National Acute Medicine Programme (NAMP)

2018

Survey Report

Medical Assessment Units (MAU)
Model 2 Hospitals
Introduction:

The National Acute Medicine Programme undertook a comprehensive survey of acute hospital sites which follow the NAMP pathway for their acute medical patients. The purpose of the survey is to measure the current implementation of the NAMP model of care (2010) from an operational standpoint and also to review whether the programme objectives, outlined in the Model of Care, were being achieved. The Acute Medicine Programme was established in 2010 to standardise and improve the management of acutely ill medical patients in the Irish Healthcare system and its seminal report was published in 2010: https://www.hse.ie/eng/services/publications/hospitals/amp.html. Since its publication the management of acute medical patients attending hospitals in Ireland has progressed and improved significantly and many of the programme objectives have been realised. However considerable challenges exist. The increasingly older, frailer population and rising prevalence of chronic disease in addition to the limited expansion of primary and community care are putting a strain on capacity within the acute hospital system which hinders the implementation of the NAMP Model of Care and its aim to enhance and improve the quality and experience of acute care for medical patients.

Acute Medicine is concerned with the immediate and early management of adult patients suffering from a wide range of medical conditions who present to an acute hospital and require urgent or emergency care. The key objectives of the programme are to increase access to timely diagnostic tests and eliminate trolley waits for medical patients, reduce cost and increase value by promoting an ambulatory model of care and shorten average length of stay for admitted patients. The Programme emphasises the fundamental importance of allowing senior clinical decision makers to assess acutely ill patients without delay and to initiate rapid investigation, diagnosis and treatment, and the concept of Clinical Justice. An important focus of the model is close collaboration and interdisciplinary working with GPs and community care colleagues.

The Key Objectives of the NAMP Model of Care include:

Location: The model of care defines the Medical Assessment Unit (MAU) within Model 2 Hospitals as designed to manage GP referred differentiated medical patients who have a low risk of requiring full resuscitation. The MAU should have assessment spaces in a defined area and serve a clinical decision support function. If required, admissions will be to in-patient beds in a model 2 hospital. Patients who deteriorate unexpectedly will have guaranteed transfer to a model 3 or model 4 hospital. The Model of Care also recommends that every MAU should have a designated lead consultant physician (rotating role), a designated clinical nurse manager and assigned therapy resource. MAUs provide a daytime service and potentially could be operational from 8am to 8pm, 7 days per week, depending on local service need. Ideally consultant physicians will be jointly appointed to the model 2 and associated model 3 or 4 hospital.

Standardised, safe patient care: detailed guidelines, algorithms, care pathways and patient information materials should be developed and implemented for the most common acute medical presentations.

National Early Warning Score (NEWS): The programme developed and implemented the NCEC (Guideline No.1) National Early Warning Score (NEWS) and associated communication and handover (SSTAR) protocols to enable early identification of acute deterioration in patients and how they should be best managed.

Governance and metrics: the programme sets key accountabilities for the management of assessment units and key metrics to monitor their performance and effectiveness and so enable continuous improvement.

New working practices/continuous presence: the programme sets out recommended enhancements to clinical work practices in order to ensure patients receive timely care from a senior decision maker working within a dedicated multidisciplinary team.

New approach to education, training and development: the programme recommends the development of Acute Medicine as a specialty and the establishment of a cadre of Acute Medicine physicians (i.e., physicians with Acute Medicine as their primary specialty and physicians with a 50/50 Acute Medicine/other specialty interest). The programme also recommends the development of Acute Medicine as a specialty for nursing and therapy professions.

Model 2 Hospitals: The model of care recognised that the future of healthcare for Acute Medical patients will be focused on Ambulatory Care, including management of chronic disease and that diagnostics and rehabilitation will be based in model 2 hospitals, requiring a growth in their activity to meet the increasing demand. Therefore GPs need to be able to directly refer lower acuity patients to consultant led care within an Ambulatory Care setting and have access to inpatient admission.
Programme Key Performance Indicators:

The programme KPIs include:

- 95% of all medical patients attending should spend less than 6 hours from registration to discharge in AMU/MAU/MAU
- All patients will be seen by a senior clinical decision maker within 1 hour of arrival
- Implementation of the National Early Warning Score (NEWS) and iSBAR
- Access to same day diagnostics and reporting
- 25% of admissions should receive appropriate care without an overnight hospital stay
- 31% acute medical admissions should spend no more that 1-2 nights in hospital
- 33% of AMAU admissions should require LOS of between 3 – 14 days
- 11% or less of AMAU admissions will require no more than 14 days

Survey Design:

The survey was split into different sections which reflects the original model of care and also incorporates the newer initiatives that have been developed since its publication. This ensures that future recommendations on the implementation of the model of care are based on current practice whilst retaining the original principles and objectives. The survey design was specific to the different hospital models. This report covers the model 2 hospitals’ survey. Model 3 & 4 Hospitals’ survey is in a separate report.

