AIM: Suspected cardiac pathology constitutes a significant portion of acute general medical referrals and often requires rapid assessment. Electronic patient referral lists allow data gathering beyond diagnosis and demographics. We assessed waiting times for medical assessment in all cardiac referrals to a district general hospital acute medical service.

METHODS: Using prospectively collected data from a computerised list of all acute medical referrals from 1 January to 11 May 2012, we identified those with suspected cardiac diagnoses and measured the medical assessment time – from hospital arrival after referral (or from in-hospital referral) to medical assessment. Subgroup analysis was performed according to sex, age, time of day and method of referral.

RESULTS: Of 3866 consecutive referrals, 984 (25.5%) had suspected cardiac diagnoses (Table 1). Mean medical assessment was 70±70 minutes; 66.7% of assessments were within 1 hour and 97.7% within 4 hours. Assessment time was similar according to age, gender, time of day and method of referral (Table 2).

CONCLUSION: Suspected cardiac diagnoses represented ¼ of the medical take. The national 4-hour target was achieved. Although ⅓ of patients were not assessed within 1 hour, no correlation with clinical outcome can be made. Importantly, all patients had comparable assessment times to, suggesting equivalent service delivery to GP and A+E referrals irrespective of age, gender or time of day. Computerised patient referral lists allow valuable insight into effectiveness of delivery of acute medical services.
AIM

Analysis following the London 7/7 bombings highlighted communication failures and the need for extra support during a major incident (MI) [1].

Anecdotally, there are reports of medical students presenting themselves to their allied hospital during MIs to help however they can [2, 3].

We wanted to establish a formalised system to contact students in response to the declaration of an MI and organize them once on site.

METHODS

The Royal London Hospital has collaborated with Barts and The London School of Medicine to create the Major Incident Response Student (MIRS) group, a collection of medical students who have volunteered to be contacted.

Should an MI be declared, the lead medical consultant can call upon 80 students to present to the hospital, who have undergone MI briefing, orientation, and completed a manual handling course.

RESULTS

We describe a novel cascade communication system to mobilise medical students in the event of an MI. It is designed as a pyramid cascade, separate from hospital communication systems, thus overcoming the difficulties faced during the London bombings.

The first point of contact is the lead contact and if not available, the group leaders. The lead contact is then responsible for contacting a set number of group leaders who themselves are responsible for contacting five students and so on. (See Figure 1)

CONCLUSION
The main failure in previous MIs has been communication. By creating an independent communication cascade, the MIRS group can rapidly provide extra support to alleviate this weakness.

References

1) Coroner’s inquest into the London Bombings of 7 July 2005
http://7julyinquests.independent.gov.uk/


AIM

One key recommendation of the Royal College of Physicians for acute medical care is consultant physicians working consecutive days to improve continuity. While intuitive, there is little prospective data to support this. We sought to compare our existing model of 24 hour consultant cover with a model of continuous days of cover for the acute medical take.

METHODS

We ran a pilot week of acute medical care on our clinical decision unit (CDU) where the consultants worked consecutive days. We selected a priori to compare common measures of process between the pilot week and a comparator week a fortnight later to limit any contamination. We also collected data for the intervening (middle) week. Process measures were proportion of discharges from the CDU; the number of breaches from the Emergency department (ED); the 30 day readmission rate; adherence to Venous thromboembolism guidance (VTE); hospital length of stay (LOS) and 30-day mortality rates. Results were compared using Chi-squared test and Mann-Whitney U statistic.

OUTCOMES/RESULTS

Comparing the pilot week with the comparator week, there was no significant difference in 30-day mortality rates, hospital LOS or adherence to VTE. There were significant differences in the discharge rate from CDU (58.7% vs 51.2%, p 0.017), the breaches from the ED (3.4% vs 8.1%, p<0.001) and the 30-day readmission rates (2.9% vs 6.0%, p=0.024).

CONCLUSION

The provision of consecutive days consultant input into the acute medical take led to greater discharges, better flow from the ED and fewer re-admissions. (245 words).
Aim

Structured handover is recognised as an important step in communication between medical and nursing staff, and is critical to patient safety (1). We observed that doctors and nurses are often called away from acute ward rounds, resulting in ad hoc task allocation and risk of non-completion.

