



Current Status: *Active*

PolicyStat ID: 2354503



Origination Date: 7/27/2013
Last Approved: 7/6/2016
Last Revised: 7/6/2016
Next Review: 7/6/2017
Owner: Julie Mcallister: VP NURSING
Policy Area: Nursing
Reference: CARF
Applicability: Confluence Health
 Central Washington Hospital
 Wenatchee Valley Hospital

Admissions Policy

Replaces: CWH PFF-81 and WVH 1175

POLICY:

It is the policy of Confluence Health, to establish admission criteria for inpatient service, acute rehabilitation and skilled nursing facility (TCU).

1. Admissions shall be appropriate for the level of care that can be provided at Confluence Health.
2. Admissions, transfers and referrals will be carried out in a consistent and efficient manner.
3. No admission will be denied based on race, creed, age, sex, sexual preference, religious status, color, national origin, disability or financial status.

See Attached Guidelines for specific admission criteria.

- A. Inpatient Admission Guidelines
- B. Acute Rehabilitation Guidelines
- C. Skilled Nursing Facility (Long-Term Bed)(TCU) Guidelines

RELATED POLICIES:

Admission of Newborn, Late Preterm, and Very Low Birth Weight to Special Care Nursery

Admission to Hospice Program

Admission/Documentation of a Patient to the Emergency Department

Patient Admission Policy

REFERENCES:

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and other Corporate policies.

**Note: policy must be published on DOH Hospital website as updates occur.

Attachments:

-  [Guideline Inpatient Admission Criteria.doc](#)
-  [Guideline Acute Rehab Admission.doc](#)
-  [Guideline TCU Admission Criteria.doc](#)

Approval Signatures

Step Description	Approver	Date
	Patricia Wilhite: MEDICAL STAFF SPECIALIST	7/6/2016
	Peter Rutherford: CHIEF EXECUTIVE OFFICER	7/6/2016
	Tracey Kasnic: VP SR INPATIENT & CNO	7/5/2016
MEC	Katherine Lucas: MED STAFF SERVICES MGR	5/6/2016
CLC/HSIC	Julie Mcallister: VP NURSING	4/13/2016
	Julie Mcallister: VP NURSING	4/13/2016



TITLE:	Guideline: Skilled Nursing Facility (TCU) Admission Criteria		
Submitted By:	Thea Wertman	Director of TCU	03/02/16
Approved By:	Tracey Kasnic	SVP Inpatient, CNO	03/28/16
Implementation:	03/02/16		
Last Revised:	03/02/16		
Last Reviewed:	03/02/16		

Replaces TCU-2

Purpose: It is the purpose of this guideline to provide staff with admission criteria that is **applied** equally to ensure non-discriminatory admissions based on diagnostic related groups, including persons who are HIV positive, persons with AIDS and persons with other communicable, infectious diseases (where the unit has facilities suitable for the prevention of transmission of infections and communicable diseases). There is no discrimination or separation, direct or indirect, or any other distinction made in patients or prospective patients on the basis of color, race, national origin, disability, or funding source unless Central Washington Hospital is not an identified provider or the patient is not eligible for Central Washington Hospital's uncompensated care program.

Pre-Admission Screening: Pre-admission screening for patients who inquire about admission to TCU will be completed by the assessment coordinator. This may include an interview with the patient and/or family and/or review of the medical records relating to the admission. This will be done prior to admission to allow the care team to evaluate the patient's care needs.

Procedure:

1. General Admission Requirements:

- A. Care needs do not exceed the ability of the staff to provide a safe environment for all patients.
- B. The attending physician is a member of the medical staff at Central Washington Hospital.
- C. Physician provides appropriate orders and sufficient information to provide care (i.e., updated history and physical).
- D. Patients of Central Washington Hospital will receive priority in admitting.
- E. Patient/responsible party has agreed to admission and signed consent.

2. Admission Criteria:

- A. Patient must meet the pre-admission requirements of the payer such as three (3) day medically necessary hospital stay within 30 days of admission for Medicare patients.
- B. Patients must no longer require acute care which means:
 - a. Diagnosed
 - b. treatment plan initiated
 - c. medically predictable effective response
 - d. no longer requires daily physician visits
- C. Daily skilled services are required by Registered Nurse or 5-6 days of skilled therapy required weekly (i.e., PT, OT, ST).
- D. The expected length of stay is not less than 2 days and not longer than 100 days.
- E. The patient has the rehabilitation potential to improve function (based on measurable outcomes) and is likely to return home or to another less restrictive environment

3. Patients not appropriate for admission to the Transitional Care Unit:

- A. Acute respiratory TB.

