Transfer of Patients from Home or Clinics as “Direct to Unit” Admissions

Objective: Outline the process to have a patient admitted directly to a unit bed and bypass the emergency department

Description: This document contains important steps to ensure that a patient admission can be directed to the floor and bypass the emergency department.

Scope: Please refer to the appropriate section

Section A: Transfer of ILI/suspected COVID 19 patient from AHS Facility to Direct to Unit admission via RAPPID

Section B: Transfer of patient from outpatient clinic to SHC unit bed

Section C: Transfers of non-COVID-19 patient from home to SHC unit bed

SECTION A: Transfer of ILI/suspected COVID 19 patient from AHS Facility to Direct to Unit admission via RAPPID

Context: Requests made to COVID Physician for Admission and transfer of care- Direct to Unit by RAPPID can be considered according to the following document:

1. **Triage Patient as per CURB 65:**

Curb 65: 2-5 deemed appropriate for admission direct to unit.

CURB-65 greater than 5: Deemed not stable for admission Direct to Unit- RAAPID to Call Emergency for consideration for Transfer of Care

Request referring physician to have a Goals of Care discussion with the patient and their family prior to the transfer and ensure that this is documented via a Green Sleeve GOC order.

2. **Assess pre-transfer vitals:**

Vital signs: BP/ HR/RR/Temp. /O2 GCS to ensure no signs of acute deterioration such as RR **greater than 30, O2 Sat less than 92 on greater than 5 LPM 02, Decreased LOC**

If patient stable for transfer, Accepting COVID physician- Makes plans to transfer the patient to the "Hot Zone- Inpatient Bed" by:

1. Call Bed Placement to notify them direct to unit admission.
2. Discussion with unit manager / Charge Nurse regarding the details of the transfer with instructions to notify the COVID pager immediately when the patient arrives on the floor.

Rapidly Deteriorating Include:

RR greater than 30, O2 Sat less than 92 on greater than 5 LPM 02, Decreased LOC

Activate transfer to SHC ED as per current EMS/ED protocols. ED requires a patch in to know that the patient is unstable and on way to their emergency department.

ED to liaise with COVID physician via the COVID pager to get sign over regarding patient coming in.

For Stable Patients:

Patient can come to the designated COVID- POSITIVE area to be admitted.

For patient admitted to the unit- Unit Manager/Charge Nurse to be notified by accepting physician about patient's arrival.

COVID Accepting Physician:

Affirm Goals of Care with patient

Admit using the COVID Admission Pathway and Algorithms recommended.

SECTION B: Direct admissions of patients from the SHC Outpatient Clinics to the SHC Inpatient Units

Context: From time to time, patients seen in the SHC Outpatient Clinics require admission to SHC for investigation and/or management of their medical conditions, include suspected COVID / ILI.

1. **Suspected COVID / ILI:**
    a. The patient will be put in a contact/droplet isolation room in the clinic, and provided with a simple mask.
    b. The requesting clinic MD contacts the COVID MD via the COVID pager to discuss the most appropriate accepting physician service (COVID Team, Internal Medicine, Hospitalists) with the patient history/physical etc and admission request.
        i. If the patient requires oxygen at 6L/min or more, consider contacting the ICU for R goals of care and high suspicion / confirmed COVID patient.
        ii. If the patient is hemodynamically unstable in the clinic, a Code Blue should be initiated.
    c. The requesting clinic MD confirms calls SHC Bed Placement / Site Manager to request a bed under the admitting MD.
        i. If there is a bed available prior to clinic closure (usually 16:00 – 17:00 h), the patient can wait in the clinic area for the inpt bed
        ii. Site Manager / Bed Placement will need a Vocera or phone contact to communicate to the clinic when bed is ready
        iii. If there is no bed available, the patient will need to be transferred to the ED to wait for a bed.
    d. The requesting clinic MD establishes and documents Goals of Care with the patient.
    e. Bed Placement can create an in-patient encounter in SCM: They will create a Holder Bed in SCM on the unit the patient is going to. However, the patient cannot be activated to the unit until they are physically there. The MD can search the patient by RHRN in SCM and enter orders that way.
        i. The requesting clinic MD enters the admission, creates a brief admission note in SCM, enters preliminary orders
        ii. The clinic medication reconciliation will be used as the initial med req for the admission
    f. Initial investigations (ie bloodwork, x-rays, ECG) may be initiated in the clinic while the patient is waiting for an inpt bed.
    g. RN staff chart vitals as per local clinic practices (ie, on paper or in SCM).
    h. Clinic staff prepare copies of key outpatient clinic chart documents needed for the inpt chart.
    i. When a bed is available:

    i. Site Manager / Bed Placement will contact clinic
    ii. Clinic RN will provide a verbal report to the accepting Unit RN
    iii. The patient will be transported via wheelchair or stretcher with a porter +/- Clinic RN with the appropriate contact/droplet precautions in place.
    iv. The accepting Unit clerk will page the admitting MD to notify that patient has arrived on the unit.

2. **Any other medical issue:**
   a. The requesting clinic MD contacts the on-call MD for the most appropriate accepting physician service (Internal Medicine, Hospitalists, General Surgery, etc) with the patient history/physical etc and admission request.
      i. If the patient is hemodynamically unstable in the clinic, a Code Blue should be initiated.
   b. The requesting clinic MD confirms calls SHC Bed Placement / Site Manager to request a bed under the admitting MD.
      i. If there is a bed available prior to clinic closure (usually 16:00 – 17:00 h), the patient can wait in the clinic area for the inpt bed
      ii. Site Manager / Bed Placement will need a Vocera or phone contact to communicate to the clinic when bed is ready
      iii. If there is no bed available, the patient will need to be transferred to the ED.
   c. The requesting clinic MD establishes and documents Goals of Care with the patient.
   d. Bed Placement can create an in-patient encounter in SCM: They will create a Holder Bed in SCM on the unit the patient is going to. However, the patient cannot be activated to the unit until they are physically there. The MD can search the patient by RHRN in SCM and enter orders that way.
      i. The requesting clinic MD enters the admission, creates a brief admission note in SCM, enters preliminary orders
      ii. The clinic medication reconciliation will be used as the initial med req for the admission
   e. Initial investigations (ie bloodwork, x-rays, ECG) may be initiated in the clinic while the patient is waiting for an inpt bed.
   f. RN staff chart vitals as per local clinic practices (ie, on paper or in SCM).
   g. Clinic staff prepare copies of key outpatient clinic chart documents needed for the inpt chart.
   h. When a bed is available:
      i. Site Manager / Bed Placement will contact clinic
      ii. Clinic RN will provide a verbal report to the accepting Unit RN
      iii. The patient will be transported via wheelchair or stretcher with a porter +/- Clinic RN
      iv. The accepting Unit clerk will page the admitting MD to notify that patient has arrived on the unit.

SECTION C: DIRECT ADMISSIONS COMING FROM HOME

1. The requesting MD contacts the on-call MD for the most appropriate accepting physician service (Internal Medicine, Hospitalists, General Surgery, etc) with the patient history/physical etc and admission request.
2. The requesting MD confirms calls SHC Bed Placement / Site Manager to request a bed under the admitting MD.
3. The requesting MD establishes and documents Goals of Care with the patient.
4. Site Manager / Bed Placement will notify patient when a bed is available.
    a. Bed Placement can create an in-patient encounter in SCM: They will create a Holder Bed in SCM on the unit the patient is going to. However, the patient cannot be activated to the unit until they are physically there. The MD can search the patient by RHRN in SCM and enter orders that way.
5.
    a. The requesting clinic MD enters the admission, creates a brief admission note in SCM, enters preliminary orders
    b. The clinic medication reconciliation will be used as the initial med req for the admission
6. When a bed is available:
    a. Site Manager / Bed Placement will contact the patient directly
    b. When patient arrives to hospital they will be screened at one of the designated access points. The screeners will notify Bed Placement of the patient's arrival and a Unit Representative will meet them to ensure proper isolation and take them up to the unit.
    c. The accepting Unit clerk will page the admitting MD to notify that patient has arrived on the unit.