Survey Structure

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It was designed through the online portal ‘Survey Monkey’ and relevant survey links were sent via email to three selected people from each site (Patient flow, Acute Medicine Nurses & Acute Physician). The purpose of this was two – fold; to increase the likelihood of completion for each site and also to review whether there are differing perspectives in the implementation of the model of care. The Model 2 Survey contained 64 questions and took approximately 15 minutes to complete.

Survey Response: For the purposes of display in the hospitals where there were multiple respondents, all but one have been removed to ensure statistical data displayed reflects each site, however if there is a disparity in the answers given by respondents within the same hospital this is highlighted in the analysis.

Respondents: All seven (n=7) relevant Model 2 Hospitals who participate in the Acute Medicine Programme responded. All respondents were either an Acute Medical consultant or a nurse. All Nursing respondents were Clinical Nurse Managers, except MWRH Ennis who was the Director of Nursing. There were two (n=2) respondents from St. John’s, Bantry & Roscommon Hospitals, and one (n=1) each from Mallow, Nenagh, Loughlinstown and Ennis Hospitals.
Unit Structure & Governance: These appears, largely, to be compliance with the NAMP model of care amongst all hospitals. All units are called a Medical Assessment Unit (MAU). A dedicated location for assessing and managing patients exists in all hospitals. However Roscommon gave conflicting responses with one respondent saying yes but the other saying it is not dedicated but MAU is incorporated within the Urgent Care Centre, which houses other services. There is conflicting views as to how many numbered spaces are available for MAU, with one saying 0-4 and the other 5-10. All other units, except Nenagh & Ennis, are co-located with a Local Injuries Unit (LIU), and Bantry and Ennis are the only two units with their own waiting area. Other units have between 5-10 spaces, mostly trolleys, but with some chair & bed spaces. Nenagh is moving to a new location with a larger area in the coming months. All units are operational over a 10-12 hour period and only Bantry has a dedicated overnight unit for Acute Medical patients, with the general medical team on call providing out of hours cover.

All but Mallow, Bantry & Loughlinstown have a designated consultant during care working hours, and Roscommon gave differing responses, with one respondent saying yes and the other no. All units have a dedicated Clinical Nurse Manager assigned to the MAU permanently however in four hospitals (Mallow, Roscommon, Bantry & Loughlinstown) they also hold responsibility for additional areas. All units have an operational policy except Nenagh and Ennis. Boarding is an issue, as it is for Model 3 & 4 Hospitals. Bantry & Nenagh have between 0-5 boarders daily, Roscommon having between 6-10 and Loughlinstown reports only occasional boarding in their unit.

Patient Streaming & Patient Experience: All units, except Mallow and Roscommon have patient information leaflets, explaining the services provided. All have an IT system, although systems differ, which can record patient activity electronically and all state that diagnostic tests are stored electronically. Three (n=3) hospitals do not take direct GP referrals, which is not compliant with the programme recommendations; they are St. John’s, Nenagh & Ennis, all of whom are within the same governance of UL Hospital Group. All others do and hold between 6-10 protected slots per day for direct GP referral. All patients have a NEWS score recorded once in the unit within either 20 or 40 minutes of arrival. Over 50% of units state that a senior decision maker review occurs within one hour. All units recognise consultants, registrars or SPRs as senior decision maker. The target of a decision regarding admission or discharge within 6 hours following registration is complied with across all units. Wait times and targets are audited and in some units the NEWS recording within 20 minutes is also audited. All units have a documented protocol for the urgent transfer out, to Model 3 or 4 hospitals, of acutely unwell patients except Nenagh.

Ambulatory Care: Since the publication of the model of care in 2010 Ambulatory Care in Medical Assessment Units has grown exponentially. Ambulatory Care pathways exist in all units but Bantry, Mallow & Nenagh. Out of the other units, three do not have extra spaces for Ambulatory Care activity. St John’s appears to have the most Ambulatory Care pathways for acute clinical conditions but across the others there is a high prevalence. All units have same day access to X-ray and CT diagnostics, none have access to MRI scanning. The majority of hospitals have access to US, EST and other diagnostic tests, not guaranteed within 72 hours but they are accessible. Four units (Roscommon, Bantry, Mallow & Nenagh) confirm that they admit patients solely to wait diagnostic tests, which if they had been available would have avoided inpatient admission.

