**Anesthesiology Transport Policy on ICU patients for 3D (Endoscopy Area)**

**Per Dr. Lavu dated 8-20-15**

ICU patients (MICU, STICU) will require an anesthesia pre-evaluation and consent prior to transport to endoscopy

ICU patients (MICU, STICU) should be signed out from ICU RN directly to Senior Staff Anesthesiologist (or their designee) and to the endoscopy RN

The following subset of ICU patients who require anesthesiology services should be booked for the main OR:

1. Patients requiring invasive hemodynamic monitoring (i.e. arterial line, Pulmonary Capillary Wedge Pressure)

2. Patients needing vasoactive medications/drips to maintain hemodynamic stability

3. Patients currently intubated

4. Patients deemed unstable by senior staff anesthesiologist (or their designees)

NOTE: Per Senior Staff Anesthesiologist discretion exceptions to above policy may be made

**Additional Endoscopy Procedural Exclusion Criteria**

1. History of adverse reaction to anesthesia and/or endoscopy (i.e. requiring intubation, past Hx of cardiac arrest, etc.)

2. Patients requiring aggressive noninvasive respiratory support such as continuous BiPap or C-Pap (other than QHS)

3. Recent Hx (<48 hours) of unstable arrhythmias

4. Airborne isolation such as r/o Tb with either pending T-spot or sputum sample

5. Mutual (GI Staff, Anesthesia Staff, and Endoscopy support staff) concern with patient safety occurring at 3D Endoscopy

6. Weekend ICU patients who need endoscopic intervention and who do not meet the above criteria:

A. Please try to perform most if not all of the procedures in the ICU or O.R. setting. Technicians are available.

B. Exceptions are for Advanced cases such as EUS/ERCP. Those ICU patient’s need to be reviewed by the Staff Anesthesiologist (Hall Runner) for the day, GI staff of course, and the on-call 3D nursing staff before deciding where to perform the procedure = ICU vs O.R. . Please be respectful and mindful of what can and could go wrong.

***\*\* These guidelines are not for you and me, but rather for delivery of appropriate patient care. They are hard stops that are being placed in order to prevent near misses and accidents from occurring. The final decision rest with me, the Endoscopy Director, as we all try to maintain a safe and healthy environment for all. We all need everyone’s respect and professionalism, not filled with pride or hurt egos. We have the right to edit these guidelines as the need arises to maintain this unit as a patient safe area. \*\****

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