Name of Policy: Admission and Discharge Criteria for Intensive Care Units **Policy Number**: 3364-100-01-09 **Approving Officer**: Chief Medical Officer, Chief of Staff **Responsible Agent**: Chief Medical Officer **Scope**: University of Toledo Medical Center and its Medical Staff	UTOLEDO HEALTH **Effective date: 4/2025** **Original effective date**: 6/25/1987
Key words: Criteria, Admission, Discharge, Intensive Care Units, Patient Safety	

☐	New policy proposal	☐	Minor/technical revision of existing policy
☒	Major revision of existing policy	☐	Reaffirmation of existing policy

(A) Policy statement

The University of Toledo Medical Center (UTMC) establishes criteria for admission to and discharge from the center's intensive care units (ICUs).

(B) Purpose of policy

Prioritize safe patient care and ensure appropriate and efficient ICU bed utilization by outlining mechanisms for:

1. Admitting patients to the intensive care units based on clinically based criteria.
2. Assigning available ICU beds to the most appropriate patients.
3. Address overflow placement of ICU patients during times of maximum bed occupancy.
4. Coordinate appropriate patient discharge from the ICU.

(C) Procedure

The specific procedures relating to admission and discharge for the intensive care units (ICUs) are outlined below. The outlined admission criteria are not all inclusive and circumstances may arise that necessitate deviation from the below stated criteria.

1. **ICU**
    a. Vital Sign Criteria:

        i. Pulse or Heart Rate <50 or >150 beats per minute
        ii. Systolic Blood Pressure <85 mm Hg or >190 mm Hg
        iii. Diastolic Blood Pressure > 120 mm Hg
        iv. Respiratory Rate > 35 breaths/minute
        v. Respiratory Rate < 8 breaths/minute
        vi. Temperature <32 °C or > 40 °C

b. Respiratory Criteria:

i. PO2 < 60 mm Hg or FiO2 > 50%
ii. PCO2 > 50 mm Hg
iii. pH < 7.3 or > 7.6
iv. Mechanical ventilation
v. Initial Non-invasive positive pressure ventilation (NIPPV) with impending respiratory failure
vi. Impending respiratory failure

c. Abnormal Lab Criteria:

i. Glucose < 40 or > 500 mg/dl
ii. Sodium < 115 mEq/L or > 160 mEq/L
iii. Potassium < 2.5 mEq/L or > 6.0 mEq/L with or without ECG changes or arrhythmias
iv. Calcium < 6 or > 12 mg/dl
v. Hemoglobin < 6 g/dL

d. Clinical and Diagnosis-related Criteria:

i. Mechanical ventilation
ii. Status epilepticus
iii. Care requiring infusion of vasopressor medications
iv. Care requiring use of infusion of hypertonic saline
v. Treatment of complicated acid-base or electrolyte imbalances
vi. Large volume resuscitation (e.g., 3 L of fluid, 3 units of blood product within 12 hours)
vii. Active gastrointestinal bleeding either upper or lower gastrointestinal (GI) bleeding requiring utilization of multiple blood products or balloon tamponade
viii. Status post cardiac arrest
ix. Cardiac tamponade
x. Acute aorta conditions: dissections, transections, aneurysms
xi. Hypertensive emergencies
xii. Acute congestive heart failure
xiii. Imminent respiratory failure
xiv. Acute stroke
xv. Acute subarachnoid hemorrhage
xvi. Severe head injury
xvii. Hemodynamically unstable after drug overdose
xviii. Diabetic ketoacidosis with hemodynamic instability or severe acidosis (pH<7.2)
xix. Sepsis with hemodynamic instability
xx. Delirium tremens, delirium, other acute mental status change issues requiring escalating level of care
xxi. Care requiring continuous renal replacement therapy (CRRT)
xxii. Patients requiring intra-cranial pressure (ICP) monitoring
xxiii. Acute stroke without thrombolytic therapy
xxiv. Post anaphylaxis
xxv. Vasoactive agents may be used under Cardiology direction.
xxvi. Care of patients requiring Impella device
xxvii. Care of patients requiring extracorporeal membrane oxygenation (ECMO)
xxviii. Care requiring intra-aorta balloon pump
xxix. Care of cardiogenic shock
xxx. Care of unstable arrythmia
xxxi. Care of patients with left ventricular assist device (LVAD)
xxxii. Post-thrombolytic therapy both mechanical and chemical for stroke after 24 hours
xxxiii. Post-EKOS for acute pulmonary embolism after 24 hours

