USC Arcadia Hospital
Keck Medicine of USC

Title: Admission, transfer and Discharge Creiteris foe Intermediate Care Unit (IMCU)	Page 1 of 5
Policy #: CR1042	
Type: Critical Care	
Standard: N/A	

PURPOSE:

To promote consistent guidelines for admission, discharge, and transfer (ADT) practices of the Intermediate Care Unit (IMCU) based on population served, severity of illness and intensity of services required. An intermediate care unit is defined as a unit which is organized, operated, and maintained to provide for the monitoring and care with moderate or potentially severe physiologic instability requiring technical support but not necessarily artificial life support. IMCU patients require less care than intensive care, but more than that which is available from medical/surgical care and not meant to be long-term.

POLICY:

1.0 The American College of Critical Care Medicine developed by consensus the following recommendations to promote safe triage of patients to intermediate care units. (CCM Guidelines, 1998).

1.1 Rating System

1.1.1 Level I: convincingly justifiable on scientific evidence alone.

1.1.2 Level 2: Reasonably justifiable by available scientific evidence and strongly supported by expert critical care opinion.

1.1.3 Level 3: Adequate scientific evidence is lacking but widely supported by available data and expert critical care opinion.

1.1 Admission criteria are based on the illness of severity, intensity of the service and acuity of the patient. IMCU is designed to provide nursing care services/practices at a 1:3 nurse to patient ratio and based on patient acuity of illness. Appropriate patients for this level of care require nursing reassessment/intervention every two (2) hours and less than four (4) hours.

1.2 Patients requiring nursing reassessment/intervention at a frequency greater than every two (2) hours for more than four (4) hours may be assessed for a higher or lower level of care.

1.3 The following categories of conditions or diseases that could quality for this level of care:

1.3.1 Cardiac Patients

1.3.1.1 Post procedural or clinical monitoring that requires between Q2 and Q4 hour frequency Patients with EKG changes or elevated troponins requiring Q2-Q4 monitoring.

1.3.1.3 Acute arrhythmias (bradycardia, tachycardia, intermittent) requiring interventions Q2-Q4 hours

1.3.1.4 Patients who may need drips but, do not require nurse driven titration.

1.3.1.5 Acute ST-Elevation Myocardial Infarction (STEMI) patients with no cardiac assist device, no balloon pump or drips.

1.3.1.6 Patients with epicardial pacing post cardiac surgery.

1.3.1.7 **Exclusion:** Patients with uncontrolled chest pain or cardiac arrest, uncontrolled significant arrythmias (Ventricular tachycardia, supraventricular tachycardia, or any arrhythmias requiring intensive unit care (ICU) with be transferred to the ICU.

1.3.2 Continuous Infusion

1.3.2.1 Inotropes and Vasopressor titration will be directed by provider order only.

1.3.2.2 Medication dosages based on IMCU medication guidelines.

1.3.2.3 Patients with stabilized acute clinical condition with titration off vasopressors or continuous infusions after an acute illness.

1.3.2.4 Patients whose inotropes are not titrated.

1.3.3 Neurological

1.3.3.1 Neurological checks will be performed every two (2) hours and less than four (4) hours.

1.3.4 Palliative Care and Pain Management

1.3.4.1 Patients who have uncontrolled pain medication requiring high dose medication and SpO2 and CO2 monitoring.

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1.3.5 Post -Op

1.3.5.1 Post operative surgical patients should recover in the Post Anesthesia Care Unit (PACU) before moving to the IMCU.

1.3.6 Renal

1.3.6.1 Patients that require electrolyte monitoring every 3 hours and above frequency.

1.3.6.2 Electrolyte abnormalities without EKG changes or hemodynamic instability

1.3.7 Transfusions

1.3.7.1 Patients who are asymptomatic/symptomatic anemia or bleeding requiring every 2–4-hour monitoring and intervention.

1.3.8 Vascular

1.3.8.1 Patient that require every 2 hours to 4-hour pulse checks.

1.3.8.2 Post operative patients requiring chest tube management.

1.4 Hemodynamic Stability

1.4.1 Patients with persistent change from baseline vital signs without improvement after intervention.

1.4.2 Hemodynamic monitoring every two hours or greater.

1.5 Respiratory

1.5.1 Patients with a Tracheostomy and on a ventilator requiring 3:1 nursing care.

1.5.2 Tracheostomy patients weaning off the ventilator.

1.5.3 Stable patients requiring high flow nasal canula (e.g. FiO2. than 60% or non-rebreather >80% maintaining O2 saturation >88%)

1.5.4 Patients requiring airway clearance or suction every 2 hours or less than 4 -hours.

Nasal Intermittent Positive Pressure ventilation (NIPPV)

1.5.5 Patients with continuous bi-level positive airway pressure (Bipap) with settings with a pressure support (PS) up to 15, FiO2 100%

1.5.6 Patients with Intermittent NIPPV as long as they may be off NIPPV for 2-hour periods every 4-6 hours and inspiratory positive airway pressure (IPAP) settings is less than or equal to 15. (Continuous NIPPV is acceptable).

1.5.7 Escalation criteria for a level of care upgrade assessment: If the patient requires an increase in FiO2 or IPAP requirements by 20% or more, without being able to bring patient back to previous setting within one hour.

Ventilator:

1.5.8 Vital signs stable for the past 24 hours (Systolic Blood pressure (SBP) >90, Heart Rate >50, Respiratory Rate between 12-24.)

1.5.9. No titration of vasoconstriction medications within the past 12 hours.

1.5.10 Last two ABG's show stable acidosis and/or hypoxia.

Exclusions:

1.5.11 Respiratory failure patients requiring full ventilation support via endotracheal tube.
1.5.12 Intubated patients
1.5.13 Chemotherapy
1.5.14 Continuous O2 monitoring is performed on tele unit.
1.5.15 Final IMCU decision will be based on clinical judgement.

1.6 Discharge/Transfer Criteria Will take place when:

1.3.6.1 When a patient's physiologic status has stabilized and the need for intensive patient monitoring is no longer necessary, and the patient can be cared for at a lower level of care.
1.3.6.2 When a patient's physiological status has deteriorated and active life support is required or highly likely, the patient will be transferred to a higher level of care.

References/Appendices

Critical Care Medicine 1998. Mar; 26(3):607-610 Guidelines on Admission and Discharge (anestit.org)

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