American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Writing Admission and Transition Orders

Policy Resource and Education Paper (PREP)

This policy resource and education paper (PREP) is an explication of the policy statement "Writing Admission and Transition Orders"

Background

The emergency department (ED) is acute medical care's decompression zone, where a widely fluctuating demand for urgent and often life-threatening emergent medical care is met. In the ED, patients are separated into those requiring ongoing hospital-based medical care (observation or admission) and those who have been treated or are able to continue their care in alternative setting, such as home, a psychiatric facility or a nursing facility. For the ED to fulfill its critical safety net functions to the community, it must retain adequate treatment capacity to absorb the normal fluctuations in demand on its services. Reasonable flow through the ED is required to maintain this capacity. Anything that jeopardizes this flow jeopardizes the availability of emergency services to the surrounding community and directly impacts the health of community members. It also may subject the hospital and ED personnel, especially emergency clinicians to both legal and regulatory consequences.

EDs generate a significant number of hospital admissions, and are often the major source of all admissions for the hospital. The admission process is a significant transition of care with multiple steps, encompassing both the caregivers and the facility. Such transitions are known to be a significant source of medical error. In addition, due to the multiple complex steps and significant handoff of information between multiple providers, the process may be time consuming and become a major contributor to reduced ED flow and ED crowding. Required steps include screening for financial eligibility, acceptance and sometimes evaluation by the admitting physician, bed location and assignment, information transfer from both emergency clinicians and nursing staff in the ED to inpatient caretakers, and the physical movement of the patient to the non-ED care setting. This document deals with the provision of transition orders, one key step in the process of care transition between emergency clinicians and admitting physicians.

Introduction

In a perfect world, admitting physicians would respond in a timely fashion to the ED and, after evaluating their patients, write admitting orders, verbally transmit admitting orders to the ED nursing staff, or enter admission orders in the electronic health record so that their patients would move quickly to inpatient beds. The advent of the electronic health record, which allows the admitting physician, absent from the care site to get a detailed picture of the patient without a face-to-face evaluation, can facilitate this process.[1]

In the real world, there are often delays in the completion of admitting orders by the admitting physician for a variety of reasons, resulting in delays in moving patients out of the ED and backup of flow in the ED and out to the waiting room. Admitting physicians may be unavailable due to other work or may not be on site. They may prefer to personally evaluate ED patients prior to writing admission orders, possibly due to mistrust of the emergency clinicians' impression of the patient.[2] In some cases emergency clinicians write admitting orders for the convenience of the admitting physician.[3]

Due to a lack of inpatient bed capacity or availability, many hospitals elect to hold admitted patients in the

ED, rather than move them to the proper inpatient setting, a procedure known as boarding. This results in ED crowding even with a normal patient volume, due to inefficient admission processes or use of inpatient beds.[4] ED crowding with increasing length of stays has been linked to increases in mortality from 2 to 8%[5], decreases in patient satisfaction, and may cost some hospitals significant lost revenue.[6] For these reasons, regulatory agencies monitor ED throughput times and EDs have developed alternative processes to facilitate the throughput of patients waiting to be admitted. One process for decreasing lengths of stay that has some scientific support is the use of "transition orders." Sometimes known as "holding orders" or "bridging orders", these orders are a truncated set of orders that facilitate the movement of the ED patient to the inpatient setting while ensuring that important aspects of care are continued until a full set of admission orders can be written by the admitting physician.

Many emergency clinicians have reservations about the use of transition orders, including concerns about medical errors, medical staff privileging issues, increased responsibility for direct patient care outside the ED and a concomitant concern regarding increased liability. There is little published about the safety and efficacy of transition orders[1, 7-9] but in at least one published abstract they do appear both safe and effective.[7] It is probably safe to say that most emergency clinicians would prefer to work in a system that functions efficiently without transition orders. However, the reality is that in many EDs, the ability to write transition orders is key to patient flow. In 2010, ACEP conducted a poll of leaders from 14 state chapters that estimated that 50% of emergency wrote orders for admitted patients.[3] Any ACEP policy on transition orders should at a minimum include the organization's position on desirability of transition orders, but also assist in defining the safest approach to the use of transition orders when they are needed.

