Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Midland Regional Hospital Tullamore
Address of healthcare service:	Arden Rd Puttaghan Tullamore Co Offaly R35 NY 51
Type of inspection:	Unannounced
Date(s) of inspection:	1 February 2024
Healthcare Service ID:	000-1078
Fieldwork ID:	NS_0069

The following information describes the services the hospital provides.

About the healthcare service

Model of Hospital and Profile

Midland Regional Hospital Tullamore (MRHT) is a Model 3* statutory hospital owned and managed by the Health Service Executive (HSE). It is a member of the Dublin Midlands Hospital Group (DMHG)†. The hospital is the largest hospital in the midlands of Ireland and serves a population within the four counties of Laois, Offaly, Longford and Westmeath and other surrounding counties. The hospital provides acute, emergency, general and tertiary specialist services, across a range of medical and surgical specialties. Services provided by the hospital include

- acute medical in-patient services
- elective surgery
- emergency care
- critical care
- diagnostics services
- outpatient care

The following information outlines some additional data on the hospital.

Model of Hospital	3
Number of beds	232 inpatient beds

The hospital is the receiving centre for all orthopaedic trauma activity in the regional and provides a tertiary referral service for Orthopaedics, Ear, Nose and Throat, Nephrology, Haematology, Oncology and Rheumatology including a 24-hour emergency department and 10 critical care beds.

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

† The Dublin Midlands Hospital Group (DMHG) comprises the following hospitals at the time of inspection – St James' Hospital, Tallaght University Hospital, Naas General Hospital, Midland Regional Hospital Portlaoise, Midland Regional Hospital Tullamore, The Coombe Hospital, St Luke's Radiation Oncology Network, and most recently, Midland Regional Hospital Mullingar.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare. HIQA carried out a one-day unannounced inspection of the emergency department at MRHT to assess compliance with four national standards from the *National Standards for Safer Better Healthcare*.

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

During the inspection, inspectors:

- spoke with people who used the emergency department to ascertain their experiences of receiving care in the department
- spoke with staff and hospital management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the emergency department
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during this inspection.

About the inspection report

A summary of the findings and a description of how MRHT performed in relation to compliance with the four national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

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

[§] Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

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

2. Quality and safety of the service

This section describes the experiences, care and support people using MRHT's emergency department 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 also includes information about the environment where people receive care.

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

Compliance classifications

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
01 February 2024	09:00hrs – 17:30hrs	Aoife O' Brien	Lead
		Denise Lawler	Support
		Aedeen Burns	Support

Information about this inspection

This inspection of MRHT's emergency department and acute medical assessment unit (AMAU) focused on compliance with four national standards of the *National Standards for Safer Better Healthcare* and on:

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

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

- Representatives of the Senior Management Team (SMT)
  - General Manager
  - Director of Nursing
  - Clinical Director
  - Quality and Patient Safety Manager
- Clinical Risk Manager
- Assistant Director of Nursing, Patient flow
- Assistant Director of Nursing, Workforce Planning, Emergency Department and Acute Medical Assessment Unit
- Clinical Lead for emergency department
- Clinical Nurse Manager in emergency department

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

Acknowledgements

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

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

On the day of inspection, inspectors visited the emergency department and the acute medical assessment unit (AMAU). The emergency department provided undifferentiated care for adults with acute and or an urgent illness or injury. Attendees to the department were self-referred, presented by ambulance or were referred by their general practitioner (GP).

The total planned capacity of MRHT's emergency department was 21 treatment areas separated into the following areas:

- a waiting area with 30 seats and a separate paediatric waiting area
- a triage area with one triage assessment room and a mobile workstation to facilitate triage in adjoining areas when necessary
- a resuscitation area: comprising three separate treatment bays, one of which was designated for patients with respiratory symptoms.
- three assessment rooms where ambulatory patients received post-triage assessment and diagnostics.
- Advanced Nurse Practitioner (ANP[**]) assessment area for minor injuries
- six bays, separated by privacy curtains designated for more acute patients (area A)
- eight bays, separated by privacy curtains designated for less acute patients (area B)
- four isolations rooms, two of which had ensuite facilities and one was a negative pressure room.[††]

