Title: Ambulant management of suspected pulmonary embolism; is it feasible?

Author: Kalina Popkirova

Co-Authors: Katherine Bunclark

Topic: Service Organisation and Design

Title

Ambulant management of suspected pulmonary embolism; is it feasible?

Aim

To investigate the feasibility and safety of ambulatory management in suspected and confirmed PE at PCH.

Methods

All emergency medical admissions to the ESS unit at PCH between December 2010 and March 2011 with suspected PE requiring CTPA were investigated.

Retrospectively, clinical risk stratification was employed using Southampton General Hospital criteria (for suspected PE), and the Pulmonary Embolism Severity Index (PESI, for confirmed PE), to identify suitability for ambulatory management.

Complications were death, bleeding, re-admission and recurrent PE within 3 months.

Results

Case notes of 63 patients were analysed. Age range 18 – 97 years (mean 67 years), equal sex distribution. Eight patients had positive CTPA scans. Overall complication rate was 6%. Average time between admission and CTPA was 3.7 days. 51% of the patients were discharged immediately following scan results.

In suspected PE, eight patients were identified by Southampton Hospital criteria as suitable for ambulatory management, two of which suffered complications (one death and one re-admission). In contrast, the PESI identified three of the patients with confirmed PE as safe for outpatient management, none of whom experienced complications.

Conclusions
We found that whilst the PESI appropriately identified those patients with known PE as clinically safe for outpatient management, the Southampton criteria identified fewer patients with suspected PE as suitable for ambulatory management and had a significant complication rate. Further investigation using alternative criteria across a larger sample needs to be undertaken to ensure feasibility and safety.

References

1 JS Rowlinson, J Deagle, CD Roseveare, “Ambulatory investigation and treatment of patients with suspected pulmonary embolism: a retrospective review of one year’s experience” J R Coll Physicians Edinb 2006; 36:12–16


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AIM

Effective medicines reconciliation (receiving/sending accurate medicines history) (MR) can limit medicines related problems (MRP). This project evaluated and improved upon these processes on the Acute Medical Unit (AMU) at West Middlesex University Hospital. The project was made possible through collaboration with NIHR CLARHC for Northwest London.

METHODS

The impact relating to intervention was assessed by patient questionnaire and by weekly data collection which measured the quality of MR. The changes implemented include adaption of a Medicines Alteration Policy, additional training for healthcare staff, also a trigger tool to identify patients at higher risk of MRP with a patient counselling checklist for staff to improve patient education. Finally, there has been creation of an IT based ‘safe discharge checklist’, ‘usual medicines list’ and a bespoke ‘patient information leaflet’ relating to discharge medication.

RESULTS

The measurable but unwanted effects of relocation of AMU and unusual levels of staff turnover had provided challenges to the project. Despite this, there had been a significant fall in the average number of medications recorded incorrectly on prescription charts from 1.7% to 0.6% (fig 1). Information relating to medication change being relayed to the General Practitioners had also shown significant improvement (fig 2). Patient satisfaction with medication counselling had advanced in the expected direction.

CONCLUSIONS

With methods, procedures and technology of this project embedded in routine practice, the advancement of the project encompasses rollout to other areas within and beyond the Hospital Trust. This will ensure that information relating to medicines will flow readily accurately and safely at all transitions of care.
Avoiding acute admissions: justifying the use of OPAT in a London teaching hospital

Author: Katherine Whitcroft

Co-Authors: Zita Mickute
Nidhi Vaid
Gary Davies

Topic: Service Organisation and Design

Aim

Outpatient antimicrobial therapy (OPAT) is a widely and successfully used modality for the treatment of skin and soft tissue infections (SSTI) outside of the UK[i]. By reducing acute admissions, studies suggest that OPAT reduces healthcare costs[ii]. Despite this, relatively few cost analyses have been performed in the UK and the NHS has been slow to introduce OPAT.

This study aimed to determine whether cellulitis patients suitable for OPAT are routinely admitted to a London hospital and the consequent cost of their inpatient therapy.

