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# Surgical SDEC

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Mrs Victoria Hitchen (lead nurse)
BEST event 18th May 2022

PROUD to care

# Same Day Emergency Care - Concept

- For stable patients requiring emergency care that day or who can be treated on an ambulatory basis without admission
- NHS long term plan – increase same day discharges for acute presentations from a fifth to a third.
- We are aiming for same day discharges of 80%, and less than 20% follow up.
- Surgical SDECs are a newer concept, but now more than 40 hospitals have established units.

# Barnsley SDEC

- Our bespoke surgical SDEC unit opened in July 2021.

# Surgical SDEC Team

# Iris screenshot

| Yr2 | Month Name2 | Same Day Disch Rate | Conversion Rate | Avg Lo S Hours |
|---|---|---|---|---|
| 2021 | June | 37.50% | 62.50% | 2.8 |
| | July | 55.25% | 49.03% | 3.5 |
| | August | 56.67% | 47.78% | 3.5 |
| | September | 57.48% | 46.06% | 3.4 |
| | October | 59.42% | 43.84% | 3.7 |
| | November | 62.99% | 39.76% | 3.3 |
| | December | 69.20% | 34.42% | 3.3 |
| 2022 | January | 67.56% | 40.08% | 4.1 |
| | February | 70.91% | 34.91% | 3.4 |
| | March | 68.28% | 38.43% | 3.7 |
| | April | 64.02% | 39.33% | 3.5 |
| | May | 70.77% | 35.38% | 3.5 |

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## Contact Details

**Nursing Team**
**6311/6312/6313/6314**

**SDEC Registrar 878**
Mon-Fri 8am-5pm
outside these times
on-call Registrar **783**

# Who is Surgical SDEC for?

The **Surgical Same Day Emergency Care (SDEC)** unit is for stable patients who require emergency surgical care that day or can be treated on an ambulatory basis without the need for admission.

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**When is it open?** Monday to Sunday 07:30-20:00 (referrals accepted 8am-6pm)

## Direct Admissions

***exclusion criteria applies**

Patients can come straight to Surgical SDEC from triage. Please could staff just make a courtesy call to nursing staff to say a patient is coming.

- Post-operative problems
- Abscess on the trunk (not diabetic/immunocompromised/not IVDU)
- Known gallstones (awaiting treatment, consultant at BDGH) with flare of symptoms
- Limited PR bleeding

## SDEC Referral after ED review

***exclusion criteria applies**

In such cases the SDEC SpR should be contacted for referral and transfer. Out of hours these patients may be considered suitable for SDEC hot clinic. Results of bloods may not be necessary to be available but should be in process.

- RUQ pain/RIF pain/LIF pain
- Hernias without skin changes/peritonism or obstruction
- Equivocal abdominal pain in whom non-surgical causes (including gynaecological) have been reasonably excluded.

## Has the patient been seen in ED but is fit to go home and return to Surgical SDEC for review?

**Please inform Surgical SDEC of patient details so they can prepare for their attendance. E-form booking imminent.**
**Options**
1) Surgical Review following day – Patients you feel are well enough to go home that day but still require a surgical review. If potentially for theatre please inform the patient to attend fasted (e.g. abscess).
2) Hot Clinic 9-11:30 – Monday, Wednesday, Friday – Consultant led. (No Breast, Urology, ENT or Orthopaedic)

## ENT and Orthopaedic patients

**These need to be accepted by speciality, discussed with nursing team and meet the inclusion criteria before transfer to Surgical SDEC.**

## Does the patient need admitting from ED?

**Please send straight to inpatient surgical bed.**
(If there is bed pressure please discuss with Surgical SDEC on a case by case basis)
***Please consider at the weekends there is no Doctor based on Surgical SDEC***
*(they to have to cover the surgical wards and operate in theatres)*

## Exclusion Criteria

Some patients are not suitable for referral/ admission via the surgical SDEC and these surgical patients should be referred to the On-call surgical SPR.

