Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET

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SUMMARY	Guidance on the criteria and processes for admission to, transfer or discharge from, the COU for RHW patients. Includes referral for outreach monitoring for pregnant women who require cardiac monitoring in the Birthing Unit (Section3.1.3)

Royal Hospital for Women (RHW)
CLINICAL BUSINESS RULE

RHW Close Observation Unit: Admission, Escalation, Transfer and Discharge — RHW CLIN013

CONTENTS

1. BACKGROUND

The RHW Close Observation Unit (COU) (formerly known the Acute Care Ward) operates as a Level 4 COU[1] The purpose of the CBR is to provide guidance on:

1. the criteria and processes for admission to, transfer or discharge from, the COU for RHW patients.
2. outreach liaison support by the Prince of Wales Hospital (POWH) HDU/ICU of patients with complex clinical needs that have or are likely to exceed the ceiling of monitoring and treatment that are available in the COU. (Section 3.1.1: 5-8/ Section 3.1.5/Section 3.3.2).
3. outreach monitoring for pregnant women who require cardiac monitoring in the Birthing Unit (Section3.1.3)

[1] Agency for Clinical Innovation, Establishment, governance and operation of a close observation unit

4. the management of COU beds to ensure timely and appropriate admission and discharge.

2. RESPONSIBILITIES - PEOPLE AND ROLES

1. The Senior Medical Admitting Officer (SMAO) is the medical consultant under whom a patient is admitted to hospital. The SMAO has overall responsibility for decisions to admit and discharge patients based on clinical criteria. After-hours, the first point of contact for this role is the anaesthetic registrar (for critical care criteria), the POW breast-plastics registrar (for surgical criteria) and the obstetric registrar (for other criteria).
2. The admitting team is the multidisciplinary team/service under which the patient is admitted including as examples, Maternal Foetal Medicine, Obstetrics, Gynaecology, Gynae oncology, Breast/Breast plastics.
3. The referring officer is the doctor or nurse who requests admission on behalf of and in consultation with their clinical supervisor/SMAO, as needed. This includes the anaesthetic registrar/ consultant anaesthetist and or clinical nurse consultant for referrals of post-operative patients.
4. Obstetric physicians, anaesthetists, and other specialists who have a consulting role provide input into decisions to admit and discharge patients in addition to relevant treatment advice. In the after-hours period, the junior medical staff are first point of contact for this role and are expected to consult appropriately with their respective supervisors.
5. The POW Intensive Care team (medical and nursing) provides outreach liaison support on an as requested basis for patients who are at risk of requiring transfer to POW HDU/ICU and or as referred by the admitting team (See Section 3.1.1: 5-8/ Section 3.1.5/Section 3.3.2)
6. The RHW Access and Demand Manager (ADM)/After Hours Nurse Manager (AHNM) is responsible for final approval of all admissions and discharges as a function of bed management.
7. The Executive On Call is available to support arbitration of decisions and or assistance with bed block, on request from the AHNM.
8. The COU team are nursing, midwifery and allied health staff attached to the COU or Birthing Services.
9. Nursing staff from other wards teams ensure patients are appropriately monitored and escalate concerns, where these exist, if patients meet admission criteria for the RHW COU. (See Section 3.1.1: 5-8/ Section 3.1.5)
10. Medical and Midwifery teams from MFM and Birthing Unit should observe the procedures for pregnant women who require cardiovascular monitoring (Section3.1.3)

3. PROCEDURES

3.1 ADMISSION (REFERRAL) CRITERIA

INCLUSIONS

Patients should be assessed and considered for admission to the COU where there is acute clinical deterioration or a high risk of acute clinical deterioration, that will need monitoring and or treatments that cannot be provided in the general wards, perioperative setting or Birthing Unit AND where their condition is not of very high acuity that warrants admission to a High Dependency Unit (HDU) or Intensive Care Unit (ICU).

