Division of Acute Care Surgery and Surgical Critical Care

Expected communication initiation for patients admitted to ward, IMC or SCU:[1-4]

1. **Critical Changes in patient's condition:**
   Upgrade in care: Transfer from Ward to IMC or SCU
   Cardiac
   - New onset bradycardia or rapid arrhythmias (e.g. ventricular tachycardia/fibrillation, atrial fibrillation, SVT, etc.) with special attention for hemodynamic instability
   - Hemodynamic instability
     - HR < 40 or > 120
     - SBP <90 or >180
   - Initiation of vasopressors or antiarrhythmic IV gtts (levophed, neosynepherine, epinephrine, vasopressin, amiodarone, Lasix, etc)
   - Cardiac arrest or Code event
   - First/Unexpected blood transfusion (without attending prior knowledge)
   - Need to start therapeutic anticoagulation

   Respiratory

   - New/unplanned intubation
   - Respiratory failure
     - O2 saturation < 90%
     - PCO2 > 60 mmHg
     - PaO2 < 60 mmHg
   - Inability to protect airway (GCS <8 or obstruction)

   Neurologic

   - New stroke symptoms
   - Decline in GCS by 2 points
   - New neurologic deficits of extremities
   - New seizures
   - ICP ≥ 20 or CPP ≤ 60
   - Na+ < 120 meq/L or > 159 meq/L

Vascular

- New signs of hemorrhage
- New signs of limb ischemia or compartment syndrome

Renal

- New/ AKI (unexpected increase in creatinine or UOP < 30 ml/hour x 3 hours)
- Severe hyperkalemia (K+ ≥ 6.0)

2. **Medical/Treatment Errors**
3. **New radiographic findings**
4. **Major wound complications**
5. **Escalation in level of care**
6. **Death**
7. **Abnormal lab results**
    a. Elevated Troponin
    b. PF4 or serotonin assay
    c. Progressive elevation in CK
    d. Elevated lactate
    e. Abnormal ABG
    f. Significant drop in Hb/HCT (≤ 2 g/dL in 24 hour period)
8. **New Consults and Consultant recommendations**
9. **Major deviations from agreed upon plan**

Appropriate Contact:

1. Who (for these critical conditions, there should be a response within 15 minutes, otherwise escalate to the next level):
    a. Primary Attending: Attending on service for the week (Check AMION for updated information/also listed on SICU nursing boards)
    b. Backup: Either SICU or Trauma attending
    c. Backup to Backup: Contact Burn Attending
    d. Ultimate backup:
        i. For SICU issues, contact SICU Director (Dr. Sheppard or appointee);
        ii. For trauma issues, contact TMD (Dr. Rappold or appointee);
        iii. For burn issues, contact the Director of Burns (Dr. Carter or appointee)

2. How:
    a. Direct communication (person to person communication) is optimal.
    b. If attending is directly unavailable temporarily (eg, OR, meeting, etc), telephone is acceptable
    c. Contact by MMC pager is also acceptable.
3. What: A brief synopsis (SBAR) should be reported with plan.

These communications guidelines identify specific criteria that should trigger calls to an attending. Evidence demonstrates that 70 percent of surgery-related malpractice cases are related to failures of communication.[4] In most cases, attending surgeons were not always aware of changes in the status of their patients which would have necessitated their input. In addition, frequently, physician extenders and residents were reluctant to notify the attending surgeon even in complex clinical circumstantes. This list is NOT exhaustive. In general, if the provider is checking the list then a call to an attending is likely warranted. [4]

1. Silverman AT, Goldfarb MA, Baker T. When should a surgical resident call an attending surgeon? J Surg Educ. 2008 May-Jun;65(3):206-12.
2. C.C. Greenberg, S.E. Regenbogen, D.M. Studdert, et al. Patterns of communication breakdowns resulting in injury to surgical patients. J Am Coll Surg., 204 (2007), pp. 533-540.
3. http://www.jointcommission.org/SentinelEvent/Statistics/
4. https://www.rmf.harvard.edu/Clinician-Resources/Article/2009/Triggers-for-Resident-to-Attending-Communication