Garfield County Hospital District
Caring for Generations

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| **Origination:** | *10/2012* |
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| **Last Approved:** | *03/2019* |
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| **Next Review:** | *03/2020* |
| **Owner:** | *Jayd Keener: DNS* |
| **Department:** | *Acute Care* |
| **References:** | |

# Acute Admission Criteria

## Purpose:

To establish standards for admission and discharge that meet the requirements of Medicare and render appropriate care to the individual and completion of appropriate assessments and care plans.

## Policy:

Hospital staff will follow the established guidelines for admission and discharge of patients.

## Procedure:



Admission criteria are used to verify the medical necessity of any hospitalization. Medical necessity as defined by CMS means **the patient has a condition requiring treatment that "can only be safely provided in a hospital setting"**. The following information outlines specific criteria that the GCHD hospital will adhere to.

**HOSPITAL PATIENT STATUS REQUIREMENTS:** Providers will determine a patient's status, in conjunction with input from the Nurse Manager or hospital Discharge Planner. This decision is based on the level of care that the provider believes or expects the patient will require during the episode of care; this status is documented by the provider in an order.

To determine a patient's status the admitting provider must:

- Assess the severity of the presenting signs and symptoms of the patient on presentation
- Attempt to predict the clinical course for the patient
- Estimate whether or not the patient's condition will require hospitalization of more or less than 24 hours
- Anticipate the intensity of services to be provided to the patient during the episode of care
- On presentation, order inpatient admission when the expected hospital care is 48 hours or longer **and** there is no less intensive setting available that will not be a threat to the safety or harm of the patient. Treat all other patients as outpatients, including outpatient observation.
- Patient status can be changed from outpatient to inpatient status: providers will use clinical judgment to determine if an outpatient should be transitioned to an inpatient stay due to care needed. **This requires a provider order.**

**Documentation required for all admissions:**
**Providers must document the reason for choosing a patient status. Medical records may be evaluated to determine the consistency between the provider order (intent of admission) the services actually provided (inpatient or outpatient) and the medical necessity of those services. The documentation will**

**be different for each patient, however both types of status require:**

- Provider order stating the patient status
- Treatment plan
- Documentation of allergies
- Medication history, medication reconciliation, and medication sheet, with diagnosis for each medication ordered.
- Emergency room documentation (if applicable)
- Provider readmission (readmission vs. admission-evaluation and assessment for direct admissions to outpatient observation)
- Medical necessity support in progress notes and response to treatment
- Discharge note and discharge instructions
- Rationale for change of status (if applicable)

The medical records should substantiate the care setting required, support the medical necessity for services provided and state the rationale to support the level of care ordered.

**OUTPATIENT STATUS: can be either outpatient status or outpatient observation status**

**OUTPATIENT/MEDICATION ADMINISTRATION ETC:**

Outpatients have orders for diagnostic testing or treatment that can be performed on an outpatient basis with an appropriate diagnosis/symptom to establish the medical necessity.



- Outpatient status occurs when a patient with a **known diagnosis** enters the hospital for a **minor procedure or treatment** that is expected to require a stay **less than 24 hours** regardless if a patient uses a bed.
- **Required documentation includes:**
    1. Face sheet
    2. H&P
    3. Provider progress notes
    4. Provider orders: medical necessity of services ordered documented, such as observation, radiology, heart monitor, lab procedures and medication orders
    5. MAR/TAR/IV flow sheets
    6. Nursing assessment
    7. Nursing notes **(must stay for monitoring for 20 minutes after injection/infusion, etc.**)
    8. Nursing graphics
    9. Diagnostic test results
    10. ABN (if applicable)
    11. Discharge instructions

**OUTPATIENT OBSERVATION:**

Observation patients though classified, as outpatients are more complex than a simple clinical outpatient who is presenting for a diagnostic test such as a CXR, lab panel or blood count. Observation patients generally:

- Present to the hospital on an unscheduled basis (no planned procedure)i.e. through the ED.
- Arrive **without** a providers order for tests or services