Referral to the COU may be relevant to patients who are booked for admission or who have been admitted for any services that are provided at the RHW including obstetrics related care, gynaecology, gynae oncology, fertility and reproductive services, breast surgery and pain management.

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Assessment for admission, transfer or discharge should take in account risks for deterioration within the context of a patient's pre-existing and newly acquired co-morbidities. Any of the following criteria support a request for a patient's admission (ie a referral) noting the roles of the Senior Admitting Medical Officer, the Patient Flow Bed Manager or their delegates in approval of admission and discharge:

1. General criteria

Consideration for elective referrals should apply to patients with the following co-morbidities:

1.1. Current or likely need for invasive arterial blood pressure or central venous pressure monitoring and or monitoring of heart rate, cardiac rhythm, and or continuous pulse oximetry.
1.2. Supportive treatment of blood pressure with infusion of vasoactive drugs including metaraminol or GTN but not including inotropic drugs for an extended period.
1.3. Airway or breathing supportive therapies including high flow nasal oxygen or non-invasive ventilation (CPAP/BiPAP) where this is not the patient's usual home treatment, as in the case of CPAP.
1.4. Acutely impaired renal function and or electrolyte or acid base disturbance.
1.5. Patients following major surgery, birthing or other procedures who have experienced complications including major blood loss (including post-partum haemorrhage of >1.5L), serious drug reaction, compromised airway, breathing or cardiac function, or where they meet any other general criteria.
1.6. Patients who have epidural analgesia regimens via thoracic level epidural catheters.
1.7. Inpatients who for other reasons will require special nursing care that is otherwise not available such as titration of analgesia, observation of surgical wounds, or fluid balance monitoring.
1.8. Psychiatric or psychosocial conditions requiring one-to-one specialist nursing care.
1.9. Any other condition requiring admission, as determined by the admitting consultant.

2. Pre-admission

Consideration for elective referrals should apply to patients with the following co-morbidities:

2.1. Patients booked for major surgery (e.g. open laparotomy for gynae-oncology, breast-plastic) who have existing co-morbidities of BMI>45, age >75, Type 1 Diabetes Mellitis, COPD, Obstructive Sleep Apnoea (OSA), moderate to severe cardiac dysfunction, a history of chronic opioid dependent pain, or other conditions or functional limitations that pose risks listed under the **general criteria**.
2.2. Patients booked for minor surgery who have serious co-morbidities consistent with American Society of Anesthesiologists (ASA) class 4 and or a BMI of >50.
2.3. Pregnant women who have congenital or acquired structural heart disease and or a history of peripartum cardiomyopathy or other conditions or functional limitations that pose risks listed under the **general criteria.**
2.4. Patients with a known history of unstable mental health or psychosocial risk factors.

3. Pregnant women requiring outreach cardiac monitoring in the Birthing Unit or post operative CTG monitoring.

3.1. Pregnant women who are booked for vaginal delivery in Birthing Unit AND who have a cardiac condition that warrants either invasive blood pressure monitoring and or continuous ECG monitoring for cardiac dysrhythmias may require telemonitoring from the COU.
3.2. Pregnant women who require CTG monitoring in the post operative period, as determined by MFM.

4. In-patients

Patients who during the early post-operative, early post-partum or at any time during their admission show evidence of deterioration that meets any of the **general criteria.**

5. Transfers from other facilities including patients returning from POW.

Patients booked for transfer from another facility should be assessed against the **general criteria**. This includes RHW in-patients scheduled for transfer back from POW HDU/ICU

EXCLUSIONS

6. Patients for whom there is a high risk of requiring care in an HDU/ICU

Very high acuity patients whose needs may exceed treatment ceilings of treatment offered by the RHW COU should be referred to the POW HDU/ICU admitting officer for outreach liaison support and consideration for transfer to POW. These include:

6.1. Patients who are assessed in the preoperative period as likely to experience:
- 6.1.1. Respiratory failure requiring intubation and ventilation.
- 6.1.2. Major blood loss (1/2 blood volume in <4 hours) in conjunction with other existing comorbidities
- 6.1.3. Cardiovascular instability requiring ongoing infusion of inotropic agents and or unresolved cardiac dysrhythmias

6.2. Patients whose condition deteriorates during admission despite having reached a ceiling of treatment that is available at the RHW COU. Examples may include patients:
- 6.2.1. receiving maximum non-invasive ventilation (BiPAP 15/7mmHG)
- 6.2.2. receiving maximum levels of vasopressor infusions (metaraminol 10mlph)
- 6.2.3. where deterioration is evident in more than one of the general criteria.
- 6.2.4. where nursing capacity is insufficient to provide appropriate nursing ratios by appropriately skilled and credentialled nursing staff.
- 6.2.5. where events occurring in other parts of the hospital has limited the availability of medical staff to provide a response in a reasonable time frame.

Early ICU input may help prevent progression to the point where ICU/HDU admission is necessary The SMAO (or anaesthesia registrar after hours) should request an outreach assessment by the POWH HDU/ICU team in the event that a patient deteriorates. POW ICU should be notified well before a patient receives the maximal treatment that is available in the COU (as described above). Suggested criteria to trigger a notification and request for review are:
- 6.2.6. FiO2 >50%, BiPAP >10/5 or failure to improve on institution of NIV
- 6.2.7. 2 or more concurrent organ dysfunctions, or when the primary organ dysfunction is outside the usual scope of the COU (i.e. non-Ob/Gynae pathologies).

7. Patients whose goals of care are palliative and or where the care offered in the COU is not aligned with their Advanced Care Plan or Resuscitation Order.

7.1. Early involvement of the Palliative Care team and a multidisciplinary case conference may guide decision-making for these patients.

3.2. REFERRAL AND ADMISSION PROCESSES

1. Elective preoperative referral and approval for admission

1.1. Patients can be referred by the clinical nurse consultant (CNC) or medical staff at the time of preoperative assessment. Requests for bookings should be communicated to the CNC who will subsequently communicate this to the Access and Demand Manager at the weekly A&D meeting. The request should also be noted in the anaesthetic assessment and or medical admission request.

2. Elective referral for outreach cardiac dysrhythmia monitoring

2.1. Pregnant women who are booked for vaginal delivery AND who have a cardiac condition will require assessment at the MFM clinic AND the anaesthesia antenatal (high risk) outpatients clinic.
2.2. A COU referral is required for any patient that is deemed to require invasive blood pressure monitoring and or continuous ECG monitoring for cardiac dysrhythmias.
2.3. Invasive blood pressure monitoring can be undertaken by midwives in the BU with telemonitoring oversight by COU staff.
2.4. Continuous ECG monitoring for cardiac dysrhythmias may be outside the scope of practice of midwives. An COU credentialed nurse may need to be booked in advance.
2.5. Heart rate monitoring can be undertaken by midwives using a standard bedside vital sign monitor.
2.6. A referral should be made by the anaesthetist to the MGP/MFM team including verbal communication and written note in eMR.

3. Unplanned referrals to COU

The medical officer who identifies a patient as needing admission to the COU according to the admission criteria (above) must:

1. contact the Access and Demand Manager (ADM)/After Hours Nurse Manager (AHNM) to confirm safe level of staffing, skill mix and bed availability (Refer to Appendix 1)
2. contact the SMAO or their delegated first point of contact.
3. consult with the obstetric physician, as relevant.

