the patient who transfers out of AMU immediately before a weekend may wait more than 48 hours for the next scheduled discharge evaluation. This can lead to delays in assessing patients who are in a cycle of regular readmission or failed discharges.

- best discharge practice is adopted including the use of EDIS, discharge checklists and the use of regular focused multidisciplinary meetings to monitor progress against discharge plans;
- mechanisms are in place to ensure that staff and care are made aware that discharge is imminent and all discharge documentation is completed in advance on ward round; and potential discharges are reviewed first and any outstanding discharge documentation completed at the time of review;
- where discharge is anticipated out of hours (eg weekends) the discharge criteria clearly recorded in the case notes and communicated to ward nursing staff, enabling nurse-led discharge where possible.

Recommendations:
- All patients transferred out of AMU should have a discharge review within 24 hours of transfer irrespective of their ward location. This provides a reliable consultant review at a critical juncture in the patient’s pathway; confirms decision related to treatment, discharge and any care of renal and assesses these to the staff on the patient’s new ward;
- Consultant review of mortally transfused patients represents an important element of seven day working for consultant physicians and priority during the first hour of the working day – ‘golden hour’ review. The review provides a framework for consultant discussion on all medical wards, and identifies a cohort of patients likely to benefit from review, including patients requiring review for clinically urgent reasons or potential discharge. On weekdays the review is conducted daily by the consultant physician. In the event that a patient is transferred out of AMU, the consultant physician on AMU immediately before a weekend may wait more than 48 hours for the next scheduled discharge evaluation. This can lead to delays in assessing patients who are in a cycle of regular readmission or failed discharges.

Recommendations:
- A key principle is to enable consultant-led teams to set a tempo of reviewing and discharging selected patients at the start of each working day. seven days a week.
- The ‘golden hour’ review law 5 above. For patients not ready for discharge at the time of the review, the management plan should include an estimated date of discharge (EDD), planning to enable discharge early in the day and communication of the criteria for discharge to the ward team.
- All staff should have a clear understanding that the consultant physician will not be available on all wards early each day. seven days a week, including the presence of transport, to ‘take out’ medications, and the use of the discharge lounge.
- Consultant physicians with responsible practitioners should ensure that:
  - all staff are able to make a timely decision to discharge and that the relevant services or available discharge team are integrated and provided with social care and community care input, related to the patient’s fitness to leave hospital.

References:

The risk to the patient is increased where the receiving ward is poorly staffed, has little experience of the patient’s illness, or has no access ready to consultant decision making – circumstances that should not be tolerated.

Involvement of non-medical work is a designated medical consultant team to ensure continuity of care. This also helps identify patients who are in a cycle of regular readmission or failed discharges.

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References:
Recommendations:

1. Limited acute physician hours in AMU

Issue: There are currently insufficient acute physicians (and physicians undertaking acute duty) for 24-hour shifts in periods of high activity workconstantly in AMUs throughout weekdays, weekends and bank holidays.

Recommendations:

1. The principle of high quality care for acutely ill patients (see Box 1) should be applied widely. Further plans, jobs, role and work patterns designed to meet these principles will usually address both to determine the needs of the acute care system, including acute physicians, required.

2. Trusts should recognise the importance of GIM physicians on call continuing to support the acute take on the AMU. No one set of physicians provides the necessary full-time presence in the emergency floor or support on their jobs, which may impact on adequate care of the patient and recommendations of the acute care work.

3. Box 1) should be applied widely. Further plans, jobs, role and work patterns designed to meet these principles will usually address both to determine the needs of the acute care system, including acute physicians, required.

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5. The principle of high quality care for acutely ill patients (see Box 1) should be applied widely. Further plans, jobs, role and work patterns designed to meet these principles will usually address both to determine the needs of the acute care system, including acute physicians, required.

6. The principle of high quality care for acutely ill patients (see Box 1) should be applied widely. Further plans, jobs, role and work patterns designed to meet these principles will usually address both to determine the needs of the acute care system, including acute physicians, required.

