Unscheduled Care
RVH Observational Study

3rd – 10th October 2022

Feedback Workshop
from clinical specialties

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AGENDA

	Agenda	Responsibility	Timeframe
1.	Welcome	Brian Armstrong	1:35pm
2.	Background and context	Brian Armstrong	1:40 – 1:50pm
3.	Stroke Presentation Q&A	Dr Ivan Wiggam / Jane Buckley	1:50 - 2:00pm
4.	Mental Health Presentation Q&A	Dr Ashling OHare TBC	2:00 – 2:10pm
5.	Acute Medicine Presentation Q&A	Dr Ian Carl	2:10 – 2:20pm
6.	Cardiology Presentation Q&A	Dr Colum Owens	2:20 – 2:30pm
7.	Fractures Presentation Q&A	Dr Ciara Stevenson	2:30 – 2:40pm
8.	Emergency Medicine Presentation Q&A	Dr Emma Greenwood	2:40 – 2:50pm
9.	Care of the Elderly Presentation Q&A	Dr Ruben Tauro	2:50 – 3:00pm
10.	Tea/ Coffee Break		3:00 – 3:15pm
11.	Respiratory Presentation Q&A	Dr Gareth Riddell	3:15 – 3:25pm
12.	Gastroenterology Presentation Q&A	Dr Graham Turner	3:25 – 3:35pm
13.	Hepatology Presentation Q&A	Dr Neil McDougall	3:35– 3:45pm
14.	General Surgery Presentation Q&A	Dr Aidan Armstrong TBC	3:45 – 3:55pm
15.	Neurology Presentation Q&A	Dr Rachel Todd	3:55 – 4:05pm
16.	Hospital at Home Presentation Q&A	Dr Jan Ritchie / Sarah McCauley	4.05 – 4.15pm
17.	Discharge Hub Presentation Q&A	Gillian Russell / Kevin Duffy	4:15 – 4:25pm
18.	Summary of Key Findings	Brian Armstrong	4.25 – 4.30pm
19.	Immediate Action Required & Agreed Next Steps	Chris Hagan	4.30 – 5.00pm
20.	Workshop Close	Chris Hagan	

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Welcome
&
Workshop Propose

Brian Armstrong
Director Unscheduled Care

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STROKE

Key Findings

Dr Ivan Wiggam & Jane Buckley

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Barriers to Flow	Opportunities for Improvement
Case 1 73y old, triaged 19:40 with TIA. Almost 4h until ED doctor. CT scan. Another 3h until stroke referral. S/B stroke >1h later. Ed overnigh, brought to SAB next am (no space overnight as already boarder)	Needed CT scan as on apixaban. Could have been sent home after scan and referred back to SDAS – ED decision. (Had 90% carotid stenosis). Stroke team unable to provide overnight TIA assessments.
Case 2 56y old, triaged 16:59 with ?stroke. S/B ED doctor 1h, referred 1h later, seen in 30 min, overnight in ED, PTWR in ED, CT scan, for OP MRI. MFFD at 11.30am, wait in ED for meds until 4pm. Diagnosis FND	Bed availability Delay in ED before DC waiting on meds. Went home came back for meds. Could pharmacy predict time to collect meds and allow patients to leave earlier?
Case 3 95y old man. Lysis call, 10:23. CT 13 min. Large stroke. Not for intervention. Waited in ED 23h for bed. Admitted to SU as boarder. Palliative.	Bed availability Sit rep – 5 delayed D/C in SU. 3 stroke patients in ED
Case 4 77 year old. Recent DC intracerebral bleed. Represented with headache/hypertension at 09:55. S/B ED in 5 hours, then CT. S/B stroke 4 h later (team in thrombectomy). Admitted SU 12 h after presentation. Inpatient 2 days (BP)	Bed availability Another SU doctor could have seen in afternoon, but would not have changed bed availability.
Case 5 51y old self presented. Lysis call 14.49. Stood down, symptoms >24h, ?BPPV, handed over to ED. ED arranged CT, referred to stroke, accepted to stroke 20:30, admitted SAB next morning.	Bed availability At time of acceptance to stroke, one inlier, 5 delays and 3 strokes in ED

Barriers to Flow	Opportunities for Improvement
Case 6 77y old man, self presented, triaged 12:39, SB ED doctor 6½ h later, CT, referred to stroke 4h after ED assessment, accepted, overnight in ED, SAB next am, diagnosis pre-syncope, discharged later.	?Correct referral pathway (although not always easy) Bed availability At time of acceptance to stroke, one inlier, 5 delays and 3 strokes in ED
Case 7 91 year old, lysis call 10:22 to resus, CT in 13 min, lysed 10:37, admitted to lysis bed. 28 min in ED, including getting staples in head.	None! This shows what can happen when there is rapid assessment in right place and available bed.
Case 8 60y old lady, lysis call 08:25, CT brain at 09:19 min (multiple lysis calls going on), MRI at 10:58 excluded stroke, handed over to medical team. Remained in ED until following morning, discharged after 3 days	Good initial pathway with access to MRI, delay in admission to medical bed delated to lack of beds.
Case 9 71 year old man with temp POC after recent admission, triaged 15:03, seen 6½ h later by ED, referred to stroke 2h later (after CT), reviewed 00:35, overnight in ED. PTWR in ED, diagnosis ?post-ictal, for pacemaker check. Was MFFD. Not seen by MDT in ED until after all tests. Confirmed not at baseline so admitted to stroke unit that afternoon at 13.20, back to baseline next day, but discharge hub needed to check care package met needs, confirmed, but at that stage >48h in hospital, his temporary package as withdrawn. Went home next day with family support (no POC – needed 2)	Incorrect pathway – drowsy, not stroke. Delay in ED physio/OT assessment until after medical tests – earlier assessment could have allowed alternative plan for DC. Delay accessing stroke ward as 5 delayed DC, one in SAB overnight.. Delay in DC home as delay in hub confirming that existing POC met needs, and then lost POC. (if family had not accepted, could have been much longer)

Barriers to Flow	Opportunities for Improvement
Case 10 37y old female, triaged 12:13, seen by ED after 4h, referral to stroke after almost 7h (after CT), accepted to stroke 23:18, spent night in ED, PTWR in ED, MRI at 10:40, then SB eye casualty, DC from ED at 20:00 (31h in ED)	Incorrect pathway – red swollen eye ++, cheek felt numb around this. Should have been referred to eye casualty versus stroke Lack of beds on stroke unit – 5 delays, already one in SAB overnight.

