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Providence St. Joseph Hospital

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Owner	Rhona Tristan-Evans: Manager Nursing
Area	Admission, Discharge & Patient Hand-off
Applicability	CA - St. Joseph Hospital Orange

SCOPE OF SERVICES/ADMISSION, TRANSFER AND DISCHARGE DEPARTMENT: DEFINITIVE STEP-DOWN UNIT (DSU)

COST CENTERS INCLUDED WITHIN THIS SCOPE: 615002

I. PURPOSE:

A. We are committed to providing a high quality of nursing care to all patients, regardless of the patient's circumstance, through the application of sophisticated research based clinical skills, and knowledge, advocacy of patient/family rights, and respect for the dignity of human life.

B. Our mission is to serve the healthcare needs of the critically ill, providing a bridge between MICU/Hybrid CVICU and the Telemetry and Med/Surg units.

C. We provide supportive care to patients, and significant others through crisis situations including end of life decisions while respecting their beliefs and preserving their dignity.

II. SERVICES:

A. Description of Service Provided

1. The Definitive Step-Down Unit (DSU) and Hybrid CVICU beds 1-6 are intermediate care units for adolescent, young adult, middle adult, and geriatric patients of St. Joseph Hospital of Orange (SJO), located on the third floor of Building II (DSU) and the first floor of Building I (Hybrid CVICU beds 1-6). The DSU patient is characterized by the presence of or being at high risk for developing life threatening problems. The DSU patient requires observation and assessments by the multidisciplinary team in order to maintain stability, prevent complications, and achieve and maintain optimal responses.

2. The DSU is defined as a unit which is organized, operated and maintained to provide for the monitoring and care of patients with moderate or potentially severe physiologic instability requiring technical support but not necessarily artificial life support. DSU patients are those who may routinely require less care than intensive care, but more than that which is available from medical/surgical care, or those with short term therapeutic intensive care. Short-term therapeutic intensive care, defined as acuity that will require intensive therapeutic management for a crisis time period, may be initiated and continued in the DSU. When long-term therapeutic intensive care is needed, the patient will be transferred to medical intensive care.

   Artificial life support is defined as a system that uses medical technology to aid, support, or replace a vital function of the body that has been seriously damaged. Technical support is defined as specialized equipment and/or personnel providing for invasive monitoring, telemetry or mechanical ventilation, for the immediate amelioration or remediation of severe pathology.

3. Nursing services focus on support of patient adaptation, restoration of health, and preservation of patient rights, including the right to refuse treatment or to die. Inherent to the patients' response to illness is the need to maintain spiritual, psychosocial, emotional, and social integrity. The focus includes the interaction and impact of the patient's family and/or significant other(s). Assessment,

treatment, education and plan of care are tailored to the specific needs for each patient and their family and/or significant other(s). This holistic approach to patient care management is discussed and coordinated through multidisciplinary rounds that are held twice daily and occur seven days a week.
ADMISSION, TRANSFER AND DISCHARGE requires LIP (Licensed Independent Practitioner) order and admitting physician will remain attending unless other arrangements are made.

B. Admission Criteria: (Intensity of Service) for the Definitive Step-Down Unit:

Listed below are admission and discharge guidelines with some examples of specific conditions or diseases that could qualify for intermediate care. These conditions would require monitoring not deemed appropriate for the staffing ratios of the telemetry units. Patients must meet inpatient admission criteria

1. Cardiac System

a. Low-probability myocardial infarction; rule out myocardial infarction.
b. Hemodynamically stable myocardial infarction.
c. Any hemodynamically stable dysrhythmia.
d. Permanent pacemaker.
e. Post cardiac surgery patients requiring temporary pacemaker with epicardial wires.
f. Post Cardiac Catheterization Laboratory or Interventional Radiology (CVIL) procedures with venous and/or arterial femoral sheath(s)

(1) Venous/ Arterial Sheath Management

a. For patients requiring sheath removal, may be admitted to DSU during day shift, up to 6pm
b. For patients requiring sheath removal, admit to critical care after 6pm, after CVSSU closes, due to available resources for groin management monitoring.
c. Patient may then transfer to DSU after sheath removal and groin site stabilization.