- B.** Acute alcoholism.
- C.** Uncontrolled psychosis resulting in disruptive or combative behaviors and/or inability to participate in care.
- D.** Behavioral/criminal history that would make them a potential danger to other patients, staff or visitors.
- E.** Telemetry patients.
- F.** Pediatric patients (15 years or younger). Exceptions may be made on a case by case basis with approval of the TCU and Peds/OB Directors and the attending physician.
- G.** Patients who have been assessed to need long term care placement.
- H.** Patients who have only custodial and not skilled care needs.
- I.** Patients with orders for treatment with medical marijuana.

Reviewed By:

Julie McAllister VP of Nursing: 3/2016

Thea Wertman, Director of TCU: 3/2016

Connie Stevens, Director of Compliance: 3/2016



TITLE:	Guideline: WVH Acute Rehabilitation Admission Criteria		
Submitted By:	Debra Connelly, RN	Director of Acute Rehabilitation Services	03/02/16
Approved By:	Tracey Kasnic	SVP Inpatient, CNO	03/28/16
Implementation:	03/02/16		
Last Revised:	03/02/16		
Last Reviewed:	03/02/16		

Guideline for WVH regarding CH Admissions Policy

Purpose: It is the purpose of this guideline to provide staff with established admission criteria for Acute Rehabilitation Services.

Procedure:

1. **Purpose:** To provide intensive rehabilitation therapy in a resource intensive hospital environment for patients who, due to the complexity of their nursing, medical management and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary approach to the delivery of rehabilitation care.
 - A. IRF has 9 beds.
 - B. Direct admits will be accompanied by orders or the patient must be seen by the physician and orders entered within one (1) hour of admission. (See CWH Medical Staff Rules and Regulations)
 - C. Criteria for IRF to be considered reasonable and necessary: Required Preadmission Screening: Per CMS Final Rule 2010, a comprehensive preadmission screening process will identify appropriate candidates.
 - a. Preadmission screen will be conducted by a licensed or certified clinician, designated by a rehabilitation physician.
 - b. A rehabilitation physician will review and document his or her concurrence with the findings and results of the preadmission screen within 48 hours immediately preceding the IRF admission.
2. **Level of Service:** Appropriate admissions to the IRF include patients who require:
 - A. Routine nursing care for patients accommodated by an RN/Patient ratio of 1:4 – 5.
 - B. Nursing assessment every twelve (12) hours and as needed.
 - C. Vital signs every 12 hours routinely.
3. **Treatment provided** includes, but not limited to care of:
 - A. STROKE
 - B. SPINAL CORD INJURY
 - C. AMPUTATION
 - D. MAJOR MULTIPLE TRAUMA
 - E. HIP FRACTURE
 - F. BRAIN INJURY
 - G. NEUROLOGIC DISORDERS – (MS, Guillian Barre, Polyneuropathy, Parkinson’s)
 - H. ACTIVE POLYARTICULAR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, SERONEGATIVE ARTHROPATHIES*
 - I. SYSTEMIC VASCULIDITIES w/ JOINT INFLAMMATION*
 - J. SEVER or ADVANCED OSTEOARTHRITIS w/ 2 or more major weight bearing joints*

K. KNEE OR HIP JOINT REPLACEMENT*

- a. BMI 50 or above at admission
- b. Age 85 or older

L. COGENITAL DEFORMITY

4. **General Patient Guidelines:**

A. Admission Orders, History and Physical, Post-Admission Physician's Evaluation and Initial Plan of Care: Must be generated by a rehabilitation physician and documentation must demonstrate a reasonable expectation that the following criteria are met and necessary at the time of admission to the IRF.

- a. Need for multiple therapy disciplines: The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must be physical or occupational therapy.
- b. Intensive level of rehabilitation Services: the patient must be able to tolerate and benefit from at least three (3) hours of therapy per day, at least five (5) days per week, or an average of at least fifteen (15) hours per week, with documentation in the medical record as to reasons for such.
- c. Ability to benefit from therapy program: documentation will reflect significant functional improvements, in a reasonable period of time, sufficient to allow a patient to live in a community setting with assistance.

B. Physician Supervision; Frequent and direct close medical supervision by a rehabilitation physician. Documentation will demonstrate frequent and direct medically necessary physician involvement and supervision, and will reflect at least three – face to face visits per week throughout the patients IRF stay.

C. Individualized Overall Plan of Care: A rehabilitation physician will develop an individual overall plan of care for each IRF admission with input from the interdisciplinary team within 72 hours of the patient's admission to the IRF.

D. Interdisciplinary Team Meetings: Will occur at least once per week throughout each IRF stay, and will have physician documentation demonstrating concurrence with all decisions made by the interdisciplinary team at each meeting.

5. **Patients who may not be appropriate for Admission to IRF**

A. Patients not meeting in-patient acute rehabilitation criteria will be referred to the appropriate facility based on individual needs or to appropriate community resources.

