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 total a population of 1.1 million.

In 2014 CUH had 65,000 ED presentations, 33,000 inpatient discharges, 82,000 day case discharges and 200,000 outpatient attendances. In 2014 CUH Maternity service (CUMH) had 14,800 inpatient discharges, 4,000 day case discharges and 8,000 births annually, making it one of the busiest maternity hospitals in the country.

CUH has 800 beds and the maternity service has 198 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 (3,555 WTE) of multiple professions and is the primary teaching hospital for the Faculty of Health and Science in University College Cork.
THE CHANGE PROGRAMME

Foreword

Our ambition for Cork University Hospital (CUH) Group is for patients and the quality of clinical care to be at the heart of everything we do and the Executive Management Board (EMB) will continue our collective efforts to put in place optimum arrangements for quality improvement and patient safety.

Key to this is the participation of patients in the planning and delivery of care we provide. To this end the EMB has endorsed and are fully supportive of the implementation of the Staff Guide to Patient & Public Participation Doing it with us, not for us launched in April 2015.

Over the last 5 years there have been major changes to improve patient care: implementing the regional cancer centre; service reorganisation; implementation of the Small Hospitals Framework in Mallow and Bantry General Hospitals and the clinical care programmes. In conjunction with these significant projects, the EMB has also led on the implementation of a Clinical Directorate governance structure supporting the delivery of all clinical services to patients.

The EMB have redesigned and are progressively implementing a hospital wide governance structure for quality & safety in line with HSE policy, HIQA standards and international experience. When fully implemented this will give effect to the necessary structures, processes and oversight to ensure the services in CUH are safe and provided to an evidential standard of excellence.

The purpose of this publication is to provide a summary of the many individual change initiatives that have been implemented in CUH in recent times that have contributed to the emergence of a culture of quality and safety that is critical to the delivery of the services that we provide. It is also very important that the contribution of very many dedicated staff who strive to continually improve services for patients is documented as part of the story of evolving services in the Hospital.

J. A. McNamara,
Chief Executive Officer.

1. Introduction

Quality improvement is one of the three activities described by Joseph Juran (a recognised quality leader and early influencer of improvement science) required for an effective quality system. The Juran trilogy consists of:

- QUALITY PLANNING
- QUALITY CONTROL
- QUALITY IMPROVEMENT

Considerable work has been undertaken by many individuals, teams and services to progress improvements in the quality of care provided to the users of our services. This has been undertaken mainly within the context of reducing budgets, staff moratorium and pay reductions and it is a tribute to staff that despite these factors they have continued to strive to deliver services to the highest standard possible. However it is acknowledged that there is an on-going requirement to further improve the quality and standard of care delivered to the users of our services.

2. HSE Quality Programme

The HSE Quality and Safety Programme was established under the 2015 National Service Plan, the aim of which is ‘to improve the quality of services with measurable benefits for patients and service users.’

The programme sets out a number of key objectives:

- Services must subscribe to a set of clear quality standards based on best practice;
- Services must be safe with robust levels of both quality improvement and quality assurance;
- Services must be relevant to needs of the population and
- Patients must be empowered to interact with the system delivering the service.

The programme has been structured in three distinct elements:

**PART 1:** National Quality Assurance & Verification Division - services that are caring, well led, effective and safe (Appendix 1)

**PART 2:** National Quality Improvement Division - support development of a culture where quality improvement is primary focus (Appendix 2)

**PART 3:** Joint quality related initiatives in the area of quality indicators and quality measurement systems.
2.1 Framework for Improving Quality

The HSE has developed a Quality Improvement Framework that sets out a model for the planning and delivery of care that is person centred, safe, effective and supports health and wellbeing and importantly provides a framework for all staff to improve the quality of care.

Six key elements make up this framework (Figure 1) and these have enabled CUH developed a quality improvement agenda that incorporates the distinct elements of the Framework.

3.0 Key Deliverables

The implementation of a quality and safety programme is an on-going ever evolving process and the following sections provide an overview of the progress made to date in this area;

3.1 Leading for Improvement

Leadership is arguably the most important element required to prioritise and improve quality of care and reduce harm to service users. All executive and clinical leaders have the opportunity and indeed the responsibility to be advocates for continuous improvement, to demonstrate their commitment to quality by speaking about quality, responsible for listening to service users/providers and seeking assurance that services are providing quality care by way of evidence.

In 2012 the Executive Management Board (EMB) commenced the process of introducing revised management structures that put quality and safety at the core of the business of the Hospital. This Clinical Directorate model is outlined in Figure 2.

Figure 1: Quality Improvement Framework

Figure 2: Clinical Directorate Model
The commencement of the introduction of this model has resulted in a focused approach to the development of the quality agenda and in particular:

- The inclusion of quality as a standard item on the EMB agenda;
- The establishment of the Clinical Directorate model;
- The Establishment of the Executive Quality and Safety Committee;
- The completion of Self-Assessment against the National Standards for Safer Better Health Care;
- The development of quality improvement plan for Hygiene to embed at all levels of the organisation the Hygiene and Environmental Standards;
- The development of quality improvement plan for Housekeeping services to reorganise the delivery of service in line with HIQA and HSE cleaning and infection control standards and the catering and hydration standards;
- The continuous focus on the retention of accreditation in services such as Pathology, Radiology and Endoscopy services.

3.2 Engaging and Enabling Patients and Service Users

Person centred care advocates placing service users as equal partners in planning an improving care. In the CUH Group the participation of patients in the planning and delivery of the care we provide is an entitlement to which we are all committed.

In 2015 CUH Group published its framework on patient involvement entitled Doing It With Us, Not For Us: Strategic Direction 2015-2018. The aim is to provide a staff guide for the CUH Group to foster patient and public participation at all levels and for staff to ensure that the services they deliver are patient centred.

A key requirement in engaging with patients and users of our services is listening to them as an integral part of our culture. This can provide a critical early warning mechanism where things are going wrong, provide assurance for the quality of the system and an indication of areas for improvement.

This process has been very useful in identifying key areas of improvement including:

Complaints Management
- Review of monthly Key Performance Indications;
- Completion of 6 monthly trends and analysis from patient complaints;
- Detailed statistics on numbers of complaints received under National Charter.

Complaints Handling
- Lean Mapping project to identify areas of improvement in the handling of complaints to include timeframe for completion;
- Complaints managed at Directorate level which allows for improvement in complaint management and the identification of learning opportunities for staff;
- Investment in systems to support improvement in the management of complaints and central database.