<u>Admission process for unplanned referrals</u>

1. The patient is admitted under the SMAO. The SMAO and junior medical staff are the admitting team.
2. Communication across medical teams must occur, meaning the admitting team must notify anaesthesia and anaesthesia (if referring a patient) must notify the admitting team, and the obstetric physician (for obstetric patients).
3. The referring medical officer must:
   - conduct a clinical assessment and document the management plan in eMR prior to transfer to the COU or at the time of admission. The management plan should include specific advice and parameters for triggering clinical reviews and or requests for outreach review by POWH, if these are different to those on the standard CERS chart.
   - provide a verbal handover to the nursing team leader.
   - notify the “outside’ anaesthetic registrar who is rostered to the COU.
   - notify POWH HDU/ICU for anticipated or required clinical advice and support, as relevant.
4. The admitting team’s Junior Medical Officer (JMO) must ensure that the patient’s medications along with other ordering and management tasks are completed by the time of admission.
5. The nurse in attendance in the COU must ensure a comprehensive nursing care plan is in place.
6. The nursing team leader should: notify/consult with the following people, as relevant:
   - Identify the need for allied health services commensurate with case mix and clinical load
   - Refer to the Perinatal Mental Health service if required
   - Consult with Aboriginal Hospital Liaison Officer if required.

3.3.CLINICAL PRACTICE -ROUNDING, ESCALATION, TRANSFER AND DISCHARGE

3.3.1. Daily rounding, management plans and handover

1. Rounding

The purpose of the daily rounds is to establish the goals of care and provide practical guidance to junior medical staff and nursing staff for the next 24 hours, and beyond, as relevant.

- The admitting team conducts two ward rounds/clinical reviews each business day.
- The consulting obstetric physician (Tuesday/Wednesday/Friday) /anaesthetic consultant (Monday /Thursday) conducts a ward round each morning at 0800.

2. Weekend and overnight rounding and reviews

- On weekend days, the admitting team rounds once or more frequently as required
- The on call obstetric physician rounds on weekends on an as needs basis.
- The evening shift anaesthetic registrar (Outside pager) conducts a check in round between 1600-2100 every day to check the status of patients and update the management plan, as required.
- The night shift anaesthetic registrar does likewise between 2130 and 0700 every day. Rounds are preferably face to face, or by phone, according to clinical priorities.
- Scheduled reviews that are required between these times can be delegated by the admitting team and or on call obstetric physician to the on-site obstetric team or anaesthetic registrar by negotiation and if guidance if communicated clearly in eMR. In principle, matters related to general care, fluid and medication management or review of pathology are best delegated to the obstetric team and matters related to cardiovascular or respiratory deterioration are best delegated to the anaesthetic registrar. The responsibility for clinical review lays with the admitting team in the event that the on-site medical staff are unable to attend.

3. Management plans, handover and documentation

- All clinical staff who round in the COU are expected to clearly communicate with other members of the multidisciplinary team and consulting clinicians.
- The COU nurse or team leader should attend rounds.

4. The daily management plan should be written in eMR and specify guidance criteria supporting discharge (including expected date/time for this) to **support bed capacity and demand management** where a patient's acuity is reducing OR Escalation of care /outreach POW assessment if a patient's acuity is increasing.

5. At each subsequent round, the patient's status and change in goals of care should be updated, as relevant. A verbal update should be given to the COU nurse or team leader in attendance.

6. The admitting team's JMO must ensure that ordering, documentation, prescribing and management tasks are completed by the end of the working day and in a timely manner according to clinical need. This may include consultation with an anaesthetic team member.

7. Titration of prescribed treatments such as non-invasive ventilation, vasopressor infusions and analgesia regimens should be conducted according to prescriptions, defined parameters and standing policies.

8. Referrals should be considered and documented as relevant to

- the Clinical Nursing Consultant (CNC)/Clinical Midwifery Consultants (CMC) and allied health services.
- the POW ICU team for scheduled outreach consultation, if and when required.
- to specialty services at POWH (e.g., Stroke, Cardiac Services). Transfer care to the appropriate specialty if and when required.

3.3.2. Management of deteriorating patients

1 Management of clinical deterioration should follow existing policies and vital signs parameters as per CERS charts with respect to activation of requests for clinical reviews, Rapid Response and CODE BLUE calls.

2 On -site junior medical staff should seek advice from the admitting team and or on call obstetric medicine consultant in the first instance if a patient's status changes and requires changes to treatment plans and or upgraded monitoring.

