LITTLE COMPANY OF MARY-SAN PEDRO HOSPITAL

CRITICAL CARE CENTER
RULES AND REGULATIONS

ARTICLE I. **NAME**

The name of the Unit shall be the Critical Care Center (CCC) of LCM-San Pedro Peninsula Hospital.

ARTICLE II. **ORGANIZATION**

A. Medical Directors - The Medical Directors of the CCC will be selected in accordance with the Medical Staff Bylaws. A Medical Director or Co-Director of the CCC is Board Certified in Cardiology/Critical Care Intensivist. In the absence of the Co-Directors, a designee assumes responsibility for the patients in the CCC. The Medical Director or designee should be contacted in an emergency if the attending physician is unavailable. As noted in the policy on the chain of command, when a nurse is concerned about a questionable order, the nurse may contact the Director or Administrative Supervisor and the Medical Director of the CCC.

B. Nursing Administration - The Manager, Critical Care and Telemetry Services is directly responsible for the administrative aspects of the CCC. The Critical Care Coordinator is responsible for the clinical nursing aspects of the CCC.

C. Policy (Rules and Regulations) - Policy will be generated by the Critical Care/Code Blue Committee that will meet at least quarterly.

D. The Unit - The CCC shall consist of a minimum of twelve (12) patient beds. Appropriate monitoring and critical care equipment shall be maintained by the hospital in accordance with the decisions of the Nursing Administration, Hospital Administration, Critical Care/Code Blue Committee and the rules and regulations of the JCAHO, Title 22 and the American Heart Association.

F. Critical Care/Code Blue Committee - The Committee shall function as follows:
   1. Members shall be appointed by the Chief of Staff.
   2. Meetings shall be held at least quarterly or more often if deemed necessary.
   3. Purpose of the Committee:
      a. To establish policies and procedures for the CCC in

conjunction with nursing.

ARTICLE II. **ORGANIZATION** cont'd

3. Purpose of the Committee: cont'd
   b. To make recommendations as to equipment and supplies for the CCC.
   c. To supervise and maintain high professional standards within the CCC.
   d. To review all complications, codes and deaths occurring in the Critical Care Center, the findings and actions taken to be documented in the minutes.

ARTICLE III. **ADMISSION CRITERIA**

Admission criteria for the Critical Care Center are based on the identification of patient risk in addition to the requirements for continuous or frequent observations or measurements. Physicians will see any admission to the Critical Care Center as soon as necessary but not more than within 24 hours following admission based on the patient's clinical condition with the exception of MI patients who must be seen within at least 2 hours of admission per American Heart Association guidelines. All patients sent to the hospital with acute coronary syndrome (regardless of where they are sent by the admitting physician) will be directed to the Emergency Department for stabilization and then be admitted to the hospital. Patients may be admitted directly to the CCC with the exception of acute coronary syndrome patients. The physician must notify the nurse in charge in the CCC of this impending admission. Admitting personnel will come to the CCC to admit the patient.

A. **CORONARY INSTABILITY:**
   1. Chest pain over 20 minutes duration while at rest.
   2. Sustained chest pain with suspected or documented acute myocardial infarction.
   3. Intermittent chest pain with suspected or documented acute myocardial ischemia:
      a. Crescendo or pre-infarctional characteristics.
      b. Increasing exertional (anginal) characteristics.
   4. Intermittent atypical chest pain.
   5. Patients with a complicated MI admitted by a non-cardiologist must receive a cardiology consult within one hour of the complication. That complication can be, but is not limited to: recurrent or continued chest pain, complex arrhythmias or pump failure.
   6. Congestive Heart Failure.
   7. Angina with new or worsening mitral regurgitation murmurs.

