Pediatric Critical Care Medicine Privileges
Department of Pediatrics

Name: _____
(Please print)

- ' Initial privileges (initial appointment)
- ' Renewal of privileges *(reappointment, on 2 year specialty cycles)*
- ' Modification of privileges *(request for any additional privileges beyond those previously granted)*

Basic Education: MD or DO

Minimal formal training: Successful completion of an ACGME or AOA accredited residency in pediatrics, followed by successful completion of an accredited fellowship in pediatric critical care medicine and/or current subspecialty certification or active participation in the examination process (with achievement of certification within 5 years of training completion) leading to subspecialty certification in pediatric critical care medicine by the ABP. Maintenance of Pediatric Advanced Life Support (PALS), ATLS as applicable.

Required current experience: At least 50 pediatric critical care patients, reflective of the scope of privileges requested, during the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

Facility (Check ALL that are applicable to your request)				
Baroness*	Children's**	North	East	Bledsoe/Sequatchie

** Includes BEH Main Hospital, Miller Eye Center, Plaza Surgery and all Erlanger Ambulatory Clinics*
***Includes Children's Hospital Inpatient, Children's Ambulatory clinics, Children's OR and Kennedy Children's Outpatient Center*

Core Pediatric Critical Care Medicine Privileges:

Core privileges for pediatric critical care medicine include the ability to admit, evaluate, diagnose, and provide treatment or consultative services and critical care management of life-threatening organ system failure from any cause in children from the 34 weeks gestation until early adulthood, as well as support of vital physiological functions. These privileges also include providing care to patients in the intensive care setting in conformance with unit policies. Core privileges further include the ability to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff regulations regarding emergency and consultative call services.

The core privileges in this subspecialty include the procedures on the following procedures list and such other procedures that are extensions of the same techniques and skills.

Performance of history and physical exam

Evaluation and management of life-threatening disorders or injuries in ICUs, including but not limited to shock, coma, elevated intracranial pressure, seizures, infections, acute and chronic renal failure, acute endocrine electrolyte emergencies (including diabetic ketoacidosis), non-kenotic hyperosmolar coma, thyrotoxicosis, syndrome of inappropriate antidiuretic hormone, diabetes insipidus, adrenal insufficiency, systemic sepsis, heart failure, trauma, acute and chronic respiratory failure, drug overdoses, massive bleeding, central nervous system dysfunction (including cerebral resuscitation), diabetic acidosis, and kidney failure, perform brain death exam.

Airway maintenance intubation, including fiberoptic bronchoscopy

Basic and advanced cardiopulmonary resuscitation

Calculation of oxygen content, intrapulmonary shunt, and alveolar arterial gradients

Cardiac output determinations by thermodilution and other techniques

Cardioversion

Establishment and maintenance of an open airway in non-intubated, unconscious, paralyzed patients

Evaluation of oliguria

Insertion and management of chest tubes

Insertion of central venous, arterial, and pulmonary artery balloon flotation catheters

Interpretation of antibiotic levels and sensitivities

Intracranial pressure monitoring

Maintenance of circulation with arterial puncture and blood sampling

Management of anaphylaxis and acute allergic reactions

Management of massive transfusions

Management of pneumothorax (needle insertion and drainage systems)

Management of renal and hepatic failure, poisoning, and complicated h ematological, infectious, and immune problems

Management of the immunosuppressed patient

Monitoring and assessment of metabolism and nutrition

Percutaneous needle aspiration

Percutaneous tracheostomy/cricothyrotomy tube placement (Seldinger technique)

Pericardiocentesis or tube placement

Peritoneal dialysis

Peritoneal lavage

Pharmacokinetics

Pressure-cycled, volume-cycled, time-cycled, and flow-cycled mechanical ventilation

Stabilization for transport

Thoracostomy tube placement

Use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry

Ventilator management, including experience with various modes

Special Non-Core Privileges in Pediatric Critical Care Medicine:

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges may include:

Procedure	***Baroness***	***Children's***	***North***	***East***	***Bledsoe/Sequatchie***
High frequency ventilation					
Management of patients on ECMO					
Management of patients on CRRT					
Administration of Moderate sedation and analgesia (see below for criteria) - 5 per year required.					
Deep Sedation (see criteria below) – 10 per year required.					

Request for Privilege Not Listed in Core or Special Non-Core *(please list the privilege and provide justification as well as any accompanying certifications or case logs)*

Special Procedures Privileges Criteria
Moderate Sedation
CRITERIA – To administer Moderate Sedation
Moderate Sedation (formerly Conscious sedation) is defined as: A medically controlled state of depressed consciousness that (1) allows protective reflexes to be maintained; (2) retains the patient's ability to maintain an airway independently and continuously; and (3) permits age-appropriate response by the patient to physical stimulation or verbal command, e.g. “open your eyes”).

