

HSE West North West Multi-Agency Discharge Event (MaDE)

Patient Flow Academy Webinar

28th August 2025



Multi-agency discharge event

A Multi-Agency Discharge Event (MaDE) is a collaborative initiative aimed at:

- improving patient flow
- reducing discharge delays
- optimising bed utilisation
- brings health and social care partners together to streamline discharge processes



Multi-agency discharge event

Method:

- **Daily Data Collection:** Captured real-time hospital status to inform decision-making
- **Ward and ED Visits:** Teams assessed patient journeys, identified delays, and supported timely discharges
- **Complex Case Discussions:** Enabled real-time escalation and resolution of discharge barriers
- **Command Centre Operations:** Centralised coordination with pre-assigned roles and visual tracking tools
- **Hospital-Wide Communication:** Maintained through forums, visual tools, and consistent messaging

Approach:

- **Multi-Stakeholder Engagement:** Included IHA managers, senior hospital and community leaders and frontline staff
- **Integrated Working:** Hospital and community teams collaborated across boundaries to streamline patient flow
- **Real-Time Problem Solving:** On-the-ground presence and documentation enabled immediate action
- **Patient Focused:** Emphasis on understanding and improving individual patient journeys ***“Last 1000 Days”***

Preparation:

- **Crib Sheets and Training Sessions:** Ensured all participants were informed and aligned
- **Development of Documentation and Schedules:** Provided structure and clarity for the event
- **Pre-Populated Flip Charts:** Enabled quick visual reference and tracking in the command centre
- **Role Assignment:** Clear delegation of responsibilities to streamline coordination



Multi-agency discharge event - Data Collection Tool

Purpose

- To support Multidisciplinary Agency Discharge Events (MaDE) by simplifying patient data collection and improving discharge planning during the MaDE rounds

Key Features

- Simple and intuitive layout for ease of use
- Pre-populated patient data to reduce manual entry
- Structured prompts to guide consistent data capture
- Tracks Red/Green days, discharge readiness, and actions
- Flexible format adaptable to team needs

Implementation

- Collaborated with the team responsible for scribing data during rounds
- Delivered training sessions to ensure confident and consistent use of the tool

Action Tracking and Follow-Up

- An Excel template was used to capture live actions discussed during the event. These actions were categorised into Quality Improvement Projects (QIPs), Quick Wins, and Challenges. Each item was assigned an owner and a responsible team. The information collected was then fed into a tracker designed to monitor progress and follow up on all actions identified on the day

05/08/25



Multi-agency discharge event

Next Steps

A Multi-Agency Discharge Event (MaDE) is a collaborative initiative that brings together a variety of multidisciplinary team members from the hospital and community, that can truly make a difference to patient flow and egress

- Importance of bringing everyone together in a hospital environment – the power of integration
- Adopting this approach and building it into a standard approach to support patient flow across the region
- Modifying and using a smaller scale – all medical wards only, one day event, pre-October BH and in advance of Christmas and New Year
- Training up staff, fostering IHA ownership and business as usual
- Day to day operations of patient flow



Multi-agency discharge event Galway University Hospitals Profile



Galway University Hospital- two sites one hospital:

University Hospital Galway

- Emergency / Theatre Services, Critical Care, Cancer and a wide range of Tertiary Referral Services
- The hospital is a designated supra regional Centre for Cancer and Cardiac Services
- Secondary, regional and supra-regional West/North West
- One of the major academic teaching hospitals in Ireland, with academic partners with the University of Galway (UoG)

Merlin Park University Hospital

- Non-complex elective Medical, Surgical and OPD Services including renal dialysis, orthopaedics, respiratory, rheumatology and Interventional Radiology
- Acute rehabilitation service

| Galway University Hospitals | Level |
|--|--------------|
| University Hospital Galway (UHG) | 4 |
| Merlin Park University Hospital (MPUH) | 2 |

Challenges –Access, Bed Capacity
Infrastructure, Staffing

Action plans- Unscheduled Care
initiatives including patient flow
improvement projects (year 3 of
cycle), use of private hospital
capacity, development of
data/metrics to performance
manage



