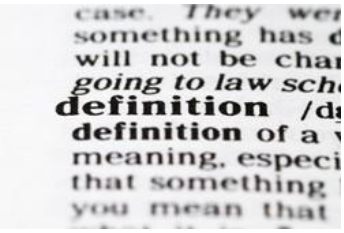
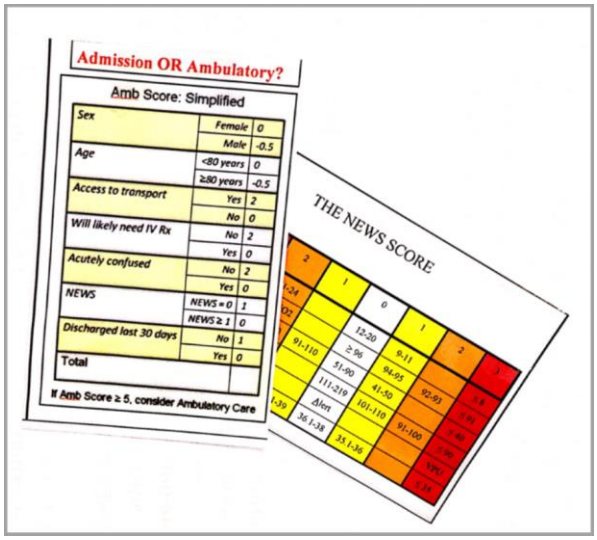
Definition of AEC



For the purpose of this statement AEC is defined as the provision of same day emergency care for patients being considered for emergency admission.

Ambulatory Emergency Care services can also facilitate early supported discharge by offering the option of early clinical review, follow up diagnostics and patient reassurance. However this should not be the main focus of the service.

Patient Selection for AEC



Patient selection is a key step to ensure that those most likely to benefit will be able to access AEC Services. Optimal patient selection is often compromised by access, staffing and facilities. If these issues are addressed, patient selection should be based on:

- Clinical stability established by recording a NEWS and a clinical discussion
- AEC being the best place to meet the patient's required clinical needs
- The staffing and facilities can ensure the patient's privacy and dignity are maintained

Where there is an AEC service, any patient who needs an admission should be considered for care within that service.

Teams must regularly review reasons for patients being excluded from the AEC service and consider changes necessary to give these groups access to same day emergency care.

It is equally important to ensure the 'wrong' patients are not referred to AEC as this will block capacity, deny access to the service for patients who would most benefit and limit patient flow within the hospital. The types of patients that should NOT be managed in an AEC service are listed below;

