

Kings County Hospital Admitting Guidelines – July 25, 2019

The following guidelines specify which inpatient service will be primarily responsible for the admission of patients according to diagnosis. The list of diagnoses is not a complete one, and the guidelines are intended to be used flexibly. Patients should be admitted to the most appropriate service based upon the primary presenting problem/diagnosis.

In all cases, the Emergency Department (ED) physician is expected to conduct an evaluation sufficient to ascertain the need for admission, determine the appropriate admitting service, and identify significant medical comorbidities if they are present. The ED physician has discretion to interpret the guidelines in a way that best serves the patient. Discussions about the appropriate service should never take place in front of the patient, and decisions should be made collaboratively, professionally, and in a patient-centered manner.

Disagreement / Escalation

In the case when a service disagrees with an ED Attending's plan to admit the patient to its service, the chief resident of the service in question may briefly and professionally discuss the case with the ED attending. If a disagreement as to the appropriate service persists, the Attending on the receiving service may call the ED Attending directly to discuss the decision. The ED Attending will allow 30 minutes for discussion to take place. If an attending is not available for discussion within this timeframe, the ultimate decision on admission and admitting service will remain the decision of the ED Attending. If the Attending on the receiving service believes that a patient would be better served on a different service but does not fit within the criteria outlined in this document, the Attending on that service may contact the responsible Attending of the other service to discuss placement - **the disposition must be agreed upon within 30 minutes.**

Preoperative Clearance

Patients requiring surgery should receive preoperative and postoperative evaluation and care on the service that will perform the surgery. Medical preoperative evaluation can be performed following admission to a surgical service and is not a requirement in advance of admission to a surgical service.

Postoperative Issues

All patients requiring admission within 30 days of surgery for postoperative pain or failure of outpatient management will be readmitted to the surgical service that performed the procedure.

Patients with fever within 7 days of surgery will also be readmitted to the surgical service (or SICU, if requiring higher level of care) that performed the procedure.

Patients with post-operative wound infections or other directly related complications from procedures at an outside institution who require hospitalization will be admitted to the corresponding surgical service (or SICU, if requiring higher level of care).

Interventional Radiologic Procedures

Patients being admitted for a procedure by Interventional Radiology should be admitted to the service most appropriate as determined by these admitting guidelines.

Medical Comorbidities

There are comorbidities that when present, the patient will be admitted to medicine, regardless of primary admitting diagnosis. If an admitting service feels that a patient would be better served on a medical service but does not fit within the criteria outlined below, the Attending provider on that service may contact the Medicine Attending on call to discuss placement.

A patient with a medical condition who needs to be admitted primarily because of inability to function or comply with care in the outpatient setting should be admitted to the service associated with the primary diagnosis. The ED Attending will have discretion to decide whether these or other medical comorbidities outweigh the primary diagnosis in determining the appropriate service. This list covers the most common significant comorbidities but is not meant to be exhaustive.

- Respiratory failure secondary to uncompensated CHF (patients who require ICU level care and those requiring supplemental oxygen therapy or ventilator support)
- Respiratory failure secondary to acute exacerbation of COPD or asthma (patients who require ICU level care and those requiring BiPAP/CPAP, continuous nebulizer treatment, or intubation)
- Probable or definite Acute Coronary Syndrome
- Any arrhythmia requiring telemetry admission
- Seizure secondary to metabolic derangement (e.g., hyponatremia or hypercalcemia)
- Any patient with severe electrolyte imbalance
- Seizure secondary to alcohol withdrawal or other manifestations of moderate to severe alcohol withdrawal (Patients at risk for alcohol withdrawal, or those in withdrawal managed with benzodiazepines in the ED will be admitted to the medicine service.)
- Non-obstructive acute renal failure requiring hemodialysis

Admissions to Critical Care Units

Patients will be admitted after a discussion with appropriate critical care consult and acceptance by the unit. This includes MICU, CCU, SICU and Neuro ICU

Admissions to the General Surgery Service

Patients with the following diagnoses will be admitted to General Surgery regardless of whether or not they are operative (including patients who require GI procedures):

- Appendicitis (suspected or definite)
- Acute Biliary Tract disease (including cholecystitis, choledocholithiasis, ascending cholangitis, acalculous cholecystitis)
- Anatomic Small or Large Bowel Obstruction (partial or complete)
- Pancreatitis with hemorrhage, necrosis, or biliary tract disease as above
- Complicated Abscess requiring drainage in the OR
- Necrotizing Fasciitis/or suspected requiring surgical debridement
- Complicated Diverticulitis (perforation, fistula, abscess, obstruction)
- Any GI Bleed with unstable vital signs not responding to initial resuscitation in the ED
- Acute abdomen (rebound and guarding) as confirmed by ED attending and/or surgery attending (surgery attending's assessment takes precedence in case of discrepancy in the exam)

