UAMS MEDICAL CENTER
Surgical Critical Care Guideline

SUBJECT: Indications for SICU Care & Transfer Out Process

SUPERSEDES: New **PAGE:** 1 of 2

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CONCURRENCE(S): Division of Trauma & ACS **EFFECTIVE: 1/22/21**

PURPOSE: To standardize the indications for admission to the SICU as well as transfer to non-SICU surgical services after resolution of critical care issues. Patients with none of the indications for critical care listed below are eligible for transfer to the primary surgical service.

NOTES:
- The following list is not exhaustive. ICU indications listed may arise and may require an attending-to-attending discussion.
- In cases in which there is disagreement amongst services, an attending-to-attending discussion by phone or in person is required.
- If no agreement can be reached, the SICU director shall arbitrate. If the SICU director is unavailable, next choice is SICU Associate Director/SICU Fellowship Director, followed by Chairman of Surgery.
- Clinical scenarios with dedicated protocols adopted by SICU faculty override this document.

INDICATIONS FOR SURGICAL CRITICAL CARE:

I. General:
   a. Up to 24 hours of monitoring in the immediate postoperative period for complex surgery or extensively comorbid patients
   b. Special situations requiring intensive care – attending to attending discussion required

II. Neurological:
   a. Need for Q1 hour neuro-checks for any indication
   b. Agitation requiring sedative drips or 1:2 patient to nurse ratio (if no sitter available)

III. Cardiovascular
   a. Sustained HR greater than 120
   b. Systolic blood pressure $\leq$ 90 mmHg or MAP $\leq$ 65
   c. On titratable, hemodynamically active drip in last 8 hours
   d. Q1 hour vascular checks

IV. Respiratory
   a. O2 Requirement $\geq$ 50% FIO2
      i. PaO2 target 95% for healthy lungs, 88-92% depending on history
   b. On ventilator (or bipap) support other than stable/home CPAP settings
      i. Exception: tracheostomy patients with stable vent schedule
   c. Intubated patients:
      i. If intubated $\geq$ 72 hours – monitor in SICU until next morning
      ii. If intubated 24-72 hours – monitor in SICU $\geq$8 hours
      iii. If intubated < 24 hours – monitor in SICU for 4 hours
      iv. May consider earlier transfer if services agree patient condition warrants

V. Renal/Electrolytes/Endocrine

a. Need for CRRT
b. Severe, untreated electrolyte abnormalities
c. On insulin drip

PROCEDURES FOR TRANSFER

I. When a patient is thought to be safe for transfer by the SICU team (or vice versa) the other team must be paged/called to discuss the transfer.
   a. No transfer orders to be placed before this discussion
   b. Discussion should be document in the EMR
II. Transfer orders will be placed AND RELEASED by the SICU team
   a. Transfer orders will include orders to change patient status to floor/progressive orders
   b. Transfer orders (eg neurovascular checks, VS frequency take effect immediately
   c. Patients with orders to floor/progressive unit are to be removed from the monitor
      i. Exception: patients going to a monitored location
III. After transfer orders have been placed, the primary surgical team assumes full responsibility for the patient, including nursing calls from H4, rounding, etc.
   a. SICU team will “sign off” the moment floor/progressive orders are released