

HARBOR-UCLA MEDICAL CENTER

SUBJECT: ADULT EMERGENCY DEPARTMENT
CONSULTATION AND ADMISSION GUIDELINES

POLICY NO. 312

PURPOSE:

To ensure that all workforce members are aware of the consultation and admission guidelines for the Adult Emergency Department.

POLICY:

The following guidelines are intended for use by Emergency Department (ED) staff and the inpatient services that provide consultations to the Adult ED and admit patients from the ED in order to facilitate and expedite patient care. The guidelines have been reviewed and agreed upon by all of the Departments and Divisions that provide consultation to the Adult ED.

PROCEDURE :

- I. **General Consultation and Admission Guidelines**
 - A. Departments of Medicine and Family Medicine
 - B. Departments of Surgery, Orthopedics, Neurology and Obstetrics and Gynecology
 - C. Department of Psychiatry
 - D. Observation
- II. **Admission of Patients with both Medical and Surgical Problems**
- III. **Emergency Department Evaluation of Admitted Patients**
(Ancillary Tests, Procedures and Consultations)
- IV. **Guidelines for Specific Medical Disorders**
 - A. Aortic Aneurysms
 - B. Brain Death/Organ Donation
 - C. Burns
 - D. Cellulitis (Non-maxillofacial)
 - E. Clotted Dialysis Grafts
 - F. Decubitus Ulcers

EFFECTIVE DATE: 04/10/84

SUPERSEDES:

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- G. Deep Venous Thrombophlebitis
- H. Delirium/Dementia
- I. Disposition Problems
- J. Gastrointestinal Bleeding
- K. Hand Injuries
- L. Intracranial Mass Lesions
- M. Low Back Pain
- N. Maxillofacial Trauma
- O. Maxillofacial Infections
- P. Meningitis
- Q. Osteomyelitis
- R. Painless Jaundice
- S. Pancreatitis
- T. Pyelonephritis
- U. Septic Arthritis
- V. Spinal Injuries
- W. Stroke
- X. Thyroid Mass
- Y. Trauma Patients

I. GENERAL CONSULTATION AND ADMISSION GUIDELINES

A. DEPARTMENTS OF MEDICINE AND FAMILY MEDICINE

The decision regarding the need for admission of a patient to the Internal Medicine or Family Medicine services is made by the Emergency Medicine attending physician in their capacity as supervisor of the resident evaluating the patient in the ED.

The admitting team is to be notified immediately once a decision for admission has been made.

When an inpatient ward bed is available the patient is to be immediately transported to that bed after notification of the admitting resident. If the admitting team has not written admission orders, the ED staff is to write holding orders. The admitting resident should always be informed when holding orders have been written.

When an inpatient monitored (telemetry, PCU or ICU) bed is available, the admitting resident should be immediately notified of the admission. The admitting resident will have 30 minutes from the time they are notified of the admission to write admission orders for these beds. If the admitting resident does not write admission orders within 30 minutes of notification, the ED staff are to write holding orders and have the patient transported to the available bed. The admitting resident should be notified when holding orders are written.

The holding orders should include the following:

1. Admit Medicine (or Family Medicine).
2. Diagnosis:
3. Resident: Beeper:

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4. Activity:
5. Diet:
6. Vital signs upon arrival:
7. IV order:
8. O₂ order:
9. Call admitting resident immediately upon patient arrival for further orders.

All Monitored Beds

10. Continuous cardiac monitor

ICU Beds

11. Ventilator settings
12. Continuous medication infusion orders

When an inpatient bed is not available, the admitting service should evaluate the patient in the ED as soon as possible, write admitting orders, and assume responsibility for the patient's ongoing management. The patient should be transported to an inpatient bed as soon as one becomes available. The ED staff should write holding orders if an inpatient bed becomes available and the admitting team has not written admission orders (even if they have not yet seen the patient); in such cases, the admitting team should be informed that holding orders have been written and that the patient is being transported to an inpatient bed. Note: Holding orders may not be written for admissions to Ward Call or to the Hospitalist Service.

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.

Disagreements regarding admissions between the residents in the ED and the admitting teams will be resolved in one of the following ways:

1. 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 write a consultation note for the medical record and will assume responsibility for the patient's ongoing care.
2. If the attending physician for the admitting service is not available to evaluate the patient, a final decision will be made by the Emergency Medicine attending physician on duty. The Emergency Medicine faculty have admitting privileges to the Internal Medicine and Family Medicine services.

