Guideline for Inpatient Admission Facilitation

Guideline

QH-HSDGDL-025-3:2015

1. Statement

This Guideline describes the steps for the process of admitting patients to an inpatient unit from the Emergency Department (ED).

2. Scope

This Guideline applies to all Hospital and Health Services (HHS) employees and all Queensland Health employees working in or for HHSs. This Guideline also applies to all organisations and individuals acting as an agent for HHSs (including Visiting Medical Officers and other partners, contractors, consultants and volunteers).

Compliance with this guideline is not mandatory, but sound reasoning must exist for departing from the recommended principles within a guideline.

3. Requirements for Inpatient Admission Facilitation

3.1 HHS Chief Executives (CEs) shall ensure that:

3.1.1 **Patients presenting to the ED are discharged, transferred to another facility or admitted to an inpatient unit, within four hours of arrival;**

3.1.2 **A safe and efficient process is in place for patient flow from the ED to the inpatient units;**

3.1.3 **The Inpatient Admission Facilitation Guideline and Flowchart (figure 1) is adhered to by relevant clinical and clerical staff;**

3.1.4 **A hospital wide capacity escalation response procedure is in place to address episodes of increased activity in the ED;**

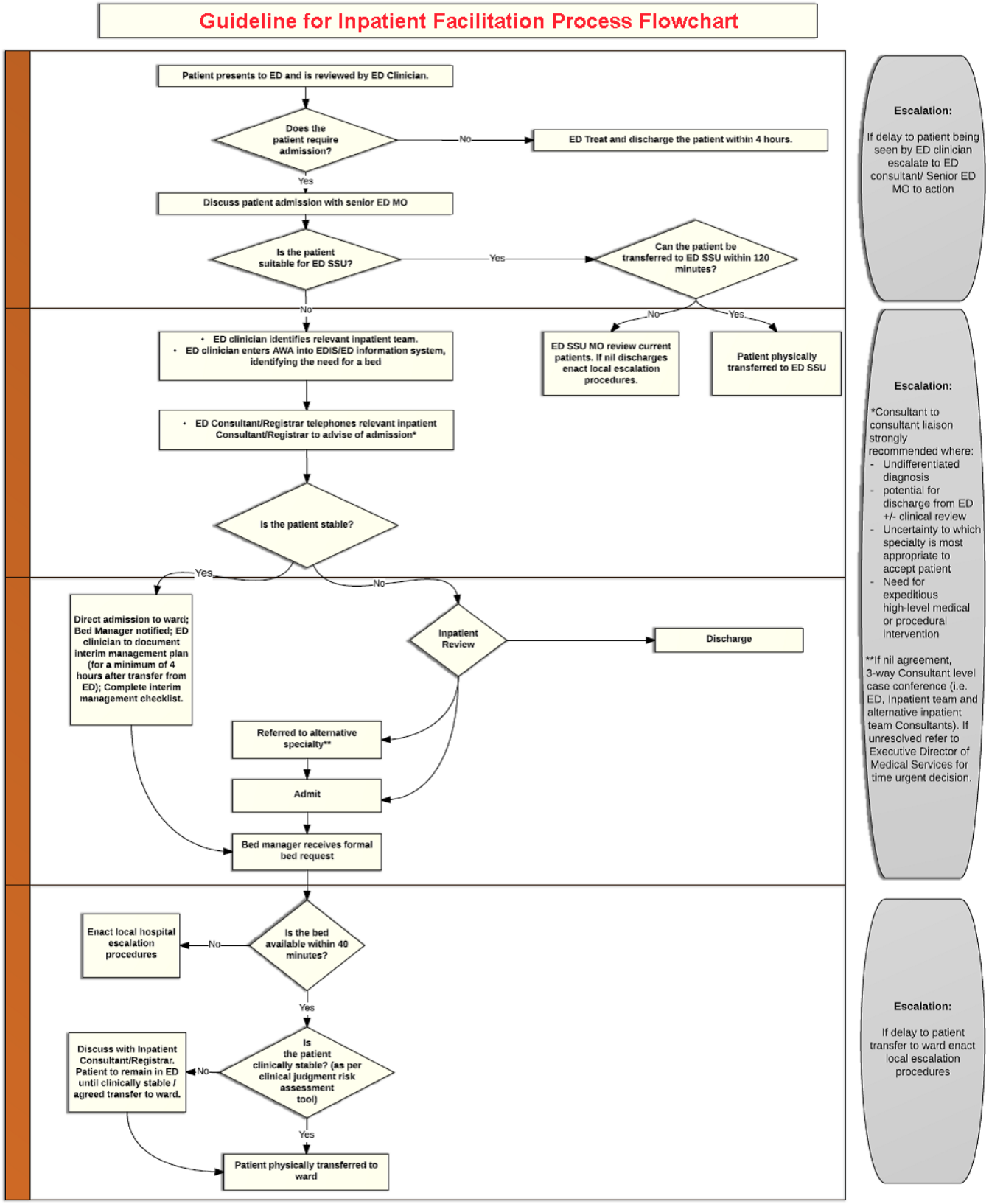
3.1.5 **Stable Inter Hospital Transfer (IHT) patients shall be transported directly to an available inpatient bed unless they have an agreed clinical requirement for ED treatment or have deteriorated intransit, necessitating ED intervention;**

