HSE MID WEST COMMUNITY HEALTHCARE
Mental Health | Older Persons | Disabilities
Primary Care | Health & Wellbeing

NORTHSIDE ENGAGEMENT PROJECT: NORTH LIMERICK CITY

AUTHORS

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INTRODUCTION

Listening to patients, service users, community members and community partners is the corner stone of delivering and developing services tailored to the needs of communities. By listening and engaging we can improve access for patients and improve service integration. This project kept at its heart the, principles of Sláintecare delivering the **Right Care in the Right Place at the Right Time.**

The 2019 Pobal deprivation index found that on average the life expectancy in Limerick's most deprived areas was 6.5 years lower for women and 7.5 years lower for men then that of the most advantaged area in the country. The 2023 Pobal deprivation index compounds the 2019 statistics and classifies the areas of King's Island, Ballynanty and Kileely as 'extremely disadvantaged'. This area demographic of mainly 'extremely disadvantaged' and 'very disadvantaged' with smaller pockets of 'affluent small areas' provided a unique opportunity to the project team to engage with patients, community members and service providers. identifying the barriers faced when accessing Primary Care services across these mixed demographics.

OBJECTIVES

- Engage with Primary Care service users, community members, Primary Care staff and community service providers to establish the barriers and enablers to accessing Primary Care services
- Co-produce a set of recommendations with service users, staff and service providers to address the barriers identified to present to senior management
- Co-produce a way of working to inform patient engagement into the future within the Northside of Limerick city and across the wider HSE Mid West services

OUR ENGAGEMENT APPROACH

- 277 people were engaged with across a wide range of social demographics within North Limerick City
- 14 face to face engagement sessions
- 3 online surveys
- An informal, open and honest approach taken to discussing the barrier faced when accessing Primary Care on the North side of Limerick city
- A responsive approach to engagement, being flexible to including newly identified groups throughout the project to ensure a broad representation of North Limerick city

RESULTS/FINDINGS

Enablers Identified

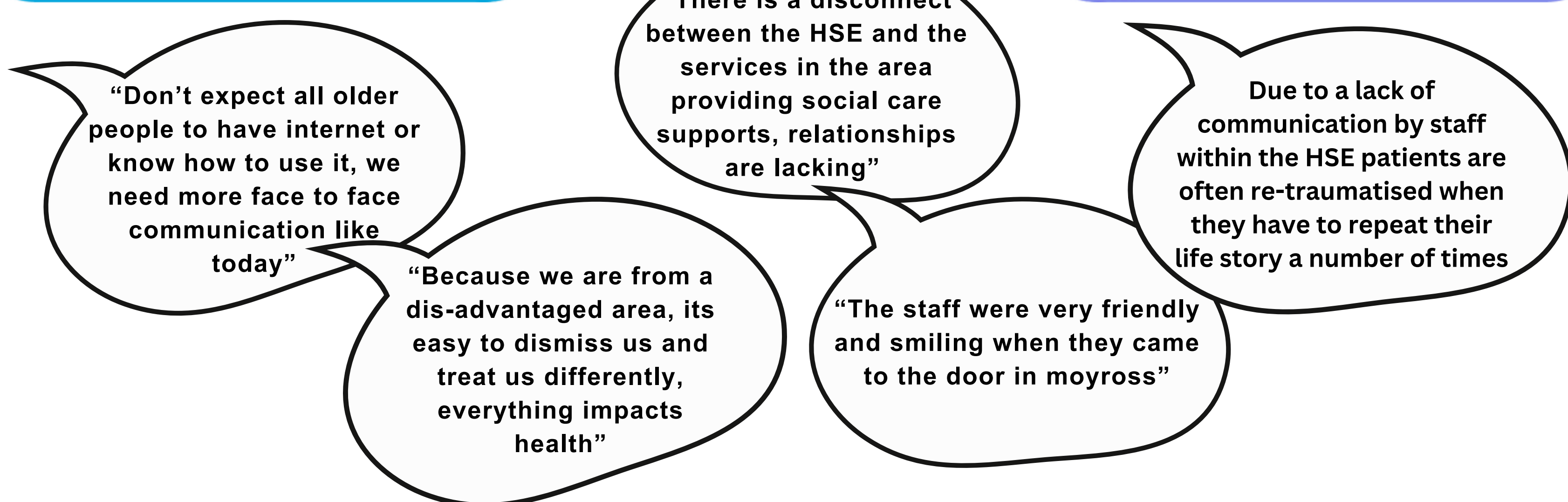
- Empathetic and friendly interactions
- Timely appointment scheduling

Barriers Identified

- Low awareness of Primary Care services
- Lack of understanding and sensitivity
- Judgmental staff attitudes
- Poor data sharing and transactions within services
- Poor interagency co-ordination
- Excessive wait times
- Transport challenges to services

RECOMMENDATIONS

- Client centered approach - understanding the community you serve
- Patient Engagement skills training - training staff on the HSE Better Together Roadmap
- Provide options of outreach/home visits
- Accessible age friendly information - co-producing information with service users to suit their specific needs
- Inter-agency collaboration - working with community agencies to support the community
- Appointment reminder system



King's Island Community
Love your Heart
Valentine's Day Event
February 14th
Community Health
Time: 11 am to 1 pm
Venue: King's Island Community Centre
Who is this for? Everyone who lives in the King's Island Community
Available on the day:
- Diabetes Nurses Specialist (Diabetes monitoring)
- The cardiology Nurse specialist (BP monitoring)
- Dr Nessa Starr
- Health Promotion Officer
- The PCT- PHN,OT assistant & Paeds Physio
- Free Complementary Therapies
- Goodie Bags
- Complimentary Tea/Coffee

Come meet your local Primary Care Healthcare Providers

Primary Care Services
Limerick North-side

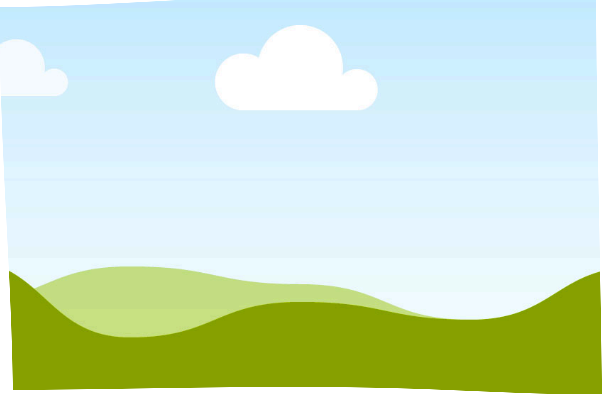
Your Primary Care Team

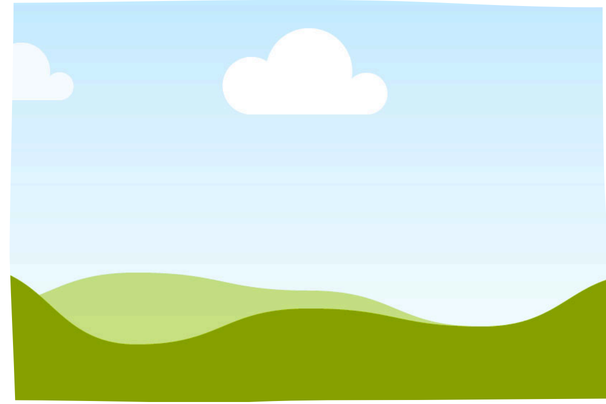
Your Community Healthcare Network Manager is : Sheila Mulcair, Ballynanty Health Centre

CONCLUSION/NEXT STEPS

This collaborative approach to consultations with service users and service providers, allied with the partnership with the academic PPI Ignite research unit in the University of Limerick, has produced robust, reliable socio-demographic and stakeholder data and recommendations.
This will now inform the development of an area service improvement plan and priorities for the future HSE patient engagement structures to progress.
A final event will be held in mid-September 2024 to offer service users and community partners in North Limerick city the opportunity to co-produce priorities for multi-stakeholder collaboration, and to be involved in their implementation to improve access and integration across Primary Care services within the North side of Limerick city

HSE | UNIVERSITY OF LIMERICK OLLSCOIL LUIMNIGH | School of Medicine Health Research Institute | PPI Ignite @UL | HSE MID WEST COMMUNITY HEALTHCARE





