West Middlesex University Hospital NHS
NHS Trust

AMBULATORY EMERGENCY CARE UNIT

OPERATIONAL POLICY

Lead Clinician Ambulatory Emergency Care	**Dr Emma Rowlandson**	**1st October 2014**

Ambulatory Emergency Care Unit - WMUH

Operational Policy

Contents

Ambulatory Emergency Care Unit - WMUH

Operational Policy

1. Purpose

This policy aims to describe the operational, leadership, function, and service provision of the Ambulatory Emergency Care Unit (AEC) at the West Middlesex University Hospital.

This version is specific to phase 1 of the service prior to the full implementation of SystmOne and the extended AEC service scheduled to start in March 2015.

2. Aim

The aim of the Ambulatory Emergency Care Service is that no one stays overnight in hospital if they could have gone home.

3. Background

There has been a rapid change in how emergency care is accessed and delivered within the last decade. Recently attention has been focussed on ensuring that only patients whom require admission are actually admitted and this requires senior and competent decision makers who can streamline patients into congruous alternatives to an acute hospital bed.

Ambulatory emergency care is one such alternative. Awareness of and methods of entry into such alternatives are paramount. Multiple definitions of what constitutes 'ambulatory emergency care' exist.

The Royal College of Physicians (RCP) Acute Medicine Task Force defines it as follows;
' ..it is care of a condition that is perceived either by the patient or by the referring practitioner as urgent, and that requires prompt clinical assessment, undertaken by a competent clinical decision maker. The healthcare setting may vary, but for optimal clinical care will often require prompt access to diagnostic support.'

4. Objectives

The underlying principle is that a significant proportion of emergency adult inpatients can be managed safely and appropriately on the same day without admission to a hospital bed. Ambulatory Emergency Care is a transformational change in the care delivery, similar to that seen in the development of elective day surgery. Ambulatory models create a 'virtual ward' of patients undergoing clinical supervision but staying overnight within the usual place of residence, and have the potential to transform emergency care as profoundly as day surgery has impacted elective care. The avoidance of unnecessary overnight stays for emergency patients (similar to day surgery for elective care) not only improves the quality of patient care and experience but also reduces occupied bed days in hospitals.

Ambulatory Emergency Care is defined by the Royal College of Physicians as:
"clinical care which includes diagnosis, observation, treatment and rehabilitation, not provided within the traditional hospital bed base or outpatient services and can be provided across the primary/secondary care interface"

Royal College of Physicians 2007

The benefits of ambulatory care include:

- Improved patient experience and outcomes
- Transformed emergency care processes
- Released acute care bed days
- Improved staff experience

5. Hours of Operation

Day	Open	Close	Last patient accepted at:
Monday to Friday	8.00am	8:00pm	5:00pm
Saturday and Sunday (nurse led service)	11.00am	2.00pm	3.00pm

Senior Clinical Leadership and Decision Making from a Senior Clinician (Consultant Level) will be in place Monday to Friday 8.00am to 8:00pm. The arrangements can be summarised as follows:

Time Slot	8:00am to 10:00pm	10:00am to 1:00pm	1:00pm to 6:00pm	6:00pm to 8:00pm
Who will be using the AEC Service?	Patients with a decision to treat at the AEC made the previous day following the assessment plan agreed at that time	Patients with a decision to treat at the AEC	Patients with a decision to treat at the AEC	Patients with a decision to treat at the AEC who are able to complete treatment that day
What Decisions will be being made?	• Is AEC service appropriate for the patient who has arrived at A&E or Primary Care	• Deciding the agreed treatment plan with ongoing clinical supervision by primary care with or without community support • Is the AEC service appropriate for the patient who has arrived at A&E or Primary Care?	• Deciding the agreed treatment plan with ongoing clinical supervision by primary care with or without community support • Is the AEC service appropriate for the patient who has arrived at A&E or Primary Care?	• Is AEC service the following day appropriate for the patient who has arrived at A&E or Primary Care and the assessment plan to be followed
Who will make the decisions?	AMU Consultants speaking directly to A&E colleagues or liaising with clinical colleagues within AEC to make the decision based on the completed referral form from primary care. AMU consultant will cover both AEC and AMU in the morning.	AMU Consultants visiting the AEC on a frequent basis to ensure that the prompt timeline for senior clinical leadership of decision making is maintained	AEC Consultant in AEC and available for direct telephone access	Physician on call(Consultant or Medical registrar)

6. Staffing Model

Medical	Number	Band/Level
Consultant	3	Cons
Junior Clinical Fellow	2	JCF
Nursing, Administration, AHP & Facilities		
Pharmacist	1	7
Ambulatory Emergency Nurse Practitioner	1	7
Sister / Charge Nurse	1	6
Staff Nurse	4	5
Administrator / Receptionist	2	3

