Ballarat Health Services
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Emergency Department

Short Stay Unit

Operational Procedures for HMO's and Registrars

Introduction to the ED Short Stay Unit

Short Stay Units (SSU) have been developed to provide a short period of assessment, a course of therapy or medical observation for a group of patients who no longer require care delivered in the ED. Traditional models of care for these patients would involve remaining in the ED for long periods, or admission by inpatient units.

The SSU is designed to provide short-term (<24 hours) assessment and/or therapy for select conditions in order to streamline the episode of care. The ED SSU "front loads" resources to provide an intensive period of evaluation, treatment and supervision.

The emphasis is on enhancing patient flow through ED by standardised "pathway" models of care for specific medical conditions. This is combined with rapid effective discharge planning and allows for early discharge home. ED bed access is then significantly improved.

The ED SSU model of care is managed by Emergency Physicians and is not designed for the first 24 hours of care before admission to a ward. These patients are managed via usual admission processes, which includes the MAP unit.

FAQ'S

1. **How Do SSU's Work?**

   As well as being advantageous to patients and their family/carers, an ED SSU model of care is complementary to ED aims and objectives. It allows the ED to function more efficiently by:

   - Increasing ED turnover.
   - Reducing ED length of stay.
   - Facilitating ambulance off load.
   - Allow for focused allied health assessment and intervention.
   - Provides a safety net against inappropriate discharge, especially overnight.
   - Provides a more comfortable environment for patients.

   The establishment of an ED SSU will increase the overall BHS hospital bed capacity and results in saving hospital bed days.

   ED SSU staff will not have commitments to outpatients, theatre, multiple wards etc, and work in one location, closely associated with the ED.

   The combined impact of reduced length of stay and early allied health intervention can result in reduced levels of de-conditioning in elderly patients whilst they are in hospital.

2. **What Are The SSU Hours of Operation?**

- 24 hours a day / five days per week.
- The initial implementation is proposed for five days per week, from Monday 7.00 a.m. through to Friday afternoon 3.30 p.m.
- This coincides with the first morning nursing handover and the medical staff rosters.

3. **When Can I Start to Admit to, or Have to Stop Admitting Patients to SSU?**

- Patients can be admitted from 7.00 a.m. Monday morning.
- In order to have the ward **EMPTY** of patients by 3.30 p.m. Friday afternoon, care should be taken as to cases selected for admission Thursday evening or Friday morning.
- It would be expected that simple cases of delayed test results, observation until a set time-point or clearly planned discharges may arrive in the SSU up until 1100 a.m. Friday.

4. **What About Overnight?**

Patients will be commonly admitted to the SSU overnight. As a more comfortable place to sleep whilst awaiting an expected morning discharge, or to free the ED cubicles for more acute patients, the SSU is a good choice.

The overnight registrar in charge / Admitting Officer (A0) acts as the "gate-keeper" and it is their decision, in consultation with the receiving /on-call overnight ED consultant as to who is suitable for admission.

The AO and the ED staff are responsible for overnight ward calls from the SSU.

5. **What Will My Roster Be?**

The ED registrar will work day shifts and be rostered for training time on Tuesdays.

The ED SSU HMOs will be rostered for either early shifts or late shifts, with training time Thursday 8.00 a.m. in the ED.

6. **Why the 7.00 a.m. Starts?**

The 7.00 a.m. nursing handover is the ideal time for the resident to attend and begin their day's work.

There will be many tasks to complete, patients to re-assess and orders required from this round. It would be expected that all required imaging tests and referrals have been ordered/booked by 8.00 a.m. or 9.00 a.m. when the supervising registrar (Dr Stephen Luke) or the Consultant will expect another progress report.

7. **Ward Rounds?**

Standard nursing handover times apply (7.00 a.m., 1.00 p.m., and 9.00 p.m.). The ED HMO will attend the 7.00 a.m. nursing handover.

Frequent consultant/ senior registrar ward rounds will expedite ED admissions, SSU discharges and improve patient care. Consultant led ward rounds will occur at approximately 8.30 a.m. and 3.30 p.m., with handover at 10.00 p.m. when the night ED registrar commences.

Rounds will initially be conducted in the meeting room to the right of the entrance to the SSU. This room has the advantage of privacy, confidentiality, and the large screen TV/monitor that can display the ward MAP, results etc. Review of individual patients will occur at the bedside as required. This room is also used by the care co-ordinators/discharge planners to make calls, keep resources. The ANUM and care co-ordinators currently share the desk space here.

8. **Admission Process**

Patients will be admitted to the ED SSU under the bed card of a nominated ED physician. There will be a clearly defined roster.

