NHSO Supporting CUH Discharges

Deborah Harrington, Project Manager, Disability Services
&
Paula Murphy, Continuing Care Placement Coordinator

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Overview

- NHSS application process.
- Bed availability reporting – Continuing Care.
- Service improvement initiative to support ED admission avoidance.
- Quality improvement initiative involving placement coordinators.

Processing Acute Applications for NHSS

- NHSS staff specifically assigned to work on acute applications.
- Clear contact for acute staff queries.
- Ensures as quick a turnaround as possible and minimise any delays on the processing side.
- Critical to bring applications to waiting list status (2.4 letter) – leading to discharge to public units and accessing transitional funding for private nursing homes.

Tracking and Reporting

- Development of tracking updates.
- Provides guidance to NHSS staff to ensure maximum effort is invested in bringing medically discharges patients applicants to waiting list status (2.4 letter).
- Prioritisation of workload.
- Updates to Discharge Coordinator.
- Delayed Discharge Management Report to wider system.

Bed Availability Unit

- Comprehensive listing of available beds within the public and private system.
- Recently updated to two full updates per week plus updates as office is informed of NH vacancies.
- Circulated to Discharge Coordinators, Social Workers, PHNs Consultant Geriatricians etc.
- Key resource is supporting A&E

Supporting A&E Discharges

- Rapid Response Bed in city private nursing home.
- 72 hour bed.
- Limitations on length of stay and admission criteria.
- Analysis showed only 25% utilisation.

Supporting A&E Discharges

- In consultation with A&E and nursing home, bed ceased from September 2015.
- New approach – appropriate bed sourced as required NHSO, using bed availability as guide.
- Utilised the savings from cancelled Rapid Response Bed
- Public beds also in available bedstock but tended to be less availability as used to support convalescent discharges from wards.
- Respite cancellations in city respite beds also made available if no community match.
- Criteria developed with Catherine O'Mahony, Liaison Nurse, A&E.

Eligibility Criteria

To be eligible for accessing a short stay bed the patient must:

- Be able to independently perform activities of daily living or potential to do so within one week or a maximum of two weeks, i.e. patient will be back to their baseline in 1 – 2 weeks
- Need time to recover strength, endurance, or functioning and would benefit from a short stay in a nursing home
- Have needs that can be met in a nursing home
- Be able to return home within 7 – 14 days (maximum) of admission
- Assistance with activities of daily living at frequent intervals, or
- On–site supervision or monitoring at frequent intervals to insure his/her safety or well-being

Exclusion Criteria

- Cognitive impairment, behavioural issues or unstable psychiatric disorders
- More than two weeks of convalescent care required
- Permanent long-term care, complex care, slow stream rehabilitation (awaiting active hospital rehabilitation) or end stage palliative care admissions
- Patients cannot be admitted to a short stay nursing home bed to await for LTC placement

Number of Discharges from A&E

No of Discharges	Location
26	Private Nursing Homes
3	Vacant public convalescent Beds
3	Cancelled city respite beds

Accessing transitional funding enabled more discharges than would have been possible with just the savings from Rapid Response Bed

Integrated Service Planning

Nursing Home Support Office

Quality Improvement Plan

- Cork/Kerry Escalation Protocol
- **Background:** This protocol is designed to support Hospital Groups and Community Health Organisations in developing integrated escalation plans such that capacity and patients throughput is appropriately managed at a time of excess demand on emergency and acute services.
- **Purpose:** To ensure that admission, discharge and escalation (surge capacity) procedures are organised in a controlled and planned way that supports and ensures the delivery of optimum patient care in Cork and Kerry in 2016

- Community Placement Co-ordinators became leads in Community for each acute hospital.
- Lead Community Placement Co-ordinators for acute hospitals Cork/Kerry
  - Cork University Hospital – CPC North Lee West
  - Mercy Hospital- CPC South Lee
  - South Infirmary- CPC North Lee East
  - Bantry General Hospital- CPC West Cork
  - Mallow General Hospital – CPC North Cork
  - Kerry General Hospital- CPC Kerry

Organisational Arrangements

- Community Placement Co-ordinators contact Bed Manager/Discharge Co-ordinator in their allocated acute hospital each morning and afternoon to request
  - Number of expected discharges
  - Number of Community short stay beds required and required vacancies
  - Number of Community long stay beds required and liaise re: placements required

Organisational Arrangements

- Bed statistics are reported to Residential Services Manager's office daily.
- Information regarding Cork Hospitals is forwarded to General Manager, Cork Community Hospitals at 9.30am the following morning.
- Community Placement Co-ordinators liaise with colleagues and then escalate to Manager if difficulty accessing beds on that day
- In Complex cases Community Placement Co-ordinators will work with discharge co-ordinators and MDT to achieve a suitable/ appropriate placement. However if all efforts fail to resolve placement issues, the case is escalated to General Managers

- Community placement Co-ordinator North Lee West is now the point of contact for Farranlea CNU
- Community placement Co-ordinator South Lee is now the point of contact for Ballincollig CNU