I. **SCOPE:** Patients who meet admission criteria that require rehab recovery following an acute illness, injury, or surgery.

II. **PURPOSE:** To outline the process of determining admission eligibility and the admission process.

III. **POLICY:** The goal of the Summit Pacific Medical Center (SPMC) Swing Bed program is to provide another vital layer to the broad spectrum of patient care services available in a hospital setting. Admission is limited to adult patients who require short-term skilled nursing care or therapy services beyond their acute hospital stay prior to returning back to the community. Each admission to the Swing Bed program will have an admission order signed by a provider with SPMC hospital privileges.

IV. **DEFINITIONS:**

none

V. **PROCEDURE/REQUIREMENTS OF POLICY:**

1. Referral will be reviewed by the Social Worker, Acute Care Manager, Therapy Department and attending SPMC Provider.

2. The patient must meet criteria for admission to the Swing Bed Program:
   a. Patient has Medicare/Medicaid or other insurance with hospital based, skilled-care benefits and prior authorization is obtained by SPMC.
   b. The patient has completed a qualifying acute inpatient stay of at least three consecutive midnights in the previous 30 days or has had a procedure included in the Comprehensive Care for Joint Replacement Model as defined by CMS.
   c. Their medical condition has the potential for rehabilitation through therapy services.
   d. A need for continued skilled nursing care exists i.e. wound management, medication management. (One example might be an actively dying patient who requires IV pain management for comfort care.)
   e. If a SPMC acute care inpatient is to be changed to swing bed status, the patient must be discharged as an acute inpatient, meet the requirements above, and be re-admitted as a swing bed patient.

3. Admission Limitations
   a. The swing bed program is located in the acute care unit of the hospital. Therefore, the census and acuity of hospital patients will affect the number of swing beds available at any given time.
   b. Therapy services that are not provided through SPMC are contracted through third party agencies. Patient referrals and anticipated needs will be carefully reviewed
and compared against current availability of third party services, and only those patients whose therapy needs can be adequately met will be admitted.

4. Admission to SPMC
   a. Admission will be without regard to race, color, religion, creed, ancestry, nation of origin, gender, sexual orientation or source of payment.
   b. Admitting will obtain any active Advance Directive paperwork and will provide a copy of the Patient Rights and Responsibilities.
   c. The Social Worker or nursing staff will ensure that each resident/resident family is provided a copy of resident rights and responsibilities upon admission as outlined by Chapter 70.129 of the RCW.
   d. The Social Worker or admitting RN will have the patient or patient representative sign the Swing Bed Admission Contract.
   e. The admitting physician will complete the “Admission to Swing Bed” medical orders and sign the Medicare Certification form if necessary.
   f. The admitting nurse will initiate the patients care plan and admission assessment.
   g. Nursing staff will also inventory the patient’s belongings and secure patient valuables.
Title: Admission to Swing Bed

CREATION

Creation Date: 12/17/2017
Department: Swing Bed
Replaced policy: Swing Bed Program, Swing Bed Contract Policy

Approved:

Name, Title ____________________________ Signature ____________ Date: ________

Name, Title ____________________________ Signature ____________ Date: ________

REVISION HISTORY

Revision Dates: ____________________________

Approved:

Name, Title ____________________________ Signature ____________ Date: ________

Name, Title ____________________________ Signature ____________ Date: ________

REVIEW HISTORY

Review Dates: ____________________________

RETIRED

Requested By: ____________________________ Date: _____________
Approved By: ____________________________ Date: _____________
Reason: ____________________________