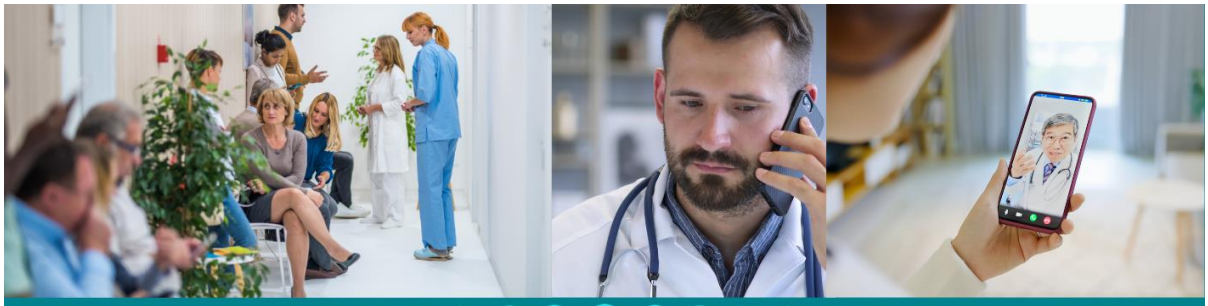

ACCESS TO CARE: ADULT SERVICES

Pathways of Care Handbook

29/04/2025

CDI Clinical Practice Guidance Document Cover Sheet

Document Type	Guidance document outlining initial points of access to acute services on the acute hospital floor
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Electronic Location:	

* Refer to HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs)

Version	Revision Date	List Section Numbers Changed	Author

Table of Contents

Glossary

AppCAR	Alternative Pre-Hospital Pathway
AMAU	Acute Medical Assessment Unit
AMU	Acute Medical Unit
AMP	National Clinical Programme for Acute Medicine
ANP	Advanced Nurse Practitioner
ASAU	Acute Surgical Assessment Unit
CDU	Clinical Decision Unit
CHO	Community Health Organisation
CHN	Community Health Network
CNS	Clinical Nurse Specialist
ECG	ElectroCardioGram
ECU	Emergency Care Unit
ED	Emergency Department
EMEWS	Emergency Medicine Early Warning System
EMP	National Clinical programme for Emergency Medicine
GCS	Glasgow Coma Scale
GP	General Practitioner
HSE	Health Service Executive
IU	Injury Unit
ICTS	Irish Children's Triage System
IPC	Infection Prevention and Control
IV	Intravenous
MAU	Medical Assessment Unit
MTS	Manchester Triage System
NAS	National Ambulance Service
NCPS	National Clinical Programme for Surgery
OB/Gyn	Obstetrics and Gynaecology
PAU	Paediatric Assessment Unit
PDU	Paediatric Decision Unit
PET	Patient Experience Time
PED	Paediatric Emergency Department
PTMHTT	Post-Triage Mental Health Triage Tool
RAT	Rapid Assessment and Treatment
RHA	Regional Health Area
SIFT	Senior Intervention Following Triage
SDM	Senior Decision Maker
UCC	Urgent Care Centre

Introduction

The premise of developing this document between the following stakeholders, National Clinical Programme for Emergency Medicine, National Ambulance Service, National Clinical programme for Acute Medicine and the National Clinical Programme for Surgery (Acute) was to provide a map of the access points into acute adult services. The access points: Self-presentation, GP Referral and Ambulance transfer (112/ 999), are defined both nationally and services available per Health Region.

The scope of this document relates only to the Acute Floor services whereby the receiving medical personnel are a permanent physical presence on the acute floor at the initial point of access. This initial iteration acknowledges that other aspects of the health system should also be defined, such as, children and young person's access points, mental health access points and orthopaedic access points.

Working Group
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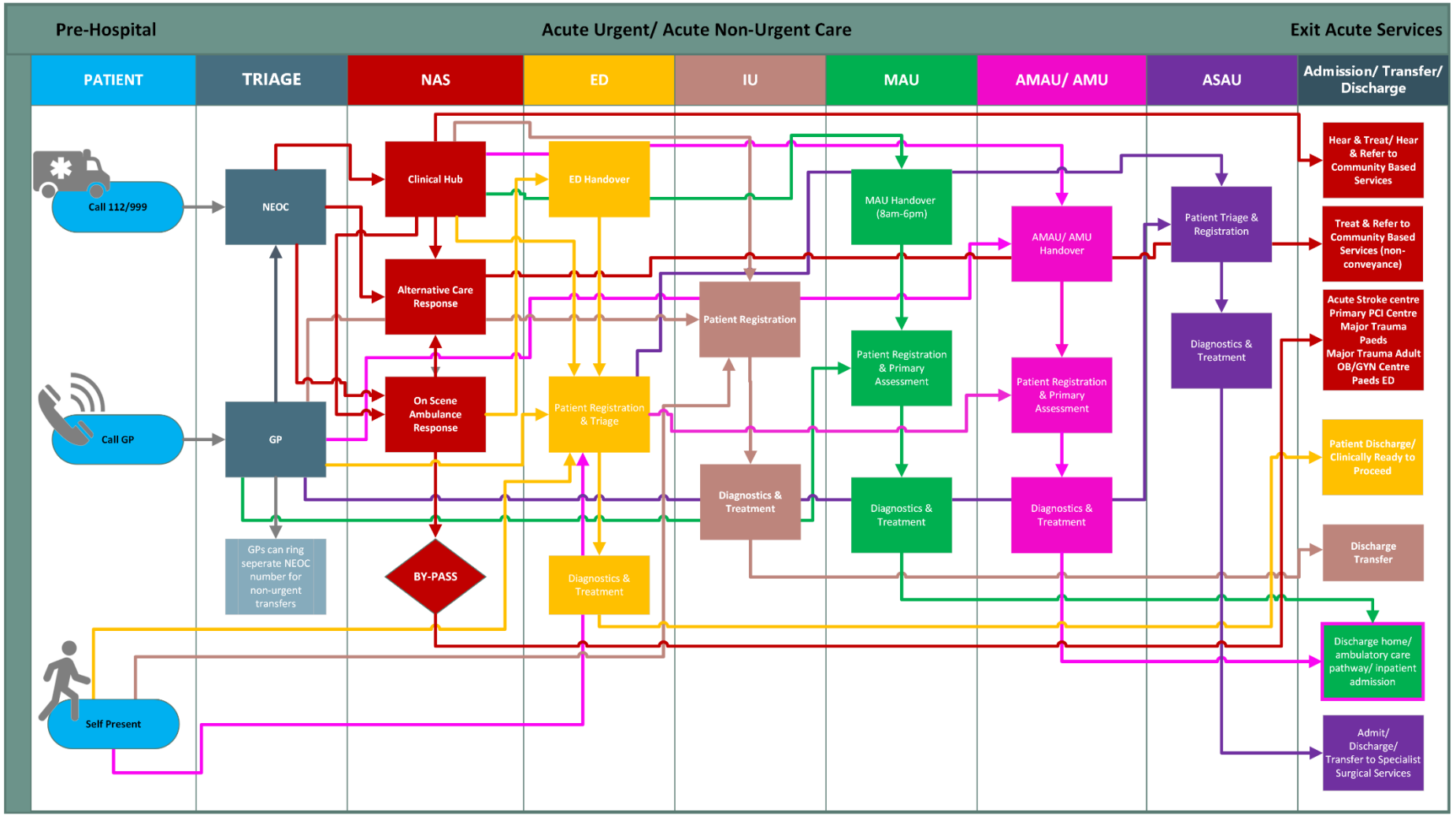
Pathways Process Map



