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*** ADDENDUM ***
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Division of Nursing

TITLE: **ADMISSION AND DISCHARGE CRITERIA FOR THE PROGRESSIVE CARE UNIT**

An approved member of the Hackettstown Community Hospital Physician staff may admit patients to the Step Down Unit if the patient falls within the following guidelines. The admitting physician assumes responsibility for the care of the patient while in the unit.

All criteria for admission do not necessarily have to be met. All criteria needs to be met for discharge from the unit unless otherwise noted.

I. MEDICAL GUIDELINES

A. ACUTE MI/ANGINAL SYNDROME

Any chest pain and/or EKG changes suggestive of an acute MI, the patient should go to ICU. A patient hemodynamically stable though no current EKG changes, by order of physician may be admitted to Step Down Unit.

Admission:

1. Acute Serial CK/MB returning to normal
2. No EKG changes
3. No severe chest pain x 24 hours
4. Hemodynamically stable
5. Nitroglycerin drip may be infusing.

Discharge:

1. Transferred to Medical/surgical unit with telemetry when stable.
2. Stable hemodynamics, no life threatening dysrhythmias, no drips other than heparin

B. UNSTABLE ANGINA/RULE OUT MI

Admission

1. No EKG changes indicating an acute MI
2. CK/MB and/or troponin returning to normal
3. Hemodynamically stable but requiring closer monitoring and vital signs q 4 hours
4. Require medication adjustments to control chest pain
5. Nitroglycerin drip may be infusing.

Discharge

1. MI ruled out
2. Hemodynamically stable, no longer requiring frequent vital signs or closer monitoring
3. Patient remains pain free at least 24 hours

C. POTENTIAL LIFE THREATENING DYSRHYTHMIAS

Admission

1. Dysrhythmias requiring close monitoring for medication therapy/adjustments
2. Patient has a controlled ventricular response after treatment. (may be an antiarrhythmic or pacing)
3. Patient should be free of severe CHF/PE
4. Patient may have Antiarrhythmic drip infusing

Discharge

1. Stable vital signs x 24 hours
2. Dysrhythmias controlled - off intravenous infusions other than heparin

D. PACEMAKER SURVEILLANCE

Admission

1. Requiring close monitoring and observation
2. Requiring pacemaker adjustments by cardiologist
3. Transvenous pacemaker in clinically stable patient
4. Transthoracic (external) pacemaker in clinically stable patient

Discharge

1. Temporary pacer discontinued at least 24 hours without instability.
2. Discontinued transvenous pacemaker, with underlying cause resolved.
3. Permanent Pacemaker in for 24 hours.

E. SYNCOPE

Admission

1. Strong suspicion of dysrhythmia related cause
2. Dysrhythmias noted on monitor (ER/MD office)
3. Orthostatic changes
4. Requiring medication adjustment and/or close monitoring of vital signs

Discharge

1. Dysrhythmias controlled (see above)

2. Vital signs stable x 24 hours or if etiology defined

F. CONGESTIVE HEART FAILURE

Admission

1. Clinical evidence of CHF (rales, dyspnea, tachypnea, hypoxia, hypoxemia-evidenced by ABGs, or chest x-ray findings).
2. Requires frequent monitoring, lung assessments, intensive respiratory therapy, oximetry continuous.
3. Frequent IV medication and/or Natrecor drip.

Discharge

1. Chest clearing by x-ray, or clinical evidence of stabilization
2. Vital Signs stable.
3. Patient has no evidence of distress.

G. Respiratory Insufficiency (including but not limited to pneumonia, pulmonary disease)

Admission

1. Mechanical ventilation not required on an emergent basis
4. Requires close observation, frequent/continuous pulse oximetry and intensive respiratory therapy.
5. Tachypnea/mild hypoxemia.

Discharge

1. Clinically stable and/or improved ABGs
2. Tachypnea resolved or within acceptable parameter

H. VENTILATOR DEPENDENT PATIENTS

Admission

1. Stable ventilator patients

Discharge

1. Stable ventilator patients who will need long term placement or home care

I. PSYCH/DRUG OVERDOSE

PATIENT SHOULD GO TO ICU UNTIL MEDICALLY CLEARED OR AFTER INITIAL PSYCHIATRIC EVALUATION AND CLEARANCE. PATIENT MAY BE TRANSFERRED TO AN APPROPRIATE BED UNDER PROPER SUPERVISION PENDING PSYCHIATRIC EVALUATION.

Admission

1. Prior to psychiatric clearance for suicide with one-on-one observation upon approval of Critical Care Coordinator or Administrative Supervisor and physician

Discharge

1. Clinically stable.
2. Appropriate psychiatric referral

J. G.I. BLEED (Sections J, K, and L to be discussed with G.I. physicians or attending)

Admission

1. S/S associated with or identified to be a high risk for bleed but not requiring ICU (e.g., SBP < 90, tachycardia > 100, orthostatic hypotension, HGB/HCT < 9/27, tarry melanous stools with + guiac, bright red blood via NGT that clears with NS lavage, s/p EGD with cautery/sclerosis of ulcers/lesions
2. Patient requires frequent monitoring of VS and fluid status
3. Tarry melanous stools with stable vital signs

Discharge

1. Hemodynamically stable x 24 hours
2. Stable/improved HGB/HCT
3. No evidence of fresh bleeding
4. Physician determines patient not at risk for massive bleed

K. HEPATIC FAILURE

Admission

1. Encephalopathy (note new onset encephalopathy may require ICU monitoring)
2. Coagulopathy with controlled or without bleeding
3. Hemodynamically stable
4. Hepato renal syndrome

Discharge

1. Reversal of coma or coma deemed irreversible
2. Stable vital signs
3. Improved renal function or deemed irreversible

L. ACUTE PANCREATITIS

Admission

1. Stable vital signs
2. $P0_2$ >60
4. Glasgow Coma Scale >8
5. Frequent monitoring of pain, intake and output, respiratory assessment and therapy.