B. There are four categories of ineligible candidates:

- a. Medically inappropriate- acute tracheostomy, ventilated, cardiac monitoring, combative behavior
- b. Physically cannot tolerate the demands of Acute Rehabilitation
- c. Patients under the age of eighteen (18) years of age.
- d. Patients weighing greater than 350 lbs.

Reviewed By:

Julie McAllister, RN, VP of Nursing: 3/2016

Debra Connelly, RN Director of Surgical and Acute Rehab Services: 3/2016

Connie Stevens, Director of Compliance: 3/2016

Jacob Egbert, DO Medical Director of Rehabilitation Inpatient: 3/2016



TITLE:	Guideline: Inpatient Admission Criteria		
Submitted By:	Julie McAllister	VP of Nursing	07/06/16
Approved By:	Tracey Kasnic	SVP Inpatient, CNO	07/06/16
Implementation:	03/02/16		
Last Revised:	07/06/16		
Last Reviewed:	07/06/16		

Replaces PFF 81 and 1175

Purpose: It is the purpose of this guideline to provide staff with established admission criteria for inpatient service.

1. Surgical/Orthopedic Unit Admission Guidelines
2. Medical and Oncology (MOU) Admission Guidelines
3. Medical Unit 1 (MU-1) Admission Guidelines
4. Progressive Care Unit (PC-3 and PC-1) Admission Guidelines
5. Intensive Care Unit (ICU) Admission Guidelines
6. WVH Medical/Surgical Unit (Med/Surg-W) Admission Guidelines

Procedure:

1. Surgical/Orthopedic Unit Admission Guidelines – 4th Floor

- A. **Purpose:** To provide quality care to the adult patient who has emergent or elective surgery that require routine pre and post-operative care and/or close observation and rapid intervention to maintain their physical, psychosocial, and spiritual well-being.
 - a. Surgical/Orthopedics has 42 beds. See below for a list of surgical procedures that could be placed on another unit if beds not available.
 - b. Direct admits must be stable and have been examined by a physician on date of admission and patient is accompanied by orders or orders must be received within one (1) hour of admission.
- B. **Level of Service:** Appropriate admissions to the Surgical / Orthopedic Unit include patients who require:
 - a. Routine nursing care for patients accommodated by an RN/Patient ratio of 1:4 – 5.
 - b. Nursing assessment every four (4) to eight (8) hours.
 - c. Vital signs every 4 – 8 hours.
 - d. Routine telemetry monitoring of stable rhythms not related to an acute cardiac event.
 - e. Intermediate level care patients as defined in the step down guidelines.
- C. **Patient Types to admit to Surgical/Orthopedics:**
 - a. Elective post-operative patients requiring an overnight stay.
 - b. Emergent surgical procedures requiring an overnight stay.
 - c. Pre-operative patients awaiting surgery
 - d. When ACU is closed emergent cases that do not require an overnight stay may be admitted.
 - e. Patients transferred from the ICU must be hemodynamically stable with stable respiratory status for at least six (6) hours.
 - f. Patients admitted from the ED should be hemodynamically stable with a stable respiratory status. Consider step down status for patients who were initially unstable in their ED course.

- g. Medical unit overflow in consultation with the charge nurse, HS / Clinical Manager and Hospitalist.
- D. Treatment Provided:**
- a. Vital signs monitoring and assessment every 4 – 8 hours.
 - b. Routine or step down level care of post-operative patients.
 - c. Routine telemetry monitoring of stable rhythms
 - d. Alcohol withdrawal treatment up to maximum dosing criteria provided adequate staffing is available.
 - e. Finger Stick Blood Glucose (FSBG) monitoring every one (1) hour for up to four (4) hours with subcutaneous insulin dosing.
 - f. Acute pain management
 - g. Stepdown level care based on stepdown criteria (See section I.6.A-F)
- E. Patients not appropriate for Surgical/Orthopedics:**
- a. Hemodynamically unstable patients except those already on the unit who develop hemodynamic instability responsive to non-pharmacologic interventions (such as IV fluid challenge).
 - b. Acute respiratory distress except those already on the unit who develop respiratory distress who do not require intubation and are responsive to intervention.
 - c. Intubated or ventilated patients.
 - d. Patients requiring telemetry for monitoring of acute cardiac events
 - e. Patients requiring cardiac or vasoactive drips (except diltiazem).
 - f. Patients requiring Narcan drips or insulin drips.
 - g. Post-op open heart patients.
 - h. Acute spinal cord injury during the acute post injury phase (potential for spinal cord shock)
 - i. Patients under the age of 16.
- F. Exception:** Stepdown Status: If it is anticipated a patient will require increased assessment and intervention for a 4 – 12 hour period of time and Surgical/Orthopedic Unit staff is competent to provide the care, the patient may stay on or be admitted to SOU. Staffing will be adjusted to accommodate according to level of care required. The charge nurse will determine staffing needs in conjunction with the patients nurse based on the information from the provider regarding patient condition. If appropriate staffing is not available or the patient continues to decline transfer to ICU will be considered.
- a. Step down Guidelines: Surgical Unit will implement stepdown staffing and monitoring following the criteria outlined below. The following patients will be considered for placement in stepdown status (Acuity 10):
 - i. OSA without CPAP
 - ii. CIWA (in active withdrawal)
 - iii. Patients with large blood loss or requiring large volume IVF or blood replacement
 - iv. Multiple pre-existing comorbid conditions (Hypertension; cardiac disease – including arrhythmias, valvular disease, hx of MI or heart surgery, angina; chronic respiratory compromise – COPD; DM)
 - v. SIRS (Systemic Inflammatory Response Syndrome – i.e. ‘pre-sepsis’)
 - vi. Extensive/lengthy abdominal/thoracic or back surgery
 - vii. Abnormal vital signs
 - viii. Multiple Narcan administrations
 - ix. Difficult pain management requiring epidural and PCA or multiple boluses
 - x. Patients in rapid SVT requiring active titration of a diltiazem drip
 - b. Monitoring and staffing will be based on patient condition and risk.
 - c. Each patient must be evaluated on a case-by-case basis. If prolonged monitoring or frequent interventions are required, the care requirements should be reassessed every 4 hours by the primary RN and the Charge Nurse to determine staffing levels and appropriateness of patient to remain on the unit.