Regional Health Areas Map

Health regions

FSS an Iarthair agus an Iarthuaiscirt
HSE West and North West

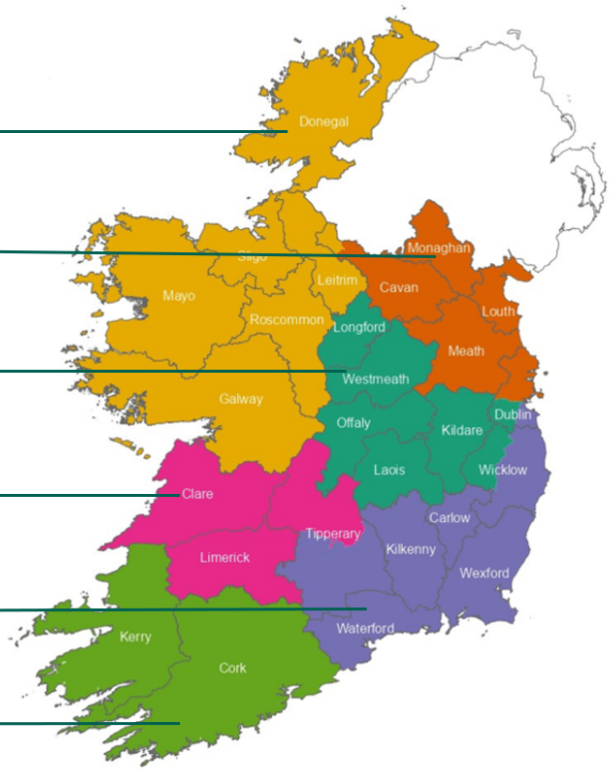
FSS Bhaile Átha Cliath agus an Oirthuaiscirt
HSE Dublin and North East

