GUIDELINES FOR CALLING PICU ATTENDINGS

Rule #1: When in Doubt: *call*
Rule #2: If you are too busy to leave the bedside, ask someone else to call for you
Rule #3: ANYONE can call (MD, RN, RT...)
Rule #4: If multiple services are involved, the PICU attending should always be your first call.

Call **BEFORE** accepting pt if:
- any non-emergent (not coding) transfer from the ward or IMC
- any concern about subspecialty availability
- pt to be refused admission for any reason
- any questions from referring facility
- transport team other than **ACT/Lifestar** being considered
- delay of > 1 hour in **ACT/Lifestar** departing to transport patient

Call **after** accepting but **before** pt arrives if:
- VS > 1SD above or below limits for age
- pt intubated
- pt in shock
- pt without IV access or only IO access
- any other reason to think pt will need attending present at beside

Call **within 1 hour** of pt arrival for:
- all patients admitted to PICU service
- intubated patients arriving from OR on any service
- all CV surgery patients

Call on Asthmatic patients
- tachypneic or increased WOB but without tightness or wheeze
- not responsive to albuterol/atrovent/steroids
- when implementing heliox/terbutaline/Magnesium/aminophylline

Call within one hour (or sooner) of event for any patient who:
- arrests
- requires intubation
- requires Heliox, CPAP, Vapotherm or BIPAP
- has unplanned extubation
- has new O2 requirement of > 50%
  (if arrives on 100% unable to wean to ≤ 50% with 2 hrs)
- requires new institution of pressors
- requires an increase of >5 mcg/kg/min dopamine/dobutamine or
  >0.1 mcg/kg/min epi, norepi, phenylephrine
- receives more than 40cc/kg fluid bolus in ≤ 8 hours
- receives reversal agents for sedation (Narcan, Flumazenil)
- receives unplanned/unscheduled Mannitol
- requires an increase of > 100% (2x) previous sedation dose
- requires a new consult from a service not previously involved
- any patient who dies, or in whom death seems imminent (even if DNR)
- anytime a DNR order is written
- any patient in whom abuse is suspected or advocacy is involved
Guideline for use of telemedicine equipment

1) In general, should be used to “check in” with resident in the evening. Call will be initiated by attending.
Goal: 75% of check in calls to be done through telemedicine.

2) Patients who should be considered for telemedicine evaluation include:

WARD/IMC PATIENTS WITH:
- Medical need for transfer (not space/isolation issue) from IMC/ward to ICU unless arresting this should occur BEFORE the patient is transferred
- Physician, nursing or family concern about condition or potential for deterioration (i.e., Rapid Response Evaluation)
- Any Peds Code Blue
- Any patient admitted with abnormal neurologic exam or with significant change in neurologic exam
- Patients in whom ICU nurse is unable to gain IV access (ICU or floor/IMC)
- Asthmatic patients failing intensive treatment protocol on floor
- Need for FiO2 > 0.50

ICU PATIENTS WITH:
- new admission from CV service
- new admission who is intubated
- new admission under 1 year old admitted as an ICU (not boarder) patient to the critical care service
- asthma and need to escalate support beyond albuterol/atrovent/steroids
- cardiac or respiratory arrest
- need for intubation or reintubation
- new institution of Heliox, CPAP, Vapotherm or BIPAP
- new O2 requirement of > 50%
- (if arrives on 100% unable to wean to ≤ 50% with 2 hrs)
- new institution of pressors
- increase of >5 mcg/kg/min dopamine/dobutamine or >0.1 mcg/kg/min epi, norepi, phenylephrine
- receives more than 40cc/kg/fluid bolus in ≤ 8 hours
- receives reversal agents for sedation (Narcan, Flumazenil)
- receives unplanned/unscheduled Mannitol
- requires an increase of > 100% (2x) previous sedation dose
- physician, nursing or family concern about condition or potential for deterioration (i.e. Rapid Response Evaluation)

Goal: 75% of patients meeting above criteria to be evaluated by telemedicine
Stretch goal: 100% of patients meeting above criteria evaluated by telemedicine

3) Evaluation Form should be completed before completion of shift in which telemedicine assessment of actual patient (not test calls) was done

Updated 7/20/11