5.0 Frailer and older patients with complex needs after discharge

There is a growing community of frailer and older patients who often have complex care needs which will continue following discharge. A proactive approach should be adopted to identify the requirements for addressing these needs during the patient’s acute care episode and beyond, in line with the guidelines of the National Clinical Programme for Older People. It is expected that no more than 11% of admissions would fall into this group and require a length of stay >14 days in an acute medical bed. Early liaison with specialists in care of the older person services is imperative. This can be achieved by:

- Maintaining regular review of the patient, daily board rounds and Consultant review.
- Undertaking multidisciplinary team meetings with key actions assigned to team members identifying target dates. Proactive discharge planning with activities to promote re-enablement and self care is also important.
- Proactive engagement of discharge planner with external bodies required for discharge.

6.0 Critical Success Factors

The critical components for safe, efficient and effective management of Acute Medical Care include:

- An identified clinical lead for the AMAU and medical short stay unit who works closely with a senior nurse and has management and administrative support.
- The clinical support of the wider physician group and the specialist medical wards for the AMAU and the acute medicine team. Physicians and Registrars should all be familiar with their role when on acute take and be consistent and reliable in its execution.
- Support by the hospital management team, and in future, by the hospital group board with a clear understanding of the role and responsibilities of the local team within the group.
- Constant monitoring of the capacity and demand for acute medical assessment and care. Regular reviews of the capacity and performance of the AMAU and all the medical wards should be routinely provided to physicians. This analysis should include Length of Stay (LoS) by Consultant and bed days used by patients after they are considered prepared for discharge from the acute wards.
- An agreed standard operating procedure for the management of patient flow through the medical pathways for medical admissions which must be familiar to all staff responsible for bed management. These standard operating procedures must ensure that the AMAU always has capacity for the prompt admission of patients referred by the Emergency Department and GPs and does not become congested with patients waiting for beds elsewhere. There must be active management systems in place which support the assessment of patients within the national patient experience times and avoid trolley waits.
- Prioritisation in the allocation of vacated specialist beds to the patients from the MSSU. This will ensure the medical pathway flow and efficient use of resources. The MSSU must not be allowed to become congested and hence non-functional.
- Undertaking multidisciplinary team meetings with key actions assigned to team members identifying target dates. Proactive discharge planning with activities to promote re-enablement and self care is also important.
- Organisational and frontline awareness of the impact of extended length of stay on patient safety and wellbeing, as well as operational effectiveness of the whole unit to manage capacity to meet ongoing demand.

NAMP BENCHMARK
No more than 11% of AMAU admissions will require >14 nights in hospital.
1.0 An Acute Medical Assessment Unit (AMAU)

Patients referred for medical assessment by GPs and Emergency Medicine Consultants/NCHDs should be seen in an AMAU where the acute medical resources are available. The following criteria are essential for an effective AMAU:

1.1 The AMAU capacity must reflect the Planning Number (PN) (i.e. anticipated demand) consistent with the planned operating procedures and patient flows.

1.2 Must be staffed with senior medical decision makers (Consultant and registrar/specialist registrar).

1.2.1 A rota of protected Consultant time must be in place i.e. the Consultant is not assigned to other duties or clinics.

1.2.2 An NCHD roster must also be in place with protected time allocated to AMAU. The roster will be appropriate for the predicted demand and the anticipated pattern of attendances.

1.3 Must have dedicated nursing staff with experience in medical care provision, including:

1.3.1 A Clinical Nurse Manager (CNM) to manage and coordinate the activity of the unit.

1.3.2 Maintaining a high level of acuity of patients being accepted to the AMAU i.e. triage category 2 and 3.

1.3.3 Direct referral from nurse triage in ED.

1.3.4 Ensuring access to a multi-disciplinary team.

1.4 Appropriate equipment must be available in the AMAU e.g. monitors.

1.5 Rapid access to diagnostics to match predicted clinical demand must be negotiated at local level, this includes:

1.5.1 Protected allocation of radiology resources e.g. C.T. and ultrasound.

1.5.2 Rapid turnaround of laboratory sample analyses and reports.

1.6 Patient experience must be continuously monitored and managed safely, for example:

1.6.1 Validate compliance with the National Early Warning Score (NEWS) policy by participating in National Audits.

1.6.2 Track time to senior doctor review (reviewed within 1 hour of arrival in the AMAU as per NAMP standard).

1.6.3 Track total patient experience time (National standard <8 hours).

1.7 Consistently use safe patient transfer/handover protocols including the use of standardised communication tools, whenever a patient’s care is transferred from one Consultant or clinical team to another.

