Department of Health

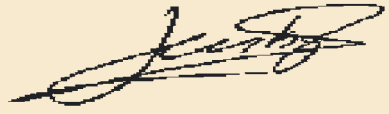
Welcome

Against a high level of demand, the improvements in emergency care are widely known, with the 98% operational standard now being met on a regular basis.

These guidelines on emergency medical and surgical admissions aim to help you extend the consistent, high quality provision of emergency care seen within the Emergency Department to the entire patient journey.

Many of you already work to these guidelines and they have been seen to provide both the best level of care and the best patient experience and help to sustain the operational standard.

Feedback: If you have any feedback about these guidelines, please email us at emergencycare@dh.gsi.gov.uk or phone us on 020 7633 4208.



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Overview

The emergency medical and surgical admissions process is made up of two broad stages:

1. Assessment
2. Admission

The basic principles of these guidelines include:

- Assess once to determine initial investigations and management
- Find out what is wrong accurately and quickly
- Ensure the patient goes to the right place for the right treatment, first time round;

Resulting in:

- Appropriate access to treatment; and
- Appropriate length of stay;

Supporting an organisational vision of quality where there are:

- No avoidable deaths or adverse incidents
- No delays
- No feelings of helplessness; and
- No unnecessary pain
- No waste

And addressing what we already know patients want – someone who:

- Knows what is wrong and explains it (diagnosis)
- Knows what to do and makes it happen (treatment plan)
- Communicates clearly and respectfully
- Treats them in a dignified manner in a clean environment.

The entire model is geared toward delivering the best possible standards of care through a focus on outputs rather than inputs.

The principles behind the two broad stages of assessment and admission are described in part one below.

Part two demonstrates these principles in practice with a case study. The remainder of the checklist describes the processes which need to be in place to support effective emergency medical and surgical admissions, guidelines on the establishment and commissioning of assessment units and descriptions of their various functions.

Part One – The principles of Assessment and Admission

Stage One – Assessment

Output: Assessment leads to a working diagnosis and the development of the most appropriate care plan, including the likely location of care provision (be it acute, community based or at home) and, if admitted, an estimated length of stay / estimated date of discharge.

Key Principles: Delays and duplication are avoided through assessment and investigation taking place once. This should be undertaken early on with a senior clinical decision maker.