(2) Post-procedural care of the following CVIL procedures:

a. Transaortic Valve Repair (TAVR)
b. Mitral Valve Clip (MitraClip)
c. Watchman Device placement
d. Mild-to-moderate congestive heart failure without shock
e. Hypertensive urgency without evidence of end-organ damage

Admission Criteria for BiPAP/CPAP patients

Category	Type of Patient	Unit for Admission
1	Patients who are a full DNAR on comfort care who are placed on Bipap for comfort.	Can be initiated and maintained on Med/Surg
2	Patients with orders for DNAR, Do not Intubate, Yes Pharmacologic measures and Yes for Bipap (Once do not intubate option is chosen, the potential for less optimal outcomes should be explained to patient and family by the physician.)	Can be initiated and maintained on Med Surg
3	Patients with diagnosed obstructive sleep apnea with CPAP or BiPAP who are not in acute respiratory failure	Can be initiated and maintained on Med/Surg
4	Patients with neuromuscular diseases who use CPAP or Bipap at home	Can be initiated and maintained on Med/Surg
5	Patients with acute respiratory failure	Must be admitted/

Category	Type of Patient	Unit for Admission
		transferred to Critical Care or DSU
6	Patients on Med/Surg on Bipap who are full Code and become unstable requiring titration of Bipap for oxygenation or acute respiratory failure	Must be admitted/ transferred to Critical Care or DSU

2. Pulmonary System

    a. Medically stable ventilator patients with tracheostomy, for weaning and chronic care.

    b. Hemodynamically stable patients with evidence of compromised gas exchange and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or nasal continuous positive airway pressure.

    c. Patients who require frequent suctioning or aggressive pulmonary physiotherapy.

    d. Bipap: see table

3. Neurologic Disorders

    a. Patients with established, stable stroke who require frequent neurologic assessments up to every 2 hours, or frequent suctioning or turning.

    b. Traumatic brain injury patients who require monitoring no more frequently than every 2 hours for signs of neurologic deterioration.

    c. Stable traumatic brain injury patients who require frequent positioning and pulmonary toilet.

    d. Subarachnoid hemorrhage patient's post-aneurysm clipping who require observation for signs of vasospasm or hydrocephalus.

    e. Patients with chronic but stable neurologic disorders, such as neuromuscular disorders, who required frequent nursing interventions.

    f. Stable subarachnoid hemorrhage patients awaiting surgery.

4. Drug Ingestion and Drug Overdose

    a. Any patient requiring frequent neurologic, pulmonary, or cardiac monitoring for a drug ingestion or overdose who is hemodynamically stable.

5. Gastrointestinal (GI) Disorders

    a. GI bleeding with minimal orthostatic hypotension responsive to fluid therapy.

    b. Acute liver failure with stable vital signs.

6. Endocrine

    a. Diabetic ketoacidosis patients requiring insulin drip, or frequent injections of insulin during the early regulation phase after recovery from diabetes ketoacidosis with blood sugar every 2 hours.

    b. Diabetic patients on insulin drips requiring every 1-2 hours monitoring of blood sugar and titration of insulin. Transfer to critical care if more frequent blood sugar checks are required, e.g. every 1 hour.

7. Renal

    a. Post-operative Kidney Transplant, following stabilization

    b. Pre-operative Kidney Transplant

    c. Kidney transplant patients undergoing treatment for rejection

8. Surgical

    a. Post-operative cardiovascular surgery patients who require hemodialysis and /or frequent monitoring.

    b. The postoperative patient who, following major surgery, is hemodynamically stable but may require fluid resuscitation and transfusion due to major fluid shifts

c. The postoperative patient who requires close nurse monitoring during the first 24 hrs. Examples include but are not limited to peripheral vascular reconstruction; the post-op spine surgeries, and neurosurgical patients requiring frequent up to every 2-hour neurological exams.

9. Med/Surg and Obstetrical

a. Appropriately treated and resolving early sepsis without evidence of shock or secondary organ failure.

b. Complicated medical-surgical or obstetrical patients requiring increased intensity of service.

C.		Severity of Illness Admission Criteria: (used as guidelines)
	1.	Vital Signs: requiring monitoring Q2-4hrs
		a) Temperature < 95F
		b) Symptomatic HR < 50/minute or > 120/minute
		c) Systolic BP < 90 mm Hg or > 160 mm Hg
		d) Respiratory rate <10 or > 30 per minute
		e) Symptomatic pulse oximetry <89%
	2.	Laboratory-Blood (newly diagnosed)
		a) Abnormal electrolyte levels follow critical care electrolyte protocol
		b) Pa02 and HCO3 below normal range
		c) PC02 above or below normal range
		d) Blood pH above or below normal range
		e) Toxic levels of drugs/chemicals and potential for significant arrhythmia(s)

D. Aspects of Care

1. Management of the patient with central lines and may include CVP monitoring for stable post-operative patients
2. Management of hemodynamically stable patients with radial arterial lines
3. Patients requiring warming with warming device, (for example Bair Hugger)
4. Management of patients with stable long-term mechanical ventilators with tracheostomy
5. Nursing interventions at least every 2 hours
6. Vasoactive and/or antidysrhythmic medication infusions

a. For patients who are on DSU level of monitoring: may be on the following vasoactive and/or antidysrhythmic medication infusions at fixed rates. If patient status necessitates, may titrate up to one medication listed below, based on the IV Adult Titration guidelines and/or specific provider orders. (for example: if patient's blood pressure goes down, may increase dopamine per titration guidelines). If patient becomes hemodynamically unstable and requires titration of vasoactive medications more frequent than every 1 hour, evaluate for conversion to ICU level of care.

