Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	University Hospital Limerick
Address of healthcare service:	St Nessan's Rd Dooradoyle Co. Limerick V94 F858
Type of inspection:	Unannounced
Date(s) of inspection:	21 November 2023
Healthcare Service ID:	OSV-0001064
Fieldwork ID:	NS_0065

About the healthcare service

The following information describes the services the hospital provides.

Model of hospital and profile

University Hospital Limerick (UHL) is a model 4* hospital managed by the University Limerick Hospitals Group (ULHG)† on behalf of the Health Service Executive (HSE). The University Limerick Hospitals Group comprises six hospitals, University Hospital Limerick, University Maternity Hospital Limerick, Nenagh Hospital, Ennis Hospital, Croom Orthopaedic Hospital and St John's Hospital. ULHG operate a hub-and-spoke model, where critical care facilities are centralised at UHL supported by model 2‡ and model 2S (specialised) hospitals in the hospital group.

A range of healthcare services are provided across the six hospital sites under the leadership of six clinical directorates — cancer service, medicine, peri-operative, diagnostics, maternal and child health directorates and the recently formed urgent and emergency care directorate.

University Hospital Limerick has the only emergency department in the ULHG providing a 24/7 service for a Mid-West catchment area of approximately 401,000 people. The region also has three medical assessment units and injury units located in St John's Hospital, Ennis Hospital and Nenagh Hospital. ULHG has no model 3 hospital within its functional domain.

UHL provides the following services in the Mid-West region of Ireland on an inpatient and outpatient basis:

- major elective surgery
- cancer treatment and care
- emergency care
- high-dependency care
- a range of other medical inpatient services, diagnostic and therapy services
- outpatient care.

* A model 4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. The hospital has a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit which is open on a continuous basis (24 hours, every day of the year) and an Emergency Department, including a Clinical Decision Unit onsite.
† The University Limerick Hospitals Group (ULHG) comprises six hospitals - University Hospital Limerick, University Maternity Hospital Limerick, Nenagh Hospital, Ennis Hospital, Croom Orthopaedic Hospital and St John's Hospital. The hospital group's academic partner is the University of Limerick.
‡ A model 2 hospital provides inpatient and outpatient care for differentiated, low-risk medical patients, who are not likely to require full resuscitation.

The following information outlines some additional data on the hospital.

Model of hospital	4
Number of beds	536 inpatient beds 140 day care beds

How we inspect

Under 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 among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part of the Health Information and Quality Authority's (HIQA's) role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors[§] reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service 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 observed and what people told inspectors.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection 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 before, during and following the inspection.

[§] Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012).

1. Capacity and capability of the service

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

2. Quality and safety of the service

This section describes the experiences, care and supports that people using the service receive on a day-to-day basis. It is a check on whether the service is good quality, caring and one that is both person-centred and safe. It also includes information about the environment where people receive care.

A full list of the national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance on how the service performed has been made under each national standard assessed. The judgments are included in this inspection report. HIQA judges the healthcare service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with national 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.

Service provider's sets out a compliance plan to outline intended actions following an inspection by HIQA whereby the service was not in compliance with the *National Standards for Safer Better Healthcare.* Limerick University Hospital compliance plan is included in Appendix 2.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
21 November 2023	09:00 – 16:30hrs	Nora O' Mahony	Lead
		John Tuffy	Support
		Danielle Bracken	Support

Information about this inspection

An unannounced inspection of the emergency department (ED) in University Hospital Limerick was conducted on 21 November 2023.

The inspection was a follow-on to HIQA's inspection of UHL's emergency department in March 2022 and the wider hospital, including the emergency department, in February 2023. The purpose of this inspection was to assess:

- compliance with four national standards from the National Standards for Safer Better Healthcare in the emergency department
- the effectiveness of measures implemented to address the issue of overcrowding in the emergency department, insufficient inpatient bed capacity and patient flow through the hospital identified during HIQA's last inspection in February 2023.

The inspection team visited the following areas:

- emergency department (ED)
- acute medical unit (AMU)
- acute surgical assessment unit (ASAU)
- geriatric emergency medicine unit (GEMU).

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

- representatives of the Executive Management Team
- representatives for Quality, Risk and Patient Safety
- representatives for Patient Flow.

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

Acknowledgements

HIQA would like to acknowledge the co-operation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the service who spoke with inspectors about their experience of the service.

What people who use the emergency department told inspectors and what inspectors observed in the department

The emergency department provided care for undifferentiated patients with acute and urgent illness and injuries.

The emergency department has a planned capacity for 49 service users divided into three zones A, B and C, a paediatric area, a clinical decision unit and a resuscitation area. There were three adult and one paediatric triage rooms. Associated pathways from the emergency department included the geriatric emergency medicine unit (GEMU), the acute medical unit (AMU) and the acute surgical assessment unit (ASAU). These are described in more detail under standard 5.5.

At 10am on the day of inspection, the emergency department was very busy, relative to its intended capacity and function. There were 82 patients registered in the department, eight of these patients were waiting to be triaged and 32 were admitted and accommodated in the emergency department, while awaiting an inpatient bed.

The waiting area in the emergency department had been recently refurbished and electronic monitors in the waiting area provided patients with expected waiting times in the emergency department as well as the waiting times in the model 2 hospital's medical assessment units.

There was one toilet located in each of zone A, B and C, which at 11am on the day of inspection accommodated approximately 69 patients. There were additional toilets located in other areas of the ED. There were two showers in the emergency department.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the emergency department. Staff were observed wearing appropriate personal protective equipment.

Inspectors observed staff actively engaging with patients in a kind and respectful manner. Inspectors spoke with a number of patients in the emergency department to ascertain their experiences of the care received in the emergency department on the day of inspection. Patient were complimentary about staff describing them as *'amazing' 'great'* and '*so nice'*. Patients commented that staff were *'so busy'.* Patients felt they were kept informed of their plan of care, but commented on the *'long wait'* for decisions to admit or discharge and the long waits for an inpatient bed. One patient on a corridor off zone A, referred to the fact that they had no way to call nurses and had to wait until a staff

member passed by to get the required assistance. Another patient commented that *'they keep moving me up and down the corridor to make room'* and *'it is so difficult to sleep on the corridor'.*

Inspectors observed staff promoting and protecting patients' privacy and dignity, in so far as possible within the context of a very overcrowded environment. For example, to ensure privacy and dignity, patients were brought to an assessment cubicle when being clinically assessed.

Patients who spoke with inspectors were knowledgeable on how to make a complaint. However, one patient commented that '*it might not make any difference'* referring to the fact that there were so many '*sicker patients in the department*,' complaints regarding '*long wait'* or '*lack of an inpatient bed*' could not be resolved promptly by staff.

Overall, there was consistency between what inspectors observed in the emergency department and what patients told inspectors about their experiences of receiving care in the department.

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.

