



Stony Brook
Medicine

Stony Brook Medicine Graduate Medical Education

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Responsible Department/Division/Committee:

Graduate Medical Education Committee

Policy:

To establish an institutional policy regarding times when communication must occur between residents/fellows and attending physicians for all graduate medical education (GME) training programs sponsored by Stony Brook.

Definitions:

None

Procedures:

1. The Surgeon or Medical Attending Physician, or for dental programs, Dentist of record (referred after this as Attending of Record), or the designated covering attending is at all times responsible for the care and welfare of the patient.
2. The Attending on-call is responsible for assuring that the residents on-call are aware of the overall patient care plan and the parameters for when residents must communicate with the Attending for each patient.
3. Each training program must have a current set of specialty-specific criteria outlining when the resident and fellow must communicate with the Attending on-call or Attending of Record. These criteria must be updated and communicated to all residents and faculty in the program (see Policy: Supervision and Communication).

4. Residents on-call are required to notify the Attending on-call (or Attending of Record, if so directed) of any changes in the clinical status of any of their patients using the following criteria:

a. The resident must notify the Attending if a patient meets criteria which trigger a Code Rapid Response, or age-appropriate acute changes.

- 1) Staff member is worried about the patient
- 2) Acute change in heart rate to <40 or >130 bpm
- 3) Acute change in systolic blood pressure to <90 mmHg
- 4) Acute change in respiratory rate to <8 or >28 per min
- 5) Acute change in saturation to $<90\%$ despite O₂
- 6) Acute change in level of consciousness
- 7) Acute change in urinary output to <50 ml in 4 hours

b. The resident must notify the Attending if a patient exhibits acute mental status changes.

c. The resident must notify the Attending if a new restraint order is written.

d. New onset tachypnea, significant change in respiratory rate or pattern, increase need for oxygenation (greater than nasal canula requirements e.g., venti-mask, non-rebreather mask, BIPAP, impending need for intubation).

e. Unanticipated need for transfusion of blood or blood products if not planned.

f. Multiple (two or more) sedatives are required to treat an agitated patient on a non-psychiatric unit.

g. Persistent deviations in vital signs (e.g., hypotension/hypertension unresponsive to treatment)

h. Acute changes in mental status or new focal neurologic deficits

i. The resident must notify the Attending if a patient exhibits clinical findings which pertain to the program-specific criteria as described in section 3 (above).

j. The resident must notify the Attending if a patient meets triggers established in specific order sets developed by each clinical service based on specific cases that are not covered by the first two criteria. These are part of the orders for that particular case/diagnosis (i.e., in a neurosurgical post-op case, the order may include "call attending if intracranial pressure exceeds >20 cm H₂O").

5. The Attending on-call and Attending of Record must always treat residents with proper respect and dignity. The Attending on-call must never criticize, belittle, mock, or question the necessity for calls by the residents. In the event that an Attending acts as described or in any other way acts to discourage any resident from calling the Attending, residents should notify the Program Director, Chief of Service, Designated Institutional Official (DIO) and/or Chief Medical Officer (CMO). The resident may also utilize the SB Safe system for such an event as actions which discourage open patient-related communications create a safety hazard for patients.

6. The Graduate Medical Education Committee (GMEC) collaborates with the Medical Staff QA Committee to perform regularly scheduled audits to evaluate compliance with this policy and reports the results of these audits to the relevant department QA committee.

7. The Chiefs of Service (Department Chair, or site Department Chief) are responsible for the implementation of and compliance with this policy.

8. Stony Brook University Hospital provides resources to the GMEC and the Chiefs of Service for implementation and monitoring of this policy. Program-Specific Criteria for Communication

9. In the event of an emergency, whatever interventions which must be done to preserve the patient's life should be undertaken without delay. The attending physician should be notified as soon as possible. For more information, please refer to GME0036 page 5.

Program-Specific Criteria for Communication

In addition to the general criteria A through I (above), all residents, and fellows must adhere to the following program-specific policies for communication to the attending physician of record in the event of any of the following:

Anesthesiology

The PACU follows the Rapid Response criteria with the following additions:

1. Any airway manipulation (i.e., changing an ETT, extubation, intubation)
2. Prior to transporting patients to SICU
3. When paged for codes or intubations on the floor

Cardiology

The Stony Brook Cardiology Fellowship Training Program requires all fellows to communicate with the supervising faculty member urgently whenever the following situations arise. The event must be documented in the patient's chart. The covering resident of the CICU or CACU may also notify the attending in circumstances where the fellow is involved in patient care and unable to call, if the fellow is otherwise unavailable, or if the resident and fellow agree that the resident should call. The purpose of this is to ensure good communication amongst all members of the team—resident, fellow, and attending, and in no way is the resident discouraged or prevented from contacting the attending. The supervising faculty member will co-sign the note within 24 hours.

Residents must communicate to the supervising fellow of record in the event of any of the following

- All new admissions
- CCU transfers
- Any interval change in patient/family directives or wishes (including DNR or other end of life decisions; per hospital policy the attending must initiate DNR orders)
- Patient death
- Changes in the acuity of the care of CACU or CICU patient
- Patient leaving against medical advice (AMA).

All cardiology fellows at all levels must contact the attending physician (or the covering resident must contact the attending if the fellow is involved in patient care and unable to call) when any of the following occur:

- Code Blue or rapid response is called
- All new admissions/transfers to the CCU or CACU, or changes in the acuity of the care of a CCU/CACU patient
- Patient death
- New critical lab values
- Unexpected episodes of hypotension <80 mmHg or new onset sustained hypotension not responsive to treatment.
- Initiation or increasing requirements for vasopressors or inotropes
- Any patient on mechanical circulatory support with alarms that do not resolve with initial guided interventions
- Any patient with pericardial drain with new bloody pericardial drainage
- Bradycardia <40 bpm or tachycardia >140 bpm or arrhythmias associated with hemodynamic compromise.
- New onset tachypnea or significant change in respiratory rate/pattern
- Acute change in mental status or new focal neurologic findings
- Oliguria or anuria
- Need for transfusion of blood or blood products if not planned in advance
- New onset seizures or prolonged seizure activity
- Acute life, limb, or organ threatening event

- New onset unexplained pain requiring use of narcotics
- Unexpected or new critical lab values
- New onset fever in an immunocompromised patient
- Persistent angina or ST elevation/dynamic ST changes

Clinical Informatics

- If on-call for an EHR go-live, and they are notified of an issue with EHR that critically affects patient care such as inability to place orders, review results, or document.
- If they encounter roadblocks that may impact the timeline of an ongoing project.

