An examination of the role and activities of nurses caring for patients who are admitted to a model 4 hospital as part of the National Acute Medicine Programme

Dr Melissa Corbally

Dr Gloria Macri

Ms Susan Hawkshaw

Final Report

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Ultimately, this project would not have been possible without the contributions of the staff of Beaumont Hospital. We would like to thank all of those who participated in the study and gave their precious time to enhance the understanding of the nature of nursing care given to patients who attend Beaumont Hospital as part of the Acute Medicine Programme. We appreciate your contribution to the study and also to patient care given the challenges in contemporary healthcare delivery.
Acute Medicine Nursing is an important emergent practice in the Irish healthcare context. As nurses, we are privileged to have the opportunity to make a difference to people’s lives when they and their families may be vulnerable and need our help most. We have the opportunity to care for patients with dignity, respect and compassion.

The National Acute Medicine Programme recognises the important and essential role played by nurses working in Acute Medical Assessment Units (AMAU’s) for the successful implementation of the programme nationally. The unique role played by nurses working as part of a team in AMAU’s requires a specific knowledge base along with a set of skills and competencies to provide high quality, safe care to patients. This is very much in line with the National Acute Medicine Programme model of care.

This research which seeks to understand nurses’ contributions to patient care and identification of the scope for role expansion within current nursing practice in acute medicine will directly affect nursing practice and ultimately patient outcomes.

Nurses’ willingness to acquire new skills was motivated to ensure good ‘patient flow’ and also gave nurses confidence and pride as well as a sense of independence in being able to assist patients through their journey in preventing unnecessary delays in their treatment. Further role development to Advanced Nurse Practitioner level was also suggested.

I congratulate the nursing team in Beaumont under the leadership of Ms Sheila McGuinness, Director of Nursing, for undertaking this important ground breaking piece of research which underscores their commitment to delivering high quality nursing care to patients in the AMAU. The product of this research will surely result in a more enabled and empowered nursing team working in acute medicine.

Eilish Croke
A/Programme Manager
National Acute Medicine Programme
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¹ The HIPE scheme, established in 1971, is a health information system designed to collect clinical and administrative data on discharges from, and deaths in acute hospitals in Ireland. It is the principal source of national data on discharges from acute hospitals. (Source HIPE Data dictionary version 4.0) url: [http://www.esri.ie/__uuid/19de9200-8896-4971-8bba-b4320830ddcc/HIPE-Data-Dictionary-2012-Version-4-0.pdf](http://www.esri.ie/__uuid/19de9200-8896-4971-8bba-b4320830ddcc/HIPE-Data-Dictionary-2012-Version-4-0.pdf)
Executive Summary

This project examined the role and activities of nurses caring for patients who are admitted to a model 4 hospital as part of the National Acute Medicine Programme. The recent launch of the National Acute Medicine Programme (HSE et al., 2010) resulted in a change in the context of care delivery for patients suffering from medical conditions requiring urgent or emergency care. Although nursing staff have responded to this change, little is known about the core nursing competencies which have evolved as a result in this shift in care contexts. This study is innovative insofar as it elucidates the nursing activity undertaken in a model 4 hospital (HSE et al., 2010, p.28).

In order to understand these aspects, two key research objectives were formulated:

1. The first objective of this study was to articulate nurses’ contributions to patient care by examining their activities and decision-making at individual, interpersonal and organisational levels.

2. The second objective focussed on exploring the scope for role expansion within current nursing practice along with clinical nursing pathway development within the context of acute medicine nursing within a model 4 hospital (e.g. CNS /ANP roles).

The study was carried out in Beaumont Hospital, one of the pilot sites involved in the National Acute Medicine Programme. As a model 4 hospital, Beaumont Hospital contains all the components of an Acute Medical Unit described by the Health Service Executive (HSE) et al (2010). These include: an Emergency Department (ED), an Acute Medicine Unit (AMU) and a Medical Short Stay Unit (SSU).

Staff working within the three inter-related areas within the National Acute Medicine Programme (ED, AMU and SSU) were invited to participate in the project which endeavoured to achieve an understanding of the nature of acute medical nursing in Beaumont hospital. This exploratory study utilised mixed methods of inquiry (a combination of focus group discussions and one to one interviews) to collect data pertaining to Acute Medical Nursing care. A combination of stakeholders and nursing staff comprised the 24 individuals who participated in the study.

The report is structured into three main sections, each containing a number of thematic chapters/subsections. The first section of the report presents an overview of the National Acute Medicine Programme, focusing on the implications for nurses’ roles and activities. The second section highlights the key methodological issues involved in the process of data collection and analysis. The third section provides an in-depth account of the research findings. Existing literature, both at the national and international level, was used throughout this section in order to benchmark the findings obtained as part of this study and are referred to within the relevant sections. Following this executive summary, some recommendations are made. As with all research studies, these recommendations must be considered in the context in which they were generated; as an outcome of
a small research study with the intention to improve knowledge, and practices relating to quality patient care.

A lot of data was obtained through respondent’s verbal accounts of their experiences of working within the National Acute Medicine Programme in Beaumont Hospital. Although some similarities can be drawn from the findings of this study and other studies of nursing work, the theme of timeliness and speed permeate all aspects of nursing work and as a result influence the nursing role within the Acute Medicine floor. The following page contains a summary of the key findings of the study.
### Key findings

The range of acute medical patients who were admitted to Beaumont Hospital included:

- Patients with a wide variety of conditions, some with co-morbidities.

The key access routes into the AMU/SSU were:

- Via the ED (through triage) following judgements of suitability: typically Manchester category 2 or 3 patients which can be quickly assessed treated and discharged.

- Occasionally patients who did not fit the criteria of “quick turn-around” were accepted in the AMU/SSU:
  - in order to provide relief for the ED or for other wards
  - because of the location of the AMU/SSU ward on the Lower Ground Floor for safety reasons (e.g. psychotic patients, overdose, self-harm patients or other high-risk patients).

- At times, out-patients coming in for review or for tests/procedures were admitted.

- Participants stressed the importance of distinguishing between an acute medical patient (suitable for admission into the AMU) and the acuity of a patient’s illness (i.e. they may be too unwell for admission to the AMU even though they may have the same condition).

The activities and roles of nurses caring for acute medical patients included:

- Quickly and continuously assessing patients (often assessing for aspects which were not always quantifiable)

- Making judgements and decisions in relation to patient’s condition and treatment

- Thinking ahead and anticipating potential patients’ needs

- Assessing, planning, implementing and evaluating care in a holistic way (nursing process)

- Direct nursing care
  - Fundamental nursing (e.g. toileting, washing, helping patients putting on their gown)
  - Tasks performed:
- Performing venupunctures and cannulations
- Taking blood tests (which were deemed by many nurses as a priority)
- Performing ECGs
- Checking blood results
- Ensuring that other tests were ordered depending on the patient’s condition and needs (ECHO, x-rays, MRI etc.).
- Performing frequent clinical observations (temperature, pulse, blood pressure, respiration and oxygen saturation, peak flow).
- Checking patients’ weight
- Catheterisation (for female patients only)
- Preparing the patient for their journey

Indirect nursing care
- Processing the patients, doing the paper-work
- Documentation of care
- Following up on tests/procedures (“fighting” for the patient) - making many phone-calls, scheduling their tests, getting the tests prioritised if needed, following up on the tests etc.
- Communicating and liaising with other teams
  - communicating vital information to the doctors/consultants
  - offering logistic support for consultants
  - teamwork - working as a team, keeping an eye on each other’s’ patients
- Interacting with other organisations and institutions outside the hospital
- Communicating with patients and relatives
  - informing patients and families
  - educating patients and families
  - ‘translating’ the information for patients

The key qualities and skills for acute medical nursing were:

- Difficult to articulate

Newly acquired skills (i.e. ordering blood tests, venupuncture and cannulation) were believed to be useful insofar as they were beneficial for the patient (e.g. reduced waiting time for diagnosis, fluid therapy etc.). It gave nurses confidence and pride as well as a sense of independence to be able to facilitate a smoother patient journey.

- Having a broad medical and nursing knowledge was felt to be essential.
Being experienced, discovering vital information and clues that are sometimes ‘hidden’ in what patients are saying was felt to be important.

Good clinical decision-making and the ability to think very quickly and to be able to ‘juggle’ all cases in one’s mind was important.

Being able to cope with “whatever is thrown at you” and to manage the complexity of multi-tasking.

Communication and teamwork skills.

Offering a holistic approach to the care of the acute patient.

Friendliness.

Protecting/ “sheltering” the patient.

Ability to ‘translate’ (explain information clearly) to the patient and their relatives.

The unique aspects of acute medical nursing included:

The nature of the work in acute medicine
  - quick, fast-tracked nature of work
  - a very interesting and very dynamic environment
  - better patient experience
  - knowing what to expect - knowing the patterns, the specificities of acute medical patients
  - very rich and broad knowledge needed in order to cope with the variety of acute medical conditions.

The set of skills which nurses working with acute patients have
  - the ability to assess patients and make good clinical decisions quickly.
  - a great deal of teamwork and a lot of coordination skills required in order to get things done quickly.
  - making very quick assessments and judgements
  - holistic approach.

The distinct profile of acute patients admitted to AMU - older patients.

Acute medicine nursing is not a speciality yet.

The AMU is like a pathway which links general nursing and ED nursing.
The changes since the introduction of the Acute Medicine Programme included:

- The quick nature of the process led to a positive impact on patients’ perceptions of their journey and their experiences.
- There was less emphasis on bedside care and more focus on checking that tests were ordered.
- A move to a consultant-led service
- The existence of pathways allowed nurses to see the patient’s journey, to be more aware of the plan of care
- The nature of the patients also changed with older (over 60 years), sicker patients being now the typical patients admitted into the AMU/SSU.
- Newly expanded nurses’ roles improved their confidence when contrasted with their experience in general medical wards.

The challenges encountered in caring for acute medical patients included:

- The quick, fast-tracked nature of the process
- Trying to keep up with everything, to keep everything flowing and coordinated and getting patients through the system
- Not having enough time to carry out all tasks which they are expected to do
- Finding time to spend with patients
- Finding time to attend study days/ courses
- Space limitations, lack of beds/waiting for long periods on a chair, and the lack of dignity caused by the fact that patients are too close to one another
- The lengthy duration needed to run some of the tests (e.g. CT, MRI) or the occasional cancelling of some procedures
- The frequent blocks to the flow of the service - due to seasonal variations in the number of patients as well as due to patients who require a longer stay.
- Difficulties in caring for patients who don’t easily fit into a clear cut speciality (i.e. complex patients with multiple morbidities)

- Challenges surrounding the staffing process (referring to nursing staff as well as the need to have more junior doctors)

- Certain patient groups presented more of a diagnostic challenge for the acute team (e.g. patients with chest pains, Afib and acopia patients)

Further skills needed in caring for acute medical patients included:

- The need for on-going training and education

- Technical skills - ordering X-rays, interpreting ECGs

- Participants mostly indicated that they already had a wide scope of skills - venupuncture, cannulation, phlebotomy, doing ECGs, doing urine tests, etc. Some participants mentioned that further development of their skills and roles is needed in the following areas
  - ABGs
  - Ordering x-rays
  - BiPAP
  - Nurse-led discharge
  - Prescribing medication, especially antibiotics
  - Reading/Interpreting tests
  - Knowing more about triage scoring of patients in ED
  - Having a broader spectrum of knowledge and experience and being able to perform a quick assessment
  - Ensuring follow up care in the community

In relation to developing an ANP/CNS role,

- Most nurses and all stakeholders felt that having an ANP/CNS would positively and significantly impact on the patient experience.

- The positive example set by the Advanced Nurse Practitioner in cardiology working in the ED, was deemed as a benchmark for future developments of ANP roles. Multiple comparisons were made by the participants to this practitioner.

- There was a lack of clarity in relation to the separation between the ANP/CNS roles amongst nursing staff. Consultants however mentioned that an ANP would be preferable to a CNS due to the fact that ANPs could manage a patient from the beginning to the end of their hospital journey. Participant’s accounts of this role also closely matched the role description of an ANP.
Possible skills which could be enacted through an ANP in acute medicine included:

- the ability to triage and assess patients, admit them, prescribe medication and order tests (x-rays, telemetry etc.)
- making clinical decisions arising from the interpretation of diagnostic tests.
- the authority to discharge patients.
- assisting in managing the AMU/SSU, referring more precisely to running the place, coordinating activities, “keeping it together”, communicating with the team and hence making things run smoothly.
- Educating staff.

The potential de-skilling of present nurses working on the acute medical floor was voiced by some as a challenge in developing an ANP pathway.

While many nurses were supportive of the development of an ANP role, they did not refer to these positions as being opportunities for expansion of their role.

Despite the fact that this was a small study, several interesting additional findings emerged. One of these related to the how nurses differentiated ‘acute medical patients’ from ‘acute medical patients who were suitable for admission to the AMU/SSU). In nursing and medical terminology ‘acute’ refers to a recent, abrupt onset of symptoms (Mosby’s Medical Nursing and Allied Health Dictionary 2002). The severity of symptoms can and does vary - particularly in the clinical context. Although all acute medical patients attending Beaumont Hospital were sick, acute medical patients who were well (relatively speaking - in comparison with participant’s knowledge of the clinical presentation of severe exacerbations/illnesses of patients with similar conditions) were the candidates who were usually eligible for admission to the AMU or SSU. Nurses and doctors are familiar with the fact that patients with, for example, chronic obstructive pulmonary disease, can be ‘relatively well’ or ‘very sick’ depending on many factors. This is potentially in contrast to a service user or patient’s definition of being sick enough to warrant attendance at an Emergency Department. Key to this distinction is the many clinical judgements and assessments made by nurses and doctors during their interactions with patients. Although some stakeholders mentioned that there was a move to admit ‘sicker’ patients to the AMU/SSU, at the time of the study this was not voiced by the majority of participants.

Implicit in the conduct of nursing is the exercise of judgement in the provision of care (Royal College of Nursing 2003). The exercise of clinical judgement was very evident in many of the participant’s accounts of their assessment and care of patients on the acute medical floor. Such clinical judgement, made more difficult by the fast-paced nature of the acute medical floor, underpinned many contributions made by participants in articulating influences on their role and activity.
Nursing roles and activities were difficult to articulate, complex and overlapping. Classification into categories, although necessary for the writing of this report, fall short in illustrating the complexity of acute medical nursing activity, undertaken in an ever changing context. It is hoped that the contents of this research report will assist in making visible to others, the complex nature of acute medical nursing and will prompt further investigation into this newly emerging area of nursing practice.

Acknowledging the limitations inherent in a study of this nature, some recommendations and suggestions are made overleaf.
Recommendations

On the basis of this study, we have made the following recommendations and suggestions.

**Suggestions for research**

- A national study of the role and activities of nurses caring for patients who are admitted to all model 4 hospitals as part of the National Acute Medicine Programme.
- An exploratory study into the patient experience/patient journey within the Acute Medical Floor.
- An examination of nursing documentation in relation to acute medical nursing activity.

**Suggestions for practice**

- Continue to facilitate and support the professional development of nurses working in the acute medical floor.
- Consider developing a needs analysis towards developing an Advanced Nurse Practitioner pathway. In performing this needs analysis, consultation with current ANPs who interface with the acute medical floor would be important.
- Consider developing a framework for Nurse Prescribing of Medical Ionising Radiation (X-Ray) with the purpose of enhancing patient flow /meeting patient need in the Acute Medical Floor.
- Consider developing professional links with the Society for Acute Medicine UK (Nursing).

**Suggestions for education**

- Further exploration of educational needs of staff working on the Acute Medical Floor.
- Exploration of the feasibility of a dedicated post registration programme of study which may further enhance acute medical nursing practice.
- Reflection of acute medical nursing activity within the undergraduate curriculum.
Literature review

Overview of the Acute Medicine Programme

The Acute Medicine Programme is an initiative of several healthcare groups within the HSE which aims to ensure that patients presenting with acute illnesses benefit from quality medical care with a greater efficiency of resources. This initiative is reflective of international structural responses to medical care delivery challenges within hospitals (Scott et al 2009). The Acute Medicine Programme in Ireland was implemented in 2011. It is estimated that by the end of 2013 up to 500,000 bed days will be saved (Department of Health, 2012).

The Acute Medicine Programme Report (HSE et al., 2010), is focused on the patient experience and is aimed towards providing safe, quality care. Expedited diagnosis and correct treatment in an appropriate environment, timely care from a senior medical doctor working within a dedicated multidisciplinary team, respect of patient’s autonomy and privacy, improved communication with the patient and an overall better patient experience are some of the goals of care espoused by this report (p. 8).

Summarising the above-mentioned aims, the programme’s key objectives revolve around **quality** (which involves reducing the admission rate of patients by 10% per year for 3 years following its full implementation without increasing 30 day readmission), **access** (guaranteeing that patients presenting to the AMU/AMAU/MAU will be examined by a senior medical doctor within one hour) and **cost** (bed day savings of 10% per year for 3 years following the full implementation of the programme) (HSE et al., 2010, p. 13).

Among the key patient-related benefits envisaged by the proponents of this programme are: the elimination of extended periods of trolley waits, the provision of dignified care, and the promotion of patient safety and quality, all of which will lead to better patient outcomes. It could be suggested that this ideal is a natural goal for all hospitals and is not necessarily unique to acute medicine programme. However, evidence illustrating a multiplicity of challenges particular to delivering care to those presenting with acute medical issues compelled the medical communities to consider novel structural responses which were clinically and cost effective. Acute Medical Units and Short Stay Units are acknowledged as an internationally recognised response to such challenges (Scott et al 2009).

