Aim
To develop a curriculum specific to self assessed needs of nurses working in the Acute Medical Unit with the aims of supporting professional development, creating incentives for recruitment and guiding program development for Universities.

Methodology
Educational needs of nurses in Acute Medical Care have been highlighted [1] but are only partly met [2]. We conducted a consensus process involving registered nurses from Acute Medical Unit in three hospitals in North Wales. Nursing teams designed a curriculum for training of junior nurses working on the Acute Medical Unit to cover the specific educational requirements of their job. Staff in each unit compiled a ranked list of 20 conditions and 10 skills. The lists were then reviewed and ranked by a group of senior nurses, nursing managers and educationalists from the three hospitals during a seminar and a final list was generated.

Outcomes and Results
The top 10 final conditions and skills are shown below (Fig 1).

Conclusion
The 20:10 project represents the first attempt to map educational needs of nursing staff on the AMU. It has been used locally to drive the program for educational seminars and for NHS providers to negotiate with local universities about Masters or Diploma programs for this new and increasingly important group of nurses. The curriculum does not cover training of advanced nurse practitioners in AMU which will require a separate review.

References
Aim
Venous thromboembolism (VTE) prophylaxis is an important quality assurance indicator. Previous audits at our hospital have shown that improvements in risk assessment and/or prescribing low molecular weight heparin (LMWH) are necessary. This study asks whether pharmacists improve VTE prophylaxis care.

Methodology
A Year 4 medical student attended acute medical unit (AMU) ward rounds, observing 300 patient consultations for process and documented outcomes. VTE risk assessments and/or LMWH prescriptions were recorded. In our AMU a pharmacist independent prescriber attends the morning 7am (acute physician) ward round but not the afternoon (acute physician) or evening (general physician) ward rounds.

Outcomes and Results
VTE prophylaxis care (risk assessment and/or LMWH prescription) was completed in 94% of cases when a pharmacist was on the ward round compared to 38% of cases when a pharmacist was absent (p<0.05). There was no statistically significant difference in VTE prophylaxis care between the afternoon and evening ward rounds. For patients where VTE care is not undertaken on a consultant-led ward round, 65% will ultimately have their VTE risk assessment by a pharmacist as opposed to a doctor.

Conclusion
Pharmacists play an important role in ensuring that VTE prophylaxis care occurs. Acute physicians and general physicians show no difference in undertaking VTE prophylaxis care.
MDT3
Title: Development of a functional screening tool to aid discharge planning in the Acute Medical Unit (AMU)

Category: The Functional AMU: The Multi-Disciplinary Team
Abstract Title: Development of a functional screening tool to aid discharge planning in the Acute Medical Unit (AMU)
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Aim
Effective discharge planning for older people is a key driver in achieving patient flow through AMU and downstream wards. We developed a simple screening tool to capture information re the patient's normal function to ensure discharge planning commenced on admission and to streamline assessment.

Methodology
The tool was developed as a series of questions on a prompt sheet. The questions related to the patient's normal level of function, services and any patient/ carer concerns re discharge. Following an initial test the tool was revised to include information re domestic and personal activities of daily living in the same format as the joint OT/ physio assessment document to minimise duplication of information-gathering. Nursing staff were trained to assess patients using the tool and to document the findings systematically in the medical notes.

Outcomes and Results
The tool is now used for patients over 75 years and those admitted with falls, confusion and poor mobility. Audit of the use of the tool revealed a rise in completion from 10% to 80% over a 4 week period. Staff opinions on ease of use and relevance were sought via a questionnaire and revealed consistent support for benefit in enhancing assessment, guiding appropriate referrals and aiding discharge planning.

