Canberra Health Services

ACT Government

Model of Care – Acute Medical Unit

May 2024

Approvals

Position	Name	Signature	Date

Document version history

Version	Issue date	Issued by	Issued to	Reason for issue

Once this document has been approved please remove the DRAFT watermark.
Design > Watermark > Remove Watermark

Information about the directorate can be found on the website:
www.canberrahealthservices.act.gov.au

Acknowledgement of Country

Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and contribution to the life of this region.

Accessibility call (02) 5124 0000

Interpreter call 131 450

canberrahealthservices.act.gov.au/accessibility

Contents

Accessibility

Making documents easy to read is your responsibility.

1. Font and colour contrast needs to be considered for people with low vision:
   - White text on dark colours is accessible.
   - Dark text on dark colours is not accessible.
2. Please use heading styles sequentially as this impacts the way screen readers interpret your content e.g. heading order should always be 1, 2, 3 not 3, 1, 2. Never skip heading levels e.g. heading 1 should always be followed by heading 2, not heading 3.
3. Descriptions need to be added to images for people using screen readers:
   - To add a description, right click on the image and click 'View Alt Text'.
   - To see an example of this, right click on the image below and click 'View Alt Text'.

4. Acknowledgement of Country and Accessibility block must appear at the end of your document.
5. Run an accessibility check. Select 'Review' and 'Check Accessibility'.
6. Remove these instructions when your document is ready for publishing.

Based on the Disability Action and Inclusion Plan, documents must be compliant with standards. For more advice, visit HealthHub.

1. Introduction

This Model of Care (MoC) for the Acute Medical Unit (AMU) sets out the evidence-based framework for describing the right care, at the right time, by the right person / team and in the right location across the continuum of care. A clearly defined and articulated MoC helps ensure that all health professionals are 'viewing the same picture', working towards common goals and most importantly evaluating performance on an agreed basis.

This MoC:

outlines the principles, benefits and elements of care,

provides the basis for how we deliver evidence-based care to every patient, every day through integrated clinical practice, education and research; and

contains information of patient/client flows (the areas from where patients enter and exit the service) and service co-ordination, that is the linkages required for seamless patient treatment.

A MoC is a dynamic document and will be updated over time to support new evidence and improved ways of working. Any updates will include relevant change management principles and processes to ensure clear engagement and communication.

This MoC should be stored on the Canberra Health Services (CHS) 'Models of Care' intranet site. It will be reviewed and updated regularly through consultation and the relevant communication.

2. Principles

Our vision and role reflect what we want our health service to stand for, to be known for and to deliver every day. The vision and role are more than just words, they are our promise to each other, to our patients and their families and to the community. We all have a role to play in delivering on this promise:

- Vision: Creating exceptional health care together
- Role: To be a health service that is trusted by our community

Our values together with our vision and role, tell the world what we stand for as an organisation. They reflect who we are now, and what we want to be known for. They capture our commitment to delivering exceptional health care to our community. Our values:

- We are reliable - we always do what we say
- We are progressive - we embrace innovation
- We are respectful - we value everyone
- We are kind - we make everyone feel welcome and safe.

Our Strategic Plan sets out our path forward as an organisation for the next three years. It is values driven—it outlines how we will deliver against our vision of 'creating exceptional health

care together' for our consumers, their families, and carers. Our Partnering with Consumers Framework provides clear principles for a shared understanding of our approach and what is required from all team members for effective partnerships with consumers and carers in line with our organisational values. The principles have been developed in collaboration with our consumer and carer organisations and underpin this Framework.

3. Benefits

The expected benefits of the AMU service include:

- Providing a dedicated space outside of the ED for adult, medical admissions to be "worked up" by a physician-led interdisciplinary team
- Creating capacity in the ED to see new patients by reducing ED treatment time and ward bed block
- Utilising Clinical Care Pathways for common conditions to maximise use of evidence-based therapies and minimise variations in care
- Minimising errors in medication prescription and charting
- Reducing overall Relative Stay Index for CHS Internal medical units and therefore reducing hospital acquired complications and maintenance of inpatient bed base
- Ensuring additional senior support for our junior doctors
- Allowing allied health and nursing staff to work to their scope of practice, including in advanced capacities.
- Overall improved patient journeys through the hospital system and at the tertiary community interface

This will be achieved by:

- Staffing the AMU with the appropriate level and number of clinicians and enabling staff, including in the after-hours period
- Priority access to diagnostics and specialty consultations
- Ensuring clinicians are working to their scope of practice (including nursing and allied health)
- Using care pathways for common presentations and leveraging off the Digital Health Record
- Having clear exit pathways for discharge and transfer
- Early in-reach from subspeciality teams

4. Description of Service

The Acute Medical Unit (AMU) is a 24-bed, short-stay ward and unit for adults, designed to deliver timely, evidenced-based, and holistic care during the admission phase of medical inpatient care. The AMU provides early senior medical and interdisciplinary care for these patients, allowing a model of care that facilitates the further work up of patients with acute undifferentiated conditions in a non-ED clinical space. This early pull from ED facilitates subsequent downstream unit transfers, to minimise outlier patients across other internal medical units. Concurrently it reduces the known morbidity and mortality associated with ED LOS > 4 hours.

The overarching aims of the AMU are to:

- Provide comprehensive multidisciplinary care for adults (>16 years) needing admission under an internal medicine specialty for up to 48 hours
- Provide senior oversight of care from the beginning of an admission
- Reduce Emergency Department and overall hospital Length of Stay
- Reduce variation in care and hospital complications
- Create capacity for inpatient teams to undertake other tasks (e.g. ambulatory care)

The AMU is the engine room of the internal medicine group and as such, functions as a service unit to the internal medicine specialty units during the initial phase of a patient's admission. A key feature therefore of the AMU MoC is the early frontloading of initial multidisciplinary assessments to ensure patients are established on the right trajectory from the beginning of their admission. This ensures that care delivery is consistent with a patient's care goals, optimizes patient's overall length of stay, reduces hospital related complications and assists the maintenance of overall in-patient bed base. The AMU therefore has dedicated medical, nursing, allied health and support staff which ensures that patients begin their hospital journey with a comprehensive management plan. Noting that a large proportion of non-elective admissions occur in the after-hours period, the AMU is staffed to facilitate MDT assessments into the evening and on weekends.

