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Emergency Medicine - Management of Relocated Short Stay Units (COVID)

1. Overview

A key action in creating extra Emergency Departments capacity, to manage the demand surge associated with the Covid-19 Pandemic, at both Sunshine and Footscray Hospitals, has been the relocation of both sites' Emergency Observation Units to other areas in the hospital. The new Units/Wards have been renamed as follows:

- Sunshine: 1B - Short Stay Unit
- Footscray: 3A -Short Stay Unit

These Short Stay Units will function in a very similar way to the Emergency Observation Units, with a few changes. They will continue accepting patients for whom discharge is considered most likely but for whom a short stay is required for ongoing investigation, management and medical intervention. The temporary SSU will also no longer be accepting patients directly from the waiting room, but will draw patients from the main Emergency Departments. Maintaining high turnover through these units remains important to retain overall hospital flow.

2. Applicability

This procedure relates to all staff working within both Short Stay Units, including but not limited to medical, nursing and clerical staff as well as clinical and non-clinical support staff.

3. Responsibility

Responsibility lies with the Division of Emergency, Medicine & Access Divisional Director and Clinical Services Director, the Directors of Emergency Medicine the Footscray and Sunshine Emergency Departments, and the Nurse Unit Managers for the Footscray and Sunshine Emergency Departments, and Short Stay Units.

4. Authority

Other than staff identified in ***3. Responsibility***, exceptions to this guideline can only be authorised by the Senior Medical Staff member in charge and the nurse-in-charge managing the Short Stay Unit.

5. Associated Documentation

In support of this guideline, the following Manuals, Guidelines, Instructions, Guidelines, and/or Forms apply:

Code	Name
DP-AC1.1.1	Admission Procedure for Adult Patients in Emergency Departments who require Inpatient Admission
DHHS	Guidelines for Emergency Department short stay units.
OP-GC1	Nursing handover

6. Definitions and Abbreviations

6.1 Definitions

For purposes of this guideline, unless otherwise stated, the following definitions shall apply:

ED Demand	Presentations to ED, including surge in demand
Disposition	Final end-point of patient care e.g. discharge, SSU admission, inpatient admission
SSU Failure	Conversion of SSU admission to inpatient admission. Accepted standard is less than 15%.
SSU Pathway	Clinical pathway outlining management plan for patients

6.2 Abbreviations

For purposes of this guideline, unless otherwise stated, the following abbreviations shall apply:

Abbre'n	Expanded abbreviation, including reference if there is a separate authoritative source of the definition
BOC	Behaviours of Concern Score
BP	Blood Pressure
ED	Emergency Department
EDIS	Emergency Department Information System
EOU	Emergency Observation Unit
EP	Emergency Physician
GCS	Glasgow Coma Scale
HR	Heart rate
NEAT	National Emergency Access Target
NIC	Nurse In Charge
KPI	Key Performance Indicator
LMO	Local medical officer i.e. general practitioner
SSU	Short Stay Unit

7. Guideline Detail

7.1 Aim

The Short Stay Unit (SSU) is geared towards patients with defined single clinical problems and high likelihood of discharge. Patients can be admitted for up to 24 hours, and the unit provides:

- Time and space for management, symptom control and further risk stratification and assessment (through observation, reassessment or investigation)
- A decanting area to assist with flow through the Emergency Department (ED)

Working with SSU patients involves a level of uncertainty that may be unfamiliar to those who have not worked in an ED space. This may be due to some or all of the following factors i.e. patients presenting early in the course of their illness, dynamic information, undifferentiated presentations, and frequently, a lack of definitive final diagnosis after investigation.

Diagnostic certainty is not a mandatory function of the SSU provided that on discharge, patients are well, have been determined to be low-risk for adverse outcome, and are able to have further outpatient investigations.

Proactive discharge is a key component of the Short Stay Unit. Most conditions selected for SSU admission should have a length of stay of approximately 6-8 hours. This is in order to maintain flow both through the Emergency Departments, the SSUs, and the hospital in general. In applying this time frame, extra care should be exercised in discharging patients overnight.

The maximum stay in the SSU is 24 hours and patients not considered to be dischargeable in this time frame should be referred on to an inpatient team (either prior to admission to SSU or at any point this is determined during their SSU admission) at the earliest time point at which this can be identified.

Additionally, during the COVID pandemic, 4 additional beds at 1B-SSU (Sunshine) may be allocated for the treatment of low risk mental health (MH) and alcohol and other drugs (AOD) presentations. Governance of these patients remains under the Emergency Department. For the purposes of this document this part of the SSU will be designated SSU-MH.

7.2 Inclusion and Exclusion Criteria

The identification of patients suitable for the SSU will initially be by ED medical staff who will discuss the patient with the ED senior (EP or registrar overnight) before making the referral to the SSU medical officer.

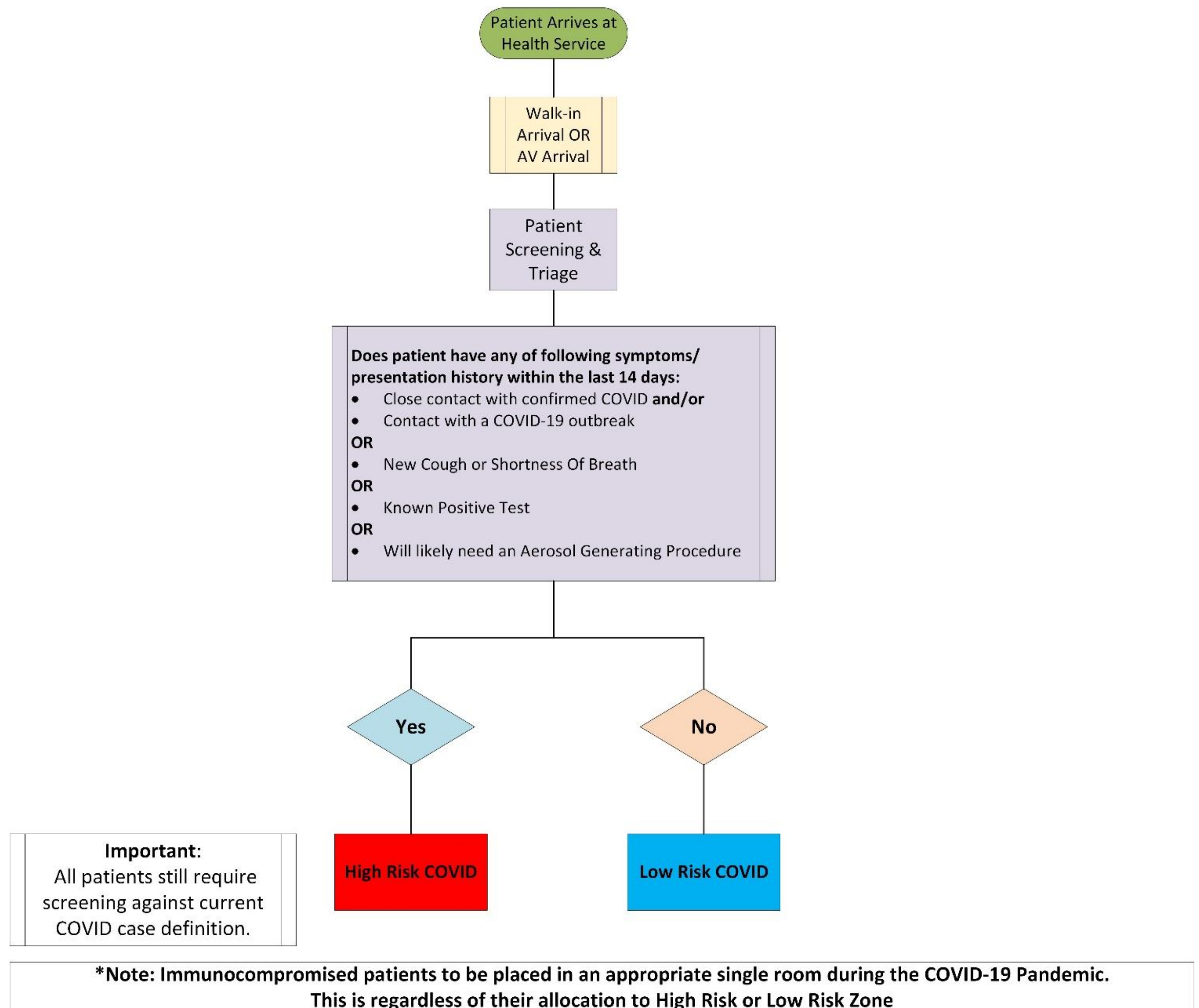
Inclusions: to facilitate SSU functions, patients for admission:

- Must have a defined management plan with a projected discharge trajectory
- Must meet inclusion and exclusion criteria as per the defined pathway
- Should have a predicted length of stay of < 24 hours

Exclusion Criteria for the Short Stay Units is as follows:

1. Those patients who meet the High-Risk criteria for Diagnosis of COVID 19

Figure 1: Emergency Medicine COVID 19 High Risk and Low Risk sorting Algorithm



Important: patients with the following conditions, that are commonly associated with **Shortness Of Breath** can be admitted to the Short Stay Unit.

- Congestive Cardiac Failure
- Acute Asthma Exacerbation
- Pulmonary Embolism

Admission must be approved by a Consultant Emergency Physician or the Senior Registrar in Charge on Night Duty.

Note: these patients should be placed on contact and droplet precautions.

1. **And/Or patients who meet the following criteria:**

- Vital signs meet MET call criteria
- Major co-morbidity
- COPD on home oxygen
- Dialysis
- Medium to high grade heart failure requiring ward admission
- Transplant
- Active cancer, with or without chemotherapy
- IVDU
- High care needs – excepting those purely awaiting transport back to RACF (consider transit lounge)
- Third presentation in less than 1 week

In all cases admission exceptions can be granted by a Consultant Emergency Physician or the Senior Registrar in Charge on Night Duty.

In reference to SSU-MH

Inclusions are:

- Low-dependency Mental health presentation requiring admission or further time for treatment e.g. Anxiolytic and reassessment by a qualified mental health practitioner (e.g. EMH / CL psych clinician / psychiatric registrar or consultant)
- Low-risk recreational drug presentation requiring time for reassessment of physical condition and mental state.

Exclusions are:

- Behavioural disturbance either presently or predicted to be at risk to self or staff e.g. BOC 1 or above (see Behaviours of Concern chart)
- Requiring parenteral sedation (IM, subcut, IV) in ED
- Unable to assess risk to self or staff at initial presentation
- Meeting COVID exclusion criteria
- Unstable vital signs – respiratory and/or haemodynamic compromise
- Patients with concomitant medical issues requiring inpatient admission

7.3 Handover to SSU from ED and transfer requirements

Medical: Medical staff must adhere to two-point handover process:

1. Phone handover. ED medical staff must call SSU medical staff to handover care of the patient, using the structure of the SSU-Medical Handover Form (Appendix A)
2. Handover form. ED medical staff must complete the SSU-Medical Handover Form. This will follow the patient to the SSU.
3. SSU pathway. ED medical staff must print and label the agreed upon SSU pathway. This will follow the patient to the SSU.

Nursing: Nursing staff must follow standard procedure regarding phone handover (ISBAR – refer to policy OP-GC1).

