



The Society for Acute Medicine

# **THE COORDINATOR ROLE IN ACUTE MEDICINE**

PRINCIPLES FOR EFFECTIVE COORDINATION OF AN ACUTE MEDICINE UNIT

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## INTRODUCTION

The purpose of this document is to provide clarity regarding the function of Coordinators on an Acute Medicine Unit (AMU). The coordination of patients into and out of an AMU is regarded as a core role for the multi-disciplinary team. If executed efficiently coordination will positively impact upon the organisation and efficient working practice of an AMU. Coordination is part of a registered nurses role on all wards, however the differentiation and distinction on an AMU is seen through the intensity and nature of workload, namely the large volumes of patients admitted, discharged or transferred within 24 to 48 hours. With the exception of other emergency areas the level of activity within an AMU is not seen in any other areas of a Hospital.

This document will illustrate an analysis of the coordinator role using key questions to guide the reader and key domains to define the role. Key principles underpinning coordination are also detailed to provide a guide of what should be expected within a Registered Practitioner (nurse) role on an AMU.

## KEY POINTS

1. Coordination is a core function within an Acute Medicine Unit. Safety and patient flow are key aspects of the role
2. This paper offers a definition of a Coordinator role within an AMU; the role may be transferrable to other clinical areas.
3. Registered Nurse Coordinators are responsible for the safety of patients following handover, and transfer, during placement, discharge and transfer from AMU.
4. Coordinator roles can be developed in a registered or non- registered capacity following an analysis of domains of the role required (Table 1).
5. Not all AMUs will identify the need for a coordinator and this is likely to be dependent upon the size of the AMU and patient volumes.
6. There are three broad principles that have been identified to frame the coordinator role, namely – (1) leadership, organisation and coordination; (2) maintaining effective communications; and (3) clinical decision-making.

## WHAT IS A COORDINATOR?

Coordinators maybe registered or non registered practitioners – generally but not exclusively assumed to be Nurses.

A registered nurse coordinator is a person who is capable of organising the AMU workload and appropriately delegating patient care to facilitate the safe handover, assessment, admission, transfer or discharge of all patients during their shift. They are responsible for patient safety and will ensure key decisions are made.

A non-registered practitioner – generally but not exclusively assumed to be health care assistants or ward clerks.

They will be responsible to carry out mostly tasks delegated by a registered practitioner (nurse). They will be predominantly simple tasks to support the organisation and flow of patients within AMU. The distinction between registered and non-registered practitioners is that a non-registered practitioner will NOT be responsible for clinical decisions but may be follow guidelines, or be guided by criteria; for example - in conjunction with either bed management they may allocate patients to bed capacity arising within the Hospital. Again, this will vary according to AMU and Hospital policy and is cited as an example only.

## DO ALL AMUs NEED A COORDINATOR?

It is understood that some AMUs may not identify the need for a coordination role – this paper does not mandate coordinator roles. This paper does hope to assist the development of a coordination role, which is bespoke to your AMU with due consideration of the aspects of the role highlighted – later tabled.

Smaller units (less than 24 beds/spaces/trolleys) may wish to consider coordination as part of a registered nurses role – where the nurse or nurses are ‘in charge’ of the shift. In this case the role of coordinating the unit will be rotated between several experienced nurses who take charge for short period of time – thus giving them each opportunity to develop skills in this area. It is suggested that the way in which an AMU is coordinated, in particular with regard to the parity or disparity between different individuals who carry out the coordinator function may affect the performance of the AMU<sup>1</sup>. Too many different characters that do not operate to the same principles will negatively impact upon patient flow.

Larger units (more than 24 beds/spaces/trolleys) may wish to develop the coordinator role as a job undertaken as a supernumerary role within the AMU; meaning that when they are on duty – they will coordinate the unit for the duration of their shift. They will not have a clinical case load.

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<sup>1</sup> [How a clinical coordinator improved emergency care.](#) O'Brien D, Lees L. Nurs Times. 2005 Apr 12-18;101(15):34-6.