There are four intervention areas identifying patient pathways detailed in the following sections:

2.0 The Ambulatory Care Pathway

Ambulatory care pathways are being developed to allow patients receive safe and effective treatment without an overnight stay in hospital. The NAMP benchmark is that at least 25% of AMAU admissions should follow such pathways of care. This works best when:

2.1 There is rapid access to Consultant decision making.

2.2 There is quick and consistent links with specialist ambulatory care initiatives e.g. in diabetes, heart failure, acute coronary syndrome, asthma, chronic obstructive pulmonary disease and epilepsy programmes.

2.3 There are effective working relationships with the Community Intervention Team (CIT), Public Health, GP Liaison, etc. using agreed care pathways which are regularly reviewed.

2.4 There is rapid access to OPD clinics and follow-up review to cope with predicted clinical demand.

2.5 Available Outpatient Parenteral Antibiotic Therapy (OPAT) facilities are used appropriately.

3.0 The medical short stay pathways (1-2 nights)

During clinical assessment, it is important to identify the patients who require inpatient care not expected to exceed one or two nights. Successful management of patients whose care does not exceed a one or two night stay requires a high level of clinical supervision if the NAMP benchmark of 31% is to be sustained.

3.1 For larger hospitals, a specialist Medical Short Stay Unit (MSSU) is a very valuable resource. In other hospitals there should be an agreed process to manage patients who require a 1-2 day admission, to include identification of patients in this group, the Consultant in charge, the plan of care, discharge target, interventions and treatments required. This generally requires twice daily review by a senior doctor. Senior doctor supervision of medical short stay facilities should be continuous (i.e. 7 days a week).

3.2 Continuity of Consultant supervision with twice daily clinical reviews and carefully documented handovers are essential.

4.0 Routine specialist in-patient care pathways

Approximately 33% of medical admissions will be expected to stay more than 2 days and less than 14 days in hospital but will have a straightforward discharge after their acute episode of care. It is expected that this group of patients will not require an acute medical bed for more than 10-14 days. Following AMAU assessment, these patients will be admitted either directly to specialist medical wards or via the MSSU usually within 2 days of arrival. Care will be formally handed over from the AMAU team to the appropriate Consultant Physician in line with locally agreed pathway management arrangements which should include:

4.1 All inpatient admissions to be seen by a Consultant within 12-16 hours of transfer from AMAU/MSSU.

4.2 Each patient needs to have written medical and nursing care plans including an estimated length of stay, target dates for interventions, evaluations, reassessment, and discharge. NEWS assessments must continue in line with national policy.

4.3 The care plan and discharge arrangements must be reviewed every day on a board/ward round with Consultant/senior decision maker.

4.4 Pro-active consideration for multi-disciplinary assessment and intervention.

4.5 Pro-active and timely planning of patient needs for discharge with family and/or carers, hospital discharge planner and transport co-ordinator.

4.5.1 Discharge planning should comply with the national standard for Integrated Discharge Planning (HSE, 2010).

NAMP BENCHMARK

33% of AMAU admissions should require admission lengths of between 3 and 14 days.
1.0 An Acute Medical Assessment Unit (AMAU)

Patients referred for medical assessment by GPs and Emergency Medicine Consultants/NCHDs should be seen in an AMAU where the acute medical resources are available. The following criteria are essential for an effective AMAU:

1.1 The AMAU capacity must reflect the Planning Number (PN) (i.e. anticipated demand) consistent with the planning procedures and patient flows.
1.2 Must be staffed with senior medical decision makers (Consultant and registrar/specialist registrar).
1.2.1 A rota of protected Consultant time must be in place i.e. the Consultant is not assigned to other duties or clinics.
1.2.2 An NCHD roster must also be in place with protected time allocated to AMAU. The roster will be appropriate for the predicted demand and the anticipated pattern of attendances.
1.3 Must have dedicated nursing staff with experience in medical care provision, including:
1.3.1 A Clinical Nurse Manager (CNM) to manage and co-ordinate the activity of the unit.
1.3.2 Maintaining a high level of acuity of patients being accepted to the AMAU i.e. triage category 2 and 3.
1.3.3 Direct referral from nurse triage in ED.
1.3.4 Ensuring access to a multi-disciplinary team.
1.4 Appropriate equipment must be available in the AMAU e.g. monitors.
1.5 Rapid access to diagnostics to match predicted clinical demand must be negotiated at local level, this includes:
1.5.1 Protected allocation of radiology resources e.g. CT and ultrasound.
1.5.2 Rapid turnaround of laboratory sample analyses and reports.
1.6 Patient experience must be continuously monitored and managed safely, for example:
1.6.1 Validate compliance with the National Early Warning Score (NEWS) policy by participating in National Audits.
1.6.2 Track time to senior doctor review (reviewed within 1 hour of arrival in the AMAU as per NAMP standard).
1.6.3 Track total patient experience time (National standard <6 hours).
1.7 Consistently use safe patient transfer/handover protocols including the use of standardised communication tools, whenever a patient’s care is transferred from one Consultant or clinical team to another.

1.8 The medical short stay pathways (1-2 nights)

During clinical assessment, it is important to identify the patients who require inpatient care not expected to exceed one or two nights. Successful management of patients whose care does not exceed a one or two night stay requires a high level of clinical supervision if the NAMP benchmark of 31% is to be sustained.

3.1 For larger hospitals, a specialist Medical Short Stay Unit (MSSU) is a very valuable resource. In other hospitals there should be an agreed process to manage patients who require a 1-2 day admission, to include identification of patients in this group, the Consultant in charge, the plan of care, discharge target, interventions and treatments required. This generally requires twice daily review by a senior doctor. Senior doctor supervision of medical short stay facilities should be continuous (i.e. 7 days a week).

3.2 Continuity of Consultant supervision with twice daily clinical reviews and carefully documented handovers are essential.

There are four intervention areas identifying patient pathways detailed in the following sections:

2.0 The Ambulatory Care Pathway

Ambulatory care pathways are being developed to allow patients receive safe and effective treatment without an overnight stay in hospital. The NAMP benchmark is that at least 25% of AMAU admissions should follow such pathways of care. This works best when:

2.1 There is rapid access to Consultant decision making.
2.2 There is quick and consistent links with specialist ambulatory care initiatives e.g. in diabetes, heart failure, acute coronary syndrome, asthma, chronic obstructive pulmonary disease and epilepsy programmes.
2.3 There are effective working relationships with the Community Intervention Team (CIT), Public Health, GP Liaison, etc. using agreed care pathways which are regularly reviewed.
2.4 There is rapid access to OPD clinics and follow-up review to cope with predicted clinical demand.
2.5 Available Outpatient Parental Antibiotic Therapy (OPAT) facilities are used appropriately.

NAMP BENCHMARK

At least 25% of AMAU admissions should receive appropriate care WITHOUT an overnight stay in hospital.

3.0 The medical short stay pathways (1-2 nights)

3.1 For larger hospitals, a specialist Medical Short Stay Unit (MSSU) is a very valuable resource. In other hospitals there should be an agreed process to manage patients who require a 1-2 day admission, to include identification of patients in this group, the Consultant in charge, the plan of care, discharge target, interventions and treatments required. This generally requires twice daily review by a senior doctor. Senior doctor supervision of medical short stay facilities should be continuous (i.e. 7 days a week).

3.2 Continuity of Consultant supervision with twice daily clinical reviews and carefully documented handovers are essential.

NAMP BENCHMARK

31% of AMAU admissions should spend no more than 1-2 nights in hospital.

4.0 Routine specialist in-patient care pathways

Approximately 33% of medical admissions will be expected to stay more than 2 days and less than 14 days in hospital but will have a straightforward discharge after their acute episode of care. It is expected that this group of patients will not require an acute medical bed for more than 10-14 days.

Following AMAU assessment, these patients will be admitted either directly to specialist medical wards or via the MSSU usually within 2 days of arrival. Care will be formally handed over from the AMAU team to the appropriate Consultant Physician in line with locally agreed pathway management arrangements which should include:

4.1 All inpatient admissions to be seen by a Consultant within 12-16 hours of transfer from AMAU/MSSU.
4.2 Each patient needs to have written medical and nursing care plans including an estimated length of stay, target dates for interventions, evaluations, reassessment, and discharge. NEWS assessments must continue in line with national policy.
4.3 The care plan and discharge arrangements must be reviewed every day on a board/ward round with Consultant/senior decision maker.