7.4 Staffing

- Initial medical and nursing staffing will be provided by the Emergency Departments at both sites.
- Oversight will be provided by the ED Emergency Physician allocated to SSU. On night shift this will be the Senior Medical Officer in Charge of the respective Emergency Department.
- Management plans will be enacted by the HMO allocated to the SSU in consultation with the Emergency Physician.
- Progression of the COVID pandemic and increased ED workload is anticipated to eventually draw senior ED doctors back from the SSU to the ED.
- In preparation for this eventuality, additional non-ED medical and nursing staff will transition into the SSU to gain experience with SSU processes and may eventually assume overall care.
- Allocation of non-ED staff will occur in conjunction with the nursing and medical workforce units.
- Senior medical staff
  - Optimally, EP on site in SSU 16/24hrs (0730-2330)
  - With increasing demand, EP-led 4 hourly review from 0730-2200 to allow redeployment of the senior staff between times to the main ED
  - Review times may have to be reduced to twice a day depending on increased ED demand for senior staffing time, with the consequences being a reduction in flow through the SSU and concomitant rise in patient safety issues.
  - Between 2330-0730, senior oversight in the SSU is currently provided by an ED registrar, who also undertakes additional tasks within the ED. With geographical isolation of the SSU from the main ED, senior oversight of the SSU should optimally be by a dedicated ED registrar and in the event this is not possible due to increasing ED demands, senior oversight could be assumed by a medical registrar or HMO of similar seniority.
- Junior medical staff
  - With the starting capacity of 12 beds at Footscray and 16 beds at Sunshine, ideally 2 and 3 HMOs per shift
  - Ideally, as beds in SSU open at each site, the number of HMOs allocated to each SSU will also increase.
  - At least 1 HMO will cover each SSU overnight, with senior oversight.
- Nursing staff
  - Significant ED nursing staff presence will be retained at both SSU sites. The experience of senior ED nurses, e.g. CNEs/ANUMs to run the SSU is vital to maintain adherence to protocols, maximise patient safety and optimise flow.

- Should the COVID pandemic progress to a stage where all ED resources are required in ED at all times the model of support and governance will be decided by the Clinical Services Director EMA, in consultation with the inpatient units.

In reference to the SSU-MH staffing required:

- A mental health nurse as per standard ratio who is able to perform routine observations.
- Special nursing staff on an “as needed basis” for patients identified to be a high risk of absconding.
- Additional cover from EMH / CL Psychiatry or Psychiatric registrar will be required for treatment decisions
- It will be the responsibility of the EMH / CL clinicians or psychiatric registrar to review all referrals and formulate a plan for discharge or admission
- Patients awaiting admission bed overnight must be reviewed daily for suitability of discharge
- A psychiatric registrar must be available on-call 24/7 either by phone or in person for all treatment and disposition decisions

7.5 Clinical care

- SSU management pathways will be provided for all common conditions and outline the following components of clinical care:
  - Inclusions and exclusions (see also section 7.2 / Appendix B)
  - Objectives of admission:
  - Investigations
  - Management
  - Referral criteria
  - Discharge criteria
  - Discharge advice
- Management pathways are found in Appendix C.
- Admissions outside common management pathways should have clear instructions for care requirements in the admission notes.

7.6 Flow through SSU

- There should be multiple regular reviews of patients by a senior decision maker to maximise flow.
- Unit flow reviews should be done at least every 3-4 hours with a formal ward round after handover at 0800hrs and 1500hrs (minimum twice per day).
- To expedite discharge, patients should ideally be reviewed in order of their likelihood of discharge to allow ongoing discharge by the resident staff as the review round progresses; not in the order of bed numbering.

  For instance: pregnant patient with vomiting who is tolerating oral intake will be reviewed before the undifferentiated abdominal pain (unless unwell) to allow ongoing discharge by the resident staff as the review round progresses; not in the order of bed numbering.
- This will allow the gradual creation of bed stock and stagger admissions rather than packaging discharges in bulk.
- Patients for admission can be drawn from all non-COVID areas of the ED and once identified should be expedited for admission to the SSU firstly in order of time of arrival to the ED and subsequently by care needs.
- Patients who have completed discharge requirements should be asked to wait for transport in the transit lounge or waiting area unless they are unable to mobilise or self-care e.g. dementia.

7.7 Escalation and admission

- Urgent clinical review criteria calls will be addressed by the SSU HMO or senior doctor.
- MET calls and Code blue calls will also be attended by the MET team, and the Emergency Physician/Senior Registrar assigned to the SSU.
- Patients who fail SSU discharge criteria (either clinical or LOS) must be referred and admitted under the most appropriate unit, as per the WH admissions policy. The one-way referral policy stands for SSU patients. Use ISBAR to refer appropriately.
- Communication with the Bed Manager is critical to highlight those patients who have been referred to expedite ward beds and clear space in SSU. This should occur as soon as the patient is flagged for admission and as a minimum, after the morning and afternoon ward rounds.

7.8 Discharge and Disposition

- Most patients admitted to the SSU are expected to be discharged home
- In general, patients should not be discharged if their symptoms are unmanageable with oral medications and/or if their vital signs are unstable.

- Patients need to have adequate social support. Engage the Allied Health (ACE) team where needed, particularly for older patients, where the ED geriatrician may also be of assistance.
- Individual clinical diagnoses may have further specific safety conditions to meet prior to discharge – see each pathway for guidance and refer to the plan outlined by the referring ED clinician.
- All investigations and abnormal findings must be reviewed and acted upon and any pending results must have a plan for follow up e.g. LMO.
- Ensure patients understand advice for return for medical review (either ED or LMO). Utilise the interpreting service where needed.
- Ensure all patients have a written discharge letter for ongoing health providers and understand the follow up plan which may include any or all of: LMO, specialist clinic, or private provider.

7.9 Teamwork

- The SSU team is a multidisciplinary unit and regular and effective communication across members from medical to nursing to allied health and clerical staff will enhance the experience and outcomes for our SSU patients.

8. Document History

Number of previous revisions:

Previous issue dates: (state month and year)

Documents superseded and/or combined:

9. References

State any references that are relevant to this guideline.

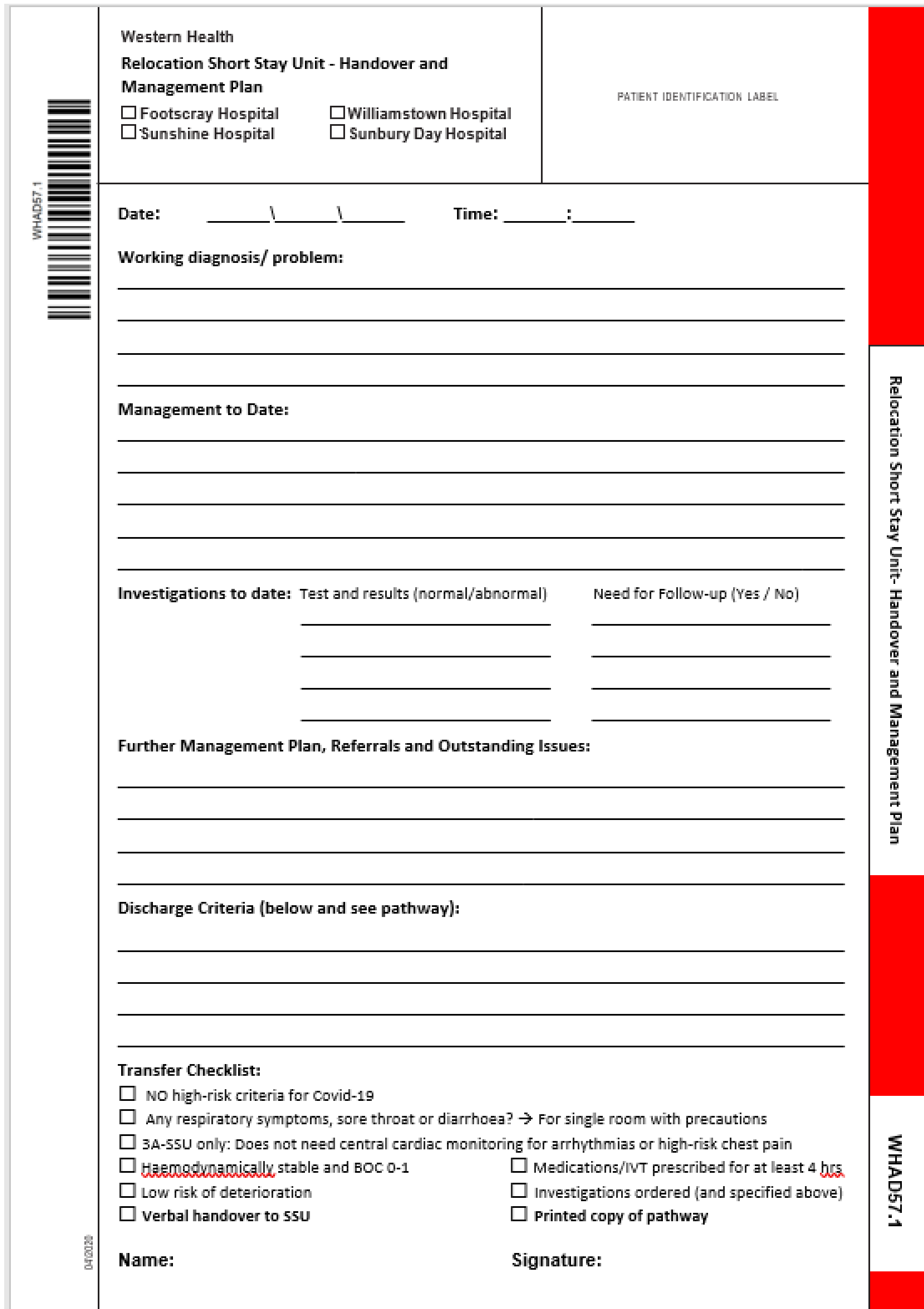
10. Sponsor

Clinical Service Director of Emergency, Medicine and Access

11. Authorisation Authority

Divisional Director of Emergency, Medicine and Access

APPENDIX A: Handover checklist



WHAD57.1

Western Health

Relocation Short Stay Unit - Handover and Management Plan

☐ Footscray Hospital ☐ Williamstown Hospital
☐ Sunshine Hospital ☐ Sunbury Day Hospital

PATIENT IDENTIFICATION LABEL

Date: _____________________ Time: _______:_______

Working diagnosis/ problem:

Management to Date:

Investigations to date: Test and results (normal/abnormal) Need for Follow-up (Yes / No)

Further Management Plan, Referrals and Outstanding Issues:

Discharge Criteria (below and see pathway):

Transfer Checklist:

☐ NO high-risk criteria for Covid-19
☐ Any respiratory symptoms, sore throat or diarrhoea? → For single room with precautions
☐ 3A-SSU only: Does not need central cardiac monitoring for arrhythmias or high-risk chest pain
☐ Haemodynamically stable and BOC 0-1
☐ Low risk of deterioration
☐ Verbal handover to SSU
☐ Medications/IVT prescribed for at least 4 hrs
☐ Investigations ordered (and specified above)
☐ Printed copy of pathway

Name: Signature:

042020

Relocation Short Stay Unit- Handover and Management Plan

WHAD57.1

APPENDIX B: Inclusion and Exclusion Criteria

PRESENTATION	INCLUSION CRITERIA	EXCLUSION CRITERIA

ALL presentations	• **Stable vital signs**
	• **GCS 15**
	• **BOC 0**
		• **High Risk COVID**
		• **MET call criteria vital signs**
		• **Unstable vitals**
		• **Major comorbidity:**
		  ○ COPD on home oxygen
		  ○ Dialysis
		  ○ Heart failure requiring admission
		  ○ Transplant
		  ○ Active cancer, with/without chemo
		  ○ IVDU
		• **High care: wheel-chair or bed-bound**
		• **Third presentation in < 1 week**

Listed below are all the available SSU pathways.