1. Basic education: MD, DO, DDS, or DMD
2. Successful completion of a post-graduate residency training program of at least three years’ duration.
3. Trained in the professional standards and techniques to administer pharmacologic agents to predictably achieve either minimal or moderate sedation and monitor patients carefully in order to maintain them at either of these levels of sedation-either intentionally or unintentionally. Acceptable training may be the completion of a course offered by any local hospital or the local Medical Society. Documentation of completion is required.
4. Must be able to evaluate and document evaluation of the patient prior to performing minimal or moderate sedation.
5. Must be qualified to rescue patients from *deep* sedation and trained to manage a compromised airway and to provide adequate oxygenation and ventilation.
6. Current proof of ACLS, PALS, or ATLS
7. Able to demonstrate that he/she has administered minimal or moderate sedation or analgesia to at a minimum of five (5) patients during the past 12 months.

Deep Sedation
CRITERIA – To administer deep sedation
Deep Sedation is defined as: A medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. It may be accompanied by partial or complete loss of protective reflexes, and by the inability to maintain a patient airway independently and respond to physical stimulation or verbal command. Agents considered deep sedatives when used in <u>any dose</u> include, but are not limited to, Propofol, Etomidate, and Ketamine as well as sufficient doses of other analgesics such that the patient achieves the clinical state outlined in the deep sedation definition above. Use of these medications in life-threatening situations or for rapid sequence intubation (RSI) is considered an exception to this definition and is not considered use of deep sedation.)

1. Basic Education: MD, DO, DDS, or DMD and completion of residency/fellowship in at least one of the following:
    a. Anesthesiology, Emergency Medicine, Medical Critical Care, Surgical Critical Care, Pediatric Critical Care
2. Be a credentialed practitioner to order and/or select the medication(s) to achieve Deep Sedation.
    a. Must be credentialed to provide Moderate Sedation, Deep Sedation, and to perform intubation
3. Be familiar with proper dosages, administration, adverse reactions, and interventions for adverse reactions and overdoses. Know how to recognize airway obstruction and demonstrate skill in airway management resuscitation.
4. Have ACLS and/or PALS Certification.
5. Agents likely to produce deep sedation must be administered only by a qualified credentialed physician.
    a. This credentialed physician must be specifically and solely focused on the administration of the medication and monitoring of the patient's response to the medication.
        i. Exception 1: It is recognized that the Emergency Department and ICU is a unique environment where patients present on an unscheduled basis with problems that often require urgent or emergent interventions to prevent morbidity and mortality.
        ii. The supervising Emergency Medicine and ICU physician may be the same physician that is performing the procedure ONLY when a delay may increase morbidity and mortality, provided that the procedure may be abandoned without compromise to patient safety and there is not a second physician available to provide deep sedation.
        iii. If the patient has a secured airway (well positioned endotracheal or tracheostomy tube), deep sedation medications can be given for the purposes of performing a procedure by a CCRN (provided a second RN is present to record vital signs and record assessments). In this case a single credentialed physician may perform the procedure.
6. Pre-Procedure Assessment Responsibilities of the Physician
    a. Obtain baseline history. Assess the airway including mouth and neck and note ASA status. An airway assessment and ASA classification must be present prior to the administration of sedation. Obtain and document appropriate informed consent. Address NPO status.
    b. The patient will be reassessed by the physician performing the sedation immediately prior to the procedure, and the reassessment will be documented in the record.
7. Intra-Procedure Monitoring • Qualified personnel will be present in the room throughout the conduction of all cases requiring deep sedation.
    a. The minimum number of personnel available for all cases requiring deep sedation shall be two: (1) the operator (physician) and (2) the qualified personnel administering and monitoring sedation unless one of the exception rules is met as outlined above.
    b. Please see the full policy for details of required documentation for the sedation procedure
8. Post-Procedure Assessment Responsibilities of the Physician For Deep Sedation, the physician who administered the sedation and analgesia will perform and document a post-procedure evaluation no later than 48 hours following the deep

sedation procedure but no earlier than the time from which the patient is considered sufficiently recovered from the sedation so as to participate in the evaluation (e.g. answer questions appropriately, perform simple tasks).

a. The elements of an adequate post anesthesia evaluation should be clearly documented and include the following: Respiratory function including respiratory rate, airway patency, and oxygen saturation; Cardiovascular function including pulse rate and blood pressure; Mental status; Temperature; Pain; Nausea and vomiting; Post procedure hydration.

NOTE: Deep Sedation is limited to Anesthesia/CRNAs, Critical Care, and Emergency Medicine and full Anesthesia is limited to Anesthesiologists and CRNAs and is outlined in their delineation of privileges.

Department Chief Recommendation:

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant.

' Recommended as Requested

' Recommended with Modifications (See comments below)

' Not Recommended (See comments below)

Chief Comments: _____

_____ _____

Provider Signature Date

_____ _____

Chief Signature Date

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