Bellevue Hospital Admitting Guidelines

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General

The following guidelines specify which inpatient service is primarily responsible for accepting patients with certain diagnoses. The list of diagnoses is not a complete one and the guidelines are intended to be used flexibly as described. Patients should be admitted to the most appropriate service based on the primary diagnosis.
In all cases, the Emergency Department (ED) physician is expected to conduct an evaluation sufficient to ascertain the need for admission, to determine the appropriate admitting service, and to identify significant medical comorbidities if they are present. Furthermore, the ED physician has discretion to interpret the guidelines in a way that best serves the patient. Discussions about the appropriate service should never take place in front of the patient and decisions should be made collaboratively, professionally, and in a patient centered manner.

Disagreement / Escalation

In the case when a service disagrees with an ED attending's plan to admit the patient to his or her service, the chief resident of the service in question may briefly and professionally discuss the case with the ED attending. If a disagreement as to the appropriate service/level of care persists, the ED attending will wait 30 minutes before placing an admission order to allow the attending on the receiving service an opportunity to discuss the decision by calling the ED attending directly. The ultimate decision on admission and to what service and level of care (floor vs SDU vs ICU) will remain the decision of the ED attending. Disagreements can be discussed with service leadership to resolve individual cases or an overall approach to the guidelines.

Preoperative Clearance

In general, patients requiring surgery should receive preoperative and postoperative evaluation and care on the service that will perform the surgery. Medical preoperative evaluation can be performed following admission to a surgical service and is not a requirement in advance of admission to a surgical service.

Postoperative Issues

All patients requiring admission within 30 days of surgery for postoperative pain or failure of outpatient management will be readmitted to the surgical service that performed the procedure.

Patients with fever within 7 days of surgery will also be readmitted to the surgical service that performed the procedure (or SSDU/SICU if appropriate).

IR Procedures

Patients being admitted for a procedure with Interventional Radiology should be admitted to the service most appropriate as determined by the admitting guidelines. Attempts to avoid admission should be made if services are in agreement that an admission is not medically necessary and the main obstacle is financial clearance.

Medical Comorbidities

The following is a list of diagnoses that will be admitted to medicine when present, regardless of primary admitting diagnosis. For all other co-morbidities and secondary diagnoses, patients will be admitted to the service most appropriate to their primary presenting diagnosis/problem. If an admitting service feels that a patient would be better served on a medical service but does not fit within the criteria outlined below, the Attending provider on that service may contact the medical attending on call to discuss placement.

A patient with a medical condition who needs to be admitted primarily because of inability to function or comply with care in the outpatient setting should go to the service associated with the primary diagnosis. The ED attending physician will have discretion to decide whether these or other medical comorbidities outweigh the primary diagnosis in determining the appropriate service. This list covers the most common significant comorbidities but is not meant to be exhaustive.

- **Respiratory failure secondary to uncompensated CHF** (patients who require High Acuity/ICU level care and those requiring Bipap/CPAP/or intubation)
- **Respiratory Failure secondary to acute exacerbation of COPD or asthma** (patients who require High Acuity/ICU level care and those requiring Bipap/CPAP/continuous nebs or intubation)
- **Acute myocardial infarction as evidenced by abnormal EKG or biomarker**
- **Probable or definite Acute Coronary Syndrome**
- **Diabetic ketoacidosis** (hyperglycemia without ketosis does not necessitate a medicine admission. If primary team uncomfortable with management of hyperglycemia, medical consultation can be obtained at the time of admission)
- **New onset atrial fibrillation or atrial flutter with uncontrolled heart rate**

- **Unstable Cardiac rhythm requiring telemetry**
- **Seizure secondary to metabolic derangement** (e.g., hyponatremia or hypercalcemia)
- **Seizure secondary to alcohol withdrawal** or other manifestations of moderate to severe alcohol withdrawal (patients at risk for alcohol withdrawal or those with mild withdrawal managed with Librium do not necessitate admission to the medicine service. Toxicology should be consulted by the admitting service at the time of admission for assistance with management)
- **Non-obstructive acute renal failure with sequelae** (volume overload, hyperkalemia)

Admissions to the General Surgery Service

Patients with the following diagnoses will be admitted to General Surgery regardless of whether they are or are not operative (including patients who require GI procedures). Patients with a primary surgical diagnosis and a secondary medical co-morbidity listed above who require ICU level care may be admitted to a surgical service in the SICU/SDU.

