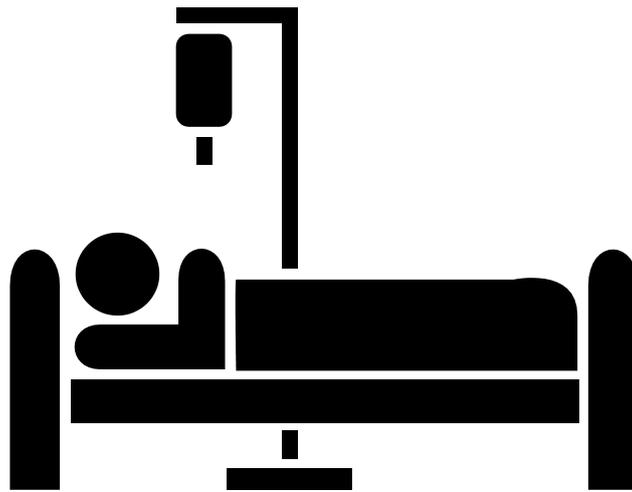


St. Joseph's Hospital Review



Medical Beds

January 1998

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INTRODUCTION

According to the Strategy document (1) the primary aim of the Department of Health and the health services should be to enhance the health and quality of life of people, based on the principles of equity, quality of service and accountability. From the service aspect the Strategy document highlights the need for appropriate care and the importance of linkages, within and outside the health services, in order to achieve this. Linkages are a key objective of the National Health Strategy. A key objective of the Corporate Strategy of the South Eastern Health Board (2) is integration.

This report was written with the above considerations in mind together with the aim of identifying (preventable) factors which were impacting on medical bed usage in St. Joseph's Hospital, Clonmel. The members of the group were:-

Dr. Maire O'Connor, Public Health Specialist (*Chairperson*)
Dr. Paud O'Regan, Consultant Physician, St. Joseph's Hospital, Clonmel
Dr. Sam Kingston, Consultant Physician, St. Joseph's Hospital, Clonmel
Dr. Najmuddin Banatwala, Temporary Consultant Physician, St. Joseph's Hospital, Clonmel
Mr. Robert Quinn, Matron, St. Joseph's Hospital, Clonmel
Mr. Seamus Healy, Hospital Administrator, St. Joseph's Hospital, Clonmel
Mr. Eamonn Lonergan, Project Manager, Cashel Project, St. Luke's Hospital, Clonmel
Dr. Paul Gannon, Public Health Specialist
Dr. Margaret O'Riordan, GP Unit, Tipperary
Dr. Marie Ryan-Carew, A/DCC MOH SAMO, Sth. Tipperary
Ms. Rosa Gardiner, Supt. P.H.N., Sth. Tipperary
Mr. Brendan O'Keefe, Administrator, Sth. Tipperary
Dr. James Morrison, Chief Psychiatrist, St. Luke's Hospital, Clonmel
Ms. Mairead Cantwell, Matron, St. Patrick's Hospital, Cashel
Ms. Stephanie Lynch, Asst. Hospital Administrator, St. Joseph's Hospital, Clonmel *Secretary*

The report which follows is based on the group's deliberations and consultation with colleagues within the assigned time frame of one month.

BACKGROUND

Demands for health service provision are rising steadily, and will continue to rise with changing health technology and social, including care structures. The demand and need for health care services will increase for the foreseeable future.

The catchment area of St. Joseph's is largely that of South Tipperary Community Care Area which incorporates part of Waterford. Between 1991 and 1996 the population of South Tipperary increased by 0.8%. However, amongst those aged 75-79 years and ≥ 80 years, the increase for Tipperary South Riding was 5.50% and 12.82% respectively (Appendix 1), compared with the regional figures of 5.39% and 10.88%. The elderly have greater health service needs.

There have been many national and international studies linking poor health status and shorter life expectancy with low economic status and deprivation. The reasons for this are complex

but include a higher proportion of risk factors associated with increased ill health in areas of deprivation. An indicator of economic status in Ireland is the proportion of the population with a medical card. As of 31/12/97, 36% of the residents of the South Tipperary Community Care Area had a medical card. 70.2% of these aged 65 years and older qualify for medical cards, i.e. have an index of economic deprivation while belonging to an age with higher ill health risk. Based on the 1991 census 16.1% of the population of Tipperary South Riding were unemployed compared with the national and regional figures of 14.8% and 15.5% respectively. The same census (1991) showed Tipperary South Riding as having higher than national and regional figures in the more deprived social classes of 5, 6 & 7.

As part of a larger European survey, elderly residents of the population in the South East were surveyed for their use of various health services (Appendix 2). For all community services, the residents of the South East compared relatively unfavourably with their European colleagues. Admission to hospital in the preceding 12 months showed the South Tipperary residents to be the second lowest users compared with their colleagues elsewhere in the South East, despite having the highest attendance at GPs.

Mortality is a crude indicator of health service needs, but has the advantage of (when standardised to allow for population differences) enabling comparisons to be made. For all cause mortality (1991-1995), males in South Tipperary had higher death rates than their colleagues in other areas of the South East and this was especially so when deaths from circulatory diseases were compared. For the major causes of mortality and morbidity i.e. circulatory disease, and more specifically, ischaemic heart disease and cerebrovascular disease, neoplasms and respiratory disease, South Tipperary males did worse than the regional average. For females the picture was repeated for circulatory disease, specifically ischaemic heart disease and cerebrovascular disease. The elderly compared unfavourably with the regional average for all but respiratory disease (Appendix 3).

In terms of predicting future health care needs, in a recent survey of 14-16 year olds attending secondary schools in Tipperary (3), 66.4% of respondents had ever smoked while 31% were regular smokers, 30.2% drank alcohol on a regular basis. In the absence of effective health promotion, preventable aspects of morbidity and mortality will contribute to future health care needs.

THE REVIEW

During the process of the review, the aspects of which are presented and discussed in the following sections, other issues linked directly or indirectly with the review topic became apparent and have been included here where appropriate.

Methodology:

The time frame within which this report had to be produced, one month, and taking account of members of the review group's existing commitments, was a major factor in deciding methodology. A number of sub groups of the review group members (varying in size from 1-3) were formed. Each subgroup was given suggested headings (but were not limited to these) to examine the aspect of the issue – acute medical bed use – which related most to their service. Three general meetings were held, which were attended by the review group members where the dates did not clash with existing commitments. Documents and reports

were circulated as they were obtained. A draft report was distributed prior to the final (4th) meeting which all members attended or sent comments/representation.

