Improving Efficiencies in Access to care and Patient flow in Scheduled Care in a Level 4 Academic Hospital

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Improving Efficiencies in Access to care and Patient flow in Scheduled Care in a Level 4 Academic Hospital

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“I hereby certify that this material, which I now submit for assessment for Organisational Development Module on the MSc Leadership is entirely my own work and has not been submitted as an exercise for assessment at this or any other University.”

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Abstract.

**Rationale:** Advancing the schema to reduce waiting times and shortening length of stay requires fundamental changes to current practice in healthcare with an emphasis on treatment that is efficient, effective and high quality. The Health Service Executive launched its ‘Model of Care for Pre-assessment Units’ (2014) as a guide for organisations to implement pre-admission units locally and facilitate pre-assessment as an out-patient service. This model was designed to be used in collaboration with the ‘Model of Care for Elective Surgery’ (2012) which promoted Day of Surgery Admission (DOSA) and improved access to scheduled beds. Within the writer’s organisation, Day of surgery admissions were reaching the national target of 75% despite an inefficient use of the pre-assessment clinic with only 20% of patients pre-assessed prior to DOSA. Furthermore, a total of 28 patients were breaching over 15 months for routine surgical procedure.

**Aims:** To ensure that:
- 80% of scheduled patients were pre-assessed prior to DOSA.
- To ensure access for routine surgical patients who are currently breaching national waiting times of 15 months by end of December 2015...

**Methodology:** HSE Change Model was used for the Implementations of this project and the CIPP (Context, Input, Process and Product) evaluation model was used for the evaluation of data.

**Findings:** Pre-assessment rates have risen from 20% prior to implementation of the project to 80% within a 17 week period. All 28 patients breaching the 15 month waiting time had their surgery completed by end of December 2015. **Conclusion:** Ritualistic practices have been weaned out and replaced with this new process. Organisationally there is evidence of a collaborative approach, maintaining momentum for this change and a staff nurse on the day ward is the change champion for this project.
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Chapter 1:

1.1. Introduction:

For the purpose of this dissertation, the writer will design and implement a change management project using the 2008 Health Service Executive (HSE) change model. The change which the writer proposes to introduce is to 'improve efficiencies in access to care and patient flow for scheduled care in a level 4 academic hospital'. This change will greatly benefit patients, staff and the organisation as a whole.

Chapter 1 will focus primarily on the organisational context, where and how the change project was implemented, the reasons for the change, and finally its aim and objectives.

1.2. Organisational Context

The writer is currently employed as a Clinical Nurse Manager 3 in a level 4 Dublin academic teaching hospital, part of the Ireland East Hospital Group. This organisation provides frontline services, both inpatient and outpatient, for over 40 medical and surgical specialities, to a network population of approximately 400,000. It is also a tertiary referral centre for surgical patients both regionally and nationally for pancreatic and breast specialities.

1.3. Background:

In the current climate, the pressure on hospital emergency departments (ED) across the country is at critical levels, resulting in overcrowding, unacceptable numbers of patients on trolleys, staffing issues, even industrial dispute. An increased service demand on ED also
has the predictable effect of lowering the number of patients gaining access to scheduled beds. This effect of reducing the level of scheduled activity transpires when the prompt and immediate need for beds required for ED patients is deemed to outweigh and supersede the non-immediate and elective nature of scheduled admissions. On any given day, scheduled admissions can be cancelled, often on very short notice, and the scheduled bed capacity reallocated to cater for seemingly more urgent bed requirements for ED admitted patients. Nationally there has been an overall increase of 1.7% in emergency admissions resulting in a drop of 4.6% in scheduled activity (Health Service Executive, 2014b). More specifically following the reconfiguration of emergency services within the writer’s organisation in 2013, there was a striking increase of 25% emergency admissions.

Within the writer’s organisation, two national targets of the elective surgery programme (2012) have been achieved i.e. ‘Day of Surgery admission’ (DOSA) and ‘length of stay’ (LOS). The targets for both DOSA and surgical LOS were set nationally by COMPSTAT at > 70% and 6.55 days respectively. The writer’s organisation is currently achieving 83% and 5.6 days respectively (Health Service Performance Report, 2015). Importantly however, the writers organisation is not achieving the recommended standards of 80% of surgical patients undergoing pre-assessment prior to DOSA (HSE, 2014a), with a discouraging figure of 20% currently been pre-assessed. Consolidating and improving these statistics further, is where the pre-operative assessment and a streamlined admission process can and will unlock greater potential benefits to the organisation and patients alike.

The HSE recognised in 2014 that patient waiting time targets were not being achieved due mainly to, increased emergency admissions, increased age profile of patients and delayed discharges (Acute Hospital Division, 2015). The then minister for Health set revised waiting
time targets of where no patient would wait longer than 18 months by June 2015 and no longer than 15 months by December 2015 for a scheduled procedure (HSE 2014b).

As and from the 14th September 2015, there remains 28 patients in the writer’s organisation awaiting routine general surgery for over 15 months. A blanket financial penalty of 48,000 euro has already been triggered in respect of 25 patients that failed to be admitted within 18 months by end September 2015. The writer’s organisation is facing the same challenges experienced by other hospitals nationally with increased pressure in achieving the national targets of pre-assessment, DOSA, and waiting list times set by the HSE as 80%, 75%, and < 8 months.

For the purpose of this project the writer will focus on two issues that can and will improve access to scheduled care.

1. Pre-operative assessment of all patients whether day or inpatient prior to day of surgery resulting in a lean approach on DOSA, facilitating a reduction in delays to theatre.

2. Ring-fencing of surgical beds to ensure access for routine surgical patients who are currently breeching national waiting times of 15 months

1.4 Rationale for the Project Proposal

Fiscal budgetary restraints set out by the International monetary fund (IMF) in 2011, have forced hospitals nationally to make better, more efficient use of allocated resources. Surgery absorbs a substantial amount of healthcare resources with the cost of a hospital
bed approaching 1000 euro a day and an operating theatre up to 2.5 million euro annually. It is imperative that these resources are optimally used to maximise capacity.

The National Service Plan, (2015), National Waiting List Management Protocol (2014), Model of Care for Pre-admission Units (2014) and Model of care for Elective Surgery (2012), all identified the following aims to assist in improving patient flow for scheduled activity,

- Pre-assessment and surgical optimisation of surgical patients in an out-patient setting prior to DOSA, reducing the risk of cancellations on the morning of surgery
- Reducing waiting times.
- Improving access to elective surgical beds by ring-fencing beds.
- Reducing cost to the patient by preventing delays to treatment and reducing risk of further complications.
- Reducing financial penalties to the organisations for patient who breach the 8 month waiting time set out by the HSE.

The writer’s organisation is now challenged with increased service demands, a requirement to deliver a high quality efficient standard of care, all of which must be achieved within budget. Driving performance improvement is dependent on the full engagement of all members of the multidisciplinary team, medical, nursing; administration etc. (Schoemaker and Krupp, 2015). A stakeholder analysis will be carried out to assess individuals’ current levels of power and interest in this project (Appendix 1).
1.5. Aim and Objectives.

1.5.1 Aim:

The aim of this change proposal is to improve access to care and patient flow for scheduled care in a level 4 Dublin Hospital. This will support the organisation in providing a streamlined process for scheduled patients, in parallel with unscheduled patient pathways.

1.5.2 Objectives

1. By March 31st 2015, 80% of surgical patients will be pre assessed prior to day of surgical admission in line with National standards (HSE, 2014b).

2. By December 31st 2015, there will be one point of entry for all patients admitted on the morning of surgery eliminating time waste.

3. By January 31st 2015, the first daily surgical case in all theatres will start at 8.30 am.

4. By December 31st 2015, all 28 general surgical patients breaching the 15 to 18 month waiting period will have their surgical procedure completed reducing financial implications to the organisation.

5. By April 1st 2016, there will be a minimum of 10% of all scheduled surgical beds ring-fenced for elective surgery.

1.6. The writer's organisational role

As and from the 23rd November 2015, the writer had been promoted for a 2 month period to devise and project manage this identified organisational development. As a novice
change agent, it was vital to endeavour to adapt to the varied challenges experienced whilst providing dynamic, receptive and transformational leadership.

Effective communication skills were imperative throughout the project. The writer ensured that she exploited every opportunity to communicate plans, report progress and consolidate engagement at all levels.

1.7. Organisational Impact and Expected Outcomes

This proposed change will have the following positive impacts and on the organisation:

- Ensuring pre-assessment is accessible to all surgical patients as an outpatient service.
- Improving compliance within national targets for DOSA, pre-assessment rates, waiting lists.
- Streamlined admission process with one point of patient entry on the morning of surgery
- Reduction in cancellations on morning of surgery.
- Increased integration of day-ward, pre-assessment, and admission lounge.
- Increased staff morale.
- Reduce financial penalties to the organisation.
- Increased overall patient experience, reduced anxiety etc.
Expected outcomes;

- User engagement, both top down and bottom up
- Reduction in number of patients breaching waiting list times
- Access to proposed funding from HSE and validation of waiting list.
- Increased access for patients.

1.8. Potential Threats to implementation

The writer anticipates several administrative threats may emerge during this project. Firstly, restrictions imposed by ED consultants as protected beds will impact emergency admissions. Mandated Industrial action within the ED department by staff nurses is also a prospective threat that the writer is not trained to deal with unaided, hence the need for additional stakeholders with this specialised managerial experience. Finally, financial implications are a real concern as this change process must be achieved on a cost neutral basis with a projected increase in revenue generated for the writer’s organisation. However, sustained reductions in cancellations, efficient use of theatre time and staff, reduced financial penalties for patients breaching national waiting times will all assist the writer to overcome the many challenges which lie ahead.

1.9. Proposed Methods of Evaluation

Evaluation statistics need to be incorporated into the planning phase of the change process to ensure quality standards are achieved. The data collected will be analyzed and the findings incorporated into everyday practice and exported weekly to HSE. This process
will help ensure that the objectives set are measurable, realistic and relevant. Quantitative data will be measured and displayed in graph format. This data will be used twofold, firstly to measure and indicate how the objectives are met and secondly to measure the extent to which targets are not been met locally and nationally.

Organisational intelligence will allow all stakeholders to identify the strengths and weaknesses of the process and assist in embracing organisational learning through collaboration with external organisations. The data collected will be shared externally in other healthcare settings including the HSE, to facilitate both the learning and transferability of this change process. Organisational learning will only be effective if all organisations speak the same language. Inter-organisational learning is critical in improving overall processes and products through the integration of new knowledge and insights.

The writer has established with the Ethics Board of her organisation (i.e. securing a letter from the head of the Ethics committee) that there is no requirement for Ethical approval as data is collated from internal hospital statistics and there is no necessity to interview patients individually (appendix 2).

The writer will use the CIPP Model to evaluate the organisational development project, focusing on, Content evaluation, Input evaluation, Process evaluation and Product evaluation. A personal reflective log will be also used for the evaluation phase.
2.0 Conclusion

The overall and ambitious aim of this project is to improve efficiencies in access to care and patient flow in scheduled care. The key to achieving this objective is to streamline the patient journey, exploit currently underutilised resources, and integrate the various specialities. The role of the writer in this quality improvement is to ensure the result is achieved by providing leadership through vision, planning and implementation of the project under the guidance of the HSE change model. The following chapters will provide the reader with the literary evidence available to support the change, the change journey and overall results. The final chapter will provide discussion and reflection on the process.
Chapter 2: Literature Review.

2.1 Introduction

The purpose of this chapter is to present the literature and evidence available in relation to “improving efficiencies in patient access and patient flow for scheduled surgical procedures in a level 4 Dublin Hospital”. Following a comprehensive critique and appraisal by the writer of the available literary evidence, common themes were identified and will be discussed later in this chapter.

Modernisation in the current Health care system demands changes to time-honoured practices so hospitals nationally can optimise all and every allocated resource (HSE, 2014b).

In tandem with economic and globalisation factors it is necessary that as health professionals we enhance the overall patient journey and experience in our health care institutions. Ensuring patient safety, with accurate outpatient pre-operative assessment, is a key and critical element in ensuring cost effective and clinical successful surgical outcomes for patients (Nicholsan et al. 2013)

Advancing the plan to reduce waiting times and shortening surgical length of LOS requires studied fundamental changes to current practice (HSE, 2012) with an emphasis on treatment that is efficient, effective and high quality (HSE, 2014b). In order to progressively reduce current waiting times, overall patient throughput needs to be increased (Audit Commission, 2003). This increased throughput can be achieved through, Day of Surgery Admission (DOSA), protected (ring-fenced) beds, a functional pre-operative assessment unit, more efficient use of our day wards, and improved productivity in operating theatres.
The above listed factors are best utilised in combination rather than individual approaches.

2.2. Search Strategy.

A comprehensive search of the relevant peer reviewed literature from the last 16 years was conducted. The following databases were exploited, The Cochrane Library, Pub Med, Medline, Cinadh, Google Scholar, Emerald, the Lenus repository and the NHS and HSE websites. Research articles, some case-studies, reports and grey literature were read and synthesised for this review.

Search terms used were:


These terms were searched separately and in different groupings which yielded results from 0 yields up to > 12,000 subject to the terms used. Once limitations were set, ‘acute hospital service’, ‘adults’, ‘English language’, ‘full text articles’ a total of 37 quantitative and qualitative articles were deemed relevant. Some grey literature was also used to support the themes from a national perspective.

