Management of Patients in the Medical Assessment Unit (Cardiac)

Standard

The Cardiac Medical Assessment Unit consists of 4 dedicated beds in D3N.

The Cardiac Medical Assessment Unit is for patients requiring admission under a Cardiologist for rapid assessment and short-term (< 48 hours) management.

Only patients meeting the criteria can be admitted to the Cardiac Medical Assessment Unit.

The Care Co-ordinator (Cardiac) using the principles of case management is responsible for facilitating the coordination and review of patient care needs, including associated reporting processes related to the MAU.

A case management plan should be commenced in the Emergency Department (ED) and finalised post arrival in the Unit

Only registered nurses permanently employed within Cardiac Services may be allocated to the Cardiac Medical Assessment Unit.

Episodes of chest pain should be managed as per 7.1 Management of Chest Pain.

A medical review is undertaken within the unit at 0900 hours and 1430 hours each day (7 days a week).

During business hours (Monday to Friday, 0830 to 1700) the registrar responsible for patients in the Cardiac Medical Assessment Unit is the Cardiology (D3N) registrar allocated to the patient’s admitting consultant.

After hours, the registrar responsible for patients in the Cardiac Medical Assessment Unit is the Cardiology Fellow on-call, however the medical registrar may be contacted to review patients where appropriate.

The Cardiology Fellow should be notified of any unstable patients, preferably by the medical registrar. If there is ongoing clinical concern regarding the patient, or the Cardiology Fellow cannot be contacted, the admitting consultant should be notified.

A stress testing service is available seven days per week between the hours of 0900 – 1700.

A computerised discharge summary is completed for each patient prior to discharge home.

The Cardiology Fellow on-call after hours must **always** be notified of:

- Significant ECG or rhythm changes
- Prolonged unrelieved chest pain
- Raised troponin
- Deterioration or worsening symptoms
- Any other signs of haemodynamic instability

**N.B. Refer to Chest Pain management Guidelines for explanation of the above points.**
Cross References
Cardiac Services Clinical Practice Guidelines:
2.1 Cardiac Monitoring
7.1 Management of Chest Pain

Rationale
Patients with cardiac symptoms make up a significant proportion of presentations to the Emergency Department. A proportion of these patients require only short-term assessment and management within a hospital setting. The Cardiac Medical Assessment Unit facilitates timely access to effective and appropriate care while reducing demands on the Emergency Department.

Expected Outcome
Patients presenting for emergency investigation and/or management of cardiac conditions will receive optimal care, and patient flow in the Emergency Department will be enhanced.

Key Performance Indicators
MAU KPI's:
- Length of stay (LOS) in MAU
- % of patients transferred out of MAU within 48 hours (target 100%)
- % of patients discharged to home from MAU
- % of patients discharged to home from MAU <48 hours
- % of patients transferred to inpatient wards
- LOS in wards for MAU target medical patients
- LOS in wards for MAU target medical patients aged 75 and over
- Readmission rate within 28 days of MAU discharge
- % of admitted MAU target medical patients with ED LOS <6 hours (target 98%)
- % ED patients with an ED LOS <6 hours

Cardiac KPI's:
- % reduction of cardiac access block in ED
- % patients who require and have a stress test within 24 hours of admission to MAU

Clinical Guidelines & Procedures
1. Admission to the Cardiac Medical Assessment Unit
Patients may be admitted to the MAU directly from the Heartlink service, or the Emergency Department following acceptance by the Cardiologist or Cardiology Fellow on-call.

Admission Criteria (refer to Appendix 1 and 2)
Patients suitable for transfer to Cardiac Medical Assessment Unit must meet the following criteria:
1. Suitable for likely discharge within 48 hours.
2. Inclusion/exclusion criteria must be satisfied prior to admission via the MAU screening tool (appendix 2).

3. Transfer agreed by Cardiologist or Cardiology Fellow. Overnight (2200 to 0800) this responsibility is delegated to the medical registrar in consultation with Cardiology on call Fellow/Consultant if required.

