Accessing Outpatient, Inpatient and Day Case Services in Acute Hospitals in Ireland

January 2014
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Introduction

This policy applies to all publically-funded hospitals that provide outpatient (OP), inpatient (IP) and day case (DC) services in Ireland. This policy is being launched simultaneously with revised versions of the Protocol for the Managements of Outpatient Services (January 2012) and the National Waiting List Management Policy (January 2013). The core principles detailed in this policy are supported by the above documents.

Accessing Outpatient Services in Acute Hospitals

This access policy is relevant to patients who have been referred to a consultant-led outpatient clinic for a new appointment. The source of the referral (SOR) should be agreed between the hospital and the referrer within the range set out in the Protocol for the Management of OP Services.

Receipt of Referrals

1. All referrals should provide, at a minimum, the data set out by HIQA1. This applies to ‘direct bookings’, rapid access patients, and OP trauma patients such as fractures, ophthalmic and plastics trauma. Where the minimum data set fields have not been provided the referral request should be directed back to the source of referral (SOR) for accurate completion.

2. Urgent referrals that are incomplete should be populated by phone where possible in order to prevent any delay of processing of such cases.

3. The minimum data should be provided by all sources of referral including within hospital referrals such as consultants or ED, or other hospitals and services.

4. Referrals should be made to a speciality or a service and pooled, sub-specialisation permitting.

5. The patient should be added to the PAS/HIS within 24 hours of receipt of the referral request. All patients who attend an outpatient service, (regardless of the source of referral) should be registered and/or captured on the hospital PAS/HIS system.

6. Cross-site cover should be put in place for the management of referrals where clinicians are not present on a weekly basis (regularly or due to leave).

Determining OP Wait Time

1. The OP wait time starts on the date the referral is received by the hospital.

2. The wait time ends when the patient is seen by a consultant or an authorised member of his/her team.

3. Wait time is affected by other factors such as failure to attend, direct admission and rejection of referral. Details of counting rules for management of referrals are contained in the Definitions for the Management of Outpatient Services.

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1 Report and Recommendations on Patient Referrals from General Practice to Outpatients and Radiology Services including the National Standard for outpatient Referral Information (2011) and the National Standard for Better Safer Healthcare (2012).
Management of OP Wait Lists

1. As an overarching principle all patients should remain on the new waiting list until they have (a) been seen by the consultant or an authorised member of his/her team, or (b) directed to an authorised service with a separate wait list (e.g., day case or inpatient services).

2. All patients who have been on an outpatients waiting list for three months or more should be validated bi-annually.

3. All outcomes of the validation process should be documented on the Patient Administration System (PAS) or Hospital Information System (HIS).

4. All patients are chronologically managed on the OP wait list regardless of SOR or public/private status.

5. When a patient is removed from a waiting list the reason should be specified as per the Protocol for the Management of OP Services.

Clinical Prioritisation/triage

1. All referrals should be clinically prioritised/triaged by the relevant clinician within 5 working days of receipt into an urgent or routine category.

2. Referrals deemed urgent by SOR should expedited by the consultant’s team in regard to determination of clinical need. Outcome of clinical prioritisation by the acute hospital clinician may differ from that of the SOR.

3. SOR and patient should be acknowledged on receipt of referral, with the SOR receiving notification as to the determination of clinical prioritisation/triage by the acute clinician and expected duration of wait to be seen.

4. Where clinical prioritisation/triage exceeds the 5 working day turn around, patients should be booked as per SOR categorisation of urgency.
Scheduling of Patients for OP Appointment

1. All patients should be scheduled within agreed maximum wait time guarantees whether urgent (including rapid access and suspected cancer) or routine cases.

2. Patients determined to have urgent clinical needs by the acute clinician must be booked within the maximum wait times agreed locally with clinicians and the clinical programmes for that specialty/condition.

3. Routine patients should be booked in chronological order as per the current waiting list.

4. Patients should be offered a choice of appointment and afforded a minimum of three weeks’ notice to attend.

5. If the hospital cancels a scheduled urgent appointment, the patients should be re-appointed urgently into the consultant’s next clinic.

6. If the hospital cancels a scheduled routine appointment the patient should be offered an alternative appointment within 3 weeks.

Failure to attend/appointment rescheduling

1. If the patient fails to attend (DNA) a scheduled OP appointment he/she should be removed from the wait list and returned to the care of the SOR.

2. The SOR and patient should be notified by letter of removal from the wait list.

3. As a general rule, patients who fail to attend will not be offered a second appointment, unless the clinician indicates high clinical or other need that requires immediate and/or special attention.

4. If the patient could not attend (CNA) their scheduled appointment and gives reasonable notice to the hospital (not less than 24 hours) they should be re-scheduled to an appointment date within six weeks of the request.

Discharge Planning

1. Discharge planning should commence at the first appointment and should continue until the patient is referred back to their source of referral as appropriate.