Frailty: The NAMP model of care recognised in 2010 that the management of older, frailter patients is complex and requires a proactive approach to acute care management and discharge planning. What has evolved since then is now recognised as a frailty model, which includes identification of frailty and comprehensive management approach led by consultant geriatricians supported by a nursing and a HSCP team. The survey aimed to ascertain what approach participating units are taking in the management of frail patients. None of the units surveyed have a protected space allocated for the frail, older adult or has a process in place for the identification of frailty. Roscommon piloted a tool for 3 months at the beginning of 2018. Bantry are planning on incorporating a tool, and Loughlinstown state the Rockwood scoring tool is used within the hospital. Four (n=4) units have a consult with special interest in Geriatrics in place, whilst St John’s state they had a physician attached to unit on Fridays but the service was discontinued by University Hospital Limerick and no explanation was given when it was withdrawn. Not surprisingly without a frailty identification process it is unlikely that there will be a pathway in place for managing frail patients. Almost 50% of the hospitals have a specialist geriatric service within their hospital (Roscommon, Ennis & Loughlinstown), two of whom have a referral criteria in place to refer from the MAU. All hospitals have staff who have completed the frailty education programme and two hospitals (Roscommon & Loughlinstown) have a trainer in place; this is a very positive move towards embedding the identification and management of frailty within Acute Medical services.
Discharge Planning: For the seven hospitals surveyed there was a combined same day discharge rate of 51% in 2017 for medical patients. Therefore discharge planning is relevant to those patients requiring admission. There was a mixed response on the management of discharge planning and liaising with GPs regarding discharge. Four of the seven units do not assess patients for estimated length of stay, and there was a mixed response to criteria and nurse led discharge planning. Loughlinstown state they have discharge protocols for specific nurse led pathways and Bantry have a discharge checklist for MAU patients. With regard to sending GP discharge letter on the same day, this again received a mixed response, for some hospitals communication challenges exist particularly with rural GPs or those who have no linked IT system. It appears to be more common for the Public Health nursing or residential care setting to get discharge documentation on the same day, perhaps because this is a nursing communication channel. Only Loughlinstown and Ennis give a copy of any discharge documentation to the patient.

Data: All units electronically record new patients and none record review patients except St John’s. There was a mixed response to whether review patients returned to MAU; it appears they do, but are managed differently in different units. In Ennis the clinical nurse specialist patients are also recorded within MAU numbers. There is a mixed response to recording of Ambulatory Care patients. These patients are still in an acute episode of care and are not just for review; this appears to be challenging for some units. This is an issue that needs to be addressed in terms of clearly defining this activity and recording it as an entire episode so that active measures to avoid inpatient admission can be incentivised. All units audit their activity and five (n=5) of the seven (n=7) have a person responsible for collating data. Bantry & Mallow do not. Unfortunately no units are using the National Quality Assurance & Improvement System (NQAS Clinical) for data analysis, although one hospital states training has been completed by one of their physicians. This is disappointing and will hopefully be rectified as national training continues to be rolled out.

Analysis & Discussion: This survey has highlighted the success of the National Acute Medicine Programme model of care, which despite challenges over a tumultuous economic period in Ireland, saw the reconfiguration and development of a new flow for acutely unwell medical patients in Irish hospitals. Over the last number of years resources have been limited despite the year on year, increase in acute medical patients accessing services. It is evident, however, that once an acute medical patient is admitted to the MAU they receive consistently high quality, standardised care under the direction and management of a senior clinical decision maker and with an increasing likelihood of same day discharge or Ambulatory Care. The success of the Model 2 hospitals is their high volume of same day discharge for acute medical patients. It is surprising to see some hospitals do not have direct GP access as this is one of the successful factors of having MAU available within Model 2 Hospitals, however those hospitals did not state where their patients stream from.

In 2017, the seven hospitals surveyed had a combined total of 26,000 medical patients who attended, 57% of whom were over 65 years of age. The survey shows there is a lack of structured processes and pathways for the early identification, assessment and management of frailty in this group of patients. It is very encouraging that the frailty education programme, a collaborative across three clinical programmes (NCPOP, NAMP & EMP) has been successfully implemented. Further work is required to ensure the identification and structured management of frailty is recognised and formalised to improve the experience and health outcomes for those patients. The NAMP is currently developing a guideline, which builds upon the key elements in the model of care, to provide all units with the minimum requirements to ensure the MAU is attuned to ‘Frailty’.

