Capita's Report to the Employers and Unions

National Review of Bed Management Function

Final Report

27th January 2003

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1. INTRODUCTION

1.1 Introduction and Context

In May 2002, Capita Consulting was commissioned by the health service employers and nursing unions to undertake a comprehensive review of the bed management function on a national basis. This review was commissioned to address issues that arose as a result of industrial action taken early in 2002 by nursing staff working in Accident and Emergency Departments nationally.

Following the resolution of the nursing dispute on 20th March, it was agreed that certain tasks needed to be taken forward in order to provide a more long-term solution to the issues at the centre of the dispute. These tasks included, *inter alia*, the development by each acute hospital of admission and discharge policies, definition of the role of the bed manager across the acute sector, a review of A&E Department security within each hospital, and a national review of A&E nursing staffing structures. It was agreed, through the Labour Relations Commission, that urgent attention would be given to these topics and that management and staff sides would reconvene on a regular basis to review progress.

A central aspect of this process involved the establishment of a National Working Group on Bed Management, whose terms of reference were "to examine the role which an effective bed management function can play in reducing the current overcrowding in Accident and Emergency Departments." The Working Group has provided a general description of the role of bed management, outlining the reporting and other working relationships, the main roles and responsibilities at both strategic and operational levels, and the broad skills required to discharge the role.

Three particular aspects of the Working Group's document (dated 19th April) represented areas that the Group could not reach consensus on, and therefore required further review. These included:

- A review of grading for the head of bed management function due to "significant variation in grades and organisation structures" with respect to it;
- A definition of the support structures for the head of the bed management function; and
- A determination as to how best to accommodate the requirement for bed management cover on a 24 x 7 basis, taking account of the "significant differences between and within bands."

Further to the Working Group's report, Capita met with representatives of the health service employers and the nursing unions on 8th May 2002 to discuss the further work which would be required in order to provide more detailed analysis of the three issues set out above.

1.2 Terms of Reference

The following specific bed management issues were to be examined and a recommended framework established that should apply nationally for different types of hospital (between and within bands):

- ***Grading – Head of Bed Management Function***
  There is significant variation in grades and organisation structures with respect to the head of the bed management function. A systematic review is required to deal with the complexities of the issues involved. This review should be carried out by an independent agency and completed within a reasonable time frame.
- ***Support Structures for Head of Function***
  Support to Head of Function is provided in two contexts: professional/clinical and administrative. A major component for the professional/clinical support will come from the nursing profession.
- ***Cover***
  It is fully agreed that bed management cover must be provided on a 24 x 7 basis. The level of cover required is determined by such issues as:
  - size
  - complexity
  - activity
  - bed numbers
  - nature of hospital (A&E / non A&E) etc.

Deliverables for the review were to include:

- a Progress Report approximately half way into the engagement highlighting progress and key issues and
- a Final Report that addresses all of the issues contained within the terms of reference, with recommendations that encompass both the staffing issues and the organisational/process issues required to enhance bed management in Irish acute hospitals.

1.3 Methodology

The methodology applied by Capita to this review was as follows:

- ***Task 1: Project Set-Up***
  This task formally initiated the project through a project initiation meeting with the employers and unions at which we would agreed the terms of reference, refinements to the overall approach, the proposed sampling to be used in Task 3, the project organisation and reporting arrangements, the project timetable, relevant documents/contacts to aid research and an interview/workshop programme.

- ***Task 2: Define Bed Management Process***

  The National Working Group on Bed Management described the fundamental role of bed management, the reporting and other working relationships, as well as the main roles and responsibilities at both strategic and operational levels, and the broad skills required to discharge the role. Capita's brief included the provision of a more robust and detailed definition of what constitutes effective bed management, bearing in mind international best practice. In this task Capita defined effective bed management, and set out a generic bed management process as it should apply within Irish hospitals. This definition of the bed management function (and competencies required to discharge it) would provide the basis for grading recommendations for the bed manager post.

- ***Task 3: Site Reviews***

  To assess how bed management is currently practiced within Irish acute hospitals and to gain an understanding of the realities at operational levels, Capita spent approximately one day on site per hospital across the three bands, on the following basis:

  - **11 Band 1 hospitals**, which include the Dublin Academic Teaching Hospitals and major regional centres. This included the following Hospitals:

    Adelaide & Meath Hospital, Tallaght
    Beaumont Hospital
    Cork University Hospital
    Letterkenny Hospital
    Mater Hospital
    Mid-West Regional Hospital
    Our Lady of Lourdes Hospital, Drogheda
    St James's Hospital
    St Vincent's University Hospital
    University College Hospital, Galway
    Waterford Regional Hospital

  - **7 Band 2 hospitals,** which constitute around 50% of the total. These were typically larger county hospitals, or smaller urban hospitals, which provide 24-hour A&E services alongside a broad range of inpatient surgical and medical specialties. Hospitals visited included:

    Our Lady's Hospital, Navan
    Cavan General Hospital
    Midland Regional Hospital, Tullamore
    James Connolly Memorial Hospital, Blanchardstown
    St Luke's Hospital, Kilkenny
    Tralee General Hospital
    Wexford General Hospital

  - **5 Band 3 hospitals,** again constituting more than 30% of the total. These were typically smaller county hospitals which provide A&E facilities but which otherwise offer a reduced level of clinical service and often do not have a dedicated bed manager. The following Hospitals were visited:

    Ennis General Hospital
    Mallow General Hospital
    Naas General Hospital
    Portiuncula Hospital
    St Michael's Hospital, Dun Laoghaire

At each site, a semi-structured interview process was conducted involving one-to-one and/or group discussions with key individuals involved in bed management. For each hospital visited, the interviews included:

- General Manager and/or Chief Executive Officer
- Director of Nursing
- Senior Nursing Staff involved in bed management (i.e., Assistant Directors of Nursing, Night Supervisors)
- Bed Manager(s)
- Patient Services Manager
- Accident and Emergency Department Senior Nursing Staff
- A&E Consultant (or supervising Consultant in charge of A&E).

We also gathered a range of background information and quantifiable data that would provide a basis for analysis of bed management across hospital bands. In addition to hospital visits, Capita was invited to join a meeting of the national Bed Managers' Forum to provide feedback to the group on main themes emerging from research to date and to receive the collective group's views and opinions in relation to the overall project

- ***Task 4: Collation and Analysis of Findings/Develop Outline Models***

  Task 4 included a comprehensive assessment of all of the information gathered during the site visits, and of the various factors that influence the bed management function across different types of hospital. During this phase, we examined the skills and competencies required for the discharge of the bed management function. In establishing the grade of the post, we paid attention to the comparative factors affecting nursing grades within Ireland. In addition to determining the bed manager grade(s), we will also defined the support structures and 24 x 7 cover arrangements which should apply to bed management, again on the basis of a framework which can be applied nationally. All of the recommendations made were informed by both the current situations as observed within the hospitals visited by the Capita team, and by international best practice.

- ***Task 5: Development of Draft and Final Reports***

  The final stage entailed the production of Draft and Final Reports for the health service employers and nursing unions, reflecting all of the earlier work. As part of our normal approach, we also included an action plan geared towards the implementation of the recommendations.

2. REVIEW OF CURRENT SITUATION

2.1 Introduction

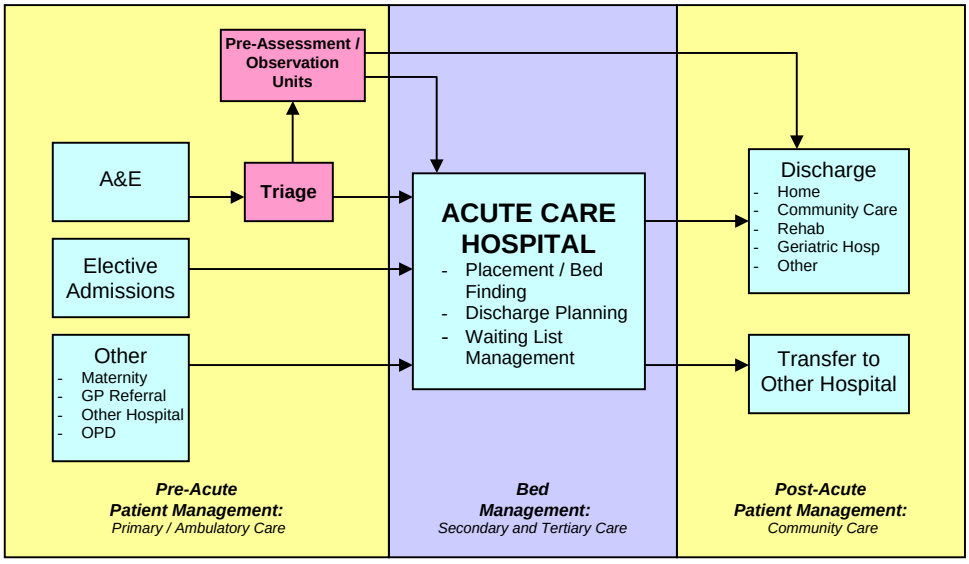
As part of our consultation process, we sought to gain understanding of current bed management structures, practices and needs through a combination of individual and group meetings with key stakeholders at hospitals of various sizes around the country. In the following paragraphs, we present a high-level composite of the functions and limitations of current bed management practice in Ireland.

2.2 Bed Management Definitions Used in This Study

Bed management is not practiced uniformly around the country, or indeed even among similar hospitals within the same band. In some hospitals, the focus of the Bed Manager is strictly on placing patients in beds (or "bed finding"), while in others, the Bed Manager only deals with strategic issues such as finding and negotiating for long-term care beds, leaving all bed finding to hospital nursing administration. To facilitate discussion of our analysis, the following definitions will be used:

- **Bed Manager.** Used generically for all heads of Bed Management function. Actual job titles vary and include titles such as Inpatient Coordinator, Bed/Waiting List Manager, Bed Coordinator and Bed Manager.
- **Bed Management.** The set of processes and procedures that provide for the management of the hospital's bed resources. This includes (a) finding beds for all emergency and non-emergency patients requiring admission to an acute care bed and (b) expediting discharge of patients who have been deemed by a Consultant as medically fit for discharge. In this context, *bed management is an operational role* of a Bed Manager. The typical bed management role in managing patient flow is shown in Figure 2.1.