7. Standardisation of early warning score to track deteriorating patients and trigger intervention

Issue: Emergency patients presenting to the AMU affect the work of the entire hospital, from pre-admission to AMU discharge, and may have a fluctuating clinical course. The early warning score (EWS) is the first line of defence in the recognition of the acutely ill patient, and distinguishing between patients who require in-hospital emergency care for work that are not in the AMU (up to 40% of all emergency admissions)

Recommendations:

1. The standardised EWS early warning score (EWS) recommendations in the Acute Medicine “Bedside” will be launched in 2011.

2. Box 1) should be applied widely. Further plans, jobs, role and work patterns designed to meet these principles will usually address both to determine the needs of the acute care system, including acute physicians, required.

3. Standardisation of documentation and prescribing

Issue: AMUs differ across the NHS in the recognition of the acutely ill patient and the recognition of the acutely ill patient. The early warning score (EWS) is the first line of defence in the recognition of the acutely ill patient, and distinguishing between patients who require in-hospital emergency care for work that are not in the AMU (up to 40% of all emergency admissions)

Recommendations:

1. The enhanced staffing, dedicated consultant time and resources involved in the provision of care to medical emergencies should be organized on the basis of seven-day working.

2. The assessment, documentation and treatment of acute medical illness should be standardized across the NHS. The EWS early warning score (EWS) should be integrated into the assessment of ill patients, and the recognition of the acutely ill patients.

3. Staffing: an acute staff out of hours (AOS) team is critical to delivering quality care, particularly in a high-pressure setting.

4. Issues: the level of care required should determine the clinical response to the patient and the staffing to manage such patients. All AMUs should have a core team of 2-3 areas and 2-3 areas in the long-term.

5. Box 1) should be applied widely. Further plans, jobs, role and work patterns designed to meet these principles will usually address both to determine the needs of the acute care system, including acute physicians, required.

6. The principle of high quality care for acutely ill patients (see Box 1) should be applied widely. Further plans, jobs, role and work patterns designed to meet these principles will usually address both to determine the needs of the acute care system, including acute physicians, required.

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8. Staffing: an acute staff out of hours (AOS) team is critical to delivering quality care, particularly in a high-pressure setting.

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Acute care toolkit 2: High-quality acute care October 2011

1. Limited acute care hours in AMU

Issue: There are currently insufficient acute care (and physicians undertaking acute duties) in post to staff the emergency floor for supported and their job plans made appropriately.

Recommendations:

- All consultants involved in acute medical care should be liable for their acute ratio. They should have a critical role in teaching is prioritised. Consultants have a critical role in teaching and continue to support the acute on call plan.

2. Standardisation of early warning score to track deteriorating patients and trigger intervention

Issue: Emergency patients presenting to the AMU reflect the emergency pathway. Clinical review, transfer and handover occurring on the AMU often contrast sharply with the situation on the wards. Clinical review, transfer and handover should be conducted in the 12-hour period. Staff on the receiving ward need to be available to take the handover as the patient is transferred to the consultant day four. Although on-site consultant duties should be tailored to support the emergency service.

Recommendations:

- The standardised early warning score (NEWS) should be launched in 2011. Guidelines, based on NICE guidance on the recognition of the acute ratio, should be taken by staff and their urgency, if a trigger score is reached. They enable nursing staff to take appropriate and timely assessments, irrespective of the clinical setting, of the nurse, or in depth knowledge of the patient's clinical status.

3. Care bundles for the management of common acute medical conditions

Issue: Care bundles (eg sepsis resuscitation bundle) ensure consistent clinical actions or flag electronic alerts during real time. The importance of NEWS and the triggering of urgent clinical review within a maximum of 12–14 hours. Although on-site consultant duties should be tailored to support the emergency service.

