**PICU Buffer Fellow Guidelines**

\*\*Please do not call Patient Placement unless you have patient transfer that needs to be expedited. In general, the charge nurse will facilitate discussions with Patient Placement.

1. PICU bed occupancy and bed flow
   1. Identify open and expected bed availability as follows:
      * Current open PICU beds
      * Expected PICU discharges (immediate vs. late)
      * Expected PICU transfers to acute care floor (immediate vs. late)
   2. Identify incoming admissions to ensure adequate bed spaces
   3. If PICU census >22, please discuss with PICU attending contingency plans
      * Identification of code bed in either PICU or CVICU
        1. If all beds are occupied, the identified code bed must be a bed swap with an acute care level patient in either unit awaiting bed placement or a patient capable of being transferred to NICU
        2. If all beds are occupied by ICU level patients, the bed cap is 43 between both units. One bed must remain open to accommodate unexpected emergency/admission as a Level 1 Trauma and Transplant center.
      * # of available beds in CVICU (open beds, scheduled ORs and anticipated movers) for PICU overflow
      * Identification of any PICU patient ready to transition to acute care and transfer out of PICU
      * Identification of any PICU patient < 3 months of age as a potential NICU transfer
      * Identification of any hospital patient able to transfer to PEC (PICU or general care)
      * Acute care level patients in the PICU may be staffed by an acute care level flex nurse (2:1) so that our ICU trained nurses may care for ICU level patients
   4. General escalation of bed occupancy issues as follows (discuss with PICU attending):
      * Charge nurse 🡪 Patient Placement 🡪 Nursing Supervisor 🡪 AOC (Administrator on Call) or Hospital MCP (Medical Control/Command Physician) depending on the request
2. External ICU referrals:
   1. All outside hospital requests for transfer and follow-up conversations should occur through the Transfer Center recorded line. If contacted directly, please request that the referring facility call our Transfer Center (650-723-7342). This allows our Transfer Center to triage the call, refer them to the appropriate service(s) and facilitate the transfer.
   2. All traumas less than 24hrs old must go through the ED trauma bay unless already admitted to an outside inpatient unit. Please do not accept medical command. Please defer to trauma surgeon on call.
   3. There three types of transfer requests. 1) ICU admission from EDs or for higher level of care, 2) out-of-state/region transfer for secondary evaluation or tertiary care (i.e. transplant) and 3) emergent transfer for acutely decompensating patients
   4. **ICU admission from EDs or for a higher level of care:**
      * From EDs, PICU/NICU/MICUs, and inpatient units at other hospitals
      * Acutely ill with progressive disease. Calls for transfers are usually because the outside institution has exhausted their resources and the patients require a higher level of care.
      * In general, accept everyone with consideration to PICU census outlined in 1c. Defer traumas to the trauma surgeon.
      * The following information should be obtained:
        1. Name, age, weight of patient
        2. Diagnoses, recent vitals & reason for admission
        3. Past medical history
        4. Current medications and allergies to medications
        5. Last meal (make all patients NPO unless unable to obtain IV access)
        6. IV access and important labs & imaging
        7. Establish airway stability
        8. Determine Glasgow Coma Score/mental status
      * Make recommendations to assist in the care of the patient and facilitate transfer. There needs to be balance between intervention and transportation to ensure expeditious but safe transfer. Necessary imaging that would alter the disposition of the patient (e.g. to OR) should be performed prior to transfer if it can be obtained safely and timely. Determine mode of transfer based on location and acuity. Please discuss with PICU attending.
      * Make sure important imaging and recent X-Ray’s are copied.
      * Determine mode transportation (ground, helicopter, fixed wing) and team components (RNTS ± RT, Stanford Life Flight ± RNTS vs. one-way transfer arranged by referring facility). RNTS/Life Flight will assess the patient and provide update upon arrival to referring facility. Check ETT position prior to leaving the referring hospital.
      * Notify charge nurse for bed assignment. Determine time of assigned bed availability. Notify PICU attending of transfer request.
   5. **Out-of-state/regional transfer for secondary evaluation or tertiary care:**
      * These calls usually come through Transfer Center or via a subspecialty service. They are usually for secondary opinions, families moving to the bay area, or for care that is not available elsewhere. They come from everywhere across the country. These patients usually reside in a PICU/NICU and are relatively stable.
      * Obtain report/intake on the patient. Establish clearly, the reason for transfer request and expectations for evaluation/management.
      * Determine if we can provide the care requested (i.e. discuss with subspecialty).
      * Determine the disposition of the child after care at Stanford is complete (i.e. will the patient be returning to the facility from where they came?)
      * These patients require pre-approval prior to transfer. The Transfer Center will facilitate this for you.
      * Notify the charge nurse and PICU attending. If the transfer is to occur at a later date, email the attendings/fellows on service/call so everyone knows this patient transfer is pending and the reason why it is pending.
      * Once all the above are established, accept the patient as appropriate and notify the referring hospital. At that time, they should prepare a transfer summary and start copying everything…CT/MRI imaging, etc.
      * These transfers are scheduled at a time determined based on bed and transport availability. These should mostly be one-way transfers, i.e., transported by the referring hospital.
   6. **Emergent transfers**
      * These are requests for transfer where the patient is in refractory multi-organ failure, experiencing an airway emergency or post-cardiopulmonary arrest.
      * Patients in asystole are not good candidates for transfer.
      * Patients without a stable/definitive airway are not good candidates for transfer. If a patient has a significant possibility of airway compromise or has significant ventilation/oxygenation difficulties, he/she should have a definitive airway placed prior to transfer. Discuss with PICU attending.
      * Determine the safest, quickest mode of transportation. Make sure transport team is arranging a respiratory therapist for the trip.
      * Get a detailed report. Discuss ventilation/oxygenation, circulation, and neurologic issues. Note what interventions have been attempted. Discuss with PICU attending to make a plan for a safe transport home.
      * Things to consider bringing along with you:
        1. Resuscitation medications
           1. Epinephrine
           2. Atropine
           3. Calcium gluconate/chloride
           4. Tham & Sodium bicarbonate
        2. Vasopressor infusions
           1. Dopamine
           2. Epinephrine
           3. Norepinephrine
           4. Vasopressin
           5. Prostaglandin E2 (if left-sided lesions suspected)
        3. Volume expanders
           1. Normal Saline
           2. Albumin
        4. Blood products — this will have to be provided by the outside institution on our request. You should try to optimize your indices prior to transporting the patient
        5. Activated Factor 7 — life-threatening bleeding
        6. Intubation medications
        7. Anesthetic/analgesic (choose judiciously)
        8. Neuromuscular blockade
        9. Antiepileptic medications, 3% saline, mannitol
        10. Respiratory equipment
        11. Cuffed ETTs (include smaller sizes)
        12. Self-inflating bag and appropriate size anesthesia bag
        13. Nitric oxide
        14. Multiple portable suction machines
        15. Lines and tubes
            1. Central line kit
            2. Thoracostomy pigtail vs. chest tube tray
            3. Pericardiocentesis kit

* Call home after you arrive at the outside hospital and assess the patient. Have someone order everything you may need when you arrive back in the PICU so it is ready when you get there.
* Check the CXR and lines/tubes before you leave the referring facility. Make sure the XR is recent. Check an iStat before you leave. Balance bedside intervention vs. expeditious and safe travel home. The window for safe transfer home is usually short.
* Fasten your seatbelt. Safety first.
* Remind yourself that this is why you chose critical care!!