RISING ADMISSION TRENDS IN EMERGENCY DEPARTMENT. IS IT THE RIGHT TIME TO ADOPT THE NEW MODEL OF ACUTE MEDICAL UNIT?

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In the last two decades there has been a significant change and improvement in the delivery mode of acute care and in the team that delivers it. With the introduction of acute physicians at the forefront as well as unscheduled care has shown a significant reduction in length of hospital stay, readmission rates and risk of mortality. Acute medicine is a relatively new specialty that is evolving rapidly. Because of its crucial role, it is expected to become a key player for the provision of healthcare in future. Acute medicine is one of the most versatile medical specialties. It is a sub-branch of internal medicine related to the early and immediate treatment of adult emergency patients by acute physicians.

Patients presenting with acute emergencies, after being properly triaged to acute medicine, are assessed and treated by acute physicians. Moreover, as unplanned patients are being taken care of, the admission process is remarkably improved. Care is provided for a designated period (usually 48 hours) before the patients are discharged home or shifted to medical units for continued care. If short stay unit is available, then the stay can be increased up to 72 hours. The acute medical staff based at the forefront of the hospital deliver immediate and comprehensive care. Close liaison is kept with other specialist teams of the hospital for multidisciplinary team approach and provision of patient-centred care which ultimately leads to improved patients flow as well as admission and discharge process[1].

In United Kingdom (UK), United States and Europe acute medicine is well established and well recognised. In the most populated countries like India and Pakistan there is growing need to adapt to this new specialty. Although Accident and emergency department (A&E) used to be and is still at the forefront of accepting the very sick patients but those patients who still need non-urgent medical attention can be seen in acute medical unit or in ambulatory clinics. The need and role of acute medicine was recognised in the United Kingdom after the publication of joint report by the Royal Colleges of Edinburgh and Glasgow in 1998. The importance of appropriate care for people with acute medical problems was recommended which later on led to the development of acute medicine across the UK with more than 225 hospitals having an Acute Medical Unit (AMU). As expected there are now estimated over 450 consultants specialising in acute internal medicine and there is a big drive to recruit more trainees. Amongst the many factors which triggered development of acute medicine as a new speciality, the concerns over quality of acute care, rising number of medical admissions and others like the European working time directive played key roles[2].

The Royal college of Physicians have now defined an AMU as a dedicated facility within the hospital that acts as the focus for acute medical care for patients who have presented as medical emergencies to the hospital or who have developed an acute medical illness during the hospital stay[3]. The dedicated consultants working on AMU called acute physicians are responsible for care on the AMU for the first 48–72 hours of hospitalisation. They are responsible for the care of these patients (while they are in the AMU) and for handover of care to other subspecialties when transferred to the other units.

There has been convincing evidence that has demonstrated the benefit of AMU models of care with special improvement in quality indicators like mortality, hospital length of stay (LOS), hospital readmission, patient/staff satisfaction and saving beds[4-6]. Attempts have been made to rightly name the acute unit. Many synonymous names were previously assigned including acute

assessment unit (AAU), acute medical assessment unit (AMAU), acute medical wards (AMW), acute planning units (APU), medical assessment and planning units (MAPU), rapid assessment medical units (RAMU) and early assessment medical units (EMU) but acute medical unit (AMU) is well adopted by most of the trusts across the UK.

Both ambulatory unit and short stay unit are functional units associated with acute medical unit. Time wise, ambulatory unit provide patient care up to 12 hours, acute medical unit up to 48 hours and short stay unit up to 72 hours. The ambulatory care unit (sometimes called ACU) is a type of health care service, which offers same day care to patients at the hospital. This means that patients are able to go home the same day after being assessed, diagnosed and received treatment without being admitted into hospital overnight. The short stay unit (SSU) is a ward providing targeted care to those patients requiring hospitalization for up to 72 hours. Once their clinical conditions are resolved, they are discharged home as soon as possible. Therefore, for the treatment of selected patients, SSU may be an alternative to the ordinary ward[6].

