Report of the unannounced inspection of the Emergency Department at Cork University Hospital against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	Cork University Hospital
Address of healthcare service:	Wilton Manor, Glasheen, Cork
Type of inspection:	Unannounced
Date of inspection:	15 June 2022
Healthcare Service ID:	OSV-0001064
Fieldwork ID:	NSSBH_0006

About the healthcare service

The following information describes the services the hospital provides.

Model of hospital and profile

Cork University Hospital is a Model 4[*] tertiary referral centre. The hospital is a member of, and managed by, the South/South West Hospital Group[†] on behalf of the Health Service Executive (HSE). Within the South/South West Hospital Group, Cork University Hospital also forms part of Cork University Hospital Group with Cork University Maternity Hospital, Mallow General Hospital and Bantry General Hospital.

The hospital is a regional centre for secondary and tertiary care for the catchment area of the HSE South and supra-regional areas of Limerick, Kerry, Tipperary, Waterford and Kilkenny. The hospital is one of two Level 1 trauma centres[‡] in the country, comprising 40 different medical and surgical specialties. The hospital is also one of eight cancer centres aligned with the HSE National Cancer Control Programme (NCCP) and one of two cancer centres in the southern region of Ireland.

The hospital currently employs 3,488.26 whole-time equivalent (WTE)[§] staff of multiple professions and is the primary teaching hospital for the Faculty of Health and Science in University College Cork. The hospital comprises 700 beds and provides a range of services under the governance and leadership of six clinical directorates, namely the unscheduled care directorate, peri-operative directorate, medicine directorate, diagnostics directorate, cancer directorate and paediatrics directorate. Services provided at the hospital include:

- all major medical specialities
- a range of surgical specialities including cardiothoracic, neurosurgical, gynaecological, plastic and reconstructive, maxillofacial, breast and colorectal

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[*] A model 4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. The hospital has a category 3 or speciality level 3(s) Intensive Care Unit on site, a Medical Assessment Unit which is open on a continuous basis (24/7) and an Emergency Department, including a Clinical Decision Unit on site.

[†] The other hospital groups are the Dublin Midlands Hospital Group, University of Limerick Hospital Group, Saolta University Health Care Group, Ireland East Hospital Group and Royal College of Surgeons in Ireland (RCSI) Hospital Group.

[‡] The establishment of the major trauma centres represents the first phase in the development of the acute hospital trauma services as set out in the National Trauma Strategy. The services comprise regional trauma networks each with a major trauma centre, the Mater Misericordiae University Hospital in Dublin and Cork University Hospital, which provide specialist trauma care in the one hospital to the most severely injured patients.

[§] Whole-time equivalent allows the working hours of part-time workers to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to a full-time worker. 0.5 refers to an employee that works half full-time hours.

- interventional radiology, interventional pain management and palliative care.

The emergency department at Cork University Hospital is one of the busiest departments in Ireland with 62,974 attendances in 2020,[**] which added up to approximately 190 attendances to the department each day. The emergency department provides a full range of adult and paediatric emergency services and also provides a number of pre-hospital care pathways. This includes a rapid response team in west Cork, an alternative pre-hospital pathway (APP) and a 24-hour emergency telemedicine support service (Medico Cork) for Advanced Paramedics in the National Ambulance Service and for ships at sea. The alternative pre-hospital care pathway was set up to reduce emergency department overcrowding and enhance national ambulance service capacity, the non-conveyance rate[††] for the pathway is 70%.

How we inspect

Among other functions, under the Health Act 2007, Section 8(1)(c) the Health Information and Quality Authority (HIQA) has statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out a one day unannounced inspection of the emergency department at Cork University Hospital to assess compliance with four national standards (5.5, 6.1, 1.6 and 3.1) from the *National Standards for Safer Better Healthcare* and to determine effectiveness of measures implemented by hospital management to address the issue of overcrowding, ineffective patient flow and limited surge capacity in the hospital's emergency department.

To prepare for this inspection, inspectors[‡‡] reviewed relevant information about the hospital. This included any previous inspection findings, information submitted to HIQA by the hospital and the South/South West Hospital Group, unsolicited information and other publically available information.

As part of this inspection, HIQA inspectors:

- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who attended the hospital's emergency department

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[**] At the time of writing this inspection report, the full and complete year data for 2021 was not available from the HSE. A full completed year's data on attendances to the emergency department at Cork University Hospital was available for 2020.

[††] Rates of patients who were sent an ambulance, but were not conveyed to an emergency department.

[‡‡] Inspector refers to an Authorised Person appointed under Section 70 of the Health Act 2007, as amended, for the purpose of monitoring compliance with the *National Standards for Safer Better Healthcare.*

- observed care being delivered, interactions with people who attended the emergency department and other activities to see if it reflected what people told inspectors
- reviewed documents to see if appropriate records were kept and if they reflected practice and what people told inspectors.

About the inspection report

A summary of the findings and a description of how the hospital performed in relation to the four national standards assessed are presented in the following sections, under the two dimensions of capacity and capability and quality and safety. Findings are based on information provided to inspectors during the course of the inspection at a particular point in time – during the onsite inspection.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the management arrangements were to support and ensure a good quality and safe service is being sustainably provided in the hospital's emergency department. It outlines how people who work in the service are managed, and whether there is appropriate oversight and assurance arrangements in place to ensure the high-quality and safe delivery of unscheduled and emergency care.

2. Quality and safety of the service

This section describes the experiences, care and support people received in the hospital's emergency department. It was a check on whether the service was a good quality and caring one, which was both person-centred and safe. It includes information about the environment and circumstances in which people attending the emergency department were cared for.

The four national standards assessed as part of the inspection and the resulting compliance judgments are set out in Appendix 1. Table 1 below shows the main sections of the inspection report and the dimension, theme and national standards from the *National Standards for Safer Better Healthcare* discussed in each section.

Table 1- Sections of the report and corresponding dimension, theme and national standards

Section of Report	Theme	Relevant national standard
Section 1: Capacity and capability	Leadership, governance and management	5.5
	Workforce	6.1

Section of report	Theme	Relevant national standard
Section 2: Quality and safety	Person-centred care and support	1.6
	Safe care and support	3.1

Details of the inspection

Date	Times of Inspection	Inspector	Role
Tuesday, 15 June 2022	09:00 to 16:00hrs	Denise Lawler	Lead Inspector
		Sean Egan	Support Inspector

Information about this inspection

Cork University Hospital provides a 24/7 service and is a regional centre providing secondary[§§] and tertiary[***] care for a catchment population of 550,000 in the HSE southern area and a supra-regional centre for a population of 1.1 million people from Limerick, Kerry, Tipperary, Waterford and Kilkenny. Local injury units located in St Mary's Health Campus, Gurranabraher, Bantry General Hospital and Mallow General Hospital provide treatment for people with minor injuries unlikely to need attendance at an emergency department or admission to hospital. Since March 2020, major infrastructural work and reconfiguration of the hospital's emergency department has been undertaken to develop single room capacity and reduce infection risks. Consequently, the overall footprint of the department has increased threefold over the last two years.

Before the onset of the COVID-19 pandemic, the hospital's emergency department at Cork University Hospital experienced record numbers of attendance, with approximately 186 to 191 people attending the department each day.[†††] In 2020, the number of attendees to the department decreased by 10%. In that year, a total of 62,974 attendees attended the emergency department, with the majority (69%) of attendees completing their entire episode of care in the department. The hospital's rate of admission from the emergency department (conversion rate), to an inpatient bed for specialist care and treatment, is higher (31%) when compared to the norms of emergency care in other similar sized units, where the conversion rate is approximately 25%. The hospital's conversion rate of 31% may be in part due to the fact that the local injury units and the hospital's Acute Medical Assessment Unit function by taking minor cases from the emergency department. Therefore, the cases that are treated at

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[§§] Secondary care is specialist treatment and support provided by doctors and other health professionals for patients referred to them for specific expert care.
[***] Tertiary care is highly specialised medical care, usually provided over an extended period of time, involving advanced and complex diagnostics, procedures and treatments provided by medical specialists.
[†††] In 2018, attendance rates to the hospital's emergency department were 67,879. This increased to 69,781 in 2019.

the department are more serious and complex, which in turn translate into higher rates of admission from the department to an inpatient bed. In addition, the profile of attendees to the Clinical Decision Unit usually require additional support and follow-on care from an inpatient perspective. This is different to other Clinical Decision Units in other emergency departments and contributes to the emergency department's conversion rate.

The hospital's emergency department experienced an increase in the volume of attendance in quarter one of 2022 and the department was significantly challenged by this. In mid-February 2022, HIQA was concerned about the reported high number of patients (84 patients on 15 February) attending the department who had finished their episode of emergency care and were awaiting admission to an inpatient bed. HIQA subsequently sought information and assurances on the situation from the Chief Executive Officer of the South South/South West Hospital Group. Specifically, HIQA sought information about the hospital group's analysis of the causes and factors contributing to the overcrowding of the emergency department, the immediate measures enacted or in planning to address the situation and to reduce the associated risks posed to patient safety and welfare.