FSS Bhaile Átha Cliath agus Lár na Tíre
HSE Dublin and Midlands

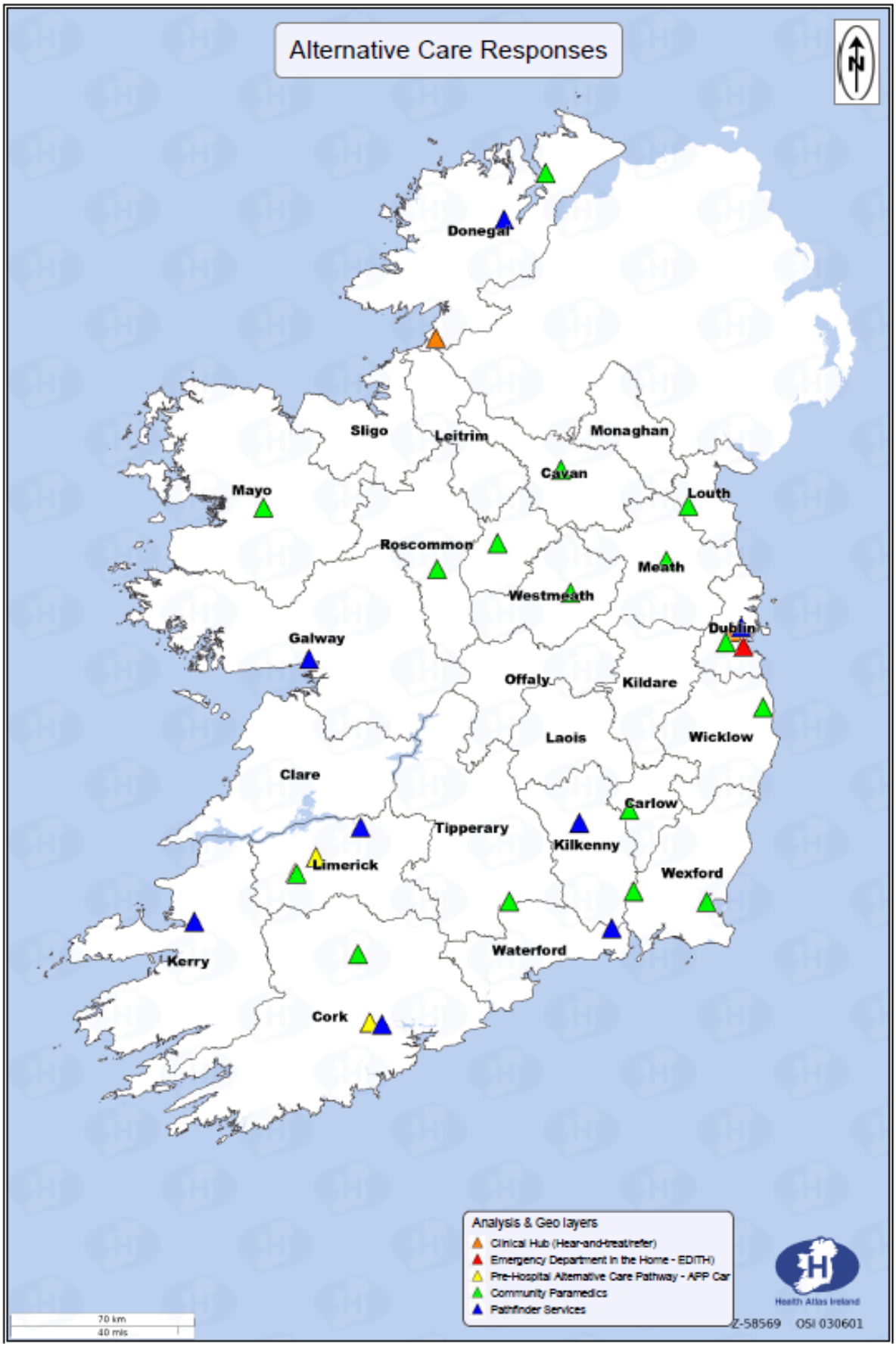
FSS an Iarthar Láir
HSE Midwest

FSS Bhaile Átha Cliath agus an Oirdheiscirt
HSE Dublin and South East

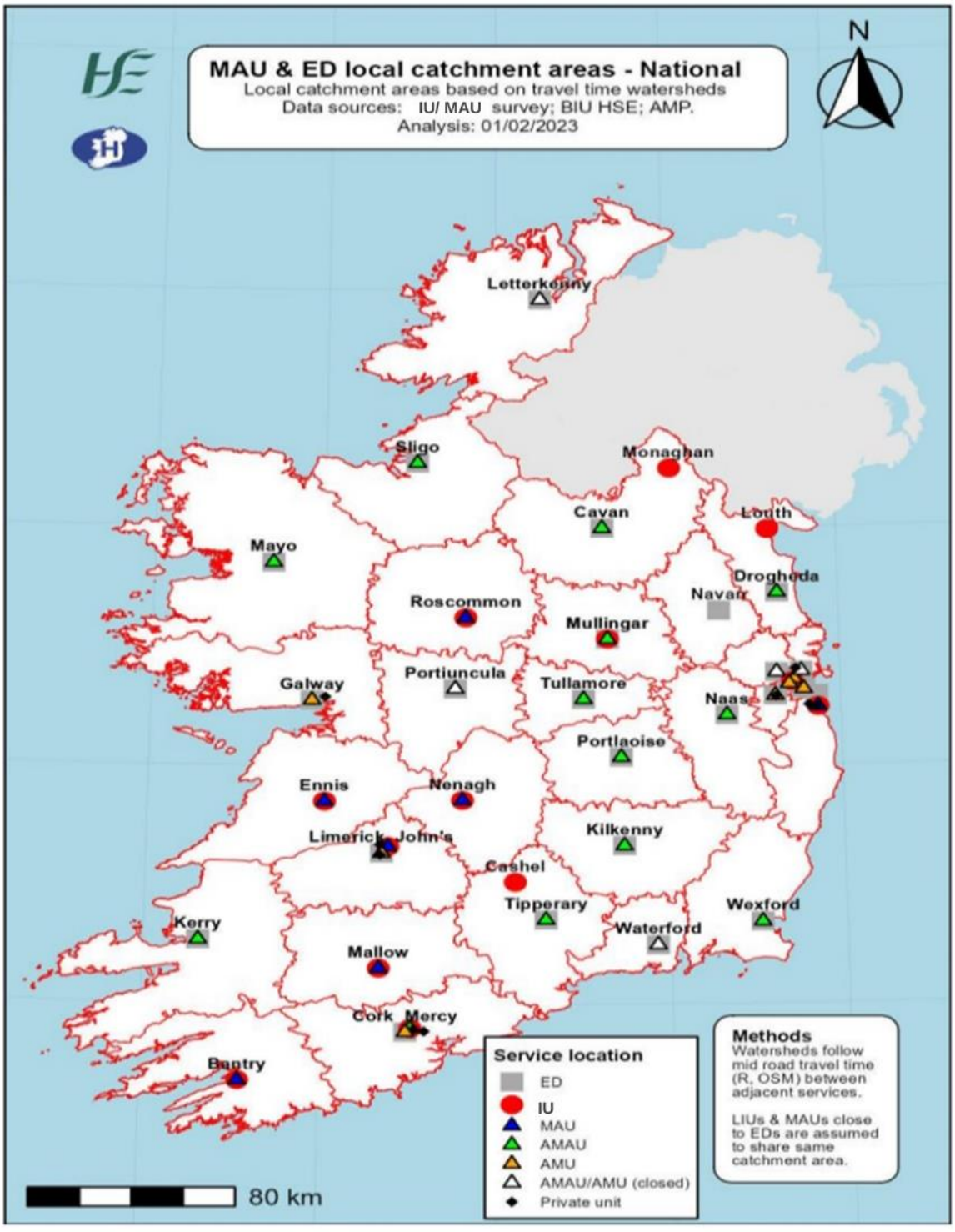
FSS an Iardheiscirt
HSE South West



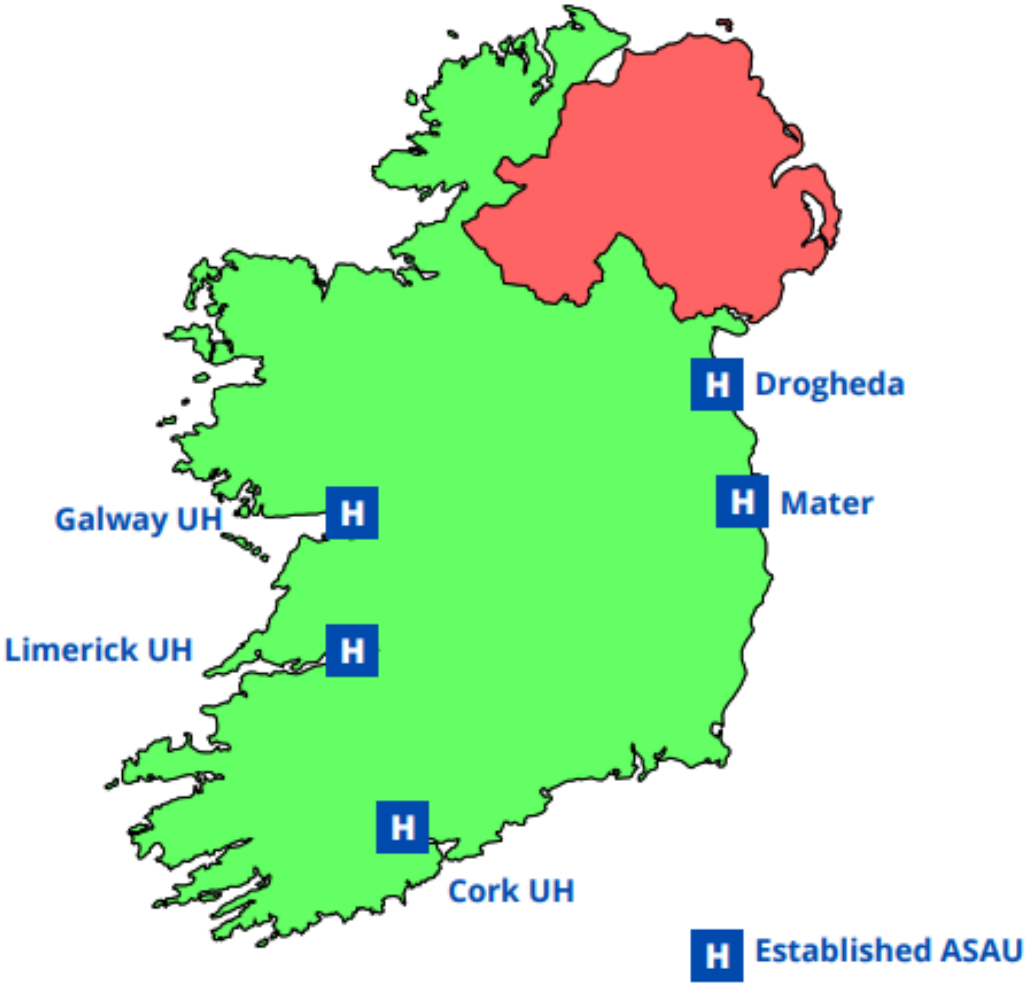
National Ambulance Service: Alternative Care Locations Map



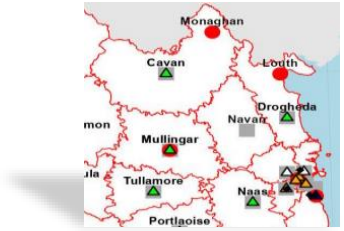
MAU & ED Local Catchment Areas Map



Acute Surgical Assessment Unit Locations



HSE Dublin & North East

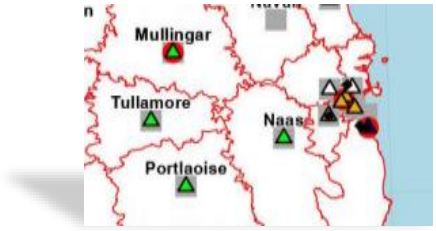


Pathfinder Service	Community Paramedic Service
Beaumont Pathfinder	Cavan Dublin Louth Meath

Dublin & North East	IU	ED	Acute Medical Assessment	ASAU	PPCI Service	Acute Stroke Care Service	Obstetrics & Gynaecology Service	Neck of Femur injuries accepted
Beaumont Hospital	None	ED 24/7 Adult Only	None	None	No	Yes	No	Yes
Mater Misericordiae University Hospital	Smithfield IU	ED 24/7 Major Trauma Centre Adult Only	AMU	None	Yes	Yes	No	Yes
Connolly Hospital Blanchardstown	None	ED 24/7 Adult	None	None	No	Yes 09:00-17:00	No	Yes
Our Lady of Lourdes Hospital Drogheda	None	ED 24/7	AMAU	ASAU	No	Yes	Yes	Yes
Cavan General Hospital	None	ED 24/7	AMAU	Trialling**	No	No	No	No
Our Lady's Hospital Navan	None	ED 24/7	AMAU	None	No	No	No	No
Monaghan Hospital	IU	None	None	None	No	No	No	No
Louth County Hospital, Dundalk	IU	None	None	None	No	No	No	No

*Temple Street CHI ED (24/7) and Connolly CHI Paediatric Urgent Care Centre (12/7) is geographically within this area for children **Cavan has set up an ASASU but this has not been validated as yet until the trial period has been completed

HSE Dublin & Midlands

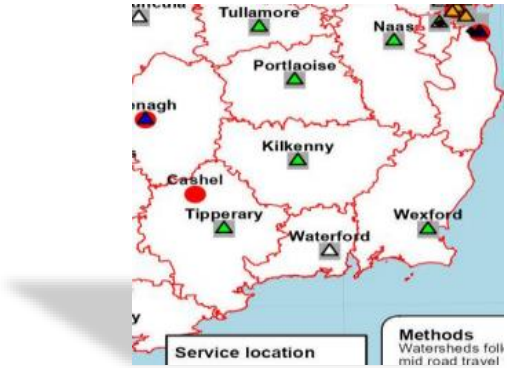


Community Paramedic Service
Dublin Longford Westmeath

Dublin & Midlands	IU	ED	Acute Medical Assessment	ASAU	PPCI Service	Acute Stroke Care Service	Obstetrics & Gynaecology Service	Neck of Femur injuries accepted
Tallaght University Hospital	None	ED 24/7	AMU	None	No	Yes	No	Yes
St. James's Hospital	None	ED 24/7 Adult Only	AMU	None	No	No	No	Yes
Midland Regional Hospital Tullamore	None	ED 24/7	AMAU	None	No	No	No	Yes
Midland Regional Hospital Mullingar	IU	ED 24/7	AMAU	None	No	No	Yes	Yes
Midland Regional Hospital Portlaoise	None	ED 24/7	AMAU	None	No	No	Yes	Yes
Naas General Hospital	None	ED 24/7 Adult Only	AMAU	None	No	No	No	No

* Tallaght Emergency Unit (24/7) and Crumlin Hospital CHI ED (24/7) geographically in this area for children