Figure 2.1 Generic Bed Management Process



Critical elements for effective bed management include the following:

- A designated bed management function;
- A single accountable manager with authority;
- Appropriate professional and administrative support arrangements;
- Explicit authority levels;
- Explicit protocols to support patient flows;
- Effective information systems to support decision making; and
- Regular audit/review systems.

- **Patient Management.** The set of processes, procedures and protocols that provide for management of the patient's continuum of care. Continuum of care refers to appropriately treating and managing the patient throughout the whole of the patient's care episode, from GP to transition back into the community. The hospital role in enhancing patient management is accomplished by improved admission processes (e.g., pre-assessment, investigations prior to admission), comprehensive discharge planning and coordination with non-acute services. In this context, *patient management is a strategic role* of a Bed Manager. The typical patient management role in managing patient flow is shown in Figure 2.1.
- **Integrated Bed Management.** This is the management of all admissions, stays transfers and discharges by a hospital within a framework that integrates and coordinates all processes related to these activities. This is done by balancing the access demands of A&E and of elective medical and surgical patients with available beds. Integrated Bed Management includes both Bed and Patient Management.
- **Principles of Bed Management.** In the context of agreements to date between the Labour Relations Commission, the nursing unions and the employers, the following parameters for Bed Management functions have been identified as appropriate goals:
  - Bed managers should have strategic roles to perform including trend analysis, service planning, developing proposals to address of the elderly and the young chronically sick and best practice benchmarking. They should hold three key strategic responsibilities:
    - Deflection of inpatient admissions
    - Maximising appropriate bed utilisation, e.g., Waiting List initiative
    - Expediting discharge
  - Bed managers should have operational roles to perform that would include bed placement, reporting, implementing policies and participating in relevant committees.
  - Heads of Bed Management functions should have a nursing qualification.
  - Bed management cover must be provided on a 24-7 basis.

2.3 Systemic Findings

In our meetings at hospitals around the country, managers and clinicians described what is working and what is not working at their own facilities. In addition, they identified a number of key areas where the health system as a whole works against effective bed and patient management in acute facilities. The following summarises key findings for the health system as a whole.

- **National acute care bed shortage has contributed to unacceptable levels of Acute Care Occupancy.** Chronic shortages in acute care beds across the country are well known and are acknowledged by the Department of Health and Children (DOHC) as a primary cause for high levels of occupancy in acute hospitals. The recent National Health Strategy identified a need for an additional 3,000 hospital beds. Inpatient and day case activity have increased by 4% per year for the last 10 years, while during the same period, hospital beds have remained almost static. This bed shortage has led to ongoing occupancy rates of 85-100% in almost all hospitals in the country.

  International experience has demonstrated that some spare capacity is essential if A&E admissions are to be accommodated. Bed shortages begin to emerge at a mean occupancy rate of about 85%. Occupancy rates greater than 90% are generally considered to be clinically risky for A&E patients.

- **Access to inpatient beds are frequently blocked as the result of so called "delayed discharge patients,"** i.e., patients who have been discharged medically, but have nowhere to go for intermediate or long-term care. This problem is especially acute in a number of Dublin hospitals, where as many as 20% of acute care beds are occupied *at all times* by delayed discharge patients. About half of the Band 1 hospitals visited for this study reported that 7% or more of beds were occupied by these patients. The problem was found to be relatively infrequent for Band 2 and 3 hospitals.

- **High incidence of delayed discharge patients is a direct result of shortages of long-term care, rehabilitation and step-down facilities (and beds).** Approximately two-thirds of hospitals visited for this review reported shortages of nursing home, rehabilitation, intermediate care and step-down beds in their catchment areas. The dearth of community facilities appears to be particularly acute in the greater Dublin area. Ultimately, the national problem of excessive acute care bed occupancy will not be resolved until additional post-acute capacity is added to the system as a whole.

- **Hospital Banding designations do not accurately reflect differences in bed management practice or indeed of resource usage.** The current system of classifying acute care hospitals into "bands" for planning purposes is fairly arbitrary and does not reflect, in our view, an accurate method for grouping hospitals (the basis of banding is annual inpatient admissions, which does not take into account A&E, outpatient or day activity; nor does it account for specialised tertiary services). Band 1 hospitals, for example, exhibited a wide variety of bed management practices and needs. Additionally, Band 2 hospitals were actually closer in practice to smaller Band 1 hospitals than to Band 3 facilities. While we used the banding system to describe our findings relative to differences in bed management practice, we found it necessary to devise our

own classification system in order to recommend appropriate grading, support structures and cover.

- **Local solutions to local issues are to be encouraged.** In general, we observed that bed managers are highly proactive at developing solutions that work within their hospitals. Each hospital's organisational/professional culture is unique, and frequently structures must be established that might only make sense in a certain cultural setting. While establishing national standards for grades and structural support is a desirable goal, we are very cautious about "one-size-fits-all" recommendations. Given that bed management succeeds in a hospital largely based on goodwill among professions and management, hospitals must retain high degrees of autonomy regarding staffing levels and reporting relationships. We intend in this review to offer general guidelines within which that sort of autonomy can be exercised.

2.4 Bed Management Structures and Practice

2.4.1 Overview

In conducting this review, Capita visited an agreed sample of 23 hospitals around the country. 19 of the 23 currently have a dedicated bed management function; 4 facilities have no bed management function, with Nursing Administration performing all bed placement responsibilities. The sample included:

- **Band 1 Hospitals** – 11 facilities all of which have a bed management function; 10 of those hospitals have a single accountable manager in charge of bed management, and 8 of 11 have or are actively recruiting a discharge coordinator.
- **Band 2 Hospitals** – 7 facilities were visited, 6 of which have a bed management function. One of those 6 has a bed management function with no single accountable manager in charge. Another facility has a single manager for 3 facilities, but has no real bed management staff at any of the facilities; that bed manager essentially addresses regional and strategic bed management issues, and does not perform bed placement tasks. 5 of 7 hospitals have or are actively recruiting a discharge coordinator.
- **Band 3 Hospitals** - 5 facilities were visited, 3 of which have a bed management function. 3 of 5 hospitals have or are actively recruiting a discharge coordinator.

2.4.2 Bed Manager Role

Generally we found that the role of Bed Manager (often titled Inpatient Coordinator), while still a new one in some hospitals, is developing very quickly in Ireland. The national Bed Managers' Forum is effectively serving Bed Managers by providing a means to share professional and best practice experience from colleagues. In practice, the roles assumed by bed managers vary somewhat around the country, but most of the variation lies in greater responsibilities being assumed by managers in larger hospitals. Figure 2.2 (overleaf) summarises our findings regarding the bed manager role. Key observations include:

- 18 of 19 facilities with a bed management function fulfil the operational role of finding beds for patients.
- About half of those 18 facilities also assume strategic roles to better manage patient flow including discharge coordination functions and active participation in planning for, or placing patients in, post-acute care settings.
- Bed managers are responsible for the discharge coordination function in 9 of hospitals visited (39% of total); another 6 hospitals have discharge coordinators in post who report to other managers.
- Only 30% of hospitals visited hold responsibility for the admissions office; most of those are Band 1 hospitals.

Figure 2.2 Bed Manager Role

	Operational-Bed Finding	Strategic-Pt Mgmt	Disch Coord Responsibility	Admissions Office Responsibility
Number				
Band 1	11	5	5	5
Band 2	5	2	2	1
Band 3	2	2	2	1
Total	**18**	**9**	**9**	**7**
Percent of Total				
Band 1	100%	45%	45%	45%
Band 2	71%	29%	29%	14%
Band 3	40%	40%	40%	20%
Total	**78%**	**39%**	**39%**	**30%**

2.4.3 Bed Manager Reporting Structure

The reporting relationship of bed managers also varies considerably around the country. Although many Directors of Nursing (and a few General Managers) expressed the view that bed management should stay within the nursing structure, the clear trend is a shift toward GMs as line managers for the bed management function. General consensus was that strong liaison relationships between bed management and nursing are crucial in either case. Despite the variation, bed management functions seem to work well in either arrangement, with very little dysfunctionality observed. Figure 2.3 (overleaf) summarises reporting structure findings.

- Band 1 and Band 2 Bed Managers are fairly evenly split between those reporting to clinical managers and those reporting to general management. Two Band 1 facilities have a shared reporting arrangement for bed management – shared between the Director of Nursing (DON) and the GM.
- Hospitals reported below as having no reporting relationship represent facilities with no dedicated bed management function. At those hospitals, actual bed management functions fall under nursing administration.
- In 2 Band 1 hospitals, bed management does not hold a high organisational profile and reports to Patient Services.
- At one hospital, bed management reports a consultant Clinical Director.

- In Band 3 hospitals all bed management functions report to the DON.

Figure 2.3 Bed Manager Reporting Relationship

	DON	GM/Hosp Mgr/DCEO	Shared-GM/DON	Patient Svcs Mgr	Clinical Director	None	*Totals*
Number							
Band 1	4	2	2	2	1	0	***11***
Band 2	3	3	0	0	0	1	***7***
Band 3	2	0	0	0	0	3	***5***
Total	**9**	**5**	**2**	**2**	**1**	**4**	***23***
Distribution							
Band 1	36%	18%	18%	18%	9%	0%	*100%*
Band 2	43%	43%	0%	0%	0%	14%	*100%*
Band 3	40%	0%	0%	0%	0%	60%	*100%*
Total	**39%**	**22%**	**9%**	**9%**	**4%**	**17%**	***100%***

2.4.4 Grade of Bed Manager Function

As already noted by the Bed Management National Working Group, significant variations were observed in grades for the head of bed management functions around the country. The vast majority of stakeholders (all bands) expressed the view that the Bed Manager post is of such operational and strategic significance, that it should be graded at a minimum of CNM3 (or its management equivalent of Grade 7). Almost all interviewed agreed that a nursing qualification is crucial for effective functioning of the Bed Manager, but many were neutral regarding whether the grading should be on a nursing or a management scale. In all cases, stakeholders suggested that management grade pay should be adjusted to a nursing scale equivalent (e.g., Grade 7 pay should match CNM3 pay). Despite the variation, bed management functions seem to work well in either arrangement, with very little dysfunctionality observed. Figure 2.4 summarises findings regarding current bed manager grading.