- Amiodarone
- Diltiazem
- DOBUTamine
- DOPamine
- Esmolol
- Fenoldapam
- Isoproterenol
- LaBETalol
- Lidocaine
- Milrinone

- Narcan
- Nesiritide
- Nicardipine
- Nitroglycerin
- Procainamide

b. Patients who are on ICU level of care may be initiated and titrated on vasoactive and antidysrhythmic medication infusions applicable to critical care as per IV administration guidelines or as per provider orders.

c. On initiation of medication infusion listed above, vital signs are to be taken every 15 minutes x four, then every 1-hour x four, then every 2-4 hours, as indicated by the patient's condition or by MD/NP provider order.

d. Refer to IV administration guidelines for specific dose limits to the above listed medications and for a complete list of other medications that can be given in DSU and critical care.

7. Sedative Medication Infusions

a. For patients who are on DSU level of care: Dexmedetomidine (Precedex) may be initiated and titrated for agitation in ventilated and non-ventilated patients as per IV Adult Titration Guidelines and/or specific provider orders.
b. Patients who are on ICU level of care may be initiated and titrated on sedative medication infusions applicable to critical care as per IV administration guidelines.
c. Assessment and frequency of vital signs and RASS scores monitoring are performed as per established critical care monitoring standards.
d. Refer to IV administration guidelines for specific dose limits to the above listed medications and for a complete list of other medications that can be given in DSU and critical care.

E. Transfer Criteria

1. **Internal Transfer Criteria:** Relocation of a patient from one level of care unit to another level of care unit within SJO.

a. No longer meets admission criteria for this unit.
b. When a patient's physiological status requires a higher level of care and critical intervention is necessary, the patient will be transferred to the critical care unit.
c. Meets criteria for accepting unit, level of care.
d. Physician/NP order.

2. **Internal Transfer Out Criteria:** An inpatient referred for inpatient care directly from SJO to another inpatient facility.

a. Physician/NP order.
b. Facility has agreed to accept the patient and thereby acknowledges that it has the capacity to provide for the patient's needs.
c. Appropriate interfacility transfer forms are completed and appropriate information accompanies patient.

3. Triage:

a. When all DSU beds are filled, the admitting physician/NP and Nursing Director and/or designee in collaboration with the nurse manager should assess the capacity of the unit and have the responsibility and authority in consultation with the attending physician to admit/transfer patients from the unit.

4. Discharge Criteria for the DSU:

a. No longer meets admission criteria for DSU. The Intensivist has the authority to triage patients out of the DSU when the discharge criteria have been met. The Intensivist will communicate to the attending physician prior to the patient being transferred.
b. Physician order to discontinue care provided by St. Joseph Hospital.
c. Prior to discharge, post discharge needs are addressed.

5. Exclusion criteria:

a. ICP monitoring
b. Balloon Pump
c. Impella
d. Invasive hemodynamic monitoring lines, e.g. pulmonary artery line
e. Endotracheally intubated patients
f. CRRT
g. Nursing care requiring more frequent than every 1-hour interventions
h. Vasoactive medications requiring titration more frequent than every 1 hour
i. Paralytics: requiring ventilation, sedation and TOF monitoring.
j. Temporary transvenous pacemaker
k. Patients requiring immediate post-operative recovery, bypassing PACU
l. Moderate Procedural Sedation by DSU RN. Procedures may be done in DSU if the procedural department provides the monitoring and recovery, e.g. endoscopy monitoring by GI lab RN

6. Hours of operation

a. The Definitive Step-Down Unit is an inpatient unit that delivers care 24hour a day, 7 days a week.

7. Customers or Populations Served

a. The DSU staff delivers care to patients from different ethnic groups. This population is evenly distributed among genders. The average age groups are 30-90 years.

