Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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Health Sector Workers Network

Email: fyi-request-6957-5b6a9c2e@requests.fyi.org.nz;

Dear Health Sector Workers Network

RE Official information request CDHB 9756

I refer to your email dated 7 December 2017, requesting the following information under section 12 of the Official Information Act from Canterbury DHB.

1. **What are the percentages of patients presenting to the Emergency Departments that were admitted, discharged or transferred within six hours of presentation for each month of the year July 2016 to June 2017?**

Please refer to **Table one** (below) for the percentage of patients presenting to the Canterbury DHB Emergency Departments that were admitted, discharged or transferred within six hours of presentation for each month of the year July 2016 to June 2017.

Table one: Percentage and number of patients in Emergency Departments admitted, discharged or transferred within six hours.

Month / Year	Ashburton Hospital ED		Christchurch Hospital ED		Total CDHB	
	%	Number of patients.	%	Number of patients.	%	Number of patients.
1/07/2016	95%	439	93%	7742	93%	8181
1/08/2016	91%	467	93%	7738	93%	8205
1/09/2016	90%	417	94%	7586	94%	8003
1/10/2016	94%	483	96%	7725	96%	8208
1/11/2016	92%	441	95%	7641	95%	8082
1/12/2016	93%	571	95%	7953	95%	8524
1/01/2017	90%	496	95%	7589	94%	8085
1/02/2017	92%	485	95%	7031	95%	7516
1/03/2017	93%	483	95%	7682	95%	8165
1/04/2017	94%	485	95%	7360	95%	7845
1/05/2017	93%	503	96%	7719	96%	8222
1/06/2017	96%	503	94%	7539	94%	8042

2. **Please provide any DHB policy concerning guidelines and use of the ED observation unit? By "ED observation unit", we are referring to the usage defined by the Ministry Of Health in the paper Streaming and the use of Emergency Department Observation Units and Inpatient Assessment Units.**

Please find attached as **Appendix 1**, the Canterbury DHB Emergency Observation Guidelines.

3. **What percentage of total ED presentations for each month of the year July 2016 to June 2017 utilised the ED Observation unit?**

Please refer to **Table two** (below) for the percentage of total Emergency Department presentations for each month of the year July 2016 to June 2017 that utilised the Christchurch Hospital ED Observation Unit.

Table two: Percentage and number of patients admitted to Christchurch Hospital ED Observation Unit.

Month / Year	%	Number of patients admitted to ED Observation Unit.
1/07/2016	9%	723
1/08/2016	10%	752
1/09/2016	9%	717
1/10/2016	10%	808
1/11/2016	12%	880
1/12/2016	10%	822
1/01/2017	12%	875
1/02/2017	11%	779
1/03/2017	11%	855
1/04/2017	11%	812
1/05/2017	11%	876
1/06/2017	12%	872

4. **What percentage of patients utilising the ED observation unit were discharged home from this location for each month of the year July 2016 to June 2017?**

Please note: Ashburton Hospital does not have an Emergency Department Observation Unit.
Please refer to **Table three** (below) for the percentage of patients utilising the Emergency Department Observation Unit who were discharged home from this location for each month of the year July 2016 to June 2017.

Table three: Percentage and number of patients admitted to Christchurch Hospital ED Observation Unit who were discharged from there.

Month / Year	%	Number of patients discharged from ED Observation Unit.
1/07/2016	85%	614
1/08/2016	86%	647
1/09/2016	82%	585
1/10/2016	86%	695
1/11/2016	87%	765
1/12/2016	87%	712
1/01/2017	86%	750
1/02/2017	85%	663
1/03/2017	86%	736
1/04/2017	83%	677
1/05/2017	82%	722
1/06/2017	82%	719

5. **What is your DHB's expected length of stay for the patients utilising the ED observation unit?**

Our expectations for patients in ED Observation Ward, arriving between 0900 – 2259 is a Length of Stay (LOS) <8hrs, and for those arriving between 23:00 and 08:59 a Length of Stay (LOS) <12hrs.

6. **What percentage of patients for each month of the year July 2016 to June 2017 exceeding the length of stay given in question 5?**

Please refer to **Table four** (below) for the percentage of patients for each month of the year July 2016 to June 2017 exceeding the length of stay given in Question 5.