- More than half of hospitals visited (52%) have heads of bed management who are graded on the nursing scale. 35% had heads graded on the management scale.
- Most of the manager-graded posts are in Band 1 hospitals (5 of 7, or 71%).
- CNM3 is the most common nursing grade used among hospitals in all bands.
- Band 1 facilities exhibited the largest variety of grades, with 2 posts at the Assistant DON level and one at CNM2 level.
- Bed management heads tended to be graded at the high end of nursing and management scales, reflecting the importance of the post. Almost 75% (14 of 19) of hospitals with bed managers are graded at CNM3/G7 or ADON.

Figure 2.4 Bed Manager Grade

	Nursing Grades			Management Grades			SUMMARY			
	ADON	CNM3	CNM2	G8	G7	G6	Nursing Grade	Management Grade	None	*Post with No Head of Function*
Number										
Band 1	2	3	1	0	3	2	**6**	**5**	**0**	***1***
Band 2	0	3	1	0	1	1	**4**	**2**	**1**	***1***
Band 3	0	2	0	0	0	0	**2**	**0**	**3**	***0***
Total	**2**	**8**	**2**	**0**	**4**	**3**	**12**	**7**	**4**	***2***
Distribution										
Band 1	18%	27%	9%	0%	27%	18%	55%	45%	0%	*9%*
Band 2	0%	43%	14%	0%	14%	14%	57%	29%	14%	*14%*
Band 3	0%	40%	0%	0%	0%	0%	40%	0%	60%	*0%*
Total	**9%**	**35%**	**9%**	**0%**	**17%**	**13%**	**52%**	**30%**	**17%**	***9%***

It should be noted that several hospitals had established bed management functions, but did not have a single accountable manager responsible to lead the bed management function. This was observed in one Band 1 and one Band 2 hospital. In addition, one Band 2 hospital visited had no bed management staff in post, but shared a Grade 7 Inpatient Coordinator with 2 other hospitals.

2.4.5 Bed Manager Support Structures

Support structures for bed management generally include the professional and administrative staff that report to a bed manager. The following observations were made regarding existing support arrangements:

Assistant Bed Managers

- The majority of Band 1 hospitals visited (8 of 11) have one or more assistant bed manager posts, usually at CNM2 level.
- None of the Band 2 or Band 3 hospitals visited has an assistant bed manager post.

Junior Professional Staff.

- More than one-third of Band 1 hospitals visited (4 of 11) have one or more junior professional posts reporting to the bed manager; these posts range from Grade 3 to Grade 6/CNM2.
- None of the Band 2 or Band 3 hospitals visited has junior bed management posts.

Discharge Coordinators.

- While 70% of all hospitals visited (16 of 23) have or are currently recruiting a Discharge Coordinator, only 9 hospitals (39%) have this activity reporting to the bed management function.

Admissions Office

- In almost half of Band 1 hospitals visited (5 of 11), the bed management function holds responsibility for Admissions office staff. Among Band 2 and 3 facilities, only one hospital each holds this responsibility.

Clerical Support

- Most Band 1 hospitals visited (8 of 11) have a single bed management clerical officer in post, usually at Grade 3 level.
- One Band 2 and one Band 3 hospital visited have a single bed management clerical officer in post, at Grade 3 level.

2.4.6 Bed Management Cover

Although the Bed Management Working Group identified 24-7 bed management coverage as a desired goal, virtually all stakeholders interviewed (including in the largest hospitals in the country) expressed the view that 24-hour coverage by *bed management professionals* is not actually needed, nor is it desirable from a cost perspective. All hospitals visited do provide 24-7 bed management, but in all hospitals nursing administration provides at least part of that coverage. In general, we found that few hospitals with a bed management function provide that service beyond the normal workweek of 8 hours each weekday. Figure 2.5 summarises findings regarding current bed management cover.

Figure 2.5 Bed Manager Professional Cover

		Mon - Fri			
	None	0-8 Hrs	8-12 Hrs	12+ Hrs	Weekend
Number					
Band 1	0	8	1	2	3
Band 2	2	3	2	0	0
Band 3	3	2	0	0	0
Total	**5**	**13**	**3**	**2**	**3**
Percent of Total					
Band 1	0%	73%	9%	18%	27%
Band 2	29%	43%	29%	0%	0%
Band 3	60%	40%	0%	0%	0%
Total	**22%**	**57%**	**13%**	**9%**	**13%**

Key findings include:

- Hospitals without a bed management function provide 24 hours cover through local nursing administration.
- All hospitals with a bed management function provide at least 8 hours cover Monday to Friday. Almost 60% of hospitals visited provide this level of cover. Arrangements for these facilities typically include:
  - Bed Management – 8am to 5pm, M-F
  - Nursing Administration/Out of Hours Coordinator – 5pm to 8pm, M-F and 8am to 8pm weekends
  - Night Superintendent – 8pm to 8am, M-F and weekends
- 3 of 23 hospitals visited extend weekday bed management hours to between 8 and 12 hours.
- 2 Band 1 hospitals visited have weekday bed management hours of 12 or more.
- 3 Band 1 hospitals provide weekend bed management hours.
- In all hospitals, bed management responsibility is executed by Night Superintendents between 8pm and 8am every day. Based on discussions with stakeholders involved, this arrangement does not appear to cause difficulties.

In addition to the above issues, Capita also asked hospitals to document their average daily admissions for weekdays and for weekend days. This was done to determine potential need for the addition of weekend hours for bed managers. Of

the 11 hospitals that supplied us with this data, all indicated that their average daily weekend admissions were within 30% of their weekday admissions. This indicates a fairly high level of weekend admissions in all bands of hospital across the country.

2.4.7 Bed Manager Operational Practice

In addition to the above areas of bed management structure, a number of issues of operational practice bear consideration.

- **The mix of strategic and operational responsibility of bed managers varies** among bands and among hospitals within bands. In larger hospitals (mostly Band 1) where varied tertiary inpatient activity is high, accompanied by high occupancy, bed managers most frequently assume strategic roles and delegate most bed placement activities to assistant bed managers. As hospital size and clinical complexity are reduced, strategic bed management roles reduce.
  - Most Band 1 facilities require a high degree of strategic focus from bed managers.
  - In Band 2, bed manager responsibility is usually a mix of strategic and operational, and Band 3 bed manager responsibility is largely operational.
- **The bed management analysis function is very underdeveloped around the country.** Bed management, to be effective, requires access to and analysis of empirical data on historical/seasonal activity, patient status, A&E / bed management placement times, patient stay, patient discharge and consultant admission/discharge practices. We found that very little analysis or forecasting is being done by bed management departments. Most hospitals simply do not have the staffing within the bed management function to address anything but immediate operational issues. Information systems and analytical capabilities need to be given higher priority.
- **The state of current information systems for bed management departments needs swift improvement.** Integrated bed management needs to be supported by accurate real time information. Data needs to be continuously collected, audited, analysed and disseminated to guide resource management and to optimise efficiency.
- **Many bed management functions are performed by, or in coordination with hospital nursing staffs.** In virtually every hospital in the country nursing administration provides at least 50% of the bed management coverage, through night superintendents. Additionally, ward sisters play key coordinating roles in both placing patients into beds and planning for patient discharge. Clearly, it is important that constructive working relations continue between nursing and the bed management function.

2.5 Patient Management Strategies that Support Bed Management

2.5.1 Policies and Protocols

Bed managers use a range of policies and procedures to direct the functioning of acute bed placement in hospitals. Virtually all hospitals in our sample have in the past year either drafted new admission, discharge and A&E escalation policies or have revised existing policies. Beyond those fundamental policies, hospitals varied in their levels of need for, or proactivity toward, increased formality or protocols to support bed management. Figure 2.6 details these differences.

Figure 2.6 Bed Management Policies

	Admission, Discharge, Escalation	Unique Bed Management Policy	Audit / Review System	Periodic Operational Bed Mgmt Meetings	Periodic Strategic Bed Mgmt Meetings
Number					
Band 1	11	4	4	7	5
Band 2	7	0	2	2	1
Band 3	5	2	4	2	1
Total	**23**	**6**	**10**	**11**	**7**
Percent of Total					
Band 1	100%	36%	36%	64%	45%
Band 2	100%	0%	29%	29%	14%
Band 3	100%	40%	80%	40%	20%
Total	**100%**	**26%**	**43%**	**48%**	**30%**

Key findings:

- Only a quarter of all hospitals had initiated a formal bed management policy that was separate from inclusion in the admission policy.
- Formal systems of audit for bed management are in place in fewer than half of sampled hospitals.
- Only about half of hospitals held operational (i.e., day-to-day patient placement) bed management committee meetings on less than an annual basis – most of those that did not are smaller hospitals, where blocked access to hospital beds is less severe.
- Less than a third of all hospitals held periodic strategic bed management meetings; 5 of the 7 that did are Band 1 facilities.

2.5.2 Admission/Demand Management Strategies

Demand management strategies are those that seek to reduce or better manage the demand for inpatient care (i.e., admissions). These strategies typically require innovative thinking and often require challenging the status quo. The underlying principle behind these strategies is that bed occupancy will be reduced if patients requiring less intensive treatment are seen outside the acute care setting, or as day cases, and that this treatment would be more cost-effective than conventional inpatient care. A more detailed description of these strategies is presented in Section 4 of this report. Current demand management initiatives taking place among our sampled hospitals are presented in Figure 2.7 (overleaf).

Figure 2.7 Strategic Demand Management Initiatives

	Surgical Pre-Admissions Unit	Medical Assessment Unit	Ambulatory / Urgent Care Facilities	GP Alert System	A&E Clinical Pathways
Number					
Band 1	5	5	0	1	4
Band 2	2	3	0	0	0
Band 3	0	0	0	0	0
Total	**7**	**8**	**0**	**1**	**4**
Percent of Total					
Band 1	45%	45%	0%	9%	36%
Band 2	29%	43%	0%	0%	0%
Band 3	0%	0%	0%	0%	0%
Total	**30%**	**35%**	**0%**	**4%**	**17%**

Key observations include:

- Surgical Pre-Admissions Units (SPAUs), which provide for diagnostic investigations to be performed prior to scheduled surgery, are in place in 30% of sampled hospitals; most of these are Band 1 hospitals.
- The most common demand strategy currently being used is the Medical Assessment Units (MAU); such units are 12-18 hour wards that perform observation and diagnostic functions for A&E patients who may not require hospitalisation. Currently 8 of the hospitals visited have such units, and another 6 have them included in their 2003 service plans.
- Clinical pathways are beginning to be used in A&E departments; currently only 4 Band 1 facilities have initiated them.
- Ambulatory or Urgent Care facilities have proven extremely effective in reducing A&E attendances and inpatient occupancy in the UK, Europe, the US, Australia and New Zealand. Such services are not yet developed in Ireland, reflected by the lack of such facilities among visited hospitals.