There was an even distribution of American, English, and Irish articles. Some Irish literature was sourced in most recent years and this may be secondary to the fact that pre op assessment clinic are still relatively new concept in Irish healthcare.

- Day of Surgery Admission (DOSA)
- Pre-op assessment clinics
Optimisation of admission process
Patient experience
Waiting lists

2.3.1. Day of Surgery Admission (DOSA).

DOSA is defined as “an elective, stay-case, surgical patient who is admitted on the day of their intermediate or major surgical procedure, all necessary work-up having been carried out prior to admission” (HSE, 2012:86).

The need for DOSA was first identified in the United States of America in 1993 for cardiac patients with a focus on reducing costs for patients whose Health insurance did not cover admission prior to day of surgery (Vijay, Kazzas and Refson 2008). This continued to extend out to both vascular and general surgery patients.

Aims of DOSA:
- Reduce or eliminate cancellations
- Improve efficiencies in utilising theatre time and space
- Reduced length of stay
- Improved patient experience (HSE, 2012).

Transformation of healthcare delivery has been instrumental in driving healthcare directors and staff on the ground to utilise current resources effectively (Health Service Executive (HSE,2014b). One such change in practice is the transition from admitting patients several days before surgery, to admitting patients as near to, if not on, the day of surgery itself (O’Connor et al. 2011). The introduction of pre assessment clinics (POAC) has been
instrumental in facilitating DOSA and assisting in streamlining the surgical patient pathway (Concannon et al. 2013, NHS Institute for Innovation and Improvement, 2008). Both DOSA and POAC are directly linked and supported by evidence based literature; this will be discussed later in this chapter.

DOSA most crucially is the process by which patients are admitted to hospital on the morning of their scheduled surgery, (Harries et al. 2013. Kulasegarah et al. 2008., Vijay, Kazzas and Refson 2008.). Same day admissions have been seen as highly influential in reducing the overall length of hospital stay for the patient and financial costs to hospitals (Keranen at al. 2007). Patient satisfaction and lifestyle choice are important factors when supporting the rationale and benefits of DOSA.

Harries et al. 2013 carried out a study on 149 patients in the Aneurin Bevan Health Board, Wales, to obtain their perspective of DOSA and supporting factors. Overall results showed that 75 % expressed a preference for DOSA, 19% preferred admission the day before surgery and 6% had no preference. Reasons for same day admission were 1.spending less time in hospital = 41 % and 2.less anxiety = 12.5%. Contrary to this an overwhelming 61 % of the 19% group favouring admission the day before felt this process helped to reduce anxiety and increase familiarity with the environment. Not surprisingly, age was the dominant factor for choosing DOSA with staggering 87% preferences for DOSA in the age group less than 40 years. Harries et al. 2013 suggested that DOSA rates could increase if staff adequately addressed anxiety issues at pre-assessment.

Concannon et al. (2013) carried out a prospective cross-sectional study to determine the impact of ring-fenced beds and POAC on DOSA rates in an Irish hospital over an 18 month period, (July 2010- December 2011). There was a noted increase in DOSA rate
from 56% to 85% which exceeded the national target of 75% (Healthstat). A previous study carried out in this same Irish hospital by Coyle et al. (2011) indicated a rise in DOSA rates in the first 6 months post implementation of ring-fenced beds. This study supports the sustained increase in DOSA rates. General surgery admission median rates increased from 5 per month prior to ring-fencing of beds to 42 patents per month post implementation. A non-parametric statistical test (Mann–Whitney) was used to determine that this increase in DOSA rate was statistically significant (p<0.0387). There was also a definitive decline in the number of patients admitted the night before surgery from 92% of 472 patients to 40% of 437 patients post implementation of ring-fenced beds.

Furthermore a study was carried out by Kulasegarah et al (2008) between May 2006 and January 2007 on seventy-five consecutive Head and Neck surgery patients who were admitted on the same day as their surgery. They found that 28% of these patients were delayed going to theatre with an average delay time of 51 minutes. There was also a cancellation rate of 5.3%. They concluded that in order for DOSA to work effectively patients required a thorough pre-op assessment where patients not suitable for admission were identified and admitted prior to day of surgery. They also suggest that risk analysis needs to be carried out before implementing DOSA policies in hospitals and a properly run pre-op assessment is essential to prevent negative outcomes, be it delays or cancellations of patients surgery.

All three studies support the concept of DOSA, all three for different reasons, be it to reduce cancellations, eliminate theatre delay times, assuage patient anxiety. Tellingly, they all identified that in order for DOSA to be effective; organisations will require a functional pre-operative assessment clinic (for identifying high-risk patients), ring-fenced or protected beds and a focus on dealing with patients concerns at pre-assessment. Nonetheless, it
should be noted not all patients are suitable for DOSA and these patients will require admission prior to surgery to reduce the risk of day of surgery cancellations. It is also logical that changes in surgical culture and bed management are necessary components of successful DOSA.

2. 3.2 Pre-op assessment Clinics

Pre-operative assessment Clinics (POAC) facilitates a comprehensive medical assessment of patients who require general anaesthetic in advance of their admission for surgery (HSE, 2012).

The introduction of pre assessment clinics dates back as far as the 1970’s (Crosby et al. 1972). Despite this quality improvement of POAC existing in North America and other countries since the 1990’s, Irish healthcare remains at the infancy stage of embedding this concept into practice (Heaney & Hahessy, 2011). The four principles of ‘quality’, ‘equity’, ‘people centred’ and ‘accountability’ set out in the Irish Health Reform Programme (2001), are integrated into the concept of POAC, which strives to reduce waiting times and improve quality of individualised care for each patient accessing surgical treatment (HSE, 2012., Government of Ireland, 2001). A national target of percentage of patients pre-assessed prior to DOSA has been set nationally at 80%, to assist the national target 75% (HSE, 2014b). The POAC are pivotal in Irish hospitals achieving the national DOSA target by ensuring all patients are pre-assessed and medically optimised to increase suitability for DOSA (HSE, 2012)

From a total of 234 million operations that are carried out globally every year, approximately 7 million patients develop post-operative complications and roughly one
million lead to a fatality (Wesier et al. 2008). The Helsinki Declaration for patient safety in Anaesthesiology (2010) identified pre-operative care as an essential objective in ensuring the safety to patients who require general anaesthetic. Jones, Swart and Key (2014) concur, stating that comprehensive pre-operative assessment is imperative in delivering high quality care and ensuring high standards of care for all patients.

The primary aim of POAC is to assess patients prior to day of surgery thus identifying any medical issues that can be treated and optimised before surgery (Akhtar et al: 2013, Concannon et al. 2013, Nicholsan et al, 2013). A shift has occurred from the traditional practice of admitting patients 2-3 days before surgery for pre-op assessment to a more contemporary practice of assessment of the patient pre-operatively in the outpatient setting (HSE, 2014a, HSE, 2012). The preoperative assessment clinic is a vital tool in optimising patient flow, from the date a surgical decision is made to actual day of surgery (HSE, 2014a). The first point of contact with the surgical pathway is POAC and can have a major impact on the patients’ first hospital experience (Harnett et al. 2010).

The outpatient pre-assessment clinics are typically run by a multidisciplinary team with nurse-led clinics becoming routine practice (HSE, 2012). This extended role for the nurse has been identified by many (Harnett et al, 2010., Mundinger et al, 2000.) to be effective and cost efficient (Kinley et al. 2002) once suitably supported by medics and anaesthesiasts (Swart & Houghton, 2010). Nurse led POAC are not a new phenomenon, Kinley at al carried out, one of the first randomised control trials in 1998 on 1,907 patients in 4 NHS hospitals based in 3 separate trusts. They found that nurses were not as accurate as junior doctors when it came to medical assessment; however they were more pointed when ordering appropriate tests. These trials concluded that nurses should not be inhibited form carrying out nurse led POAC once they had qualified medical support. Anaesthetic consultant leadership is seen as essential in the overarching scheme of a nurse-led clinic.
and they should take responsibility and accountability for the effective running of the POAC (Jones, Swart and Key, 2014).

Previous studies by Mundinger et al. (2000), and Pinkerton and Bush (2000) found no variance in the outcomes of care delivered by a nurse practitioner or a physician regarding patient satisfaction levels. Mundinger et al. (2000) analysed comparisons between nurse practitioner and physician care in the primary care setting on the following areas, 1. ‘Time spent with the patient’ and 3. ‘quality of information given specific to their condition’. No significant differences were identified in the scores between the two health professional groups, after the first visit, in regard to patient satisfaction and communication rates. Patients did rate the physician group higher on the provider attribute skills. Harnett at al (2010) however, found higher satisfaction scores from patients assessed solely by nurse practitioners compared with a collaborative approach of nurse and surgical practitioner.

Gillmartin (2004) carried out a small study where he interviewed a total of 30 Maltese patients about their experience of a Day Surgery Pre-operative clinic. While overall the findings showed the patients found the clinic useful and valued the information given, they variously felt that their individual needs were not met as the practice was too generic, leading to increased anxiety. Aquilina & Badacchino (2007) qualitative exploratory study supports the need for individualised focus on patients at pre-assessment clinics.

These studies show that POAC is essential for the provision of clinical information, however in order for these clinics to be seen to be beneficial to the patient, healthcare workers need to be cognizant of the need of the patient to ask personal questions pertaining to their own individual concerns. Effective pre-assessment clinics need to find a balance between content and delivery of written and verbal information so the patient and
their carers leave the clinic feeling reassured and respected as a valued human being (Sjoling et al, 2003). The POAC mechanism needs to become part of the day-to-day culture of the organisation (Aquilina & Badacchino, 2007).

Concannon et al. (2013) highlighted the value of POAC in their Irish hospital in facilitating DOAS admissions and ensuring they reached the national target of 75% for DOSA. There was a noted reduction in admitting patients one to two days prior to surgery.

POAC not only facilitates medical optimisation, but also reduces patient anxiety, concerns, number of day of surgery cancellations (Akhtar et al.: 2013, Nicholsan et al., 2013, HSE, 2012), reduced average length of stay (HSE, 2014b), it also facilitates DOSA.

2.3.3. Optimisation of Admission process

Cancellations of planned surgical procedures are not a new occurrence and continue to be a long-standing issue for healthcare organisations both nationally and across the world (Dimitriadis et al. 2013). They represent a substantial loss of revenue and waste of time and resources, resulting in significant psychological, social and financial consequences for patients (Vijay, Kazzas & Refson 2008). There is also a noted loss of training opportunities for surgical trainees (Marriott et al. 2011, Vijay, Kazzas & Refson, 2008., Nasr et al. 2004) and inadequate use of already stretched theatre resources (Argo et al. 2009). Reasons for cancellations can be multifactorial such as bed unavailability due to increased Emergency admissions (Griffin et al. 2005., Schofield et al. 2005.), and patients deemed unfit for surgery on the morning of surgery (O’Connor et al, 2011., Hanna et al. 2009).
Dimitriadis et al. (2013) carried out a study to investigate reasons for day of surgery cancellations at their NHS Foundation Trust in the United Kingdom. They retrospectively correlated and analysed data from the period January 2012 – December 2012 using their patient management software and established that 5% of planned surgical procedures were cancelled on the day of surgery. Patients identified as medically unfit was the main reason for cancellation despite the availability of a pre-op assessment clinic in this hospital. One conspicuous limitation of this study was there was no control group for comparison. Griffin et al (2006) supports these findings as he also found no reduction in cancellation rates for patients deemed medically unfit on the morning of surgery despite pre-assessment. Dimitriadis et al (2013) highlighted the need for patients to be pre-assessed within 2 weeks therefore avoiding a pre assessment that was either out of date, or one that was only carried out too close to day of surgery.

An older study by Rai and Pandit (2003) retrospectively looked at 2726 patients that had been pre-assessed in a nurse led clinic in the previous two years. They found that a total of 105 patients (3.9%) were cancelled or postponed for medical optimisation after pre-assessment. A staggering 137 patients were cancelled (5.0%) on the day of surgery, despite pre-assessment. It should be noted that only 36 were for anaesthetic or medical reasons and 2 of these were only seen as a failure of proper pre-assessment. They concluded that pre-op assessment had assisted in reducing cancellation rates on day of surgery where the mean cancellation rate for the trust was 11%. This study supports the use of nurse led clinics as, had the patients not been postponed for further tests at pre assessment the cancellation rate on DOSA would have been up to 9%. These studies support the use of pre-operative assessment in the run up period before surgery to medically optimise high risk patients, potentially reducing cancellations on
DOSA. Limitation of Rai & Pandit study was there was again no control group and it was only a short stay hospital.

Cancellations can occur for many reasons, as previously discussed, however, the availability, or lack thereof, beds is one of the main reasons found in the literature (Vijay, Kazzas and Refson 2008). A heavy emergency patient load the previous day may lead to cancellations of elective procedures due simply to lack of beds. A need for ring-fenced beds has been identified as a solution to tackling this problem. Ring-fencing can be achieved by blocking access to surgical beds by acute surgical or medical patients (Coyle at al. 2010, O’ Malley et al. 2005, Coyle et al. 2010) study demonstrated that ring-fencing surgical beds not only facilitated day of surgery admissions, it also helped to prevent unnecessary admissions before surgery, reducing length of stay and number of cancellations.