- d. All patients in Stepdown status will be placed on continuous oximetry. If this is placed by nursing it may be discontinued when the patient is stable. If ordered by a physician it must remain in place until the physician discontinues.
- e. Patients that may be prioritized off SOU if beds not available:
 - i. Eye surgeries
 - ii. Extremity amputations
 - iii. Microdissectomies or single level laminectomies
 - iv. Appendectomy
 - v. Breast reduction or mastectomies
 - vi. Cysto/Lithotripsy (no irrigation),
 - vii. GYN procedures
 - viii. Cholecystectomy
 - ix. Hip or extremity fracture
 - x. Foot procedures
 - xi. Oncology patients who have procedures – may be placed in Oncology
 - xii. Unanticipated ACU patients who spend the night or 24 hour ACU patient

2. **Medical and Oncology Unit Admission Guidelines – 5th Floor**

- A. **Purpose:** To provide quality care to the adult patient who is acutely ill, including exacerbation of chronic illness, that requires close observation and rapid intervention to maintain their physical, psychosocial, and spiritual well-being. Patients less than 16 years of age will be admitted on a case by case basis.
 - a. Medical / Oncology unit has 42 beds. Twelve beds on the West end are designated as Oncology beds, but can accommodate Medical patients as census permits.
 - b. Direct admits will be accompanied by orders or the patient must be seen by the physician and orders entered within one (1) hour of admission. (See Medical Staff Rules and Regs)
- B. **Level of Service:** Appropriate admissions to the Medical / Oncology Unit include patients who require:
 - a. Routine nursing care for medical patients accommodated by an RN/Patient ratio of 1:4 – 5.
 - b. Routine nursing care for oncology patients accommodated by an RN/Patient ratio of 1:3 – 4.
 - c. Nursing assessment every four (4) to eight (8) hours.
 - d. Vital signs every 4 hours routinely.
 - e. Routine telemetry monitoring of stable rhythms not related to an acute cardiac event.
 - f. Intermediate level care patients as defined in the stepdown guidelines (section II.6.A-C)
- C. **Patient Types to admit to Medical or Oncology:**
 - a. General medical diagnosis excluding stroke
 - b. EOL patients – especially those requiring medicated drips for comfort
 - c. Chemotherapy – including acute inductions.
 - d. Patients requiring medical / symptom management of an Oncologic condition.
 - e. Surgical overflow patients as defined by Surgical triage out criteria.
 - f. Patients transferred from the ICU must be hemodynamically stable without pharmacologic hemodynamic intervention for at least six (6) hours.
 - g. Patients transferred from the ICU must have been extubated for at least four (4) hours and have a stable respiratory status
 - h. Patients admitted from the ED should be hemodynamically stable with a stable respiratory status. Consider stepdown status for patients who were initially unstable in the ED (See below)
- D. **Treatment Provided:**
 - a. Routine level care for general Medical and Oncology patients
 - b. Alcohol withdrawal treatment up to maximum dosing criteria
 - c. Finger Stick Blood Glucose (FSBG) monitoring every one (1) hour for up to four (4) hours with subcutaneous insulin dosing
 - d. Acute pain management