On the morning of inspection, the emergency department was functioning within its intended capacity. At 11.00am there was a total of 29 patients registered in the department. At that time, there were no patients accommodated on trolleys in the corridor and no patients were admitted or boarding in the department while awaiting an inpatient

[**] An Advanced Nurse Practitioner (ANP) is a nurse who having followed a defined career pathway for registered nurses including commitment to formal continuing professional development and clinical supervision has been deemed qualified and registered with the Nursing and Midwifery Board of Ireland (NMBI) to practice at a higher level of capability as an autonomous and expert practitioner in a pre-defined field of nursing practice.

[††] Negative pressure rooms refer to isolation rooms where the air pressure inside the room is lower than the air pressure outside the room. Therefore, when the room door is opened, potentially contaminated air or dangerous and infective particles from inside the room will not flow outside to non-contaminated areas.

bed in the main hospital, although inspectors observed patients on trolleys in the corridor for a short time, later in the morning. The AMAU operated from 8.00am to 6.00pm Monday to Friday, with a planned capacity of six trolleys and four chairs. On the morning of inspection, there were five admitted (surge capacity) patients in the AMAU. These were patients awaiting diagnostics and were expected to be discharged on the same day.

During this inspection, inspectors spoke with a number of patients about their experience of care in the emergency department. Patients' experiences were generally positive. Patients were complimentary about staff describing them as 'very good', 'approachable', 'kind' and 'excellent'.

Some patients commented on the short wait times and timely access to tests and diagnostics during their period of care and commented that they were moved to a place of privacy for assessment and confidential discussions.

Patients in the emergency department who spoke with inspectors did not have any complaints but said they would speak with a member of staff if they wanted to make a complaint. Patients confirmed they were not provided with information on the HSE's complaints process 'Your Service, Your Say' and or independent advocacy services. Inspectors saw information on the HSE's 'Your Service, Your Say' and independent advocacy services displayed in the emergency department waiting room on the day of inspection but not within the emergency department. Staff told inspectors that leaflets were available to staff to offer to patients when appropriate. This is something hospital management could address following this inspection.

Capacity and Capability Dimension

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

Inspectors found MRHT had defined lines of responsibility and accountability for the governance and management of unscheduled and emergency care. Organisational charts submitted to HIQA detailed the direct reporting arrangements of the hospital's governance and oversight committees to the hospital's Senior Management Team (SMT) and onwards

to the Dublin Midlands Hospital Group (DMHG). These arrangements aligned with inspector's findings on inspection. Inspectors found that there was effective governance, good operational grip and agile management arrangements at MRHT to support and promote the delivery of high-quality, safe and reliable healthcare services in the emergency department.

The hospital's General Manager (GM) had overall responsibility and accountability for the governance of MRHT and reported to DMHG. Inspectors found there were clear lines of accountability with devolved autonomy and decision-making for unscheduled and emergency care at MRHT, which was governed and overseen by the medical directorate, Emergency Department Governance Committee (EDGC) and Clinical Governance Committee (CGC).

The SMT was the senior decision-making group in MRHT and had responsibility for the executive governance and oversight of the quality and safety of the healthcare services provided at MRHT. This group was chaired by the GM and met weekly. The SMT led on the strategic planning and development for the hospital and provided direct operational oversight of the hospital's activity and outcomes. Each clinical directorate provided an update at SMT meetings. The emergency department was part of the medical directorate in MRHT, however the role of clinical director for the medical directorate was vacant at the time of inspection and inspectors noted from meeting minutes submitted to HIQA, that updates to the SMT from the medical directorate had not taken place in the previous three months. This will be discussed in Standard 6.1. The SMT was accountable via the GM to the office of the Chief Operating Officer of DMHG. MRHT's unscheduled and emergency care activity and compliance with relevant quality indicators were also reviewed at monthly performance meetings with DMHG as part of the HSE's performance accountability framework.