3 Where input is required from multiple teams to guide the management of patients with complex issues and needs, high level discussions should occur between consultants from relevant teams to clarify decision making and this should be clearly documented in eMR and through verbal handovers.

4 **The JMO should seek guidance from their supervising consultant if they feel concerned about their capacity to provide safe and appropriate care to any patient**.

5 The AHNM and Executive On Call are available to assist with arbitration of decisions relating to admission or transfer. This may include instances when nursing staff ratios are inadequate to manage the acuity of care requirements (**See Appendix 1**)

6 Early ICU input may help prevent progression to the point where ICU/HDU admission is necessary The SMAO (or anaesthesia registrar after hours) should request an outreach assessment by the POWH HDU/ICU team in the event that a patient deteriorates. POW ICU should be notified well before a patient receives the maximal treatment that is available in the COU, (See Admission criteria - Patients for whom there is a high risk of requiring care in a HDU/ICU). Suggested criteria to trigger a notification and request for review are:

6.1 FiO2 >50%, BiPAP >10/5 or failure to improve on institution of NIV

6.2 2 or more concurrent organ dysfunctions, or when the primary organ dysfunction is outside the usual scope of the COU (i.e. non-Ob/Gynae pathologies).

7 If the POWH ICU Code Blue team is required, then this should be requested as a CODE BLUE POWH through the **Code Blue activation system (2222 POWH)**

3.3.3. Transfer of patients to POW

In the event a patient requires transfer to POWH ICU/HDU the following should be completed:

- The COU nurse should document the event and the status of the patent, including vital signs, ventilatory support settings and infusions, at the time of transfer on the Patient Handover eMR form.
- The COU nurse must enter the Inter Hospital Transfer (IHT) to POWH ICU/HDU in the Patient Flow Portal (PFP)
- The anaesthetic registrar should:
  - remain with the woman continuously prior to transfer.
  - provide full clinical handover to POWH ICU/HDU
  - notify the SAMO at an appropriate time.

3.4. **DISCHARGE AND BED CAPACITY/DEMAND MANAGEMENT**

Patient Flow

The ADM/AHNM has oversight of bed capacity and management across the hospital. Key functions include to:

- Regularly review patient dependency, staff skill mix, capacity and demand factors to ensure the service can be provided safely and in a timely manner.
- Ensure the admitting teams assist and manage patient flow at a general ward level by adhering to timely clinical review and decision-making. Ensure capacity in COU is available for any woman requiring that level of care.
- Provide communication and thereby a good relationship between COU and other hospital wards to optimise efficient patient flow. This is a hospital-wide responsibility.

- Ensure all teams have the correct clinical review procedures in place to assist in capacity and demand management. This includes early and timely ward rounds and effective and predictive discharge planning.
- Ensure the COU team leader updates the ADM/AHNM on current and predictive capacity and demand for the service.
- Predict COU bed management by
    - COU team leader communicating all planned admissions and discharges to the ADM/AHNM in advance so that forward planning of capacity can be enabled and supported. Any short-falls can then be proactively managed early.
    - Discussing all theatre cases at the weekly access meeting. COU beds are assigned pre- and post-operatively. Predictive capacity will be available at the time the woman requires the bed through normal capacity or through the departure of another woman (in the absence of any other emergency taking priority)
- Review daily the elective surgery lists and decide whether any cases need to be postponed
- Ensure the registered nurse/midwife-to-patient ratio is appropriate as per Appendix 1. This does not include the COU CNC in the ratios. Changes to ratios cannot occur without medical review/clearance.

