Front Door to the Ward: Differentiating Acute and Emergency Medicine

Same Storm, Different Boats: Emergency vs Acute Medicine

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Overview

- Brief Introduction – Setting the scene
- Patterns of Patient Behaviour that led to the Rise of ED
- What is Acute Internal Medicine? – the UK journey
- Contemporary Acute Internal Medicine
- The Future is now
- Food for thought

Background

My perspective is UK experience but with a colonial foundation….

Background

Indian diaspora 185 years out of India

Brian Lara Country

Background


Tobago is about 20 miles from Trinidad
scuba-diving-smiles.com
SAINT LUCIA
Castries
BARBADOS
Bridgetown
Kingstown
SAINT VINCENT AND THE GRENADINES
GRENADA
Saint George's
Aruba (NETH.)
Oranjestad
Curacao (NETH.)
Willemstad
Bonaire (NETH.)
Punto Fijo
Isla La Tortuga
Isla de Margarita
Tobago
Port of Spain
TRINIDAD AND TOBAGO
Trinidad
Gulf of Paria
La Guaira
Caracas
Valencia
Maracay
Barquisimeto
Cumaná
Barcelona
Maturín
Barinas
Ciudad Bolívar
Ciudad Guayana
San Fernando
Río Orinoco
Embalse de Guri
Georgetown
VENEZUELA
Linden
GUYANA
Puerto

Early Hospital Emergency Services

Early 20th Century "Casualty Rooms"

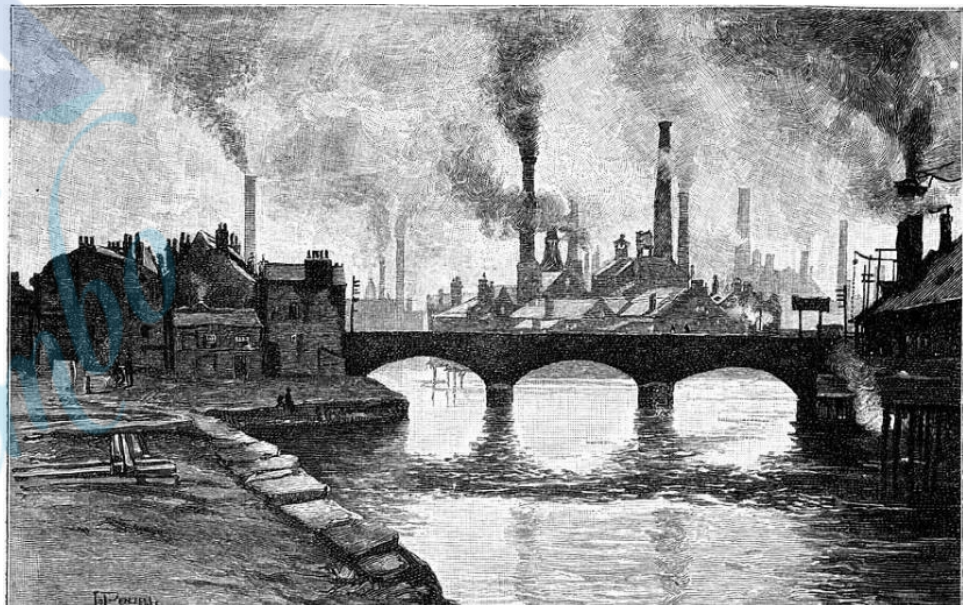
- Originally single rooms "**Casualty rooms**" often within hospital departments of surgery
- Minimally staffed and lacked specialized training.
- Usually, staff was whoever was free
- There were no dedicated emergency staff
- A patchwork of clinicians
- Managing illness or injury as best they could
- Rotating from all specialties
- House officers with minimal supervision
- Quality of Care Inconsistent

"In the Accident Ward"

Royal Free Hospital, London

Early Hospital Emergency Services

Post World War II…

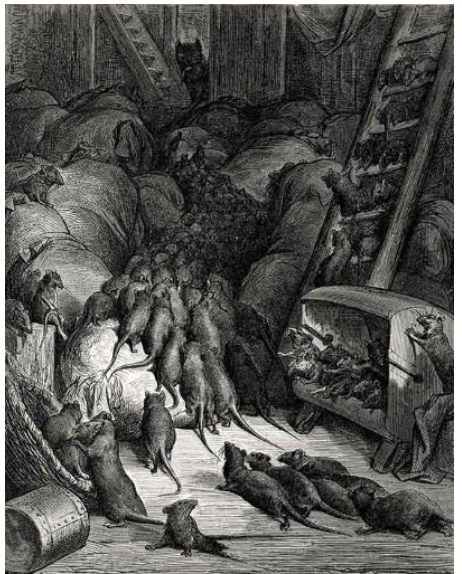


In the 19th Century, with rapidly growing urban populations, public health conditions were poor and there was rapid spread of diseases.

Ongoing expansion of industrial settings with poor safety records, trauma related to industrial accidents were frequent.

Combined with more widespread use of the motor car, "Accident rooms" were becoming overwhelmed.

"Casualty" departments attendance swelled, often overloaded and understaffed… out of this chaos… and came the need to organise care...



A handful of "Casualty physicians" began working in emergency rooms full-time, realizing the work demanded its own skill set and rapid, organized care….

Development of EM Specialty (1960s-1970s)

Establishing Accident & Emergency Medicine

- **1962:** There was the Platt report recommended the name change to “Accident & Emergency”.
  - Listed under management of orthopedics but still understaffed…
- **1967**: First meeting of the Casualty Surgeons Association (CSA) at BMA House
- **1968:** American College of Emergency Physicians founded**.**

- **1971:** The Bruce report recommended dedicate consultant posts
- **1972:** 32 consultant posts were appointed
- **1977:** 1st SPR was appointed in 1977
- **1997**: 400 consultants in post and 256 SpRs in training
- **By the Late 1980s**: EM positions were being appointed across the globe and trainings schemes set up to support this new subspeciality of medicine

Contemporary View ED dept

Royal College of Emergency Medicine

"…A field of practice based on the **knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders.**

An expectation of the understanding of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development."
International Federation for Emergency Medicine, 1991

The Royal College of Emergency Medicine (RCEM) sets the standards of emergency medicine care and provides training to ensure that the expectations of the public are achieved.

Three main types of ED ‘departments’…

Type 1 departments are consultant-led services with full resuscitation facilities, typically treating the most serious incidents. There are around 170 Type 1 A&E departments in England.

Type 2 departments provide accident and emergency services for single specialist areas, such as eye care or dentistry.

Type 3 departments (Urgent treatment Centres) : treat the least serious injuries or illnesses

- GP- or Nurse-led, open at least 12 hours a day,
- Allow appointments through 111 or GP referrals.
- Urgent Treatment Centres can be co-located with Type 1 emergency departments or situated in local communities

Emergency Medicine KEY Concepts

Focus Is on full spectrum of truly undifferentiated physical and behavioural disorders.

Training initially was rooted in surgical specialities…

Require the knowledge of resuscitation of all age groups and all disease presentations

Fast pace, rapid turn around, treat, stabilize and discharge or refer on.

RCEM
Royal College of Emergency Medicine

SLCEP
Sri Lanka College of Emergency Physicians

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEM
Australasian College for Emergency Medicine

Shifting TIDEs

While there was consolidation of the Emergency Medicine as a subspeciality

There was a shifting pattern of patient behaviour that influenced the types of patients presenting to ED departments around the country

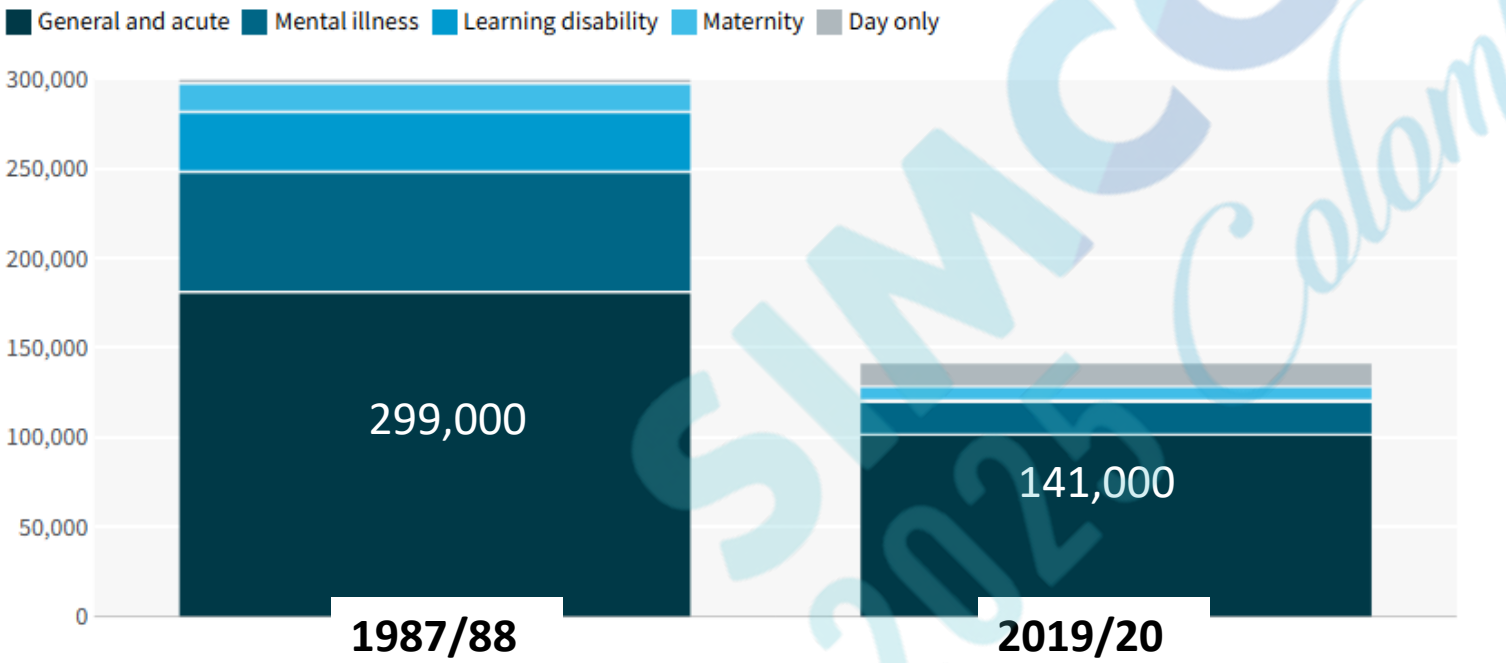
20th Century Medical Revolution

- Germ theory of disease (Pasteur, Koch) led to a greater understanding of infectious disease
- Discovery of **Antibiotics** reduce infectious disease mortality
- **Improved workplace safety** and **multivehicle safety** led to decline presentations of trauma to ED
- **Improved antiseptic techniques & anesthesia transformed surgery**
- And there was a shift in surgery to day cases….
- **Medicine increasingly evidence-based science and clinical outcomes improve …**
- **Population was living longer resulting in rising of chronic disease burden**

DECLINE IN TOTAL NUMBER OF HOSPITAL INPATIENT BEDS….

Figure 2 There are around half the number of hospital beds in the English NHS compared to 30 years ago. In 1974 total number of hospital in patient beds was 400000

Number of beds



Source: NHS England
From 1987/88 to 2009/10 data were based on an annual snapshot. From 2010/11 the data collection changed and figures are not directly comparable over this period. 2019/20 based on the average of quarterly data over the year. Data not compared to most recent year (2020/21) due to the impact of covid on bed numbers.

