Comhairle na nOspidéal

Acute Medical Units

October 2004

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1 INTRODUCTION

1.1 CONTEXT

In July 2000, Comhairle na nOspidéal approved a post of Consultant General Physician to be based at the Mid-Western Regional Hospital, Limerick. The letter of approval indicated that the appointee to the post would be responsible for ambulatory care and would be in charge of the medical assessment unit in the hospital. Comhairle na nOspidéal subsequently approved two similar posts of Consultant General Physician at St. James's Hospital in October 2000, noting that the appointees to these posts would have responsibility for the acute medical admissions unit at St. James's Hospital.

Arising from these posts and in the context of a range of initiatives in various hospitals being established to focus on acute medical patients, Comhairle na nOspidéal decided in July 2002 to establish a committee with the following terms of reference:-

> *"To examine the role, organisation and staffing of Acute Medical Admissions / Medical Assessment Units and other similar initiatives that are taking place in hospitals around the country and to make appropriate recommendations to Comhairle na nOspidéal regarding how such units, if deemed a positive development, could best be developed, organised, staffed and integrated within the acute hospital system."*

1.2 MEMBERSHIP OF THE COMMITTEE

The following members of Comhairle na nOspidéal were appointed to serve on the Committee:

Prof. D. Moriarty (Chairman),
Consultant Anaesthetist, Mater Misericordiae Hospital and Professor of Anaesthesia, UCD

Mr. J. Cregan, Principal Officer, Acute Hospitals Division, Department of Health & Children

Prof. M. FitzGerald, Consultant Respiratory & General Physician,
St. Vincent's University Hospital and Professor of Medicine, UCD

Dr. J. J. Gilmartin, Consultant Respiratory & General Physician, Merlin Park Hospital, Galway

Ms. M. Topham, Planning & Development Manager, South Infirmary-Victoria Hospital, Cork

Dr. C. Twomey, Consultant Physician in Geriatric Medicine,
Cork University & St. Finbarr's Hospital, Cork

Mr. T. Martin, Chief Officer, Comhairle na nOspidéal.

Mr. S. Ó Cinnéide (Executive Officer) was secretary to the committee and undertook the preliminary drafting of and research for this report prior to undertaking a career break. Subsequently Ms. M. J. Biggs (Higher Executive Officer) was appointed secretary to the committee and undertook the drafting of this final version of the report.

1.3 THE CONSULTATION PROCESS

The committee commenced its work in September 2002 with a wide-ranging information gathering process. Each health board and relevant voluntary hospitals were informed of the establishment of the committee, its membership, terms of reference and work programme. They were then invited

to make a submission relating to its terms of reference, detailing initiatives currently underway, in relation to the assessment and admission of acute medical patients. These submissions, which included information regarding role, staffing and organisation, were used to examine and compare developments throughout the state.

The committee also visited a number of hospitals throughout Ireland where specific medical initiatives were either in operation or in planning phase. Information regarding these visits is provided in Section 3 of the report. Submissions were also sought from the Irish Association of Emergency Medicine (IAEM), the Royal College of Physicians of Ireland (RCPI) and the Irish College of General Practitioners (ICGP). The committee met with the RCPI and the ICGP early in 2004.

In December 2002, representatives of the committee travelled to Edinburgh to view and discuss the operation of the Medical Assessment Unit in the Royal Infirmary of Edinburgh. The unit in Edinburgh, established over a decade ago, had been recommended to the committee as an efficient and effective model with potential for application in Ireland. Indeed this model already appears to have influenced the development of some of the medical assessment / admission units that have been developed in Ireland. The visit to Edinburgh gave the committee a valuable insight into the development and operation of a successful medical assessment / admission unit.

The committee wishes to record its sincere appreciation to the many people and organisations that contributed to the formulation of this report. Special mention must be given to Dr. Derek Bell, Clinical Director, Medical Assessment, Royal Infirmary of Edinburgh, who provided particular assistance and advice to the committee.

1.4 CONTEXT OF REPORT

This report is written and its recommendations are made in the context of the existing medical staffing system and hospital network. Comhairle na nOspidéal in writing this report and making its recommendations is aware that the Irish health service is currently undergoing major reform as outlined in the Government's Health Service Reform Programme announced in June 2003 and the planned establishment of the Health Service Executive on 1st January 2005. In addition, the implementation of the Report of the National Task Force on Medical Staffing (June 2003) and the impending work of the Acute Hospitals Review Group will influence hospital configuration and medical staffing requirements.

2 ACUTE MEDICINE

2.1 DEFINITION OF ACUTE MEDICINE

As defined by the Royal College of Physicians, UK, acute medicine is that part of general (internal) medicine concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present in hospital as emergencies.

2.2 SPECIALISATION WITHIN INTERNAL MEDICINE

In the past, most consultant physicians functioned as general physicians covering the broad range of general internal medicine. However, in recent decades there has been a marked rise in specialisation and sub-specialisation in internal medicine. There has been a steady increase in the number of recognised medical specialties with corresponding training programmes. This increasing specialisation within internal medicine, in conjunction with medical, technological and therapeutic advances, has led to better patient outcomes for a wide range of medical conditions. The trend towards specialisation, which in itself generates a substantial workload, has resulted in reduced availability and/or willingness of consultant physicians to be on the general medical call for acute emergency cases. The bulk of acute general medicine "take" is currently dealt with by consultants and non-consultant hospital doctors in the specialties of cardiology, endocrinology/diabetes, gastroenterology, geriatric medicine, nephrology, respiratory medicine and rheumatology. Other medical specialties such as dermatology, medical oncology and neurology do not generally participate in acute general medical call.

2.3 ACUTE MEDICAL ADMISSIONS

The relative proportion of inpatients in acute hospitals in Ireland that are medical - as distinct from surgical - has increased steadily over the past number of years. As of 2003, the proportion of medical to surgical inpatients in acute hospitals nationally stood at 76% and 24% respectively (source HIPE data 2003, Department of Health and Children)

Furthermore, there has been a change in the nature of these admissions. Just over 70% of all inpatient admissions to acute hospitals are admitted as emergencies. The latest available HIPE data (2003) shows that 84% of all medical inpatients were admitted as emergencies. This compares to 39% of surgical inpatients being admitted as emergencies.

The consequent demands placed on medical services in acute hospitals are further increased when a number of other factors are taken into account. These include:

- heightened public expectation and demand for prompt and high quality healthcare and hospital treatment
- increased public expectation that the acute care of emergency admissions should have direct consultant input
- a preponderance of medical emergencies being older people, often with multiple medical conditions in addition to the acute illness for which they have presented
- the acknowledged bed capacity deficit within acute hospitals in Ireland - the number of acute beds per capita in Ireland, at 3.1 per 1,000 population, is one of the lowest among EU and OECD countries (Acute Hospital Bed Capacity Review)

- occupancy of acute hospital medical beds by patients who no longer require acute treatment, but who are not discharged for prolonged periods because of a lack of appropriate alternative facilities and infrastructure outside the hospital to receive and support them.

The increasing number of acute medical cases presenting to acute hospitals is not unique to Ireland and has been reported in numerous countries worldwide. There is no evidence to suggest that the number of patients presenting with acute medical conditions to hospitals in Ireland and requiring assessment and admission will decrease in the foreseeable future. Indeed demographic projections are more likely to have the opposite effect.

The Central Statistics Office has predicted that the general population could increase from 3,917,336 in 2002 to 4,566,600 in 2031. In addition demographic projections indicate that an increasing portion of the population will be aged 65 years of age and over. By 2026, it is predicted that persons aged 65+ will constitute 16.4% of the population of Ireland as compared to 11% currently. By 2050, it is predicted that one in four of the overall population will be aged 60 years or more.

In 2000, persons aged 65+ years comprised 27% of the Irish hospital inpatient population and consumed 46% of the bed days used in acute hospitals nationally. The increase in the proportion of elderly persons within the general population represents the biggest challenge in the area of acute medical assessment and admissions to hospitals.

In addition to demographic factors, on-going improvements in medical technology and knowledge are likely to result in earlier and improved diagnosis and treatment of a wider range of medical conditions. These advances will, of necessity, lead to increased specialisation and sub-specialisation within medicine and will bring additional pressures to bear on general internal medicine in terms of beds, participation in acute medicine on-call rotas and skill maintenance.

The combined result of all the above factors is severe pressure on acute hospitals, their beds, their staff and other resources, by virtue of the sheer volume of patients presenting with acute medical illnesses. Some of the greatest effects of this pressure can be seen in the regular disruption and frequent cancellation of elective work, both medical and surgical and the persistence of waiting lists nationwide despite a series of initiatives to address this problem. Additionally, there is an increasing practice of acute patients being referred to A&E who should be more appropriately admitted directly to a medical or surgical bed. Furthermore, an increasing number of patients, for whom an elective admission to hospital would be more appropriate, choose to access inpatient care via attendance at the A&E department, as this route may offer the only prospect of being admitted expeditiously.

2.4 NATIONAL REPORTS

The committee reviewed recent published reports and policies regarding hospital services in Ireland with a view to identifying the policies and recommendations proposed to manage the increasing number of acute medical admissions. From the extensive range of reports reviewed, particular account was given to:

- **Quality & Fairness - A Health System for You**.
  Department of Health & Children. Dublin, 2001
- **Acute Hospital Bed Capacity – A National Review**.
  Department of Health & Children. Dublin, 2002
- **Report of the Committee on Accident & Emergency Services**.
  Comhairle na nOspidéal. Dublin, 2002

- **Report of the National Task Force on Medical Staffing**. Department of Health & Children. Dublin, 2003
- **Admission and Discharge Guidelines, Health Strategy Implementation Project**. The Health Boards Executive, 2003.

A summary of the relevant observations, recommendations and comments contained in these reports is provided below.

2.4.1 Quality & Fairness - A Health System for You. Department of Health & Children

The Government's Health Strategy, *Quality & Fairness, A Health System for You*, was launched in November 2001. This strategy outlines the principles, values, goals and objectives which will underpin and guide the development and direction of health service delivery in Ireland over a 10-year period. Among the weaknesses identified within the current health system were inadequate bed capacity and unequal access to services. It was noted that despite considerable reductions in acute hospital bed numbers since the 1980s, hospital activity had increased significantly in the subsequent 20 years. This has imposed serious strain on hospital staff, facilities and services. In addressing these issues the Strategy states that "*systems in hospitals will be reviewed to enhance clinical pathways. This will be aimed at improving the flow of patients through A&E departments, diagnostic services and the hospital generally.*" Actions identified in the Strategy include commissioning an additional 3,000 acute hospital beds for patients over the ten years to 2011, as well as initiatives to be undertaken to improve the operation of accident and emergency departments by directing patients to the most appropriate location of care, thus ensuring that patients are seen as quickly as possible and in the most appropriate facility.

