

SCVMC ED Admission Grid Guidelines

In order to optimize inpatient flow, patient care and related publically reported metrics, this chart has been developed to guide the appropriate admitting service for illnesses that may be viewed as overlapping between medical and surgical specialties for ED or transfer admissions. The admitting specialty may request additional consultations from other specialties. Also, transfers between services can be made as the cases define themselves over time. It is inappropriate for patient care or admission to be slowed by prolonged disagreement regarding the admitting specialty service or inefficient consultation process. This chart has been developed in conjunction with medicine and surgery department leadership.

This chart is a guideline based on the MOST concerning diagnosis requiring admission. When there are active co-morbidities compromising the patient’s condition then clinical judgment is needed. In many cases consultation by another specialty may add the needed support. The medicine consultation service is now available daily (7d/wk). If there are significant active co-morbidities (acute tachy or brady-arrhythmias, DKA, hypertensive crisis, acute coronary syndrome, decompensated CHF, unstable severe sepsis etc.) that require acute care then this may be the most important reason for admission and may determine the appropriate service and level of care. Disposition problems are not considered a co-morbidity. Behavioral concerns can usually be appropriately handled with a consult.

If there is a disagreement between specialties then urgent resolution is expected. The initial specialty contacted should contact their attending. If this attending believes the patient should be admitted by another specialty then he/she needs to contact the other specialty’s attending and resolve the admitting responsibility. If they cannot agree then the initial specialty contacted is expected to admit the patient. This service may request a consult from the other specialty if needed. Either attending or the ED attending may elect to have the case reviewed by the Medical Staff Hospital Peer Review Committee for review with the goal of process improvement for the future

Thank you for your commitment to our patients and SCVMC

Medical Director, SCVMC

	Diagnosis	Surgery	Medicine
Neurosurgery	Intracranial or Spinal lesions (tumor/infection)	Neurosurgery if emergent surgery needed	Not immediate surgical need- Medicine with neurosurgery consult if needed
	Aneurysmal SAH	Neurosurgery	
	Spontaneous ICH		Medicine
	Acute proven shunt failure needing surgery	Neurosurgery	
	Acute traumatic brain or spine Injury	Trauma	

Neurosurgery	Subdural non operative with acute medical co-morbidities and no other trauma		medicine
	Chronic subdural hematoma-symptomatic and requiring non-emergent surgery	Neurosurgery	
Skin, soft tissue Infection	Cellulitis and/or abscess requiring surgery (i.e. large abscess, nec fasc)	Gen Surgery- if above elbow, trunk, buttock, perineum, lower extremity (excluding joints) Hand Call-if at or below elbow to hand	
	Cellulitis not requiring surgery- may include laceration or wound		Medicine
	Post-operative wound infection	Specialty that performed the surgery	
	Decub ulcers	-Urgent ER consultations go to General Surgery for consideration for debridement if patient is septic and there is concern that the wound is the primary source. There is NO role for urgent flap coverage. Only stable, clean wounds are candidates for flap coverage and this will be determined in coordination between PM&R and Plastic Surgery on an elective basis. - Ortho to be involved if surgical plan by Plastic Surgery deems Ortho involvement necessary - If Plastics does not see a role for their involvement and the consulting service feels that patient would benefit from Ortho consultation, requesting	

		MD should contact Ortho attending.	
	Ischemic extremity – no pulse	Vascular Surgery	
	Foot ulcers – wet Or Bone Biopsy	Consult Podiatry during regular business hours -If after 5pm during week or weekend and concern of sepsis or need for emergent amputation, can consult Gen Surg, Vascular or Ortho as deemed necessary.	
	Foot ulcers – sig. comorbidity (DKA, etc)		Medicine
	Foot ulcer - dry		Medicine
Urologic	Pyelonephritis		Medicine
	Nephrolithiasis requiring admission for concerning hydro, pain or concurrent pylo,	Urology	
	Urological mass, lesion or isolated Uro trauma	Urology	
	Isolated scrotal infection, inflammation	Urology	
	Testicular torsion or trauma	Urology	
Abdominal	Abdominal abscess	Gen Surgery	
	Pelvic female abscess	Gynecology	
	Diverticulitis with perf & peritonitis or abscess	Gen Surgery	
	Diverticulitis(includes micro-perforation)		Medicine
	Appendicitis - all treatment plans	General Surgery	
	Gallbladder, cholelithiasis cholecystitis,	Gen Surgery	
	Gallstones and pancreatitis	Gen Surgery	
Abdominal	Pancreatitis- no GB stones		Medicine
	GI Bleed		Medicine

