Chapter 4 - Task Force findings and recommendations by hospital

Methodology used to assess hospitals

For the purpose of assessing the 18 hospitals within its remit the Taskforce divided into sub-groups. Each sub-group visited 6 hospitals and met with key stakeholders. The purpose of the visits was to diagnose the key factors that were contributing to the challenges in ED and to develop appropriate solutions with the hospitals that would enable improved performance and delivery on the short and medium targets. The subgroups and relevant hospitals were as follows;

Ms Angela Fitzgerald, Dr Emer Feely, Dr Gerard Lane

- Galway Regional Hospitals,
- Mercy University Hospital,
- Cork University Hospital,
- Sligo General Hospital,
- Mayo General Hospital, Castlebar,
- Mid-Western Regional Hospital, Limerick

Mr Ian Carter, Dr Gerard McCarthy, Ms Mary McHugh

- Connolly Hospital Blanchardstown
- Beaumont Hospital,
- Mater Misericordiae Hospital
- Our Lady of Lourdes Hospital, Drogheda,
- Cavan General Hospital
- Letterkenny General Hospital

Mr Jim Breslin, Dr Dermot Power, Dr Richard Brennan, Dr Conor Burke

- Wexford General Hospital,
- St James's Hospital,
- St Vincent's University Hospital
- Naas General Hospital,
- St Columcille's Hospital Loughlinstown,
- Adelaide & Meath Hospital incorporating the National Childrens' Hospital Tallaght,

From the visits to the hospitals, three broad groups emerged within the 18 hospitals.

i) There were a small number of hospitals that were capable, with targeted supports, of moving to a total wait time of 6 hours for patients requiring admission.
ii) A second group who have for the most part delivered on the 24 hour targets but need additional structural supports if they are to achieve the medium targets of 6 hours from time of identification of bed requirement to actual admission
iii) A final group (seven or eight hospitals) was identified that were not fit for purpose in terms of physical environment and require priority attention to address dignity and privacy issues.

The findings and recommendations for the individual hospitals are grouped under the following headings: **Capacity, Capability and Control**. The issues raised and recommendations are consistent with the overall framework developed by the Task Force.

The Task Force has also considered the proposed initiatives submitted by the hospitals and has made recommendations as appropriate[ii]. The following points emerge from the overall approach adopted and challenges identified by the Task Force:

- The Task Force's recommendations on site-specific proposals are consistent with the findings from the site visits, the efficacy of the initiatives in terms of the targeting ED volumes and wait times and have regard to the level of overall internal management control.

- In some cases, hospitals have not put forward relevant proposals to address issues identified by the Task Force and the individual commentaries highlight this as appropriate.

- In other cases, hospitals have proposed an ambitious set of initiatives that are efficacious and are consistent with the gaps identified but may pose practical challenges in terms of implementation and oversight. In such cases, it is recommended that a phasing or sequencing of implementation be adopted supported by rigorous review and audit processes.

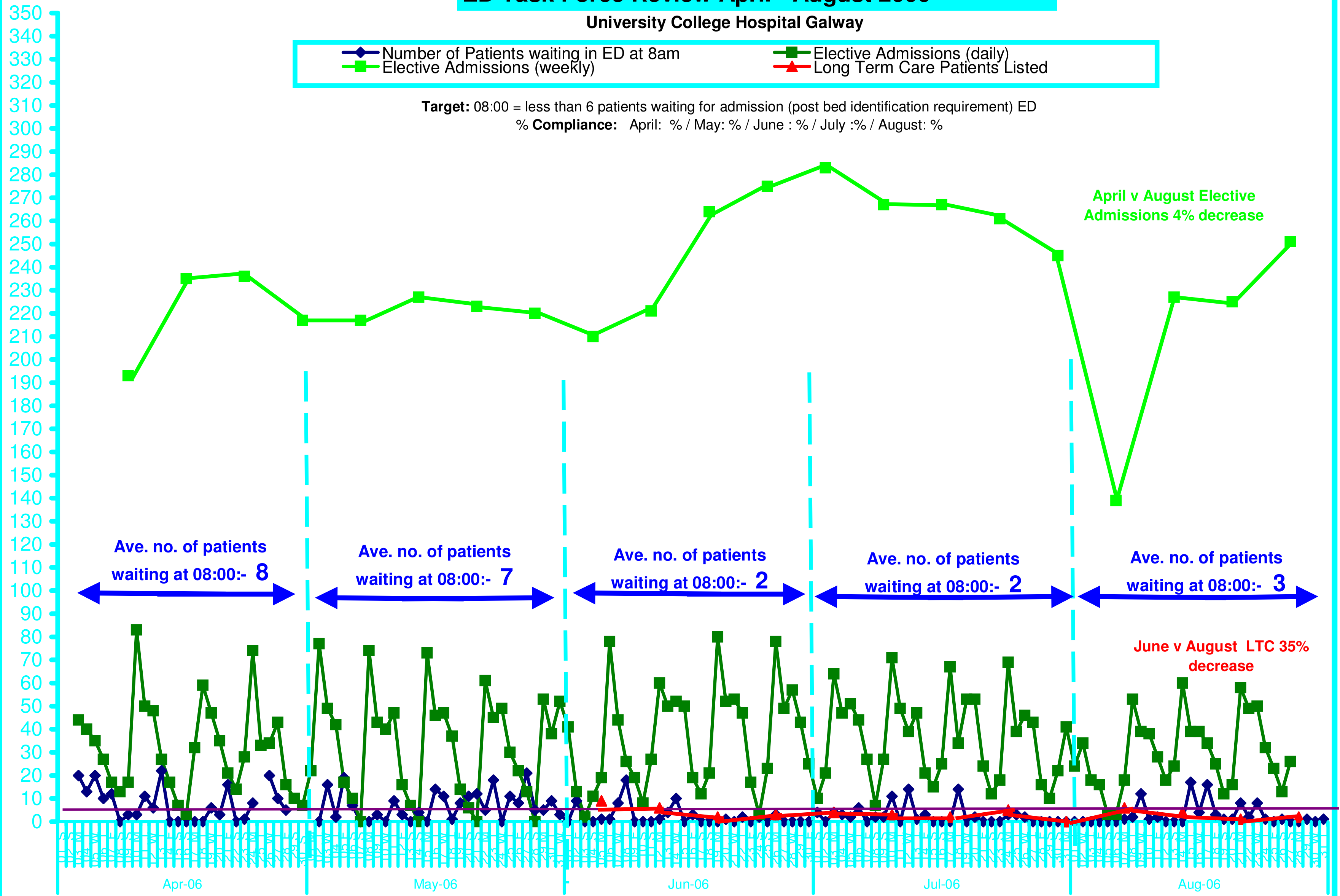
- The success of any of the initiatives proposed is dependent on strong management controls being in place so that those bed days saved are appropriately targeted at ED volumes and wait times.

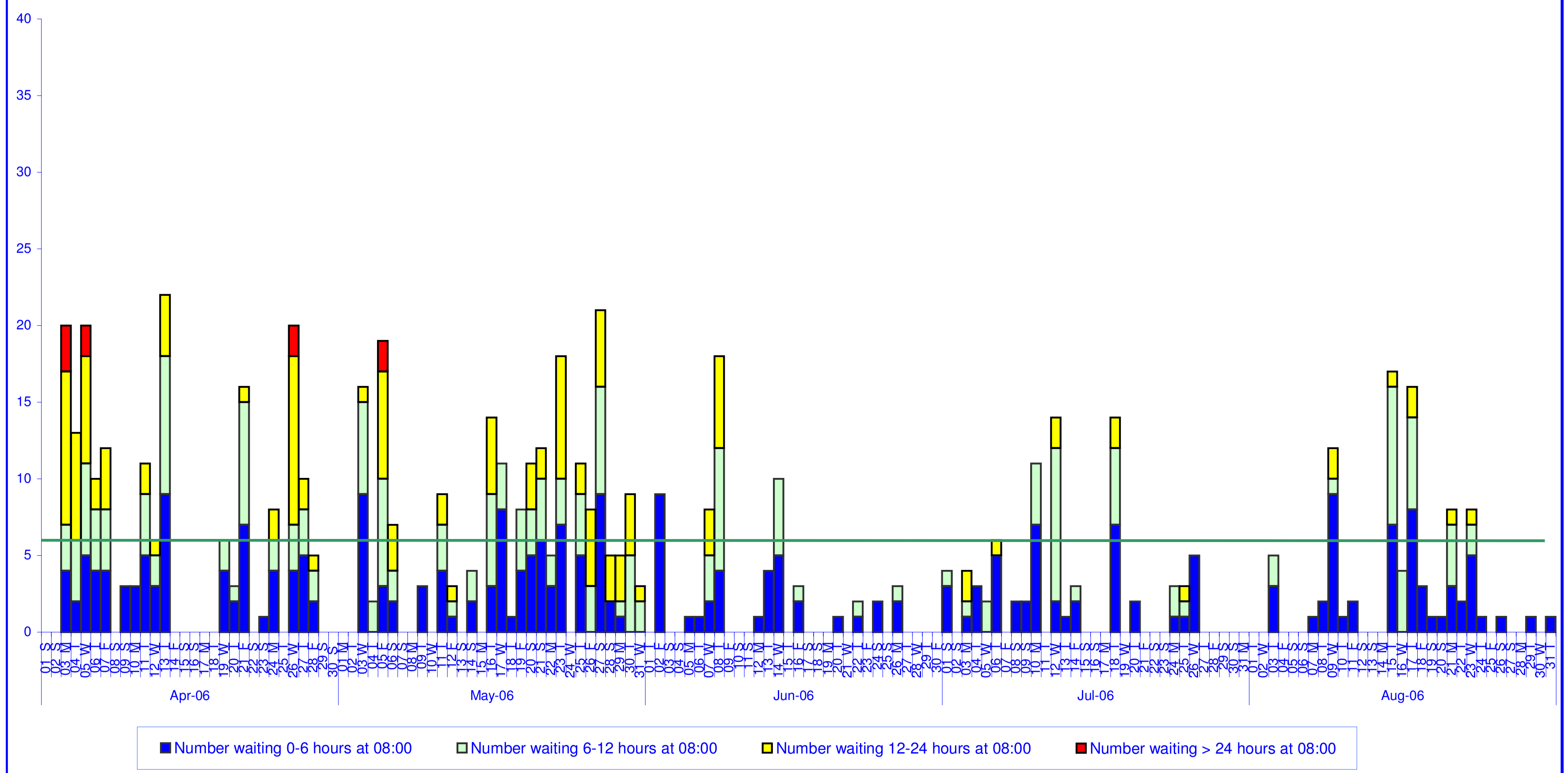
- In a number of hospitals, the proposals submitted for enhanced capacity and capability need to be supported by tangible initiatives aimed at improving internal controls and these are identified in the commentaries. The Task Force recommends that the HSE seeks evidence of whether such controls have been put in place before funding is released for initiatives.

Galway Regional Hospitals

University College Hospital Galway

Merlin Park Hospital


ED Task Force Review April - August 2006
University College Hospital Galway
Data supplied by HSE
Number of Patients waiting in ED at 8am
Elective Admissions (weekly)
Elective Admissions (daily)
Long Term Care Patients Listed
Target: 08:00 = less than 6 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: % / May: % / June : % / July :% / August: %
April v August Elective Admissions 4% decrease
Ave. no. of patients waiting at 08:00:- 8
Ave. no. of patients waiting at 08:00:- 7
Ave. no. of patients waiting at 08:00:- 2
Ave. no. of patients waiting at 08:00:- 2
Ave. no. of patients waiting at 08:00:- 3
June v August LTC 35% decrease
Apr-06
May-06
Jun-06
Jul-06
Aug-06



Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
University College Hospital Galway
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 38% May: 38% / June: 56% / July: 56% / August: 60% compliant
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

Capacity

- The hospital has a unique arrangement with Merlin Park Hospital. One ED serves both hospitals and has led to significant difficulties in optimising overall capacity with consequent pressures on UCHG
- The potential for the development of rehabilitation capacity at Merlin Park needs to be accelerated to unlock existing capacity at University Hospital, Galway
- There is a need for improved communication with GPs to facilitate better planning of patient admission and treatment
- There is an urgent need to address patient transportation issues, which appear to have deteriorated over last number of months. Up to seven patients per day are delayed waiting for ambulances.
- Development of supra-regional cancer services in recent years has led to significant increase in number of beds allocated to cancer patients with associated difficulties for ED.

Capability

- The hospital identified long waiting times for GPs using radiology service in UCHG. (Example given of 9 months wait for outpatient lumber spine X-Ray.) As a result many GPs refer these patients directly to ED.
- The absence of a robust IT system in ED has impeded the measurement of the efficiency of department and systematic data collection.
- There is a number of initiatives in place for fast tracking/diverting patients (Chest pain clinic, heart failure clinic, oncology direct admissions),

Control

- Patients often experience delays in ED waiting to be seen by the admitting team. Significant potential exists for improved senior in-house decision making for emergency patients.
- There is an urgent need to review the practice whereby patients who are seen in OPD and require admission after 5pm are sent to ED for admission often leading to long delays.
- There is a need to maximise use of Merlin Park Hospital so that overall capacity between the two hospital sites is optimised and a more appropriate balance is achieved in managing emergency and elective demands.
- The current discharge planning practices needs to be reviewed in order to reduce delays

Commentary: Hospital Focus in relation to ED-wait volumes/times

- Pan Hospital focus was evident from the site visit
- A high degree of compliance with individual hospital target of 6. In May the hospital still had a number of days when the numbers waiting exceeded the national daily target of 10. A significant improvement has been observed since June 2006 with average numbers waiting at 8 am in June , July and August ranging from 2.1-2.8
- Full compliance with wait time target of 24 hours was observed with a significant improvement achieved between May and June in relation to the proportion of patients waiting 12-24 hours.
- These improvements have been maintained by prioritising the emergency over the elective workloads. Concerns have been expressed by the hospital about the sustainability of this approach.

Recommendations

Capacity

- ***Optimising Acute Capacity*** – From the information available, the hospital is operating at 93%. The single biggest priority for UCHG given its unique arrangements with Merlin Park is to develop short and medium term strategies that deliver improvements in the use of the overall capacity across the sites of the two hospitals.
  Specifically, there is a need to re- balance the emergency and elective arrangements so that the ED workload at UCHG is appropriately prioritized. The hospitals' proposals for the development of stroke rehabilitation and pulmonary facilities at Merlin Park would go someway towards integrating the operation of the two sites and freeing up capacity at UCHG.
  The recent development of oncology services at UCHG has created significant additional pressures on bed utilization with up to one sixth of the bed complement at UCHG being occupied by oncology patients. The hospital has developed proposals for establishment of hostel accommodation, which will go someway towards alleviating these pressures.

- ***Development of Day Surgery and AMAU -*** The hospital's proposals for day surgery appear to have considerable merit in the context of delivering on medium- term strategies for the two hospitals. The re-location of day surgery would have an impact on bed days utilised and would also deliver benefits beyond the ED in terms of optimising the two sites. The capital and revenue requirements would militate against delivering this initiative in the short term but given the strategic benefits for the hospital it should be advanced through the capital plan

  The site visit would highlight the merits of developing an AMAU in order to effect an appropriate diversion of patients from the ED and to support the requirement for whole-hospital engagement in tackling issues that manifest themselves in the ED. However, the revenue and capital costs are very revenue and capital costs are significant and this may militate against it being delivered in the short-term. The potential for linking the day surgery proposal with the proposal for the AMAU was discussed with the hospital and should be exploited fully. The benefits of such an approach would be that the space freed up by moving the day surgery

unit could re re-developed as an interim AMAU which could come on-stream quickly.

- ***Admissions Lounge -*** The proposals for the transit lounge need to be reviewed given the capital and revenue costs involved. Specifically there is an imperative to ensure that a facility is place by the winter to ensure that patients in the ED are accommodated on beds rather than trolleys. The hospital is examining options in this regard and has identified a leasing arrangement which could deliver a modular build within a short time-frame

- ***Discharge Lounge -*** The establishment of discharge lounge needs to be accelerated particularly given the delays in transportation experienced by the hospital

- ***Long Stay Capacity*** - The emerging issues in relation to consistent and timely access to long-term care need to be addressed urgently within the overall PCCC framework for long-term care.

Capability

- ***Diagnostics*** - The hospital needs to develop direct GP access to diagnostics as a priority. However, it has not been included in its overall priorities. Outsourcing to the private sector should be considered as an immediate option to address unacceptable waiting times for routine diagnostic tests.

- ***Fast-tracking/Diverting patients*** **-** The preferred option for the hospital in terms of improving senior decision making by the admitting team and having regard to its tertiary workload is the development of an AMAU with senior decision making, admission capability (beds) and adequate diagnostics. The proposals submitted would have a significant lead-time and require further review. The option of using the space freed up by moving day surgery to Merlin Park should be considered as a priority to enable an early and cost effective approach to the provision of an AMAU.

- Specific internal management controls need to be developed urgently to ensure that the needs of ED are appropriately balanced against the needs of tertiary patients.

Control

- There is a need to put measures in place as a matter of urgency to address the following:
    - Delays in senior decision making within the admitting team
    - Balancing tertiary and emergency workloads more effectively
    - Consistent and timely approach to escalation policy with key stakeholder involvement
    - Admission of OPD patients through the ED

- The hospital's submission includes a number of cost neutral initiatives aimed at improving control. In addition, the benefit of having a senior dedicated manager with responsibility for ED combined with improved escalation measures should be considered as a priority for the hospital for the hospital.

Galway Regional Hospitals – Site specific initiatives

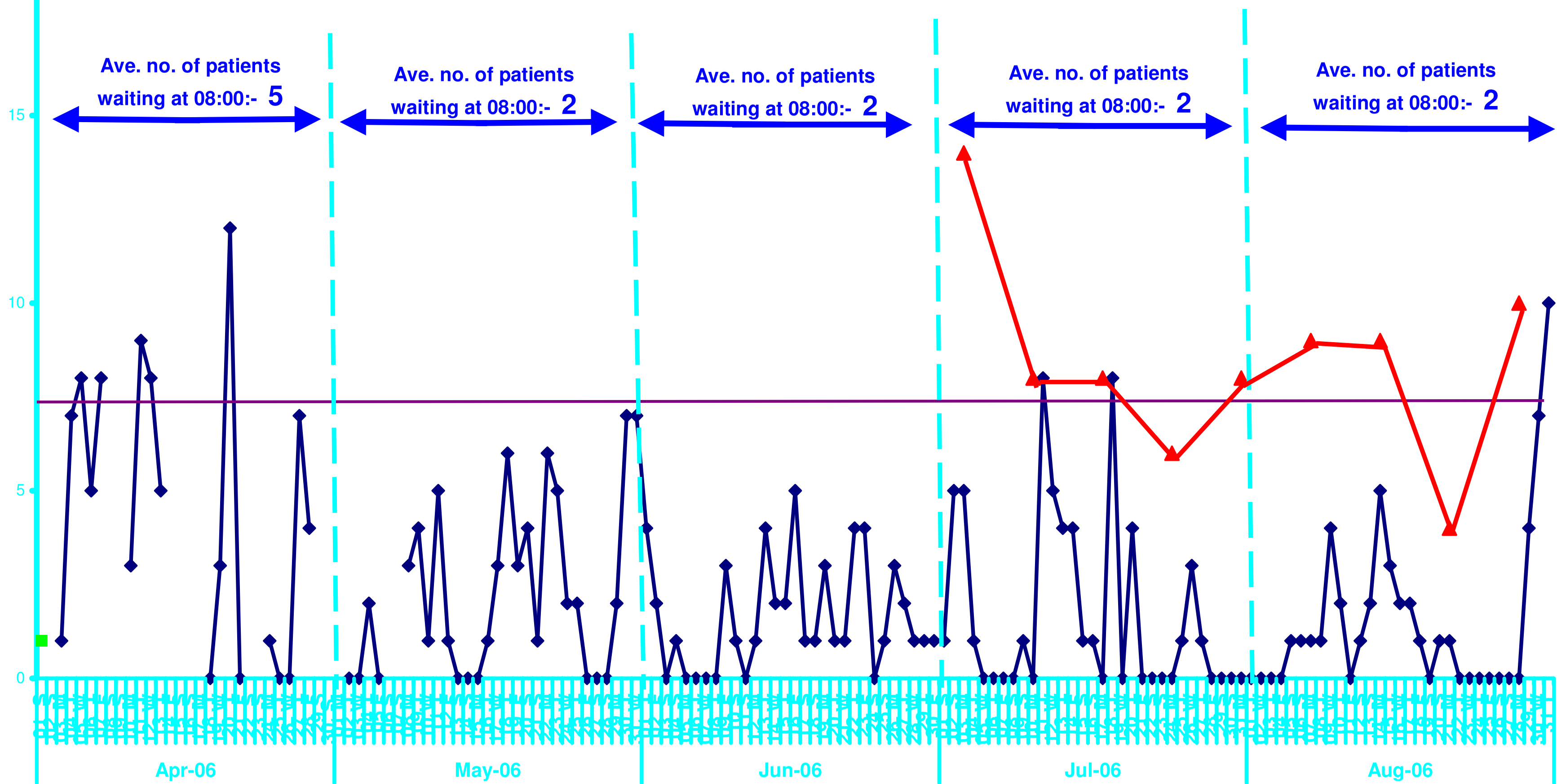
Proposals		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	2007		Annual revenue (€ million)	Capital (€ million)
		4 additional beds in CCU as protected 5 day CCU step-down facility	Faster patient processing. Reduced waiting times for specialised services. Early transfer to local care.		May	2.5	0.100	Nil
		Transfer of stroke patients to Merlin Park	3,382 additional bed days available per annum		June	12.8	0.572	0.517
		Transfer of Day Surgery to Merlin Park and Development of AMAU	Revised proposal to be submitted as part of Service Planning process					
		Increase capacity for Rehabilitation patients by 12 beds	Reduce ALOS for patients. 1,035 additional bed days PA		June	4.5	0.204	0.3
		Develop Pulmonary Rehabilitation service	Community based care for COPD patients. Reduction of 138 in ED attendances	Immediate			Nil	Nil
		Rapid Access to Elderly and Respiratory Assessment	Additional bed days	End 2006			Nil	Nil
		Implement protocols for direct admissions of oncology patients wards form OPD	reduce overcrowding in ED and provide appropriate care to oncology parities	End 2006			Nil	Nil
		10 additional Home Care packages	**840 additional bed days available PA**			**PCCC**	**PCCC**	**PCCC**
		Expansion of High Dependency Nursing Home places – elderly and young chronic sick	More appropriate care .1100 additional bed days available PA		August	**PCCC**	**PCCC**	**PCCC**

		Operate 2nd CT Scanner Capability)	Diagnostic process enhanced		2007	3	0.177	0
		Improve patient consult process	Speed admission process by enhancing discharge process	2006			Nil	Nil
		Admission Lounge	Provide dignity and privacy to patients awaiting admission		June		Leasing arrangement being developed	
		Development of Heart Failure Clinic 1*	Preventive; will allow early management resulting in reduced admissions – 800 additional bed days PA		June	0.5	0.035	Nil
		24 hour ward clerk service	Average wait time reduced by 5 minutes per patient		February	2	0.066	
		Re configuration of ward round process		Immediate			Nil	Nil
	Capability	Extend radiographers working day		End 2006			Overtime basis	
		Medical and Surgical- SHOs assigned to ED	Reduction in waiting time for medical and surgical patients – by 2.5 hours each	Immediate			Nil	Nil
		Develop ANP Service in ED including provision of DVT service	Average wait time reduced by 20 minutes per patient		March	1	0.065	Nil
		Expand Chest Pain Clinic	Additional bed days available – reduction of 182 in ED attendances PA. Outpatient treatment.		February		Nil	Nil
		Clinical Governance for Point of Care laboratory system in ED	Reduced waiting times for lab results	End 2006		0.5	0.025	0.077
		Develop structures to provide support for patients to return to community in conjunction with PCCC (PHNs, AHP etc)				PCCC	PCCC	PCCC

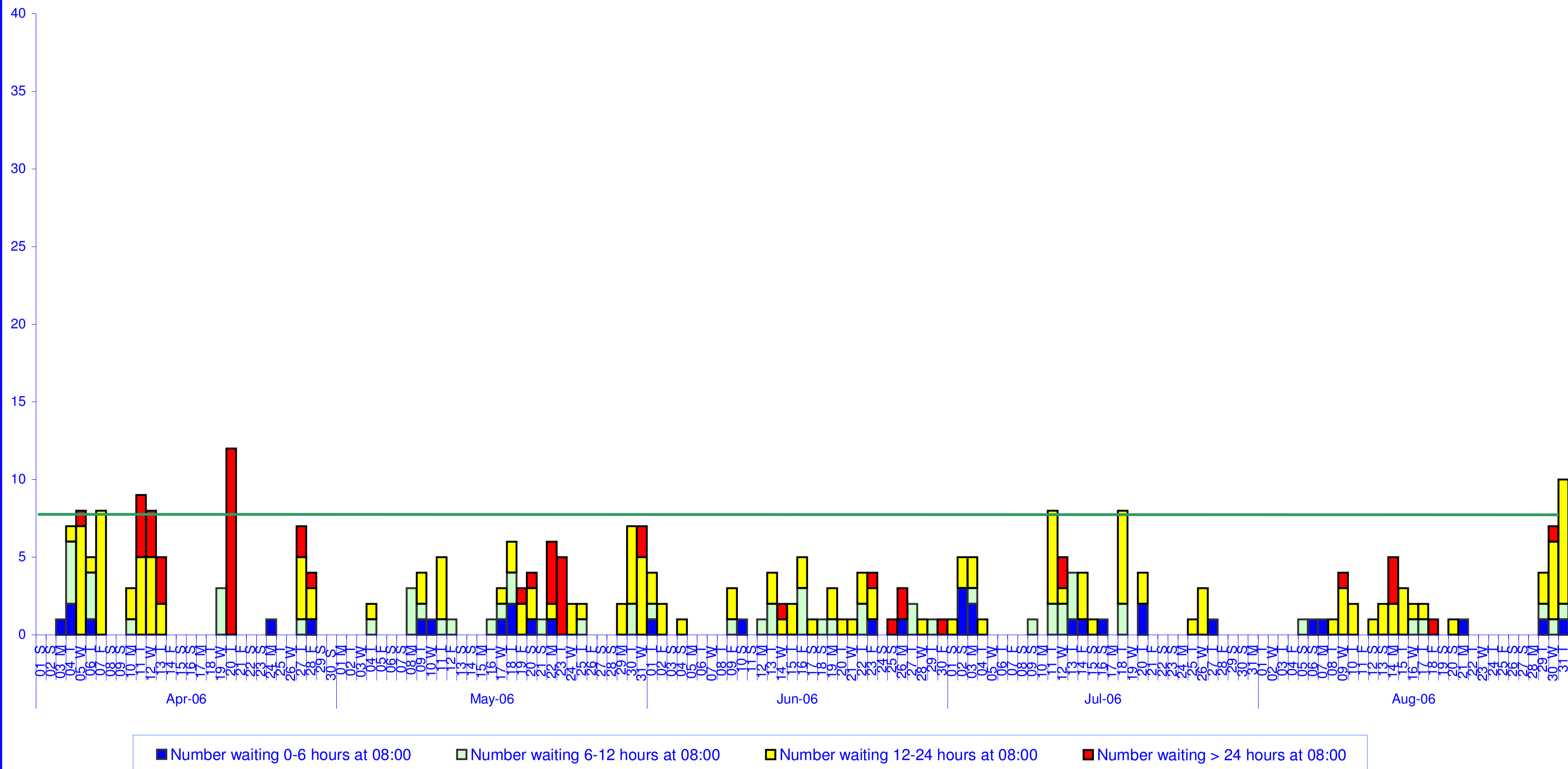
		Direct Admission of Oncology patients			February	1	0.040	
	Control	Enhanced Bed Management function, improved admission process in ED	Reduction in amount of time spent in ED		March	3	0.177	
		Enhance IT system, automatic GP letters	Frees nursing and clerical staff time.		March		0.075	
	Totals					**30.8**	**1.536**	**.894**

* AMAU submission not included

Mercy University Hospital, Cork



ED Task Force Review April - August 2006
Data supplied by HSE
Mercy Hospital
Number of Patients waiting in ED at 8am
Elective Admissions (weekly)
Elective Admissions (daily)
Long Term Care Patients Listed
Target: 08:00 = less than 7 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 61% / May: 93% / June : 100% / July :94% / August: 94%
Ave. no. of patients waiting at 08:00:- 5
Ave. no. of patients waiting at 08:00:- 2
Ave. no. of patients waiting at 08:00:- 2
Ave. no. of patients waiting at 08:00:- 2
Ave. no. of patients waiting at 08:00:- 2
25
20
15
10
5
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Mercy Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 7% May: 11% / June: 8% / July: 21% / August: 10% compliant
40
35
30
25
20
15
10
5
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

The biggest challenge facing the hospital is the inadequate physical environment of the ED and this militates against providing an effective ED service. The hospital is to be commended for its performance in tackling the issues in ED since the start of the year with significant improvements being achieved in volumes and wait times in the ED. Its efforts in prioritising the development and commissioning of a new ED are also to be commended.

