Acute Medicine Programme and Emergency Medicine 2011
- A Briefing Document for IAEM Members

The key issues from the Acute Medicine Programme (AMP) that are relevant to Emergency Medicine are:

1. Background

Is the AMP an opportunity or a threat?

- The AMP document is not aimed at a Consultant in EM audience, but primarily at physicians. It represents a significant change in how acute medical care is delivered in Irish hospitals and places an unprecedented emphasis on the initial hours of patient care. The AMP requires senior clinicians to be free of conflicting demands when on-call, to assess patients within an hour of their arrival or referral. It brings new levels of accountability to bear on acute medical care and is also intended to have a major influence on the postgraduate training of future consultant physicians.
- Experience in the UK indicates that the development of Acute Medicine has **not** resulted in a decrease in ED attendances. ED attendances there have increased year on year.
- Emergency Medicine involvement in the AMP has resulted in the development of the Emergency Medicine Programme (EMP), which is now considered one of the 5 Key DQCC Acute Care programmes, along with AM, Critical Care, Medicine for the Elderly and Surgery. The EMP will be implemented in conjunction with the AMP, though the AMP is at a more advanced stage. It is likely to be advantageous to EM to have the AMP implemented in part, as reducing ED in-patient boarding is a key goal of the AMP. In the initial AMP Implementation Team visits to three hospitals to date, the importance of EM has been strongly reinforced to hospital management and the need to ensure it is properly supported to allow it carry out its key role has been emphasised.
- When the AMP is implemented, there undoubtedly will be in changes in ED attendance patterns as GPs will have the option to refer patients directly to AMUs. This is likely to impact more significantly on EDs with relatively large medical attendance numbers and good primary care infrastructure.
- The concept of clinical justice (taken from an EMJ Review paper on Triage reference: *Emerg Med J 2010;27:86-92*) means that patients receive care appropriate to their need and in a timely fashion and this concept has been interpreted such that benefits intended for AMU patients will equally apply to ED patients. These include access to diagnostics, timeliness of medical specialty assessment/consults, access to therapists.
- AMUs will be standardised nationally. Thus certain AMUs cannot be used as replacements for, or to bypass, OPD services or as Day-ward facilities. This should make the ED/AMU interface easier to manage.

2. Generic Hospital Models:

The Generic Hospital Models developed through the AMP are going to be used to inform the reconfiguration process nationally and locally and requires careful consideration as they will also impact on EM.

- There are 4 levels of acute hospitals in relation to acute medicine patients, as proposed by the National Clinical Programmes. The models are: Model 4 - tertiary hospital; Model 3 - general hospital; Model 2 - local with selected (GP-referred) medical patients and Model 1 - Community/District.
    - An **Acute Medical Unit (AMU)** is a facility whose primary function is the immediate and early specialist management of adult patients (i.e. aged 16 and older) with a wide range of medical conditions who present to a Model 4 (Tertiary) hospital. It will have short stay beds for admissions with an estimated length of stay of less than 48 hours.
    - An **Acute Medical Assessment Unit (AMAU)** will operate as an AMU with the following exceptions: It will be located in a Model 3 (General) hospital; the hours of operation may vary

from 12 to 24 hours, 7 days per week, depending on service need and it will not have contiguous short stay medical beds.

- **A Medical Assessment Unit (MAU)** in a Model 2 (local) hospital will see GP-referred differentiated medical patients who have a low risk of requiring full resuscitation. It will have assessment beds in a defined area and serve a clinical decision support function. Admissions will be to in-patient beds in a Model 2 hospital. Patients who deteriorate unexpectedly will have guaranteed transfer to a Model 3 or 4 hospital.

- The provision of an MAU in model 2 hospitals that will not in future have 24/7 EDs allows those hospitals to continue to provide some level of medical services to local communities through the direct referral by GPs of patients to the MAUs. Protocols will be developed to ensure that patients who require higher acuity care are directed to Model 3 or 4 hospitals.
- In AMAUs that are not open on a 24-hour basis, acute medicine patients will be seen in ED from two hours before the AMAU closes. This transition will need to be carefully managed and the EMP will provide guidance in this regard. Also, it will be important that process measures for the acute medicine programme include those patients managed by AM teams in EDs out-of-hours. These patients deserve the same level of care that they would receive were the AMAU open.

3. Potential Benefits for Patients:

AMU patients will not be denied the benefits of ED Triage and resuscitation if required:

- All patients should have Manchester Triage Score (MTS) in ED and ideally all AMU patients should enter through a common door.
  "Ideally, patients attending model 3 and 4 hospitals should access ED and AMU/AMAU through a common entrance."
  "AMU/AMAU accepted patients should be briefly assessed to ensure that they do not require immediate transfer to the ED resuscitation area. This brief assessment must not result in preventable delays for patients. Prioritisation according to the Manchester Triage System is recommended for patients entering a shared ED/AMU/AMAU care area."
- Patients requiring resuscitation, as identified by MTS, will still receive EM care in the ED resuscitation room if they were originally referred by their GPs to AMU but they will also have access to Consultant physician input as required. This will be possible, as the Consultant physician on call will not have conflicting duties outside his/her on-call work.

