ADMISSION GUIDELINES
UPDATED JANUARY 2014

1) Resolution of Disputes:
   a) To insure optimal care for patients, the following admission guidelines have been
   established. The ED attending has responsibility for all admission decisions. Once an
   admission decision is made, the receiving inpatient service will be notified of the
   admission. No patient shall be moved to the inpatient service without this notification and
   appropriate clinical handoff. The receiving inpatient service shall then determine the level
   of care (floor, MSOU, stepdown, telemetry, or critical care unit). Disputes over the level
   of care shall be resolved by attending-to-attending dialogue as described below. If an
   inpatient house officer is unsatisfied with the ED attending’s admission decision, (s)he
   may ask the attending on the admitting service to discuss that decision directly with the
   ED attending. During off-hours, if there is no admitting attending in-house, the attending
   carrying the on-call beeper for the admitting service shall serve this purpose. If, after
   discussion, the ED attending and the admitting attending cannot agree on the patient’s
   disposition, then the admitting attending shall see the patient in the ED and the two
   attendings will decide jointly how the patient’s needs will best be served. The admitting
   attending is expected to see the patient within 90 minutes of his/her notification of the
   case and must document his/her findings in the Medical Record. If the admitting
   attending is unavailable to come to the bedside, the ED attending’s decision shall prevail.
   b) If a satisfactory resolution for a patient’s disposition is not reached by the process
   described in paragraph 1a above, the Medical Director of the Hospital shall arbitrate and
   have final authority for the decision.

2) Back Pain:
   a) Patients with atraumatic cord, cauda equina, or nerve root compression (excluding pain-
      only radiculopathy) are to be evaluated by the orthopedic spine service. If surgical
      intervention is a likely outcome, the patient is to be admitted to the orthopedic service. If
      not, the patient is to be evaluated by the neurology service and admitted to Medicine.
   b) Patients with non-traumatic or trivial traumatic back pain (including back strain) who
      cannot be managed at home are to be admitted to Medicine.
   c) If infection or cancer of the spine is suspected, and no neurologic findings are present
      on exam, the patient should be admitted to Medicine after consultation by the neurology
      service. If, however, there is evidence of cord, cauda equina, or serious nerve root
      compression (e.g. motor findings), then the guidelines in paragraph 2a are to be followed.
   d) Acute Spinal Trauma: see Trauma – Spinal

3) Bariatric Surgery:
   a) Any patient with a history of bariatric surgery who presents with an abdominal complaint
      should have a Bariatric Surgery consult in the ED. Those with post-operative
      complications of bariatric surgery should be admitted to Surgery after consultation by the
      Bariatric Surgery service.
4) **Cancer:**
   a) A patient with a medical or non-operative complication of malignancy (e.g.: hypercalcemia) is to be admitted to Medicine.
   b) A patient with a surgical complication of malignancy, potentially requiring an operation, is to be admitted to either the surgery service or the GYN service, depending upon the nature of the surgical emergency (e.g.: complete or partial small bowel obstruction should be admitted to Surgery). Should the patient or family not be agreeable to surgical intervention, admission to medicine is permissible.
   c) A patient with an intracranial malignancy who, in the opinion of the Neurosurgery Service, requires an operation within the next 72, should be admitted to Trauma Surgery on behalf of the Neurosurgery service. Non-operable or less urgent operable brain lesions should be admitted to Medicine. Atraumatic spinal cord compression requiring emergency medical therapy (e.g. radiation therapy) should be admitted to Medicine following the Spinal Cord Compression RRT protocol. Spinal cord compression requiring immediate surgical intervention (in the opinion of the Neurosurgery or the Ortho Spine Service) should be admitted to the service proposing the surgery.
   d) Patients who are admitted for palliative care, or for inability to be managed at home (e.g. PO intolerance), are to be admitted to either Medicine, Surgery, or GYN, in a way that either maintains the most recent longitudinal care (first choice) or assigns the patient to the service that would ordinarily care for the patient’s primary tumor.