If no bed is available in the COU

- Consider the capacity and demand factors
- Allow any patient who no longer warrants COU services and has been cleared for transfer/ discharge from COU to be moved to the ward as soon as possible. This should occur before the six-hour time frame recommended by the Australian Council of Healthcare Standards.
- Escalate to ADM/AHNM if there is a delay in moving a woman from COU. This should be communicated to allow the COU team to manage any demand for the service. There may be a woman exiting from COU services who requires other special consideration, and this may take longer to coordinate (e.g., isolation requirements).
- Consider altering the order of the theatre list if a COU bed cannot be confirmed to ensure procedure lists are not cancelled. When there are several surgical teams aligned for one patient procedure, and it is not possible to change the theatre schedule, the procedure should be allowed to begin if a COU bed is anticipated
- Review each woman in COU by the anaesthetic team member when a decision is needed to make a bed available. This decision needs to be confirmed/discussed with the admitting team
- Obtain additional nursing/midwifery staff to care for the woman in COU if an unstaffed bed is available
- Escalate to admitting team consultant level if a decision cannot be agreed
- Escalate to divisional level if a decision still cannot be made
- Escalate promptly a request for transfer to POWH ICU/HDU if no bed can be created in COU
- Continue to manage and hold the woman in recovery/inpatient ward until a bed is available in COU
- Escalate to the RHW Executive on-call if no bed available in POWH ICU/HDU

Transfer/Discharge from the COU by the Nursing/ Midwifery Team Leader

- Notify the ADM/AHNM (page 44020) of the plan to transfer/discharge, for bed allocation
- Communicate transfer out of COU to ward by COU nursing team leader
- Ensure transfer/discharge documentation is completed by nursing/midwifery staff and admitting team JMO prior to transfer/discharge.

4. EQUIPMENT

- Non-invasive ventilation devices including high flow nasal oxygen (Airvo™) and BiPap.
- Telemetry
- Centralised haemodynamic monitoring.
- Epidural (Sapphire™/CadZolis™) and intravenous infusion pumps

5. DOCUMENTATION

- Medical Records
- COU admissions book
- COU daybook
- Patient Flow Portal (PFP)
- Electronic Patient Journey Board (EPJB)

6. EDUCATION NOTES

- The COU is a Level 4 Close Observation Unit (COU), according to MoH NSW Health Guide to the Role Delineation of Clinical Services[1], as outlined below:
  - Dedicated unit in health facilities with an Intensive Care Service (ICS).
  - Provides level of care between standard ward and an intensive care unit (ICU), with close monitoring and observation e.g. women transitioning out of the ICU, women likely to need intensive care outreach support such as rapid response or ICU liaison.
  - Admission and medical care of woman remains under the direction of the Admitting Medical Officer or an Intensivist.
  - May provide non-invasive ventilation (NIV) where the intention is not to escalate to invasive ventilation.
  - May provide short term low level vasopressor therapy where there is low likelihood for or intention to escalate to intensive care.
  - Each woman must have a medical management plan that includes a process to facilitate escalation of care and patient transfer when required.
  - Each woman must have at least daily medical review and care planning.
  - Access to allied health services commensurate with case mix and clinical load.
  - Access to consultation-liaison psychiatry.
  - Referral pathways to relevant Aboriginal programs and services.
  - Quality and risk management programs in line with current National Safety and Quality Health Service (NSQHS) standards.
  - Close relationship with the ICS, including clinical advice and professional development support.
- Early access to COU services has been evidenced to have a positive impact on survival rates and reduce lengths of stay.
- Operationally, day to day, the COU CNC and Midwifery Unit Manager (MUM)/Nursing Unit Manager (NUM) along with the ADM/AHNM are responsible for making decisions around capacity and demand, and making clinical decisions that affect patient flow.
- Responsibility for the clinical governance of the COU is with the Director of Medical Services