- **Acute abdomen**
- **Appendicitis** (suspected or definite)
- **Cholecystitis** (suspected or definite, acute or chronic)
- **Symptomatic cholelithiasis or choledocolithiasis** (suspected or definite, acute or chronic--including patients requiring ERCP/MRCP)
- **Diverticulitis**
- **Small or large bowel obstruction** (functional or anatomic, partial or complete)
- **Suspected or definite small or large bowel ischemia, infarction, or perforation**
- **Pancreatitis**
- **Patients admitted with post-operative pain or complications** within 30 days of a general surgical procedure
- **Cholangitis**
- **Proposed: Patient admitted for maintenance of a biliary tube or drain**

The decision whether to obtain a CT scan prior to admission in the evaluation of a patient with pancreatitis will be at the discretion of the ED physician.

Patients with the following diagnoses will be admitted to Medicine.

- **Colitis**
- **Diarrheal illness** (even with pain if diarrhea is prominent)
- **Inflammatory bowel disease**

- **Lower GI bleed** (surgical consultation will be obtained if appropriate as determined by ED Attending)
- **Upper GI bleed**
- **Non-diarrheal abdominal pain** that does not meet surgical criteria (negative CT and surgical consultation and no concern for bowel ischemia)

Direct Admission Program: Addendum to General Surgery Service Admissions

Objective: To allow for quicker admission, and decrease the time that patients are boarding in the Emergency Department, decrease work burden of the surgical service, and improve flow.

For the following patients, the admission would mirror how admissions are done to the Medicine Service: the ED physician would call surgery, discuss the case on the phone, and then put the admission into Epic. Over the phone the surgery resident can discuss if admission should be "on call to the OR" or "admit to the floor", as for these relatively stable patients this decision is often made by time of day of availability of OR and staff. The patient would be held in the ED for at least one more hour before going upstairs.

- **Appendicitis**
    - **Diagnosed by official radiological study**
    - **No abscess, no perforation, no signs of severe sepsis**
- **Cholecystitis**
    - **Diagnosed by official radiological study**
    - **No abscess, no perforation, no signs of severe sepsis**

Admissions to the Neurology Services (Stroke and Epilepsy)

Neurology can be the primary team for 16S/17S patients.
Patients with "nonsurgical" ICH who have signs and symptoms of severe alcohol withdrawal will be admitted to Medicine.

Patients with the following diagnoses will be admitted to the Stroke service:

- **Ischemic stroke**
- **Nontraumatic, non-surgical intracerebral hemorrhage** in a neurologically stable patent

- For the above, any stroke patient requiring q1h neuro checks, continuous IV BP medication, or other concern for rapid neurologic deterioration should be admitted to the NeuroICU and not the stroke service.
- **Cerebral vein thrombosis** if there is no concern for increased ICP or large territory of infarct
- **Reversible cerebral vasoconstriction syndrome**
- **Non-aneurysmal, nontraumatic SAH** in a neurologically stable patient can be admitted to the Stroke Service in consultation with the NeuroICU attending
- Patients with non-surgical traumatic bleeds **will not** be admitted to the stroke service – a traumatic bleed is not a stroke
- Patients with subdurals **will not** be admitted to the stroke service – subdural is not a stroke
- Patients with stroke and uncontrolled cardiac dysrhythmias will be admitted to CCU as deemed by Cardiology in consultation with the Neurology Service.[RS8]
- Patients receiving TNK will be admitted to the NeuroICU for first 24h following treatment
- Transient ischemic attack patients requiring admission will be admitted to the stroke service
- Stroke patients who are downgraded from an ICU to the stroke service must be on trach collar. Patients who are ventilator dependent **cannot** be admitted to the stroke service.