We evaluated the effectiveness of the SAFE handover innovation, to improve the proportion of assigned tasks completed following consultant-led ward rounds. The SAFE innovation comprises structured consultant-led task allocation following review in a sequence of four bedded areas. Doctors and nurses are present for a focused (one minute) summary of each case, with allocation of specific tasks.

Methods

Interrupted time-series design over four consecutive months on an elderly admissions unit. In month 1 and 3, usual procedures were followed (ad hoc task allocation). The SAFE innovation was used in month 2 and 4. Generated tasks were recorded. Proportions of these tasks completed during weeks with, and without, the SAFE innovation were calculated and tests of their equivalence performed.

Results

A total of 801 junior doctor and 154 nursing tasks were generated from 498 patients during the four month period. The proportion of non-completed tasks was significantly lower in SAFE weeks for both nursing and medical staff (Table 1).

Conclusions

The SAFE innovation as a handover method appears to be effective in increasing the proportion of tasks that are completed by both medical and nursing staff following consultant-led ward rounds on an elderly care admissions unit. This innovation could be generalisable to improve patient safety on acute wards.

(1) Manser T, Foster S “Effective handover communication: an overview of research and improvement efforts” Best Practice and Research Clinical Anaesthesiology 2011;25(2)181-191
Aim:

To determine the benefits of consultants in acute medicine delivering triage and management on arrival of unselected acute medical patients.

Methods:

An East Midlands Innovation Fund award in 2010 supported this project. 100 sets of case notes from six separate months of acute medical admissions to the Royal Derby Hospital were analysed; 300 episodes of care before and 300 after the introduction of consultant delivered triage and management of patients. 120 parameters for each patient were recorded. We looked at appropriateness of referrals, timeliness and quality of care, the patient pathway, documentation and safety.

Outcomes / results:

Time to be seen and admission avoidance:

Table 1

Following intervention significantly more patients were judged to have no acute medical issues and up to 10% of patients were discharged directly from triage without hospital treatment or investigation. Recording pain scores and Early Warning Scores on arrival increased, as did the administration of first doses of antibiotics for sepsis. Completeness of thromboprophylaxis assessment increased from 33.7% on arrival to 73.7%.
Re-attendance rates fell significantly after intervention:

Table 2

Conclusion:

We have shown that a model of acute physician delivered triage and immediate management of patients does improve outcomes. Waiting times reduced, important assessment parameters that matter to patients like pain management and sepsis treatment improved, we increased early discharge without jeopardising re-attendance rates, and reduced base ward admissions. Demonstrating these efficiencies to our Trust Board and Executive resulted in investment for consultant expansion and ongoing service development.
Title: How many tick-boxes, guidelines, pathways and checklists might a doctor be expected to use when treating a complex elderly patient in hospital?

Topic: Service Organisation and Design

Author: Ninan Sean

Co-Authors: Elizabeth Stopford

Aims

We wished to investigate the number of tick-boxes, guidelines, pathways and checklists that a doctor would be expected to use when treating a complex elderly patient in the first 3 days of admission.

Methods

We took a fictional patient through our hospital admissions process until the third day. A 74 year old lady was admitted with acute confusion, productive cough, shortness of breath and wheeze. She was hypoxic, hypotensive and tachycardic. She was diagnosed with a COPD exacerbation, pneumonia, severe sepsis, acute kidney injury and delirium. We completed the relevant paperwork for this patient.

Outcomes/Results

Two bundles were completed. Six organisational guidelines were consulted. Nine checklists were completed and two pathways were followed. A total of 169 boxes were ticked and a further 10 options were circled.

Conclusion

Hospitals in the United Kingdom are under pressure to use ever increasing numbers of guidelines, pathways and “bundles” in an attempt to conform to prescribed standards of care. Such tools may result in improved outcomes when organisations focus their attention on specific issues.(1) However, when checklists achieve success many factors are in play (2) and an overemphasis on processes may impede healthcare professionals’ ability to provide good quality care. A proliferation of such paperwork may prove onerous in a way that was unintended by the authors of the individual components and may be inappropriate in the setting of multimorbidity.(3) We would urge organisations to carefully consider the impact of multiple burdensome tools on the clinical care of complex older patients.


