Swedish Transfer and Operations Center (STOC) Admission Guidelines

Criteria	Patient Population	Inclusion Criteria	Level of Care	Considerations	Policy/ Guideline Statement	Units
Adult Med-Surg						
K+ (Serum Potassium)	General Med-Surg Patient	2.5 mEq - 6.0 mEq may be managed on a unit with remote cardiac monitoring	Med-Surg with remote cardiac monitoring	Patients with less than 2.5mEq or greater than 6.0 mEq are managed on a telemetry unit or higher	Remote Cardiac Tele Monitoring Acute Care	Ballard: Acute Care 4 South Cherry Hill: Neurology 5-East First Hill: Short Stay 3-Southwest, Nephrology 11-East, General Surgery- 10E, Oncology 12E, Clinical Decision Unit (CDU) Issaquah: General Medical 3 Olympic South, Surgical 4 Cascade
	Dialysis Patient	K+ between 6.0 mEq -8.0 mEq is acceptable for remote cardiac monitoring only if scheduled for STAT (less than 2 hours) dialysis		K+ above 8.0 mEq transferred to Telemetry or Higher level of care		FH: 11E only
Remote Cardiac Monitoring	General Med-Surg Patient	Chest pain: Low risk- with troponin and cardiac enzymes within normal limits with normal. ECG (unchanged from patient baseline) or with only non-specific, non-ischemic changes.		Exclusion Criteria: a) Clinical acuity of patient requiring Telemetry care or above. b) New and or unstable cardiac arrhythmias. c) Administration of continuous IV antiarrhythmic or other IV cardiac medications (see Medications with Special Requirements for Cardiac Monitoring)	Remote Cardiac Tele Monitoring Acute Care	Ballard: Acute Care 4 South Cherry Hill: Neurology 5-East First Hill: Short Stay 3-Southwest, Nephrology 11-East, General Surgery- 10E, Oncology 12E, Clinical Decision Unit (CDU) Issaquah: General Medical 3 Olympic South, Surgical 4 Cascade
		Syncope of unknown origin			Medications with Special Requirements for Cardiac Monitoring	
		Acute Stroke				Cherry Hill: Neurology 5-East

Criteria	Patient Population	Inclusion Criteria	Level of Care	Considerations	Policy/ Guideline Statement	Units
Telemetry						
K+ (Serum Potassium)	Telemetry	Patients with less than 2.5mEq or greater than 6.0 mEq are managed on a telemetry unit or higher	Telemetry	2.5 mEq - 6.0 mEq may be managed on a unit with remote cardiac monitoring	Remote Cardiac Tele Monitoring Acute Care	CH ICVU, 4-E non-high intensity beds, 3E Neuro-telemetry, CH SSU, Edmonds Telemetry, Issaquah Telemetry, FH 7SW, 10SW
	Dialysis Patient	K+ above 8.0 mEq transferred to Telemetry or Higher level of care		K+ between 6.0 mEq -8.0 mEq is acceptable for remote cardiac monitoring only if scheduled for STAT (less than 2 hours) dialysis on FH 11E only		
Mg (Magnesium)		Hypo or hypermagnesemia if stable (absence of hypotension or altered mental status) with dysrhythmias.		Consider IMCU for hypo or hypermagnesemia with hypotension (MAP less than 65 or systolic greater than 90mmHg) or dysrhythias.		
Patients Requiring Telemetry Monitoring		a) Clinical acuity of patient requiring Telemetry care or above. b) New and or unstable cardiac arrhythmias.		See inclusion criteria for considerations for Med/Surg Remote Cardiac Monitoring for cardiac pain, syncope, and acute stroke.	Medications with Special Requirements for Cardiac Monitoring	CH ICVU, 4-E non-high intensity beds, 3E Neuro-telemetry, CH SSU, Edmonds Telemetry, Issaquah Telemetry, FH 7SW, 10SW
Special IV Medications (e.g., antiarrhythmic)		c) Administration of continuous IV antiarrhythmic or other IV cardiac medicationsAmiodarone; Diltiazem, titrate (max 20 mg/hr), Nitroglycerine IV; titrate (max 50 mcg/min)				

