Working with SAM to develop the SDEC model

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Same Day Emergency Care – Standards for Ambulatory Emergency Care

Background

- Increasing activity/acuity nationally
- AEC departments growing in demand
- Managing acute patients as a zero LOS, that previously would have had an admission
- AEC Network/Directory
- RCPE/SAM working group - Standards for AEC/SDEC

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SAMBA data

Ambulatory Emergency Care (AEC)

- 103 hospitals had an AEC service as part of acute medicine (83% of total hospitals, 95.3% of hospitals submitting complete data for this question)
- The majority of AEC units use a combination of trolleys, chairs and separate clinic rooms.
- The median number of trolleys and chairs per unit was 8 (range 1 - 54)
- The median number of clinic rooms per unit was 3 (range 1 - 9)
- 68% of AEC units were separate from AMU
- 49.6% (46.8%) of hospitals had access to speciality 'hot' clinics

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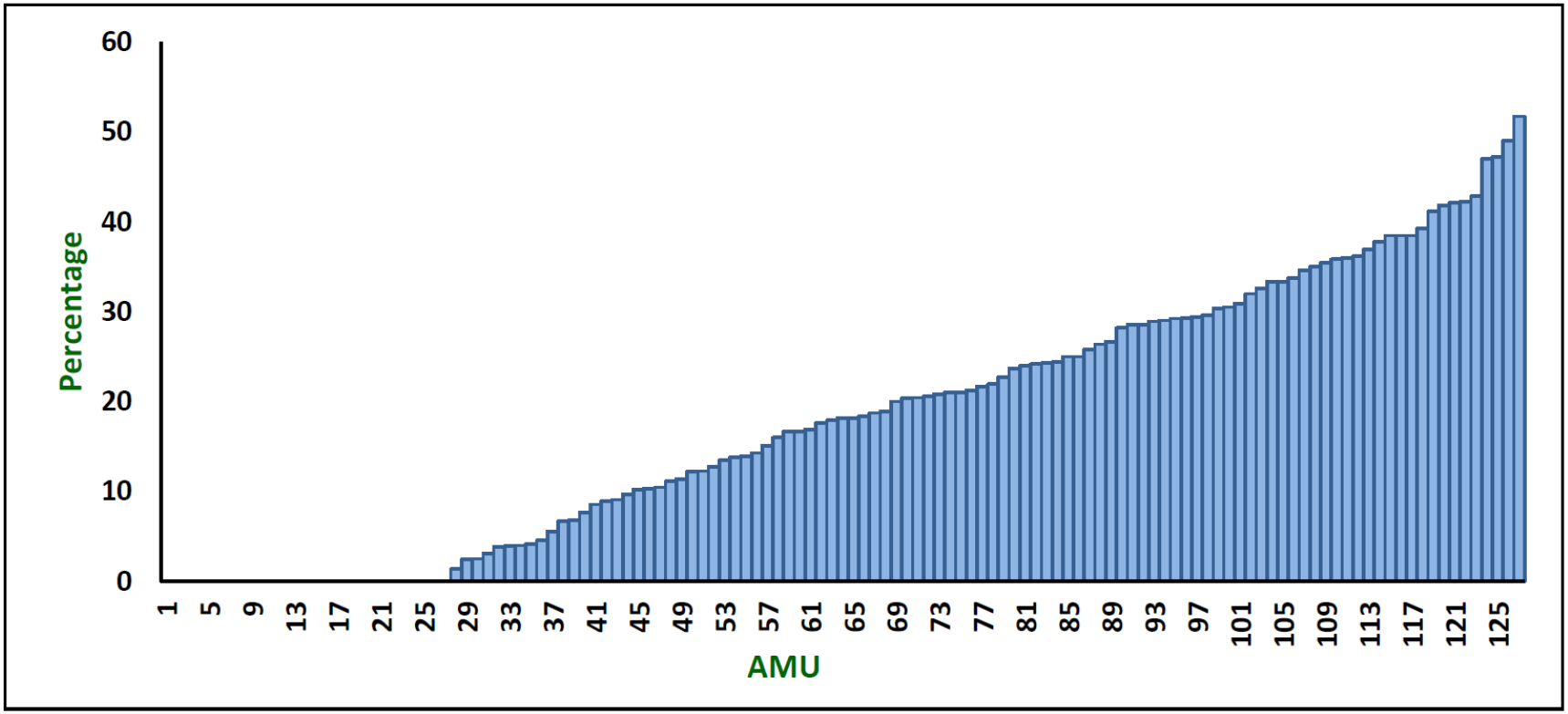
Figure 6 Variation in Percentage of Initial Medical Assessments Undertaken in AEC



