THE MOUNT SINAI HOSPITAL

Emergency Department Guidelines

PEDIATRIC EMERGENT ESCALATION PATHWAY

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PURPOSE:

To describe the emergent care planning, intervention algorithms, and care escalation specific for use by the Division of Pediatric Emergency Medicine and the Division of Pediatric Critical Care.

GUIDELINE:

Clinician judgment should supplement and supersede any clinical guidelines or decision protocol. Departure from these guidelines may be appropriate and necessary in certain clinical situations. The use of the guideline allows for an appropriate and uniform treatment in a population that has the potential to become critically ill. This guideline was developed with the joint input of the Departments of Emergency Medicine and Pediatrics.

I: PEDIATRIC EMERGENCY MEDICINE (PEM) TO PEDIATRIC INTENSIVE CARE UNIT (PICU) HANDOFF

1. A verbal hand-off & interdisciplinary huddle will be completed by the PEM fellow/attending to the PICU fellow/attending for all prospective admissions.
    a. Intravenous access/plan for intravenous access and stability for intra-hospital transport will be included in this discussion.
2. A second communication will be sent by the admitting fellow/attending (text or phone call) stating that the patient is imminently leaving the ED for the PICU if more than one hour has passed since the initial huddle or if there have been any changes in the patient's condition or plan since that huddle.
3. If there is attending to attending disagreement after discussion regarding the level of care required, a PICU fellow or attending will evaluate the patient in the Emergency Department and complete a consultation note documenting their acceptance or rejection of the patient to the ICU. This evaluation will be completed within 30 minutes from when the disagreement in disposition occurred.
4. If there remains any question of further discussion is required for any reason, the following escalation pathways are in place:
    a. PICU
        i. PICU Medical Director
        ii. PICU Quality Director
        iii. PICU Division Chief
    b. PEM
        i. ED Physician Administrator On-Call
        ii. PEM Division Chief
        iii. ED Medical Director
        iv. ED Chairperson

II: IV ACCESS IN PATIENTS ADMITTED FROM PED TO PICU

1. It is preferred that all patients who require ICU level of care have IV or equivalent access prior to being transferred from the ED to the PICU
2. If a patient is being admitted without IV or equivalent access, a fellow/attending to fellow/attending huddle should confirm that either:
    a. The patient is stable, low acuity, well hydrated and tolerating PO/GT intake such that intravenous access is NOT warranted.
    b. IV access cannot be obtained despite multiple attempts or the family is refusing further attempts AND an alternate plan for access to be obtained is agreed upon and documented. *Please refer to the Pediatric Emergency IV Escalation Pathway.*

III: SEPSIS/SIRS TRIGGER IN THE PED AND THE MSH APPROVED SEPSIS TREATMENT PATHWAY IS INITIATED

1. For patients noted to have Severe Sepsis or Septic Shock, a Sepsis Huddle (phone or in-person) will occur between the PED attending/fellow & PICU attending/fellow.
    a. Plans for access, stability, treatment and disposition will be discussed
    b. This discussion should occur within 30 minutes of initiation of the MSH Stop Sepsis Pathway & will be documented in the patient chart.
2. For patients on the Stop Sepsis Pathway without intravenous access within 30 minutes of pathway initiation, a multidisciplinary huddle will take place (over the phone or in-person) with the PED attending/fellow, PED RN, and PICU attending/fellow regarding the plans for access (how this might be achieved most rapidly and safely), stability, treatment and disposition.

IV: PICU CONSULTS TO THE PED

1. If the PED attending requests a bedside consultation for any reason, the PICU fellow or attending will respond with a bedside consultation within 30 minutes.
2. If there is disagreement about the level of care (ICU vs. floor) required, a bedside consult will be conducted by the PICU as described above in I:3.
3. If there is a rapid escalation in respiratory, hemodynamic or metabolic instability, a bedside consult will be conducted by the PICU. This will occur within 30 minutes of consultation request.
4. All PICU to ED consults will be followed by a written consult note in the patient's chart.

V: PRE-INTRAHOSPITAL TRANSPORT FAILSAFE

1. The PICU RN will ask PED RN during hand-off about stability of access, stability of patient and assess safety of intra-hospital transport.
2. PICU RN will escalate to PICU fellow/attending and PICU Charge RN any concerns he/she has about the patient's safety on transport.
3. This safety-oriented escalation should trigger an immediate attending-to-attending discussion about the concern.
4. If a concern persists after discussion, the escalation pathways outlined in section I:4 should be used.