Methods

A retrospective cohort study of all patients admitted with cellulitis over a one-year period was performed. Exclusion criteria included patients under 16 and those requiring surgical management.

Data was extracted from discharge summaries and included patient demographics, length of stay (LoS) and suitability for OPAT (table 1)[iii].

Results

Of 471 admissions, 262 were included. Of these, 53% were male, ages ranged from 17-96 years and the leg was most commonly affected.

57% (148) of admissions were suitable for OPAT, amounting to 349 hospital nights (LoS range 0-38 nights, μ2).

Using current tariffs for co-morbidity adjusted HRG4 definitions, this amounted to £253,015 for inpatient treatment of patients suitable for OPAT.

Conclusion

Nearly 60% of acute admissions for cellulitis could be avoided. Evidence shows that OPAT is more cost-effective than inpatient care[iv]. Such admissions therefore provide a significant source of potential savings. We suggest similar cost analyses be conducted in other trusts, with a view to increasing use of OPAT within the NHS.
References:


[ii] See ref i


[iv] See ref i
Title: Intentional Rounding on the AMU

Author: Jacqueline Phillips

Co-Authors: Nicolai Wennike
Andrew Thompson

Topic: Service Organisation and Design

Aims

Intentional Rounding (IR) aims to improve patient care and experience as part of the Safer Patient Initiative. It involves visiting all patients every hour to assess their needs and environment with respect to a list of criteria. The concept is still in its infancy, and so far has only been tested on selected patient groups (e.g. patients who have fallen) on a general medical ward, and using only one or two criteria\(^1\). This is the first study where the implementation of IR on ALL patients, on an Acute Medical Unit (AMU - with a high patient turnover) AND a complete care bundle have been evaluated.

Methods

One 8 bedded bay on AMU was allocated for implementation of IR and care continued as standard for the remaining 14 beds. Staff workshops educated the staff about Intentional Rounding, and a standardised IR proforma was designed (figure 1) and outcome measures developed. Data collection occurred daily for 4 weeks and then weekly for 3 months.

Outcomes/Results

Compared to the control group there was a significant increase in call bell availability (29%) but a significant decrease in patient’s usage (70%). Documentation was improved in all areas e.g. Waterlow, Early warning scores (figure 2). Patient feedback showed an improvement in patient experience (patient complaints decreased from 18 to 1 over a 3 month period) and to date the process has been embedded into everyday practice without a subjective increase in workload.

Conclusion

The success of IR within AMU is clear with an improvement in patient satisfaction and safety. Following the success of this project IR is currently being implemented trust wide.

Reference


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Title: Level of Care Provided in Enhanced Care Area on an Acute Admissions Unit (AAU)

Author: Hannah Skene

Co-Authors:

Topic: Service Organisation and Design

Aim

To document the level of care patients received in the enhanced care area of AAU, determining future bed and training needs and potential income.

Methods

Chelsea and Westminster Hospital has 9 enhanced care beds on AAU which are staffed to provide Level 1 care.

This study documented the level of care provided in these 9 beds over 3 weeks. Twice daily each enhanced care bed was scored as unoccupied, Level 0, Level 1 or Level 2 (Intensive Care Society guidelines).

Results and Discussion

Overall bed occupancy is high. 10% were Level 2, which the area is not officially staffed or trained for. 50% Level 0 patients can be explained by patients admitted to these beds when AAU ward beds are unavailable, and by patients who were originally Level 1 or 2 but then improved and awaiting a downstream bed.

HRG codes for Adult Critical Care are detailed in Table 3. The Level 1 tariff is similar to a normal adult ward admission, but the difference between Level 1 and 2 tariffs is significant.