7. Location

The service is located within OPD 1

8. Referral into AEC

Between 8am and 8pm Monday to Friday, referrals are received by the Consultant / Ambulatory Emergency Nurse Practitioner / Clinical Fellow, on the dedicated GP referral line. They will take a detailed assessment from the referring clinician and determine their suitability for the AEC. An AEC Referral form must also be completed and sent through to the unit via SystmOne, fax or nhs.net email. Patients accepted to the AEC will then be given an appointment to attend the AEC for further assessment and treatment. For patients referred from A&E the AEC referral form must be completed for every patient and sent to the AEC. It should be noted that in some circumstances patients may be required to bring the referral form with them to the AEC unit.

Please see Appendix I – Referral Form for the AEC

Those patients who are unsuitable for the AEC will either be referred to the admitting Medical team for further management or advice will be given regarding a more appropriate management plan/an alternative referral pathway.

Please see Appendix II – Referral instructions for the AEC

Referrals will be accepted from the following healthcare groups:

- General Practitioners
- Urgent Care Centre
- Accident & Emergency
- Consultant teams from in-patient areas
- Outpatients Department

- Integrated Community Response Service
- Community Geriatrician
- Speciality Nurses with input from the GP/Consultant
- Radiology – patients sent in by GP for e.g. Chest XRays, noted to be abnormal should go to AEC as they are ambulatory and usually otherwise well.

There is not an exhaustive list of conditions currently accepted into the AEC and those patients who the AEC team feel can be managed within the existing capacity will be considered.

9. Clinical Exclusion Criteria for Referral to the AEC

- Any 'physical trauma' related problem
- The patient is physiologically unstable or at risk of deteriorating.
- Should the patient suffer a deterioration in their condition , they should present to the nearest A&E department and call 999 for LAS as appropriate.
- If the patient's clinical condition presents a cross-infection risk for the patient or others (*Please see section 13 for infection control procedures)
- Patient is on a speciality clinic waiting list for the same problem
- Patients under the age of 16 (service accepts adults 18 years if in full time education and 16 if not)
- Disruptive/disorientated patients
- Patients who have deliberately self-harmed
- Patients whose problem is best served by a speciality / other clinic
- Patients with potential to deteriorate rapidly
- Patients whose problem will need regular 'Therapist' input
- Medical problems in Pregnancy

These exclusions are subject to change and will be reviewed and updated accordingly.

10. Clinical Accountability and Responsibility

There will be an AEC Consultant providing overall clinical accountability for the patients within the AEC and providing clinical leadership for the unit. Patients will remain under the clinical responsibility of the AEC (with relation to their presenting problem) from their arrival at the unit until they are discharged from AEC back to the care of the GP.

11. IT and Patient Information Management Systems

- Referral into the AEC is via SystmOne, by fax to AEC or via secure NHS email
- Patient booked appointment on bespoke scheduler system
- On arrival patient booked onto Realtime system and remains on virtual ward for duration of AEC episode of care, being put on home leave whilst not on the unit.
- The patient will be discharged from Realtime with discharge summary to GP and other services if referred on when the episode of care is complete.
- Written clinical notes will be used in the AEC as an interim solution until SystmOne is introduced and an adapted AEC clerking booklet will be used by both medical and nursing staff for initial assessment.

12. Medicines Management

All medication administered on the unit will be prescribed on a Trust inpatient drug chart. Discharge medications will be prescribed on a Trust Outpatient Prescription, and medicines will either be dispensed from the unit if a pre-pack is available or dispensed from the hospital Outpatients Pharmacy on the Ground Floor.

Details of treatment administered on the unit and discharge medication, including any changes to medication will be detailed in the Realtime summary in the free text section for the GP.

The AEC team includes a pharmacist who will contribute to medicines optimisation and will be involved in medicines reconciliation, reviewing medicines use and adherence, patient counselling and warfarin education as part of their role. The pharmacist will be available from 9:00am to 5:30pm on Mondays to Fridays.

13. Infection Prevention and Control Measures

- At the time of triage, any patient accepted into the AEC must be assessed for any known infection control risk e.g. MRSA, *Clostridium difficile*
- Patients who have symptoms of diarrhoea and/or vomiting or have been in contact with anyone with diarrhoea and/or vomiting within the last 48 hours are not suitable for the AEC
- All interventional procedures must be prepared and performed using strict aseptic technique
- All packs and equipment used must be disposable

14. Discharge and Follow-up

Every patient will have a discharge summary detailing their assessment, treatment and any further management required in primary care. Any changed to medication will be highlighted in the free text section of the document. It will be made clear both during and after the episode of care within AEC who is clinically responsible for the patient and which other services are involved in the treatment plan. This will be documented in both the clinical notes and in the SPA referral

See Appendix IV – AEC Pathway

15. Patients Requiring Admission

A) If patient condition deteriorates on the unit and they become unstable, such that it is no longer safe to assess or treat them in the AEC they will be transferred from AEC to A&E.