Epilepsy Service:

- **Seizures** not clearly related to alcohol or substance abuse or other primary medical problems
- Patients with status epilepticus patients who are stabilized after ICU stay.
- Bed availability in the Epilepsy Management Unit (EMU) is not a requirement.

Patients with the following diagnoses/patient states will **NOT** be admitted to Neurology. Neurology consultation prior to admission to Medicine is at the discretion of the ED Attending for the following diagnoses:

- Dementia
- Meningitis, encephalitis, and spinal column infections
- Acute altered mental status
- Syncope
- Seizures related to alcohol or substance abuse or other primary medical problems

Neurology consultation (initiation of consult prior to admission; recommendations prior to admission at the discretion of the ED attending) prior to admission to Medicine is mandatory apart from critical care patients for the following diagnoses:

- Primary brain abscesses
- Intubated Patients or those going to the 10th Floor (NSICU, MICU, CCU, SICU) with a neurological disorder
- Primary neurological disorders (e.g., myasthenia gravis, Guillain-Barre)
- Patients with severe sepsis in addition to a Neuro admitting diagnosis
- Primary and Metastatic brain tumors
- Patients transferred/admitted to rule out status epilepticus requiring intubation or near intubation to administer IV anesthetics will get admitted to MICU under Medicine

Admissions to the Neurosurgery Service

For transfers from outside hospitals, please see the separate Neurosurgery transfer guidelines.

Patients with the following diagnoses will be admitted to Neurosurgery:

- Traumatic and non-traumatic intracranial hemorrhage requiring, or likely to require, a neurosurgical procedure.
- Non-traumatic, non-surgical lobar hemorrhage > 2 cm in diameter will be admitted to Neurosurgery for observation, regardless of anticoagulation status (exceptions listed below). If the lesion remains non-surgical after follow-up imaging at 3 hours, the patient may be transferred to Medicine (intubated) or Neurology (non-intubated)
- Patients who have an uncorrectable coagulopathy from an underlying systemic disease (i.e. liver failure, DIC, etc) are not surgical candidates and may be admitted to Medicine regardless of intracranial pathology.
- Patients on anticoagulation or antiplatelet agents will be admitted to the Neurosurgery Service for emergent correction of their coagulopathy if they require either a craniotomy or ventricular drain (unless the patient has multi-system trauma).
- Patients who are not surgical candidates (including non-traumatic hemorrhage in the brainstem, thalamus, or basal ganglia, traumatic subarachnoid hemorrhage, and traumatic parenchymal hemorrhages that do not meet the radiographic criteria outlined in the TBI guidelines) may be admitted to Neurology (non-intubated) or Medicine (intubated) or Trauma (traumatic mechanism) regardless of anticoagulation status.
- Patients who are not surgical candidates, but require placement of an intraparenchymal monitor or closed ventricular drain (no active drainage of CSF) for medical management

of ICP, may be admitted to Neurology (non-intubated) or Medicine (intubated) or Trauma (traumatic mechanism).

- Patients who are not surgical candidates, but require placement of a ventricular drain for active drainage of CSF, should be admitted to the Neurosurgery service unless they have a significant medical co-morbidity, or have multi-system trauma.
- Patients on warfarin or other anticoagulants or antiplatelet agents who are not salvageable (e.g., regardless of hemorrhage progression they will not become surgical candidates) will be admitted to Medicine (intubated) or Neurology (non-intubated), or Trauma (if in the setting of a traumatic mechanism).
- Non-surgical patients near brain death (i.e. with some residual neurological function [e.g., response to pain, gag reflex, spontaneous respirations]) will be admitted to Medicine (see directly above) for supportive care and eventual brain death documentation.

Admissions to the Orthopedics Service

Patients with the following diagnoses will be admitted to Orthopedics.

- Acute fracture including hip fracture and non-operative fractures requiring admission for rehab evaluation or pain control
- Osteomyelitis as per the osteomyelitis protocol

Admission of Patients with Traumatic injuries

All patients status-post trauma requiring admission are to be evaluated by the Trauma Service.