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

Since the previous inspection in February 2023, the hospital had established an Urgent and Emergency Care (UEC) Directorate responsible for the operational and strategic governance of the emergency department and acute medical unit in UHL and the injury units and medical assessment units in St John's Hospital, Nenagh Hospital and Ennis Hospital. The UEC directorate was led by a Directorate Management Team who provided clinical and corporate support to the development of a three-year Mid-West Health Region Integrated Urgent and Emergency Care Delivery Plan. The UEC Plan set clear priorities to be achieved within set timeframes to bring the hospital into compliance with national targets. The overarching core outcome measure, was the reduction of Patient Experience Times (PETS) in the ED, with an immediate target to eliminate breaches for patients over 75 years of age. To achieve this, the hospital set priority targets for example, that 100% of patients over 75 years of age would be admitted or discharged with 24 hours by June 2024 and that all patients would be compliant with 24 hour PET with trajectory for improvement over three years. Evidence of progress on some areas of initial key focus was seen during

the inspection and in data provided, and are included throughout this report. Significant gains will need to be achieved by the hospital beyond those identified through this inspection to meet all set targets. Progress on priorities was monitored monthly by the UEC.

The University Hospital Limerick Hospital Group and Mid-West Community Healthcare Organisation Integrated Unscheduled Care Committee was set up in October 2022. This multidisciplinary committee was assigned the responsibility to prepare and implement an integrated response to ensure patients accessing unscheduled care at the hospital. To ensure timely access to care in the most appropriate setting, while optimising patient flow through acute and community services, and improving compliance with national key performance indicators. The Committee had set objectives such as enhancing admission avoidance and egress pathways to improve hospital and community capacity. The Committee implemented defined processes for patients over 75 years of age, and had objectives to reduce metrics such as average length of stay (ALOS) and delayed transfer of care (DTOC) and improving 24-hour patient experience times** (PETs). Evidence of progress with achieving these objectives was provided to inspectors during this inspection. There was evidence of close monitoring of services which supported admission avoidance and of actions taken to enhance or improve the performance of these services. This Committee, also aimed to deliver the initiatives set out in the Mid-West Integrated Patient flow and Preparedness Winter Plan 2023/2024, which was reviewed by inspectors.

As previously identified through prior HIQA reports, the CEO of ULHG had commissioned an Independent Review of Patient Flow across ULHG during 2022. The Review Report, published in September 2022, included a series of recommendations to support and better improve patient flow across ULHG. An updated report on the implementation of the recommendations from this Report was viewed by inspectors and demonstrated some progress with the implementation of the recommendations under the five fundamental areas of the HSE's unscheduled care improvement and change programme:

- Leadership culture and governance
- Patient flow at pre-admission
- Patient flow at post-admission
- Integrated community and hospital services
- Using information to support sustainable performance improvements.

In 2022, there were 79,780 attendances in the ED, approximately 6,648 attendances per month or 218 attendees per day. In 2023 year to date, total attendances at the hospital's emergency department were 68,768, which was comparable to 2022 attendances, but 11% higher than 2019 pre-pandemic attendance rates. Despite the increase in attendances to the ED, the average 8am trolley count was 18, year to date, down 20.7% on 2022 figures and 22% below 2019 figures and fourth lowest of all model 4 hospitals.

** Patient experience time measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.

On the day of inspection, the emergency department was very busy relative to its intended capacity. At 11am, there were 92 patients registered in the emergency department with 35 patients admitted (38%) awaiting an inpatient bed. Although the level of overcrowding was still unacceptable, the number of attendees on the day was an improvement on the previous two inspections. In February 2022, there were 139 attendees in the department with 60 patients (43%), admitted awaiting an inpatient bed and in and February 2023 when there were 121 attendees in the department with 55 admitted patients (45%). Patients awaiting inpatient beds were accommodated in single cubicles or trolleys on the corridors in zones A, B and C. There were eight patients awaiting triage. The average waiting time from registration to triage was 27 minutes and was similar to average triage times on the previous inspection.

The hospital's escalation plan, internal escalation processes and the triage risk mitigation and escalation process had been last reviewed in May 2023. On the day of the inspection, the hospital was in level 2 escalation in response to the situation that there were greater than 33 admitted patients in the emergency department. Actions taken in response to level 2 escalation were outlined to inspectors. Elements of the emergency department's escalation plan were seen in operation as surge capacity in the hospital was being utilised. For example, an additional nurse was allocated to triage when 10 patients were waiting greater than 20 minutes for triage, in line with the ED internal escalation framework. However, on the day of inspection there were still 35 patients admitted in the ED, surpassing the cap set by the hospital of 23 admitted patients in the ED's internal escalation plan.

Attendees to the emergency department presented by ambulance, were referred directly by a general practitioner (GP) or self-referred. At the time of inspection over half the people (52%) attending the emergency department were self-referrals. This was similar when compared with the 48% percent self-referrals reported on the previous inspection.

At 11am on the day of inspection, the hospital was not compliant with the HSE's key performance indicators for patient experience times for all patients in the department. However, the average ED PETs year to date for all patients had improved between 1-3% on 2022 data. The ED PETs for patients over 75 years admitted or discharged within 24 hours had also improved, with the average compliance rate increasing from 76.7% in 2022 to 80.6% in 2023 year to date. Although this was an improvement for the hospital, it was still well below the national target of 99% and will require continuous monitoring and further action to bring in line with expected norms.

The hospital had 1,862 instances where the 24 hour PET for patients 75 years of age and over[††] up to the week ending 12 November 2023 was exceeded, this was the third highest of all model four hospitals. The hospital also had the third highest number of instances the

[††] % of all Emergency Department (ED) patients 75 years who wait less than 24 hours. Total Emergency Department Time is measured from Registration time to ED Departure Time. Target 99%

24 hour PET for all patients was exceed up to the week ending 12 November 2023 amongst all model 4 hospitals. However, the average duration in ED (time patients spent in ED) was 8.8 hours, which was the third lowest of all model 4 hospitals.

In published UEC data the ED conversion rate for 2023 was reported at 32%, which the hospital outlined included AMU and ASAU data. In documentation provided to HIQA, the emergency department's conversion rate was 26% year to date 2023, meaning that of all patients who present to the ED – 26% go on to be admitted to a hospital bed. This was comparable to the average conversion rate for all hospitals. In

A consultant in emergency medicine was allocated to triage from 8am to 8pm Monday to Friday to support patient assessment and to direct patients to the most appropriate area for assessment and management. This included referral to the acute medical unit (AMU), the acute surgical assessment unit (ASAU), the geriatric emergency medicine unit (GEMU) or an MAU in a model 2 hospital.

The AMU operated 24/7 with clear referral criteria. The unit had a planned capacity of 25, with direct referral from triage and primary care, coordinated by the bed bureau service in University Hospital Limerick. The unit now also functioned as a short stay unit (less than 48 hours) for patient treatments or observations. On the day of inspection, the AMU was functioning as a pathway for patients from the emergency department's triage area and patients referred from GPs. There were 14 admitted patients in the unit, however, over 50% of these patients exceeded the proposed stay of 48 hours, which impacted patient flow through the unit.

