

Irish Association for Emergency Medicine
Position Paper on Acute Medical Units (AMUs)

March 2006

The IAEM welcomes the publication of the Comhairle na nOspideal report on Acute Medical Units dated October 2004 as a useful contribution to the debate on how Emergency admissions should be handled by a hospital. We note that no single model was endorsed in the Comhairle report reflecting that there are a number of models of AMU use currently in Ireland and elsewhere. Instead Comhairle proposed some general principles which need to underpin the operation of such units and in particular reinforce the need for “effective communication systems [to be] in place between the AMU, the A&E [Emergency Department], General Practitioner, the Hospital Bed Manager and Hospital’s OPD”.

There is considerable confusion about the concept of Medical Admission Units and Medical Assessment Units and this lack of clarity is detrimental to patient care. Furthermore many AMUs represent combinations of these concepts.

It must be recognised that whatever model of AMU is employed by a hospital, the presence of an AMU in isolation will do little to address the bed capacity difficulties being experienced by hospitals. Unless there are beds within the system, to which patients can be moved as soon as the need for admission has been confirmed, these AMUs will become blocked and experience the same difficulties currently being experienced by Emergency Departments.

In considering this report the IAEM have been anxious to ensure that critically ill patients are not disadvantaged by a system which encourages GPs to send such patients to an AMU simply because they have made a “medical diagnosis”. In general, patients attending Acute Medical Units for medical assessment have a lesser degree of acuity than those who are brought to the Emergency Department. As such we believe that safeguards should be put in place to ensure that those patients who require immediate resuscitation or who may require time critical intervention are brought directly to an Emergency Department, where medical and nursing staff with appropriate experience and expertise in resuscitation are available.

The IAEM believes that the following principles will enhance the standard of care delivered to the generality of acute medical patients

- Acute Medical Units (AMU) should be co-located adjacent to Emergency Departments and have easy access to the Emergency Department’s resuscitation facilities and expertise, if required.
- There should be a single portal of entry to the hospital for all acutely ill patients attending by ambulance. This should be part of the Emergency Department.

- Patients should be triaged at this portal of entry. The necessity for and the importance of this assessment cannot be overstated. Patients already referred to the AMU, who are not in need of resuscitation or time critical intervention, will be directed to the AMU at that point. Patients who need immediate resuscitation or other time critical intervention will be transferred to the Emergency Department where such care can be given immediately.
- If no hospital bed is available for an AMU patient who is clinically well enough not to require resuscitation or time critical intervention, such patients should wait in the AMU and not be transferred to the Emergency Department.
- Ideally AMUs should be operational 24 hours a day, seven days a week. This may not be practical in smaller units. However as a minimum they should operate an extended working day seven days a week. Where an AMU is only operational for a portion of the day then outside its hours of operation all acute medical admissions should be directed to the Emergency Department.
- In view of the overlap between the types of patients seen in both AMUs and Emergency Departments there should be liaison between both departments to ensure that, where appropriate, common diagnostic work ups and therapeutic approaches are used.
- It is acknowledged that an AMU requires senior medical decision making and access to appropriate diagnostic services. It must be equally acknowledged that the current access to emergency diagnostics particularly out-of-hours available to many Emergency Departments is inadequate. The establishment of AMUs must not result in Emergency Departments having diminished access to diagnostic services.
- Further work needs to be carried out to ensure that GPs have ready access to urgent specialist outpatient clinics to avoid the need for patients to be inappropriately referred to an AMU or an Emergency Department.

When the patient who has been seen, assessed and treated in the Emergency Department is deemed to require admission, they should be transferred to a Medical Admission facility in a timely manner (certainly within two hours). Such a Medical Admission facility should exist in each hospital so that acute medical admissions are managed in a centralised area where appropriate medical and nursing care can be provided. While such an admission unit may be part of an AMU there are clearly differences between the requirements for medical assessment and medical admission which need to be borne in mind in the structuring and management of such a unit.

References

Acute Medical Units Comhairle na nOspideal, October 2004
A Guide to Emergency Medical and Surgical Admissions – Alberti et al, Department of Health UK

This document was approved by the Irish Association for Emergency Medicine at its meeting on 3 March 2006.