3.1.6 **Each hospital has a nominated staff member responsible for bed management at all times. This role may be performed alongside other duties. This person will be referred to as the "Bed Manager" from here on in this document;**

3.1.7 **The Bed Manager has 'write access' to EDIS / ED information system to facilitate timely bed allocation;**

3.1.8 **A review process is in place to monitor patient safety with an accountable officer nominated to document and audit incidences and issues that may arise from the inpatient admission facilitation process.**

Figure 1: Inpatient Admission Facilitation Process Flowchart



3.2 The Director of Emergency Medicine and ED Nurse Unit Manager (NUM) (or equivalent) shall ensure that:

3.2.1 **Patients presenting to the ED are to be discharged, transferred to another facility or admitted to an inpatient unit within four hours of arrival where clinically appropriate;**

3.2.2 **Appropriate service delivery models, according to site specific demographics and local casemix, are utilised;**

3.2.3 **A Senior ED Medical Officer (MO) (Registrar or Consultant) is involved early in the care and treatment of all patients to facilitate definitive decision making;**

3.2.4 **The relevant inpatient team shall be notified as soon as it has been identified that a patient requires admission;**

3.2.5 **The hospital Bed Manager shall be notified as soon as it has been identified that a patient requires admission;**

3.2.6 **All potential admissions to an Inpatient Unit shall be reviewed and approved by the ED Medical Shift Coordinator; and**

3.2.7 **Any increase in ED activity which impacts on ED capacity is identified early and local escalation procedures activated in a timely manner.**

3.3 The Inpatient Unit Director and NUM (or equivalent) shall ensure that:

3.3.1 **Patients are admitted to an Inpatient Unit from the ED within four hours of arrival where clinically appropriate;**

3.3.2 **Staffing models are in place to enable the timely review and admission or admission pending review on ward of patients waiting in the ED; and**

3.3.3 **Local procedures for responding to incidences of capacity escalation are adhered to.**

3.4 Process for inpatient admission from the ED

3.4.1 **All patients shall be reviewed by an ED clinician, their case discussed with a senior ED MO and a clinical management plan established and documented within 3 hours of arrival to ED.**

3.4.2 **In the event of any delay to patient review by an ED clinician, the Nursing Shift Coordinator shall escalate this to the Medical Shift Coordinator to action and rectify;**

3.4.3 **Once the patient is identified as requiring an inpatient admission, the treating ED clinician, after discussion with the Senior ED MO, shall notify the relevant inpatient team.**

3.4.4 **Bed Manager is notified as soon as it is identified that an inpatient bed will be required. At a minimum this shall occur by entering the code "Awaiting Ward Allocation " (AWA) into the EDIS / ED information system.**

3.4.5 **All MOs making or receiving referrals / clinical handover shall be at Registrar level or above.**

3.4.6 **The treated ED clinician shall document the time of referral in EDIS / ED information system using the "Consultations" box.**

3.4.7 **If the patient is stable according to clinical judgement of the senior ED MO, the patient should be sent directly to the inpatient bed with a four hour interim management plan including the completion of an admission risk screening tool (examples in Appendix B – E).**

- At a minimum, the four hour interim plan shall include all components listed in Appendix A.

- Immediately prior to admission to the wad, a final check of the patient's clinical condition shall be completed and admission authorised by the Senior ED MO.
- If the patient is considered to be clinically unstable and the inpatient bed is ready, the Senior ED MO shall confer with the Senior Inpatient MO to decide the safest location for the patient.
- A member of the inpatient medical team shall review the patient within four hours of admission to the inpatient bed.

3.4.8 Inpatient Registrars shall not refuse an admission from the Senior ED MO.

3.4.9 Inpatient Registrars should only review patients in ED at the specific request of the ED SMO

3.4.10 ED Consultant to Inpatient Consultant referral shall occur in cases of:

- Undifferentiated diagnosis or uncertainty over the appropriate accepting specialty
- Potential for discharge from ED with outpatient clinic review
- Need for expeditious medical or procedural intervention.

3.4.11 A member of the inpatient medical team shall review the patient within four hours of admission to the inpatient bed.

3.5 Escalation process for dispute resolution

3.5.1 If, on review, the inpatient team disagrees that a patient requires admission to the respective specialty, the inpatient team shall make the onward referral to the alternate specialty. The senior inpatient MO shall provide the alternate specialty with a clinical handover and advice of the time frame in which the patient must be reviewed.