Universal Medication Kardex that Follows the Child across Community Services

H. Noonan, M. Corcoran, N. Quinn, L. Power, S. Gallagher

Background

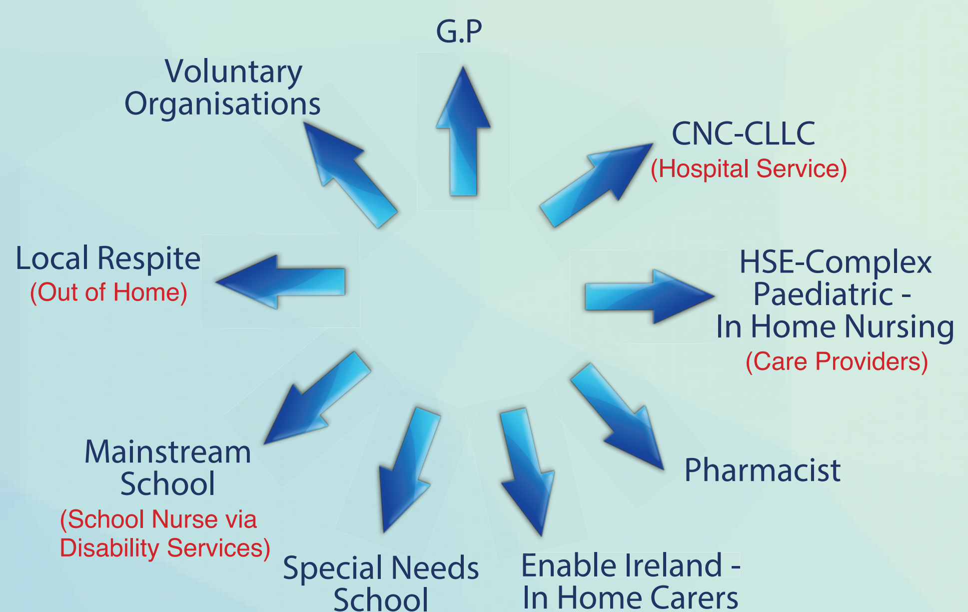
Children with complex care needs have multiple care providers involved in their care, primary care, disability services, respite, school and voluntary agencies. Different care providers have their own specific versions of medication kardex in use that are not transferrable between organisations and settings. When a medication change is requested by a Consultant or General Practitioner (GP), the Clinical Nurse Coordinator for Children with Life Limiting Conditions (CNC-CLLC) ensures all providers and GP are informed.
The parent/guardian receives a copy of the new prescription, necessitating changes to a number of kardexes that need to be amended. As a result of feedback from parents the CNC-CLLC and the Complex Paediatric Department recognised that multiple kardexes in the home creates a potential risk for medication errors or omissions and care planning confusion with risk of harm to service users.

Aims & Methods

AIM: To devise a universal kardex system that is transferrable between multiple care providers. Governance around new MPAR (Medication Prescription Administration Record) use would lie with each of the services using the new kardex system.

METHODS: A core team was established to ascertain if a universally acceptable kardex system could be developed for complex needs children that had potential to be transferrable between relevant agencies. Meetings were scheduled with key stakeholders. Pre and post testing is being completed using the PDSA (Plan, Do Study Act) model in line with IHI (Institute for Healthcare Improvement) methods.

Professionals/ Stakeholders Involved



MPAR

CHILD	1	2	3	4	5	6
ACT Category	3	4	3	4	4	3

PHOTO

Paediatric Medication Record – Community Healthcare Mid West

Last updated: ________

Child's Name			
Address			
Date of Birth			
Weight		Date	Weight
Height		Date	Height

ALLERGY/ADVERSE REACTIONS OR CONTRAINDICATIONS

IF NO KNOWN DRUG/other ALLERGY: please tick ☐ Signature and Registration Number: Date:
IF YES, PLEASE COMPLETE BELOW:

MEDICATION/OTHER	NATURE OF REACTION	SIGNATURE & REGISTRATION NUMBER	DATE

THE FOLLOWING MEDICINES ARE CONTRAINDICATED, PLEASE AVOID

MEDICATION AND REASON	SIGNATURE & REGISTRATION NUMBER	DATE

- Summary Instructions for prescribers
  - Please write legibly and use block capitals
  - Never abbreviate a medication name and use generic names, where possible
  - Circle time medicine to be administered
  - Please do not use abbreviations – write units and micrograms in full
  - Please use a zero before the decimal point e.g. 0.5mg
  - Please ensure decimal points are clear
  - When the medication is discontinued a line must be clearly placed through the remaining prescription and signed in the 'Cancelled By' section, signed and dated by the prescriber
  - Never alter a prescription. If changes are necessary, re-prescribe in a new prescription
  - Please clearly state route (PO/PEG/PEJ) and if the medicine is to be crushed

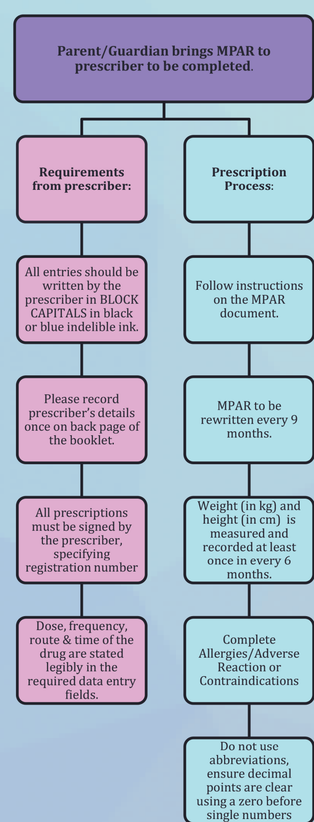
- Summary Instructions for Nurses/Administrators of Medication
  - If you have any doubt about the details of a prescription, check with prescriber BEFORE administration
  - Check each section to avoid omissions
  - Initial the appropriate box when administering a medication. Include your initials and name once on the back page
  - In the event of non-administration, enter the relevant code in the box and document reason in nursing record

In the event of non administration, enter the appropriate code and document reason in nursing record:

1. Child refused medicine	2. Parent refused medicine	3. Medicine not available	4. Withheld on doctor's orders	5. Prescription not clear, prescriber contacted – await clarification	6. Withheld see clinical file	7. Other – see clinical file

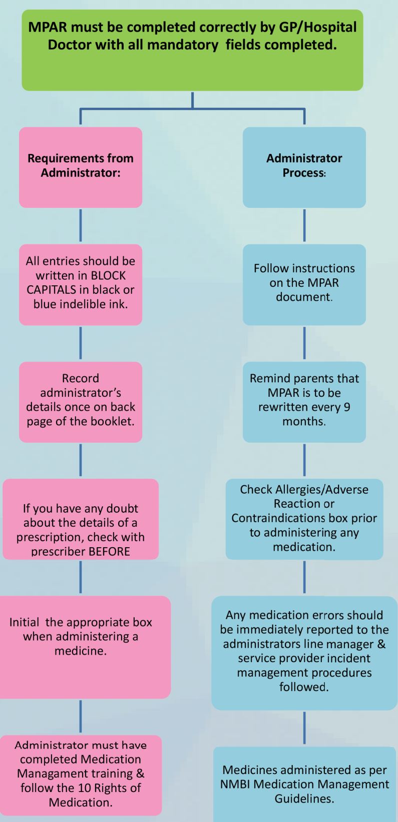
Test Document Version 1 August 2022

MWCH Complex Paediatric MPAR Process Map For Prescriber



Governance of the MPAR lies with each service using it.

MWCH Complex Paediatric MPAR Process Map For Administrator



Governance of the MPAR lies with each service using it

Outcome

A test of the MPAR involving 6 children with complex needs who have multiple agencies involved in their care is underway. It will take 6 months and will evaluate the ease of use amongst all organisations involved, reduce the need for multiple transcriptions thus reducing risk for errors.
An information leaflet and instructions, on how to complete the new kardex will be refined, once outcome of test is known.