5) **Cellulitis:**
   a) Patients with facial cellulitis requiring consultation or admission are to be referred/admitted to the service covering maxillo-facial trauma. Included in this definition are cellulitis of the ear and all cellulitis, abscesses, and subcutaneous infections of the midface.
   b) **Cellulitis, infections, abscesses, and furuncles of the neck** are to be admitted to Surgery.
   c) **Cellulitis/infection of the hand** requiring admission should be admitted to the Service covering 'Hand'.
   d) **All other cellulitis** is to be admitted to Surgery if the MR# is odd, or Medicine if the MR# is even, unless the cellulitis is complicated by either vascular compromise, a suspected collection or deep tissue infection, or an open wound requiring wound care, in which case it is to be admitted to Surgery.

6) **CVAs:** see 'Neurologic Disease'

7) **Decompression Sickness:**
   a) Decompression Sickness (DCS) types II and III will usually require Hyperbaric Treatment prior to admission.
   b) DCS I will usually not require admission.
   c) DCS II or III requiring admission should be admitted to Medicine

8) **Decubitus Ulcers:**
   a) If the primary problem necessitating admission is a decubitus ulcer requiring mechanical wound care, debridement, or other surgical intervention), admit to Surgery.

9) **Dental/Alveolar Ridge Trauma:**
a) Isolated Dental/Alveolar Ridge Trauma requiring consultation or admission should initially be referred to the service covering maxillo-facial trauma. If multiple facial injuries requiring consultation are present, the maxillo-facial trauma service will be responsible for the patient, and for involving Oral Surgery as a secondary consult service if necessary.

10) **Disposition – Social Disposition Rotation:**

a) Patients with no acute illness requiring hospitalization who have a social situation that precludes safe discharge will be admitted to Medicine or Surgery in alternating sequence.

i) Criteria for exclusion from the Social Disposition Rotation include: 1) recent significant trauma, 2) altered mental status not known to be chronic, 3) unstable or poorly controlled medical problems, 4) any infection requiring treatment, 5) rape, 6) alcohol or drug intoxication, 7) any complication of malignancy, 8) significantly abnormal vital signs, 9) significantly abnormal lab or xray data, 10) any patient requiring an IV, 11) low back pain requiring hospitalization.

ii) The Bed Board will maintain a log of patients admitted to the Social Disposition Rotation to determine whether Medicine or Surgery is next up to receive a case, based on the last service to receive a case. The rotation will assign three cases to the Medicine Service for every one case assigned to the Surgery service.

iii) The ED will submit a completed “Disposition Admission Notification Form” to the Bed Board for each case, documenting ED attending responsibility for assigning the patient to the Social Disposition Rotation. This form is for Quality Assurance purposes only. It will be kept on file by the Bed Board, and is NOT to be placed in the Medical Record.

iv) The ED will assign a diagnosis to Social Disposition patients reflecting the medical condition that most accurately explains why the patient requires admission.

v) Social Disposition is NOT an acceptable diagnosis for the Medical Record.

11) **Diverticulitis:**

a) All patients with diverticulitis requiring admission should be admitted to Surgery.

12) **Diving Injuries:**

   a) See 'Decompression Sickness'
   b) See 'Near Drowning'

13) **Deep Vein Thrombosis:**

   a) DVT (proven or suspected) requiring admission should be admitted to Medicine.
   
   i) Exception: phlegmasia cerulean dolens should be admitted to Surgery.

   b) Ante-partum DVT (proven or suspected) should be admitted to the Medical service with phone notification to the OB service that an antepartum patient is being admitted to Medicine. The Medicine service may decide in consultation with the Ob service to have the patient admitted to antennal Ob with Medicine serving as consultants.

14) **Electrical Injury:**

   a) All electrical injuries requiring admission should be admitted to Burn Surgery, unless they are associated with significant trauma, in which case they are to be admitted to the Trauma Service.

15) **Esophageal foreign body:**
a) ENT accessible foreign bodies are to be referred to ENT. If admission is required, stable patients with minimal comorbidities will be admitted to ENT. Less stable patients or those with significant co-morbidities should be admitted to ENT with Surgery consultation.

b) GI accessible (i.e. flexible endoscope accessible) foreign bodies are to be referred to GI and admitted to Medicine if necessary.

c) Esophageal foreign bodies with suspected perforation and/or mediastinitis are to be admitted to the Surgery Service.

d) Patients with foreign bodies claimed inaccessible by all services are to be admitted to Surgery for coordination of multidisciplinary care.

16) Eye Problems:

a) Isolated eye problems resulting from acute trauma and requiring admission should be admitted to Surgery. All other isolated eye problems requiring admission should be admitted to Medicine.

