Ambulatory Emergency Care Network

Ambulatory Emergency Care

Six Weeks to Launch a New Ambulatory Care Unit

Milton Keynes Hospital

Milton Keynes hospital was consistently failing to meet its four-hour emergency access standard. From time to time, fewer than 70% of emergency admissions were dealt with within the target time.

The problem was the number of medical patients awaiting admission who were waiting in the Emergency Department (ED). This created backflow problems, which meant that patients who were less sick could wait for many hours in the Clinical Decision Unit (CDU) before seeing a doctor.

Often, the medical intervention required by these patients ended up being minimal, but they were forced to endure a long wait in a chaotic environment.

An archaic admissions process

Acute Physician, Chris Lindesay comments: "Our admission process was based on archaic medical processes in a pre-ambulatory era. It was not unusual for an 80-year old lady to wait for eight hours to be given some oral antibiotics for a chest infection and then sent home. This is poor care;similarly, some patients required minimal intervention in order to become ambulatory. Lack of a well thought-out environment meant these patients could wait for hours for a bed to allow them to have one single bag of fluid so they could, finally, be discharged. Sometimes, they would wait so long that same-day discharge was impossible."

Milton Keynes NHS Foundation Trust recognised that its systems were failing badly. "The four-hour target is a barometer of how well systems in the hospital function," says Chris. "Failing to meet the target indicates overcrowding in ED which is strongly linked to poor quality of care."

Something had to change

The Trust joined the Ambulatory Emergency Care (AEC) Delivery Network to learn about the experience of other Trusts in implementing ambulatory care. They wanted to convert emergency admissions to same day care. They were looking for support from the Network and wanted to be able to use its tried and tested tools in their redesign. Matron, Jacqui Burnett was a keen advocate of this new approach and pitched the idea of an ambulatory emergency care unit to colleagues in acute medicine.

Chris Lindesay admits:

"At first, I was sceptical that ambulatory emergency care could have quite the level of impact that was being claimed, but it has delivered amazing results. In acute medicine, we are basically seeing two different groups of patients – those who are sick and require immediate admission to hospital and those who are, essentially, well but who need rapid diagnosis and stabilisation before they can begin a course of treatment and go home. I was concerned that we needed to address the care of both groups and wasn't convinced that introducing an ambulatory emergency care unit would do this. I didn't fully appreciate how converting admitted patients to ambulatory care would impact in a different part of the hospital."

Six weeks to launch the ambulatory care unit

Under the leadership of a new Chief Executive, Joe Harrison, who joined the Trust on 4th February 2013, the acute medicine team was charged with creating and implementing an ambulatory emergency care unit within just six weeks. Project Manager, Claire McGillycuddy, says: "An audit revealed that 65% of our daily medical admissions had a zero or one-day length of stay – approximately 19 patients per day on the 85th percentile – so these were our target ambulatory care patients.

It was a challenging timescale to open the unit in just six weeks but we knew that we needed to do something radical to address the problems we were having. We are lucky here in Milton Keynes that there is a very strong 'can-do' culture. I had fantastic meetings with colleagues in pathology, pharmacy and imaging who we were reliant upon to make the ambulatory model work. They basically said to us "tell us what you want and we'll make it happen". It was fantastic to have this level of support from colleagues."

In November 2012, the NHS IMAS (Interim Management and Support) Emergency Care Intensive Support Team (ECIST) carried out a review of services in Milton Keynes. The ECIST team made a range of recommendations to improve pace and best practice in Milton Keynes, including avoiding unnecessary overnight stays by implementing ambulatory emergency care.

Claire comments:

> "They made us hold our nerve when we doubted ourselves and the decisions we were making. We visited Middlesbrough to see an ambulatory emergency care unit working, and working well. Dr Connelly at Middlesbrough was fantastic and talked us through the successes and pitfalls; we drew real inspiration from this visit."

Scoring system

Milton Keynes decided that all patients would be considered as potential candidates for ambulatory care unless there were clear clinical indications to the contrary. The team adapted the AMB score, introduced to them by the AEC Delivery Network, to help stream patients into ambulatory care.

"Our aim is to ensure that everyone who could possibly avoid admission goes home the same day," says Chris.

"We decided not to adopt a pathway approach because a) it would have taken us a few years rather than a few weeks to create the number of pathways needed and b) clinicians tend to be reluctant to commit themselves on paper and tend to err on the side of caution. We felt that this could mean we were admitting people who were really able to go home.

So, we opted for a process model using the AMB score, which we use to predict the kind of patients who we think will be suitable for ambulatory care. It is not absolutely foolproof but we regard it as perfectly acceptable for some people who have been treated in ambulatory care to be admitted subsequently if their condition deteriorates. This should not be judged as a failure of ambulatory care. Support from the top is important here and we are lucky enough to have that in Milton Keynes."

