CUH
Ospidéal na hOllscoile Corcaigh
Cork University Hospital

UNSCHEDULED CARE PATIENT PATHWAY

THE CHANGE PROGRAMME 2013–2015

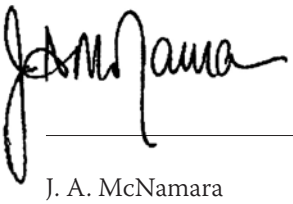
Preface

In 2013 the CUH Unscheduled Care Governance Group was established and incorporated the Acute Medical Care Programme and Emergency Care Programme governance groups that were already in existence. This enabled a structured work programme to be developed encompassing processes and strategies to be implemented to effect an improvement in the management of the unscheduled care patient pathway. These strategies were documented in the CUH Unscheduled Care Patient Pathway Booklet 2014.

The Executive Management Board, cognisant of the need to further develop and build on the strategies in place, have continued to identify initiatives that will improve the unscheduled care patient pathway and ultimately enhance the patient experience.

In this revised edition we have provided an update in relation to the further changes that were identified for implementation in 2015. A number of these changes are encompassed in two major initiatives (i) Patient Flow Ten Point Action Plan and (ii) Patient Flow Action Cards.

It is clear that in order to address the multiple challenges strong leadership is required both in hospitals and in the community and the resolution of the management of unscheduled care lies in the implementation of multiple changes initiatives.



J. A. McNamara
Chief Executive Officer
Cork University Hospital Group

October 2015

Overview of Cork University Hospital

Cork University Hospital (CUH) with over 40 different medical and surgical specialties on site is the largest university teaching hospital in Ireland and the only Level 1 Trauma centre in the country.

It is the tertiary referral centre for the HSE Southern area, and the supra-regional area of Limerick, Clare, Tipperary, Waterford and Kilkenny. CUH functions as a regional centre for secondary and tertiary care for the catchment population of 550,000 served by the HSE Southern area and a supra-regional centre for a population of 1.1 million.

In 2014 CUH had 65,000 ED presentations, 8,300 births, 210,000 out-patient attendances, 48,000 inpatient discharges and 86,000 day cases.

CUH has 800 beds and has undergone significant change in respect of the service configuration as a result of the implementation of strategies such as the reconfiguration programme, the cancer strategy and the implementation of the small hospitals framework. As a direct consequence of these changes both scheduled and unscheduled activity has increased in the Hospital and managing these, at times conflicting demands, is a constant challenge.

The hospital currently employs 4,000 staff (3.300 WTE) of multiple professions and is the primary teaching hospital for the Faculty of Health and Science in University College Cork.

CUH Unscheduled Care Governance Programme

Unscheduled care can be defined as health and/or social care which cannot reasonably be foreseen or planned in advance of contact with the relevant professional. It follows that such demand can occur any time and that services to meet this demand must be available 24 hours a day seven days a week. Improving the patient pathway through the Emergency Department for either subsequent admission or discharge is the most important challenge for the Hospital and requires collective commitment from all medical, surgical and diagnostic services. In this regard the Hospital constantly seeks to apply a multi-disciplinary approach to the implementation of change as in the embedding of Care Programmes.

In 2013 the CUH Unscheduled Care Governance Group was established and incorporated the Acute Medical Care Programme and Emergency Care Programme governance groups that were already in existence. This enabled a structured work programme to be developed encompassing processes and strategies to be implemented to effect an improvement in the management of the unscheduled care patient pathway. The group meet on a monthly basis and work to an Unscheduled Care Quality Improvement Plan that is based on the High Impact Change Assurance Process guidance document issued by the Special Delivery Unit that focuses on front end inflow, throughput and egress.

The programme outlines a programme of actions designed to improve the management of the unscheduled care programme and we set out here a number of the key actions that were implemented and which resulted in improvements in the patient pathway.

Acute Medicine Programme

The implementation of the Acute Medicine Programme was a key priority for the Hospital and the underlying philosophy was the desire to create a single integrated acute care system that incorporated emergency care provided in the Emergency Department and acute assessment and in-patient care in the Acute Medical Unit.

