# Six To Help Fix

## Acute medicine's tips to improve in-hospital flow

- Acute Medicine (AM), like the rest of the urgent and emergency care system is under extreme pressure.

- There are some **'must dos'** that should be implemented now, that will make a difference to patient care, safety and staff well-being through the coming Winter.

- These will form the basis of a more detailed piece of work, looking at medium and long-term strategies to provide consistent high-quality care, improve flow through the hospital and achieve better outcomes.

*If you would like advice, support or share examples of good practice in relation to the 'six to help fix' areas and/or you would like to be involved in the next stages of this work please contact us:* ***nhsi.iuec@nhs.net*** or *contact the* ***Society for Acute Medicine***

You can also join the **iUEC Network here**

NHS England and NHS Improvement

# Introduction

- These six recommendations are aimed to help hospitals manage the acute medical take during the winter months.

- It is not believed that they will solve all the issues that the winter demand will be bring but they will help to reduce some of the burden if adopted and followed in a comprehensive manner.

- They have been developed by and represent the views of acute physicians currently working in a range of clinical settings across the country. We are aware that ‘one size won’t fit all’ and that we need a flexible approach to help manage the winter pressures. We believe these recommendations will, however, help.

# Executive summary (1/2)

## 1. Protect Same Day Emergency Care (SDEC) Capacity and Function

- Same Day Emergency Care (SDEC) units should **not** be bedded.
- Avoid moving the staff to separate areas.

## 2. Diagnostics

- Diagnostics should be provided on the **basis of clinical need**; but areas such as AMU, SDEC, and ED must have the same level of access in terms of availability, priority and reporting times.

## 3. Ward Rounds and Handover

- Acute Medical Unit - Twice daily review on the AMU 7-days per week. An initial structured face-to face ward round followed by an afternoon board round and targeted review or a structured second ward round. All ward rounds should have a senior nurse present.
- Base medical/specialty wards - daily ward and board round on weekdays and board round with targeted patient reviews at weekends.

# Executive summary (2/2)

## 4. Workforce Optimisation

- Acute medicine teams should consider options to optimise workforce which can help deliver safe, high quality care to patients and service users.
- Review rotas and amend to meet peaks in demand and provide continuity of care where possible.
- Use evidence-based decision support tools (e.g. Shelford tool) for setting the nursing establishment, if not possible in the short term we recommend the minimum registered nurse:patient ratio to be 1:6 on the AMU.
- Occupational Therapist and Physiotherapist should provide extended 7-day working for patient assessment, management and to start the comprehensive geriatric assessment if needed.
- Direct extended 7-day pharmacy cover to the front door services and ward discharges.

## 5. Access to Acute Medicine

- Acute medicine teams should start to develop services to enable direct access, ensuring clinical conversations are used to direct patients to the most appropriate service/areas to meet their clinical needs.

## 6. Specialities and In-reach

- It must be recognised that medical patients who present as a emergency admission are the responsibility of all relevant specialties working within the hospital.

# 1. Protect SDEC Capacity & Function

- Same Day Emergency Care (SDEC) units should **not** be bedded. It should be seen as the option of last resort.  Whilst providing extra capacity overnight, this action is massively outweighed by the knock-on effect of a non-functioning SDEC unit. This is the impediment of patient flow well into the next day and importantly it prevents the early gains that are possible from decanting the ED first thing in the morning.
- Teams should review and update Site management plans and Operational Pressures Escalation Level (OPEL) framework to avoid SDEC being used as an escalation area.
- **In extremis** if SDEC is bedded, the trust should enact standard operating procedures to de-escalate and prioritise patients within ED and Acute Medicine based on clinical prioritisation rather than physical location. Teams should implement a reporting function so that any instances of the estate being used as an escalation area can be audited.
- The capacity of the SDEC includes the multi-disciplinary team, as well as, the physical areas. Staffing for SDEC must be protected so that staff are not relocated or reduced in numbers which will prevent it working optimally.
- SDEC must be supported by other specialties in a timely manner, especially where access to advice or specialist follow up is required.

*For further supporting information, follow the link below:*

***NHSE/I Maintaining SDEC through exceptional circumstances***

NHS England and NHS Improvement

# 2. Diagnostics

- Diagnostics should be provided on the **basis of clinical need**; but areas such as AMU, SDEC, and ED must have the same level of access in terms of availability, priority and reporting times.
- Access may be affected by the location of the AMU or SDEC and in that case efforts should be made to reduce this impediment e.g. increased portering, air tube/pod systems, bed side ultrasound etc.
- Pathology blood tests should be prioritised with the aim to provide results within one hour of the sample arriving to the lab for the common tests performed during an acute assessment of a patient.
- Point of care (PoC) testing with the appropriate quality assurance should be considered if it can facilitate urgent turnaround of results leading to earlier same day discharge especially where the pathology lab is on another geographical site.

