ICU/MEDICINE MEMORANDUM ON LEVEL OF CARE, ESCALATION, AND COMMUNICATION

Responsible Owners: Dr. Lepler and
Dr. Arundel

Service Line(s): Medical & Critical Care
Effective Date: January 2023

1. PURPOSE AND AUTHORITY

a. The purpose of this standard operating procedure (SOP) is to provide guidance for admitting and transferring patients throughout the inpatient environment, from the ED and between MICU, SICU, and stepdown units (PCU/SICU stepdown). This SOP should be followed by physicians who work and take care of such patients.

b. This admission criteria serves as a guideline for the most appropriate level of care (LOC) based on the needs of a patient as well as nursing capabilities on various units. Nevertheless, the provider will determine their final disposition based upon their clinical assessment.

c. This policy will also outline standard operation procedures for transfers from the ICU to the medical ward, communication and documentation requirements from the care teams including during rapid responses (RRT) and code blues, and communication and documentation from care teams for ICU consults.

d. This policy will also outline appropriate steps for escalation when there are disagreements about the most appropriate LOC.

e. This policy sets forth measures and processes to ensure compliance with the Washington DC Veterans Affairs Medical Center (DC VAMC) standards.

2. PROCEDURES

a. Transfers from the critical care service to medicine teams

- Transfers can only occur if a bed has been assigned

- ICU team must complete a transfer note and a verbal handoff to the accepting team

b. PCU ADMISSION AND ICU BOARDING POLICY

PCU/Telemetry Guidelines/Admissions:

In order to 1) better match PCU bed allocation with house staff and faculty resources; 2) provide increased critical care expertise to our higher illness acuity veteran patients; 3) ensure that ICU and ward teams have access to PCU beds when needed; and 4) minimize care handoffs in the interest of patient safety, involved stakeholders have agreed to the following guidelines for admission to PCU and/or Telemetry under the different services. These are guidelines that do not capture all clinical scenarios and can be adjusted after an attending-to-attending conversation.

<u>PCU Telemetry Under Critical Care Service</u>

1. Patients with acute coronary syndrome with escalating symptoms, dynamic EKG changes, requiring gtt for pain control, or hemodynamic instability.
2. Supraventricular tachycardia (SVT) not controlled by initial therapy.
3. Decompensated congestive heart failure, if:
    a. Patients are hemodynamically stable and receiving continuous IV diuresis
    b. Requiring fixed dose of Dobutamine (i.e. 2-3 mcg/kg/min) after therapeutic goal is achieved; Amiodarone IV after the initial 6-hour dose (or once titrated to 0.5mg/min over 18 hours). **Other IV inotropes must be in the ICU.*
4. Unstable or deemed at high-risk patients for complications with presumed device malfunction, or patients with an ICD and syncope.
5. Patients deemed to be unstable or high-risk for complications admitted after device implantation (pacemaker/defibrillator) or ablation.
6. Patients deemed to be unstable or high-risk for complications with presumed device malfunction
7. Patients deemed to be unstable or high-risk for complications with ICD and syncope
8. Patients with escalating oxygen requirements who are not candidates for ICU transfer (excluding comfort care). For example, increasing high flow requirements, need for non-rebreather etc.
9. Patients requiring **initiation** of bipap for acute or acute-on-chronic hypercapnic respiratory failure (pH<7.3 with pCO2 of greater than 45) or severe pulmonary edema not meeting ICU admission criteria. Bipap is limited to the front half of the PCU only (beds 14-19).
10. Patients presenting with sepsis and concern for hemodynamic instability.
11. All RRT's that transfer to the PCU for hemodynamic instability.
12. Stroke patients getting TPA or need transfer for mechanical thrombectomy to the critical care service, likely ICU

<u>PCU Under Medicine Service</u>

1. Stable patients admitted after device implantation (pacemaker/defibrillator).

2. Stable patients admitted after an electrophysiology procedure such as ablation.
3. Stable patients with presumed device malfunction, or patients with an ICD and syncope.
4. Hyperglycemia/Hypoglycemia if requiring q2h blood sugar checks (limited to an 8-hour time frame before re-evaluating for ICU admission)
5. Patients who meet SIRS/sepsis criteria initially and are currently normotensive after resuscitation with 2 liters or less of fluids.
6. Patients requiring suctioning more frequently than every 4 hours, particularly those with a tracheostomy or altered mental status.
7. Patients requiring neuro checks more frequently than every 4 hours.
8. Patients requiring scheduled nebulizer treatments more frequently than every 4 hours. (Does NOT include prn nebs).
9. Patients with peritoneal dialysis catheters in situ (needs a private room).
10. Hemodynamically stable lower GI bleeds.
11. Confirmed acute ischemic stroke, or large stroke <96hrs in patients who are TPA ineligible
12. Patients requiring hemodialysis not in the dialysis unit **ONLY when determined necessary by nephrology.*
13. Patients with high-risk acute coronary syndrome requiring heparin gtt but <u>without</u> escalating symptoms, dynamic EKG changes, or hemodynamic instability.

