



Report of an inspection against the *National Standards for Safer Better Healthcare.*

Name of healthcare service provider:	Tallaght University Hospital
Address of healthcare service:	Tallaght Dublin 24 D24 NR0A
Type of inspection:	Unannounced Inspection
Date of inspection:	27 October 2022
Healthcare Service ID:	OSV-0001002
Fieldwork ID:	NS_0016

About the healthcare service

The following information describes the services the hospital provides.

Model of hospital and profile

Tallaght University Hospital (TUH) is a model 4* acute teaching hospital and is part of the Dublin Midlands Hospital Group. The hospital provides local, regional, and national specialities, catering for a direct catchment area of 110,000 people and broader catchment area of 800,000 people across five counties. The hospital is a national urology centre, the national memory service, the second largest provider of dialysis services in the country and a designated trauma centre.

The hospital has an inpatient complement of 450 beds with an additional 61 off-site beds under TUH governance. The hospital's clinical referral base includes: general surgery, colorectal surgery, hepatobiliary and pancreatic surgery, vascular surgery, urology, orthopaedics, gynaecology, ear nose and throat, gastroenterology, hepatology, neurology, endocrinology, rheumatology, medical oncology and haematology, radiation oncology, cardiology, respiratory medicine and emergency department.

How we inspect

Among other functions, the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare services. HIQA carried out a one-day unannounced inspection of the emergency department at Tallaght University Hospital on 27 October 2022, to assess the compliance with four national standards (5.5, 6.1, 1.6 and 3.1) from the *National Standards for Safer Better Healthcare*.

* The National Acute Medicine Programme model of hospitals describes four levels of hospitals as follows:

Model 1 hospitals: are community and or district hospitals and do not have surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care.

Model 2 hospitals: can provide the majority of hospital activity including extended day surgery, selected acute medicine, treatment of local injuries, specialist rehabilitation medicine and palliative care plus a large range of diagnostic services including endoscopy, laboratory medicine, point-of-care testing and radiology - computed tomography (CT), ultrasound and plain-film X-ray.

Model 3 hospitals: admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine and critical care.

Model 4 hospitals: are tertiary hospitals and are similar to Model-3 hospitals, but also provide tertiary care and in certain locations, supra-regional care.

To prepare for this inspection, inspectors[†] reviewed relevant information about Tallaght University Hospital. This included any previous inspection findings, information submitted by the hospital and the Dublin Midlands Hospital Group, unsolicited information and other publicly available information.

As part of the 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 emergency department
- 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 that 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.

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 being sustainably provided in the 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 high-quality and safe delivery of care.

2. Quality and safety of the service

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

[†] 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*.

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, themes and national standards from the *National Standards for Safer Better Healthcare* discussed in each section.

Table 1 Sections of the report and corresponding dimension, themes 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 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
Thursday 27 October	09:00hrs to 16:20hrs	Nora O' Mahony	Lead
		Patricia Hughes	Support
		John Tuffy	Support
		Lisa Corrigan	Support

Information about this inspection

The emergency department at Tallaght University Hospital provides 24/7 access for undifferentiated emergency and urgent presentations for patients with medical, surgical, trauma, mental health and behavioural conditions. The department has over 52,000 attendances per year.

Following the review of available information, HIQA identified that the hospital was reporting increased ED attendances in the emergency department over a period of time with associated instances of overcrowding. In light of this, HIQA conducted a risk-based unannounced inspection of the adult emergency department in Tallaght University Hospital on 27 October 2022, to determine the hospital's level of compliance with four standards from the *National Standards for Safer Better Healthcare*.

The inspection focused in particular, on key issues that impact on the delivery of care in the emergency department. These included:

- 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 emergency department
- staffing levels in the emergency department.

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

- representatives of the hospital's Executive Management Team:
 - Chief Executive Officer
 - Director of Nursing and Integrated Care
 - Clinical Director for the Medical Directorate
 - Director of Quality, Safety and Risk Management
 - Director of Human Resources
 - Chief Operations Officer
 - Deputy Chief Executive Officer
- Deputy Chief Operations Officer and the Clinical Nurse Manager for Patient Flow.

Inspectors also spoke with medical staff, nursing management, staff nurses and people receiving care in the hospital's emergency department. Inspectors reviewed a range of documentation, data and information received after the on-site inspection of the emergency department at Tallaght University Hospital.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and all the 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.

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

Tallaght University Hospital has a modern emergency department comprising of a reception area, waiting area, triage area, rapid access and treatment unit with three cubicles (RATU), respiratory waiting area, zone 1 and zone 2 and an area referred to as the Clinical Decision Unit with 6 curtained cubicles.

On arrival at the hospital, people attending the service were assessed for risk of COVID-19. Patients not at risk of COVID-19 were referred to the main waiting area which contained 24 seated areas, segregated by transparent partitions, to await triage. Signage was in place regarding both physical distancing and hand hygiene, and hand sanitiser stations were available on entry to the emergency department and within the waiting areas.

Patients at risk for COVID-19 were streamed and guided to follow signage to a separate respiratory waiting area for rapid COVID-19 testing. At this point, triage staff were notified and patients with suspected COVID-19 were identified on the computer system. The COVID-19 waiting area comprised of individual seated areas separated by transparent partitions. Once streamed, the hospital had separate COVID-19 and non-COVID-19 pathways in place. The emergency department had three isolation rooms designated for COVID-19 patients, two of which were en suite. There were no COVID-19 patients in the department at the time of inspection and all three isolation rooms were occupied by patients with other communicable infectious diseases. This will be discussed further under section 3.1

The emergency department comprised of the following:

- A three cubicle rapid assessment treatment unit (RATU), which included a cubicle for ambulance triage.
- Zone 1 comprised of three separate areas:
 - the first area accommodated the nurses and doctors' station, five spacious resuscitation cubicles, 10 walled cubicles, a four seated area and two designated psychiatric assessment rooms. This area, which had capacity for 21 patients had only one toilet and no shower facilities.
 - zone 1 continued through adjoining doors to an area with nine additional walled cubicles, two toilets and one shower facilities. This area also had three single rooms, two rooms had en-suite facilities and one room had negative pressure ventilation[‡] and an anteroom[§]. A seated 'respiratory waiting area' was also within this area.

[‡] Negative pressure rooms are isolation rooms, in which the air pressure inside the room is lower than the air pressure outside the room. This means that when the door is opened, potentially contaminated air or other dangerous particles from inside the room will not flow outside into non-contaminated areas.

[§] Anteroom, is an airlocked room that provides a safe area for healthcare professionals to change into or out of protective clothing, transfer or prepare equipment and supplies, and can protect other rooms from contamination if pressure is lost within the negative pressure room.

- The third zone 1 area was referred to as the 'clinical decision unit,' although currently not functioning as such. This area had six curtained cubicles which accommodated emergency department patients or patients admitted under a specialist consultant within the hospital awaiting an inpatient bed.
- Zone 2 was the ambulatory care area which contained four minor injury cubicles, five ambulatory care cubicles and a separate waiting area comprising of seven partitioned seats.

Following triage and Manchester triage categorisation, patients were referred to either the: RATU, zone 1, zone 2, medical assessment unit** or the age-related assessment unit.†† However, due to overcrowding in the department on the day of inspection, people attending services were referred back to the waiting area for prolonged periods of time following triage to await medical review.

On entering the emergency department, inspectors observed that zone 1 of the department was very overcrowded. All patient spaces in zone 1 were occupied by patients. There was an additional ten patients on trolleys in a congested space around the nurses and doctors' station and surrounding the designated psychiatric assessment rooms. The designated psychiatric assessment rooms were brightly light with windows on three sides. Inspectors noted patients sleeping on the couches in these rooms.

Despite the overcrowded and busy department, the atmosphere was calm, with staff undertaking their duties in a professional manner. Staff were observed to be kind, caring and respectful towards patients and introduced themselves by name. Staff were also observed to draw curtains where possible and use mobile curtains for patients on trolleys. The interactions observed among staff in all areas was very respectful and considerate. The staff in the emergency department who spoke to inspectors were committed and constantly striving to provide the best experience to the patients who attended the ED in what was a very challenging environment, with admitted patients awaiting an inpatient bed and staffing shortages.

Inspectors observed that staff working in the clinical area were wearing appropriate personal protective equipment (PPE) in line with current public health guidelines and PPE donning and donning signage was also observed. Inspectors observed a staff member conducting a hand hygiene audit.