Key Team members on acute medical unit include:

- Senior medical staff: Consultant acute Physicians
- Junior medical staff: Trainees, speciality doctors and foundation doctors
- Nursing staff: A dedicated trained nursing team
- Allied health professionals: Pharmacists, Physiotherapists, Associate physicians, ward clerks, Ward manager etc.

Aims and objectives of acute medical unit include:

- Presence of professional multidisciplinary team who can provide delivery of early, safe, effective patient’s care.
- Providing early senior consultation with clear guidelines to junior medical team.
- Liaising and taking advice from other subspecialties to improve patients overall care.
- Aiming to provide standardised evidence based patient’s care according to local protocols and guidelines.
- With the available resources locally optimizing of bed management using care pathways that obviate the need for hospitalization.
- Triaging patients who do not need admission to be reviewed and followed up in acute clinics
- Triaging patients to be reviewed and followed up in ambulatory clinics or send to short stay unit for an extended acute admission up to 72 hours
- Liaising with community workers and teams to facilitate early discharges
- Working together with A&E facilitating in reducing waiting time and breeches
- Providing a hub for teaching for undergraduate students and postgraduate trainees.
- Working together with local communities, hospital management and senior local clinicians to introduce locally agreed protocols and patient safety guidelines.

The role of acute physicians is developing and extending into the management of short stay units, rapid access clinics and ambulatory care services. Acute physicians are now considered as an integral part of service development teams in any hospitals.

A standard AMU in addition to a formal care plan for admitting patients should have care pathways, audit programmes and clinical governance procedures. These procedures include investigating and responding to critical incidents, morbidity and mortality reviews and answering complaints. In addition to above all AMUs should also carry out patient satisfaction surveys to drive improvements to their service through the experiences and feedback of patients and relatives. In the last couple of decades most of acute hospitals have seen many fold rise in emergency admissions along with with a reduction in numbers of hospital beds and an increase in bed occupancy rates to above 85% leading to overcrowding in hospitals and congestion in emergency departments[3]. All these, place the bed management teams in difficult situations which unfortunately leading to inefficiencies in service delivery and at times result in compromised overall patient care[1].

In developed countries medical admissions usually with elderly patients having multiple chronic diseases are continuously on rise and contribute to high admissions through A&E. At front door a dedicated medical team with an acute physician with an interest in elderly care medicine may help to minimise admitting these patients. If admitting team has lower thresholds for admissions, traditionally, it resulted in admission and distribution of patients to multiple wards, which are usually located distant from investigative facilities, and in fragmented unsupervised care by junior medical staff. Patients are expecting higher standards of care nowadays, believing in early assessment by the right person and at the right time.

An AMU can function successfully if it has a strong clinical and operational leadership. Medical leadership should come from a consultant physician specialising in acute internal medicine. Nursing leadership is equally

important along with a multi-disciplinary team consisting of ward clerk, physiotherapist, ward pharmacist and other allied health workers.

In United Kingdom, The Society for Acute Medicine (SAM) is the specialist body that represents physicians practising AIM. It emphasises and highlights its members to provide best care to their patients. The society through acute physicians has contributed to many important reports, recommendations and guidelines concerning acute medical care. The Society of Acute medicine is contributing in the National Institute for Health and Care Excellence (NICE) for guidelines relevant to AIM. RCP works closely with SAM and plays a pivotal role in developing quality services for acutely Unwell and sick patients.

It is fundamental to the functioning of hospitals for those struggling with a rising number of patients turning up in busy A&Es to now adopt the front door acute medical model. This model has proven benefits across, the world. It is now time to strengthen our front door medicine with full integration of acute medical units to avoid in-patient admissions, if possible reduce length of stay, escalate early discharge, minimise medical errors and prevent avoidable deaths.

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