Examples include:

- Early medication reconciliation
- Early assessment and prioritisation of subsequent allied health input by allied health clinical leads
- Early commencement of comprehensive care pathways
- Comprehensive medical admission that includes patient's goals for admission, GoC documentation and commencement of discharge planning

- Early commencement of standardised care pathways for common conditions and establishment of targets for criteria led discharges
- Timely phlebotomy access with early morning phlebotomy rounds
- Timely access to radiology (equity of ED access, 7 days per week)

Patients are expected to stay in the AMU for maximum 48 hours before either discharge or transfer to a home ward under an appropriate inpatient team. There are some patients who would clearly benefit from early transfer to a downstream inpatient unit, and this is facilitated where required. 50% of patients are discharged home from the AMU and thus discharge planning from the time of admission also remains a cornerstone of care in the unit. Specialty teams are required to in-reach early into an AMU admission to provide their expertise, take over patients as appropriate and assist with discharge planning and outpatient follow up. The AMU also has strong links with the Hospital in the Home program, AMU and specialty outpatient clinics, links to internal and external stakeholders and pathways to integrate care with primary health and community-based clinicians.

AMU Governance Structure

The Division of Medicine AMU Director, CNC and CHS acute allied health manager are responsible for the day-to-day running of the AMU and supervision of associated medical, nursing and allied health staff. They report to the Division of Medicine Clinical and Nursing Director and CHS executive staff. It is acknowledged that overarching policies relating to the management of Canberra Health Services clinical areas continue to apply.

5. Patient/client Journey

Describe how the different types of patients/clients, flow differently through the unit. Workflow could include arrive, admission, intervention, deterioration, discharge and referral.

Include several patient pathway maps / diagrams showing how patients will move through the unit. This may include pre-admission and post-discharge for some services.

Non-clinical areas should describe overarching and the different phases of workflows.

Also include distinct processes that may be used or offered e.g. specific care planning processes, therapies, etc

Most patients entering the AMU will come from the TCH Emergency Department. Inter-hospital transfers will be initially stabilised in the AMU if arriving after-hours, prior to communication with and transfer to a down-stream medical inpatient ward. Occasional patients may be admitted from CHS outpatient clinics (including the CHS AMU clinic) or Hospital in the Home Service. Direct community admissions are planned to occur in the next phase of AMU expansion.

Inclusion Criteria

Adults (≥ 16 years) who require hospital admission under a medical inpatient team.

Exclusion Criteria

1. Patient needs are better serviced under another Division (see CHS Inpatient Unit Admission Criteria):
    - Mental Health, Justice Health and Alcohol & Drug Services
    - Women's Youth and Children
    - Surgery
        - Note: Patients with Surgical Diagnosis requiring Medical Admission (eg # pubic rami, # C-spine that does not need inpatient Neurosurgical treatment etc).
            - Surgical delegate (ie Reg/consultant) will review the patient in ED and document plan of treatment. Name of on-call consultant will be included.
            - Surgical delegate will convey this information to the patient/carers.
            - Patient can then be admitted in the following way:
                - Primary team is the medical team – this will define the most appropriate ward location. This will be the team taking primary responsibility for care of the patient.
                - The primary team will have documentation regarding the surgical team that were involved initially.
                - If there is a requirement for further input about management or family conversations, then the surgical team will respond in a timely fashion to the medical team.
2. Need for a subspecialty unit/ward:
    - High Dependency or Intensive Care Unit
    - Coronary Care Unit
    - Stroke Unit
    - Haemodialysis or Peritoneal Dialysis Unit
    - Tracheostomy Patients
    - Specific isolation requirements not able to be accommodated on AMU. For example:

- Positive pressure room for neutropenia <$0.5x10^9$/L
- No available negative pressure or single isolation room for respiratory precautions

- Need for a secure ward or subspecialized care for behavioural disturbance. For example:
  - Patients admitted with significant behavioural/psychological symptoms of dementia

3. Patients with the following medical conditions should be admitted under subspecialty units:
   - Gastrointestinal bleeding (of any type: upper or lower; including stable patients for observation only)
   - Diabetic ketoacidosis, regardless of cause
   - Cancer related presentations related to:
     - Recent/impending chemotherapy/immunotherapy/novel therapies
     - Complication from haematological or solid organ malignancy
   - Ischemic/haemorrhagic stroke or high-risk transient ischemic attack (as per the ED TIA pathway).
   - Cardiac Arrest/ Unstable arrhythmia/ Unstable heart failure/ Acute Myocardial Infarction/ Worrying syncope/ Endocarditis/ Acute Pulmonary Oedema
   - Orthogeriatric presentations
   - Requirements for Non-Invasive Ventilation
4. Patients with the following medical conditions should be discussed with the relevant subspecialty team(s) and considered for admission, prior to referral to the AMU:
   - Impending need for renal replacement therapy
   - Renal, Liver, Cardiac transplant
   - Patients expected to need a procedure within 24 hours of their admission
5. Patient clinical instability should be addressed before ward transfer and prompt consideration for HDU/ICU review/admission, contextual to the patient's Goals of Care. Examples may include:
   - MEWS of > 4

- FiO2 requirement of > 40%
- Requirements for telemetry due to severe electrolyte disturbance or pharmaceutical toxicity
- Reduced level of consciousness
- Current trajectory of deterioration

If there is a question about a patient's clinical stability or suitability for the unit, the AMU Consultant is the delegated authority to determine suitability for transfer to the AMU. This may be facilitated by a timely medical review in the ED by the AMU Consultant or their nominated delegate.

AMU Admission Process

1. **Admissions from ED** (see Figures 1 and 2):

    - **ED Assessment**

        i. ED assessment occurs and determines that an inpatient admission is required. ED team will have made a provisional/working diagnosis and initiated a treatment plan.

    - **Disposition to ward**

        i. Patients admitted to the AMU:

            1. Patients who meet AMU inclusion criteria will be transferred to the AMU after ED has communicated with the AMU admitting officer (AMU consultant or their delegate).

        ii. Patients excluded from the AMU:

            1. **Weekday Business Hours (0800 – 1630):** Patient will be transferred directly from ED to the ward under the Direct Admissions Policy or be reviewed by the sub-specialty team in ED following direct communication between ED and the relevant subspecialty team.

            2. **After-hours (1630 – 2200):** Patient will be transferred to the ward under the Direct Admissions Policy or be reviewed by the Admitting Registrar for Medicine (ARM) in ED (as requested by the relevant subspecialty team following direct communication between ED and the relevant subspecialty team).

            3. **After-hours (2200 – 0800) and Weekend:** Patient will be transferred to the ward under the Direct Admissions Policy or be reviewed by the ARM in ED (as requested by the ARM).

Notes:

Stable patients may be directly admitted to the ward, following discussion with the accepting Sub-Specialty consultant (or delegate) according to the existing Direct Admission Policy, without medical registrar review.

Patients transferred directly to ICU from ED will be required to have an admitting sub-specialty prior to transfer.