Dr Chris Lindesay Acute Consultant Physician

Claire adds: "In terms of recording, we set up a virtual ward, and admit the patients to trolleys. Elderly patients who are well enough to sit in the waiting room are admitted to ambulatory care. Those who are not well enough for this go to MAU. Activity is clinically coded to attract the Best Practice Tariffs where possible. We are using the following metrics to measure the impact: attendances by HRG; source of referral i.e. GP, ED, Ward etc; HRGs that match back to the 49 in the Directory of Ambulatory Emergency Care relating to medicine; that sit outside of AEC – to ascertain if we can pull these patients in; re-admission rates (within 7 days); increases in zero length of stay; number of admissions from AEC; ALOS (Average length of stay) on AEC; and ALOS (MAU and AEC)."

Executive support

In a demonstration of his top-down support for ambulatory emergency care, Joe Harrison, Chief Executive says:

> "This innovative and patient centred model of care has been developed by the team here at Milton Keynes to support the smooth running of emergency care. I am extremely proud of how the team has risen to challenge of providing excellent care to the population that we serve, by thinking and acting differently and changing services in the best interests of our patients."

Changing the mindset of clinicians

One of the key success factors for the introduction of an ambulatory emergency care model is the ability to change the mindset of clinicians. Chris Lindesay has worked hard to convey his vision to acute medicine colleagues: "I have made the case to them that admitting patients to hospital is not necessarily providing the "safe, high quality care" that it has always been perceived to be. Is an 80-year old with pneumonia any safer lying on a trolley all night or in a hospital ward than she would be at home in her own bed? We have only been open for six weeks but, already, my colleagues are starting to see the evidence for doing things differently. Between 80 and 90% of the patients we care for in the ambulatory care unit are sent home 'same day'; having their care managed in the community, rather than in traditional hospital settings."

Senior Sister Liz Clark, Karen Mumford Ward Clerk & Sharon Mitchel Medical Assistant.

Keeping colleagues on board

Communication is key to keeping hospital colleagues on board with the idea of ambulatory emergency care. According to Chris: "Other people in the hospital see investment at the front door – ambulatory emergency care has a new unit and new staff – and they could easily become alienated and disengaged from what we are trying to do. It is important to communicate with others and keep them on board.

We need our specialties to work with us in order for ambulatory care to function properly. We can send people home but, in some cases, we still need them to come back into the hospital for scans and follow-up treatment. If anyone else was trying to develop an ambulatory emergency care model I would say it is vital to talk to each department that you will be working with and agree a standard operating procedure. Claire did this for us, to great effect."

Reducing waste

Another important lesson learned by the team in Milton Keynes is to cut out waste and redundant processes wherever possible. "I liken it to the Olympic cycling team," says Chris. "To improve, they identified every small thing that might impact on the team's performance. For us, it is about being aware of everything that happens when patients come onto the unit and looking at how these processes could be made more efficient. For example, instead of Drs recording a patient's medical history, we could ask the receptionist to give the patient a form when they are admitted so they can do it themselves. Instead of nurses sending blood samples in batches, causing a bottleneck for the analyser, the samples are sent down for analysis as and when they are taken. We are keen to identify and eliminate waste like this wherever it occurs."

A better patient experience

It is early days to begin measuring the impact of the new ambulatory emergency care unit in Milton Keynes, however, already the patient experience is noticeably better. "Patients are not spending ages waiting to be seen," says Chris. "They see a consultant within minutes of arriving on the unit, which gives them a greater degree of certainty and reassurance. They are invited to go off and have a coffee in one of the hospital cafes and return to the unit at a pre-determined time for their appointment. It makes for a less charged atmosphere."

One patient said: "A few days ago my leg swelled up and as my GP was concerned it was a blood clot or DVT they arranged for me to go immediately to the AEC (ambulatory emergency care) unit. I cannot praise the staff enough, I was dealt with efficiently; with care and good humour.

The nurses on duty were superb and although there was some waiting time for tests and ultrasound checks, the professionalism shone through."

Claire comments: "MAU is now a more manageable environment and it can operate as a true medical assessment unit. Rather than a queue of patients waiting in ED for a bed, you can walk onto the unit in the morning and, at times, there are empty beds."