HSE (2012) identified another form of ring-fencing beds by the separation of elective and emergency services. Appropriate collaboration and organisation between various disciplines involved in the surgical pathway, such as outpatient clinics, admissions, pre-assessment clinics, anaesthetists and surgeons, will facilitate restructuring of elective procedures and will assist in reducing “bottlenecks” along the patient journey.

2.3.4. Patient Experience:

Lack of information and latent fear are two main stress causes for individuals and patients awaiting surgical procedures, leading to heightened anxiety. Many studies have been carried out (Johansson at al, 2002., Kindler et al: 2000) which found that patient education can assist in reducing anxiety. Aquilina & Badacchino, (2007) carried out a qualitative exploratory study on a purposive sample of 30 Maltese patients scheduled for total joint
replacement measuring their experience of a day surgery pre-assessment clinic. Their findings were as follows, patients valued not only the information but also the individual time given to them by the nurse. This study supports Malkin’s study in 2000 which identified the need for the nurse to be present to provide expert knowledge and intervention. Concannon et al. (2013) measured patient satisfaction as a secondary aim in their study on the impact of ring-fenced beds and POAC on the rate of DOSA. The study though small, eighteen participants out of a possible twenty-seven rated their state of readiness for surgery as ‘excellent’.

Heaney & Hahessy (2011) carried out a quantitative exploratory study to examine patient satisfaction within an orthopaedic pre-operative assessment clinic in an Irish setting. The sample size was a convenient sample of 91 patients who were all invited to complete questionnaires, with a response rate of 88%. The overall findings were that patients were satisfied in general but identified the need for more emphasis to be placed on individualised care and patient information. These findings, though positive, are limited to a small sample size in the west of Ireland and do not give a true representation of patients that attend larger level 4 hospitals where the process may be varied. Other studies have previously explored patient satisfaction and measured this rate against levels of quality in the specific service provided (Flynn & Whitehead, 2006., Henderson, 2005). Information sharing has been identified as a commonality in many studies to increase patient satisfaction at POAC (Heaney & Hahessy, 2011., Harnett et al. 2010., Aqualina & Baldacchino, 2007).

2.4. Implications for the Project

Ample literature is widely available to support the process for improving efficiencies in access to scheduled care. Pre-operative assessment is the essential link available to
patients to ensure they are medically optimised for surgery, thus increasing their suitability for day of surgery admissions, reducing cancellations and improving overall patient experience.

Nationally the HSE have shifted their focus to pre-operative assessment and have set targets of 80% to facilitate national targets for DOSA at 75%. The cancellation rate of less than 5% on DOSA was set as a Key performance indicator by the HSE (2012) to measure effectiveness of pre-op assessment clinics. The Model of Care for Elective Surgery (2012) and the Model of Care for Pre-admission units (2014a) are the main drivers supporting this improved pathway for surgical patients in Ireland.

Efficient and effective use of limited resources has shifted the trend of pre admission days before surgery to admission on the same day as their scheduled surgery. Thorough pre-assessment facilitates a comprehensive assessment of the patient and provides a time frame for specific tests to be carried out which in turn can eliminate cancellation on morning of surgery for medical reasons and address patient anxiety. Bed unavailability is both a local and national problem that will continue to challenge us organisationally. However, as health care manager and workers we have to strive to ensure both scheduled and unscheduled admission are afforded the same level of importance in the health care organisations.

2.5. Conclusion.

This literature review has highlighted the growing importance of quality assessment in healthcare, with pre-op assessment, DOSA and patient experience used as the key performance indicators. There are common findings across the literature that supports the
need to change from the ritualistic practice of admission days prior to surgery to that of a patient-centred process.

This literature review supports the need for Irish healthcare organisations to provide pre-operative assessment locally, adapting pre-operative assessment clinics that suit both the type and volume of patients it cares for.
CHAPTER 3

“There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things.”

Niccolo Machiavelli

The Prince (1532)

3.1 Introduction:

This chapter will comprise of two parts. First, a brief critique of change theory, including the rationale for the change agent in choosing the Health Service Executive (HSE) model over other referenced change models. Secondly a clear insight into the change agents’ journey, underpinned by evidence, and guided by the four stages of the HSE model.

The aim of this change is “Improving efficiencies in access to care and patient flow for scheduled care in a level 4 Dublin Hospital”.

3.2. Change Theory.

Kurt Lewin, a prolific theorist and pioneer of change models, carried out seminal experiments on both ‘leadership style’ and ‘planned change’ during World War II, and in so doing, launched a whole generation of research into the implementation of change programs (Burnes, 2004). He determined change requires action, and that successful action is based on evaluating a given situation correctly, recognising all possible solutions and selecting the most suitable solution for that situation.
Planned models of change have focused on the top down approach, with change enforced by senior management in a rigid, linear manner. Contrastingly, emergent change models have focused on a bottom up approach with change viewed as a continuous, unpredictable process, including the interplay of culture, political astuteness and open-ended viewpoints. Dawson (1995) and Wilson (1992) challenged the appropriateness of planned change models and argued that these models view change as a succession of linear steps of unfreezing, moving, and then refreezing and ignore the complex dynamic nature of change and the need for employee flexibility and adaptability. The process of ‘unfreezing’ or recognising a prescient need for change, disturbs the status quo in any organisation, reducing resistance and creating positive motivation. ‘Changing or ‘moving” is the step that initiates, plans and implements the change into the organisation. The final step of ‘refreezing’ establishes and stabilises the change (Lewin, 1951). An unambiguous flaw of this model of course is the assumption that all change is successful (Carney, 2006), when in fact only 20% of changes succeed. (HSE, 2008).

A critical factor in determining the success or failure of any change programme is the competency and awareness of the leader. Organisational culture is complex, and we often fail to notice it until the culture becomes disturbed. Organisational culture tends to be embedded deep in the day to day routine, and often controls us more than we control it. Inherently, culture sets up normality, while change, by its very nature, conjures unpredictability and volatility. Accordingly, the uncertainty implicit in any change programme can and may lead to anxiety and resistance (HSE, 2008).

Accordingly, resistance is a normal phenomenon in any change process and should be treated by managers with respect. Lewin viewed resistance as a powerful restraining force
and Garside (1998) suggested that people resist change for many predictable reasons such as, loss of power, increased workload, misunderstanding due to inadequate communication and individual low tolerance of change. Some literature depicts resistance as negative and irrational behaviour that needs to be managed. However, Vas et al (2005) and Coghlan and McAuliffe (2003) argue that leaders should encourage individuals to express their reluctance to change, and that these concerns should be acted on.

Force field analysis was the foundation for Kurt Lewin’s mode of thinking, where he envisioned change as a balance of forces working in opposing directions. Change will arise when there is an imbalance in equilibrium between driving and restraining forces. Driving forces include increased competiveness, innovation, strategic advances and dynamic creativity within the organisation, while restraining forces, which impede change, can include existing work customs, inertial practice, trade union agreements etc. (Carney, 2006, & McAuliffe & Van Vaerenbergh 2006).

Both Lewin and Kotter’s variously stepped models (appendix 3) focus on stages of planning, implementing and evaluating, and are arguably well suited for use in today’s changing health service environment. Organisations are not static entities and are constantly changing, requiring a change model that allows flexibility and the opportunity to overlap stages of the process where necessary (Burnes, 2004).

3.3 Organisational Development Models:

Organisational development is value driven; action research orientated, interconnected with all disciplines within an organisation and involves collaboration and input from all stakeholders, both at senior level and on the front line. This approach focuses not only on
content but also on process (McAuliffe & Van Vaerenbergh, 2006). Coghlan and McAuliffe (2003) argue that over the past 40 years, there has been a rising mindfulness that the ‘process’ of change can be as important as its ‘content’. Organisational Development is one of the few approaches that place as much emphasis on process as it does content.

3.3.1 HSE Change Model:

The HSE identified a need for a new change model in 2008, subsequent to recognising the changing demands in healthcare and increased expectations from both service users and employees, (HSE, 2008). The HSE model comprises of four steps, is cognisant of bi-directional flow within all four steps, identifying that change is a cyclical process and not a linear, step by step affair (HSE, 2008 & Burnes, 2004).

The HSE acknowledge that with the rapid pace of change in healthcare, it is unrealistic to design a model that is not centralising and/or sufficiently adaptable (McAuliffe & Van Vaerenbergh, 2006). The change agent will use the four step HSE model for the following reasons:

1. The four steps are adaptable and easy to use.
2. This Irish model is clearly designed and structured within context and jurisdiction.
3. It is not unyielding and is attuned to the constant state of flux in healthcare organisations.
3.4. Change Process

The HSE Change Model articulates the four stages of the project management lifecycle as 1. **Initiation**, 2. **planning**, 3. **implementation** and 4. **mainstreaming**. The change agent will discuss in detail each step with relevance to this change project.

**Figure 1 HSE Change Model (2008)**

![HSE Change Model Diagram](image)

3.4.1 Initiation Phase.

This stage is essential to help build a solid foundation for effective change within the organisation with support mobilised from all departments (HSE, 2008). It aids the change agent and the team in designing a blueprint to support the rationale for this change. A needs assessment must be carried out at this stage, reviewing the staff involved, resources required and the current working environment (HSE, 2008).

A need was identified to create a change team that compensated for the limitations of each identified individual, thus attempting to encompass all the required skills to implement this organisational development change (Ancona et al, 2007). By involving the whole team, each member felt they had a role and a sense of ownership of the project, (Brookes, 2011).
3.4.1.1. Assess the drivers and the degree of urgency for change

Change is determined by both internal organisational factors and external factors present in the wider community. A wealth of strategic tools are available to assess drivers for change, i.e. SWOT (‘Strengths’, ‘weaknesses’, ‘opportunities’ and ‘threats’) analysis and PEST (Political, Economical, Social and Technological) analysis (Illes and Sutherland, 2001).

The change agent carried out a SWOT analysis with the entire change team to identify the drivers for this recognised organisational change (Appendix 4). Due to the subjectivity of the SWOT analysis, team inclusion was promoted (Gopee & Galloway, 2014).

SWOT analysis was originally designed by an American business man called Albert Humphreys in the early 1970’s, and is still an effective strategic tool used to assess both internal and external drivers of change. ‘Strengths’ look at the internal attributes helping the organisation to achieve set objectives and ‘weaknesses’ looks at internal attributes that challenge it in achieving its objectives. Contradictory to this, ‘opportunities’ looks at the external conditions that promote achievement of organisational objectives and ‘threats’ look at external conditions that challenge or threaten the achievement of the organisational objectives (Marquis and Huston, 2009).

The completion of the SWOT analysis (appendix 4) afforded the change agent, and the team, a clearer understanding of the drivers and barriers for the proposed change. Internal and external drivers of clear governance, resources readily available within the department, and a wealth of national and international literary evidence to support the change, outweighed the identified internal weaknesses of a fragmented culture, a lack of...
cohesion between departments and uncompromising financial budgetary restraints.

Following on from the SWOT analysis, a PEST (political, economic, social and technological) analysis was carried out to assess the need for the change proposed and the readiness of the organisation to support and drive this change (appendix 5). Crucially, the HSE model of care for pre-assessment units; in tandem with national targets for pre-assessment of 80%, were powerful driving forces for the proposed change of 'improving efficiencies in access to scheduled care'.

Force Field Analysis.

Lewin (1951) theorised that behaviour is not static in any organisational setting and instead contains a vigorous balance of socio-psychological forces working in opposite directions (Gopee and Galloway, 2014). The change agent carried out the force field analysis independent of the change team as the level of subjectivity is not as prevalent as in the SWOT analysis previously discussed (Gopee and Galloway, 2014).

The driving forces outweighed the restraining forces prompting the need for change (HSE, 2008).

Table 1: Force Field Analysis adapted from Senior and Swailes, (2010) for “Improving efficiencies in Access to Scheduled care”

<table>
<thead>
<tr>
<th>Driving Forces</th>
<th>Improving Efficiencies in In</th>
<th>Restraining Forces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Leaders assigned solely to day ward for 2 months→</td>
<td>Improving Efficiencies In</td>
<td>← Fragmented culture</td>
</tr>
<tr>
<td>Project team→</td>
<td></td>
<td>← Change overload</td>
</tr>
<tr>
<td>Clear organisational Governance structure→</td>
<td></td>
<td>← Financial restraints</td>
</tr>
<tr>
<td></td>
<td></td>
<td>← Fear of Change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>← Perceived work overload</td>
</tr>
</tbody>
</table>
The findings of the SWOT, PEST and Force-Field analysis provided adequate and persuasive evidence to develop a clear mandate for improving efficiencies in access to scheduled care. This mandate was drawn up by the change agent and change team and communicated compellingly throughout the organisation.

At this stage in any process, communicating and communication strategy are essential competencies for the change agent and are imperative when articulating the vision (HSE, 2008, Kotter, 1996). The communication plan needs to incorporate a clear and definable policy that engages and respects all stakeholders, and must be more of a continuous process and less a simple reference document (Gill, 2011, Senior and Swailes, 2010 and Barr and Dowding, 2008).

Concise and articulate instruments of communication were chosen to ensure all disciplines successfully understood the process (Barr and Dowding, 2008), enabling them to perceive evidently the intended benefits on a personal and professional level.