2.4.2 Acute Hospital Bed Capacity – A National Review. Department of Health & Children

This review, carried out by the Department of Health and Children as part of *The Programme for Prosperity and Fairness*, focused on bed capacity in publicly-funded acute hospitals in Ireland. This was carried out with the aim of examining the need for change to the current acute bed complement and utilisation patterns, taking account of factors which impact on demand for acute hospital beds now and in the future. The review took into consideration strategies with the potential to reduce the need for additional beds, including substitution of elective inpatient surgery with day surgery. The review recommended that 2,840 additional inpatient acute hospital beds were required in Ireland by 2011.

This figure was deemed sufficient to address goals such as reducing average bed occupancy in major hospitals while meeting projected demographic changes and coping with increased demand for healthcare. Assessing and measuring current acute hospital activity in Ireland the review concluded that, "*in short, current acute hospital bed capacity is unable to respond adequately to the demands to which it is subjected*." Making its recommendations regarding additional beds, the review group noted however "*that adding beds is only part of the solution to the difficulties being experienced in the acute hospital system… Examining ways in which current capacity could be used more effectively and efficiently is another. It is unlikely that one solution can be found for such a complex problem. More likely is that a combination of measures will be required*."

2.4.3 Report of the Committee on Accident & Emergency Services. Comhairle na nOspidéal

In February 2001, Comhairle na nOspidéal established a committee to undertake a review of the structure, operation and staffing of Accident and Emergency Services and Departments. In its report, published in February 2002, Comhairle na nOspidéal noted that many of those consulted stated that "*significant improvements in emergency services, including reduced waiting times, would not happen without changes in the organisation of emergency care, better use of care pathways, increased and more timely access to diagnostics and better access to and management of inpatient beds".* The report further noted that *"improvements in patient flow in the Emergency Department are limited by difficulties in accessing inpatient beds and the congestion caused by being unable to move patients to a ward."*

In making its recommendations Comhairle na nOspidéal concurred with the view expressed to it during its consultation process that a "*whole system*" approach to hospital care was required in order to ensure that hospital emergency services can be delivered effectively. In this context, Comhairle na nOspidéal recommended "*that hospital services are explicitly organised in three distinct but interdependent streams or services:*

1. ***Emergency care***
   Organised so that patients, depending on their needs, can move smoothly between Emergency Departments, assessment beds, intensive care, coronary care, the best inpatient medical and surgical care and have rapid access to appropriate diagnostic services and primary care.

2. ***In-patient Elective Care***
   Encompassing inpatient beds in clinical specialities, diagnostic facilities and services as well as strong links to outpatients and day care facilities.

3. ***Day and Outpatient care***
   Addressing the needs of patients who require non-urgent care in a hospital setting but who do not need admission to the hospital. These include out-patients appointments, many diagnostic investigations, day surgery and various therapies."

The report noted that the above reconfiguration of services would require a range of designated beds including emergency department observation beds, intensive care beds, coronary care beds, rehabilitation beds and beds in acute admission wards for short duration inpatient stay. Making its recommendations regarding hospital emergency services, Comhairle na nOspidéal proposed that for "*emergency care to work efficiently, the hospital emergency service must be organised so that patients, depending on their need, can move smoothly between Emergency Departments, minor injury and illness areas, primary care, assessment beds, intensive care, coronary care, the best inpatient medical and surgical care and have rapid access to diagnostic services.*"

2.4.4 Report of the National Task Force on Medical Staffing

The National Task Force on Medical Staffing was established in February 2002 by the then Minister of Health and Children, Mr. Micheál Martin. The Task Force was asked to devise an implementation plan for reducing substantially the working hours of NCHDs to meet the requirements of the European Working Time Directive (EWTD), to plan for the implementation of a consultant-provided service and to address the medical education and training needs associated with the EWTD and the move to a consultant-provided service. The report of the Task Force, adopted as Government policy in October 2003, made a number of recommendations regarding the configuration and staffing of the Irish hospital system.

During the formulation of its report, the Task Force considered whether there was a role for doctors termed "*hospitalists*" or "*generalists*" within the Irish Health System, "*who could provide a considerable level of frontline clinical service in hospitals before referring patients to the appropriate specialists*". The Task Force concluded that it would not be desirable to develop the hospitalist or generalist model extensively in Ireland. Rather the Task Force believed "*that it would be valuable to have a number of consultants concentrating mainly on general internal medicine but with an interest in another medical specialty. Such consultants would have an 80/20 or 70/30 commitment to general internal medicine and a subspecialty and share on-call rotas with consultants in the sub-specialties of general internal medicine*". The Task Force felt that this approach would combine some of the efficiencies offered by a generalist model with the important benefits of sufficient links with specialist work.

The Task Force recommended that Medical Assessment Units and Medical Admission Units play a key role in the effective management of emergency department attendees with medical problems. The report defined Medical Assessment Units as providing "*a short stay area for assessing medical*

patients who need further investigations before a decision on the most appropriate care can be made" and Medical Admission Units as facilities that provide "*rapid assessment, diagnosis, observation and early treatment to patients with medical problems who are referred for admission to hospital. Patients could be referred to the Medical Admission Unit by the hospital emergency department, directly from GPs or from outpatient clinics.*"

2.4.5 Admission and Discharge Guidelines, Health Strategy Implementation Project. The Health Boards Executive

These guidelines were produced by the Health Boards Executive in response to specific commitments made in the Government's Health Strategy 2001. These commitments related to enhancing the discharge function in each acute hospital to ensure that patients do not have to stay in hospital any longer than is necessary and to ensure emergency patients will be the only group admitted to hospitals via A&E departments. The report makes a number of recommendations regarding best practice, protocols and policies for improving emergency and elective admissions and discharges within the hospital system.

In addressing the issue of admitting patients from emergency departments, it is noted in the report that more rigorous assessment of patients is needed to ensure the appropriateness of hospital admission and to maximise the number of beds available for elective admission. A number of factors, which are considered important in admitting patients from the emergency departments, are identified. These include:

- extended access to rapid assessment clinics and outpatient radiology and pathology services
- rapid assessment and extended access to diagnostics
- early senior medical decision-making available at the point of admission
- close multidisciplinary team work
- patients being streamlined into a number of categories, including resuscitation, minor illness and injury and specialised medical/surgical team assessment for patients who may require admission and
- rapid access facilities such as Medical Assessment Units (MAU) requiring robust, specific and auditable operational policies.

Concluding its recommendations, the report notes the essential need for a "*whole systems approach*" to admission planning, underpinned by high quality communication and information systems.

2.4.6 Comment

Comhairle na nOspidéal notes that each of the reports highlighted the need for change with respect to how hospital services were organised, resourced and delivered. **Comhairle na nOspidéal concurs with the view that while essential, the putting in place of additional beds in the public hospital system will not on its own address all the current difficulties being faced by acute hospitals in the state. Rather, additional measures and steps need to be taken in order to ensure that current and additional capacity is used more effectively and efficiently and existing processes changed in order to guarantee that patients have access to the right care, at the right time, in the right place, delivered by the right people**.

Two of the reports reviewed expressed direct support for changes in the utilisation of beds in the form of the development of medical units with acute admission or assessment beds. The committee in proceeding with its work focused on examining the value of such units with respect to acute medical patients, and how such units, if deemed a positive development, could best be developed, organised, staffed and integrated within the existing acute hospital system.

2.5 DEVELOPMENTS IN THE UNITED KINGDOM

Medical assessment units and medical admission units have been introduced in the UK in the past number of years. They are considered to have had a positive effect on the provision of acute medical services there. In many hospitals, these units are under the clinical leadership and administrative charge of particular consultant physicians who have chosen to specialise in the first 24 hours of medical care for acutely ill patients. These consultant physicians are often referred to as **acute care physicians** in the medical literature and in UK hospitals. They have come from a range of backgrounds, including general medicine, anaesthesiology and intensive care medicine.

In June 2000, the Federation of the Royal Colleges of Physicians of the UK published "*Acute Medicine: the physician's role – proposals for the future*". This document considered issues such as how acute medical care can best be provided in hospitals, what type of physicians are needed to provide this care and whether the established method of physicians providing both specialist and general care should be changed. The report encouraged the development of medical admission units which would have specific consultant sessional time allocated to them. It further recommended dual certification – in general (internal) medicine and in a sub-specialty area of medicine – for all physicians, but especially those practising in eight specialist fields: cardiology, diabetes and endocrinology, gastroenterology, geriatrics, infectious disease, renal medicine, respiratory medicine and rheumatology. The June 2000 report did not recommend the development of a sub-specialty of acute medicine or singly accredited acute physicians.

Subsequently however, arising from such factors as an increasing demand for emergency medical care and the introduction of the European Working Time Directive, the Royal College of Physicians (RCP) in 2002 endorsed the development of acute medicine as a distinct sub-specialty and authorised the development of an appropriate training programme. In July 2003, the Specialist Training Authority in the UK formally recognised acute medicine as a subspecialty of general internal medicine (GIM) for the purposes of training. The programme requires that trainees undertake an additional year of training in acute medicine after completion of higher specialist training in GIM. In light of these developments, the Royal College of Physicians reviewed and updated its 2000 report, publishing in May 2004 a report entitled "*Acute Medicine: making it work for patients*". This report makes a number of recommendations regarding the delivery of acute medical services, including:

- that the term "acute medical unit" as opposed to medical assessment unit or medical admission unit, be used to describe the dedicated area in hospitals where acutely ill medical patients are managed
- that consultant physicians in the new specialty of acute medicine be developed and supported, with such post-holders spending 50% of their time providing direct clinical care in acute medicine
- that appointments in acute medicine be developed that include commitments to A&E departments, high dependency units and/or intensive care units as well as acute medical units
- that at least three consultants with primary responsibility for acute medicine be put in place in every acute hospital in the UK by the year 2008, with greater numbers of such posts in the larger acute hospitals i.e. those with a catchment area of 400,000
- that any consultant physician responsible for receiving acute medical patients should have no other scheduled commitments during the period of their acute call.

It is envisaged in the RCP report that as the number of individuals qualified with a subspecialty interest in acute medicine increases over the coming years, the proportion of acute medicine delivered by consultant physicians with most of their training in another specialty will proportionally decrease.

In the larger hospitals in the UK, it is recommended by the RCP that physicians in acute medicine, numbering from 7 – 12, provide the majority, if not all, of the acute medical services. This will allow those consultants based in AMUs to triage directly to the specialties that may not be directly involved in the initial assessment of acutely ill medical patients. Allowance is also made in the report for consultant physicians in acute medicine with an additional specialty interest.

In small and medium sized district general hospitals in the UK, (i.e. acute hospitals with two to three consultants in most major medical specialties) the RCP recommended that consultant physicians in other specialties continue to be significantly involved in the delivery of acute medicine alongside the consultant physicians in acute medicine.

2.5.1 Comment

Comhairle na nOspidéal acknowledges the merits of a number of aspects of the approach being undertaken in the UK in addressing the increasing acute medical workload. However, while Ireland can learn from how acute medical services are being managed and developed in the UK, there are significant differences between Ireland and the UK in terms of how hospitals are networked, the average size of hospitals, consultant staffing and hospital catchment populations.