The King's Fund

TOTAL BED NUMBERS IN UK FELL >50% OVER THE LAST THIRTY YEARS

SHIFT OF TRAINING AWAY FROM THE TRUE GENERALIST PHYSICIAN…..

For the 2 decades leading up to 2000….there was a shift away from General Internal Medicine with no Sole GIM training options and Trainees were encouraged down single site specialisation pathways

Thought there was dual accreditation of GIM with Subspeciality, most would focus their efforts on their subspecialist interests and there was waning depletion of commitment to GIM

The changing demographics of the UK population is meaning an increase in the number of patients with complex comorbidities many of whom do not necessarily fall into a frail and elderly category and therefore a vacuum was being created need for physicians who were true generalists.

The thinking doctor???

GIM → Single SITE

Every year for the past 20 years….leading up to 2000

- A rise in the number of emergency admissions throughout the UK
- A decrease in the number of hospital beds
- An increase in medical single specialisation with loss of the GIM physician
- A decrease in the number of consultants who wish to undertake general internal medicine
- A decrease experienced junior staff
- A greater demand for accountability

A PERFECT STORM…. AND RISE OF THE AIM

History repeated itself…. Rising number of patients

Patient burden now was a shift to General Internal Medicine Patients … who were living longer, and presenting with multisystem disease rather than Trauma

In 2000: Ratio of Medical to Non-Medical Patients attending ED was 5: 1

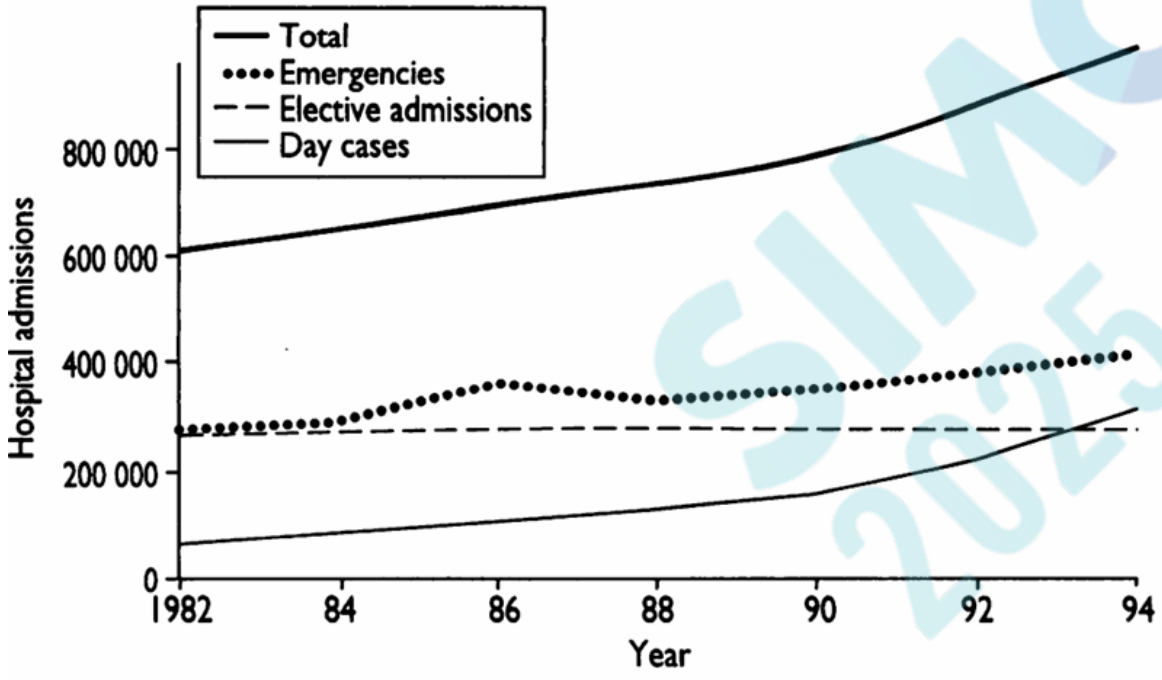
Later reports suggested that is increasing…

Late 20th Century Healthcare Evolution

The continuing rise in emergency admissions

Explanations and responses must be properly evaluated

BMJ VOLUME 312 20 APRIL 1996



Trends in elective and emergency admissions in Scotland

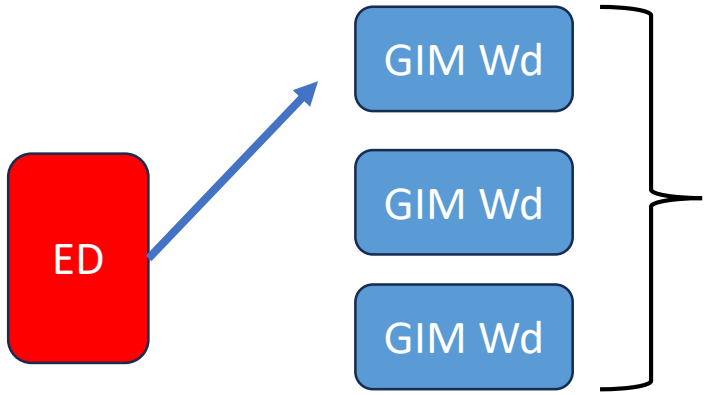
In Scotland, emergency admissions increased by 45% between 1981 and 1994

Even steeper increases have been reported by individual hospitals throughout Britain

Stark contrast
Elective admissions increased by only 1% with a rise in the number of day elective cases

Emergency hospital admissions account for about 40% of total acute bed use in the NHS

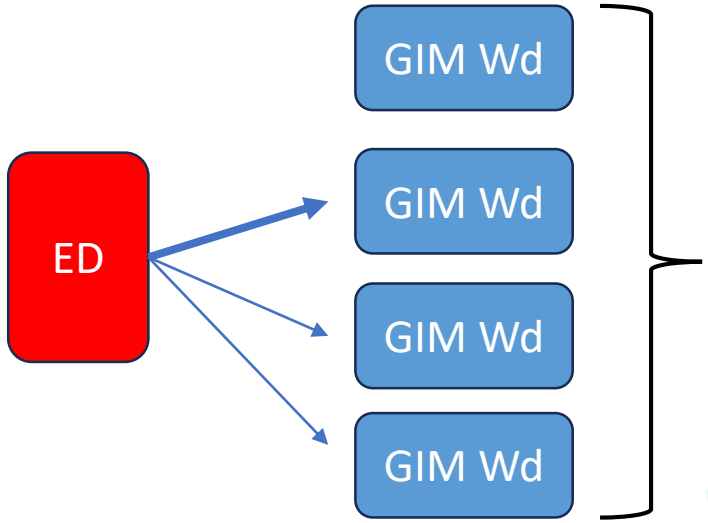
Evolution of the Patient journey – Impact of FLOW



Medical Wards took turns admitting patients from ED

- ✓ Manageable with lower numbers of admissions
- ✓ Wards had sufficient turn around to have capacity when their turn next came up to admit patient
- ✓ More Generalists Physicians
- ✓ Fewer Single site specialists primarily in tertiary hospitals
- ✓ Day to day care of the patient was more managed by the registrar and the more junior members of the teams Consultant Input twice weekly.

Patient journey…. With increased med admissions numbers



Insufficient capacity in the admitting med ward and so patient will go to other wards…. Not on take…

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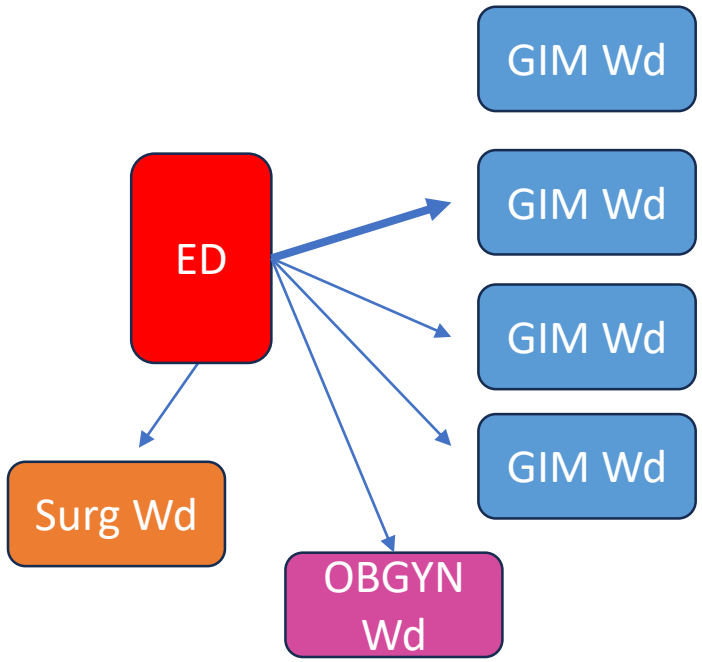
- ✓ More Generalists
- ✓ Consultants visited wards twice weekly and most care provided by junior medical teams

Advent of **the Safari ward round**
Patients on Wards by under the care of ward teams not based there

Patient journey…. With increased med admissions numbers



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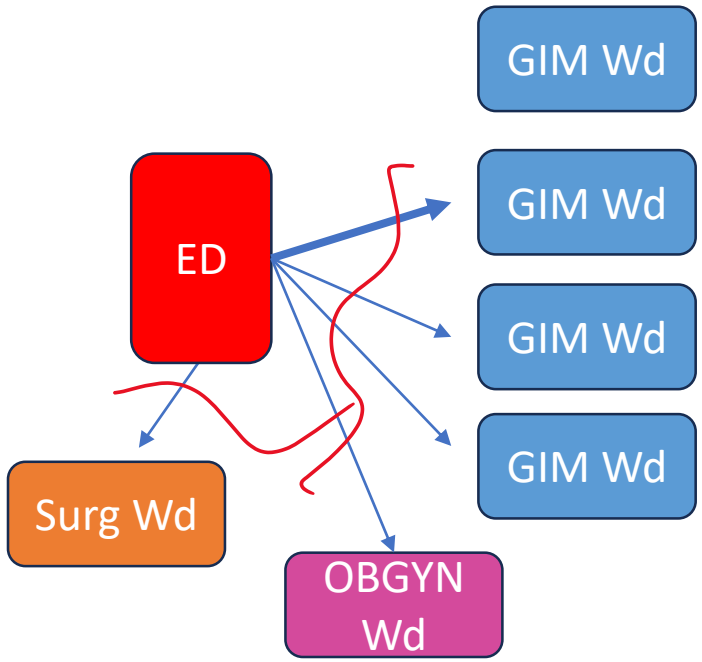
Quality of care falls even further as well as patient experience as medical patients being cared for by Non-Medical nurses

Patient journey…. With increased med admissions numbers



Insufficient capacity in the admitting med ward and so patient will go to other wards…. Not on take… Including Non-Medical Wards

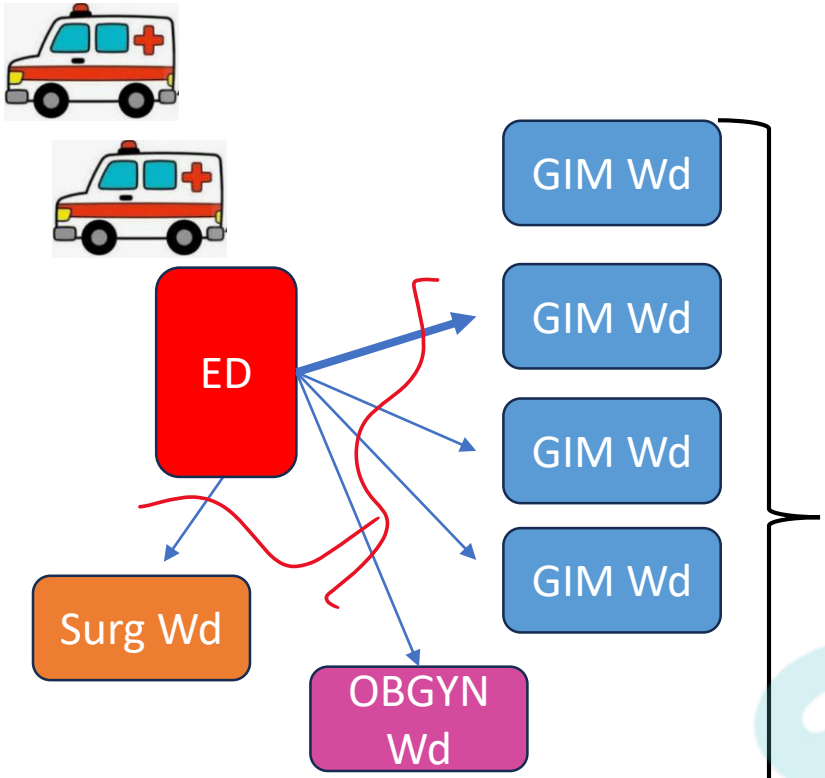
PATIENT NOW QUE IN ED…. AND CORRIDOR CARE BEINGS!!!!