Inspectors spoke with a number of patients in the emergency department about their experience of care in the emergency department. Some patients were complimentary, telling inspectors they were '*really impressed, only waiting 10-15 minutes to be seen following triage*' and '*really liked the idea of the cubicles to protect people*'.

** The medical assessment unit was an area adjacent to the ED where medical patients, streamed from the ED, were reviewed by a senior decision-maker.

†† The age-related assessment unit was adjacent to the emergency department designated for review of older persons with medical conditions.

Most patients reported that staff were doing their best, however, one patient commented on being discharged and having to return to the emergency department. Patients in the main waiting area reported that the toilet facilities were very clean and triage was very quick. One patient in the main waiting area described observing another patient becoming aggressive with staff and upsetting other patients. It was noted by inspectors that there were security personnel on hand in the department to deal with any security issues that arose. There was a suggestion from one of the patients of a small coffee station and a TV in the main waiting area to improve the patient experience. Patients who spoke with inspectors were able to voice how to make a complaint if they had an issue or concern.

The following two sections, capacity and capability and quality and safety outline the quality of the care and services provided to people receiving care in the emergency department on the day of HIQA's 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 standards 5.5 and 6.1. Key inspection findings leading to these judgments are described in the following sections.

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.

Tallaght University Hospital had defined lines of responsibility and accountability for the governance and management of unscheduled care in the hospital. The Chief Executive Officer (CEO) had overall responsibility for the governance of the hospital and reported to the Hospital Board. The CEO and senior hospital managers attend monthly performance meetings with the Dublin Midlands Hospital Group.

The emergency department was under the governance and leadership of the Medical Directorate, led by the Medical Clinical Director who in turn reported to the CEO.

The hospital's Executive Management Team (EMT) had overall accountability for the hospital and reported to the CEO and the Board. The EMT met twice a month and meetings were well attended. Monthly reports were presented by hospital departments such as, human resources, finance, quality safety and risk management and the directorates. Hospital activity and performance were reviewed and discussed. The risk register was reviewed and newly identified risks were accepted to the EMT risk register or referred back to the department to manage locally as appropriate. Hospital policies were reviewed and approved by this committee.

Tallaght University Hospital Board met monthly and the agenda included:

- A 'Patient Story' presented by the Director of Nursing and Integrated Care which included positive stories and stories which identified areas for improvement. Measures implemented to improve practice, based on the patient's story and to mitigate against a recurrence were shared with the Board.
- The Board chairperson, hospital CEO and Medical Board chairperson provided update reports for members.
- The Hospital's EMT Integrated Management Report was reviewed at this meeting which included rotating agendas:
 - agenda 1: activities and performance for unscheduled and scheduled care, human resources, information technology, facilities and estates, radiology and perioperative directorates
 - agenda 2: quality safety and risk management, nursing, finance, medical and laboratory directorates.
- Items for decision by the Board were included such as: annual reports, strategies and service level agreements
- Heads of hospital departments such as finance, quality, safety and risk management and the audit committee provided updates.
- The hospital's 'Issues Log' was reviewed and updated at meetings. One issue on the issue log related to ED access, patient experience and communication. A quality improvement project to manage these issues was presented to the Board on minutes reviewed by inspectors. This is discussed in more detail under standard 1.6.

Recruitment and capacity were highlighted as major challenges in Board minutes reviewed by inspectors, as well as an increase in ED activity and the impact on scheduled care. These challenges were observed by inspectors and communicated by staff on the day of inspection.

The Clinical Lead post for Emergency Medicine was a 1-2 year voluntary position between emergency medicine consultants. This position had been vacated two months prior to the

inspection and was currently unfilled. Inspectors were informed that the emergency medicine consultants within the emergency department were encouraged to nominate a new clinical lead. At the time of inspection, a clinical lead nominee had not been identified among the current staff. Senior management outlined that new emergency medicine consultants were due to take up post in the near future. The lack of a clinical lead for emergency medicine was of concern to HIQA and the hospital management and emergency department clinicians should seek to fill this vacant position as a priority.

The emergency department was under the governance of the Medical Directorate and the Emergency Medicine Consultants reported to the Medical Clinical Director. The Medical Director represented the ED at directorate, management and board level. Inspectors were informed that relationship and communication with the Medical Clinical Director was positive, however staff in the ED expressed the view that more direct representation from the emergency department at management level might be beneficial, considering the size, activity and complexity of issues within the department. The hospital may consider this feedback in order to ensure that the Acute Floor^{‡‡} is sufficiently represented at directorate level.

The Medical Directorate met twice a month and reported to the EMT via the Medical Director. The committee had a standing agenda which included, Clinical Director's update, operations, nursing, finance, human resources and work force planning. The purpose of the committee, outlined in the terms of reference, was to ensure the running of the medical service within the hospital. The committee's membership included the Medical Clinical Director, Operations Manager, nursing representative, medical human resources (HR), HR partner, finance partner, and the medical non-consultant hospital doctor lead. The committee's action log was reviewed and updated at the meeting and each action was assigned to a named person.

The Chief Operations Officer chaired the Emergency Department Operations Group which had a set agenda which included: a review of activity data, equipment issues, staffing issues, ED-focused patient flow matters, and quality improvement planning and support. The committee escalated issues of concern related to medical staffing to the Medical Clinical Director, nurse staff issues were escalated to the Director of Nursing and Integrate Care, issues that affected the acute floor were escalated to the Acute Floor Steering Group, and clinical concerns were escalated to the relevant Clinical Director. In minutes reviewed by inspectors, the committee was well attended. This group, as per the terms of reference, were to meet monthly, but the minutes submitted to HIQA for the last meeting were dated July 2022. Inspectors were informed on the day of inspection that this committee had met again in August. The hospital needs to ensure that this important committee meets in line with the committee's terms of reference to action and progress agenda items. The hospital's Unscheduled Care Group

^{‡‡} The acute floor comprised of the emergency department, the acute medial assessment unit, the age-related assessment unit, medical short unit the acute and the surgical assessment unit (currently accommodating admitted patients awaiting an inpatient bed). The emergency department and the other units of the acute floor had separate medical and nursing staff.

meetings were temporarily reconfigured into the Acute Floor Steering Group in order to agree the acute floor standards and project implementation. A log of all active acute floor programme actions was reviewed by inspectors.

The role of the hospital's Quality, Safety and Risk Management Executive Governance Committee (QSRMEGC) was to oversee the operation of quality, patient safety and risk management. The committee's membership was inclusive of senior management representatives including the Director of Nursing and Integrated Care, Directorate Clinical Directors and Directors of quality, safety and risk management, finance, information communication technology, estates and facilities and human resources. The Quality, Safety and Risk Executive Governance Committee reported to the Executive Management Team and reported via the chairperson to the CEO. The committee's agenda included a review of the EMT risk register and annual presentations from subgroup on topics such as: patient casebooks, national clinical effectiveness committee guidelines update, nursing national quality care metrics and incidents and claims.

The emergency department at Tallaght University Hospital had attendances of 52,025 in 2021. This was an increase of 6.85% on 2020 attendees, but comparable to 2019 attendances of 52,398, pre-COVID-19 pandemic. In 2022, the monthly ED attendances were approximately 4,377 per month, an average daily attendance of 141. Although similar to attendance levels in 2021 and 2019, the hospital reported patients presenting with greater acute illnesses' in 2022. In 2021, the majority of patients (88%) attending the ED were under 75 years of age, however there was an increase of 4% in the number of patient over 75 years of age presenting in 2022 in the year to date.

Inspectors were informed that the hospital was challenged with emergency department attendees who required specialist services that were not available within the hospital, such as child and adolescent mental health services (CAMHS). Access to community services to facilitate transfer of care back to the community and access to community beds at weekends was also cited as an increasingly challenging issue.

Some of the hospital's catchment areas had a high deprivation score which had the potential to negatively impact on the health of that population which can be challenging for healthcare delivery in the area.^{§§} In addition, inspectors were informed that the catchment area was further hampered by a low number of general practitioners (GPs) per capita in the locality.

On average, 26% of ED attendees were referred by a GP. Inspectors were informed that this indicated the difficulty in accessing GP services for people within the catchment areas. For the year to date in 2022, an average 29% of people who presented to the ED were admitted to the hospital (conversion rate), this percentage compared well to other model 4 hospitals.