Nowhere is this difference more apparent than with respect to the catchment populations of acute general hospitals in Ireland. In the UK, "small and medium" sized hospitals serve populations of between 150,000 to 400,000, with "large" hospitals serving a population of 400,000 plus. This is not comparable to Ireland, where a number of hospitals serve populations of 50,000 or less and no single hospital alone exclusively serves a local population greater than 300,000.

Due to these significant differences it would not be appropriate for Ireland to attempt to mirror exactly the approach being undertaken in the UK with respect to staffing acute medical services at consultant level. For instance, this report envisages that in every acute hospital in Ireland it will remain essential that consultant physicians in a range of medical specialties and sub-specialties continue to be involved in the acute general medical on-call rota. However, other important components of the UK approach are deemed to be suitable in an Irish context and should be developed here.

3 NEED FOR CHANGE

3.1 LIMITATIONS OF CURRENT SITUATION

3.1.1 Admission of emergency medical patients

Hospitals which receive medical emergencies must be in a position to provide comprehensive investigation and treatment services to emergency patients 24 hours a day. The efficiency and effectiveness of this emergency medical care is dependent on the organisation and delivery of acute services. During its consultation process, the committee examined in detail the assessment-admission-discharge pathways currently in place for acute medical patients in acute hospitals throughout Ireland. A diagrammatic representation of this pathway is given in Figure 1.1.

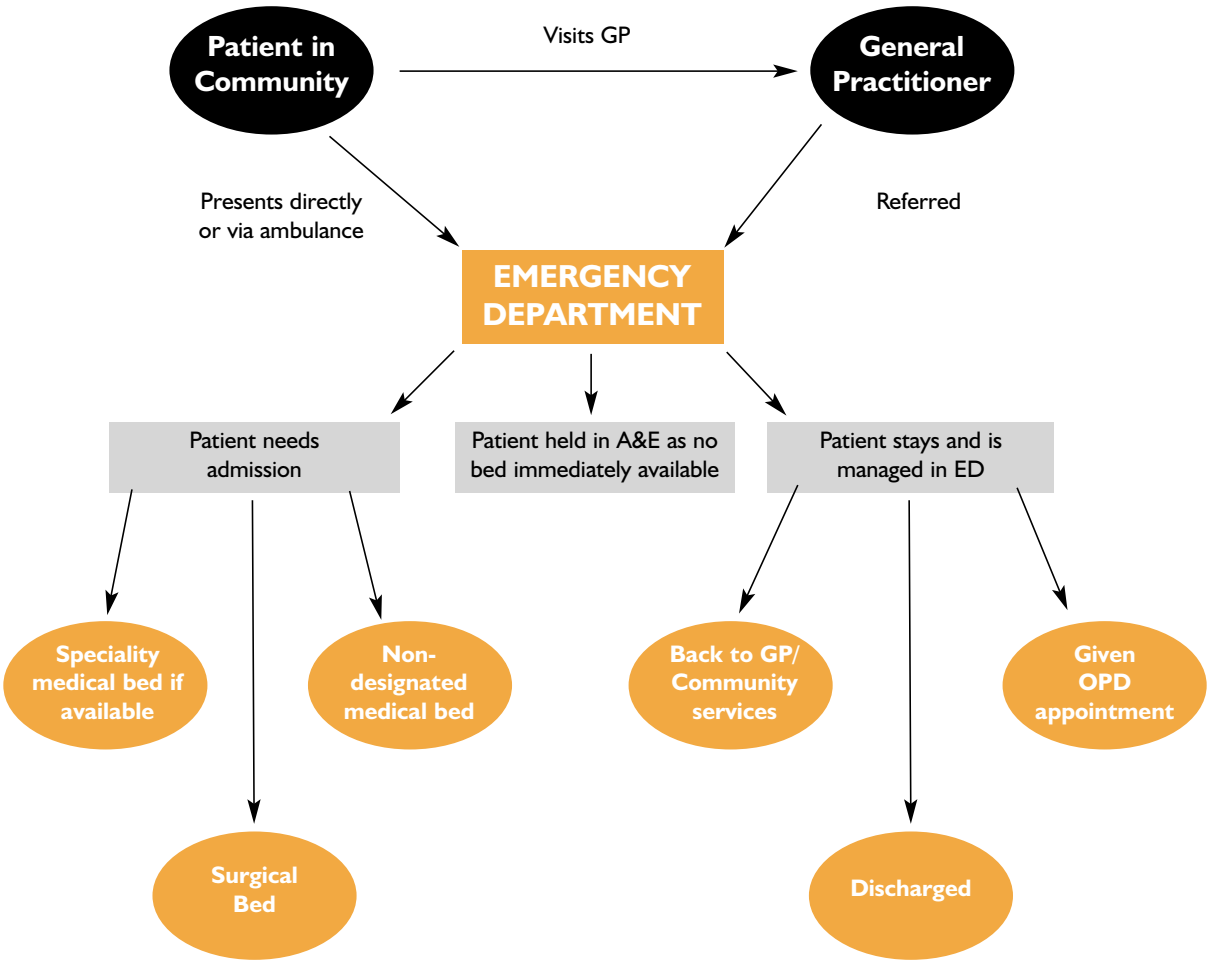


Figure 1.1 Admission – discharge pathway

Although the pathways as presented in Figure 1.1 may seem at first glance relatively simple and straightforward, the actual processes and procedures involved along these pathways contribute to many of the difficulties associated with the management of an increasing acute medical workload. A number of the limitations and associated consequences as identified by the committee, health boards, hospitals, the Irish College of General Practitioners, the Irish Association of Emergency Medicine and the Royal College of Physicians are outlined in Figure 1.2.

Figure 1.2

Limations of Current Pathway	Consequences
Shortage of acute medical inpatient beds	Significant delays, sometimes up to a few days, before an acute medical patient can be admitted to an inpatient bed. Increase in trolley days and trolley usage in A&E departments
Inability of local GPs to directly access hospital services, thereby causing them to instruct their patients to present themselves at A&E departments.	No incentive for patients to attend their GP in the first instance, and no benefits for the patient if they have attended a GP and where further medical assessment is required. Perception among GPs that they have little support from their local hospitals. Increased workload in A&E departments. Increase in waiting times in A&E departments for all patients.
Repeat inappropriate re-assessment by emergency department staff of acutely ill patients already seen and referred by GPs for admission	Delays by hospitals in treating patients who have been diagnosed by their GPs as needing inpatient treatment and/or urgently required investigations
Majority of care in A&E is delivered by junior doctors, many of whom are relatively inexperienced Due to the nature of their complaint, many medical patients can be left waiting for long periods of time in A&E departments before being assessed or treated as other more "urgent" cases are continually prioritised ahead of them. Delays associated with waiting for the relevant on-call medical team to assess an acute medical patient in A&E.	Decision making pathway slowed due to lateral referrals and insufficient senior clinical decision makers. Significant delays in treating and diagnosing acute medical patients and in identifying and implementing optimal care pathways. Patients' and relatives' perceptions of experiencing an unsatisfactory hospital service.
Delays in admitting medical patients until relevant medical team agrees	A&E department playing the role of a holding facility with respect to emergency medical patients.
Patients with similar conditions who are being treated by the one consultant and their NCHD team being scattered throughout the hospital rather than located in one designated section/ward of the hospital	Chaotic ward rounds for medical teams, commonly referred to in international literature and in the hospitals consulted as "safari" rounds. In certain instances, patients may be overlooked for a considerable period as the relevant teams may not have been informed of their precise location.
Admission of medical patients to inappropriate wards including surgical wards.	Patients can undergo a number of bed-to-bed transfers, as inappropriately placed patients are later moved to the appropriate wards as beds become available Issue of the ability of surgical ward staff to look after medical patients.
Pressure in A&E departments to admit patients to any bed that is unoccupied in any part of the hospital in order to get patients off trolleys and chairs and free up much needed space in A&E departments.	Increased interruption and cancellation of elective activity and urgent inpatient investigations in both medical and surgical specialties.

3.1.2 Discharge of medical patients

The length of stay of medical patients will vary depending on the extent of their illness. The Acute Hospital Bed Capacity Review reported that the mean length of stay of medical patients nationally was in the region of 6.6 days. One of the major difficulties experienced by patients and hospitals at this point in the process is the shortage of alternative facilities and services such as rehabilitation, community care support and long term nursing care, for patients no longer in need of acute medical care. One Dublin hospital informed the committee that, at any one time, the hospital would have in the region of 60-70 patients awaiting placement in long term care. Delays in accessing long stay beds for these patients can range from six months up to three years. Twenty percent of these patients are in the younger/middle-age group. The committee was informed of similar situations in other hospitals throughout Ireland.

3.1.3 Comment

In a number of hospitals visited by the committee, management and consultant staff described the current medical assessment, admission and discharge pathway as being "chaotic". The most serious issues cited concerned resource utilisation, the impact of delays on patients' health and well-being and ultimately the public's perceptions of the health service.

It was outlined in one hospital that it would not be uncommon that a typical pathway of an acute medical patient through the hospital system would involve up to four or five days before appropriate treatment is initiated. These delays centred on waiting in the A&E department, waiting for an inpatient bed, waiting to be seen by the relevant consultant and his/her team, waiting for tests, their results and waiting for a diagnosis.

Overall the acute hospital system in Ireland at present deals with unplanned acute medical assessments and admissions in a largely reactive manner. Pressure begins in the A&E department and then builds up and spreads throughout the hospital. **There is now an urgent need within the hospital system in Ireland to ensure that acute medical patients, whose numbers are growing, are dealt with in a more centralised, planned and co-ordinated manner. This would lead to more effective care of these patients and more efficient use of hospital resources.**

3.2 CURRENT INITIATIVES

In response to this growing issue within hospital care, a number of Irish hospitals have examined alternative ways of dealing with patients requiring emergency medical assessment and/or admissions. This has resulted in these hospitals introducing and implementing a range of new initiatives which have been variously described as "medical assessment units", "medical admissions units", "medical day units", "medical receiving wards" and "medical emergency departments". They differ to varying degrees in terms of their organisation, operation, staffing, facilities, size, types of patients seen, source of patients, number of beds and hours of opening. In spite of these differences, the main objective of these various initiatives is to streamline the process of assessing, treating and admitting acute medical patients.

Outlined in the next section is a description of some of these initiatives underway around the country.

4 FINDINGS OF CONSULTATION STAGE

4.1 INTRODUCTION

As part of its consultation process, the committee visited a number of hospitals and held discussions with management and medical staff. These hospitals included those who had introduced medical initiatives in the past but had abandoned them, those who had them in place, those who were at a relatively early stage of development and those that were in the process of planning the implementation of new initiatives. The hospitals visited by the committee were:

- Cork University Hospital
- Mater Misericordiae Hospital, Dublin
- Mayo General Hospital, Castlebar
- Mid-Western Regional Hospital, Limerick
- St. James's Hospital, Dublin
- St. Luke's Hospital, Kilkenny
- Tallaght Hospital, Dublin
- University College Hospital, Galway
- Waterford Regional Hospital

In addition, the committee visited the Royal Infirmary of Edinburgh, Scotland, whose Medical Assessment Unit had been recommended to the committee as a useful model to study.