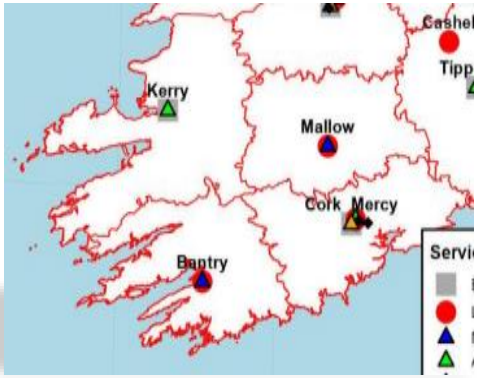
HSE Dublin & South East



Pathfinder Service	Community Paramedic Service	ED In The Home (EDITH)
Kilkenny Pathfinder	Wexford	St Vincent's University Hospital
Waterford Pathfinder	Carlow	
	Wicklow	
	Dublin	
	Tipperary	

Dublin & South East	IU	ED	Acute Medical Assessment	ASAU	PPCI Service	Acute Stroke Care Service	Obstetrics & Gynaecology Service	Neck of Femur injuries accepted
St. Vincent's University Hospital	None	ED 24/7 Adult only	AMU	None	No	Yes	No	Yes
University Hospital Waterford	None	ED 24/7	None	None	09:00 – 17:00 Mon-Fri	No	No	Yes
St. Luke's General Hospital Kilkenny	None	ED 24/7	AMAU	None	No	Yes	Yes	No
Wexford General Hospital	None	ED 24/7	AMAU	None	No	Yes	Yes	No
Tipperary University Hospital	None	ED 24/7	AMAU	None	No	Yes	Yes	No
St. Michael's Hospital, Dun Laoghaire	None	ED 12/7	None	None	No	No	No	No
St. Columcille's Hospital	IU	None	MAU	None	No	No	No	No

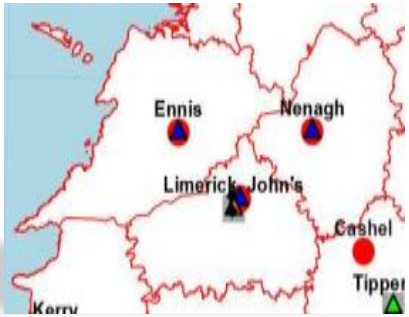
HSE South West



Pathfinder Service	Community Paramedic Service	AppCAR
Kerry Pathfinder	Cork	Cork University Hospital
Cork Pathfinder		

South West	IU	ED	Acute Medical Assessment	ASAU	PPCI Service	Acute Stroke Care Service	Obstetrics & Gynaecology Service	Neck of Femur injuries accepted
Cork University Hospital	None	ED 24/7 & Major Trauma Centre	AMU	ASAU	Yes	Yes	Yes	Yes
University Hospital Kerry	None	ED 24/7	AMAU	None	No	Yes	Yes	Yes
Mercy University Hospital	IU	ED 24/7 Adult only	AMAU	None	No	Yes	No	No
Bantry General Hospital	IU	None	MAU	None	No	Yes	No	No
Mallow General Hospital	IU	None	MAU	None	No	No	No	No

HSE Midwest



Pathfinder Service	Community Paramedic Service	AppCAR & EDiTH
Limerick Pathfinder	Limerick	Limerick University Hospital
	Tipperary	

Midwest	IU	ED	Acute Medical Assessment	ASAU	PPCI Service	Acute Stroke Care Service	Obstetrics & Gynaecology Service	Neck of Femur injuries accepted
University Hospital Limerick	None	ED 24/7	AMU	ASAU	Yes	Yes	Yes	Yes
Ennis Hospital	IU	None	MAU	None	No	No	No	No
St John's Hospital Limerick	IU	None	MAU	None	No	No	No	No
Nenagh Hospital	IU	None	MAU	None	No	No	No	No

HSE West & North West

Pathfinder Service	Community Paramedic Service
Letterkenny Pathfinder	Donegal
Galway Pathfinder	Roscommon
	Mayo

West & North West	IU	ED	Acute Medical Assessment	ASAU	PPCI Service	Acute Stroke Care Service	Obstetrics & Gynaecology Service	Neck of Femur injuries accepted
Galway University Hospital	None	ED 24/7 & Trauma Unit with Speciality Services	AMU	ASAU	Yes	Yes	Yes	Yes
Sligo University Hospital	None	ED 24/7	AMAU	None	No	Yes	Yes	Yes
Letterkenny University Hospital	None	ED 24/7	AMAU	None	No	Yes	Yes	Yes
Mayo University Hospital	None	ED 24/7	AMAU	None	No	Yes	Yes	Yes
Portiuncula University Hospital	None	ED 24/7	None	None	No	No	Yes	No
Roscommon University Hospital	IU	None	MAU	None	No	No	No	No

National Ambulance Service Pathways

Patient Pathways from the point of 112/999 call[1]

- Call triage using AMDPS system (currently performed by non-clinical call takers)

Resulting in triage to:

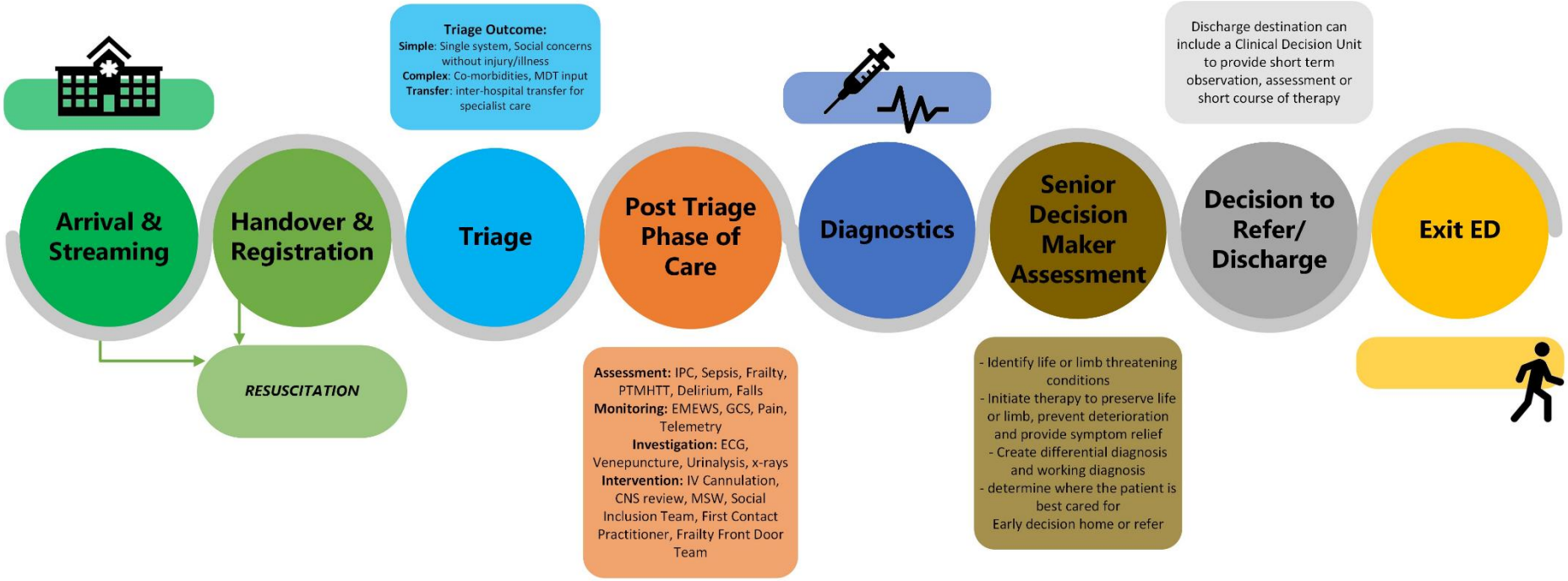
- Clinical Hub – hear-and-treat/ hear-and-refer (MTT)
- Community-based paramedic care including Pathfinder, APP Cars and Community Paramedics – see-and-refer (non-conveyance) or see-and-transport (conveyance to ED via emergency ambulance or intermediate care vehicle)
- Emergency Ambulance crew (+/- Advanced Paramedic support)
- Emergency Ambulance crew with HEMS support
- HEMS as primary response
- Emergency Ambulance crew with Community First Responder support

Definitive care following assessment and treatment on scene:

- Referral to community services (Pathfinder and Community Paramedics only)
- Nearest ED
- Nearest Medical Assessment Unit
- Bypass to specialist centre i.e.
    - Acute stroke care centre
    - Primary PCI centre for STEMI confirmed by 12-lead ECG
    - Major Trauma centre, different pathway for adults and paeds
    - OB/GYN centre
    - Paediatric ED

[1] i.e. does not include NAS Critical Care Retrieval Services, emergency inter-facility transfer services or coordination of international transfer (e.g. for organ recipients travelling to UK).

