Document Review

Timeframe for review: every five (5) years, or earlier if required.
Document authorisation: Council of Advocacy, Practice and Partnership
Document implementation: Standards Committee
Document maintenance: Department of Strategic and Strategic Partnerships

Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Pages revised / Brief Explanation of Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mar 19</td>
<td>New document</td>
</tr>
</tbody>
</table>
1. Purpose

The purpose of this document is to provide guidance on the clinical governance, staffing, admission inclusion and exclusion criteria, and design of an emergency department short stay unit (ED SSU).

ACEM recognises that some health providers have requirements relating to the design and clinical governance for ED SSUs. These guidelines supplement those requirements.

2. Scope

In scope of this policy are all clinical and administrative staff of Australian and New Zealand emergency departments (EDs) and administrative staff external to the ED, including senior hospital executives and administrators.

The staffing requirements outlined in this document are applicable to medical, nursing and allied health staff and non-clinical staff.

Mental health short stay units/mental health assessment units are out of scope for this guideline.

3. Definitions

Fellowship of the Australasian College for Emergency Medicine

_Fellowship of the Australasian College for Emergency Medicine_ (FACEM) is the recognised qualification of a specialist emergency physician in Australia and New Zealand.(1)

Junior medical staff

As outlined in ACEM’s _Policy on the Supervision of Junior Medical Staff in the ED_ (P53), a junior medical officer is defined as a registered medical practitioner who is in their first or second postgraduate year. This stage of the medical education continuum is referred to as prevocational training. First and second postgraduate year trainees require supervision from senior medical practitioners.(2)
4. Defining an Emergency Department Short Stay Unit

An Emergency Department Short Stay Unit (ED SSU) is designed and designated for the short-term treatment, observation, assessment and reassessment of patients following triage and assessment in the ED. Short stay units optimise the care and safe discharge of these ED patients.

Short stay units have specific admission and discharge criteria and policies. Admission criteria can include stable patients who require observation and/or further investigation to ascertain the seriousness of their condition (e.g. minor head injury, chest pain, infections), or a short course of treatment for conditions that might rapidly resolve (e.g. asthma, allergic reactions and renal colic). Emergency department SSUs also provide a designated space for ED patients who may require allied health and social support interventions prior to discharge, such as physiotherapy, occupational therapy or social welfare services.

Short stay units have a static number of beds with oxygen, suction, patient and ablution facilities. They are physically separated areas from the ED acute assessment area and are designed for lengths of stay of up to 24 hours. An ED SSU should provide a 24-hour seven day per week service to provide a consistent standard of patient care.

Short stay units improve patient flow by providing timely assessment and treatment, thereby allowing patient discharge in the shortest, clinically appropriate timeframe. They have been shown to reduce lengths of stay for appropriately selected patients who would otherwise have been admitted to an inpatient ward bed, and improve the care experience of patients who may have otherwise stayed in the ED for prolonged periods. (3) Short stay units also positively contribute to patient comfort and safety, allowing for more extensive ED care in a low-stimulus environment with less noise and lower lighting, and provide a clinical alternative to inpatient admission or inappropriate discharge (e.g. elderly patients at night).

Governance of an ED SSU, including resourcing, clinical management, standards, policies and procedures, rests in the ED within the emergency medicine governance structure. Other specialties and departments may contribute to ED SSU clinical pathways and guidelines, but do not have overarching governance roles.

Models of care for ED SSUs should be based on a clear description of:

- Admission and discharge processes
- Procedures for the management of clinical conditions
- Skill and resourcing requirements to ensure quality care for patients, including inpatient specialties, diagnostics, allied health and community health services support.

Emergency department SSUs are not a temporary ED overflow area. They should not be used for admitted patients who are waiting for an inpatient bed, or those who are waiting for treatment in the ED prior to medical assessment. As such, it is essential to closely monitor the designation and use of ED SSUs, with well-defined admission criteria and maximum length of stay. This is to limit the potential for reinterpretation of the function of the ED SSU.

1 Local terminology may be applied to ED SSUs, e.g. ED Observation Ward or Unit, Clinical Decisions Unit, etc.
5. **Staffing**

Emergency department SSUs will be staffed by medical, nursing, clerical and allied health staff with appropriate skills and knowledge to manage ED SSU patients. FTE for each will be designated specifically for the management of the ED SSU.

5.1 **Medical staff**

As a minimum, ACEM recommends that ED SSU medical staffing incorporates the following:

- Clinical governance as delegated by the Director of Emergency Medicine
- Sufficient medical staffing in number and seniority to provide timely, quality care
- Admission of patients under the care of a designated medical officer with delegated admission and discharge authority
- Review and handover of patients at least once every clinical shift
- Supervision of practice for junior medical staff who are rostered to the ED SSU at the same level as other clinical areas of the ED
- A clearly identified primary contact doctor for each patient, who is accessible to ED staff.

5.2 **Nursing and allied health staff**

The ED SSU nursing staffing should be integrated with other clinical areas of the ED. Wherever possible, staff should work shifts across all clinical areas.

The number, skill set and seniority of nursing staff must meet established requirements for ward staff, taking into consideration capacity, acuity and ED SSU role delineation.