7. RELATED POLICIES / PROCEDURES / CLINICAL BUSINESS RULES

- Admissions Business Rule
- Inter-hospital Transfer Procedure, Business Rule

- Discharge - Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals Business Rule
- Demand Access Escalation Business Rule
- Escalation for Birthing Services
- Patient (adult) with acute condition for escalation (PACE) criteria and escalation
- Implementation guide Putting a model into practice – Clinical Program Design and Implementation https://www.aci.health.nsw.gov.au/resources/acute-care/cou/close-observation-units
- PD2012_011 Waiting Time and Elective Patient Management Policy, NSW Health https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_011.pdf
- PD2011_031 Inter-facility Transfer Process for Adult Patients Requiring Specialist Care https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_031.pdf
- PD2018_011 Critical Care Tertiary Referral Networks & Transfer of Care (Adults) https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2018_011
- SESLHDPR/228 Critical Care Bed Management Procedure https://www.seslhd.health.nsw.gov.au/sites/default/files/documents/SESLHDPR228.pdf
- SESLHDPR/562 ICU/HDU Admission Criteria https://www.seslhd.health.nsw.gov.au/sites/default/files/migration/Policies_Procedures_Guidelines/Clinical/Critical_Care_Emergency_Medicine/documents/SESLHDP562ICUHDUAdultadmissionCriteria.pdf

8. RISK RATING

- Low

9. ABORIGINAL HEALTH IMPACT STATEMENT

It is important to discuss all aspects of care with Aboriginal women in a culturally sensitive, respectful and supportive manner. It is also important to engage and work in partnership with Aboriginal women, including and where appropriate involve their family. When clinical risks ae identified for an Aboriginal woman, she may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services.

10. NATIONAL STANDARD

- Standard 8 – Deteriorating patient

11. REFERENCES

1. Ministry of Health NSW Guide to the Role Delineation of Health Services, 2018 https://www.health.nsw.gov.au/services/Publications/role-delineation-of-clinical-services.PDF
2. Agency of Clinical Innovation. Establishment, Governance and Operation of a Close Observation Unit https://www.aci.health.nsw.gov.au/resources/acute-care/cou/close-observation-units
3. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards guide for hospitals, 2nd edition. Sydney: ACSQHC; 2017. https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf

12. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
9/11/2022	1	Leonie Watterson, Co-director Anaesthesia
11/10/2023	2	Leonie Watterson, Co-director Anaesthesia
27/10/2023	2	Endorsed by RHW SQC. Review date Nov 2025

APPENDIX 1: Close Observation Unit – Patient Acuity Guideline

A Close Observation Unit (COU) is a specially staffed and equipped area of a hospital that provides an intermediate level of care between intensive care and general ward care.

- The ratio of nursing staff must meet the patient acuity, volume and scope of clinical services
- **A** clear process must be in place to identify additional nursing staff above the baseline nursing profile, when required
- A senior nurse with the appropriate skills, experience and postgraduate qualifications for the clinical environment should be in charge whenever necessary
- **At** least one nurse on each shift within the COU must hold postgraduate qualifications for the clinical environment or significant experience in critical or acute care
- The following patient conditions related to these physiological systems are managed with the following ratios.

SYSTEM / CONDITION	1:1 PTS WHO ARE ACUTELY UNWELL	1:2 ALL OTHER PTS	1:5 WAITING WARD BED
General	Unstable condition: >2 pace Level 2 calls in 2 hours Greater than 5 infusions / multiple medications >1 organ system impaired not requiring ICU IV infusion requiring greater than or equal to 2 titrations per hour Pt requiring observations greater than or equal to observations taken 2 times per hour		
Obstetric	Unstable pre-eclampsia on IV MgSO4 or IV Hydralazine infusions, acute condition.		
Respiratory		When on BiPAP or CPAP requiring titration	
Cardiac / cardio vascular	GTN / IV concentrated KCL infusion Vasopressor infusion (e.g. Metaraminol) requiring greater than or equal to 2 titrations per hour.		
Electrolytes		Intensive electrolyte replacement	

- Notify ADM/ AHNM when the patient is no longer acutely unwell meeting 1:1 criteria the patient will return to 1:2 patient ratio

Psychosocial patients: Patients that require 1:1 psychiatric nursing special can be categorized with a nurse/midwife to patient ratio of 1:3