Figure 1: AMU Admissions from ED Assessment (Mon-Fri 0800 – 1630):

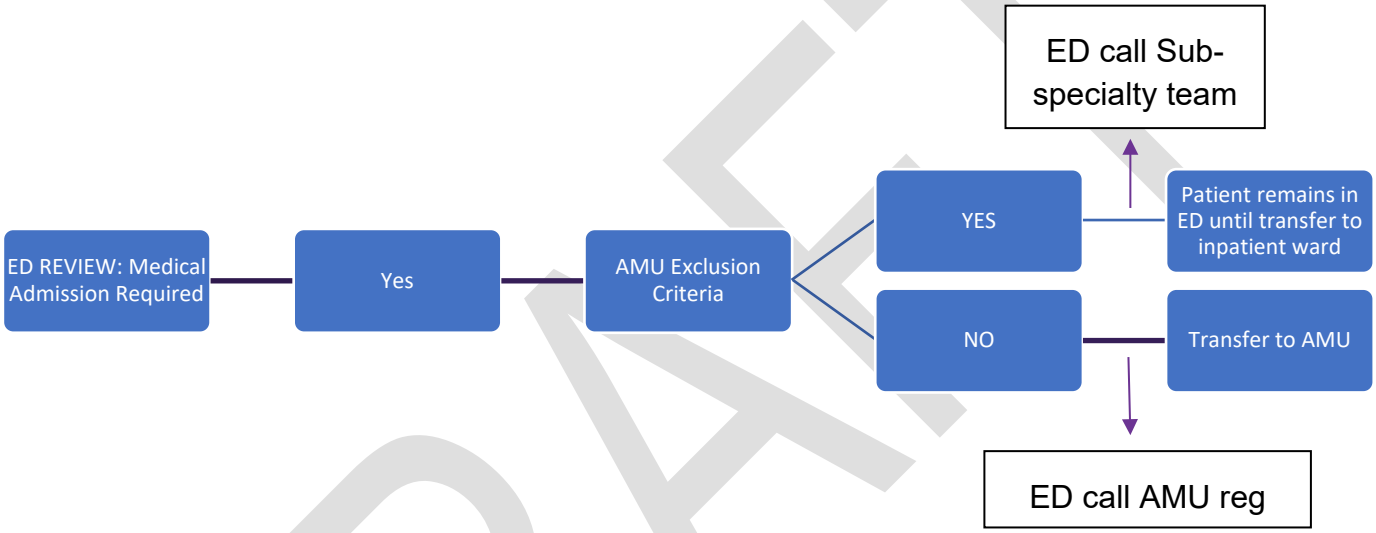
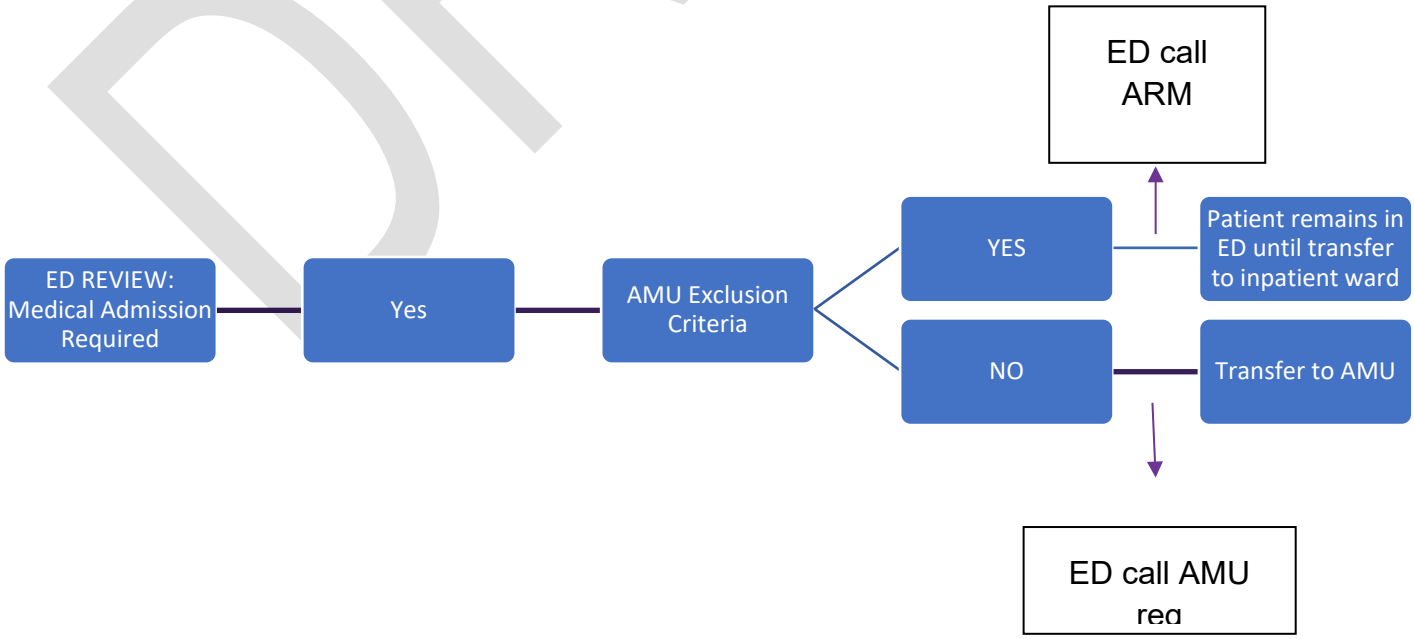


Figure 2: AMU Admissions from ED Assessment (Mon-Fri 1630 – 0800, Sat/Sun/PHol):



2. **Planned (Expected) Admissions under Specialty teams arriving via ED** (See Figures 3 and 4):

    - **Weekday Business Hours (Mon-Fri 0800 – 1630):**

        i. Clinically stable:

            1. Ward Bed available

                a. Patient should be transferred directly to the ward bed and sub-specialty team notified.

            2. Ward Bed not available

                a. Patient should be directed to the AMU if the following criteria are met:

                    i. Patient has no exclusion criteria for the AMU

                    ii. AMU has accepted the admission

                    iii. Bed Management Unit have identified the AMU bed

                    iv. AMU Team Leader is aware

        ii. Clinically unstable patients should be stabilised in ED prior to ward transfer.

    - **After Hours and Weekends:**

        i. Clinically stable:

            1. Patient should be directed to the AMU if the following criteria are met:

                a. Patient has no exclusion criteria for the AMU

                b. AMU has accepted the admission

                c. Bed Management Unit have identified the AMU bed

                d. AMU Team Leader is aware

            2. Patients who meet exclusion criteria for the AMU should be directed to the relevant sub-specialty ward bed. They would be admitted by the Ward Medical Registrar (M1).

        ii. Clinically unstable patients should be stabilised in ED prior to ward/AMU transfer.