Dermatology

Specific criteria for notification of attending

1. New onset of blisters or loss of skin (diagnoses include toxic epidermal necrolysis, Stevens Johnson, pemphigus)
2. Palpable purpura with systemic symptoms or evidence of sepsis
3. Patients on isotretinoin (Accutane) onset of severe headache (possible pseudotumor cerebri)
4. Erythroderma
5. Necrotizing fasciitis
6. Neonatal herpes simplex
7. Disseminated herpes simplex

Emergency Medicine

Residents working in the ED are directly supervised by attending physicians 24 hours/ day. They are required to notify the attending physician of any change in the patient's status in any disease process, immediately.

Emergency Medical Services (EMS)

The EMS Attending must be notified following completion of a transport in which the EMS fellow performed a procedure for which they are credentialed but is not within the existing protocols for EMT and paramedics. The EMS fellow should immediately contact the EMS attending if they feel a patient requires an intervention for which no provider on scene is credentialed to perform to discuss alternative options for patient management. Fellows must notify the EMS Attending for any Mass Casualty Incident (MCI) or potential MCI they are contacted for as the medical director on-call.

Family Medicine

In addition to calling the attending based on the criteria developed for the rapid response team, residents are required to notify the Attending on call of any changes related to patients for the following top 10 diagnosis seen on the inpatient service.

1. Pneumonia and increasing acidosis/CO2 level on blood gas

2. CHF and new positive troponin/new arrhythmia
3. Chest pain and new positive troponin/new arrhythmia/new EKG changes
4. Syncope with recurrent episode syncope after admission, new arrhythmia, new positive troponin
5. Acute Renal failure with new potassium level >6
6. UTI with sepsis- no additional criteria
7. Cellulitis with systemic symptoms or inadequate response to initial therapy
8. COPD exacerbation with increasing acidosis/CO₂ level on blood gas
9. Dehydration with evidence of end organ damage or electrolyte disturbance
10. Asthma exacerbation- increasing acidosis/CO₂ level on blood gas
11. Initiation of opioid therapy in an opioid-naïve patient

Hospice and Palliative Care

1. Acute change in mental status from baseline not expected based on current condition or illness trajectory
2. Severe symptoms, including pain, dyspnea, nausea or vomiting despite up-titration of medications
3. Severe or unusual reaction to symptom management treatments, including concern for overdose
4. Anytime the resident or fellow is uncomfortable with a situation (either clinical or social. For example, family member behaving erratically or making inappropriate demands)

Internal Medicine (including Southampton IM and TY)

Residents/Fellows on call are required to notify the attending-on-call* (or medical attending of record, if so directed) of any changes in any designated clinical or diagnostic parameters using the following criteria:

Rapid Response Team criteria:

Staff member is worried about the patient

Acute change in heart rate to <40 or >130 bpm

Acute change in systolic blood pressure to <90 mmHg

Acute change in respiratory rate to <8 or >28 per min

Acute change in saturation to $<90\%$ despite O₂

Acute change in conscious state

Acute change in urinary output to <50 ml in 4 hours

Also:

- All codes/RRTs
- Transfer or potential for transfer to a higher level of care (MICU, MICR, CCU, CTICU)
- Any interval changes in patient/family directives or code status or other end of life decisions
- Patient death (expected or unexpected)
- Patient leaving against medical advice (AMA)

- New onset seizure or prolonged seizure activity
- Acute life, limb, or organ threatening event (e.g., new blue toe)
- New onset pain requiring use of narcotics, use of two or more narcotics, any increase use of benzodiazepines
- Pain out of proportion to patient's current working diagnoses
- Worsening sepsis requiring broadening of antibiotic coverage or aggressive fluid resuscitation
- Sepsis with multi-organ system failure
- Hemodynamically unstable GI bleed
- Acute hyperkalemia (serum k>6.0 mmol/L)
- Acute hyponatremia (Serum NA<125 mmol/L)
- Need for urgent acute dialysis in AKI or ESRD for hyperkalemia, acidosis (HCO₃<15), fluid overload, or uremic encephalopathy

If the resident/fellow contacts the attending of record for situations defined above, a note documenting the communication must be placed in the medical record by both the resident/fellow and the attending.

*Attending on call can always be determined by checking the on-call paging system.

Endocrinology

- Pituitary Apoplexy consult inpatient
- Adrenal crisis consult inpatient

Epilepsy

The Stony Brook Epilepsy Fellowship requires the physical presence of a supervising physician for morning rounds on patients who are on the epilepsy monitoring service. EEG reading is directly supervised, either in person or through remote technology, on a daily basis, most often during morning rounds.

Fellows are encouraged to call the supervising physician on service at any time with questions about patient care. Fellows must call attendings for any medical emergencies that occur in the patients on the epilepsy monitoring service. This includes any transfer to a higher level of care or any consult being placed to another medical service. Fellows must call the attending for any EEG which is concerning for status epilepticus.

Gastroenterology

- Hemodynamically unstable GI bleed
- Hemodynamically unstable cholangitis
- Unstable acute pancreatitis

- Acute liver failure/severe hepatitis
- Toxic megacolon
- Severe inflammatory bowel disease
- Food impaction/Foreign body ingestion
- Sigmoid volvulus
- Pregnant patients
- Post-procedure complications
- Any patient/provider requesting the attending be contacted.

Hematology/Oncology

- Any change in status for which there is no standard policy or institutional guideline (for example, neutropenic fever does not generally require a call because there is a standard policy; same for transfusion reactions)
- Change in clinical status (e.g. sepsis, stroke, MI etc) which may or may not warrant a change in level of care.
- Severe or unusual chemo-related toxicity (e.g. acute cerebellar toxicity from high dose ara-C)
- For patients on clinical trials, any grade 3 or higher toxicity needs to be reported to the attending and/or clinical trials office when it opens, unless #2 or #3 above apply.
- Anytime the resident or fellow is uncomfortable with a situation (either clinical or social, for example family member behaving erratically or demanding things inappropriately)

Infectious Disease

- Fulminant sepsis with multi-organ system failure
- Acute bacterial meningitis
- Ebola infection
- Rapidly necrotizing soft tissue infection

Medicine/Pediatrics

Med/Peds residents will follow attending notification criteria for internal medicine or pediatrics, in accordance with the age of the patient

Nephrology

- Acute hyperkalemia (Serum K > 6.0 mmol/L)
- Acute hyponatremia (Serum Na < 125 mmol/L)
- Metabolic acidosis (HCO₃ < 10; Ph < 7.20)
- Need for urgent acute dialysis (HD/CVVHDF) in AKI or ESRD for hyperkalemia, acidosis or fluid overload.
- AKI with oligo/anuria (urine output < 0.5 ml/kg/hr for > 6 hrs)
- Acute drug overdose and need for dialysis
- Malignant hypertension (systolic BP > 180 or Diastolic > 120)