In event of the SSU senior oversight devolving to non ED units, the guidelines have been grouped alphabetically under suggested “medical” and “surgical” streams.

Medical stream pathways

PRESENTATION	INCLUSION CRITERIA	ABSOLUTE EXCLUSION CRITERIA	RELATIVE EXCLUSION CRITERIA
Alcohol intoxication	• Elevated blood alcohol with no other metabolic derangement or traumatic injury and absence of respiratory or cardiovascular compromise	• High suspicion of traumatic injury or metabolic derangement • Agitation/Confusion or other behavioural risk • Alcoholic psychosis • Wernicke's encephalopathy • Medium or high-risk suicidality • Presence of other co-ingestions that require admission • Respiratory compromise and lack of protected airway	• Withdrawal symptoms – severe cases should be referred to medical unit
Anaphylaxis / Allergy	• Severe allergic reactions associated with airway, respiratory or haemodynamic compromise (+/- GI symptoms)	• Ongoing or worsening haemodynamic or respiratory compromise/bronchospasm in spite of IM Adrenaline • IV infusion requirement e.g. Adrenaline/Salbutamol	
Asthma	• Mild-moderate exacerbation of asthma	• PEFR (Peak Expiratory flow rate) < 30% predicted • IV adrenaline required • Evidence of respiratory failure or exhaustion e.g. deteriorating vitals or blood gas • Infective cause requiring admission	• Previous ICU/HDU admissions
Atrial fibrillation	• ECG proven rapid atrial fibrillation requiring rate control (either new onset or exacerbation)	• Intercurrent illness requiring admission on its own merits e.g. Ischaemia, infection • New wide complex tachycardia • Loss of end organ perfusion e.g. Syncope • Emergent DCR required for haemodynamic compromise	
Back pain	• Atraumatic or minor trauma-related back pain for analgesia	• High suspicion of red flag diagnoses e.g. ○ Cauda equina (retention, loss of anal tone, abnormal distal neurology) ○ Epidural abscess (IVDU, DM, systemic infective symptoms, elevated WCC/CRP) ○ Abdominal aortic aneurysm (abdominal mass, haemodynamic compromise) ○ Pathological fractures • Likely LOS > 24 hours	• Age > 65 years – exercise caution • Back pain in non-lumbar regions

PRESENTATION	INCLUSION CRITERIA	ABSOLUTE EXCLUSION CRITERIA	RELATIVE EXCLUSION CRITERIA
Blood transfusion	• Symptomatic anaemia with no need for acute definitive intervention	• Active bleeding • Moderate to severe cardiac failure where fluid management will be difficult • Complex haemolytic anaemia • Asymptomatic anaemic patients that do not meet criteria for immediate transfusion as per WH Standard 7	• Iron infusion indicated as an alternative
Chest pain (ACS)	• Low and medium risk ischaemic chest pain with normal initial cardiac markers and no acute ischaemic ECG changes	• STEMI for cath lab • High risk ischaemia e.g. o Unstable angina o Significantly raised initial troponin (from baseline) o Recent CAGs / PCI o Ischaemic ECG e.g. ST elevation or depression, LBBB o Dynamic ECG changes o Syncope	• Cardiac failure • Ongoing chest pain requiring IV opiates (after consideration of alterative chest pain diagnoses and risk stratification for ACS)
Chest pain (PE)	• Low-moderate risk PE for exclusion with no respiratory or haemodynamic compromise	• Other diagnosis more likely that needs admission e.g. ACS / pericarditis / pneumonia • High risk for significant PE e.g. o Hypoxia / tachycardia o Right heart strain – elevated troponin, RBBB on ECG, S1Q3T3	• SOB without fever o Needs to be discussed with ED and SSU senior in consideration for COVID exclusion o Admission to SSU on senior oversight discretion after discussion
Congestive Cardiac Failure	• Left or right ventricular failure with mild symptoms	• High risk ACS (see chest pain ACS pathway) – in particular o Ongoing chest pain o ECG changes o Significant troponin rise • APO requiring IV infusions or CPAP/non-invasive ventilation • Suspected co-infection or infective trigger requiring admission	• Significant decrease in exercise tolerance • Poor/worsening renal function (either baseline or current) which would make diuresis challenging • New oxygen requirement
DVT	• Unilateral limb swelling +/- erythema and pain	• Neurovascular compromise • Unable to cope at home with mobility • If concomitant suspicion of PE, see PE pathway • If suspicion of cellulitis, see pathway	• Suspicion of upper limb DVT – SSU to await confirmatory imaging, but likely to require admission

PRESENTATION	INCLUSION CRITERIA	ABSOLUTE EXCLUSION CRITERIA	RELATIVE EXCLUSION CRITERIA
Migraine	• Headache requiring IV hydration and/or IV antimigraine/analgesia and antiemetic	• Lateralising neurological deficit • Altered conscious state or GSC <14 • Fever or other symptoms/signs of meningitis • Symptoms and signs of intracranial bleed	• New focal neurological deficit • Age over 60 – unusual first presentation for migraine • Any first presentation of headache

Paracetamol overdose	• N-Acetyl-Cysteine treatment for paracetamol overdose in patients with possible toxic ingestion and paracetamol level requiring treatment as per Rumack-Matthew nomogram and low risk of mental health deterioration	• Co-ingestions requiring LOS > 24 hours
		• Established hepatotoxicity e.g.
		  ○ Acidosis
		  ○ Encephalopathy / coagulopathy
		• Pregnancy
		• Behavioural disturbance or high suicidality or high flight risk
			• Still awaiting ED Mental Health team review

Pyelonephritis	• Loin pain with/without radiation and renal angle tenderness, urinary symptoms of infection +/- fever, FWT leucocytosis and/or nitrates	• Known renal tract abnormality • Known or worsening renal failure • Septicaemia/Haemodynamic compromise • Immunocompromised • Pregnancy	• Previous ureteric calculi • Recent urological instrumentation or surgery (discuss with urology) • Male gender – atypical presentation, consider other diagnoses
Seizure	• Witnessed seizure activity requiring observation	• GCS < 13 • Suspected sepsis • Toxicological seizure • Persistent focal neurological signs • Three or more witnessed seizures in last 24 hours • Pregnancy • Malignancy	• Age > 60 years with first seizure
TIA	• Resolved neurological deficit – for admission under Neurology and unit review prior to discharge	• Intracranial abnormality found on CTB • Recurrent neurological deficit during ED visit • More than 1 TIA in the last month • Known high-grade carotid stenosis	

PRESENTATION	INCLUSION CRITERIA	ABSOLUTE EXCLUSION CRITERIA	RELATIVE EXCLUSION CRITERIA
Vertigo	• Vertigo / dysequilibrium without lateralising or cerebellar neurological deficits in the absence of presyncope or syncope	• Arrhythmia suspected – presyncope/syncope or abnormal ECG at any time • Altered conscious state • Neurological deficits e.g. lateralising or cerebellar signs or other posterior circulation including brainstem and visual field deficits – including transient or persisting • Other coexisting pathology requiring admission e.g. RAF, cardiac ischaemia, infective source	• Exercise caution with patients with transient neurological deficit and also utilize TIA pathway • Age > 60 years
Vomiting in Early Pregnancy	• Poorly controlled vomiting in pregnancy, rarely presents for the first time > 10 weeks, usually resolved by 20 weeks, requiring education, IV hydration and reestablishment of oral intake routine.	• Presence or suspicion of non-pregnancy related pathology e.g. cholecystitis • Ectopic pregnancy	• Multiple prolonged (>24 hour) previous admissions for similar presentations

Surgical stream pathways

PRESENTATION	INCLUSION CRITERIA	ABSOLUTE EXCLUSION CRITERIA	RELATIVE EXCLUSION CRITERIA
Abdominal pain	• Non-specific abdominal pain for Investigation or Observation	• Acute surgical or gynaecological pathology identified or highly likely e.g. ○ Peritonism ○ Grossly abnormal WCC / CRP / LFT/lipase ○ Ovarian torsion ○ Ectopic pregnancy	• Pregnancy with no haemodynamic compromise – may use admission to expedite surgical and gynaecological review • Exercise caution with age >70 years
Biliary colic	• RUQ/Epigastric pain likely to be cholelithiasis	• Evidence of systemic infection • Peritonism • Jaundice	
Cellulitis	• Single limb cellulitis that is not responding to oral antibiotics or is systemically unwell	• Features of necrotizing fasciitis • Lymphoedema • Undrained collection • Diabetic foot ulcers with cellulitis (should be admitted under Diabetic Foot Unit – shared endo/vascular bedcard)	• Facial / orbital cellulitis • IVDU • Diagnostic doubt e.g. DVT / foreign body (consider admission while awaiting ultrasound) • Suitable for oral therapy or therapy with HITH
Minor head injury	• Isolated head injury, GCS >13, normal CT brain, imaging awaited or not required • Admission for ongoing observation or analgesia	• Abnormal CT scan • Focal neurology • Deteriorating GCS <14 • Escalating agitation/ confusion • Skull fracture • Other truncal traumatic injuries • Complications of head injury e.g. seizure	• Significant pre-existing disease e.g. anticoagulation, dementia • Vomiting on admission • Retro or anterograde amnesia • Intoxication
Pain and bleeding in Early Pregnancy	• Pregnancy <17 weeks with controlled PV bleeding, no haemodynamic compromise and confirmed intrauterine pregnancy (IUP)	• Not pregnant • Ongoing, uncontrolled bleeding with haemodynamic compromise – will need emergent PV exam and clearing of any ostial contents • Ectopic pregnancy proven on ultrasound • Pregnant with proven non pregnancy related pathology	• No sonographic documentation of IUP - if stable, might consider SSU admission to await ultrasound • Pelvic pain without bleeding • Pain and bleeding 16 weeks and older to be referred to MAC
Pneumothorax, Spontaneous	• First spontaneous pneumothorax, onset < 8 hours for conservative management or post successful aspiration	• Underlying chronic lung disease • Trauma • Bilateral pneumothorax • Tension pneumothorax • Significant haemothorax	

PRESENTATION	INCLUSION CRITERIA	ABSOLUTE EXCLUSION CRITERIA	RELATIVE EXCLUSION CRITERIA
Post procedural sedation recovery	• Awaiting recovery and discharge after procedural sedation e.g. DCR, dislocated shoulder reduction	• Other injury or pathology requiring admission e.g. cardiac ischaemia, ongoing AF, traumatic injury requiring further definitive treatment • Complication of sedation e.g. aspiration, intubation • Ongoing respiratory or haemodynamic compromise	• Poor baseline mobility
Renal colic	• Unilateral flank pain +/- radiation to groin	• Systemic symptoms or signs of infection • Significant deterioration of GFR from baseline ○ Pulsatile mass (AAA) • Other diagnosis strongly suspected that requires admission e.g. Surgical abdomen, testicular torsion	• Single kidney • Pregnancy

Tonsillitis	• Acute febrile sore throat requiring analgesia, IV hydration +/- antibiotics	• Impending airway obstruction or high suspicion of deep neck space collection/infection e.g.
		  ○ Stridor
		  ○ Trismus
		  ○ Drooling/unable to tolerate own secretions
		  ○ Inability to lie flat
		• Quinsy (refer ENT)
			• Low-mod suspicion of other deep neck space infection e.g. retropharyngeal abscess – depending on clinical picture some cases can be admitted by ED consultant to SSU for imaging (CT neck)
			• Tonsillitis is rare in older populations i.e. age > 50 – consider other pathology

Trauma	• Minor trauma or ED trauma (see guideline) for imaging or analgesia	• Trauma CALL and ALERT patients are unlikely to be SSU candidates -> refer
		• Major head / chest / abdominal / pelvic trauma suspected or detected e.g.
		  ○ Intracranial haemorrhage
		  ○ Haemo/pneumothorax
		  ○ Intraabdominal bleeding
		  ○ Complex pelvic fractures (excluding simple pubic ramus fracture)
		• Compartment syndrome suspected
		• Neurological deficit
		• Unlikely to cope on discharge even if simple injuries found	

Urinary retention	• Urinary retention	• Unable to manage leg bag • Other pathology causing retention requiring admission e.g. neurogenic / haematuria / abdominal mass • Septicaemia of high risk thereof	• Recent urological instrumentation/surgery • Inadequate social supports – might admit to SSU if potential to uplift outpatient support services in the next 24 hours.