^{§§} Trinity College Dublin. *The Trinity National Deprivation Index for Health and Health Services Research 2016*. 2019. https://www.tcd.ie/medicine/public_health_primary_care/research/deprivation/

Inspectors were also informed that there was a significant and sudden influx of people, many vulnerable persons to temporary accommodation within the catchment area of this hospital.

The average length of stay (ALOS) for medical patients reported in October 2022 was 11.6 (KPI target ≤ 7.0), with an ALOS for surgical patients at 7.8 (KPI target ≤ 5.2). Inspectors were informed that there were a number of patients with extended lengths of stay due to their level of acuity and lack of community supports. At the time of inspection, there were approximately 50 patients in the hospital who had completed their acute episode of care and were experiencing a delay in the transfers of care^{***} to the community. This number of patients was higher than that in other model 4 hospitals. The lack of long-term care facilities and community support was outlined by the hospital as the main reason for delayed transfers of care, as well a number of persons who have complex discharge needs.

The ALOS and the delays in transfer of care impacted the hospital's occupancy rate which was in the range of 105% to 116%. This is well in excess of the optimum level of 85% recommended in the capacity review published by the Department of Health in 2018.⁺⁺⁺ As a consequence, there were admitted patients in the ED awaiting an inpatient bed. According to the hospital's Integrated Management report October 2022, there were 736 patients on trolleys awaiting admission to inpatient beds in September 2022, the highest monthly number recorded for 2022. The hospital staff who spoke with inspectors cited bed capacity and lack of isolation facilities as a major challenge. The hospital also had 450 inpatient beds which was lower than most other model 4 hospitals.

On the day of inspection, the hospital stated that it was in 'full escalation'.⁺⁺⁺ At 11am, there were 85 people registered in the emergency department. 47 of these patients were in the department greater than nine hours and 15 patients were in the ED over 24 hours. There were 24 admitted patients in the emergency department and six admitted patients in the acute surgical assessment unit, under the care of specialist consultants awaiting an inpatient bed.

There were 31 patients in the waiting room at 11 am occupying all 24 partitioned seats and seven additional seats in the waiting area. From review of the hospital's data for the week prior to the inspection, the numbers of patients registered in the ED at 4pm, 10pm and midnight was often over 100 with a peak of 128 patients registered in the department on the previous Friday at midnight. Accommodation and provision of timely assessment and management for these large numbers of attendees was very challenging for the department.

^{***} Delayed transfers in care: A patient who remains in hospital after a senior doctor (consultant or registrar) has documented in the healthcare record that the patient care can be transferred.

⁺⁺⁺ 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/>

⁺⁺⁺A hospital's escalation policy, sets out (within the parameters of the national framework) the key stages of steady state, escalation, full capacity protocol, de-escalation and review.

The overcrowding in ED impacted the hospital's 'Patients Experience Time'^{§§§} (PET) which was well below the national target for the percentage of all attendees to ED who were admitted or discharged within six hours, nine hours and 24 hours of registration. In September 2022, the percentage of all ED attendees who were admitted or discharged within nine hours of registration was 44.05% (national target 85%). The hospital PET's were lower than the average PETs for other model 4 hospitals in data published^{****} for 2021 and Q1 2022. The average percentage of all attendees at ED Q1 March 2022 who were:

- discharged or admitted within six hours of registration was 31.5% (national target 70%)
- discharged or admitted within nine hours of registration was 44.5% (national target 85%)
- discharged or admitted within 24 hours of registration was 84.4 (national target 97%).

To support patient flow, the hospital had initiatives in place and planned, as outlined below:

- Meetings were held daily to review the hospital and emergency department activity to support patient flow through the hospital and into the community. Medical handover meetings are held at 10am, bed management meetings at 11am and 1.30pm and additional escalation meetings at 3.30pm when there were over 24 patients in the emergency department awaiting an inpatient bed. A handover meeting was held on Fridays to discuss acutely ill patients and planned discharges.
- The hospital held a weekly meeting with community partners to expedite transfers of care to community.
- Suitable patients were transferred to the transition lounge for continued care and management until discharge.
- A 'trolley to ward transfer agreement' was a recent initiative which allowed two patients from the ED, who were awaiting admission, to be transferred to a ward pending discharges of other patients on that ward. These patients were provided with a bed once the planned discharges were completed.
- Acute floor development:
 - The age related assessment unit (ARAU) was a newly opened four cubicle area adjacent to the emergency department designated for review of older persons with medical conditions who were streamed from the emergency department. This area was staffed by an advanced nurse practitioner with oversight by the acute medical unit consultants. The service was actively recruiting for multidisciplinary support

^{§§§} Patient experience time (PET) refers to the total time spent by patients within the emergency department, inclusive of time spent awaiting admission

^{****} Health Service Executive, Management Data: December 2021 and March 2022.

from an occupational therapist, a physiotherapist and speech and language therapists.

- The acute medical unit (AMU) was an eight cubicle unit adjacent to the ED into which medical patients were streamed from the ED. The unit reviewed in the range of 15-18 patients per day, but only operated Monday to Friday.
- The hospital had a plan in place to open a six cubicle acute surgical assessment unit (ASAU), once staff were in place.
- The Gerontological Emergency Department Intervention team was an interdisciplinary initiative which aimed to meet the needs of the growing older population through the provision of a comprehensive geriatric assessment, to aid admission avoidance or early discharge with appropriate supports in place.
- Tallaght University Hospital and National Ambulance Service (NAS) were about to commence a joint initiative, whereby a whole-time equivalent^{††††} medicine consultant will provide telephone support to the staff of the NAS with the aim of reducing the need for emergency department attendances or to support safe transition to the emergency department if required.
- Community general practitioner (GP) appointments: The hospital had an arrangement in place with a local GP service whereby appropriate ED attenders could avail of three allocated daily appointments to avoid a prolonged ED wait for review. The hospital reported that the uptake of these daily appointments had been limited. An attempt was made to recruit a GP on site in the emergency department but the position could not be filled.
- Senior Intervention Following Triage (SIFT model) was a model to facilitate early senior clinical decision-making and appropriate diagnostics post triage with a view to reducing the Patient Experience Time (PET). This initiative had commenced informally in the hospital when staff were available, was proposed to run Monday to Friday from 8am to 6pm. The SIFT was supported by ED diagnostic technicians to support earlier access to diagnostics.
- The hospital had a plan in place to introduce a computerised tomography (CT) scanner within the emergency department in Quarter 1 2023 to expedite access to CT scans.

†††† Whole-time equivalent - allows part-time workers' working hours 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

- The hospital outlined other medium to long terms plans for a number of initiatives to facilitate improved patient flow and manage increased demand, which were staff and funding dependent:
 - ‘Tallaght in the Home Programme’ integrated community and hospital services
 - ‘Pathfinder Team’* to support ED admission avoidance and alternative pathways
 - Building of a 72 bed extensions, comprising of three wards of single rooms.

Despite these initiatives in the emergency department, on the day of inspection:

- The waiting time for patients from registration to triage ranged from 1-59 minutes.
- The waiting time for patients from triage to medical review ranged from 10 minutes to 20 hours and 32 minutes, with an average time of 4 hours and 33 minutes.
- The waiting time for patients from medical assessment to decision to admit ranged from 1 hours and 16 minutes to 25 hours and 8 minutes with an average time of 8 hours and 42 minutes.
- The waiting times for patients in the ED for an inpatient bed following decision to admit ranged from 5 hours and 5 minutes to 59 hours (2 days and 11 hours) with an average time of 18 hours and 25 minutes

An instance in which a patient waited 20 hours and 32 minutes from time from triage to medical review was of concern to HIQA. HIQA subsequently wrote the hospital to ascertain how the hospital were addressing the risk(s) associated with patient(s) waits of up to 20 hours and 32 minutes for medical review following triage. The hospital’s response outlined a number of time-bound actions to mitigate the risk which included actions previously outlined above and additional actions to improve patient flow and the patient experience time.

In summary, Tallaght University Hospital had management arrangements in place to support and promote the delivery of healthcare services. While measures were being taken to improve patient flow through the emergency department, HIQA found that these measures were not fully effective in ensuring delivery of high-quality, safe and reliable healthcare services to the people who used the hospital’s emergency services.

