



## **Physiotherapy and Occupational Therapy in the Acute Medical Unit: Guidelines for Practice**

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## 1. Background, Purpose and Scope of Document

Acute Medical Units (AMUs) have become an increasingly common part of the assessment and decision-making pathway for acutely-presenting medical patients in NHS hospitals throughout the United Kingdom over the past 15 years. Patients who present at AMUs are often older, frail and with complex medical and care needs. Consequently, many AMUs have developed full multidisciplinary team working, with the aim of achieving timely, accurate and holistic patient assessments at or very near the first point of a patient's hospital attendance.

At time of writing no guidance for both physiotherapy (PT) and occupational therapy (OT) working within an AMU has been published or widely circulated through either printed or electronic media. Consequently, a group of senior PT and OT staff working in AMUs in the NHS convened under the stewardship of the Society for Acute Medicine (SAM) in London with the aim of:

- Sharing current established experience, working practices and guidance adopted in AMUs at local level;
- Identifying core elements of effective organisational and working practice for PT and OT in the AMU that could be proposed as common to both professions;
- Authoring and circulating through SAM a guidance document for PT and OT staff working in AMUs to reflect current best practice as agreed by this group.

Due to the collaborative nature of working between PT and OT, and a commonly-encountered overlap of the professional boundaries experienced in AMUs this document sets out the group's agreed suggestions for cross-professional guidance to cover:

- The purpose of an AMU and its normal functionality;
- The most commonly-encountered roles and skill sets of AMU PT and OT staff;

- A common and clear pathway illustrating the place of PT and OT in assessment and destination identification for patients in the AMU;
- Indications of commonalities in documentation and patient activity data collection;
- Other specific areas of screening, assessment and discharge of the AMU caseload considered useful to reflect current common practice in PT and OT.

This document's scope is to suggest guidance for PT and OT in the AMU. Application of this guidance in the context of a therapist's specific circumstances, expertise and service users is anticipated. It does not replace or supersede any area of formal uni-professional or regulatory guidelines for PT or OT. Rather, it indicates a starting point for best practice for bi-professional working where clear commonality of purpose and practice already exists for the delivery of best patient care in busy AMUs.

## 2. What is an Acute Medical Unit?

The Royal College of Physicians (London) defines acute medicine as:

“That part of general (internal) medicine concerned with the immediate and early specialist management of adult patients suffering from a wide range of medical conditions who present to, or from within hospitals requiring urgent or emergency care” (Royal College of Physicians, 2007).

The Society for Acute Medicine (SAM) defines the Acute Medical Unit (AMU) as:

“The specialised area of an acute hospital where patients suffering from acute medical illness can be assessed and initially managed” (Society for Acute Medicine, 2010).

The AMU wards, or wards that sit in a broadly similar functional position in a hospital are often located close to the Emergency Department, from where their admissions often arrive. These are sometimes referred to by a variety of differing names and terms, such as Medical Assessment Units, Assessment, Clinical Decision-making Units, Assessment Areas and other terms besides. For clarity the term Acute Medical Unit is used throughout this document.

Patients will generally stay in the AMU for 48 hours or less, and after their assessment a decision will be made for either discharged home, or for transfer to an in-patient acute medical ward or other relevant speciality. Due to the complexity, age and frailty of patients presenting to the AMU, many units have multi-professional teams consisting of nursing, medical, pharmacy and AHP staff to aid in-depth, timely and detailed patient assessment. This should facilitate accuracy of destination planning, and to enable safe discharge for the more complex patient. Some AMUs devolve discharge decision-making to the most relevant professional, dependent on the nature of the patient’s presentation: this is likely to include both the PT and OT professions.

PT and OT frequently work in a collaborative manner in the AMU, and by the nature of the practical and functional breadth of these profession’s practice there may often be an overlap of scope of intervention during patient

assessment. This may lead to joint assessment and destination decision-making. Alternatively, it may be that either PT or OT individually are best-placed and skilled to lead the individual patient's assessment, dependent on the nature of a patient's presenting condition and surrounding circumstances. Consequently, and to aid efficient, thorough and timely patient assessment it is important that guidance for PT and OT is considered to avoid repetitious processes and practices in the AMU.