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STROKE

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Mental Health

Key Findings

Dr Ashling OHare

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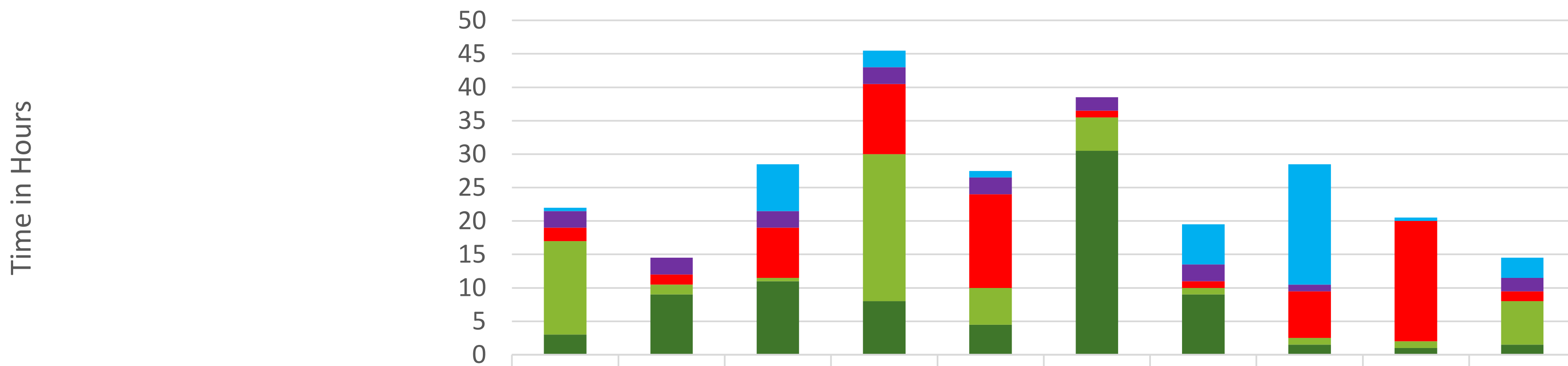
Time spent @ each part of the patient journey in ED by MH Patients



	1	2	3	4	5	6	7	8	9	10
MHLT Assessment - Discharge from Dept	0.5	0	7	2.5	1	0	6	18	0.5	3
Duration of MH Assessment	2.5	2.5	2.5	2.5	2.5	2	2.5	1	0	2
MHLT Referral - MHLT Assessment	2	1.5	7.5	10.5	14	1	1	7	18	1.5
ED Medic RV - Referral to MHLT	14	1.5	0.5	22	5.5	5	1	1	1	6.5
ED Booking - Medic RV	3	9	11	8	4.5	30.5	9	1.5	1	1.5

ED Booking - Medic RV
ED Medic RV - Referral to MHLT
MHLT Referral - MHLT Assessment
Duration of MH Assessment
MHLT Assessment - Discharge from Dept

Mental Health Findings

- Time in ED before referral to MHLT
- Sensitivity to staffing levels for response times
- Time in ED post MH assessment
- MHO assessment / Homelessness / Inter-Trust issues / Overnight assessments

Mental Health

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Acute Medicine

Key Findings

Dr Ian Carl

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Acute Medicine & CoE

Patients

- 20 patients
- Mean age 65.1
- 10 Males

- 8*Frailty
- 4*Seizures
- 2*Drug/alcohol misuse
- 2*Infection (cellulitis/UTI)
- 2*Mood disorder
- 1*Headache
- 1*ICH secondary to mets

- 14 discharged within 48 hours. At day 7, 7 are still inpatient.

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Acute Medicine & CoE

Barriers to Flow	Opportunities for Improvement
Several admitted under medicine then transferred to CAU or discharged within 24 hours	Better access to CAU
Of the frail cohort all were appropriate in that needed MDT (not all needed medicine)	Better DTA service and access to social care. Default remains admission not discharge.
One of the frail cohort, one had a UTI requiring IV's; ACAH might have accepted	Better ACAH model*-*
One admitted under medicine for neuro review (chronic headache)	Better access RANC

Acute Medicine

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Cardiology

Key Findings

Dr Colum Owens

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Recurrent Barriers:

- Triage to assessment (ED or cardiology)
- Under-utilisation of CP specialist nurses (3/10)
- Time delays in lab results and thus decision making
- Access to IP beds and delay to WB for eligible patients (6/10 went to lab)(2 patients >24hrs in ED)

Suggestion:

- New CPN led rapid access cath lab pathway and expanded chest pain nurse role in COTW

Barriers to Flow	Opportunities for Improvement
• ED- categorisation • Triage to medical assessment	• Chest pain nurse (CPN)ongoing education and interface with triage staff • 8am-6pm CPN assessment of suspected cardiac CP
• ED- blood results for decisions • DTA to cardiology assessment	• Ongoing assessment of delays (audit) • Outside 6- time limits on assessment
• DTA to admission	• Direct patient flow from ED to cath lab (CPN) for patients needing procedures • CPN to liaise directly with COTW team Expanded role of CPN
• Bed availability	• Maintain current footprint • Ensure early identification of patients ready for discharge
• In patient journey	• Reduce delay to WB (CPN to hot lab consultant with bypass of ward and WB)

