Ambulatory Care Centre Standard Operating Policy	**Type:** Policy **Register No:** **Status:**

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Consulted With	**Post/Committee/Group**	**Date**
Ambulatory Care Consultant team		
Ambulatory Care Nursing team		
Acute Medicine Matron		
Acute Medicine GM		
Acute Medicine SM		
Professionally Approved By		

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Related Trust Policies (to be read in conjunction with)	

Document Review History

Version Number - (for updated documents – also list the changed paragraph numbers)	**Authored/Reviewed by**	**Active Date**

1.0 Context

1.1 The role of the Ambulatory Care Centre (ACC) is to provide rapid assessment, investigation and management of the medically unwell patient so an admission may be avoided. With this in mind, the ACC at the Luton and Dunstable Hospital has been created to manage patients appropriately, safely and efficiently using evidence-based medicine in a community setting.

1.2 ACC has been developed to work with all medical specialties. Its main aim is to improve the patient's experience and choice while obtaining the best practice tariff for each patient episode. It should not duplicate readily available services that GPs, ED or specialists can refer to directly.

1.3 A benefit of this care is that it facilitates expedited discharge in a safe manner and prevents admission for relevant conditions, providing a zero length of stay.

1.4 "*In the context of acute medicine, Ambulatory Care is the care of a condition that is perceived either by the patient or by the referring practitioner as urgent and requiring prompt clinical assessment by a competent clinical decision maker. This type of care includes diagnosis, observations, treatment and rehabilitation, not provided within the traditional hospital bed or outpatient service."*

(NHS Institute of Innovation and Improvement, 2006.

1.5 ACC remains a process-driven service, accommodating and assisting the flow of front door work. Support from Specialist services (hot clinics, urgent specialist reviews, pathways etc.) is key to ensuring patients can be safely discharged and managed as outpatients or in primary care.

2.0 Opening Times

2.1 The Ambulatory Care Centre is open as below:

- Weekdays 8.30am-9pm
- Weekends and Bank Holidays 9am-5pm

2.2 A patient remaining after the unit closes will be transferred to the Emergency Assessment Unit (EAU) until their care is completed. If there are no beds on EAU, patients from Ambulatory Care should be seated in the EAU chairs. The Nurse in Charge on EAU and patient flow teams will be informed as soon as it becomes apparent that the patient may be remaining in the hospital for longer than originally anticipated.

2.3 New admissions to ACC will not be accepted two hours prior to the unit closing without authorisation of the Nurse in Charge and the senior medical doctor on duty for that day.

2.4 In exceptional circumstances ACC may have to stay open past 9pm to assist with patient flow. This will only be done after agreement with the Ambulatory Care Consultant and Nurse in Charge.

2.5 If the decision is made to keep ACC open beyond 9pm the General Manager on-call will have instigated this plan and should be liaising with the ACC Consultant and Nurse in Charge. A clear plan should be in place for how long the unit will remain open and how each patient in the unit will be managed.

3.0 Contact details for Ambulatory Care Centre

3.1 Contact details for ACC are as below:

Internal extension: 7302 and 8341
Direct Line: 01582 497302 and 01582 718341
Acute Liaison Advice Line (for GPs to reach Acute Consultant): 01582 718986

4.0 Normal staffing levels (non-medical)

4.1 Normal non-medical staffing levels for the unit are given below:

Weekdays AM: 4 Registered Nurses (excluding the unit manager)
1 Healthcare Assistant
1 Receptionist

Weekdays PM (after 5 pm)
4 Registered Nurses
1 Healthcare Assistant
1 Receptionist

Weekends: 2 Registered Nurses
1 Healthcare Assistant
1 Receptionist

OR
3 Registered Nurses
1 Receptionist

4.2 If these standards cannot be met then it is the Nurse in Charge's responsibility to contact the Acute Matron in hours or the 555 bleep holder out of hours.