Recommendations:

- The provision of care within the local health economy should be geared to support the emergency service. The AMU are within 48–72 hours of admission and despite careful procedures for dealing with acute medical emergencies on the AMU, often contrast sharply with the situation on the wards. Patients transferring out of AMU often face restrictions on the transfer and handover. Because of frequent transfers of care between clinical staff, patients may deteriorate post transfer. The risk is the patient is transferred when the receiving ward is poorly staffed, has little experience of the patients' history, and has no ready access to consultant decision-making.

Box 1: Principles of high-quality care for critically ill patients

1. Acute medical care should be of the highest quality throughout the patient’s stay.

2. The staffing, resources and expertise involved in the provision of care to medical emergencies should be prioritised in the team.

3. The assessment, documentation and treatment of acute medical care in post should be of the highest quality. The NEWS early warning score (NEWS) should be used for this purpose.

Box 2: Principles of high-quality care for critically ill patients

1. A consultant physician without conflicting duties should be available on site to review patients at least 12 hours per day. Although on-site consultant duties should be tailored, the patient and the ward should be included in the 72-hour period.

2. During periods that the AMU is not covered by consultant, all newly admitted patients should be reviewed within 6–8 hours. Patients admitted overnight should have consultant review as soon as possible. Clinical review, transfer and handover occurring on the AMU should be included in the 72-hour period.

3. Patients transferring out of AMU should be transferred to high-quality care, particularly at change of shift and when patients transfer out because of frequent transfers of care between clinical staff, patients may deteriorate post transfer. The risk is the patient is transferred when the receiving ward is poorly staffed, has little experience of the patient's history, and has no ready access to consultant decision-making.
Limited acute physician hours in AMU
Issue: There are currently insufficient acute physicians (and specialists undertaking acute duties) in many trusts over periods of high intensity work contributing to AMUs in a handful of weekend, weeknight and bank holiday periods.

Recommendations: 1. The principle of high-quality care for acutely ill patients (see Box 1) should be applied widely. Furthermore, job plans and work patterns designed to meet these principles, will assist trusts to develop their services, including acute physicians, required.

2. Trusts should recognise the importance of GIM physicians on call to support the acute take on the AMU. It is crucial that physicians who work on call are supported in the emergency floor or supported on their job plan made available to them, with rapid consideration of the duration of on-call work and the support available from other medical staff. Trusts should ensure for these physicians should include flexible negotiation of job plan, recognising the acute nature and intensity of the on-call duties, both in and out of hours.

3. Consultants from other medical specialties should continue to commit to working sessions dedicated to acute medicine on the AMU. This provides a healthy mix of disciplines working in the acute care environment and enables continuity of care and participating medical specialists to retain competencies.

4. Box 2: Core Box 2: Core Bundle

Box 2 Core bundles
Core bundle (eg sepsis escalation bundle) ensures critical care for all patients,

- Identify patients with a specific clinical problem relating to care of clinical interventions specified by the bundle.
- Provide standardised, comprehensive assessment and care plan (a bundle of best practice guidelines) that deliver rapid, consistent treatment in line with best practice guidelines.

- Clinical documentation and verbal handover must be of sufficient quality to ensure that subsequent ‘owning’ teams follow (and document) a stepwise format which details what clinical interventions are required and whose responsibility they are.

-ძ The importance of NDDG and the triggering of agent clinical interventions cannot be overemphasised. Nursing and medical staff ensure critical acute patients should be trained in the integration of NDDG into clinical decision making and handover of each stage of the patient pathway.

- The enhanced staffing, dedicated consultant time and early consultant review system outlined in the acute care toolkit (see Box 2) assists the delivery of rapid, standardised care in line with best practice guidelines.

- The input of specialty medicine teams should be integral to the decision-making process; for example, the patient requiring critical care, sepsis, and transfer to specialty wards according to patient need.

- The enhanced staffing, dedicated consultant time and early consultant review outlined in the acute care toolkit (see Box 2) assists the delivery of rapid, standardised care in line with best practice guidelines.

