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Overview of the Programme

A Message from the National Clinical Lead

Prof Garry Courtney

At the beginning of 2014, it is a good time to take stock of progress with the National Acute Medicine Programme and to consider future plans.

The context: the unprecedented national austerity campaign has seen €3 billion and 12,000 staff removed from the public health service, which itself has faced a retention and recruitment crisis for frontline staff and rapidly escalating demands due to the ageing population, new investigations and treatments, exacting regulatory standards and greater public expectations of care. Though there have been several health scandals and staff morale has fallen, the overall standards of care have been maintained and even improved in certain areas, due to the dedication and professionalism of our colleagues right across the service.

How then are we to cope in 2014 and beyond, faced with further budget cuts and staff reductions and yet deliver high quality care with greater access and at reduced cost? The answers are to be found in the clinical programmes, conceived in 2010 and 2011 at the height of our austerity woes, precisely to answer these looming problems. Though all of the CCPs have their specific roles and benefits, it is the NAMP which must deliver the greatest system change because approximately one third of all hospital admissions, one half of bed days used and two thirds of the costs in acute hospitals are due to medical patients. Health Service reform depends on the efficient and cost effective care of the rapidly increasing numbers of acute medicine patients. This requires an end to end solution, encompassing health promotion, self care, community supports, re-enablement, primary/secondary/tertiary care integration, all supported by accessible, appropriate National ICT and eHealth strategies which will drive improved communication, efficiencies and savings. Only in this way can Universal Health Insurance and Money Follows The Patient be successfully introduced and the ultimate goal of Outcomes-based Payment be achieved.

This is the fair, proper and correct way to bring about meaningful reform in any complex system. All the factors required for success are in place or being assembled e.g. HSE transformation, Hospital Groups/Trusts, Small Hospitals Framework, Clinical Programmes and most importantly, the political and public realization that the current system is under intolerable strain and will prove unsustainable in the medium to long-term.

In the future, all health care staff will work in radically different ways, which will be difficult to accomplish, but will bring huge benefits to patients, carers, staff and the public purse.

It is important to acknowledge many significant achievement to date: every acute hospital has established Acute Medical Assessment Units, the National Early Warning Score has been introduced to all acute and single specialty hospitals, medical trolley numbers have fallen dramatically, patient experience time has improved, average length of stay for medical patients has reduced and new
educational and training curricula for acute and general medicine have been introduced for doctors and nurses - all delivered in spite of our current financial and staffing challenges.

To augment these benefits in 2014, we will extend opening hours and introduce seven day working in selected AMAU’s, enhancing the flow of acute medicine patients through these units and also increase the presence of senior medical decision makers on the floor to bring maximum benefits to patients and improve supervision and training of NCHDs. Close co-operation with the National Clinical Programme for Older People, the National Surgery Programme, the National Emergency Medicine Programme and the Special Delivery Unit will allow for a multidisciplinary approach, including real-time ICT data capture and analysis, to benefit those hospitals which are most challenged by unscheduled care patient delays.

The entire NAMP team really appreciates the sterling efforts of the many staff members right across the country who helped deliver these programme improvements in acute hospitals.

Best wishes and Good Luck in 2014.
The Programme at a Glance

What is the National Acute Medicine Programme (NAMP)?

The National Acute Medicine Programme (NAMP) is a clinically led initiative within 33 acute medical hospitals which aims to:

- Improve quality and safety: each medical patient to be seen by a senior doctor within 1 hour of arrival.
- Improve access: the patient’s journey through the Emergency Department and Acute Medical Unit should not exceed 6 hours.
- Increase efficiency: reduce overnight admissions and shorten lengths of stay resulting in significant reduction in bed days and resources used
- Reduce overnight admissions: increased use of ambulatory care pathways.
- Ensure no increase in 7 day and 28 day readmission rates.

