LOS ANGELES GENERAL MEDICAL CENTER POLICY

Subject:	Original Issue Date:	Policy #
ADMISSION TO LOS ANGELES GENERAL MEDICAL CENTER	7/1/98	**703**
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Policy Owner(s): Assoc. Chief Medical Director
Executive Sponsor(s): Chief Medical Officer

Departments Consulted:	Reviewed & Approved by:	Approved by:
Ambulatory Care Health Information Management Patient Financial Services Nursing Services	Attending Staff Association Executive Committee Senior Executive Officer	Chief Medical Officer Chief Executive Officer

PURPOSE

To delineate the official mechanism for admitting patients to Los Angeles General Medical Center.

POLICY

Individuals may self-refer or be referred by a clinician for services at the Los Angeles General Medical Center facilities. Specialty outpatient services require a physician referral through the LA County eConsult system. ED to ED or inpatient to inpatient transfers must be completed through the Medical Alert Center (MAC)/Patient Transfer Center. Physician to physician transfers, bypassing the MAC, are not allowed.

Only attending staff with admitting privileges for Los Angeles General Medical Center may admit patients.

The Bed Control Department, in collaboration with the Patient Flow Manager, Nurse Manager or Nursing Supervisor, Medical Consult Physician, and appropriate Medical/Surgical service, coordinates bed activity

EMERGENCY ROOM TO INPATIENT ADMISSIONS
The choice of inpatient service to which a patient is admitted is generally determined by separate agreements between Departments 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 (see appendix A of policy) which is maintained by the service chiefs, in consultation with the Chief Medical Officer and Attending Staff Association leadership. 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.

Patients admitted for inpatient care will meet criteria for medical necessity based on InterQual® admission criteria or via secondary medical necessity review by a designated physician.

ADMISSIONS DURING HOSPITAL OVERCROWDING

In times of hospital severe overcrowding, alternate admission locations are permissible, as determined by the Patient Flow Manager in coordination with Bed Control. Triggers specifically indicating severe overcrowding include:

1) Code Red or Code Black hospital-wide (based on NEDOCs score); OR
2) Insufficient beds in a specific ICU, PCU, or telemetry ward to house patients currently admitted and boarding in the ED.

Alternate admission locations in these cases may include:

A) Placing PCU-level patients in ICU beds or telemetry patients in PCU beds; OR
B) Admitting patients older than age 18 to the Pediatric Intensive Care Unit (PICU), consistent with California Title 22, Section 70537(d). This provision requires approval of the PICU attending on duty for each individual patient. In these cases, the PICU attending must have privileges to care for older patients and will document in the admission note the justification for placing the older patient in the PICU. The PICU will maintain unit structure standards and nurse training to ensure competency to care for such patients. In general, efforts should be made to limit admissions to an approximate patient age of 25 years. Patients over 18 should be cohorted on to one side of the PICU, with maximum separation from younger patients on the opposite side of the ward.

PROCEDURE- GENERAL

All patients seen in Medical Center facilities shall:

- Sign a Conditions of Admission/Clinic visit or Emergency Medical Treatment (aka general consent).
  - At each visit to the Emergency Room
  - At each inpatient admission.
  - At least annually for receipt of ambulatory care.
- Receive a unique Medical Record Number (MRN).
- Be registered and financially cleared when coverage (insurance) is verified and appropriate or screened to determine coverage options for those with no insurance.
- Receive a complete assessment of his or her physical and psychosocial status by a professional staff member.
- Be informed of a coordinated interdisciplinary plan of care based on his or her health care needs.

In addition to the above, inpatients admitted to Los Angeles General Medical Center shall:

- Receive the Los Angeles General Information Booklet, which includes patients' rights and responsibilities, patient safety and advanced directive information, and the Joint Notice of Privacy and Practice.

- Be informed of the Patient Self-Determination Act.

- Provide a copy of their advance directives, if applicable, for placement in their health/medical record.

