Worcestershire Acute Hospitals NHS Trust

Emergency Medicine Standard Operating Procedures

Worcestershire Royal Hospital Ambulatory Emergency Care Service (AEC) and Acute Med Take

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Approved by	
Date of Approval	
Date of next review This is the most current document and is to be used until a revised version is available	

Aim and scope of Standard Operating Procedure

The acute medical take refers to the process by which medical patients are seen as acute medical emergencies by the hospital. These patients should be seen in the Ambulatory Emergency care (AEC) or on the Medical Assessment unit (MAU).

Ambulatory Emergency Care (AEC) is an acute area of the trust that provides same day emergency care for ambulatory medical patients. These patients are accepted and pulled from both primary and secondary care with the aim to assess, diagnose, treat and discharge the same day. The service is Consultant led with Junior doctor and advanced practitioner support. The service will be adjacent to the MAU. The current coverage is a 5 day service 0730-1800, with plans to extend to seven day working 0730-2000. Patients are referred into the AEC via two routes; the medical triage sisters located on MAU and pulling systems from Accident and Emergency (A&E) to support the right treatment in the right place first time.

Target Staff Categories

One of the key pressures in emergency services is managing increasing demand.
The AEC approach and underlying principles describe a model where systems are redesigned to manage adult patients safely, providing same day emergency care. These patients are seen, diagnosed, treated and discharged on the same day. Some of these patients then continue their treatment at home or in a community setting, leaving admission to a hospital bed reserved only for those who are requiring in-patient services.

The core aims are to:

- Improves patient outcome and experience
- Prevent crowding in emergency departments
- Reduce unnecessary overnight hospital stays and hospital inpatient bed days
- Improve the 4 hour ED target

(Directory of Ambulatory Emergency Care for Adults)

Scope of this document

In 2016 the NHS Institute produced a Directory of Ambulatory Emergency Care for Adults with listed 34 potential medical AEC pathways.

The fundamental principles are around:

- Improving patient experience
- Reducing waits for tests
- Early and frequent senior review
- Improving patient flow
- Improving 4 hour ED target
- Improving ED internal professional standards
- Better outcomes for patients

There are 4 main models of AEC delivery:

- Passive – receive referrals
- Pathway driven – restricted to particular agreed pathways
- Pull – senior clinician takes calls for emergency referrals
- Process driven – all patients considered for AEC

The AEC model at the Worcestershire Royal Hospital will be based a combination of all existing models but the over-riding principle is that all patients as ambulatory until proven otherwise. AEC is strongly aligned with the following Trust strategic goals:

1. Deliver safe, high quality, compassionate patient care
2. Design healthcare around the needs of our patients with our partners
3. Ensure the Trust is financially viable and makes the best use of resources for our patients

Statement of Function

Location

The area currently used at Worcestershire Royal Hospital (WRH) is three clinic rooms and 11 flexible chair/trolley assessment spaces. The AEC clinic rooms and AEC assessment trolleys are to support activity only between the working hours of AEC i.e. 07.30am to 6pm (ultimately expanding to 0730am to 2000 7 days a week)

Patient Group
The AEC will see medical patients meeting the AEC criteria based on the AEC scoring protocol. (See appendix 1). Moving forward the AEC will be used to fully support the emergency pathway and the approach is that all medical referrals are assumed to be Ambulatory until clinically proven otherwise.

Patients will be either referred from GPs, community HCP or have been sourced from ED either being pushed/streamed by the ED team, pulled from A&E by members of the AEC or acute medical team or accepted via GP referrals to our triage team.

The AEC can be utilised to facilitate early discharge (and admission avoidance) for patients discharged from the MAU or A&E that require early review within 72 hours of discharge. During the normal working hours, these patients must be discussed with the triage or a member of the acute member team (AEC facilitator/Pull coordinator/CAP or Acute Med Reg) to ensure they are appropriate for AEC. Out of hours and after discussion with the medical registrar, an email must be sent to the generic AEC email stating who it the referral was discussed with member of the medical team.

Patients who are discharged for ambulatory type management are logged by AEC team on a 'Virtual Ward'. This allows the team to closely track the patient's under the AEC team while being managed as outpatients. On completion of their care on acute medicine the GP will be informed of their outcome in writing.

The Acute Medical Take

The acute medical take refers to the process by which medical patients are seen as acute medical emergencies by the hospital. At WRH there are two broad routes into the acute medical take as outlined in the diagram above (i.e. GP referrals to the medical triage nurses and self-referrals or paramedical patients presenting via ED).

At a time of referral to medicine the decision will be made as to the most appropriate area for the patient to be managed (AEC/MAU/ED Resus).

No medical patient will be managed on the MAU corridor

Patients who are medically unstable and require a resuscitation room should be managed in ED. Patients who are medically unstable but not requiring a resuscitation room OR are definite admissions to hospital should be admitted directly to MAU for processing. All other medical patients should be considered potentially ambulatory type patients and managed in the AEC space. This decision will be undertaken at the time of telephone triage or when review by the CAP/AEC pull facilitator.

