COUNTY OF LOS ANGELES **DEPARTMENT OF HEALTH SERVICES**

HARBOR-UCLA MEDICAL CENTER

SUBJECT: EMERGENCY DEPARTMENT ADMISSION PROCESSES **POLICY NO. 312**

PURPOSE:
To define the processes by which patients are admitted from the Emergency Department.

POLICY:
At Harbor-UCLA Medical Center, the following processes are to be used by Emergency Department (ED) staff when admitting patients to the hospital for inpatient care, in order to facilitate and expedite safe patient care. For the purposes of this policy, the term ED staff includes staff working in the Adult Emergency Department (AED), the Pediatric Emergency Department (PED), and the psychiatric emergency department (Psych-ED).

Attending physicians supervising care in the Adult Emergency Department (AED) have admitting privileges to all adult inpatient services. Attending physicians supervising care in the Pediatric Emergency Department (PED) have admitting privileges to all pediatric inpatient services. Attending physicians supervising care in the psychiatric emergency department (Psych-ED) have admitting privileges to all psychiatry inpatient services.

The choice of inpatient service to which a patient is admitted is generally determined by separate agreements between Departments and Divisions providing inpatient services, pre-existing physician-patient relationships, and the need to fairly distribute clinical work load among inpatient services. These agreements are documented in the Admitting Service Guideline which is maintained by the clinical chairs, in consultation with the Chief Medical Officer and Associate Medical Director for Inpatient Services. For diagnoses listed in the Admitting Service Guideline, ED personnel will use those agreements to guide the selection of admitting service. In the absence of applicable criteria for making such determinations, the ED personnel admitting the patient will use their best professional judgment is determining the admitting service.

PROCEDURE:

A. Admissions from the Adult Emergency Department

1. The ED Attending will determine need for all admissions. This determination will be informed by applicable Interqual (IQ) criteria.

EFFECTIVE DATE: 04/10/84 **SUPERSEDES:**
REVISED: 9/89, 6/92, 10/95, 7/96, 5/98, 12/98, 12/02, 2/03, 1/05, 5/06, 12/08, 9/09, 2/12, 5/15
REVIEWED: 8/86, 8/89, 10/92, 10/95, 8/96, 6/98, 12/98, 2/02, 12/02, 2/03, 1/05, 5/06, 9/09, 2/12, 6/14, 5/15
REVIEWED COMMITTEE:

APPROVED BY:

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Acting Chief Nursing Officer

2. After the initial decision to admit a patient for inpatient care is made, the ED Attending documents in the electronic medical record the rationale for the admission, the designated admitting service, and the required level of care. This step, though required, does not constitute the actual admission to the inpatient service.

3. The ED provider then contacts the inpatient service to provide information regarding the patient and the rationale for the admission. The information shall be sufficiently detailed to justify the need for admission, the selection of the inpatient service, and the level of care required. Unless required as described above, laboratory, imaging, or other diagnostic results will not necessarily be available at this time. The conversation where the ED provider discusses the admission with the admitting service should be a collaborative discussion. If at the end of the conversation the ED attending physician continues to feel that admission is indicated to the contacted service, the patient will be admitted to that service. If, after a good faith effort to contact the inpatient service, the Emergency Department is unable to discuss the patient with the inpatient service, then the process can proceed to the next step. However, regular attempts to contact the inpatient team will continue until successful.

4. After discussion between the ED provider and the admitting service, the ED provider will place an order admitting the patient to the inpatient service. This action constitutes the actual admission decision and completes the Emergency Department personnel's involvement in determining the need for admission and the selection of inpatient service. After the admission order is entered into the computer, the admitting service is responsible for the patient's medical care, with the exception of responding to medical emergencies.

5. However, if after the discussion with the initially proposed admitting service, the Emergency Department personnel no longer believe the patient requires admission, then they will receive further Emergency Department care and disposition as appropriate. If alternatively, after the discussion with the initially-proposed admitting service, emergency department personnel believe the patient requires admission but to a different inpatient service, then the process will begin again with step 3.

6. The admitting service has two hours from the time the patient is admitted to evaluate the patient and either enter admitting orders, transfer to another admitting service, or disposition the patient from the ED.
   a. If the decision is made by the admitting service to attempt to transfer the patient to a different service, the admitting service is responsible for contacting the other service.
   b. If the other service agrees to admit the patient, they will notify the Emergency Department and the 2 hour time window will restart.
   c. If the newly-proposed inpatient service does not agree to admit the patient, then the assigned service is responsible for admitting the patient and within the original 2 hour window.

7. At two hours after admission, if admitting orders are not submitted by the admitting team, ED physicians may submit abbreviated admission orders to move the patient to an inpatient bed or to the Gold Unit. ED personnel will attempt to contact the admitting team before submitting abbreviated admission orders.

8. Abbreviated admission orders should include: admitting service, diagnosis, resident physician with contact information, activity level, vital signs upon arrival, IV order(s) as applicable, oxygen or ventilator order(s) as applicable, orders for continuous infusions as applicable, and to call the admitting resident upon patient arrival for further orders.

9. Discharge of admitted patients from the ED may only occur with the approval of the attending physician of the admitting service or the Emergency Medicine attending physician.