Furthermore, the Acute Medicine Programme recommends the development of appropriate evidence-based care pathways and protocols which will enable the delivery of improved and standardised care to patients requiring acute medical care in Ireland (Kincső, 2012; HSE et al., 2010). One of the initiatives arising from the acute medicine programme is the implementation of a national early warning scoring tool, a standardised system of scoring the patient’s condition, predicting deterioration and initiating early intervention (HSE et al., 2010, p. 41). The acute medical floor concept (discussed in more detail below) is another initiative arising from this key national report.
International comparison

In the United Kingdom, acute medicine is an established medical speciality focused on the initial phase of care for patients admitted to departments of Internal Medicine (Subbe et al., 2011). There is an established society for acute medicine in the United Kingdom which has been integral in the development of acute medicine and also acute medical nursing. The practice of acute medicine in Ireland is relatively new in comparison with the United Kingdom. Other countries operating Acute Medicine Units are Australia and New Zealand, however, as Subbe et al. (2011) note, in the two above-mentioned countries acute medicine is not an independent specialty. In countries such as Holland and Germany, similar to Ireland, acute medicine is emerging. Holland and Ireland, have begun implementing Acute Medicine type care models, while Germany has recently founded a society for Interdisciplinary Emergency Medicine. (Subbe et al., 2011).

The aims of the acute medicine speciality are similar to the ones espoused by the Acute Medicine Programme in Ireland, namely to ensure that patients are treated in a safe environment, in a timely and efficient manner, reducing the need for prolonged hospitalisation. Its close proximity to the Emergency Department is particularly important given the easy access to acute care and diagnostic services. In the national report, four generic hospital models are presented to reflect the varying sizes of hospitals in Ireland and their associated facilities. A model 1 hospital for example refers to a community/district hospital whereas a model 4 hospital represents large tertiary hospitals with potential capacity to support an acute floor concept (HSE et al.2010).

The Acute Floor in a Model 4 Hospital

The Acute Medicine Programme proposes the development of an acute floor concept in Model 3 and 4 hospitals “comprising a co-located emergency department, acute medical unit, coronary care unit, acute stroke unit, intensive care unit, high dependency unit, interventional cardiology unit, acute surgical assessment unit and clinical decision unit” (HSE et al., 2010, p. 9).

For Model 4 hospital, the Acute Medicine Programme report (HSE et al., 2010) presents a particular vision of what the acute medicine floor should consist of. Figure 1 overleaf presents the concept of the acute medicine floor espoused by the Health Service Executive (2010).


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As illustrated above, a Model 4 hospital will have an Acute Medical Unit (AMU) which is open on a continuous basis (24 hours, every day of the year) and “will be staffed by acute medicine physicians and/or acute physicians with a specialty interest during core working hours” (HSE et al., 2010, p. 28).

The acute floor in Beaumont Hospital closely follows the concept of the acute floor of a Model 4 hospital presented in the Acute Medicine Programme report (HSE et al., 2010). Some slight differences are evident. Firstly, in Beaumont Hospital the Acute Medical Unit (AMU) comprises of a medical assessment unit as well as a Short Stay Unit. Furthermore, while Beaumont hospital does not yet have a High Dependency Unit or an Acute Surgical Assessment Unit, these two units are currently in planning, according to the Project Manager of the Acute Medicine Programme.

In order to appreciate the similarities and differences between the HSE acute floor conceptual model regarding a Model 4 hospital and the acute floor concept in Beaumont Hospital, Figure 2 overleaf provides a conceptual illustration of the acute floor in Beaumont Hospital at the time of the study.
Implications for nursing roles

The conduct of nursing and medicine are inextricably linked given the fact that they practice in the healthcare context, share an interest in patient wellbeing and operate as members of the multidisciplinary team. Unlike medicine, an ever present problem for nursing has been its relative invisibility both in relation to its direct effect on patient wellbeing and patient outcomes (Scott et al 2006). The significant impact nurses make to the lives of their patients and clients is implicit in several ways; from virtue of its very endurance and strength within societies worldwide to countless individual anecdotes from those who experienced professional nursing care. More recently, attempts to make explicit the nursing contribution to care have demonstrated the influence experienced nurse staffing levels have on patient mortality and morbidity (Aiken et al. 2002, 2012, 2013). However, articulating exactly what nurses do remains a challenge given its complexity and contextual embeddedness. A Delphi study of general and mental health nurses undertaken by Scott et al. (2006) generated a useful framework to articulate the actual work of nurses throughout the nursing process from an Irish perspective. The findings of the study undertaken by Scott et al. (2006) will be discussed within the context of findings obtained in this study.

The Acute Medicine Programme acknowledges the importance of the nursing contribution placing a strong emphasis on the roles of nurses working on the acute floor (HSE et al. 2010). At the same time, there is a signalling by this report of the
need for development and expansion of the roles of nurses working with acute medical patients. These expanded roles include ensuring appropriate patient prioritisation, discharge planning, X-rays, prescribing medication and using the early warning score to facilitate the identification of acute patients with risk of deterioration of their condition. (HSE et al., 2010). It is expected that these expanded roles will ultimately have a key role in a more efficient distribution of resources. The expansion of nurses’ skills takes place in close correlation with a process of identification and assessment of existing skills of nurses working in acute medicine in the light of the present and estimated future needs of the department. To date, little is known about the existing or projected skills of nurses working on the acute medical floor.

Skill mix represents according to Buchan and Dal (2005, cited in DOHC, 2010) “the mix of positions, grades and occupations in an organisation” and also “the combinations of activities or skills needed for each job within the organisation” (p. 25). By assessing the skill mix available in the acute team, it can be determined whether the mix is appropriate for current and expected future caseload as well as determining whether other skills and competencies are required and whether such needs could be covered by an expansion of the roles of nurses. (DOHC, 2012, p. 25).

The Department of Health and Children (DOHC) DOHC (2012) differentiates between role extension and role expansion. The strategic framework highlights that while role extension represents “a mechanism whereby nurses require certification for skills which involve taking on new tasks” (p. 20), role expansion needs to be understood more in the terms of “becoming more competent, reflective and autonomous practitioners and developing expertise and skills to meet patients’ [...] needs” (pp. 20-21). From this perspective, expansion of the role is preferred as it involves a complex process which is more than developing competencies and involves taking new roles. However, there is no doubt that nurses are challenged to provide optimum nursing care within particularly challenging work contexts. Recent international research has highlighted that nurses in Ireland expressed moderate to high levels of burnout, perhaps resulting from practising in less than satisfactory work environments with high bed occupancy rates (Scott et al. 2013). The relevance of the research undertaken by Scott et al. (2013) to the findings obtained by this study is discussed in the context of the findings chapter (below).

Given the relative newness of the acute medicine programme in Ireland, it is unsurprising that little is known about the role and activities of nurses caring for patients who are admitted to a model 4 hospital. Most of the what is known about acute medical nursing activity arises from data specific to the United Kingdom, where acute medical units are larger in size and require a broader spectrum of skill mixes (including those at nurse consultant level) (Lees 2012). In searching the literature, only one study (a survey of junior and senior nurses practising in acute medical units across the UK n=127) was found which endeavoured to explore practitioner’s perceptions of their role. (Lees et al 2013). Nursing, at the Society of Acute medicine have played a key role in making visible, the acute medical nursing role. Additionally, other nursing specific studies and publications relevant to acute medical nursing (e.g. Lees et al. 2010, Lees, 2012, Myers and Lees 2013) are discussed further within the context of the findings presented.

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3 Nursing at the Society for Acute Medicine can be accessed by the following link:
Methodology

A combination of mixed methods of inquiry (i.e. interviews and focus groups) was used in the study. Given the nature of the topic researched, the use of qualitative methods presented a key advantage in allowing the researcher to capture in rich detail nurses’ discourses about their role and activities. Given the scale of the study and the relative newness of acute medical nursing, it was felt that qualitative approaches would facilitate the generation of a baseline understanding of its nature.

Nursing staff in the three inter-related areas (ED, AMU, SSU) and key stakeholders (e.g. programme consultants, Director of Nursing, directorate nurse manager, project manager, etc.) from within the organisation who have involvement with care delivery associated with the Acute Medicine programme were invited to participate in the study.

It is important to mention that only registered nurses with greater than three months experience working in the ED, AMU or SSU were selected for this study. Agency nurses, student nurses and registered nurses with an experience of less than 3 months were excluded from the outset of this study.

The fieldwork stage was carried out between May and July 2013. A total of 24 individuals were recruited to participate in this study. Due to staffing constraints, focus groups were carried out on small groups in rooms adjacent to the clinical area. The following table provides a detailed overview of the interviews and focus groups carried out.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ED</th>
<th>AMU/SSU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>- 3 focus group discussions (8 nurses - including one CNM2)</td>
<td>- 2 focus group discussions (4 nurses)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 3 individual interviews with nurses (3 nurses)</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>9 interviews</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 4 CNMs (AMU/SSU, ED, Patient Flow) - 1 x CNM3; 2 x CNM2; 1 x CNM1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 2 consultants (AMU/SSU)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 1 Project Manager of the Acute Medicine Programme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 1 Director of Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 1 Patient Flow Manager</td>
<td></td>
</tr>
</tbody>
</table>

Ethical permission for carrying out this research was sought and granted by Beaumont Hospital Research Ethics’ Committee. In addition, all research participants given verbal and written information about the project and, prior to the interview or focus group discussion, were informed in relation to the confidentiality of the information that they provided.

Upon completion of the interview/focus group discussion each participant was handed a very short questionnaire which anonymously collected information in relation to participants’ age, gender, their position/role as well as the years of
experience since registration. This information allowed for the construction of a profile of participants to this study.

It thus emerged that slightly under 50% of participants are aged between 26-35 years of age (46%), while almost a third are aged between 36-45 years (29%). A detailed breakdown can be found in Figure 1 below.

![Age Distribution](image1)

**Figure 3 - Age of respondents**

Almost all staff interviewed as part of this research were female, which was expected given the rather gendered profile of the nursing profession.

![Gender Distribution](image2)

**Figure 4 - Gender of participants**

As specified in Table 1, a total of 9 stakeholders were interviewed for this project: 3 CNMs (two from AMU/SSU and one from ED); 2 consultants (both from the AMU/SSU), the Project Manager of the Acute Medicine Programme, the Director of Nursing and two members of staff from the Patient Flow team (the manager and another senior member of the team).
Table 2 - Profile of respondents

<table>
<thead>
<tr>
<th>Grade</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>DON</td>
<td>1</td>
</tr>
<tr>
<td>Staff Nurse Grade</td>
<td>14</td>
</tr>
<tr>
<td>CNM grade</td>
<td>5</td>
</tr>
<tr>
<td>Manager grade</td>
<td>2</td>
</tr>
<tr>
<td>Consultant</td>
<td>2</td>
</tr>
</tbody>
</table>

In relation to the number of years since registration, it emerges that only very few of those interviewed (14%) have an experience of under 5 years. This suggests that the respondents in this study had an extensive amount of clinical experience. Figure 3 presents a detailed breakdown of participants by the number of years since registration.

![Years of Experience since Registration](image)

Figure 5 - Number of years since registration

Data obtained following the data collection process was analysed using a combination of content analysis (Bryman 2008) and thematic analysis (Gomm 2004) depending on the research questions being answered. For example, ascertaining the key access routes into the AMU/SSU required analysis of the content (textual data) which identified descriptions of how patients entered the service. Descriptions of nursing were obtained by analysing the content (textual data) for their presence. Whilst content analysis was necessary in parts, it was not sufficient as it did not incorporate the analysis of meaning in relation to how participants described the nature of acute medical nursing nor would it address particular issues and aspects arising from the data. Themes emerged through the presence of recurring regularities within all participants’ descriptions. Such commonalities were analysed for their relevance to the research questions and subsequently coded as theme or subthemes depending on their prevalence. Attention was also given to variation from commonality and is addressed in the presentation of findings. Validation of such themes required to strengthen their rigour (Polit, Beck and Hungler 2001) was obtained from two methods. Firstly, cross-validity was assisted through the use of focus groups which facilitated cross-validation of themes which emerged. Secondly, during data analysis, themes which emerged were validated through their replication in consequent interviews with other participants.
While questions used in the interview schedule acted as the main thematic frame around which data was collected, a number of new themes also emerged during the interpretation of data. Moreover, it was often noticed that data obtained for different questions asked during the interviews/focus group discussions was interconnected. Hence, the analysis contains manifold cross-references between the themes.

Within each of the thematic sections/sub-sections a clear indication is given in relation to whether the views expressed belonged to the nursing staff or to the stakeholders. Furthermore, when exact citations from the interviews/focus group discussions were used, a unique code corresponding to each respondent is used in order to indicate the source of the quote. The code reveals only details about the department in which the research participant is working, while maintaining their identity as anonymous. It is however important to mention that, due to the unique position which some of the stakeholders have (e.g. Director of Nursing or Programme Manager of the Acute Medicine Programme), in such cases the anonymity of their views is more difficult to maintain.

Given that this project represents a small-scale study, there are several inherent limitations to it. Firstly, the study presents a case study of one Model 4 hospital in Ireland, namely Beaumont Hospital. In order to formulate broader conclusions in relations to the roles and activities of nurses working in acute medicine, a wider sample of hospitals would be necessary. Secondly, the short duration of the project was also a limiting factor. This study strived to achieve a comprehensive understanding of the issues by interviewing nurses and stakeholders in the hospital. Given the time limitations, patients or other health and social care professionals did not form part of the project.

Last but not least, we acknowledge that the context of acute medicine and acute medical nursing operates within a new and very dynamic environment. Hence, it is likely that some of the aspects presented in this report may have already changed since the finalisation of this report. The following section presents the study findings.
Research findings

Introduction

This section represents the outcome of a qualitative analysis of the role and activities of nurses caring for patients who are admitted to a model 4 hospital as part of the National Acute Medicine Programme. As highlighted above in the executive summary, the findings were classified into seven thematic sections which are listed in table 3 below. A more detailed discussion about each of these sections follows.

Table 3 - Overview of thematic sections

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The range of acute medical patients admitted to Beaumont Hospital</td>
</tr>
<tr>
<td>2</td>
<td>Routes into the AMU / SSU</td>
</tr>
<tr>
<td>3</td>
<td>Activities and roles of nurses caring for acute medical patients</td>
</tr>
<tr>
<td>4</td>
<td>Qualities and skills</td>
</tr>
<tr>
<td>5</td>
<td>What is unique to acute medical nursing?</td>
</tr>
<tr>
<td>6</td>
<td>Changes since the introduction of the Acute Medicine Programme</td>
</tr>
<tr>
<td>7</td>
<td>Challenges encountered in caring for acute medical patients</td>
</tr>
<tr>
<td>8</td>
<td>Developing advanced practice</td>
</tr>
</tbody>
</table>

The range of acute medical patients admitted to Beaumont Hospital

Participants who worked in either the AMU (Acute Medical Unit)/SSU (Short Stay Unit - St. Patrick’s Ward) or the ED (Emergency Department) indicated that they received a wide variety of acute patients including cardiac, respiratory, medical, neurological patients as well as care of the older person into their respective departments. Table 3 provides an insight into the various types of conditions experienced by acute medical patients admitted to Beaumont Hospital as articulated by study respondents. Participants of one of the focus groups carried out in the ED pointed out that numerous patients coming to the department do not experience just one of the conditions mentioned below, but rather a long list of co-morbidities which need to be managed in addition with the presenting complaint.
Table 4 - The range of acute medical patients admitted to the AMU/SSU/ED in Beaumont Hospital (based on the views of the interviewees)

<table>
<thead>
<tr>
<th>TYPES OF PATIENTS</th>
<th>CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>Chest pains</td>
</tr>
<tr>
<td></td>
<td>Atypical chest pains</td>
</tr>
<tr>
<td></td>
<td>Cardiac patients</td>
</tr>
<tr>
<td></td>
<td>CCF (Congestive Cardiac Failure)</td>
</tr>
<tr>
<td></td>
<td>MIS/Heart attacks</td>
</tr>
<tr>
<td></td>
<td>STEMI (ST elevation MI)</td>
</tr>
<tr>
<td></td>
<td>Non-STEMI</td>
</tr>
<tr>
<td></td>
<td>ACS (Acute Coronary Syndrome)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Palpitations</td>
</tr>
<tr>
<td></td>
<td>COAD (Chronic Obstructive Airways Disease)</td>
</tr>
<tr>
<td></td>
<td>Infective exacerbations of that</td>
</tr>
<tr>
<td></td>
<td>COPD (Chronic Obstructive Pulmonary Disease)</td>
</tr>
<tr>
<td></td>
<td>Shortness of breath</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
</tr>
<tr>
<td></td>
<td>PE (Pulmonary Embolism)</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
</tr>
<tr>
<td></td>
<td>Pneumothorax</td>
</tr>
<tr>
<td></td>
<td>Emphysema</td>
</tr>
<tr>
<td></td>
<td>Chronic lung infections</td>
</tr>
<tr>
<td></td>
<td>Lower respiratory tract infections</td>
</tr>
<tr>
<td>Medical</td>
<td>DKA (Diabetic Ketoacidosis)</td>
</tr>
<tr>
<td></td>
<td>HONK (HyperOsmolar Non ketotic Ketoacidosis)</td>
</tr>
<tr>
<td></td>
<td>Diabetes, low blood sugar and high blood sugar</td>
</tr>
<tr>
<td></td>
<td>Dehydration and hypothermia</td>
</tr>
<tr>
<td></td>
<td>Sepsis</td>
</tr>
<tr>
<td></td>
<td>Pyelonephritis</td>
</tr>
<tr>
<td></td>
<td>Liver disease</td>
</tr>
<tr>
<td></td>
<td>Osteomyelitis</td>
</tr>
<tr>
<td></td>
<td>Crohns disease</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal disease</td>
</tr>
<tr>
<td></td>
<td>Alcohol related conditions</td>
</tr>
<tr>
<td></td>
<td>Overdoses</td>
</tr>
<tr>
<td></td>
<td>DVT (Deep Venous Thrombosis)</td>
</tr>
<tr>
<td></td>
<td>Urinary tract infections</td>
</tr>
<tr>
<td></td>
<td>Cellulitis</td>
</tr>
<tr>
<td></td>
<td>Delerium Tremens (in relation to alcohol withdrawal)</td>
</tr>
<tr>
<td></td>
<td>Collapsed patients</td>
</tr>
<tr>
<td>Neuro</td>
<td>TIA (Transient Ischaemic Attacks)</td>
</tr>
<tr>
<td></td>
<td>CVA (Cerebro-Vascular Accident/Stroke)</td>
</tr>
<tr>
<td>Care of the older person</td>
<td>Elderly patients who need antibiotics</td>
</tr>
<tr>
<td></td>
<td>Acopia</td>
</tr>
<tr>
<td></td>
<td>Patients with diarrhoea from Nursing Homes</td>
</tr>
</tbody>
</table>

Summary and discussion

Nursing staff in the acute medical floor encounter patients with a wide variety of medical conditions. The wide diversity of patient groups who present to the acute medicine floor is not a surprising finding given the fact that the ED in particular is the primary point of access for every patient who requires medical assistance in an emergency situation.