Emergency Department Pathways



Patient Arrival and Streaming

Patients may **self-refer** or be **referred to an ED by a GP** or other healthcare provider within the hospital or from another setting. They may arrive by ambulance or by their own transport. Ambulances will pre-alert the ED if the patient needs to be received by a clinical team.

Streaming is "a hands off" assessment that involves asking the patient what their presenting complaint is, identifying any major risk factors, to inform a decision as to which zone of the ED or other assessment area (e.g. an Acute Medical Assessment Unit or Acute Surgical Assessment Unit) the patient will be directed. Streaming allocates patients to different physical areas/services, pathways or processes, to improve efficiency and effectiveness. A trained clinician should always perform streaming. It is incumbent upon the person performing the streaming to understand the process and be assured that the area to which they have streamed the patient is appropriate, open and has capacity to receive them. Streaming may include streaming to co-located or specialist services (e.g. collocated primary care services, ophthalmology services, acute medical unit or acute surgical unit). Patients may be streamed (redirected) to off-site services.

The main objective of streaming is to ensure that the patient is directed to the correct location/service and to the correct clinician to manage their clinical needs at the earliest appropriate opportunity. This achieves time saving, reduces duplication, decreases clinical risks, and improves outcomes for patients.

Handover and Registration

The handover of ambulance patients in the ED follows a standard national protocol

All patients need to be registered so that there is a record of their attendance at the ED or hospital. Registration also involves matching a patient to their pre-existing hospital record and the collection or checking of a range of demographic and other healthcare-related data. Triage and registration occur concurrently for the most severely ill and injured patients. Triage, Ambulance Patient Handover Time and Registration time/ED arrival time will be almost identical for resuscitation patients. For ambulatory patients most EDs currently undertake registration before triage.

Triage

Triage is the preliminary assessment of patients to determine the urgency of their need for treatment and the nature of treatment required. Currently the two triage systems recommended for use in EDs by the National Emergency Medicine Programme (EMP) are:

- Manchester Triage System (MTS) ≥ 16 years of age
- **Irish Children's Triage System (ICTS) < 16 years of age**

Both of the triage systems are 5-tier systems employing 1) the recognition of the presentation (flowchart) and 2) reductive discriminator identification as the principle of the system. Triage is not used in Injury Units, as patients either self-triage as suitable for an IU or are referred by their GP. Each system is validated for its current applications and is periodically updated, in light of advances in medical care.

Infections Prevention and Control Assessment

Infection Prevention and Control at Triage for Adults

The Resuscitation Room (Resus)

Every ED has a dedicated area known as the resuscitation room/area (resus). This area should be reserved for patients requiring intensive resuscitation, including simultaneous assessment and treatment by medical and nursing staff. It is characterised by sufficient space around each resuscitation trolley to allow several members of the resuscitation team space and ready access to monitoring and equipment for critical care interventions in patients with compromise of one or more of the airway, respiratory, cardiovascular or neurological systems. Category one patients and many in triage category two will begin their ED journey in the resuscitation room. Many of these patients will have been brought directly to the resuscitation room by the paramedic crew bringing them by ambulance or by the triage nurse who identifies their need in the triage room.

Rapid Assessment & Treatment

The aim of RAT is to provide early senior assessment of undifferentiated 'majors' patients. The model has been implemented by a number of Emergency Departments in Ireland and the UK, with considerable benefits to patient safety and satisfaction and has been endorsed by the Emergency Care Intensive Support Team. The model works to support EDs in achieving their Patient Experience Time (PET) indicators.

However, RAT implementation can be difficult, particularly in poorly staffed departments. Senior clinicians who lead RAT teams can find the intensity of work a challenge. Persisting exit block in the ED also presents a challenge and rapidly assessing a patient to require admission can be frustrating if no bed is available.

Note: Other terms for RAT in the EM literature include IATU, Advanced Triage, IMPACT, Team Triage, Senior Intervention Following Triage (SIFT).

Post-triage Phase of Care

- **Assessment:** IPC, Sepsis, Frailty, PTMHTT, Delirium, Falls
- **Monitoring:** EMEWS, GCS, Pain, Telemetry
- **Investigation:** ECG, Venepuncture, Urinalysis, x-rays
- **Intervention**: IV Cannulation, CNS review. Specialist services to begin patient assessment before or in parallel with EM assessment. These specialist services would include Frailty Front Door Teams, Liaison Psychiatry, Clinical Pharmacists, Social Inclusion teams and Health and Social Care Professionals (e.g. Medical Social Work, Physiotherapy, Dieticians, Speech and Language and Occupational Therapy).

Examples include patients presenting with frailty, mental health problems, vulnerable patients or patients requiring physiotherapy input. Parallel assessment plays an important role in the care of very frequent attenders.

Diagnostics

Diagnostic Imaging is a core component of ED processes and of fundamental importance in delivering safe and efficient emergency care. The successful use of care bundles and pathways mandates timely access to investigations while the risks of misdiagnosis of some conditions are too high to be left to clinical assessment alone. Timely access to diagnostics prevents unnecessary hospital admission and

reduce the transmission risk of having patients wait in EDs overnight for imaging to support their admission, referral or discharge.

Senior Decision Maker Assessment

Following triage, the patient should be seen by a Senior Decision-Maker (SDM) in order of time of arrival in their particular triage category. Whilst awaiting SDM review, many interventions may be applied by other ED staff (primarily nursing staff), including the requesting of blood tests, performance of ECGs and other investigations (according to pre-agreed templates based on the patient's presentation) and the delivery of nursing care and supportive treatments, including analgesia and intravenous or oral fluid supplementation (the Post-Triage Phase of Care).

In practice, the results of some of these interventions lead to some patients being "retriaged" (somewhat informally) after discussion with relevant SDMs prior to the SDM having assessed the patient in person. The Emergency Medicine Programme has developed a National Clinical Guideline, the Emergency Medicine Early Warning Score (EMEWS) that describes a formal process of patient re-assessment and allows for an auditable mechanism of re-triaging by nursing staff that has been partially implemented in a number of EDs in the country.

The core responsibilities during the initial medical and nursing assessments are to:

- Identify life or limb threatening conditions.
- Initiate therapy to preserve life or limb, prevent a condition worsening and provide symptom relief
- Create a differential diagnosis and from this a likely working diagnosis. Instigate the investigations needed to facilitate decision-making
- Determine where the patient is best cared for i.e. home, community or admission

Senior Decision Makers in blended multidisciplinary team include Consultants, Specialist Registrars, Staff Grade or Registrar, ANPs, CNMs. They balance risk and cope with the decision-density, high uncertainty and limited clinical information to achieve the best outcome for the patient.

Decision to Refer or Discharge

Following initial assessment, resuscitation as required, and treatment, 70-80% of patients are discharged from ED and 20-30% are referred for inpatient admission. Referral of a patient for admission under another on-call specialty team usually begins with a telephone call or bleep requesting the representative of the on-call specialty, to which the patient is being referred, to contact the referrer. There then follows a discussion of the patient's presentation, clinical findings, results of investigations performed and reason for referral. It is recommended that this follows the ISBAR format (ISBAR3) communication tool (Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk) as a structured framework which outlines the information to be transferred. The tool may be available in written format, but preferably electronically. Ideally, following this discussion, a patient who is stable enough to go to a ward bed should go to a ward bed, where the admitting team can assess them. Demand/capacity mismatch in numbers of patients requiring emergency admission and number of available beds frequently results in the patient waiting on an ED trolley. In these circumstances, it is recommended that the on-call team accepting the referral complete their assessment within two hours of the referral.

A CDU is an area, adjacent to the Emergency Department (ED), that provides for a short period of observation, assessment or short course of therapy for patients who no longer require active ED care. Note: Throughout the ED process, patients may leave before the completion of their treatment. Guidance on the Management of Patients in Emergency Departments who Leave Before Completion of Treatment.