ADMISSION PROCEDURE- EMERGENCY ROOM

1. To initiate an admission, the ED provider contacts the appropriate 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 and isolation status. Unless required as described above, laboratory, imaging, or other diagnostic results will not necessarily be available at this time.
2. If, after the discussion with the initially proposed admitting service, the ED personnel no longer believe the patient requires admission, then the patient will receive further ED care and disposition as appropriate. If, at the end of the conversation, the ED personnel continue to feel that admission is indicated to the clinical service contacted, the patient will be admitted to that service. If, alternatively, after the discussion with the initially proposed admitting service, ED personnel believe the patient requires admission but to a different inpatient service, then the process will begin again with Step 1.
3. The Admit to Inpatient order cannot be placed until discussion occurs between the ED and a member of the inpatient team or an individual in the chain of command for that inpatient team. In the event that the ED provider is unable to contact the inpatient service, the ED provider will continue to escalate contact through the chain of command using the contact information found on Amion.com. All inpatient services are expected to maintain accurate call schedules on Amion.com, including for both residents, attending physicians, and back up attendings/service chief. Failure of attending physicians to call back in a timely manner (within 15-30 min) should be reported via the Attending Absenteeism link on the Los Angeles General Medical Center intranet.
4. The ED provider will document the rationale for the admission, the designated admitting service, the required level of care, and place the Admit to Inpatient order after discussion between the ED provider and the admitting service, or department attending notified through the chain of command. 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.
5. For patients being admitted to the Medical-Surgical wards, Telemetry Unit, or Progressive Care unit, the admitting inpatient service will have primary responsibility for the patient once the "Admit to Inpatient" order is entered, and the ED provider has given a verbal hand-off to the admitting service provider.

6. For medical ICU patients being admitted to the Critical Care units, the ED provider will maintain clinical care responsibilities until the patient departs the ED en route to the assigned critical care unit. Once the patient departs the ED, the Medical ICU service will assume responsibility.
7. For all other ICU patients being admitted to the Critical Care units, the appropriate ICU service will assume responsibility for the patient once the ED provider has provided verbal sign-out to the admitting service.
8. For patients who are admitted but are waiting in the ED for a hospital bed to be available, the ED providers will provide emergency care for unstable patients if the inpatient team is not immediately available.
9. The admitting service has a maximum of two hours from the time the patient is admitted ("Admit to Inpatient" order placed) to evaluate the patient and either write 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 initial admitting service is responsible for contacting the other accepting service and providing a verbal hand-off of the patient.
    b. If the other service agrees to admit the patient, the new admitting service 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 initially assigned inpatient service is responsible for admitting the patient within the original 2-hour window.
10. Patients may not be sent to an inpatient bed without admission orders. These orders may be a full set of orders from the admitting service or may be abbreviated admission orders provided by the ED provider.
11. While awaiting orders from the admitting team, ED physicians may submit abbreviated admission orders to admit the patient to the inpatient service or to an observation unit in the event that all of the following conditions are met:
    a. an inpatient bed becomes available,
    b. discussion has occurred between the ED and the inpatient service,
    c. the inpatient service has not written orders,
    d. the two-hour window has elapsed.
12. Abbreviated admission orders should include: the Admit to Inpatient Order, the admitting service, diagnosis, resident physician with contact information, vital signs upon arrival, IV order(s) as applicable, oxygen or ventilator order(s) as applicable, orders for continuous infusions as applicable, pain medications as applicable, and to call the admitting resident upon patient arrival for further orders.
13. Should a patient experience a medical emergency en route from the ED to the destination nursing unit, the appropriate code or medical emergency team should be called to respond.