THE PEOPLE

As discussed in the background, South Tipperary Community Care has a sizeable elderly population – a population known to have greater health needs than their younger colleagues – which has increased especially in the oldest old category since 1991. The South Eastern Health Board established a multi-disciplinary review group in 1995 to plan for the health needs of the elderly population. **It is recommended that the elderly review report should be made available as soon as possible and its recommendations, in so far as they apply to the population of South Tipperary, be implemented as quickly as possible.** As will be evident in the sections which follow, the health needs of the elderly are impacting on acute medical bed use in St. Joseph's, so inevitably this current review group had to make a number of recommendations in this area, but this does not take away from the need for a more holistic approach to the health needs of the elderly.

Norms for health services for the elderly, both for community services and institutional, including hospital services, were published many years ago in "The Years Ahead" (4). How Health Boards and various Community Care Areas have achieved these are available in "The Years Ahead Report, A Review of the Implementation of its Recommendations by the National Council of Ageing and Older People in 1997" (5). Achievement on factors such as the liaison nurse, district teams, co-ordinators of services, care in general hospitals, care in the home, mentally infirm, community hospitals, care in the community, etc. are available in detail in this report. It is evident from the contents of this that South Tipperary has some way to go in achieving the recommendations of "The Years Ahead". In the absence of achieving these norms acute institutions such as St. Joseph's, Clonmel will continue to, in some way, take up the slack for the absence of or less than adequate nature of other services. It is worth noting that the review report addresses the importance of partnership in care.

Current acute medical facilities are dealing with people, many of whom are at the end stages of preventable diseases. With changing health care technology, demands for acute care are likely to continue to rise. If for no other reason than to be able to cope with this demand, it is incumbent on the health services to ensure that effective health promotion services are in place to change the type of behaviour evident in the schools' survey mentioned in the background section. **It is recommended that the Health Board put in place an effective health promotion programme for the population of the South Tipperary Community Care Area.**

MEDICAL IN-PATIENTS

The catchment area of St. Joseph's, as mentioned earlier, is largely that of South Tipperary Community Care Area. Based on hospital in-patient enquiry (HIPE) data (Appendix 4), it would appear that in terms of numbers of admissions to hospitals outside the region for acute general medical care, the population of South Tipperary are having a large percentage of their needs met within the region.

Admission:

The Accident & Emergency service for South Tipperary is based in Our Lady's Hospital, Cashel (OLHC), and will remain there until surgical services are moved to Clonmel, in accordance with the overall hospital plan. St. Joseph's has a treatment room where acute medical patients are seen. The treatment room has no assigned nursing staff at night (after 10.00pm – 4 nights per week, after midnight – 3 nights per week) and has only one Nurse on duty during the day, except from 2-5.00pm (2 Nurses). If the treatment room is very busy during the day or the wards are very busy at night (i.e. no Nurse can be sent to cover the treatment room) patients may be admitted directly to the wards. In the past, patients referred by GPs were admitted directly to wards. Now where possible, patients are first seen in the treatment room.

The numbers seen in the treatment room are increasing annually (1987-1,661, 1995 – 4,481, 1996 – 6,195, 1997 – 6,419). This cannot be fully accounted for by the move to having GP referrals seen in the treatment room. The average monthly attendance in 1997 was 517, of whom 46% were GP referrals, 31% self referrals, 4% ambulance referrals and 19% from other sources. Almost a quarter (23%) of those who attend do so after 9.00pm, of whom 50% are self referrals and 36% GP referrals, and therefore likely to occur when there is no assigned nursing staff. (Self referrals here are as noted in manual records, those recorded as self referrals by PAS refer to in-patients only). It would appear that to the public the treatment room in St. Joseph's is in fact an Accident & Emergency unit.

It is recommended that attendance at the treatment room should be by GP/ambulance referrals. Self referrals should be discouraged. One option would be the immediate/visible application of the £20.00 levy with its staffing implications. Another would be emphasising to the public the message that where available their own GP should be their first source of care.

The Accident & Emergency (A&E) department in acute hospitals can serve as the interface between the wards and the public and other services. Although not an A&E department, as part of this review, how the treatment room functioned in this regard was evaluated by reviewing the people seen there over one 24 hour period, chosen at random.

In that period, 25 people attended of whom 6(=25%) came after 10.00pm (i.e. no assigned nursing staff). The outcome of attendance for the 25 was:-

- 1 admitted to gynaecology
- 9 admitted to medical ward (3 of whom died within 24 hours)
- 1 transferred to WRH Eye Unit
- 1 transferred to WRH for emergency CAT scan
- 1 sent to A&E OLHC after stabilisation for suturing

- 2 treated and discharged after treatment for burns and injury
- 1 discharged after a number of hours following LOC in GP surgery (?reaction to LA)
- 2 discharged after arranging urgent OPD appointment
- 1 routine venesection
- 1 arrived at treatment room for “blood test”
- 5 referred back to GP

Among the nine admitted, one arrived when both beds in the treatment room were full and was unfit to wait in a chair so had to be sent directly to the ward.

This suggests that the treatment room is becoming a semi A&E unit. It is acting as a gatekeeper on admissions but the question must be raised, can it continue to function in this manner, given the rising numbers and the seriousness of many of those attending. It was outside the remit of this group, and would not have been feasible in the time span, to examine the A&E services (or equivalents) in the South Eastern Health Board but **it is recommended that the Health Board review the functioning of the current treatment room and A&E service in South Tipperary, including their functions as gatekeepers to acute hospital beds.**

Hospital Stay:

High levels of inappropriate hospital use defined as the care of patients whose needs could be catered for in a lower level institution or outpatient setting has been demonstrated in different acute settings.

The appropriateness evaluation protocol (AEP) is a criteria based instrument specifically designed to measure inappropriate use and to determine the reasons and responsibilities for same. It has been used internationally and nationally including hospitals in MWHB, NWHB and EHB.

Given the time frame limitations, in the study in St. Joseph’s it was only possible to carry out the study on sufficient numbers to show trend rather than statistical significance. The aim of the study was to determine what proportion of medical inpatients could have been catered for in a lower level institution or outpatient setting and to identify the reasons why such patients were admitted and why they remained in hospital. A systematic sample of admissions, followed by a second systematic sample of days of care were selected from the population of acute medical inpatients in St. Joseph’s in 1997.

