Forum for National Clinical & Integrated Care Programmes

BOOK OF ABSTRACTS
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The journey to person-centred integrated care - NEW WAYS OF WORKING
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1. Improving the Care of Patients with Sepsis – A National Approach

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Consider for Poster Presentation

Abstract

In 2014, Ireland published National Clinical Guideline, No 6: Sepsis Management. Its development and implementation was supported by National Clinical Strategy and Programmes, Health Service Executive (HSE) and the National Clinical Effectiveness Committee (NCEC), Department of Health. The guideline was quality assured by the NCEC, endorsed by the Minister for Health and later accredited by the National Clinical Institute for Excellence (NICE). The guideline outlines the importance of early recognition and appropriate treatment and referral of patients with sepsis, ensuring maximum survival opportunities and reducing chronic sequelae associated with sepsis survival. The guideline also provides clinical decision support tools to help achieve this.

A five-year implementation plan commenced in 2015 with the National Sepsis Team embarking on a nationwide programme of site visits to inform and educate. Two National Sepsis Summits promoting the guideline and showcasing individual hospital initiatives and experience of implementing the guideline were also held. The HSE appointed six Group Assistant Directors of Nursing, (ADONs) for sepsis, one for each Hospital Group, to support implementation of the guideline at local level and to work as part of the National Sepsis Team.

In 2016 a phased roll-out of structured education began and hospitals started using the clinical decision support tools. Compliance audits were also conducted as planned. Through collaboration and empowerment of sepsis committees at local level, progress on identifying and addressing issues has been made in all hospitals.

The National Sepsis Team is also engaged in extending the sepsis agenda via national projects including, e.g. development of sepsis pathways for maternity, primary care, paediatrics and neonates and an eLearning programme for on-going education.
2. Guidance for healthcare staff: Advance Care Planning and Advance Healthcare Directives with People with Dementia

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Co-authors:
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Aim:
To develop guidance in relation to advance care planning and advance healthcare directives with people with dementia for health and social care professionals in Ireland following recent enactment of The Assisted Decision Making (Capacity) Act 2015

Methods:
An expert advisory group was established. A systematic literature review, searching online databases, CINAHL and PubMed was carried out. Grey literature was also accessed. The themes were presided on by the expert advisory group. Identified literature review themes directed the scope of the guidance.

Results:
288 articles were deemed appropriate. Themes were identified. Post review with the expert advisory group guidance based on the literature and legislation was devised on the following areas:

Developing understanding of advance care planning
Developing understanding of advance healthcare directives
Developing understanding of the decision making supports

Conclusion
The final document is available for health and social care staff caring for people with dementia. It hosts up to date information and has the potential to impact on the care provided to people living with dementia.
3. Is it safe to feed? - Establishment of a dysphagia management programme to Nursing Homes as part of a SLT service initiative.

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Abstract:

Background: Speech and Language Therapy (SLT) services have historically been concentrated in acute settings with limited or no access to services in the community or residential care settings. This situation presents avoidable risk of acute hospital admission, social isolation, and even life threatening illness. Nursing home staff play a significant role in implementing SLT dysphagia management guidelines when feeding residents. Aims: The aim of this project was to develop, implement and evaluate a dysphagia management programme across two nursing home settings as part of a SLT service initiative. Change Process: The HSE change model (2008) was used to guide this project. Twenty training sessions were delivered across the two nursing homes to 251 (97%) of total staff. Evaluation: Kirkpatrick's 'Four level evaluation model' (1994) was used to evaluate this project. This included a feedback form, pre, post, and follow up training knowledge questionnaires and an observational checklist to evaluate levels 1-3 of the training. Evaluations demonstrated that learning was achieved with an increase in attendee's knowledge and skills of dysphagia management (net gains of 22% - Nursing Home A & 17% - Nursing Home B). Organisational Impact & Conclusion: The data gained can be used to establish new standards of dysphagia education and performance. SLT dysphagia management training is effective in increasing staff's knowledge and learning. It is intended that through the SLT training and service provision that nursing home patients receive the highest standards of dysphagia care and related negative consequences are reduced and eliminated.
4. Loss and Grief in Dementia

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Aim:
A range of losses occur throughout a person’s journey with dementia. Losses occur for the person and for their families as the disease progresses. Grief as a result of these losses is under-recognised and under-reported by people with dementia and their families. The aim of this work is to develop a guidance document and factsheet to support healthcare staff to recognise, acknowledge and respond to loss and grief in dementia thus enhance the provision of person centred care.

Methods:
An Expert Advisory Group (EAG) was convened. The group followed the National Clinical Effectiveness Committee approach to developing guidelines which included literature reviews, consensus building and consultation with key stakeholders.

Results:
The guidance document and factsheet are available to support healthcare staff in working with loss and grief in dementia. Key considerations for good practice are listed. The guidance focuses on 3 key areas: loss and grief for the person with dementia, loss and grief for families and loss and grief for staff. Resources are listed for each of these areas.

Conclusion:
Recognising loss and grief as part of the experience of having dementia is a core part of good person centred dementia care. Provision of supports to people with dementia and their families at transition points is essential.

5. Supporting people with dementia to die at home in Ireland

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Aim:
The Irish Hospice Foundation has funded a night nursing service for people dying at home with non-malignant illnesses since 2007. The number of people with dementia referred to this service has risen significantly since 2007 with 86 people with dementia accessing the service in 2014. The aim was to explore components of care which support a person with dementia who accessed the night nursing service to die at home.

Method:
Supplementary information was gathered from specialist palliative care teams (SPCT) for 50 dementia referrals to the night nursing service between May and December 2015. This information included demographic information, type of dementia, living situation, informal and formal care supports, out of hours supports and co-morbidities.

Results:
80% of the sample were women, average age: 85.
63% of the sample had co-morbidities
Families provided between 12- 24 hours of care per day with some formal paid supports.
GP support and/or availability to do home visits
was reported to be a significant support in 60% of the sample.

The Public Health Nurse was involved in 100% of cases.

Most people were referred to SPCT in the last week of their life.

Conclusion:

This audit demonstrates the range of supports and services that people with dementia need to die at home. Earlier referral to specialist palliative care teams may support and enable more people with dementia to remain at home. There is a need to increase awareness of the palliative care needs of people with dementia.

6. Empowering Home Helps to implement a service change to improve the quality and efficiency of the service delivered in the community.

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Aims.

1. To deliver a patient centred service to help older people to continue to live independently in their homes.

2. To support and relieve stress for carers and families, thus enabling them to continue to provide care.

3. Enhance and support existing services and foster a culture that is compassionate, transparent and accountable.

4. Staff in the HSE are an investment, we aim to empower home helps to deliver the highest level of care.

5. Improve work/lifestyle balance for home helps working within the organisation. Also ensuring compliance with the relevant legislation

6. To maximise resources providing value for money.
7. To enhance a dementia friendly approach to our service.
8. Reduce length of stay in hospitals providing seamless transparent access to integrated services and reduce pressure on Nursing Home Support Scheme.
9. To provide an immediate response to a home help service for palliative patients.

**Approach**
- Collaboration and consultation with all stakeholders.
- The Home Help Co-Ordinator shadowed the staff in the community to gain an invaluable insight into the level of service required by clients.

**Benefits**
- A reduction of 1,500kms monthly in travel costs.
- Variation in service delivery hours from previous months.
- No waiting lists.
- Home help hours directly from HSE staff.
- Transformation developed by Home Help staff who have felt disenfranchised from the HSE
- A Primary Care initiative to implement change.

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7. A Qualitative Investigation of the Introduction of the STarT Back Programme in St. James’s Hospital Physiotherapy Musculoskeletal Outpatient Department

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**Background:** Evolving evidence suggests that the STarT Back model of stratified care - whereby low back pain (LBP) patients are matched to specific treatment pathways based on their risk of poor prognosis –
offers a valuable approach to treating patients with LBP. However, little is known about the patient’s own perceptions of the StarT Back programme.

**Aim and objectives:** A focus group was conducted in order to explore the perceptions of the LBP patient who had experienced the STarT Back programme.

**Methods:** 28 patients were shortlisted as suitable for the focus group and 5 patients attended on the day. 4 females and 1 male participated with a mean age of 51. Group discussions on perceptions around LBP management were facilitated, audio recorded and verbatim transcripts were thematically analysed.

**Results:** 3 main themes were identified ie treatment beliefs/expectations, LBP aetiology and specific StarT Back management.

The majority of patients believed that their expectations were met but they had received insufficient ‘hands on’ treatment, and predominantly were treated with exercise. The majority of patients expressed a preference for ‘hands on’ treatment. Two of the five participants felt they had an understanding of the cause of their back pain however the remaining participants noted that they had little understanding around the aetiology of their LBP. The majority of patients felt attending physiotherapy had increased their confidence around managing their condition, however felt that both the number of physiotherapy sessions and duration of the appointments were insufficient. 4 out of the 5 participants did not recall any cognitive-behavioural intervention.

**Recommendations:** These findings highlight the importance of physiotherapists providing patients with a clear explanation as to the cause of their low back pain, considering patient’s treatment preferences, and clearly addressing the cognitive component of pain.

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**8. Lower Limb Lymphoedema – A journey towards expanding a new service.**

Exploring the experiences of patients with primary and secondary, non-cancer related, lower limb lymphoedema during the intensive and maintenance phases of Complex Decongestive Therapy (CDT) and its impact on their lives.