Meet the Team

**Clinical Lead:** Prof Garry Courtney  
**GP Lead:** Dr Barbara Kearns  
**Acting Programme Manager:** Ms Eilish Croke  
**Public Health Lead:** Dr Orlaith O'Reilly  
**NEWS Project Lead:** Ms Celine Conroy  
**HSCP Lead:** Ms Alison Enright  
**Interim HSCP Lead:** Ms Pauline Burke (Mar – Dec, 2013)  
**Programme Coordinator:** Mr Louis Lavelle

Key links to the programme team are maintained with:

**Pharmacy Leads:** Ms Anne Marie Cushen & Ms Fiona Kelly  
**Quality and Patient Safety Directorate, HSE:** Ms Maureen Flynn
What are the key objectives of the NAMP?

- **Quality**: Reduce overnight medical admissions by 10% without increasing the 28 day readmission rate, thus enhancing the global patient experience. Use National Early Warning Score (NEWS) to reduce the number of patients suffering adverse events. Use the NEWS as a trigger for sepsis screening.
- **Access**: Medical patients presenting to the Acute Medical Assessment Unit (AMAU) will be seen by a senior medical doctor within 1 hour.
- **Cost**: Medical bed day savings of 10% post full implementation

What are the programme successes to date?

- The National Acute Medicine Programme is now being implemented to some degree in all 33 hospitals in Ireland where patients receive acute medical care
- A reduction nationally in medical average length of stay of 0.5 days (from 8.6 days in 2010 to 7.49 days which is a 13% decrease, with some hospitals showing validated improvements of more than 2 days)
- Bed day savings on approx 60,000 (equivalent to €13m)
- 41 acute and single specialty hospitals have implemented the National Early Warning Score, as well as a large number of private hospitals.
- 8 Acute Medicine WTE positions have been filled with 15 locums in place and 9 further posts in line for filling.
- Performance inpatient experience time (6hr target) has improved in a number of hospitals.
- Demonstrable change in work practice and culture in a significant number of sites.
National Early Warning Score Conference 2013
by Ms Eilish Croke

The 3rd annual conference of the National Early Warning (NEWS) and COMPASS Programme, ‘Early Warning for Safer Better Care’ was held in the Royal College of Physicians in Ireland (RCPI) in Dublin on June 4th 2013. It was attended by over 200 participants from a wide variety of backgrounds in healthcare.

The opening address was given by Professor Garry Courtney, National Clinical Lead for the National Acute Medicine Programme.

Dr Philip Crowley, National Director, Quality and Patient Safety launched the patient information leaflet on the NEWS. The development of this leaflet, co-ordinated by Ms. June Boulger, from the Patient Advocacy Unit in the HSE, is viewed as an important piece of work by the National Acute Medicine Programme as it provides information for patients about the NEWS and how it works.

Speakers on a wide variety of interesting topics included Dr Deirdre Mulholland, Deputy Chief Medical Officer, Dr John Cullen, Consultant Physician, Acute Medical Assessment Unit at Tallaght Hospital, Anne Marie Barnes, Emergency Response System co-ordinator in Tallaght Hospitals, Ms Celine Conroy Project Officer NEWS / COMPASS programme, Captain Tom Croke, former airline pilot and safety expert in the airline industry, Prof Michael Turner, National Clinical Lead for the Obstetric Clinical Programme, Ms Maureen Flynn, National Lead for Clinical Governance, Mr Brendan Doyle, Leadership Consultant, Dr Criona Walshe, Consultant Anaesthetist, Beaumont Hospital, Dr Turlough Bolger, Paediatric Consultant, Tallaght Hospital, Ms Anne Marie Oglesby, Clinical Risk Advisor, Clinical Indemnity Scheme, States Claims Agency, and Ms Cathriona Greene, Nurse Tutor, Waterford Regional Hospital.

Ms Liz Roche, Interim Director, Nursing and Midwifery Planning and Development, Dublin Mid-Leinster launched the Healthcare Assistant Education Session on NEWS. This programme was developed as a result of service demand for the up-skilling of Healthcare Assistants on the use of the National Patient Observation Chart.

