National Acute Medicine Programme (NAMP)

2018

Survey Report

Acute Medical Units (AMU)

Model 4 Hospitals

&

Acute Medical Assessment Units (AMAU)

Model 3 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, trailer population and rising prevalence of chronic disease in addition to the limited expansion of primary and community care is 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 specialist 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 programme include:

Location: Acute Medical Units (AMUs) in Model 4 hospitals and Acute Medical Assessment Units (AMAsUs) in Model 3 hospitals have been developed to support the delivery of this care. The model of care defines these different type of units and outlines location, structure and operational requirements of the units. It also recommends model 4 hospitals to have a Medical Short Stay Unit (MSSU) to assist in the clinical management of patients requiring a 1-2 day admission under the governance of Acute Physicians as these can be shown to reduce length of stay (LOS) for acute medical patients.

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 (SBAR) protocols to enable early identification of acute deterioration in patients and how they should be best managed.

Navigation hub/bed bureau and case manager (CM): the programme believes that acute medical services are best delivered utilising a navigation hub concept where case managers (CMs) are able to stream patients referred by GPs and other services to the most appropriate pathways of care and back into the community or residential setting again following treatment and discharge.

Goveriance 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.
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/AMAU/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 to incorporate 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 will just cover model 4 and 3 hospitals as the model of care outlines very similar guidelines for these hospitals. The model 2 hospitals survey will be in a separate report.

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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. Each survey contained between 64 - 88 questions and took approximately 20 minutes to complete. Some participants found it challenging to gain access to the survey because of the HSE IT firewall, but were able to complete it from an alternative PC.

**Respondents:**

Of the seven \((n = 7)\) participating sites in Model 4 hospitals, only four hospitals responded. Mater Misericordiae University Hospital (MMUH) and Tallaght University Hospital (TUH) had one respondent each. With more than one respondent from the two other hospitals Cork University Hospital [CUH] \((n = 3)\) & University Hospital Galway (UHG) \((n = 4)\). St Vincent’s University Hospital or University Hospital Limerick did not respond. University Hospital Waterford did not respond, however their Acute Medical Unit was closed in January 2018 and only reopened with a small number of beds in recent months.

Of the fifteen participating sites in Model 3 hospitals, only three did not respond, Sligo University hospital, OLOL Drogheda & Mayo University Hospital, all others had one respondent each except St Luke’s Kilkenny Hospital & Our Lady’s Hospital Navan who had more than one respondent each \((n = 2)\).
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.

Model 4 Hospitals: The survey was completed by a total of nine (n=9) respondents representing four hospitals. Four Acute Medical Consultants (n=4), three (n=3) colleagues working within patient flow and two (n=2) clinical nurse managers. Within UHG two consultants, one nurse manager and one patient flow manager completed a survey each and in CUH one consultant, one nurse manager and one patient flow manager completed the survey. There was no significant variances in their responses but those present will be outlined.

Unit Structure & Governance: There appears, largely, to be compliance with the NAMP model of care amongst the respondent hospitals. All but one respondent stated that the unit was called an Acute Medical Unit (AMU), and that it has a dedicated location within the hospital. Only one hospital (MMUH) is co-located with ED, which is a recommendation but not mandatory within the model of care. All units, except MMUH, have between 11-15 assessment spaces, which are a combination of chairs, trolleys & beds. MMUH has sixteen spaces when accounting for admissions they take overnight for their short stay ward, under an agreed transfer protocol. All units not co-located with ED have their own waiting area separate from ED. It is recommended within the model of care that AMU’s in model 4 hospitals operate on a 24hr, 7 day basis. None of the units in the survey operate on a 24 hour basis, with all who responded stating a 12-13 hour operational policy with most units. Generally all units start accepting patients between 7 – 9am. Tallaght states they take patients from 11.00am and one respondent from CUH gave a conflicting view that patients were accepted from 9-11am. The acceptance of the last patient in TUH and MMUH & UHG it is between 5-7pm. In CUH there were conflicting responses with two respondents saying before 5pm and the third saying after 5pm.

The learnings from AMU’s who previously operated on a 24/7 basis, will be discussed in more detail when analysing the survey response. None of the units have a navigation hub for streaming appropriate patients to the AMU. The establishment of a navigation hub is considered to be a ‘critical factor’ in the overall success of the implementation of the model of care, as the navigation hubs allows efficient streaming of patients to the most appropriate available care setting and is operated by appropriately trained case managers who are available to services inside and outside the hospital setting. CUH stated that when the unit first opened they had a navigation hub and that currently the shift leader is now responsible for streaming. UHG also previously had a navigation hub but this responsibility now sits within the bed management and patient flow office. The ‘Acute Floor Model for Ireland’, currently at early stages of implementation, recommends an acute care hub which should operate in a similar fashion and facilitates appropriate streaming at the earliest opportunity.

From a governance perspective all hospitals who responded have an acute medicine governance group and/or an unscheduled care governance committee. Two of the hospitals have a liaison committee which includes GPs, but there were conflicting responses from those hospitals which may indicate that the liaison committee may be a wider hospital committee, not just specific to Acute Medicine. Two hospitals MMUH & TUH do not have a liaison committee with GP representatives. All units confirmed they have dedicated acute medical consultant who has primary responsibility for the unit during core working hours and who commit more of their allocated time to the AMU than their area of special interest (Si).