Quality standards for Acute Medicine:

All quality standards in acute medicine service will aim to comply at least with the national standards (or better) as lay out by the society of Acute Medicine. All patients accepted by the medicine take will have a NEWS score <15 minutes of arrive to the AEC/MAU, clerked <2hrs (local internal standard) and consultant review <4hrs (local internal standard) during the hours 8am to 6pm (or <14hrs between 6pm and 8am).

This activity will be tracked using Patient First and monitored as part of the departmental KPIs. Other standards in line with quality standards as per trust guidelines will also be monitored regularly.

Process & Capacity

MAU patients: Patient may be admitted to MAU 24hrs in the day. This will compromise of patients who are accepted as referrals from GPs or from ED that are definite admissions to medicine and are not requiring management in a resuscitation space or do not have an already well defined referral pathway. (e.g. Fast positive CVAs or PCI pathway)

AEC patient cohort: Patients will be managed in AEC from 730am to 8pm. They will compromise of patients who are accepted referrals from GPs or ED that are potentially have the potential for same day discharge. The last patient admitted into AEC would be at 6pm.

In flow from ED to AEC (or MAU):
Patients can be sourced from ED for acute medicine via two methods (PULL/PUSH). The absence of an appropriate space in AEC or MAU to pull a patient into from the ED will be escalated in line with trust escalation policy and a datix will be completed.

PUSH:
Patients can be PUSHED (referred/streamed) into the medicine at multiple stages of their patient journey (i.e. at pre hospital triage, at ED triage, at SIAN area or from within the ED department)

Method of PUSH:
From 8am to 530pm: Patients are referred to the Medical Triage team, the PULL coordinator or the CAP and it would be determined if they are appropriate for AEC/MAU (see Appendix 4 for referral to medicine cascade).

From 530PM to 730pm: Patients are referred to the Medical Triage team and it would be determined if they are appropriate for MAU or to be brought back to AEC the following day.

From 730pm to 8am & Weekends: Referrals into medicine is via the RMO on Bleep 697 or Med Reg on bleep 698.

Rules of PUSH:
Any patient who potentially can be discharged in <4hr from ED and do not require medical advice should be remain in the ED pathway.

Once a patient has been accepted to medicine they will be moved immediately from ED to the next most appropriate place for their care. This move should not take longer than 30mintues.

The time of referral to medicine to the time of review by medicine should be no longer than 1hr.

The ED team where appropriate will try to facilitate initial investigations (including bloods, ECGs, x-rays) before transfer to the acute medicine footprint to minimize delays in investigations and management of these patients.

Any patients seen out of hours that require referral to AEC must be discussed with the medical registrar on call and then an email is sent to AEC email outlining the patient details, the reason for referral, what investigations have been undertaken, the consultant responsible for the care of the patient and a copy of the scanned A&E notes must be sent to AEC. (See Appendix 6 with details with what is needed in the AEC referral letter.)

PULL:
The PULL in ED requires a quick but comprehensive review of all patients in all areas the department to see if any patients suitable for the AEC process or direct triage to medicine.

The PULL from ED will be undertaken by the CAP & Pull coordinators at regular intervals throughout the day or when requested by ED/Acute Physician (esp if there is a surge in the ED).

Timings for the formal PULL include the following: 730am, 11am, 230pm and 530pm (to allow pull into AEC by 6pm and a minimum of 120minutes turnaround time for the last patient).

7.30am PULL: The night coordinator on MAU will laise with the night coordinator in ED to identify patients admitted to ED overnight that are suitable for AEC. The Triage nurse/AEC faciliator will start their morning in ED to confirm the patients appropriate to be pulled and begin the PULL process.

Rules of PULL:
Once a patient has been accepted to medicine they will be moved immediately from ED to the next most appropriate place for their care. This move should not take longer than 30mintues.

If there are patients within ED that are suitable for AEC but no capacity to do so, the trust escaltion process will be followed and a datix will be filled document the insufficent capacity in the AEC/MAU footprint

Patients are being pulled from ED, where appropraite will have all intial investigations such a bloods/blood cultures/CXR undertake before the move to medicine to minimize delays in the patient management.

Cases that may be amenable to AEC management:

The following presenting complaints have been taken from the AEC directory and can act as a guide of what presenting complaints are can potentially be PUSHED to AEC. This is not an exhaustive list and so any patient in ED felt to be appropriate for AEC can be discussed with the triage/AEC team if they are uncertain.

The exception for all the presenting complaints below is that these patients are haemodynamically stable; do not require IV treatment that needs cardiac monitoring or GIT bleed patients requiring blood transfusions.

