# Emergency Observation Units, the Short Stay Unit solution for Emergency Departments: An integrative review.

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# Abstract

Emergency Observation Units are the Emergency Department version of a Short Stay Unit, and they have been around in various forms since the 1960s when the Nuffield Provincial Hospitals Trust (1960) recommended their use.

As demand on Emergency Department resources has increased and overcrowding prevails, Emergency Observation Units have proliferated worldwide in response.

Emergency Observation Units have developed not only as areas to provide ongoing Emergency Department care but also as places to provide short periods of therapy or observation.

They are often used by patients with differential diagnoses, many of whom would have historically been admitted to inpatient facilities. The potential benefit of this is the prevention of inpatient admissions and the freeing up of valuable hospital resources.

# Objectives

This study presents an integrative review of the literature available from 2002 to the present.

The intention is to identify how Emergency Observation Units function, their governance and staffing, and what contribution they make to the patient's journey.

# Preface

Prior to August 2012 the Dunedin Hospital Emergency Department functioned without an Emergency Observation Unit.

However, it had been noted by the New Zealand Ministry of Health that Dunedin Hospital was a poor performer of the 6 Hour Emergency Department Health Target (Ministry of Health, 2011a) with quarterly performance indicating that only 72% of patients were processed by the Emergency Department within six hours of arriving.

In an effort to address the six hour performance, two potential changes in models of care were identified; one being a Medical Assessment and Planning Unit with the other an Emergency Observation Unit.

# Background

Internationally it is acknowledged that the performance of EDs plays a pivotal role in monitoring the function of the health care system as a whole. EDs have been described as the ‘canary’ of the health system, that is, when EDs are becoming congested this is an indicator that wider systems are failing (FitzGerald & Ashby, 2010).

In the United States of America (USA) patients can spend long periods of time in EDs due, in part, to fiscally driven policies to maintain high occupancy rates within inpatient facilities (Baugh, Venkatesh, & Bohan, 2011).

Along with this, ageing populations are contributing to the increase in presentations to EDs (Madsen, Bledsoe, & Bossart, 2008; Ross et al., 2003).

Commentators in Italy attribute an increase in workload to a breakdown in primary care, suggesting that this is impacting upon admission to hospital and creating overcrowding problems for EDs (Iannone & Lenzi, 2009).

The report “Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments” (Working Group for Achieving Quality in Emergency Departments, 2008).

Acknowledged that multiple factors had contributed to the overcrowding problems in EDs and proposed that a “*whole-of-system and whole-of-hospital*” approach was required to make improvements to ED services.

Fourteen recommendations were made. One of those recommendations was that “*A Health Target should be introduced as a formal accountability measure of ED performance*” (Working Group for Achieving Quality in Emergency Departments, 2008, p. 5).

In May 2009 the Right Honourable Tony Ryall, revised and replaced the then existing ten health targets with six new targets. While most of the new targets encompassed several of the previous targets, one new target was introduced, this was "*Shorter Stays in Emergency Departments*" (Ministry of Health, 2011b, p. 2; Tenbensel, 2009, p. 1). This was the first time an ED specific target had been included.

With the evolution of the "6 Hour Target", a commonly used abbreviation for the "*Shorter Stays in Emergency Departments*" health target, a performance indicator was implemented to assess how well hospitals were performing (Ministry of Health, 2011a).

The key performance indicator (KPI) for this target was that "*95% of patients will be admitted, discharged or transferred from an ED within six hours*" (Ministry of Health, 2011b, p. 2).

While this target is a direct measure of ED performance it is also considered a proxy measure of how well the whole hospital is functioning, with a poorly functioning hospital not expected to meet the six hour target.

Worldwide there has been a proliferation of ED Obs Units, which may also be referred to as Short Stay Units (SSU).

SSU is a term used generically to describe inpatient facilities that have been designed to accommodate patients, as the name describes, for a short period of time, which can vary from hours up to two days (Australian Resource Centre for Healthcare Innovation, 2011; Ministry of Health, 2010; The Advisory Board Company, 2008).

ED Obs Units are SSUs with a specific purpose, to observe patients for up to a specified time with a view to discharge home (Ministry of Health, 2010).

In order to provide an environment that has the ability to meet the 6 Hour Target it has become evident that most EDs require an area to admit patients who need longer than a six hour length of stay to complete their episode of care.

ED Obs Units are considered to be inpatient facilities and the record of ED length of stay (LOS) ceases once a patient is admitted to an ED Obs Unit (Ministry of Health, 2010).

Those departments that do not have these facilities will find it difficult to meet the health target, particularly for those patients who require a longer than six hour episode of care but do not require admission to an inpatient facility.

It has been identified that ideally, an acute hospital should have an ED Obs Unit (Ministry of Health, 2010).

# Research Focus

The aim of this study is to search and assess international literature which discusses ED Obs Units, from 2002 to 2012.

The findings are grouped into themes and presented to demonstrate the impact that ED Obs Units have upon the journey of the patient.

# Research Design

- **Methodology**

An integrative review seeks to explore existing research from a wide range of methodologies, therefore an understanding of various theoretical perspectives is required to interpret the range of study designs available for review (Whittemore & Knafl, 2005)

Being mindful of the various methodologies used in the primary research reviewed, this integrative review bases its methodology on constructionism with the intention to construct meaning from the various paradigms being reviewed. That is, primary research, from both qualitative and quantitative studies are reviewed together with expert opinion and acknowledgement of previously conducted reviews related to the question (Whittemore & Knafl, 2005).

- **Method**

Is the how research is conducted

The methodology for this integrative review utilises the methods, including tools and software, from the Joanna Briggs Institute (JBI).

A step by step approach is taken with each step needing to be completed prior to progression to the next step. Initial assessments require agreement from a secondary reviewer to enable progression and inclusion of articles for the review (Joanna Briggs Institute, 2012b).