Capacity

- The physical capacity is totally inadequate. A six bedded drop down unit will add to the current limited capacity of the ED this autumn. The hospital proposes to open a new ED in 2007.
- The Task Force observed evidence of good relationships with local GPS. Access to diagnostics for GPs appears to be good
- Hospital introduced mew pan-hospital bed management structures which has enabled better planning and management of elective and emergency beds Since the introduction of the new measures no elective admissions have been cancelled and. ED numbers have also been managed .effectively
- Immediate and consistent access to long stay community hospital beds and dementia beds is required. Young chronic sick also require access to beds.

Capability

- It is proposed that an AMAU be introduced next year with 1.3 consultants. It is vital that AMAU works in conjunction with other fast track and diversion initiatives and does not compete for resources in terms of senior making and diagnostics
- In general diagnostic services available to ED are good. Although on a 9 to 5pm Monday to Friday basis Many patients remain in ED while they have investigations carried out which then enables them to be discharged home
- A six bedded rapid assessment and treatment unit is scheduled to open before the end of June 2006.

Control

- The Task Force observed strong evidence of whole hospital engagement and focus on ED
- Deputy CEO has overall responsibility for ED with evidence of strong leadership from the CEO

Commentary: Hospital Focus in relation to ED-wait volumes/times

- The hospital is compliant with National volume performance targets.
- The hospital is compliant with wait time targets
- Central control and pan hospital focus is evident – enabling ED/Elective access tensions to be managed quite effectively.

Recommendations

Capacity

- The single biggest priority for the Mercy Hospital is to address the deficits in the ED physical infrastructure. The proposals in relation to the development of immediate additional accommodation in the form of two admission lounge areas, a dedicated paediatric facility and the overall ED development are welcomed in this context. All of the projects are well advanced and the new ED will be completed be year-end and fully commissioned in March 2007.
- There is an urgent need to develop short-term specific proposals aimed at addressing the immediate long-term care requirements for Cork City. The HSE assessment of need for long term care has highlighted deficits in Cork and identified the requirement for the development of public community beds. As with Cork University Hospital, the option of purchasing private beds needs to be urgently progressed.

Capability

- The existing ad-hoc arrangements for provision of radiography services to the ED need to be urgently addressed and in this context the dedicated radiographer proposal has some merit. However the potential for delivering an extended day and weekend service should be considered by the hospital in line with those being developed by other hospitals.

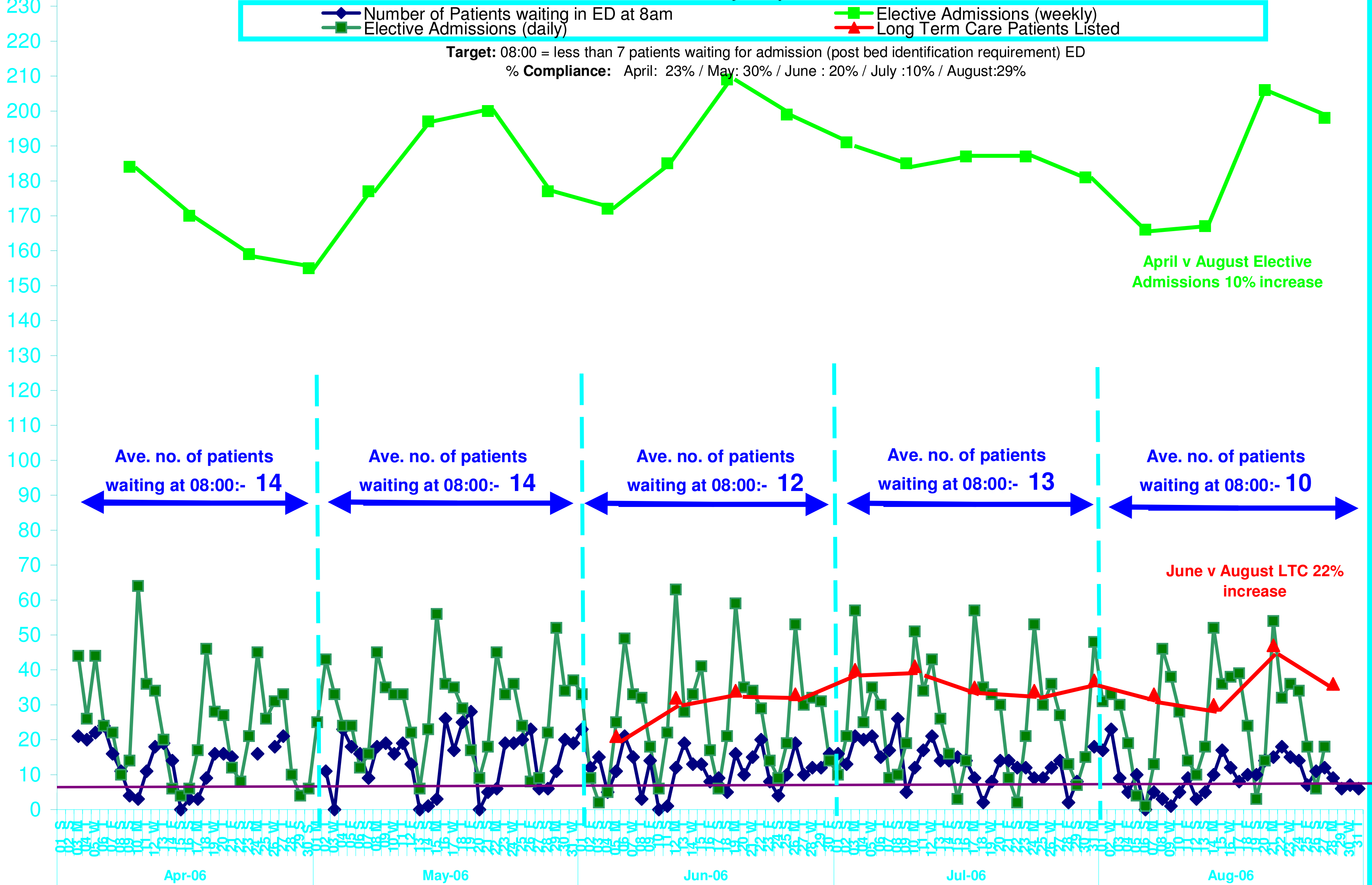
Control

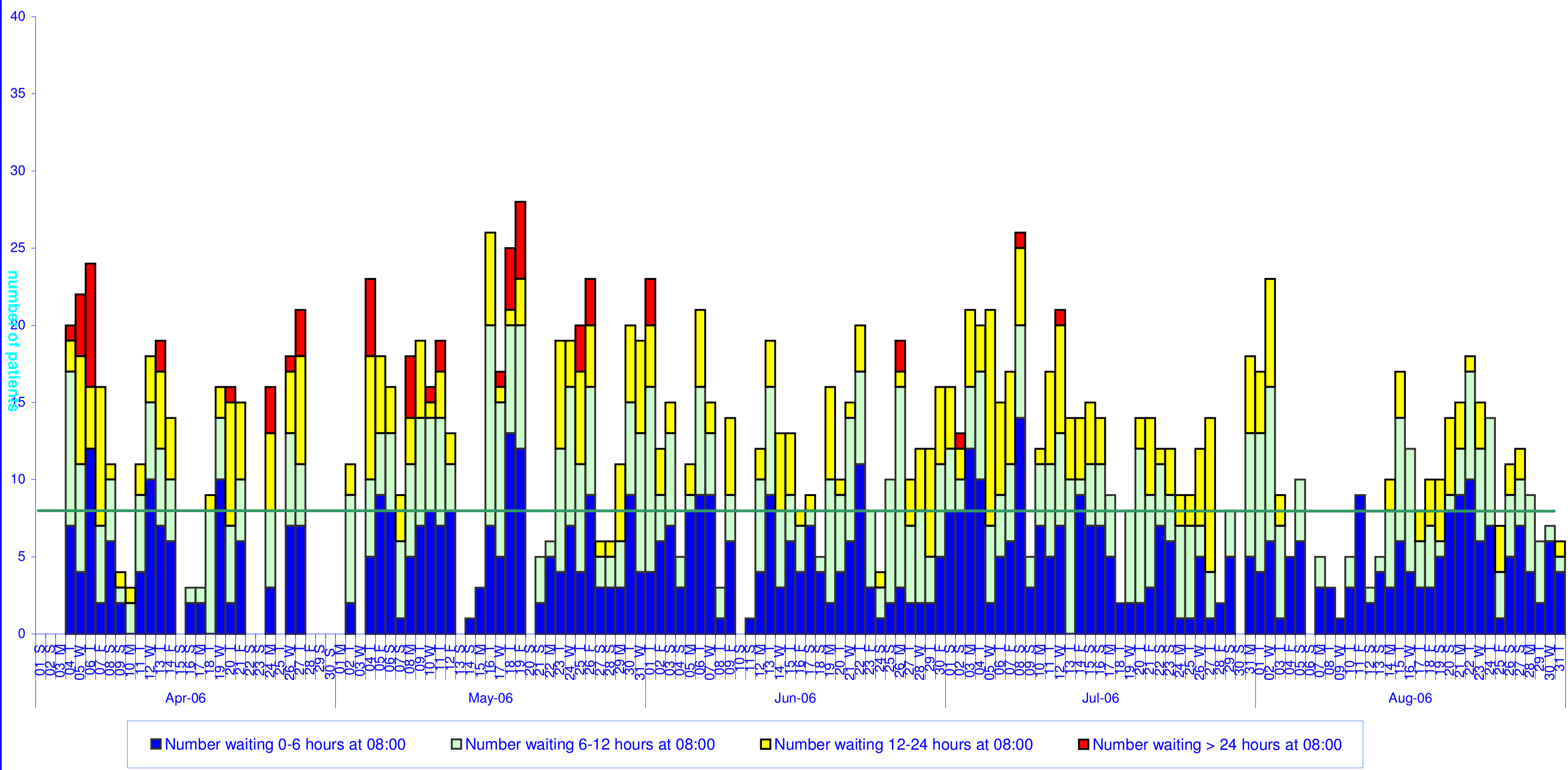
- The proposals for fast-tracking geriatric patients and diverting COPD patients are endorsed by the Task Force due to their impact on volumes and wait times.
- The hospital- wide efforts in tackling the issues in ED should be strongly acknowledged; specifically the measures adopted recently in relation to balancing emergency and elective workloads and the implementation of improved escalation policies. It is critical that these measures remain in place through the winter and in 2007.

Mercy Hospital, Cork – Site specific initiatives

		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	**2007**		Annual revenue (€ million)	Capital (€ million)
Proposals	**Capacity**	Creation of dedicated Paediatric facility alongside ED	Reduction in waiting time, better and more rapid management of paediatric attendees	November		3	0.162	0.050
		Convert day ward into 4-bed admission lounge for ED patients	Improved privacy and comfort. Reduce trolley wait for patients.			7	0.375	**(0.13)**
		8 additional beds created via prefab	Improved privacy, comfort and bed capacity		April	8	0.400	(0.385)
	Capability	COPD Outreach programme	Reduced ALOS for COPD patients – 200 bed days freed .Protocol based early discharge home.		June	4	0.2	
		Radiographer dedicated to ED	Reduce ED waiting times. Extended day		February	1	0.060	
	Control	Rapid Response Rehabilitation Team	Multi disciplinary team. Early rehabilitation and home assessment for 250 elderly patients		June	5	0.224	
	Totals					**28**	**1.421**	**.050**

Cork University Hospital


ED Task Force Review April - August 2006
Data supplied by HSE
Cork University Hospital
Number of Patients waiting in ED at 8am
Elective Admissions (daily)
Elective Admissions (weekly)
Long Term Care Patients Listed
Target: 08:00 = less than 7 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 23% / May: 30% / June : 20% / July :10% / August:29%
April v August Elective Admissions 10% increase
Ave. no. of patients waiting at 08:00:- 14
Ave. no. of patients waiting at 08:00:- 14
Ave. no. of patients waiting at 08:00:- 12
Ave. no. of patients waiting at 08:00:- 13
Ave. no. of patients waiting at 08:00:- 10
June v August LTC 22% increase
Apr-06
May-06
Jun-06
Jul-06
Aug-06


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Cork University Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 35% May: 37% / June: 38% / July: 39% / August: 47% compliant
number of patients
0
5
10
15
20
25
30
35
40
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

Capacity

- The Cork-wide rota for ED consultants poses operational challenges in terms of supporting the requirements for senior decision-making within the ED
- More senior in-house decision making is needed within ED to support patient flow and reduce waiting times
- Potential for improved communication with GPs to facilitate better planning and management of patients requiring admission.
- There is a need for increased long-stay capacity. Key issues here are:
  - The community hospital model was put forward as a good model.
  - Reduction of availability of beds in St Finbarr's Hospital has increased the pressure on services for the elderly.
  - The need in Cork for access to dementia beds
- Potential for shifting significant workload to day case basis with the commencing of the day unit later this year

Capability

- In general, diagnostic services available to ED are good. although they are only available on Monday to Friday, 9 to 5pm basis A critical need was identified for:
    - Improved access to ultrasound
    - Improved access to upper GI endoscopy.

  In common with other hospitals, the need for extended day in diagnostics was highlighted.
- CUH has submitted a proposal for an acute medical assessment unit (AMAU). The Task Force visit highlighted the critical importance of ensuring that the scope of the unit is sufficient to impact on ED and that it supports whole hospital focus on patient flow. Also the unit should not compete with the ED for its resources such as diagnostics and decision-making.
- A number of initiatives are in place aimed at fast tracking patients. These include
    - Rapid access services include chest pain clinic and rapid access services for melanoma and breast cancer and rapid access to OPD appointments for cardiology, gastroenterology, neurosurgery and geriatrics.
    - Clinical decision unit attached to ED (operational since April 2005).
    - The impact of these initiatives in terms of reducing volumes and waiting times requires further assessment.

Control

- The hospital would benefit from having a dedicated senior manager with specific responsibility for ED issues.
- The hospital has been pro-active in developing initiatives for improving patient management. However there is a need for improved cohesion in the overall planning and operation of such initiatives with particular reference to RAT, clinical decision unit (CDU) and proposed AMAU.
- The hospital has strong track record in managing length of stay (6.03 days). This should be enhanced by the development of the day surgery unit.
- There would appear to be ongoing tensions between balancing tertiary and emergency workloads, particularly given its regional and supra-regional roles

Commentary: Hospital Focus in relation to ED-wait volumes/times

At the time of the visit, the potential for improved pan-hospital focus on ED was observed, with particular reference to senior decision-making. Since the site visits, the hospital has put in place a number of control measures which has resulted in significant improvements in their volume and wait time targets. It is now fully compliant with the national volume and waiting time targets

- From April to July the hospital was not fully compliant with National volume performance targets (at 8am the hospital had more than 10 patients awaiting admission in the ED). From August onwards the hospital had succeeded in meeting target – on average no patient is recorded as waiting more than 24 hours. This can be attributed to increased internal control measures including escalation processes and senior decision making.
- Balancing elective and emergency workloads needs to remain a corporate priority. The targeting of delayed discharges and the development of day surgery services would assist in this regard.

Recommendations

Capacity

- ***Optimising Existing Capacity -*** A key issue in the city is optimizing the use of the three Emergency Departments. From CUH's perspective, given its tertiary role and the potential for competing demands between tertiary and prospective emergency admissions, there is a need to agree on the roles and relationships of the three emergency departments so that all relevant resources are used to better effect.
  As a short-term measure, there is a need to address each of the Emergency Consultants rota arrangements to allow for better on call arrangements and patient care. The potential for developing clinical networks across the three hospitals should be fully explored.

- ***Long Term Care -*** There is an urgent need to develop specific proposals aimed at addressing the long-term care requirements for Cork City. The HSE assessment of need for long term care has highlighted deficits in Cork and this is evidenced by numbers of Delayed Discharges in CUH alone. The short – term option of purchasing long-term care beds from the private sector should continue to be supported and expanded. CUH has a strong track record in securing and appropriately placing patients in private long stay facilities and pending the development of public long stay capacity, this will continue to be required.
- In the medium term, there is a need to develop public community hospitals, which can adequately address the requirements in this area.

Capability

- ***Development of AMAU -*** There is an urgent need to improve senior decision-making by the admitting team for patients requiring admission from the ED. The Task Force agrees that the hospital's proposal to develop an AMAU has the potential to go some way towards addressing the issue but it will require full support and participation by the admitting teams and adequate diagnostic capability. The revised proposals to the Task Force from the hospital make provision for dedicated physicians as well as full participation by other physicians in the operation of the AMAU. The proposal for the use of the 19-bedded ward has been developed to support the functioning of the AMAU. The hospital management has proposed the concept of piloting the initiative with a formal evaluation framework to assess it impact on volumes and wait times in ED.

- ***Diagnostic Capability* -** While the hospital has relatively good access to diagnostic capability it highlighted some delays in diagnostic tests, which should be outsourced in the short term. This proposal should be pursued, however there will need to be strong controls to ensure that the freed up bed capacity is cohorted for emergency patients.

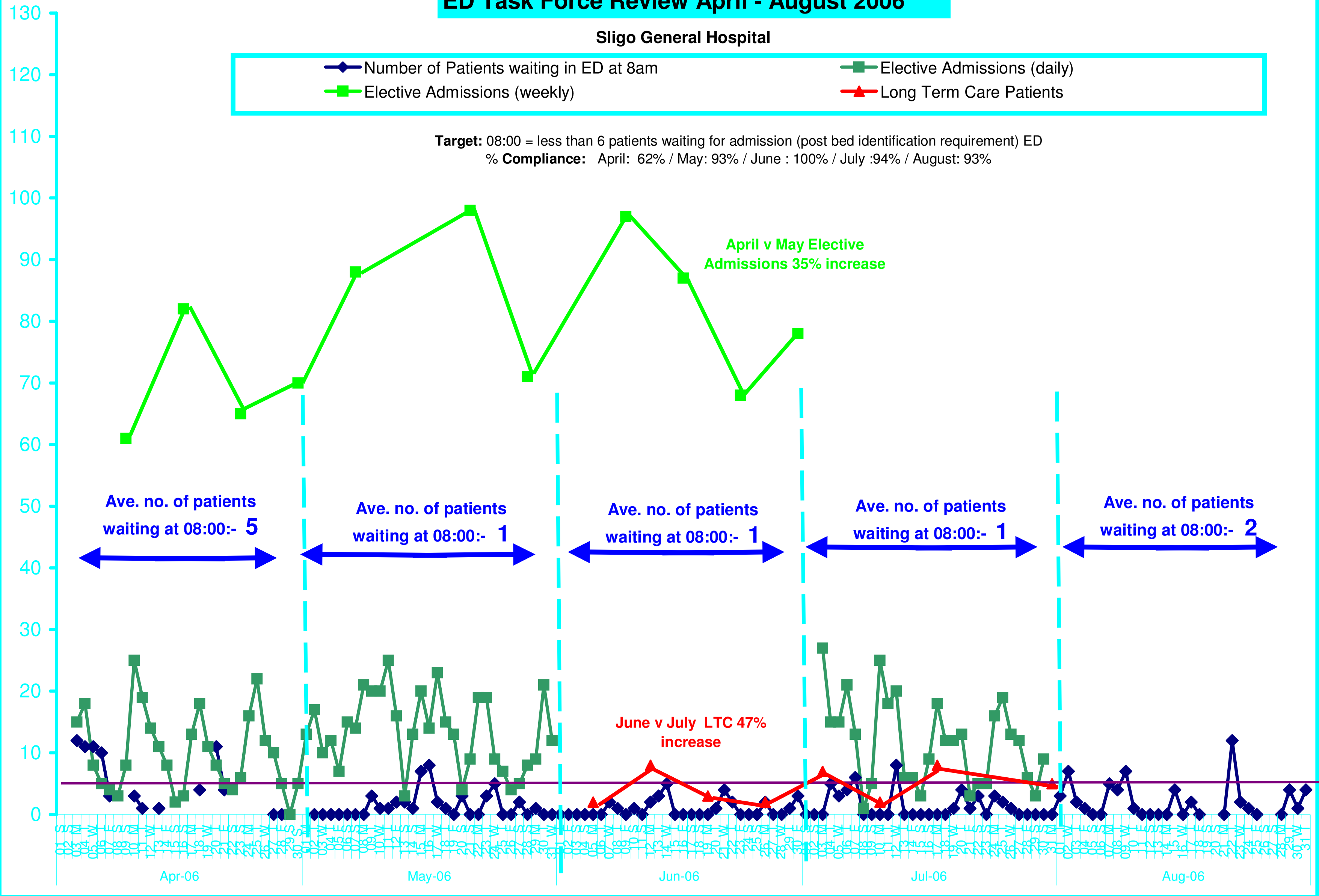
Control

- Following the Task Force visit and follow up, the hospital has taken a number of hospital-wide initiatives to improve overall bed management to ensure that the ED is appropriately prioritised in the allocation of beds.
- The hospital's arrangements for dealing with escalations have also changed recently and would appear to be working well. These arrangements need to continue to be supported locally so that volume and wait times in ED can be managed appropriately throughout peak times.
- The recent appointment of a dedicated senior manager with overall responsibility for the ED management has been beneficial. The arrangement needs to be underpinned by appropriate decision making capability and supports

Cork University Hospital

		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	**2007**		Annual revenue (€ million)	Capital (€ million)
Proposals	**Capacity**	Establishment of Discharge lounge	Decrease number of patients on trolleys by 6 each day	3 months		4.3	0.196	
		Open former day unit as to facilitate transfers from ED and to support the establishment of a Physician led AMAU on a 24/7 basis.	Ensure registration to exit time of no more than 6 hours. Discontinue use of trolleys in ED. GP access to senior decision making. Reduction by 20 patients presenting in ED for assessments / diagnosis each week	6 months		28	1.7	
	Capability	Ortho-geriatric service	Fast track patients from acute beds in CUH to Rehab beds in St Mary's .Increased availability of 13 beds.	3 months		7	.435	.350
	Control	Discharge Coordinator for over-65s	Increased inpatient bed capacity	3 months		1	0.048	
		Clerical Officer support for bed management	Data quantification and reporting. In place on a temporary basis.			0.35	0.0105	
		Community Beds					**PCCC**	**PCCC**
	Totals					**40.65**	**2.3895**	**.350**

Sligo General Hospital


Data supplied by HSE
ED Task Force Review April - August 2006
Sligo General Hospital
Number of Patients waiting in ED at 8am
Elective Admissions (weekly)
Elective Admissions (daily)
Long Term Care Patients
Target: 08:00 = less than 6 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 62% / May: 93% / June : 100% / July :94% / August: 93%
April v May Elective Admissions 35% increase
Ave. no. of patients waiting at 08:00:- 5
Ave. no. of patients waiting at 08:00:- 1
Ave. no. of patients waiting at 08:00:- 1
Ave. no. of patients waiting at 08:00:- 1
Ave. no. of patients waiting at 08:00:- 2
June v July LTC 47% increase
130
120
110
100
90
80
70
60
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06

Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Sligo General Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 19% May: 38% / June: 41% / July: 22% / August: 45% compliant
0
5
10
15
20
25
30
35
40
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

Capacity

- The hospital has an AMAU facility already in place but it is not working to full capacity. The hospital proposals n expanded AMAU have been approved by the HSE within the overall Capital Plan
- Diagnostic capacity needs to be expanded within the hospital to address the competing demands of ED, GPs and rest of hospital. Specifically, there is a need for extended hours in X-Ray. (622 bed days lost in August 2005 due to delays in diagnostics).
- Bed capacity issues identified (124% bed occupancy for medical patients and 105% for surgical patients)
- ICU capacity constrained which impacts overall patient flow
- The hospital has a proposal with HSE for ED reconfiguration aimed at improving patient flow and streaming.(check capital plan)

Capability

- The Task Force observed good evidence that ED is a priority across the hospital as reflected in the initiatives already in place and whole hospital engagement in identification of solutions
- Timely access to senior decision making is required. Current rostering arrangements pose a practical impediment resulting in delays in ED.
- The Task Force observed that there were well developed links with GPs and PCCC (e.g. joint discharge planning project.)
- Some evidence of control of elective admissions in line with ED demands. However, the potential for smoothing elective activity was identified.

Control

- Pan hospital approach is evident
- Bed management function Monday – Friday 08:00 – 17:00
- Discharge planning pilot project commenced in Jan 2006. Audited results will be used to inform whole hospital processes.
- Potential for development of care pathways to support chronic disease management identified.
- Average LOS is 5.3 days for medical patients and 5.1 for surgical patients

Commentary: Hospital Focus in relation to ED-wait volumes/times

- From the information available, the hospital is largely compliant with National volume/wait time performance targets.
- The hospital achieved a significant reduction in the number of patients waiting between April – September. 2006
- The Task Force noted that there was evident central control and a pan-hospital focus, enabling ED/Elective access tensions to be managed effectively.

Recommendations

Capacity

- ***Long Stay Capacity***: The emerging issues in relation to consistent and timely access to long-term care and optimizing the use of nursing home subvention and home care packages need to be addressed as a matter of priority. The existing good links between PCCC and the hospital need to be supported in this context.

Capability

- The optimisation of the AMAU facility is a key priority for the hospital in the overall functioning of the ED Department. In this context the recent approval of a new AMAU within the HSE Capital Plan is welcomed. A key requirement for the hospital is to ensure that the new facility is supported by senior decision-making, adequate diagnostic capability and clinical processes. Critically the practice within the existing AMAU of taking high complexity patients needs to be further developed so that it continues to act as an appropriate diversion from ED.

- The hospital's proposals for hospital / ED approaches to Chest Pain, TIA and falls would appear to be well-supported by clinical processes and evidence.

Control

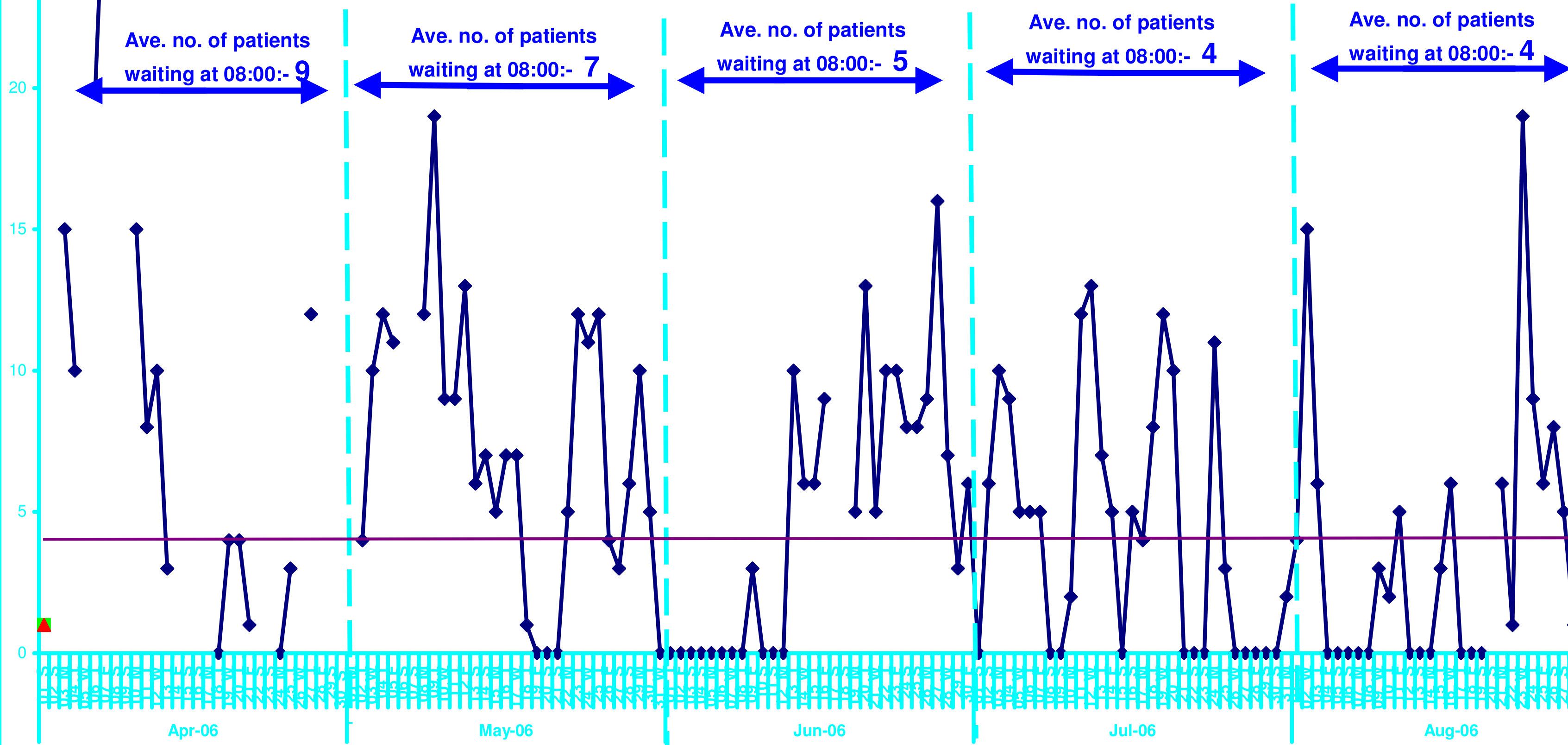
- The Task Force endorsed the hospital's proposals for improving discharges based on its pilot study. The pilot in relation to discharge planning currently being undertaken by the hospital should be supported. Subject to the findings of a formal evaluation the project should be continued with a view to extending it nationally.