Concepts, Principles and Definitions

Definitions

Admitting Physician - healthcare provider who has hospital admitting privileges and who assumes patient care responsibility from the emergency clinician at the time of admission.

Order to Admit - this is not the same as admission orders. This order initiates the inpatient stay for purposes of billing and may be written by the emergency clinician but needs to be supplemented with admission orders to institute full inpatient care.[10]

Admission Orders - a comprehensive set of orders individualized to the clinical condition of the patient and written or dictated by the admitting physician and signed by the admitting physician, or the admitting physician’s designee (resident, advanced practice nurse, physician assistant, etc.) with countersignature by the attending physician. [11]

Transition Orders - also known as “Holding Orders,” “Bridging Orders,” or “Interim Orders.” These orders represent a truncated set of orders for the inpatient care team, generally limited to extending care started in the ED, which allow a patient to be moved from the ED to the inpatient setting prior to admission orders being written by the admitting physician. Transition orders are skeletal by nature, and only cover basic patient maintenance, not inpatient evaluation, diagnosis, or non-essential treatment. These orders are sometimes written in the ED to begin inpatient care while the patient awaits an inpatient bed, and are generally written by physicians without hospital admitting privileges.

Acceptance of Admission - the time at which the admitting physician, either through verbal communication with the emergency clinician, or by writing admission orders, or by some other mutually agreed-upon event (for example, assignment of the patient to the admitting physician by the emergency clinician), assumes responsibility of care of the patient from the emergency clinician. The ED is an outpatient unit of the hospital and its practitioners have outpatient privileges. Since emergency clinicians do not have inpatient privileges, it is inappropriate for them to write orders for inpatient care. The admitting physician’s act of

accepting the patient for admission triggers the formal transfer of responsibility and is recognized by placing the admitting physician's name on the chart as the physician now responsible for the patient's care.

Transitions of Care

Transition of care from one provider to another increases the risk of adverse outcomes. The Joint Commission's Center For Transforming Healthcare Hand-off Communications project reported that 80 percent of serious medical errors occur due to miscommunication between medical providers during hand-offs.[12] In 2010, the ACEP Quality Improvement and Patient Safety Section reviewed the body of current, available data related to hand-offs and patient safety. In this article the authors proposed: (i) communication structures that facilitate the potential for successful hand-offs, (ii) quality measures specifically designed for transitions of care within that facility, and (iii) an evaluation of the need for unnecessary handoffs.[13] An ACEP task force published a report in 2012 outlining several strategies aimed at improving the safety of care transition in the ED.[14] In 2016, the Council of Residency Directors noted increasing rates of standardized handoffs, however, it did not specifically examine how often transition orders are a standard part of the handoff.[15]

Transition orders have the potential to be an effective tool for improving patient safety, however, the study of transitions of care is in its infancy, and very little is known specifically about transition orders. Several studies looking specifically at transition orders have found improvements in throughput, including one study finding a 90 minute decrease in admitted patient length of stay[8] and another finding that transition orders decreased length of stay for both admitted and discharged patients.[9] Given the association of ED overcrowding with increasing mortality, the resulting reduction in boarding could lead to improvements in patient safety. As noted in these publications, the importance of patient safety related to transitions of care will continue to play a key role in our health care system.

Regulatory Aspects

CMS guidelines establish an admission order process, stating that only a person with admitting privileges can "admit" a patient, but they allow for the creation of transition orders by someone who is a surrogate of the admitting physician. Emergency clinicians, unless they have admitting privileges, do not write the "order to admit," though they still may write transition orders. For this reason, transition orders do not establish admission from a billing or EMTALA standpoint.

The Joint Commission requires that care for any patient in a particular status be uniform across locations in the hospital (LD.04.03.07), an argument for patients being seen in a timely fashion by the admitting physician, since emergency clinicians have neither the training nor experience to deliver ongoing inpatient care.[16, 17] Attempting to provide an inpatient level of care in the ED puts undue stress on ED staff in terms of training, experience, availability of time to carry out orders, and appropriate equipment and supplies.[18]

Although there are few specific regulations regarding transition orders, there are several regulations addressing timeliness of care, which may be heavily impacted by boarding, which in turn is impacted by the writing of transition orders. The Joint Commission makes recommendations about boarding issues as part of the accreditation process[19] and has recognized that boarding time is related to delays in care and compromised outcomes. The Joint Commission has several standards related to flow (LD.04.03.11, EP 5-8), and has gone as far as to recommend (though not require) that boarding times not exceed four hours (EP 6).[16, 20]