- ✓ Erosion of quality of care that can be provided… as more and more medical patients are being seen in non-medical areas
  - ✓ Corridors
  - ✓ Back of ambulances
  - ✓ Cupboards
- ✓ Long waits, patients leave without being seen
- ✓ Terrible patient experience

Quality of care falls even further as patient being cared for by Non-Medical nurses and also with corridor care in ED…

Recognised that longer the stay in ED the worst the patient outcome.

Patient journey…. With increased med admissions numbers

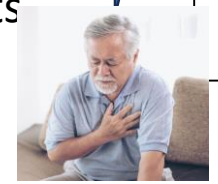


Insufficient capacity in the admitting med ward
Patients overspill into:

- Other med wards
- Non- Med wards
- ED
- And with time now into…Ambulances

PATIENT NOW QUE IN ED…. AND CORRIDOR CARE BEINGS…and ultimately will queue into the ambulances!!!!

Knock on for this is patients sit at home with unknow unassessed risk waiting to be collected…



- ✓ Erosion of quality of care that can be provided… as more and more medical patients are being seen in non-medical areas
  - ✓ Corridors / Back of ambulances / Cupboards
- ✓ EWTD has eroded the Team structure and junior members of the team are rarely on call with their team. This
  - ✓ Undermines continuity of care
  - ✓ Undermines Training
  - ✓ Undermines Accountability

Rising Patient Numbers Undermined Patient Experience & Safety

Rising emergency admissions disrupt NHS

BMJ 1994 ; 309 doi: https://doi.org/10.1136/bmj.309.6965.1322 (Published 19 November 1994)
Cite this as: *BMJ* 1994;309:1322

Editorials

Rising emergency admissions

BMJ 1995 ; 310 doi: https://doi.org/10.1136/bmj.310.6974.207 (Published 28 January 1995)
Cite this as: *BMJ* 1995;310:207

Editorial > BMJ. 1996 Apr 20;312(7037):991-2. doi: 10.1136/bmj.312.7037.991.

The continuing rise in emergency admissions

S Capewell

In 2000…

The Federation of the Royal Colleges of Physicians of the UK - global leaders in physician education

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

A working party the federation of Royal Collages made recommendations for improving the quality of care for patients admitted with medical emergencies

2000 -

The Federation of the Royal Colleges of Physicians of the UK - global leaders in physician education

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

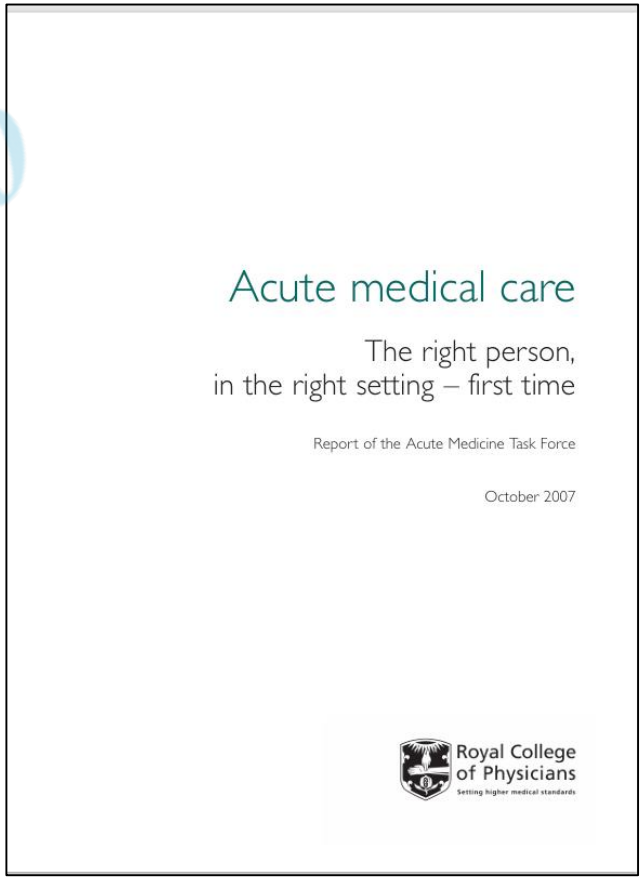
Royal College of Physicians

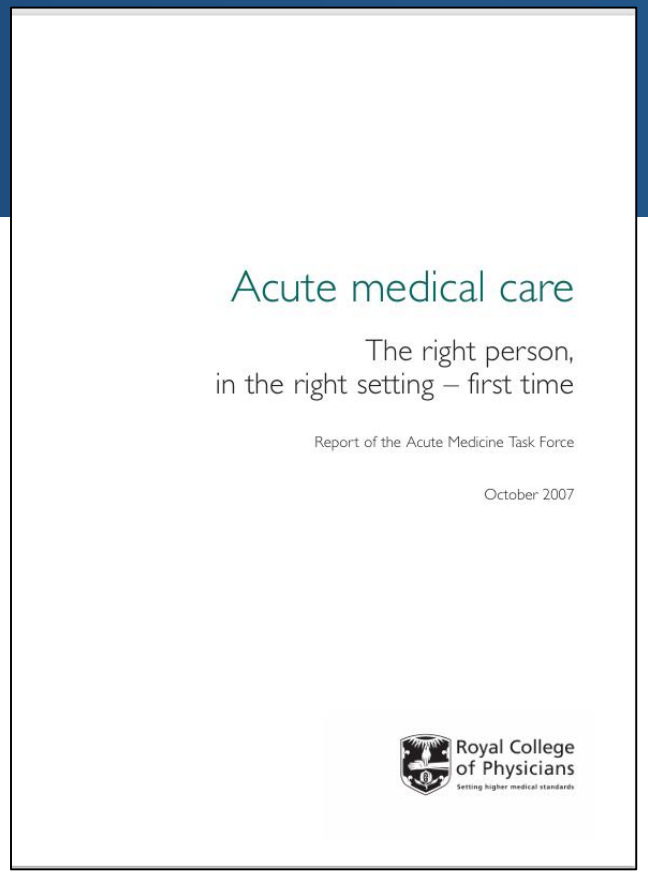
- Its recommendations were addressed to trusts, health boards, health authorities, the government, and the Royal Colleges for their consideration and subsequent action.
- Recognised many **acute patient took quite some time before they were seen by the senior doctors**, and the acute **admission was being** managed by **SHOs and Registrars**
- There were more than 20 recognised subspecialties of internal medicine and a **decrease in the number of physicians taking a broader, holistic approach** to care.
- It concluded that a **CCST in acute general medicine** is a prerequisite for taking responsibility for acute medical patients
- The working party has recommended **that trusts** should recognise the level and complexity of work required to provide adequate care for acute medical admissions and ensure that there are a **sufficient number of consultants**
- It identifies the need for the **Faculty of A&E Medicine and the medical Royal Colleges to determine the training requirements** for those doctors who wish to be involved in ªextended responsibilityº for medical patients.
- **There should be audits of the care of acute medical conditions monitor care**.

Acute Medicine: A New Specialty

- **2000:** Society for Acute Medicine founded (UK)
- **2003:** Recognized as subspecialty of General Internal Medicine
- **2004:** Formal training scheme established
- **2007**: Acute Medical Care Taskforce document
- **2009:** Approved as distinct specialty by General Medical Council

sam
THE SOCIETY FOR ACUTE MEDICINE





Corner stone of Units today…

- Sets out guidance for everything…
- Size and Working rhythm of the units
- Collocations of the unit to key ED and Radiology
- Staffing model
- Educational expectations of the Unit

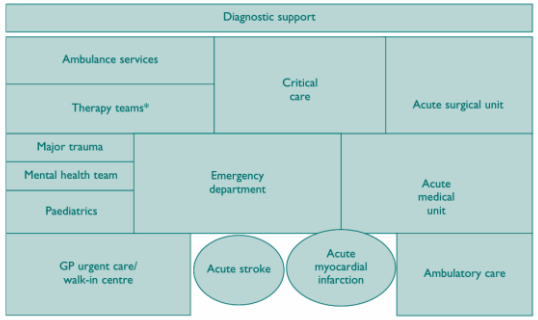


Fig 2 Emergency floor of large acute hospitals. This schematic illustrates some of the components required for an emergency floor in a major acute hospital. It would be scaled and configured to meet local needs. This model fosters closer working and more efficient clinical assessment and treatment by the right person, first time.
*Therapy teams include physiotherapy, occupational therapy, mental health and specialist multidisciplinary teams.

Many many took kits available for use…to plan and develop

Rapid Growth & Expansion

AMUs Become Standard of Care

- **63% increase** in Acute Medicine consultants by 2007
- **92% of UK hospitals** admitting via AMUs by 2007
- **75% of emergency medical patients** admitted directly to AMUs by 2009
- **60%+ of all hospital admissions** now treated by acute medicine teams

International Adoption:

AMU model spread to Ireland, Australia, New Zealand and beyond

Acute Medicine Training Requirements

Dual Accreditation Training Scheme

- **4 yrs AIM accreditation**
- **5 yrs GIM accreditation as well**

- **Sign off includes all practical skills needed to manage the acute medical take**
  - **Includes POINT OF CARE ECHO**

- **Speciality skill**
  - **Clinical Sub Interest – Stroke/ITU/ OBGYN/Acute Oncology/Dermatology/Infectious Disease & Tropical Med/Neurology/Palliative care/Peri-Operative Med/Psychiatry/Syncope/Toxicology/Out Pt Antibiotic Treatment**
  - **Procedure driven – Echocardiography**
  - **Educational Training – MSc Med Ed (Including Simulation)**
  - **Medical Management & Leadership Training**
  - **Patient Safety/ Care Quality Review Methodology**
  - **Research**

- **Skills and Knowledge Based Assessment Speciality Certificate Examination (SCE)**

AMU – Acute Medicine Unit (also called MAU)

PAUSE FOR A MINUTE TO CONSIDER THE AMU….