The committee also received submissions from a range of other hospitals and employing authorities including

- Coombe Women's Hospital
- Mercy Hospital, Cork
- Midland Health Board
- Northern Area Health Board
- North Western Health Board
- Rotunda Hospital
- St. John's Hospital, Limerick
- South Eastern Health Board
- Southern Health Board
- South Infirmary Victoria Hospital, Cork
- South Western Area Health Board

A brief description of the medical initiatives in place in hospitals visited is outlined below. A description is also provided of the unit in the Royal Infirmary of Edinburgh. **It should be noted that the terminology used in relation to these initiatives is that used by the relevant hospitals or health boards involved.** Information in relation to the hospitals is presented in the order that they were visited by the committee.

4.2 HOSPITALS VISITED BY THE COMMITTEE

4.2.1 Mid-Western Regional Hospital, Limerick

A medical initiative, termed the Medical Day Ward (MDW), was introduced in Limerick by the Mid Western Health Board as a strategic investment to provide rapid access for GP services, avoid unnecessary admissions and reduce the average length of stay for certain defined diagnostic categories. The operation of the MDW relies on the use of evidence-based diagnostic-driven integrated care pathways. The MDW provides an alternative assessment pathway for defined medical patients and helps bridge the gap between outpatient clinics and A&E. The MDW is staffed by one consultant physician, NCHDs, nurses and administrative staff. The consultant with overall responsibility for the MDW is a specialist in general internal medicine and geriatric medicine. The ward also receives further consultant input from various other specialties.

The MDW currently has 5 beds and 14 treatment couches (i.e. 19 treatment slots) and has close links with rehabilitation services. The opening hours of the MDW are from 9.00 to 17.00, Monday to Friday, with patients being received up to 16.30. At the time of the committee's visit the MDW was looking to extend its opening hours. The workload of the MDW is based primarily around the following diagnostic pathways: deep vein thrombosis (DVT), syncope, transient ischaemic attack (TIA), stroke, asthma/chronic obstructive pulmonary disease (COPD), shortness of breath (SOB), falls, atrial fibrillation/congestive cardiac failure (CCF), anaemia, bronchoscopy and non-orthopaedic fractures. If a patient does not fit into any of the identified clinical care pathways, then the patient is directed to the general medicine pathway. The MDW provides open referral from A&E for certain diagnostic categories and provides a priority service to GPs, with a response time of two working days for the latter. The MDW also provides services in certain pre-designated medical procedures including for example blood transfusions.

The MDW receives approximately 20 patients per day (at least 5 new and 10 review patients) and on average sees 360 patients a month. 40% are referrals from GPs, 40% from A&E and 15% from other consultants. The committee were informed that the introduction of the Medical Day Ward in Limerick has resulted in a 1.2 day reduction in the average length of stay for patients over 75 years of age.

4.2.2 St. Luke's Hospital, Kilkenny

In November 2000, the South Eastern Health Board established in St. Luke's Hospital, Kilkenny a facility which they called a Medical Assessment Unit (MAU) in response to the growing number of medical admissions and bed capacity problems being experienced by the hospital. The objectives of the unit were to improve the efficiency with which medical emergencies were assessed and admitted to the hospital, and to reduce or eliminate the use of corridor beds and bed-to-bed transfers to different wards in the hospital. In essence, the purpose of the MAU was to provide an alternative pathway to the traditional casualty route for medical emergencies.

Medical cover for the unit is provided by the medical team on-call, which gives a priority service to the MAU. All the physicians in St. Luke's Hospital are involved in the MAU and work a 1 in 6 rota. The on-call physician takes lead responsibility for all acute emergency medical admissions processed through the unit during his/her on-call period. A clinical nurse manager II is in charge of the day-to-day running of the unit and is assisted by 7 staff nurses. Two ward rounds take place everyday, the morning being consultant led, the evening one registrar led.

The MAU currently has 6 beds and has a central position in the hospital with easy access to facilities such as radiology. Hospital representatives noted that the location of the MAU facilitates the rapid

assessment of acute medical referrals. The MAU operates from 8am to 8 pm, 7 days a week, with patients being accepted up to 7pm. It was indicated to the committee that the current bed capacity in the unit was insufficient to meet the demand on the service and that ideally the unit would be enlarged and its opening hours extended. However, there was a reluctance to open the MAU on a 24 hour basis, for fear that it would operate like a normal medical ward and lose its ability to meet its core objectives. During the period of the opening of the unit, extra medical beds were provided in nearby Kilcreene Hospital.

Of the patients admitted to the unit, 95% are acute GP referrals, with only 5% being self-referred. Patients are triaged, assessed and their suitability for appropriate placement defined in the MAU. The majority of patients are assessed in 2-3 hours. By this time a decision is made to discharge the patient or admit the patient to a hospital ward or refer the patient for an urgent OPD appointment. 23% of patients admitted to the MAU are discharged on the same day. Thus, almost a quarter of potential admissions are avoided, as prior to the introduction of the MAU all GP medical referrals were admitted to the hospital. 66% of all medical admissions to St. Luke's Hospital in 2001 were assessed and admitted through the MAU, with the remaining 33% having arrived and being admitted after closing hours of the unit. In order to expedite decision making in relation to patients there is a commitment from the x-ray department, cardiac investigation and laboratory in St. Luke's Hospital to prioritise MAU patients and ensure that investigations are fast-tracked.

The committee was informed by St. Luke's representatives that the MAU has helped streamline and organise acute medical admissions in the hospital and that no patients have been admitted to corridor beds since the introduction of the MAU. In addition it was noted that surgical services in the hospital had been greatly facilitated by the opening of the unit, as the previous regular cancellation of elective surgery had virtually ceased.

4.2.3 Mater Hospital, Dublin

In December 2001, the Mater Hospital established a facility which it called the Medical Emergency Department (MED) project. The project was designed to specifically improve the level of care for emergency admissions, to reduce admission delay in A&E and to significantly enhance the hospital's ability to reduce waiting lists by increasing its capacity and efficiency through a reduction in overall length of stay of medical patients. It was aimed to achieve this *via* the MED project allowing focused management of emergency medical admissions. This was not possible when such admissions were dispersed throughout the hospital.

The MED project is effectively divided into three operation areas:

(a) Acute Cardiology Unit (ACU) including CCU and Chest Pain Centre

(b) Acute Geriatric Unit (AGU) including Stroke Unit

(c) Acute Medical Unit (AMU) including Medical Special Care Unit (SCU)

The ACU is a 44-bedded unit to which the cardiology team provides 24-hour cover. The AGU is a 56-bedded unit to which the geriatric team provides 24-hour cover. The AMU is a 62-bedded medical ward which includes a 6-bed special care unit for high dependency patients to which the general medical teams provide cover. The MED operates on a 24 hr/7-day basis. Overall the MED is staffed by 6 consultant led main on-call take teams and three subsidiary teams.

The MED receives medical emergency patients directly from the A&E department. These patients will have been triaged in A&E and directed to the appropriate team/unit within the MED. Once admitted to the MED, patients undergo comprehensive initial clinical assessment, with the focus

being on the completion of all investigations by the third hospital day and initiation of management of the patient as soon as a treatable diagnosis is made. Patients may be discharged directly from the MED or transferred for the remainder of their treatment to a specialty ward within the hospital. Discharge planning for the patient commences at the time of admission, in order to ensure in so far as is possible that the required facilities are in place at the time of discharge.

The committee were informed that some of the outcomes resulting from the introduction of the MED project include the average length of stay of medical emergencies being reduced from 13.6 days to 6.1 days and the average length of stay of chest pain patients being reduced from 13 to 6.2 days. In addition, the average number of patients delayed in A&E each week for greater than 6 hours was down from eighteen to nine. The view was expressed to the committee that the main advantage of the MED project was that the care of acute medical conditions is centralised within the hospital and it creates the ability to fast track patients and to provide rapid access to facilities. However, the MED was and is experiencing difficulties due to problems arising from the discharge of patients who need access to long term care beds and rehabilitation beds.

4.2.4 Royal Infirmary of Edinburgh, Scotland

In 1987, the Royal Infirmary of Edinburgh established a facility which it called a Medical Admissions Unit. In 1994, the philosophy and the focus of the unit changed from admission to assessment. The Medical Assessment Unit (MAU) was established to facilitate an efficient, high quality, emergency admission process and to reduce the length of stay of patients. The emphasis in the MAU was stated to be on early diagnosis, backed up by prompt investigations and treatment.

The MAU is staffed by dedicated medical rota teams incorporating 16 of the 30 medical consultants in the hospital, and dedicated junior doctors with protected sessions in the unit. The 16 medical consultants involved in the MAU are arranged into four medical teams, each of which has a fixed admission week (every 4th week). All admissions on a given day to the unit are the responsibility of the admitting consultants and senior nurse in charge. Patients in the unit remain under the care of the admitting consultant unless directly transferred to another consultant. Each consultant involved in the MAU is also on-call for their individual specialty which ensures that links with the various specialties are maintained. The MAU has two consultant-provided ward rounds each day (8am and 4.30 pm). In addition the MAU has 7-day access to specialty consultant input including cardiology, respiratory medicine and care of the elderly. The unit also has access to support services such as occupational therapy, physiotherapy, pharmacy and social work.

The MAU is a short-stay medical assessment area with 42 beds including 6 monitored beds. The throughput of the unit is approximately 400 patients per bed per annum. The unit has a separate ward for males (17 beds) and females (16 beds) and also has a 9-bedded toxicology unit. The MAU operates 24-hours a day. The majority of patients admitted to the unit are either transferred or discharged from the MAU in less than 24 hours, with the average length of stay being 18 hours. Patients may be kept in the MAU for longer than 24 hours and worked up to discharge in situations where it is anticipated that safe discharge can take place within 48 - 72 hours. Patients whose length of stay is expected to exceed 72 hours or who require specialist care are admitted to the appropriate specialty ward within the hospital. Of the 18,000 medical emergencies that present at the hospital per annum, 15,500 (85%) go through the MAU. All medical emergencies except those admitted directly to CCU and other specialty wards are directed to the unit. The vast majority of patients are referred from A&E, whilst 5-10% are referred directly by GPs. Of those patients attending the unit, fifty percent are discharged directly from the MAU. Routine / elective medical admissions are not admitted via the MAU.

When patients are admitted to Medical Assessment, a plan of care is established which involves:

- Diagnosis of the patient and determination of the severity of illness
- Determination of required investigations and therapy
- Identification of a suitable ward (or hospital) for transfer
- Proposed discharge date
- Prompt ordering of discharge drugs and preparation of discharge summary
- Outpatient arrangements where appropriate

It was stated that the MAU enabled the hospital to concentrate manpower and technological resources at the point of entry to clinical care.