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**Background**

Lymphoedema is an incurable, progressive condition, which results in the swelling of a limb or limbs and impairs mobility and joint movement (Lymphatic Framework, 2006). The psychosocial impact of lower limb lymphoedema is also devastating (Lasinski et al, 2012). Lymphoedema is manageable through the initiation of specific treatment modalities which include manual lymph drainage, compression bandaging, compression hosiery, skin care and exercise, otherwise known as Complex Decongestive Therapy (CDT) (Todd, 2012). The area of lower limb, non-cancer related, lymphoedema is poorly resourced and poorly researched, thus the focus of this research study.

**Aims/Objectives**

- To evaluate the impact of CDT on limb volume and quality of life.
- To explore the patients reported experience of living with lower limb lymphoedema and CDT.
- To examine the patients reported maintenance regimen of self care and its resulting effect on limb volume and quality of life.

**Methods:**

A mixed method approach will be utilized to explore the research question.

**Benefits/Risks**

Having worked in the area of tissue viability for 4 years I quickly identified a gap in expertise and service provision for clients with lower limb, non-cancer related lymphoedema. I developed a service in the community for this population. Patient benefits include improved mobility, self-esteem, ease of access, reduced complications.

**Conclusion**

Allocation of resources must be based on evidence, thus I commenced the above research study in Oct 2015. Due to complete in 2018. Funding assistance given through HSE.
9. Eating, Drinking and Swallowing: Exploring Some of the Challenges of Person-Centred Care for Persons with Dementia in a Residential Setting

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Aims/ Objectives: To explore some of the challenges of providing person centred care in eating, drinking and swallowing for persons with dementia in a residential setting.

Method: Following a care plan review of current practice, the residents’ food and drink preferences and dislikes (FDPD) were reviewed from multiple perspectives. A 70 probe questionnaire based on the current menu cycle was administered to staff (SQ) and family (FQ). Following this, selected residents were interviewed re FDPD using Talking Mats* (TM), a supported conversation approach involving a pictorial system. This system was also used to explore some broader issues related to eating and drinking with selected residents. A staff observation exercise was completed, and themes from support sessions noted.

Results: Prior to the project, there was limited information in the care plans re FDPD. Although there was a high degree of correlation across responses in SQ, FQ and TM, there was also significant variance in some incidences, e.g. SQ stating Resident likes something when the Resident states he does not. A brief case study is included illustrating and discussing an incidence of variance.

Conclusions: Person-centred care is a primary objective for persons with dementia in residential settings but in practice, can be very challenging for residents, staff and family members. The implications of some of the challenges from a quality of life perspective are explored. Recommendations regarding a systematic way of exploring and documenting issues related to eating drinking are outlined. Themes from meetings with staff indicated that staff may benefit from more support in this area.

* www.talkingmats.com
10. Adaptation and implementation of a Paediatric Early Warning System (PEWS) resource to support parents and carers to communicate concerns about their child’s condition

AUTHORS: Rachel MacDonell, Paediatric Early Warning System Coordinator, CSPD
Claire Browne, Dietician Manager, Temple St.

PLEASE CONSIDER THIS ABSTRACT FOR ORAL AND POSTER PRESENTATION

AIM: To increase parents’ awareness of the Paediatric Early Warning System (PEWS) and the central role that their concern plays within PEWS, by increasing their perception of their ability to express concern about their child’s condition while in hospital, by August 2016.

BACKGROUND: PEWS is a patient safety system that incorporates standardised age-specific paediatric observation charts, a PEWS scoring tool, escalation guide, paediatric ‘Sepsis 6’ and ISBAR communication framework. PEWS includes concern on the part of the clinician or family as a core scoring parameter. Post-pilot evaluation highlighted the importance of scoring parent / carer concern as it recognises the importance of a parent’s knowledge and expertise about their own child and helps to facilitate open communication. However, follow up audits in pilot sites found that there was variation in some units in how concern is assessed and scored. The aim of this project was to increase parents’ awareness of the Paediatric Early Warning System and the central role that their concern plays within PEWS, by implementation of a resource to support the communication of concern about their child’s condition to their nurse (or doctor).

METHODS: Two wards were selected in Our Lady’s Children’s Hospital Crumlin, (OLCHC) and a series of PDSA cycles were completed to adapt and test ‘Listening to you’ parent information resources and enhanced communication processes around clinical concern. A test of spread was then completed in
the paediatric wards in University Hospital Limerick (UHL). Data were collected on PEWS scoring compliance, and parent and nursing staff experiences of communicating concerns.

**RESULTS:** While parent awareness of PEWS did not increase, there was an increase in reporting concerns by parents across both sites; however this had reduced to baseline levels in OLCHC by the end. 95% (n=103) of parents thought it was useful to ask about their concerns, 98% (n=106) said it helped them feel included and 94% (n=102) said it helped them feel safer about their child’s care. The proportion of parents who received information about PEWS and ‘Listening to you’ increased over the period studied, with those that did providing positive feedback. PEWS concern scoring compliance improved in UHL but not in OLCHC.

**DISCUSSION AND CONCLUSIONS:** ‘Listening to you’ should be considered in all units that implement PEWS as a way to enhance and ensure accuracy of concern scoring assessment, and as part of a wider safety culture. A toolkit of resources for parents and staff should be made available to help ensure standardisation of care nationally. Local champions are essential for successful implication to provide clinical leadership, create a will to change and to encourage everyone to participate and own the change.

**NUMBER OF PATIENTS/CLIENTS/SERVICE USERS AFFECTED POSITIVELY:** 107 parents took part in this project across four ward areas between May – August 2016.

**THERE WAS NO SOURCE OF FINANCIAL SPONSORSHIP OR SUPPORT FOR THIS PROJECT**

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**11. Partners in Care**

Introducing the *INFORMED-DECIDER* Shared Decision Making Framework to Optimise Patient-Practitioner Concordance

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Objectives/aims:
This MSc organisational change project relates to the development and pilot of a shared decision-making framework to assist Public Health Nursing teams to optimise concordance. The initial rationale for choosing this project was the requirement for a standardised approach to the management of perceived patient non compliance. As the change progressed incrementally, framed by the HSE change model and informed by the literature review, an interesting shift occurred which altered the direction of the project to one which would aim to optimise concordance. Concordance appears to offer an alternative method consistent with person-centred approaches as opposed to focusing on labelling patients as non compliant when in fact they are simply exercising choice. This places the onus on the practitioner to facilitate informed decision-making through patient centred learning with the desired effect of informed patients exercising choice through shared decision-making conversations.

Method:
Public Health Nurses, Community Registered General Nurses, Clinical Nurse Specialists and management voluntarily participated in a focus group (n=7) and an optional questionnaire which explored their experience of the promotion of concordance and the management of non concordance. The focus group and questionnaire yielded some insightful, qualitative and quantitative findings. The qualitative findings are representative of the real experience of the practitioner and were found to be in congruence with the literature. The overarching message that arose was that patients’ needs, choice, values & desires must be respected, recognised and acknowledged once we have established that they have the ability to make sound decisions.

Benefits/results:
Following the focus group, the project aim and objectives were refined and what resulted was the development and pilot of a shared decision-making framework underpinned by patient centred learning. A pilot evaluation questionnaire based on the use of the draft shared decision-making framework provided the author with incremental guidance which will inform the final draft of this framework. The resultant shared decision-making framework will reside within a practice guideline which will be developed in phase two of this collaborative project. The CIPP evaluation model informed the main conclusion from the process to date which is the need for structured training to enhance the competency of the practitioner around the facilitation of client centred learning and shared decision-making.
making conversations with the effect of mainstreaming the change within the culture, processes and structures of the Public Health Nursing service.

*With grateful appreciation to the NMPDU for enabling my MSC via scholarship.*

### 12. Criteria Led Discharge – Improving Patient Flow, Discharge Planning And Experience In An Acute Medical Ward in Ireland

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**Background**
Devolving discharge to competent members of the Multidisciplinary team is a nationally agreed target for acute hospitals. It was hypothesized that Criteria Led Discharge (CLD) - a tool to support safe, timely and effective discharge may be a suitable discharge planning tool to support devolving of the discharge process to competent interdisciplinary team members in Irish hospitals. One Consultant led team in one acute medical ward commenced planning and testing in February 2016.

**Aims / Objectives**
To improve patient flow and experience by including 100% of COPD patients admitted to acute medical wards in St Lukes Hospital Kilkenny on CLD pathway by November 2016

- To ensure staff educated and CLD competent (target 100%)
- Test a model of CLD
- To reduce AVLOS for COPD patients to < 6 days
- Reduce readmissions within 30 days of discharge by 50%
- Achieve ‘Home by 11am for 90% of CLD patients
- Achieve increased patient and staff satisfaction with discharge planning

**Methods**
• Hospital Governance, Interdisciplinary (hospital & community) steering group, planning and testing team established.
• Pareto analysis of ward admissions. COPD identified as test cohort (most common cause of medical admission and higher AVLO’s than other diagnostic related groups.
• Driver Diagram of initiatives developed
• PDSA cycles of staff education and information, CLD forms, Patient information, referral pathways, Patient reported experience (PREM), and Patient Reported Outcome of Care (PROM) and COPD Self Management / sick day plan
• Data measures agreed

Benefits / Results
Results and data measures March to Sept 2016 will be presented i.e Number patients included and removed from pathway, AVLOS, Home by 11am, Readmissions within 28 days

Learning / Conclusions
• CLD very well received by staff particularly nursing
• Patient experience and patient reported outcomes difficult to obtain
• CLD an easily adaptable tool for short stay ward settings and clinical specialities

Critical success factors:
• Governance support and stakeholder engagement
• Single Clinical Lead
• Staff education and competence development
• Programme visibility
• Team learning from PDSA’s
• Data, and mode of presentation to demonstrate impact and outcomes
• Supporting teams in developing QI capacity
• Creating clinical and cultural fit
• Mentoring others through application of tools and techniques for engagement
**13. A Change Initiative: Piloting a Child Health Team approach in Mullingar Town**

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The inspiration for / intention of the project?