APPENDIX C: COVID-SSU Care Pathways

ABDOMINAL PAIN FI

Non-specific abdominal pain for current or pending Investigation and/or Observation with none of the absolute exclusion criteria identified

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Acute surgical or gynaecological pathology identified e.g. ○ Peritonism ○ Grossly abnormal WCC / CRP / LFT/lipase ○ Ovarian torsion ○ Ectopic pregnancy	• Pregnancy with no haemodynamic compromise – may use admission to expedite surgical and gynaecological review • Age >70 years

KEY CONSIDERATIONS DURING SSU ADMISSION

- Observe for recurrent or evolving symptoms
- Repeat abdominal examination looking for interval changes
- Pre-menopausal females must have urinary BHCG
- Low threshold for imaging e.g. CT abdo/pelvis or abdominal USS and referral for admission, especially if:
  - Increasing age
  - Ongoing or increasing analgesic requirement
- Analgesia + antiemetic
  - Paracetamol 1g QID po prn / Ibuprofen 400mg TDS po prn
  - Oxycodone 5mg Q3H po prn
  - Ondansetron 4-8mg po/IV TDS prn / Metoclopramide 10-20mg po/IV TDS prn

REFERRAL CRITERIA (to Gen Surg or Gynaecology)	DISCHARGE CRITERIA
• Ongoing abnormal or worsening vital signs • Pathology identified on imaging or lab results requiring admission • Increasing analgesic requirement • Deteriorating abdominal examination	• Normal vital signs • No acute pathology identified on imaging and normal lab investigations • Tolerating oral intake • Adequate social support

DISCHARGE REQUIREMENTS

- Patient education e.g. analgesia usage, bowel habit management
- Follow up plan - LMO for review within the week and ongoing investigations as indicated e.g. colonoscopy
- Re-attendance advice + information sheet
- Medical certificate
- Prescription for discharge medications as indicated

ALCOHOL INTOXICATION

Elevated blood alcohol with no other metabolic derangement or traumatic injury and absence of respiratory or cardiovascular compromise

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• High suspicion of traumatic injury or metabolic derangement • Agitation/Confusion or other behavioural risk • Alcoholic psychosis • Wernicke's encephalopathy • Medium or high risk suicidality • Presence of other co-ingestions that require admission • Respiratory compromise and lack of protected airway	• Withdrawal symptoms – severe cases should be referred to medical unit

KEY CONSIDERATIONS DURING SSU ADMISSION

- Re-establish hydration
  - Antiemetic – Metoclopramide 10 mg QID oral or IV/Ondansetron 4-8 mg TDS or IV prn
  - Oral and IV fluids
- Thiamine – IV 300mg TDS
- Complete Alcohol Withdrawal Scale during admission – ensure that appropriate benzodiazepines are charted as per AWS protocol
- Traumatic injury screen
- Seek and treat nutritional deficits and metabolic imbalances – UEC/CPM/LFT/Lipase/BSL
- Seek and treat other toxidromes or co-ingestions
- Suicidality assessment – when patient competent to participate, use SADPERSONS prompt
- Repeated reassessments to check on conscious state and look for focal neurology
- Drug and Alcohol service referral offered to patient (ED D&A Clinician during referral hours)
- Social issues addressed e.g. personal hygiene, housing, driving, employment

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Continuing altered conscious state • Identification of acute pathology requiring admission e.g. intracranial injury, trauma, focal neurology, alcoholic hepatitis • Alcohol related pathology e.g. D&V, immobility • Suicidality risk	• Baseline function, mentation and mobility • Absence or control of withdrawal symptoms

DISCHARGE REQUIREMENTS

- Ongoing prescription - Thiamine 100 mg orally daily
- D&A information sheet
- Transport home – can be provided with daily public transport ticket, or taxi voucher.

ANAPHYLAXIS (and ALLERGY)

Severe allergic reactions associated with airway, respiratory or haemodynamic compromise (+/- GI symptoms)

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Ongoing or worsening haemodynamic or respiratory compromise/bronchospasm in spite of IM Adrenaline • IV infusion requirement e.g. Adrenaline/Salbutamol	

KEY CONSIDERATIONS DURING SSU ADMISSION

- Observation for resolution of symptoms
- Report anaphylaxis to Department of Health via website https://forms.business.gov.au/smartforms/servlet/SmartForm.html?formCode=anaphylaxis-notify
- Prednisolone 50 mg po daily for 3 days
- Promethazine 10-25mg po TDS prn – for allergy symptoms
- Salbutamol 8-12 puffs MDI via spacer – for bronchospasm
- Ranitidine 150mg po BD prn – if itch prominent

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Recurrent symptoms of anaphylaxis requiring treatment • Haemodynamic or respiratory compromise • Inability to tolerate oral intake	• No recurrence of symptoms 4-6 hours after resolution • Adequate social supports and geographically not far from return medical care • Do not discharge anaphylaxis cases overnight • Patient educated about Epipen use

DISCHARGE REQUIREMENTS

- Anaphylaxis information sheet, action plan and patient education of the same - https://www.allergy.org.au/hp/anaphylaxis/ascia-action-plan-for-anaphylaxis
- Also see resources in SSU "Anaphylaxis folder" and patient hand outs
- Prescriptions for Epipen (adrenaline autoinjector) x 2 (requires PBS authority script)
- Prescription for Prednisolone 50 mg daily for 2 days and antihistamine if needed
- Letter to LMO requesting allergen testing where allergen unclear

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check: □ No airway or haemodynamic compromise □ Document specific observation period length and projected discharge time □ Discharge documentation and education completed	NID: **Not Appropriate / Appropriate** Signature
Outcomes pending (to be filled in by MO): 4 Hour Observation from (time):	
Nursing staff to check: □ All "discharge criteria and requirements" have been met □ Vital signs normal □ No recurrence of symptoms within documented observation period or for 4 hours since last review	NID: **Not Appropriate / Appropriate** Signature

ASTHMA

Mild-moderate exacerbation of asthma

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• PEFR (Peak Expiratory flow rate) < 30% predicted • IV adrenaline required • Evidence of respiratory failure or exhaustion e.g. deteriorating vitals or blood gas • Infective cause requiring admission	• Previous ICU/HDU admissions

KEY CONSIDERATIONS DURING SSU ADMISSION

- Consider and treat triggering causes
  - Infection – CXR prior to SSU admission to exclude pneumonia/pneumothorax; check FBE/CRP
  - Drug non-compliance – history, check inhaler and spacer technique and escalation of asthma management plan
  - UEC for hypokalemia in setting of excessive salbutamol therapy
- Bronchodilator
  - If not previously received "burst therapy" then Salbutamol 12 puffs via spacer, 3 times over 1 hour and Ipratropium bromide 6 puffs via spacer stat
  - Pre and post PEFR measurement at each bronchodilator dosing will allow objective measurement of improvement or deterioration
  - Additional doses of bronchodilator e.g. Salbutamol 12 puffs per dose should be charted initially hourly and then, depending on response stretched to 2 hourly and then 4 hourly with a view to discharge
- Steroid therapy - Prednisolone 50mg po stat
- Continue usual preventer and other therapies
- Progress
  - Discharge will require patient to be able to tolerate lengthening periods (e.g. 1-> 2-> 4 hours) between inhaled bronchodilators without recurrence of symptoms e.g. SOB, dyspnoea, auscultatory wheeze

REFERRAL CRITERIA (Respiratory/Medicine)	DISCHARGE CRITERIA

• Ongoing abnormal or worsening vital signs
• Pathology identified on imaging or lab results requiring admission
• Deteriorating symptoms
  ○ Ongoing salbutamol requirement of 2 hours or less
  ○ Deteriorating PEFR in spite of treatment
	• Able to stretch more than 2 hours without bronchodilators
	• Normal vital signs
	• Tolerating oral intake
	• Adequate social support
	• Return to baseline mobility and exercise tolerance

DISCHARGE REQUIREMENTS

- Do not discharge overnight
- Patient education e.g. printed asthma action plan and triggers for return
  - Must have suggested plan for steroid e.g. 3 day course vs tapering or none
  - Must have suggested plan for reliever medication
  - Continue usual preventer medication
- Follow up plan - LMO for review within the week or usual respiratory physician
- Prescription for discharge medications as indicated e.g. steroids / spacer / fresh bronchodilator or usual preventer, oral antibiotic

ATRIAL FIBRILLATION

ECG proven rapid atrial fibrillation requiring rate control (either new onset or exacerbation)	
EXCLUSION CRITERIA	
ABSOLUTE	**RELATIVE**
• Intercurrent illness requiring admission on its own merits e.g. Ischaemia, infection • New wide complex tachycardia • Loss of end organ perfusion e.g. syncope • Emergent DCR required for haemodynamic compromise	

KEY CONSIDERATIONS DURING SSU ADMISSION

- Seek and treat underlying trigger
  - Infection (CXR, FWT), cardiac ischaemia (trop/s if indicated), electrolyte (K, CPM), medication error, poisoning (ETOH, digoxin), anaemia (FBE), metabolic e.g. hyperthyroidism (TFT), haemorrhage (PR loss)
- Control rate
- Oral or IV agents – be aware of drug interactions
  - B-blocker e.g. metoprolol – avoid in asthma / COPD
  - Ca-channel blocker e.g. verapamil
  - Fleccanide + amiodarone – consult with cardiology first
- Consider IV Magnesium for alcohol induced AF
- Semi-elective DCR – when fasted and anticoagulated (Clexane 1mg/kg) in resus area
- Anticoagulation
  - All patients should have stroke risk assessed using CHA2DS2-VASC score and have anticoagulation options discussed (if not already commenced) e.g. NOAC or warfarin

REFERRAL CRITERIA (Cardiology)	DISCHARGE CRITERIA
• Haemodynamic or respiratory compromise • HR >120 in spite of maximal treatment	• HR < 110 • Cardiac ischaemia excluded • Trigger addressed if found • Anticoagulation + rate control discussed • Social support adequate, no discharges after midnight

DISCHARGE REQUIREMENTS

- Follow up plan with letter; options include –
  - LMO with outpatient ECHO if nil recent
  - Cardiology – own cardiologist or cardiology outpatients/new electrophysiologist
- Prescriptions for antiarrhythmic and/or anticoagulation where indicated
- Medical certificate
- Re-attendance advice

BACK PAIN

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• High suspicion of red flag diagnoses e.g. ○ Cauda equina (retention, loss of anal tone, abnormal distal neurology) ○ Epidural abscess (IVDU, DM, systemic infective symptoms, elevated WCC/CRP) ○ Abdominal aortic aneurysm (abdominal mass, haemodynamic compromise) ○ Pathological fractures • Likely LOS > 24 hours	• Age >65 years • Back pain in non-lumbar regions