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Recommendations:

- Transfer from AMU should be needed-based, not time-
based. All patients transferred out of AMU should have a consultant review within 24 hours of their admission and an assessment of their need for transfer. This would ensure that patients are not transferred unnecessarily or readmitted quickly back to the AMU.
- Early identification of patients who are not ready for discharge at the time of this review, the tempo of reviewing and discharging selected patients at the point of first assessment. This should also identify patients who are in a cycle of regular readmission or failed discharge.
- Best practice discharge practices should be adopted including the use of EDD, discharge checks and the use of regular follow-up multidisciplinary meetings to monitor progress against discharge plans. Mechanisms are in place to ensure that staff and care is made aware that discharge is imminent and all discharge documentation is completed in a timely fashion. If ward round potential admissions are reviewed first and any outstanding discharge documentation is completed at the time of review.
- Where discharge is anticipated out of hours (e.g., weekends) the discharge criteria are clearly recorded in the case notes and communicated to ward nursing staff enabling ward-led discharge where possible.

Consultant physicians are at the forefront of delivering care to patients presenting to hospital with medical emergencies. Delivering this care depends on competent and expert clinical staff, organised with optimal working arrangements to match patient demand, supported by the right level of resources and facilities. The pressures on acute medical services are relentless and intense. Factors that may compromise timely, high-quality care to patients largely relate to staffing, casemix and the organisation of care (see Box 3).

The risk to the patient is increased where the receiving ward is poorly staffed, has little experience of the patient’s illness, or has no access to consultant decision making—circumstances that should not be tolerated.
Acute care toolkit 2: High-quality acute care 2011

Consultant physicians are at the forefront of delivering care to patients presenting to hospital with medical emergencies. Delivering this care depends on experienced and competent clinician staff, organised with optimal working arrangements to match patient demand, supported by the right level of resources and facilities. The pressures on acute medical services are relentless and intense. Factors that may compromise timely, high-quality care to patients largely relate to staffing, casemix and the organisation of care (see Box 3).

Background

The Royal College of Physicians (RCP) recognises the importance of consultant physicians in leading on the provision of high-quality care in all acute medical patients. The 2004 Royal College of Physicians (RCP) Acute Medicine T ask Force made recommendations about the organisation and staffing of the AMU to ensure it could instigate the emergency department (ED) to improve ED capacity across all health economies. Additionally, the AMU should have strong links with community services, such as intermediate care. Consultant lead work on the acute floor was seen as critical to rapid decision making, discharges occurring late in the day cause a mismatch in the availability of ambulatory care facilities.

In 2007, the Acute Medicine Task Force made recommendations about the organisation and staffing of the AMU and that it should instigate the emergency department (ED) to improve ED capacity across all health economies. Consultant lead work on the acute floor was seen as critical to rapid decision making, discharges occurring late in the day cause a mismatch in the availability of ambulatory care facilities.

To minimise the time taken for patients to be transferred to surgical or other units, an agreed ‘golden hour’ review is recommended. This review is set at the beginning of each working day, seven days a week. The ‘golden hour’ review (see 5 above). For patients not ready for discharge at the time of this review, the management plan should include an estimated date of discharge (EDD), planning to enable discharge early in the day and communication of the criteria for discharge to the ward team.

All staff should have access to their responsibilities and updates that ensure that only patients who should be discharged are able to leave hospital. The consultant physicians and nurse-led discharge team are responsible for a prioritised handover, which is used to update the patient’s care plan. Additionally, the AMU should have strong links with community services, such as intermediate care. Consultant lead work on the acute floor was seen as critical to rapid decision making. Revising the time taken for patients to be transferred to surgical or other units, an agreed ‘golden hour’ review is recommended. This review is set at the beginning of each working day, seven days a week. The ‘golden hour’ review (see 5 above). For patients not ready for discharge at the time of this review, the management plan should include an estimated date of discharge (EDD), planning to enable discharge early in the day and communication of the criteria for discharge to the ward team.

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