Table four: Percentage and number of patients 'exceeding' expected Length of Stay (LOS) in Christchurch Hospital Emergency Department Observation Unit.

Month / Year	%	Number of patients exceeding LOS in ED Observation Unit.
1/07/2016	15%	108
1/08/2016	16%	121
1/09/2016	13%	96
1/10/2016	14%	116
1/11/2016	12%	107
1/12/2016	11%	88
1/01/2017	14%	120
1/02/2017	11%	84
1/03/2017	11%	91
1/04/2017	12%	97
1/05/2017	10%	90
1/06/2017	11%	91

I trust that this satisfies your interest in this matter.

Yours sincerely

Carolyn Gullery
General Manager
Planning, Funding & Decision Support

Emergency Observation (ED Obs) guidelines

Table of Contents

1 Standard

ED Obs is an acute care area of the Emergency Department that provides treatment, support and a period of observation, to patients who are expected to be discharged home.

A plan from the medical staff for the patient is expected before admitting a patient to ED Obs.

Patients may be admitted to ED Obs when the pandemic Red Zone Plan is implemented.

ED Obs KPIs

- Use of ED Obs: 10-15% of the total ED presentations (Ministry target = < 20%)
- Conversion from ED Obs to inpatient admissions: < 15% (Ministry target = < 20%)
- LOS: 90% to be discharged or admitted within 12 hours (longer if patient admitted during the evening) (Ministry target = 80%)

2 Scope

- ED and Casual Pool Nurses
- ED Medical Officers
- ED Hospital Aides
- ED Clerical Officers

3 Associated documents

Ministry of Health (2014) Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand. Wellington

Hospital HealthPathways

Volume 10 – Infection Control and Prevention

Volume 11: Clinical Policy and Procedure Manual

- Transfer of patients policy
- Transfer of patients to Christchurch Hospital from other CDHB and non CDHB hospital policy

ED Location Manual:

- 7.01 Models of care
- 7.02 ED shift management standards – ED overload (EDOD)
- 7.05 Patients waiting referral to inpatients team
- 7.06 Requesting an inpatient bed
- 7.07 Transfers from ED and decision to escort
- 7.15 ED Obs patient returning to ED
- 7.19 Discharge planning
- 7.24 Red zone pandemic planning
- 7.24b Influenza pandemic – red zone assessment
- 7.26 Guidelines of ED nurse roles by treatment area
- 8.02 Imaging Guidelines

- 8.03 Drug Guidelines
- 8.03c Adult antiemetic guidelines
- 8.08 Guidelines for care of the deceased patient in ED
- 8.29 Policy for care of the patient undergoing a procedural sedation
- 8.33 CT imaging overnight

Telephone Notification to ED (C21007)
ED Record (C110002)
Admission Form (Green Sheet) (C110001)
Smoking Cessation online learning
Pathways:

- Abdominal pain pathway (C240006)
- Acute heart failure pathway (C240095)
- Acute pyelonephritis pathway (C240078)
- Adult asthma pathway (C240004)
- Adult mild head injury pathway (C240092)
- AF in ED pathway (TBC)
- Aggression de-escalation pathway (TBC)
- Alcohol intoxication pathway (C24008A)
- Assessing Competence In Non-Consenting Patients Pathway (C240358)
- Back pain pathway (C240091)
- Cardiac chest pain pathway (C240005)
- Community acquired pneumonia pathway (C240144)
- COPD pathway (C240081)
- Eating disorders patient pathway (C240303)
- Epistaxis pathway (C240030)
- Macroscopic haematuria pathway (C240329)
- Mental health assessment pathway (C240093)
- Palliative care interim care plan TB(C)
- Palliative care pathway (with referral) T(BC)
- Pelvic inflammatory disease pathway (C240141)
- Probable peritonitis in CAPD patients pathway (C240145)
- Procedural sedation clinical pathway (C270078)
- PV bleeding pathway (C240143)
- Renal colic pathway (C240080)
- Suspected TIA pathway (C240034)
- Testicular pain pathway (C240087)
- Urinary retention pathway (C240083)