Patients with the following diagnoses will be admitted to Medicine:

- Uncomplicated Diverticulitis
- Uncomplicated Pancreatitis (not secondary to biliary tract disease, i.e. gallstones)
- Inflammatory Bowel Disease
- Colitis
- Functional Small Bowel Obstruction
- Functional Large Bowel Obstruction (after surgical consult)

Admissions to the Neurology Service

Patients with the following diagnoses will be admitted to Neurology:

- Non-hemorrhagic stroke (thrombotic, embolic, lacunar, etc).
- Transient ischemic attack

- Seizures not clearly related to alcohol or substance abuse or other primary medical problems including status epilepticus patients stabilized in ICU
- Primary neurological disorders (e.g., myasthenia gravis, Guillain-Barre) that do not require ICU observation

Patients with the following diagnoses will be admitted to Medicine:

- Meningitis, encephalitis, and non-operable spinal column infections
- Syncope
- Seizures related to alcohol or substance abuse or other primary medical problems
- Primary brain abscesses
- Primary and metastatic brain tumors not requiring neurosurgical intervention
- If neurology service is full, Neurology attending will discuss with Med senior attending for medicine admission

Admissions to the Neurosurgery Service

Patients with the following diagnoses will be admitted to Neurosurgery:

- Patients with isolated head injury requiring a craniotomy
- Patients with isolated head injury and a GCS of 8 or less with concordant anatomic injury on neuroimaging
- Patients with isolated gunshot wound to the head and a GCS of 8 or less
- Any primary spinal condition that requires emergent neurosurgical spinal surgery (e.g. spinal stenosis, herniated disc, etc.). Patients requiring spinal surgery for secondary reasons (e.g. cord compression from metastatic disease, epidural abscess, etc.) should be admitted to the most appropriate service based upon the secondary problem/diagnosis.
- Intracranial mass that requires operative management
- Non-traumatic ICH requiring emergent craniotomy will be admitted to SICU (under neurosurgery)

Patients with the following diagnoses will be admitted to Neurology:

- Non-traumatic hemorrhage (brainstem, thalamus, basal ganglia, subarachnoid, and parenchymal) determined by Neurosurgery Attending to not require a craniotomy (under neurology service)
- Non-traumatic hemorrhage complicated by warfarin or other anticoagulants or antiplatelet agents
- Non-operative primary Intracranial mass

Patients with the following diagnoses will be admitted to Trauma:

- All patients with multi-trauma (even if craniotomy is necessary)
- Patients with isolated head injury with GCS of 9 or higher
- Patient's with trans-facial gunshot wounds regardless of GCS
- Patients with hypotension, hypoxia or hemodynamic instability non-attributable to an isolated head injury
- Patients with extremely poor prognosis that do not require a neurosurgical intervention or are near brain death

Admissions to the Orthopedics Service

Patients with the following will be admitted to the orthopedic service:

- Mild, controlled chronic systemic diseases with acute musculoskeletal problems requiring admission
- Intractable pain due to acute orthopedic injury (see section "Intractable Pain")
- Inability to follow-up for outpatient management of a primary orthopedic problem

Patients with the following should be admitted to the medicine service:

- ESRD, Decompensated Congestive Heart Failure, exacerbation of Chronic Obstructive Pulmonary Disease
- Significant medical comorbidities (see section "Medical Comorbidities")

Geriatric trauma patients (age ≥ 65) with:

- Fractures and other significant concomitant injuries related to trauma will be admitted to the trauma service.
- Isolated fractures and mechanism of injury greater than ground-level fall must be cleared by trauma service for admission to orthopedics or medicine.
- Isolated femur/subtrochanteric Fx (excluding hip/femoral neck Fx) will be admitted to trauma service.
- *All pelvic fractures will be admitted to the **trauma service**.*

Admission of Patients with Traumatic injuries

Once the patient has been initially stabilized, undergone a primary and secondary survey, and completed all imaging studies, the guidelines delineated below will determine the admitting service.

Isolated Trauma

Patients sustaining isolated (orthopedic, facial trauma or other specialty) trauma (requiring an operative intervention or not) will be admitted to the respective service for management. A Tertiary Survey must be completed by the Trauma service within 24 hours after admission.