**B. DEPARTMENTS OF SURGERY, ORTHOPEDICS, NEUROLOGY AND
OBSTETRICS AND GYNECOLOGY**

The initial decision regarding the need for admission of a patient to the General Surgery or surgery subspecialty services, to Orthopedics, to Neurology, or to Obstetrics and Gynecology is made by the resident evaluating the patient in the ED under the direct supervision of the Emergency Medicine faculty.

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Consultations may be performed by a junior level resident from the admitting service, in consultation with the chief resident or attending physician for that service, using the following guidelines:

- A. All consultations (including patient assessment, discussion with the chief resident or attending physician, provision of a consultation note for the medical record and, when appropriate, writing admission orders) should be completed within 2 hours of the initial request for consultation. If a consultation cannot be completed within 2 hours the attending physician for the consulting service is to be contacted by the Emergency Medicine attending physician to facilitate completion of the consultation.**

Note: Non-emergent consultations provided by the divisions of Plastic Surgery and Head and Neck Surgery can be deferred until the following morning when requested after 8:00 PM, using the following guidelines:

- 1. Cases should be presented over the phone to the on-call resident who can choose to defer the consultations until the following morning if they are non-emergent in nature and the emergency physician agrees.**
 - 2. Non-emergent patients requiring hospitalization can be admitted by the in-house resident covering the consulting service following discussion with the on-call resident.**
 - 3. Consultations for non-emergent patients who do not require admission will be performed by the consulting service as a first order of business the following morning.**
 - 4. Clinical procedures for patients receiving consultation should be performed by the on-call resident or fellow, or by the in-house resident in the presence of and under the direct supervision of the on-call resident or fellow.**
- B. If the Emergency Medicine attending physician disagrees with the treatment or disposition suggested by the consulting service, a final decision will be made in one of the following ways:**
- 1. If the attending physician for the consulting service is available to personally evaluate the patient, they will make a final decision. The consulting service will write a note for the medical record and assume responsibility for coordinating the patient's ongoing care.**
 - 2. If the attending physician for the consulting service is not available to personally evaluate the patient, a final decision will be made by the**

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Emergency Medicine attending physician after they have personally evaluated the patient; in such cases, the Emergency Medicine attending should discuss the case with the attending physician for the consulting service.

C. DEPARTMENT OF PSYCHIATRY

The Department of Psychiatry supervises a separate area of the emergency department where patients with behavioral disorders are evaluated. The following guidelines pertain to interactions between the Adult ED and the Psychiatric ED.

Consultations between the Adult and Psychiatry areas of the ED are performed by the residents (PGY2 or above) assigned to those areas using the following guidelines:

- A. Whenever possible, patients requiring consultation should be seen in the area of the emergency department seeking the consult. If the consulting service decides to take over the care of the patient or feels that for safety reasons the patient is better served in the psychiatry emergency room, the patient should be transferred.
- B. All consultations (including patient assessment, discussion with the department's supervising resident or attending physician, and provision of a consultation note for the medical record) should be completed within 2 hours of the request for consultation. If a consultation is not performed within 2 hours, the appropriate service's attending physician should be contacted to facilitate completion of the consultation.
- C. If after personally evaluating the patient, the Emergency Medicine attending physician disagrees with the treatment or disposition suggested by the consulting service, a final decision will be made in one of the following ways:
 1. If the attending physician for the consulting service is available to personally evaluate the patient, they will make a final decision. The consulting service will write a note for the medical record. The service where the consult originated will retain responsibility for coordinating the patient's ongoing care, with continued consultation as necessary.
 2. If the attending physician for the admitting service is not available to personally evaluate the patient, the patient will be kept in the consulting service's area of the emergency department until the attending physician for that service is available to evaluate the patient and render a final decision.
- D. Patients in the Psychiatric ED with BMI greater than 45, who are also being treated with medications that have the potential to suppress their respirations, should be observed in the Adult ED overnight to monitor their respiratory status. These patients will be given first priority to move back to the Psychiatric ED in the morning.