Cardiology

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Fractures

Key Findings

Dr Ciara Stevenson

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Barriers to Flow	Opportunities for Improvement
Case 1 Delays during inpatient care 4 days to theatre for hip fracture In breach of national guidelines and increasing trend on National Hip fracture database	• Decompress main A theatres- access to DPU/DSU • 17 cases performed in A block during 4 days that were suitable for day case - Taking up inpatient beds awaiting theatre
Case 2 Delays during inpatient care 5 days to theatre for hip fracture Subsequent SSI and readmission and reoperation Spike in SSI rates currently under Investigation from M+M	• 9 cases performed in main theatre suitable for DPU/DSU
Case 3 Dislocated Total Hip Replacement 2 weeks post-op performed elsewhere Failed reduction in RVH ED Transferred to MPH for reduction but waited 24hrs on ambulance in RVH ED	• Ultimately went to appropriate unit • Ambulance access
Case 4 Simple ankle fracture Suitable for day case, admitted as outlier to 2E Waited in A&E for bed for 24h Waited for surgery for 3 days, 3 days for d/c	• Pathway for day case surgery • Post op physio access • Under wrong consultant on ECR (spinal surgeon)- admin support • Operated on by upper limb surgeon
Case 5 Simple ankle fracture Suitable for day case, admitted to fractures escalation ward Waited in A&E for bed for 24h Waited for surgery for 4 days	• Pathway for day case surgery • Post op physio access • Under wrong consultant- admin support

Barriers to Flow	Opportunities for Improvement
Case 6 Complex elbow fracture admitted 8th waited for upper limb consultant for 7 days for surgery Total elbow replacement 15th Remains inpatient on 18th	• Upper limb surgeons busy doing lower limb fractures in breach of GIRFT recommendations. • Open DPU to offset main theatres
Case 7 Ankle fracture CTMA from A&E due to caring responsibilities Re-attended following day for theatre in RVH	• Staff an ambulatory bookable day case list and patient could be booked on to that list
Case 8 91yr hip fracture – gamma nail day 2 Transferred to ward 29 post-op – remains inpatient 14days later	• Frail hip fractures not to be outlied post-operatively • Access to step down facility with acute medical care
Case 9 81yr hip fracture – hip hemi day 2 Transferred to Withers day 10 for rehab	• Access to step down facility with acute medical care
Case 10 73yr old conservative pelvis fracture Decision made on admission – conservative 9day inpatient stay in Major trauma centre	• Access to rehab facility for medically fit patients

Fractures

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Emergency Medicine

Key Findings

Dr Emma Greenwood

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RVH ED: Key Findings

1 day observation: (10 patient journeys studied, live patient feedback, live staff feedback)

- 390 triaged (around 300 to RVH ED/minors)
- 72 admitted patients awaiting bed (elderly patients waiting almost 3 days)
- 65 ambulance arrivals
- 56 admissions
- Resus rooms over capacity
- Delay to triage (2 hrs)
- Delay to NIAS offload (4 hrs)
- Delay going to ED from triage
- Delay to ECG/investigations
- Waiting time 10 hrs (16 hrs on 4th)
- No trollies, obs machines hard to find
- 50 did not wait/left against advice
- 1 death
- Patient feedback: 2 patients cried, poor at giving pain relief, patients understanding of pressures, some felt unsafe

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Barriers to Flow	Opportunities for Improvement
• No clinical space to see patients resulting in increased waiting time substandard clinical assessment and no dignity	• New model for COE/frailty assessment/MDT etc • Alternatives to ED for direct specialty referrals e.g.Post op or known chronic issues to go to a specialty assessment area outwith the ED (obviously critically unwell/patients requiring immediate intervention go to ED)
• Flows within ED	• Relocate triage back to ED, improve communication & flows to UCC/CAU etc MSK area in ED/zone C (more support, increase scope of practice etc)
• Patients transferred from other sites/services/facilities	• Direct assessment in specialty areas/wards (e.g. cancer centre, ward areas) • If patient requires ED there should be: Communication with ED staff & Communication directly to receiving specialty
• Improve time to ward (once bed available 15 minutes)– quick wins	• Transfer teams, pull from wards (rather than push, handover on wards/proforma) • Early senior decision making • Consider pull to investigations (e.g. xray)
• Completion of tasks on admitted patients to reduce wasted time in ED	• Admitting teams responsibility - maybe phlebotomist/FY1 to be in ED to complete tasks (repeat bloods, request imaging or chase results etc.)
• Disagreement about who is primary specialty team for patients requiring an admission: ‘that’s not my patient’	• Timely senior discussion and agreement between the specialty teams. Revisit internal professional standards for safer, faster hospital • Direct access to senior doctors (e.g. phone numbers)
• We have been boarding in resus	• Protect the resus spaces, no more boarding in resus (patients must be prioritised to go to ward from resus). Ring -fence resus spaces

‘The exit block I observed was among the worst I have seen in the UK’

(Dr Adrian Boyle, RCEM President)

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Emergency Medicine

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Care of Elderly

Key Findings

Dr Ruben Tauro

Belfast Health and Social Care Trust
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Patients/Stats

- 15 admissions (7 Acute Med >75) (8 admitted to 5E)
- 4 from SET (27%)
- 7 admitted 3/10, 4 on 4/10, 3 admitted 5/10, 1transfer into 7/10
- 13 NIAS, 2 GP(1 sent via NIAS),1NIAS transfer, 1 private transport
- 4 discharges (1 same day, 1 next day, 2 D5)
- 11/15 Trauma presentation - fall with head injury/limb injury +/- confusion +/- on anticoagulation

✓ Trauma with head injury on anticoagulation
✓ Trauma with head injury with alcohol on board
✓ Trauma with increased confusion X 2
✓ Trauma with limb pain X 4
✓ Trauma with back pain
✓ Haematuria

- 5 of the above trauma patients had a fracture
- 12 own home, 1 Temporary placement, 1 assisted living, 1 Retirement housing

Flow and aspects of care (Good/Could be improved)

- Good OT/PT support within ED
- Active screening by Hospital @ Home. Under surveillance for 24 hours.
- Delirium recognition remains poor – There is no 4AT scoring in PTWR. Out of 9 patients with acute fluctuating confusion only 1 had a diagnosis of delirium
- No documentation of Clinical Frailty score in any of the patients