It is the policy of the PHN service in Longford/Westmeath to provide equitable, evidence based clinical care to all clients in the active caseloads of the integrated public health nursing teams. The traditional approach of geographical areas was not providing equitable care. The aim was to provide a seamless delivery of service which adhered to national and local guidelines.

Approach

A corporate caseload means shared responsibility for a defined case load whilst retaining individual accountability for each client and their families; the successes and failures belong to the team, not to the individual. Each PHN must ensure that she is familiar with An Bord Altranais Code of Practice (2000). All files were amalgamated as per date of birth not address. A team leader role was developed. Regular team meetings. Improved communication tools.

Challenges and how they were addressed

Team buy in. Complex cases evenly divided. Weekly team meeting scheduled to facilitate the team members. The Asst DPHN attends this meeting regularly. The role of the team leads is to co ordinate the activities of all the team members. They ensure the smooth running of the team and has over all caseload management responsibility. The team lead is not responsible for staff management. All queries re staff management and staff performance must be referred to line manager/ADPHN

Conclusion

Yes. We have had many queries from PHN managers around the country and have dates set up for visits. The role of ADPHN (all nursing staff have a direct reporting relationship to the ADPHN) must be clear.
The ADPHN has total responsibility for staff management and staff performance of all team members. The ADPHN is responsible for reporting any relevant clinical issues to the DPHN including commencement of waiting list for services. A communication diary is vital to the team staff for recording messages, phone calls and keeping staff up to date of leave, training etc. The team leader or designate is ultimately responsible for entering information and updating information onto the ECP.

References

14. The role of the Clinical Nurse Specialist (CNS)-Mental Health, Cashel Primary Care Team.

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Aim-The aim of the role of CNS -mental health in primary care is to provide early intervention mental healthcare.

Method- Referrals come from members of the Primary Care team.
The person with a mental health issue meets the Clinical Nurse Specialist in the Primary Care Team building. Together the Carlow/Kilkenny/South Tipperary Mental Health Services: Integrated Assessment and Collaborative Care Plan is completed. This process identifies the person’s difficulties and provides a picture for how the person’s life is currently. The therapeutic relationship between the Clinical Nurse Specialist and the person commences. Therapeutic intervention depends on the person’s needs. If there are stresses such as financial difficulties, referral to the Primary Care Social Worker can happen immediately. Similarly, in the case of a young mother whose mood is low, concerns regarding the baby
such as feeding, sleeping, development etc can be communicated to the Public Health Nurse who will offer advice and support. This integrated care process happens in a non threatening way with each team member as the need arises.

If there are concerns regarding the person’s mental health e.g. evidence of suicidal thoughts or psychotic features these are communicated to the General Practitioner immediately and if necessary the Consultant Psychiatrist for the area. The CNS meets with the area secondary care team each Tuesday morning. If the person requires a meeting with the Consultant Psychiatrist the completed Integrated Assessment and Collaborative Care Plan is forwarded to the Consultant Psychiatrist with the person’s consent.

Benefit—Early intervention holistic mental health care.

Conclusion—There was 610 interventions by the CNS (mental health) at Cashel PCT in 2015. None of the people who attended were admitted to an in-patient mental health service.

15. Developing a drug and alcohol Information program within the National Forensic Mental Health service.

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(Considered for both verbal and poster presentations)

Objectives and Aims:
The aim of this incentive is to provide an empirical sound drug and alcohol information program that could be adopted into the National Forensic Mental Health Service (N.F.M.H.S). This approach should be designed in a way that supports continuous care towards the client’s needs and wants. This incentive should motivate the client to be more responsible for their own mental health and change the client’s role from attendee to participator.

The objectives will be;

1. Gain an understanding of program and group dynamics to deliver the aims.
2. Through research identify key messages and points to deliver in the group.
3. Up skill my personal and professional development to enhance and encourage a more person centred approach.
4. Use psychometric testing to identify further needs and goals for the client.

Method:

- Attend educational workshops of group’s delivery and dynamics.
- Conduct an extensive literature review on the key issues surrounding drug and alcohol misuse and mental health issues.
- Utilise motivation interviewing techniques to encourage and motivate clients to voluntary attend the group.
- Research and avail of clinical supervision to formulate appropriate testing tools.

Benefits and results:

The benefits of voluntary attending the group allows for the client to be the catalysis to their own recovery. This approach promotes self awareness, self confidence and primarily self-efficacy. The results should identify where this person is in the personal journey and what is the next step.

Conclusion of study:

1. There has been a successful 90% attendance rate to the program.
2. A more comprehensive outlook on the client’s needs is more transparent.
3. Once the needs are identified recommendations can be liaised to significant clinical professionals.

16. Paediatrics in an Adult Emergency Department

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Background

A retrospective audit of 100 samples of nursing documentation in the paediatric ED identified many problems. Nursing documentation consisted of two progress sheets and a fluid balance and observation chart that were stapled together. It jeopardised the safety of paediatric patients because
there was no comprehensive or standardised assessment, no coherent account of the patient journey and oftentimes there were key omissions in critical data. Additionally, there was no evidence that nurses in the paediatric unit were screening to detect children at risk, as they are obliged to do under the Children First Guidelines.

**Objective**
To develop a Nursing Proforma that would:
- Reflect the complexity of paediatric emergency nursing work
- Promote seamless care transitions
- Act as guide for new staff and non-paediatric trained nurses working in the unit


**Anticipated Benefits and Outcomes**
The Proforma delineates the activities of nurses in the Paediatric Unit and provides an opportunity for development of quality nursing metrics and determination of minimum safe staffing levels. Early feedback suggests that the Nursing Proforma is an effective aid for those who are under-confident in paediatric emergency nursing and it enhances communication between ED nurses and the multidisciplinary team.

**Conclusion**
This project is about new ways of working, sharing insights and experiences to co-create, with ED nurses, a document that will work in a challenging environment. Representatives from the paediatric wards were included in consultations. Next steps include PEWS integration, audit and transition to an electronic format.

17. To reduce antisocial behaviour on one ground floor team at the National Drug Treatment Centre to zero by June 2016.

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Abstract
High levels of anti social behaviour both inside and in the vicinity or our clinic led to this project. Staff morale was low and there was recognition of the need to change. Patients referred to our clinic as “the punishment clinic” and staff saw it as merely a methadone clinic. We set about utilising the skillset of the multidisciplinary team in a more effective and therapeutic way, with the quadruple aim to improve patient experience, staff experience, patient outcomes, all at lower cost.

Methodology involved recording and analysing incident forms, producing weekly run charts and using the data to recognise our outliers. This led us to the discovery that 7% of our patients are responsible for nearly 50% of incidents, and the realisation that these outliers were a special cause effect and needed to be managed differently and individually. Other primary drivers included the introduction of low intensity CBT interventions which included training workshops for staff and a post amicus intervention “The Welcome Back Pack”. Sustainability and spread will have to be managed through leadership and communication and day to day management. The team has an average of 150 patients at any time and through improved work practices, we have freed up time to work in a more therapeutic way with more emphasis on active key working and individualised care packages. There was no financial cost to the project but there are unknown potential cost savings to the Criminal Justice System, Gardai, General Hospitals, Emergency Departments and the Child and Family Agency.

18. INTEGRATING CARE THROUGH THE NATIONAL CLINICAL PROGRAMMES – A COLLABORATIVE APPROACH TO PATIENT SAFETY

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OBJECTIVES: Sodium valproate (VPA) (Epilim®) is an anticonvulsant drug licensed to treat epilepsy and bipolar disorder. It is also used in migraine prophylaxis (unlicensed indication). A Europe-wide review in 2014, highlighted that children exposed in-utero to VPA were at a high risk of serious developmental disorders (in up to 30-40% of cases) and/or congenital malformations (approximately 10% of cases). This risk of adverse pregnancy outcomes strengthened restrictions on the use of VPA in women and girls. The Health Products Regulatory Authority (HPRA) communicated this review to prescribers in December 2014. The aim of this project was to develop a Valproate Toolkit for the HSE to support prescribers and patients to minimise this risk.

METHODS: The Medicines Management Programme (MMP) convened a working group with representation from the National Clinical Programmes for Epilepsy and Mental Health to review currently available resources for the safe use VPA in females. The MMP consulted patient groups including the Foetal Anticonvulsant Syndrome (FACS) Forum, Epilepsy Ireland and the Disability Federation of Ireland. Agreement was sought from Sanofi (Epilim® manufacturer) to utilise their educational material. The HPRA were consulted.

RESULTS: A HSE valproate toolkit consisting of a patient information booklet, summary guide for prescribers and patient/prescriber checklist was produced as an online resource for patients and prescribers. A communication plan was agreed with the Clinical Strategy and Programmes Division.

CONCLUSIONS: This study demonstrated individual clinical programmes working collaboratively to support the safe use of medicines in Ireland. Further research is necessary to evaluate the impact of this intervention on prescribing practices.

19. CLOSING THE GAP: FOR CHILDREN WITH PROMINENT FRONT TEETH

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ABSTRACT:
This process change was introduced in one HSE Regional Orthodontic Unit to improve patient flow and the quality of care for children very prominent front teeth. (IOTN Grade5a)¹

Many growing IOTN5a patients have a ‘window of opportunity’ when treatment will be most efficient and most effective. Long sequential waiting lists create bottlenecks. Perception of wait encourages younger referrals. The sequential waiting list was unbalanced and inefficient due to the wide variation of age and urgency. Any system of prioritisation must be transparent, equitable and standardised.

