Title: Emergency Department Admission Policy	
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Approved by: MOH committee on hospital clinical services and polices	
Approved by: Director of technical affairs	
Approved by: Assistant undersecretary of technical affairs	
Notes	

1.0 Purpose

1.1 The purpose of this policy is to outline rules and regulations that governs the Emergency Department and patients including preparing for patients care, admission of ED patients, optimizing patients flow, managing all emergencies and regulate all clinical practice in the Emergency Department.

1.2 This document is intended to support the Department's resources to ensure proper and efficient allocation.

2.0 Policy Statement(s)

2.1 The Emergency Department is the practice site for emergency physicians that provides patients care and direction to emergency medical services in hospitals including disasters and mass trauma situations.

2.2 All patients who present to the Emergency Department for emergency medical evaluation will receive care by qualified personnel in a timely manner according to the acuity of their illness

2.3 Emergency evaluation and care will be provided to all patients regardless of their gender, age, ethnicity, religion, personal life choices, political opinion or immigration status.

2.4 Patient assessment in the Emergency Department include the following:

2.4.1 Initial Assessment and workup of patient's physical status (Work up in emergency department includes various laboratory tests and radiological investigations (US, CT, MRI))

2.4.2 Setting appropriate treatment plan

2.4.3 Given patient's right to choose the preferred offered plan

2.4.4 Appropriate discharge process to meet patients medical, psychological and functional needs.

3.0 Responsibility

3.1 The responsibility to carry and implement this policy lies with hospital staff as follows:

- 3.1.1 Area Director
- 3.1.2 Hospital Director
- 3.1.3 Emergency Department Chairman
- 3.1.4 Deputy Director
- 3.1.5 Administrative staff
- 3.1.6 Clinicians (in all departments)
- 3.1.7 Nursing Department
- 3.1.8 ED Staff Nurses
- 3.1.9 Pharmacists
- 3.1.10 Data managers and health information managers
- 3.1.11 Social workers

4.0 Definitions

4.1 **Emergency Medicine:** is a horizontal specialty requiring a vast knowledge and expertise regarding the first hours of care of acutely ill or seriously injured patients requiring evaluation, stabilization, management and disposition. This domain requires sound clinical skills, the ability to work under stressful circumstances, as well as a precise ability to intervene often without certainty as to a definite diagnosis. In addition to the breadth of knowledge required, specific in-depth training, as well as expertise in toxicology, environmental medicine, acute resuscitation, disaster medicine and pre-hospital care is essential.

4.2 **Team Leader (TL):** Team Leader is the senior physician on duty who is responsible for ensuring smooth functioning in relation to the Emergency Room. The TL should supervise patient care and delegate work to other team members.

4.3 **Group Leader (GL):** The senior nurse during the shift in charge of all nursing staff in designated area.

4.4 **Assistant Team Leader:** He/she acts as the Team Leader in case the TL is absent or on-leave and holds the same responsibility as the team leader during the shift.

4.5 **Charge Nurse:** the ER bed manager and in charge of assigning patients to beds in the observation room, follow up with patient's management plan and alert the ERPs for the arrival of new patients. The Charge Nurse owns all beds in the Emergency Department

4.6 **Emergency Room Physician (ERP):** the most responsible emergency physician of a pre-assigned area in the emergency room

4.7 **Pre-Triage Nurse:** a nurse in charge of the pre-triage station located near the entrance of the triage room in the waiting area to alert the triage staff for any sick-looking patients that require immediate urgent care.

4.8 **Triage:** the process by which patients are sorted and/or classified according to the type and urgency of their medical conditions utilizing the Canadian Triage and Acuity System (CTAS). *refer to the attachment

4.9 **Triage Staff:** the ED staff in the triage room is in charge of triaging all patients coming to the ER and dispose them according to their complaints and clinical assessment (CTAS level).

4.10 **Resuscitation Room**: the most critical room in the ED where patients need urgent care and continuous assessment.

4.11 **Observation Room:** rooms that are meant to provide care or continued evaluation of patients who may need continued monitoring, or non-ambulatory patients, or ones who require management on a bed.

4.12 **Quick-care area:** This area is designated for ambulatory patients who do not appear to require monitoring nor management on a bed

4.13 **Waiting Rooms:** There are several waiting rooms in the ED. All cold cases that do not require a bed, continuous monitoring or IV access are assigned to one of these rooms by the triage staff. In addition, there are treatment rooms that provide certain services (e.g. blood extraction, injections, ECG, nebulization)

4.14 **Minor Operating Room (OR):** The ED has its own operating room for minor procedures that can also be used for major ones in case of disasters or unstable patients. Minor procedures include stitches, abscess drainage…etc.

4.15 **Isolation Room:** Appropriate isolation room is available for all patients who are potentially contagious and poses significant risk to other patients and staff as judged by the ED staff and meet international standards. This room can also be used for reverse isolation if the patient is immunocompromised.