This was the first visible change in the many to come with the advent of acute internal medicine

AMU – Acute Medicine Unit (also called MAU)

- ‘Clinical area within a hospital that acts as the focus for acute medical care for patients who have presented as medical emergencies to hospital’
- Holding area before moving to the appropriate next ward
- As standardised admitting hub – fosters best practice and standardise care
- LOS Less than or equal to 24hrs

Clinical outcomes

- Reduced 30-day mortality
- Earlier senior decision-making
- Coordinated investigations
- Reduced medical errors
- Improved patient safety

System Efficiency

- Faster time to treatment
- Appropriate bed allocation
- Earlier discharge planning
- Reduced ED overcrowding
- Better resource utilization

Acute care toolkit 4

Delivering a 12-hour, 7-day consultant presence on the acute medical unit

October 2012

Recent reports have highlighted the value of consultant-delivered care in improving outcomes for patients. The Academy of Medical Royal Colleges document *The benefits of consultant-delivered care*[1] emphasises the importance of consultant intervention in the acute setting, where rapid diagnosis, with appropriate investigations and clinical response to the patient's condition, is paramount.[2]

The rapid expansion of the specialty of acute internal medicine (AIM), along with the development of over 225 acute medical units (AMUs) across the UK, has increased the provision of consultant-delivered care for acutely unwell medical patients admitted to hospital. Furthermore, the presence of an acute medicine consultant on the AMU has been shown to be associated with improved outcomes.[3] However, there remain concerns regarding the consultant provision outside of normal working hours.[4]

The Royal College of Physicians (RCP) and Society for Acute Medicine (SAM) recommend that a consultant presence should be maintained on the AMU for a minimum of 12 hours per day, seven days per week.[5,6] This toolkit has been produced by the RCP and SAM to provide guidance and describe working practices to help achieve this.

What is an acute physician?

Most consultants working on AMUs fall into one of three categories:

- physicians who have trained specifically in AIM, with or without dual accreditation in general internal medicine (GIM)
- physicians who have undertaken training in GIM, with or without a specialty other than AIM, whose *predominant* direct clinical care (DCC) commitment is on the AMU
- physicians who have trained in GIM and a medical specialty other than AIM, whose *predominant* DCC is in the specialty, but who provide some non-specialty DCC on the AMU.

For the purposes of this toolkit, consultants in the first two categories will be referred to as 'acute physicians', while the third group will be termed 'specialty/general physicians'. The term 'AMU consultant' will be used to describe a consultant in any of the above categories, working on the AMU.

A recent study ... identified an association between consultant working patterns involving greater continuity of care, and improved patient outcomes.[11]

CLEAR GUIDANCE AND STANDARDS SET IN THE AMUs ….

NHS England

Principles for Acute Patient Care

Overarching principle: Patients should have equitable access to professionals with the skills required for their individual care, independent of the location of their bed or the nominal admitting specialty.

GIRFT GETTING IT RIGHT FIRST TIME

*Definitions for tiers of clinicians are outlined on slide 4.

CLEAR GUIDANCE AND STANDARDS SET IN THE AMUs ….

NHS England

Principles for Acute Patient Care

Overarching principle: Patients should have equitable access to professionals with the skills required for their individual care, independent of the location of their bed or the nominal admitting specialty.

1. Urgent cross sectional (CT/MRI) imaging requests should be reported within 4 hours of request.

2. Core laboratory services should be available 24/7, and turnaround times should be monitored regularly and reported monthly.

6. When it is agreed that a patient should transfer from the assessment unit to a non-medical ward, e.g. from medicine to general surgery, the receiving specialty team becomes responsible for the patient's care.

7. Patients transferring out of critical care units (CCU, ICU, HDU, ECU) should be prioritised for inpatient bed allocation, above other requests for available beds.

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2. Core laboratory services should be available 24/7, and turnaround times should be monitored regularly and reported monthly.
3. All patients arriving on or being transferred to an assessment unit (e.g. AMU, SDEC, SAU etc) should have NEWS2 calculated. The NEWS2 should be used in conjunction with the presenting condition to prioritise care.
4. All patients should have a full assessment undertaken by a competent clinical decision maker*, ideally within one hour and within a maximum of four hours of the decision to admit or of arrival on the assessment unit (whichever is earlier).
5. All patients should be reviewed by an expert clinical decision maker within six hours of the decision to admit or of arrival on the assessment unit (whichever is earlier) from 08:00-20:00h or within 14 hours outside of these times.
6. When it is agreed that a patient should transfer from the assessment unit to a non-medical ward, e.g. from medicine to general surgery, the receiving specialty team becomes responsible for the patient's care.
7. Patients transferring out of critical care units (CCU, ICU, HDU, ECU) should be prioritised for inpatient bed allocation, above other requests for available beds.
8. Where specialties provide an admissions unit, an expert/senior decision maker should receive referrals and provide advice to the community and hospitals every day to prevent unnecessary hospital attendance/admission and to facilitate hospital discharge.
9. Twice-daily consultant ward rounds is the optimal model and should be delivered in higher acuity areas, e.g. ICU, AMU, SSW, SAU, CCU, and other medical wards if possible.
10. Patients aged over 65 presenting to hospital as an emergency should be assessed on arrival using the Clinical Frailty Scale (CFS) and 4AT tool for delirium.

GIRFT GETTING IT RIGHT FIRST TIME

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WHAT IS CONTEMPORARY ACUTE MEDICINE???

WHAT IS CONTEMPORARY ACUTE MEDICINE….

- Admission avoidance
- Triage of patients, “right patient, right place, first time”
- Aim for best practice in the patient’s first 24-72hrs of admission
- Hub for Quality Improvement, Education & Learning

WHAT IS CONTEMPORARY ACUTE MEDICINE….

Admission avoidance

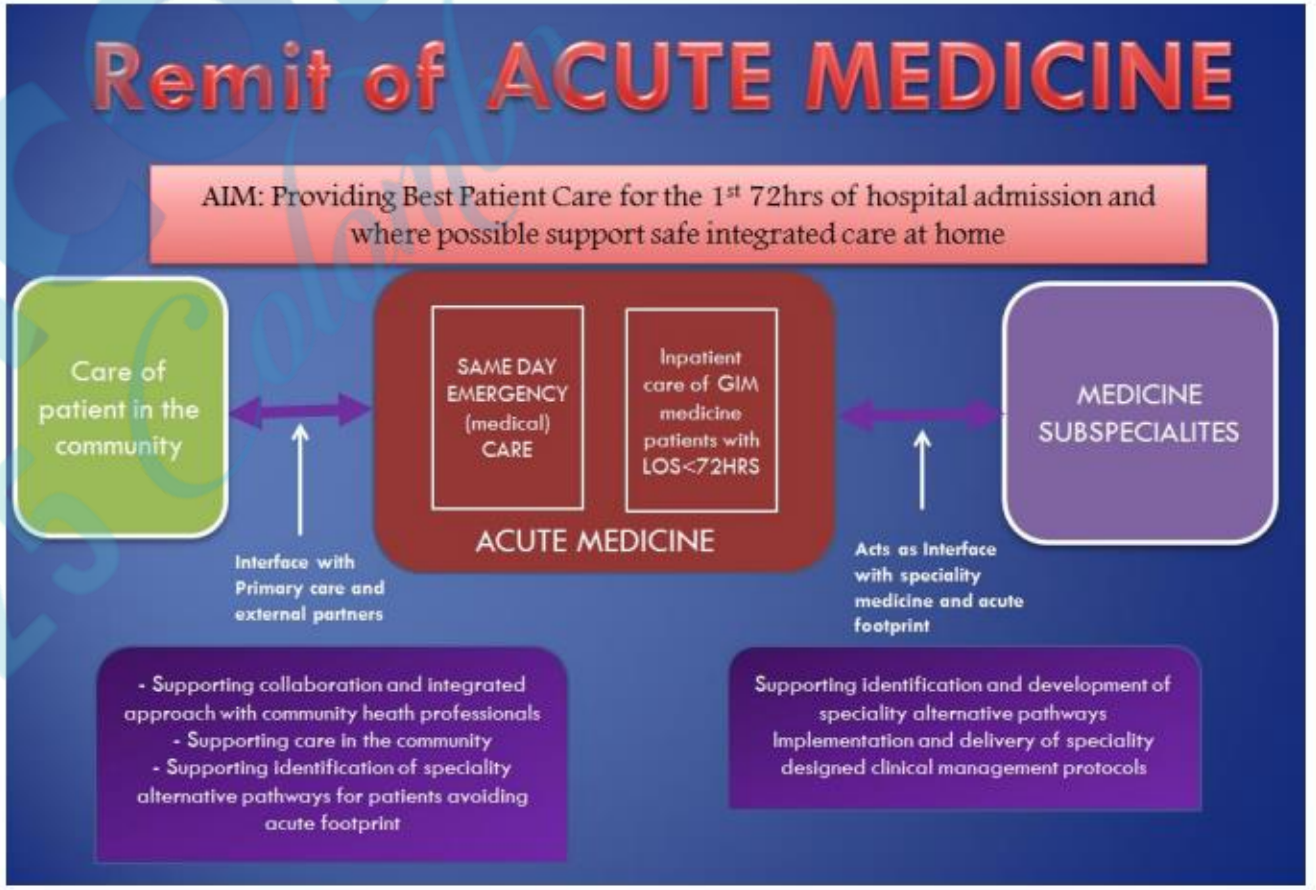
GATE KEEPERS FOR ADMISSION TO HOSPTIAL

HOSPITALS NOT SAFE EVIROMENTS

- Unfamiliar and more prone to injury
- Hospital acquired functional decline
- Risk of Infection

WHERE POSSIBLE TREAT AT HOME - ACUTE MEDICINE KEY INTERFACES WITH COMMUNITY STAKEHOLDERS / ED & INPATIENT SPECIALITES

A decision for discharge must be based on clinical need and not based on getting a bed!



WHAT IS CONTEMPORARY ACUTE MEDICINE….

