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Emergency Department Short Stay Units

Guideline

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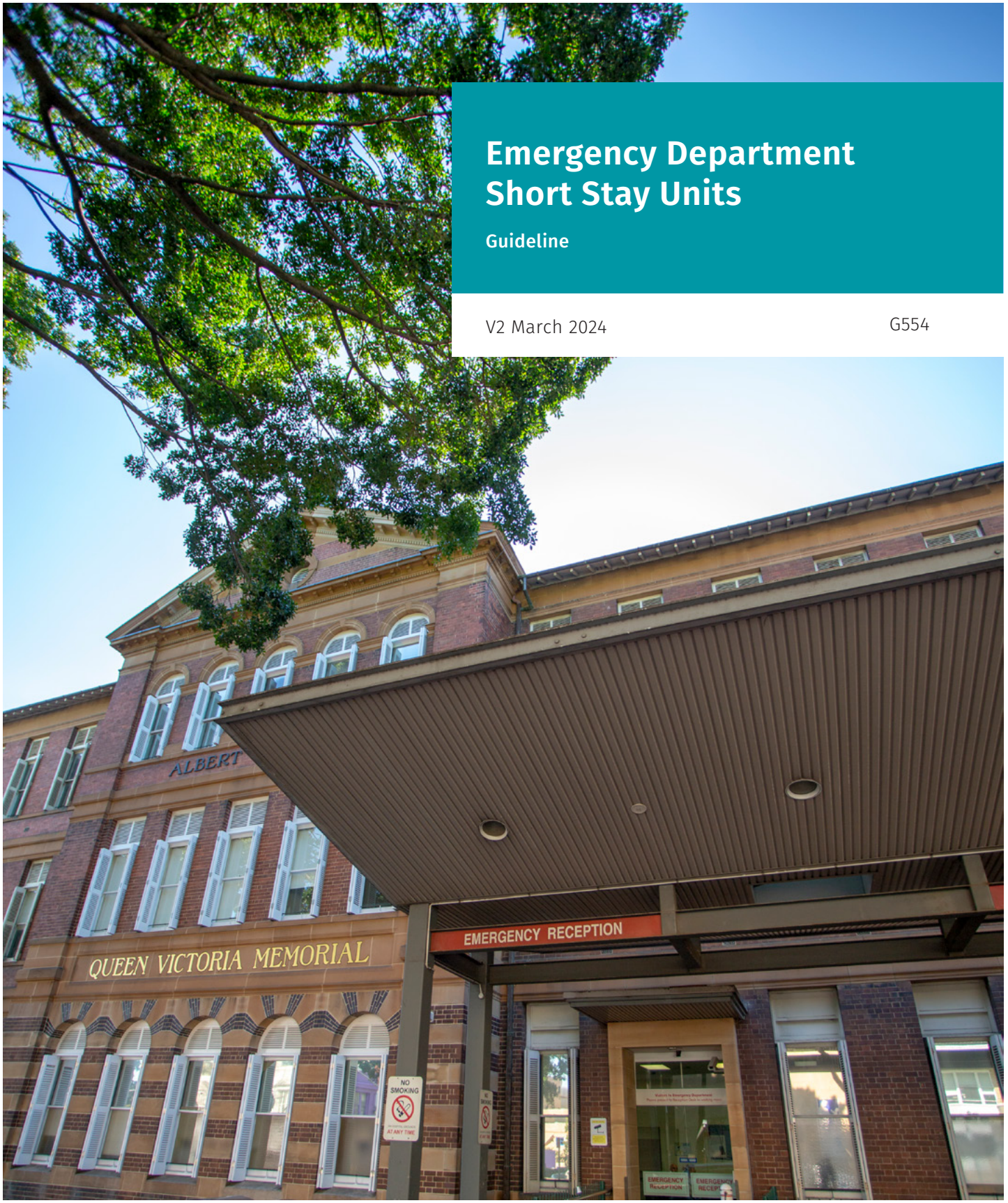

Document review

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Version	Date	Revisions
1	Mar 2019	New document
2	Mar 2024	Revised in alignment with changes to other ACEM standards, and to include contemporary referencing.

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1. Purpose and scope

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 (ED) short stay unit.

In scope for this policy are all clinical and administrative staff of Australian and Aotearoa New Zealand EDs and administrative staff external to the ED, including senior hospital executives and administrators. Mental health and/or alcohol and other drugs assessment units are out of scope for this guideline.

2. Defining an emergency department short stay unit

An emergency department short stay unit (ED SSU or 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. ED SSUs would be available in EDs delineated at Levels 4-6 in the ACEM Statement on the Role Delineation of Emergency Departments and Other Hospital-based Emergency Care Services. (1)

SSUs 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). ED 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 work.

SSUs 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 (LOS) 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.

SSUs 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 LOS 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 or have been inappropriately discharged. (2) SSUs 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.