- While there was evidence of control of elective workload from the analysis of data and site visits, it is felt that there is a need for the following:
    - Establish specific control measures in place to ensure that the demands in ED are more appropriately balanced in relation to elective workloads.
    - Ensure that existing escalation measures are maintained and developed.

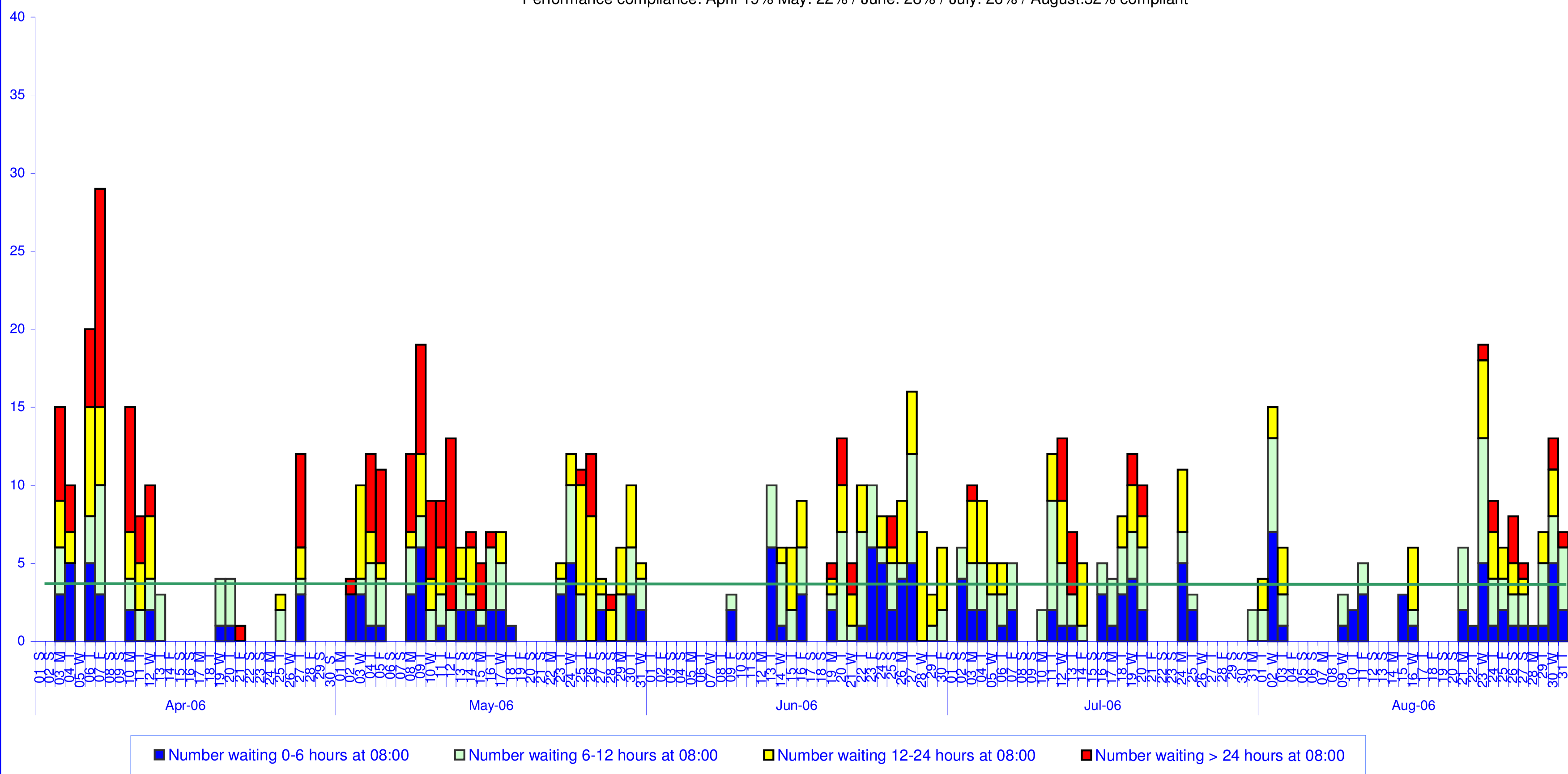
Sligo General Hospital

		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	2007		Annual revenue (€ million)	Capital (€ million)
Proposals	**Capacity**	**Development of 14-bed Admission / Transit Lounge**	**Reduce waiting time for patients in Trolleys**		May	**(18.5)**	**(0.463)**	**(1)**
		Opening 10 five-day beds at weekends	Reduce wait times in ED		June	6	0.4	
		Development of AMAU	**Reduction in waiting time**		**(Dec 07)**	**(27)**	**(1.455)**	**(7.7)**
		Increase Pre assessment clinic to 5 days per week	Reduced ALOS		February		Nil	Nil
		2 HDU beds			June	4	.250	.175
		Falls unit Chest Pain and TIA initiatives			March	5	.35	
	Capability	Radiology	Direct Access to GPs , Hospital avoidance		March	4	.205	.075
		Equipment to facilitate early discharge			January			0.300
		Rapid access to diagnostics (Laboratory)	Enhanced decision making/ extended day	6 months	May	2	0.105	
	Control	Enhancement of bed-discharge pilot, community liaison and improved communication with GPs	Reduced waiting time and improved bed capacity		February	3	0.115	
	Totals					**24**	**1.425**	**.550**

Mayo General Hospital
Castlebar



ED Task Force Review April - August 2006
Mayo General Hospital
Data supplied by HSE
Number of Patients waiting in ED at 8am
Elective Admissions (weekly)
Elective Admissions (daily)
Long Term Care Patients Listed
Target: 08:00 = less than 4 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 33% / May: 21% / June : 46% / July :48% / August: 43%
Ave. no. of patients waiting at 08:00:- 9
Ave. no. of patients waiting at 08:00:- 7
Ave. no. of patients waiting at 08:00:- 5
Ave. no. of patients waiting at 08:00:- 4
Ave. no. of patients waiting at 08:00:- 4
35
30
25
20
15
10
5
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Mayo General Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 19% May: 22% / June: 28% / July: 26% / August:32% compliant
0
5
10
15
20
25
30
35
40
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

Capacity

- Acute capacity is compromised due to difficulties in terms of accessing long stay beds following the closure of 150 beds in the sacred Heart Nursing Home.
- Potential for improved focus on and access to home supports to optimise discharge of elderly patients.

Capability

- The hospital has an eight-bedded medical assessment unit that sees up to 30 patients a day Monday-Friday. The AMAU potentially competes for resource with ED in terms of both decision-making and diagnostics. The on- call registrar covers the medical assessment unit as well as the ED and the rest of the hospital. This can lead to delays in ED. The medial team will not see a patient in ED until blood results are back.
- The Acute Medical Assessment Unit not accepting acutely ill patients so its utilisation is not fully optimised.
- GPs have direct access to the Medical Assessment Unit for non acute patients.
- Some fast tracks are currently in place within the hospital (paediatrics/oncology/psychiatry)

Capability – Challenges

- Limited ED access to ultrasound for example to rule out /diagnose cholecystitis/ ovarian cysts etc. Diagnostics available on a Monday to Friday 9-5 basis.
- Certain lab tests such as troponin and d-dimers are sent to UCHG. These tests are sent to Galway by shuttle at midday Monday to Friday. Patients presenting in the afternoon do not have these tests processed until the following day. This causes particular difficulties for patients admitted on Friday afternoon where bloods are not sent until the following Monday.
- An audit of troponin testing carried out over a one month period found that 38 patients experienced delays of three days awaiting test results amounting to 114 lost bed-days.
- Angiography is done in UCHG. UCHG will not accept day patients and hence all patients for angiography are admitted to Mayo General Hospital.
- In terms of discharge planning, the hospital does not have a dedicated discharge planner / function.

Control and measurement challenges

- Ward rounds are only twice a week which adversely impacts effective discharge of patients and overall length of stay. (The ALOS is 5.3 days but for medical patients it ranges between 7 – 12 days)
- Escalation meetings are not attended by physicians
- Elective surgery is not routinely cancelled to address ED challenges
- The need for a whole- hospital response to the issue was raised
- The need for the designation of a senior manager to drive and oversee the whole hospital approach to ED

Commentary: Hospital Focus in relation to ED-wait volumes/times

- The hospital has not complied with the volume / waiting time targets. Significant improvements were observed between May and June in relation to the numbers waiting. However, the position has deteriorated since and the hospital is not compliant in relation to waiting times.
- Hospital is not compliant with individual target of 4 patients and has also exceeded national daily target of 10 on a number of days.
- There is an urgent requirement for improved balance between management of elective and emergency workloads.
- There is also an imperative to improve internal escalation measures and whole hospital engagement in tackling the issues in ED

Recommendations

Capacity

- ***Continuing Care Requirements;*** The challenges in relation to accessing Long Term Care need to be addressed within the HSE's medium term programme of work in this area in order to address length of stay issues.
- There is a need to ensure that processes for assessment and prioritization for home care is consistent with other areas and that the home care option is fully exploited.

Capability

- ***Diagnostic Capability***; There is a critical need to develop on site diagnostic capability in the areas of d-diamers and troponin and key diagnostic investigations such as cardiology.
- In the short term there is a need to enhance the cover arrangements with UCHG for critical diagnostic testing to reduce the length of stay for inpatients.
- There is an imperative to re-instate core capacity in areas such as cardiac investigations. As a short term measure the potential for out-sourcing to private hospitals should be developed as a priority. (The hospital has submitted proposals with regard to the above)

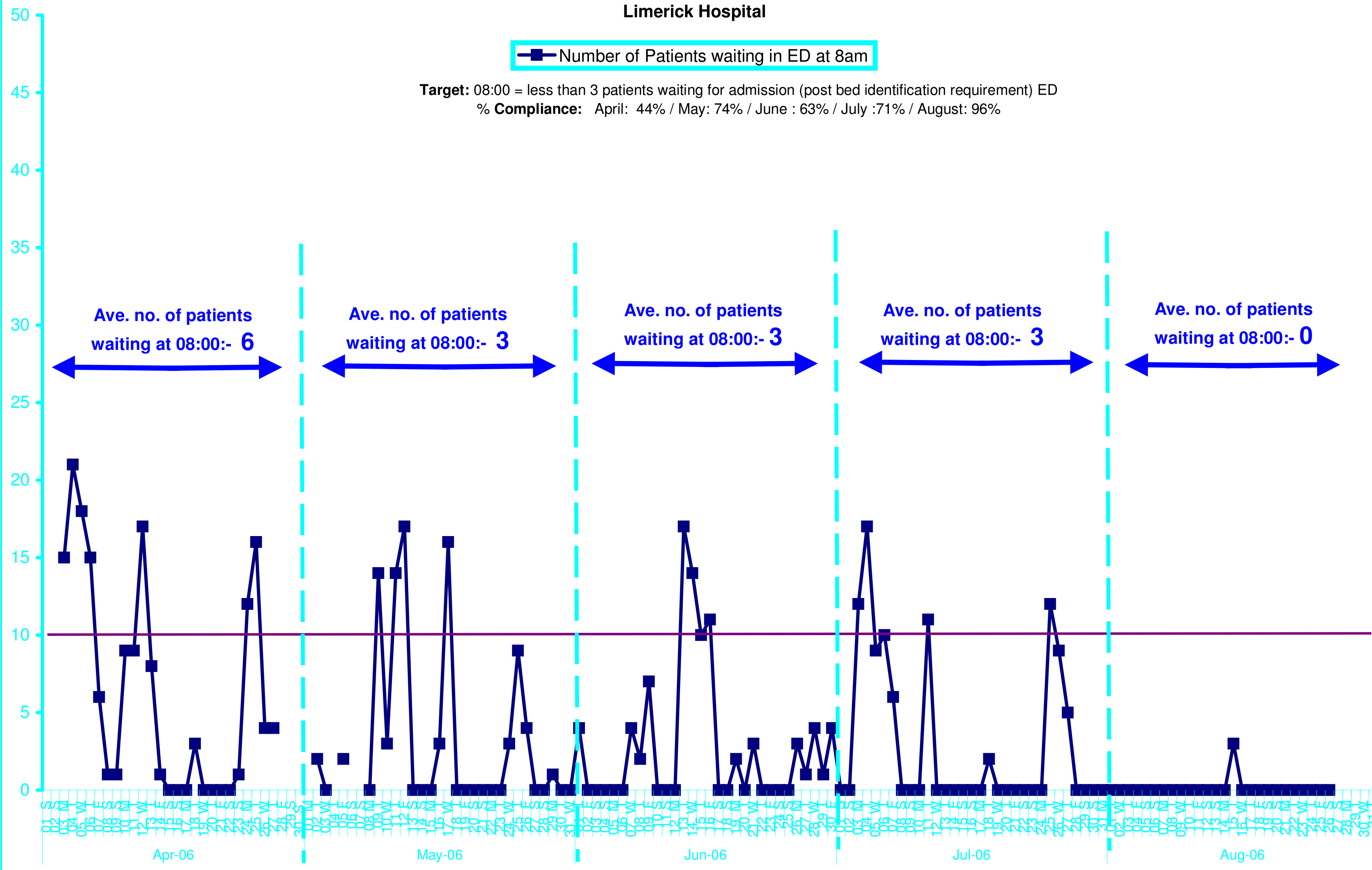
- ***Evaluation of Acute Medical Assessment Unit -*** The hospital's decision to evaluate the functioning of the AMAU on foot of the Task Force site visit is welcomed. A key priority is to ensure that the AMAU is optimized and that the competing requirements for senior decision making both AMAU and ED are addressed.
- Specifically the need for the AMAU to treat patients with higher acuity so as to effect an appropriate diversion from the ED needs to be prioritised.
- The requirement for an admissions lounge is endorsed on the basis of frequent over-crowding however the revenue costs need to be re-assessed for this proposal.

<u>Control</u>

- The overall hospital control arrangements in relation to the management of the bed base need to be urgently addressed. Specifically, there is a need to urgently put in place control measures to ensure that emergency patients are appropriately prioritised within the overall allocation of beds.
- The current arrangements in relation to escalation meetings must to be changed as a matter of priority to ensure that all relevant clinicians actively participate.
- The hospital needs to formally designate a senior manager with overall responsibility for the ED with a specific focus on addressing the volume and wait times in ED and the associated control issues.
- The Task Force acknowledges that the hospital has commenced a review of its AMAU in order to optimise its utilisation and overall management of patients in ED. However, it notes that no specific control measures have put forward by the hospital as part of their overall response.

Mayo General Hospital, Castlebar								
		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	2007		Annual revenue (€ million)	Capital (€ million)
Proposals	Capacity	Contract short-term nursing home beds while long-term arrangements are being finalised. Replace community beds lost in district hospital and resource high-dependency care in district hospitals	Approximately 2,000 bed days made available – shorter ALOS	Immediate		PCCC	(0.22)	PCCC
		Establishment of Admission Ward	Better environment for patients. Improved ward rounding system. Reduced risk of infection.			15	0.913	
		Enhanced NCHD presence in ED, development of ANP service in ED	Better and faster clinical decision making			2	0.125	
		Evaluation of AMU					Nil	Nil
	Capability	On-site troponin and d-diamer testing; enhanced phlebotomy service, contracting out cardiac investigations to private providers	Enhanced access to diagnostics to facilitate decision making Reduction in ED waiting time and ALOS	Immediate			0.35	
	Totals					17	1.388	0

Mid-Western Regional Hospital, Dooradoyle, Limerick


Data supplied by HSE
ED Task Force Review April - August 2006
Limerick Hospital
Number of Patients waiting in ED at 8am
Target: 08:00 = less than 3 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 44% / May: 74% / June : 63% / July :71% / August: 96%
Ave. no. of patients waiting at 08:00:- 6
Ave. no. of patients waiting at 08:00:- 3
Ave. no. of patients waiting at 08:00:- 3
Ave. no. of patients waiting at 08:00:- 3
Ave. no. of patients waiting at 08:00:- 0
50
45
40
35
30
25
20
15
10
5
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06

Data supplied by HSE

Emergency Department Activity Review April - August
Number of patients waiting for admission (post bed identification requirement) ED

Limerick Hospital

Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 25% May: 28% / June: 39% / July: 43% / August:33% compliant

Findings

Capacity

- There is an urgent need to review the hospitals current arrangements for looking at overflow in the context of the proposals for the admissions lounge so that all capacity is optimised.
- Community intervention teams will be operational in September to support patients in the community .so it is hoped that this will impact overall bed utilisation and patient flow
- Considerable potential exists for developing a wider range of responses to patients requiring continuing care (enhanced subvention, home care and long stay not fully optimised). Need to address admitting arrangements in St Camillus Hospital.

Capability

- There is considerable potential for more appropriate use of the day assessment unit with benefits for patients who would otherwise present to the ED.
- The Task Force observed tensions in relation to balancing the requirements for hospital radiology services and those to GPs.
- Rapid assessment service to the ED is impeded by delays in decision in decision- making by on-call team.
- There in an immediate opportunity to extend the use of the observation ward in ED to treat acutely ill patients such as stable upper GI bleeds.
- The absence of a dedicated minor injury unit results in minors joining the queues with majors with adverse implications for the waiting times for both cohorts
- There was evidence that medical consultants do regular rounds in ED and discharge patients to early OPD clinics where possible.
- View was expressed that there is a need to increase the radiology capacity within the hospital rather than directly to GPs.

Control

- The Task Force observed strong evidence of whole system focus on ED issues (e.g.) management, clinicians, PCCC and GP.
- Concerns were expressed with regard to waiting time (e.g. 4 hours) for medical SHO to see patient in ED where ED consultant has already decided that patients will need to be admitted. This delay is attributed to competing pressures on the on-call team (e.g. clinics, theatre lists)
- Potential for improved cohesion between the range of initiatives identified for addressing patient flow. The development of proposals for an AMAU should take account of existing arrangements and initiatives for patients processing. Similarly, the use of the observation ward and the rapid assessment facilities need to be reviewed so that resources and patient flow are optimised

Commentary: Hospital Focus in relation to ED-wait volumes/times

- Pan hospital focus is evident
- The hospital is not fully compliant with individual volume performance targets (but would meet National daily average of ten).

- Hospital is compliant with wait time targets and improvements observed in June in proportion of patients waiting over twelve hours.

Recommendations

Capacity

- ***Continuing Care*** - The access to St. Camillus long- stay facilities need to be urgently reviewed to ensure that patient flow is optimized and delayed discharges are contained.
- There is a need to urgently review local arrangements for Nursing Home Subvention and long term care to ensure that options available in other areas are fully optimized.

Capability

- ***Fast-tracking/diverting -*** The hospital needs to urgently review its existing arrangements for fast tracking and diverting patients (e.g. Rapid Assessment, Day assessment) to ensure that there is better cohesion and appropriate use of diagnostic capacity. The hospital's proposal for an AMAU and 16 bedded ward need to be reviewed with a view to economies of scale, VFM and also the streamlining of the steps in the admission process. Specifically the current use of the geriatric day ward needs to be reviewed so that the unit can meet the needs of those patients with higher acuity, with lower acuity patients being diverted to the hospital's OPD.
- ***Diagnostics -*** The existing arrangements in relation to radiology services need to be urgently examined so that GP's, the demands on ED, and the admitting teams are appropriately managed. The hospital has not put forward proposals for additional radiology capacity so it may be more appropriate to conduct an internal review of practice.

Control

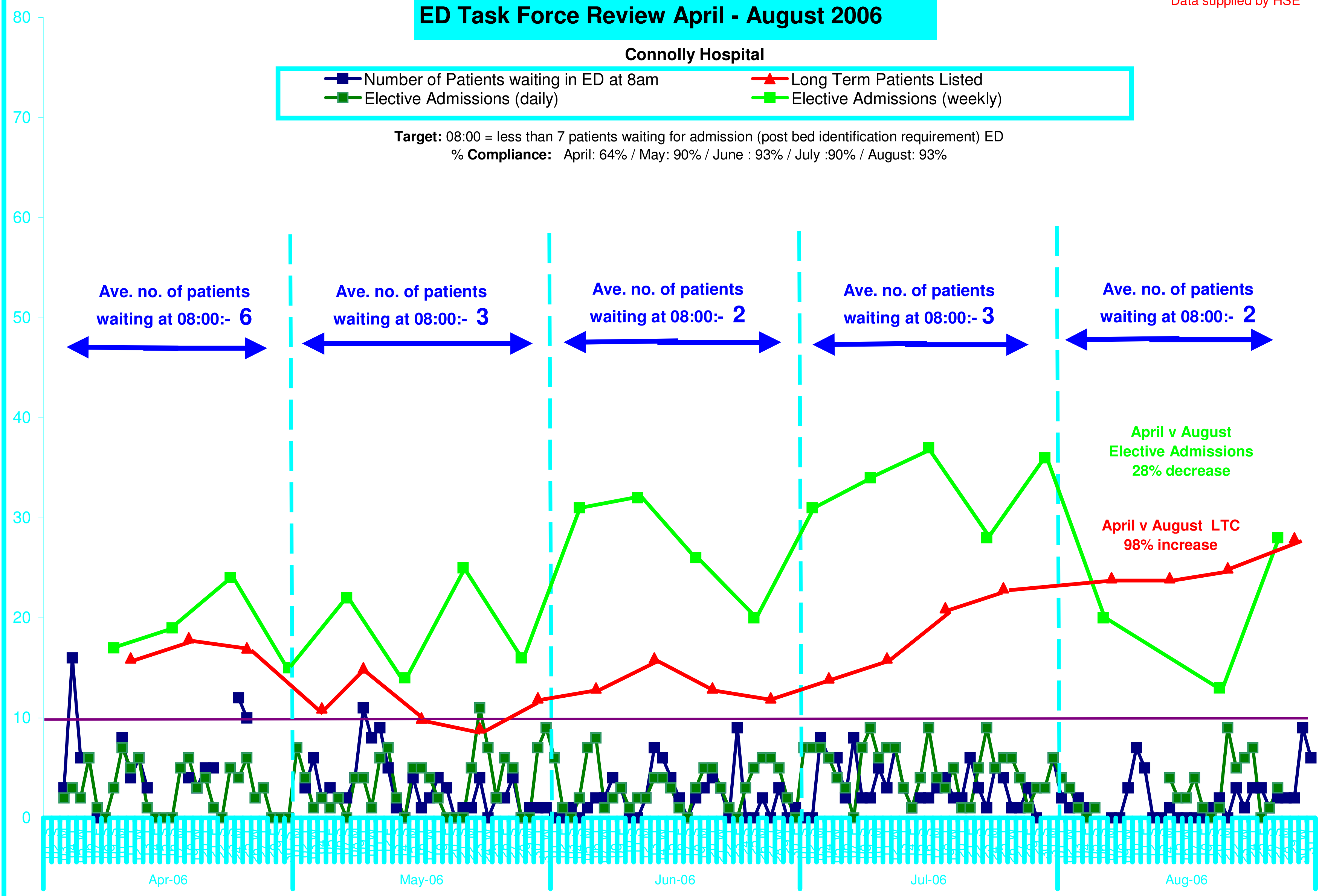
- A key issue raised by the site visit was delays in decision making by the admitting team. The AMAU, if properly supported by diagnostic and clinical capability, should go some way towards addressing the issues but this needs to be made explicit in the hospital's proposal.
- There is a need to build on specific control measures in place to ensure that the ED is appropriately prioritised in the overall allocation of beds.
- The hospital needs to identify fast tracking mechanisms and optimal supports for patients presenting with psycho-social issues. These include provision of appropriate security measures within ED, enabling consults with liaison psychiatry and appropriate discharge arrangements.

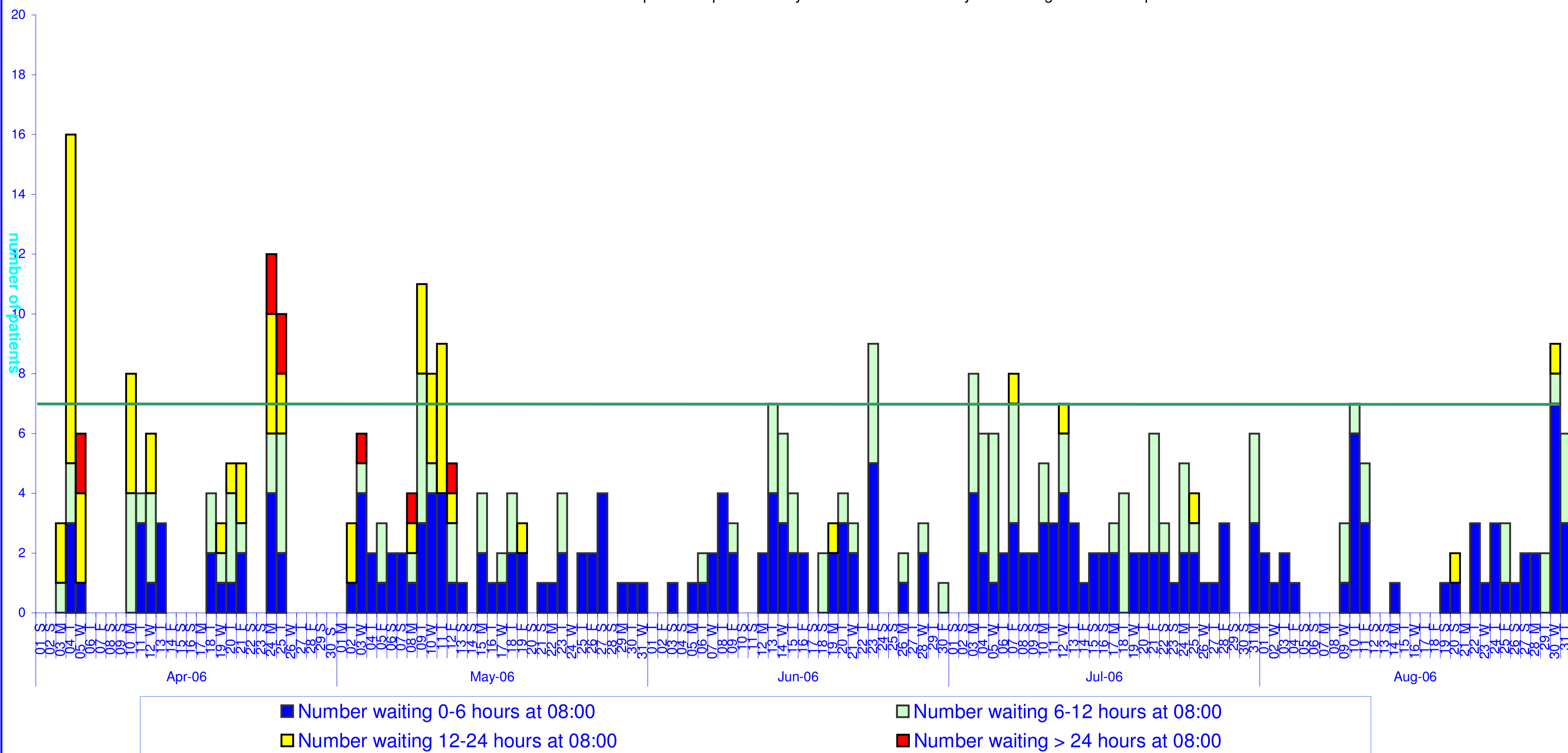
Mid-Western Regional Hospital, Limerick

		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	2007		Annual revenue (€ million)	Capital (€ million)
Proposals	Capacity	15-bed inpatient ward to support the operation of the AMAUs	Revised cost to be submitted	6 months		25.02	1.998	0.5
		10-bed Admissions / discharge lounge	More appropriate environment while awaiting admission /discharge. Reduce waiting times for admission.	3 months		2.67	0.252	0.1
	Capability	Provision of 11-bed AMAU	Revised cost to be submitted	3 months		16	1.5	
	Control							
	Totals					43.69	3.75	.600

* No diagnostic or control measures identified by the hospital.
** Revised costs required on Capacity initiatives.

