

DEPARTMENT OF ANESTHESIOLOGY

VANDERBILT  UNIVERSITY
MEDICAL CENTER

Standard Operating Procedure Title: Operating Room Transport of ICU Patients

Policy Number: C 95

Date Established: 3/19/2010

Date Reviewed: 4/26/16

Date Revised:

Rationale: The transport of critically ill patients to and from the operating room is a potentially hazardous event. This policy was created to reduce these risks and improve patient safety for patients during transport in either direction.

A. Transport of Stable Patients:

1. For patients who are not unstable as defined below, the in-room provider (SRNA, CRNA, fellow, or resident physician) will review the patient's status with the attending anesthesiologist and determine the transport and management plan **PRIOR TO TRANSPORT** (ideally at the bedside) including:
 - a. Current vital signs and parameters of any invasive monitors (ICP, ABP, PAP, CVP, PCWP, etc.).
 - b. Ventilator settings (if applicable): Vent mode, VT and PIP (or VT if in PCV), FiO₂, PEEP
 - c. Most recent ABG
 - d. Rate of all infusions
 - e. Available vascular access
2. Prior to departing the ICU, the anesthesia team will ensure that:
 - a. 3 people are available to transport in ALL cases, as per hospital policy CL 30-03.05 (not all need to be anesthesia personnel)
 - b. Monitoring and resuscitative equipment is in working order
 - c. Oxygen tank is full
 - d. Transport IV poles function properly (if applicable).
 - e. The patient can maintain oxygen saturation for a minimum of 2 minutes on the ambu bag (if applicable).

B. Transport of Unstable Patients

Any patient who is unstable, regardless of whether intubated or not, should be transported from the ICU to the OR with an attending anesthesiologist present.

Instability may be heralded by the presence of one or more of the following:

1. Infusion rate of blood products, colloid, or crystalloid >500cc/hr

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2. Continuous infusion of vasopressors or inotropes (possible exception for physiologic dose vasopressin)
3. Use of pulmonary vasodilators
4. Significant metabolic acidosis
5. Persistent Hypotension (SBP<80) with or without tachycardia
6. PaO₂ / FiO₂ ratio <200
7. A potentially unstable airway (neck or facial injury/hematoma/abscess, high spinal cord injury, etc)
8. Signs of respiratory distress where there is clinical concern for impending respiratory failure
9. Consultative opinion from the attending intensivist that the patient is unstable

C. Handoff Communications for ICU Patients:

1. The transport of unstable ICU patients should be preceded by a conversation between the attending anesthesiologist and the attending surgeon and/or attending intensivist regarding the patient's issues and perioperative plan. Ideally, this should occur in the ICU prior to transport to the OR and after transport to the ICU. The OR anesthesia provider must receive and provide report from the ICU nurse as well.
2. For the transport of stable ICU patients who do not require the participation of the attending anesthesiologists, the attending to attending report may not be required.
3. Anesthesia providers who are relatively inexperienced in airway management outside of the OR shall have direct supervision and support by a CRNA or an anesthesiology senior resident, fellow, or attending during transport of stable (as well as unstable) patients.

D. Equipment and medications: Prior to transport, the in-room provider will assemble items for monitoring, airway management and hemodynamic support. In addition to a transport monitor and cables plus a bag-mask ventilation system, consideration should be given to the following (as needed):

1. Airway management and reintubation equipment (LMA, laryngoscope, bougie, endotracheal tube 1/2 size smaller than that currently in use, as required)
2. Any needed medications for management of level of consciousness, pain, movement, and hemodynamic status, plus flush syringes