It must be mandated that patients require observation or treatment for less than 24 hours duration before discharge home. Admission and discharge criteria are unambiguous, succinct and reproducible. They must be able to be consistently applied and understood by all staff. All admissions to the ED SSU will be from the ED. At this stage we do not intend to admit to the ED SSU directly from other areas.

In the Emergency Department

- Recognition/identification of patient in ED potentially suitable for care in the ED SSU.
- Early discussion with AO/ED physician/ANUM.
- Need for admission agreed – patient eligible for clinical pathway.
- ED to liaise with ED SSU re admission.

- ED Clinical documentation MR265.0 completed - including diagnosis and management plan.

- Arrange transfer to ED SSU (target < 30 minutes).

- Notify ED reception.

In the ED or the ED SSU

- SSU Clinical pathway documentation completed by HMO/registrar.
- Medication chart completed.
- IV fluid chart completed (where appropriate).
- PFC notified of admission.
- Discussion and handover to nursing staff of SSU.
- Patient admitted to SSU within 30 minutes.

In the ED SSU

- SSU admission paperwork ensured complete - a continuation of ED notes.
- Clinical care provision.
- Patient medical review with a minimum of eight hourly intervals. Nursing observations minimum four hourly.
- If patient is likely to require a more prolonged inpatient admission, this should be identified by the 16 hour mark. Inpatient unit referral is made and PFC notified of bed request.

9. **Who Chooses the Patients Suitable for SSU from the ED?**

The SSU strives to be constantly full or have one spare bed only for the next patient from ED. It is the task and goal of the SSU staff to relieve as much bed pressure on the ED as possible by constant reassessment for suitable new admissions and effective discharge planning of its own patients.

ED SSU registrar and residents will review IBA PAS and attend ED regularly to liaise with ED AO and "pull" patients towards the ED SSU. Selecting patients for SSU will be a major task for the care co-ordinators of ED and SSU also.

10. **Who Gets in to Short Stay?**

"YOU DON'T GET IN UNLESS WE CAN EXPECT TO GET YOU OUT".

Check pathways for admission and exclusion criteria before discussing case with AO or SSU staff.

11. **Who Authorizes Admissions to SSU?**

The SSU registrar will report to their consultant just like any other inpatient unit.

Patients in the ED SSU will be admitted and management overseen by ED consultants with admitting rights to the ED SSU only. The admitting SSU consultant will be clearly rostered for each day time and overnight period. The responsibility for choosing who is admitted to the SSU is entirely the prerogative of the admitting SSU consultant at all times. No other unit patients will be housed or admitted to the SSU.

Initially all patients will be admitted under the bed card of Dr Cruickshank but managed by the team as outlined above.

Any other unit registrar that requests a patient could be on-referred to the SSU consultant would be expected to have called their own unit consultant prior to this request.

12. **Can I Admit a Patient to the SSU Overnight?**

Yes. The AO has this authority on behalf of the on call consultant.

It is the responsibility of the overnight staff to establish the preferences of the on call ED specialist – do they want to be called about every admission overnight, do they want to be called about "judgement" decisions or disputes.

The emergency specialists are responsive and enthusiastic to provide their registrars with appropriate support and advice for difficult decisions. Common-sense is always appreciated.

13. **What is a "Pathway" Anyway?**

At present there are 26 SSU pathways, listed below. These represent a cross-section of the patient groups that commonly spend longer periods of time in the ED. Anyone who can be anticipated to spend between four to 24 hours in the ED might be suitable for SSU.

- Allergic reactions.
- Asthma.
- Awaiting transfer to home – to avoid overnight discharge risks.
- Awaiting social supports /care co-ordination.
- Biliary colic.
- Generic Blank Pathway (ED consultant discretion).
- Cellulitis.
- Chest pain.
- Drug overdose.
- Epistaxis.

- Ethanol intoxication.
- Gastroenteritis.
- Head Injury.
- Hyperemesis Gravidarum.
- Hypoglycaemia.
- Migraine.
- Pneumonia.
- Pneumothorax.
- Post procedure injury or sedation.
- Psychosocial crisis.
- PV Bleeding / threatened miscarriage.
- Pyelonephritis.
- Renal colic.
- Seizure.
- Syncope.
- Tonsillitis.

14. **What if the Patient Doesn't "fit" the Pathway?**

Check with the AO or the care co-ordinators/SSU staff.

A "blank" pathway is provided for discretionary admissions, which works with an individual plan for that patient that may fit well into SSU timeframes.

Pathways can be added as we all gain more experience with the SSU processes.

