The Miriam Hospital Administrative Manual	Subject: Intensive Care Unit Admission	File Under: Medical Staff MS-16 and A-60
Issuing Department: Department of Nursing	**Page of 1 of 3**	**Latest Revision Dates: 05/01/08**
Original Date:	**Approved By:**	

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PURPOSE

To promote the appropriate level of care for patients by providing guidelines for appropriate and efficient patient admission to the intensive care unit (ICU)

POLICY and PROCEDURES

Patient care in the intensive care unit (ICU) is delivered by a team that consists of critical care attending physicians, critical care fellows, critical care nurses, respiratory therapists, and house officers from the Departments of Medicine and Emergency Medicine.

I. ADMISSION CRITERIA

The following conditions are considered appropriate for admission to the ICU:

A. Neurologic Conditions

1. Acute stroke that has been treated with thrombolytic agents
2. Status epilepticus
3. Acute change in mental status that is perceived as life-threatening
4. Neuromuscular weakness with acute or impending respiratory failure

B. Cardiovascular Conditions

1. Any condition that requires intravenous infusion of a vasoactive agent
2. Any condition that might benefit from hemodynamic monitoring
3. Life-threatening arrhythmias
4. Arterial occlusion with limb ischemia at rest
5. Acute coronary syndromes complicated by numerous or severe co-morbid conditions

C. Respiratory Conditions

1. Respiratory failure:
    a. Acute respiratory failure
    b. Exacerbation of chronic respiratory failure
    c. Impending respiratory failure
2. Airway compromise

D. Fluid and Electrolyte Disorders

1. Hypovolemia with hemodynamic instability
2. Life-threatening electrolyte and acid-base abnormalities
3. Acute renal failure with potential need for dialysis
4. Any condition that requires hemofiltration or emergent hemodialysis.

E. Postoperative Care

Patients who do not meet the usual criteria for ICU admission will receive immediate postoperative care in the ICU if they have any of the following conditions.

1. Any condition or surgical procedure with a high risk of postoperative complications
2. An intraoperative adverse event

F. Specialized Care

Admission to the ICU may be necessary for initiation of specialized techniques that require close supervision (e.g. plasmapharesis).

II. ADMISSION PROCESS

A. Service Designation and Approval for Admission

1. All patients (except boarders) will be admitted to the Critical Care Service.
2. The critical care fellow assigned to the ICU must approve *all* admissions to the ICU (including PACU- and other boarders).
3. For all *emergency* admissions to the ICU, as soon as the attending physician or house officer is aware of the need to transfer a patient to the ICU, the on-call critical care fellow must be notified.
4. The critical care fellow will evaluate the patient and confirm that the ICU admission criteria are met. If the critical care fellow considers the patient not to be a candidate for the ICU and this cannot be resolved through the patient's attending physician, the critical care attending will make the final decision.

B. Elective Admissions to the ICU

1. All *elective* admissions to the ICU must be scheduled at least 24 hours before the time of admission.
2. To schedule an admission to the ICU:
    a. When the patient is scheduled for surgery, the surgeon will indicate to the O.R. Scheduling Office that an ICU bed will be needed postoperatively, *or*
    b. The attending physician or house officer will contact the on-call critical care fellow directly.

C. Direct Transfer from Another Facility

If a physician wishes to transfer a patient from another hospital to the ICU, the physician must contact the on call critical care fellow. TMH Policy and Procedure Manual, Administration Folder, A-64a: *Direct Transfer to ICU from Other Hospitals* must be followed.

D. Admission Medical Assessment and Orders

1. The patient must be evaluated immediately upon admission to the ICU by a house officer, attending physician, physician designee or consultant.
    a. Medical or surgical patients from the floor or PACU: The covering resident will discuss the patient with the ICU resident or critical care fellow.
    b. Postoperative surgical patients admitted from the operating room: The surgical resident will discuss the patient, including intra-operative events, with the ICU resident.
2. Orders
    a. Medical or surgical patients from the floor or PACU: The ICU resident will write ICU admission orders using the critical care admission order form or enter the written orders using the computerized order set.
    b. Postoperative surgical patients admitted from the operating room: The surgical resident will review the immediate postoperative orders with the ICU resident. The postoperative orders will be written or entered into the physician computerized order entry system by the ICU resident. The ICU resident shall also fill out the critical care admission order set, incorporating the postoperative orders and any changes.
    c. Orders must be written or rewritten or entered into the physician computerized order entry system within 30 minutes of admission, with specific attention to indicating the attending physician and service of record.
3. A medical admission note must be written within two hours of admission.

E. BOARDERS

Boarders from the PACU or other services in the hospital can be admitted to the ICU, but these patients are not the responsibility of the ICU team (i.e., attending, fellow, or housestaff).

1. Service Designation/Responsibility, non-PACU Boarders:
    a. CCU team covers all CCU boarders.
    b. CVT team covers all CVT boarders.
    c. Anesthesiologists, surgical residents and/or surgery attendings cover PACU boarders.
    d. General medicine team covers general medicine service boarders.
2. PACU Boarders
    a. Short-term care for PACU patients will be provided for up to six hours after admission to the ICU.
    b. If the patient requires care in the ICU beyond the six-hour limit for PACU boarders, the on call critical care fellow must be notified for the patient to be transferred to the Critical Care Service and the ICU Team.