**PATIENTS WITHOUT A SURGICAL PROBLEM SHOULD NOT BE SENT TO SDEC**
**e.g awaiting social, awaiting transport**

**Patients who are excluded are identified below**

- NEWS 4+ /over 3 in one parameter
- Oxygen requirement
- Signs of sepsis/obstruction/perforation/peritonism/ haemodynamic instability
- Pain not controlled with simple analgesia
- Diarrhoea and vomiting with no abdominal pain
- Known COVID contacts or positive/symptomatic of COVID
- GCS <15 or requirement for neurological observations
- Non-ambulatory patients (mobility issues, immobile or bed bound patients) (Long term wheelchair users – discussed on case by case basis)
- Large volume PR bleed
- Children (under 16)
- Pregnant females unless discussed first with Obstetrics Gynaecology on call and pregnancy issues have been excluded before transfer to SDEC.

***This list is not exhaustive.***
*If you have any concerns or require advice, please contact SDEC SpR and discuss on a case by case basis regarding your referral.*

An ambulatory, stable adult with a surgical problem that can be dealt with that day/or on an ambulatory basis

# Who can refer

- General Practitioners through right care
- Emergency Department
- Yorkshire Ambulance Service
- Surgical team (supported ward discharges)
- Outpatient Clinics

# How to refer

- Opening hours for referrals 8:00 – 18:00 (unit opens 7:30 – 20:00)
- All GP referrals go via right care
- Coordinator phone – single point of contact 6099
- Out of hours referrals in hospital are completed digitally (eForm)

# Why is our criteria important?

- Maintain flow
- Ensure staff can care for all patients
- Appropriate use of ambulatory resources (scans)

Emergency Care Improvement Support Team
Safer, faster, better care for patients

NHS

This tool is to be used after a decision has been made to admit the patient to ensure all options are considered

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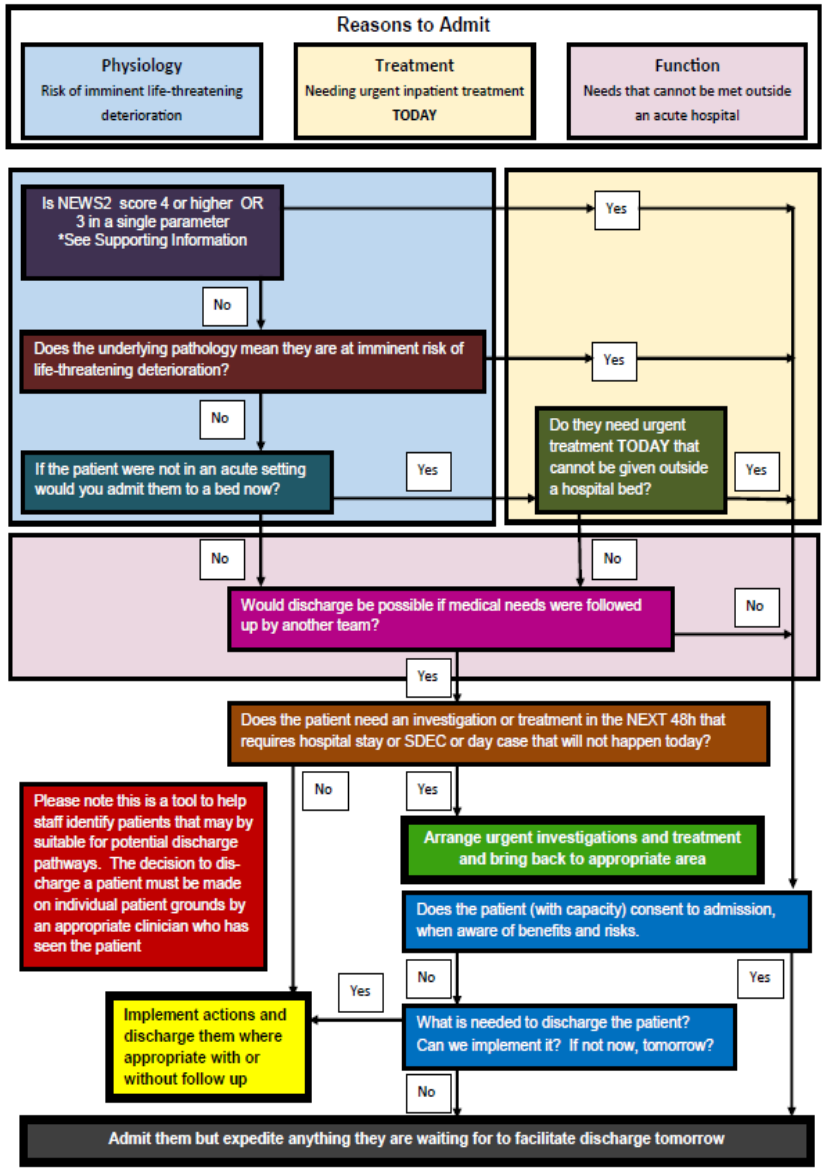
## NEWS2 flow chart – Admission Decision support tool