The Cardiac Medical Assessment Unit will accept the following patients and others at the discretion of the Care Co-ordinator, Cardiologist or Cardiology Fellow on-call:

- Chest pain with **no high-risk features** (refer to Appendix 1), before the first troponin result is known, it is preferable that the patient is able to undertake a treadmill exercise stress test (EST).
- Acute Coronary Syndrome over 75 years of age with a known history of cardiac disease
- Atrial fibrillation requiring management
- Syncope requiring short-term cardiac monitoring or other patients requiring specific short-term cardiac monitoring
- Patients managed by the Heartlink team requiring short-term symptom management. This may include decompensated heart failure; symptomatic atrial fibrillation and deterioration in pre-existing cardiovascular conditions (i.e. IHD, HT). Direct admission to the unit under the appropriate Cardiologist will be negotiated by the Heartlink Nurse Practitioner with the Care Co-ordinator.

**Exclusions**

1. Chest pain with any **high risk** features (refer to Appendix 1).
2. Clear evidence of a non-cardiac cause of chest pain.
3. Patients identified under the MAU exclusion criteria (appendix 3).

**Initial Assessment**

All patients presenting to the Emergency Department with chest pain, atrial fibrillation or other cardiac conditions requiring short-term cardiac management will be assessed for suitability for transfer to the Cardiac Medical Assessment Unit.

With the exception of those referred by Heartlink or Triage, patients will initially be assessed in the Emergency Department by the Emergency Department registrar. The initial assessment will include:

- History
- Physical examination
- 12 lead ECG
- Troponin I, UEC, LFTs, blood glucose, FBC and coagulation
- Chest X-ray

Patients with chest pain identified as high risk **at any stage** should be admitted to an inpatient Cardiac Services bed following consultation with the Cardiologist on-call or Cardiology Fellow on-call. Where high risk features are not immediately apparent, risk stratification will be undertaken once the first troponin result is known. Patients may be transferred to the Cardiac Medical Assessment Unit prior to the first troponin result being known.
Initial Management

Aspirin should be considered for all patients presenting with a suspected acute coronary syndrome, regardless of initial risk stratification.

Intravenous heparin is not usually commenced on low risk patients but may be considered by the Cardiologist for patients who are classified as an intermediate risk for suspected acute coronary syndrome.

Admission Process

Patients may be transferred to the Cardiac Medical Assessment Unit following consultation with the Cardiologist or Cardiology Fellow on-call. Overnight this responsibility is delegated to the medical registrar.

When a patient is identified as suitable for transfer to the Cardiac Medical Assessment Unit, the Emergency Department consultant/registrar will notify the Cardiologist or Cardiology Fellow and Care Coordinator. Out of office hours the Cardiologist or Cardiology Fellow (or medical registrar overnight) will be notified. The Emergency Department is responsible for notifying the Patient Flow Manager. Patients should be transferred promptly (within 30 minutes) once the decision to transfer is made.

Patients being transferred to Cardiac Medical Assessment Unit requiring cardiac monitoring must have continuous cardiac monitoring from ED and be escorted by a registered nurse. The nurse receiving the patient in the Cardiac Medical Assessment Unit should receive a full verbal handover from the Care Coordinator or nurse before accepting care.

2. Management in the Cardiac Medical Assessment Unit

Initial Assessment and Management on Arrival:

- Receive handover from ED registered nurse.
- Commence continuous cardiac monitoring via hardwire monitor as per 2.1 Cardiac Monitoring and record a rhythm strip if applicable.
- Take a full set of vital signs (minimum: temperature, pulse, respirations, blood pressure, oxygen saturation and pain assessment).
- Review all documentation accompanying the patient, including the 12 lead ECG.
- Instruct the patient to report all episodes of discomfort as per 7.1 Management of Chest Pain.
- Check all pathology results for the patient and report abnormal results to the medical team.
- Ensure that the patient has a patent IV cannula in situ.
- Identify cardiac risk factors.

Developing the case management plan

Within 2 hours of patient arrival

- Clinical assessments completed by nursing and medical staff
- Commencement of management plan
- Order diagnostic services
Within 4 hours of patient arrival (During Business Hours)

- All assessments completed (including Allied Health)
- Care management plans completed and communicated to patient/family/carer
- Estimated Date of Discharge (EDD) allocated and communicated to multidisciplinary team and patient/family/carer

Within first 24 hours of patient arrival

- Multidisciplinary team co-ordination
- Discharge requirements scheduling (e.g. discharge letter, pharmacy, equipment, transport)
- Community services (e.g. access, referral and assessment)
- Outpatient clinic (e.g. access and appointments)

Within first 48 hours of patient arrival

- Confirm and execute all care management activities
- Enable transition out of MAU (e.g. discharge home or to alternative inpatient unit)

Ongoing Assessment and Management

Patients should remain on bed rest until the second troponin result is known, unless otherwise advised.
Ensure Multi-disciplinary Assessment Form is completed (appendix 4).