3.5.2 In the event of a dispute regarding inpatient team acceptance of the patient, a Consultant level case conference shall be convened. The case conference shall include the ED, original inpatient and alternative inpatient Consultants. The three Consultants shall make a timely clinical decision regarding the patient's admission.

3.5.3 If the matter remains unresolved, then the case shall be escalated to the Executive Director of Medical Services (EDMS) for a clinical and time urgent decision.

3.6 Bed request and allocation process

3.6.1 The Bed Manager shall monitor EDIS / ED information system at regular intervals to enable early identification of patients requiring admission, denoted by the EDIS code "AWA" in the "bed ready / bed request" column on the EDIS tracking screen.

3.6.2 All patients with the EDIS code "AWA" shall be treated as likely admissions by the Bed Manager and preliminary allocation of an inpatient bed shall occur at this time.

3.6.3 The Bed Manager shall receive notification of a confirmed patient admission from the ED Nursing Shift Coordinator, who shall also complete the EDIS Admission Screen at this point. Patient clinical details shall be provided to the Bed Manager to enable accurate bed allocation.

3.6.4 The ED Nursing Shift Coordinator shall ensure that the patient has departed the ED at the time designated as ward ready. If the Inpatient bed is not available within the designated 40 minute timeframe the Bed Manager shall enact local escalation procedures. This shall take place as soon as a potential problem is identified to allow for timely action and resolution of the situation.

4. Supporting documents

- Hospital and Health Boards Act 2011
- National Health Reform Agreement 2011
- National Healthcare Agreement 2012
- National Safety and Quality Health Service Standards

5. Definitions

Term	Definition
Hospital and Health Services (HHSs)	From 1 July 2012, Hospital and health Services will be statutory bodies with Hospital and Health Boards, accountable to the local community and the Queensland Parliament.
Emergency Department Information System (EDIS)	The Emergency Department Information System (EDIS) captures Queensland Health Emergency Department (ED) attendance data
Inter Hospital Transfer	Transferred to another hospital: All separations for the period where the patient is transferred to another hospital for continuation of their admitted care and management.

Version Control

Version	Date	Comments
1.0	18/12/2012	Protocol for Inpatient Admission Facilitation developed
2.0	06/08/2015	Protocol for Inpatient Admission Facilitation updated
3.0	22/03/2016	Protocol amended to a Guideline
4.0	05/07/2016	Document updated