xxxiv. Tracheostomy tube malfunction with hypoxia
xxxv. Care for patients requiring extensive nursing intervention (e.g., multiple times every hour)

2. Step down unit. The step-down unit serves as a place for the monitoring and care of patients with moderate or potentially severe physiologic instability, requiring technical support but not necessarily artificial life support. The step-down unit is reserved for those patients requiring less care than standard intensive care, but more than that which is available from ward care

a. Respiratory Criteria:

i. Bi-level positive airway pressure (BiPAP)
ii. Patients with new tracheostomy tube (e.g., awaiting long-term care placement)
iii. Patients with chronic tracheostomy tubes on mechanical ventilation who do not require ICU admission

b. Clinical and Diagnosis-related Criteria:

i. Medical conditions not requiring titration of vasoactive agents (e.g., epinephrine, norepinephrine, dobutamine, dopamine, vasopressin, phenylephrine)
ii. Gastrointestinal bleeding (Upper or Lower GI)
iii. Hypertensive emergencies
iv. Alcohol withdrawal and delirium tremens
v. Diabetic ketoacidosis without hemodynamic instability and severe acidosis
vi. Acute pulmonary edema requiring noninvasive positive pressure ventilation (NIPPV)
vii. Hemodynamically stable Myocardial infarction
viii. Hemodynamically stable cardiac arrhythmia
ix. Mild to moderate Congestive heart failure exacerbation
x. Hypertensive Urgency without end organ damage
xi. Pulmonary patients who require frequent vital signs or aggressive pulmonary physiotherapy
xii. Patients with established, stable stroke
xiii. Hemodynamically stable post-operative patients
xiv. Stable neurosurgical patients who require a lumbar drain
xv. Sepsis without evidence of shock or secondary organ failure
xvi. Any patient requiring frequent nursing observation (e.g., every 1-2 hours)

3. Discharge of patients out of ICU: Patients no longer meeting criteria for ICU will be discharged from the ICU after placement on the accepting service's list and communication with accepting service. The ICU service will write transfer orders. The ICU nurse or charge nurse will notify the house supervisor of required bed.

4. Census Management: Patients meeting ICU criteria should be admitted directly to the ICU A. In case of emergent intra-hospital transfer, a bed in ICU A should always be available. In the case that ICU beds are not available, attempts to satisfy the request for an ICU bed will be reviewed by the house supervisor and assigned accordingly. Post-anesthesia care unit (PACU) or Emergency Department (ED) may be considered as potential ICU overflow areas.

5. Conflict Resolution: Each admission and intra hospital transfers to the medical ICU will be discussed with the pulmonary/critical care fellow and attending

Approved by: /s/ _____ Michael Ellis, MD Chief Medical Officer 4/15/2025 _____ Date /s/ _____ Puneet Sindhwani, MD Chief of Staff 4/29/2025 _____ Date *Review/Revision Completed by:* *HAS* *Chief Medical Officer* *Administrative Director, Outcome Management* *Nursing Administration*	**Policies Superseded by This Policy:** • *7-01-09* Initial effective date: 6/25/1987 Review/Revision Date: 1/18/89 5/9/90 12/11/91 10/13/93 9/11/96 7/14/99 6/13/01 9/11/02 7/13/05 5/28/08 4/27/2011 11/1/2012 11/1/2015 10/1/2019 4/2025 Next review date: 4/2028