Vital Signs

Record vital signs (minimum: pulse, respirations and blood pressure) at least hourly for the first four (4) hours after presentation to the Emergency Department, and at least four (4) hourly thereafter.

Vital signs should be attended more frequently with chest pain or alterations in haemodynamic status.

ECGs

A repeat ECG should be performed six (6) to eight (8) hours after the first ECG in patients with an Acute Coronary Syndrome. Any changes identified **must** be reviewed immediately by a registrar. During business hours ECGs may be reviewed by the cardiology registrar. After hours the medical registrar may be called to review an ECG but if significant changes are identified the Cardiology Fellow on-call must be notified.

ECGs must be performed promptly with chest pain and reviewed by a registrar, as above. ECGs must be repeated at least 15 minutely with chest pain, as per 7.1 Management of Chest Pain. ECGs should be performed promptly with any change in cardiac rhythm, and a rhythm strip also recorded.

Troponin I

A second troponin I should be collected eight (8) hours after the first troponin in patients with an Acute Coronary Syndrome.
As soon as the second troponin result is known it should be reported to the appropriate registrar or Fellow to enable prompt organisation of a stress test. Outside of stress testing hours, the Cardiology Fellow on-call must be notified of a positive troponin result, to permit reclassification of risk and intensification of therapy.

**Reassessment**

When the second troponin result is available, the patient should be reassessed by the appropriate cardiology registrar/fellow. This reassessment should include:

- Recurrence of chest pain or other symptoms
- Physical examination
- Evaluation of the first and second troponin results
- Review of the patient’s cardiac rhythm and ECGs

If any high-risk features are identified (including positive troponin result, ECG or rhythm changes or recurrent pain) or the patient is assessed as being clinically unfit for discharge within the expected timeframe, the patient should be admitted to an appropriate inpatient bed following consultation with the admitting Cardiologist or Cardiology Fellow. Patients transferred to the Cardiac Medical Assessment Unit may not return to the Emergency Department.

For patients with suspected acute coronary syndrome, if the ECG remains unchanged or has non-significant ECG changes, and the troponin is normal, the patient should have an exercise stress test (EST) as per 8.1 Exercise Stress Testing.

**Exercise Stress Testing**

Exercise stress testing is available from 9.00am till 5pm seven days per week. ESTs conducted outside business hours will be arranged with the Cardiology Fellow on-call.

Depending on the result of the EST, the patient will be reclassified as a high risk patient or low risk patient. Patients with a positive EST are considered to be high risk patients and should be admitted to an appropriate inpatient bed. Patients with a negative EST are considered low risk patients and may be discharged. Where the result of the EST is equivocal, the medical officer conducting the test will determine whether the patient should be admitted or discharged.

**Access to in-patient and primary health care services**

- MAU patients require access to diagnostics such as X ray, endoscopy, ultrasound etc. with similar priority to ED and ICU
- Priority access to early outpatient clinic or ambulatory care appointments is required for MAU patients
- Priority access to community services such as Com Packs and transitional care will be given to MAU patients

3. **Discharge from the Cardiac Medical Assessment Unit**

- Patients may be discharged any time from 9.00am up to 8.00pm. In accordance with their clinical
management plan.

- Ensure a computerised discharge summary is completed for each patient prior to discharge.
- Ensure that the patient is referred for follow up with a Cardiologist or GP within 2 weeks.
- Provide the patient with information regarding risk factor modification and/or referrals to outpatient sources of information.
- Provide patients with appropriate education on self-management after discharge. For patients admitted with chest pain, inform them of appropriate actions in the event of chest pain and give them a chest pain action plan. As these patients are at low risk of cardiac events, they should not require sub-lingual nitrates, and should be advised to attend their local doctor or the Emergency Department promptly if pain recurs. For other diagnoses be guided by the relevant patient education plans.
- Educate the patient about any medications commenced in hospital to be continued after discharge (eg. aspirin, beta-blockers, warfarin, anti-arrhythmics).
- If a discharge prescription is needed, an outside script may be used after hours.
- Patients who are awaiting transport may be transferred to the Patient Discharge Lounge.
- Should the patient be transferred to an alternative inpatient or subspecialty team, the team CANNOT refuse transfer of the care and must sign off on the clinical management plan as documented in the MAU at the time of handover.