The Clinical Governance Committee (CGC) provided the SMT with assurance that the clinical governance structures and processes at MRHT were appropriate, effective and robust. The CGC was a multidisciplinary group that met monthly and was chaired by the Clinical Director in line with its terms of reference. A wide range of committees were accountable to the CGC including the Drugs and Therapeutics Committee (DTC), Infection Prevention and Control Committee (IPCC), Deteriorating Patient Governance Group (DPGG) and the Transitions of Care Committee (TOCC). The CGC also had oversight for a range of other safety and quality functions such as research and audit, health and safety and healthcare records. The CGC had oversight of the structures, processes and standards relating to incident and risk management, safe and effective care, quality assurance and compliance in all areas of MRHT, including the emergency department. Minutes of meetings reviewed by inspectors showed that the CGC had oversight of the risks, patient experiences, auditing activity and patient-safety incidents that occurred in MRHT's emergency department. Actions were time-bound with an assigned person.

The medical directorate was responsible for the clinical governance, quality management and operational oversight of medical disciplines in MRHT including the emergency department. The group was multidisciplinary, met monthly and was accountable to the GM. At the time of inspection, there was no clinical director appointed for the medical directorate. Inspectors were told that, in the interim, issues were escalated to the hospital's Clinical Director, GM or the relevant ADON or business manager, as appropriate.

The Emergency Department Governance Committee (EDGC) was a multidisciplinary group that met every three months and was co-chaired by two emergency medicine consultants in line with its terms of reference. The group had oversight of the structures, processes and standards for the emergency department including incident and risk management, safe and effective care, compliance and assurance reporting and quality improvement initiatives and actions. The committee used an agenda focused on quality and patient safety, aligned to the *National Standards for Safer Better Healthcare*, as recommended by HSE Quality Improvement Division. The EDGC reported and was accountable to the Medical Directorate. There was also a pathway for the chairs of the EDGC to directly escalate clinical and non-clinical issues to the senior management team.

The Integrated Urgent Emergency Care Governance Group (UEC) was an integrated cross-care group with the purpose to optimise patient flow into and out of MRHT and to provide assurance on the management of urgent and emergency care. The group was co-chaired by MRHT's GM and the Head of Service for Older Persons in Community Healthcare Organisation 8 (CHO 8). UEC meetings served as a forum for discussion and escalation of specific cases of delayed discharge through engagement between the hospital and community services to improve patient care pathways. The UEC also provided oversight of emergency department performance, delayed transfer of care (DTOC)[‡‡] and discharge operations with a focus on hospital admission avoidance services to ensure care was provided in the most appropriate setting.

Emergency medicine consultants met monthly to discuss rostering, training and any specific issues relating to the emergency department. Meetings were minuted, actions were recorded and allocated to a specific person. Inspectors were told that emergency department staff meetings were held every three to four months to discuss operational issues and to provide a forum for feedback and learning. However these meetings were not recorded.

On the day of inspection, there was evidence of strong clinical and nursing leadership in the emergency department. A Clinical Nurse Manager grade 3 (CNM3), had overall responsibility for the nursing service within the emergency department. During core working hours, operational governance and oversight of the activity of the emergency department was the responsibility of the on-call consultant in emergency medicine, supported by consultant and non-consultant hospital doctors (NCHDs). Extended rosters for

[‡‡] Delayed transfer in care: A patient who remains in hospital after a senior doctor (consultant or registrar) has documented in the healthcare record that the patient care can be transferred.

emergency medicine consultants were also in place. The emergency department had a clinical lead who was a consultant in emergency medicine. Outside core working hours, clinical oversight of the emergency department was provided by the on-call consultant in emergency medicine.

Bed management and patient flow were monitored closely and managed through the following structures and processes:

- a number of patient flow meetings daily (depending on level of escalation), including senior management and a weekly review of key performance indicators (KPIs).
- flow huddles on each ward, each morning.
- weekly meeting of patient flow team.
- fortnightly meeting of the UEC.