NAMP BENCHMARK

33% of AMAU admissions should require admission lengths of between 3 and 14 days.

For further information and contact details please visit the National Acute Medicine Programme website at www.hse.ie/acutemedicine
5.0 Frailer and older patients with complex needs after discharge

There is a growing community of frailer and older patients who often have complex care needs which will continue following discharge. A proactive approach should be adopted to identify the requirements for addressing these needs during the patient’s acute care episode and beyond, in line with the guidelines of the National Clinical Programme for Older People. It is expected that no more than 11% of admissions would fall into this group and require a length of stay >14 days in an acute medical bed. Early liaison with specialists in care of the older person services is imperative. This can be achieved by:

5.1 Maintaining regular review of the patient, daily board rounds and Consultant review.
5.2 Undertaking multidisciplinary team meetings with key actions assigned to team members identifying target dates. Proactive discharge planning with activities to promote re-enablement and self care is also important.
5.3 Proactive engagement of discharge planner with external bodies required for discharge.

5.4 Organisational and frontline awareness of the impact of extended length of stay on patient safety and wellbeing, as well as operational effectiveness of the whole unit to manage capacity to meet ongoing demand.

NAMP BENCHMARK
No more than 11% of AMAU admissions will require >14 nights in hospital.

5.5 Undertaking detailed discharge planning with external bodies required for discharge.
5.6 Support by the hospital management team, and in the future, by the hospital group board with a clear understanding of the role and responsibilities of the local team within the group.
5.7 Support by the hospital management team, and in the future, by the hospital management team with a clear understanding of the role and responsibilities of the local team within the group.
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The critical components for safe, efficient and effective management of Acute Medical Care include:

6.1 An identified clinical lead for the AMAU and medical short stay unit who works closely with a senior nurse and has management and administrative support.
6.2 The clinical support of the wider physician group and the specialist medical wards for the AMAU and the acute medicine team. Physicians and Registrars should all be familiar with their role when on acute take and be consistent and reliable in its execution.
6.3 Support by the hospital management team and in the future, by the hospital group board with a clear understanding of the role and responsibilities of the local team within the group.
6.4 Constant monitoring of the capacity and demand for acute medical assessment and care. Regular reviews of the capacity and performance of the AMAU and all the medical wards should be routinely provided to physicians. This analysis should include Length of Stay (LoS) by Consultant and bed days used by patients after they are considered prepared for discharge from the acute wards.
6.5 An agreed standard operating procedure for the management of patient flow through the medical pathways for medical admissions which must be familiar to all staff responsible for bed management. These standard operating procedures must ensure that the AMAU always has capacity for the prompt admission of patients referred by the Emergency Department and GPs and does not become congested with patients waiting for beds elsewhere. There must be active management systems in place which support the assessment of patients within the national patient experience times and avoid trolley waits.
6.6 Prioritisation in the allocation of vacant specialist beds to the patients from the MSSU. This will ensure the medical pathway flow and efficient use of resources. The MSSU must not be allowed to become congested and hence non-functional.

6.7 Review of every medical patient on every ward each day on a board/ward round which includes a senior doctor and senior ward nurse. Every day the patient is in hospital carries some risk for them and must have some demonstrable benefit. Pro-active referral for multi-disciplinary support and early recognition of complex needs after discharge are vital for the efficient use of available resources. Pro-active discharge planning is part of every patient’s care.
6.8 Identification of agreed parameters by the hospital and AMAU team which suggest that demand is not being met within standard operating procedures, should trigger escalation demand management protocols. These should also be pre-agreed across all clinical teams in the hospital and consistently applied. (In general, the use of day case surgical units for “boarding out” medical patients is inappropriate and is to be strongly discouraged).
6.9 A continuous process of clinical and operational management audit in acute care. IT support is extremely valuable but it’s absence is not an excuse for failing to monitor the efficient use of resources, patient experience times, medical trolley waits and the quality of care and outcomes for patients. The hospital should continuously monitor the LoS of medical patients against the four benchmarked subgroups in the National Acute Medicine Programme and seek support for intervention where difficulties are identified.
6.10 An Unscheduled Care Governance Group within the hospital which includes local GPs and other key stakeholders from the health and social care community. It should meet regularly and provide objective information about the efficiency, effectiveness and patient experience of care, benchmarked against a variety of internal and externally derived norms.