B) If, following assessment by the AEC clinical team, it is agreed with the AEC Consultant that treatment cannot be completed prior to closure of the AEC for that day and that asking the patient to return to the AEC the following day to continue treatment is not appropriate, the patient will require an in-patient admission. This will be facilitated in the usual way by the site practitioner team. The assessing AEC clinical team will contact the site practitioner team to request an in-patient admission and if appropriate they will move directly to an appropriate bed. They will also liaise with the on call medical team and patients will not be diverted to A&E.

16. Training and Professional Development

All staff will be up to date with both their mandatory and statutory training prior to commencing work on the unit. Staff will also have AEC service specific training as part of their induction process.

There will be monthly multi-disciplinary educational meetings which will also include our local GPs from Hounslow, Richmond and Ealing and UCC and ICRS staff. This will consist of specific case presentations and discussions, an opportunity for two way feedback and teaching on a topic of the month.

Staff will also be expected to attend other formal educational events within the trust.

The AEC environment will support regular educational opportunities through the Consultant review process and GPs will be welcomed to join the AEC team for clinical sessions as part of their Continuing Professional Development (CPD). Community nursing staff will also be able to gain CPD through experience on the unit.

17. Data Measurement and Reporting

A standard monthly monitoring report will be used to stimulate performance review across four areas:

1) Activity
- Referrer e.g. GP, UCC, A&E, ICRS
- GP Practice
- Time and date of referral
- Diagnosis
- Method of referral e.g. SystmOne, Telephone
- Referral receiver
- Referral assessor
- Diagnostics
- Pathology
- Pharmacy prescribing, administration, medicine reconciliation
- Interventions required
- Management plans agreed and signed off by the Consultant
- Advice provided to help patients manage their medications and documented in the management plan
- Number of patients seen in AEC
- Nature of attendance
- Number of patients referred to AEC as a proportion of total number of patients seen in UCC / A&E

2) Data Quality
- NHS Number

3) Responsiveness
- Time management plan sent to GP, HRCH, other
- Length of time on AEC
- Time of referral (diagnostics)
- Time received diagnostic
- Time received diagnostic report
- Time to review by senior clinician

4) Activity
- Speciality input on AEC
- Refer to specialty clinic, two week wait pathway or other service
- Number of patients with a 0-1 day LOS
- Number of patients admitted to ward/speciality as a proportion of total number of patients seen in UCC / A&E
- Total bed days in medicine

- Number of clinical handovers
- Discharge destination
- Number of patients re referred to AEC
- Time since initial referral
- Number of patients admitted to ward / speciality
- Time of day of admission
- Reason for admission
- Length of stay following ward admission
- Number of medical outliers

5) Quality

- Patient satisfaction survey
- Carer satisfaction survey
- Number of complaints
- Number of compliments
- Number and type of clinical incidents
- Time to review by senior clinician
- Friends and family test
- EBD
- Staff satisfaction survey
- Staff sickness and vacancy rates
- Safeguarding incidents
- Safeguarding training

6) Workforce

- Number and type of staff
- Environment
- Annual appraisal , PDP
- Monthly Clinical Supervision
- Recruitment and retention
- Sickness rate
- Agency and locum use
- Skill mix analysis
- Training for all grades of staff

18. Governance

The Ambulatory Emergency Care service is an integral part of Acute Medicine within the Division of Medicine. All clinical and professional leadership and governance arrangements will be maintained in line with the family of services within Acute Medicine, including participation in clinical governance arrangements.

Monthly Multidisciplinary Team meetings will be held, which will include representatives of Primary and Community Care. The purpose of the meetings will be to review the effectiveness of the service and to identify opportunities for continuous improvement.

19. Review

The AEC operational policy will be under regular review during the first 6 months of operation. It will be formally updated prior to the change in service specification in March 2015.

