ACUTE CARE CENTRE (ACC) - ADMISSION CRITERIA, PROCESS, MANAGEMENT and ESCALATION

1. AIM

- To provide appropriate clinical guidance on the clinical criteria and decision making process for admission to ACC
- To outline the principles for the management of ACC beds to ensure timely and appropriate admission and discharge

2. PATIENT

- Woman with any of the following criteria:
  - High risk of deterioration, needing monitoring that cannot be provided on the general ward
  - Haemodynamic instability
  - Invasive pressure monitoring required
  - Non-invasive ventilation required
  - Vasoactive or inotropic drugs required
  - Cardiac monitoring required
  - Impaired renal or electrolyte function
  - Following major surgery and/or with perioperative complications
  - Psychiatric or psychosocial conditions requiring one-to-one specialist nursing care
  - Any other condition requiring admission, as determined by the admitting consultant

3. STAFF

- Medical, nursing and midwifery staff - including Prince of Wales Hospital (POWH) staff
- Allied health – including POWH staff

4. EQUIPMENT

- Non-invasive ventilator
- Telemetry
- Centralised haemodynamic monitoring

5. CLINICAL PRACTICE

Admission

- Identify woman needing ACC admission according to criteria above
- Consult with the anaesthetic medical officer rostered to ACC
- Consult with obstetric physician if relevant
- Contact the Access and Demand Manager(ADM)/After Hours Nurse Manager(AHNM) to confirm safe level of staffing, skill mix and bed availability (Refer to Appendix 1)
- Contact the ACC and provide clinical handover to the nursing team leader
- Conduct a clinical examination and document the management plan prior to transfer to ACC. This needs to be performed by a medical officer.
- Admit the woman under appropriate consultant
- Ensure comprehensive clinical handover is provided on admission
- Prepare a medical management plan for the woman, once admitted, that includes a process to facilitate escalation of care and transfer when required
- Identify the need for allied health services commensurate with case mix and clinical load
- Refer to psychiatry service if required
- Consult with Aboriginal Hospital Liaison Officer if required
- Ensure a comprehensive nursing care plan is in place
- Notify POWH Intensive Care Unit(ICU)/High Dependency Unit(HDU) for anticipated or required clinical advice and support

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ACUTE CARE CENTRE (ACC) – ADMISSION CRITERIA, PROCESS, MANAGEMENT and ESCALATION cont'd

Daily Management

- Conduct a twice daily ward round by the admitting team and update management plan as appropriate
- Conduct a review of each woman by anaesthetic consultant on Monday and Thursday. The admitting team member(s) must be present at these reviews and management plan updated.
- Conduct a review of each woman by the obstetric physician on Tuesday, Wednesday and Friday. The admitting team member(s) must be present at these reviews and management plan updated.
- Ensure ordering, documentation, prescribing and management tasks are completed by the admitting team Junior Medical Officer (JMO). This may include consultation with an anaesthetic team member
- Review of woman is required within 20 minutes of request from team leader, by the admitting team JMO. Escalate to the anaesthetic team member for assistance as required
- Refer to Clinical Nursing Consultant (CNC)/Clinical Midwifery Consultants (CMC) and allied health services as required
- Document and communicate a plan of management after each visit by any member of the multidisciplinary team
- Refer the woman to specialty services at POWH and transfer care to the appropriate specialty when required (e.g. Stroke, Cardiac Services)

Unstable or deteriorating patient

- Activate Clinical Emergency Response System (CERS) call
- Activate Code Blue POWH ICU team when indicated
- Communicate to the admitting team, by the anaesthetic team member, if need for transfer to ICU/HDU following a Code Blue or deteriorating/unstable woman
- Refer the woman to POW ICU by the anaesthetist team if:
    - The woman is requiring increasing amounts of vasoactive or inotropic drugs and ventilator support without improvement
    - Increasing organ dysfunction
- Ensure the anaesthetic team member remains with the woman continuously prior to transfer. Attending any other woman within the hospital at that time is not permitted
- Provide full clinical handover to POWH ICU/HDU by anaesthetic and admitting teams

Capacity/Demand Management

Patient Flow

- Review regularly patient dependency, staff skill mix, capacity and demand factors to ensure the service can be provided safely and in a timely manner
- Ensure the admitting teams assist and manage patient flow at a general ward level by adhering to timely clinical review and decision-making. Ensure capacity in ACC is available for any woman requiring that level of care
- Provide communication and thereby a good relationship between ACC and other hospital wards to optimise efficient patient flow. This is a hospital-wide responsibility
- Ensure all teams have the correct clinical review procedures in place to assist in capacity and demand management. This includes early and timely ward rounds and effective and predictive discharge planning.
- Ensure the ACC team leader updates the ADM/AHNM on current and predictive capacity and demand for the service