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

Ospidéil OL
UL Hospitals

LIFE SKILLS FOR BODY AND MIND COMMUNITY THERAPUETIC GROUPS

AUTHORS and AFFILIATIONS

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INTRODUCTION

With the Introduction of the National Access Policy, the paediatric Primary Care Teams in Community Healthcare Network (CHN) North Tipperary has seen a significant increase in referrals and subsequently wait times for children in this area have increased. While individual access to therapies is essential for these children, Primary Care strives to provide ongoing services for children within their own community. Health Promotion is integral to our work in Primary Care. Partnering with community groups to develop services for these children not only provides effective support for these children in their own community, it also may decrease the needs of some these children needing to access therapies individually.

Looking at linking with our community partners to maximize our resources across CHN North Tipperary and the community, we developed a partnership with Children and Young People's Services Committees (CYPSC), who are a key structure identified by Government to plan and co-ordinate services for children and young people in every county in Ireland. The overall purpose is to improve outcomes for children and young people through local and national interagency working.

Meeting with CYPSC and identifying the need, we proposed to set up and run community groups for children, focusing on life skills for body and mind.

ENGAGEMENT and PARTNERSHIP

Through the network model a partnership with CYPSC was developed to support local services in North Tipperary set up and run community groups for children, focusing on life skills for body and mind. Regulation and executive functioning skills were highlighted through the community groups and primary care therapists as an identified need to target. Effective self regulation is key to all participation and required to develop executive functioning skills, which become more of a priority for children as they progress through primary and secondary school.

Through the CHN structure we linked with the CYPSC coordinator, who in turn linked with the local community services and secured funding for groups to be set up and run within local communities in North Tipperary, based on the above identified need.

Having proposed a structure and outline for the groups, we will come together for training and support of local services on how to run the groups and provide the necessary resources required for roll out. We intend the groups to be rolled out by local services across North Tipperary in the last quarter of 2024.

CONCLUSION/NEXT STEPS

Community groups are a targeted and specific intervention – teaching and using activities that children and their families can continue to do at home and in the community will ensure long term and ongoing benefits.

Using the network model enables collaboration and partnership across Primary Care and the community , maximising both our resources to provide a quality service to our clients.

Working in partnership with the community will enable timely, effective and ongoing interventions to be offered to children in their own community alongside their peers. It increases access to services and integration of children within their own communities.

RESULTS

Funding secured for Community groups to be set up in Thurles, Nenagh and Roscrea for children - targeting life skills. Therapeutic goals to be achieved. Carry over of benefits after group completed into the home and community.

We are meeting with all the community groups this month to deliver our training and support for set up and for both of us to share our knowledge and expertise, with subsequent roll out of the groups across North Tipperary.

Partnership

Increased Access to services

Integration within Communities

Exploring the impact of a GP Social Deprivation Grant - A Case Study in the MidWest

Chloe Heslin on behalf of HSE National Contacts Office, Dr. Muiris O' Keeffe, GP & Geraldine Crowley, Assistant National Director Primary Care Contracts & ECC

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Introduction & Background

Following the 2019 GP Agreement between the IMO, the HSE and the DoH, funding has been allocated on an annual basis to support GP services in communities with a high degree of social deprivation. The grant ranges between €7,500 and €12,500 and can be used for costs incurred for additional services such as; doctor hours, nursing hours, key worker hours or additional counselling hours.

Case Study

This case is based on a GP practice in Midwest of Ireland who received €7,500 as part of the 2023 Grant allocation. The practice established a psychotherapy service located in the same building as the GP practice. Patients accessed this service via a GP referral and the service was provided on a needs basis. Socioeconomically deprived areas are associated with common mental health disorders (Wilkinson & Pickett, 2007) and have a greater demand for psychological care (Delgadillo et al., 2018).

Method

A retrospective data analysis of patient records from July 2023 to July 2024 was carried out at the GP practice to determine;

- the number of patients who accessed the service in one year
- the total number of sessions that were provided to patients in one year.

Qualitative feedback was also sought from the psychotherapist providing the service to add further context and to discuss the overall impact of the newly established service.

Findings

The €7,500 grant allocation allowed for a total number of 187 psychotherapy sessions to be carried out in one year. 48 individual patients accessed this service.

€7,500 Grant Allocation	
Total no. of Psychotherapy Sessions provided	187
Total no. of individuals who attended psychotherapy sessions	48

Qualitative feedback received highlighted the current challenges regarding access to mental health services in the community. All patients referred to this service by the GP were seen by the psychotherapist within 7 days (on average) and the sessions were available to patients at a subsidised rate. All referrals were accepted, no exclusion criteria was applied to the service. This qualitative feedback indicated that a large number of patients who attended these sessions have benefitted from the treatment provided, with a reported improvement in their quality of life.

Conclusion

A number of benefits of allocating a Social Deprivation Grant are highlighted in this review. The provision of the Social Deprivation Grant facilitated this GP practice to provide a relevant, convenient and beneficial service to the local community. The service allowed patients to access a mental health service in a timely manner and at an accessible cost. Without this service, it is likely that these patients would experience longer waiting times to access a similar treatment. The case study has illustrated the benefits of this service to the local community as patient improvements were anecdotally reported.

References:

Wilkinson, R. G., & Pickett, K. E. (2007). The problems of relative deprivation: Why some societies do better than others. Social Science & Medicine, 65(9), 1965–1978.

Delgadillo, J., Farnfield, A., & North, A. (2018) Social inequalities in the demand, supply and utilisation of psychological treatment, Counselling and Psychotherapy Research, 18(2): 114–121

The impact of a Clinical Team Meeting (CTM) in promoting an integrated approach to service user care

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Background:

- Case study involving a service user in his 60's.
- Previously independent with all activities of daily living.
- GP attendance with progressive speech difficulties.
- Linked with Acute Services & Primary Care SLT.
- Diagnosed with MND.
- Initial functional difficulties: communication & swallow.
- Linked with other members of the multi disciplinary team and additional services as condition progressed.

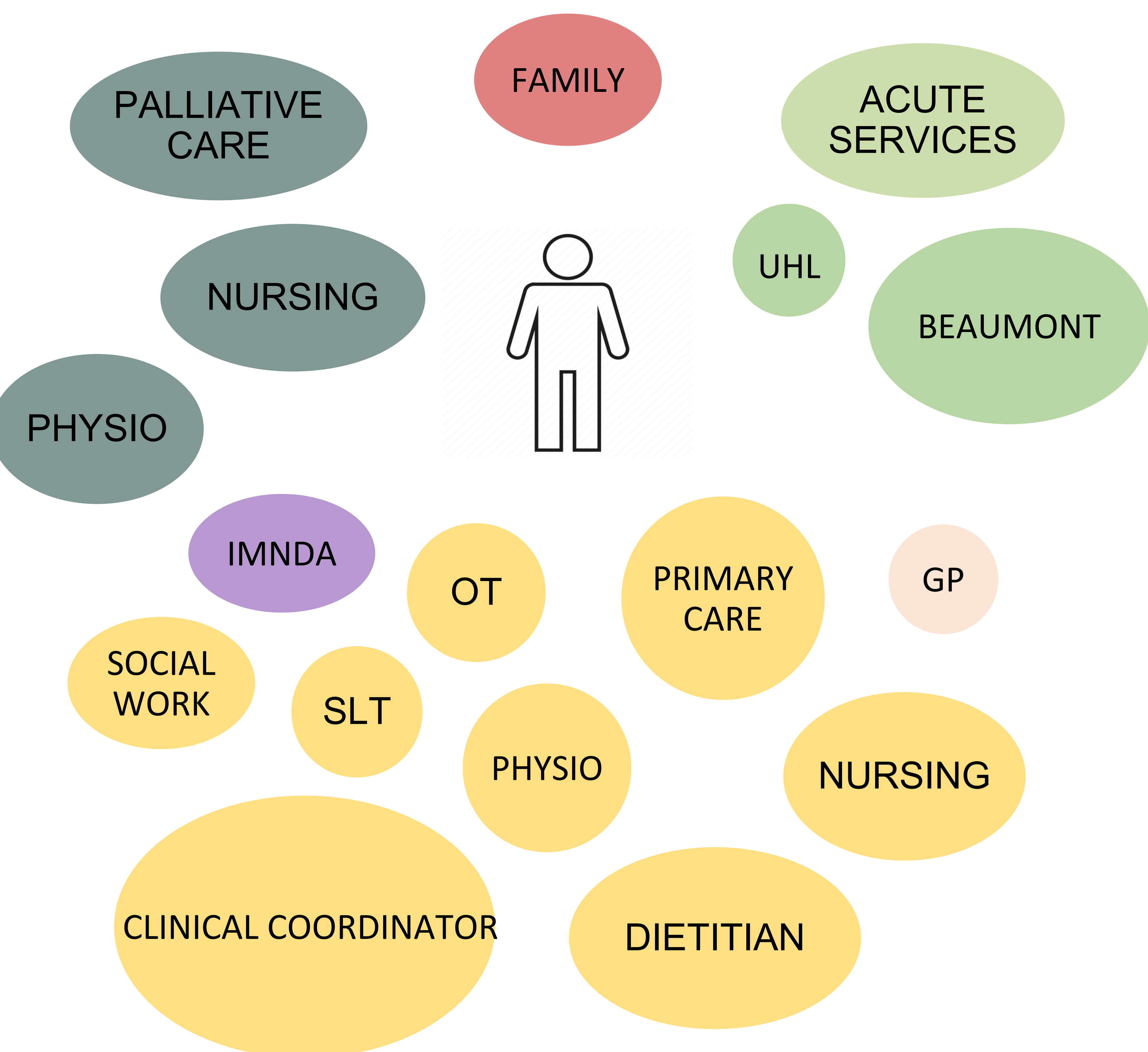
- The World Health Organisation defines Integrated Care as a concept bringing together inputs, delivery, management & organisation of services related to diagnosis, treatment, care, rehabilitation & health promotion (Carroll 2015).