Results: no of charts requested = 177
Proposed bed days for evaluation: 177 admission days + 172 other days of care = 349

no. of charts obtained = 100 (56.5%)
no. of charts with “usable” information =86 (86%)

(Staff were advised, in view of short time frame, to do their best to provide maximum number of charts, rather than spending time pursuing difficult to locate charts. All charts included in this study were located with 6 hours.)

In a small number of cases, the Consultant listed on the admission print-out, was not the Consultant who cared for the patient based on chart information. Likewise some patients transferred to psychiatric care according to chart notes, on admission print-out remained assigned to Physician for total stay.

Source of admission was of little value, as many sent in by GP were seen in treatment room prior to going to ward. For this part of the review where a GP letter was found (absence of letter ≠ letter not sent at time) the admission was classified as GP referral, otherwise source of referral was classified as self referrals, ambulances etc. to treatment room.

Consultants:	Medical (x3)
No. of charts	= 86
No. of days of care:	admission: 86
	other days: 74
	Total: 160

Patients readmitted with same problem within 1 month of discharge = 3

Admissions:	Appropriate (criteria)	65 (75.6%)
	Appropriate (override)	4 (4.6%)
	Inappropriate	17 (19.8%)
	Total	86

Inappropriate: 17

Age group:	<65 years = 8	Sex: Male = 8	Source: GP = 8
	65 – 74 years = 3	Female = 9	Treatment room (including self referral)= 6
	≥ 75 years = 6		Other (OPD=2, not sp.= 1) = 3

Day of week admitted:	Sunday= 3	Home Circumstances: Alone = 5
	Monday = 4	Spouse = 3
	Tuesday = 4	Family = 7
	Wednesday = 1	Other,
	Thursday = 2	not specified = 2
	Friday = 2	
	Saturday = 1	

Appropriate care were these facilities available (alternative)

District Hospital type bed (i.e. lower level of nursing & medical support)	= 6
Observation bed for a number of hours in staffed A&E	= 7
Immediate OPD appointment with immediate investigations	= 2
Observation bed for a number of hours in staffed unit on a daily basis while undergoing diagnosis & therapy if patient had lived near hospital	= 1
Readmission to acute unit elsewhere from which patient had been discharged on previous day	= 1

Days of Care other than 86 admission days

Number = 74 (50 patients)

Appropriate (criteria) = 44 (33 patients) = 59.5%
 Appropriate (override) = 5 (5 patients) = 6.7%
 Inappropriate = 25 (22 patients) = 33.8%

Inappropriate: (25 days)(22 patients)

Appropriate admission = 15 patients

Inappropriate admission = 7 patients

Table 1a: Inappropriate Days of Care after *Appropriate Admission* (17 days)

Day of Care Since Admission: Evaluated	Day of Week	Patient's LOS (length of stay)	Age Group	Home Circumstances
<5 days = 3	Sunday = 2	<5 days = 0	<65 yrs = 5	Alone = 4
5-9 days = 8	Monday = 1	5-9 days = 9	65 – 74 yrs = 4	Spouse = 5
10-14 days = 2	Tuesday = 3	10-14 days = 2	≥75 yrs = 7	Family = 4
15+ days = 4	Wednesday = 5	15+ days = 6		Other = 4
	Thursday = 2			(NFA = 1, UK sheltered house resident = 1, not sp. = 2)
	Friday = 3			
	Saturday = 1			

Table 1b: Inappropriate Days of Care after *Inappropriate Admission* (8 days)

<5 days = 6	Sunday = 2	<5 days = 3	<65 yrs = 1	Alone = 5
5-9 days = 1	Monday = 2	5-9 days = 2	65 – 74 yrs = 1	Spouse = 1
10-14 days = 1	Tuesday = 0	10=14 days = 3	≥ 75 yrs = 6	Family = 2
15+ days = 0	Wednesday = 2	15+ days = 0		Other = 0
	Thursday = 1			
	Friday = 0			
	Saturday = 1			

Sex: (days of care) Female: 45.8%
 Male: 54.2%

Appropriate Care were these Facilities Available (alternative):

Appropriate admissions (15 patients, 17 days)

Convalescent bed/district type hospital bed/step down bed = 8

Awaiting test results = 1

Awaiting assessment by paramedic (on leave) = 1

Discharge day = 1

Awaiting bed at lower level of care = 1

Awaiting urgent orthopaedic review

(patient sent by ambulance to WRH A&E eventually, following day patient admitted to surgical bed)	= 1
Non Irish resident: UK resident sheltered housing.	
DC following improved medical control	= 1
Awaiting radio therapy	= 3

<i>Inappropriate admission (7 patients, 8 days)</i>	
Awaiting test results	= 2
Convalescent/district hospital type bed/step down bed	= 5
Management problem: dementia: to long stay	= 1

Overall:	Days	Appropriate	= 118 (73.8%)
		Inappropriate	= 42 (26.2%)
		Total days	= 160

Discussion:

The proportion of inappropriate admissions was 20%, that of days of care other than the admission day was 33.8%. This compares with the MWHB (6) which also looked at medical admissions only where the figures were 23.1% inappropriate admissions and 43% inappropriate days of care. When days of care (all specialities) were assessed in James Connolly Memorial Hospital, 19.4% was deemed inappropriate. In the NWHB, using the AEP method only, of emergency medical admissions to Sligo 16% were deemed inappropriate while for Letterkenny the figure was 15%.

It is generally recognised, and has been borne out by the other Irish studies, that the factors responsible for inappropriate days of care, can usually be classified as 1/3 medical, (i.e. awaiting tests/results/ward rounds etc.), 1/3 family factors and 1/3 environmental factors (i.e. awaiting access to appropriate care setting for patient. It should be emphasised that in the St. Joseph's results medical factors were at a minimum suggesting that they have already been removed in so far as they existed and as the facilities in St. Joseph's allow.

Inappropriateness of admissions and inappropriateness of days of care in hospital are not a new feature. If such studies had been done in the 1960s, 1970s and early 1980s, it is likely that the inappropriateness would have been of a much larger nature. With the increasing pressure on finances and acute beds over the past ten years, the level of inappropriateness has probably decreased. It would be wrong to assume that obtaining the impossible of 0% inappropriateness would solve the problem of pressure on medical beds. However, reducing the level of inappropriateness by providing the other facilities identified as being needed would help cope with the increasing numbers of medical admissions which is being experienced throughout Ireland and internationally at present and is likely to continue into the future, given changing life expectancy, demography and health technology. Problem areas identified by the NWHB (7) in terms of emergency medical admissions included the question of an assessment and/or observation unit in A&E, access to urgent OPD appointments, rapid access chest pain clinic, community hospital facilities, discharge planning, cost sharing, development of day hospital facilities, redesignation of some care beds to provide step down, rehabilitation and on-going low level nursing care beds and further development and formulation of hospital community care liaison. All of these could be equally applied to St. Joseph's.

