# The Acute Medical Unit (the 'AMU')

The Acute Medical Unit (AMU) was defined more than 15 years ago by the Royal College of Physicians as 'a dedicated facility within a hospital that acts as the focus for acute medical care for patients that have presented as medical emergencies to hospitals or who have developed an acute medical illness while in hospital'.

There have been as many names for this unit as there are units in the NHS but the GiRFT report for Acute and General Medicine (to be published 2022) is expected to mandate that the term AMU is adopted across the NHS for these areas and that coding should match this

The AMU remains the area in the hospital to focus the work done by Acute Medicine teams despite the multiple facets of care delivered there by the multidisciplinary workforce

The precise roles of the AMU can vary from hospital to hospital but 'core functions' now include:

1) The assessment, investigation, and stabilisation of patients with an acute medical 'need' referred from the community or from Emergency Departments (ED)
2) The onwards referral of patients to an appropriate speciality bed base/team for ongoing specialist care
3) Continuing care of patients with an expected length of inpatient care no greater than 72 hours
4) Enhanced medical care (i.e. level 1) as outlined in the ICS document from 2021 which may include the delivery of Non-invasive Respiratory support (e.g. High Flow Nasal Oxygen, BiPAP)
5) Same Day Emergency Care – as described in the NHSE/RCPE/SAM documentation these areas are often embedded or adjacent to the AMU - AIM teams probably look after majority of those treated by SDEC pathways

A patient admitted to the AMU will receive care that will include the necessary investigations and management required until the patient is discharged, stabilised or transferred to a higher level of care. This means having level 1 care facilities in the AMU and immediate access to level 2 care when this is required.

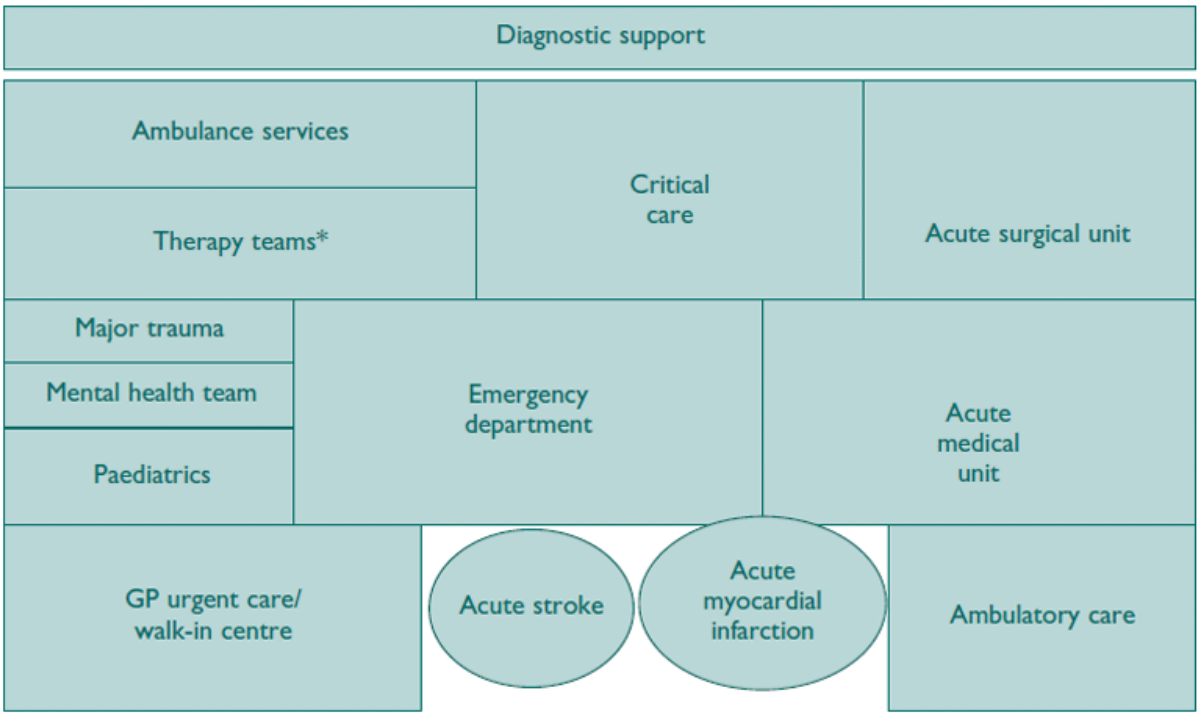
Currently it is estimated that at least 60% of all people admitted to UK hospitals for non-elective care needs are treated at some point by Acute Medicine teams.

