EMERGENCY DEPARTMENT POLICY

SUBJECT: Critical Care Consult Policy

NO. 34.5
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Original Date of Issue: 3/97

Patient Population

<table>
<thead>
<tr>
<th>Patient Population</th>
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<td>Neonate</td>
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<td>Pediatric</td>
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<td>Adolescent</td>
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<td>Adult ✓</td>
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<td>Geriatric ✓</td>
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POLICY:

The following procedure will be implemented when a patient is in need of intensive care placement in any of the ICUs within Mount Sinai.

IMPLEMENTATION:

1. When a critically ill patient is treated in the Emergency Department, the attending emergency physician will determine the need for critical care admission and select the clinically most appropriate unit for a patient. **Goal**: MICU patients should be transferred from the ED to an available MICU bed in under one hour.

2. **Inter-department communication**: ED and MICU leadership will designate liaisons who will work to resolve ED/ICU issues both in real time as they arise (by prompt email reporting) and with regular meetings to address patient care issues that affect both departments.

3. **Transfer of moribund patients from the ED to the ICU**: The ED will seek to identify the subset of critically ill patients not expected to survive more than 1-2 hours, and the management focus for these patients will be on optimizing all aspects of care in the ED rather than transfer to the ICU. A set of criteria to identify these patients was discussed and includes are:

   serum pH<7 in an intubated patient,
   
   HR <40 or SBP<60 on high dose vasopressors
   
   two or more cardiac arrests in the ED.

   The ICU will be available to provide consultative intensivist support in the ED for these patients and their families, but will not assume primary management of the patient. If patient is sustained >2hours after initial notification of the ICU, despite moribund physiology, then transfer to MICU will be discussed on a case-by-case basis, as the MICU recognizes the need to admit patients with sustained care needs.

4. **Management of patients who are difficult to ventilate or oxygenate after intubation**.

   Routine post-intubation blood gas analysis will be obtained promptly after intubation. The ED will focus on identifying the subset of intubated patients who are difficult to ventilate; this includes but is not be restricted to the following specific criteria: high peak airway pressures (>35 sustained despite sedation attempt), refractory hypoxemia, and severe patient ventilator dyssynchrony. Repeat blood gas analysis will be performed as soon as difficult to ventilate status is detected. The ICU will strive to arrange for early transfer of these patients and, when this is not possible, will focus on providing timely substantive intensivist consultation in the ED.

5. **Recognition and early intervention for severe sepsis**: The ED and MICU have initiated efforts to join the GNYHA sepsis identification and treatment collaborative STOP Sepsis
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(Strengthening Treatment and Outcomes for Patients) project. This participation includes adoption of an automated EPIC-based ED triage instrument that helps to identify patients with severe sepsis or sepsis with shock, and to utilize protocol driven resuscitation measures. Time stamped data collection will document the completeness, timeliness, and effectiveness of protocol components including time to antibiotics, time to fluid resuscitation, lactate clearance measurement, ivc collapsibility index measurement, cvp measurement, according to protocol triage instrument/resuscitation protocol/ data collection instrument.

6. **No Beds policy.** This is to reaffirm existing medical board policy [circa 2003] regarding the situation when no bed is readily available for a patient accepted by the MICU. If the patient is deemed by the MICU fellow as an appropriate candidate for MICU admission, then several situations may occur:
   a. If no bed is available, all attempts should be made as rapidly as possible to create an open bed for the patient. Ongoing efforts to increase the available stepdown beds and to establish a safe/acceptable cohorting program are two examples of efforts to enhance throughput and improve bed availability. If no patient can be transferred out of the MICU safely, then the MICU fellow is responsible to call the fellow on call in another ICU [in the following order: SICU, NSICU, and then CCU]; he/she will arrange transfer. The fellow will notify the MICU attending of the transfer process.
   b. If the patient is accepted to another ICU, daily attempts will be made by the MICU attending and fellow to transfer the patient to the MICU according to bed availability, with fellow to fellow communication on a daily basis.
   c. A top down evaluation will be undertaken by ED/MICU/hospital administration to develop an improved process to address the care needs of the critically ill patient who remains in the ED for an extended interval because of bed unavailability. At present, MICU will not be responsible for managing the patient in the ED, but the MICU attending and fellow are available to provide Critical Care Consultation for patient management questions. Critical Care consultation is not an avenue to “make” a bed for a patient or to adjudicate triage decisions. The MICU not having available beds does not preclude formal consultation when intensivist decision support is requested by the ED.
   d. Patients who are intubated in the ED but deemed not to benefit from ICU admission (e.g., severe co-morbidity that precludes meaningful functional recovery) may be admitted to available step down or medical ward floor bed as appropriate. Each medical floor has capacity to accept at least 2 patients with mechanical ventilatory needs, and the palliative care service may be an appropriate destination for some patients in this category.

7. Critical care and cardiology consultation at the attending level is to be available on a 24-hour/day basis. In accordance with medical board policy, consultations will be answered in ten minutes for emergent consultations and one hour in urgent cases.

8. If the admitting attending disagrees with the emergency physician's decision to admit, the admitting attending will see the patient, make a clinical assessment, write a note and if desired, arrange for the transfer of the patient to another service.

9. ICU and CCU admissions and consultations will have quality assurance review in the Care Center Quality Council.