Multi-agency discharge event - GUH activity and challenges

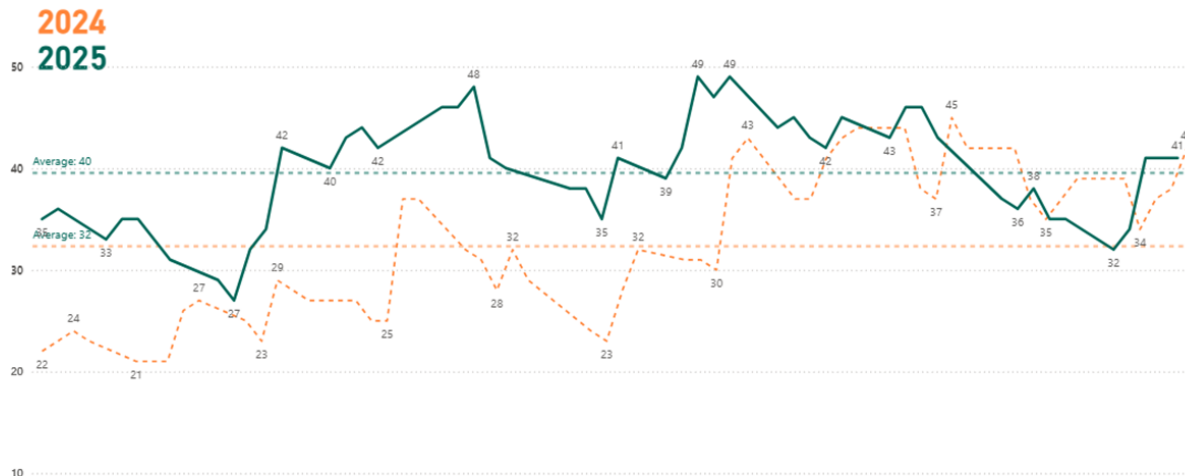
| Year ▲ | ED Attendances | ED Admissions | 8AM Trolley Count | Average Trolley Count |
|--------|----------------|---------------|-------------------|-----------------------|
| 2022 | 75,997 | 18,696 | 13054 | 36 |
| 2023 | 75,628 | 18,525 | ↓ 8252 | ↓ 23 |
| 2024 | ↑ 81,588 | ↑ 20,278 | ↓ 7994 | ↓ 22 |