- Present to the hospital with a condition or symptom requiring immediate treatment and/or further evaluation to decide if the patient needs inpatient services (if the provider anticipates on presentation that the services will not require constant monitoring or the intensity of the services provided with inpatient services).
- Involve patient specific services; not services that are part of a protocol or standing orders
- Observation status does not generally **exceed 24 hours** but can be allowable up to 48 hours
- Observation hours begin when the patient is placed in the observation bed
- Observation hours end when the provider writes the order for acute inpatient admission or discharge
- **Required documentation includes:**

1. Face sheet
2. H&P
3. Provider progress notes
4. Provider orders: medical necessity of services ordered documented, such as observation, radiology, heart monitor, lab procedures and medication orders
5. CPR/Organ Procurement code sheet or POLST
6. MAR/TAR/IV flow sheets
7. Nursing assessment
8. Nursing care plan/problem list **(to be initiated at time of admission and completed within 24 hours of admission)**
9. Any change in the patient's condition shall require an immediate reassessment with changes in the plan of care reflecting the change in condition.
10. Nursing notes **(must chart every hour for OBS patients**)
11. Nursing graphics
12. Diagnostic test results
13. ABN (if applicable)
14. Discharge instructions
15. Preferred wording is "Outpatient Observation Status"
16. Medically necessary reason for observation status that is strictly unplanned outpatient service. Order must be dated and timed.

**Examples of acceptable use of observation:**

- Patient with serious condition that can probably be ruled out in less than 24 hours or an identified medical condition that is likely to abate in less than 24 hours
- Patient with an unconfirmed acute diagnosis that will require more intensive service if confirmed
- Patient with a condition that requires further monitoring and evaluation to determine the appropriate diagnosis and the need for admission
- If observation is associated with another outpatient services (ED evaluation) **there should be a clear event or decision point that triggers an order of physical transfer to mark the beginning of the observation period.**
- Postoperative complications following an outpatient procedure that require additional monitoring and evaluation beyond what is expected in the normal course of recovery for the procedure that was performed such as:

1. abnormal postoperative bleeding
2. poor pain management
3. intractable vomiting
4. delayed recovery from anesthesia

**INPATIENT STATUS:**

A patient is admitted for inpatient services based on the provider order and the expectation that the patient needs inpatient care.

- Provider expectation is **based on information available at the time of admission regarding the severity of the illness and the intensity of the services needed.**
- Inpatient status involves a complex medical judgment that is made after considering a number of factors including but not limited to:
    1. patient's history
    2. current medical needs
    3. severity of the signs and symptoms
    4. medical predictability of something adverse happening
    5. need for diagnostic studies to assist in assessing whether the patient should be admitted
    6. availability of diagnostic procedures at the time and location of presentation
    7. The provider intent at the time of admission is controlling. If in the judgment of the admitting provider, a patient has an acute condition that requires treatment in an inpatient setting at the time of admission, the provider should document this in the medical record. If the patient responds more rapidly to treatment than was anticipated, this should be documented. The medical record documentation will allow an outside reviewer to determine what the provider was thinking at the time of admission and understand that medical necessity for inpatient admission was present.
    8. patient leaving AMA
    9. patient transfer
    10. patient recovery in a shorter period of time
- **Time consideration:** The general rule is that the provider should order an inpatient admission for patients who are expected to need hospital care for 48 hours or longer and meet inpatient severity of illness and intensity of service.

**Documentation for inpatient status: (in addition to standards previously identified)**

- Patient face sheet
- Provider order( is required documenting medical necessity of inpatient stay)
- **Preferred wording "admit to inpatient status".** Inpatient status is based on the information available at the time of admission.
- CPR/Organ Procurement code sheet or POLST
- Provider discharge summary
- Provider H&P
- Provider orders
- Provider progress notes for each day of inpatient stay
- Nursing physical assessment

- Nursing care plan/problem list **(to be initiated at time of admission and completed within 24 hours of admission)**
- Any change in the patient's condition shall require an immediate reassessment with changes in the plan of care reflecting the change in condition.
- Nursing flowsheet
- Nursing notes (**must be comprehensive note every shift and charted on every 1-2 hours)**
- MAR/TAR
- IV flow sheets
- Diagnostic test results
- Nursing discharge plan
- Discharge instructions
- ABN (if applicable)
- Transfer form (if applicable)
- **NOTE: Outpatient observation converted to inpatient must have a physician order to inpatient admission and documentation in the chart supports the acute condition that requires treatment that can be safely provided only in the inpatient setting**