Aims and objectives:
To develop and implement a clinical protocol using NCEC Guidance for IOTN5a patients to start treatment. This was based on the best clinical evidence for the timing of treatment and the evidence for cost-minimisation and cost-effectiveness of treatment.

Method:
A retrospective review of 115 completed IOTN5a cases measured the bottlenecks in patient flow in the old system. Using the HSE Change Model, the new process was implemented, using the protocol to record an indicative date for treatment to start. A key performance indicator was developed to measure compliance with protocol and to measure the new quality standard.

Benefits and Results:
This process change was successful in improving IOTN5a patients’ access to start treatment at the right time. Improved patient flow increases capacity. Further evaluation of outcome measures is required.

Conclusion:
This quality improvement is patient-centred, but the balanced score card evaluation outlined benefits for all the stakeholders. There is a cost-benefit to the service by providing treatment at the most efficient and effective time. This process change could be extended for other IOTN criteria.

1. IOTN5a: Index of Orthodontic Treatment Need, Grade 5a describes prominent front teeth which are more than 9mm in front of the lower teeth.

This OD project was approved by the PCRC
20. Systematic Review of Patient Reported Outcome Measures utilised by Advanced Practice Physiotherapists in Musculoskeletal Services

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Aim and objectives
The aim of this systematic review was to inform the addition of PROM fields to the national advanced practice physiotherapist (APP) rheumatology and orthopaedic database. Objectives included establishing and classifying PROMs used by APPs internationally.

Method
A search strategy related to adults with a primary MSK disorder, physiotherapists working in an advanced practice role and PROMs, was conducted in 5 databases (PubMed, Embase, Cinahl, CENTRAL and PEDro) and the resulting 12,302 studies were screened for eligibility. A quality appraisal was completed by 2 review authors independently, study data were extracted and PROMs were classified into outcome domains.

Results
Included studies (n=32) utilised 53 different PROMs with Pain VAS being the most commonly collected, followed by SF-36 and EuroQoL. Function and/or Quality of Life (QoL) were measured utilising 18
different PROMs due to the collection of disease-specific tools in studies with multiple MSK disorders. PROMs were classified most commonly under the following outcome domains; Satisfaction, Disease-specific Function, Generic Function/QoL, and Pain and less commonly under; Psychological Well-being, Global Status, Work Ability and Healthcare Consumptions and Costs. Satisfaction was the most frequently captured outcome domain, often with non-standardised tools which did not report on the measured dimensions. Consistent measurement of dimensions of satisfaction, related to process, structure and outcome, along with consistent utilisation of other standardised, generic PROMs, would enable comparative analyses across hospital sites and internationally.

**Conclusion**

The current national database collects process-related data, with little focus on patient outcomes and experiences. This review highlights the need for an increase in PROM utilisation by APPs, while informing stakeholder discussions regarding the addition of PROMs to the national database.

**Financial Support:** This study was completed as part of a Research Masters of which the fees were funded by the National Clinical Programmes for Orthopaedics and Rheumatology and by the HSE.

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**21. The Integrated Critical Care Pathway**

M Power, D Cribbin, U Quill, Critical Care Programme

The survival of the critically ill patient in Ireland depends on timely access to an integrated critical care pathway. Arising from a historic legacy arrangement of acute hospitals, acute care and critical care service provision fragmentation has been evident. Government, DH and HSE national reforms ongoing aim to integrate service provision in the acute sector. In line with these reforms, Critical Care Programme, as part of the Clinical Strategy and Programmes Division, launched the Model of Care for Adult Critical Care which includes an integrated care pathway for the critically ill patient.
The care journey of the unique individual critically ill patient continues along the Integrated Critical Care Pathway until his or her need is met. The many ongoing boundary-spanning reform initiatives are supported by Critical Care Programme. The “hub-and-spoke” Model of Care aligns with the Hospital Groups “Higgins Report” and the Smaller Hospital Framework. Critical Care Programme has identified critical care capacity requirements and deficits at “hub” hospitals for the Estimates process. The Critical Care Nursing Workforce Plan, Career Pathway, now provides a seamless integrated pathway for graduate nurses in Ireland to access Critical Care Nursing Education and Training and to commence a sustainable career in critical care nursing while remaining in Ireland. The National Adult Critical Care Retrieval Service as part of the National Transport Medicine Programme Service will on commencement provide access for the critically ill patient e.g. a critically ill mother to meet her need. The ICU- Bed Information System or BedBureau is a critical care capacity information service designed to enable access along the integrated pathway. Finally, the National Critical Care Audit (NOCA) provides risk-adjusted outcome comparators and activity information to inform clinical governance and clinical service planning decision making. Accordingly, the various integrative initiatives above serve to strengthen capacity and capability and build and provide an Integrated Critical Care Pathway.
22. Seeing the person: developing person centred practice through a PAR approach in an older adult residential setting.

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Abstract:
Person centred practice is a culture that is gaining momentum within the organisation of care for older adults living in community hospitals. Practice development has been mooted as a means of building cultures that empower residents and participatory action research has been seen as an approach to realise this vision. Participatory Action Research (PAR) was selected as the most appropriate approach for this study which aimed to develop a shared understanding of person centred care by exploring the beliefs and values of participants.

14 Clinical Nurse Managers(CNM) participated in a study which involved the researcher and participants working together in cycles of exploration, planning, action, reflection, evaluation to identify and implement an action that reflected their beliefs and values in relation to person-centred practice. Ethical approval was obtained. Data collection and analysis are structured around the following: Beliefs and values workshop, feedback from residents and interviews with nurse managers. From the analysis of the interviews four themes emerged; seeing the person, creating a special place, learning together and rippling effect. The participatory nature of the research approach was fundamental in achieving the aim of the study. The strengths, limitations and challenges of a PAR approach are addressed.

In looking toward the future, this study demonstrates that participants have a commitment to continuing this journey for themselves as practitioners towards seeing residents as individuals. It is hoped that such beliefs and values will endure beyond the study as we move together to an ever evolving cycle of learning and working together towards a vision for person centred care.
This study formed part of my MSc in Nursing and Midwifery which I completed in Dec 2015 at the University of Limerick.

My supervisors from the university were
Dr. Margaret Graham
Ms. Jill Murphy.

23. The Role of Care bundle in the prevention of Catheter-associated urinary tract infections-Evidenced Based practice in enhancing journey to person centered integrated care

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Current Appointment & Place of work: Staff Nurse -Surgical Area, Member of steering group for CAUTI care bundle implementation hospital wide HSE, (Cork University Hospital, Wilton, Cork)

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Submission presented for oral presentation.

Background: Catheter Associated Urinary Tract Infection (CAUTI) is the second leading cause of device related bacteremia (CDC 2009). Data from 2006 prevalence survey of health care associated infections in acute hospitals in Ireland revealed that UTI’s were one of the most common HCAI of which 49.4% were Catheter related (Smyth ET, et.al 2006). Although studies have identified the need for evidenced based practice to enhance patient care, there hasn’t been a comprehensive review of studies that have evaluated the implementation of a care bundle in prevention of CAUTI.

Aim and objectives: The presentation offers a critical review of the current literature published in relation to the role and impact of implementing a care bundle in prevention of CAUTI.

Methods: Following a literature search of electronic databases, 23 peer reviewed research articles were retrieved that met the selection criteria: addressing the topic of CAUTI, its prevalence and Strategies in prevention of CAUTI.
Analysis and Results:
A critical review of most of these studies clearly indicate that incidence rates of CAUTI are quite high, and also that the duration of catheterization is the key risk factor for the development of CAUTI's. A bundle of evidenced based interventions implemented Used in 28-bed unit Acute Care Medicine Unit, (US) showed a significant reduction in CAUTI, with a 0 prevalence of CAUTI in 2012. (Carter, M.N et.al(2014). A 70% reduction in CAUTI over a 36 month period was achieved by nurse directed interventions Parry, F. M, et.al (2013). A significant decrease from 32 cases of CAUTI to 2 CAUTI in two year time frame post implementation of a care bundle. (Topal, J.et.al (2005). Almost all studies analyzed recommended the use of a care bundle or protocol to reduce CAUTI, suggestive from their findings.

Recommendations: The development of a protocol or care bundle or all of these factors will potentially reduce the incidence of CAUTI, as per indicative of most of these studies. This will assist in optimizing the quality of life of patients by improving their recovery time, as per evidenced by these research studies

Abstract Submission for Oral/Poster Presentation

24. A Journey of Change: Developing Excellence in End-of-Life Care in Residential Care Settings

Presenting Author: Anna de Siún, National Development Coordinator, Residential Care, Irish Hospice Foundation (IHF)

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Title: A Journey of Change: Developing Excellence in End-of-Life Care in Residential Care Settings

Aim: Each year in Ireland 25% of deaths, approximately 7,500, occur in a residential care setting. The Irish Hospice Foundation (IHF) believes no-one should face death or bereavement without the care and support they need. In order to ensure that each person who dies in residential care receives compassionate, dignified, and person-centred end-of-life care, the IHF developed A Journey of Change. This programme aims to support staff working in residential care centres for older people gain the insight, knowledge and skills needed to continually review and develop the end-of-life care they provide.