Conditions potentially amenable to AEC care sourced from the AEC directory

Acute headache (including SAH/GCA)
Abnormal LFTs (painless jaundice)
Anaemia
Arrhythmia – AF
Chest pain – low risk
CCF
Cellulitis
DVT (not suitable to alternative pathway)
Diabetes – (not DKA)
Epilepsy (1st Fit)
Electrolyte disturbance
Syncope
GIT bleeds – stable
Inflammatory bowel disease flare not requiring admission
LRTI – with or without COPD
Suspected Neutropenic sepsis
Oesophageal stenosis
PEG related complications
Worsening eGFR/ AKI
Uncomplicated UIT/pyelonephritis
Pharmacological overdoses
Poorly controlled hypertension

Cases not for AEC
Medical patients requiring admission with well-established pathways (such as Stroke Thrombolysis pathway or PCI pathways, unstable medical cases (NEWS>4) or infectious cases that require isolation will not be managed in the AEC. They will be directed to either ED or a side room in MAU or elsewhere in hospital. Exclusion criteria also includes patients with established pathways e.g. uncomplicated DVT/Preg patients with suspected PE/TIA pathways or CVA appropriate for stroke assessment therapy.

AEC Treatment Areas:
There are 11 flexible trolly/chair assessment spaces and three rooms for clinical assessment and management of patients in the AEC.

Treatment chairs can be used for stable patient for delivery of IV fluids, antibiotics and other oral medications.

The trolleyed area can be used for assessment of patients who are not fit-to-sit such as GIT bleeds who are still amenable to same day discharge. This trolleyed area can also be used to undertake procedures such as lumbar punctures, peritoneal taps and drain placements

These treatment areas will be equipped with moveable curtained partitions that can be shifted in emergency to increase the size of the cubical spaces to suit the needs of the emergency team.

In line with privacy and dignity requirements for patients in a mixed sex assessment area all patients should be fully dressed and not in night ware

Patient well-being: Cold Food and drink will be available to the patient throughout the day.

New vs Follow up patients:
Patients seen in AEC <72hrs after discharge from MAU/ED will be considered new patients if it is their first review in the AEC service

Follow up patients are patient who were previously seen in the AEC and require early review (within 72hrs) of their visit to AEC. These appointments will tend to be late morning, with a specific time of review and where ever possible will be seen by the acute physican who initally managed them to faciliate continuity of care

Every effort will undertaken to try to plan the patient management so that follow ups are not required more than twice in the AEC service. Patient will then be referred ether back to their GPs for care or the appropriate subspecialites of medicine.

Closure of the AEC:
The AEC will close at 8pm. It will be locked and this area will not be used for any clinical activity till 730am when the morning staff arrive.

Beds will be given to MAU as they become available to facilitate admissions to medicine of patients streamed from GP to MAU or AEC patients that are found to require admission

At 8pm, there will be no patients left in the AEC with all patients either discharged or transferred into beds on the MAU/or appropriate speciality bed. No AEC patient is to be transferred to the MAU corridor awaiting bed placement.

Flow into and out of the Acute Medicine footprint:
The prompt supply of downstream capacity is vital to the smooth functioning of the AEC & MAU as assessment areas and so every effort will be made by the hospital capacity team to facilitate persistent capacity in the MAU (ideally at least 6 empty beds at the start of the night shift). This is to avoid congestion within the AEC and loss of its ability to function as a place to process patients effectively and to have a receiving area for late arriving GP admissions or ED referrals.

Structure of the team and supporting services

The AEC/Acute take team will comprise the following: AEC facilitator, Coordinating Acute Physician (CAP), AEC consultant, ED acute physician, Triage nursing team, the take junior doctors, the MAU junior team including MAU junior doctors, advance nursing and pharmacy practitioners, physician's associates, pharmacists, Health care assistance and a ward clerk. Among this team there will be a nominated person who is the Pull Coordinator for the day. (More details of the new roles below).

The on call medical team will be based in AEC.

Daily Acute Medical Take Team

8.30 am to 7pm - CAP - Coordinating Acute Physician (this role will be combined with AEC AP when staffing levels do not permit an allocated AP)
8.30 am to 730pm - AEC AP - AEC Acute Physician
8.30 am to 5pm - ED AP - ED Acute Physician
5pm to 9pm - Gen Med consultant oncall
9am to 9.30pm - Acute Medical Registrar (9pm to 945am - Night Acute Med Reg)
9am to 9.30pm - RMO (9pm to 945am - Night RMO)
12 midday to 12 midnight - SHO medicine
3pm to 1am - SHO medicine
7.30 am to 8pm - AEC Facilitator (Senior Nurse)
7.30 am to 8pm - Acute Med Triage nursing team
7.30 am to 8pm - AEC Advance care practitioners (ANP/APP)
7.30 am to 8pm - Band 5 Staff Acute Med Nurse
7.30 am to 8pm - Acute Med HCA
7.30 am to 8pm - Acute Med Ward Clerk

Daily operation of the Unit:
730am: AEC will open when the morning staff arrive. The PULL coordinator will go to ED at the start of their shift to confirm the appropriateness of the patients allocated for AEC and initiate the morning pull. All appropriate patients should be in AEC by 8am.

830am: **AEC safety huddle**: allocation of daily roles (AEC facilitator/PULL coordinator/Triage/AEC consultant/Junior clerking team/HCA/ward clerk). Board round of patients within the AEC

9am: The Night oncall junior medical team handover to the day on call take team in AEC. The night RMO or registrar is expected to touch base with the Triage sisters to insure acute medicine expected list is up to date.