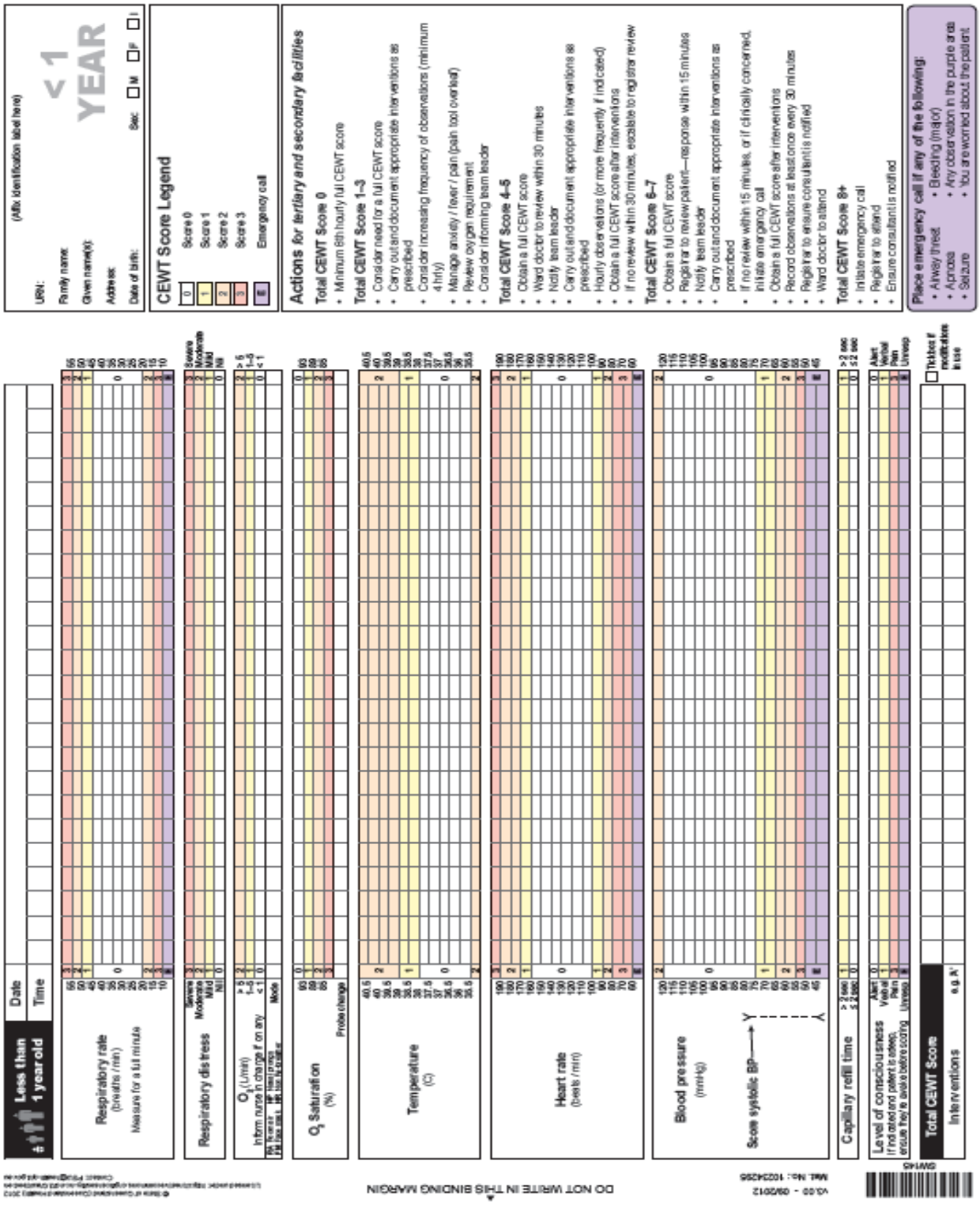
Appendix

Appendix A: Interim Management Plan Checklist

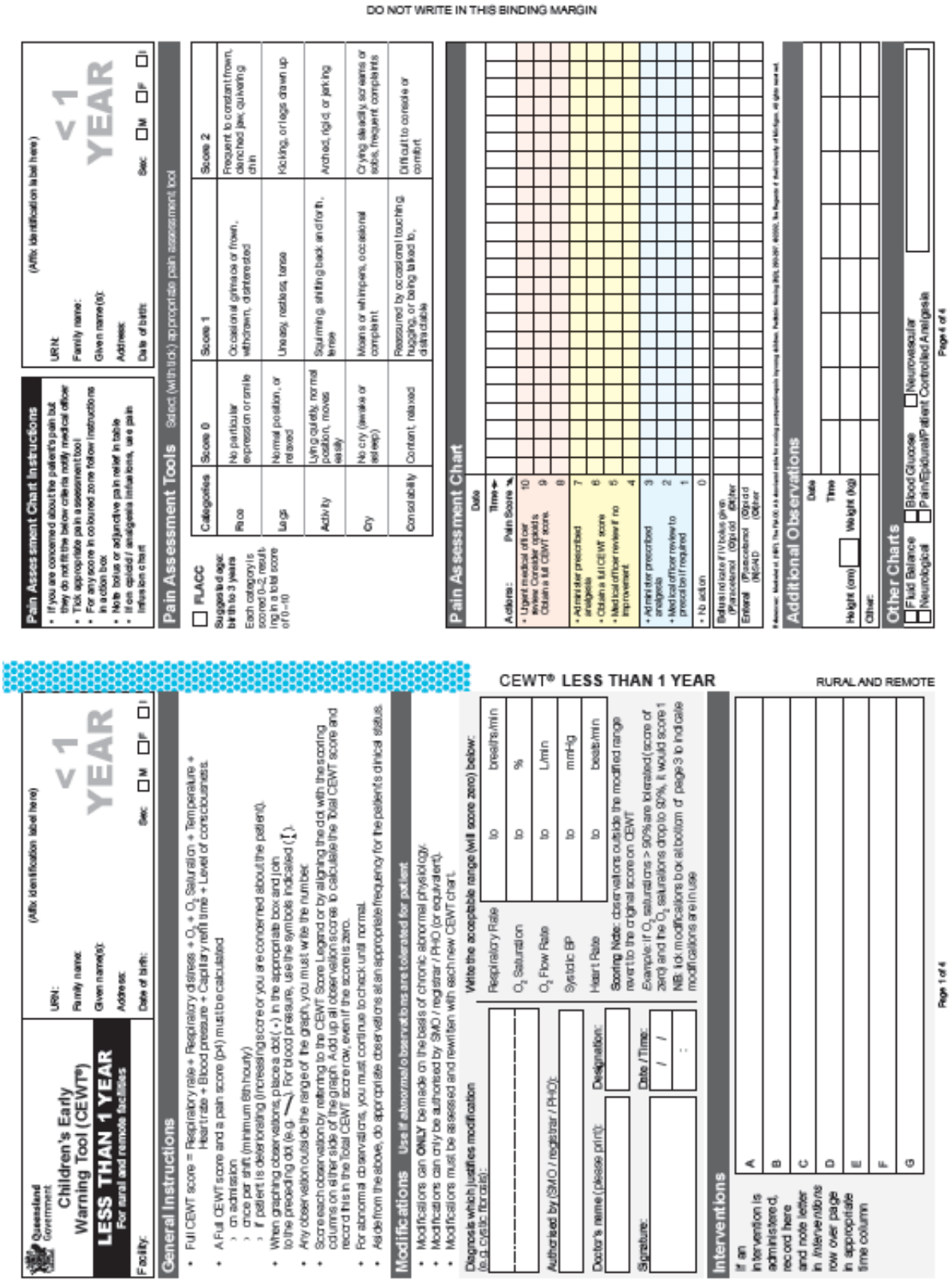
Affix Patient Identification Label Here

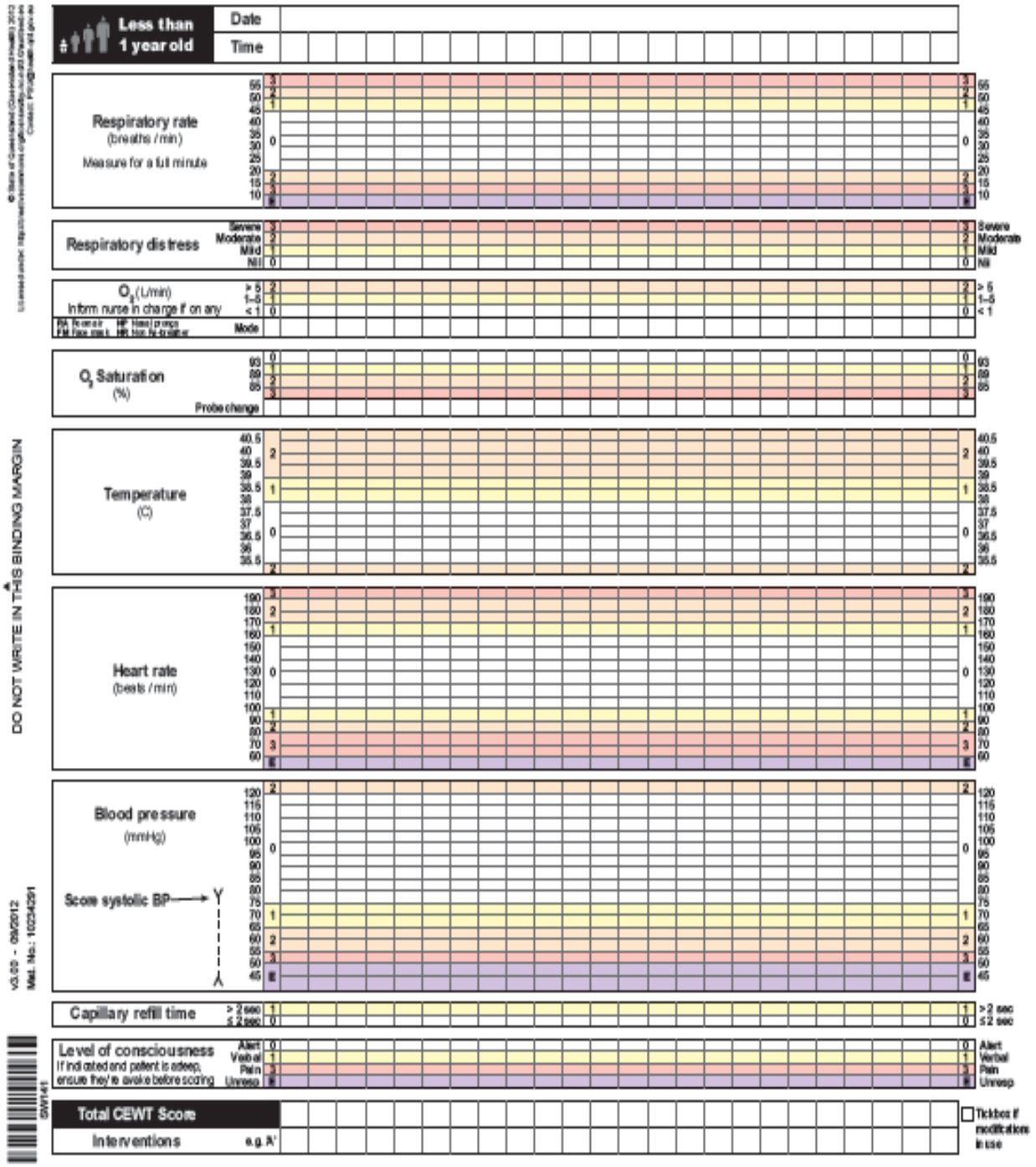
Task (documented in patient medical record)	Yes	No	N/A
Current diagnosis:			
Inpatient Team contacted and accepted patient transfer to ward:			
IV access:			
Basic bloods taken:			
If yes, Results awaited & require review:			
ECG:			
All radiology complete:			
If no, Radiology still awaited:			
Medications / IV Infusions (routine and newly added) charted:			
Pain relief charted:			
Fluid orders charted:			
BGL (frequency) Notify Dr if BSL >15 or <4			
Commence ADDS/CEWT (admission risk screening tool)			
Nil by Mouth:			
Observations:			
O_2 sats ☐ 1 hourly ☐ 2 hourly ☐ 4 hourly			
BP ☐ 1 hourly ☐ 2 hourly ☐ 4 hourly			
HR ☐ 1 hourly ☐ 2 hourly ☐ 4 hourly			
RR ☐ 1 hourly ☐ 2 hourly ☐ 4 hourly			
Neuro ☐ 1 hourly ☐ 2 hourly ☐ 4 hourly ☐ N/A			
Neurovascular ☐ 1 hourly ☐ 2 hourly ☐ 4 hourly ☐ N/A			
Plan for Nursing staff:			
Inpatient team Consultant/Registrar who accepted admission: (Must be completed) Name: Number: Specialty:			
ED Consultant/Registrar: Name: Number:			