### 3. The Key Roles of Physiotherapy and Occupational Therapy in the AMU

The NHS is being organisationally challenged to respond to the demands of an ageing population. This demographic change suggests a rise of 35% in those over 65 by 2028, increasing pressure on hospital capacity, thereby potentially reducing efficiency of care and quality of patient experience on the current background of financial constraints. As a result there is a need to streamline processes, reduce waste and provide more efficient and patient-centred care pathways that bridge the primary and secondary care systems. AMUs are an example of modifying pathways and practice to achieve these ends. Full multidisciplinary assessment of complex needs patients, particularly older people who are more likely to have long term conditions, is essential if the correct pathway from the AMU is to be attained, whether discharge home or speciality admission. Consequently, all AMUs should have a full dedicated multidisciplinary team (MDT) to achieve best outcome for the acutely presenting patient.

The PT and OT should be a core part of the AMU MDT, due to their core professional roles of assessment and rehabilitation of mobility and function. They will therefore be key in facilitating timely, patient-focussed holistic assessment and intervention for patients who are frail, elderly and / or complex in functional and social care needs. The unique assessment skills that PT and OT deliver should therefore aid rapid risk assessment, support timely decision-making and as appropriate early discharge planning.

By providing prompt expert, skilled and proficient assessment at the Front Door the therapists directly contribute to:

- Improving the patient's journey by either facilitating early discharge or providing early therapy goal-setting and intervention at the start of a hospital journey.
- Reducing the length of stay of patients who do not require an in-patient hospital stay, particularly where community support can assist in achieving this goal.

- Rapid generation of onward referrals to intermediate care services thereby providing ongoing therapy intervention and enhanced supported early discharge.
- Promoting an approach to care that is holistic, team-based with patient-focussed outcomes, particularly for those with complex needs.
- Focussing on quality and value so that care and support for this patient group is safer, fair and person-centred, and delivered faster and closer to home where appropriate.
- Promoting partnership working between health and social care to ensure best value is achieved by shifting the balance of care to community services.

#### **4. Suggested Skills for Physiotherapists and Occupational Therapists in the AMU**

Depending on the size of the AMU the number of PT and OT staff required will vary. This section outlines suggestions of grades of staffing and their roles the AMU.

**Band 7 or above:**

This staff member will be the lead for their profession in the AMU. In addition to the skills, abilities and responsibilities expected of a band 7 PT / OT they may also:

- Be best placed to take role of specialist lead in acute medicine for the hospital
- Demonstrate higher-level diagnostic and prognostic clinical decision-making abilities for acute medical patients
- Lead and prioritise clinical service delivery for AMU on a daily basis
- Be responsible for acute medical therapy service development and evaluation

**Band 6:**

This qualified staff member is in a senior training role. They will be key on a day-to-day basis to clinical PT / OT service delivery in the AMU, and will deputise for the band 7 in their absence. In addition to the skills, abilities and responsibilities expected of a band 6 PT / OT clinical team member they will also:

- Demonstrate sound diagnostic and prognostic clinical decision-making abilities for acute medical patients
- Be able to prioritise clinical service delivery for AMU on a daily basis, and take lead of this role in their band 7's absence
- Assist in acute medical service development and evaluation