15. **What Paperwork is Required to Admit to SSU?**

Once the ED admitting doctor or SSU staff (SSU doctor and care co-ordinator) have assessed the patient in the ED as being suitable for admission, there is no reason why the patient should not be immediately transferred physically to the SSU.

The ED notes should have been completed by medical and nursing staff and form part of the SSU admission. Unnecessary duplication of this record is avoided.

The pathway paperwork can be completed in the SSU to avoid further transfer delays. Clinical pathways have been developed for each of the admission problems and should be adhered to. Inclusion and exclusion criteria are clearly marked on the first page.

Any variance from defined treatment pathways must be documented and will be audited. Clinical pathways will be revised and updated on a regular basis. Clinical pathways must be signed or countersigned by the senior medical officer or consultant on duty.

16. **Where Inside the SSU Does the Doctor Actually Sit / Work?**

The ED SSU has been designed to have medical staff provide care near the patient, with point of care devices located at two small writing desks at satellite work stations - the SSU doctors should not be sitting down very often. The patient notes are shared with the nursing staff and should otherwise stay in the pigeon holes near the patients.

Given the dynamic nature of this ward and our expectation of multiple patients per bed per day, the SSU resident and registrar will spend any "spare" time looking for more work related to SSU in the general ED.

17. **How do I Get Pathology Tests Done?**

Standard pathology requests. The ED stationery means our tests have more urgent priority and results should be returned sooner.

All tests ordered must be reviewed in BOSSNET, signed off, and included in the discharge summary.

18. **Radiology Investigations Booking?**

Book them before anybody else! This is one of the reasons for starting at 7.00 a.m.

For example, the radiology department currently has emergency ultrasound appointments reserved for 10.00 a.m. and 4.00 p.m., with patients ringing at 8.00 a.m. for these appointments.

Patients with suspected miscarriage or DVT after hours could be admitted to the ED SSU, and after the 7.00 a.m. nursing ward round these planned tests could be booked with radiology. This system would assist with prioritization of tests and could be integrated with a system to triage after hours U/S requests.

We hope to develop a system of electronic test booking using the Bossnet system soon. Patients should be discharged with formal radiology reports checked and included in discharge summary.

19. **Documentation and Handovers**

Use the SSU chart and progress notes for clinical documentation. The BOSSNET system allows handover notes to be written which can then be used to produce the UNIT TASK LIST and cut and pasted into the summary of treatment to assist with discharge summary. Please refer to the BOSSNET manuals.

20. **Discharge Process**

Discharge planning commences prior to admission and requires involvement of the discharge planning co-ordinators. All patients over 65 years of age will be referred to the discharge ED care co-ordinators.

Patients requiring referral to either specialist medical practitioners or allied health practitioners will have referral documentation completed at the earliest possible opportunity.

Safe discharge criteria are stipulated on each care pathway. If a patient is assessed as likely to exceed the 24 hour SSU admission target, or is unable to be safely discharged they will be referred for inpatient hospital admission by the most appropriate clinical specialty. This must be completed by the 16 - 20 hour mark of an SSU stay.

Following this referral, if inpatient unit registrars are delayed in their subsequent assessment and admission process, then patients may be transferred to the ward with an appropriate Interim Orders Admission. Admission notes and clerking by inpatient registrars should be seen as a re-assessment and continuation of the ED and ED SSU clinical notes, rather than a repetition of this documentation.

21. **What Paperwork is Required to Discharge from SSU?**

Discharge planning begins on admission ("YOU DON'T GET IN UNLESS WE CAN EXPECT TO GET YOU OUT") and includes family/carers.

Completed discharge documentation includes prescriptions, work certificates, outpatient referrals, investigation requests and patient fact sheets. SSU Discharge Summary (page 4 of pathway) completed – copy to patient and GP.

Bossnet/EMR discharge completed (this is the single current duplication of paperwork upon the computer – sorry).

22. **Discharge Medications**

Just like all the wards, except FASTER. Patients have to pay (PBS benefits) for any prescriptions that the hospital provides for discharge. Most ambulant patients can be directed to pass via pharmacy on their way out of the hospital.

Discharge prescriptions SHOULD NOT delay discharge in any way.

23. **When is Education and Training Time?**

ED registrar training 8.00 a.m. – 12 noon Tuesday.

ED HMO training 8.00 a.m.-11.00 a.m. Thursday.

24. **Meal Breaks**

A meal break is best taken during the period of time in the afternoon when there is more than one doctor on duty. Meals to be eaten in the tea room provided rather than offsite because you will not have a pager to be recalled urgently.

25. **What if I Have Some Free Time?**

Unlikely – ask Dr Beck for more work (and his mobile phone number).