The pathways for the AMU were under review at the time of inspection The time frame for this review had been extended to quarter 1, 2024. The hospital monitored compliance against the national target that 75% of patients are discharged or admitted from the AMU within six hours of registration. Compliance against this metric in UHL was only 25% in 2022 and 2023, well below the national target.

The acute surgical assessment unit (ASAU) operated 24/7 and had a planned capacity of 24. At the time of inspection, there were 21 patients in the ASAU, 9 (43%) were admitted patients accommodated in the unit awaiting an inpatient bed. The ASAU was functioning as an alternate flow pathway for patients from ED following triage and for GP referrals, but this function was limited due to inpatients accommodated in the ASAU. These findings are similar to the findings on the two previous inspections.

At the time of inspection, the ED attendances for people over 75 years of age, year to date, was 10,129, similar to the attendances for 2022. This was the 5th highest rate of all acute hospital attendances. The conversion rate (admission rate) for people over 75 years attending the ED was 55% (average for all acute hospitals was 51.8%). The PET times for patients over 75 years admitted or discharged from the emergency department within 9 hours January to November 2023 was 47.37%, lower than the average for all hospitals which was 53.34%, and below the national target of 75%.

The hospital and group had received support and financial resourcing to improve operational and clinical effectiveness and efficiencies at UHL and across ULHG, and to further strengthen and enhance integration with the Mid-West Community Healthcare Organisation (MWCH). During this inspection, there was evidence that initiatives arising from the increased support and resourcing of UHL were in the process of being implemented. Evidence of improvements in operational efficiencies were provided such as increases in model 2 MAU services, development of Alternative pre-hospital pathway (APP car) services, extended geriatric emergency medicine unit (GEMU) services, increased uptake of services such as ICPOP and mobile diagnostics. Based on information previously published by HIQA and updated information provided by the hospital, it demonstrates ongoing improvement in PETs in 2023, albeit marginal and well below national targets, as seen in Table 1 and Table 2 below.

Table 1: Median PET time comparison seen on data submitted by the hospital for HIQA inspections

	Total median PET time	Admitted patient median PET time	Non-admitted patient median PET time
2022	9.6 hours	14.1 hours	7.6 hours
January- March 2023	8.6 hours	12.4 hours	6.6 hours
January – November 2023	5.6 hours	12.33 hours	4.38 hours

Table 2: Average patient experience times when compared to HSE targets and national average of all hospitals in published data January to June 2022 and 2023.

	Average % of all patients admitted or discharged within:			Average % of patients aged 75 or over admitted or discharged within:	
	6 hours	9 hours	24 hours	9 hours	24 hours
HSE Target	70%	85%	97%	99%	99%
National average 2022	57%	73.3%	95.4%	52.4%	88.9%
UHL 2022	50.9%	66.3%	91%	46.8%	76.7%
National average Jan-June 2023	56.6%	73.1%	95.4%	53.3%	89.5%
UHL Jan-June 2023	54.9%	70.8%	93.1%	48.2%	80.4%

Overall, it was evident that the hospital had defined management arrangements in place to manage and oversee the delivery of care in the emergency department. Operationally, the department was functioning better than on previous inspections, but still has a way to go to match the best performing emergency department's inspected by HIQA. The newly

formed UEC Directorate provided a single entity for the strategic and operational function of the emergency and urgent care services across the six hospital sites of the ULHG.

HIQA acknowledges the current capacity constraints relative to the volume of activity. The mismatch between the number of people attending the emergency department, approximately 68,768 year to date, the second highest of all acute hospitals, and the hospital's bed capacity of 536 inpatient beds, which is among the lowest of all model 4 hospitals, significantly contributed to an overcrowded ED with admitted patients in the ED.

The hospital was performing relatively well in relation to patients' ALOS and DTOCs in comparison to many other model 4 hospitals, which demonstrated good patient flow processes through the hospital and on to the community. The AMU and ASAU, although providing a pathway from the ED, had their full functionality with respect to how they were designed to work impeded by patients accommodated in these units awaiting inpatient beds. Consequently, as a means of promoting patient flow they were less effective than they were designed to be.

The hospital was closely monitoring metrics for people over 75 years of age, and had recently set up an 'Over 75's Pathway Working Group' for Urgent and Emergency Care. The purpose of this Group was to enhance the experience of patients over 75 years of age attending the ED and to ensure that their journey through the ED, the wider hospital and onwards to the community was as seamless as possible. The working group was multidisciplinary, including staff from the ED, patient flow and community. The Group had set and was monitoring key performance metrics for patients over 75 years such as

- PET's, six hour, nine hours and 24 hour
- reduction of ED attendances by 5%
- reduction of ED admissions by 3%
- increase the HSE's Integrated Care Programme for Older Persons (ICPOP) referrals by 5%.

The achievement of these metrics was supported by a number of initiatives that the hospital and community had in place to support admission avoidance or early discharge. These are outlined below. Some of these initiatives were at an early state of implementation, and their full impact had yet to be realised, although gains and improvement had been noted and are outlined throughout this report.

Recent and progressing hospital and community initiatives to support admission avoidance and patient flow included:

- The hospital's geriatric emergency medicine unit (GEMU) incorporating OPTIMEND [‡‡] had a dedicated multidisciplinary team who provided an appropriate pathway to assess and treat people aged 75 years and over who were referred from the

[‡‡] The OPTIMEND study introduced a dedicated team of health and social care professionals in the ED who focused on timely assessment and intervention of people 65 years and older.

emergency department's triage area. The aim of the unit was to support safe discharge with appropriate follow-on referrals to community services such as the ICPOP and the Community intervention team (CIT).[§§] At the time of inspection, the unit was fully operational 24/7 Monday to Friday, with a proposed plan to move to 7/7 in December 2023.

- The emergency department had a number of patient pathways in place to streamline patient's journey through the ED and improve patient flow.
- Patients waiting in ED were signposted to the services and waiting times within the medical assessment units (MAUs) in St John's, Nenagh and Ennis Hospitals. Patients in the ED were also transferred to these hospitals when appropriate. The weekend capacity of these MAUs had been increased from 32 to 38 overall, since the previous inspection. The patient flow team had been expanded to support the maximum transfer of suitable patient to these model 2 hospitals.
- Pathfinder service[***] — in the past 12 months the service had received 370 referrals with on average, a 51% non-conveyance [†††] rate. The non-conveyance was increasing month on month with the highest non-conveyance rate at 75% in October 2023.
- Alternative Pre-hospital Pathway (APP car) was a new collaboration set up in recent weeks between ULHG and the National Ambulance Service (NAS). The APP Team comprising an emergency medicine doctor at registrar level and NAS personnel, operated the service Monday to Friday 10am to 6pm. The APP Car responded to low acuity emergency calls to provide definitive patient care in the community or referral to an appropriate alternative pathway to avoid an ambulance transfer and ED attendance where possible. To date, the services had seen between 12-19 patients per week resulting in 54.6% admission avoidance.
- ICPOP had 1,384 new referrals this year, a 27% increase on last year's new referrals (1,004). The referrals had been gradually rising month on month, with October 2023 referrals of 156, the highest monthly rate to date. 227 (16%) of these referrals were generated from the hospital's acute floor, inpatient or out parent departments. Referral to ICPOP services supports admission avoidance or early discharge.
- 16,489 community diagnostics such as x-ray, MRI's, ultrasounds, CT, and DEXA[‡‡‡] scans had been undertaken year to date 2023, which was a 6% increase on last year's figures, and avoided hospital attendances and the requirement for ambulance transfers.