Appendix B: Children's Early Warning Tool <1 year for Tertiary and Secondary Facilities.



Appendix C: Children's Early Warning Tool <1 year for Rural and Remote Facilities





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(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

< 1 YEAR

CEWT Score

- 0 Score 0
- 1 Score 1
- 2 Score 2
- 3 Score 3
- E Emergency call

Actions *for rural and remote facilities*

Total CEWT Score 0

- Minimum 8th hourly full CEWT score

Total CEWT Score 1–3

- Consider need for a full CEWT score
- Carry out and document appropriate interventions as prescribed
- Consider increasing frequency of observations (minimum 4 hrly)
- Manage anxiety / fever / pain (pain tool overleaf)
- Review oxygen requirement
- Consider informing team leader

Total CEWT Score 4–6

- Obtain a full CEWT score
- Notify medical officer to review within one hour
- Notify team leader
- Carry out and document appropriate interventions as prescribed
- Hourly observations (or more frequently if indicated)
- Obtain a full CEWT score after interventions
- If no review within one hour, follow local escalation plan for medical support or advice

Total CEWT Score 6–7

- Obtain a full CEWT score
- Local doctor to review within 30 minutes
- Notify team leader
- Local doctor to discuss with paediatrician at either their regional or tertiary facility or medical coordinator QCC[1] (1300 799 127)
- Carry out and document appropriate interventions as prescribed
- Obtain a full CEWT score after interventions
- Record observations at least once every 30 minutes
- If review delayed or clinical concern at bedside – **Nurse to directly notify QCC[1] (1300 799 127) or RFDS[2] (if normal referral pathway)**

Total CEWT Score 8+

- Initiate emergency call
- **Local doctor to attend immediately**
- **Nurse to directly notify QCC[1] (1300 799 127) or RFDS[2] (if normal referral pathway)**

QCC = Queensland Emergency Medical System (QEMS) Coordination Centre
RFDS = Royal Flying Doctors Service (Cairns Base: 4040 0500; Charleville Base: 4658 1445; Mt Isa Base: 4743 3800)

Place emergency call if any of the following:

- Airway threat
- Apnoea
- Seizure
- Bleeding (major)
- Any observation in the purple area
- You are worried about the patient

