

System	Needs ICU	9W Stepdown	Consider downgrading to floors
Monitoring or patient care	<ul style="list-style-type: none"> Q1 hr vital signs Q1 hr monitoring Critical care medications 	<ul style="list-style-type: none"> Q2 hr vital signs Q2 hr nursing interventions Q2 hr nursing assessments Q4 hr labs New initiation of NIV Won't benefit from ICU level of care 	<ul style="list-style-type: none"> Q4h vital signs, nursing interventions or nursing assessments Q6h labs
ID	<ul style="list-style-type: none"> Septic shock 	<ul style="list-style-type: none"> Sepsis including fluid-responsive hypotension, organ failure 	<ul style="list-style-type: none"> Sepsis responsive to fluids and with stable/improved end-organ dysfunction in last 48 hrs
Cardiac	<ul style="list-style-type: none"> Hemodynamic instability requiring vasopressors or hypertensive emergency requiring continuous intravenous medications 	<ul style="list-style-type: none"> Tachyarrhythmia with sustained heart rate >130 bpm Recently weaned off vasopressors (>6h) 	<ul style="list-style-type: none"> Stable tachycardia to HR <130 bpm
Pulmonary	<ul style="list-style-type: none"> high risk for intubation Intubated Massive PE and/or s/p catheter directed or systemic thrombolysis non-invasive positive pressure ventilation: BIPAP, CPAP, HFNC with <i>altered mentation</i> Increasing NIV requirements Recent extubation with high-risk features requiring frequent monitoring or pulmonary physiotherapy 	<ul style="list-style-type: none"> non-invasive positive pressure ventilation: continuous BIPAP, CPAP, HFNC, RR<35 Sub-massive pulmonary embolism (SBP>90, no vasopressor/inotropic support) with right heart strain on echocardiogram or elevated troponins/BNP 	<ul style="list-style-type: none"> Stable O2 requirement via nasal cannula NIPPV at night for stable chronic conditions (COPD, OHS) Submassive PE with stable hemodynamics and O2 requirement
Neurology	<ul style="list-style-type: none"> severe alcohol withdrawal new onset stroke opioid overdose with respiratory failure or requiring naloxone drip 	<ul style="list-style-type: none"> Moderate alcohol withdrawal chronic neuromuscular disorders: protecting airway, no impending respiratory failure 	<ul style="list-style-type: none"> Mild alcohol withdrawal
GI	<ul style="list-style-type: none"> Hemodynamically unstable GI bleed 	<ul style="list-style-type: none"> GI bleed requiring q4h labs 	<ul style="list-style-type: none"> Stable GI bleed without associated hypotension requiring labs q8h or less
Endocrine	<ul style="list-style-type: none"> Diabetic ketoacidosis or hyperosmolar state requiring insulin drip 	<ul style="list-style-type: none"> Hypo- or hypernatremia requiring q4 laboratory monitoring 	
Renal	<ul style="list-style-type: none"> CVVH or aquapheresis Hyponatremia requiring hypertonic saline (2% if lab draws more frequent than q4h or 3%) ** Hyponatremia with Na < 120 should be <i>discussed</i> with ICU for admission evaluation 	<ul style="list-style-type: none"> Hyponatremia with Na <125 Hyponatremia requiring hypertonic saline (2%) if lab draws q4h or less frequent 	<ul style="list-style-type: none"> Hyponatremia >125, off hypertonic saline, requiring labs q6h or less

MEDICATION	DOSE
Amiodarone (Cordarone)	Initial bolus (stable tachyarrhythmia): 150 mg in D5W 100 ml IVPB over 10 min Maintenance dose: 1 mg/min x 6 hrs, then 0.5 mg/min x 18 hrs
Argatroban	Normal hepatic function: Start at 2 mcg/kg/minute Hepatic impairment/critically ill: Start at 0.2-0.5 mcg/kg/minute
Sodium bicarbonate gtt	6.25-50 mEq/hr
Digoxin iv	500 to 1000 mcg generally given over 2-4 doses every 4 – 6 hours as load
Hydromorphone (Dilaudid)	<i>For analgesia or for trach/vented patients</i> Initial bolus: 0.2 – 0.4 mg over 2 min; Maintenance dose: start 0.2 mg/hour, MD will determine dose of medication
Morphine	<i>For analgesia or for trach/vented patients</i> Bolus dose: 0.5-1mg IV push over 2 min; Maintenance dose: start at 1 mg/hr MD will determine dose of medication
Octreotide (Sandostatin)	25-50 mcg/hr
Pantoprazole	Loading dose: 80 mg IV Maintenance dose: 8 mg/hr x72 hours

Note: non-titrated vasopressors are permitted for patients who will not benefit from ICU

Note: intubated patients are permitted for patients who will not benefit from ICU