14. Discharge of admitted patients from the ED by the inpatient service may only occur with the approval of the attending physician of the admitting service or the ED attending physician.
15. Disagreements regarding admissions between the residents in the ED and the admitting teams will be resolved by discussion between the ED attending and the admitting team attending physicians. If a disagreement persists, the admitting team attending physician will make the final decision regarding the need for hospitalization and instruct the admitting team to discharge the patient. If the attending physician for the admitting service is not available to evaluate the patient in person or discuss the case by phone, a final decision will be made by the ED attending physician on duty.
16. If the decision is made to discharge the patient, the admitting team will discharge the patient and assume responsibility for the patient's ongoing care.

NURSING CARE

Each patient care service/Unit Structure Standards address the following admission standards developed jointly by nursing, medicine, and hospital administration:

- Physicians qualified to admit patients
- Admission criteria and/or InterQual criteria
- System for patient admission
- Communication with Bed Control Office
- Maintenance of patient information
- Circumstances governing admission including issues of medical admission orders, reasonable time frames for assessment by physician and nursing, and required documentation
- Initial physician orders for the patient admitted as an "emergency," scheduled, routine, STAT expedite, and/or expedite admission are to be written as per the Attending Staff Manual Rules/Regulations/Policies

Each nursing unit admitting patients shall obtain admission orders. If nursing staff is unable to obtain physician orders for a new admission within one hour, the staff needs to notify the nurse manager / supervisor. The nurse manager / supervisor will within one hour notify the CMO / MOD.

Each nursing unit sets standards for completion of the admission assessment process by identifying factors including anticipated length of stay and complexity of the nursing care needs of the major patient population(s) served

Bed Utilization Standards

- Each nursing unit monitors their unit patient list and maintains a computer-generated listing of current patients by bed and room assignments (census) on a continuing basis throughout the day.

- The census is updated for all room and bed changes (admissions and transfers) by the Bed Control Department at the point and time of each patient transaction upon notification by the unit via telephone

- Discharges are entered into the electronic health record (EHR) by Unit Staff as soon as the discharged patient physically leaves the unit.

- Length of Stay: each unit must designate the determinants of length of stay, the comparison with averages, medical justification, and use of available resources

- Maintenance of patient logs for operating rooms, delivery rooms, emergency rooms, and ambulatory care is described in the respective Unit Structure Standards Manuals

- The nurse in charge may change the bed placement on the unit based on nursing assessment of the patient's care and/or environmental or safety needs and will communicate the changes to the Bed Control Department

Concerns Regarding Utilization of Beds:

- In each setting of the Los Angeles General problems related to bed utilization are resolved by the patient flow manager, nurse manager or nursing supervisor, medical consult physician, and appropriate service/specialty, in collaboration with the Bed Control Department.

- Administration is notified to effect closure to admissions/transfers when designated service beds are no longer available

- Mechanisms for closing or combining units during bed utilization crises are described in the Medical Center's Disaster Plan and Contingency Plan

- When difficulties arise in placing a patient in an appropriate available bed, the senior physicians of the involved medical services (on duty or on call) work collaboratively with the patient flow manager, nurse manager or nursing supervisor to resolve the problem. Medical Alert Center and/or Los Angeles General Bed Control Department are involved in the process in order to assist in identifying available space within the County facilities or within the Medical Center

RESPONSIBILITY

Attending Staff
Nursing Staff
Bed Coordination Unit
Health Information Management
Patient Access and Patient Financial Services

PROCEDURE DOCUMENTATION

Attending Staff Manual
Nursing Services Unit Structure Standards
Office of Patient Access: Patient Demographics & Registration Guide, Coverage Verification & Health Coverage Options Guide
Bed Control Unit Policy and Procedure Manual
Health Information Management Policy and Procedure Manual

REFERENCES

Joint Commission Standards (Ethics, Rights, and Responsibilities; Provision of Care, Treatment, and Services)
California Code of Regulations, Title 22, Sections 51108 and 70537(d)
Welfare and Institutions Code, Sections 14059 and 14132
Patient Self-Determination Act

ATTACHMENTS

Admission Service Guidelines

REVISION DATES

January 6, 1999; April 16, 2002; June 22, 2004; October 16, 2008, April 12, 2016; December 24, 2019; March 27, 2020; October 30, 2020; August 7, 2023