- **Limitations**

While an integrative review will give a snapshot of current opinion and research, in some fields it does not hold the weight of an RCT.

However, the field of nursing research recognises the benefits of research methods from the social sciences and places value upon qualitative methods.

Integrative reviews are also known to provide more information than is required to answer a simple question (Crawford & Johnson, 2012),

- **Five stages of an Integrative Review**

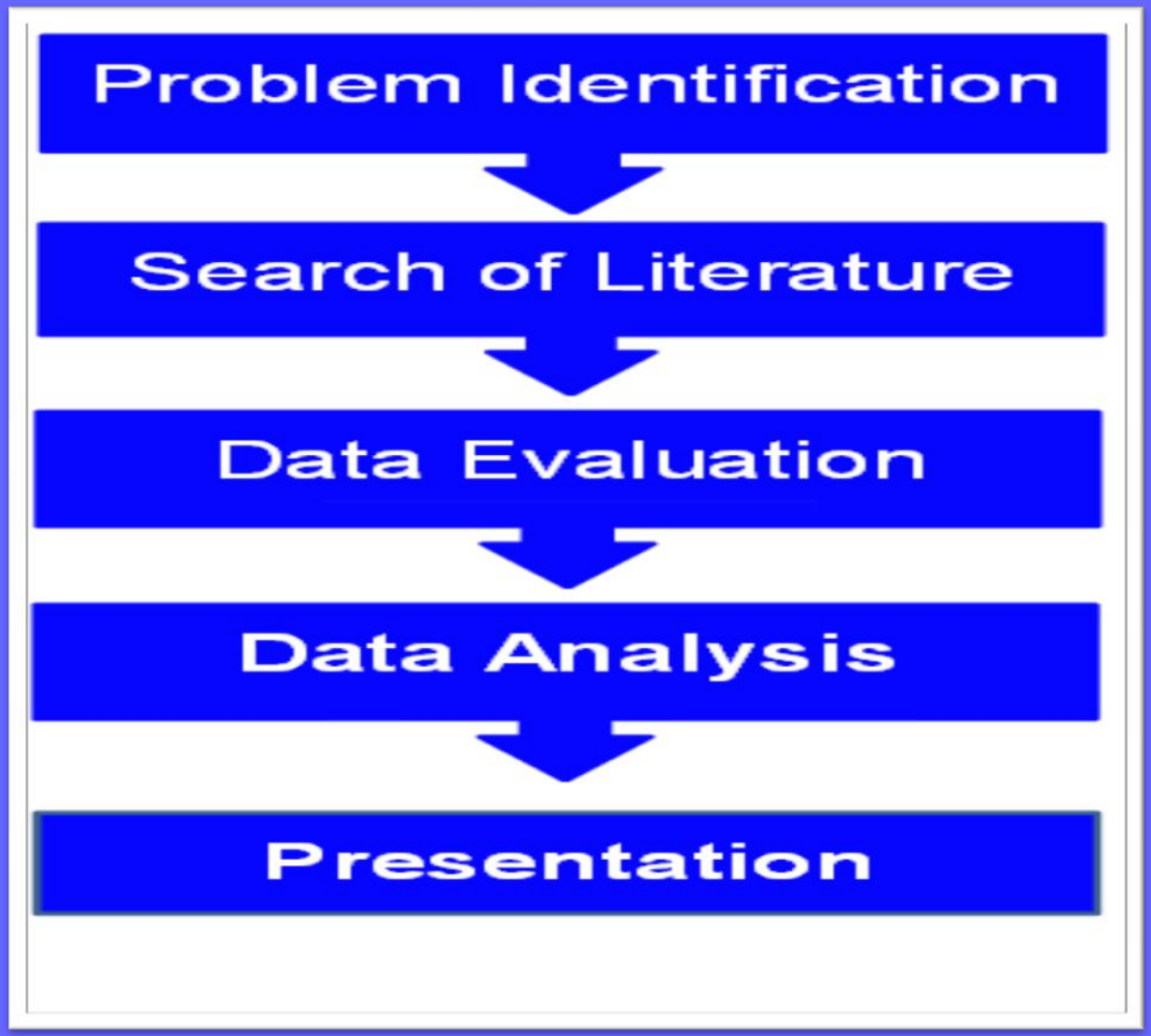



*Figure one - Process for an integrative review* Adapted from Whittemore and Knafl (2005) and Cooper (1984)

# Search Strategies and Results

- **Search Strategy**

Databases; Cumulative Index to Nursing and Allied Health Literature; Google Scholar; and Ovid. Ovid includes Medline, PsycInfo, AMED, Books @ Ovid and Your Journals @ Ovid.

Key words; words “observation”, “assessment”, or “short stay” combined with “ward” or “unit” and “emerg$” ($ being a wild card). The medical sub heading “observation” was also searched.

Filter; restricting to publications between 2002 and 2012.

- **Inclusion Criteria**

Studies, guidance statements and expert opinion were included if they focused on ED Obs Unit development or provision of patient care, this included all known variations of ED Obs Units

All documents were required to be written in English

In an attempt to reduce the volume of literature available all literature reviewed and included was published after 2002 and focused on the adult population, 15 years and over

- **Exclusion Criteria**

Studies and statements were excluded if they did not focus primarily upon ED Obs Units.