Criteria	Patient Population	Inclusion Criteria	Level of Care	Considerations	Policy/ Guideline Statement	Units
Adult Intermediate Level of Care (IMCU)						
Patients Requiring Intermediate Level of Care (IMCU)	Adult Intermediate	a) Nurse to patient ratio of 1:3 is needed b) Frequent vital signs (every 2hrs, every 1hour for 4hrs after admission) and frequent nursing intervention c) High risk for decompensation as detailed in policy per organ system	Adult Intermediate	If there are placement appropriateness disagreements, it will be escalated to the ICU intensivist.	Intermediate Care Unit (IMCU) Admission and Continued Stay Criteria **Yet to be published	FH: IMCU, Edmonds IMCU
K+ (Serum Potassium)		K+ 2-2.5 mEq & 6-7 mEq *consider patient stability/trends*		Consider ICU for symptomatic hypokalemia or hyperkalemia where K+ is less than 2mEq or greater than 7mEq		
Na+ (Serum Sodium)		Hypo or hypernatremia with seizures, altered mental status		Consider ICU for symptomatic hyponatremia or hypernatremia where Na+ is less than 116mEq or greater than 165mEq		
Ca+ (Serum Calcium)		Severe hypercalcemia (Ca+ greater than 14mg/dL) with altered mental status, not requiring hemodynamic monitoring		Consider ICU for severe hypercalcemia requiring hemodynamic monitoring		
Mg (Magnesium)		Hypo or hypermagnesemia with hypotension (MAP less than 65 or systolic greater than 90mmHg) or dysrhythias.		Consider telemetry if stable (absence of hypotension or altered mental status) with dysrhythmias.		
pH		Severe acidemia or alkalemia with respiratory failure, hemodynamic instability (hypotension MAP less than 65 or systolic greater than 90mmHg or dysrhythmias or altered mental status.		Consider ICU for persistence of pH less than 7.2 or greater than 7.6 after initial stabalization or persistent hypotension.		

Cardiovascular		a) Mild to moderate congestive heart failure requiring CPAP/BIPAP b) Hemodynamically stable MI not requiring tissue plasminogen activator (tPA) therapy c) Hypertensive urgency without evidence of end-organ damage d) Hypotension responding to fluids		For hypotension, discuss with ICU intensivist for persistent hypotension after 2-4 liters, signs of volume overload, or not responsive to fluids on NICOM assessment; for ESRD/CKD4-5 patients after 1 liter max due to risk of CHF)		
CIWA		a) CIWA score of 15 or greater for 4 hrs on Med/Surg orderset b) Treatment with dexmedetomidine infusion		Consider IMCU for CIWA greater than 20 or RASS greater than 3+ for two consecutive assessments; or RASS score of -3 for 4-6hrs. Patients with RASS score -4 or -5 require transfer to ICU.	Intermediate Care Unit (IMCU) Admission and Continued Stay Criteria **Yet to be published	FH: IMCU, Edmonds IMCU
Endocrine		a) Diabetic ketoacidosis patients, with pH greater than 7.2 b) Thyroid storm or myxedema coma without hemodynamic instability		a) For diabetic ketoacidosis, consider patient stability and trends and transfer to ICU for depressed mental status, worsening anion gap or frequency of labs q2hrs or less b) For myxedema coma, consider ICU for hypotension, moderate or severe hypothermia, mild hypothermia not responding to treatment and depressed mental status.		
Gastrointestinal		Acute GI bleed with hematocrit greater than 18 and hemodynamically stable		Downgrade to med/surg for stable hematocrit x3 and hemodynamic stability, no high-grade lesion on endoscopy, no plan for repeat endoscopy evaluation within 24hrs.		