10. Disagreements regarding admissions between the residents in the ED and the admitting teams will be resolved in one of the following ways:
    a. If the attending physician for the admitting service is available to personally evaluate the patient, they will make a final decision regarding the need for hospitalization. If the patient is discharged, the admitting team will enter a note into the medical record and will assume responsibility for the patient's ongoing care.
    b. If the attending physician for the admitting service is not available to evaluate the patient, the ED and admitting attending physicians will discuss the patient by phone to reach resolution.
    c. If the attending physician for the admitting service is not available to evaluate the patient and is not available to discuss the case with the ED attending physician within a reasonable time frame, a final decision will be made by the Emergency Medicine attending physician on duty.

B. Admissions from the Pediatric Emergency Department (PED)

1. The PED Attending will determine need for all admissions. This determination will be informed by applicable Interqual (IQ) criteria. When an attending physician is not physically present in the PED, the attending physician in the AED may determine the need for admission for pediatric patients.

2. Patients with primary psychiatric problems or those that potentially pose a physical threat to other pediatric patients due to size or history of violence will not be admitted to Pediatric wards.

3. After the initial decision to admit a patient for inpatient care is made, the Attending physician making that decision will document in the electronic medical record the rationale for the admission, the designated admitting service, and the required level of care. This step, though required, does not constitute the actual admission to the inpatient service.

4. The PED provider then contacts the inpatient service to provide information regarding the patient and the rationale for the admission. The information shall be sufficiently detailed to justify the need for admission, the selection of the inpatient service, and the level of care required. Unless required as described above, laboratory, imaging, or other diagnostic results will not necessarily be available at this time. The conversation where the PED provider discusses the admission with the admitting service should be a collaborative discussion. If at the end of the conversation the attending physician making the admission decision continues to feel that admission is indicated to the contacted service, the patient will be admitted to that service. If, after a good faith effort to contact the inpatient service, the Emergency Department is unable to discuss the patient with the inpatient service, then the process can

proceed to the next step. However, regular attempts to contact the inpatient team will continue until successful.

5. After discussion between the PED provider and the admitting service, the PED provider will place an order admitting the patient to the inpatient service. This action constitutes the actual admission decision and completes the Emergency Department personnel's involvement in determining the need for admission and the selection of inpatient service. After the admission order is entered into the computer, the admitting service is responsible for the patient's medical care, with the exception of responding to medical emergencies.

6. The admitting service has two hours from the time the patient is admitted to evaluate the patient and either write admitting orders, arrange to have the patient moved to the Pediatric ward, transfer to another admitting service, or disposition the patient from the PED. Pediatric patients may be moved to the Pediatric inpatient ward prior to the writing of admitting orders, at the sole discretion of the Pediatric admitting service.
   a. If the decision is made by the admitting service to attempt to transfer the patient to a different service, the admitting service is responsible for contacting the other service.
   b. If the other service agrees to admit the patient, they will notify the Emergency Department and the 2 hour time window will restart.
   c. If the newly-proposed inpatient service does not agree to admit the patient, then the assigned service is responsible for admitting the patient and within the original 2 hour window.

7. At two hours after admission, if admitting orders are not submitted by the admitting team, Pediatric ED physicians may submit abbreviated admission orders to move the patient to an inpatient bed if one is available. Pediatric ED personnel will attempt to contact the admitting team before submitting abbreviated admission orders.

8. Abbreviated admission orders should include: admitting service, diagnosis, resident physician with contact information, activity level, vital signs upon arrival, IV order(s) as applicable, oxygen or ventilator order(s) as applicable, orders for continuous infusions as applicable, and to call the admitting resident upon patient arrival for further orders.

9. Discharge of admitted patients from the Pediatric ED may only occur with the approval of the attending physician of the admitting service or the PED or Emergency Medicine attending physician making the admission decision.

10. Disagreements regarding admissions between the residents in the ED and the admitting teams will be resolved in one of the following ways:
    a. If the attending physician for the admitting service is available to personally evaluate the patient, they will make a final decision regarding the need for hospitalization. If the patient is discharged, the admitting team will enter a consultation note into the medical record and will assume responsibility for the patient's ongoing care.

b. If the attending physician for the admitting service is not available to evaluate the patient, the PED and admitting attending physicians will discuss the patient by phone to reach resolution.
c. If the attending physician for the admitting service is not available to evaluate the patient and is not available to discuss the case with the PED attending physician within a reasonable time frame, a final decision will be made by the PED attending physician on duty.

C. Admissions from the Psychiatric Emergency Department

1. The Psychiatric ED residents and psychiatry attending physicians overseeing care in the Psychiatric ED determine the need for all admissions to the inpatient psychiatry services.

2. After the decision to admit a patient is made, the Psychiatric ED provider will contact the inpatient Psychiatric service to provide information regarding the patient and the rationale for the admission. The information shall be sufficiently detailed to justify the need for admission and the level of care required.

D. Observation and CORE Status

Patients who have been evaluated in the Adult ED or Rapid Medical Evaluation (RME) area and meet criteria for observation or CORE services will be transferred to the Observations and CORE services as appropriate. The Adult ED attending physician will determine when a patient qualifies for Observation or CORE status.