ACUTE CARE CENTRE (ACC) – ADMISSION CRITERIA, PROCESS, MANAGEMENT and ESCALATION cont'd

- Predict ACC bed management by:
    - ACC team leader communicating all planned admissions and discharges to the ADM/AHNM in advance so that forward planning of capacity can be enabled and supported. Any short-falls can then be proactively managed early.
    - Discussing all theatre cases at the weekly access meeting. ACC beds are assigned pre and post-operatively. Predictive capacity will be available at the time the woman requires the bed through normal capacity or through the departure of another woman (in the absence of any other emergency taking priority)
- Review daily the elective surgery lists and decide whether any cases need to be postponed
- Ensure the registered nurse/midwife-to-patient ratio is appropriate as per Appendix 1. This does not include the ACC CNC in the ratios. Changes to ratios cannot occur without medical review/clearance

If no acute care bed available

- Consider the capacity and demand factors
- Allow woman who no longer warrants ACC services and has been cleared for transfer/ discharge from ACC to be moved to the ward as soon as possible. This should occur before the six-hour time frame recommended by the Australian Council of Healthcare Standards.
- Escalate to ADM/AHNM if there is a delay in moving a woman from ACC. This should be communicated to allow the ACC team to manage any demand for the service. There may be a woman exiting from ACC services who requires other special consideration and this may take longer to coordinate (e.g. isolation requirements)
- Consider altering the order of the theatre list if an ACC bed cannot be confirmed to ensure procedure lists are not cancelled. When there are several surgical teams aligned for one patient procedure, and it is not possible to change the theatre schedule, the procedure should be allowed to begin if an ACC bed is anticipated
- Review each woman in ACC by the anaesthetic team member when a decision is needed to make a bed available. This decision needs to be confirmed/discussed with the admitting team
- Obtain additional nursing/midwifery staff to care for the woman in ACC if an unstaffed bed is available
- Escalate to admitting team consultant level if a decision cannot be agreed
- Escalate to divisional level if a decision still cannot be made
- Escalate promptly a request for transfer to POWH ICU/HDU if no bed can be created in ACC
- Continue to manage and hold the woman in recovery/inpatient ward until a bed is available in ACC
- Escalate to the RHW Executive on-call if no bed available in POWH ICU/HDU

<u>Transfer/Discharge from ACC by the Nursing/ Midwifery Team Leader</u>

- Notify the ADM/AHNM (page 44020) of the plan to transfer/discharge, for bed allocation
- Communicate transfer out of ACC to ward by ACC nursing team leader
- Ensure transfer/discharge documentation is completed by nursing/midwifery staff and admitting team JMO prior to transfer/discharge

6. DOCUMENTATION

- Medical Records
- ACC admissions book
- ACC day book
- Patient Flow Portal (PFP)
- Electronic Patient Journey Board (EPJB)

ACUTE CARE CENTRE (ACC) – ADMISSION CRITERIA, PROCESS, MANAGEMENT and ESCALATION cont'd

7. EDUCATION NOTES

- ACC is a Level 4 Close Observation Unit(COU), according to MoH NSW Health Guide to the Role Delineation of Clinical Services[1], as outlined below:
  - Dedicated unit in health facilities with an Intensive Care Service (ICS).
  - Provides level of care between standard ward and an intensive care unit (ICU), with close monitoring and observation e.g. women transitioning out of the ICU, women likely to need intensive care outreach support such as rapid response or ICU liaison.
  - Admission and medical care of woman remains under the direction of the Admitting Medical Officer or an Intensivist.
  - May provide non-invasive ventilation (NIV) where the intention is not to escalate to invasive ventilation.
  - May provide short term low level vasopressor therapy where there is low likelihood for or intention to escalate to intensive care.
  - Each woman must have a medical management plan that includes a process to facilitate escalation of care and patient transfer when required.
  - Each woman must have at least daily medical review and care planning.
  - Access to allied health services commensurate with case mix and clinical load.
  - Access to consultation-liaison psychiatry.
  - Referral pathways to relevant Aboriginal programs and services.
  - Quality and risk management programs in line with current National Safety and Quality Health Service (NSQHS) standards.
  - Close relationship with the ICS, including clinical advice and professional development support.
- Early access to ACC services has been evidenced to have a positive impact on survival rates and reduce lengths of stay.
- Operationally, day to day, the ACC CNC and Midwifery Unit Manager (MUM)/Nursing Unit Manager (NUM) along with the ADM/AHNM are responsible for making decisions around capacity and demand, and making clinical decisions that affect patient flow.
- Responsibility for the clinical governance of the ACC is with the Director of Medical Services
- Admitting medical team members are:
  - Resident Medical Officer (RMO)
  - Registrar
  - Fellow
  - Consultant