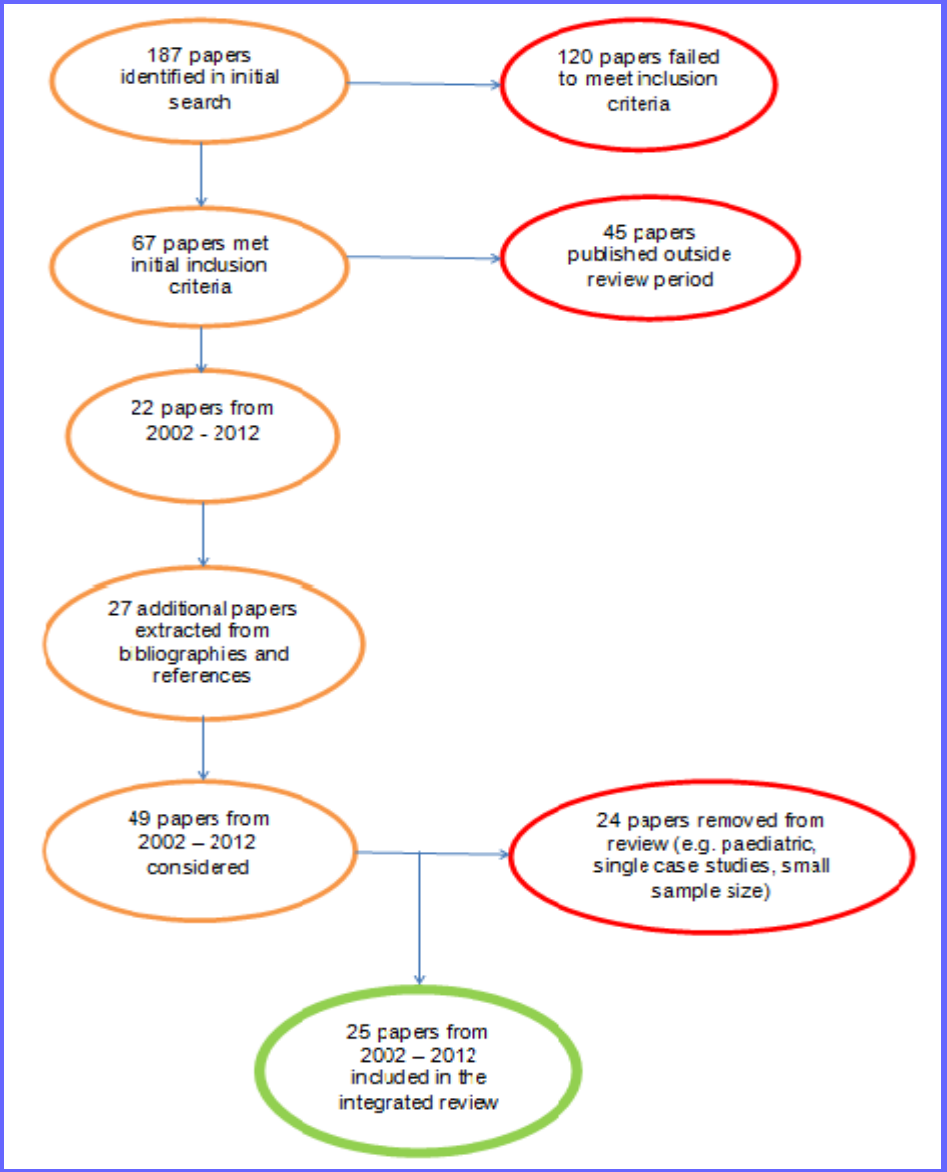
If they were not written in English.

Or published prior to 2002.

Paediatric studies were also excluded.

- **Search Results**

All 49 papers were appraised by the researcher and two secondary appraisers. Final selection of papers to be included in this review was based upon relevance to the study with guidance provided by the JBI tools for data extraction (Joanna Briggs Institute, 2012a).



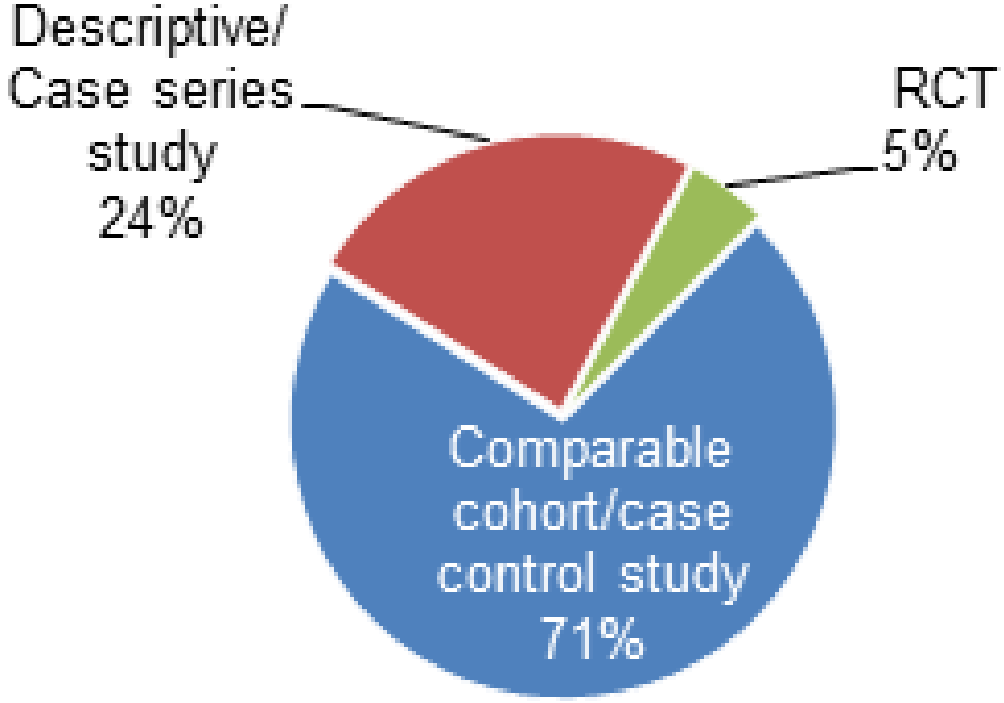

*Consort Chart: Search strategy results*

In total there were 25 pieces of literature reviewed for this study.