Delayed Transfers of Care (DTOCs) 2024 & 2025 Weeks 1-10

Average DTOC
Week 1-10

2024 = 32

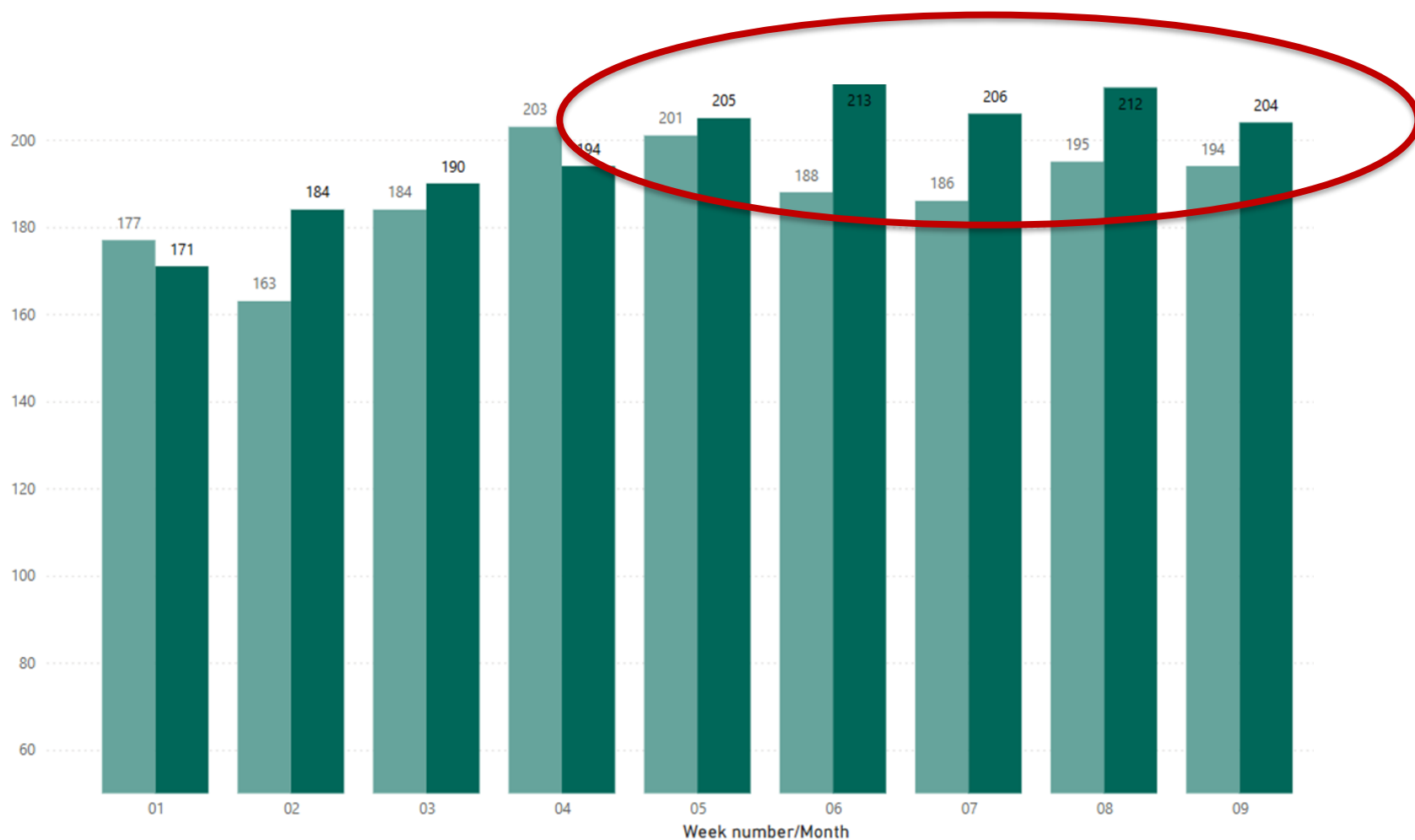
2025 = 40





Multi-agency discharge event - GUH activity and challenges

Total Patients >14 days 2024/2025 Week 1-9

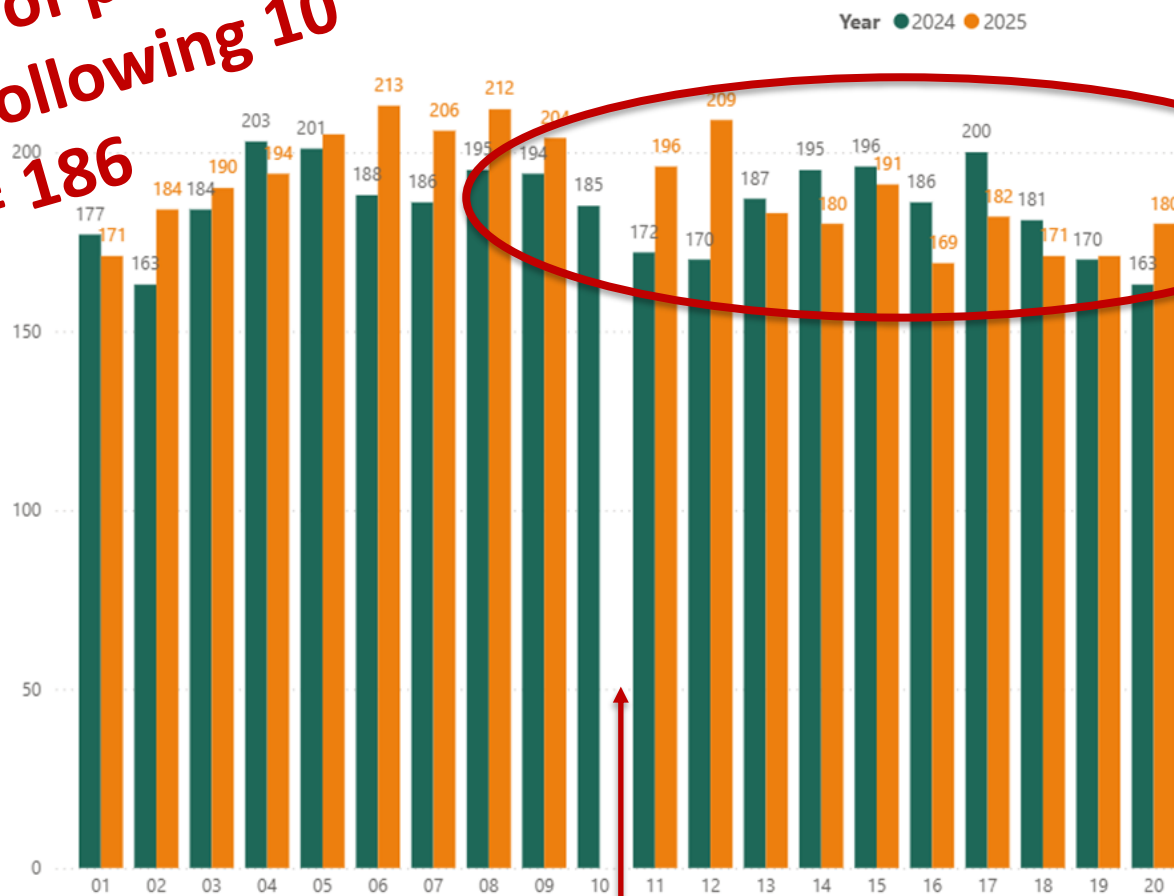




Multi-agency discharge event - GUH activity and challenges

Total Patients >14 days 2024/2025 Week 1-20

Average number of patients
post MaDE for following 10
weeks = 186



MaDE replaced ILOS round week 10



Multi-agency discharge event - GUH

Summary:

- 24 challenges identified on the day
- Team reviewed and drafted potential QIPs or corrective actions
- Monthly tracker to update status of QIPs
- Working groups convened to focus on particular QIPs
- In-person meeting held 4th June, plan to reconvene Sept 12th

Themes captured

Internal Challenges



Communication within and between MDTs e.g. Consults, HSCP referrals



Surge areas – limited capacity



Clear discharge planning- next steps/timelines



Red days awaiting procedure/ intervention



Logistics transport, bi-directional flow,



Complex patient profile

External Challenges



Access to egress facilities LTCF, Private beds



Communication between various services



Admissions not based on Medical need



Regular visibility of availability in the system



Access to Alternative pathways e.g. Rehab, OPAT, CIT



Multi-agency discharge event - GUH

Outcomes

- Working groups** specifically focused on-
- ✓ ED avoidance of “admissions without medical need”
 - ✓ ED management of frequent attenders
 - ✓ IT/reporting solution for community bed availability
 - ✓ Complex case management team
-
- Approval for staffing for EDTA surge area
 - **Accountability and decision making** as an MDT across services for patients
 - Ongoing **engagement** across services, following the patient journey
 - **Enhanced networking** across acute and community

Lessons learned

- Greater **understanding** of internal/external processes across services
- **More clarity** of each others roles and responsibilities
- Greater **knowledge** of the pressures felt within the acute system
- **Edit/Refinement** of bed utilisation tool for action based progression of d/c
- **Stronger links** with sharing of patient details across their journey in the healthcare environment (e.g. PHN profile to ward managers on admission)



Multi-agency discharge event – Mayo University Hospital

- On the 12th and 13th of March 2025, a multi-agency discharge event was carried out in Mayo University Hospital (MUH). The primary goal of this event was to unblock delays and simplify processes across the whole system, to free up beds, increase flow as part of an escalation process, to reduce length of stay and to increase morning discharges. 8 wards of different types were included over the two days

Keys learnings

- That although Planned Dates of Discharge were documented and updated they were nurse rather than medically driven
- It was essential that all patients had a medically documented PDD and shared on white boards
- An understanding of the complexity of the different resources available in community was useful for acute staff to understand wider health ecosystem available post discharge
- Some identified delays like MRI scans and Cardiac Investigations when discussed with consultants were not always essential prior to discharge