It is important, however, that given the breadth of patient groups, the implied assumption that nurses responding to the care and management of these patients require an equally broad spectrum of knowledge and experience to draw from in order to provide holistic individualised care to each patient in the acute phase of their illness.

Additionally, whilst the list above is illustratively useful in giving an overview the spectrum of severity in which particular cases present themselves is not visible. For example, patients can present with illnesses with a clear pattern of exacerbation, management and treatment. Similarly, patients can present with an initially clearly defined illness and yet develop catastrophic complications.
Attempts to classify severity are undertaken by the Hospital Inpatient Patient Enquiry (HIPE) system, a database of clinical and administrative data on discharges from, and deaths in acute hospitals which use Diagnostic Related Groups (DRG) to classify information. A comparison of the range of acute medical patients admitted to Beaumont found by participants (above) with the comparative DRG data (from 2012)\(^4\) was undertaken to provide a deeper illustration of the diversity and severity of patients admitted to the acute medical floor. This table can be found in Appendix 5.

It is notable that the types of conditions most often encountered in Beaumont hospital are mirrored by the Myers and Lees (2013) integrated career and competency framework in the United Kingdom. This suggests that although there are differences in patient numbers and throughput, there are similarities in typical patient groupings between the Irish and UK context.

\(^4\) This was the most up to date HIPE data available at the time of the study
At the time of the study, participants said that there are several routes for patients into the AMU. The main route is through the ED at triage. Following the initial assessment and categorisation by the triage nurse, nurses from AMU/SSU take those patients who fit the main criterion of the AMU, namely if they can be quickly assessed, treated and discharged. This implied that patients with co-morbidities (i.e. more complicated presenting cases) tended not to be suitable for admission to the AMU/SSU.

Typically what we do take are the ones that we can turn over: we can get tests done and... And then the ones we take and need a little bit longer go up the house (AMU4)

This is key to understanding why not all acute patients are assessed and admitted to the AMU, but only those who are stable, who can walk (“the walking wounded”, PF2). Hence there is the distinction between being an acute patient and the acuity of the patient’s illness.

The patients that are stable more so and be able to manage ... a quick transit through the AMU. They wouldn’t take anyone like with any abnormalities on their ECG, like they wouldn’t take anyone with ST depression or anything like that. Even if they were young they wouldn’t take them with a [heart] rate of 120 or anything like that (ED2)

While the consultants mentioned that patients with a Manchester triage score of 2 or 3 are accepted by the AMU/SSU, the CNM3 in the ED stated that orange category patients and elderly patients are generally kept in ED and that yellow category patients usually go to the AMU.

[Patients going to the AMU] are usually category yellow, they would be probably quite well when they arrive, they would be able to walk down to the unit and they would be seen there [...]. We wouldn’t send patients down there who are quite unwell. If they’re an orange category we keep them here. They don’t go around. And also if we’ve got elderly patients who are category yellow, but who, say they are very immobile, may have dementia, may need help to the toilet, may need help with feeding, they wouldn’t go down. Because the whole purpose of the unit down there is to get people seen quickly, get their diagnostics done, get them either referred for admission or get them home. And it all needs to happen within a time frame” (M3)

This distinction explains why several nurses participating in this research argued that, for example, TIAs and neurological patients are admitted to the AMU, while others mention that these types of patients are not among the patients admitted to the AMU, primarily because nurses perceive that given the particular

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The Manchester Triage System is an internationally recognised system used in the ED to assist in the classification and categorisation of injury/illness. There are five levels of classification which are distinguished either by colour or number (Cronin 2003)
presentation of patient and their present nursing dependency there is a likelihood that the patient may have an admission of longer duration. While the more severe cases go to specialist wards, some of the less severe cases are admitted to the AMU, but they may not always be categorised as TIA or neurological patients.

Hence, as one of the participants to the study stated, there can be a considerable difference between ‘acute medical’ patients who are admitted to the AMU and patients who are acutely unwell. A distinction thus emerges between the ‘really well’ acute patients and ‘the real acute sick medical patients’

*You wouldn’t have the real acute sick medical over there [AMU/SSU]. They probably end up being moved to HDU for monitoring* (ED7)

On rare occasions, patients who do not fit the criteria of “quick turn-around” are accepted in the AMU/SSU in order to provide relief for the ED or for other wards:

*Sometimes the bed manager will make the decision to open it up if they’re stuck or if they’re closing some other wards. We can usually only take 4-6 at night time, but that sometimes changes* (AMU6)

Another reason for accepting patients who are not necessarily ‘quick turnover patients’ is related to the location of the AMU/SSU ward. Because this ward is located at the Lower Ground Floor in Beaumont hospital, several types of patients (such as psychotic patients, patients following overdose/self-harm or also patients expressing suicidal ideation) are occasionally placed and managed in this ward.

Participants indicated that given the very limited number of assessment trolleys and beds in the AMU/SSU, this may lead to problems as the service can very easily get congested if patients have a longer duration of stay than predicted.

While the general rule is that patients are to be taken from triage and not from the pool of patients already admitted to the ED in order to avoid the double-processing of the patients (as they have already been seen by a consultant), there are exceptions. On occasions, patients admitted to the ED and who have been waiting in that department for a long time are taken by the AMU with the aim to get them quickly discharged. Hence, according to one of the stakeholders working in the Patient Flow department, the AMU criteria are not ‘set in stone’ as rules can be adjusted and changed on a trial and error basis (PF2).

Apart from ED, another route for patients in the AMU/SSU is out-patients coming for review or patients just coming in for tests and procedures and an overnight stay at times. As some of the nurses participating in this research indicated, this route often creates delays in assessment and treatment and may lead to a further service congestion.

At the time of the study, it was reported that GP referrals into the AMU have been stopped. One reason for this was given by the Project Manager. When GP referrals were being accepted - it was noted that they had a relatively low acuity than estimated. The resulting patient group, according to the Project Manager produced long delays for sicker patients in the ED. As a result, a decision was made to revert to admit patients primarily from ED through the triage route to the AMU/SSU.
Summary and discussion

The primary route of patients into the AMU and SSU is following a nursing triage decision in the ED. Usually, patients from the ED are admitted into the AMU following triage if they are Manchester 2 or 3 patients and also if they fit the main criterion of the AMU, namely if they can be quickly assessed, treated and discharged. The discussion around the triage of patients raised a crucial point in relation to participant’s understanding regarding ‘acute medical patients’ and acute medical patients who are suitable for admission to the AMU/SSU’. Relatively speaking - ‘well enough’ patients or ‘the walking wounded’ are judged to be suitable for AMU/SSU. This is in spite of them being ‘sick enough’ to warrant admission to hospital. This distinction reflects the fact that nurses and stakeholders in this study have experience of severely ill acute medical patients and judge AMU/SSU candidates from their own frame of reference.

In other words, clinical judgement of a number of factors (e.g. severity of the patient’s illness, severity of presenting symptoms, actual and potential nursing problems, co-morbidities and potential consequences of interventions) appear to influence decisions regarding the patient route through the hospital. Implicit in this is the fact that such patients are assessed and monitored for these factors by nurses and doctors to ensure the appropriateness of this route.

As with all health care settings, occasionally patients who do not fit normal criteria of “quick turn-around” are accepted in the AMU/SSU to relieve pressures in other areas of the hospital (such as the ED for example). Occasional use of the unit by outpatients, or indeed due to its location as a safe setting for patients with mental health difficulties could be argued to be an unfavourable yet necessary means to achieve the best possible care within the available hospital resources. Not having criteria for AMU/SSU admission ‘set in stone’ allows some flexibility for service providers. The use of services for non-specific patients whilst essential does run the risk of causing congestion for usual AMU/SSU patients.

It is notable that GP referrals into the AMU had been stopped at the time of the study. This is in contradiction to the forecast for the acute medicine programme which proposed a pathway for GP referral directly into the AMU (HSE. et al. 2010, p.15). With the exception of the GP referral pathway (which is absent in Beaumont Hospital), the findings in our study mirror to a certain extent the literature around the pathways into the acute medicine service in UK hospitals. For example, Subbe et al. (2011) present a diagram of the patient flow through a UK hospital operating an Acute Medical Unit (see Fig. 6 below).

It can be noted that while in many ways similar, there are also several differences between the UK model and the flow into - and out of the AMU/SSU in Beaumont hospital. Firstly, Beaumont hospital no longer admits patients on GP referrals to the AMU/SSU. Secondly, following a period of up to 48h when patients are being assessed and observed in the Acute Medical Unit, patients in Beaumont may be discharged, admitted to a general ward or, admitted to a Short Stay Unit (SSU). The average stay for the SSU in Beaumont Hospital is currently 5.4 days. The admission avoidance clinic described by Subbe et al (2011) is not operationalized in Beaumont.
In summary, the findings regarding routes into the AMU/SSU whilst broadly straightforward revealed elements of intricacies regarding who is ultimately admitted to these units. These intricacies can be likened to the “complex multi-layered process” acknowledged regarding clinical decision-making in the context of a large tertiary hospital (HSE et al., 2010, p. 341). No opinions regarding the usefulness (or not) of this route were voiced by participants - which suggests perhaps that the current route into the AMU/SSU is not problematic.

This discussion reflects the findings and situation in Beaumont Hospital at the time of the study. Given the fact that the acute medical floor is a new area which is open to changes relating to service, demands etc., it is entirely possible that changes in this area may have already occurred since the publication of this report.
Activities and roles of nurses caring for acute medical patients

While nurses still carried out fundamental nursing skills such as supporting patients with their activities of daily living (Holland et al. 2005), in the context of the acute medicine floor, several participants mentioned that there is less emphasis on this type of activity and more emphasis on clinical judgement with the need to quickly and continuously assess patients, making judgements and decisions in relation to their condition and treatment:

*It’s less of the turning and feeding and things like that. You have to be very quick in your assessment and liaising with the doctor. That kind of way (AMU1)*

In addition to providing care, according to one of the interviewed nurses, the role of the nurses becomes predominantly “*mental, rather than physical*” (AMU1).

In relation to the patients’ journey, nurses working with acute medical patients in both the AMU and the ED stated that they were performing the following tasks:

- Performing venepunctures and cannulations
- Taking blood tests (which is deemed by many nurses as a priority)
- Performing ECGs
- Checking blood results
- Ensuring that other tests are ordered depending on the patients’ condition and needs (ECHO, x-rays, MRI etc.).
- Performing frequent clinical observations (temperature, pulse, blood pressure, respiration and oxygen saturation, peak flow).
- Checking patients’ weight
- Female catheterisation

Several nurses participating in the study felt that many of their daily activities and roles are specific to the AMU and they revolve around preparing the patients, getting them started on their journey. By striving to get many tasks (such as taking the bloods, putting the IV line, etc.) sorted before patients are seen by the consultants or sent for further tests, nurses caring for acute medical patients are often required to think ahead and anticipate many of the patients’ medical needs.

Apart from these tasks, nurses also mentioned that they are often assessing for aspects which are not always quantifiable, but which, for an experienced nurse could reveal a great deal about the patient’s condition.

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6 This information emerged in the interview with consultants
You’re probably assessing the things that you can’t measure, like not only the vital signs, I mean things that aren’t measured. Like the look of the patients, their colour, their pallor, are they sweaty, you know, are they cold... There’s not actually a scale to put it on, but stuff that you are watching out for the whole time. Are they short of breath when they walk out of the bathroom? Are there things that make the pain worse or better? (ED5)

In addition to direct care, nurses stated that they performed many other activities on behalf of the patient. This was termed ‘indirect care’. Indirect care activities included processing the patients, doing the paper-work, entering a bed request form on the system, documenting their care and checking that everything has been ordered.

This at times involved “fighting” for the patient (AMU7) or actively advocating on behalf of the patient. For example, one participant stated that part of her work involves making many phone-calls in order to schedule patient’s tests and if needed to get their tests prioritised, chasing the consultants and other members of the team, following up on the tests etc.

[...] you have to ring the porter and the porter they don’t answer you and then you have to ring them again in 5 minutes... So you do have to make a lot of phone calls and... (AMU7).

And even if they’re not on the list, but they will be on the list in the afternoon and you try to ring again, and you go to the doctor to get them on the list. (AMU6)

[...] calling CTs and checking that they are on the list. And then if they are not on the list, calling the teams to get them on the list. So these things do tend to take a lot of the time, so we’re not actually hands-on the patient all the time (AMU4)

[...] ringing for scans, chasing doctors, chasing after A&E and chasing the team to come back and do the patients to prevent overcrowding, ringing the porter... doing the porter’s job... We’re doing everybody’s job, doing stuff at the desk, photocopying notes the whole lot... A massive amount of indirect care... more of that than there is of the rest (ED5)

Communicating and liaising with other teams thus emerges as a very important part of the daily activities which nurses caring for acute medical patients do. Apart from ordering and following-up on tests, nurses constantly communicate vital information to the consultants, such as results of the tests, updates in the patients’ condition and, last but not least, the things that the patient forgot to mention:

[...] you can say [to the doctors]: “Listen, they’re not doing as well as they were doing two hours [ago]” [...] It’s more holistic... You say: “Listen, I was talking to the mother, the wife, the... you know... and they said such and such and the last time they came in...” [...] I think there’s a holistic quality where you’re looking at it all (ED1)

[...] there are times when the patients forget to say something to the team and then they remember and say it to the nurse. So I would then say that to the doctor as well [...] Because sometimes the patients feel that if they are surrounded by a big entourage of doctors they won’t remember a thing and if you do their blood pressure they tell you: “You know what? I had this diarrhoea for a
few months and I forgot to mention it”. They come in with a low haemoglobin and they say: “My GP gave me Difene and I’ve been taking it for one week” And that’s very relevant information for the team because maybe it’s the Difene causing the low haemoglobin. Things like that... (AMU1)

Nurses also stated that they provide logistic support for consultants and, apart from preparing the patient for the treatment (e.g. inserting IV lines, etc.), they strove to anticipate the possible future needs and requests from the consultants and facilitate them access to the needed resources. All of this was with the undertaken with the purpose of improving the patient journey.

Participants in the study also said that communication with the bed manager and the rest of the patient flow team was also important in order to facilitate the functioning of the unit. Several nurses mentioned that by communicating with the Patient Flow department the unit ensures that each morning there are trolleys left unoccupied in the AMU for assessing incoming patients.

Last but not least, in case a patient becomes unwell and essentially unable to stay in the AMU, nurses stated that they liaised with the Patient Flow department and the specialist wards to attempt moving the patient to the correct ward (“up the house”).

Apart from communicating with other teams in the hospital, nurses caring for acute medical patients also mentioned that, due to the nature of their work, they are constantly interacting with other organisations and institutions outside the hospital in order to ensure that patients have a range of support mechanisms when they return home/in their community (e.g. public health nurse, social workers, community organisations and networks of support, etc.).

Teamwork emerges as an important element in the interviews and focus groups carried out as part of this research. Nurses indicated that they are often working back to back in order to discover an answer or a solution to the challenging problems they encounter in treating some of the cases.

*Last week a cardiac patient came in with chest pains like there was no ST elevation on her ECG, but we myself and another nurse were working together in Resus and as the day was progressing and we were repeating the ECGs it turned out that she was an evolving MI and we were informing the doctor as we were going on* (ED3)

In a similar vein, keeping an eye on each other’s’ patients, was mentioned by one interviewee as a very important part of caring for acute medical patients.

Communicating with patients and relatives also emerges as a key component of the nurses’ roles and activities. This includes: informing patients about the reason why they have been admitted to the hospital, what the course of action will be (e.g. what tests will be performed, when they will be seen by the consultants, etc.), as well as discussing possible delays in taking tests or receiving results.

Especially in relation to the relatives of those coming to the ED by ambulance, nurses felt they have a responsibility in keeping them “up to date and informed because they’re generally very anxious. They don’t know what’s going on” (ED2). Hence, providing them with information and moral support is very important:
They’ve just seen their relatives come in by ambulance so they’re kind of away from it all. You’re constantly telling them that it’ll be ok or you’re giving them the seriousness of the situation (ED1)

Participants stated that nurses on the acute medical floor played an essential part in educating patients. This involved offering them information about their condition, their treatment and the tablets prescribed by consultants and providing them with crucial information about available networks of support in their community. According to one of the nurses interviewed, this is particularly important for patients who are going home over the weekend.

Often nurses felt that they have a key role in ‘translating’ the information for the patients:

[…] patients who are asking […] “What is this tablet” I was not told about this tablet’. And I thought: “Why did the doctor just prescribe this table and did not explain why and what it is for?” You know, it’s your time, time that you spend explaining (AMU5)

According to the participants in this study, nurses on the acute medicine floor carry out stated that they were carrying out a wide range of specific roles and activities which included both direct and indirect care for these patients. It can be noted that in many instances nurses used the term ‘holistic care' to describe their role in relation to the patient. Holistic care, according to the participants involved moving beyond an exclusive focus on the medical condition of the patient and considering broader needs of the patient such as social, psychological, environmental, etc.