Method: In order to embed a continuous quality improvement approach to end-of-life care a series of onsite workshops are delivered that give staff the skills to implement the Compassionate End of Life (CEOL) Review Process. As part of the CEOL Review Process staff:

1. establish a CEOL group
2. develop a unique vision for end-of-life care in their centre
3. facilitate CEOL Review Meetings after the death of a resident
4. invite feedback from bereaved friends and relatives
5. make meaningful sustainable change, where change is needed

Benefits: The CEOL Review Process has a number of benefits including:

- **Continuous Quality Improvement:** It provides a framework for reviewing and developing end-of-life care practices on a continuous basis.
- **Staff Support:** It provides a space for staff to come together to remember the person who has died and acknowledge that loss.
- **Service User Engagement:** It ensures the voice and experience of families and friends is heard, and that their feedback is integrated into a structured process of review.

Results: Over 100 public, private and voluntary RCCs for older people are currently engaged with the programme, with approximately 300 staff taking part in multiple workshops. A number of bespoke change projects have been implemented in participating centres, while initial evaluation feedback suggests that participating in the programme also impacts positively on level of team-working and communication. A formal external evaluation of the programme is currently taking place.
25. Towards a more person-centred homecare service: A study of the preferences of older adults and homecare workers

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Professor Charles Normand, School of Medicine, Trinity College Dublin
Professor Virpi Timonen, School of Social Work and Social Policy, Trinity College Dublin

Abstract

The purpose of this study was to investigate the views of older home care recipients on the care that they receive and the preferences of the home help staff to work more flexible times, in order to provide a more person-centred service for the older person. A mixed-methods design was used, incorporating both qualitative and quantitative research methods. The qualitative phase involved five focus groups (total participants: n=23), to gain information on the recipients’ views on the home help received and how the service may become more person-centred. The quantitative phase involved sending postal questionnaires to Health Service Executive (HSE) home help employees (n=202) and to home help employees from a voluntary home help agency in Dublin South West (n=147). The findings from the qualitative phase of the research highlighted that the recipients were mainly satisfied with the service received but would like more communication with home help managers, and to be consulted regarding their care to allow for a more person-centred service. Companionship was also identified as a need for the older person. Data from the quantitative analysis indicated that home help employees, particularly in the HSE, are willing to work outside current contracted hours; for example, 8p.m. to midnight midweek, or on Sunday evenings. Therefore, the future possibility of recruiting HSE home help staff to work more flexible hours needs to be considered to allow for a more person-centred home help service.

Keywords: Home help, home care, older person, outsourcing, person-centred care

Words: 232
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Abstract
Sepsis is a time-dependant medical emergency with a mortality rate of 28.8% in Ireland (HIPE 2013). This mortality rate can be reduced by the implementation of time-dependant pathways both for recognition and treatment. The National Sepsis Programme has developed tools to facilitate compliance with the National Management Guideline which was published in November 2014. Deployment of these tools requires awareness, education, and training but most of all it requires buy-in as it involves behaviour change in order to achieve the desired outcomes.

Method: A top-down, bottom-up approach was used for the implementation of the guideline with identified roles and responsibilities for stakeholders and the formation of local sepsis committees to oversee the implementation of the guideline. Education sessions and tools were provided by the Sepsis Lead during site visits to increase awareness and to educate staff.

Aim of the Quality Improvement (QI) project was to undertake a baseline assessment of the: Usability of the sepsis screening tool (SST) in recognising sepsis compliance with the use of the form. This was carried out through a series of audits in an acute hospital setting.

Results:
Improvements were incorporated onto the SST. The audit demonstrated an increase of compliance up to 50% in 3 months, time to first dose antibiotic improved over the audit period. Audit demonstrated compliance with the use of the SST of between 40 to 50%. Of patients with a sepsis diagnosis 71% patients were documented with sepsis diagnosis correctly however 29% were not.

Conclusion: Behaviour change is hard. A culture change is required and this will not occur over night but rather through sustained effort in the clinical setting and with improved education in medical and
nursing programmes and internal training supported by data demonstrating the effectiveness of the intervention in terms of mortality and patient length of stay.

27. Dare to DREAM Kilkenny: The Power of Peer Support

Presenters Mary Hickey and Joan Mc Donald,

Co-Founders and Facilitators on behalf of the Members of Dare to DREAM Kilkenny

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**Background** Following the establishment of the Kilkenny Memory clinic the lack of supports for people in the early stages of dementia became very clear.
There was plenty of information available, but no support group for them specifically. Many groups offered supports for carers, but none for the person with Dementia.
This gap in the care pathway along with the challenges and enormity of setting up a support group, who would take it on, funding, resources all discussed with MDT.

Decided to look and see what was available elsewhere in Country. At the Sonas Conference 2013 DREAM (Dementia, Research, Education, Advocacy in Motion) had a poster presentation and at around same time it was highlighted to a member of MDT studying an MsC in Dementia.

**Methodology:** we made contact with DREAM, Galway and over a six month period met with the founder, attended DREAM meetings in Galway and DREAM facilitators came to Kilkenny. We settled on a Parish Centre in Kilkenny City as a location. Meetings to be the first and second Friday every month

The first meeting is cafe style at which the person with dementia (member), family/carers and friends attend. Second meeting is just for members only. We are facilitators and the form of the meetings is dictated by the members.
Outcomes  Social outlet provides inclusion when their social outlets are reducing gives people confidence, friendships have formed, dementia confronted and members are able to voice their fears. They give one another advice, some tears and lots of laughter. It’s about hearing the voice of people with dementia; three of the members are now part of Irish Dementia Working Group and took part in the budget submission in June. Members have taken part in focus groups for research and individuals are taking part in research. In collaboration with the Genio Memory Matters project Kilkenny Dare to Dream members made the video “See ME” (attached) https://youtu.be/-CIHLLCgZzw

Because we have direct links to the memory clinic and the support of the consultant we are able to see that individuals are attending DREAM and are doing ok thus reducing the need for follow up appointments. Links with other support groups and community supports have strengthened; we are part of the community. Above all the direction of Dare to Dream Kilkenny is dictated by the members

Acknowledgements s Heather Gately DREAM Founder, Facilitators, St Patrick’s Parish Centre Loughboy, Kilkenny City and the Family and friends of our members.

28. Clinical Pharmacy Service for the Programme for the Homeless

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Aim
Phoenix Pharmacy Department (PPD), part of the North West Dublin Mental Health Services provide clinical pharmacy service (CPS) and supply of medicines to St Ita’s Hospital, Phoenix Care Centre, and have the largest population of clozapine clients in Ireland. PPD are the first in the country to develop a CPS for the Programme for the Homeless (PfH), with the aim of delivering medicines optimisation in one of the most vulnerable populations in the country with severe mental health illness and multiple co-morbidities. Established in 1979, PfH is the first multi-disciplinary (MDT) mental health service in the world for people who are homeless and mentally unwell.
Method
16% of PfH clients take clozapine and at least 30% have co-morbidities excluding polysubstance misuse (n=120). Due to polypharmacy in this vulnerable population, PfH was allocated a 0.4WTE of a senior pharmacist. The pharmacist attends MDT meetings, reviews all medicines, interprets clozapine assays, answers medicines related queries, and provides medicines reconciliation (MR). The pharmacist is a member of the family and carers’ engagement group, and trains staff on the use of psychotropics. They are available to each client for medicines education and any medicines related queries.

Benefit
CPS increases integration of care through evidence based prescribing. This allows optimisation of treatment choices and minimisation of drug related errors, particularly high risk drugs e.g. clozapine, Hepatitis C treatment. MR increases safety at the care interface, a particular risk in PfH. Medicines education increases clients’ understanding of medicines, increasing the likelihood of engagement and compliance.

Conclusion
CPS delivers clinical governance, supports the medical and nursing team, and benefits patient care proving the extensive scope to broaden the reach of the service in order to continue to increase safety and reduce vulnerabilities. CPS empowers patients to participate in medication related decisions and their recovery.

29. ONCOLAMP: Accessibility of Community Based Services Relevant To Patients with Cancer and their Relationship to Social Deprivation and Cancer Incidence

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Objective:
The social determinants of health that influence inequalities in cancer outcomes for different social classes are well established. Consequently, a new focus is on reducing health inequalities through
community-based health initiatives. ONCOLAMP (Oncology Needs in the Community Online Local Asset Mapping Project) aims to be one such initiative through facilitation of ‘social prescribing’ via an online repository of relevant services.

The aim of this study was to identify health and wellbeing services in the community relevant to cancer patients and to investigate spatial accessibility of these services. A further aim was to investigate the relationship between accessibility and degree of deprivation/cancer incidence.

**Methods:**
A pre-existing LAMP database, of a Dublin inner city region, was used to identify services. Geographical Information Systems (GIS) was used to measure spatial accessibility for all service classes. Variations in accessibility were examined by deprivation index and cancer incidence.

**Results:** 784 health and wellbeing services, relevant to patients with cancer, were identified. Most deprived areas and areas of higher cancer incidence tend to be better served by health and wellbeing services, in terms of spatial proximity. However, cancer screening services, cancer support groups and alternative/complimentary therapies were less accessible in most deprived areas.

**Conclusion:** Deprived areas are not necessarily devoid of services. Other factors such as awareness of existing services may prove to be more significant in creating health inequalities. One of the aims of ONCOLAMP as an online resource, is to enhance this awareness for both clinicians and patients.

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This is a qualitative study using a purposive semi-structured interview methodology to determine if recently qualified Public Health Nurses (PHNs) feel they are academically prepared to undertake child protection work. If that academic training, coupled with practical experience ensures they fulfil their remit in relation to child protection and welfare. Eight PHNs who qualified in the last four years were interviewed.

Literature and Policies pertaining to public health nursing and education, from a National and International perspective, were evaluated. In addition, interrelated literature on inter-agency working was assessed.

