to admit the patient
   + Prior to patient approval, the surgical team MUST speak to the SICU team & SICU MUST speak w/ Charge RN to verify bed/staffing
   + Unsure if the patient meets ICU criteria? Check with your attending

3. Admit patient to ICU
   + Update LLEAP to reflect SICU provider, verify code status and allergies, complete med rec, update problem list, place orders
   + Consider obtaining consents for any/all potential procedures including A-line, CVC, and intubation

4. Patient leaves OR and care transferred to SICU
   + If the patient goes to PACU prior to the unit: the resident on call must go to PACU to evaluate the patient within 45 mins of notification (unless emergency/procedure in process).
   + Make sure the PACU nurse releases all orders so that appropriate care is not delayed while awaiting a bed & leave contact info for any questions or concerns. PACU patients need extra attention since they are so far away!

5. Once the SICU RN releases the held orders, review any orders written by surgical services
   + After the patient is physically on the unit, surgery should no longer be generating orders

6. Add patient to list
WHEN WRITING ORDERS IN SICU...
**ADMISSION ORDERS**

- All new admits and patients returning from OR requires a medication reconciliation with allergies as well as code status verification.
- Consider the Generic “CCC Order Set” as a starting place.

**Nursing Care**
- Vital sign frequency
- Neuro checks/flap checks
- Vigileo monitoring (nursing communication)
- Notification of Provider: Clarify specific notifications as this automatically defaults to preset parameters
- Incentive spirometry x10 Q1H or Q2H if indicated on non-vent pt

**Labs/ Imaging**
- Should be ordered as appropriate for most of our post-op patients (esp. those patients with prolonged procedures)
- Daily labs/imaging should be ordered during rounds and as patients are admitted throughout the day
- Transthyretin and albumin Q Monday for nutritional evaluation
- Please remember to pan-culture when cultures are indicated: UA (without reflex), 2 peripheral BCs, tracheal aspirate or induced sputum

**Medication**
- Ensure that when ordering IV medications that are weight based that you select the DOSING WEIGHT as the order does not automatically default to this setting
- For titratable gtts, note a start rate, titration dose and frequency to achieve set parameters (i.e. RASS 0 to -1 or MAP 60-70) up to a max dose
Blood sugar goals: 140-180 mg/dL. Please complete the appropriate order set (SQ or IV infusion). You will have to d/c the order set and start a new one for each dose change.

VTE prophylaxis:
- SCDs alone are not sufficient for DVT/PE prophylaxis
- Choose heparin SQ or LMWH SQ
- Can hold post-operatively x 24 hours. Use caution with head bleeds, coagulopathic conditions, and solid organ lacerations and document contraindications if not ordered.
- Always check with the surgical service if in doubt. If it is indicated and the service refuses administration then notify the attending.
- DVT evaluation for patients who are at risk have surveillance scans on Monday

GI prophylaxis:
- Pepcid (with appropriate renal function/plt count) or pantoprazole.
- Order in pill form if patient is receiving oral or enteral feedings.

Foley catheters:
- Every patient who has a foley should have an order for it
THE INTUBATED PATIENT

**Vent Settings**

- Ventilator settings (rate, setting, PEEP, FiO2)
- Titrating parameter for FiO2 if indicated
- PRN/Recurring order for ABG (“daily and PRN with vent changes”)

**Sedation & Analgesia**

- Select “dosing weight” when ordering the medication for weight-based medications
- Sedation (Propofol, Precedex) is titrated to a RASS score typically (0 to -1)
- Pain medication (Fentanyl) is usually dosed as non-titratable and increased as needed
THE INTUBATED PATIENT, CONTINUED…

Tube Feedings

- “OK to use” order for OGT or NGT unless contraindicated
- We do not hold tube feedings for procedures typically (i.e. no “NPO after midnight” orders)

Vent Bundle

- Artificial tears (2 gtts) or Lacrilube ointment OU q 6 hrs if no spontaneous eye opening
- Peridex oral care 15mL BID swish and suction
- GI prophylaxis with Pepcid or Protonix
- Daily SBT and SV as previously discussed
- HOB elevated to 30’ or reverse Trendelenburg
THANK YOU FOR YOUR ATTENTION & WE HOPE YOU THAT YOU FIND YOUR SICU ROTATION BOTH A CHALLENGING & REWARDING EXPERIENCE!

DON'T FORGET:

Our attendings are here 24/7 to help you! Never be afraid to ask for clarification or help in making decisions for these critically ill patients!