3.3 Engaging and Enabling Staff

Staff are central to the promotion and delivery of quality care. It is recognised that staff wellbeing, morale and values are key factors that influence patients experience of their care and staff must at all times treat patients with kindness and empathy – something that is not always achieved in a highly pressurised environment. We are committed to supporting staff in pursuit of a culture of quality and it is essential that staff opinions are listened to and used to inform improvements. A number of initiatives are being progressed to help develop the culture of supporting staff to this end:

- The introduction of leadership walkabouts within the hospital
- Participation of staff in the Hygiene Quality Improvement Group which allows staff the opportunity to identify deficits and areas for improvement in their work area
- Participation of staff in change projects and in project teams
- Participation in staff surveys on patient safety culture and on organisation culture
- Securing agreement for CUH as a location for implementing the National Framework for Improving Quality
- Encouraging staff participation in the Diploma in Leadership and Quality in Healthcare
- Facilitating three staff multidisciplinary teams undertaking the IHI Quality Improvement Programme
- Provision of training for staff in Staff Engagement and Induction.
3.4 Delivering on Improvement in Care

Working to achieve a change culture requires us to not only identify opportunities to deliver safe, effective and patient centred care but to plan and deliver improvement outcomes that will make a material difference to patients. In support of these goals HiQA has developed a set of standards (National Standards for Safer Better Care) that form the basis of our quality assurance programme represented in Figure 3.

The national standards are intended to be used in day-to-day practice to encourage a consistent level of quality and safety in all acute healthcare settings. A process of self-assessment against the National Standards provides an opportunity for hospitals to make an assessment of the quality of care being provided and to prioritise improvements in areas that need greater focus and action. It also provides an opportunity to identify, recognise and applaud the excellent work that is undertaken by staff.

The Authority has four core activities or functions aimed at achieving these outcomes that are delivered in four Clinical Directorates (i) Regulation (ii) Supporting Improvement (iiii) Assessing Health Technologies (HTA) and (iv) Improving outcomes through information.

CUH has completed the self-assessment process through a Hospital Standards Committee and Clinical Directorate Structure and initially identified 400 Quality Improvement Plans. These have now been combined into 48 plans which have been aligned against the 8 standards and will form the basis of the work programme for the committee in 2016 (Appendix 3).

National Clinical Care Programmes

In 2015 the key actions for the Acute Hospital Division included a range of measures encouraged by the National Clinical Strategy and Programmes to develop Integrated Care Programmes (ICP). These ICPs are key to service delivery and reform and collectively they have been a catalyst for significant improvements in the delivery of care. This work is continuing and clinical models of care will be further enhanced to improve quality and to promote an integrated approach to patient flow, chronic disease management, and prioritising service enhancements to address demographic pressures.

CUH is an approved site for the implementation for the following Care Programmes
• Acute Medicine Programme
• Emergency Medicine Programme
• Elective Surgery Programme
• Diabetes Programme (Diabetic Retinopathy Screening Programme)
• Stroke Programme
• Trauma & Orthopaedic Programme
• Heart Failure Programme
• Epilepsy Programme
• Chronic Obstructive Pulmonary Disease Programme (COPD)
• Asthma Programme
• Epilepsy Programme
• Outpatient Programme
• Critical Care Programme
• Sepsis Programme

CUH Cancer Centre

In line with the National Cancer Forum, Cork University Hospital is committed to responding to the priority that needs to be given to advances in cancer care as set out in the second National Cancer Strategy A Strategy for Cancer Control in Ireland 2006, a vision of an Ireland that will have a system of cancer control to reduce cancer incidence, morbidity and mortality rates, relative to other EU countries.

Cork University Hospital is designated as one of 8 Cancer Centres and the purposely designed Cancer Centre was completed in November 2009 and provides high quality evidence based cancer care in accordance with the standard set by the National Cancer Control Programme and HiQA.

Services provided in the Cancer Centre include:
• Symptomatic Breast Service;
• Dedicated Breast Service Family History Clinic;
• Rapid access Prostate Service;
• Rapid Access Thoracic Lung service;
• Rapid Access Colorectal Service – delivered by Advanced Nurse Practitioner.

The services are governed by National Key Performance Indicators used to measures patient access, care and treatment delivery against pre-determined standards. Data is returned on a monthly basis to the National Cancer Control Programme and is used to measure outcomes and inform service improvements.
Staff in the centre are committed to improving patient care for their patients and have completed a number of initiatives that have improved the quality of patient services.

Lung Cancer Survivorship Programme
The purpose of this programme was to determine whether quality of life and exercise tolerance can be improved following a six week exercise and education programme for survivors of Lung cancer. The results of this programme were presented at a national oncology conference and lung cancer forum and other cancer centres are interested in running this programme.

Development of Clinical Audit Programme
The Executive Management Board are committed to the development of a Clinical Audit Programme and in support of this challenge in August 2015, appointed a Senior Clinician as Clinical Audit Lead with the following core responsibilities:

- to assist the Clinical Directors and teams in evaluating clinical effectiveness and patient outcomes through clinical audit
- to increase the level and activity of clinical audit in the hospital
- demonstrate enhanced levels of clinically effective treatments and pathways.

The EMB and Clinical Directorates are entirely committed to further developing the clinical audit function and will support the audit lead to do the following:

- Liaise with clinical services and department in the development of clinical audit at CUH
- Build an educational and structural framework to support the development of clinical audit
- Ensure that the work being carried out related to clinical audits is communicated within the clinical service and to clinical service management
- Capture the existing audit activity within and without the organisation to highlight the development of our current clinical activities and its outcomes
- Integrate with internal and external bodies in the promotion of quality activity
- Develop an Audit policy and Plan for CUH to include a catalogue of audits completed

The following is a sample of the clinical audit activity in the Hospital since the commencement of this function in 2015 as a sample of the activity that will be undertaken by the Clinical Audit Programme in the Hospital:

- From October 2014 to October 2015 Quality Office in CUH has registered 111 Clinical Audits
- Direct UCC link with, on average, 35% of audits registered
- Audit supports include Dr. O’Brien, Quality Manager and administration staff, Healthcare Records Manager and Record Retrieval Staff
- Approximately 50-100 charts on average are ‘pulled’ per audit by key staff in the Health Records Department which is a measure of the team approach to audit in the Hospital.

The advent of Activity Based Funding as the means by which hospitals will be funded as and from 2016, brings with it a need for validation of the coding processes to ensure that the complexity of the work undertaken in CUH is accurately documented. The Clinical Audit Office will have a key leadership role to play in overseeing this work through regular audits of coding activity. This will also provide an opportunity to enhance the training of NCHDs in many departments in the Hospital and will provide an insight for them into the importance of coding of cases and the impact on hospital funding.