CRITERIA TO ADMIT:

- **Physiological** – too unstable
- **Treatment** – only available as an inpatient
- **Function** – needs cannot be met outside (eg. Social support)

PROUD to care

# Clinical scenario 1- Hernia

## Referral

- 67 year old lady with a right femoral hernia. PMH anxiety and depression

## Background

- Seen by GP with groin pain after gardening. Hernia identified and attempted to reduce unsuccessful. Call made to right care for SSDEC assessment patient asked to fast from now.

## Presentation to SDEC 11:30am

- Details taken by nursing staff . Pain score of 2, News score of 1. HR 92
- Clerked in by ACP
- Reviewed by SDEC Reg. Decision made to try and reduce further after pain relief (oramorph) given.
- 13:00 Unable to reduce. Booked for theatre.
- 15:55 Op start time
- 17:56 Recovery on ward
- Discharged next day

# Patient Journey

What worked well

- Good initial referral by GP after failed to reduce.
- Right care prompt referral to SSEDC.
- Patient arrived quickly to SSDEC NBM.
- Effective care given decision for theatre.
- Timely anaesthetic review.

Excellent patient journey through the surgical pathway.

# Clinical scenario 2- Post op wound infection

**Referral**

- 38 year old lady with post op wound infection. PMH Breast CA and reconstruction, Hysterectomy.

**Background**

- Referred from GP with post op wound problem? Infected wound. No mention of raised HR or raised temp when referred to surgical Registrar, no phone call to nursing staff with handover.

**Presentation to SSDEC**

- Details taken by Nursing staff. Tachycardic and pyrexical systolic BP 106. News score 5, pain score 2. Close to fainting on arrival to SSDEC due to pain.
- Bloods cultures and IV access done.
- Clerked by junior doctor IV fluids and IVAB prescribed and given.
- Reviewed by SSEDC Reg
- Decision made to admit for IVAB and monitoring

# Patient Journey

What could have been done better.

- Systemically unwell patient
- Significant level of pain
- Capacity for same day discharge unlikely? – ED assessment or more in depth discussion with SDEC team

# Clinical scenario 3 – ambulatory care

**DAY 1**

- 54 yr old female left sided abdominal pain ref'd to ED from GP after 6pm
- Known diverticulosis
- Abdomen soft but tender L side, pulse 105, wcc 12 otherwise stable
- Discussed with surgical on-call – details taken, sent home from ED with analgesia and PO abx to return to SDEC next morning.

## DAY 2

- 08:15 – surgical SDEC – pulse 124, rest obs in normal range
- Given IV Abx, IVI and CT scan arranged.
- 10:00 - CT showed acute diverticulitis and contained perforation.
- 12 noon patient reassessed – improving, pulse now 84
- 15:30 - Discharged after second dose IV Abx, with PO Abx, analgesia and plans for re-review in morning.

**DAY 3**

- 08:30 – SDEC – bloods and observations taken (MEWS 0)
- 13:00 – Medical review – observations in normal range, wcc N, CRP 137 (44), clinically feeling much improved.
- Plan to return on DAY 6 for final review.

**DAY 6**

- 12 noon – SDEC –bloods and observations taken (MEWS 0)
- 13:40 – medical review - Abdomen soft, minimal tenderness to deep palpation CRP 15, rest N
- Given open access to surgical SDEC for 2 weeks and made aware of signs of concern.
- Flexible sigmoidoscopy awaited on 19.5.22.

# Patient journey

- Initial ED assessment from GP to assess how stable the patient was and to re-direct to appropriate specialty for review.
- Timely reviews and imaging meant diagnosis could be confirmed and effect of initial interventions reviewed within the day.
- Robust unit for ambulatory review meant admission could be avoided in the knowledge that the patient was not going to be missed.

# Where are we going? – in process

- Working with orthopedics to develop ambulatory care and use of surgical SDEC
- Supported discharge from wards
- Clearer pathways for breast patients
- Direct access for patients for discrete issues and prescribed length of time – preventing unnecessary repeat attendances at ED or GP for same issue.

# THANK YOU –
# ANY QUESTIONS?