A newly installed ‘white board’ in the nurses’ station on St. Mark’s ward enabled visual
communication of important patient data, i.e. number of DOSA, number of patients pre-assessed, number of cancellations and reasons for same and finally the transfer time from the admission lounge to theatre. A daily record was kept by photographing the white board with the data then digitised into the computer system for analysis.

Structured fortnightly meetings chaired by the clinical lead were arranged for the change team and updates and data were sent directly to all members of the team via email prior to each meeting, ensuring opportunity for discussion and debate during the meetings. The surgeons were consulted as a singular group and the benefits of this change to their day to day practice were highlighted. They realised that this service was available to assist them in increasing the number of patients they could operate on during their allocated theatre time and reduce risk of cancellations on DOSA for medical reasons. Organisationally, regular memos were sent to all nursing and medical teams to keep them apprised of any changes or updates.

Proposed aims and SMART objectives were discussed at different forums i.e. Nursing Clinical executive meeting, bed-management, senior surgical committee, Heads of department for South eastern division of surgeons, affording all disciplines within the organisation a platform for questions and feedback. This extensive communication policy mandated the vision for change, while also identifying top level stakeholders and senior management individuals who were highly committed supporters of the change process (Daft, 2005).

Kotter (1995) identified that senior management are normally at the core of the change team or coalition, as their role is to improve service delivery organisationally (HSE, 2008).
Once stakeholders were identified they were then further weighed for their individual levels of power and interest (Appendix 1). This offers the change agent an understanding of the level of communication and engagement required for each individual and group going forward (HSE, 2008, Polonsky and Scott, 2005).

The change agent continued to regularly map the stakeholders' expectations, level of engagement and satisfaction throughout the change process. The initial stakeholder analysis of power versus influence levels varied greatly to the final stakeholder analysis in the implementation stage, (Appendix 6). Interestingly, the Director of Nursing moved from the High Power, High Influence group to the high power, low interest group, i.e. she had the power to redeploy the change agent back into her CNM3 role, however, her overall interest in the operational function of the change project was low and effectively pseudo a hands-off approach allowing the change agent complete control of the project.

The following stakeholders moved into the High power. High interest group,

**HSE:**

Following a formal visit to the writers organisation the HSE team for pre-op assessment, displayed a keen interest in the local implementation of the HSE model of pre-op assessment. As this model was been implemented nationally the HSE were anxious to assess local challenges and enablers experienced by the writer and stakeholders to support transferability of this project to other healthcare organisations. They provided feedback of their visit (Appendix 7).

**Trade Union.**

During the initial stakeholder analysis stage the power and influence of the relevant
nursing trade union group was considered by the novice change agent to be well down the list of stakeholder importance. This, as the project unfolded, was clearly a mistake. Unexpected mandated industrial actions by ED staff in October prompted a heightened awareness of the number of scheduled admissions throughout the organisation, resulting in a lost opportunity to ring-fence bed capacity and reduce waiting lists in this way. A revised focus on pre-operative assessment was facilitated at this stage.

*Administration Staff.*

The administration manager had both high power and interest helping to source two administration staff to improve both ‘checking in’ on the morning of procedures and streamlining the booking process for the admission lounge.

Throughout this process of continuous evaluation a determination was made that the consultant anaesthetist be afforded the opportunity to formally join the change team, as he would have the power and influence to galvanise anaesthetic support for the pre-op assessment.

**3.4.1.2. Assess readiness and capacity for change.**

Readiness to embrace change is closely linked to organisational culture, and the relationships between individuals, teams and service users is key (HSE, 2008). Readiness may pre-empt resistance and increase latent potential for effective change. The Change agents’ key role therefore is to analyse individual attitudes and motives towards the change, cognizant that culture is complex, and disruption to the day–to-day flow can lead to unpredictable outcomes (McAuliffe & Van Vaerenbergh, 2006).
Initially, a fragmented culture was conspicuous on St. Mark’s ward, as all three departments (day-ward, pre-assessment unit and admission lounge) had been relocated to work as one unit with no clear leadership or direction (Goffee & Jones, 1998). The CNM was a novice manager who lacked the operational know-how to translate strategies into plans, and was finding it problematic to foster commitment from all three departments (Ancona et al., 2007). The change agent used her leadership skills in teambuilding and motivation to support and assist the CNM to develop a strong mentoring, supportive relationship with her staff (Northouse, 2013, Gill, 2011).

Encouragingly, the change agent clearly identified a culture of in-group collectivism where all staff on St. Mark’s Ward displayed loyalty, pride and devotion to the organisation as a whole (Northouse, 2013). The change agent met with the staff on an individual and group basis to afford them the opportunity to showcase their ideas on how to improve efficiencies in the day to day running of the ward. Staff engagement in this process from day one, fostered mutual respect, commitment and trust between staff and the change agent (Dani et al. 2006) The change agent was focused on changing the prevailing practice, to that of a future-orientated culture where staff would engage in strategic planning and a performance orientated culture, and where they would be acknowledged for the planned improvements on St. Marks ward (Northouse, 2013).

As the change agent was assigned solely to St. Mark’s ward as project manager, she was able to provide individual support for all disciplines and groups affected by the change locally i.e. the nurses, anaesthetics, and surgeons and their teams. The consultants required maximum support in the early stages of the process as the normality and predictability of the day was interrupted, which led to some resistance and unrest (Mohr et al., 2011).
‘Capacity for change’ relates to both organisational commitment and provision of adequate support for all staff in implementing and sustaining the change (HSE, 2008). It is also determined, importantly, by whether the change agent has the formal power and authority to allocate resources. The strong commitment from the director of unscheduled care and the overarching governance structure (Appendix 8 ) afforded the change agent the opportunity to restructure the layout of the ward with, i.e. extra information technology resources, sourcing an additional site for pre-assessment, newly installed white board, two additional administration staff, one for checking in all scheduled patients, both day-case and DOSA from 7am, and the second administrative person assigned solely to the restructuring of the booking schedule for pre-op assessment and DOSA.

Ultimately, readiness and ‘capacity for change’ can be measured using the Beckhard and Harris, Readiness-Capacity Assessment Chart (1987) which enables the user to list individuals or groups critical to the change effort, and to rank them (high, medium, or low) each according to their readiness and capability with respect to change.

3.4.1.3. Leverage points and opportunities for change

At the end of the initiation phase the change agent and the change team had identified several leverage points and opportunities for change.

The SWOT analysis previously carried out identified several strengths and opportunities to leverage the change i.e. clear governance with support galvanized from senior management, ample literary evidence and HSE national targets to support this process. Threats and weaknesses identified, such as financial constraints, fragmented culture in all three departments and increased emergency admissions, were distinct and obvious risks
to the success of this process (HSE, 2008). The possible transferability of this project however, is a strong and palpable advantage, and with recognition, can galvanize support and ‘buy-in’ across the relevant health sectors locally and nationally.

Critically, the staff nurses on St. Marks’ ward already possessed a high level of experience and knowledge of scheduled care, pre-assessment and DOSA. Notwithstanding this positivity, some evidence of fear and inertia was present. One particular staff nurse was markedly skeptical of this change process. When questioned, her expressed concern was the ‘effect this would have on her role and whether she would be of any increased benefit to the organisation’. By expressly including this staff member from day one, her reservation evaporated and has now become an effective and motivated change champion.

The change agent also met with staff already involved in day pre-assessment and anesthetic pre-assessment. An efficient scheduling system for DOSA was not evident and a non-coherent approach was currently used for booking patients into the admission lounge using a first come, first served system. The provision of 2 extra administration staff was crucial to the redesign of booking forms and streamlining the scheduling process.

Some practical working relationships already existed between theatre staff and staff on St. Marks’ Ward; however, structured communication channels were not evident. Ostensibly delays in transferring patients from the admission lounge to theatre had become normal practice. A collaborative relationship with the consultants was required, and with developed trust and professional judgement, it was agreed the solution was to completely break with the ritualistic practices that were limiting this service.

3.4.1.4. Initial Impact of change

It was imperative at this stage that an assessment of the impact the change would have on
the organisation generally was carried out. This would allow the change team an opportunity to identify resources and areas where focus or refocus was required (HSE, 2006). This impact analysis is a powerful tool when calculating the amount of attention, planning and resources the change will require. SMART objectives have been set, agreed and accepted by front line staff and key stakeholders (refer to Chapter 1). Fortnightly meetings were set up for the change team with agreed terms of reference. The change agent was released from other duties to support staff and project manage during the change process. Continuous communication of the proposed vision was conveyed to all relevant disciplines.

3.4.2. Planning Phase

This stage involves consolidating engagement and support from all leaders, and the involvement and empowerment of service users. The mandate for change is now clear and support is required from all stakeholders to help forge this change going forward. There are three steps in this phase, 1. Building Commitment, 2. Determining the detail of the change, and 3. Developing the implementation plan.

3.4.2.1. Building Commitment:

This process required the change agent to translate and adapt the determined vision for change and make it a reality for all staff directly involved. Engagement of all staff including trade-union representatives resulted in a clearer picture of the shared vision and perceived future improvements (Larson, 2011). Once staff understood the vision, they could then explore the implications it had on day to day operations and culture (HSE, 2008).

The specific vision for this change was to improve efficiencies in access to scheduled care. The identified aims were,

- Combine the admission lounge, pre-op assessment unit and the day ward
under one governance structure.

✓ Ensure 80% of patients were pre-assessed prior to DOSA in line with National standards set by HSE.

✓ A more efficient use of theatre time with a notable reduction in cancellations on the day of surgery

✓ One point of entry for all scheduled patients on morning of surgery.

✓ Administration staff available to ‘check in’ patients on St. Marks ward.

✓ Identify administrative staff assigned to streamline the booking process for the admission lounge

✓ Develop a lean approach for the patient pathway on the morning of surgery.

✓ Reduce waiting times by improving access.

The change agent articulated the vision clearly, communicating the benefits to the service users and organisation in a variety of forms and forums.

The identified benefits were:

- A cohesive, streamlined efficient pathway for the scheduled patient.
- Reduction in cancellations on the morning of surgery which reduced loss of revenue to the organisation and reduction in teaching hours lost to surgeons.
- Increased patient satisfaction.
- Economic benefit of reducing length of stay and maximising use of current theatre space and time (HSE, 2012).
- Avoiding financial penalties for patients breeching national waiting times for surgical procedures.

An opportunity to query the process and ask questions generally was afforded to all team
members which provided them with a broader understanding of the proposed benefits to
the organisation. Questions such as “how will this change add value to the current service”
and “what is the vision for the future” can provide lively and informative discussions and
debates between the stakeholders, which in turn will help the change agent and team set
strategies and achievable targets (HSE, 2008). Feedback stimulates reflection on the
planned process and allows changes to be made as required thus strengthening the
chance for success (Larson, 2011).

Sensitivity needed to be shown to stakeholders and staff that were feeling threatened at
this stage (HSE, 2008). The change agent was aware that a perception by key
stakeholders of a lack of support from the change team could increase resistance towards
change (Marquis & Huston, 2003). Resistance has been viewed by many writers as
destructive (Vas at al, 2005, Coghlan and McAuliffe 2003), when in fact it should be treated
as an opportunity for staff to identify real and actual problems and solutions (McAuliffe and
Van Vaerenbergh, 2006)

Pursuant to the ‘assessment of readiness’ and ‘capacity for change’ carried out in the
initiation phase, the change agent now needed to assist individuals to develop and
enhance their skills and relevant competencies. (HSE,2012). All staff members on St.
Marks ward were met individually to assess their level of knowledge and skill in pre-
assessment. Staff nurses were afforded the opportunity to work in all three clinical areas to
provide them with greater insight into the day to day running of each area and how all
three areas work in harmony with the overall aim of improving the patient journey. The
CNM was supported here by the change agent and provided with guidance and skills on
how to lead and manage her team during the change process.
3.4.2.2 Determining detail of the Change:

During this phase the change agent observed existing practice on the ground for two days to mentally map the patient journey and identify areas for improvement and existing bottlenecks. A process map was prepared to capture existing practice, analyse the process and at that point find solutions for the identified problems. This map is a visual representation of the current patient journey and administrative processes. Prior to the change, the patient journey for scheduled care consisted of an excessive thirteen steps on the day of surgery with an inefficient use of time and an increased risk of cancellation on the morning of surgery (Appendix 9). The process map post implementation of the project now involves a more workable three steps on the morning of surgery prior to transfer to theatre, with the majority of important remaining steps are carried out preceding the morning of surgery.

The change agent was conscious of the importance of finding a balance between the surviving historical practice that was changing and the new ideals that were been initiated into practice. Necessarily change needs to happen in parallel with day to day running of the department. (HSE, 2008)

The change agent now carried out a gap analysis to scrutinize the disparity between the existing practice and the shared vision for the future. Gap analysis assists in identifying current practice, what needs to be changed or superseded and what needs to be instigated (Ajami et al. 2014, HSE, 2008).

The overall findings of the gap analysis were:

- Presently only 20% of scheduled patients were pre-assessment prior to DOSA.
- No booking structure/ system available in admission lounge
- All three departments working separately in silos
- Evident lack of leadership
- Fragmented culture in day ward
- Time delays in transferring patients to theatre on the morning of surgery.
- Twenty-eight patients in breach of current waiting times.

