


Name of Policy: <u>Access to Care</u> Policy Number: 3364-100-01-17 Department: Hospital Administration Approving Officer: Chief Executive Officer - UTMC Responsible Agent: Manager, Outcome Management Scope: The University of Toledo Medical Center	 Effective Date: 8/1/2020 Initial Effective Date: December 1, 2006
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy	<input type="checkbox"/> Minor/technical revision of existing policy <input checked="" type="checkbox"/> Reaffirmation of existing policy

(A) Policy Statement

It is essential that appropriate measures be in place to maximize the capacity of the nursing units.

(B) Purpose of Policy

To maximize patient throughput, prevent delays in admissions, or cancellations of planned procedures.

(C) Procedure

Communications

1. An 8:15am bed meeting will be held daily in the hospital to review current census and anticipated throughput. Representatives from each patient care area, Nursing Administration Staff (House Supervisors (HS)/Admission Coordinators (AC)) and environmental services will attend. Patients with scheduled admissions are assigned available beds, anticipated discharges are discussed, and available beds for additional admissions are identified.
2. All care givers must identify patients’ discharge planning needs upon admission so these can be addressed timely and not become barriers at the time of the actual discharge.
3. Physicians should write discharge orders and reconcile discharge medications as early as possible to facilitate completion of the discharge process in a timely manner.
4. Final discharges will be communicated by the bedside RN, or the Lead RN in the Care Organizer ordering system using the discharge complete order when the patient has been discharged from the unit. .
5. The HS/AC will collaborate with Environmental Services of the discharges and will determine the need for a “stat” clean by placing this into the ABC Tracking Board. The HS/AC will communicate with Environmental Services and Lead Staff to coordinate any immediate requests that have been identified during periods of high census within the hospital. (an additional bed meeting will be held at 2pm during periods of high census when necessary)
6. Physicians and departments are to call all requests for “beds” and/or direct admissions to the Nursing Administration Staff (HS/AC) at 419-383-2337 (BEDS). Should an outside/regional transfer be considered for admission, Hospital Administration policy #3364-100-01-11 “Regional Transfers” will be enacted to manage this type of admission. The HS/AC will work with the various patient care areas to identify appropriate beds for admissions and will notify the requestor of bed availability. Only the HS/AC can assign floor beds. The HS/AC will assign all ICU beds, step-down beds and any overflow bed use in PACU, or the ED.
7. HS/AC will notify Lead RN’s, representatives from various admission areas, environmental services, and appropriate Attendings when there are no beds, and patients are waiting.

Coordination of Daily Bed Assignments

1. Unit and bed assignments are based upon individual patient care needs. All assignments are coordinated by the HS/AC, attending physician, and Lead or Charge nurses. All bed assignments (including transfers) must be coordinated with the HS/AC.
2. Unit and room assignments should be focused on directing major patient populations to units best skilled in providing specialized nursing care and based upon the assessment of level of care (ICU, Stepdown, and Medsurg):

- a. Presence of infection or isolation needs;
 - b. Complexity of nursing care needs;
 - c. Diagnosis;
 - d. Age;
 - e. Gender; and
 - f. Patient's condition/status.
3. General guidelines to be used in room assignments include:
- a. Telemetry is available on all floors;
 - b. 6AB: Medsurg, Ortho, Pediatric Ortho, and overflow;
 - c. 5CD: Medsurg, Family Medicine, Stroke, , and Neurosurgery,
 - d. 5AB: Step Down, Gen and Vas Surgery, Trauma, Vascular, and Plastics
 - e. 4CD: Medsurg, Hem, Onc, Gyn, Pulmonary-no crisis, ENT, and Ophthalmology,
 - f. 4AB: Stepdown, Medsurg, Medicine, GU, Hemo, and Transplant;
 - g. CVU: ICU, Step down Cardiac, CT Surgery, and Pulmonary.
 - h. SICU: ICU, Surgical, Vasc, and Trauma
 - i. MICU: ICU, Medical, Neuro
4. When units are full and unable to take their usual patients, patients will be assigned a bed on any available unit.

Coordination of Bed Assignment during Periods of High Census

1. Rounds on the patient care unit will be conducted to determine points of patient movement (transfers/discharges). These rounds will be conducted by the House Supervisor on duty.
2. Nurse Directors will assess the bed availability on their unit(s) on an ongoing basis, assure that all discharges/transfers have been communicated to the HS/AC, and seek physician assistance in discharging patients.

