



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

Name of healthcare service provider:	University Hospital Limerick
Address of healthcare service:	St Nessian's Rd, Dooradoyle, Co. Limerick
Type of inspection:	Unannounced Inspection
Date of inspection:	15 March 2022
Healthcare Service ID:	OSV-0001064
Fieldwork ID:	NS_0003

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

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. The six sites are described as functioning as a single hospital system using a hub-and-spoke model whereby critical care facilities are centralised at University Hospital Limerick supported by Model 2 and Model 2S (specialised) hospitals. A range of services are provided across the six hospital sites under the leadership of five clinical directorates, namely the cancer service directorate; medicine directorate; peri-operative directorate; diagnostics directorate and maternal and child health directorate.

University Hospital Limerick is the only Model 4* hospital providing major surgery, cancer treatment and care, emergency department services, as well as a range of other medical, diagnostic and therapy services on an inpatient and outpatient basis to the population of the Midwest region of Ireland. The hospital has an inpatient[†] bed complement of 530 beds (98 of these inpatient beds were added in late 2020 and early 2021) and 149 day case[‡] beds. Of note, there is no Model 3 hospital in the University Limerick Hospitals Group which contrasts with the structure of other hospital groups in Ireland.[§]

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 University Hospital

* Model-4 hospital is a tertiary hospital that provide tertiary care and, in certain locations, supra-regional care. The hospital have 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.

[†] Inpatient refers to a patient who goes into hospital for medical or surgical care and remains there for one or more nights while having treatment.

[‡] Day case refers to a patient admitted on a planned basis for a procedure or treatment who are admitted and discharged from hospital on the same day, with no overnight stay.

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

Limerick to assess the effectiveness of measures implemented to address the issue of overcrowding in the hospital's emergency department and to assess compliance with four national standards (5.5, 6.1, 1.6 and 3.1) from the *National Standards for Safer Better Healthcare*.

To prepare for this inspection, inspectors** reviewed relevant information about University Hospital Limerick. This included any previous inspection findings, information submitted by the hospital and University Limerick Hospitals Group, unsolicited information and other publically 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 is being sustainably provided in the hospital's emergency department. It outlines how people who work in the service are managed, and whether there is appropriate oversight and assurance arrangements in place to ensure high-quality and safe delivery of care.

** 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*.

2. Quality and safety of the service

This section describes the experiences, care and support people received in the hospital's emergency department. It was a check on whether the service was a good quality and caring one 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.

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
Tuesday, 15 March 2022	09:00 to 16:00hrs	Sean Egan	Lead Inspector
		John Tuffy	Support Inspector
		Denise Lawler	Support Inspector

Information about this inspection

University Hospital Limerick has the only emergency department in the Midwest region of Ireland providing a 24/7 service for a catchment of approximately 385,172 people. The Midwest region also has three local injury units located in St John's Hospital, Ennis General Hospital and Nenagh General Hospital that provides treatment for a smaller number of people with minor injuries unlikely to need admission to hospital.

HIQA has been in ongoing communication with the hospital group regarding the overcrowding in the emergency department at University Hospital Limerick since July 2020. In May 2021, the hospital group provided HIQA with a detailed analysis of the factors that they considered contributed to ongoing overcrowding in the hospital's emergency department, and the measures enacted or in planning to alleviate the situation. Correspondence received from the hospital group outlined the short, medium and long-term measures to increase inpatient bed capacity and improve patient flow in the hospital. In January and February 2022, the number of people presenting to the hospital's emergency department was unprecedented, leading to instances of significant trolley numbers in the emergency department, including patients already admitted awaiting an inpatient bed on a ward. At that time, HIQA sought further assurances from the hospital group on measures enacted to address overcrowding in the hospital's emergency department and the associated risks to patients.

In reviewing all information available to it in 2021 and 2022, HIQA identified that the hospital had the potential to experience additional severe crowding over the impending long weekend due to public holidays that occurred on 17 and 18 March 2022.^{††} In light of same, HIQA conducted a risk-based unannounced inspection of the emergency department in University Hospital Limerick on 15 March 2022 to determine the hospital's level of compliance with four standards from the *National Standards for Safer Better Healthcare*. In particular, this inspection intended to ensure that the hospital had adequate contingency measures in place to mitigate the worst potential safety impacts of crowding in the emergency department over the imminent long weekend.

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

- 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.

^{††} While acute hospitals in Ireland that have emergency departments remain open to receive patients 24/7 365 days of the year, due to the nature of staffing levels and rosters, access to routine levels of service are much reduced at weekends and on public holidays. As a consequence, given that acute hospitals ordinarily operate at very high occupancy rates, it can be expected and is regularly observed that extreme crowding in emergency departments may follow public holidays. The 18 March 2022 was a special public holiday in Ireland – as it followed the normal public holiday of 17 March – it meant that the hospital would in effect experience a four day weekend at a time of already unprecedented overcrowding.

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

- Representatives of the hospital group's Executive Management Team
 - Chief Executive Officer
 - Chief Clinical Director
 - Chief Director of Nursing and Midwifery
 - Chief Operations Officer
 - General Manager Medicine Directorate
- Associate Clinical Director for Medicine Directorate who was a consultant in emergency medicine
- Director of Quality and Patient Safety for University Limerick Hospitals Group.

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

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 receiving care in the emergency department who spoke with inspectors about their experience of the service.

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

On the day of inspection, inspectors visited the emergency department and Acute Medical Unit. The emergency department provides care for undifferentiated patients with acute and urgent illness or injuries and comprises four triage rooms (three for adults and one for paediatrics) and 49 single treatment cubicles set out in four zones. The emergency department is the entry point for all patients presenting to the hospital with symptoms or suspected symptoms of COVID-19. Non COVID-19 patients were assigned to Zone A. Patients from Zone A were further streamed to the Acute Medical Unit or Acute Surgical Assessment Unit. Patients with suspected or confirmed COVID-19 were assigned to Zones B and C. The resuscitation area was part of the COVID-19 pathway. On the day of inspection, the number of patients in the resuscitation area was double its intended capacity. Patients were boarding in the resuscitation area while awaiting an inpatient bed, which had the potential to impact on the department's capacity and ability to deal with acutely ill patients and or major trauma and emergencies. This was a concern for inspectors.

The emergency department also has a Clinical Decision Unit with 12 cubicles. This is a designated area where patients were monitored and treated for a period of time, usually for six to 24 hours, according to disease-specific protocols under the care of a consultant physician specialised in emergency medicine.

Patients who attended the hospital's emergency department either presented by ambulance, were referred directly by their general practitioner or self-referred. Almost half (49%) of the patients attending the emergency department on the day of HIQA's inspection were self-referrals.**

On the day of inspection, inspectors observed that the emergency department was grossly overcrowded. Hospital management told HIQA that, on the day, the hospital had 59 COVID-19 positive patients and there was a total of 78 COVID-19 positive patients across the University Limerick Hospitals Group. At the time, the hospital was also managing nine declared infection outbreaks and had enacted its escalation plan. This was further compounded by a number of infection outbreaks in the community and reduced bed capacity in the Model 2 hospitals within the hospital group.