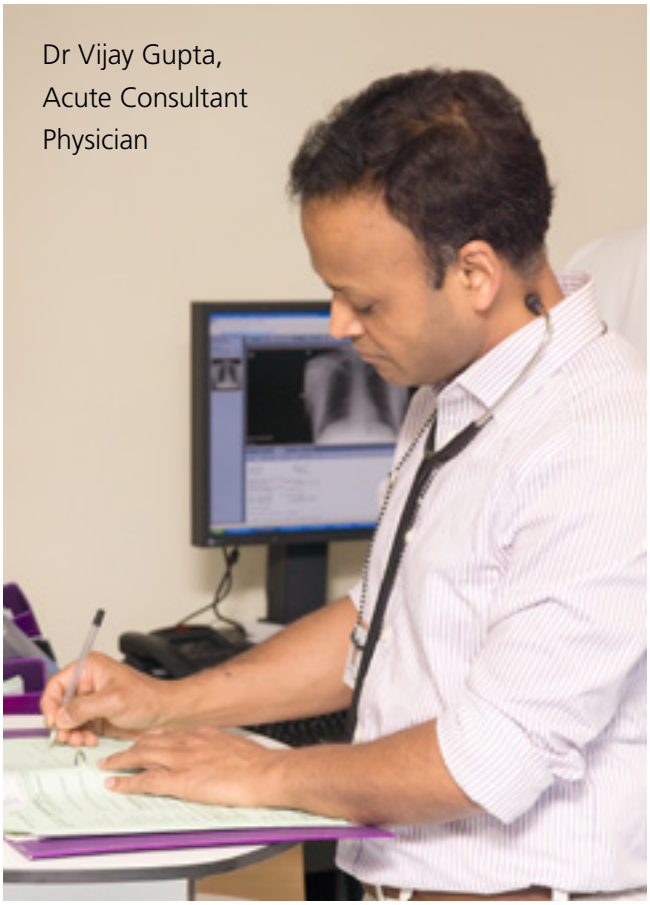
Positive staff and GP feedback

Staff and GP feedback is also positive. In response to an email informing them of the new approach to emergency care, one local GP commented: "We wish to convey our hearty congratulations and best wishes from all GPs and myself for commencement of this project. We all feel that it will be a great service and we will be fully supportive."

Impact across the hospital

Clinical Site Team Manager, Ian Duncan comments:

> "The AEC has made an immediate impact to the patient experience. They are seen quicker, are assessed by a consultant, and have a shorter length of stay in the hospital. The impact on MAU (the medical assessment unit) has been immediate, with fewer patients waiting and only the most appropriate patients being referred for admission. For ED the effect has meant improved patient flow, releasing time to focus on the sick, unstable patients."



Dr Vijay Gupta, Acute Consultant Physician

Improvements in five key areas

Claire comments: "We have had a significant impact in five key areas – safety, timeliness, efficiency, effectiveness and patient-centred care.

Before the advent of ambulatory emergency care, patients could wait for several hours in a busy waiting room and, as well as becoming anxious and uncomfortable, their condition could deteriorate. Now, they are seen, diagnosed and treated far more quickly and we have a robust system of follow-up.

"More timely diagnostics is the biggest gain for patients since we introduced the service. Faster access to senior decision-makers means that treatment can begin sooner, leading to improved clinical outcomes and far less anxiety for patients.

A more efficient approach to diagnosing and treating patients has had a significant impact on other parts of the hospital.

Clinical Site Team Manager, Ian Duncan points out., 'We have had no serious untoward events in ambulatory emergency care and we are not seeing high levels of admissions, so the ambulatory approach is clearly working effectively.' and, are we patient-centred? Absolutely; instead of making patients wait and fit in around our schedules, we have now rearranged our model of care for the convenience of patients."

Next steps

The team in Milton Keynes plans to build on the early success of its new ambulatory emergency care unit by developing a number of specific pathways for commonly occurring conditions on the unit. "This must come after the diagnosis, however," says Chris. "We need specialist clinics that we can refer patients on to that can see patients at short notice."

Claire adds: "We are building links with speciality nurses, such as the tissue viability nurse, so they can become more involved on the unit. We are also looking at ways of providing increased weekend cover and integrating more closely with surgery."

Challenges and rewards

Claire concludes: "It has been challenging to implement ambulatory care within such a tight timeframe and it wasn't always easy to convince people that we could achieve the improvements we wanted to make. But, to see how buoyant staff were on the first day of the new unit and to observe the number of patients who had been seen on the unit that day, made us feel very proud."

Chris says: "The key thing is that the patient experience is better. They are not spending ages waiting around and worrying. The conventional approach to emergency treatment is that patients are seen in priority order of sickness. With ambulatory care, the consultant sees patients as they arrive on the unit. This gives patients a greater degree of certainty and, particularly for elderly or frail patients, it is better as we are not making them wait around for hours.

"It is better for the hospital, too. We are now consistently achieving our four-hour emergency access standard. Ambulatory care is just one contributory factor in this, but it is a big one. It has been an incredibly rewarding experience for me to be given carte blanche to design a new unit like this. It is not about spending lots of money. Even if you have no money to spend, you could make major improvements by streamlining your processes, cutting out waste and reducing duplication."

To find out more about Ambulatory Care please go to:

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