The emergency department staff were striving to provide safe, quality care to the high number of patients presenting to the ED, many with challenging conditions. Staff efforts were hampered by high numbers of admitted patients remaining in the department while awaiting an inpatient bed and patients awaiting specialist review and decision to discharge or admit.

The hospital was challenged with capacity issues, lack of isolation facilities within the hospital and lack of community facilities and services to enable transfer of care to the community for the high numbers of patients who had completed their acute episode of care. The hospital needs to address capacity issues, but also patient flow issues though the hospital and into the

community. The hospital management and ED clinicians need to progress leadership in the ED through the filling of the vacant clinical lead position.

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 the service to be effective there needs to be sufficient staff with the right skills to deliver safe, high-quality care.

The Clinical Lead for Emergency Medicine was a rotational voluntary post between emergency medicine consultants. As previously mentioned, this position had been recently vacated and was currently unfilled. There were six whole-time equivalent (WTE) emergency medicine consultants in the emergency department and inspectors were informed that the hospital's WTE emergency medicine consultants had been increased to nine, with recruitment in progress. All consultants in post in the emergency medicine were on the specialist register with the Irish Medical Council.

A senior clinical decision-maker,**** consultant or registrar, was available on site in the emergency department 24/7. Consultants were on site from 8am to 6pm Monday to Friday, with one consultant providing on-call cover during evenings, nights and weekends. Non-consultant hospital doctors (NCHDs) provided medical cover in the department 24/7.

Attendees to the emergency department were assigned to the emergency medicine on-call consultant until admitted or discharged. If admitted, the patient was assigned under the care of a specialist consultant and remained in the emergency department while awaiting an inpatient bed. However, if the patient's clinical condition deteriorated, staff in the emergency department provided the necessary emergency response.

The emergency department had an approved complement of 29 WTE non-consultant hospital doctors comprising of 15 WTE registrars, 12 WTE senior house officers (SHO) and two WTE interns. Inspectors were informed that the hospital was challenged in filling NCHD posts for the department. A recent overseas recruitment drive had proved successful, but there was still a current shortage of two WTE senior house officers. Inspectors reviewed rosters for the four week period prior to the inspection and noted that some NCHD shifts were unfilled, with some shifts covered by locum or agency. Unfilled shifts in the emergency department creates

**** Senior decision-makers are defined here as a doctor at registrar grade or a consultant who have undergone appropriate training to make independent decisions around patient admission and discharge.

a potential risk of extending patient experience times and compromising the delivery of safe, quality care.

A clinical nurse manager 3 (CNM3), had responsibility for the nursing service within the emergency department. The CNM3 reported to the Assistant Director of Nursing (ADON) for the Acute floor. Issues such as staffing shortages were escalated to the nursing office. A CNM 2 was on duty each shift, and had responsibility for out-of-hours nursing services and at weekends. The CNM 2 escalated issues to the out-of-hours nursing office. An additional CNM 2, who was working core hours, was responsible for admitted patients remaining in the emergency department.

There were 82 WTE approved nursing posts in the emergency department comprising of staff nurses and CNM 1, 2, 3 posts, including a CNM2 post for admitted patients within the ED. At the time of inspection, eight WTE staff nurse posts and one WTE CNM 1 post were unfilled. The ED also had 19 WTE approved healthcare assistant posts, 3.8 WTE of which were unfilled. Inspectors were informed that recruitment was ongoing with six staff nurses due to commence by November 2022.

The department required 18 nurses on day shift and 15 nurses on night shift to staff all areas of the department. On the day of inspection, the department did not have its full complement of nursing staff on duty. There were 14 nurses rostered on day shift and 12 nurses rostered for the night shift. As a consequence, inspectors were informed that the rapid assessment and treatment unit and the areas for ambulatory medical care in zone 2 were not fully opened because nurses were relocated to other areas such as triage. These areas were being used by doctors to examine patients with assistance from the ED circulating nurse as required.

At 11am on the day of inspection, as well as providing care for the large number of patients with undifferentiated and or urgent presentation within the ED, staff were also caring for 24 patients admitted under the care of specialist consultants awaiting inpatient beds.

Nursing staff shortages resulted in an increase in the nurse-patient ratio which had the potential to impact on the provision of safe, quality care to the patients within the department. This risk was further increased as a result of overcrowding in the department. On the day of inspection, all cubicles and seated areas within zone 2 (major area) were full and there was an additional 10 patients on trolleys around the doctors and nurse's stations and an additional six patients on seats beside this area.

A review of ED nursing rosters for the four week period prior to the inspection demonstrated that the emergency department was on average staffed by 15 nurses on day shift (requirement 18) and on average 13 nurses on night shift (requirement 14).

Inspectors were informed that the department nursing staffing complement was set to increase to 83.5 WTE (from 82 WTE) as a result of the workforce assessment undertaken as part of the Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings

in Ireland.^{§§§§} This framework, launched by the Department of Health in June 2022, 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 hospital's staff absenteeism rates in September 2022 was noted to be 4.9% (no absences were associated with COVID-19). The national target for absenteeism is less than or equal to 4%.

Staff training records provided to inspectors outlined that nursing and medical staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice. HIQA found that there was opportunities for improvement with compliance rates for mandatory training. The compliance with mandatory and essential training was as follows:

- 66% of nurses were up to date with Irish National Early Warning System
- 46% of nurses were up to date with the Irish Maternity Early Warning System
- 83% of nurses were up to date with Basic Life Support
- all nursing staff who carry out triage were up to date on their training related to the Manchester Triage System.

Training records for medical staff showed that:

- 63% medical staff were up to date in basic life support training
- 10% of medical staff were up to date with training on the Irish National Early Warning System
- 42% of medical staff had training on national guidance on clinical handover with ISBAR.

At the time of inspection, ED staff had not commenced training in the Emergency Medicine Early Warning System.

In summary, hospital managers need to ensure that there are sufficient staff available at the right time to deliver safe, high-quality care in the emergency department. At the time of inspection, the hospital had made progress in recruitment of medical staff for the emergency department assisted by overseas recruitment. However, there were still some NCHD posts vacant. This resulted in unfilled shifts which created a risk of increased patient experience times and compromise in the delivery of safe, quality care. There was also the opportunity to improve compliance with mandatory training for staff in the ED

Nurses and healthcare assistant posts were also unfilled resulting in daily staffing shortages. The ongoing impact of unfilled shifts meant that areas of the department were not always

^{§§§§} 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>

fully operational and the nurse to patient ratio was increased and this had the potential to impact on the provision of safe, quality care to the patients within the department.

Judgment: Partially compliant

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 non-compliant with standards 1.6 and partially compliant with 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 would 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 environment in which care is delivered should also promote and protect the patient's dignity and privacy, and protect the personal information of people who use the service.

At 11am on the day of inspection there were 85 patients registered in the emergency department. 43.4% of patients were self-referrals, 21.7% arrived via ambulance and 27.7% via General Practice (GP). Of the 85 patients in the department:

- 47 patients had registered in the ED greater than nine hours, five of these were over 75 years of age or over.
- 15 patients had registered in the ED greater than 24 hours, one of these was 75 years of age or over
- 24 patients were admitted under the care of a specialist consultant and remained in the ED awaiting an inpatient bed.

**** 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.higa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services>

There were ten patients on additional trolleys placed along the nurses and doctor's work station and surrounding the psychiatric assessment rooms in zone 1 of the emergency department. There were four patients in a seated waiting area. This area was a busy thoroughfare for all emergency department activity. The overcrowding impacted on the potential for staff to provide dignity and privacy for these patients.

Considering the overcrowding and the number of admitted patients within zone 1 of the emergency department at the time of inspection, the number of toilets and showers available was not adequate to meet the needs of these patients. This did not protect or promote the dignity and respect and independence of the patients in this area of the ED.

Staff were doing their best to maintain privacy by using mobile curtains and lowering the volume of their voices. Patients who spoke with inspectors expressed the negative impact the overcrowding had on their care experience and the dignity and respect afforded to them and other patients.

The designated psychiatric assessment rooms (DPAR) were brightly light, with windows on three sides which enabled direct visualisation of patients in the DPAR by staff at the nurses' station. However, these rooms were also within full sight of patients on trolleys which were placed close to, or surrounding these rooms, as was the case on the day of inspection. Inspectors noted patients sleeping on the couches in the DPARs. Acknowledging the requirement for direct but discreet observation of this vulnerable cohort of patients, but cognisant of staffing challenges within the department, the hospital should consider how these rooms might be best used for observations as intended. This also includes due regard for the overall needs of people cared for within them while also ensuring the safety, privacy and dignity of such patients.