Waiting times:

- All patients referred to acute medicine must be seen by a registrar or consultant within one hour of referral. Patients requiring consults from other medical specialties can expect to be seen within two hours of consult request. The AMP does not determine the response time for Consultants in EM or any other ED processes.
- Medical patients do not have to be held in EDs until all their investigations are completed.
  "Patients will be admitted from the ED/CDU directly to the AMU/AMAU after discussion between the consultant in EM or their delegate and the AMU/AMAU on-call physician or their delegate. Patient transfer can occur prior to the results of all clinical investigations being available. The assessment by the acute medicine team should, in general, occur in the AMU/AMAU rather than the ED unless the clinical status of the patient requires care in a resuscitation area, or when the AMU is closed."

Retrieval:

- ED patients should benefit from the development of regional retrieval teams as these may be activated to transfer ED patients to specialist centres (e.g for neurosurgery).
  "A regional critical care retrieval team is proposed as part of the critical care programme for the safe regional or supra-regional transport of critically ill patients."

Therapy, social work and other support services:

- It is envisaged that therapists, social workers and other allied health professionals would work in a seamless manner across the acute floor. Patients in some hospitals may have enhanced access to therapists: *"Therapy profession and medical social work services should be integrated across the acute floor."*

4. Potential Impact on EDs:

- EM and AM are considered to be complementary systems of care.

  "The interface between acute medicine, emergency medicine and critical care
  ..*Emergency medicine, critical care and acute medicine are complementary systems of patient care. The interface between these specialties should be developed and managed in a co-ordinated manner to maximise the quality and cost-effectiveness of care provided by both services."*

  " The respective roles, responsibility, authority and accountability of the EM and acute medicine staff should be explicitly stated with respect to the overlap/boundary between the two services."

- AMUs will not be developed at the cost of EDs nor are they intended to replace EDs. There should be no "asset stripping" of EDS for AMU development. Consultants in EM should contact their regional EMP leads if they consider that ED resources are being redirected to AMU development.
  "*Duplication of infrastructure and facilities should be avoided in the interest of system efficiency and optimal resource management, but services should not compete for resources*".

- Acute Medicine Units (AMU/AMAU/MAUs) are only for GP referred patients and those medical patients the ED team refer there. Patients who self-present to EDs with medical problems remain the remit of ED teams, who will determine the appropriate stage to refer to medical teams for admission or further investigation or who may elect to care for these patients through EM delivered ambulatory care pathways. Direct medical sub-specialty referral may also occur:
  " Local arrangements, protocols and policies will determine whether medical patients are admitted through ED/AMU/AMAU or are admitted under the care of other medical specialty on-call teams."

- EDs should have access to the services of the *Acute Floor Data Manager* and allied health professionals.
  " The acute floor data manager's role will encompass responsibility for the collection and dissemination of all acute floor metrics. The role should be developed to support clinical audit within the acute medicine service and across the related specialties (EM, critical care and surgery)."

- The Acute Floor Concept means that all new AMUs and EDs should be co-located, with critical care and Diagnostic Imaging also adjacent. New relationships between all acute and emergency specialties are to be forged through the five Acute Care programmes.

- The *Navigation Hub* should result in improved bed management across regions and networks. It may also be a resource for communication across other specialties and agencies such as primary care, liaison psychiatry, community services and the ambulance service.

5. Surge Capacity:

- This is recognised as a problem for AMUs and not just EDs. The additional workload should be shared.
  " Where in-patient bed occupancy has reached a level of 85% within a hospital, the decision to implement surge capacity is the responsibility of lead physician for the AMU/AMAU/MAU…to prevent AMU and ED overcrowding."
  "There should be planning for surge capacity across the ED/AMU/AMAU interface and across the ISA

to prevent overcrowding. In cases when demand exceeds capacity, a shared response will be required and the extra workload should be managed effectively across the ED and AMU/AMAU."

6. Professional issues for EM:

- EM will have input to all national guidelines, algorithms, care pathways and patient information materials developed for use in AMUs.
- The role of the EM CDU is recognised (Section 5.2). We need to develop CDU work and advance research in this field.
- There is nothing in the AMU document precluding Consultants in EM becoming involved in their local AMU, if they wish to do so. The AMP group nationally would encourage this.
- Joint training programmes, analogous to the UK Acute Common Stem training may be developed. AM is likely to wish to rotate medical SpRs through EDs for resuscitation room experience.
- The EMP will bring similar changes to EM, so it is likely that our resources will need to be focussed on the timeliness and quality of EM care. It may be helpful, in the long-term to have our physician colleagues directly involved in managing patients who have already been determined by their GPs to need medical admission such that we can focus on core ED work. Reconfiguration of services and centralisation of time-critical care such as cardiac and stroke reperfusion and trauma care may place new demands on EDs and shift workloads between centres.

The only certainty is change!

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