2.5.3 Throughput Improvement Strategies

Strategies to improve throughput of patients in hospital beds are those that seek to improve bed placement and discharge planning processes to free beds more quickly, to reduce patient length of stay or to better coordinate appropriate discharge. Figure 2.8 (overleaf) presents current throughput initiatives among sampled hospitals.

- Although many hospitals identified the need for and value of discharge lounges, only 3 Band 1 hospitals have initiated them.
- Analytical audits of occupancy and bed management initiatives are not frequently conducted in Irish hospitals. Only 5 of 23 hospitals indicated that they routinely analyse the results of bed management actions.
- Only 5 hospitals (all Band 1) indicated they have prepared detailed service plans for bed management.
- Regional or multi-site bed management is practiced by 3 facilities, with only limited results reported.

Figure 2.8 Strategic Throughput Initiatives

	Discharge Lounge	Weekly Audit	Bed Mgmt Service Plan	Regional Bed Mgmt / Discharge Planning
Number				
Band 1	3	4	5	2
Band 2	0	0	0	1
Band 3	0	1	0	0
Total	**3**	**5**	**5**	**3**
Percent of Total				
Band 1	27%	36%	45%	18%
Band 2	0%	0%	0%	14%
Band 3	0%	20%	0%	0%
Total	**13%**	**22%**	**22%**	**13%**

2.6 Other Issues

Other global issues that need addressing to improve the effectiveness of bed management nationally include the following:

- **A&E is most often the entry point for all acute care admissions.** In most hospitals around the country, virtually all patients (including planned elective admissions) are processed for admission and enter a bed through the A&E. In Capita's view, this practice diverts scarce A&E resources from the business of casualty care. Centralised control of beds could be improved if planned admissions were processed through the admissions office.
- **Many facilities use "ring-fenced" beds, which are usually outside the control of the bed management function.** Typically, these include isolation beds, ICU and CCU beds, beds related to tertiary centres. They often also include maternity and psychiatry beds. While the examples given represent appropriate segregations of beds, hospitals should be wary of ring-fencing beds for specific consultants or for every specialty available. The allocation of beds to clinical units should be notional; a flexible bed base should be built into the operating requirements to accommodate fluctuating bed demand.

3. ISSUES REQUIRING RESOLUTION

3.1 National and Regional Issues

From Capita's research as part of this assignment, it is apparent that whilst effective bed management arrangements can have a positive influence on the number of patients waiting for admission, other issues have a greater impact on bed availability beyond the ability of a bed manager to control. Whilst many of these issues have previously been examined as part of the work of the A&E Forum, it is worth revisiting them briefly as they both establish a context for the work of bed managers, and also indicate clearly the matters over which bed managers will have relatively limited control. These issues include (but are not restricted to):

- The lack of availability of step-down beds in nursing homes, convalescent homes, community hospitals and other institutions was frequently cited as a major factor causing problems in bed management. Some hospitals reported that between 10% and 20% of their current in-patients at the time of our visit were ready for discharge (and in many instances had been medically discharged), but could not be moved out of the hospital because there was no suitable place for the patient to go. It should be acknowledged that progress is being made in parts of the country, such as ERHA contracts with local nursing homes for their vacant beds and the impending public-private partnership arrangements for supply of nursing home beds in Cork and Dublin. However, even where step-down capacity does actually exist, often bed managers and discharge planners are not aware of availability. **We believe that post-acute capacity is probably the key issue causing problems in bed management nationally, and the one whose resolution would provide the health services with the greatest potential to improve the bed management process quickly. Shortages of rehabilitation, step-down/intermediate care and nursing home/long term care facilities is a direct cause for the high levels of delayed discharge patients in major tertiary hospitals.** In our view, this clearly points to a need for post-acute supply/demand capacity analyses to be conducted on a region to region basis across the country (a simple national analysis will not address the issues).
- In some locations, inadequate arrangements for service provision in primary care or community care meant that patients who might otherwise be treated without needing hospital admission were having to be admitted, reducing the availability of acute beds overall. For example, some hospitals reported a higher-than-expected rate of readmission due to lack of GP support post-discharge; others reported that local GPs send unnecessarily high numbers of patients to A&E for non-urgent attention which could be given at the GP's surgery. The lack of community-based diagnostic services was also cited as a reason why A&E departments are very busy in many areas, leading to bed availability problems.
- In one region, a reported executive policy of the local Health Board not to provide nursing home subvention from its community care budget, and an inability or unwillingness of some families to make up the difference between

nursing home costs and other state funding, meant that patients who were medically discharged could not leave the acute hospital and were acting as "bed blockers". One case reported to us involved a patient whose discharge was delayed by 74 days due to a dispute over subvention.

- Several hospitals reported what appear to be unnecessarily long delays in discharge for administrative reasons, mostly connected with the meeting schedule of Health Board staff involved in managing nursing home subvention (for example, patients being kept in for up to a week after they could be medically discharged, simply because the Subvention Committee only meets once a week).
- Patient transfers between regions are sometimes not smooth and may delay discharge. Reported cases included patients who lived at the periphery of one Health Board region and who were treated in their nearest acute hospital in an adjoining Board area, but whose transfer to a community hospital in their local area was delayed because of what appears to be a low priority attachment (i.e. their local Health Board was more concerned at finding convalescent places for people in its own acute hospitals).
- In at least one region, some young chronically sick patients are kept in acute beds for very lengthy periods, as there is no dedicated facility in the region to cater for them; typically, these are patients with head injuries needing a higher level of care than is possible in nursing homes. This reduces bed utilisation substantially.
- Certain private insurance requirements encourage inappropriate bed utilisation, especially the lack of adequate coverage for outpatient or preventive procedures. For instance, VHI reportedly will not cover routine CAT scans on an outpatient basis; as a result, consultants admit private patients as inpatients, so the procedure can be paid for by private insurance.
- Several hospitals reported that nursing staff in district hospitals and nursing homes are not trained or authorised to administer IV fluids, with the consequence that they receive many elderly patients who have to be admitted from a district hospital/nursing home bed and who simply need IV fluids or IV antibiotics.
- An ongoing series of national initiatives has added bed management-related posts (e.g., waiting list managers, discharge coordinators), but this has led to fragmentation of bed management functions as they were introduced with no relationship to bed management. In Capita's view, the Bed Manager should be the designated senior post, leading a team of persons involved in all aspects of admission, transfer and discharge of patients.

Clearly, many of the above issues are beyond the ability of any individual Bed Manager to resolve or even influence at the local level, but have very significant implications for the effective functioning of bed management in all of the Irish acute hospitals. Whilst the focus of this report is on the staffing issues surrounding bed management, it is important that we highlight the regional and national factors which are inhibiting the development of the bed management function, and whose

resolution is required in order to let Bed Managers provide optimum benefit in their designated roles.

3.2 Issues at Hospital Level

Capita's review has also identified a wide range of issues at local hospital level which have a serious impact upon bed utilisation and the ability of Bed Managers to function effectively. Many of the features which we observed are very common across all acute hospitals in Ireland, and – as with the national and regional issues reported above – may be beyond the immediate control of the Bed Manager. The most common problems include the following:

- Consultant practices and medical culture have significant implications for bed management in many hospitals, including a number of routine consultant practices which directly contribute to high occupancy and blocked access to acute care beds:
  - Infrequent ward rounds (for example, some consultants may only attend a particular hospital on one day a week, and may insist that only they take discharge decisions).
  - Ward rounds being done too late in the day for discharge
  - Discharge documents being incomplete or incorrect, leading to delays
  - Process-related delays, such as the writing of prescriptions, the issue of prescribed drugs for discharged patients, etc.
  - Patients held in bed over weekend to facilitate admission of consultant's own (mostly private) patients on Monday.
  - Some consultants allow their registrars to make discharge decisions, provided that certain agreed criteria are met; others will not. Some consultants also allow their registrars to discharge public, but not private, patients.
- Equally, we observed some practices amongst bed management and nursing staff which cause unnecessary delays, including – in a number of hospitals – the Bed Manager's working day commencing at 9am, when ward rounds start at or before 8am. It was suggested by several A&E Consultants that if the Bed Manager was on hand from 8am, it would speed up the process of discharge and free the bed earlier in the day.
- Many hospitals are affected by long delays in having discharged patients collected by their families. In some hospitals, the presence of a discharge lounge enables these patients to be moved from the ward to an area of reduced supervision, thus freeing up the bed for reuse. In others, the absence of a discharge lounge means that the bed does not become free until the patient is collected, which may not occur until the evening; this also creates added work for ward nursing staff who have to look after patients who have been discharged and are waiting to be collected.
- Some Bed Managers are performing first-line A&E triage over the phone: this creates problems of risk management and should be discouraged.

- Bed Managers identified a number of causes outside of their control, which create difficulty in discharging patients from acute care beds. These include:
  - Diagnostic Laboratory and Radiology services are often only available 9-5, Monday-Friday; if diagnostics could begin to accommodate evening surgery, for example, significant bed pressure could be eased. More flexibility from these services is desired.
  - Community services are not available beyond 9-5 Monday-Friday; outside those hours, there is nowhere to discharge patients to.
  - Community services for the under 65 chronically ill are very under-developed in most parts of the country .
  - Ambulatory or Urgent Care clinics, for urgent but non-emergency cases are almost non-existent.
  - Limited access to specialty beds where ring-fencing occurs.
  - Professional self-interest is prevalent nationally with regard to changing service delivery; even small changes in the status quo are opposed by one professional group or another. As one A&E consultant put it, "For every solution, there's a problem."