The total number of new attendances to MRHT's emergency department in 2023 was 41,593. The majority of attendees were referred by a GP or self-referred. When compared to 2022, attendances to MRHT's emergency department had increased by 6% and admissions had increased by 17%. In 2023, MRHT had the third highest rate of attendances for patients aged 75 years or over (18.2%) nationally, (for both model 3 and model 4 hospitals).

In 2024, up to and including the week of inspection (week 5), total attendances recorded were 21% higher and admissions were 12% higher than the same time in 2023. In addition, MRHT had the fourth highest rate nationally (for both model 3 and model 4 hospitals) of attendances for patients aged 75 years or over (18.9% of total attendances).

On the day of inspection, at 11.00am, the emergency department was functioning within its intended capacity. There were no patients admitted or boarding in the emergency department while awaiting an inpatient bed in the main hospital. There was a total of 29 patients in the emergency department. Nine patients (31%) were aged 75 years or older. There were no patients accommodated on trolleys at 11.00am, however inspectors observed patients on trolleys for a short time later in the morning. The AMAU was situated adjacent to the emergency department and operated from 8.00am to 6.00pm Monday to Friday, with a planned capacity of six trolleys and four chairs. However the trolleys in the AMAU were also used to increase surge capacity when required and accommodated five surge patients at the time of inspection. These were patients awaiting diagnostics and were anticipated to be discharged later in the day.

On the day of inspection, MRHT was in escalation at the black escalation level.[§§] There were a total of five beds subject to delayed discharges in MRHT on the day of inspection.

[§§] A hospital's escalation policy, sets out (within the parameters of the national framework) the key stages of steady state, escalation, full capacity protocol, de-escalation and review. Black is the highest level of escalation.

There was evidence that the majority of measures outlined in MRHT's escalation plan for this level of escalation were implemented in the emergency department on the day of inspection. These included the use of surge capacity beds, surge capacity staffing, daily review of elective inpatient procedures with cancellation where appropriate and the use of three patient flow huddles daily to discuss predicted discharges and to ensure optimal use of all additional capacity within the community. Inspectors were told that capital development funding was secured for an acute floor model and this project was progressing to the design phase at the time of inspection. The implementation of this project has the potential to improve the flow of patients through the emergency department and wider hospital level.

Continuous and effective flow of patients through MRHT was essential to optimal patient flow through the emergency department. Hospital management and staff described the measures in place to improve bed capacity and patient flow through the emergency department including the use of surge capacity, weekly meetings of the patient flow team, daily patient flow huddles in all clinical areas and fortnightly meetings of the UEC. MRHT discharged patients to a number of step-down and convalescent care services in multiple counties, including community rehabilitation inpatient services, sub-acute community inpatient services and nursing homes. These beds were also in demand from other acute and community services.

In 2023, MRHT's average length of stay (ALOS) was 6.25 days for medical patients and 4.7 days for surgical patients which were both within the targets set by the HSE. At the time of inspection, there were five patients in MRHT who had completed their acute episode of care and who experienced DTOC. The factors affecting delayed transfers included complex care requirements and available residential care placements. DTOCs, surge activity, ambulance turnaround times and the availability of community step-down beds were discussed fortnightly at UEC meetings and at SMT meetings. Inspectors were told that KPIs relating to patient flow, including DTOCs were also discussed at weekly meetings of the patient flow team, although these meetings were not minuted. Data were reported monthly to the HSE for inclusion in the HSE urgent and emergency care weekly update reports.

In 2024, up to the week of inspection, MRHT was the only hospital nationally, (for model 3 and model 4 hospitals), that did not have any patients waiting over 24 hours in their emergency department. MRHT was the second best performing hospital in relation to average duration of time in the emergency department (5.0 hours compared to 4.6 hours at University Hospital Waterford). Staff who spoke with inspectors described how, in addition to the measures implemented in MRHT to improve patient flow, the close working relationship with the national ambulance service and the use of intermediate care vehicles also helped to ensure that waiting times were kept low and that no patient was waiting over 24 hours in the emergency department. The coordination of intermediate transfers

was facilitated by the daily presence of a hospital ambulance liaison person (HALP)*** in the emergency department.