Conclusions

- 10% Level 2 care raises the need for appropriate levels of trained staff
- 50% Level 0 care may imply 9 beds are not needed, or alternatively the area could be trained and staffed to provide more level 2 care, easing intensive care bed pressure
- Level 2 care attracts a higher tariff which is not currently being claimed for

References

1. Levels of Critical Care for Adult Patients, Intensive Care Society (2009), London
2. Payment by Results Guidance for 2010-11, Department of Health (2010), London
Title: Impact of seeing unselected patients in a Medical Assessment Unit on the Emergency Department

Author: Iain Keith

Co-Author: Immo Weichart
Gautam Ray

Topic: Service Organisation and Design

Aim
The merger of acute services of two district general hospitals necessitated restructuring of acute medical services in our hospital. A new 12-bedded medical assessment unit (MAU) was launched to rapidly assess, diagnose and treat GP referrals at weekdays 10am-7pm. A proposal to expand the remit of the MAU to treat all medical presentations regardless of referral route, was introduced. We investigated the impact of this on the emergency department (ED).

Methodology
Using the EDIS patient tracking system, patients presenting three weeks before and after the change were analysed using SPSS software.

Results
There was no difference in attendances 2506 vs 2498 or admissions from ED (481 vs 433) P=0.092. Admissions did not increase from MAU (95 vs 107) P=0.09 despite an increase in presentations 145 vs 190. There was a significant reduction (287 vs 194) P<0.0005 in the number of patients who were in the ED greater than four hours, this was most marked in the medical admissions out of hours with a 56.9% reduction (68 vs 38) P=0.008.

The first assessment time and the overall length of stay in the ED was reduced for all attendees. Medical admissions had a 37 minute average reduction in length of stay. For medical admissions bed waits was reduced by 26mis (70 vs 44) P=0.0005.

Conclusion
The expansion of the MAU remit, with no extra resources, has significantly improved the patient flow for all patients in the ED regardless of speciality, reducing first assessment times, time in the department, bed waits and increased discharges in MAU.
Aim:

Service evaluation and gap analysis assessing feasibility of NEWS in General Practice (GP).

Method:

We analysed records from electronic clinical documentation of 217 consecutive patients seen by the local GP out-of-hours service (including home visits) and 50 daytime home visits of another practice. We collected GP triage categories and parameters needed to generate locally used triage tools [1,2]. Hospital admission within 7 days was outcome measure.

Results:

Mean age of patients was 57 (+/-25), 29 were nursing home residents, 117 patients were seen as home visits. 59 were admitted to hospital, a further 21 were admitted within a week. Mean hospital stay was 3 (+/-6) days after office reviews and 10 (+/-9) days after home visits.

Recordings were noted for respiratory rate (n=32), saturations (65), blood pressure (95), heart rate (121), level of consciousness (12) and temperature (134). 6 patients had complete sets of observations.

GPs triage categories led to admission in 2/2 very urgent, and 14/20 urgent patients. Assuming normal values for missing parameters, 5 patients would have had a NEWS of >5 (Figure), 4 of these were home visits with subsequent admission, All SCS “very high” risks were home visits (Table). 6 deaths occurred, all in delayed admissions; only one of these had a complete set of observations (NEWS=3) at first contact.

Conclusion:

Recorded physiological parameters in the GP out of hours setting are often insufficient to calculate NEWS. We recommend a review taking into account workload and risks identified in home visits.

References


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Title: The EPOC of the frail patient: Using the Clinical Frailty Scale in Acute Medicine

Author: Christian Subbe

Co-Authors: Sioned Prilce, Julie Ward-Jones, Anthony White, Farook Jishi, John Kellett

Topic: Service Organisation and Design

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Authors

Aim:
We aimed to quantify the likely workload for an intermediate care team dealing with low-mortality-risk patients with frailty admitted to Acute Medicine using a simple triage tool.

Methods:
Non-cardiac admissions to Acute Medicine Unit (AMU) were triaged using a PC based system (Electronic Point of Care, EPOC) and a measure of disease severity [1] to trigger senior review in very high and very low risk patients and since March of 2011 a measure of frailty [2] (Figure, Table) to trigger early support by intermediate care specialists in patients classified as “vulnerable”, “mildly frail” and “moderately frail”.

Results:
Between October 2010 and May 2011 we saw 3955 patients (range per month from 437 to 522). Mean age of patients was 65 (+/-21) years, median SCS 4 [IQR 2-7].