4.2.5 University College Hospital, Galway (UCHG)

In February 2002, UCHG introduced on a pilot basis an initiative which the hospital called an Emergency Medical Admission Receiving Unit / Emergency Admission Ward (EAW). The objectives of the receiving unit were to streamline emergency medical admissions from the A&E department, to improve the quality of service to patients, to facilitate referral to the appropriate specialty, to reduce trolley waits in A&E and to concentrate resources in one area. It was noted that 90% of all medical admissions in UCHG come through the A&E department.

The EAW consists of 30 beds which were additional to the existing bed complement at the time of the implementation of the unit. The unit is located upstairs in the hospital and quite a distance away from the A&E department. Patients are admitted to the EAW via A&E with no provision in place for direct GP referral to the unit. It was stated that lack of space in the unit had prevented this from being put in place. With respect to the admission procedure to the EAW, the medical team on-call is called to the A&E department to assess medical patients deemed to be in need of admission. The medical team then decides whether to admit the patient from A&E to the EAW depending on bed availability within the unit. Once a decision to admit to the EAW is made in A&E, a patient is transferred to the unit under the care of the physician on call. No one consultant physician has been designated or has assumed the responsibility of being the lead clinician in the unit and this was noted by UCHG medical staff present as being a disadvantage.

A major difficulty with respect to the running of the unit highlighted to the committee is that medical on-call in Galway city rotates between UCHG and Merlin Park on alternate days. In addition, the temporary closure of two surgical wards in the hospital due to capital developments had increased greatly the pressure on beds in UCHG. In this context, the hospital was experiencing problems in transferring patients on from the EAW unit due to bed capacity issues. Though it had been intended that the maximum length of stay in the unit would be 48 hours, at the time of the committee's visit, some patients had been in the unit for 72 – 96 hours. In addition, emergency surgical patients were also being admitted to the unit on the days when UCHG was not on medical call. Of the 30 – 35 emergency medical admissions to UCHG on the days when the hospital was on-call, only 15 of these were being admitted to the EAW due to the above difficulties. Initially it had been envisaged that 100% would go through the unit.

4.2.6 Mayo General Hospital, Castlebar

In 1995, Mayo General Hospital established their Medical Assessment Unit (MAU) to help alleviate A&E overcrowding. The unit accepts patients with acute medical conditions who require emergency management and who are referred from GPs, District Hospitals, Public Health Nurses, OPD and the

A&E at Mayo General Hospital. The unit operates between 8am and 6pm, Monday to Friday, with some additional flexibility. The unit also provides a service in certain pre-designated procedures including blood transfusions, pleural tap biopsies and venesections, with the division of work being approximately 80% assessment and 20% procedures.

The MAU is an 8-bedded, nurse-led unit. Four consultant physicians in the hospital are clinically responsible for the unit when on-call on a 1-in-4 rota. The consultant physician in the hospital who initiated the MAU also has a de facto lead role in the organisation and management of the unit. The unit is staffed on a daily basis by the SHO or the registrar from the medical team on-call that day, with a consultant or registrar led ward round taking place in mid-afternoon each day. After assessment, patients in need of admission are transferred to the appropriate ward within the hospital while the remaining patients are discharged directly from the unit. An average of 20 patients are seen daily. The committee was informed that this has relieved pressure on A&E staff and helped to reduce waiting time for patients. In 2000, the unit assessed 2,574 patients, admitting 706 to appropriate wards and discharging 1,868. In 2002, 3,365 patients were assessed and/or treated in the unit, an increase on previous years due to a decision in 2002 to have no overnight patients in the unit. It was noted that to date this has operated successfully. However, it was acknowledged that there remains some overspills of medical patients into surgical beds in the hospital. Hospital representatives stressed that no cancellation of elective surgery takes place in Mayo General despite this overspill. Patients in the unit are given priority for inpatient beds over all other patients and the unit is also given priority for diagnostic facilities. Patients who are discharged are provided with a discharge letter for their GP.

4.2.7 Waterford Regional Hospital

Waterford Regional Hospital established a unit, called a Medical Assessment Unit in 2000. The MAU is a 12-bedded unit, open between the hours of 11 a.m. and 7 p.m. Monday to Friday. The unit is staffed on a temporary basis by a general physician who works full time in the unit and is in charge of the unit; an SHO from the relevant medical team on-call that day; and nurses. The unit also has the services of a community nurse, occupational therapist and physiotherapist. The majority of patients seen in the unit are referred from the A&E department, after being triaged there and meeting set triage requirements. A limited number of patients are accepted by the unit from GP referrals via a doctor-to-doctor consultation process. In 2002, of the patients seen in the unit, 971 were admitted to hospital, 625 were same day discharges and 391 were followed up at the unit at a later date. In addition, the unit undertakes a number of day case procedures, for example venesections. The unit is given priority access on par with the A&E department to the hospital's laboratory, radiology and cardiology departments.

The committee was informed that the unit had had a very positive impact on service delivery in other areas of the hospital, including the A&E department. With respect to A&E, it was stated that the number of complaints, particularly with respect to the treatment of elderly patients, had decreased considerably. It was felt that the unit had allowed patients to be seen by a senior decision maker in a more timely manner and facilitated more rapid access to other services such as OT and physiotherapy. The length of stay of patients admitted from the unit was stated to have decreased compared to the length of stay these patients would have had without the unit. This was attributed to the fact that these patients would have already had a number of key diagnostic tests and would have been seen by a senior clinical decision maker at an earlier stage upon their arrival at Waterford Regional Hospital than would have been the case under the traditional system.

4.2.8 St. James's Hospital, Dublin

The committee visited St. James's Hospital twice; once prior to the opening of its Acute Medical Admissions Unit (AMAU) and again when the unit had been operating six months. The unit was opened in March 2003 in response to the growing number of acute medical admissions to the

hospital. The aim of the unit was to facilitate a high quality efficient admission process by concentrating staff and technological resources at the point of entry to clinical care thereby enabling prompt investigation and early diagnosis and treatment.

The AMAU is a 59-bedded unit that is centrally located close to the A&E and x-ray departments. The opening of the unit coincided with the provision of 60 additional beds in the hospital. The unit admits emergency medical patients 24 hours a day, 7 days a week and operates a 'consultant of the day' system whereby the consultant physician on-call takes responsibility for patients in the unit for a 24-hour period. A senior nurse manager is responsible for the day-to-day activity of the AMAU. The unit runs a 1 in 9 consultant rota with shared teams between the consultants. The AMAU is overseen by a director and deputy director, both of whom are consultant general physicians occupying posts which were specifically approved by Comhairle for this role. The committee noted that the two consultants do not have additional clinical input into the unit over and above that of other physicians on the general medical on-call rota involved in staffing the unit.

Approximately 400 patients per month go through the unit, of which 14% go home within 24 hours. The maximum length of stay of patients in the unit was 5 days, at which point patients are discharged or admitted to a specialty medical ward. At present the unit only admits patients referred from the A&E department in the hospital. It was indicated that direct referral of patients to the unit from GPs will be considered in the future. All non-elective medical admissions go through the unit with the exception of those patients sent directly to CCU, ICU or the acute geriatric unit. The decision to refer to the unit is a joint decision between A&E clinicians and AMAU clinicians. The unit is given priority access by a number of diagnostic services in the hospital including laboratory and X-ray. As a general rule, same day assessments are provided by other medical specialties to the unit. It was noted that some medical specialties are unable to do this due to manpower issues. Transfer of clinical responsibility of patients may take place after these assessments depending on each case. The unit is currently in the process of drawing up protocols with all medical specialties regarding this issue.

In the first few months after the unit opened, a significant portion of patients admitted to the AMAU from A&E were referred and accepted within one hour. However, over time, the period involved in this transfer had lengthened due to difficulties in transferring patients to specialty medical wards in the hospital from the unit when needed. This was indicated to be due to the number of other inpatients in the hospital deemed no longer in need of acute medical care and awaiting alternative services or placements. Since 2002 somewhere between 80 to 100 of the 197 acute medical beds in the hospital were considered inappropriately occupied at any given time. It was reported by St. James's Hospital that the unit had managed to eliminate duplication of assessment of patients, resulting in a decline in waiting time in the emergency department and leading to a significant reduction in length of stay for acute medical admissions. Early trends had indicated that there was an increase in elective surgical activity.

Recent correspondence from St. James's Hospital (April 2004) indicated that from 2002 to 2003 there was an overall increase of 9.7% (5038 to 5528 episodes) in acute clinical episodes presenting to the hospital requiring emergency medical admission. Bed days (adjusted to the same volume of 5,250 patients) were reduced from 39,343 to 35,322 in the same period. Based on data available from January – June 2004, the hospital is predicting that a further 4,500 bed days will be saved in 2004. With the opening of the unit, there has been an across-the-board increase in the efficiency of all 9 "on-call" teams, with median LOS reducing from 6 days in 2002 to 5 days in 2003. For the first 6 months of 2004, the medical LOS has dropped even further to 4 days. The time spent by patients in the Emergency Department awaiting the availability of a hospital bed has reduced by 30% since the advent of the AMAU. The months with more than 10 patients on average waiting for identification of a bed at 7 a.m. in the ED had decreased from 9 in 2002 to 4 in 2003. Almost 50% of the acute medical patients admitted to the unit had had their entire inpatient episode within the

AMAU and were discharged directly home from the unit within five days. Those patients who had required a longer stay were transferred from the unit as quickly as possible (target within 24 hours) to suitable beds in the hospital.

4.3 OTHER UNITS

In addition to the hospitals visited, the committee were notified via submissions about the existence of other medical initiatives taking place in a number of other hospitals such as Kerry General Hospital and Sligo General Hospital.

4.3.1 Kerry General Hospital, Tralee

In November 1993, Kerry General Hospital, Tralee, established a facility called a Medical Assessment Unit. One of the objectives identified for this unit was to give priority access to GP patients who may not necessarily need admission to hospital but who need urgent medical assessment. Its other objective was to assist the hospital bed management services in managing bed demand. A medical registrar is assigned to the unit five days a week, from 9 a.m. – 5 p.m., with the medical consultant on-call supervising the unit. The unit is also staffed by 1 WTE registered nurse. Since opening, the unit has had a positive effect on bed management in the hospital. In 2002, funding was made available to increase the size of the unit from 2 to 6 beds. The unit is given priority access to laboratories, X-Ray, OPD appointments and inpatient beds. Patients are also accepted into the unit from OPD clinics, from ENT and general surgeons and from the ophthalmology service.

Upon discharge from the unit, patients receive a written summary to give to their GP/referring doctor, a prescription, if necessary, and an OPD appointment, if necessary. A copy of any investigations carried out, when available, is forwarded to the referring doctor. In 2001, a total of 1419 patients attended at the unit, of which 52% were discharged back to their GP, 25% were reviewed at a future date in the unit, 16% were given OPD appointments and 7% were admitted to Kerry General Hospital.

4.3.2 Sligo General Hospital

In response to increasing bed pressures and the resulting effect on elective surgery, Sligo General established an initiative, termed the Medical Assessment Unit, on a pilot basis in the winter of 1999/2000. The overall purpose of this unit was to streamline the processing of acute medical emergency GP referrals, ensuring that patients were prioritised on a needs basis and where necessary admitted for acute medical care. The unit was initially a 6-bedded unit, based in the A&E department and staffed separately from the A&E department. Following a review of the pilot period, it was noted that there was an average discharge rate of 15% in relation to the numbers assessed. Previously these patients would have been admitted to an acute medical bed in the hospital. The pilot unit was deemed a useful development and was transferred to one of the medical wards in the hospital.