KEY CONSIDERATIONS DURING SSU ADMISSION

- Thorough neurological exam – tone / power / reflexes / sensation including perineum / anal tone
- Pre- and post-void bladder scan – residual volume <150mls
- Analgesia - multimodal
  - Paracetamol 1g QID po REGULAR + NSAID REGULAR e.g. ibuprofen 400mg TDS po
  - Oxycodone 5-10mg Q6h po REGULAR with prn breakthrough doses
  - Consider initial doses of IV Morphine 2 mg aliquots titrated to effect in the first hour
- Allied health review
- Inflammatory markers (FBE/CRP, Ca in prostate cancer/multiple myeloma)
- FWT and follow-up MSU if leucocytosis or nitrates present
- Imaging (plain lumbosacral XR) reasonable in high risk groups – elderly trauma, past history of cancer

REFERRAL CRITERIA (Gen Med/AAC)	DISCHARGE CRITERIA
• Unstable vital signs • Pathology found on imaging that requires management • Increasing analgesic requirement • Failed mobility assessment with ACE	• Tolerating oral intake • Adequate social support • Mobilising safely • Passing urine / post void residual normal

DISCHARGE REQUIREMENTS

- Follow up plan; LMO to manage gradated return to activity/physiotherapy and to consider outpatient MRI if disc pathology suspected
- Re-attendance advice
- Prescription for discharge medications where indicated
- Advice regarding stool softener and bowel regularity if prescribed oral opiates
- Medical certificate

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check:	NID: **Appropriate/ Not Appropriate**
□ Causes other than mechanical back pain excluded □ Analgesic requirements met for discharge □ Discharge documentation completed □ Documented observation period length	Signature
Outcomes pending (to be filled in by MO):	
Nursing staff to check: □ All “discharge criteria and requirements” met □ Patient able to mobilise and completed ACE review □ Ensure discharge prescriptions issued	NID: **Appropriate/ Not Appropriate** Signature

BILIARY COLIC

EXCLUSION CRITERIA	
ABSOLUTE	**RELATIVE**
• Evidence of systemic infection • Peritonism • Jaundice	

KEY CONSIDERATIONS DURING SSU ADMISSION

- Confirm diagnosis (biliary USS) - if pain resolved and normal inflammatory markers and biochemistry, may obtain as outpatient
- Exclude complications of cholelithiasis
    - Infection (FBE/CRP)
    - Obstruction of biliary tree (LFTs), Pancreatitis (Lipase)
    - Dehydration (UEC)
- Exclude differentials - Ischaemia (ECG); perforated PUD (erect CXR)
- Analgesia
    - Simple: regular - paracetamol 1g QID, Ibuprofen 400 mg TDS oral regular
    - Opioid: Oxycodone 5-10mg prn; Morphine 2.5mg IV aliquot prn
- Antiemetic - Ondansetron 4-8mg sublingual or IV / Metoclopramide 10mg oral or IV

REFERRAL CRITERIA (Surgical)	DISCHARGE CRITERIA
• Systemic infective symptoms or haemodynamic compromise • High grade obstruction on USS • Grossly abnormal LFTs/Lipase • Unable to tolerate oral intake	• Tolerating oral analgesia • Tolerating oral intake • Cholelithiasis confirmed or USS arranged for next working day

DISCHARGE REQUIREMENTS

- Follow up plan; options include –
    - LMO with outpatient surgical referral via BOSSNet
    - Patient can explore private surgical options if insured
    - More urgent surgical follow up if recurrent biliary colic – discuss with surg reg
- Prescriptions for prn analgesia
- Medical certificate
- Education – avoid fatty meals and any other individually identified triggers e.g. alcohol

BLOOD TRANSFUSION

Symptomatic anaemia with no need for acute definitive intervention

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Active bleeding • Moderate to severe cardiac failure where fluid management will be difficult • Complex haemolytic anaemia • Asymptomatic anaemic patients that do not meet criteria for immediate transfusion as per WH Standard 7	• Iron infusion indicated as an alternative

KEY CONSIDERATIONS DURING SSU ADMISSION

- Transfusion of 2-4 units packed red cells depending on initial Hb
- Fluid review required between each unit of packed cells
    - Consider IV frusemide 20mg between units if history of CCF (only chart after review, do not chart as proforma)
- Screen for potential causes of anaemia (iron-deficiency / B12 / folate / other)
- No requirement to check Hb on completion of transfusion

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Systemic symptoms or haemodynamic instability • Development of fluid overload • Significant transfusion reaction • Abnormal blood film • Recurrence of blood loss	• Vital signs normal post transfusion • No transfusion reaction • Adequate social support • Appropriate follow up plan

DISCHARGE REQUIREMENTS

- Follow up plan;
    - If iron-deficiency related – for LMO to review and refer to DAGE (endoscopy) if nil recent, or Gynaecology for menorrhagia
    - If unclear source consider referral to Haematology clinic
    - If chronic blood loss and likely to be recurrent – LMO to refer to MADU for future elective transfusions
- Medical certificate

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check:	NID: **Appropriate/ Not Appropriate**
☐ All investigations reviewed and results actioned ☐ Discharge documentation and patient education completed ☐ No clinical cardiac failure	Signature
Outcomes pending (to be filled in by MO):	
Nursing staff to check:	NID: **Appropriate/ Not Appropriate**
☐ Transfusion completed ☐ Vital signs normal ☐ All 'Discharge Criteria and Requirements' met ☐ Patient mobilising and available transport home	Signature

CELLULITIS

Single limb cellulitis
Not responding to oral antibiotics or systemically unwell

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Features of necrotizing fasciitis • Lymphoedema • Undrained collection • Diabetic foot ulcers with cellulitis (should be admitted under Diabetic Foot Unit – shared endo/vascular bedcard)	• Facial / orbital cellulitis • IVDU • Diagnostic doubt e.g. DVT / foreign body (consider SSU admission to await U/S) • Suitable for oral therapy or therapy with HITH

KEY CONSIDERATIONS DURING SSU ADMISSION

- IV antibiotics –
  - Flucloxacillin 1g IV Q6H OR
  - Cefazolin 2g IV Q8H (non-immediate penicillin hypersensitivity) OR
  - Clindamycin 600mg IV Q8H (immediate penicillin hypersensitivity)
- Analgesia + antiemetic
  - Paracetamol / Codeine / Ibuprofen
  - Ondansetron 4-6 mg TDS sublingual or IV/ Metoclopramide 10mg QID oral or IV
- Limb rest + elevation
- Treat predisposing conditions e.g. tinea pedis
- Swab if ooze present
- Blood cultures especially if vital signs abnormal

Red flags: diabetes + ulcers, immunosuppression, prev. MRSA, IVDU

REFERRAL CRITERIA (Med/Plastics)	DISCHARGE CRITERIA
• Systemic symptoms or haemodynamic instability • Rapidly progressive cellulitis • ANY concern for necrotizing fasciitis needs Plastics consult immediately	• Systemically well • Tolerating oral analgesia • Mobility safe + able to immobilise limb • Social supports adequate

DISCHARGE REQUIREMENTS

- Follow up plan;
  - Mark cellulitis boundaries for LMO / HITH follow up
- Prescription for oral antibiotics
  - Flucloxacillin 500 mg QID for 7 days
  - or Cephalexin 500 mg QID for 7 days (for penicillin hypersensitivity)
  - or Clindamycin 450 mg TDS for 10 days
- Medical certificate
- Re-attendance advice

CHEST PAIN (ACS)

Low and medium risk ischaemic chest pain with normal initial cardiac markers and no acute ischaemic ECG changes

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE

• STEMI for cath lab
• High risk ischaemia e.g.
  ○ Unstable angina
  ○ Significantly raised initial troponin (from baseline)
  ○ Recent CAGs / PCI
  ○ Ischaemic ECG e.g. ST elevation or depression, LBBB
  ○ Dynamic ECG changes
  ○ Syncope
	• Cardiac failure
	• Ongoing chest pain requiring IV opiates (after consideration of alterative chest pain diagnoses and risk stratification for ACS)

KEY CONSIDERATIONS DURING SSU ADMISSION

- Analgesia
  - Aspirin 300mg po daily/ Glyceryl Trinitrate 1-2 spray sublingual (if ACS suspected) prn
  - IV Morphine 2.5mg prn
- Antiemetic – Ondansetron 4-8 mg TDS oral or IV/ Metoclopramide 10 mg QID oral or IV prn
- *** NB. Seek, exclude or treat other causes as clinically indicated e.g.
  - Aortic Dissection (older age, HTN, known aortic disease)
  - Pulmonary Embolism (apply PERC, Wells)
  - Pneumonia (CXR)
  - Pneumothorax (CXR)
  - Pericardial effusion +/- tamponade (features of myo/pericarditis, raised JVP)
  - Biliary (LFT/lipase)
- Cardiac monitoring
- Serial troponin as per WH guideline (if ACS suspected) – usually 3hrs apart, i.e. Raised troponin with Z-score > 2

REFERRAL CRITERIA (Cardiology)	DISCHARGE CRITERIA
• Systemic symptoms or haemodynamic instability • Significant troponin rise • Dynamic ECG changes (at any point of stay) • Unresolved significant chest pain • Other diagnosis declared	• Systemically well • Stable vitals • Tolerating oral analgesia • Serial troponins and ECGs negative and sighted by medical officer • Mobilising safely • Social supports adequate

DISCHARGE REQUIREMENTS

- Follow up plan;
  - Consider outpatient stress ECHO / MIBI if multiple vascular risk factors
  - LMO or patient's own cardiologist follow up with letter, copies of ECG and investigation results
- Prescription for aspirin / anti-anginal where indicated by vascular risk
- Medical certificate

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check:	NID: **Appropriate/ Not Appropriate**
☐ All investigations reviewed and results actioned ☐ Discharge documentation and patient education completed	Signature
Outcomes pending (to be filled in by MO):	
Nursing staff to check: ☐ All "discharge criteria and requirements" met ☐ Patient remains pain-free	NID: **Appropriate/ Not Appropriate** Signature

CHEST PAIN (PE)

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE

• Other diagnosis more likely that needs admission e.g. ACS / pericarditis / pneumonia
• High risk for significant PE e.g.
  ○ Hypoxia / tachycardia
  ○ Right heart strain – elevated troponin, RBBB on ECG, S1Q3T3
	• SOB without fever
	  ○ Needs to be discussed with ED and SSU senior in consideration for COVID exclusion
	  ○ Admission to SSU on senior oversight discretion after discussion

KEY CONSIDERATIONS DURING SSU ADMISSION

- Analgesia
  - Paracetamol 1 g QID oral/ Ibuprofen 400 mg TDS oral
- Antiemetic – Ondansetron 4-8 mg sublingual or IV/Metoclopramide 10 mg QID IV or oral
- Exclude other causes (pneumothorax, pneumonia – CXR +/- ACS work-up)
- Confirm pregnancy status with urinary bHCG
- Risk stratification using Well's criteria +/- pulmonary embolism rule-out criteria
- Decision re: utility of D-dimer vs imaging i.e. CTPA / VQ should be made in ED by experienced clinician.
- Ensure patient has 18G peripheral IV access if imaging requested.
- Assess for DVT and exclude if suspected (doppler limb USS)
- Anticoagulate early if anticipated delay to definitive test – i.e. Clexane 1mg/kg subcut stat (max dose 100 mg)
- Thrombophilic screen for proven PE or DVT prior to commencing long-term anticoagulation