Correspondence received from the hospital group detailed how the hospital experienced a significant increase in emergency department attendances and subsequent admissions to the hospital in quarter four 2021 and quarter one 2022. This outlined the initiatives implemented or being implemented to address overcrowding, and to improve and support patient flow in the department. These initiatives are discussed in more detail under national standard 5.5.

While HIQA noted and acknowledged the factors that were identified by the hospital and hospital group as contributing to the overcrowding situation at that time, HIQA remained concerned about increasing attendances to and resultant crowding of the hospital's emergency department.

Subsequently, HIQA conducted a risk-based unannounced inspection of the hospital's emergency department on 15 June 2022 to determine the hospital's level of compliance with four standards from the *National Standards for Safer Better Healthcare*. In particular, this inspection intended to ensure that the hospital had implemented or were implementing adequate measures to reduce the potential safety risks and the impact of overcrowding in the emergency department and to ensure continuous, effective patient flow.

The inspection focused in particular, on four key issues that impacted on the delivery of care in the emergency department, these included the:

- effective management to support high-quality care in the hospital's emergency department
- patient flow and inpatient bed capacity in the hospital
- respect, dignity and privacy for people receiving care in the hospital's emergency department
- staffing levels in the hospital's emergency department.

During this inspection, the inspection team spoke with the following staff at the hospital:

- Representatives of the hospital group's Executive Management Team
  - Chief Executive Officer
  - Clinical Director for the Unscheduled Care Directorate who was a consultant in emergency medicine
  - Director of Nursing
  - Chief Operations Officer
- Business Manager for the Unscheduled Care Directorate, Cork University Hospital.
- Assistant Director of Nursing Unscheduled Care, Cork University Hospital.
- Assistant Director of Nursing Emergency Department Patient Flow, Cork University Hospital.
- Patient Safety Strategy Manager, South South/West Hospital Group.

In addition, inspectors spoke with medical staff, nursing managers, staff nurses and people receiving care in the hospital's emergency department. Inspectors also reviewed a range of documentation, data and information received before and after the on-site inspection of the emergency department.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people receiving care in the emergency department who spoke with inspectors about their experience of the service.

What people who use the service told inspectors and what inspectors observed

On the day of inspection, inspectors visited the area known as the Acute Floor, which comprised the emergency department, Geriatric Emergency Medicine Service, Bandon Areas and Acute Medical Assessment Unit Blackwater Suite. The emergency department provides care for undifferentiated adult and paediatric patients with acute and urgent illness or injuries. Attendees to the hospital's emergency department presented by ambulance, were referred directly by their general practitioner (GP) or self-referred.

The hospital's adult emergency department has a total planned capacity of 85 and comprises:

- Twelve cubicles for the treatment of patients categorised as major (11 assigned for adult patients and one assigned for paediatric patients).

- Four resuscitation spaces (three assigned for adult patients and one assigned for paediatric patients).

- Five isolation spaces used for the high-dependency unit and or infection streaming.

- A Rapid Assessment Streaming Triage Treatment Area (RASTTA). This is a purpose-built area where ambulatory care[‡‡‡] is intended to be provided with rapid access to medical assessment. The area comprises 47 individual patient pods divided into RASTTA A and RASTTA B. There were 12 reclining chairs in the larger treatment pods in RASTTA A, and 35 chairs in smaller pods in RASTTA B.

- A Clinic Decision Unit comprising 12 beds, where vulnerable patients are monitored and treated for a period of time, usually for six to 24 hours and according to disease-specific protocols, such as detox, head injuries and overdose, under the care of a consultant physician specialised in emergency medicine.

- A designated and specially designed area within the emergency department — the Geriatric Emergency Medicine Service — comprising six single rooms where older persons attending the emergency department are medically reviewed and treated.

- A designated paediatric area comprising nine assessment areas (six seated and three trolleys).

Children account for about 20% of patients that present to the hospital's emergency department. There is a designated area in the emergency department for the provision of paediatric emergency care. However, HIQA noted that at the time of this inspection, there was no audiovisual separation of children from adult emergency care as recommended in the national model of care for paediatric healthcare services. The absence of such separation was a concern for inspectors. HIQA was informed that hospital management are progressing with the capital development project of a designated paediatric emergency department, which is due to be completed and fully commissioned later this year (October 2022).

On the day of inspection, the emergency department was very busy and overcrowded with a total of 196 people attending the department. The mean daily number of attendance to the emergency department for quarter one and quarter two 2022 was 195 people. At 11.00am on the day of inspection, there were 108 patients in the department, 21% more than its intended capacity. At that time, a total of 52 patients had been admitted and were awaiting an inpatient bed in the Acute Floor area;

- 38 of these patients were boarded in the emergency department. This represented (35%) of the total 108 patients in the department at 11.00am

- the remaining 14 patients were awaiting inpatient beds in single occupancy areas in the Acute Floor, namely the Geriatric Emergency Medicine Service and Bandon Areas, and the Acute Medical Assessment Unit Blackwater Suite.

[‡‡‡] Ambulatory care refers to medical and healthcare services provided by healthcare professionals on an outpatient basis, without admission to hospital.

At the time of inspection, there was no defined surge area for the hospital, the Acute Floor was the surge area. The hospital needs to define a surge area which does not hinder the delivery of emergency and acute ambulatory care.

All 38 patients boarding in the emergency department were waiting longer than the nationally recognised safe and acceptable timelines for an inpatient bed. More specifically;

- 18 of the 38 patients (47%) were waiting six to nine hours to be admitted to an inpatient bed or be discharged.

- 12 of the 38 patients (32%) were waiting nine to 24 hours to be admitted to an inpatient bed or be discharged. Ten of these patients were aged 75 years and over.

- 8 of the 38 patients (21%) were waiting over 24 hours to be admitted to an inpatient bed or be discharged.

Despite the crowding, inspectors only observed one person on a trolley on a corridor. Patients were instead accommodated in the Rapid Assessment Streaming Triage Treatment Area (RASTTA), in single cubicles or in a multi-occupancy area in the main emergency department. There were four treatment bays in the multi-occupancy area, but on the day of inspection six patients were accommodated in this area, with very little free space available between bays. One metre physical spacing was not maintained in this area, which increases the risk of infection and poses a risk to patient safety.

On arrival to the emergency department, all self-presenting attendees checked in at reception and waited to be called for triage. The waiting area comprised of 16 individual patient pods that facilitated minimum physical spacing of one metre, these were in place to reduce the risk of overcrowding and to manage surge capacity. Attendees to the department were observed wearing facial coverings. Throughout the day, inspectors observed that staff working in the clinical area were wearing appropriate personal protective equipment (PPE) in line with public health guidelines at the time of inspection.

Inspectors spoke with a number of patients in the emergency department to ascertain their experiences of the care received. All patients who spoke with inspectors were complimentary about the staff. They described staff as '*fantastic and very helpful*' and how '*staff were doing their best*'. All patients commented on how busy the department was, how '*staff were run off their feet*' and were concerned about how this might impact on the delivery of care they received.

In the opinion of inspectors, the individual patient pods in the RASTTA were somewhat preferable from a patient safety, privacy and dignity perspective, when compared to being accommodated, as per prior arrangements, on trolleys in the emergency department corridor. Notwithstanding this, these patient pods were built to manage surge capacity and enable ambulatory care in the context of the COVID-19 pandemic. These were not intended for use by patients for prolonged periods of time, which had become practice due to delayed throughput of patients through the department. Patients accommodated here and who spoke

with inspectors, expressed concerns about the comfort of the chairs, and the lack of privacy and confidentiality when interacting with others. There was no curtains or doors on the individual patient pods so there was the potential that others (patients, staff and visitors) could overhear conversations between patients and medical and or nursing staff.

Patients commented on the '*need for inpatient beds instead of chairs*' – a sentiment that was fully acknowledged by hospital management and staff. Two patients recounted how it was uncomfortable and impossible to sleep in the chair. Patients also remarked on how the patient pods were confining and the space inside was very limited.

Two patients who spoke with inspectors raised concerns about waiting times, interactions and follow up by the medical team. Both patients were accommodated in the RASTTA, one was there for 18 hours and the second for 16 hours. Both patients recounted how they were triaged, medically reviewed and that their treatment commenced relatively quickly, but since then they had not been assessed or their plan of care updated by the medical team and or discussed with them. At the time they spoke with HIQA, they felt they did not know anything about their ongoing plan of care. The hospital's performance compliance with national key performance indicators for patient experience time[§§§] set by the HSE, are discussed in more detail under national standard 3.1.

Patients who spoke with inspectors did not recall or recount delays for diagnostics and all felt confident that if something was wrong, and or if they wanted to make a complaint, they knew who to complain to and felt sure that their complaint and concerns would be managed and resolved.

The following two sections, capacity and capability and quality and safety outline the quality of the care provided to people receiving care in the emergency department on the day of inspection.

Capacity and Capability Dimension

Inspection findings in relation to the capacity and capability dimension are presented under two national standards (5.5 and 6.1) from the two themes of leadership, governance and management and workforce. The hospital was found to be partially compliant with the two national standards assessed. Key inspection findings leading to these judgments are described in the following sections.