The intermediate care target group of patients with intermediate frailty and very low or low risk in the SCS was 37 – 64 per month. Frailty did influence length of stay independent of SCS (p<0.000) with patients in the “Well” group staying a mean of 3 (SD 6) days and those with “moderate” frailty 14 (SD 16) days. Patients with worse frailty (classified as “vulnerable” or greater frailty) had fewer 0 or 1-day admissions (p<0.000).

Discussion:
The CFS is a feasible fast assessment of patients on the AMU. We are currently piloting an intervention that uses the information to enhance flow in these patient groups. This project is part of a service improvement grant by the Health Foundation.
References:


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Title: An Evaluation of an alternative model of Acute Medical Admissions

Author: Nicholas Jones

Co-Authors:

Topic: Service Organisation and Design

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Aims: To assess the impact of a new medical tracking system for acute admissions at a District General Hospital, introduced in July 2010. The system has been designed to move away from generalised AMU and medical firms by delivering early senior specialist input and rapidly allocating patients to specialist firms in contrast to standard national practise (1,2).

Methods: Mixed quantitative and qualitative approach to compare outcomes before and after the introduction of the track system. Measures included average length of stay, mortality rates and length of stay for the 9 top acute medical presentations (fig.1). We also evaluated the impact of the track system on patient numbers per medical firm. Both outcomes are triangulated with qualitative semi-structured interviews and survey data.

Results: The total number of admissions at Ealing has increased, but we have also seen a decreased length of stay and decreased Mortality (fig.2). There has also been a significant reduction in length of stay for 7 of the 9 top conditions (fig.1). Qualitative data suggests these results may be due to quicker access to a Consultant/Senior Specialist opinion and a more consistent number of patients per firm.

Conclusions: The study makes the assumption that a reduced length of stay and decreasing mortality reflect improved quality of care as a result of the track system, however correlation with the qualitative results confirms the positive impact from the new system. The evaluation supports further improvement through a rebalancing of junior staff to reflect patient numbers, new roles for specialist discharge facilitators and direct access to on-call daytime speciality registrars.

References:


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Title: Acute care pathway redesign: Activity and Impact of an Emergency Multidisciplinary Unit (EMU).

Author: Amulya Misra

Co-Authors: James Price
Debbie Thompson
Daniel Lasserson

Topic: Service Organisation and Design

AIM:

To assess the impact of a change in the acute medical care pathway for elderly patients.

METHODS:

An existing Community Day Hospital site was re-engineered to provide acute multidisciplinary diagnosis and treatment. Assessments were tailored to individual patient need, and delivered by Geriatrician, Physiotherapist, Occupational therapist, Nurse and Social worker. Patients were assessed the same day. Near-patient blood testing, X-ray, community hospital beds and dedicated transport were available. Referrals were by telephone from Primary Care (‘step-up’; eight practices, population 100,000) and Secondary Care (‘step-down’). Activity was audited from clinical records and unit performance data. Impact on hospital usage was compared with that of a neighbouring equivalent population.

RESULTS

In five months there were 566 attendances among 302 referred patients with mean (SD) age of 79.2 (15.4) years. Median time to assessment from time of GP referral was 61 minutes (inter-quartile range 85 minutes). Patients requiring two attendances for their care were significantly older than those whose acute care was delivered at one attendance (82.8 vs 76.4 yrs, t test p< 0.001). A ‘Pareto’ effect was evident in that 70% of all attendances were by 42% of the referred patients. Greatest impact was seen on excess acute bed day usage which fell by 34% (comparator practices: 0%). Numbers of acute medical admissions fell by 10% (comparator: 6%).

CONCLUSION:

A Community EMU providing comprehensive geriatric assessment and treatment reduces use of acute hospital resources. There was a modest reduction in acute admissions but greater impact was seen in reducing excess bed days.
Title: Medication-related Problems after Discharge from Acute Care: A telephonic pilot survey

Author: Louella Vaughan

Co-Authors:

Topic: Service Organisation and Design

AIM

Transitions of care are risky periods for the development of medication-related problems (MRPs). This project aimed to identify the type and number of MRPs experienced by patients following a short-stay medical admission and to pilot the use of telephony to remedy any MRPs identified.