The findings of the study would indicate that PHNs view their responsibility in child protection and welfare as a significant one but it is hampered by their lack of preparation in both the academic and community setting. The results reveal the necessity for a review of current educational guidelines and curricula as well as analysis of the PHNs role and clinical workload. Additionally, challenges in inter-agency working were identified.

Recommendations from the study advocate the need for change in the PHN curriculum and community collaboration in the PHN training with a particular emphasis on inter-agency partnership between the HSE and TUSLA to provide integrated care for children and their families. Any changes should link with current International and National legislation and policies with local policies reflecting these changes. A large scale study is required to explore this area in greater detail as no such study has ever been undertaken in Ireland.

This study was 20,000 words and received ethical approval from both Trinity College Dublin and the HSE North–East Ethical Committee and was completed as part fulfilment of the MSc in Child Protection and Welfare at Trinity College from 2015-2016.

Funding in relation to completion of the thesis was provided by the author.
A six month profiling study of referral pathways between interdisciplinary team members working together in St. James’ hospital Emergency Department in managing acute musculoskeletal injuries and conditions.

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Aims/Objective- To profile the interdisciplinary referral pathway of musculoskeletal injuries and conditions between Advanced Nurse Practitioners (ANP), Physiotherapists (PT) and Occupational Therapists (OT) over a six month period in the Emergency Department (ED) in St. James’s Hospital (SJH).

Background - Advanced Nurse Practitioners (ANPs) have been working in the Emergency Department (ED) in St James’s Hospital (SJH) for over 20 years. As part of the ANP role there is an agreed referral pathway to dedicated ED MSK PT and OT, this arrangement has been in existence for 10 years and was the first interdisciplinary pathway of its kind in the country. Patients suitable for referral are those who have an injury that does not require immediate orthopedic or plastics management. The PT and OT review takes place on site in a dedicated clinical space located within the ED.

Method:
All patients referred by ANP’s and Emergency Medicine doctors and reviewed by ED PT’s and OT’s from January- June 2016 were included in this study. Chart reviews of 683 patient records were undertaken by the lead investigator and second investigator. The referral process and condition treated was recorded. Data was analysed using excel.

Benefits/results
Within January to June 2016, 60% (n=267) of MSK referrals received by ED PT’s were sent by ANPs. The most common reasons for referrals were ankle 25% (n=67) and knee 23% (n=23%) soft tissue injuries. Within January to June 2016, 67% (n=58) of MSK referrals received by ED OT’s were sent by ANPs. 13% (n=11) of MSK referrals received by ED OT were sent by PT’s. The most common reasons for referrals were for mallet injuries and fractures.

Conclusion- This profiling study shows this successful pathway of the independent management of MSK injuries between three disciplines within the ED in SJH. Continuation of this dedicated onsite interdisciplinary referral process is recommended.
32. Service Provision and Development in UL Hospitals

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Objective/Aims
To create and support a culture of person-centred care with exceptional patient and family experience of inpatient care at in UL Hospitals enhanced by the active and meaningful involvement of members of the public in service provision and development.

Method
This is a multi-faceted approach which will take several years to implement. Since June 2014 this process has begun with the development of a PALS Volunteer service in University Hospital Limerick and then expanded to Nenagh Hospital and Ennis Hospital in 2015. The volunteer roles have developed to include wayfinder, patient feedback, befriender and in the Emergency Department.
In April 2016, a Patient Council for the UL Hospitals group was established with eleven members of the public representing the population of the Mid-West successfully recruited to act in an advisory capacity for the Group. Members of the Council also sit on various committees in UL Hospitals.
A Patient Engagement Strategy in 2016 underpins this ongoing work.

Benefits/ Results
The voice of the patient is clearly and objectively represented through these channels, with collaboration and participation in all aspects of decision-making- at the experience level, at the clinical microsystems level and at the organisational level. A respectful partnership between patients and staff, informed by evidenced-based care, will allow optimal outcomes for patients.

Conclusions
Patient and family engagement facilitates the delivery of healthcare to patients and their families in a person-centered way.
33. A Quality Improvement Initiative to determine the Patients’ Experience in the Cardiac Catheterization Laboratory at University Hospital Waterford.

Authors: O’ Connor, A., Cronin, E., Lambert, C., Morris, R., Glynn, K., Lawrence, P. & Mackey, E. Cardiac Catheterisation Laboratory Nursing Staff, University Hospital Waterford

Background:
In 2015, 2200 patients attended the Cardiac Catheterisation Laboratory (CCL) in University Hospital Waterford. 3,142 procedures were completed (Source: data extracted from CVIS.) This gives an average of 60 cases per week hence an average 12 cases per day. The CCL in UHW operates between the hours of 9am – 5pm, Monday to Friday inclusive.

The safety and comfort of the patient are of paramount importance to all members of the multidisciplinary team. As a quality initiative we have decided to determine the patients' level of satisfaction with their experience. This survey will illuminate the positive and negative aspects of the patients' experience. The feedback gained will allow us to improve on the patient experience.

Method:
Lean’s six sigma approach of define, measure, analyse, improve and control has been chosen as a suitable methodology. To define our aims, the CCL staff have adapted a weekly Healthcare Utilising Deliberate Discussion Linking Events (HUDDLE) approach. We sourced a validated patient satisfaction tool from another health system and adapted it for local context. All patients’ using the service in the month of September will be invited to participate, under informed consent. Patients’ will be approached after their procedure and prior to discharge from the Cardiology Day Ward.

Results & Conclusion:
It is planned that this process will enable us to improve our patients’ care pathway and this information can be shared and may be transferrable to other services and sites.

34. PREVENTION OF ACUTE ADMISSIONS – THE IDT APPROACH

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INTRODUCTION:

The Rapid Response Service in Harrow, North West London enables patients who are entering crisis to be treated at home rather than be admitted to hospital. Referrals are received from General
Practitioners, Local Emergency Departments, London Ambulance Services and Advance Nurse Practitioners.

Patients have a holistic review in two hours from time of referral. The service offers short-term intensive Interdisciplinary care, supported by a Medical Consultant and daily virtual ward rounds. Within seven days, patients are referred to other appropriate services.

**AIMS AND OBJECTIVES:**
The case study evaluates the Rapid Response Service. It considers the structure of the prevention of admissions team. The interdisciplinary working, skill sharing and clinical governance of the service’s Medical consultant.

**METHODS:**
Personnel account of clinician’s involvement as a Highly Specialist Physiotherapist in the Rapid Response team. These personal accounts will be supported by case studies and preliminary quantitative data.

**FINDINGS:**
The Rapid Response Services is a dynamic team with strong interdisciplinary working and skill sharing. Clinical support is ensured with access to an on-call medical consultant. The service helps to avoid inappropriate hospital admissions; this particularly benefits vulnerable elderly people, for whom hospital admission is associated with a risk of deterioration. This in turn helps to reduce pressure on acute hospital services.

**CONCLUSIONS:**
The pressure on acute hospital services in Ireland is well publicised. Services such as the Rapid Response Team offer clinicians in primary care an alternative to hospital attendance. The Rapid Response is a model of care which may translate well to the Irish health care landscape.

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35. **The National Rare Disease Office (NRDO): a patient focused approach to providing Integrated Care**

Deborah Lambert, Jacqueline Turner, Rita Marron, Grace O’Sullivan, Sally Ann Lynch, Eileen P Treacy.
National Rare Disease Office, Mater Misericordiae University Hospital, Dublin 7, and HSE/RCPI National Clinical Programme for Rare Diseases
A rare disease (RD) is a life-threatening or chronically debilitating disease affecting no more than 5/10,000 individuals in Europe, with 260,000 affected with RD in Ireland. Accurate and timely diagnosis and access to treatment is complicated for RD patients by poor informatics and lack of continuity of care.

The National Rare Disease Office (NRDO) was established in June 2015 as a recommendation of the National Rare Disease Plan (2014-2018). Its goals include to collect and disseminate Irish RD information and to populate Irish services on Orphanet (www.orpha.net), an international online portal for RD information and resources encompassing >6,000 RD. NRDO’s RD information line and HSE-hosted website provides reliable rare disease information, support and links to services and organisations. NRDO engages with clinicians, expert centres and researchers to map-out Irish RD resources to act as a ‘hub’ for integrating National Centres of Expertise in the emerging European Reference Networks (ERN), to facilitate mobility of expertise (physically and virtually) between European Health Care Providers in line with the EC 2011 Cross-Border Care Directive.

In NRDO’s first year, >50% of calls logged were from patients and their families, most commonly for signposting of medical specialists for specific RDs. The Irish data on Orphanet is undergoing validation, to expand from the <10% of RDs currently covered. Over the next few years, it is proposed that the NRDO will liaise with all 5 integrated care programmes, to progress integrated care pathways for RD patients within Irish and European (ERN) contexts.

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36. DEVELOPMENT OF CULTURES OF PERSON-CENTREDNESS PROGRAMME THROUGHOUT THE HSE

The HSE Corporate Plan incorporates a strong theme of person-centred throughout, indicating that person-centredness is everyone’s business in the organisation. The Quality Improvement Division of the HSE has identified person-centred care and culture as a key driver and outcome for safe quality care placing it at the heart of safe care provision.

However we know that person-centredness is complex and multi faceted and required a fundamental shift in thinking and behaviour. Evidence from recent research into person-centred practice highlights the lack of integrated continuity of care, lack of attention to the everyday needs of people, practice cultures that do not enable and support innovation, a focus on economic targets at the expense of ‘care targets’ and a lack of education and development programmes in practice settings that could drive person centred care.