3.3 Analytical Issues Relative to This Review

As indicated in Section 2.3 above, Hospital banding designations do not accurately reflect differences in bed management practice or resource need. Upon close examination, we found bed management needs in acute hospitals are functions of:

- **Bed Occupancy** – Higher levels of occupancy require more bed management resources, especially resources dedicated to strategic solutions. This is easily measured as a ratio of Total Annual Bed Days used to Total Beds on a 365-day a year basis.
- **Service Complexity** – Hospitals with a more varied mix of tertiary specialties and subspecialties require high levels of skilled bed management resources. Hospitals with a large tertiary service complement typically draw 10 to 25% of their patients from outside its own regional catchment (often from outside their own Health Board area). This can be measured by the number of tertiary specialties or by admissions from outside their catchment.
- **Level of Total Activity** – The need for increased levels of bed management is also determined by the total level of patient activity, including A&E attendances, OPD attendances, day cases and inpatient admissions. In practice, this is difficult to measure, as composite metrics for inpatient and outpatient activity do not account for differences in resource usage.
- **Size of Facility** – Usually corresponds to service complexity and total activity use and can be used as a surrogate measure for both.

While we used the banding system to describe our findings relative to differences in bed management practice, we found it necessary to devise our own

classification system in order to recommend appropriate grading, support structures and cover.

Based on the analysis of data provided by the sample hospitals, we have re-classified the hospital bands into Groups that more closely identify levels of levels of service complexity and composite activity. In our view, these categories will provide more meaningful breakpoints in defining formal bed management functional needs. These groupings are as follows:

Group A: A limited number of the most complex tertiary hospitals that provide supra-regional services, have more complex mix of services, provide major A&E Services (usually Trauma) and have a total activity level that dictates the process of Bed Management is demonstrably more difficult/complex.

Decision Criteria:
1. Bed Occupancy > 85%
2. Supra-regional remit and service mix
3. 500 or more acute care beds.

Group B: Remaining Band 1 hospitals and most Band 2 hospitals that provide a less complex mix of services, provide significant A&E Services and have a total activity level that dictates the process of Bed Management is demonstrably less difficult/complex than at the level of Group A. While service complexity varies widely from the largest to the smallest hospital in this group, the *normative practice of bed management* is more alike among these facilities than with the required practices of Group A or Group C hospitals

Decision Criteria:
1. Bed Occupancy > 85%
2. Regional remit or moderate to large degree of tertiary services
3. 200 or more acute care beds.

Group C: Remaining Band 2 hospitals and all Band 3 hospitals that provide a less complex mix of services, and have a total activity level that dictates the process of Bed Management is demonstrably less difficult/complex than at the level of Group B.

Decision Criterion:
1. Remaining hospitals.

Based on the above criteria, we have re-grouped our hospital sample for bed management decision-making purposes as presented in Table 3.1 (overleaf).

Table 3.1 Redesignation of Hospital Groupings

Hospital	Band	Capita Grouping	2001 New A&E Attendance	2001 Inpatient Admissions	Inpatient Beds[1]
UCH Galway	1	A	59,912	34,923	729
St James'	1	A	50,934	21,391	683
Cork UH	1	A	48,709	27,214	611
Beaumont	1	A	51,223	21,437	570
Mater	1	A	58,217	16,005	502
Waterford Reg	1	B	55,444	23,364	474
St Vincent's	1	B	38,000	30,381	463
Tallaght	1	B	44,984	12,847	420
Letterkenny	1	B	25,630	17,186	359
MWRH, Lim	1	B	50,895	20,928	340
OLLH Drogheda	1	B	32,733	19,297	318
Tralee	2	B	28,708	15,304	328
Kilkenny	2	B	23,985	13,390	224
Blanchardstown	2	B	28,798	9,031	214
Tullamore	2	B	23,128	14,239	211
Wexford	2	B	22,447	13,440	208
Navan	2	C	21,004	6,997	162
Cavan	2	C	20,000	8,948	150
Portiuncula	3	C	18,216	9,934	191
St Michael's	3	C	25,214	5,594	123
Naas	3	C	18,998	6,198	117
Ennis	3	C	19,519	6,434	88
Mallow	3	C	13,765	4,071	76

Numbers in RED are 2000 data

[1] Excludes Extended Care, Long Term Care and Rehabilitation

4. BEST PRACTICE IN BED MANAGEMENT

4.1 Examples of Best Practice in Irish Bed Management

Hospitals in Ireland have initiated a wide range of operational and strategic initiatives designed to improve bed management and discharge planning. The national Bed Managers' Forum performs a very proactive role in informing Bed Managers around the country about international best practice and about initiatives underway within Ireland. Bed Managers are actively sharing experiences and ideas for improved practices. Some of the initiatives that are currently in place around the country are presented below.

Demand/Patient Management Initiatives:

- Development of a cooperative hospital organisational culture where bed management/discharge planning is viewed as everyone's job;
- Medical Assessment Units (MAUs);
- GP alert systems;
- A&E Community Liaison;
- Use of clinical pathways in A&E;
- 1 and 5-Day short stay wards;
- Increased use of outpatient departments.

Throughput Improvement Initiatives:

- Surgical Pre-Admission Units (SPAUs);
- High Dependency Units (HDUs);
- Flexible bed base (i.e., ability to open additional inpatient beds);
- Unisex wards (mixed-gender beds);
- Day of surgery admissions;
- Early discharge planning;
- Discharge or transit lounges.

4.2 Overview of International Best Practice Lessons

Much recent attention has been given internationally to researching and initiating improved practices in bed management. In the UK, an extensive report entitled "Inpatient Admissions and Bed Management in NHS Acute Hospitals" was published in February 2000, documenting evidence of good practice in admissions, bed management and discharge management processes. In 1999, the Australian Department of Health and Aged Care completed a 3-year demonstration program (NDPH-2) that was designed to identify and evaluate innovative service delivery approaches that would overcome barriers to efficient,

high quality integrated management of all hospital admissions, focusing specifically on bed management and discharge planning.

The concept of "integrated bed management" is common in international health management research. To integrate the management of all hospital beds, the operational demands of an organisation need to be balanced with the needs of patients who require admission from emergency and elective admission sources. While the definition can be simply stated, the strategies and processes that are used to integrate bed management are frequently complex. Current difficulties and "growing pains" experienced by Irish hospitals in starting to coordinate bed management services are quite consistent with the experience of other health systems. Difficulties faced by Irish bed managers, such as lack of appropriate information systems and the need to update policies on how the organisation prioritises and manages its beds, are similar to difficulties of international counterparts.

A key lesson from international experience is the imperative that accountability and responsibility for bed utilisation not be fragmented. All elements of bed and discharge management need to be coordinated together to develop an integrated approach to bed management The following lists essential elements of best practice that are necessary to optimise the use of a hospital bed and manage the continuum of care.

Principles for Integrated Bed Management

- There is an organisation-led commitment to manage all hospital beds.
- There is a centralised point of authority and accountability for the allocation of all hospital beds.
- A Bed Managers' Forum is established to identify and resolve bed management problems. The hospital executive supports this forum.
- A documented policy framework supports integrated bed management principles.
- The function of allocating all hospital beds is centralised.
- Bed allocation staff have appropriate authority to allocate beds.
- Integrated bed management occurs 24 hours per day, every day.
- Integrated bed management must be linked with the needs of inbound and outbound patient traffic.
- Allocation of hospital beds is based on agreed medical criteria.
- The allocation of beds to clinical units is notional.
- A flexible bed base is built into the operating requirements to meet fluctuating bed demands.
- Patients are admitted to their correct specialty ward/unit on admission or within 24 hours where appropriate.

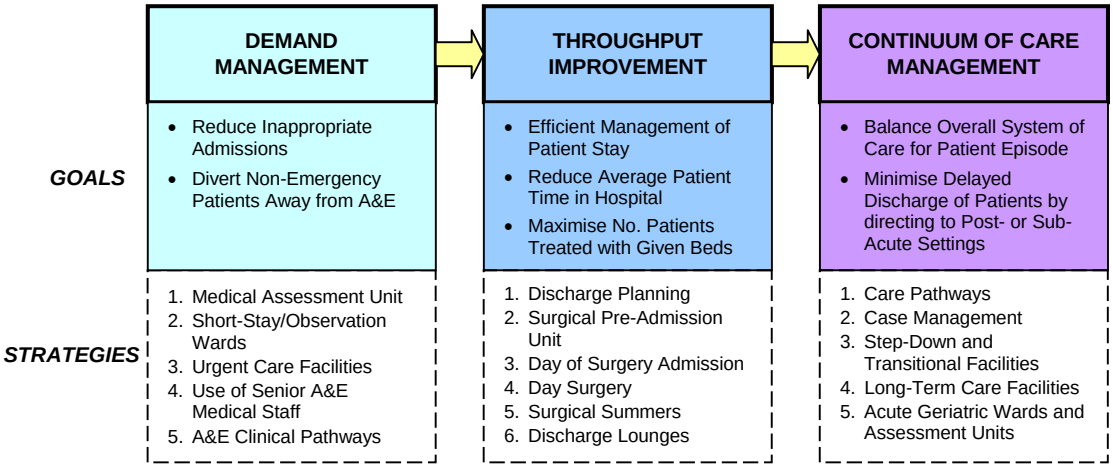
- A patient's episode of care is planned from pre-admission/emergency, through admission and discharge back to the community. Patients and carers are partners in this process.
- An interdisciplinary team plans and coordinates care and support services for a patient's episode of care.
- Integrated bed management is supported by accurate real time information. Data is continuously collected, audited, analysed and disseminated to guide resource management and optimise efficiency.

4.3 Integrated Bed Management Strategies

4.3.1 Overview

Components of an integrated bed management system as informed by best practice are summarised in Figure 4.1, below.

Figure 4.1 Integrated Bed Management



4.3.2 Managing Inpatient Demand

An overview of leading strategies that seek to reduce or better manage the demand for inpatient care include:

- *Medical Assessment Unit* – A short-stay transitional unit usually designed to assess medical patients referred by GPs for admission or to perform investigations on A&E medical patients to determine whether inpatient admission is appropriate. Additional objectives of these units are to streamline investigations, reduce lengths of stay and minimise overcrowding in A&E.
- *Short-Stay/Observation Wards* – Short-stay wards are 1- or 5-day units designed to admit patients for observation or short-term treatment. They diagnose and treat patient within a defined time period, prior to discharge.
- *Urgent Care Facilities* – Urgent Care units are often stand-alone facilities that are staffed by a GP or nurse practitioner and offer non-emergency but urgent

services. Urgent care is defined as the care needed to treat an unforeseen condition that requires immediate medical attention in an outpatient setting for the treatment of acute pain, acute infection, or protection of public health. An urgent condition is not life-threatening but may cause serious medical problems if not promptly treated.