*For further supporting information, follow links below:*

***Diagnostics: Recovery and Renewal***

***SAME DAY Strategy***

# 3. Ward Rounds and Handover

- Ward rounds are the key decision-making process to undertake clinical assessments and care planning with their patients. Coordination of assessments, plans and communication is essential for effective and efficient care. *RCP Modern ward rounds*
- To achieve adequate flow of patients through the hospital, ward rounds of all patients on the AMU should start in the morning, **ideally 08:00h or before**, with priority given to the unstable patients first, followed by those where discharge is anticipated and then the remainder *(example: S.H.O.P model)*
- A senior nurse who has been appropriately updated regarding the status of the patients, or the nurse responsible for the care of the patient **should** be present on the ward round, board rounds and handover.
- Further ongoing consultant assessment can be performed by either a rolling review complemented by a second structured ward or board round on the AMU.
- Opportunities to maximise training, including workplace-based assessments where relevant, should be taken during ward rounds and patient reviews.
- A handover **must** occur for each change of shift.

*For further supporting information, follow the links below:*

***RCP Acute Care Toolkit: Handover*** ***RCP Modern ward rounds***

***Modern ward round collaborative***

NHS England and NHS Improvement

# 4. Workforce optimisation

- Acute medicine teams should consider options to optimise workforce which can help deliver safe, high quality care to patients and service users.
- Options include:
  - Consider skills and competencies of all multi-disciplinary team members to increase workforce effectiveness including the use of criteria led discharge and use of non-medical prescribers.
  - Utilise additional roles to release clinical time; e.g. ward clerks, porters, patient flow coordinators, etc
  - Maximise use of technology to improve effectiveness of clinical time; e.g. adequate access to computers, use of electronic patient tracking systems, etc

*For further supporting information, follow the links below:*

**A better future for the NHS workforce**

**Clinical workforce optimisation**

**SAME DAY Strategy**

# 4a Medical staffing

- Acute medical illness is a 7-day problem, with patients just as likely to develop an acute illness requiring an emergency admission on a Saturday or Sunday as on a weekday. Evidence that patients admitted at weekends have poorer outcomes than those admitted on weekdays, and that patient mortality is higher at weekends, led to the Royal College of Physicians and the Society of Acute Medicine (SAM) recommending that a consultant physician – dedicated to the care of acutely ill patients – should be available on site to review patients for at least 12 hours a day, every day.

- Acute medicine teams should consider options to optimise medical workforce:
  - There should be adequate direct clinical care programmed activities within consultant job plans to provide senior cover for AM services including; acute take, SDEC and short stay.
  - Review rotas and amend to meet peaks in demand and provide continuity of care where possible.

*For further supporting information, follow the links below:*

**RCP Acute Care Toolkit 4: Delivering 12 hour-7-day consultant presence AMU**

**Staffing tools and demand/capacity informatic tools**

# 4b. Nurse staffing

- Patients on the AMU are often unstable and/or have a higher acuity of illness/disease than ward areas, requiring a higher concentration of dedicated and skilled nursing care. Staffing levels should be protected to ensure safe, timely care and hospital flow.
- The staffing levels should be considered not just in relation to the physical footprint (beds/trolleys) but the care demands which include admission, discharge and transfer, which assessment units by design, need to meet. Local data could inform this.
- The registered nurse:patient ratio should be preserved at a level reflective of the acuity and dependency of patients on the unit and to maintain safety and the efficient turnover of patients within the AMU. Biannual safe staffing audits should be used to inform establishments and record Care hours per Patient Day (typically using the Shelford safer nursing care tool) **If this is not possible in the short-term then a ratio of 1:6 should be viewed as the minimum required for safe and effective care.*
- Given the high volume, acuity and rapid turnover of patients, coordination of the team should be led by a dedicated, supernumerary, senior nurse on shift.
- The need for a registered nurse to accompany a patient transfer should be determined on a case by case basis and can be delegated to a competent member of staff.
- *For patients requiring enhanced care**, staffing needs to be increased** appropriately to the level of acuity and **1:2** for those units that provide Level 2 or HDU care in accordance with national enhanced care guidance.*