A panel discussion proved very interesting and informative for the conference participants. The panel included Dr John Cullen, Professor Garry Courtney, Ms Susanne Dunne, Director of Nursing, Midwestern Regional Hospital, Nenagh, and Ms Anne Marie Barnes. A number of questions were tabled on issues arising from the implementation of the NEWS including, the use of NEWS in day wards and the management of patients with high scores due to chronic conditions.

Professor Garry Courtney gave the closing remarks.

Immediately following the conference, a Train the Trainer Programme for nurses providing Healthcare Assistant training on the NEWS was delivered to over 70 participants.

The conference evaluations were very positive and will assist the organisation of future conferences. Ms Eilish Croke acknowledged the assistance of Ms Ciara Buckley, Ms Celine Conroy and Ms Anne Marie Keown, Ms Sinead O’Reilly and the staff at the RCPI for their assistance in organising of the conference.

A NAMP conference incorporating work-streams is planned for May 27th 2014 in RCPI.
Incorporating Acute Medicine into Postgraduate Specialist Training

Higher Specialist Training Update

Prof Colm Bergin, Dean of Postgraduate Medical Training in the Royal College of Physicians of Ireland recently chaired a meeting of the Irish Committee on Higher Medical Training, the National Acute Medicine Programme, represented by Prof Gary Courtney, the Clinical Care Programmes represented by the Clinical Director, Dr Aine Carroll, and the HSE Medical Education and Training Programme, represented by Prof Eilis McGovern. The purpose of the meeting was to review the interface between training, service requirements in the setting of the evolving Acute Medicine Programme and future workforce planning.

This meeting, the first in which all parties were present, was of significant benefit in confirming agreed principles on which dual specialty training will continue and the governance and structures around which training for acute medicine will be delivered.

It was agreed by all parties that Acute Medicine represented a new model of care delivery rather than a change of specialty and that dual-training would remain. Therefore Acute Medicine will be incorporated into General Internal Medicine (GIM) training and that any trainee who has completed GIM training will be eligible to apply for future consultant posts which carry a requirement for acute medicine in the job specifications. Thus no trainee, past or present, would be disenfranchised by these developments.

It was also agreed that acute medicine training will be incorporated within presently aligned dual-medicine programmes and the Internal and Acute Medicine Specialty Training Committee (formerly the GIM STC) will work to establishing the training framework. Trainee representation to future working group meetings will be requested to enable a better communication structure across all parties.

The RCPI will also commence work partnering the Irish Society for Acute and Internal Medicine (ISIAM), the IAM STC and the RCPI Postgraduate Medical Education department to develop the curriculum for a postgraduate training diploma in Acute Medicine that may be offered to trainees as an additional component of training, though would not be a requirement for dual-specialty registration.
Health and Social Care Professions (HSCP) Update

*Alison Enright and Pauline Burke*

Year One of the HSCP Implementation Programme has been particularly busy for representative members from the 14 professions. In order to deliver on our commitment to the AMP, work streams have been established and members are working steadfastly on agreed priority objectives as outlined below.

In addition to work ongoing in the three work streams, the HSCP Implementation Steering Group, comprising a lead representative from each of the 14 professions, continues to hold monthly meetings to direct and oversee the implementation programme.

Furthermore, in June 2013, the full HSCP Implementation Team (steering group members and advisors) held a mid-year workshop to review progress and agree the Q3 and Q4 work plan and a further planning workshop will be held later this month.

Our huge thanks to Pauline Burke who led the HSCP Implementation Team during Alison Enright’s maternity leave in 2013.

HSCP Work Streams Outlined

**Patient Flow**
- Care pathway design
- Common assessment tool
- Development of performance targets

**Education/Competency Framework**
- Competency framework
- Roles and responsibilities/job descriptions
- Education programme in partnership with HEIs

**Communication Strategy**
- Managing communication with stakeholders

**Work Stream 1 - Patient Flow**

This group is chaired by Paul Nolan (Clinical Measurement Science) and comprises HSCP representation from Clinical Biochemistry, Speech and Language Therapy, Physiotherapy, Occupational Therapy, Nutrition and Dietetics and Orthoptics. The work stream was previously chaired by Anne Marie Cushen (Pharmacy).