- Acute rapidly progressive glomerulonephritis in need of immunosuppression including steroids, rituximab, cyclophosphamide, plasmapheresis

Neurology

Neurology Residents and Fellows are expected to contact their supervising attending for any of the following patient criteria:

1. Acute change in level of consciousness
2. New or significant change in focal neurologic deficit
3. Hemorrhagic conversion of a bland infarct
4. New onset or unexpected seizure
5. Status epilepticus or seizure that doesn't stop with routine measures
6. Significant EEG abnormality and/or contacted by Epilepsy attending/fellow
7. Decision to perform routine or video EEG in middle of the night
8. Abnormal spinal tap results
9. Unexpected major laboratory/imaging test abnormality
10. Unexpected significant allergic or other reaction to a medication
11. Changes in VC to <20mg/kg, or NIF<-60
12. Any acute change in medical condition (non-neurologic)
13. Unexpected change in MAP of more than 30 mmHg
14. ICU consult called on patient or patient moved to ICR
15. Patient asking to leave AMA
16. Any Code called on Neurology patient (e.g. BAT, CSI, Press, RRT, Blue, M)
17. Any Death

Neurosurgery

- Acute change in mental status
- A new restraint order is written
- Any significant hemorrhage or new lesion, mass effect, shift or neurological compression on new imaging study.
- Any airway manipulation (i.e., changing an ETI, extubation, intubation)
- Codes or intubations on the floor for neurosurgery patients
- Pneumonia with increasing acidosis/CO2 level on blood gas
- CHF with new positive troponin/new arrhythmia
- Chest pain with new positive troponin/new arrhythmia/new EKG changes
- Syncope -with recurrent episode syncope after admission, new arrhythmia, new positive troponin
- Acute Renal failure with new potassium level >6
- Urinary Tract Infection with sepsis- no additional criteria

- All codes/RRTs
- Any change in code status
- Patient is transferred to a higher level of care
- Patient requests leaving against medical advice (AMA)
- New onset seizures or prolonged seizure activity
- Acute life, limb, or organ threatening event
- New onset unexplained pain requiring use of narcotics
- Pituitary Apoplexy
- Post-procedure complications
- Any patient/provider requesting the attending be contacted.
- Anytime the resident or fellow is uncomfortable with a situation (either clinical or social, for example family member behaving erratically or demanding things inappropriately)
- Fulminant sepsis with multi-organ system failure
- Acute bacterial meningitis
- Malignant hypertension (systolic BP >180 or Diastolic >120)
- Unexpected change in MAP of more than 30 mmHg
- New or significant change in focal deficits, new objective neurologic deficit
- Hemorrhagic conversion of bland infarct
- Development of depressed level of consciousness
- Unexpected major laboratory/imaging test abnormality
- New onset or unexpected seizure
- Status epilepticus or seizure that doesn't stop with routine measures
- Abnormal spinal tap
- Unexpected significant allergic or other reaction to a medication
- Changes in VC to <20mg/kg, NIF <-60
- Any acute change in medical condition
- Patient death
- If you discover a complication from surgical procedures that was not previously noted.
- If you are notified of a patient with an impending airway problem.
- If you are present at or know of an impending mortality.
- If you receive a request for an emergent surgical intervention.
- If you receive a request to accept a transfer from another hospital.
- If you are fatigued and resident back-up coverage is not available to you
- If you receive a request by an attending in another service to speak to the neurosurgery attending on call.
- If there is an emergency declared at Stony Brook, such as a massive number of incoming casualties, you must notify the attending on call.
- If you and your senior resident are unsure of diagnosis in a patient who requires emergent treatment that depends on the correct diagnosis being made by the study.
- If you are unable to complete your work in a timely manner (e.g. you

become ill, or there are a massive number of backed up patients, or there is equipment failure) you must notify your General Surgery attending on call.

If the resident/fellow contacts the attending of record for situations defined above, a note documenting the communication must be placed in the medical record by both the resident/fellow and the attending.

Otolaryngology – Head and Neck Surgery

- All new admissions or transfers to any unit
- ICU transfers
- Any interval change in patient/family directives or wishes (including DNR or other end of life decisions)
- Patient death
- Changes in the acuity of the care of a medically complex patient
- Patient leaving against medical advice (AMA)
- Rapid response team is called
- Unexpected episodes of hypotension
- New onset bradycardia or tachycardia
- New onset tachypnea or significant change in respiratory rate/pattern.
- Acute change in mental status
- Oliguria or anuria
- Need for transfusion of blood or blood products if not planned in advance
- New onset seizures or prolonged seizure activity
- Acute life, limb or organ-threatening event
- New onset, unexplained pain requiring the use of narcotics
- Unexpected or new critical lab values
- New onset fever in an immunocompromised patient
- New onset sustained hypertension
- Staff concern for patient
- Transfer of the patient to an intensive care unit
- An airway that is in distress with stridor that may progress to a surgical airway
- Free flap where there is no further Doppler signal indicating failure, or venous congestion
- Uncontrolled bleeding including epistaxis beyond control of anterior nasal packing

OB/GYN

The Ob/Gyn dept has developed specific order sets for each of the following:

1. Ob/Gyn Vaginal Delivery Transfer
2. Ob/Gyn Cesarean Delivery transfer
3. Ob/Gyn Obstetrical Hemorrhage

4. Ob/Gyn Wound infection
5. Labor and delivery pre-epidural
6. Labor and delivery immediate post partum
7. Labor and delivery premature rupture of membranes
8. Labor and delivery OB triage
9. Labor and delivery newborn immediate post partum
10. Hysterectomy preoperative admission day of surgery
11. Hysterectomy preadmission testing
12. Hysterectomy immediate postoperative
13. Hysterectomy postoperative (daily orders)
14. Gyn postoperative orders
15. Gyn pelvic inflammatory disease
16. Antepartum pyelonephritis
17. Antepartum preterm labor
18. Antepartum hypertension
19. Antepartum hyperemesis
20. Antepartum admission orders
21. Anesthesiology postoperative orders for patients receiving epidural or subarachnoid morphine
22. Admission to labor and delivery