With the exception of chest pain patients and A&E referrals for medical consults, all GP referred medical emergencies are now reviewed through the unit. The unit is staffed by the Medical SHO from the on-call team who has direct access for backup to the Medical Registrar. The consultant physician on-call reviews the position in the unit on a daily basis. The unit is also staffed by a clinical nurse manager, staff nurses and ward attendant staff. A senior member of the medical team (specialist registrar/consultant) reviews each patient prior to discharge from the unit. Benefits identified by the hospital resulting from the establishment of this unit include improved bed management, better use of resources and the establishment of a streamlined process to deal with acute medical emergencies referred by GPs.

Sligo General Hospital is currently in negotiation with the Department of Health & Children regarding the commissioning of additional beds on the ground floor of the hospital. Subject to this it is hoped to incorporate the medical assessment unit (8 – 10 bay unit) with a medical short stay ward to ensure rapid assessment, diagnosis and treatment of emergency medical patients in the acute phase of their illness.

4.3.3 Units at Planning Stage

A significant number of other hospitals indicated to the committee, either in submissions or in discussions, that they were currently giving consideration to or in the process of planning the development of new medical facilities in their hospitals to deal with an increasing acute emergency medical workload. These hospitals include

- Cork University Hospital – addressed below
- James Connolly Memorial Hospital – discussions are on-going with the ERHA regarding the funding required for the establishment of an emergency medical admissions unit
- Letterkenny General Hospital
- Naas General Hospital – a proposal for a 31-bedded medical admission unit has been submitted to the ERHA
- South-Infirmary Victoria Hospital, Cork
- St. John's Hospital, Limerick
- Tallaght Hospital – addressed below
- Wexford General Hospital – a medical assessment unit was opened in 2002 with the capacity to treat ten patients at a time

4.3.4 Cork University Hospital (CUH)

In a meeting with CUH representatives, the hospital's plans for a unit to be called a Medical Admissions Unit were discussed. Hospital representatives acknowledged the need for a designated leader/director for the unit from its commencement, and identified the need for an additional consultant physician for the proposed unit to carry out this administrative role. The view was expressed that this role could rotate on a five-year basis, so as to avoid individual consultants "burning out" and to ensure that the momentum of the unit continued. It was envisaged that in addition to the designated director of the unit, other consultant general physicians based in the hospital would be clinically involved and responsible for the unit on a rotating basis, based on the general medical on-call rota. Regarding admissions to the unit, it was proposed that patients would be triaged in the Emergency Department and directed to the unit if deemed appropriate, rather than developing a separate stream/pathway of admission to the unit in the hospital. With reference to GP referrals, it was expected by CUH representatives that a system of doctor-to-doctor liaison over individual admissions would be put in place to facilitate direct GP access. The committee were informed that in recent times a formal project team has been established to focus on the development of the proposed unit. The committee were informed at the meeting that another initiative already well advanced is the proposal for an Ambulatory Day Care and new inpatient facility for elderly patients under the aegis of the Elderly Services Division in CUH/St. Finbarr's Hospital. Proposals for this initiative have already been submitted to the Department of Health & Children for formal approval.

4.3.5 Tallaght Hospital

The committee met with representatives of Tallaght Hospital and discussed the hospital's plans for a unit to be called a Medical Admissions Unit. The unit proposed appeared to be similar in nature to the one currently operating in St. James's Hospital. It was outlined by hospital representatives that the unit was being planned in the context of, amongst other things, inadequate numbers of acute medical beds, the problems arising from dealing with 130 – 140 unplanned medical admissions per week from A&E, acute medical admissions being scattered all over the hospital, including surgical wards, and severe problems with patients remaining for long periods on trolleys in A&E. Certain requirements needed for the proposed unit were identified, including the establishment of selection criteria for the unit, the support of other parts of the hospital, participation by all relevant consultant physicians, clear leadership of the unit and the establishment of clear policies and protocols for the unit. Anticipated benefits from the establishment of the unit are expected to include concentration of resources, better management of medical patients and a shorter average length of stay for acute medical patients. With respect to admission pathways to the unit, it was proposed that referrals to the unit would come solely from A&E, which could act as a triage for patients for the unit. Direct access to the unit by GPs and OPDs would be considered. In recent correspondence from Tallaght Hospital, it was indicated that the architectural plans for the hospital's planned unit have been completed and that the hospital has submitted a proposal to the ERHA to develop the unit.

4.3.6 Units No Longer in Place

A small number of hospitals, including the Mercy University Hospital and Tallaght Hospital, indicated that in the past they had experimented with new medical units on a pilot basis, but that these units were no longer in place. In the Mercy Hospital, hospital management stated that a number of lessons had been learned during the pilot unit's existence. These lessons included the need to ensure dedicated "fast track" diagnostic services for these units, the need for assessment/admissions units to be an integrated and complementary part of the hospital bed management process and the need to involve the local health board with respect to transferring patients in need of long-stay accommodation to suitable accommodation.

Tallaght Hospital representatives indicated that upon the opening of the hospital in 1998, a pilot 12-bedded unit had been established, with a high nurse to patient ratio and rapid access to diagnostics. However, after 6 months, the unit had been unable to move patients onwards from the unit due to a bed capacity issue in the hospital. Lack of ownership and leadership in the unit were cited by hospital representatives as contributing to the eventual closure of the unit.

4.4 VIEWS OF PROFESSIONAL BODIES

The views of the Irish College of General Practitioners (ICGP), the Irish Association of Emergency Medicine (IAEM) and the Royal College of Physicians of Ireland (RCPI) were sought regarding establishing units which would focus solely on acute medical assessment and admissions. The development of such units was supported by the three professional bodies consulted.

In their response, the ICGP, supporting the assessment component of units, stated that "*GPs do not always require admission in cases of clinical uncertainty, but they often require particular investigation or assessment, to clarify a diagnosis. The absence of an assessment option may result in unnecessary admission, even for a short period.*"

In advocating that such units should accept direct GP referrals, thereby eliminating the need for such GP-referred patients inappropriately attending A&E departments, the ICGP stated that "*the failure to recognise and maximise the potential of General Practice results in duplication, time delay, and is an inefficient use of scarce resources and expertise in our healthcare system. Lack of proper communication*

structures between the two sectors in effect ensures that the capacity of General Practice to reduce demand on A&E departments and hospital services, especially at times of crises, is underutilised."

This view was supported by the Irish Association of Emergency Medicine (IAEM) who stated that "*the use of emergency departments as admission units for all general practice referrals to hospital is inappropriate. A vast amount of resources in A&E departments are taken up dealing with patients who have already been assessed by GPs and other doctors who think that the patient requires assessment by a specialist or admission to hospital. It is unreasonable to expect A&E department staff to reassess these patients basically to check out the opinion of the referring doctor before they are passed on. We would envisage these patients bypassing the A&E department direct to an admission/assessment area for the attention of the specialist team.*"

The RCPI, in expressing their support for acute medical units, commented that the successful operation of such units "*is as much an art of management and integration of a myriad of professionals, as it is about the specific disciplines of medicine*."

Hospitals visited by the Committee

Location (name)	Times of Opening	Bed Numbers	Beds	Responsibility	Other Consultant Staffing	Workload	Referrrals	Max. length of stay	Other
Limerick (Medical Day Ward)	9 a.m. – 5 p.m. Mon. – Fri.	5 beds 14 couches		Designated consultant physician based in unit	Consultant input from other specialties as required	360 patients per month	40% GP 40% A&E 15% other consultants	Less than 24 hours	Specialise in number of pre-specified diagnostic pathways including stroke, falls & anaemia. A number of agreed medical day procedures also take place in the unit.
Kilkenny (Medical Assessment Unit)	8 a.m. – 8 p.m. 7 days a week	6 beds	Additional beds in nearby Kilcreene	Consultant physician on-call has lead responsibility for unit	Medical team on call gives unit priority	483 cases in 2001	95% GP 5% Self	72 hours	Two thirds of all medical admissions now go through unit. 23% of patients discharged on same day
Royal Infirmary of Edinburgh (Medical Assessment Unit)	7 days a week 24 hours	42 beds	Additional	16 medical consultants, rotate based on 4-team model.	Access to specialty input from other consultants	400 patients per annum per bed	90% A&E 10% GP	72 hours	50% of patients discharged directly from unit.
Mater (Medical Emergency Department)	7 days a week 24 hours	AGU – 56 beds ACU – 44 beds AMU – 62 beds	Redesignated	Director of MED may be appointed	Geriatric, cardiology and medical teams all provide 24 hour cover to MED		100% A&E	10 days	
St. James's Hospital (Acute Medical Admissions Unit)	7 days a week 24 hours	59 beds	Additional	Two designated consultant physicians are Director and Deputy Director of unit	1 in 9 medical consultant on-call rota involved in "consultant of the day" concept	400 patients per month	100% A&E	5 days	Efficient running of the unit being adversely affected by exit block in hospital with respect to patients no longer in need of acute care
U.C.H.G (Emergency Medical Admission Ward)	7 days a week 24 hours	30 beds	Additional	No one consultant appointed with lead responsibility for the unit	Medical team on take – 6 teams involved		100% A&E	Ideally 48 hrs Reality 3-4 days	Efficient running of unit is being affected by capital developments on hospital site and on-call arrangements in Galway city
Mayo General Hospital (Medical Assessment Unit)	8 a.m. – 6 p.m. Mon- Fri	8 beds	Additional	Informally one consultant has assumed lead responsibility for the unit	Medical teams on call clinically responsible for unit. Works on 1 in 4 rota	In 2002 – 3,365 patients A&E	OPD District Hospitals Public Health Nurses	Less than 24 hours	Workload in unit is a mixture of unselected acute medical patients and agreed pre-designated day procedures (approx 20% of workload)
Waterford Regional Hospital (Medical Assessment Unit)	11 a.m. – 7 p.m. Mon-Fri	12 beds		Temporary general physician based in unit		In 2002 – 1,987 patients	A&E Limited GP referrals	Less than 24 hours	Unit undertakes a number of day case procedures. In 2002 –49% patients admitted, 31% discharged & 20% followed up in unit at later date.

Note: The information outlined in the above table was gathered at different points in time. Operational arrangements of the different units may not be directly comparable.

5 RECOMMENDATIONS

5.1 ACUTE MEDICAL UNITS

Arising from its consultation process, the committee examined and considered a wide variety of alternative ways of dealing with emergency medical admissions and presentations. Though the facilities reviewed differed across a number of areas including size and staffing arrangements, the impact of these facilities on the relevant hospitals, with very few exceptions, was reported as having been positive from the perspective of the patient, the staff and the hospital. There exists good reason and real scope to effectively manage and streamline the process of assessment and/or admission of acute medical emergencies from General Practitioners/Primary Care, A&E, and hospitals' OPDs. Taking into consideration the strengths and weaknesses of the units reviewed, and in light of the rapidly developing area of acute medicine, Comhairle na nOspidéal makes recommendations below regarding how it believes such units could best be developed, organised, staffed and integrated within the acute hospital system.