Connolly Hospital, Blanchardstown Dublin


ED Task Force Review April - August 2006
Connolly Hospital
Data supplied by HSE
Number of Patients waiting in ED at 8am
Elective Admissions (daily)
Long Term Patients Listed
Elective Admissions (weekly)
Target: 08:00 = less than 7 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 64% / May: 90% / June : 93% / July :90% / August: 93%
Ave. no. of patients waiting at 08:00:- 6
Ave. no. of patients waiting at 08:00:- 3
Ave. no. of patients waiting at 08:00:- 2
Ave. no. of patients waiting at 08:00:- 3
Ave. no. of patients waiting at 08:00:- 2
April v August Elective Admissions 28% decrease
April v August LTC 98% increase
80
70
60
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Connolly Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 27% May: 56% / June: 64% / July: 58% / August:74% compliant
number of patients
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

The visiting team met representatives from senior management, senior nursing, bed management, medicine, radiology and emergency medicine. The Task Force wishes to commend the hospital for having clearly considered solutions to the problem of patients waiting in ED for admission prior to the Taskforce bringing it into focus. In particular, the plans for the development of Rapid Access clinics were at an advanced stage.

Capacity

- During site visits, Task Force representatives noted that the hospital was running at a high level of occupancy, with resultant difficulty in accommodating surges in numbers of ED admissions. This was aggravated by insufficient critical care (ICU/HDU) capacity, ward closures arising from infection outbreaks and insufficient/slow access to psychiatric inpatient facilities. This latter point was evident on the day of the visit.
- The ambulatory care function in the ED was consistently compromised by inappropriate inpatient occupancy of cubicles.
- Diagnostic capacity was largely centred around Monday-Friday 08:00-17:00. Delays in accessing diagnostics and/or diagnostic reports (arising from limitations in facility/consultant workforce) were reported as important factors in slowing up decision making.

Capability

- Insufficient ED ‘senior decision maker’ availability was identified as limiting capability to promptly ‘see – treat – move’ patients. There was obvious enthusiasm amongst the ED staff to expand their practice in terms of “Short Stay” type patients.
- The visiting team felt opportunities were evident for improving ED/In-house interface in terms of promptness of transfer of care and avoidance of duplication of work.
- The smooth running of Rapid Access clinics was significantly limited by inadequate clerical support.
- There was significant scope to implement/improve chronic disease management programmes/coupled with significant OPD wait times for certain specialties.

Control

- Formal Bed Management function was limited to 08:00 – 17:00 Monday-Friday. There appeared to be significant scope to increase the hours of availability, leading to improvements in admission and discharge planning.
- Limited audit capacity/capability was highlighted by the hospital, leading to limited pan-hospital performance targets.
- The PCCC/Hospital interface appeared to be predominantly patient specific and would probably benefit from a broader approach.

- There was a very evident focus on reducing 'wait times' for patients requiring admission, combined with appropriate pan-hospital 'escalation' practices designed to locate beds when overcrowding in ED occurs.
- The hospital had already successfully utilised increased bed availability created by LTC initiative to further reduce number of patients waiting in ED whilst increasing elective admissions.
- Focus and actions predominantly appeared to relate to 'wait times' after the decision to admit in line with existing targets. The hospital has now clearly recognised the requirement to focus on total wait times and has commenced necessary data collection methodologies.

Recommendations

Capacity

- In the short-term the priority for optimising the acute bed capacity is the consistent and timely provision of the hospital's identified long-term care community placements.
- The provision of appropriate accessible 24/7 access to psychiatric facilities is an imperative to negate current unsafe practises of accommodating patients for long periods/ overnight within the Emergency Department.
- An Admission/ Discharge lounge will enable appropriate comfort/dignity provision to be effected and as well ensure/promote access to acute beds.
- There is a need for early clarity and decision in relation to full year funding of recently-opened beds.

Capability

- Proposed additional diagnostic capacity will as well significantly aid/improve current capacity to appropriately secure optimum patient progression from ED to the ward and to discharge.
- The development of an Acute Medical Assessment Unit should yield identified benefits, but it is essential to ensure that the introduction of this facility does not compete with the ED for key diagnostic and decision-making service.
- Identified "seen decision maker" consultant combined with expansion of ED centred ANP services will significantly enhance ED, ED → In-house capability in terms of patient progressing and should be progressed.
- The creation of necessary support for recently introduced rapid access clinic will optimise functionality of these services.

Control

- The hospital has appropriately identified requirements for improved/extended audit/bed manager's function. These will enable and enhance existing pan – hospital control function.

Connolly Hospital, Blanchardstown

	Proposal	Impact on ED Volume / Wait Time	Timelines for Implementation 2007	WTE	Financial: Annual revenue (€ million)	Financial: Capital (€ million)
Capacity	Expansion of ANP assessment service in ED	Rapid assessment of Chest pain, MI and elderly	March	3	0.18	.10
	Development of AMAU	Diversion of medical patients from ED	June	9	0.400	.15
	Stand-alone general x-ray room	Faster access to diagnostics	March	4	0.280	.35
	Second ultrasound facility		March	2.5	0.200	.20
	Development of 'mini-PACS'	Faster reporting	March	2	0.14	0.15
	Increased psychiatric bed provision only (capacity)	Divert psychiatric patients from ED	Immediate		PCCC	PCCC
	Long term care bed requirement		PCCC		PCCC	PCCC
Capability	3rd Consultant in Emergency Medicine	Improved senior clinical decision-making	July	1	0.200	
	Expansion of Rapid Access Clinics	Patients diverted from ED	July	9	0.35	
Control	AM discharge through Discharge Lounge	Early home discharge	July	2	0.1	
	7-day Bed Management Function	Additional discharges at weekend	July	1	0.06	
Totals				**33.5**	**1.91**	**.95**

Beaumont Hospital
Dublin

Data supplied by HSE
ED Task Force Review April - August 2006
Beaumont Hospital
Number of Patients waiting in ED at 8am
Elective Admissions (daily)
Long Term Care Patients Listed
Elective Admissions (weekly)
Target: 08:00 = less than patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 32% / May: 19% / June : 40% / July :39% / August: 55%
Ave. no. of patients waiting at 08:00:- 13
Ave. no. of patients waiting at 08:00:- 15
Ave. no. of patients waiting at 08:00:- 12
Ave. no. of patients waiting at 08:00:- 12
Ave. no. of patients waiting at 08:00:- 11
April v August Elective Admissions 29% decrease
April v August LTC 22% increase
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06

Data supplied by HSE

Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED

Beaumont Hospital

Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 35% May: 52% / June: 36% / July: 49% / August:47% compliant

number of patients

Apr-06 May-06 Jun-06 Jul-06 Aug-06

Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

The Team met representatives from senior management, senior nursing, bed management, medicine, surgery and emergency medicine. The associated visit to the ED gave rise to concern at inpatients being accommodated on rows of trolleys that appeared to be too close to each other in the centre of the department to allow rapid access to individual patients in the event of unexpected deterioration in their condition.

Capacity

- The hospital operated at approximately 94% occupancy between April and August 2006.
- During Task Force site visits, the hospital was running at 99% full inpatient occupancy, with resultant difficulty in accommodating surges in numbers of ED admissions. This was often aggravated by delays in patient transfer to critical care (ICU/HDU) beds.
- There is limited psychiatric bed availability, with frequent overnight accommodation of psychiatric inpatients on ED trolleys was noted.
- The existing ED capacity was limited and overflowing with both new ED arrivals and inpatient boarders on the day of the visit. The ongoing use of the main ED reception for large numbers of boarded inpatients seemed to be the most apparent reason for circuitous patient pathways to areas for ambulatory care and resuscitation.

Capability

- There was concern about delays in having patients assessed by in-house specialty teams and duplication of assessment by these teams in ED.
- There had been prior development of chronic disease management programmes, with proven benefit to patients and hospital specifically in COPD. There remains capacity for further expansion in the COPD programme. The hospital would also benefit form other initiatives aimed at diverting or fast tracking patients. A key priority in this regard is cardiology services.
- Diagnostic capacity was centred on Monday-Friday 08:00-17:00. Reported delays experienced in accessing diagnostics out of hours (ED), hampering rapid decision making were noted.

Control

- The team recognised and accepted tension between Beaumont's role in dealing with national urgent/elective cases for services it provides on a national and regional level and emergency cases arising from the local population.
- Bed Management function was limited to 08:00 – 17:00 Monday-Friday, leaving significant room for expansion beyond these hours.

Hospital focus on Volume / Wait time targets

- The hospital has initiated the necessary pan-hospital control structure and analysis demonstrates the positive effect in April of HSE initiatives to increase long-stay capacity.
- As a result of the increased requirement for long-term care placements and the unavailability of public or private beds early benefits were not sustainable.
- Notwithstanding this, the hospital achieved some improvements in wait times as a result of internal processes. However, the hospital remains non-compliant with existing wait time and volume targets.

Recommendations

Capacity

- The proposed creation of additional 100 long-term beds (St Joseph's in 2007) will address the current most significant acute bed limitation .This, combined with other proposed bed reorganisations initiatives, including the creation of an Admission /Discharge lounge will yield significant and necessary additional acute bed capacity.
- In terms of further improving both capacity and capability, it is recommended that designated the AMAU facility becomes operational at the earliest opportunity.

Capability

- The hospital has proposed the establishment of a Clinical Decision Unit / Chest Pain Assessment Unit. While this would have a positive effect on overall numbers presenting and assorted other issues, it is recommended that in the first instance, the hospital focuses on enhancing and optimising existing capacity. Accordingly, the proposed approach is to expand chronic disease management projects with specific reference to cardiology.
- The provision of identified additional diagnostic capability will yield significant ED/in-patient processing improvement and it recommended that these be progressed.
- Developments in psychiatry capacity should reduce current inappropriate delayed and overnight accommodation of patients within the ED.
- The Hospital is encouraged to consider the further expansion of its current chronic disease programme.

Control

- The hospital has put forward an ambitious set of hospital wide initiatives. The success of these initiatives in impacting volumes and wait times in ED is dependent upon the development of robust pan-hospital control mechanisms with specific reference to the requirement for;
    - Single control function in relation to the admission bed base – effecting both emergency and tertiary/complex priorities.
    - Appropriate responsiveness to ED patient's requirements from admission teams
    - Bed management/patient processing functionalities [including discharge provision] to be extended to 24/7.

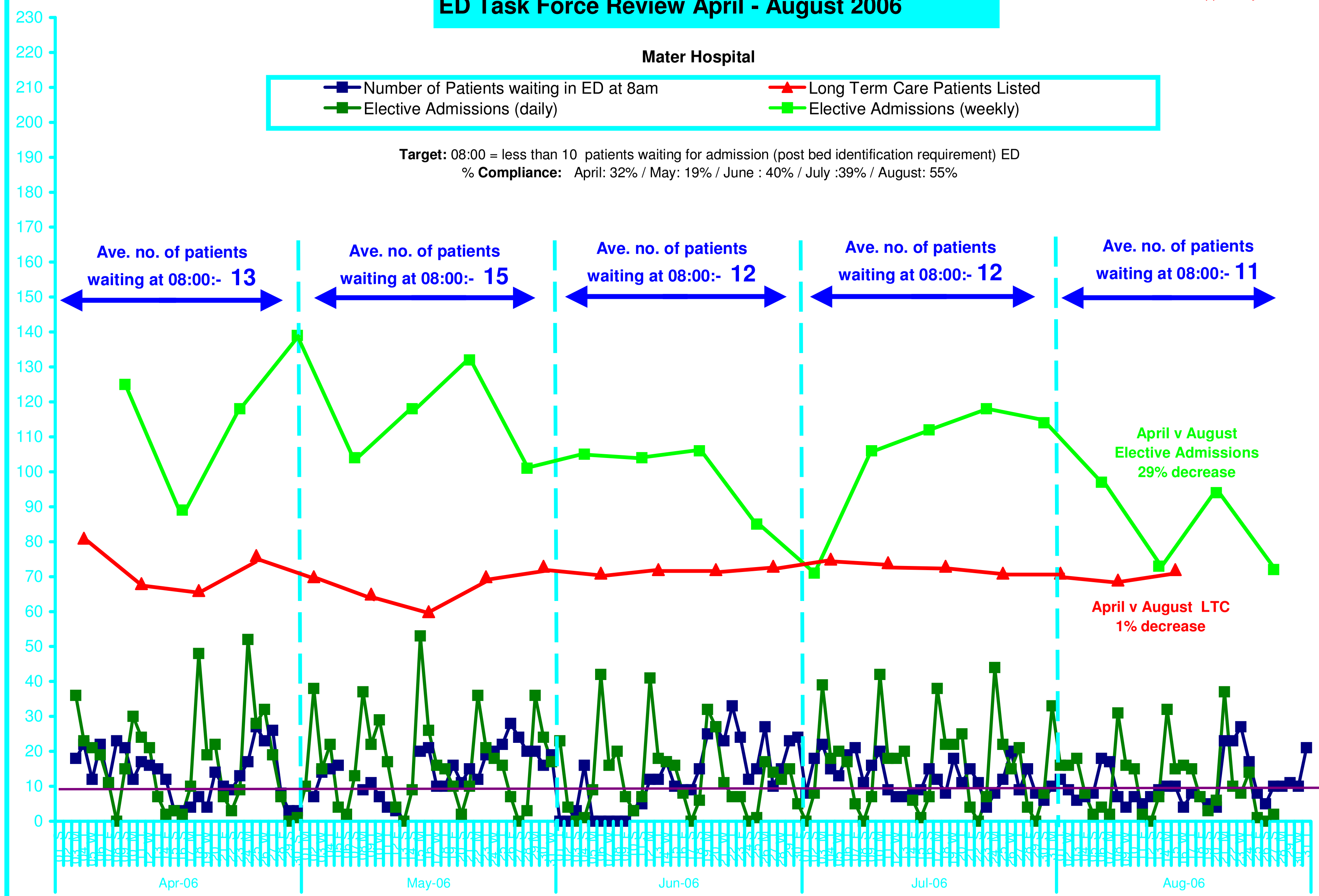
Beaumont Hospital

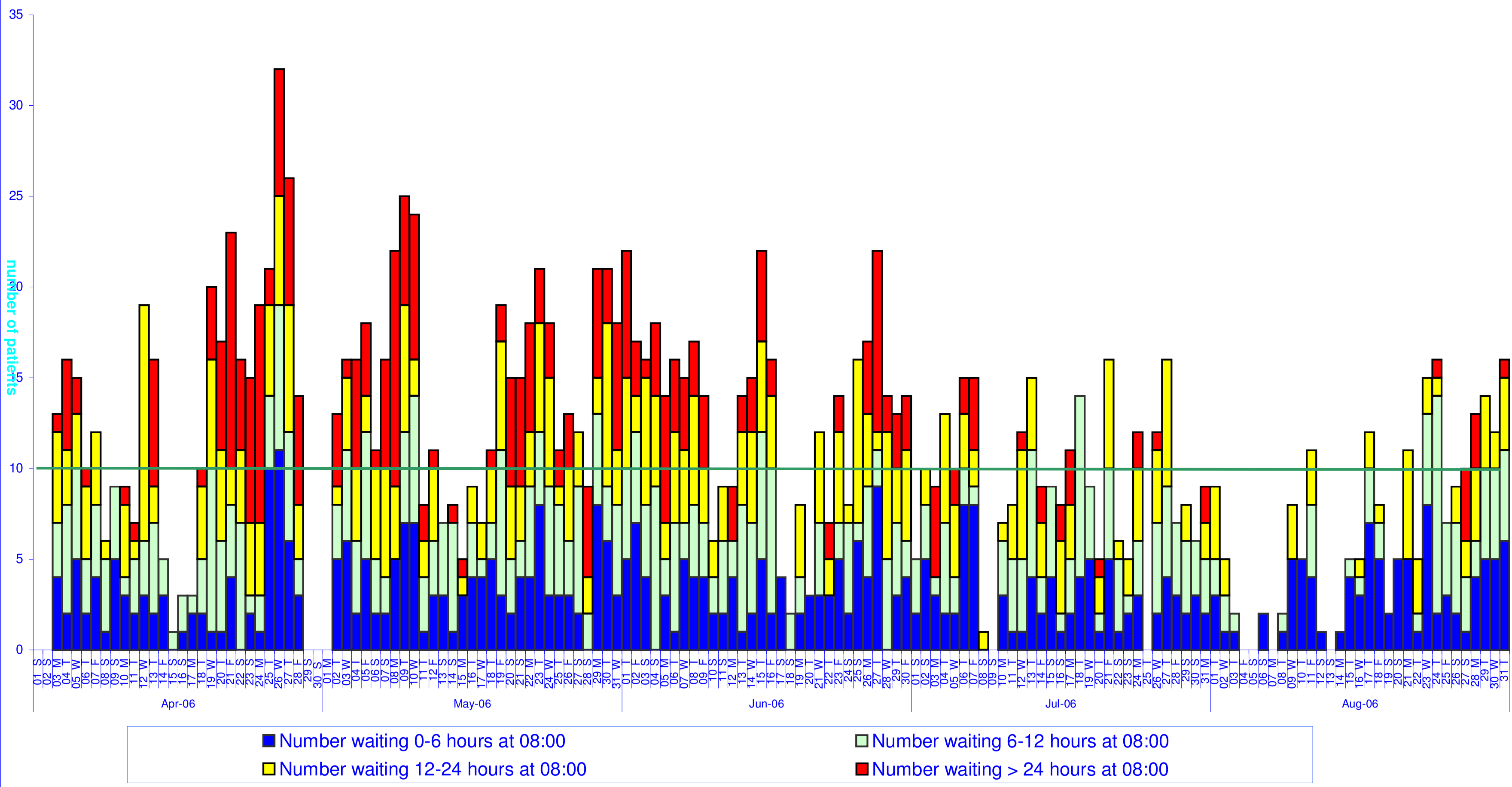
	Proposal	Impact on ED Volume / Wait Time	Timelines 2007	WTE	Financial	
					Annual revenue (€ million)	Capital (€ million)
Capacity	24 hour psychiatric cover and increased beds	24 Hour Psych cover for assessment in ED. Appropriate placement of ED psychiatric patients. As 2 patients per day are admitted to psych facility this will enable faster decision making	June	3	0.2	0.02
	Combined Transit / Discharge /Admission Lounge	10 additional beds to reduce wait times Revised WTE/Cost to be submitted	Jan 07	14	0.550	**(0.047)**
	Long Term care beds	St Josephs		PCCC	PCCC	PCCC
	Additional rehabilitation capacity – 16 beds	Defined pathway of care for stroke patients. Alleviate delays for 20 patients on average awaiting rehab beds. Increased turnover of medical beds facilitating admission of ED patients	September	15	0.856	1.00
Capability	**AMAU**			**(32)**	**(1.14)**	**(2.2)**
	Expansion of COPD outreach to weekends	2-day reduction in LOS. Decreased admission rates.	September	1	0.07	0.05

		CDU Chest Pain Unit	50% reduction in waiting times for patients with chest pain. Protocol based care for 1200-1500 patients a year. Revised cost to be submitted	September			3	.210	.895
		Enhancing OT Discharge	OT assessment reduced by 13-17 days	March			2	0.16	
		Physio triage		January			1	.007	
		Additional Echocardiography facility	2 day reduction in wait for test	March			2	0.15	0.07
		Ultrasound x2		March			2	.150	.800
	Control	Implementation escalation control mechanisms		Immediate					
		7 Day bed mgt function	Additional discharges at weekends				1	0.06	
		Rapid response team					PCCC	PCCC	PCCC
	Totals						**44**	**2.413**	**2.585**

* AMAU provided for under A&E 10 Point Plan

Mater Misericordiae University Hospital
Dublin


ED Task Force Review April - August 2006
Data supplied by HSE
Mater Hospital
Number of Patients waiting in ED at 8am
Elective Admissions (daily)
Long Term Care Patients Listed
Elective Admissions (weekly)
Target: 08:00 = less than 10 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 32% / May: 19% / June : 40% / July :39% / August: 55%
Ave. no. of patients waiting at 08:00:- 13
Ave. no. of patients waiting at 08:00:- 15
Ave. no. of patients waiting at 08:00:- 12
Ave. no. of patients waiting at 08:00:- 12
Ave. no. of patients waiting at 08:00:- 11
April v August Elective Admissions 29% decrease
April v August LTC 1% decrease
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Mater Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 22% May: 26% / June: 25% / July: 30% / August:44% compliant
number of patients
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

The team met representatives from senior management, senior nursing, bed management, medicine, surgery and emergency medicine. The hospital emphasised that development of ED services at the Mater had suffered from the repeated deferment of an overall plan to develop that part of the hospital.

Capacity

- The overall ED space and infrastructure was inadequate. At the time of the visit, patients requiring admission were routinely accommodated for more than twenty-four hours on chairs within the ED. This was evident on the day of the visit and was agreed that this practice must be discontinued immediately. The need to expand the physical space available to the ED is urgent and the potential for using the adjacent OPD area should be considered for this purpose.
- The hospital operated at approximately 99% occupancy between April and August 2006 with resultant difficulty in accommodating surges in numbers of ED admissions. This was often aggravated by delays in patient transfer to critical care (ICU/HDU) beds.
- Diagnostic capacity was centred on Monday – Friday, 0800 – 1700. Frequent delays in accessing certain diagnostics out of hours were reported.

Capability

- There was concern about some in-house specialty teams not prioritising ED calls and duplication of assessment by these teams in ED.
- There had been prior significant development of chronic disease management programmes, with proven benefit to patients and hospital. There remains capacity for further expansion.
- The hospital raised that fact that there were challenges in relation to key supports such as allied health professionals.

Control

- The challenges for the Mater in dealing with national urgent, elective and emergency cases for workloads were acknowledged.
- Pan hospital control of the admission process was clearly evident. Ad hoc/insufficient access to community beds that were sometimes inappropriate to the needs of the particular patient significantly hampers operational control.
- The Task Force felt that the direct impact on ED volumes and wait times of addressing capability issues would be limited unless the long term capacity issues are also addressed.

Hospital focus on wait times

- The hospital was not compliant with volume and wait time targets in April and May, however, it is noted that the hospital has largely been meeting its targets in relation to wait times since July 2006.
- The hospital has achieved a reduction in the number of patients waiting. More significantly, it has achieved a substantial wait-time reduction – particularly during the period July – August. This is attributed to internal control processes and the availability of additional long-term care beds.

Recommendations

Capacity

- The key priority for the hospital in line with other Dublin Hospitals remains the immediate and ongoing transfer of elderly patients who have completed acute episode of care to appropriate community facilities. This requirement needs to be addressed urgently within overall PCCC Framework for long-term care. This initiative coupled with St Mary's based initiatives specifically Extended Stroke Unit, Expanded RAC and Expanded ED Admission Unit and planned Day Care Unit will yield significant inpatient acute bed capacity.
- The proposals for the ED expansion are clearly appropriate, however the identified time frame for delivery (>12 months) militates against this initiative having a short-term impact on the current situation. The hospital is encouraged to identify short term options to improve the physical environment.

Capability

- The hospital has appropriately identified the requirement for additional CT provision and this will obviously have a positive impact in terms of improved access to diagnosis/patient processing. The hospital is encouraged to consider and develop other initiatives that would improve GP/ED/inpatient access in relation to diagnostics.
- The hospital has identified specific proposals in relation to securing consultant clinical mass in relation to general 'medical take' and specific medicine sub specialities – Cardiology, Neurology. In total this would have a positive impact on both elective and emergency workloads. The Task Force recommends that the immediate priority for progression would be those posts that have a high positive impact on ED, specifically Respiratory, Cardiology and Neurology. Associated P.A.M staff identified will enable and support patient's discharge requirements.

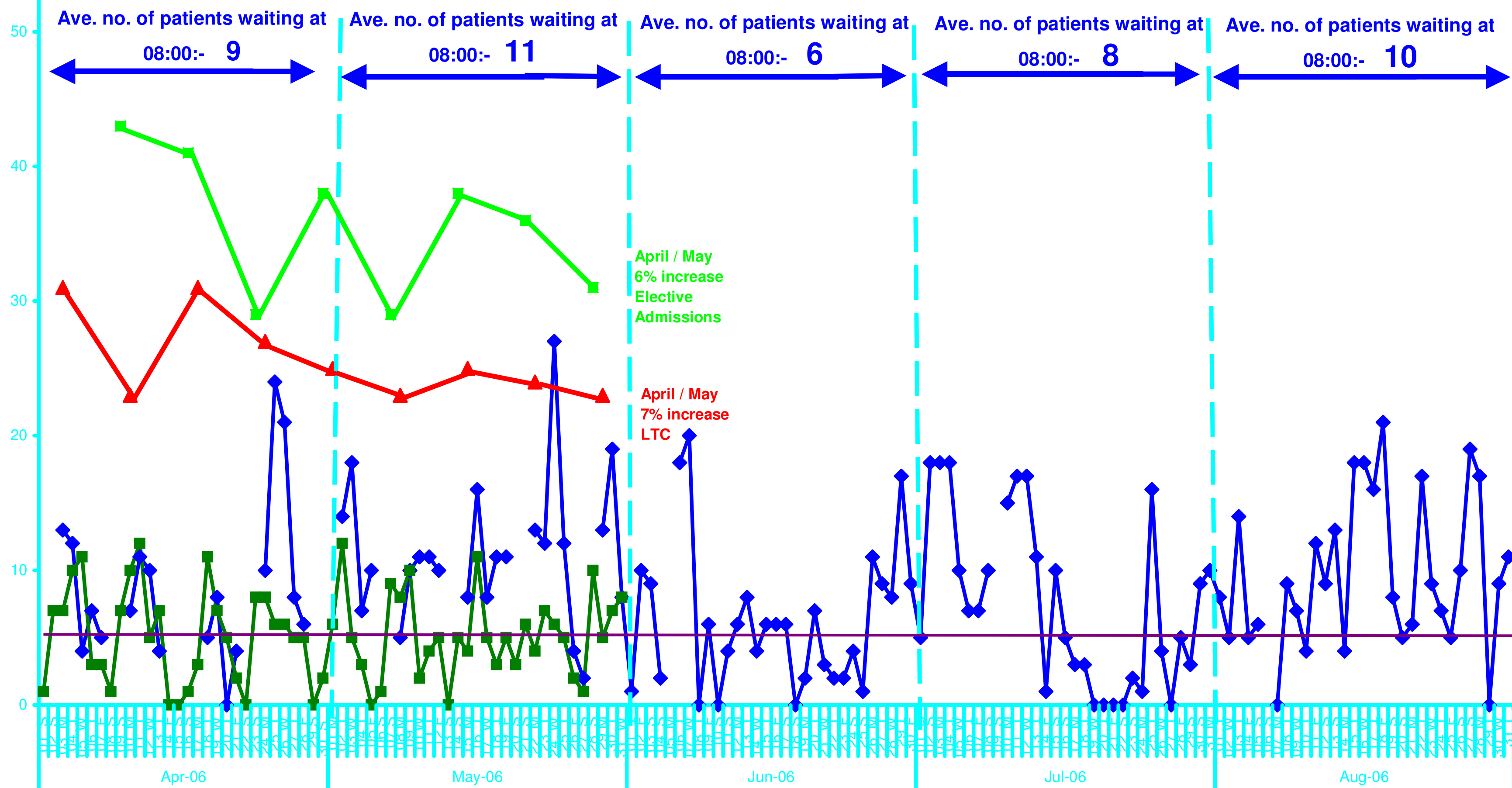
Control

- There is a requirement to ensure that the observed practice of accommodating patients awaiting admission on chairs is discontinued.
- There is a requirement to ensure that the additional capacity created by the provision of long stay initiatives is appropriately used to achieve a balance between emergency and elective workloads. The hospitals performance since July 2006 in this context is acknowledged.