ARTICLE III. **ADMISSION CRITERIA**: cont'd

A. **CORONARY INSTABILITY**: cont'd
8. Rest angina with dynamic ST changes >1mm.
9. Angina with S3 or rales.
10. Angina with hypotension or shock.
11. Cardiogenic Shock

B. **CARDIAC ELECTRICAL INSTABILITY:**
1. Malignant ventricular arrhythmias:
   a. Paroxysmal ventricular fibrillation.
   b. Sustained or paroxysmal ventricular tachycardia.
   c. Ventricular arrhythmias known to predispose to #1 and #2. For example: R on T PVC's, Torsade de Pointes.
2. Malignant atrial arrhythmias:
   a. Atrial fibrillation with ventricular response >160.
   b. Atrial fibrillation with ventricular pre-excitation, e.g. WPW.
   c. Atrial flutter with 1:1 or rapid conduction.
   d. Atrial tachycardia with ventricular rates >160.
   e. Atrial ectopic tachycardia with block.
3. Sinus node dysfunction:
   a. Sinus arrest or block.
   b. Tachycardia-bradycardia asystole syndrome.
4. Atrio-ventricular block:
   a. Complete or paroxysmal AV block.
   b. Intermittent AV nodal conduction.
   c. Bifascicular or trifascicular block.
5. Syncope with suspected arrhythmic origin.

C. **NEUROLOGICAL INSTABILITY:**
1. Coma or acutely varying levels of consciousness requiring continuous or frequent observation.
2. Central Nervous System dysfunction with impairment of:
   a. Respiratory function
   b. Swallowing or airway protective reflexes
   c. Vasomotor control
3. Cerebral edema.
4. Requirement for intracranial pressure monitoring.
5. Spinal cord injury requiring continuous or repetitive observation.
6. Paralytic disease processes with potential for respiratory complications.

ARTICLE III. **ADMISSION CRITERIA**: cont'd

D. **RESPIRATORY INSTABILITY:**

1. Ventilatory insufficiency of any etiology characterized by:
   a. Severe hypoxemia ($P0_2$ <55 with or without oxygen supplementation.)
   b. Hypercapnia of any degree, especially when associated with acidosis, particularly when ventilatory assistance is required or anticipated.
2. Paroxysmal ventilatory insufficiency, e.g. with severe bronchospasm.
3. Ineffective ventilatory mechanism:
   a. Inability to clear secretions (ineffective cough or protective reflexes).
   b. Intermittent upper airway obstruction, e.g. laryngospasm.
   b. Impending airway obstruction particularly when intubation or tracheostomy is required or anticipated:
      i. Epiglottitis
      ii. Laryngeal edema
      iii. Upper airway burns or toxic exposures
4. Pulmonary hypertension requiring continuous pulmonary arterial pressure monitoring.
5. Noncardiac pulmonary edema.
6. Massive hemoptysis.
7. Status asthmaticus, exacerbation of COPD - with severe respiratory distress and where ventilatory assistance is required or anticipated.

E. **HEMODYNAMIC INSTABILITY:**

1. Shock of any etiology.
   a. Hypovolemic
      i. Acute blood loss
      ii. Postsurgical or postdialysis
   b. Chemically mediated
      i. Anaphylactic
      ii. Intoxication, e.g. drug overdose
   c. Septic
   d. Central nervous system mediated or due to autonomic insufficiency.
   e. Cardiogenic shock
2. Congestive heart failure characterized by:
      a. Acute pulmonary edema
      b. Severe pulmonary vascular congestion with respiratory distress

ARTICLE III. **ADMISSION CRITERIA**: cont'd

E. **HEMODYNAMIC INSTABILITY:** cont'd

2. Congestive heart failure characterized by: cont'd
   c. Pleural effusions with respiratory distress
3. Marked lability of systemic arterial pressure requiring continuous or frequent monitoring.
4. Hypertensive crisis
5. Severe pulmonary arterial hypertension with hemodynamic instability or heart failure.
6. Continuous or frequently intermittent acute blood loss:
   a. Postoperative
   b. Gastrointestinal
   c. Traumatic
7. Patients with impending or high probability of acute blood loss, e.g. leaking abdominal aortic aneurysms.