2. Bosk CL, Dixon-Woods M, Goeschel CA, Pronovost PJ. Reality check for checklists. The
AIM
The Scottish Patient Safety Program has recently undertaken a workstream to improve outcomes from sepsis. The vehicle for this is delivery of the sepsis6 bundle within 60 minutes to patients with sepsis. The aim is a 10% reduction in mortality from sepsis by December 2014.

METHODS
At Forth Valley Royal Hospital (FVRH), the Scottish Ambulance Service has worked with the Acute Medical Unit to develop a sepsis screening tool (Fig 1) for use in the community. Patients referred from primary care for urgent hospital admission fulfilling the criteria for suspected sepsis are telephoned ahead by the ambulance crew as a ‘sepsis standby’, administering oxygen and intravenous fluids en route. A dedicated trolley is available, and the multidisciplinary team works together to deliver the bundle within 60 minutes.

OUTCOMES/RESULTS
228 patients meeting SIRS criteria were conveyed to FVRH in January 2013. As this was being undertaken as a test of change by just three crews, only a proportion were pre-alerted. The sepsis6 bundle was successfully delivered within 60 minutes in 8/12 patients (67%) who were pre-alerted, compared with just 35% overall sepsis6 bundle compliance for January (Fig 2). Furthermore 8/10 patients demonstrated a reduction in EWS en route with O2 and/or fluids administered by the crew.

CONCLUSION
Patients identified by the ambulance crew as having potential sepsis being pre-alerted to AMU at FVRH improved delivery of the sepsis6 bundle within 60 minutes. Spread to use the screening tool to identify possible sepsis in patients transported to the Emergency Department is now underway.
Aim: Following low trainee satisfaction identified by the GMC survey and deanery visit at Eastbourne DGH we re-structured the medical SHO on call system.

Method: We identified the current issues using a staff survey, it was felt to be unfair with doctors on larger firms working fewer on call shifts and some firms none at all. We proposed a new rota that met service provision requirements, improved continuity of care and evened out any inequalities. We split SHO’s from their parent firm and introduced a three-day weekend so that patients would be seen by the same doctor everyday therefore improving continuity. We introduced a Friday handover meeting so that every firm has identified and handed over their patients to the on-call doctor. The new system was implemented in the summer 2012 rotation, after which we re-surveyed the SHOs to gauge success.

Results: The new SHO system changed the trainee satisfaction percentage from 20% to 100%. There was no change in mortality when comparing the yearly figures for August and July 2011 to 2012 (5.1 % and 5.7 % in 2011; 5.0 and 5.0% in 2012).

Conclusions: A rota designed by trainees has improved trainee satisfaction; the trainees also feel that it has led to an improvement in continuity of care particularly at the weekends, without any effect on overall mortality figures. It has saved the trust £3406 per trainee per annum by a reduction in banding from 50% to 40% without reducing the number of staff covering out of hours.
Introduction

In 2011 our DGH developed an Excel spreadsheet patient list for acute medicine referrals, simultaneously accessible from any trust computer, password protected and updated in real-time during patient admission.

Method

We report outcomes from analysing 1 year of consecutive medical referrals.

Results

Wait to initial medical assessment in 13,866 patients was 80±75 minutes with 54.8% waiting <1 hour and 94.9% <4 hours. Subgroup analysis revealed equivalent waiting times irrespective of age, gender, daytime vs. overnight or GP vs. A&E referral. Initial wait was 30 minutes shorter on quieter days (referrals <33) with fewer waiting >4 hours vs. busier days where increased workload resulted from more afternoon and early evening referrals.

Wait to consultant review did not differ according to patient age, gender, method of referral, or workload. There was near-continuous PTWR activity from 08:00-21:00. Whilst overnight referrals waited longer for consultant review, more daytime patients waited >12 hours, a difference driven by early evening referrals reviewed on morning PTWRs.

Patients referred un-clerked to the next shift after waiting >1 hour had highest likelihood of prolonged wait for initial assessment or consultant review.

Conclusions

Unlike consultant work patterns, junior doctor work patterns were less able to cope with busy days. Composite markers of adverse wait and unique indicators of patient backlog may be more useful than simply measuring waiting times.

Longer waiting times were not associated with likelihood of re-referral within 1, 7 or 30 days. Handwritten or retrospectively compiled lists of acute medical referrals have no further role within hospitals with networked computers.
INTRODUCTION

Referrals to the acute medicine team require prompt assessment and timely consultant review. We compared time to assessment in daytime (08:00-20:59) and overnight (21:00-07:59) referrals to a DGH medical take.