	Intractable pain or emesis (-CT)		Medicine
	<i>Intractable pain or emesis; +CT- operative</i>	Gen Surgery	
	SBO - operable	Gen Surgery	
	SBO – non-operable/medical		Medicine
	AAA	Vascular surg	
Vascular	Type A aortic dissection	CV surgery	
	Type B aortic dissection		ICU- Medicine
Musculoskeletal	Back pain		Medicine
	Back pain - stable Fx		Medicine
Musculoskeletal	Back pain + new neuro finding or unstable Fx	Neurosurgery	
	Fx – long bone	Orthopedics	
	Fx – Femur Fracture ≥ 65	See geriatric femur fracture guidelines below	
	Fx – pain (non-operable)	Orthopedics (if no significant co-morbidities)	Medicine (if significant co-morbidities)
	Fx – pathologic +OR	Orthopedics	
	Fx – pathologic –OR		Medicine
	Fx- Closed Adult Metatarsal and Phalanx		Podiatry
Hand* May change with new Hand service starting Fall 2109	Hand deep space abscess, injury, tenosynovitis	Hand call	
	Hand trauma needing consultation or admit	Hand Call	
	Hand/Wrist with Neurovascular Tendon injury	Hand Call -If pt emergently going to OR with another team and Ortho is on hand call; it should be clear that Ortho Attendings <i>do not</i> perform neurovascular or flexor tendon repairs - If pt stable for DC/Outpt follow-up and Ortho on hand call, Ortho fields call & advises ED/referring MD to place Urgent referral to Hand Surgery specifying need for Plastic Surgery f/u	

		-if pt admitted, admitting service to notify Plastic Surgery in a.m. <i>DO NOT notify overnight.</i>	
	Cellulitis		Medicine
	Replant/Revascularization	To Stanford or Buncke Clinic	
Trauma Transfers from Gen Surg to Ortho		<p>-Initial evaluation, mechanism-appropriate observation and management on General Surgery Trauma service until deemed stable for transfer to Ortho</p> <p>-Gen surg PA/resident should contact Ortho Resident/PA with transfer requests during daytime hours. <i>Any disagreements or concerns should be addressed on attending level.</i></p> <p>-Prior to transfer acceptance, Ortho Resident/PA must get approval from accepting Ortho attdg</p>	
Pediatric Ortho Patients *Trial protocol until August 2019		<p><2 years old</p> <p>>2 years old</p>	<p>Pediatrics</p> <p>Ortho is primary, Peds electing to auto-consult and leave recommendations</p>

Femur Fractures in Elderly:

Admission Criteria and Management

Goals:

- 1) To define admission criteria and care guidelines regarding elderly patients with femur fractures.
- 2) To create protocols for geriatric fracture care management, recognizing the established benefit of Ortho and Medicine co-management models for improving patient care and outcomes.

Definition of Geriatric Femur Fractures: Femoral neck, intertrochanteric, subtrochanteric, shaft or distal femoral fractures in patients ≥ 65 years of age.

Admission Guidelines and Care Teams:

Goals:

- 1) To define admission criteria and acute care guidelines for elderly patients with femur fractures.
- 2) To create protocols for geriatric femur fracture management, recognizing the established benefit of Ortho and Medicine co-management models for improving patient care and outcomes.

Definition of Geriatric Femur Fracture: Femoral neck, intertrochanteric, subtrochanteric, shaft or distal femoral fractures in patient ≥ 65 years of age (*NB: pts <65yo may be appropriate for protocol and should not be excluded*)

Admission Guidelines and Care Teams:

ED Role:

- Order appropriate XRs, make NPO and start IV when femur fracture suspected
- Utilize Geriatric Femur Fracture Epic order set **after** femur fracture is confirmed
- Order set currently named "ED Hip Fracture"
- Notify Geriatric Fracture Team: Ortho Jr Resident on call, Gold Medicine, Anesthesia
- Gold Medicine Hospitalist will determine if pt is *not* appropriate for co-management with Ortho and better managed by Medicine Primary and communicate these recommendations to the ER attending.
- Anesthesia does femoral nerve block for appropriate candidates and Regional Team follows patient on floor (6:30am to 4pm AMION pager for Regional Anesthesia & Acute Pain, 4pm to 6:30am dial x74016)
- Indications for TTE:
 - Newly suspected or undiagnosed moderate-severe valvular dysfunction.
 - Possible/suspected decompensated heart failure in patient with dyspnea of unknown reasons or patients with pre-existing heart failure and worsening dyspnea or other change in clinical status.

Orthopedics Primary Admission Criteria with Gold Medicine co-follow:

- Low-risk or chronic stable medical conditions (i.e. DM not in DKA, HTN without e/o urgency or emergency, Controlled COPD or asthma, medical conditions such as Afib controlled after routine care in ER).
- Mechanical fall or obvious trauma as mechanism of injury (i.e. pt does not require w/u for syncope, AMS, sepsis).
- All pts ≥ 65 yrs with hip fracture or patients < 65 yo with chronic medical conditions that would benefit from co-management

Medicine Primary Admission (with Ortho co-follow):

- Acutely unstable or decompensated medical conditions
- Chronic high-risk medical conditions (i.e. decompensated CHF, h/o recent MI or CVA, stable angina), signs of cardiac ischemia, persistent hypoxia, uncontrolled arrhythmia, severe valvular disease, evidence of echo EF<30%, sepsis, acute kidney injury, active internal bleeding, acute alcohol withdrawal, end-stage liver disease with MELD > 8 or undiagnosed liver disease, focal neuro changes concerning for stroke or TIA, CRF on HD, hospice patients deemed non-op.
- Patients requiring work up for syncope, AMS, sepsis.

- Patients who develop an acute medical condition or decompensation should be transferred to medicine team based on medicine consult physician's assessment

CURRENT GROUND RULES:

Admitting service is the primary service and places all orders

All patients seen by anesthesia, ortho, & medicine

Anesthesia team does perioperative risk assessment

Medicine addresses acute, chronic, & exacerbated medical conditions.