According to the Council of International Hospitals in 1996 (8), professional staff considered that up to 40% of admissions may be avoidable but only if appropriate alternatives to hospital care both exist and are available. Although various planned and acute responses to excess emergency admissions have now been described, few have been evaluated. Isolated changes have generally produced little effect, even when backed up with large cash injections. “A systems approach would suggest a comprehensive, integrated response co-ordinated across an entire community or region. This would include primary care as well as hospitals, social services as well as health services. More openness implies involving the other stakeholders, social services, politicians, purchasers, primary care practitioners, patients and the public. Greater honesty means recognising that we will get what we are prepared to pay for. Future debates will need to focus on the most contentious issue, prioritisation” (9).

It is recommended that, where a patient changes consultant after admission, that mechanisms are in place to ensure that such changes are incorporated on manual and computerised data bases including PAS.

It is recommended, given international, national and local findings, that at a minimum the Health Board address the availability and access to step down/convalescent/district hospital beds for patients of St. Joseph’s, which will cater for the current transition phase – Clonmel/Cashel projects - and the long term phase and also the availability of and access to community support services.

Discharges:

Discharge planning starts on the day of admission. It recognises that lack of environmental or family support facilities can delay discharges of many patients even when the patient is medically fit. This has been recognised both internationally and nationally (6,7). Various methods have been developed (10,11) to predict those patients who are likely once admitted, to have a non medical hospital stay based on factors known at the time of admission. Discharge planning also facilitates continuity of care for patients. An example of one such discharge plan from the UK is included in this report (Appendix 5). Additional sources/examples are included in the references (12,13).

It is recommended that a formalised written discharge planning procedure be adapted and adopted for St. Joseph’s patients which could act as a pilot for all hospital admissions in the South Eastern region.

In addition to discharge planning there is a need for more input from the liaison Public Health Nurse to facilitate implementation of discharge plans. **It is recommended that there should be a full time geriatric liaison Nurse (or equivalent) who would be provided on a daily basis with the admissions list for each of the hospitals indicating new admissions of those aged 65 years and over, and who would have access daily, at a specified time, with the Ward Sisters to formulate discharge plans.**

To facilitate discharge, where it is anticipated that admission to another institution or access to community services will be needed at the end of the acute episode, it is recommended that these be booked at the time of admission, or as near as possible, with a provisional date set as to when discharge to that facility will be required.

DATA

Data is collected and provided by three main formats from the acute hospitals; hand-written returns, patient administration system (PAS) and Hospital Inpatient Enquiry System (HIPE). Each hospital makes their own hand written returns to headquarters where the medical returns for St. Joseph's and Our Lady's, Cashel are combined, (as St. Joseph's).

Before examining the actual data which precipitated this review, it is worth noting two other aspects of the data system. During the appropriateness study it was noted that very occasionally a patient was recorded as an inpatient when there was no evidence in the notes that this was so and occasionally notes in charts were missing or incomplete making it impossible to assess the admission/hospital stay. This has serious implications including those of a medico-legal nature. On the same theme, the current patient administration system has the advantage of being easy to use and is used throughout the Health Board. However it has limitations in the knowledge and information which can be obtained from it, and does not allow for a detailed analysis of patient profile. This hampered this review and is likely to hamper future reviews. In addition, the quality of the information being inputted into the system is difficult to assess, as there is no apparent audit or check programme in place. Neither of these two features are unique to St. Joseph's Hospital, but both are areas which need to be addressed to allow for more informative analysis of quality data and to facilitate comparisons, between different years and different institutions.

Using data from the PAS system (Appendix 6) it is evident that the age profile of medical patients is increasing, the lengths of stay for those aged ≥ 65 years is increasing while that for the younger group is decreasing. Given the results of the survey mentioned earlier (appendix 2) on use of services by the elderly i.e. the South Tipperary elderly had the highest GP attendance but the second lowest hospital admission figures, the admission rate of the elderly potentially could be much higher.

The impact of older age on health services is evident from the above figures with the burden largely falling on the medical services. Given the 1996 demographic figures for South Tipperary, this will continue. Based on sources of admission (Appendix 7) for all specialities the trend to self referral (classified as emergency: other) shows an increase from 1995 to 1997 and supports the earlier discussion on the function of the treatment room.

Comparisons between hospitals (Appendix 8) are difficult at present, as it's not always clear what is being compared which can lead to errors. For example when comparing medicine and paediatrics, its not always specified whether paediatrics refers to the unit, the age group or the speciality. This is important for example, when comparing St. Joseph's and St. Luke's. The former's paediatric unit usually has adult medical patients while the latter's includes paediatric surgical patients. Similarly, in other than WRH, the general medical figures include geriatric medicine.

It is recommended that a data accuracy check programme be put in place (e.g. an automatic recheck of every 1 in 50-100 charts).

It is recommended that the current interpretation of those supplying data e.g. source of admission (referring doctor/usual doctor/self-referral), paediatrics (medical/surgical/both) be clarified, differences identified and eliminated so that the statistics produced throughout the South East are uniform.

It is recommended that at a regional level, basic data information requirements (administrative, medical, nursing) be identified by a multidisciplinary group and means of meeting these requirements be identified.

It is recommended that all forms are specifically labelled as to whether they refer to unit, speciality or age group and in the case of St. Joseph's whether or not the medical beds in Our Lady's Hospital, Cashel are included.

In 1997, as a response to the pressure on medical beds in St. Joseph's, 10 medical beds were made available in OLHC for patients well enough to be transferred over, i.e. in need of step down care. Once in this setting the pressure for discharge is less severe than it is in the acute setting of St. Joseph's as is appropriate for a convalescent/step down facility. If convalescent/step down beds, in adequate numbers were available in district hospitals or other institutions these bed days would appear under the appropriate heading. There is a need to classify these bed days accurately on data forms. If they continue to be treated from a statistical point of view as acute hospital bed days then the logic is that medical patients should be admitted directly to OLHC and not via St. Joseph's, and that the full range of acute services should also be available to these patients.