ATTACHMENT

Admission Service Guidelines

Purpose:

This guideline is required to comply with hospital policy 703: ADMISSIONS TO LOS ANGELES GENERAL MEDICAL CENTER. It delineates appropriate admitting services based on specific adult patient primary diagnoses. The guideline will be used by the ED provider to inform which is the most appropriate admitting service for the adult patient. The guideline is to be maintained and updated regularly by the inpatient clinical service chiefs, in consultation with the Chief Medical Officer (CMO) and Attending Staff Association leadership. As this is a guideline and not a policy, it may be updated as needed without

formal presentation at the Medical Executive Committee or the Senior Executive Council. As emphasized in hospital policy 703, this document is for guidance purposes only. The final decision regarding to which service a patient will be admitted is at the discretion of the ED attending physician as per the policy above.

Adjudication by Diagnoses:

AORTIC DISSECTIONS AND ANEURYSMS
Patients with **traumatic thoracic aortic injuries** should be evaluated and admitted to **Trauma**.

Patients with non-traumatic, thoracic aortic dissections or aneurysms should be admitted to **Cardiothoracic Surgery** (**ACS** to facilitate during off-hours). Patients with non-traumatic, non-thoracic aortic dissections or aneurysms should be admitted to **Vascular Surgery** (**Acute Care Surgery** to facilitate during off-hours)**.**

BRAIN DEATH/ORGAN DONATION
Patients who have had brain death determined in the Emergency Department, or who are expected to have brain death determined following admission, should be admitted to the service that would normally have cared for their primary illness or injury, e.g., multiple trauma patients to **Trauma**, isolated head injury patients to **Neurosurgery**, and adult and pediatric patients with medical diagnoses to the **Medicine** and **Pediatric Services**. *In all instances, the admitting service should notify the appropriate organ procurement organization.*

CAUSTIC INGESTION
Patients should be admitted to the Thoracic Surgery service, with SICU assistance for management of metabolic problems. If ENT evaluation is necessary, they can be called as consultants. And, if and when access to the GI tract is deemed suitable for feeding, Thoracic Surgery can consult ACS or General Surgery as appropriate. If tracheostomy is warranted, this would best be done by the ENT service.

CLOTTED DIALYSIS GRAFTS
Patients requiring an **Interventional Radiology** procedure for clotted dialysis grafts should be admitted to **Medicine** with consultation from **Vascular Surgery** as needed.

DECUBITUS ULCERS
Patients who require hospitalization primarily for wound care of decubitus ulcers should be admitted to **Medicine** with appropriate consultation to **Plastic Surgery** if debridement is needed.

DEEP VENOUS THROMBOPHLEBITIS (DVT)
Women with suspected DVT who are pregnant or less than six weeks postpartum should be admitted to **Obstetrics**. Women with suspected DVT who are followed by the Gynecology Oncology Service and those who are less than six weeks post-op following surgery performed by the Gynecology service should be admitted to **Gynecology**. Patients with post-op DVT should be admitted to the **ACS** or the surgical subspecialty that would normally have cared for the patient, if they present within 6 weeks of the operation. All other patients with suspected DVT should be admitted to **Medicine.**

DELIRIUM/DEMENTIA
Patients suffering from **acute delirium** (toxic, metabolic, or infectious) should be admitted to **Medicine**. Patients with previously diagnosed dementia, confusional states, developmental disorders and behavioral

symptoms resulting from irreversible brain injury who need placement should be sent to **Observation** until Social Work can arrange placement.

Patients presenting with **new onset or previously undiagnosed dementia** should be admitted to **Neurology.** Patients with new onset or previously undiagnosed dementia who have other significant acute medical problems should be admitted to **Medicine**.