11am: PULL from ED

1.30pm: Board round (in attendance: Consultant/AEC junior team/AEC shift facilitator)

2.30pm: PULL from ED

5pm: Handover & Board round (in attendance: Gen Med Consultant on take/AEC junior team/AEC shift facilitator/AEC Consultant)

6pm: PULL from ED

8pm: AEC closed. (All medical patients should have been discharged home or admitted into beds.)

Patient Clerking process:
All patients that arrive to AEC will have the following undertaken:

- Be booked into Oasis by the receptionist and be given an AEC patient information leaflet to manage the patients' expectation while in the AEC service and a feedback form.

- Have a NEWS score within 15mins of arrival, clerked within 2hrs of arrival and senior decision maker review within 4hrs of arrival.

- Nursing Documentation: Before DTA - care comfort assessment/skin map & waterlow score

- A named member of the junior team (ANP/Junior doctor/PA/APP) allocated to them as identified on the patient first system. This team member will be responsible for the clerking and processing of this patient under consultant supervision.

- *Post take reviews from 830am to 5pm will be by an Acute Physician and from 5pm to 8pm the On Call Medical consultant. (In time, there will be an acute physician on site supporting AEC and the evening take till 7pm.)*

- At discharge a TTOs will be dispensed via CAS PACs or via Pharmacy. The ward clerk will be expected to collect feedback form from the patient at the time of discharge.

Senior decision maker and Posts take review:
There will be a consultant review or review by appropriate speciality consultant <4hrs of admission during the hours 8am to 6pm (or <14hrs between 6pm and 8am).

The general medicine consultant on take after 5pm is expected to have post taked all patients who have arrived before 8pm before leaving the hospital to then consultant on call cover from home.

The AEC consultant will be on site till 730pm supporting the processing of AEC patients an working toward the closure of the unit at 8pm.

After 5pm, the General Medicine on call consultant and AEC consultant are expected to flex their role to support acute take in ED, MAU and AEC as the activity of the take dictates.

Overnight all FY1 patients will have review by a senior decision maker (registrar) and the RMO is expected to discuss their cases with the oncall registrar.

No patient is to leave the acute medicine footprint or ED at any time during the 24hr period without senior decision maker review.

Speciality In-Reach to AEC
When appropriate, sub-specialities of medicine will be asked to review patients in the AEC environment. This is to facilitate best practice and hopefully avoid unnecessary admission to hospital. Any patients referred for a speciality opinion have this review within 1hr of referral. If admission is required this should be into the appropriate speciality bed. If follow up is required this should be in the appropriate speciality area.

This in-reach can be undertaken the following day if safe enough to do so and the speciality gives a specific time for the patient to return to the AEC. Alternatively, the patient can be redirected to a hot clinic slot if this is safe to do so and in the patient's best interest

Rapid response
Elderly patients admitted to the acute medicine footprint that are medically fit and appropriate for a rapid discharge process will be referred for review by the Rapid response team. This team will be available to review of patients in ED/MAU/AEC and the Short stay ward, undertake their specialist assessment and where possible access their resources to facilitate rapid turnaround and discharge.

Diagnostic service
Investigations:
All investigations will be undertaken in as timely a manner as is possible to facilitate the rapid processing and hopefully discharge of patients.

Blood investigations:
All blood samples label as AEC will be processed as a matter of urgency and results where possible will be available within 1hr of the sample arriving to the lab. Blood test results are accessed via the ICE system and radiology via PACS

Radiology investigations:
Where possible an appointment will be provided within 24hrs if this facilitates a safe discharge of the patient. Currently there is access to dedicated CT & MRI slots

Once an investigation has been undertaken, a result will be available 2hrs of the imaging.

Cardiac investigations:
An echo slot will be made available at least twice week. If the acute med team has not booked the available echo slot then it can be made available for inpatient use. There may be need for additional slots based on the case mix presenting to AEC.

A 24hr monitor will be made available at least twice weekly for AEC patients especially for patients that are actively symptomatic but safe enough for discharge. There may be need for additional slots based on the case mix presenting to AEC

Endoscopy: There is an emergency endoscopy list every morning and afternoon in the GI suite. GIT bleeds brought into AEC must be kept nil by mouth until it is decided they do not require an OGD.

Discharge process:
Patients in AEC may be discharged home or into the main hospital.

Discharge home: All patients seen in the AEC clinic will have a discharge letter typed on Bluespire sent out to the patients GP on the day of discharge. The letter will be typed of the junior team member that has clerked the patient. A copy of this discharge letter will be sent electronically to the acute medical secretary.

Admission to hospital:
Should a patient require admission the bed manager will be informed and a suitable bed will obtained be obtained within 1hr of decision to admit (DTA). The MAU coordinator must also be informed of this patient requiring admission to guide the correct destination for the patient. Every effort will be made to get the right patient into the right bed first time.