4.3 On occasions where the nursing staffing levels are lower than those set out above and this causes a risk to patient safety, an incident should be raised on Datix by the Nurse in Charge or nominated employee.

5.0 Normal staffing levels (medical)

5.1 Normal medical staffing levels for the unit are given below:

Weekday:
3 Foundation Year 2 or above
1 Specialist Registrar
1 Consultant

Weekend and Bank Holiday:
2 Foundation Year 2 or above
1 Specialist Registrar
1 Consultant

5.2 Based on the above staffing level ACC would typically be able to accommodate

- 35-45 patients per day on the weekdays
- 16-21 patients on the weekends

5.3 In the event of inadequate medical staffing, the Nurse in Charge will escalate to the Rota Co-ordinator and Matron. If the Nurse in Charge is unavailable, the Consultant or SpR will make contact. Staffing levels will be confirmed at 10:30am via Rota Co-ordinator and if inadequate, the Nurse in Charge should inform:

1- Acute General Manager/Service Manager
2- General Manager on call (Bleep 500)
3- ED Nurse in Charge

5.4 In the event that there is no Consultant to cover an ACC shift the following will take place

1- The SpR on ACC will discuss new referrals with the on-call A rota Consultant before agreeing on a joint plan for safe management of the unit
2- If there is no Consultant cover for two consecutive shifts in one day:
    a. ACC will not accept any new referrals from A&E and the medical take. GP referrals for that day will be referred to the medical take team
    b. The medical take team will be able to see patients in ACC. Patients will be listed under the A-rota Consultant
    c. Urgent Yellowboards that should attend on the day will be discussed with the on-call A-rota Consultant to see if the patient should still attend. If so, they will be listed under the on-call A-rota Consultant's name

5.5 For every FY2+ or SpR that is absent, ACC will:

a. Stop accepting referrals one hour earlier

AND

b. See 10 fewer patients for that day per FY2 and above or SpR that is absent

5.6 This will be communicated to ED in advance.

5.7 Junior Doctors from the Acute medical placement should be assigned to attend ACC for at least 1-2 weeks. In this way discharge summaries can be done on time, a backlog can be avoided and Junior Doctors will get more job satisfaction and one-to one training from a Consultant.

6.0 Appropriate patients and recognised clinical pathways

6.1 A summary of recognised clinical pathways and patients accepted into ACC can be found in Appendix 1 of this document.

6.2 More detail on these pathways is available on the intranet (http://webserver.xldh.nhs.uk/default.asp), in 'Departments' – 'Ambulatory Care'.

6.3 There should be no duplication where GPs are able to directly refer to services such as the Diabetes team or St Mary's for blood transfusions.

7.0 Patients NOT suitable for ACC

7.1 ACC should be the default setting for the assessment of GP expected patients whose physiological observations are stable, whose ECG does not suggest acute ischaemia (in the case of patients presenting with chest pain) and who are independently mobile or near their functional baseline with respect to mobility / transfers.

Patients NOT suitable for ACC

- Patients that are bed bound or who cannot tolerate sitting for a long period
- Patients with delirium or those who are confused and wandering
- Patients that are medically unstable and require intensive resuscitation
- Patients requiring ITU/HDU/CCU
- Patients that require cardiac monitoring
- Patients with acute onset hemiplegic stroke who are within the window for thrombolysis
- Acute severe asthma
- Any conditions requiring oxygen
- Patients with infective vomiting or diarrhoea
- Patients with possible contagious infectious diseases (open TB, Haemorrhagic fever etc.)
- Following up of non-urgent results by discharging teams
- Where services that are readily available and that can be accessed directly via hospital and GP teams
- Procedures or infusions where St Mary's are able to accommodate or where there are already services who already have a clear pathway

8.0 ACC referral methods

8.1 All ward referrals should be done on ICE irrespective of the time of the day. Yellowboards should contain the patient name, hospital number, primary diagnosis, ACC input required and timeline of when the patient should be seen in the unit