4 Indications for admission / placement into ED Obs

- Patients suitable for ED Obs should be identified as early as possible.
- **Suitable patients include those who have been seen by and remain under the care of ED and are likely to be discharged following a period of treatment and observation.**
- Junior medical staff need to consult with SMO about the suitability of patient for ED Obs.
- Senior nursing staff (ACNM) can direct junior medical staff to admit patients into ED Obs.
- A plan from the medical staff for the patient is expected before admitting to ED Obs, including analgesia, antiemetic, IV fluid, x-ray as required, and other requirements such as plan for observation, NBM status, and ability to mobilise.
- Patients admitted generally need to be SMO cleared before discharge. This may be after discussion with the RMO caring for the patient.
- Patients waiting for speciality review may be placed in ED Obs while they await for review in order to create capacity in other ED areas according to capacity plan (not admitted into ED Obs to ensure transparency of use)
- Children can be admitted to ED Obs at the discretion of SMO and ACNM.
- All patients discharged from ED Obs require a discharge summary to be completed by medical staff. Speciality patients who have been admitted into ED Obs require a discharge summary to be completed by the speciality team.

5 Types of patients suitable for ED Obs

a. Head injury

- The patient is generally observed for four or more hours post injury
- Complete the adult mild head injury pathway (start one if not already in place)
- Complete a neuro observation sheet (this includes GCS, limb movement and pupil monitoring). See adult mild head injury pathway for ongoing nursing care including frequency of observations
- Any abnormal signs need to be reported to the doctor looking after the patient or the SMO

Prior to discharge give:

- Head injury advice sheets
- ACC
- Prescription
- Refer to Concussion Clinic as clinically indicated-back to the GP in the first instance who can then refer on if needed. Most will settle down without concussion clinic

b. Post procedural sedation

- The patient is to be monitored until fully awake
- May eat and drink and be mobilised as condition allows (contact Physiotherapist if clinically indicated e.g., after a hip relocation and if needed)
- Review by medical staff before discharge

Refer to Procedural Clinical Pathway

c. Alcohol intoxication

- Follow the alcohol intoxication pathway
- Consider the need for Alcohol Withdrawal Scale and ensure medication is charted as needed
- This group is high risk for seizure, close observation and access to emergency equipment is necessary
- Follow-up should be arranged with Social Work team in the morning and is mandatory for underage patients

d. Overdose

- Treatment and observation is dependent on the drug taken
- Follow-up ECGs and / or blood levels may need to be taken, as well as regular vital sign recording
- Organise Static Guard watch, if required. Ensure the guard has the observation form and understands the level of observation required (Security staff will also ask that their request form is signed).Two patients may be able to be observed by one security guard depending on the level of observation required.
- All patients should have had Psychiatric Consult Liaison Team (PCLT) assessment prior to admission
- Follow up with CR must occur before discharge
- Clothes and belongings should be labelled and securely stored away from patient (locked in the drug room) until they are deemed safe to leave by CR

e. Patients awaiting review by Crisis Resolution

- Admit under Emergency Team even if the patient is medically clear whilst they are waiting for review from CR.
- Organise Static Guard watch, if required. Ensure the guard has the observation form and understands the level of observation required (Security staff will also ask that their request form is signed).Two patients may be able to be observed by one security guard depending on the level of observation required
- The CR patient is to remain in a hospital gown
- Clothes and belongings should be labelled and securely stored away from patient (locked in the drug room) until they are deemed safe to leave by CR

f. Renal colic

- Ensure regular / PRN analgesia charted prior to admission and give as charted
- Encourage oral fluids or give IV fluids if vomiting
- Check CT scan appointment – patients who have stayed overnight can usually go to radiology at 0700 for CT.
- Follow up CT results
- Complete renal colic pathway
- The Urology Registrar should review these patients at 0900h (document if this does not occur)

g. Post-ictal

- Hourly vital sign recordings and neuro observations required

- Be prepared for further seizure activity and have resuscitation equipment available. (Know where airway, ambu-bag, suction, anticonvulsant medications etc. are stored)
- Check area for hazards

h. Chest pain

- Patients identified as suitable according to the Low Risk Cardiac Chest Pain Pathway need to follow pathway for follow up blood tests and exercise tolerance test (ETT)

i. Patients pending discharge or transfer

Discharged patients

- Some patients from other areas of ED who are waiting for a ride home may sit in ED Obs to be collected.
- These patients will not be admitted to ED Obs but have ED Obs in loop 17 of the computer screen

Patients who are waiting for an ambulance transfer

- These include patients who sometimes wait an extended time for an ambulance and may require nursing input and should be admitted into ED Obs.

