8. Improving patient flow: Optimising ED to ward processes

A Timely Emergency Care Collaborative how-to guide for health services

OFFICIAL

VICTORIA State Government | Department of Health

Institute for Healthcare Improvement

To receive this document in another format phone 1300 475 170, using the National Relay Service 13 36 77 if required, or email Timely Emergency Care 2 Program <TEC2@health.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.
ISBN 978-1-76131-737-8 (online/PDF/Word)
Available at Emergency care <https://www.health.vic.gov.au/patient-care/emergency-care>

Contents

Introduction

The Timely Emergency Care Collaborative (TECC) aimed to reduce delays for patients needing emergency care in Victoria through improving hospital-wide patient flow.

The project involved 14 teams from hospitals across Victoria, as well as a team from Ambulance Victoria. The Victorian Department of Health delivered the project in partnership with the Institute for Healthcare Improvement.

The project ran from December 2022 until the end of June 2024. Almost every team showed significant improvements in the timeliness of emergency care, as measured by Emergency Department (ED) lengths of stay.

The project set out with a change theory of how to improve hospital-wide patient flow. This change theory was developed by drawing on international evidence, local and international expert input and the ideas of the participating teams.

Through the results of testing and the insights from participating teams, the change ideas that were found to be most impactful (feasible to implement, demonstrated improvement) were identified as 'high-impact change ideas'. These ideas have been written up as a series of 'how-to guides'.

This guide is one of a series outlining each of these high-impact change ideas. All guides are available from Emergency care <https://www.health.vic.gov.au/patient-care/emergency-care> or by emailing the department <TEC2@health.vic.gov.au>. A summary of the overall change theory from the TECC can also be found on the Emergency care webpage <https://www.health.vic.gov.au/patient-care/emergency-care>.

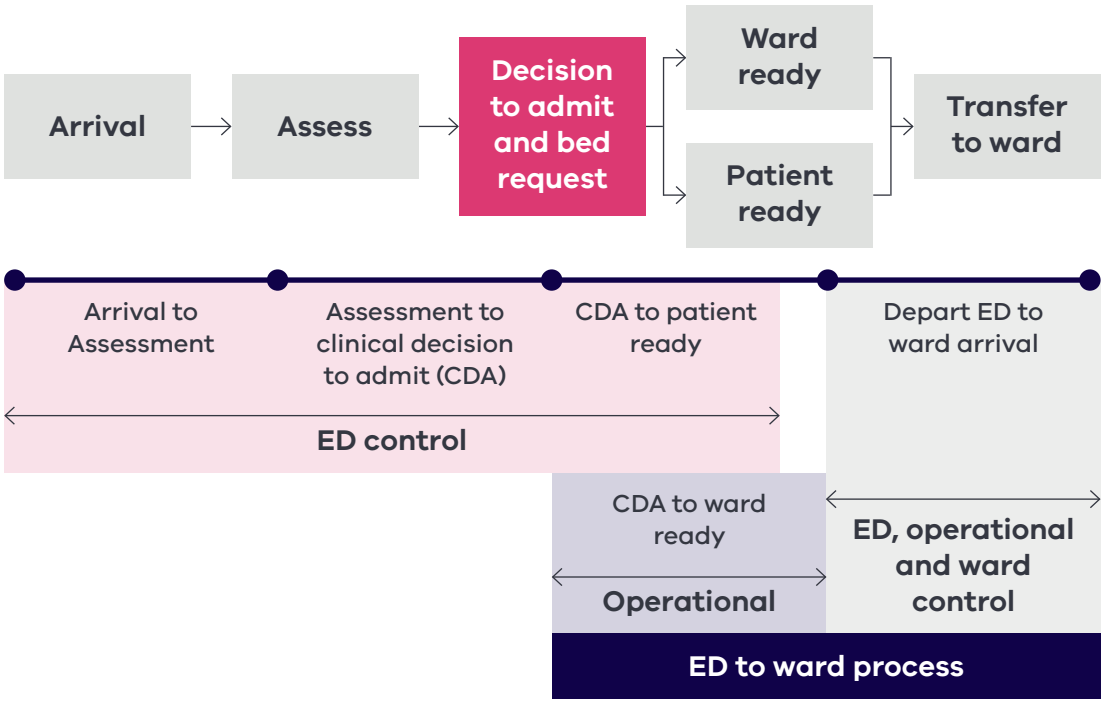
The change theory and learnings from the TECC project continue to inform other departmental projects including the Timely Emergency Care (TEC) 2 Program.

Note: The content provided below is intended as guidance only. The concepts should be adapted to suit your specific local context and needs.

Problem these change ideas address

Emergency patient flow is a complex issue that requires a system solution to minimise care delays and maximise patient outcomes. Solutions and accountability for emergency patient flow can be classified by timeframes that are routinely measured and reported (**Figure 8.1**).