The Centers for Medicaid and Medicare Services also makes flow data from the ED for standards ED 1-3 publicly available at Medicare.gov. Several other mandated reporting elements are related to timeliness of care, including the length of stay for discharged ED patients (OP-18), "Door to Doctor" time (OP-20), number of patients left without being seen (OP-22) and time to pain management in long bone fractures (OP-21). Inpatient measures that are part of CMS's Value-Based Purchasing program and can be affected

by boarding and can influence hospital reimbursement, include items such as timing of thrombolytics (AMI-7a) or primary percutaneous coronary intervention (AMI-8a).[21]

CMS's Merit-Based Incentive Payment System (MIPS) program, which influences provider payment, may be tangentially related to flow via the Component for Practice Improvement Activities (CPIA) section, where clinicians can meet the requirement through improvements in practice and process.[22]

In addition, it is well-established that patient satisfaction in the ED is strongly linked to wait times, such that departments with long boarding times resulting in higher wait times for all patients may detrimentally influence the HCAHPS surveys performed on discharged inpatients. It's generally recognized that "an overwhelming number of hospital-based measures address ED throughput and timeliness of care".[23]

Legal Aspects

From a legal and liability perspective, emergency clinicians would prefer not writing transition orders for several compelling legal reasons:

1. Writing transition orders may create ambiguity over when acceptance of the patient has occurred and who is responsible for the patient.
2. Transition orders may extend the liability of the emergency care provider beyond the ED.
3. Despite time-limit specifications in transition orders, the possibility exists for orders to be continued, resulting in orders that are duplicative or conflicting with the final admit orders written by the admitting physician.[24]

In practice, the contribution to liability for writing short-term transition orders is probably nowhere near as significant as many espouse. If the patient deteriorates or something goes wrong over the first few hours in the hospital after the admitting physician accepts the patient but before the admitting physician arrives or writes proper admitting orders, a plaintiff's attorney can always question the quality of the work-up or care provided in the ED and/or the communication of the nature and seriousness of the patient's condition to the admitting physician, regardless of whether transition orders were written or not. Nevertheless, the concern that writing admitting orders could otherwise extend the liability of the emergency clinician does exist, and there are steps emergency clinicians can take to minimize this liability. These include:

- Have hospital specific privileges for writing "transition orders," not "admitting orders," that cover the patient for an appropriate period of time to enable the admitting physician to see the patient and/or write proper admitting orders. (See the section on "Medical Staff Considerations" below).
- Document transition discussion with the admitting physician in the ED record, including the patient's clinical status, abnormal lab values or imagining findings, critical tasks or results that remain outstanding on the patient and any concerns about potential adverse events, and when the admitting physician is expected to appear and/or write admission orders.
- Note the time of acceptance by the admitting physician.
- Explicitly time limit the transition orders to no more than two (maximum of four) hours.
- Write orders only for the time period between acceptance of the admission by the admitting physician and the required appearance/ writing of admitting orders by the admitting physician.
- Do not order tests or treatments beyond the transition period.
- Hospital/medical staff policies should define an appropriate period of time for the admitting physician to see the patient and/or write official admission orders.
- Include an order to call the admitting physician for any clarification of orders or a change in the patient's medical condition, or if any issue arises.
- If pushed by the hospital to write "admitting orders," request indemnification for the potential liability in the group's contract with the hospital.

- Define clear roles and responsibilities and procedures in written medical staff and ED policies so that the administration, the medical staff, emergency clinicians, and nursing all know exactly what is expected of them during the admission process. Setting these expectations avoids confusion and thus risk.
- Make sure orders written by the emergency clinician have an appropriate title that adequately differentiates between admission and transition orders.