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Admissions Business Rule
- Inter-hospital Transfer Procedure, Business Rule
- Discharge – Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals Business Rule
- Demand Access Escalation Business Rule
- Escalation for Birthing Services
- Patient (adult) with acute condition for escalation (PACE) criteria and escalation
- Implementation guide Putting a model into practice – Clinical Program Design and Implementation https://www.aci.health.nsw.gov.au/resources/acute-care/cou/close-observation-units
- PD2012_011 Waiting Time and Elective Patient Management Policy, NSW Health https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_011.pdf
- PD2011_031 Inter-facility Transfer Process for Adult Patients Requiring Specialist Care https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_031.pdf

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- PD2018_011 Critical Care Tertiary Referral Networks & Transfer of Care (Adults) https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2018_011
- SESLHDPR/228 Critical Care Bed Management Procedure https://www.seslhd.health.nsw.gov.au/sites/default/files/documents/SESLHDPR228.pdf
- SESLHDPR/562 ICU/HDU Admission Criteria https://www.seslhd.health.nsw.gov.au/sites/default/files/migration/Policies_Procedures_Guidelines/Clinical/Critical_Care_Emergency_Medicine/documents/SESLHDP562ICUHDUAdultadmissionCriteria.pdf

9. RISK RATING

- Low

10. NATIONAL STANDARD

- Standard 5 – Comprehensive Care

11. REFERENCES

1. Ministry of Health NSW Guide to the Role Delineation of Health Services, 2018 https://www.health.nsw.gov.au/services/Publications/role-delineation-of-clinical-services.PDF
2. Agency of Clinical Innovation. Establishment, Governance and Operation of a Close Observation Unit https://www.aci.health.nsw.gov.au/resources/acute-care/cou/close-observation-units
3. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards guide for hospitals, 2nd edition. Sydney: ACSQHC; 2017. https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf

REVISION & APPROVAL HISTORY

Amended August 2019 – PACE changed to CERS
Reviewed and endorsed Maternity Services LOPs 7/5/19
Replaced previous titles:
Acute Care – Patient Acuity Guide
Approved Quality & Patient Safety Committee December 2010
Endorsed ursing & Midwifery Clinical Practice Group December 2010

Acute Care Admission Criteria, Process and Management
Approved Quality & Patient Care Committee 2/6/16
Reviewed and endorsed Obstetrics LOPs group 24/5/16
Approved Quality & Patient Safety Committee 15/10/09
Endorsed Obstetrics Clinical Guidelines Group July 2009

Escalation Guideline for Acute Care Centre
Approved Clinical Operations Committee 28/1/10

FOR REVIEW: MAY 2024

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APPENDIX 1
RHW Acute Care Centre – Patient Acuity Guideline

- A close observation unit (COU) provides an intermediate level of care between a general ward and an intensive care unit. A COU is a specially staffed and equipped area of a hospital that provides an intermediate level of care between intensive care and general ward care
- The ratio of nursing staff must meet the patient acuity, volume and scope of clinical services
- A clear process must be in place to identify additional nursing staff above the baseline nursing profile, when required
- A senior nurse with the appropriate skills, experience and postgraduate qualifications for the clinical environment should be in-charge whenever necessary
- At least one nurse on each shift within the COU must hold postgraduate qualifications for the clinical environment, or have significant experience in critical care or acute care
- The following patient conditions related to these physiological systems are managed with the following staff:patient ratios:

SYSTEM **Condition**	**1:1** **WOMAN** **WHO IS ACUTELY UNWELL**	**1:2** **ALL** **OTHER** **WOMEN**	**1:3** **AWAITING** **WARD** **BED**
GENERAL	Unstable condition ≥ 3 CERS calls in two hours ≥ 5 infusions of multiple medications ≥ 2 organ systems impaired, not requiring ICU Intravenous(IV) infusion(s) requiring ≥ 2 titrations/hour Requiring observations taken ≥ 2 times/hour		
OBSTETRIC	Unstable pre-eclampsia on IV MgSO4 or IV hydralazine infusion Acute condition		
RESPIRATORY	When on BiPAP or CPAP requiring titration Unstable airway		
CARDIAC CARDIOVASCULAR	Inotropes Glyceryl trinitrate(GTN) IV concentrated KCl infusion		
ELECTROLYTES	Intensive electrolyte replacement		
PSYCHOSOCIAL/ PSYCHIATRIC	Woman that has 1:1 psychiatric nursing special, can be categorised 1:3 for nurse/midwife staff:patient ratio		

- Notify ADM/AHNM when woman is no longer meeting 1:1 criterion and may return to 1:2 care
- Document patient categories in the ACC Day Book for data collection

Staffing Escalation:

- Review each woman by her admitting medical team and Team Leader ACC
- Team Leader ACC to notify the ADM/AHNM to address skill mix needs and staffing requirements
- Deploy or acquire a third staff member as is required to manage increased acuity in patient care, as the other patients are 1:2 staff:patient ratio
- Arrange transfer to the appropriate ward for a woman who has been reviewed and cleared for transfer by her admitting medical team