In 2024, up to the week of inspection, MRHT was also the second best performing hospital for patient experience times (PETs)††† relating to patients aged 75 years and over waiting less than nine hours, (76.4% compared to 76.8% in St Luke's General Hospital, Kilkenny). In terms of patients aged 75 years and over who did not need to be admitted from the emergency department, MRHT had the shortest waiting times nationally (for both model 3 and model 4 hospitals), 88.9% were waiting less than nine hours. However this was still below the HSE target of 99%.

On the day of inspection, there was a good flow of patients through the emergency department and a close match between the availability and demand for inpatient beds at MRHT. This was reflected in the patient experience times. At 11.00am on the day of inspection, 29 patients were registered in the emergency department.

The waiting time from:

- triage to medical review ranged from 10 minutes to 6 hours 12 minutes. The average waiting time was 47.46 minutes.
- there were no patients in the emergency department who had received a decision to admit, nine patients had been referred to a medical specialty for further assessment.
- there were no patients in the emergency department awaiting an inpatient bed.

In the case of the patient waiting 6 hours 12 minutes, inspectors discussed the circumstances of this case in further detail and were assured that the decision was appropriate, the patient had been reviewed promptly by emergency medical staff and was awaiting a specialty review at the time of inspection. Staff could view the status of all patients in the department including their prioritisation category levels and waiting times on the emergency department's electronic information system and mobile application (app).

All patients were triaged and prioritised in line with the Manchester Triage System 3rd Edition‡‡‡ or the Irish Children's Triage System 2nd Edition§§§ as appropriate. Following triage and categorisation, patients were referred to the most appropriate care pathway,

*** The Hospital Ambulance Liaison Person is responsible for managing the ambulances that arrive at the hospital, liaising between the ambulance service and the hospital's emergency department team.
††† Patient experience time measures the patient's entire time in the emergency department, from the time of arrival in the department to the departure time.
‡‡‡ Manchester Triage System is a clinical risk management tool used by clinicians in emergency departments to assign a clinical priority to patients, based on presenting signs and symptoms, without making assumptions about underlying diagnosis. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.
§§§ The Irish Children's Triage System is a clinical risk management tool for the assessment and prioritisation of clinical urgency of paediatric patients (up to the eve of 16th birthday) presenting to Emergency Departments and Urgent Care Centres in Ireland. It is endorsed by the National Emergency Medicine Programme in Ireland. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.

which included: neck of femur, hip, chest pain, atrial fibrillation and deep vein thrombosis pathways. The emergency department also had a rapid access treatment team (RATT) pathway, the RATT identified suitable patients for fast-tracking diagnostics and treatment. A rapid access frailty team (RAFT) was also in place to facilitate a safe and coordinated discharge for all frail elderly patients from the emergency department. In 2023, the RAFT treated 4% of all attendances to the emergency department and had a conversion rate (for admissions) of 27.8%. The ANP pathway for minor injuries operated from 08.00 to 20.00, seven days per week and was a key function in the emergency department, treating presentations and conducting review consultations. In 2023 the ANP pathway treated 11.8% of total attendances (15.9% of attendances during operating hours). Staff also described a urology pathway for referral to Tallaght University Hospital. Inspectors were told that stroke patients were transferred to Midlands Regional Hospital Mullingar and head injury patients were transferred to specialist hospitals via protocol 37[****] as required.

There were a range of community based hospital admission avoidance measures available to MRHT in CHO 8, such as community day services, home supports and an outpatient parenteral antibiotic therapy service (OPAT).[††††] There was no pathfinder service[‡‡‡‡] available at MRHT, management described plans for an alternative national community paramedic initiative but inspectors were told that this service was not yet operational. There were also integrated structures between CHO 8 and MRHT aimed at streamlining community supports and hospital admission avoidance such as RAFT, frailty hub and a recent frailty at the front door initiative. Additional supports included an outreach clinic for patients with chronic obstructive pulmonary disease (COPD) and review clinics facilitated by ANPs or AMAU. Further integration and collaboration with community services and in particular, the National Ambulance Service (NAS) could increase access and availability to other hospital admission avoidance options.