Hand-written returns are made separately for these patients to headquarters where they are subsequently combined with those of St. Joseph's as reflecting medical activity costed to St. Joseph's, so that discharges from St. Joseph's to OLHC are counted again when discharged from OLHC.

The figures used in the data which follows varies slightly depending on whether the data was that obtained from each of the hospitals or that available in head-quarters. The variation is slight e.g. 3856 vs. 3843 medical/paediatric discharges from St. Joseph's in 1997, 24749, vs. 24803 medical/paediatric bed days. For the sake of simplicity, the raw figures from both hospitals (St. Joseph's, OLHC) are used in the discussion which follows. Overall, these were the higher figures, and so are more likely to over-estimate than under-estimate in-patient medical activity.

The figures in Table 2(a) refer to various factors making up the total figures costed to St. Joseph's.

Table 2(a) 1997 Medical & Paediatric Discharges

	St. Joseph's				Our Lady's, Cashel (OLHC)			
	Day Cases	Inpts Discharges	Bed Days	Av. LOS	Day Cases	Inpts Discharges	Bed Days	Av. LOS
Medicine	1269	3410	23773	6.97	-	157	2442	15.55
Paeds.	-	446	976	2.19	-	-	-	
Total	1269	3856	24749	6.42	-	157	2442	

Table 2(b) treats the two institutions separately, and therefore allows those discharged from St. Joseph's to OLHC, to be treated as discharges again for OLHC i.e. treats both institutions as two independent units. If this was the reality of the situation, acute medical admissions would be allowed directly into OLHC with all ancillary medical and nursing care. Clearly, this is not the case.

Table 2(b) St. Joseph's & OLHC as 2 Independent Medical Facilities

	Day Cases	Inpts Discharges.	Bed Days	Av. LOS
Medicine	1269	3567	26215	7.35
Paeds.	-	446	976	2.19
Total	1269	4013	27191	6.77

Table 2(c) treats those in OLHC as another acute medical ward of St. Joseph's and therefore does not count transfer to OLHC as discharges from St. Joseph's.

Table 2 (c) St. Joseph's plus OLHC as an acute medical ward of St. Joseph's

	Day Cases	Inpts Discharges.	Bed Days	Av. LOS
Medicine	1269	3410	26215	7.69
Paeds.	-	446	976	2.19
Total	1269	3856	27191	7.05

Currently medical discharges and bed days from St. Joseph's and OLHC are summated and assigned to St. Joseph's. This is not correct as it double counts those discharged from St. Joseph's to OLHC.

The importance of the above, is reflected in how one compares figures with other years and with other institutions, as shown in table 3 and Appendices 8 and 9. If one counts St. Joseph's alone the increase in medical/paediatric discharges was 6.1%, that of bed days used 3.2%. If St. Joseph's with OLHC as an additional acute medical ward of St Joseph's is counted, the increase in discharges for medical and paediatrics in 1997 was 6.1% with the increase in bed days used of 13.4%. If St. Joseph's and OLHC are counted as two independent acute medical facilities, i.e. those transferred to OLHC from St. Joseph's are counted as discharges for St. Joseph's and again as discharges for OLHC, the increase in discharges (medical & paediatrics) was 10.4% while their combined bed day use showed an increase of 13.4%.

Table 3 Medical/Paediatric Figures 1995, 1996, 1997

	St. Joseph's	St. Joseph's		St. Joseph's only		St. Joseph's plus OLHC as an acute medical ward of St. Joseph's		St. Joseph's & OLHC as two independent medical facilities	
	1995	1996 % change on 1995		1997 % change on 1996		1997 % change on 1996		1997 % change on 1996	
Beds (Med. & Paeds)	74	74	-	74	-	84	-	84	-
Patients Discharged	3608	3635	0.75	3856	6.1	3856	6.1	4013	10.4
Bed Days	23659	23981	1.40	24749	3.2	27191	13.4	27191	13.4
Average LOS	6.56	6.60	0.61	6.42	-2.72	7.05	6.82	6.77	2.57

(Source: 1996 & 1995 – Statistical Abstracts. 1997 - Individual hospitals)

It is recommended that in future the figures returned for medical units in both OLHC and St. Joseph's should be displayed separately and if combined should reflect the different type of care provided in one facility (convalescent/step down bed days) and that discharges from one are in fact transfers to another.

While the above helps explain some of the apparent increase in medical admissions and bed days in 1997 and shows them as being in line with other acute facilities (although comparisons between different institutions are difficult given the different underlying populations, different starting points, different service structures and in some cases what the figures include), it does not alleviate the financial burden incurred by the acute hospital programme, in needing to provide convalescent/step down beds in the acute hospital, OLHC. Two thirds of those treated in Our Lady's eventually went home, 4.5% died, while 27% went to other institutions. If kept in St. Joseph's until they were suitable for movement to and places become available in those institutions, they would have seriously added to the pressure on acute beds.

BEDS: Acute & Other

All the other acute medical departments in the region, are experiencing increasing medical admissions, in line with those being experienced by St. Joseph's. When medical beds are full in St. Joseph's, female medical patients can be placed in gynaecology and paediatric beds. Other hospitals have the option of putting additional male and female medical patients in surgical and other speciality beds (with resulting cancellation of elective admissions and theatre lists) but this option is not available in St. Joseph's. Therefore, compared with the other acute units in the region, St. Joseph's is forced at a much earlier stage into putting up additional beds. In purpose built units – wide corridors, wide door openings, piped oxygen etc. – patients in a few extra beds, with appropriate staffing, can be adequately treated. The difficulty with St. Joseph's is that it lacks all these advantages of a purpose built unit.

Paediatrician posts have been approved for St. Joseph's hospital, which will mean sooner or later the loss of the paediatric unit for adult medical patients, which will further add to the pressure on medical beds.

Some of the above pressures will be relieved when the Clonmel and Cashel projects are completed, while others will be helped if the recommendations of this report are implemented. However, in the meanwhile interim measures are required to help staff provide adequate care for patients.

As a temporary measure, additional space should be identified in the hospital which if staffed could serve as an observation unit, and additional space, which could be opened as a temporary ward to avoid the necessity of putting up extra beds.

Given the work-house structure of the hospital, much time is spent moving patients around wards as yet another admission comes in. Nursing staff are required, in this moving process, to perform work which could be done by porters and ward clerks. The provision of oxygen, telephones and bed access for emergency trolleys are inadequate, and given the expected duration of the transition phase, temporary measures need to be provided.