- *Use of Senior Medical Staff in A&E* – International experience demonstrates conclusively that more appropriate medical decisions are made when A&E departments are staffed and supported by experienced and qualified A&E consultants. Junior medical staff tend to admit patients more readily than experienced consultants do.
- *A&E Clinical Pathways* – Care pathways are written protocols that help to map out the whole sequence of quality care for a patient from the time they are assessed up to the point of departure from A&E. Pathways avoid delays in patient treatment.

4.3.3 Improving Patient Throughput

Typical strategies that address the need to manage patient stays in the most efficient and effective manner possible are summarised as follows:

- *Discharge Planning* – Discharge planning is a process that serves as a patient advocate vehicle by planning for patient needs and ultimate discharge, identifying when complex care needs are required after discharge. The process is the critical link between treatment received in hospital by the patient, and post-discharge care provided in the community. It is generally accepted that discharge planning should start prior to admission (for planned admissions), or at the time of admission (for unplanned admissions), and that it ideally comprises these four stages:
    1. Assessment of patient physiological, psychological, social and cultural needs.
    2. Care plan development - identifying and documenting discharge strategies as part of an integrated planning process.
    3. Implementation of plan - arranging for the provision of services, including patient/family education and referrals
    4. Follow-up post-discharge and evaluation of the effectiveness of the discharge strategies
- *Surgical Pre-Admissions Unit* – Pre-admission clinics are well-established strategies that prepare elective surgical patients for their procedures by conducting tests or diagnostic assessments on an outpatient/ambulatory basis prior to the date surgery is actually scheduled.
- *Day of Surgery Admission* – This involves the practice of admitting elective surgical patients into the hospital on the day of surgery, either to a surgical ward or to a day surgery centre. The effect of the policy is to reduce overall length of stay by at least one day.

- *Day Surgery Centres* – These facilities accommodate single day surgical procedures for elective and non-elective surgical patients for procedures that are deemed to be medically suitable for day surgery. The effects of the strategy are to reduce costs, relieve pressure on hospital beds and reduce post-operative infections. They are also generally more convenient and less traumatic for patients and their families.
- *Surgical Summers* – In some health systems, elective surgeries are routinely reduced during winter months, when occupancy pressures are the greatest, and planned for summer months to balance out seasonal shifts in bed demand.
- *Discharge Lounges* – A nurse-managed unit where patients spend a short time before they leave the hospital, thereby releasing inpatient ward beds for new patient admissions.

4.3.4 Managing Patient Continuum of Care

Strategies to manage continuum of care look at the whole picture of a patient's episode of care, crossing Primary, Specialist, Hospital and Community settings. They aim to get rid of bottlenecks in the system as a whole, so that patients do not occupy beds simply because alternative forms or settings for care are not available when needed.

- *Care Pathways* – Similar to A&E pathways, care pathways in a continuum of care context refers to written protocols that map the entire sequence of care for a patient's episode of care. Pathways recognise that many aspects of patient care are predictable and their adoption encourages hospitals to schedule in advance and coordinate the resources the patient will need throughout their stay, and in transition to other care settings.
- *Case Management* – A collaboration process that assesses, plans, implements, monitors and evaluates options and services to meet an individual's health needs through communication and all available resources, promoting quality, cost-effective outcomes. In essence, this approach (widely promoted in the US) provides comprehensive management of complex patients through the entire episode of illness (i.e., the entire continuum of care) to transition back to the pre-hospital state.
- *Step-Down and Transitional Care Facilities* – These facilities provide lower resource-intensive care for patients who no longer require acute care, but need a lower level of added or continuing care. The aim of these facilities is to aid patient recovery in an appropriate setting.
- *Long-Term Care Facilities* – Designed for chronically ill or very elderly patients who require continuous care, but care that is less intensive in an acute setting.
- *Acute Geriatric Care Wards and Assessment Units* Multidisciplinary units designed to provide care for and/or targeted assessments of unique geriatric conditions; such units are designed to meet the needs of the frail elderly.

5. GRADING OF BED MANAGERS

5.1 Guiding Principles

The following principles have guided our analysis regarding the determination of relevant and appropriate recommendations for grading of heads of the bed management function.

- **For hospitals with occupancy rates are consistently higher than 85% over time, a designated Bed Management Department is required.** International experience is well documented that somewhere between 80% and 85% bed occupancy, a critical point is reached where an acute care hospital is no longer able to cope with demand for beds. The view that 100% equals full capacity was actually discredited in the 1960s. Current international best practice literature concludes that occupancies above 90% are unsustainable and unsafe from a risk management perspective. Thus, in keeping with international best practice, hospitals with annual bed occupancy less than 85% do not require a Bed Management Department.
- **Hospitals that establish a Bed Management Department need to designate a single department head post of Bed Manager (the specific title should remain flexible) that is vested with clear authority, responsibility and accountability for all bed management functions**. It is essential that the role, authority and responsibilities of the Bed Manager be made explicit within each hospital. Senior management and clinicians must be able to recognise the authority and leadership of the Bed Manager and should reflect this by contributing to the development of operating processes necessary for the role of Bed Manager to be effective.
- **The Bed Manager grade should reflect the importance and complexity of function**.
  - A relatively high grade is necessary for Bed Manager credibility with consultants and nursing staff.
  - Bed Manager is responsible for significant strategic/policy decision-making.
  - Bed Manager is required to make major operational decisions, e.g., cancellation of planned admissions.
  - Bed Manager in larger hospitals is required to manage a team of professional and clerical staff.
  - Bed Managers have a 24-hour "on-call" responsibility.
- **The Bed Manager grade should also reflect that the post is required to maintain ongoing collaborative relationships with consultants, nursing administration and senior management.**
  - Bed Managers are required to have multi-professional influencing skills.
  - Bed Managers have a role as change agent within the organisation - often challenging cultural power bases; grading impacts directly on the ability to challenge and influence changes to current practices.

- **The Bed Manager role is shifting from that of a "bed finder" to one of the principal gatekeeper of acute hospital admissions.** This new evolving role is increasingly a strategic one that requires higher levels of professional expertise.
  - Bed Managers now need to develop the analytical role of bed management and proactively conduct data analyses and daily audits.

5.2 Skills and Competencies Required

The role of Bed Manager requires a range of high-level skills, including

- Significant knowledge about hospital services;
- An ability to relate to staff of many different professions within the organisation;
- Leadership and influencing skills; and
- Knowledge and competency in the use of information technology..

These skills are in addition to the requirement for bed managers to be qualified as nurses as previously agreed by the National Working Group on Bed Management. The following summarises some of the specific competencies necessary for the post include:

Qualifications and Experience

- Registered General Nurse
- Experience as Ward Manager
- Management qualification or experience.

Analytical Skills

The Bed Manager must have an ability to manage and co-ordinate the placement of patients into appropriate beds with maximum efficiency. In addition, the post-holder must be able to conduct detailed analyses of bed management issues and possess the foresight to predict and plan necessary bed movements (including seasonality needs) to ensure the best possible care for patients at all times.

Communications Skills

The Bed Manager must have exemplary communication and diplomacy skills to enable them to communicate effectively between the many disciplines that have a role in efficient bed management. The Bed Manager will be required to have exceptional judgment and to develop effective, collegial working relationships between all concerned. The Bed Manager will be skilled at managing the sometimes conflicting agendas relative to the efficient management of admissions.

Strategy Skills

The Bed Manager will need a solid grasp of the Irish health service and the effect of both internal and external forces upon the hospital in relation to admissions, discharges and length of stay. The Bed Manager must possess the capability for long-term vision with respect to all hospital services. The post will be skilled at

preparing and implementing service plans and will understand their effects on overall hospital activities.

5.3 Recommended Structural Relationship for Bed Managers

Capita recommends that Bed Manager posts structurally report to the highest level of general management within the hospital, i.e., to the CEO, Deputy CEO or General Manager, with a dotted line relationship to the Director of Nursing. The majority of Bed Managers we interviewed indicated that this type of reporting relationship minimises friction among professions in the long run. In our view, the post should not report to other front-line management posts that report to the CEO/GM (such as Patient Services Manager); it needs a higher profile to be able to gain and maintain credibility with consultants. Additionally, removing the post from Nursing Administration will serve to reduce potential conflicts with ward sisters (as are evident in larger hospitals). This does not mitigate the necessary liasing role with the Nursing Administration that is required within the hospital environment. Clearly the multi-professional involvement in bed management processes must be maintained.

Operational management of beds during late evening, night time and at weekends is currently the responsibility of Nursing Administration. The "bed state" also is reported within the nurse reporting system at shift changes, Day➔Night and Night➔Day. Thus, it is clear that there is a continuing requirement for the nursing service to contribute directly to the process of bed management and to be implicitly involved at many levels. However, it is equally apparent that when significant organisational decisions have to be taken (e.g., the cancellation of elective admissions) such decisions tend to require the involvement of hospital general management.

It is also apparent that when decisions are required that will impact directly on a Consultant's activity/routine, general management are best placed to address such issues, which are primarily regarded as management and not clinical decisions.

5.4 Recommended Minimum Grading for Bed Managers

It is Capita's view that dictating grades for Bed Managers for all Irish hospitals will not serve the purpose of improving bed management services. Each hospital around the country has a unique organisational culture, and managers within each have worked hard to forge positive professional relationships. We do not wish to undo the positive strides made by these hospitals. Therefore, we are structuring our recommendations as *minimum standards* that we feel are necessary for appropriate bed management care in various size hospitals.

Based on the above considerations and on our reclassification of hospital groupings (Table 3.1), Capita recommends that the Bed Manager posts be graded at the following minimum grades:

- **Group A Hospitals:** **Administrative Grade 8, with salary adjusted to be equivalent to the Assistant Director of Nursing grade.**
- **Group B Hospitals:** **Administrative Grade 7, with salary adjusted to be equivalent to the CNM-3 nursing grade.**
- **Group C Hospitals:** **Administrative Grade 6, with salary adjusted to be equivalent to the CNM-2 nursing grade.**

Rationale for Grades

The grade structure for Group A Hospitals is, for several existing post-holders, higher than their current grade. We believe the Grade 8 / ADON level is necessary for several key reasons.