DIABETIC FOOT INFECTIONS/OSTEOMYELITIS

Patients who require admission for diabetic foot infections should be admitted to **Medicine** with **Orthopedics** or **Acute Care Surgery** consulting as needed.

DIVERTICULITIS

Patients who require admission for diverticulitis should be admitted to **ACS** to be redistributed to **Colorectal Surgery** as appropriate.

HAND INJURIES

All Hand injuries and pathology that require admission should be admitted to **Orthopedics. Orthopedics** will redistribute to the **Hand Surgery** team as appropriate. This includes soft-tissue pathology up to the shoulder, excluding burns.

HIP FRACTURES

Patients with hip fractures who have an ASA Score of 2 or less AND who are <80 years old are admitted to **Orthopedics**. Patients with hip fractures who have an ASA score of 3 or more OR who are ≥80 years old are admitted to **Medicine**.

Those patients who are ASA2, but have systolic blood pressure > 220, diastolic blood pressure > 120 or glucose > 300 on admission will also be admitted to medicine.

INTRACRANIAL MASS LESIONS

Stable patients with solitary intracranial lesions who do not have other significant medical problems should be admitted to **Neurology**. A history of HIV positivity or suspected HIV infection does not constitute a significant medical problem.

Patients with non-hemorrhagic intracranial mass lesions who have urgent or emergent medical problems should be admitted to **Medicine.**

Patients with solitary intracranial lesions who have new hemorrhage, new shift or are at other risk for herniation should be admitted to **Neurosurgery**.

MAXILLOFACIAL TRAUMA

Patients who require admission primarily for their maxillofacial trauma should be admitted to the service taking **Face** Call that day (**Head and Neck Surgery, Plastic Surgery,** or **Oral and Maxillofacial Surgery**

Patients with ocular injury that requires admission only for their ocular injury should be admitted to **Ophthalmology**.

Patients with multisystem trauma or those with significant comorbidities will be admitted to the **Trauma** service.

NEPHROLITHIASIS/HYDRONEPHROSIS/PYLONEPHRITIS

Patients who require admission for pain control or pyelonephritis in the presence of nephrolithiais or urinary stents with concurrent obstruction, should be admitted to **Urology**. Patients who have bilateral hydronephrosis, renal insufficiency or a solitary kidney with an obstructing stone, should be admitted to **Urology**. All other patients with pyelonephritis that require admission should be admitted to **Medicine**.

PANCREATITIS

Patients who have gallstone pancreatitis or necrotizing infections of the pancreatitis should be admitted to **Acute Care Surgery**. All other patients with pancreatitis should be admitted to **Medicine**.

SKIN/SOFT TISSUE INFECTIONS

All abscesses with complex wounds and skin/soft tissue infections that are expected to require OR intervention, should be admitted to **Acute Care Surgery** except in the following specific instances:

1. **Hand** service (**Orthopedics or Plastic Surgery**) taking call that day for infections of the upper extremity that are distal to the antecubital fossa.
2. **Head & Neck Surgery** for infections of the head and neck, excluding infections that are primarily dental in origin. Infections that are primarily dental in origin should be admitted to **Oral and Maxillofacial Surgery**
3. **Orthopedics** for infections of the joints (including septic arthritis, except as specified by **Hand**), lower extremity, knee and below.
4. **Urology** for infections of the scrotum
5. Surgical subspecialty of origin for post-operative wound infections/complications

All other skin and soft tissue infections should be admitted to **Medicine**.

SMALL BOWEL OBSTRUCTION/ILEUS

Patients who have complete small bowel obstruction should be admitted to **Acute Care Surgery**. All other patients who have a partial small bowel obstruction must have **Acute Care Surgery** consult but may be admitted to other services with input from the **Acute Care Surgery** team.

STROKE

Patients with an ischemic stroke, intracerebral hemorrhage, or transient ischemic attack should be admitted to the **Neurology** Service**,** unless they have intracranial hemorrhage that requires surgical intervention, in which case, they should be admitted to **Neurosurgery.**