In 2024, up to and including the week of inspection, 26.3% of attendees to MRHT's emergency department were admitted to the main hospital for further care and treatment (conversion rate), which was a slight reduction (2.1%) compared to the same time in 2023 and is comparable to other similar model 3 hospitals and a little below the national average for this time period (28.4%). The conversion rate for patients aged 75 years or over was 50.3%, which was 6.8% lower than the same time in 2023. These figures suggest a slightly lower overall acuity of patients presenting to the emergency department over time, particularly in relation to patients aged 75 years or over. This may also reflect improvements in hospital admission avoidance measures and community services for these patients, or may be indicative of a decrease in the availability of primary care services such as GPs. Staff who spoke to inspectors, said that that patients were reporting difficulties

[****] Protocol 37 is the name used to describe the HSE's emergency inter-hospital transfer policy.
[††††] Outpatient parenteral antibiotic therapy (OPAT) is a treatment option in patients who require parenteral antibiotic administration, and are clinically well enough not to require inpatient hospital care.
[‡‡‡‡] A HSE National Ambulance Service (NAS) led service called Pathfinder was designed to safely keep older people who phone 112/999 in their own home rather than taking them to a hospital emergency department.

accessing a GP and inspectors observed that there were a high number of low urgency patients presenting at triage on the day of inspection. In 2024, up to and including the week of inspection, 2.98% of patients left MRHT's emergency department before completion of care was which was lower than 2023 (4.9%) and well within the HSE's target of less than 6.5%. Staff described the processes in place in the emergency department to ensure that patients who had registered for care in the emergency department and had tests carried out, but left before completing care, were followed up by medical staff when required.

The AMAU functioned as an alternative flow pathway from the emergency department for patients who met the AMAU inclusion criteria, as opposed to being an alternative pathway for patient self-referral or GP referral as is the case in some hospitals. The capacity of the AMAU was limited due to the conversion of five trolleys to surge capacity on the day of inspection. These surge patients were under the care of their admitting consultant and were awaiting diagnostics and expected to be discharged on the same day. Inspectors found that, whilst the specific use of AMAU beds for surge capacity was effective during black escalation, the practice impacted on the number and acuity of patients that could be accepted by the AMAU on any given day. This in turn affected the ability of the AMAU to relieve the pressure caused by increased attendance rates to the hospital's emergency department. This was discussed with hospital management on the day of inspection. Findings from this inspection suggest that the AMAU could be used more effectively and efficiently to improve the patient experience and patient flow through the hospital's emergency department.

Overall, it was evident that MRHT had defined management arrangements in place to manage and oversee the delivery of care in the emergency department. Hospital management had implemented a range of measures to improve the flow of patients through the emergency department such as the use of surge capacity beds and the use of extended rosters for emergency medicine consultants. Notwithstanding the use of part of the AMAU for surge capacity, MRHT's emergency department was functioning well on the day of inspection, despite an extended period of escalation in the hospital due to a period of unusually high hospital attendances at the time of inspection.

Judgment: Substantially Compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.
MRHT had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare in the emergency department. Medical staffing levels in the department were maintained at levels to support the provision of 24/7 emergency care. The hospital was approved and funded for seven whole time equivalent

(WTE)[§§§§] consultants in emergency medicine, six of whom were available for on-call. At the time of inspection, all positions were filled, six on a permanent basis and one on a locum basis, however inspectors were told that a recruitment process was ongoing for the seventh permanent position. Attendees to the emergency department were assigned to an emergency department consultant on-call until admitted or discharged.

Inspectors noted that there was no clinical director in place for the medical directorate at the time of inspection, this was discussed with staff who told inspectors that they could escalate issues to other clinical directors or the GM and they felt well supported. However, the absence of a clinical director for the medical directorate, represents a potential weakness in governance structures that should be rectified as soon as possible.