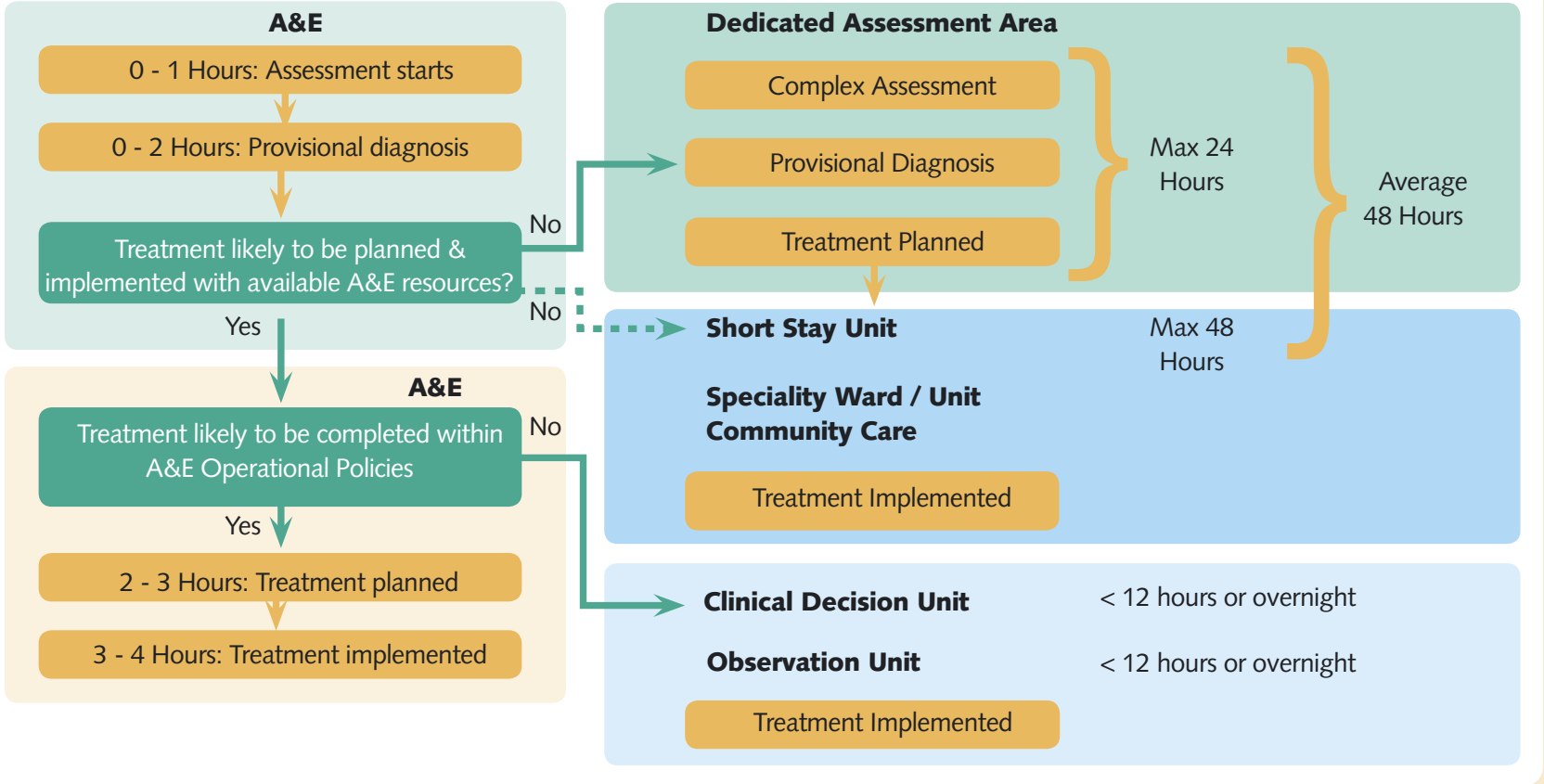
Where GPs and / or A&E departments quickly recognise that a patient's treatment cannot be planned and implemented with the available A&E resources, the patient is immediately referred for a full assessment in a dedicated area staffed by professionals free from other commitments with access to the appropriate range of diagnostics. GPs ensure appropriate use of the facility and that it is not used as an outpatient's clinic.

The Emergency Department also manages clinical decision units (CDUs) or observation units for patients who need further observation before a treatment plan can be developed. These are typically short stay areas delivering protocol driven care, treating predominantly three groups:

1. Rapid diagnosis to exclude potentially serious conditions
2. Short observation and reassessment, e.g. for head injuries
3. Predicted short course, e.g. some exacerbation of asthma.

Emergency Medical and Surgical Admissions

The assessment pathway could therefore be as follows:



Each area described in the model above has a dedicated and discrete function contributing to improved patient care.

Stage Two – Admissions

Output: Appropriate admission should eliminate any delay to initiation of care plan, ensure the patient has equal and fair access to the appropriate care provider and minimise length of stay.

Key Principles: All emergency admissions to specialist wards are made via a single point of contact.

Agreed protocols, including direct admitting rights, where appropriate, ensure patients go to the environment most suited to delivering the appropriate treatment. This ensures patients are cared for in the environment most suited to their needs. This leads to better management of short estimated lengths of stay and enables decisions to be made for patients with a more complex set of needs.

Part Two – Positive Practice Example

The Royal Wolverhampton Hospitals NHS Trust

The Royal Wolverhampton Hospitals NHS Trust has dedicated surgical and medical assessment areas managed by senior ward sisters.

Referrals to the assessment area tend to be via GPs or A&E. Agreed protocols have been set up for these referrals. GP referrals tend to be accepted, resulting in an agreed time for patient arrival while representatives from the assessment areas liaise with A&E to agree A&E referrals.

Full assessments are undertaken in the assessment areas, resulting in a care plan and estimated length of stay. This stage is usually completed within 12 hours.

Medical Assessment Unit (MAU):
Upon arrival in the MAU, patients are triaged and a Modified Early Warning Score (MEWS) is used to ensure the appropriate care pathway can be initiated unless triage has already taken place elsewhere, in which case these views are accepted. Relevant diagnostics are performed, with diagnostic slots prebooked based on predicted demand, and the diagnosis and treatment plan are developed. This stage is completed as quickly as possible with the more complex cases taking no more than 24 hours.

