WASHINGTON ADVENTIST HOSPITAL
PATIENT CARE POLICY MANUAL

ADMISSIONS/DISCHARGE/TRANSFER CRITERIA: ICU/CCU

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SCOPE

All Critical Care Areas

PURPOSE

To provide guidelines for admission to ICU, along with criteria for discharge in order to provide for appropriate utilization of ICU/CCU beds.

GENERAL ADMISSION POLICIES

Admission or transfer to ICU is made by the private physician or house officer through consultation with the Intensivist. The charge nurse is notified by the Admitting Office and or the Nursing Supervisor.

A. ELIGIBILITY

1. Intensive care units provide both intensive monitoring and intensive treatment. During times of high utilization and scarce beds, patients will be triaged in order of priority classification. Eligibility is also based on reversibility of the clinical problem as well as the likely benefits of intensive care treatment and expectation of recovery.

2. In case of conflict regarding admission or discharge criteria, the medical director (or designee) will decide which patients should be given priority. Whenever possible, objective criteria of illness and prognosis should be considered when reaching decisions to continue, limit, or terminate critical care support.

B. OBLIGATIONS OF ATTENDING PHYSICIANS

1. The attending physician assumes responsibility for the overall coordination of the care of the patient, and agrees to be available to the unit in a timely fashion to address problems as they arise. If the training, expertise or availability of the patient's own attending physician does not permit the fulfillment of that responsibility, then the overall responsibility of care may be transferred to another physician.

2. When a patient is admitted from outside the Hospital to the ICU, the patient must be seen within twelve hours of admission by the admitting physician (or designee). This requirement begins when the patient is admitted to the Hospital, not the unit. An admitting note and history and physical shall be placed on the chart within twelve hours of admission. If these items are dictated, a note should also be written to that affect and sufficient information given so that emergency treatment can be appropriately administered.

3. Admission orders should be obtained upon the patient's arrival to the admitting unit. When a patient is transferred from another facility to a critical care unit, complete admission orders must be written.

4. The attending physician or his designee will see his patients at least once daily and record in the progress notes. More frequent visits may be necessary because of patient condition.

C. ADMISSION CRITERIA

The following classifications are appropriate ICU patients and are admitted in order of priority:

1. ICU

Priority I: This category includes critically ill, unstable patients in need of intensive treatment. These are patients whose care requirements are such that no other alternate setting or staffing would be appropriate.

a. Unstable respiratory status requiring continuous monitoring and aggressive intervention.
b. Unstable/unprotected airway
c. Immediate post-operative cardiac surgery
d. Evidence of acute myocardial infarction
e. Unstable/uncontrolled chest pain
f. Gross uncontrolled hemorrhage
g. CVVH
h. Assist device/support

Priority II: This category includes non-Priority I patients whose condition requires either the technological monitoring services or intensive nursing care normally present in an intensive care environment, but whose care requirements are such that an alternate setting or staffing with appropriate modifications would suffice. These patients would benefit from intensive monitoring (ECG/invasive) and are at risk for needing immediate intensive treatment.

a. Unstable/deteriorating neuro vital signs
b. New onset/seizures/status epilepticus
c. Drug overdose
d. Management of excessive pulmonary secretions
e. Immediate post-operative major vascular surgery
f. Critical or unstable dysrhythmia
g. Suspected AMI
h. Unstable coronary artery disease
i. S/P interventional cardiology procedure (Note: patient with dissection or bleeding may receive higher prioritization)
j. Severe hypo-hyperthermia
k. Major organ failure
l. Emergent hemodialysis
m. DKA on insulin drip (first 24 hours)
n. Extreme electrolyte/metabolic imbalance requiring frequent monitoring and intervention

Priority III: This category includes:

a. Low risk monitor patients:

1. Immediate post-operative vascular, GI, thoracic, renal surgery

b. The critically ill, unstable patients whose previous state of health, underlying disease, or acute illness, either alone or in combination, severely reduces the likelihood of recovery and benefit of intensive care treatment. Examples of such admissions may include patients with metastatic malignancy complicated by infection, patients with end-stage heart or lung disease complicated by a severe acute illness. Priority III patients receive intensive therapy to relieve acute complication, but therapeutic efforts might stop short of other measures such as intubation or CPR.