- e. Patients requiring diltiazem drip for management of medically related SVT
 - f. Intermediate level care based on stepdown criteria (See below)
 - E. **Patients not appropriate for Medical or Oncology:**
 - a. Acute Stroke or patients requiring assessment utilizing the NIH Stroke Scale.
 - b. Acute respiratory distress requiring intubation and unresponsive to intervention.
 - c. Intubated or ventilated patients.
 - d. Patients requiring telemetry for monitoring of acute cardiac events
 - e. Patients requiring cardiac or vasoactive drips (Except Diltiazem).
 - f. Patients requiring Narcan drips or insulin drips.
 - g. GI bleed patients with an **acute** drop in hemoglobin and hematocrit or active bleeding.
 - h. Patients with an Ion Potassium (K+) less than 2.2 mEq/L must be evaluated for cardiac risk.
 - i. Patients in four (4) point locked restraints and are being held solely for psychiatric diagnosis.
 - j. Patients under the age of 16.
 - F. **Stepdown Status:** If it is anticipated a patient will require increased assessment and intervention for a 4 – 12 hour period of time and Medical/Oncology Unit staff is competent to provide the care, the patient may stay on or be admitted to MOU. Staffing will be adjusted to accommodate according to level of care required. The charge nurse will determine staffing needs in conjunction with the patients nurse based on the information from the provider regarding patient condition. If appropriate staffing is not available or the patient continues to decline transfer to ICU will be considered.
 - a. Stepdown Guidelines: Patients to consider for placement in stepdown status (Acuity 10):
 - i. Unstable vital signs
 - ii. Every 1 to 2 hour volume monitoring and intervention
 - iii. Unstable respiratory status
 - iv. Level 2 CIWA scores
 - v. Analgesic/Benzo drips with titration – EOL
 - vi. Chemotherapy induction
 - vii. Diltizem drip titration
 - (a.) Examples: Patients with SIRS (pre-septic) with hypotension, who have large volume or blood loss, have difficulty controlling their pain with multiple boluses and/or analgesic drip titration, pre-existing co morbidities.
 - b. Monitoring and staffing will be based on patient condition and risk.
 - c. Each patient must be evaluated on a case-by-case basis. If prolonged monitoring or frequent interventions are required, the care requirements should be reassessed every 4 hours by the primary RN and the Charge Nurse to determine staffing levels and appropriateness of patient to remain on the unit.
3. **Medical Unit 1100 (MU-1) Admission Guidelines – 1st Floor**
- A. **Purpose:** To provide quality care to the adult medical patient who requires behavioral observation. These patients may include substance misuse, dementia, behavioral and mental health exacerbation requiring close observation and rapid intervention to maintain their physical, psychosocial, and spiritual well-being. Patients under 16 years of age will be admitted to Pediatric Unit.
 - a. MU-1 has 10 beds.
 - b. Direct admits will be accompanied by orders or the patient must be seen by the physician and orders entered within one (1) hour of admission. (See Medical Staff Rules and Regs)
 - B. **Level of Service:** Appropriate admissions to the MU-1 include patients who require:
 - a. Routine nursing care for medical patients accommodated by an RN/Patient ratio of 1:4 – 5.
 - b. Nursing assessment every four (4) to eight (8) hours.
 - c. Vital signs every 4 hours routinely.
 - d. Routine telemetry monitoring of stable rhythms not related to an acute cardiac event.
 - C. **Patient Types to admit to MU-1:**

- a. General medical patients requiring behavioral observation, excluding stroke
- b. Experiencing behavioral disturbances, psychosis or personality disorders
- c. Patients that would benefit from behavioral assessment or psychiatric consultation
- d. Patients requiring a daily Suicide Assessment Risk
- e. Involuntary hold patients requiring medical treatment for continuity of care
- f. Behavior disturbances secondary to an exacerbation of a mental health disorder
- g. Patients that have been admitted to the hospital as a result of suicidal behaviors who are waiting to be medically cleared
- h. Patients exhibiting sexually inappropriate behavior
- i. Patients requiring a Posey bed for safety
- j. At high risk for fall
- k. With delirium or dementia
- l. Pulling at lines, tubes, or devices
- m. Attempted suicide but not actively suicidal
- n. Patients with complex chemical dependency/substance misuse
- o. Patients transferred from the ICU must be hemodynamically stable without pharmacologic hemodynamic intervention for at least six (6) hours.
- p. Patients transferred from the ICU must have been extubated for at least four (4) hours and have a stable respiratory status
- q. Patients admitted from the ED should be hemodynamically stable with a stable respiratory status.