Conclusion
This project demonstrated the benefit os using a simple systematic process to assess normal functional level in a busy AMU. The benefits include better communication with patients and carers, more appropriate referrals to therapists and reduced duplication of assessment.
Aim
Adverse drug events contribute to hospital admission, impact on length of stay and, thereby, manifest financial implications. Previous literature reviews indicated a medicines-related admissions incidence of approximately 6%, with NSAID’s and anticoagulants most commonly cited. However, more reliable and robust medicine reconciliation processes within our AMU suggested that the rate of medicines-related admissions may be higher. A scoping exercise was undertaken to prospectively measure the rate of medicine-related admissions within the AMU and identify the most commonly implicated medications.

Methodology
Medicine-related admissions, classification and implicated medicines were collaboratively identified between the AMU Consultant and Specialist Clinical Pharmacist during the ward-rounds on each testing day during the study period (two ward rounds per study day). Data was collected and collated.

Outcomes and Results
A total of 68 medicine-related admissions were identified over 13 study days and a total of 105 medications were implicated. The most frequently implicated therapeutic medicine groups were diuretics (23%) and ACE inhibitors and AII antagonists (15%). The majority of medicine-related admissions were due to recognised adverse effects (70%) and occurred as a consequence of concurrent illness.

Conclusion
With optimal medicines reconciliation and the adoption of a collaborative working model between AMU consultants and appropriately skilled clinical pharmacists, the incidence of medicines-related admissions is significantly higher than earlier literature findings. This may be due to increasing age of population and complex medication regimes due to evidence-based medicine. Timely identification and review of implicated medicines at the start of the patient journey is required to enhance clinical management and patient outcomes.
Aim
Are we prudent at prescribing medications in patients who get admitted to Acute Medical Assessment Unit with Renal impairment (i.e. Acute, Acute on Chronic or Chronic Renal impairment).

Methodology
Data collected prospectively over a month period.
Patient’s notes and Drug prescription sheet were reviewed to assess whether medications were adjusted in keeping with Acute Kidney Injury network guidelines, UK Renal Pharmacy Group and BNF on admission when clerked in by the medical oncall team

Outcomes and Results
A total number of 113 cases were reviewed.
Patient demographics were sex 52% male, median age male 79 years and female 81 years.
Median eGFR 35 (range 5-76) ml/min/m²
Acute renal failure 28%
Chronic renal failure 46%
Acute on Chronic 26%

Conclusion
This study shows that there is a lack of awareness among junior medical staffs in prescribing drugs in patients with renal impairment. As normal creatinine level does not necessarily mean normal GFR, laboratories which report eGFR will flag up renal injury which should alert the prescribing doctor. Education of junior doctors at various stages of training need to address this issue both at a local and a regional level

References
Acute Kidney Injury network guidelines, UK Renal Pharmacy Group and BNF
Aim
AMAN in Arabic means “trust” and “safety”.
We have created the Acute Medical Assessment Nurse (AMAN). She plays a fundamental role in the assessment and management of the acutely unwell medical patient.
Previously all GP admissions were booked under the ED. This resulted in patients waiting on average 2 hours 22 minutes within ED. This service was unacceptable for the patient and created waste and duplication of work and more importantly dissatisfaction for patients.

Methodology
Since June 2010 all stable GP patients are admitted directly to MAU. The AMAN has strict competencies including ALS certification, the ability to carry out and interpret arterial blood gases and request CXR. She/he will take GP calls, accept/divert the calls and decide how soon the patient needs to see a doctor (RED, AMBER, GREEN) according to physiology and the TRUST colour coded observation chart.

Outcomes and Results
- Time to see the AMAN from arriving onto MAU on average 8 minutes (range 0-25 minutes)
- All investigations (bloods, CXR, ABGS) were instigated appropriately by the AMAN.
- Time to see a junior doctor from arriving onto MAU average 1 hour 30 mins (10 mins-3 hours 5 mins)
- Time to see an acute physician from arriving onto a MAU on average 2 hours 22 mins (1 hour 5 mins-4 hours 5 mins)

Conclusion
The AMAN has dramatically changed the service we offer. Our GP patients are getting prompt assessment, diagnosis and management. They see a nurse, doctor and Consultant within 4 hours. The nursing team are empowered and work closely with out GP’s, junior doctors and acute physicians.