Staff working in the hospital's emergency department were committed and dedicated to promoting person-centred care. Staff were observed to be kind and caring towards patients in the department, and tried to respond to their individual needs, which was challenging in an overcrowded department with patients on trolleys and patients sitting in waiting areas. Communication observed between staff and patients was respectful.

However, the close proximity of all patients and the number of trolleys around the doctors and nurses' station compromised privacy. Patients and staff could overhear patient-clinician conversations and personal information being exchanged between patients, medical and nursing staff. This is not in line with the human-rights based approach to healthcare as promoted and supported by HIQA.

Curtains were secured around patients in designated bays to provide privacy and protect their dignity when providing personal care, assessment and consultation and screens were available for trolleys outside designated areas.

The findings from the 2021 National Inpatient Experience Survey, ² in relation to the provision of dignity, respect and privacy were compared to the national average scores:

- When asked if overall they felt they were treated with dignity and respect while in the emergency department the hospital scored 8.5, lower than the national average score of 8.8.
- When asked if they were given enough privacy when being examined or treated in the emergency department the hospital scored 8.5, higher than the national average score of 8.3.

The hospital had implemented a number of person-centred initiatives to improve the experience of patients attending the emergency department or to reduce or avoid the need for patients to come to the emergency department. These included:

- Patient comfort packs – staff reported providing patients awaiting assessment, admission or a bed with comfort packs containing anti-slip socks, toothpaste, toothbrush and a wash cloth.
- Inspectors were informed that patients 75 years of age and over were prioritised for review following triage.
- An age-related assessment unit with four designated dementia-friendly cubicles had recently been opened. Patients were streamed according to need from the emergency department. However, on occasions this unit was not opened due to staff shortages and the need to relocate nursing staff to other areas of the acute floor.⁺⁺⁺⁺⁺
- An acute medical assessment unit adjacent to the ED where medical patients could be seen and assessed in a more suitable environment by an appropriate senior decision-maker.
- Designated psychiatric assessment rooms.
- The hospital's project to improve the access, experiences and communication regarding waiting times for people in the emergency department had some person-centred initiatives planned for the department such as:
 - the introduction of a process for communication of wait times for people in the waiting room
 - the recruitment of a patient liaison officer for the ED
 - the introduction of charging stations for mobile phones

⁺⁺⁺⁺⁺ Acute floor comprised of the emergency department, the acute medial assessment unit, the age-related assessment unit, medical short unit the acute and the surgical assessment unit (currently accommodating admitted patients awaiting an inpatient bed). The emergency department and the other units of the acute floor had separate medical and nursing staff.

- the introduction of food provision for patients in the waiting area.

Overall, despite staff efforts, the environment in which care was provided to patients in the emergency department on the day of inspection did not fully promote dignity, privacy and confidentiality for the patients in the emergency department. The practice of admitted patients awaiting inpatient beds on trolleys in the emergency department contributed to overcrowding in the department and non-compliance with this national standard.

The overcrowding made it impossible to maintain, promote and protect patients' dignity, privacy and confidentiality, which impacted on the meaningful promotion of patients' human rights, especially those accommodated in trolleys and seats around the doctors and nurses' station in zone 1. The lack of adequate toilet and shower facilities in this area further compounded the issues. Both the physical facilities and the processes of patient flow need to be further reviewed and addressed by hospital management.

Judgment: Non-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 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 to people who use the healthcare service, safe care and support identifies, prevents or minimises this unnecessary or potential harm.

Tallaght University Hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks identified in the emergency department were recorded on the emergency department's risk register which was reviewed and managed at regular meetings by the Emergency Medicine Consultant, Clinical Nurse Manager 3 and the Assistant Director of Nursing for the Acute Floor. Risks outside the scope of the emergency department were escalated to the Executive Management Team for review and added to the corporate risk register or referred back to the department to manage locally as appropriate. The emergency department risk register identified risks, including red-rated risks which had the potential to result in harm to patients and or staff, with existing controls in place to mitigate the risks outlined. The ED risks which had been escalated to the hospital's corporate risk register included: prolonged triage time, insufficient inpatient capacity, insufficient isolation facilities for patient with communicable infectious diseases, patient flow pressures resulting in prolonged escalation periods, gaps in

mental health services with risks to adolescents, staff shortages and the limited hospital liaison psychiatric consultant resources.

The hospital's corporate risk register included existing control measures in place and additional actions required to mitigate the risk. The hospital had implemented some of the required actions such as: the opening of the age related assessment unit to improve patient flow, a triage quality improvement plan to ensure efficient and effective triage processes and international recruitment for medical staff. A number of the actions proposed by the hospital included: a new facility with single rooms (72 bed unit), ongoing recruitment for required staff and additional capacity in community beds by year end. The majority of risks identified in the ED and corporate risk registers were observed by inspectors or highlighted by patients or staff throughout this inspection.

The hospital had a system in place for the reporting, reviewing and management of incidents in the hospital. Incidents related to the ED were reported to the Clinical Nurse Manager who escalated them to the ADON for the acute floor and the quality, safety and risk management (QSRM) department. Hospital incidents were tracked and trended by the QSRM department. Serious incidents were reported to the Hospital's Serious Incident Management Team for review.

In line with the national HSE reporting requirement, the hospital collected data on a range of different quality and safety indicators related to the emergency department. Data collected was reviewed at meetings of the Board, EMT and the ED Operations Group. Initiatives and actions undertaken to address non-compliances were previously outlined under national standard 5.5.

According to published data, the percentage of ED patients who left the department before completion of treatment in the 12 months up to March 2022 was 23.5%. This was high in comparison to other model 4 hospitals. In October 2022, the hospital reported that 19.7% of patients left the department before completion of treatment which was of concern to HIQA.

Inspectors were informed that Monday to Friday, a non-consultant hospital doctor contacted all patients with abnormal bloods who left the hospital prior to completion of treatment and blood results were sent to the patient's GP. The hospital should review the profile of patients who leave the department before completion of treatment and implement any potential improvements identified. The hospital also needs to ensure a system is in place to minimise risk(s) to those people who leave the department prior to completion of treatment seven days a week.

Inspectors were informed that complaints relevant to the ED were reviewed at the Patient Advocacy Liaison Meetings in the emergency department. This meeting was attended by the ED CNM3, the Lead Administrator, the ADON for the acute floor and the Patient Advocacy Liaison Person. Incidents were reviewed and responded to by the relevant ED medicine consultant. All ongoing emergency department investigations were tracked and monitored by

the Patient Advocacy Liaison and reported at this meeting. The department had responded to patient complaints through the development of quality improvements plans (QIPs) related to themes such as communication, meals, triage and patient flow. The QIPs were action focused with a recorded timeline and an assigned responsible person. The QIPs were monitored and progressed by ED working groups.

The COVID-19 and non-COVID-19 streaming pathways were in operation in the emergency department. The department had three isolation rooms designated for COVID-19 patients, two of which were en suite. There were no COVID-19 patients in the department at the time of inspection and all three isolation rooms were occupied by patients with other communicable infectious diseases. A risk assessment process was in place when all three isolation rooms were full, to determine which patient(s) could be relocated to accommodate a COVID-19 patient. The hospital needs to continue to review this on a daily basis, taking into account the competing demands for isolation rooms.

The hospital had identified insufficient single rooms within the hospital to isolate patients with communicable infectious diseases (CID) as a risk to patient safety. The lack of isolation facilities within the hospital impacted on the emergency department and created infection prevention and control risks for patients and staff within the department as patients with CID remained in the ED awaiting an inpatient bed. The ED is not a suitable environment to accommodate patients with CIDs requiring isolation and transmission-based precautions. Inspectors observed insufficient space between additional trolleys in the emergency department and were concerned that the minimum physical spacing of one metre was not possible, giving rise to infection prevention and control risks. The hospital should ensure minimal distancing between people receiving care, in line with national guidance.