This approach has the advantage of continuity over a whole shift allowing focus on flow and safety without risk of fragmented communications across several team members.

Whether this role is considered to simply merge with the function of being in charge, or as a new role in its entirety; will depend upon your staffing numbers, skill-mix and overall composition of the AMU multi-disciplinary team.

In addition and worthy of consideration is the bed-management model used on your AMU – this will affect the decision whether or not to introduce the coordinator role. For example, how are your patient referrals generated? What is the system of bed management? What is process used for discharges? These all need to be considered to avoid duplication of roles or gaps in service provision.

In summary – consider how effective your patient flows are at busy times and what existing mechanisms are in place to manage them before the introduction of this role.

## THE EVIDENCE

A telephone survey of ten AMUs was undertaken to aid the development of this paper – the following questions were asked; -

1. Do you employ a coordinator role on AMU?
2. What is your AMU size (<24 beds) or (>24 beds)?
3. If yes to Q1, is the Coordinator supernumerary?
4. Is your coordinator Registered or Non-registered?
5. Do you have a Job Description or guidance for the coordinator role?

All AMUs had a coordinator role.

None of the AMUs surveyed carried out the coordinator role in a supernumerary capacity.

Three AMUs used non-registered staff as coordinators and described the simple functions appertaining to non-registered staff, as per table 1. They were employed in the role to support the Nurse In Charge. Issues were highlighted when Nurses in Charge were also given ‘bays of patients’ to care for – described as ‘juggling patient care and coordination’. This was a concern when the non-registered coordinator needed clinical decisions making by the nurse in charge. The three AMUs using non-registered coordinators had less than 24 beds.

Seven AMUs used registered staff as coordinators. Although none were supernumerary their patient contact was described as ‘limited’ during busy period of the shift. They were mostly able to

concentrate on coordinating – but ‘felt guilty’ about leaving the others nurses to pick up their clinical work. It was expressed that a supernumerary role even if at busy times would be ‘safer’. The aspects of the service that they felt would improve with a supernumerary coordinator were chasing blood results, appointments and speeding up patient discharges and transfers.

None of the registered or non-registered coordinators had a Job Description or guidance for this aspect of their role and they welcomed some guidance on the development of the role.

## WHAT IS MEANT BY EFFECTIVE COORDINATION?

For simple tasks coordinator roles work well. For complex tasks involving two or more stages to complete coordinators are liable to task overload and queuing of tasks will occur. This means they will not be undertaken in a timely manner and render the role ineffective. Moreover, coordinators cannot be subsumed in clinically demanding care - perhaps with critically ill patients - otherwise the AMU will flounder (slowing down flow) without adequate guidance for patient activity. Finally, coordination is a demanding role and regardless of whether supernumerary or rotating within the establishment of the shift – it is suggested short bursts for half of a shift would be better received.

## SHOULD COORDINATORS BE REGISTERED OR NON- REGISTERED?

This cannot be stipulated hence due consideration of the aspects of the role is necessary. Registered nurses undertaking this role will have the advantage of clinical knowledge underpinning their authority and confidence in decision- making. This will enable them to challenge decisions to maintain patient safety if/where appropriate. Registered nurses will also direct care and maintain AMU safety for the benefit of patients and staff. They represent the AMU team and are a focal point for decisions and communications. They inspire staff confidence.

Evidence suggests that there is also a role for a non-registered practitioner (healthcare assistant or ward clerk) to undertake a similar role on an AMU. Experience of working in a fast moving environment, customer services or bed management function are likely to be prerequisite to such a role. There have been many guises of non-registered coordinators discovered – they are often developed to fit the unit in which they work. It is suggested that such a role on an AMU is a hybrid of clerical and bed management support<sup>2</sup>.

In summary – they can be either registered or non-registered roles, there is a clear distinction between the two and they are liable to confusion

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<sup>2</sup> [The role of a flow coordinator in an emergency assessment unit](#). Lees L, Ferreday J. Nurs Times. 2003 Aug 12-18;99(32):32-4.