**Appropriate use of inpatient status:**

- Patient requires services that can only be provided in an acute care facility and the patient's clinical presentation (i.e. severity of illness) necessitates the need for high intensity of service with provider involvement with daily visits and close medical monitoring by health care professionals.
- Though a stay is less than 24 hours, the admit can be appropriate if it is reasonable for the provider to expect the presenting problem required more than 24 hours to resolve when the patient was admitted.

**Swing bed admission status:**

- Refer to Admission Swing Bed policy #620-9001

**EMERGENCY DEPARTMENT:**

- Patient face sheet
- Provider orders (should reflect medical necessity of hospitalization)
- Provider note
- Nursing ED assessment and medications sheets
- Diagnostic test results
- ABN (if applicable)
- Transfer form (if applicable)
- Discharge instructions

| Indications for Inpatient hospitalization: | Treatment documentation includes: | Discharge Screens: |
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| **Acute cardiac related pain or pressure:**<br>• acute dyspnea/ respiratory rate >30 per min<br>• acute absence of pulse at axilla, wrist, elbow, groin, knee or | • antiarrhythmic medications<br>• anticoagulation medications<br>• parenteral digitalization<br>• parental diuretic therapy | • Documented evidence of controlled chest pain after two days of appropriate activity<br>• no further progression of EKG changes and/or serial acute cardiac injury enzymes normal or decreasing for 24 hours<br>• Prothrombin time controlled or plans for |

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| ankle<br>• suspicion of pulmonary embolism<br>• 4+ pre-tibal edema or generalized edema<br>• syncope<br>• orthopena | • parental pressor therapy for CHF or HTN,<br>• cardioversion performed on an urgent basis for new onset of arrhythmia<br>• EKG monitoring<br>• fibrillation <24 hr. poorly controlled rate<br>• flutter <24 hr. poorly controlled rate<br>• bradycardia <50beats per minute or <45 beats per minute if patient on beta-blocker<br>• tachycardia >120 beats per minute<br>• dysrhythmia producing a rate >120 min<br>• medication monitoring | follow up as outpatient<br>• No intravenous Antiarrhythmic drugs for last 24 hours<br>• Vital signs stable for age for last 24 hours<br>• Transfer to another medical facility |
| **Change in mental status:**<br>• unconsciousness<br>• delirium<br>• disorientation<br>• motor function loss<br>• loss of sensation<br>• an abrupt deterioration over previous functional level<br><br>*** Provider documentation must substantiate the need for greater than 24 hours monitoring, treatment and/or observation** | • Diagnostic testing appropriate to needs of patient<br>• observation for head trauma<br>• medications administered at least two times daily<br>• documentation of effects of medications<br>• Vital signs every two hours<br>• Clinical signs of dehydration | • Vital signs within limits for age for 24 hours prior to discharge or an abnormal reading within 24 hours followed by a subsequent normal reading<br>• prescribed diet tolerated for last 12 hours prior to discharge<br>• self initiated activities of daily living<br>• voiding without difficulty for last 12 hours prior to discharge |
| **Dehydration clinical signs of dehydration including two or more of the following:**<br>• altered mental status<br>• decreased skin turgor<br>• dry mucous | • Intravenously administered volume<br>• documentation of intake and output<br>• daily weights<br>• documentation of mental status | • voiding without difficulty<br>• vital signs normal for last 24 hours prior to discharge<br>• patient and/or family received education for condition<br>• prescribed diet tolerated for last 12 hours prior to discharge |