On a serious note, we feel that at the end of each shift that all notes and discharge summaries will be complete and all results checked in BOSSNET.

26. **Am I Allowed Back in the Main ED?**

It is anticipated that most of your time will be spent in SSU and the radiology department.

27. **Do I Have to see ED Patients as Well?**

The ED SSU registrar is expected to attend the ED and assist with 'recruiting' appropriate patients for admission to SSU. This will include review of some patients.

28. **What if an Inpatient Registrar Wants a Patient to go into SSU?**

The Emergency Physician will have absolute discretion about any patient being admitted to SSU. The SSU does NOT replace the function of the MAP unit or act for surgical units expecting next day discharge of their patients.

The Emergency Physician will have absolute discretion regarding the use of cardiac monitoring in the ED SSU. Referrals from the cardiology/medical registrar concerning patients in ED must be via duty ED physician 24 hours a day.

29. **Why is an Empty or Full ED SSU "Bad"?**

The ED SSU beds are quarantined beds for ED SSU patients only. To maintain effective flow, given the anticipated high turnover of patients, we need to keep unit occupancy rates below 90% (seven of eight beds occupied at any point in time).

30. **"Failed" Discharges and Interim Orders**

Any patient likely to require general hospital inpatient admission will require early referral for transfer of care.
If a patient is assessed as likely to exceed the 24 hour SSU admission, or is unable to be discharged within 24 hours, they would automatically meet criteria for needing inpatient hospital admission and thus should be accepted by the most appropriate clinical specialty.

If the inpatient registrars are delayed in their subsequent assessments then patients may be transferred to the ward after appropriate referral and Interim Orders Admission is completed. The interim orders admission will proceed **TWO HOURS** after the registrar was properly notified (this means spoken with, or a clear paged referral - not a message left with a theatre nurse) by referral.

Admission notes and clerking by inpatient registrars should be seen as a continuation of the ED and ED SSU clinical notes, which should reduce paperwork and save time.

31. **CODES in SSU?**

The SSU is best seen as another ward away from the ED.

As such all "codes" (blue, grey, red, black or MET Response) should be called through standard ward procedure. **IF (and only IF)** there are adequate extra staff in the ED to provide back-up, then ED staff could attend and assist the day time SSU staff in attending code calls. Overnight the usual ward response would be expected.

32. **Who's in Charge?**

A senior ED nurse and senior ED doctor have first line management responsibility for the running of the unit on a daily basis.

ANUM for the ED SSU and Clinical Director ED SSU (ED physician Dr Nigel Beck), report to ED NUM (Phil Catterson) and Director of ED (Dr Jaycen Cruickshank).

33. **Who Else is Involved in Running the SSU?**

Nursing staff with well-developed clinical skills as appropriate (e.g. advanced life support, cannulation, venepuncture, ECG interpretation).

CARE CO-ORDINATORS work in the SSU, their role includes:

- Early effective discharge planning.
- Assessing and meeting patient's needs.

- Providing patients with information about what services / options exist both within the Health Service and in the community.

- Prevention of unnecessary patient representation to the ED.

- Allocation of patient resources efficiently and effectively.

SSUs who neglected care co-ordination had patients staying multiples days to weeks decreasing SSU bed access.

Allied Health and Support Staff include:

- Environmental Services cleaner.
- Patient Service Assistant.
- Physiotherapy.
- Meals service.
- Pharmacy.
- BHS Transport.
- Access to Allied Health staff including social worker, occupational therapist and mental health clinicians.

34. **Who DOESN'T get into SSU?**

Patients shall not be admitted to SSU solely for the purpose of avoiding a penalty for extended stay in the ED. The ED SSU has no role as a buffer for other bed management strategies.

Patients who require inpatient unit admission for > 24 hours will likewise also not be admitted to ED SSU. The unit cannot function if it is seconded in any part to alleviate general ward bed blockage.

35. **Is it still an Emergency?**

Absolutely!! These are the same patients with emergency needs that would otherwise just spend a longer period of time on a hard trolley occupying a needed cubicle in the emergency assessment and treatment area.

All the skills of emergency medicine are utilised in the SSU. There will need to be frequent re-assessment of your patients' needs to ensure that we are still heading in the appropriate direction of care.

A "pathway" model does not replace your intelligence, or make the right decisions for you. It standardises medical recommendations just like any other guideline system, which results in more patients receiving similar high standards of attention.

The effective functioning of the ED SSU is dependent upon proactive management. We have priority access to diagnostic services, priority access to CT and ultrasound, including pre-booked appointments each day (e.g. 10.00 a.m., 3.00 p.m.) that can be used for other urgent bookings when not required by the ED SSU.

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GOOD LUCK!!

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