It is recommended that interim measures such as those mentioned in the two paragraphs above be considered and implemented.

It is recommended that measures to deal both with the structure of the St Joseph's, the impact of developing new/improved services e.g. Paediatrics and the transition stages of the Clonmel and Cashel projects are put in place, to enable staff to adequately care for patients.

It is recommended that an effort be made to fast track the implementation of the Cashel-Clonmel projects, especially those aspects which will provide additional beds and services, and in addition the planned extended care beds (27) in St. Anthony's, Clonmel, and the nursing unit (10 beds) in Tipperary town.

On the wider issue of beds in South Tipperary, **district hospital beds** are available in Clogheen and Carrick whose patients are cared for by GPs, and to which all acute hospitals can request to send patients. It is evident that this is not working effectively or is inadequate given the fact that the medical patients in Our Lady's, Cashel, are in receipt of care which

should be available in a district hospital, and given the fact that the appropriateness evaluation review identified so many inappropriate admissions and days of care as being more appropriate to convalescent/step down/district hospital care.

Within the time frame and remit of this review group, it was neither feasible nor appropriate, to assess the two district hospitals in South Tipperary. However, on the basis of discussions with their matrons, the following areas were identified as some of the areas which could impact on medical bed use in St. Joseph's:

* Neither hospital has a formal /written policy/criteria for accepting admissions. It is up to the person requesting the bed to make a case with regard to need and urgency of the request.

Sources of admission (estimate): Carrick: GP > WRH > St. Joseph's.

Clogheen: GP > St. Joseph's > WRH.

* Apart from hospice beds, other beds within both district hospitals have no specific designation. Both hospitals provide respite care on a need basis.

* In terms of ancillary and nursing services, neither provide IV therapy, chiropody is available if paid for by the patient, occupational therapy is available on a request basis, physiotherapy is available 1 hour per week in Clogheen, while in Carrick the physiotherapist visits one half day per week.

* There are no formal meetings/co-ordination procedures with the matrons of other local institutions nor with the liaison nurse.

* Neither hospital has formal care or discharge plans. As for the acute hospital problems which prevent/delay patients being discharged include;

-lack of community supports especially home helps and sheltered housing,

-need for long term beds,

-delays in processing nursing home subvention applications - even if this process was started while the patient was in an acute unit, once transferred to the district hospital, the whole process seems to start at the beginning again.

* Pharmacy supplies for Clogheen are provided by Cahill, May, Roberts while those for Carrick come from St. Joseph's.

While visiting both hospitals, it was not possible to formally evaluate the appropriateness of patient stay but the following examples illustrate some of the difficulties being encountered by the District Hospitals in maintaining patient throughput.

- Patient stay of 4 months: family unwilling to take patient home. House with inadequate heating. No nursing care needed.

- Patient stay of 3 months: poor home conditions, initially in need of sheltered housing, now in need of nursing home bed.

- Patient stay of 3 years: poor home conditions, (declared unfit for human habitation). Patient wants to return to that home.

- Patient stay of 1 year: admitted as death thought to be imminent. Spouse would be unable to cope with him alone.

- Patient stay of 6 months: post CVA, in need of long term bed as patient has insufficient income for nursing home.

It is recommended that the role, function, control of district hospitals, adequacy of bed numbers and geographical distribution is reviewed, linked with the acute hospital programme, integrated across all programmes and shortfalls rectified. This would enable them to serve a role which includes both alleviating the need for admissions to acute hospitals and facilitates earlier discharge by providing a number of convalescent/step down beds for all the acute hospitals, in an equitable manner.

If all district hospitals in the region are dealing with the same type of patients, providing the same range of therapies and facilities, it is difficult to explain their wide variations in lengths of stay (18.32 days – 48.15 days) (Appendix 10). It is recommended that as part of the recommendation recommended above, that these factors be examined and addressed.

Until both of these recommendations have been addressed, the step down medical beds in OLHC will continue to be needed and in fact may be needed in greater numbers than currently provided. By default the medical side of OLHC is beginning to function as it's envisaged to function in the future. **It is recommended that the medical beds - step-down - in OLHC remain open until the short fall in non acute beds is addressed.**

Respite beds, by helping families to care for their relative at home, reduce pressure on long-term beds and in a crisis situation on acute beds. Their provision within South Tipperary does not meet demands.

It is recommended that a larger number of respite beds, for planned and emergency respite, should be available in each of the non-acute hospitals on a geographical basis.

Welfare homes were provided in the past for frail, mobile elderly, in the absence of other community services including sheltered housing. The need for such beds has been questioned in recent times but maybe needed in the absence of other more appropriate services. Welfare home beds serve a different function to long term and nursing home beds, all of which require nursing care. If community services including sheltered housing were developed to meet norms (Appendix 11 – Table C), some of the welfare home bed units could be redesignated as long term beds, respite beds, etc.

In view of the changing life expectancy and demography of the area, it is unlikely that the provision of additional **long term beds** in South Tipperary will impact directly on acute hospital bed usage. However by taking patients awaiting beds from other institutions, movement of patients could be facilitated.

Reference has been made earlier, together with a recommendation, to increase the speed of delivery of the Clonmel-Cashel projects, and the beds in St. Anthony's and Cluain Arann, Tipperary, especially those aspects which will provide beds and services to ease pressure on St. Joseph's, Clonmel. Appendix 11, Table A shows some of these, while Tables B & C show the inadequate distribution of beds throughout the region, a matter which presumably has been addressed by the review group on the elderly.

In order to try to link a person with the most appropriate bed, and to minimise the need for phone calls to each institution by staff seeking a bed for a patient, **it is recommended that a**

bed co-ordinator be appointed who, on a daily basis would know what beds and types of beds are available in the area, and the potential flows.

During 1997 there was a delay with processing **nursing home** subventions at a local level due to the relocation of one of the CWOs. This should not arise in future years. An additional problem is that of the need to assess the families of people for whom application for subvention is received. This may change as plans are afoot not to take family circumstances into account in the future based on a letter from the Department of Health. The Department of Health has issued a letter stating that family circumstances need no longer be taken into account. The position remains that information on families is still sought where possible. **It is recommended that at a National, Health Board and local level, the position on the assessment of families is clarified in line with the Department of Health's letter.**

At a local level it is recommended that a target should be set whereby subvention applications for emergencies and people in hospital beds are dealt with within a week of application.