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| membranes<br>• orthostatic,hypotension<br>• syncope<br>• tachycardia<br><br>**Pediatric**: sunken eyes or fontanels, weight loss >5% and/or decreased urine output | • vital signs | |
| **Endocrine symptom:**<br>• newly diagnosed adrenal, pancreatic, or pituitary mass<br>• patient admitted for definitive treatment of a known adrenal, pancreatic or pituitary mass<br>• diabetic complications | • B/S monitored at least 2 times per day<br>• documentation of changes in dosage or administration of medications and patient response<br>• monitoring of metabolic/endocrine lab parameters<br>• blood pressure monitored every 2 hours for a minimum of 8 hours<br>• documentation of comorbidities clearly defined and responses | • no change in dosage or types of insulin for 12 hours unless documentation reflects planned outpatient follow up<br>• no change in steroid therapy for 12 hours or patient receiving prescribed tapered dose of steroids<br>• blood sugar in acceptable range for 24 hours<br>• blood pressure controlled for 24 hours<br>• symptoms stabilized for 12 hours<br>• patient demonstrates ability to administer correct dose of insulin |
| **Gastrointestinal system:**<br>• blood in vomitus or gastric aspirate<br>• blood in peritoneal aspiration<br>• ascites<br>• acute or subacute dysphagia<br>• blood in stool<br>• nausea/vomiting | • appropriate diagnostic testing to identify cause/location of bleed<br>• parenteral antiemetic or anti-nausea medications at least 2 times daily with documented response to medications<br>• parental replacement of fluids/electrolytes with evidence of dehydration (per lab values) | • no purulent blood or vomitus<br>• no evidence of new bleeding<br>• parenteral analgesic administration not to exceed one dose within 3 hours to discharge<br>• documentation of improvement of dehydration<br>• prescribed diet tolerated for 12 hours prior to discharge without nausea/ vomiting (excluding chemotherapy patients) |
| **Musculoskeletal system:**<br>• dislocation of knee or hip;<br>• fractured pelvis | • neurovascular or circulatory checks at least every 2 hours<br>• bed rest with | • Ability to ambulate without assistance with walker, cane, crutches or wheelchair<br>• ability to transfer from bed to chair or |

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| requiring bed rest & medication for pain<br>• incapacitating muscle pain, spasm or edema<br>• swollen or painful joints requiring medication<br>• trauma/soft tissue injury/ laceration or crush injury requiring observation for neurologic or vascular compromise | medications for pain<br>• analgesic medication at least two times a day or continuous infusion<br>• Physical Therapy other than heat and massage<br>• Documentation of patient response to medications and treatment | commode<br>• satisfactory restoration of joint range of motion sufficient to permit outpatient management<br>• decrease in pain 12 hours prior to discharge |
| **Oncology:**<br>• significant weight loss,<br>• management of severe side effects (nausea, vomiting, diarrhea, etc)<br>• end of life or palliative care | • Appropriate medication administration to meet pain/side effects of patient<br>• rehydration measures as needed<br>• documentation of patient response to medications and treatments | • Patient and family received education for discharge; prescribed diet tolerated for last 12 hours prior to discharge without nausea/vomiting or appropriate arrangements made to address nutritional support in home setting<br>• Hospice arrangements |
| **Respiratory system:**<br>• chest pain-pleuritic type<br>• respiratory rate> 30 per minute or <10 per minute<br>• pleural effusion<br>• cyanosis<br>• dyspnea<br>• distended neck veins<br>• use of accessory muscles<br>• altered level of consciousness in patients with COPD<br>• intractable wheezing; orthopena<br>• O2 sats < 88% or <85% in patients with COPD supplemental oxygen | • appropriate diagnostic testing identifying pleural effusion, lung abscess or infiltrate<br>• provider documentation of worsening hypoxemia and hypercapnia with symptoms (dyspnea, decreased activity)<br>• documentation of outpatient treatment<br>• croup tent;<br>• chest tube drainage<br>• endotracheal suctioning and/or lavage<br>• chest physical therapy (CPT) 4 times per day<br>• nebulizer treatments with | • availability of necessary home therapy (02)<br>• provider progress notes reflect clinical improvement in respiratory status<br>• 02 sats remain within reasonable range 12 hours prior to discharge<br>• vital signs stable for age last 24 hours |