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D. OBSERVATION

1. Patients who have been evaluated in the ED and meet criteria for observation services will be considered for observation. For further details, please see the DHS Policy on Observation Services (376.000) and the Harbor-UCLA ED Hospitalist Observation Services Guidelines. Patients who are deemed not appropriate for Observation will be admitted to the appropriate inpatient service as determined by the ED Attending Physician.

II. ADMISSION OF PATIENTS WITH BOTH MEDICAL AND SURGICAL PROBLEMS

Patients with known or suspected surgical disorders who have minor co-existing medical disorders (ex. hypertension or diabetes) should be admitted to the appropriate Surgical Service. If desired, the Surgical Service can obtain consultation from the Medical Consultation Service following the ED guidelines for consultation on admitted patients (see below).

Occasionally, patients with known or suspected surgical disorders are found to have significant co-existing medical disorders. Patients requiring an emergent surgical procedure should be admitted to the appropriate Surgical Service with immediate consultation from the Medical Consultation Service. Patients requiring medical management prior to surgery should be admitted to Medicine with immediate consultation from the appropriate Surgical Service. The appropriate admitting service will be determined by the Emergency Department attending physician using the following guideline: if the patient's medical problem would normally have been admitted to Medicine for inpatient care, the patient should be admitted to Medicine with consultation from the appropriate Surgical Service. This decision can be changed by mutual decision of the services involved.

III. EMERGENCY DEPARTMENT EVALUATION OF ADMITTED PATIENTS

ANCILLARY TESTS

In general, only those tests necessary to evaluate a patient's acute problem(s) and allow prompt initiation of urgent therapies should be done within the Emergency Department.

NOTE - Admitted patients with an available inpatient bed who are waiting for a radiographic study (e.g., CT, ultrasound, angiogram) or surgical procedure should be transferred to their hospital bed while they wait for these procedures if the expected delay exceeds 1 hour.

PROCEDURES

Those procedures (lumbar puncture, central venous lines, arthrocentesis, etc.) which are required to stabilize a patient's condition, or which are necessary to assess the need for hospitalization or to determine the appropriate admitting service, should be performed by the physician evaluating the patient within the Emergency Department. Once the decision to hospitalize a patient has been made, further procedures should be performed by the admitting team.

The decision as to where procedures for admitted patients are to be performed is to be made by the

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Emergency Medicine senior resident or attending physician after discussion of the case with the admitting team. Such factors as the condition of the patient, inpatient bed availability and the number and acuity of patients awaiting Emergency Department evaluation should be taken into account.

CONSULTATIONS

Consultations for admitted patients should be performed after the patients have been transferred to an inpatient bed **unless** such consultation is deemed necessary for the immediate management of the patient, i.e., urgent therapies rendered during the first 6 hours following the decision for admission.

When an inpatient bed is available, the decision as to where a consultation for an admitted patients is to be performed is to be made by the Emergency Medicine attending physician or senior resident after discussion of the case with the admitting team.

Such factors as the condition of the patient and the number and acuity of patients awaiting Emergency Department evaluation should be taken into account.

IV. GUIDELINES FOR SPECIFIC MEDICAL DISORDERS**A. AORTIC ANEURYSMS**

Patients with **traumatic thoracic aortic injuries** should be evaluated and admitted to **Trauma Surgery**.

Patients with **non-traumatic thoracic aortic dissections** involving the proximal aorta (between the heart and left subclavian artery) and those with significant complications of dissection (e.g., hypotension, aortic valve insufficiency, major vessel occlusion or cardiac tamponade) should be admitted to **Cardiothoracic Surgery**.

All other patients with possible or documented non-traumatic descending thoracic aortic dissection should be admitted to **Medicine**. Cardiothoracic Surgery consultation should be initiated by the ED staff in all such cases.

Patients with expanding or ruptured **abdominal aortic aneurysms** should be admitted to **Trauma Surgery**, or to **Vascular Surgery** if immediately available.

B. 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 Surgery, 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 as outlined in hospital policy #316.*

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C. BURNS

Burns requiring hospitalization should, if possible, be transferred to a hospital with a burn unit. **Trauma Surgery** should provide consultation for patients with burns, and admission if a burn unit bed is unavailable.