- Slaintecare supports the idea of integrated care particularly when needs are complex, emphasising patient centred & a patient empowered community (Byrne et al 2020).

- MND is a progressive neurodegenerative condition which results in loss of physical function due to degeneration of upper and lower motor neurons (Galvin et al 2017).
- Literature in relation to MND supports the need for multidisciplinary team input along with a person centred approach through the journey, thus an integrated approach to care in strongly indicated.

A clinical team meeting is the forum for PCT members to develop a care plan for implementation to meet the increasingly complex needs of service users who require the diverse skills of different professionals, the purpose of which is to identify, plan & coordinate care effectively & efficiently (Procedure for clinical team meetings in mid west community healthcare, Primary Care 2023).

New development implemented as part of the Community Healthcare Network model.



Issues/ Challenges	Impact
Large volume of health professionals involved across different services making communication difficult	Service user receiving lots of phone calls/ visits, often having to repeat the same information again & again
Secretion management – unmet service user goals & ongoing difficulties	Knock on impact to other ADLs, negatively impacting areas for intervention
Devastating diagnosis & rapid progression	Service gaps evident e.g. psychology – huge need for supports

When considering the pillars of integrated care, the author has chosen to focus on the concepts of people as partners & shared vision.
Key considerations in the literature:

- People are living longer with higher levels of complexity therefore we need to empower and engage people as partners to improve outcomes.
- Multidisciplinary teams seen as the cornerstone of the provision of care (WHO 2015).
- Importance of health professionals understanding each others roles and building trusted relationships.
- Goal orientated care and care coordination.
- Importance of regular monitoring and review as well as the need for co-production and supporting informed decision making.

Conclusions & Learnings:

- This case was complex in nature due to the rapid progression of the condition and subsequent associated functional difficulties.
- Challenges around communication were evident from the beginning due to the volume of disciplines and services involved.
- A main source of frustration for the service user and his family was in relation to the subsequent volume of phone calls and visits received leading to constant repetition of the same information.
- The CTM promoted a more integrated approach to this service users care particularly when considering the people as partners & shared vision pillars. The CTM outcomes in this case were positive and dealt with many of the issues including unmet goals, role clarity, communication.
- The key worker role was also a positive feature in this case helping to better coordinate care and a point of contact for the service user and his family.

One needs to consider the enablers and barriers when it comes to completing a CTM:

- Enablers include: promotion of the benefits/ buy in from all relevant disciplines/ services, clinical coordinator to lead the process, service user attendance.
- Barriers include: non attendance/ poor participation, IT support to access remotely.

Final thoughts:

- Difficult to effectively evaluate CTM outcomes currently and limited evidence from the service users perspective.
- Integrated care as a concept is something which all staff need to be exposed to in order to truly change culture and practice.
- There is scope to enhance and develop the clinical coordinator role further and potential to develop links and pathways between primary care and additional services.

Reference list:

- Byrne, N., Turner, J., Marron, R., Lambert, D. M., Murphy, D. N., O'Sullivan, G., Mason, M., Broderick, F., Burke, M. C., Casey, S., Doyle, M., Gibney, D., Mason, F., Molony, D., Ormond, D., O' Sé, C., O'Shea, C., & Treacy, E. P. (2020). The role of primary care in management of rare diseases in Ireland. *Irish Journal of Medical Science*, *189*(3). https://doi.org/10.1007/s11845-019-02168-4
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- WHO. (2015). People-centred and integrated health services: an overview of evidence. *World Health Organisation*.

SEEING IS BELIEVING: THE NENAGH DEDICATED CATARACT CLINIC (DCC) MODEL OF EXPEDITED EXCELLENCE

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Introduction and objectives

Cataract remains one of the leading causes of reversible blindness worldwide, affecting millions of individuals, particularly the elderly population[10]. With advancements in healthcare and an aging global population, the demand for cataract surgery continues to rise, posing significant challenges for healthcare systems in terms of timely access to care and efficient resource allocation[4]. In response to these challenges, dedicated cataract clinics (DCCs) have emerged as a promising solution to streamline the management of cataract surgery, optimize patient flow, and enhance overall healthcare delivery[5]. The DCC model represents a strategic approach to patient-centred care, aiming to consolidate multiple stages of cataract surgery management into a single, comprehensive visit. Traditionally, patients undergoing cataract surgery would navigate through a series of appointments with various healthcare professionals, leading to prolonged waiting times and fragmented care[1]. By contrast, the DCC model offers a multidisciplinary and coordinated approach, bringing together ophthalmologists, nurses, optometrists, and support staff to deliver efficient and effective care[1].

The aim of this research is to evaluate the effectiveness of the Dedicated Cataract Clinic (DCC) at Nenagh General Hospital in streamlining patient care and reducing wait times for cataract surgery.

Objectives: To assess the efficiency of the DCC model in reducing the time from initial assessment to cataract surgery.

To identify factors contributing to patient non-attendance or delays in cataract surgery scheduling at the DCC.

Methods

This study employed a retrospective observational design to assess the effectiveness of the Dedicated Cataract Clinic (DCC) at Nenagh General Hospital. The study period spanned one year, from July 2022 to July 2023, to capture a comprehensive dataset of patient interactions with the DCC. Data collection and analysis were conducted in accordance with ethical guidelines and standards of patient confidentiality. The findings from this study aim to provide valuable insights into the operational efficiency and patient outcomes associated with the DCC model.

Of the 253 patients who attended their appointments, 226 patients underwent cataract surgery post-referral to the DCC. Most patients (89.8%) had their surgeries within 4 months of clinic attendance, highlighting the DCC's success in reducing surgical wait times. However, a small proportion of patients (10.2%) experienced delays beyond 4 months, with delayed anesthetic pre-assessment identified as the primary reason for prolonged wait times.

0.7% (27 patients) did not proceed to surgery for various reasons:

- o OPD review instead of surgery – additional ocular pathology identified (11 patients)
- o Pseudophakia (already had cataract surgery) (5 patients)
- o Patient passed away (RIP) (1 patient)
- o Awaiting pre-assessment (2 patients)
- o Did not attend pre-assessment (1 patient)
- o Transportation issues to Nenagh (2 patients)
- o Not suitable for local anesthesia (2 patients)
- o Awaiting surgery (3 patients)

Addressing these factors and implementing strategies to expedite pre-operative assessments could further optimize patient flow and reduce the likelihood of surgical delays.