8.2 Referrals will not be accepted if the notes are not sent to ACC or if the patient arrives without EDLs

8.3 All new GP referrals and same-day ED referrals will be accepted over the phone between 8.30am-7pm

8.4 All phone referrals will be documented on the ACC acceptance proforma and whiteboard immediately; this is also reflected on the Take List under the ACC tab

8.5 All Yellowboards and ACC referral acceptance forms will be filed in the ACC notes immediately

8.6 The name of all new referrals will be written up on the ACC white board

8.7 Yellowboard referrals will stay in the query folder on ICE until the patient is accepted to be seen in ACC

8.8 Yellowboards will only be accepted on ICE by the clinical team

8.9 Only the ACC Consultant will have the authority to reject a referral on ICE

9.0 Rejected referrals to ACC from wards

9.1 Should a ward referral to ACC be rejected the reasons will be added on ICE

9.2 The referring Consultant and Junior Doctor will also separately be emailed the rejection reason

9.3 The referring Consultant's ward will also be posted a copy of the rejected Yellowboard and a copy will be placed in the patient's notes

10.0 Rejected referrals to ACC from ED

10.1 Inappropriate referrals to ACC from ED will be rejected on ICE with a reason recorded on the system. A copy of the rejected referral will be printed off and walked round to ED. The ED Nurse in Charge and Consultant will be made aware of this.

11.0 Onward referrals from ACC to speciality

11.1 No Yellowboard referral from ACC to specialty should be rejected

11.2 Rejection of yellow boards will not be checked

12.0 Person responsible for receiving ACC phone referral

12.1 Phone referrals should be made to the ACC Nurse in Charge

12.2 Phone referrals from 9am-10am and during the Virtual Ward Round (VWR) will be taken by the ACC senior staff nurse to avoid any disruption of the ward round.

12.3 The ACC Nurse in Charge must discuss all cases with the ACC Consultant before rejecting any referral.

12.4 The A rota Consultant can stream patients to ACC. However, this should also be discussed with the ACC Consultant or SpR so the 'To Come In' list can be updated

13.0 Patients attending the unit

13.1 All expected patients from Yellowboard referrals or from a previous review will be discussed in VWR to plan ahead

13.2 All expected patients' initials will be written up on the white board as soon as VWR is completed

13.3 All new phone referrals initials will be written up on the white board as soon as the referrals are accepted

13.4 All expected patients notes will be prepared in advance by the Ward Clerk using the ACC proforma and ACC continuation sheet

13.5 The ACC Ward Clerk will receive/register patient at ACC desk and complete PAS/ prepare labels

13.6 Patients will be greeted by staff and orientated to the unit. Their arrival time will be recorded on white board. 'All about me' or 'This is me' documentation will be completed if necessary

13.7 All ACC patients should have observations, routine bloods and an ECG done (exceptions to this to be discussed with the ACC Nurse in Charge or Consultant) within 15 minutes of arrival

13.8 A Healthcare Assistant will record observations and will complete necessary tests (blood, ECG, urine dip etc) and will record the time on white board

13.9 Once the above has been done, patients will be given an appointment time to see the doctor/consultant; preferably with a one hour interval between bloods and consultation

13.10 The expected consultation review time will be recorded on the white board

13.11 If the investigations are not available within expected consultation time, ACC sister will inform the patient and the Consultant

13.12 Patients will be clerked by the Junior Doctor as per clinical priority or may directly be seen by the Consultant – particularly when department is busy