This was achieved with the construction of an Acute Medical Unit adjacent to the Emergency Department in two phases. Phase I consisted of the construction of a 24 bed Medical Short Stay Unit and a further Phase 2 comprising of an Acute Medical Assessment Unit (AMAU) was completed in January 2011. In addition the appointment of 4 Acute Medical Physicians was a key enabler in the implementation of the programme as was the rotation of nursing staff to promote the concept of an acute care focus. The AMU is operational 24 x 7 days and the Acute Medical Assessment Unit is operational Monday to Friday from 8.00am-8.00pm with plans to extend to weekend working in 2015 consequent on the appointment of a 6th Acute Medical Physician.

Surgical Care Programme

The Hospital has been identified as an exemplar site for the implementation of the Surgical Care Programme and this has been supported through the multidisciplinary approach adopted by the staff involved and their willingness to embrace change. In addition the Hospital prioritised capital investment in key infrastructural projects including;

(i) provision of a dedicated acute surgical ward incorporating a 6 bed surgical assessment unit, 6 surgical day beds and 10 inpatient beds;

(ii) construction of a pre – admission assessment unit;

(iii) construction of a day of surgery admission unit (DOSA);

(iv) allocation and staffing of a dedicated emergency theatre and

(v) provision of a second Orthopaedic trauma theatre.

Lean & Six Sigma Process – Emergency Department

The Hospital is committed to implementing Lean and Six Sigma principles to improve the efficiency of services and to minimise redundancies therein. In 2014 these principles were applied in a week-long study of patients attending the Emergency Department to ascertain the potential to improve the patient pathway and to reduce time spent in the Department. In the process the multiple steps in the patient journey were mapped and timed in order to identify the real problems preventing the department from meeting the patient turnaround target of 6 and 9 hours. The resulting recommendations are encompassed in the Unscheduled Care Quality Improvement Plan that was approved by the Executive Management Board and are now being implemented.

The Visual Hospital

The Visual Hospital Process was developed in April 2013 and provides a representation of the status of the hospital and real time data on patient movement. The model encompasses a plan for critical processes in the patient journey including;

(i) Predicted day of discharge

(ii) Home by 11.00am

(iii) Weekend discharge plan

(iv) Plan for every patient and

(v) The assignment of a process owner which has led to improved patient flow, reduced length of stay and reduced trolley numbers.

Use of Informatics and Data

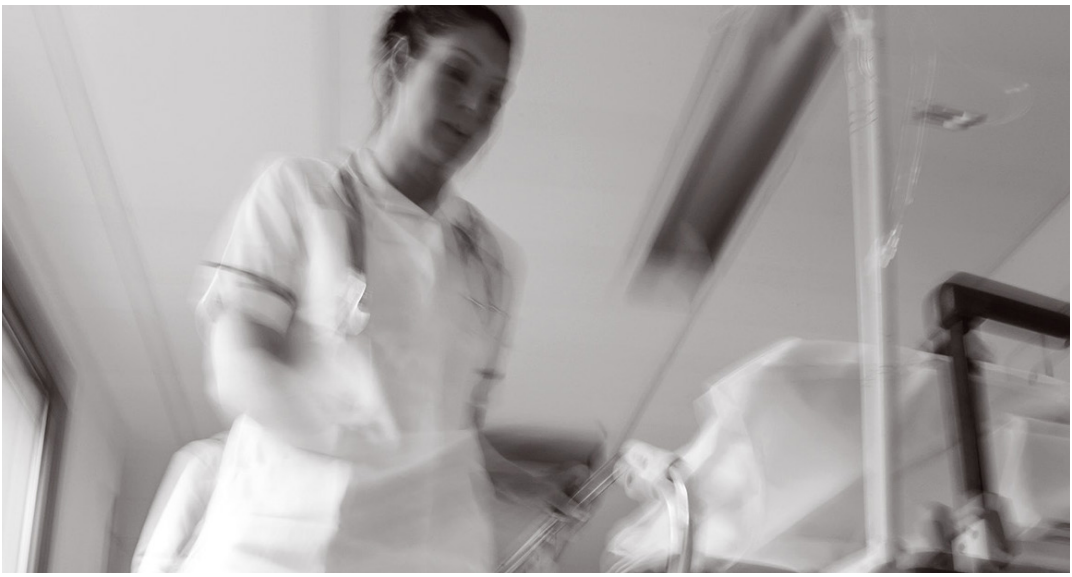
The use of data to support decision making and to inform strategy is a critical issue for the Hospital. The existence of real-time data provides transparency in the bed management process and the selective distribution of this data on an hourly, daily or weekly basis is central to creating a collective engagement in the performance of acute care.