In the emergency department, extra patients were accommodated on trolleys on corridors with very little free space available between them. At 11.30am there were 50 extra patients accommodated on trolleys, double the capacity of the emergency department. In addition, all 25 beds in the Acute Medical Unit were occupied. An additional four patients were accommodated on trolleys on the corridor of the Acute Medical Unit. In effect, the Acute Medical Unit was acting — like many other areas of the hospital — as an overflow ward for non COVID-19 patients from the emergency department, and was not functioning as designed, as an alternate flow pathway for patients in order to take pressure from the emergency department. This indicated to HIQA that the normal means of facilitating patient flow were simply not working at the hospital at the time of inspection.

Throughout the day, inspectors observed that staff working in the clinical area were wearing appropriate personal protective equipment (PPE) in line with current public health guidelines. Inspectors observed the practice of donning and doffing PPE and were satisfied that the practice was in line with national guidance.

On arrival to the emergency department, all attendees checked in at reception and waited to be called for triage. Attendees to the department were required to wear a facial mask in the waiting room and the waiting area allowed for minimum physical spacing of 1 metre, with signage reminding attendees to maintain minimum physical distancing.

Inspectors spoke with a number of patients in the emergency department to ascertain their experiences of the care received. All patients who spoke with inspectors were complimentary about staff. They described staff as 'lovely and very helpful' and how 'staff were doing their

** In 2019, University Hospital Limerick reported 35,000 general practitioner (GP) referrals to the hospital's emergency department and the number of self-referrals was 32,565. In 2020, GP referrals decreased to 31,531 while the number of self-referrals increased to 40,027.

best'. One person commented on how busy the department was. The majority of patients commented on the staffing levels saying that there was 'not enough staff', and remarked on how staff were 'run off their feet', and again 'how staff were doing their best'. Patients expressed concerns about the overcrowding in the department and on how it impacted on their safety.

Patients commented on the 'lack of space' in the emergency department and 'the need for more beds' and suggested that people were almost resigned to the overcrowding and extra trolleys in the department, with one person saying they 'just expected that was the situation'. They also expressed concerns about the lack of privacy and confidentiality and how 'everyone could hear their diagnoses' when discussing their care and treatment with the medical team and nursing staff.

The patient experience time^{§§} (PET) was raised by the majority of patients who spoke with inspectors. One patient described how they waited for 90 minutes for triage and were waiting in a wheelchair for 14 hours while awaiting a trolley. Another described how they came into hospital in an ambulance and waited over three hours for a trolley. The recounting of experiences of lengthy waiting times were consistent with the findings of the National Inpatient Experience Survey for University Hospital Limerick in 2021.^{***} The hospital's performance in relation to national key performance indicators for patient experience time set by the HSE are discussed in more detail in the section of this report related to national standard 3.1.

Some patients spoke about waiting times for diagnostics and the delays they were experiencing. One person was in the emergency department for 45 hours while waiting for an angiogram.^{†††} Another person, who was in the department for 24 hours, was waiting on a computed tomography scan.^{†††}

Patients who spoke with inspectors felt confident that if something was wrong, and or if they wanted to make a complaint, they knew who to complain to and felt sure that their complaint and concerns would be resolved.

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.

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

^{***} The findings of the National Inpatient Experience Survey are available at:

<https://yourexperience.ie/inpatient/national-results/>

^{†††} An angiogram is a procedure that uses X-ray imaging to see the blood vessels of the heart.

^{†††} A computed tomography (CT) scan is a diagnostic imaging exam that uses X-ray technology to produce images of the inside of the body. A CT scan can show detailed images of any part of the body, including the bones, muscles, organs and blood vessels.

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 standard 5.5 and non-compliant with standard 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.

On the day of inspection, inspectors were not assured that the management arrangements in place to support and promote the delivery of high-quality, safe and reliable service were effective in managing the demand, overcrowding and patient flow in the hospital's emergency department. This included the adequacy of management arrangements for escalation of specific issues identified on the day of inspection – such as, sudden or unexpected change in staffing levels; the long waiting times for patients from reception to triage; or delays in patient flow that resulted in the boarding of 60 admitted patients in the department who were awaiting an inpatient bed in the hospital. Furthermore, there were significant deficits in nurse staffing levels which impacted on the functioning of the department. This is discussed further in the next section related to national standard 6.1.

Documentation reviewed by inspectors detailed the measures that management at the hospital group had introduced or were planning to introduce to improve staffing levels and patient flow in the emergency department, and increase capacity for emergency, cancer and critical care services at the hospital.

Short-term measures, in keeping with the standard HSE national emergency department escalation protocol, enacted by the University Limerick Hospitals Group to address the overcrowding situation in the emergency department at University Hospital Limerick included:

- cancelling or curtailing scheduled care.
- transferring patients to Model 2 hospitals where possible.
- utilisation of all surge beds and additional trolleys in inpatient wards.
- maximising and utilisation of community and rehabilitation beds.

- using beds in specialist hospitals to transfer patients needing rehabilitation when no community rehabilitation beds were available.
- engaging and communicating with the public advising them to only use emergency department for emergency cases and to choose alternative options, such as general practitioner and injury units for non-urgent cases.

There was evidence before and after HIQA's inspection, that hospital management had engaged and communicated with the public through local media, a range of social media platforms and local government representatives, advising them to use the hospital's emergency department only for emergencies and to consider alternative clinical pathways.

Management at the hospital had implemented a number of other measures that aimed to improve patient flow generally in the hospital and across the hospital group. These included:

- safety huddles held at 8.30am and 3.30pm in the emergency department where activity, inpatient bed capacity and potential or existing risks that may affect patients in the department were discussed. In addition, HIQA was told that a hospital-at-night meeting, held by nursing staff at 11pm, was being progressed to include senior clinical staff on duty.
- a teleconference held twice daily across the University Limerick Hospitals Group with all directorates in attendance. This teleconference was chaired by the lead for unscheduled care Monday to Friday and at weekends by the member of the executive management team on call. The purpose of the teleconference was to improve patient flow in the hospital and across the hospital group.
- weekly meetings of the hospital crisis management team, chaired by the chief executive officer of the University Limerick Hospitals Group's or a member of the executive management team, where operational issues impacting on patient flow and bed capacity were discussed.
- the activation of escalation plans, which included measures such as a no refusal policy to Model 2 hospitals, discharge meetings to be held with medical and peri-operative teams to identify patients for discharge and or barriers to discharge, and clinical directors to discuss the need to increase discharges and transfers with consultants.
- using the red to green electronic patient flow system to identify and quantify delays and factors that prolonged the inpatient stay. This information was immediately available to key persons with responsibility for the management of patient flow.

On the day of HIQA's inspection, the short-term measures were not sufficient as an exceptional response to the numbers of patients awaiting admission in the hospital's emergency department and the hospital did not demonstrate additional preparedness for the expected pressures in advance of the forthcoming bank holiday weekend.

Given the imminent extra-long weekend, HIQA also sought further detail from the hospital as to the additional plans that were in place to mitigate risk related to the potential for additional

crowding of the emergency department over the impending long weekend. The hospital was able to provide documentation which outlined its plans to prepare for and manage flow over the following days. This included the frontloading of some work that would occur in a normal working week to earlier in the week. It was also anticipated that a natural reduction in the volume of surgical work conducted later in the week relative to a normal week due to the bank holiday would likewise alleviate pressure on an already overcrowded hospital. Inspectors were therefore assured that extra planned measures were either enacted or planned by the hospital to address the risks posed by the longer four-day weekend. However, the presence of these extra measures needs to be considered in the context of the wider findings that HIQA found related to the general management of crowding and staffing in the emergency department, as articulated throughout this report.