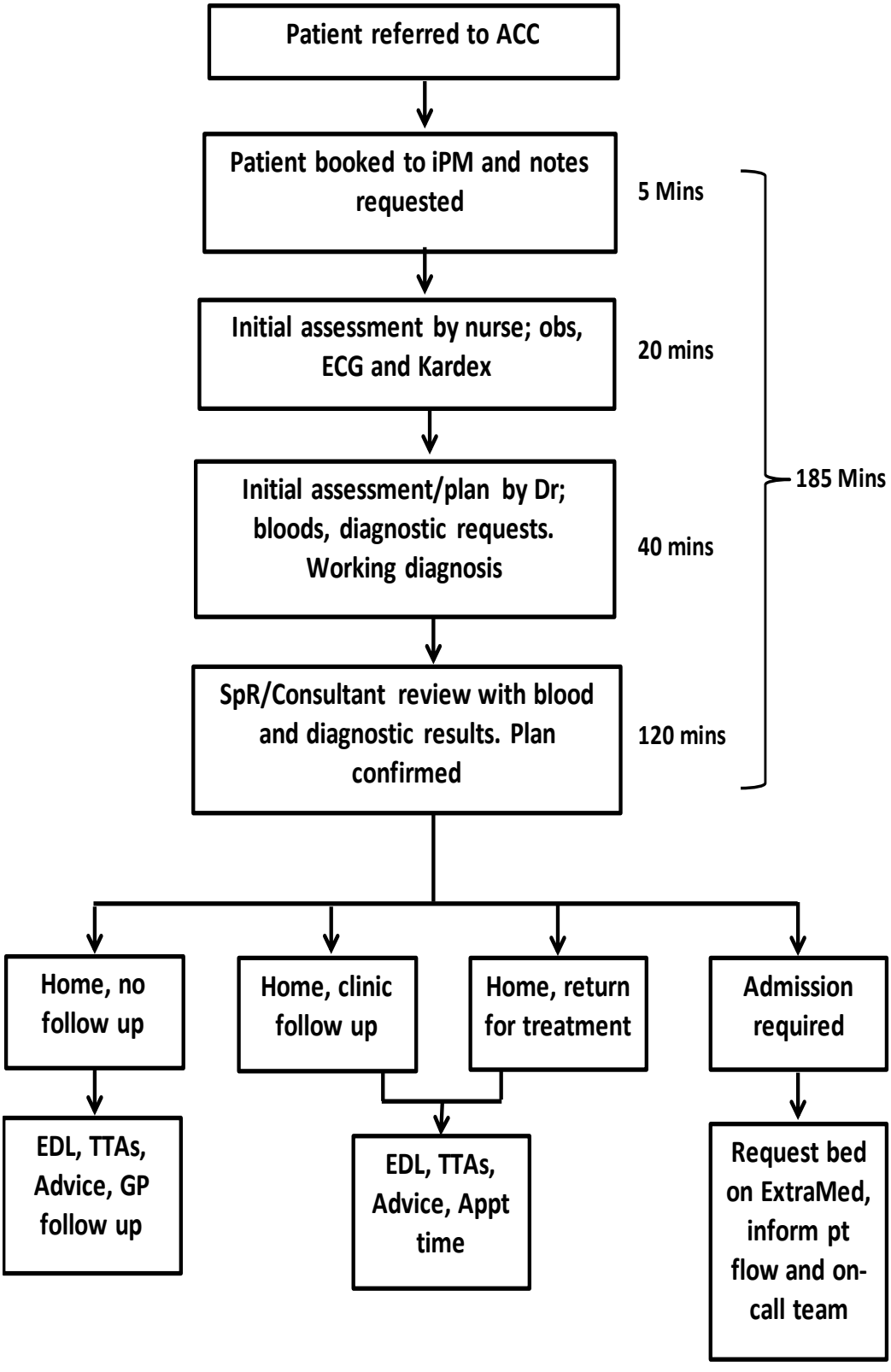
13.13 All patients are to have a senior clinical review by the SpR or Consultant

13.14 The consultation outcome will be communicated to ACC Nurse in Charge, if the patient needs to return to ACC the specific date and time will be confirmed to the patient at the time of discharge

13.15 All patients should complete their episode in ACC within 4 hours

13.16 All discharge summaries are to be completed by Junior Doctors and Consultants within 12 hours of discharge.

ADMISSION PROCESS



14.0 ACC discharges

14.1 The discharge plan will be recorded clearly in each patient's notes with the patient details populated from their first visit

14.2 When patients are discharged the ACC EDL will be used – this will not be done if the patient has a follow up appointment at ACC though

14.3 ACC EDL copies will be sent to GPs, patients and to the referring team. Once this is done, the discharge tick box will be completed in the ACC acceptance form by the ACC Nurse in Charge. Printed discharge summaries will be given to the ward clerk along with the patient's notes for scanning within 24 hours.