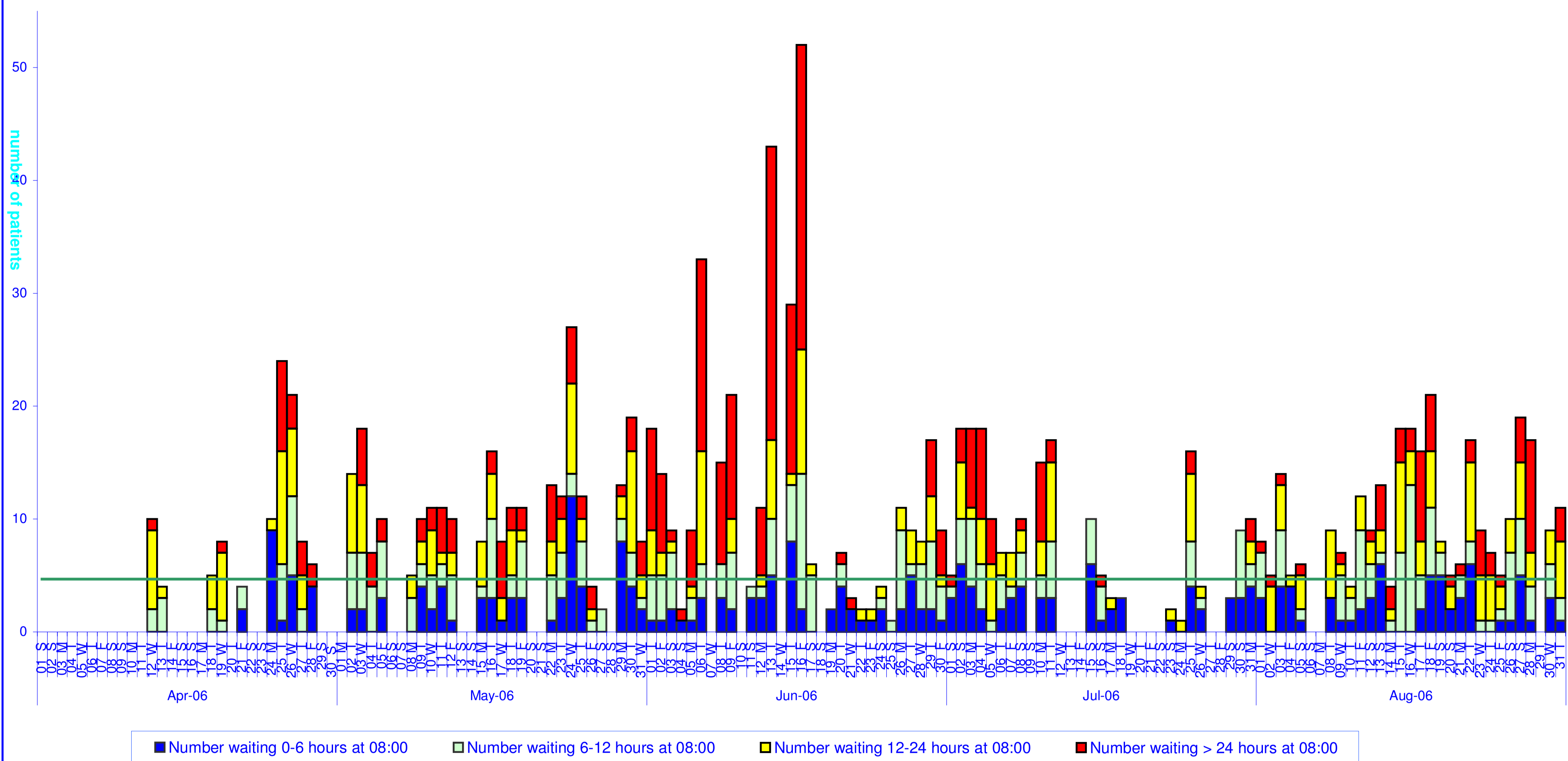
Mater Hospital

		Proposals	Impact on ED Volume / Wait Time	Timelines	2007	WTE	Financial	
							Annual revenue (€ million)	Capital (€ million)
Proposals	Capacity	Moving Delayed Discharges to long-term care	30 beds additional beds per month			PCCC	PCCC	PCCC
		Development of a Day Hospital	**Remove 750 elderly patients from ED. 6 additional beds per day. Direct GP access.**	**2007**	**June**	**(18)**	**(1.23)**	**(In CP)**
		St Mary's Stroke Rapid Access ED admission Unit		Nov 2006		(11.5)	(.72)	.55
	Capability	Enhanced Neurology service	Same day assessment/admission. Rapid access clinics. Weekend ward rounds. Reduced LOS		July	3	0.380	.40
		Enhanced Cardiology service	50% of admissions. Core diagnostics/therapeutic procedures within 24 hrs. 3600 bed days per annum ,3 additional beds per day		June	3	.380	
		Enhanced Emergency Department service	Opening of CDU. Increased Clinical support services. Expansion of outreach services, links with Ballymun MIU. Extension of Emergency review clinics.		June	3	.400	2.3
		Diagnostic / CT Scan project	Extended working day. Second CT scanner increased capacity better turn around times.2 additional beds per day		June	6	0.87	1.7
		Respiratory	COPD out reach		March	3	.380	1.0
	Control	Development of internal medicine service (respiratory)	Consultant delivered ward rounds, senior decision making 7 days a week. More rapid assignment of patients to appropriate consultant/speciality.		June 2007	3	.400	
	Totals					**221**	**2.81**	**5.95**

Our Lady of Lourdes Hospital, Drogheda



ED Task Force Review April - August 2006
Our Lady of Lourdes Hospital Drogheda
Data supplied by HSE
Number of patients waiting in ED @8am
Long Term Care Patients
Elective Admissions (daily)
Elective Admissions (weekly)
Target: 08:00 = less than 5 patients waiting for admission (post bed identification requirement) ED
% Compliance: April 2006: 22% May 2006: 9% June: 45% July: 40% August: 13%
Ave. no. of patients waiting at 08:00:- 9
Ave. no. of patients waiting at 08:00:- 11
Ave. no. of patients waiting at 08:00:- 6
Ave. no. of patients waiting at 08:00:- 8
Ave. no. of patients waiting at 08:00:- 10
April / May 6% increase Elective Admissions
April / May 7% increase LTC
70
60
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Data supplied by HSE (incomplete provision)


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Our Lady of Lourdes Hospital Drogheda
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 21% May: 25% / June: 17% / July: 31% / August: 22% compliant
number of patients
0
10
20
30
40
50
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

The team met representatives from senior management, senior nursing, bed management and emergency medicine. The team found that the ED was totally unfit for purpose. The additional daily burden of inpatient boarders made for an extremely difficult working environment with a high risk potential. The regular housing of inpatients on trolleys in the Outpatient Department was highlighted as unacceptable practice but is directly linked to the inadequate space within the ED. Nursing staff retention difficulties were identified as a major problem.

Whilst it is noted that the building of a new ED at Drogheda is in the capital plan, the Task Force would like to stress this should be a top priority to proceed without delay.

Capacity

- The ED capacity was extremely limited and poorly designed for the volume of attending patients.
- During site visits, the hospital was running at 99% inpatient occupancy, with resultant difficulty in accommodating surges in numbers of ED admissions. Limited psychiatric bed availability, with frequent overnight accommodation of psychiatric inpatients on ED trolleys was noted.
- Recent and imminent increase of surgical commitments (elective activity and trauma bypass of neighbouring hospitals) was further limiting available capacity for ED generated admissions. Recent and projected population increases are a further stressor on capacity.
- There is an immediate requirement for proactive /ongoing transfer of long-term care patients inappropriately occupying acute beds.

Capability

- There are significant opportunities to:
    - Develop Chronic Disease Management Programmes.
    - Enhance existing discharge co-ordination
- Diagnostic capacity was centred on Monday – Friday 0800 – 1700.
- Whilst it is acknowledged that addressing capability issues would be beneficial, it should be noted that direct ED impact would be limited unless capacity issues are also addressed.

Control

- The implications of increasing elective activity on existing insufficient ED/Inpatient bed base must be recognised, considered and planned for.
- There was scope for significant enhancement of the Bed Management function.
- The PCCC/Hospital interface appeared to be predominantly patient specific and would probably benefit from a broader more structured approach.
- In general, it was felt that greater pan-hospital engagement with and focus on the issues of patients requiring admission in and around the ED is vital to the future delivery of emergency services in the region.

Hospital focus on volumes / wait time targets

- The hospital is largely non-compliant with volume and wait time target and consistently has patients waiting more than 24 hours.
- The hospital would benefit from enhanced internal control systems.
- The hospital has demonstrated that it recognises the problems experienced and the requirement for proactive immediate / ongoing transfer of long-term care patients inappropriately occupying acute beds
- Implications of increasing elective activity on insufficient ED and inpatient bed base must be considered.
- The bed management function is limited.
- Proactive and effective hospital – PCCC interface – despite the paucity of long-term care beds.
- Limited tracking / trend analysis available – accordingly limited performance focus / target setting.

Recommendations

Capacity

- The overall Emergency Department structure and size does not fit current purpose/volume of attending patients and proposed capital development should be advanced without delay.
- Given that the delivery of this capital development was identified by the hospital as being in excess of 12 months, the immediate hospital focus must be to create additional bed capacity, thereby at a minimum removing patients requiring admission at the earliest opportunity. Accordingly it is recommended that proposed initiatives generating inpatient capacity including additional community provisions are effected promptly with specific reference to the obstetrics and gynaecology Outpatient Department – since externally, it is suggested that this would largely be revenue neutral. The hospital should also consider how it can ensure prompt placement if psychiatric patients - avoiding common unsafe practice of overnight accommodation in Emergency Department.

Capability

- The hospital is encouraged to consider further developments of admission avoidance initiatives and develop a more structured and focused response to attending ED patients. This should include a proactive development of Chronic Disease programmes in conjunction with PCCC.

Control

- It was explained by the hospital that recently introduced surgical presence and commitment (elective & trauma bypass) had placed an additional demand on existing bed capacity and that further similar developments were imminent. It is suggested that without additional capacity and capability development current unacceptable ED – centred overcrowding will further increase.
- The Task force view is that without capacity and capability development the current unacceptable ED overcrowding will increase further. The task force recommends that the existing hospital – PCCC interface be reconsidered to ensure the development of purposeful action that effects prompt transfer of patients. The current arrangements are not optimal.

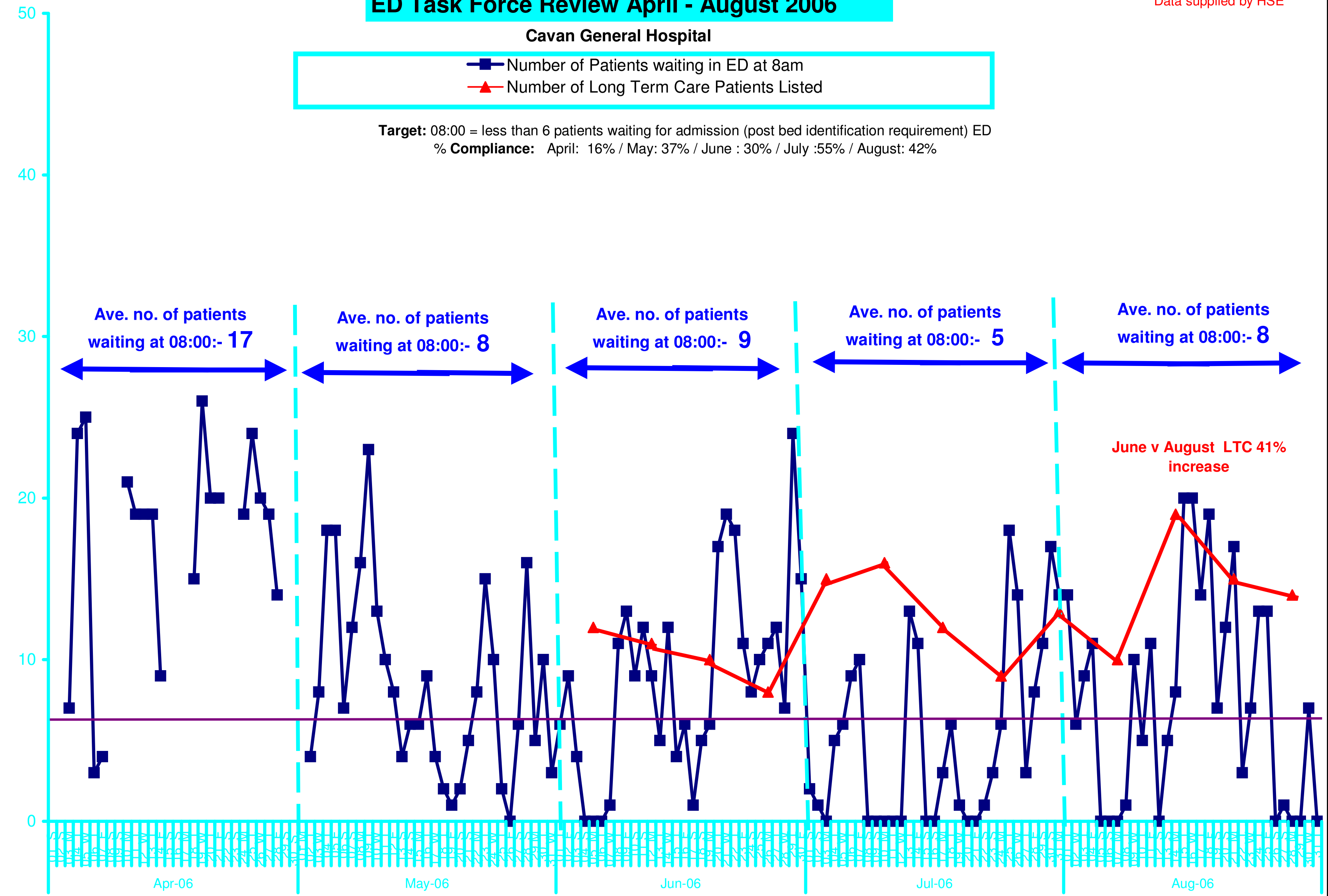
- Whilst the hospital has proposed increases in existing admissions control/discharge function it is suggested that these will have limited impact unless there is establishment of a pan-hospital control mechanism assuring:
    - Clarity of accountability/responsibility
    - Application of control mechanism across totality of patient pathway
    - Measurable performance metrics
    - Performance feedback (internally/externally) - It should be noted that hospital was not routinely able to produce HSE basic reporting sets

Our Lady of Lourdes Hospital, Drogheda

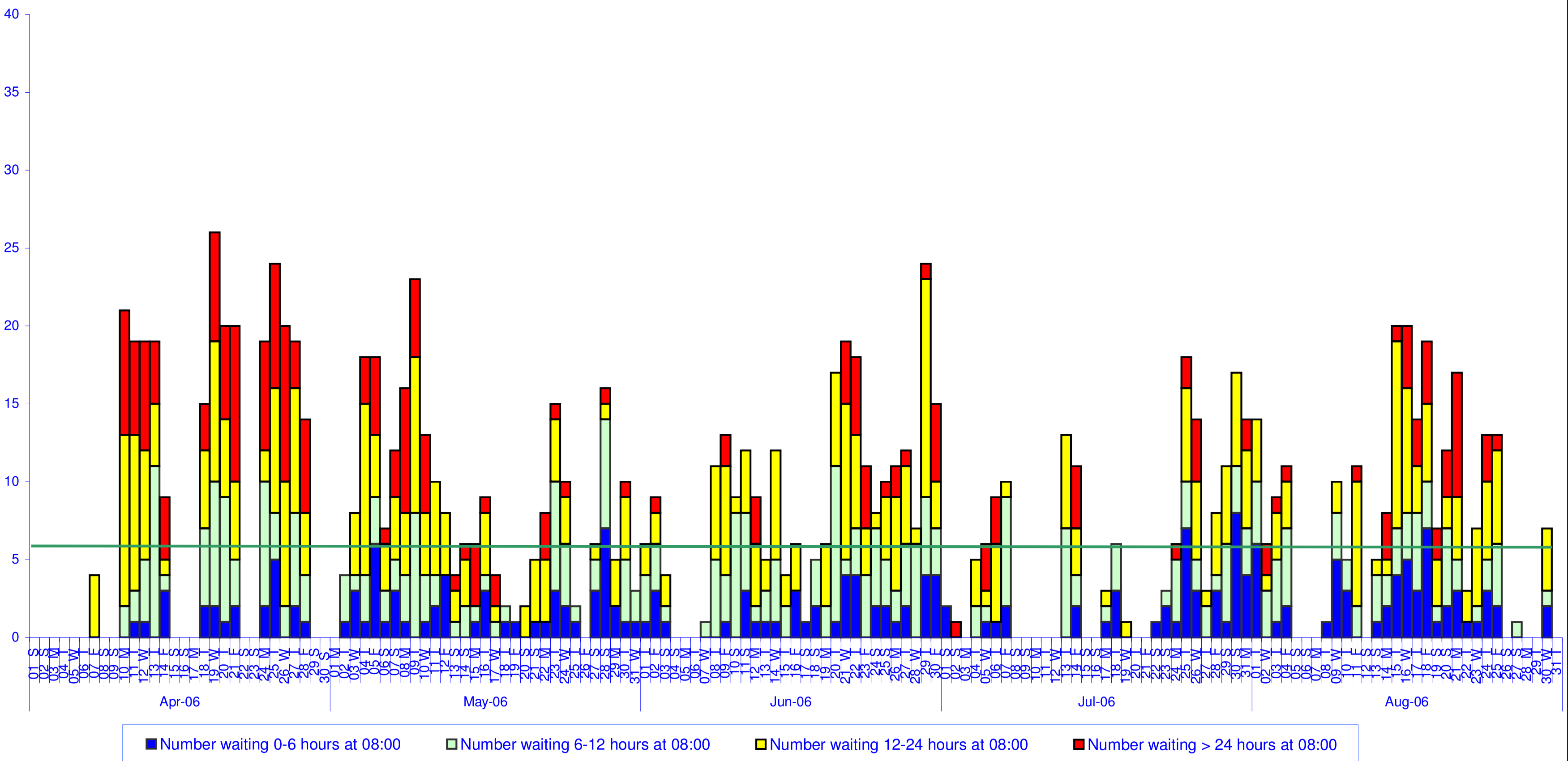
Proposals		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	2007		Annual revenue (€ million)	Capital (€ million)
	Capacity	**Development of Regional Emergency Department**	**Additional capacity for both patients and staff**			**(45)**	**(2.8161)**	**In capital plan**
	Capacity	**Purchase of 28 private nursing home beds in Louth region**	Faster discharge	6-9 months		PCCC	PCCC	PCCC
	Capacity	**Additional 12 beds**	Revised proposal to be submitted			20.5	0.714	
	Capacity	Enhanced Obstetric & Gynaecology Department	Reduction in number of day case surgery. Better access to Colposcopy. More space for ED		2007	5	0.300	0.8 (to be confirmed)
	Capability	Regional Rapid Access Chest Pain Service	Reduce referrals to ED. One stop assessment for patients. Improved times for intervention and treatment and reduced waiting time for treatment in ED		April	6	0.457	

		COPD Service	Multidisciplinary team to act as resource for patients and community based carers .20-30% reduction in need for admission in attendees		April	3	0.150	
		DVT Service (develop as part of ANP)	Protocol based model. Rapid diagnostics with efficient care pathways .Reduced admission rates. ALOS		April	1	.060	
	Control	Bed Management / Discharge Coordinator	Reduction in ALOS better management of bed resource		April	3	.180	0
	Totals					**38.5**	**1.861**	**.8**

Cavan General Hospital



ED Task Force Review April - August 2006
Cavan General Hospital
Data supplied by HSE
Number of Patients waiting in ED at 8am
Number of Long Term Care Patients Listed
Target: 08:00 = less than 6 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 16% / May: 37% / June : 30% / July :55% / August: 42%
Ave. no. of patients waiting at 08:00:- 17
Ave. no. of patients waiting at 08:00:- 8
Ave. no. of patients waiting at 08:00:- 9
Ave. no. of patients waiting at 08:00:- 5
Ave. no. of patients waiting at 08:00:- 8
June v August LTC 41% increase
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Cavan General Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 8% May: 20% / June: 16% / July: 26% / August: 24% compliant
40
35
30
25
20
15
10
5
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

The team met representatives from senior management, senior nursing, bed management, medicine and emergency medicine. The hospital repeated emphasised its concerns that significant treatment decisions were often very significantly delayed, due to lack of access to relevant diagnostic imaging with consequent risk exposure for patients as well as inappropriate admissions.

Capacity

- The visit to the ED gave rise to concern that it had no purposeful design and inadequate emergency ambulance access. Patients on trolleys were being accommodated along a short corridor that inevitably resulted in overspill into a main hospital corridor and the outpatient department. This is unacceptable.
- The capacity for timely diagnostic imaging was felt to be the single biggest risk exposure evident during the visit.

Capability

- There is a single-handed locum consultant in the ED, with inevitable limited availability of senior clinical decision-making. There appeared to be ready availability of a senior medical opinion when the need for this was clearly identified. However, 'slow' response times by in house specialties when called to ED for "routine" emergencies were reported. This was felt in part to be due to difficulty for on-call General Medicine teams to optimally managing a significant and onerous workload volume/acuity.
- There had been some prior development of chronic disease management programmes. There remains capacity for further expansion in this area.

Control

- Whilst staff appeared to be coping well and working hard to find ways of alleviating ED overcrowding, it was felt that there was a need to recognise the inadequacies of the infrastructure of the ED and plan a renovation, as well as finding more appropriate accommodation for patients waiting on trolleys.
- The proactive and effective Hospital/PCCC interface was noted as an example of good practice.

Hospital focus on wait time / volume

- The hospital has secured improvements in terms of both wait times and volume reduction but are still largely non-compliant with targets (based on 8am figures).
- The hospital needs to move immediately to put in place central controls in relation to the bed base.

Recommendations

Capacity

- The necessary acute bed capacity will be secured by the proposed provision of "step-down" facility and should be progressed directly.
- The development of the AMAU initiative should enhance patient processing significantly. It is essential that this service does not compete with the ED and the in house team for key resources such as senior decision makers and diagnostics.

Capability

- The provision of additional medical staff (Consultant Radiologists) will enable appropriate provisions of timely diagnostic results and should be progressed. It is essential that along with these additional capabilities, the hospital develops and effects an appropriate control mechanism, which assures prompt priority access to diagnostics necessary to support ED requirements/optimise patient processing.
- Proposed respiratory response team will enhance overall service provision.
- The hospital is encouraged to work with PCCC and develop appropriate Chronic Disease Management programmes.

Control

- It is essential that with introduction of additional capacity/capabilities initiatives, the hospital effect an appropriate pan-hospital control mechanism that optimises access diagnosis, treatment, and discharge and removes current unacceptable practice of inappropriately accommodating patients on corridors / within the outpatient department.

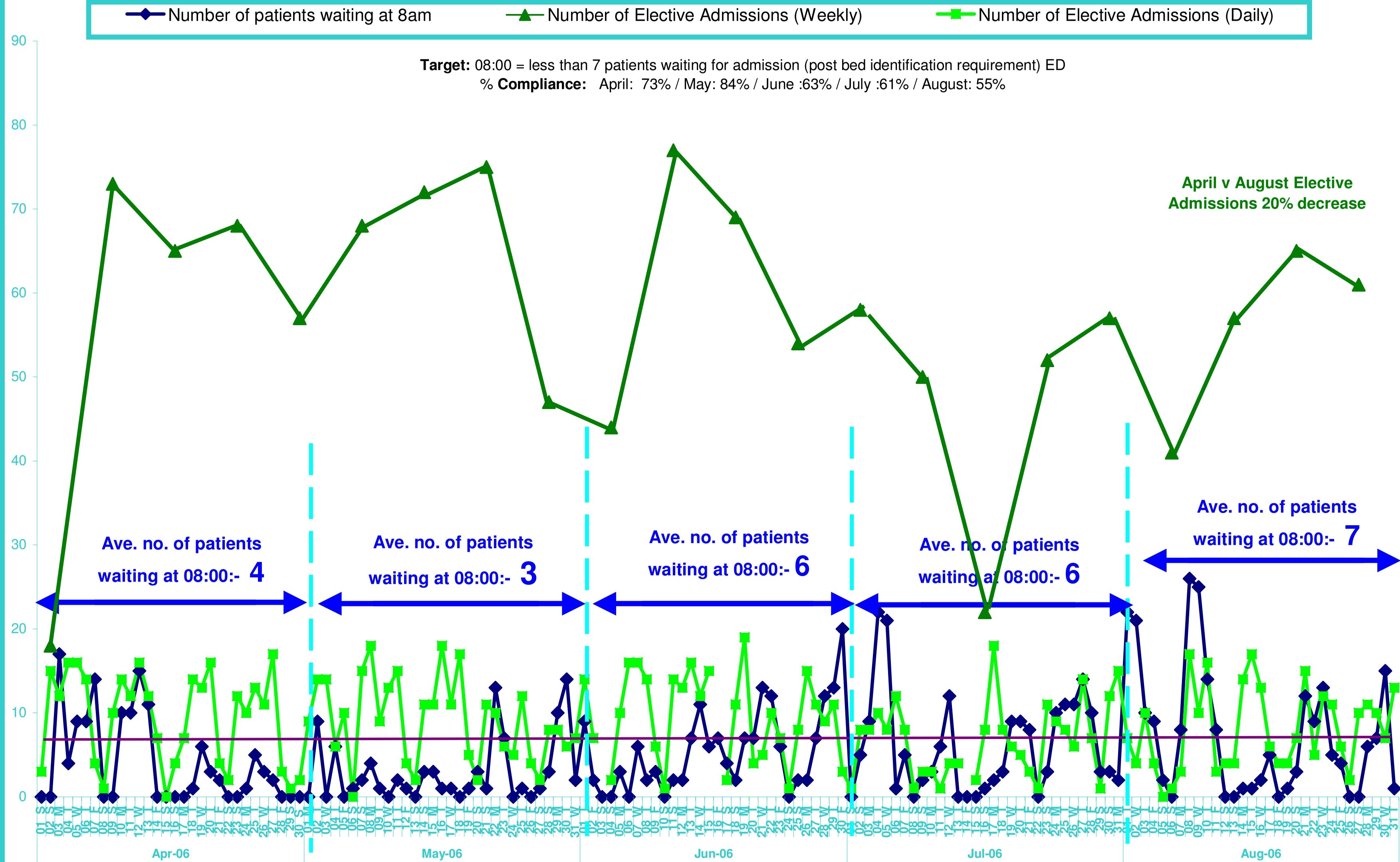
Cavan General Hospital

Proposals		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	2007		Annual revenue (€ million)	Capital (€ million)
	Capacity	12 step-down / intermediate care beds in Lisdaran Unit for elderly	More appropriate care for non acute patients. Access to inpatient beds Reduction in ED wait time	2 months		PCCC	PCCC	PCCC
		ED avoidance for Early pregnancy service	More appropriate care pathway for gynaecology patients .Reduce admissions by 600 PA	3-6 months		1.5	0.084	
		6-bed AMAU	Reduced medical admissions / readmissions	6-9 months		To be confirmed	0.735	
		2 additional Consultant Radiologists *	Improved reporting time		2007	2	(0.430)	
		Respiratory Service response team	More rapid assessment of patients facilitating early intervention and treatment	3-6 months		4	0.678	
	Capability							
	Control							

	Totals		**7.5**	**1.497**	**0**

*** These posts were submitted on a cost neutral basis.**

Letterkenny General Hospital


Data supplied by Letterkenny Hospital
ED Task Force Review April - August 2006
Letterkenny General Hospital
Number of patients waiting at 8am
Number of Elective Admissions (Weekly)
Number of Elective Admissions (Daily)
Target: 08:00 = less than 7 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 73% / May: 84% / June :63% / July :61% / August: 55%
April v August Elective Admissions 20% decrease
Ave. no. of patients waiting at 08:00:- 4
Ave. no. of patients waiting at 08:00:- 3
Ave. no. of patients waiting at 08:00:- 6
Ave. no. of patients waiting at 08:00:- 6
Ave. no. of patients waiting at 08:00:- 7
90
80
70
60
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06

Findings

Capacity

- The current ED space is clearly inappropriate and insufficient to accommodate and process presenting patient volumes. Patient accommodation and flow is further compromised by the location of the AMAU within department.
- Existing ED and general hospital capacity is routinely challenged by presenting ED patients requiring admission with resultant adhoc inappropriate temporary accommodation of these patients in other areas such as Outpatients, Day surgery and corridors – there is no transit facility identified.
- Analysis of the period April – June demonstrates elective peak values on Monday and Tuesday and subsequent peak *ED* wait and volume values Wednesday/Thursday.
- Diagnostic treatment capacity is predominantly centred Monday - Friday 0900 – 1700 with resultant access and report availability delays. The hospital has also confirmed insufficient capacity in relation to echocardiography, endoscopy, ultrasound and nuclear medicine with subsequent delays in patient processing leading to increased average length of stay.

