Escalation Protocol

- Chest tube output greater than 150/hr X2hrs.
- Hypotension- Refer to current policy for this. MAP less than 60 or SBP less than 90.
- Call if PA pressure is greater than 2/3 of the SBP (arterial). Please use the first PA pressure upon arrival to unit.
- Urine output less than 30 mL per hour for 3 consecutive hours or if patient has decreased UOP and you're titrating up on inotropes or pressors. You do not have to call if patient UOP is >1L in a 24 hour time frame from the last MD notification.
- K of 5.5 or greater. Use policy to treat once. If K is still elevated on repeat then please reach out to a provider.
- NA <127
- New creatinine value greater than 50% increase above the lowest pre-op creatinine
- pCO2 >50 or pO2 <60 –call after one failed intervention
- Change in neurological status
- Change in vascular exam or concern for limb or organ ischemia
- Concern for upper or lower gastrointestinal bleed-
- Significant change in abdominal exam (severe tenderness, emesis
- Arterial lactate >3
- pH <7.3
- HCT < 21
- PLTs >50% drop or <20
- ST changes
- Ventricular arrhythmia
- Newly, non-functioning pacemaker - All pacemakers should be checked at the beginning of each shift.
- Displacement of central line or endotracheal tube
- Malpositioned IABP on CXR read

Airway needs after hours - CT surgery would rather utilize ACE as primary when needing an urgent airway for our patient. However, we shouldn't be delaying care for patients who need to be intubated. Please reach out to PCC if you are unable to get in contact with ACE.

Recurrent AFib - For new onset AFib, utilize our standing order set. If patient converts to NSR, but then later flips back into AFib, assess patient's vitals and repeat order set once more. If patient coverts to NSR again, but goes back into AFib at a later time, do not repeat order set a 3rd time without talking with a provider. The order set should only be repeated if the patient has converted to NSR. If AFib persist, despite intervention, contact provider.