4.16 **Incident Command Room:** It is the command and authorization center for the ED in all mass casualties/internal and external disasters. The room is also the command room for the entire ED that would harbor telemetry equipment, internal and external communication devices, mass casualties equipment, hospital Emergency Committee meetings.

4.17 **Bed Crisis:** It's a situation where number of patients exceeds the number of beds available in the ED.

5.0 Equipment and forms required

5.1 **Triage sheets**: Triage sheets are required to categorize patients coming to the ER and dispose them according to their complaints and clinical assessment (e.g. CTAS level) * refer to attachments.

5.2 **Handover sheets:** These sheets are created by the Department to be used by all ERPs at the end of their shift to handover their patients to their colleagues in the next shift.

5.3 **Emergency kit:** A kit that includes specific drugs and equipment that can be used in case the patient collapses during transfer

6.0 Procedures:

6.1 Admission to Emergency Room

6.1.1 Routs of admission

6.1.1.1 Emergency Department patients

6.1.1.1.1 The ED receives all patient in need of emergency medical evaluation and care.

6.1.1.1.2 Patients should be classified according to the urgency of their medical conditions (e.g. CTAS).

6.1.1.2 Outpatient Department (OPD)

6.1.1.2.1 The ER can receive patients from OPD only if they are in critical condition or if they need an urgent assessment or treatment. The treating physician should communicate such admissions earlier to the ER Team Leader.

6.1.1.2.2 The treating physician's team is responsible for evaluating and admitting the patient during the official working hours before 2 pm or the on-call team after 2 pm.

6.1.1.2.3 No elective admissions will be accepted in ER even if no beds in the wards are available as these admissions can be deferred.

6.1.1.2.4 No elective investigations sent from OPD to ER

6.1.1.3 Referrals from other healthcare centers

6.1.1.3.1 *Transfer from another hospital:* If a patient is transferred from another government/private hospital, it needs be communicated to the on-call team beforehand and decide whether to accept the patient or not.

6.1.1.3.1.1 If the on-call team agrees to accept the patient, the emergency department will receive the patient and perform the necessary evaluation. The accepting on-call team will be informed and the patient should be seen within 20

minutes for final plan regarding disposition.

6.1.1.3.1.2 If the on-call team was not informed about the patient, the ER will receive the patient for full assessment and inform the on-call team if admission is needed. (in such cases an incident report should be filled)

6.1.1.3.2 *Transfer of patient from abroad:* receiving patients from abroad has to go through specific process as follows:

6.1.1.3.2.1 A full medical report and notification should be sent to the Director's office about the exact date and time

6.1.1.3.2.2 The Director should inform the Emergency Department and treating department about the patient's arrival

6.1.1.3.2.3 The Emergency Department will inform the Team Leader(s) covering the day of the arrival

6.1.1.3.2.4 As the patient's condition may change during transfer, the patient should first land in the ER for triage. Then, the admitting team will do the initial assessment and decide accordingly where to admit the patient

6.1.1.3.2.5 In case of no prior notification is received, the ER team will assess the patient and call the appropriate service accordingly.

6.1.2 **Admitting patients belonging to other catchment areas**

6.1.2.1 The ED welcomes patients from all catchments areas when emergency medical care is required. Those patients shall receive all the necessary treatment.

6.1.2.2 No patient shall be discharged from ED without an ERP triage/assessment first.

6.1.2.3 If admission is needed, the on-call team will be consulted, and that team has to make a decision whether to admit the patient or refer him/her to other hospital according to their Department's policy.

6.1.2.4 Patient who needs active intervention, close observation, or unstable, should not be transferred routinely (based on residency area) and should be managed in the index hospital.

6.1.2.5 In case of shortage of resources (e.g. Lack of beds), communication should be made between the admitting team (senior to senior) to transfer to another hospital after the approval of a specialist and above and acceptance from the recipient hospital.

6.1.3 **Most Responsible Physician (MRP)**

6.1.3.1 MRP is the title of the head of unit or consultant under which the patient is admitted to the hospital or is being followed in the hospital. MRP can be one physician, one of others ancillary services consulted and concurrently following the patient with the MRP, or the patient can have an equally joint care of two specialties.