During 2013, work focused on the following key priority areas:
1. Identifying HSCP key intervention points
2. Developing Key Performance Indicators
3. Designing a Common Assessment Tool for HSCPs delivering services in AMAUs

Understanding the key intervention points (below) for HSCPs working with acute medicine patients has been essential in order to recommend key performance indicators which will improve patient flow and aid decision-making at the appropriate stage on the patient journey. Furthermore, it has facilitated the design of a common assessment tool for use by relevant HSCPs.

**Fig 1** Patient Flow Diagram highlighting the Key Intervention Points for HSCP working with Acute Medicine Patients

The development of HSCP Key Performance Indicators is at an advanced stage and the consultation process is expected to commence in Quarter 2, 2014.

The Common Assessment Tool, to be used by the Therapy Grades across the acute floor (ED and AMAU) will enable a single therapist to complete an initial common assessment with acute medicine patients. This assessment will:

1. Serve as the core basis of the patient’s initial assessment which will travel with the patient through his/her in-patient journey
2. Identify need for referral to HSCP (particularly therapy services)
3. Provide an early indication of potential delays to discharge
4. Facilitate communication between ED and the AMAU and hospital and primary care teams
The Common Assessment Tool, together with recommended standard operating procedures, is at final draft stage and will be piloted and sent for consultation shortly. Also being addressed by the group at present is the issue of workforce planning for HSCPs in the AMAU. To this end, a Workforce Planning Survey will be carried out across all sites in Q2, focusing specifically on the 14 HSCPs represented on the AMP HSCP Implementation Team.

**Work Stream 2 - Education and Competency Framework**

This group was initially chaired by Dervilla Danaher and later by Paula Markey and in January, 2014, Pat Mulhare (Medical Lab Science) took over the role of chair. Representative members on the group include Speech and Language Therapy, Physiotherapy, Occupational Therapy, Medical Physics and Nutrition and Dietetics.

Over the past number of months, work has been ongoing to develop a competency framework for Physiotherapy, Occupational Therapy, Speech and Language Therapy and Nutrition and Dietetics staff working in the AMAU. The draft framework is due out for consultation later this month. Phase 2 of the competency framework development will include the HSCP diagnostic professions and will commence later in the year.

In addition, the group has been focusing on the development of Roles and Responsibilities and Job Descriptions for therapy staff working in the AMAU and further updates on these will be available shortly.

**Work Stream 3 - Communication Strategy**

This group was chaired by Paula O’Connor (Nutrition and Dietetics) until August, 2013 when Róisín O’Hanlon (Physiotherapy) took over as chair. Also represented on the group are Occupational Therapy and Nutrition and Dietetics.

Priority work for this group has included a) the identification of key stakeholders nationally, including HSCP staff, professional body representatives, local site representatives, management team representatives etc. and b) the development of an AMP HSCP Implementation Update. This update was circulated in Q3 2013 and further updates will be sent to stakeholders on a twice-yearly basis.

**HSCP Implementation Team Members**

Alison Enright, Pauline Burke, Paula O'Connor, Dervilla Danaher, Maeve Murphy, Christine Kiernan, Emma Goodall, Anne Marie Cushen, Niamh Coleman, Paul Nolan, Orla Maguire, Paula Markey, Pat Mulhare, Martina Glynn, Wil Van der Putten, Anne Healy, Karen Kirrane, Liz Moran, Patricia Kennelly, Sinead Crowe, Carole Murphy, Aine O’Byrne, Judy Colin, Roisin O’Hanlon, Jenny Gilchrist, Linda Killeen, Anne Marie Fanning, Grainne O’Byrne, Majella Doherty, Marie-Claire Jago Byrne, Janice Hanlon, Gerry Monahan, Margaret Moore, Natalie Hession, Keith Morrissey and Jaina Byrne.
An Innovative Community Based Cardiac Diagnostics Service Prevents Hospital Attendances
By Paul Nolan