Benchmarking against other comparable institutions offered the change agent the opportunity to broaden the gap analysis findings and identify areas for further improvement. The change agent assessed what assets were currently available in the organisation to support the success of this change, e.g. pre-assessment room, admission lounge, nurse trained in pre-assessment etc. The findings of the gap analysis and the results were again reported to the stakeholders, as a matter of course.

Feedback was provided at both local level and at scheduled meetings by the change agent with the hope of not only prompting debate, but also gaining perceived ownership of the change process, (McAuliffe & Van Vaerenbergh, 2006). The identified disparity between current practise and future vision was indeed evident from the Gap analysis results. This determination assisted in identifying what needed to change and which refined triggers and drivers were required to service this process.

By example, the analysis identified a requirement for patient theatre lists to be submitted one week in advance of scheduling surgical procedures, breaking with the existing more lenient system of ad hoc or flexible surgical itineraries. This new requirement caused unrest and raised pointed questions with surgeons as to why this flexibility was being removed from the system. The change agent then met formally with the heads of surgery in all specialities highlighting and explaining the rationale and proposed benefits this
particular change would deliver. Once again, fear and resistance evaporated upon seeing the projections and a realisation among the surgeons that these proposed benefits were actually achievable. The heads of surgery became hereafter one of the most proactive groups regarding this change process and a valuable ally in corralling further support among surgical teams and registrars.

### 3.4.2.3. Developing the Implementation Plan

Rigorous preparation and planning up to this stage ensured a smooth implementation stage. The change agent liaised with operational and strategic directors and heads of department to further cement and refine the process (Larson, 2011). Each stakeholder has a valuable skill or attribute to bring to the process and a combination of these skills can ensure all the essential attributes of a leader are captured, strengthening the finding by Ancona et al, (2007) who suggested that no leader possesses all key leadership skills.

The important questions that the change agent needed to answer in relation to transition from current practice were as follows:

“What will stay the same?
What will need to be discontinued?
What will be different?
What opportunities are there for improvement?
What are the perceived risks? “(HSE, 2008).

The above questions when asked provided meaningful answers to support the Implementation phase of the organisational development change and set milestones and timeframes. This will be further discussed in the implementation phase. The change agent
also identified at this stage any further education or support required for staff development such as employee wellness programmes and in house education.

3.4.3. Implementation

This stage involves the implementation of what has been, up to now, purely a proposed plan. The change agent viewed this stage as the “going live” phase. Throughout this stage, the change agent needed to continue to provide support to staff at ward level and acknowledge personal conflicts and challenges experienced with the change process. A performance and future orientated culture is required to support continuous learning and promote a capacity for institutional and personal tolerance (HSE, 2008).

A clear and judicious agenda was communicated to all staff and service users both local and organisationally, relating to commencement dates for the proposed objectives. This was delivered via an all users email in memo format, locally at ward updates and organisationally at designated meetings. The project start date was set as the 23rd November 2015. Following the initial stakeholder analysis, key members of the project team were identified with clear role responsibility and a new governance structure was designed and agreed. Terms of reference were agreed and meetings were set on a fortnightly basis with a minute taker identified.

The change agent was released from all other duties to facilitate the implementation of the project on the 23rd November 2016 for a 2 month period. Week 0 of the project was used as an observational week where agreed SMART objectives were discussed locally with all key stakeholders and commencement times agreed. Following week 1, a meeting was arranged with the Director of unscheduled care, Director of administration and facilities
and a list of requirements identified and discussed. The urgent need for administration staff to check in all scheduled patients on St. Marks ward was identified to ensure all patients were provided with an identification bracelet on arrival to the ward.

From 30th November 2015, a second administration staff member was allocated to work at the check in desk on St. Marks’ ward to assist with registering all patients for admission i.e. day-surgery, DOSA or pre-assessment. The admission office on the ground floor of the building, which customarily checked in all patients for the admission lounge and the porters at the front desk, were formally notified of the change in the check procedure and were given a list of patients planned for each day so that patients were directed to St. Marks ward reception. Patients were contacted by phone and clearly informed of where to present for check in and in this way every effort was made to pre-empt patient and indeed staff confusion.

The administrative staff member allocated to streamline the admission process and design the scheduling admission form for the admission lounge was already in place. At this stage guidance and support was provided by the change agent to implement this process efficiently. A surgical notification form was designed following collaboration with all relevant stakeholders and feedback was received and amendments made. The form was revised a total of 3 times prior to finalisation. Memos were sent to all Clinical Nurse Managers with the new notification form attached for their familiarisation and use. By week 4 a need for shared access to a pre-assessment patient log was identified and a servers request was sent to IT. This was set up by week 5. Further revised Rules/ guidelines for the admission lounge were agreed at senior level and were ingrained into practice from Monday 30th November (Appendix 10).
The relevant CNM2 was appointed, by agreement, to take responsibility of pre-assessment unit, day ward and admission lounge, under the initial guidance and direction of the change agent. A ward meeting was held on week 1 (23rd November) and day-staff informed of the new change. The existing staff nurse in the pre-assessment unit initially expressed unhappiness with this new structure and felt it threatened her autonomy. A series of reconciliatory meetings were held with the difficult staff nurse, CNM2 and the change agent in attendance with the result that non-nursing jobs were reallocated to the administration staff, freeing up more nursing time for patient assessment. Buy-in was gradual, and by week 6 staff engagement was decidedly improved. In terms of resources a total of 3 rooms were identified to support pre-assessment for day services, DOSA and anaesthetic pre assessment. This reallocation of a finite resource i.e. space in the hospital, was an under estimated but welcome achievement in a pressing environment. This increase in space and capacity has allowed the pre-assessment suite to function efficiently but vitally, to cope with the projected increase in patient flow expected throughout the change process.

The pre-op assessment definition was established in line with HSE model of care for pre-op assessment and therefore it was agreed not all patients required anaesthetic input. A full medical, nursing admission and routine laboratory work-up if required were now recognised as and termed, pre-assessment, (HSE, 2014a).Surgeons and medical teams were informed of this and agreed to this change in practice. All major surgical cases would continue to have a full anaesthetic pre-assessment work-up prior to DOSA. The commencement day for pre-assessment was set for the 30th November and this was now to be referred to as Week 1 for statistical purposes and will be discussed in detail in Chapter 4. A comparative measure of time from admission lounge to theatre was agreed at 36 minutes and comparative data was measured from week 0 = before the 30th November
and Week 1 (30<sup>th</sup> November). Data was collected by the change agent for the first 2 months; thereafter the staff in the admission lounge captured the data on a daily basis and send it to the change agent for analysis. Data collected measured KPI’s in line with National Targets

- Pre-assessment percentage rates – 80%
- DOSA admission- 75%
- % of cancellations < 5% on DOSA
- Time to theatre reception from admission lounge= < 36 minutes

As the change agent was allocated solely to St. Mark’s ward, this afforded her the opportunity for continuous scanning of the environment ensuring old ritualistic ways were being phased out and replaced with new improved practices. Continuous staff support was provided with ongoing opportunities for staff to discuss both individual and ward issues as they emerged (Pons, 2012) It was imperative that the change agent be realistic and not rush the change process while acknowledging that implementation of any change takes time and can be challenging (Gill, 2011).

4. Mainstreaming,

The focus of analysis must now be placed on how effective the change project actually was and how well it integrated into the day to day running of the organisation. Carney (2006) assuredly suggests all change should be celebrated even if it is not 100% successful. Data collected in the first 17 weeks was displayed in graph form and shows a steady increase in pre-assessment rates, which will be discussed further in chapter 4. Staff morale increased once they saw an increased rate in pre-assessment, a more efficient transfer time to theatre and a streamlined, structured booking process for the admission
Despite concern at the beginning of the change, ritualistic practices have been weaned out and replaced with this new process. Staff no longer see this new process as an extra workload added to their already busy schedule, but as a more efficient use of their time, with an overall positive experience for the surgical patient.

As the change agent has now left the ward and is back in her previous role as CNM3 in scheduled care, a need to assign a change champion was identified. Initially the change agent had concerns that a staff member who had worked on St. Marks ward for over 5 years would offer the biggest resistance to the change. However, this staff member began to contribute her ideas in scheduled meetings, her input was acknowledged and acted on, and she now displays passion and drive to continue to achieve pre-assessment rates of up to an over 80%. This staff member is now the de-facto change champion, remains on the ward, day to day and is fully committed and authorised to manage this new cycle into the future.

As previously discussed, any given change proposal is not ‘set in stone’. The Health service is constantly faced with changes in practice, advances in treatments, medical breakthroughs etc, so all stakeholders need to be aware that any proposed change to practice, may, in the future need to be revised and improved. Timely and targeted audits will help to identify further opportunities for improvement. The writer will review the current change team at this stage and identify if they need to become part of the day to day running of the organisation or if they can be reassigned to other projects. In order to receive constructive feedback the writer should use a reflective cycle to identify areas that worked well and areas that require refinement and change in the future.
Chapter 4.

4.1. Introduction.

In this chapter the writer will discuss the implication of evaluation in healthcare, and apply it to the Organisational Development project using the CIPP (Context, Inputs, Process, Product) evaluation model.

Evaluation models are imperative in identifying improvements that work prior to their widespread replication (Parry et al., 2013). Formal evaluation methods also assist in aligning the aims of the change with the evaluation process. This alignment strengthens the change, reducing normal diminishing effects when implemented on a wider scale, a phenomenon described by Peter Rossi in (1987) as ‘Iron Law of Evaluation’.

This project was directed by the HSE change model (2008), which included the use of SMART objectives. Emphasis was placed on quantitative data; allowing evidence to be gathered quickly, to illustrate overall improvements in the change introduced.

In addition the writer, as a novice change agent, will reflect on what she learned using Rolfe’s evaluation model.

4.2 Healthcare Evaluation.

Evaluation is defined as a process of obtaining, defining, and providing useful information on a change experience, quantifying its worth or value and deciding what needs to be changed or further established (HSE, 2008). Evaluation is a key element in healthcare, where accountability and quality are significant outcome measures (Larson, 2011., Polit & Beck, 2006).
Green and South (2006) listed six key reasons for evaluation, which are particularly applicable to this change project as they address many of the relevant drivers in this case. Green and South (2006), stated evaluation is necessary:

- To establish whether or not interventions have worked
- To improve implementation of health programmes/models
- To improve accountability to funders
- To increase support for sustaining or expanding an intervention
- To contribute to the scientific base for intervention
- To impact policy decisions

4.3 Evaluation Models.

There are presently several healthcare evaluation models available, choosing one over the other can be challenging. A clearer understanding of some of these models and their relevance to the project undertaken here will support the writer’s rationale for choosing her favoured model.

Kirkpatrick’s four step evaluation model was designed by Donald Kirkpatrick, Professor Emeritus of University of Wisconsin in 1959. This model can be used to analyse the effectiveness of a training project and how improvements can be made for the future. This four step model has more relevance to education environment.
The Donabedian framework of ‘Structure’, ‘Process’ and ‘outcome’, is a validated approach used to examine safety and quality of service innovation in Healthcare. ‘Structure’ describes the context, in which care is delivered. ‘Process’ signifies the interactions between patients and providers and ‘Outcomes’ refer to the effects of healthcare on the service user (Donabedian, 1988). The strict chronological progression from structure to process to outcome was promptly deemed too linear (Gardner et al. 2013), frustratingly rigid (Carayon et al. 2006) and ultimately unsuitable for the purpose of this project.

The CIPP evaluation model designed by Daniel Stufflebeam (founder and Director of Ohio state University, USA) in 1963 was intended to systematically guide both evaluators and stakeholders when conducting assessments at the beginning of a project (context and input evaluation), during the project (input and process evaluation), and at the end (product evaluation), Zhang (2011). Based on planning, structuring, reviewing and revising decisions, this model evaluates both summative and formative data. The CIPP model was chosen for this OD as the writer found it uncomplicated to use, relevant as applied and assisted her in focusing on four core concepts - **Context** (Goals), **Input** (Plans), **Process** (Actions), and **Product** (Outcomes).

**Figure 2**
4.3.1 Context Evaluation:

Context evaluation or the identification stage is where the change agent conducts a thorough needs assessment to identify drivers for the change (Appendix 5), and develops SMART objectives to achieve the proposed change (Stufflebeam & Shinkfield, 2007). Chapter 1 and 3 have previously provided the reader with the detailed rationale and methodology for this change project.

4.3.2 Input Evaluation:

Input Evaluation includes a comprehensive analysis of the current environment, resources available and any additional resources required to enable the change process, refer to Chapter 3 (Frye and Hemmer, 2012). An in-depth review of the literature is also required at this stage to support the change. The writer has already critiqued relevant literature on “improving efficiencies in access to care” please refer to Chapter 2.

4.3.3 Process Evaluation:

This stage is an assessment of the implementation of the change with measurement of the practical changes achieved (Frye and Hemmer 2012). It ideally validates the achievement of the aims and objectives and measures the outcomes, projected or otherwise (Zhang et al., 2011). This implementation is supported by the HSE change model (2008) which promotes continuous evaluation throughout the change journey.

Quantitative data was chosen to measure the SMART objectives for this change project.
**Objective 1:** “By March 31st 2015, 80% of surgical patients will be pre assessed prior to day of surgical admission in line with National standards”.