6.1.4 **Emergency Room bed manager**

6.1.4.1 Observation Room Charge Nurse is the ER bed manager and in charge of:

6.1.4.1.1 Assigning beds to the patients in the observation room

6.1.4.1.2 Follow-up with patient's management plan and the results of blood/radiological investigations

6.1.4.1.3 Notify the ERP about the arrival of new patients

6.1.4.1.4 Notify the Team Leader about bed crisis that could happen any time during the shift

6.1.4.1.5 Updating the ER screens regarding the status/arrival/departure of patients.

6.1.4.2 The Charge Nurse has to be aware and notified by the ERP/MRP about:

6.1.4.2.1 Patients arrival from abroad

6.1.4.2.2 Patient transferred from one care area to another care area in the Emergency Department or outside the ED.

6.1.4.2.3 Any critically ill patients that were informed about through the telemetry system.

6.1.4.2.4 All consultations to other services for any patient in the observation/resuscitation rooms

6.1.5 **Team Leader (TL):**

6.1.5.1 The TL is the most senior ERP in the ER with the following responsibilities:

6.1.5.1.1 Provide an overview management of the entire emergency department

6.1.5.1.2 Provide a senior opinion of a senior caliber to all emergency department staff

6.1.5.1.3 Divide ERPs on different emergency department areas as appropriate and constructive to patient care, and to provide most efficient patient flow

6.1.5.1.4 Oversee the flow of patients at different areas of the emergency department, and take corrective actions to avoid neck bottling effect by altering ED human and medical resources to different areas as seen needed

6.1.5.1.5 Authority to request emergency radiology investigations e.g. CT, U/S, MRI, contrast imaging, interventional radiology procedures, as seen required for all emergency department patients

6.1.5.1.6 All residents and medical students must report to him/her at the beginning and end (handover time) of all shifts, in order to be assigned to specific area/job in the shift, review their medical cases, and report to site education coordinator of their attendance, progress, performance, and potential pitfalls

6.1.5.2 The TL must be notified and involved in all the following:

6.1.5.2.1 Resuscitations, critical patients, deaths in the emergency department, expected deaths, and death on arrivals (DoA)

6.1.5.2.2 Disasters, mass casualty incidents (MCl/expected MCl).

6.1.5.2.3 All declared hospital codes, and all emergency situations and contingency plans

6.1.5.2.4 Hospital evacuation plans (partial & complete)

6.1.5.2.5 Violent threats and incidents in the ED

6.1.5.2.6 Discharges against medical advice (LAMA)

6.1.5.2.7 All incidents that warrant reporting (incident reports), of most important are sentinel events

6.1.5.2.8 All and any arising problems, and issues of concern in the ED

6.1.5.2.9 Patients transfer from abroad or from OPD

6.1.6 **Emergency Department Triage System**

6.1.6.1 **Triage Room**

6.1.6.1.1 A specific room is assigned for the triage at the entrance of the ED

6.1.6.1.2 The room has to be equipped with at least one vital sign monitor that is adaptable to adults and pediatrics as well as a glucose meter

6.1.6.1.3 No patients should be seen in the ER without being triaged first.

6.1.6.2 **Pre-triage**

6.1.6.2.1 A pre-triage station is situated at the entrance of the triage room.

6.1.6.2.2 Pre-triage station is assigned to pick up and expedited the care of all emergency presentations (pre-determined), other presentations as seen appropriate, and any obviously unstable patients in the waiting area.

6.1.6.2.3 A nurse should be assigned to the pre-triage station and meant to stay in that area at all times. The nurse can be replaced by an alternative at any time during the shift after the approval of the Group Leader.

6.1.6.3 **Triage Room staff**

6.1.6.3.1 Appropriate number of ER triage staff should be assigned to the triage (nurse). The hospital ED triages patients based on the Canadian Triage and Acuity Scale (CTAS)

6.1.6.3.2 The triage staff has to be in the room at all time throughout the shift.

6.1.6.3.3 All staff breaks should be informed to Group Leader in order to assign replacement staff during break time.

6.1.7 **Consultation to other departments**

6.1.7.1 Definition of a Consult**:** “a procedure whereby, upon a physician request, another physician reviews a patient's medical history, examines the patient, and makes recommendations as to care and treat. The medical consultant often is a specialist with expertise in a particular field of medicine”

6.1.7.2 Consults cannot be refused once issued without patient assessment

6.1.7.3 Tenants of a consult should be met and fulfilled before a consult is declared to be completed. These tenants include:

6.1.7.3.1 Attendance of the consulted service to the source of the consult and respective patient

6.1.7.3.2 Assessment of the patient by the respective consulted service

6.1.7.3.2.1 Assessment includes history, physical examination, patient's file and/or HIS review if available and follow up the results on ordered investigations (including laboratory and radiological investigations) necessary to formulate the final diagnosis and management plan.

6.1.7.3.3 Documentation by the consulted service of the impression, plan of management and disposition.

6.1.7.3.3.1 Disposition includes admission, discharge (with or without follow up), or transfer of care to another service

6.1.7.3.4 Cases being followed by a consult service thereafter are expected to be provided with serial assessment, management plan and documentation until admission, discharge or transfer of care to another service is documented.

6.1.7.4 It is the responsibility of the consulted service to organize sign over and plan of management between the members in their team to ensure continuation of care.