There are multiple other quality and change initiatives in the process of implementation that reflect national priorities including the following:

Hospital Wide Quality Improvement Programmes
- Care Bundles
- National Early Warning Scores
- National Sepsis Programme
- Haemovigilance
- Productive Theatre and Productive Ward
- Hygiene Improvement

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Nursing Metrics
The quality of care provided at the bedside is a key indication to patients and their families and there is a particular commitment on the part of the EMB to support quality programmes that support the delivery of nursing care including the following:
- Pressure Ulcer Prevention & Documentation
- Medication Rounds
- Pilot of nutrition metric
- GBR & ITU national medication metric
- Falls, Restraint
- Patient Observations
- Developing a balanced suite of Quality Key Performance Indicators.

We have worked with the national quality team on the development of outcome indicators from HIPE, second round testing (Post-operative Respiratory Failure; Post-operative Haemorrhage / Haematoma; Post-operative DVT)

3.5 Measuring and Sharing Learning
Improvement of the quality of care is strongly linked with analysing information in relation to the service and making changes based on data. This requires the service to have the capability to measure and analyse information to provide assurance that the care is person centred, safe and effective. It also requires transparency in the measuring, sharing and reporting of data.

In CUH a number of measures have been implemented to provide assurance that there is measurement of the data and subsequent learning opportunities for staff.

Risk Management Activity
The management and mitigation of risk is a key challenge for the EMB and through the clinical governance programme the Hospital has implemented many processes to this end. These have been underpinned by a culture of learning from incidents that occurred in other hospitals and in CUH that inform improvements in practice.

External Reviews
The Hospital is committed to the implementation of findings and recommendations that have emerged from multiple external sources including HIQA investigation reports and specialist reviews that have been completed in other jurisdictions such as the Berwick Report in the NHS and the Mid-Staffordshire Report.

Internal Reviews
- Completion of comprehensive Internal Reviews where adverse incidents have occurred;
- Monitoring of trends and analysis on internal adverse events, complaints reports and recommendations from internal serious events investigation reports to inform decision making;
- Quality assurance of all internal reviews into adverse incidents to ensure learning for the service and to improve performance.

Quality Reviews
- Completion of reports for presentation and discussion at Executive Quality & Safety Committee;
- Quarterly reports from Executive Quality & Safety Committee to EMB.

To prevent harm we must understand where harm has been caused and learn from adverse events and management oversight coupled with a culture of reporting and investigation of adverse incidents is the basis for learning and improvement.

Serious Adverse Events
- Safety Incident Management Teams (SIMT) oversee the management and investigations of serious incidents in accordance with HSE policy;
- The Hospital is committed to a policy of Open Disclosure and on-going communication with families;
- At any one time there are 8-12 Systems Analysis Investigations on-going.

Reporting on Internal Investigations
- As part of the governance process quarterly reports are presented by the Clinical Directorates on recommendations from investigations to the Executive Quality & Safety Committee;
- The Chairman of the EQ&S committee reports to the EMB on a quarterly basis on key issues as part of the quality assurance process for the Hospital.

System Analysis Investigations & Learning
- In order to build capacity and capability for investigations in CUH there are over 30 trained experienced investigators and the Hospital has an on-going programme of training in these competencies;
- A key challenge is to review the time taken to undertake systems analysis investigations and to work with the State Claims Agency to improve the time taken to bring legal cases to resolution.

Risk Register Development
- Much work has been done to build capacity in the Hospital for risk identification and assessment for inclusion in the Hospital's Risk Register;
- There has been substantial development of Directorate and non-clinical managerial Risk Registers that is now improving the management of risk and the implementation of risk mitigation measures;
- The Risk Department continues to develop Q Pulse expertise which is an electronic support for the management of risk registers;
- EMB & Senior Management Team bi-monthly review the effectiveness of controls on the Hospital's Risk Register;
- The EMB is supporting and encouraging the development of Directorate and Department risk register management processes as part of our quality assurance process.

The Risk Management Committee is presently developing a plan to embed patient safety within all individual staff and management processes by:
- Developing a strategic approach to proactive and reactive risk management
- Redesigning of escalation and management procedure for risks and risk registers
- Working towards the overall aim of explicitly linking registers to performance management reviews as part of the control assurance framework.
As a major trauma hospital the EMB is committed to participation in a number of national clinical audits in areas such as Major Trauma, ICU, Hip fracture and Comparative Hospital Mortality all of which help to inform practice and improved service delivery to patients. The outcome of these audits are used in many ways such as:

- Encouraging clinical leaders and departments to participate in national audits;
- Presentation of audit reports at the Executive Quality and Safety Committee;
- Provision of Hospital Standardised Mortality data to relevant clinicians to assist in the review of performance;
- Informing discussion at internal Mortality and Morbidity fora.

### 3.6 Governing for Quality

Governing for quality and safety means having the necessary structures, processes and oversight in place to ensure the delivery of services that are safe and provide excellent quality of care. Central to this is having a well governed Board/Management Team in place and providing supporting policies and incentives for improvement. There should also be defined structures for quality and safety and the monitoring of services through intelligent use of information. In support of these goals CUH has developed a model for Corporate and Clinical Governance outlined in Figure 6.

**Figure 6: CUH Clinical and Corporate Governance Structure**

**Governance for Quality and Safety**

Over the past 5 years CUH has been engaged in a programme to redesign the Hospital committee structures and processes in order to prioritise quality & safety and to increase transparency and accountability for the delivery of safe high quality services to patients.

In support of this management structure and in recognition of the importance of quality and safety, the EMB has prioritised investment in the clinical governance department in the Hospital and in the management systems needed to assure it of the quality of services provided.

In this regard the establishment of an Executive Quality and Safety Committee with broad professional representation reporting through the chairman to the EMB has been particularly important in providing oversight of quality and safety in the Hospital. It’s views and recommendations have been particularly important in informing decision making on the prioritisation of resources allocation and the setting of priorities.

The on-going implementation of the very many regulatory requirements for the Hospital is provided through a range of Hospital Committees on which sit multi-disciplinary staff with appropriate expertise.

**Balanced Scorecard**

The HSE recognises that continually strengthening accountability and good governance within the HSE is of critical importance. The Accountability Framework introduced in 2015 sets out the means by which the Acute Hospital Division (to include CUH Group) will be held to account for performance in relation to quality and safety of services, financial resources, access to services and effective management of their overall workforce.

As part of the accountability framework the performance of the Hospital is incorporated into a Balanced Scorecard which reflects the balance that needs to be achieved between apparently competing requirements such as financial performance and minimising waiting lists. The four dimensions used for the Balanced Scorecard are set out in Figure 7 hereunder.