14.4 Incomplete discharges will be reported to the Rota Co-ordinator who will contact the Junior Doctor who did not complete the discharge letter

- If the Junior Doctor is a locum and does not complete the discharge within one week, no locum pay will be issued until there is completion of discharge summary
- If the Junior Doctor is a trainee and does not complete the discharge summary within one week of Rota Co-ordinator contact, then their educational supervisor will be informed

14.5 Notes of ACC follow up patients will be kept in the unit until they are discharged from ACC

15.0 Patients who are not contactable or DNA

15.1 Should a patient not arrive for their pre-booked appointment in ACC, reception staff will try to contact them once by telephone. If the patient does answer they will be discharged back to their GP

16.0 Medicine administration

16.1 When administering medicines the NMC code for administration of medicines and the Trust's Policy for the Use of Medicines will be adhered to at all times.

16.2 Each time medicine is offered to the patient it will be explained what it is for and why it is being given.

16.3 If medication is refused:

- The individual's capacity will be assessed
- Strategies will be used from the 'All About Me' document to encourage compliance with essential medications
- The doctor will be informed

16.4 'As required' medication will be administered following assessment by the nurse using the appropriate skill or tool such as a pain assessment

16.5 ACC will use hospital outpatient prescriptions. Most of the ACC patients are mobile and stable enough to collect the discharge medications from hospital pharmacy as frequently they are accompanied by their family or friends.

16.6 FP10s will be highly discouraged in ACC unless hospital pharmacy is closed at the time the discharge medication decision was made and the clinical need for the medications cannot wait for the next day. FP10s cost the Trust and this is an unnecessary expenditure which can easily be avoided.

17.0 Acute Medical Advice Line

17.1 The Acute Adult Medical Advice Line is a direct line which GPs can use to contact an Acute Consultant who will provide clinical advice and guidance to support their decision making and aim to reduce demand on the Emergency Department and Short Stay Admission wards. The service is available Monday to Friday, 9am–6:30pm.

17.2 All telephone advice is documented on the advice line proforma

17.3 If the Consultant is busy, the Nurse in Charge or SpR will take the referral details and document in proforma before informing the Consultant

17.4 The Consultant will aim to return a call to the GP within one hour of the call

Appendix 1 Recognised clinical pathway summary

Outpatient Antibiotic Therapy (OAT) – This is group of patients requiring treatment for an infection with intravenous (IV) antibiotics who do not require an inpatient bed. Initially they should be referred to Hospital at Home or district nursing Service, if they are unable to provide the service they would stay under the care of ACC.
They should be able to attend ACC on a regular basis for the administration of IV antibiotics (ideally no more than once a day) appointment time will be given, cannulation change and clinical review. They should be fit for discharge, safe in their own home and competent to manage any other clinical conditions. ACC staff will monitor the patient's bloods, intravenous access site access, observations and wound (if present). Appropriate conditions include Osteomyelitis, Cellulitis, Infected wounds, Urinary Tract Infections, etc. Other conditions may be accepted once discussed with the medical team. ACC will maintain communication with district nursing teams and Hospital At home service, and arrange supply of medication, dressings and follow up appointments for as long as is required. Patient will be considered for long term IV access device if indicated. Discuss with the Vascular Access Device Service