*For further supporting information, follow the links below:*

**Shelford safer nursing care tool** **Enhanced Care guidance**

NHS England and NHS Improvement

# 4c. Allied Health Professionals

- There should be a dedicated allied health professional (AHP) team with appropriate support workers on the AMU, who are appropriately trained to recognise and understand the complexities of acute medicine, particularly in the frail person. This team should be an integral part of the acute medical service.
- The AHP should provide an extended 7-day service, mirroring the patient demand. This is particularly important for occupational therapy (OT) and physiotherapy (PT). The AHP team should provide part of the complex geriatric assessment (CGA) for the frail older person.
    - Some AHPs such as speech and language need only to be available in a timely manner when contacted but this will require weekend working.
    - Other key individuals such as discharge co-ordinators, social care professionals should also provide support to the acute medical service.
- Pharmacy services should be available on and to the AMU during extended day working hours, 7-days per week to:
    - provide specialist advice
    - manage medicines reconciliation
    - prepare and dispense discharge medication(s) in a timely manner

*For further supporting information, follow the links below:*

**AHPs into action** **&** **Transformation of 7-day clinical pharmacy services**

NHS England and NHS Improvement

# 5. Access to Acute Medicine

- Acute medicine has a unique place to coordinate and direct the unselected medical take.
- Acute medicine teams should start to develop services to enable direct access across all parts of the healthcare system including 111, 999, primary care, community care and mental health so that patients are navigated to the right service, first time (SAME DAY strategy)
- Systems should be in place to ensure a clinical conversation can be used to direct patients to the most appropriate service/areas to meet their clinical needs.
- Where logistically possible Acute medicine units should aim to provide direct physical access to clinical appropriate patients accepted via consultation and arriving by ambulance.
- **SDEC/AMU must be supported by other specialties**, including HOT clinics, access to urgent advice and direct access to medical speciality beds. Internal professional standards should support this ensuring patients are seen by a senior clinician without delay.

*For further supporting information, follow the links below:*

**RCP Acute Care Toolkit 4: Delivering 12 hour-7-day consultant presence AMU**

**SAME DAY Strategy**

NHS England and NHS Improvement

# 6. Specialties and In-reach (1/3)

- It must be recognised that unselected general medical (GM) patients who present as a non-elective acute or emergency admission are the responsibility of all medical specialties working within the hospital.

- An acute physician should be present on the AMU, with no other responsibilities or duties for at least twelve hours per day, aiming to match the periods of highest demand to maximise on-take senior review rather than post-take.

- Acute physicians should be based on the AMU and SDEC and in-reach into ED at regular intervals i.e., when it is deemed by clinical interaction with the ED that the intervention will affect patients' outcome in a positive way (e.g., facilitating discharge, initiating appropriate treatment earlier) or if urgent expert clinical advice is needed.
    - Acute physician ED in-reach should not occur to the detriment of input to the AMU i.e., leaving the AMU understaffed or without senior decision being made because this will prevent the AMU being able to provide capacity for the ED to transfer patients out or decant patients.

# 6. Specialties and In-reach (2/3)

- Medical specialties in particular the three common specialties e.g., Cardiology, Geriatrics and Respiratory, should have dedicated time to in-reach onto the AMU seven days a week. Other acute specialties should be encouraged to do this. This support should be consultant-led.
    - Smaller specialties should have robust methods of less frequent in-reach that occurs in a timely manner.

- All acute medical specialties should provide responsive telephone advice by a consultant during peak hours to the community and the emergency floor within the hospital (ED, AMU and SDEC) to maximise the use of alternatives to admission.

- Specialty teams should be available to see a patient within 1 hour of referral; this should be a tier 3 clinician.
    - Specialties should aim to provide a specialty consultant of the week to improve continuity of care in case of repeated contacts regarding the same patient.
    - Specialty consultants should be able to book patients into **‘rapid access’, ‘hot’ clinics or ‘diagnostics hubs’** in a timely manner that prevent unnecessary hospital admission or SDEC attendance. This service should be available to the emergency floor for the out of normal working hours including weekends.

# 6. Specialties and In-reach (3/3)

- The AMU consultant should have the ability to direct patients from the AMU to the most appropriate downstream wards in order to facilitate flow through the hospital and ensuring the ‘right patient gets into the right bed’.
- If a patient is unable to move to a speciality ward in a timely way, then the speciality team should provide a structured management plan and continue to in-reach as clinically required.
- Speciality areas should not ring fence empty ward beds, nor block transfers to them at the expense of patients with generalist needs.
- The SDEC staff should actively look to pull patients from the ED and AMU to the SDEC.
    - Regular reviews of the ED should occur to ensure all appropriate patients are identified.
- Regular meetings should be instigated between the SDEC team, ED and medical specialties to review clinical criteria, up to date guidance and evidence to maximise appropriate use of SDEC and other assessment areas.

*For further supporting information, follow the links below:*

**RCP Acute Care Toolkits** **RCP Safe Medical Staffing**

**SDEC Collaboration Platform**

NHS England and NHS Improvement