Summary and discussion

This study revealed that nurses on the acute medicine floor operate in a fast-paced context and undertake a broad spectrum of activities and skills in order to deliver quality patient care. Fundamental nursing skills are often attributed as typical nursing activity. This kind of work reflects particular aspects of the nursing role and is strongly associated with relevant theories about what nursing is. For example, the Roper, Logan and Tierney model of care (Holland et al 2005) articulates the conduct of nursing through an ‘activities of daily living approach’ where care is directed towards particular activities (e.g. mobilising, communication, safety, hygiene). The influence of this theory is strong in general hospital settings and is used as a framework for many care plans.

However, more recent approaches to theorising nursing emphasise the cognitive element as the primary determining factor which shapes the nurses’ attitudes and conduct. A central concept of nursing is the ability to exercise of judgement in providing care (Royal College of Nursing 2003). The exercise of clinical judgement was very evident in many of the participant’s accounts of their assessment and care of patients on the acute medical floor. Such clinical judgement, made more difficult by the fast-paced nature of the acute medical floor, underpinned many contributions made by participants in articulating influences on their role and activities. While still carrying out fundamental nursing skills (e.g. toileting, washing, helping patients putting on their gown), nurses seem to be multi-tasking, quickly and continuously assessing patients through their seemingly mundane interaction. Additionally, nurses in the acute medical floor are
actively involved in educating and advocating for their patients. In undertaking caring work for acute medical patients, nurses performed both direct and indirect care activities.

Direct care includes tasks such as performing venupuncture and cannulations; taking blood tests (which is deemed by many nurses as a priority); performing ECGs; checking the bloods; ensuring that other tests are ordered depending on the patients’ condition and needs (ECHO, x-rays, MRI etc.); performing frequent clinical observations (temperature, pulse, blood pressure, respiration and oxygen saturation, peak flow); checking patients’ weight. Fundamental nursing skills (i.e. addressing daily living activities) are also classified as direct care. In addition to this, nurses see themselves as preparing the patients for their journey, thinking ahead and anticipating many of their medical needs. Hence, they are often assessing for aspects which are not always quantifiable. There are several similarities between these study findings and that the competency framework developed by Myers and Lees (2013, p.5) (see below).

<table>
<thead>
<tr>
<th>Acute Medical Nursing ‘Skills'</th>
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<tbody>
<tr>
<td>1 Patient assessment</td>
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<tr>
<td>2 Diagnostic procedures</td>
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<td>3 Interpretation of test results</td>
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<td>4 Team working</td>
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<td>5 Principles of clinical governance</td>
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<td>6 Legal and professional issues</td>
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<td>7 Planning discharge</td>
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<td>8 Communication and organisation</td>
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Indirect care refers to: processing the patients, doing the paperwork, documenting their care and checking that everything has been ordered; advocating/"fighting" for the patient (e.g. making many phone-calls, scheduling their tests, getting the tests prioritised if needed, following up on the tests etc.); communicating and liaising with other teams; interacting with other organisations and institutions outside the hospital; communicating with patients and relatives (which pertains not only to offering information to patients and their families, but also to educating patients about their condition and also frequently ‘translating’ the information for patients).

Similarities between the direct and indirect care activities articulated by participants in this study have been found in previous studies of general and mental health nursing (Scott et al 2006). The fast-paced context in which acute medical nursing care is delivered is worth acknowledging as it forces nurses charged with delivering care to speed up their assessments and interventions to match the overall flow of the department. This study found that nurses in Beaumont strove to provide holistic care to acute patients. As highlighted earlier, recent research found that moderate to high levels of burnout was prevalent amongst general nurses (Scott et al. 2013). The findings of this study suggest that nurses’ continue
to endeavour to provide a high standard of care regardless of their own personal beliefs about their workplace.

The Irish Nursing Board defines “competence” as a “multidimensional phenomenon [which] is defined as the ability of the Registered Nurse to practice safely and effectively, fulfilling their professional responsibility within his/her scope of practice” (www.nursingboard.ie/competency/comp2). The 5 domains of competence mentioned by the Irish Nursing Board are: 1) Professional/Ethical practice; 2) Holistic approaches and integration of knowledge; 3) Interpersonal relationships; 4) Organisation and management of care; 5) Personal and professional development. This study found evidence that acute medical nursing activity demonstrated evidence of all five core competencies mentioned by the Irish Nursing Board. Again, it is important to acknowledge the context of care in which these competencies are exercised.

The Strategic Framework for Role Expansion of Nurses and Midwives (DOHC, 2010) mentions that an expansion of nursing roles is key to improving the quality of care provision to patients (p.7). The Framework mentions the following areas in which nurses now working in the acute medical/surgical wards need to be competent in (p. 20):

- intravenous (IV) cannulation and venepuncture
- electrocardiogram (ECG) analysis
- application and care of continuous positive airway pressure (CPAP), and bi-level positive airway pressure (BPAP) and non-invasive ventilation (NIV)
- male catheterisation
- nurse-led discharge under agreed protocols
- use of early warning scores (EWS)

Our research concluded that nurses in Beaumont are already competent in many of the above-mentioned areas, while others are still in development. The primary motivating factor for such skill development was an overarching interest in the patient and a willingness to undertake skills which improved the patient experience/patient journey. In other words nurses did not express interest in developing skills for personal development or just for the sake of it. For example, nurses interviewed in this study are already carrying out intravenous (IV) cannulation and venepuncture. Furthermore, even though they have not mentioned the CPAP and BPAP, several nurses indicated caring for patients requiring NIPPV. Last but not least, while respondents mentioned that they perform ECGs, some of the nurses interviewed highlighted the need for further expansion of their role in analysing the ECG results. According to the consultants, nurses were already catheterising patients. Many nurses interviewed mentioned that nurse-led discharge constitutes a key competency and priority for role expansion in the context of the ANP/CNS role (but not for them). Last but not least, several nurses also indicated that training in the use of the early warning score tools are essential for their work.

Apart from the medical skills, nurses found it difficult to define the entire set of activities and tasks which they perform in caring for acute patients. This finding is in line with numerous studies which point out that all categorisations and approaches fail to enumerate the complexity of the work nurses do (Cowman et al., 1997; Bowker et al., 2001; Corbally et al, 2003; Scott et al., 2006). The difficulty to define nursing and the invisibility of nursing work had been highlighted as early
as 1859 by Florence Nightingale as she argues in her classic book *Notes on Nursing: what it is and what it is not* that the very elements of nursing are all but unknown.

Scholars point out two key reasons which may explain the relative invisibility of the nursing work. On the one hand, according to Morris et al. (2007), nursing is commonly defined in functional terms. Having analysed several definitions of ‘nursing’ in existing literature, the authors conclude that these definitions tend to focus on the function of the nurse in the area of health care and the physical environment in which they are working (p. 464). This implies that nursing work which is non-patient-specific (e.g. training, management, administration, advocating, educating etc.) may at times be downplayed or rendered as invisible.

On the other hand, the invisibility of the nursing work may also be explained by the fact that the care which they offer patients is holistic. For example, our study showed that nurses in Beaumont hospital often times find it difficult to spell out all the activities and tasks which they carry out due to the fact that the care they give to the patient is continuous and holistic. Nurses are constantly keeping an eye on patients, and this is not just their patients, but also patients which are cared for by the other nurses. Hence there is a very fine line of separation between the time which nurses spend caring for the patients and the time spent carrying out non-patient-specific tasks (e.g. administrative and managing tasks, breaks etc).

Last but not least, it is important to note that many studies highlight the fact that a large proportion of the work which nurses do could not be categorised as direct patient care (Cowman et al., 1997; Westbrook, 2011, Munyisia and Hailey, 2011). For example, studies show that only about a third (37% - Westbrook, 2011; 29% - Munyisia and Hailey, 2011) of nursing time-spent represents direct patient care. Most of nursing work contemporarily, is undertaken not necessarily in the presence of the patient, but on behalf of the patient indirectly (with the intention of bringing about the best outcomes for patients). This suggests that in a similar vein to previous studies exploring nursing activity, acute medical nursing activity seems to reflect both elements of indirect and direct nursing.

While our study is mainly qualitative and did not quantify the amount of time nurses in Beaumont Hospital spent on direct care or other types of activities, findings seemed to echo previous studies insofar as there was more mention by participants of indirect nursing compared with direct nursing. This is not unexpected given the the clinical context in which the study took place. Lees (2011) articulates five ‘modes’ of acute medical nursing activity from her study of workforce planning, arguing that separation of these tasks can be useful to provide expedited safe care to patients on the acute medical floor. The five modes of acute medical nursing activity are:

<table>
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<th>Table 6 Modes of acute medical nursing activity (Lees 2011)</th>
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<tr>
<td><strong>Acute Medical Nursing ‘Mode’</strong></td>
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<tr>
<td>First mode Emergency care and stabilisation</td>
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<tr>
<td>Second mode Assessments and related actions</td>
</tr>
<tr>
<td>Third mode Admission and general patient care post admission</td>
</tr>
<tr>
<td>Fourth mode Ward rounds, reviews, progress chasing, referrals and follow up</td>
</tr>
<tr>
<td>Fifth mode Co-ordination, discharging and transfers</td>
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Note that the five ‘modes’ can be attributed to mostly indirect nursing activity in a similar way to what was found in this study. It is clear that several similarities in the content of acute medical nursing work as described by Lees (2011) and what was articulated by participants in this study. It could be suggested that Lees’ task related work modes contradict the holistic approach espoused by the staff in this study. However, what is clear is that nursing activity in the context of acute medical nursing is far from simple to articulate. It is important to note also that there is overlap between the activities and roles of acute medical nurses discussed in this chapter and the essential qualities and skills identified by participants which is discussed in the following chapter.
Qualities and skills

When asked about the qualities and skills which they bring to the care of acute medical patients, the participants in this study were initially hesitant in answering and found it difficult to clearly articulate their individual qualities or skills.

*It is kind of hard to articulate... You just do it and nobody really asks you then... and you’re never gonna' say how great you are or your qualities or things like that* (AMU3)

Thus, for some of the nurses who are, in their words, perhaps too modest to enlist their qualities and skills, the fact that they are simply caring for the patient was deemed as sufficient. Others pointed out that “just doing your job” is the best skill which nurses can bring to the care of patients. For these interviewees, a nurse’s ability to perform their tasks successfully constitutes a sign of a being a good nurse.

It emerged from several interviews that the newly acquired skills (such as the ability to order and take bloods, to insert IV lines and do cannulations, etc.) were initially motivated by nurses’ mindfulness of ensuring good patient flow and also gave nurses confidence and pride as well as a sense of independence in being able to assist patients through their journey in preventing unnecessarily delays to their treatment. Expedient care was the priority.

*It’s actually nice... because you are doing things like taking bloods and putting an IV line in, you’re not waiting on doctors to do it because you know how to do them. And once you have those skills you feel good about the fact that you have these skills* (AMU7)

Another important skill mentioned during the conversations with nurses is linked to having a broad medical and nursing background of a wide variety of conditions. Given the broad spectrum of acute patient groups, it was argued that nurses caring for these patients needed to know a lot about a lot of things in order to make appropriate decisions for the patients in their care and make good clinical decisions. The skill of clinical interpretation and judgement through a nursing assessment is explained well by the participants. Also the ability perform a good patient assessment is articulated.

*When you’re talking to the patients, you’re hearing from the point of view of objective symptoms [...] You know, if the patient will say: “I’m really short of breath” and then looking at the ankle swelling and say - “oh, maybe CCF”. You kind of listen to them and do your assessment at the same time. And I find it really important. COPD patients will say: “Oh, my breathing is much improved” but you can see the patients using accessory muscles. You’d know that the patient is still not stable from the breathing point of view* (AMU1)

*It’s not always down to the vitals, you have to look at the patient, their background* (ED8)
Being able to correlate theoretical knowledge with symptoms described by patients was, according to the participants, key in quickly assessing patients. This invariably assisted in speeding up the decision-making process. Having a broad knowledge base in the field also helped nurses provide patients with up-to-date information on, for example, the contraindications of medicines prescribed by consultants.

Participants emphasised the importance of good clinical experience and a broad spectrum of knowledge by highlighting how sometimes inexperienced nurses or newly qualified nurses can miss the key cues of illness/deterioration if they lack experience.

*If you’re talking about the new graduates coming straight from college a lot of them…it’s difficult even talking to patients [...] you need to be able to spot things [...] this comes with time. And there is a gap between theoretical... [...] Just being able to see a sick patient, follow up through* (ED8)

Furthermore participants stated that clinical experience enabled acute medical nurses to read between the lines, to discover vital clues and information that are sometimes ‘hidden’ in what patients are saying, particularly when patients do not necessarily associate the medication that they are taking with their condition:

*You find somebody that comes in and then [you ask] “Have you any medical issues?” and they say “No.” and then you ask “Are you on any regular tablets?” and they say “Loads”. And they wouldn’t know what they’re on. Or why they’re on them for. They don’t actually have an actual knowledge of their... Like “Have you had any heart problems?” “No. No” “Have you had a heart attack?” “Yes.”. You know, you find out a lot from...* (ED1)

Another central skill which many nurses participating in this study mentioned referred to their ability to think very quickly and to be able to ‘juggle’ all cases in one’s mind. In this respect, good time management and the ability to efficiently prioritise all tasks was deemed as highly important. ‘Thinking quickly’, was a necessary skill which took time to develop.

*If you’re working at this end, a lot of it is in your head more so than on paperwork. Especially when we’ve got the assessment patients we don’t admit them if we’ve no paperwork on them. So it’s all [...] in your head: knowing what they’ve gone for, what they’re waiting for; or the doctors might come up to you and say they need another blood test in two hours* (AMU4)

*We have to make decisions very quickly. When you’re in triaging people you’ve a very small window of opportunity to decide what’s going on with them. Obviously they look... they’re sick, but on the other side you’re thinking: what boxes do they tick? Where do they go? You have to think quickly* (ED7)

Managing complexity was viewed as a key skill in acute medical nursing. In a similar vein, it was pointed by nurses that it is essential to “be able to cope with whatever is thrown at you” (AMU4), and to manage the complexity of multi-tasking:
[Managing] different things at the same time, like having a few balls up and the air and trying to manage them and not being like headless chicken... (AMU7)

Nurses also mentioned that communication and teamwork skills are essential for their work caring for acute medical patients particularly in a busy environment as the ED and the AMU/SSU are. Being a good communicator (in addition to being a good observer) was important, particularly given current resources.

You come to a point where you are watching everything, you are watching everyone. [...] when it’s really busy your mind is rolling over the whole thing, you’re watching everyone and you could be keeping an eye on each other’s patients as well because everyone is so stretched here lots of the time that you are watching all of them... (ED5)

In spite of working consistently under time pressure and in a very busy environment, nurses felt that, in comparison with the doctors, they are offering a holistic approach to the care of the acute patient:

It’s easy for doctors to come in here see them unwell and be like: “You’ve done this, that, or the other” But then they walk away once the patients... like they’re happy enough, they have other priorities and other sick patients... But if you’re in Resus [...] you are watching them constantly. You have a better picture I think (ED1)

Participants interviewed in this research project also pointed to a few other skills which are deemed to be highly important for the care of acute medical patients. For example, one interviewee said that friendliness is an essential quality which nurses bring to their care of patients and their relatives because it helped them feel more comfortable and relaxed:

I like to develop a relationship with a patient and be light-hearted, in the sense that it’s not all doom and gloom (AMU7)

In addition to this, protecting/‘sheltering’ the patient was also stated as a key skill by one of the nurses in the study. She mentioned that while it can be very daunting for a patient to have a team of doctors “staring at him/her” (ED1), nurses can offer comfort to the patient in these circumstances by their very presence. This articulation of the advocacy role in action is something which was mentioned by several participants.

Nurses also pointed out that having a calm approach was an important quality which had a positive influence on the patients and also on other staff.

I think you have to keep calm all the times. Because if you look calm, the patients think everything is ok [...] So you can’t look stressed even if you are under pressure (ED6)

Last but not least, all participants in this study mentioned that the ability to ‘translate’ or interpret information and communicate information was an essential skill. Participants stated that they were continually involved in interpreting meaning and communicating information to doctors, patients, relatives and others. At times they had to use medical lexicon (in communicating to doctors for example) and at other times they used lay language in conveying important information to patients and families. This ‘translation’ or communication skill, was called on continually - nurses moved between the two lexicons depending on the context.

Like if somebody had atrial fibrillation or something, we could explain to them from the beginning what an atrial fibrillation is,
where they may never have had that explanation before. And they go: “God I never knew that before about my condition (ED2)

And [we] also have an explanation of who’s on the team. [...] the patients think doctors are all of the one level, but they don’t realise that they are consultants, registrars and maybe medical students (ED2)

The stakeholders in this study reinforced all aspects mentioned by nurses caring for acute medical patients in the ED and the AMU/SSU about essential qualities and skills. In particular, they emphasised the ability to make quick and informed judgements and assessments as an essential skill. One interesting aspect which can be noted from the discussions with several stakeholders is that nurses working in the AMU/SSU mentioned that nurses in the AMU/SSU had a supplementary set of skills compared with ED nurses. This related to the differing background in medical nursing (and not emergency nursing) that AMU/SSU staff had.

There’s a certain amount of skills that an A&E nurse has. And it doesn’t... stand to just basic nursing care. It doesn’t. They are what they are around there whereas the girls here [AMU/SSU] are coming from a different background. They’re coming from looking after full medical care patients (M1)
Summary and discussion

This study highlighted that emphasising the important skills and activities acute medical nurses bring to the care of acute medical patients is difficult to articulate initially. This is not a new phenomenon. Other studies have identified nurses’ hesitancy in talking about the important job they do and the skills which come into play in carrying out their role (Cowman et al., 1997; Scott et al., 2006). Although qualities and skills are presented in a separate chapter here, they cannot be considered in isolation from the overlapping activities and roles of nurses which was discussed in the previous section.