Patients who need to be admitted under an inpatient team following ED review:

- General Medical team: contact the AMAU ACNM who will arrange a bed
- Other teams: order the bed through the duty manager **then ring the ward to inform them of the transfer and provide handover**
- The green sheet is amended, the patient is then transferred to the new ward, and on the computer they are transferred to the new ward)

j. Isolation

- EO6 and EO7 can be used as the first choice for isolation patients. Other cubicles can be used, with curtains around, as isolation rooms
- There are two Isolation toilets available to EO patients. Place signs on the doors to identify them if they are in use for isolation
- Ensure Personal Protective Equipment (PPE) is outside door and use it
- Display open Isolation Flip Chart on door (or curtain)
- Use red linen trolley with dissolvable liner and yellow rubbish bag, as necessary
- Order Terminal Clean through operator or page OCS and fill out maintenance request book

k. Wound management

- Patients requiring wound care can have their wound care undertaken and managed in ED Obs

l. Back pain

- Sinister causes have been considered-see pathway
- Usually patients with mechanical back pain who require analgesia and mobilisation

m. Patients who primarily have social issues

- Ensure early Social Work / MDT referral

6 Staffing

a. Nursing

- x3 RNs per shift* comprised of 1 Team Leader and 2 nurses
- x1 hospital aid working between ED Obs and WU

*Night shift - the third RN will commence the shift in WU and remain there until 0300 or when it closes (whichever is the earlier time), then go to ED Obs

b. Medical

- SMO/RMO – responsible clinician

c. Clerical

- Clerical cover 0915-2300

d. Hospital Aid

- x1 HA morning and afternoon working across WU and ED Obs
- x1 HA night shift working across whole of ED

7 Nursing team leader role and responsibilities

Step	Action / expectations
1.	**Patient load** The Team Leader on the morning and afternoon shifts does not have a patient load. On the night shift the team leader will share the patient load until the 3rd RN joins the team .Patient flow, support and supervision are the key responsibilities of the Team leader.
2.	**Start of shift** • Receive handover from departing nurses • Check the allocation, staff skill-mix and allocate the patients. On night shift locate the 3rd nurse and liaise with them. • Know which doctors have responsibly for the patients in ED Obs • If there are concerns about skill mix or staffing, then discuss this with the ACNM • Check nurses allocated to bay/equipment checks • Identify the order in which patients should be reviewed by the SMO to facilitate early discharge of patients who are ready to go quickly
3.	Patient Flow Patient flow is a key role of the team leader in ED Obs. This is facilitated through: Inflow of patients from Resus Monitored, Work Up and Ambulatory: • Use the Bed Management Screen to 'pull' patients • Use ED Queue Screen to identify patients suitable for ED Obs • Liaising with Resus Triage nurse, WU and Ambulatory Team leaders to identify suitable patients for ED Obs. • Liaising with medical staff regarding all patients who have been seen and remain under the care of ED and are likely to be discharged as to their suitability for ED Obs. • Seek handover from nurses re patients coming to ED Obs and arrange transfer • Using the dashboards to assist with patient flow management • Consider the patients being admitted to ED Obs in the early evening to ensure there will be capacity overnight. Outflow Discharged from ED Obs • Create bed capacity by organising discharging patients into chairs • Ensuring patients have a discharge letter on leaving ED Obs • Assisting with transport options-liaise with and arrange ambulance/taxi/family member/ rest home Transfers to IP wards • Ensuring DNM phoned with bed request. • Ensuring ward rung with handover once bed allocated. Communication • Liaise with and keep ACNM and SMO informed of ED Obs activity and capacity
•	• **Supervision and clinical oversight** • Provide support and clinical expertise to the RNs working in ED Obs. • Follow up on treatment plan and medication prescribing • Update the computer as necessary • Relieve meal breaks

