

Specialty Care Unit Guidelines

Below is to be used as a guideline, however, nursing and medical judgement need to be considered.

Appropriate for patients with the following conditions/ treatments /status, and need for nurse monitoring:

Vitals Frequency: Q2H or Less frequently (Q2H-Q4H) (*Q1H Consider ICU)

Neuro Checks: Q2H or Less frequently (Q2H-Q4H) (*Q1H Consider ICU)

Other nursing interventions: Q2H or less frequently (*Q1H Consider ICU)

RN: Patient Ratio: 1:3 (Depending on accuity and number of flagged patients)

Nursing Assessments: Full system assessments every shift then subsequent focused reassessments Q4H

***Patients requiring vital signs/other interventions more frequently than every 2 hours for greater than one shift will need to be considered for the ICU**

Admission Criteria

SCU Denial Criteria *Consider ICU Consult

Patients with **Acute Hypoxic Respiratory Failure** with O2 supplementation <10L per minute (estimated FiO2 ~40%)

Patients with **Acute Hypoxic Respiratory Failure:** receiving O2 support via
 -Venti mask or FiO2 >60% **OR**
 -100% non-rebreather mask **OR**
 ->10L per minute continuous O2

Patients with **Chronic** hypercarbic respiratory failure requiring BiPAP/CPAP at hour of sleep.
 -**Blood gas:** pH >7.3 and pCO2 level near patient's baseline.

Patients requiring **NEW Continuous** BiPAP ventilatory support for Acute Hypoxic Respiratory Failure, acute hypoxic (e.g., CHF) **or** hypercarbic respiratory failure (e.g., COPD).
Per CCU Guidelines: Acute onset of CHF/Pulmonary edema may accept patient on BIPAP

Patients with **Acute Hypoxic Respiratory Failure** whose care goals **do not** include invasive mechanical ventilation or continuous BiPAP support.
 (ex: CMO)

Need for invasive continuous mechanical ventilation

Patients with tracheostomy requiring respiratory care **less frequently or equal to every 2 hours**

Need for respiratory therapy treatments, pulmonary toilet, tracheostomy care **more frequently than every 2 hours (Q1H)**

Airway monitoring for airway edema requiring suctioning or other airway care every 2 -4 hours

Concern for acute airway compromise (i.e., patients with severe angioedema or epistaxis) Or who require suctioning **more frequently than every 2 hours**

All patients with venous thromboembolic disease (DVT or PE) who receive thrombolytic agents, first 24 hours
 Ex: Alteplase/TPA

Respiratory

	Admission Criteria	SCU Denial Criteria
SIRS, Severe Sepsis & Septic Shock	Two of four SIRS criteria AND hemodynamically stable AND lactate < 4.0 SBP greater than or equal to ≥90 SIRS criteria = WBC count > 12,000 or < 4,000 or 10% bands; HR >90, RR >20, T>100.4F or <96.8F	Two of four SIRS criteria, suspected infection, and systolic blood pressure <90 mm Hg , and serum lactate ≥ 4.0 without clear etiology despite 30 cc/kg initial resuscitation
Endocrine	DKA (diabetic ketoacidosis) requiring continuous insulin infusion with pH ≥ 7.1 , expected to improve within 8-12 hours	DKA or hyperglycemia requiring continuous infusion of insulin and pH <7.1 or concomitant renal failure, sepsis, myocardial infarction, severe electrolyte
	Severe hyperglycemia (serum glucose 600-900) requiring continuous insulin infusion, expected to improve within 8-12 hours	Hyperglycemia >900 mg/DL
Acute Hypertension	Patients with acute hypertension without evidence of end-organ damage (intracranial hemorrhage, renal failure, myocardial infarct)	Acute hypertension requiring continuous infusion of antihypertensive agent or with evidence of end-organ damage
Neurological	Patients requiring neurological checks ≥Q2 hours	Acute change in mental status or Comatose patient with Glasgow coma scale ≤ 10 OR Patients requiring neuro checks more frequently than Q2H hours
	Chronic spinal cord injured patients (quadriplegic patients) without evidence of critical illness	
		Acute Status epilepticus
		Patients receiving thrombolytic agent, or have been treated with thrombolytic agents within first 24 hours for acute ischemic stroke Need for neuromuscular blocking agents (NMBA)
	Severely agitated patients (i.e., alcohol withdrawal) requiring escalating doses of sedatives or continuous infusion of sedative	