2. Patients who do not meet routine admission criteria are:

a. Patients who have confirmed clinical and laboratory evidence of brain death (such patients can be admitted if they are potential organ donors but only for the purpose of organ support prior to donation).

b. Patients with non-traumatic coma causing a permanent vegetative state.

These patients would be admitted to the ICU under unusual circumstances, at the discretion of the medical director, and they should be discharged if necessary to make room for patients that have been prioritized to a higher level of need.

3. Patients for whom limits have been placed on treatment or resuscitation may be admitted to critical care units if they meet other admission criteria.

E. FURTHER SPECIFIC CRITERIA

1. The attending physician in consultation with the Intensivist shall decide if the patient medically requires an ICU bed.

2. If the physician orders ICU and the patient does not meet the criteria for admission, the medical director will be notified.

3. All admissions and transfers will be coordinated through the head nurse/charge nurse in critical care.

4. When an ICU bed is needed and all physicians report that their patients are not transferable, the nurse manager (or designee) will confer with the medical director (or designee) who will, in consultation with the attending physician, make final triage decisions.

5. Cardiac Telemetry and IMCU patients admitted to ICU due to non-availability of beds, may be admitted with routine orders, as appropriate, and shall be transferred to the appropriate unit as soon as possible. If the patient is admitted from outside the Hospital, the patient must be seen within twelve hours of admission by the admitting physician (or designee).

F. PATIENT PLACEMENT

1. All reasonable efforts will be made to place patients in the unit most appropriate for meeting the requirements of that patient's care.

The following guidelines are based on unit specific resources:

a. Post open-heart surgery patients (immediate recovery phase) - Unit 1500.

b. IABP patient - Unit 1500

c. CRRT patients – Unit 1500 and 4300

d. Impella patients –Unit 1500

e. post delivery patients – 4300

f. Stroke and neuro – 4300

g. other cardiac-related conditions – Unit 1500

2. When a request is received to admit or transfer a patient to a specific critical care unit and that unit is full, the request will be evaluated and processed as follows:

a. The desired unit will evaluate patients for transfer to a lower or alternate level of care.
b. The patient will be evaluated for the type of care required. All the units are capable of providing critical care except as noted in F.1.
c. Except in the cases identified in F.1., requests received after 9:00p.m. which require an inter-ICU transfer will be executed the following morning.

PATIENT TRANSPORT

Patients transferred to another hospital for equal or higher levels of care, or to another critical care area of the Hospital, will be monitored (portable monitor/defibrillator) and accompanied by a nurse unless otherwise ordered by the physician.

GENERAL TRANSFER/DISCHARGE POLICIES

A. ATTENDING PHYSICIAN OBLIGATIONS

1. Attending physicians and/or Intensivists are responsible for transferring patients out of intensive/coronary care in a timely fashion when their patients meet discharge criteria. Patients shall be evaluated by the attending physician every 24 hours to determine progress and downgrading of their care.

2. When patients are transferred out of intensive care to a different level of care, the attending physician, or his designee who will be following the patient after discharge from the unit, is responsible for executing a complete set of transfer orders prior to transfer. Medications to be continued must be reordered by name.

B. NURSING RESPONSIBILITIES

1. The ICU nurse will give a complete report to the receiving nurse, and assist staff with orientation to unusual therapies or equipment.