METHODS

Eligible patients were those having a short-stay admission (<3 days) to the Acute Medical Unit of the Chelsea and Westminster Hospital. Consented patients had their discharge summary relayed to NHS Direct, who administered a telephonic survey 3 weeks after discharge. The NHS Direct pharmacists attempted to remedy any MRPs identified.

OUTCOMES

54 patients were initially consented; 20 were unable to be contacted and 7 were removed from analysis. 20 MRPs were identified in 12 of the remaining 27 patients (44.4%): 5 potential side effects; 5 problems with taking medication and 4 felt that their medication did not suit them. NHS Direct identified 1 other MRP and 3 patients received counselling for other medication issues. Only 1 MRP was potentially harmful. 19 (70.4%) found the call to be helpful and 25 (88.9%) would like to have a similar follow-up call if admitted to hospital again.

CONCLUSION

Although nearly half the patients were found to have MRPs, a low level of potential harm was found. Further, only half the patients were able to be contacted by phone. This suggests that although the service was highly acceptable to patients, issues of patient selection need to be explored before the service could be recommended in times of financial constraint.
Title: Acute Medicine Nurse Led Discharge- The Holy Grail!

Author: Sarbjit Clare

Co-Authors: Peyton Sarah
Julia Haines
Sheila Lorimer

Topic: Service Organisation and Design

The Acute Medicine Nurse Practitioners at City Hospital are fundamental to the flows and capacity issues faced out of hours. They work within MAU, SSU and the rest of the hospital "out of hours". The Trust within 2009-2010 invested in Acute Physicians to do out of hours discharge rounds hoping they could make a difference.

Aims

- Is nurse led discharge as effective as Consultant led discharge?
- Is there a difference in the cohort of discharged patients?
- Is there an increase in re-admissions?

Methods

Both NP’s and Consultants carried out ward rounds on MAU, SSU and peripheral general medical wards looking for discharges on the weekends. Data was collected with regards to discharges, diagnosis and readmission rates.

Outcomes

- Acute Med NP’s discharged significantly higher than the Acute Physician
  - 2009 71% versus 29%
  - 2010 67% versus 33%
- Discharges in both groups were classed as “simple” (DOH 2004)
- Data suggested that there was no increase in readmissions in both groups

Conclusions

Acute Medicine NP’s are cardinal to the running of the hospital. Acute Physicians are no longer doing out of hours weekends rounds. In the recent “Royal Wedding Bank Holiday” the NP’s discharged 54 patients. The reason for such high discharges is because the NP’s have developed

- competence and skills within acute medicine
- strong links with nursing staff across the hospital
- strong links with community teams such as Respiratory outreach
- awareness of fast track clinics and ambulatory care
- a new IT system which highlights possible discharges
Title: Quantifying the Number of Patients with Cancer Presenting to an AMU

Author: Mark Holland

Co-Authors: Jonathan Berger
Ryan Petrucci
Olivier Gaillemin
Mark Holland

Topic: Service Organisation and Design

AIM

Following publication of the report ‘Chemotherapy Services in England: Ensuring quality and safety (2009)’ by the National Chemotherapy Advisory Group, the Department of Health asked all hospitals with an Emergency Department to establish acute oncology services. We feel that acute medicine will have a role in developing such services. This study asks how many patients with cancer present to the AMU and how their presentations vary.

METHODS

We collected data from AMU patients seen on consecutive morning ward rounds. Data pertaining to demographics, presenting complaint, previous cancer history and suspicion of cancer as a new diagnosis was collected. Patients with a suspected new diagnosis of cancer were tracked during their in-patient stay to review the outcome of investigations.

RESULTS

300 patients, mean age 66 years, 163 female, were included. 51 (17%) patients had cancer. Of these, 31 (10.3%) presented with a condition unrelated to their cancer. Where the admission was related to cancer, 5 (1.7%) cases were complications of the malignancy, 5 (1.7%) cases had palliative care needs, 3 (1%) cases were complications of cancer treatment and 7 (2.3%) cases were new cancer presentations.