Once the patient has been initially stabilized, undergone a primary and secondary survey, received her/his imaging studies, and is deemed appropriate for admission, use the guidelines delineated below to determine the admitting service:

-Isolated Trauma

Patients sustaining isolated (orthopedic, facial trauma or other specialty) trauma (requiring an operative intervention or not) will be admitted to the respective service for management. A Tertiary Survey must be completed by the Trauma Team within 24 hours after admission.

1. All unstable pelvic fractures (irrespective of being an isolated injury) will be admitted to and managed by the Trauma Service. “Unstable pelvic fracture” is defined as a pelvic fracture that requires operative fixation (or would be offered surgery in ideal circumstances) or that has associated hemorrhage that requires an intervention (i.e. REBOA, packing, ex-fix, IR). Isolated acetabular fractures are excluded from this definition.

2. All patients with confirmed spinal cord injury (irrespective of being an isolated injury, partial or complete, operative or not) will be admitted to and managed by the Trauma service.

For patients with isolated traumatic brain injury:

- Neurosurgery will admit all patients undergoing craniotomy, those requiring ICP management and those with CT characteristics of a full brain requiring seven day admission
- Trauma will admit those patients not meeting the above criteria who require admission to ICU or SDU

Single system injury requiring multiple services will be admitted to the respective team most responsible.

Special Considerations for Ophthalmology

Ophthalmology no longer has an inpatient service with overnight coverage as of 12/21/20 so if the single system injury is an ophthalmologic case these patients will be transferred to Medicine (as long as they are in a regular room). General Medicine CANNOT care for patients on the 10th floor. Patients on the 10th floor will remain on the Trauma service. If the patient has a poly-trauma they will remain on the Trauma service or go to another appropriate surgical service per below. All non-traumatic ophthalmology patients will be admitted to medicine with ophthalmology consultation. Same day ophthalmology admissions for surgery will remain on the ophthalmology service but if the patient needs to be admitted overnight the patient will be transferred to Medicine. If the reason for admission is solely ophthalmic in nature, ophthalmology is expected to provide a comprehensive note for the admitting team to use.

Isolated ophthalmological trauma that is operative or requiring admission to a regular floor will go to the medical service. Isolated ophthalmological trauma that is operative or requiring admission to a critical care bed will go to the Trauma service for peri op SICU care with either discharge or transfer to Medicine once peri operative ICU issues are resolved. Ophthalmological trauma that is conjunction with facial injuries that is either operative or requiring admission will go to the facial trauma service of the day based upon the current rotating schedule. Should the

patient require ICU level of care the TRACC service will manage these issues peri operatively but the primary team will still be the facial trauma service admitting patients that day.

Multiple System Trauma

Patients sustaining poly-trauma (significant trauma to more than one system… one of which involves the pelvis, torso, head, neck, or a major vascular injury) will be admitted to the Trauma Service for initial management.

Upon stabilization from the Trauma Surgery perspective, a patient may be transferred to another service at the discretion of the Trauma / Trauma Surgical Intensive Care Unit Attending after discussion with all involved services.

Patients with isolated rib fractures requiring admission will be admitted to Trauma.

Admissions to the Urology Service

Patients with the following diagnoses will be admitted to the GU service:

- Renal or perinephric abscess >3cm
- UTI or pyelonephritis with urinary obstruction (e.g. ureteral stone, retained GU stent, regardless of planned intervention approach (e.g. percutaneous, endoscopic))
- Urinary obstruction/retention and admission for its primary sequelae (AKI, post obstructive diuresis) or patients requiring CBI (continuous bladder irrigation).
- Urinary calculi with intractable pain or vomiting
- Testicular mass or epididymitis/orchitis with fever or intractable pain
- Refractory Priapism
- Patients in the 30 day post-op period after GU procedure with procedure associated infection or complication
- Patients with a dislodged GU device requiring replacement (e.g. percutaneous nephrostomy tube replacement)

Patients with UTI or pyelonephritis without obstruction or ureteral stone will be admitted to the Medicine Service (if pregnant female see OB/GYN section), including patients with infected indwelling tubes or long-standing diverting urostomy other than ureteral stent (ie suprapubic tube, nephrostomy tube, urinary diversion such as neobladder/ileal conduit).

