CKHA POLICY

Title:	Medical Directive: Interventions Delegated to the Critical Care Outreach Team (CCOT) (Chatham Campus)		**Document Number:** PTC-4-013
Approved by:	Medical Advisory Committee	Date Revised:	**September 9. 2017**
Policy Owner:	Professional Practice, Critical Care Program	Effective Date:	**May, 2006**

BACKGROUND

The CCOT team (nurse) functioning under these Medical Directives is enabled to initiate orders for diagnostic tests and implement urgent interventional therapies in a way that is timely and may be most effective for obtaining positive patient outcomes.

The CCOT is comprised of**:**

Registered Nurse (RN), certified in the Delegated Controlled Acts of application of energy, arrhythmia recognition and administration of life-saving medications (PTC-4-014 http://manuals.ckha.on.ca/d.aspx?f=n4dc9g8A7a9B)

Registered Respiratory Therapist (RRT) as required.

MEDICAL DIRECTIVE

To support the Critical Care Outreach Team (CCOT) responding to a request for assessment of **acute, unanticipated** changes in patient acuity, the CCOT may implement any of the following diagnostic and / or therapeutic interventions, as individual patient assessment may dictate.

1: Airway or Respiratory Compromise	• Administer oxygen (21-100%) via most appropriate route to attain and maintain SpO2 greater than 90%. • Insert a large bore peripheral intravenous. • Nasal or oral airway as indicated. • Suction nasally or orally as indicated. • Portable chest Xray. • 12 lead EKG as indicated. • Full lab (CBC, electrolytes, BUN, creatinine, random blood sugar), troponin • ABG's (RRT) or venous blood gas if indicated. • Salbutamol (4-8 puffs via MDI with or without aero chamber or 2.5-5 mg via nebulizer and may repeat x 1 as required. • Epinephrine per anaphylaxis protocol

2: Circulatory Compromise (hypotension with or without arrhythmia or tachycardia)	• Administer oxygen as required. • Patent peripheral IV access • 12 lead EKG/18 lead ECG • Portable chest Xray • Full labs, phosphorus, magnesium, ionized calcium, troponin, lactate, INR/PTT, type and cross if bleeding evident. • Fluid bolus of Normal Saline 500 ml • Blood Cultures x 2 (septic patients). • Urinalysis (if suspected). • Portable 2 view abdominal x-rays (in patients with abdominal distention, pain, tenderness, infection or respiratory distress).
3: Cardiovascular (ischemia or arrhythmias	• Administer oxygen and support airway as required • Patent peripheral IV access • 12 lead EKG (or 18 lead if indicated) • Full lab, phosphorus, magnesium, ionized calcium, troponin, INR/PTT • Portable chest x-ray • ASA 160 mg (chewed) unless contraindicated • If hypotensive with suspected RV involvement-give 250cc bolus NS x1 • Nitroglycerine 0.4 S/L, repeat Q5 minutes times 3
4: Altered Level of Consciousness	• Administer oxygen and support airway as required • Patent peripheral IV access • Stat glucometer • Administer 50 ml 50% Dextrose IV slowly (see Adult Hypoglycemic Protocol) • 12 lead ECG • Full labs, phosphorus, magnesium, ionized calcium, with ABG's/ venous blood gases, toxicology screen (serum and urine drug screen), ammonia, LFT, lactate, troponin. • If overdose of opiates is suspected, give Naloxone 0.2mg IV and repeat per PDAM guidelines or 0.4mg IM if no IV access. • For seizure: call MRP or Internist for direction.
5: Acute Stroke Symptoms: Last Seen Well (LSW) less than 4.5 hours	• Signs of acute stroke including dysarthria, focal signs (unilateral arm or leg weakness, facial droop): identify time Last Seen Well and if less than 4.5 hrs, notify Stroke Internist on call to obtain order for STAT CT Head. • Notify MRP of change in condition immediately • Call CT with CODE STROKE: requisition for non-contrast Head CT can be faxed with "verbal order: Dr……." • Notify ICU of potential transfer post CT

	• Ensure adequate IV access • Full lab, PTT/INR • Transport patient to Diagnostic Imaging • Transport patient to ICU for tPA administration and/or transport to London for Endovascular therapy. ICU to prepare patient and arrange for transport to LHSC if indicated.

PROCEDURE

- CCOT implementation can be initiated by any staff or family with coverage for 24 hours per day for 7 days per week.
- CCOT nurse will respond to all calls for in-patients in a timely manner (every effort will be made to respond within 5 minutes of initial call). If the CCOT nurse is already attending a patient who is too unstable to leave AND the second call is deemed urgent, the CCOT nurse will instruct the caller to notify the MRP immediately of concerns and request attendance at the patient's bedside.
- Women and Children's Program will continue with current process and call CCOT for support when required.
- MRP (most responsible physician) will be contacted by CCOT nurse or primary care nurse within 15 minutes and no longer than 30 minutes to inform him/her of CCOT consult, patient's change in condition, recommended plan of care, diagnostic tests to be reviewed and to request additional diagnostic tests and interventions.
- The MRP is responsible to review any and all diagnostics ordered under the medical directive or to make arrangements for urgent review by a physician colleague. For X-rays completed during off hours, Canadian Tele-radiology Services (CTS) can be contacted by MRP for assistance in reading films.
- CCOT will consult Stroke Internist on call for patients exhibiting signs of acute stroke.
- To support safe and timely care, consultation of Internist will be done using the SBAR tool and request of additional diagnostic tests and interventions.
- If transfer to a higher level of care(ICU or PCU) is recommended, MRP of patient must be notified so that physician to physician communication can be done to complete handover of care.
- The CCOT record will be initiated and completed by the CCOT nurse with the original remaining on the patient chart and a copy for CCOT stats reporting.
- CCOT nurse will respond to all code blues.

REFERENCES

Alspach, J., G., (2012) Recognizing the tipping points in vitals signs: beware the treacherous triads, *Critical Care Nurse 32(2)*, 10-11.

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Hillman, K., Chen, J., Cretikos, M. & Bellomo, R. (2005). Introduction of the medical emergency team (MET) system: A cluster-randomized controlled trial. *Lancet*, 365: 2091-2097.