The ED SSU should also have access to dedicated allied health professionals with the appropriate skills and knowledge to provide early intervention and discharge planning, and prevent non-medical admission of patients. Allied health services should be delivered as part of a multidisciplinary team, with staffing levels and skill mix varying in response to the clinical needs of the facility. Allied health services should be available for extended hours, on weekends and/or on-call.

5.3 **Non-clinical staff**

The ED SSU should have support for clerical, administrative and reception duties to ensure efficient and effective admission and discharge processes. Consultation with Indigenous Liaison Officers should be offered to patients who identify as Aboriginal and/or Torres Strait Islander, and Māori and/or Pacific Islander.

6. **Admission criteria**

The College recommends the following criteria to determine those patients that are appropriate for ED SSU admission.

6.1 **Patient inclusion criteria**

Emergency department SSUs are appropriate for ED patients who:

- Are clinically stable
- Have low to moderate risk symptoms
- With optimal diagnostic support and clinical management, are expected to be discharged within a four to 24 hour period
- Have a clear, documented management and disposition plan endorsed by the senior clinical decision maker, which includes planned and ongoing patient reviews, and assessment and reassessment.
Examples of patients who may be appropriate for ED SSU admission are as follows:

**Patients requiring observation for**
- Post minor head injury (GCS 14-15)
- Post procedure monitoring
- Post sedation monitoring
- Toxicology.

**Patients requiring treatment for**
- Renal colic
- Short-term rehydration
- Uncomplicated urinary tract infection
- Stabilisation of acute pain management for minor trauma.

**Patients requiring social and clinical support arrangements**
- Patients for whom it would be unreasonable to discharge and send home alone late at night (e.g. elderly, anxious, physical disability).

### 6.2 Patient exclusion criteria

The criteria for patient exclusion from an ED SSU should be consistent with the following principles:

- Anticipated duration of treatment is more than 24 hours
- The patient is admitted under the care of an inpatient team
- The patient has been transferred to the hospital for admission under care of an inpatient team
- The patient is clinically unstable
- The patient has complex care needs, which are unable to be met in the ED SSU
- The patient remains undifferentiated and has an unclear management plan
- Patients are not be admitted to ED SSUs for the sole purpose of meeting time-based targets.

Some patients are unsuitable to be cared for in an ED SSU, unless appropriate resources are available for their management. These include patients who require:

- Advanced physiological monitoring
- Increased supervision, e.g. behavioural disturbance
- Assistance in transfers beyond the staffing capacity.

### 6.3 Toxicology patients

ED SSUs can be used to manage toxicology patients with the support of the local toxicology service. The length of stay for these patients may be extended, in accordance with the anticipated duration of specific toxidromes.

### 6.4 Risks of ED SSUs

Due to ED overcrowding, sometimes inappropriate patients are admitted to ED SSUs. ACEM does not support the use of ED SSUs as a way to ameliorate ED overcrowding and access block.
7. Design considerations

The size and design of an ED SSU are informed by a number of factors:

- The size of the hospital, and the number and case-mix of ED presentations
- The number of inpatient and rehabilitation beds available within the hospital
- The available workforce, including specialist, doctor and nursing staff
- The availability and capacity of existing community-based services.

The number of the required ED SSU treatment spaces varies with the size and function of the individual unit, taking into account seasonal variation, projected changes in demand for services and in response to changes in models of care.

Emergency department SSUs are designated inpatient care areas and, as such, should have facilities and amenities similar to inpatient wards (e.g. design, environment, activity, structure and provision of nursing care).

The following are essential ED SSU design criteria:

- The design must allow for physical separation but close proximity to the ED
- Static beds with oxygen and suction
- Separate beds to the ED bed base
- A dedicated staff station and adequate desk space for medical, nursing and other staff
- Dedicated patient toilet and shower facilities
- Appropriate separation of paediatric and adult patients in mixed presentation EDs.

Additionally, the following should be considered:

- At least one room with an ensuite for the management of short-term infectious patients
- A lounge or recliner chair area where patients who do not require a bed can be treated
- Storage facilities, as well as clean and dirty utility located in the unit (or in close proximity) to maximise productivity and efficiency
- Access to a kitchen area/beverage bay.

8. Key performance indicators

ACEM recommends the following ED SSU key performance indicators:

- < 15% of patients admitted to an ED SSU should be transferred to an inpatient ward
- < 10% of patients admitted to an ED SSU should have a length of stay > 24 hours
- Percentage of patients admitted to the ED SSU with a combined ED and ED SSU length of stay < 4hrs.
- Patients with an ED SSU length of stay <1 hour must have documentation confirming the admission was appropriate and the care provided.

Subject to ongoing research, analysis, discussion and review as required.
9. Related documents

- S12 – Statement on the delineation of emergency departments
- G15 – Emergency department design guidelines
- G23 – Guidelines on constructing and retaining a senior emergency medicine workforce

9.1 The College acknowledges the following guidelines in the development of this document:

- New Zealand Ministry of Health Paper – Streaming and the use of Emergency Department Observation Units and Inpatient Assessment Units (2017)
- Queensland Health Guideline – Emergency Department Short Stay Unit Guideline (2014)
- Council of Australian Governments National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services

10. References