#### Band 5:

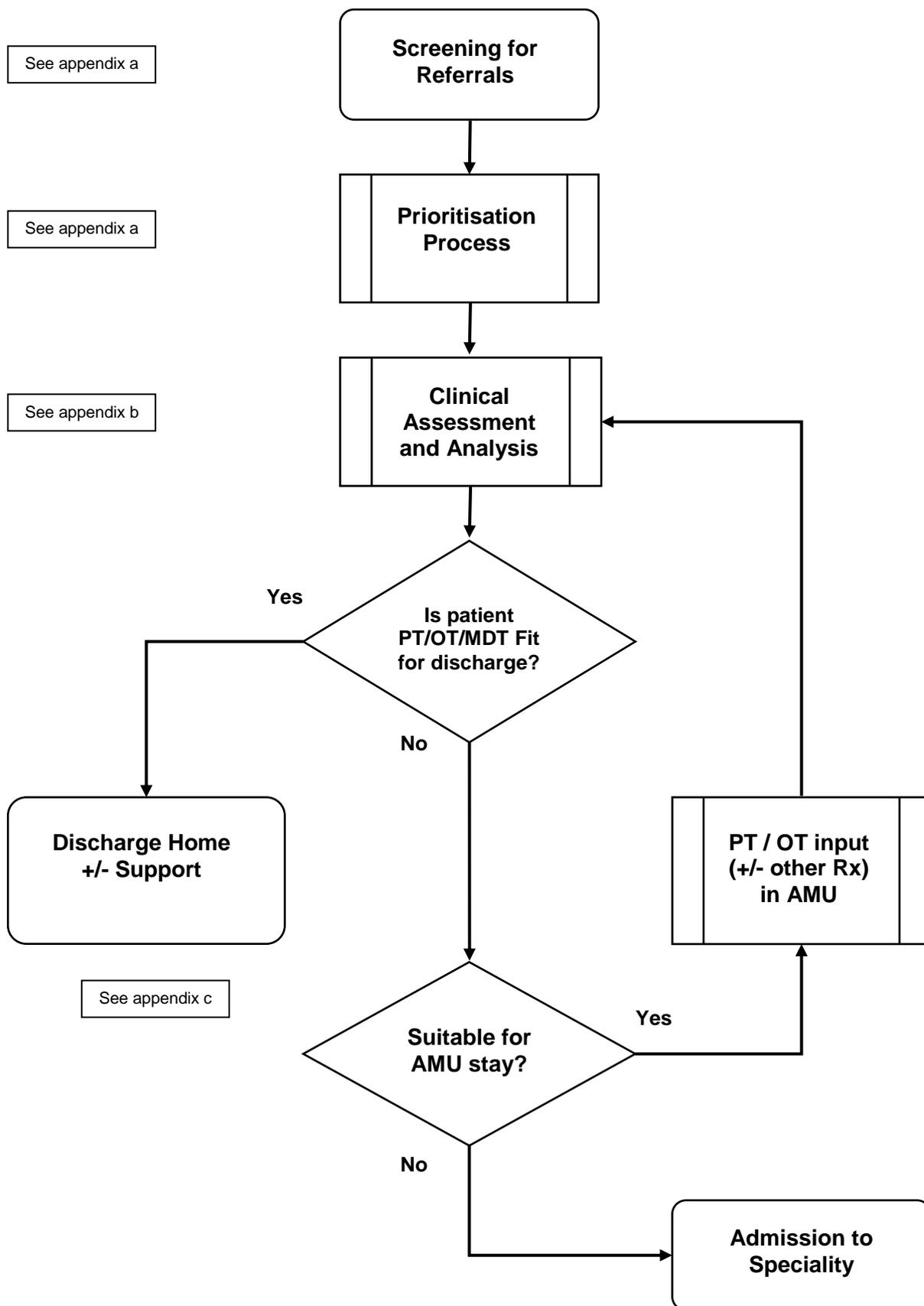
This grade of qualified staff member is in a junior training role. It is envisaged that the AMU may have a band 5 staff member assisting with PT/OT service delivery. Due to the wide variety, complexity and acuity of caseload in the AMU their learning needs and potential skills gap must be assessed and training plans instituted as indicated. These staff should display the general skills, abilities and responsibilities expected of a band 5 PT / OT clinical team member. They will be supervised and supported by a band 6 / 7 staff member of their own profession.

#### Band 2, 3 and 4:

These grades of staff will achieve workplace competency based training and potentially college-based vocational certificate training. These assistant practitioner PT / OT clinical team members will:

- Work within the scope and practice of the grade and competencies achieved
- Proactively gather information on acute patients to assist in accurate assessment and decision-making by the qualified therapists
- Communicate in a timely, relevant and effective manner in the AMU to ensure that rapid decision-making is achieved in this environment

## 5. Physiotherapy and Occupational Therapy Process: An Algorithm



## 6. Documentation in the AMU

All PT and OT interventions must be recorded in accordance with the Health Professions Council standards (Health and Care Professions Council, 2013), and adhere to Chartered Society of Physiotherapy (The Chartered Society of Physiotherapy, 2013) or College of Occupational Therapists (College of Occupational Therapists, 2010) documentation guidance. Local documentation policies should be adhered to, and these must also allow compliance with regulatory and professional body guidance (Health and Care Professions Council, 2012).