Figure 8.1: Key steps from ED arrival to departure to the ward



ED improvement teams often overlook the bed request to departure timeframe, yet it offers significant opportunities to reduce the overall length of stay for ED-admitted patients. Delays in readiness, handover and physical transfer are usually easier to address than speeding up clinical decisions or finding an appropriate bed.

Patient flow from the ED to an inpatient ward requires the efficient transfer of location and clinical responsibility for an admitted patient.

Safe patient transfer requires:

1. **Clinical readiness:** Clear parameters and signalling that a patient is safe for transfer.
2. **Clinical handover:** All clinical information necessary to support the patient's ongoing care is exchanged between the ED and the ward medical and nursing teams.
3. **Logistics:** Available resources to relocate patients to their admitting ward or unit.

The Victorian TECC program identified effective ways to move patients from EDs to wards more efficiently. This how-to guide will highlight the change ideas aligned to each of the transfer principles outlined above.

Understanding the problem

The first and most important step to improve ED-to-ward transfers is to review your current state. Multiple steps in the admission process can be improved, but the greatest impact on patient flow will be achieved by identifying and prioritising the most significant delays.

The following steps are recommended:

Process mapping

All the processes from the clinical decision to admit a patient to the patient's arrival to a ward bed should be outlined in a process map. This is a visual representation of all the tasks and decision points of the process, with the aim of identifying preventable delays, bottlenecks, non-value-added steps, duplication or rework. Process mapping should be:

- conducted with the staff directly involved in the process because they are most familiar with the actual procedures as they currently occur
- validated through direct observation to confirm staff feedback
- reviewed and finalised by the staff who originally provided input.

These findings will highlight opportunities to improve and inform the design of change ideas.

More information on process mapping and observation <https://www.ihi.org/insights/5-steps-creating-value-through-process-mapping-and-observation> is available from the IHI website, including a toolkit <https://www.ihi.org/sites/default/files/QIToolkit_Flowchart.pdf>.

Data review

The ED-to-ward process includes several timestamps that can be used to divide the patient journey into segments (**Figure 8.1**). By measuring the average duration of each segment, we can identify and address the longest delays or greatest opportunities to improve on ED-to-ward flow. The following timestamps may be useful for a current state review and monitoring for improvement:

- Outcome measure (the overall metric for this progress): Time from ED bed request to actual departure from ED.
- Process measures (metrics that inform where delays are occurring):
  - Time from ED bed request[1] to bed allocation
  - Time from bed allocation to nursing handover complete
  - Time from clinical handover complete to actual departure from ED.

1 Where there is ED 'right to admit' in place, we can infer that the clinical decision to admit time = bed request time.

Overview of the change ideas

Change concept 1: Clinical readiness

Clinical readiness of transfer

The decision to admit occurs when an emergency physician recognises that a patient needs inpatient care. This decision should be made as early as possible to facilitate bed allocation and transfer to the ward. The admission decision often takes place before a patient is ready for transfer to a ward because resuscitation and other time-dependent treatments must be provided beforehand.

From an operational perspective, ED patients with a bed request are waiting for a bed and are presumed ready for transfer.

This ambiguity creates clinical and operational risk:

- **Clinical:** Transferring patients before their care is complete can delay time-critical treatment.
- **Operational:** Beds may be allocated to patients who are not ready for transfer, impacting the timely transfer of other patients waiting for a bed.

This risk can be addressed with a 'ready to go' signal that indicates which admissions are ready to be transferred to the ward and have completed all required emergency care.

A suggested approach for planning this change could involve the following:

1. Audit your current state to understand your timeline for admitted ED patient flow using the measures outlined in the 'Understanding the problem' section above. The time from bed-ready to departure is most likely to improve with 'ready to go' signalling because patient transfer may be delayed if the patient is not clinically ready for transfer.
2. Meet with ED leadership to identify the problem and explain how an additional flag ('ready to go' signalling) will benefit the accuracy of bed allocation and reduce the risk of premature transfers.
3. Develop a method to flag patients who are clinically ready for transfer. This may be an icon on your electronic patient tracking system or a manual notification to the nurse in charge for services without an electronic system.
4. Review and adjust your bed allocation system to prioritise transferring patients who are both clinically 'ready to go' and have an appropriate bed available.
5. Develop and deliver a promotional and educational package to the ED, inpatient and bed management teams before launch.
6. Launch the new process and apply Plan-Do-Study-Act (PDSA) improvement cycles to reduce the time from bed request to 'ready to go' and from 'ready to go' to departure.