Maternal Fetal Medicine

1. When covering labor and delivery:
 - a. Vaginal, operative (vacuum or forceps), or Cesarean deliveries
 - b. Progress of laboring patients (once in active phase of labor, during 2nd stage of labor)
 - c. Obstetrical Hemorrhage
 - d. Labor and delivery OB triage dispositions
 - e. New admissions
 - f. Other obstetrical emergencies aside from hemorrhage (cord prolapse, eclampsia, shoulder dystocia, hypertensive crisis, fetal bradycardia)
2. When covering antepartum:
 - a. Unstable vital signs
 - b. Non-reassuring fetal status
 - c. Obstetrical emergencies as above (cord prolapse, eclampsia, shoulder dystocia, hypertensive crisis, fetal bradycardia)
3. When covering outpatient services:
 - a. Any ultrasound procedure (chorionic villus sampling, amniocentesis, percutaneous umbilical blood sampling, cardioplegia)

Ophthalmology

- Any patient that needs a procedure or surgical management.
- Any transition of care (transfer or discharge)

Orthopaedics

- 1) Deficit on physical exam not signed out as 'attending aware' or previously directly observed by the examining clinician.
- 2) Change/Discrepancy in physical exam findings from chart documentation, sign out or prior observation.
- 3) Pain uncontrolled by traditional pain control interventions
- 4) Evidence of urinary retention not signed out as 'attending aware' or previously directly observed by the examining clinician.
- 5) Observed or reported neurologic/cognitive change in a patient not signed out as 'attending aware' or previously directly observed by the examining clinician.
- 6) Any concern or perceived uncertainty about patient's condition or change in condition
- 7) Scripted contact parameters contained within preprinted postoperative order sets

Ortho/Hand:

Same as orthopedics

Pathology

Anatomic Pathology communication between residents/fellows and attending physicians

1. Residents-on-call are required to notify the attending-on-call of any request for frozen sections. Residents cannot deny or delay a frozen section without consulting with the pathology attending. The pathology attending will then discuss the case directly with the requesting attending on the clinical/surgical service.
2. Residents on the surgical pathology rotation will notify the attending-on-call of any mislabeled specimens as soon as the error is noted. This includes incorrect patient name or any significant discrepancy in designation of specimen type.
3. Residents on the surgical pathology rotation will notify the attending-on-call of any missing/untraceable specimens (including empty containers received from any clinical site or missing/untraceable specimens/cassettes/blocks in the lab) as soon as the problem is noted.
4. Residents on the surgical pathology rotation will notify the attending-on-call of any cases with an unexpected diagnosis or a significant problem that needs to be communicated to the clinician as soon as the resident becomes aware of the problem or diagnosis. Examples of such cases are below; however, this list is

not exhaustive. Residents should notify the attending on-call of unexpected significant situations, or any situation in which the resident is unsure about the appropriate response.

Cases that require the pathology resident to notify the pathology attending as soon as possible are:

1. Specimen problems, for example:

- Missing specimen
- Irresolvable labeling error
- Improper submission which precludes diagnostic evaluation

2. Significant positive diagnosis, for example:

- Unexpected malignancy
- Significant disagreement between outside slide diagnosis and ours
- Significant disagreement between frozen section diagnosis and permanent diagnosis
- Evidence of complication of surgical procedure
- Necrotic bowel margin
- Preliminary result and notification of final report delayed
- Specific or life threatening infection (includes, but not limited to: TB, Pneumocystis, significant fungal process, endocarditis, and meningitis)
- Reportable infection according to Infection Control guidelines (see below). Notify Infection Control at 4-2239, fax 4-8875. This applies to autopsy, surgical and cytology cases.

3. Significant negative diagnosis, for example:

- No products of conception (possible ectopic)
- No fallopian tubes or vas deferens in sterilization procedures
- No biopsy site in breast resections with prior cores
- No tumor in resections done for a neoplasia (unless preoperative therapy)

4. Findings consistent with a reportable disease:

See the link below for specific procedures and diseases.

http://inside.hospital.stonybrook.edu/sbuh/epidemiology/contents/IC_Section_3.pdf

5. Hand off policies

Whenever a resident is changing rotations or going on vacation and has pending cases, the resident must give these cases to the attending to whom the cases have been assigned without delay. The resident needs to communicate with the attending about these cases; verbal communication is preferred; e-mail is acceptable provided that there is confirmation that the attending has received the message.

Whenever a resident or PA is finishing a period of coverage and there are cases pending for frozen section, or requiring other special handling, this person will

contact the resident who will replace him/her and make the resident aware of the issues pertaining to pending cases.

Clinical Pathology communication between resident/fellows and attending physicians

1. Unresolvable specimen labeling errors: the resident should contact the attending if the problem has not been resolved after discussing the situation with the ordering physician and/or lab personnel
2. Request for test that are not routinely available on evenings, nights or weekends: the resident should not deny a request for a test without first contacting the lab and the attending.
3. Calling critical values: contact the attending if you are unable to communicate critical value results
4. Other on call questions: contact the attending for any question that is not addressed in the Lab User's manual or the ARUP users manual (the primary reference lab, [www. aruplab.com](http://www.aruplab.com))

Pathology/Blood Services

1. The Blood Service attending of record or designated covering attending is responsible for the welfare of the patient during apheresis or other transfusion therapy events taking place at the Blood Bank Apheresis station and during apheresis at other sites.
2. The attending on call is responsible for assuring the resident and/or fellow on call is aware of the overall care plan for therapeutic apheresis or other transfusion therapy requiring patients.
3. the fellow and/or pathology resident on call is required to notify the attending on call of any changes in the treatment plan, patient status or request for physician action from blood service or other hospital personnel or any physicians. This includes but is not limited to:
 - a. New requests for therapeutic apheresis and the tentative treatment schedule
 - b. Change in the patient status as it relates to the treatment
 - c. New requests for products requiring physician approval
 - d. Consultation requests on blood and component use and complications
 - e. Requests for physician input on blood supply and availability related problem solving

- f. Writing orders for apheresis procedures and medications. This encompasses usual orders for apheresis, volume of the planned exchange, volume of replacement such as 5% albumin, FFP, RBCs as appropriate, volume and concentration of IV calcium gluconate solution (if needed) and flow rate, heparin units in citrate solution (if needed), premedication dose and route of administration (if needed, such as Benadryl, Tylenol, solumedrol), target hematocrit for RBC exchange, and use of blood warmer (if needed).
- g. Counseling donors, patient and/or their family members on matters of blood donation, transfusion and testing
- h. Availability of on call physician on demand to the nurse performing apheresis

Cytopathology

The cytopathology fellow will notify the supervising attending of unexpected diagnoses or significant problems that need to be communicated to the submitting physician, as soon as the fellow becomes aware of the diagnosis or problem, including, but not limited to:

- a. Unexpected malignancy
- b. Significant disagreement between outside slide diagnosis and ours
- c. Preliminary result and notification of final report delayed
- d. Specific or life-threatening infection (includes, but not limited to: TB, Pneumocystis, significant fungal process, endocarditis, and meningitis)
- e. Reportable infection according to Infection Control guidelines (see below). Notify Infection Control at 4-2239, fax 4-8875. This applies to autopsy, surgical and cytology cases.