Model 2 hospitals are ideally placed to deliver Ambulatory Care for acutely unwell patients, who would ordinarily be admitted as an inpatient. More than half of units have Ambulatory Care pathways in place, with most units having multiple. The further enhancement of existing Ambulatory Care services will be achieved through the implementation of the critical factors which are highlighted in the Framework for Ambulatory Care across the Acute Floor recently published by the National Acute Medicine Programme and shared nationally. Implementing this framework is also relevant to Model 2 hospitals and will embed the Ambulatory Care model within Acute Medicine, however this activity needs to be incentivised. There is, both an inherent risk that exists when managing an acute episode of care and avoiding inpatient admission and, a perverse incentive to admit patients, especially those with private medical insurance; this needs to be addressed by incentivising Ambulatory Care appropriately. Ambulatory care is “clinical care provided on a “day basis” that is not provided within the traditional hospital bed base...It includes diagnosis, observation, treatment and rehabilitation.....There will be immediate access to diagnostic support to facilitate “one stop” rapid diagnosis, treatment and/or reassessment (NAMP 2010)”. Developing a pricing structure for Ambulatory Care activity will incentivise services to increase this activity leading to increasing same day discharge rates and easing pressure on demand for inpatient beds. Also in some Model 2 hospitals there is a lack of extended diagnostic services to prevent patient admission for diagnostic tests, particularly access to MRI scanning, which needs to be addressed. The programme is working with the Healthcare Pricing Office in the HSE to define and price Ambulatory Care activity appropriately and guidance will be provided to MAUs when available.
A minimum requirement for the collation, analysis and reporting of data using NQaS Clinical will be provided by the NAMP in 2019; therefore it is imperative that those working within MAUs familiarise themselves with NQaS Clinical and receive training as needed, particularly those hospitals where a data person is assigned. This will ensure that units are aligned to the NAMP model of care and key performance metrics.

With regard to data analysis, the availability of the performance and measurement data system National Quality Assurance & Improvement system (NQaS Clinical) which is based on HIPE coded data, allows hospitals to measure and analyse the management of patients in different ways. NQaS can identify the types of patients who flow through their hospital, the different admission streams and comparative length of stay in addition to the clinical disease and conditions groupings patients are admitted under and how these hospitals and teams perform in terms of bed day usage and length of stay. According to the survey responses, the uptake of NQaS Clinical is generally poor across most hospitals at present, however this is expected to change following widespread training and super-user training programmes being available through the NQaS Clinical Programme office over 2018.

In summary the survey shows that the NAMP model of care has had a significant impact on the flow and management of acute medical patients; this is very evident in the exponential and sustained development of clinical care pathways for specific conditions, commonly seen in Acute Medical patients. Having an evidence based, standardised high quality approach to patient care improves patient experience, increases same day discharge rates and decreases prolonged inpatient admission length of stay. This is the cornerstone of how care is delivered successfully within Medical assessment Units and, despite, the challenges that must be overcome there are also significant opportunities to be gained in continuing to implement the model of care and ensuring the commitment to the programme is continued and maintained by all sites. See below for a minimum requirements guidance checklist for MAU within Model 2 hospitals.
Medical Assessment Unit (MAU) in Model 2 Hospitals

**PRIMARY FUNCTION IS THE MANAGEMENT OF GP REFERRED DIFFERENTIATED MEDICAL PATIENTS WHO HAVE A LOW RISK OF REQUIRING FULL RESUSCITATION. HOWEVER, DEPENDING ON THE GEOGRAPHICAL LOCATION MAY HAVE UNDIFFERENTIATED MEDICAL PATIENTS. (SUGGESTED OPERATIONAL HOURS 12 HOURS/DAY 5/7 DAYS PER WEEK DETERMINED BY LOCAL SERVICE NEED)**