D. Treatment Provided:

- a. Routine level care for general Medical patients
- b. Psychiatric consultation in coordinator with the Hospitalist
- c. Close observation for behavioral or mentally impaired
- d. Alcohol withdrawal treatment up to maximum dosing criteria
- e. Finger Stick Blood Glucose (FSBG) monitoring every one (1) hour for up to four (4) hours with subcutaneous insulin dosing
- f. Acute pain management

E. Patients not appropriate for MU-1:

- a. Acute Stroke or patients requiring assessment utilizing the NIH Stroke Scale.
- b. Acute respiratory distress requiring BiPAP or intubation and unresponsive to intervention.
- c. Intubated or ventilated patients.
- d. Patients requiring telemetry for monitoring of acute cardiac event
- e. Patients requiring cardiac or vasoactive drips (Except Diltiazem).
- f. Patients requiring Narcan drips or insulin drips.
- g. GI bleed patients with an **acute** drop in hemoglobin and hematocrit or active bleeding.
- h. Patients with an Ion Potassium (K+) less than 2.2 mEq/L must be evaluated for cardiac risk.
- i. Patients under the age of 16.
- j. Comfort Care patients.

4. Progressive Care Unit (PC-3 and PC-1) Admission Criteria

A. Purpose: To provide quality care to adult and adolescent patients who are seriously ill and require close observation and rapid intervention to maintain their physical, psychosocial and spiritual well-being. Patients less than 16 years of age will be admitted to PCU on a case by case basis.

- a. PCU has 22 dedicated beds on the third floor, and 16 on PC-1. PCU can overflow into ICU if rooms are available. PCU can provide telemetry monitoring to all patients. During times of high census, triage of patients into and out of Progressive Care will be performed by the Charge RN in association with the attending physicians or the Chief of ICU Services as needed.
- b. Patients admitted to PCU by the ED physician must be seen and examined by the admitting MD within six (6) hours. (Medical Staff Rules and Regs)

- c. Direct admits must be stable and have just been seen by a physician in the office. Orders must accompany the patient or be entered within one (1) hour of admission.
- B. **Level of Service:** Appropriate admissions to the Progressive care Unit include patients who require:
 - a. Routine nursing care for patients accommodated by an RN/patient ratio of 1:3-4.
 - b. Nursing assessment every two (2) to four (4) hours.
 - c. Vital signs every four (4) hours routinely.
- C. **Patient Types to Admit to PCU:**
 - a. Patients transferred from ICU must be hemodynamically stable for at least four (4) hours without pharmacologic hemodynamic intervention prior to transfer. Patients from the ER who demonstrate hemodynamic instability in the ED must be hemodynamically stable for at least one (1) hour without pharmacologic hemodynamic intervention prior to transfer.
 - b. Hemodynamically stable dysrhythmia
 - c. Strong suspicion of non-ST Segment Elevated Myocardial Infarction (non STEMI) or unstable coronary syndrome by history, electrocardiogram, or laboratory testing for cardiac injury with resolution of chest pain and without hemodynamic instability or life threatening arrhythmias.
 - d. ST Segment Elevated Myocardial Infarction (STEMI) patients after 12 -24 hours of ICU monitoring and stability.
 - e. Patient's status post Percutaneous Transluminal Coronary Angioplasty (PTCA) without STEMI, hemodynamic instability or life threatening arrhythmias.
 - f. Heart failure without hemodynamic instability or high near-term danger of respiratory failure requiring intubation/mechanical ventilation.
 - g. Suspected pacemaker malfunction
 - h. Observation post pacer, defibrillator placement or post ablation
 - i. Post cardiothoracic surgery patients (Third floor PCU only)
 - j. PCU is the designated Stroke unit for those patients not requiring ICU. Diagnoses of TIA and acute stroke will be admitted to PCU unless patient is "Comfort Care Only" and then can be admitted to Medical/Oncology.
 - k. Medical/Surgical patients requiring telemetry monitoring and a higher intensity of service for suspected or documented dysrhythmias with anticipated or actual need for intravenous pharmacologic intervention which requires acute monitoring per the IV Medication Administration Safety Provisions and Monitoring Policy.
- D. **Treatment provided:**
 - a. Monitoring every two (2) to four (4) hours.
 - b. Vital signs every four (4) hours routinely.
 - c. Full system assessments every two (2) hours for a maximum of four (4) hours.
 - d. Finger Stick Blood Sugar every one (1) hour for a maximum of four (4) hours. Exceptions are Pre and Post Cardiothoracic surgery patients who are on an insulin infusion.
 - e. Cardiac or vasoactive drips/IV Meds that are stable, or require titration for no more than 90 minutes to stabilize patient include:
 - i. Nitroglycerin for control of chest pain
 - ii. Dobutamine for chronic heart failure
 - iii. Dopamine
 - iv. Abciximab (ReoPro)
 - v. Adenosine (IVP)
 - vi. Amiodarone
 - vii. Atropine (IVP)
 - viii. Diltiazem drip/IVP
 - ix. Enalapril (IVP)
 - x. Eptifibatide (Integrilin)
 - xi. Furosemide drip