Barriers to Flow	Opportunities for Improvement
Before admission	Community based resources- FFAU To advertise at GP federation
ED Trolley weights	More appropriate Specialty specific ward Frailty Intervention unit Hospital @ Home 2-3 day screening
During Ward stay	Recognition of delirium Clinical Frailty score and Anticipatory care plans Appropriate Discharge pathways
At time of discharge	Improved information on Delirium, Clinical Frailty score and consideration of Anticipatory care plans

Care of Elderly

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11.	Respiratory Presentation Q&A	Dr Gareth Riddell	3:15 – 3:25pm
12.	Gastroenterology Presentation Q&A	Dr Graham Turner	3:25 – 3:35pm
13.	Hepatology Presentation Q&A	Dr Neil McDougall	3:35– 3:45pm
14.	General Surgery Presentation Q&A	Dr Aidan Armstrong TBC	3:45 – 3:55pm
15.	Neurology Presentation Q&A	Dr Rachel Todd	3:55 – 4:05pm
16.	Hospital at Home Presentation Q&A	Dr Jan Ritchie / Sarah McCauley	4.05 – 4.15pm
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18.	Summary of Key Findings	Brian Armstrong	4.25 – 4.30pm
19.	Immediate Action Required & Agreed Next Steps	Chris Hagan	4.30 – 5.00pm
20.	Workshop Close	Chris Hagan	

Respiratory

Key Findings

Dr Gareth Riddell

Belfast Health and Social Care Trust
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Respiratory Medicine	Barriers to Flow
• 10/10 needed admitted to hospital • None known well enough for direct admission with subspecialty diagnosis • 1 documented under review with community respiratory nurse team • 2/10 under or possibly under the wrong team • 1 patient potential delayed discharge awaiting rehab bed.	**ED:** Finding the patient Getting bloods etc. Getting treatment started **Ward:** Getting Ix quickly Getting AHPs involved quickly Getting tests and referrals **At discharge** MDT input Discharge letters Pharmacy errors **MFFD** MDT input Timely contact with families Expired and bridging POC

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Respiratory

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Gastroenterology

Key Findings

Dr Graham Turner

Belfast Health and Social Care Trust
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- First 10 patients from ED presenting after 3/10/22 triaged to GI
- Random, no bias
- ?? Representative
- Known issues came up despite this

	2nd on/ GOTW	Date seen in ED	Date triaged to GI	Brief summary	Admission avoidance/ Alternative pathway?	Barriers to patient journey and discharge	Additional Comments
1	Leah/ Inder	admitted 30/9 AMU	4/10 PTWR on 7C	51 renal stone (passed). AKI. covid positive. vomiting not settling to triaged GI. settled when seen on PTWR.	• Could possibly have been d/c under AMU.		Patient was in corridor bed for her admission and then tested positive for covid 4/10 DC day after TOC
2	Leah /Inder	admitted 3/10	4/10 seen 8CC PTWR.	84 IDA- known to Mr Wallace- Ix for weight loss anaemia in last few years. Felt tired so bloods done- Hb 65 (normally sits around 80). Keen for home. had 2 units PRC.	• Ambulatory anaemia pathway as this was longstanding and no acute GI bleeding as cause.	• Patient d/c on same day as PTWR following transfusion for OP f/u	Patient on 8CC so transfusing units was very straightforward and allowed patient home same day.
3	Leah /Inder	4/10	4/10	36 Swallowed button battery (accidental) alcohol ingestion. seen PTWR, ogd that morning. home after		• Unable to scope from ED but bed identified in PTU which allowed endoscopy that morning.	
4	Leah or Gerard/ Inder	4/10	*NB seems to have been triaged 2 days in a row…) 4/10	34 Crohns. perianal abscess	• Wasn't clerked in on first morning. (hadnt yet been seen by overnight team) • Main issue of perianal abscess identified on PTWR and referred to colorectal surgery. • I&D 7/10	• Should have gone to colorectal surgery from ED. • Could potentially have been managed through EMSU pathways.	Refused surgery so Graham saw him for me and he agreed to see surgeons
5	Gerard/ Inder	4/10	5/10 (within 24 hours)	88yrs. Diarrhoea and vomiting. Recurrent problem; longstanding. Na 128, CRP 40. Recent acute pancreatitis. Keen to go home.	• Patient was keen to go home.	• none	Home next day and Nick follow-up

	2nd on/ GOTW	Date seen in ED	Date triaged to GI	Brief summary	Admission avoidance/ Alternative pathway?	Barriers to patient journey and discharge	Additional Comments
6	Gerard/ Inder	4/10	4/10	64 Abdo pain & vomiting. Alcohol dependence but abstinent 5 weeks. Hx gallstones/CBD stones/biliary stent 2017. DNA to f/u.	• No delay	• No delay – got ercp next day	Got home following day
7	Gerard/ Inder	Inder saw in endo	5/10	30 Vomiting ? UGIB Also had UTI	• Acute med/short stay	• n/a	OGD normal
8	Gerard/ Inder	5/10	5/10	85 Admitted with sepsis – UTI. CT double duct sign – not fit for further investigations	• Needed Abs - ? acute medical	• a/e then ward –no change in treatment	NOT FIT - ?appropriate
9	Gerard/ Inder	5/10	6/10	49yrs. Alcohol dependence. Vomiting and withdrawal x 2 days. High lactate, metabolic acidosis. LFTs/Amylase normal.	• No delay	• Discharged the next day	
10	Carolyn / Inder	9/10	10/10 (within 24 hours)	75 Coffee ground vomit, LD, NHR, schizophrenia, epilepsy. Hb 114, plt 112, urea 6. Not a good candidate for endoscopy	• Not fit – should not of been admitted	• Discharged on ward round	NOT FIT - ? appropriate

