Development of a short-stay unit in an emergency department

John Power and Olivia McManus describe the training and practical requirements of introducing advanced nurse practice in a hospital in Northern Ireland

Abstract

In 2009, the Royal Victoria Hospital, Belfast, established a nine-bed, short-stay unit in its emergency department. This article explains the rationale for the model of care delivery adopted, and the importance of developing and working with integrated care pathways. It also discusses four areas essential to the effective running of the unit: interdisciplinary collaboration, training for clinical nurse leaders, management of change and leadership.

Keywords
Care pathways, short-stay units, nurse-led services

IN 2009, the Royal Victoria Hospital, Belfast, set up a short-stay unit (SSU) in its emergency department (ED) to:
- Reduce delays in patient admissions and transfers to the ED’s medical receiving unit.
- Lower costs by reducing the number of bed days and locum doctor fees.
- Reduce variability and inconsistencies in the delivery and efficacy of care.
- Meet a desire among nurses for their roles to be extended.
- Ensure that smaller teams of nurses would deliver integrated care pathways (ICPs).
- Improve the quality and delivery of patient care.

In the authors’ experience, however, similar units in Northern Ireland often become overwhelmed by demand as patients occupy their beds for extended periods. It was deemed crucial, therefore, that the SSU at Royal Victoria Hospital was planned meticulously, that its staff were trained appropriately and that its practice was delivered according to specific protocols.

A steering group comprising senior nurses and consultant doctors was set up to plan the unit and supervise the training of nurses who would work in it. By remaining committed to their vision of an SSU, adopting an incremental approach, responding to feedback and suggestions, protecting care pathways, and advancing the idea of nurse practitioners, the group eventually succeeded in establishing the SSU.

The steering group decided that the success of the SSU would depend on its patients being managed according to specific and rigorously enforced care pathways, and on diagnoses and treatments being delivered quickly.

At an early stage of the unit’s development, therefore, the multidisciplinary team drew up a prototype ICP. This was designed to ensure that future ICPs would be:
- Based on evidence.
- Encompass best practice.
- Enhance communication among team members.
- Include specific goals derived from NHS Scotland (2012) and Royal College of Nursing (RCN) (2012) guidelines.
- Promote effective monitoring.
- Support clinical governance.

According to informal feedback from patients, carers and clinical staff, ICPs based on the prototype worked safely and effectively, and their use led to improvements in the quality of nursing care. As a result, resistance to the introduction of advanced nurse practice diminished significantly.

It should be noted, however, that, patients’ journeys are unique and there must be scope for individual patients’ care pathways to vary from those described in ICPs, according to the patients’ specific needs (Wilson et al 2001, Wiles et al 2003).
This article discusses some of the most important features of the SSU, including team collaboration and the development of an integrated pathway, nurse training, management of change and leadership.

**Development**

**Team collaboration** Before the SSU was established, teams involved in, for example, patient transfers were not integrated. As a result, patient throughput was delayed, costs were high, target times were missed and quality of care varied.

Interdisciplinary communication and collaboration were important aspects of the development of the SSU, and evidence suggests that such communication should extend to patients’ relatives and carers (British Association of Day Surgery 2004).

To ensure professionals from different disciplines collaborated with each other and that care delivery was standardised, care pathways were drawn up in line with the appropriate National Institute for Health and Care Excellence (NICE) (2013) and Scottish Intercollegiate Guidelines Network (SIGN) (2013) guidelines.

**Enhanced training** While the SSU was being developed, the Royal Victoria Hospital could not fill all of its middle-grade clinical posts, which resulted in delays in care, overcrowding in the ED and the use of locum doctors, who tended to be unfamiliar with organisational policies and practices, and the needs of some patients.

For these reasons it was proposed that nurses in the SSU should undertake a recognised training programme to become advanced clinical nurse practitioners.

No such pathway exists in emergency care in Northern Ireland, however, so an interim training programme has been prepared by one of the ED consultants in collaboration with the ED’s advanced clinical practitioner and senior consultants.

All nursing staff in the SSU began this programme before the unit opened and continued to undertake it for six months a year while they worked there.

**Managing change** The NHS Leadership Framework (NHS Leadership Academy 2013) emphasises the importance of all staff becoming involved in, or leading, change. However, not all staff wanted the SSU to be introduced and their concerns had to be addressed.

To this end, weekly meetings involving senior nursing and medical staff were held to explore these concerns and develop solutions together. These meetings continued to be held for two years after the SSU opened.

Lewin’s (1951) three-stage approach to the management of change was adopted to identify the concerns of members of staff, including those clinical and senior nurse managers. The three stages of this model are:

- Actively listening to staff, and addressing the strengths and weaknesses of change proposals.
- Progressively and incrementally initiating and developing change.
- Embedding the change process.

Lewin’s model also accommodates the emergence of resistance to change (Bratton et al 2010). In addition, Lewin’s (1951) force-field analysis, which focuses on objectives of, drivers for and obstacles to, change, was undertaken to help ‘unfreeze the status quo’.

One of the most significant obstacles to organisational change in the NHS is the resistance of staff (NHS Institute for Innovation and Improvement 2008, Kerridge 2012).

After listening to feedback about the service the steering group found that many staff were concerned that it would use too many resources and would undermine the structure of management in the trust, in which nursing was limited to care delivery.

Some of the most senior nursing staff were concerned about the extension of nursing roles to include assessment and treatment, particularly because the nurses concerned would receive no formal training.
Patient flow coordinators wanted to retain the right to admit patients and insisted that SSU beds should be regarded as part of the overall number of beds in the hospital to ensure that the 12-hour waiting time target for emergency care would not be breached.

Clinical staff, who were already stretched, thought that the unit would create additional work for them, and some also doubted that nurses could undertake extended roles.

In addition, some emergency nurses regarded work in the SSU to be less demanding than that in the ED. Such resistance to organisational change is inevitable and healthy (Bratton et al. 2010), but must be managed (Curtis and White 2002) to ensure that professional attitudes do not become fixed (Bainbridge 1996).

In the author’s experience, there was a tendency among nurses of all grades at the Royal Victoria Hospital to emphasise their supportive, rather than their proactive, roles, sometimes to the detriment of their career development.

There was no significant resistance from SSU nurses, who appeared eager to take on the challenge of extended roles, possibly because they had been briefed by the steering group early in the process. Some emergency nurses subsequently worked shifts in the SSU and five of them joined the SSU staff.

Resistance to change was addressed through a model of engagement involving the collaboration of individuals and groups to achieve agreed results (Borden and Perkins 1999, Bratton et al 2010). This involved:

- Emphasising the benefits of change, while recognising that resistance to it is inevitable.
- Listening and responding to the individuals and groups involved in change.
- Educating and helping the individuals and groups affected by change.
- Ensuring that the individuals and groups involved in change develop a sense of ownership of the results.

Leadership Effective leadership, characterised by ‘emotional intelligence’ and an ability to motivate people (Goleman 2002), is required whenever organisational change must be managed (Bratton et al 2010, Finkleman 2010).

Such leadership was required to transform the culture and model of nursing at Royal Victoria Hospital ED, and was provided by the co-author (OM), a senior sister with extensive experience of ED service delivery and medical admissions. The qualities and abilities she required included:

- Motivation and an ability to motivate others.
- Assertiveness, particularly in the development and application of care pathways.
- A vision of how an effective SSU would improve care.
- An understanding of why SSUs elsewhere in Northern Ireland have not been effective and an ability to build on the experiences of their staff.
- A willingness to understand and engage with all staff involved in the management of change and establishment of the unit.

Implementation

The nine-bed SSU was opened in the Royal Victoria Hospital ED in August 2009. Staff initially worked there between Monday and Friday each week but, since November 2011, they have worked 24 hours a day, seven days a week.

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Case study

A 17-year-old man accompanied by his mother arrived by ambulance at the hospital’s emergency department (ED). He revealed that he had taken an unknown quantity of citalopram and other drugs, and he confirmed his intention to kill himself.

Following a revised ED protocol, staff brought the young man to the hospital’s short-stay unit (SSU), where he was seen immediately by its senior nurse assessor.

The patient’s full history was obtained and assessments and interventions, including blood screening and electrocardiography, were begun.

A therapeutic relationship between staff and patient was quickly established, and he appeared to become more comfortable about discussing the reasons for his suicide attempt.

After discussions with the patient, his mother and the ED consultant doctor, the senior nurse assessor found the patient to be clinically fit. The young man was assessed by the hospital’s community social work team before being referred to an adolescent crisis-intervention team.

He was then discharged to the care of his mother, and follow-up care at home with a community mental health team was arranged for the next day.

The patient’s total length of stay in the SSU was six hours.
From the outset, the unit has had a strong multidisciplinary team ethos and effective relationships have been formed between its medical, nursing and allied health professional teams, which are co-ordinated by a senior nurse and an advanced clinical practitioner with assessment skills.

The teams observe, diagnose and treat about 300 patients a month according to agreed protocols in an ICP. The maximum anticipated patient stay is 36 hours.

Patients present with conditions, including:
- Asthma.
- Chest pain.
- Community-acquired pneumonia.
- Head injuries.
- Pleuritic chest pain.
- Pyelonephritis.
- Renal colic.
- Tonsillitis or quinsy.
- Trauma rest and review.

The teams also manage patients who have misused alcohol, experienced falls or self-harmed.

**Alcohol misuse** Before the SSU opened, patients who misuse alcohol were admitted to a medical unit, where they were seen by different members of staff at each admission. Such patients are now seen in the SSU by the same team of nurses at each admission, which improves the continuity of their care.

About 30 patients who misuse alcohol are admitted to the SSU each month. Some experience withdrawal symptoms in the SSU or have histories of seizure and cannot be discharged safely.

When the SSU opened, staff assessed such patients with a revised version of the Clinical Institute Withdrawal Assessment of Alcohol (CIWA) scale, known as CIWA-Ar (Sullivan et al 1989).

The scale appeared to produce inconsistent scores, however, so SSU staff now use the Glasgow Modified Alcohol Withdrawal scale (Benson et al 2012) and alter patients’ dosages of, for example, chlordiazepoxide according to the scores it produces.

Members of the SSU nursing team use such tools to provide standardised care for patients and have an excellent working relationship with alcohol-liaison nurses, who assess patients before they are discharged.

Team members know those patients who attend regularly, which means they can quickly determine if they are safe to be discharged home after being prescribed chlordiazepoxides and can encourage them to take more responsibility for their condition.

**Falls** Patients who have fallen and injured themselves in their homes tend to be older than the average for all patients. Before the SSU was opened, bed shortages were such that many of these patients had to lie on trolleys after their treatments until sedation wore off and they could be discharged home.

Between ten and 15 patients who have fallen or who require post-sedation observation are admitted to the SSU each month. Because falls among older people is included in the SSU protocol, and because patient turnover there is rapid, beds are almost always available for such patients in the SSU.

In addition, these patients can be assessed by occupational therapists, physiotherapists and social workers in the SSU, and have their medications reviewed by nursing staff and pharmacists, before being discharged. Before the SSU was set up, such assessments would not have occurred or would have been less integrated.

**Self-harm** While suicide rates among some sections of the UK population have decreased (Office for National Statistics 2012), among young men in Northern Ireland they have risen (Northern Ireland Statistics and Research Agency 2012).

An example of the care offered to people who self-harm is described in the case study (left). If the SSU had not been established, it is unlikely that the patient it describes would have been seen and treated so quickly or that he would have received such good care. He may have waited six hours to be seen in the ED, and would then have experienced an extended admission and hospital stay.

To develop a rapport with patients such as the young man described in the case study, the senior nurse assessor needs the appropriate clinical skills, and must be able to understand and work across political, social and sectarian divides.

**Conclusion**

Although some of the characteristics of nursing in Northern Ireland are unique, valuable lessons can be learned from Royal Victoria Hospital’s experience of developing advanced nursing practice in an SSU.

The development of ANP roles can improve services without drawing on additional resources, and can increase the competence and
professionalism of nurses. Such developments represent significant changes from existing structures and practices, however, and may be resisted by some staff at all levels.

To manage these changes, effective nursing leadership, a vision, resources for education and training, and a collaborative interdisciplinary approach are needed.

In establishing the SSU, the development of ICPs proved to be crucial and two other EDs in Northern Ireland have adopted the ICPs with a view to developing similar services.

Meanwhile, the Royal Victoria Hospital is drawing up plans to move the SSU to a 16-bed unit attached to its ED and to double the nursing complement accordingly.

References


Royal College of Nursing (2012) Care Pathways. tinyurl.com/cgln2d (Last accessed: April 17 2013.)


