AHP Multidisciplinary Working on an AMU

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CONTENT

• Definitions
• Professional roles
• Collaborative working
• Professional guidelines
DEFINING THE AMU

• The Royal College of Physicians (London) defines acute medicine as:

“That part of general (internal) medicine concerned with the immediate and early specialist management of adult patients suffering from a wide range of medical conditions who present to, or from within hospitals requiring urgent or emergency care”.

• SAM defines the Acute Medical Unit (AMU) as:

“The specialised area of an acute hospital where patients suffering from acute medical illness can be assessed and initially managed”.

DEFINING THE FIELD

Assessment / Intervention

24 hours

24 – 48 hours

Ward/ Rehab
EMERGENCY MEDICAL ADMISSIONS

• The progressive rise in acute medical admissions has led to review of the process of care with focused and innovative developments in the management of emergency admissions.

• The present evidence shows the greatest increase in admissions and readmissions is in the over 65s and in particular the over 80s.

• This patient group usually present with elderly complex needs as a result of multi system chronic disease
CLIENT GROUP

- 90% delayed medical discharges are emergency elderly complex admissions
- Significant proportion are unknown to health care or social services
- Complex needs
  - chronic or acute
  - Functional impairment
  - Often minor insult
COMPLEX NEEDS SERVICE

• Determining ‘normality’ for the patient

• Avoid ‘medicalising’ need

• Admission reinforces community/patient/carer belief ‘cannot cope’

• Reduce dependency

• Facilitate safe & timely discharge
WHAT CAN AHP OFFER?

• To help deliver high quality care for this older sub group of patients, a multi professional team approach in the acute medical assessment unit is essential.

• The aim is to provide point of entry multi professional assessment and treatment to prevent deterioration and/or dependency

• In addition to medical and nursing staff, the MPT should also have an embedded / dedicated
  – Experienced Physiotherapy team*
  – Experienced Occupational therapy team*
  – Experienced Pharmacy team
• Proactive multi professional referral

• Prompt mobilisation
  - early analgesia

• Prompt functional assessment
  - including cognition
SERVICE USER AND ORGANISATION BENEFITS

By providing this service at the Front Door OT/PT professions contribute to:

• Improving the patient’s journey by either facilitating early discharge or providing early therapy goal-setting and intervention at the start of a hospital journey.

• Reducing the length of stay of patients who do not require an in-patient hospital stay, particularly where community support can assist in achieving this goal.

• Rapid generation of onward referrals to intermediate care services thereby providing ongoing therapy intervention and enhanced supported early discharge.
• Promoting an approach to care that is holistic, team-based and with patient-focused outcomes, particularly for those with complex care needs.

• Focussing on quality and value so that care and support for this patient group is safer, fair and person-centred, and delivered faster and closer to home where appropriate.

• Promoting partnership working between health and social care to ensure best value is achieved by shifting balance of care
ROLE OF OT/PT

• “The therapist must have a high-level working knowledge of how to carry out and interpret a comprehensive subjective and objective assessment of differing patient presentations in the AMU. All items of these assessment components must be considered where relevant, with appropriate weight given to those that are key for the individual patient. A thorough comprehension of the patient’s admission history and general medical status is essential.”

• Reference – Guidelines 2012
REASON FOR PHYSIOTHERAPY / OT

To obtain as clear a picture as possible of an individual’s functional ability in the context of an acute illness presentation, and to facilitate best destination of the individual from a short-stay ward area.
PRINCIPLES & PHILOSOPHY

• Patient-centred
• Point of Entry diagnostics / management
• Needs met by best-placed professional
• Information follows patient in real-time
• Specialist advice availability
• Delivery to consistent standards
A TYPICAL AMU PRESENTATION?

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Male 88yrs
Collapse / fall ?cause, # R head of humerus (RHD). Lacerations to face.
Lives alone in FF Flat. Family support for shopping/domestic tasks. No other formal support. No walking aid. Mild cognitive impairment. Increasing number of falls.
Problems/solutions:
- mobility – walking aid
- transfers – equipment/CCA
- personal care/meals – Crisis Care
- ongoing care needs – Social Care Direct
- ongoing risk of falls – Rapid Response, telecare referral
SUBJECTIVE ASSESSMENT

Basic History:
- Presenting complaint
- History of presenting complaint
- Past medical history (including falls history)
- Drug history
- Social history

Functional history:
- Mobility (use of aids)
- Falls history
- Equipment (household / adaptations)
- Continence history

Advocacy:
- Individual capacity
- Indicators of vulnerable adult status
- Safeguarding alerts

Support:
- Familial
- Formal / agencies
- Informal (e.g. friends / neighbours)

Ref Therapy Guidelines 2012
OBJECTIVE ASSESSMENT

Baseline core assessment:
- Tone
- Power
- Range of Motion
- Sensation, including pain
- Proprioception
- Coordination
- Other components (e.g. cranial nerves; vision)
- Respiratory assessment (where relevant)

Cognition:
- Mini-mental State Examination
- Insight
- Attention
- Memory
- Retention
- Self-awareness
- Mood
- Planning and sequencing
- Instruction-following

Functional and combined movement:
- Balance
- Transfers (e.g. lie↔sit↔stand)
- Gait
- Exercise tolerance
- Stair climbing
- Falls risk assessment
  *(Note: Functional score may be useful)*

Functional Activities:
- Self-care and toileting
- Dressing
- Kitchen assessment
- Self-medication assessment

Ref Therapy Guidelines 2012
ROLE OF OCCUPATIONAL THERAPY

• Occupational therapy is the treatment of people with physical and psychiatric illness or disability through specific selected occupation for the purpose of enabling individuals to reach their maximum level of function and independence in all aspects of life.