F. **GASTROINTESTINAL INSTABILITY:**

1. Documented or suspected intestinal vascular accident
2. Hepatic insufficiency with severe CNS depression
3. Gastrointestinal volume loss requiring continuous or frequent evaluation of hemodynamic parameters.
4. Pancreatitis, severe.

G. **RENAL, METABOLIC OR ELECTROLYTE INSTABILITY:**

1. Severe disturbance of fluid or serum electrolytes requiring rapid adjustment or dialysis.
2. Chemical intoxications requiring dialysis or filtration.
3. Acute anuria (oliguria) requiring dialysis or filtration.
4. Diabetic Ketoacidosis, hyperosmolar coma, refractory hypoglycemia.
5. Thyroid storm, myxedema coma.

H. **MISCELLANEOUS-CONDITIONS REQUIRING THE USE OF:**

1. Thrombolytic agents such as Streptokinase, tPA, Urokinase.
2. Continuous intrathecal drug administration.
3. Medications known to have the potential for immediate life threatening side effects or unpredictable severe side effects.

ARTICLE IV. **PATIENT STABILIZATION**

Patients admitted to the CCC must be stabilized in the Emergency Department prior to transfer to the unit by ACLS trained personnel with an IV placed and with a monitor/defibrillator and emergency drugs.

ARTICLE V. **DISCHARGE CRITERIA**

Discharge criteria for the Critical Care Center are based on the identification of patient risk and the requirements for less frequent observations or measurements. The Co-Directors of the Critical Care Center have the authority to discharge patients from the Critical Care Center in the event of a lack of bed availability and based on triage principles in the best intereset of patient care and when that level of care is no longer necessary. All Arterial Lines and Swan Ganz catheters will be discontinued prior to the patient's discharge to a lower level of care. Patients will be deemed capable of discharge from the Critical Care Center upon the achievement of stability of the clinical indicators prompting admission for a period of 8-24 hours for most conditions and 24-48 hours for neurologic / neurosurgical conditions. Discharge from the Critical Care Center will be upon the written or verbal order of the attending physician. Priority for discharge will be updated each shift, coordinated by the charge nurse, attending nurses and physician staff.

A. **CORONARY PATIENT:**

1. Myocardial infarction is ruled out as evidenced by three sets of negative enzymes.
2. Acute myocardial infarctions are stable as evidenced by no chest pain or chest pain that is controlled with oral, sublingual or topical medications for twelve hours.
3. The coronary patient requires transfer to another facility to receive care not provided by San Pedro Peninsula Hospital (e.g. coronary artery by-pass grafting, angioplasty).
4. The patient with electrical instability may be transferred to telemetry when that instability is controlled, e.g. atrial fibrillation with ventricular response rate of less than 100 beats per minute for a period of 12 hours or no excess ventricular arrhythmia or ectopy for 24 hours, the patient with symptomatic bradycardia has a permanent pacemaker implanted with accompanying rate of 60 beats per minute for a period of 12 hours.
5. The patient with congestive heart failure demonstrates:
   a. Clear lung sounds
   b. Urinary output of at least 25 cc/hr.
   c. Hemodynamically stable for 12 hours

ARTICLE V. **DISCHARGE CRITERIA** cont'd

B. **NEUROLOGICAL PATIENT:**

1. Neurological status is stable and within normal expectations for the patient for a period of 24 hours.
2. Stabilization of respiratory function with rate between 12 and 20 and cardiac rate consistently above 60.
3. If swallowing / airway protective reflexes are in jeopardy and feeding is to be resumed, a dysphagia evaluation will be completed prior to discharge to a lower level of care.
4. Intracranial pressure monitoring and ventriculostomy tubes will be discontinued prior to discharge to a lower level of care.

C. **RESPIRATORY PATIENT:**

1. Respiratory sufficiency will be evidenced by:
   a. Pulse oximetry of 90 or more with or without oxygen supplement.
   b. The ventilator assisted patient must have DNR orders, unless the patient is chronically ventilator dependent.
   c. The ability to maintain a clear airway.
   d. The patient maintains a patent airway without stridor or spasm.
   e. Resolution of massive hemoptysis (600 cc/24 hours).