4. Admission to Cardiac Services from the Cardiac Medical Assessment Unit

Normal admission procedures will be followed when the patient is admitted to Cardiac Services from the Rapid Cardiac Assessment Unit.

- Complete the Admission and Discharge Planning Tool
- Develop an appropriate care plan for the patient
- Commence the relevant patient education plan
- Determine the need for repeat troponin measures and serial ECG recordings
- IV cannulas inserted in the Emergency Department should be replaced within 24 hours if the patient is admitted to an inpatient Cardiac Services bed as per 5.A.4. Adult Standards and Clinical Procedures Manual. Removal of peripheral IV cannula.

References


Health Care for Older People Earlier Program, Medical Assessment Units Operational Guide (Draft) (N.D.)

NSW Health

**Ratified By**

<table>
<thead>
<tr>
<th>Director Cardiac Services</th>
<th>Co-Director Acute Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Gregory Cranney</td>
<td>Ms Heather Walker</td>
</tr>
</tbody>
</table>

Effective Date: April 2008   Revision Due: April 2009

Cardiac Services Clinical Practice Guidelines
Management of Patients In the Cardiac Medical Assessment Unit
Appendix 1: Risk Stratification of Patients with Non-ST Segment Elevation Acute Coronary Syndromes

High Risk: Admit to CCU or Cardiology Ward
Presentation with clinical features consistent with acute coronary syndrome and any of the following high risk features:
- Chest pain at rest > 10 minutes needing IV analgesia or IV GTN
- Chest pain with dynamic ST elevation or depression ≥0.5 mm
- Chest pain with deep T wave inversion ≥2mm in 3 or more leads
- New MR murmur
- Signs of LVF
- Syncope or hypotension (SBP < 90mmHg)
- Elevated serum markers (troponin I)

Intermediate Risk: Transfer to Rapid Cardiac Assessment Unit
Presentation with clinical features consistent with acute coronary syndrome, no high risk features and any of the following intermediate risk features:
- Chest pain or > 10 minutes resolved spontaneously or with sub-lingual GTN
- New onset angina
- ECG has pathological Q waves or ST depression < 0.5mm or T wave inversion in < 3 leads
- Previous AMI or PCI/CABG
- Diabetes
- Exertional chest pain with increased frequency, severity or duration, or provoked at a lower threshold

To be transferred to the Rapid Cardiac Assessment Unit, patients must also meet this criteria:
- No significant co-morbidities
- Able to perform a treadmill exercise stress test
- Suitable for rapid discharge (ie, must not need multidisciplinary discharge planning)
- Transfer agreed by Cardiologist or Cardiology Fellow

Low Risk: Consult Cardiology Team re Discharge or Transfer to Rapid Cardiac Assessment Unit
Presentation with clinical features consistent with acute coronary syndrome, with no high or intermediate risk features and any of the following low risk features:
- Chest pain low likelihood of cardiac cause
- Normal ECG
- Chronic stable angina

6 month risk of death or MI
High risk = >10%
Intermediate risk = 2-10%
Low risk = <2%
### Cardiac Services Clinical Practice Guidelines

**Management of Patients In the Cardiac Medical Assessment Unit**

**Effective Date:** April 2008  
**Revision Due:** April 2009

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<table>
<thead>
<tr>
<th>FOR MEDICAL RECORD USE ONLY</th>
<th>Surname:</th>
<th>MRN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL RECORD COPY -</td>
<td>Other Names:</td>
<td>Sex:</td>
</tr>
<tr>
<td>A Facility of South Eastern Sydney Illawarra Health</td>
<td>DOB:</td>
<td>AMC:</td>
</tr>
</tbody>
</table>

**ACUTE CORONARY SYNDROME PATHWAY**

**HIGH / INTERMEDIATE / LOW RISK MANAGEMENT AND DISPOSITION PLAN**

**GENERAL MANAGEMENT - All patients**

- Date ED Pres:  
- Time ED Pres:  

