Principles of Care and Conduct – Acute Patients

High level principles (the Ideal or Goal state)

1. All staff will be guided first and foremost by what is best for the patient, and how they would like our services to be if this were a member of their family presenting to the Emergency Department acutely unwell or injured.
2. All patients will be admitted or discharged from the ED within 6 hours unless there is a compelling clinical reason for them to remain there.
3. There will be no patients waiting in corridors in the ED.
4. GP s will be able to easily contact inpatient consultants or registrars without delay.
5. Clear guidelines will spell out the appropriate service to whom patients with particular problems should be referred.
6. The service may be able to offer an urgent outpatient consultation, but if that is not acceptable to all parties, they must see the patient in the ED.
7. Emergency physicians will only become involved with referred patients if the patient is Triage Category One or Two, or if a Service Level Agreement exists for them to manage particular problems on behalf of a service.
8. Patients requiring admission will be rapidly identified, and moved out of the ED promptly to an assessment or admitting area or ward provided they are physiologically stable. If stability cannot be achieved rapidly they will go for definitive intervention (eg OT) or to higher-level care (HDU/ICU).
9. 95% of patients admitted should be placed in a “home ward” within 24 hours.
10. Patients presenting spontaneously, referred by a PRIME nurse or brought in by ambulance will be assessed promptly by an Emergency physician, with the primary goals of resuscitation in the first instance and/or establishing the need for admission to hospital, followed by referral to an inpatient service; or treatment and discharge.
11. Patients referred to inpatient specialties in this way must be seen promptly and either treated and discharged or admitted.
12. All patients being assessed in the ED should have a plan in place by a maximum of 4 hours after arrival.
13. All services accepting acute admissions must provide a prompt response. This will require sufficient human resource and capability to cope with demand for assessment and admission, as well as rostering/job description that matches need. This responsibility is a shared one between DHB management, the RMO unit and the service itself. If a service cannot provide such a response, then an agreement with another service to provide assistance must be reached.
14. If it turns out that the patient’s problem may be better managed by another service, the responsibility for care remains with the primary team until another service has accepted care, but this must not delay admission.

Detailed proposals

15. All services receiving acute patients must develop a clear guideline as to which patients/problems are appropriate to their service, and a consensus must be reached across all services that the boundaries (inclusion/exclusion) are just and reasonable, and that there are no gaps for patients to fall down.
16. These guidelines will then apply consistently and cannot be varied by the whim of individuals.

17. General Practitioners and Emergency physicians will be given these guidelines and expected to refer in accordance with them.

GP -referred patients (and patients from other hospitals)

18. General Practitioners should refer to the care of the Emergency Physicians only those patients whom they expect to be discharged, but who require -

    - treatment for injuries or other emergency problems that they themselves cannot provide (e.g. fractures, complex lacerations), or
    - investigations that they cannot access.

19. Patients for whom inpatient admission is anticipated must be referred to an inpatient service, and every effort made to discuss this by phone with the registrar or consultant. Inability to contact the designated person should be noted on the referral letter, and a notification emailed to the Chief Medical Officer, and to Mike Hunter.

20. All services receiving acute patients must have a nominated person available at all times to be contacted by telephone by General Practitioners, and this must be made known to the telephonists.

21. That person must accept a referral from a GP who wishes the patient to be reviewed acutely, either by offering to see the patient urgently in the Emergency Dept. or if appropriate, the opportunity for an urgent outpatient review (which must be acceptable to the practitioner and patient).

22. Once a referral for acute assessment or admission is made, the service must see the patient. Even if the GP has not made phone contact, a referral letter requires that the patient be seen. If the registrar for that service believes the patient would be better managed by another service, it is his/her responsibility to speak with that service and ask them to see the patient. If there is disagreement, the original service must make the first assessment.

23. It is not acceptable to have a patient referred by a GP sent to the ED and then expect the Emergency Physicians to assess and sort out the patient, nor to refuse to see a patient simply because there has not been phone contact.

24. Once the inpatient specialty knows a patient is “expected” the person who took the call must notify the receptionist or Associate Charge Nurse (ACN) in the ED. If there are specific clinical issues or requests for tests or interventions then this must be communicated to the ACN not the receptionist.

25. If the patient can be admitted directly to the ward once the clerical admission process has been completed, this should be communicated, so that it can be expedited.

On Arrival

26. On arrival, the patient will be assessed by the triage nurse for signs of physiologic instability or other problems requiring urgent intervention.

27. If these are present, the patient will be seen urgently by ED staff and the responsible inpatient team contacted urgently as well. Resuscitative measures will be undertaken, a SEAM or Medical Emergency call made if appropriate, and the ICU team involved if required. A full assessment may be necessary in the ED, and the patient then moved to a care area appropriate to their needs (ICU, an HDU, Theatre or a ward), via radiology if needed.