20. Appendices

Appendix I – Referral Form for the AEC
Appendix II – Referral instructions for the AEC
Appendix III – AEC Referral Pathway
Appendix IV – AEC Pathway

Appendix I – Referral Form for the AEC

Patient		**Referrer**
Name: Address: Telephone: DoB: NHS Number: Gender:		Name: Practice E-Number: Practice Address: Telephone: Fax: E-mail: Date of Referral:
Interpreter Required	Yes ☐ No ☐	GP GMC Code:
Assistance with Booking Required	Yes ☐ No ☐	Language
Hospital Transport Required	Yes ☐ No ☐	Ethnicity
Consent to share record given?	Yes ☐ No ☐	

NEWS

National Early Warning Score (NEWS)*

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

*The NEWS initiative flowed from the Royal College of Physicians' NEWS Development and Implementation Group (NEWSDIG) report, and was jointly developed and funded in collaboration with the Royal College of Physicians, Royal College of Nursing, National Outreach Forum and NHS Training for Innovation

AMB Score

FACTORS	1 if applicable 0 if not applicable
Female sex	
Age < 80 years	
Has access to personal / public transport	
IV treatment not anticipated by referring doctor	
Not acutely confused	
MEWS score = 0	
Not discharged from hospital within previous 30 days	
TOTAL *Amb* Score (Maximum 7)	

Reason for Referral to AEC / Request for opinion *Ensure the NEWS and AMB scores have been completed*
Presentation/ Problems/ Issues *Please provide as much relevant clinical information as possible to ensure the most appropriate investigation is performed.*
Past Medical History/ Social Situation/ Additional Information
Current Medication
Referrers' Signature: **Date:**
To Be Completed by AEC
Date & Time Received by AEC: **Name of accepting doctor** **Referral Outcome:** **Advice given** **Recommend referral to A&E** **Accept to AEC** **Recommend referral to SPA** **Name:** **Signature:** **Designation:**

Appendix II – Referral instructions for the AEC

Referral Instructions for Ambulatory Emergency Care Service (AEC)

Identification of patient appropriate for the AEC (with the help of NEWS and AMB scores)

GP | **ICRS** | **UCC** | **A&E** | **OPD**

Complete AEC referral form and

- Send via SystmOne
- Mail via NHS Mail to wmuh-tr.aec@nhs.net
- Fax to 020 8321 2572 **NB: Contact telephone number for the patient is vital**

Call AEC mobile 07825 044 391 Monday to Friday 8:00am-8:00pm
Or call AEC direct: 0208 321 5966
At weekends/Bank Holidays and from 8:00pm to 8:00am on weekdays - Call Medical Registrar via WMUH switchboard on 0208 560 2121

Referral appropriate for AEC

- 8:00am–8:00pm Appointment will be given to attend the AEC either the same day or within 48 hours as appropriate
- 8:00pm-8:00am Patient will be telephoned by AEC staff between 8:00am and 9:00am next working day to be given an appointment
- Give Patient AEC Information Leaflet