Following prompting, the skill of clinical experience appeared to be the most articulated factor which was most essential in effectively caring for acute medical patients. Implicit in experienced practitioners is the ability to consider complex situations, draw on a wealth of knowledge and be proficient/expert in assessment and decision-making. The participants in this study made an important distinction between having a broad medical knowledge and having a rich experience, both of which enables them to develop their intuition and pattern recognition.

We can draw multiple parallels between these findings and Benner’s (1984) five stages in the process of acquisition and development of a skill. While in the first stage (Novice) the nurse has no experience and confidence in the situation in which they are expected, the second stage (advanced beginner) implies that nurses become more efficient and skilful in their practice while still needing occasional support in performing their tasks. In the third stage (Competent) the nurse is, according to Benner able to demonstrate efficiency and to be confident in their actions. Stage 4 (Proficient) – nurses become proficient and achieve a holistic understanding of their work. Their work situations are perceived as wholes rather than a series of isolated tasks. In the last stage (Expert) nurses achieve a deeper understanding of the situation and analytic). Clearly, expertise in acute medical nursing is most desirable given the potential consequences for error (Benner, 1984).

Expert acute medical nursing is often exercised through mundane approaches or by nurses working in ‘ordinary situations’ such as talking to patients. Searching for hidden cues (e.g. breathlessness, cyanosis) using ordinary contexts is a practice (e.g. a relaxed chat). In other words, extraordinary nursing work is hidden in the ordinariness of day to day interactions. Apart from this, they pointed out that having a broad medical and nursing background of various conditions as well as being an experienced nurse play a significant role in enhancing their ability to make quick clinical judgements. Furthermore, the ability to ‘juggle’ many cases in one’s mind, to cope with “whatever is thrown at you” and to manage the complexity of multi-tasking were all mentioned as important skills during the interviews and focus groups.

Having a broad spectrum of knowledge was an essential antecedent to such practice. Good assessment techniques were underpinned by such knowledge. Myers & Lees (2013) echo the importance of knowledge in the acute medical setting. They articulate that knowledge and skills of the nurse working in the acute medical settings are broad-ranging (p.4). In their view, “appropriate assessment and care for patients presenting to the AMU can only be delivered by nursing staff able to demonstrate very well developed skills regarding patient assessment, re-assessment, patient observation, immediate treatment, coordination and implementing good clinical decision-making skills” (p.4). The resonance between these two studies is interesting. Similarities between the
competency framework identified from the Myers and Lees (2013) study (see table 5 above) illustrates further the resonance of findings obtained from a UK cohort (using survey methodology) and findings obtained from this qualitative study.

Being able to continually and quickly assess patients and to make clinical judgements was deemed an important skill for acute medical nursing. The findings expressed by the nurses reflect the call for fast-tracked, expedited diagnostics which will ultimately translate into a better patient experience has been formulated as key objectives of the Acute Medical Programme (HSE et al, 2010). As was mentioned earlier, undertaking expanded roles were motivated primarily for their interest in improving patient care. It was the ability (and authority) to improve the patient experience which gave nurses a sense of pride and independence.

Respondents also mentioned a set of personal skills which are essential in their care for acute medical patients. These skills include interpretation, judgement, communication, advocacy and teamwork. Several skills mentioned by nurses interviewed for our research are in line with findings from other studies. For example, Jones (2005) finds that personal characteristics such as confidence, interpersonal communication and teamwork skills are key facilitators of role development and effective practice.
What is unique to acute medical nursing?

This chapter refers to conceptual responses given from participants when asked about what makes acute medical nursing unique. In responding to this question, participants in this research referred to three distinct interlinked areas: a) the nature of the work in acute medicine; b) the set of skills which nurses working with acute patients have; and c) the distinct profile of acute patients admitted to AMU. This is discussed sequentially below.

a) The nature of the work in acute medicine

Many nurses described acute medicine as a very interesting and very dynamic environment: “It’s never boring and time flies. And I know sometimes it gets too busy here [...] But it is part of our role” (AMU2).

Almost all nurses participating in this study felt that the main difference between working with acute patients and working in a general ward lies in the quick, fast-tracked nature of work.

“... Literally from the minute they come in you ask them who’s at home with them [...] what’s there in terms of home help. You’re kind of getting them out the door before they even sat in the chairs sometimes” (ED8)

In a similar line, consultants mentioned that speed is what makes acute medicine unique. The importance of having senior clinical decision makers be in contact with patients within their first hour of admission distinguished acute medical care from general medical care. This was something which was voiced as a distinguishing and positive characteristic.

“If you look at the ones up the house they probably wouldn’t see patients up to maybe until 12-24h after they were admitted. Whereas we are very much on the ground doing the work (D1)

Due to the speedy discharge process, all tests ordered by the AMU/SSU are performed quicker than in the other wards. For example, as one nurse indicated, the results of blood tests are generally back within an hour depending on the stickers and ECHOs are done faster than before the transition from AMAU to a short stay unit, when patients could be waiting a week for the tests (AMU3). Ultimately, this fast-tracked processing of patients translates into a better patient experience:

“I mean anybody that comes via this way they think: “Wow, it’s great, I can go out so quickly”... And I think that when people are in with chest problems they do need to be dealt with quickly because [otherwise] they can get lost in the maze that is A&E” (AMU7)

Stakeholders also emphasised the quick, fast-tracked nature of the work in the AMU, arguing that in order to get things done at this pace, having access to speedy test results represents only one side of things, but that team work effort is often required. Hence, consultants and nurses as well as the other teams work together in an effort to provide a seamless path for the patient.

“And it is more focused [...] on the discharge process because the estimated length of stay in the Short Stay Unit is 48h [...] So there’s a huge focus on discharge planning for nurses’ role and coordination as well: making sure that patients have had their tests, that delays
are not further escalated. It is a little bit different than the general medical ward in that the focus is on what we can do in the early stage is to reduce the stay and get people home quicker and in better health (PM)

You’re trying to get things done quicker. You’re trying to get patients assessed and you’re trying to get everything done and turn them around quicker. And picking up on any delay that goes from the moment they come through the door. Like if you think they need physio, get physio involved straight away or get the social worker involved straight away. While before you maybe knew that you had a bit of time to get those things done, now you’re trying to get all that right at the start (M2)

They’re constantly looking to: “What’s next? What’s next?”, to move the patient if it’s not to discharge but to move them along to the next point of care or the decision point. And it’s probably unique in that it’s quite a fast setting from a turnover perspective. And it means they’ve a lot of... they’ve a big leadership role in that sense, that they can proactively manage the patient (PF2)

Many of the nurses working in the ED department felt that one of the key differences in working with acute patients (for admission to the AMU/SSU) is that one broadly knows what to expect. Knowing the patterns, the specificities of acute medical patients means that one has a good idea of how patients are going to respond to treatment. This was contrasted with trauma patients.

With the road traffic accident you just don’t know what it involves. There’s a lot of underlying issues which you don’t know (ED3)

Road traffic accidents involve several loads of teams: like orthopaedic and surgical, neurological (ED2)

However this does not necessarily translate in an ease to categorise acute patients as, according to several nurses, many acute patients present themselves to the hospital with various co-morbidities, and uncertainty is an ever-present fact underpinning patients and their presentations. Mindfulness of uncertainty was voiced as also needing to be considered and incorporated in the decision-making process.

For this reason, stakeholders stressed that in acute medicine nurses need to have a very rich and broad knowledge in order to cope with the variety of acute medical conditions and that this exposure to the a wide-range of acute medical conditions is unique. Furthermore, knowledge of the different organisations, and other forms of support in the community is essential.

I suppose they’re very aware of what’s available in the community from a CIT perspective from OPAT they have quite good relationships with those support networks in the community and that is a skill that they're relying on and that they’re building because these patients are coming in and in order to turn them around they need access to certain services like that. So that’s probably unique to that ward. Although it should be across all the wards and it probably is, but to a much more intense on that ward (PF2)

Other differences mentioned include: carrying out more frequent observations than in the other wards (AMU5), and using a different documentation (AMU6).
b) The set of skills which nurses working with acute patients have

As highlighted earlier, a broad spectrum of patients attend the Acute Medical Floor. Typical admissions to the AMU/SSU tend to be acute medical patients who are to be relatively ‘well’ in comparison with sicker patients, and are likely to require a short hospital stay. As a result, the specific set of skills nurses use in caring for their particular patient group has emerged as a response to caring for this particular patient cohort. Many nurses as well as stakeholders felt that the ability or, as some argued, the privilege of making decisions about what bloods to take represents a unique aspect of acute medical nursing. The independence associated with such decision-making is closely linked to meeting patient needs. As a result of having authority to undertake additional skills to assist the patient, participants expressed that this fostered as sense of independence and voice compared to the other wards.

You’re not so dependent [anymore]. You’re more independent down here. And it’s more about discharge planning, trying to get the next patient in... (AMU6)

I think that we are getting more of a voice [...] The consultants that are here they do listen to your opinion [...] so that gives you the feeling that I do have a voice, I do have an input here. But I think everyone needs to work together and that echoes I that the wheels don’t stop turning... (AMU7)

This suggests that working with acute patients requires a great deal of teamwork and a lot of coordination skills in order to get things done quickly.

The fast-tracking of patients puts significant demands on nurses to make very quick assessments on the condition of the patient and this was considered by several participants to the study to be unique comparing to the core wards in the hospital.

It’s a different sort of busy because you do have a high turnover and you have a lot of admissions (AMU4)

Nurses as well as stakeholders referred to acute medicine as a holistic approach and felt that this requires unique skills comparing to the other wards

I think it’s the capacity to do an overall assessment and initiate a treatment in a very short period of time and actually to see out that treatment to an end. So I think you would work very closely with a consultant, but actually you’re in there doing the assessment and carrying out the treatment with them in the background (DoN)

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7 More detailed description about skills can be found in an earlier chapter ‘Activities and Roles of Nurses Caring for Acute Medical Patients.'
c) The distinct profile of acute patients admitted to AMU

According to several nurses the profile of patients assessed and admitted to the AMU/SSU is also distinct from the typical patients in the other wards\(^8\). This had naturally created a particular patient cohort which had brought about its own nursing challenges. Participants stated that the AMU/SSU tended to get patients who are mainly over the age of 60 (ED7). However this appeared to be only a recent change: during the period when the AMU was part of the ED, another participant stated that they were only taking young acute patients.

The issue of acute medical nursing having a distinct profile was raised as an issue. Two stakeholders highlighted the fact that Acute Medicine as a speciality is not as well acknowledged/established as other specialities within medicine.

*Acute medicine as a specialty has a long way to go I think in order to be more integrated and seen as a specialty like maybe respiratory or cardiology (PM)*

*I suppose because it’s all so new, it is evolving [...] It’s possibly because it’s new and ... it doesn’t have a reputation maybe it... so it is important to build on it, to encourage people to choose this specialty... I mean any specialty that attracts nurses seems to have a higher diploma course attached to it. It seems to have a specific qualification... so probably there is something about doing something particular relating to acute medicine (DoN)*

Consultants felt that there is scope for acute medicine to become a speciality given the fact that it involves “hands-on” work, it is a fast-moving and fast-paced environment, thus having a good potential for attracting young nurses into the field (D1). One of the CNMs pointed out that, for the moment being, the AMU is like a pathway which links general nursing and ED nursing

*It’s just there. I would think it is neither A&E, but it’s not full ward care either. It’s the best of both worlds really (M1)*

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\(^8\) More detailed description about this topic can be found in two earlier chapters; ‘The Range of Acute Medical Patients Admitted to Beaumont Hospital’ and ‘Routes into the AMU/SSU’.
Summary and discussion

This chapter highlighted three broad conceptualisations regarding the uniqueness of acute medical nursing made by participants in this study. Our research indicated that there are three distinct areas which make acute medicine nursing unique:

The nature of the work in acute medicine - Nurses emphasised the fact that the speedy nature of their work, the fast-tracking of patients represents one of the key differences between working in an acute ward and a general ward. This distinction is a key determinant - Acute Medical Floors are configured to facilitate fast throughput (Lees 2011). The effort to provide an expedited diagnostic, a seamless patient journey and improved patient experience is in line with the Acute Medical Programme objectives formulated by HSE et al. (2010). This HSE vision appeared to be operational in the acute medicine floor. The fact that patients were seen by senior clinical decision makers within one hour of admission (in contrast to other medical disciplines), distinguished acute medicine from general internal medicine in Beaumont Hospital and was a source of pride for staff. In essence, this fast-tracked nature was a differentiating factor, both for nursing and medicine.

Other aspects which are unique to acute medicine nursing (which have been discussed in earlier sections) relate to the rich and broad knowledge needed in order to cope with a variety of acute medical conditions. Furthermore, compared to trauma patients, nurses mentioned that the evolution in the condition of an acute patient is, to a certain extent, predictable, hence the focus in acute medicine is on knowing and recognising the patterns, knowing what to expect. Similar findings to these are mirrored in a survey of practising acute medical nurses across the United Kingdom (Lees et al 2013). That said, there remains an appreciation of the uncertainty that is characteristic of any emergency/acute medical area in a large hospital. The uncertainty of not knowing what is coming next has been recognised in other studies as a positive aspect for nurses working in this area (Lees et al 2013). In essence there appears to be elements of both predictability and unpredictability within acute medical nursing.

The set of skills which nurses working with acute patients have was also mentioned as a theme in response to this question. In the acute medical floor, nurses’ assertions of their ability to make decisions and act on observations gave them a sense of independence, leadership and more voice compared to the other wards. Teamwork and coordination skills are essential in order to make very quick assessments and judgements. A skill emphasised by participants which strongly reflects the fast paced environment is a focus on discharge planning which appears to happen almost at the point of admission. Although this is not essentially a ‘unique’ nursing activity, the frequency of turnover, and discharges in relation to the wider hospital, suggests that the frequency of discharge planning (and not discharge planning per se), is what is unique to nursing activity in the acute medical floor. Similarly, the frequency of undertaking vital signs would be much higher than in other wards. Emphasis on discharge planning has been identified in previous UK studies with dedicated programmes of studies developed for nurses practising in acute medical floor work in the UK (Lees et al 2010).
Last but not least, the distinct profile of acute patients admitted to the AMU/SSU who are determined by the admission criteria form a distinct cohort of patients (older, frailer patients) who have particular health needs given the fast paced context in comparison with that of the larger hospital. As was identified in an earlier chapter above, a broad spectrum of patients are admitted to the AMU/SSU through ED. The severity of illness determines choices regarding admission (or not) to the AMU/SSU. As a result, this category of patient (relatively well compared with other patients) though always potentially unstable has created a particular category of needs from which a nursing response is determined. The increasing age profile of patients (and associated potential co-morbidities), calls for a different kind of nursing than was in place previously.

The fact that acute medical nursing is not recognised as a specialised practice distinguishes this kind of nursing activity from other activity (such as intensive care, theatre etc.) which are clearly defined is not surprising given its relative newness. It could be argued that Acute Medicine as a medical practice needs to evolve and become more established in order for nursing to develop its own specialist practice.

Nursing activities often reflect the context in which medical care is delivered. Clearly, speed and a high patient turnover strongly determines the nature of acute medical nursing and has shaped a distinct set of skills which are not essentially unique in themselves, but the frequency in which they are used makes them unique for nurses working in this context. The nature of patients is similarly reflective of the nursing response to tailor care towards this particular group. Whilst outside the scope of this study, consideration of skill mix may also invariably influence the nursing function on the Acute Medical Floor (Lees et al 2011). Lees (2005, 2012) also notes that there is often ambiguity and overlap in relation to nursing roles and scope of practice, particularly from the UK perspective. In her view, roles are often nowadays evolving faster than the job specifications or the demands which the organisation might have, concluding that this is a significant challenge posed to nursing activity. This is an important consideration in relation to acute medical nursing roles in the Irish context.
Changes since the introduction of the Acute Medicine Programme

Nurses participating in this study mentioned that the implementation of the Acute Medicine Programme had brought about changes to the way traditional medical and nursing care had been delivered. Most of the comments here related to the speed in which nursing and medical processes operated.

I have worked before in an ordinary ward, so there it’s just the routine they have. Here it’s action, all action and [...] it’s like very quick turnover and like you do one blood test after another and one venupuncture after another, follow up procedures and, you know, your mind will be really like: “This patient needs this. Maybe this patient would be needing this. I don’t think she needs this” [...] You have to think quick. (AMU5)

By managing to “get patients into the right place quicker” (DoN), the work led by the Acute Medicine Programme according to participants, functioned well in improving expedited care delivery for acute medical patients. For example, one of the consultants interviewed noted that the discharge rate over 40% within 48h, which constitutes a significant improvement from the way it was traditionally (D2).

Apart from the fast-tracked assessment and treatment of the patients, nurses also mentioned that the implementation of the Acute Medicine Programme had resulted in less emphasis on bedside care and more focus on checking and following up on tests undertaken.

I think it’s a lot more non-patient contact in the sense of checking that everything is ordered or following up on things, but still we get the heavy patients [difficult cases] so we’re still doing the basic nursing care... but the main focus is on making sure that things are ordered. (AMU4)

However, while some of the nurses felt that the move away from the patient is simply a result of the fact that patients’ care needs are different, others pointed out that the lack of quality care and interaction with the patient represents an increasing concern in working with acute patients.

