“Our population is changing and so too are the needs and expectations of our patients and service users, and indeed our staff”
Drumm, B. 2008 - Improving Our Services. A Users’ Guide to Managing Change in the Health Service Executive

INTRODUCTION

The Brain Injury Programme (BIP) of inpatient rehabilitation at the National Rehabilitation Hospital (NRH) provides specialised, interdisciplinary rehabilitation for people with acquired brain injury (ABI) from the age of 18-64 years. Governed by a Medical Director and a Programme Manager, the programme, through its scope statement, addresses the unique needs of persons with ABI.

Programme referrals are received from acute hospitals and community based services from all over the Republic of Ireland for the 46 inpatient beds located in one of four different ward areas at NRH. Programme beds also incorporate three beds that are dedicated to persons with ABI who have a

Disorder of Consciousness and a small number (two to four beds) dedicated to Neurobehavioural patients. The programme has national brief and is funded centrally through the Health Service Executive (HSE).

Baseline data and analysis of the Brain Injury Programme Waiting List in October 2012 revealed a significant delay for many patients in accessing inpatient specialist rehabilitation beds with a range between 5 and 321 days waiting:

53% OF PATIENTS WITHIN TARGET OF 70 DAYS WAITING
8% OF PATIENTS WAITING BETWEEN 70 AND 90 DAYS
39% OF PATIENTS WAITING 90 DAYS OR LONGER

AIM

All patients will have equitable access in less than or equal to 70 days to inpatient specialist rehabilitation services provided by the Brain Injury Programme at the National Rehabilitation Hospital by April 2013.

Issues identified from the outset included:

• Waste and duplication of tasks and activities
• Poor communicating with stakeholders
• Varied locations for information (hard copy and electronic)
• System processes were not consistent or standardised
• These issues subsequently led to delay in responding to referrals, loss of referral information, and subsequently a delay in placing a patient on the inpatient waiting list

The Model for Improvement

Plan, Do, Study, Act (PDSA) cycle was applied in effect to small tests of change in this project.

With repeated use of the cycle, a number of changes have been introduced, tested, reviewed and implemented.

RESULTS

Over the course of 6 months, this project has led to a 31% reduction in the number of patients waiting longer than 70 days for access to specialist inpatients rehabilitation beds.

BASELINE DATA

Percentage of Patients waiting longer than 70 days

As you remove outliers and re-measure more outliers are revealed until patients are waiting less than or equal to your target.

- 75% of patients within target of 70 days waiting
- 10% of patients waiting between 70 and 90 days
- 15% of patients waiting 90 days or longer

OBJECTIVES ACHIEVED

A comprehensive Policy and SOP for NRH Waiting List Management System (WLM)

The WLM Committee with representatives from all key stakeholders, which provides guidance and oversight of developments

The WLM Review Team who meet weekly

Guidance and support from the hospital CEO, Executive Management and Operations Management Teams

Approval and support from the Medical Board

A standard of patient information, replacing previous system and captures all information required to make clinical & operational decisions relating to admissions

Improved communication procedures which is key both in and out of the Programme

IMPROVEMENTS

A waiting list policy and associated standardised procedure was established and implemented

Consultants moved to a ‘Pooled Shared’ Single Waiting List approach, which focused on placing the patient in the right bed at the right time according to need

Average Waiting for Admission targets were reviewed and established under the hospital’s KPI system

The number of systems (paper and electronic) and the number of people involved in the management of the waiting list was reduced

Robust clinical review of each patient waiting was conducted by a clinician every six weeks.

NEXT STEPS – Spread The Improvement

• Review or abolishment of current geographical Patch System of referral
• Criteria for admission of complex Neurobehavioural and Disorder of Consciousness patients
• Development of Escalation Policy for consistent breach of targets
• Development of comprehensive ‘reporting’/’output’ systems from meetings
• Implementation plan for beyond project duration to ensure sustainability
• Roll out of system across the hospital

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