System	Needs ICU	9W Stepdown	Consider downgrading to floors
Monitoring or patient care	● Q1 hr vital signs ● Q1 hr monitoring ● Critical care medications	● Q2 hr vital signs ● Q2 hr nursing interventions ● Q2 hr nursing assessments ● Q4 hr labs ● New initiation of NIV ● Won't benefit from ICU level of care	● Q4h vital signs, nursing interventions or nursing assessments ● Q6h labs
ID	● Septic shock	● Sepsis including fluid-responsive hypotension, organ failure	● Sepsis responsive to fluids and with stable/improved end-organ dysfunction in last 48 hrs
Cardiac	● Hemodynamic instability requiring vasopressors or hypertensive emergency requiring continuous intravenous medications	● Tachyarrhythmia with sustained heart rate >130 bpm ● Recently weaned off vasopressors (>6h)	● Stable tachycardia to HR <130 bpm
Pulmonary	● high risk for intubation ● Intubated ● *Massive* PE and/or s/p catheter directed or systemic thrombolysis ● non-invasive positive pressure ventilation: BIPAP, CPAP, HFNC with *altered mentation* ● Increasing NIV requirements ● Recent extubation with high-risk features requiring frequent monitoring or pulmonary physiotherapy	● non-invasive positive pressure ventilation: continuous BIPAP, CPAP, HFNC, RR<35 ● *Sub-massive* pulmonary embolism (SBP>90, no vasopressor/inotropic support) with right heart strain on echocardiogram or elevated troponins/BNP	● Stable O2 requirement via nasal cannula ● NIPPV at night for stable chronic conditions (COPD, OHS) ● Submassive PE with stable hemodynamics and O2 requirement
Neurology	● severe alcohol withdrawal ● new onset stroke ● opioid overdose with respiratory failure or requiring naloxone drip	● *Moderate* alcohol withdrawal ● chronic neuromuscular disorders: protecting airway, no impending respiratory failure	● Mild alcohol withdrawal
GI	● Hemodynamically unstable GI bleed	● GI bleed requiring q4h labs	● Stable GI bleed without associated hypotension requiring labs q8h or less
Endocrine	● Diabetic ketoacidosis or hyperosmolar state requiring insulin drip	● Hypo- or hypernatremia requiring q4 laboratory monitoring	
Renal	● CVVH or aquapheresis ● Hyponatremia requiring hypertonic saline (2% if lab draws more frequent than q4h or 3%) ● ** Hyponatremia with Na < 120 should be *discussed* with ICU for admission evaluation	● Hyponatremia with Na <125 ● Hyponatremia requiring hypertonic saline (2%) if lab draws q4h or less frequent	● Hyponatremia >125, off hypertonic saline, requiring labs q6h or less

Medical Stepdown Permitted Infusions

MEDICATION	DOSE
Amiodarone (Cordarone)	Initial bolus (stable tachyarrhythmia): 150 mg in D5W 100 ml IVPB over 10 min Maintenance dose: 1 mg/min x 6 hrs, then 0.5 mg/min x 18 hrs
Argatroban	Normal hepatic function: Start at 2 mcg/kg/minute Hepatic impairment/critically ill: Start at 0.2-0.5 mcg/kg/minute
Sodium bicarbonate gtt	6.25-50 mEq/hr
Digoxin iv	500 to 1000 mcg generally given over 2-4 doses every 4 – 6 hours as load
Hydromorphone (Dilaudid)	***For analgesia or for trach/vented patients*** Initial bolus: 0.2 – 0.4 mg over 2 min; Maintenance dose: start 0.2 mg/hour, MD will determine dose of medication
Morphine	***For analgesia or for trach/vented patients*** Bolus dose: 0.5-1mg IV push over 2 min; Maintenance dose: start at 1 mg/hr MD will determine dose of medication
Octreotide (Sandostatin)	25-50 mcg/hr
Pantoprazole	Loading dose: 80 mg IV Maintenance dose: 8 mg/hr x72 hours

Note: non-titrated vasopressors are permitted for patients who will not benefit from ICU. Midazolam drip is permitted for patients who will not benefit from the ICU.

Note: intubated patients are permitted for patients who will not benefit from ICU