I suppose we’re moving away from the patient a bit [...] Historically you’d be very much hands on doing washing and all... But most of the patients coming into AMU would be independent, they’d do their own wash. So your role is changing a bit [...] We’re meeting those care needs, but they are just different (AMU7)

Back when we started people would be waiting in beds, now people are waiting on chairs for a couple of days before they are seen [...] That’s how life is here. It’s hard to do something with one patient without any interruptions (ED4)

The existence of pathways was perceived by nurses as a positive change in caring for acute medical patients as it allows them to see the patient’s journey, to be more aware of the plan and, last but not least, it considerably reduces patient waiting times.
Compared to the old days, yeah. You see, you’ve got your patients who will stay and they could be transferred directly on the pathway to the medical assessment unit. Whereas before they could have been sitting here for 6-8 hours to be seen by an emergency department doctor. Whereas now they’d be taken within a few minutes to do to the medical assessment unit. And they themselves find that service brilliant because they are seen straight away and they are happier (ED3)

The nature of the patients also changed with older (over 60 years), sicker patients being now the typical patients admitted into the AMU/SSU. The presence of co-morbidities also presents a new challenge for nurses caring for these patients.

[…] the demographics are changing, people are sicker for longer, more chronically unwell patient, repeat admissions, more patients with diabetes and those types of conditions that are becoming more prevalent and it’s very common to get patients with a long list of what’s wrong with them (ED6)

In relation to patient triage, consultants indicated that in the beginning of Acute Medical Programme vast numbers of lower acuity patients were assessed and then discharged from the AMU, however it was then observed that this strategy was not having any impact on the trolley waits. Hence, the AMU is currently focusing on the sicker patients who are more than likely going to need admission to the ward. This is a potential contradiction to the relatively ‘well’ patients whom nurses articulated were typical admissions to the AMU/SSU.

[…] that has evolved, that is a really big change that we don’t want to get involved with the lower acuity patients because they can be seen by the ED. If we see then sicker ones and they get the diagnostics and if the consultant is involved more at the earlier stages of the intervention then I think that can be a benefit for the patient and they length of stay will actually decreased. That has evolved, that is a new thing. (D1)

Many nurses as well as stakeholders interviewed for this research highlighted the fact that they experienced an expansion to their roles since the implementation of the Acute Medicine Programme and that, in turn, these new skills helps them feel more confident, more involved, having more input comparing to nurses working in other general medical wards.

You are more involved and you come to the point where you ask: “Oh why is this patient sitting here when all the tests have been done? (AMU1)

Consultants pointed out that they have recently undergone a major change in their role. While in the first year of the Acute Medicine Programme the care of acute medical patients was very much “consultant delivered”, the programme is evolving and there are perspectives to become “consultant-led”. Because we didn’t have many junior doctors and CHDs under us so it was very much consultant delivered. A lot of time we’d be doing their history, we’d be ordering the x-rays, a lot of time we’d be doing the scans, and liaising with the other consultants. Now that the Acute Medical Programme have expanded we have a few junior doctors underneath us. So now it can be more consultant-led (D1).
Summary and discussion

There is no doubt that the introduction and implementation of the Acute Medicine Programme has had an effect on the work practices of staff working in the Acute Medical Floor. This is not a surprising finding given the fact that all large scale structural changes invariably influence staff not to mention the fact that this was the intention of the Acute Medicine Programme (HSE et al 2010). The quick nature of the process was mentioned as the main change since the implementation of the Acute Medical Programme. Nurses and stakeholders interviewed highlighted the fact that has largely been beneficial for patients. The implementation of pathways allowed nurses to visualise the patient’s journey, a positive change also.

A negative comment made by nurses related to their beliefs that there was less emphasis on bedside care and more focus on indirect nursing activity. Again, this closely links with the context of Acute Medicine - which is delivered in a fast-paced environment, and also with conceptualisations of what ‘nursing’ really consists of. An important change relating to consultants in the Acute Medicine Programme related to a shift from consultant-delivered care to a consultant-led service. This change perhaps reflects the evolution of acute medicine care delivery as it becomes a more defined feature of model 4 hospitals. Another potential change in future care delivery mentioned by stakeholders was the broadening of the admission criteria for the AMU/SSU resulting in older, sicker patients (with co-morbidities) now being considered for admission. This potential change may influence the nature of acute medical nursing into the future.

Last but not least, nurses felt that their roles have expanded to meet patient need. They expressed feelings of being more confident, more involved, and having more input comparing to nurses working in other general medical wards. This is positive, particularly given the current human resource challenges in the Irish healthcare system (Scott et al. 2013)

This section mirrors to a great extent the information presented in the previous section which focused on the uniqueness of caring for acute medical patients. This is mainly because nurses working in Beaumont hospital and interviewed as part of this study highlighted the fact that many of the changes in their work are the result of the quick nature of the process of assessment, treatment, and diagnosis of acute patients.
Challenges encountered in caring for acute medical patients

In relation to the challenges faced when caring for the range of acute medical patients, many nurses pointed out that the quick, fast-tracked nature of the process remains one of the greatest challenges they have to face.

Trying to keep up with everything, to keep everything flowing and coordinated and getting patients through the system is, according to several nurses, closely linked to this challenge. This point view is reinforced by the stakeholders interviewed:

*It can be such a busy unit with so many people coming and going and trying to keep track of all of that....* (M1)

*So to keep all that in your head is very challenging particularly for the nurses on the bedside because you are managing staffing issues, patient safety issues, patient care. And they’re quite under-resourced at all times* (PF2)

Given the constant pressure to discharge patients and to move them quickly through the system, many nurses felt that there is not enough time to do all tasks which they are expected to do.

*We do blood tests but sometimes they kind of expect us to check results, but sometimes we don’t have enough time to do it because all of the times it’s “come and go”* (AMU5)

One nurse suggested that time could be saved and patient experience could be improved if blood tests could be clustered in order to save patient having multiple venepunctures. Having such clustered blood tests would mean the patient would not have to have blood extracted again. The very busy work schedule and the constant focus on discharge planning was mentioned to have a negative impact on the amount of time which can be spent interacting with patients and offering them moral support:

*I find it challenging that you don’t always have time to talk to the patient because it is busy. So we do have a lot of people with general ache or something which turn out to be a new diagnostic of cancer, a new diagnostic of a condition... And you don’t necessary have time to talk to the patient about their condition; so I find that hard that you don’t get time to sit down [with them]* (AMU4)

Last but not least, a busy schedule appears to deter some of the nurses from attending study days/courses.

*Well... I have to pay a baby-sitter, I don’t get the time back, I don’t get the money for the extra... And just getting the time to do it.... I mean I’m happy to come but sometimes when it is your time and you have to pay somebody and you get nothing back it can be a bit frustrating [...] So you have to be self-motivated*” (AMU7)

Apart from the busy nature of working in acute medicine and its implications for caring for acute patients, participants to this research mentioned several other important challenges.
Space limitations, lack of beds/waiting for long periods on a chair, and the lack of dignity caused by the fact that patients are too close to one another represented some of the key issues with which nurses in the Emergency Department in particular are struggling to cope with.

Too many patients, not enough space, nowhere to sit quietly down, no privacy. Sometimes we have 37 patients at one time (ED4)

It’s just the structural difficulties: you know our toilets are very small and that... impacts on care. And lack of privacy is a major issue: even stuff like men and women, people in their 90s on trolleys sitting side by side [...] There is not enough space between them [...] Let’s say if a person can’t go to the toilet and you have to make room in the cubicle to get them sorted and that’s not really very good. I feel bad sometimes going home and I wish I could give better care... but you’re just limited, you just can’t... you can only give the best you can and that’s one thing that you have to adapt to: that you can’t do the best, you just do whatever you can. And after that you just have to say: “I am not super-human...” (ED6)

The noise level in this place will drive you bananas if you’re not feeling well (ED8)

The location and the layout of the AMU were also deemed as unsuitable by one of the stakeholders working in the AMU/SSU, however a significant improvement from the previous location (in the back of the ED) is noted.

The lengthy duration needed to run some of the tests (e.g. CT, MRI) or the occasional cancelling of some procedures were perceived by staff in the AMU/SSU as challenging and frustrating: “[...] you push for a while but you can’t do anything about it” (AMU2). Dealing with the patients in these situations also becomes a challenge.

Like for example procedures they are all prepared and then at the end of the day cancelled. And waiting times for like doctors, if they are just here for a review, like if they had a scanning and they came back here for a review, they are here waiting and waiting and they’re asking: ‘What’s the result? The result?’ and it takes time for them sometimes to deal with the patient (AMU5)

Several participants to this research also mentioned a key challenge relating to the frequent blocking of the service. On the one hand, the system appears to get invariably blocked up during winter time, due to the seasonal variations in the number of patients. On the other hand, the system also gets blocked by patients who require a longer stay. This is particularly the case for older, frailer patients. Last but not least, more potential blockages are caused by the patients who are not acutely ill, but who attend the unit.

And things that have an impact on that are that people can spring in... They could admit the patients through, but they don’t; they tell patients to come in while they’re on call. They’re patients that aren’t acutely ill and they’re told to come in for a whole set of examinations and other people are stuck because they’re holding up. And it’s not our consultants’ fault (ED5)

Another challenge is related to the difficulty to categorise some of the patients and this will further have an impact on their patient journey and the quality of
their experience. This mostly relates to patients who have multiple complaints on admission and it is difficult to decide which consultant/ward is most appropriate given the fact that they fit the criteria for admission to several care areas.

Sometimes if they get caught up [...] in the system because they mix with a variety of other patients, more complex patients and often don’t get to a core ward or a specialty ward that they should be on (DoN)

[...] if you get a definite cardiology patient, or a definite gastro patient, very definite respiratory failure patient... But certain patients fall in-between. You know, just general medical [patients] maybe low sodium, slightly confused type patients that don’t fit a particular speciality. There’s often difficulty in handling the patient often and getting other teams to reach in for those patients. So as a result for us it’s a challenge [...] cause it’s not clear-cut and it’s hard to put patients into boxes, into categories. Somebody can be very straightforward on paper, but be a little bit more complex [in reality] or sound very complex but probably be a straightforward admission (PF2)

Several stakeholders mentioned key challenges surrounding the staffing process:

I suppose the other thing is that whilst we [AMU/SSU] are one unit, you’re looking at nearly having two rosters out of the one pool of staff. Because you’re constantly looking at having a skill mix at the Short Stay and at the other end [...] So you try to get somebody senior... We are working on two areas out of the same pool of staff and that can be a drain on resources (M1)

And that’s another challenge: because skill mix and experience...getting people who are qualified... for a long time is very difficult, people are very junior, and they are kind of inexperienced on the ground [...] even though we do try to have back-up everything that is happening at the moment: staffing embargo, resources, the acuity of patients... (M3)

In a similar line, consultants pointed out that a lack of junior doctors has significant limitations on the service:

We’re the frontline person to see them and I don’t know if that is quite our role [...] you can only see a limited number of patients when you’re on the frontline. Whereas I think if you can have more juniors under you, you can direct things a bit more and then spend some time managing the unit as opposed to spending our time managing one single patient (D1)

There was also a mention that access to patients from ED is hindered by “consultants taking over” (AMU3), however it is likely that this happens only when the AMU team attempts to take patients from the ones already admitted to the ED instead of the triage.

In relation to the types of patients which are proving more challenging for the acute team, one participant to the study mentioned the asthma patients as they are taking longer to get CT scan (AMU2)

We have to take into consideration their history. Because if they have asthma they have to be covered with steroids and it will take
It wouldn’t be a thing that would be done straightaway. I see the patients staying overnight just to have steroid cover (AMU2)

Several nurses referred to patients with chest pains, which, according to many views expressed in the study, are the most common patients in the AMU/SSU

You need to take into consideration, to check what type of medication they are on and if they have CCF, you kind of really double-check with the patient and the team whether they have been fluid and how compliant the patient was at admission (AMU1)

[...] to make sure that they’re on a cardiac monitor when they’re in, take all their troponin. And you have to liaise with the doctor to make sure you do everything... you have their ECGs ready” (AMU6)

Last but not least, mentions also included patients with Afib (AMU6) and with acopia.

The ones with acopia we’ve identified social issues within 24 hours so they are the ones who need to be moved up, or they need a longer course of antibiotic or some of the tests take a bit longer, like MRI and things take maybe two weeks to get done. Or they come in on Thursday and Friday and then it’s the weekend, they’d be staying as well (AMU4)
Summary and discussion

The fast paced context of the acute medicine floor appears to be a double edged sword. On one hand, it is a positive thing, stimulating nurses to operationalize all of their expertise. On the other hand, this fast pace has the potential to be counterproductive - as was mentioned by participants in this study. Identical findings regarding this context have been found in a national survey of acute medicine nurses (n=127). Nurses interviewed as part of our study mentioned that the quick, fast-tracked nature of the process and the constant need to keep everything flowing and coordinated represent the main challenges in caring for acute medical patients. This implies that nurses are frequently under pressure to carry out all tasks which they are expected to do and also to interact with patients and offer them moral support. From this point of view, finding the time to attend study days/ courses was also considered by some nurses as challenging.

Several stakeholders mentioned challenges surrounding the staffing process, referring both to nursing staff as well as the difficulty to attract a bigger number of junior doctors. In addition to human resource challenges, environmental and structural challenges such as space limitations, lack of beds/waiting for long periods on a chair, and the lack of dignity remain a cause of concern for those working on the Acute Medical Floor. Blockages to patient flow are frustrating for all and are part of a system which is already overburdened. Similarly, challenges to patient flow in terms of patients with multiple illness presentations, not fitting in to a single consultant remit are another source of frustration. Ironically, it is these very challenges in hospital systems which prompted the Acute Medicine Movement (Scott et al 2009).

However, most of the challenges mentioned by participants in this short section are not necessarily unique to the Acute Medicine Programme, but pertain to challenges experienced by those endeavouring to work within the present Irish healthcare system (Scott et al 2013). What is reassuring is that in spite of such challenges, the participants in this study continued to voice that they were working to the best of their abilities in an effort to surpass the inherent limitations and scarcity of resources of the general health system.
Further skills

Participants in this study acknowledged that further training and on-going education was an important factor in ensuring that they were fit for practice. When initially asked are there any skills which you feel should be performed by nurses in order to improve the care of acute medical patients?, most of the participants in the study responded by saying that they did not feel that they needed any additional skills in order to augment their practice. Stakeholders and nurses supported this statement by stating that in the acute medical floor, nurses were already utilising a wide scope of skills in their practice. These skills were wide ranging and included venepuncture, cannulation, phlebotomy, doing ECGs, doing urine tests, and being supportive of non-invasive diagnostics (PM, M1, M3). Though it is acknowledged that some of the skills mentioned below relate to continuing professional development, following further skills were mentioned by participants as being useful:

- Nurse-led discharge, especially at weekends when there is not a consultant in there and if there would be a clear protocol for nurse-led discharge (PM)
- Prescribing medication, especially antibiotics
- Interpreting test results (e.g. ABGs, ECGs)
- Ordering x-rays (However consultants mentioned that there seems to be an opposition on the part of the radiographers to allow nurses to order x-rays)
- Male catheterisation (Nurses only catheterise female patients at the moment)
- BPAP
- Knowing more about triage scoring of patients in ED
  
  I think it would be nice to know a little bit more about all the scoring that they do round in A&E. You know like the Manchester score and categorising patients (M1)
- Having a broader spectrum of knowledge and experience and being able to perform a quick assessment

  To look at somebody and know they are quite unwell, just by looking at somebody without having to do a whole platter of tests. Lots of clinical intuition […] you would need certain levels of experience going into the AMU for the simple reason that… (M3)

  So I suppose one of the key bits would be the skill in identifying the correct type of patient and then the skill in doing I suppose an analysis or an assessment of that patient to see what their needs are (DoN)

- Providing psychological reassurance to patients and community follow up

9 More detailed description of the skills undertaken by nurses working on the acute medicine floor can also be found in the above chapter ‘Activities and roles of nurses caring for acute medical patients’
I suppose in terms of the patients because their length of stay should be quite short [...] you are discharging these patients more quickly home than they would have previously, so ensuring that they have their point of contact, that they know how to re-access the service and giving them confidence and reassurance and I suppose that psychological support that it is ok to leave the hospital [...] So ensuring I suppose the community links, the GP and methods for re-checking back into the hospital, whether a follow-up appointment is in place (DoN)

- Leadership role

We’re quite short on junior doctors now [...] they have actually moved away, they have gone oversees. Things are changing over the medical end of things so I think maybe nurses should take on a more active role [...] I find that if there’s a critically ill patient or something happens, sometimes there’s a tendency for nurses to call a doctor, to let the doctor decide. But sometimes I think that there needs to be more initiative, to take a more leadership role over this patient (D1)

It was suggested by both the project manager of the Acute Medicine Programme as well as the DoN that a rotation between staff in ED and staff in AMU/SSU will be conducive to learning new skills and acquiring experience.

Last but not least, it is interesting to note that while participants stated that expansion of the nurses’ roles is already underway (as nurses have learnt more and more technical skills), experience was identified as an inherent part of role expansion. The ‘skill’ of experience cannot be trained in a quick, straightforward manner, but is rather the outcome of a lengthy individual process.