METHODS

Using prospectively collected data from a computerised list of all medical referrals from January to May 2012, we analysed: time to initial assessment—from readiness for clerking (patient referred and arrived) until medical assessment; time to consultant review; patients handed over to the next shift; and composite adverse wait (>4 hours for assessment, >12 hours for consultant review or handover the next shift).

RESULTS

From 3785 patients, 2894 (76.5%) were daytime and 891 (23.4%) overnight. No demographic differences between groups occurred, however GPs referrals were significantly fewer overnight (20.9% vs. 45.0%; P<0.01). Time to initial assessment and proportions of patients waiting >1 hour or >4 hours were similar. Although overnight wait for consultant review was longer, >12 hours consultant wait and composite adverse wait were more frequent in the daytime, largely driven by increased handover of daytime patients (7.1% vs. 4.8%; P=0.05).

CONCLUSION

Daytime and overnight medical referrals received equivalent service. Early evening referrals were more often handed over to the night shift thereby missing consultant review within 12 hours.

Electronic lists of referrals allow tracking of patients throughout admission, permit detailed analysis of service delivery and offer benefits beyond improved communication.

In response to these findings, junior doctors working patterns are being reviewed to
Improve early evening cover and reduce handovers to the night shift.
Aim

In the UK over 19 million\(^1\) people are on the Organ Donor Register (ODR) yet 52% have not informed their next of kin\(^2\). With demand outstripping supply, we questioned whether we are failing our patients by denying them their final wish.

Methods

Surveys were collected from 53 junior doctors working at a district general hospital. Doctors were asked if they routinely enquired about ODR status on admission. Knowledge questions regarding organ and tissue donation were posed and confidence in discussing donation assessed. 111 consecutive deaths were reviewed by case note analysis to see if donation was raised either before or after death. Their ODR status was then checked by the local co-ordinator.

Outcomes/Results

When surveyed, 6% of doctors were aware that some tissues are viable for up to 48hrs post mortem. Only 19% described themselves as confident discussing donation with patients and families. More doctors would be confident (32%) to routinely ask about ODR status.

21 of the cases reviewed were found to be on the ODR (19%). Of these only one case displayed any evidence of discussion about donation. 5 further cases showed evidence of discussion despite not being on the ODR. No donations took place.

Conclusions

We suggest from this study that lack of awareness and confidence in doctors may explain why we are not discussing donation with patients. GMC \(^3\) and NICE \(^4\) guidance offers no specific recommendations to when and how this should be approached. Hospital admission offers an opportunity to routinely check patient donation status.

247 words
Introduction

Quality indicators for AMUs are well established\(^1\). Computerised systems may aid data collection and adherence to standards.\(^2\)

Method

A re-audit of adherence to SAM Quality Indicators was completed over a week during September 2012. Data were collected retrospectively from our electronic doctors’ worklist and compared to a previous audit using paper-based data collection.

Results

286 admissions were recorded; time of consultant ward round was not recorded on the electronic list in 21\% of patients compared to 4\% using conventional documentation records. Consultant review time was often recorded at the end of the ward round, which may have exaggerated apparent delays.
Conclusions

- Time to consultant review is dependent on time of arrival on AMU; patients who arrive during the early evening are less likely to be seen within 14 hours due to timings of consultant ward rounds.
- Time to management plan is less variable, due to the 24 hour cover provided by junior medical staff.
- An electronic worklist can generate useful data, although accuracy remains dependent on those inputting data; incomplete recording may affect this.
- Retrospective notes review may provide more accurate time documentation, although data analysis is more time consuming

References


Background

In April 2011, Rochdale Infirmary, as part of a multi-hospital reorganisation was re-designated from an A&E department supported by a full range of hospital services to a stand alone UCC supported by a 14 bedded in patient unit with the remit of maintaining 85% of medical activity on site.

Aim

To develop a patient focussed, efficient pathway.

Method

All aspects of the patient journey were reviewed, from admission to discharge, in a weekly Task and Finish meeting.

The optimal patient journey was designed and with the support of the PCT and Community Foundation Trust a new pathway was introduced.

