Progressive Care Unit Admission, Triage and Discharge Criteria

Purpose:
Criteria for admission into the Progressive Care Unit and discharge from the Progressive Care Unit at St Mary's Hospital-Madison

Policy:
Physicians with admitting privileges may admit to the Progressive Care Unit. The following guidelines were established as criteria for patient placement and prioritization.

Admission:
It is the responsibility of the primary physician to determine if a patient meets requirements for admission to or transfer from the Progressive Care Unit. The final decision for admission or discharge of a patient is normally made by the primary physician. In some instances, the consulting physician may make the decision for admission or discharge. A physician order is required to admit/transfer to the Progressive Care Unit.

Predicted patient population include the **Priority level 3** and may include **Priority level 4** patients as defined by the Society of Critical Care Medicine. Priority level 3 is defined as acutely ill patient with a lesser severity of organ dysfunction as compared to Priority level 1 and level 2 (defined below). Patients are at a high risk for deterioration but are not actively decompensating to the point of intensive care unit (ICU) environment therapies, thus requiring an intensive level of monitoring and /or frequent assessments with no active ICU interventions or treatments described in Priority 1.

> *Priority level 1* is defined as critically ill patient who requires life support for organ failure, intensive monitoring and therapies that can only be provided in the ICU environment by critical care trained staff. Life support includes invasive mechanical ventilation, continuous renal replacement therapy, intra-aortic balloon pump, invasive hemodynamic monitoring for the purpose of directing hemodynamic management.
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> *Priority level 2* is defined as critically ill patients requiring treatments and/or medications delivered in the ICU environment by critical care trained staff. From an operational stand point, Priority 2 is synonymous with Priority 1, in that patients are receiving the same level of treatments and interventions as Priority 1 but have a significantly lower probability of recovery and family/patient decision was made for no cardiopulmonary resuscitation in case of cardiac arrest. (DNR status)
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> *Priority level 3* is defined as acutely ill patient with a lesser severity of organ dysfunction as compared to Priority level 1 and level 2. Patients are at a high risk for deterioration but are not actively decompensating to the point of intensive care unit (ICU) environment therapies, thus requiring an intensive level of monitoring and /or frequent assessments with no active ICU interventions or treatments described in Priority 1.
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> *Priority level 4* is defined as acutely ill patients with a lesser severity of organ dysfunction as compared to Priority level 1 and 2. From an operations stand point, Priority level 4 is synonymous with Priority level 3, in that patients are receiving the same level of treatments and interventions as Priority level 3 but have a significantly lower probability of recovery and family/patient decision was made for no cardiopulmonary resuscitation in case of cardiac arrest (DNR status)

Priority level 5 is defined as patients with a terminal disease or condition with no possibility of recovery. Individuals are declining or have documented wishes declining intensive care therapies. Priority level 5 is not appropriate for a Progressive Care Unit environment and should be deferred with preference to initially offer palliative care.

The following are *absolute exclusions* for admission to the Progressive Care Unit

- Mechanical ventilation via endotracheal tube
- Intra-aortic Balloon Pump Therapy
- Continuous Renal Replacement Therapy
- Pulmonary Artery Catheter
- tPA for acute strokes
- Targeted Temperature Management
- Requiring more than one vasoactive medication
- External ventricular drain with continuous cerebral spinal fluid management

Triage and prioritization of current PCU patients:
It is the responsibility of the patient's Attending physician (or designee) to promptly transfer patients to lower levels of care when appropriate. When demand exceeds availability, the Hospitalist assigned to the PCU will determine which patients are to be given priority and help determine which patients may transfer to lower level of care. Triage decisions will be made without bias. The admission/discharge and triage criteria will also recognize patient autonomy, including advance directives, such as living wills, or durable powers of attorney for healthcare decisions.

The priority of patients admitted to the PCU should be revised continuously, formally daily during interdisciplinary care round, to identify patients who may no longer need PCU care:

- When a patient's physiologic status has stabilized and the need for PCU monitoring and care is no longer necessary.
- When a patient's physiologic status has deteriorated, and active interventions are no longer planned.

Disclaimer:

These clinical guidelines may not be appropriate for all patients under all circumstances. New information and evidence may become available that renders their content less valid. Practitioners must utilize their clinical judgment to determine what is helpful to them and what is appropriate.

REFERENCES:

Society of Critical Care Medicine---https://journals.lww.com/ccmjournal/Fulltext/2016/08000/ICU_Admission,_Discharge,_and_Triage_Guidelines__A.15.aspx

IV administration guidelines—http://intranet.ssmhc.com/entity/smhmadison/policy/PharmacyFormulary/Current%20IV%20Medication%20Administration%20Guidelines.pdf