- xii. Ibutilide (IV bolus)
- xiii. Lidocaine
- xiv. Metoprolol (IVP)
- xv. Milrinone
- xvi. Natrecor
- xvii. Procainamide
- xviii. Sandostatin

E. Patients not appropriate for PCU include:

- a. Patients requiring intensive monitoring with assessments every two (2) hours and/or more frequent interventions for greater than four (4) hours
- b. STEMI first 12 hours
- c. Transvenous temporary pacemakers
- d. Uncontrolled chest pain thought to be cardiac
- e. Patients who are hemodynamically unstable including those requiring initiation/active titration of pharmacologic hemodynamic interventions.
- f. Patients with indwelling femoral sheath; exception, short-term, daytime care pending OR availability for PCT back-up or pending removal by cath lab personnel.
- g. Patients requiring invasive hemodynamic monitoring (arterial line, PA catheter)
- h. Intubated or ventilated patients
- i. Chronic stable supraventricular arrhythmias not requiring adjustment of antiarrhythmic medications.
- j. Patients requiring continued active titration of antiarrhythmic infusions for life threatening or hemodynamically unstable arrhythmias.
- k. Patients requiring the following continuous, intravenous medications:
 - i. Epinephrine
 - ii. Insulin (exception for Post Open Heart Surgery patients)
 - iii. Narcan
 - iv. Nicardipine
 - v. Nitroprusside
 - vi. Norepinephrine
 - vii. Phenylephrine
 - viii. Vasopressin
- l. Systemic or direct arterial fibrinolytic therapy.

F. Exception: If a patient is requiring 1:1 assessment and intervention for a prolonged period of time, and ICU is unable to accommodate the patient, and PCU staff is competent to provide the care, the patient may stay on PCU after staffing is adjusted to accommodate and a staffing variance written. This decision will be made jointly by the PCU Charge Nurse, Clinical Manager or Director and House Supervisor to ensure that it is the best decision for the patient and the facility. The attending physician or Chief of ICU may be consulted to assist in decision making and prioritization.

5. Intensive Care Unit (ICU) Admission Criteria

- A. Purpose:** To provide quality care to patients from pediatric to geriatric who are critically ill and require intensive observation and rapid intervention to maintain their physical, psychosocial and spiritual well-being.
 - a. Intensive Care has 20 beds with a potential overflow to 30 beds. During times of high census, triage of patients into and out of Intensive Care will be performed by the Charge RN in association with attending physicians or the Chief of ICU Service as needed utilizing the ICU triage flow sheet guidelines.
 - b. All pediatric patients will have a pediatric consultation or pediatric evaluation within 12 hours of admit to ICU. (Per Medical Staff Rules & Regs)
 - c. Any direct admit to ICU must have orders entered prior to arrival and a receiving physician immediately available in the department.

B. **Patient Types to Admit to ICU: Note:** This listing is not meant to be all inclusive, but rather illustrative of the intensity of patient condition. Intensive Care Unit placement should be considered for any patient felt to exceed care capabilities of all other units.

a. **Medical**

- i. Acute Respiratory Failure
- ii. Septic Shock
- iii. Diabetic Ketoacidosis (DKA) requiring insulin drip therapy
- iv. Multiple trauma or severe single system trauma
- v. Hypertensive crisis requiring IV infusion and titration
- vi. Status post cardiac arrest with or without induced hypothermia
- vii. Cardiogenic shock
- viii. Acute pulmonary edema
- ix. Life threatening arrhythmias requiring cardioversion/defibrillation
- x. Cardiac Tamponade
- xi. Acute STEMI with or without rescue PTCA
- xii. Environmental injuries (near drowning, hypo/hyperthermia, etc.)
- xiii. Acute stroke with serious risk of airway compromise or increased intracranial pressure, fibrinolytic therapy
- xiv. Coma: metabolic, toxic or anoxic
- xv. Intracranial hemorrhage with instability
- xvi. Life-threatening GI bleed with hypotension, angina, continued bleeding
- xvii. Current systemic or direct arterial fibrinolytic therapy.

b. **Surgical**

- i. Major surgical procedures; open Abdominal Aortic Aneurysm (AAA) repair, major abdominal or thoracic surgeries, or those surgeries with resulting hemodynamic instability or requiring continued ventilatory assistance
- ii. Cardiovascular surgeries
- iii. Neurological surgeries
- iv. Temporary Transvenous Pacemaker