The national early warning system (INEWS) was used in the department for admitted patients to support the anticipation, recognition and response to a deteriorating patient in the emergency department. From review of training records received, inspectors were informed that the Irish Maternity Early Warning System was currently undergoing a pilot in the ED. The INEWS was in use for pregnant women presenting to the ED (with specific protocol) and women 42 days post-childbirth miscarriage or termination of pregnancy. The hospital had also not implemented the Emergency Medicine Early Warning System (EMEWS) and were awaiting a visit from the EMEWS national lead to support implementation. Inspectors were informed that the ISBAR^{*****} communication tool was used when requesting patient reviews and the IMIST AMBO^{§§§§§} communication tool was to be introduced for patient handover.

On the day of inspection, inspectors highlighted a potential risk of harm to service users or staff as a consequence of a lone working environment and lack of appropriate cover for

***** ISBAR: Identify, Situation, Background, Assessment, Recommendation is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

§§§§§ IMIST: Identification, Mechanism of injury or Medical complaint, Injury, Signs, Treatment and trends. AMBO: Allergies Medication, Background history and Other information.

breaks in the clinical decision unit. The hospital completed and submitted a risk assessment to HIQA which outlined the existing control measures in place and the additional control measures required to mitigate this risk. Furthermore, there was no clinical pharmacist in the emergency department which was identified as a risk on the ED risk register.

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.***** The hospital was in the process of developing an 'Escalation Triggers for TUH' procedure, which would highlight the steps to be taken based on triage waiting times and the number of admitted patients in the ED awaiting an inpatient bed. The hospital should focus on actions that will prevent the need for escalations triggers, but when the need for escalation arises, ensure that the proposed steps are solution focused with involvement from all relevant stakeholders.

Overall, the hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Although many of the actions required to mitigate the risk were in progress by the hospital, a number of actions were associated with long-term plans and were dependant on capital funding. HIQA was not fully assured that the hospital currently protected service users from the risk of harm associated with the design and delivery of healthcare services in the emergency department.

The hospital should implement the appropriate nationally agreed early warning systems to anticipate, recognise and respond to the deteriorating patient, and to ensure that appropriate infection prevention and control processes are in place for patients with communicable infectious disease, including COVID-19, within the emergency department. The hospital needs to review the patients who leave the department before completion of treatment and implement initiatives to reduce this number, while also having systems in place to minimise risk(s) to those who do leave before completion of treatment.

Judgment: Partially compliant

***** 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>.

Conclusion

Tallaght University Hospital has a busy emergency department with over 52,000 attendees per year within catchment areas and with a population of 800,000 people across five counties. In 2022, the monthly ED attendances were approximately 4377, an average daily attendance of 141, with a peak of 177 attendees on one day in the week prior to inspection.

Some of the hospital's catchment area has a high deprivation score which has the potential to negatively impact on the health of that population and can be challenging for healthcare delivery in the area. This is further hampered by a low number of GPs per capita in the locality.

Tallaght University Hospital had management arrangements in place to support and promote the delivery of healthcare services. While measures were being taken to improve patient flow through the emergency department, HIQA found, that these measures were not fully effective in ensuring delivery of high-quality, safe and reliable healthcare services to the people who used the hospital's emergency services.

The emergency department staff were striving to provide safe, quality care to the number of patients presenting to the ED, many with challenging presentations. Staff efforts were hampered by high numbers of admitted patients remained in the department awaiting an inpatient bed and patients awaiting specialist review and decision to discharge or admit.

The hospital was further challenged with capacity issues, insufficient isolation facilities and a lack of community facilities and services to support transfer of care to the community. The hospital needs to address capacity issues, but also patient flow issues through the emergency department through the hospital and into the community.

The hospital management and emergency department clinicians should progress clinical leadership in the ED through the appointment of a lead clinician, and consider how issues in the Acute Floor are being addressed at directorate level, given the strategic importance of a well-functioning ED in relation to the overall performance of the hospital activity.

Despite staff efforts, the environment in which care was provided to patients in the emergency department on the day of inspection did not promote dignity, privacy and confidentiality for the patients in the emergency department. The practice of admitted patients awaiting inpatient beds on trolleys in the emergency department contributed to overcrowding of the department. This made it impossible to maintain, promote and protect patients' dignity, privacy and confidentiality, which impacted on the meaningful promotion of the patients' human rights. The inadequate toilet and shower facilities to meet the needs of the additional patient numbers in this area further compounded the issues. Both the physical facilities and the processes of patient flow need to be further reviewed and addressed by hospital management.

At the time of inspection, the hospital had made progress in recruitment of medical staff for the emergency department assisted by overseas recruitment. However, there were still some NCHD posts vacant, resulting in unfilled NCHD shifts which were then covered using locum and agency staff when available. Unfilled NCHD posts creates a risk of prolonged patient experience times and may compromise patient safety.

Nurses and healthcare assistant posts were also unfilled impacting the full functioning of all areas of the department and increasing the nurse-patient ratio which had the potential to impact of the provision of safe, quality care to the patients within the department. Recruitment was ongoing and hospital management highlighted the progress achieved to date in recruitment of staff nurses to fill vacant posts.

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Many of the actions required to mitigate the risks were in progress by the hospital, however, a number of actions were associated with long-term plans and were dependant on capital funding.

The hospital should progress implementation of the relevant nationally agreed early warning systems to anticipate, recognise and respond to the deteriorating patient. The hospital needs to ensure that appropriate infection prevention and control processes are in place in the emergency department for patients with communicable infectious disease, including COVID-19.

The hospital had identified some opportunities for improvement within the emergency department under the themes of communication, triage, staff shortages and patient flow. The hospital had developed time-bound quality improvements plans (QIPs) which were monitored and progressed by the ED working group to enhance care and the patient experience within the ED.

The presence of admitted patients waiting in the ED is a sign of system-wide problems. The hospital needs to address capacity issues, but also patient flow issues though the hospital and into the community with the support of the HSE. Primary care services are the foundation for the enhancement and reform of community services and must be enhanced and supported in line with the 2022 HSE service plan to reduce the need for people to attend hospital and enable people to access increased care and supports in their own communities. Following this inspection, HIQA will continue to monitor the progress of the hospital in implementing actions to enhance the capacity, capability, quality and safety of the emergency services provided by the hospital though the compliance plan submitted by the hospital.

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 Tallaght 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 sets out the actions taken or planned 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 actions in the compliance plan within the set time frames to fully comply with the national standards. HIQA will continue to monitor the hospital's progress in implementing the actions set out in the compliance plan (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.	Non-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.	Partially compliant

Appendix 2 Compliance Plan: Tallaght University Hospital'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
<p>Outline how you are going to improve compliance with this standard. This should clearly outline:</p> <p>(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.</p> <p>(b) where applicable, long-term plans requiring investment to come into compliance with the standard</p>	

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action (if applicable) due date	Person Responsible
Standard 5.5	The hospital should ensure that meetings are action orientated and that progress in implementing actions is monitored from meeting to meeting	TUH does this in practice. To further enhance the process an action sheet will be developed from the minutes, by mid-January 2023	N/A	CEO PA
	Lack of ED Clinical Lead	ED consultants have agreed to appoint a Clinical Lead for Emergency Medicine. A Clinical Lead will be in place by end January 2023. They also have representation to EMT through CD and COO. ED		Clinical Director of Medicine, ED Consultants

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action (if applicable) due date	Person Responsible
		Consultants also participate in governance and steering groups with members of the EMT.		
	Monthly Emergency Department Operations Group meetings chaired by COO - the hospital needs to ensure that this important committee meets in line with it's terms of reference to action and progress items	Monthly meetings scheduled with the first having being held this month. Terms of Reference have been updated with membership expanded to include the Unscheduled Care manager and Patient Flow Manager		COO
	High number of admitted patients remaining in department	<p>Agreed acute floor standards and associated KPI's in advanced stage of development and will be agreed by end of Jan 2023.</p> <p>Suitable patients who have been allocated a bed on a ward are being moved to the ward to await the bed there rather than remaining in ED.</p> <p>Utilisation of real time data ED dashboard is in live pilot- this will highlight all stages of</p>	Develop ambulatory pathways to avoid admission for frequent presentations. An example of this is the Headache Pathway which enables for safe discharge of patients presenting with this condition with prompt specialist follow-up. This is currently in pilot phase with	COO, DCEO, Clinical Director of Medicine, and Clinical Director of Peri-operative Services