Admission avoidance

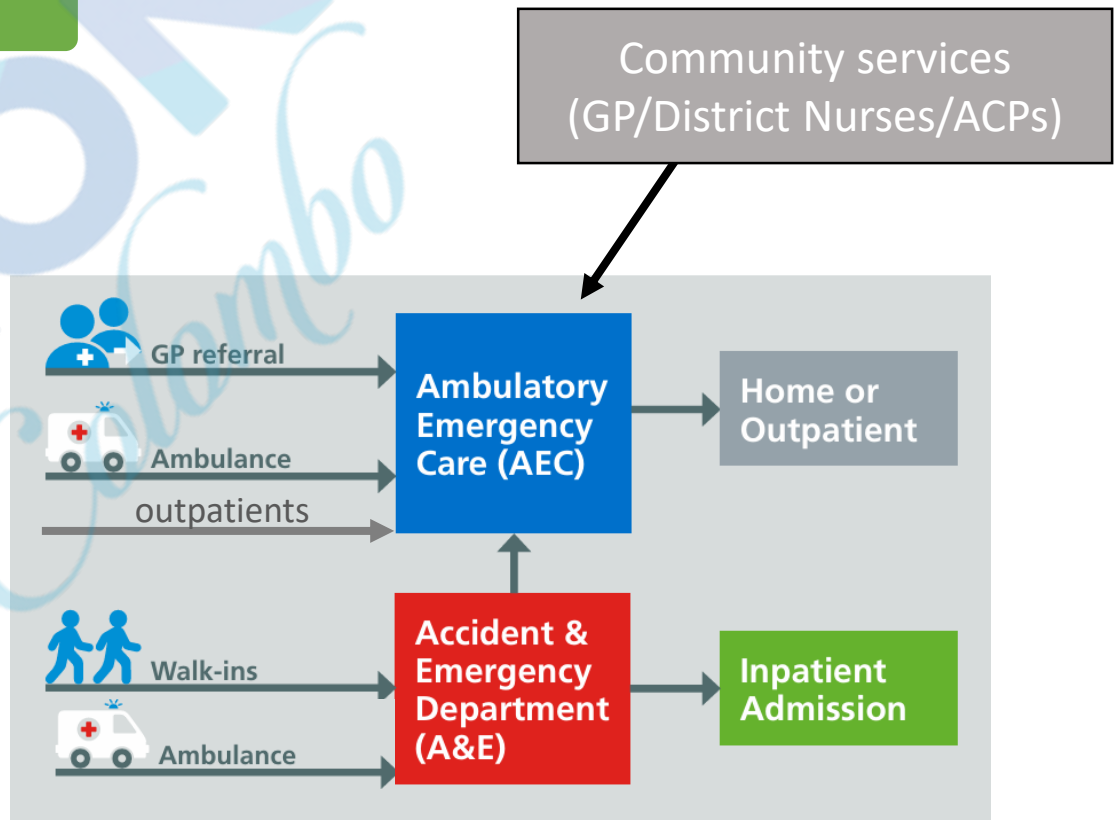
Same Day Emergency Care (SDEC)

Also called Ambulatory Care
Patients who would previously be admitted
Now managed in their own homes
Zero Length of stay (LOS)

It is expected that 30 to 40% of the acute medical
Take is amenable to ambulatory care

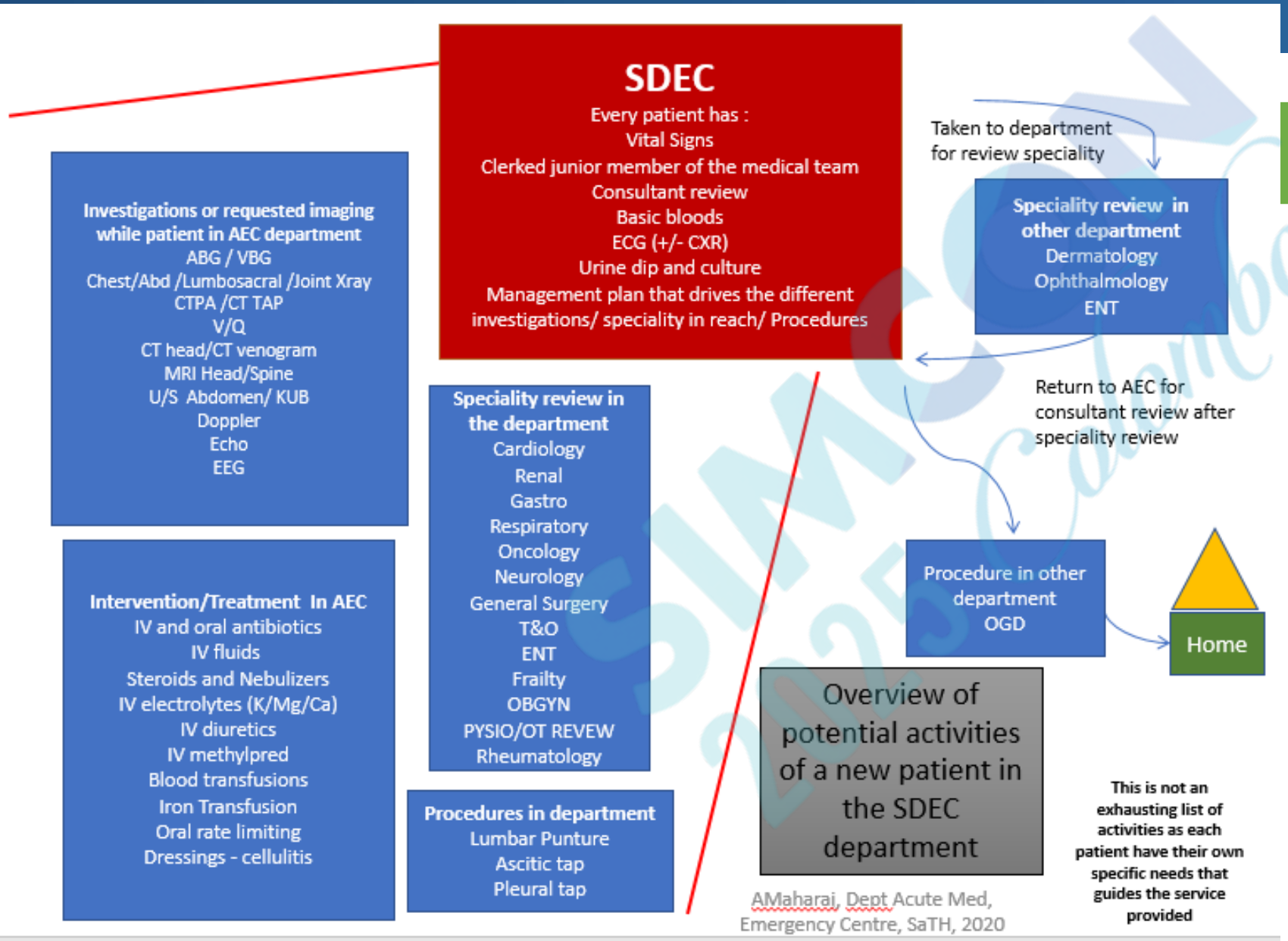
Senior Decision maker must always be available to support discharge mindset

All decisions in the best interest of the patient and NOT influenced by flow



AMBULATORY CARE NETWORK…. (resource)

SDEC continued.....



Admission avoidance

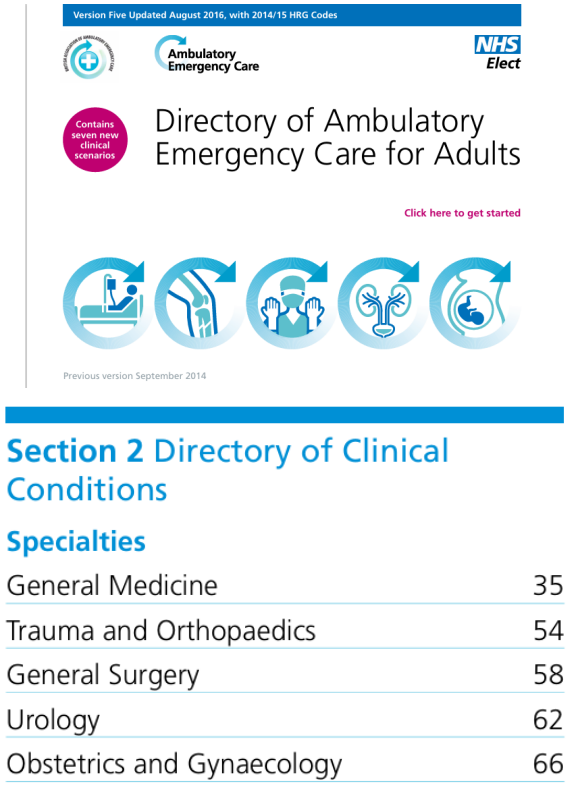
Can be a very complex space as it is managing patients who were previously inpatients

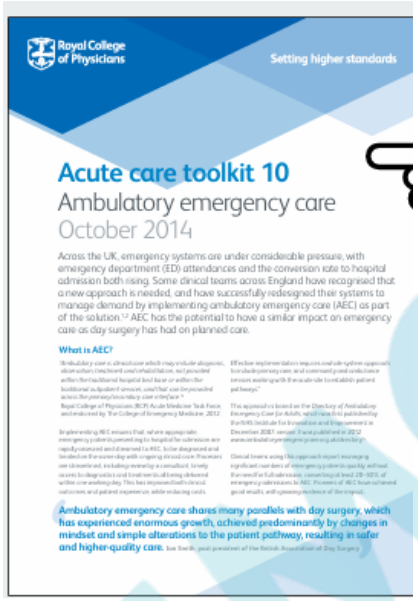
Manage the expectations of your non-clinical planners

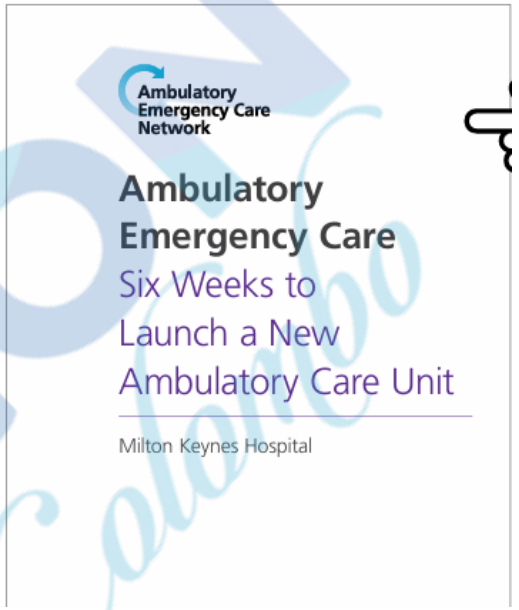
- This is not routine outpatients
- Patient previously admitted being managed with new measured risk as outpatients

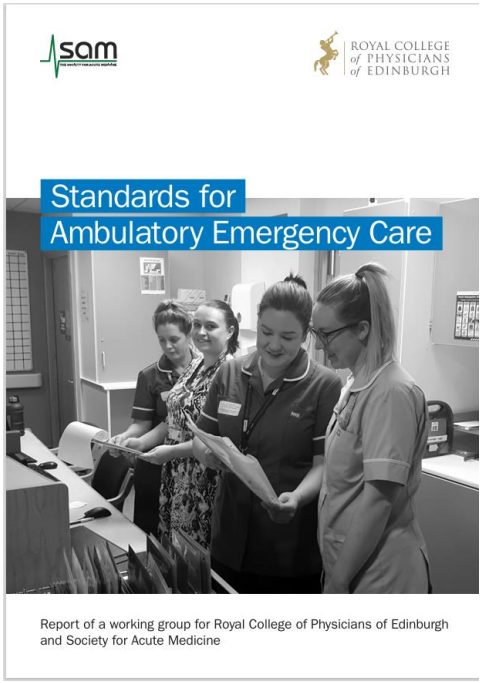
- You can start off simple with just single pathways… that are amenable to being managed in chairs…e.g. PE

SAME DAY EMERGENCY CARE (AMBULATORY EMERGENCY CARE)









It is about championing a shift in Mind set…

"ALL medical patient referred for admission is considered potentially ambulatory unless proven otherwise"

SAME DAY EMERGENCY CARE (AMBULATORY EMERGENCY CARE)

Principles of AEC

The overarching principle of AEC is that all emergency patients should be considered ambulatory until proven otherwise. Principles listed in the RCP toolkit (2014) are:

1. Senior clinical input is needed at the point of referral to redirect suitable patients to ambulatory care
2. Clear exclusion criteria based on the NHS early warning score (NEWS) should be developed to maximise patient flow to ambulatory care
3. Where possible the ambulatory emergency care service should be closely located to A&E
4. Staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the same day
5. The time standards in AEC should match the Clinical Quality Indicators for A&E i.e. time to initial assessment: 15 minutes, time to medical assessment; 60 minutes and completion within 4 hours
6. Patients should be informed early in their journey (ideally in A&E or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight to manage their expectations and those of their family