For patients with isolated traumatic brain injury:

- Neurosurgery will admit all patients undergoing craniotomy and those requiring ICP monitoring except for multi-system trauma.
- Trauma will admit those patients not meeting the above criteria who require admission

Single system injury requiring multiple services will be admitted to the most appropriate service based upon the primary presenting injury/diagnosis.

Multiple System Trauma

Patients sustaining significant trauma to more than one system - one of which involves the pelvis, torso, head, neck, or a major vascular injury - will be admitted to the Trauma service for initial management.

Upon stabilization from the Trauma perspective, a patient may be transferred to another service at the discretion of the Trauma / Trauma Surgical Intensive Care Unit Attending after discussion with all involved services.

Patients with isolated rib fractures who require admission will be admitted to Trauma.

Admissions to the Urology Service

Patients with the following diagnoses will be admitted to the GU service:

- Pyelonephritis (UTI + fever) with urinary obstruction (e.g. ureteral stone, retained GU stent, regardless of planned intervention approach (e.g. percutaneous, endoscopic)

- Urinary retention requiring admission
- Severe hematuria requiring admission (e.g. patients requiring continuous bladder irrigation)
- Ureterolithiasis with intractable pain or vomiting
- Testicular mass
- Refractory Priapism
- Procedure-associated infection or complication within 30-days post-op after GU procedure

Patients with a dislodged GU device requiring replacement by IR (e.g. percutaneous nephrostomy tube replacement) will be placed in observation or admitted to medicine (if admission is required)

Patients with UTI or pyelonephritis without obstruction or ureteral stone will be admitted to the Medicine service (if pregnant female, see OB/GYN section), including patients with infected indwelling tubes or long-standing diverting urostomy other than ureteral stent (ie suprapubic tube, nephrostomy tube, urinary diversion such as neobladder/ileal conduit).

Patients with renal or perinephric abscess, epididymitis/orchitis with fever or intractable pain will go to Medicine Services.

Admissions to the Vascular Surgery Service

Patients with the following diagnoses will be admitted to the Vascular Surgery service:

- Infected diabetic or vascular ulcer requiring debridement in the OR (or wet gangrene) of the lower extremity
- Peripheral arterial disease, injury, thrombosis, or obstruction from any cause
- Threatened limb or acute limb ischemia secondary to DVT or arterial ischemia.
- Planned elective vascular surgery (including patients needing vascular access procedures, carotid endarterectomy, ESRD on dialysis, and patients who need warfarin reversal)

Patients with the following diagnoses will not be admitted to the Vascular service:

- Dry gangrene
- Proven DVT and other venous disease (will be admitted to Medicine)
- Stroke (will be admitted to Neurology)
- Cardiovascular disease (will be admitted to Medicine)
- Aortic Dissection Stanford classification A will be transferred for higher level of care
- Aortic Dissection Stanford classification B (will be admitted to MICU)

Admissions to the Cardiothoracic Surgery Service:

- Spontaneous Pneumothorax requiring Chest Tube or Pigtail Placement

Admissions to the Obstetrics/Gynecology Service

Patients with the following diagnoses will be admitted to the Ob/Gyn service:

- Active vaginal bleeding with symptomatic anemia
- Chronic vaginal bleeding without active bleed but with symptomatic anemia (will be placed on observation)
- Pyelonephritis or UTI in pregnant patients ≥ 20 wks EGA failing outpatient antibiotics and not requiring ICU level care
- Pyelonephritis or UTI in pregnant patients < 20 wks EGA failing outpatient antibiotics and not requiring ICU level care will be admitted to Medicine.
- Intractable pain due to a confirmed gynecologic pathology will be admitted to Gyn
- Diagnoses requiring ICU level care will be admitted to appropriate critical care unit after Ob/Gyn service's discussion with the critical care consult and acceptance

Intractable Pain

- Criteria for admission: Pain refractory to two doses of parenteral opioid and one dose PO opioid
- Patients with intractable pain due to a known condition will be admitted to the service primarily responsible for management of the specific condition.

Mental Status Change

- Any acute change in mental status must be worked up for a diagnosis in the medical ED for an appropriate disposition.
- A patient with the diagnosis of Dementia should not be admitted to Psychiatry service.

Cellulitis/Wound Infections

If concern for necrotizing soft tissue infection, STAT general surgery consultation should be obtained prior to admission via the guideline set forth below.

