

Program Flexibility Application

Please do not include any patient identifying or personnel information in your application. The information in your application is considered public information and may be disclosed as part of a public records act request.

Contact Details

Please provide the applicant’s direct number should the Centralized Program Flex Unit have any questions regarding your application.

Applicant Contact Number *



Duration of Request

Requested Start Date *



08/09/2024

Requested End Date *



08/10/2026

Specify Type of Request *



☐ Emergency ☒ Non-Emergency

What regulation(s) are you requesting program flexibility for? *



Select Facility Type

General Acute Care Hospital

Search Regulations by Title or Regulation Number

Selected Regulations

Intensive Care Service Space, T22 DIV5 CH1 ART6-70499(a)(1)
(1) An intensive care unit shall consist of not less than four (4) nor more than twelve (12) patient beds, including at least one isolation room. Multiple, interconnected units may be approved by the Department.

Effective January 1, 2023, HSC 1276 (e) and (f) references a new category for a program flexibility request, for a **general acute care hospital (GACH)**, that allows the facility to designate a bed, or beds, in a critical care unit as requiring a lower level of care.

Is this request related to a GACH designating a bed, or beds, in a critical care unit as requiring a lower level of care? *



☒ Yes ☐ No ☐ N/A (Non-GACH Facility)

Request Description



Kaiser Foundation Hospital South San Francisco (KFH SSF) is requesting a program flexibility to care for telemetry patients in ICU when ICU census allows when there is a need to have overflow capacity of telemetry patients. Care would be provided at standard nurse ratio of 1:4 or 1:3 for these telemetry patients depending on the patient acuity. All policies and procedures that cover care in the telemetry unit would adhere to if this situation. Care is provided under the direction of the ICU Nurse Manager

JUSTIFICATION

Describe why program flexibility is needed. *

KFH SSF is requesting the flexibility as the demand for telemetry monitoring exceeds capacity of telemetry capable designated rooms. The ICU being used are vacant and would only be used if there is not a need for critical care beds.

ALTERNATIVE CONCEPT



Describe the proposed alternate method for meeting the intent of the regulation. Include the alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, or the conducting of pilot projects. Include a description of the provisions for safe and adequate care so that the proposed alternative does not compromise patient care. *

ICU rooms would be used to provide care for lower acuity telemetry patients when there is no need for ICU bed. The physician and nurse managers review appropriateness for continued telemetry monitoring daily. Those patients no longer requiring telemetry monitoring have the telemetry order discontinued. Expansion of telemetry capacity into other medical surgical rooms has been explored. The rooms proposed are generally not needed for ICU patients and are able to provide care for the needs of telemetry patients. All policies and procedures that apply to the telemetry unit would remain in effect for care in this setting. Care is provided under the direction of the ICU Nurse Manager and the Clinical Adult Nursing Director.

Additional Information



Provide any additional information as desired.

Attached picture show the oxygen outlets, cardiac monitor, handwashing sink and crash cart for the ICU-west area.



Please attach any supporting documentation for the request.

More than one document may be uploaded here.



ICUWESTHandwashingsinkadjacenttoroom107.jpeg

Date Attached: Aug 09, 2024



o2setupICUWrm106.jpeg

Date Attached: Aug 09, 2024



ICU WEST crash Cart rm101rm102.jpeg

Date Attached: Aug 09, 2024



ICUWEST02sxmonitorsetup.jpeg

Date Attached: Aug 09, 2024

Revise and Update



Add updates to the original application.

I agree to submit this application and certify under penalty of perjury that my answers are correct and complete to the best of my knowledge. I also certify that:



- I understand the questions and statements on this application.
- I understand the penalties for giving false information.
- I understand that this acknowledgment has the same legal effect and can be enforced in the same way as a written signature.
- I am authorized to submit this application on behalf of the licensee.
- This application does not include any patient identifying or personnel information.

This Information provided on this form is mandatory and is necessary for waiver approval. It will be used to determine whether to approve the request for a waiver. **The information in your application is considered public information and may be disclosed as part of a public records act request.** *



I acknowledge and agree to the above Terms of Acceptance