Time does not permit me to do a detailed discussion around SDEC but key is:

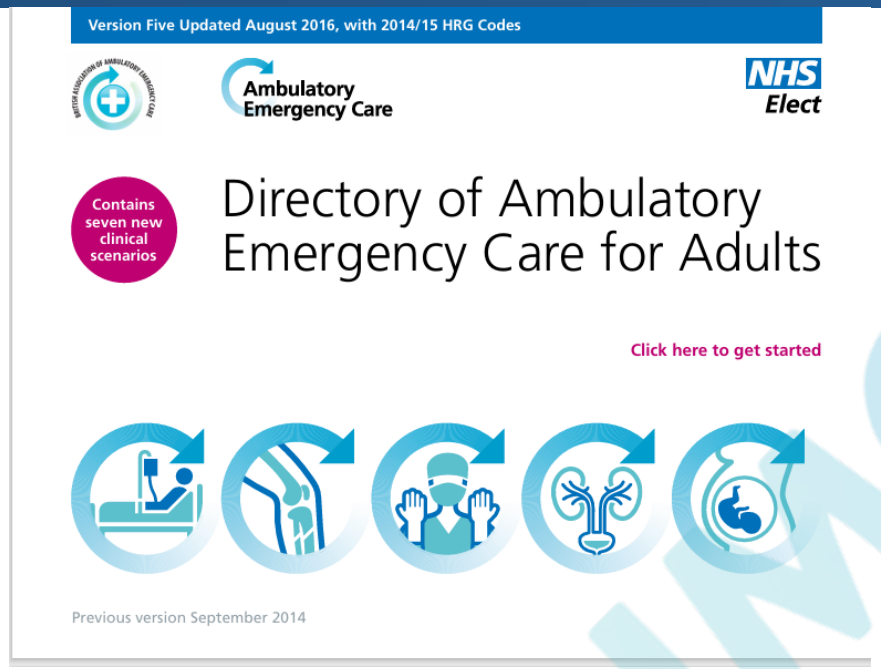
- Planning governance structure

-Tracking discharges and monitoring discharge percentages…

- Expect 10-15% admissions – less than this is a risk averse, more than that you are pulling the wrong patients… (too sick)

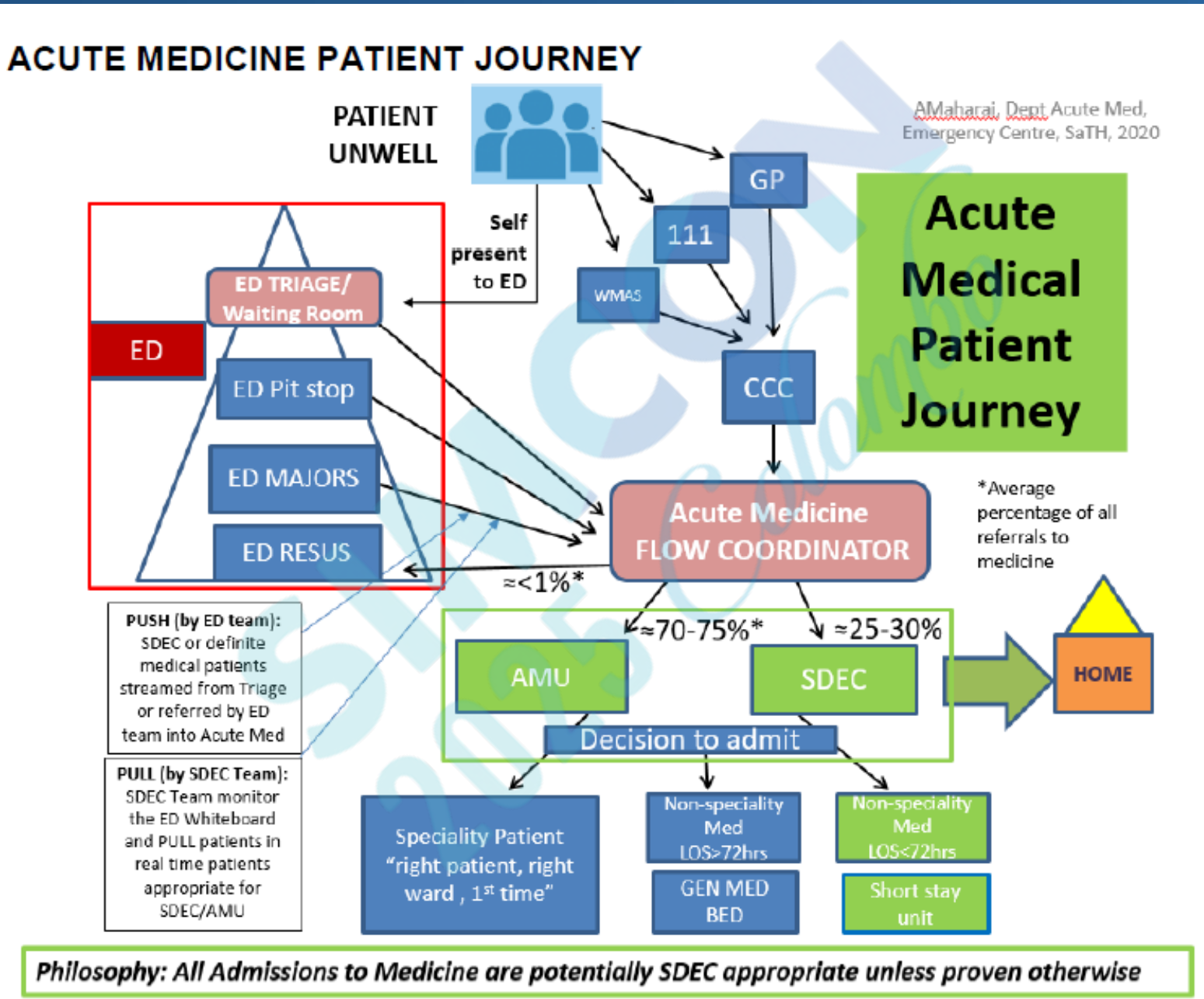
Diagram 1

	Suitable for AEC	Unsuitable for AEC
Seen in AEC	Success (expect about 10% conversion rate)	**Risk** (patient too sick/complex at time of selection)
		Waste (patient could be managed in other outpatient service)
Not seen in AEC	Missed opportunity	**Success** (appropriate inpatient care)

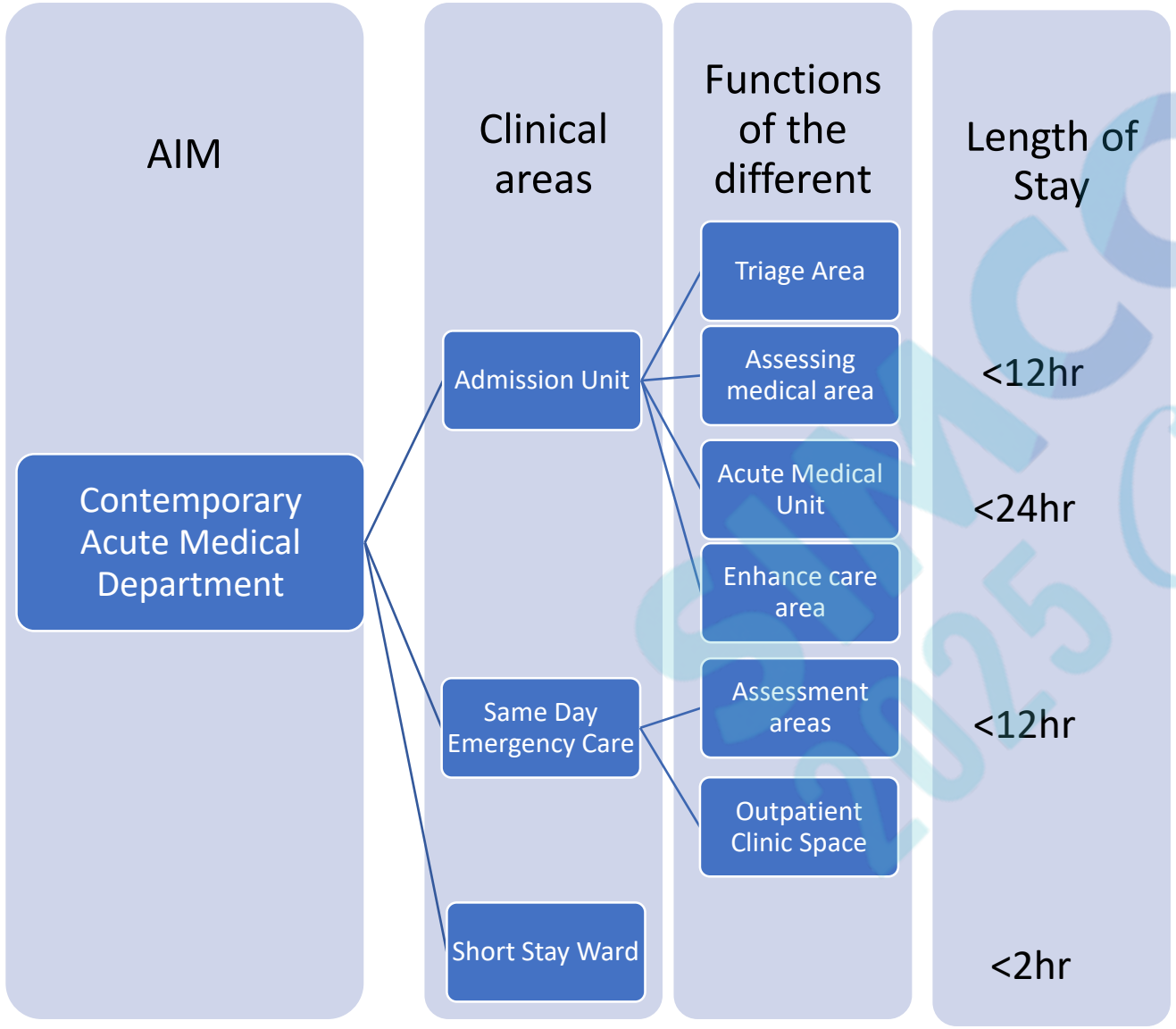


Medicine presentations that should be considered for SDEC ….