8. Department Goals

a. To properly direct staff according to the nature of the anticipated patient care needs and the scope of services offered.
b. To prepare all personnel for their responsibilities through appropriate orientation, in-service training and continuing education programs.
c. To guide patient care by written standards that meet regulatory and practice criteria (TJC, Title 22, AACN, etc).
d. To design and equip the unit to facilitate effective care and safety for patients and personnel.
e. To monitor, identify problems, plan, implement solutions, and evaluate the quality of patient care provided.
f. To maintain adequate resources (e.g., support services, supplies, equipment, ancillary personnel) to provide appropriate care to the DSU patient population and their significant others.
g. To support a Healthy Work Environment: Skilled Communication, True Collaboration, Effective Decision-Making, Appropriate Staffing, Meaningful Recognition and Authentic Leadership

9. Department Performance Improvement

a. The goal of Performance Improvement activities is to improve the existing processes and outcomes and then sustain the improved performance. Performance Improvement activities at SJO are consistent with the commitment of the ministry to provide the highest quality, comprehensive care to the people served. Improving quality of care is accomplished by identifying those issues that are high risk, low volume, problem prone, and high cost related to the care and services provided. Outcomes are consistently evaluated to assess effectiveness and provide feedback for improving care.
b. The Performance Improvement Model selected by SJO is the St Joseph Way. The St. Joseph Way is a framework and philosophy for continuous performance improvement -- organizing and improving work that emphasizes patient safety, quality standards, improved patient, physician, and staff satisfaction, operational and financial performance. Improving Performance: the St. Joseph Way acknowledges our heritage and assists in shaping our future.

c. Performance Improvement for the Definitive Step-Down Unit includes, but is not limited to:

1. Demonstrate increased compliance with ventilator bundle to eliminate Ventilator Associated Pneumonia (VAP) and to continue to monitor for compliance.

2. Demonstrate an increase in staff retention as evidence by a decreased turnover rate of ≤5% from last year.

3. Demonstrate compliance with the central line bundle to eliminate Central Line Associated Blood Stream infections.

4. Demonstrate compliance with foley bundle to eliminate Catheter Associated Urinary Tract Infections

5. Demonstrate compliance with glycemic management as evidenced by 80% of all Blood Glucose levels will fall into the range of 80-150mg/dl

6. Demonstrate increased compliance with 4-eyes inspections, following skin care protocol, prevent HAPU

10. Qualifications of Staff

a. Registered Nurses

1. Current unrestricted license in the state of California
2. Basic Life Support (BLS)
3. Advanced Cardiovascular Life Support (ACLS)

b. Secretary

1. High School Diploma

c. Nursing Assistant

1. High School Diploma
2. and/or at least 6 months of nursing school
3. Certified nursing assistant (CNA)

11. Staffing Plan

a. The number of staff on duty is determined by census and patient acuity. The census is used as a base to determine how many nurses are needed to provide care, measured in hours per patient day (HPPD). The number of nurses is adjusted to provide care based on patient acuity.

b. Primary nursing is the model used for care delivery. The ratio of patient to nurse is 3:1 depending on the patient's acuity and level of care needed.

c. Patient acuity is determined utilizing the GRASP patient classification system. Nurse competency is matched to patient acuity and patient care needs.

d. The DSU patients are not mixed in the same unit with MICU/CVICU patients. If more critical care beds are required, the DSU patients are triaged for proper placement.

e. The Nurse Manager oversees administrative management 24 hours a day.

f. A Clinical Coordinator/Charge Nurse is assigned daily to oversee the unit's daily shift operation.

12. Variance Staffing

a. Staffing will be increased or decreased to accommodate fluctuating volume and acuity. The clinical coordinator/Manager, Administrative Supervisor, or Central Staffing office handles accommodating staff variances.

b. The variances in staffing to accommodate increases in patient census and acuity are:

1. Utilizing per diem RN's, and secretaries

2. Utilizing nursing staff from other units, competent to work in the unit

3. Requesting existing staff to work additional shifts

4. Requesting support from agency personnel

c. The variances in staffing to accommodate decreases in patient census and acuity are:

1. Re-assigning staff within SJO
2. Utilizing SJO time-off policies

III. RELATED POLICIES:

Bi-Level Positive Airway Pressure (BiPAP) / Continuous Positive Airway Pressure (CPAP), PC-116

Scope of Services / Admission, Transfer and Discharge: Medical Intensive Care Unit (MICU)

IV. REFERENCES:

AACN Progressive Care Fact Sheet, Retrieved 10-17-12 http://www.aacn.org/WD/Practice/Docs/ProgressiveCareFactSheet.pdf

California Code of Regulations Title XXII Section: Admission, Transfer and Discharge Policies

Guidelines of Admission and Discharge for Adult Intermediate Care Units by the Society of Critical Care Medicine (1998). Critical Care Medicine: 26(3):607-610 retrieved 10-17-12 from: http://www.sccmorg/professional_resources/guidelines/table_of_contents/Docum ents/Adult_Interm_AD.pdf

Wiegand, D. L. (2017). AACN procedure manual for high acuity, progressive, and critical care (7th ed.). St: Louis, MO: Elsevier.

Approval Signatures

Step Description	Approver	Date

Standards

No standards are associated with this document