[§§§] Patient experience time (PET) refers to the total time spent by patients within the emergency department, inclusive of time spent awaiting admission.

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place to deliver high-quality, safe healthcare.

Sufficient capacity and effective patient flow within and external to the hospital, together with effective management, is needed to support the timely care and, where necessary, admission of all who attend the hospital's emergency department and achieve compliance with national standards and performance metrics. Hospital management needs to ensure that all patients attending the emergency department are reviewed and assessed in line with national targets set by the HSE. On the day of inspection, the hospital had defined, integrated, corporate and clinical strategic and operational governance arrangements in place, in order to manage and oversee the performance and quality of unscheduled and emergency care at the hospital.

At corporate level, it was clear to HIQA that the hospital had defined lines of responsibility and accountability for the governance and management of unscheduled and emergency care. The hospital was governed and managed by the Chief Executive Officer who, in turn reported to the Chief Executive Officer of the South South/West Hospital Group. Unscheduled care at the hospital was provided under the governance and leadership of the Unscheduled Care Directorate. This directorate was led by a Clinical Director who was a consultant in emergency medicine and who reported to the hospital's Chief Executive Officer.

The hospital's Executive Management Board was the strategic governance committee who had oversight of the effective management and the quality and safety of unscheduled and emergency care provided in the hospital. It was noted that the terms of reference for this committee was dated 2008 and the reporting arrangements outlined therein predated the establishment of the South South/West Hospital Group structure in 2013. Notwithstanding this, it was apparent from minutes of meetings submitted to HIQA, that membership of the Board comprised appropriate members, which included the Chief Executive Officer, Director of Nursing, Clinical Leads of the six clinical directorates, Chief Operations Officer, Service Manager and Quality and Patient Safety Manager. The Board met every week and while the agenda for meetings varied from meeting to meeting, it was clear from documentation that the Board had oversight of the significant issues that impacted or had the potential to impact on the provision of high-quality, safe healthcare in the hospital's emergency department.

The Executive Quality and Patient Safety Committee were assigned with responsibility for providing the Executive Management Board with assurances on the quality and safety of services within the Cork University Hospital Group. This multidisciplinary committee met monthly as per the terms of reference and received quality and safety reports from the management team of the Unscheduled Care Directorate regularly. The committee reported to

the Executive Management Board every three months and submitted a formal report to the Board annually.

HIQA found that in relation to unscheduled and emergency care, the hospital had good clinical leadership and there were clear lines of accountability with devolved autonomy and decision-making. Strategic governance and oversight of unscheduled care was the responsibility of the Site Level Integrated Unscheduled Care Governance Group. This multidisciplinary group included representatives from both the acute and community sector, including the National Ambulance Service. It was clear that the group had a schedule of meetings, a structured agenda and that meetings were action orientated. The group met monthly as per the terms of reference and had oversight of the hospital's compliance with national key performance indicators for unscheduled care. Meetings of the group were co-chaired by a member from each sector (acute and community sector). It was clear from documentation submitted to HIQA that progress on implementing agreed actions were tracked and discussed at each meeting of the group. The group had a dual-reporting structure at hospital and regional level. At hospital level, the group reported to the hospital's Executive Management Board. At regional level, the group reported to the Regional Unscheduled Care Governance Group, a regional governance structure that comprised members from the South South/West Hospital Group and Cork/Kerry Community Healthcare.

At operational level, two groups — the Acute Floor Operations Group and Emergency Department Clinical Operations Group — had operational governance and oversight of the day-to-day workings of the clinical areas under the remit of the Unscheduled Care Directorate. These clinical areas include the emergency department, Acute Medical Assessment Unit and Geriatric Emergency Medicine Service.

- The Acute Floor Operations Group was chaired by the clinical director for unscheduled care. This multidisciplinary group met every two weeks as per the terms of reference and had oversight of the issues that impacted the operational functioning of the hospital's emergency department including attendances and patient experience times. The group reported to the Site Level Integrated Unscheduled Care Governance Group.

- The Emergency Department Clinical Operations Group had oversight of operational processes in the emergency department, including those that impact on patient flow and capacity in the department. This multidisciplinary group, chaired by the clinical director for unscheduled care, met every week and reported to the Site Level Integrated Unscheduled Care Governance Group.

Of note, the governance arrangements at the Cork University Hospital had recently been subject to an external review commissioned by the Chief Executive Officer of the South South/West Hospital Group. This review identified a number of areas for suggested improvement — the hospital's governance structure and processes, engagement with staff, culture and leadership, quality improvement and the development of relationships — that hospital management committed to progressing. The hospital's Chief Executive Officer

outlined to HIQA that, at the time of inspection, the hospital was working to address the findings of this review.

Notwithstanding this, HIQA found examples through this focused inspection that at senior clinical and administrative management levels, the hospital was attempting to address the challenges posed by emergency department overcrowding. This was evidenced through how the hospital addressed emergent risk issues, such as infrastructure challenges, and indeed in terms of future plans to seek to address capacity issues which are outlined later in this report. HIQA found good and appropriate levels of ownership and autonomy for decision-making amongst senior leaders in the emergency department. However, HIQA also noted that unlike some other similar sized hospitals in the state, Cork University Hospital does not have a designated Lead Clinical Director for the whole hospital. Instead, each clinical directorate had a designated Clinical Director who provided clinical leadership and strategic direction for that directorate only.

In consideration of the fact that overcrowding in hospital emergency departments reflects wider issues within and external to each hospital, pertaining to patient flow, it is HIQA's view that the designation of a lead clinical director for the hospital has the potential to provide greater clarity within the hospital for overall clinical leadership and oversee all aspects of the hospital's clinical processes, including patient care and quality assurance. In addition, as a member of the executive team, the lead clinical director would have the executive authority and accountability for planning, developing and managing all clinical services at the hospital, inclusive of potential competing challenges and risks that the hospital needs to navigate in the context of finite resources.

Continuous and effective flow of patients within and out of the hospital is essential for optimal service delivery in an emergency department. On the day of inspection, the hospital had 15 COVID-19 positive patients with two clinical wards closed to new admissions because of COVID-19 outbreaks. In addition, there were 44 patients with delayed discharges from the hospital, with the majority of these patients awaiting residential and rehabilitation care in the community. Hospital management recounted how the delay in discharging and transferring patients from the hospital was affected by the limited availability of beds in the community. The relatively high admission rate of 31% from the emergency department further increased the pressure for inpatient beds at the hospital. Collectively, the delay in the transfer of care and the mismatch between the number of inpatient beds needed and actual bed capacity, significantly impacted the flow of patients through the hospital's emergency department. This contributed to the boarding of admitted patients in the department and negatively impacted on patient waiting times, especially those for triage and also from triage to medical review. In response, the hospital had enacted the full capacity protocol,**** which in turn had an impact on the delivery of scheduled care at the hospital.

**** Full capacity protocol is the final step in a hospital's escalation plan, where extra beds are placed in inpatient wards and corridors of hospitals, as a measure to address emergency department overcrowding.

On the day of inspection:

- the average waiting time from registration to triage was 25 minutes

- the waiting time from triage to medical review ranged from 20 minutes to eight hours

- the waiting time from decision to admit to actual admission in an inpatient ward ranged from two hours to 58 hours 28 minutes.

Hospital management had implemented or were implementing measures to improve and support effective patient flow in the emergency department, and increase surge capacity across the hospital and hospital group.

Immediate measures implemented included:

- activating the hospital's escalation plan which included the cancellation of non-time critical surgeries. Cancelling non-time critical surgeries is far from ideal for a major regional hospital that undertakes emergency and complex surgeries, or for those patients who remained on waiting lists as a result of the need to focus on unscheduled care and time sensitive surgical cases

- introducing winter plan initiatives mapped to the five fundamentals for unscheduled care, a framework comprising five elements developed by the HSE to manage patient flow across the healthcare sector[††††]

- reviewing cases of delayed transfer of care to identify issues with discharge and transfer

- using private hospital and private nursing homes to increase capacity for transitional care

- maximising and utilising community and rehabilitation beds

- reviewing inpatient diagnostics every day to ensure delays in flow and the inpatient pathway are minimised

- facilitating escalation meetings five times a day, to ensure effective patient flow within and external to the hospital

- carrying out additional ward rounding by medical consultant staff to identify patients for discharge and or issues impacting on discharge

- using the Virtual Navigation Hub located in the emergency department to direct patients to the most suitable care pathway based on their clinical condition. In the Hub, the emergency medical team in the emergency department reviewed referrals received electronically via Healthlink from GPs. Thereafter, patients were directed to the most suitable area of the hospital or another hospital, such as the Geriatric Emergency Medicine Service, the Acute Medical Assessment Unit, Acute Surgical

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[††††] The five fundamentals for unscheduled care as set out by the HSE are leadership and governance, operational processes and pathways pre-admission, operational processes and pathways post-admission, integrated working and data, and business intelligence.

Assessment Unit, Cork University Maternity Hospital (gynaecological conditions) or South Infirmary-Victoria University Hospital (ear, nose and throat conditions). On the day of inspection, the Virtual Navigation Hub was not operational because of issues with medical staffing.