Patient attends AEC

Referral not appropriate for AEC

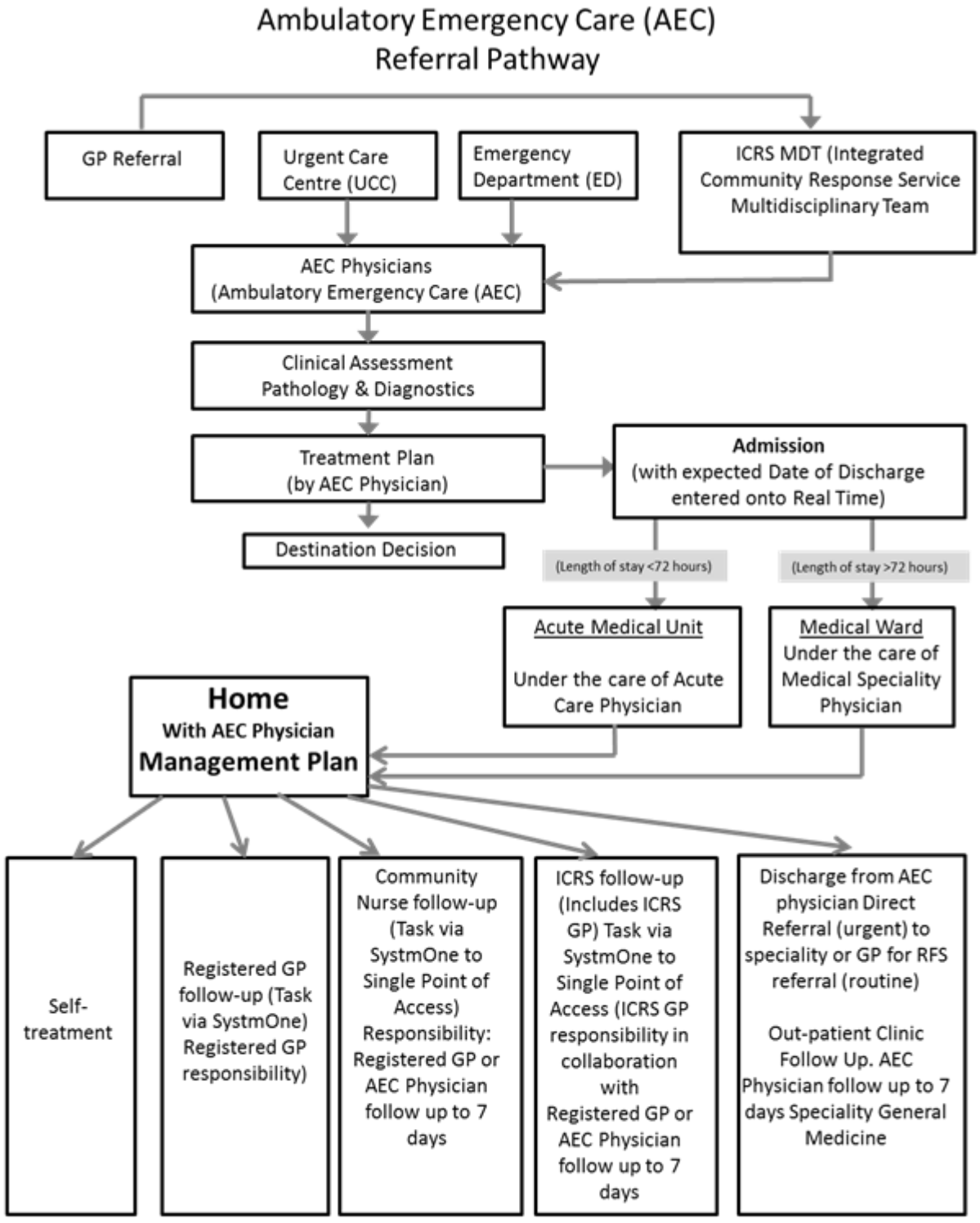
Advised patient needs medical admission

- AEC/ Medical Reg will facilitate this

Advice given

- re: alternative service/pathway
- clinical management in Primary Care

Appendix III – AEC Referral Pathway



Ethos: "No-one stays overnight if they could have gone home"

Appendix IV – AEC Pathway

Process A - Identification and selection of patient from Primary Care and community (GP)

1. Initial Assessment and Selection

Referrers

- GP
  - In hours
  - Out of hours
- London Ambulance Service
  - 24/7
- ICRS
- Community Geriatrician
- Outpatients Department
- Walk in centres

Assessment

- To confirm NEWS and AMB scores
- Assessment prior to arrival at WMUH
- Assessing Transport Access

2. Logistics of Referrals

Must be a verbal referral:
Phone call to AEC directly not via switchboard
- Dedicated mobile number
- Direct dial landline into service

Make referral
- Via e-mail using secure NHS.net account in 2014 to wmuh-tr.aec@nhs.net
- Via fax to 020 8321 2572
- On SystmOne

(Richmond and Ealing GPs via fax/NHS email only)
- Via SystmOne in 2015

After the referral is accepted:
-Appointment is given (time slot same day/following day)
(Please note that only AEC staff will have the authority to book appointments into the AEC service)
-Emergency attendance is required- as soon as possible

Patient attending AEC:
- Patient will be offered a specific time slot to attend the AEC
- AEC takes clinical responsibility from the time the patient arrives at the unit
- AEC will follow up DNAs and offer another appointment where appropriate

3. Information to Patient
Patient information leaflet/ website

Process for next day attendance – information to patient
If referral received after 5:00pm the patient will have to wait for an appointment until the next day if referred out of hours and accepted by the medical registrar the patient will be telephoned between 8:00am-9:00am the following morning with an appointment

4. Transport

- Private transport
- Public transport
- Taxi
- Ambulance Transfer (as identified and arranged with Primary Care)
- Hospital transport identified in Primary Care and arranged in AEC

5. Feedback for referrals

Issue log
Monthly MDT meetings

Monthly clinical review meeting acts as a feedback loop to London Ambulance Services, ICRS and GPs

Process Stage B - Identification and selection of patients from the front door of the hospital

- AEC Pathway (eg DVT and cellulitis)
- Name
- Reception

Streaming nurse identifies the AEC patient. Highlight from System (approximately 1 hour)

UCC GP / Emergency Nurse Practitioner assess patient and refer to AEC (approximately 1 hour)

Process Stage C – Scenario 1 - AEC in hours:

Refer to AEC by phone or telephone appointment system

A&E refer to AEC via triage sister - History of London Ambulance risk stratify UCC/A&E