CONCLUSION

Patients with cancer are common in the AMU. A unit with 40 admissions per day would expect to see an average of 6.8 patients with a history of cancer and an average of 2.7 patients with a cancer related problem. This volume of cancer related work leads us to suggest that acute physicians have a role in helping to develop acute oncology services.
Title: Handover tasks within the first 48 hours of general medical admissions and its impact on service provision in the Acute Medical Unit (AMU) ? Data from an electronic handover solution (eHandover®)

Author: Pairaw Kader

Co-Authors: Emmanuel Selvaraj
Richard Haines
Susan Thompson
Khansa Mazhar
Richard Reddiar
Aklak Choudhury

Topic: Service Organisation and Design

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AIM

The advent of shift-work pattern has created greater emphasis on continuity of information through effective handover processes1. This study analyses the volume and nature of medical handover tasks faced by junior doctors out-of-hours using datasets generated by eHandover® and explores its implication to service organisation in AMU.

METHODS

Electronic ‘handover notes’ from March-October 2010 were scrutinised retrospectively and categorised by type, number and timing of tasks. These were matched to respective patients’ date and time of admission to hospital.

Tasks created within the first 24 hours of admission were defined ‘Day 0’, the next 24 hours ‘Day 1’ and so forth.

RESULTS

7775 entries were analysed. The majority of handover tasks occurred within the first 48 hours of patients’ admission. 16.8% (n=1305) of tasks generated were on ‘Day 0’ and 12.1% (n=941) on ‘Day 1’ with an exponential decline over subsequent days [figure 1]. The majority of handover tasks within the first 48 hours included D-dimer checks 82.2% (n=37), Troponin checks 74.3% (n=413), performing lumbar puncture (LP) 76.2% (n=48) and chasing CT/MRI reports 61.8% (n=222) [figure 2].

CONCLUSION

The high volume and nature of tasks handed over within the first 48 hours of a patients’ admission highlights the need for an adequately resourced AMU out-of-hours. AMU should organise services to ensure adequate radiology cover and supply of pre-assembled LP sets. The AMU should be at the centre of general medical handover in acute hospital trusts. This will allow continuity and discussion of information from acute admissions at handover meetings.

Reference:

Title: 30 minutes: Door to Doctor

Author: Lynn Evans

Co-Authors: Gordon Caldwell
Roger Duckitt
Ilhaq Masih
Mark Dennis

Topic: Service Organisation and Design

Aim

Rapid assessment and initiation of treatment following hospital admission is associated with improved outcomes and greater patient satisfaction.1,2 Worthing Hospital introduced the simple initiative “door to doctor in 30 minutes” with the aim of improving quality of care and improving outcomes by early clinical decision making.

Methods

In 2006 the concept that all patients presenting to the AMU should be seen within 30 minutes was introduced. An electronic whiteboard was developed to allow automated collection of arrival and subsequent waiting time. From 2009 performance statistics were reported daily to the on-call teams.

Data collected from January 2007 to December 2010 was analysed looking at the trend in number of admissions, the average time to be seen and the achievement of “door to doctor in 30 minutes.”

Outcome/Results

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Admissions</th>
<th>Patients seen within 30 minutes</th>
<th>Duration of average wait</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>8864</td>
<td>3222 (36%)</td>
<td>101</td>
</tr>
<tr>
<td>2008</td>
<td>10811</td>
<td>3291 (30%)</td>
<td>86</td>
</tr>
<tr>
<td>2009</td>
<td>10798</td>
<td>5170 (48%)</td>
<td>54</td>
</tr>
<tr>
<td>2010</td>
<td>10277</td>
<td>6126 (60%)</td>
<td>40</td>
</tr>
</tbody>
</table>

Over 4 years there was a 15% increase in admissions from 8864 to 10277. Despite this there was steady improvement in performance with 36% of clerking starting within 30 minutes in 2007 to 60% in 2010. The average door to doctor time fell from 101 to 40 minutes, with significant improvements with daily reporting of statistics and feedback to staff.