Beds coming up in the hospital must be available to the MAU coordinator in real time as they become available to allow smooth inflow of admissions to medicine and prevent bottle necks

Destination wards (Signposting function of Acute Med):
The best destination ward will be determined by the MAU coordinator in discussion with the consultant or registrar. The destination wards will be determined based on the expected length of stay and if the patient would benefit from a specific speciality bed. LOS <3days and not requiring a speciality bed can be managed on short stay ward. LOS> 3 days and not requiring a specific speciality can be sent to **any** medical ward (so called Gen Med patient).

TTOs: TTOs where possible will be dispensed from “cas pacs” that are kept in the department. There is a 30min turnaround time from the arrival of the prescription to pharmacy to the TTOs being available for collection. This is to facilitate rapid discharged from hospital. Any patient who is well enough to walk to pharmacy (or has a relative that can undertake this on their behalf) will be encouraged to fill their prescriptions themselves to facilitate more rapid discharge from the department

Transport: A turnaround time of 1hr is expected for discharge from any patient leaving the AEC.

Workflow
Method of referrals – GP referrals
All General Practitioners (GPs) can access the service via the medical triage sisters via switchboard on 01905 763333 Bleep 417 or via ext. 30033/36203 during the hours of 8am –730pm week days. The triage sister assesses the suitability of all patients as potentially ambulatory appropriate

Method of referral – ED patients direct to AEC consultant/ PULL coordinator
The PULL coordinator can be bleeped though out the day by the ED team to refer patients. These cases may required dicusssion with the AEC consultant. Patients can also be referred by discussion with the triage nurse or any other member of the AEC team. Patients that are accepted must be moved as soon as possible to AEC to avoid delays in assessment or treatment.

Method of referral – follow up from Emergency Care / MAU
Appointments for patients requiring early review (within 1 to 2 days) on discharge from ED/MAU can be book with the Triage nurse on the numbers above or out of hours by email referral to the generic AEC email. (See PUSH AND PULL above)

Responsibilities and duties
Medical cover
Current medical lead – Dr David Jenkins

The current substantive consultants are:
Dr Miguel Marimon Ortiz De Zarate
Dr Weng Oh
Dr Anuroop Vishwanth (NHS locum)
Dr Aruna Maharaj (locum)
Dr Ashraf Niazi (locum)

Nursing team
Matron Jo Adams
Ward Manager MAU/AEC Laura Jupp

The current triage sisters are:
Sr Lizbeth Neel
Sr Nicky Thomas
Sr Alison Richings

The current Nurse Practitioner team is:
Lisa Valentine
Julie Lee

The current Advanced Pharmacy Practitioner team is:
Lindsey Smith
Matthew Harris

Ward Clerks : Caroline Campion (rest to be filled in)

Roles and Responsibilities:
Coordinating Acute Physician (CAP): This will be a nominated acute physician who will be responsible for the overall flow of the take activities and also be the AEC champion on the ED shop floor. This consultant will be part of the team that can do early senior review in ED to pull the right patients into the medical system (either directly admitted to Medicine/AEC) or facilitate rapid turn round and discharge where possible.

AEC facilitator: This will be an allocated member of the AEC team who is responsible for overseeing the smooth running of the area. The AEC facilitator will be mindful of the patients in the department and acts as an advocate for the AEC process. (Including challenging the patient process to minimize delays).

PULL coordinator: A member of the AEC team nominated on a daily basis to be responsible for the PULL from ED at the times listed above. He/She will carry Bleep??? and can be contacted though out the working hours of AEC to by the ED team if they find a patient they wish to push to AEC. They will join the CAP in the pull process in ED.

AEC Consultant: The AEC consultant will be responsible for the smooth running of the AEC process. He/She will attend the nominated board rounds to try to facilitate discharges from the department in preparation for the next PULL. They will have a bleep (Bleep???) that enables them to be easily contactable.

ED Acute Physician: The AEC consultant will be responsible for post taking medical patients clerked in ED. They will have a bleep (Bleep???) that enables them to be easily contactable.

On call medical team: This team comprises of an on call medical registrar (Bleep 698), a RMO (bleep 697) and multiples SHO grade medical doctors that arrive at various times during the 24hr period. Overnight there is also and FY1. (See staff list above for times of work).

During the hours of 9am and 930pm, Monday to Fridays the teams focus is to clerk and initiate initial management of acutely unwell medical admissions to ED/AEC and MAU and present these patients to the post take consultant. Each junior member of the team is responsible for all investigation and treatment initiated from the post take ward round and a discharge summary if there is a decision to discharge the patient. The on call medical team will be based on the AEC and work in harmony with the acute medical junior and senior team seeing patients in AEC/MAU and in-reaching into ED to clerk patients that have not managed to make it into the acute medicine footprint.

During the hours of 9pm to 9am Monday to Friday and over the weekend on call acute medicine team is responsible clerking and initial management of all admissions to medicine overnight and for the care of medical patients in all areas of the hospital. There are additional team members in place to support this expanded role (additional Ward cover reg and SHO on weekends).

For the entire 24hrs, the acute medical team is part of the cardiac arrest team for the hospital.