REFERRAL CRITERIA (various)	DISCHARGE CRITERIA
• Systemic symptoms or haemodynamic compromise • CTPA or VQ positive for PE (Respiratory or Obstetric Medicine for pregnant patients) • Dynamic ECG changes (Cardiology) • Unresolved significant chest pain (Cardiology) • Other diagnosis declared	• Systemically well • Stable vitals • Tolerating oral analgesia • D-dimer or imaging negative for PE • Risk stratification completed for ACS

DISCHARGE REQUIREMENTS

- Follow up plan;
  - LMO – suggest follow up test as indicated after risk stratification e.g. provocative testing for ACS
- Prescription for analgesia where needed
- Medical certificate
- Re-attendance advice – e.g. worsening pain, dyspnoea, collapse

CONGESTIVE CARDIAC FAILURE

Left or right ventricular failure with mild symptoms	
EXCLUSION CRITERIA	
ABSOLUTE	**RELATIVE**

• High risk ACS (see chest pain ACS pathway) – in particular
  ○ Ongoing chest pain
  ○ ECG changes
  ○ Significant troponin rise
• APO requiring IV infusions or CPAP/non-invasive ventilation
• Suspected co-infection or infective trigger requiring admission
	• Significant decrease in exercise tolerance
	• Poor/worsening renal function (either baseline or current) which would make diuresis challenging
	• New oxygen requirement

KEY CONSIDERATIONS DURING SSU ADMISSION

- Consider and treat triggering causes
  - ACS – serial troponin where indicated; ECG for rhythm disturbance
  - Infection – CXR should occur prior to SSU admission (see exclusions)
  - Fluid and electrolyte disturbance – UEC, check compliance with any fluid restrictions
  - Medication compliance – take a detailed history including OTC and natural therapies, check levels e.g. digoxin in AF
- Diuresis
  - Will be case dependent based on degree of overload and symptoms
  - Chart usual medications including usual doses of diuretics
  - IV frusemide 20-40mg stat and ongoing doses based on severity of disease and titrated to effect
  - Consider a brief period of increased diuretic dose on discharge with LMO follow-up and repeat UECs in 5-7 days

REFERRAL CRITERIA (Cardiogeriatrics/Medicine)	DISCHARGE CRITERIA
• Ongoing abnormal or worsening vital signs • New and ongoing requirement for oxygen • Pathology identified requiring admission • Deteriorating symptoms • Ongoing and increasing diuretic requirement • See admission guideline policy for differentiation between cardio/medicine	• Normal vital signs • No acute pathology identified on imaging and normal lab investigations • Tolerating oral intake • Return to baseline mobility and function • Adequate social support

DISCHARGE REQUIREMENTS

- Patient education e.g. reinforce fluid restrictions where applicable, medication compliance
- Follow up plan - LMO for review within the week or usual cardiologist
- Re-attendance advice + information sheet
- Medical certificate
- Prescription for discharge medications as indicated e.g. increased or new diuretic

DVT

<table>
<tr><th colspan="2">Unilateral limb swelling +/- erythema and pain</th></tr>
<tr><th colspan="2">EXCLUSION CRITERIA</th></tr>
<tr><th>ABSOLUTE</th><th>RELATIVE</th></tr>
<tr><td>• Neurovascular compromise
• Unable to cope at home with mobility limitations
• If concomitant suspicion of PE, see PE pathway
• If suspicion of cellulitis, see pathway</td><td>• Suspicion of upper limb DVT – SSU to await confirmatory imaging, still likely to require admission on confirmation</td></tr>
</table>

KEY CONSIDERATIONS DURING SSU ADMISSION

• Imaging – doppler limb USS in hours
• Anticoagulate if staying overnight for USS in AM
  ○ Clexane 1mg / kg subcut stat (max dose 100 mg)
• Consider other diagnoses
  ○ Infection / trauma
• If DVT confirmed consider triggers i.e. immobility / travel / trauma / malignancy / OCP
  ○ Anticoagulate with NOAC or warfarin where safe for at least 3 months
  ○ Thrombophilic screen prior to long-term anticoagulation
  ○ Haematology review in 3 months

REFERRAL CRITERIA (Medical/Vasc)	DISCHARGE CRITERIA
• Unstable vital signs • Upper limb DVT • Lower limb DVT within 10 cm of saphenofemoral junction or pelvic extension • Failed mobility assessment with ACE • No other diagnosis requiring admission e.g. cellulitis	• No symptoms of PE • Tolerating oral intake • Adequate social support • Mobilising safely

DISCHARGE REQUIREMENTS
• Follow up plan;   ○ LMO with letter; Haematology clinic in 3 months – BOSSNET request required • Advice for return including symptoms of PE • Medical certificate • Prescription for NOAC or warfarin + analgesia, avoid NSAID

MIGRAINE

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Lateralising neurological deficit • Altered conscious state or GSC <14 • Fever or other symptoms/signs of meningitis • Symptoms and signs of intracranial bleed	• New focal neurological deficit • Age over 60 – unusual first presentation for migraine • Any first presentation of headache

KEY CONSIDERATIONS DURING SSU ADMISSION

- Analgesia regular – Paracetamol 1g QID / Aspirin 600mg TDS/Ibuprofen 400mg QID
- Antiemetic prn – Ondansetron 4-8 mg TDS IV or sublingual/ Metoclopramide10 mg TDS IV or oral
- Migraine therapy
  - Chlorpromazine 12.5mg in 100 ml IV N/saline run over 20 min
  - Can be repeated 3 times, total maximum dose of 37.5 mg IV, titrated to effect
  - **AND** concurrent 1 L N/saline (to mitigate any hypotension)
- CTB +/- LP if suspicion for subarachnoid haemorrhage (SAH)
  - CTB within 6hrs of headache onset will obviate need for LP

REFERRAL CRITERIA (Neurology)	DISCHARGE CRITERIA
• No improvement of symptoms despite maximal therapy (Neurology) • SAH found on CTB or LP (Neurosurgery) • New or progressive neurological signs	• Migraine resolved or improved • Tolerating oral intake • Baseline function, mentation and mobility • Stable vitals and no systemic symptoms including no fever • No focal neurological deficit

DISCHARGE REQUIREMENTS

- Follow up plan;
  - LMO letter
- Prescription for analgesia or patient's usual anti-migraine meds
- Medical certificate
- Re-attendance advice – e.g. recurrent headache, neurological symptoms

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check:	NID: **Appropriate/ Not Appropriate**
☐ Causes other than migraine considered/excluded ☐ All investigations reviewed and results actioned ☐ Discharge documentation and patient education completed	Signature
Outcomes pending (to be filled in by MO):	
Nursing staff to check:	NID: **Appropriate/ Not Appropriate**
☐ All "discharge criteria and requirements" met ☐ Patient eating, drinking and mobilising ☐ Headache settled or resolved ☐ Patient keen for discharge	Signature

MINOR HEAD INJURY

Isolated head injury, GCS >13, normal CT brain,
Imaging awaited or not required.
Admission for ongoing observation or analgesia

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Abnormal CT scan • Focal neurology • Deteriorating GCS <14 • Escalating agitation/confusion • Skull fracture • Other truncal traumatic injuries • Complications of head injury e.g. seizure	• Significant pre-existing disease e.g. anticoagulation, dementia • Vomiting on admission • Retro or anterograde amnesia • Intoxication

KEY CONSIDERATIONS DURING SSU ADMISSION

- Analgesia: regular + prn
- Oral hydration
- Hourly vital signs and neurological observations
- Treatment of any soft tissue injuries
- Radiological clearance completed if imaging obtained

REFERRAL CRITERIA	DISCHARGE CRITERIA

• GCS < 15 persistently after 4 hours
• Development of focal neurology or other exclusion criteria
• Inadequate social supports
• Referral to:-
  ○ Neurosurgery if CT positive
  ○ Gen med/Aged Care if CT negative
	• Comfortable with oral analgesia
	• No ongoing vomiting
	• GCS 15 and no worsening of amnesia
	• No focal neurology
	• Usual level of personal ADLs and mobility

DISCHARGE REQUIREMENTS

- Head injury information sheet
- Prescriptions for analgesia +/- anti-emetics
- Education for patient and carer on “return to ED” criteria
- Follow-up for soft tissue injuries e.g. suture removal, dressings and wound care advice
- Ongoing anticoagulation needs addressed

PAIN & BLEEDING IN EARLY PREGNANCY

Pregnancy <16 weeks with controlled PV bleeding, no haemodynamic compromise and confirmed intrauterine pregnancy (IUP)

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Not pregnant • **Ongoing, uncontrolled bleeding** with haemodynamic compromise – will need emergent PV exam and clearing of any ostial contents • **Ectopic pregnancy** proven on ultrasound • Pregnant with proven non pregnancy related pathology	• No sonographic documentation of IUP - if stable, might consider SSU admission to await ultrasound • Pelvic pain without bleeding • Pain and bleeding 16 weeks and older to be referred to MAC

KEY CONSIDERATIONS DURING SSU ADMISSION

- Analgesia – Paracetamol 1g QID/Oxycodone 5-10 mg TDS **(NSAIDs contraindicated in pregnancy)**
- Routine PV examination <u>not</u> indicated unless emergent ostial clearing of products of conception (POC) is required
- Investigations
  - Confirm pregnancy with urinary bHCG if no ultrasound documentation
  - Pelvic ultrasound to exclude ectopic as clinically indicated
  - If no specific concern of ectopic pelvic, formal ultrasound can be arranged for next available appointment, including as an outpatient
  - Rhesus blood group – can be reviewed in EPAS if <12 weeks pregnant
  - Quantitative bHCG – for EPAS follow-up
  - FBE if PV bleeding heavy
  - FWT +/- MSU to exclude UTI

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Ectopic pregnancy confirmed (Gynaecology) • Intractable, colicky pain with no bleeding – consider ovarian torsion (Gynaecology) • Threatened/incomplete/missed miscarriage with heavy ongoing bleeding (Gynaecology) • Hemodynamic compromise – speculum exam to remove ostial contents and Gynaecology referral	• Settled/controlled bleeding • No haemodynamic compromise • Threatened/incomplete/missed miscarriage, without haemodynamic compromise can be referred to Early Pregnancy Assessment Service (EPAS) clinic

DISCHARGE REQUIREMENTS

- Empathic discussions with patient / family regarding possible diagnoses is critical
- Ensure follow up plan is clear
- Analgesia advice – prescription as required
- Activity advice
- Re-attendance advice
- EPAS booking request – via ED Communications Clerk
- EPAS information brochure

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check:	NID: **Appropriate/ Not Appropriate**
☐ Analgesia requirements met for stay and discharge ☐ All investigations reviewed and results actioned ☐ No haemodynamic compromise ☐ Formal ultrasound showing singleton intrauterine pregnancy with HB > 120 ☐ Discharge documentation and patient education completed	Signature
Outcomes pending (to be filled in by MO):	

Nursing staff to check:	NID: **Appropriate/ Not Appropriate**
☐ All "discharge criteria and requirements" met ☐ Bleeding slowed or controlled ☐ EPAS appointment requested	Signature

PARACETAMOL OVERDOSE

N-Acetyl-Cysteine treatment for paracetamol overdose in patients with possible toxic ingestion and paracetamol level requiring treatment as per Rumack-Matthew nomogram and low risk of mental health deterioration

