# AMU and DoM Bed Footprint Consultation Sessions FAQ

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**Question: When will this all take place if supported.**

Answer: It is hoped that we will re-arrange the bed base to allow the 12-bedded AMU to move into it's new 24-bedded home on 6A in mid-February 2023. This will be timed to meet nursing rostering requirements and to coincide with the Registrar and JMO rotation. The logistics of the move will be undertaken over several days as it relies on discharges and transfers being optimised. When the AMU initially opens on 6A it may also be the case that they will start with 12 or 16 patients on transfer, and that we will increase the AMU bed footprint to 20 then 24 in line with discharges from that ward.

**Question: What will happen to 6A nursing staff?**

Answer: All permanent nursing staff will have roles either on 6A/AMU or in a location where there are vacancies and where the staff would prefer to work will be offered. 6A will also have 8 respiratory beds so the expertise of those acute respiratory skills will be important for those beds and the AMU high-acuity model.

**Question: Will there be seven day a week allied health?**

Answer: Yes. We know that patients need to have care initiated from admission, and we also know that some patients can decondition when allied healthcare is not optimised. There will be physiotherapy seven days a week, and access to other allied health (eg social work and pharmacy) over the weekend hours also. This will assist with front-loaded care as well as discharge planning from the point of admission.

**Question: Why is the nursing ratio higher than other inpatient units.**

Answer: The AMU model of care is based on taking those admitted patients from the Emergency Department as quickly as possible during their hyper-acute care needs. For the two daytime shifts we have mirrored the ED staffing profile of 1:3 nursing in line with the high acuity case load. The night duty is 1:4 ratio, again to support the higher acuity and high workload related to those initial 24-48hours of admission.

There will also be frequent transfers out to other wards and HITH from the AMU 24-bed base as the MOC is for a maximum of 48hours, so the higher nursing ratio will also assist with those outflows as well as optimise discharge (or transfer) planning from the point of admission.

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**Question: How will we know if the AMU model will work?**

Answer: The DoM leadership team will meet with the AMU team on a monthly basis to review their key performance indicators and clinical outcomes to monitor for success. We will also be monitoring the other perceived benefits such as the lowering of length of stay and Relative Stay Index, time in the ED waiting for bed allocation after an admit decision, occupancy of the AMU, admitted NEAT, discharge NEAT – all of which are indicators of improved patient journeys and outcomes.

**Question: How was the new DOM bed footprint developed?**

Answer: The new bed base was derived from some modelling done by Ernst and Young from historical data between 2019 and 2021 (excluding periods of COVID-19). The data analysed which diagnosis related groups (DRGs) were excluded in the criteria for admission to the Acute Medical Unit and which would be included. Analysis of these then helped form the updated bed numbers for each Unit based on a 24-bed AMU being implemented. The science is not exact as we have to apply an operational lens as variations like elongated RSI/LOS also impact on the bed base that each specialty requires.

**Question: How do we know the Ernst and Young data is correct?**

Answer: The data that was used is from a reliable source, and the methodology applied was considered appropriate at the time; and the use of an external team with experience in other health jurisdictions was thought to be of benefit for CHS.

What it does provide is a baseline for future measures and comparisons so we can trend change and improvements. Like some other patient data sets, it can be difficult to control for some factors given the nature of healthcare, so it is not an exact science so we need to ensure we have good clinical governance processes in place to ensure the modelling (and the AMU MOC) express themselves as predicted, and if not, that we have a review and decision-making to make any minor adjustments if required.

**Question: Is there a plan to adjust junior medical staffing with the change in the bed footprint?**

Answer: Not at this stage. For the first six months the Division of Medicine will be reviewing how the new model of care for AMU is working. Teams will be asked to in-reach into the AMU for consultations and to pull their specialty patients to their home wards when required. We expect the in-reach and pull to specialty wards to be as expeditious as possible to maintain good AMU flow.

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**Question: When will the care pathways be ready?**

Answer: Work is currently ongoing with finalising some care pathways. The DHR is being looked at to assist with ordering of tests and pre-ordering processes related to the care pathways to create sensible test ordering for those conditions which will standardise our approach.

**Question: Will education occur for staff who will be looking after a different cohort of patients on their ward?**

Answer: Yes. We will be looking at what educational requirements will be required for staff and supporting that through in-service, education, training, practice development and some experiential learning where that is available and where that can be enabled. We have various supernumerary education and clinical care roles which can assist us with this on-boarding for staff in new specialty areas.

**Question: With the integration of DHR into order sets for certain conditions are there set reviews in the system?**

Answer: If there is a defined order set from a protocol then a review date on the DHR will be incorporated to ensure that they are consistent with each other, and that they are revised or checked to ensure they are contemporary.

**Question: How will patients know the difference?**

Answer: We hope, overall, that patients will not notice any difference to the overall excellent care provided at DoM and CHS. However, what we hope patients start to see over time as the MOC matures and beds down (which will also be picked up in the data and audits) is that they spend less time waiting in the ED to be seen, less time in the ED waiting for an inpatient bed, that they experience quicker diagnostics and tests, and have improved communication about their care and the care plan when on the AMU and then across the DoM. We believe the AMU MOC will continue to enhance and improve the overall quality of care for our patients, as has been seen in other jurisdictions with similar models.

We will also need to consider a 3 or 6 month patient feedback survey or audit on their perceptions of care in the AMU so we can start using that as service feedback and to prioritise suggestions for improvement.

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**Question: Will other Divisions be reducing their bed footprint to assist with the AMU?**

Answer: Discussions are occurring with other Divisions who will benefit from the AMU around their bed base. Other divisions also have access to HRT RSI data so we would expect that they will also look at local quality improvements - as we are in the DoM. There is a CHS Inpatient Capacity Committee, and we would expect that data reviewed at that higher-level committee will also encourage improvements to patient flow, modernisation of models of care, and the bed base across CHS.

**Question: Is the AMU open to other types of patients for whom only a 5 day/week currently exists (eg renal dialysis)**

Answer: The AMU does/will provide a 7-day service so there are opportunities for those patients under specialty teams who deteriorate afterhours or at weekends to be seen in the ED and AMU (then discharged back to the existing service). This would provide quick access to senior clinicians and diagnostics to prevent further patient deterioration. We encourage any such patient cohorts to be discussed with the AMU team whilst reviewing the MOC document.

**Question: What is the level of service expectation from an Allied Health perspective?**

Answer: Some will be newly funded FTE for allied health staff (some of which will be allocated from the recent FTE increase allocation given to AH and recognised as 'catch-up), and some will be FTE redistribution from other wards. Work is being done with Allied Health Leadership Staff to ensure a smooth transition into the AMU MOC where we believe allied health input 7/7 is core to the model.

**Question: The current Cardiology long stay patient's go to Ward 6A – if Ward 6A is not available where do sub-acute cardiology patients (for example, heart failure) go?**

Answer: Ward 7A is the proposed location for LLOS or sub-acute complex planning patients, which may be from General Medicine, Respiratory or heart failure. We have pragmatically placed those 12 beds on ward 7A as there may also be some neuro patients who would fit into this group and that is where there is expertise in complex discharge planning already. We wanted to have one ward location within the Division of Medicine for sub-acute complex discharge planning patients (eg social care, sub-acute, nursing home, NDIS) so that the proposed CHS Complex Discharge Team (if implemented) could have a ward for focused attention and support to enable discharge or transfer to other services.