Multi-agency discharge event - MUH

- Better understanding in the community of the complexities of integrated discharge
- We need to build relationships with onward care location providers – need for clear communication, comprehensive assessment of care needs
- Full disclosure on discharge to location receiving patient – e.g. behavioural issues, family complexities, ADMA, What Matters to the Patient
- Understanding on the use of White Boards in managing discharges was very helpful and this has now been implemented in the District Hospitals for the management of discharge, length of stay and DTOC's in these locations
- Everyone involved in patient flow needs to have a knowledge of the local health ecosystem and what services/supports are available. Having community representatives in the room was a big help
- There is an urgency to change practice in public units regarding the filling of beds – need to bring people into the patient flow space and increase understanding of integrated bed management. This is difficult work and requires patience, and a spirit of co-production on what the new processes need to look like



Multi-agency discharge event - MUH

- The MaDE event held in Mayo University Hospital led to the identification of a number of key challenges. As a result a dedicated Working Group was established to monitor progress, meeting fortnightly to maintain focus and ensure delivery. 17 Quality Improvement Projects (QIPs) were identified by the Working Group
- One of the significant outcomes of the MaDE event was the formation of the Mayo Integrated Working Group, which brings together both Community and Acute services in Mayo with a focus on patient flow. This group was chaired by the IHA Manager Mayo in the initial set up and is now handed over

Improved Management of Delayed Transfers of Care (DTOCs)

- The MaDE event also provided a valuable opportunity to strengthen the management of Delayed Transfers of Care (DTOCs) in Mayo University Hospital
- In May, an Integrated DTOC and Complex Patient Management Group was established to enhance oversight and coordination



Multi-agency discharge event - MUH

- Initially chaired by the IHAM, it is now co-chaired by the Hospital Deputy General Manager and the Disability Services Manager.
- Heretofore, DTOC's were managed by Acute and Older Persons Services (OPS). The new integrated group brings together a broader representation, including:
 - Mayo University Hospital
 - Older Person Services
 - Primary Care
 - Disability Services
 - Home Support
 - ICPOP (Integrated Care Programme for Older Persons)

A SOP has been drafted to guide the work of the group enabling:

- review all DTOC and complex patients in MUH on a weekly basis.
- early identification and tracking of complex patients, enabling timely intervention before they become DTOC's.
- A tracked log of patients which is circulated weekly to ensure transparency and coordinated action



Multi-agency discharge event - Sligo University Hospital

- SUH overview – 333 inpatient beds
- **Challenges**
 - Highest older persons population in Ireland
 - Daily trolleys; 24 hr breaches; Increasing Occupancy rates; Delayed transfers of care
- **Highlights from MADE event**
 - Senior decisions made from acute & community present for 2 days
 - First time for this type of event
 - Commitment to improving experience/care for patients
 - Team of over 30 involved
 - 280+ inpatients reviewed
 - Active engagement with ward staff (nursing; medical; HSCPs) about patients discharge plans
 - Immediate action taken on wards by senior decision makers re discharge decisions
 - 4 complex patients given specific discharge discussion: agreed plans put in place



Multi-agency discharge event – SUH

- Several opportunities to improve flow when patients are already in an in-patient bed
- A structured Consultant Post-Take ward round helps highlight key flow parameters
- Ownership, particularly senior ownership of “Red” constraints towards discharge
- Targeting re-admissions to SUH from more appropriate neighbouring hospitals
- A Quality Improvement Methodology to target care home residents admitted after 5pm
- Targeted liaison with diagnostic services such as Radiology Dept for “Red” constraints
- Standardising Supported Discharge Access across county boundaries to eliminate variation
- Improving the recognition and use of what “*Acute Medical Offsite*” bedded unit can offer
- QIP on Management of Challenging Behaviours/BPMD
- The use and misuse of Telemetry Beds....and the wait for these. Educational event
- ICTOP referrals out of area. Single point of access to eliminate delays
- Weekend discharging ward rounds



Multi-agency discharge event - SUH

Multidisciplinary Collaboration:

- Strengthened inter-agency communication: Quarterly MADE MDT events to sustain collaboration.
- Unified participants around shared goals. Consultant presence enhanced decision-making during Ward Rounds