Pulmonary		a) Airway precautions (epiglottitis) b) Acute or chronic respiratory failure on non-invasive ventilation with appropriate indications and who demonstrate improving trends and stability with oxygenation and hypercapnia. c) Hypoxemia requring HFNC d) Chronic respiratory failure requiring positive pressure ventilation e) Acute asthma or COPD exacerbation with high risk for decompensation f) Frequent (no more than q2hr x2; then Q4) nasotracheal or tracheostomy suctioning g) New tracheostomy not requiring mechanical ventilation				
Sepsis		Severe sepsis patients, septic shock patients that meet diagnosis by lactate greater than 4 only, with no need for vasopressors and has responded to fluid.		If vasopressors are required, transfer to ICU.	Intermediate Care Unit (IMCU) Admission and Continued Stay Criteria **Yet to be published	FH: IMCU, Edmonds IMCU

Criteria	Patient Population	Inclusion Criteria	Level of Care	Considerations	Policy/ Guideline Statement	Units
Adult Intensive Care Unit (ICU)						
Patients Requiring Intensive Care Unit Level of Care (ICU)	Adult Intensive Care	a) Nurse to patient ratio of 1:2 is needed b) Frequent vital signs and frequent nursing intervention c) High risk for decompensation as detailed in policy per organ system	Adult Intermediate	If there are placement appropriateness disagreements, it will be escalated to the ICU intensivist.	ICU Admission Transfer & Triage Guidelines	FH: ICU, CH CVICU, CH Neuro ICU, Edmonds ICU, Issaquah ICU
K+ (Serum Potassium)		K+ Less than 2.0 mEq or Greater than 7.0 mEq		Consider IMCU for asymptomatic hypokalemia or hyperkalemia where K+ is 2-2.5 mEq & 6-7 mEq.		
Na+ (Serum Sodium)		Symptomatic hyponatremia or hypernatremia where Na+ is less than 116mEq or greater than 165mEq. Chronic vs. Acute hypnatremia (HM)				
Ca+ (Serum Calcium)		Severe hypercalcemia (Ca+ greater than 14mg/dL) with altered mental status, requiring hemodynamic monitoring		Consider IMCU if hemodynamic monitoring is not needed.		
pH		Persistence of pH less than 7.2 or greater than 7.6 after initial stabalization or persistent hypotension.		Consider ICU for persistence of pH less than 7.2 or greater than 7.6 after initial stabalization or persistent hypotension.	ICU Admission Transfer & Triage Guidelines	FH: ICU, CH CVICU, CH Neuro ICU, Edmonds ICU, Issaquah ICU

Cardiovascular		a) Moderate/severe congestive heart failure requiring CPAP/BIPAP b) Hemodynamically unstable MI requiring tissue plasminogen activator (tPA) therapy c) Hypertensive urgency with evidence of end-organ damage d) Hypotension not responding to fluids		SBP Less than 80 mm Hg (or 20 mmHg below usual pressure) DBP Less than60 mm Hg Greater than 120 mm Hg MAP Less than 60 mm Hg		
CIWA		CIWA greater than 20 or RASS greater than 3+ for two consecutive assessments; or RASS score of -3 for 4-6hrs in IMCU. Patients with RASS score -4 or -5 require transfer to ICU.				
Endocrine		a) For diabetic ketoacidosis, consider patient stability and trends and transfer to ICU for depressed mental status, worsening anion gap or frequency of labs q2hrs or less b) For myxedema coma, consider ICU for hypotension, moderate or severe hypothermia, mild hypothermia not responding to treatment and depressed mental status. c) Blood Sugar greater than 800 mg/dL	Adult Intensive Care			
Ischemic and Hemorrhagic Strokes		Hyper-acute stroke patients where treatment involves the timeliness and effectiveness of the acute treatment of both ischemic and hemorrhagic strokes and the prevention of complications. Thrombectomy and subarachnoid hemorrhage/ICH transfer to CH.		See Transfer of Cerebrovascular Patients for considerations in transfer to CH or other levels of care.	Swedish Command Center- Hyper-acute Stroke Patient Protocol for ED and ICU Charge RN and House Supervisor	
Pulmonary		a) Airway precautions (epiglottitis) b) Acute or chronic respiratory failure on non-invasive ventilation with appropriate indications and who demonstrate improving trends and stability with oxygenation and hypercapnia. c) Hypoxemia requring HFNC d) Chronic respiratory failure requiring positive pressure ventilation e) Acute asthma or COPD exacerbation with high risk for decompensation f) Frequent (no more than q2hr x2; then Q4) nasotracheal or tracheostomy suctioning g) New tracheostomy not requiring mechanical ventilation			ICU Admission Transfer & Triage Guidelines	FH: ICU, CH CVICU, CH Neuro ICU, Edmonds ICU, Issaquah ICU

