

## **CCOT** Calling Criteria

CCOT Calling Criteria is separated into categories. Includes: BREATHING AIRWAY

CIRCULATION DECREASED LOC OTHER (Subjective concern for patient)

refer to badge card



### MRN responsibility

- Provide report to CCOT nurse-watch trends and know patient's normal values
- Have chart and CMARs available
- Code status
- Call MRP to notify that CCOT has been called
- Assist CCOT nurse with Meds/interventions/transfer to higher level of care
- If transfer occurs SBAR needed and MRN needs to handover care to ICU /PCU staff

# CCOT nurse's responsibility

- Follow medical directives
- Assist staff with patient concerns
- Relay information to MRP if MRN needs support to clarify patient concerns
- Informal rounds/provide education to staff
- Call IM for concerns if unable to reach MRP

# Additional Information

- CCOT nurse rounds on all patients that have transferred from ICU/PCU to acute inpatient units for 2 days post transfer (exception – transfers to inpatient psychiatry unit)
- MRN should expect the CCOT nurse to touch base with them for quick report to identify any concerns (by MRN or CCOT)

### **Additional Information**

- Use FAST for signs of stroke (code stroke)
- VITALS: -most *simple intervention* not done frequently

enough.

-Resp. rate *most* accurate predictor of serious illness.

-*At least* 8 hours prior to ICU transfers, abnormal Vitals signs were seen.

• THINK ABOUT- causes for altered LOC .... new or chronic

-CO2 retainer, Iow SPO2, hi ammonia with liver low blood sugar, Iow B/P, Iow/fast HR, narcotic/ sedative over use

• TRY FIRST- *calling RRT* first for resp concern.

-*Chest pain*- O2, nitrospray

-Hi temp with regular HR- treat fever

- causes of hi HR (100-130)- fever, anxiety, pain

dehydration.

• TRENDS and NORMAL VALUES - Examples

-Low B/P that's pt's norm or Dr.'s has been treating unchanged-Dr aware

-SOB after ambulating- try O2 and rest initially to

see if pt responds