Admission and Discharge to Inpatient Units Policy

Purpose

The intention of this policy is to provide the most appropriate treatment to all patients uniformly and consistently.

Audience

The target audience for this policy includes, but is not limited to, all workforce members who are involved in providing care, treatment and services to patients.

Key Concepts and Terms

Units:

Intensive Care Unit (ICU) an inpatient unit that provides life support (e.g., intubation, invasive mechanical ventilation, cardiac support/ cardiopulmonary resuscitation) to critically ill patients in organ failure. The care and services provided, such as continuous invasive monitoring and the management of invasive mechanical ventilation, infusion and titration of intravenous inotropes and vasopressor medications constitute the highest level of care in the institution.

Medical/Surgical (Med/Surg) The inpatient unit that provides a level of care appropriate for patients with moderate physiologic instability. The care and services provided, such as continuous monitoring, (for example, oximetry, electrocardiography) and/or continuous or intermittent intravenous fluids.

Status:

- Inpatient (INPT)
- Observation (OBS)

Level of Care: The following descriptions of the levels of care in the hospital is intended to: a) understand the type of patient requiring different degrees of nursing and medical support in the hospital, and b) help determine the intensity of their monitoring and care necessary.

Intensive Care: Patients who need life supportive therapies, those who need intensive care support for at least two failing organ systems, or have multi-organ failure. Patients

requiring complex hourly nursing care and a minimum of 3 monitors. Patients with IV infusions and titration of the following medications: dobutamine, epinephrine, isoproterenol, phenylephrine, norepinephrine, vasopressin, labetalol, dopamine >10 mcg/kg/min, nitroprusside, lidocaine, procainamide.

Intermediate care: Patients who are stable but at risk of cardiac arrhythmias or physiologic deterioration and require close electrocardiographic monitoring and or higher intensity of care than a medical/ surgical level of care.

Pediatric/Adult Med/Surg care: Patients receiving continuous or frequent intermittent intravenous therapy.

Available bed - A physical bed, is the determination by the Charge Nurse and Nursing Supervisor/Director of satisfactory staffing resources, skills and ability for that patient status and for existing patients, including considerations of subsequent nursing shifts, previously requested beds, the status of floor patients and other considerations that bear directly on the proper and efficient care of a particular patient as well as other hospital patient care responsibilities.

Policy

Patients are admitted under one of two statuses – Outpatient/Observation (OBS) or Inpatient (INPT).

Admission designations – In all cases, determining the admission level of care and the status (INPT or OBS) and the diagnosis are the statutory responsibility of the Attending (Admitting) Physician.

Admission Management

Admission to the hospital requires an order in the Electronic Health Record (EHR) from a physician with admitting privileges

1. Admission from the Emergency Department

   a. Periodically, the availability of patient beds will be determined by Nursing Supervisor and the status will be relayed to the ED.

b. The Emergency Department will notify of an admission and request a room number through Nursing supervisor. Staff will facilitate the transfer at the earliest opportunity.

c. If staff is unable to receive the patient timely, they will notify the Nursing Supervisor/Director.

d. The admitting physician will enter PSO orders through the EHR prior to transfer of the patient.

    a. In the event that there are no available beds in the ICU, and a room is needed for a trauma patient post-surgery or pending transfer, the Attending Physician of the patient with the lowest acuity will be called to consider possible transfer to the Medical-Surgical Unit.

e. Lower level of care patients can be admitted to ICU (e.g., Med/surg status, Intermediate status) but ICU level of care patient should be admitted to ICU. Med/Surg and Intermediate care level of patients can be admitted to the Med/Surg unit with the appropriate resource allocation.

D. Reporting

Patient admissions will be communicated to the Admitting Department by Nursing Supervisor. Information reported to the Admitting Department will include patient information, admission status, bed number, admitting physician and time of admission.

E. Discharge Guidelines

1. The attending physician should be the leader in the team decision to discharge or transfer a patient in or out of the ICU or change the patient status of a patient.

2. Discharges from any unit should only occur under the following conditions:
    a. when the patient is transferred to another Unit in the Hospital;
    b. when the patient is transferred to another institution;
    c. when the patient is discharged home;
    d. when the patient self-discharges against medical advice (AMA);
    e. when the patient expires.

3. Do Not Resuscitate Status: Patients admitted to the Intensive Care Unit with a Do Not Resuscitate status, or acquiring that additional status during an ICU admission may have a higher eligibility for discharge from Intensive Care status in the event of an ICU resource restriction.

F. ICU Utilization Review

All patients will be informally assessed on a daily basis by the Nursing staff for their eligibility to either Intensive Care or Intermediate Care status. Factors to be considered in this assessment include the clinical status of the patient in the context of their diagnosis(es), nursing support requirements, behavioral considerations, other patient management constraints or requirements and the documentation in the record including documentation by physicians and allied personnel. In the event that there is an apparent discrepancy between this assessment and the treatment plan, the procedure will be as follows.

1. The attending RN will request a utilization management review by the UR Coordinator, or designee.

2. In the event that this review confirms a possible utilization concern, the UR Coordinator will contact the Attending Physician for an informal case review, including issues specifically related to the requirement(s) for intensive care resources.

3. In the event that there is a patient management consensus, further utilization assessment will continue routinely. The Attending Physician should reflect the basis for the continued ICU stay in the documentation.

4. In the event that a UR Coordinator - Attending Physician consensus is not reached, the UR Coordinator will request a utilization assessment by the Physician Advisor (or designee) for Utilization Review. Subsequent patient ICU utilization issues will be addressed through Medical Staff policies and practices.

Related Documents

Policy: Advanced Directives; Care Planning; Bylaws of the Medical Staff