A&E sister following triage refers directly to AEC

Post Assessment in A&E, A&E doctors refers to AEC

UCC – Pick up the phone and make verbal referral which could be 25 mins delay

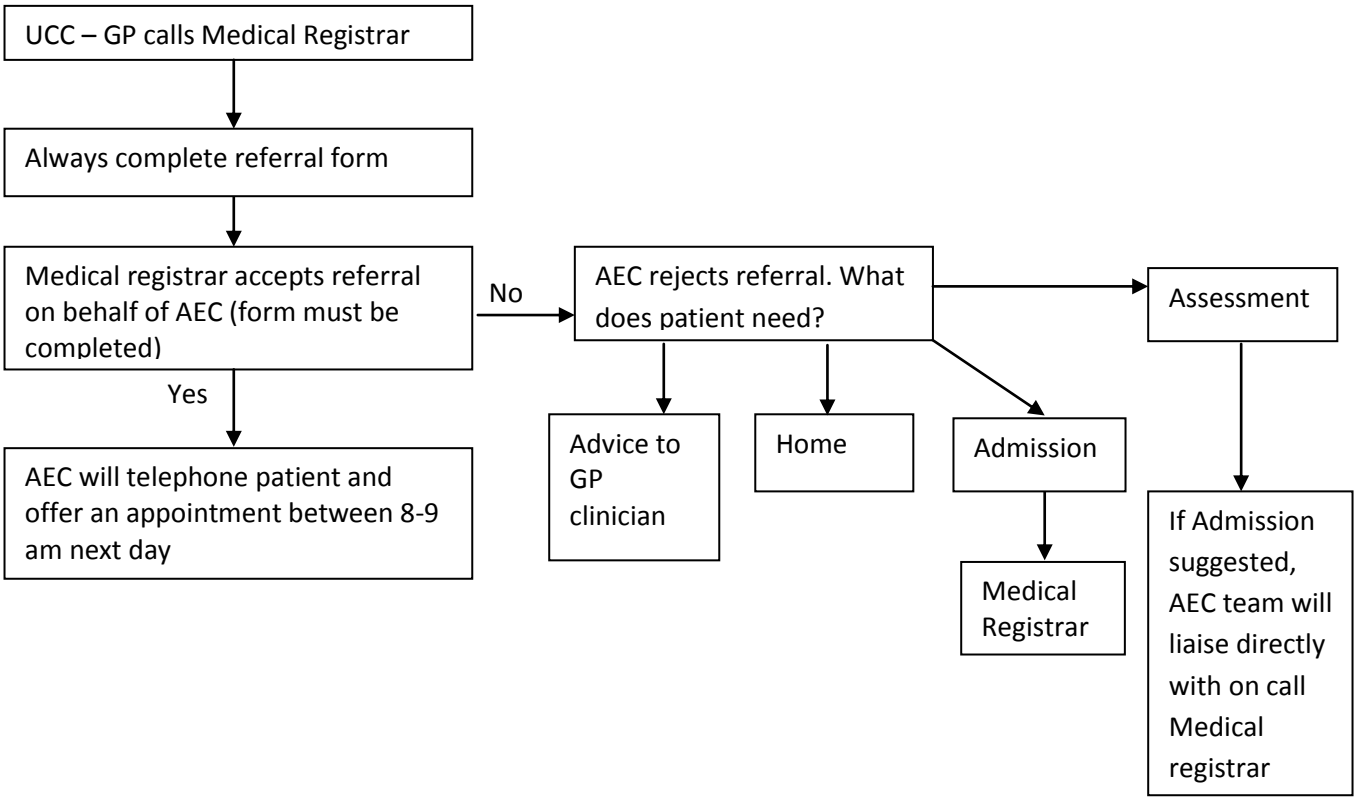
AEC Consultant accepts referral then UCC doctor sends referral via e-mail (2014) or SystmOne

Outpatient

Clinician

Telephone referral to AEC consultant

Process Stage C – Scenario 2 **-AEC Out of hours accept referrals from A&E and UCC**



Process Stage D - Clinical service delivery assessment, diagnosis and treatment

Arrival/Booking

-Receipt of referral
- Welcome
- Create access hospital number
- Request patient notes
- Admitted on e-CaMIS / Realtime
- Wristband and patient stickers
- Preparation of clerking documents
- Print off SystmOne summary
- Information leaflet to patient
- Refer to nurse

Unitary Document

- Clerking proforma used by MDT and follows patient

Nurse Assessment
- Baseline observations – NEWS score
- Identify problems/presentations
- Identify any allergies
- ID wristband (Refer to ANP or Medic)

Phlebotomy (Service 4:30pm-8:00pm) by AEC doctors
- Request blood tests on Order Comms
- Patient walks round for phlebotomy service
- Bloods taken
- Sent to laboratory and results back within 30 mins

Medical Assessment / (Ambulatory Emergency Nurse Practitioner)

Radiology
- The process for requesting radiological investigations will be similar to that in A&E and on AMU with the same expectation on turnaround times.
- Request on Ordercomms (ICE)
- Print off plain film forms and send with patient
- main X-Ray reception 8:00am-5:00pm
- After 5:00pm use porters same process followed by A&E department currently
- CT PA/CT head and other CTs should be discussed with the Radiologist of the day and coordinated with the Radiographer in CT and will be done within 1 hour wherever possible.
- There will be dedicated AEC slots for ultrasound in the morning and the radiology department will make every effort to meet the needs of the service.