D. **HEMODYNAMICALLY COMPROMISED PATIENT:**

1. Hypovolemic Shock
   a. Blood pressure over 90 systolic for previous 12 hours.
   b. Hemoglobin over 8 grams/dil. with exception for chronic anemias.
   c. Absence of any signs or symptoms of active bleeding.
   d. Pulmonary artery pressure monitoring will be discontinued prior to transfer to a lower level of care.
2. Chemically Induced Shock
   a. Patients must be alert and oriented.
   b. Hemodynamically and neurologic signs must be stable and within normal parameters for the previous 6 hours.
   c. All overdoses must receive clearance regarding suicidal risk by a psychiatrist, or two physicians and the attending Critical Care Center nurse, or an LPS certified nurse.

ARTICLE V. **DISCHARGE CRITERIA** cont'd

D. **HEMODYNAMICALLY COMPROMISED PATIENT:** cont'd

3. Septic Shock
   a. Blood pressure above 90 systolic.
   b. Urinary output of at least 25 cc/hour.
4. Hypertensive Crisis
   a. Blood pressure below 180 systolic and 100 diastolic and stable within parameters for the past 12 hours.
   b. Urinary output of at least 25 cc/hour.
   c. Neurologic status stable.

E. **THE RENAL PATIENT**

1. Electrolytes stable with Potassium below 5.0.
2. Cardiac rhythm without life threatening arrhythmias for previous 12 hours.

F. **ENDOCRINE PATIENT**

1. Blood glucose controlled and less than 300.
2. Patient will be alert.
3. Patient will have resumed oral intake.

G. **PSYCHIATRIC PATIENT**

1. A consult by a psychiatrist for patients who have taken purposeful overdoses or committed self-harmful acts.

ARTICLE VI. **PHYSICIAN'S RESPONSIBILITIES**

A. The Medical Director(s) will review the patients daily for the appropriateness of admission and for potential transfer.

B. Written orders and direct patient examination and evaluation must be performed by an appropriate physician within four (4) hours of admission of the patient to the CCC unless for myocardial infarction (MI) in which case the above must be done in two (2) hours (excludes neurosurgery). The nursing staff will notify the attending physician or his/her designated covering physician when the patient arrives in the unit and if the attending, or his designated covering or consulting physician does not respond within the established time frame, the charge nurse in the CCC will notify the Medical Director of the CCC. If the patient has been examined in the office just prior to admission, the above assessment is not necessary.

ARTICLE VI. **PHYSICIAN'S RESPONSIBILITIES** cont'd

Physician orders must be given to the respiratory therapist for ventilator management as soon as the patient enters the CCC. It is further requested that the respiratory therapist document verbal orders given by the physician on the physician's order sheet.

C. Initial orders and/or progress notes should include all specific diagnoses.

D. Contacting a physician for consultation will be done by a physician.

E. Physicians shall see patients and enter appropriate progress notes at least daily or more often as indicated by the condition of the patient.

F. A physician must be present at the initiation of IV thrombolytic therapy in the patient with a diagnosis of acute MI. A cardiologist must be contacted and enroute.

G. A cardiology consult is required for a complicated MI (i.e. recurrent chest pain or continuous chest pain, complex arrhythmias or pump failure) if the patient is admitted by a non-cardiologist; this consultation must take place within one hour of complication.

I. If one or more physicians are involved in the care of a patient, there shall be a physician designated to coordinate the care. This responsibility shall fall to the admitting physician unless otherwise documented in the physician's orders.

J. Any physician member (MD or DO) can manage a ventilator for the initial 24 hours within the context of the judgment of the CCC nurse and/or respiratory therapist. After the initial 24 hours, it is expected that a physician member (MD or DO) with specialty training in pulmonary diseases, critical care medicine or anesthesia will take over management of a ventilator.

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