Conclusion

Despite the challenge of rising hospital admissions and an ageing population with multiple chronic needs, we demonstrated that “door to doctor in 30 minutes” is achievable. This facilitates the identification of patients in whom a timely intervention is paramount and has been proven to impact on outcome such as sepsis and stroke.3,4 It should also improve patient flow, safety and satisfaction.
Title: Communication of End of Life Care on the Acute Medical Unit

Author: Ryan Petrucci

Co-Authors: Jonathan Bergen
Mark Holland
Olivier Gaillemin

Topic: Service Organisation and Design

Aim

Public opinion supports Advanced Care Planning (ACP). Although 65% of people wish to die at home, in reality 60% die in hospital.

The Gold Standards Framework (GSF) Prognostic Indicators Guidance was introduced to identify patients at high risk of dying in the next 6-12 months, facilitating ACP.

Here we evaluate the potential role of the Acute Medical Unit (AMU) in ACP.

Method

Over a 4-week period we prospectively identified all the AMU patients on morning ward rounds with the following conditions: cancer, chronic obstructive pulmonary disease, heart failure and dementia.

We applied GSF criteria to identify high-risk patients and asked:

1. Whether they had ACP in place?
2. If so, is it available to the AMU team?
3. If not, why?
4. Did discharge communication address ACP?

Outcome / Results

103 patients were identified, 46 high-risk (45%) (Fig. 1).

3 high-risk patients had ACP (all living in nursing homes) but in no case was this available to AMU staff.

2 of 10 high-risk patients discharged from the AMU and 2 of 14 high-risk patients discharged from general wards had ACP addressed in discharge communication.

Conclusion

Whilst a high proportion of patients presenting to the AMU with common chronic conditions are at high risk of death within the next 6-12 months, ACP is not the norm. We contend that the AMU has a pivotal role in facilitating ACP both into and out of secondary care.
Title: Development and utility of patient information leaflets in an Acute Medical Setting

Author: Richa Sinha

Co-Authors: Louise Rix
Eau Consultants

Topic: Service Organisation and Design

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Aims

Patients are encouraged to read information leaflets to aid their understanding; however this is not always practical in an emergency setting. The aim of this service improvement study was to assess the usefulness of relevant patient information leaflets pertaining to emergency presentations in an Acute Medical Ward.

Methods

Patient information leaflets were adapted for local use from upToDate.com and patient.co.uk after conducting patient interviews in our department. The following conditions were covered.

- Headache
- Chest Pain
- Collapse
- Vomiting Blood
- Pneumonia
- Seizure

Data was collected prospectively over a 2 week period. We used structured interviews with relevant patients to assess the usefulness of our information leaflets before and after reading the leaflet. Visual analogue scales (0-10) were used to quantify the data, with 10 indicating the most positive response.

Results

18 patients agreed to assess the leaflets (7 - chest pain, 4 - headache, 2 - seizures, 2 - pneumonia, 2 - collapse and 1 - vomiting blood). Perceived understanding of their condition following reading of the leaflets improved from a mean of 2.6 to 7.7. Mean score for understanding of verbal information alone was 4.5 compared with 8.8 after reading the leaflet. Patients rated the overall usefulness of the leaflets as 8.9 and the likelihood of reading them as 8.4.

Conclusion

The results show an improvement in patient’s perceived understanding of their condition after reading the leaflet. Patients rated these leaflets as being very useful and most patients would read leaflets in an Acute Medical Setting.

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Title: Communication and Miscommunication: Handover between Healthcare Professionals

Author: Rosalind Pool

Co-Authors: Adrian Hayes
Chris Roughley
Laurence Sharifi
Rebecca Woodside

Topic: Service Organisation and Design

Aims

Handover between doctors is still highly variable, unstructured with poor record keeping (WHO 2007). Handovers are recognised as key to maintaining patient safety (Woodward et al, 2010). This study aimed to identify problems and make recommendations for improvement in the process and training for handover.

Method

Qualitative methodology and semi-structured interviews were conducted with 19 doctors of varying grades across 3 West Midlands hospitals. 50% were in Foundation years. Open-ended questions included what makes a good/bad handover, suggestions for improvement and consequences of bad handovers.