Procedures
- Semi-planned appointments will be booked according to staff availability and clinical need
- Booked into AEC procedure clinic according to urgency and type of procedure

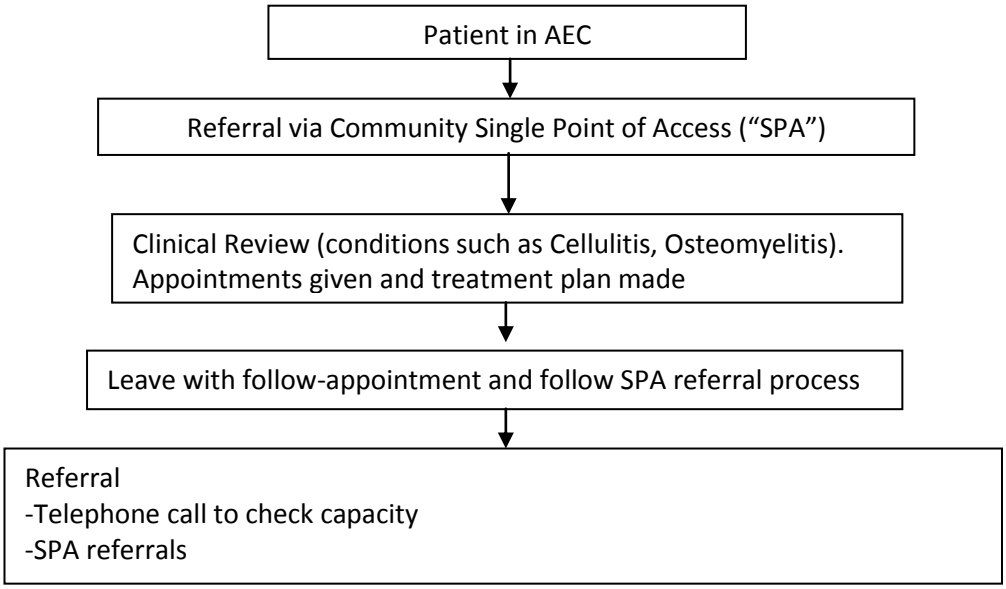
Medications

On the AEC unit

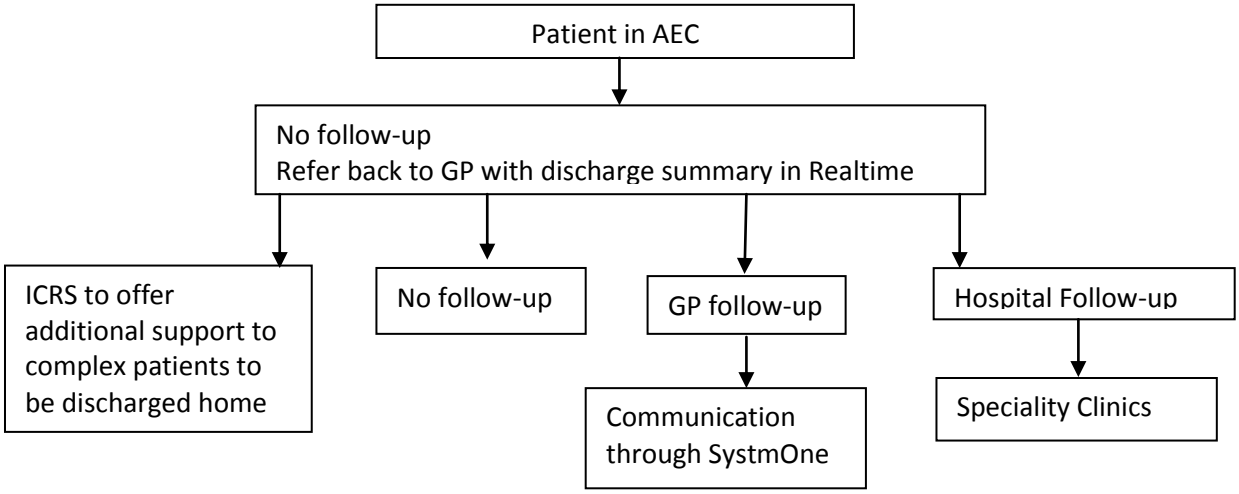
- All medication administered on the unit will be prescribed on a Trust inpatient drug chart. Discharge medications will be prescribed on a Trust Outpatient Prescription, and medicines will either be dispensed from the unit if a pre-pack is available or dispensed from the hospital Outpatients Pharmacy on the Ground Floor.
- Details of treatment administered on the unit and discharge medication, including any changes to medication will be detailed in the Realtime summary in the free text section for the GP.
- The AEC team includes a pharmacist who will contribute to medicines optimisation and will be involved in medicines reconciliation, reviewing medicines use and adherence, patient counselling and warfarin education as part of their role. The pharmacist will be available from 9:00am to 5:30pm on Mondays to Fridays.