Figure 3: Planned (Expected) Admissions under Specialty teams arriving via ED (Mon-Fri 0800-1630):

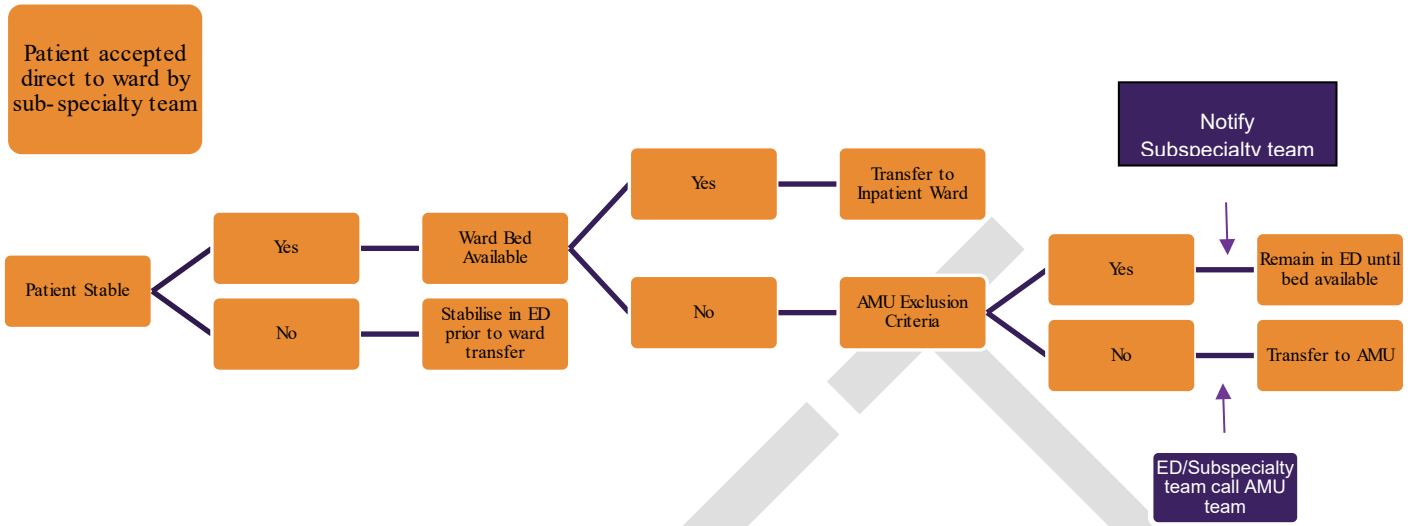
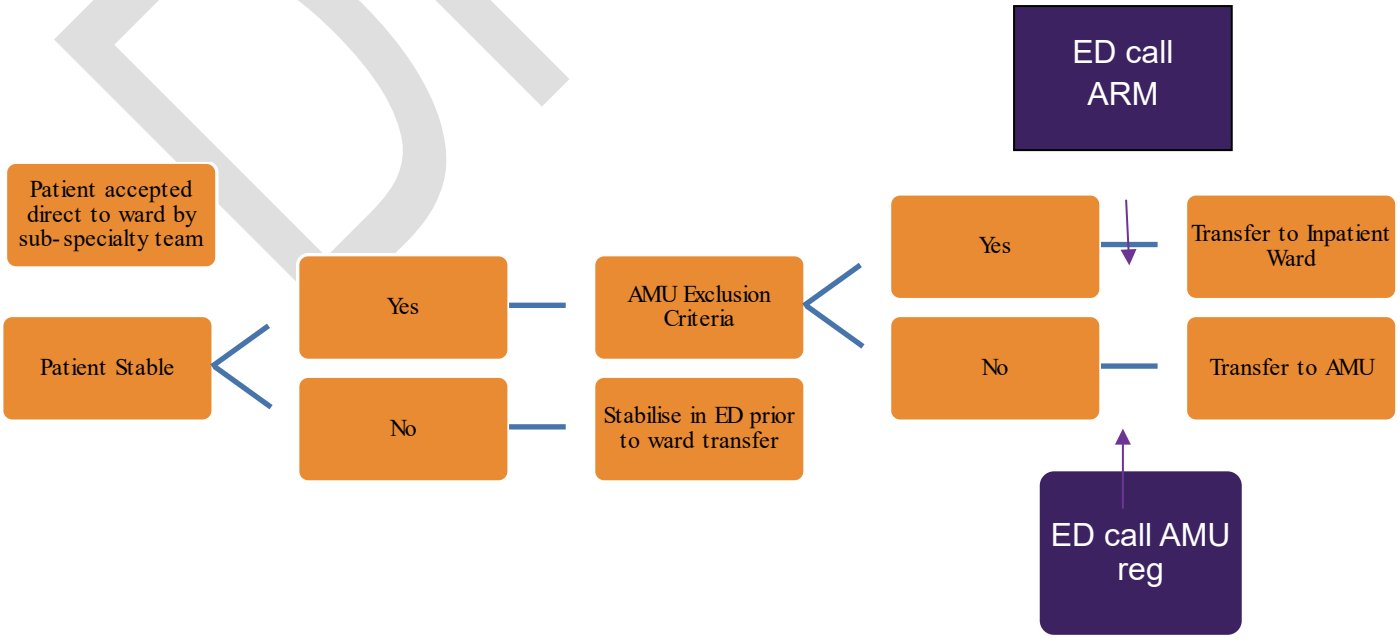


Figure 4: Planned (Expected) Admissions under Specialty teams arriving via ED (After Hours and Weekends)



AMU Bed Request

1. Once the inpatient team has been notified of an admission, the AMU bed request is made by the ED Navigator if the patient does not meet exclusion criteria.

2. ED staff will ensure that the patient is ready for ward transfer within 30 minutes of a Bed Request including completion of:

    - Direct Admissions Form

        i. Documentation of management plan

        ii. Goals of Care (as appropriate)

        iii. Outstanding investigations for review.

    - Prescription of intravenous fluids, analgesia and other medications as per management plan.

ED to AMU Transfer

- The patient is then admitted and transferred to the AMU. This process is coordinated by the Nurse Navigator and Patient Flow Team in consultation with the receiving ward.

- Patients that meet AMU ward criteria will be transferred to the AMU within 60 minutes of Bed Request.

- Patients that meet AMU exclusion criteria will either remain in ED for stabilisation or be transferred to an appropriate clinical ward as per the Admissions from the Emergency Department to Ward Procedure [CHS 20/292].

3. Admissions from CHS Outpatient Clinics, Hospital in the Home, External Hospitals

Admission requests from areas external to TCH ED should be discussed with the AMU consultant-on-call. Once accepted, the AMU consultant-on-call should discuss acceptance of the admission with the AMU Registrar, the AMU Nurse Team Leader and the Patient Flow Team. Patient admission is then coordinated by the Patient Flow Team.

Note: Patients can only be admitted under the AMU consultant if they are being transferred to the AMU ward.

AMU Assessment Process

The AMU Registrar is the delegate of the AMU consultant to receive referrals from TCH ED for AMU admission. Patients admitted to the AMU should undergo an initial medical assessment as soon as practicable. Mandatory admission processes include: Standard diagnostic work-up

and creation of a management plan (including a patient's likely disposition), completion of Goals of Care and completion of AMU Discharge Planning questions.