Capability

- There is a limited senior decision making presence within ED across seven day period (2 Consultants).
- ED – In-house existing functionality resulting in "time lag"/delays with opportunities for improvement.
- There are limited chronic disease management programmes in place.
- Inadequate Hospital – PCCC interface and there is a requirement for extension of home care packages /to adopt a more vigorous pan-hospital approach to discharge.
- Delays routinely arise as a result of slowness in being able to effect (when required) patient transfer.

Control

- The Task Force observed limited pan-hospital controls
- Patient pathway optimisation - with required ED prioritisation/discharge evident –
- There were insufficient control staff to effect this function optimally.
- Restricted performance metrics were identified and there is a subsequent difficultly in producing routine timely and accurate data sets relating to actual performance including necessary periodic reports for HSE.

Recommendations

Capacity

- The priority for Letterkenny remains the creation of significant Emergency Department and inpatient bed capacity. It has been confirmed by the hospital that both of these capacity requirements will be achieved through major capital development projects and therefore of no short-term benefit (2006-2007 – estimated >12 month to be operational).
- The hospital has proposed externally securing diagnostic/treatment services specifically echo-cardiography, endoscopy, angiography, ultrasound, nuclear medicine and pacemaker insertion. In total a proposed 3,425 patient transfer and returns annually – representing 17% of annual inpatient episodes. Whilst in theory these initiatives will yield significant bed day 'savings', unless an "on demand" hospital provider contract is secured, in conjunction with an 24/7 transport service, it is unlikely that projected savings will be fully actualised. Should these initiatives progress, the hospital will also have to ensure that returning patient accommodation does not compete with ED generated admission demands. The hospital may do well to consider whether in fact certain of these services could be provided locally/on site.

Capability

- The hospital has proposed an expansion of Home Care and increasing bed management/discharge function. It is suggested that these initiatives will be successful, if approached within a vigorous work relationship Hospital – PCCC whereby proactive prompt discharge is normal routine.
- The proposed radiographer extended working day will shorten access/wait times, if supported by prompt reporting and will have some benefit in terms of securing shorter length of inpatient stay.
- Chronic Disease Management programmes identified will have a positive impact, in terms of reducing emergency readmissions/shorter ALOS and should be progressed.
- The creation of an interim GP assessment unit with a focus on medical patients will potentially shift out from ED a certain number of patients; but it is unlikely to reduce actual emergency admission requirement values. It will also be important to ensure, if this service is progressed, that it does not lead to a diminution/deflection of hospital services from ED/inpatient bed base.
- The Hospital has identified the appointment of a 3rd Geriatrician (50:50 split Hospital/Community) as being likely to secure reductions in number of emergency readmissions from Community units – it is suggested that this initiative (if appropriately controlled/structured) may also lead to quicker/increased number of transfer out from hospital, and should therefore be progressed.
- The Hospital has proposed development of a falls unit facility (previously unsuccessfully submitted to SPRI) – sufficient internal analysis undertaken would suggest that its introduction would prove beneficial to current ED situation.
- Proposed ANP development (ED) would have clear benefits for "minors" attending, but no impact on patients requiring admission, it is also unclear, given extreme spare limitations of current ED, as to how function could be successfully implemented.
- Proposed initiatives to reduce elective cancellations would have no impact on current ED situation.

- Proposed introduction of PAM support would if utilised/controlled effectively be beneficial and should be progressed.
- ED centred physiotherapy (pain/initiative proposal will have no impact on current inappropriate ED generated admissions accommodation.

Control

- The Hospital has proposed the introduction of proactive bed management, and it is recommended that this should be lead by the General Manager and be effected immediately. If appropriately managed, this on a pan-hospital basis it will yield significant benefits/improvements in relation to ED inappropriate patient accommodation.
- The Hospital have proposed a significant variety of capability and capacity initiative, not necessarily automatically fitting within required paradigm that focuses on emergency patient admission requirement – without this pan-hospital requirement, proposed initiatives will be unsuccessful.
- The Hospital should also consider the existing management capability and capacity to manage significant and complex change requirements short term and the requirement for appropriate central control mechanisms.
- Whilst HSE have set national target of <10 patients waiting, it is suggested that hospital, given limited ED space, work in a target of <5.
- In conjunction with this target, given major capacity generation will not be available short term, that this hospital consider how it can on a more sustained basis stabilise appropriate ED generated admissions and routinely use elective capacity.

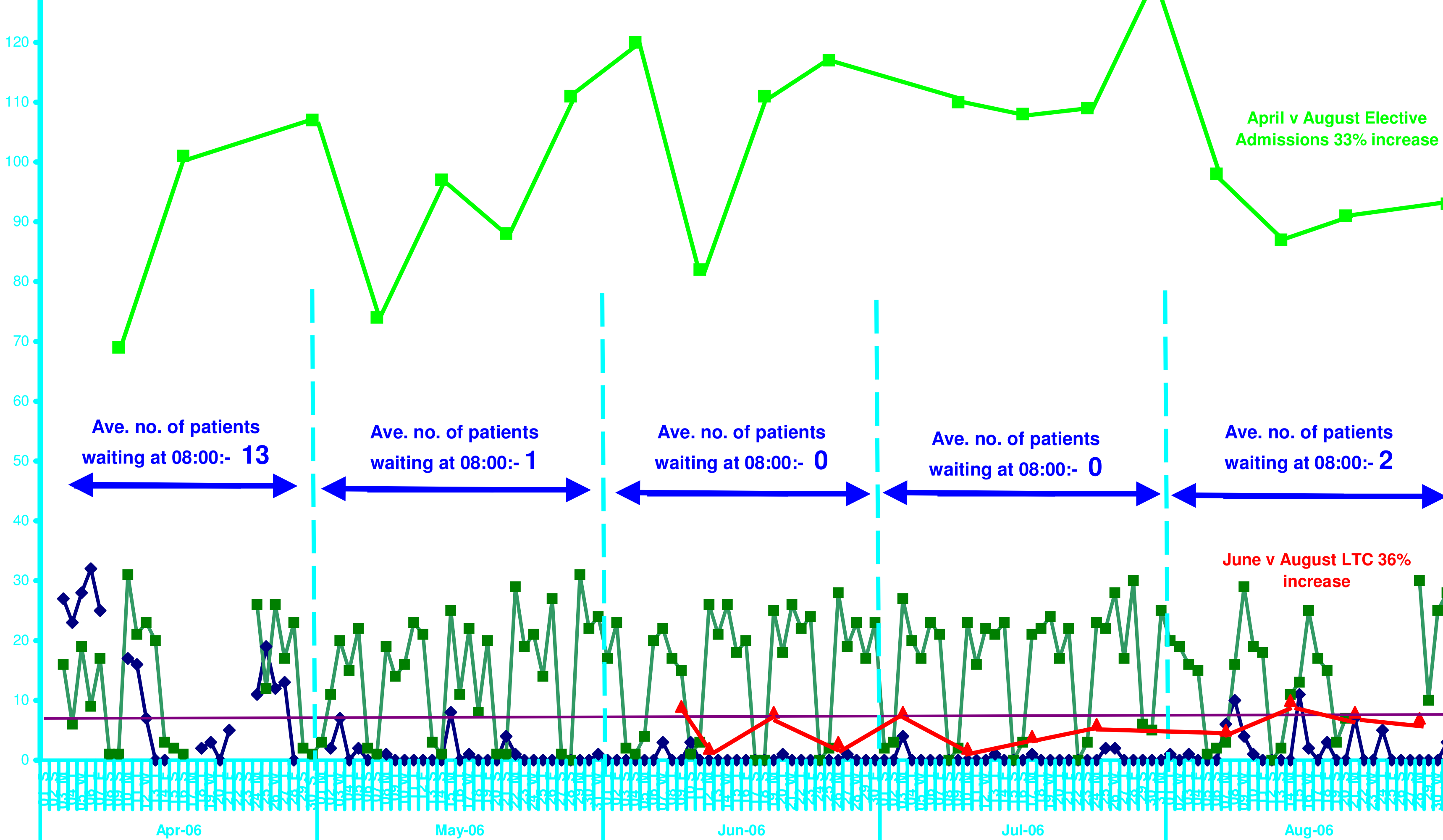
Note: It is suggested that a pilot initiative be undertaken on the following for 6 months to assess impact on ED volumes and wait times

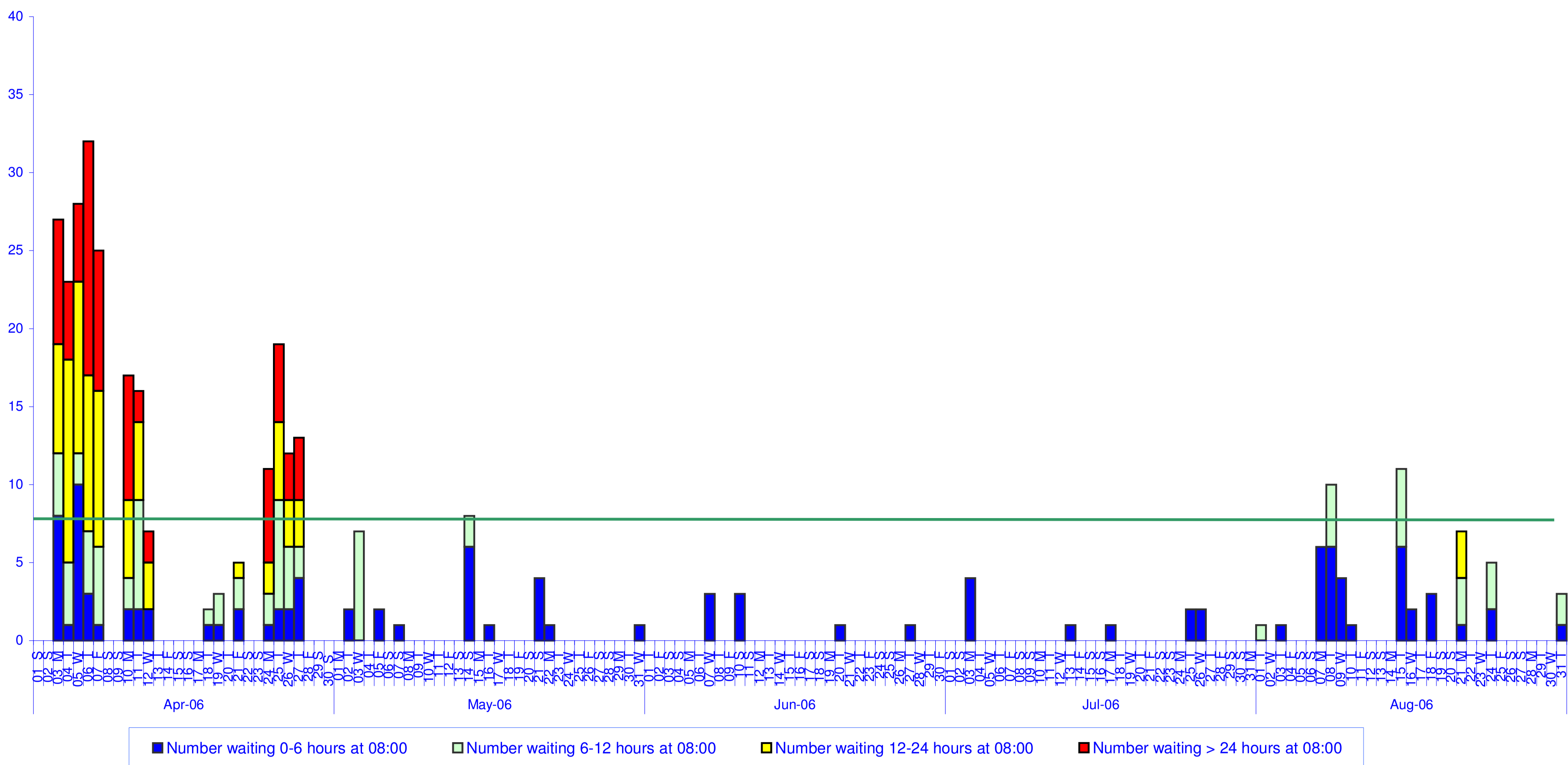
Letterkenny General Hospital (Outsourcing of Diagnostics)

Proposals		**Proposal**	**Impact on ED Volume / Wait Time**			**WTE**	**Financial**	
				2006	**2007**		Annual revenue (€ million)	Capital (€ million)
	Capacity	800 Angiograms purchased per annum	Facilitate throughput of patients in ED. Save 4 bed days per day	immediate			2.0	
		1000 Echocardiograms purchased per annum	Facilitate throughput of patients in ED. Save 4 bed days per day	immediate			0.6	
		400 Ultrasounds purchased per annum	Facilitate throughput of patients in ED Save 2 bed days a day	immediate			0.1	
		1000 Endoscopies purchased per annum	Facilitate throughput of patients in ED Save 3 bed days a day	immediate			0.6	
		200 Nuclear Medicine tests purchased per annum	Facilitate throughput of patients in ED Save 3 bed days a day	immediate			0.14	
		25 Pacemaker insertions purchased per annum	Facilitate throughput of patients in ED Save 1 bed day a day	immediate			0.0375	
		Sub total for private provision * Costs and quantum of service will need to be verified before proceeding with this initiative					**3.477**	

		30 bed modular ward	**Immediate transfer out of ED once decision to admit**	**Already Approved**	**2007**	**(15)**	**(1.8)**	**(1.6)**
		Extend Radiographers working day	4 hours radiological time per day	3-6 months			Over time basis	
		Develop ANP Service in ED	Reduction in ED wait time and number on trolleys	3 months		1	0.065	
		Develop Pulmonary Rehabilitation Service	Reduced readmission rates and improves COPD patient ED utilisation rate	3 months		3.11	0.204	0.3
		Develop Heart Failure Clinic	Reduced admission rate and saving of 800 bed days	3 months		1.5	0.1	
	Capability	**12 bed AMAU**	**Compliance with ED targets**		**2007**	**(90.5)**	**Included in Capital Programme**	**(11.0)**
		Establish a Falls Unit	Prevent chronic illness and disability in elderly patients .Reduced ED utilisation – 8 less admissions per month	3 months		4.5	0.163	0.768
		3rd Geriatrician			2007	4	0.395	.125
		AC /ED			2007	1	0.027	
	Control	Enhanced bed management function	Average discharge time to be brought back to 2 hours per day			2	0.120	
	Sub-total for private provision * Costs and quantum of service will need to be verified before proceeding with this initiative						**3.477**	
	Sub-total for public provision					**17.11**	**1.074**	**1.2**

Wexford General Hospital


ED Task Force Review April - August 2006
Data supplied by HSE
Wexford General Hospital
Number of Patients waiting in ED at 8am
Elective Admissions (Daily)
Elective Admissions (Weekly)
Long Term Care Patients Listed (daily)
Target: 08:00 = less than 7 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 37% / May: 93% / June : 100% / July : 100% / August: 90%
April v August Elective Admissions 33% increase
Ave. no. of patients waiting at 08:00:- 13
Ave. no. of patients waiting at 08:00:- 1
Ave. no. of patients waiting at 08:00:- 0
Ave. no. of patients waiting at 08:00:- 0
Ave. no. of patients waiting at 08:00:- 2
June v August LTC 36% increase
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Wexford General Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 18% May: 67% / June: 100% / July: 100% / August: 61% compliant
40
35
30
25
20
15
10
5
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

Capacity

- The hospital operated at approximately 92% occupancy between April and August 2006 with resultant difficulties in appropriately accommodating ED peaks/troughs
- 19 additional beds to come on-stream this year.
- The main observation was that the hospital's physical infrastructure militated against effective patient management within the ED. The Emergency Department was not fit for purpose. This is to be addressed by the National Hospital Office capital plan for 2007 where funding has been allocated to develop and staff a new Emergency department. However, it is noted that the new facility will not be completed before the end of 2007.

Capability

- Diagnostic capacity is centred Monday – Friday 08:00 – 17:00 with access difficulties for ED.
- There is insufficient 'senior decision maker' (ED) availability particularly at night with adverse implications for overall patient management and admission rates.
- It was noted that the current admission rate was __. This is at variance with international and Irish best practice.
- Significant opportunities to build on and expand existing chronic disease management programme
- Diagnostics- Access to diagnostics both in house and for GPs is sub optimal.

Control

- The Task Force observed considerable hospital-wide focus on issues in ED.
  The need for more effective control of emergency/elective workloads was highlighted.
- The potential to optimise Ely House for less acute cases (day medical and those approaching discharge)
- An exemplar approach to hospital/PCCC interface was outlined.

Hospital focus on wait time / volume

- There was a significant reduction in volumes and wait times from May onwards.
- The hospital is largely compliant with volume targets and partially compliant with waiting time targets.

Recommendations

Capacity

- The Task Force strongly supports the development of an appropriately designed and staffed ED at Wexford General
- Wexford General Hospital needs to fully utilise the capacity available at Ely Hospital to alleviate the pressures on the main hospital.

Capability

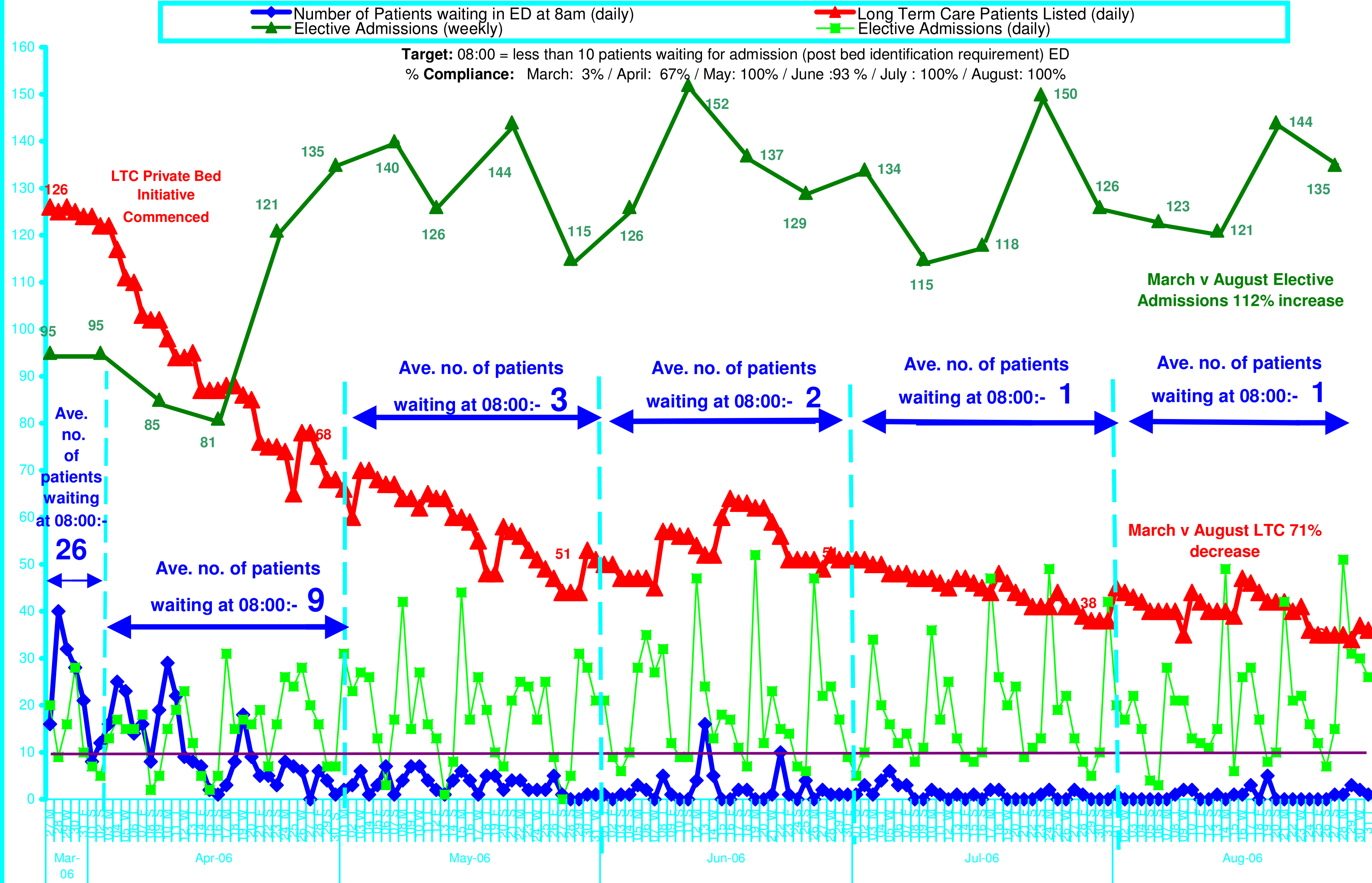
- ***Senior Decision-making -*** The current system has an SHO in the hospital and a registrar on call from home. As an immediate step a medical registrar should be available on site to process admissions.
- **Diagnostics –** The hospital needs to review its current arrangements for GP and ED access to diagnostics and bring forward appropriate proposals for consideration.

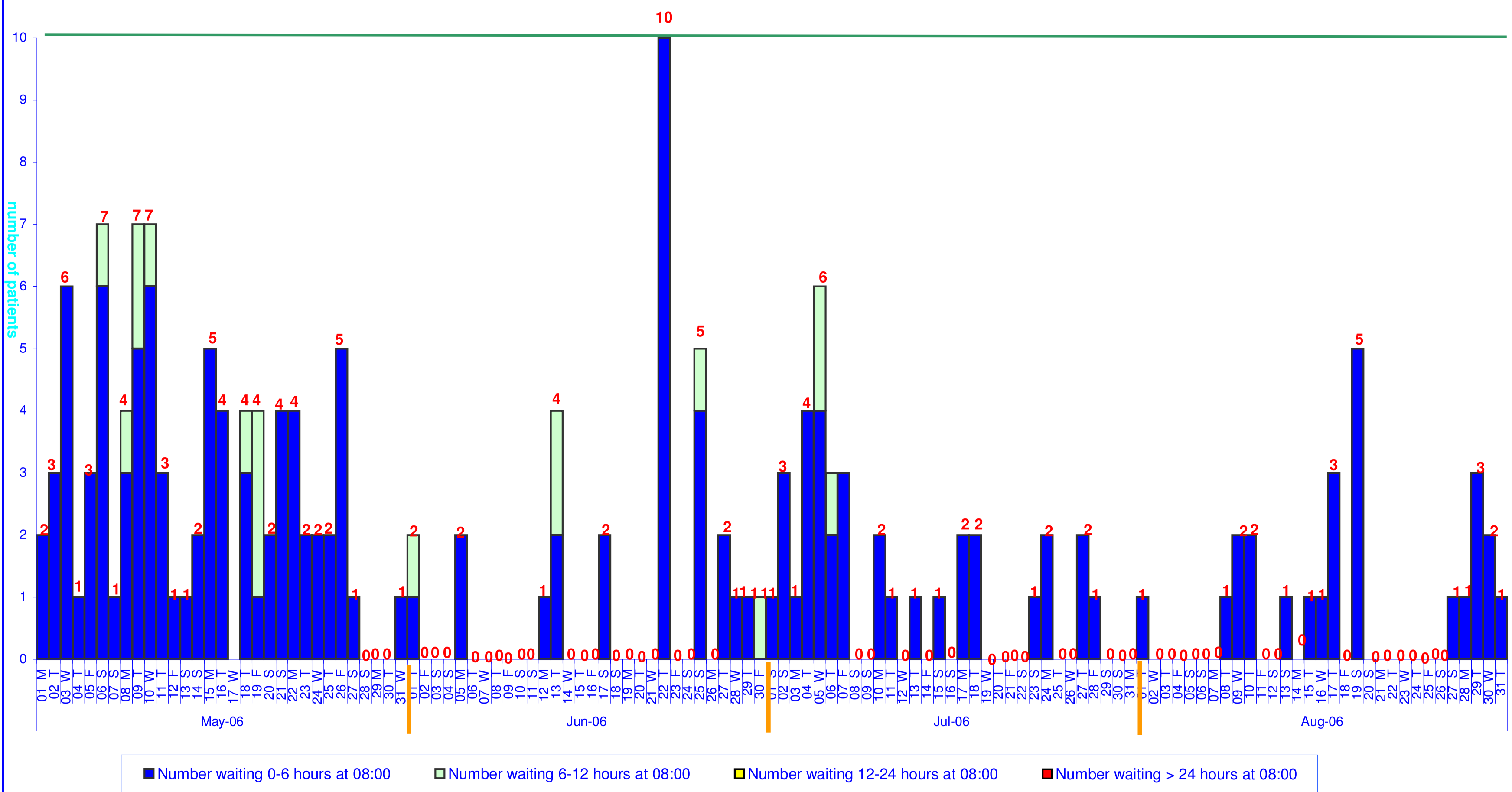
Control

- The overall hospital control arrangements in relation to the management of the bed base need to be urgently addressed. Specifically, there is a requirement to put in place control measures that ensure that emergency patients are appropriately prioritised.
- The current arrangements in relation to escalation meetings need to be enhanced so that peaks in ED presentation are managed.
- The hospital needs to formally designate a senior manager with overall responsibility for the ED with a specific focus on addressing the volume and wait times in ED and the associated control issues.

