**Canberra Hospital and Health Services**

**OperationalProcedure**

**Admissions from the Emergency Department to Ward**

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| Purpose |

This procedure outlines the process for referring and admitting non-critical emergency patients into the appropriate inpatient speciality ward in a timely manner. This is to ensure that patients are cared for by the most appropriate team in the most appropriate ward within the hospital.

This Standard Operating Procedure (SOP) describes for staff the process to

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| Scope |

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| Alerts |

If the requested consultation has not occured and decision by the admitting inpatient team is not resolved within one (1) hour, and/or in the event of a difference of opinion, the following escalation process applies:

* In hours, the Director of Operations (or delegate) should be notified of the problem by the ED Navigator, and attempt a resolution. The final decision rests jointly with the Emergency Department Consultant and the Director of Operations.
* Out of hours, the Canberra Hospital and Health Services (CHHS) Executive on call should be notified of the problem by the ED Consultant or Registrar, and attempt a resolution. The final decision rests jointly with the Emergency Department Consultant and the CHHS Executive on call.
* A Consultant specialist cannot refute the decision making of the ED Consultant and Director of Operations or CHHS Executive on call, without reviewing the patient themself in ED and documenting findings and decisions in the patient’s progress notes.

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| Scope |

This procedure applies to all Canberra Hospital and Health Services staff involved in the admission of patients from the Emergency Department (ED) to inpatient wards, including medical, nursing, midwifery, bed management, patient flow, ward and administrative staff.

The authority for this policy lies with the Deputy Director General, Canberra Hospital and Health Services. The primary responsibility for implementing the procedures described lies with the Director, Operations, Canberra Hospital and Health Services.

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| Section 1 – Business as usual |

1. ED Medical staff determine which patients seen in the ED should be referred for admission to inpatient beds and refer the patient to an inpatient speciality.

**Responsible Person/s:**

**ED Interns and ED Resident Medical Officers (RMO’s)** should refer to inpatient team Registrars, after discussion with an ED Registrar or ED Consultant.

**ED Senior Resident Medical Officers (SRMO’s), ED Registrars and ED Consultants** should refer to inpatient team Registrars or Consultants.

1. The bed may be booked once contact has occurred, unless the inpatient team wishes to review the patient first. The rationale for that delay must be clinically appropriate and documented. Should the inpatient team wish to review the patient first, then this review must be completed within 1 hour of the initial contact. It is the responsibility of the first inpatient team contacted to complete within a maximum of one (1) hour of the initial call:
2. Review of the patient in the Emergency Department
3. Referral to any other inpatient teams, if required
4. Resolution of the original admission decision

If this process is not complete within one (1) hour of the initial referral call, then the escalation pathway of this policy is enacted, see Section2 of this Procedure.

Inpatient teams must put in place a strategy to meet this benchmark. The rationale for delay will be reviewed the next working day by the Director of Operations or delegate.

**Responsible person: Admitting Team and Director of Operations or delegate.**

1. If, after referral but within one (1) hour, the inpatient Registrar or Consultant decides that this patient should be admitted under a different specialty, it is the responsibility of that inpatient Registrar or Consultant to refer the patient to the appropriate team. See (b) and (c) above. If this is NOT completed within the hour, the Escalation Pathway of this policy is enacted.

**Responsible Person: Admitting Team and ED Medical staff**

1. The referral for admission for the patient is to be documented, with a date/time entry and a legible name in the patient’s progress notes.

**Responsible person: ED Medical staff**

1. If the patient has been reviewed and accepted by the inpatient team, an *Emergency Department Direct Admission* form No. 30236 located on the Clinical Record Forms Register does not need to be completed, as the inpatient team is responsible for documenting the ongoing management plan in the medical record.

**Responsible person: Admitting Inpatient Team.**

1. If the patient has been admitted prior to inpatient specialty team review, in line with the procedures above, an *Emergency Department Direct Admission* No. 30236 form located on the Clinical Record Forms Register must be completed.

**Responsible person: ED Medical staff.**

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| Section 2 – Commencement of Escalation Pathway |

**The escalation component of the policy is enacted if:**

* **Referral has been made and 1 hour has elapsed without a decision as to the patient admitting team.**
* **Referral has been made and the patient has not been accepted by the initial team to whom the referral has been made and they have not located an alternative team.**
* **There is indecision about which specialty team should admit this patient.**

1. ED Consultant or ED Registrar contact the proposed specialty Consultant or Registrar.

* **The patient’s condition is to be discussed and the receiving doctor** is informed of the admission decision.
* The inpatient team Registrar cannot decline an admission without discussion with their admitting Consultant.
* Contact with a more junior member of the inpatient team does not constitute appropriate transfer of care and is not acceptable.