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE

• Co-ingestions requiring LOS > 24 hours
• Established hepatotoxicity e.g.
  o Acidosis
  o Encephalopathy / coagulopathy
• Pregnancy
• Behavioural disturbance or high suicidality or high flight risk
	• Still awaiting ED Mental Health team review

KEY CONSIDERATIONS DURING SSU ADMISSION

- Initial investigations – FBE/UEC/LFT/INR/bedside glucose
- 4 hour post ingestion Paracetamol level to guide treatment start (for single timed ingestions only)
- If 4 hour level above level of toxicity; commence 24 hour NAC infusion as per current WH guideline
- For multi-timed ingestions or presentations >8 hours post ingestion, commence NAC infusion as soon as possible
- Ensure ED mental health review completed and ongoing care plan documented
- No subsequent blood tests are required for ingestions taken within 8 hours of presentation to ED as long as baseline investigations normal and NAC infusion completed
- For multi-timed ingestions or ingestion > 8 hours before presentation, consider repeating FBE/UEC/BSL/LFT/INR after infusion protocol completed

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Incomplete infusion for any reason e.g. reaction, patient refusal • Deteriorating mental health • Ongoing or worsening liver dysfunction	• ED Mental Health team review completed and outpatient follow-up plan in place • Stable vital signs • Tolerating oral intake

DISCHARGE REQUIREMENTS

- Follow up plan;
  - LMO and / or mental health clinician
- Medical certificate

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check: ☐ All investigations reviewed and results actioned ☐ Discharge documentation and patient education completed ☐ EMH assessment completed and follow-up plan appropriate and timely	NID: **Appropriate/ Not Appropriate** Signature
Outcomes pending (to be filled in by MO):	
Nursing staff to check: ☐ All "discharge criteria and requirements" met ☐ NAC infusion completed as per protocol ☐ EMH assessment completed and follow-up plan appropriate and timely ☐ Support and transport person available	NID: **Appropriate/ Not Appropriate** Signature

SPONTANEOUS PNEUMOTHORAX

First spontaneous pneumothorax, onset < 8 hours, for conservative management or post successful aspiration

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Underlying chronic lung disease • Trauma • Bilateral pneumothorax • Tension pneumothorax • Significant haemothorax	

KEY CONSIDERATIONS DURING SSU ADMISSION

- Observation and serial CXR (4hrs post ED presentation/aspiration procedure and again at 8-12 hour prior to discharge)
- Analgesia – paracetamol 1 g QID/NSAID 400 mg TDS/Oxycodone 5-10 mg TDS, all regular
- Oxygen therapy to enhance pneumothorax re-absorption if conservatively managed (ensure communication with nursing staff regarding this to avoid inadvertent O2 cessation)

REFERRAL CRITERIA (Respiratory / Thoracics)	DISCHARGE CRITERIA
• Unstable vital signs • Increasing size of pneumothorax on CXR • Ongoing intractable symptoms – dyspnoea, chest pain	• Stable vital signs • Baseline mobility • Adequate social support • No increase in pneumothorax size on CXR

DISCHARGE REQUIREMENTS

- Follow up plan;
    - Respiratory/Thoracic clinic – discuss early follow up with unit registrar
    - LMO – letter for information
- Patient education, specifically – no diving / flying until clearance from Respiratory / Thoracics
- Re-attendance advice – e.g. Dyspnoea / pain
- Medical certificate

PROCEDURAL SEDATION RECOVERY

Awaiting recovery and discharge after procedural sedation e.g. DCR, dislocated shoulder reduction

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Other injury or pathology requiring admission e.g. cardiac ischaemia, ongoing AF, traumatic injury requiring further definitive treatment • Complication of sedation e.g. aspiration, intubation • Ongoing respiratory or haemodynamic compromise	• Poor baseline mobility

KEY CONSIDERATIONS DURING SSU ADMISSION

- Observe till return of baseline conscious state, mentation and mobility
- ACE referral as required, more likely in older age groups
- Ensure associated pathology is excluded e.g. cardiac ischaemia in RAF DCR
- Ensure post procedure care e.g. post reduction xray, VFRAC referral, POP care advice

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Poor mobility • Identification of other pathology requiring admission	• Return of baseline function, mentation and mobility • No ongoing adverse effects from sedation

DISCHARGE REQUIREMENTS

- Post procedure care advice e.g. mobility limitations, follow-up appointments
- ACE / Allied health team satisfied (where indicated)
- VTE (DVT) risk assessment if lower limb injuries and discussion of anticoagulation
- LMO review prn
- Transport home and carer advice

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check: □ All investigations reviewed and results actioned □ Discharge documentation and patient education completed	NID: **Appropriate/ Not Appropriate** Signature
Outcomes pending (to be filled in by MO):	
Nursing staff to check: □ All "discharge criteria and requirements" met □ Vital signs normal □ Follow-up appointments requested □ Transport home available	NID: **Appropriate/ Not Appropriate** Signature

PYELONEPHRITIS

Loin pain with/without radiation and renal angle tenderness, urinary symptoms of infection +/- fever, FWT leucocytosis and/or nitrates

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Known renal tract abnormality • Known or worsening renal failure • Septicaemia/Haemodynamic compromise • Immunocompromised • Pregnancy	• Previous ureteric calculi • Recent urological instrumentation or surgery (discuss with urology) • Male gender – atypical presentation, consider other diagnoses

KEY CONSIDERATIONS DURING SSU ADMISSION

- Investigations
  - UEC – ensure normal or no change from baseline
  - FBE, CRP – to monitor progress
  - MSU – send prior to antibiotic administration
  - Renal imaging not mandated, consider if worsening renal function or concern regarding obstruction
- Analgesia – paracetamol 1 g QID/NSAID 400 mg TDS/Oxycodone 5-10 mg TDS prn
- Antibiotics
- Gentamicin 5 mg/kg IV daily, maximum 400 mg dose, infused over 40 min + Amoxycillin 2g IV 6/24
- **Or** Ceftriaxone 1g IV daily

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Proven ureteric calculi or abscess on imaging (Urology) • Ongoing fever or septic symptoms or signs (medical) • Worsening renal failure • Intractable pain	• Resolution of pain, fever and infective symptoms • Oral antibiotic tolerated

DISCHARGE REQUIREMENTS

- Prescriptions for antibiotic and analgesia
- Presumptive treatment with **oral Trimethoprim 300 mg nocte for 3 days** while awaiting MSU results (alternative antibiotic choices include sensitivities identified on previous UTIs and Augmentin Duo Forte (875/125) BD oral for 5 days.
- LMO review with letter to check MSU result in 48 hours
- Medical certificate

RENAL COLIC

Unilateral flank pain +/- radiation to groin

EXCLUSION CRITERIA

ABSOLUTE

- Systemic symptoms or signs of infection
- Significant deterioration of GFR from baseline
  - Pulsatile mass (AAA)
- Other diagnosis strongly suspected that requires admission e.g. Surgical abdomen, testicular torsion

RELATIVE

- Pregnancy
- Single kidney

KEY CONSIDERATIONS DURING SSU ADMISSION

- Establish diagnosis and exclude red flag diagnoses
  - CTKUB if
    - Age > 50 and no prior history of stones (AAA for exclusion)
    - Significant opiate requirement
    - Deterioration of renal function
    - Any symptoms or signs of urinary tract infection – to exclude need for nephrostomy
    - Intractable and recurrent pain during admission
  - Management without imaging can otherwise be considered if
    - Age < 40 and normal renal function, no infective features OR
    - Previous history of stones and pain consistent
    - With good response to analgesia
- Analgesia + antiemetic
  - Paracetamol 1 g QID, NSAID (Ibuprofen/Indomethacin) TDS, Oxycodone 10mg QID regular
  - IV morphine 2.5mg prn
  - Metoclopramide 10 mg IV or oral QID/Ondansetron 4-8 mg IV or sublingual TDS prn
- Tamsulosin 400microg po daily if stone > 5mm or proximal
- Hydration – encourage oral hydration and food +/- IV N/saline

REFERRAL CRITERIA (Urology)

- Calculi > 5mm
- Development of UTI
- Unstable vital signs or persisting fever
- Ongoing pain in spite of maximal analgesia
- Deterioration in renal function during admission
- Alternative diagnosis

DISCHARGE CRITERIA

- Stable vital signs
- Stable renal function
- Tolerating oral intake
- Tolerating oral analgesia
- Pain resolved or controlled

DISCHARGE REQUIREMENTS

- Follow up plan; LMO for small distal stones, discharge letter with CT report; Urology clinic (via BOSSNet) for others (need plain KUB XR before dc)
- Prescription for oral analgesia as needed e.g. Oxycodone, NSAID
- Medical certificate
- Re-attendance advice e.g. recurrence of pain unresponsive to oral analgesia

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check:	NID: **Appropriate/ Not Appropriate**
☐ Analgesic requirements met for stay and discharge ☐ All investigations reviewed and results actioned ☐ Discharge documentation and patient education completed	Signature
Outcomes pending (to be filled in by MO):	
Nursing staff to check:	NID: **Appropriate/ Not Appropriate**
☐ All "discharge criteria and requirements" met ☐ Pain free and tolerating diet ☐ Transport home available – should not drive home if recent opiates	Signature

SEIZURE

<table>
<tr><th colspan="2">Witnessed seizure activity, now ceased, requiring observation</th></tr>
<tr><th colspan="2">EXCLUSION CRITERIA</th></tr>
<tr><th>ABSOLUTE</th><th>RELATIVE</th></tr>
<tr><td>• GCS < 13
• Suspected sepsis
• Toxicological seizure
• Persistent focal neurological signs
• Three or more witnessed seizures in last 24 hours
• Pregnancy
• Malignancy</td><td>• Age > 60 years with first seizure</td></tr>
</table>

KEY CONSIDERATIONS DURING SSU ADMISSION
• Reversible causes sought and treated e.g. o Infective (FBE / FWT) o Traumatic (CTB) o Metabolic (BSL) / electrolyte (EUC/CPM) o Toxic (look for toxidromes, alcohol level) o Medication compliance – drug load as needed o CTB if first seizure o Re-establish oral hydration and mobility

REFERRAL CRITERIA	DISCHARGE CRITERIA
• GCS < 15 • Further seizures • Persisting neurological deficit Discuss with neurology any significant departures from patient’s usual seizure pattern	• Stable vital signs • Tolerating oral intake • GCS 15 • Baseline function, mentation and mobility • Seizure free > 4hrs • Adequate social support

DISCHARGE REQUIREMENTS
• Follow up plan; o First seizure clinic (via BOSSNet) with outpatient MRI-B and EEG o If known epileptic – back to usual Neurology service/follow-up o LMO for prn follow-up and to check antiepileptic levels • Patient education, specifically – no driving / diving / operating heavy machinery/ risky recreational activities until review • Medical certificate • Discharge prescription and confirm antiepileptics

TIA

<table>
<tr><th colspan="2">Resolved neurological deficit – for admission under Neurology and unit review prior to discharge</th></tr>
<tr><th colspan="2">EXCLUSION CRITERIA</th></tr>
<tr><th>ABSOLUTE</th><th>RELATIVE</th></tr>
<tr><td>• Intracranial abnormality found on CTB
• Recurrent neurological deficit during ED visit or
• More than 1 TIA in the last month
• Known high-grade carotid stenosis</td><td></td></tr>
</table>