Special Care: Paediatric EM

In Ireland, the delivery of unscheduled care for children involves the following units:

- Two Paediatric Emergency Departments (PED) in standalone Paediatric Hospitals (CHI Crumlin and CHI Temple Street) provide emergency care for children and young people 24 hours a day, 365 days per year.
- The Paediatric Urgent Care Centre (UCC) in Connolly Hospital Blanchardstown treats children with minor injuries and illnesses that are not life-threatening and do not require a visit to the ED.
- The Paediatric Emergency Care Unit (ECU) at Tallaght Hospital treats all medical emergencies and walk-in trauma but not major trauma.
- 18 mixed EDs outside Dublin provide unscheduled care for patients of all ages, including children. Approximately 20-25% of all attendances in these units will be children.
- Paediatric Assessment Units or Paediatric Decision Units are facilities run by paediatricians and children's nurses, where children can be seen, investigations performed, and treated, in a timely fashion. The majority of the caseload in these units is elective (e.g. for investigations/infusions and booked in by the consultant paediatricians) though in many sites children are seen in the PAU for unscheduled care.
- Injury Units (IU) provide unscheduled emergency care for patients with non-life-threatening or limb-threatening injuries. Most Injury Units treat patients over 5 years of age but some have higher age restrictions.

In 2022, there were 166,440 attendances in total across Children's Health Ireland (CHI) which includes the two PEDs, one ECU and one UCC in Dublin. The 18 mixed EDs saw 238,710 attendances in 2022.

Paediatric Emergency Medicine in Ireland – Development to date and future direction

Framework for Paediatric Urgent and Ambulatory Care Centres

Special Care: Older Persons EM

Where it is feasible and patient numbers justify, it is recommended that EDs run a separate triage stream for older adults. The older adult, if thought to need admission should be referred to the specialty that best meets their need. Priority must be given to avoiding prolonged trolley waits for older people who do not need emergency intervention, as evidence shows this can adversely affect outcomes.

Releasing time-to-care will be used to implement the changes to triage and post-triage care.

The fundamental **change to triage** is:

- **Category 3 is the lowest triage category** used for those aged 75 years and older. This is in recognition of the high risk of morbidity and mortality associated with ED attendance for older people

In addition, we recommend the following tools which may act as modifiers to the triage category (i.e. a Triage 3 becoming a Triage 2).

- A "**Modified EWS for Older People**" is implemented. Any trigger should lead to upward revision of the patient's triage category and/or appropriate specific response proportionate to the trigger.
- **Delirium screening** is carried out in line with the national guideline for Delirium management and assessment in the ED/Acute Medical Assessment Unit (Health Service Executive, 2021).
- The **Trauma Safety Net** is carried out as a prompt to identify older people who may have more serious injury and thus require a coordinated trauma response.

Following triage, parallel assessments and interventions should commence, replacing the consecutive model. This model encourages early assessment and interventions by senior members of the ED team and geriatric medicine, thus optimising the early decision-making process, especially in relation to likely need for admission. The decision to refer for admission remains with EM.

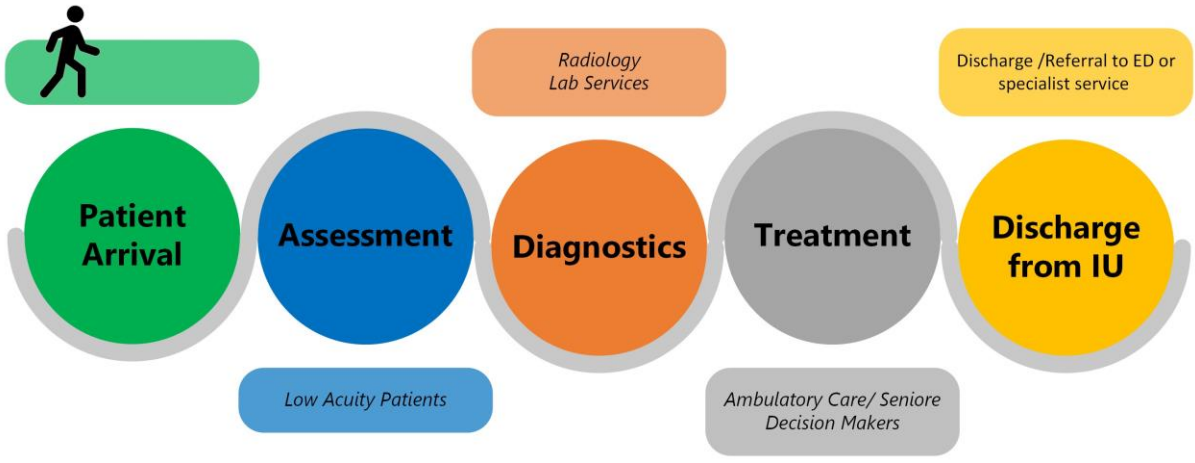
A Trauma System for Ireland

https://www.hse.ie/eng/about/who/acute-hospitals-division/trauma-services/further-information-and-documentation/report-of-the-trauma-steering-group.pdf

The Acute Floor

The Acute Floor is an integrated service configured to manage unscheduled care demand. These may be proximally located clinical and support services which work together to manage unscheduled demand on a day-to-day basis. The Acute Floor section of this guide summarises the concepts of the Acute Floor as defined in the document "Developing an Acute Floor Model for Ireland".

Injury Unit Pathways



Injury Units (IU) provide unscheduled emergency care for patients with non-life-threatening or limb-threatening injuries as conveniently as possible, while ensuring patient safety and equitable standards of care within a network of emergency care. IUs will integrate with the wider trauma system to ensure trauma patients can have their needs met in an efficient and patient-centred manner.

Generally, the units are open 12 hours per day 7 days per week, but with some local variations.

Opening hours and days per week of existing units are available here

Injury units are designed and equipped for the treatment of patients with broken bones, dislocations, sprains, strains, wounds, scalds and minor burns that are unlikely to need overnight admission to hospital. Staff members perform x-rays, reduce joint dislocations, apply plaster casts and treat wounds by stitches or other means. They have swift access to diagnostics including x-ray and laboratory tests and some have rapid access to physiotherapy services. The team of doctors, Advanced Nurse Practitioners (ANPs), nurses, radiographers and physiotherapists operate under the governance of a Consultant from the Hub ED. Patients can go directly to the IU or be referred by a GP.

IUs are an opportunity for patients to be seen and treated in an appropriate clinical setting with a potential turnaround time in some cases of less than an hour. Each IU is part of a wider system of care and is linked to a Hub Emergency Department (ED) in an acute hospital. Therefore, if a patient in an Injury Unit needs to be admitted to hospital they will be referred directly to a linked hospital, in exactly the same way as if they had attended the Hub ED. This aligns well with IUs becoming part of a networked trauma system.

IUs provide the same level of expertise and service as EDs, for the appropriate group of patients but they are not designed to treat serious head, back or neck injuries, abdominal pain, medical illnesses or mental health problems. They do not treat children under the age of five because of the special requirements of young children attending hospital. These children will attend Emergency Departments or, in Dublin, Paediatric Urgent Care Centres. Some IUs have a higher age threshold.