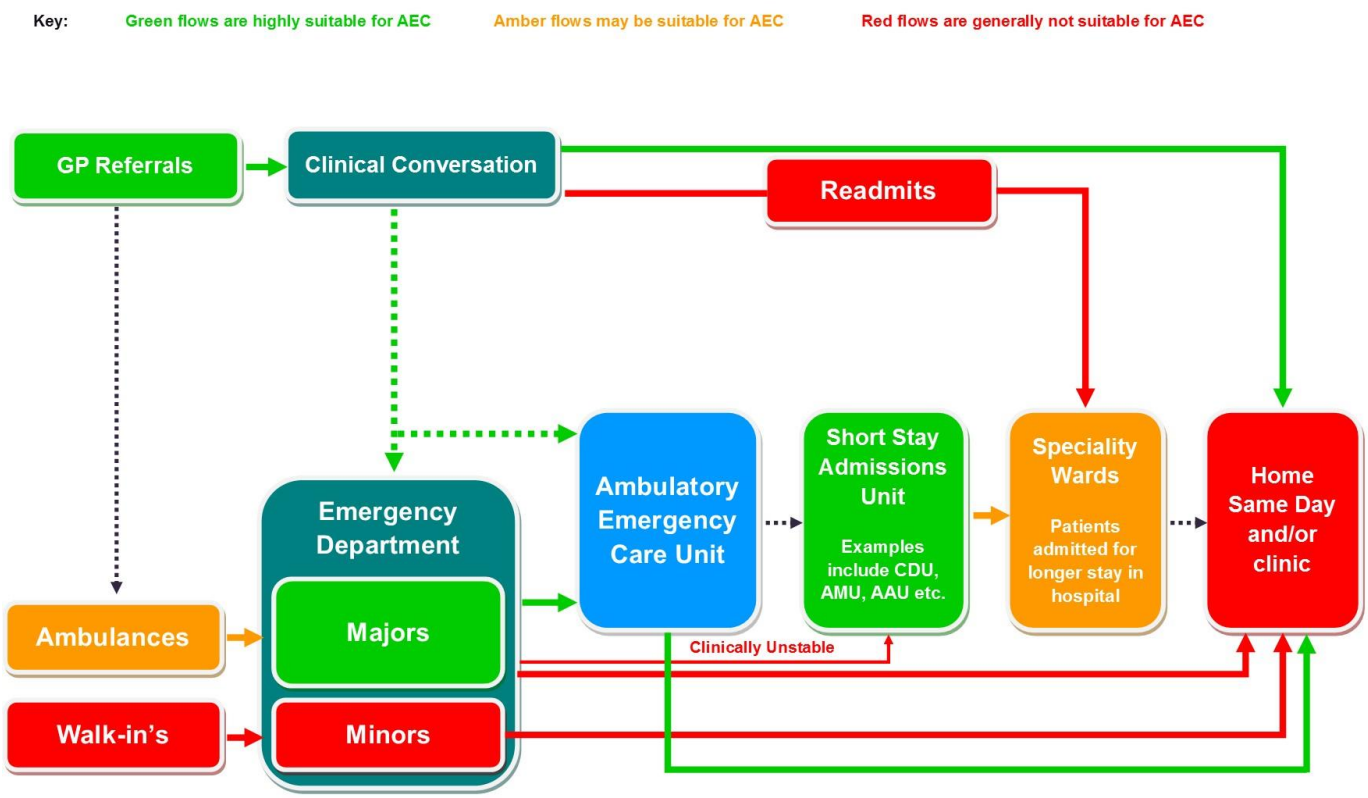
- Patients needing the facilities of a discharge lounge
- Type 2 ED attenders (Minors). These patients should continue to receive their care in ED within the 4 hour standard.
- Type 3 ED attenders. These patients should continue to receive their care in the ED within the 4 hour standard.
- Clinically unstable patients
- Patients who will breach the 4 hour standard but whose clinical care does not require a move to another team.
- Patients overflowing from other services that do not have the capacity to manage their care

Sending the wrong patients to AEC will have a negative impact on the system. With this in mind robust gatekeeping processes are needed to ensure the right patients are streamed to the service. A simple way of achieving this rigour is to judge all referrals against the question; 'Would this patient have been admitted to a bed in the hospital if AEC didn't exist?'

What data fields do we require to analyse the flows?

You might need to use a combination of systems including your patient administration system and emergency department information system.

It is essential that you can identify your AEC patients through a designated area code such as a ward code; this code needs to be separate from your assessment unit.



Once you can identify your AEC patients, the next step is to determine whether they were appropriate for AEC both in terms of whether they could have been discharged from the Emergency Department (with or without a future clinic appointment) or whether they should have bypassed AEC and been admitted to the assessment unit/speciality ward.

The latter is easier to determine by looking at whether the AEC patient was discharged or transferred. If the patient was transferred, a medical notes review would help to determine whether it was for clinical need as the patient deteriorated, whether it was a timing issue and the AEC unit was closing yet the patient was not ready to be discharged or whether the patient should not have been transferred/accepted by AEC in the first instance i.e. inappropriate for AEC.

The former is much more difficult to determine and once again, would require a medical notes review but there might be away to identify the cohort of patients this might apply to. The key is to look at where these patients came from, if they came from the Emergency Department, were they classified as a major or minor patient? If they were identified as a minor patient, it would be worth reviewing the medical notes to determine whether they could have been discharged directly from the Emergency Department and whether they actually needed to go to AEC.

You might want to use the 2x2 matrix as a checklist to ensure you have got the correct data to assess the appropriate/inappropriate balance.

Other routes into AEC may include GP admissions where following a clinical discussion AEC is decided as the appropriate destination. The decision might also be made that AEC is used for Early Supported Discharge – it is key that this is not at the expense of its primary use to prevent emergency admissions.

	Managed in AEC	Not managed in AEC
Appropriate for AEC	**Success** (expect around 10-15% conversion)	**Missed opportunity**
Not appropriate for AEC	**Wasted capacity** (Non-urgent case)	**Appropriate** inpatient / outpatient care
	Potential clinical risk (Patient too acute ± too complex)	