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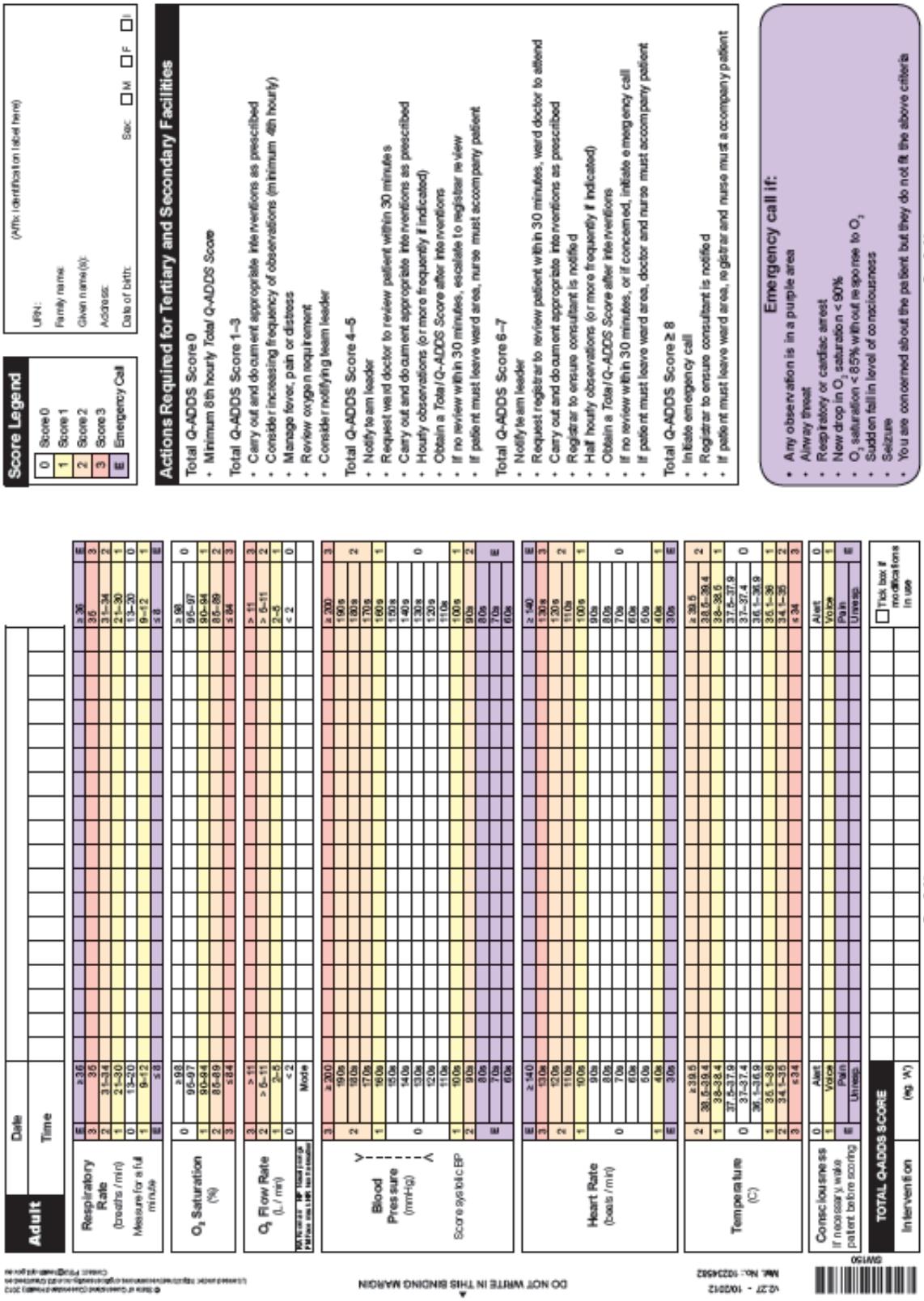
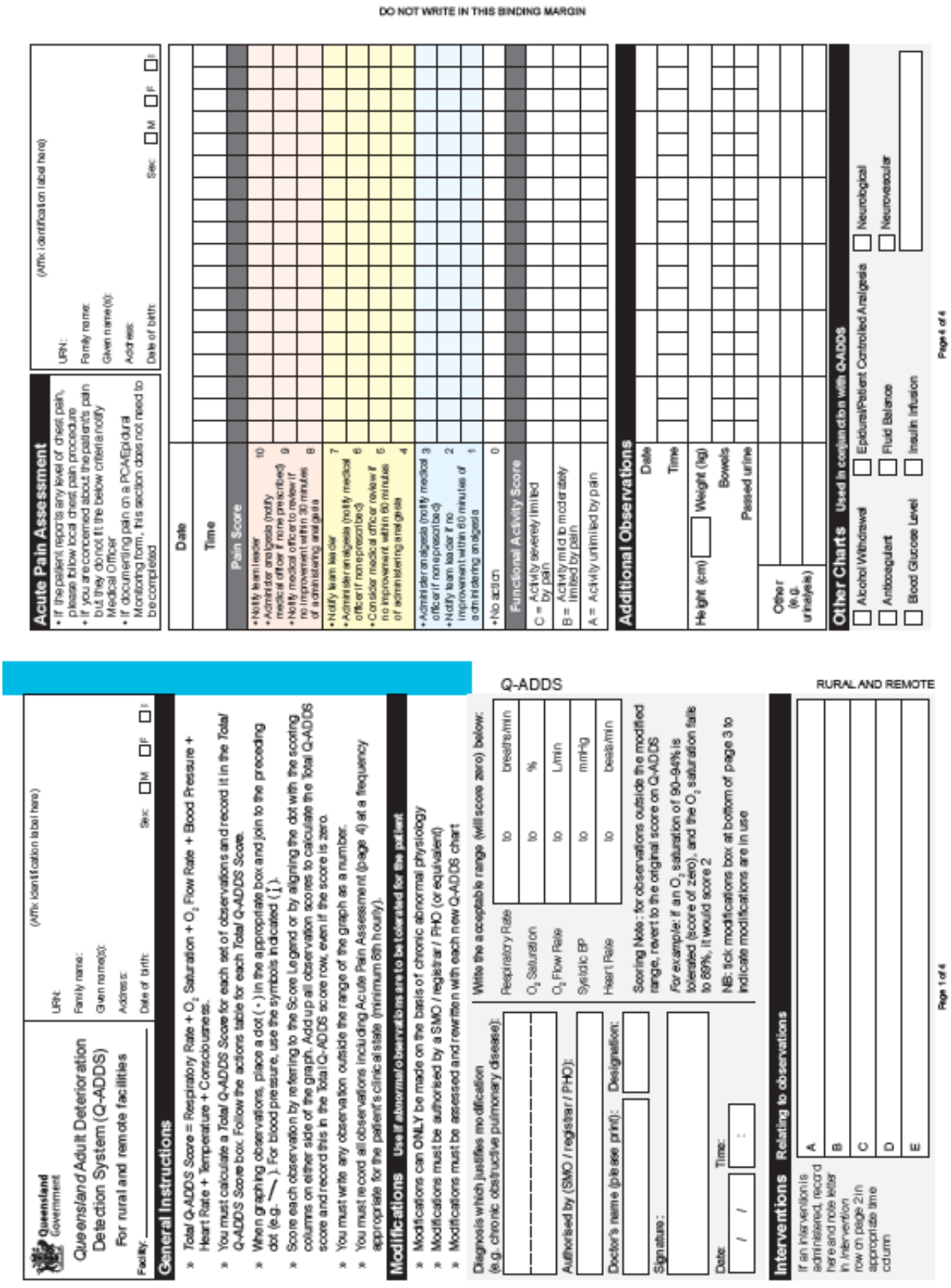
Appendix D: Queensland Adult Deterioration Detection System for Tertiary and Secondary Facilities