Hematopathology

While the fellow has progressive responsibility for case management, and graded supervision, the fellow is required to communicate urgent findings with the attending promptly in certain circumstances such as :

- 1- All cases of new or clinically unsuspected hematologic malignancies which require emergency assessment eg leukemia, high grade lymphoma (if the attending is not already aware of it) .
- 2- Weekly tumor board cases for review are chosen and prepared ahead of time, any additional last-minute requests are discussed with the attending before being presented.
- 3- " Stat" requests for tests especially off hours which are not handled by the clinical pathology resident on call, such as, flow cytometry requests

4- Unexpected leave of absence when they are unable to perform their duties or responsibilities such as illness, family emergency etc

5- In the absence of the attending on service, the fellow will be able to communicate with clinicians and show the findings on previewed bone marrow aspirates to hematology oncology fellows, residents from other specialties, and other personnel involved in patient care.

Pediatrics

Stony Brook Pediatrics Residency Training Program requires all residents to communicate with the supervising faculty member in a timely manner whenever the following situations arise. The event must be documented in the patient's chart using an SBAR note. The supervising faculty member will co-sign the note within 24 hours.

- All new admissions to any unit (with the exception of the healthy newborns in the Newborn Nursery)
- ICU transfers
- Any interval change in patient/ family directives or wishes (including DNR or other end of life decisions)
- Patient death
- Changes in the acuity of the care of a medically complex patient
- In the Newborn Nursery, PL-1s must call the attending with any of the following:
 - a. All critical lab values
 - b. All new admissions or transfers with Neonatal Abstinence Syndrome
 - c. Concerning or abnormal physical exam findings, such as (but not limited to), fractured clavicle, hip dysplasia, cleft palate, abnormal heart murmurs, unstable vital signs

Additional Level-Based Criteria:

PL-1s must call the supervising attending in the absence of a credentialed PL-2 or PL-3 or Fellow before initiating any procedure he/she is not already credentialed to perform.

PL-2s must call the supervising attending in the absence of a credentialed PL-3 or Fellow before initiating any procedure he/she is not already credentialed to perform.

PL-3/4s must call the supervising attending in the absence of a credentialed senior resident or fellow before initiating any procedure he/she is not already credentialed to perform.

****In addition, all residents — at all levels — must contact the attending physician when any of the following occur:**

1. Acute life, limb, or organ-threatening event
2. Unexpected episodes of hypotension
3. New onset bradycardia or tachycardia
4. New unexplained acidosis pH <7.25
5. Emergent intubation
6. Acute change in mental status
7. Unexpected oliguria or anuria
8. New onset, sustained hypertension
9. Unexpected critical lab value (s)
10. Need to institute anti-arrhythmic, pressors or inotropes
11. PEWS score of orange or red
12. New onset tachypnea or significant change in respiratory rate/pattern
13. Need for transfusion of blood or blood products if not planned in advance
14. New onset seizures or prolonged seizure activity
15. New onset, unexplained pain requiring the use of narcotics
16. New onset fever in an immunocompromised patient
17. The adolescent service must be notified if their patients refuse psychotropic medications

****This policy applies any time of day, any day of the week (24hours/day, 7 days each week).****

****This policy applies any time of day, any day of the week (24hours/day, 7 days each week).****

Pediatric Endocrinology

Stony Brook Pediatric Endocrinology Fellowship Program requires all residents to communicate with the supervising faculty member in a timely manner whenever the following situations arise. The event must be documented in the patient's chart, using an SBAR note. The supervising faculty member will co-sign the note within 24 hours.

- All new admissions to the pediatric Endocrinology service
- Patients on pediatric Endocrinology service requiring ICU transfers
- Any interval change in patient/ family directives or wishes (including DNR or other end of life decisions)
- Patient death
- Changes in the acuity of the care of a medically complex patient

Additional Level-Based Criteria:

1st Year Fellow must call the supervising attending for all consultations and if patient's condition requires change of investigational or treatment plan.

2nd Year Fellow must call the supervising attending to discuss all consultations before plan is conveyed to the consulting team.

3rd Year Fellow must call the supervising attending for oversight of the outlined plan before it is implemented or conveyed to the consulting team.

In addition, all fellows at all levels must contact the attending physician when any of the following occur for patients admitted to the Pediatric Endocrinology service or for whom the service assumes a major role as consultants:

1. Acute life or organ-threatening event
2. Unexpected episodes of hypotension
3. New onset bradycardia or tachycardia
4. New unexplained acidosis pH <7.25
5. Emergent intubation

Pediatric Gastroenterology

Stony Brook Pediatric Gastroenterology Fellowship Program requires all residents to communicate with the supervising faculty member in a timely manner whenever the following situations arise. The event must be documented in the patient's chart, using an SBAR note. The supervising faculty member will co-sign the note within 24 hours.

- All new admissions to the pediatric Gastroenterology service
- Patients on pediatric Gastroenterology service requiring ICU transfers
- Any interval change in patient/ family directives or wishes (including DNR or other end of life decisions)
- Patient death
- Changes in the acuity of the care of a medically complex patient

Additional Level-Based Criteria:

1st Year Fellow must call the supervising attending for all consultations and if patient's condition requires change of investigational or treatment plan.

2nd Year Fellow must call the supervising attending to discuss all consultations before plan is conveyed to the consulting team.

3rd Year Fellow must call the supervising attending for oversight of the outlined plan before it is implemented or conveyed to the consulting team.