NAMP recommends a 50% split between the two at an absolute minimum, the responses varied with MMUH having a 70/30 (70% to AMU) and CUH is an 80/20 split. TUH did not outline the split percentage and UHG had conflicting responses, one respondent said there was no split, however all others stated a 60/40 split, with one saying that it leaned heavier towards the area of special interest.

All units have a dedicated short stay unit but only MMUH share it with another assessment unit. The Acute medical consultant has clinical governance over this unit also and on call it is covered by them or the general medicine on call consultant. All respondents confirmed that there is no adherence to the 48 hour admission policy, except for one respondent from CUH who said that it was adhered to. It is acknowledge by the other respondents that it would be ideal but adherence is problematic with TUH stating that often patients will stay for the full duration of their stay. With regard to the protocol for egress out of the short stay unit the response was similar, one respondent from CUH stated it was followed but this conflicts with the other respondents who said it wasn’t and was often overruled by bed management staff. TUH do not have an egress protocol which may explain the full length of stay. UHG again provided different responses with some saying it was in place but not adhered to and another saying it did not exist. MMUH have a protocol which is managed by their patient flow team. All units have an operational policy as per the model of care requirements.

The boarding of patients remains a significant problem for most units. All hospitals have a surge capacity protocol with both TUH and MMUH stating that AMU is outlined as last possible option for boarding. UHG do not have this outlined within the policy and CUH respondents are conflicted in this with two saying yes and one saying no. In MMUH and TUH where the policy is clear they have less of a boarding issue, MMUH state it is rare and as per agreed they take 4 patients to short stay AMAU beds in the morning who would be AMU patients ordinarily as it supports the ED and GIM on call team. TUH have agreed to 2 boarders daily. CUH have between 6-10 boarders daily with one respondent commenting that it is the first option chosen for boarders despite the policy stating
otherwise. UHG have much less boarders than in previous years and it has become an occasional event rather than recurring. Their stated monthly numbers conflict, however SBAR figures show cumulative number of less than 20 boarders, per month, since May 2018 which is a significant reduction from the beginning of the year. Overall boarding continues to be problematic in hospitals where a formal management approach is either not agreed or not followed.

**Patient Streaming & Patient Experience:** All units except MMUH take direct GP referrals, TUH and MMUH do not have protected GP slots available but all other hospitals have. With regard to direct Ambulance to AMU there was a mixed response both TUH and MMUH do, while three respondents from UHG say yes and 1 other say no, CUH say yes but dependent on space, and another from CUH says that their ED policy is to see these patients first, which is not direct triage. All units, not surprisingly, stream from ED with a variation of how this is managed locally, all generally have the same process which is based on clinical appropriateness and also include triaging of patients from ED directly and triaging from GPs by phone. In MMUH & TUH the acute physicians also go to ED to pull patients into AMU. From a safety perspective all units state that clinical investigations and records travel with patients transferred, except one respondent from CUH who said it didn’t, however this may be from personal experience and may not be a consistent problem.

Once in AMU there is an evident streamline approach to patient management which adheres to the principles of the model of care. All patients have a National Early Warning Score (NEWS) recorded on arrival and almost all see a senior decision maker within one hour, or have been discussed with a senior decision maker within an hour of arrival. Senior decision makers are categorised appropriately as being either consultants, specialist registrars and registrars, but only one respondent from CUH, considered the Advanced Nurse Practitioner as being a senior decision maker. With regard to a decision to admit or discharge the patient within six hours following assessment, this occurs in MMUH, TUH and CUH. In UHG 2 respondents said yes and 2 disagreed. All but MMUH audit these metrics.

Whilst all units have provision for review of AMU patients, there appears to be limited access to specialist OPD clinics, which is a crucial factor in increasing same day discharge rates and reducing length of stay for acute medical patients. MMUH have no access to specialty OPD slots, and only rapid access to AMU review clinic slots. TUH only have respiratory and endocrinology access, CUH one respondent said none but another said there is access to neurology, oncology, renal and gastroenterology. UHG had the broadest access to multiple specialties except oncology. The accompanying graph does not represent the mixed answers because of the question design. There is, however, effective collaboration with medical colleagues working within other specialties as they attend AMU to review patients upon request. There is also extensive collaborative working with nurse specialists and advanced nurse practitioners working across multiple varied specialist areas including others that are not listed in the graph. Finally on patient experience, TUH and CUH have a patient information leaflet on AMU, all but one respondent from UHG said no & MMUH missed this question.

**Ambulatory Care:** Since the publication of the model of care in 2010 Ambulatory Care in Acute Medical Units has grown exponentially. All of the respondents confirmed that an Ambulatory Care service exists within their unit, but only TUH have confirmed additional seats for this service. Two respondents from UHG stated that 0-4 seats were in place, however the other respondents disagreed. A similar picture emerges in CUH where one respondent said 0-4 seats were available but both other respondents said none were available. Despite the absence of a protected service across most units, all units have multiple pathways in existence for the standardised, same day care approach, and there is some level of agreed priority access for urgent investigations for patients to facilitate the Ambulatory Care approach, also CUH, TUH and 2 respondents from UHG confirm that there is protected space for the return and review of Ambulatory care patients, all of these factors combined increases the likelihood of being able to deliver a robust same day service for acutely unwell medical patients who would have been admitted as an inpatient but now follow an Ambulatory Care pathway.