[§§] Community Intervention Teams are nurse-led teams, supported by other healthcare professionals and services that provide a rapid and integrated approach to delivering specific clinical interventions to eligible patients within their own home.

[***] Pathfinder is a service which was introduced to change the then model of conveyance to the emergency department following a 999 call for over 65 year olds. This service provides an ambulance team comprising an advanced paramedic, clinical specialist in occupational health, or physiotherapist to respond to 999 calls from low acuity older patients at the scene as an alternative to emergency department conveyance, if appropriate.

[†††] Non-conveyance: Patients not requiring transported by ambulance to hospital.

[‡‡‡] A DEXA Scan (Dual Energy X Ray Absorptiometry) scan is a special non-invasive form of imaging that measures bone density and loss.

- Direct national ambulance access to medical assessment unit in model 2 hospitals based on specific agreed criteria.

The hospital had systems and processes in place to support patient flow through the ED, the hospital and on to the community. These included:

- Hospital management meetings that took place daily at 9am with an additional 2pm meeting when the hospital was in escalation. This meeting included representatives from all sites across the hospital group and the community and was chaired by the hospital's Head of Operational Service. The purpose of the meeting was to improve patient flow by identifying beds and services availability across ULHG and community services and raising any issues that were impacting on patient flow. Patients in ED awaiting diagnosis were referred as priority to support patient flow.
- A Long Stay Tuesday Forum was held weekly to review all patients with a length of stay over 10 days to support patients' safe discharge and improve patient flow across ULHG. Attendees included representatives from the patient flow team, health and social care professionals, nursing and the Mid-West Community Healthcare Organisation. This forum was working well with UHL's average length of stay (ALOS) for medical patients being 6.2 days which is below the HSE's national target of ≤7.0 days.
- Additional patient flow coordinators were now in post at UHL to specifically focus on patient discharges at weekends.
- The integrated Delayed Transfer of Care (DTOC) Group including representation from the ULHG hospitals and community services met to review and discuss cases of DTOC and associated discharge plans. This Group, and the processes in place, were functioning well with 13 DTOC on the day of inspection, this was the lowest rate of DTOC of all model 4 hospitals, and an improvement on the previous inspection.

The hospital had medium and long-term plans to increase inpatient bed capacity and building works had commenced on the UHL site to build a new 96 bed block. The new block will consist of single en-suite inpatient rooms. The current proposed date for completion is Quarter 1, 2025. Under current plans, 44 of these beds will be replacement beds that will be used to bring UHL into compliance with best practice standards in infection prevention and control. Therefore, based on current plans, the full 96 bed complement will not be added to the bed stock at the hospital on the conclusion of this build. This should be risk assessed by management to ensure this has been appropriately considered in the context of persistent high levels of overcrowding in the ED. A further 96-bed block was at the early stages of planning and would provide an additional 96 single en-suite inpatient rooms, with a proposed completion date of 2027.

In summary, the hospital had defined management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the emergency department. Some improvements were seen on the day of inspection in comparison to the previous two inspections and data provided demonstrated increased

activity in many services to support patient flow and higher compliance with national metrics related to unscheduled care. A greater degree of operational grip with a focus on improving PETs was evident on this inspection, relative to findings from HIQA's prior inspections in 2022 and 2023. The hospital was also undertaking significant work both internally and with colleagues in the community setting to establish measures to seek to improve patient flow and provide alternate pathways for patients for example, with the addition of progressive pathways through GEMU and App Car initiatives. On the day of inspection, these supported pathways aimed to provide the right care to patients, in the most appropriate setting.

Notwithstanding these positive changes, management at the hospital still need to progress further improvements with national targets such as PET. At the time of the inspection, the pathways of the AMU were under review by the hospital. This needs to be progressed to facilitate patient flow. Indeed, while it was clear to inspectors that lots of different ways of working had recently been established to try to alleviate overcrowding, they were still at an early stage of implementation and the improvements to date are marginal but important, in particular for PETs and ED avoidance measures. The effectiveness of these combined changes, and the ability of management to sustain and build upon these changes needs to be further embedded at the hospital over time. The hospital also must continue to focus on collaboration within the Mid-West region incorporating acute, community and general practice and on increasing bed capacity to comprehensively address the continued overcrowding situation at UHL.

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.

On the day of inspection, there was evidence of strong executive, clinical and nursing leadership in the emergency department. Since the previous inspection, the Emergency and Urgent Care Directorate had been established with a remit across the emergency and urgent care areas of the six hospital sites within ULHG. It was led by a Clinical Director, Director of Nursing and General Manager which enhanced governance and operational effectiveness for unscheduled care.

A senior clinical decision-maker[§§§] at consultant level was on-site in the hospital's emergency department Monday to Friday 8am to 8pm, at weekends from 8am to 1pm. A consultant was on call each night and at weekends. As per the ED Internal Escalation Framework, if 20 or more 'category 2' patients (patients requiring very urgent emergency

[§§§] 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.

care) were waiting greater than 30 minutes for an ED doctors review (excluding resuscitation), the emergency medicine registrar would contact the emergency medicine consultant on call to attend the ED to review the situation and to implement further actions as defined in per the ED Internal Escalation Framework. This plan is discussed in more detail under standard 3.1.

The consultants in emergency medicine at University Hospital Limerick were supported by 45 approved non-consultant hospital doctors at specialist registrar (NCHD) (five), registrar (14), senior house officer (25) and intern (one) grade. All except one registrar post was filled at the time of inspection. This was an improvement on the previous 2023 inspection, when 20% of NCHD posts were vacant. The hospital was an approved training site for non-consultant doctors on the basic training scheme and higher specialist training scheme in emergency medicine.

The ED had an approved complement of 123.8 WTE nursing staff (Staff nurses and management grade). The variance between the approved and actual nurse staff complement was 23.2 WTE (18.7%) which was an improvement on the previous inspection where the ED was short 34.6 WTE nurses (27.5%). The hospital was in the process of recruiting the additional nurses required, with six nurses due to start in November 2023. The department had its full complement of nursing staff rostered on duty on the day of inspection which was an improvement on the previous inspections. This level of cover included two nurses deployed to the ED to cover short-term absenteeism. Inspectors were informed that nurses also worked extra shifts to cover short-term absenteeism which offers an immediate solution but is not sustainable in the long term. A clinical nurse manager (CNM) 3 was rostered on duty on the day of inspection and had overall nursing responsibility for the department.