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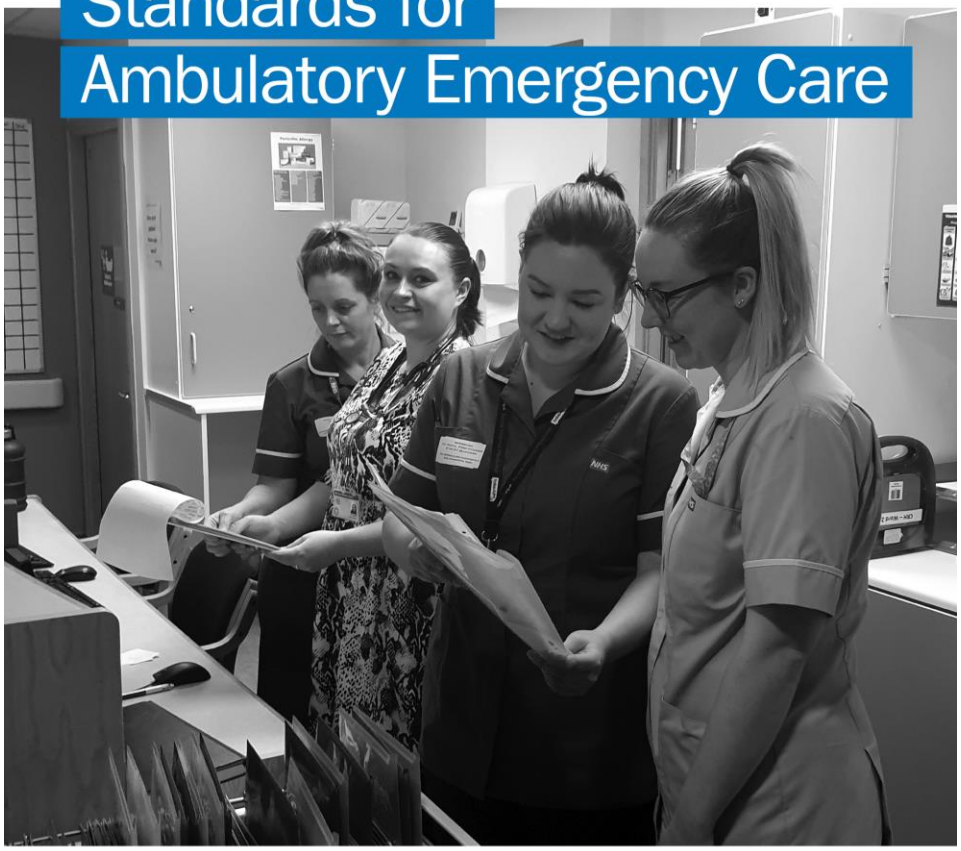
Standards for Ambulatory Emergency Care



Report of a working group for Royal College of Physicians of Edinburgh and Society for Acute Medicine

1. Patient feedback

All units undertaking AEC should regularly survey a representative and consecutive number of patients treated in this manner. This should take the form of a short questionnaire. At least 5% of all patients should be surveyed and the total time spent in the unit for each patient calculated.

Survey results should be used by the multi-disciplinary team (MDT) in a dedicated meeting to identify possible areas for quality improvement at least every 6 months. Although more challenging, one of the surveys should take place in the winter months.

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2. Waiting times should be minimised

a. Observations contributing to a NEWS2 score (National Early Warning Score version 2 - a system to standardise response to acute illness) should be obtained within 30 minutes of a patient's arrival.
b. Patients should be seen promptly and certainly within one hour by a clinician who has the capabilities to assess and investigate the patient's symptoms and signs. This clinician should have immediate access to a more senior clinical decision maker for review when the presentation proves more complex.
c. A validated risk stratification tool for specific conditions should be used to guide management including the need for investigation.

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3. Physician input

A consultant physician should be available on the hospital site day and night throughout the opening times of the AEC unit to review AEC patients.

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4. Overall Leadership

A nominated clinician from the MDT should take responsibility for the overall leadership of the AEC unit to ensure there are active clinical governance and quality improvement processes and strategies.

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5. Diagnostics

AEC unit patients should have the same access to urgent investigations as inpatients or patients attending the emergency department In order to minimise patient waits monitoring of waiting times for diagnostics, including the generation of reports, should occur at least monthly and discussion held with relevant departments to ameliorate delays.

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6. Performance review

Review of AEC performance should occur regularly using at least the metrics suggested by the AEC network.
Additional measures that are relevant to the local health system may also be needed to understand factors influencing performance.
Results should be reviewed with the aim of quality improvement.

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7. Monitoring/safety

Non-attendance of patients who have been referred to the AEC unit should be reviewed. If a patient does not attend and cannot be contacted this should be communicated with the relevant GP practice.

Similarly, robust systems must be in place to ensure that patients do not get lost whilst under the care of the ambulatory unit including those in any ‘virtual ward’ or undergoing investigation.

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8. Communication

A same day discharge summary for a single episode of care should be created at the end of the AEC episode and sent to the GP and given to the patient. This should include details of investigations undertaken, any new therapies instigated and the follow up plan required and arranged.
If there are multiple attendances then it is mandatory that the primary care team receives regular communication, with the mechanism and content defined locally.
In either circumstance it should be clearly communicated when the AEC episode has been completed and continuing management has been transferred back to the care team in the community.

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9. Operational model

Each unit should have a standard operational policy that defines the specific clinical pathways that have been developed and should also define the local arrangements that exist to ensure that the AEC unit does not become the default referral pathway for patients who would be managed more appropriately by a particular specialty or if in-patient care is required.

10. Commissioning

All patient pathways should be adequately defined and resourced in association with the commissioning organisation (where applicable) to avoid duplication and provide clarity of care for specific conditions.

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11. Information to patients

During the period of care under the ambulatory team, patients should have clear written instructions for actions to take if they feel they are deteriorating or if they wish to discuss concerns prior to their next scheduled visit.

12. Use of resource

Activity within AEC must be protected including during periods of escalation when the hospital is under pressure. Loss of this activity will undoubtedly make the acute pressures worse. AEC units should not be used for the non-acute management of long term conditions.

13. Infrastructure/environment

The infrastructure and space in the AEC unit must be adequate and reviewed regularly for the throughput and the needs of patients anticipated. Waiting areas should be equipped with adequate seating, refreshment facilities, TV and toilets.

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14. Information

All patients referred to the AEC unit should have an explanation of the service and reassurance that it can provide safe and effective care including the need for escalation of care if this is thought to be necessary.

15. Privacy and dignity

A private area must be available where all confidential conversations should be conducted.

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Thank you

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