In addition, all fellows at all levels must contact the attending physician when any of the following occur for patients admitted to the Pediatric Gastroenterology service or for whom the service assumes a major role as consultants:

1. Acute life or organ-threatening event
2. Unexpected episodes of hypotension
3. New onset bradycardia or tachycardia
4. New unexplained acidosis pH <7.25
5. Emergent intubation
6. Acute change in mental status
7. Unexpected oliguria or anuria

Pediatric Infectious Disease

- Suspicion or confirmation of necrotizing fasciitis
- Infant botulism
- Exposure or suspected or confirmed infection with a bioterrorism agent: Anthrax, Botulism, Plague, Tularemia, Viral hemorrhagic fever (i.e. Ebola)
- Suspected or confirmed infection with SARS or MERS
- Suspect measles
- HIV high risk infant (born to HIV mother with no antiretroviral treatment during pregnancy)

Neonatology

Criteria for resident to call fellow

1. all x-rays
2. All blood gases
3. all abnormal critical labs
4. Bilirubin requiring phototherapy
5. Sodium less than 132 and more than 145
6. Glucose less than 50 more than 150
7. Potassium less than 3.5 more than 6
8. Calcium less than 8 more than 11
9. Deviations from the blood pressure protocol
10. All consults to well baby nursery
11. Feeding intolerance/abdominal distension
12. New medication orders
13. Temperature instability
14. Transfusions
15. any increase in FIO₂ greater than 10% over baseline
16. Significant, increasing or persistent apnea for bradycardia
17. Infants requiring positive pressure ventilation
18. Arrhythmias
19. Loss of IV access

Criteria for fellows to call attending

1. change of vent mode
2. CO₂ more than 80
3. Serial bad blood gases
4. Base deficit more than 8
5. Ph less than 7.20
6. Deviations from blood pressure protocol
7. Anything decided on lightening rounds
8. Pneumothorax: placement or replacement of chest tubes
9. Admission to NICU

10. Existing patient/initiation of antibiotics
11. transport calls
12. Deliveries (immediately) less than 32 weeks and/or less than a kilogram
13. NAS scores requiring initiation of morphine
14. Bilirubin requiring exchange transfusion
15. Prenatal consult

All calls to attending must be documented in the medical record

Osteopathic Neuromusculoskeletal Medicine

- a. The resident must notify the Attending if a patient meets criteria, which trigger a Code Rapid Response, or age-appropriate acute changes.
 - i. Staff member is worried about the patient
 - ii. Acute change in heart rate to <40 or >130 bpm
 - iii. Acute change in systolic blood pressure to <90 mmHg
 - iv. Acute change in respiratory rate to <8 or >28 per min
 - v. Acute change in saturation to $<90\%$ despite O₂
 - vi. Acute change in level of consciousness
 - vii. Acute change in urinary output to <50 ml in 4 hours
- b. The resident must notify the Attending if a patient exhibits acute mental status changes.
- c. The resident must notify the Attending if a new restraint order is written.
- d. New onset tachypnea, significant change in respiratory rate or pattern, increase need for oxygenation (greater than nasal canula requirements e.g., venti-mask, non-rebreather mask, BIPAP, impending need for intubation).
- e. Unanticipated need for transfusion of blood or blood products if not planned.
- f. Multiple (two or more) sedatives are required to treat an agitated patient on a non-psychiatric unit.
- g. Persistent deviations in vital signs (e.g., hypotension/hypertension unresponsive to treatment)
- h. Acute changes in mental status or new focal neurologic deficits
- i. The resident must notify the Attending if a patient exhibits clinical findings which pertain to the program-specific criteria as described in section 3 (above).
- j. The resident must notify the Attending if a patient meets triggers established in specific order sets developed by each clinical service based on specific cases that are not covered by the first two criteria. These are part of the orders for that particular case/diagnosis (i.e., in a neurosurgical post-op case, the order may include "call attending if intracranial pressure exceeds >20 cm H₂O").

Physical Medicine and Rehabilitation

1. The covering PM&R attending should be involved in any decisions regarding the need for specialist consultation.
2. The covering PM&R attending should be notified immediately regarding the status of any patient who becomes acutely ill or is transferred off the PM&R Service for medical reasons, as the designated covering attending is responsible for the welfare of the patient. The Attending-on-Call is responsible for assuring that the residents-on-call are aware of the overall patient-care plan and the parameters for notification on each patient.
3. Residents-on-Call are required to notify the Attending-on-Call (or attending physician of record) of any changes in patient status including, but not limited to the following criteria from the Rapid Response Team or age appropriate acute changes such as:
 - a. Staff member is worried about the patient
 - b. Acute change in heart rate
 - c. Acute change in systolic blood pressure
 - d. Acute change in respiratory rate
 - e. Acute change in O2 saturation
 - f. Acute change in level of consciousness
 - g. Acute change in urinary output
4. The resident must notify the attending in the event of acute mental status changes and/or new episodes of restraint.
5. Other conditions including:
 - a. Consultation for urgent condition (e.g., autonomic dysreflexia)
 - b. Transfer of patient to a higher level of care
 - c. Code Blue Team activation
 - d. Change in DNR status
 - e. Patient or family dissatisfaction
 - f. Patient requesting discharge AMA
 - g. Patient death.
 - h. Any other clinical concern whereby the intern or the resident feels uncertain of the appropriate clinical plan.
 - i. Instances where patient's code status is in question and faculty intervention is needed.

Preventive Medicine

Patients are only seen in outpatient setting during regular work hours. The supervising attending is present on site or reachable by phone, text, or email for questions.

If a patient presented with an issue that could not wait for a response from a supervising attending that is not on site, the trainee would call 911

For tele-preventive medicine service:

The covering attending should be contacted for any concerns regarding mental instability (i.e., suicidal/homicidal ideation), concerns for abuse, or other urgent or emergent medical concerns. If there is a medical emergency during a TPM visit, residents should also call 911. Attendings are available to discuss the following:

1. Pre-Visit Precepting
 1. Prior to the visit, discuss the patient's gaps in care and proposed plan for counseling with the attending.
2. Post-Visit Precepting
 1. Review the patient visit with the attending and discuss proposed recommendations to the PCP.

Psychiatry (including Eastern Long Island Hospital)

There is 24 hour/day, 7 day/week Attending presence in the hospital. The residents contact the Attending to address any and all specific clinical situations that might arise.

- a. Circumstances in which residents ***must*** communicate with appropriate supervising faculty include:
 - i. Substantial changes in the patient's condition (including but not limited to; acute change in vital signs, acute chest pain, acute respiratory distress, dystonic reaction, patient fall with injury, acute change in mental status, cardiac arrest, nonresponsive patient, severe agitation and/or code M, violent behavior, suicidal or self-harm behavior, patient elopement, refusal of recommended treatment, threat of self-initiated discharge from the hospital)
 - ii. Issues regarding code status, including DNR/DNI, and end-of-life decisions
 - iii. Transfer to and from ICU/Critical Care Unit
 - iv. If any identified patient error or unexpected serious adverse event is encountered at any time.
 - v. If requested to do so by patients or family
 - vi. If requested by a faculty attending
 - vii. Transferring patients to a higher level of care
 - viii. If resident is uncomfortable with carrying out any aspects of patient care for any reason, such as a complex/difficult patient.