Tables & Graphs

Attendance at Direct Cataract Clinic
July 2022 - July 2023

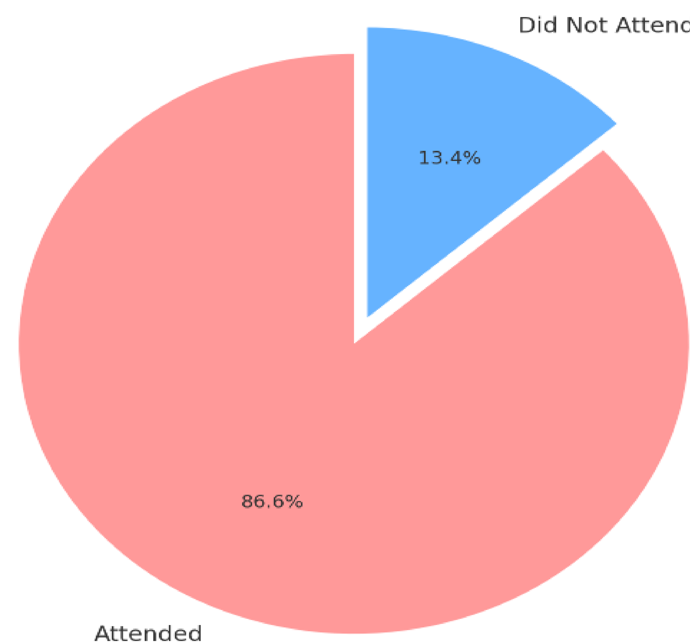

Figure 1: A pie chart displaying the attendance at the Dedicated Cataract Clinic from July 2022 to July 2023. It shows that out of 292 patients, 253 attended the clinic, which represents a significant majority of the patient appointments.

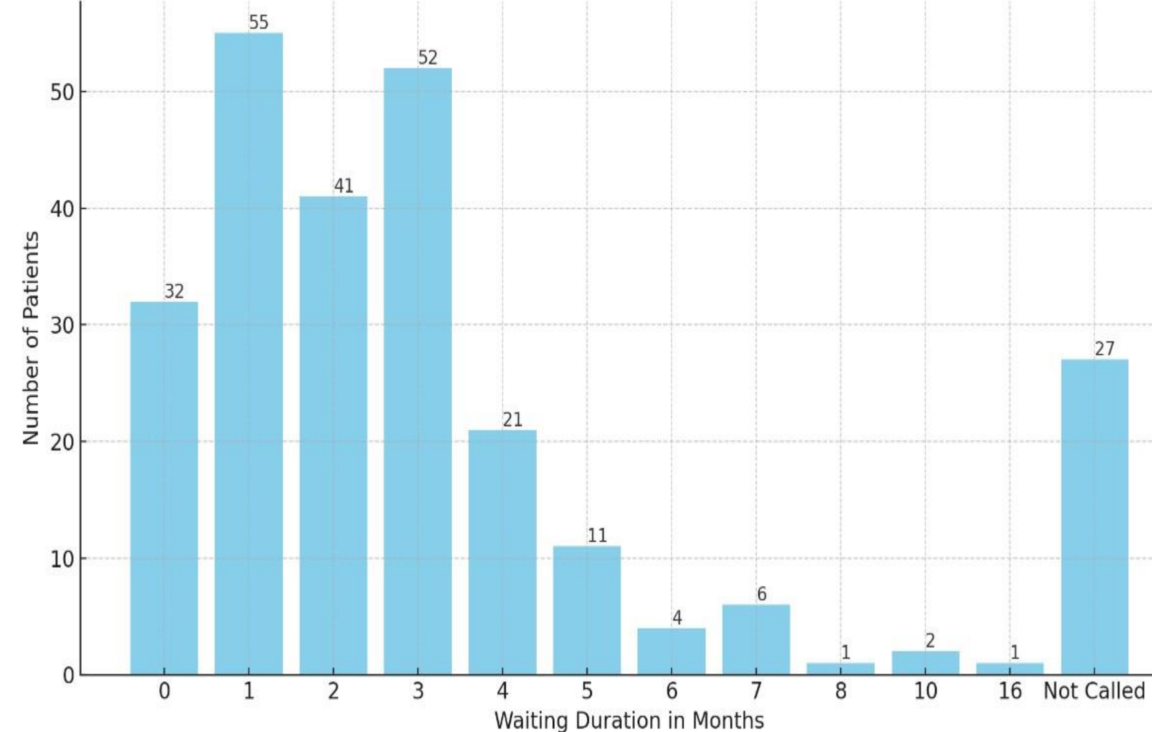

Figure 2: The remaining patients (N=23 – 10.2%) had surgery in more than 4 months, with the most common reason for delay being delayed anesthetic pre-assessment

Outcome for Patients Attended Direct Cataract Clinic

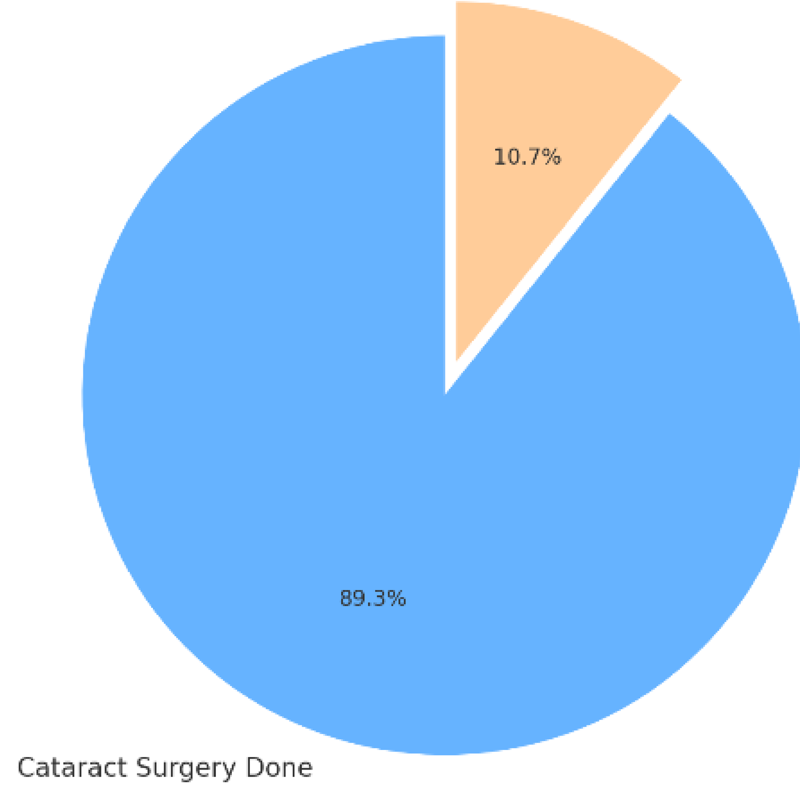

Figure 4: The pie chart illustrates the outcomes for the 253 patients who attended the Dedicated Cataract Clinic. Out of these, 226 patients had their cataract surgeries, while 27 were not called for surgery due to various reasons. This visualization clearly depicts the high proportion of patients who successfully underwent surgery after attending the clinic.

RESULTS

The Nenagh Dedicated Cataract Clinic (DCC) Model of Expedited Excellence for ophthalmology outpatients at Nenagh Hospital has emerged as a leading centre for cataract surgery pre-assessment, with more than a third (more than 40 percent/almost half) of its patients having surgery within a month of consultation, and 90% undergoing their operations within four months. Prior to the implementation of the DCC Model, most cataract patients have an average waiting time of 3 to 4 years for the procedure. Since the opening of a stand-alone, high-volume, consultant-led DCC Clinic in Nenagh in July 2022, the total number of patients waiting for a procedure has reduced from 647 to 131 (Mean Wait Time), the number of patients waiting longer than 12 months has decreased from 134 to just 10 and the average wait time for patients on the day case waiting list has reduced to four months - and continues to fall.