The Quality Improvement Division is rolling out an innovative transformational practice development programme in 2017. A tried and tested methodology will be used to enables and empower staff, facilitators and managers to recognise the attributes necessary to build person-centred cultures and person-centred practices. With a focus on developing an infrastructure that will support continuous quality care and practices, capacity and skills are grown and spread systematically throughout the health and social care system thus enabling an integrated approach to developing cultures of person-centredness in the workplace.

The first leg of the programme will focus on residential services for people with intellectual disabilities and the second leg, rolled out in tandem, will focus on the HSE system wide.

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37. Working together to develop a water quality alert system for home haemodialysis patients

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The provision of home haemodialysis (HHD) is increasing in the HSE and is an excellent example of patient centred and patient led care. It greatly enhances patients’ quality of life and evidence clearly demonstrates improved patient outcomes. There are also important cost savings to the HSE.

However this therapy is reliant upon the continuous supply of potable water to a patient’s home.

The Renal Home Therapies Unit (RHTU) in University Hospital Waterford approached Waterford County Council enquiring about the possibility of establishing an alert system should there be an interruption to the water supply or quality of the supply to the homes of HHD patients.

A multidisciplinary review group was established which brought together for the first time the HSE disciplines of Public Health Medicine, Environmental Health, Renal Medicine and Biomedical Engineering with representation from the County Council’s Water Services. The group also received input from the healthcare company involved in pre-installation evaluation and provision and maintenance of necessary equipment.

The aims were to address:

1. Assessment of water quality prior to selecting patients for HHD
2. Ongoing water quality issues for patients
3. Options for an alert system for patients on public water supplies

A review of relevant scientific literature, guidelines and standards, practices in other jurisdictions, and existing communication pathways between relevant stakeholders was undertaken.
A report of the group’s findings was produced for the Assistant National Directors of Environmental Health and Public Health, and the Clinical Director of the National Renal Office. This report served the basis for establishing dialogue with the newly established national water utility, Irish Water.

The bringing together of different disciplines within the HSE and the engagement of relevant external stakeholders in a collaborative fashion enabled the successful establishment of a national standardised, systematic and safe alert system for HHD patients on public water supplies throughout the country.

38. Maternity and Child Care, Mother and Child Program

Presenting author: Patricia Weldon M.I.S.C.P.

33 years’ clinical experience and specialised training working with mothers, babies, children and families in the fields of paediatric physiotherapy, early intervention and prenatal and birth work.

Current appointments & addresses of work:
Enable Ireland - Senior Paediatric Physiotherapist, 0-6 yrs Early Intervention multidisciplinary team
Aerbridge House, Dunshaughlin Business Park, Dunshaughlin Co. Meath

Private Practice: Rainbows End Family Physiotherapy and Prenatal & Birth Therapy Clinic
Riverstown, Kilmessan, Co. Meath

Daytime phone: 046-9025660 / 086-8520623

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The problem:
“...when another woman is talking about birth, the trauma is evident as they recount the loop of experience trapped in birth, invariably ending with, ‘but I suppose I am lucky, thank god, I know much worse’. Why is this so hidden...how has it become accepted that we can’t complain about the level of care? ...why are women confining these conversations to online forums and whispered dark thoughts?”
Mother / Psychotherapist

Objectives/aims of the program:
- To educate health care professionals and parents about the critical importance of the birth-to-12 weeks period for the mother’s emotional wellbeing and for how the baby ‘is’ throughout life. A powerful underlying dynamic develops between mother and baby and this dynamic governs whether or not a baby is ‘settled’ and secure in the world.
- To raise awareness of the impact that (physical or emotional) separation at birth has on baby’s bonding, attachment, breastfeeding and development. When the mother is disconnected (in a non-natural birth) or is too sore to relate to her baby a vital window for bonding and attachment is lost.
- To teach health care professionals how to recognise behavioural characteristics of a child who is not well bonded and how to work with mother and child to resolve this.

Method:
The Mother and Child Program: an online program of 6 training modules specifically designed for healthcare professionals to address the objectives.

Benefits/results:
- The Program will help the HSE develop, nurture and provide a mother-and-child-centred care system by training staff to truly understand what is going on between mother and baby.
- Imparts knowledge, skills and practical tools to work with and support mother and baby at this early vulnerable time to resolve imbalance.
- Equips students to protect themselves emotionally in clinical practice.
Online mentoring allows students to ask questions and build confidence while learning new key skills.

Testimonial:

‘A brilliant program providing in-depth knowledge of the physical, emotional and mental aspects of conception, birth and beyond and offering a set of skills focusing on facilitating change to help mothers and babies with difficulties. Ongoing support and valuable feedback from Patricia made it a truly transforming learning experience on both a professional and personal level!’

Zsofia Szendrei PT, CST-T

Conclusions of the study

The HSE urgently must address the level of care given pre- and post-natally to nurture the relationship between mother and baby. The numbers being referred to early intervention in Ireland, and the high rate of colic, are escalating exponentially.

Sources of financial support for the study:

Personal funding

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39. Starting again from scratch: The re-development of North Dublin Early Intervention Service (EIT).

Authors: Dr. Helen O’Connell Senior Clinical Psychologist, Suzanne Kirwan Speech and Language Therapist and Sophie Dungan Occupational Therapist.

In 2013 a decision was made by North Dublin EIT to close the service to new referrals. Due to various pressures including reduced staffing and significant demand for services, the model was no longer fit for purpose. It was agreed that managers and clinicians would come together over a period of six months to engage in a planning process to reconfigure and redesign a new service model.

The process entailed setting up two sub groups, made up of clinicians and managers, who met on a weekly basis, to work their way through a detailed itinerary of issues, policies and procedures. Individuals were tasked with researching how other EIT models operated, best practice guidelines, the wider policy environment, a detailed analyses of referral patterns, the profiles of the children and families presenting, staff capacity and an inventory of existing clinicians competencies.
From this bottom up and participatory process, a new through-put EIT model has emerged, one which has translated concepts such as inter-disciplinary working and family-centred care into genuine practice. While not without its challenges, this process formed the basis for a model which is generally achieving good outcomes for families, which is highly reflexive and which has resulted in a high level of ownership and commitment by team members.

This presentation/poster aims to outline the process undertaken to redesign the EIT model from scratch and the challenges and lessons learned.

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40. Evaluation of Referrals to the Department of Nutrition and Dietetics as part of the Frail Elderly Pilot Programme in Connolly Hospital Blanchardstown January to June 2016

Caroline Stapleton, Senior Dietitian, Connolly Hospital Blanchardstown, Dublin 15, Co. Dublin

Objective/Aims

The Specialist Geriatric Services Model of Care aims to improve the quality and efficiency of care for the older person with complex health care needs whom may warrant a comprehensive geriatric assessment (CGA). Nutritional status should be a component of the CGA (HSE, 2012). 27% of those admitted to hospital are at risk of malnutrition (BAPEN, 2012). The Frail Elderly Pilot Programme commenced in Connolly Hospital Blanchardstown in January 2016.

Methods

- Development of Department of Nutrition and Dietetics referral pathway
- Early identification and nutritional assessment of those at risk of malnutrition and for management of chronic disease

Benefits/Results

There is 136 referrals to the Dietitian from the emergency department (ED) and acute medical assessment unit (AMAU). There has been an 83% increase in Dietitian referrals of those aged ≥ 75 yrs
from February to June 2016 compared to the same months in 2015. 31% of those referred to the Dietitian are at high risk of malnutrition. Of the recorded anthropometric measurements, 84% and 46% were below the 25th centiles for hand grip strength and mid arm circumference respectively. 26% of Dietitian referrals in ED / AMAU were secondary to management of chronic disease.

Conclusions
Nutrition screening on admission is recommended for the early identification of those at risk of malnutrition whom may warrant nutrition support (HIQA, 2016). The National Clinical Programme for Older Persons recommends that the Dietitian should be part of the multidisciplinary team throughout the whole pathway of care (HSE, 2012).

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41. SAOR Screening and Brief Interventions for problem Substance Misuse in the HSE South

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Poster Presentation Only

Background: A national alcohol survey conducted in 2013 purported that there were 1.34 million people drinking harmfully in Ireland. A number of national policy documents have recommended that screening and brief interventions for problem alcohol and substance use be delivered across all health and social care settings. The agreed HSE national model for screening and brief intervention (SBI) for problem alcohol and substance use is SAOR (Support, Ask and Assess, Offer Assistance, Refer).

Aims and objectives: SAOR SBI aims to contribute to improved health outcomes for individuals with issues relating to substance misuse and reduce the burden on the criminal justice, health and social-care systems. It is integral to the development of appropriate integrated care-referral pathways for statutory, community and voluntary organisations providing services to those affected by harmful alcohol and
substance use in line with the objectives of National Protocols and Common Assessment Guidelines to accompany the National Drugs Rehabilitation Framework.

**Method:** A phased implementation process model including exploration, installation and initial implementation was used to guide the stakeholder recruitment, buy-in, training, reviewing and ongoing support. The process is overseen by a dedicated implementation group who meet fortnightly.

**Results:** Since 2013, over 600 health and social care staff have been trained in SAOR SBI in Cork and Kerry. SAOR SBI is now included as part of the development of an integrated care-pathway for rehabilitation in this region. SAOR SBI has been included as a major component of the HSE South Alcohol Strategy 2016-2018. Feedback garnered by the implementation group suggests that SAOR SBI provides a practical approach for non-specialists in diverse health and social care settings to work confidently with those affected negatively by drug and alcohol use.

