SHORT STAY MEDICINE

A quick guide on how to use the SSOU

Why do we need observation units?

- Health care has been shifting from inpatient to outpatient setting.
  - Efficiency-based funding is the main driver

- Traditional length of stay:
  - ED 2-6 hours.
  - Inpatient >24 hours.
- This leaves a gap => SSOU.

Benefits of SSOU

- Ultimate aim is to improve patient flow through ED:
  - Increase turnover
  - Reduce ED length of stay
  - More timely ambulance offload
  - Increase overall hospital bed capacity
- Safety net function against inappropriate discharge
- More comfortable environment than ED.

- For most ED patients we can determine a patient's trajectory within the first 2 hours.

- There is a small subset of patients for whom this is not adequate:
  - Too sick to go home but not sick enough to be admitted.

- Other characteristics:
  - Potentially serious condition but diagnosis can't be reliably made within a few hours.
  - Pressing psychological or social problems that do not justify admission but take a while to sort out.

- These patients have unique needs:
  - Observation
  - Specialist assessment and diagnosis
  - Short-term high-level management

7 principles of observation units

1. Focused patient care goals:
    1. Diagnostic
    2. Therapeutic
    3. Psychosocial
2. Limited duration and intensity of service
3. Appropriate hospital location
4. Appropriate staffing, skills and equipment

7 principles of observation units

5. Provisions for continuing care in an outpatient setting

6. Intensive managerial review

7. Economical service

Local usage patterns

(2000-2009 Melbourne figures from Lowthian et al EMA 2012;24:610-616)

- Overall approx 25% of ED patients need admission:
  - 2/3 inpatient, 1/3 SSOU
  - If age >70y, 55% need admission
- Demand is growing:
  - ED presentations increasing by 3.6% per year
  - Disproportionate rise of SSOU admissions
    - Risk adverse medical culture
    - Major changes of process of care for certain common conditions
    - More SSOU availability
    - Improved diagnostic and treatment capability preventing inpatient admissions
    - Time-based ED discharge targets

Local usage patterns

(2000-2009 Melbourne figures from Lowthian et al EMA 2012;24:610-616)

- Mortality rates:
  - Same day/overnight: 9 per 1000 ED presentations
  - Multiday stay: 33 per 1000
- SSOU disposition destination:
  - Home 82%

The ideal SSOU patient

- Single system acute problem with a low associated mortality rate.
- High likelihood of successful discharge within 24 hours.
- Clear working diagnosis and specific management plan stated:
  - diagnostic or management pathways helpful
- Clear delineation of clinical responsibility.
- Impeccable documentation.

Examples of appropriate admissions

Condition	SSOU action
Hyperemesis gravidarum	IV rehydration and antiemetics
Migraine	Termination therapy +/- rehydration
Awaiting transfer	Condition diagnosed, patient stable, and treatment initiated or completed
Low risk chest pain	Initial vitals, enzymes, ECG normal. For serials.
Low risk toxicology pt	NAC infusion / can't discharge at night
Simple low back pain	Analgesia / mobility
Post procedure	Recovering from procedural sedation
Medically clear, expected discharge, awaiting other non-inpatient service	ECATT, social work, ED physio, ACAS

Inappropriate SSOU use

Physician can't decide ('indecision me molesta')
Lack of appropriate initial ED treatment / waiting for the day team
Elderly patients with abdominal pain
Children
Pregnant >20weeks
Sexual assault
Disruptive patient
Non-emergency procedures that can be better done in day surgery
Toxicology patient with altered mental state or abnormal vitals
Temporary ED overflow area
Storage for patients awaiting inpatient bed.
Overflow area for other specialty services.
Solely to improve a KPI (4 hour rule!)

Points to consider

- KPIs:
  - Failure (patient goes on to need inpatient admission
    - Acceptable failure rate 10-15%.
  - Breach (SSOU stay >24 hours)
  - Bounce back (within 5 days)
    - Review of these patients will get you good material for ED M+M meeting.
  - Plus the usuals: length of stay/LAMA/etc..

- Funding is allocated if the patient is actually managed:
  - Document what you do for the patient
  - e.g. ~~Observation~~ Telemetry

Business rules

- Policies and guidelines:
  - Strong adherence to operational policies.
  - The most effective SSOU model pulls patients from the ED.
  - Use of evidence-based guidelines/pathways.
- Culture:
  - Multidisciplinary focus
  - Proactive planning and intervention
- Staff and management:
  - Dedicated nursing and medical staffing with appropriate skill sets.
  - Clearly defined clinical governance

Discharge from SSOU

- Treat this as you would an inpatient admission:
  - Decisions to admit and discharge are ultimately made by the nominal treating physician. They must be informed, must accept the patient, and must review the patient during the stay.
  - Discharge can be nurse-initiated on the completion of specific and clearly-documented management goals.

- Discharge summary:
  - Pre-written on admission to SSOU.
  - Updated at SSOU discharge (intern can do this)
  - Co-signed by treating physician.

- Use of nursing discharge checklists strongly encouraged.