Results (Diagram-CAU flow)

Key areas of service redesign:

Direct phone line-Nursing staff triage patients

Private ambulance service -timely transfers
Rapid senior doctor assessment

Rapid access diagnostics - daily CT, ECHO, U/S slots

Ambulatory care pathways - IVAbs, VTE, community alcohol detoxification service

Daily ward attender service

Transfer of Care Team - liaise with social services and IMC facility

Nurse Led Discharge

Patient activity has steadily increased from 350 patient episodes in April 2011 to on average 550 per month over the last 6 months achieving the 85% target. 38% of GP referrals have a zero length of stay (LoS), of those admitted 90% are discharged within 48 hours (average LoS 2.1 days).

Conclusion

The downgrading of our hospital presented us with the opportunity to redesign our service to one that is patient focussed and efficient. This innovative service is popular with patients and the local healthcare community and is attracting visits from other Healthcare Trusts seeking to redesign their services.
Aim

The care provided in NHS hospitals at weekends has been described as “fractured”, partly due to the lack of senior medical staff[1]. Week-end emergency admissions have been linked with increased mortality[2] and length of stay[3] (LOS). Seven day working has been proposed[4],[5]. We conducted a pilot assessing the effect of 7 day working on LOS.

Methods

Rotas were designed to provide seven-day by medical, nursing and allied health professionals cover on AMU for 6 weeks.

Results

We achieved an 8% reduction in LOS compared to the previous six weeks despite a 10.3% increase in referrals, and a 21% reduction in LOS equating to a yearly saving of 2785 bed days compared to the same period the previous year.

Conclusion

Our pilot delivered a significant length of stay reduction, resulting in a successful business case. The impact of 7 day working on mortality will need to be evaluated in a larger study.


London: Dr Foster Intelligence, 2011.


Quality & Performance indicators in Acute Medical Unit in a Large Teaching Hospital: Hull Royal Infirmary

Dr Ruhail Mir, Dr C. Weerasekera, Dr M. Thakur

AIM: The aim of this Audit was to see compliance with quality standards published by SAM in June 2012 and to compare performance with data from 2011.

METHODS: It is a Prospective audit. Data was collected from 112 patients randomly over 1 week out of 475 admissions using proforma with all SAM’S Quality indicators.

RESULTS: The average time of transfer from A&E to AMU was 3 hrs. 13.3% of patients were transferred from A&E within 1 hr. Initial nurse assessment took place within 30 minutes in 88.6% of patients. Early warning score was documented in 66.8% patients on initial assessment. Within 4-hours of admission to the unit 78% of patients had a full clinical assessment of which 58% were assessed by senior clinical decision maker (≥FY2). Within 14-hours 88.7% of patients were reviewed by a consultant physician. The hospital mortality rate for patients admitted to the AMU was 3.2% as compared to 6.5% mortality over the same period in 2011, a 50% decrease in mortality. AMU’s 7-day readmission rate was 1.0% as compared to 1.5% over the same period in 2011. 35.2% of admissions were discharged directly from AMU within 48 hours.

Conclusion: Marked improvement in mortality figures, Early direct discharges and low 7 day readmission was noted as compared to 2011. This has been achieved because of improvements in the overall structure in AMU including Acute consultant cover on the floor for 14 hrs a day, Specialist input from cardiology, Respiratory, neurology, Geriatrics and infectious disease as In-reach services. Further improvements can be achieved by appropriate workforce planning according to patient-flow.

References:


2. ‘Quality Standards for Acute Medical Units’, by the West Midlands Quality Review Service in association with the Society for Acute Medicine (SAM) - Sam Website. June 2012
Title: Streamlining the use of inpatient biochemistry and haematology and sustaining the change

Topic: Service Organisation and Design

Author: Caroline Sarah Lebus

Co-Authors: Gareth Corbett

Aim

Pathology requests account for a significant proportion of a hospital budget. We aimed to introduce a sustainable reduction in requests.

Methods

All medical junior doctors received education sessions regarding pathology requests. Interventions were then carried out on 4 wards for a 2 week period. Table 1 shows the interventions.

The number of biochemistry and haematology tests requested for the 2 weeks before and 2 weeks after the interventions were collected. Results for the subsequent weeks were also collected.

Results

Wards 2, 3 and 4 all showed a reduction in pathology test requesting compared with the previous 2 weeks. Ward 1 showed an increase in tests overall. Figure 1 demonstrates the results for the 4 wards.

