What is CCOT/PCCOT?

Team of clinicians who bring critical care expertise to the bedside or wherever it is needed

**GOAL**

Prevention of pre-arrest and arrest situations in adults and children who deteriorate outside of intensive care settings
Why Do We Have CCOT/PCCOT?

- Patients on wards are sicker
- Brings critical care expertise to areas outside of CCTC/ICU/PCCU
- Enhancement of the system – shared expertise provides the best care for the patient
- Improves patient safety
Team Members

3 Discipline Team
- Critical Care MD – teams are intensivist led
- Critical Care RN
- RRT

THERE IS ALWAYS A CCOT/PCCOT TEAM AVAILABLE
Five Core Functions

- Early identification of patients at risk
  - Consultation and care of patients at risk for deterioration
  - Stabilize patient for transfer to CCTC/ICU/PCCU

- Prophylactic intervention
  - Follow up visits for patients discharged from CCTC/ICU/PCCU for minimum 24 hours (CCOT) or 48 hours (PCCOT)
  - Provide interventions as required
Five Core Functions

- **Knowledge dissemination**
  - Unit specific inservices
  - Debriefing post CCOT/PCCOT call

- **Support and coordination**
  - Facilitating transfers and communication between critical care areas and wards, assist with EOL discussions to ensure appropriate transfers to critical care areas
  - CCOT responds to all pre-arrests/enhances current arrest team
  - PCCOT responds to all pre-arrests and arrests
Five Core Functions

- **Education**
  - Ensuring all staff know how and when to access CCOT/PCCOT
  - Providing education for all staff including medical personnel in the care of critically ill or deteriorating patients
  - Unit specific education as requested/required
CCOT Calling Criteria

CCOT Calling Criteria are separated into the same categories used by ACLS

- Airway
- Breathing
- Circulation
- Neurology
- Other
Call the Critical Care Outreach Team (CCOT) if there is Serious Concern about the patient or

**Acute change in:**

**Airway**
- Threatened
- Stridor
- Excessive secretions

**Breathing**
- Respiratory rate ≤ 8 or ≥ 30
- Distressed breathing
- Saturations < 90% on ≥ 50% O₂ or 6 litres/min

**Circulation**
- Systolic blood pressure ≤ 90mmHg or ≥ 200mmHg or decrease > 40 mmHg
- Heart rate ≤ 40 or ≥ 130

**Neurology**
- Decreased level of consciousness

**Other**
- Urine output < 100mL over 4hrs
- SERIOUS CONCERN ABOUT THE PATIENT
- NEED MEDICAL ASSISTANCE

CALL **33333** to activate the CCOT
To Activate CCOT Call

33333333
PCCOT Calling Criteria

- Airway
- Breathing
- Circulation
- Disability
- Arrests and Pre-arrests
PCCOT Activation Criteria

Healthcare Provider or Caregiver WORRIED about patient

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
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<tbody>
<tr>
<td><strong>Airway</strong></td>
<td>• Airway Threat (i.e. excessive secretions, dysphonia)</td>
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<td></td>
<td>• Stridor</td>
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<tr>
<td><strong>Breathing</strong></td>
<td>• Apnea</td>
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<td></td>
<td>• Hypoxemia (in any amount of oxygen)</td>
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<td></td>
<td>- SpO2 &lt;90%</td>
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<tr>
<td></td>
<td>- SpO2 &lt;60% for children with cyanotic heart disease</td>
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<tr>
<td></td>
<td>• Moderate to severe respiratory distress</td>
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<td></td>
<td>• Tachypnea (breaths/min)</td>
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<td></td>
<td>0-3 months &gt;60</td>
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<td>4-12 months &gt;50</td>
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<td>1-4 years &gt;40</td>
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<td></td>
<td>&gt;5 years &gt;30</td>
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<tr>
<td><strong>Circulation</strong></td>
<td>• Heart Rate (beats/min)</td>
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<tr>
<td></td>
<td>&lt;1 years &lt;100 or &gt;180</td>
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<tr>
<td></td>
<td>1-4 years &lt;90 or &gt;160</td>
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<tr>
<td></td>
<td>5-12 years &lt;80 or &gt;140</td>
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<td></td>
<td>&gt;12 years &lt;60 or &gt;130</td>
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<tr>
<td></td>
<td>• Hypotension (Systolic BP, mm Hg)</td>
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<td>&lt;3 months &lt;50</td>
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<tr>
<td></td>
<td>&lt;6 months &lt;60</td>
</tr>
<tr>
<td></td>
<td>&lt;1 years &lt;70</td>
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<tr>
<td></td>
<td>1-10 years &lt;70 + (age x 2)</td>
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<td></td>
<td>&gt;10 years &lt;90</td>
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<tr>
<td><strong>Disability</strong></td>
<td>• Change in neurological status</td>
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<tr>
<td></td>
<td>• Seizure</td>
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<td></td>
<td>• Acute drop in GCS &gt;2</td>
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Page 15555 to Activate PCCOT - Notify the Patient’s Primary Care Team
To Activate PCCOT Call

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Team Members

- **Bedside nurse**
  - You are the 1\textsuperscript{st} member of the team
  - Nurses **DO NOT** need permission to activate CCOT/PCCOT

- **CCOT/PCCOT**
  - Critical Care MD, Critical Care RN, RRT (Paediatric RRT assigned to PCCOT)

- **Attending Team**
Where?

- **CCOT**
  - All adult in-patients including admitted ED patients

- **PCCOT**
  - All areas that care for paediatric patients including admitted ED patients, outpatient clinics
  - Attend all arrest and pre-arrest calls (slightly different from CCOT)
Do I call Code Pink or PCCOT?

- If urgent resuscitation is required call Code Pink
- PCCOT does not replace the Code Pink team but will attend all Code Pink calls

If you are unsure, Call Code Pink… those who are not needed can leave
REMEMBER

- Staff DO NOT need an order to activate CCOT/PCCOT

- The staff member activating CCOT/PCCOT should attempt to notify the MRP (Most Responsible Physician) for that patient

- Inability to contact the MRP should not delay CCOT/PCCOT activation

- CCOT/PCCOT can be activated by anyone who is concerned about a patient
Contacts

- Any questions contact
  - Jasna Gole RN, Co-Lead CCOT, VH, pager # 14494
  - Jackie Walker RN, Co-Lead CCOT, UH, pager # 14055
  - Karen Laidlaw RN, Clinical Educator PCCU, Co-Lead PCCOT, VH, pager # 18781
  - Janet vanLuttikhuizen RN, Co-Lead PCCOT, VH, via email