**Figure 7: Balance Scorecard**
Within these dimensions there are a range of metrics that are monitored to ensure transparency and accountability and which form a critical part of the overall governance of the Hospital. The Balance Scorecard has been used as a reporting tool to the Executive Management Board and to the SSW Group and it will be further developed in 2016.

4.0 Patient Focused Improvement Projects

The EMB is committed to improving the quality of services delivered and developing a culture of safe effective patient care. A number of projects have been identified that reflect national priorities and the need to improve the management of patients who attend the Hospital as emergencies and who are treated as elective patients. The following represents a sample of the many projects that CUH is delivering in support of delivering efficient services in respect of the 500,000 patient interactions that the Hospital has each year.

4.1 Hand Hygiene Performance Improvement

Hand Hygiene is recognised internationally as the single most important preventative measure in the transmission of Healthcare Associated Infections (HCAIs). It is essential that a culture of hand hygiene is embedded in every service at all levels. (National Standards for the Prevention and Control of Healthcare Associated Infections; HIQA). HCAIs place a serious disease burden and have a significant economic impact on patients and healthcare systems throughout the world. It is well recognised that good hand hygiene, the simple task of cleaning hands at the right time and in the right way can save lives (WHO 2009).

To maintain a focus on continuous improvement in relation to hand hygiene and cleanliness of the environment a CUH Hygiene Quality Improvement Team was set up in 2014. The team is chaired by the Chief Executive Officer (CEO) and its membership is representative of the multi-professional staff in the Hospital. The team meets on a monthly basis to oversee the implementation of the quality improvement plans at which key staff are accountable for the outcome of audits on topics such as hygiene and the environment.

The key priorities for the Team can be classified into four main areas:
1. Revised governance and reporting systems;
2. Hand hygiene performance improvement;
3. Cleaning practices and cleanliness of patient equipment
4. Management of the physical environment;
5. Education.

The Hospital has developed a quality improvement plan to include an audit mechanism and review of all hand hygiene facilities and a plan for replacement of equipment where required. The details are outlined in the CUH Policy and Procedure on the Management of Hand Hygiene Audits.

4.2 Role of the Health Care Assistant

The role of the Health Care Assistant is evolving and is acknowledged as a critically important part of the multidisciplinary team delivering patient care. As part of the work of the Hygiene Quality Improvement Group, a review of the Job Description was undertaken to identify areas of improvement and in particular the opportunities to support Care Assistants in respect of their continuous education and professional development needs.

4.3 Scheduled Care Programme

In 2013 a CUH Scheduled Care Governance Group was established chaired by the CEO to oversee the implementation of the HSE policy on the management of inpatient and day-case elective care. The Group leads the implementation of processes that are standardised on a national basis and which set standard for the management of waiting lists for scheduled care.

The Groups’ critical function is to ensure appropriate governance is exercised in the management of inpatient / day case waiting lists and to ensure that there is complete, accurate, validated patient information for waiting lists. Critical to the achievement of waiting list targets is assurance that key functions such as theatre, out-patient facilities and diagnostic services are delivered optimally and these critical support departments have undergone enormous change in the past three years with more changes planned for 2016 based on lean management techniques.

A number of key change initiatives have been implemented which have resulted in an improvement in the delivery of scheduled care including:

1) Compliance with national policy on the management of waiting lists;
2) Implementation of measures to achieve waiting list targets in a sustainable way;
3) Implementation of recommendations contained in the Surgical Care Programme to improve patient experience;
4) Supporting the Surgical Directorate and the Theatre Users Group to improve efficiency in the management of patients through theatre, recovery and the ward;
5) Implementation of a Surgical Assessment Unit to support the Emergency Department;
6) Implementation of Day of Surgery Assessment Unit and Pre-Admission Assessment Unit;
7) Implementation of a theatre management IT system to improve efficiency in theatre and to support Activity Based Funding;
8) Reorganisation of the Bed Management Department to ensure that all admissions are managed through a centralised booking system;
9) Implementation of an Electronic Booking System.
The key enablers to support the full programme are outlined in Appendix 4 and in the CUH Scheduled Care Patient Pathway Booklet.

In 2013 the CUH Unscheduled Care Governance Group was established to oversee the delivery of emergency care. This Group incorporated the Acute Medical Care and Emergency Care Programmes to maximise the potential synergies in both. This enabled a structured work stream to be developed to effect improvements in the management of emergency care and to improve the patient experience. These strategies and change initiatives are documented in the CUH Unscheduled Care Patient Pathway Booklet 2014.

The Executive Management Board, cognisant of the need to further develop improvement strategies for emergency care continues to implement initiatives that will improve the patient pathway and enhance the patient experience.

In 2015 a number of these changes were encompassed in two major initiatives (i) Patient Flow Ten Point Action Plan and (ii) Patient Flow Action Cards. The Action Cards are outlined in Appendix 5 with the set of key enablers introduced to support the work of the group.

In order to address the multiple challenges in emergency care, strong leadership is required both in hospitals and in the community and the delivery of efficient smooth emergency care lies in the implementation of multiple changes initiatives involving the hospital, community and ambulance services which will be a focus for 2016.

**Lean Six Sigma - Value Stream Mapping Projects**

A value stream map is a visual depiction of a process or workflow which originated in the lean manufacturing industry. It is a series of techniques and measurement processes that helps organisations identify and minimise waste in its process and is becoming increasingly important in improving healthcare delivery.

The EMB is committed to implementing Lean and Six Sigma principles to improve the efficiency of services and to minimise redundancies in the process of delivering care. 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 and this work has been extremely important in improving patient care for patients presenting as emergencies.

The EMB will continue to support the use of lean mapping techniques to identify improvements in the patient flow areas and a number of staff have completed projects from which the learning has been applied within the Hospital such as:

- Predicted Date of Discharge – a lean management initiative to improve the identification of the Predicted Date of Discharges (PDD) for patients to improve patient flow processes;
- Reduction in Theatre Collection Times – a lean management project that has reduced the time taken to transfer patients from theatre to wards resulting in improved patient flow and better use of resources.

**5.0 Regulation in Healthcare Delivery**

The pervasive nature of health care regulation stems from the very nature of what the health services do which often involves providing advice and treatment that can involve risk to oftentimes vulnerable patients. In these circumstances it is clear that in a mature well developed society, oversight is needed to safeguard patients and to ensure that standards are set and complied with by providers. The government and by extension the Irish health system has had to evolve to reflect these concerns and in the hospital setting regulation and oversight takes place at multiple levels including:

(i) Conformance with laws that have been enacted to protect the public and to reflect what is required of providers in a developed society;
(ii) Health and Safety and other related legislative provisions make it mandatory that hospitals are inspected by the appropriate authorities to ensure conformance to standards;
(iii) HIQA, the body charged with overseeing the provision of safe healthcare, has the authority and responsibility to be the guarantor for the provision of quality healthcare;
(iv) As an academic teaching hospital, CUH is obliged to have in place well structured training programmaes for medicine, nursing, midwifery and for a range of therapies. Regular external assessments are carried out by the accrediting bodies to ensure conformance with these standards;
(v) In relation to employment processes a large body of law exists to protect the rights of employees and that define the relationship between the employer and employees.