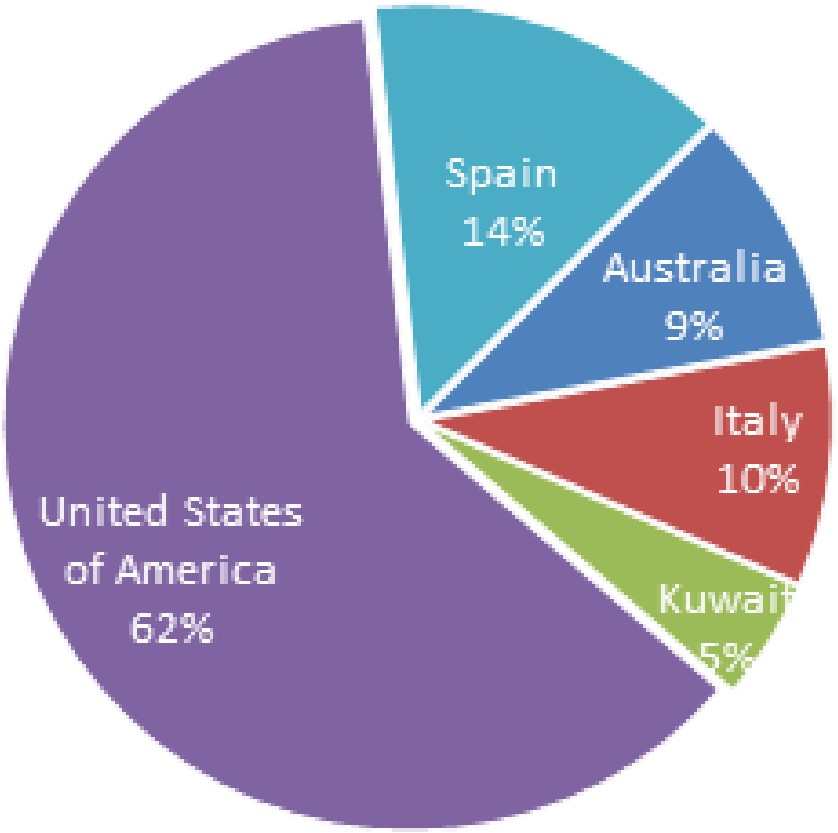
21 were quantitative studies and four pieces of work were policy or guidance statements pertaining to the development and operation of an ED Obs Unit.

The search strategy utilised did not identify any qualitative material to include in this study.