WFOT 2012
HOW DOES OT ACHIEVE IT’S AIMS WITHIN CONTEXT OF AMU?

What does this person need to be able to do to cope at home today?

What is this person able to do for themselves right now?
CORE SKILLS/ ROLE OF OT

• Social /Occupational Performance verification
  - detailed history taking

• Functional/ADL assessments
  - Baseline or complex needs assessments

• Falls Risk Assessment

• Cognitive / psychological assessments
  - alert flags, advocacy
• Holistic assessment

• Discharge Home Assessments
  - exception rather than norm

• Discharge planning/ onward recommendations

• Networking / communicating with Primary, social and Intermediate care services
ROLE OF PHYSIOTHERAPY

• Physiotherapy helps restore movement and function to as near normal as possible when someone is affected by injury, illness or by developmental or other disability.

(CSP website 2012)
CORE SKILLS/ROLE OF PHYSIO

• Neuro-biomechanical assessment
• Falls assessment
• Specific condition defined assessment
• Patterns of normal movement and coordination
• Balance and gait
• Exercise tolerance
• Walking aid assessment
• Identifying rehab needs
INTERVENTIONS

- Simple mobilisation
- Soft tissue injuries
- Pain management (eg LBP)
- Early neurological rehab
- Respiratory care
- Provision of walking aids
- Falls management/ gait re-education
- Onwards referrals
COLLABORATIVE WORKING

• The acting together of two or more people from different professions either within the same or from different agencies to deliver a service which neither can deliver alone

Loxley (1997)
DEFINING COLLABORATIVE WORKING

• Multidisciplinary
  – a team of professionals including representatives of different disciplines who coordinate the contributions of each profession, which are not considered to overlap, in order to improve patient care.
3 DIMENSIONS OF MD WORKING

- Structural
- Interpersonal
- Cultural

(Gorman P 1998)
THE WIDER TEAM

- Social Services
- Rapid Response
- Community Rehab Services
- Discharge teams
- Equipment Stores
- Volunteer services
- Care environments/day centres
- GP's
- Mental Health Services
- Ward based teams
- Community Nursing Services

Team
• **Interdisciplinary**
  
  – a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient.
• **Transdisciplinary**
  – a team composed of members of a number of different professions cooperating across disciplines to improve patient care through practice or research.
BENEFITS OF INTERDISCIPLINARY WORKING

• Avoid duplication and overlap of services with a streamlining of care delivery
• Improve time effectiveness
• Pool specialist skills of the team
• Enhance and maintain comprehensive not duplicated communication

Loxley (1997)
BARRIERS TO INTERDISCIPLINARY WORKING

• Change of ethos
• Blurring/ fears regarding boundaries
• Organisational design or geographical separation
• Concerns over professional responsibility
• Dependent on effective leadership with joint vision and buy-in
• Different employers/ organisations involved in a healthcare team
COMPETENCIES FOR COLLABORATIVE WORKING

1. Describe your role and responsibilities clearly to other professions

2. Recognise and observe the constraints of your own roles, responsibilities and competence, but understand the needs in the wider framework for mutual respect and shared values
3. Recognise and respect the roles, responsibilities, competence and constraints of other professionals in relation to your own, knowing when, where and how to involve those others.

4. Work with other professions for service changes, improving standards, problem solving and conflict resolution
5. Work with other professions to assess, plan, provide and review care for individual patients and support carers.

6. Tolerate differences, misunderstandings, ambiguities, shortcomings and unilateral change to other professions
7. Enter into interdependent relationships, teaching and sustaining other professions, learning from & being sustained by those other professions

8. Facilitate inter-professional case conferences, meetings, team working and networking

Barr (1998)
SUCCESS FOR PRACTICE

• Skills in collaborative practice are essential
  – Skills for Health competencies
• Strong MDT working
• Organisational structures need to be transparent and understood for it to be sustainable
• Is contextually driven but suits the complex needs of older people that present on AMU
NEW THERAPY GUIDELINES

Physiotherapy and Occupational Therapy in the Acute Medical Assessment Unit: Guidelines for Practice

Society for Acute Medicine
Physiotherapy and Occupational Therapy Group
October 2011
GUIDELINE CONTENTS

• What is an Acute Medical Assessment Unit (AMU)?
• The Key Roles of Physiotherapy and Occupational Therapy in the AMU
• Skills required for Physiotherapists and Occupational Therapists
• Algorithm of Physiotherapy and Occupational Therapy Process in AMU
• Documentation Guidelines
• Activity Analysis
• Appendices
  – Screening and Prioritising of Referrals
  – Subjective and Objective Components of Assessment
  – Discharge Support
  – Useful Information: Links to Aid and Inform Practice
CONCLUSION

• Virtual communication essential within MPT

• Network with Primary, secondary and tertiary care services

• Empowered multi professional team allows for interprofessional opportunities between OT & physio

• Will reduce dependency at point of entry and facilitate safe and effective discharges

• New guidelines developed to guide AHP’s in this process
REFERENCES