Child and Adolescent Psychiatry

- a. Circumstances in which fellows ***must*** communicate with appropriate supervising faculty include:

- i. Substantial changes in the patient's condition (including but not limited to; acute change in vital signs, acute chest pain, acute respiratory distress, dystonic reaction, patient fall with injury, acute change in mental status, cardiac arrest, nonresponsive patient, severe agitation and/or code M, violent behavior, suicidal or self-harm behavior, patient elopement, refusal of recommended treatment, threat of self-initiated discharge from the hospital)
- ii. Issues regarding code status, including DNR/DNI, and end-of-life decisions
- iii. Transfer to and from ICU/Critical Care Unit
- iv. If any identified patient error or unexpected serious adverse event is encountered at any time.
 - v. If requested to do so by patient or family
 - vi. If requested by a faculty attending
- vii. Transferring patients to a higher level of care
- viii. If fellow is uncomfortable with carrying out any aspects of patient care for any reason, such as a complex/difficult patient

Geriatric Psychiatry

1. Patient reporting suicidal or homicidal ideations
2. Transfer of patient to CPEP or ER
3. Admission of patient to In-patient psychiatric unit

Pulmonary Critical Care and Critical Care Medicine

Residents must communicate to the supervising fellow of record in the event of any of the following

1. Worsening clinical status including:
 - a) tachycardia >120 , bradycardia <50 , persistent for >10 minutes or despite standard/planned interventions
 - b) sustained hypotensive episodes (SBP <85 mmHg) despite standard/planned interventions and or persistent on multiple readings >5 minutes
 - c) any desaturations $<70\%$, or persistent (>5 min) $<80\%$ despite standard interventions
 - d) mental status with GCS <10 , difficulty to arouse/unresponsive
 - e) CODE BLUE
2. Specific lab values/data
 - a) New or unexpected lab values including but not limited to:
 - b) Lactic acid > 5
 - c) pH < 7.25
 - d) HCO₃ < 15
 - e) New or rising troponinemia >1.0
 - f) EKG changes (ST elevations/depressions, BBBs, QRS >150 ms)
3. Starting new vasopressors/inotropes or increasing vasopressor/inotrope requirements over 100% (doubled) in a 15-minute period
4. Starting Non-Invasive ventilation, either HFNC or BIPAP
5. Any proposed ventilator changes (other than FiO₂ titration)
6. Loss of access despite attempts at replacement
7. Proposed consults at discretion of attending

Fellows must communicate to the supervising Attending of record in the event of any of the following

1. Code BLUE
2. Addition of 3rd vasopressor or inotrope
3. Use of peripheral vasopressors as a bridge to central access

4. Respiratory failure with proposed intubation
5. Proposed extubations in stable patients
6. Persistent acidosis or worsening ABGs despite ventilator changes
7. Proposed procedures to be done (other than PIV)
8. Rising oxygen requirements (e.g., starting Non-Invasive ventilation, either HFNC or BIPAP)

Radiology

1. If you are notified of a complication from a special procedure that was performed by our IR radiologists, you must notify the IR attending-on-call.
2. If you are notified of a complication from a special procedure that was performed by our Neuroradiologist, you must notify the IR attending-on-call.
3. If you receive a request for an emergent special procedure examination to be performed by our interventional radiologists, you must notify the IR attending-on-call.
4. If you receive a request for an emergent enema exam on an infant or child to diagnose and/or reduce an intussusception, you must notify the appropriate attending radiologist.
5. If you receive a request by an attending from another service to speak to the radiology attending, you must notify the appropriate in-house radiology attending.
6. If there is an emergency declared at Stony Brook, such as a massive number of incoming casualties, you must notify the appropriate senior radiologist(s), as well as the overnight radiologist if already in house.
7. If you and your senior resident are unsure of a diagnosis in a patient who requires emergent treatment that depends on the correct diagnosis being made by the study, you must contact and consult the appropriate attending.
8. If you are unable to complete your work in a timely manner (e.g. you become ill, or there are a massive number of backed up patients, or there is equipment failure) you must notify your radiology attending.
9. You should communicate results of critical tests and values as outlined in department protocol to the appropriate clinical service.

Musculoskeletal Radiology

1. If you are notified by clinician, house staff, ancillary staff, radiology resident or patient/family member of a procedural complication performed by you or by Musculoskeletal Radiology Section Faculty you are to notify Musculoskeletal Radiology Faculty Member who

performed/supervised the procedure or, if unavailable, the MSK faculty member available (on-call) or Interventional Radiologist on-call

2. You are to review the specifics of the case and obtain pertinent information, review medical record, and, in case of In-patient - ED patients, assess patient in person, as clinically warranted when available.
3. You are to document the complication in writing, perform follow up and review the specifics of the case and what intervention was required with faculty involved. This factual account is to be discussed as soon as possible with the Chief of Musculoskeletal Radiology and this case to be discussed in educational/quality venue in MSK Sectional meeting.
4. If you receive a request for an emergent MSK special procedure examination, you are required to review the specifics and indications of the case in addition to any alternative imaging or procedures and notify the MSK or Interventional radiology section who performs these procedures. If MSK faculty is not available, you must contact Interventional Radiology attending on-call and appraise the attending of the specifics of the case and determine the appropriateness of the requested procedure.
5. If you receive a request by an attending in another service to speak to an MSK attending radiologist, you are to obtain specifics of the issue or case and notify the MSK attending. If MSK faculty is not available, you are to notify appropriate Radiology attending on call.
6. The attending –on- call must treat resident/fellow with proper respect and dignity and use any fellow procedural complication or misread as an educational opportunity and not in a punitive manner.
7. If radiology resident requests MSK Fellow assistance on case or course of action- fellow is to assist resident.
8. MSK Fellow is required to notify clinical service of any unanticipated diagnosis/findings immediately or as soon as possible following case review depending on the critical nature of the finding. This includes but is not limited to: unexpected, recurrent or new malignancy, large bleed/hematoma in which intervention may be required, active bleed, suspected compartment syndrome, gas gangrene/necrotizing fasciitis, acute osteomyelitis, septic joint, unknown fracture, significant procedural or post procedural complication as well as department critical tests/critical values as outlined in policy.