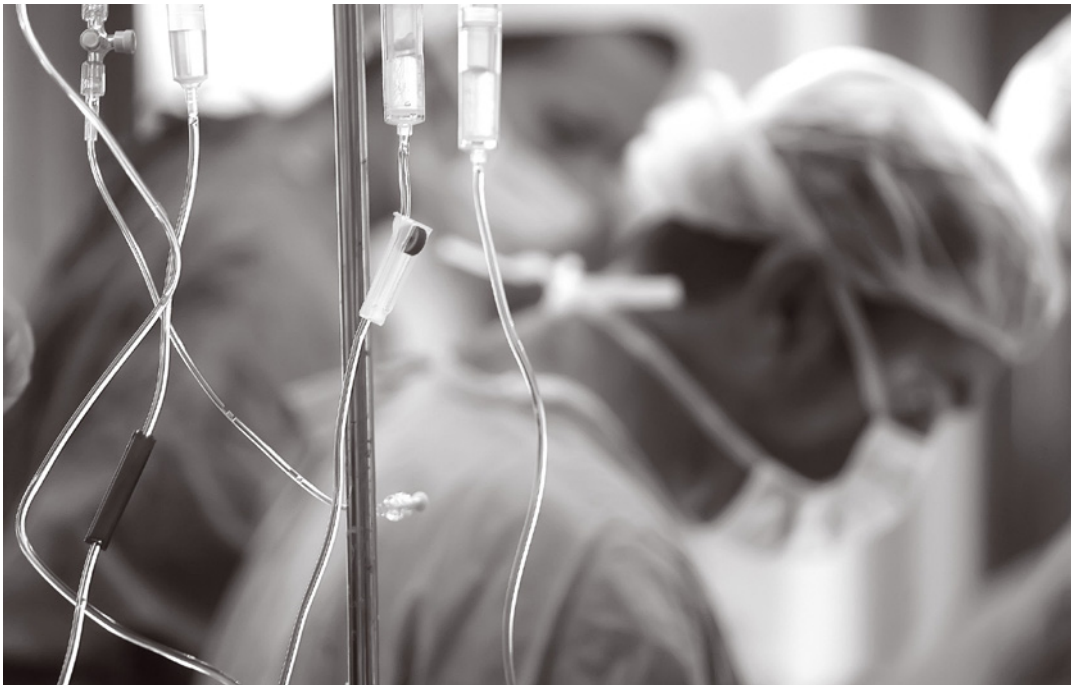
The use of data has been critically important in the successful implementation of initiatives such as the Visual Hospital, Theatre management and the performance of the ED. The result has been the creation of a shared language that is understood by clinicians and executives that facilitates better decision making and a focus on performance.

Implementation of Change Programme

The Hospital has undergone substantial change as a result of the implementation of various strategies and one of the most significant outcomes has been to increase ED attendances by 30% to 65,000 over the past 3 years. This coupled with the implementation of other strategies has necessitated a challenging change programme in which the implementation of new processes is a key part. The commitment of staff to continue to implement change particularly at a time of very constrained resources has resulted in significantly improved patient pathways and outcomes.

At this point the Hospital has been through multiple change programmes and change is now very much embedded in the organisation's culture. The key issue is to ensure sustainability and to demonstrate resilience in order that these changes become the norm in the functioning of the Hospital.





