NORTHERN AREA HEALTH BOARD

Report No 4/2004

Services to Older Persons
Summary Bed Management System Audit Report

An essential element in the continuum of care for the elderly is the provision of suitable long-term care facilities. Our Board is concerned that long-term beds are not being fully utilised with occupancy rates showing: 10% of public beds under-utilised and 15% of contract beds under-utilised.

There are insufficient long-term care beds available to meet the demand. *The Years Ahead* provides service norms indicating the number of long-term care beds required per 1000 elderly in the population. Using these norms, 1,839 beds are required to serve the 48,396 elderly living in our Board's region. When the Bed Management System was introduced there were 1,113 beds in our Boards area, which indicates a shortfall of over 700 long-term care beds required to serve the elderly population living within our area.

We decided there was a need to develop a new information system for the management of the public long stay beds in our Boards area and set up the Bed Management System, which would produce a combined community and hospital waiting list for long-term care beds and enable the gathering of accurate information regarding bed occupancy rates and other key performance indicators.

A steering committee was established to oversee the implementation of the Bed Management System. An IT system was designed using the Patient Administration System (PAS) and three our Board administrative staff members were appointed bed coordinators to operate this IT package. Agreement was obtained from the Consultant Geriatricians and Consultants in Psychiatry of Old Age to divide the public and contract beds between the three Community Care Areas. The steering committee set three basic standards prior to the implementation of the system;

1. Referral form was designed
2. Operation guidelines for the bed coordinators were drawn up
3. Client's position on the waiting list would be determined by the date upon which they were assessed to require long-term care.

The steering committee also requested an independent audit of the new system over a six-month period. The Department of Public Health and Primary Care, Trinity College Dublin was commissioned to conduct this audit. The aim of the audit was to act as a safeguard for the integrity of the Bed Management System and to act as a mechanism to facilitate reviews by an independent observer.

A clinical audit tool was chosen as the framework for the audit. The structure of the audit was to review the allocation of long-term care beds in 2002 and following the implementation of the Bed Management System from 1st May until 31st October 2003. The process entailed establishing communication with the main stakeholders involved in the placement of older people into publicly funded long-term care. Through this communication the collection of data on the clients admitted into long-term care in 2002 and during the audit period (***Table 1***). The audit report highlights the outcomes of the new system, the changes made and the issues, which still require attention in order for the system to meet its aim and objectives (***Table 2***).

Table 1: Total number of clients admitted into long term care in 2002 and during the audit period (01.05.03 – 31.10.03)

Time	Total admissions	Location prior to admission to long-term care
2002	379: o 200 public* o 179 contract	41% (150/363) acute hospital 24% (87/363) St. Mary's 14% (51/363) community 13% (47/363) nursing home 8% (28/363) psychiatric services
Audit period	64: o 34 public o 30 contract	28% (17/60) nursing home 27% (16/60) community 23% (14/60) acute hospital 22% (13/60) St Mary's, St. Ita's, welfare home

* Includes 38 admissions to Lusk Community Unit, which opened during 2002

Table 2:Outcomes and changes required, which were identified during the audit.

Topic	Outcomes	Changes required
IT Package	Additional reports designed; waiting list and tracking movement.	Adequate distribution of waiting lists. Establish feedback to bed coordinators of changes in the clients details. Establish a method of ongoing monitoring.
Operating procedures	Operating procedures were revised. Regular contact established between the social workers and the Manager of Services for Older People.	Review the staffing implications of the new system; clinical and administrative in the hospital and community settings.
Refusal to avail of a long-term care bed o 26% of those offered a bed declined the offer	Recording of the decision to decline offer on the waiting list report.	Agree the management of those who decline a bed offer.
Referral form	Form adapted to capture the location of the client while awaiting placement.	Review the data requested on the form.
Bed closures: o 30 beds in St Mary's o 28 contract beds since 01.09.03 o 64 public beds intermittently in Cuan Ros, St, Clares, St. Monicas, Lusk	The number of clients placed during the audit period reduced by 66% compared to 2002 (64 *versus* 190).	Agree criteria to allow prioritisation of urgent cases on the waiting list. Re-division of the long-term care beds in light of bed closures.
Acute hospital discharge initiative	Hospital based clients placed into long-term care outside the Bed Management System. Recording of these clients on the waiting list.	Agree how the funding for this initiative is to be managed in the future. Seek clarity on the issue of eligibility to publicly funded beds.
Phasing out of contract beds	Drop in the number of beds available to the Bed Management System.	Agree how the funding for these beds is to be redistributed.
Emergency cases	OUR BOARD agree to provide temporary emergency accommodation for emergencies within the existing budget.	Agree the criteria for and management of emergency cases.
Tracking movement on the waiting list	Waiting list reviewed weekly by the auditor. New report designed to track movement.	Set up ongoing monitoring of movement to ensure the system is open and transparent.