6.1.7.5 **General agreed on regulations**

6.1.7.5.1 Admissions from the ED ensue following a consultation from the ERP

6.1.7.5.2 ERP has the right to consult any specialty according to hospital policy. The consultation process has to include the following:

6.1.7.5.2.1 Direct verbal physician to physician discussion of the condition stating the degree of urgency.

6.1.7.5.2.2 Written consultation sheet with a brief description of the clinical details, diagnosis, deferential diagnosis, a rule out condition, or the reason of

consultation and the date and time of consultation. The sheet should also include the name of receiving specialty as well as the name of notified physician.

6.1.7.5.2.3 The evaluation, initial work up and management should be carried out by the ERP is based on the scope of ED management. Further work up needed by the consulting unit can be ordered by them after attending and evaluating the patient. No verbal orders will be carried out by the ED staff. Further work up should not delay a consultation.

6.1.7.5.2.4 The ER sheet (MR3) is filled strictly and solely by the ERP. All physicians from other specialists/departments seeing patients in consultation are prohibited from writing any notes or orders on MR3 and should use the respective assigned sheets for the consulted service.

6.1.7.5.2.5 Consulted team should document their assessment, clinical notes, their orders and treatment in the respective forms and/or HIS if the team decided to admit the patient.

6.1.7.5.2.6 In case the patient is planned for discharge, then the consulted team can write his notes and clinical findings on the respective sheet and/or HIS that should be filled by the ERP. Only the discharge medications can be written on ER sheet MR3 and/or HIS.

6.1.7.5.2.7 A consultation from the ED should be made to a registrar on duty or above. No consultation should be made to any rank lower than a registrar level. Trainees and assistant register can attend the patients in the ED under the supervision of the registrar on duty.

6.1.7.5.2.8 The patient refusing specific proposed interventions does ***not*** equate refusal of admission and/or medical management/care.

6.1.7.5.2.9 The patient may refuse an intervention but accept admission and medical treatment. In such a case, he/she is admitted and managed accordingly by the respective service responsible and specialized in the index pathology/complain BUT made to sign the REFUSAL OF INTERVENTION form.

6.1.7.5.2.10 ONLY if a patient refuses a specific intervention AND refuses medical care/management AND refuses admission, he/she is requested to sign the DISCHARGE AGAINST MEDICAL ADVICE form (doctors should write the full explanation that is given to the patient with possible consequences of his/her decision of discharge against medical advice) and allowed to be discharged accordingly.

6.1.7.5.2.11 In case the senior on-call doctor believes that the consultation is outrageously inappropriate, the ER Team Leader should be notified by the on-call senior registrar to solve this issue and an official incident report form is filled by the on-call team.

6.1.7.5.2.12 In case the Team Leader still believes that the patient needs a consult opinion then the patient should be seen.

6.1.7.5.2.13 If more than one specialty team were called to see the patient and there was a disagreement on whom should be the MRP or admitting team, the following sequences showed be followed:

6.1.7.5.2.13.1 During the conflict, both teams should attend and manage the patient until the conflict has

been resolved to avoid any delay in the management of the patient.

6.1.7.5.2.13.2 The discussion should be raised to senior level i.e. senior to senior, specialist to specialist or consultant to consultant.

6.1.7.5.2.13.3 In case a conflict persists, the ERP should inform the Team Leader. If the team leader failed to solve the issue, the conflict should be raised to ED Chairman or the deputy who would be the responsible party to decide on the most appropriate admitting service (based on the most objective level of clinical, laboratory and radiological evidence (preliminary/validated)), and this is considered as a forced admission.

6.1.7.5.2.13.4 The above should be done within 4-6 hours from the first consult.

6.1.7.5.2.13.5 Incident report should be written by the ERP for obligatory/forced admission and should be discussed with the administration and the involved teams the next day. And a copy should be sent to the technical affairs department in the ministry of health (the assigned email)

6.1.7.5.2.14 A multidisciplinary consultation can be made simultaneously by the ERP should the condition of the patient warrants it. The first service to be consulted is the most in need given the nature of the patient's condition, but all consulted services should attend to the care of the

patient as soon as possible, and their care should not under any circumstances be deferred until another service attends to the care of the patient.

6.1.7.5.2.15 In case a conflict raised regarding discharging a patient where the ERP believes the patient needs admission while the on-call doctor thinks otherwise, the Team Leader should raise this issue and discuss it with senior on call. If no agreement is achieved, the discussion should be raised to a higher level i.e. specialist to specialist or consultant to consultant and the final decision should be the taken by the consulted service.

6.1.7.5.2.16 Patients should be directed and admitted to the specialty most relevant, and never to the less relevant specialty or based on hospital file records of prior assessments. A joint follow up of a patient by the previous service can be requested if needed.