<table>
<thead>
<tr>
<th>Medical Assessment Unit (MAU) in Model 2 Hospital</th>
<th>Y</th>
<th>N</th>
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<tbody>
<tr>
<td>Dedicated location for the rapid assessment, diagnosis and commencement of appropriate initial treatment and ongoing management</td>
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<tr>
<td>Direct GP referral of low-risk medical patient (i.e. unlikely to require high intensity cardiopulmonary and/or neurological support)</td>
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<tr>
<td>Patients have a NEWS score with 20 minutes of arrival to MAU</td>
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<tr>
<td>All patients streamed will be considered for the Ambulatory Care Pathway and clinical assessment, diagnosis and treatment will be facilitated by rapid access to diagnostics, including radiology, cardiology and vascular and laboratory services</td>
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<tr>
<td>Following assessment, decisions regarding discharge/admission for inpatient care will be made within 6 hours of patient arrival</td>
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<tr>
<td>Patients requiring more or less complex inpatient care will be transferred appropriately subject to locally agreed guidelines</td>
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<tr>
<td>An Advanced Nurse Practitioner service may be available to provide a senior decision making role</td>
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<tr>
<td>HSCP multi-disciplinary team is available to provide appropriate assessment and support and to avoid hospital admission</td>
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<tr>
<td>Ambulatory Care Pathway for Common Clinical Conditions identified for Model 2 Hospitals (see Framework for Ambulatory Care across the Acute Floor 2018 for guidance)</td>
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<tr>
<td>Inpatient admission, if clinically necessary, will be to in-patient beds in a model 2 hospital</td>
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<tr>
<td>Designated lead consultant physician will have a primary responsibility to be present and make management decisions during core working hours and should not be allocated to OPD or other clinical duties whilst allocated to MAU during working hours</td>
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<tr>
<td>Appropriate NCHD presence in the MAU (considered essential to its proper functioning)</td>
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<tr>
<td>Dedicated Clinical Nurse Manager and appropriate allocation of Nursing Staff</td>
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<tr>
<td>Operational Procedures: All MAU’s should operate in line with the NAMP minimum requirements</td>
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<tr>
<td>Key Performance Metrics and recording of Patient Activity should meet with the NAMP model of Care KPIs and Minimum requirements for data</td>
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<tr>
<td>See other NAMP documents for relevant guidance</td>
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</table>
Q1: Select which Model 2 Hospital you are from the list below

- [ ] Prince of Wales
- [ ] Wollongong
- [ ] St John of God Latrobe
- [ ] PRH Goulburn
- [ ] NSW Women's
- [ ] Wollongong
- [ ] Logan
- [ ] Other - please specify

Q2: How far are you from the list below

- [ ] Close
- [ ] Medium
- [ ] Far

Q3: What is your position within the hospital?

- [ ] Consultant
- [ ] Acute Medical
- [ ] Clinical Nurse Manager
- [ ] Medical Nurse Practitioner
- [ ] Infection Prevention
- [ ] Radiology
- [ ] ICU
- [ ] Administration
- [ ] Other - please specify

Q4: Is unit called an MAU? If no add name in other box

- [ ] Yes
- [ ] No
- [ ] Other - please specify

Q5: Does it have a dedicated location for the rapid assessment, diagnosis and commencement of appropriate initial treatment and ongoing management of acute medical patients?

- [ ] Yes
- [ ] No
- [ ] Other - please specify
Q6: Is it co-located with an injuries unit?

Yes: [Bar Chart]

No: [Bar Chart]

Q7: How many assessment spaces does it have?

Yes: [Bar Chart]

No: [Bar Chart]

Q9: Please provide a breakdown of assessment spaces, by bed, trolley, and chair.

Yes: [Bar Chart]

No: [Bar Chart]

Q10: Do you have a dedicated overnight unit for Acute Medical Patients?

Yes: [Bar Chart]

No: [Bar Chart]

12/11/2018
Q11: Who provides out of hours cover to this unit?

Q12: Does the unit have its own waiting area for patients? (separate from injuries unit etc.)

Q13: Do you have Ambulatory Care pathways in place? If Yes list pathways below

Q14: If Ambulatory Pathways in place is there additional seats/recliners for review of Ambulatory pathway patients?
Q15: Does it have Provision/Space protected for review/return patients seen under Ambulatory Care pathways?

Q16: Are MAU patients reviewed in OPD or MAU? Comment if necessary

Q17: Do you have a designated consultant acute medical physician who will have a primary responsibility to be present and make management decisions during core working hours?

Q18: Is there a Clinical Nurse Manager 11 or above designated to work in MAU permanently? Comment if necessary
Q19: Do you have patients boarding in MAU? (boarding patients are those that are not admitted on the NAMP pathway but are occupying space in AMU/AMAU/MAU as a consequence of over crowding in other departments and significantly impede the work of the AMU/AMAU/MAU? Add comment if necessary

Q20: If Yes, state below approximate daily numbers, if daily numbers not available you can divide total monthly numbers by 30/31 days, tick below

Q21: At what time does your MAU begin accepting patients from each day select one option below?

