NYC HEALTH+ HOSPITALS | Kings County

Emergency Department Clinical Guidelines

CCT Clearance Guidelines

Clinical Context and Purpose
To provide guidelines for the appropriate triage and/or clearance of patients presenting to the Emergency Department Critical Care and Trauma (CCT) area.

Background
The CCT is the dedicated area in the Emergency Department where high quality, evidence-based critical care services are provided in a patient-centered manner with the goals of optimizing patient safety and outcomes. In addition, the CCT is an environment that fosters collaborative, inter-disciplinary care of high acuity medical and surgical patients. Critical illness is defined as: o "Illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition." Patients presenting to the CCT should be assessed in a rapid and efficient manner to determine the most appropriate level of care based on the acuity of patient illness, availability of resources, and in an ethical and rational fashion. The following guidelines present an algorithm for the clearance process of patients who may be transferred to the Main Adult ED, the process by which this occurs, as well as outlines indications for CCT level of care. Documentation of the CCT clearance process should take place in the medical record. Patients remaining in the CCT for their care should have the appropriate level/frequency of cardiopulmonary monitoring and reassessments and their care should be guided by clinical policy and/or evidence-based guidelines where available.

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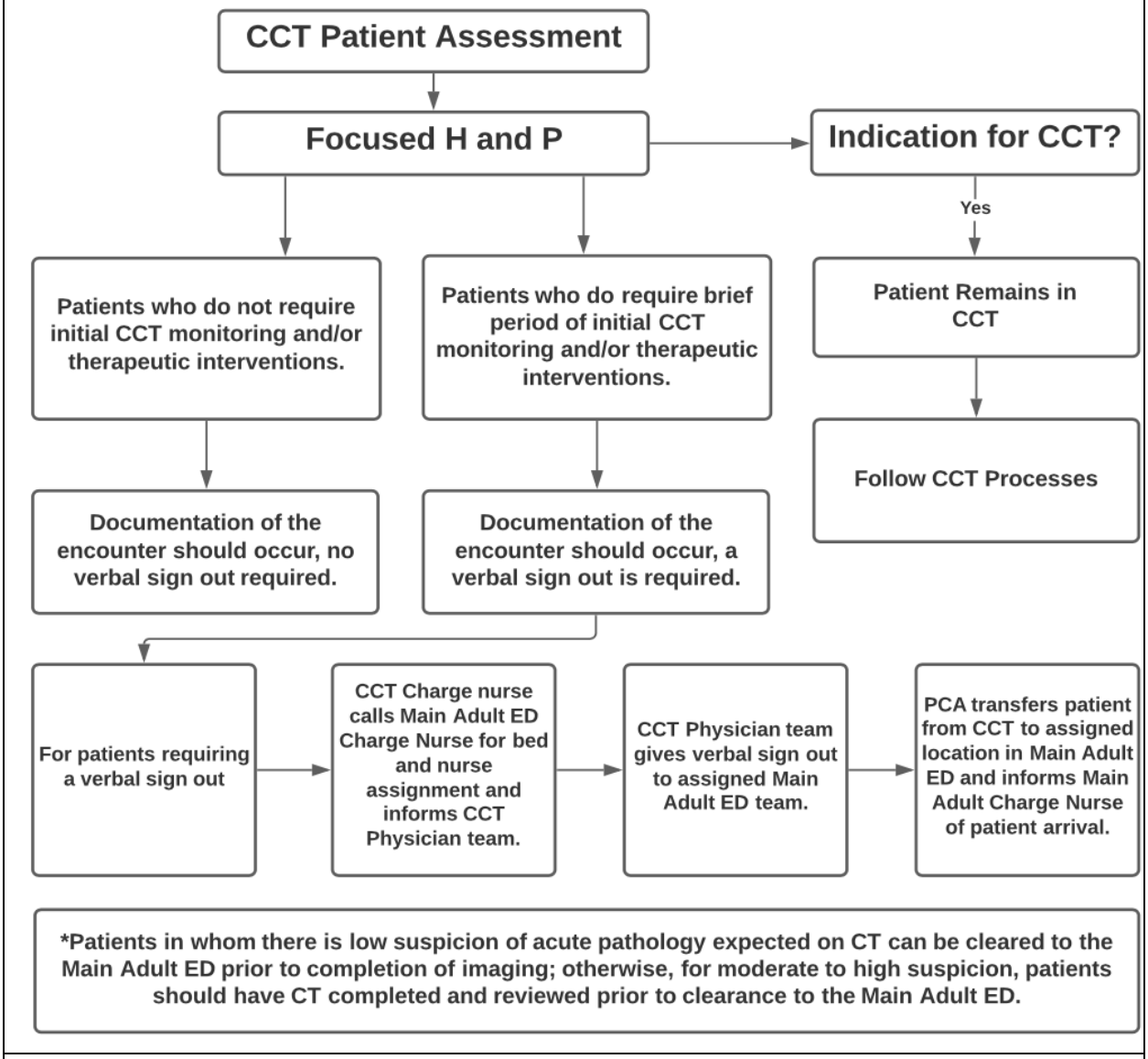

*Be sure to assign yourself as the patient's provider in CCT.