Junior acute medical / advanced practice team (ANPs/APP/PAs): Responsible for the clerking and processing of this patient under consultant supervision. This includes the requesting of appropriate investigations, post taking the patient with the AEC or on call consultant and writing communications to GPs for patients being discharged

Staff Nurse (band 5): Is responsible for the initial NEWS on arrival to hospital and observations every 4hrs whilst in the department unless this NEWS score dictates sooner review. The HCA role also includes phlebotomy, undertaking ECGs and ensure that food and drink are available and offered on a regular basis to patients

Porters: There will be a porter available who is dedicated to focusing to the processing of patients in AEC.

Ward Clerk: Will meet and greet patients and relatives, book transport, enter patient's details on the system, facilitate friends and family, organise portering of patients, collate follow up information and book follow up appointments with GPs.

Interdepartmental relationships / specialist and support service
Medical Assessment Unit

Emergency Department

Sub-specialities – including but not limited to Resp, Renal. Stroke, Cardiology, Dermatology, Endocrine, Gastroenterology, Rheumatology, General Surgery, T&O and ENT. Radiology

Pathology

Clinical Investigations

Medical Wards

Physiotherapy and Occupational Therapy via bleep

Specialist nurses

Alcohol liaison

Rapid response team

Access to discharge liaison nurses / Hospital at Home / IV antibiotic at home team and community services via designated telephone numbers.

This document will be reviewed within six months of the launch of the new AEC assessment space.

Worcestershire Acute Hospitals NHS Trust

Appendix 1 - Medical Referrals & AEC Scoring Performa

Date: ……..... Time: …… Referral taken by: ……..…

Patient Name: ……..

Date of Birth: ……..

NHS No: .....

Address:
……..
…

……..
.....…

Patient Contact Number ……

Referrer's Name: …… GP Practice/ Dept:…….....
Problem and provisional diagnosis:

Referral For? AECU ☐ MAU ☐ ED ☐ Specialist Nurse ☐

Referral Information:

PMH:

Ambulatory (AEC) Suitability Questions For Transfer from ED (08:00-17:30):	**Yes**	**No**
1. Do you think the patient is suitable to sit in a waiting room on a chair, wheelchair or receive a brief treatment intervention on a trolley?		
2. The patient should not be critical ill:		
• Pulse <130 (with systolic BP>100 if pulse >100)		
• Systolic BP >90 (with pulse <100 if BP<100).		
• Sats on usual oxygen > 92% or >88% if normally on home oxygen.		
• GCS = 15 (or 14 in the case of known dementia).		
3. The patient could cope being discharged with their current package of care.		
4. Specific condition considerations:		
• Cardiac Chest Pain: Should be assessed in ED. Patients should not have ongoing ischaemic chest pain. A normal ECG is required (see chest pain pathway).		
• Upper GI bleed: Patients should be aged <60, have a pulse<100 and systolic BP>100 without liver, cardiac, renal disease or cancer.		
• Cancer Patients: The patient should not be potentially neutropaenic.		

If the answer to all of these questions is Yes patient is suitable for AEC. If the answer to any of the above questions is No, AEC is not suitable.

Suitable for: AEC/Triage Medical Admission Unit Emergency Department

Any Other Comments:

Appendix 2: ED Referrals to AEC

The Ambulatory Emergency Care (AEC) has been designed to provide a rapid medical consultant opinion and same day medical diagnostic service for patients who are likely to be suitable for same day discharge but would otherwise be admitted to a medical bed for investigation. It is open from 7:30am until 8pm, Monday to Friday with the last referral to AEC at 530pm (arriving at no later than 6pm).

AEC is:

- An alternative route to a medical opinion and access to same-day diagnostic services for patients who would otherwise be admitted.

- A place where limited therapeutic interventions e.g. IV fluids, antibiotics, rate control medication could be given in patients who may only require a brief period of treatment before discharge on the same day.

- A place where a low risk patient could wait for a 3 hour troponin.

AEC is NOT:

- A replacement for primary care. Most medical conditions that do not require emergency admission should be advised to consult their GP who may refer to hospital if required.

- A replacement for speciality clinics. Specific conditions, including potential diagnoses of cancer are best dealt with in specific clinics. Access is via primary care. If it is not an emergency, the patient should be an outpatient.

- A reassurance service, providing routine follow-up and safety netting. If they are well enough to leave ED, review should be performed in general practice.