All this being said, on a recent ACEP survey of state chapter presidents, none of the 14 who responded were aware of any litigation resulting from emergency clinicians writing admission orders, and one respondent reported that his contract management group had 40 million patient visits over 7 years with not a single claim related to writing admission orders. It was estimated 50-60% of emergency clinicians in that state write admission orders.[3]

Medical Liability Insurance Considerations

Emergency clinicians typically do not have admitting privileges and do not provide continuing inpatient care. Consequently, an insurance carrier may consider that writing transition orders is "outside the scope of practice" for an emergency clinician and decline to defend or cover the physician for any liability that may arise out of the practice. To avoid such a determination, the group should ensure the hospital and medical staff define the practice in the medical staff bylaws and include the activity in the scope of practice for emergency clinicians. Orders should be time-limited, intended to facilitate the transition of care between the ED and inpatient services, and should reflect development of the plan of care with the admitting physician. In this way, the practice is sanctioned by the hospital and medical staff bylaws and within the "usual and customary practice of emergency clinicians" at that hospital. Nonetheless, the emergency clinician group should always confirm coverage for writing such orders with their carrier and in their insurance contract.

Medical Staff Considerations

Medical staff bylaws, hospital polices, and ED policies are critically important in determining responsibilities for patient care and to ensure patient safety. Responsibility for writing admission and/or transition orders and responsibility for on-going patient care must be clearly delineated.

1. The emergency care providers should be responsible for care of the patient only while the patient is physically present in the ED, under their care, prior to the acceptance by the admitting physician. The exception is for boarded patients with a medical emergency, during which time the emergency clinician should respond. Emergency clinicians are generally neither trained, credentialed, nor insured to provide inpatient care.
2. The admitting physician should be responsible for care of the patient after they have accepted responsibility for admission, regardless of the patient's physical location within the hospital. Once accepted, the patient is an inpatient. Hospital policy should clearly delineate this.

When an emergency clinician writes transition orders, it is understood that the admitting physician retains responsibility for providing inpatient care. Transition orders may include essential treatments and assessment parameters required before preparation of suitable admission orders, yet it must be clear to the admitting physician and hospital staff that these are, by nature, temporary orders and that they are not intended to be complete. Medical staff bylaws should define an appropriate period of time for the attending physician to both see the patient and to prepare admission orders.

Many believe privileges for emergency clinicians should explicitly NOT include admitting privileges. There is concern that having admitting privileges could increase liability and add to confusion regarding transition orders, though as previously mentioned this does not appear to be borne out in practice. A specific privilege allowing transition orders can reinforce the limited responsibility emergency clinicians have for

writing these orders and the absence of responsibility for orders outside of the scope or time frame defined for transition orders.

Operational Issues/Best Practices
At all times, whether in the ED or elsewhere in the hospital, there must be a clear procedure for staff to know which physician is responsible for a patient's care. Furthermore, the staff must have orders/procedures in place to provide care for each patient. The emergency clinicians should always be aware of the existing hospital policies, protocols and regulations concerning writing transition orders and adhere to them. The roles and responsibilities of the emergency clinicians and the admitting physician must be clearly delineated.

In some hospitals, the admitting physician writes or verbally dictates admitting orders immediately after accepting the patient from the emergency clinicians. This provides a very clear demarcation of patient responsibility and is consistent with distinctions in inpatient vs. outpatient medical staff privileges. This best practice approach works optimally when the patient is well known to the admitting physician. However, if there will be significant delays waiting for the admitting physician to write orders, the patient's care may be fragmented. Ongoing patient care should be seamless from the patient's perspective. Any indicated care pathways should continue. Patient flow may be disrupted if there are unneeded delays in moving patients out of the ED due to delays in obtaining orders for hospitalization.

Orders should be considered in three broad categories. Emergency clinicians may write orders in some or all of these categories as transition orders. Orders should be titled so it is clear that they are time limited transition orders and not admitting or complete orders.

1. Admit order. Used for billing and EMTALA purposes; according to CMS regulations a physician who has admitting privileges must authenticate an admission.[10] This order defines whether the patient is an admission (in-patient) or an observation patient (out-patient). If a physician who writes these orders does not have admitting privileges, then the admission order must be authenticated (co-signed) by the admitting physician, though this may be done retroactively.
2. Level of care (location). Required by the patient in the hospital (med-surg, tele, ICU, etc.)
3. Medical care (medications, treatments, etc.).