D. CELLULITIS (Non-maxillofacial)

All patients with non-maxillofacial cellulitis requiring hospitalization should be admitted to **Medicine** with two exceptions:

1. Patient with cellulitis (or an abscess) of the upper extremity (from the hand to the antecubital fossa) should be admitted to the service taking hand call for the day (**Plastic Surgery or Orthopedics**).
2. Patients with suspected necrotizing fasciitis and patients requiring a surgical procedure (ex. abscess drainage) within the first 24 hours of hospitalization should be admitted to **General Surgery**.

E. CLOTTED DIALYSIS GRAFTS

Patients requiring an Interventional Radiology procedure for clotted dialysis grafts should be admitted to **Medicine** with consultation from **Vascular Surgery**. The **Vascular Surgery** consult should be provided on the ward after the patient has been admitted.

F. DECUBITUS ULCERS

Patients who require hospitalization primarily for wound care of decubitus ulcers should be admitted to **Plastic Surgery** (regardless of whether the patient requires a surgical procedure). Patients with decubitus ulcers who require hospitalization primarily for management of medical problems and/or nursing home placement should be admitted to **Medicine**.

G. 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 surgical service that operated on the patient, if they present within 6 weeks of the operation. All other patients with suspected DVT should be admitted to **Medicine**.

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H. 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 require **hospitalization for placement** should also be admitted to **Medicine**.

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**.

I. DISPOSITION PROBLEMS

Patients must sometimes be hospitalized for problems which do not usually require admission simply because they are unable to care for themselves in an outpatient setting. Such patients are, in general, admitted to **Medicine**. However, there are *two exceptions*:

1. A patient who develops complications from a medical or surgical problem who is already being followed by a particular service in the outpatient setting should be admitted to that service if hospitalization becomes warranted.
2. If a patient's problem is solely surgical and the patient does not have co-existing medical problems requiring acute therapy, the patient should be admitted to the appropriate surgical service for care and disposition (e.g., a patient with a fracture who cannot care for him/herself at home because of the injury should be admitted to Orthopedics).

J. GASTROINTESTINAL BLEEDING

Patients with **upper gastrointestinal bleeding** should be admitted to **Medicine**. General Surgery consultation should be obtained in the Emergency Department for unstable patients.

Patient with **lower gastrointestinal bleeding** should be admitted to **Trauma Surgery**. Medical consultation should be obtained in the Emergency Department for patients with unstable medical problems requiring acute therapy.

K. HAND INJURIES

Open and closed fractures of the forearm and hand should be referred to **Orthopedics**. Soft tissue injuries of the upper extremity up to and/or involving the antecubital fossa should be referred to the service taking hand call for the day (**Plastic or Orthopedic Surgery**).

L. 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**. Neurology consultation is not necessary in the ED unless the patient's clinical status is deteriorating.

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Patients with solitary intracranial lesions who are at risk for herniation should be admitted to **Neurosurgery**.

M. LOW BACK PAIN

Consultation/admission for patients with low back pain associated with a neurologic deficit (motor, sensory, or reflex change) should be provided by **Neurosurgery**.

Consultation/admission for patients with low back pain unassociated with a neurologic deficit should be provided by **Orthopedics**.

N. MAXILLOFACIAL TRAUMA

Consultation/admission for patients with maxillofacial soft tissue injuries and other maxillofacial fractures (mandible, maxilla, orbital floor fractures, etc.) should be rotated between the **Head and Neck Surgery, Plastic Surgery, and Oral and Maxillofacial Surgery** services based upon the monthly maxillofacial trauma call schedule. While **Maxillofacial Call** runs from 7:00 AM-7:00 AM, nighttime requests for consultation should be placed before 6:00 AM when possible.

Patients with orbital floor fractures associated with ocular injury should be admitted to **Ophthalmology**.

O. MAXILLOFACIAL INFECTIONS

Consultation/admission for patients with maxillofacial infections involving the orbit should be provided by **Ophthalmology**.

Consultation/admission for patients with dental infections or odontogenic abscesses should be provided by **Oral and Maxillofacial Surgery**.

Consultation/admission for patients with maxillofacial infections involving the sinuses and complicated dental infections with secondary facial or neck infection (i.e., extension into the soft tissue of the head and neck area) should be provided by **Head and Neck Surgery**.

Other patients with maxillofacial infections should be rotated between **Head and Neck Surgery, Plastic Surgery and Oral and Maxillofacial Surgery** services based upon the monthly maxillofacial trauma call schedule. While **Maxillofacial Call** runs from 7:00 AM - 7:00 AM, nighttime requests for consultation should be placed before 6:00 AM when possible.