Investment in Infrastructure

Central to improvements in the patient pathway was the requirement to improve the infrastructure to support multiple changes and initiatives. To this end the Executive Management Board prioritised capital developments that would support the implementation of the care programmes and the following are some of the key developments that have made a difference to the quality of patient care;

Acute Medical Unit	Surgical Assessment Unit
Acute Medical Assessment Unit	Infusion Centre
Interim Endoscopy Suite	Cardiac Day Unit/Assessment Unit
Paediatric Assessment Unit	Dedicated Emergency and Trauma theatres
Clinical Decision Unit	

Reorganisation of Bed Management Function

One of the many changes implemented to address the twin challenges of scheduled and unscheduled care has been the establishment of a centralised bed management function. Due to the competing demands for beds all requests for patient beds are managed electronically via a centralised bed booking office. This allows the Bed Manager total control of access to beds for emergency, elective and waiting list management In addition this is a key enabler in the management of waiting lists.

Appointment of an Ortho-geriatrician

In support of improving the quality of care and the patient pathway, the physicians, orthopaedic surgeons and consultant geriatricians advocated for the appointment of a consultant Ortho-geriatrician to work with the physicians to improve the length of stay for hip fractures post-surgery in CUH and among the cohort of patients transferred to the South Infirmary University Hospital for rehabilitation. A collective database of orthopaedic inpatients in CUH (excluding paediatrics and day cases) and SIVUH rehabilitation patients is being developed that will serve as a reference point for teams in both hospitals - NCHD's, nursing staff, discharge co-ordinators and bed managers. The implementation of this initiative has resulted in significant reductions in the length of stay for this cohort of patients and has contributed to improved patient care.

Community Interface

Improved communication has been a key element in developing a working relationship with our community partners. A number of initiatives have been progressed to include;

(i) the development of a Home Dialysis programme reducing the need for admission to hospital;

(ii) implementation of the OPAT programme which facilitates early discharge and continuing care at home or in the nursing home setting

(iii) formation of Community Intervention Teams again facilitating early discharge from hospital

(iv) pathways to smooth the placement of patients in Community Hospitals and Nursing Homes. In this regard the number of delayed discharges has reduced from 35 to 15 per day since Q4 in 2013 which has significantly contributed to the patient pathway.

Further Change in 2015

The demand for smooth, safe unscheduled patient care pathways remains an on-going challenge and while much progress has been made, there remain strategies and changes to be implemented that should yield further improved performance. These measures include the following initiatives;

(i) improvement in the weekend discharge rates;

(ii) reduction in the ED conversion rate from the current level of 33%;

(iii) open a 4 bed High Dependency Unit to improve access for the critical care patient group;

(iv) open a discharge lounge to maximise the "Home by 11" target;

(v) reorganise acute medical beds into one dedicated ward to improve flow and maximise capacity;

(vi) progress the appointment of a 5th Consultant Physician post to allow the commencement on a phased basis of weekend working in the AMAU;

(vii) work to improve the Patient Experience Time in the ED by working on redundancies identified in the Lean Mapping project;

(viii) progress the development of a Transitional Care Bed Unit to provide step down facilities for patients that are medically discharged but awaiting placement in the community;

(ix) maximise resources in Community Hospitals as a discharge option;

(x) maximise the bed resource within the South Southwest Group to improve patient flow and ED performance;

(xi) align the Unscheduled Care Pathway and Scheduled Care Pathway within the Hospital Group;

(xii) seek to extend community programmes such as the OPAT programme to allow for the management of patients in the community.

Implementation

The Executive Management Board (EMB) continues to pursue improvements in performance with the implementation of a set of strategies that reflect requirements in respect of entry to the Emergency Department, patient processes within the Emergency Department and egress from the Department and the Hospital. In addition to the individual change initiatives that are intrinsic to this process, the following is the first of two new initiatives that we believe will make a significant difference to the Hospital's performance and to the experience of patients.

Initiative 1 - Ten Point Action Plan

In March 2015 the EMB developed a ten point plan to further improve the patient pathway which is being fully implemented with the support of the Acute Hospitals Division and the allocation of funding within our 2015 budget.

1. BED CAPACITY

The average length of stay for patients in CUH compares very favourably with peer hospitals and the achievement of a length of stay of c. 6 days for medical patients is accepted by the SDU as evidence that very many improvements have been made in the internal processes in the Hospital and continued focus on internal initiatives have the capacity to reduce length of stay by very little.

