Transferring to another hospital

Some patients require transfer to other hospitals because they need specialist care not available on this site (e.g. head trauma, fractures). Rarely, patients will require transfer to another hospital because of lack of beds here.

Never transfer ill patients, for example those with unresolved chest pain, severe asthma or impaired consciousness unless a properly trained and equipped doctor accompanies them. If there is no one available to transfer such patients - speak to one of the Emergency Department consultants or StR. You cannot leave the Emergency Department. A senior ED doctor or anaesthetist should transfer patients who may require airway management or ventilatory support. Ill children should be generally be transferred by paediatricians or paediatric anaesthetists. NICATS (the RVH ICU-based anaesthetic transfer service usually collects stabilised patients *from ICU* who are going to RICU and is rarely appropriate for ED transfers). *ALL PAEDIATRIC TRANSFERS MUST BE EXAMINED BY / DISCUSSED WITH THE ED CONSULTANT/ SpR and PAEDIATRIC REGISTRAR. The bed to be arranged by the PAEDIATRIC REGISTRAR. ALL POLY-TRAUMA-TRANSFERS AND TRANSFERS TO RICU MUST BE DISCUSSED WITH THE EMERGENCY DEPARTMENT CONSULTANT ON CALL.*

Emergency Department Short Stay Ward

There must be a single focused goal for the patient's care.

("To get better" is not one!!!)

The Emergency Department Obsevation Ward is a ten-bedded ward that is an integral part of the Emergency Department. The unit has a dedicated ward manager and nursing staff, while medical staffing is provided by the ED doctors on duty.

The purpose of the Observation ward is to extend the time available for investigation and treatment of selected ED patients from 4 to 24 hours thereby reducing the emergency admission rate to the inpatient wards. Its ultimate goal is to improve the quality and effectiveness of care for patients.

The key principles governing the unit are:

- **It functions as an *integral* part of the Emergency Department**
- **There is careful patient *selection* by ED doctors**
- **The admitting doctor identifies a *single focused goal* for the patient's care**
- **There is frequent *monitoring and re-evaluation* by SSW nurses and doctors**
- **There is rapid access to *diagnostic* tests**
- **There is rapid access to *psychiatric* assessment**
- **There is rapid access to multi-professional assessment for *community care***
- **There is open access to *inpatient services***
- **The length of stay is limited to *24 hours***

Admission Criteria

There are set criteria and proformas for admission to the Obs ward, these must be accurately completed and Kardex filled before admission to the ward. Any urgent treatment must be completed in the ED prior to admission to the ward.

Only patients aged fifteen or over may be admitted to the Observation Ward. A list of suitable conditions for Obs care is given later, however this is for guidance only and doctors must use their clinical judgement in every case while applying certain general principles:

- **There must be a single focused goal for the patient's stay in the Obs ward.**
- **The goal must be achievable within 24 hours**
- **The patient must not have any grossly abnormal vital signs following therapy in ED (ie GCS<12, P<50 or >110/min, SaO2<94, BP<90 systolic, CRT> 3secs) – record vitals before admission**
- **The patient must not have complex medical problems (usually only one organ-system involved) or have multiple medical problems (elderly patients tend to have these).**

Specific Exclusion Criteria

Patients with the following conditions must not be admitted to the SSW without the ED consultant's permission:

- **Low back pain (unless due to acute extrinsic injury)**
- **Post-Chemotherapy complications**

Admission Procedure

When the ED doctor has decided to admit a patient to the Obs Ward he/she should:

- **Tell the patient and relatives or carers that he or she will be kept in the Short Stay Ward for a period of observation/treatment and that discharge home is likely within 24 hours**
- **Enter "ADMIT OBSERVATION WARD" on the Emergency Department notes and on Symphony**
- **Must complete a properly labelled Obs ward proforma and ensure all tasks have been completed in accordance to each individual condition.**
- **Must write up the patient's regular medication (where appropriate) on a properly labelled drug kardex and prescribe iv fluids if required.**
- **Analgesia must be prescribed regularly.**
- **Ask the Emergency Department nursing staff to arrange admission to the Obs ward**

Medical Re-assessment

It is essential that patients' progress in the OBs is reassessed regularly. There is a named Consultant responsible for this area throughout the day. However if you admit to the ward it is YOUR responsibility to ensure that the patient receives the correct investigation/ management. For some conditions Nurse led discharge may be appropriate if certain criteria are met.(see proformas)
There can be no OBSERVATION WARD OUTLIERS if no bed is available refer on to medical/ surgical team.

Emergencies in the Observation Ward

Emergencies in the obs ward will be managed in exactly the same way as those arising elsewhere in the Emergency Department. Clinical guidelines and policies are available in the Emergency Department Handbook. Patients in cardiac arrest due to VF/VT should be defibrillated immediately. If necessary patients who become critically ill can be escorted by a doctor to the Emergency Department resuscitation room immediately for further care (it

should not normally be necessary to move the patient from a bed onto a trolley for this purpose).

RAID and CAHMS service

The northern trust is unique in offering an adult psychiatric review service from the point of triage and providing first assessment for all patients regardless of age and learning ability. There is a CAHMS service until 10pm and after this RAID will also provide a first assessment for 16-18yr olds
In some cases when mental status is clouded by drugs or alcohol it may be appropriate to admit to the observation ward for a short period.

DISCHARGING PATIENTS

Patients should be discharged home according to the Trust's Discharge Policy. The discharging doctor is responsible for completing a handwritten discharge coding and medication record and filling out the relevant details (Diagnosis, DADT and relevant details) on the Symphony system.

Examples of Conditions appropriate for the SSW

I.	Diagnostic Evaluation	Head Injury – fulfilling criteria for admission without scan
		DVT & PE (see clinical section)
		Chest Pain – see CLINICAL section
		Chest Injury –normal initial examination, ECG and CXR
		Abdominal Injury –normal initial examination and CXR
		Non-Specific Abdominal Pain *(under 50 years)*
		Drug Overdose – Clinically stable
		Anaphylactic Reaction – after responding to 1st dose of adrenaline
II.	Short Term Treatment	Pain Control (eg severe renal colic, headache, rib fracture)
		Selected Infections –including pyelonephritis, severe cellulitis
		Seizure Disorder – including first seizure but not status
		Primary Spontaneous Pneumothorax –after aspiration
III.	Psycho-social needs	Self Harm
IV.	Recovery	Recovery from procedural sedation

This list is not exhaustive; it is for guidance only. Not all patients with the conditions above will be suitable for SSW care – general admission / exclusion criteria apply.

RULE OF THUMB

If more than three lines are written on the white board in SSW, they probably were not suitable as a SSW patient.