# Summary of Quantitative studies

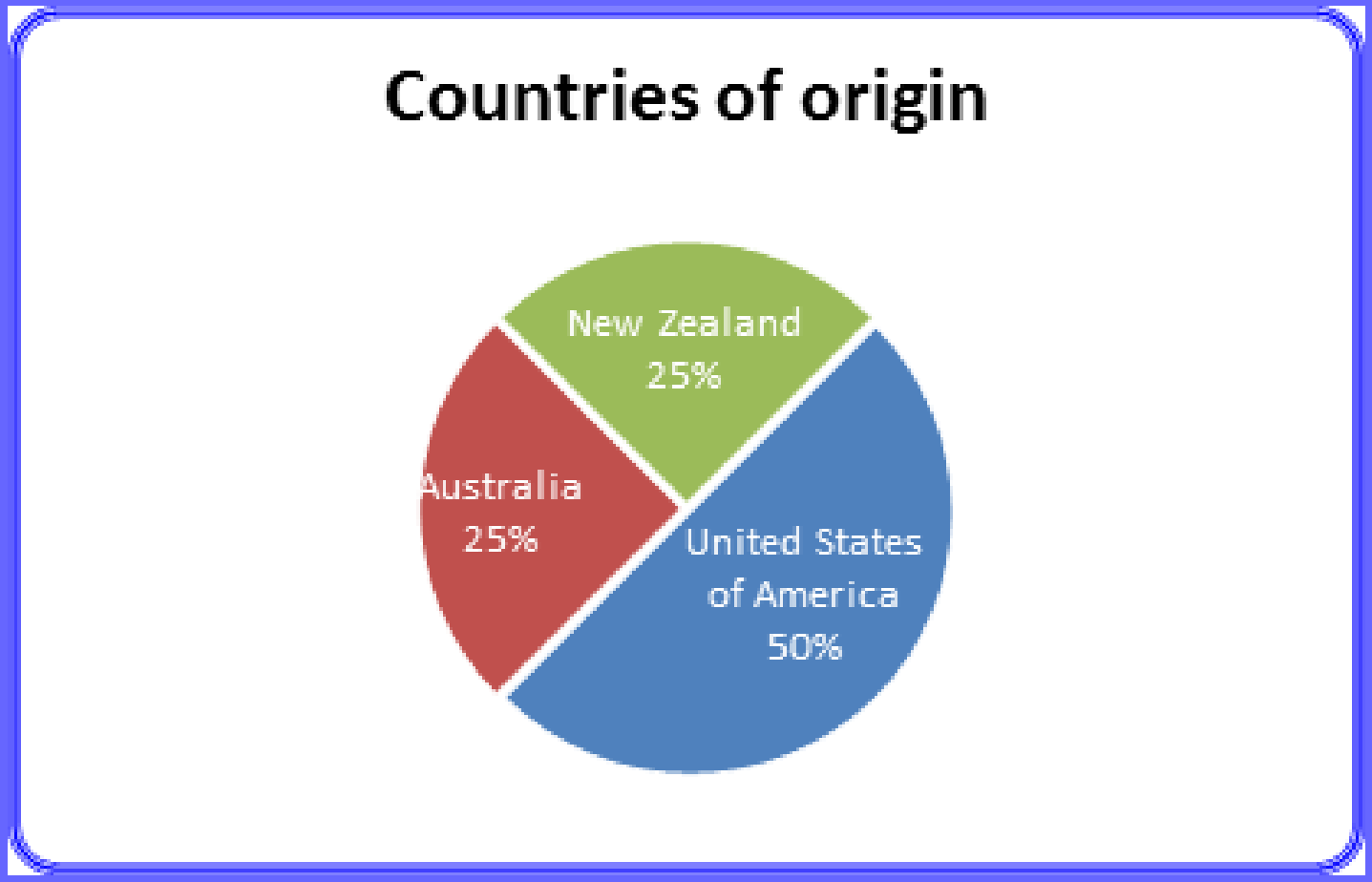


# Country of origin



- **Policy and Guidance statements**

Four were sourced



# Analysis of Literature

The following themes emerged as data was assessed during the data evaluation and analysis phase of this study.

| Themes | Number of papers |
| --- | --- |
| Theme one | |
| Rationale for developing an ED Obs Unit | 17 Papers |
| Theme two | |
| Effects of an ED Obs Unit upon length of stay | 20 Papers |
| Sub theme | |
| ED Obs Units reduce LOS for ED pts | 3 Papers |
| Theme three | |
| ED Obs Unit and how they benefit the pt | 25 Papers |
| Sub theme | |
| Elderly patients in the ED Obs Units | 3 Papers |
| Sub theme | |
| Diagnostic groups | 15 Papers |
| Sub theme | |
| ED Obs Units improve care in ED | 3 Papers |
| Sub theme | |
| Patient safety | 3 Papers |
| Theme four | |
| ED Obs Unit and governance | 17 Papers |
| Theme five | |
| ED Obs Unit and staffing | 17 Papers |

- ***Theme one: Rationale for developing an ED Obs Unit***

The majority of studies (17 out of 21) included reference to or discussion of the underlying rationale for establishing an ED Obs unit.

The primary reasons for developing an ED Obs Unit appear to be born from the need to address issues with patient flow within EDs and the wider hospital (Decker et al., 2008; Holly et al., 2011; Storrow et al., 2005; Venkatesh et al., 2011).

Juan et al. (2006, p. 833) states that *“The emergency department short-stay unit (EDSSU) was essentially created to provide an alternative to conventional hospitalisation for patients with urgent pathologies.”*

The American College of Emergency Physician (2008) ACEP promote the use of ED Obs Units to improve patient safety and the quality of care provided in EDs.

Recognition of ED and hospital overcrowding is acknowledged as one of the main issues (Ross et al., 2012)

ED Obs Units have been found to decrease ED boarding, avoidable inpatient admissions and the diversion of ambulances (Ross et al., 2012).

Three out of four policy and guidance statements reviewed identified that ED Obs Units lead to an improvement in hospital wide efficiencies, the fourth policy did not comment upon gains in efficiency beyond the ED (American College of Emergency Physician, 2008).

Prior to the establishment of ED Obs Units many patients would have been admitted to a ward who are now able to be cared for in the ED Obs Unit.

As a result, most experience a much shorter LOS than if they were admitted to an inpatient facility (Australian Resource Centre for Healthcare Innovation, 2011; Ministry of Health, 2010; Ross et al., 2012)

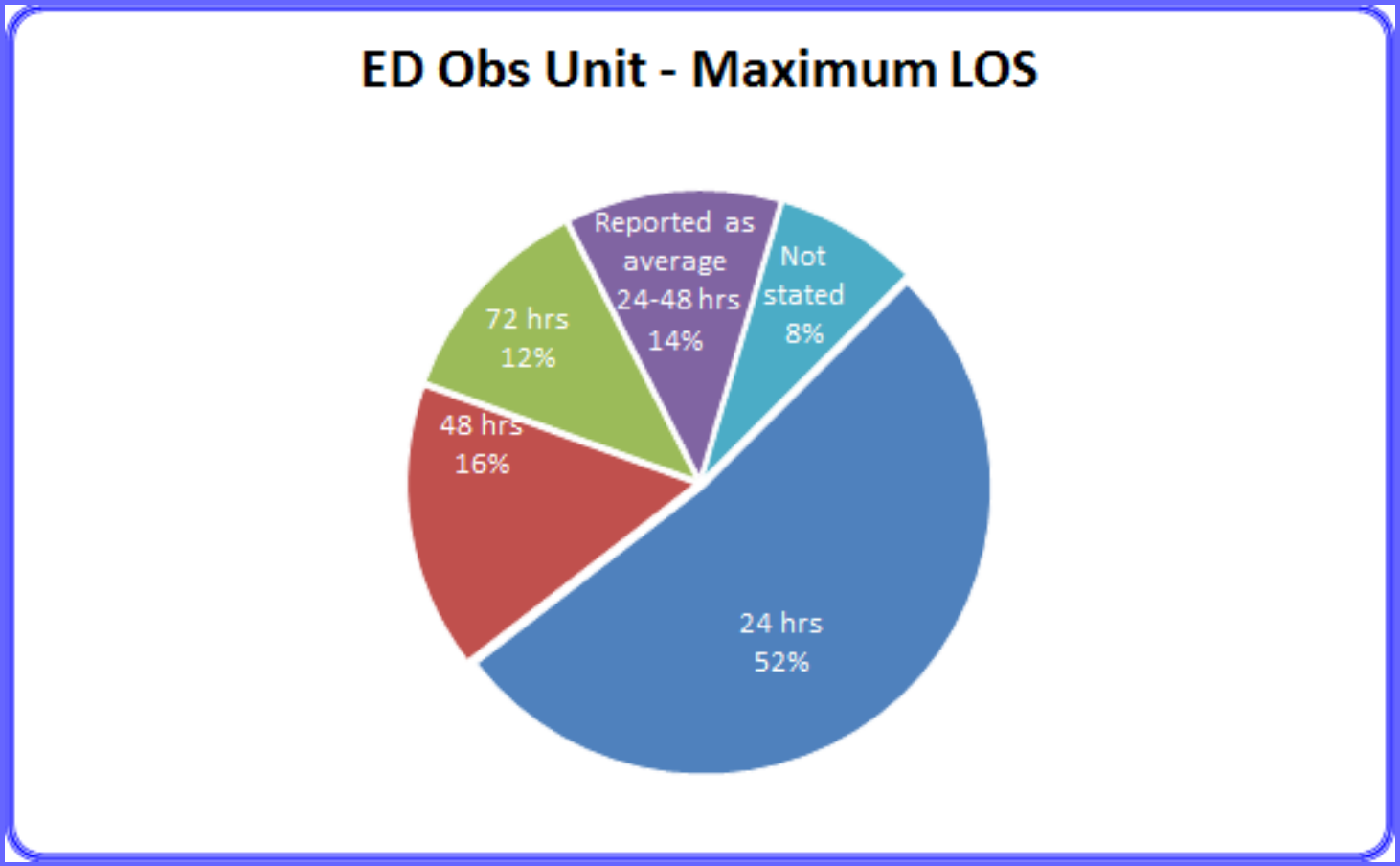
There is potential for such units to improve patient care in EDs by decreasing their patient loads, reducing LOS, increasing turnover and enabling ambulances to off load (Australian Resource Centre for Healthcare Innovation, 2011).