The diagnostic assessment is only completed when a senior doctor has discussed the diagnosis and treatment plan with the patient and the estimated length of stay and appropriate place for care has been documented.

A lounge area is set aside within the assessment unit for ambulant patients who may well go home that day and are often on a community shared care pathway e.g. DVT or cellulitis.

Once a **decision to transfer** has been made, patients are admitted either to:

- A specialist ward – where locally agreed clinical pathways state patients should be admitted directly to the specialist ward, usually due to the specialist ward being best equipped to initiate treatment, for example, strokes and respiratory problems; or
- The short stay unit

The short stay unit typically provide two types of services:

- Short interventions resulting in early discharge as a response to more general complaints; and
- Early implementation of the treatment plan while waiting for a space in the specialist ward

As the maximum length of stay should be 48 – 72 hours, patients receive the most appropriate length of stay and the best patient experience.

Patients are either discharged home upon completion of the treatment plan within

Part Two – Positive Practice Example

this timeframe or transferred to a specialist ward through a combination of inreach case management and allocation to a ward.

Inreach case management reduces delays through ensuring patients are advised by appropriate specialists and go to the right place for the right treatment first time round.

Patient lists for each specialist area are maintained within the short stay unit and specialties retain the responsibility for checking into the unit on a daily basis to proactively draw patients into the specialist wards.

Allocating patients with complex conditions to an appropriate ward minimises delay to treatment, which is known to improve outcomes. The short stay unit liaises with the discharge co-ordinator throughout the day to maintain an up to date understanding of bed capacity and likely discharges throughout the hospital. This enables the short stay unit to secure the appropriate bed for patients with more complex needs and ensure ownership of treatment.

Staff within the MAU are freed up from other commitments and shifts are matched to predicted levels of demand to ensure decisions about treatment and discharge can be made without delay. In the practice of an average medical assessment and short stay unit, for example, a registrar is committed to task 24/7 and two or three consultant sessions provided in each 24 hour period. Specialist nursing teams are involved at an early stage, enabling treatment to be initiated early on and managing tertiary referrals where required. Shifts overlap to provide increased cover at periods known to be busy. As a result, many clinical conditions, for example MI, call to needle times and sickle cell crisis treatment have been vastly improved.

Care pathways ensure nurses can lead on all common and important conditions and ensure consultant attention is directed toward patients with more complex or uncertain needs.

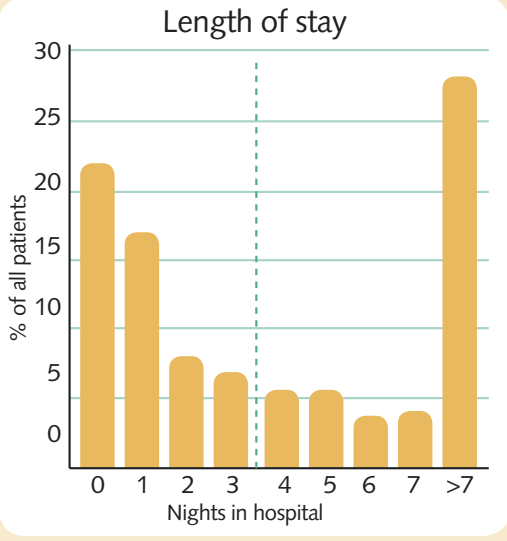
The Surgical Assessment Unit:
Once a decision to admit has been made, the patient may either go directly to surgery or to surgery via the short stay unit (which comprises a male and female ward). From surgery, patients recover in prebooked wards or, on occasion, in the short stay unit before being discharged home.

As with the MAU, staff are freed from other commitments and matched to demand. The skill mix is regularly reviewed and compared to national benchmarks.

Part Two – Positive Practice Example

Protocols for all common conditions have been developed by nurses in conjunction with consultants and agreed at the governance boards. Protocols exist for some patients to go straight to the appropriate specialist ward where they are better equipped for specific clinical requirements (e.g. head and neck injuries).

The SAU maintains an up to date understanding of bed capacity throughout the hospital through contacting all wards at set times throughout the day to understand new arrivals, medical outliers and discharges.