Sepsis		Severe sepsis patients, septic shock patients that meet diagnosis by lactate greater than 4 only, with need for vasopressors.				
Special IV Medications (e.g., antiarrhythmic)		See Medications with Special Requirements for Cardiac Monitoring			Medications with Special Requirements for Cardiac Monitoring	
Ventricular Assist Device (VAD)/ Impella		Initial Post-operaative management		Transfer 4E or ICVU once stable		CH: CVICU

Criteria	Patient Population	Inclusion Criteria	Level of Care	Considerations	Policy/ Guideline Statement	Units
Pediatrics						
Cardiovascular	Pediatric	a) Syncope/pre-syncope and hemodynamically stable b) Hypertension-stable on oral medications c) Medication adjustments d) Cardiac dysrhythmias	Intermediate	All Intermediate Care patients will have a pediatric intensivist consultation after 24hrs of Intermediate Care status, if patient is unstable or requested by admiting LIP and it will be a the disretion of the Pediatric Intensivist if ongoing involvement is appropriate.	Intermediate Care Admission Criteria	PICU 9E or Pediatrics 9E
Endocrine	Pediatric	a) Glucose sampling greater than q2hrs b) HCO3 greater than 10 c) Intermittent insulin dosing (no continous insulin gtt) d) No altered mental status				
Surgery		a) Complex wound care greater than 3 times per day and greater than 30 mins b) Neurologically and/or cognitively impaired c) Pain control via PCA with basal rate d) Requiring fluid resuscitation more frequent than Q4hrs e) Epidural f) Osteotomy	Intermediate		Intermediate Care Admission Criteria	PICU 9E or Pediatrics 9E
Gastrointestinal		a) Fluid replacement greater than q4hrs b) Jaundice, progressive, greater than or equal to one elevated AST/ALT or Elevated PT/decreased factorV without active bleeding				
Sepsis		Sepsis syndrome/SIRS and hemodynamically stable; requires frequent or continuous fluid resuscitation				

Neuro/Neurosurgery		a) Infrequent seizures requiring frequent monitoring or intervention b) Controlled seizures with occasional break though seizures requiring frequent monitoring or itnervention c) New onset seizures without respiratory distress d) Withdrawal syndrome, mild to moderate without delirium e) Near drowing without mental status changes f) VP shunts with other risk factors g) Craniofacial greater than 24-48hrs after inital repair with minimal facila swelling and no risk for airway compromise		No EVDs on 9E Peds		PICU
Pulmonary/ENT		a) Continuous nebs less than 4hrs b) No Mg Sulfate IV (continous or bolus) c) No Terbutaline gtt d) Newly placed chest tube e) Infants with unwitness apnea by healthcare provider f) Heated high flow Nasal Cannula O2 g) Pneumothorax without chest tube h) Pneumomediastinum with subcutaneous emphysema				PICU 9E or Pediatrics 9E
Renal	Pediatric	Anuria/oliguria with less than 1ml/kg/hr (1 year old or less) or greater than 0.5ml/kg/hr (1-17years) responsive to fluid challenge	Intermediate		Intermediate Care Admission Criteria	PICU 9E or Pediatrics 9E
Toxic Ingestion/Exposure	Pediatric	Altered mental status, no respiratory instability, no loss of airway protective mechanisms, hemodynamically stable, smoke inhalation and O2 sats 90% or greater, CO2 poisoning without CNS changes or altered mental status, no risk of delayed onset of respiratory depression, altered mental status, hemodynamic instability, Steven Johnson Syndrome				