Furthermore it is accepted by the Special Delivery Unit that there is a need to increase bed capacity using the very limited potential that there is to do so in the Hospital presently.

Initiative No. 1 – Reorganise beds in the context of a plan that has been signed off by the EMB to create a 31 bed acute medical ward on a 24/7 basis. This will provide 10 additional beds and will require the transfer of day beds to another ward.

Present position: New bed plan collated and the recruitment of additional staff is underway.

2. AMU – 7 DAY WORKING

The Acute Medical Assessment Unit has made a very substantial contribution to improved performance since its opening in 2012. For the period January-December 2014, 1,800 patients were admitted to the MSSU, 6,000 patients were assessed and managed in the AMAU and an additional 1,300 patients were assessed at the Review Clinic that would otherwise have presented at ED or through another entry point into the Hospital.

Initiative No. 2 – The Acute Medical Assessment Unit currently opens 7.30am to 8.00pm daily and accepts patients up to 4.00pm on the basis that this provides an adequate period of time for patients to be accommodated with a bed thereby

minimising the risk of patients having to be re-directed to ED. There is a need to review this policy and the appointment of an additional 2 Acute Physicians will enable a number of changes to be implemented to include:

(a) The AMU Physicians would work a shift system on Saturdays and Sundays from 0800hrs to 1800hrs with the support of the on-call NCHD team. The provision of an additional 2 WTE for nursing staff would allow the opening of the AMAU on Saturdays and Sundays.

(b) The shift from 0800hrs to 1800hrs would aim to round in MSSU and identify discharges. Following this, the AM Consultant would attend the ED or AMAU and supervise the on-call take until 1800 pm. The AM consultant would see medical reviews, provide a consult service to the ED and ideally maximise safe patient discharge from the MSSU and ED as well as optimising care. The target would be to reduce conversion rate of medical patients at the weekend from 33% to 30% on Saturday and from 40% to 35% on Sunday.

Present Position: The extended working day to be operational by mid November 2015

3. DISCHARGE LOUNGE

A key priority for the EMB is the early establishment of a Discharge Lounge to facilitate the early discharge of patients that is a requirement to facilitate the earliest possible transfer of patients from the ED. This will improve the efficiency with which patients can be placed in beds and will improve the 6 and 9 hour significantly.

The Discharge lounge will provide a 5 day service from 8.00am to 3.00pm.

Present position: The Discharge Unit opened on Monday 11th May 2015 and the ultimate aim is to have 40% of inpatients discharged via this unit.

4. ACCESS TO DIAGNOSTICS

One of the key difficulties that emerged from the Lean Study into the patient pathway in ED was the delay in accessing diagnostics. The EMB is anxious to prioritise improved resourcing of the Radiology Department on the basis that there will be an improved turnaround time for patients requiring Radiology services. One of the initiatives that will be undertaken immediately is to develop a new protocol for accessing CT services for patients that will improve access and response times. In addition a number of other supporting interventions will help the flow of patients through the Radiology Department;

Initiative No. 4 – Recruit a porter and a health care assistant to improve the throughput of patients in the Radiology Department.

Present position: Recruitment of staff is progressing. Two public MRI Scanners were commissioned in July and have improved access for patients. We still have some issues to address in particular access to CT services and continues to work with the department of Radiology on maximise capacity.

5. ORTHO-GERIATRICIAN

The appointment of the first Ortho-Geriatrician in CUH in 2014 transformed the patient pathway for elderly patients resulting in a 20% reduction of inpatient orthopaedic patients with the potential for a significant further reduction in length of stay and earlier discharge with a second post. The current appointee has a level of input into the rehabilitation service in SIVUH that could be significantly increased with a second appointment.

Initiative No. 5 – Appoint a second Ortho-Geriatrician to CUH / SIVUH at a cost of €187,191 to be supported by a Registrar and an Administrative Officer at a cost of €291,444.

Present position: Funding for the additional post has been allocated and the recruitment process is to commence.