**Frailty:** The NAMP model of care recognised in 2010 that the management of older, frailer 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 appropriate and immediate identification of frailty and comprehensive management approach led by consultant geriatricians. The survey aimed to ascertain what approach participating units are taking to the management of frail patients. All units have one or more consultants with a special interest in geriatric medicine and all hospitals have a specialist geriatric service, but there is a mixed response as to whether there is a referral criteria in place, CUH has one, as do TUH, 2 respondents from UHG say no and 2 say yes, while the MMUH answered no to this question. However with regard to formal structures in place for identifying and managing frail patients the results are poor. TUH and 1 respondent from UHG state they have a process in place to identify frailty, another UHG respondent states this is being introduced. With regard to having a specific frailty pathway all respondents said no, except for 1 respondent from CUH and 1 from UHG. Only TUH & MMUH carry out a comprehensive geriatric assessment within AMU. MMUH have a frailty response rapid access team for same day response, as do UHG, however traditionally they did not provide a service to AMU, this was confirmed by all but 1 respondent. There is no allocated assessment area for the older adult with frailty within any of the surveyed units. However, despite not having a designated trainer for the frailty education programme all units have between 0-5 staff trained under the national frailty education programme which is positive recognition of the need for formal frailty identification and management.
Discharge Planning: Again mixed responses were returned on the planning of discharges. TUH and MMUH yes with mixed Yes and No from CUH and UHG. Where there is discharge planning the context of information is either complete or done on an adhoc basis. With regard to estimating the expected length of stay being determined by the consultant in conjunction with the multi-disciplinary team. There was a largely yes response with one respondent from CUH saying no, this was much the same for the documentation of estimated discharge in the medical notes. The communication to patient as early as possible is largely done, but is not always consistent. No units have nurse led or criteria led discharge planning, MMUH have ANP’s managing their own caseloads which includes discharge. With regard to GP liaison, no formal structures exist, TUH & MMUH have GP liaison in emergency departments but this service does not extend to AMU. It is more likely that the public health nurse or nursing homes will get a discharge letter on same day of discharge than GPs. The MMUH give a copy to the patient and UHG patients receive an electronic discharge summary. The other hospitals conflicted as to whether this happens.

Data: All units have an IT system for the recording of data, but only TUH and UHG have an assigned person for collating and reporting of data. All units audit activity and record new and review patients either as attendances or admissions. All new patients attending AMU are recorded on HIPE which is then fed into NQAS clinical for data analysis. All, but TUH, utilise NQAS clinical. The recording of Ambulatory Care patients, who are still in an acute episode of care and are not just for review, appears to be challenging for units with some respondents giving conflicting responses. 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. UHG are currently reconfiguring their system to address this which will be helpful for other units.
Model 4 Slides

Q4: Is unit called AMU or AMAU?

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?

Q6: Is it co-located with ED?

Q7: How many assessment spaces does it have?

Q9: Please provide a breakdown of spaces available by bed, trolley, or chair

Q10: Does the unit have its own waiting area for patients? (separate from ED etc.)
Q11: Is there an Ambulatory Care service (patients are assessed, treated and discharged following completion of care within same day or over a short defined period without a hospital admission)?

Q12: Is there additional seats/recliners for Ambulatory Care?

Q13: Does it have Provision/Space protected for review/return patients seen under Ambulatory Care pathways?

Q14: Is there an AMU/AMAU review clinic for AMU/AMAU patients?

Q15: Do you record AMU/AMAU review and Ambulatory Care follow up activity separately?

Q16: 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?
Q17: Do your Acute Medical Physicians have a 50/50 split (or more) commitment to the Acute Medical Unit (AMU/AMAU) and other requirements within their area of special interest (SI) ? please detail split commitment below

Q18: Do you have a dedicated Short Stay Unit for Acute Medical Patients?

Q19: If yes, is it shared with Acute Surgical or other clinical assessment unit?

Q20: Does the AMU/AMAU Acute Physician also cover AMSSU?

Q21: Who provides out of hours cover to your AMSSU?

Q22: Does your AMSSU adhere to a policy of 48 hours admission? Add comment if answer is No
Q23: Is there a protocol for egress of patients out of AMSSU to other specialty wards after 48 hours? Add comment if necessary

Q24: Do you have an Acute Medicine Governance group? If Yes are they represented on the unscheduled care governance committee? Comment if necessary

Q25: Do you have a liaison committee which includes GP representatives? Add comment if necessary

Q26: Does your hospital have a surge capacity protocol?

Q27: Does the surge capacity protocol state that AMU/AMAU is last possible option for boarding of patients?

Q28: Do you have patients boarding in AMU/AMAU? (boarding patients are those that are not admitted on the NAMP pathway but are occupying space in AMU/AMAU as a consequence of overcrowding in other departments and significantly impede the work of the AMU/AMAU? Add comment if necessary
Q29: If Yes, state below approximate daily numbers, if daily numbers not available you can divide total monthly numbers by 30/31 days, tick below

Q30: Is your AMU AMAU open 24 hours?

Q31: If not 24 hour, what time does your AMUAMAU begin accepting patients from each day select one option below?

Q32: What time do you stop accepting patients, choose one below?

Q33: If not 24 hour, What are the closest hours to your opening hours, select from below

Q34: Do you have a case manager/navigation hub for streaming patients? Add comment if necessary
Q35: GP direct: Do you take direct GP referrals?

Yes

No

Q36: GP direct: Do you have protected daily slots for GP referrals? If Yes, select closest number

Yes

No

Q37: Streaming from ED: Do you stream patients from ED?

Yes

No

Q38: Streaming from Ambulance triage: Do you stream patients from Ambulance triage?