To enable this, the AMU must

1) Have adequate bed numbers – the only previous 'recommendation' (from >15 years ago) was the bed base should be the size of the 24hr 'intake' + 10% - with monitoring to suit the needs of the patients (e.g. telemetry). GIRFT have added to this 'There should be adequate bed capacity to enable the potential 50% of patients admitted to the AMU who have a short stay to be discharged without being moved further into the hospital'
2) Have adequate staffing levels as per NHS guidance including in the Enhanced Care areas – see NHS recommendations, RCP Safer Staffing reports etc.
3) Have access to investigations deemed necessary in a time frame that reflects patient need – often needs to be comparable to that offered to the Emergency Departments
4) Have geographical adjacencies to support the flow of patients in and out of the unit in a timely fashion, the access to investigations and the 'accessory' areas such as SDEC
5) Have access to sufficient 'downstream' beds to meet the needs of the patients on the AMU requiring further care in a timely fashion to avoid 'exit block' of the AMU
6) Have access to specialist opinions as required (i.e. 'in reach') in a timely manner and of sufficient seniority to make a definitive management plan
7) Have adequate IT provision, administration, and managerial support
8) Have access to therapy/pharmacy services to enable timely treatment and discharge processes 7-days a week
9) Have estate that provides space for private/sensitive conversations with patients/families, the performing of necessary procedures, storage for the necessary equipment/medications and for staff rest and education.

Schematic diagrams of the support needed by an AMU

1) RCP 2007 *Acute medical care: the right person, in the right setting – first time*.




2) Adapted from GIRFT AIM/GIM report 2021

# AMU Configuration

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| **SAME DAY EMERGENCY CARE (SDEC) or AMBULATORY CARE** | | | |
| **AMU SHORT STAY BEDS** (LoS < 72 hours) | | | |
| **Seminar Room** – Handover/Teaching etc. | **Level 1 Area** (Enhanced care Area) CPAP, HFNO$_2$, NIV, Vasoactive Drugs | **AMU Assessment Area** | **Other Rooms**<br>- Offices<br>- Staff Room<br>- Procedure Room<br>- Waiting Area<br>- Relative/Discussion |

## Staffing the AMU

The AMU can be staffed by people from across the MDT fulfilling roles appropriate to their capabilities

## Medical roles

Consultants specialising in AIM – other consultants may also work 'sessions' on an AMU as in the 'acute take' but not be classed as Acute Medicine specialists

Trainees in AIM -ST4-7 doctors on the AIM training program or employed at this level by a trust training to join the Specialist Register via CESR process

Trainees in (G) IM – IMT 3 and ST4-7 in other specialities working in the acute unselected take

IMT/GPST/Foundation doctors

Advanced Level Practitioners

Physician Associates

For advice on staffing numbers people can refer to the RCP publications regarding 'Safe Staffing' (Report of a working party RCPL 2019 ) and the Acute Care toolkit 4: Delivering a 12-hour, 7-day consultant presence on the acute medical unit 2012
We would strongly recommend that senior decision makers (i.e. consultants, senior registrars) have no other commitments whilst working on the AMU

## Nursing

The AMU must be staffed with sufficient numbers and skill mix to ensure safe care. There is no published UK guidance on this beyond a generic 1 nurse for 8 patients but the Patient Safety Network recommended that the minimum should be 1 nurse for 5 patients -for further details see RCN publications

We would strongly recommend that a senior nurse Co-Ordinator is on duty 24/7 when they have no other patient focused tasks

More recently the NHS has published , under the auspices of recovering urgent care, the 'six to help fix' document which recommends a qualified staffing level on AMU of 1:6 with more required for enhanced areas and protecting the numbers on the units

**Allied health Professionals**

The AMU must have staff available from the following areas 7 days a week

Pharmacy

Physiotherapy

Occupational Therapy

Speech and Language Therapy

Mental Health practitioners

Social work

Administration

Clinical Educator

Others maybe including bed management/discharge teams

The AMU must have named operational and general managers responsible for the day to day running of the AMU

**SDEC staffing**

A working group under NHSE/I and chaired by Acute Medicine have developed a range of guidance notes and toolkits to aid teams staff their SDEC units. These are all available (free) on the NHS Futures platform.

It is also the first action point on the previously mentioned 'Six to help fix' document that states that SDEC must be protected i.e. not used as an inpatient area but also that its staff must also be maintained to provide the vital efficient service.

**Functions of the AMU/AIM team**

The AMU is the hub for the assessment and treatment to either discharge home or onward referral for patients referred with an acute medical need (excepting those requiring higher level or immediate specialist care e.g. acute stroke, CCU)

The AMU can include, depending on the local hospital estate, the SDEC unit and if delineated and staffed to recommended levels an enhanced care area. These can offer single organ support (e.g. BiPAP) above general ward level

The AMU must have access to physiological monitoring appropriate for the patients' acuity

The AMU is not to be used as a 'holding' area for patients requiring treatment by another speciality when a bed might not be immediately available in that speciality (e.g. surgery, ICU, mental health)

The AMU should not be an area to which patients with no acute medical needs are admitted (i.e. purely social needs)

Patients should not be referred to the AMU from downstream wards when HDU/ICU care is needed

The AMU team is defined as those working on the AMU for a shift but also those with responsibility for the smooth running of the unit/governance issues etc.

The AMU/SDEC team should not routinely work outside the AMU/SDEC unit during a rostered shift there

Consultants in AIM should not be routinely rostered to work in the EDs – it is perfectly reasonable for them to offer in reach assessments, but they should not be based there to the detriment of the skill mix on AMU