6. VACANT ENDOSCOPY RECOVERY AREA

In July the Endoscopy Department transferred from its existing location and as a consequence an Endoscopy Recovery area suitable for the management of children attending the ED has become available. The development of such a facility will free up space in the ED for use as a Rapid Assessment and Treatment area that will assist in improving the PET times.

Initiative No. 6 – Transfer Paediatric ED services from the main ED to the Endoscopy Recovery area to create additional treatment space in the ED assisting in improving PET times.

Present position: The department has identified a plan that will allow for the transfer of the paediatric service to the separate location and in addition provide enhanced accommodation for the Rapid Assessment and Treatment service. Refurbishment of the accommodation will commence in the 4th quarter 2015.

7. BED MANAGEMENT STRUCTURE

The Bed Management function has become ever more central and critical to the efficient functioning of the Hospital and it is vital that it is staffed with specialists in that area of the highest caliber. The implementation of the Visual Hospital coupled with the department having responsibility now for both Unscheduled Care and Scheduled Care has emphasised further the need for expertise in bed management.

In due course as the SSW Hospital Group evolves we must proceed to have a Group (at least in Cork City and County) structure to manage beds with real-time transparency on the status of beds. In the meantime we need to support the Bed Management function in CUH and initiate discussions on the establishment of a Group structure possibly to be managed from CUH.

Initiative No. 7 – Appoint a CNM 3 Bed Manager to increase the expertise in the function of bed management.

Present position: This post has been approved by the EMB and the paperwork has been submitted to the NRS for advertising.

8. UTILISE OPD AT WEEKENDS

The Out Patients Department is located immediately adjacent to the ED and is available for use as an assessment / treatment area from 5 pm Friday to 8 am Monday. This would allow the rapid assessment and treatment of those patients (66%) who will not require admission thereby improving PET times.

Initiative No. 8 – Use the OPD at key times over weekends for assessment / treatment of patients. This would facilitate the use of the OPD from 6.00pm to 10.00pm Monday to Friday and from 2.00pm to 8.00pm on Saturday and Sunday. This would yield a resultant improvement in the PET for those patients who will not require admission.

Present position: This initiative requires the recruitment of additional nursing staff and this is currently under review.

9. NURSE STAFFING

An extensive recruitment programme is underway to recruit nursing staff to fill the vacant posts throughout the hospital. The process of recruiting nurses which has impeded these developments heretofore is continuing but for the first time this year the number of staff nurses commencing exceeds the number of nurses leaving the service and we have much to do in order to fill the 40 vacancies that we have currently. Of the 52 nurses graduating this year 47 have agreed to continue their nursing career in CUH and we continue to recruit nurses through various recruitment campaigns.

In due course as the SSW Group evolves we must move to devolve recruitment of staff including nursing staff to address the significant impediment that exists as a result of delays in the appointment of staff.

Initiative No. 9 – Expedite the filling of vacant nursing posts as a matter of extreme urgency.

Current position: continue to recruit the additional nursing staff require utilising all recruitment processes available

10. STEP-DOWN BEDS

A good deal of attention has been given to reducing the number of delayed discharges and funding in support of this initiative has been very welcome.

A key challenge and significant impediment to the efficient throughput of patients is the paucity in step-down beds and a resolution to this will need to be found before Q4 in 2015.

Initiative No. 10 – Open Step-Down Unit. Funding has been secured to open a Step-down unit. Following advice from procurement we have used the framework which exists and sought tenders from 3 companies who are listed on the framework. We have asked that they provide a solution that would provide the necessary nursing and care assistant staff required to open the additional beds by mid-November

bridging the time frame when the permanent recruitment process has been completed.

Present position: One of the companies has tendered on the basis that they can provide these resources to enable us to implement this initiative within that timeframe

SUMMARY

The EMB is confident that the implementation of these initiatives coupled with the completion of the work programme that it is currently in progress will significantly improve ED performance and the patient experience.

Initiative 2 – Patient Flow Action Cards

The hospital is challenged with providing capacity to deal with the daily demand for inpatient beds on a daily basis. It is clear that the most significant factor in this problem is appropriate number of inpatient beds. The tangible effects for patients can include prolonged wait times in the Emergency Department, prolonged wait for inpatient bed and at times cancellation of planned elective activity.