Neonatal Patient Less than 72 years old	Neonatal	a) Acute respiratory distress one or more of the findings: Chronic lung disease; Grunting/nasal flaring/retractions; Hyaline membrane disease (HMD)/RDS on imaging; O2 sats less than 90% on RA; Perinatal hypoxia/ hypercarbia/metabolic acidosis evidenced by one or more: (Apgar score 7 or less at 5 min; Bag-valve mask ventilation/ intubation greater than 5 min; Cord blood/ scalp pH less than 7.20); Respiratory rate greater than 60/min, sustained or at rest; Transient tachpynea of newborn (TTN)/retained fetal lung fluid b) Apnea of prematurity c) Cyanosis on less than 40% (0.40) FIO2 d) Cyanosis on less than 40% (0.40) FIO2 e) Infection, congenital (ie., syphilis, Toxoplasmosis, CMV, Herpes, Hepatitis B) f) Planned admission post surgery/procedure g) Polycythemia with central Hct greater than 65% / heel stick Hct greater than 72% and not requiring exchange transfusion h) Seizures, suspected/ potential i)Withdrawal symptoms/ withdrawal scoring greater than 7 Q2-4hr x 3 requiring intervention	PICU			PICU
	Neonatal	a) Infant of diabetic mother (IDM), one or more of the following: BS less than 40 mg/dL (2.2 mmol/L) requiring at least Q3hr PO feedings/ IV glucose; Jitteriness/ lethargy/ temperature instability; Apnea b) Jaundice first 24 hours of life c) Birth Weight less than 2000 g Large/ small for gestational age, requiring evaluation for complications d) Dehydration greater than 10% by weight loss e) Specialist evaluation, one or more: Anuria 24 hours of life or greater; Congenital/ genetic disease requiring supportive treatment; Failure to pass meconium; Hypotonia/ hypertonia	Intermediate			PICU 9E or Pediatrics 9E

Criteria	Patient Population	Inclusion Criteria	Level of Care	Considerations	Policy/ Guideline Statement	Units
Neonatal						
Gestation	Full Term Newborn	37 weeks gestation or greater; greater than or equal to 2000 grams	Post-Partum Unit	Consider NICU/SCN for the following: Vital signs not within defined limits; Need for supplemental oxygen; Apgar score of less than or equal to 6 at 10 minutes of life; Naloxone (Narcan®) administered to infant	Care of the Term Newborn	Postpartum FH, Issaquah, Edmonds Birth Center
	Late Preterm Infant	35 0/7 through 36 6/7 weeks gestation at birth and greater than 2000 grams	Post-Partum Unit	Consider NICU/SCN for the following: Deterioration of vital signs including respiratory distress, cyanosis, and bradycardia; Any apneic episode lasting more than 20 seconds; Chemstrip or serum glucose outside of acceptable limits; Any significant changes from the most recent assessment; Change in activity; Need for gavage feed because of poor, intolerance of, or refusal of feedings; Abdominal distention, bilious vomiting; Intermediate or high risk bilirubin results per BiliTool™; Clinical instability as determined by LIP	Care of the Late Preterm Infant	Edmonds LDRP, FH PP, Issaquah PP