6.1.7.5.2.17 The on-call team should see and evaluate the consultations received from the ED, based on the following timeline:

- 6.1.7.5.2.17.1 Resuscitations room: 5-15min
- 6.1.7.5.2.17.2 Urgent consult 15-30min
- 6.1.7.5.2.17.3 Routine consult: 30-60min

6.1.7.5.2.18 All critically ill patients should be evaluated by the senior on-call doctor.

6.1.7.5.2.19 A maximum of 4 hours (in case of conflict 6 hours) is allowed from the time of the verbal acceptance of the consultation till the disposition of the patient from the ER.

Any unreasonable delay beyond the limit, the issue should be escalated to the senior of the consulted team. If the issue was not solved within 2 hours, the

ER has the right to force admit the patient. (refer to 6.1.7.5.13)

6.1.7.5.2.20 After the arrival of the on-call team and until the final disposition, the first consulted team is responsible for the management of the consulted patient.

6.1.7.5.2.21 In case of any deterioration in patient's clinical status who was evaluated by the on-call team, the ED staff (ERP/Nurse), should inform the on call group meanwhile the initial management should be conducted by the ER staff till the arrival of the consulted team.

6.1.7.5.2.22 Legal documents including referrals to the investigator can be initiated and filled out by any treating physician caring for the patient and is not limited for the ERP. If the ERP does not believe the condition is a legal case, and the consulting physician does, then the consulting physician should initiate the legal documents and should not force the ERP to declare a legal statue against his/her own clinical judgment.

6.1.7.5.2.23 In case a patient necessitate admission but for some reason the consulted team believes transferring the patient to another hospital is preferable, the consulted team should do the full arrangement with the receiving hospital verbally and written. The mode of transportation, medical escort and the needed equipment should be arranged. The final arrangement should be notified to the Team Leader and Charge Nurse.

6.1.7.6 **Unidirectional consultation policy**

6.1.7.6.1 Consultations from the ED are unidirectional. No consulted patient should be returned to the care of the ERP following a consultation and under any

circumstances, whether that return of care is for discharge or for any further consultations.
(any investigation requested by the consult team should be followed by the requesting doctor e.g. labs/radiological imaging)

6.1.7.6.2 If the consulted team believes that the patient is in need for another service's opinion or transfer of care, then it is the full responsibility of the consulted team to organize the new referral by verbal discussion and a written consultation form.

6.1.7.6.3 The consulting service have only one of four different dispositions to the patient:

6.1.7.6.3.1 Admission to the hospital

6.1.7.6.3.2 Discharge from ED/hospital

6.1.7.6.3.3 Discharge from ED/hospital with a referral to the OPD for further follow up and management

6.1.7.6.3.4 Consult another service

6.1.7.6.4 The ER doctor will oversight the process till the disposition of the patient

6.1.7.7 **Consultation content**

6.1.7.7.1 Each consultation by any ERP should be done both verbally and in written format (MR-9)

6.1.7.7.2 Verbal consultation is done by phone stating the patient's chief complaint, brief history and the degree of urgency

6.1.7.7.3 Consultation sheet is filled by the ERP and submitted to the assigned nurse of the patient.
Each sheet should include the following

6.1.7.7.3.1 Patient details (Name, age, nationality)

6.1.7.7.3.2 Chief complaint

6.1.7.7.3.3 Brief description of clinical details, relevant physical findings and investigation results

6.1.7.7.3.4 A diagnosis (if applicable)

6.1.7.7.3.5 Rule out condition, differential diagnosis or the reason of consultation

6.1.7.7.3.6 Date and time of the consultation

6.1.7.8 **Written records of consultation**

6.1.7.8.1 All Consultation sheets need to have two copies.

6.1.7.8.2 Upon admission, both copies are kept in patient's file.

6.1.7.8.3 Upon discharge, one copy is given to the patient and the other is kept in his/her file. In case the patient doesn't have a file in the hospital, the other copy is kept in a specified folder at the Charge Nurse station (for audit and medico-legal purposes)

6.1.8 **Timely-bound Protocols Available in the ED that have the following services**

6.1.8.1 Acute Stroke Pathway according to set policy by the Neurology Department

6.1.8.2 Primary percutaneous coronary intervention according to Cardiology Department

6.1.8.3 Trauma Team/surgical team activation according to the disaster policy set by the ED

6.1.9 **Bed Crisis**

6.1.9.1 In case of bed crisis, all MR3 sheets have to be stamped with bed crisis stamp by the Charge Nurse indicating date and time.

6.1.9.2 Once there is a bed crisis in any area in the ER, the Charge Nurse and/or the ERP assigned in that area need to inform the Team Leader. The TL can follow up with the bed management team in case many admitted patients are in the observation rooms and to discuss the management plan of patients who stayed in ER longer than expected with the assigned ERP.

6.1.9.3 In case of unavailability of beds in the wards, the admitted patient would stay in ED until the bed is available.

