LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HARBOR-UCLA MEDICAL CENTER

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

CATEGORY: Provision of Care	**EFFECTIVE DATE:** 4/84
POLICY CONTACT: Susan Stein, MD	**UPDATE/REVISION DATE:** 3/22
REVIEWED BY COMMITTEE(S):	

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, to facilitate and expedite safe patient care. In 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).

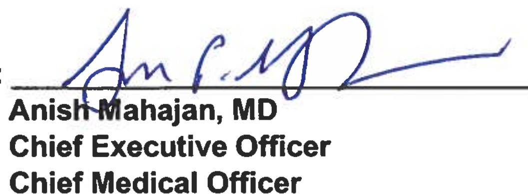
Admissions to inpatient services are done in discussion with inpatient and consulting providers as outlined in this policy.

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 workload 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 services. In the absence of applicable criteria for making such determinations, the ED personnel admitting the patient will use their best professional judgment in determining the admitting service.

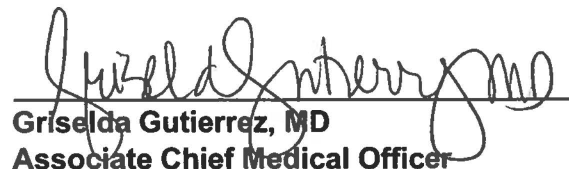
Attending physicians supervising care in the Adult Emergency Department (AED) have admitting privileges to all adult inpatient services. Attending physicians supervising care in the Pediatric Emergency Department (PED) have admitting privileges to all pediatric inpatient services. Attending physicians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

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, 3/22
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, 3/22

APPROVED BY:



Anish Mahajan, MD
Chief Executive Officer
Chief Medical Officer



Griselda Gutierrez, MD
Associate Chief Medical Officer

Jason Black, MBA, DNP, RN
Chief Nursing Officer

PROCEDURE:

A. Admissions from the Adult Emergency Department

1. As informed by Interqual (IQ) criteria, the ED Attending will determine and document the eligibility for the consultation to specialty services or admission to Harbor-UCLA. Utilization Review (UR) will review the care to see if the patient meets criteria or needs a secondary attending physician review for an override note. Patients that are out-of-plan (OOP) may be transferred to their health plan for admission when stable and the receiving facility has the capacity and services
2. needed to care for the patient's needs as determined by the ED Attending. The patient's Interqual status must be 'MET' prior to admission at Harbor-UCLA.

3. The ED provider 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 ED 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. After the discussion with the inpatient services the need for admission, the ED attending documents in 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. After discussion between the ED provider and the admitting service, the ED provider will place the request for admit order for the patient to be admitted to the inpatient service. This action constitutes the actual admission decision and completes the ED personnel's involvement in determining the need for admission and the selection of inpatient service. After the request for the admit order is entered into the computer, the admitting service is responsible for the patient's medical care, except for responding to medical emergencies or extenuating circumstances as agreed upon by both the ED and admitting provider in a collegial discussion regarding the best interest of the patient. The admitting team will place their contact info into the 'Care Team' field of the banner bar, so that nursing will know who to contact.

5. However, if after the discussion with the initially proposed admitting service, the ED personnel no longer believe the patient requires admission, then they will receive further ED care and disposition as appropriate. If alternatively, after the discussion with the initially proposed admitting service, the ED provider believes the patient requires admission but to a different inpatient service, then the process will begin again with step 2.

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 ED staff 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 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 holding orders to move the patient to an inpatient bed. ED personnel will attempt to contact the admitting team before submitting abbreviated admission holding orders.

8. Abbreviated admission holding orders should include: admitting service, diagnosis, admitting 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 a 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. As informed by Interqual (IQ) criteria, the PED Attending will determine and document the eligibility for the consultation to specialty services or admission to Harbor-UCLA. Utilization Review will review the care to see if the patient meets criteria or needs a secondary attending physician review for an override note. Patients that are out of plan (OOP) may be transferred to their health plan for admission when stable and the receiving facility has the capacity and services needed to care for the patient's needs as determined by the PED Attending. The patient's Interqual status must be 'MET' prior to admission at Harbor-UCLA.

2. The PED provider 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 PED 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 PED 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. After the

discussion with the inpatient services the need for admission, the PED attending documents in 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. Patients with primary psychiatric problems or those that potentially pose a physical threat to other pediatric patients due to history of violence will not be admitted to Pediatric wards.

4. After the discussion with the inpatient services the need for admission, the PED attending documents in 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.

5. 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.

6. After discussion between the PED provider and the admitting service, the PED provider will place the request for admit order for the patient to be admitted 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 request for the admit order is entered into the computer, the admitting service is responsible for the patient's medical care, except for responding to medical emergencies or extenuating circumstances as agreed upon by both the ED and admitting provider in a collegial discussion regarding the best interest of the patient. The admitting team will place their contact info into the 'Care Team' field of the banner bar, so that nursing will know who to contact.

7. 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 within the original 2-hour window.

8. At two hours after admission, if admitting orders are not submitted by the admitting team, Pediatric ED physicians may submit abbreviated admission holding 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 holding orders.

9. Abbreviated admission holding orders should include: admitting service, diagnosis, the 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.

10. 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 attending physician making the admission decision.

11. 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 a 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 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.

Reviewed and approved by:
Medical Executive Committee 03/2022

Beverley A. Petrie, M.D.
President, Professional Staff Association