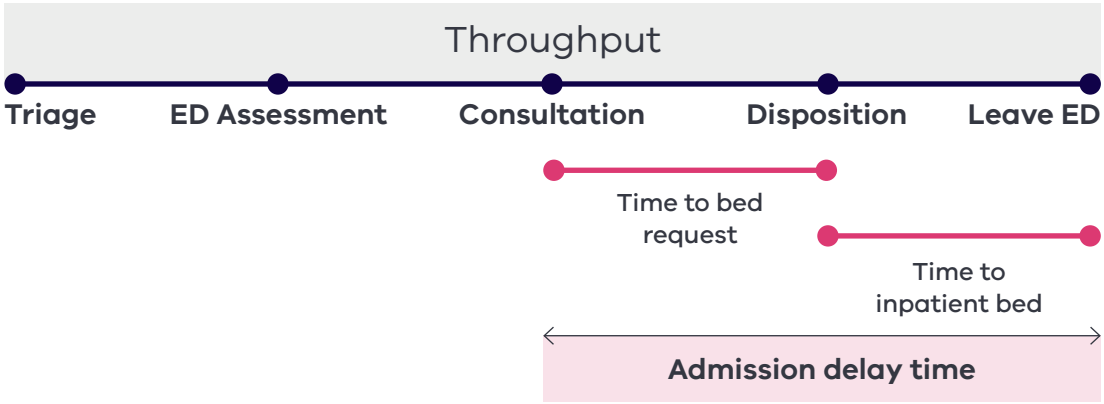
Change concept 2: Clinical handover

ED right to admit

Optimal patient flow requires early clinical decisions on admission or discharge to facilitate timely access to definitive care and to mitigate ED overcrowding, which poses increased risk to newly arriving patients. Specialist emergency physicians are trained and experienced to identify the need for inpatient hospital care on clinical grounds, without the benefit of definitive imaging or pathology results.

Traditional models require the ED to refer a patient for an admitting doctor consultation, who would then request a bed if they deemed admission necessary after their review. But this creates admission delays (**Figure 8.2**). ED right to admit allows an experienced ED clinician to make a bed request immediately after the ED assessment, facilitating bed allocation without waiting for an inpatient service review.

Figure 8.2: Factors that delay admission (Lee EEM, et al., 2020)



Multiple studies (see box on page 9) have confirmed the accuracy of admission decisions by emergency physicians, supporting the broad implementation of an ED right to admit to improve patient flow.

The decision to admit by an emergency physician requires a comprehensive assessment of a patient's ability to safely function with their presenting illness while also considering their social circumstances and any pre-existing chronic disease.

The ability to make early admissions carries a slight risk of inappropriate admission or discharge. A safety perspective would indicate greater concern for inappropriate discharges because appropriate care may be delayed for these patients. This is encouraging because the studies mentioned above also considered the accuracy of discharge decisions, which were consistently higher than that of admission decisions (90–95%).

Inappropriate admissions create operational challenges, where admitted patients may be considered suitable for discharge on review by the inpatient team. The decision to discharge benefits from additional time, during which definitive investigations are completed and reported and the disease course becomes clearer. Like medical

Supporting studies

Vaghasiya MR, et al. (2014): A prospective cohort study conducted at Westmead Hospital in Sydney measured the accuracy of admission decisions made by various types of ED clinicians in a cohort of 490 patients. They found that emergency physician and ED registrar admission decisions had a sensitivity of 91%.

Lee EEM, et al. (2020): A prospective cohort study conducted in Canada measured the accuracy of emergency physician admission decisions in a cohort of 454 patients. The study found that emergency physician admission decisions were 90.5% accurate, with higher sensitivity predicted for general surgery and the largest cohort, general medicine (96.5%). The ability to make bed requests from an ED decision saved an estimated 922.1 hours of ED stretcher time.

Velduis LI, et al. (2024): A prospective observational multi-centre study compared the accuracy of paramedic, ED nursing and physicians' predictions on the need for hospital admission following clinical assessment with an objective scoring system. They found that all healthcare providers outperformed the scoring system, with the strongest performance by emergency physicians, achieving 91.9% sensitivity in predicting hospital admission.

conditions, the decision to admit is dynamic and varies with reassuring results and an improving trajectory, both of which take time to establish. Such patients should not be considered process failures but as patients who responded to early management, which could not have been confidently predicted on arrival.

The ED right to admit approach is likely to meet with resistance from inpatient teams, who have traditionally been responsible for deciding whether to accept emergency patients. Significant effort will be required to show inpatient teams the benefits of this approach and gain their commitment.

A suggested approach for planning this change could involve the following:

1. Meet with clinical directors (or appropriate heads) and share data showing: the delay in the transfer of patients to the ward caused by the current process; evidence of the impact of this delay on patient safety and outcomes; and the supporting evidence for the change idea (safety and accuracy of the decision).
2. Seek support from the chief medical officer or the associated clinical governance group to foster organisational support for the improvement.
3. Review and adapt the admission policies of local health services that have successfully deployed an ED right to admit policy into a local draft proposal.