Conclusion

Reducing inpatient biochemistry and haematology is important as it provides clinical benefits such as faster results from the laboratory, patient satisfaction as there is less phlebotomy and financial benefits. Intervening in a hospital to produce a sustainable reduction in pathology requesting is challenging. We concluded that using a senior ward doctor (the registrar) to sign off requests was most likely to provide a long term reduction in requesting that is sustainable. We plan to implement this within the medical division of our hospital.
AIM

Patients with complex needs represent a significant challenge to acute care services. Frailty is associated with functional decline, increased length of stay and death(1, 2). Vulnerability and disability are considered to be related but distinct concepts(3), and are associated with increase risk of harm. These respective physical, social and functional lenses result in fragmented approaches to healthcare, and inconsistent measurement of outcomes. We seek to develop a conceptual framework that is better integrated and robust in operationalizing care for this cohort of patients.

METHODS

Stakeholders (carers, hospital MDT, researchers, managers and CCG representatives) within Northwest London participated in focus groups of three iterative cycles, with results being fed back into subsequent cycles. External observers captured qualitative data for thematic analysis. Quantitative consensus statistics were not obtained as the purpose was exploratory.

OUTCOMES

Definition of fragility:

1)Someone with deficits from multiple domains:
   
   a. Physical
   b. Mental
   c. Social
   d. Environmental

2)The accumulation and interaction of these deficits puts the person at risk of harm beyond the effect of individual deficits or stressors
3) Dynamic within the individual and over time

What this adds:

1) Fragility recognizes the importance of all dimensions, and can be present at any age

2) Severe deficits or stressors in any domain will likely impact on others in measurable ways (Fig 1)

3) Actions taken to prevent the accumulation of deficits in any of the domains could mitigate poor outcomes later in the life-course (Fig 2)

CONCLUSION

This framework provides a concise multidimensional operational definition for patients with complex needs

REFERENCES


Providing quality care for the frail elderly admissions to an acute hospital

K Rainey, H Gentles

Elderly Care Department, Cheltenham General Hospital, Cheltenham

Aim

The complex, frail elderly patient is increasingly dominating the acute medical take, and is often associated with prolonged hospital stay. Harari et al[j] (Age and Aging (2007) 36(6): 670-675) demonstrated a 4 day reduction in length of stay through implementation of an OPALs team. Based on this work we examined the effect of such a team for inpatients on a medical ward in our hospital.

Methods

Over a 2 month period patients over age 70 years were assessed by the OPAL’s team. The team (geriatrician, physiotherapist, 2 occupational therapists, and a discharge sister) did daily board rounds with nursing staff, and weekly multidisciplinary team meetings. At board rounds patients for physiotherapy, occupational therapy, community hospital and social work referral were identified. All patients had a medical review. After the pilot feedback surveys were completed.

Outcome/Results

<table>
<thead>
<tr>
<th>Length of stay: (days)</th>
<th>Pre-OPALs (n=80)</th>
<th>Post-OPALs (n=57)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>10.9</td>
<td>9.55</td>
</tr>
<tr>
<td>Once ‘medically fit’</td>
<td>4.56</td>
<td>3.17</td>
</tr>
<tr>
<td>discharged to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community hospital</td>
<td>28%</td>
<td>18%</td>
</tr>
<tr>
<td>Same as admission</td>
<td>68%</td>
<td>72%</td>
</tr>
<tr>
<td>Time to (days):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>3.65</td>
<td>2.82</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>8.3</td>
<td>4.71</td>
</tr>
<tr>
<td>Social work referral</td>
<td>5.12</td>
<td>3.28</td>
</tr>
</tbody>
</table>
The geriatrician assessment resulted in more medications being discontinued and cognitive screens completed.

The feedback from ward staff was positive. One staff member said:

“Establishing a plan with the entire MDT first thing was very beneficial, all working towards the same goal, enhanced communication”

**Conclusions**

It is clear from this study that the aging population benefits from multidisciplinary team input. Early access to therapy, geriatrician review and effective team communication is essential for improved quality of care and efficient discharge planning.
Communication within the Multi Disciplinary Team is Key to Safe and Effective Discharge of Older People from the Acute Medical Unit

AIM:

Demographic trends and multi-morbidity results in patients presenting to the Acute Medical Unit (AMU) requiring ever more complex assessments and interventions from ever increasing numbers of professionals.