Yes

No

Q39: Streaming from ED: How does this streaming occur, chose most relevant from below Comment if necessary

Q40: Streaming from ED: Are patients prioritised according to their clinical need and appropriateness to Acute Medical Unit? Comment if necessary
Q41: Streaming from ED: Do the Acute Medical Physicians attend ED to assess patients? Comment if necessary

Q42: Streaming from ED: Do all clinical investigations and relevant documentation accompany the patient on transfer from ED to AMU/AMAU? Comment if necessary

Q43: Do all patients have a NEWS recorded on arrival?

Q44: Do all patients see a senior decision maker within 1 hour of arrival?

Q45: Who is categorised as a Senior Decision Maker?

Q46: Following Assessment, diagnosis and treatment, is a decision regarding admission/discharge made within 6 hours? Comment if necessary
Q47: Do you audit the above metrics (NEWS, I hour & 6 hour) ? Comment if necessary

Q48: Tick from list which Medical Specialties you have access to Urgent OPD Slots

Q49: Inter-dependencies: From the list below tick all medical specialties who attend the AMU/AMAU to review patients ? Add any additional that are not listed

Q50: Inter-dependencies: From the list below tick all ANP/CNS who attend the AMU/AMAU to review patients ? Add any additional that are not listed

Q51: 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

Q52: Patient Discharge Assessment: Are all patients assessed with regard to estimated length of stay, the need for specialist care and early discharge planning?
Q53: Patient Discharge Assessment: Does it include information about the patient's pre-hospital abilities in relation to potential discharge issues?

Q54: Admitted Patients: Is the estimated length of stay determined by the consultant in conjunction with the MDT?

Q55: Admitted Patients: Is Estimated Discharge Date (EDD) documented in the notes?

Q56: Admitted patients: Is discussion on EDD discussed with and communicated to patient at the earliest available opportunity?

Q57: Discharge Planning: Do you have nurse facilitated discharge planning? Comment if necessary

Q58: Discharge Planning: Do you have criteria led discharge planning? Comment if necessary.
Q59: GP liaison: Do you have mechanisms in place to liaise with GPs to manage patient discharge? Comment if necessary

Q60: 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 and other healthcare providers (e.g. nursing home)? Add comment on time frame if not same day please

Q61: On discharge: Is a copy given to the patient?

Q62: Same Day: Do you have same day facilitated / priority access for any of the following diagnostic tests? Tick all that apply

Q63: 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

Q64: Are patients admitted solely to await diagnostics
Q65: Storage: Are your diagnostic test requests and reports processed and stored electronically? Add comment if answer No please

Q66: Data: Do you have an IT data collection system? In comment box: If Yes, Add name of system. If No, Add collection source of data

Q67: Data: Does IT data collection system? Record patients as admissions or patients as attendances or patients as OPD attendances

Q68: Are all new patients recorded?

Q69: Are all review patients recorded

Q70: Do you have a mechanism for recording Ambulatory Care patients? Please add comment
Q71: Do you have an assigned admin/data person for collating of data?

Yes
No

Q75: Which of the following clinical conditions do you have existing Ambulatory Care Pathways operating? Add additional if not listed

Q76: Frailty: Has an assessment area been allocated to the older adult with frailty in the AMU?

Yes
No

Q77: Frailty: Do you have one or more consultant acute physicians with a SI in Geriatric Medicine?

Yes
No

Q78: Frailty: Is there a process in place to identify frailty? If Yes, please add name/details of tools used

Yes
No

Q79: Frailty: Is there a specific pathway in place for the delivery of acute medical care to the older person with frailty?

Yes
No
Q80: Frailty: Is there a frailty assessment and response team in place? If yes add disciplines involved and response times

Q81: Frailty: Do you carry out Comprehensive Geriatric Assessment within your AMU or AMISSU?

Q82: Frailty: Does your hospital have specialist geriatric service?

Q83: Frailty: If yes, is there referral criteria in place, to this service, for relevant patients in the AMU/AMAU?

Q84: How many of your staff have completed the National Frailty Education Programme?

Q85: Do you have a trainer for the National Frailty Education Programme?
Q86: Deteriorating Patient: Do you have systems in place to identify and review patients whose clinical status is deteriorating? Add Comment if necessary.

Q87: Do you have an Operational Policy

Q88: Do you have patient information leaflets/documentation providing information on AMU/AMAU?
**Model 3 Hospitals:** Out of fifteen sites survey only three did not respond Sligo University Hospital, Mayo University Hospital & OLOL Drogheda. Both Our Lady’s hospital, Navan & St Luke’s Kilkenny had two respondents each, but one of the respondents for St Luke’s did not complete the survey fully. Seven respondents were nursing, five were consultants and two were patient flow.