I think nurses are very much up for an expansion of role that allows them to carry out more direct patient care and this would be things like the technical skills... that would allow them a broader assessment of the patient, it’s all to do with doing more for the patient, doing more hands-on the patient. [...] I think in terms of the role expansion at the moment there are the technical skills like cannulation and phlebotomy that they do [...] I suppose a lot has to do with the stability of the staff and the level of experience of the staff because obviously anyone can learn a technical skill, but the idea that you would do an assessment and make a judgement on what pathway someone would go on [...] It would be down to an experienced and a knowledge... so I suppose that others [other nurses] will be in process of being trained, but it is a slow process, given the resources and the skills that they have at the moment (DoN)
Summary and discussion

This short section presented responses to a direct question which attempted to ascertain if there were any outstanding further skills which would augment acute medical nursing care. The fact that almost all study participants didn’t initially feel the need for ‘further skills’ as they were already exercising an expanded scope of practice in the acute medical floor suggests that there is little need for new skill development. Of the ‘further skills’ that were mentioned, some relate to continuing professional development whilst others (such as male catheterisation) are potential skills which could be incorporated into a nursing role. Consideration of extending or expanding the role (and differentiating roles between nursing ranks) is not straightforward. Appreciation of experience, relationships between multidisciplinary team members and resources has been identified as considerations required when considering expanded practice roles (Lloyd, Jones 2005). Discharging patients, prescribing medication and ordering ionising radiation for example could be more closely attributed to individuals in advanced practice roles (rather than at the level of staff nurse for example) given the fact that this requires a level of advanced decision making (Begley et al 2010). Again, this delineation is not simple either. Lees et al (2010) illustrate the need for education to shape current and future practices rather than a traditional top down approach - decided from a more abstract policy. Acute medical nursing is an emergent practice and as a result, acknowledgement of the context of this practice (and associated knowledge, judgement and decision-making) is of prime importance. Appreciation of the breadth and depth of this role (and its associated skills) is something which will require greater time and attention. It is suggested that further exploration of the educational needs of staff working on the Acute Medical Floor which would inform the needs analysis towards developing an Advanced Nurse Practitioner pathway would be a worthwhile endeavour.
The role for an ANP/CNS

When participants were asked if there was a role for an ANP/CNS in the acute medical floor, almost all of the participants indicated that this would be useful, particularly in enhancing the patient experience. Nurses in ED and AMU/SSU as well as stakeholders immediately drew multiple comparisons with the positive example set by the cardiology Advanced Nurse Practitioner working in the ED. They viewed this individual’s advanced nursing practice as a huge advantage for the treatment of cardiac patients as it speeds up their assessment and treatment.

*People go directly to speak with him. It’s a very ordered stuff, [...] no roadblocks, no roundabouts, no odd turns. Everything just falls into place (ED5)*

*He would have protocols where he would see a lot of the patients and he would be supervised by the consultant. And when [name] is here there’s a huge amount of people seen. And out PET time goes up and patients’ satisfaction would be very good. (M3)*

It is interesting to note that the Advanced Nurse Practitioner working in ED was often times referred to as Cardiac Nurse Specialist. This highlights the fact that in practice there seems to be a lack of clarity in relation to the separation between these two types of roles. It also signals the fact that great emphasis is placed on personal input and achievements of this member of staff and less on the nature of the role (ANP vs. CNS).

For this particular reason, this section cannot present the research findings separately for the ANP and the CNS roles as almost all participants to this study did not discriminate between the two types of roles, but rather used them interchangeably. It seemed that even though they used the terms interchangeably - most of the accounts in response to this question matched that of an ANP.

When referring to the potential roles which could be undertaken by an ANP/CNS in the area, many nurses felt that the ability to triage and assess patients, admit them, prescribe medication and order tests (x-rays, telemetry etc.) is vital for these roles and, hence, an ANP or a CNS can significantly contribute towards moving the patient through the system more quickly.

* [...] the consultants are very good, they do come in on the weekend, but if there was somebody out of hours, doing different shifts, they could help that way. Or they could help during the week down the assessment unit admitting and seeing patients and... [...] So it could move a lot quicker if there was someone to do the admission and prescribe some of the patient medication as well (AMU4)*

*They could get them rolling on the pathway quicker. Like we do have the RAT at the moment: the Rapid Access Triage nurse [...] So there is definitely a need for the role in the department. There is a need for lots of ANP roles in the department, They could be developed (ED2)*

While the ANP/CNS was interpreted by participants as potentially playing a key role in triaging and filtering the patients, nurses felt that they will act as more than the Rapid Access Triage nurse.

* [...] because while the triage nurse only sorts them into priorities and categories, the rapid access triage nurse would see the patient...*
after it’s triaged and treat the patient and the discharge them (ED3)

Nurses saw a key role for an ANP/CNS in managing the AMU/SSU, referring more precisely to running the place, coordinating activities, “keeping it together” (AMU3), communicating with the team (ED1) and hence making things run smoothly (AMU7).

In the nurses’ views the ANP/CNS can also play a key role in educating staff or in guiding them, being able to answer their questions and help them when in doubt:

It’s handy to educate us on the ward when things do come up or when a new policy comes up. Because unfortunately […] you don’t always have the time to learn… So sometimes I think it is handy to learn the policy in the hospital as well the new policies in the community […] So it would be useful to update the education on the ward continuously (AMU4)

I suppose if you’re in doubt and you had queries you could go to that person and say: “What do you think of this situation?” (AMU6)

The need for an ANP was explicitly stated by stakeholders interviewed in this research project. While it was emphasised by both the Manager of the Acute Medicine Programme as well as the Director of Nursing that the breadth of acute medical patients makes it difficult for ANPs/CNSs to be ‘specialist’ in one field (as is the case for the cardiac nurse or epilepsy nurse), they felt that there is a possibility to build and agree on many very simple pathways which could then determine a protocol-driven role for an ANP in the area.

Because a lot of these patients would be quite predictable, you would agree the type of patients they are. Then the protocol pathways agreed with the medics, with the specific diagnostics, with the specific outcomes could be very easily written and agreed and that’s where you would see a nurse specialist function very well: within agreed pathways (DoN)

Interpreting and making clinical judgements regarding diagnostic tests, prescribing medicine and nurse led discharge were also seen by stakeholders as important components of the roles which ANPs/CNS could potentially have. These roles were felt to be of ultimate benefit to patients by speeding up their discharge and improving their experience.

[…] if they [potential ANP] could look at a chest ray and decide yes that patient needs to stay in or no they can go on antibiotic… There’s no point if having somebody down there who can’t make decisions and prescribe discharge. They need to have the full range of skills (M1)

From this point of view it was expressed by consultants that having an ANP would be preferable to having a CNS, given that the CNS would need supervision and cannot discharge patients whereas ANPs can actually “manage the patient from start to finish and can actually discharge the patient” (D1).

Last but not least stakeholders also felt that ANP/CNS could have an important role in managing the unit, particularly in relation to the flow of patients coming into the unit.

If we were to open up our service to the GPs again, some sort of nurse-led role… in other hospitals they call it like a Liaison Nurse
role or acute manager role, but it’s not a clinical role, they manage […] They could act as a filter […] (PM)

[…] certainly I see a role like that as being useful in the AMU: just somebody who managing how many patients are coming through, have you room for these patients and the feedback from the nursing staff because sometimes they get caught with patient care or with different issues and maybe there’s a bit of a gap in that they could pull around more patient or there’s too many patients coming from ED and they’re struggling trying to process them or there’s a couple of days where there may be 2-3 beds locked while they are waiting for diagnostics and scans or results or reviews so if you’ve somebody focused on that piece, you are moving the patients, getting them through as safely and quickly as possible. That should be the ideal for the acute medicine (PF2)

The study noted that while many nurses are supportive of the development of an ANP/CNS role, they did refer to these positions as being opportunities for expansion of their role, but rather referred to these roles generically. Not all nurses and stakeholders saw however a role for an ANP/CNS within the area of caring for acute medical patients. One nurse for example feels that all staff working on the ward should all be on the same page:

There’s only one ward here, so they’d be working on this ward and we should all be on the same page I think so I don’t know if there would be a need (AMU6). ***However, later in the interview the participant agrees it might be useful

Getting patients out quicker is something that every nurse should do (PF1)

Another nurse interviewed for this study indicated that adopting an ANP or CNS role could potentially result in the de-skillig or ED nurses. It is worth noting however that this nurse referred strictly to the ANP in Minor Injuries, therefore this point of view may not be generalised to other specialist areas.

We have an ANP that treats all the minor injuries, but myself… I don’t see any minor injuries […] because it’s all taken by the ANP. And in a way you just want to make sure that everybody is equally skilled. That that would not detrimentally impact on (ED6)

It is also suggested that while the AMU is not a stand-alone unit and they have already a CNM2, adding an ANP/CNS might not contribute significantly to a smoother patient journey.

I think if the AMU stays where it is now, no, there isn’t. Because already that unit has a CNM 2. So I don’t think there is [a need] at the moment. But if it was a separate, stand-alone unit, there would definitely be [a role]. But as it is there now at the moment, at the end of the ward, with a limited number of beds… […] I don’t think ours [the AMU] functions in the way that it should. I think it needs to move from there because it couldn’t be attached to any... because it wouldn’t make any sense” (ED5)

Several nurses mentioned that if there would be a role for an ANP/CNS it will have to would span both areas, namely the ED and the AMU/SSU.
One of the stakeholders also mentioned that the decision to adopt an ANP/CNS role in the department needs to be analysed in close correlation with existing statistical data:

*It depends on what they are doing. I think you have to look at the data from maybe the last year and see if there’s any shortcomings... Because within the hospital... Beaumont is a big, large hospital. We have stroke nurses, epilepsy nurses, we have oncology nurses. We do have a load of good people that you can call on for various things. [...] Another chest pains nurse practitioner would be beneficial. Because it seems to be the most common reason why people are admitted: chest pains. So [it would be] targeted for most frequent flyers [...] Because there’s so many [...] Chest pains must be highest presentation for this department. It’s huge.* (M3)
Summary and discussion

One of the key objectives of this study was to explore the scope for role expansion within current nursing practice along with clinical nursing pathway development within the context of acute medicine nursing within a model 4 hospital (e.g. CNS /ANP roles). This study found that there is broad support for the development of an advanced practitioner on the Acute Medical Floor. It must be acknowledged that this view was not held by all participants, though the number of participants not in favour of developing such a role was minimal. Although the terminology of ANP/CNS was used interchangeably by nurses, it is clear that the nature of the potential role matches that of an ANP. As a result, it is suggested that an ANP role would be the most desirable to assist with the smooth operation of the Acute Medical floor.

The fact that almost all interviewees identified the cardiac Advanced Nurse Practitioner in ED as a benchmark and a role model for advanced nursing roles development in the acute medicine floor is firstly a compliment to the good example illustrated by this individual in doing his daily work. Whilst it was evident that the terms ANP and CNS were at times used interchangeably, it is notable that a remarkable clarity regarding the role enacted by this ANP and his effectiveness in improving patient experience and outcomes. The existence of this strong role model, overcame the ambiguity of the role differentiation. This signals the fact that great emphasis is placed on personal input and achievements of this member of staff and less on the nature and title (terminology) associated with the role.

A recent report (Begley et al., 2010) details the core concepts of Advanced Nursing and Specialist Nursing. For ease of reference these are contained in Appendix 3 and Appendix 4 respectively. In relation to the ANP roles, four key areas are relevant. These include: autonomy of practice (which implies that advanced nurses have a higher level of decision making and responsibility); expert practice (advanced nurses demonstrate knowledge as well as critical thinking skills); professional and clinical leadership (they are clinical leaders as well as acting as role-models and mentors for the nursing staff); research (initiating and coordinating nursing audit and research). Considering these core concepts, it is clear that evidence of all of these concepts were mentioned by participants as key functions of a potential ANP in the acute medical floor. The ability to admit, order diagnostic tests, interpret tests, make clinical decisions and potentially discharge patients are skills which require a certain degree of autonomy (and authority) and clearly require knowledge only present in an expert practitioner. Nurse led discharge has been identified in this study as a key aspect which would improve patient flow in the SSU/AMU. This resonates with the vision of the Acute Medicine Programme strategy also (HSE et al 2010), suggesting support for this is both evident strategically and also at the practice level.

Specialist roles (i.e. a CNS) on the other hand have five defining areas: clinical focus (strong patient focus including both direct and indirect care); patient/client advocate (communicating on behalf of the patient, representing the patient); education and training (engaging in continuous professional development which includes both formal and informal educational activities); audit and research (audit of the current nursing practice as well as keeping up-to-date with developments in their speciality field); consultant (inter-disciplinary consultations across sites and services). Whilst elements of this (e.g. having a clinical focus and being a patient/client advocate) were mentioned by participants,
this was not done in the context of responses to a question on advanced practice - it was more an expression of how they operated in their daily role. Considering both ANP and CNS role concepts, elements autonomous practice and expertise appear to be strongest in terms of potentially meeting practice needs.

Lees (2012) notes that in relation to acute medical nursing activity, ambiguity and overlap in relation to nursing roles at all levels of practice is evident. This mirrors the findings of participants in this study suggesting that blurring of conceptual role boundaries is not surprising given the relative newness of the Acute Medical Floor concept.

However, it is important to be mindful of the potential for role ambiguity to influence (or stifle) the development of advanced nursing practice. In his review of the qualitative research studies on the barriers and facilitators to role development and/or effective practice, Jones (2005) pointed out that role ambiguity constituted a key barrier in effectively carrying out specialist and advanced nursing roles. At the same time, having a model for a particular role is often identified as a facilitator. Given the emphasis on ensuring smooth patient flow, it is suggested that aspects of a clinical co-ordinator role (O’Brien, Lees 2005, 2012) may prove a useful inclusion into the development of an advanced nurse practitioner skill set within a model 4 hospital.

However, it is important to recognise that this study has simply identified a broad support for the role by the respondents who agreed to participate in this study. Greater attention to the feasibility and workability of such a role (and what it entails) are required. It is suggested that further exploration in the form of a needs analysis towards developing an Advanced Nurse Practitioner pathway for the Acute Medicine Floor would be a worthwhile endeavour.
Conclusion

This study sought to examine the role and activities of nurses caring for patients who are admitted to Beaumont Hospital as part of the National Acute Medicine Programme. The qualitative approach used in this study endeavoured to address the following objectives:

1. The first objective of this study was to articulate nurses’ contributions to patient care by examining their activities and decision-making at individual, interpersonal and organisational levels.

2. The second objective focussed on exploring the scope for role expansion within current nursing practice along with clinical nursing pathway development within the context of acute medicine nursing within a model 4 hospital (e.g. CNS /ANP roles).

24 individuals representing stakeholders and practitioners agreed to participate in this study providing a large and diverse data source which illustrated mostly similarities but some differences of opinion regarding the nature of acute medical nursing. This study found that nurses on the acute medical floor contribute to the care of their patients in a multiplicity of ways. The context of the acute medical floor (and indeed the context of the acute medicine programme) which is focussed upon a ‘quick turnaround’, timeliness and speed largely dictates the nursing response and activity undertaken in this area. Given the contemporary pressures on the healthcare system, it is admirable that the nurses in this study appeared remarkably positive about their contributions (in spite of the challenges they faced) when accounting for the work they undertook in caring for acute medical patients.

Acute medical nursing activity has a lot of similarities with traditional nursing activities. However, there are distinct differences particularly relating to themes of speed and diversity. It is the frequency of activities and the speed in which they are undertaken which makes acute medical nursing distinct. It is also the diversity of patients from many branches of ‘traditional medicine’ which challenges nurses’ knowledge and skills for practice. Having a diverse patient group requires a unique broad knowledge base, which is unlike other specialisms which are largely focussed around one particular area (e.g. cardiology, respiratory etc.). This study found that a broad spectrum of knowledge across many specialities (instead of an in depth knowledge of one) characterises acute medical nursing knowledge from traditional ‘medical nursing’. The fact that many nurses had already expanded their role in order to bring about a better standard of care to their patient group is testament to the willingness of acute medicine staff to expand their role if there is a clear benefit to patients.

Although the diversity of patient group is apparent, the relative ‘wellness’ of patients who attend the AMU/SSU illustrates how nurses and doctors classify the intensity of the patients they care for. This particular patient group brings their own challenges in ensuring their speedy assessment, treatment and in most cases, discharge. Central to the practice of nursing is the exercise of clinical judgement and decision making (Royal College of Nursing 2003). The conduct of acute medical nursing occurs in a difficult and challenging environment. It is evident from this study that the nature of acute medical nursing has evolved to address the demands of this fast-paced environment. Despite initial hesitation in articulating their role, prompt comprehensive assessment, care and discharge were voiced as core goals for the acute medical floor staff in operationalizing all aspects of the
nursing process (assessment, planning, implementation and evaluation). This reflects the vision of the Acute Medicine Programme (HSE et al 2010) and also of other studies of acute medical nursing activity (Lloyd Jones 2005, Lees et al. 2010, Lees 2012, Lees et al 2013) suggesting that acute medical nursing in Beaumont hospital is reflective of national policy and international practice. It is important to acknowledge that this statement is made in the context of the small body of literature available in the area.

In the acute medical floor, the exercise of judgement in the provision of care (Royal College of Nursing 2003) was very evident in many of the participant’s accounts of their assessment and care of patients on the acute medical floor. Appreciation of the fast paced context of in which this judgement is exercised further illustrates the complex nature of acute medical nursing. This context proves both stimulating yet challenging by the participants in this study.

Lees (2012) identifies that in relation to acute medicine, roles are often evolving faster than the job specifications or the demands which the organisation might have. The findings of this study suggest that there is broad support for the introduction of an ANP role. Some suggestions for inclusion into an ANP role specification are made in this study. However, greater exploration in relation to the finer details regarding ANP role development in acute medicine is required. The characteristics of ideal ANP practice are illustrated through participants’ accounts of the cardiology ANP identifies the scope of good role modelling in influencing beliefs about good practice. The presence of a good role model in this hospital will be of benefit in shaping the development of an ANP role in this area.

As is well acknowledged, skill acquisition and expert practice takes time to develop. Given the fact that acute medicine as a medical speciality, is relatively new, it is suffice to say that acute medical nursing expertise, will continue to evolve and emerge. This study has illustrated present acute medical nursing activity. It will be interesting to see how nursing practice evolves into the future.