- ***Theme two:  Effects of an ED Obs Unit upon length of stay***

Ross et al. (2012) found that ED Obs Unit patients had an average LOS of 5.5 hours compared to five days for an inpatient admission.

Findings also suggested that where there were no ED Obs Units available, that patients suitable for ED Obs Unit care are admitted by default to inpatient facilities and have LOS well beyond 24 hours.

ED Obs Units are described as providing an effective model of care for patients who cannot have their clinical needs realistically met within a 6 hour ED visit but who require no more than 24 hours of care (Ross et al., 2012).




**The majority of studies, by a slight margin, identified 24hrs as a maximum LOS**

- ***Sub-theme 2.1:  ED Obs Units lead to a reduction in LOS for ED patients***

ED Obs Units allow an extension of ED care in a more appropriate environment separate from the ED, therefore reducing the LOS for patients in the parent ED (Australian Resource Centre for Healthcare Innovation, 2011; Ministry of Health, 2010; Ross et al., 2012).  This opinion is supported by the all of the studies reviewed.

- ***Theme three: ED Obs Units and how they benefit the patient***

Themes emerging from the data reviewed demonstrate that as the ED Obs Units evolve, they start to identify specific cohorts of patients that could be better served when cared for in the ED Obs Unit environment.

Four sub-themes emerged from the literature reviewed which related to how ED Obs Units benefit the patient by improving the patient's journey, they include –

- Elderly patients in the ED Obs Unit environment
- Diagnostic groups
- ED Obs Units improve patient care in EDs
- Patient safety

- ***Sub-theme 3.1: Elderly patients in the ED Obs Unit environment***

While it is often assumed that older patients (those over the age of 65 years) may be unsuitable for transfer to an Obs Unit due to a perceived higher rate of subsequent in-patient admission, other authors have recognised this population as suitable in general for ED Obs Unit care (Madsen et al, 2008).

Several studies have identified that elderly patients can be safely discharged from an ED Obs Unit, after a period of treatment and observation, without an increase in adverse events when compared to traditional admission to an inpatient ward (Chan, Arendts, & Stevens, 2008; Madsen et al., 2008; Ross et al., 2003).

Ross et al. (2003) conducted a large comparable cohort study over a four year period observing 22,530 patients. In that study, various age groups admitted to an ED Obs Unit were compared, 99% of patients admitted to the ED Obs Unit were over the age of 18 and 37.2% were over 65 years old. The average ED Obs Unit LOS for elderly patients was 15.8 hours, 1.4 hours longer than the younger population, but well under the 18 hour goal (Ross et al., 2003).

The elderly had a higher rate of admission to inpatient services at 26.1% in comparison to 18.5% for the younger group. The return visit rate for the elderly was 19.8% compared to 10.6% for the younger population, with none of the younger return visits resulting in death within 30 days compared to two patients in the elderly group, both explainable and related to existing co-morbidities rather than initial treatment (Ross et al., 2003).

In the study by Ross et al., 73.9% of 8,385 elderly patients admitted to the ED Obs Unit were able to be discharged home, avoiding the risks associated with inpatient care (Ross et al., 2003).

These include nosocomial infection, falls, pressure sores and adverse events including drug errors.

Geriatric patients without coronary disease were found to have admission rates from an ED Obs Unit to an inpatient facility similar to that of the non-geriatric cohort, with these rates falling below the 10% to 15% which is considered to be an acceptable admission rate (Madsen et al., 2008).

- Four variables were found to indicate a higher chance of admission to an inpatient facility, these included; inability to mobilise independently; requiring ongoing active treatment while in the ED Obs Unit; needing a referral to a subspecialty pre ED Obs Unit transfer; and requiring allied health input while in the ED Obs Unit (Chan et al., 2008).

These studies acknowledge that the elderly are suitable candidates for ED Obs Unit care, however they do indicate that they also require more resources compared to the younger patients cared for in the same unit.

