Advanced Clinical Practitioner Led Ambulatory Emergency Care – does this improve flow in Emergency Surgery?

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Introduction

Increasing pressure on emergency services requires efficient, rapid assessment and management of patients. Consultant delivered front door care in general surgery has reported advantages of enabling key decisions to be made early, reducing emergency admissions, easing pressure on acute beds and allowing more efficient use of trust resources[1]. However, 'acute care surgeons' are a rarity therefore we explored if utilising an existing Ambulatory Emergency Care Unit (AEC), run by Surgical Advanced Clinical Practitioners (ACP) could improve the flow of surgical patients from the Emergency Department (ED) therefore supporting a same day emergency care model, working towards the ambitions of the NHS long term plan[2].

PLAN Methods

Previous retrospective audit looking at patient's with a 0-1 day length of stay (LOS) identified that 58% of these admissions were potentially avoidable with the opinion that a surgical assessment unit could have prevented up to half of these admissions. Furthermore, 25% of the admissions could potentially have been avoided if earlier senior review had occurred (<4 hours from attending).

A Plan, Do, Study Act (PDSA) change management model was chosen to test whether a Surgical ACP led AEC could improve the flow of emergency surgical patients and reduce our 0-1 day LOS.

The PDSA was planned and undertaken over a 2 week period utilising the trust's current medical AEC unit. We operated with the same admission criteria to stream patients from ED to AEC for assessment with a focus on admission avoidance and same day turnaround.

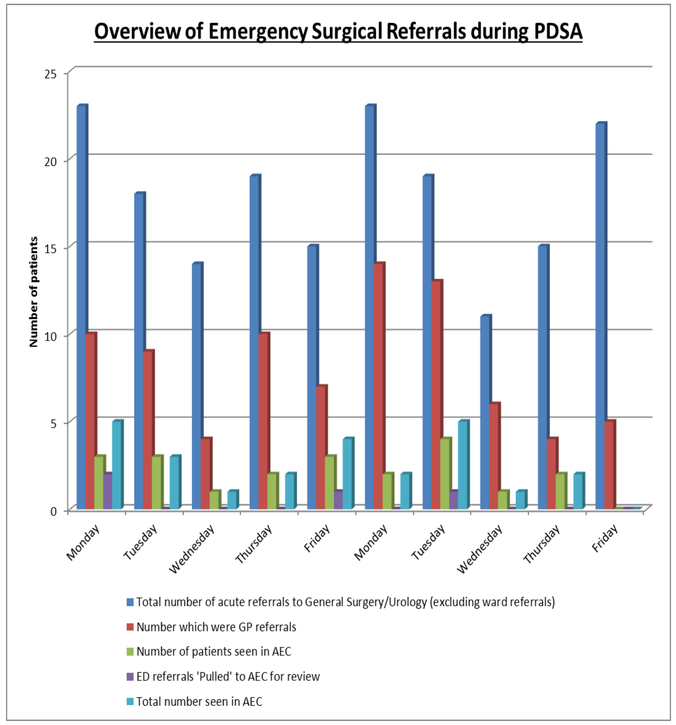
AEC Criteria

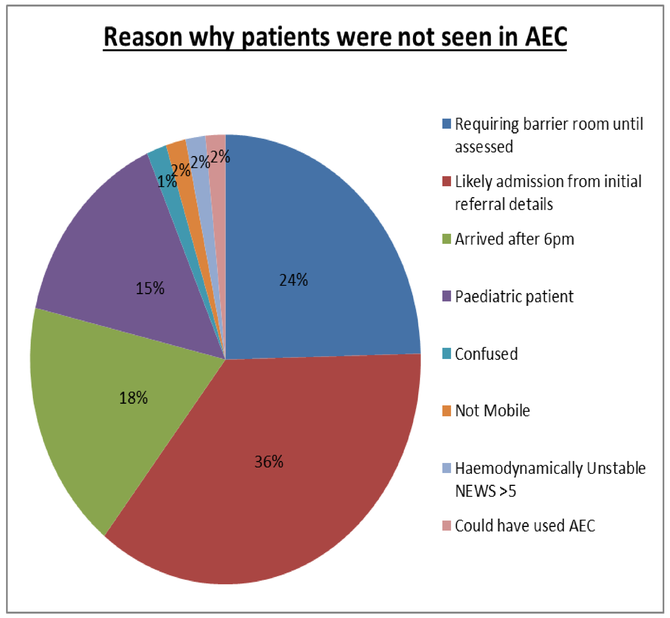
- Independently mobile
- Able to sit in a chair/not confused
- Haemodynamically stable
- Not requiring barrier nursing
- Likely to be able to discharge on the same day / not requiring admission

Surgical GP referrals arriving between 10am and 6pm meeting the AEC criteria were streamed to AEC for assessment.

Data was collected on outcomes including admission rates, length of stay and time to senior review. We also collected data on the number of referrals not seen in AEC.

DO Results





STUDY Findings

82 GP referrals were received during the PDSA timeframe of which 25% (n=21) were seen in AEC with only 5% (n=1) being admitted.

91% (n=19) had a senior review within 4 hours of attending AEC.

It was highlighted by the on-call team that it was challenging to make a decision about the 'potential to be able to avoid admission' and therefore AEC suitability from a GP phone referral.

The lack of side room availability also excluded any patient with a history of vomiting or diarrhoea due to the potential to require barrier nursing.

The lack of ambulatory radiology slots was also highlighted as a limiting factor to reduce admissions during this PDSA.

Due to the low numbers seen on AEC over the two week period no significant reduction in length of stay was identified, however the PDSA was received positively by all staff and within the confines of limited NHS resources, ACP led AEC is still a viable option. This model has the potential to reduce admissions and facilitate quick assessment towards early same-day discharge.

ACT Next Steps

Repeated use of small PDSA cycles to facilitate change has been shown to result in the best likelihood of sustained improvements.

A further PDSA is currently being planned with a less restrictive admission criteria, in a unit dedicated to emergency surgical admissions with side room availability, to evaluate the impact this has on ED flow.

Engagement with key stakeholders including Radiology has started as part of the next planning phase.

References

1. Navarro, AP., Hardy ,EJO., Oakley ,B., Mohamed, E., Welch, NT., Parsons, SL. The front-line general surgery consultant as a new model of emergency care. (2017) Annals Royal College Surgery England 99:550-554
2. NHS. The NHS long term plan (2019) https://www.longtermplan.nhs.uk/ (accessed 28/10/2019)