Pre-assessment was historically only carried out for major surgical cases i.e. Whipples procedures, bowel surgery etc. Data collected prior to the implementation of the change recorded a 20% pre-assessment rate in the writer’s organisation. In line with the HSE model for pre-assessment, 80% of all surgical cases require outpatient pre-assessment prior to the day of surgery (HSE, 2014a). Due to the structured and restricted timelines for this project, data collected from Week 1 – Week 17 was analysed and presented in graph format. Data will continue to be collected on a weekly basis allowing an opportunity for any deviations in achieving the national target to be observed and addressed locally. **Graph 1:**

**Graph 1: Pre assessment rate prior to DOSA.**

The 80% line refers to the national target set by the HSE. Week 0 refers to the percentage of patients pre-assessed prior to the change which was 60% below the national target.
Within the first week of implementation, there was a pronounced increase in pre-assessment rates from 20% to 55%, this steady escalation continued until week 4 (21st December) where there was a discouraging reduction in pre-assessment to 42%. The seemingly divergent drop in pre-operative rates can be partly explained thus, week 4, coincided with an anomalous set of circumstances, or, put simply, it was Christmas.

Despite the challenges of increased emergency admissions in January 2016 a steady increase was achieved in pre-assessment. The change agent was redeployed back to her previous role of CNM3 on the 1st Feb (Week 9) and as the graph displays pre-assessment rate was still continuing to rise, reaching an encouraging 74%.

A pre-op assessment rate of 85% was achieved on week 12 which was celebrated and acknowledged organisationally. A decline in momentum was noticed in week 13 when the pre-assessment rate dropped to 63%. A review was carried out locally and a reminder memo was send to all surgical teams, secretaries and CNM of the surgical ward to reinforce the booking process. The current pre-assessment rate is at 80%, which is the agreed national target. The admission lounge will continue to measure weekly pre-assessment rates and will benchmark against national targets. Any drop below the target line will be investigated and action taken.

**Cancellation rates on DOSA**

In line with collecting data for pre-assessment rates, data was also collected to measure the percentage of cancellations on the DOSA. The Model of care for Elective surgery (2012) propose a cancellation rate of less than 5% on DOSA as a good barometer to display effectiveness of pre-assessment clinics. It is imperative to mention here that no
comparative in house data existed on cancellation rates prior to commencement of this project. Week 0 was therefore recorded as 0%.

**Graph 2 – Cancellation rate on DOSA in line with National Cancellation rates.**

The percentage rate of cancellations varied from 0% to as high as 14% on Week 3 and 14.5% on Week 6. The reasons for cancellations were multifactorial and were categorised under the following headings:

**Graph 3:**
Out of a total of 569 DOSA, only 2 patients were cancelled as they were deemed not medically fit on the morning of surgery. This low percentage can be directly attributed to the introduction of pre-op assessment for all DOSA. Comparing the local percentage rate of cancellations on DOSA with the recommended rate of < 5% set by the HSE (2012) demonstrates that the organisation is clearly achieving the predicted results.

**DOSA**

As previously mentioned in Chapter 1 the writer’s organisation was already achieving DOSA rates in line with national targets of 75% Data was collected in relation to actual number of DOSA on a weekly basis and this was mapped in line with a locally agreed weekly admission number of 50 patients. The number 50 was agreed as the admission lounge had capacity for 10 admissions per day.

*Graph 5: Number of DOSA admissions.*
The admission lounge had a steady admission rate of 30 – 48 patients on a weekly basis. The drop in Week 4, to 12 admissions occurred as the admission lounge was only open Monday- Wednesday on Christmas week. The last 2 weeks have seen a decline in admissions; due to increased pressure in the ED department, resulting in reactionary cancellations by bed management.

Objective 2: By December 31st 2015, there will be one point of entry for all patients admitted on the morning of surgery eliminating time wasted.

On commencement of this project two additional administration staff were appointed to work solely on St. Marks Ward. Historically all day cases were retrospectively admitted when the secretary came on duty at 9am, and all DOSA were admitted in the admissions office situated on the ground floor, then sent to a separate Admission lounge on the first floor. As and from 30th November (Week 2) all patients for day-surgery and DOSA were registered exclusively by the receptionist on the day-ward on the first floor. This new system has provided a more streamlined admission process for all scheduled patients on the morning of surgery.

Retrospective registration of day cases was the normal practice- however as of 30th November all day cases were registered as they arrived, as per JCI standards. The number of registrations on the day ward has risen from zero to thirty-three patients.

Table 2 Registration of all daily scheduled Admissions

<table>
<thead>
<tr>
<th>Week - Number of cases daily</th>
<th>Number of DOSA registered Daily</th>
<th>Pre-assessment patients Registered daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Formerly, only patients requiring pre-assessed by the anaesathist were registered on the day of their appointment. Following implementation of the new process a consultant anaesathist was assigned by the change agent to facilitate registration, so all patients attending pre-assessment were registered. This permitted collection of accurate data of patient throughput in the day-ward for day surgery, DOSA and pre-assessment identifying the actual daily activity in the day-ward.

Objective 3: By January 31\textsuperscript{st} 2015, the first daily surgical case in all theatres will start at 8.30 am.

Graph 6 – Transfer time from admission lounge to Theatre reception.

Objective 4 By December 31\textsuperscript{st} 2015, all 28 general surgical patients breaching the 15 to 18 month waiting period will have their surgical procedure completed.
Prior to the implementation of the project, a total of 28 general surgical patients were in breach of the 15-18 month national waiting times set by the HSE (2014b). A financial penalty of 48,000 euro had already been triggered for 25 patients that failed to be admitted within 18 months by end September 2015. A scheduling committee was set up as a sub group of the change team with the overall aim of reducing the current patients breeching the 15-18 month waiting times. All 28 general surgical patients were discussed with relevant consultants and dates identified for surgery. By December 28th 2015 all 28 patients had their surgical procedure completed.

This sub-group will continue to focus on achieving national waiting times of 9 months by December 2016 with patient’s waiting 12-14 months now the new focus. A heightened awareness in the culture of the organisation has occurred with a drive to avoid financial penalties that as an organisation we can control.

Objective 5 By April 1st 2016, there will be a minimum of 10% of all scheduled surgical beds ring-fenced for elective surgery,
Due to the current industrial action nationally in Emergency Departments, it was agreed at senior level to keep this objective on hold at present. The vision for ring-fenced beds will be reviewed in line with achieving national waiting times and avoiding financial penalties by the HSE at local level in the near future.

4.3.4. Product Evaluation

The final stage of the CIPP model is the product evaluation, which recognises and measures whether the project succeeded in achieving the agreed objectives and outcomes. It also gauges if all the individual stakeholders’ needs were met (Zhang, 2011). The three noted benefits to product evaluation are,

1. Provides summative information that can be used to analyse and measure the overall influence of the change.
2. Provides formative information that can be used to readjust processes and improvements to the change in future.
3. Provides insight into the sustainability and transportability in the change and whether it could be used in another healthcare setting (Zhang, 2011).

As previously highlighted in the process evaluation section, the change as a whole was an overwhelming success. Table 3 provides the critical success factors.

<table>
<thead>
<tr>
<th>Critical Success Factor</th>
<th>Reason for Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Communication of overall findings was imperative at all stages, ensuring that both successes and failures were noted and addressed (Stufflebeam and Shinkfield, 2007). Communicating the outcomes was key for</td>
</tr>
</tbody>
</table>
both dissemination of the information, and sustainability of the new process (Kotter, 2012, HSE, 2008). Open communication provided a forum for discussion and any changes to be amended as required increasing success of the change project.

| Data Collection | Data collected was benchmarked against the National HSE targets for comparisons. Visual graphs provided local information on both the progress of the project and challenges met |
| Collaborative change team | Dynamic team of experts were identified as key stakeholders who were committed to the success of this project. Staff inclusion from day one increased a sense of ownership in the project. |
| Effective Change Agent | Accessibility of the change agent working on the ground for the first 2 months provided support, guidance and mentorship for all staff. An awareness of organisational culture assisted in improving overall staff morale with a group-orientated culture where all staff worked as a team |
| Planning phase | Planning phase set realistic time-frames keeping all stakeholders focused. |

The change agent implemented this project in a restricted timeframe, in future projects more time should be afforded to the initiation and planning phases.

Collaboration between organisations and trade unions may in the future support the implementation of Objective 6 (ring-fenced beds).

These strategic tools and processes can be adapted and used in conjunction with the HSE model for pre-assessment units to implement this project within any Irish healthcare organisation. The data collected can be shared externally with other healthcare organisations including the HSE facilitating both learning and the transferability of this change process. Organisational learning will only be effective if all organisations speak the same language and clinical directorates transcend hospital boundaries and are prepared to export learning experiences and knowledge gained.
The writer maintained a reflective diary throughout the project to capture both positive and negative experiences. A sample of five of these reflective pieces using Rolfe model of reflection (2001) are attached (Appendix 12). Rolfe et al.’s (2001) reflective model (Appendix 11) is based upon three simple questions: What? So what? Now what?

Øvretveit (2010) states evaluation only becomes valid when it is disseminated effectively. The project outcomes are currently shared by key stakeholders and departmental leaders at Ward meetings, MDT meetings, CNM meetings, Heads of Department meetings, Bed Management Committee meetings and staff briefings. The writer was also invited to present the project findings at the Consultant executive meeting a rare occurrence with a positive response. The writer has agreed to present the project results to the Ireland East Hospital Group study day on 16th May 2016 and at the HSE pre-op study day on 26th May 2016.

4.5 Conclusion

Evaluating the outcomes of the project has highlighted a marked improvement in efficiencies in patient access to care and patient flow to scheduled care. The CIPP evaluation model provided clear structure for a novice change agent enabling her to evaluate the overall process and highlight that no change agent implements a change alone, it is a team effort. Strengths and limitations will be discussed further in Chapter 5 with a discussion for recommendations for the future.
Chapter 5.

5.1 Introduction

The following chapter will discuss the overall organisational impact of this project. Reference will be made to both theory and practical application. Limitation of the project will be discussed with suggested future alterations and recommendations identified. Critical discussion will be included on the author’s experience of leading an Organisational Development project in the current public healthcare setting.

Changes to services and hospitals are a challenging undertaking, and require openness to a new way of doing things and letting go of ritualistic practices (Kalisch & Curley, 2008). As with any change project a need will be identified, existing policies and current practices will be reviewed, and subsequent discussion and prospective modifications to systems and processes acknowledged (Batalden & Davidoff, 2007; Atkinson et al., 2010.).

The overall aim of the initiative was to “improve efficiencies in access to care and patient flow for scheduled care in a level 4 Dublin academic hospital”.

SMART objectives focused on ‘streamlining the admission process’, ‘adapting a lean approach on morning of surgery’, ‘pre-assessment carried out prior to DOSA’, ‘access to care within national timeframe’s and ‘reduction of cancellations on the DOSA’.
5.2 Project Impact

This project has had an extremely positive impact organisationally with national pre-assessment targets achieved within a short timeframe and potential financial penalties for patients breaching admissions avoided.

5.2.1 Stakeholders

The impact of the project was considered from the perspective of all key stakeholders; and will be discussed under the following group headings, service users, multidisciplinary team, organisation and the author as leader and change agent.

5.2.1.1 Service User

The overall verbal feedback from patients was very positive in relation to pre-assessment, promoting a heightened awareness of the admission process prior to DOSA. Throughout the entire project timeframe a total of 569 patients were admitted on the morning of surgery, with only 2 patients (0.35%) cancelled on the morning of surgery as they were deemed unavoidably not medically fit for surgery. Going forward, patient experience could be measured more comprehensively using a detailed questionnaire to provide objective data to continue to improve services.
Continuous engagement from all members of the MDT from day one helped maintain momentum throughout the project. As with any change, ‘mainstreaming’ can be challenging as staff tend to lose momentum. However, throughout this project the honest display of data and acknowledgement of staff for their hard work instilled a willingness by all team members to continue to improve processes. Building an engaged workforce was a prevention strategy against burnout throughout the project and generated enthusiastic gatekeepers and dynamic change champions (HSE, 2008, Schaufeli et al., 2009).

Feedback sessions at varying interval in the project allowed individual staff-members to express concerns they may have had, allowing improvements to be made quickly. In the initial stage of this change process, an increased workload, change in ritualistic practice and a fear of change were the main stressors identified. An atmosphere of mutual respect, trust and consideration for each other was reinforced by all team members (Maslach, 2011; 2009; NHS, 2013). The team gained strength and inspiration from each other in achieving a common goal with a palpable tangible improvement in current services provided to the scheduled patients.

Engaging the MDT within all stages of the change project, from the initial stage of creating the vision to the implementation of the agreed SMART objectives, equipped the team with the necessary coping skills to deal with the challenges encountered. Effective change requires such engagement, whilst being mindful of job demands and related stressors (HHS, 2011, Gill, 2011). A clear governance structure and a strong sense of organisational ownership of project outcomes supported the MDT throughout the project implementation.
5.2.1.3 Organisation

From the first day of this project, Organisational support was evident, primarily focusing on achieving outcomes from both a local and National perspective. The HSE Model of care for pre-assessment units (2014), Model of care for elective surgery (2012) and the National waiting list management protocol (2014), assisted enormously in creating a constructive focus on improving efficiencies in access to care and patient flow for scheduled patients. Working within an organisation already challenged financially required creativity and innovation to maximize use of current resources and improve overall patient experience and sustain performance.