DISCUSSION

The Bed Management System was introduced to provide equitable access for community and hospital based clients at a time when there were insufficient long-term care beds in our Board's area to meet the demand. Shortly after its introduction there were further reductions in the number of beds available, which resulted in consultants having, on occasions, to prioritise the clients that were admitted into a long-term care bed. The provision of additional funding by the Department of Health to alleviate the pressure on the acute hospital beds saw hospital-based clients being accommodated ahead of community-based clients and overcame a small reduction in nursing home provision in line with budgetary constraints*. In addition, the ERHA's policy decision to phase out contract beds by replacement with Enhanced Subvention was a new challenge to the System. Despite these external factors the Bed Management System has continued to operate.

A combined waiting list or database is now in place, which provides, for the first time, central information and vital statistics across our Board's area on the total number of older people awaiting long-term care. The information on this database is essential to the region's service planners in aiding the identification of the geographic distribution of the more vulnerable elderly who have been assessed as requiring long-term care. This information is also valuable to community-based health professionals, including general practitioners and public health nurses, by enabling them to identify the elderly awaiting placement in the community setting.

The reduction in the number of beds in our Board's area has resulted in fewer clients awaiting placement being accommodated and results in the need to prioritise clients to ensure beds are allocated equitably to those in the greatest need. The lack of clarity around an individual's entitlement to a publicly funded long-term care bed in the current climate of insufficient beds is an issue, which also requires attention.

The placing of names on the waiting list in chronological order according to the date upon which the client was assessed favours those who have been known to the service over those clients who, for whatever reason, are new to the service and does not allow for the prioritisation of cases according to clinical need. This could result in clients being referred for long-term care placement in anticipation of them requiring the service some time in the future.

At the time when the new system was being introduced plans were in place to expand the care of the elderly services within our Board's area. The Home First Programme and a stroke unit were to be introduced in CCA 6. These services and the rehabilitation beds in St. Mary's Hospital and James Connolly Memorial Hospital enable clients to reach their maximum potential and could potentially reduce the demand for long-term residential care. However, there has been a delay in introducing the new programmes and clients who are awaiting long-term care placement are currently occupying many of the rehabilitation beds. It is vital that these types of preventative services are available to improve the quality of the services being offered to the elderly in an effort to reduce the need for residential long-term care.

The implementation of the Bed Management System involved many people across disciplines. The process was labour-intensive as anticipated, particularly for the bed coordinators and the members of the audit committee. However, there was evidence of a huge willingness to work with the new programme. Through the audit period

there was evidence of inter-agency communication and collaboration, which enabled issues which required attention to be effectively addressed. By its nature there was collaborative working between Northern Area Health Board staff and their colleagues in the Mater and Beaumont Hospitals. This commitment is greatly appreciated, as we understand enriching experiences were gained. Now that the pilot is complete, our Board in partnership with all stakeholders is proceeding, informed by the recommendations of the Audit Report, with the full implementation of the Bed Management System Phase II.

If the system is to continue within our Boards area there is a need to consider the establishment of a more formal structure to support its implementation, involving an implementation team, and working groups to explore specific issues.

M. Windle
Chief Executive ***19th February, 2004***

**Work programme to re-commission all closed beds -approved by ERHA*