The medical assessment forms the foundation for subsequent multi-disciplinary involvement.

Value-adding interventions:

- Pharmacy medication reconciliation and additional pharmacy interventions
- Review by a senior allied health clinical lead to commence prioritisation and co-ordination of timely referrals to and reviews by required allied health
- Comprehensive Care Plans commenced
- Diagnostic work-up for the undifferentiated patient in a non-ED space
- Commencement of standardised common care pathways
- Establishment of targets for criteria led discharges
- Further Pathology and Radiology investigations ordered and results reviewed while patient is in the AMU
- Clarification of patients' resuscitation status and patients' goals of inpatient treatment (for all AMU patients)
- Early in-reach from CHS sub-specialty teams
- Determination of appropriate down-stream inpatient team and ward if not able to be discharged within 48 hours

If an AMU patient deteriorates whilst in the AMU and requires an urgent ICU transfer, the patient should be transferred to ICU under the AMU bed card until downstream sub-specialty bed card disposition can be made as soon as practicable.

Flow Between AMU and Sub-Specialty Teams (see Figure 5):

- It is the responsibility of the AMU Registrar (or delegate under supervision) to complete the admission and commence initial patient management in consultation with the AMU Consultant.
- The Registrar is also responsible for completing an Estimated Discharge Date (EDD) in DHR, communicating it to the team, and updating it as required.

Transfers of Care:

- The AMU Consultant (or their nominated delegate) has the authority to determine subsequent inpatient admitting team disposition. AMU Senior Staff will always attempt to work collaboratively with sub-specialty teams for the transfer of a patient's care, however

under the Chief Operating Officer's directive, AMU consultants (or their senior delegate) may need to enact authority to downstream if there are contentions that delay the decanting of the unit.

- Disposition decisions are based on the CHS Inpatient Unit Admission Criteria document, and/or assessment of equitable/safe distribution of patients based on specialty team staffing and inpatient numbers.
- The timing of disposition decisions relate not only to patient acuity or complexity but also ED demand.
- The standard process for a transfer of care is a phone notification at a Consultant to Consultant level (or the consultant's delegate – a senior clinician within the department (usually an AT) who is aware they are receiving notification of care takeover over the phone.
- If the relevant delegate-on-call is not contactable within 1 hour, this will be escalated to the Executive-on-call.
- It is desirable that a subspecialty team reviews their patient in the AMU prior to downstream ward transfer however, provided a verbal handover has been completed, flow out of the AMU will not be delayed if this does not occur.
- If the subspecialty team assesses the need to physically review a patient prior to formal transfer of care, this review with subsequent management confirmation must be conducted within 1 hour (same priority and process as ED) during standard business hours.
- The escalation pathway, if required, is through direct Consultant to Consultant conversations.
- **Before 2200**: Following initial diagnostic work-up and completion of admission in the AMU between 0800 - 2200, early referral to the relevant sub-specialty team is essential before 2200 on a given day, provided the patient has been discussed with the AMU consultant and the ongoing management plan confirmed.
- **2200 – 0800**: If the patient is admitted by the AMU Reg between 2200 - 0800, the patient will be discussed at the virtual AMU Morning Medical Handover.
    - It is imperative that a senior representative (consultant and/or inpatient service registrar) from all internal medicine subspecialty teams, attend the virtual morning handover (0800 – 0830) to ensure direct hand-over of all patients admitted by the AMU Registrars after-hours. This is recommended to be the post-take consultant (or their nominated delegate). This will include a handover of patients admitted to the AMU and those admitted to other wards.

- The Morning Medical Handover will also be a primary communication point for subspecialty teams to be notified of AMU patients who require subspecialty team input (ie Consult) or who are determined to be transferred to their downstream unit.

- Relevant post-take sub-specialists must review their relevant patients on AMU as soon as practicable each morning (after handover) to assist in management/ discharge planning

- All patients in the AMU remain under the AMU primary care team until they have been discharged or transferred to a sub-specialty team. Patients on AMU who have been transferred to sub-specialty teams will remain under the principal oversight of the sub-specialty team however, the AMU will be listed as an additional care team until the patient has left the AMU. AMU Registrars and RMOs are still required to respond to all deteriorating patients in the AMU regardless of bed status. After-hours, the AMU Reg/RMO is responsible to assist in any management issues arising for all patients in the AMU regardless of bed status.

Sub-Specialty Consults:

1. Non-life threatening sub-specialty consults within the AMU are considered sub-acute due to the AMUs role in maintaining patient flow.

2. Consult requests will be made via DHR (to enable the provision of written responses) and (not or) over the phone.

3. Consults received within standard business working hours should be seen on the same day as the referral.

4. Wherever possible, consults should also be discussed at the morning medical handover, to facilitate timely staff specialist reviews on morning ward rounds.

- Sub-specialty consultants on-call (or their nominated delegate) should be available to respond to calls from the AMU consultant/Registrar if advice is required.

- On-call subspecialists (or their delegates) are still responsible to receive direct calls from external hospitals for direct admissions, relevant to their subspecialty.

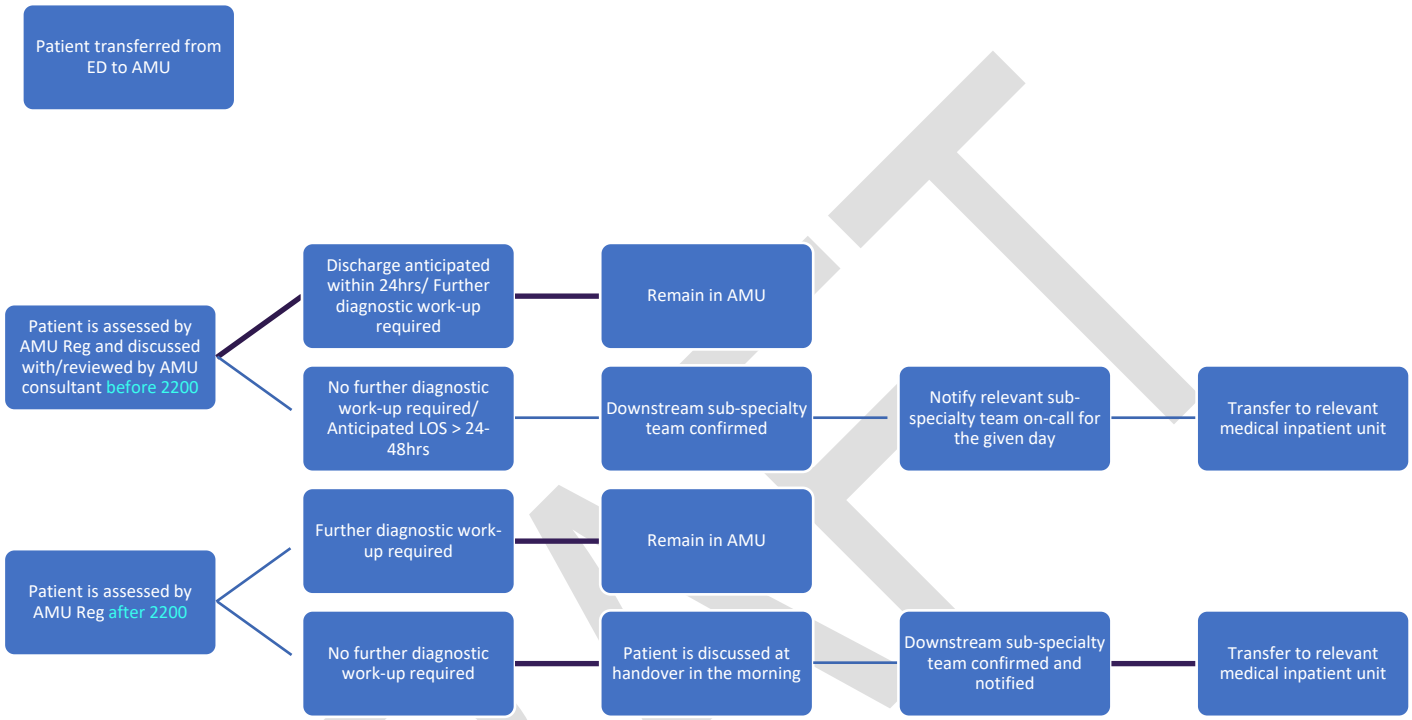
    - Unstable patients should be stabilised in ED prior to ward transfer.