C. **Treatment provided:**

- a. Monitoring every one (1) to two (2) hours
- b. Full system assessments every one (1) to two (2) hours
- c. Treatment requiring continuous hemodynamic monitoring by pulmonary artery catheter or arterial line
- d. Mechanical ventilation
- e. Intracranial pressure monitoring or drainage systems
- f. Intraaortic balloon pump therapy
- g. Hypothermia therapy post cardiac arrest
- h. Continuous infusions or intermittent dosing of medications that include but are not limited to:
 - i. Epinephrine
 - ii. Norepinephrine
 - iii. Phenylephrine
 - iv. Vasopressin
 - v. Nitroprusside
 - vi. Insulin
 - vii. Narcan
 - viii. Nicardipine
 - ix. Continuous neuromuscular paralysis
 - x. Fibrinolytic therapy – systemic for Acute Myocardial Infarction (AMI), Pulmonary Embolism (PE), Cerebrovascular Accident (CVA) or local for acute arterial thrombosis
- i. The following medications **may** be given in PCU unless the stability or clinical picture of the patient is such that transfer to CCA is required:

- i. Nitroglycerin
- ii. Dobutamine for chronic heart failure
- iii. Dopamine
- iv. Abciximab (ReoPro)
- v. Adenosine (IVP)
- vi. Amiodarone
- vii. Atropine (IVP)
- viii. Diltiazem drip/IVP
- ix. Enalapril (IVP)
- x. Eptifibatide (Integrilin)
- xi. Furosemide drip
- xii. Ibutilide (IV bolus)
- xiii. Lidocaine
- xiv. Metoprolol (IVP)
- xv. Milrinone
- xvi. Natreacor
- xvii. Procainamide
- xviii. Sandostatin

D. Patients not appropriate for ICU include:

- a. Patients with a sole diagnosis of psychiatric pathology

6. Medical /Surgical Unit Admission Guidelines – WVH

A. Purpose: To provide quality care to the adult patient who has elective surgery that requires routine post-operative care and/or close observation or who is acutely ill, including exacerbation of chronic illness, that requires close observation and rapid intervention to maintain their physical, psychosocial, and spiritual well-being. Patients less than 16 years of age will be admitted on a case by case basis.

- a. Medical / Surgical unit has 11 beds.
- b. Direct admits will be accompanied by orders or the patient must be seen by the physician and orders entered within one (1) hour of admission. (See Medical Staff Rules and Regs)

B. Level of Service: Appropriate admissions to the Medical / Surgical Unit include patients who require:

- a. Routine nursing care for medical patients accommodated by an RN/Patient ratio of 1:4 – 5.
- b. Routine nursing care for surgical patients accommodated by an RN/Patient ratio of 1:3 – 4.
- c. Nursing assessment every four (4) to eight (8) hours.
- d. Vital signs every 4 hours routinely.
- e. Routine telemetry monitoring of stable rhythms not related to an acute cardiac event.

C. Patient Types to admit to Medical / Surgical:

- a. General medical diagnosis excluding stroke
- b. End of Life patients – especially those requiring medicated drips for comfort
- c. Patients requiring medical / symptom management of an Oncologic condition.
- d. Patients admitted from the Walk-in Clinic should be hemodynamically stable with a stable respiratory status.
- e. Elective post-operative patients requiring an overnight stay

D. Treatment Provided:

- a. Routine level care for general Medical and Surgical patients.
- b. Finger Stick Blood Glucose (FSBG) monitoring every one (1) hour for up to four (4) hours with subcutaneous insulin dosing
- c. Acute pain management

E. Patients not appropriate for Medical or Surgical:

- a. Acute Stroke or patients requiring assessment utilizing the NIH Stroke Scale.
- b. Acute respiratory distress requiring BiPAP or intubation and unresponsive to intervention.
- c. Intubated or ventilated patients.

- d. Patients requiring telemetry for monitoring of acute cardiac events
- e. Patients requiring cardiac or vasoactive drips (Except Diltiazem).
- f. Patients requiring Narcan drips or insulin drips.
- g. GI bleed patients with an **acute** drop in hemoglobin and hematocrit or active bleeding.
- h. Patients with an Ion Potassium (K+) less than 2.2 mEq/L must be evaluated for cardiac risk.
- i. Patients in four (4) point locked restraints and are being held solely for psychiatric diagnosis.
- j. Surgical patients under the age of 11 and medical patients under the age of 16.
- k. Hemodynamically unstable patients except those already on the unit who develop hemodynamic instability responsive to non-pharmacologic interventions (such as IV fluid challenge).
- l. Acute respiratory distress except those already on the unit who develop respiratory distress who do not require intubation and are responsive to intervention.
- m. Acute spinal cord injury during the acute post injury phase (potential for spinal cord shock)
- n. Patients weighing greater than 350 lbs.

Reviewed By:

Julie McAllister VP of Nursing: 3/2016

Debra Connelly, Director of Surgical and Acute Rehab Services: 3/2016

Connie Stevens, Director of Compliance: 3/2016