Longer-term measures implemented or in planning to improve and support patient flow and increase capacity at the hospital included:

- proactively working with Cork/Kerry Community Healthcare to assist with transfers of care and the integration of unscheduled care at hospital and regional levels

- using local private hospitals to increase bed capacity and diagnostic services

- increasing access to diagnostics in the hospital's emergency department

- increasing the hospital's capacity and bed stock through a number of innovative measures, including:

  — opening 40 inpatient beds in Mallow General Hospital by end of 2022, increasing to a total of 48 inpatient beds by 2023

  — Cork University Hospital to assume governance of St Finbarr's Hospital Rehabilitation Unit and Farranlee Nursing Home

  — purchasing and reconfiguring beds in a hotel in Blarney that will be used as a step down facility for Cork University Hospital

  — developing and reconfiguring Heather House on the St Mary's Campus that will be used as a long-stay facility for patients with dementia and as step down facility

  — seeking capital development funding from the HSE to progress a 24-bedded modular build to increase the hospital's inpatient bed capacity.

On the day of inspection, there was evidence of implementation of the short-term and some longer-term measures described above. Notwithstanding this, HIQA found that the emergency department was running at 21% greater than its intended capacity, and that there were issues with surge capacity and ineffective patient flow, especially through the RASTTA, which all contributed to the crowding and boarding of 38 admitted patients in the department.

In addition, the RASTTA was not fully functioning as intended. Admitted patients were boarding in the area while awaiting an inpatient bed, which impacted on the ability to fully function as an area for the delivery of ambulatory care. Furthermore, the waiting times for triage and from triage to medical review experienced by some patients would indicate that the short-term measures implemented by hospital management were not fully effective in managing the challenges experienced in the emergency department.

The Acute Medical Assessment Unit was also partially functioning as designed, as an alternate flow pathway for patients in order to take pressure from the emergency department. While patients were being directly referred to the unit and were being seen, treated and discharged by clinical teams as intended, six of the rooms in the unit were used as an overflow from the

emergency department for patients awaiting admission to an inpatient bed. This indicated to HIQA that while the normal means of facilitating patient flow were working to some degree at the hospital, they were not as effective as they should be. This combined with reduced surge capacity and the total volume of attendees to the hospital's emergency department further contributed to the overcrowding of the department.

Access to real time information and trends is essential to support the continuous and effective flow of patients through the emergency department. The hospital's Business Intelligence Unit used local dashboards to ensure clinicians and hospital management had information on the department's activity and performance. The hospital was a pilot site for the testing of the Health Performance Visualisation Platform being implemented across the healthcare sector by the HSE. Hospital management are hopeful that the platform will be fully implemented at the hospital soon, which will then ensure availability of real-time health data and trends across the emergency department, diagnostics and bed management. This data can then be used to support continuous, effective patient flow within the hospital and across the hospital group, and as a means to compare performance with other similar sized emergency departments.

Overall, the hospital had defined management arrangements in place to manage and oversee delivery of care in the emergency department. However, circumstances such as unprecedented high numbers of attendances to the department combined with issues of ineffective patient flow, limited surge capacity and reduced access to transitional, rehabilitation and step down beds in the community impacted on the continuous and effective flow of patients through the emergency department. Hospital management were aware of the situation and had implemented a range of short-term and longer-term measures to improve the functioning of the department. HIQA acknowledges it will take time to progress measures, especially the longer-term measures with Cork/Kerry Community Healthcare. However, it was evident from findings on the day of inspection, that the measures implemented to date were not fully effective in managing the potential patient safety risks associated with overcrowding of the department, such as long waiting times for triage and from triage to medical review.

In the context of reviewing the approach to wider governance within the hospital following the recent external review, it will also be important following this inspection, to ensure that clinical leadership arrangements across the hospital are working optimally to enhance patient flow through a whole of hospital approach. In particular, hospital management need to ensure that required measures for the timely medical review of patients awaiting admission to an inpatient bed from the emergency department are fully optimised. Moreover, efforts to more clearly define overall clinical leadership within the hospital through the designation of a Lead Clinical Director should be considered.

Judgment: Partially compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.

For a healthcare service to be effective there needs to be sufficient staff with the right skills to deliver safe, high-quality care. Staffing levels for medical staff in the emergency department at Cork University Hospital were maintained at levels to support the provision of 24/7 emergency care. At the time of inspection, the hospital had nine WTE consultants in emergency medicine. All nine consultants in emergency medicine were on the specialist register with the Irish Medical Council. A senior clinical decision-maker[‡‡‡‡] at consultant level was on site in the hospital's emergency department each day, with availability on a 24/7 basis. Consultants in emergency medicine from Cork University Hospital also provided 50 hours consultant cover to the emergency department in the Mercy University Hospital each week and had assigned governance of the local injuries units at Mallow General Hospital, Bantry General Hospital and St. Mary's Health Campus, Gurranabraher.

Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and boarded in the emergency department while awaiting an inpatient bed. Consultants in the emergency department were supported by 32 non-consultant hospital doctors at registrar, senior house officer and intern grades providing 24/7 medical cover in the department.

The hospital was a pilot site for the testing of phase 2 of the *Framework for Safe Nurse Staffing and Skill-Mix in Adult Emergency Care Settings in Ireland*.[§§§§] This framework supports emergency department nurse managers and hospital management to assess and plan their nursing and support staff workforce to meet the needs of their specific emergency care setting. The framework was launched by the Minister of Health in June 2022.

According to the staffing and skill-mix framework, the nursing staff complement for the emergency department at Cork University Hospital was 164.5 WTEs. The framework is a new initiative being implemented by the HSE across the 29 emergency departments in Ireland on a phased basis, so it will take time for the uplift in nursing and support staff determined for each of the 29 emergency departments to be realised. This was the case in Cork University Hospital, where on the day of inspection, the actual nursing staff complement in the emergency department was 108 WTEs. This represented a variance of 56.5 WTEs, a difference of 34% between the determined and actual nursing staff complement.

Hospital management were managing the difference in nurse staffing levels through an ongoing recruitment campaign and the use of agency nurses. On the day of inspection, the department did not appear to be running short on the number of nurses rostered on each

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[‡‡‡‡] Senior decision-makers are defined here as a doctor at registrar grade or a consultant who has undergone appropriate training to make independent decisions around patient admission and discharge.
[§§§§] Department of Health. *Framework for Safe Nurse Staffing and Skill-Mix in Adult Emergency Care Settings in Ireland*. Dublin: Department of Health. 2022. Available online https://assets.gov.ie/226687/1a13b01a-83a3-4c06-875f-010189be1e22.pdf

shift. The department had its full rostered complement of 27 WTEs staff nurses (including management grades) on day duty (8am-8pm) and 18 WTEs staff nurses (including management grades) on night duty (8pm-8am). Inspectors reviewed nursing staff rosters from the preceding four-week period and noted that the rostered nurse staffing levels for the department was relatively consistent, ranging between 20-28 nurses during the day and 17-23 nurses at night.

An Assistant Director of Nursing had overall nursing responsibility for the emergency department. An Assistant Director of Nursing and a Clinical Nurse Manager grade 3 were rostered on duty Monday – Friday during core working hours (8am-6pm). A Clinical Nurse Manager grade 2 was rostered on each shift (day and night). Nursing staff were supported by an average of seven to 11 healthcare assistants during the day and an average of five to seven healthcare assistants at night.

Other members of the multidisciplinary team in the emergency department included:

- four advanced nurse practitioners (ANPs) with recruitment of a fifth ANP in progress. HIQA was told that hospital management were planning to seek funding and approval from the hospital group to increase the number of ANPs in the emergency department by an additional three posts in the areas of trauma, paediatrics and older persons

- an infection prevention and control nurse

- a clinical pharmacist.

Medical and nurse staffing was an identified risk recorded on both the Unscheduled Care Directorate risk register and hospital's corporate risk register. Hospital management had enacted controls and actions to mitigate this risk and these controls were reviewed and updated every month by the Executive Management Board.

It was evident from staff training records reviewed by inspectors that nursing and medical staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years. The hospital had a system in place to monitor and report on staff attendance at mandatory and essential training, and this was overseen by the clinical skill facilitators assigned to the emergency department. HIQA found that the percentage of staff attendance and uptake at mandatory and essential training could be improved, especially training on the national early warning system and Manchester Triage System. Training records for nursing staff showed that:

- all nurses were up to date in basic life support training

- all nurses were up to date with training on the national early warning system

- all paediatric nurses were up to date with training on the paediatric early warning system

- all nurses were up to date in training on national guidance in clinical handover and Introduction, Situation, Background, Assessment, Recommendation (ISBAR)***** communication tool

- 83% of eligible staff (staff who carry out triage) were up to date in training on the Manchester Triage System.

Training records for medical staff showed that:

- all medical staff were up to date in basic life support training

- 75% of medical staff were up to date with training on the national early warning system — above the minimum target of 50% set by the HSE, but significantly below the HSE's target of 85%

- all paediatric emergency medicine staff were up to date with training on the paediatric early warning system.