The widely varying terms in place to describe the functioning of existing units was noted. It is recommended by Comhairle na nOspidéal that, in the interests of consistency, the dedicated area in hospitals used to manage acutely ill medical patients be called the **Acute Medical Unit**.

Accordingly, Comhairle na nOspidéal recommends the development of Acute Medical Units (AMUs) in all acute general hospitals receiving acutely ill medical patients. These AMUs should treat patients referred for urgent medical assessment and/or admission. The AMU, a centrally located facility in the hospital, should provide rapid assessment, diagnosis and treatment of acute medically ill patients referred from General Practitioners, the A&E department, and the hospital's OPD. Each AMU should be staffed by a multidisciplinary acute care team led by a designated consultant physician with appropriate training. When on AMU duty, the consultant physician should have no other fixed/scheduled commitments so as to ensure the immediate availability of senior clinical decision making for patients during their assessment, on-going care and management in the unit. Pathways available to AMU patients should include discharge directly home, provision of continuing care in the AMU in cases where a short length of stay is envisaged, transfer to a specialty/general ward within the hospital or referral to an outpatient clinic. The AMU must have priority access to acute investigative facilities and inpatient beds within the hospital.

5.2 KEY COMPONENTS

In order to ensure the success of any Acute Medical Unit, the following key components have been identified as essential:

- strong management and clinical support for the AMU
- clear and agreed protocols and guidelines for access to and discharge from the AMU
- designated consultant leadership of the unit
- consultant physicians with the appropriate training having a dedicated commitment to the AMU
- all consultant physicians in the hospital being involved in providing designated services to the unit
- evidence-based protocols for the management, diagnosis and treatment of patients in the AMU which would be reviewed and updated on a regular basis
- fast-track access to the full range of diagnostic services for AMU patients

- provision of high level multidisciplinary services in AMUs including medical staffing (consultant physicians and NCHDs), specialist nursing, occupational therapy, physiotherapy and access to rehabilitation and community based services
- effective communication systems in place between the AMU, the A&E, general practitioners, the Hospital Bed Manager and the hospital's OPD.

A number of factors will influence the exact structure and organisation of Acute Medical Units within each acute general hospital. These factors include:

- size of hospital
- population served by hospital
- role of the hospital within its region
- the specialty mix within the hospital
- bed capacity of hospital vis-à-vis population served
- staffing of hospital
- level of provision of primary care in region
- number of long-stay beds available for population served
- access to rehabilitation beds

5.3 OPERATION OF ACUTE MEDICAL UNITS

5.3.1 Assessment and Admission

Any general hospital receiving acutely ill medical patients should have an Acute Medical Unit. The AMU should combine the functions of acute medical assessment and medical admission. It is envisaged that the units will provide services to two broad categories of patients. These are

1) patients who are acutely medically ill and need immediate assessment and treatment
2) medical patients where there exists clinical uncertainty, who may be potentially acutely ill and who require further assessment and treatment

Following assessment and treatment, some patients will be discharged directly from the unit on the same day as being referred. Other patients will be identified as requiring admission to hospital for ongoing inpatient care. Of these patients, those with an anticipated short length of stay should remain in the AMU for their entire inpatient episode. Others in need of specialist inpatient medical care and/or with an anticipated greater length of inpatient stay should be admitted to a specialty/general ward *via* the AMU, as the appropriate beds become available in the hospital.

It is acknowledged that the exact proportion between assessment and admission within any given AMU will be influenced by local circumstances and need, including the size of the hospital, bed capacity and average daily clinical intake of acute medical patients. Some AMUs may focus primarily on acute assessment and in this context will transfer all patients identified as needing inpatient care after assessment directly to the relevant wards within the hospitals.

Other AMUs will provide both assessment services and admission services i.e. inpatient care. In hospitals with AMUs of this kind, all medical admissions not planned for (with the exception of those directed to ICU, CCU and other specialised services allowed under agreed protocols), should be directed to and admitted *via* the AMU.

All AMUs, regardless of the exact mix of assessment and admission, must retain a protected assessment component, as not all patients referred to the unit will require admission.

5.3.2 Hours of Operation

The opening hours of an Acute Medical Unit will be influenced by the balance of assessment and admission functions provided and the role of the hospital. If providing both assessment and admission, the unit should be open 24 hours a day, seven days a week. If providing an assessment function only, local circumstances will best inform the ideal opening hours of the unit.

5.3.3 Access to Unit

Access to the AMU should be based on clear patient-driven protocols and guidelines which have been agreed by all the relevant parties. Access to the AMU should be provided to the following:

- General Practitioners
- Accident & Emergency Department
- Hospital OPD

5.3.4 Size and Location of Unit

A variety of factors will each play a role in determining the size of unit, including the balance between the assessment and admission functions of the unit, the catchment population of the hospital, the average daily clinical intake of acute medical patients and available resources.

It is recommended that where feasible, the Acute Medical Unit should be sited near the A&E department within the hospital and close to diagnostic facilities.

5.3.5 Bed Capacity Requirements

The manner in which the beds for the acute medical unit are sourced will vary from hospital to hospital. In some hospitals, a process of re-designation of existing beds may be possible. In others, it may be that additional beds will have to be provided. Bed availability outside the hospital in the form of rehabilitation and community service beds will also need to be considered and taken into account, as these influence the patient-flow through all hospitals. A shortage of community-based beds can present a serious exit block in hospitals, and will impact negatively upon the effective functioning of the AMU.

5.3.6 Leadership of AMU

Clear consultant leadership of the Acute Medical Unit is a crucial issue. With respect to the variety of units visited by the committee, a major determinant of the success or failure of the units was the presence or absence of a designated consultant physician leader for the unit, and the management skills of this consultant physician.

In this context, Comhairle na nOspidéal recommends that one consultant general physician should be clearly identified by both management and medical staff, as having a lead role to play in the management, running, auditing and development of the Acute Medical Unit. It is recommended that this lead consultant physician would have a major interest in and commitment to the unit and have the appropriate management skills to undertake satisfactorily the leadership role envisaged. This lead role in the AMU could be a renewable appointment with the additional option of a rotation among interested consultant physicians involved in the unit.

In line with the recommendations contained in the Comhairle na nOspidéal report on Accident and Emergency Services, the lead clinician in the Acute Medical Unit should be a member of the Hospital Emergency Service Committee. The establishment of such a committee in each acute hospital was proposed in the Comhairle A&E Report to aid the co-ordination of emergency services within hospitals. The Report envisaged that the membership of the committee would be comprised of a range of staff including acute medical, surgical, paediatric, obstetric, psychiatric, anaesthetic, radiology and pathology medical staff, together with nursing, health and social care professionals, ambulance staff and general practitioners.

5.3.7 Staffing of Acute Medical Unit

All Acute Medical Units should have dedicated staff to ensure the provision of a high quality service. The success of any unit will be dependent on the provision of adequate staffing levels and senior experienced medical and nursing staff to treat patients and make decisions.

CONSULTANT STAFFING OF THE ACUTE MEDICAL UNIT

- Acute medical units should be staffed at all times by a consultant physician who has designated responsibility for the unit for a particular time period.
- The number of consultant physicians working in the AMU will vary from unit to unit depending on the hospital's workload, size, consultant staffing and other local circumstances.
- In Acute Medical Units in major hospitals i.e. those that provide both an assessment and admission service and which experience a busy daily clinical intake of acutely ill medical patients, it is recommended that additional consultant physicians with appropriate training in acute medical care be appointed to and based in the AMU.
- It is envisaged that a minimum of two such consultant physicians' posts will be needed in AMUs in the major hospitals.
- It is recommended that, in the first instance, these posts be structured with 8-9 sessions to the AMU for acute medicine and 2-3 protected sessions to maintain and facilitate a special interest.
- The commitment to the AMU by these consultants should involve providing assessment, diagnosis and treatment of patients referred to the AMU and participation in the acute on-call rota in association with their fellow consultant physicians. These consultants should also lead the development of protocols for the AMU and be involved in teaching, research and audit centred on the AMU.
- In all hospitals, the day-to-day consultant staffing and responsibility for the AMU could rotate amongst consultant physicians based on the 24-hour general medical on-call rota.
- Comhairle na nOspidéal recommends that all consultant physicians leading on-call teams should ensure that their principal responsibility when on AMU call is to the evaluation and management of acutely ill medical patients presenting to the AMU. This is essential given the requirement for their instant availability and the need for at least twice daily consultant-led major ward rounds in the AMU.
- In major hospitals with larger AMUs, where consultant physicians with the appropriate training in acute medical care will be appointed to and based in the AMU, it is envisaged by Comhairle na nOspidéal that these consultants will cover the AMU and the medical patients referred to it during working hours, Monday to Friday. The 24 hour general medical on-call rota, which would still be in operation in these hospitals, would de facto be supplanted during office hours by this arrangement with respect to consultant staffing of the AMU. The general medical on-call rota would determine which consultant physician and medical team would be responsible for acute

medical patients and the AMU outside of core working hours and at the weekends. This on-call rota would include the consultant physicians based in the unit.

- Comhairle na nOspidéal wishes to stress the importance of every hospital with an AMU putting in place clear, precise and agreed protocolised arrangements which will cover such issues as the shared care of patients, assumption of care of patients, continuity of care of patients and transfer of care of patients in the AMU. These protocols will clarify the roles and relationships between the different consultant physician teams involved in staffing the unit and the interaction of the unit with other services in the hospital.
- All medical patients admitted via the AMU should be admitted under the designated on-call physician for that day unless there exists agreed protocols for specific groups of patients to be directed or transferred onto other pathways of care.
- There is scope in the future for the development of consultant physician posts which would be dedicated full-time to acute medicine. It is expected that these individuals would be based full-time in the AMU.
- As all AMUs will need on-going input from the range of medical specialties, it is fundamental to a unit's success that all consultant physicians, including those who may not partake in the general medical on-call rota, are involved in providing their specialised services to the AMU. It is important therefore that agreed protocols are drawn up regarding how such inputs will be accessed and provided to the unit, and how transfer of care between different specialties, if deemed appropriate, will operate.

NCHD STAFFING OF THE ACUTE MEDICAL UNIT

It is expected that the medical team of the consultant physician on-call will identify the AMU as their principal responsibility for that period. It is recommended that all Acute Medical Units be staffed on the floor, at all times, by at least one senior experienced NCHD with appropriate skills in acute medicine. This doctor should be at Registrar/Specialist Registrar level at the minimum.

In AMUs in the major hospitals it is envisaged that a team of dedicated NCHDs will be attached full time to the unit, akin to the arrangement within Accident and Emergency Departments, and be under the supervision of the acute medicine consultant physicians appointed to and based in the AMU. In such large units, it is envisaged by Comhairle na nOspidéal that the NCHD staffing of the unit will be a blend of NCHDs based full-time in the unit and NCHDs from the consultant physician on-call team.