4. Meet with inpatient units to discuss the strategy and to identify and address any challenges or concerns in your final strategy.
5. When formulating your policy, carefully consider factors that may impact the local safety of ED right to admit, including:
    a. **Local ED staff capability:** Smaller health services may have limited availability of specialist emergency physicians. For these services, adjust your hours of operation, or define your level of registrar seniority that would allow for ED-directed admissions to occur.
    b. **Local inpatient unit capability:** Some services don't have on-site junior medical staff to admit patients under some specialties, particularly after hours. These units may need a team-based approach to ensure patients are reviewed and treated promptly.
6. Seek support from organisational leadership, including the chief operating officer or their equivalent. Enlist the help of your ED clinical leaders to highlight the clinical and operational benefits of this approach, including risk-mitigating strategies.
7. Consider connecting the ED right to admit with a one-referral strategy. This approach requires an inpatient team to provide an onward referral if it is more appropriate for another service. This will prevent referral 'rejections' that then require ED to reassess the patient and make additional referrals elsewhere.

Refer to Appendix 1 for ED right to admit policy examples (Austin and Alfred Health).

Interim admission orders

After referral to an inpatient team, patients awaiting ward admission continue to receive care in the ED until reviewed by the admitting team and transferred to the ward. The need for an admitting team to review patients in the ED before transferring to the ward often creates a bottleneck in patient flow, which can be effectively addressed with interim admission orders ('interim orders').

Interim orders work synergistically with ED right to admit, linking an early decision to admit with a patient management plan that can be applied in both the ED and the inpatient ward.

Interim orders enable emergency doctors to prescribe treatments to be administered on the ward before a patient is reviewed and a definitive inpatient care plan is established.

An interim order is a treatment plan created by the ED treating doctor that is then refined and confirmed with the admitting team to ensure alignment with ongoing care. They are created when deciding to admit and typically feature:

- a provisional diagnosis or presenting complaint
- input from the admitting team
- specific treatment for the presenting complaint
- supportive treatment including diet, fluids and analgesia
- patient needs such as fasting status, telemetry isolation and special nursing requirements
- pending investigations that require follow-up
- approvals from both the receiving team and senior ED clinician for the order.

Interim orders should not be used for transferring critically unwell or unstable patients to a ward. Admitting teams should review and provide definitive care as soon as possible and urgently consider the need for intensive care or evacuation to a higher capability service.

Supporting studies

Haydar SA, et al. (2015): A multi-phase, quasi-experimental design study to measure the impact of an emergency physician admission protocol that integrated ED holding orders to reduce ED length of stay. ED flow metrics were compared before and after the intervention, which followed a 5-phase PDSA cycle quality improvement methodology. They achieved a 22% decrease in their ED length of stay, primarily by improving their bed-request-to-departure times.

Traub SJ, et al. (2017): A retrospective study of ward admissions from the ED to the hospital internal medicine service aimed to compare the ED length of stay of patients with interim orders to those without. They discovered that patients with interim orders experienced a 44-minute reduction in ED length of stay compared with those without interim orders. A shorter length of stay was also noted for patients who were later admitted by the inpatient team before being transferred to a ward.

Interim orders enhance the flow and quality of patient care by:

- enabling a safe ward transfer if a bed becomes available before the inpatient team review
- encouraging ED clinicians to extend the duration of their management plans to be applied on the ward or, similarly, during an extended stay in the ED.

A suggested approach for planning this change could involve the following:

1. Meet with clinical directors (or appropriate heads) and share data showing: the delay in the transfer of patients to the ward caused by the current process; evidence of the impact of this delay; and supporting evidence for the change idea (safety and accuracy of the decision).
2. Seek support from the chief medical officer or the associated clinical governance group to foster organisational support for this improvement.
3. Review and adapt the interim orders of another health service that has successfully introduced an interim order process.

4. Meet with your ED and inpatient teams to:
    a. define the problem
    b. articulate how interim orders will address it
    c. invite concerns, develop solutions and incorporate suggestions into the final format
    d. develop a document or electronic template that captures the clinical and operational components to enable the safe transfer of admissions to wards.
5. Develop and deliver an engagement and educational package to the ED and inpatient ward team before launch. This should include both medical and nursing staff.
6. Launch the new process and apply PDSA improvement cycles to reduce the time from bed request to departure.

Refer to Appendix 2 for an ED interim order example template (Northern Health).

Change concept 3: Logistics

Dedicated transport services

Relocating admitted patients from the ED to a ward is often overlooked in ED flow improvement projects. The logistics of patient transfer are simpler than clinical decision-making and can be quickly improved with a reconfiguration or minor investments in the healthcare workforce.

The demand for patient transportation arises when admissions are waiting for beds and suitable beds become available. This typically happens in the late afternoon and early evening when many beds become available in a short period. If a limited number of orderlies are available for these transfers, patients will queue to leave, leading to preventable transport delays.