	Late Preterm Infant	Less than 35 weeks gestation at birth or less than 2000 grams	NICU/SCN	If the mother is still hospitalized, the infant may be transferred to the mother-baby unit only if the infant has: Completed three successful feedings with consistent bedside glucose check of 47 mg/dL or above and vital signs are within defined limits and stable for 12hrs.		FH NICU/SCN; Issaquah NICU; Edmonds NICU
Born at Swedish	Newborn	a) All viable premature infants regardless of gestational age. b) Low birth weight infants (less than 2.0 Kg) and/or less than 35 weeks, requiring 24-hour observation. c) Full-term infants with evidence of illness or maladaptation to extrauterine life. d) Infants awaiting transfer from SMC NICU to another tertiary care center.	Neonatal Intensive Care Unit		Addendum J. Admission to the NICU	FH NICU
	Newborn	a) Recovering neonates from the intensive care unit. b) Babies without anticipated feeding complications. c) Stable respiratory status (in room air or supplemental ambient oxygen). d) Additional points of consideration, such as apneic events, active seizures, etc	Neonatal Intermediate Care Unit	May consider Pediatrics for stable infants who are in the convalescing or chronic phase of illness, or infants who have special needs and whose parents may benefit from a supervised rooming-in environment prior to discharge.	Addendum K: Transfer from NICU	FH NICU/SCN; Issaquah NICU; Edmonds NICU
Outside Admission	Infants born outside of Swedish	a) Infants from another care center who are in need of SMC NICU services b) Infants born while mother was in transit to SMC or who were born at home and require intensive care after birth.	NICU/SCN	Outside admissions require that the attending physician have full pediatric privileges at SMC or that a designated attending physician with full privileges agrees to accept the admission prior to transfer.	Addendum K: Transfer from NICU	FH NICU/SCN; Issaquah NICU; Edmonds NICU

Criteria	Patient Population	Inclusion Criteria	Level of Care	Considerations	Policy/ Guideline Statement	Units
Perinatal						
Triage	Perinatal	Class 1 Immediate	Triage to LD or Antepartum	Uterine contractions; severe abdominal pain, vaginal bleeding, severe pregnancy induced hypertension, decreased or absent fetal movement, history of trauma	OB Triage Patient Management	Edmonds LDRP, FH LD, FH PP, FH Antepartum, Issaquah Antepartum, Issaquah LD, Issaquah PP
Triage		Class 2 Urgent	Triage to LD or Antepartum	Premature reupture of membranes at 20-36 weeks gestation; fetal movement present and not contracting	OB Triage Patient Management	Edmonds LDRP, FH LD, FH PP, FH Antepartum, Issaquah Antepartum, Issaquah LD, Issaquah PP
		Class 3 Non-Urgent	Triage to LD or Antepartum	Spontaneous rupture of membranes at term, fetal movement present and not contracting, fever/chills, backache, rash, psychosocial problems, presenting for a scheduled procedure such as a version or C/S		
Postpartum		Following delivery and recovery, patients may be transferred to the mother-baby postpartum unit//return to the antepartum unit/stay in their LDR room until discharge.	Post-Partum Unit or LDRP	Average length of stay for patients having a vaginal birth is 24-36 hours post birth; Cesarean birth is 48-60 hours post birth. Generally, determined by physiological status	Perinatal Services Dept. Manual: (FH Campus); Care of the OB Patient In Non-OB Units	Edmonds LDRP, FH PP, Issaquah PP
Active Labor		Labor • SROM • Obstetric or medical complication • Fetal or maternal assessment not WNL	Labor and Delivery, LDRP			Edmonds LDRP, FH LD, FH PP, FH Antepartum, Issaquah Antepartum, Issaquah LD, Issaquah PP
High-Risk antepartum		Women with pregnancy complication 20 weeks or > Ex, placenta previa, premature rupture of membranes, premature labor, preeclampsia, diabetes mellitus, and hyperemesis	Admitted to the antepartum area or to labor and delivery			Edmonds LDRP, FH LD, FH Antepartum, Issaquah Antepartum, Issaquah LD
Invasive Monitoring	Perinatal	Pt requiring invasive vascular monitoring and/or endotracheal intubation with ventilator management	Adult Intensive Care Unit	Perinatal Services providing obstetrical care.		FH ICU