9. Fellow is required to document in the radiological report the following:
Fellow name, who and when clinical service or health care provider was notified of significant or unintended imaging or procedural findings as per ACR guidelines.
10. If resident and MSK Fellow is unsure of a diagnosis or course of action that requires treatment, you are to notify MSK faculty and if off hours /on- call then notify appropriate faculty member on- call or on off- hour shifts.
11. If Fellow is unable to complete work in a timely manner, attending is to be notified.
12. Currently MSK Fellows are supervised on off hour shifts with 24/7 Radiology faculty available.
13. MSK Fellow is required to sign-out any completed procedure in which is high risk for complication to radiology resident or faculty on-call (off hours) and appraise them of issues and potential complications.
14. It is responsibility of MSK Fellow to follow up on patients following procedures both clinically and review any respective biopsy, histology, lab results.
15. The MSK Fellow should notify the MSK, IR or faculty available on off hours in the following circumstances following procedures:
 - Excessive, immediate or delayed bleeding,
 - Unexpected or un- anticipated change in patient status
 - Unexpected lab results
 - Uncontrolled pain
 - Significant concerns made by clinical services in regards to procedure performed

RADIATION ONCOLOGY

1. Residents working in Radiation Oncology are supervised by the attending physicians and are required to notify attending physicians if there is a change in the patient's status in any disease process, which may or may not warrant a level of care.
2. They are also required to notify attending of any change in the treatment planning or in daily set up on the machine.
3. Resident is to contact attending for any Grade 2 or higher toxicity which may or may not be related to treatment.
4. Attending is to be notified of any unanticipated break in treatment course or deviation from the intended course of treatment.
5. The attending is to be notified anytime the resident is uncomfortable with a situation) either clinical, or social, for example problems with a patient's family member behaving erratically or demanding things inappropriately).

Surgery (General) – including Stony Brook Southampton

1. If you discover a complication from surgical procedures that was not previously noted.
2. If you are notified of a patient with an impending airway problem.
3. If you are present at or know of an impending mortality.
4. If you receive a request for an emergent surgical intervention.
5. If you receive a request to accept a transfer from another hospital.
6. If you are fatigued and resident back-up coverage is not available to you
7. If you receive a request by an attending in another service to speak to the General Surgery attending on call.
8. If there is an emergency declared at Stony Brook, such as a massive number of incoming casualties, you must notify the attending on call.
9. If you and your senior resident are unsure of diagnosis in a patient who requires emergent treatment that depends on the correct diagnosis being made by the study.
10. If you are unable to complete your work in a timely manner (e.g. you become ill, or there are a massive number of backed up patients, or there is equipment failure) you must notify your General Surgery attending on call.
11. All new admissions/consultations
12. Any patient who has triggered a Rapid Response or any activation of a Hospital Code (e.g., Code BAT, Code CSI, Code Blue
13. Any acute change in mental status or any new onset focal neurologic finding
14. New onset seizure

15. Any new restraint order that is placed
16. Any request for a change in patient code status
17. Any unanticipated death (e.g., any death besides a patient who has been placed on Comfort Care)
18. Any unanticipated change in drain output (quantity or quality)
19. Any unexpected change in laboratory value (this includes any change in laboratory values that do not already have a plan in place-e.g., if a plan is in place the attending need not necessarily be informed ("transfuse if the next hemoglobin comes back as less than 8"))
20. Any new onset arrhythmia
21. Need for unplanned bedside procedure (central line insertion, arterial line insertion, etc.)
22. Any request from another service for emergency surgical intervention or bedside emergent surgical procedure
23. Requests for transfer between services or from another hospital
24. If attending input is specifically requested by the consulting service
25. If there is concern for a patient with an impending airway problem
26. If there is any concern regarding the patient's diagnosis and an accurate diagnosis is paramount to further work-up and/or treatment
27. Any acute episode of hypotension
28. Any patient with impending respiratory failure or requiring either intubation or need for BiPAP
29. Any discovery of a complication from a surgical procedure, not previously noted
30. All patients who require an upgrade in level of care
31. Any significant, unanticipated radiologic finding
32. Evidence of developing or new onset renal failure (oliguria, anuria)

Surgery (Colorectal)

The colorectal surgery resident is responsible to lead the resident and student team in managing all patients and consults on the colorectal surgery service, in conjunction with the attendings.

The CRS resident is supervised by the on call attending at all times. Resident responsibilities for communication include:

1. Always let the attending of record or on call know of any changes in condition of a patient(ie: significant hypotension, tachycardia, oliguria, unexpected changes in labwork, etc).
2. All new patient consultations or admissions must be discussed with the colorectal surgery attending on call.
3. If you receive a request for an emergent surgical intervention.
4. If you receive a request to accept a transfer from another hospital.
5. If you are fatigued and resident back-up coverage is not available to you let the CRS program director know.

6. If you receive a request by an attending in another service to speak to the colorectal surgery attending on call.
7. If there is an emergency declared at Stony Brook, such as a massive number of incoming casualties, you must notify the attending on call.
8. If you are unsure of diagnosis in a patient who requires emergent treatment that depends on the correct diagnosis being made by the study.
9. If you are unable to complete your work in a timely manner (e.g. you become ill, or there are a massive number of backed up patients, or there is equipment failure) you must notify your attending on call and/or the CRS program director.

Surgery/Critical Care (SICU)

The SICU fellow will notify the attending of any clinically significant change in patient status including but not limited to:

1. New onset hemodynamic instability
2. Emergent intubation or substantial deterioration in pulmonary status
3. Significant change in neurovascular status

Surgery (Vascular)

1. If you discover a complication from surgical procedures that was not previously noted.
2. If you are notified of a patient with an impending airway problem.
3. If you are present at or know of an impending mortality.
4. If you receive a request for an emergent surgical intervention.
5. If you receive a request to accept a transfer from another hospital.
6. If you are fatigued and resident back-up coverage is not available to you
7. If you receive a request by an attending in another service to speak to the Vascular Surgery attending on call.
8. If there is an emergency declared at Stony Brook, such as a massive number of incoming casualties, you must notify the attending on call.
9. If you and your senior resident are unsure of diagnosis in a patient who requires emergent treatment that depends on the correct diagnosis being made by the study.
10. If you are unable to complete your work in a timely manner (e.g. you become ill, or there are a massive number of backed up patients, or there is equipment failure) you must notify your General Surgery attending on call.

Urology

Additional diagnoses:

Renal Stone:

- Temp >101 in untreated stone

Nephrectomy:

- Suspect bleeding
- Need Transfusion
- Hematocrit <27%

Partial Nephrectomy:

- Suspect bleeding
- Need for Transfusion
- Hematocrit < 27%

TURP:

- Bleeding Refractory to CBI
- Catheter malfunctions; unable to fix at bedside.

Simple Prostatectomy:

- Hematocrit < 27
- Drain output > urinary cath output
- Cath malfunction

Transplant Recipient:

- Hematocrit < 27
- Abrupt < in urine output
- Leg Ischemia

Radical Cystectomy:

- Hematocrit < 27
- Signs of Acute Abdomen

Forms: (Ctrl-Click form name to view)

None

Policy Cross Reference: (Ctrl-Click policy name to view)

GME0036 Resident Supervision

Relevant Standards/Codes/Rules/Regulations/Statutes:

None

References and Resources:

None