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department to support the provision of high-quality, safe healthcare. This was despite the fact that the number of WTE nursing staff employed at the hospital was below what has recently been determined as optimal for ensuring safety in the emergency department. Immediate risks to patients posed by this deficit were being prevented by the use of agency staff to maintain the nursing roster. However, the hospital needs to move away from the practice and reliance on using agency staffing as a means of maintaining nursing staff rosters where possible, as such an approach is not a sustainable long-term solution. Furthermore, staff attendance and uptake of mandatory and essential training is an area that needs to be improved, especially training on the national early warning system and Manchester Triage System. It is essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. This issue should be easy to implement, and should represent a key focus for early improvement efforts following this inspection.

Judgment: Partially compliant

***** The Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (For example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under two national standards (1.6 and 3.1) from the two themes of person-centred care and support and safe care and support. The hospital was found to be partially compliant with national standards 1.6 and non-compliant with national standard 3.1. Key inspection findings leading to these judgments are described in the following sections.

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

People have a right to expect that their dignity, privacy and confidentiality will be respected and promoted when attending for emergency care.[†††††] Person-centred care and support promotes and requires kindness, consideration and respect for the dignity, privacy and autonomy of people who require care. It supports equitable access for all people using the healthcare service so that they have access to the right care and support at the right time, based on their assessed needs.

The emergency department in Cork University Hospital was significantly reconfigured over the past two years. The reconfiguration resulted in an enhanced infrastructure and greater numbers of single cubicles, which aimed to mitigate the risk of hospital-acquired infections and promote the privacy and dignity of patients. At 11.00am on the day of inspection, the number of patients in the department exceeded the planned capacity of 85. There were 23 extra patients accommodated in the department, which represented a 21% increase in the total number the department was designed to hold. The 23 extra patients were accommodated in designated treatment areas or single rooms, with inspectors observing only one patient on a trolley in the corridor.

Over a third (35%) of the patients in the emergency department were admitted and were awaiting an inpatient bed. The boarding of admitted patients in the emergency department directly contributed to the crowding of the department. This together with the increased volume of presentations to the department impacted on the timeliness of review and care, specifically for triage and medical review after triage for non-urgent cases.

Staff working in the hospital's emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed by inspectors to be kind and caring towards patients in the department, and tried to respond to their individual needs, which was challenging in the context of an overcrowded department.

[†††††] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

Inspectors observed patients accommodated in single cubicles and in a multi-occupancy area. It was clear that in single cubicles, the confidentiality, dignity and respect of patients was promoted and protected. However, notwithstanding the efforts of staff and hospital management, the privacy and dignity of patients accommodated in the multi-occupancy area could not be protected in the same way and maintenance of confidentiality was a challenge. Here, there was a risk that others (patients, visitors and staff) could overhear patient-clinician conversations and personal information exchanged between patients, medical and nursing staff.

Furthermore, the use of individual patient pods in the waiting area and RASTTA aimed to reduce the risk of overcrowding by managing surge capacity and admitted patients, but while this is commendable, the patient pods were small and confined. Also, the footprint of the RASTTA was small for the accommodation of 47 patient pods and while one metre physical distancing between pods was achieved, the area was observed to be very crowded.

These findings were consistent with the findings of the 2021 National Inpatient Experience Survey,[‡‡‡‡‡] where the hospital scored below the national average in questions related to privacy, dignity and respect, and length of time waiting in the emergency department before being admitted to a ward. More specifically, with regard to:

- privacy when being examined or treated in the emergency department, the hospital scored 7.4 (national average - 8.3)

- being treated with respect and dignity in the emergency department, the hospital scored 8.4 (national average - 8.8)

- length of time waiting in the emergency department before being admitted to a ward, the hospital scored 5.6 (national average - 6.9).

HIQA found that efforts to ensure that patients who required end-of-life care in a setting other than in the overcrowded emergency department were not always effective. This resulted in the privacy and dignity of these patients being compromised and was not in line with best practice, national standards or a human rights-based approach to care.

The hospital had implemented some person-centred initiatives to improve the experiences of older persons attending the emergency department. This included integrating with community initiatives, such as the Community Intervention Team and Outpatient Parenteral Antimicrobial Therapy and the Integrated Care Programme for Older Persons (ICPOP).[§§§§§]

The Geriatric Emergency Medicine Service is a service for older persons who attend the hospital's emergency department that work in parallel with the emergency medicine team. This service is provided by a designated multidisciplinary team led by a consultant geriatrician who had clinical and operational accountability for the service. There was a dedicated and

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[‡‡‡‡‡] The findings of the National Inpatient Experience Survey are available at: https://yourexperience.ie/inpatient/national-results/
[§§§§§] Health Service Executive. *Integrated Care Programme for Older Persons*. Dublin, Health Service Executive. 2022. Available online from: https://www.hse.ie/eng/about/who/cspd/icp/older-persons/

specifically designed area in the emergency department comprising six spaces where care and treatment was provided to older persons. Each space was designed to meet the complex needs of the older person, including comfort, sensory and cognitive needs. The service was supported by the frailty at the front door team[******] and used the ICPOP hubs to promote integration of primary and secondary care services. The service had established defined quality indicators to monitor activity, quality of care and service performance. Compliance with these indicators was reviewed and any non-compliance actioned every month at meetings of the Site Level Integrated Unscheduled Care Governance Group.

It was not possible for inspectors to fully evaluate the effectiveness and impact of the Geriatric Emergency Medicine Service within the confines of a short-unannounced inspection. However, the fact that the service was embedded and work was ongoing to improve the experience for older persons attending the hospital's emergency department is commendable. It was clear from documentation submitted to HIQA that the numbers of frail older persons seen during core working hours was high (87%) and that the numbers of older persons being discharged by the Geriatric Emergency Medicine Service for the first five months of 2022 had increased month on month (range of 17%-28%). This data would indicate that the service is having a positive impact on the outcomes for older persons attending the hospital's emergency department.

At the time of inspection, the hospital were in the process of recruiting persons to act as an advocate and provide support to patients. This was further evidence that the hospital were endeavouring to promote person-centred care and protect the patient's right for respect, dignity and autonomy.

Notwithstanding the initiatives implemented for the older person, the practice of boarding admitted patients in the emergency department contributed to overcrowding of the department, which impacted on any meaningful promotion of the patient's human rights especially those accommodated in the multi-occupancy area. In such settings, it was a challenge to maintain, promote and protect patients' dignity, privacy and confidentiality, which is not consistent with a human rights-based approach to care. This challenge was fully acknowledged by hospital management on the day of inspection.

Judgment: Partially compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.

A healthcare service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers, and to ensure

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[******] Frailty at the Front Door is a designated care pathway for older persons who present for unscheduled care with frailty signs and symptoms.

there are arrangements and contingencies in place to manage any increase in demand for the service. Furthermore, while the delivery of care has some associated element of risk of harm for people who use the healthcare service and receive care, safe care and support identifies, prevents or minimises this unnecessary or potential harm.

Cork University Hospital had put measures in place to reduce the risk of harm to people who attended the hospital for unscheduled and emergency care. The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks were managed at directorate level with oversight from the Executive Management Board. The effectiveness of actions and controls implemented to mitigate the risks were reviewed and updated at monthly meetings of the Unscheduled Care Directorate and the Executive Management Board.

At the time of inspection, 19 of the 38 open risks on the risk register for the Unscheduled Care Directorate related to the emergency department. Risks that could not be managed at directorate level were escalated to and recorded on the hospital's corporate risk register. Three of the 37 open risks on the hospital's corporate risk register related directly to the emergency department — nursing and medical staffing, patient flow in unscheduled care and infrastructure. The hospital's corporate risk register detailed the actions and controls to manage and minimise the three risks. These included:

- establishing an operational hub, which facilitated daily communication with the South South/West Hospital Group and Community Healthcare Organisation, and weekly meetings with Community Healthcare Organisation regarding complex discharges

- establishing a governance group and working group for unscheduled care

- implementing daily operational meetings

- activating the hospital's escalation plan

- reconfiguring space in the emergency department to accommodate ambulatory and paediatric assessment

- developing a joint escalation plan with Cork/Kerry Community Healthcare up to and including full capacity protocol

- tracking key performance indicators for unscheduled and emergency care

- facilitating weekly Acute Floor meetings.

HIQA identified evidence in each case of these actions and controls being applied. However, the 38 patients boarding in the emergency department while awaiting an inpatient bed on the morning of HIQA's inspection would suggest that these measures were not fully effective in managing the immediate and potential risks to people attending the emergency department. In their correspondence to HIQA in February 2022, hospital management did acknowledge this and identified the need for additional measures to support and improve patient flow and

increase capacity in the hospital and wider community. As detailed previously under national standard 5.5, extra measures were being implemented at the time of HIQA's inspection.

The hospital collected data on a range of different quality and safety indicators related to the emergency department in line with the national HSE reporting requirements. Data on inpatient capacity and patient flow including the number of presentations to and admissions from the hospital's emergency department, compliance with national key performance indicators set by the HSE and delayed transfers of care was collected and monitored. Collated performance data was reviewed at meetings of relevant governance and oversight committees — Executive Management Board and Site Level Integrated Unscheduled Care Governance Group.