IOL Master - Biometry

Conclusion

In conclusion, the Dedicated Cataract Clinic (DCC) at Nenagh General Hospital has demonstrated considerable success in streamlining patient care and reducing wait times for cataract surgery. Prior to the implementation of the DCC Model, most cataract patients have an average waiting time of 3 to 4 years for the procedure. Since the opening of a stand-alone, high-volume, consultant-led DCC Clinic in Nenagh in July 2022, the total number of patients waiting for a procedure has reduced from 647 to 131 (Mean Wait Time), the number of patients waiting longer than 12 months has decreased from 134 to just 10 and the average wait time for patients on the day case waiting list has reduced to four months - and continues to fall. The high clinic attendance rate and timely surgical interventions underscore the effectiveness of the DCC model in optimizing patient flow and enhancing access to care. While challenges such as non-attendance and surgical delays exist, addressing these barriers through targeted interventions can further improve the efficiency and effectiveness of DCCs in managing cataract surgery. Overall, the findings of this study highlight the importance of patient-centered care and continuous quality improvement in healthcare delivery.

Nenagh Ophthalmology OPD

SLIT LAMP

Acknowledgements

We would like to express our gratitude to all the patients who participated in this study and the healthcare professionals at Nenagh General Hospital Ophthalmology Outpatients Department for their dedication and support.

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IMPLEMENTATION OF AN OCCUPATIONAL THERAPY ACTIVITIES OF DAILY LIVING (ADL) CLINIC IN A PRIMARY CARE SETTING.

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1- Occupational Therapists HSE Mid West Community Healthcare shauna.moran@hse.ie

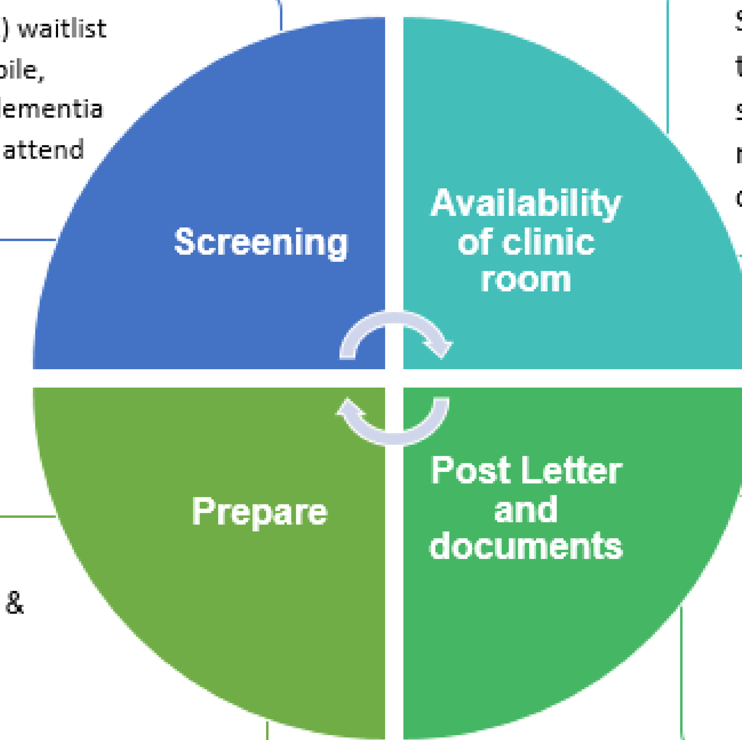
Introduction: Background

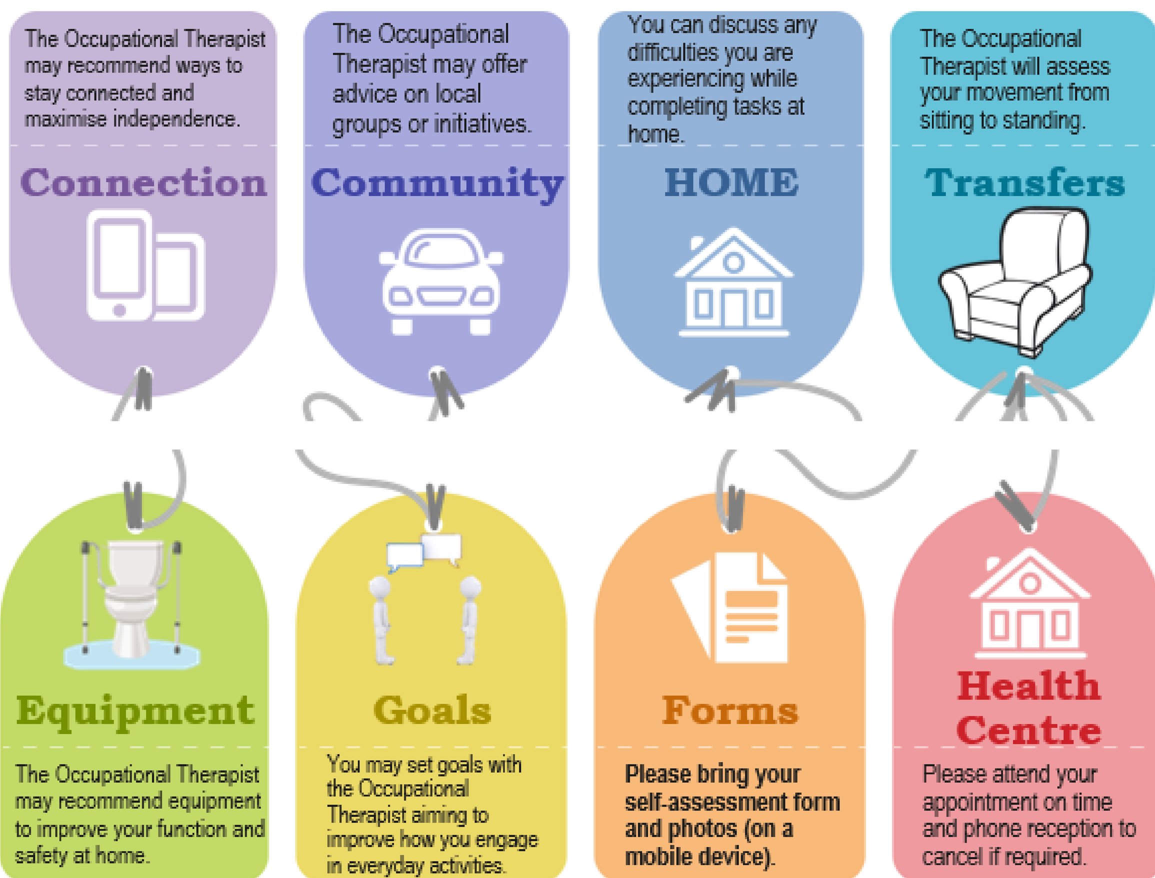
- Despite advantages of Primary Care Occupational Therapy (OT) service delivery in the client's home, limitations exist; therapist travel time and resources, lengthy waiting lists, reduced client autonomy and transportation of equipment.
- Evaluation through staff engagement identified challenges and opportunities to develop alternative strategies to address wait lists and highlighted client's capacity to be more involved in the process.
- A clinic based assessment and intervention process was planned and implemented to address the issues highlighted and augment traditional practice.
- Initial pilot of three ADL clinics at one site in Ballina, Killaloe & Newport Primary Care Team, Community Healthcare Network East Limerick & Ballina.

Aim:

- Reduce waiting times for clients.
- Utilise resources in a cost and time effective manner.
- Reduce handling/ transporting of equipment.
- Increase client autonomy and involvement in the OT process.

Methods:





Results:

Total: 45% (N=27/60) Clients from P2 waitlist

Discharged post phone contact	Discharged Post Tele Health	Discharged Post ADL Clinic	Placed back on waitlist
7	1	8	11

Conclusion- Advantages:

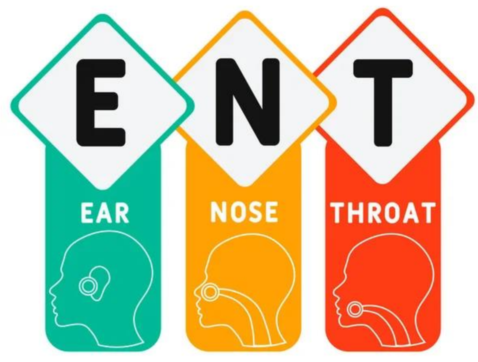
- Timely access to client-centred care, reduced wait times for service.
- Promotes autonomy, clients identify strengths and difficulties through self-assessment.
- Promotes community integration and engagement.
- Increases the understanding of the role of Occupational Therapy and scope within primary care.
- Multidisciplinary Team collaboration potential and expansion to other Primary Care centres.
- Clients are familiar with attending clinics for other healthcare providers; General Practitioner (GP), physiotherapy, dentist etc.
- Reduced travel time, paperwork and equipment delivery for clinical staff.
- Equipment available to trial at the clinic.
- Often client issues resolved following phone call or tele health.