- ***Sub-theme 3.2:  Diagnostic groups***

  - Cardio/Respiratory patients
  - Trauma patients
  - Trans ischaemic attack (TIA) patients
  - Toxicology patients

# Cardio Respiratory patients

There were seven studies reviewed that concluded some cardiac and pulmonary conditions are able to be safely managed within the ED Obs Unit environment (Decker et al., 2008; Diercks, Peacock, Kirk, & Weber, 2006; Gonnah et al., 2008; Juan et al., 2006; Miro et al., 2010; Salazar et al., 2007; Storrow et al., 2005)

Evidence exists that ED Obs Unit care for selected cardiac patients can reduce length of stay, effectively reducing costs to patients and the care providers (Juan et al., 2006; Miro et al., 2010; Storrow et al., 2005).

The treatment of patients with respiratory conditions, such as pneumonia, has been shown to be suitable to be catered for in an ED Obs Unit (Gonnah et al., 2008) as are some patients presenting with chronic obstructive pulmonary disease (COPD) (Juan et al., 2006; Salazar et al., 2007).

It is not uncommon for the COPD patients to have had several prior admissions to hospital and ED Obs Unit care with associated short term admissions, which are appreciated by patients with chronic health problems, resulting in improved patient satisfaction (Juan et al., 2006).

## Trauma patients

High acuity and therefore trauma patients have often been excluded from care in these units. It has been identified in three studies that certain trauma patients can be safely cared for in an ED ObsUnit (Madsen et al., 2009; Menditto et al., 2012; Sherwood et al., 2011).

It was identified in the Madsen et al. (2009); Sherwood et al. (2011) studies of 364 and 2,297 respective patients, that trauma patients placed on a care protocol can be managed safely in an ED Obs Unit, with low return rates and both studies observing only one representation due to a missed injury.

ED Obs Units were found by Menditto et al. (2012), to be a useful system to improve the safety and discharge of blunt thoracic trauma patients, by providing an area to observe patients for delayed complications.

Traditionally these patients were admitted to an inpatient facility with an average LOS of 72 hours, with those being treated and observed within an ED Obs Unit having a reduced LOS of 40 hours

## Transient ischaemic attacks

One study investigated the use of a treatment protocol for patients presenting to the ED with a transient ischaemic attack (TIA) and found that ED Obs Units provide an environment where accelerated diagnosis can be actioned with the patient being safely monitored and treatment initiated (Nahab et al., 2011).

These units also provided the safety of immediate access to additional medical care in the event of sudden deterioration of a patient within the first 24 hours of assessment (Nahab et al., 2011).

Patients with recurrent TIAs are at risk of their condition developing into a full blown cerebrovascular stroke (Gattellari, Goumas, Garden, & Worthington, 2012). An additional period of observation in the ED Obs Unit provides clinicians with the security of the patient remaining under their care as an alternative to discharging home.

This is a practice that has the potential to increase the traditional LOS of a TIA patient presenting to the ED

## Toxicology patients

In the study by Sztajnkrycer et al. (2007) they concluded that deliberate ingestion patients are ideal for ED Obs Unit care, with 64.7% of presentations resolving within eight hours and over 80% resolved in less than 24 hours, which fits with the 23 hours observational care policy.

In this study of 86 participants, all medical admissions for deliberate overdose were discharged within 24 hours (Sztajnkrycer et al., 2007) this identifies these patients as ideal candidates for ED Obs Unit care.

- **Sub-theme 3.3:  ED Obs Units improve patient care in EDs**

It was identified by three of the four statements reviewed that ED Obs Units have an overall impact by improving the care of patients within EDs.  This is due to the observation patient being taken out of the parent ED to enable the valuable ED resources to be made available to those patients who require emergency care.

The clinicians in the ED are not distracted from acute resuscitation work by needing to provide less urgent care to the ED Obs Unit patients (Australian Resource Centre for Healthcare Innovation, 2011; Ministry of Health, 2010; Ross et al., 2012).

- **Sub-theme 3.4:  Patient safety**

The Ministry of Health (2010) in their guidance statement believe that ED Obs Units improve patient safety and comfort.

The Australian Resource Centre for Healthcare Innovation (2011) states that the utilisation of the ED Obs Unit model of care improves patient safety within the parent ED by improving efficiencies.

They also argue that ED Obs Units provide an environment for focused allied health interventions (Australian Resource Centre for Healthcare Innovation, 2011), with it being acknowledged that this function is now restricted within the ED due to the Australian four hour target (FitzGerald & Ashby, 2010).

All 21 studies presented their findings in favour of ED Obs Units and discussed how they had a positive influence upon the journey of the patient.

Arendts et al. (2006) found that there was an improvement in discharge advice given with 85% of ED Obs Unit patients receiving discharge advice compared to 33% in other studies.

Studies that conducted follow up and assessed outcomes, sometimes up to 30 days post discharge, found that there were no greater numbers of adverse events for ED Obs Unit patients than for those patient either admitted to an inpatient facility or discharged directly from the ED, even for the elderly with chronic health conditions (Decker et al., 2008; Diercks et al., 2006; Holly et al., 2011; Iannone & Lenzi, 2009; Madsen et al., 2009; Menditto et al., 2012; Miro et al., 2010; Nahab et al., 2011; Sherwood et al., 2011; Storrow et al., 2005)

- ***Theme four:  ED Obs Units and governance***

The policy and guidance statements reviewed are clear that ED Obs Units need to have defined governance to oversee operations by determining criteria for use and co-ordinating any initiatives or changes in operations (American College of Emergency Physician, 2008; Australian Resource Centre for Healthcare Innovation, 2011; Ministry of Health, 2010; Ross et al., 2012).

The ACEP (2008, p. 656) are clear that *“An emergency physician and an emergency nurse should direct ED observation area with clearly defined administrative responsibilities for the unit”*.

In the USA over 50% of ED Obs Units are administrated by EDs, with the governance of the remaining units not specified (Ross et al., 2012).