The medium to long-term measures introduced or planned by the hospital group to manage the issue of capacity and patient flow included, a proposal to:

- develop a Model 2S (specialist) five day service to increase capacity for patients waiting for sub-acute care^{§§§} whose planned treatment was consistently cancelled due to the need to create capacity for unscheduled care admissions. In early March 2022, the chief executive officer of the hospital group had written to Department of Health requesting that the development of this service be considered in the rollout of the Sláintecare plans. At the time of HIQA's inspection, there was no further available information that the development of this specialist service would advance as proposed.
- build an additional 96-bed block to further increase the bed stock at University Hospital Limerick and ensure consistency in bed numbers with other Model 4 hospitals. At the time of inspection, the 96-bed block had full planning permission and the tender process was completed, the hospital group had requested funding for the build from the Department of Health.
- increase the number of non-consultant hospital doctors at the hospital to assist senior decision makers during core and outside core working hours.
- improve base funding for service improvement.

The hospital used the Manchester Triage System to allocate patients to the most appropriate category of urgency for review which is in line with best practice. However, at 11.30am on the day of inspection, HIQA found that eight people were waiting in excess of 60 minutes to be triaged, with one person waiting over 180 minutes. This is an excessively long period of time, and was a significant concern to HIQA given the potential risk this presented to the health and welfare of patients. Staff who spoke with inspectors identified shortages in the rostered number of nurses for the emergency department as being a key causal factor for the delay in triage.

^{§§§} Subacute care is defined as comprehensive inpatient care for people who has an acute illness, injury or exacerbation of a disease process.

HIQA was also concerned about the number of patients boarding in the emergency department while awaiting an inpatient bed. Of the 139 attendees in the emergency department at 11.30am, 60 (43%) patients were boarding in the department while awaiting an inpatient bed. The majority of these patients were being accommodated on trolleys in corridors with very limited space between each trolley, which impacted on patients' privacy and confidentiality. Three of the 60 (5%) patients were waiting an especially long time. One patient was waiting in excess of 116 hours, a second was waiting over 85 hours and a third was waiting 71 hours. Hospital management told inspectors that all three patients were awaiting suitable inpatient isolation facilities.

Staff and hospital management who spoke with inspectors described how attendance and the acuity of patients presenting to the emergency department had increased since the onset of COVID-19. This increase in acuity resulted in some patients needing a prolonged hospital stay which impacted on the patients' average length of stay in a medical or surgical bed. This in turn negatively affected inpatient bed availability and capacity, thereby contributing to the boarding of patients and overcrowding in the hospital's emergency department.

Almost a quarter (range from 23% to 26%) of patients who attended the hospital's emergency department during October 2021 to March 2022 were admitted for specialist care and treatment. This rate of admission is not excessive when compared to the norms of emergency care in other similar units. However, the sheer volume of patients presenting to the hospital's emergency department over this time period resulted in some scheduled care activity being curtailed or restricted to time sensitive cases only (for example, urgent cancer or vascular surgery). Inspectors were told that consultant surgeons met every day to review surgical cases and to determine what cases were time sensitive and should be progressed, while non-time sensitive cases were deferred. This was far from ideal for a major regional hospital that undertakes emergency and complex surgeries, or for those patients who remained on waiting lists as a result of the need to focus on time sensitive cases. It may also impact on the number of presentations to the emergency department as a patient's condition may worsen, and consequently require attendance for emergency care, thus contributing to increased volumes of attendees to the hospital's emergency department.

Staff who spoke with inspectors identified how access to diagnostics was a contributing factor impacting on the length of time patients were in the emergency department. This was also evidenced in conversations with patients in the department on the day of inspection and in minutes of governance meetings reviewed by inspectors. Evidence on the day of inspection showed that patients were waiting lengthy periods for diagnostics, despite a computed tomography scanner being available in the emergency department. ****

Circumstances such as the hospital being the only Model 4 hospital in the Midwest region, combined with the hospital experiencing unprecedented numbers of presentations of COVID-19 and non COVID-19 cases to the emergency department and the increased acuity of

**** The American College of Emergency Physicians recommend a maximum 2 hour turnaround for emergency investigations.

patients, contributed to and significantly impacted on the effective workings of the hospital's emergency department.

Hospital management had developed a plan comprising short, medium and long-term measures to address the issue of overcrowding in the hospital's emergency department. However, evidence collected during HIQA's inspection of the hospital's emergency department showed that the short-term measures enacted by management had limited impact on the day-to-day workings of the emergency department. On the day of inspection, overcrowding, poor patient flow and limited inpatient bed capacity all contributed to the ineffective functioning of the department — and indeed the rest of the hospital which was equally impacted by this situation. HIQA was not fully satisfied that there were effective management arrangements to support and promote the delivery of high-quality, safe and reliable services in the emergency department in the short-term. While the hospital did have some contingency plans to manage expected increase in demand for services, more effective measures were needed to alleviate emergency department overcrowding and address insufficient nurse resourcing in the department to enable the timely triage, medical review and assessment, and subsequent admission or discharge of people presenting to the emergency department.

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. Staffing levels for doctors in the emergency department were maintained at adequate and nationally acceptable levels for the 24/7 emergency department service at University Hospital Limerick. At the time of inspection, the hospital had nine whole time equivalent (WTE)⁺⁺⁺⁺ consultants in emergency medicine. Eight of the nine consultants in emergency medicine were on the specialist register with the Irish Medical Council. A senior clinical decision-maker^{****} at consultant level was on-site in the hospital's emergency department each day, with availability on a 24/7 basis. One consultant in emergency medicine was also specifically assigned to triage from 8am to 4pm. After 4pm, the on-call consultant in emergency medicine was responsible for triage.

Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and boarded in the emergency department while awaiting an inpatient bed. In this case, the

⁺⁺⁺⁺ 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.

^{****} 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.

patient was under the care of the speciality team. However, if the patient's clinical condition deteriorated, staff in the emergency department provided the necessary emergency response. Consultants in the emergency department were supported by 25 non-consultant hospital doctors at registrar, senior house officer and intern grades providing 24/7 medical cover in the department.

Documentation reviewed by inspectors showed that the hospital and hospital group had experienced high levels of staff absenteeism due to COVID-19. There was also evidence that hospital management did redeploy nursing staff from other areas of the hospital to address nursing staff deficits in the emergency department.

The University Limerick Hospitals Group was successful in recruiting 286.12 WTE staff nurses to University Hospital Limerick in 2021. However, despite this increase in staffing, HIQA found that on the day of inspection the nurse staffing levels in the emergency department were insufficient to meet the needs of people attending the department. This significantly impacted on the delivery of safe, quality care and on the timely triage and assessment of attendees to the department.

The emergency department had an agreed nursing staff complement of 120.36 WTEs with a variance of 15.24 WTE, equating to an overall nursing staff deficit of 13% for the department. However, on the day of HIQA's inspection, the emergency department had a shortfall of 17% in the agreed number of nurses rostered on duty for the department.

A clinical nurse manager grade 3 had overall nursing responsibility for the emergency department with a clinical nurse manager grade 2 on each shift. The core complement of emergency department nursing staff included staff nurses at expert, intermediate or novice level. Nursing staff were supported daily by six healthcare assistants. Radiology professional support was provided by diagnostic imaging and administrative support by administrative staff.