Prioritization of Patient Flow

1. When only one SICU/MICU bed, one step down bed, and/or two med/surg beds are unoccupied, beds will be assigned in priority by the HS/AC, Nursing Administration or the Nursing Director. The Medical Director, or designee, will be contacted for assistance in decision-making as needed.
2. When no ICU beds are available for new admission in the SICU or MICU, beds will be assigned by the HS/AC utilizing PACU, the ED, and CVU as ICU level of care holding areas. Staffing level and nurse skill set will reflect patient status (ICU or Stepdown).
3. The patient that is to receive ICU level care in the ED holding area may only be a patient that has been brought to the ED and admitted. A floor or post-surgery patient may not be sent to the ED holding area.
4. Should any patient in the facility be of such severe acuity (post code, impending arrest or post-op high acuity) and there is no question that the patient must be transferred to an ICU bed, and an ICU bed is not available, then an CVU or PACU bed may be utilized if available and the patient will be transferred to this bed. This patient will be placed in PACU/CVU with an ICU trained nurse that has the skill set and has met competency requirements necessary to provide care for the patient.
5. If available float staff is not of a sufficient skill level to care for this patient then the HS/AC is to pull an appropriately skilled nurse from SICU, MICU, or the CVU to care for the triaged patient.
6. When 5AB, 4AB or CVU beds are unavailable, PACU may be used for step-down. The incorporation of a ProPacc for monitoring must be used with the physician's permission and appropriate staffing to facilitate monitoring.
7. When bed space in the PACU or CVU is not available, the bedded patient may be kept in their existing room, however an ICU trained RN that has skills commensurate with the patient's needs, will be assigned to the patient by the HS/AC. The physician will be kept apprised of the patient's status.
8. The Medical Director or Chief of Staff will then be responsible for making the decision as to who to triage out of SICU or MICU to provide a bed for the more emergent patient in the ED, Floor, CVL or from surgery. This will be communicated to the HS/AC and executed as directed.

9. In the event that a floor patient's condition deteriorates even to the point of coding and an ICU or PACU bed is unavailable, the HS/AC may place the patient on a monitor (hardwire or ProPacc) and place an ICU skilled nurse with that patient on the floor until an ICU or PACU bed becomes available.
10. When more than one ICU pending patient is waiting for a bed to become available, the HS/AC, the medical director or his designee will be responsible for making the triage decision as to the order with which the ICU pending patients will be selected and placed in the first forthcoming ICU bed.

Management of Hospital Beds

The Nursing Units and Nursing Administration Staff will adhere to the following protocol for the assignment of beds. When only one SICU/MICU bed, one step-down bed, and two med/surg beds are unoccupied, beds will be assigned in the following priority, with the HS/AC making the final judgment depending on the specific circumstances encountered. The Medical Director, or designee, will be contacted for assistance in decision-making. The guidelines are as follows:

1. Intensive care beds will be assigned to patients requiring SICU/MICU/CVU care in the following priority based on overall hospital clinical needs:
 - a. Post code in-house patients.
 - b. In-house emergencies (may consult with Medical Director or Chief of Staff).
 - c. Transfers from other facilities.
 - d. ED patients.
 - e. Post-op surgical patients.
2. Other beds (Med/Surg, Step Down Care) will be assigned in the following priority based on overall hospital clinical needs:
 - a. ICU transfers to other units – if an ICU bed is needed.
 - b. Transfers from other facilities.
 - c. Emergency department admissions.
 - d. Post-surgical patients/post procedural patients (i.e. – CVL patients).
 - e. Clinic admissions.
 - f. Elective admissions.
3. Physicians should order the level of care required for the patient (ICU, step down, or med/surg). To meet the prescribed level of care ordered and to meet special needs of patients, Nursing Administration Staff will determine the most appropriate bed/unit for the patient.
4. If only one ICU bed is available and the patient meets admission criteria for an ICU bed, the attending service of the ICU with the open bed will not refuse to relinquish the bed for another service. Acuity of the patient and not the attending service should determine bed utilization.

<p>Approved by:</p> <p>/s/ _____ 07/10/2020 Richard P. Swaine, CPA Chief Executive Officer – UTMIC Date</p> <p><i>Review/Revision Completed By:</i> HAS Nursing</p>	<p>Review/Revision Date:</p> <p>5/9/07 3/24/2011 5/1/2014 8/1/2017 8/1/2020</p> <hr/> <p>Next Review Date: 8/1/2023</p>
<p>Policies Superseded by This Policy: 7-01-17 - Access to Care</p>	