Heretofore a fragmented culture was evident on day 1 of the project with all three departments working in silos with no clear leadership. In contrast, by Week 17, the day ward displayed a communal culture, cohesion between all three departments, and clear leadership from the CNM2 supported by clear governance.

The writer would like to acknowledge that the project sponsorship by the Chair of Surgery was fundamental to project awareness, and provided both power and invaluable influence throughout the change process.

5.2.1.4 Writer as Leader

This was the writer’s first experience of leading a change project. The knowledge and leadership theory gained in year one of the RCSI Masters program was fundamental in supporting the journey of this novice change agent.
The choice of the HSE change model (HSE, 2008) provided structure and guidance to the project with added support from the HSE change hub, providing necessary change tools. The literature review revealed the intensive efforts being made nationally and internationally to support the benefits of POAC and DOSA and how they can both work together to improve efficiencies in access and patient flow for scheduled care. The personal journey of the writer has been evaluated using Rolfe’s reflective model (see appendix 12).

The writer has developed an enduring regard for the importance of leaders and leadership to achieve change. Throughout the project the author was actively learning and developing as a leader, using effective interpersonal skills to influence others to accomplish project goals (Gill 2011, Joyce, 2012).

5.2.2. Practice

Overall, this project has been a resounding success with national targets achieved in relation to pre-op assessment rates and waiting times. Ritualistic practices have been weaned out and replaced with this new process. Organisationally there is evidence of a collaborative approach to maintaining momentum for this change. The original change team has agreed to continue their fortnightly meetings to measure progress and change processes as required. The sub group is also going to focus on the 14 month waiting times with a drive to achieve the national target of < 8 months.
5.2.3 Theory

Both the extensive literature review carried out and the wealth of grey literature from the HSE provided ample evidence and resource to drive this change. Modernisation in the current Health services demands change to time-honoured practices so hospitals can optimise all and every allocated resource (HSE, 2014). Studies have shown that DOSA and POAC are beneficial firstly to the patient, by reducing cancellations on DOSA, medical optimisation and improved patient experience (Akhtar et al, 2013, Nicholson at al, 2013), and secondly to the organisation, by reducing length of stay and delivering safe efficient care (HSE, 2012, HSE, 2014)

5.3 Strengths of the Project

The HSE change model and the CIPP evaluation model provided tremendous structure, guidance and adaptability throughout the process.

Overall this project achieved targets set by the HSE making it a viable project,

1. Achieved 80% pre-assessment rates prior to DOSA
2. Minimal number of cancellations of DOSA.
3. Avoided financial penalties for patients waiting between 15-18 months for surgery.
4. Streamlined admission process.

As the writer was allocated solely to St. Marks ward for the first 2 months, this enabled issues to be addressed directly, as they arose (Ford et al, 2008), facilitating constant
scanning of the environment, ensuring old ritualistic ways were being identified and phased out, and providing continuous support to staff (Pons, 2012).

Initial resistance was in reality minimal, all issues were addressed as they happened, allowing flexibility within the project plan (HSE, 2008), and the appointment of a committed change champion continuing to drive the project in the absence of the change agent. Another key strength was the strong buy-in and support from senior level management in the organisation (Kotter, 1996). In financial terms, the change process was delivered on a cost-neutral basis, with the added bonus of a reduction in cancellations having the effect of reducing overall revenue loss for both the organisation and the patient alike.

5.4. Limitations of the Project

Time restrictions were a limiting factor preventing the writer from evaluating the patient experience with a full patient satisfaction questionnaire.

The inadvertent and surprising absence of any in-house data on cancellation rates prior to the change presented a problem as the writer had no local data to benchmark success or failure of cancellation rates against. The writer ultimately did benchmark against the HSE rate (HSE, 2012). This historically heedless practice actually facilitated increased numbers of cancellations and reduced ownership and responsibility felt by relevant stakeholders.

Sadly, unforeseen mandated industrial action in the Emergency department resulted in Objective 6 (protected beds) of the project being shelved/postponed.
5.5 Recommendations

Key decisions for the future direction of this change project include continued monitoring of the effect of this change process.

The appointed change champion needs to be supported and encouraged to improve and change processes as required.

The data needs to be regularly presented locally both at ward level and senior executive level, keeping all stakeholders informed of successes and failures.

A patient satisfaction questionnaire needs to be audited to measure objective feedback from service users.

Protected (ring-fenced) beds need to be implemented in the near future as they are a key factor in streamlining the entire admission process, reducing the number of cancellations on DOSA due to ‘no bed available’.

5.6 Conclusion

There is little doubt that one of the biggest challenges facing healthcare today is change and unless change becomes an intrinsic part of everyone’s job within healthcare, hospitals and staff cannot realise their full potential (Atkinson et al., 2010; HSE, 2008; HIQA, 2012). Too often a poorly orchestrated process can overshadow the standard of care delivered to service users. Organisational development projects like this one enable organisations to
deliver the rightful and humanistic level of healthcare the public deserves (Coughlan and McAuliffe, 2003).

Effective leadership requires an awareness of how actions and behaviors affect the experiences of patients and service users of an organisation, the quality of care provided and the reputation of the organisation itself (NHS Leadership Academy, 2013, Gill, 2011). The writer endeavoured to create a shared purpose for change, supported by the HSE change model in order to develop the service to meet the pressing needs of patients and staff (HSE, 2008; NHS Leadership Model, 2013).

Undertaking the project allowed the writer and the change team to “improve efficiencies in access to care and patient flow in scheduled care”. The benefits to the patient, the staff and the organisation are already evident by the data collected. The change champion will now be the gatekeeper, sustaining momentum for the future.
References:


Health Service Executive (2014 a) Model of Care For Pre-Admission Units. Dublin: Health Service Executive.


Illes, V., Sutherland, K. (2001) Managing Change in the NHS. Organisational Change. A
review for Health Care Managers, Professionals and Researchers. London: National Coordinating Centre for NHS Service Delivery and Organisation R&D.


http://www.wilmarschaufeli.nl/publications/Schaufeli/316.pdf


## Appendix 1:
### Stakeholder Analysis

<table>
<thead>
<tr>
<th>High Power/low interest</th>
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<tbody>
<tr>
<td>CEO</td>
<td>CNM2 clinical area</td>
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<tr>
<td>HSE- Low interest at organisational level</td>
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<tr>
<td>Medical consultants</td>
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<td>ED</td>
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<td>Head of Bed management</td>
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<td>Finance</td>
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<th>Low Power/ Low interest</th>
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<tr>
<td>Admissions office</td>
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<tr>
<td>Porters</td>
<td>Administration manager</td>
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<td>Filing room</td>
<td>Finance</td>
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<td>Admission Lounge, Pre-op assessment and Dayward</td>
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<td>Business Manger</td>
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<td>Statistics</td>
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<tr>
<td></td>
<td>Trade unions</td>
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Appendix 2

22nd September, 2015.

Ms Josephine Ryan,
Clinical Nurse Manager 3,
Diagnostic and Peri-operative Directorate
St. Vincent’s University Hospital,
Elm Park,
Dublin 4.

Re:- The Implementation of Ring-fenced beds for scheduled general surgical patients within national guidelines.

Dear Ms Ryan,

Thank you for your correspondence dated 22nd September 2015 to the Ethics Committee regarding the above project.

As Chairman of the Ethics and Medical Research Committee I have reviewed your correspondence and I have decided that this does not require Ethics Committee approval.

Yours sincerely,

Dr. E. Molloy,
Chairman,
Ethics & Medical Research Committee
Appendix 3

Lewin 3 step Change Model

Kotter 8 Step Change Model
### Appendix 4

#### Swot Analysis

<table>
<thead>
<tr>
<th><strong>Strengths</strong></th>
<th><strong>Weaknesses</strong></th>
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<tbody>
<tr>
<td>Supportive management Structure</td>
<td>Financial Budgetary constraints</td>
</tr>
<tr>
<td>Clear governance</td>
<td>Fear of change.</td>
</tr>
<tr>
<td>Support and protected time given to the change agent to implement the project and support staff.</td>
<td>Fragmented culture with a lack of leadership</td>
</tr>
<tr>
<td>Pre-assessment unit already available</td>
<td>All three departments- day ward, pre-op assessment and admission lounge working in silos.</td>
</tr>
<tr>
<td>Admission lounge relocated to the day ward</td>
<td>Lack of space</td>
</tr>
<tr>
<td>Organisation already achieving national targets of DOSA</td>
<td>Workforce planning – no new head count available to support the increased throughput.</td>
</tr>
<tr>
<td>Adherence with HSE targets</td>
<td>Bed management due to increased throughput through ED</td>
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<table>
<thead>
<tr>
<th><strong>Opportunities’</strong></th>
<th><strong>Threats</strong></th>
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</thead>
<tbody>
<tr>
<td>HSE model of care for Pre-assessment units.</td>
<td>Financial constraints</td>
</tr>
<tr>
<td>Wealth of literature to support the need to change.</td>
<td>Increased demands on an already stretched ED resulting in cancellations of scheduled admissions.</td>
</tr>
<tr>
<td>Reduced length of stay for patients</td>
<td></td>
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<tr>
<td>Patient centred and increased patient satisfaction.</td>
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Appendix 5
Pestle Analysis

P (Political)

- Health Service Executive.
- Ireland East Hospital Group (IEHQ)
- Special Delivery Unit
- National service plan 2015
- RCSI Model of Care for Pre-assessment Units 2014
- National waiting list management protocol 2014
- Key performance indicators, both internally both local and national.
- Politicians
- Patients
- Trade unions/ patient representative groups.

E (Economical)

- HSE finance directorate with overall responsibility for operational financial support to health services, delivering finance and enhanced accountability and value for money (HSE, 2011).
- Increased demands on beds for the emergency department resulting in cancellations of scheduled procedures.
- Increased demands on pre-operative assessment units to facilitate DOSA.
- Budgetary cuts within the organisation.
- Increased expectations from patients to arrive on morning of surgery to reduce hospital length of stay.
- Management of allocated budget for the scheduled directorate-overall responsibility Director of Scheduled care.
S (Social)

- National demand on Level 4 Hospital within the Ireland East Directorate
- Lack of tertiary referral centers to refer these patients
- Increased awareness by the public, patient representative groups.
- Increased demands by patients
- Low morale of nursing and other allied health professionals resulting from increased demands and pressures.
- Pressures on CNM to cancel patients by telephone at short notice.

T (Technological issues).

- Data managers
- E-referral systems
### Appendix 6. Revised Stakeholder Analysis

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<td>Hospital Business Manager</td>
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Appendix 7 – Correspondence from the HSE

TO: Ms. Mary Day, CEO, Ireland East Hospital Group

CC: Prof. Michael Keane, CEO, St. Vincent’s University Hospital
    Mr. Kevin O’Malley/Prof. Risteard O’Laoide, Clinical Directors, Ireland East Hospital Group
    Mr. Stephen Sheehan, Clinical Director, St. Vincent’s University Hospital
    Ms. Ann Donovan, CNO, Ireland East Hospital Group
    Ms. Ann Flynn, DON, St. Vincent’s University Hospital
    Ms. Josephine Ryan, CNM3, Scheduled Care, St. Vincent’s University Hospital
    Dr. Hugh Gallagher, Chair of Anaesthesia, St. Vincent’s University Hospital

17th February 2016

Dear Ms. Day,

Re: Model of Care for Pre Admission Units

The National Clinical Programme for Anaesthesia published the Model of Care for Pre Admission Units in December of 2014 and has been tasked by the Acute Hospitals Division of HSE to follow on with the implementation of the Model in hospitals nationally with emphasis on the group structure and report on progress.

The Model sets out the key components essential for the optimisation of patient flow and throughput which begins with pre assessment and pre-operative preparation of the patient, which is achieved by the implementation of a successful Pre Admission Unit which in turn increases DOSA rates and reduces patient cancellations. In all of our site visits we found very enthusiastic people working on the ground to progress pre admission locally with good support from hospital management.

In compliance with the directive from the HSE, NCPA visited St. Vincent’s University Hospital, Dublin on 15th February 2016 to meet with hospital management and the multi-disciplinary team working in pre admission to present the Model and to see what is in place on the ground.

In SUVH we were delighted with the multi-disciplinary team present at our presentation, Ms. Josephine Ryan, CNM3, who was appointed Project Lead for Scheduled Care in November last made a very informative presentation to our team on the background and areas for improvement in PAU and is an excellent champion for PAU, utilising the Model of Care for Pre Admission Units to enable quality improvement. The NCPA were very impressed with the progress to date and the multidisciplinary teamwork and governance structure in place in SVUH which has seen an increase in DOSA rates. Future targets are in place and audits planned.

Of note however, urology patients are not seen in PAU and this is an area which NCPA feel should be addressed. NCPA would also like to see improvement in the IT system currently in place to enable hospital group access to diagnostic results. There is currently no documented and clear pathway to access diagnostic referrals for patients in PAU, and the programme would like to see this addressed.

Follow up reports are required by HSE and to assist with this and in keeping with the directive, NCPA have devised a set of standard KPIs in the form of a RAG Status Report that each unit should incorporate into its performance management approach. This RAG status report will be circulated in the coming months to each hospital for completion and continuous review by NCPA.

