

Transition Orders in the Emergency Department

Question

What factors should be considered when developing policies and procedures for transition orders in an emergency department (ED)?

Answer

Differentiating between the terms “transition order” (also sometimes referred to as a “bridge order”), “order to admit,” and “admission order” is essential to answering this question because these terms can cause confusion among clinicians and healthcare staff.

An order to admit is a dated and timed order from a licensed independent practitioner (LIP), such as a physician or surgeon, who has appropriate privileges. The order to admit notifies hospital registration, health information management, and case management of the admission and the desired location of a patient within the hospital.

An order to admit requires four elements: (1) the admitting LIP’s name and service, (2) the patient’s diagnosis, (3) the location in the hospital where the patient should be taken, and (4) the patient’s clinical status. However, an order to admit does not constitute an admission order.

An admission order is a set of orders individualized to the clinical condition of the patient. An LIP who has admission privileges writes this type of order in a timely manner following the order to admit. Each hospital must define an acceptable timeframe for LIPs to provide admission orders (usually based on the patient’s acuity level or clinical condition and the requested location for the patient within the hospital). Hospitals should monitor compliance with these rules and policies.

A transition order — or bridge order — falls somewhere in between an order to admit and an admission order. A transition order is (or should be) a time-limited order that facilitates the transfer of care between the ED and inpatient setting. The purpose of a transition order is to provide continuation

of essential measures started in the ED, as well as measures immediately necessary for the acute care of the patient.

Transition orders are considered a “handoff” communication — that is, they are a real-time, interactive process of passing patient-specific information from one caregiver or team to another to ensure the continuity and safety of the patient’s care. However, transition orders do not replace admission orders.

Before implementing transition order protocols, many factors must be considered. For example, do ED physicians have privileges to admit patients to inpatient units or observation status, and who ultimately is responsible for the patient when transition orders are executed?

Consider also whether using transition orders will delay attending physician response times or increase the amount of time a patient waits to be transferred to an inpatient unit. Above all, consider whether transition orders are in the best interests of the patients and staff. Will transition orders expose ED practitioners to unnecessary additional risk or place ED physicians at odds with guidance or policies from their professional organizations?

For example, the American College of Emergency Physicians (ACEP) believes that the best patient care occurs when no ambiguity exists about who is responsible for the patient. Admission orders help eliminate ambiguity by establishing which physician is in charge of a patient’s care. Further, because ED physicians generally are not credentialed to provide continuing inpatient care, admission orders are essential for transitioning care. Therefore, ACEP endorses the following principles:

- The best practice for patients admitted through the ED is to have the admitting physician (or designee) evaluate and write admitting orders at the time of admission or as soon as possible thereafter.
- The admitting physician (or designee) is responsible for ongoing care of the patient after accepting responsibility for the patient’s care whether verbally, by policy, or by writing admission orders, regardless of the patient’s physical location within the hospital.
- When it is necessary for an emergency clinician to write orders that appear to extend control and responsibility for the patient beyond treatment in the ED to the inpatient setting, it is understood that the admitting physician is responsible for providing inpatient care, and that by writing transition orders, the emergency clinician will not be assuming that responsibility.

- Hospital and ED policies should clearly delineate responsibility for writing admission orders. These policies and procedures also should set standards of timeliness for patient assessment and admission orders.¹

From a risk management perspective, consider these points:

- The best patient care occurs when admitting physicians take immediate or early responsibility for patient care. Therefore, having the admitting physician write the admission order at the same time the order to admit is written provides the highest quality and safest care, minimizes liability exposure for the emergency physician, and aligns with ACEP's principles for writing admission and transition orders.²
- When the previous scenario is not possible, or when an attending physician asks an ED physician to write admission orders — if the ED physician is permitted to do so in accordance with the hospital's bylaws — transition orders might be a reasonable alternative to a lapse in care. Transition orders can bridge the gap in care until the attending physician takes over (between the order to admit and the actual admission order).
- If transition orders are used, they should be time-limited, and close communication between the attending physician and ED physician should be maintained.

Guidelines for Implementing a Transition Order Policy

- Medical staff must understand that a balance should exist between ED transition orders and admission orders that optimizes and individualizes comprehensive/complete care.
- Hospital and ED policies should clearly delineate responsibilities for writing admission orders.
- For every transition order written, a corollary must exist — that is, admitting physicians need to execute their admission orders promptly.
- To optimize the transition strategy, hospital policies and procedures and medical staff rules and regulations should set standards of timeliness for patient assessment and admission orders.
- The admitting physician of record, who has appropriate privileges to coordinate the care, treatment, and services for the patient, has the ultimate responsibility for the patient's care during the hospital stay.

- At all times, both hospital staff and the patient should clearly understand that an attending physician is responsible for the patient's care once an order to admit is written.
- The admitting physician is responsible for the history and physical, medication reconciliation, and other coordination-of-care services for the admitted patient.
- The medical staff should develop and monitor the utilization and frequency of transition orders.
- The hospital's handoff policy and credentialing and privileging standards should include the appropriate privileging of the ED physician's order writing based on the transition order definition.
- Patient perception of who is responsible for clinical decision-making is an important consideration in policy development. If appropriate, patients should be advised of the name of the physicians and services overseeing their care.

Resources

- [American College of Emergency Physicians: Policy Resource and Education Paper: Writing Admission and Transition Orders](#)
- [American College of Emergency Physicians: Policy Statement: Writing Admission and Transition Orders](#)

Endnotes

¹ American College of Emergency Physicians. (2017). *Writing admission and transition orders*. Retrieved from <https://www.acep.org/patient-care/policy-statements/writing-admission-and-transition-orders/>

² Ibid.

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