P. MENINGITIS

Patients with meningitis should be admitted to **Medicine** if they have an even HH# and to **Neurology** if they have an odd HH#. Patients with meningitis who have other significant medical problems should be admitted to **Medicine** regardless of the HH#. A positive HIV test is not considered to be a significant medical problem when deciding admitting service.

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Q. OSTEOMYELITIS

Patients with osteomyelitis requiring hospitalization should be admitted to **Medicine** if they have an even HH# and to **Orthopedics** if they have an odd HH#. Patients with urgent or emergent medical problems should be admitted to **Medicine** regardless of the HH#. Patients requiring surgical treatment should be admitted to **Orthopedics** regardless of the HH#.

Patients with **chronic osteomyelitis** who do not require hospitalization should be followed by **Orthopedics**.

R. PAINLESS JAUNDICE

Patients suffering from painless jaundice should be admitted to **Medicine** for evaluation.

S. PANCREATITIS

Patients experiencing their first episode of pancreatitis should be admitted to **Trauma Surgery**. All episodes of recurring pancreatitis should be admitted to **Medicine**. An exception to this rule may be made if recurrent pancreatitis presents in a patient who may require surgery.

T. PYELONEPHRITIS

Pregnant women with pyelonephritis who require hospitalization should be admitted to **Obstetrics and Gynecology**. Men and nonpregnant women with pyelonephritis, including patients with renal stents in the absence of urinary tract obstruction, who require hospitalization should be admitted to **Medicine**. Pyelonephritis associated with nephrolithiasis, or the urinary stents in the presence of urinary tract obstruction, should be admitted to **Urology**.

U. SEPTIC ARTHRITIS

Patients with septic arthritis involving the shoulder or hip should be admitted to **Orthopedics** unless they have medical problems requiring urgent or emergent therapy. Patients with septic arthritis involving all other joints should be admitted to **Medicine**.

V. SPINAL INJURIES

Consultation/admission for patients with isolated cervical spine injuries, or any isolated acute spinal injury associated with a neurologic deficit, should be obtained from **Neurosurgery**. Consultation/admission for patients with thoracic or lumbar spine injuries unassociated with a neurologic deficit should be obtained from **Orthopedics**.

W. STROKE

Patients with strokes should be admitted to **Neurology** with the following exceptions:

1. Patients with traumatic intracranial hemorrhage from isolated head injury should be admitted to **Neurosurgery**.
2. Patients with non-traumatic intracranial hemorrhage who require surgical intervention should be admitted to **Neurosurgery**.

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3. Patients with strokes requiring urgent or emergent medical therapy should be admitted to **Medicine**. Such patients do not require neurological consultation within the Emergency Department unless there is no inpatient bed available or the patient's neurological status is unstable.

X. THYROID MASSES

Patients with thyroid masses or enlargement should be referred to Thyroid Mass Screening Clinic (Endocrinology) for evaluation.

Y. TRAUMA PATIENTS


In those instances when it is clear that only **one major organ system** is involved, traumatized patients should be admitted to the appropriate surgery sub-specialty service (e.g. Neurosurgery for isolated head trauma, Orthopedics for extremity injuries, etc).

Traumatized patients with **2 or more major organ systems** involved, or patients who have a history of significant trauma who require observation for possible occult injuries, should be admitted to **Trauma Surgery**.

Patients should be admitted as soon as it is determined that they will require hospitalization and following admission become the responsibility of the surgery service (admission orders should be written at the time of consultation and physician monitoring of the patient during special procedures, when necessary, should be provided by the surgery service). If surgery sub-specialty consultation is not required for the *immediate* management of the patient, such consultation should be obtained following admission of the patient to a hospital bed.

Some traumatized patients suffer **multiple minor injuries**, no single one of which would require hospitalization, but the sum total of which results in a patient who requires observation or who cannot care for himself on an outpatient basis. Such patients should be admitted to the appropriate surgical service (e.g. head trauma patients with confusion but a normal CT scan to Neurosurgery, fractures of both hands or feet to Orthopedics, bilateral ocular trauma to Ophthalmology, and multiple minor injuries to Trauma Surgery).

Revised and Approved by:
Medical Executive Committee on 2/27/12



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