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Deputy David Cullinane TD

Dáil Éireann

Leinster House

Dublin 2

PQ No. : PQ 19983/22

To ask the Minister for Health the classification criteria for hospital models; the list of hospitals currently classified for each; and if he will make a statement on the matter.

Dear Deputy Cullinane,

The Health Service Executive has been requested to reply directly to you in the context of the above Parliamentary Question, which you submitted to the Minister for Health for response. I have examined the matter and the following outlines the position.

Response:

The organisation of acute medicine services recommends four generic hospital models. The purpose of these models is to provide a clear delineation of hospital services based upon the safe provision of patient care within the constraints of available facilities, staff, resources and local factors. The level of service that can be safely provided in any hospital will determine which model applies.

Model 1 hospital Characteristics:

1. This hospital will be a community/district hospital, with sub-acute in-patient beds.
2. Admissions can be requested by a GP, consultant geriatrician and/or other consultants following agreement with the medical officer.
3. Patients with rehabilitation, respite and/ or non-complex palliative care needs and patients who remain under the care of GPs may be admitted appropriately to in-patient beds in this hospital. These patients will be managed under the care of a medical officer (e.g. a designated GP or groups of GPs) who will be supported as necessary by consultant physicians. All patients will have an appropriate care plan.
4. This hospital will not have an ED, ICU, high dependency unit (HDU), coronary care unit (CCU), or an AMU/AMAU/MAU.
5. As this hospital will not have an ICU, patients requiring a higher level of care will be transferred to the ISA model 2, 3 or 4 hospital.
6. There will be guaranteed transfer of patients whose clinical status deteriorates from the model 1 hospital to the ISA model 2, 3 or 4 hospital(s). Where a patient is critically ill (ICS Levels 2 and 3), the regional critical care retrieval team will effect safe transfer. Remote critical care

retrieval will include continued resuscitation, stabilisation and safe transport by the retrieval team (ref appendix 17.9).

7. Patients whose clinical status has improved sufficiently may be transferred from a model 3 or 4 hospital to a model 1 or 2 hospital for further care (i.e. bi-directional patient flow must also occur). However, patients should not be transferred if a 'Do Not Resuscitate' order is made and/or if patients make an informed decision to remain in the model 1 hospital.
8. The following services could be made available 5 days a week, based on local need:
    - Out-patient department (OPD)
    - Day services/ambulatory care assessments for older persons
    - Venesection/phlebotomy
    - Warfarin service
    - Chronic obstructive pulmonary disease (COPD) outreach service
    - Pulmonary rehabilitation
    - Supra-pubic catheter re-insertion Percutaneous endoscopic gastrostomy (PEG) tube re-insertion
    - Antenatal/postnatal clinics
    - Other services (depending on local policies and protocols)
9. Many of these services can be nurse-led and/or therapy-led with expansion of nursing and therapy practice in response to service need.
10. Clinical pharmacy services will be provided by clinical pharmacists attached to model 3 or model 4 hospitals.
11. All model 1 and 2 hospitals must have an in-house clinical pharmacy service or formal access to and reporting relationship with the service in a model 3 or 4 hospital.
12. All hospitals must have a person trained and responsible for infection prevention and control on site and formal access to advice from a consultant microbiologist/infectious disease physician

Model 2 hospital Characteristics:

1. This hospital will have a daytime MAU.
2. GPs will refer low-risk (i.e. unlikely to require high intensity cardiopulmonary and/or neurological support) medical patients for assessment in the MAU during daytime hours.
3. This hospital will provide in-patient and out-patient care for differentiated, low-risk medical patients, who are not likely to require full resuscitation. All patients will have an appropriate care plan.
4. This hospital will not have an ICU, so the patient will be assessed and tracked using the national early warning score (ref section 6.4) and where appropriate, this score will prompt an acute medicine response and if necessary, transfer to the associated model 3 or 4 hospital.
5. A patient's condition may deteriorate and after detection and treatment by acute medicine a patient's acuity level may be ICS Level 2 unstable or Level 3 (ref appendix 17.9) requiring critical care retrieval and transfer to ICU in a model 3 or 4 hospital.
6. There will be guaranteed acceptance of transfer of all patients who deteriorate by the associated model 3 or 4 hospital (bi-directional patient flow must also occur if required).
7. Patients requiring palliative, respite, rehabilitation and pre-discharge care and patients for direct GP to consultant referral (via MAU) can be admitted to this hospital.
8. Patients will be admitted from the MAU under the care of a named consultant, and outof-hours selected medical patients can be admitted by agreement between the G.P. and the on-call medical team/consultant.
9. The medical department and medical staff need to be part of a wider rotation under the governance of the acute medicine service in the ISA-linked model 3 or 4 hospital. During the day there will be appropriate NCHD presence in the MAU and wards.