On the day of inspection, nursing staffing levels in the emergency department were not maintained at adequate levels to meet service need. The department had an agreed nursing roster of 24 nurses per day for the whole department (22 nurses for the emergency department plus two nurses for admitted patients). However, on the day of HIQA's inspection, due to vacancies and short-notice absenteeism, the complement of nurses was 18 — six nurses short of the agreed rostered number of 24. Two nurses were redeployed into the emergency department. However, despite this redeployment the emergency department still had a nursing staff deficit of four nurses (17%).

Nursing rosters provided to HIQA for a four-week period showed that, on average, the department was short in the range of four to eight nurses per shift (day and night shift), which represented a nursing staff deficit within the range of 17%-33% per shift. On average, one to two staff were redeployed to the emergency department over this four-week period. However, even with this redeployment there was still a shortfall in the range of two to six

nurses (8%-24%) per shift, which significantly impacted on the operational functioning of the department.

Patient satisfaction and clinical outcomes are negatively affected by delayed, unfinished or omissions of care with occur due to inadequate nurse staffing levels. At the time of HIQA's inspection, the hospital was not formally monitoring the proportion of care delayed, unfinished or omitted. As such, it was difficult to quantify the specific impact that the nursing staff deficit had on care delivered in the hospital's emergency department. However, HIQA found that the prolonged delay in triage experienced by attendees to the department on the day of inspection was evidence of the impact of the understaffing of the department.

The hospital group had established a nursing and midwifery workforce department in 2020 and was using the Benner model from novice to expert to identify and support nurses working in the hospital's emergency department. Three clinical skills facilitators were assigned to the emergency department to support nurses to maintain and further develop their clinical skills. The hospital group had also commissioned a quality and workforce review of the emergency department in early 2022. This review was due to start in quarter two of 2022 and was to be completed within three months of commencement. The review intends to assess current workforce and the delivery of care to those presenting to the hospital's adult emergency department from presentation to admission and discharge. The review will be led by the director of quality and patient safety and the assistant director of nursing from the nursing and midwifery workforce department. As the review had not commenced at the time of HIQA's inspection, the outputs of this work will be followed up by HIQA as part of continued monitoring of compliance with national standards at the hospital.

Staffing levels and absenteeism was discussed at meetings of two governance committees — the monthly executive management team and the weekly hospital crisis management team. Notwithstanding this, HIQA was concerned about the potential risk and effect the deficit in nursing staff levels had on the quality and safety of healthcare provided in the emergency department and the management response for contingency measures in advance of the bank holiday weekend. This was raised with the hospital group's chief executive officer on the day of inspection. Subsequently, HIQA sought confirmation from the hospital group that the nursing staff levels and deployment patterns were appropriate to maintain the safety of healthcare in the emergency department. HIQA also sought assurance that adequate contingency arrangements were in place to maintain appropriate nursing staff levels in the department, in the event of surges in presentation rates and or short-notice absenteeism. The response received from the hospital group provided some assurance that the hospital had a contingency plan to address the staffing deficit and ensure the timely triage, medical review and assessment of patients attending the emergency department.

HIQA also escalated concerns about the potential risk and effect on the quality and safety of care provided in the emergency department at University Hospital Limerick to the HSE's chief operations officer. As part of this correspondence, HIQA sought clarification on the HSE's

wider plans to support effective patient flow and address the overcrowding in the hospital's emergency department and the wider Midwest region of Ireland.

It was evident from staff training records reviewed by inspectors that nurses working in the emergency department undertook multidisciplinary team training appropriate to their scope of practice at a minimum every two years. Training records showed that 61% of nurses were up to date in basic life support training, 71% of nurses were up to date with training on the early warning system and 60% of nurses were up to date in sepsis training.

Overall, as a result of the evidence collected on the day of inspection and documents provided to HIQA post inspection, HIQA was not satisfied that the hospital was adequately planning, organising and managing their nursing workforce in the emergency department to ensure high-quality, safe and reliable healthcare in the department. Although no deficiencies in medical resourcing of the department were identified, the nursing staff levels were insufficient to meet the needs of the volume of patients receiving care in the emergency department on the day of inspection. Hospital managers need to ensure that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care in the emergency department and that there are contingencies in place to ensure that the service can meet increase in demand such as that caused by the increased numbers of patient presentations. It is also essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Judgment: Non-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 the two national standards assessed. 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 emergency department in University Hospital Limerick was a new purpose-built unit which opened in 2017 with 49 single treatment examination cubicles. At 11.30am on the day of inspection, there were 50 extra patients accommodated on trolleys in the department. Therefore, there were twice as many patients accommodated in the department as it was designed to hold. Furthermore, on the day of inspection, patients were also being accommodated on trolleys on wards, and the Medical Assessment Unit was likewise being used for this purpose rather than the rapid assessment of patients.

Inspectors visited the resuscitation area and Zone A of the emergency department. In Zone A, inspectors observed 19 patients on trolleys accommodated on the corridor and there was no additional floor space available. There were 14 patients in the resuscitation area, of which seven were on trolleys located around the nurse's station which, although a restricted area, was very busy.

In an emergency department, issues such as overcrowding, a lack of privacy, ineffective communications with caregivers and an uncomfortable environment all impact on a patient's experience of care.^{*****} Effective communication in the emergency department is vital to the provision of safe, quality care and essential to respecting the patient's autonomy where

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

^{*****} Sonis JD., Aaronson EL., Lee RY., Philpotts LL. and White BA. *Emergency Department Patient Experience: a systematic review of the literature*. Journal of Patient Experience. 2018. 5(2). Available online from: <https://pubmed.ncbi.nlm.nih.gov/29978025/>

decisions about care may have to be made quickly. Healthcare professionals are professionally and ethically obliged to respect and protect a patient's privacy and confidentiality. Inspectors observed the severe difficulty caused by the overcrowding and trolley congestion in the department and it was clear that patients' confidentiality was compromised. Notwithstanding the efforts of staff, patients on trolleys had little to no privacy or dignity. Staff working in the hospital's emergency department who spoke with inspectors were committed to promoting a person-centred approach to care in difficult and challenging conditions. Staff were observed by inspectors to be kind and caring towards patients in the emergency department, and tried to respond to their individual needs, which was challenging in the context of an overcrowded and understaffed department.

Clinical consultations and assessment were carried wherever the person was located, for patients on a trolley, this was usually on a corridor. In this setting, it was not possible to maintain privacy and confidentiality when communicating and interacting with patients. There was a significant risk that others (patients, visitors and staff) could overhear patient-clinician conversations and personal information exchanged between patients, medical and nursing staff. Overheard conversations and disclosures adversely affect patients' trust and can lead to a breakdown in the relationship between them and their caregivers, and is not in line with a human rights-based approach to healthcare promoted and supported by HIQA.