During a patient's short stay in the AMU a significant number of assessment outcomes and other results pertaining to the individual will need to be documented. To ensure clarity of communication in such a short time period multidisciplinary documentation in the AMU should be used and kept centrally in a unitary patient record (UPR). This may be in paper or electronic form. This will provide a logical, time-linear record of interventions, and will aid avoidance of unnecessary repetitious assessments. Clear and accessible recording of consent and capacity must be present in this document. Development of joint goal-setting and discharge planning should also be improved by use of the UPR format.

In the rapidly-changing environment of the AMU it is particularly important that documentation is written contemporaneously, preferably after each patient is assessed and treated. Writing clinical notes as a batch at the end of a shift will be likely to result in an entry being written out with the short timeline in which discharge or admit decisions are made, and could result in delay or confusion over patient placement decisions.

After initial assessment, a brief summary of PT and / or OT findings, followed by logically set goals and plan should be recorded. Goals must be set after discussion with both the patient and other relevant MDT members. These goals may be the primary determinants of whether a patient will achieve discharge from an AMU or if further rehabilitation is indicated. The use of the "SOAP"

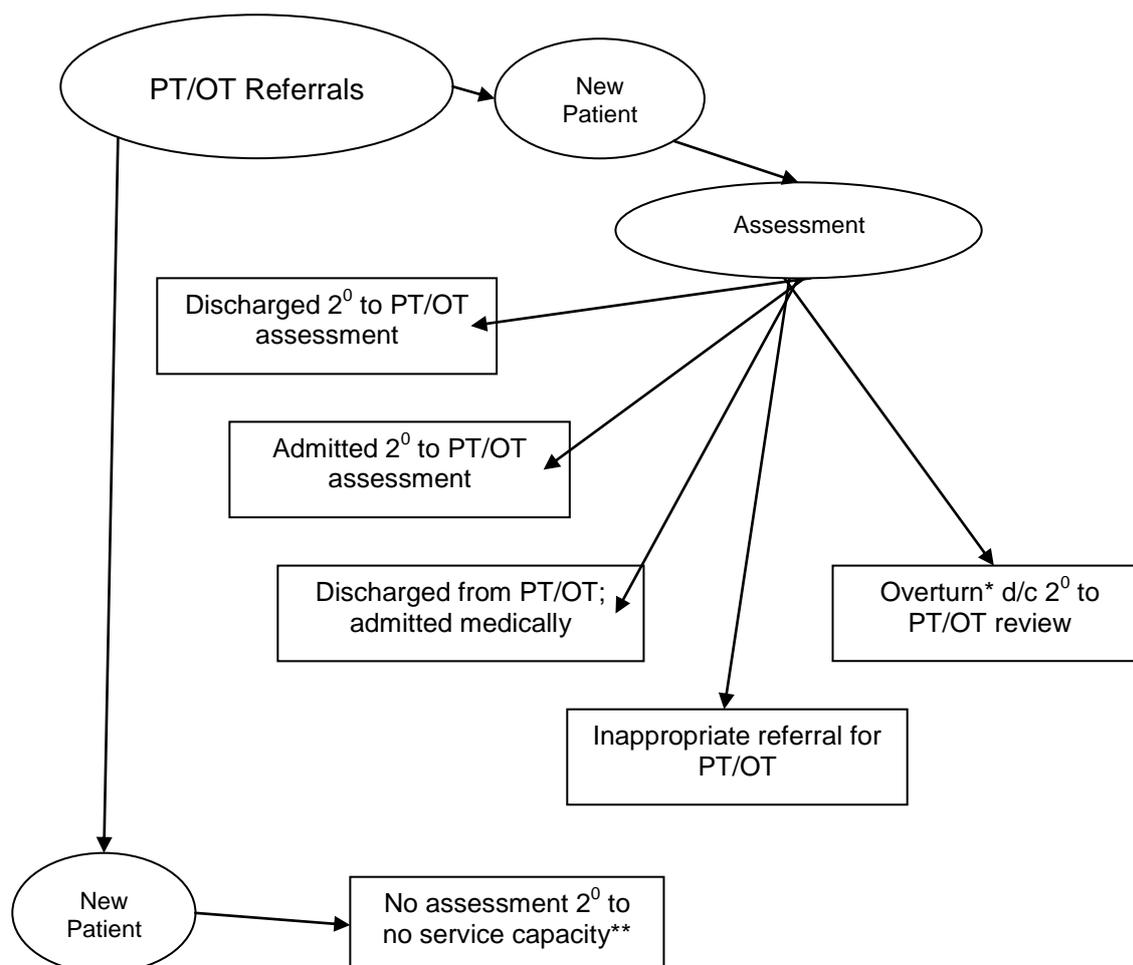
model (subjective, objective, assessment / analysis, plan) of documentation by PT and OT should be applied in the AMU to structure continuation notes and to prompt continual evaluation of an individual case (Gateley & Borcharding, 2012).