Our 55-bedded AMU is well resourced with all members of the Multi Disciplinary Team (MDT) using an Electronic Patient Record (EPR).

MDT assessments took place independently with members looking at the EPR for each other’s recommendations.

We tested whether a “Board Round” meeting of the existing MDT prior to and post the morning Ward Round (WR) would enhance EPR communication and subsequent management of Older Patients.

METHODS

The only intervention was that of a ten-minute pre and post-WR MDT meeting.

We evaluated outcomes for patients aged over 70 years admitted to 3 bays (12 beds).

Outcomes were mean Length of Stay (LOS) and discharge over a four-week period prior to and post initiation of intervention.

LOS for patients moving through target bays to the wards proper was also measured.

OUTCOMES/RESULTS

AMU discharge rates increased from 45% to 50% of admitted patients aged over 70 years.

LOS of discharged patients reduced by 17 hours from 75 hours to 58 hours.

LOS of patients transferred to medical wards prior to discharge reduced by over a day from 12 days 10
hours to 10 days 18 hours.

CONCLUSION

Old fashioned, face-to-face discussion of the MDT enhances EPR communications with positive patient outcomes.

Improvements appear to have enduring effects even when patients are transferred to wards.

Future service developments have accelerated as a result of relationships built between MDT members.
Aim

The British Medical Association\textsuperscript{1} and Royal College of Physicians\textsuperscript{2} stress the importance of medical handover in minimizing patient error. We aimed to improve medical handovers at Royal Albert Edward Infirmary, ensuring all patients who were referred were not missed.

Method

We introduced formal night time medical handovers, in a dedicated room, attended by critical care outreach, bed managers and all on-call medical team members. Handovers were led by medical registrars. We also designed and piloted (for 6 weeks) an electronic patient list, to track patients during an on-call shift. Using SurveyMonkey.com, we collected data on the number of patients seen during each shift, and handed over to the next team.

Results

Of the 60 shifts we collected data for, 36 (60\%) were pre and 24 (40\%) were post implementation of the electronic list. Over 90\% of patients referred had been "clicked" on the list as seen. There was a 11.6\% increase in the number of patients seen by the medical registrar, over 24 hours, after the list was implemented (Figure 1). A correlating reduction of patients seen by the senior house officers was also noted. There was a 1.6\% reduction (258 patients per year) in the number of patients being handed over as "waiting to be clerked" to the next team.

Conclusions

Use of an electronic patient list, helps distribute the workload more evenly amongst all members of the on-call team, and though not significant, there is a slight reduction in the percentage of patients being handed over.

References

2. RCP: (RCP Guidelines on effective patient handover for physicians)
Reducing the burden of emergency readmissions for patients with recurrent ascites

Dr G Samra
Blackpool Teaching Hospital NHS Foundation Trust

Background
A study of 100 patients readmitted within a month of discharge from hospital to the Department of Medicine highlighted that 12% of all readmissions were due to recurrent ascites \[^1\].

Aim
To determine whether an individual case management approach for patients readmitted with ascites may be used as an alternative management strategy aimed to –

- Reduce readmissions
- Reduce inpatient length of stay
- Improve patient experience

Methodology

Stage 1: ‘A profile of patients admitted to Blackpool Teaching Hospital with ascites; September- December 2011’ revealed-

- 19 patients admitted with ascites contributed 50 admissions
- Total number of readmissions = 34 (68% of all admissions)
- 90% of patients required therapeutic paracentesis
- Average length of stay/admission = 3.8 days

Stage 2: A clinical pathway (Ascites Clinic) was established to facilitate planned admissions for therapeutic paracentesis as a day admission.

Stage 3: The impact of the Ascites Clinic was assessed for the corresponding period of September –
Results

- 23 patients admitted with ascites contributed 31 admissions
- Total number of readmissions = 4 (13% of all admissions)
- 17 therapeutic paracentesis were performed for 7 patients in the Acites clinic
- On two occasions a patient required hospital admission post paracentesis
- Number of complications post therapeutic paracentesis = 0

Conclusion

An ‘individual tailored case management approach’ via the Acites Clinic has reduced emergency admissions to hospital, reduced inpatient readmissions and has improved the overall patient experience.