17) Head and Neck Problems:

a) Admissions to the ENT service will be restricted to patients whose ENT condition is the sole reason for admission, who are clinically stable, and who have no significant or clinically active co-morbidities. Patients with ENT conditions that could have been treated in the outpatient setting but who require admission because of co-morbidities or social conditions will be admitted to Medicine.

b) Facial Cellulitis and Superficial Infections: see Cellulitis 5a.

c) Deep neck infections, retro- or para-pharyngeal abscesses, and epiglottitis stable enough for floor admission should be admitted to ENT. Those requiring step-down or SICU admission should be admitted to ENT with Surgery consultation.

d) Complications of sinusitis or mastoiditis stable enough for floor admission should be admitted to ENT. Those requiring step-down or SICU admission should be admitted to ENT with Surgery consultation.

e) Patients requiring admission for epistaxis who are stable enough for floor admission should be admitted to ENT. Patients with formal posterior packs (i.e. Foley catheters) should be admitted to the SICU and assigned to ENT with Surgery consultation. All other admissions for epistaxis should be admitted to Medicine.

f) Patients with esophageal foreign bodies should be managed according to paragraphs 15a-d (Esophageal Foreign Bodies).

g) Stable patients requiring floor admission for facial trauma in the absence of multi-trauma should be admitted to the service covering maxilla-facial trauma. Those with multi-trauma and those requiring step-down or SICU admission should be admitted to Trauma.

h) Patients requiring admission for compromised upper airway should be admitted to ENT with Surgery consultation.

i) e.g. upper airway angioedema, Ludwig’s angina

i) Patients requiring admission for head and neck tumors who are stable enough for admission to the floor should be admitted to ENT. Those requiring step-down or ICU admission should be admitted to ENT with Surgery consultation.
j) Patients requiring admission for **cranial nerve dysfunction** should be admitted to Medicine.

18) **GI Bleeding - Upper:**
   a) **Patients with UGI bleeding** are to be admitted to Medicine.
   b) **Bed availability:** If beds at the appropriate level of care are unavailable on Medicine but available on Surgery, then patients with UGI Bleeding are to be admitted to Surgery.

19) **GI Bleeding - Lower:**
   a) **Patients with lower GI bleeding** are to be admitted to Surgery.
   b) **Bed availability:** If beds at the appropriate level of care are unavailable on Surgery but available on Medicine, then patients with LGI Bleeding are to be admitted to Medicine.

20) **GU Problems:**
   a) **GU Admission Limitations:**
      i) Pregnant patients and seriously ill patients requiring admission for GU problems (e.g. those who are potentially unstable, difficult to manage, or require a higher level of care than a regular floor bed) are to be admitted to Medicine, Surgery, or OBGYN, in accordance with the nature of the case and the relevant tenets of the Admission Guidelines.
      ii) **Kidney problems:**
           (1) Non-pregnant or first trimester pregnant patients requiring admission for pyelonephritis should be admitted to Medicine, unless the condition is associated with ureteral stents or obstruction, in which case stable floor admissions should be admitted to GU, with Surgery consultation for patients requiring stepdown or SICU care. Second and third trimester pregnant patients requiring admission for pyelonephritis should be admitted to OBGYN.
           (2) Patients with renal infarcts should be admitted to Medicine unless they need an operation, in which case they should be admitted to GU.
      iii) **Ureteral problems:**
           (1) Patients requiring admission for **ureteral stones** should be admitted to GU, unless they are seriously ill as defined above (20a, 1), in which case they should be admitted to Medicine.
      iv) **Bladder problems:**
           (1) Admissions for **urinary retention** should go to Medicine unless surgical management is required, in which case they should be admitted to GU.
           (2) Admissions for **gross hematuria** should go to GU.
   v) **Prostate problems:**
      (1) **Acute prostatitis** requiring admission should go to GU, with Surgery consultation for patients requiring stepdown or SICU care.
      (2) **Advanced or metastatic prostate cancer** patients requiring admission should go to Medicine.
   vi) **Male genitalia problems:**
      (1) Admissions for **testicular torsion** should go to GU
      (2) Admissions for isolated **genital trauma** excluding burns should go to GU. **Burns** to the external genitalia should go to Burn.
(3) Admissions for priapism secondary to sickle cell disease should go to Medicine. All other priapism admissions should go to GU.

(4) Fournier’s gangrene and perineal cellulitis should go to Surgery, with GU consultation.