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

In 2020, the hospital had introduced some person-centred initiatives as part of an improvement plan to improve the patient experience times for older persons attending the emergency department. These person-centred initiatives included participation in the OPTIMEND study,⁺⁺⁺⁺ frailty at the front door⁺⁺⁺⁺ and the Integrated Care Programme for Older Persons (ICPOP) hubs. With the OPTIMEND initiative, a dedicated team of health and social care professionals in the hospital's emergency department were focused on ensuring the timely assessment and intervention of people aged 65 years and over to enhance the quality of care, improve the patient experience and optimise overall patient flow. The Integrated Care Programme for Older Persons (ICPOP) was a national initiative that aimed to integrate primary and secondary care services for older people, especially those with more complex needs. The programme comprised 10 steps that enabled integrated care for older people to be implemented, evaluated and sustained.^{§§§§§} As part of this programme and to

⁺⁺⁺⁺ OPTI-MEND was a research study funded by the Health Research Board that aimed to determine and measure the impact of early assessment and intervention by a multidisciplinary health and social care professions team in the emergency department by avoiding a hospital admission where appropriate, improving the patient experience and optimising overall patient flow. See: <https://www.hrb.ie/funding/funding-awarded/awards-made/award/cancer-prevention-fellowship-1/>

⁺⁺⁺⁺ Frailty at the Front Door – a designated care pathway for older persons who present for unscheduled care with frailty signs and symptoms.

^{§§§§§} Health Service Executive. *Integrated Care Programme for Older Persons*. Dublin, Health Service Executive. 2022. Available online from: <https://www.hse.ie/eng/about/who/cspd/icp/older-persons/>

offer an alternative pathway for patients aged 75 years and over, the University Limerick Hospitals Group was progressing the development of ICPOP hubs. Each acute hospital in the hospital group was resourced to appoint at least one consultant for integrated care. ICPOP hubs were operational in Limerick, Ennis and Clare and were accepting referrals from the emergency department at University Hospital Limerick. The frailty at the front door initiative was introduced as part of the ICPOP to identify frail older people presenting to the hospital's emergency department that need timely and appropriate intervention. This initiative involved the person's complete episode of care in the emergency department being managed by designated medical and nursing staff from triage to discharge and or admission with the person followed up in the ICPOP hub in the community. Implementing these initiatives means that the older person attending the emergency department can receive timely and appropriate care, as per their assessed needs, which is the essence of person-centred care. While it was not possible for inspectors to evaluate the effectiveness and impact of these initiatives within the confines of a short unannounced inspection, the fact that work was ongoing to embed alternate pathways for patients is acknowledged as positive by HIQA.

In January 2022, the hospital appointed and assigned two dedicated people to act as patient advocates and provide support to patients, especially older people, attending the emergency department. These advocates reported to the director of quality and patient safety. This was further evidence that the hospital were endeavouring to promote person-centred care and protect patients' rights for respect, dignity and autonomy.

Notwithstanding these initiatives, the practice of boarding admitted patients in the emergency department and the inadequate efforts of hospital management to address the issue of overcrowding in the department, all compromised patients' dignity, privacy and confidentiality on the day of inspection. Furthermore, this environment posed a significant risk to the safety and quality of healthcare provided and to the health and welfare of patients attending the emergency department. While the appointment of patient advocates to the hospital's emergency department is commendable, the overcrowding in the department experienced on the day of HIQA's inspection impacted negatively on any meaningful promotion of the patients' human rights.

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 and receive care, safe care and support identifies, prevents or minimises this unnecessary or potential harm.

University Hospital Limerick had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risk advisors were assigned to each directorate in the hospital group including the medical directorate, which had oversight and responsibility for the emergency department at University Hospital Limerick. However, on the day of HIQA's inspection, the actions and controls implemented to manage the issue of overcrowding and associated risks in the hospital's emergency department were ineffective.

At the time of inspection, chronic overcrowding related to the emergency department was the one open high-rated risk recorded on the hospital's corporate risk register. The hospital had articulated on its risk register a number of actions and controls to manage and minimise the risk. These included:

- transferring a targeted number of patients to the Model 2 hospitals in the University Limerick Hospitals Group every day.
- monitoring breaches of patient experience time.
- activating the hospital's escalation plan.
- holding huddles two times a day with directorate management teams, management from Model 2 hospitals, the bed management manager, the unscheduled care manager and patient flow assistant director of nursing to address operational issues and patient flow challenges.
- implementing the hospital's escalation plan when 10 or more patients were on trolleys.
- using trolleys on inpatient wards once the decision to admit is made.

HIQA identified evidence in each case of these measures being applied. However, the following controls were also listed on the risk register, yet on the day of inspection, HIQA found that these measures were not enacted, either in part or in full:

- capping the number of patients in the emergency department to ensure compliance with fire regulations.
- establishing a rapid assessment team in the emergency department.
- close monitoring and compliance with triage times – inspectors found that ensuring compliance with times was not happening and escalated a concern to management in respect of this measure.
- expanding the remit of the discharge lounge.***** The discharge lounge was closed early during the COVID-19 pandemic because there were no isolation facilities and

***** The discharge lounge is a clinical assessment area for health and social care professionals, for example, speech and language therapists and occupational therapists.

only one toilet in the unit. However, two years after the onset of COVID-19, HIQA had concerns that this risk was not being considered in the context of the risk of transmission of COVID-19 in what was a grossly overcrowded emergency department.

Staff absence associated with COVID-19 was another high-rated risk on the hospital's corporate risk register. However, staffing in the emergency department was not a risk recorded on the hospital's corporate risk register. Given the pattern of insufficient nursing staff levels in the emergency department identified by HIQA and the potential significant risk to the health and safety of patients, this is a risk that should be included on the hospital's corporate risk register.

On the day of HIQA's inspection, the hospital had activated its escalation plan in response to the increased number of patients in the emergency department. This plan was revised in 2020 to meet the challenges associated with COVID-19. There was evidence that huddles to address operational issues and patient flow challenges were taking place in the morning at 9am and in the evening at 4pm. However, the 60 patients boarding in the emergency department while awaiting an inpatient bed on the morning of HIQA's inspection would suggest that these measures were not effective in managing the issue of patient flow at the hospital.

The hospital collected data on a range of different quality and safety indicators relevant to the emergency department in line with the national HSE reporting requirements. Data on inpatient capacity and patient flow including the number of presentations to and admissions from the hospital's emergency department, national key performance indicators set by the HSE and inpatient length of stay of 30 days or more was collected and monitored by the hospital. Collated performance data was reviewed at meetings of relevant governance committees — executive council of the hospital group, University Hospital Limerick's executive management team and the hospital group's quality and safety executive committee.

In 2020, the re-attendance rate to the hospital's emergency department was 4.5% which was below the national target of 8.1%. The average number of patients who left the hospital's emergency department in 2019 before completing their care was 4.3%, which was below the national target of 6.5% for that year.

Performance data on the patient experience time collected on the day of HIQA's inspection was poor. The data showed that at 11.30am the hospital was not compliant with any of the national key performance indicators for the emergency department set by the HSE. At that time:

- 76 (55%) attendees to the emergency department were in the department for more than six hours after registration. This was not in line with the national target which requires that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- Over half (51%) of the attendees to the emergency department were in the department for more than nine hours after registration. This figure falls short of the

national target of 85% of attendees being admitted to a hospital bed or discharged within this time frame.

- Just over one in five (21%) attendees to the emergency department were in the department for more than 24 hours after registration. The department fell significantly outside the national target which aims for 97% of patients to be admitted to a hospital bed or discharged within 24 hours of registration.⁺⁺⁺⁺⁺
- 28 attendees to the emergency department were aged 75 years and over. None were admitted or discharged within nine hours of registration, which was not in line with the national target of 99% of patients aged 75 years and over being admitted to a hospital bed or discharged within nine hours of registration.
- Half of the attendees to the emergency department aged 75 years and over were not discharged or admitted within 24 hours of registration. The national target for this indicator was 99%, which again the department fell significantly short of.