Discharge

1. Stable vital signs and less frequent monitoring needed.

M. CEREBRAL HEMORRHAGE/EMBOLUS/THROMBUS
CEREBRAL VASCULAR ACCIDENT
ALTERATION IN CONSCIOUSNESS

Admission

1. Hemodynamically stable
2. Stabilization in level of consciousness
3. Alteration in level of mobility (paresis)
4. Frequent assessments of neurological status and vital signs (every four hours or more)
5. Stable airway (see H)and/or frequent assessment of airway status.

Discharge

1. Stable level of consciousness
3. Stable vital signs
4. Less frequent assessments needed.

N. EPILEPSY

Admission

1. Generalized seizures in an otherwise medically uncompromised patient
2. Frequent medication administration and neurological checks q 4 hours or more

Discharge

1. Adequate control of seizures
2. Neurological assessments no longer required q 2 hours

O. MENINGITIS

THOSE PATIENTS IN OR NEAR SHOCK SHOULD GO TO ICU

Admission

1. Lumbar Puncture evidence of meningitis
2. Neurological assessment, vital signs q 4 hours or more
3. Elevated temperature

Discharge

1. Improvement in above mentioned parameters to within acceptable limits

P. NEURO-MUSCULAR WEAKNESS

Admission

1. Neuromuscular weakness and neuro checks as per MD. Patient with ascending polyneuropathy or poorly controlled myasthenia gravis when complicated by other medical conditions
2. Requires assessments, respiratory assessment, intensive respiratory therapy with frequent or continuous oximetry
3. Stable airway (see H.)

Discharge

1. Stable or controlled neuropathy no longer requiring frequent intensive therapy and monitoring

Q. RENAL FAILURE
ELECTROLYTE IMBALANCE

Admission:

1. Renal failure requiring frequent monitoring
2. Condition is associated with abnormalities of serum electrolytes; i.e., volume overload to the degree that CHF develops, volume depletion, (dehydration, H_2O toxicity, hypo/hypercalcemia with altered cardiac status or altered sensorium, hypo/hypernatremia with altered sensorium/seizures, hypo/hyperkalemia with altered cardiac status, imbalances with CNS impairment, malignant hypertension

   SEE ICU CRITERIA FOR CRITICAL CARE ADMIT

3. Patient requires frequent urinary monitoring (as frequently as Q 1-hour urine outputs)
4. Frequent monitoring for dysrhythmias
5. Frequent medication intervention that requires frequent taking of vital signs
6. Renal dose dopamine may be used on an otherwise stable patient to increase output

Discharge

1. Improved renal output and status
2. Improved electrolyte status
3. No longer requires frequent monitoring or assessments q 4 or more
4. Above mentioned symptoms improved

R. DIABETES MELLITUS

Admission

1. Ketoacidosis
2. Hyper osmolar, hyperglycemia without ketoacidosis resulting in altered neurological function
3. May be on insulin drip
4. Requires frequent neurological, cardio-pulmonary assessments and glucose monitoring

Discharge

1. Control of hyperglycemia and acidosis with improvement of neurological function

II. SURGICAL ADMISSION GUIDELINES

A. TRAUMA, PRE- OR POST-OPERATIVE

Admission:

1. Post-op patients who do not require ICU but require more intensive respiratory therapy, oximetry, monitoring of cardio-pulmonary status, neuro-vascular and circulatory assessments than can be provided on the surgical unit (every 4 hours or less).
2. Multiple system trauma, thoracic, head, etc. injuries that require close observation but do not require ICU.

Discharge:

1. When close monitoring no longer necessary
2. Improved neurological, cardio-pulmonary, hemodynamic status
3. Adequate appropriate pain management

III. HEMODYNAMIC MONITORING

1. CVP monitoring may be done in the Progressive Care as long as it is limited to q 4 hour recordings.
2. Patient must be clinically stable.

IV. PEDIATRIC

A. GENERAL

Admission

1. Patient requiring more frequent vital parameters than is allowable on pediatric unit, q 2 hours or more or requiring nursing care more frequent than every 2 hours can be admitted to PCU while awaiting transportation to a tertiary facility.

Discharge

1. Patient has been discharged to tertiary facility.

IV. MEDICATIONS ON PCU

A. ADMISSIONS

1. The following type of medication drips maybe taken on the PCU. Physician orders are required to start, titrate and discontinue all IV medication drips. If patients on any of these become hemodynamically unstable or require more intensive care the PCU nurse may request physician to transfer patient to ICU. Those types of IV infusion may include:

   a. Antihypertensives
   b. Vasopressors
   c. Inotropes
   d. Vasodilators
   e. Anitarrhythmics
   f. Calcium channel blockers
   g. Beta blockers

2. Any drip initiated on the Progressive Care Unit will have vital signs monitored every 15 minutes or more. Advance to every 1 hour x 4 hours. Once therapeutic drug dosage is reached and patient is hemodynamically stable, patient then may be placed on routine Progressive Care vital signs.

A. DISCHARGE:

1. IV medication drips are discontinued.