10. The medical staffing at night will be a resident medical registrar/SpR and senior house officer (both of whom are advanced cardiac life support (ACLS) certified). In addition there will be a consultant on-call.
11. Nurse staffing at night will include a nurse manager/supervisor for the nursing services.
12. Therapy staffing will be at senior grade within each therapy discipline with additional therapy resource comprising staff and assistant grade positions. Clinical specialists in ISA model 3 and 4 hospitals will provide advice and/or support as required.
13. Standards of care should be measured and should be comparable to those delivered in model 3 and 4 hospitals.
14. The hospital may have a minor injury unit (MIU).
15. The following day services could be made available 5 days a week, based on local need: •
    - Day surgery
    - Pre-operative clinics
    - Day services/ambulatory care assessment for older persons
    - Antenatal care/postnatal care
    - Endoscopy/PEG tube insertion
    - Non-invasive cardiology
    - Cardiac failure clinic
    - Cardiac rehabilitation service
    - Venesection, infusion and transfusion therapy
    - Bone marrow aspiration and trephine biopsy
    - Abdominal paracentesis and thoracentesis
    - Lumbar puncture
    - Diabetic day centre
    - Rheumatology day services
    - Dermatology day services
    - Oncology/haematology day ward
    - Mental health day services
    - COPD outreach
    - Pulmonary rehabilitation
    - Hepatology day services
    - Diagnostic imaging
    - Other services, depending on local policies and protocols.
16. Patient flow will be enhanced by expanded nursing and therapy practice (e.g. nurse prescribing of medicinal products and ionising radiation/X-rays and therapy facilitated discharge). These services will be developed in response to service need.
17. Clinical pharmacy services will be provided by clinical pharmacists attached to model 3 or model 4 hospitals.
18. All model 1 and 2 hospitals must have an in-house clinical pharmacy service or formal access to and reporting relationship with the service in a model 3 or 4 hospital.
19. All hospitals must have a person trained and responsible for infection prevention and control on site and formal access to advice from a consultant microbiologist/infectious disease physician.

Model 3 hospital Characteristics:

1. This hospital will admit undifferentiated acute medical patients.
2. This hospital will have an AMAU which will open on a 12 to 24 hour basis every day of the year (where the AMAU is closed at night medical patients will be managed by the on-call senior medical doctor in the 24 hour ED).

3. There will be an ED on site and there may be a clinical decision unit (CDU, ref section 5.2) on site as part of the ED service.
4. The hospital will have a category 1 or 2 ICU6 and may have a HDU (ref appendix 17.9).
5. There will be guaranteed bi-directional patient flow for appropriate medical in-patients between hospital models 1, 2 and 4. There will be bi-directional flow of critical care patients between hospital models 3 and 4.
6. There will be streaming to appropriate specialty units/wards as per protocols.
7. Where a patient requires category 3 or 3S ICU care the regional critical care retrieval team will effect safe transfer (ref appendix 17.9).
8. The medication needs and supplies for patients in model 1 and 2 hospitals will be coordinated through the model 3 hospital.
9. All hospitals must have a person trained and responsible for infection prevention and control on site and formal access to advice from a consultant microbiologist/infectious disease physician.

Model 4 hospital Characteristics:

1. This hospital will admit undifferentiated acute medical patients including tertiary referred patients.
2. There will be a category 3 or 3S ICU on site6 (ref appendix 17.9).
3. There will be an AMU present which is open on a continuous basis (24 hours, every day of the year).
4. There will be an ED, including a CDU on site.
5. There will be guaranteed bi-directional patient flow for appropriate medical inpatients between hospital models 1, 2 and 3. There will be bi-directional flow of critical care patients between hospital models 3 and 4.
6. Where a patient becomes critically ill in a model 1,2 or 3 hospital the regional critical care retrieval team will effect safe transfer to a model 4 hospital. Retrieval between model 4 hospitals will be required for national specialty transfers. Remote critical care retrieval will include continued resuscitation, stabilisation and safe transport by the retrieval team (ref appendix 17.9).
7. There will be streaming to appropriate specialty units/wards as per locally agreed protocols.
8. All hospitals must have a person trained and responsible for infection prevention and control on site and formal access to advice from a consultant microbiologist/infectious disease physician.(https://www.hse.ie/eng/about/who/cspd/ncps/acute-medicine/report%20of%20the%20national%20acute%20medicine%20programme.pdf)

Acute Medicine Hospital Models

Hospital	Model
BEAUMONT HOSPITAL	4
CORK UNIVERSITY HOSPITAL	4
GALWAY UNIVERSITY HOSPITAL	4
UNIVERSITY HOSPITAL LIMERICK	4
TALLAGHT UNIVERSITY HOSPITAL	4
MATER HOSPITAL	4
ST JAMES'S HOSPITAL	4
ST VINCENT'S UNIVERSITY HOSPITAL	4
UNIVERSITY HOSPITAL WATERFORD	4

CAVAN HOSPITAL	3
CONNOLLY HOSPITAL	3
OLOL HOSPITAL, DROGHEDA	3
UNIVERSITY HOSPITAL KERRY	3
LETTERKENNY UNIVERSITY HOSPITAL	3
MAYO UNIVERSITY HOSPITAL	3
MERCY HOSPITAL, CORK	3
MULLINGAR REGIONAL HOSPITAL	3
NAAS GENERAL HOSPITAL	3
PORTIUNCULA UNIVERSITY HOSPITAL	3
PORTLAOISE REGIONAL HOSPITAL	3
SLIGO UNIVERSITY HOSPITAL	3
SOUTH TIPPERARY HOSPITAL	3
ST LUKE'S HOSPITAL KILKENNY	3
TULLAMORE REGIONAL HOSPITAL	3
WEXFORD GENERAL HOSPITAL	3
OUR LADYS HOSPITAL NAVAN	3
BANTRY HOSPITAL	2
ENNIS GENERAL HOSPITAL	2
ST COLUMCILLE'S HOSPITAL, LOUGHLINSTOWN	2
MALLOW GENERAL HOSPITAL	2
NENAGH GENERAL HOSPITAL	2
ROSCOMMON UNIVERSITY HOSPITAL	2
ST JOHN'S HOSPITAL, LIMERICK	2

I trust this answers your question to your satisfaction.

Yours sincerely,

Emma Benton

General Manager

Acute Operations