2. The attending physician, patient and family shall be notified of transfer or discharge.

E. DISCHARGE (TRANSFER) CRITERIA

In general, patients shall be considered appropriate for transfer/discharge when their conditions are no longer life-threatening, they no longer require advanced technological and/or pharmacological treatment modalities, and/or they will no longer benefit from intensive nursing care.
Patients will be considered eligible for transfer from ICU when:

1. Patients meet the admission criteria for the accepting unit.

2. Patients admitted for procedures, treatments or monitoring available in ICU shall be eligible for transfer/discharge upon meeting the goal of the admission or meeting the objectives noted on the clinical pathway.

3. Patients who experience further deterioration of a condition, with no apparent hope of recovery and/or who are not to be resuscitated.

   The charge nurse will evaluate patients each shift to determine readiness for discharge (transfer). The medical director or designee on duty will assist in determining bed priorities and interpreting criteria when all beds are full. Transfers in and out of the ICU will be at the discretion of the attending physician in consultation with the Intensivist.. The patient who derives the least benefit from the facilities of the critical care unit shall be the first to be transferred out of the unit. Specific transfer/discharge criteria are as follows:

4. Specific criteria for transfer/discharge from ICU are:

   Cardiac
   a. Absence of evidence of ischemia x 24 hours.
   b. Hemodynamic stability without assist/support devices.
   c. Controlled arrhythmias by medication or interventional devices
   d. Absence of invasive monitoring lines.
   e. On maintenance levels of IV cardiac medications

   Pulmonary
   a. Airway stable X 12 hours
   b. 02 therapy </= 60%
   c. Frequency of interventions to maintain respiratory status not > q. 2 hours

   Neuro
   a. Neuro vital signs stable X 12 hours
   b. Absence of invasive monitoring devices

   GI
   a. Absence of gross GI bleeding with stable hematocrit

   Misc
   a. Electrolytes stable or replaced and no longer requiring frequent intervention

   Additional guiding criteria by priority:

   Priority I: When the need for intensive care treatment as listed is no longer present or when treatment has failed so that short-term prognosis is poor, and there is little likelihood of recovery or benefit from continued intensive treatment.
   Priority II: When intensive monitoring has not resulted in a need for intensive treatment as listed and the need for intensive monitoring is no longer present.

Priority III: When the need for intensive treatment as listed is no longer present, but they may be transferred earlier if there is little likelihood of recovery or benefit from continued intensive treatment.

Note: In consideration of the continuing and often specialized care needs of these patients, arrangements for appropriate non-critical care will be made prior to critical care unit discharge.

5. If, at any time, a bed is needed for a more critically ill patient, the physician, at his/her discretion, may transfer the patient without meeting the discharge criteria.

G. SPECIAL CIRCUMSTANCES: ADMISSION/DISCHARGE

1. Direct admissions/Outside Hospital

   Direct admissions are not routinely accepted, but will be considered on an individual basis pending bed availability.

2. Direct admissions/Operating Room

   Direct admissions from the Operating Room may be accepted if:

   a. The patient came from ICU pre-op, and remains appropriate for Intensive Care Unit post-op

   b. Or, the patient is appropriate for the ICU based on his/her course during surgery, and

      + Appropriate notification of the ICU takes place, and

      + an ICU bed is available for that patient

3. No Available Beds

   a. When an ICU bed is needed and all physicians report that their patients are not transferable, the director (or designee) will confer with the medical director (or designee) who will, in consultation with the attending physician, make final triage decisions.

   b. In the event no ICU beds can be made available, the director or, after hours, the AOC and clinical coordinator will determine if interim placement in an alternate setting sufficient to support ICU patient care can be utilized.

   c. Cardiac Telemetry and IMCU patients admitted to ICU due to non-availability of beds, may be admitted with routine orders, as appropriate, and shall be transferred to the appropriate unit as soon as possible. If the patient is admitted from outside the Hospital, the patient must be seen by the admitting physician (or designee) as stated in Patient Care Policy #5615, Admission/Discharge/Transfer Criteria: Cardiac Telemetry.

Reference:
IHI (2011). Intensive care unit admission, transfer and discharge guidelines.

SCCM (1999). Guidelines for ICU admission, discharge and transfers. 27(3):633-638.