**Unit Structure & Governance:** The survey shows that there appears to be almost complete compliance with the model of care recommendations for acute medical care in Model 3 hospitals. All units are called AMAU, and 5 are co-located with ED, although this is not mandatory. All have separate dedicated space and the majority operate over a 12 hour basis. All except for Naas General Hospital have an operational policy and 3 units, University Hospital Kerry, Connolly Hospital Blanchardstown and Cavan General Hospital, have patient information leaflets outlining AMAU services. Porttunica, Naas & the Mercy have 0-4 dedicated spaces, whilst the others have between 5-15 spaces. With regard to clinical and other governance, the unit is covered either by the physician on call or a dedicated physician appointed to AMAU only. Seven units have a case manager/navigation hub for streaming of patients appropriately. It is unclear whether the case manager is part of the patient flow or bed management team as this was not asked within the survey. Letterkenny University Hospital have recently appointed a patient flow manager. Eight units take direct GP referrals and 7 have protected GP slots. Seven hospitals have a liaison committee which includes GPs, Mullingar are currently piloting direct GP access. Portunica & Naas do not have an Acute Medicine governance group, all other hospitals are represented under unscheduled care governance. The model of care does not state that there should be a contiguous short stay unit, however 3 of the hospitals surveyed have one, Cavan General Hospital, Connolly Hospital Blanchardstown and Mullingar General Hospital, it is shared with surgical services in Mullingar & Cavan. All units are covered by the on call medical team. And Cavan follows a 72 hour admission policy, the others aim to adhere to 48 hour. Egress out is managed by bed management or patient flow teams.

Not surprisingly, boarding is also a significant problem for almost all hospitals, Wexford and Mullingar have no boarding of patients in AMAU, one respondent from Kilkenny said yes and the other said no. The approximate number varies between 5-10 patients boarding daily. All hospitals except Naas GH & UH Kerry have a surge capacity management protocol, of those that do all but Cavan GH, OL Navan & Letterkenny UH have AMAU as the last possible place for boarding.

**Patient Streaming & Patient Experience:** All units stream patients from their ED department by the process of clinical communication. Six units stream from Ambulance triage and Mullingar is also piloting this at present. All clinical documentation accompanies the patients following transfer. The Mercy Hospital have reconfigured their AMAU to within the Emergency department with Acute Medical governance within ED. This is not in line with the NAMP model of care, as the pathway recommends that patients are streamed to AMAU from ED. Six other hospitals state that their acute medical physicians attend ED to assess acute medical patients, 4 state this does not happen, in Connolly Hospital Blanchardstown this only happens when capacity in AMAU is full. Once the patient is in AMAU the majority (9) units record and complete a National Early Warning Score (NEWS) within twenty minutes, whilst 3 do not attain this goal. Only 4 units confirm that patients see a senior decision maker within one hour, the others aim to. However all but Cavan GH state that a decision to admit or discharge the patient following assessment, diagnosis and treatment is made within 6 hours. Not all hospitals are able to audit these metrics. There is comprehensive access to outpatient slots for multiple specialties, however it is not clear whether urgent access is obtainable, in some hospitals it is possible on request. Other specialists do attend the AMAU to provide a service, particularly clinical nurse specialists & Advanced Nurse Practitioners in multiple specialties. Most units have pathways in place to manage acute exacerbation of chronic conditions particularly COPD where a pathway exists in 7 different units. UH Kerry, OLH Navan & St Luke’s KK do not have any pathways in place and Mullingar are currently developing specific pathways.

**Ambulatory Care:** All units, except Wexford have an Ambulatory Care service, there were conflicting responses from Navan, one respondent said yes and the other said no. Five sites have no additional seats for Ambulatory care with others having between 0-4 or 5-10 spaces. Most units do not have protected space to see return Ambulatory Care patients and they are generally recorded as review or same day patients. Despite challenges in promoting the Ambulatory Care model there appears to be good access to same day or 72 hour diagnostics and all units, except Navan, have Ambulatory Care pathways in place for commonly seen acute medical conditions.

**Frailty:** Four units, Kilkenny, Mullingar, Mercy & Blanchardstown have an allocated area for the assessment of frailty. All units, except The Mercy have a consultant with a special interest in Geriatric Medicine, Navan also conflicts on this question. Only Portinucula, Kerry & Navan have no process in place to identify frailty, Five units have a frailty pathway in place and seven units have a frailty assessment team, made up of differing members of the MDT. Comprehensive geriatric assessment is carried out within the AMAU in 7 units and all but 3 hospitals
have a specialist geriatric service within their hospital. There has been a comprehensive uptake of the frailty training programme, with 4 units having a designated trainer. Navan conflicts on this response with 1 respondent stating there is a trainer and the other saying no one is available.

**Discharge Planning:** All units, except Kerry and Letterkenny have early discharge planning in place, and most estimate the discharge day with the MDT, with most having this documented in notes. Not all units can confirm that this is communicated to the patient at the earliest opportunity. All but Navan, Letterkenny & Portinucula have nurse led discharge, and Cavan, Portinucula and the Mercy having criteria led discharge. Most units have mechanisms to liaise with GPs on discharge and send the discharge communication on the same day or soon thereafter, Portinucula have no daily admin support in AMAU, so this is very challenging for them. Seven units confirm that patients are often admitted solely to await diagnostic tests which is a poor use of capacity.

**Data:** All units have an IT recording system with mixed response on the recording of patients as attendances or admissions, all new AMAU patients are registered on HIPE. All new patients are recorded, and all units, except South Tipperary GH, record review patients. Ambulatory care activity is recorded within this data as either new for first attendance and review for subsequent attendances. Only Blanchardstown and Cavan confirm they have an IT/Data person and Navan conflicts on this response. Seven units undertake audits of their activity, this responsibility presumably lies with the clinical staff, in those units with a data person. Only Kilkenny and one of the respondents from Navan state they use NQAIS clinical for data collation and analysis.
Model Three Slides

Q1: Select which Model 3 Hospital you are from the list below

Q4: Is unit called AMU or AMAU?

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?

Q6: Is it co-located with ED?
Q1: How many trolleys does it have?