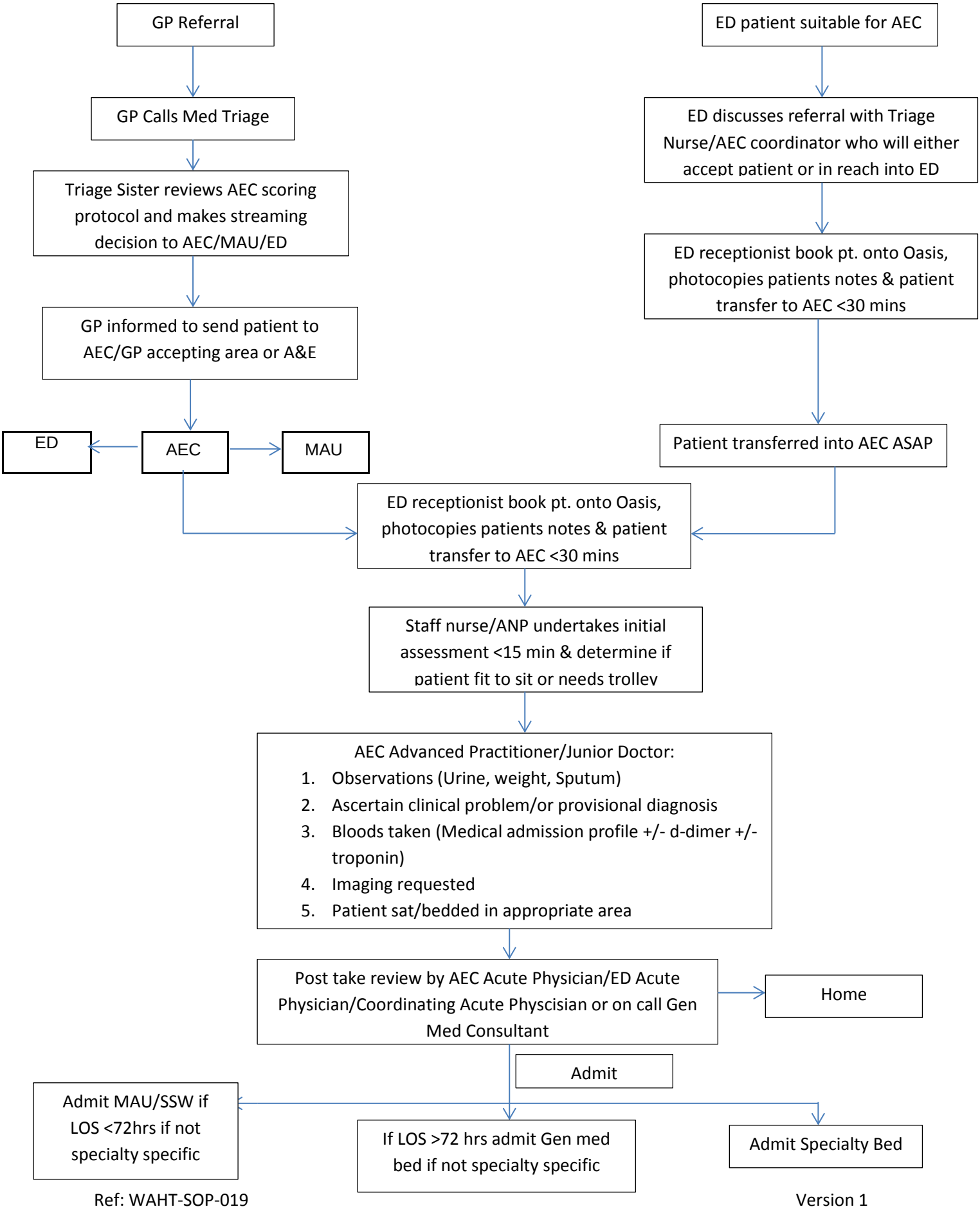
- Able to sort out complex social problems.

Ambulatory (AEC) Suitability Questions For Transfer from ED (08:00-17:30):	**Yes**	**No**
1. Do you think the patient could be safely discharged home before the AEC unit closes?		
2. Without the option of AEC would you be forced to admit the patient to a speciality or observation area?		
3. Do you think the patient is suitable to sit in a waiting room on a chair, wheelchair or receive a brief treatment intervention on a trolley?		
4. The patient should not be critical ill:		
• Pulse <130 (with systolic BP>100 if pulse >100)		
• Systolic BP >90 (with pulse <100 if BP<100).		
• Sats on usual oxygen > 92% or >88% if normally on home oxygen.		
• GCS = 15 (or 14 in the case of known dementia).		
5. The patient could cope being discharged with their current package of care.		
6. Specific condition considerations:		
• Cardiac Chest Pain: Should be assessed in ED as low risk first. Patients should not have ongoing ischaemic chest pain and a normal ECG (see TIMI score and chest pain pathway).		

• Upper GI bleed: Patients should be aged <60, have a pulse<100 and systolic BP>100 without liver, cardiac, renal disease or cancer. • Cancer Patients: The patient should not be potentially neutropaenic.		
If the answer to all of these questions is Yes, telephone or bring the notes round to AEC & discuss the patient/ handover with the consultant or senior sister. If the answer to any of the above questions is No, AEC is not suitable.		