To deal with the capacity issue there is an extensive plan produced by the Unscheduled Care Governance Group and EMB (open physical beds, HDU beds, 7/7 working of AMU, Discharge Unit, and Access to Diagnostics). In addition the hospital functions extremely favourably when compared with our peer hospital regarding activity and length of stay.

To optimise and capture how we run the hospital on a daily basis in the face of these demands, the Unscheduled Care Governance group have developed a number of simple action cards focussed on a number of key areas which will be implemented from 5th October 2015.

The overarching goal is:

(i) To reduce the need for admitted patients to remain in the Emergency Department and access an inpatient bed as quickly as possible.
(ii) By association, freeing up space, to allow patients be seen faster in a safer Emergency Department.

1. Action Card 1 (> 28 Day stay Cohort of Patients)

This is a small percentage (3%) of our total inpatients but by the nature of their prolonged stay utilise 34% of available bed days per year. Of course there are multiple reasons for this but Action Card 1 will bring a focus to this group.

2. Action Card 2 (The Discharge Process)

This action card encapsulates the principles of Plan for Every Patient and use of PDD (Predicted Discharge Date) In addition particular attention to the Medical and Surgical teams should be paid to **Mandatory Discharge Meeting (Point 6)**, which takes daily in the Hub of CRC. Duration of attendance is approximately 2-3 minutes and any one fully briefed member of each department/team must attend. Teams will differ but it is best to assign that role to one person for any one week.

3. Action Card 3 (Discharge Unit)

This Unit is operational since Q1 2015 and the target is that 40% of discharges are through that unit.

4. Action Card 4 (Standard Daily Operation Process)

This card outlines the exact operation process and predominantly involves Bed Management, DON, ADON, Clinical Directors and Night sisters.

5. Action Card 5 (Bi-directional Flow)

There is daily movement of patients between CUH and all other hospitals in the South - South West Group. This card formalises those movements and contact details.

6. Action Card 6 (Full Capacity Protocol)

This card addresses the operation of surge capacity and how and where we do it to.

SUMMARY

The clear and absolute focus of the Unscheduled Care Governance Group and wider hospital is to significantly improve the initial experience for patients (people of Cork and beyond) in their first 24 hours.

Conclusion

Cork University Hospital is in the process of implementing a challenging change management programme comprising multiple initiatives and strategies. The Hospital has seen substantial improvements in both access to services and in the quality of services provided for our patients. This is notwithstanding the challenges of reduced staff numbers during this time and increased demands as a result of changes in the configuration of services. It is a credit to the staff of the Hospital that these changes have been embraced and that there continues to be a commitment to implementing further changes to continue this improvement trajectory.

This has been and continues to be a tremendous learning opportunity for us in Cork University Hospital and hopefully for other hospitals that face similar challenges.

J. A. McNamara
Chief Executive Officer
Cork University Hospital Group

October 2015

CORK UNIVERSITY HOSPITAL
UNSCHEDULED CARE GOVERNANCE PROGRAMME

KEY ENABLERS

GOVERNANCE

- Unscheduled Care Governance Group chaired by CEO (established 2013)
- Monthly multidisciplinary meeting with Agenda and record of Actions
- Lean Management Programme
- Quality Improvement Plan – Inflow, Throughput, Egress.

SUPPORTS IN PLACE

- Clinical Care Programmes – Surgical/Medical/Emergency
- Surgical ward
- The Productive Operating theatre
- Pre – admission assessment
- Day of surgery admission (DOSA)
- Dedicated Emergency Theatre
- Dedicated Trauma theatre
- 24/7 Access to Primary PCI for STEMI
- Ambulance bypass protocols for STEMI
- 24/7 IV Thrombolysis and access to IA
- Interventional Neuroradiology
- Stroke Unit
- Rapid Access TIA Clinic
- Acute Medical Unit
- Acute Medical Assessment Unit
- Surgical Assessment Unit
- Cardiac Assessment Unit
- Speciality Wards
- LOS monitoring by condition, by team by consultant
- Appointment of Consultant Ortho geriatrician
- Established Centralised Bed Booking Office – Bed Manager controls access to beds
- OPAT / COPD outreach programme
- Ten Point Action Plan
- Patient Flow Action Cards.