Despite the limitations of the study due to its small size, this study proves useful insofar as it provides a baseline from which to appreciate the complex activity of nursing in a model 4 hospital. In providing a qualitative account of the scope of acute medical nursing practice, there is a shaping of understanding regarding this relatively new area of healthcare from the perspective of those involved in doing it. Greater understanding of acute medical nursing activity is clearly required to strengthen the suggestions surrounding its uniqueness made in this study. Future research on a national level amongst Model 4 hospitals would provide a stronger basis from which to develop assertions regarding the nature of care and advanced nursing practice required in this context. Similarly, research into nursing activity amongst other hospital models would provide interesting data from which to compare the findings of this study. It is hoped that this study will prompt further exploration into this under-researched area.
Appendices
APPENDIX 1 - Interview schedule (Stakeholders)

1. Could you tell me about your role and its relationship to the care of acute medical patients?

2. In relation to carrying out your role (for acute medical patients), what kind of work does this typically involve?
   - Prompt: Link to the range of acute medical patients mentioned in Q1. Direct/Indirect care

3. What would you say is unique to acute medicine nursing?
   - Prompt: How has the work you do for acute medical patients changed?
     (as part of the Acute Medical Programme)

4. Are there any skills which you feel should be performed by nurses in order to improve the care of acute medical patients?

5. Is there a role for an Advanced Nurse Practitioner or Clinical Nurse Specialist in this area?
   - Prompt: If so, what would they do? If not, why is it not necessary?
APPENDIX 2 - Interview schedule (Nurses)

Contribution to nursing care

1. Could you tell me about the range of acute medical patients you care for?

2. In relation to caring for these patients, what kind of work does this typically involve?
   ▪ Prompt: Direct/Indirect care

3. What qualities and skills do you bring to the care of acute medical patients?

Expanding the roles

4. What would you say is unique to acute medicine nursing?

5. Has the work you do for acute medical patients changed? (as part of the Acute Medical Programme).
   ▪ Prompt: If yes, how has it changed?

6. What challenges do you face in caring for the range of acute medical patients you mentioned earlier in the first question?
   ▪ Prompt: please refer to a particular acute medical diagnosis such as COPD

7. Are there any skills which you would like to be able to perform to improve your role in caring for acute medical patients?
   ▪ Prompt: Challenges in acquiring these skills

8. Is there a role for an Advanced Nurse Practitioner or Clinical Nurse Specialist in this area?
   a. Prompt: If so, what would they do? If not, why is it not necessary?
### APPENDIX 3 - Core concepts - ANP/AMP role

(Source: Begley et al., 2010, pp. xii-xiii)

<table>
<thead>
<tr>
<th>Autonomy in clinical practice</th>
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<tr>
<td>An autonomous ANP/AMP is accountable and responsible for advanced levels of decision making which occur through management of specific patient/client caseload. ANPs/AMPs may conduct comprehensive health assessment and demonstrate expert skill in the clinical diagnosis and treatment of acute and/or chronic illness from within a collaboratively agreed scope of practice framework alongside other healthcare professionals. The crucial factor in determining advanced nursing/midwifery practice, however, is the level of decision making and responsibility rather than the nature or difficulty of the task undertaken by the practitioner. Nursing or midwifery knowledge and experience should continuously inform the ANP’s/AMP’s decision making, even though some parts of the role may overlap the medical or other healthcare professional role.</td>
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<tr>
<th>Expert practice</th>
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<tr>
<td>Expert practitioners demonstrate practical and theoretical knowledge and critical thinking skills that are acknowledged by their peers as exemplary. They also demonstrate the ability to articulate and rationalise the concept of advanced practice. Education must be at Master’s degree level (or higher) in a programme relevant to the area of specialist practice and which encompasses a major clinical component. This postgraduate education will maximise pre- and post-registration nursing/midwifery curricula to enable the ANP/AMP to assimilate a wide range of knowledge and understanding which is applied to clinical practice.</td>
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<tr>
<th>Professional and clinical leadership</th>
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<tr>
<td>ANPs/AMPs are pioneers and clinical leaders in that they may initiate and implement changes in healthcare service in response to patient/client need and service demand. They must have a vision of areas of nursing/midwifery practice that can be developed beyond the current scope of nursing/midwifery practice and a commitment to the development of these areas. They provide new and additional health services to many communities in collaboration with other healthcare professionals to meet a growing need that is identified both locally and nationally by healthcare management and governmental organisations. ANPs/AMPs participate in educating nursing/midwifery staff, and other healthcare professionals through role-modelling, mentoring, sharing and facilitating the exchange of knowledge both in the classroom, the clinical area and the wider community.</td>
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<th>Research</th>
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<tr>
<td>ANPs/AMPs are required to initiate and coordinate nursing/midwifery audit and research. They identify and integrate nursing/midwifery research in areas of the healthcare environment that can incorporate best evidence-based practice to meet patient/client and service need. They are required to carry out nursing/midwifery research which contributes to quality patient/client care and which advances nursing/midwifery and health policy development, implementation and evaluation. They demonstrate accountability by initiating and participating in audit of their practice. The application of evidence-based practice, audit and research will inform and evaluate practice and thus contribute to the professional body of nursing/midwifery knowledge both nationally and internationally.</td>
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### APPENDIX 4 - Core concepts - CNS/CMS role

(Source: Begley et al., 2010, pp. xiv-xv)

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<thead>
<tr>
<th>Clinical focus</th>
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<tr>
<td>The CNS/CMS’s work must have a strong patient focus whereby the speciality defines itself as nursing or midwifery and subscribes to the overall purpose, functions and ethical standards of nursing or midwifery. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to patients and their families. Indirect care relates to activities that influence others in their provision of direct care.</td>
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<tr>
<th>Patient/client advocate</th>
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<td>The CNS/CMS role involves communication, negotiation and representation of the patient/client values and decisions in collaboration with other health care workers and community resource providers.</td>
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<tr>
<th>Education and training</th>
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<td>The CNS/CMS remit for education and training consists of structured and impromptu educational opportunities to facilitate staff development and patient/client education. Each CNS/CMS in tandem with his/her line manager is responsible for his/her continuing professional development, including participation in formal and informal educational activities, thereby ensuring sustained clinical credibility among nursing/midwifery, medical and paramedical colleagues.</td>
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<th>Audit and research</th>
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<tr>
<td>Audit of current nursing/midwifery practice and evaluation of improvements in the quality of patient/client care are essential requirements of the CNS/CMS role. The CNS/CMS must keep up to date with relevant current research to ensure evidence-based practice and research utilisation. The CNS/CMS must contribute to nursing/midwifery research which is relevant to his/her particular area of practice. Any outcomes of audit and/or research should contribute to the next service plan.</td>
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<th>Consultant</th>
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<tr>
<td>Inter and intra-disciplinary consultations, across sites and services are recognised as key functions of the clinical nurse/midwife specialist. This consultative role also contributes to improved patient/client management.</td>
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APPENDIX 5 - Range of patients admitted to the acute medical floor compared with HIPE data

<table>
<thead>
<tr>
<th>TYPES OF PATIENTS</th>
<th>CONDITIONS</th>
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| Cardiovascular    | ▪ Chest Pain  
▪ Arrhythmia; Cardiac Arrest and Conduction Disorders W/O Cat or Sev CC  
▪ Valvular Disorders W/O Catastrophic or Severe CC  
▪ Circulatory Disorders W/O AMI W Invasive Cardiac Inves Proc W/O Cat or Sev CC  
▪ Hypertension W/O Catastrophic or Severe CC  
▪ Coronary Atherosclerosis W/O Catastrophic or Severe CC  
▪ Heart Failure and Shock W/O Catastrophic CC  
▪ Interventional Coronary Procs W/O AMI W Stent Implantation W/O Cat or Sev CC  
▪ Venous Thrombosis W/O Catastrophic or Severe CC  
▪ Arrhythmia; Cardiac Arrest and Conduction Disorders W Cat or Sev CC  
▪ Interventional Coronary Procedures W AMI W/O Catastrophic CC  
▪ Peripheral Vascular Disorders W/O Catastrophic or Severe CC  
▪ Circulatory Disorders W/O AMI W Invasive Cardiac Inves Proc W Cat or Sev CC  
▪ Unstable Angina W/O Catastrophic or Severe CC  
▪ Implantation or Replacement of Pacemaker; Total System W/O Catastrophic CC  
▪ Interventional Coronary Procs W/O AMI W Stent Implantation W Cat or Sev CC  
▪ Other Circulatory System Diagnoses W/O CC  
▪ Circulatory Disorders W AMI W/O Invasive Cardiac Inves Pr W/O Catastrophic CC  
▪ Circulatory Disorders W AMI W Invasive Cardiac Inves Proc W/O Cat or Sev CC  
▪ Coronary Atherosclerosis W Catastrophic or Severe CC  
▪ Unstable Angina W Catastrophic or Severe CC  
▪ Valvular Disorders W Catastrophic or Severe CC  
▪ Other Circulatory System Diagnoses W Severe or Moderate CC  
▪ Heart Failure and Shock W Catastrophic CC  
▪ Venous Thrombosis W Catastrophic or Severe CC  
▪ Implantation or Replacement of AICD; Total System W Catastrophic CC  
▪ Implantation or Replacement of AICD; Total System W/O Catastrophic CC  
▪ Trans-Vascular Percutaneous Cardiac Intervention  
▪ Hypertension W Catastrophic or Severe CC  
▪ Coagulation Disorders  
| Respiratory  | ▪ Respiratory Signs and Symptoms W/O Catastrophic or Severe CC  
▪ Chronic Obstructive Airways Disease W/O Catastrophic CC  
▪ Other Respiratory System Diagnosis W/O CC  
▪ Respiratory Infections/Inflammations W/O CC  
▪ Respiratory Infections/Inflammations W Severe or |
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<tr>
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<tbody>
<tr>
<td>Kidney and Urinary Tract Infections W/O Catastrophic or Severe CC</td>
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<tr>
<td>Other Digestive System Diagnoses W/O Catastrophic or Severe CC</td>
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<tr>
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<td>Other Respiratory System Diagnosis W Severe or Moderate CC</td>
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<tr>
<td>Respiratory Signs and Symptoms W Catastrophic or Severe CC</td>
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<tr>
<td>Bronchoscopy W/O Catastrophic CC</td>
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<tr>
<td>Other Respiratory System Diagnosis W Catastrophic CC</td>
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<tr>
<td>Respiratory System Diagnosis W Non-Invasive Ventilation</td>
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<tr>
<td>Interstitial Lung Disease W/O CC</td>
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<tr>
<td>Pleural Effusion W Severe or Moderate CC</td>
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<td>Pneumothorax W CC</td>
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<tr>
<td>Pulmonary Oedema and Respiratory Failure W/O Catastrophic CC</td>
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<td>Other Respiratory System OR Procedures W/O CC</td>
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<td>Sleep Apnoea</td>
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<td>Pulmonary Oedema and Respiratory Failure W Catastrophic CC</td>
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<td><strong>Endoscopic or Investigative Proc for Metabolic Disorders W/O Catastrophic CC</strong></td>
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<td><strong>Disorders of Pancreas Except for Malignancy W Catastrophic or Severe CC</strong></td>
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<td><strong>Complex Gastroscopy W Catastrophic CC</strong></td>
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<td><strong>Major Small and Large Bowel Procedures W/O Catastrophic CC</strong></td>
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<tr>
<td><strong>Other Gastroscopy W Catastrophic CC</strong></td>
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<tr>
<td><strong>Other Gastroscopy; Sameday</strong></td>
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<tr>
<td><strong>Colonoscopy W Catastrophic or Severe CC</strong></td>
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<td><strong>Digestive Malignancy W/O Catastrophic CC</strong></td>
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<td><strong>Uncomplicated Peptic Ulcer</strong></td>
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<td><strong>Endoscopic Procedures for Bleeding Oesophageal Varices W/O Catastrophic CC</strong></td>
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<td><strong>Endocrine Disorders W/O Catastrophic or Severe CC</strong></td>
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<td><strong>Dysequilibrium</strong></td>
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<td><strong>TIA and Precerebral Occlusion W/O Catastrophic or Severe CC</strong></td>
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<tr>
<td><strong>Delirium W/O Catastrophic CC</strong></td>
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<tr>
<td><strong>Seizure W/O Catastrophic or Severe CC</strong></td>
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<tr>
<td><strong>Stroke and Other Cerebrovascular Disorders W/O Catastrophic or Severe CC</strong></td>
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<td><strong>Seizure W Catastrophic or Severe CC</strong></td>
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<td><strong>Cranial and Peripheral Nerve Disorders W/O CC</strong></td>
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<td>Conditions</td>
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<td>Degenerative Nervous System Disorders W Catastrophic or Severe CC</td>
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<td>TIA and Precerebral Occlusion W Catastrophic or Severe CC</td>
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<td>Nervous System Infection Except Viral Meningitis W/O Cat or Sev CC</td>
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<td>Other Disorders of the Nervous System W Catastrophic or Severe CC</td>
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<td>Non-surgical Spinal Disorders W CC</td>
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<td>Non-surgical Spinal Disorders W/O CC</td>
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<tr>
<td>Chronic and Unspecified Paraplegia/Quadriplegia W or W/O OR Pr W/O Cat/Sev CC</td>
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**Other conditions which do not belong to**

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<th>Conditions</th>
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<td>Abdominal Pain or Mesenteric Adenitis</td>
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<td>Other Musculotendinous Disorders W/O Catastrophic or Severe CC</td>
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<tr>
<td>Poisoning/Toxic Effects of Drugs and Other Substances W/O Cat or Sev CC</td>
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<tr>
<td>Otitis Media and URI</td>
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<td>Signs and Symptoms; Sameday</td>
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<tr>
<td>Non-surgical Spinal Disorders; Sameday</td>
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<tr>
<td>Red Blood Cell Disorders W/O Catastrophic or Severe CC</td>
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<tr>
<td>Alcohol Intoxication and Withdrawal</td>
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<td>Signs and Symptoms</td>
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<td>Major Chest Procedures W/O Catastrophic CC</td>
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<td>Major Chest Trauma W Catastrophic CC</td>
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<td>Red Blood Cell Disorders W Catastrophic or Severe CC</td>
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<td>Injuries W/O Catastrophic or Severe CC</td>
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<td>Minor Skin Disorders</td>
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<tr>
<td>Other Disorders of the Eye</td>
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<td>Viral Illness</td>
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<td>Bone Diseases and Arthopathies W/O Catastrophic or Severe CC</td>
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<td>Minor Skin Disorders; Sameday</td>
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<tr>
<td>Injuries W Catastrophic or Severe CC</td>
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<td>Major Skin Disorders W/O Catastrophic or Severe CC</td>
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<tr>
<td>Major Skin Disorders; Sameday</td>
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<td>Menstrual and Other Female Reproductive System Disorders</td>
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<tr>
<td>Other Musculotendinous Disorders W Catastrophic or Severe CC</td>
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<td>Oral and Dental Disorders Except Extractions and Restorations</td>
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<td>Epistaxis</td>
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<td>Hyphema and Medically Managed Trauma to the Eye</td>
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<td>Specific Musculotendinous Disorders W/O Catastrophic or Severe CC</td>
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<tr>
<td>Alcohol Use Disorder and Dependence</td>
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<tr>
<td>Other Factors Influencing Health Status; Sameday</td>
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<tr>
<td>Poisoning/Toxic Effects of Drugs and Other Substances W Cat or Sev CC</td>
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<tr>
<td>Other Factors Influencing Health Status</td>
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<tr>
<td>Injuries; Poisoning and Toxic Effects of Drugs W Ventilator Support</td>
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<tr>
<td>Fever of Unknown Origin W/O CC</td>
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</table>
- Trauma to the Skin; Subcutaneous Tissue and Breast W/O Cat or Sev CC
- Skin Ulcers; Sameday
- Injury to Forearm; Wrist; Hand or Foot
- Injury to Shoulder; Arm; Elbow; Knee; Leg or Ankle W CC
- Injury to Shoulder; Arm; Elbow; Knee; Leg or Ankle W/O CC
- Other Musculoskeletal Disorders W Catastrophic or Severe CC
- Inflammatory Musculoskeletal Disorders W/O Cat or Sev CC
- Other Ear; Nose; Mouth and Throat Diagnoses W/O CC
- Other Hip and Femur Procedures W/O Catastrophic CC
- Other Elbow or Forearm Procedures W CC
- Other Skin; Subcutaneous Tissue and Breast Procedures
- Non-Malignant Breast Disorders W CC
- Trauma to the Skin; Subcutaneous Tissue and Breast W Cat or Sev CC
- Other Male Reproductive System Diagnoses
- Fever of Unknown Origin W CC
- Other Infectious and Parasitic Diseases W Catastrophic CC
- Drug Intoxication and Withdrawal
- Other Injury; Poisoning and Toxic Effect Diagnosis W/O Cat or Sev CC
- Allergic Reactions
- Reticuloendothelial and Immunity Disorders W Catastrophic or Severe CC
- Reticuloendothelial and Immunity Disorders W/O Cat or Sev CC W/O Malignancy
- Malignancy; Male Reproductive System W/O Catastrophic or Severe CC
- Lymphoma and Non-Acute Leukaemia W/O Catastrophic CC
- Paranoia & Acute Psych Disorder W/O Cat/Sev CC W/O Mental Health Legal Status
- Neurological and Vascular Disorders of the Eye W CC
- Neurological and Vascular Disorders of the Eye W/O CC
- Major Affective Disorders
- Anxiety Disorders
- Eating and Obsessive-Compulsive Disorders
- Mental Health Treatment; Sameday; W/O ECT
- OR Procedures Unrelated to Principal Diagnosis W Catastrophic CC
- Cranial Procedures W/O Catastrophic or Severe CC
- Intracranial Injury W/O Catastrophic or Severe CC
- Other Head Injury
- Other Procedures for Other Injuries W/O Catastrophic or Severe CC
- Sequelae of Treatment W/O Catastrophic or Severe CC
- OR Procedures W Diagnoses of Other Contacts W Health Services W Cat/Sev CC
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CRONIN, J.G. The introduction of the Manchester triage scale to an emergency department in the Republic of Ireland. Accident and Emergency Nursing. 11 (2), pp 121-125

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