2. Patients should be routinely discharged unless the relevant clinical lead determines that expert specialist care is required which is not available in a primary care setting.

3. All discharges should be returned to SOR with an agreed discharge summary.
Determining the waiting list

The waiting list includes all patients who are:

1. Waiting for a booked date for a procedure (Active), or

2. Have a booked date for a procedure - known as a To Come In date (TCI) or

3. Are temporarily unsuitable for their procedure (Suspended) or

4. Those patients who are waiting to be recalled for a further stage in their course of treatment. These patients are put on the Planned Procedure List.

Identifying priority

All patients added to the list must be triaged into either an urgent or routine priority. No other priority must be used.

Patients should be selected for admission in the following order of priority:

1) Urgent patients who have been previously cancelled by the hospital

2) Urgent patients

3) Routine patients who have been previously cancelled by the hospital and

4) Routine patients who have been waiting for their procedure longer than anyone else on the routine list.

Under no circumstances should a patient be scheduled for admission who has been waiting for a shorter period than another patient who has been waiting for the same procedure, with the same clinical parameters.

When to schedule the patient

The following criteria must be employed when booking a patient for a procedure (TCI):

- Patients must be fit, ready, and available for their admission.

- Patients should be scheduled no more than six weeks in advance for their procedure.

- Routine patients should be given a reasonable period of notice for their procedures, not less than three weeks is considered reasonable.

- If a patient refuses a first date for admission (in not less than 3 weeks) they should be offered one more date after that and if they refuse this they should be referred back to their GP as not available for their procedure.

- The preferred method of communicating with a patient to determine whether they are fit, ready, and available for their procedure is via the telephone. Where telephone communication fails a letter should be sent to the patient seeking the same information. If there is no response within 4 weeks the patient should be referred back to their GP.
How to add a patient to the waiting list

The decision to add a patient to a waiting list is made by a Consultant or Registrar. Patients are only added to the waiting list when the relevant waiting list application form or card is completed in full. It must be dated and signed by the Consultant or Registrar. All the information on the waiting list form or card must be entered into the hospital Patient Administration System (PAS) or Hospital Information System (HIS) within 72 hours of its completion. The initial date the ‘decision to admit’ was made should be entered onto the PAS or HIS as the ‘start wait date’. This date should not be changed or revised at any point of the patients journey through the scheduled care system.

Dealing with cancellations

There are two ways in which a patient’s procedure can be cancelled, the hospital can cancel or a patient can cancel.

If the hospital cancels the patient the patient should be re-scheduled as per above - determining the priority.

If the patient rings to cancel their own procedure within a reasonable timeframe, (i.e., not less than 5 working days before), and with a genuine reason² for the cancellation the patient should be offered another date within a reasonable time frame. If the patient subsequently rings to cancel the 2nd date they should be referred back to their GP.

If a patient fails to attend for their procedure and have not given the hospital any notice they should be removed from the waiting list immediately and referred back to their GP.

All hospitals should keep a list of patients who are willing to come in at short notice, so that if a patent does ring to postpone their procedure with a genuine reason they can fill the vacant slot.

Suspensions

When a patient becomes unavailable for their procedure due to change in their clinical condition they can be clinically suspended. This suspension should be for a maximum of three months. After the three months has expired the patient should be clinically reviewed and re-instated onto the list as active if they are fit, ready, and available for their admission. The date the patient is added to the list does not change once they are re-instated. If they are still not fit, ready and available for their admission they should be referred back to their GP and removed from the waiting list.

² A genuine reason should be something out of the ordinary that has had a profound effect on that patient.
Meaningful validation of the patients on the waiting list

All hospitals must ensure that there is an administrative process in place where patients are contacted every six months to ensure they are fit, ready and available for their admission. This can be done by telephone or in writing. Patients who are not fit, ready and available for their admission should be referred back to their GP and removed from the list.

The planned procedure list

Patients who have already accessed the hospital for their initial procedure but need to attend for follow-up ones should be added to the planned procedure list. These patients should not be on the waiting list as they are not waiting for their procedure. This includes:

1) Patients who need bi-lateral procedures, such as removal of pins following orthopaedic surgery, hip or knee replacements and removal of a 2nd cataract.

2) Timed procedures that are delivered at regular intervals, such as chemotherapy administration, immunoglobulin infusions, nerve blocks, repeat or surveillance GI Endoscopy.

3) Staged procedures such as plastic surgery where a series of procedures is required.

Audit and Quality Assurance

In order to assure the quality of the data supplied by hospitals to the National Treatment Purchase Fund an audit and quality assurance review will be carried out in each hospital on an annual basis or as required. The review will include outpatients, inpatients and day case data. The purpose of the review is to establish if hospitals are adhering to the requirements set out above and are an accurate reflection of the waiting list. Any actions emanating from the review will be monitored on a weekly basis.