Acute & community Integration

- Valuable insight for community staff into ED pressures. Inclusion of Community Directors of Nursing in future events
- Highlighted interdependence between community and acute services. Affirmed Patient Autonomy in discharge decisions when capacity is present

Discharge Planning and Patient Flow

- Facilitated discussion on complex, long-term patient cases. Provide clarity on Community Services and operations e.g. NHSS & H/S
- Consultant intervention enabled patient transfer through direct assurance. Emphasised the need for decision-makers with authority to drive change

Education and Empowerment

- Enabled constructive, safe-space dialogue around discharge decisions. Promoted the “One Thousand Day” concept
- Highlighted the pivotal role of CNMII in both community and acute hospitals

Sláinte Care Alignment

- Reinforced Sláintecare principles: Right Care, Right Place, Right Time, Right Team
- Revitalised the Model Ward approach in community short-term care units
- Advocated for stronger focus on Sláintecare to ease acute service demand by strengthening primary and community care services



Multi-agency discharge event – Letterkenny University Hospital





Multi-agency discharge event - LUH

Outcomes of the MaDE

- 37 Red Day Cases identified and discussed
- 18 Challenges identified
- 4 Complex Cases discussed
- 9 QIPs
- 17 Quick Wins
- 14 Actions for progression or further discussion
- 5 WIPs at end July 2025
- 17 cases closed out by end July 2025

Outcomes – identified solutions and avenues for investigation, by Pillar:

- **Avoidance Operations**
- **In-House Operations**
- **ED operations**
- **Discharge Operations**



Multi-agency discharge event - LUH

Lessons Learnt:

1. Operating as an integrated service requires integrated working
2. Sites can benefit from a collaborative approach to
 - Regular monitoring and evaluation of established processes, pathways, and approaches to care across the integrated care spectrum
 - Identifying and addressing simple causes of delays/information flow issues through the 'Quick Win' approach
3. Discussion of cases allows staff to question and discuss existing practices, and identify areas for improvement
4. In-person and online meetings – 3-month focus and close out – benefit of **targeted** approach
5. Real-time updates and real-time closeout of actions

Quick Wins can include:

1. Recirculating SOPs / Process flow charts
2. Regular revision and circulation of contact lists
3. Including SOPs, process documents and contact lists in staff email updates /ward induction packs

QIPs: Flagging and addressing systemic causes of delays including:

1. Gaps in resources
2. Training and education needs (including education and awareness on roles of other linked services)
3. Developing and revising SOPs / Process flow charts
4. MDT approaches
5. Pilot projects (small cohort, timebound, expert-led, scalable)
6. Improving communication flow / identifying key communicators of information

Complex Cases:

1. Are multidisciplinary and feature unique issues, so won't fit neatly into standard processes, pathways and approaches to care
2. Benefit from a deep-dive approach
3. Benefit from escalation for integrated, MDT discussion and decision-making
4. Account for high use of bed days (Addressing issues can significantly improve DTOCs)
5. Need responsible persons assigned, to progress identified actions
6. Often require lateral thinking and alternative approaches to problem-solving
7. Key points from IHA perspective – benefits for WP/UEC planning, Estimates planning, identification of systemic issues across RHA vs site-to-site issues



Multi-agency discharge event

Regional and IHA Value of MADEs – Key Takeaways

1. Value of Integrated Working

- Senior decision-makers in the room:
- Face-to-face collaboration
- Clear frameworks
- Partnerships with onward care providers

3. Communication and Information Sharing

- Safe, open dialogue
- Comprehensive discharge information
- Community voices
- Practical tools

5. Challenges and Change Management

- Cultural change in public units
- Persistence and co-production
- Community awareness

2. Shared Learning and System-Wide Improvement

- System-wide sharing
- Debrief sessions
- Case reviews
- Embedding improvements

4. Patient-Centred, Holistic Care

- Patient-first focus
- Holistic information
- Complex case interventions

Conclusion:

Effective integrated discharge relies on real-time decision-making, strong relationships, open communication, and a patient-centred approach. Embedding these practices system-wide delivers both operational efficiency and improved patient outcomes.



Multi-agency discharge event – West North West Region



Donegal



Galway



Sligo



Mayo