1. As Group A Hospitals are the largest in the country, they will have the most complex specialty service mixes of all Irish hospitals; Bed Manager posts in these hospitals need to be at a very high organisational level to be a credible force for change.
2. Group A Bed Managers are responsible for bed management and discharge coordination on a supra-regional basis, i.e., they have to plan for admission and discharge of patients from many Health Board areas and coordinate with Community Care organisations potentially from all over the country.
3. Group A Bed Managers need to take on a high proportion of strategic responsibilities than at present; the majority of their time should be spent in strategic activities, with most operational duties delegated to Assistant Bed Managers.
4. As discussed in Section 6, Capita is recommending that all discharge coordination functions and admissions office functions be assumed by the Bed Manager; these additional responsibilities should be reflected with higher grades.
5. Fundamentally, the challenges posed in Section 3.2 above – issues which can be tackled at local hospital level – present the need for many Bed Managers to step up from their current roles and to take on new, more strategically-focused and more operationally challenging responsibilities, addressing many of the local root causes of bed utilisation problems. This includes the need to challenge tradition, vested interest, and inadequacy in service provision. This being the case, we believe that grading the Bed Manager post at Grade 8 / ADON level is fully justifiable, as it represents a new departure for the Bed Manager role and places considerable added responsibility on post-holders to play the lead role in problem-solving.

The grade structure for Group B Hospitals is, for the most part consistent with the norm for those hospitals. Only a few Bed Managers in this Group are graded below the Grade 7 / CNM3 level. Capita's recommendations essentially bring all Bed Managers in Group B up to a common peer level. Again, any increase in status for some post-holders currently graded at a lower level than Grade 7 /

CNM3 is entirely justifiable because of the increased responsibility for problem-solving at the local level.

The recommended grade structure for Group C Hospitals is lower than for Group B Hospitals, reflecting lower levels of patient activity in general.

6. BED MANAGEMENT COVERAGE RECOMMENDATIONS

6.1 Key Issue

Consideration was given to the recommendations of the National Working Group on Bed Management regarding the need for 24-7 bed management coverage. After careful examination of the issues, Capita has concluded that while 24-7 coverage of *bed management functions* is a clear necessity, 24-7 coverage by a *bed management department* is neither necessary nor desirable. In our discussions with all professionals involved at hospitals around the country we found that not a single nurse, consultant or manager supported 24-7 bed management department coverage. While opinions differed regarding evening and weekend coverage by bed management staff, all agreed that bed management functional coverage at night (usually from 8pm to 8am) by Night Superintendents/Night Sisters is quite adequate currently and should be continued. We would agree with this view; additional staffing expenditure for duplicate night coverage is not justifiable, especially in the current restricted staffing environment.

Just as responsibility for the operational management of beds at night is assumed by Night Superintendents, on weekends, nurse administration takes on responsibility for bed management, most frequently on a 24-hour basis. Given resource constraints on the addition of new staff, dependence on Nursing Administration for some bed management cover will necessarily continue at least partially in all hospitals

6.2 Recommended Coverage Provided by Bed Management Departments

Capita recommends the following bed management coverage for Group A Hospitals:

1) **Bed Management staff should provide coverage in the hospital between the hours of 8.00 am and 8.00 pm, seven days a week.**
2) **Coverage for the night hours of 8.00 pm and 8.00 am, should continue to be the responsibility of the Night Superintendents on a seven day-a-week basis.**

Capita recommends the following bed management coverage for Group B Hospitals:

1) **Bed Management staff should provide coverage in the hospital between the hours of 8.00 am and 8.00 pm, Monday through Friday.**
2) **Coverage for 8.00 am to 4.00 pm Saturday should be determined by the needs of the specific hospital, and should be the responsibility of either Bed Management or Nursing Administration.**
3) **Coverage for 8.00 am to 4.00 pm Sunday should be the responsibility of Bed Management.**
4) **Coverage for 4.00 pm to 8.00 pm on Saturday and Sunday should be the responsibility of Nursing Administration.**

5) **Coverage for the night hours of 8.00 pm and 8.00 pm, should continue to be the responsibility of the Night Superintendents on a seven day-a-week basis.**

Capita recommends the following bed management coverage for Group C Hospitals:

1) **Bed Management staff (if a department is required) should provide coverage in the hospital between the hours of 8.00 am and 4.00 pm, seven days a week.**
2) **Coverage for 4.00 pm to 8.00 pm on Monday to Friday should be the responsibility of Nursing Administration.**
3) **Coverage for 8.00 am to 8.00 pm on Saturday and Sunday should be the responsibility of Nursing Administration.**
4) **Coverage for the night hours of 8.00 pm and 8.00 pm, should continue to be the responsibility of the Night Superintendents on a seven day-a-week basis.**

Figure 6.1 below summarises Capita's recommendations for bed management coverage across the three groupings of hospitals.

Figure 6.1 Recommended Bed Management Coverage Responsibilities

	Group A	Group B	Group C
Weekday Hours			
0800 - 1600	Bed Management	Bed Management	Bed Management or Nursing Administration[1]
1600 - 2000	Bed Management	Bed Management	Nursing Administration
2000 - 0800	Night Superintendent	Night Superintendent	Night Superintendent
Saturday Hours			
0800 - 1600	Bed Management	Bed Management or Nursing Administration[2]	Nursing Administration
1600 - 2000	Bed Management	Nursing Administration	Nursing Administration
2000 - 0800	Night Superintendent	Night Superintendent	Night Superintendent
Sunday Hours			
0800 - 1600	Bed Management	Bed Management	Nursing Administration
1600 - 2000	Bed Management	Nursing Administration	Nursing Administration
2000 - 0800	Night Superintendent	Night Superintendent	Night Superintendent

[1] Assignment depends on level of hospital occupancy
[2] Assignment depends on level of hospital activity

7. SUPPORT STRUCTURE RECOMMENDATIONS

7.1 Guiding Principles

The following relevant principles have been taken into consideration in the process of establishing recommendations related to support structures and functional compositions of bed management departments.

- **Effective management of bed utilisation requires Bed Management Departments to encompass all aspects of activity impacting on bed utilisation.** While some roles and functions may differ between hospitals, it is essential that the totality of bed management be addressed at a central point, i.e., within a designated Bed Management Department. This should typically include bed managers, the discharge coordinator/planner(s), waiting list coordinators and the admissions office. Planning hospital admissions for both day and in-patient procedures is most efficiently done under the control of a single Bed Management Department. This is already the case in the largest hospitals in the country.
- **For smaller hospitals where annual occupancy rates are consistently lower than 85%, a Bed Management Department is not needed and should not be required.** It is our view that all Group C hospitals should be given the autonomy to decide if they should establish a Bed Management Department.
- **Discharge planning is a function that all hospitals require, regardless of size or occupancy.** This is well established in international best practice, and in our view, all Irish hospitals, regardless of size, should establish discharge planning/coordination functions without delay.
- **Within Hospital Groups, inpatient bed management activity varies considerably.** As a consequence, recommendations about numbers of posts must be flexible to accommodate the actual activity of each hospital.

7.2 Recommended Structure for Bed Management Departments

As with Bed Manager grading, Capita believes it is not desirable to be too prescriptive about specific numbers of posts to support the bed management function. What we are recommending instead are:

- Specific functions that should unequivocally be included under the responsibility of the Bed Manager;
- Minimum guidelines for numbers of each function – actual numbers will need to be determined by each hospital based on patient activity requiring bed management and on staff needed for the hospital's targeted bed management coverage (addressed in Section 6); and
- A staffing standard that can be used as a rough guide for estimating professional bed management staffing needs based on hospital activity.

Capita recommends the following support structure for Group A Hospitals:

1) **The role of the Bed Manager should be primarily strategic in focus.**

2) **The Bed Manager should be supported by 2 or more Assistant Bed Managers (at Grade 7 level), who would mostly focus on operational tasks.** Numbers would need to be sufficient for the coverage recommended in Section 6; i.e., Assistant Bed Managers should be staffed at a level to accommodate actual hospital activity on a 12 hour a day, 7 days per week coverage using a Whole-Time-Equivalent (WTE) basis (covering sick and holiday time).

3) **The Bed Manager should be supported by 1 or more Discharge Coordinators (at CNM3/Grade 7 level, the current level of most discharge coordinators), who would be absorbed into the Bed Management Department and report to the Bed Manager.** Actual numbers of post-holders would be determined by the hospital based on levels of actual hospital discharge activity.

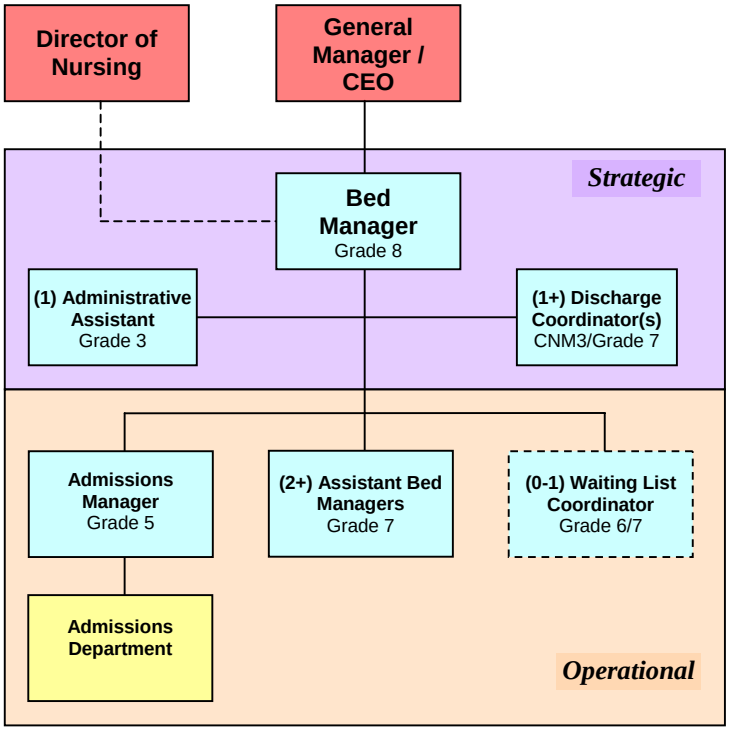
4) **The Bed Manager should be supported by a Waiting List Coordinator if a separate function is required by the hospital or is in post (at current grade level).**

5) **The Bed Manager should be supported by an Administrative Assistant (at Grade 3 level, the current level in practice).**

6) **Admissions Office functions should come under the responsibility of the Bed Manager.**

Figure 7.1 below summarises, in generic form, Capita's recommendations for grading of Group A heads of bed management function and associated support structures to bed managers.