    - Patients who arrive to TCH after hours, should be admitted through the AMU if there are no exclusion criteria, as a patient safety factor, prior to discussion with the relevant sub-specialty team and subsequent disposition.

- Once communication has occurred with a sub-specialty team for transfer of care, a bed request is made via DHR and then arranged by the patient flow team.

- Continuity of allied health referrals, assessment and management process is vital to ensure co-ordination between the AMU and ward teams and is facilitated via the DHR.
- AMU ward nursing handovers will occur as per standard ward transfer practices.

Figure 5: Transfer of care of patients between AMU and Sub-specialty teams



6. Interdependencies

Emergency Department

An efficient and collaborative service exists between the Emergency Department and the AMU to ensure the timely and safe transfer of relevant patients to the AMU for admission.

Specialty Wards

Under the governance of the Division of Medicine, the AMU works collaboratively with subspecialty teams and wards to facilitate the continuity of multidisciplinary patient care on transfer of patients from the AMU to internal medical units. This is facilitated by the daily Division of Medicine morning medical handover and direct consultant-consultant communication.

Occasionally patients are assessed to be more suitable for ongoing care under a non-medical team and ward. AMU works collaboratively with these teams to transfer patients to the most suitable unit.

Specialty Teams

AMU works closely with all subspecialty teams for early in reach and consultation for patients. This assists timely disposition decision making or facilitates discharge planning and subsequent community follow-up.

Hospital in the Home

The Hospital in the Home (HITH) service allows for hospital level care in a patient's home or outpatient clinic instead of on a hospital ward. HITH provides care to appropriate patients transferred from AMU as per the HITH Referral, Admission and Discharge Procedure.

Allied Health

TCH Acute Allied Health Service is an inpatient service. The cohesive relationship between the AMU and Acute Allied Health Services is primary in providing specialised, goal-based care and interventions to maximise a patient's functionality and quality of life.

Pharmacy

Clinical pharmacists operate within TCH Campus for extended hours 7 days per week. These pharmacists assist to manage the continuity of pharmaceutical management for patients across the tertiary community interface. Patients can access discharge medications from the TCH dispensary during operational hours. The AMU relies on the pharmacy service and impress stock contains medications to meet the requirements of acute general medical patients across the breadth of presentations experienced within the unit.

Medical Emergency Team

The TCH Medical Emergency Team (MET) Service provides support for emergency medical response to the deteriorating patients within the campus including AMU. As AMU has patients who have an unclear disposition and require further diagnostic workup, they are at a high risk of deterioration. MET are the key team supporting the unit for these high-risk patients.

Pathology

Many patients within the AMU require diagnostics including pathology services. Pathology services available to the ward include the phlebotomy services who operate significantly within the AMU.

Radiology

AMU relies on having equity of access to radiology services 7 days per week, this is crucial in the further diagnostic workup patients within AMU. Radiology services available to AMU are proportionate to that of the Emergency Department.

Patient Support Services

AMU is well supported by a team of ward clerks, wards persons, hospital assistants, central equipment stores and cleaners to facilitate the efficient flow and care of patients into, within, and from the unit.

CHS Community Based Services

Patients within the AMU may require CHS community-based services on discharge from the hospital. Examples of this include the Liaison and Navigation Service (LaNS), Community Drug and Alcohol, Community Palliative Care and Rapid Assessment of the Deteriorating Aged at Risk (RADAR). Having a strong working relationship with these services allows for continuity of care between the tertiary and primary health care/community setting. These services support the timely discharge of patients from the AMU.

7. Work Health & Safety

The physical safety of people, staff and visitors in the AMU environment is paramount. This will be achieved by:

- Staff supporting safe clinical practices with staff taking responsibility for personal safety and the safety of others,
- Monitoring of items brought into the unit which may be identified as a personal or environmental risk to others,
- Maintaining visual observations
- Conducting regular and ad hoc environmental checks
- Ensuring staff are trained and use relevant equipment such as duress alarms, safety equipment.
- Acting immediately to respond to identified risks and escalate concerns
- Understanding and being confident in initiating and responding to emergency procedures
- To enable a therapeutic environment and to promote engagement, people need to be able to move around freely without duress of any kind. Persons admitted to the unit and their visitors will be advised of unit procedures as a part of the AMU orientation process in order to promote a mutual understanding and expectations of acceptable and unacceptable standards of behaviour to promote a safety culture for all. Requirement for behaviour is set out under the Occupational Violence Policy and Procedures.

Incorporating safe design principles including:

  - clear lines of sight to all entrances
  - staff station counters of adequate height and width to prevent someone jumping or reaching over
  - restricted access of visitors as required.
  - restricted viewing of and access to pharmaceuticals
  - minimising loose objects that may be used as potential weapons as required

- clear delineation of public areas, staff only areas and restricted areas which includes the ability to easily restrict access if required (such as a lockdown button) and signage
- a duress system which is integrated to current systems to allow for response to occupational violence episodes; and
- installation of electronic access control systems (EACS) to control ingress and egress at ward entry points, staff only areas etc.
- access to a patient journey board in the staff area that identifies alerts and clinical risk indicators for staff to understand the clinical and occupational violence risk in the unit at a given time.