Results and outcomes

Systematic analysis of 35,000 words of transcript identified three repeated themes: handover content, format and impact. Content required patient identification, a specific level of detail and an urgency assessment. Comments indicated this is a key area for training for foundation years. Within format, issues of attendance, regularity and discipline were identified. Impact of handover affected quality of care, staff morale, team working. All could identify specific adverse incidents as a result of failures in handover.

Conclusion

Increased practical training in handover in undergraduates and foundation years are key now that frequent handovers of patient care occur. This should include prioritisation and clear summary of key points, essential when large numbers of patients covered by small teams. A dedicated room, set time, register of attendance and formalised documentation are necessary. These recommendations are being implemented. We are re-auditing to assess the impact of the changes and identify further areas for improvement.

Funded by grant from Reinvention Centre for Undergraduate Research.
Refs:


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Title: A structured review of unplanned Emergency Department attendances and admissions for care-home residents.

Author: Kiaran Flanagan

Co-Authors:

Topic: Service Organisation and Design

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Aim

It has been suggested that up to 40% of admissions from care-homes are avoidable, but there is little systematic analysis of these admissions. This study maps the emergency care demand of care-home residents in Coventry, examining the ‘avoidable’ attendance and admission.

Methods

Care-home residents admitted in December 2010 were identified. 53 medical/nursing records randomly selected from this cohort were examined by a multidisciplinary team who considered method of presentation, quality of information available with patient, whether attendance or admission was avoidable, interventions and whether the patient benefited overall.

Results

41/53 patients came from private residential homes. 27% presented with delirium or decreased conscious level, 21% with falls or collapse. Nearly half presented in the evening or overnight. Although 68% patients had accompanying written information, quality of communication was poor, 79% judged as having inadequate information. 10 patients, of whom 6 had dementia, had no written information or accompanying carer/relative. Investigations were frequently done in ED (mostly blood tests and plain X-rays), only 31/121 altered management. Most interventions could have been provided in a community setting (e.g. intravenous fluid, antibiotics, analgesia). Tables 1 and 2 indicate potential alternatives. With an average length of stay of 5.9 days, these avoidable admissions account for 153 bed days in the one month survey. Overall, only 45% of patients admitted were judged to have benefited from admission.

Conclusion

This study provides evidence for avoidable admissions and emergency attendance of patients from care-homes, identifying potential community-based ambulatory care alternatives which could improve patient experience.

Refs

1. Directory of Ambulatory Emergency Care for Adults, NHS Institute for Improvement & Innovation. 2010

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AIM:

There has been an increase in shift pattern work since implementation of EWTD\(^1\). This has resulted in more handovers between different shifts of junior doctors. Experimental studies have shown information is poorly retained if verbal or handwritten handovers are transferred across multiple shifts\(^2\). The risk is greatest at weekends when handover tasks can be requested on a Friday for completion on Sunday (i.e. junior doctor ‘shift gap’ of five).

METHODS:

We analysed all general medical handover entries collected using eHandover from Queen’s Hospital (March-October 2010, 158 weekdays and 32 weekends) and King George Hospital (June-October 2010, 94 weekdays and 19 weekends). All handovers across shifts were mapped and the ‘shift gap’ for each handover task was calculated.

RESULTS:

A total of 7166 electronic handover entries were analysed (weekday n=3011, Saturday n=2307, Sunday n=1848). Figure1 and Figure2 show the complexity of handover for general medicine across weekdays and weekends respectively. On weekdays, 513 (17.0%) of handover tasks will not be verbally communicated between teams. The potential failure of direct verbal communication for tasks increases significantly in the weekend, 2672 (64.3%).

CONCLUSION:

Many handover tasks will not be verbally communicated across shifts due to large shift gaps, more so at weekends. Furthermore, handover tasks are commonly created by the on-call teams themselves, which are difficult to capture without an electronic tool. eHandover is the first solution to recognise and quantify the shift gap issue. Communication failure across shifts may be an important factor in the 7% higher mortality for acute admissions at weekends\(^3\).

References:


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