

Emergency Department - Direct Admission to Inpatient Wards

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Functional Sub group Clinical/ Patient Services - Medical Treatment
Clinical/ Patient Services - Surgical
Clinical/ Patient Services - Governance and Service Delivery

Summary This policy directive sets out the policy to be followed where a patient in an Emergency Department requires admission and an inpatient clinical team has not confirmed acceptance of the admission within two hours of the clinical decision that the patient requires admission. The policy reflects discussions with the Emergency Care Taskforce and AMA NSW and implements Recommendation 96 of the Garling Special Commission of Inquiry.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Public Health System Support Division, Public Hospitals

Audience Administration, Clinical Staff, Emergency Dept, Medical & Surgical Dept in Level 3 Hospitals & above

Distributed to Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, NSW Department of Health, Private Hospitals and Day Procedure Centres

Review date 07-Sep-2014

Policy Manual Patient Matters

File No. 09/1583

Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

DIRECT ADMISSION TO INPATIENT WARDS FROM EMERGENCY DEPARTMENT

PURPOSE

Timely and efficient handover of clinical care of admitted patients from the Emergency Department medical staff to in-patient medical staff is essential for the safe and effective care of each patient and for maintaining the effective operation of the Emergency Department. An essential component of this transition of responsibility for the clinical care of the patient is timely confirmation of acceptance of the clinical handover by the relevant inpatient clinical team.

This policy directive seeks to avoid delays in the admission of patients from the Emergency Department through the application of a clear local protocol in each hospital. As smaller rural hospital Emergency Departments do not have full time separate Emergency Department medical staff and are supported by general practitioners who also care for admitted patients, this policy directive applies to public hospitals with Emergency Departments designated as level 3 or above.

The key benefit of the development and use of a local protocol is that it provides a prior written agreement developed locally by clinicians setting out which clinical unit/team accepts which patients.

Application of this policy directive will enable a timely and clinically appropriate direct admission of a patient from the Emergency Department where an inpatient clinical team has not confirmed acceptance of the admission of the patient under that team within two hours of the clinical decision that the patient requires admission to the hospital.

MANDATORY REQUIREMENTS

Each hospital must have in place by 31 October 2009 an agreed written local protocol that sets out a decision framework for the transfer of care of a patient requiring admission from the Emergency Department to an inpatient clinical team/unit.

The key components of the local protocol are set out in the Associated Document – *Key Components Local Protocol – Admission Decision Framework*. Where a hospital already has a local protocol, the protocol should be reviewed to ensure that it complies with this policy directive.

The local protocol should be reviewed on a six monthly basis and also updated when the clinical service mix of the hospital materially changes.

IMPLEMENTATION

Chief Executives are to ensure a written local protocol as described in this policy and its associated documents is in place for all hospitals designated level 3 or above with Emergency Departments.

Local protocols should be developed by a local hospital executive lead governance group with input from Emergency Department senior medical staff, clinical units/teams and the Medical Staff Council. This consultative process will ensure that gaps in the draft framework are identified and addressed and that the requisite clinical engagement and commitment occurs.

REVISION HISTORY

Version	Approved by	Amendment notes
PD2009_055	Deputy Director- General Health System Quality Performance and Innovation	New policy directive

ASSOCIATED DOCUMENTS

1. Key Components Local Protocol – Admission Decision Framework
2. Implementation Checklist

KEY COMPONENTS LOCAL PROTOCOL – ADMISSION DECISION FRAMEWORK

1. A comprehensive list of clinical conditions for which the hospital is able to provide inpatient care and the clinical team/unit that primarily provides inpatient care for each listed clinical condition. This list will be based on the clinical team/unit skill set.
2. The senior medical staff who are appointed and credentialed to accept admissions in each clinical team/unit listed.
3. If a hospital does not have the facilities or skills to admit certain patients, this should also be clearly stated and an appropriate networked hospital identified which will accept such patients.
4. A clearly set out admission process for patients presenting with co-morbidities, undifferentiated illness or conditions involving more than one clinical discipline (eg. the protocol may set out that a joint admission should occur).
5. An agreed mechanism for ongoing review, improvement and further development of the protocol as issues arise (e.g. a periodic standing agenda item for local clinical unit and medical staff council meetings)
6. A clearly defined dispute resolution process for dealing with unforeseen circumstances with these circumstances then informing the ongoing review and improvement process. The dispute resolution process must NOT delay the admission of a patient from the Emergency Department and transfer of care to an inpatient clinical team in accordance with the protocol.
7. A clear written outline of the agreed admission decision process for patients in the Emergency Department requiring admission to the hospital. The process should comply with the following principles.

Emergency Department inpatient admission process principles

8. Following assessment in the Emergency Department, a senior doctor in the Emergency Department will:
 - a. decide if the patient requires admission,
 - b. determine the condition(s) necessitating admission
 - c. apply the agreed local protocol to determine the clinical team under whose care the patient will be admitted
 - d. request the clinical team to accept the admission.
9. In situations where there is not agreed acceptance of the admission by the inpatient consultant or team, discussion should take place at the most senior clinical level possible, preferably consultant level, based on the agreed local protocol.

10. If the appropriate admitting team for the patient is unable to be determined by the above steps in the required time frame, then the most senior medical officer **who has seen the patient** will make the admission decision. In the emergency department the specialist emergency physician would be the most senior medical officer. If an emergency physician is not on duty, another senior medical officer (specialist, registrar or CMO) who has seen the patient will make the decision.
11. A reasonable time for conclusion of this decision-making process would be no more than **2 hours** from the time of the clinical decision that the patient requires admission.
12. This process must result in a clear decision to admit the patient under a specific consultant or clinical team. The decision-maker **must** then notify the admitting team. The **admitting team will accept the patient once this decision is made**. An inpatient consultant who remains unwilling to accept the patient after all these steps have been followed may elect to see the patient and having done so, take personal responsibility for discussing with, and arranging admission under, another consultant.
13. Occasions requiring the most senior doctor to make a contested decision to admit the patient under a specific consultant or clinical team must be the subject of a subsequent review at the local hospital level to determine whether further refinement of the local protocol is required, as part of the ongoing review, improvement and further development of the local protocol.
14. Should the patient subsequently require transfer to another clinical unit after admission from the Emergency Department under the local protocol, the clinical team on call will arrange this. The local protocol should include prior agreement about processes to expedite the transfer of such patients between units where necessary.

This checklist can be used to review the implementation of this policy directive.

Assessed by:		Date of Assessment:			
Requirement:	Assessment:				
	Not commenced	In development	Partial compliance	Full compliance	
IMPLEMENTATION REQUIREMENTS					
1. Comprehensive list of clinical conditions and inpatient teams primarily responsible for these conditions by October 31 st 2009	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Comments:</u>				<input type="checkbox"/> Not applicable
2. Written Emergency Department admission decision process in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Comments:</u>				<input type="checkbox"/> Not applicable
3. Regular review process for the local protocol in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Comments:</u>				<input type="checkbox"/> Not applicable
4. Clearly defined dispute resolution process in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Comments:</u>				<input type="checkbox"/> Not applicable