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| | bronchiodialators, mycolytics or steroids at least every 4 hours and documentation of patient response to TX<br>• anticoagulant therapy: initial TX or stabilization of dose requiring daily PT/INR | |
| **Skin/Connective tissue:**<br>• acute invasive infectious<br>• necrotic ulcer (s) involving deep muscle and bone<br>• infected ulcer<br>• hemorrhagic lesions<br>• petechial or eccymotic purpura with unknown etiology that is progressive with fever >100<br>• sepsis | • Wound debridement<br>• medication administration for infections and documentation of patient response to tx.<br>• wound dressings; skin care at least two times a day requiring hospital personnel<br>• parental fluid/ electrolyte replacement if necessary<br>• specific documentation regarding wound status<br>• diagnostic tests appropriate to identify infection | • no substantial bleeding, drainage or purulent drainage<br>• vital signs normal for age for 24 hours prior to discharge<br>• ability to ambulate prior to discharge |
| **Seizures:**<br>• seizure activity uncontrolled by medication<br>• new diagnosis of seizure activity | • administered medications and treatment<br>• diagnostic testing appropriate to identify reason for seizure<br>• documentation of patient response to tx | • no seizure activity for 24 hours prior to discharge<br>• mental status appropriate prior to discharge |
| **Urinary/renal system**<br>• acute elevation of BUN >40 mg/dL and creatinine>1.8 mg/dL; urinary output <20cc/hr or 400cc/24 hrs | • Radiology identifies blockage of ureter or renal pelvis<br>• Laboratory identifies infection of UTI<br>• Parenteral analgesic | • Voiding or draining urine without difficulty for the last 12 hours or arrangements have been made for voiding or urinary drainage<br>• parenteral analgesic administration not to exceed one dose within three hours |

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| • unexplained gross hematuria<br>• suspected or documented stone or obstruction with one of the following symptoms;<br>a. documented pain<br>b. nausea and/or vomiting<br>c. bleeding<br>• acute inability to void/ urinary obstruction<br>• UTI with systemic symptoms (vomiting, chills, fever, pain despite antibiotic treatment for 3 days)<br>• obstructed or non-visualized kidney | medications based on documented indications<br>• Screening of urine and identification of calcus<br>• Infusion of fluids<br>• Documentation of patient response to treatment<br>• I&O | prior to discharge<br>• no unexplained gross hematuria<br>• prescribed diet tolerated for last 12 hours prior to discharge |
| **Vomiting:**<br>• nausea<br>• diarrhea with dehydration | • Intravenously administered volume<br>• suppository medications<br>• documentation of patient response to treatment<br>• appropriate diagnostic tests | • No vomiting or diarrhea within past 12 hours<br>• prescribed diet tolerated for last 12 hours prior to discharge |
| **Wounds:**<br>• wound disruption<br>• hemorrhage from any site<br>• purulent drainage from wound | • Wounds sutured;<br>• Documented reasons for blood component transfusions >2 units within a 24 hour period or 2 units during hospital stay<br>• Documented response to treatment<br>• Appropriate diagnostic tests to identify infection<br>• Administration of antibiotic medications<br>• Administration of pain | • No evidence of bleeding for 24 hours<br>• INR controlled or plans for follow up as outpatient<br>• Prescribed diet tolerated for last 12 hours prior to discharge<br>• Patient demonstrates ability to change wound dressing |

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| | relief and patient response to treatment | |
| **Physical Rehabilitation:**<br>• Inability to function independently with<br>a. ADL's<br>b. Mobility | • Documentation that supports medical necessity of treatment<br>• Demonstrated ability to feed, dress and perform personal hygiene<br>• Demonstrates ability to transfer to and from wheelchair, ambulation and/or stair climbing<br>• Medical management by physician<br>• Physical therapy at least 5 times each week | • Maximum functional achievement through impatient rehab as determined by rehab team (patient has met goals)<br>• Services being provided can be provided on an outpatient basis at a lower level of care |

# Related Policies & Forms:

620-9001



# Attachments:

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| CEO Approval | Julie Leonard: CEO | 03/2019 |
| Department Manager Approval | Jayd Keener: DNS | 03/2019 |