Q2: Does the unit have its own waiting area for patients? (separate from ED etc.)

Q3: Is there an Ambulatory Care service (patients are assessed, treated and discharged following completion of care within same day or over a short defined period without a hospital admission)

Q4: Is there additional seats/recliners for Ambulatory Care?
Q11: Does it have Provision/Space protected for review/return patients seen under Ambulatory Care pathways?

Q12: Is there an AMU AMAU review clinic for AMU AMAU patients?

Q13: Do you record AMU AMAU review and Ambulatory Care follow up activity separately?

Q14: 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?
Q15: Do your Acute Medical Physicians have a 50/50 split commitment to the Acute Medical Unit (AMU/AMAU) and other requirements within their area of special interest (5i)? If No, provide details.

Q16: Do you have a dedicated Short Stay Unit for Acute Medical Patients?

Q17: If yes, is it shared with Acute Surgical or other clinical assessment unit?

Q18: Does the AMU/AMAU Acute Physician also cover AMSSU?
Q19: Who provides out of hours cover to your AMSSU?

Q20: Does your AMSSU adhere to a policy of 48 hours admission? Add comment if answer is No

Q21: Is there a protocol for egress of patients out of AMSSU to other specialty wards after 48 hours? Add comment if necessary

Q22: Do you have an Acute Medicine Governance group? If Yes are they represented on the unscheduled care governance committee? Comment if necessary
Q23: Do you have a liaison committee which includes GP representatives? Add comment if necessary

Q24: Does your hospital have a surge capacity protocol?

Q25: Does the surge capacity protocol state that AMU/AMAU is last possible option for boarding of patients?

Q26: Do you have patients boarding in AMU/AMAU? (boarding patients are those that are not admitted on the NAMP pathway but are occupying space in AMU/AMAU as a consequence of over crowding in other departments and significantly impede the work of the AMU/AMAU? Add comment if necessary
Q27: If Yes, state below approximate daily numbers, if daily numbers not available you can divide total monthly numbers by 30/31 days, tick below

Q28: What time does your AMU/AMAU begin accepting patients from each day select one option below?

Q29: What time do you stop accepting patients, choose one below?

Q30: What are the closest hours to your opening hours, select from below
Q31: Do you have a case manager/navigation hub for streaming patients? 
Add comment if necessary

Q32: GP direct: Do you take direct GP referrals?

Q33: GP direct: Do you have protected daily slots for GP referrals? If Yes, select closest number

Q34: Streaming from ED: Do you stream patients from ED?
Q35: Streaming from Ambulance triage: Do you stream patients from Ambulance triage?

Q36: Streaming from ED: How does this streaming occur, chose most relevant from below? Comment if necessary.

Q37: Streaming from ED: Are patients prioritised according to their clinical need and appropriateness to Acute Medical Unit? Comment if necessary.

Q38: Streaming from ED: Do the Acute Medical Physicians attend ED to assess patients? Comment if necessary.
Q39: Streaming from ED: Do all clinical investigations and relevant documentation accompany the patient on transfer from ED to AMU/AMAU? Comment if necessary

Q40: Do all patients have a NEWS recorded within 20 minutes of arrival?

Q41: Do all patients see a senior decision maker within 1 hour of arrival?

Q42: Following Assessment, diagnosis and treatment, is a decision regarding admission/discharge made within 6 hours? Comment if necessary
Q43: Do you Audit the above metrics (NEWS, 1 hour & 6 hour) ? Comment if necessary.

Q44: Tick from list which Medical Specialties you have access to Urgent OPD Slots.

Q45: Inter-dependencies: From the list below tick all medical specialties who attend the AMU/AMAU to review patients. Add any additional that are not listed.

Q46: Inter-dependencies: From the list below tick all ANPs who attend the AMU/AMAU to review patients. Add any additional that are not listed.
Q47: 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.

Q48: Patient Discharge Assessment: Are all patients assessed with regard to estimated length of stay, the need for specialist care and early discharge planning?

Q49: Patient Discharge Assessment: Does it include information about the patient's pre-hospital abilities in relation to potential discharge issues?

Q50: Admitted Patients: Is the estimated length of stay determined by the consultant in conjunction with the MDT?
Q51: Admitted Patients: Is Estimated Discharge Date (EDD) documented in the notes?

Q52: Admitted patients: Is discussion on EDD discussed with and communicated to patient at the earliest available opportunity?

Q53: Discharge Planning: Do you have nurse facilitated discharge planning? Comment if necessary

Q54: Discharge Planning: Do you have criteria led discharge planning? Comment if necessary.
Q55: GP liaison: Do you have mechanisms in place to liaise with GPs to manage patient discharge? Comment if necessary.

Q56: 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 G.P., public health nurse and other healthcare providers (e.g. nursing home)? Add comment on time frame if not same day please.

Q57: On discharge: Is a copy given to the patient?

Q58: Same Day: Do you have same day facilitated / priority access for any of the following diagnostic tests? Tick all that apply.

- 768
- C7
- MRI
- U20
Q59: 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

Q60: Are patients admitted solely to await diagnostics

Q61: Storage: Are your diagnostic test requests and reports processed and stored electronically? Add comment if answer No please

Q62: Data: Do you have an IT data collection system? In comment box: If Yes, Add name of system. If No, Add collection source of data
Q63: Data: Does IT data collection system record patients as admissions or patients as attendances or patients as OPD attendances

Q64: Are all new patients recorded?