As a result the Hospital is a highly regulated environment with considerable external oversight that helps assure the public that the services they are receiving are being provided by highly competent staff in an environment that is safe and that meets the necessary standards of safety and regulation.

The breadth of legal and regulatory standards in which healthcare is provided is set out in Appendix 6.

**6.0 Quality Programme 2016**

The development of a culture of safe and effective patient care is an evolving process and requires continuous commitment from and the involvement of all staff.

The EMB are committed to changing the focus of the quality and safety programme to bring it to the core of service delivery and have identified a number of improvements to be progressed in 2016 that will add to the measures already in place and further assist in developing a culture of safe and effective patient care.

**Quality Improvement Plans (QIP’S) – National Standard for Safer Better Health Care**

The Standards Implementation Team provides an important multi-professional resource that if augmented by other expertise has the potential to add value and take a leadership role in the area.
As previously outlined CUH have identified 48 QIP’s that will be implemented throughout the hospital 2016.

2016 Service Plan
In relation to the 2016 Service Plan a number of key quality improvement actions have been identified for implementation such as;

• Outpatient Quality Improvement Programme
• Implementation of the full set of Care Bundles
• Nurse Prescribing
• Theatre Productivity Programme
• Progress Endoscopy/JAG Accreditation
• Antimicrobial Stewardship Programme
• Nutrition and Hydration Programme
• Child and Adolescent Management
• Staff Training and Development
• Commissioning of new designated Paediatric Facilities.

In the process of constructing our 2016 service plan a number of key development priorities and quality initiatives have been identified and a number of these are listed hereunder:

Catering Service
• Audit and improve all menus in consultation with colleagues in dietetics
• Training for catering staff, including basic food nutrition, therapeutic diets, customer service, hand hygiene, food presentation, allergens, calorie posting
• Upgrade of equipment in department on a priority basis as much of the equipment is nearing the end of its life cycle
• Introduction of Allergen and Calorie Posting Policies
• Review and update all departmental policies.

Radiology Service
• Fill vacant nursing positions
• Work with the National programme on the implementation of an Integrated RIS/PACS solution across a wide group of Hospitals
• Staffing of Hybrid vascular room with HSE staff due to commence in post in April 2016.

Services
Major Emergency Planning
• Submit emergency documents to the Management Team for approval in January 2016
• Circulate Severe Weather Plan in quarter one
• NCHD awareness of MEP – Distribute MEP info leaflets on induction
• Print, publish and circulate updated MEP document in the new format
• Flu plan to be circulated in quarter one
• Circulate Mass Fatalities Plan in quarter one
• Undertake monthly meetings
• Liaise with area Emergency Management Office regarding emergency planning issues
• Ongoing exercising and training for a Major Emergency.

Blood Bike South
• Meet quarterly to review and update SLA as necessary.

FOI/Complaints
• Attend Consumer Affairs FOI information session on February 10th
• Achieve Turnaround times to promptly address all FOI’s and Complaints logged to Services.

Smoke Free Campus
• Introduce smoke detectors and signage in areas where illicit smoking takes place
• Enhanced engagement with Line Managers in areas where non-compliance with Smoke Free Campus occurs
• Achieve BISC training targets for 2016.

Hygiene
• Trial mattress patches
• Replace sink splash-backs in CUMH
• Upgrade OPD Waste area
• Recover/replace chairs which are worn or damaged
• Painting schedule for CUH area as per maintenance department.

Physics Service
• Complete scientific reports for already completed project work
• Complete implementation of Head & Neck IMRT
• Upgrade computerised ECLIPSE Treatment Planning System to next software version (v13.6)
• Assist with on-going implementation of new Oncology Information System (ARIA v13.6)
• Commission new superficial therapy x-ray unit (Xstrahl 150)
• Implement MR/CT image guided brachytherapy
• Increase number of patients treated with IMRT in conjunction with other disciplines
• Develop Q-Pulse policy for training Treatment Planners
• Develop IMRT procedure for pelvic nodes.

Physiotherapy Service
• The development and roll out of an electronic referral system for inpatient referrals
• The development of a Spasticity clinic – senior in neurology gym will be working with the Consultant ion Rehabilitation Medicine in setting up a clinic to reduce high tone in patients with neurological conditions
• The commencement of the minor fracture clinic in mid-February between ED / Orthopaedics in order to reduce the waiting time for patients who have been seen in the ED and are waiting to be reviewed by the Orthopaedic team
• The development of an Oxygen clinic. Numerous studies have shown that many patients on home Oxygen may no longer require oxygen therapy or may require a change of prescription. It is proposed to run a clinic whereby all patients on home Oxygen will be review every 6 months and it is estimated that savings of €108,000 annually could be achieved.
Occupational Therapy Service
- Audit of ward environment’s suitability for dementia patients
- Outcome measures for all plastic and orthopaedic patients pre and post intervention, Quick DASH and PWRHE
- International Best Practice guidelines to be implemented as they are updated throughout the year.
- Development of Guidelines for the prevention and treatment of Contractures in Adults with Neurological Dysfunction.
- Development of outcomes measure with Palliative Patients
- Involvement in the National Lymphoedema Framework which is auditing Lymphoedema service in Ireland and developing National competencies.
- Development and maintenance of facilitation of Lymphoedema Support Group.
- Introduction of Fluoroscopy guided MLD into service.
- Introduction of Falls Prevention Group in Care of the Elderly Rehabilitation setting
- Implementation of Visual Scanning Treatment program
- Establishment of Cognitive Rehabilitation treatment with Care of the Elderly population
- Journal article on use of Bayley Development Screen with Premature Babies.

Housekeeping Service
- Continue to evaluate the effectiveness of the Environmental deep cleaning teams (SWOT initiative) in terms of improving hygiene standards
- Progress the amalgamation of the Environmental Audit and the Hygiene walkabout audit tool
- Prioritise staff training and development.- Basic food hygiene training , Clean pass training programme, & training for Housekeeping Supervisors.

Podiatry Service
- Patient Satisfaction Survey
- Research
- Patient Information leaflets
- Caseload Management.

