# Reforming emergency care: Length of stay and admissions avoidance

*Sara Da Costa*

Trying to manage services across health communities can feel like keeping too many plates spinning at once. You can feel stuck in the middle of acute trust targets and primary care trust (PCT) targets, asking yourself 'who is thinking about patients here?'

The political game does feel all-consuming, particularly at this time where there is additional tension due to PCT mergers, acute trust overspends and threatened redundancies or shrinkage of services. It is as important as ever that we, as senior nurses, continue to influence decisions for our patients' benefit, wherever and whenever we can. Therefore, identifying the key targets for both acute and primary care trusts is crucial.

## Emergency care reforms

Hospital admissions avoidance and reduction in length of stay remain targets for both organisations and, when managed well, can lead to improved patient experience and outcomes and better use of resources and services. This was acknowledged by the Department of Health (DoH; 2005) with the recommendation that the patient goes to the right place for the right treatment, first time round, resulting in:

- appropriate access to treatment
- appropriate length of stay.

This work on reforming emergency care (DoH, 2005) also recognised the nursing contribution in terms of implementation of change, and achievement of national and local targets. The two articles in this supplement will concentrate on such targets, and discuss the nursing issues that developed around them.

The first article, by Dionne Wamae and myself (page 101), discusses the use of accident and emergency (A&E) by people with diabetes, asking why and how they arrived there, what happened, and identifying common themes. This project arose from a larger piece of work produced by the clinical nurse specialists (CNSs) in our trust, who identified the patient journey as shown in *Figure 1.*

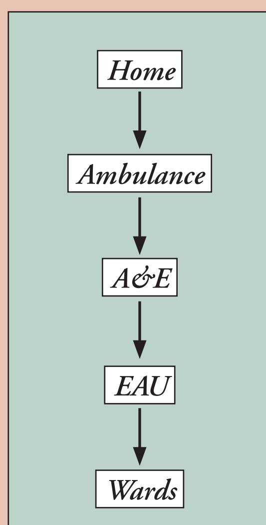


***Figure 1. The patient journey through emergency care. A&E = accident and emergency; EAU = emergency admissions unit.***

Many CNS teams identified their impact and roles at each stage of the patient journey, and demonstrated clearly their contribution to both admission avoidance and length of stay. These were shown by the amount of hours teams spent on phone triage, giving patients specialist advice which prevented admissions, and, in some cases, outpatient appointments. The teams were able to provide education by phone, to prevent recurrence of problems – e.g. advice regarding what to do when ill and using tablets or insulin, or when to access a GP. In some cases, patients were admitted directly by the CNS team for urgent review.

Although this may contradict 'admissions avoidance', we need to recognise that when patients need acute services, they often need them promptly. This project demonstrated gaps in services and gaps in education provided for clinicians, and showed that, overall, once a patient contacted the ambulance services, it was easier for everyone to proceed along the pathway outlined in *Figure 1.* This leads to inappropriate admissions, the causes of which Dionne was able to investigate through her work with our A&E department.

The second article, by Anne Prestt and Jane Rutt (page 104), discusses emergency admissions in diabetes, focusing on excess length of stay and the role of the diabetes inpatient specialist nurse both in reducing length of stay and in improving diabetes management whilst an inpatient. Anne and Jane place these targets in a wider context, discussing some of the tensions produced by payment by results and additional nursing input via community matrons.

Both articles consider these targets within a system of health care, and enable us to see how a change in one aspect of care delivery has an impact on the next steps in the journey, as well as the resources required to manage them. In many cases, reducing admissions means greater access to, and more education from, specialist diabetes teams for clinicians and people with diabetes. This requires re-direction of resources, in the same way as providing more inpatient DSN support will reduce outpatient DSN services. Given our increasing population and additional targets, we will need more resources in diabetes care, but in reality we may receive significantly less. ■

Department of Health (DoH; 2005) *A guide to emergency medical and surgical admissions.* DoH, London. Available at http://www.dh.gov.uk/assetRoot/04/12/19/02/04121902.pdf (accessed 21.03.2006)

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