Evidence Base

The maximum length of stay within the short stay unit is determined by evidence of patient flow. More than half the patients within the whole hospital are discharged home before the third night. Introducing transferrals to wards before this point would add delay, extending the length of stay.

Next Steps:

- The Surgical Assessment Unit is considering establishing an emergency clinic for patients who require further diagnostic assessment but can safely go home and come back for scheduled tests or operations. This would improve the patient experience and ensure beds are not unnecessarily occupied.
- The SAU and MAU are considering combining to form one assessment unit to ensure bed capacity is maximised.
- The SAU and MAU are considering moving closer to the A&E department to integrate the teams and further reduce any duplication. This also aligns staff training with the new training structure, ensuring both emergency assessment and admission is covered. Such increased integration would also offer advantages to the care of patient in the hospital at night.
- For further information, please contact Rhys Lodwick or Simon Walford

Part Three – Supporting processes

Initial Assessment and Care

Outputs: Clear appreciation of severity and extent of symptom and assessment of priority for treatment.

Key Principles: Initial assessment and care is really only necessary when there may be an interval before more detailed diagnostic assessments. It should prompt appropriate symptom control.

Consistent pathways

Outputs: Delays to initiation of treatment are avoided and patient experience improved. Patients receive treatment from the area and professional equipped to provide the best treatment.

Key principles: Locally developed and agreed consistent care pathways for all common emergencies, enabling nurses to undertake investigations and initiate treatment where appropriate and patients to be admitted to appropriate areas. The demand for each care pathway should be quantified and staff matched to likely peaks in attendances.

Children

It is also important to ensure that appropriate pathways of care are in place to meet the needs of sick children in accordance with the guidelines for the care of children in hospital. Appropriately skilled staff should be matched to demand and should enable direct admissions where appropriate.

• Click here for more information.

Other Specialties

The smaller number of emergency admissions in orthopaedics, gynaecology, ENT and other specialties are often managed along the same lines as described above with admission from A&E being organised without delay to designated emergency bed capacity within the unit offering treatment. There are many good examples of gynaecology services offering rapid access to an integrated "Early Pregnancy Assessment Unit" with outpatient, inpatient and homecare elements available.

• Click here for more information.

Integrated records

Outputs: Duplication of data entry is avoided.

Key principles: Integrated emergency and specialist records should be built up on one form per patient, including A&E.

Admitting rights

Outputs: Duplication of assessment process between clinical teams is avoided.

Key principles: Admitting rights are locally agreed with A&E and GPs. Specialist teams should respond promptly to GP and A&E clinical assessments, resisting the temptation to challenge or undermine them before seeing the patient. Clinical audit and governance procedures should be used to optimise the use of jointly agreed care pathways.

Part Three – Supporting processes

Timely Access to Diagnostics
Outputs: Delays to diagnosis and subsequent treatment are avoided.
Key principles: Develop flexible 24/7 cover for all diagnostics, including radiology and pathology and weekend provision for investigations such as exercise tolerance tests, endoscopy , specialist imaging and pharmacy provision. Cover should not be limited to emergency interventions but also to facilitate early discharge and timely care.

Timely discharge
Output: Patient experience is improved through optimising time in hospital and reducing delays to admission due to lack of bed availability at the right time.
Key principles:

- Discharge from wards should be anticipated by good care planning and effected before midday, including Nurse led discharge, with an estimated date of discharge / length of stay and discharges on weekends.
- Discharge from the MAU will often be expedited by close liaison with community heath and social care services.

- Click here for more information.

Tertiary referrals
Outputs: Patient flow enhanced through eliminating delays due to tertiary referrals and patient experience enhanced through recovery in most appropriate environment. Efficient use of available resources.
Key principles: Develop agreed pathways and service level agreements, including agreed repatriation of tertiary patients.

Surgical Admissions – prebooking recovery wards
Outputs: Patient care is optimised through availability of appropriate environment for recovery. Patient flow enhanced, maximising use of resource.
Key principles: Prebook recovery wards based on predicted daily numbers.

Planned Emergencies
Outputs: Patient experience improved through being able to recover in the comfort of their own home. Inappropriate use of hospital resources avoided.
Key principles: Secure capacity and resources within the assessment unit for patients who require further diagnostic assessment but can safely go home and come back for scheduled tests or operations.