Q65: Are all review patients recorded

Q66: Do you have a mechanism for recording Ambulatory Care patients? Please add comment
Q67: Do you have an assigned admin/data person for collating of data?

Yes: [Green] | No: [Blue]

Q68: Do you carry out audits on your activity

Yes: [Green] | No: [Blue]

Q69: Do you use NQAIS for data analysis?

Yes: [Green] | No: [Blue]

Q71: Which of the following clinical conditions do you have existing Ambulatory Care Pathways operating? Add additional if not listed

- [Green] Asthma
- [Green] COPD
- [Green] Deep Venous Thrombosis
- [Green] Lower Respiratory
- [Green] Presyncope
- [Green] Urinary Tract Infections
- [Green] Asthma
- [Green] Syncope
Q72: Frailty: Has an assessment area been allocated to the older adult with frailty in the AMU/AMAU?

Q73: Frailty: Do you have one or more consultant acute physicians with a Sl in Geriatric Medicine?

Q74: Frailty: Is there a process in place to identify frailty? If Yes, please add name/details of tools used

Q75: Frailty: Is there a specific pathway in place for the delivery of acute medical care to the older person with frailty?
Q76: Frailty: Is there a frailty assessment and response team in place? If yes add disciplines involved and response times

Q77: Frailty: Do you carry out Comprehensive Geriatric Assessment within your AMU or AMSSU?

Q78: Frailty: Does your hospital have specialist geriatric service?

Q79: Frailty: If yes, is there referral criteria in place, to this service, for relevant patients in the AMU/AMAU?
Q80: How many of your staff have completed the National Frailty Education Programme?

Q81: Do you have a trainer for the National Frailty Education Programme?

Q82: Deteriorating Patient: Do you have systems in place to identify and review patients whose clinical status is deteriorating? Add Comment if necessary

Q83: Do you have an Operational Policy
Q84: Do you have patient information leaflets/documentation providing information on AMU/AMAU?
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. Although, initially, the implementation of the model brought additional resources in terms of consultant appointments and dedicated space, 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 AMU/AMAUs 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. Streaming is challenging with different approaches being taken: the ‘Acute Floor Model for Ireland’ which is in the early phase of implementation will facilitate improved streaming processes as it will move streaming to the front door, to avoid patients having to be triaged in ED, prior to attendance at the AMU/AMAUs, where appropriate. It will also ensure the implementation of an Acute Care Hub, similar to that proposed in the NAMP Model of care whilst the Acute Floor Information System will also provide a real time IT system which will show the tracking and streaming of patients across the Acute Floor.

Access to AMU/AMAUs, for acutely unwell medical patients, continues to be a prevailing problem. The boarding of patients in AMU is high risk and prevents flow and normal functioning of the AMU/AMAUs. In sites where there is consistent boarding, there is an increasing likelihood that frail older medical patients with remain in Emergency Departments and younger, more mobile patients will be streamed to the AMU/AMAUs. Boarding of patients has been shown to increase the length of stay (LOS) of those patients and increase the likelihood of readmission at both 7 day and 30 day and is linked with an increased risk of mortality1.

Ideally, Model 4 hospitals would operate their AMU over a 24 hour/7 day period however it has been difficult to resource this on a consistent basis. Also any piloting of this with additional resources provided has led to an increase in boarding over the seven day/ 24 hour period effectively turning the AMU into an acute medical ward which is unacceptable and is not aligned with the optimum use of Acute Medical units. The model of care recommendation of moving to a 24/7 day operational unit remains, but only if assessment space is protected, required resources are available and if boarding is removed from AMU completely and is sustained.

From a governance perspective the availability of acute medical physicians who also have a specialist interest in another area is clearly hugely beneficial to the management of acute medical patients, the introduction of Advanced Nurse Practitioners in acute medicine increases the quality of care and experience for patients and improves access to nurse led services. 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 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. 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 reassurance (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. The survey shows that almost all AMU/AMAUs’ across model 3 & 4 hospitals have established Ambulatory Care pathways in place, but currently any activity where the patient must come back for active treatment is recorded as a review which does not account for the clinical care of this patient who would ordinarily be admitted. The programme is working with the Healthcare Pricing Office in the HSE to define and price this activity appropriately.

It is evident from the survey responses that the management of frail patients is considered important by clinicians working across AMU/AMAUs. In some hospitals there is are clear processes in place to manage the total journey for frail patients, however despite having acute physicians with a specialist interest in geriatric medicine there is a lack of structured processes and pathways for the early identification, assessment and management of this complex 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 nationally. The NAMP programme 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 AMU/AMAUs are attuned to ‘Frailty’.

1. Daniel Braddock ‘Acute Medicine: The Scottish Perspective’ 2018
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 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 and the interest in attendance at this training. The programme will provide guidance on the minimum requirements of data collation and analysis that will be provided through a communication stream between the programme and participating AMU/AMAU’s.

**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 Acute Medical 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. To assist this process below is an outline of what the AMU in model 4 and AMAU in model 3 units require as part of the Acute Floor.
Acute Medical Unit in Model 4 Hospitals (AMU) as part of the Acute Floor

**Primary Function is the Immediate and Early Specialist Management of Adult Patients (i.e. aged 16 and older) with a Wide Range of Undifferentiated Acute Medical Conditions Streamed Through the Acute Floor**

(Operational Hours 24 Hrs / 7 Days)

Acute Medical Patients in Model 4 Hospitals will be streamed through the Acute Floor. 'Developing an Acute Floor Model for Ireland' (H.S.E. Acute Hospitals Division, V1.0, Oct 2017) outlines the specific elements of the Acute Floor, governance arrangements, streaming of patients and interdependencies across the specialties within the Acute Floor. Where implemented, the Acute Medicine Service will work under the governance structure and standards outlined by the HSE for the Acute Floor model but will be guided - in respect to service delivery, access, quality, patient experience, cost and clinical pathway development - by the requirements outlined with the National Acute Medicine Report (2010) and other documents developed by NAMP to guide acute medicine services.