**Responsible person: ED Consultant or Registrar**

1. If the requested consultation and decision by the admitting inpatient team has not occurred within one (1) hour of the initial contact, and/or in the event of a difference of opinion over whether a patient should or should not be admitted under a particular specialty team, the following needs to occur in the interests of the patient and timely decision-making to provide safe patient care:

* Attempts at resolution should be by direct Consultant to Consultant discussion, or direct ED Registrar to Consultant discussion. It is expected that this will resolve the majority of cases.
* In normal working hours, if a mutually acceptable decision cannot be reached, then the Director of Operations (or delegate) should be notified of the problem by the ED Navigator, to find a solution. The final decision rests jointly with the Emergency Department Consultant and the Director of Operations. Documentation and communication should be as described in this procedure.
* Out of normal working hours, if a mutually acceptable decision cannot be reached, then the Canberra Hospital and Health Services (CHHS) Executive on call should be notified of the problem by the ED Consultant or Registrar to find a solution. The final decision rests jointly with the Emergency Department Consultant and the CHHS Executive on call. Documentation and communication should be as described in this procedure.
* A Consultant specialist cannot refute the decision making of the ED Consultant and Director of Operations or CHHS Executive on call, without reviewing the patient themself in ED and documenting findings and decisions in the patient’s progress notes.
* In the event that the escalation process has had to be enacted, an investigation will be undertaken by the Director of Operations into the circumstances where either they or the CHHS Executive on call have had to intervene in the decision making.
* As part of this investigation, a formal debrief will occur with the Executive Director of the appropriate division, along with the Clinical/Unit Director and Chief Medical Administrator.
* When deemed necessary and requested by the parties involved, the Clinical Safety and Quality Unit will consider doing a root cause analysis (RCA).
* The findings of the investigation will be notified to and appropriately actioned by the Deputy Director General, CHHS.

**Responsible person: Admitting Inpatient Consultants, ED Consultants, Director of Operations, and Executive on call.**

1. If a nominated admitting inpatient Consultant or Registrar does not believe they are the most appropriate inpatient team, they must first accept the admission as arranged in the escalation pathway of this policy and subsequently transfer the care of the patient to an alternative inpatient team. Care of patients cannot be transferred back to the Emergency Department

**Responsible person: Admitting Inpatient Consultants and Registrars**

1. As soon as the inpatient team have been notified of decision to admit a patient the:

* Navigator requests a bed from the Access Unit.
* Access Unit and the receiving ward/unit will be provided with accurate clinical information and documentation by the ED team.

**Responsible person: All ED staff and Access Unit**

1. Prior to the transfer of the patient to the ward/unit:

* The patient will be stabilised and the appropriate therapy commenced
* MEWS scores done as per the *Vital Signs & Early Warning Scores Procedure* and the admitting team informed if the MEWS is greater than or equal to 4.
* If the patient has been reviewed and care accepted by the inpatient team, an “Emergency Department Direct admission form” does not need to be completed, as the inpatient team is responsible for documenting the ongoing management plan in the medical record.

**Responsible person: Admitting Inpatient Team**

* If the patient has been admitted prior to inpatient specialty team review, an “Emergency Department Direct admission form” No. 30236 located on the Clinical Record Forms Register needs to be completed.

**Responsible person: ED Medical staff**

* ED staff will continue to have overall responsibility for the care provided to patients who are physically located within the ED.

**Responsible person: All ED staff**

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| Implementation and Evaluation |

Staff will be advised of the Emergency Department Admission procedure through:

* Executive Directors will notify staff throughout their divisions.
* An All CHHS Staff email notifying staff of the procedure, highlighting the main practice points.
* Information will be tabled at Strategic and Divisional meetings.

The procedure will be evaluated using the following indicators:

* Number of patients transferred to ICU within 24 hours of admission.
* Number of patients waiting longer than one hour from consultation request to bed book time.
* Number of reported cases waiting longer than 1 hour from time of consultation request.
* Number of reported cases of patients changing inpatient teams within 24 hours of admission.
* Number of MET calls within 6 hours of admission from the Emergency Department.
* NEAT Dashboard review by Director, Operations and escalation to CHHS Strategic Executive.
* Appropriate analysis of Quality and Safety bundle by Healthcare Improvement Division to reflect patient safety issues relevant to flow.
* Audits of cases where agreement could not be reached without escalation

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| Related Policies, Procedures, Guidelines and Legislation |

## Policies and Procedures

CHHS Admission Discharge – Adults, Pregnant Women and Neonates

CHHS Clinical Handover procedure

CHHS Patient Identification: Correct Patient, Correct Site, Correct Procedure

CHHS Vital Signs & Early Warning Scores Procedure

## Legislation

*Human Rights Act* 2004

*Health Act* 1993

*Medicare Australia Act* 2005

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| Definition of Terms |

Admitting Inpatient Team – Inpatient Team accepting patient care

Inpatient Team – Medical team providing specialty care to inpatients

ED Navigator – role responsible for the flow of patients through the emergency department

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| Search Terms |

Emergency Department, ED, admission, inpatient ward

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