These findings were consistent with the findings of the 2021 National Inpatient Experience Survey for University Hospital Limerick. In this survey, the hospital scored below the national average for people waiting in the emergency department less than six hours⁺⁺⁺⁺⁺ and between six and 12 hours^{§§§§§} before being admitted to an inpatient ward. For people waiting 12-24 hours in the emergency department for an inpatient bed, the hospital was rated slightly below (22%) the national rate of 22.7%. However, for waiting times greater than 24 hours in the emergency department, the hospital's rate of 28% was double the national average.

Prolonged waiting times in the emergency department are associated with increased frequency of exposure to error, increased inpatient length of stay, increased morbidity and mortality and decreased patient satisfaction.^{*****} Mortality generally increases with increasing boarding time, from 2.5% in patients boarded less than two hours to 4.5% in patients boarding 12 hours.⁺⁺⁺⁺⁺ Delays to inpatient admission for patients in excess of five

⁺⁺⁺⁺⁺ For context – a comparison with annual national average data for Patient experience time (PET) measured against University Hospital Limerick (UHL) performance is of value. For this purpose 2019 data – which was pre-COVID-19 and represents a level of presentation pattern more similar to the current experience – is instructive. The % no of patients still in the emergency department post registration for 6 hours in 2019 was 62.7% (national target was 75%, UHL 54.9%). The national average for 9 hours in 2019 was 78.1% (national target 99%, UHL 2019 71%). The national average for 24 hours in 2019 was 96.1% (national target 99%, UHL 2019 91.7%).

⁺⁺⁺⁺⁺ The national average for people waiting < 6 hrs in the emergency department before being admitted to an inpatient bed was 34.6%. The rate for the emergency department at University Hospital Limerick was 25.0%.

^{§§§§§} The national average for people waiting 6-12 hrs in the emergency department before being admitted to an inpatient bed was 29.1%. The rate for the emergency department at University Hospital Limerick was 25.0%.

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

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

hours from time of arrival at the emergency department are also associated with an increase in mortality. Furthermore, it is estimated that there is one extra death for every 82 admitted patients whose transfer to an inpatient bed is delayed beyond six to eight hours from the time of arrival at the emergency department.^{*****}

In 2020, the hospital's average length of stay for all inpatient discharges excluding length of stay over 30 days was 3.8 days, which was below the HSE's national target of ≤ 4.8 days for that year. For medical inpatients, the hospital's average length of stay in 2020 was 6.8 days, slightly above the HSE's national target of ≤ 6.3 days for that year. The hospital's average length of stay for surgical patients in 2020 was 5.4 days, which was below the HSE's national target of ≤ 5.6 days for that year. This relative compliance with national targets for average length of stay may suggest that a core contributing factor impacting on inpatient bed availability at the University Hospital Limerick is insufficient bed stock across the hospital group.

Delayed transfers of care further compounded the issue of availability of inpatient beds at University Hospital Limerick. In 2020, the hospital lost a total of 1,922 bed days due to delayed transfer of patients. Hospital management who spoke with inspectors attributed the delay in transferring patients mainly to restricted or no access to rehabilitation beds in the community due to COVID-19 outbreaks. On the day of HIQA's inspection, the hospital had 20 delayed transfers of care, which impacted on the availability of inpatient beds.

Overcrowding in hospitals has also been shown to increase the risk of infection and is of particular concern in the context of COVID-19.^{§§§§§§} HIQA found that the environment in the emergency department where medical and nursing staff provided care was challenging. The physical congestion caused by the extra trolleys throughout the department posed a significant risk to the delivery of safe, quality care and was an infection prevention and control risk for patients and staff. Inspectors observed insufficient space between trolleys and were concerned that the minimum physical spacing of 1 metre was not possible. This was a particular concern when considering that there was a very transmissible strain of COVID-19 circulating within the community on the day HIQA carried out its inspection.

Inspectors were satisfied that serious reportable events related to the emergency department were reported in line with the HSE's incident management framework. Serious reportable events related to the emergency department were reviewed by the medicine directorate's Serious Incident Management Team. There was evidence from documents reviewed by inspectors that the hospital were progressing with the implementation of recommendations from closed out reviews from serious reportable events that had occurred in the emergency department. Quality improvement plans related to these serious reportable events were

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

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

reviewed by inspectors and showed that hospital managers had or were in the process of implementing recommendations to:

- improve bed inpatient capacity and critical care services in the hospital. The hospital had increased bed capacity by 98 beds and had increased its critical care capacity by 11 beds.
- improve access to specialist infection prevention and control expertise in the emergency department.
- support staff education and training in the early warning system, recognition and escalation of clinical deterioration and medication safety in the emergency department.
- improve clinical audit activity within the emergency department.
- review staffing levels, which included medical, nursing and health and social care professionals, in the emergency department.

The hospital has implemented the early warning system to support the recognition and response to a deteriorating patient in the emergency department. Documentation reviewed by inspectors on the day of inspection showed that the escalation protocol for the deteriorating patient was in line with national guidance.

There was evidence that the hospital was progressing with the implementation of recommendations of reviews of serious reportable events that had occurred in the emergency department. Although noting the measures that management had implemented at the hospital, inspectors were not satisfied that the arrangements in place to identify, manage and escalate risks in relation to the emergency department were effective in managing the risks to patient safety identified on the day of inspection. Furthermore, noting the pattern of insufficient nursing staff levels in the emergency department, this is a risk that should have been included on the hospital's corporate risk register. As a result, patients were exposed to a higher level of risk, waiting unacceptably long periods to be triaged, medically reviewed and assessed in the emergency department which, considering the association of prolonged waiting times with increased morbidity and mortality, was a concern for HIQA. The persistent overcrowding in the department also increased the risk of infection and is of particular concern for HIQA, especially in the context of the surge in COVID-19 cases occurring at the time of HIQA's inspection.

Judgment: Non-compliant

Conclusion

Through continued engagement, University Hospital Limerick has provided HIQA with a detailed analysis as to the factors that it considers contributes to ongoing overcrowding in the hospital's emergency department. The issue of overcrowding in the hospital's emergency department has been persistent over the past number of years with the department experiencing unprecedented levels of attendance since January 2022. In 2021, the emergency department at the hospital had the second highest rate of attendance in Ireland. In that year, 76,473 people attended the hospital's emergency department compared to 65,824 attendees in 2020, which represented an increase of 7.2% attendees on the previous year. This equated to an average attendance rate to the department of 226 people per day. By comparison, other Model 4 hospitals in Dublin had an emergency department attendance of between 48,397 and 89,335 and rates of attendance were generally stable in 2021.

Documentation reviewed by inspectors showed that on the day of HIQA's inspection, 290 people attended the emergency department at University Hospital Limerick. While being the second busiest emergency department in 2021, the hospital has the second lowest bed stock compared to other Model 4 hospitals in Dublin, Cork and Galway. In addition to a high volume of presentations to the hospital's emergency department, the hospital also experienced an increase in the acuity of patients presenting for emergency care.

Hospital management identified insufficient inpatient bed capacity in the hospital and in the wider Midwest region as a major factor contributing to the overcrowding in the hospital's emergency department. In late 2020 and January 2021, an additional 98 new inpatient beds were added to the bed stock at University Hospital Limerick. Two bed blocks comprising a total of 38 beds were developed as part of the government's national action plan for the COVID-19 pandemic. The remaining 60-bed block was built to increase inpatient bed capacity at the hospital in response to the national capacity review in 2018 published by the Department of Health. While the new capacity had enabled the hospital to more effectively manage confirmed and suspected cases of COVID-19, the additional bed capacity had not had a major impact on reducing the number of admitted patients awaiting an inpatient bed in the hospital's emergency department.