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Guidelines

There are many indications for CCT level of care; see the appropriate guidelines/policies (SharePoint) where available for each indication to achieve initial time-sensitive targets of treatment.

Indications for CCT level of care include but are not limited to the following:

General indications:

- Procedural Sedation (see Procedural Sedation Policy)
- Advanced cardiopulmonary monitoring e.g. Arterial Line, Waveform ETCO2, high frequency vital sign measurements, cardiac monitoring, frequent Neurological checks/reassessments (see Patient monitoring Guidelines)
- Extensive nursing care not available outside the CCT
- Severe trauma (see appropriate Trauma Team Activation Guidelines)

Physiologic-based indications:

- Unstable hemodynamics and vital signs – as defined based on individual case presentation that cannot be monitored or stabilized at a level of care outside the CCT as per clinical judgement of the CCT team.

System-based indications:

A. Neurological emergencies:

- Traumatic brain injury e.g. Subdural, Epidural, SAH, DAI, intraparenchymal bleed, etc. (see TBI guidelines)
- Acute subarachnoid hemorrhage (see SAH guidelines)
- Spontaneous intracranial hemorrhage (see sICH guidelines)
- Acute ischemic stroke requiring lytic, endovascular therapy, and/or advanced cardiopulmonary monitoring, frequent neurological checks/reassessments (see Acute Ischemic Stroke guidelines)
- Status epilepticus (see Status Epilepticus guidelines)
- Altered mental status potentially or actually affecting airway protection e.g. metabolic, toxic, etc
- Peripheral nervous/neuromuscular disorders potentially or actually affecting pulmonary function
- Severe agitation/delirium (see Agitation guidelines)
- High intensity palliative care per assessment/clinical judgment of the CCT team

B. Cardiovascular emergencies:

- Acute myocardial infarction requiring PCI, lytic therapy, and/or with complications including unstable dysrhythmias, hemodynamic instability, cardiogenic shock, etc (see ACS guidelines)
- Cardiogenic shock
- Shock states e.g. septic/other vasodilatory shock states, undifferentiated shock, etc
- Acute hypertensive flash pulmonary edema
- Complex dysrhythmias (brady- and tachy-dysrhythmias) requiring close cardiopulmonary monitoring and intervention
- Cardiac arrest and post cardiac arrest care including targeted temperature management (see TTM guidelines)
- Cardiac tamponade
- Aortic dissection
- Ruptured aortic aneurysm
- Hypertensive emergencies requiring anti-hypertensive infusions and closer cardiac monitoring

C. Pulmonary emergencies:

- Acute respiratory failure requiring airway management or non-invasive ventilatory support requiring close cardiopulmonary monitoring (see Respiratory Support guidelines)
- Pulmonary emboli with hemodynamic instability
- Massive hemoptysis
- Spontaneous/Traumatic pneumothorax
- Respiratory failure due to pleural disease requiring emergent drainage e.g. large pleural effusion
- Impending or suspected upper airway obstruction

D. Gastrointestinal emergencies:

- Life-threatening lower or upper gastrointestinal bleeding (see GI Bleed guidelines)
- Fulminant hepatic failure

E. Endocrine emergencies:

- Moderate to severe DKA/HHS (see DKA/HHS guidelines)
- Thyroid storm or myxedema coma with cardiopulmonary instability
- Adrenal insufficiency with hemodynamic instability

F. Renal emergencies:

- Severe, life-threatening electrolyte derangements requiring close cardiopulmonary monitoring and immediate treatment and/or renal replacement therapy

G. OBGYN emergencies (refer to Code 54 policy/guidelines):

- Eclampsia
- Pre-eclampsia with severe features
- Emergent delivery
- Peripartum cardiomyopathy requiring ventilatory support
- Severe and/or hemodynamically significant vaginal bleeding
- Uterine rupture, placental abruption, and/or placenta previa with potential or actual life-threatening bleeding
- Ruptured ectopic pregnancy with potential or actual hemodynamic instability

H. Environmental emergencies:

- Lightening, near drowning, hypo/hyperthermia

CCT Admission/Disposition Planning:

See the admission guidelines (SharePoint) for disposition from the CCT to the appropriate level of care and/or critical care unit.