Procedural safety

Procedural safety relates to all policies and procedures which maintain safety and security and the governance systems which provide oversight. All AMU staff will be trained at the time of orientation with regular training updates provided. Staff will be expected to comply with CHS policies, procedures, and guidelines.

At a minimum, all Ward AMU staff will be required to:

- Undertake essential education as stipulated in the CHS Essential Education policy and framework 1ncludmg recent occupational violence training
- Ensure personal and professional behaviours do not contribute to the potential to
- Escalate risk
- Apply safe work practices which involve proactive assessment, mitigation and
- Management of risk
- Record all reportable incidents through Riskman, your line manager and to CHS Security as required.
- Report acts of violence to ACT Policing where appropriate
- Participate in clinical review of incidents to support a culture of learning and quality

Risk Management

The management of clinical risk for the AMU is integrated within the management of organisational, financial, workplace safety and patient safety systems as endorsed under the ACT risk management system. Clinical risks will be identified, assessed and actions taken for mitigation, incidents reported and investigated. There will be a 'lessons learned' approach to the review of incidents.

Clinical risk assessment and management will be in accordance with CHS Policies and Procedures.

8. Workforce

The Acute Medical Unit sits within the Division of Medicine Acute Care Portfolio. Staffing is designed to reflect the critical role of the unit as the “engine room” of the CHS internal medical units. The way all staff work together is as important as the role of each individual team member

in order to make a positive difference to our patients' journeys. Communication with all staff within the unit and external to the unit should always be respectful.

Medical Staffing

AMU is staffed by Consultant Specialists, a General Medicine Advanced Trainee, medical registrars and pre-vocational hospital resident doctors. The AMU medical team are expected to be familiar with clinical histories and investigation results for all AMU patients. Each staff member is responsible for ensuring compliance with CHS essential training.

AMU Consultant

The AMU Consultant is responsible for supervising the advanced trainee, medical registrars, and resident medical officers and provide clinical oversight of undifferentiated patients requiring further diagnostic work-up. The AMU Consultant has delegated authority to admit AMU patients under any medical inpatient team consistent with the CHS Inpatient Unit Admission Criteria document to ensure flow through the ward. Preferably, the admission decision is arrived at by mutual agreement, however, if agreement cannot be achieved, the AMU Consultant has final delegation authority to admit.

The AMU Consultant is allocated time for both clinical and non-clinical duties, relevant to the work of the AMU. In situations of excess clinical demand or resource shortages, clinicians may be requested to replace their non-clinical time with clinical duties. This will be at the discretion of the Unit Director.

The AMU Consultant can be contacted via the CHS Switchboard.

AMU Advanced Trainee

The Advanced Trainee (AT) in the AMU is currently sourced from the CHS General and Acute Care Training Network.

ATs are primarily responsible for reviewing patients admitted to the AMU, who have previously been seen by an AMU consultant. In this review, the AT will confirm the diagnostic direction based on investigation results and further clinical information that may have been obtained. In collaboration with the Allied Health Clinical Leads, they will formulate an ongoing management plan for the patient, including the important decisions regarding subsequent bed disposition (discharge vs transfer to a downstream medical unit). In this, they develop an enhanced understanding of the tertiary vs community interface.

Additional roles of the AT include:

- Review any unstable/deteriorating patients at the commencement of their shift.
- Under the supervision of the AMU Consultants, run the AMU Rapid Access Outpatient Clinics (Review patients only) on Tuesday and Friday afternoon.

- Under the supervision of the Unit Director, contribute to monthly AMU Morbidity and Mortality and monthly Quality and Safety meetings within the unit.
- Under the supervision of the Unit Director, be involved in research related activities relevant to the operational effectiveness of the AMU.
- Deliver a 30-minute presentation on a weekly basis, pertaining to a patient case/topic/journal article relevant to the AMU.

AMU Basic Physician Trainee

BPTs within the AMU team include both the AMU and the ARM (Admitting Medical Registrar) roles. Their primary focus is the initial admission of relevant patients into the AMU and the Division of Medicine.

Admissions will be discussed with the AMU/ARM registrars in the first instance, who will confirm if the patient is suitable for AMU admission. The AMU Registrar will have delegated authority to accept patients to the AMU for further workup under the AMU consultant. The AMU and ARM/M2 registrars are expected to work closely together to get through the admission workload. Where capacity permits, under the supervision of the AMU Registrar, less complex AMU admissions can be delegated to the AMU RMO.

The Basic Physician Trainee is the primary support the AMU evening and night RMOs and attends to the deteriorating patient in the AMU.

AMU Resident Medical Officer

RMOs are responsible for assisting in:

- AMU Consultant and advanced trainee ward rounds
- Ward work related to patients within the AMU
- Respond to the deteriorating patient within the AMU
- Communication with community health providers or down-stream medical inpatient teams via the electronic discharge summary
- Admissions of suitable patients into the AMU under the supervision of the AMU registrar (evening and night shift)

RMOs work closely with the medical, nursing, allied health and pharmacy teams within the AMU.

Nursing Staffing

Nursing leadership will be provided by the Division of Medicine A/DON Patient Flow, AMU Clinical Nurse Consultant and Clinical Care Co-ordinators. The Clinical Care Co-ordinators provide a vital link between the AMU, Patient Flow Unit, ED and internal medical wards. Their

role is to facilitate flow within and through the AMU. Education and training will be supported by the Clinical Development Nurse. The unit will be staffed 24 hours per day, 7 days per week with a mix of Registered Nurses and Enrolled Nurses. The nurse-to-patient ratios during the day and evening shifts will be 1:3 and 1:4 overnight.

Allied Health and Support Staffing

The Allied Health Clinical Lead is a strong contributor to discharge planning within the unit. The role is designed to evaluate an individual's allied health (AH) needs from a patient-centred viewpoint; and provide comprehensive and multifaceted input to maximise the positive patient journey within the healthcare setting. The role is unique in the ability to challenge the traditional silos of AH disciplines and instead apply an interdisciplinary clinical approach. The AHCL operates across the five core AH disciplines in a transdisciplinary scope of practice. Interdisciplinary screening, assessment, and planning processes allows the AHCL role to prioritise and target acute care to the individual needs of the patient, their family, and carer(s). Interdisciplinary practice improves efficiency in referrals to the appropriate discipline-specific teams. An interdisciplinary overview allows AH goals, more appropriate to a sub-acute environment, to be addressed in the relevant setting for long-term interventions. To assist this, the AHCL facilitates links to community- based services to improve continuum of care.

The AHCL prioritises and communicates with the subspecialty allied health disciplines according to unit flow and patient needs. Allied health disciplines strongly contribute 7 days per week within the unit.

Clinical pharmacy activity supports the needs of the clinician and safe prescription of medication within and on discharge from the AMU.

The high rate of clinical activity within the AMU requires co-ordinated teamwork with our dedicated ward clerk, wardspersons, ward assistants and cleaners.