- 12 Lead ECG - Baseline / Repeat ECG 90s post onset of symptoms and if when pain recurs
- IV AGES and bloods as indicated
- Continuous ECG Monitoring / Pain relief / Oxygen therapy as indicated / required
- Initial Troponin on arrival  
  - Result:  
- If negative initial troponin, repeat 6-8 hours post pain
- Chest X-ray
- Aspirin 300mg  
  - No  
  - Reason:  
- Ensure patient caffeine free 12-24hrs (inc: coffee, tea, chocolate for possible MPS)
- All cases to be discussed with Senior Medical Officer

**Recommended Management and Disposition** Refer to Drug Protocols (Tick the applicable boxes)

### HIGH RISK

- **Antithrombotic therapy**
  - Clopidogrel 300mg then 75mg TID [CV Cardiologist]
  - Ticlopidin or apixaban

- **Beta-blocker (If not contraindicated)**
  - Yes
  - No  
  - Reason:  

- **Antithrombotic (Heparin)**
  - No  
  - Reason:  
    - Unfractionated (refer protocol)
    - Low Molecular weight
    - Fondaparinux

- **Symptomatic treatment of ongoing pain/hypertension**
  - IV GTN (5 thou against pain & BP)
  - IV Morphine 2.5 - 5mg Bolus prn
  - Consider antiepileptic IV therapy
  - Refer to Cardiology

**INTERMEDIATE RISK**

- **Antithrombotic therapy**
  - Refer to High Risk
    - Recurrent ischaemic Chest pain
    - New troponin
    - New ECG changes
    - Stress test Positive
  - Refer to Cardiology Team for review and further management

- **Antithrombotic therapy**
  - Refer to Low Risk
    - Troponin I Neg initial & 6-8hr post onset of chest pain
    - No New ECG changes
    - Stress Test negative (if available)
  - Discharge According to Low Risk protocol

**LOW RISK**

- **Antithrombotic therapy**
  - If Low Risk ACS
  - Discharge
  - Stress test within 3 days of DCM
  - Discharge referral faxed to Nuclear Medicine for stress test (Nuclear Med to arrange appointment)
  - Follow up GP within 3-5 days of DCM
  - Consider Cardiology review within 2 weeks of discharge
  - Consider discharge on Aspirin (discuss with SMO)

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**Medical Officer: Print name**

This tool is intended as a guideline for clinicians to provide quality patient care. It is not intended, nor should it replace, individual clinical judgement.
STEMI ASSESSMENT & MANAGEMENT

Pt meets criteria for REPERFUSION?
☐ Chest pain > 30 min and < 12 hrs
☐ ST segment elevation > 1mm in 2 or more contiguous limb leads or 2mm ST elevation in 2 or more chest leads or presumed new LBBB
☐ Myocardial infarct likely from history

Main contraindications:
☐ Active risk of bleeding
☐ Ischaemic stroke within last 6 months
☐ Risk of intracranial haemorrhage

☐ Discuss with Cardiologist / Fellow on call: Time __ __ please use 24hr Clock
☐ Decision regarding Reperfusion Treatment: Time __ __

☐ Clopidogrel
☐ Unfractioned heparin (Consider)

☐ PCI-Cath. Lab

Organise T/F to Cath. Lab

☐ Heparin Bolus
☐ Heparin Infusion

☐ Ticritaban or Eptifibatide

Go to Catheter Lab

Door to Balloon time <90 minutes

Thrombolysis (+ Heparin)

Administered:

Cath Lab Arrival Time

On Table Time

First Balloon inflation Time

Time to Revascularization

Date __ / __ / ______

TIMI 3 flow

☐ 0-30mins ☐ 31-45mins ☐ 46-60mins ☐ 61-75mins ☐ 76-90mins

☐ >90mins Reason for delay

Medical Officer: Print name & sign

This tool is intended as a guideline for clinicians to provide quality patient care. It is not intended, nor should it replace, individual clinical judgement.
### References:

### Appendix 2: Medical Assessment Unit Screening Form

**Emergency Department**

**Medical Assessment Unit Screening Form**

<table>
<thead>
<tr>
<th>Surname: _</th>
<th>MRN: _</th>
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</thead>
<tbody>
<tr>
<td>First Names: _</td>
<td>_</td>
</tr>
<tr>
<td>Date of Birth: _ / _ / _</td>
<td>Sex: _</td>
</tr>
</tbody>
</table>

Please attach Patient Label here

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### Patient Screening Process at Triage

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Does the patient meet the following criteria?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult medical patient</td>
<td></td>
<td></td>
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<tr>
<td>Haemodynamically stable</td>
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<td></td>
<td></td>
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<tr>
<td>Non critical</td>
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<tr>
<td>Anticipated to be able to be discharged or transferred to ward within 48 hours</td>
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</tbody>
</table>

**If YES is answered to ALL the INCLUSION CRITERIAS the patient is able to be admitted to the MAU**

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
<th>Does the patient meet the following criteria?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ICU, CCU or HDU admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Require BIPAP or CPAP</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Clinically unstable</td>
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<td></td>
</tr>
<tr>
<td>Surgical patient</td>
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<td></td>
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<tr>
<td>Under 16 years of age</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>A nursing mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis patient</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Palliative</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Require isolation e.g. infectious diseases</td>
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<tr>
<td>Able to be directly admitted to specific inpatient ward</td>
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<tr>
<td>Aggressive e.g. psychiatric patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstable spinal injury requiring &gt;48 hrs in patient care</td>
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<td></td>
</tr>
</tbody>
</table>

**Head injury that is:**
- Ventilated
- GCS < 12
- GCS 13-14 without CT

**Deemed unsuitable for MAU admission by either MAU Director/MO/NP or CNC**

**If YES is answered to ANY of the EXCLUSION CRITERIA then the patient MUST NOT be admitted to MAU**

- Does the patient fit MAU eligibility?
- Has the patient been discussed with MAU Director/MO/NP or CNC?
- Has the patient been accepted for admission to MAU?

**Triage Nurse Name:**

**Triage Nurse Signature:**

**Time Arrived in Triage:**

**Time Departed for MAU:**
# Appendix 3: Medical Unit Exclusion Criteria

<table>
<thead>
<tr>
<th>EXCLUSION CRITERIA</th>
<th>Excluded Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care Patients</td>
<td>Any patient who is to be admitted to ICU, CCU, HDU or other critical care units</td>
</tr>
<tr>
<td>High Dependency Airway</td>
<td>Any patient who requires BIPAP or CPAP</td>
</tr>
<tr>
<td>Unstable Patients</td>
<td>Patients who fit into MET criteria</td>
</tr>
<tr>
<td>Surgical Patients</td>
<td>Any patient who is to be cared for under a surgical team</td>
</tr>
<tr>
<td>Acute/Chronic Renal Patients</td>
<td>Any patient who requires dialysis</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>Any patient who requires isolation</td>
</tr>
<tr>
<td>Differentiated Patients</td>
<td>Any patient who is to be directly admitted to a specific in-patient ward</td>
</tr>
<tr>
<td>Psychiatric Patients</td>
<td>Patients who are aggressive</td>
</tr>
<tr>
<td>Neurology Patients</td>
<td>Unstable spinal injuries, head injuries requiring ventilation &amp; OR GCS &lt; 12 &amp; OR GCS 13-14 without CT Scan</td>
</tr>
<tr>
<td>Other</td>
<td>Nursing mothers, palliative patients, patients under 16 years and any patient deemed inappropriate by MAU Medical Director, Registrar or NP/CNC</td>
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</table>

<table>
<thead>
<tr>
<th>MET CRITERIA</th>
<th>Unstable Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway</td>
<td>Threatened</td>
</tr>
<tr>
<td>Breathing</td>
<td>Respiratory Arrest OR Resps &lt; 8 OR Resps &gt; 36</td>
</tr>
<tr>
<td>Circulation</td>
<td>Cardiac Arrest OR pulse &lt;40 OR pulse &gt;100 OR Sys BP &lt; 90mmHg</td>
</tr>
<tr>
<td>Neurological Status</td>
<td>Fall in GCS of more than 2 points OR decrease in level of consciousness OR repeated or prolonged seizures</td>
</tr>
<tr>
<td>Other</td>
<td>Any patient you are worried about that does not fit into the above criteria</td>
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</tbody>
</table>