One of the recognised limitations of the public health care system is the difficulty that primary care physicians have in accessing diagnostics and some GP’s will admit that sometimes, patients are referred to the Acute Medicine Service simply because there is no other route to diagnostics. Croi, the West of Ireland Cardiac Foundation, in partnership with HSE West PCCC and the Cardiology Departments in University Hospital Galway and Portiuncula Hospital have, since September, 2008, provided one of the largest community based Cardiac Diagnostics Service to Primary Care Physicians in the Republic of Ireland.

Since its initiation, over 3000 cardiac investigations were performed by the service, including Echocardiography, 24hr Holter monitoring and 24hr Blood Pressure monitoring and almost all patients had their test performed within 4 weeks of referral with urgent cases receiving highest priority.

Nearly 50% of referrals were for reasons that might commonly be seen in the acute medical system (ED or an AMAU) and included dyspnoea, cardiomegaly, palpitations and suspected heart failure. Only 8% of tests required direct referral to the Cardiology team and only three of those cases required an acute medical presentation. 47% of tests were reported as normal and the value of the “normal” finding should not be underestimated as these patients were kept out of the hospital system. In the case of the further 44% of patients, follow-up care was left with the GP. It is estimated that this service prevented an estimated 663 acute medical presentations.

The overall cost of the service was €349,740 and it is estimated that if these patients had been processed through traditional hospital routes, the cost would have been €764,000 – providing a saving of around €414,000.

The service provides rapid access to Cardiac Diagnostics for Primary Care in a highly cost efficient manner which prevents acute hospital admissions by providing an alternative route of referral.
Dr Philip Crowley, National Director of Quality and Patient Safety launched the Patient Information Leaflet and Poster on the National Early Warning Score (NEWS) and the Irish Maternity Early Warning System (I-MEWS).

In line with the National Healthcare Charter ‘you and your health service, it’s safer to ask’, the leaflet and poster were developed as a result of a request from patient groups. These documents provide information for patients and their families on the National Early Warning Score (NEWS) and the Irish Maternity Early Warning System (I-MEWS) and how they are used for the early detection and management of deterioration in a patient’s condition, should this occur. For further information please contact Ms Eilish Croke at eilish.croke@hse.ie.
The Healthcare Assistant Education Session on the National Early Warning Score (NEWS) was launched at the National Early Warning Score Conference on June 4th 2013. Following an upbeat and encouraging speech delivered by Ms Liz Roche, Interim Director, Nursing and Midwifery Planning and Development, Dublin Mid-Leinster (deputising for Dr Michael Shannon, Office of the Nursing and Midwifery Services Director (ONMSD), the education session was launched.

This education session was developed as a result of identified service need. It facilitates the Healthcare Assistant to update their knowledge of measuring, recording and communicating patients’ vital signs using the National Patient Observation Chart. In developing this education session a wide consultation process was adopted and valuable feedback was obtained and incorporated.

The education session was developed by:

- Ms Celine Conroy, Nursing and Midwifery Project Officer, NEWS/COMPASS, ONMSD
- Ms Cathriona Greene, A/Specialist Co-ordinator, Regional Centre of Nursing &Midwifery Education Centre, HSE South
- Ms Maria Horgan, Clinical Nurse Specialist, Chest Pain, St. Luke’s Hospital, Kilkenny, Co. Kilkenny
- Ms Marie Laste, A/Nurse Practice Development Facilitator, South Tipperary General Hospital, Clonmel, Co. Tipperary
- Ms Mairead O’Sullivan, Clinical Placement Co-ordinator, Midland Regional Hospital, Portlaoise, Co. Laois

The support of the National Governance / Clinical Guideline Development Group for the NEWS, the Office of the Nursing and Midwifery Services Director (ONMSD), the Irish Association of Directors of
Nursing and Midwifery (IADNAM), the Irish Nurses and Midwives Organisation and staff working in the clinical area was acknowledged at the launch.