IUs treat non-life/limb threatening injuries which means they see patients with:

- Suspected broken bones to legs from knees to toes
- Suspected broken bones to arms from collar bone (clavicle) to finger tips
- All sprains and strains
- Minor facial injuries (including oral, dental and nasal injuries)
- Minor scalds and burns
- Wounds, bites, cuts, grazes and scalp lacerations
- Small abscesses and boils
- Splinters and fish hooks
- Foreign bodies in eyes/ears/nose
- Minor head injury (fully conscious patients, who did not experience loss of consciousness or did not have more than one episode of vomiting after the head injury)

IUs do not treat **adults** with:

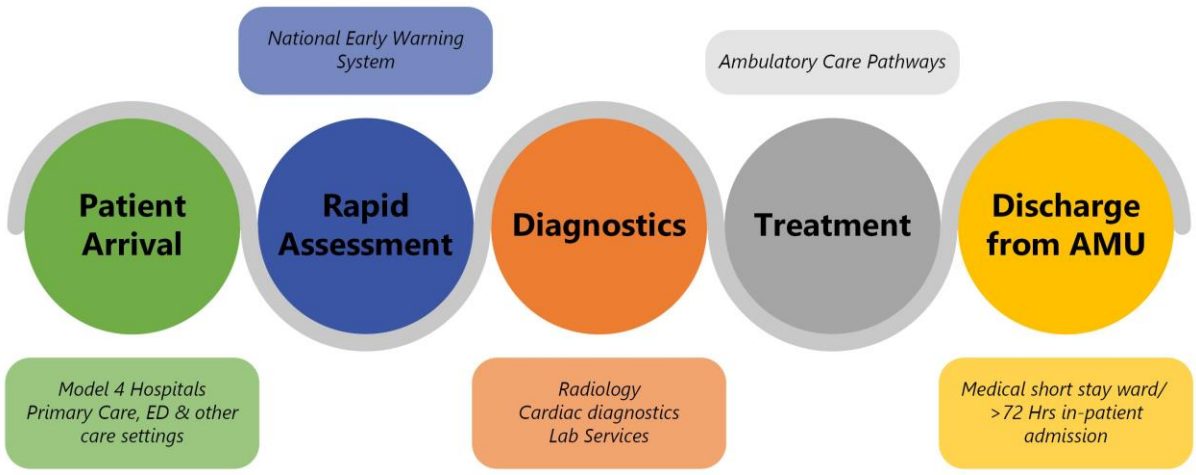
- conditions due to medical illness, for example, fever, seizures, headache
- suspected serious injury or inability to walk following a fall from a height or a motor vehicle collision. Patients with neck pain or back pain that started on the day of injury should attend an emergency department rather than an injury unit
  injury causing chest pain, abdominal pain or shortness of breath
- serious head injury
- chest pain
- respiratory conditions
- abdominal pain
- gynaecological problems
- neck/back pain
- pregnancy-related conditions
- pelvis or hip fractures
- injuries due to self-harm

IUs see children over 5 years but do not treat children with:

- a medical illness, for example, fever, seizures, respiratory symptom
- non-traumatic limp or non-use of a limb
- injuries following a fall from a height or a motor vehicle collision
- serious head injuries
- abdominal pain
- gynaecological problems
- injuries due to self-harm
- neck pain or back pain

See here for a full list of inclusion and exclusion criteria. https://www2.hse.ie/emergencies/when-to-visit-an-injury-unit/

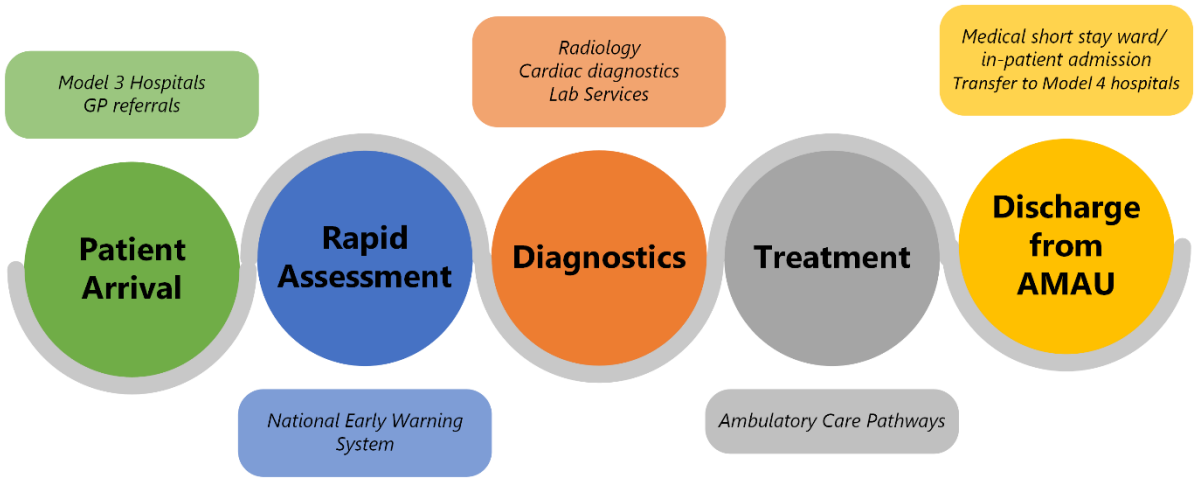
Acute Medical Assessment Pathways



Acute Medical Units – Model 4 Hospitals

An acute medical unit (AMU) is located in a model 4 hospital and sees patients aged 16 years and older:

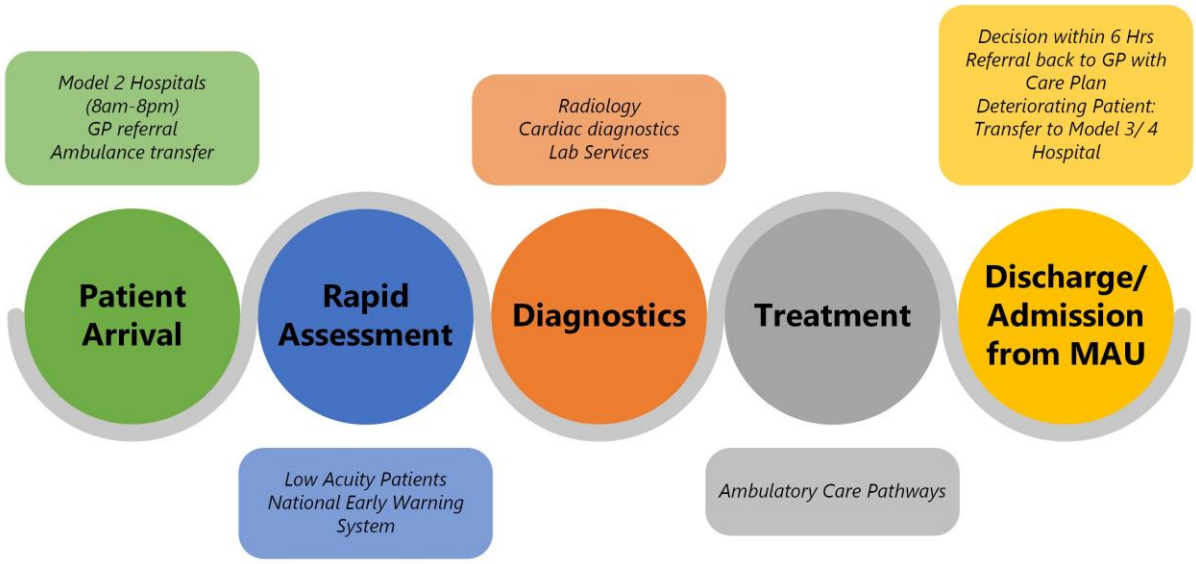
- AMUs may operate up to 24 hours per day, 5 to 7 days per week.
- AMUs may accept direct GP referrals
- AMUs may accept direct ambulance referrals
- AMUs accept patients from the adjacent emergency department within the model 4 hospital.
- An AMU will care for patients with the entire spectrum of acute medical conditions, some of whom may require urgent medical care. (Manchester triage core 2-4).
- Upon arrival to the AMU, all patients will receive an initial/rapid medical assessment.
- All patients will have an early warning score assessment (NEWS).
- The AMU is supported by a 24/7 emergency department.
- A range of radiology services, cardiac diagnostics and laboratory services supports the AMU.
- Ambulatory care pathways will be available and supported by a range of specialist nursing, diagnostics and therapy services.
- For patients requiring overnight admission, AMU physicians have access to short stay and specialist inpatient beds.
  (I.e. Acute Medical Short Stay Unit, CCU, ICU, HDU and other specialist services available in the model 4 hospital).
- AMUs are supported by follow up medical review clinics.
- A decision regarding discharge/admission overnight will be made within 6 hours of patient arrival.