<table>
<tr><th></th><th colspan="3">AMU Shift Coverage</th><th>FTE</th><th>Position</th></tr>
<tr><td>AMU Director</td><td colspan="3"></td><td>0.3</td><td></td></tr>
<tr><td>Office Manager/PA to Director</td><td colspan="3">Mon-Fri</td><td>1.0</td><td>ASO4</td></tr>
<tr><td rowspan="2">AMU consultants (FRACP/FACEM)</td><td rowspan="2"></td><td>Mon-Fri</td><td>Sat-Sun</td><td></td><td></td></tr>
<tr><td>0800 – 2200 + A/H on-call</td><td>0800 – 2200 + A/H on-call</td><td>4.6</td><td>Staff Specialist</td></tr>
</table>

AT (Gen Med)	**Day Shift**	X1	Nil	1.0	SNR Reg
BPTs	**Day Shift**	X1 AMU Reg (AMU Admissions)	X1 AMU Reg	9.0	Reg
		Subspecialties cover non-AMU admissions.	X1 Admitting Reg		
	Evening Shift	X1 AMU Reg (covers AMU, AMU admissions)	X1 AMU Reg		
		X1 ARM Reg (covers non-AMU admissions)	X1 Admitting Reg		
	Night Shift	X1 AMU Reg (covers AMU, AMU admissions)	X1 AMU Reg		
		X1 ARM Reg (covers non-AMU admissions)	X1 ARM Reg		
RMOs	Day Shift	x3 + Day/Reliever Shift	X2 +Day/Reliever Shift	10	RMO
	Evening Shift	x1	x1		
	Night Shift	x1	x1		

CNC		Mon-Fri (Day Shift)	1.0	3.2
CDN		Mon-Fri (Day Shift)	1.0	2.0
CCC (3.1)		Mon-Fri (Day and Evening Shift)	2.0	3.1
Nursing Ratio		1:3 7 days per week, day and evening shift 1:4 7 days per week, night shift		
A/Health Clinical Lead		7 days per week (0800 – 1630)	1.4	HP4
Social Worker		Mon-Friday 8am to 4:30pm 7 days per week after hours until 9:30pm (cover)	1.4	HP3
Physiotherapist		Mon-Sunday 8am to 4:30pm	1.4	HP3
Occupational Therapy		Mon-Sunday 8:30 to 4:30pm	1.4	HP3
Nutrition		Mon-Fri 8:30 to 5pm Saturday & Sunday – priority service	0.5	HP3
Speech Pathology		Mon-Sun 8am to 430pm (cover)	0.3	HP3
ALO Service		Consult service 5 days per week	0.1	ASO5
Pharmacists		2 pharmacists 8am to 4pm and 1 pharmacist 1pm to 9pm, 7 days per week	1.5	HP3
			3.0	HP2
Wardpersons		0900 – 2100, 7 days per week		
Wardclerks		0800 – 1600, 7 days per week		ASO3
Ward Assistants		0700 – 2030, 7 days per week		HSO3

Central Equipment Stores		24hr delivery service, 7 days per week	2.52	HSO3
Cleaners		0630 – 2030 (7 days per week)		
Phlebotomy		0630 rounds, 7 days per week		
Radiology		Equity of Access to ED, 7 days per week		

9. Accreditation and Training

All new staff will be provided with CHS and ward specific orientation as an essential element of their induction. Orientation and induction will include Fire & Emergency, general information relating to access and key management, an overview of equipment and technology, building management including duress, emergency procedures, room management and lighting control and ICT including TVs and multifunction devices.

All AMU Staff Specialists working in the unit receive prior credentialling from the CHS Medical and Dental Appointments Advisory Committee (MDAAC).

Advanced Trainees are accredited through the Royal Australian College (or equivalent Australian based specialist training pathway).

Basic Physician Trainees are accredited through the CHS Network Director of Physicians Education on behalf of the Royal Australian College of Physicians.

Senior Resident Medical Officers and Resident Medical Officers are accredited through the Canberra Regional Medical Education Council.

New nurses on Medicine wards will need to work towards achieving competency in:

- Patient controlled analgesia (PCA) management
- Central Venous Access Device (CVAD) management
- Venepuncture
- Intravenous cannulation (RNs only)
- Ward specific competencies may be required

10. Implementation

The MoC will be implemented through the following strategies:

- Orientation and training programs for new and existing staff to work within the service.
- Ongoing training programs for staff working within the service.
- Processes and documentation used within the service that support the principles of the AMU Models of Care.

11. Monitoring and Evaluation

Key Performance Indicators

The performance of the AMU will be regularly monitored to ensure that it is operating at a safe, efficient and sustainable manner. The KPI data will be reviewed regularly by the AMU and Division of Medicine leadership team.

Category	Determination	Indicator/Measure	Target
	% of positive patient experiences	KPI	> 85%
	% of positive staff experiences	KPI	>85%
Activity	Relative Stay Index	KPI	90%
	Admitted NEAT for AMU<4 hours		Median ≥65%
	AMU LOS ≤ 24 hours	PI	≥40%
	AMU LOS ≤ 48 hours	KPI	≥90%
	AMU LOS ≤72 hours	KPI	100%
	Time to transfer from ED when bed available ≤30 minutes	PI	≥90%
Safety	30-day unplanned readmission rate from AMU- Home	KPI	≤10%
	30-day unplanned readmission rate from AMU-inpatient ward-home	PI	≤10%

	MET calls within 24 hours of admission	measurement	
	Percentage of MET calls where there was a delay in calling a MET as required in response to MET criteria	PI	<10%
	Rate of medication incidents per 1,000 bed days	Measurement	
	Median overall LOS (acute) of AMU patients transferred to the ward ≤7 days	KPI	
	Separations from AMU	Measurement	
	% patients discharged home from the AMU		
	% patients transferred to downstream inpatient ward from AMU		
	% patients admitted directly to the AMU (Phase 4)		
Clinical	Proportion of patients with completed Goals of Care Form prior to discharge from/transfer out of the AMU	Measurement	≥80%
	Proportion of patients with Comprehensive Care Assessment commenced prior to discharge from/transfer out of the AMU	Measurement	≥90%
	Rate of compliance with antimicrobial stewardship procedure referral requirements	Measurement	≥90%
	% of multi-disciplinary discharge summaries completed within 38hrs of a patient's discharge from AMU.	Measurement	≥90%

12. Records Management

Following the relevant consultation, this finalised document and any further updates will be electronically stored on the Canberra Health Services intranet site – 'Models of Care', to ensure accessibility for all staff.

13. Abbreviations

Abbreviation	Meaning
AMU	Acute Medical Unit

14. Model of Care Development Participants

Position	Name
AMU Clinical Director	Anna Nakauyaca
AMU Business Manager	Lindsay Ottaway
AMU CNC	Jo Lewis, Louise McKenzie