Hendricks Regional Health

INTENSIVE CARE RULES AND REGULATIONS

A. Adult Admission Criteria - Intensive Care

Acute injury/alterations to system or multisystem from trauma or disease when clinical judgment dictates nearly continuous observation and assessment by nursing staff.

Criteria for admission may include but are not limited to one or more of the following. These parameters will be required as sufficient to justify placement in Intensive Care. However, based on clinical judgment, Intensive Care monitoring may not be regarded as necessary in individual situations.

1. Parameters for ICU Admission

   a) Sustained MAP<65 after adequate fluid resuscitation
   b) SBP > 180 or DBP > 110
   c) RR > 30 or < 10
   d) Blood pH > 7.60 or < 7.25
   e) HCO3 < 15
   f) PC02 >60 with pH < 7.25 or PC02 < 30
   g) Acute invasive/non-invasive airway management with positive pressure ventilation or mechanical ventilation.
   h) Pulmonary artery catheters and cardiac output monitors.
   i) EKG monitoring for severe dysrythmias that puts patient at increased risk for sudden cardiac death
   j) Significant electrolyte disturbances requiring frequent monitoring.
   k) Drug Toxicity or Overdose with organ system dysfunction
   l) Reference Section J – IV Titrated Medications (add hyperlink)
   m) Post TPA for stroke, MI or pulmonary embolus

2. Parameters for PCU Admission:
   a) Apical pulse > 130 or < 40
   b) Patient with DKA or HHS
   c) Neurovascular variations based on combination of history and changes of neurological assessment parameters to include acute stroke and may include diagnosis of TIA
   d) Acute fluid/volume replacement based on history, VS assessment, fluid losses and decreased urine output.
   e) Reference Section J – IV Non-Titrated Medications **(add hyperlink)**
   f) Venous or Arterial Sheaths
   g) High flow oxygen > 60 percent
   h) Delirium or Acute Encephalopathy requiring frequent monitoring

B. **Pediatric Admission to Intensive/Progressive Care**

Pediatric patients that become critically ill will be stabilized in the Pediatric Unit and be transferred to a tertiary pediatric care facility. On a case by case bases, the Pediatric Hospitalists may admit the patient to ICU with critical care consult for patients that are 16 years or older with mutual agreement by both physicians.

Post-operative patients that require prolonged time to wean off ventilators, but are otherwise medically stable, can be admitted to ICU by the pediatric hospitalist service or general surgery service, with consultation and ventilator management overseen by the anesthesiologist.

If a pediatric patient requires ICU admission, the nursing care will be provided by a pediatric nurse and an ICU nurse that will work as a team to coordinate and manage the patients care.

C. Intensive Care Overflow Policy

When Intensive Care beds are occupied, and a patient needing Intensive Care presents for admission, the following procedure will be followed:

1. The RN in charge of the unit will evaluate the possibility of transfer of current Intensive Care patients based upon documentation in the physician progress notes.
2. The RN will call the in-house intensive care physician of the most likely patient(s) for an order to transfer.
3. After all physicians of patients in the Intensive Care have been contacted as to the possibility of transfer, and if the acuity of Intensive Care patients makes it such that no patient can transfer, ICU Medical Director or Chief of Medicine/Intensive Care Committee will be contacted by Administration and Clinical ICU Leadership and a joint decision reached as to whether or not the Intensive Care will be at capacity to critical patients.

In the event of a disaster, the Emergency Preparedness Plan will be followed. Current admission and discharge will be utilized in prioritizing patient admission/discharge from Intensive Care. If the Intensive Care has no patients capable of being transferred out, the Emergency Department physician will be notified per Administration. In the event an inpatient's condition deteriorates to a critical event and the Intensive Care beds are at capacity, and no transfers are possible, the ICU Medical Director or Chief of Medicine/Intensive Care Committee will be contacted in consultation with the attending physician to triage patients and determine who can be transferred out of Intensive Care.

D. Intensive Care Direct Admission

1. The accepting physician or designate calls the House Supervisor to see if a patient can be received at a projected time. The physician or designate must give a brief history and or description of the patient's condition.
2. The House Supervisor will advise of bed availability and if the patient can be received at the projected time. The physician or designate will instruct the patient's family to go to the Emergency Department Ambulance entrance for expedient admission if a bed is not available.
3. Intensive Care staff will notify the Emergency Department staff of the impending admission.
4. In the event that Intensive Care is at capacity, the patient will be observed, and treatment instituted in the Emergency Department and the Intensive Care Overflow Policy will be followed.

E. Intensive Care Dismissal Criteria

Dismissal of patients will be at the discretion of the attending physician/physicians when Intensive services of the unit are no longer required. Routine dismissal from Intensive Care is: transfer to another patient care area within the hospital; dismissal to home upon the order of the attending physician,, dismissal to another medical care facility upon the order of the attending or consulting physician; or, based on clinical expertise, the unit's director may consult with patient’s primary provider regarding that no longer meets established criteria as defined in ICU Rules and Regulations.

1. Criteria are as follows:

    a) The patient is determined to be in stable condition as evidenced by assessment parameters and other objective and subjective signs.

    b) The patient has had no life-threatening arrhythmias for 24 hours or absence of arrhythmias for 12 hours without IV medications. Any persistent arrhythmias that continue are not felt to contraindicate dismissal.

    c) Patient should be stable for a suitable period of time as determined by physician after any specialized IV drips have been discontinued.

d) Satisfactory clinical status after treatment of CHF or pulmonary edema justifying less intensive monitoring.

e) Acceptable respiratory status as determined by physician and no acute mechanical ventilatory assistance is needed.

f) Discontinuation of select continuous monitoring equipment.

F. Delineation of Physician Privileges for ICU

Physician privileges for ICU are based on privileges recommended by the Physician Relations Committee, Medicine Intensive Care Service Chairperson, Medical Executive Committee, and approval by the Board of Trustees. Privileges are based on the practice specialty.

G. Sterile Procedures Performed in ICU are performed with full barrier precautions.

H. Requirements for Patient Evaluation in ICU

1. Patients admitted directly or are transferred into the ICU area from the admitting office, emergency department, or general care area must be evaluated by the attending practitioner or designee within a clinically reasonable amount of time, based on acuity, not to exceed 12 hours.

2. Patients must be evaluated daily.

3. Patients must be evaluated after successful resuscitation/code blue.

I. Post-Operative Recovery of Patients in ICU

Patients who will be requiring ICU care following surgery may be recovered in ICU with the mutual agreement of the surgeon, anesthesiologist and accepting intensivist.

J. IV Drips

These medications should only be administered in the ICU or PCU setting.

(add link to IV Drips)

1. In an emergency situation, a continuous IV infusion of any medication in the HRH formulary may be initiated anyplace in the hospital and then the patient will be transferred to the appropriate unit.

K. Nursing Intervention Policy

The following items may be performed at the discretion of all nursing staff as approved by Intensive Care Service:

1. Oximetry readings for symptoms of respiratory distress
2. ACLS algorithms

L. Role of the Medical Director

The ICU Medical Director is appointed by Administration. The Medical Director is responsible for:

1. Implementing policies established by the medical staff for the continuing operation of the unit.
2. Making decisions, in consultation with the physician responsible for the patient, for the disposition

of a patient when patient load exceeds optimal operational capacity.

3. Assuring that the quality, safety, and appropriateness of patient care services provided within the unit are monitored and evaluated on a regular basis and that appropriate actions based on findings are taken.

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