Since March 2020, University Hospital Limerick, as with all Irish hospitals, has been challenged in managing the impact and effects of COVID-19 on the health service. The hospital continued to experience an increase in both COVID-19 and non COVID-19 attendance to their emergency department which contrasted with other Model 4 hospitals who experienced a considerable reduction in the non COVID-19 attendances to their emergency departments.***** The persistent and prolonged high volume of COVID-19 and non COVID-19 attendances to the emergency department has resulted in overcrowding

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

becoming a chronic and prevailing characteristic of the department. It is an ongoing serious challenge for the hospital and those patients who require the service, and an area of very significant concern for HIQA.

The hospital group had enacted measures to address the issue of overcrowding in the emergency department in the short, medium and long-term but, as evidenced by HIQA's findings in this report, the short-term measures were ineffective in managing the issues identified on inspection and in ensuring the delivery of high-quality, safe and reliable services in the emergency department on the day of HIQA's inspection. Furthermore, the medium and longer term plans referenced by management were based on measures that were yet to be advanced by the HSE.

HIQA acknowledges hospital management's efforts to address the issues identified on the day of inspection; however, more needs to be done to ensure care delivered in the hospital's emergency department is high quality, safe and reliable and to promote the respect, dignity and autonomy for people receiving care in the department. While the mismatch of demand and capacity was a major contributing factor to the overcrowding of the hospital's emergency department, inspectors also found that insufficient staffing levels also significantly contributed to the situation on the day of inspection.

Of note, the hospital group was also planning to conduct a review to assess current workforce and the delivery of care to those presenting to the emergency department in quarter two of 2022. At the time of HIQA's inspection, the hospital group had also very recently commissioned an independent review of patient flow at the hospital. This review had commenced at the time of HIQA's inspection and was due to be completed by mid-May 2022. Findings of these two reviews have the potential to inform an action plan comprising measures to manage the factors contributing to overcrowding, ineffective patient flow and understaffing of the emergency department in the short-term. HIQA will continue to monitor progress in the conduct of these interventions and ensure that any further identified required actions are progressed. Notwithstanding this, it is also evident to HIQA that more substantive measures to address capacity deficits in the Midwest region are also likely to be required.

It is well documented that Ireland has one of the highest bed occupancy rates of any developed health system, often running at 100%.⁺⁺⁺⁺⁺ This is far in excess of the optimum level of 85% recommended in the capacity review published by the Department of Health in 2018.⁺⁺⁺⁺⁺ HIQA believes that progressing the implementation of the Sláintecare reform plans for the healthcare service in Ireland, together with the associated HSE structural reforms, will create greater capacity and meet the ever-increasing demand for care across the healthcare system. This will in turn potentially ease pressure on emergency departments and

⁺⁺⁺⁺⁺ Organisation for Economic Co-operation and Development. *Ireland: Country Health Profile 2019*. France: Organisation for Economic Co-operation and Development. 2019. Available online from: <https://www.oecd.org/ireland/ireland-country-health-profile-2019-2393fd0a-en.htm>

⁺⁺⁺⁺⁺ Department of Health. *Health Service Capacity Review 2018 Executive Report*. Dublin: Department of Health. 2018. <https://www.gov.ie/en/publication/26df2d-health-service-capacity-review-2018/>

acute hospital services more broadly. It will enable a model of care where services are re-orientated away from the predominant hospital-based model to a more integrated community-based model so that people who require the service are treated in a timely and efficient way as close to home as possible.

It is important to note that the challenges in the emergency department faced by hospital management at University Hospital Limerick reflect similar situations in many emergency departments across the country. HIQA also notes, however, that University Hospital Limerick is consistently among those services with the highest number of patients accommodated on trolleys in their emergency department. Given this regularly identified risk situation, HIQA was not assured that the hospital had adequate measures in place to address overcrowding, ineffective patient flow, insufficient nurse staffing levels and prolonged waiting times in the hospital's emergency department or that the measures enacted to date were sufficiently effective in managing the risks to patient safety identified on the day of inspection. Furthermore, HIQA was not satisfied that the hospital effectively protected people attending the emergency department from the risk of harm, which was a concern considering the association of prolonged waiting times with increased morbidity and mortality and the increased the risk of infection when COVID-19 remains within the community.

Overcrowding also compromised the dignity, privacy and confidentiality of patients attending and receiving care in the hospital's emergency department. Delivering care in an overcrowded, understaffed environment posed a significant risk to the provision of safe, quality, person-centred care and to the health and welfare of people receiving care in the emergency department and was not in line the *National Standards for Safer Better Healthcare*.

Through this inspection, and other prior engagement with the University Limerick Hospitals Group and the HSE, HIQA has been told that it is accepted there will be an ongoing deficit in required health service capacity in the region when compared to ever-increasing service demand. HIQA acknowledges the recent significant uplift in inpatient bed capacity at University Hospital Limerick. Moreover, it is likely that a potential for improved efficiencies may be realised at the hospital to further enhance patient flow in the context of pre-existing capacity – these improvements may be identified through the ongoing independent review which intends to conclude in May. However, at the time of writing this report, it remained unclear to HIQA what was intended through formally agreed and funded plans for the hospital and the wider Midwest region in order to increase capacity in the medium to long-term, and as aligned to the Sláintecare plan. Consequently, after the inspection HIQA wrote to the chief operating officer of the HSE to seek clarity as to what is planned to address these accepted structural deficits at hospital and wider Midwest region levels.

While risk issues identified by HIQA through this inspection need to be sustainably addressed in the short-term following this inspection, it is also of critical importance that a formally agreed and fully funded longer term plan for the Midwest region is implemented in relation to service configuration, capacity and resourcing. Critically, this plan should align with the principles outlined through Sláintecare, and in doing so include consideration of acute and

community services together, inclusive of those services provided in general practice. In the absence of the realisation of such a plan, the overcrowding situation in the emergency department at University Hospital Limerick will remain a persistent problem, and patients will continue to be put at risk as a consequence.

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 University Hospital Limerick was made following a review of the evidence gathered prior to, during and after the onsite inspection at the hospital. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards was identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the actions 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 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	Non-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.	Non-compliant

Appendix 2 – Compliance plan submitted to HIQA

Compliance Plan for University Hospital Limerick OSV-0001064

Inspection ID: NS_0003

Date of inspection: 15 March 2022

Introduction This document sets out a compliance plan for healthcare providers to outline intended action(s) following an inspection by HIQA whereby the service was not in compliance with the *National Standards for Safer Better Healthcare*. This compliance plan only relates to:

- standards that were deemed partially or not compliant by HIQA during the inspection.
- any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.

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

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

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

Separately, should immediate high risks be identified during an inspection, HIQA will follow its process for escalation which may have been notified to providers during or immediately after an inspection, in advance of issuing this compliance plan. Where HIQA has deemed that a service is partially or not compliant with a standard and where that non-compliance represents a significant risk to people using the service, HIQA will request a response from the provider, in writing, within five working days.

Instructions for use

The service provider must complete this plan by

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

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

- Specific to the standard
- Measurable so that it can monitor progress
- Achievable
- Realistic
- Time bound.