Future Considerations:

- Clients may forget to attend appointments, common for other discipline clinics also.
- Clients may have been advised by the referrer that the OT will visit their home, clarification required.
- Travel difficulties for some clients- prefer convenience of home visit.
- Administration time to send out appointment letter and documentation, potential for support in the future.
- Clients may be unable to complete self-assessment and take required photos- not suitable candidates for ADL clinic.
- Some clients were unable to attend clinic at present (hospitalisation, holidays, no transport).
- Follow up home visit may be required if OT identifies need to see client in their home environment.

UL Hospital – ENT Blitz Initiative

Accelerating Access To Patient Care & Reducing Hospital Waiting Lists



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BACKGROUND

The ENT Service has seen significant challenges in managing and reducing ENT Hospital waiting lists.

The complexities and reoccurrence of many ENT conditions have contributed to lengthy waiting list times with waiting times of 48+ months. This in turn can lead to delayed diagnosis, deteriorating health conditions and poorer outcomes.

METHODOLOGY

- The ENT Blitz clinics ran over the weekends to minimise disruption to other services, which allowed us access to additional OPD facilities and larger patient volumes.
- Streamlined triage process
- Collaborative Care Model included Allied Care Professionals to manage diagnostics more efficiently.
- Utilising technology – direct onsite endoscopy to maximise clinic efficiency.

RESULTS

Reduced ENT waiting times with a targeted and efficient ENT Blitz clinic appointment initiative.

- Significant reduction in waiting list time (30% reduction)
- ENT waiting list reduced by 71% in twenty months
- Timely diagnosis and treatment
- Improved patient outcomes
- Reduction in wait times for diagnostics
- Improved patient satisfaction
- Several examples of early intervention in cancer cases with improved patient prognosis

CONCLUSION

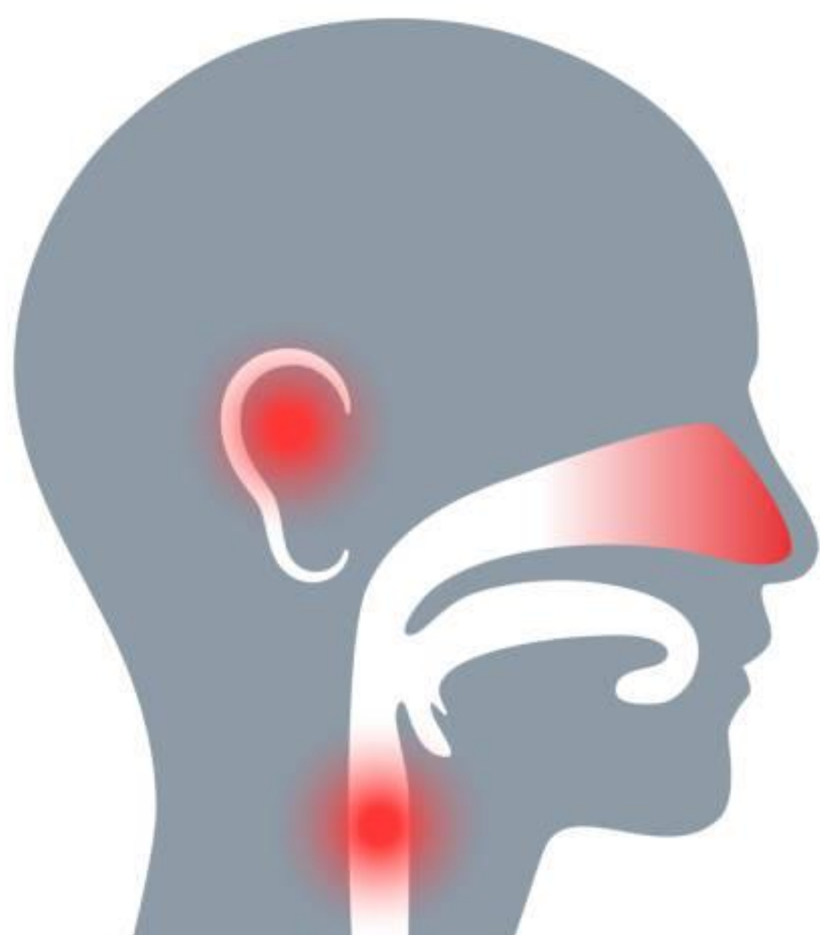
This patient centred initiative represents a comprehensive approach to tackling the challenges of waiting times, which is in alignment with goals of the 2024 WLAP, resulting in a 41% reduction in 2023 and a 30% decrease 2024.

Since the ENT Blitz clinic – 5060 patients have been seen - approx. 69% of the waiting list numbers in 2022.

	October 2022	October 2023	YTD July 1 2024	Total patients
ENT Patient Waiting list	7304	3023 (-41%*)	2244 (-30%*)	12,571
48+ months waiting time	545	N/A		
36 months waiting time		33		
12 months waiting time			87	

- Significant reduction in ENT patient wait times from 48+ months to >12 months
- ENT waiting list reduced by 41% in year 1, 30% in year 2, resulting in a 71% reduction in 20 months
- Timely diagnosis and treatment, resulting in discharges, follow up care and/or procedures
- Early detection in cancer cases resulting in improved patient prognosis

The ENT Service has seen significant challenges in managing and reducing ENT Hospital waiting lists.
The complexities and reoccurrence of many ENT conditions have contributed to lengthy waiting list times with waiting times of 48+ months. This in turn can lead to delayed diagnosis, deteriorating health conditions and poorer outcomes, which may lead to poorer patient satisfaction rates.



71% Reduction of ENT Waiting List in 20 months

Significant reduction in ENT Patient wait time from 48+ months to >12 months

THE IMPACT OF COMMUNITY CONNECTOR ON ACCESS & INTEGRATION - ICPOP TEAM & PATIENT PERSPECTIVES

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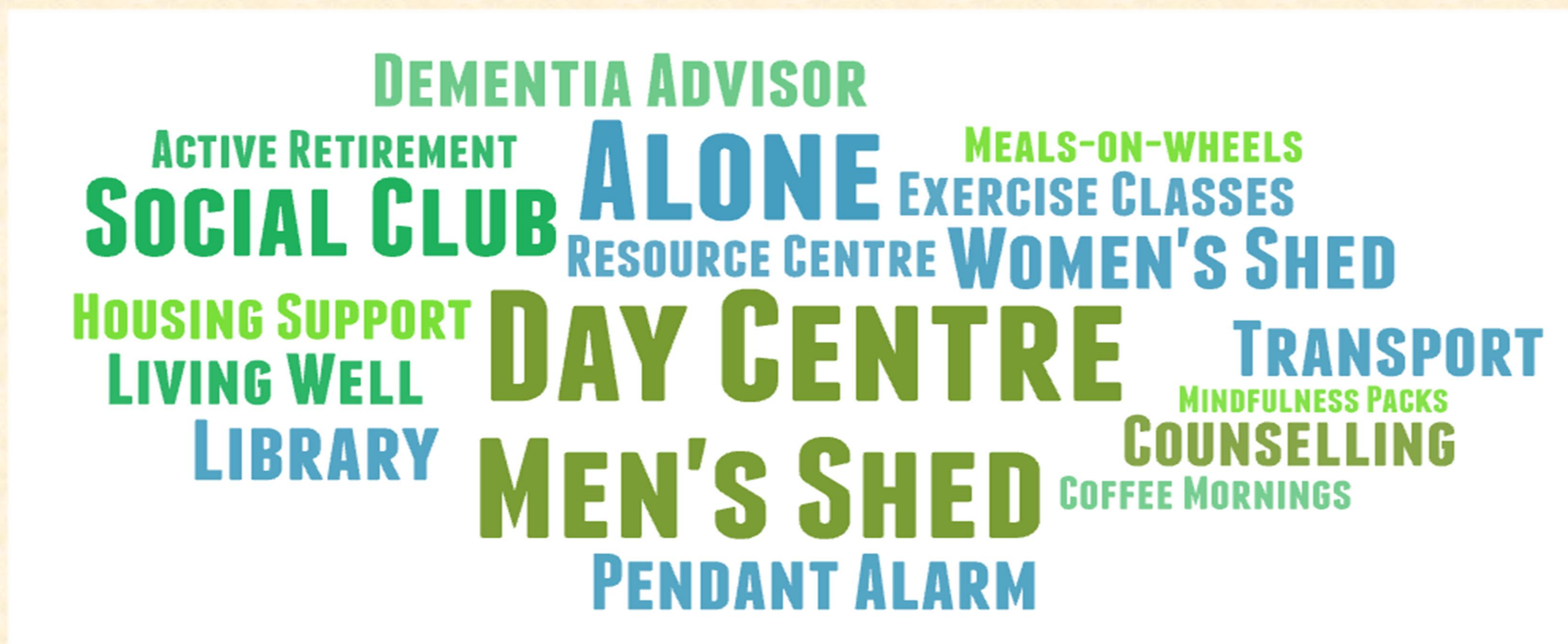
Background