Performance data on the patient experience time collected on the day of inspection was poor. The data showed that at 11.00am, the hospital was not compliant with any of the national key performance indicators for the emergency department set by the HSE. At that time:

- 74 (66%) attendees to the emergency department were in the department for more than six hours after registration. This was not in line with the national target which requires that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.

- 70 (65%) attendees to the emergency department were in the department for more than nine hours after registration. This figure falls short of the national target of 85% of attendees being admitted to a hospital bed or discharged within nine hours of registration.

- A quarter (25%) of attendees to the emergency department were in the department for more than 24 hours after registration. The department fell significantly outside the national target which aims for 97% of patients to be admitted to a hospital bed or discharged within 24 hours of registration.

- 25 (13%) attendees to the emergency department were aged 75 years and over. 60% of patients aged 75 years and over were admitted or discharged within nine hours of registration. This was not in line with the national target that 99% of patients aged 75 years and over be admitted to a hospital bed or discharged within nine hours of registration.

- Over a third (36%) of attendees to the emergency department aged 75 years and over were not discharged or admitted within 24 hours of registration. The national target for this indicator was 99%, which the department fell significantly short of. Hospital management did identify that the emergency department was a persistent outlier in this metric. However, they did indicate that the risks for an older person in an acute hospital environment were more manageable when these persons were accommodated in an area designed to meet their specific needs, as is the case with the Geriatric Emergency Medicine Service in the hospital's emergency department.

These findings on patient experience time were consistent with the findings of the 2021 National Inpatient Experience Survey where the hospital scored below the national average for people waiting in the emergency department less than six hours[††††††] and between six and 12 hours[‡‡‡‡‡‡] before being admitted to an inpatient ward. However, in relation to people waiting 12-24 hours or greater,[§§§§§§] the hospital scored above the national average. The hospital's score was double the national average for patients waiting over 24 hours to be admitted to an inpatient bed. Hospital management had developed a quality improvement plan to address findings of the National Inpatient Experience Survey. Management were, together with the office of the HSE's National Director Operational Performance and Integration, progressing the implementation of actions in that plan to improve waiting times for people who attend the hospital's emergency department.

Similar to other emergency departments, the hospital was not compliant with the HSE's performance indicator for ambulance turnaround time interval of less than 30 minutes. In the first six months of 2022, less than half (42%) of the ambulances that attended the hospital's emergency department had a turnaround time interval less than 30 minutes,[*******] which further demonstrates how the issue of insufficient capacity and ineffective patient flow affects the timely offload and review of patients in the emergency department.

Prolonged waiting times in the emergency department are associated with increased frequency of exposure to error, increased inpatient length of stay, increased morbidity and mortality and decreased patient satisfaction.[†††††††] Mortality generally increases with increasing boarding time, from 2.5% in patients boarded less than two hours to 4.5% in patients boarding 12 hours.[‡‡‡‡‡‡‡] Delays to inpatient admission for patients in excess of five hours from time of arrival at the emergency department are also associated with an increase in mortality. It is estimated that there is one extra death for every 82 admitted patients

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[††††††] The national average for people waiting <6 hours in the emergency department before being admitted to an inpatient bed was 29.1%. The rate for the emergency department at Cork University Hospital was 22.7%.

[‡‡‡‡‡‡] The national average for people waiting 6-12 hours in the emergency department before being admitted to an inpatient bed was 34.6%. The rate for the emergency department at Cork University Hospital was 21.2%.

[§§§§§§] The national average for people waiting 12-24 hours in the emergency department before being admitted to an inpatient bed was 22.7%. The rate for the emergency department at Cork University Hospital was 27.7%. The national average for people waiting greater than 24 hours in the emergency department before being admitted to an inpatient bed was 13.6%. The rate for the emergency department at Cork University Hospital was 28.5%.

[*******] Patient clinical handover times are recorded locally at Cork University Hospital (time from registration to the time to placement in clinical space). The National Emergency Operations Centre report records the time an ambulance is at the hospital (handbrake on and handbrake off) which is generally a longer time than the clinical handover time.

[†††††††] Paling S., Lambert J., Clouting J., Gonzalez-Esquerre J. and Auterson T. *Waiting times in emergency departments: exploring the factors associated with longer patient waits for emergency care in England using routinely collected daily data*. Emergency Medicine Journal. 2020. 37:781-786. Available online from: https://emj.bmj.com/content/37/12/781

[‡‡‡‡‡‡‡] Singer AJ., Thode HC., Viccellio P. and Pines JM. *The association between length of emergency department boarding and mortality*. Academic Emergency Medicine. 2011. 18(12):1324-1329. Available online from: https://pubmed.ncbi.nlm.nih.gov/22168198/

whose transfer to an inpatient bed is delayed beyond six to eight hours from the time of arrival at the emergency department.§§§§§§§

Delayed transfers of care further compounded the issue of availability of inpatient beds at the hospital. On the day of inspection, the hospital had 44 delayed transfers of care, which impacted on the availability of inpatient bed capacity and continuous, effective patient flow. Hospital management attributed the delay in transferring patients mainly to limited access to step down, rehabilitation and transitional beds in the community, and with issues related to the availability of homecare packages or home support. HIQA were told that during the COVID-19 pandemic in excess of 200 beds was removed from Cork/Kerry community healthcare bed stock, which impacted on the availability of beds.

Overcrowding in hospitals has also been shown to increase the risk of infection and is of particular concern in the context of COVID-19.******** The hospital did have a COVID-19 management pathway in place. The emergency department was the entry point for all patients presenting with COVID-19, where patients were screened and streamed to the most appropriate pathway, in line with national guidelines at the time of inspection. Inspectors observed insufficient space between trolleys in the multi-occupancy area and were concerned that the minimum physical spacing of one metre was not possible.

HIQA was satisfied that patient-safety incidents and serious reportable events related to the emergency department were reported in line with the HSE's incident management framework. In the first quarter of 2022 (January to April), the hospital reported 81 patient-safety incidents to the National Incident Management System,†††††††† which is comparable to the norm of other similar sized emergency departments.

The hospital used the Manchester Triage System in line with best practice and were tracking waiting times from registration to triage. All patients seen in triage were categorised according to prioritisation category levels 1-5. The average waiting time for triage over a 24-hour time frame was 25 minutes, which fell significantly short of the 10 minute timeframe set by the hospital and did present a risk to the timely review of patients, diagnosis and possibly early commencement of treatment.

The hospital has implemented the national early warning system to support the recognition and response to a deteriorating patient in the emergency department. The paediatric early warning system was used for paediatric patients. The Introduction, Situation, Background,

§§§§§§§ Jones S., Moulton C., Swift S., Molyneux P., Black S., Mason N., Oakley R. and Mann C. *Association between delays to patient admission from the emergency department and all-cause 30-day mortality*. Emergency Medicine Journal. 2022. 39(3). Available online from: https://emj.bmj.com/content/39/3/168

******** Kaier K., Mutters N. and Frank U. *Bed occupancy rates and hospital-acquired infections—should beds be kept empty*? Clinical Microbiology and Infection. 2012. 18 (10):941-945. Available online from: https://pubmed.ncbi.nlm.nih.gov/22757765/

†††††††† The National Incident Management System is the single designated system for reporting of all incidents in the public healthcare system.

Assessment, Recommendation communication tool was used when requesting medical reviews of patients and when transferring patients to other clinical areas.

Complaints related to the emergency department were tracked and trended locally by nurse management and the Emergency Department Clinical Operations Group. The hospital devised an information booklet on emergency care to help attendees to the emergency department understand the care pathways and workings of the department.

HIQA noted there was no audiovisual separation of children from adult emergency care as recommended in the national model of care for paediatric healthcare services. The absence of such separation was a concern for HIQA. The hospital were progressing with the capital development project of a designated paediatric emergency department and this will result in the audiovisual separation of children presenting to the hospital's emergency department. This project is due to be completed and fully commissioned later this year.

While fully acknowledging the many measures that hospital management had implemented to seek to manage patient flow and capacity, and mitigate the immediate and potential risk to patient safety, HIQA found that the measures, especially those in the short term were not fully effective in managing the issues in the department identified on the day of HIQA's inspection. On the day of inspection, the level of crowding in the emergency department, ineffective patient flow and waiting times for triage and from triage to medical review had the potential to impact on patient safety and expose patients to a heightened level of risk. Considering the increase in morbidity and mortality association with prolonged waiting times, this was a concern for HIQA. Overcrowding in the emergency department may also increase the risk of healthcare-acquired infections and is of particular concern for HIQA, especially when considering the consistent raise in cases of COVID-19 occurring at the time of inspection.

Judgment: Non-compliant

Conclusion

Management at Cork University Hospital has provided HIQA with a detailed analysis as to the factors that it considers contributes to ongoing overcrowding in the hospital's emergency department. The issue of overcrowding in the hospital's emergency department was persistent before the onset of the COVID-19 pandemic, with the department experiencing unprecedented levels of attendance since January 2022.