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action (if applicable) due date	Person Responsible
		patient journey and enable action on an individual patient basis.	<p>SPARK funding. Early reports are very positive. It should be in place permanently in Q2 2023.</p> <p>Additional CT scanner will be in place in ED in Q2 2023- CT imaging to effect safe discharge in patients with possible pulmonary embolism or abdominal pain. When the CT scanner within ED is fully operational (Q2 2023), it will allow safe discharge of a number of these patients at an earlier stage.</p>	
	Capacity issues, Lack of Community facilities, Lack of isolation facilities and patient flow through the hospital and into the community.	The Hospital with our HSE colleagues in the community, has developed pathways to reduce the number of patients presenting to ED. The Hospital is also working with the National Ambulance Service (NAS) on a new initiative called Pathfinder which is focussed on improving outcomes for older people by providing safe	The Hospital works continuously to free beds for admitted patients, but there is a clear ongoing underlying requirement to develop additional onsite bed capacity. We have submitted a	COO, DCOO

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action (if applicable) due date	Person Responsible
		<p>alternative care at home rather than in hospital. This service is being jointly run by NAS staff working with Allied & Social Health Care colleagues from the Hospital.</p> <p>Timely discharge from the Hospital remains a challenge with a high number patients currently waiting for either home care packages, housing adjustments, access to rehabilitation or a place in a nursing home.</p> <p>Bi-monthly Community Hospital Integrated Discussion Form (CHIDF) meetings have increased to weekly meetings in order to reduce the number of delayed transfer of care (DIOC) in-patients.</p> <p>Weekly Home Support Team meetings have also commenced including representation from Community Intellectual Disability services.</p> <p>TUH Senior Management attend monthly Enhanced Community Care (ECC) meetings.</p> <p>An in-house TUH ECC Working Group has also</p>	<p>capital expansion plan to the HSE which, if funded, would provide additional bed capacity and significantly improve quality of care in a range of key areas. The proposal represents an opportunity to sustainably address the access issues at TUH, by combining sizable capacity investment with clinical pathway improvement. An external capital strategic analysis review was submitted to the HSE. TUH is waiting for sign off on this to move to the next stage in the HSE process to develop a new 72 single bed facility at the Hospital to address these additional capacity requirements</p>	<p>CEO</p> <p>Director of Nursing & Integrated Care</p>

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action (if applicable) due date	Person Responsible
		been established (Chaired by COO) to support TUH related ECC / Integration projects.		
	<p>PET are well below the National target for the % of all attendees to ED who were admitted or discharged within 6, 9 and 24 hours of registration – lower than the average PETs for other model 4 hospitals.</p>	<p>We are currently working on our internal processes in order to improve our Patient Experience Times aligned to the Acute Floor standards.</p> <p>New ED diagnostic technicians and Senior Intervention Following Triage (SIFT) will result in front loading of diagnostics which means that these results will be available when a clinician reviews patients.</p> <p>There are currently three ED diagnostic technicians in post with a 4th starting in February and training programme is being delivered.</p> <p>A senior registrar/consultant will operate SIFT. This means that ECGs/covid swabbing and urinalysis will be taken out of triage which will improve our triage times.</p> <p>An ED Dashboard has been developed to provide clear oversight of ED capacity, utilisation and PETs</p>	<p>Implementation of Acute floor standards.</p> <p>ED diagnostic technicians will be fully trained and operational by end of Q1 2023</p>	ADON Acute Floor, COO

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
<p>Outline how you are going to improve compliance with this standard. This should clearly outline:</p> <p>(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.</p> <p>(b) where applicable, long-term plans requiring investment to come into compliance with the standard</p>	

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action(if applicable) due date	Person Responsible
Standard 6.1	Hospital Managers to ensure that there are sufficient staff at the right time to deliver safe, high-quality care.	The Hospital has a comprehensive recruitment strategy for nursing with a dedicated Nursing Manpower Manager. Through use of social medial and other recruitment drives including airport campaigns the Hospital promotes the benefits of working in TUH for both Nursing and HCA staff. All direct applications are reviewed weekly, with weekly interviews scheduled for Nursing and HCAs. Senior Nurse management review staffing levels on an ongoing basis and redeployment of Nursing and HCA occurs to meet department specific demands.	<p>Ongoing engagement with Safe Nurse Staffing national lead to ensure staffing numbers are adequate. We have not been given a timeline.</p> <p>QIPs will focus on recruitment, filling locum posts</p> <p>There is another ED LIG scheduled for Jan 19th and the National Lead will be present for same. After a full review of the 2022 ED figures is completed further uplifts may follow this year for the main department through safe staffing.</p>	Director of HR, Medical Directorate Operations Manager, & Director of Nursing & Integrated Care

HIQA Standard	Issue identified	Proposed Interim Action/ due date	Proposed Long term action(if applicable) due date	Person Responsible
		<p>In addition we recruit internationally supported by agencies to ensure we have a steady pipeline of staff nurses for specialist areas including ED coming through for adaptation on a monthly basis. We have increased our nursing headcount by 139 wte in the last 12 months.</p> <p>With regards to staffing and skill mix in adult Emergency settings, the first meeting occurred in December 2022 when a LIG was established. As advised by the Safe-staffing national lead following review of data, there were no RGN uplifts assigned at this time.</p>	Admitted patients will continue to be assessed separately and are based on the submitted trolley gar figures	
	Noted some NCHD shifts were unfilled, with some shifts covered by locum or agency. Unfilled shifts in the emergency department creates a potential risk of	Following a successful recruitment campaign in 2022 looking at the recruitment of NCHDs from South Africa for the July intake we successfully recruited all of our NCHD posts. Unfilled shifts are therefore related to unexpected leave such as sick leave and are approved to be filled by agency, (subject to availability).	Continue with recruitment campaign of NCHDs from South Africa which has proved very successful. Existing NCHD staff that relocated from South Africa have been offered the option of a 2 year contract and the HSE approved relocation package. Since COVID a shadow roster was	Director of HR, Medical Directorate Operations Manager, & Deputy Head of HR Medical Division

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action(if applicable) due date	Person Responsible
	extending patient experience times and comprising the delivery of safe, quality care.		<p>implemented for medical and surgical NCHDs. Consideration as to whether this could be an option for ED Department.</p> <p>The Hospital would welcome national direction on implementation of shadow rosters as there is no nationally agreed rate.</p>	
	Nurses and healthcare assistant posts were also unfilled resulting in daily staffing shortage and increase in the nurse-patient ratio which had the potential to impact on the provision of safe, quality care to the patients within the department	<p>Recruitment Plan – Currently there are 13.33 WTE nursing vacancies, 9.93 WTE permanent and 2.4 WTE temporary with on-going recruitment to fill these posts. There are 12 WTE nurses progressing through our overseas recruitment programme who will start their adaptation and assessment period by Q2 2023. To mitigate the known vacancies and unexpected sick leave, utilisation of overtime and agency staff is requested to balance the deficits in Nurse staffing in ED. Redeployment from other clinical areas has also taken place and will continue to be used as available.</p> <p>There are six wte HCA vacancies with five WTE</p>	Ongoing recruitment drive with ED specific advertised in order to attract ED trained nurses.	Nurse Manager Medical Directorate & Director of Nursing & Integrated Care

HIQA Standard	Issue identified	Proposed Interim Action/ due date	Proposed Long term action(if applicable) due date	Person Responsible
		progressing through recruitment with start dates of Q1 2023.		
	Staff absenteeism was noted to be 4.9% (no absences were associated with COVID-19). The national target for absenteeism is less than or equal to 4%	<p>Just to note the figure given of 4.9% on the day on inspection was the overall Hospital absenteeism figure for the month of September.</p> <p>A recent addition to the Nursing team in ED are two operational CNM2s who are managing absenteeism in the ED using the TUH Attendance Management Policy. Their focus is primarily on managing recruitment and retention and referring to Occupational Health as appropriate.</p> <p>Absenteeism levels are reviewed monthly at EMT and Board level. At line manager level absenteeism reports are circulated month giving a 12 month look back on the level of absenteeism for every staff member. This prompts the line managers to ensure return to work meetings are being held and referring to OH as appropriate. The HR</p>		Nurse Manager Medical Directorate, ED ADON, HR