[1] G Samra : Readmissions to Medicine, Preventable or Not?; Blackpool Teaching Hospitals NHS Foundation Trust; September-October 2011-2012
**Introduction and Aim**

A new acute medical unit (AMU) has been set up at our hospital. We undertook a project aiming to characterize the case-mix of acute medical admissions in order to evaluate the need for service development and ascertain educational opportunities for trainees.

**Method**

We retrospectively reviewed all admissions to the unit between April 2011 and March 2012 focusing on their demographic data and trends of primary diagnoses over time. We also reviewed all existing clinical pathways to establish the need for introducing new pathways.

**Results**

There were 8138 admission episodes altogether including 55.3% women (n=4500). Majority of patients were in 61-80 years age group range (n=3185,39.1%).

The common categories were respiratory (n=2410,29.6 %) followed by neurology (n=1188, 14.5%) and gastroenterology (n=1138,13.9%)(Figure1). There was a peak of admissions under the respiratory group in winter months as expected. There were 2 peaks of admissions under infections category in summer and winter months.

Clinical care pathways existed for stroke and chronic obstructive airway disease management in our hospital, although there were no pathways for other acute medical admissions.

**Conclusion**

There exists a broad case-mix of clinical presentations to adequately fulfil the educational needs of acute medical trainees.

We have introduced care pathway for neurological admissions which have successfully reduced the average length of stay for these presentations.

We also plan to provide increased support with specialist respiratory nurses during busy periods in the year.

We recommend that all AMUs should evaluate their case-mix in order to identify factors for service improvement and education.
INTRODUCTION

North Wales has three hospitals serving a large geographical area. Outpatient clinics are increasingly full and patients often travel long distances to attend resulting in great inconvenience. Moreover, not every consultation requires a face-to-face meeting. Telephone consultations can be a useful way of providing an alternative point of contact with healthcare professionals.

AIM

To set up acute medicine telephone clinics across 3 sites in North Wales.

We report on our experience of developing this service, from inception to data collection, using the PDSA model for improvement. We detail each stage of the process along with the obstacles encountered at each step.
METHOD

To overcome the distances between the 3 sites we held formal weekly telephone conferences for delegation of tasks and progress reports. The minutes of each meeting were recorded and a ‘dropbox’ account created for sharing of documents.

Stages of project development:

1) Literature review
2) Identification of potential cases
3) Production of relevant documents:
   · Patient information leaflet
   · Patient consent form
   · Appointment letter
   · Patient satisfaction survey
   · Quality control checklist
   · Welsh translations commissioned
4) Relevant stake holders identified:
   · Information Technology
   · Secretary/booking clerks
   · Clinic nurses
   · Medical teams
5) Creation of telephone clinic templates
6) Identification of barriers
   · Co-ordinating workload remotely across 3 sites
- Changing the ‘status quo’
- IT and associated time delays
- Patient confidentiality
- Patient safety e.g. lack of physical assessment
- Patient selection
- Quality control issues
- Logistics of consenting & arranging appointments

7) Test patients prior to going “live”

CONCLUSION

Telephone clinics have now gone live across the 3 sites.

REFERENCES


Alcohol related admissions (ARAs) have a significant impact on AMUs. We have previously reported ARAs of >50% attributable to alcohol account for 16.95% of male and 9.55% of female admissions in Middlesbrough. A key intervention for these patients is alcohol detox. However, few units are well enough equipped to provide this in an inpatient setting, resulting in substandard inpatient detox.

This study evaluates a hospital to home detox program. Patients were identified as suitable based on clinical & social criteria. Treatment is initiated in hospital. Patients then have a supported discharge to complete a 7 day detox course in the community. This is followed by an MDT assessment for ongoing support.

Patient outcomes were calculated using a post-detox improvement rate. At the point of detox the pre-detox admission rate for the preceding 12 months was calculated & compared to the post-detox admission rate. At 6 months follow up 29 of 37 patients had a reduction in ARAs, 22 of 37 had no ARAs. Of 24 patients with less than 6 month follow up 19 had no ARAs. On average 4 patients per month entered the program, saving 20.97 bed days a cost saving of £5241 per month. No adverse events were reported during this period.

This study has demonstrated that hospital to home detox is a safe & effective intervention. It reduces ARAs & stops admissions for a large proportion of patients at 6 months. With appropriate application this intervention could be part of the ambulatory emergency care program.