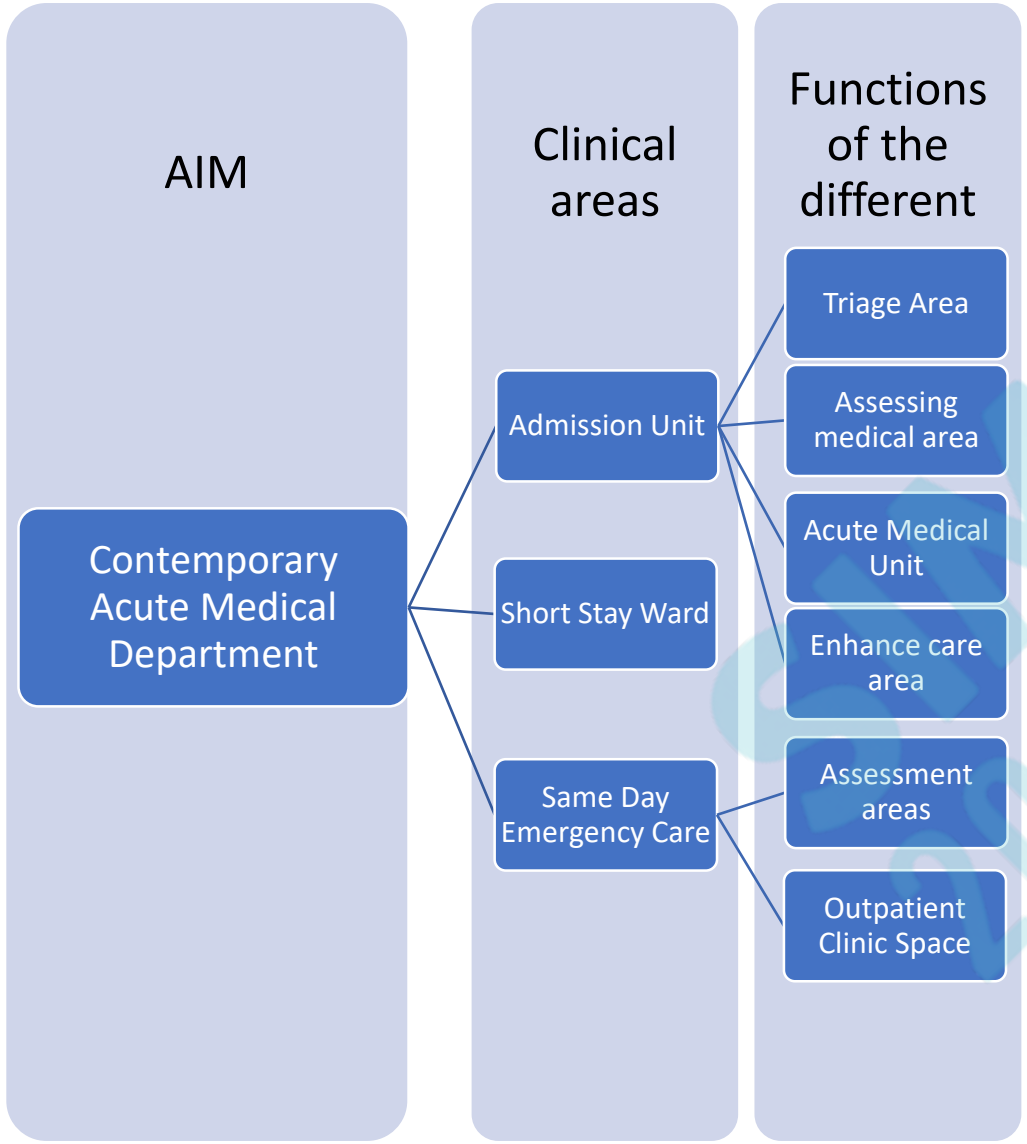
THE ACUTE MEDICAL PATHWAY….



THE ACUTE MEDICAL Department.....



THE ACUTE MEDICAL Department.....



All areas my have priority access to investigations and have the full MDT support (OT/physio/ pharmacist etc)

There must be clear operating policies to ensure safe care of patients in this rapid turn over area

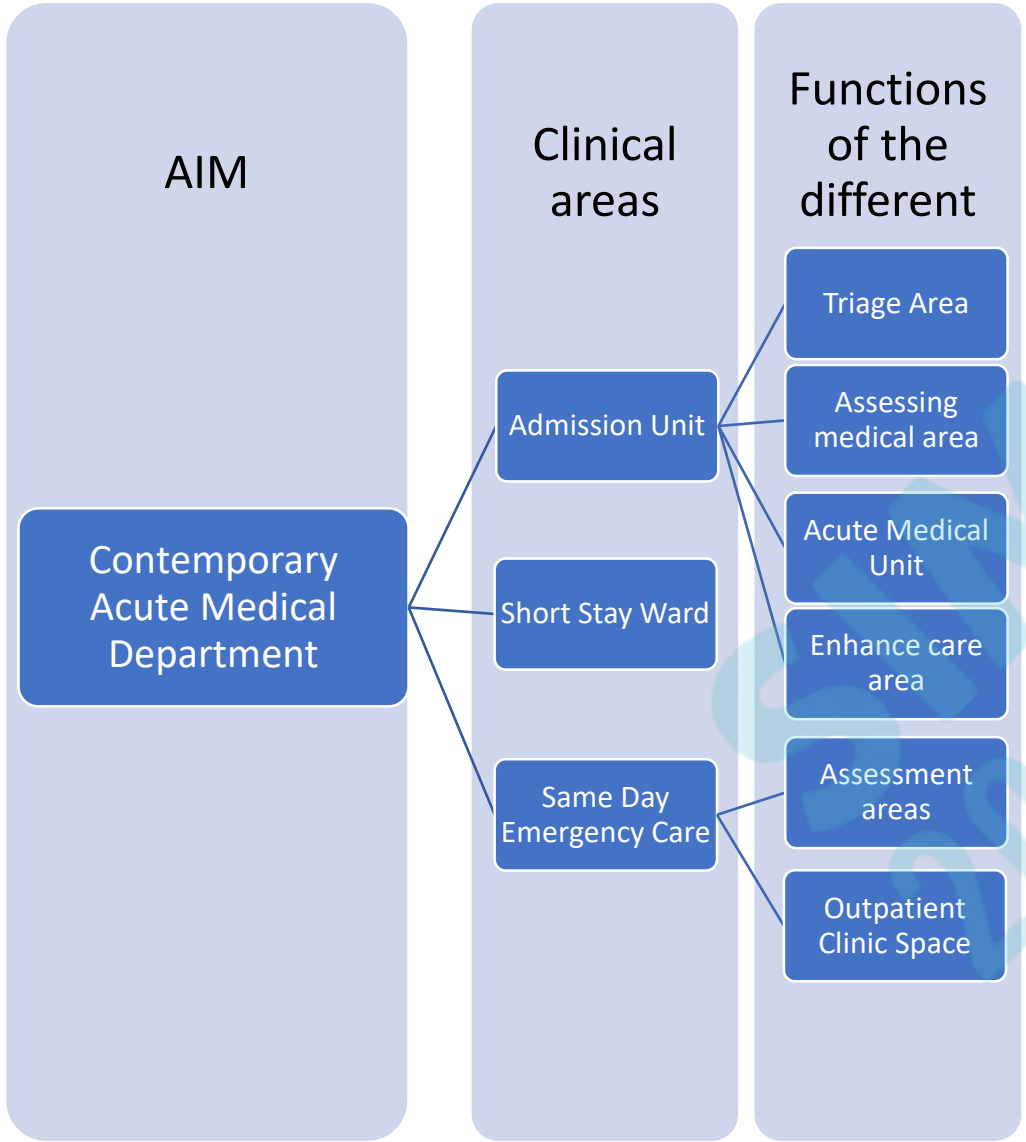
Twice daily review of patients to ensure they are improving and not remaining in hospital unnecessarily

Every attempt must be made to move the right patient to the right area 1st time. This is to facilitate best patient outcomes and shortest length of stay

There must be robust governance mechanisms to learn from mistakes

The importance of the training for all grades of staff is key to ensure continued resilience in the quality of care provided to the patients

THE ACUTE MEDICAL Department.....



Must be staffed with Trained doctors and paramedical staff to foster a safe and rapid turn around environment.

There must be active monitoring of key quality of care indicators

- time from arrival to time of triage
- time of arrival to time of 1st being clerked
- time of arrival to time of consultant review
- Patient experience

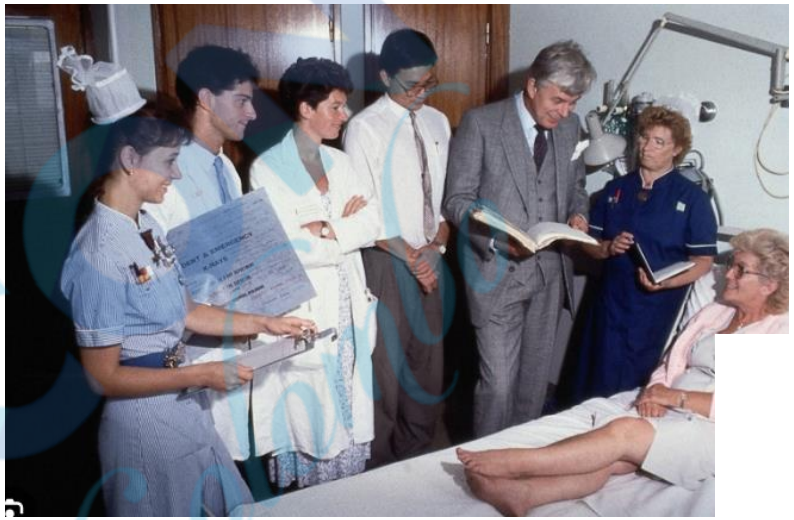
Hub for Quality Improvement, Education & Learning

Acute Medical Admission Units…

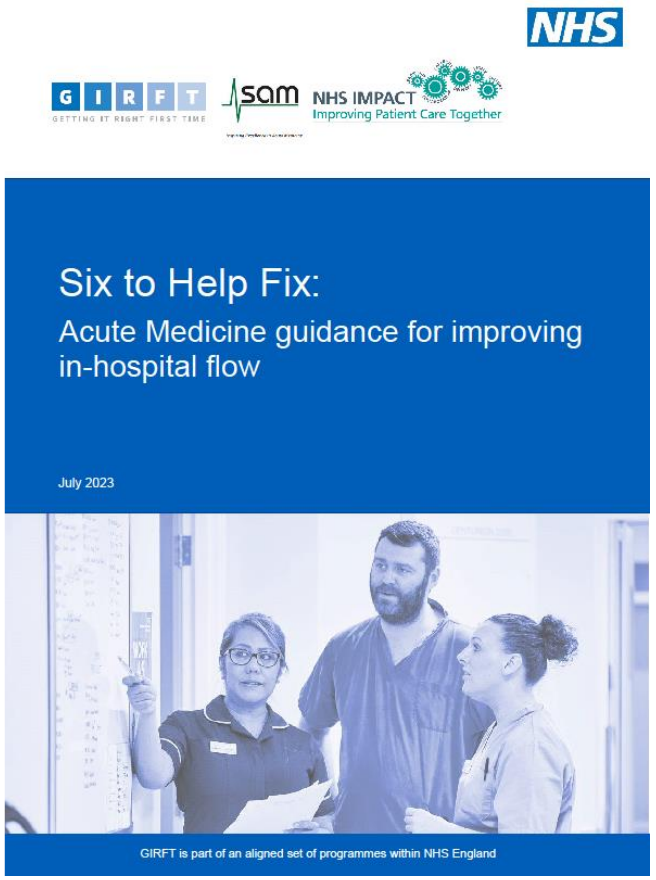
Rich environment for learning…

Cross section of patients from all medical specialties coalesce on this portal of entry and should be a focal point for teaching and modelling best practice.