The specific deployment of orderlies to the ED is an effective strategy for reducing the time from bed readiness to departure.

A suggested approach for planning this change could involve the following:

1. Audit your current workforce and access data, including:
    a. Pattern of bed availability: Identify the number of beds that become available by hour of the day, across weekdays and weekends. With a steady supply of admissions, this will tie in with the need for patient transport.
    b. Existing orderly workforce (number of staff, shift patterns and scope of responsibility): Consider the time taken to perform each task type and whether your available workforce is aligned with hourly patterns of demand for patient transport.
    c. Plot your orderly workforce volume by hour of the day for weekdays and weekends.
    d. Compare your hourly workforce supply pattern to the bed availability pattern.

    By matching your orderly workforce with the demand for patient transport, you can reduce queueing for orderly transport.

2. Review current orderly processes with operational leadership and the orderly team to identify and address existing and anticipated challenges of patient transport.
3. Adjust the scope of responsibility of your orderly team to increase their availability for ED-to-ward transportation. This can be achieved by:
    a. narrowing the scope of responsibility during certain shifts to increase the focus on ED
    b. creating an ED orderly team based in the ED to support afternoon and evening transfers
    c. expanding the orderly workforce to increase overall availability during periods of high transportation demand.
4. Roll out the new patient transport model and apply PDSA improvement cycles to learn from adjustments and continue to reduce the time from bed ready to departure as an outcome measure.

Nurse phone handover

A traditional requirement for transferring patients from the ED to an inpatient ward is that the patient must be accompanied by ED nursing staff. This places a significant burden on ED processes, which must accommodate the absence of that nurse for 20 to 30 minutes. A significant proportion of ward admissions do not require clinical supervision during transport and can be safely transferred to the ward by orderlies after a telephone clinical handover. By reducing the need for nursing escort, patient flow is improved by:

- eliminating the potential delay for nurse readiness to transfer as they deal with competing priorities
- increasing the availability of nurses to receive a new patient into the vacated ED cubicle.

A suggested approach for planning this change could involve the following:

1. Review and adapt your local policies and procedures to enable an orderly-only transfer of patients who meet the ‘unescorted’ criteria.
2. Review and adapt your local policies and procedures that govern ED-to-ward clinical handover to enable phone handover for patients who meet the ‘unescorted’ criteria.
3. Develop a checklist for nurse phone handover to be used by the ED and the receiving ward nurse to coordinate the handover process. This handover should trigger orderly-only transportation to the receiving ward.
4. Develop and deliver an engagement and educational package to the nursing (ED and inpatient) and orderly teams.
5. Launch the new process and apply PDSA improvement cycles to reduce the time from bed request to departure as an outcome measure.

How to test these change ideas

The PDSA testing framework offers guidance for testing these change ideas. This framework aims to use rapid cycle tests to quickly learn and adapt change ideas. As confidence in the idea increases, cycles can be longer and tested under different conditions. The guidance below focuses on the first testing cycle, but plan extra test cycles ahead of time so the idea is continuously tested and adapted until it is ready for permanent implementation.

Refer to the IHI website for more information about PDSAs <https://www.ihi.org/how-improve-model-improvement-testing-changes>.

Before testing

Ensure appropriate clinical leadership and engagement

The clinical director of emergency medicine and hospital operational leadership should sponsor and support changes to ED-to-ward processes. A change from existing practice will require strong leadership to increase the chances of success. Ensure there is appropriate clinical engagement of the senior emergency medicine team before beginning to plan for testing the change idea.

Co-develop ideas to be tested

A small team representing the key craft groups/roles that would be involved in testing any new criteria, model, pathway or process should be engaged to co-develop the change idea.

Once drafted, change ideas should be broadly socialised and adjusted if specific risks or issues are identified (testing will help refine the model further).

Identify other requirements for testing

Ensure systems (for example, electronic medical records or other documentation) are in place to support changes. If a change to the electronic medical record or other IT systems is needed, determine if an interim process can be implemented while undertaking initial testing. This will reduce unnecessary testing delays and avoid changes to IT systems based on an untested model.

Plan

Decide when to initiate the first test cycle and for how long

Avoid beginning testing on a Monday or after a public holiday. This is typically a day of increased pressure on EDs and may also impact staff awareness and readiness to test the change after a break.

The duration of the test should be determined by:

- the level of staff support/readiness for the change
- the potential risk associated with the change
- the level of confidence that the change will lead to improvement.

A model can be tested for a few hours if a short cycle is helpful to address the concerns of staff and to allow for rapid adaptation. However, there should be a plan to continue testing the model (with necessary adaptations through rapid PDSA cycles) for long enough to collect data that shows whether the change is leading to improvement (increased use of the ED short stay unit) and that it is not leading to any unintended consequences. This may be a few days to a few weeks, depending on the patient volumes being seen through the new model. The model may also need to be tested under 'different conditions' (different shifts or days of the week, different clinicians or teams) to give confidence that it can be consistently delivered and will lead to improvement.