A recent report has stated (5) that the amount spent nationally on developing community services such as day care, day hospitals, community hospitals, paramedical services, etc., contrasts unfavourably with the £65 million spent in recent years on implementing the Nursing Home Act. People gain admittance to Nursing Homes for many reasons, including those who are admitted due to lack of social supports, lack of community services, as well as disability. Only those who apply for subvention are assessed as being, from a nursing or medical point of view, in need of a nursing home bed. However, after a certain period of time in any institution, people, who if other services had been available might not have initially needed a nursing home bed, will eventually have a need for that, in part because of institutionalisation and in part because of whatever supports they had in the past will have disappeared.

Reference is often made to the number of nursing home beds in South Tipperary. However of the 342 nursing home beds in the area, approximately 20 beds are occupied by people from outside the area. Only 224 (65.5%) are occupied by people who qualified for subvention. It is unknown how many of those in non subvented beds would have qualified under nursing/medical assessment or how many in subvented or unsubvented beds could have remained in a non institutional setting if services had been available. Earlier discharge from St. Joseph's of those patients with VHI eligibility is being achieved by making use of convalescent beds in nursing homes.

A more equitable approach to the whole question of care for older people would have been a situation whereby an amount of money was set aside for management by a case worker, working with that patient, deciding how best to distribute the cost rather than allowing use only for nursing home care. This approach to care needs to be taken up at a national level.

The maximum subvention available is £120.00 per week leaving a minimum of £80.00 to be made up by family or from pensions. In reality it is often a great deal more. The level of subvention to nursing homes needs to be addressed at a national level if nursing home beds are to serve their purpose, otherwise there is going to be increasing demand on long-term beds and inappropriate stays in District Hospitals and acute hospitals where people who cannot afford nursing home beds will block beds. **It is recommended that at a Health Board and**

national level, the role, place and financing of nursing homes within a totality of services (institutional & community) be addressed as a matter of urgency.

In the nursing home beds in South Tipperary there are approximately 10 people who are young chronically sick and therefore maybe inappropriately placed in these institutions. They are potentially blocking beds needed by the elderly which in turn can impact on other bed use in the area including the acute hospitals. **It is recommended that young chronically sick people be placed in care services appropriate to their needs.**

SERVICES

The section which follows is not a comprehensive discussion of services for South Tipperary, but rather those services which are related to acute medical bed usage and need to be discussed but were not totally appropriate under any of the other headings. Once again, it is anticipated that the detail of addressing the health service needs of the elderly will be included in the Review Group of the Elderly report.

A permanent **Geriatrician** is to be appointed for South Tipperary. **It is recommended that the job description for the Geriatrician should specify details of the settings where he/she will work, covering the present facilities, the various transitional facilities and the eventual end stage facilities. To specify these, it will be necessary to clarify the current, transitional and future roles of facilities in Cashel, both Our Lady's Hospital and St. Patrick's, and to specify who controls access to the various bed types when required by older people. If the post remains temporarily filled, it is recommended that these details be clarified and specified for the temporary post holder.**

The medical beds in Our Lady's, Cashel are currently functioning as step down/convalescent beds, although the patients are only admitted from St. Joseph's and they remain largely under the care of a Consultant Physician visiting twice weekly. Patients receive nursing support but no ancillary services such as physiotherapy. Provision of ancillary services can help move patients through the system quicker and can help avoid an end result of needing long term care. **It is recommended that in all institutions (and those de facto, operating as such, e.g. OLHC medical) the ancillary services such be at a level appropriate to the needs of their clients.**

In addition, to the Geriatrician, there is a need for a **Co-Ordinator of Services for the Elderly**, at a senior level, whose job it would be, not just to look to bed needs or to moving people as quickly as possible out of acute beds, but to the overall care and service needs of the elderly as individuals and as a group in communities and in institutions. These posts are in place in other Health Boards and are of benefit to all concerned, both from the point of view of service providers and service recipients. **It is recommended that a Co-Ordinator of Services for the Elderly be appointed as a matter of urgency.**

The Home Help service can be vital in helping older people to get home from any institution (Appendix 13) and to remain at home. With the pay on offer, which is below the recommended minimum wage (£2.00 per hour and no entitlements), it is becoming increasingly difficult to recruit suitable home helps. This results in delayed discharges and bed blocking. **At a national and Health Board level it is recommended that the South Eastern Health Board should push to address the pay issue of Home Helps, otherwise the consequences will by default be paid for through the costs of the various institutional care facilities.**

With the move of the home helps onto a payroll system, and given the great variation and fluctuations in hours worked by any one home help each week, much nursing time is spent on administration. **It is recommended that, as for Carlow/Kilkenny, that a home help organiser be appointed for South Tipperary (Appendix 12) or that the administrative salary aspect of the home help service should be allocated to specified administrative staff.**

As part of this review, this group attempted to identify where medical admissions to St Joseph's came from. In 1997 approximately 30% were from Tipperary (including Clogheen), 23.5% from Cashel (including Slieveardagh), and 42.5% from Clonmel/Carrick. (These figures are based on the psychiatric sectors for South Tipperary). The views of the GPs, by means of a postal questionnaire have been sought as part of this review process. The results are not yet available. **It is recommended that the views of GPs be incorporated within cross programme service needs and service development plans including those of St. Joseph's hospital.**

In addition, it is recommended that liaison and communication between all service providers including GPs, the acute hospital, and community care should be strengthened.

The development of services is influenced by many factors which include history, demand, need, resources. The advantages of such development is that services can develop appropriate to the locality. The disadvantages are that disparities can develop so that different services can develop to different degrees in adjacent areas which in turn can have knock on effects on how other services develop. This is evident in the different areas of the South East region, in terms of general and regional services, availability and accessibility, community and institutional. **It is recommended that the Health Board should aim to provide all health services on an equality of need rather than geographical basis.**

CONCLUSION

This group was established to examine factors influencing acute medical bed usage in St. Joseph's. St. Joseph's, like the other acute medical facilities in the South East and indeed nationally and internationally is experiencing a rise in medical admissions. The rise in St. Joseph's is in line with that experienced elsewhere. If one discounts those moved to non-acute step down care in Our Lady's, Cashel the rise in bed days is consistent with the number of admissions. As opposed to all the other services in South Tipperary, all of which are working within resource constraints, St Joseph's cannot refuse to admit acutely ill people in need of medical care, even if they could be more appropriately cared for elsewhere, if that facility is not available or full; nor can St. Joseph's discharge people to step down care, ranging from institutional to community, if these services are not available. It was evident to this review group, that within St. Joseph's and within their resource limitations much of what could be done to improve the situation has been done. At present, St. Joseph's is bearing some of the costs of other services living within their resource limitations. Until a comprehensive cross service, cross programme integrated package of services is available (9), St. Joseph's will continue to be expected to bear this pressure.