<u>Telemetry Beds under Medical Service</u>

1. Patients admitted for evaluation of syncope, without evidence of heart block or recurrent VT in the ED.
2. Patients with atrial fibrillation that is poorly rate controlled but with stable hemodynamics.
3. Subacute stroke small/midsize (48-72hrs) or >96hrs if large, or TIA and TPA ineligible
4. Patients admitted with atypical chest pain and negative cardiac markers.

PCU/ICU Boarding:

<u>Telemetry boarders in the PCU</u>

On occasion, patients who require telemetry but do not meet criteria for PCU level of care may board in the PCU under medical service. These patients will be a priority to transfer out of the PCU at the earliest point possible and will count towards the total medicine PCU beds.

<u>Medicine boarders in the Critical Care Units</u>

On occasion, patients who do not meet criteria for Critical Care level of care may board in the MICU/SICU under medical service. These patients will be a priority to transfer out of the Critical Care units at the earliest point possible.

ICU boarding allowed if (i.e., Medicine team is primary):

- Patient is being admitted directly to medicine from the ED as a general medicine patient, but the hospital is full and the only open bed for the admission is inside the ICU.
- Patient requires airborne isolation (TB rule out, etc.), the patient is stable and not requiring critical care interventions, but all the airborne isolation rooms are full on the general floor and only open options are in the ICU.

ICU boarding should not occur if (i.e. Critical Care team is primary):

- Patient no longer requires MICU level care but there are no open general medicine floor beds. Pt will remain on MICU team until a general medicine bed has been obtained.
- Rapid is called for **hemodynamic instability**, patient needs a higher level of care, but only open bed is in the MICU (rather than the PCU).

ICU Downgrade clarifications:

- Medicine may accept ICU-to-floor and PCU-to-floor transfers up to 10pm.
- Medicine may accept ICU-to-PCU and PCU (Critical Care)-to-PCU (Medicine) transfers between 07:00am and 10:00pm due to lower staffing and to avoid additional handoffs.
- From 10:00pm-07:00am, there will be no transitions of care from the MICU team to a medicine team for patients with a bed in the PCU. The only exception is if there is an attending-to-attending conversation.

Changing orders for ICU-to-medicine transfers (Admit/Discharge/Transfer orders):

- The receiving medicine team changes the A/D/T order once a patient is accepted by the floor team. Floor teams should evaluate ICU transfers within 1 hour after receiving the request for transfer and place the A/D/T order promptly (the patient can't transfer out of the ICU without the order).

***Please note that if there is ever a disagreement, an attending-to-attending conversation is warranted and can trump the above criteria.

Patient assessments for transfers to a higher level of care i.e. Floor/Stepdown/ED to MICU

a. Admissions, MICU evaluations, and transfers to the MICU team received by the MICU Team while the MICU Fellow is in house will be evaluated prior to MICU Fellow leaving. MICU Fellow will complete a brief note which be entered in CPRS at the time of evaluation.

b. MICU Fellow will respond to and supervise Code Blues (non-ED), RRTs, and Code Strokes occurring while the MICU Fellow is in house.

c. All consults that the fellow does NOT think needs to be admitted to the ICU MUST be discussed with the attending regardless of the time of day/night. A consult note at the time of evaluation and subsequent evaluations must be documented in CPRS in a note.

ICU consultations/evaluations during duty hours:

1. Medicine team asks for an ICU evaluation
2. ICU team evaluates the patient, discusses plan with the medical team, and documents in a note
3. If transfer to the ICU team is declined, then an attending-to-attending conversation is needed
4. ICU Attending will write a separate attending note outlining their assessment and plan (per ICU recommendation put forward)
5. Pt will remain on ICU consult service for a minimum of 24 hours after consultation, will be re-evaluated at the bedside by the ICU service several times, and evaluations will be documented.

Rapid Responses:

1. Documentation is required by the ICU resident/fellow and ward resident for all RRTs and Codes
2. During duty hours, attending physicians (hospitalist, ICU) must be notified of all RRTs by their team with an attending note outlining their assessment and plan
3. After midnight, the night float team will notify the on-call hospitalist attending of RRTs as per the must call list
4. RRTs with hemodynamic instability will be transferred to the ICU service
5. A disagreement about the LOC, requires an attending-to-attending conversation is needed

Hospitalists:

1. During duty hours, all pts upgraded to PCU because of an RRT will be seen by the attending hospitalists with a separate attending note outlining their assessment
2. After duty hours
    i. Moonlighter/Swing hospitalist attend RRTs and write a separate note
    ii. Moonlighters to evaluate and write a note on unstable patients
    iii. Moonlighter/Swing hospitalist-if there is disagreement in LOC between services for unstable patients, RTTs, or CODES, an attending-to-attending conversation must be done.

iv. After midnight, an attending hospitalist must be notified of unstable patients, upgrades to a higher LOC, RRT/Codes as per the must call list. If there is disagreement in LOC between the ICU and Medicine an attending-to-attending conversation must be done.

3. SIGNATORY AUTHORITY

[Name]
[Additional title, as appropriate]
[Title of Service Line Chief]
Date Approved: Month Day, Year

[Name] (if applicable) [Delete this if not needed]
[Additional title, as appropriate]
[Title of Service Line Chief]
Date Approved: Month Day, Year