Barriers to Flow (patient related)	Opportunities for Improvement
2 patients admitted from NH – frail and not fit for any intervention/investigations Regular, recurring issue especially ??UGI bleed/coffee ground vomiting and not fit for OGD	?opportunities in community to avoid inappropriate decision to send to hospital ?Link to hospital teams/advice in this setting ??NH to secondary care emergency referral screening/help
frail elderly patients with multiple comorbidities with mild self-limiting GI symptoms that settled <24hrs, often due to UTI etc	consistently the main problem when patient numbers increase, i.e. frail patient with no specialty problem ?frail patient discharging team
Iron deficient patients and IBD patients admitted acutely regularly (2/10)	IDA pathway for transfusion/iron/Ix in development IBD flare clinic just started
2 x patients with alcohol withdrawal and vomiting needing IVF NB one did have gallstones and needed ERCP	?alternative pathway/site for managing simpler cases

Barriers to Flow (system related)	Opportunities for Improvement
Very (very) difficult to scope patient in any part of ED other than SSU/PTU One of our ‘10’ affected but sorted (and DC) however often not resolved	Easier pathway for ED/Maj/RATU/AED when patient needs OGD Eg recover in Endoscopy and return when completed (many can go straight home from endoscopy) GI team to look at ambulatory emergency endoscopy slots
We are still being asked to take non BHSCT UGI bleeds out of hours despite regional directive to manage within Trusts	Are Senior Exec Team able to help with this? Not an ED admission but important if we are considering all admissions for our BHSCT patients

Gastroenterology

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Hepatology

Key Findings

Dr Neil McDougall

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- First 10 patients from ED presenting after 3/10/22 triaged to Hepatology
- Consecutive cases, no bias
- Light week (daily triage ranges from 0 to 7)
- Excluded regional transfers that didn't go through ED

	Date triaged to Hep	Brief summary	Admission avoidance/ Alternative pathway?	Barriers to patient journey and discharge	Additional Comments
1	3 Oct	Alcohol withdrawal seizure (but normal LFTs)	• Seizures are a marker of not being suitable for community detox	• none	
2	4 Oct	Patient with cirrhosis. Fall with long lie and fractured wrist. Not really for Hepatology but AMed under pressure so accepted.	• No alternative to admission as needed treatment followed by rehab	• None	
3	4 Oct	End stage cholangioCA with jaundice. Discharged from UHD 2 days before with clear palliation plan. GP OOH decided to admit with bilirubin >400 despite plan.	• No need for admission but difficult for ED to turn around at night. Discharged by Hepatology on same day.	• Poor communication between UHD, patients family and GPOOH	
4	5 Oct	40yo Liver transplant recipient with sepsis due to UTI and electrolyte disturbance	• Definitely required admission but drove from Enniskillen to RVH rather than attending local hospital.	• Consider local admission with daily phone advice • Difficult to tell transplant recipient to go to a hospital without the expertise	Liver unit had been in contact with patient over previous weekend with advice to try to avoid admission, then infection developed
5	6 Oct	82 yr old with decompensated NASH cirrhosis, needing large volume paracentesis, treatment of anaemia (70) and SOBOE	• Was attending ACC for paracentesis to try and avoid admission but was too sick to be treated as day case	• None. Patient extremely keen for discharge and went home within 48hrs	

	Date triaged to Hep	Brief summary	Admission avoidance/ Alternative pathway?	Barriers to patient journey and discharge
6	6 Oct	87yr old with jaundice and sepsis secondary to ascending cholangitis. Imaging confirmed CBD stone which was treated by ERCP	• No alternative to admission	• None
7	6 Oct	Known cirrhosis brought in by police due to odd behaviour after RTA (no alcohol). Had encephalopathy, treated and discharged within 24hrs	• No alternative	• None
8	6 Oct	Large GI bleed in patient with known ALD cirrhosis. Required urgent OGD and then treatment for alcohol withdrawal	• No alternative	• none
9	6 Oct	Massive bleed from oesophageal varices in patient with known ALD cirrhosis (off alcohol). Ended up in theatre within 2 hrs of triage but good outcome	• No alternative	• none
10	7 Oct	Large GI bleed from gastric varices in patient with known ALD cirrhosis but off alcohol. Also electrolyte disturbance	• No alternative	• None

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Barriers to Flow (system related)	Opportunities for Improvement
• Very few barriers for Hepatology due to the fairly obvious condition of patients needing Hepatology admission	• ED to remember there is a Hepatologist on call for advice
• ACC already used for admission avoidance but some patients are very borderline and get admitted anyway	• Look at ACC capacity – cannot always fit in paracentesis at short notice

Hepatology

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General Surgery

Key Findings

Dr Aidan Armstrong

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Pt	Time ED	Time ref	Time Surg	Time Ward	Diagnosis	Problem
1	16:39	01:19	02:03	21:50:+1	Reduced stoma op	Long ED referral time/No IP bed
2	21:45	03:04	05:56	19:20:+1	Post anterior resection collection	Long ED referral time/No IP bed
3	18:10	05:50	06:17	18:20+1	Perianal abscess	No bed/Too unwell to await SaMS
4	19:30	02:00	05:30	14:00+1	Perianal abscess/Surgical staff doing laparotomy	
5	18:35	22:44	23:49	12:18+1	SBO	No delays
6	20:58	01:20	06:00	23:00 +1	SBO / awaited plain film, bloods and CT in ED	
7	19:08	03:00	06:15	16:00	Cholecystitis	No bed
8	20:18	01:11	03:30	19:30	Cholecystitis	High volume referrals/No bed
9	21:11	01:41	05:45	18:30	Cholangitis – surgical team in theatre	
10	13:18	22:00	22:30	15:20 +1	RIF pain	Long ED referral time seen within 30 mins No bed

General Surgery

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Neurology

Key Findings

Dr Rachel Todd, Neurology ST7
Dr John McKinley, Consultant Neurologist

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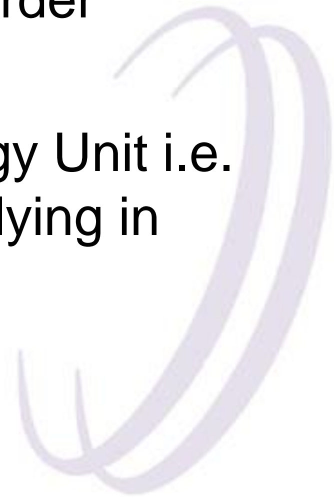
- 9 patient journeys reviewed. All admissions included. 6 from ED, 2 from home, 1 transfer from another hospital, (2) taken over from another specialty, (1) from eye casualty.