Assessment proformas may be of use for specific conditions, and should be the same format throughout a hospital site. For example, for stroke patients in AMU the same assessment proforma should be used as in the hospital's stroke unit. These are therefore of particular benefit for patients who will be admitted to a speciality from the AMU. Functional scoring where used should be recorded in either the UPR or on an assessment proforma. Scores typically used in PT and / or OT assessment most frequently include balance / mobility scales such as the Elderly Mobility Scale (Smith, 1994), Borg Balance Scale (Berg, et al., 1992), Tinetti (Tinetti et al. 1986), Timed Up and Go test (Podsiadlo & Richardson, 1991) and 10 metre timed walk (Peters, D. M., Fritz, S. L. & Krotish, D. E., 2013). For more functional aspects the FIM / FAM (Functional Independence Measure / Functional Activities Measure) (Turner-Stokes et al. 1999) and Barthel (Wade et al. 1988) are commonly used. The practicalities of their institution as assessment items for patients in AMU should be left to individual units and hospitals to determine, and no functional outcome score specific to the AMU patient group has yet been validated.

## 7. Activity Analysis

A basic level of quantification of a service's activity is important, particularly in the real-time, unscheduled environment that is the AMU. All therapy departments are likely to have a form of statistical collection to identify caseload, and local processes should be followed.

To identify the demands, capacity and impact of the PT/OT service in the AMU the schematic below demonstrates what factors could be considered as a way of quantifying these factors. Collection and audit of such data may aid demonstration of the value of PT/OT in the AMU. Routine collection of statistics should occur. The numbers of new referrals, interventions, and patient outcomes would give a routine baseline data set.



Notes:

- Number of New Patients and subsequent classification of actions as per boxes should be components of routine activity analysis.
- \*: “Overturn” discharge patient is one whom medical staff indicates admission required; however through PT/OT intervention discharge from AMU is achieved.
- \*\*: Lack of capacity is wholly undesirable. Any lack requires strategic / managerial action.

## 8. Appendices

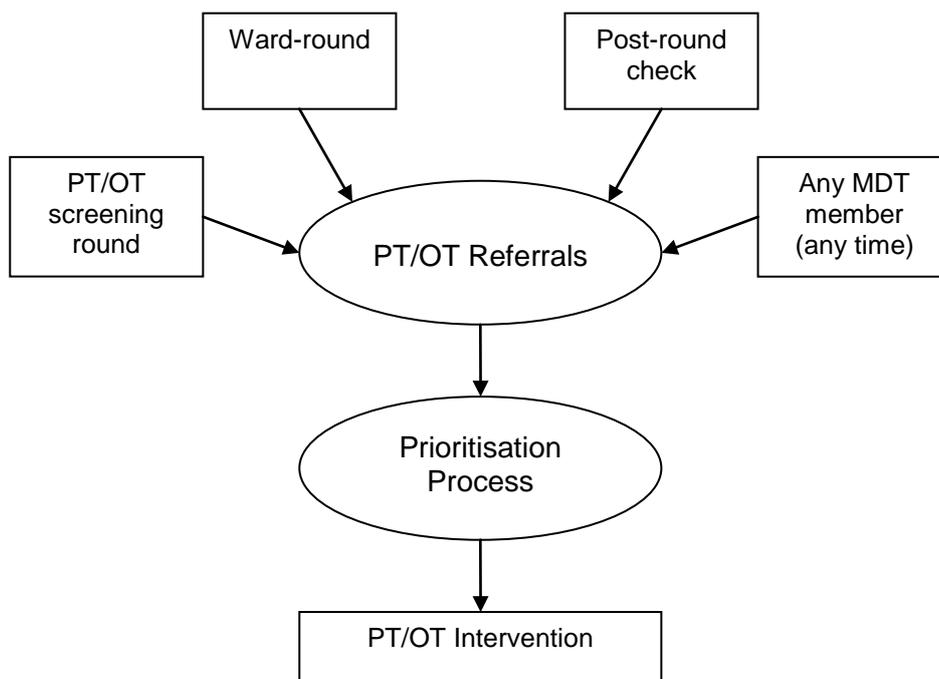
- a. Screening and Prioritisation of Referrals
- b. Components of Assessment
- c. Discharge Support