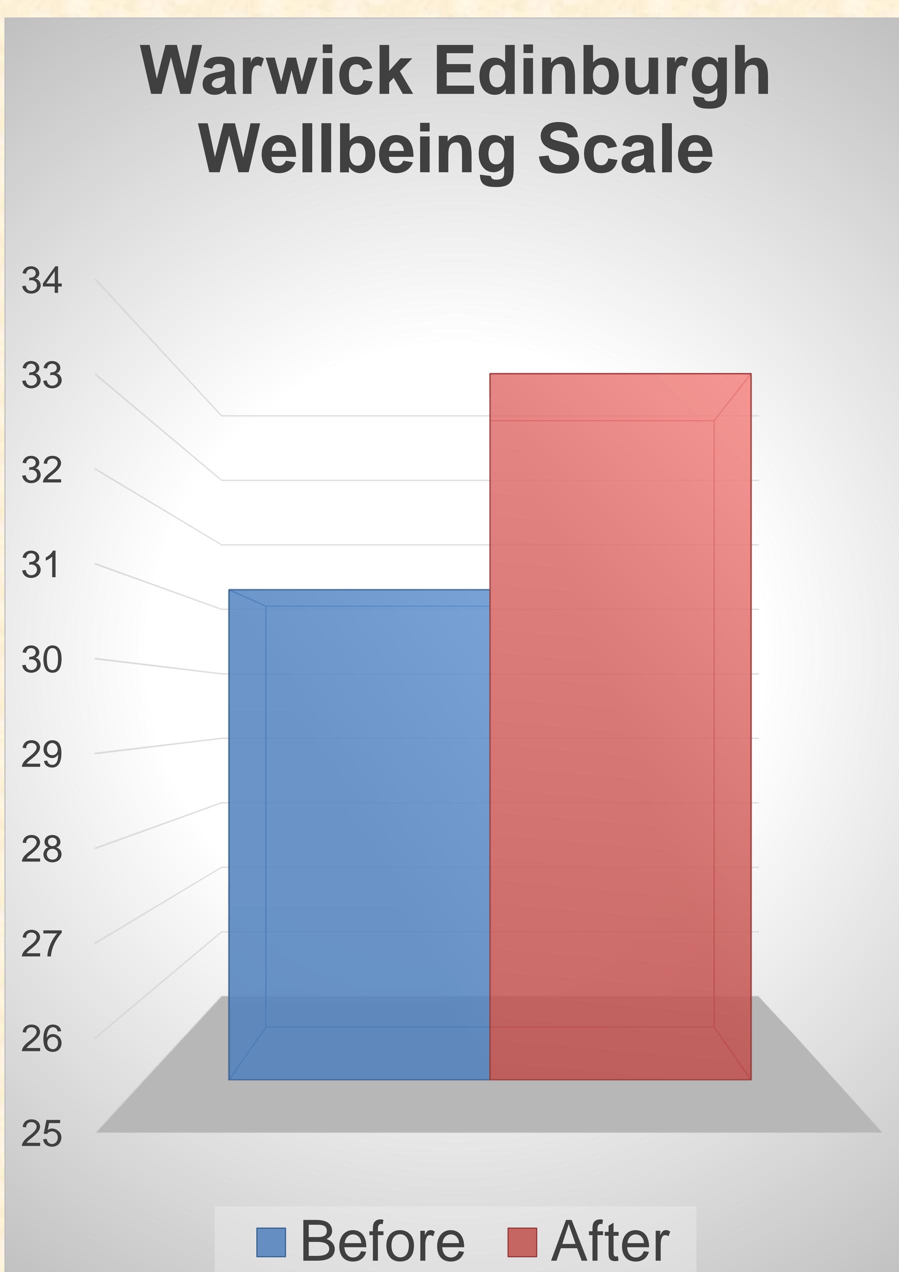
- Over the past year (May 23 – May 24), the Community Connector (CC) has seen 301 of the patients attending Clare ICPOP.
- The CC helps patients by facilitating access with local services – both HSE & External Agencies.
- This poster looks at ICPOP staff & patient perspectives, on how this contributes to improved outcomes for patients.
- Referrals to the CC generally happen at the initial CGA, and the initial consultation takes place in the ICPOP Hub.
- A collaborative plan is made with the patient, to support them in accessing local community services or activities to improve social supports, with the aim to enhance their wellbeing.
- This is delivered through: Home visits, Accompanied service introductions, Reviews in the Hub or by phone.
- This includes signposting to services, following up to check progress, guidance on how to proceed and assistance when required.



ICPOP Referrals	Patient contacts	Including
301 received	615 direct	45 home visits
301 accepted	845 virtual	236 service introductions

ICPOP Staff Perspectives

- **Physiotherapy:** We had a patient with impaired mobility, falls and social isolation. The CC met with him and discussed his previous interests and hobbies. She was able to source daytime traditional music sessions near his home. He now walks there three times per week and plays the fiddle. This has greatly helped his confidence and his mobility. In general, by sourcing activities that really suit the patient, the CC greatly helps to facilitate Physiotherapy goals of increasing physical activity and participation.
- **Occupational Therapy:** The CC has become an integral part of the team and can support the patient to make the changes to their daily routine. We have worked together on joint home visits for more complex patients which has been very beneficial. It allows the OT to focus on the functional aspects, while the CC provides assistance in accessing community activities and social supports thereby enhancing each person's social & physical wellbeing.
- **Dietetics:** The CC supports the Dietician in highlighting and supporting clients to access Meals-on-Wheels, Day-Centres, Home-help and many other community supports. She really goes above and beyond for each and every patient.
- **Advanced Nurse Practitioner:** The holistic and person-centred approach of the ICPOP team has been greatly enhanced by the contribution of the CC. We often signpost patients to external services, and the CC facilitates this through providing time, support and encouragement to engage with health promotion, social activities, support groups and to increase their activity and social interaction.
- **Doctor:** The CC has a perspective which is truly focused on each patient's quality of life. She enables the patient to make the lifestyle changes that we know can have a positive effect on physical and mental health. We have seen improvements, even after just a few weeks, to patient's mood, cognition and physical ability. She has filled a gap in the service that we did not realise was missing.
- **ICPOP Lead:** As a new role I was concerned how the CC would integrate within the team to support patients attending the service. The role of CC has proved invaluable and we have first-hand experience of this. The feedback from patients has been overwhelmingly positive, reinforcing the CC as an essential cog in the Clare ICPOP team.



Patient & Family Feedback

- "She never treated me as an old person. I loved having her at the Women's Shed with me, it helped me to go, and to make new friends while doing an activity like knitting, that I love"
- "She was very supportive and caring. She organised transport through the Red Cross so that I could make it to my appointments"
- "After talking to (CC) about the bereavement of my son, I feel now is the right time for me to attend counselling. She followed up on this for me and helped me take the next step."
- "The CC introduced us to lots of activities in the area that we wouldn't have known about. My mum is so happy and content, and has regained loads of confidence and independence, as one of her new activities is within walking distance"
- "She was a great help to me, as I wouldn't have left the house before. I never thought I would be able to go, with my medical conditions, but she made it possible, and now I love going every week.
- "This part of ICPOP is the colour in the picture.... The CC brings warmth and value to life"