Electrolyte and pH abnormalities	Patients requiring frequent monitoring of non-life threatening electrolyte abnormalities	Metabolic Acidosis with pH <7.1 Serum sodium: < 115 or > 170 Serum potassium: < 2.0 or > 6.0 with EKG changes or abnormalities or potassium > 8 Serum phosphorus: < 1.0 Serum Calcium: Abnormality with ECG changes
	Admission Criteria	SCU Denial Criteria
Hypothermia Management	Mild Hypothermia: 32-35 degrees Celsius or 92-95 degrees Fahrenheit as a single system failure (no clinical instability)	Hypothermia – temperature <92° F or multi system compromise
	Use of Blanketrol for temperature control	Use of the Bair Hugger for temperature control
Cardiac/ Hemodynamic Instability		Continuous hemodynamic monitoring by invasive means * Need for frequent titration of vasoactive drugs * Cardiopulmonary arrest with intubation with or without Hypothermia (HACA) Patient management with intra-aortic balloon pump or Impella Ventricular Assist** Peripheral vascular disease requiring EKO Sonic® with thrombolytic therapy** Hypertensive emergency with active titration of IV medications Drug desensitization (i.e., aspirin, antibiotics), during initial medication therapy * CCU does have criteria for vasoactive drugs and use of a-lines, monitoring of CVPs: See CCU Guidelines * Tachy and Brady arrhythmias, BNP/Trop right sided heart failure may also be appropriate for CCU: See CCU Guidelines
		Hypotension – systolic blood pressure <90 mm Hg, unresponsive to immediate fluid resuscitation of 30 cc/kg Tachycardia – sustained heart rate > 150 bpm despite intervention Bradycardia – sustained heart rate < 30 bpm despite intervention Hyperthermia – temperature ≥107° F Hypothermia: <92° F or presence of clinical instability
Late Alcohol withdrawal		Severely agitated condition requiring mechanical restraint Withdrawal seizure and Severe withdrawal symptoms: HR >115, SBP > 170, RR > 25, Temp > 101

Act W		Severe alcohol withdrawal requiring administration of Phenobarbital, Propofol or continuous infusion of benzodiazepine agent.
GI Bleeding		Evidence of GI bleeding and Hemodynamic instability: SBP < 90 mm Hg; HR > 120 despite 30 cc/kg resuscitation.
		Acute ongoing active blood loss (hematemesis, melena, bright rectal blood) of moderate to severe volume
		GI bleed with strong clinical suspicion for esophageal variceal bleeding
		Elevated BNP AND troponin AND signs of right heart failure on CT PE, EKG or echocardiogram
	Admission Criteria	SCU Denial Criteria
Pulmonary Embolism		Hemodynamic Instability: SBP<90mmhg; HR >130
		Elevated BNP AND troponin AND signs of right heart failure on CT PE, EKG or echocardiogram
Toxic Ingestions		Drug overdoses from TCA, ASA, Tylenol, Ethylene Glycol, Methanol, antihypertensive or anti-arrhythmic overdoses leading to Neuro issues above or expected decompensation.
Discharge Criteria	<p>Patients will be deemed ready for discharge from SCU when no longer requiring frequent monitoring of vital signs, respiratory care or neuro checks.</p> <p>Decision to transfer a patient from SCU to medical floor will be reached by attending of record in collaboration with nursing staff.</p> <p>Physician to place transfer order into Lifechart and give sign-out to appropriate accepting physician if needed</p>	