Wexford General Hospital								
		Proposal	**Impact on ED Volume / Wait Time**			**WTE**	**Financial**	
				2006	**2007**		Annual revenue (€ million)	Capital (€ million)
Proposals	**Capacity**	**Development of Emergency Department**	**Enhanced facilities and capacity for staff and patients**		**|End 2007 / 2008**	**(4)**	**(0.5)**	**(5.0)**
		24 hour medical cover, nursing triage and orderly / security cover in ED	**Senior decision making. Faster processing, reduced waiting time**		**March**	**15**	**.75**	
	Capability	Establishment of Chest Pain and Respiratory Clinics	Prompt assessment and risk stratification for patients with new onset of chest pain. Allow cardiac patients to be treated as out patients and reduce readmission rates of respiratory patients by 5%		March	5	0.3	
		Establishment of Day Facility at Ely Hospital	Rapid assessment/admission of GP referred emergency patients. Avoid duplication and Reduce waiting time by 50%		June	12	0.800	
		Establish a Pre-discharge Unit at Wexford General Hospital	More appropriate care for less acute patients. Free 10 inpatient beds. Reduce AMAU unit readmission rate by 5%		March	13	.700	
	Totals					**45**	**2.55**	**0**

St James's Hospital


ED Task Force Review March - August 2006
St. James's Hospital
St. James's Hospital
Performance Indicator Programme
CEO
Number of Patients waiting in ED at 8am (daily)
Elective Admissions (weekly)
Long Term Care Patients Listed (daily)
Elective Admissions (daily)
Target: 08:00 = less than 10 patients waiting for admission (post bed identification requirement) ED
% Compliance: March: 3% / April: 67% / May: 100% / June :93 % / July : 100% / August: 100%
LTC Private Bed Initiative Commenced
Ave. no. of patients waiting at 08:00:- 26
Ave. no. of patients waiting at 08:00:- 9
Ave. no. of patients waiting at 08:00:- 3
Ave. no. of patients waiting at 08:00:- 2
Ave. no. of patients waiting at 08:00:- 1
Ave. no. of patients waiting at 08:00:- 1
March v August Elective Admissions 112% increase
March v August LTC 71% decrease
Mar-06
Apr-06
May-06
Jun-06
Jul-06
Aug-06



Emergency Department Activity Review May - August 2006
Number of patients waiting for admission
(post bed identification requirement) ED
St. James's Hospital
Performance Indicator Programme
IC CEO
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: May: 90% / June: 84% / July: 92% / August:100% compliant
number of patients
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

Capacity

- The overriding priority in continuing to meet ED targets at St James's Hospital is the continuing availability of delayed discharge placements. When these beds are available, they are utilized quickly thus freeing up acute beds and enabling ED patients to be appropriately admitted. With limited public, community long-term care beds; the hospital is very dependent on private community provision.
- The hospital operated at approximately 96% occupancy between April and August 2006.
- There are resultant difficulties in appropriately accommodating Emergency Department peaks and troughs. There are challenges in managing elective access appropriately, negating the ability to have 'same day surgery admissions'.
- There is a 5-day elective focus and challenges for limited critical care facilities where the occupancy runs at 98% - 100%.
- There is limited psychiatric bed availability and delays are experienced when transferring externally.
- The Diagnostic capacity is centred Monday – Friday 08:00 – 17:00

Capability

- A hospital wide focus is in place for some time with improvement opportunities being tackled on an organised basis (e.g. AMAU operational for some time).
- Limited telemetry provisions resulting in patient accommodation delays.
- Limited theatre access - particularly at weekends - results in treatment / operation delays and subsequent extended length of stay, particularly for high volume National Maxillo Facial and National Plastics services.
- The current compliment of senior decision makers within ED is limiting hospital's ability to achieve High Performance Targets set by HSE.
- It is difficult for existing General Medicine consultant cohort to optimally manage significant in house work load, manage elective and OPD work volumes and effect necessary on-call ED commitment.
- Echocardiography delays were identified in relation to in-house patient cohort and resultant negative impact on in patient length of stay.
- Significant opportunities exist to build on and expand existing well established hospital chronic disease management programmes.
- In common with other hospitals, appropriate pathways of care for psychiatric patients need to be developed.
- Existing Trauma Fast Track OPD clinics require expansion to provide a daily service.

Control

- Pan hospital approach to the management of ED very evident. The hospital demonstrated strong internal control mechanisms aimed at balancing emergency and elective workloads appropriately.
- Bed management function operates Monday – Friday 08:00 – 17:00
- The hospital – PCCC interface is patient specific only.

Recommendations

Capacity

- In terms of optimising existing capacity, the single biggest priority for St. James's is consistent and timely access to appropriate long stay facilities. In this regard, the expansion of complex discharge capacity and extended bed management function would allow delayed discharges to be moved to a more appropriate setting. This is a key success factor for St. James's, given the volume of patients requiring continuing care options and the limited public capacity options available.

  The Hospital have identified the potential of developing a 62 bedded long term care facility on the campus in keeping with existing on campus long term care facilities. It is recommended that this initiative be discussed with PCCC directly.

Capability

- Expansion of telemetry facility will enhance existing AMAU capability.
- Expansion of weekend theatre provision will enable prompt surgical intervention and subsequent shorter length of stay for these national patient cohorts.
- The funding of the fourth ED consultant post identified as an outstanding requirement of recently completed major ED development will enable both patient processing and management of ED centred inpatient facilities – CPAU and Observation ward – Total annual admissions 1735.
- It is recommended that the Hospital's proposals in relation to further ED senior decision provisions necessary to effect High Performance Targets identified by HSE should be progressed through the 100+ initiative.
- The expansion of consultant physician cohort will enable improved ED – in-house interface, management of inpatients, prompt discharge and as well enhanced management of Diabetic Day Centre (10898 annual attendances).
- Echocardiography initiative will enable prompt diagnosis / intervention and subsequent shorter length of stay.
- Chronic disease management programme will be significantly enhanced with the proposed expansion of existing Respiratory, Heart Failure and Neurology outreach clinics / domiciliary services.
- Expansion of OPD Fast Track Trauma clinics will provide an appropriate alternative to ED.
- The Hospital has proposed an expansion of Diagnostic services on an overtime basis – this should be considered.

Control

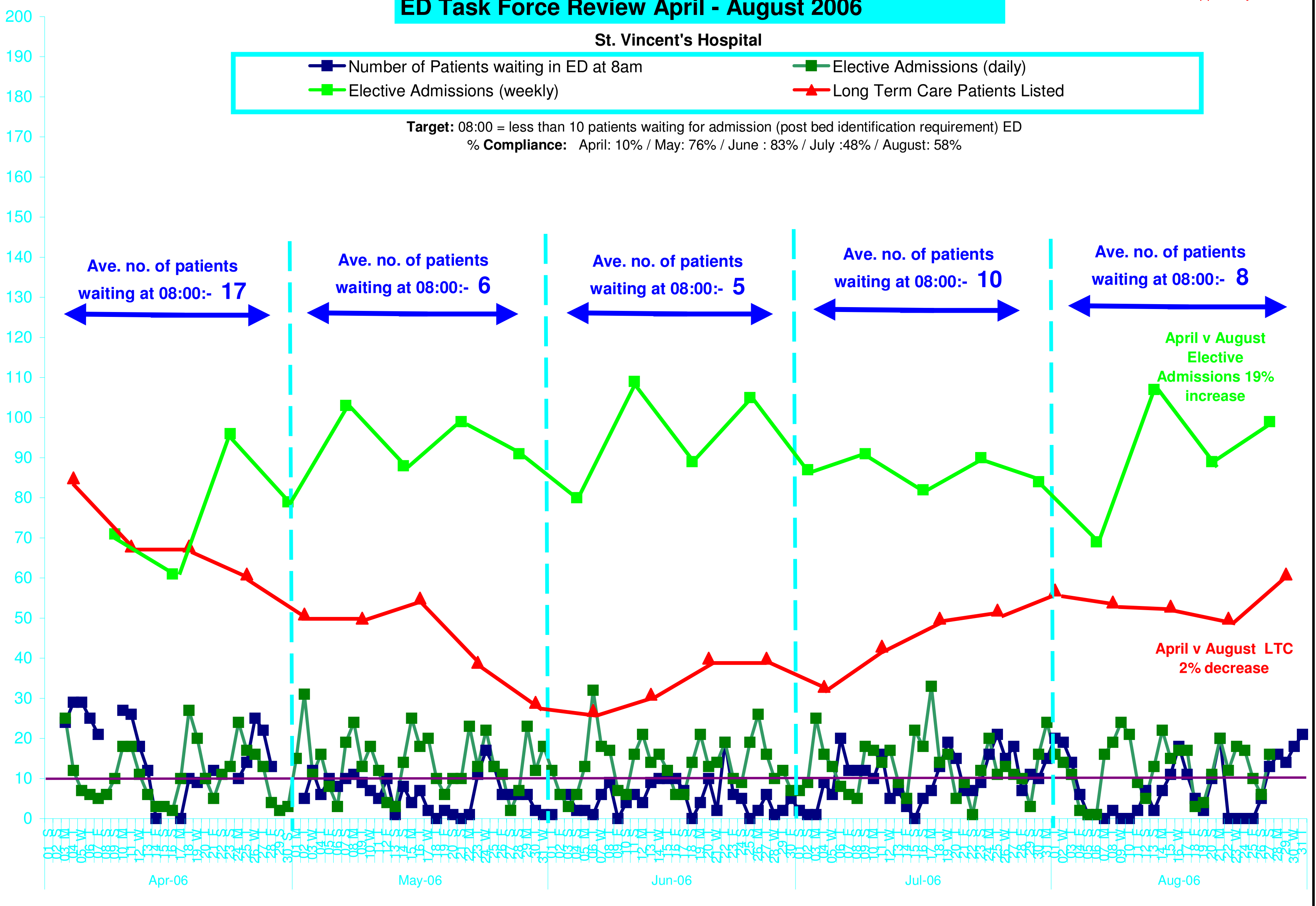
- Proposals for expansion of central bed management function should be progressed

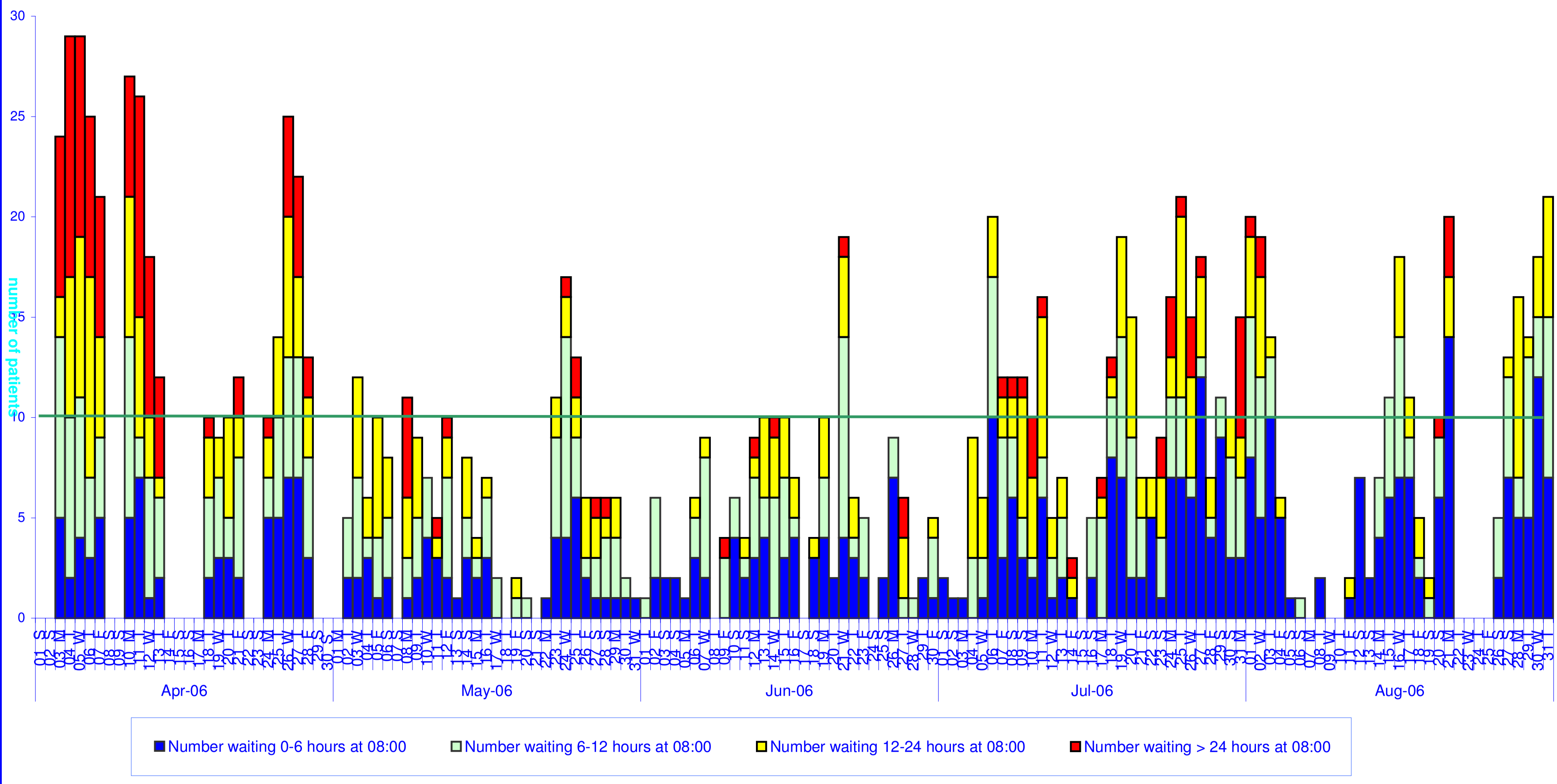
St James's Hospital

Proposals		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	2007		Annual revenue (€ million)	Capital (€ million)
	Capacity	Increased telemetry provision, Current provision 8 beds	Increase AMAU capacity, patients not waiting ED awaiting telemetry.		January		0	0.095
	Capacity	Increased weekend theatre provision to address trauma requirements.	1-2 reduction in ALOS. Increase of 1000 bed days t coincide with peak Ed demand		July	4	0.25	0
	Capacity	Enhanced Maxillo-facial Trauma service	Reduce new ED attendances by 1%		July	1.2	0.081	0.150
	Capacity	Enhanced Orthopaedic Trauma service	Reduce new ED attendances by 2%		July	4	0.288	0.530
	Capacity	Increased Acute Psychiatric bed provision	Remove 2 12-hour waiters per week		March		PCCC	PCCC
	Capacity	Increased Echo-Cardiography capacity	Reduce ALOS number of admissions		January	1	0.048	0.324
		62 long stay beds site to be determined			April		TBC	TBC
	Capability	4th permanent post of Consultant in Emergency Medicine. Post currently unfunded and forms an outstanding requirement of recently completed major ED development	Maintain patient processing at current levels. Senior Decision making		April	4	0.435	0.025

		Expansion of Consultant Physician cohort - First priority S.I. endocrinology includes supporting the Diabetic Day Centre	Faster discharge of medical patients		March	9.25	0.806	0.025
		Respiratory Outreach Programme – expansion of pilot	50% reduction in 6-month readmission rate for 200 patients	2 months	July	5.5	0.350	0.250
		Heart Failure OPD / Home Programme	Shorter ALOS, reduced ED referrals and readmission	1 months	January	4.5	0.300	0.065
		Enhanced Neurology Service	Reduced ED referrals by 30%	1 month	January	3.5	0.300	0.015
		OPD / Home management of Cellulitis / Infectious diseases	Reduction of 15-20 ED admissions per month	1 month	January	3	0.265	0.01
		OPD management of Deep Vein Thrombosis to be managed by ANPs	Reduction of 5-10 per month	1 month	January	1	0.065	0
		Extended working day in diagnostics to 8am – 8pm	Reduce ALOS by 1 day for 25% of current workload	2 months	February		Over time basis	
	Control	Extended Bed Management Function from 8am – 8pm	Increased Weekend discharges	1 month	July	1	0.065	
		Enhanced Complex Discharge capacity	20-30 additional discharges to home PA	1 month	January	4	0.246	
	Totals					**45.95**	**3.499**	**1.489**

St Vincent’s University Hospital


Data supplied by HSE
ED Task Force Review April - August 2006
St. Vincent's Hospital
Number of Patients waiting in ED at 8am
Elective Admissions (weekly)
Elective Admissions (daily)
Long Term Care Patients Listed
Target: 08:00 = less than 10 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 10% / May: 76% / June : 83% / July :48% / August: 58%
Ave. no. of patients waiting at 08:00:- 17
Ave. no. of patients waiting at 08:00:- 6
Ave. no. of patients waiting at 08:00:- 5
Ave. no. of patients waiting at 08:00:- 10
Ave. no. of patients waiting at 08:00:- 8
April v August Elective Admissions 19% increase
April v August LTC 2% decrease
Apr-06
May-06
Jun-06
Jul-06
Aug-06


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
St. Vincent's Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 21% May: 30% / June: 39% / July: 38% / August:51% compliant
number of patients
30
25
20
15
10
5
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

Capacity

- The hospital operated at approximately 94% occupancy between April and August 2006 which poses significant challenges in terms of optimising the capacity and addressing issues in ED[
- Delayed discharge placements are the overriding priority for the efficient utilisation of the bed capacity of the hospital. There have been improvements recently arising from the private initiatives - as with the other hospitals - and improvements in bed management are underway. There is a need to model ongoing steady state long- term care requirements in order to meet future needs.
- The ED physical facilities are new and provide a good environment for the management of patients.

Capability

- Diagnostic facilities are generally good with excellent access for the ED.
- There is a good track record in the management of chronic cardiac illness, which could be built upon in chronic respiratory illness and other chronic disease scenarios.
- Phase 1 of an AMAU proposal has been implemented but there is a need to focus on operating procedures and dedicated commitment and support from the total hospital consultant group.
- The Day hospital for the elderly needs additional staff specifically clinical support staff which would allow for the introduction of specialty clinics (e.g. falls assessment) which would have a positive impact on the admission of elderly patients through the Emergency department.

Control

- There is evidence that ED is a priority item across the hospital in terms of the management team, the executive board, and hospital board
- The hospital has taken a unique approach to ED care pathway development proposing to focus a large number of personnel and diagnostic resources on the ED. This model is reported as working well in several centres internationally (e.g. Adelaide, Australia). The hospital has done a number of initiatives aimed at providing solutions within the ED. Arising form the new developments it has tried to optimise existing space and developed the transit lounge and admissions unit. Significant commitment is needed from the hospital's other specialties to support this. There needs to be greater evidence of Pan-hospital support for this strategy if it is to be fully endorsed.

Hospital focus on wait time / volumes

- The hospital has achieved significant reductions in both wait times and volumes
- The hospital was largely compliant with wait time targets in August 2006.

Recommendations

Capacity

- In relation to improving access to appropriate long-stay facilities, there is potential for fruitful collaboration, building upon existing relationships, with local PCCC providers (including Donnybrook and Leopardstown) which should be accelerated and formalised in consultation with key stakeholders, including consultants in geriatric medicine. This could further speed up appropriate discharges and potentially avoid admissions. The Task Force is supportive of the work between SVUH, PCCC and the Royal Hospital in Donnybrook in this regard.
- There needs to be a defined vision of the extended hospital network so that the overall capacity is optimised.

Capability

- The hospital has identified a number of proposals aimed at diverting and fast-tracking patients, which should be supported. These include a transit lounge, clinical decision unit, and a chest pain assessment unit. The Task Force would suggest that these need to be developed within a pan-hospital control structure that ensures the benefits secured directly effect ED volumes and wait times.

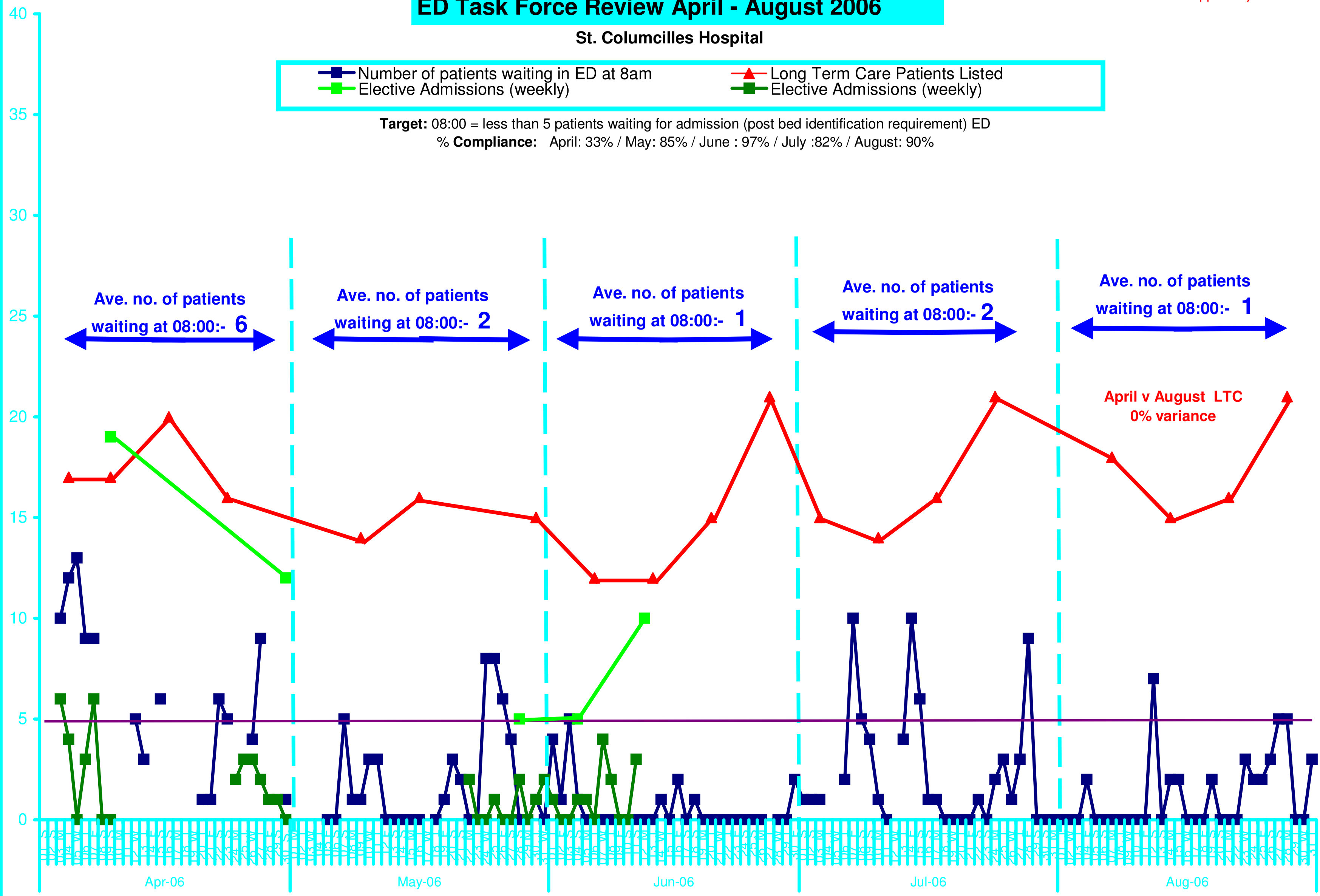
Control

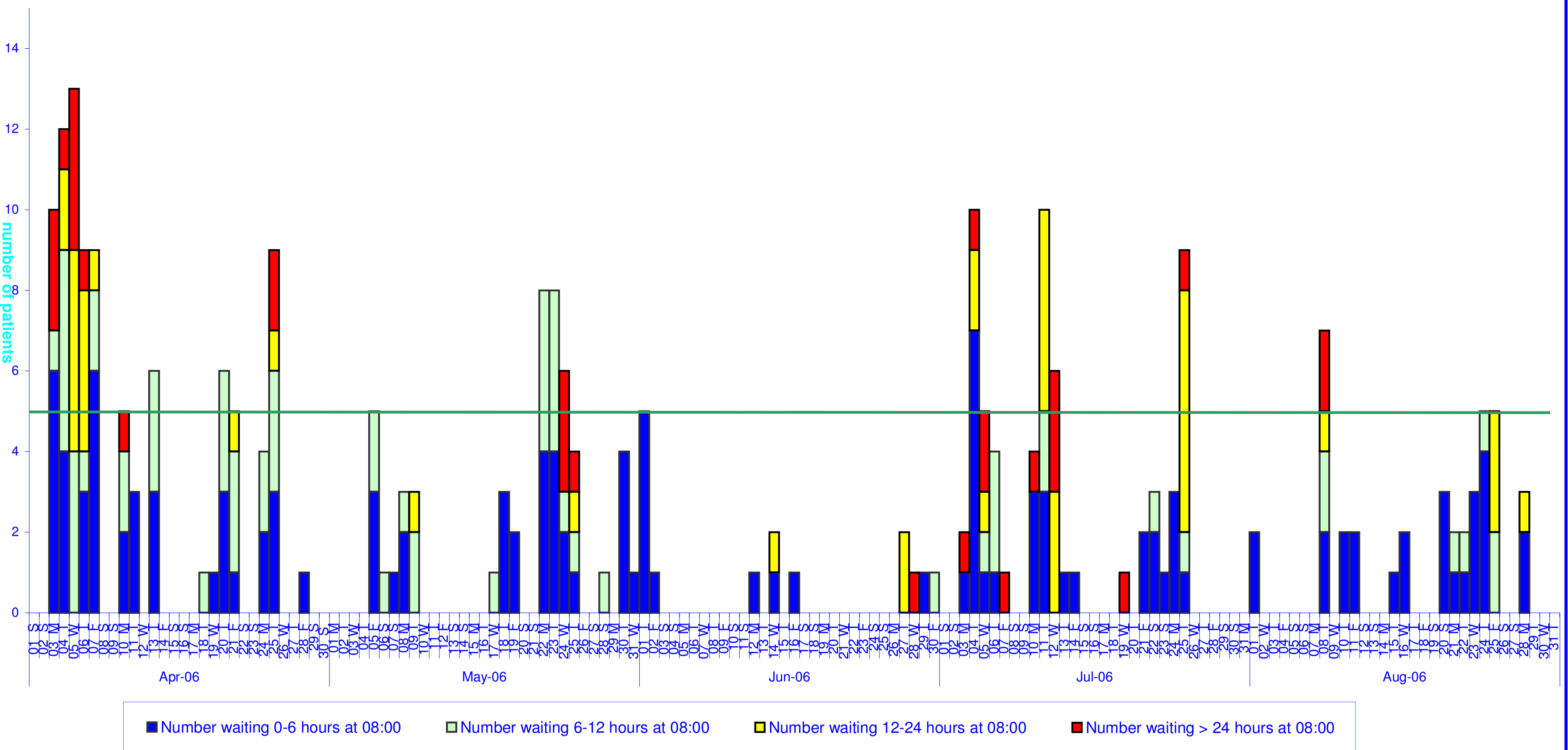
- The Task Force's overall analysis supports the finding that solutions to the Emergency Department pressures lay predominantly, outside it. A number of the proposals from SVUH seek to address emergency pressures though the building up of dedicated resources to see and treat defined patient cohorts in the ED. This model has been successful in Australia. Before considering such a model, the Taskforce would recommend that for comparative purposes an alternative model be formulated thorough engagement with the wider hospital network.

St Vincent's University Hospital

		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
					2007		Annual revenue (€ million)	Capital (€ million)
Proposals	Capacity	Phase 2 AMAU	Reduction in number waiting and waiting time				(2.2)	
		Discharge Lounge	Reduce ALOS		June			
	Capability	Develop appropriate alternatives to acute admission for those elderly patients likely to require extended care	Free up Bed capacity, joint initiative with PCCC and Royal Hospital Donnybrook		Feb	7	.613(PCCC)	PCCC
		TIA Clinic	Reduce TIA admissions ,save 580 bed days PA		Feb	1	0.06	
		Management of DVT	Clear pathway for DVT patients .Reduce LOS by 50% - save 120 bed days		Feb	1	0.06	
		CPEU	Reduce ALOS by 75% - 275 bed days			2	0.126	
		Early Discharge facility for plastics , oncology and vascular patients	Admission to discharge reduced for Elderly and Young Chronic Sick			3	0.200	
		Cardiac Failure Clinic	Immediate specialised care for patients with chronic illness			2	0.117	
	Control	Enhanced Senior decision Making	Geriatrician Consultant		2007	4	0.616	
		Respiratory Failure Clinic	COPD, alternative admission route for patients that present to ED50% reduction in ALOS – 4,900 bed days		Feb	3	0.542	
		Admission and Discharge policy	Clear clinical pathways		Feb	1	0.06	
		Audit Groups			Feb			
		Extended working day for diagnostic services – based on shift	Rapid access to diagnostics		March			
	Totals					**24**	**2.394**	**0**

St Columcille’s Hospital, Loughlinstown


ED Task Force Review April - August 2006
St. Columcilles Hospital
Data supplied by HSE
Number of patients waiting in ED at 8am
Elective Admissions (weekly)
Long Term Care Patients Listed
Elective Admissions (weekly)
Target: 08:00 = less than 5 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 33% / May: 85% / June : 97% / July :82% / August: 90%
Ave. no. of patients waiting at 08:00:- 6
Ave. no. of patients waiting at 08:00:- 2
Ave. no. of patients waiting at 08:00:- 1
Ave. no. of patients waiting at 08:00:- 2
Ave. no. of patients waiting at 08:00:- 1
April v August LTC
0% variance
40
35
30
25
20
15
10
5
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06



Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
St. Columcilles Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 40% May: 53% / June: 67% / July: 43% / August:64% compliant
number of patients
0
2
4
6
8
10
12
14
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

Although outside of its remit the subgroup noted that there are issues in relation to the strategic direction of the hospital and it's interactions with the acute providers in the area. The task force examined the hospital within the existing construct but believes that even incremental change needs to be informed by a wider strategic perspective on that nature and types of services to be developed by the hospital.

Capacity

- The hospital operated at approximately 91% occupancy between April and August 2006.
- There is very good ED linkage with St Vincent's Hospital but potential for greater linkage and resource sharing in other areas of hospital operations.
- Delayed discharges - there has been a significant improvement in volume and wait times following the first allocation to the hospital of long-stay beds. Need for continued private beds and access to public facilities.