Figure 7.1 Group A Generic Structure Recommendations

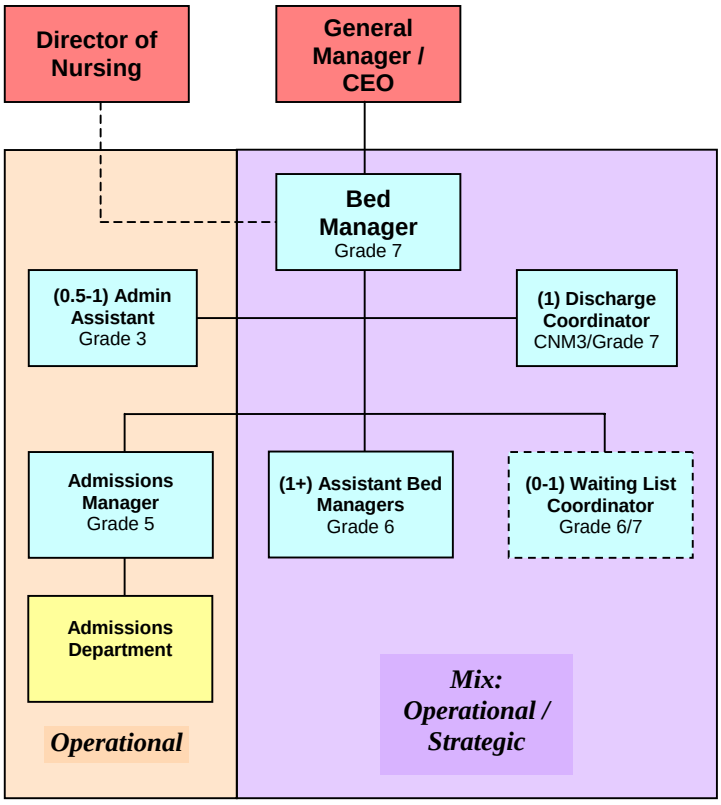


Capita recommends the following support structure for Group B Hospitals:

1) **The role of the Bed Manager should be a combination of operational and strategic, depending on the activity levels and the requirements of the hospital.**
2) **The Bed Manager should be supported by at least 1 Assistant Bed Manager (at Grade 6 level), who would mostly focus on operational tasks.** Numbers needed for this post depend on hospital size, activity and coverage, and would need to be sufficient for the coverage recommended in Section 6 on a WTE basis. The Assistant Bed Manager grade reflects lower levels of patient activity compared with Group A Hospitals.
3) **The Bed Manager should be supported by a Discharge Coordinator (at CNM3/Grade 7 level), who would be absorbed into the Bed Management Department and report to the Bed Manager.**
4) **The Bed Manager should be supported by a Waiting List Coordinator if a separate function is required by the hospital or is in post (at current grade level).**
5) **The Bed Manager should be supported by an Administrative Assistant (at Grade 3 level) for at least half of the time.** Sharing of clerical officers by hospital managers should be encouraged.
6) **Admissions Office responsibilities should come under the Bed Manager.**

Figure 7.2 below summarises Capita's recommendations for grading and support of Group B bed management functions.

Figure 7.2 Group B Generic Structure Recommendations



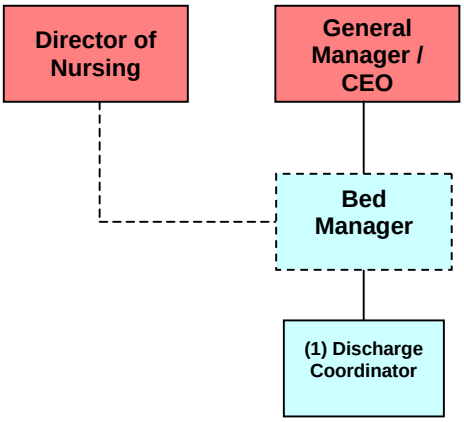
Capita recommends the following support structure for Group C Hospitals:

1) **The role of the Bed Manager, where one is in place, should be primarily operational, with strategic functions performed depending on the requirements of the hospital.**
2) **The Bed Manager, where one is in place, should be supported by a Discharge Coordinator (at CNM3/Grade 7 level). This post is required even if a bed management function is not in place.**

No additional structural recommendations are deemed appropriate for Group C Hospitals. Most Group C Hospitals will not require a bed management function, although a Discharge Coordinator post will be required by all hospitals. In Capita's view, decisions about creating and staffing Bed Management Departments in Group C Hospitals are best left to those hospitals. Moreover, current bed management arrangements that are functioning smoothly should not be required to change. For Group C hospitals just establishing a bed management function, staffing should probably be limited to a Discharge Coordinator (required regardless) and a Bed Manger.

Figure 7.3 below summarises, in generic form, Capita's recommendations for grading of Group C heads of bed management function and associated support structures to bed managers.

Figure 7.3 Group C Generic Structure Recommendations



A staffing standard of 2.0 professional bed management staff per 10,000 annual admissions can be used by hospitals to estimate staffing need. Professional staff would include Bed Managers, Discharge Coordinators, Assistant Bed Managers and Waiting List Coordinators. This standard was developed by Capita to be consistent with international experience in the staffing of bed management functions, but should only be used as a guide to determine if the bed management function is over- or under-staffed. Actual staff numbers should be established by each hospital based on its unique activity and coverage requirements.

Example of Staffing Standard Application

A sample staffing calculation is presented in Table 7.1. In this hypothetical example, a large hospital has only 3 existing professional bed management staff to manage 25,000 annual admissions; this gives the hospital a staffing ratio of 1.2. If the hospital had a staffing ratio of 2.0, it would have roughly 5 bed management staff. Thus, the standard indicates that this hospital is probably understaffed by 2 posts. This calculation would suggest that this hospital should re-assess its bed management needs.

Table 7.1 Sample Staffing Calculation

Acute Beds	550
Annual Admissions	25,000
Current Bed Mgmt Prof Staff	3.00
Actual Staffing Ratio (staff per 10,000 admissions)	1.20
Staff needed at 2.0 staff per 10,000 admissions	5.00
*Over **(Under)** Staffing*	***- 2.00***

8. CONCLUSIONS

8.1 Overall Conclusions

In general, we found considerable evidence of good bed management practice around the country. Overall, we found heads of bed management functions to be proactive not only in establishing effective bed placement practices, but also in assuming responsibility for developing strategic solutions to better screen patients coming into hospitals through A&E and to mobilise staff to focus on appropriate patient discharge practices. For a good number of Irish hospitals, bed management departments have helped to foster organisational cultures where cooperation among professional groups is very high.

For a number of hospitals (particularly among Band 2 facilities), however, bed management is underdeveloped and is not being given a high enough priority or organisational standing. While many of these hospitals face budget constraints in 2003, relatively small amounts of additional funding to establish bed management and discharge planning practices would significantly improve the care provided to patients and in the long run would minimise costs within the health service.

In this study, Capita has made specific recommendations that we believe will assist hospitals to structure more effective integrated bed management departments. However, appropriately graded and structured bed management departments, even when functioning to maximum efficiency, will only move hospitals a small way toward solving what are now national crises in A&E overcrowding and bed management. **Many larger issues, most of which are outside the control of bed managers, need to be addressed on a national basis. Some of the issues that we have discussed in this review hold much more potential to truly resolve the bed management crisis than structures do.** Specific issues that directly affect the quality of care given to patients include:

- Lack of sufficient rehabilitation, step-down, nursing home and long term care beds for patients who remain in acute care beds with nowhere else to go.
- Proactive changes in Consultant practices to encourage prompt discharge of patients.
- Hospitals/Health Boards funding for initiatives that could significantly improve patient throughput.
- Community Care services in general are not available outside standard business hours.
- Diagnostic Services working hours are inadequate to support effective bed management.
- Underdeveloped services nationally for the provision of urgent/ambulatory care and same-day surgery.

Until the strategic issues such as these are faced head-on and addressed at national, regional and Health Board levels, the bed management crisis will not be resolved.

When patients are not placed promptly in the most appropriate facilities, when admissions are cancelled or when discharges are delayed from hospital, the quality of care to patients suffers and clinical risk issues arise for hospitals.

8.3 Next Steps / Action Plan

From the preceding review and recommendations, considerable work clearly needs to be pursued both within individual hospitals, at Health Board level, and in relevant national fora. Given the scale of changes necessary, a disciplined action plan should be initiated that breaks the process down into manageable tasks based on targeted accomplishment dates. At this stage, we have not sought to develop a detailed action plan, as we believe that this may be somewhat premature. Instead, we would recommend that the employers and nursing unions should discuss this report with a view to agreeing the actions required to improve the current situation, in line with the findings of Capita's report.

Nevertheless, we can identify in outline the main activities which are likely to be required as part of the implementation process. These include:

- Discussion and agreement of the content of this report between the employers and the unions, with a view to identifying the generic structures required for different types of hospital.
- A detailed exercise to establish a specific bed management structure within each of the 23 hospitals covered in this report (based upon the generic recommendations contained herein), including the drawing up of job descriptions and role profiles, and agreement on the specific grades and other features of each post.
- A parallel exercise to review the bed management arrangements in the other 15 general hospitals not visited by Capita as part of this study, and to develop a specific structure, grading and job descriptions for the bed management function at those hospitals.

These tasks might be coordinated centrally, for example by the employers, to ensure consistency on a national basis; or the responsibility for effecting them might be devolved to each individual hospital. If that is the case, some central quality assurance will be required to guarantee consistent roll-out of the recommendations emerging from this study, with oversight by the employers, the nursing unions, and other stakeholders such as the Department of Health and Children.