Post-operative wound infections will be admitted to the surgical service (or SICU if necessary) that performed the procedure.

Patients with post-operative wound infections resulting from procedures at other institutions will be admitted to the corresponding surgical service (or SICU if necessary).

Cellulitis/Abscess:

- Cellulitis of Upper Extremities – Medicine

- Cellulitis of Hand - Orthopedics
- Cellulitis of Trunk – Medicine
- Abscess or fluid collection even if drained prior to admission – General Surgery
- Cellulitis with underlying bony hardware - Orthopedics
- Cellulitis of Face/Neck – OMFS or ENT as in “Disorders of the Head and Neck” (below)

Decubitus or other ulcers:

If signs of systemic infection, sepsis requiring intra-operative care - General Surgery

Osteomyelitis:

- With underlying hardware in pelvis or extremities – Orthopedics
- With underlying hardware in spine – Orthopedics
- If primarily ankle/foot – Medicine
- If primarily upper extremity excluding hand – Medicine
- If hand is involved – Orthopedics

Septic Arthritis

- Native joint - Medicine (definite or suspected)
- Prosthetic joint - Orthopedics (definite or suspected)

Disorders of the Head and Neck:

Facial Fractures:

- Isolated orbital fracture - Ophthalmology
- Other facial fractures - OMFS or ENT (as per current rotation agreement)

Facial Cellulitis/Abscess (excluding Orbital Cellulitis):

- Dental source - OMFS
- Other source - ENT

Orbital Cellulitis - Ophthalmology

Peritonsillar/Retropharyngeal Abscess - ENT

Ludwig's Angina - ENT (or SICU under ENT service)

Mastoiditis - ENT

Odontogenic Abscess - OMFS

Parotitis/Sinusitis/Sialadenitis - Medicine

Note: if infection source/involvement is unclear, ED attending will use his/her discretion as to most appropriate service. A patient with a diagnosis who needs to be admitted primarily because of inability to function or comply with care in the outpatient setting should be admitted to the service associated with the primary diagnosis.

Evaluation of Inpatient Behavioral Health patients for Acute Medical/Surgical Consultation

- **Medical Service**

Goal is to have direct admissions from Inpatient BH to Medicine Service, avoiding transfer to ED.

If patient is not critically ill, BH Medical Internist/NP will contact Medical Senior attending (or if no response, the Observation attending) during 8 AM -5 PM weekdays or Nocturnist (if after- hours/weekends/holidays) via Amion (www.amion.com, Login=Kings) to discuss case and reason for transfer. Medical Senior will then be contacted via Amion to assign Medicine treatment team.

BH internist/NP will complete and then fax “Referral For Admission” request to Bed Czar in admitting (fax# 718-613-8019), who will give patient next available bed, or approximate how long wait may be. If there is no foreseeable bed in next 4 hours, and/or treatment cannot be initiated on BH Inpatient Service or patient’s condition worsens, patient will be transferred to care of Medical Senior in Medical ED until bed is available. (Bed Manager contact #- 646-533-4052, if any problems).

- **Emergency Department**

If patient on Inpatient BH service becomes acutely critically ill, defined as but not limited to GI bleed, chest pain, sepsis with shock, CVA, severe facial trauma, traumatic brain injury, cardiac arrest, pulmonary embolism, open long bone fractures, unstable vitals, an SBAR will be given to CCT attending (x4601) and patient will be transferred directly to CCT via ambulance triage. ED will assume care of patient and determine disposition (admit to medicine, surgery, or return to BH).

- **Orthopedics**

As most injuries requiring orthopedic evaluation do not require an immediate surgical intervention, patients with suspected fractures will be sent to Radiology for imaging studies, in coordination with orthopedic consultant. After x-ray, Orthopedics will evaluate patient in the Radiology Waiting Area. If Orthopedics cannot do it at that time in the Radiology Suite, most interventions (splinting, casting) can wait until the next clinic day. Orthopedics will put in consult recommendations to be followed in the EMR until patient is seen in clinic. Patients will not be seen in the ED.

If orthopedic consult cannot coordinate and see patient in ED Radiology Waiting Area, they will come to evaluate patient on BH inpatient unit, to manage basic care such as splint, ace bandage, compressive dressing, etc., with assistance of unit staff.

- **Surgery**

If an acute surgical process is suspected, BH internist/NP will order appropriate CT/ X-ray, labs after consultation with General Surgery consultant. The consultant will come to see patient on the BH unit after tests are resulted and determine recommendations and disposition. If patient is critically ill, process will follow Emergency Department pathway (above). If there is delay in consultation or concern, the 24/7 Trauma/Acute Care Surgical Attending can be reached at (646)-456-8223.