Plan for data collection

Establish a plan for data collection before testing begins. Recommended measures are outlined in the next section.

Establish clear operational definitions for measures and develop a detailed plan that outlines who will be responsible for collecting (or extracting) data, how often, how the data will be analysed, and by whom.

It is also important to plan how to get qualitative feedback about the test of change. Planning a short huddle at a convenient time of day when team members can be quickly assembled can be a simple and effective way to gain rapid insights and adjust the model to address any identified issues.

Prepare the team

Align staff rosters as needed to support the new model and ensure all staff involved in the test of change are given adequate training. Providing role cards and process flows that outline the key tasks and expectations can be useful as an easy reference during early tests of change.

Communicate to others

Ensure other staff who may interact with the team are aware of the test of change, including why the change is being tested and what they can expect.

Do

Start testing

Carry out the test of change as per the PDSA plan.

Collect data and feedback

Collect data during the testing cycle. Capture feedback at huddles.

Study

At the end of the testing cycle, assemble the team to review the data and feedback. Identify what is working well and opportunities for improvement. Develop ideas for any adjustments to improve the model.

Act

Decide whether to continue testing and if the model should be adjusted. Start the next PDSA cycle accordingly.

Note that the intent should always be to continue testing unless:

- the change was determined to be inappropriate (unsafe, unsustainable or no confidence that it would lead to improvement), or
- the model has been tested long enough that it is ready to be implemented as the new standard way of working.

How to measure if the change is leading to improvement

Table 8.1 lists the suggested measures to understand if there are improvements in ED use. The IHI website has more information on measurement for improvement <https://www.ihi.org/how-improve-model-improvement-establishing-measures>.

Table 8.1: How to measure improvements

Measure number	Metric	Operational definition	Associated change idea	Why use this measure
Outcome measure 1	Mean ED admitted length of stay	Mean length of time in the ED for all patients who are admitted to an inpatient ward	All	Overall intended outcome
Outcome measure 2	Mean bed ready to departure time	Mean time from clinical decision to admit to departure	Dedicated transport services Nurse phone handover ED right to admit Interim orders	Indicator of the overall effectiveness of changes
Process measure 1	Proportion of unescorted transfers to the ward	Proportion of all ward admissions transported to the ward without a nurse escort	Nurse phone handover	Aiming to maximise the volume of appropriate unescorted ward transfers
Process measure 2	Mean bed request to 'ready to go' time	Mean length of time between bed request and a patient being clinically ready for departure	Clinical readiness for transfer	To monitor and improve the delays between bed request and being clinically ready for departure
Process measure 3	Mean 'ready to go' to departure time	Mean length of time between a patient being declared clinically ready for transport to a ward and the time of departure to the ward	Clinical readiness for transfer	A true measure of admission delay due to bed availability and logistical delays

Measure number	Metric	Operational definition	Associated change idea	Why use this measure
Process measure 4	Mean time from arrival to clinical decision to admit	Mean length of time between ED arrival and the clinical decision to admit	ED right to admit	Measures the effectiveness of right to admit on reducing delays to disposition decision
Process measure 5	Daily proportion of admissions with interim orders complete	The volume of interim orders completed per day	Interim orders	To measure the utility of interim orders
Balance measure 1	Volume of ward discharges within 24 hours	Volume of admitted patients who are discharged within 24 hours of a bed request for admission	ED right to admit Interim orders	Early decisions may increase inappropriate admission rate
Balance measure 2	Volume of clinical incidents involving unescorted patient transfers	Volume of clinical incidents involving unescorted patient transfers	Nurse phone handover	Unescorted patients may deteriorate, triggering clinical safety events
Balance measure 3	Weekly number of MET calls that occur within 4 hours of admission to a ward	The number of patients who develop MET call criteria within 4 hours of admission to a ward	Interim orders ED right to admit	To monitor clinical risk associated with patients being admitted to a ward without being reviewed by their admitting team

Appendix 1: ED right to admit – procedure examples

Royal Melbourne Hospital (2025)

EMERGENCY DEPARTMENT ADMISSIONS

a. Emergency department clinicians have the authority to determine if, when and where patients should be admitted.

b. Requests for admission are the responsibility of the ED Medical staff or ED Nurse Practitioners

c. There are 4 options that can be followed when admitting a patient from ED:

   i. The admitting team reviews the patient in ED within 60 minutes from the referral and either completes the admission or documents an alternative management plan.

   ii. If the first designated admitting team does not deem themselves as the most appropriate inpatient unit for the patient to be admitted under, they must refer the patient to the team that is more appropriate within 60 minutes of the initial ED referral.

   iii. If an admitting unit has not accepted the patient for admission or organised an alternative inpatient unit within 60 minutes of the referral, an admitting Unit may be designated by the Emergency Physician in Charge.

   iv. If an inpatient bed is available and the patient is clinically stable and all other necessary processes have been completed then the Emergency Physician in Charge will enact an Interim Admission Plan (MH01.18) and transfer the patient to the inpatient ward, where they will be reviewed by the admitting unit within 4 hours. In all cases where an Interim Admission Plan is enacted the Emergency Physician in Charge (or delegate) is to inform the admitting unit.