- Diagnosis: Bulbar dysfunction x2 (life threatening); seizure; status epilepticus x2 (life threatening); optic neuritis, likely MS (sight threatening); Idiopathic Intracranial Hypertension (sight threatening); acute spinal cord syndrome; Functional Neurological Disorder

- Barriers to flow: accessing a bed in the Regional Neurology Unit i.e. significant delay to admission/transfer or several days outlying in another ward. Neurology footprint not adequate.



Barriers to Flow	Opportunities for Improvement
Access to admissions e.g. 1 patient was originally booked for urgent admission 12/09/22 and admitted on 07/10/22.	Expand footprint. Scheduling of unscheduled care.
Access to Neurophysiology e.g. requested 07/10/22, completed 14/10/22, reported 18/10/22. Requested 04/10/22, completed 11/10/22, reported 12/10/22.	Better access to Neurophysiology.
Access to imaging e.g. MRI requested 07/10/22, completed 18/10/22. Other patients waited >2 days for an urgent MRI.	Better access to MRI e.g. dedicated Neurology slots.
Outlying in another ward e.g. 1 patient was an inpatient for 7 days and spent the whole admission in another ward. Delay in accessing AHPs/medical staff.	

Neurology

One Service Improvement by December 2022?

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Hospital @ Home

Key Findings

Dr Jan Ritchie &
Sarah McCauley

HSC Belfast Health and Social Care Trust
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Key Findings:

10 ED patients face to face review on site by Hospital:

- **Within Age Range 70 years+**: 26 patients **(6.6%)** in RVH and 12 (8.8%) MIH = **38 patients (7.1%)**

- **Out of Trust area** = 8 RVH and 2 MIH = **10 patients (26%)**

- **Patients requiring specialty referral** = 12 RVH and 4 MIH = **16 patients (42%)**

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Recurring themes (which reflect H@H exclusion criteria):

- Patients out of Trust area
- Specialty specific needs – Cardiology, Stroke, Fractures, Surgery, GI, Urology, Neurology
- Unstable patients

	Referrer	Reason for referral	Diagnosis	Trust		Outcomes
1	Family referral via NIAS	?Stroke	Confirmed stroke	BHSCT		Admitted - speciality (Stroke)
2	Self-referral via NIAS	Diarrhoea and recent d/c pancreatitis	Possible chronic pancreatitis/low Na	NHSCT	IV fluids and d/c after 24 hours with GI follow up	Admitted - speciality
3	Self-referral	Pain post catheter	Catheter trauma/erosion	NHSCT	Urology and discharged	Discharged
4	Residential Home staff via NIAS	Unwitnessed fall/ HI	Fall and head injury with laceration	BHSCT	Discharged after investigation/ imaging	Admitted under Medicine
5	GP Referral	Chest pain	Non cardiac chest pain	BHSCT	Discharged by cardiology after exclusion	Cardiology r/v and discharged
6	Family referral via NIAS	Confusion and seizure	Alcohol withdrawal seizure	BHSCT		Admitted under Medicine
7	GP OOH referral via NIAS	Shortness of breath	CAP/CCF/fast AF	SEHSCT	Discharged after 12 days for rehab	Admitted under Medicine
8	Carers referral via NIAS	Unwitnessed fall / Long lie / Alcohol dependency	C-Spine fracture Alcohol dependency Head injury and haematoma	BHSCT	Remains IP – imaging/ management	Admitted under Medicine
9	Family referral via NIAS	Unwitnessed fall	#NOF	NHSCT		Admitted under specialty - ortho
10	GP OOH with family	Abdo pain	Na 111	BHSCT	Remains IP	Admitted under Medicine

Barriers to Flow	Opportunities for Improvement
Out of Trust Area Patients particularly when Trusts are in escalation with Trust diverts in place	- If adjacent trusts follow regional model for H@H then this may improve - When appropriate we give contact details for neighbouring teams but difficult with variation in referral criteria
Specialty specific needs	- Nationally other specialties offer H@H services …. encourage other trust specialties to consider developing H@H type services or virtual wards - Work on falls/fractures pathways
Unstable patients	- Follow up on unstable patient after 24 hours and if have stabilised may be suitable for discharge to the team at that point - Timely diagnostic imaging and investigation
Avoidance for ED attendances	- Ongoing education and communication with GPs and NIAS for early engagement and advice for patients who can be signposted to FAU, Community Falls Team (CFT) or H@H - Further Primary Care engagement planned with communication and face to face presentation on available services for Older People, (FAU, H@H & CFT) November 2022 - Need to ensure capacity for community referrers – quickly lose confidence and reduce referrals if 'no capacity'….balance of resource between case finding/team caseload
Clinical confidence	- Ongoing education of referrers – good relationship with clinical staff in MIH ED who often refer appropriate patients directly before case finding - Ideal model for the future where ED teams refer directly with confidence

Hospital at Home

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Hospital Social Work & Discharge Hub

Key Findings

Kevin Duffy ASM Social Work
Gillian Russell ASM Community Discharge Service

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Key Messages

10 patients triaged and screened for Discharge Hub

- Age Range: 69-92 years - average age – 83 for 10 patients
- Gender: 3 Male patients (30%) and 7 Female patients (70%)
- 90% admitted following fall –100% admitted from home, 70% of patients were known to community services at point of attendance
- 30% potentially could have been managed in non ED setting 70% had either HI/# needed ED setting
- 60% Patients discharged within same day – x4 Discharge to Assess (turn around 1 hr) , x1 Interim (turn around 4 hr) , x1 family support to await increase POC
- 40% admitted 10% D/C within x4 days, 30% remain NMF & inpatient as of 17/10/22
- 50% referrals received before 11am, 40% referrals received between 12.30 – 3pm,10% referrals received after 3pm
- Attendance to ED and onward referral to Discharge Hub – Average 26hr 18 mins
- Discharge Hub provided immediate allocation of cases to ED as per protocol
- HSW referrals 50% – did not receive full set of Assessments - average wait 38 hrs for assessments
- 100% of referrals came from ED AHP staff