Step	Action / expectations
4.	**Drug check** • Undertake drug check at the end of each shift
5.	**Observation /Specialiing (Mental Health)** • Review the observation/specialising requirements of patients

8 Nursing team responsibilities

Step	Action / expectations
1.	**Patient care considerations** • Organise patients for CT to go up to x-ray by 0700 (weekdays) 0800 (weekends) • Ensure analgesia / medications have been given for morning assessments • Check that follow up ECG and or blood tests have been done if required • Liaise with and organise list for OT, Physio, PES, Social Worker ,Maori Health worker requirements for patients • Complete risk assessment forms • Provide hydration and nutrition • Communication with a multidisciplinary team • Follow up organised in the community as clinically indicated
2.	**Safety checks – EACH shift** • Check that you know where alarms are located • Ensure the area is stocked and prepared for the shift ahead: check nurses allocated to equipment checks are aware of their responsibility: • The defibrillator should be checked daily as per check list and signed off, including that it is plugged into red essential switch power outlet, so that it remains charged in an electrical failure • There are two other ambu-bags and assorted airways • Check other safety equipment located in ED Obs • Check each cubicle that there is O_2 and connectors and suction equipment that is working • Check fire exits are clear of obstruction
3.	**Medications** • Ensure regular and adequate analgesia is given to post injury patients, especially before mobilisation with physiotherapist, and even though patients may feel pain free at rest • Ensure usual medications are given as indicated – especially Parkinson's medications prior to mobility assessments
4.	**Smoking cessation** • All patients admitted to ED Obs are to have the smoking cessation section of the nursing risk form or the smoking cessation on the discharge note completed. • The Ministry of Health requirement is that an intervention is offered to the patient who smokes. This can simply be giving the patient a smoke free pack of information (without the prescription) to view at a later date. • All nursing staff can do the online course, and earn education hours, about smoking cessation and be deemed suitable to prescribe nicotine replacement gum, lozenges' and patches.
5.	**Meals** • Ten meal boxes supplied three times a day plus some boxed sandwiches. Order more as required.

9 Medical team responsibilities

Step	Action / expectations
1.	**Admissions** The following documents should be completed by the admitting doctor, prior to admission to EO: • Plan of care – all patients • Drugs charted – as clinically indicated • Pathway commenced – as clinically indicated • Imaging requests – as clinically indicated
2.	**Discharges** The following documents should be completed by the discharging doctor, prior to discharge from EO: • Discharge summary – all patients • ACC – as clinically indicated • Advice sheet(s) – as clinically indicated • Prescription – as clinically indicated • Referrals – as clinically indicated

10 Hospital Aide team responsibilities

Step	Action / expectations
1	**Cleaning and stocking** • From 06.30h to 08.30h the hospital aides' time is dedicated to cleaning and stocking the EO or Work Up equipment. Restock and clean as required at other times • Check CR interview rooms
2	**Care provision** • At other times the hospital aides may assist the nurses to provide personal or nursing cares. • Transfer patients to ED Obs as requested.

11 Clerical team responsibilities

Step	Action / expectations
	CLERICAL COVER 9.15AM – 11PM
	General duties • Telephone enquires • Assist Team Leader • Update screens • Restock printers • Keep all patients documentation in tidy order • Assist Dr/Nurse with data entry • Fax referral • Fax any Discharge documentation

Step	Action / expectations
	• Track Clinical Record • Transfer patients on PMS to wards and ensure all paperwork is collated and send with the patient • Put any incomplete HCS notes in the Duty Room for the doctor to complete
	Discharge • Discharge patients on PMS • Prepare discharge documentation • Fax to GP any relevant information • Track Clinical Record • Order Orderlies • Order transport for ambulance patients • Photocopy all notes for Hillmorton patients • ACC – check complete • Organise OCS to do terminal cleans • Check filing baskets complete/incomplete • 2.45pm – move to assist Resus “high chair” person with entering change of nurse codes