Using seven core domains the role has been distinguished into registered and non-registered functions Table 1, on the following page. This table is not exhaustive and should be considered in conjunction with 'Workforce considerations in Acute Medicine Units - a Toolkit'<sup>3</sup>.

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<sup>3</sup> <http://www.acutemedicine.org.uk> - Nursing – Workforce considerations for AMUs: A Toolkit. Produced by the Society for acute Medicine 2011

**TABLE 1 - REGISTERED AND NON- REGISTERED DISTINCTION**

<b>DOMAINS</b>	<b>REGISTERED PRACTITIONER</b>	<b>NON-REGISTERED PRACTITIONER</b>
Referrals	<ul style="list-style-type: none"> <li>Judges clinical appropriateness of patient referrals (liaises with Consultant on AMU as indicated)</li> </ul>	<ul style="list-style-type: none"> <li>Prepares administratively for the patients arrival.</li> <li>Prepares bed-space</li> </ul>
Handover	<ul style="list-style-type: none"> <li>Ensures verbal and written handover and asks key safety questions prior to transfer to AMU</li> </ul>	<ul style="list-style-type: none"> <li>Books patient into AMU</li> <li>Makes and receives phone calls to support registered nurses</li> </ul>
Placement	<ul style="list-style-type: none"> <li>Decides best clinical placement for patient on AMU – taking into account infection control and same sex accommodation</li> </ul>	<ul style="list-style-type: none"> <li>Writes name on ‘white board or other system in use.</li> </ul>
Assessment	<ul style="list-style-type: none"> <li>Delegates patient assessment to registered nurse and MDT according to need</li> <li>Results chasing and relaying to Doctors</li> <li>Receives update of patient condition</li> </ul>	<ul style="list-style-type: none"> <li>Greets patient and assists placement on AMU.</li> <li>Shows patient facilities on AMU</li> <li>Carries out baseline observations / NEWs score (depending on competency)</li> </ul>
Booking / organising of beds	<ul style="list-style-type: none"> <li>Uses Clinical knowledge and liaises with Consultant and team regarding best placement - right be, first time</li> </ul>	<ul style="list-style-type: none"> <li>Takes calls to update AMU regarding Hospital bed capacity</li> <li>Assures excellent communications with wider teams and places Bleep/calls to request support - delegated from Registered Nurse</li> </ul>
Transfer	<ul style="list-style-type: none"> <li>Makes clinical decisions regarding fitness for transfer</li> <li>Decides the need for a patient escort</li> </ul>	<ul style="list-style-type: none"> <li>Places calls to portering staff (etc)</li> <li>Ensures safe handover of patient on receiving ward</li> </ul>
Discharge	<ul style="list-style-type: none"> <li>Ensures patients are discharged and proactively accommodates next patients</li> </ul>	<ul style="list-style-type: none"> <li>May order TTOs, book transport, prepare for next patient, clear bed - space.</li> </ul>

## CORE FUNCTIONS OF A COORDINATOR ROLE AND KEY PRINCIPLES

Three core functions of the registered nurse coordinator role have been described as:-

1. Leadership, Organisation and Coordination
2. Maintain effective communications
3. Clinical decision making

From this three principles have been identified as:

1. Providing excellent leadership for the AMU through the organisation and coordination of all handovers, admissions, transfers and discharges.
2. Communicating effectively with all members of AMU team, all wards and departments pivotal for the handover, admission, transfer and discharge of patients.
3. Facilitating safety and high quality patient care on AMU through clinical judgment/decision making in collaboration with multi-disciplinary team.

The principles may be useful in providing parity for the role regarding the way the unit is coordinated by different coordinators perhaps on the same shift or throughout a working week. They have been written to reflect what is expected of the role in larger AMU and to this end may require modification for smaller AMUs. They could also be used as part of a job description.