Inspectors were informed that the increase in nursing staffing levels in the ED had raised issues in terms of the nursing skill mix within the department. To mitigate the risk, clinical facilitators in the ED were providing education, training and upskilling for new nursing staff.

Nursing staff were supported by a 29.26 WTE healthcare assistants with 22.38 positions filled positions (23% variance) at the time of this inspection. This was an improvement on the previous inspection, when 32.8% of the HCA positions were unfilled, but needs to be further progressed to fill current vacancies.

Staff in the emergency department had access to an infection prevention and control nurse who visited the department daily. The emergency department had an assigned clinical pharmacist who undertook medication reviews and medicines reconciliation for admitted patients in the department.

Uptake of mandatory and essential staff training in the emergency department

It was evident from staff training records reviewed by inspectors that nursing staff in the emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years. The emergency department had a system in place to monitor

and record staff attendance at mandatory and essential training, and this was overseen by the CNM 3.

Inspectors were informed that additional nurses were now eligible to work in triage and a plan was in place to provide training in the Manchester triage system for these nurses. Inspectors were also advised of a plan to provide basic life support training to staff in the department. Training records for nursing staff showed that:

- 100% of nurses were compliant with hand hygiene training
- 61% of nurses were up to date in basic life support training
- 98% of nurses were up to date with training on the national early warning system
- 98% of nurses were up to date in training on sepsis.

While outside of the scope of this inspection, inspectors were informed that the ULHG Workforce Plan-New Hospital Capacity Build had been developed in November 2023 to support the expansion of workforce for the new 96 build block. The Workforce Plan outlines funding requirements to support recruitment for both national and international campaigns.

Overall, HIQA found that hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department to support the provision of high-quality, safe healthcare. Improvements were identified relative to findings from recent inspections in the Emergency Department. There had been a considerable improvement in the staffing complement for all disciplines since the previous 2023 inspection. Although the increase in nursing staff raised issues with skill mix, the hospital were addressing this issue through additional onsite education and support. Plans to upskill staff in the Manchester triage system and basic life support should be progressed by the hospital following this inspection. Management should also progress the implementation of the ULHG Workforce Plan-New Hospital Capacity Build plan to ensure that medical, nursing, health and social care professionals and support staff are in place to support the development.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings from the emergency department related to the quality and safety dimension are presented under national standards 1.6 and 3.1 from the themes of person-centred care and safe care respectively.

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

On the day of inspection, it was evident to inspectors that staff working in the University Hospital Limerick emergency department were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards patients in the department. Staff provided assistance and information to patients in a kind and caring manner this was endorsed by patients who spoke with inspectors on the day. However, the provision of dignity and privacy was challenging in an overcrowded department with admitted patients accommodated in the department awaiting an inpatient bed.

At the time of inspection, 35 admitted patients were accommodated in the department awaiting an inpatient bed with up to 19 patients accommodated on trolleys on corridors which did not support or promote the dignity or privacy for those patients.

There was only one toilet located in each of zone A, B and C, which did not adequately facilitate the number of patients accommodated in these areas of the ED on the day of inspection. Toilets were available in other areas of the ED. In one instance, a patient told inspectors they had to go to the waiting area to access a toilet. There were two showers in the emergency department.

Staff did endeavour to support dignity and privacy for older patients and those with enhanced care needs by caring for these patients in individual cubicles. Staff also retained an individual cubicle to use for examination or invasive investigations for patients accommodated on the corridors to afford them more privacy.

The hospital was also in the process of introducing other initiatives to improve the patient experience within the department such as dementia friendly cubicles and an autistic pathway. The GEMU also promoted care for the older patients in a more suitable environment. Fundamentals of care audits were undertaken frequently within the department to ensure patients were provided with fundamental care.[****] The Chief Director of Nursing also undertook fundamentals of care audits monthly and spoke with patients about their experience of care and to staff in the emergency department to offer support and guidance.

Patients at end of life in the ED were prioritised for an inpatient bed and cared for a room in the clinical decision unit or in a cubicle while in the ED. Acknowledging the challenges facing the Irish hospital system, it is still important to ensure privacy at end-of-life for patients and relatives in a suitable environment, such as a single inpatient room. A newly refurbished bereavement room was available within the department.

[****] Personal care provided, toilet care provided, pressure ulcer assessment, INEWS observation, medications administered, fluid balance completed, care bundles completed and pain score assessed.

Overall, the situation within the department had visibly improved based on the findings from the previous two inspections. The implementation of alternative pathways for patients attending the department and promotion of fundamentals of care within the department demonstrated improvements. There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the emergency department. However, the boarding of 35 admitted patients in the emergency department with 19 of these patients on trolleys on corridors did impact on a meaningful promotion of dignity and privacy for all patient and was not consistent with the human rights-based approach to care supported and promoted by HIQA.

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.

The hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high-quality, safe services in the emergency department. The hospital collected data on a range of different quality and safety indicators related to the emergency department in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from the hospital's emergency department, delayed transfers of care and ambulance turnaround times.

Performance data

Collated performance data and compliance with key performance indicators for the emergency department set by the HSE was reviewed at the Urgent and Emergency Care Committee, Integrated Unscheduled Care Committee, ULHG's Quality Safety and Executive Committee, and ULHG's EMT.

Emergency department related risks were managed at departmental level with oversight by the CNM3, Assistant Director of Nursing (ADON) and Director of Nursing (DON) supported by the Risk Advisor. Serious high-rated risks were escalated to ULHG's EMT and recorded on UHL's corporate risk register. Patient-safety incidents and serious reportable events related to the emergency department were managed in line with the national guidance. Serious reportable events and serious incidents were escalated to the serious incident management team.

There was a process in place to manage and respond to complaints related to the emergency department with oversight locally by the CNM3, ADON, DON and the Business Manager. Complaints relating to the department were tracked and trended and monitored by the UEC committee. A patient advisory liaison service was available in the ED Monday to

Friday to advocate for patients. Learning from complaints and incidents was shared with staff.

Overcrowding in the emergency department remained a high-rated risk on UHL's corporate risk register since the previous inspection. The impact of corrective actions and controls applied to reduce overcrowding and mitigate potential and actual risks to patient safety were still not fully effective on the day of inspection. In addition to 32 inpatients accommodated in the ED, there was an additional 50 inpatients in surge capacity. Thirty five patients were accommodated on trolleys on wards averaging 1-3 per ward, with other patients accommodated in the day services area and cardiology day ward.

The hospital's risk register included the risk of harm to patients and staff related to communicable infectious diseases and fire caused by chronic overcrowding in ED in UHL hospital. Since the previous inspection, the hospital had identified designated trolley spaces in conjunction with the fire officer to help address fire safety requirements and infection control guidance. On the day of inspection all patients were accommodated on designated trolley spaces. Some patients were however accommodated on a corridor off zone A which was near, but not within view of the zone A nurse's station. These patients did not have a call bell to seek staff attention if required. When raised with staff, inspectors were informed that all patients were risk assessed prior to placement on this corridor to ensure that only low risk ambulant patients accommodated on this corridor. Inspectors were also informed that staff were vigilant to visit this corridor regularly to observe patients. However, this could prove challenging at times of severe overcrowding or staff shortages and create a risk of an unobserved patient not being provided with care when required. The hospital needs to ensure that patient placement is always risk assessed, and that required staff are in place to ensure regular observation of patients, especially in areas outside the official zoned areas of the ED. In any case, accommodating admitted patients in the ED remains an unacceptable solution to inadequate capacity.