(5) Admissions for isolated scrotal abscess should go to GU.

21) **Hand**: (see section on 'Hand Rotation')
   a) The service covering 'Hand' is responsible for:
      i) all problems involving the bones distal to the carpal bones (carpal bones are the responsibility of the Orthopedic service).
      ii) Soft tissue injuries and infections distal to the elbow, including compartment syndrome, that affect the function of the hand.
   b) The consult service responsible for hand injuries or infections requiring admission will be Plastic surgery on ODD days, and Orthopedics on EVEN days.
      i) A "day" is defined as beginning at 8am and running until the following 8am. The "day" a patient is assigned to is determined by the time listed in QuadraMed as ED Triage Time.
   c) The 'Hand' service will be responsible for involving and coordinating additional consult services if they are necessary. For example, an arterial injury at the wrist on an even day will be assigned to the Orthopedics service which will likely involve the Vascular Surgery service to repair of the injured vessel.
   d) If a patient is being followed by one of our “Hand” services and returns requiring admission for his or her hand problem, the patient should be admitted to the service following that problem.

22) **Hyperemesis Gravidarum**:
   a) Patients with uncomplicated hyperemesis gravidarum should be managed by OBGYN on the obstetrics unit after a brief evaluation in the ED. The ED evaluation and management should include each of the following:
      1. History and physical exam
         a. Patients with findings suggesting a diagnosis other than uncomplicated hyperemesis gravidarum should remain in the ED for a full evaluation.
      2. Confirmation of pregnancy by urine or serum hCG or ultrasound.
      3. Baseline CBC, QhCG titers, metabolic panel, Thyroid function tests and urine ketones sent (results not required in ED).
      4. IV with crystalloid infusion established and running during ED evaluation. (ED evaluation does NOT require a minimum volume challenge before transfer to OB)
      5. If, upon completion of the history, physical exam, and confirmation of the pregnancy, the diagnosis appears to be uncomplicated hyperemesis gravidarum, and the patient remains symptomatic, the patient should be presented to the OB service for transfer to the obstetrical unit for further management.

23) **Inhalation Injury**:
   a) Inhalation injuries, including Carbon Monoxide intoxication, are to be admitted to the Burn service with the following few notable exceptions:
i) Carbon Monoxide Inhalation leading to massive Acute Myocardial Infarction (e.g. STEMI or heart failure, but not just leaking troponins) or Stroke should be admitted to Medicine
ii) pregnant patients should be admitted to the Burn service, with notification and consultation by the OB/GYN service

b) Inhalation Injury with potential Upper Respiratory Tract injury should be endoscopically evaluated by ENT when possible (emergent need for airway control should preclude this).
c) All Carbon Monoxide inhalations requiring HBO therapy and stable enough for the hyperbaric chamber should receive HBO therapy prior to admission.

24) **Nasal Fractures:** see 'Trauma-Nasal Fractures'

25) **Near-Drowning:**
   a) All near-drowning cases should be admitted to Medicine.

26) **Neurologic Disease:**
   a) All patients with primary neurologic disease requiring admission should be admitted to Medicine. This includes, but is not limited to:
      i) new strokes/TIAs
      ii) status epilepticus, or seizure disorder requiring admission.
      iii) anticonvulsant toxicity requiring admission
      iv) mixed neurologic and psychiatric disease (eg: temporal lobe seizures).
      v) intracranial mass lesions not requiring urgent surgery
      vi) ataxia/vertigo requiring admission
   b) Patients with suspected TIAs (anterior or posterior circulation) should be admitted to the Medicine service for etiologic work-up.

27) **Ophthalmologic Problems:** (see Eye problems (16) above.)

28) **Osteomyelitis:**
   a) If secondary to PVD or arterial insufficiency (e.g. diabetes), or if amputation may be required, admit to Surgery.
   b) If secondary to orthopedic trauma (i.e.: prior fracture, orthopedic hardware), admit to Orthopedics.
   c) If secondary to suspected bacteremia, admit to Medicine.

29) **Pancreatitis:**
   a) Patients with suspected gallstone pancreatitis are to be admitted to Surgery.
   b) Patients judged by the ED attending to have severe pancreatitis (e.g. those with signs of organ failure, hemodynamic instability, significant lab abnormalities, and/or co-morbidities) are to be admitted to Surgery.
   c) Patients with routine pancreatitis are to be admitted to Medicine.
   d) **Bed availability:** If a patient with pancreatitis is assigned to the Medicine or Surgery Service by the guidelines above, but the assigned service has no beds available at the appropriate level of care, then the patient should be reassigned to the service with the available bed.