28. Any patient admitted to the ICU from the ED must have a primary team assigned before they leave the ED, and this referral is the responsibility of the ED staff unless there is already a GP or other hospital referral in place.

29. If not unstable, (Triage Category 3-5) the patient will be moved to an assessment area as soon as possible and should be seen promptly by a representative of the accepting service- usually the registrar. (*Optimal : within 30 mins ; Maximum – within 60 minutes*).
30. A preliminary assessment (*~15 mins*) should be made by the inpatient registrar in order to decide whether-
    a) The patient needs to be admitted to the hospital
    b) The patient can likely be treated and discharged
    c) The decision cannot be made yet because certain investigations or consultations are required.
31. Investigations should only be done if they are likely to improve the patient's care or outcome, particularly when they involve considerable exposure to radiation (eg CT scan). They should never be done solely to try to prove that the patient 'belongs' in another specialty, especially if the passage of time and clinical acumen would likely lead to the diagnosis becoming obvious or to a less harmful investigation.
32. If the patient is to be admitted the registrar representing the service should instigate any immediate treatment or investigations that are required for safe management of the patient and then expedite transfer (via radiology if appropriate) to an admitting ward or unit where the house surgeon can fully clerk the patient prior to further registrar or consultant review.
33. If the patient is to be discharged, the appropriate investigations, treatment, support services and/or follow–up arrangements should be completed/arranged *within 2 hours*.
34. If such a decision cannot be reached *within a further 1-2 hrs* the patient should be admitted (either to the ED Short Stay Unit if it falls within the criteria , or an inpatient bed).
35. The goal is to move patients to the place of definitive care as quickly as possible and free up the assessment areas in the ED so that patient flow is maintained.

Self-referred Patients or brought in by ambulance (BIBA)

36. These patients will be immediately triaged as are all patients arriving in the ED.
37. They will be assessed by Emergency Dept. medical staff according to clinical urgency and length of time waiting, as directed by the Emergency Physician in charge in consultation with the ACN.
38. All patients will be seen in a timely manner.(*Optimal : within 1 hour ; Maximum – within 3 hours*).
39. If the patient clearly needs admission, he/she should be referred without delay to the most appropriate inpatient specialty according to the consensus guidelines. Complete clinical workup and investigations prior to referral is neither necessary nor desirable, but both teams need to work together to facilitate safe yet rapid transfer of care. (Note Principle 12 which says every patient should have a Plan in place by 4 hours).
40. Requests may be made to the ED staff to commence the process of investigation to save time, but this must never be a pre-requisite before the patient is seen by the inpatient service.
41. Referrals to inpatient specialties need to conform to the Guidelines for Admission to Specialties. If the inpatient specialty feels the patient's problem genuinely lies outside their area of expertise or that the patient's interests would be better served by admission under a different specialty they should approach that specialty directly. If these two cannot agree, then the **Emergency Consultant in charge will make a binding decision** on which service will admit the patient.
42. The inpatient service may be asked for an opinion on a particular aspect of care for a patient who is going to be discharged by the ED, or who is being referred to another service because the principal

problem is something else. This distinction between a referral of care and a request for an opinion or additional advice needs to be very clear.

Patients admitted directly from outpatient clinics

43. Provisions already exist for patients to be admitted acutely direct to wards from outpatient clinics. There is no necessity (and it is undesirable) for them to go via the ED, although some clerical work may need to be done there if not available on the ward. There is a MIDAS document which specifies the necessary steps for this type of admission.

Transfer of care to another service following admission

44. If, after admitting and assessing the patient, the inpatient service feels the patient's most significant problem or overall management is in fact best dealt with by another inpatient service, then it is up to the first service to request that the second take over care. The urgency of referral should be graded as

    - Very urgent – (within 15 minutes)
    - Urgent - (within 1 hour)
    - Prompt - (within 4 hours)
    - Timely - (within 12-24 hours)

45. Alternatively the service may ask another service for advice/assistance on a particular aspect of the patient's care, or shared care, rather than complete assumption of care.
46. The response should meet the specified times.
47. If a service asks for shared care as the most appropriate arrangement, it should be made clear which service will have the lead role and ultimate responsibility for the overall care of the patient.
48. Any disagreement over referral or the responsibility for care should immediately prompt a direct discussion **between the consultants** involved to resolve the matter.
49. If there are unresolved disputes after discussions between the consultants concerned, then the matter is to be referred to the Chief Medical Officer at the earliest practical opportunity. Compliance with this policy and responsiveness to inpatient referrals will be monitored. Sanctions will follow for persistent non-compliance.
50. Above all, clinicians should be guided by what is best for the patient, and should endeavour to get the patient promptly to the ward or service that best meets their needs, appreciating that this may change during the course of a patient's admission. In other words, services should be pulling patients into their service because they think they're the best, not pushing them away.

Signed off by Mr Richard Bunton – Chief Medical Officer – Dunedin Hospital

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Edited by Mike Hunter

Clinical Champion: '6 hours – It Matters!'