### a. Screening and Prioritisation of Referrals

In the busy environment of the AMU it is essential that patients are referred to the right member of the MDT in a timely manner to ensure efficient care, process and flow. The AMU should have a culture whereby any member of the MDT can refer a patient to another relevant team member; hence knowledge of each professional's role is similarly prevalent throughout the team. This gives an effective and robust "push and pull" mechanism for referrals.

AMUs will usually have an early-day consultant-led ward round, a process that may be repeated in the late afternoon. Alternatively there may be continuous presence of a senior medical team member on the unit operating real-time medical assessment and direction. It is not considered time-effective for the therapists to spend time on the ward rounds. Rather, the PT and OT team should have referral guidelines that are widely known throughout the unit's MDT. Referrals should be gathered by an early-day screening process by either member of the therapy team. A combination of post-ward round check and real-time referrals from any other MDT member should ensure capture of all potential caseload. The PT/OT service must be flexible to both accommodate real-time referrals and to action these by prompt assessment.

Once referrals are gathered prioritisation of caseload is essential to ensure that patients whom PT/OT can affect discharge for most readily are seen first. A scale of prioritisation will primarily consider the factor of complexity of the patient along with how their presenting acute medical problem has affected their function, and the likelihood of this illness being resolved during a short AMU stay. This requires a high level of clinical reasoning to ensure treatment order is logical.



## b. Components of Assessment

The therapist must have a high-level working knowledge of how to carry out and interpret a comprehensive subjective and objective assessment of many differing patient presentations in the AMU. All items of these assessment components must be considered where relevant with appropriate weight given to those that are key for the individual patient. A thorough comprehension of the patient's admission history and general medical status is essential.

### Subjective Components

#### Basic History:

Presenting complaint

History of presenting complaint

Past medical history (including falls history)

Drug history

Social history

#### Functional history:

Mobility (use of aids)

Falls history

Equipment (household / adaptations)

Continence history

#### Advocacy:

Individual capacity

Indicators of vulnerable adult status

Safeguarding alerts

#### Support:

Familial

Formal / agencies

Informal (e.g. friends / neighbours)

## Objective Components

Baseline core assessment:

Tone

Power

Range of Motion

Sensation, including pain

Proprioception

Coordination

Other components

(e.g. cranial nerves; vision)

Respiratory assessment (where relevant)

Cognition:

Mini-mental State Examination

Insight

Attention

Memory

Retention

Self-awareness

Planning and sequencing

Mood

Instruction-following

Functional and combined movement:

Balance

Transfers (e.g. lie↔sit↔stand)

Gait

Exercise tolerance

Stair climbing

Falls risk assessment

(Note: Functional score may be useful)

Functional Activities:

Self-care and toileting

Dressing

Kitchen assessment

Self-medication assessment

## Falls Assessment

Prevention or reduction of the number of falls in older people is best achieved through a multifactorial risk assessment. The components of a multi factorial assessment and intervention programme are outlined in the National Institute for Clinical Excellence Clinical Guideline 21: “The Assessment and Prevention of Falls in Older People” 2004 ([www.nice.org.uk](http://www.nice.org.uk)); similarly British Geriatric Society / American Geriatric Society Clinical Practice Guideline: “Prevention of Falls in Older Persons” 2010. Local policies and guidelines should also be followed.

The following table gives a broad outline of factors that the MDT should consider in the context of falls risk reduction.