30) **Pregnancy:**
   a) Pregnant females who are < 20 weeks pregnant should be seen initially in the E.D.
b) Stable pregnant females who are $\geq 20$ weeks pregnant and have isolated obstetrical complaints (e.g. contractions, vaginal bleeding, or amniotic rupture) should be escorted directly to Labor and Delivery for triage and evaluation by the Obstetrical service. ED triage of those in labor should include evaluation with the Transport Screening Form, and those with imminent delivery or urgent conditions should include ED-to-OB attending notification.

c) Pregnant patients who are $\geq 20$ weeks pregnant and have non-obstetrical complaints (e.g. cough, injury, acute abdominal pain without active labor) should be initially evaluated in the ED. If clinically warranted, documentation of fetal heart rate with consultation by OBGYN for absent or abnormal fetal heart beat should be performed. Follow-up prenatal care should also be documented.

d) Patients with hyperemesis gravidarum should be managed according to the protocol above (see Hyperemesis Gravidarum).

e) Pregnant patients who require admission for non-obstetrical problems should be admitted to the service that admits non-pregnant patients with those problems. OBGYN should be notified of all pregnant admissions.

31) **Pyelonephritis:**
   a) See **GU Problems, Kidney, Pyelonephritis (20a, ii, 1)**

32) **Septic Arthritis:**
   a) Patients with a septic hip or knee, or any septic joint requiring repeated irrigation, should be admitted to Orthopedics.
   b) Patients with a septic arthritis resulting from joint perforation or direct trauma should be admitted to Orthopedics.
   c) Patients with a septic arthritis secondary to suspected bacteremia, and not requiring irrigation by Orthopedics, should be admitted to Medicine.

33) **Snakebites:**
   a) The snakebite specialist should be consulted for all cases of snakebite.
   b) All snakebites requiring admission should be admitted to the Plastic Surgery service. If the patient requires a monitored setting (s)he should be admitted to the Burn ICU.

34) **Thrombophlebitis:** see 'DVT'

35) **TIA:**
   a) Patients with suspected TIA's (anterior or posterior circulation) should be admitted to Medicine.

36) **Trauma-Maxillofacial:**
   a) The primary consulting service covering maxillofacial trauma rotates between ENT, Plastic Surgery and Oral Surgery. The list of assignments is posted in AMION under Plastic/Burn “maxillofacial call” for the date in question.
   b) The primary consult service will be responsible for maxillofacial trauma requiring consultation or admission.
   c) The primary consult service assumes overall responsibility for care of the patient's facial injuries, and is responsible for involving secondary consult services as necessary (e.g.: oral surgery for dental trauma, plastics for complicated cosmetic repair, etc.)

37) **Trauma-Multiple:**
   a) Multiple trauma is defined as significant involvement of more than one organ system.
b) All multiple trauma victims requiring admission are to be admitted to the Trauma service.
c) All pelvic fractures are to be admitted initially to the Trauma service.

38) **Trauma-Nasal Fractures (isolated):**
   a) Isolated nasal fractures may be referred as follows:
      i) **Odd** days, refer to Plastic Surgery
      ii) **Even** days, refer to ENT.
   b) If other facial fractures are present, the maxillofacial trauma rotation applies.

39) **Trauma-Neurosurgical:**
   a) Patients who require admission for acute isolated head trauma occurring within a week of presentation to the ED should be admitted to the Trauma service.
   b) Patients requiring admission for acute isolated head trauma occurring more than a week before presentation to the ED should be admitted to Medicine, provided the head CT reveals no lesion requiring neurosurgical intervention.

40) **Trauma-Ocular/Orbital (isolated):**
   a) All isolated ocular trauma requiring admission is to be admitted to Trauma.
   b) Isolated orbital wall or floor ("blow-out") fractures requiring consultation or admission are to be referred/admitted to the service covering maxillo-facial trauma.

41) **Trauma-Spinal:**
   a) All spinal trauma requiring consultation should be evaluated by the Orthopedics Spine service.
   b) All isolated spinal trauma requiring admission is to be admitted to the Trauma Service

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