Since March 2020, the hospital like other hospitals, has been challenged in managing the impact and effects of COVID-19 on the health service. During this time, the hospital

experienced a decrease in attendance to their emergency department.[††††††††] In 2020, the department had 62,974 attendances, which equated to an average attendance of 191 people per day. By comparison, in 2020, other Model 4 hospitals in Dublin had an emergency department attendance of between 43,456 and 72,787 and rates of attendance were generally stable in 2021. Since the beginning of 2022, Cork University Hospital has experienced high volumes of COVID-19 and non COVID-19 attendances to its emergency department. This has resulted in overcrowding becoming a serious issue for both the hospital and those patients who require emergency care, and remains an area of very significant concern for HIQA.

On the day of HIQA's inspection, 196 people attended the hospital's emergency department. In addition to high volumes of presentations to the department, the hospital's 31% conversion rate of admission for specialised care and treatment, increased demand for inpatient beds. Hospital management had implemented measures to address the issue of overcrowding and ineffective patient flow in the hospital's emergency department in the short and longer term. However, as evidenced by HIQA's findings in this report, the short-term measures implemented or planned by hospital management were not fully effective in supporting and ensuring the delivery of high-quality, safe and reliable healthcare in the hospital's emergency department. Longer-term plans were being progressed by the hospital with the wider Cork/Kerry Community Healthcare but the hospital will need time to implement these in full.

HIQA acknowledges hospital management's efforts to address the mismatch of demand and capacity, and the insufficient flow of patients identified on the day of inspection. However, more needs to be done to increase surge capacity, support better continuous, effective patient flow and ensure care delivered in the hospital's emergency department supports the timely review and medical assessment of patients and promotes respect, dignity and confidentiality for people receiving care in the department.

Last year, hospital management commissioned a review of clinical requirements and activity, and speciality development to inform the hospital's 10 year development plan. The review recommended further development of the hospital's emergency department to service the projected need of the catchment population and increased demand for unplanned care due to the hospital's designation as a major trauma centre. The review report outlined the key developments needed to meet the demand forecasted over the next 10 to 15 years. The HSE also commissioned a review into patient flow at the hospital. The report of this review was not available to HIQA at the time of writing this inspection report. Findings from HIQA's inspection and the two commissioned reviews into governance and patient flow, should form the basis of an action plan comprising measures to address the factors contributing to crowding of the hospital's emergency department and mitigate the risks to patient safety in

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[††††††††] Brick A., Walsh B., Keegan C. and Lyons S. *COVID-19 and emergency department attendances in Irish public hospital*. Dublin: Economic and Social Research Institute. 2020. Available online from: https://www.esri.ie/publications/covid-19-and-emergency-department-attendances-in-irish-public-hospitals

the short and longer term. HIQA will continue to monitor progress in the conduct of these measures and ensure that any further identified required actions are progressed.

Crucially, a system-wide approach, which includes a focussed-hospital approach is needed to address problems associated with patient flow within the emergency department, and to ensure the timely medical review of patients in the department. Measures to further clarify and further enhance clinical leadership at the hospital through the designation of a Lead Clinical Director should be explored to aid in these efforts.

Furthermore, hospital management needs to ensure that all patients attending the emergency department are reviewed and assessed in line with national targets set by the HSE. In order for this to occur, the hospital need to have systems and processes in place that record and provide information on the hospital's performance against quality metrics using real-time data. Hospital management did acknowledge this on the day of inspection and confirmed that they were progressing plans to ensure staff have access to real-time data on quality and performance metrics.

As previously noted by HIQA, the challenges in the emergency department faced by hospital management at Cork University Hospital reflect challenges also experienced in other emergency departments across the country. Given this, more also needs to be done at local, regional and national levels to address the issues of insufficient capacity and ineffective patient flow, which are key contributing factors to the overcrowding and long waiting times in emergency departments.

It is well documented that Ireland has one of the highest bed occupancy rates of any developed health system, often running at 100% or above.§§§§§§§§ This is in excess of the optimum level of 85% recommended in the capacity review published by the Department of Health in 2018.******** HIQA believes that progressing the implementation of the Sláintecare reform plans for the healthcare service in Ireland, together with the associated HSE structural reforms, will create greater capacity and meet the increasing demand for care across the healthcare system. This will in turn, potentially ease pressure on emergency departments and acute hospital services more broadly. It will enable a model of care where services are re-orientated away from the predominant hospital-based model to a more integrated community-based model, so that people who require the service are treated in a timely and efficient way as close to home as possible.

Similar, to other emergency departments inspected and despite hospital management's efforts to mitigate risks, the emergency department at Cork University Hospital was still overcrowded and the waiting times for triage, medical review and admission to an inpatient

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§§§§§§§§ Organisation for Economic Co-operation and Development. *Ireland: Country Health Profile 2019*. France: Organisation for Economic Co-operation and Development. 2019. Available online from: https://www.oecd.org/ireland/ireland-country-health-profile-2019-2393fd0a-en.htm
******** Department of Health. *Health Service Capacity Review 2018 Executive Report*. Dublin: Department of Health. 2018. https://www.gov.ie/en/publication/26df2d-health-service-capacity-review-2018/

bed were such that it represented a risk to patients. This was acknowledged by staff in the emergency department and hospital management who had put short-term mitigation measures in place, and were progressing longer-term substantive plans. Overcrowding compromised the dignity, privacy and confidentiality of patients attending and receiving care in the hospital's emergency department and was not in line the *National Standards for Safer Better Healthcare* or consistent with the human rights-based approach to healthcare promoted by HIQA. While the issues identified by HIQA through this inspection need to be addressed, further plans to address the issues should continue to include consideration of acute and community services together, inclusive of those services provided in general practice.

In response to this inspection, hospital management should progress their plans to improve patient flow, expand capacity at the hospital and manage egress. They also need to ensure and be assured that these plans and resulting operational systems and processes are effective in supporting the timely triage and medical review, and flow of patients through the emergency department, and that there are sufficient and effective arrangements in place to manage and respond to increases in service demand, when needed.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in implementing actions to enhance and strengthen the governance arrangements and physical environment at the hospital, and the patient experience times for people receiving care in the hospital's emergency department.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance classifications

An assessment of compliance with the four national standards assessed during this inspection of the emergency department at Cork University Hospital was made following a review of the evidence gathered prior to, during and after the on-site inspection at the hospital. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards was identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s) to fully comply with the national standards. HIQA will continue to monitor the hospital's progress in implementing the actions set out in any compliance plan submitted (see Appendix 2).

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Partially compliant

Quality and Safety Dimension	
National Standard	**Judgment**
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Non-compliant

Appendix 2 – Compliance Plan as submitted to HIQA for Cork University Hospital

Compliance Plan for Cork University Hospital OSV-0001064

Inspection ID: NSSBH_0006

Date of inspection: 15 June 2022

Introduction: This document sets out a compliance plan for healthcare providers to outline intended action(s) following an inspection by the Health Information and Quality Authority (HIQA) whereby the service was not in compliance with the *National Standards for Safer Better Healthcare*. Any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.

This compliance plan only relates to:
- National standards that were deemed partially or non-compliant by HIQA during the inspection.

The compliance plan should be completed and authorised by the service's Chief Executive Officer, Chief Officer, designated manager and or relevant person in charge.

It is the service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). The compliance plan should detail how and when the service provider will comply with the standard(s) that the organisation had failed to meet.

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan.

Instructions for use

The service provider must complete this plan by;

- outlining how the service is going to come into compliance with the standard
- outlining timescales to return to compliance.

The service provider's compliance plan should be SMART in nature;

- Specific to the standard
- Measurable so that it can monitor progress

- Achievable
- Realistic
- Time bound.

Service Provider's responsibilities

- Service providers are advised to focus their compliance plan action(s) on the overarching systems they have in place to ensure compliance with a particular standard, under which a partial or non-compliance has been identified.
- Service providers should change their systems as necessary to bring them back into compliance rather than focusing on the specific failings identified.
- The service provider must take action within a **reasonable** time frame to come into compliance with the standards.
- It is the service provider's responsibility to ensure they implement the action(s) within the time frame(s) as set out in this compliance plan.
- Subsequent action(s) and plans for improvement related to high risks already identified to service providers should be incorporated into this compliance plan.

Continued non-compliance

Continued non-compliance resulting from a failure by a service to put in place appropriate measures to address the areas of risk previously identified by HIQA inspectors may result in escalation to the relevant accountable person in line with HIQA policy and continued monitoring.

Long-term and medium-term work to meet compliance with the standards

HIQA recognise that substantive and long-term work may be required to come into compliance with some national standards and that this may take time and require significant investment. An example of this may be in relation to non-compliance and risks identified with infrastructure. In such cases, the medium and long-term solutions should be outlined to HIQA with clear predicted timeframes as to how the service plans to improve the level of compliance with the relevant national standard.

In addition to detailing longer term solutions, HIQA requires assurance and details of;

- how mitigation of risk within the existing situation will be addressed
- information on short and medium-term mitigation measures to manage risks and improve the level of compliance with standards should be included in the compliance plan
- the long-term plans to address non-compliance with standards.

Compliance descriptors

The compliance descriptors used for judgments against standards are as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.

Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.

Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.

Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Compliance Plan

Compliance Plan Service Provider's Response

National Standard	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Partially compliant
Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including: **(a) long-term plans to come into compliance with the standard** 1. Capital restructuring of Cork University Hospital as per Archus report. **(10 year plan)** **(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.** 1. South South West Hospital Group (SSWHG) commissioned a comprehensive report of the governance structures in Cork University Hospital. Due to COVID19 this was	

delayed and was completed in 2021.The report was recently completed and awaiting publication in **Q3 – Q4 2022.**

We anticipate that the recommendations of the report will form the basis of improvements to the Governance Structure including the appointment of a Lead Clinical Director in the Hospital.

2. Expand the current model of support with Senior Management available for over-sight and support for service delivery 7 days. **(Q4 2022)**
3. Update the Terms of Reference of the Executive Management Board. **(Q4 2022)**
4. Expand and develop the Quality & Patient Safety Department to support the Directorates deliver the Quality & Patient Safety function. **(Q1 - Q2 2023)**
5. Ensure actions from the Emergency Department Clinical Risk meeting are discussed and minuted at the Unscheduled Care Directorate meetings as appropriate. **(Q3 2022)**
6. Engage with the Clinical Directors to agree a policy on ensuring timely medical review of patients awaiting admission into an in-patient bed from the Emergency Department. **(Q4 2022)**
7. Enhance and strengthen collaborative relationships with the Community Governance Structures e.g Joint review and feedback on 6 month pilot of Community Liaison Team. **(Q3 2022)**
8. Improve visibility through dashboards of operational flow to improve streaming of patients out of the ED. (The Unscheduled Care Directorate have been working with the CUH BI unit to use the current IT system to create power BI dashboards to provide real time information on activity, flow and the hospitals performance against quality and safety metrics for unscheduled and emergency care). **(Q3 – Q4 2022)**

National Standard	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

Workforce planning:

1. Active Recruitment on-going for all Disciplines. **(On-going)**
2. Further business cases submitted to the S/SWHG for further increase in WTE to meet service demand. **(Q4 2022)**

3. Expand the current model of support with Senior Management available for over-sight and support for service delivery 7 days. **(Q4 2022)**
4. Successful Advanced Nurse Practitioner recruitment to support Senior Decision Making. **(Q3 – Q4 2022)**
5. Recruitment progressing in line with CUH designation as a Major Trauma Centre. **(In line with the project)**

Training and education:

1. Continue mandatory training for all ED Staff **(On-going):**
   a. Currently 100% of Nursing Staff are trained in the INEWS and Clinical Handover with ISBAR (see factual inaccuracy feedback).
   b. 83% of eligible staff have been retrained in the Manchester Triage System
   c. 100% of Staff are trained in BLS. (62% of whom have been re-trained in the last 24 months).
2. Recruit an additional Clinical Facilitator to support on-going training in the Emergency Department. **(Q4 2022)**

Multi Disciplinary Team training on patient flow:

1. All Teams need training on use of Business Intelligence Systems to give visibility on patient management , patient flow and performance relative to KPIs. **(On-going)**
2. Investment in Data Manager for Bed Management Office to validate in-patient data. **(Q4 2022)**
3. Application Imprivata to improve engagement in Business Intelligence systems. **(Q1 - Q2 2023)**

National Standard	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a)   long-term plans to come into compliance with the standard

1. Capital restructuring of Cork University Hospital as per Archus report. **(10 year plan)**

(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

1. Reconfiguration of the Acute Medical Assessment Blackwater Suite to increase ambulatory assessment and treatment capacity from 8 – 12 spaces. **(Q4 2022)**

2. Upgrade the Bandon Suite (Medical/Infection control) to increase treatment capacity from 8 - 10 spaces. **(Q4 2022)**
3. Increase ambulatory assessment space in GEMS. **(Q4 2022)**
4. Children's Emergency Department development is in progress. **(Q4 2022)** (To facilitate the delivery of emergency care to children)
5. Second family/interview room for Acute Floor being built as part of the Children's Emergency Department upgrade. **(Q4 2022)**
6. Establishment of the potential for a 12 space area to be reconfigured as a space for day procedures and/or discharge lounge to enable GA 5 day to return to in-patient care and return beds earlier in the day. **(Q3 2022)**
7. PALS (Patient Advocacy Liaison Service) Manager post is in active recruitment.

National Standard	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Non-compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

a) long-term plans to come into compliance with the standard

Capital restructuring of Cork University Hospital as per Archus report. **(10 year plan)**

b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

Nursing & Medical Staffing:

1. Ongoing efforts to recruit NCHDs to facilitate senior medical decision making in particular to support night rotas through national international agencies covering South Africa, India, Pakistan as well as Royal College of Emergency Medicine and Australasian College of Emergency Medicine. **(On-going)**

There is a deficit in NCHDs in all grades when benchmarked against comparable sites Nationally. Currently the ceiling is 23 Registrars,14 SHOs and 2 Interns, however there are unfilled posts in all grades due to the national & international challenges in recruitment.

2. Revision of Directorate Nurse leadership to support service delivery. **(Q3 2022)**

Patient Flow in Unscheduled Care

Access

Working with Primary Care to reduce ED attendances through the CUH GP liaison committee and Primary Care Hubs establishment:

Support NAS in development of see and treat pathways; Virtual Navigation Hub consolidation allowing telemedicine treatment and streaming; support Alternative Prehospital Pathway Service car to ensure ongoing effectiveness;

Support capacity building in the following to allow streaming to these services:

- Acute Medical Unit
- Acute Surgical Unit
- Clinicial Decision Unit
- Acute Oncology Assessment Unit
- Geriatric Assessment Unit
- Cardiac Assessment Unit
- Paediatric Assessment Unit

(Q4 2022)

Throughput

- Implementation of the S/SWHG CKCH Escalation plan
- Implementation of the Safer Bundle
- Children's Emergency Department development is in progress to facilitate audiovisual separation and enhanced capacity for the delivery of emergency care to children in CUH.
- Reconfiguration of the Acute Medical Assessment Blackwater Suite to increase ambulatory assessment and treatment capacity from 8 – 12 spaces
- Upgrade the Bandon Suite (medical/infection control) to increase treatment capacity from 8 - 10 spaces
- Access to Diagnostics:
  - CT Scanner in ED, capital approval Q3 2022. Timeline - 2023.
  - MRI slots in the Mater for discharge to assess
- In patient bed capacity creation through egress beds at Riverstick, Bridhaven as well as St. Finbarrs Hospital
- Establishment of the potential for a 12 space area to be reconfigured as a space for day procedures and/or discharge lounge to enable GA 5 day to return to in-patient care and return beds earlier in the day (Q3 2022)

(Q4 2022 – Q1 2023)

Egress:

- CUH have assumed governance of St. Finbarrs Hospital Rehabilitation Unit since April 24th 2022 with an on-going capital project to re-open to full capacity. **(Q4 2022)** (which will provide an additional 20 rebah beds)
- Assume Governance over beds in the community to include final agreement and workforce for 48 Beds in Riverstick **Q3 2022**, and Dementia specific contracted beds Bridhaven **(Q2 2022)** with approval to uplift as required.
- MDT Monthly telecon with NRH to resolve issues for brain and spine: HSCP, Consultant, CNS, Discharge Co-ordinators, Head of Bed Management
- Internal process work on identification of rehabilitation patients to impact on length of stay, there is a local rehabilitation and egress stream established via the programme for realisation of the Major Trauma Centre. (This forum will address some of the quality assurance issues associated with the current process which impacts on patient flow for patients requiring rehabilitation)
- Recommendations from the recent review of the Community Liaison Team will be reviewed with the Team.

(Q3 – Q4 2022)

Infrastructure:

- Reconfiguration of the Acute Medical Assessment Blackwater Suite to increase ambulatory assessment and treatment capacity from 8 – 12 spaces
- Upgrade our medical/infection control Bandon Suite to increase treatment capacity from 8 to 10
- Increase ambulatory assessment space in GEMS.
- Children's Emergency Department development is in process to facilitate the delivery of emergency care to children in CUH.
- Access to Diagnostics:
  - CT Scanner in ED, capital approval Q3 2022. Timeline - 2023.
  - MRI slots in the Mater for discharge to assess
- Review with Estates Department the potential for a 12 space area to be reconfigured as a space for day procedures and/or discharge lounge to enable GA 5 day to return to in-patient care and return beds earlier in the day

(Q4 2022 – Q3 2023)

Ambulance KPIs:

Reduction in boarding of patients in ED (detailed through the above) will create space in the emergency department to facilitate ambulance off load. The Hospital has instated monitoring systems to identify conflicts in data reporting between NAS and Hospital (outlier identification/data cleaning). Reporting of patient turnarounds as well as the National Ambulance KPI of vehicle turnaround will be provided.
 (On-going)

PCHAI in RASTTA Procedures:

Safety measures for 'Multi-occupancy area - RASTTA Procedures area':

- This area to be re-instated as a procedures area once Paediatric ED is opened. **(Q4 2022)**

Actions in place as follows:

- Documented infection control processes to ensure no patient is at risk of HCAI.
- All patients are point of care tested and screened for HCAI prior to being placed.