Acute Medical Assessment Unit – Model 3 Hospitals

An acute medical assessment unit (AMAU) is located in a model 3 hospital and sees patients aged 16 years and older:

- AMAUs may be operational from 8am to 8pm, 5 to 7 days per week
- AMAUs may accept direct GP referrals
- AMAUs may accept direct ambulance referrals
- AMAUs accept patients from the adjacent emergency department within the model 3 hospital.
  An AMAU will care for patients with the entire spectrum of acute medical conditions, some of whom may require urgent medical care. (Manchester triage score 2-4)
- Upon arrival to the AMAU, all patients will receive an initial/rapid medical assessment
- All patients will have an early warning score assessment (NEWS).
- The AMAU is supported by a 24/7 emergency department.
- A range of radiology services, cardiac diagnostics and laboratory services will support the AMAU.
- Ambulatory care pathways will be available and supported by a range of specialist nursing, cardiac diagnostics and therapy services.
- For patients requiring overnight admission, the AMAU physicians have access to inpatient beds including specialist units (e.g. CCU, ICU, HDU, acute stroke unit).
  Patients who require level 3 or 3S ICU support will have guaranteed transfer to a model 4 hospital.
- AMAUs are supported by follow up medical review clinics
- A decision regarding discharge/overnight admission should be made within 6 hours of patient arrival.



Medical Assessment Unit – Model 2 Hospitals

A medical assessment unit (MAU) is located in a model 2 hospital and sees patients aged 16 years and older:

- MAUs may be operational from 8am to 8pm; 5 to 7 days per week.
- MAUs accept direct GP referrals
  The patients suitable for referral are differentiated medical patients who have a low risk of requiring full resuscitation (i.e. unlikely to require high intensity cardiopulmonary and/or neurological support).
- MAUs accept selected ambulance transfers.
  (agreed between clinician on roadside and MAU Physician)
- Upon arrival to MAU, all patients receive an initial/ rapid medical assessment
- All patients have early warning score assessment (NEWS).
- The MAU will be supported by radiology services, cardiac diagnostics and laboratory services.
- Ambulatory care pathways will be available and supported by a range of specialist nursing, cardiac diagnostic and therapy services.
- For patients requiring overnight admission, MAU physicians have access to general medical inpatient beds.
  Patients who deteriorate unexpectedly will have guaranteed transfer to a model 3 or model 4 hospital.
- MAUs are supported by follow up medical review clinics.
- A decision regarding discharge/ overnight admission should be made within 6 hours of patient arrival.

Acute Surgical Assessment Unit Pathways

Emergency surgery

Emergency Surgery is safest when performed during normal working hours by fully trained staff and where sufficient volumes of surgery are performed to maintain the expertise of the multidisciplinary emergency surgery team. A networked system of emergency surgical care enables most emergency surgical care to be delivered as near as possible to the patient's home while ensuring equitable access to complex care when required.

The Role of the Acute Surgical Assessment Unit (ASAU) in Emergency Surgery ASAUs

ASAU's enable acutely ill surgical patients to access care safely and efficiently. A key characteristic is that each patient has prompt access to a senior surgical decision-maker. Treatment may be either on the spot, by ambulatory or outpatient care, or require admission. Patients who require admission may sometimes require transfer to a hospital that can better meet their needs. ASAUs do not replace Emergency Departments. Instead, they act as an additional resource within the hospital with proven benefits in reducing PET and a high degree of patient acceptability. ASAUs are designed to deal with a significant throughput of acutely unwell surgical patients, but they do not manage patients who are unwell to the level where they require active resuscitation.

Benefits of an ASAU include:

- Admissions are concentrated in one area allowing rapid transfer from the Emergency Department (ED) or direct referral from Primary Care
- Defined protocols allow nurse triage from the ED and Primary Care for a specific cohort of surgical patients
- Emergencies can be quickly prioritised by experienced staff
- Consultant-led assessment can be provided regularly throughout the day
- Same-day imaging and diagnostics are made available and provided for
- Nurse-led early discharges can be facilitated
- ED waiting time targets are supported

Developing ASAUs

There are three defined stages to the evolution of an ASAU:

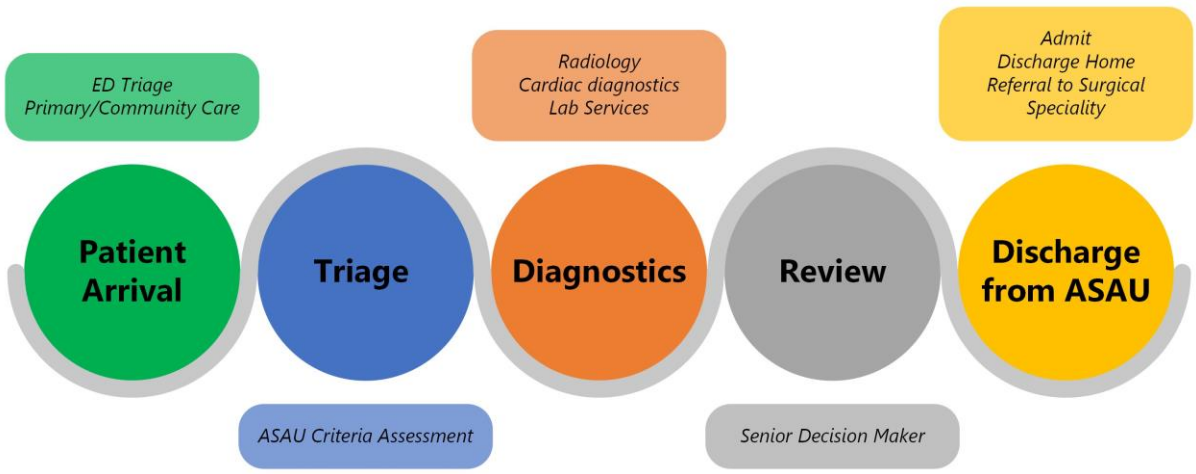
- NEW ASAUs are defined as ASAUs that have been established and running for up to two years.
- EVOLVING ASAUs are defined as ASAUs that have been established and running for two to four years.
- MATURE ASAUs are defined as ASAUs that have been established and running for four years onwards.

The following table shows the different categorisations:

ASAU Evolutionary Stages – New, Evolving and Mature

	NEW	EVOLVING	MATURE
Length of time operating as an ASAU	Up to 2 years	2 - 4 years	4+ years
Designated bed stock allocated (Acute Surgical Wards/Units)	No	Yes	Yes
Emergency Theatre access	Yes	Yes - 24/7	Yes - 24/7
Designated allocation for Diagnostics	Yes	Yes with 24/7 CT	Yes with 24/7 CT
Specialty usage	General Surgery +/- ORL-HNS, Vascular Surgery, Urology, or Plastic Surgery	Multiple	Multiple
GP referrals accepted	No	Yes	Yes
Senior Decision Makers	Practitioner, usually a Surgical Consultant, Registrar (ST3 or equivalent) or equivalent (Non-Training Grade Doctor, trained Advanced Nurse Practitioner or regulated Health and Social Care Professional for specific disorders)*	Practitioner, usually a Surgical Consultant, Registrar (ST3 or equivalent) or equivalent (Non Training Grade Doctor, trained Advanced Nurse Practitioner or regulated Health and Social Care Professional for specific disorders)*	Practitioner, usually a Surgical Consultant, Registrar (ST3 or equivalent) or equivalent (Non Training Grade Doctor, trained Advanced Nurse Practitioner or regulated Health and Social Care Professional for specific disorders)*
Triage Category for referral (Manchester Triage System)	Category 3 and 4	Category 3 and 4. Selected triage Category 2 patients may sometimes be appropriately seen if local agreement is reached.	Category 3 and 4. Selected triage Category 2 patients may sometimes be appropriately seen if local agreement is reached.

Acute Surgical Assessment Unit Pathway



The ASAU should be populated from a central referral streaming/Triage for the Acute Floor with secondary inputs from ED and AMAU-assessed patients as appropriate. Patients from triage Categories 3 and 4 should be easily routed to a newly established ASAU. Note that selected patients from triage Category 2 of the Manchester Triage System may sometimes be appropriately seen in an

evolving ASAU (that is, in operation for 2-4 years) or a mature ASAU (that is, an ASAU in operation for 4+ years). A written, agreed process should facilitate same.

Direct GP referrals should be considered once an ASAU has reached an 'Evolving' status, whereby it has been validated and operating for 2-4 years. An appropriate feedback mechanism should be in place with general practice in relation to patients who fall outside the locally agreed admission criteria.

Patients reviewed out of ASAU hours by on-call surgery in ED should be easily able to be booked into a daily review clinic. This would allow patients to be discharged during the night to a scheduled Acute Return Review Clinic the following morning.