CT Patients in the PICU

*** If questions, problems, or concerns, please contact the CT Surg Fellow, Karla (PNP), Ruben (PA), or Dr. Mill. Do not wait till the last minute when things are really bad.

*** Find out where the Heart cart and Code cart are and familiarize yourself with the contents.

Admission:

1. Use preprinted order forms available in CPOE.
2. Use preprinted electrolyte forms that are online and based on weight. Assure that patient’s K+ is ~4, Mag = 2, ion Ca++ = 4.5, Phos ~ 4-4.5, gluoses at adequate levels.
3. Get report from Anesthesia along with your Attending, Fellow, and bedside nurse at one time.
4. Find out the level at which the Atrial and Ventricular pacing wires capture while in the OR and then set your desired levels with the PICU Fellow and/or Attending. Order these settings on CPOE. Any future pacer setting changes need to be ordered.
5. Nonpump cases do not need coags sent.
6. LA lines come out in 1-2 days postop. Concerns with removal are bleeding from the chest tubes, patient agitation leading to continued bleeding and tamponade. Karla orders blood to the bedside prior to removal and it stays in the room for 3-4 hours. Kids may need extra sedation during this time frame. Extubation will need to wait the 3-4 hours until after the LA is out.
7. AV pacing wires come out depending on the patient situation. Ideally they come out at the same time as the LA line.
8. Chest tube removal is dependent on x-ray, output, and patient condition. Chest x-ray is needed while they are in and Karla orders them after pleural tube removal. You still need to look at the x-rays yourself pre- and post removal. In the event of a large pneumothorax, the PICU team places pigtail catheters. Karla d/c’s the cefuroxime as well.
9. BT shunt patients need to be started on ASA 5mg/kg po qMWF the night they come back from the OR. This aids in preventing clot formation within the Gortex tube. BE SURE TO LISTEN FOR THE SHUNT MURMUR EVERYDAY. Keep BP at least 70 systolic as well.
10. Be hyper vigilant about checking patient in the first few hours postop—chest tube output, arrhythmias, frequent ABGs, and acidosis. Assure patient has a pH of at least 7.4---no matter what repair was done, the kids are not tolerant of low pHs. They also don’t like to be acidic preoperatively either.
11. Extracardiac Fontan patients need ASA started as well.
12. Cyanotic heart defect pts need a Hct close to 40
13. Acyanotic heart defect pts need a Hct between 30-35.
14. Please order Lasix 1mg/kg IV q6-8 hrs on smaller kids and 20mg IV BID (older kids) who have been on pump. They hold on to 10-15% of their body weight in fluid from being on pump. If unstable, start a Lasix gtt at 0.1mg/kg/hr and go up from there (max dose 0.4mg/kg/hr).
Transfer:

1. Assure that the Pediatric Cardiologist is called to confirm acceptance to CICU.
2. Please order Lasix 1mg/kg IV q6-8 hrs (depending on current x-ray and previous days of diuresis) on kids who have been on pump. They hold onto 10-15% of their body weight in fluid from being on pump.
3. Order PA and Lateral films for the morning after transfer---no portables.
4. Order CPT q4 hours, frequent ambulation, and incentive spirometry q2-4 hrs while awake (depending on pt age).
5. Goal nutrition for most of the kids is ~ 120-150 kcal/kg/day. Start with 20cal formula, advance the volume first and then the calories.