Alfred Health (2025)

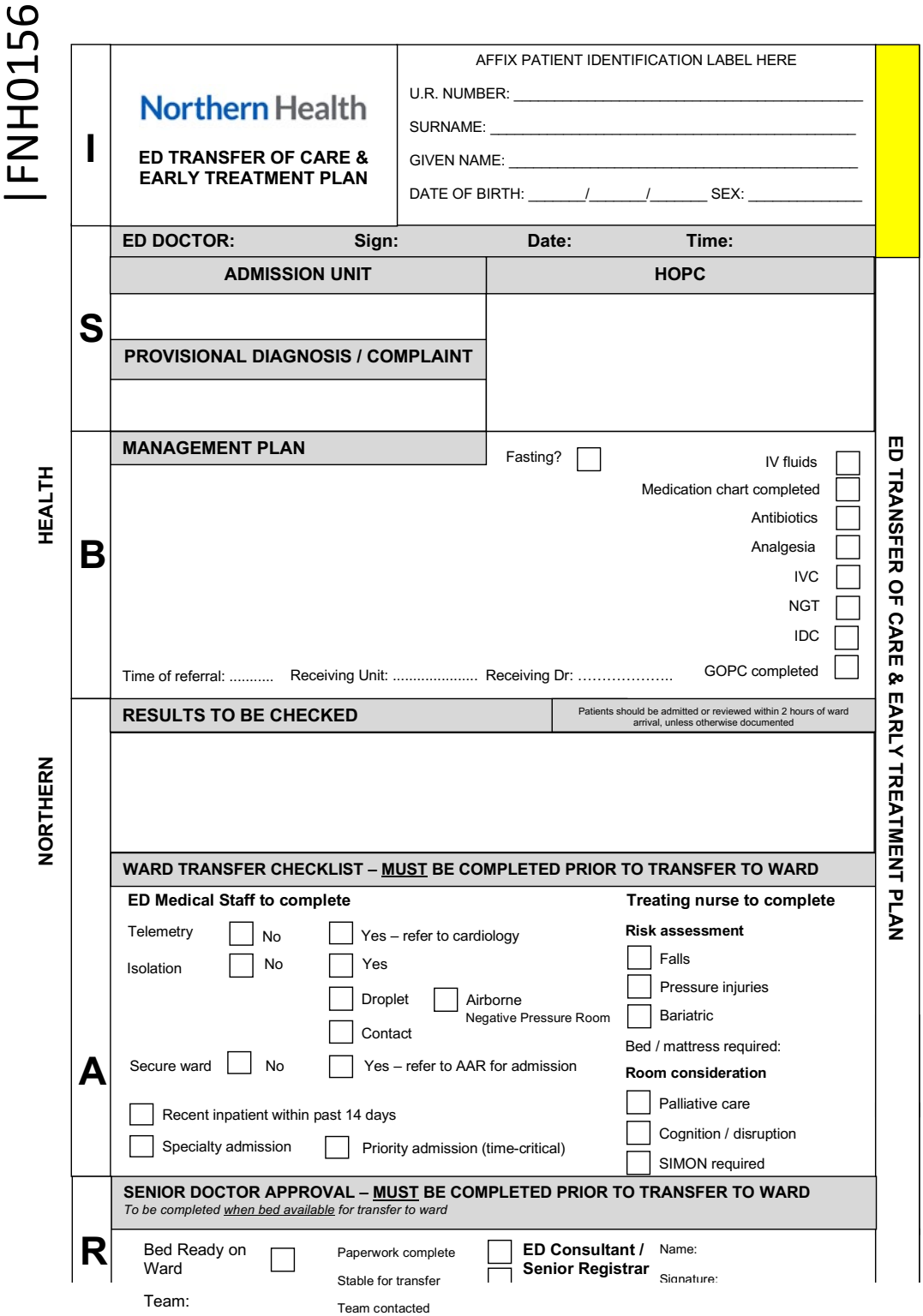
Decision to Admit → Allocated Unit / Bed Card