Appendix E: Queensland Adult Deterioration Detection System for Rural and Remote Facilities



Adult	Date	
	Time	

Parameter	Score	Range
Respiratory Rate (breaths / min) Measure for a full minute	E	≥ 36
	3	35
	2	31–34
	1	21–30
	0	13–20
	1	9–12
	E	≤ 8
O_2 Saturation (%)	0	≥ 98
	0	95–97
	1	90–94
	2	85–89
	3	≤ 84
O_2 Flow Rate (L / min)	3	> 11
	2	> 5–11
	1	2–5
	0	< 2
		Mode
Blood Pressure (mmHg) — Score systolic BP	3	≥ 200
	2	190s
	2	180s
	2	170s
	1	160s
	0	150s
	0	140s
	0	130s
	0	120s
	0	110s
	1	100s
	2	90s
	E	80s
	E	70s
	E	60s
Heart Rate (beats / min)	E	≥ 140
	3	130s
	2	120s
	2	110s
	1	100s
	0	90s
	0	80s
	0	70s
	0	60s
	0	50s
	1	40s
	E	30s
Temperature (C)	2	≥ 39.5
	2	38.5–39.4
	1	38–38.4
	0	37.5–37.9
	0	37–37.4
	0	36.1–36.9
	1	35.1–36
	2	34.1–35
	3	≤ 34
Consciousness (If necessary, wake patient before scoring)	0	Alert
	1	Voice
	E	Pain
	E	Unresp.
TOTAL Q-ADDS SCORE		
Intervention		(eg. 'A')

☐ Tick box if modifications in use

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Score Legend

Score	
0	Score 0
1	Score 1
2	Score 2
3	Score 3
E	Emergency Call

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐ M ☐ F ☐ I

Actions Required for Rural and Remote Facilities

Total Q-ADDS Score 0
- Minimum 8th hourly *Total Q-ADDS Score*

Total Q-ADDS Score 1–3
- Carry out and document appropriate interventions as prescribed
- Consider increasing frequency of observations (minimum 4th hourly)
- Manage fever, pain or distress
- Review oxygen requirement
- Consider notifying team leader

Total Q-ADDS Score 4–5
- Notify medical officer to review within 60 minutes
- Notify team leader
- Carry out and document appropriate interventions as prescribed
- Hourly observations (or more frequently if indicated)
- Obtain a *Total Q-ADDS Score* after interventions
- If no review within 60 minutes, follow local escalation plan for medical support or advice

Total Q-ADDS Score 6–7
- Local doctor to review within 30 minutes
- Notify team leader
- Local doctor to discuss with relevant medical officer at their regional or tertiary facility. If unavailable, and patient likely to require transfer, contact QCC[1] (1300 799 127) or RFDS[2] (if normal referral pathway)
- Carry out and document appropriate interventions as prescribed
- Half hourly observations (or more frequently if indicated)
- Obtain a *Total Q-ADDS Score* after interventions
- If review delayed or concern at bedside, nurse to directly notify QCC[1] (1300 799 127) or RFDS[2] (if normal referral pathway)

Total Q-ADDS Score ≥ 8
- Initiate emergency call as per local facility protocol
- Local doctor to attend immediately
- Nurse to directly notify QCC[1] (1300 799 127) or RFDS[2] (if normal referral pathway)

[1] QCC = Queensland Emergency Medical System (QEMS) Coordination Centre
[2] RFDS = Royal Flying Doctors Service (Cairns Base: 4040 0000; Charleville Base: 4654 1443; Mt Isa Base: 4743 2802)

Emergency call if:
- Any observation is in a purple area
- Airway threat
- Respiratory or cardiac arrest
- New drop in O_2 saturation < 90%
- O_2 saturation < 85% without response to O_2
- Sudden fall in level of consciousness
- Seizure
- You are concerned about the patient but they do not fit the above criteria

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