Speech and Language Therapy
- CUH wide essential in service education and training re Dysphagia and MCD/National Descriptors.
- Launch of the use of ISBAR tool to improve communication across the clinical teams and ourselves, across all of the sites where we provide care
- The training required and the roll out of Electronic Patient Record in CUMH plus the necessary SLT training of Neonatologists, their teams and the Neonatal Nurses in CUMH
- Mallow General Hospital:
- Development of Modified Consistency Diets which adhere to the National Descriptors and the delivery of an in service education and training programme about Dysphagia for all Ward based staff.

Cardiac and Renal Services
Renal
- Blood Borne Virus Committee developed to develop PPG’s for management of all Blood Borne Viruses
- Develop data base for monitoring and education of Hand Hygiene and PCHCAI attendances
- DOSA for Tenchoff Insection
- Introduced the VIVA machine for home dialysis.

Cardiology
- Undertaking 4 Nursing metrics, Medication, Pressure Ulcer prevention, Documentation and Nutrition
- PVC audits monthly
- Developed Heart Failure Care plan
- Monthly audit of EWS
- Hand Hygiene audits.
- Developed TAVI Pre and post procedure care plan
- 100 % staff have ACLS certification in CCU
- Environmental Audits.

Cardiothoracic
- Reviewing and developing Clipping policy
- MDT Reviewing HCAL Policies.
- Undertaking Nursing metrics, Medication, Pressure Ulcer prevention, Documentation and Nutrition.
- Monthly EWS Audits
- Hand Hygiene Audits
- Environmental audits.

Warfarin Clinic
- Implementation of the DAWN clinical decision support software.

Nurse Practice Development
- Development of NPDU Strategy 2015-2017
- Development of page of communication on CUH website for NPDU
- Control Drug Ordering System (To prevent delays in patients receiving their analgesia)
- New Profile Document and updating in Paediatrics
- Education sessions on implementing Children’s Nursing Metrics (Test Your Care)
- Supported the introduction of Linear Labels (To improve labelling compliance & release more time to care for frontline staff)
- Review of Paediatric Care plans
- Formulation of Heart Failure Care plan
- Synopsis of Documentation trial on 3D & 4D (To release more time to care for patients)
- Improving the current metrics system in particular the demonstration and review of results
- GA Neuro – Audit of system regarding Nursing Handover
• Development & trial of new Medication Record on 1A & GA Neuro with plan to roll out to the hospital in March 2016
• Formulation of Tropicamide protocol for eye clinic (To enable nurses to administer Tropicamide thus enhancing the patient journey)
• Nutritional Screening, Blood Glucose Monitoring, Preoperative and Falls Policy
• Psychiatric unit & 5B Student Orientation Booklets
• Review of current prescription transfer system to SIVUH
• 6 weekly rotation of 10 minute information sessions to improve metric results thus care standards
• Work on organising a forum for nurses to present their research to improve patient outcomes – “Lunch & Learn” commencing monthly from January 26th 2016
• Work on “Inaugural CUH Research Conference – Enhancing Patient Care Through Research” on 24.5.16

Emergency Department (ED)
• Major Trauma Audit
• Dartmouth Microsystems ED initiatives
• Develop ED Morbidity and Mortality
• Develop Trauma Morbidity and Mortality
• Develop CUH Resuscitations Committee
• CUH Deteriorating Patient Group
• Introduction of Entonox for minor procedures
• Ambulance Clinical Handover Policy & Procedure

Radiation Oncology
• Transperineal Prostate Biopsies – only Munster centre offering this technique in public service
• Radium 223 Xofigo – new radioisotope treatment for advanced prostate cancer initiated at CUH July 2015
• Prostate cancer clinical trials opened at CUH: PEACE-1, ENZARAD, radium223/ enzalutamide phase 2 study. CUH was the first hospital in Europe to open the ENZARAD trial
• Twice weekly consultant peer review radiotherapy treatment planning meeting
• Institution of a 3 times weekly palliative radiotherapy clinic, offering rapid access and coordinated care delivery for palliative patients
• MRI Brachytherapy Treatment Planning

Medical Oncology
• Establishment of Chemotherapy Pre-Assessment Clinic

Acute Medicine
• Establishment of TIA Clinic

7.0 Conclusion

We operate in a very dynamic and ever changing environment that challenges us to continuously review how we deliver care. Changes in science, new technologies, interventional techniques and staff each pose different challenges that are an integral part of being a large academic teaching hospital.

These changes in healthcare delivery also offer opportunities to deliver new treatments for patients and to continue to improve the quality and safety of care that we offer. These are challenges and opportunities that we take very seriously and the range of quality initiatives set out in this booklet will, I hope, provide evidence of the work done by outstanding staff in CUH.

We are aware that we must continue to change and evolve the way we provide services in the hospital. We have I believe successfully created a culture in which the pursuit of quality and safety are integral to what we do. We will continue to encourage innovation and support staff in any initiatives they undertake for improvements in patient care and we always welcome feedback to inform further change.

J. A. McNamara,
Chief Executive Officer.
Appendix 1: National Quality Assurance & Verification Division

QUALITY ASSURANCE & VERIFICATION DIVISION

Preventing Harm
- Serious Adverse Events & Safety Incident Management
- Serious Reportable Events
- National Incident Management & Learning Team
- National Incident Management System

Listening to Service Users
- Complaints Management
- National Appeals Office
- The HSE Confidential Recipient

Quality Assurance Framework
- HSE Accountability Framework
- Escalation, Intervention & Enforcement
- National Performance Oversight Group (NPOG)
- Healthcare Audit Team
- Corporate Risk

Medical Ionising Radiation
- Medical Ionising Radiation Unit (MERU)

Appendix 2: National Quality Improvement (QI) Division

QUALITY IMPROVEMENT DIVISION

Quality Themes
- Patient Centred Care
- Supporting Staff to Improve Care Information & Evaluation for Quality Improvement
- Governance for Quality & Safety

Quality Improvement Programmes led by QI Division
- Pressure Ulcer Prevention
- Nutrition & Hydration
- Safer Medication
- Healthcare Acquired Infection (HCAI)/Decontamination
- Clinical Directors Programme
- Governance for Quality & Safety

Supported Quality Programmes
- Governance for PPPGs
- Quality Improvement Teams & Improvement Capability Disability Services
- Patient Centred Care
- Supporting Quality Improvement Initiatives Across HSE Services

QID Led & Funded, Delivered Professional Colleges
- National QI programme (including Diploma in Leadership & Quality in Healthcare)
- National Office Clinical Audit (NOCA)
- National Specialty Qi Programme
- Histopathology, GI Endoscopy & Radiology

Appendix 3: National Standards for Safer Better Healthcare Quality Improvement Plans