In those situations where the emergency clinicians provide transition orders, it is important that the policy/practice incorporate several key points:

1. Prior to considering writing transition orders, the emergency clinicians should complete an evaluation of the patient to determine the appropriate hospital service and level of care required for the patient.
2. Under most circumstances, essential diagnostic studies (LP, CXR, etc.) and treatment (initiation of antibiotics, initiation of hydration, stabilization of fractures, etc.) for life threatening or emergent conditions should be completed *prior to* the patient leaving the ED.
3. The emergency clinicians should discuss and obtain agreement from the admitting physician as to need for hospitalization, the plan of care, who will be writing orders, a verbal acceptance of transfer of responsibility, and the timeframe in which the admitting physician will evaluate the patient personally.
4. The admitting physician and emergency clinicians should understand the time period covered by any needed transition orders.
5. Preferably a standardized form, either paper or electronic, which is part of the medical record should be used by the emergency clinicians to document transition orders, and should include only those orders necessary to follow through on the admission plan for a pre-determined time period (eg, two hours)
6. The emergency clinicians should not sign standardized admission "standing orders" that are often used for ICUs, step down units or other specialized hospital units.
7. The transition orders template should have a "disclaimer" which states that these are time limited orders

(duration determined by the institution), and that the emergency clinicians should only be contacted for clarification of those orders written by the emergency clinicians, with requests for new orders to be directed to the admitting physician.

8. There must be a clear process ensuring that the admitting physician reviews and either continues, modifies or discontinues all transition orders within a specified time frame to avoid conflicts between the admission orders and the transition orders.
9. The hospital must have a clear process ensuring that all studies, consults, results, or changes in patient status are communicated to the admitting physician promptly. It is crucial that this timely information gets routed to the admitting physician as the admitting physician is responsible for ongoing patient care. Furthermore, if the emergency clinicians is the ordering physician, he/she may not be available to receive and act upon the results in a timely manner.
10. The emergency clinicians should not write any orders that extend, or appear to extend, control and responsibility for the patient beyond treatment in the ED.

Boarded Patients

If transition orders are utilized in an ED, the ED boarding of admitted patients presents additional considerations. For a variety of reasons, there may be times when transition orders are written and no inpatient beds are available. In this case, the patient may be boarded in the ED (as an inpatient) and the transition orders would be used for care. Departmental policies and procedures should be in place so that the nurse caring for the patient is aware of any existing transition orders and the circumstances under which these transition orders are to be followed. The nurse caring for the patient should contact the responsible admitting physician for further orders as needed, just as if the patient was physically located outside the ED. Even after acceptance by the admitting physician, at times it can be unclear to staff who is responsible for boarded patients. Therefore, departmental policies and procedures should be in place so that nursing staff is clear on whom to contact for routine, urgent, or emergent clinical issues or orders (generally speaking the admitting physician should be responsible, except in emergencies). Staff should update the department's tracking board, adding the name of the admitting physician to assist them in directing inquiries for ongoing patient management issues. All routine order requests should be addressed to the admitting physician, and emergency clinicians may want to avoid writing orders on patients accepted by the admitting physician. If the ED writes clinically significant orders on the patient accepted by the admitting physician, the admitting physician should be notified to avoid conflicting or duplicated orders.

Unless departmental policies are in place that specify otherwise, in the event that a boarded patient is deteriorating or experiences a critical medical need, the nurse should immediately inform the emergency clinicians (as the closest physician), who should assist as they would in any emergency. In addition, the nurse should advise the admitting physician, who is expected to come to the bedside. Once the admitting physician arrives, the emergency clinicians should clearly communicate to the admitting physician a transition of responsibility for the ongoing care of that emergent issue, when transfer is appropriate.

Conclusion

The best and most patient-centric practice is for admitting physicians to evaluate and write admitting orders in a timeframe that would make transition orders unnecessary, but it is acknowledged that in many hospitals this doesn't consistently occur.

In those situations, emergency clinicians understand that to facilitate patient flow and reduce boarding in the ED, which leads to improved patient safety and satisfaction, they must at times execute transition orders as their hospital policies allow. Writing transition orders may cause concern about the emergency clinicians, liability and introduce different patient safety issues, but the practice may be undertaken safely when appropriate guidelines/policies/procedures are in place. The emergency clinicians should only be engaged in writing transition orders until such time as the best practice of timely admission orders by admitting physicians can be enacted.

Revised and updated by the members of a subcommittee of the ACEP Emergency Medicine Practice Committee
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