For minor laceration repairs (without major trauma and not requiring x-ray clearance), I&D, etc., consult will come to unit and utilize supplies in BH treatment room, with the assistance of BH staff, to address consult.

Admissions to the Pediatrics Service

All patients under the age of 21 can be admitted to the pediatrics inpatient service. Patients in police custody, incarcerated or those that are likely to pose danger to other pediatric patients will be admitted to adult med-surg units under pediatric medicine service.

The list below may not include all potential cases, but are examples of cases and where and which service the patient is to be admitted to.

Admission to the Pediatric Service ON the Pediatric Unit

Status Asthmaticus

- Pediatric Asthma Severity Score 1-3 after ED interventions
- Able to be spaced to Q2 hour nebs
- BRUE > 4 weeks
 - If a telemetry bed is unavailable on the floor, patient will be admitted to PICU under the floor service.
- Well appearing neonates with fever
- Pericarditis with small or no effusion
- Children who are victims of physical or sexual assault
- Pregnant patients with medical reasons for hospitalization < 20 weeks gestation e.g. hyperemesis gravidarum/UTI or other non- obstetrical emergencies.
- Testicular torsion (post-operative) (With Urology service back-up)
- Intussusception after successful reduction
- Patients who require frequent monitoring but not critical care can be placed on pediatric telemetry beds. If not available then admit to PICU under ped medicine.
- Tracheostomies- can be admitted to pediatric telemetry bed and if not available then PICU
- Bone fractures
- Patients with recent seizures requiring observation
- Sick cell disease (Fever, Vaso-occlusive crisis, acute chest syndrome) clinically stable
- Patients with PEG tubes

- Pregnant pts > 20 wks gestation w medical reasons for hospitalization should be admitted under OB service, but may be admitted under ped medicine- their disposition should be discussed among ED, OB and Peds.

Admissions to Pediatric Service ON Adult Med/Surg Unit

- Patients in police custody, incarcerated or those that are likely to pose danger to other pediatric patients.

Admission to Ob/Gyn ON the Pediatric Unit (with close Ob/Gyn follow up)

- Threatened abortion/spontaneous abortion
- Pregnant pts > 20 wks gestation w pregnancy related complications

Admission to Pediatric Surgery ON Pediatric Unit

- Intussusception with unsuccessful reduction
- Appendicitis
- Other surgical conditions requiring surgical interventions
- Pediatric trauma cases that are not admitted to adult trauma

Admission to General Trauma Surgery on Pediatric Unit

- Cases that are not admitted to pediatric surgery, but are 15-18 years old can be placed on the pediatric unit.

Admissions to Pediatric Intensive Care Unit (PICU) :

1. Respiratory System: Patients with severe or potentially life-threatening pulmonary or airway disease. Exclusions include but are not limited to patients requiring ECMO. Conditions include, but are not limited to:

- Endotracheal intubation or potential emergent need for endotracheal intubation and mechanical ventilation, regardless of etiology
- Rapidly progressive pulmonary, lower or upper airway, disease of high severity with risk of progression to respiratory failure and/or total obstruction
- High supplemental oxygen requirement (FIO₂ 0.5), need for HFNC or noninvasive mechanical ventilation regardless of etiology
- Tracheostomy with or without the need for mechanical ventilation
- Acute barotrauma compromising the upper or lower airway
- Requirement for more frequent or continuous inhaled or nebulized medications that cannot be administered safely on the general pediatric patient care unit (according to institution guidelines).

2. Cardiovascular System: Patients with severe, life-threatening, or unstable cardiovascular disease. Exclusions include but are not limited to patients that require ECMO, external pacing, et cetera. Conditions include, but are not limited to:

- o Shock
- b. Post cardiopulmonary resuscitation
- c. Life-threatening dysrhythmias
- d. Unstable congestive heart failure, with or without need for mechanical ventilation
- e. Congenital heart disease with unstable cardio-respiratory status
- f. After intrathoracic procedures
- g. Need for monitoring of arterial, central venous, or pulmonary artery pressures

3. **Neurologic:** Patients with actual or potential life-threatening or unstable neurologic disease. Conditions include, but are not limited to:

- Status epilepticus
- Acutely and severely altered sensorium where neurologic deterioration or depression is likely or unpredictable, or coma with the potential for airway compromise
- Acute inflammation or infections of the spinal cord, meninges, or brain with neurologic depression, metabolic and hormonal abnormalities, and respiratory or hemodynamic compromise or the possibility of increased intracranial pressure
- Progressive neuromuscular dysfunction with or without altered sensorium requiring cardiovascular monitoring and/or respiratory support
- Spinal cord compression or impending compression
- Stroke

4. **Hematology/Oncology:** Patients with life-threatening or unstable hematologic or oncologic disease or active life-threatening bleeding. Conditions include, but are not limited to:

- Exchange transfusions
- Plasmapheresis or leukapheresis with unstable clinical condition
- Severe coagulopathy
- Severe anemia resulting in hemodynamic and/or respiratory compromise;
- Severe complications of sickle cell crisis, such as neurologic changes, acute chest syndrome, or aplastic anemia with hemodynamic instability

5. **Endocrine/Metabolic:** Patients with life-threatening or unstable endocrine or metabolic disease. Conditions include, but are not limited to:

- Severe diabetic ketoacidosis requiring continuous insulin infusion

- Other severe electrolyte abnormalities, such as:
 - Hyperkalemia, requiring cardiac monitoring and acute therapeutic intervention
 - Severe hypo- or hypernatremia
 - Severe Hypo- or hypercalcemia
 - Severe metabolic acidosis requiring bicarbonate infusion, intensive monitoring, or complex intervention
 - Complex intervention required to maintain fluid balance
- Inborn errors of metabolism with acute deterioration requiring respiratory support, acute dialysis, hemoperfusion, management of intracranial hypertension or inotropic support.
- CVVH

5. **Gastrointestinal:** Patients with life-threatening or unstable gastrointestinal disease. Conditions include, but are not limited to:

- a. Severe acute gastrointestinal bleeding leading to hemodynamic or respiratory instability
- b. After emergency endoscopy for removal of foreign bodies
- c. Acute hepatic failure leading to coma, hemodynamic, or respiratory instability

6. **Surgical:** Postoperative patients requiring frequent monitoring and potentially requiring intensive intervention. Conditions include, but are not limited to:

- a. Cardiovascular surgery
- b. Thoracic surgery
- c. Otolaryngology surgery
- d. Craniofacial surgery
- e. Orthopedic surgery
- f. General surgery with hemodynamic or respiratory instability
- g. Multiple trauma with or without cardiovascular instability
- h. Major blood loss, either during surgery or during the postoperative period.
- i. Initial management of Traumatic femur fractures

7. **Renal System** Patients with life-threatening or unstable renal disease. Conditions include, but are not limited to:

- a. Renal failure

- b. Acute rhabdomyolysis with renal insufficiency
- c. Patients requiring CVVH

8. Multisystem and Other Patients with life-threatening or unstable multisystem disease. Conditions include, but are not limited to:

- a. Toxic ingestions and drug overdose with potential acute decompensation of major organ systems
- b. Multiple organ dysfunction syndrome
- c. Suspected or documented malignant hyperthermia
- d. Electrical or other household or environmental (eg, lightning) injuries;

This document provides general guidelines. To provide patient-safe-care, the Pediatric Intensive Care Attending can deny admission of an individual patient based on availability of real-time resources at the institution.

Patients **excluded** from the above general statements include but are not limited to patients who are:

- Incarcerated minors and patients that have sustained injuries because of gang related activities
 - Incarcerated minors will be admitted to the medical ICU or the surgical ICU
 - The patients' medical care can be directed by the pediatric intensivists and pediatric residents
 - Incarcerated minors can be admitted to the PICU when the medical ICU or the surgical ICU does not have available beds provided the following:
 - NYPD stays inside the room with the patient at all times
 - KC hospital police is housed outside D6N while the patient is in the PICU
 - Patient is transferred to the medical ICU or surgical ICU when a bed becomes available
 - When the incarcerated minor does not require ICU-level services, the patient is to be transferred to a bed on the general medicine floor under the care of the Pediatric Medicine. If no beds are available on the general medicine ward, the patient may be admitted to the general in-patient pediatric ward with the same stipulations in i and ii.
- Pregnant patients

Placement (admission) to Pediatric Observation Status on Pediatric Unit (as of 7/23 this is on hold and not applicable)

- Status asthmaticus
- Bronchiolitis
- Pneumonia
- Dehydration secondary to AGE or non-specific viral syndrome
- Skin and soft tissue infections
- Brief Resolved Unexplained Events (BRUE) or at risk of severe sepsis
- Croup