Q22: What time do you stop accepting patients, choose one below?
Q23: GP direct: Do you take direct GP referrals?

Q24: GP direct: Do you have protected daily slots for GP referrals? If Yes, select closest number

Q25: Is NEWS recorded on all patients?

Q26: Do you have a target time for recording of NEWS?
Q27: Do all patients see a senior decision maker within 1 hour of arrival?

Q28: Who in unit is categorised as a Senior Decision Maker?

Q29: Following Assessment, diagnosis and treatment, is a decision regarding admission/discharge made within 6 hours? Comment if necessary

Q30: Do you Audit the above metrics (NEWS, 1 hour & 6 hour)? Comment if necessary
Q31: Do you have a documented protocol for the urgent transfer of acutely unwell patients to a Model 3 or 4 Hospital? Add further comments please.

Q32: Inter-dependencies: Do you have a pathway in place to manage an acute exacerbation/presentation of any of these conditions? Add any additional that are not listed.

Q33: Patient Discharge Assessment: Are all patients assessed with regard to estimated length of stay, the need for specialist care and early discharge planning?

Q34: Patient Discharge Assessment: Does it include information about the patient's pre-hospital abilities in relation to potential discharge issues?
Q35: Discharge Planning: Do you have nurse facilitated discharge planning in MAU? Comment if necessary.

Q36: Discharge Planning: Do you have criteria led discharge planning in MAU? Comment if necessary.

Q37: GP liaison: Do you have mechanisms in place to liaise with GPs to manage patient discharge? Comment if necessary.

Q38: On discharge: Is a copy of the transfer/dischARGE communication sent on the same day by agreed mechanism (ideally encrypted and sent electronically) to the patient's GP, public health nurse, residential care setting and other healthcare providers (e.g. nursing home)? Add comment on timeframe if not same day please.
Q39: On discharge: Is a copy of the discharge letter given to the patient?

Q40: Same Day: Do you have same day facilitated/priority access for any of the following diagnostic tests? Tick all that apply

Q41: Ambulatory Care: Do you have facilitated/priority access to other urgent investigations within 72 hours for any of the following diagnostic tests? Tick all that apply. Add other tests available if not listed

Q42: Are patients admitted as an inpatient solely to await diagnostics
Q43: Storage: Are your diagnostic test requests and reports processed and stored electronically? Add comment if answer No please

Q44: Data: Do you have an 'Patient Administration System' ? In comment box: If Yes, Add name of system. If No, Add collection source of data

Q45: Data: Does 'Patient Administration System' record patients as admissions or patients as attendances or patients as OPD attendances

Q46: Are all new patients recorded?
Q47: Are all review patients recorded?

Q48: Do you have a mechanism for recording Ambulatory Care patients? Please add comment

Q49: Do you have an assigned admin/data person for collating of data?

Q50: Do you carry out audits on your activity? If answered No add comment please
Q51: Do you use NQAIS Clinical for data analysis? If answer No add comment please

Yes
No
Other (please specify)

Q52: Which of the following clinical conditions do you have existing Ambulatory Care Pathways operating? Add additional if not listed

- Non-specific Infections
- Colds
- Upper Respiratory
- Lower Respiratory
- Physiotherapy
- United Teen Services
- Cardiac Rehabilitation
- Other

Q53: Frailty: Has an assessment area been allocated to the older adult with frailty in the MAU?

Yes
No

Q54: Frailty: Do you have one or more consultant acute physicians with a Si in Geriatric Medicine?

Yes
No
Q55: Frailty: Is there a process in place to identify frailty? If Yes, please add name/details of tools used

Q56: Frailty: Is there a specific pathway in place for the delivery of acute medical care to the older person with frailty?

Q57: Frailty: Is there a frailty assessment and response team in place? If yes add disciplines involved and response times

Q58: Frailty: Does your hospital have specialist geriatric service?
Q59: Frailty: IF Yes, is there referral criteria in place, to this service, for relevant patients in the MAU?

Q60: How many of your staff have completed the National Frailty Education Program?

Q61: Do you have a trainer for the National Frailty Education Programme?

Q62: Deteriorating Patient: Do you have systems in place to identify and review patients whose clinical status is deteriorating? Add Comment if necessary.
Q63: Do you have an Operational Policy

Q64: Do you have patient information leaflets' documentation providing information on AMU/AMAU?