42. Establishment of the role of physiotherapy in an MDT Base of Skull Clinic

**Presenting Author:** Kareena Malone; Senior physiotherapist in Neurosurgery, Beaumont Hospital (kareenamalone@beaumont.ie) (086) 3993703

**Fiona Kinsella; Senior physiotherapist in Neurosurgery, Beaumont Hospital (fionakinsella@beaumont.ie) (01) 8092535**

**Aim:** Establish a physiotherapy service in the base of skull clinic, to provide a new physiotherapy service, both at clinic and outpatient levels, to a population with facial and vestibular impairment.

**Methods:**
- Liaison with relevant stakeholders to ensure a common expectation within the role and to ensure buy-in and support
- Establishment of appropriate screening tools and outcome measures battery, to assess patients
- Patients referred to physiotherapy in the clinic would be offered follow-up outpatient care in Beaumont Hospital for management of the identified impairments as a result of the base of skull lesion.
- Individuals unable to travel to Beaumont for their outpatient care would be linked in with local services to ensure appropriate local follow-up.
Results:

- Noted improved communication between all the relevant stakeholders including the consultants, nursing staff and physiotherapy with increased awareness of the benefits of physiotherapy in this population.
- Increased ease of communication between the disciplines has allowed for reduced waiting times for the patient to access outpatient services as the referrals can be made at the clinic which reduces waiting times for patient review.
- A comprehensive treatment approach for the management of this population of patients due to the access to physiotherapy services which is supported by evidence.
- Individuals who may not have previously accessed physiotherapy services in their local area are now being referred to these services more efficiently.

Conclusions: The establishment of this physiotherapy role has enhanced multidisciplinary communication, provided access to physiotherapy services for this population of patients, enhanced management of patients by providing appropriate rehabilitation and ensuring all patients gain access to rehabilitation services that they require.

43. Implementation of a multidisciplinary (MDT) goal setting programme for inpatient neurosurgical patients

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Supporting Authors:
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Aim
The implementation of the GAS (goal attainment scale) goal setting programme was a collaborative initiative undertaken by the neurosurgical physiotherapy, occupational therapy (OT) and speech and language therapy (SLT) services to formalise MDT goal setting.

Methods
The process of implementation of the MDT initiative involved formulation of an MDT working group, involving neurosurgical representation from the three disciplines. A standard operating procedure was developed outlining the process involved in the implementation of the initiative. A pilot phase was introduced that aimed to trial the process with three patients, to allow reassessment of the process and allow modifications, as required.
Suitable patients for inclusion were identified as those that required involvement of at least two of the disciplines. A core worker was identified for each patient that acted as a liaison with the patient and family members. Establishment of the MDT goals was aimed at reducing duplication of interdisciplinary goals, optimisation of goal setting by enhancing collaborative rehabilitation practices across disciplines, facilitation of interdisciplinary communication, facilitation of goal reviewing structures, optimisation of inter-hospital communication and handover and facilitation of optimal patient focussed goals, with patient involvement.

Benefits
The programme remains in the pilot phase with six patients undergoing the process to date. The benefits include enhanced MDT communication and discussion in relation to the formulation of optimal patient centred rehabilitation goals. Close collaboration between members of the MDT facilitates optimal goal setting and rehabilitation practice.

Conclusion
This neurosurgical MDT goal setting process has enhanced the setting of patient goals, reduced therapist duplication, enhanced MDT communication and facilitated patient engagement in their rehabilitation process.
44. Development of a Multidisciplinary, Brain Tumour Patient Passport

Presenting Author: Kareena Malone; Senior physiotherapist in Neurosurgery, Beaumont Hospital
(kareenamalone@beaumont.ie) (086) 3993703

Supporting Authors:
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Eloise Cowie; CNM 3, Neuro-oncology, Beaumont Hospital
Eithne Dunne, CNM 2, Neuro-oncology, Beaumont Hospital

Aim: To develop a multidisciplinary (MDT) brain tumour passport, to enhance the management of high grade brain tumour patients

Methodology: To ensure the passport was suitable to fulfil the needs of the target population, representation from all members of the MDT were involved in the design of the document. Each discipline contributed to the content and format of their individual section. Sections were also provided for input from community based colleagues to allow for use of the passport in acute, sub-acute and community based treatments.

Prior to finalising on the passport design, a questionnaire was developed and administered to a sample of high grade brain tumour patients to gain user feedback on potential usability.

Results: 16 questionnaires were administered to patients to obtain feedback on its design and to ensure it was fit for purpose. Seven were returned completed, indicating a 44% response rate. All 7 participants felt that the passport would enhance their management. Minor modifications were suggested.

Participants were requested to provide some insight into their experience with using the passport:
“...though I’m intimidated by the illness, I found it very helpful to read the guide”
“... having a record in a proper book as opposed to my own notebook makes things a lot easier...taking a good amount of stress and confusion out of my treatment and hospital visits”.

Conclusions: The passport provided a centralised location for all information, relating to their tumour management and as a result provided some relief to their burden of suffering. The passport also reduced the risk of duplication in the patient’s management by allowing access to the patient’s correct medical information, when required.
45. The Development of a Person Centred Positive Behavioural Support Plan

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Introduction

This study was conducted in 2015, and facilitated the development of a Positive Behavioural Support Plan for SU, a long term residential service user of the Mental Health Services.
SU presents with a history of Schizophrenia, and aggression towards peers and staff.
This support plan would draw on SU’s strong interest in arts and music and willingness to engage in individual Art Therapy programmes. The National Institute of Clinical Excellence, (N.I.C.E.) March 2009, has determined that of, ten therapeutic interventions evaluated for effectiveness with Schizophrenia and Psychosis, Arts Therapies was one of the three recommended.

Objective

The aim of this study was to look to new ways of working with SU and endeavour to assist in the transition from a long term Institutional Residence towards Community living.

Methodology

‘Working Positively with Behaviours that Challenge’ features;
Visuals and Art Images of interest and concern to SU were produced and employed in the support plan.

Benefits/Results

Art Therapy offer service users a safe space where they can creatively access, inner resources, qualities and strengths in working toward gains in self awareness and development.

Positive Behaviour Support offers beneficial outcomes for all the stakeholders in the Mental Health Services.

Conclusions

Person centred therapies are looking at combining methods with other disciplines and looking at more encompassing frameworks and models of practice to provide for the needs and strengths of service users. A slide presentation of visuals will be employed to relate the endeavours of this study.

46. Chronic Disease in the Emergency Department: The missing link in integrated care?

Kelly Janssens¹, Richard R.L. Drew (RIP)¹, Tim McDonnell¹, Gerry McCarthy²

¹St. Michael's Hospital, St. Vincent's University Healthcare Group.

²Emergency Medicine Programme

Objective

Chronic disease (CD) accounts for two-thirds of emergency medical admissions and approximately 80% of all healthcare costs. Presently, “integrated care” refers to GP care punctuated by specialist input on an inpatient/outpatient basis. It does not explicitly involve the Emergency Department (ED). Most (70-80%) of ED patients are discharged. Many of these presentations are acute episodes of a CD, but are not incorporated as part of any integrated care pathway. This project aims to: (1) Quantify CD-related
discharges from the ED  (2) Develop an initiative to integrate these visits into CD care. (3) Assess whether such an initiative improves quality.

Method

1000 consecutive ED presentations were reviewed over a 2-month period; patients with coexisting CDs were noted, as was whether CD was a contributing or determining factor to presenting. A pro-forma was developed in conjunction with CD specialists, two of whom are national clinical leads in CD management (COPD and CCF). The pro-forma was implemented in a subset of CD-related discharges, the first 50 of which were also accompanied by a questionnaire to evaluate the pro-forma's usefulness.

Results

A diagnosed CD was recorded in 46% of presentations; in 47% of these CD related to the presentation. While CD patients were more likely to be admitted (32% vs. 8%), the majority were discharged (68%). The questionnaire response rate was 56% with 95% finding the intervention useful, 45% reporting it affected therapy (55% for diabetes) and 30% reporting it affected patient management in non-therapeutic ways, such as appointment scheduling.

Conclusions

The ED is under-represented in the current model of integrated care: (1) The cohort of CD-related discharges from the ED was more than twice those admitted; (2) These presentations constitute a gap in integrated care, which can be closed; (3) In doing so, the ED stands to improve the quality of integrated care.

47. Establishing an interdisciplinary parent group intervention, post Autism Spectrum Disorder diagnosis (ASD) in EIT, North Dublin
Author Angela Murphy, Senior Clinical Psychologist

Background: A parents’ group intervention, Autism and Me, Autism and My Child was devised in 2013 by the Inter-disciplinary team to respond to parents’ needs after receiving an ASD diagnosis for their child. When devised, the economic context meant that monies were not available for team members to pursue EarlyBird training which is the validated parent group intervention around ASD in the UK.

Method: Having consulted widely, the team, led by the clinical psychologists, devised an eight week group programme for parents on research validated themes- coping with the diagnosis, understanding autism, promotion of strategies to support their child’s communication, independence and regulation, and ways to analyse and understand behavioural challenges. The course is led by a Clinical Psychologist, with joint sessional inputs from a Speech and Language Therapist, Occupational Therapist and Physiotherapist within the team.

Since its inception the course has adapted to meet the needs of two distinct cohorts within EIT; parents of children with ASD-level 1 and parents with children with ASD- level 2/3 (DSM V). Since 2015 two courses run concurrently to serve each group.

Results: The course has consistently been rated by parents as being of high value using anonymous evaluation measures, with attendance rates of 95% (n=15 families).

Outcome: The latest courses which are to commence in September 2016 are being extended to 10 weeks duration in response to parental feedback seeking increased time to process their own feelings in relation to autism and to allow for more time to resource themselves with strategies to promote their child’s development.

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