6.1.9.4 During the waiting period in ED, the consulted team is responsible about the management of admitted patients

6.1.9.5 The consulted team should ensure proper communication with the director and the bed management team regarding admissions, discharges and transfer potentials.

6.1.9.6 Once an admission is made in the ED, it is the responsibility of the admitting service to dispatch the patient in a timely manner in collaboration with bed management team.

6.1.9.7 The admitting team should identify the priority of patients for admission, which is based on their clinical status, and acuity of their presenting illness only. In case there is a delay in identifying the priority of patients for admission, the Team Leader must notify and demand the

admitting/on-call team to do so before shifting any patient outside the ER. If there is further unreasonable delay by the admitting/on-call team according to the bed situation in the ER and patient's condition, the Team Leader has the right to prioritize the patient according to his/her judgment.

6.1.9.8 In case the patient had to stay in ER for more than 24 hours, Senior registrar or above from admitting unit should round on the patient early in the morning and communicate with the bed management team regarding dispatching the patient as soon as possible. If the patient improved and the general condition at any point doesn't require disposition to the ward anymore, discharge plans and arrangement should be done by the admitting unit. All the patient's clinical documents should be kept in the hospital records.

6.1.10 **Patients discharge policy**

6.1.10.1 **Planned discharge**

6.1.10.1.1 When discharging patients from ER, a clear discharge plan has to be provided for each patient including but not limited to:

6.1.10.1.1.1 Patients clinical status upon discharge

6.1.10.1.1.2 Discharge medications

6.1.10.1.1.3 Home instructions

6.1.10.1.1.4 Instructions when to come back to ER

6.1.10.1.1.5 Time of discharge

6.1.10.1.1.6 Discharging ERP signature and stamp (in both MR3 copies)

6.1.10.2 **Referrals to OPD**

6.1.10.2.1 The patient can be referred to the OPD as long as his/her condition is stable, doesn't require admission, as far as he/she needs follow up

6.1.10.2.2 All patients referred to OPD should belong to the catchment area

6.1.10.2.3 Early OPD referrals: those are conditions that will require a more expedited OPD appointment within a day to a week. The MRP is responsible to provide the OPD appointment with a specific date, time and OPD room number.

6.1.10.2.4 In case the consulted doctor believes that this patient needs his/her immediate assessment rather

than OPD referral, he/she can assess the patient in the ER and dispose the patient according to his/her clinical judgement.

6.1.10.2.5 If referral to a tertiary care center is needed, it has to be done after direct discussion with the tertiary care center physician and his/her approval of the referral (with the documentation of the approval by the MRP in the referral sheet) or through OPD after initial evaluation.

6.1.10.2.6 Non-urgent referral can go to primary care clinics

6.1.10.3 **Recently discharged patients** (**Bounce back to ED)**

6.1.10.3.1 Patients discharged from emergency department **by ERP within the past 72 hours**

6.1.10.3.1.1 The patient should not be evaluated by the same ERP in the previous visit

6.1.10.3.1.2 The team leader must be informed about the patient

6.1.10.3.1.3 A thorough history, physical exam, and management must be documented.

6.1.10.3.1.4 If the patient is deemed fit for discharge, a proper documentation in MR3/HIS system of the following should be provided:

- clinical condition
- management,
- the reason for discharge
- follow up plan
- Patient contact information

6.1.10.3.2 Patients discharged from the emergency department **by the consulted service** within 72 hours,

6.1.10.3.2.1 The on-call team must be consulted (regardless of the original consulted team)

6.1.10.3.2.2 A thorough history, physical exam, and management must be documented.

6.1.10.3.2.3 If the patient is deemed fit for discharge, a proper documentation in MR9/HIS system of the following should be provided:

- clinical condition,
- management,
- the reason for discharge
- follow up plan
- Patient contact information

6.1.10.3.3 Patients discharged from the inpatient ward, within the past 72 hours, have to be fast-tracked in assessment, management and disposition by the ERP and the consulted services.
(ER-stay time <4 hours)

6.1.10.4 For patients with recurrent visits (more than one visit) to the emergency room, over the period of 7-14 days, the above policy 6.1.10.3 should be applied. A log of those patients must be reviewed by the ER Team leader and/or chairman on a daily basis for follow up and assessment as deemed necessary.

6.1.10.5 **Request of changing ERP, and second opinion**

6.1.10.5.1 *ERP requesting the transfer of care of a patient to an alternate physician of similar specialty:* The ERP may wish to transfer the care of his/her patient because of irreconcilable differences, disagreements, and/or clear risk of conflict and legal escalation. Such request has to be discussed with the Team Leader of the Shift who may asses the patient him/herself or assign another ERP to do so.