At 11am on the day of inspection the hospital was not compliant with national key performance indicators for emergency departments set by the HSE. The findings were similar to those of the previous inspection for six and nine hours PETs, however improvements in 24 hour PET, especially for the patients aged 75 years and over were noted.

- 52% of attendees to UHL's emergency department were in the department for more than six hours after registration — not in line with the national target which requires that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration in the ED.
- 48% of attendees to UHL's emergency department were in the department for more than nine hours after registration — not in line with the national target of 85% of attendees being admitted to a hospital bed or discharged within nine hours of registration in the ED.

- 23% of attendees to the emergency department were in the department for more than 24 hours after registration — not in line with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration in the ED.
- Of all attendees to the emergency department 19 were aged 75 years and over. 63% of these patients were in the department for more than nine hours after registration — not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration in the ED.
- 21% of attendees to the emergency department aged 75 years and over were in the department for more than 24 hours after registration — not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within 24 hours of registration in the ED.

Another risk on the ED risk register, and highlighted by staff on the day of inspection, related to nursing skill mix in the ED due to new nurses employed in the ED. To mitigate this risk, new staff were rostered with experienced staff and two clinical facilitators provided training and support to new nursing staff within the department.

Risk mitigation measures in respect of overcrowding

The ED had an Internal Escalation Framework which was on version nine dated May 2023. The escalation framework outlined areas of focus in the ED and the actions to take to mitigate risks when triggers were reached. Given the situation observed in the department on the day of inspection, the ED escalation plan could be triggered on multiple occasions throughout the day requiring action to mitigate risks.

Examples of triggers for escalation action included:

- Triage escalation actions ranging from yellow escalation when 10 patients were waiting greater than 20 minutes for triage, to red escalation when 25 patients were waiting greater than 20 minutes for triage. Actions to be taken ranged from the redeployment of nurses to triage when in yellow escalation, and onwards escalation to the CNM3 and triage consultant supporting triage and executive on call. Escalated actions were observed by inspectors on the day of inspection.
- Further actions to address ED congestions action when there was more than 23 admitted patients in ED to include when all resuscitation room spaces were occupied included transfer of patients to trolleys on wards and other spaces retained to facilitate patient flow. Both these escalation actions were in place on the day of inspection when the triggered cap of 23 admitted patients was exceeded.
- In instances where there were greater than twenty Manchester triage category 2[††††] patients, waiting longer than 30 minutes for an ED doctor review (excluding resuscitation), the emergency medicine consultant on call would be contacted to

[††††] Manchester triage category 2: very urgent, to see assessed within 10 minutes

attend and review the situation. If immediate de-escalation is not possible, further tiered escalations up to and including the EMT were required to address the situation.
- Speciality referral of over 2 hours trigger an orange escalation with an action that the ED consultant requested the speciality team to prioritise ED patient review.

Inspectors were informed that a nursing safety huddle occurred each morning to highlight any risks initiatives of education points, as well as highlighting the importance of fundamentals of care, documentation and staff introductions to patients. Inspectors were also advised of multidisciplinary huddles that take place in the department at 8.30am and 12.30pm.

Infection prevention and control

The infection status of each patient was recorded on the hospital's electronic operating system. A prioritisation system was used to allocate patients requiring isolation to single cubicles. Staff confirmed that terminal cleaning[‡‡‡‡] was carried out following suspected or confirmed cases of communicable infectious diseases. Infection prevention and control nurses visited the department daily to support staff and provide advice regarding patient isolation and screening.

The emergency department environment was generally clean and well maintained. The department was compliant in a sample of equipment audits reviewed, however some environmental audits viewed by inspectors' highlighted opportunities for improvements, with some monthly compliance rates of 76%.

The overcrowding in the emergency department made it difficult to maintain a minimum distance of one meter between healthcare service users as recommended in national guidance therefore increasing the risk of transmission of infection particularly respiratory viruses.

Medication safety

There was a clinical pharmacist assigned to the emergency department who undertook clinical reviews and medicines reconciliation for admitted patient's in the department. A pharmacy technician visited the department daily to replace pharmacy stock.

Deteriorating patient

The hospital was using the Irish National Early Warning System (INEWS) observation chart to support the recognition and response to a deteriorating patient for admitted patients in the ED. INEWS audits were undertaken to determine compliance with national guidance on INEWS with monthly results viewed by inspectors demonstrating between 72-100% compliance rates. The Identify, Situation, Background, Assessment and Recommendation

[‡‡‡‡] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

(ISBAR) communication tool[§§§§] was used when escalating the care of a deteriorating patient. The ISBAR3 communication tool was used for internal and external patient transfers from the emergency department. A recent audit of compliance with the ISBAR3 communication tool from the ED to inpatient wards demonstrated a 90% compliance rate.

The Emergency Medicine Early Warning System (EMEWS)[*****] was not implemented in UHL at the time of inspection, although 90% of nurses and 50-60% of doctors had received training in EMEWS. Hospital management were planning to introduce the system when the emergency department had its full complement of nursing staff. Inspectors were informed that hospital management also considered the risks of introducing a new system when the department was overcrowded. EMEWS is recommended for use in all EDs to support the recognition of, and appropriate response to, the deteriorating patient to improve the quality and safety of all patients in the ED who are at risk of physiological deterioration. The hospital should consider the immediate progression of the implementation of the EMEWS.

Overall, on the day of inspection the hospital had systems and processes in place to protect people who use the service from the risk of harm. However, given the high ED attendance rates at the hospital, and the challenges with patient flow resulting in overcrowding in the department, the processes in place may not be fully sufficient to protect people who use the service from the risk of harm. The continuous state of escalation in the ED is unsustainable and needs to be addressed by the hospital and the wider HSE in a meaningful manner to reduce risks to the patients in ED.

In summary, given the persistent overcrowding in the department there still existed risks of harm to the patients in the emergency department which were not fully managed by the hospital. The PET times for patients in the ED, despite improvements, still fell significantly short of national targets creating a higher level of risk of harm for patients in the ED for prolonged periods of time. The hospital had a number of initiatives and processes and structures in place to manage patients in the most suitable environment which would reduce ED attendances and hospital admissions. Many hospital and community services such as the GEMU, APP car, pathfinders, mobile diagnostics and ICPOP were still relatively new and may take time to establish more fully to impact positively on hospital attendance and admission rates.

Judgment: Partially compliant

[§§§§] Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool
The ISBAR clinical communication tool is a structured framework which outlines the information to be transferred when communicating information verbally and in writing between healthcare professionals. The ISBAR3 is used for inter and external transfers and shift handovers.