Barriers to Flow	Opportunities for Improvement
• Timeliness of referrals to Discharge Hub – Average 26hr 18 mins	• Lengthily attendance to referral time, early identification for MDT? Need for larger Audit to establish underlying contributors
• Once referred wait time for assessments and incomplete assessments(average wait 38 hrs)	• Target time to receive assessments – operational target to be considered with ED • IT platform • Education sessions for ED staff on requirements for assessments for discharge pathways • Better co-ordination/ communication of assessments / DC plan • Office space in ED for Hospital Social Work staff
• Receiving referrals for patients not medically stable • Challenge in use of operational resource, 40% of patients admitted to main hospital, 30% long term admissions (query inappropriate referral).	• Develop early review of referrals to clarify likelihood of admission? Tiered at point of referral • Office space in ED for Hospital Social Work staff
• Referral reason – lack of clarity or understanding	• Electronic system for ED track reason for referral
• Accessing rehabilitation beds – this is via medic to medic to COE. Non acceptance of referral for Rehab beds in Meadowlands/ Lansdowne/ Domnall from ED by Geriatricians.	• Access to COE to triage for Rehab beds

Hospital Social Work & Discharge Hub

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allied health professions
Better living matters

AHP
ED Audit

Elaine McConnell
Interim AHP Co-Director
Oct 2022

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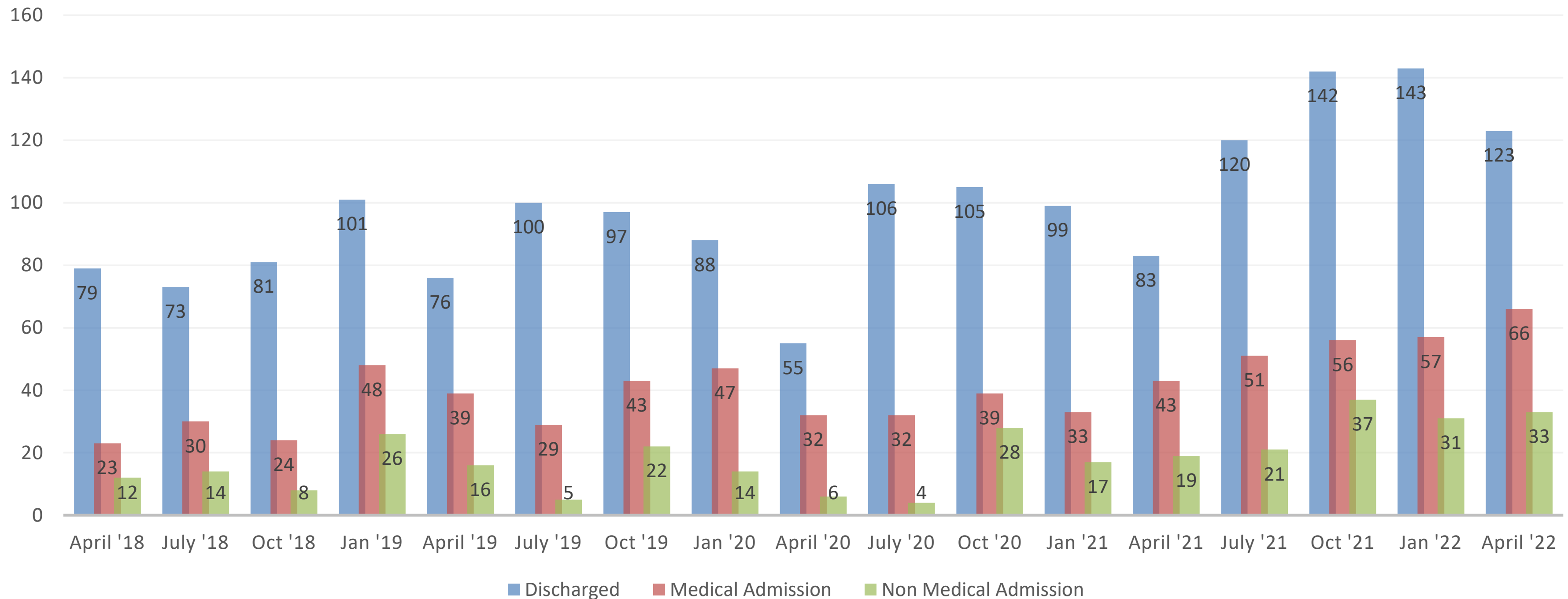
Average times & Barriers

- 11 patient journeys
- Mon-Fri and Weekend
- Time Attended to Time Referred: 8.5 hrs- 38hrs with a median time of 19 hrs.
- Time Referred to Time Assessed: 5 mins- 240 mins with a median of 30 mins. Weekend (30 & 90)
- Average assessment time 58 mins (62)

- Outcomes: 8 discharged (73%)
  3 admitted – 2 medical, 1 non medical.

Outcomes of MDT assessments
April 2018 – April 2022



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Delays & Barriers

- Difficulty contacting families, SE Trust.
- Difficulty contacting Trust services e.g. clinics, CT, portering
- Hub stops at 4.30 (2 quick restarts by staff)
- Time for communication
- Lack of Ax space,
- Space for interpreters
- having to intervene in emergencies