6.1.10.5.2 *Patient requesting a change in ERP*: Due to irreconcilable differences, any ER patient may request another ERP to assess him/her, he/she can do so by asking to speak to the Team Leader of the shift who can agree to assess the case him/herself or assign another ERP to do so

6.1.10.5.3 *Patient requesting a second opinion:* Patients in ER can request a second opinion, assigned ERP can arrange for a second opinion by discussing the case to the Team Leader. The Team Leader will assess the patient and give his/her opinion to the patient.

6.1.10.5.4 In case the patient insists to be admitted to the hospital despite the fact that his/her condition

doesn't require in-patient treatment, the ERP has to seek advice and clinical judgment from his/her Team Leader. The Team Leader has to assess the case fully and if he/she is assertive that the patient doesn't need admission, the Public Relations Department has to be involved.

6.1.11 **Patients with history of substance abuse:**

6.1.11.1 ERP does not report any patient with history of substance abuse to any authorities nor reveals the patient's history to his/her relatives or acquaintance except in the following situations:

6.1.11.1.1 Official authorities: in case a crime/possible crime is suspected

6.1.11.1.2 Public health authorities: in case the patient has an infectious disease that need to be reported

6.1.11.1.3 Any other authority that is defined by the patient after his/her agreement

6.1.12 **Deceased Patients:**

6.1.12.1 Normal death:

6.1.12.1.1 Death certificates are the responsibility of the ERP in case the patient died in ER before being evaluated or admitted by on-call team; however, if the patient was seen, evaluated and active management was given by an on-call team, this team should fill out the death certificate in case the patient coded and died anytime while waiting in the ER.

6.1.12.1.2 The dead body is kept in the ER for 2 hours. After that, the dead body is sent to the mortuary to be handed over to the respective relatives according to hospital protocol.

6.1.12.1.3 The death certificate should NOT be issued before the above 2 hours period.

6.1.12.2 Medico-legal deaths:

6.1.12.2.1 No regular death certificate is written, only a medico-legal referral form to the Forensic Medicine Specialist who will arrange for postmortem examination of the body in the index hospital mortuary or his/her department, according to the situation. The Forensic Medicine Specialist will be

responsible for issuing the death certificate and burial permit later.

6.1.12.2.2 All patients who are found to be already clinically dead upon arrival to the ER (Dead On Arrival, DOA), should be prepared and sent to Forensic Medicine Specialist as a medico-legal referral if resuscitation attempts are unsuccessful and death is declared.

6.1.12.3 **Death On Arrival (DOA)**

6.1.12.3.1 **Dead on arrival (DOA),** also **dead** in the field and brought in **dead (BID),** indicates that a patient was found to be already clinically **dead** upon the **arrival** of professional medical assistance, often in the form of first responders such as emergency medical technicians, paramedics or police

6.1.12.3.2 **Witnessed cardiac arrest** is one that is seen or heard by another person or an arrest that is monitored

6.1.12.3.3 All patients that come in cardiopulmonary arrest are resuscitated according to ACLS/PALS/ATLS/NRP protocols. The duration of the resuscitation is according to the ERP discretion that differs according to the case

6.1.12.3.4 Resuscitation will not be started only when the patient has signs of irreversible death:

6.1.12.3.4.1 Rigor mortis

6.1.12.3.4.2 Decapitation

6.1.12.3.4.3 Dependent lividity

6.1.13 **Patients Transfer to Other Departments:**

6.1.13.1 ER patients in the observation, resuscitation or isolation rooms should be accompanied by at least one nurse at all times, when transferring them to other departments (including radiology) or any other area either within or outside the ER. (refer to transfer policy)

6.1.13.2 In case of transferring the patient to Intensive Care Unit (ICU) or to Cardiac Cath lab, he/she has to be accompanied by a physician with the emergency kit (refer to index).

6.1.13.3 In case of transferring the patient to any other area, treating ERP should decide whether the patient has to be accompanied by the ERP with the emergency kit (refer to point 5.3). In case the patient was admitted, the admitting

team should decide whether the patient has to be accompanied by a doctor with the emergency kit or not.

6.1.13.4 If an admitted patient in the ER requires a procedure to be carried out including endoscopy and coronary angiography, a bed in the **ward or elsewhere** outside the ER should be arranged by the admitting service and designated to that patient first before undergoing the procedure.

6.1.13.5 Patient transfer to other department should be subjected to inter-hospital-departmental policy. (refer to MOH transfer policy)

6.1.14 **Documentation in the ER:**

6.1.14.1 ERPs shall document all their clinical notes and plans on Emergency sheet (MR3/HIS). In case more space is needed, ERPs can use the clinical progress sheet (MR8/HIS) to document their follow up notes and treatment sheet (MR12/HIS) to write down their orders.

6.1.14.2 Clinical notes and orders should be clear, specific and easy to read.

6.1.15 **Emergency Department Handover Policy**

6.1.15.1 Planned handover

6.1.15.1.1 Handover has to include efficient transfer of high-quality clinical information to ensure patient safety by providing continuity of care.