KEY CONSIDERATIONS DURING SSU ADMISSION

- Confirm any treatment plan with neurology – actioned jointly with Neurology
- Observe for recurrent symptoms
- Embolic risk stratification
  - ECG – exclude atrial fibrillation
  - Carotid doppler USS to assess for stenosis
  - Fasting lipids / glucose (can be done as outpatient, or keep NBM if staying overnight)
  - ECHO if recent AMI (previous 3 months)
- Antiplatelet management
  - Aspirin load 300mg po stat if no intracranial haemorrhage then 100mg daily ongoing
  - Discussion with neurology if already on antiplatelets
- Anticoagulation options discussed with patient if atrial fibrillation
  - NOAC vs warfarin

WARD REFERRAL CRITERIA (Neuro)	DISCHARGE CRITERIA
• Unstable vital signs • Abnormal CTB (if obtained after SSU admission) or doppler • Recurrent / persisting neurological deficit	• Stable vital signs • Tolerating oral intake • Baseline function, mentation and mobility • Adequate social support

DISCHARGE REQUIREMENTS

- Follow up plan;
  - TIA clinic (via BOSSNet) – request outpatient ECHO and Holter monitor
  - LMO for fasting bloods where indicated
- Patient education, specifically – driving advice
- Advice for return + information sheet
- Medical certificate
- Prescription for discharge medications where indicated

TONSILLITIS

Acute febrile sore throat requiring analgesia, IV hydration +/- antibiotics	
EXCLUSION CRITERIA	
ABSOLUTE	**RELATIVE**

• Impending airway obstruction or high suspicion of deep neck space collection/infection e.g.
  ○ Stridor
  ○ Trismus
  ○ Drooling/unable to tolerate own secretions
  ○ Inability to lie flat
• Quinsy (refer ENT)
	• Low-mod suspicion of other deep neck space infection e.g. retropharyngeal abscess – depending on clinical picture some cases can be admitted by ED consultant to SSU for imaging (CT neck)
	• Tonsillitis is rare in older populations i.e. age > 50 – consider other pathology

KEY CONSIDERATIONS DURING SSU ADMISSION

- Analgesia
  - Paracetamol 1g Q6H po
  - NSAID: Ibuprofen 400mg Q8H po or aspirin (dissolvable) 600mg TDS Q8H po
  - Oxynorm 5mg QID po prn
  - Lignocaine viscus gargle – 10mls in 1 cup water QID
- Antibiotics
  - IV Benzylpenicillin 1.2g Q6H or IV Cefazolin 2g TDS
- Steroid: Dexamethasone 8mg IV Q12H
- IV hydration – check UECs
- Consider infectious mononucleosis – IM screen, LFTs, FBE/CRP

REFERRAL CRITERIA (ENT)	DISCHARGE CRITERIA
• Ongoing abnormal or worsening vital signs • Pathology identified on imaging or lab results requiring admission • Increasing analgesic requirement • Deteriorating symptoms	• Normal vital signs • No acute pathology identified on imaging and normal/improving lab investigations • Tolerating oral intake • Adequate social support

DISCHARGE REQUIREMENTS

- Patient education e.g. analgesia usage and hydration requirements
- Follow up plan - LMO for review within the week
- Re-attendance advice + information sheet
- Medical certificate
- Prescription for discharge medications as indicated
  - Frequently – Phenoxymethylpenicillin 500mg QID for 5 days
  - No ongoing antibiotics if IM screen positive

ED TRAUMA

Minor trauma or ED trauma (see guideline) for imaging and/or analgesia	
EXCLUSION CRITERIA	
ABSOLUTE	**RELATIVE**

• Trauma CALL and ALERT patients are UNLIKELY to be SSU candidates -> refer
• Major head / chest / abdominal / pelvic trauma suspected or detected e.g.
  ○ Intracranial haemorrhage
  ○ Haemo/pneumothorax
  ○ Intra-abdominal bleeding
  ○ Complex pelvic fractures (excluding simple pubic ramus fracture)
• Compartment syndrome suspected
• Neurological deficit
• Unlikely to cope on discharge even if simple injuries found	

KEY CONSIDERATIONS FOR SSU ADMISSION

- Repeat secondary and tertiary (head to toe) reassessment for new symptoms / areas of concern and imaging as indicated
    - Low threshold for CT chest in chest trauma e.g. elderly / increasing analgesic requirement
- Allied health input, flag for higher age groups and lower baseline mobility
- Ensure imaging reviewed appropriately
    - CT C-spine must have finalized consultant or senior radiology registrar report
    - CTB – interim registrar report suitable
    - Correlate clinical findings and discuss plain films with radiology registrar if any concerns
- Analgesia + antiemetic
    - Paracetamol 1 g QID oral regular/ NSAID 400 mg TDS oral, age considerations/ Oxycodone 5mg QID oral prn
    - Ondansetron 4-8 mg TDS oral/ Metoclopramide 10 mg QID oral
- Limb immobilisation as indicated e.g. plaster/sling

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Unstable vital signs • Pathology identified that requires admission • Intractable pain in spite of maximal therapy • Failed mobility assessment with ACE	• Tolerating oral intake • Adequate social support • Baseline function, mentation and mobilising safely

DISCHARGE REQUIREMENTS

- Follow up plan; LMO
- Outpatient clinic requests as clinically indicated e.g. VFRAC, plastics
- VTE risk assessment and handout given to patient if lower limb immobilised
- Re-attendance advice
- Medical certificate
- Prescription for discharge medications where indicated

URINARY RETENTION

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Unable to manage leg bag • Other pathology causing retention requiring admission e.g. neurogenic / haematuria / abdominal mass • Septicaemia or high risk thereof	• Recent urological instrumentation/surgery • Inadequate social supports – might admit to SSU if potential to uplift outpatient support services in the next 24 hours.

KEY CONSIDERATIONS DURING SSU ADMISSION

- Observe for post obstructive diuresis after IDC insertion
- Exclude associated pathology
  - Infection – FWT; check FBE/CRP
  - Cauda equina – history and neurological exam, anal tone, perineal sensation
  - Recent urological tract instrumentation – urology referral
- Commence presumptive antibiotics if high risk for infection
- Check electrolyte balance and renal function – UEC
- Check for medications causing retention
- Educate patient or families re: leg bag

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Unstable vital signs • Worsening renal function • Failed mobility assessment with ACE	• Tolerating IDC • Tolerating oral intake • Adequate social support • Mobilising safely

DISCHARGE REQUIREMENTS

- Follow up plan; trial of void clinic – see TOV kit and book appointments
  - See LMO for review regarding cause of retention, ensure MSU follow-up
- PAC referral made for ongoing catheter care
- Re-attendance advice – retention / clots / decreased urine output / increasing pain
- Medical certificate
- Prescription for discharge medications where indicated

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check: □ All investigations reviewed and results actioned □ Discharge documentation and patient education completed	NID: **Appropriate/ Not Appropriate** Signature
Outcomes pending (to be filled in by MO):	
Nursing staff to check: □ All “discharge criteria and requirements” met □ Education to manage IDC and leg bag completed □ Catheter take home pack provided (extra leg bags, written information etc.) □ PAC referral checked	NID: **Appropriate/ Not Appropriate** Signature

VERTIGO

Vertigo /dysequilbrium without lateralising or cerebellar neurological deficits, in the absence of presyncope or syncope

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Arrhythmia suspected – presyncope/syncope or abnormal ECG at any time • Altered conscious state • Neurological deficits e.g. Lateralising cerebellar signs or other posterior circulation including brainstem and visual field deficits – if persisting • Other coexisting pathology requiring admission e.g. RAF, cardiac ischaemia, infective source	• Age > 60 years • Exercise caution with patients with transient neurological deficit (also consider utilising TIA pathway)

KEY CONSIDERATIONS DURING SSU ADMISSION

- Repeated examination to confirm the absence of neurological deficits
- CT brain completed (unless identical recurrent symptoms in patient with previous normal imaging)
  - All patients > 60 years
  - All patients of any age with neurological deficits
- Seek and treat exacerbating causes
  - Electrolyte imbalance – UEC/BSL
- Infective source – FBE/CRP/FWT
- Reestablishment of hydration – encourage oral fluids and supplement with IV N/saline as required
- Symptomatic treatment
  - Prochlorperazine – 10 mg TDS oral prn or 12.5mg IM TDS prn (if vomiting)
  - Serc – 8-16mg TDS oral prn
- Mobility assessment and Allied Health review for discharge planning – ACE referral
- Assessment by Physiotherapy BPPV team

REFERRAL CRITERIA	DISCHARGE CRITERIA
• CT abnormalities • Ongoing or recurrent neurological deficits • Persisting symptoms for >24 hours • Identification of other pathology requiring admission e.g. Pneumonia, cardiogenic cause	• Resolution or control of vertiginous symptoms • Functional safety established • Normal investigative findings • Tolerating oral diet • Social support established

DISCHARGE REQUIREMENTS

- Prescription for Prochlorperazine 10 mg TDS prn
- Mobility aid as required
- LMO follow-up – symptom review and Balance Clinic referral
- (if posterior circulation TIA suspected – discharge requirements as per TIA pathway)

VOMITING IN PREGNANCY

Poorly controlled vomiting in pregnancy, rarely presents for the first time > 10 weeks, usually resolved by 20 weeks, requiring education, IV hydration and reestablishment of oral intake routine

EXCLUSION CRITERIA

ABSOLUTE	RELATIVE
• Presence or suspicion of non-pregnancy related pathology e.g. cholecystitis • Ectopic pregnancy	• Multiple prolonged (>24 hour) previous admissions for similar presentations

KEY CONSIDERATIONS DURING SSU ADMISSION

- Antiemetic
  - Metoclopromide 10 mg IV or oral TDS prn
  - Ondansetron 4-8 mg IV or sublingual TDS prn
  - Antihistamine – Doxylamine 12.5 mg oral daily; Promethazine 10 mg orally TDS prn as second line
- Investigations
  - UEC - seek and treat electrolyte abnormalities, confirm normal renal function
  - TFT – hyperthyroidism exacerbates vomiting
  - bHCG – disproportionate elevation in molar or multi-pregnancies
- Fluids – encourage oral fluids and food and IV N/saline
- Consider pelvic ultrasound to establish intrauterine pregnancy or multi-pregnancy
- Ensure that CVS and haemodynamics return to baseline state
- Ensure ongoing antenatal care arranged

REFERRAL CRITERIA	DISCHARGE CRITERIA
• Length of stay > 24 hours without improvement despite appropriate management (Gynaecology) • Identification of ectopic pregnancy • Identification of non-pregnancy related pathology to appropriate unit	• Reestablishment of self-feeding and hydration pattern • Social support adequate

DISCHARGE REQUIREMENTS

- Vomiting in early pregnancy information sheet, and relevant therapeutic guidelines for specific lifestyle and non-pharmacological strategies (available on Therapeutic Guidelines via the intranet)
- Discharge prescriptions e.g. Metoclopromide 10 mg oral TDS prn **or** Ondansetron 4-8 mg sublingual TDS prn **and** Doxylamine 12.5 mg oral daily
- Check has follow-up plan with antenatal clinic review
- Letter for LMO follow-up prn

NURSE INITIATED DISCHARGE CRITERIA

Medical staff to check:	NID: **Appropriate/ Not Appropriate**
☐ No haemodynamic compromise ☐ All investigations reviewed and results actioned ☐ Discharge documentation and patient education completed	Signature
Outcomes pending (to be filled in by MO):	
Nursing staff to check:	NID: **Appropriate/ Not Appropriate**
☐ Vital signs normal ☐ All “discharge criteria and requirements” met ☐ No longer vomiting ☐ Tolerating diet	Signature