The first ‘train the trainer’ programme for the education session was delivered immediately following the conference on the day and attended by 70 participants. The resources required to deliver the education session are available on the NEWS website as follows: NEWS Website

For further information please contact: Ms Celine Conroy at celine.conroy@hse.ie.
Biomnis Healthcare Innovation Awards 2013

by Ms Ciara Buckley

The National Acute Medicine Programme was the recipient of the Innovation in Quality of Service Delivery (Hospital Based) at the Biomnis Healthcare Innovation Awards 2013.

The Acute Medicine Programme has continued to be recognised for its successes with another award to add to the collection. The programme won the Innovation in Quality of Service Delivery – Hospital Based category at the Biomnis Healthcare Awards which were held in Dublin in May 2013.
National Acute Medicine Programme – Team Update

We have a number of changes to the team since the last Newsletter.

Anne Marie Keown and Avilene Casey have taken up positions with the Special Delivery Unit and Ciara Buckley has been appointed Programme Manager for the Qatar Clinical Revalidation Programme in the RCPI. The NAMP would like to thank them for their valuable contribution to the programme and wish them well in their new roles. We would also like to congratulate Alison Enright on the birth of her daughter, and to thank Pauline Burke for continuing the work of the HSCP in her absence.

Eilish Croke has been appointed as Acting Programme Manager, Celine Conroy has joined the team as National Early Warning Score and COMPASS education programme lead and Louis Lavelle has been appointed Programme Co-ordinator.
Interaction with the Programme

Where have all the trolleys gone?
St Vincent’s University Hospital
by Kay Connolly

The picture above is a sight to behold and one we have seen several times in the last few months. The trolleys may be gone but they certainly have not been forgotten, and indeed there have been days when there have been patients waiting on trolley’s in the ED for admission but thankfully this has been the exception rather than the norm. The answer to the question – ‘Where are all the trolleys gone?’ is………

*Patient flow, patient flow, patient flow*

CNM2 in the ED is quoted as saying:
“We are able to provide a higher quality of care to our patients which enhances their journey through the Organisation”
Over the last 18 months there has been unprecedented continued and sustained change in relation to patient flow through SVUH. In particular, in the last 6 months we have seen the development of:

- The Navigational Hub
- The Transitional Care Unit
- The AMAU

Not one but all of the above developments have played an integral role in the improvements of patient flow and hence in the reduction of patients waiting on trolleys for beds in the Emergency Department.

**The Navigational Hub**

The inauguration of the Navigational Hub was on the 13th February 2013. The purpose of its development was to focus on active discharge planning, reduce length of stay and improve patient flow throughout the organisation. It has been successful in its endeavours in increasing the discharge rate in the medical wards and reducing length of stay, thus increasing patient flow.

The Navigational Hub has exceeded beyond its own expectations by creating an environment of active engagement of the MDT, a support mechanism for all staff and a positive “Can Do” attitude from all those involved. Its members include the Discharge Coordinators, Bed Management, Occupational Therapists, Physiotherapists, Social Workers, CNM 2s from the medical wards, ADONs and NCHDs. It is supported by the senior management team who frequently attend the sessions which are held at 9am and 2pm each day.
An Assistant Director of Nursing from the Medical Division completed her dissertation for the MSc in Leadership and Management Development on the Navigational Hub:

Quote from Head of Occupational Therapy:

“It increases communication amongst the MDT which plays an integral role in successful Discharge Planning”

The Transitional Care Unit

The Transitional Care Unit (TCU) opened on March 20th 2013 in an effort to address the blockage of patient flow which was being caused by the ever increasing numbers of patients medically fit for discharge but waiting long term care in acute medical beds.

The aim was to create an environment conducive to the patient’s needs whilst simultaneously actively driving the discharge process for these patients.