6.1.15.1.2 Handover process has to be done verbally and electronically in the health information system (HIS)/written handover sheet if HIS unavailable:

6.1.15.1.2.1 Written: by filling the handover sheet that includes the following:

6.1.15.1.2.1.1 Name of ER area that is handed over to

6.1.15.1.2.1.2 Name of each patient in that area

6.1.15.1.2.1.3 Most likely diagnosis of each patient

6.1.15.1.2.1.4 Patient status (waiting investigations, consultation, admission, discharge)

6.1.15.1.2.1.5 Signature and stamp of the ERP covering that shift

6.1.15.1.2.1.6 Time and date

6.1.15.1.2.2 Verbally: The ERP from previous shift has round with the new shift ERP and exchange the following information (Mnemonic ***I SBAR***):

6.1.15.1.2.2.1 ***I*** Identity of patient (name, age, nationality)

6.1.15.1.2.2.2 ***S*** Situation: symptom, chief complaint, patient stability

6.1.15.1.2.2.3 ***B*** background: history of presentation, past medical history, allergy to medication

6.1.15.1.2.2.4 ***A*** Assessment and action: what is your impression? What is the most likely diagnosis? What have the patient received so far? What kind of investigations carried out?

6.1.15.1.2.2.5 ***R*** Response and rationale: what you want done to the patient? what kind of treatment that need monitoring what's the patient plan depending on the result? what can go wrong with the patient

6.1.15.1.3 In case no proper handover was done, the next shift ERP has to write an incident report and inform his/her Team Leader.

6.1.15.1.4 The next shift Team Leader has to discuss that incident with the previous shift Team Leader during the next Team Leader meeting with the Department Chairman

6.2 **Implementation**

6.2.1 Implementation process include a training program to be conducted once a revised version is released. Training could be given in form of:

6.2.1.1 Lectures

6.2.1.2 Workshops

6.2.1.3 Audiovisuals

6.2.1.4 Departmental meetings

6.2.2 Training program can be provided several times if any difficulty to implement the policy is found or if there is lack of understanding among the staff

7.0 Monitoring procedure

7.1 MOH committee on hospital clinical services and polices will monitor the above policy.

7.2 Senior doctor of the related team can email the above-mentioned committee, in case of any incidence.

7.3 The email address will be: incident@moh.gov.kw

Attachment

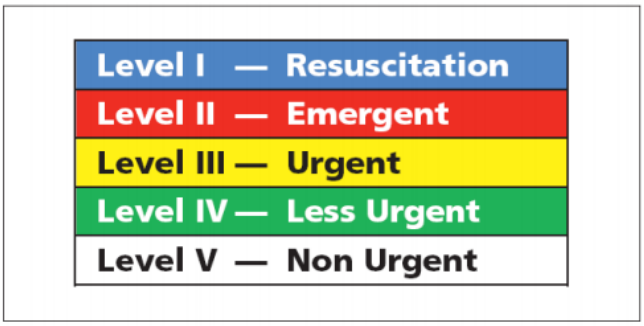


Fig. 1. Canadian Emergency Department Triage and Acuity Scale colour scheme.

TRIAGE SHEET

Name:		State of Kuwait
Civil ID:	Gender:	Ministry of Health
DOB:	Address:	

Triage Level: I II III IV V

Triage Disposition: ☐ Office ☐ Observation ☐ RR ☐ Others(Specify)

ECG
Time (s)

REQUESTED

PERFORMED

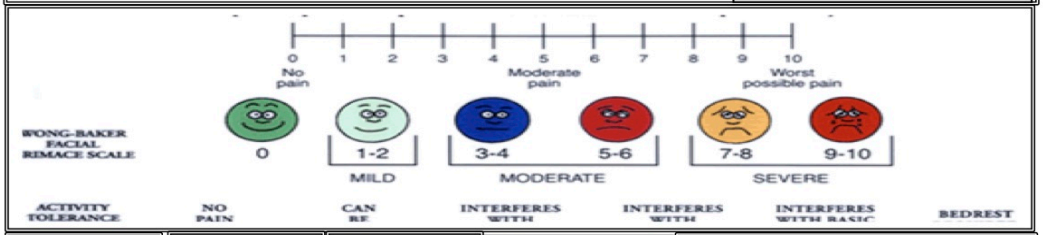
INTERPRETED

Triage Time	BP	P	RR	Temp.	SpO2	RBS	Sign

Chief Complaint:

☐ Return ED visit in <48hrs ☐ Yes, Reason:_____

LMP:



Allergies	Arrival Mode	Ambulatory status	PMH	MEDS
	Ambulance Self Family Police Unknown	Ambulatory Wheel chair Stretcher		

Standing Order

Date: Signature:

TS20180403