Admissions to the Peripheral Vascular Service

Patients with the following diagnoses will be admitted to the Peripheral Vascular service.

- Gangrene or ulcer with concern for arterial or venous insufficiency or exam c/w with lymphedema of the lower extremity
- Concern for needing BKA
- Peripheral arterial disease, injury, thrombosis, or obstruction from any cause
- Elective Vascular surgery (including patients needing vascular access procedures, patients for carotid endarterectomy, patients who are prisoners, patients on dialysis, and patients on coumadin needing reversal).
- Threatened limb or acute limb ischemia secondary to DVT

Patients with the following diagnoses will not be admitted to the Peripheral Vascular service.

- Proven DVT and other venous diseases will be admitted to Medicine.
- Strokes will be admitted to Neurology or Medicine.
- Cardiovascular disease will be admitted to Medicine or CV.
- Suspected DVT if unable to obtain definitive testing and ED team feels patient is unsafe or ineligible for discharge will be admitted to Medicine unless concern for threatened limb or acute limb ischemia

Admissions to the Cardiovascular Surgery Service:

- Aortic Dissection (Stanford classification A and B)

Admissions to the Cardiothoracic Surgery Service:

- Spontaneous Pneumothorax requiring Chest Tube or Pigtail Placement

Admissions to the Pediatrics Service

In general patients who are appropriate for admission to the pediatric service are those patients who are being evaluated in the PES, because screening criteria have already been applied to many of these patients. However, this is not a rule. The ultimate decision about the appropriateness of any particular patient rests with the PES attending physician.

- All patients under the age of 18 will be admitted to the pediatrics service (including patients in the custody of law enforcement)
- All patients ≥ 18 but < 21 years old requiring medical admission to a general ward will be admitted to the pediatric service, unless:

  1. The patient is a prisoner or

2. The patient is not considered safe and appropriate to be on a ward with young children by the PES attending physician (e.g., a significant history of current substance use such as heroin or cocaine; has violent behavior)

- Patients ≥ 18 but < 21 years old requiring admission to a surgical services may also be admitted to the pediatric service, but this decision is at the discretion of the surgical service involved
- Patients with complications of pregnancy will be admitted to the OB/GYN service
- Patients ≥ 18 but < 21 years old requiring medical admission to an intensive care unit should be admitted to the PICU if they meet the eligibility criteria described above and there is a bed available (the PICU is a 5-bedded unit). Otherwise, the patient will be admitted to one of the adult medical ICUs. Patients ≥ 18 but < 21 years old who are PICU patients may require transfer to an adult ICU if a young child requires admission to the PICU, the PICU has all beds filled, and there is an adult ICU bed available for transfer.
- Patients ≥ 18 but < 21 years old requiring medical admission to an isolation bed should be admitted to the pediatric service if they meet the eligibility criteria described above tand an isolation bed is available. At present, pediatrics has two isolation rooms on its general ward and one in the PICU.
- Patients with tracheostomies who require mechanical ventilation cannot be managed on 8 North, the general inpatient pediatric ward. Such patients ≥ 18 but < 21 years old requiring medical admission may be admitted to the PICU if a bed is available. Otherwise the patient will be admitted to one of the adult medical services.

Disorders of the Head and Neck:

- Facial Fractures: Facial Trauma Service of the day (or to service at BHC that performed previous operative procedure, when applicable)
- Facial Cellulitis/Abscess (excluding Orbital Cellulitis): Facial Trauma Service of the day
- Orbital Cellulitis: Ophthalmology
- Paratonsillar Abscess/Retropharyngeal Abscess: ENT
- Ludwig's Angina: ENT (or SICU)
- Mastoiditis: ENT
- SSTI of neck- ENT
- Odontogenic Abscess: OMFS
- Parotitis/Sinusitis/Sialadenitis: Medicine

Note: if infection source/involvement is unclear, ED attending will use his/her discretion as to the most appropriate service.