THEME 1

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• National Early Warning Score (NEWS)
• Prevention and Control of MRSA
• Clostridium difficile
• Irish Maternity Early Warning System (IMEWS)
• Clinical Handover in Maternity Services
• Sepsis Management |
| 2.2      | 1.1    | —— |
| 2.3      | 3.1    | Mandatory Transfer Policy
Awaiting National Handover Policy
Nation Integrated Care Guidance – Bed Management
Nation Integrated Care Guidance – Bed Management
Discharge Planning
Plan for every patient
Visual hospital |
| 2.4      |        | —— |
| 2.5      | 8.2, 8.3 | National Clinical Guidelines
Clinical Information System – ITU & CCU
Electronic Patient Record
On-going project in CUMH – Plan to go live 2015 |
| 2.6      | 2.1, 6.1 | Statement of Purpose Recommission |
| 2.7      | 5.5, 6.4, 7.1 | —— |
| 2.8      | 5.2, 5.5, 5.8 | Executive Quality & Safety Committee |
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Appendix 4

Cork University Hospital – Scheduled Care Governance Programme

Key Enablers – Inpatient and Day Case Governance

GOVERNANCE

- Scheduled Care Governance Group chaired by CEO (established 2013)
- Theatre Governance Group
- Perioperative Directorate Core Group
- Perioperative Operations Management Team
- Theatre Operations Manager
- National Surgery Clinical Care Programmes
- Quality Improvement Plan
- Implementation of single governance structure for theatres
- LOS monitoring by condition, by team by consultant

SUPPORTS IN PLACE

- Day of Surgery Admission (DOSA)
- Dedicated Surgical Ward
- The Productive Operating Theatre
- Pre – admission assessment
- Dedicated Emergency Theatre
- Dedicated Trauma theatre
- Surgical Assessment Unit
- Appointment of Consultant Ortho geriatrician to facilitate patient flow for post trauma patients between CUH and the SIVUH
- Established Centralised Bed Booking Office – Bed Manager controls access to beds
- Electronic Bed Booking System

- Electronic Theatre Scheduling System
- Implementation of Electronic Theatre Lists
- Theatre scheduling/management of overruns – daily monitoring
- Rotation of nursing staff on campus to create greater economies of scale and efficiencies
- Opening of Hybrid Laboratory
- Implementation of Safe Site Surgery Protocol
- Implementation of EWTD Maximisation Day beds – turnaround of two patients per day
- Appointment of Clinical Facilitator for Theatres
- Increased uptake of Theatre sessions at MGH
- Additional Outpatient & Theatre capacity at BGH
- Participation in weekly cost containment meetings
- Participation in weekly hospital cost containment meetings

MANAGEMENT INFORMATION FLOWS

Use of NOCA data to inform performance and audit
Collation of date in relation to Turnaround Times – Start – Finish time of list
Time to Anaesthesia
Theatre Management Reports
Implementation of cost accounting process in theatres

TRAINING AND DEVELOPMENT

Lean Management Training for staff
Introduction of Anaesthetic Nurse training course
Finalising the commencement of a Foundation Corse for theatre nurses within the South-South West Hospital Group.

Key Enablers - Outpatient Services

GOVERNANCE

Outpatient Service Management Group chaired by CEO (established 2013)
Monthly meeting to review performance
Liaison meetings with the South-South West Hospital Group Lead for Scheduled Care in relation to waiting list management and national KPI’s
Direct Liaison with Clinical Directorates and Clinical Leads.

SUPPORTS IN PLACE

National Outpatient Improvement Programme
Centralised Referral and Appointment Management Office
Restructure of consultant OPD clinics by speciality to provide dedicated consulting rooms for the Neurology service
Introduction of generic waiting lists – commenced in Neurology, Rheumatology, Paediatric Neurology and Cardiology
Maximisation of capacity across the hospital group – access to OPD capacity in Mallow General Hospital and Bantry General Hospital
Management Reporting System – detailed management reports on identified KPI’s
Aligning Consultant theatre lists with OPD lists to maximise capacity
Rolling validation of waiting lists to ensure accuracy
Introduction of ‘out of hours’ clinics as part of the waiting list management in line with national targets
Introduction of Physiotherapy led clinics – Rheumatology and Neurosurgery
‘See and Treat’ clinics for Plastic Surgery patients ‘out of hours’ clinics
Commenced the introduction of GP sessions in the OPD clinics to maximise patient throughput

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Appendices
**Appendices**

**ACTION CARD 1**

28 day cohort CUH

A 5% reduction in LOS in this cohort will yield 1900 bed days (on 2014 estimates)

A 10% reduction in LOS in this cohort will yield 3,800 bed days (on 2014 estimates)

**ACTIONS:**

1. Each Monday and Thursday 9am. Bed Management Unit will print inpatient census of those >21 days. (excluding Mental Health Unit, Intensive Care and Paediatrics) Copy provided to Discharge co-ordinators, Bed Manager and Flow Manager.

2. Each morning each CNM/Nurse in Charge prints out Ward Census from iPM. (This list has automatic LOS generation on print out).

3. That patients greater than >21 days will be discussed bi-weekly at a meeting every Monday and Thursday at 2pm-2:30pm.

4. This meeting is held in the HUB in the CRC.

5. Present at this meeting is Bed Manager, ADON, 28 Day Coordinator, Business Manager Medical Directorate.

6. 28 Day Coordinator has discussion with Discharge Coordinator and Ward CNMs and Medical Team as appropriate to facilitate discharge.

7. Unresolved issues from this meeting will be escalated to the Clinical Director, Chief Executive Officer and Chief Executive Officer.

8. In particular, transfers back from the National Rehabilitation Hospital or any patient identified on admission likely to be an inpatient in excess of 28 days, need to have a clear plan of care and discharge, prior to transfer to Cork University Hospital.

**ACTION CARD 2**

Discharge Process

**ACTIONS:**

1. **Plan for Every Patient** must be completed and updated live by all disciplines. The ultimate responsibility of completing this rests with allocated nurse and overseen by Nurse in Charge.

2. Each Consultant/Firm needs to identify designated ward round time (ideally before 10am) and communicate plan for patient and specifically to include PDD. This ALWAYS needs to be communicated nurse in charge.

3. Mandatory component of inpatient care is Plan for Every Patients this involves
   - Check Yesterdays Plan
   - Review Today’s Plan
   - Review Future Plans
   - Record and ACTION issues

Potential impediments to discharge need to highlighted and escalated to nurse in-charge.

Planned Discharge Date must be addressed and recorded for all patients daily

4. Every morning the Nurse in charge from individual ward attends the HUB to confirm discharges in their area.

**ACTION CARD 3**

Discharge Unit, Ward 4D

Target patient flowing through the Discharge Unit is 40% of all discharges.