[*****] Emergency Medicine Early Warning System (EMEWS) is a national clinical guideline developed by the HSE's National Clinical Programme for Emergency Medicine launched in 2018 by the Minister for Health. It applies to adults patients (16 years and older) attending an emergency department in Ireland.

Conclusion

HIQA carried out an unannounced inspection of University Hospital Limerick to assess compliance with four of the national standards from the *National Standards for Safer Better Health*.

Capacity and Capability

University Hospital Limerick had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare.

Since the last inspection, the hospital had established the UEC Directorate to provide a single entity for the strategic and operational function of the emergency and urgent care services across the six hospital sites of the UL Hospitals Group. Improvements were seen on the day of inspection in comparison to the previous two inspections and data provided demonstrated increased activity in many services to support patient flow and higher compliance with national metrics related to unscheduled care. The hospital still had significant progress to make to be compliant aginst many national targets, but had set priorities and targets to work incrementally toward compliance. Hospital management did demonstrate a higher level of operational grip and was solution focused in actions to achieve higher compliance and to provide the right care to patients, in the most appropriate setting.

The ongoing mismatch between the number of people attending the emergency department and the hospital's capacity, resulted in an overcrowded ED with admitted patients accommodated in the ED. The hospital was performing well in relation to patient's ALOS and DTOCs in comparison to a number of other model 4 hospitals. The AMU and ASAU, although functioning as a pathway from the ED, had their full functionality impeded by patients accommodated in these unit awaiting inpatient beds. The hospital's use of GEMU/OPTIMEND, ICPOP, pathfinder, model 2 hospitals, community links such as CIT and the recently established APP Car were supporting hospital avoidance and discharge.

Hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department to support the provision of high-quality, safe healthcare. There had been a considerable improvement in the staffing complement in ED for all disciplines since the previous 2023 inspection. The increase in nursing staff in the ED had raised issues with nursing skill mix, which the hospital were addressing through additional onsite education and support. Plans to upskill staff in the Manchester triage system and basic life support should be progresses by the hospital following this inspection.

Quality and Safety

There was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the emergency department. The situation within the department had improved in comparison to the two previous inspections. Notwithstanding this, it remained very overcrowded. People who spoke with inspectors were very complimentary of the staff and the care received, but did raise long wait times as an issue and outlined difficulties experienced on trolleys on ED corridors.

The ongoing promotion of alternate pathways for patients attending the department and promotions of fundamentals of care within the department demonstrated improvements. However, the boarding of 35 admitted patients in the emergency department, with 19 of these patient's on trolleys on corridors, did impact on a meaningful promotion of dignity and privacy for all patients and was not consistent with the human rights-based approach to care supported and promoted by HIQA.

The hospital did have systems and processes in place to protect people who use the service from the risk of harm. However, the persistent overcrowding and current nursing skill mix in the department created risks of harm to the patients in the emergency department. The continuous state of escalation requiring actions to mitigate risks is unsustainable, and needs to be addressed by the hospital in a meaningful manner to reduce risks to the patients in ED.

The PET time for patient in the ED, despite improvement, still fell significantly short of national targets creating higher level of risk of harm for patients with prolonged periods of time in ED. Many of the initiatives and improvements introduced by the hospital were still relatively new and may take time to establish more fully to impact positively on hospital attendance, PETs and admission rates.

HIQA acknowledges the significant improvement in resourcing, supports and alternate pathways that have been introduced at UHL, since March 2022. The resultant improvements to date have focused on patient flow and efforts to improve operational efficiency and resourcing in UHL. A notable expansion of the GEMU unit, provided a dedicated care pathway for elderly patients whose care is better managed outside an emergency department environment. In this report, a slight improvement of compliance levels particularly in relation to organisational pathways and resourcing across a number of the national standards assessed in UHL's emergency department in February 2023 and March 2022. However, significant risks to patient safety remain. The underlying issue of ineffective patient flow, in the context of a continued mismatch between capacity and demand for services at UHL is yet to be fully addressed.

The planned addition of extra inpatient bed capacity in the form of a new 96 bed block in early 2025 is to be welcomed. However, as highlighted in prior HIQA reports, the impact on overcrowding of any proposed increase in inpatient capacity gains at UHL, will likely be

tempered should a significant proportion of this new stock be utilised as replacement stock with older capacity being decommissioned. This should be risk assessed by management to ensure this has been appropriately considered in the context of risks posed by overcrowding in the ED. Furthermore, in anticipation of finalising the new capacity, management at UHL should ensure that recruitment is further progressed to support the staffing required to open the new unit.

In the meantime, the hospital must continue to focus on collaboration within the Mid-West region incorporating acute, community and general practice and on increasing bed capacity to comprehensively address the continued overcrowding situation at UHL.

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 selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. 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 is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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	
Theme 5: Leadership, Governance and Management	
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
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.	Substantially compliant
Quality and Safety Dimension	
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 Service Provider's Response

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

Outline how you are going to improve compliance with this standard. This should clearly outline:

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

(b) where applicable, long-term plans requiring investment to come into compliance with the standard

AMU

- The Governance of the AMU was changed in June 2023 from the Medicine Directorate to the Urgent & Emergency Care Directorate. **Completed**

- AMU **KPI - 75% of patients to be discharged or admitted within 6 hours** To improve compliance with the KPI by 50% by the end of Q3 and to 75% when the 96 bed block opens in Q1 2025

- Patients are referred directly to AMU from primary care via the bed bureau with some onward referrals from other sources including the emergency department (ED), outpatient department and other care settings, co-ordinated by the ULHG bed bureau. **Completed**

- Criteria for referral to the AMU is currently under review to ensure that the most appropriate patients are being referred to the unit to comply with max. length of stay of 48 hours. **(To be completed end of Q2 2024).**

ED

- ED PET for patients over 75 Years admitted or discharged within 24 hours National target is 99%. Target set by the ED team to achieve full compliance with this KPI. **(To be completed end of Q3 2024)**.

- The rate of conversion for ED patients noted in the HIQA report incorporates AMU, ASAU, and CDU data. ED conversation rate data, specific to ED will be reviewed by the Directorate Management Team (UEC) to ensure compliance with the national rate. (**To be completed Q2 2024)**

- A streamlined pathway for the >75's who attend ED is currently in place to the GEMS unit. The GEM unit resources, the Rapid Response Frailty team, pathfinder's team complement the existing Service to ensure that older persons follow the

appropriate pathway and are safely discharged home when appropriate from the ED. These services operate out of the dedicated GEM (Geriatric Elderly Medicine) area. The aim of the unit is for the patient group to be supported directly to the unit from Triage for ED and HSE team input in a dedicated over 75's unit. **Completed**

- The ED internal escalation processes within the Emergency Department will be reviewed to ensure that delays are minimised for the patients availing of the services. Further improvements will be looked at to enhance operational efficiency in the Emergency Department and build on the gains in recent months. We will review our data to drive and sustain operational efficiencies. A review of the ED internal escalation plan will be completed. (**To be completed Q2 2024)**

- CCD & consultants meet with GP's in the region on a quarterly basis at the GP forum where overcrowding and alternative pathways to ED are discussed. **Completed**

- Education meetings are being held twice yearly for the GP's. Webinar for the GP's held twice yearly by the Communications team. **Completed**

UHL will continue to work actively on identifying and addressing opportunities both inside and outside the Hospital to optimise its bed capacity and improve the effectiveness and efficiency of care and experience for patients attending the ED. Specific measures are being implemented to improve patient flow and reduce ED congestion as outlined in the Hospital's response to the Leadership, Governance and Management standard judgement.