Forums and Clinical Governance:
Outputs: Any shared issues are resolved quickly and effectively. Structures are in place to agree new pathways.
Key principles: Locally developed mechanisms for A&E, SHOs, registrar and representatives from assessment areas to discuss and resolve any common issues. Governance arrangements developed to enable new clinical pathways to be approved and continuing clinical audit of their effectiveness.

Part Three – Supporting processes

Medical and Clinical Directors

Outputs: Improved consistency in practice

Key principles: Clinical Director to ensure consistent approaches regardless of consultant specialties. Medical Director to ensure consensus is reached should any disputes regarding patient pathways arise.

Staffing

Outputs: Any delays to treatment through unavailability of appropriate staff first time round are avoided.

Key principles:

- Ensure consultants / senior doctors / Specialist Registrar on assessment areas are freed up from any other duties
- Arrange daily senior input on specialist wards as a minimum
- Develop agreed multi-professional team working to empower nurses, use of specialist nurses throughout the system
- Ensure appropriately experienced nurses with the ability to practice autonomously are placed on units.
- Use agreed protocols with social care agencies, extending the use of existing emergency arrangements to the Assessment Unit, including social care presence on the Assessment Unit
- Use agreed care pathways with all allied health professionals, including physiotherapy
- Consider reviewing your skill mix and comparing it against national benchmarks.

Appendix A – Commissioning and Establishing Assessment and Short Stay Units

Capacity
The capacity is established through an understanding of the expected arrivals and length of stay.

Assessment Units: Capacity of the assessment unit can be approximated through establishing the use of each bay within a 24 hour period and the number of patients (including planned and unplanned emergencies) e.g. if 20 patients are seen in one day and each bay is used 4 times in a 24 hour period, 5 bays are required.

Short Stay Units: The capacity of the short stay unit can be approximated by establishing the daily in take and doubling this number to determine the number of beds required.

Planning of capacity for both assessment areas and short stay units should also consider the peak requirements, using a range of prediction and the diurnal variations in workload. The acute bed pool to which patients are first admitted should be operated at a planned maximum occupancy, under normal conditions, of about 85%

- Click here for more information on managing bed flows.

Principles supporting the commissioning and establishment of Assessment and Short Stay Units

The following need to be considered when establishing assessment and short stay units:

- A clear statement of purpose
- Developing and implementing an operational policy
- Senior focus and direction for the assessment and short stay unit management team comprising doctors, managers and senior nurses
- Staff rotation between the Assessment Unit and A&E and between specialist wards and A&E
- An understanding of the range of services available both within and outside the hospital
- The local population
- The local demography
- The case mix and levels of attendance and variability of this
- Agreed pathways for common conditions best suited to community or intermediate care
- The Assessment Unit must establish and maintain strong links with community and intermediate care providers to enable the smooth flow of patients from acute to primary care.

Appendix B – Assessment Unit Functions

Contained within the table are some guidelines as to the various purposes of assessment units.

The way in which this practice has evolved has resulted in many local variations as to the naming and function of dedicated assessment areas. Some trusts have one unit to perform more than one of the functions described below while other trusts may have separate areas to perform the different functions.

What is paramount is that any assessment area within your trust has a dedicated function, resulting in an improvement to the patient care, and is not just a holding bay for admissions.

	Observation Ward	Clinical Decision Unit (CDU)	Medical Assessment Unit (MAU) & Short Stay Unit	Surgical Assessment Unit (SAU)
Purpose	Reason for attendance expected to be resolved within 12 hours but not less than 4 hours. Patient expected to be discharged home from the observation ward.	Further assessment prior to development of treatment plan, operates across various specialties. On average, 10-20% of these patients are admitted.	Specialist assessment to determine appropriate care and commence delivery.	Specialist assessment to determine appropriate care and commence delivery.
Supervisor	Consultant in Emergency Medicine	Consultant in Emergency Medicine	Acute Physician or physician of the day / week.	General Acute Surgeon
Enviroment	< 12 hours or overnight	< 12 hours or overnight	Full assessment within 12 hours, if not admitted to specialty ward, may stay for period of up to 48 hours	12 – 24 hours before being sent for surgery or discharged home.