**ACTIONS:**

1. The Discharge Unit is open Monday to Friday 8am to 4pm (last patient admitted at 3pm). It is currently located on Ward 4D-Room 10 and 11.

2. The goal of the Discharge Unit is to optimise patient flow and have patients in 2 hours.

3. Exclusion Criteria:
   - End stage Palliative care
   - Wandering and confused patient
   - MRSA Patients
   - Patients for acute inter-hospital transfers

4. Contact Number is 085-851-5566-Contact Nurses are Lisa Murphy and Ann Marie Calnan

5. Ideally the patient should transfer with completed Discharge documentation; however this can be completed in the Unit by teams. In addition Allied Health Professional and Clinical Nurse Specialists review can happen in the Unit also.

6. The patients and their family must be informed of the transfer to the Discharge Unit and the collection time.

7. All Patients Identification Bands MUST remain in place.

8. All patients MUST be transferred on iPM from parent ward to Discharge Unit/Lounge.

**ACTION CARD 4**

Standard Daily Operation Process

Every day, Cork University Hospitals needs to generate the demands of Unscheduled and Scheduled Care. There is a daily requirement for (only subject to minor fluctuations) of approximately 40-45 Medical Beds, 30-35 Surgical Beds.

**ACTIONS:**

1. Bed allocation is based on principle of clinical justice and in accordance with National Key Performance Indicators
   - No patient over 75years with a Patient Experience Time over 9hours
   - No patient to have PET time over 24 hours

2. Only time stamp to be discussed is Patient Experience Time (PET)
3. Morning report by Night Sister at 7.45am to Senior Nursing Team and Bed Management in the HUB.

4. Allocation of beds by Bed Management to CNMs at HUB meeting 8.30am (see Action Card 2). **Allocated patients must be moved from the Emergency Department between 8.30-10.30am.** Options to facilitate this transfer include-sitting patients out, early communication with relatives, Home by 11am initiative, ambulance transfers and Discharge Unit (Action Card 3).

5. ALL Bed allocations can only be made by Bed Management. NO EXCEPTIONS.

6. 11am meeting in the ED Bed Management CNM 3/2 ED and ADON.

7. Hospital Status Meeting at 11.30am – 11:40am in HUB

**Attendees:** Bed Management, Clinical Directors, ADON’s, Theatre Manager, Orthopaedic Coordinator, Cardiology Liaison Officer, CNM III Emergency Department, EM Consultant, AM Consultant, Community Representative

**Agenda**

a. Review of previous 24 hours activity including Trolley Status and Bed allocation, Ambulance Offload times, Review PET
b. Discharges from Main Wards and CDU
c. Critical Care Capacity
d. Coronary Care Unit/Cath Lab/Outside Hospital referrals
e. Extra Beds review
f. Staffing
g. Bidirectional Flow (Bantry; Mallow; SIVUH, SFH)
h. Scheduled Care

A verbal action plan is produced from these meetings to address any additional actions are required to ensure patient safety and experience is maintained. Trigger points as identified in Action Card 6 will indentify necessity to use surge capacity and escalate further.

8. Communication between wards and Bed Management will continue throughout the day as per Visual Hospital Protocol.

9. Discharge as per Action Card 2

10. Nursing hand over at 5pm to Assistant Director of Nursing responsible for hospital in the evening

11. Nursing hand over at 7:45pm to Night Superintendent and Night Sisters.

**ACTION CARD 5**

**Bi-Directional Flow**

Cork University Hospital (CUH) is a Level 4 hospital and provides specialist services for Level 2 & Level 3 hospitals in the South Southwest Hospital Group (SSWHG). There are more than 40 specialties covering a population of 1,200,000. There is a mandatory no refusal policy for transfer from these hospitals to CUH. In addition it is imperative that once the episode of care is completed that these patients are repatriated back to their referring hospitals.

Ideally patients should transfer back to an inpatient bed however if a bed is not available they will be transferred to ED/AMU.

**ACTIONS:**

1. Each day Bed Management will have an account of available beds in SSWHG by 9am.
   a. South Infirmary Victoria University Hospital (by e-mail or telephone contact Scheduled Care Manager 021 4926617)
   b. St Finbarr’s Hospital (by e-mail & telephone contact with Nurse Liaison Officer, Ext 23231/087 9370913)
   c. Mallow General Hospital (by telephone contact with Nursing Administration, Bleep 204 through Mallow Switchboard 022 21251)
   d. Bantry General Hospital (by telephone contact with Nursing Administration, Bleep 023 through Bantry Switchboard 027 50133)
   e. Kerry General Hospital (by telephone contact with Nursing Administration 086 0431238)
   f. South Tipperary General Hospital (by telephone contact with Nursing Administration 086 7952875)
   g. Waterford University Hospital (by telephone contact with Nursing Administration 051 842336)
   h. Mercy University Hospital (by telephone contact with Bed Management 086 8283698)

2. Patients that are deemed suitable for transfer are handed over by a single telephone conversation, which will involve Bed Management, Nursing Administration and Medical Team.

3. All patients that require ambulance transfer are highlighted to Bed Management as early as possible. (National Ambulance Service require at least 24 hours notice).

**ACTION CARD 6**

**Internal CUH Surge Capacity for Admitted Patients in Emergency Department**

By maximising the performance of the throughput and egress of the hospital the requirement to utilise Surge Capacity will be minimised or indeed eliminated. However the following triggers indicate immediate action from Senior Management:

A. No of admitted patients in the Emergency Department is >6 patients
B. Any one patient over the age of 75 years in the ED more than nine hours
C. Any patient in the Emergency Department >24 hours
D. Three ambulances waiting to offload patients
E. Any ambulance waiting >30 minutes to hand over their patient

**ACTIONS:**

1. Optimise use of the following surge areas:
   a. Ward 4C (1 bed space)
   b. Ward 3D (4 surge beds)
   c. Acute Medical Assessment Unit (6 bed spaces)
   d. Ward 2A (31 bed spaces)

2. If all other action cards are adhered to and all surge areas are considered and triggers remain as outlined A to E above then an additional admitted patient is allocated to each ward. **This action must be approved by Chief Executive Officer or Director of Nursing or Clinical Director.**

Ideally the surge areas are for inpatients that are for discharge within 24 hours, therefore allowing the patients from the ED to go to their specialty ward.

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**Appendices**
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.

**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 / Cfo / 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, DON, AMU, 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**
- 12.30 pm Saturday/Sunday operational teleconference
- Hub meeting at 11am-attended 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
- 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 LIASON (SDU)**
Since 2012 there has been very frequent and extremely beneficial liaison with the SDU on the management of unscheduled care.

- Trolley Performance
- 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.
Appendix 6

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