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action(if applicable) due date	Person Responsible
		<p>Business Partners support the line managers with this process. In addition a QI project with regards to the management of staff on long terms sick leave started in December 2022. HR have engaged with Occupational Health to review all cases and are engaging with the relevant line managers</p>		
	<p>At the time of inspection, ED staff had not commenced training in EMEWS</p>	<p>If a patient requires recording of vital signs at triage, INEWS is generated at this time and appears on ICT system (Symphony) in a dedicated column.</p> <p>ED will start INEWS chart on a patient when they are referred for specialist review.</p> <p>If it is evident at the time of arrival that a patient will be likely for referral and admission INEWS chart will be commenced immediately.</p> <p>A meeting with national nurse lead is scheduled for January 16th 2023 to provide overview of EMEWS (Emergency Medicine Early Warning System).</p> <p>Further plans on implementation will be</p>	<p>Implementation plan of EMEWS will be developed post meeting (on 16th January 2023) with National Nurse lead.</p>	<p>Director of Nursing & Integrated Care</p>

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action(if applicable) due date	Person Responsible
		provided following this presentation.		
	Compliance with Mandatory training for staff in ED	<p>Mandatory training reports are circulated to Senior Managers on a monthly basis identifying staff who are non-compliant.</p> <p>Plan in place to further support staff to undertake the mandatory training applicable to them in their roles in the Emergency Department. Compliance will be monitored again at the end of February 2023 and two monthly thereafter to ensure mandatory training has been undertaken.</p> <p>Clinical facilitators are liaising with the Centre for Learning Development to ensure that all relevant training is being captured.</p> <p>We have successfully recruited a 3rd Clinical Facilitator for the acute floor to assist with training and development of staff across all areas.</p>		ADON Acute Floor, Clinical Director for Medicine, Head of Learning & Development, & ED Consultant
	On-going impact of unfilled shifts was that areas of department were not always fully	Nurse management have reviewed alternative nurse agencies in order to minimise the number of unfilled agency shifts. SLAs with new agencies are currently being reviewed which should	These efforts will continue on recruitment to fill vacant shifts.	Director of Nursing & Integrated Care, ADON Acute Floor & Director of HR

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action(if applicable) due date	Person Responsible
	operational and nurse patient ratio was increased which had the potential impact on the provision of safe, quality care to patients within the department	result in reduction of unfilled shifts.		

National Standard	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non-compliant
<p>Outline how you are going to improve compliance with this standard. This should clearly outline:</p> <p>(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.</p> <p>(b) where applicable, long-term plans requiring investment to come into compliance with the standard</p>	

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action(if applicable) due date	Person Responsible
Standard 1.6	One toilet and no shower facilities for the number of patients was inadequate, and did not protect or promote the dignity and respect and independence of patients in the area of the ED	<p>Additional toilet and shower facilities are available within the acute floor. Refer to attached floor plan</p> <p>TUH ED was designed as per building standards in 2014.</p> <p>Efforts will be made to reduce number and the length of time patients are in ED through the implementation of the acute floor Standards.</p>		Director of Facilities & COO
	The designated psychiatric assessment rooms (DPAR)	We are working with psychiatry to design and apply manifestations to the windows on the DPAR rooms. The aim is to reduce the visibility into the rooms in a limited fashion (whilst simultaneously maintaining the ability for external supervision.) Once we have approval for the proposed design it will take 3-4 weeks to implement.		Director of Facilities & COO
	Close proximity of all patients and the number of trolleys around doctor's & nurses station	The ED Nursing Management, Clinical Lead in conjunction with EMT will continue to implement all measures outlined above to reduce number of admitted patients in ED. In the situation where there are a high number		Clinical Director of Medicine, COO, ADON Acute Floor, ED Clinical Lead

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action(if applicable) due date	Person Responsible
		<p>of admitted patients in the department a judgment balancing patient safety and dignity will be made on where to place trolleys. Patient privacy screens are used for any patients who are on trolleys and not in cubicles in order to promote dignity, respect and privacy of patients.</p> <ul style="list-style-type: none"> • Shift leaders and operational CNM2s are ensuring efficient use of clinical space and timely streaming of patients to the AMU/ARAU. 		
	<p>Patient Flow and meaningful promotion of patient human rights to be addressed by hospital management</p>	<p>As above, plus; We have successfully recruited and now have two Patient Liaison Officers in post. Their main aim is to communicate with patients across the Acute Floor and ensure that patients are listened to and concerns are responded to in real time. They also provide timely information to patients and families.</p>	<p>We have submitted a capital expansion to the HSE which would provide additional bed capacity, improve decontamination facilities and significantly improve quality of care in a range of key areas. The proposal represents an opportunity to sustainably address the access issues at TUH, by combining sizable capacity</p>	<p>COO, Director of Nursing & Integrated care, Clinical Director of Medicine, Director of Facilities and Estates</p>

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action(if applicable) due date	Person Responsible
			<p>investment with clinical pathway improvement. An external strategic analysis review was submitted to the HSE, TUH is waiting for sign off on this to move to the next stage in the HSE process to develop a new 72 single bed facility at the Hospital to address these additional capacity requirements</p> <p>Capital developments 72 beds.</p>	

National Standard	Judgment
<p>Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.</p>	<p>Partially compliant</p>
<p>Outline how you are going to improve compliance with this standard. This should clearly outline:</p> <p>(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.</p> <p>(b) where applicable, long-term plans requiring investment to come into compliance with the standard</p>	

HIQA Standard	Issue identified	Proposed Interim Action/due date	Proposed Long term action(if applicable) due date	Person Responsible
Stand ard 3.1	ED patients who left department before completion of treatment (23.5% in March, 19.7% in October) Profile of patient to be completed and a risk mitigation plan.	<p>The recently appointed Patient Liaison officers (PLOs) communicate with patients in the waiting room and ensure they are kept informed of wait times.</p> <p>PLOs are also advocating for patients and liaising with doctors.</p> <p>ED Medical team review records of patients who did not wait and contact GPs/patients with abnormal results, if available</p> <p>Implementation of SIFT model with upfront diagnostics- in place since Jan 2023</p>	TUH will review the impact of PLO's on this standard in Q2 2023.	ADON Acute Floor
	Lack of isolation facilities especially patients waiting in ED for inpatient bed	<p>Shortage of single rooms is on the Hospital risk register and has been escalated to the DMHG</p> <p>Bed management use the TUH IPC isolation prioritisation scoring system and complete and document a risk assessment. IPC monitor all patients with isolation requirements daily.</p> <p>TUH use the modified Lewisham Infection Prevention Scale. This is used to prioritise</p>	In the medium to long term a 72 single bedded unit is planned.	COO, Director of Facilities

		bed allocation for patients with infectious diseases.		
	Lone working environment CDU	A risk assessment for the CDU area was completed and submitted to HIQA and EMT. This risk was addressed immediately hand has been removed from the Hospital Risk Register.		
	Lack of Clinical Pharmacist in ED	At the time of the visit, ED had an approved Clinical Pharmacist, the post holder had resigned. Post currently in recruitment		Chief Pharmacist
	The hospital should focus on actions that will prevent the need for escalations triggers, but when the need for escalation arises, ensure that the proposed steps are solution focused with involvement from all relevant stakeholders	Addressed under revised Hospital Escalation Policy/Full Capacity Protocol Jan 2023 The Escalation Triggers have been finalised following consultation with key stakeholders		COO
	Overall, the hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Although many of the actions required to mitigate the risk were in progress by the hospital, a number of actions	Implementation of Acute Floor Plan subject to staffing in Q1 2023.	Secure staffing to implement Acute Floor Plan subject to HSE approval. Secure funding from HSE for 72 bedded capital development	CDs / COO CEO/HSE

	<p>were associated with long-term plans and were dependant on capital funding. HIQA were not assured that Service users were protected from the risk of harm associated with the design and delivery of healthcare services in the ED</p>			
	<p>Implementation of EMEWS</p>	<p>Currently INEWS is used for admitted patients in ED. There is a meeting with national nurse lead scheduled for the 16th of January 2023 to provide overview of EMEWS (Emergency Medicine Early Warning System). Further plans on implementation will be provided following this presentation.</p>	<p>Implementation plan of EMEWS will be developed post meeting (on 16th January 2023) with National Nurse lead.</p>	
	<p>Appropriate IPC processes for CID within ED</p>	<p>IPC processes & PPGS are in place. A COVID pathway is in place which is audited monthly by CNM2s. ED has three isolation rooms and one negative pressure room.</p>		<p>DCEO, IPC</p>