AHP Patient time in motion ED 03/10/22 – 09/10/22

Patient ID	3808488087	3768633918	3229091833	3631420900	3341507701	3721044983
Time attended	03/10/22 @ 13:22pm	03/10/22 @ 14:55pm	03/10/22 @ 18:43pm	04/10/22 @14:22pm	05/10/22 @18:15pm	08/10/22 @ 02:26am
Time referred	04/10/22 @ 08:30am	04/10/22 @8:30am	05/10/22 @08:30am	05/10/22 @09:25am	07/10/22 @08:15	08/10/22 @ 10:55am
Time Initial Ax	08:50am	11:35am	09:00am	13:15pm	09:00am	12 noon
Length of Ax	90 mins	40 mins	70 mins	55 mins	15 mins	30 mins
Outcome	Provided with W/Aid. Referred to DTA followup	Recommended interim bed x1	CTO brace fitted but uncomfortable Provided with W/Aid	Restart POC with medication support	Community Physio ALD referral Referral to CSW - Long term suitability of supported living	Patient at baseline – Indep with W/S. Postural drop
Barriers	Booked transport with Red cross	Attempted contacting family x6 as lady confused Referred to Hub @12:15 re POC. Difficulty contacting SE trust	CT imaging X2 attempted contact # clinic x2 – no answer Delayed in fitting CTO brace due to lack of space to Ax patient	Functional Ax completed btw sub wait and trolley on corridor Numerous calls to SW – 1.5hrs	Patients medical condition managed overnight – could have been managed by GP (Laxido mx) ED not the environment with autistic non verbal LD client	Unable to determine baseline until NOK arrived – Interpreter required Environment not appropriate in majors – moving patients around to complete Ax
Final outcome	D/C home @ 12:49 awaiting transport (no room in DC lounge)	Non medical admission as no services available – Level 8 Escalation	CTO brace no longer required DTA followup D/c home with family 13:33	05/10/22 @ 18:57pm Followup with GP Pharmacist Community SW Referral to Physio Doms team	07/10/22 Admitted medically for bowel mx @ 16:46pm to ward 7C as awaiting supported living to clarify if he could return	D/C'd 14:17pm Referral to FAU for BP postural mx

Patient ID	3284039260	3697824104	3439793710	3360263472	3533032051
Time attended	05/10/2022 22:56pm	05/10/2022 19:00	06/10/2022 06.06	06/10/2022 09.04	08/10/2022 18.46
Time referred	06/10/2022 10:00am	06/10/2022 09:00	07/10/2022 09:20	N.B. DTA 06/10/2022 15.42 07/10/2022 16.25	09/10/2022 08.20 in morning meeting
Time Initial Ax	06/10/20222 11:50am	06/10/2022 09:30	09:25	07/10/2022 16.50	09/10/2022 08.50
Length of Ax	70MINS (INCOMPLETE)	60 mins	50 mins	70 mins	90mins
Outcome	Only initial completed still awaiting functional assessment Ax will be completed post transfusion (1 unit)	Patient discharged to sons property at 11:00. Son aware requiring supervision mobilising and on stairs as per preadmission function.	Patient discharged back to residential home, Community Physio follow up as 3 falls over short period.	Home Pt @baseline	Home Pt @baseline
Barriers	Pt dinner arrived - OT needed to get pt table to eat lunch Pt needed disconnected from completed iv's Needed to attend another choking pt (5-10 mins) Needed to clear pathway for crash trolley & sick pt to be moved out of majors Ax then stopped as medic decided blood transfusion required	Nil available bathroom in majors Had to porter to stairs in level 6 for stair assessment.	Assessment completed in narrow space on Majors floor. Had to await medications and transport prior to discharge.	S/n interupted Ax to advise pt had bed on ward & could transfer up. MDT advised may be able to get pt home & will update nurse & pt flow in 20mins ie.Post Ax OT had to find & contact OOH care company to restart POC as son advised unable to restart same	Empty cubicle & tidy - Find space in sub wait. Get porters chair. Handover given to sub wait nurse Find ED consultant as night duty doctor now off duty to provide handover & D/C 20mins trying to get porter to take pt to dc lounge Note writing delayed as responding to requests of new pt info whilst trying to complete current pt info
Final outcome	Pt had another fall whilst awaiting blood – DTA 16.50 Pt transferred to 7B 07/10/2022 01:43	Patient discharged to patient's sons property at 11:00.	Patients discharge to residential home at 13:15	18:00 pm D/C'd Red cross transport. No hosp bed req'd	PT discharged home.

AHP Roles in ED

- Evolved OT & PT Assessment, Intervention, treatment, advice, equipment
- Discussion with MDT & Hub
- Discharge Co-ordination
- Referrals

- Time intensive Role
- Significant non clinical time
- Holistic approach
- High rates of Discharge

Summary of Key Findings

&

Actions to take forward

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Service Area	Improvement Focus
Stroke	• New Direct Access Pathway for TIA
Mental Health	• Pilot new Side by Side approach for ED Mental Health Patients
Acute Medicine & CoE	• Increase ability to refer directly to AC@H • Dedicated Frailty Assessment Area on RVH site
Cardiology	• QI project for Troponin • Increasing hours for Chest Pain Nurses to work 8am – 8pm • Ring-fence Cath Labs slots for ED patients to ensure procedures on same day as presentation • Explore potential of direct admission pathways
Fractures	• Conversion of inpatient list to daycase list on RVH site
Emergency Medicine	• Relocate Triage & MSK service to Level 2, RVH to provide more senior decision making
Care of the Elderly	• Integration across 3 teams to ensure services are more accessible Community Falls team Falls & Frailty Unit Care & Support Team
Respiratory	• More direct admission pathways for Respiratory ward • Greater use of Community Respiratory Team in regards to oxygen support
Gastroenterology & Hepatology	• Iron Deficiency Pathway • IBD Flare Clinic /Pathway • Ability for fast tracking ED OGDs in regards to patients not having to wait for available inpatient bed before procedure carried out

Service Area	Improvement Focus
General Surgery	• Improved post-surgery discharge advice to avoid unnecessary ED attendances • Pathway for perianal abscess attending ED
Neurology	• QI project for Neurophysiology to improve waiting time and subsequent reports • Eye Casualty & Regional Papilledema Pathway
Hospital at Home	• Expansion of active case finding to cover both Mater & Royal sites • Greater liaison with NIAS in regards to AC@H services
Hospital Social Work & Discharge Hub & AHPs	• Additional HSW & AHP support for ED • HSW ICT platform

Overarching Actions:

- Rapid Access Clinics (54 clinical teams all to have rapid access clinics)
- Follow up workshop in December 2022