The NZ Shorter Stays in ED group believe that governance of an ED Observation Unit is the responsibility of the ED (Ministry of Health, 2010), this includes medical and nursing management, development of policies, standards and procedures with other specialties contributing to the development of clinical pathways.

- ED Obs Units require strong management to police the operational policies as set out by the governance group (Australian Resource Centre for Healthcare Innovation, 2011).

- ***Theme five:  ED Obs Units and staffing***

The policy and guidance statements reviewed are clear in directing or advising that ED Obs Units must be staffed by Emergency Physicians and Registered Nurses with some stating that this staffing needs to be dedicated to the unit and not shared (Ministry of Health, 2010; Ross et al., 2012 )

ARCHI recommends ED Obs Units should be staffed by senior personal, with dedicated medical and nursing staff and provide a multi-disciplinary approach to care (Australian Resource Centre for Healthcare Innovation, 2011).

- Ross et al. (2012) mentions emergency physicians, physician assistants and nurse practitioners, but also states that on average ED Obs Units have a patient to RN ratio of 4.2 to 1

The ED Obs Units provide an environment for focused allied health interventions and therefore require additional allied health staffing (Australian Resource Centre for Healthcare Innovation, 2011).

There was no comparison made in the literature reviewed between the various staffing models to assess how they improve either the service or the journey of the patient.

# Discussion

This study compared finding with that of two reviews conducted prior to 2002 Cooke et al. (2003) and Daly et al. (2003).

The material available for this review, conducted from the period 2002 to the 2012, has found the majority of research originating from the USA.

The literature reviewed has resulted in the identification of several themes which correlate to and build upon the data presented in the systematic reviews conducted by Cooke et al. (2003) and Daly et al. (2003).

- ***Reasons for developing an ED Obs Unit***

In this research, the reasons identified for the development and functioning of an ED Obs Unit are similar to those discussed by both Cooke et al. (2003) and Daly et al. (2003).

That is, the main drivers for opening an ED Obs Unit are; to reduce admission to inpatient areas; to improve the workload and patient flow of the main ED; to reduce the cost of health care; and to reduce the overall LOS of all patients (Ross et al., 2012).

Improved efficiency is one of the main reasons for the development of an ED Obs Unit. This is echoed by the NZ Ministry of Health (2010) when promoting the development of ED Obs Units as a tool to improve performance in reaching the NZ 6 Hour Target.

Overall, the literature reviewed is supportive of ED Obs Units improving efficiencies for both the parent ED and the wider hospital. However, it must be remembered that those efficiency gains are offset by the cost of building a unit and the ongoing daily operational costs

Recent literature reviewed for this research demonstrated that ED Obs Units had an overall positive effect upon hospital efficiencies, without significantly increased numbers of re-presentations to the ED in the cases studied (Arendts et al., 2006; Holly et al., 2011).

It is believed that by decanting patients from the main ED to an area designed to provide the level of care required, whether that be an area for minor injuries treatment or observational care, that this frees up resources in the acute setting for urgent care to be provided.

# Recommendations - related to research

**Recommendation One**

*To develop qualitative studies demonstrating the lived experience of the patient being cared for and the clinicians providing the care in an ED Obs Unit.*

**Recommendation Two**

*To promote the involvement of nursing in the publication of research related to ED Obs Units.*

# Recommendations - related to practice

**Recommendation Three**

*A comparative study is conducted to investigate how the variations of LOS used by individual ED Obs Units changes the acuity and types of patients eligible for care within ED Obs Units.*

**Recommendation Four**

*A comparative study of ED Obs Unit models of governance be undertaken.*

**Recommendation Five**

*A comparative study of ED Obs Unit staffing compositions and ratios.*

# Conclusion

Over the past three decades ED Obs Units have proliferated internationally.

Within NZ the development of ED Obs Units has largely been due to the need to improve hospital efficiencies and patient flow through EDs.

When patients are decanted from the ED through to an ED Obs Unit, they free up valuable resources in the ED.

This enables safer more timely access to care for acute ED patients.

ED Obs Units are an extension of ED care, like an ED, they provide a wide variety of patient care to a large age range of patients.

Research has shown that care delivered in ED Obs Units does benefit the patient including those over the age of 65 years.

The literature demonstrates how the proliferation of ED Obs Units has led to variations of practice not only internationally but also within individual countries.

This integrative review has provided a snapshot of current development and has made recommendations for future research to further enhance the safety of care delivered in ED Obs Units.

This ultimately leads to improvements in the patient's journey.

# The Dunedin Experience

- The following KPIs that were proposed:
  - % of patients transferred or discharged from ED within 6 hours is 95%
  - % of patients admitted to inpatient wards from ED Obs Unit is less than 20%
  - % of patients discharged from ED Obs Unit with LOS in ED Obs Unit of less than 23 hours is 90%
  - A 50% reduction in number of patient complaints in ED/ED Obs Unit

# The Results

- 91% of patients were transferred or discharged from ED within 6 hours i
- 21% of patients were admitted to inpatient wards from ED Obs Unit is less than 20% (This figure includes acute patients placed in the ED Obs Unit when acute capacity has been reached – the clock does not stop for these patients)
- 100% of patients were discharged from ED Obs Unit with LOS in ED Obs Unit of less than 23 hours is 90%
- There was a 40% reduction in number of patient complaints in ED/ED Obs Unit
- The projected 9.54 patients a day admitted to the ED Obs Unit has stabilised at 14.4 patient a day (Sept 2013), in addition to the official ED Obs patients there is approximately 140 additional acute patients per month placed in the Obs Unit when acute capacity has been reached – this equates to an additional 4.5 patients per day (Tweedale, 2013 & SDHB reporting, 2013)
- It is extremely rare that to have corridor patients within ED