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 referral pathways for community-based support

SSUs are not an 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 LOS (defined as starting from the time of physical arrival in SSU until physical departure). This is to limit the potential for reinterpretation of the function of the ED SSU. (3)

* Local terminology may be applied to ED SSUs, for example ED Observation Ward or Unit, Clinical Decisions Unit, Short Term Treatment Areas.

3. Staffing

ED SSUs will be staffed by medical, nursing, allied health and clerical staff with appropriate skills and knowledge to manage ED SSU patients. Operational models for ED SSUs are highly variable. Specific staffing needs for ED SSUs should be considered separately from the recommended minimum staffing requirements of the ED provided in Section 6 of the ACEM Guidelines on Constructing a Sustainable Emergency Department Workforce (4) if the ED is supporting an SSU.

3.1 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 officers* 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.

3.2 Nursing and allied health staff

The ED SSU nursing staffing (5) should be integrated with other clinical areas of the ED. Wherever possible, staff should work shifts across all clinical areas.

The number, skillset, 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.

3.3 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.

4. Admission criteria

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

4.1 Patient inclusion criteria

ED 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; and
- 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.

* Junior medical officers (JMOs) are doctors in the early phase of their career who work under supervision from more experienced medical practitioners. They usually rotate between clinical services, including EDs. Job titles vary across health services and include Resident Medical Officer (RMO), Senior Medical Resident Officer (SRMO), and Hospital Medical Officer (HMO).

Table 1: Examples of patients who may be appropriate for ED SSU admission

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, for example elderly, anxious, physical disability.

4.2 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 to 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, for example behavioural disturbance; and/or
- assistance in transfers beyond the staffing capacity.

4.3 Toxicology patients

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

4.4 Inappropriate Use

Due to ED flow problems, patients are sometimes inappropriately admitted to ED SSUs. ACEM does not support the use of ED SSUs purely for the purposes of ameliorating ED overcrowding and access block.

5. Design/amenities

ED SSUs are designated inpatient care areas and should have facilities and amenities similar to inpatient wards.

5.1 Spatial requirements

The size of an ED SSU is informed by several factors:

- The size of the hospital, and the number and case-mix of ED presentations.
- Projected changes in demand for services and in response to changes in models of care.
- 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.

5.1 Functional requirements

The following are all essential ED SSU design criteria:

- The design must allow for physical separation but proximity to the ED.
- Static beds with oxygen, suction, and ready access to resuscitation equipment.
- 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.

5.2 Other considerations

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 proximity) to maximise productivity and efficiency.
- Access to a kitchen area/beverage bay.

6. Key performance indicators/monitoring considerations

ACEM recommends the following ED SSU key performance indicators*:

- < 10% of patients admitted to an ED SSU have a LOS > 24 hours
- < 15% of patients admitted to an ED SSU are transferred to an inpatient ward

EDs should also monitor the percentage of patients admitted to the ED SSU with a combined ED and ED SSU LOS < 4hrs.

Patients with an ED SSU LOS (from physical arrival until departure) <1 hour must have documentation confirming that the admission was appropriate and outlining the care provided.

* Subject to ongoing research, analysis, discussion, and review as required.

7. Acknowledgments

ACEM acknowledges the following guidelines in the development of this document:

- NSW Ministry of Health. Policy Directive. Emergency Department Short Stay Units (NSW Health: Sydney; 2014)
- Manatū Hauora New Zealand Ministry of Health. Streaming and the use of Emergency Department Observation Units and Inpatient Assessment Units (Manatū Hauora: Wellington; 2017)
- Queensland Health. Guideline. Emergency Department Short Term Treatment Areas (Brisbane: Queensland Health; 2022)
- Council of Australian Governments. National Health Reform Agreement. National Partnership Agreement on Improving Public Hospital Services (Canberra: COAG; 2017)

8. References

1. Australasian College for Emergency Medicine. Statement on the Role Delineation of Emergency Departments and other Hospital-based Emergency Care Services. Melbourne: ACEM, 2023.
2. Jelinek G, Mountain D, O'Brien D, Rogers I, Wilkes G, Wenban J, et al. Re-engineering an Australian emergency department: can we measure success? J Qual Clin Pract. 1999;19(3):133-8.
3. Hession M, Forero R, Man NW, Penza L, McDonald W. Gaming National Emergency Access Target performance using Emergency Treatment Performance Definitions and Emergency Department Short Stay Units. Emerg Med Australas. 2019 Dec;31(6):997-1006.
4. Australasian College for Emergency Medicine. G23 Guidelines on Constructing a Sustainable Emergency Department Medical Workforce (Melbourne: ACEM; 2023).
5. Australasian College for Emergency Medicine. P67 Extended Role of Nursing and Allied Health Practitioners Working in Emergency Departments (Melbourne: ACEM; 2022).

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