<table>
<thead>
<tr>
<th>The AMU on the Acute Floor in Model 4 Hospitals</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated location for the rapid assessment, diagnosis and commencement of appropriate initial treatment and ongoing management.</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Senior decision maker (Consultant / Specialist Registrar / Registered Advanced Nurse Practitioner on site during opening hours)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Must have a designated consultant acute medical physician who 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 AMU on the Acute Floor</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Patient streaming through Acute Floor Hub and through Direct GP referral</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Ambulance patients will be streamed through the Acute Floor</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Patients have a NEWS score with 20 minutes of arrival to Acute Floor</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>All patients streamed must 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>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Following assessment, decisions regarding discharge/admission for inpatient care will be made within 6 hours of patient arrival to the Acute Floor</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>An Acute Medicine Short Stay Ward (AMSSU) for the transfer and management of appropriate patients for up to 72 hours under the governance of the Acute Medicine Physicians</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Dedicated Advanced Nurse Practitioner (ANP) Service</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>A dedicated interdisciplinary team of health and social care professional (HSCP) and a Therapies Lead for the Acute Floor</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Ambulatory Care pathways must be in place for relevant common clinical conditions identified for Model 4 Hospitals (see Framework for Ambulatory Care across the Acute Floor NAMP 2018)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Frailty attuned care pathways are in place as per the NAMP minimum requirements for the identification and management of Frailty</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Operational procedures: All AMUs should ensure operation in line with the Acute Floor Model requirements and the operational policy minimum requirements [NAMP 2019]</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Measurement of Key Performance Metrics (KPIs) and recording of patient activity should meet the NAMP model of Care and the minimum requirements for data [NAMP 2018]</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Provision/Space is protected for review/return patients seen under Ambulatory Care pathways and (if necessary) relevant patients are accommodated in the AMU</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other Return/review patients being, where possible accommodated in the OPD, and not AMU</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Refer to the other NAMP documents for further guidance</td>
<td>Y</td>
<td>N</td>
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Acute Medical Unit in Model 3 Hospitals (AMAU) as part of the Acute Floor

PRIMARY FUNCTION IS THE IMMEDIATE AND EARLY SPECIALIST MANAGEMENT OF ADULT PATIENTS (I.E. AGED 16 YEARS AND OVER) WITH A WIDE RANGE OF ACUTE MEDICAL CONDITIONS

(OPERTATIONAL HOURS WILL BE 12-24 HOURS 5/7 or 7/7 DAYS DETERMINED ON LOCAL SERVICE NEED)

Acute Medical Patients in Model 3 Hospitals will be streamed through the Acute Floor. ‘Developing an Acute Floor Model for Ireland’ H.S.E. Acute Hospitals Division, V1.0. Oct 2017 outlines the specific elements of the Acute Floor, governance arrangements, streaming of patients and interdependencies across the specialties within the Acute Floor. Where implemented, the Acute Medicine Service will work under the governance structure and standards outlined by the HSE for the Acute Floor but will be guided in respect to service delivery, access, quality, patient experience, cost and clinical pathway development - by the requirements outlined within the National Acute Medicine Report (2010) and other documents developed by NAMP to guide acute medicine services.

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<tr>
<td>Dedicated location for the rapid assessment, diagnosis and commencement of appropriate initial treatment and ongoing management.</td>
<td></td>
<td></td>
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<td>Senior decision maker [Consultant / Specialist Registrar /Registered Advanced Nurse Practitioner] on site during opening hours</td>
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<td>Must have a designated consultant physician of the day who 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 AMU on the Acute Floor</td>
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<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>
<tr>
<td>May have an Acute Medicine Short Stay Ward (AMSSU) for the transfer and management of appropriate patients for up to 72 hours under the governance of the Acute Medicine Physicians</td>
<td></td>
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<tr>
<td>Ideally have a dedicated Advanced Nurse Practitioner (ANP) Service</td>
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<tr>
<td>HSCP inter-disciplinary team should be available to provide appropriate assessment and support to avoid hospital admission [see NAMP HSCP Service Delivery Report 2017]</td>
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<tr>
<td>Ambulatory Care Pathways must be in place for relevant common clinical conditions identified for Model 3 hospitals [see Framework for Ambulatory Care across the Acute Floor NAMP 2018]</td>
<td></td>
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<tr>
<td>Frailty attuned care pathways as per minimum requirement (NAMP 2019)</td>
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<td>Operational procedures: All AMU’s should ensure operation in line with the Acute Floor Model requirements and operational policy minimum requirements (NAMP 2019)</td>
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<td></td>
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<tr>
<td>Measurement of Key Performance Metrics (KPI’s) and recording of patient activity should meet with the NAMP model of Care Minimum Data Sets [see below for example] and in line with AFIS [Acute Floor Information System]</td>
<td></td>
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<td>Provision/Space is protected for review/return patients seen under Ambulatory Care pathways and (if necessary) relevant patients are accommodated in the AMU</td>
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