### Principle 1

**Provides excellent leadership for the acute medicine unit through the organisation and coordination of all handovers, admissions, transfers and discharges.**

#### Performance criteria set 1:

1. **In flow:** Proactively identifies and manages patients requiring transfer from the Emergency Department (ED) to AMU based on decision to admit data (time elapsed since presentation in ED); this will require regular contact/communications with ED to ensure patients are transferred in a timely manner.
2. **AMU Capacity:** Makes the best use of the AMU capacity by ensuring that patients are allocated to the most appropriate assessment or treatment location, according to their clinical condition and to ensure patient safety is paramount at all times.

3. **AMU safety:** identifies potential patient safety issues at the outset of each shift, ensuring that acuity of patients, safeguarding and governance concerns are addressed. Ensure they are thoroughly aware of the unstable patients, those with the need for 'specials' and safeguarding issues. The placement of patients requiring side rooms/infection control considerations and single sex accommodation must also be organised.
4. **Out flow:** Organises and controls AMU workload by managing the transfer and flow of patients from AMU to base wards, in accordance with the local policy. Clearly invokes an escalation at times of poor bed availability - according to local policy to ensure support for patient flow is achieved in a timely manner.
5. **Transfer:** Pre-empts and actively manages patient handover and transfer to base wards, ensuring that locally agreed guidance, including use of checklists, is followed.
6. **Discharges:** Ensure that patients are discharged using discharge checklist, which includes explanation of TTO and any follow up. Timely discharge from AMU must include use of the discharge lounge.

## Principle 2

**Communicates effectively with all members of AMU team, all wards and departments pivotal for the handover, admission, transfer and discharge of patients.**

### Performance Criteria set 2:

1. **In Flow:** Attends a morning handover or capacity meeting as indicated and in accordance with local policy to ensure awareness at site situation and trust situation.
2. **AMU capacity:** Ensures all AMU handovers take place in a timely manner at the allocated times – leading input of communications to this as required.
3. **AMU capacity:** Ensures staffing levels are safe in advance – perhaps at least for next 72 hours and shortfalls are recognized to ensure booking of staff.
4. **Out flow:** Updates bed managers hourly with bed requests and transfers. Provides an update on all exceptions to bed availability to bed manager on event driven basis.
5. **Handovers:** Regularly liaises with the AMU consultant or Registrar (RMO) in regarding any changes in workload, unstable patients, and discharges and identifies where the support of the AMU Consultant or RMO is best focused.

### **Principle 3**

**Facilitates safety and high quality patient care on AMU through clinical judgment/decision making in collaboration with MDT**

#### Performance criteria Set 3:

1. Actively supports (guides and directs) AMU registered nursing staff to undertake activities to meet health and wellbeing needs of patients with a greater degree of dependency in AMU.
2. Appropriately delegates senior clinical staff to take responsibility for emergency situations and clinical support – to ensure they are aware but free to continue to coordinate the AMU.
3. Uses clinical judgement (with rationale) to support appropriate placement within AMU – ensuring appropriate utilisation of monitors, beds, chairs and clinical areas. This includes safe/appropriate placement of patients with infections and single sex considerations.
4. Uses clinical judgement, protocols and pathways to ensure patients are monitored, clinical investigations are supported, patients are chaperoned and acts as a resource for junior staff to support safe patient care.
5. Recognises, refers and reports situations where there might be a need for patients protection and implement aspects of a protection plan
6. Supports staff on AMU to recognise and prioritise care needs to ensure efficient operation of the AMU.
7. Proactively challenges nursing practice to ensure that the responsibility for patients is effectively demonstrated by registered nurses

## CONCLUSION

The role of a coordinator is regarded as a core function in an AMU. The choice of whether or not to introduce such a role will depend upon analysis of needs – concerning aspects of the role highlighted. Two aspects of the role remain paramount – patient safety and flow. These roles support busy AMUs where flow and safety might otherwise be compromised. Notwithstanding, AMU function as a team and the coordinator role must equally serve to coordinate and support the team as an integrated role.

## RECOMMENDATIONS

It is recommended that all AMUs considering the introduction of a coordinator role or the adaptation of an existing 'coordinator' role should undertake an analysis of their service needs. For this purpose it is suggested that the domains within Table 1 are reconsidered in the context of your AMU.