Patients are cared for in a calm, friendly, caring environment. Events such as afternoon tea occur on a weekly basis where family and friends can join their relative for light beverages. A retired member of staff who works voluntarily in the hospital has decorated the walls entering the unit which enhances the ambience for the patients and their relatives.
The Transitional Care Unit has developed its own Navigational Hub which occurs each day at 10am. The members include Discharge Coordinators, ADONs, Social Workers, CNM 3, CNM 2 and the COO, Clinical Services Manager and Medical Division Lead ADON as ex office members. There were 14 long-term care patients discharged from this unit over a 3 week period in July 2013.

A CNM 3 in the Medical Division has played an integral role in this project since its inception. It will be her chosen subject for her dissertation in her MSc in Leadership and Management Development. Quote from Senior Social Worker:

"Through a task force team approach we have achieved tremendous results in discharges of our patients to the nursing home of their choice. Tasks are delegated and actioned on a daily basis"

The Acute Medical Assessment Unit (AMAU)

The AMAU commenced on 15th March 2013 and made steady progress until June 2013 when radical changes were introduced into the running of the unit which included opening the unit 24/7, an active
focus on discharge planning, and changes to the bed management processes. These changes have resulted in an improvement in patient flow and a reduction in patients waiting for beds on trolleys in the ED – from a high of 35 to 0 on occasion. Admissions to AMAU increased from 14 to 70 in one week and ALOS reduced from 5.5 in January 2013 to 2.2 in August 2013.

These results were achieved by hard work, dedication, energy and drive to make this happen by the whole AMAU team. It has proven that the process will work but to sustain it more resources are required.

**St Vincent’s University Hospital**

![Graph showing 30 Day Moving Average INMO Trolley Count]

*Quote from AMAU Consultant:*
*“The ambition and hard work of the staff in continuing to strive to deliver timely high quality and safe care in an appropriate environment is to be commended”*

**Conclusion**

The reduction in the number of patients waiting on trolleys for beds in the ED has occurred because of the increase in the efficiencies of patient flow throughout the organisation. The unintended consequence of this change has been an organisational wide cultural change. For patient flow to continue it will need the continued support, good will, hard work, dedication, and team work of every member of staff within SVUH, the NAMP team and the SDU team – which will benefit the patient, the staff and St Vincent’s University Hospital.
Nursing in an AMAU - Our Lady of Lourdes Hospital Drogheda Experience
by Ms Angela T. Boyle

The AMAU in Our Lady of Lourdes Hospital in Drogheda was opened by Minister for Health Dr James Reilly on 22nd February 2012. The unit which is currently consultant led is open over 7 days. The average patient attendance is 35 per day.

The Unit consists of a reception - 1 initial assessment room, a large waiting area and a small waiting area, with 12 cubicles.

It has been an exciting and challenging time for nurses to develop the skills required for this fast paced environment. Many of the patients that come to the unit are very acutely unwell and require rapid assessment and skilled nursing care. Nurses need to have the skills and competence to ensure all aspects of the assessment and treatment process are carried out efficiently and effectively ensuring sufficient patient flow through the unit. A key skill is the ability to ensure that the cubicle spaces available are utilised effectively to maximise their use, and to minimise patient delay in the unit or in the emergency department.

Nursing staff within the unit have had exposure to a variety of training, coaching and education to develop the skills and competencies required for acute medicine nursing. All new staff participate in a tailored induction programme devised by the department nurse manager to develop the competencies and skills they require. The programme includes building expertise on the acute management of typical presentations such as acute asthma, chest pain and diabetic ketoacidosis. A central focus of the programme is developing skills for the ‘coordinator role’. I would describe this role as similar to a ‘conductor’. The role centres on the use of a ‘whiteboard.’ This board contains all the information about who is in the unit at a given time and where they are in their journey. It also logs who is coming into the unit from the general practitioners or the emergency department. It is this nurse’s responsibility to ensure that the flow through the unit is coordinated and controlled. This role is currently rotated among senior staff. They are responsible for liaising with the medical teams, with bed management and other departments. The role is vital for the safe and effective running of the unit on a daily basis.

The other important role is the ‘rapid assessment’ nurse. This nurse sees all patients on arrival to the unit. They are assessed, guided by the documentation the team developed; the patients are prioritized depending on clinical condition. This role is rotated among staff who have developed skills in areas such as cannulation, phlebotomy and interpreting E.C.G’s.

If I was recruiting nurses to the unit in the future I would look for staff with the following skills and competencies:
Sound knowledge of the management of acute medical conditions, good time management, good communication, extended nursing skills, good decision making skills and most importantly the ability to keep calm under pressure! I believe we have developed these skills and competencies in our current nursing workforce and will continue to do so to further develop the service we provide to patients in our unit.
Patient Flow Manager Mercy University Hospital Cork

By Ms Deirdre O'Donovan

The role of the Patient Flow Manager involves examining processes to ensure the effective streaming of patients through the ED and AMAU, between hospital departments and across community services. It also includes identifying barriers to patient treatment and investigation and supporting ward managers and staff in expediting patient discharge when clinically discharged by consultant.

My initial focus has been on streamlining medical patients from ED to AMAU, working closely with ED and AMAU staff in supporting AMAU to reach its capacity.

This involved an analysis of all medical patients attending ED daily to ensure that all patients suitable for assessment in AMAU are referred and the reasons why this may not occur. Patients not referred to AMAU, in the majority of cases, followed an alternative care pathway e.g. acute chest pain, Stroke/TIA pathway, Oncology pathway, patients requiring isolation and in some instances patients' required urgent resuscitation.

The analysis took place over 2 separate 3 week periods and involved liaising with ED staff in relation to all presentations to the ED, between 0800 and 2200 Monday to Friday, to distinguish medical patients and to ascertain their suitability for referral to AMAU. The ED notes of patients that presented in the late evenings were analysed to identify their presenting complaint and potential suitability for AMAU referral.

In the 1st instance a small number of cases suitable for AMAU were not referred, these cases were highlighted and discussed with ED and AMAU staff. These cases included neurology patients and a small number of respiratory patients who were initially unstable on arrival to ED but once stabilised potentially could have been referred to AMAU to continue their treatment and investigations. Improvements’ are evident in the 2nd analysis and can be seen in the numbers now being referred.

The data below is a summary of the analysis of medical presentations to the ED.

<table>
<thead>
<tr>
<th>Times</th>
<th>17-21.06.13</th>
<th>24-28.06.13</th>
<th>01-05.07.13</th>
<th>02-06.09.13</th>
<th>09-13.09.13</th>
<th>16-20.09.13</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800-2200 Total Medical Presentations</td>
<td>105</td>
<td>96</td>
<td>91</td>
<td>88</td>
<td>100</td>
<td>118</td>
</tr>
<tr>
<td>0800-1700 - Patients referred to AMAU</td>
<td>46</td>
<td>46</td>
<td>46</td>
<td>49</td>
<td>61</td>
<td>65</td>
</tr>
<tr>
<td>0800-1700 - Patients outside criteria for AMAU</td>
<td>27</td>
<td>22</td>
<td>16</td>
<td>13</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>1700-2200 - Potential patients suitable for AMAU</td>
<td>32</td>
<td>28</td>
<td>29</td>
<td>26</td>
<td>21</td>
<td>28</td>
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</tbody>
</table>

The AMAU governance group is satisfied that the AMAU has reached its referral capacity from ED within the current opening hours 0800-1700 Monday to Friday. This analysis has enabled an understanding of the category of medical patient attending the ED and the pathways utilised. It also...
enables us determine what additional steps and actions need to be taken to meet the needs of the patients that attend when the AMAU is closed. The challenges that are now being considered include expansion of AMAU opening hours to capture medical patients that attend ED in late evenings and/or direct GP access, both of which will require analysis of diagnostic availability and staffing implications.