If you require any further clarification or assistance in addressing the above concerns, please do not hesitate to contact us

Dr. Jeremy Smith, Clinical Lead, NCPA

Ms. Una Quill, Programme Manager, NCPA
Ms. Aileen O’Brien, Clinical Nurse Lead, NCPA
Appendix 8 – Organisational Governance Structure for the Change Project

Clinical Director of Peri Operative Care
  Mr Stephen Sheehan

Chair of Department of Surgery
  Mr James Geraghty

Director of Unscheduled Care
  Ms Kay Connolly

Project Team Lead
  Ms Josephine Ryan
  CNM 3

CNM2 Day Ward
  ADON for Scheduled Care Directorate
  Anaesthetic Consultant
  Administration Manager
  CNM3 Theatre
Appendix 9

Process Mapping of Patient’s Journey prior to the change.

Patient is referred via e-referral for surgery → Patient get listed at MDT meeting for surgery → CNM on ward sends list to theatre Junior doctors slips patient for theatre.

Patient receives a phone-call from CNM two days before surgery

Patients arrives to hospital and goes to admissions office 7.30 am

Patient walks from admission office to admission lounge on first floor.

Admitted by nurse in a treatment room.
Returns to admission lounge

Patient sent down to get pre-operative bloods taken.
Returns to Admission Lounge

Admitted by doctor.
Returns to Admission lounge

2 hour delay waiting for bloods to be cross matched

Called for from theatre
Up to 1 hour delay before arriving in theatre reception

Assessed by anaesthetist in theatre check-in
Plan: Either proceed to operating room or Cancelled as medically unfit for surgery.
Appendix 10

RULES FOR ADMISSION LOUNGE.

1. There will be 10 slots allocated for each day and these have to be divided evenly between all specialties – (these slots include both public and private patients)- see attached sheets for each day.

2. Booking or amendments to the list have to be done by 12.30pm the day before. Any changes after this time will not be facilitated.

3. The lists needs to be sent 1 week in advance to ensure at least 80% of patients are pre-assessed on the morning of surgery.

4. Communication need to be made direct to Patrice Burns via email or in person- no post-it notes accepted.

5. Teams to ensure slots available for their patients as an email is not confirmation of a slot.

6. In the absence of Patrice Burns the teams need to communicate with the CNM of St. Marks ward.

7. Nurses in the Admission lounge cannot accept booking from the medical teams or Clinical Nurse specialists.

8. The surgical team or CNM's of the Clinical area are to inform patients when they are cancelled by the team.

9. Any specific requests for pre assessment need to be added to the surgical notification form- see amended form.
Appendix 11 Rolfe et al Reflection Model 2001

[Diagram showing a cycle with labels: What?, Framework for reflective practice, Now what?, So what?]

Rolfe et al. (2001)
Appendix 12- Personal Reflective using Rolfe et al Reflective Model 2001

Reflective Piece 1: Mandated industrial action impact on Ring-fenced beds implementation.

What:
The initial vision for the writer’s change project was to implement a program of ring-fenced (protected) beds for scheduled care in line with the HSE model of care for elective surgery (2012). This vision was communicated to all relevant stakeholders and support provided by the chair of surgery and senior management from Day one.

So What:
Mandated industrial action in the Emergency department in the writer’s organisation impacted severely on the implementation of this vision. The Irish Nursing Midwifery Union (INMO) instructed that all patients were to transfer out of the ED department once a ward bed became available to facilitate a reduction in the number of admitted patients waiting on trolleys. As a knock on effect of this mandated industrial action, the organisation was prohibited not permitted ring-fencing beds.

Now what?
The writer realised that this project would fail before it even begun- hence the vision for the change project was reviewed with senior management and a new direction taken. The focus was now going to be place on improving efficiencies in access to care to scheduled patients. However, this vision of ring-fenced beds was set as one of the SMART objectives. To-date this objective is still on hold. Notwithstanding this position, a definite need has been identified by senior management to support this vision in the next few months in line with all the phenomenal work that has been achieved with pre-assessment and day of surgery admission.
Respective Piece 2: First meeting at senior management level

What
A clear governance structure was developed for this change project with clear and defined roles established early on. As part of my role as the change agent, I had to attend many different strategic and operational meetings at varying levels within the organisation. A senior surgical committee was set up with defined terms of reference and stakeholders identified, i.e. chair of surgery, clinical lead, Director of unscheduled care, anaesthetic consultant, business manager etc. I was asked to communicate my objectives, and timelines for this project at the first meeting with updated data to be presented every fortnight.

So what:
At first I was apprehensive when interacting with members of senior management and felt that I had to build respect with these key people. I was fortunate to have support and guidance from the Director of unscheduled care and this armed me with the necessary skills and confidence to communicate my points to other stakeholders. In addition I also used the skills I had developed in year one of my masters, i.e. engagement, feedback, communication and respect for individual viewpoints (GILL, 2011). Throughout the first meetings I recorded key words and made notes of what was expected of each member of the team. I realised that this team was willing to support me with this implementation and this positivity strengthened my resolve to succeed.

Now what?
Throughout the change project I have continued to attend these meetings on a fortnightly basis and have developed rewarding and collaborative relationships with senior management within the organisation. Data was presented clearly and honestly, at every
meeting identifying the progress and achievements that were made on St. Mark’s ward. Data not only supported the success of the project but also helped the writer as novice change agent to gain good credibility and respect within the organisation.

**Reflective Piece 3: Day 1 of the project- fear of change from staff**

**What?**
As the change agent I was assigned to work solely on St. Marks ward for a 2 month period. I had never worked on this ward before so staff had no previous experience of working with me. On the first day there was an air of uncertainty from the staff nurses of what exactly was going to change and apprehension about the impact this change was going to have on their day to day routine.

**So what?**
I was acutely aware that in order for this project to succeed I needed ‘buy in’ from all the staff. I spent the first few days observing the day to day running of the ward identifying the ritualistic practices and areas for improvement. I communicated with all the staff and asked for their opinions and ideas. I realised that the staff were invaluable in helping to improve current processes. Open communication from day one allowed staff involvement and engagement which in turn reduced resistance. Fear of extra work onto their already busy workload was the main concern expressed. Constant communication at ward level and recognition of challenges that were met and dealt with has assisted in developing a motivated team. Results were celebrated and recognition for the hard work of the staff on St. Marks ward was recognised organisationally.
Now what?

Ritualistic practices have been replaced with the new process; these changes are now embedded into the day to day ward culture. Staff nurses now appreciate that efficiency in the admission process on day of surgery eliminates time wasting and actually decreases stress level, while increasing patient throughput. Staff have reported that they feel they now use their time more efficiently and experience less frustration trying to get medical teams down to admit and consent patients prior to transfer to theatre. A champion nurse is continuing to drive this change and is constantly identifying other areas for improvement, i.e. development of a patient information leaflet.

Reflective Piece 4: Presenting to HSE

What?

I was invited by the Surgical Clinical Lead to formally present to the Health Service Executive team for the Model of Pre-assessment units to update them of our success in pre-assessment rates to-date.

So What?

I was apprehensive presenting to the HSE as I had never been afforded this opportunity before. My previous experiences were presenting both in classes during my Masters and locally in my work environment. I delivered my presentation in a positive manner, highlighting our success in achieving the national target and openly discussed future plans. I strongly recommended the need for the champion nurse to sustain momentum of this new process. Following the presentation I took the three members from the HSE on a guided tour of the pre-op assessment units and provided an opportunity for them to meet staff and see our documentation. This informal setting allowed me the opportunity to
network with external collaborative bodies and helped me develop new networks to support both my project and also my career development. Following the visit a letter was sent to the Ireland East group CEO and the CEO of the organisation highlighting the positive progress that they had seen during their visit.

**Now What?**
This experience has allowed me to develop my confidence, increasing my awareness of the value of my skills and abilities to lead and succeed in a project implementation. Also, I have become a devoted believer in the power of data. If you want to convince someone of something, show them the numbers.

**Reflective Piece 5. Reaching the national target**

**What?**
Prior to implementation of this project, the pre-assessment rate in this organisation was around 20% and in reality often lower. The HSE model for pre-assessment units (2014) set the National targets at 80% pre-assessment prior to Day of surgery admission (DOSA). By week 10 of the project, St. Mark’s ward reached this target. A sense of accomplishment is almost better than a day off.

**So what?**
The data was presented locally in graph form and presented at various different meetings within the organisation. The senior stakeholders and consultants were delighted with this achievement and staff on St. Marks ward were congratulated by other staff, hospital wide. These successes provided momentum and drive to continue to achieve the national target. It also affirmed that the target was achievable and required constant commitment and drive from all members of the change project. I with my team am scheduled to present the
results of this project to the Ireland East Hospital Group in Farmleigh in May

Now what?

A continuous drive to achieve the national target remains and despite a slight drop, we have once again reached the national target. Following recommendations and suggestions from staff, amendments have been made and there is more buy in from the surgeons to achieve pre-op assessment prior to DOSA. Theatre nurses have reported a noted improvement in theatre times since implementation of this project.
Appendix 13. Poster Presentation

Streamlined Day of Surgery Admission Process in a level 4 Dublin Academic Hospital.

Introduction & Background

Modernisation of the current hospital care system demands changes to time-honoured practices.

Factoring the cost of a hospital bed at 1000 euro a day and an individual surgical case costing 5,000 euro, it makes sense to maximise use of the day of surgery admissions.

Pre-operative assessment is key in ensuring both efficient and effective patient care.

Aims & Objectives

Aims:

To streamline admission process for scheduled patients.

Ensure 80% of patients are pre-assessed prior to day of surgery admission.

To ensure all 26 patients breaching the 15-18 month waiting time have their surgery completed by Dec 2015.

Objectives

1. By February 2016, 80% of surgical patients will be pre-assessed prior to day of surgery admission in line with National standards.
2. By February 2016, there will be one point of entry for all patients admitted on the morning of surgery eliminating time waste.
3. By February 2016, the first daily surgical case in all theatres will start at 6.30 am.
4. By December 2015, all 26 general surgical patients breaching the 15-18 month waiting was will have their surgical procedure completed reducing financial implications to the organisation.
5. By April 2016, the writer’s organisation will have achieved the national KPI’s for waiting times of 8 months.

Methodology

The HSE Change model was chosen because:

- Four steps are adaptable and easy to use for a novice change agent
- This Irish model is clearly designed and structured within control and jurisdiction.

Initiation:

- SWOT analysis, POST Analysis, Stakeholder Analysis, Force Field Analysis.

Planning:

- Communicating the Vision.

Implementation:

- "Going live" phase
- “Mainstreaming” phase
- Replacing ad-hoc practice.

Evaluation

Organisational Impact

- Achieved 80% pre-assessment rates prior to DOSA.
- Minimal number of cancellations of DOSA.
- Avoided financial penalties.
- Streamlined admission process.
- Staff Nurse is the Change Champion.

Conclusion

Ritualistic practices have been weaned out and replaced with this new process.

References

Abstract

This organisational development change project focused on improving 'efficiencies in access to care and patient flow in scheduled care' in a level 4 Dublin Academic Hospital. The Health Service Executive (HSE), launched its 'Model of Care for Pre-assessment Units' (2014) as a guide for organisations to implement pre-admission units locally and facilitate pre-assessment as an out-patient service. This model was designed to be used in collaboration with the 'Model of Care for Elective Surgery' (2012) which promoted Day of Surgery Admission (DOSA) and improved access to scheduled beds. Within the writer's organisation, DOSA were reaching the national target of 75% despite an inefficient use of the pre-assessment clinic with only 20% of patients pre-assessed prior to DOSA. Twenty eight patients on the waiting list, the hospital was going to incur a financial penalty from the HSE if the patients were not treated by the end of December 2015.

Aim: Our aim was to ensure that 80% of scheduled patients were pre-assessed prior to DOSA in line with HSE targets. As a secondary aim, the organisation requested that 28 patients currently breaching the 15-18 month waiting times for surgery would be operated on by end December 2015.

The role of the writer was to lead this change initiative and feedback progress and data to all internal and external stakeholders. The HSE change model (2008) was used through the four phases of the change process it was clearly designed for the Irish Healthcare system. The CIPP model was used to evaluate the impact of this change project, and assisted the writer on focusing on four core concepts: Context (Goals), Input (Plans), Process (Actions), and Product (Outcomes).

Overall, this project has had an extremely positive impact organisationally with national pre-assessment targets achieved quickly and potential financial penalties avoided. Pre-assessment rates have risen from 20% prior to implementation of the project to 80%, with the project completed at Week 10,12 and 17. All twenty eight patients breaching the 15-18 month waiting time have had their surgery completed. Ritualistic practices have been weaned out and replaced with this new process. Organisationally there is evidence of a collaborative approach, maintaining momentum for this change and a staff nurse on the day ward is the change champion for this project.

To conclude, undertaking the project allowed the writer and the change team to ‘improve efficiencies in access and patient flow in scheduled care’. The benefits to the patient, the staff and the organisation are already evident by the data collected. The change champion will be the gatekeeper sustaining momentum for the future.

Change is an unending journey that has no end because, hospitals succeed by constantly changing and adapting new ways of doing things (Kalisch & Curley, 2008).