Admissions to the GYN Service

- Vaginal Bleeding requiring admission including symptomatic anemia with OR without active vaginal bleeding
- Pyelonephritis or UTI failing outpatient antibiotics in pregnant patients not requiring ICU level care. Patients requiring ICU level care will be admitted to the MICU.

Admissions to the GYN Oncology Service

- Should we add a section here to formalize the process?

Cellulitis/Wound Infections

If concern for NSTI (necrotising soft tissue infection) STAT general surgery consultation should be obtained prior to admission via the guideline set forth below.

Post-operative wound infections will be re-admitted to the surgical service that performed the procedure, or go to the SICU/SSDU if requiring a higher level of care.

Patients with post-operative wound infections resulting from procedures at other institutions will be admitted to the corresponding surgical service at Bellevue, or go to the SICU/SSDU if requiring a higher level of care.

Cellulitis:

- Cellulitis of Upper Extremities distal to Elbow – Hand
- Cellulitis of Trunk and/or extremities apart from distal to elbow – Medicine (if associated with an abscess or fluid collection even if drained prior to admission – General Surgery)
- Cellulitis with underlying bony hardware - Ortho
- Cellulitis of Face (including Orbital Cellulitis) – See “Disorders of the Head and Neck” (below)

Decubitus ulcers:

- Plastics – non-operative

- General Surgery – if signs of systemic infection or sepsis and/or operative
- *if a ulcer doesnt fall into above categories please do notify XXXX

Osteomyelitis:

- With underlying hardware in pelvis or extremities – Ortho
- With underlying hardware in spine – Neurosurgery
- If primarily ankle/foot – See podiatry admission addendum
- If primarily wrist/hand – Plastics
- If related to decubitus or other ulcer – use the decubitus rule
- Otherwise – Medicine

Septic Arthritis of native joints
All to Medicine (definite or suspected)

Septic Arthritis of joint with prostheses
Orthopedics

Podiatry Admission Addendum- 4/25/22

Vascular Surgery: will admit all foot and ankle wounds (including ulcers and gangrene) with concern for arterial or venous insufficiency or exam c/w lymphedema.
Concern for emergent amputation.

Internal medicine: will admit all foot and ankle wounds (including ulcers and gangrene) without evidence for arterial or venous insufficiency and who do NOT require a surgical/podiatric procedure in the operating room.

Orthopedics: will admit all foot and ankle wounds (including ulcers and gangrene) without evidence for arterial or venous insufficiency and who require a surgical/podiatric procedure in the operating room; (podiatry would serve as consultant and manage the patient)

Podiatry will be consulted by the primary service for all of the above, be involved in any operative care as necessary, and administer any required bedside care and management.

Suggested edits:

Skin and Soft Tissue Infections (SSTI):

- SSTI of upper extremities distal to elbow – Hand
- SSTI with underlying bony hardware - Ortho
- SSTI of face (including orbital cellulitis) – See “Disorders of the Head and Neck”
- SSTI of trunk - Medicine
- SSTI of lower extremities:
    - SSTI with intact skin without abscess or drainage - Medicine
    - SSTI with abscess or fluid collection, even if already drained prior to admission - General Surgery
    - SSTI involving (ulcer, wound, gangrene) in distribution of 1. arterial disease as evidenced by known peripheral arterial disease or absent peripheral pulses (doppler or other mode of assessment is not a criteria) or 2. venous disease as evidenced by known venous disease or signs/symptoms of venous disease or 3. concern for need for emergent amputation - Vascular Surgery.
    - SSTI involving (ulcer, wound, gangrene) in the absence of above criteria for arterial or venous disease of the foot (at or below the malleolus) - Orthopedic Surgery

The following patients will be placed on Observation status under the care of the Observation Medicine Team unless beds are not available. Under those circumstances the patients will go to the secondary service as listed. At the discretion of the ED attending, patients with these diagnoses may be admitted to medical or surgical services if the ED attending attests that despite the qualifying diagnosis the patient will qualify for admission under the ‘2 midnights

rule.’ Patients in Observation who need to be converted to admission at the discretion of the Observation team will be admitted to the appropriate inpatient service under the Admitting Guidelines in this document.

Transfusions?