Worcestershire Acute Hospitals NHS Trust

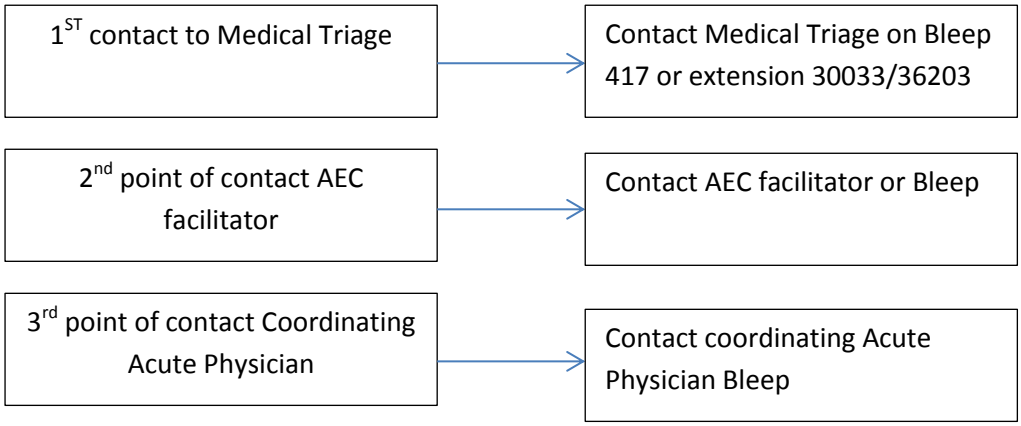
Appendix 3 – Acute Medicine Referral Pathway



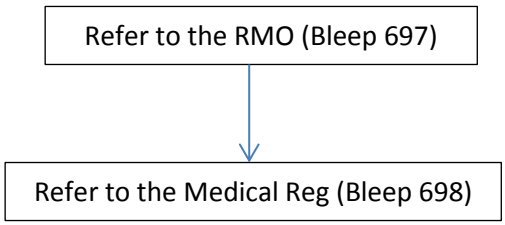
Appendix 4 – Acute Med Referral Pathway

During the 24hrs of take, if at any time there is a very sick patient that requires referral to medicine always refer directly to the Acute Medical registrar on Bleep 698

During the hours of 8am to 730pm please use the following referral escalation cascade of referral



During the hours of 730pm to 8am & Weekends please use this referral cascade:



Appendix 5 – Morning Handover

Morning handover: AEC office 09.00

1) PTWR starts at 8am

2) Reg (+/- FYI) post take their night patients first to enable them to peel off at about 9am for handover. The night SHO does not have to attend handover as more often they are not seeing ill patients on the ward and have more patients that need to be post-taked. They carry on with the post take ward round.

3) Morning handover from 09.00 – 09.20 (09.30 at w/e)

4) **In attendance**: Night reg, Day on call reg, night FY1, Day FY1 (bleep 656), AEC facilitator, Triage nurse, MAU coordinator, CAP)

At w/e in addition: ward reg, ward FY1 and community FY2

5) The handover of the wider hospital patients will be undertaken by the night Reg/FY1 contacting (either on the phone or in person) the appropriate wards around 8-830am in line with the different start times of the ward teams.

6) Objectives of handover

a. Introduction of who is present

b. Handover

i. number of patients left to clerk from previous shift

ii. sick patients in A&E and MAU

iii. at w/e run through ward jobs as per handover email

c. Identify if any on call staff fail to attend– to be escalated to medical staffing/on call consultant and inform acute medicine team.

d. Allocation of Cardiac Arrest /Medical Emergency team roles – Lead /Defib /Access /Notes

Appendix 6 – AEC Generic email: out of hours referral must be undertaken

DEAR ALL

From MONDAY 6TH MARCH 2017, The Department of Acute Medicine will have an established generic email address for referral of patients to AEC out of hours.

******NB: THIS EMAIL IS NOT MONITORED ON A WEEKEND******

WHO SHOULD BE REFERRED?

Any patients seen during the Acute Medical Take where early senior review within a couple days of discharge can facilitate an early discharge.

PROBLEMS EXPERIENCED:

PLEASE DON'T: Tell your patent to just come back; our team will contact them once the referral has been reviewed and is deemed appropriate.

We have had some patients told "you will see a neurologist tomorrow" or "your test will be definitely tomorrow" and they are unhappy this cannot be always facilitated. I am sure you are aware imaging & reviews are available 'as and when' via an emergency service.

Please remind your patients that they are coming back to another acute service and so their visit to hospital may take hours to an entire day depending on what tests/treatment they require. This information is very important to us as patient expectation has direct impact on patient experience when they return to hospital. (See attached information leaflet which can be given to the patient).

DURING HOURS	OUT OF HOURS
ALL patients to be referred to MEDICINE via the MEDICAL TRIAGE NURSES on Ext 30033 / 30818 BLEEP 417	Please ask your juniors to do a formal email referral to the following email address: **wah-tr.AEC@nhs.net** (can also copy into the email any person you may have spoken to about the referral.)

In the referral include the following information:

- Name of the referring consultant (copy that consultant into the email)
- Name of Patient and details such as hospital number & DOB & contact numbers
- A brief summary of the history and tests you have booked to facilitate the process
- Why is the patient being referred to AEC?
- Has you consultant arranged any other follow up for the patient?

And finally

- Where have you left the patients notes?

ANY CONCERNS:

We hope this stream lines the referral process into AEC. If there are any difficulties or you wish to provide feedback, please speak or email any senior nurses or doctors on the unit.

******NB: THIS EMAIL IS NOT MONITORED ON A WEEKEND******

Department of Acute Medicine, Worcester Royal Hospital, 02.03.2017