Capability

- In terms of senior decision making the in-house consultant capacity both medical and surgical limits the resource, which is available to consistently manage solutions
- Significant access problems were reported around diagnostics. If this cannot be addressed in the short term then use of external providers should be considered. In the medium term a strategy is required which will determine the optimum diagnostic capacity on site based on acute and community needs, volume, cost and quality.

Control

- There is evidence that ED receives a hospital wide focus. A series of individual proposals were identified but there is a requirement for a cohesive plan that links individual initiatives directly to the targets.

Hospital focus on wait time / volumes

- The hospital has secured significant improvements in terms of volume and wait times
- In August, the hospital was fully compliant with volume targets and largely compliant with wait time targets of 24 hours or less.

Recommendations

Capacity

- The hospital identified challenges associated with a high level of complicated admissions from nursing homes. Many of these patients have been discharged from the major academic teaching hospitals to nursing homes in St. Columcille's catchment area and when they become unwell they are admitted there. The Task Force recommends that St Columcilles should develop an elderly care strategy for the management of patients that are admitted from nursing homes following discharge from other hospitals.

Capability

- In relation to addressing the Senior Decision making requirements, at a minimum there needs to be one surgeon and physician on site daily to enable efficient decision making. Shared working arrangements need to be utilised to ensure close cooperation in the management of the total hospital inpatient workload. There are many multi – site consultant appointments.

Control

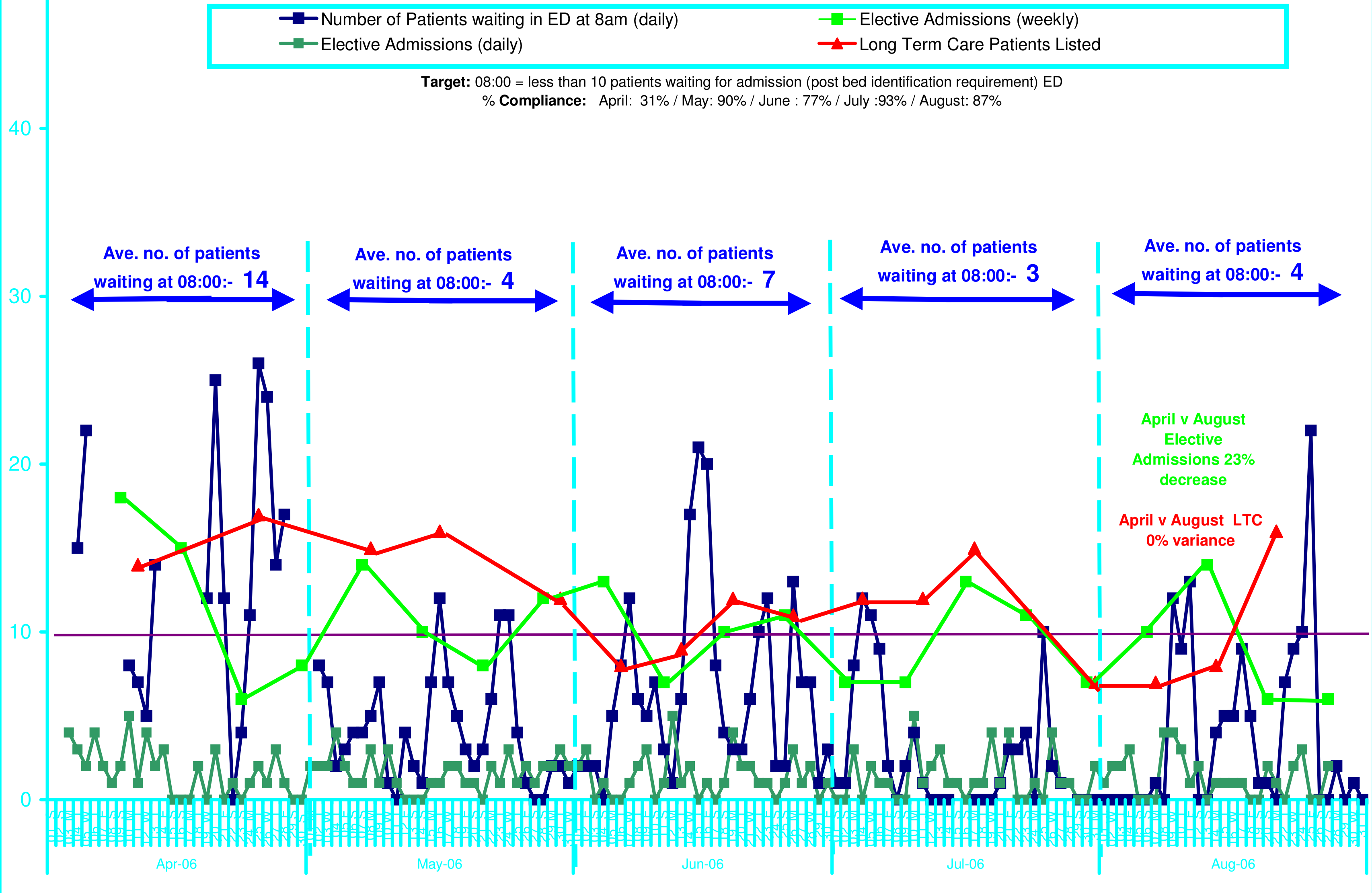
- There is a clear opportunity to develop a joint strategy with SVUH, St. Michaels Hospital Dun Laoghaire, Leopardstown Park Hospital and the Royal Hospital Donnybrook in the management of ED referrals, ED admissions, admission alternatives and in supporting the early discharge of patients who have completed the management of their acutely presenting episode.

St Columcille's Hospital, Loughlinstown

Proposals		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	2007		Annual revenue (€ million)	Capital (€ million)
	Capacity	**Development of Admission Lounge**	**Enhanced surroundings and reduction in number accommodated on trolleys Query Revenue costs**	**3 months**			**(0.35)**	**(0.25)**
	Capability	Dedicated Stroke Unit with links to St. Vincent's	Significant reduction in ALOS of Stroke patients	6 months		10	0.46	
		Rapid Access Clinical Evaluation service for elderly	Reduced elderly attendance and admission		2007	7	0.29	0.065
		Enhanced Occupational Therapy Service	Direct GP access to OT services. Reduced demand on ED. Admission avoidance and enhanced discharge process for elderly. Community outreach	6 months		3	.2	0.025
		Rapid Access Social Work service	Diversion of non medical admissions for patients and enhanced discharge process	3 months		1	0.062	
	Control	ANP service in ED	Reduction in re-attendances and admissions from ED	2 months		4	0.192	
		Respiratory Nurse Specialist	Reduction in ED wait time and reduced number of admissions			1.5	0.066	

	Totals		**26.5**	**1.27**	**.090**

Naas General Hospital

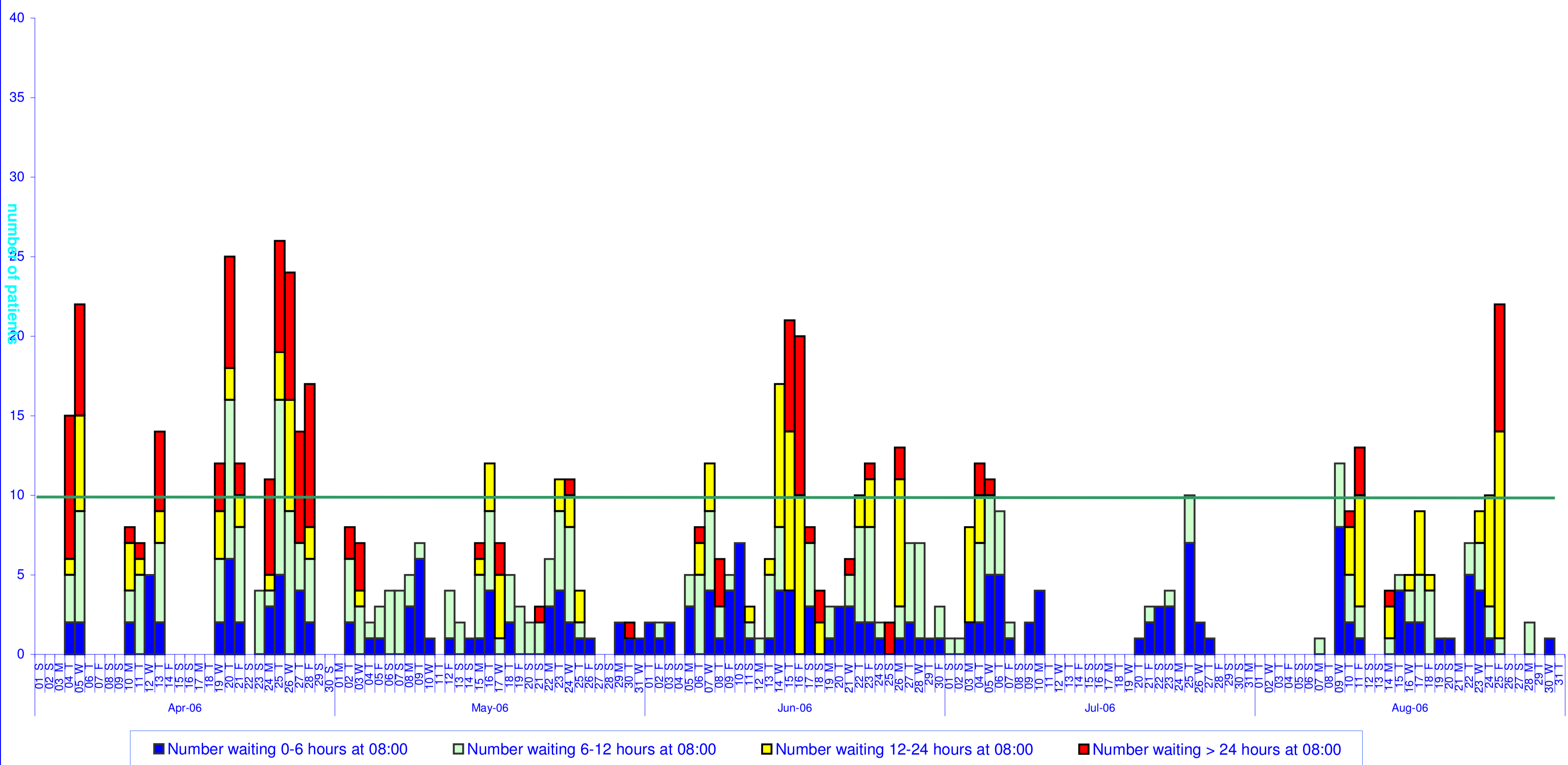

ED Task Force Review April - August 2006
Naas General Hospital
Data supplied by HSE
Number of Patients waiting in ED at 8am (daily)
Elective Admissions (daily)
Elective Admissions (weekly)
Long Term Care Patients Listed
Target: 08:00 = less than 10 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 31% / May: 90% / June : 77% / July :93% / August: 87%
Ave. no. of patients waiting at 08:00:- 14
Ave. no. of patients waiting at 08:00:- 4
Ave. no. of patients waiting at 08:00:- 7
Ave. no. of patients waiting at 08:00:- 3
Ave. no. of patients waiting at 08:00:- 4
April v August Elective Admissions 23% decrease
April v August LTC 0% variance
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06

Data supplied by HSE

Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED

Naas General Hospital

Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 17% May: 30% / June: 28% / July: 54% / August: 28% compliant



Findings

Capacity

- The hospital operated at approximately 95% occupancy between April and August 2006.
- The Emergency Department in Naas operates against a backdrop of transformation in physical infrastructure and a limited increase in staffing. The physical infrastructure of the Emergency department is very good. .

Capability

- Good diagnostic capability, with the exception of ultrasound where there are process issues.
- The reliance on agency staffing as part of hospital development is seen to pose efficiency/effectiveness challenges. The over reliance on agency nursing staff due to factors associated with the commissioning of the new hospital and the expansion of services need to be addressed.

Control

- Discharge planning and bed management functions are under resourced. Additionally there is a requirement for greater clinical leadership among the medical staff to reflect the recent growth in consultant numbers.

Hospital focus on wait time / volumes

- The hospital has achieved significant improvements in the volume of patients waiting but continues to have patients waiting more than 24 hours once a decision to admit has been taken.

Recommendations

Capacity

- There is potential for several local community residential units to be utilised for consultant-supervised transitional care of appropriately selected patients.

Capability

- ***Senior Decision making;*** the task force sub group felt that an increase in senior decision making both in the Emergency departments and in house would be the man driver of performance improvement. Introduction of additional senior decision makers needs to be supported by close cooperation across medical and surgical teams and an emphasis on discharge planning amongst existing and new staff.
- ***Clinical Leadership****,* the idea of the Medical assessment unit is worthwhile however for it to function effectively there will need to be active clinical leadership and compliance with robust operational protocols.
- ***Chronic Disease management****,* there is considerable scope for the development of chronic disease management programmes in line with the task forces overall recommendations.

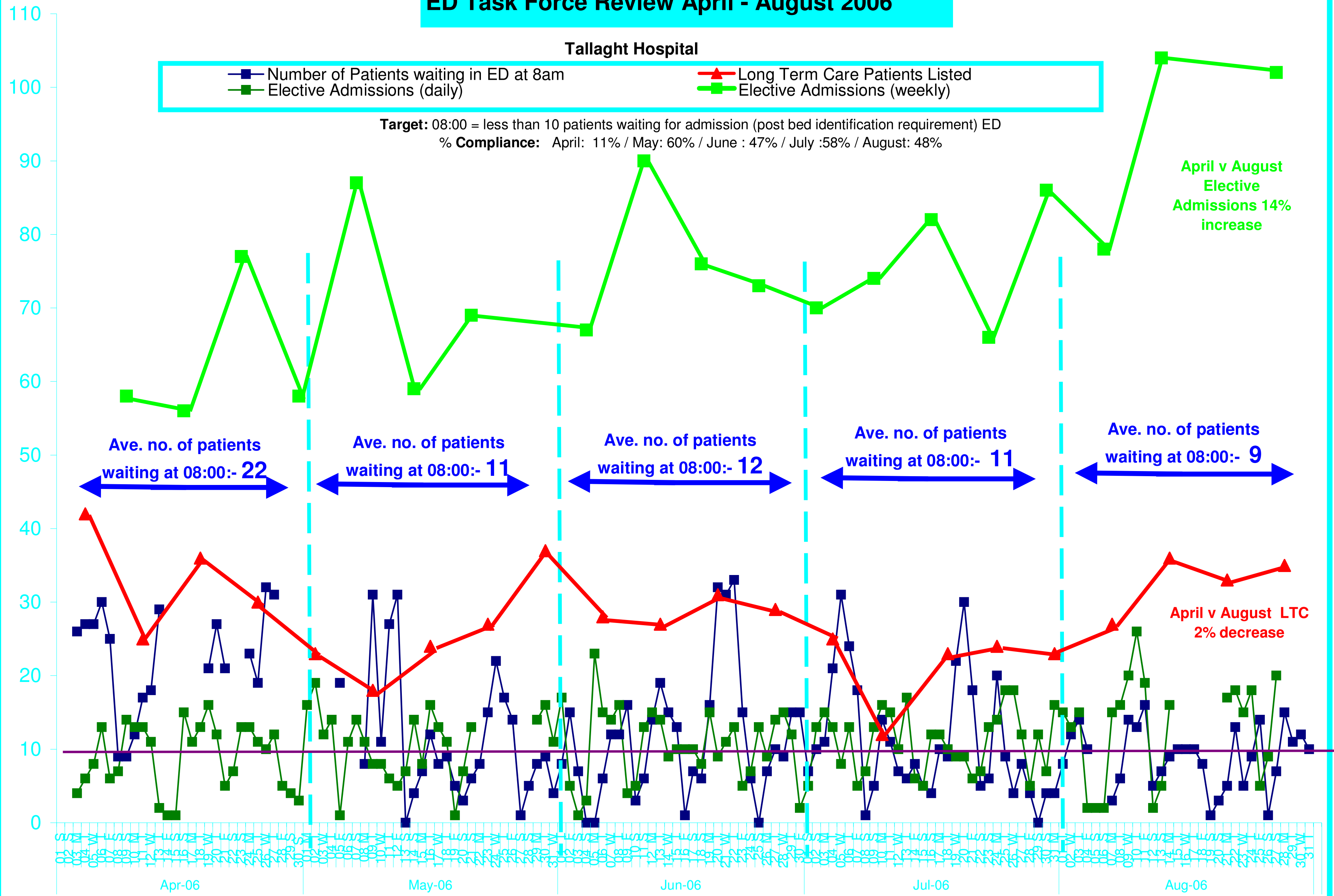
Control

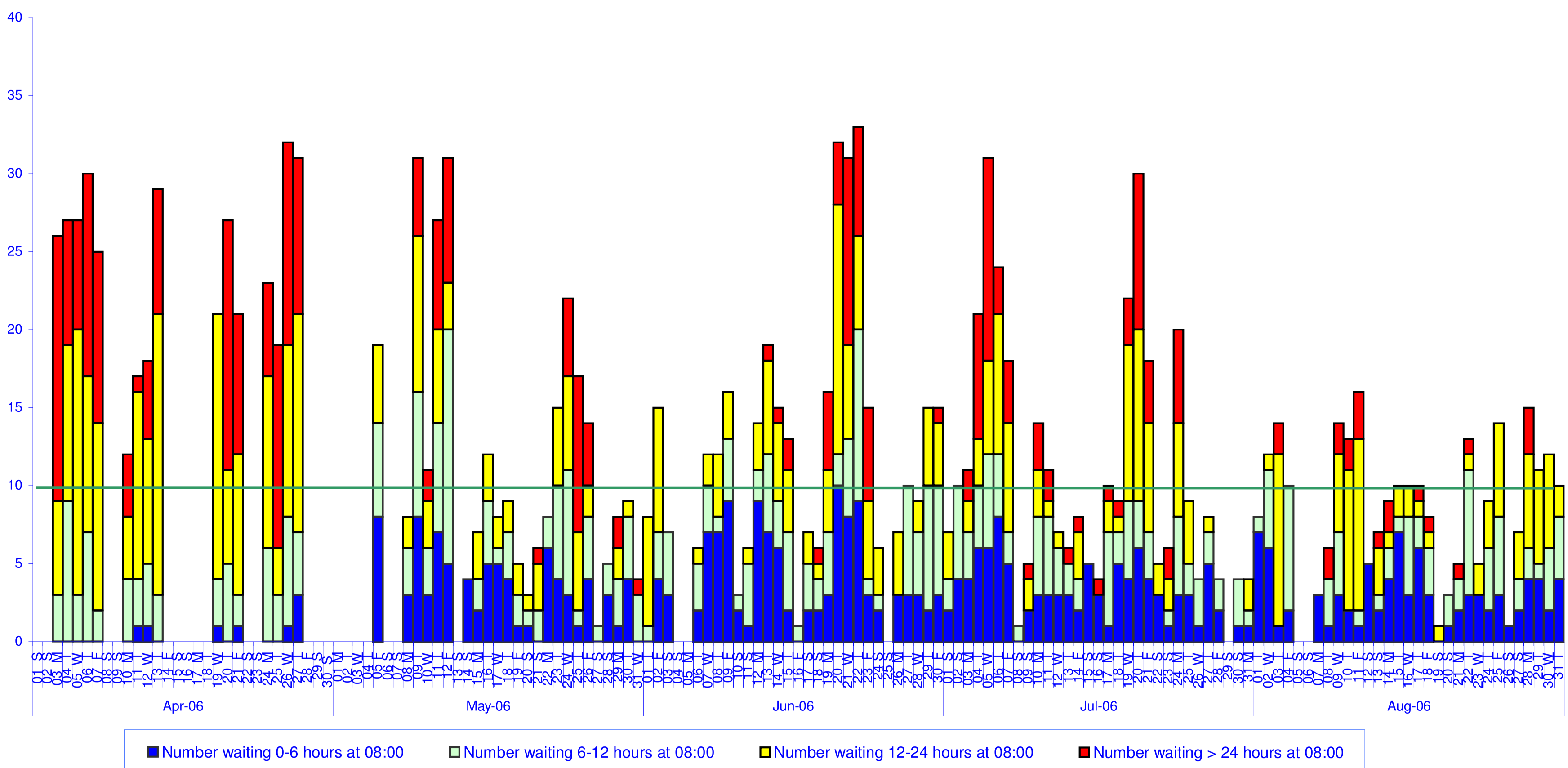
- There is work underway on discharge planning, with an increase in dedicated staff.
- However, there is a need to ensure work patterns are consistent with contemporary international practice and optimal patient processing. For example, new consultants in prospect can leverage greater teamwork, discharge planning and clinical leadership across the new and existing complement of staff.

Naas General Hospital

		Proposal	Impact on ED Volume / Wait Time			WTE	Financial	
				2006	2007		Annual revenue (€ million)	Capital (€ million)
Proposals	**Capacity**	Additional Long stay requirements	Reduce waiting times for patients to be accommodated in more appropriate setting		March		PCCC	
		Establish 10-bed transit ward/AMAU	Reduction in wait time and better access to appropriate accommodation		June	13.5	0.79	(0.35)
	Capability	Additional Occupational Therapy Joint hospital / community OT Service	To facilitate timely discharge home		July	3	0.18	0.2
		Additional Radiology and Ultrasound capacity	Direct GP access to diagnostics. Also to facilitate speedier discharge.		March	1	0.109	
		Additional Consultant in Emergency Medicine	Faster access to senior clinical decision-making		June	1	0.25	
	Control	Enhance Discharge Planning service	Discharge co-ordinator to enhance discharge process and free in patient capacity. Reduction in ED wait time		July	2	0.130	
		Extend bed management opening hours to 8am – 8pm	Facilitate early discharge		March	0.5	0.047	
	Totals					**21**	**1.506**	**.2**

The Adelaide and Meath Hospital incorporating the National Children's Hospital, Tallaght


ED Task Force Review April - August 2006
Tallaght Hospital
Number of Patients waiting in ED at 8am
Elective Admissions (daily)
Long Term Care Patients Listed
Elective Admissions (weekly)
Target: 08:00 = less than 10 patients waiting for admission (post bed identification requirement) ED
% Compliance: April: 11% / May: 60% / June : 47% / July :58% / August: 48%
Data supplied by HSE
Ave. no. of patients waiting at 08:00:- 22
Ave. no. of patients waiting at 08:00:- 11
Ave. no. of patients waiting at 08:00:- 12
Ave. no. of patients waiting at 08:00:- 11
Ave. no. of patients waiting at 08:00:- 9
April v August Elective Admissions 14% increase
April v August LTC 2% decrease
110
100
90
80
70
60
50
40
30
20
10
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06


Data supplied by HSE
Emergency Department Activity Review April - August
Number of patients waiting for admission
(post bed identification requirement) ED
Tallaght Hospital
Target 08:00 = 0 patients waiting > 6 hours for admission (post bed identification requirement) ED
Performance compliance: April 2% May: 29% / June: 32% / July: 29% / August:33% compliant
40
35
30
25
20
15
10
5
0
Apr-06
May-06
Jun-06
Jul-06
Aug-06
Number waiting 0-6 hours at 08:00
Number waiting 6-12 hours at 08:00
Number waiting 12-24 hours at 08:00
Number waiting > 24 hours at 08:00

Findings

Capacity

- The Task Force identified that reductions in volumes and wait times in ED achieved in the current year were as a result of prioritising the re-balancing of emergency over elective workloads. The concern about relying on such measures was highlighted by the hospital. The Task Force notes that the level of elective activity in August represents a significant increase over the level of elective activity in April (50%) and would appear to have impacted on the establishment of the Transit Ward. This underlines the requirement for strong controls to ensure the balancing of the emergency and elective workloads.
- The issues in relation to delayed discharges are not as marked as in other Dublin Hospitals given the profile of the hospital's population. However, the hospital has benefited from the recent initiatives in relation to private long-stay beds and as a result, its delayed discharges were reduced to a satisfactory level. The requirement for consistent access to such beds was highlighted on the site visit and follow-up. Issues were also raised about difficulties in community interface, which require PCCC support, as well as internal improvements.
- The development of the AMAU is the biggest priority for the hospital. By agreement with the HSE in 2006, the hospital moved to address the dignity and privacy issue in the first instance having regard to the very significant volumes and wait times in ED. The next step must be to develop improved patient processes with a particular emphasis on the effective management of chronic disease and medical conditions. The establishment of the AMAU is key in this regard however the hospital needs to develop the internal capability to support the effective functioning of the AMAU.
- Delayed discharges reduced to satisfactory level. Issues were raised about difficulties in community interface, which require PCCC support, as well as internal improvements.

Capability

- Consultant manpower is seen to be a priority internal capability issue.
- Work is underway to map and streamline high impact processes.
- There is a dedicated project resource (including clinical leadership) in place to drive improvement.
- At the time of its visit, the Task Force observed a unified approach to the management of issues in ED.
- Greater clarity required on status of AMAU and associated operating procedures.

Control

- The Trolleys Action Group (TAG) within the hospital appears to have had some effect. However, the persistent problems in relation to volumes and wait times following the establishment of the Transit Ward point to a need for enhanced centralised controls on the bed base.
- Discharge planning has been enhanced by the multi disciplinary discharge planning team which was put in place on a pilot basis.

Hospital focus on wait time / volumes

- While the hospital achieved some early effects in relation to volume targets as a result of the long-stay initiatives, and recently following the establishment of the Transit Unit it is still not fully compliant with volume targets.
- In relation to wait time targets, the hospital has made considerable progress; there remain patients waiting more than 24 hours following a decision to admit.

Recommendations

Capacity

In relation to long stay facilities the issues for AMNCH are not as problematic as for the other DATHS. Notwithstanding this the correlation between long stay initiatives and numbers in ED is still applicable. Accordingly the hospital will continue to require constant access to long stay beds. A key consideration in this regard is access to beds for young chronic sick

Capability

- Diagnostics - In light of the limited capability of the existing CT scanner and the requirement to outsource capacity on an ad-hoc basis, there needs to a quantification of the volumes and associated cost so that an appropriate proposal around diagnostics can be brought forward.

- Establishment of the AMAU - The Task Force findings highlighted the need to develop internal clinical and patient processes and the importance of the AMAU in that context. There is a requirement to give greater clarity around the operational aspects of the AMAU and how it the services delivered will be supported by the general physicians. In relation to the supporting beds requirement for the AMAU, the use of the transit ward should be considered as an immediate priority so that these beds are optimised and the benefits for ED can be realised.
- Chronic Disease management, there is considerable scope for the development of chronic disease management programmes, particularly in COPD; and this should be conjointly developed with Naas and Peamount as a matter of priority. In this context, the pulmonary rehabilitation facility at Peamount which was approved under the A&E 10 Point Plan should be fully optimised by the hospital.

Control

- Discharge planning - has been enhanced by the establishment of the multi disciplinary discharge planning team. The multi disciplinary discharge planning team was put in place on a temporary basis. There is evidence that this was effective and the hospital and the Task Force would support the appointment of this team on a more permanent basis.

Centralised Bed control – A key requirement for the hospital is the development of internal management controls to ensure that there is appropriate placement of ED patients and a smoothing of elective workloads. In this context the management of the private elective workload is a priority.

Adelaide and Meath Hospital incorporating National Children's Hospital Tallaght

						Annual revenue (€ million)	Capital (€ million)
			2006	2007			
Capacity							
Capability	**AMAU proposal already submitted**				**To be confirmed**	**To be confirmed**	**To be confirmed**
	Additional Consultant in Emergency Medicine	Reduced patient wait time increased availability of senior clinical decision making		2007	1	0.250	
	Additional Consultant Physicians with s.i's in Respiratory Medicine	Better response time for specialist referrals, increased availability of senior clinical decision making		2007	1	0.400	
	COPD Outreach Service	Patients diverted from ED, reduced ED wait time. Decrease ALOS	3 months		3	0.2	
	1 additional Consultant Radiologists	Reduce waiting in ED, rapid reporting		2007	1	0.2	
	Diagnostics CT Scan	Replacement of CT facility with improved capability, improve turnaround time, increased		2007			(1 – Capital Plan)
Control	Multi-disciplinary Discharge Planning Team	Rapid discharge of appropriate patients, continued effective bed management. Already in existence on a temporary basis.			4	0.270	
Totals					**10**	**1.320**	**(1)**