Falls History on admission	Risk Factors Checklist on Assessment
Number of falls in past month / 12 months; Ability to get up from the fall; Injuries sustained.  Mechanism of fall: <ul style="list-style-type: none"> <li>• Loss of balance / dizziness</li> <li>• Collapse</li> <li>• Simple trip</li> </ul> Relevant medical history, for example: Neurological conditions; cardiac conditions; arthritis; bone health problems e.g. osteoporosis / fragility fractures; pain.	Vision: Reported / observed difficulty seeing objects / finding way around ward  Mobility: Unsafe / impulsive / forgets mobility aid / inappropriate aid  Transfers: Appears unsafe / over-reaches / impulsive  Behaviors: Confusion / disorientation; difficulty following instructions or non-compliant
Relevant pharmaceutical history: Polypharmacy;	Activities of Daily Living: Risk-taking behaviours reported or

<p>Specific medications for example; sedatives, antihypertensive, opiate analgesics, diuretics.</p> <p>Psychological status, for example: Anxiety; reduced insight or judgement; fear of falling.</p> <p>Cognition: Abbreviated Mental Test Score or Mini Mental State Examination</p> <p>Lifestyle factors: Alcohol intake Normal physical activity</p> <p>Nutrition: Underweight / low appetite</p> <p>Continence: Reported or known urgency / nocturia / accidents</p>	<p>observed</p> <p>Footwear: Unsafe footwear / inappropriate clothing</p> <p>Environment: Cluttered, stairs, trip hazards (e.g. rugs, flexes, floor coverings, unsafe thresholds, and pets.)</p> <p>Poor lighting, low furniture.</p> <p>No access to telephone or alarm call system</p> <p>Access to property, bins, garden, uneven ground or footpaths</p>
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## Clinical Judgement and Reasoning

Clinical judgement is based on the therapist's:

- Interactive knowledge
- Propositional knowledge, from an academic knowledge base
- Professional knowledge, or knowledge through practice
- Personal knowledge from individual reality and experience
- Information gained from a full therapy assessment, inclusive of MDT findings

Clinical reasoning is a critical skill and central to the therapists' professional autonomy. It is a complex process in a multidimensional context. It underlies the action taken in clinical situations and is based on facts, principles and experiences.

Clinical reasoning will involve any of the following:

- Procedural/scientific reasoning
- Interactive reasoning
- Narrative reasoning
- Conditional / predictive reasoning
- Ethical reasoning
- Pragmatic reasoning

## Consent

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care for a patient. This principle reflects the right of the patients to determine what happens to their own bodies, and is a fundamental part of good practice. A health professional who does not respect this principle may be liable both to legal action by the patient and action by their professional body. Employing bodies may also be liable for the actions of their staff. (Health and Care Professions Council, 2012)

### c. Discharge Support

Home Assessment / Discharge Visit:

Local Operational Home Assessment Guidelines should be adhered to.

CPR Status must always be observed, and familiarisation of local CPR guidelines is essential.

In exceptional circumstances, a home assessment / discharge visit may be carried out if the following issues are identified:

- Significant change in function/cognitive state
- Require provision of equipment at time of discharge
- Environmental/social concerns
- Sensory impairment precludes accurate hospital-based assessment

The purpose of the home assessment/discharge visit will be explained to the patient, carer/s and family. All involved will be made aware of the date/time of the assessment. All relevant persons involved, including the patient will be informed of the outcome of the visit and a copy of the home assessment report will be sent to all relevant persons. Should a discharge visit prove unsuccessful the patient will return to the hospital according to local procedures.

Hospital / Community Interface

Discharges may be classified as follows:

Simple: Patients with stable circumstances, minimal social care or equipment provision needs or where there are no concerns from care providers and is discharged with pre existing services.

Moderate needs: patients with a change in health not requiring treatment within the hospital setting, but requiring short-term social care and equipment provision.

Complex but rapid discharge: Patients with complex needs, but pre-existing arrangements meet the needs of patient and all care providers, including family. Patient is discharged with pre-existing or minor increase of services.

Complex and complicated discharge: This may include patient with multiple needs (e.g. frail elderly, terminal illness, palliative care needs, carer stress, housing issues, ongoing health needs), including high level of risks and anxiety surrounding potential discharge. There is a need for MDT co-ordination of services to ensure appropriate safe discharge planning.

Support services will vary with locale. The aim of these services should be to facilitate safe, effective and timely discharge. The following are generic examples of such services:

Intermediate care services:

Rapid response teams, community rehab teams, crisis management intervention teams

Uni-or Multiprofessionally-led services:

Day Hospital; Domiciliary OT /PT services; Specialty services such as Domiciliary COPD Physiotherapy services

Health and Social Care

Home care, Re-enablement services; Community Alarm Services; Telecare services

Other services:

Day centres; Voluntary organisations

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