Timescale:

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

Outline how you are going to improve compliance with this standard. This should clearly outline:

(a) Details of interim actions and measures to mitigate risks associated with non-compliance with standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the standard

Interim Measures

- There are 13 toilets in the ED department for patient use. The Urgent and Emergency Care Directorate will review and update the signage for easier location of the toilets & 2 shower facilities. **(To be completed Q2 2024)**

- Patients are risk assessed within the ED to determine suitability to be allocated to corridor 2 & the zones. At handover a review is undertaken by the team as to the most appropriate patient location. This is recorded on the handover sheet. **(Completed).**

- Nursing Staff are allocated to the various areas and Zones at the beginning of each shift with full cover for breaks. Only patients who are mobile are allocated to corridor 2. Audit of compliance with same to be completed. HCA are allocated to each zone to be on hand at all times for the patients in each zone to communicate & assist with hygiene needs, pillows/blankets, provides comfort & toiletry packs (which include eye mask/sleep mask, foam ear plugs) in the ED. Safer staffing levels have been implemented. (**To be completed in Q2 2024**)

- Nursing staff were supported by 22.38 healthcare assistants with a remaining 6.8 positions to be filled. To complete the recruitment of the remaining 6.8 WTE (**To be completed in Q2 2024**)

- A Protected Cubicle is in place for use by the clinical teams when carrying out intimate clinical care within the zones in the ED to promote the dignity, privacy and autonomy of patients, a cubicle is protected. **(Completed)**

- Patients at end of life in ED UHL are always prioritised for a single room while awaiting a bed on the wards. This is either an ED cubicle but is predominantly a room in the CDU. There is a dedicated bereavement suite within the Emergency Department for families and loved ones. **(Completed)**

- Patients who present to the ED who are part of the Haematology/Oncology service are prioritised for isolation if required and are transferred to the 2 assessment

cubicles in Haematology/Onc Ward (6B) for work up as per pathway - if Resus is not required. **(Completed)**

- A speech privacy memo will be issued to all staff within the Emergency department and incorporated into the ongoing communication training being rolled out in the department. **(To be completed Q1 2024)**

- The 2 PALS Managers allocated to the ED complete rounds within the department to support patients in the Department. They offer the comfort packs, pillows, clinical care updates if required. They offer to contact family/N.O.K. if a patient requires same. They offer support and give the contact details for the PALS service if required. They offer to address any immediate concerns the patient has and make every effort to resolve them quickly **(Completed)**.

- The PALS team manage an emergency clothing and toiletries stock within the ED which provides clothing to patients, who find themselves in the department without essentials from home. **(Completed)**

Longer term Measures

- UHL has a well-advanced major capital development plan underway for the construction of a new 96 Bed block. The development will significantly increase the bed capacity of the hospital, increase patient flow and will support patient flow from the ED. **(To be completed Q1 2025)**

- To progress a further 96 inpatient bed block. **(To be completed Q1 2027)**

- To progress the implementation of ULHG workforce plan, to ensure that the necessary multidisciplinary team resources are in place the new build **(To be completed Q4 2024)**

UHL will continue to work actively on identifying and addressing opportunities both inside and outside the Hospital to optimise its bed capacity and improve the effectiveness and efficiency of care and experience for patients attending the ED. Specific measures are being implemented to improve patient flow and reduce ED congestion as outlined in the Hospital's response to the Leadership, Governance and Management standard judgement.

Timescale:

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

Outline how you are going to improve compliance with this standard. This should clearly outline:

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

(b) where applicable, long-term plans requiring investment to come into compliance with the standard

Interim Measures

- To continue to move patients from the ED to inpatient ward corridors when inpatient capacity has been exhausted, surge capacity opened in line with the escalation plan to address overcrowding in the ED. **(ongoing)**

- To utilise the designated floor spaces as per the fire plan to maximise patient safety and dignity.**(ongoing)**

- To continue to maximise the transfer of patients to the model 2 sites with daily review of performance **(ongoing)**

- To improve the discharge rate of patients at the weekend across all sites, performance will be monitored on a weekly basis. (**To be completed in Q4 2024**)

- When capacity demands patients are risk assessed within the ED to determine suitability to be allocated to corridor 2 & the zones. At handover a review is undertaken by the team as to the most appropriate patient location. This is recorded on the handover sheet. **(Completed).**

- Nursing Staff are allocated to the various areas and Zones at the beginning of each shift with full cover for breaks. Only patients who are mobile are allocated to corridor 2. Audit of compliance with same to be completed. HCA are allocated to each zone to be on hand at all times for the patients in each zone to communicate & assist with hygiene needs, pillows/blankets, provides comfort & toiletry packs (which include eye mask/sleep mask, foam ear plugs) in the ED. Safer staffing levels have been implemented. (**To be completed in Q2 2024**)

- The Urgent and Emergency Care Directorate will review the provision of a call bell system on corridor 2. (**To be completed in Q2 2024**)

- To increase the numbers of patients going through the Geriatric Emergency Medicine Unit (GEM Unit) unit on a daily basis. Target to be agreed. (**To be completed in Q2 2024**)

- ED PET for patients over 75 Years admitted or discharged within 24 hours National target is 99%. Target set by the ED team to achieve full compliance with this KPI **(To be completed end of Q3 2024)**.

- MDT Safety huddle will continue to be a priority in the emergency department to ensure that there is a multidisciplinary approach to patient care and that there is the appropriate escalation of concerns. **(Ongoing)**

- Every effort is made to encourage the use of existing patient flow pathways. This is managed through daily hospital management team meetings which includes all of the sites, across the Group, community/ region to maximise flow across the system. Operations team meetings at held at 9am and 4pm, chaired by the Head of Service for the site. **(Ongoing)**

- Daily review of patients in ED with diagnostic requirements through Red2Green with early communication to pathology, radiology & cardiology to ensure prioritisation. **(Ongoing)**

- ULHG collaborate with the community services to maximise capacity in Rehab, Long term Care/ Home Care Support across the region through a number of forum, the USC meeting and the DTOC meeting, **(Ongoing)**

- To implement EMEWS in the Emergency Department (**Completed January 2024**)

- To ensure that staff within the Emergency Department have completed their BLS training. **(To be completed end of Q2 2024)**.

- To upskill further staff on the Manchester Triage System. (**To be completed in Q2 2024**)

Timescale: