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Mini Review

A Reflection on Establishing Acute Surgical Clinic in a District General Hospital

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Received: June 15, 2021; **Published:** July 28, 2021

Abstract

It is a general observation that most of the patients presenting as emergency to the hospital get admitted in the ward. However more than one third of them get discharged the very next day either after a morning review or certain radiological or endoscopic investigations. This pattern seen worldwide led to the talks of economic burden on health care system. Multiple meetings and discussions resulted in the idea of development of rapid assessment and care units.

Different names have been given to the model providing day service for example surgical ambulatory care (SACU), acute surgical clinic (ASC), ambulatory emergency care (AEC) and same day emergency care (SDEC).

Development of ambulatory care units was full of hurdles in the start not only from staffing point of view but also in space and organising a safe patient care pathway. Over a period of time when the difficulties were overcome, they became highly efficient not only in providing care to the referred patients but also were able to give rapid telephonic advice to other health care professionals based in the community. Ambulatory cares units eventually became a host to many surgical conditions like abscess, biliary pathologies, hernias, and appendicitis, diverticulitis and post-operative complications.

Clinical teams that are keen to develop an effective SAEC service should sit down together with stakeholders across the system and consider the principles of provision of such service in effective way. In doing this, the team should assess whether the principle is currently incorporated into their system. If it is not, the system and processes should be reviewed to understand why and what it would take to adopt the principle.

We present reflection on development of acute surgical clinic in our health board.

Keywords: *Acute Surgical Clinic; Ambulatory Care; Surgical Clinics; Business Case*

Identifying a problem

Almost every day we faced a huge shortage of beds in our units. When we went through acute admissions list, the consensus was that atleast one half of the patients could have gone home the same day to return next day for further assessments and investigations. It might help in increasing the availability of the beds for the ones who really need it and can also decrease staff workload.

Creating high performance organisations [1]

We discussed the issue with the clinical director of surgery who agreed with concern raised and we started working on solution to the problem.

Though it was difficult to get the like-minded participants from different department for a common goal but somehow few agreed after lengthy discussions [2] especially radiology and endoscopy department for daily dedicated slots for such kind of patients to avoid overnight bed occupancy.

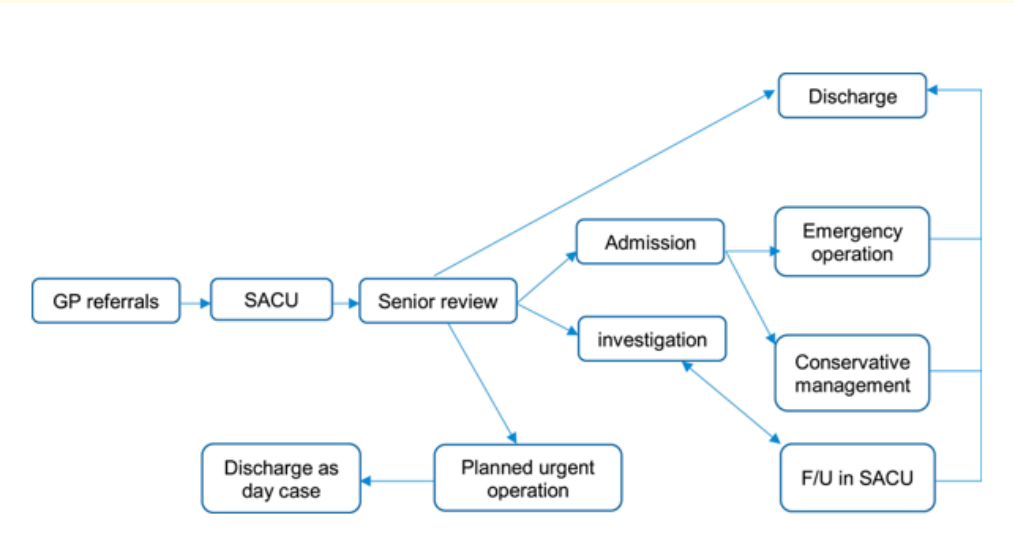
Meeting and discussing the matter with others opened new opportunities. We explored different options and appreciated working habits of participants. It was like thinking out of the box to design a project with equal participation, self-motivation, and shared responsibilities.

We also took patient's reviews about being admitted in hospital. To our surprise, significant number of patients requested outpatient management if safe to do so.

There was need for team members who could check vitals (temperature, pulse, BP, respiratory rates etc), take blood and urine samples for investigations from patients as soon as they step in the ward and someone who could do initial review and request relevant imaging. We chose a Colorectal nurse specialist and a junior doctor [3], both well trained and had mixed skills to understand and support each other maintaining safe patient care.

Model

Unwell patients were followed with normal pathway of acute admission. Those who had stable vitals were assessed in "Acute surgical clinic" either by the surgical registrar or the consultant, who then decided which patient to stay overnight and which one to come back next day for their further investigations and reviews.



Initially the project failed due to lack of coordination, communication and different working attitudes. The main obstacle here was the co-operation from the radiology department as their workload increased. Somehow with circulation of several emails and discussions, everyone started to comply with each other, all working towards a common goal. Urgent investigations started to get executed the very next day [4]. They realised that the failure of one individual can lead to the failure of the team.

This study was piloted over two weeks and it was shown that about one third of the patients did not require admission at all thus saving beds for almost 6 - 7 patients every day. Each bed overnight costed £450 in NHS thus saving approximately £80,000 - 90,000 per month. It became a topic of debate in almost each of the departmental meetings with further implications and new changes for improvement [5].

Cross team collaboration and system thinking

This study project was discussed in different meetings among team leaders and surgical managers. We were asked to talk about this in several other departments as more or less every other department had similar issues. Overall, it gave a motive and vision to every department to overcome these challenges [6]. It involved formulations of different teams, trainings and awareness protocols and care pathways. It was like an initiation of a chain reaction in the right direction.

With all this mass efforts we created mind change of the people who did not favour this initially.

Final rewards

With such huge savings it was possible to establish two well equipped rooms for running Acute surgical clinic and hiring the additional staff for the same purpose which is still up and functioning in the hospital.

This model has been adopted in different departments and has been a big success with different names like acute medical assessment, medical ambulatory unit, rapid access clinic etc.

Although this is a reflection on our past work but today we can correlate the progress of a team through different stages. It seemed that the whole process was natural and evolved at its own pace.

What went well

It was an absolute pleasure to be a part of this project. There was a lot of debate and positive criticism which led everyone to join hands together for betterment. Many innovative ideas floated in and were welcomed.

Similar acute clinics started running in other departments like Medicine, Gynaecology with great success. These clinics highlighted the importance of triaging group of patients who need treatment on an urgent basis, ones who need treatment on emergency basis with in 24 - 72 hours and then the ones who can wait longer and need treatment on an elective basis in 2-4 months' time.

Results were astonishing as it led to huge savings, cost effectiveness, smart use of staff and resources with safe outcomes. Almost all the hospitals in UK now have similar strategies to overcome the burden of staff and bed crisis.

Learning from your own mistakes

We faced a challenge of involving other departments especially radiology and endoscopy. Accident and emergency department had their own targets of either discharging or shifting the patients to other units within four hours of their arrival. For them it was a short

cut to simply send the patient to acute surgical clinic without proper communication. It led to inter-departmental friction and required designing of new referral pathways.

Nursing staff had difference of opinions due to their shifts and available number. We realised not only need of a separate team to work in acute surgical clinic but also location to run it safely. Again, these were resolved with inter-departmental meetings, well formulated protocols, structured emails and poster displays.

We noticed the main model did not work on certain population groups like the extremes of age groups, very elderly or very young patients. Always have an insight of the similar issues as they need a slight deviation for better patient care.

Points to ponder

1. Organisational teaching programs and medical leadership courses should form a mandatory part in all the doctors training. Early phases of delays and obstacles can be cut short by training and awareness. Like minded should lead and formulate an example for influencing and motivating others.

2. Learning from other's mistakes, anticipating and preparing for the challenges is a smarter way to approach such desirable goals in teamwork fashion. Often the decision taken and performance results in the team work are superior, cost effective, timely and more efficient than by the work performances by single individuals.

3. Desirable goals should be practical and achievable, and leaders should have an insight into the situation. Acquired knowledge and awareness from other projects, departments and institutions should be welcomed. Always try to find the similar issues prevailing elsewhere and finding out what has been done there to overcome those issues.

4. It is of utmost importance that all the team members understand their roles. It is useful and advisable to have small number of participants with likeminded ideology then to have robust teams with each of its member facing in different direction.

5. Appropriate communication skills lay a big stone of foundation in the teams. All the different means of communication and spreading awareness should be used to influence others, to encourage cooperation and participation from them.

Conclusion

Establishing an acute surgical clinic or emergency surgical ambulatory service has saved significant hospital beds occupancy by increasing the same day discharge. This service requires a dedicated team of senior surgeon and nurses, easy access to diagnostic tests, must have a protected clinical area and support of the senior management. The scope of SAEC is going through a period of rapid development and needs further audits to assess the patient safety and quality of care provided.

Acknowledgement

Thanks to all the authors for their contribution in writing of the article.

Credits

KA: Concept, original writing; AG: Concept, search, drafting, SD: writing review and editing; RP: writing review; KS: writing editing.

Funding Support

No funding was needed.

Conflict of Interest

None.

Ethical Approval

This project does not require application for ethical approval as it is a quality improvement project and will only report on local outcomes.

Provenance and Peer Review

Not commissioned, externally peer reviewed.

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Volume 8 Issue 8 August 2021