Clear protocols will need to be worked out in each hospital regarding the NCHD staffing of AMUs, as the number of NCHDs and extent of coverage needed will vary from hospital to hospital.

Comhairle na nOspidéal wishes to stress the training potential that the development of Acute Medical Units could have for medical NCHDs in the future. It is recommended that training programmes be considered and developed by the Irish Committee on Higher Medical Training (ICHMT, RCPI) to include structured rotation of trainees through AMUs supervised by recognised trainers in Acute Medicine.

NURSE STAFFING OF THE ACUTE MEDICAL UNIT

An AMU will require a higher nurse-patient ratio than in general medical wards due to the nature of the work and the rapid turnover of patients in these units. It is recommended that an AMU would be staffed by the appropriate level of senior nursing staff with high level of skills and competencies to aid the efficient and effective care and streamlining of patients through the units.

ALLIED HEALTH PROFESSIONALS

The committee observed from the consultation process that the medical units which had the greatest positive impact on patients and their well-being were those that had the dedicated on-site services of allied health professionals including occupational therapists, physiotherapists and direct access to community services. The ability of patients to access these services when most needed i.e. after an acute medical episode, allowed these units to provide a comprehensive service. Care followed the patient into the community immediately after discharge, particularly in situations where joint appointments between hospitals and community care existed.

In this context, it is recommended by Comhairle na nOspidéal that employing authorities make arrangements for the provision of, or timely access to, such support services for patients attending AMUs.

ADMINISTRATIVE & CLERICAL STAFF

All AMUs should have sufficient dedicated administrative and clerical staff to deal with the volume of activity and the maintenance of patient records.

5.3.8 Access to Diagnostics

All AMUs should have dedicated "fast-track" diagnostic services available to them from the range of diagnostic facilities in the hospital including laboratory, radiology and cardiology.

5.3.9 Ward Rounds

Consultant-led ward rounds should take place at least twice daily in an AMU, once in the morning and once in the afternoon/evening. This will ensure that patients requiring transfer to a specialty bed or discharge home are identified on a regular basis throughout the day. It is envisaged by Comhairle na nOspidéal that in the major hospitals with large AMUs, these will be joint ward rounds, involving one of the consultant physicians appointed to and based in the unit and the relevant consultant physician on-call.

5.3.10 Length of Stay

Each Acute Medical Unit will estimate its ideal length of patient stay. For those units focussing solely on medical assessments this will be in the 8-12 hours range. For those AMUs with the ability to provide inpatient care, i.e. those with an admission function, the maximum length of stay is likely to be from 3 – 5 days. Patients with an anticipated short length of stay could spend their entire inpatient episode in the unit. Patients identified as in need of specialist inpatient medical care or with an anticipated greater length of stay may have to remain in the unit until the appropriate inpatient bed in the hospital becomes available. No patient should remain in the unit beyond the pre-determined maximum length of stay. Local circumstances will guide the appropriate length of time to be set for each unit.

It is important that these time objectives are met and sustained, because if they break down, the AMU will be in danger of functioning sub-optimally and not meeting its objectives.

5.3.11 Discharge from Unit

The routes of discharge from an Acute Medical Unit include

- discharge home from the unit with a letter for the GP and/or an appointment to a relevant out-patient clinic or other specialist service
- admission to a specialty/general ward within the hospital for further inpatient treatment

Patients from the AMU needing hospital admission should be given priority access for beds in the hospital. To function smoothly, it is essential that AMUs become an integral part of the bed management policy of all hospitals and that clear and continuous communication takes place between the AMU and the Hospital Bed Manager.

5.4 SUITABLE PATIENTS FOR ACUTE MEDICAL UNITS

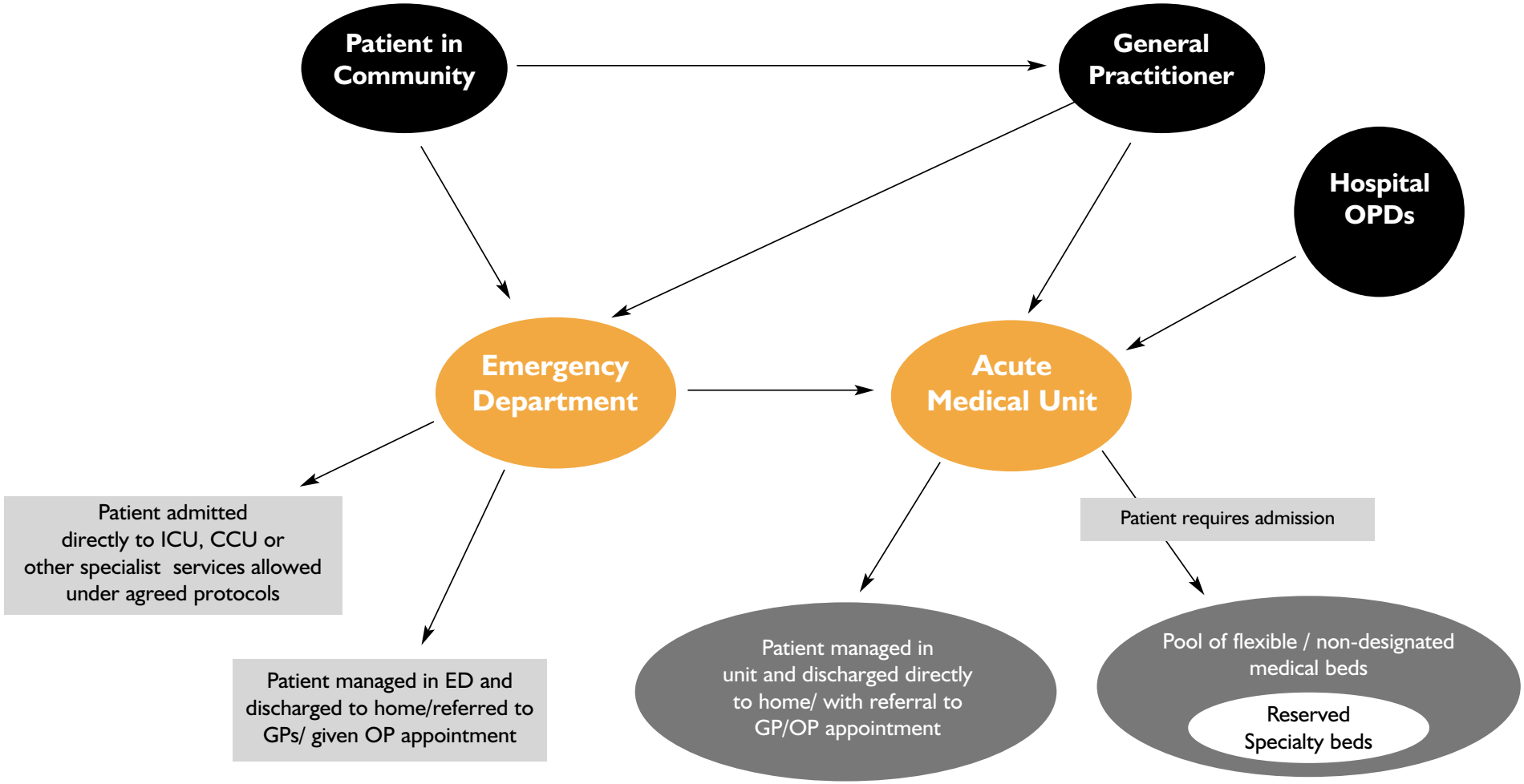
Acute Medical Units should treat acutely ill medical patients that present from General Practitioners/Primary Care, the Accident & Emergency Department and the hospital's OPD, whom the referring physician feels warrants urgent assessment and/or admission i.e. those patients with unexpected acute medical illness.

Patients that would be clearly inappropriate for AMU referral, include

- patients in need of routine, elective medical opinion, more appropriate to OPD
- semi-elective patients whose needs would be more appropriately met in a Five-Day or Day Unit.

Figure 1.3 illustrates the proposed new admission-discharge pathway envisaged for acute medical patients to an acute general hospital, with the Acute Medical Unit playing a central role.

Figure 1.3 High level process map showing new admission-discharge pathway for acutely ill medical patients with Acute Medical Unit in place.



5.5 CONCLUDING REMARKS

The development of Acute Medical Units in all acute general hospitals receiving acutely ill medical patients will contribute greatly to a better and safer service for patients and will enhance the ability of hospitals to manage their workloads more efficiently.

By establishing a streamlined and resource-focussed approach to acute medical patients, Acute Medical Units can provide an effective mechanism for the assessment, diagnosis, stabilisation, observation and early treatment of patients by a senior clinical decision-maker, in most cases a consultant physician. These developments will be supported by the development of clear and agreed evidence-based protocols for the care of acute medical patients and the introduction of a cohort of consultant physicians dedicated to acute medicine in larger hospitals to complement the cohort of existing consultant physicians.

The benefits to be gained for patients, staff and the hospital from the effective implementation of AMUs include:

Benefits for Patients

- More appropriate and timely care
- Quicker and smoother movement along the appropriate pathway of care
- More rapid assessment
- Quicker access to consultant opinion
- Earlier diagnosis and treatment
- More rapid access to ward admission
- Improved outcomes
- Reduction of unnecessary admissions
- Reduction of average length of stay
- Reduction of waiting times / lists
- Planned discharge care with community services
- Access to evidence-based, protocol-driven, optimum care

Benefits for Staff

- More efficient and effective bed management for specialty wards
- More organised work environment
- Restored specialty activity to specialty wards
- Effective discharge planning for patients
- Improved training in acute medicine and specialties
- Greater interdisciplinary interaction
- GP triage of patients
- Restoration of "direct assessment and admission" rights for general practitioners to acute hospitals

Benefits for the Hospital

- Elimination of admission delay for all medical emergencies
- Streamlined admission process
- More elective specialty admissions in specialty wards
- Less disruption to specialty wards as work-up is done prior to admission
- Re-establishment of tertiary referral activity
- Earlier identification of patient problems allows better planning
- Improved bed management
- Improved risk management
- More effective use of resources
- Increase in bed days available in the hospital
- Good retention of staff and good team spirit

This report follows on from the A&E report published by Comhairle na nOspidéal in 2002 which dealt with accident and emergency services within the Irish hospital system. Similar in thinking to the "*whole system*" approach advocated for hospital care in the A&E Report, Comhairle na nOspidéal concurs with the views expressed during the consultation process that **the development of Acute Medical Units is only one element of the changes and reforms needed to facilitate the efficient and effective assessment, admission and discharge of medical patients in the acute hospital system.**

Other elements of the Irish healthcare system which will contribute to the improvement of services provided to patients include the further development of primary care, a review of the role and operation of hospitals' outpatient departments, analysis of patient's access to elective care vis-à-vis emergency care and the impact that these two competing pathways have on hospital services, development of elective medical day units and provision of an adequate infrastructure outside hospitals to receive and support medical patients no longer in need of acute care in an acute hospital.

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