1.1 Key Responsibilities:

- While the patient is in the ED, the ED medical team is responsible for coordinating the management of the patient. The decision to admit a patient to a ward lies with the ED Physician/Registrar based on their assessment of the patient. The ED Physician/Registrar must notify the appropriate receiving clinical unit of a patient admission and complete an Interim Admission order
- Once an inpatient admission decision has been made, the ED medical staff is responsible for informing the parent medical team of all significant events that occur to the patient during their ED stay.
- It is the responsibility of the parent medical team to discuss with the ED team any management requests/suggestions they have for the patient.
- All essential investigations and initial management as described within agreed ED and unit specific care guidelines will be initiated whilst the patient is within the ED.
- Prescribing of time critical medications lies with the unit responsible for the patient's care at the point of time at which these medication requirements become known, as defined by the allocated bed care/unit overseeing treatment.
- A bed request and unit allocation is placed in LaunchPoint (CERNER) by the ED staff
- If at any point during the patient's admission the inpatient unit find the patient's care would be optimised under another inpatient unit, a representative from that unit is to arrange to have the patient transferred for ongoing management. Transfer of care between inpatient units is seen as a priority to ensure the most appropriate ongoing care is provided to patients

Appendix 2: Interim admission order template

Northern Health – Transfer of care form



FNH0156

Northern Health

ED TRANSFER OF CARE & EARLY TREATMENT PLAN

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____/_____/_____ SEX: _____

I

ED DOCTOR: **Sign:** **Date:** **Time:**

S

ADMISSION UNIT	HOPC

PROVISIONAL DIAGNOSIS / COMPLAINT

B

MANAGEMENT PLAN

Fasting? ☐

IV fluids ☐
Medication chart completed ☐
Antibiotics ☐
Analgesia ☐
IVC ☐
NGT ☐
IDC ☐
GOPC completed ☐

Time of referral: ..... Receiving Unit: ..... Receiving Dr: ……

A

RESULTS TO BE CHECKED

Patients should be admitted or reviewed within 2 hours of ward arrival, unless otherwise documented

WARD TRANSFER CHECKLIST – MUST BE COMPLETED PRIOR TO TRANSFER TO WARD

ED Medical Staff to complete

Telemetry ☐ No ☐ Yes – refer to cardiology

Isolation ☐ No ☐ Yes
☐ Droplet ☐ Airborne Negative Pressure Room
☐ Contact

Secure ward ☐ No ☐ Yes – refer to AAR for admission

☐ Recent inpatient within past 14 days

☐ Specialty admission ☐ Priority admission (time-critical)

Treating nurse to complete

Risk assessment

☐ Falls
☐ Pressure injuries
☐ Bariatric

Bed / mattress required:

Room consideration

☐ Palliative care
☐ Cognition / disruption
☐ SIMON required

R

SENIOR DOCTOR APPROVAL – MUST BE COMPLETED PRIOR TO TRANSFER TO WARD

To be completed when bed available for transfer to ward

Bed Ready on Ward ☐

Team:

Paperwork complete
Stable for transfer
Team contacted

☐ **ED Consultant / Senior Registrar**

Name:

Signature:

HEALTH NORTHERN

ED TRANSFER OF CARE & EARLY TREATMENT PLAN

Chapter references and further reading

Policies and procedures

Alfred Health (2021) *Emergency patient admission guideline*, Alfred Health, Melbourne.

Austin Health (2021) *Emergency department clinical policy: timely emergency admissions*, Austin Health, Heidelberg.

Northern Health (2020) *ED transfer of care: an early treatment plan*. Northern Health, Epping.

The Royal Melbourne Hospital (2023) *Approval of admissions to Royal Melbourne Hospital City Campus procedure*, The Royal Melbourne Hospital, Parkville.

Literature

Haydar SA, Strout TD and Baumann MR (2016) Sustainable mechanism to reduce emergency department (ED) length of stay: the use of ED holding (ED transition) orders to reduce ED length of stay. *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine*, 23(7), 776–785. Available at: https://doi.org/10.1111/acem.12967

Lee EEM, Kwok ESH and Vaillancourt C (2020) Using emergency physicians' abilities to predict patient admission to decrease admission delay time. *Emergency Medicine Journal*, 37(7), 417–422. Available at: https://doi.org/10.1136/emermed-2019-208859

Traub SJ, Temkit M and Saghafian S (2017) Emergency department holding orders. *The Journal of Emergency Medicine*, 52(6), 885–893. Available at: https://doi.org/10.1016/j.jemermed.2017.01.042

Vaghasiya MR, Murphy M, O'Flynn D and Shetty A (2014) The emergency department prediction of disposition (EPOD) study. *Australasian Emergency Nursing Journal*, 17(4), 161–166. Available at: https://doi.org/10.1016/j.aenj.2014.07.003

Veldhuis LI, van der Weide L, Nanayakkara P and Ludikhuize J (2024) The accuracy of predicting hospital admission by emergency medical service and emergency department personnel compared to the prehospital MEWS: a prospective multicenter study. *BMC Emergency Medicine*, 24(1), 111. Available at: https://doi.org/10.1186/s12873-024-01031-9