Introduction

Bradford Royal Infirmary is an inner-city, acute hospital serving 500,000 patients.

In 2015, a dedicated ambulatory care unit was developed with permanent consultant presence. It is open from 8am till 8pm, seeing 26 patients per day.

Prior to this a six bedded trolley bay was used on the AMU with junior doctors taking referrals and seeing patients. The coordinating nurse would decide which patients were suitable based on history and observations.

The Intervention

Creation of a dedicated Ambulatory Care Unit, with four trolley beds and six consultation rooms.

Consultant present at all times, with an additional Consultant present from 1pm till 5pm.

Consultants take all referrals, see patients, review junior’s patients and manage patient flow.

Additional help from a nurse, health care assistant, SHO and an Advanced Care Practitioner.

AMB Score used to help guide emergency department as to which patients to refer, but flexibility of what patients accepted based on consultant expertise.

Methods

Data analysis of 2966 patient visits over 140 days was undertaken and compared to a pre-implementation audit of 59 patients.

Data was collected in real time using the unit’s electronic white board. Statistical analysis was undertaken and results reported as the median, 25% and 75% interquartile range.

Previous audit did not differentiate between Consultant and SPR as the Senior Decision Maker (SDM). SPR input was only 10% of SDM reviews in current audit.

Results

60.3% of patients were seen directly by a SDM compared to 35% previously. Patients with SDM input had a reduced total stay, 2.7 hours (IQR 1.6 – 4.3) compared to 3.2 hours (IQR 2.1 – 4.5) for patients only seen by SHOs and Nurse Practitioners. When applying statistical analysis, it was found to be statistical significant, p < 0.0001, with juniors taking 19.4% longer, (95% CI 11.5% to 27.9%).

Juniors were frustrated with repetition of only seeing patients with chest pain.

The new unit has a more diverse range of patients, with suspected cardiac chest pain and pulmonary embolus decreased from 51% to 19.4% longer, (95% CI 11.5% to 27.9%).

Increased opportunities for work based assessments and counts towards clinic numbers.

Conclusions

- Previous ambulatory care unit ran by SHOs and Nurse in charge. Lacked dedicated leadership, selection criteria and oversight.
- There was a long wait to see a doctor, with RCP standards (1) not being met for initial review, SDM input and time till discharge.
- Having a consultant present has led to median times meeting these standards.
- Time on unit significantly decreased with SDM involvement, with a reduction in time spent awaiting test results.
- Better selection of patients by consultant has led to number of patients with a NEWS score greater than 4 reducing from 10% to 4%.
- Increased educational opportunities and feedback for juniors. Reduced repetition of seeing common conditions.
- Dedicated Nurse and HCA has improved timings of first NEWS score from 42 minutes to 12 minutes (IQR 5 – 25).
- 90% of patients were discharged home in both audits.

Future Considerations

- Push to get 90% of patients seen within RCP times.
- To see if demand present for consultant led ambulatory care on the weekend.