Review Process
-Consultant R/V
-D/C?
-Ongoing plan
- To GP
-Further investigation or R/V

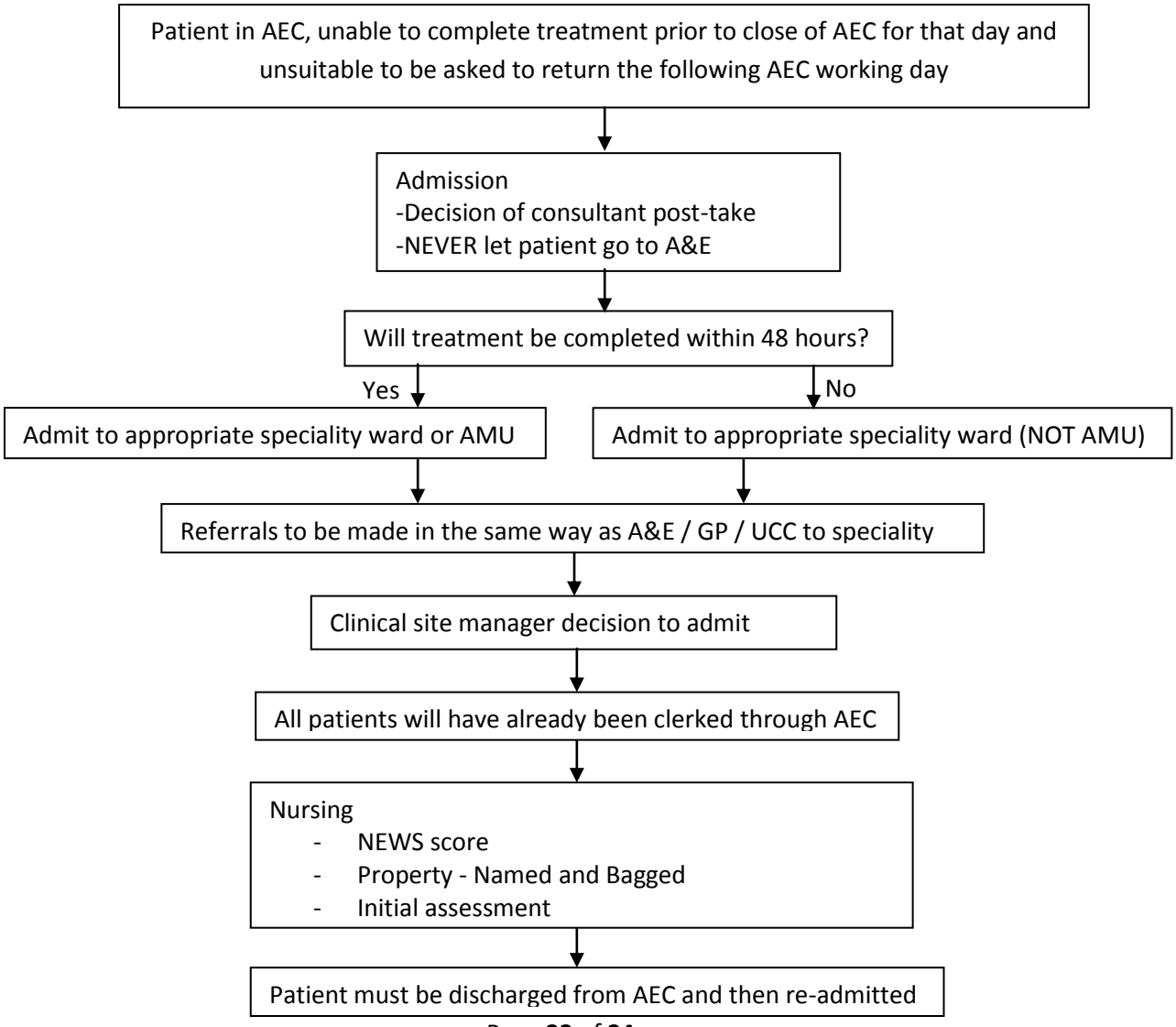
Process Stage E – Leaving AEC – Scenario 1 - Discharge to Community



Process Stage E – Leaving AEC – Scenario 2 - Discharge to Primary Care



Process Stage E – Leaving AEC – Scenario 3 – Patient Requires Admission to Complete Treatment



Process Stage E – Leaving AEC – Scenario 4 – Patient Condition Deteriorates