This group is aware of the resource implications for the Health Board, the various programmes and various services of many of the recommendations made in this report. None of these recommendations taken on their own will ease the problem. It is important that each recommendation is seen as one part of a total package aiming to provide an integrated, equitable, seamless comprehensive health service to the population of South Tipperary. The group is aware of the financial restrictions within which the Health Board has to operate. However, we believe St. Joseph's need is special for reasons outlined in this report.

RECOMMENDATIONS

It is recommended that the elderly review report should be made available as soon as possible and its recommendations, in so far as they apply to the population of South Tipperary, be implemented as quickly as possible.

It is recommended that the Health Board put in place an effective health promotion programme for the population of the South Tipperary Community Care Area.

It is recommended that attendance at the treatment room should be by GP/ambulance referrals. Self referrals should be discouraged. One option would be the immediate/visible application of the £20.00 levy with its staffing implications. Another would be emphasising to the public the message that where available their own GP should be their first source of care.

It is recommended that the Health Board review the functioning of the current treatment room and A&E service in South Tipperary including their functions as gatekeepers to acute hospital beds.

It is recommended that, where a patient changes consultant after admission, that mechanisms are in place to ensure that such changes are incorporated on manual and computerised data bases including PAS.

It is recommended, given international, national and local findings, that at a minimum the Health Board address the availability and access to step down/convalescent/district hospital beds for patients of St. Joseph's, which will cater for the current transition phase – Clonmel/Cashel projects - and the long term phase and also the availability of and access to community support services.

It is recommended that a formalised written discharge planning procedure be adapted and adopted for St. Joseph's patients which could act as a pilot for all hospital admissions in the South Eastern region.

It is recommended that there should be a full time geriatric liaison Nurse (or equivalent) who would be provided on a daily basis with the admissions list for each of the hospitals indicating new admissions of those aged 65 years and over, and who would have access daily, at a specified time, with the Ward Sisters to formulate discharge plans.

To facilitate discharge, where it is anticipated that admission to another institution or access to community services will be needed at the end of the acute episode, it is recommended that these be booked at the time of admission, or as near to as possible, with a provisional date set as to when discharge to that facility will be required.

It is recommended that a data accuracy check programme be put in place (e.g. an automatic recheck of every 1 in 50-100 charts).

It is recommended that the current interpretation of those supplying data e.g. source of admission (referring doctor/usual doctor/self-referral), paediatrics (medical/surgical/both) be

clarified, differences identified and eliminated so that the statistics produced throughout the South East are uniform.

It is recommended that at a regional level, basic data information requirements (administrative, medical, nursing) be identified by a multidisciplinary group and means of meeting these requirements be identified.

It is recommended that all forms are specifically labelled as to whether they refer to unit, speciality or age group and in the case of St. Joseph's whether or not the medical beds in Our Lady's Hospital, Cashel are included.

It is recommended that in future the figures returned for medical units in both OLHC and St. Joseph's should be displayed separately and if combined should reflect the different type of care provided in one facility (convalescent/step down bed days) and that discharges from one are in fact transfers to another.

It is recommended that measures to deal both with the structure of the St Joseph's, the impact of developing new/improved services e.g. Paediatrics and the transition stages of the Clonmel and Cashel projects are put in place, to enable staff to adequately care for patients.

It is recommended that interim measures such as those mentioned in the fourth and fifth paragraphs of Page 17 be considered and implemented.

It is recommended that an effort be made to fast track the implementation of the Cashel-Clonmel projects, especially those aspects which will provide additional beds and services and in addition the planned extended care beds in St. Anthony's, Clonmel (27 beds) and the nursing unit (10 beds) in Tipperary town.

It is recommended that the role, function, control of district hospitals, adequacy of bed numbers and geographical distribution is reviewed, linked with the acute hospital programme, integrated across all programmes and shortfalls rectified. This would enable them to serve a role which includes both alleviating the need for admissions to acute hospitals and facilitates earlier discharge by providing a number of convalescent/step down beds for all the acute hospitals, in an equitable manner.

If all district hospitals in the region are dealing with the same type of patients, providing the same range of therapies and facilities, it is difficult to explain their wide variations in lengths of stay (18.32 days – 48.15 days) (Appendix 10). It is recommended that as part of the recommendation recommended above, that these factors be examined and addressed.

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It is recommended that a bed co-ordinator be appointed who, on a daily basis would know what beds and types of beds are available in the area, and the potential flows.

It is recommended that at a National Health Board and local level, the position on the assessment of families is clarified in line with the Department of Health's letter.

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At a local level it is recommended that a target should be set whereby subvention applications for emergencies and people in hospital beds are dealt with within a week of application.

It is recommended that at a Health Board and national level, the role, place and financing of nursing homes within a totality of services (institutional & community) and finances be addressed as a matter of urgency.

It is recommended that young chronically sick people be placed in care services appropriate to their needs.

It is recommended that the job description for the Geriatrician should specify details of the settings where he/she will work, covering the present facilities, the various transitional facilities and the eventual end stage facilities. To specify these, it will be necessary to clarify the current, transitional and future roles of facilities in Cashel, both Our Lady's Hospital and St. Patrick's, and to specify who controls access to the various bed types when required by older people. If the post remains temporarily filled it is recommended that these details be clarified and specified for the temporary post holder.

It is recommended that in all institutions (and those de facto, operating as such, e.g. OLHC medical) the ancillary services such be at a level appropriate to the needs of their clients.

It is recommended that a Co-Ordinator of Services for the Elderly be appointed as a matter of urgency.

At a national and Health Board level it is recommended that the South Eastern Health Board should push to address the pay issue of Home Helps, otherwise the consequences will by default be paid for through the pay costs of the various institutional care facilities.

It is recommended that, as for Carlow/Kilkenny, that a home help organiser be appointed for South Tipperary (Appendix 12) or that the administrative salary aspect of the home help service should be allocated to specified administrative staff.

It is recommended that the views of GPs be incorporated within cross programme service needs and service development plans including those of St. Joseph's hospital.

It is recommended that liaison and communication between all service providers including GPs, the acute hospital and community care should be strengthened.

It is recommended that the Health Board should aim to provide all health services on an equality of need rather than geographical basis.

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