MANAGEMENT INFORMATION FLOWS

- Access to Senior Decision Maker
- 07.45 – Patient flow handover (night / day staff, bed management, DON, AMU physician, CEO)
- Bed management feedback to DON / CEO / CD on ED status and bed status on wards as day progresses
- 11.30 – Formal ED / Bed Management situation status
- 12.30 – Formal Group Teleconference
- 16.00 – Bed Management update to DON/CEO/CD
- 20.00 – Patient flow handover day/night staff and bed management
- 3 times daily reporting to SDU and weekend reporting structure in place with senior management.

EMERGENCY DEPARTMENT – PATIENT FLOW

- Daily board round at 11.30am and 4pm
- 11.30 – EM Consultant; EM Medical Team; Bed Management; Flow co-ordinator; ED CNM 3
- 4pm – ED consultant; On call Physician; On call Medical Registrar; Bed Management; CNM 3
- Patients moved from ED between 7-8am to AMU/SAU/CAU
- Rapid 1 hour rule for referral
- Registrar to Registrar referral (12th Jan 2015)
- Patients to move to identified beds within 30 minutes of bed allocation
- Radiology prioritisation of ED/AMU discharge dependent diagnostics
- Maximisation of the management of minor injuries – Advanced Nurse Practitioner Increased x2.

VISUAL HOSPITAL

- Programme developed in 2013
- Visibility of Hospital wide bed capacity
- Identification of blockages
- Levelling of Ward Discharges
- Engagement with ward CNMs
- Active Management of patients awaiting LTC
  - Predicted Day of Discharge (PDD) Audits of same
  - Home First Approach
  - Home by 11
  - Weekend discharges
  - Plan for Every Patient
  - Process owner.

EACH WARD

- Twice daily board round
- Board round focus on EDD and PLAN for each patient
- Predicted discharges to sit out or transferred to discharge area by 9.30am
- Each ward to take one patient initially by 9.30am
- Weekend discharges to be collated by Friday-no later than 2pm.

DELAYED DISCHARGES

- Commence process on day of admission
- Weekly submission to Nursing Home Support Office
- Access to interim home care packages
- Access to funds for long term care.

WEEKEND DISCHARGES

- 12.30pm Saturday/Sunday operational teleconference
- Hub meeting at 11am-attendet by each department
- Weekend Discharge team (presently being progressed).

ORGANISATIONAL

- Weekend teleconference at 1.30pm (Saturday and Sunday)
- Daily assessment of capacity in the region
  - Mallow General Hospital
  - Bantry General Hospital
  - Mercy University Hospital
  - St Finbarr's Hospital
  - South Infirmary-Victoria University Hospital
- Discharge Area (presently being progressed).

BI DIRECTIONAL FLOW

- Daily assessment of Capacity in the region
  - Mallow General Hospital
  - Bantry General Hospital
  - Mercy University Hospital
  - St Finbarr's Hospital
  - South infirmary-Victoria University Hospital
- Mercy Urgent Care Centre (St Mary's Orthopaedic Hospital) 2012
- Local Injury Units (Mallow and Bantry Hospitals) 2012
- Transfer of non-benign surgical cases from day case waiting lists to Bantry General Hospital
- Improved access to theatre capacity in Mallow General Hospital for surgical and endoscopy lists.

SPECIAL DELIVERY UNIT LIAISON (SDU)

Since 2012 there has been very frequent and extremely beneficial liaison with the SDU on the management of unscheduled care.

Particular focus has been on:

- Trolley Performance
- 6 and 9 Hour PET
- Older Person Pathway
- Length of stay reduction
- Acute Medical Programme
- Orthogeriatrics
- Community Interface
- Delayed discharges
- Capacity analysis
- ED Conversion rates
- In addition the SDU have set the scene for high impact changes that affect significant access metrics
  - EDD Documentation
  - Home by 11am
  - Weekend Discharges.

CUH
Ospidéal na hOllscoile Corcaigh
Cork University Hospital