- Clinical Reviews – Patients can be referred to ACC for an early and planned follow-up after an inpatient or Emergency admission. The patient details and reason for referral must be documented in the diary with a contact bleep number for the referring team. The notes must be forwarded to ACC. Without these details, the team on ACC may refuse to accept responsibility for the patients care.
- Suspected Deep Vein Thrombosis (DVT) and/or Pulmonary Embolism (PE) – Patients will be accepted for assessment and management on ACC if they are well enough to be managed in an outpatient environment - at the discretion of the IAT in Accident and Emergency (A&E), GP liaison and ACC team who meet the clinical pathway criteria. Thrombosis Positive patients will be seen by ACC until Anticoagulation Clinic can accommodate their care.
- ACC headache - Patients, who are neurologically intact, not confused and clinically stable, who are felt to have a non-organic cause - at the discretion of the IAT in Accident and Emergency or GP liaison and ACC team who meet the clinical pathway criteria. Headache associated with trauma and particularly patients who are anticoagulants should not be accepted in ACC
- Lower respiratory tract infection. Patients will be accepted for assessment and management on ACC if they are well enough to be managed in an outpatient environment- at the discretion of the IAT in Accident and Emergency or GP liaison and ACC team who meet the clinical pathway criteria.
- Community acquired Pneumonia. Patients will be accepted for assessment and management on ACC if they are well enough to be managed in an outpatient environment, - at the discretion of the IAT in Accident and Emergency, GP liaison and ACC team who meet the clinical pathway criteria.
- Pleural effusion. Patients will be accepted for assessment and management on ACC if they are well enough to be managed in an outpatient environment, - at the discretion of the IAT in Accident and Emergency, GP liaison and ACC team who meet the clinical pathway criteria.

- Low risk Gastro-intestinal bleeds. Patients will be accepted for assessment and management on ACC if they are well enough to be managed in an outpatient environment, - at the discretion of the IAT in Accident and Emergency, GP liaison and ACC team who meet the clinical pathway criteria.
- Anticoagulation and other INR Monitoring – Please discuss with ACC clinician or nurse in charge.
- Neutropenic Sepsis
- Ascitic drainage
- Lumbar puncture- elective
- Medical conditions in pregnancy
- Uncontrolled diabetes/Newly diagnosed diabetes/HONK/DKA
- Uncontrolled hypertension
- Low risk cardiac chest pain

Other patients may be suitable for ACC at the discretion of the staff
e.g. Low risk Pneumothorax requiring review, UTI, Anaemia, chest pain, deranged blood results requiring treatment.

Appendix 2 ACC Framework

VWR (virtual ward round) 9:15am-10.30am

Greeting and meeting the team including planning ahead for the day. This will also cover many aspects of clinical governance.

- All ACC staff including the Consultant will attend this meeting on time.
- The meeting will be led by ACC Nurse in charge and ACC Consultant
- All referrals will be discussed and a management plan will be made
  All referrals to be accepted or rejected on ICE
- The date and time will be allocated for all patients attending ACC
- All cases seen on the previous day will be discussed quickly e.g. ensuring EDLs are completed, Ix results chased up, necessary referrals and Ix requested
- The TCI list from previous day needs to be discussed daily, highlighting non-attendees and ensuring that the Consultant formulates a plan for these patients as a safety net
- ACC Ward Clerk will organise the administrative part of the VWR
  1. Will start shift at 8:30am
  2. Query Yellowboards on ICE and take print outs in yellow paper
  3. Collect all the notes referred to ACC via Yellowboard from EAU tray

- All expected patients name will be written up on the ACC white board (any staff can do this, guided by ACC Nurse in charge)
  All Yellowboards with an expected to come in time on the day to be added to the expected take list under the tab ACC
- ACC Ward Clerk will ring patients to inform their time slot to attend ACC
- 9:00 to 9:15- virtual ward round with H&H team (provisional)

The Nurse-in-Charge must call the control room with ACC numbers/activity on a daily basis before 11:30am and 4pm, and also at 7pm with a forward view of the departmental activity and anticipated admissions.