Standardise approach to enable embedding of best practice habits in the teams that rota though the area



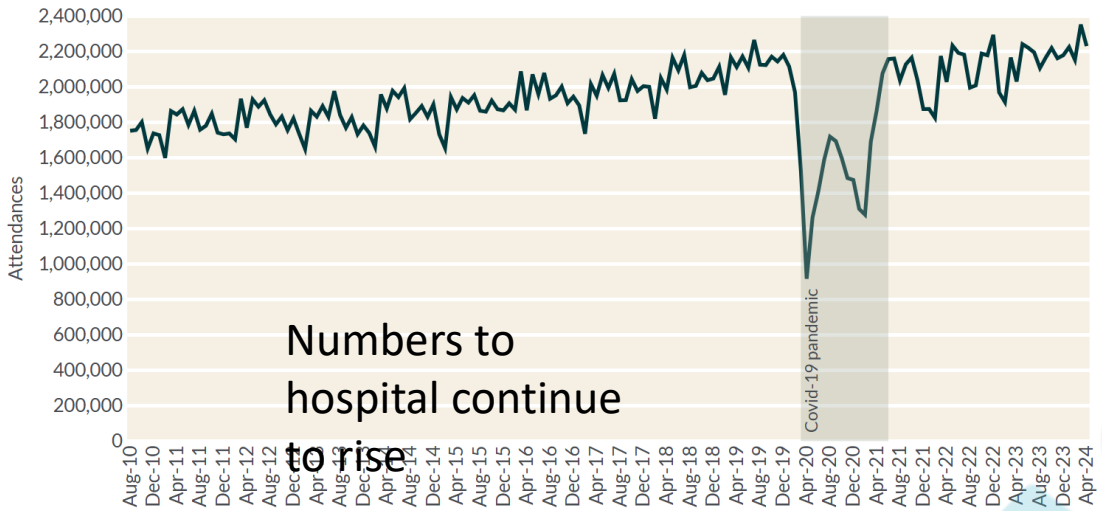
Supportive Publications & Online Information Developing Service



Where is the UK now??....

Figure 2 A&E attendances have surpassed pre-pandemic levels

A&E attendances, all types, England



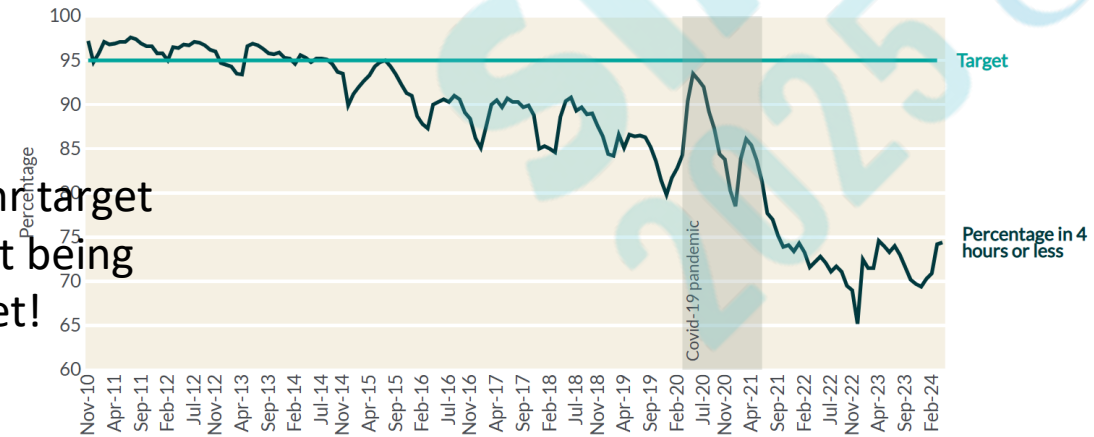
Numbers to hospital continue to rise

Source: NHS England

The King's Fund

g over the past decade

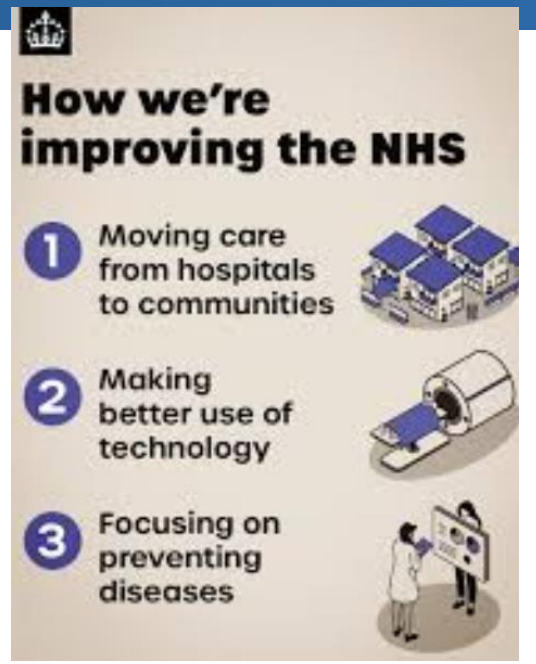
Percentage of attendances admitted, discharged or transferred within four hours, all types of A&E, monthly, England



4 hr target not being met!

Source: NHS England

The King's Fund



NHS 10 Year Plan – released 2025

Original research

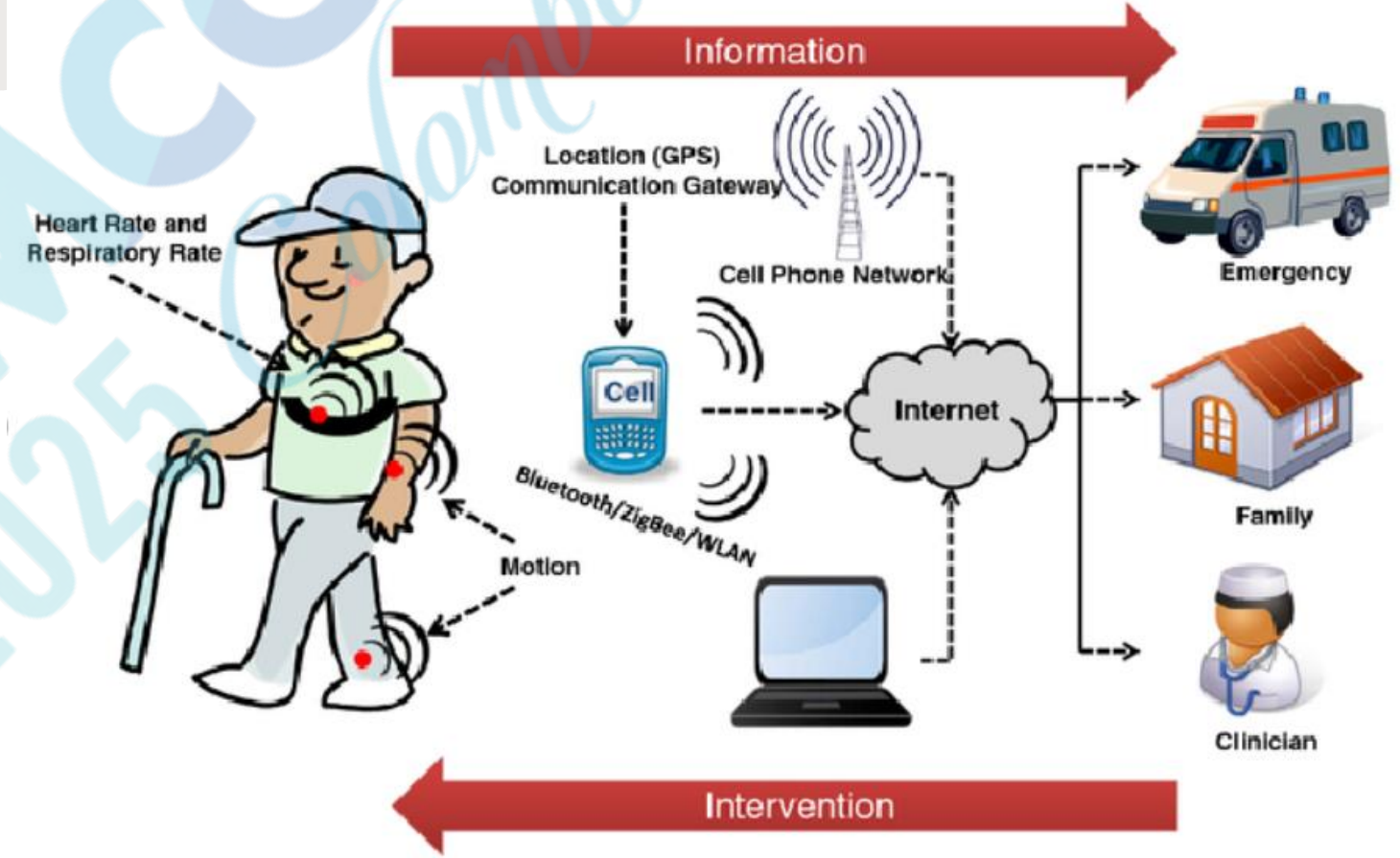
Association between delays to patient admission from the emergency department and all-cause 30-day mortality

Simon Jones [1, 2], Chris Moulton [3, 4], Simon Swift [2, 5], Paul Molyneux [2], Steve Black [6], Neil Mason [2], Richard Oakley [2], Clifford Mann [3, 7]

Correspondence to Dr Chris Moulton, Emergency Department, Royal Bolton Hospital, Bolton, UK; Chris.Moulton@boltonft.nhs.uk

The future is NOW!

- AI technology being used to support provision of patient care and learning
- Remote monitoring allows development of hospital at homes
- AI generated algorithms that can monitor deteriorating patients with trends in their vital signs in and outside of hospital…**allowing acutely ill patients being monitored in the community for longer prior to admission to hospital and also early supported discharges.**



Challenges in Sri Lankan Current system

- Challenges of ongoing Austerity
- Immature community structure
- Disproportional utilizations of current capacity across the island
- High cardiovascular burden and chronic disease burden
- Lack of IT infrastructure to support monitoring and caring for expanding patient burden

Sri Lankan Good practice (non-exhaustive list!!!)

- No Safari Ward rounds
- Maintenance of the Team structure (better for training and accountability)
- Current 'terms of reference' is ED & Assessment areas LOS of 4-6hrs
- Consultant Presence all day, not just in the mornings
- Prompt Assessment of the patients on arrival to the wards
- Ongoing established Extended family networks
- Good patient choice with ability to go to where they wish to
- Existing knowledgeable GPs in the community (though standalone practitioners)
- Highly skilled and motivated workforce

Food for thought…

- **Look for ways of piggybacking on existing systems to bring about IMPROVEMENTS**
  - - Does not need to be a big new unit, it is about a different patient pathway
    - acute medicines about mindset and patient pathway

- **Find shared collection collective views and visions and work towards a common goal**

- **We all sometimes need to get out of our way sometimes (mindset)**….
  - - Look for the “Yes we can!”….”Rather than No we can't!”
  - - E.g. Start small, low risk patients, limited pathways… and with time build experience and confidence with your discharge mind set…

Food for thought…

- **Learn to the JOURNEYs of other countries…** “There's no need to reinvent the wheel!
  - EG: Try not to lose the firm structure and all benefits it brings

- **Be proud and excited at your ability to embrace the future now** and make the world a better place for your patients

- Based on what I've seen so far you have the resources, knowledge and skills to start shifts in acute pathways and practice …
- the current work of the Sri Lankan College of Internal Medicine – One Nation, One Standard Achieving Excellence in Healthcare…acute internal medicine gives you many avenues to consider

- Always remember **DATA IS YOUR FRIEND!**

Final thoughts….

Patients are like babies in baskets, and it is our responsibility when we carry them from person to person….we do so with similar care and attention.

In planning for their care… you must also plan for the ones carrying the baby…

Ensure in planning changes for the patients that adequate thought is put in for all members of the MDT… looking after the wellbeing for all so they can be solid resilient foundations of care.

THANK YOU….

Special THANK YOU.....

A special thank you to the colleagues who took time out of their busy schedules to show me around

Dr Krishantha Jayasekera
Dr Ganaka Senaratne
Dr Arosha Abeywickrama
Dr Harsha Sathsihchandra
Dr Hiruni Fernando