Provider's responsibilities

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

Continued non-compliance

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

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

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

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

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

Compliance descriptors

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

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

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

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

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

In order to summarise the inspection findings within this compliance plan, the national standards are grouped under the two dimensions of:

1. Capacity and capability of the service

This section describes the governance, leadership and management arrangements in place in the healthcare service. It considers how effective they are in ensuring that a good quality and safe service is being sustainably provided. It outlines how people who work in the service are managed and supported through education and training, 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 receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It includes information about the environment in which they are cared for.

Compliance Plan

Capacity and Capability Dimension - Compliance Plan Service Provider’s Response

National Standard	Judgment
<p>Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.</p>	<p>Partially compliant</p>
<p>Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:</p> <p>(a) long-term plans to come into compliance with the standard (b) details of interim actions and measures to mitigate risks associated with noncompliance with standards.</p> <p>Short term</p> <p>To review the current UHL site management arrangements.</p> <p>To review the current escalation plans to ensure that measures enacted are effective and contribute to reducing the numbers in the Emergency Department. This review will also consider the effectiveness of the bank holidays weekends and seasonal changes preparedness.</p> <p>To review the internal escalation processes within the Emergency Department to ensure that delays are minimised for the patients availing of the service.</p> <p>- Triage risk mitigation and escalation process has been developed and agreed.</p> <p>4. To ensure that the Deloitte Review into the analysis and review of patient flow across the Group, including CHO3 is completed with the development of the appropriate implementation plan.</p> <p>5. To explore with the National Acute Hospitals Team, the funding of staff for the provision of an assessment area in the Emergency Department for older people as a hospital avoidance measure.</p> <p>Medium Term</p> <p>1. To maximise the use of all beds on the St. John’s hospital site and reopen the 8 beds in Nenagh Hospital. To be completed by Q2 2022 DON & Estates</p>	

2. To establish following completion of the Deloitte review if the review to assess the current workforce and the delivery of care to those presenting to the adult emergency department from presentation to admission and discharge needs to be completed.

Long-Term

Highlighted in the report is the absence of a model 3 hospital within the group in comparison to other hospital groups. To explore the provision of a Model 3 hospital with the National system, to support the model 4 site and manage a higher acuity patient while increasing capacity.

To build an additional 96 (44 replacement beds for the renovation of nightingale wards) bed block to further increase the bed stock and ensure consistency in bed numbers in line with other Model 4 hospitals. The 96-bed block for UHL has full planning permission, fire certification and is fully designed. The tender process has now been completed and a recommendation has been made to the HSE for their approval to appoint a contractor. Construction of this four storey, single room inpatient facility will take approximately 18 months to complete.

A shortfall of over 200 beds on the UHL site has been identified.

To explore with the National Team the provision of additional of non-consultant hospital doctors to assist senior decision makers during core and out of hours. A bid has been submitted as part of the estimates process in 2021 for 96 additional NCHD posts to support the increased work demands and the newly appointed consultant posts.

Timescale:

Short Term – within 3 months Medium

Term – within 6 months

Long Term – within 3 years.

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	Non-compliant
<p>Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:</p> <p>(a) long-term plans to come into compliance with the standard</p> <p>(b) details of interim actions and measures to mitigate risks associated with noncompliance with standards.</p>	

Short term

The Senior Nursing Management team have redeployed nursing staff with experience to the Emergency Department

Medium term

Nurse management to complete a review of Nurse staff levels within the Emergency Department to ensure a high quality safe and reliable healthcare service is provided.

To secure approval for the UHL site to be one of the first hospitals for the implementation of the Phase 2 safer nurse staffing framework for ED patients.

To seek approval from National Cost and Numbers subgroup to apply the safer staffing framework Phase 1 for medical and surgical wards to the admitted patients in the ED.

To ensure that all nursing staff have undertaken their mandatory and essential training appropriate to their scope of practice.

Long term

To secure support and additional funding for the provision of additional consultants and NCHD resources to support the delivery of a high quality and reliable service.

Timescale:

Short Term – within 3 months Medium

Term – within 6 months

Long Term – within 3 years.

Quality and Safety Dimension - Compliance Plan - Service Provider's Response

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. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:</p> <p>(a) long-term plans to come into compliance with the standard (b) details of interim actions and measures to mitigate risks associated with noncompliance with standards.</p>	

Short term

Model 2 Hospitals to take transfers from ED following review from ED consultant or SPR. If a medical review is requested by the Model 2 consultant it should take place in the Model 2 MAU.

Ensure Ennis/Nenagh/SJH's take a minimum 5 patients per day including weekends. Croom Orthopaedic to take 2 patients per day.

Implementation of Pathfinder Programme with completion of the recruitment process for the necessary resources.

Maximise frailty at the front door team to ensure patients are appropriately referred in order to achieve "discharge to assess" rather than admission.

To explore with the National Team the development and extension of the OPTIMEND service to 8 - 8 Mon –Fri.

Unscheduled Assessment Bays Inpatient Ward (OOHs) - opening of 2 unscheduled care bays in inpatient ward to operate out of hours to 'pull' patients post triage from ED to Haem/Onc Service.

To develop an over 75 year assessment area in ED (extend OPTIMEND/FIIT Team service as an admission avoidance measure)

To maximise and monitor the numbers seen by the specialist community supports such as ICPOP at the Integrated Unscheduled Care meetings.

Medium term

To re-establish the AMU & SAU pathway's to ensure that they are operating in line with the model of care to support patient flow.

To review the Avlos for all medical consultants and address any deviations.

To work with our CHO3 colleagues to deliver a Mobile Diagnostics service (aimed at Private Nursing Homes) through a managed delivered service as a hospital avoidance measure.

Long term

Highlighted in the report is the absence of a model 3 hospital within the group in comparison to other hospital groups. To explore the provision of a Model 3 hospital to support the model 4 site and provide an alternative for higher patient acuity and build capacity.

Timescale:
 Short Term – within 3 months Medium
 Term – within 6 months
 Long Term – within 3 years.

Standard	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Non-compliant
<p>Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:</p> <p>(a) long-term plans to come into compliance with the standard (b) details of interim actions and measures to mitigate risks associated with noncompliance with standards.</p> <p>Short term</p> <p>To renew the focus by the Patient Flow Teams and the Directorates on Red to Green to assist patient flow and reduce length of stay.</p> <p>To complete a review of the conversion to admission rate across the Group with the development of a corresponding implementation plan on completion.</p> <p>As part of the weekly Unscheduled Care Meeting to explore a cap for the DTOC's with CHO3 to create capacity.</p> <p>Collaborate with the CHO3 and the deputy chief Nurse DOH to progress the virtual ward concept.</p> <p>Medium Term</p> <p>To complete the cohorting of patients to the relevant specialist ward and reduce the risks to patients.</p> <p>To embed the initiatives around frailty at the door & Igpop and maximise use of the service.</p> <p>To progress the initiatives identified in the Unscheduled Care Joint Plan between the ULHG and CHO3 to improve patient flow once approved and funding secured.</p>	

To review the access to rehab and step down facilities to ensure that delays for patients are minimised.

Long-term

To develop and foster closer working relationships with our CHO3 colleagues through the Unscheduled Care committee.

To work with CHO colleagues to address the reduction in GP referrals and increased self-presentation rate to UHL.

Timescale:

Short Term – within 3 months Medium

Term – within 6 months

Long Term – within 3 years.