Confluence HEALTH | Central Washington Hospital & Clinics

Policy & Procedure #PFF-81

PATIENT FOCUSED

TITLE:	**ADMISSION CRITERIA TO IN-PATIENT SERVICE**		
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POLICY: It is the policy of Confluence Health, Central Washington Hospital & Clinics to establish admission criteria for inpatient service.

I. Surgical/Orthopedic Unit Admission Guidelines
II. Medical and Oncology Unit (MOU) Admission Guidelines
III. Progressive Care Unit (PCU) Admission Guidelines
IV. Intensive Care Unit (ICU) Admission Guidelines

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

1. **Purpose:** To provide quality care to the adult patient who has emergent or elective surgery that require routine post-operative care and/or close observation and rapid intervention to maintain their physical, psychosocial, and spiritual well being.
   A. Surgical/Orthopedics has up to 34 beds. The number of available beds depends on PC4 census and required needs of each unit. 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.
2. **Level of Service:** Appropriate admissions to the Surgical / Orthopedic Unit include patients who require:
   A. Routine nursing care for surgical 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.
3. **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. When ACU is closed emergent cases that do not require an overnight stay may be admitted.

D. Patients transferred from the ICU must be hemodynamically stable with stable respiratory status for at least six (6) hours.
E. 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.
F. Medical unit overflow as deemed appropriate by the charge nurse and or HS / Clinical Manager

4. **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 attached)
5. **Patients <u>not</u> 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 the age of 16 or under.
6. **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. See Stepdown Guidelines. 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):
      a. OSA without CPAP
      b. CIWA (in active withdrawal)
      c. Patients with large blood loss or requiring large volume IVF or blood replacement

d. Multiple pre-existing comorbid conditions (Hypertension; cardiac disease – including arrythmias, valvular disease, hx of MI or heart surgery, angina; chronic respiratory compromise – COPD; DM)
e. SIRS (Systemic Inflammatory Response Syndrome – i.e. 'pre-sepsis')
f. Extensive/lengthy abdominal/thoracic or back surgery
g. Abnormal vital signs
h. Multiple Narcan administrations
i. Difficult pain management requiring epidural and PCA or multiple boluses
j. 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:
a. Eye surgeries
b. Extremity amputations
c. Microdiscectomies or single level laminectomies
d. Appendectomy
e. Breast reduction or mastectomies
f. Cysto/Lithotripsy (no irrigation),
g. GYN procedures
h. Cholecystectomy
i. Hip or extremity fracture
j. Foot procedures
k. Oncology patients who have procedures – may be placed in Oncology
l. Unanticipated ACU pts who spend the night or 24 hour ACU patient\

II. Medical and Oncology Unit Admission Guidelines – 5th Floor

1. **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 17 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)
2. **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 below.

3. **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)
4. **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)
5. **Patients <u>not</u> appropriate for Medical or Oncology:**
   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. Patients the age of 16 or under.
6. **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. See Stepdown Guidelines. 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):
    a. Unstable vital signs
    b. Every 1 to 2 hour volume monitoring and intervention
    c. Unstable respiratory status
    d. Level 2 CIWA scores
    e. Analgesic/Benzo drips with titration – EOL
    f. Chemotherapy induction
    g. Diltizem drip titration
        i. 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.

III. Progressive Care Unit (PCU) Admission Criteria

1. **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 15 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 up to 12 more on PC4. 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 ER 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.
2. **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.
3. **General Patient Guidelines:**
    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
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.

4. **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:
      a. Nitroglycerin for control of chest pain
      b. Dobutamine for chronic heart failure
      c. Dopamine
      d. Abciximab (ReoPro)
      e. Adenosine (IVP)
      f. Amiodarone
      g. Atropine (IVP)
      h. Diltiazem drip/IVP
      i. Enalapril (IVP)
      j. Eptifibatide (Integrilin)
      k. Furosemide drip
      l. Ibutilide (IV bolus)
      m. Lidocaine
      n. Metoprolol (IVP)
      o. Milrinone
      p. Natrecor

q. Procainamide
r. Sandostatin

5. **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:
      a. Epinephrine
      b. Insulin
      c. Narcan
      d. Nicardipine
      e. Nitroprusside
      f. Norepinephrine
      g. Phenylephrine
      h. Vasopressin
   L. Systemic or direct arterial fibrinolytic therapy.
6. **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.

IV. Intensive Care Unit (ICU) Admission Criteria

1. **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 within 12 hours of admit to ICU.

C. Any direct admit to ICU must have orders entered prior to arrival and a receiving physician immediately available in the department.

2. **General Patient Guidelines:**

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

a. Acute Respiratory Failure
b. Septic Shock
c. Diabetic Ketoacidosis (DKA) requiring insulin drip therapy
d. Multiple trauma or severe single system trauma
e. Hypertensive crisis requiring IV infusion and titration
f. Status post cardiac arrest with or without induced hypothermia
g. Cardiogenic shock
h. Acute pulmonary edema
i. Life threatening arrhythmias requiring cardioversion/defibrillation
j. Cardiac Tamponade
k. Acute STEMI with or without rescue PTCA
l. Environmental injuries (near drowning, hypo/hyperthermia, etc.)
m. Acute stroke with serious risk of airway compromise or increased intracranial pressure, fibrinolytic therapy
n. Coma: metabolic, toxic or anoxic
o. Intracranial hemorrhage with instability
p. Life-threatening GI bleed with hypotension, angina, continued bleeding
q. Current systemic or direct arterial fibrinolytic therapy.

B. Surgical

a. 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
b. Cardiovascular surgeries
c. Neurological surgeries
d. Temporary Transvenous Pacemaker

3. **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:
   a. Epinephrine
   b. Norepinephrine
   c. Phenylephrine

d. Vasopressin
e. Nitroprusside
f. Insulin
g. Narcan
h. Nicardipine
i. Continuous neuromuscular paralysis
j. 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:
   a. Nitroglycerin
   b. Dobutamine for chronic heart failure
   c. Dopamine
   d. Abciximab (ReoPro)
   e. Adenosine (IVP)
   f. Amiodarone
   g. Atropine (IVP)
   h. Diltiazem drip/IVP
   i. Enalapril (IVP)
   j. Eptifibatide (Integrilin)
   k. Furosemide drip
   l. Ibutilide (IV bolus)
   m. Lidocaine
   n. Metoprolol (IVP)
   o. Milrinone
   p. Natrecor
   q. Procainamide
   r. Sandostatin

4. **Patients not appropriate for CCA include:**
   A. Patients requiring only observation
   B. Patients with a sole diagnosis of psychiatric pathology

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