The hospital's emergency department was an approved training site for NCHDs on the basic and higher specialist training schemes in emergency medicine. Consultants in emergency medicine were supported by 21 WTE NCHDs – four specialist registrars, nine registrars, eight senior house officers including two GP trainees. At the time of inspection, all positions were filled. At least one senior decision maker[*****] at consultant grade was on-site in MRHT's emergency department during core working hours 8.00am to 6.00pm Monday to Friday, and 10.00am to 5.00pm on Saturdays, with enhanced rostering to 9.00pm on Mondays and Tuesdays, which had been identified as busier days. Outside of rostered hours, a consultant in emergency medicine was on-call and available off-site. During busy times, the operation of the emergency department, including consultant involvement, was formally underpinned by the MRHT emergency department escalation policy, MRHT escalation plan and major emergency plan as appropriate.

A clinical nurse manager grade 3 (CNM3), had overall responsibility for the nursing service within the emergency department. The CNM3 reported to the Assistant Director of Nursing for the emergency department (ADON-ED). The emergency department's total approved and funded nursing staff complement was 76.7 WTE (inclusive of specialist and management grades). This number included 21 WTE nursing staff approved as part of the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*.[†††††] The department's compliment of nursing staff included 3.0 WTE Advanced Nurse Practitioners, 1.0 WTE clinical nurse specialist (frailty), 1.0 WTE staff nurse involved in the rapid access treatment team (RATT) and 1.0 WTE clinical skills facilitator. The department also had 2.0 WTE physiotherapist positions which were filled and 2.0 WTE

[§§§§] 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 consultants or doctors at registrar grade who have undergone appropriate training to make independent decisions around patient admission, treatment and discharge.

[†††††] Department of Health. *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*. Dublin: Department of Health. 2022. Available online https://assets.gov.ie/226687/1a13b01a-83a3-4c06-875f-010189be1e22.pdf

occupational therapist positions which were vacant at the time of inspection. These positions were part of the frailty at the front door initiative.

At the time of inspection, the department's actual complement of nursing staff was 65.9 WTE, with 14% of nursing positions unfilled (6.3 WTE staff nurses, 1.0 WTE CNM1, 3.0 CNM2 and 1.0 WTE ADON-ED/Acute Floor). Inspectors saw evidence that the emergency department was also experiencing a significant level of ongoing temporary nursing vacancies due to staff maternity leave which had been discussed at DMHG level. At the time of inspection, inspectors were told that upcoming maternity leave affected 12% of nursing staffing in the emergency department and the risk assessment process in relation to this was ongoing. Hospital management were managing the resourcing deficit in nursing staff levels with the use of agency staff with emergency department experience, where possible. Prior to the recent HSE recruitment embargo, hospital management were also conducting an ongoing nursing recruitment campaign. Inspectors were told of plans for an additional 2.0 WTE staff nurses by the end of March 2024 and management were exploring the possibility of increasing the number of clinical skills facilitators from one to two with the purpose of optimising the skills of existing staff.

The emergency department's total approved and funded staff complement of healthcare assistants (HCAs) was 7.5 WTE. However only four of these positions were filled at the time of this inspection which was a shortfall of 47%.

The emergency department had 12 nurses rostered on day shift and 10 nurses rostered on night shift (inclusive of CNM1s and CNM2s) Monday to Friday. On weekends, 10 nurses were rostered on day shift and nine nurses rostered on night shift (inclusive of CNM1s and CNM2s). On the day of inspection, the department was short one nurse, which was a shortfall of 8%. HCA staffing was also reduced because one HCA was assigned to accompany a patient during a transfer. There was evidence that staffing challenges were impacting the emergency department's performance in routine audits. This will be discussed further in Standard 3.1.

MRHT had the highest occupancy rate of their surge capacity beds nationally (for model 3 and model 4 hospitals). Whilst this was a key factor in maintaining patient flow and services in MRHT, some of the additional beds required additional staffing and this occasionally led to staff redeployment from the emergency department to other areas of the hospital. Inspectors reviewed records of staff redeployment from the emergency department and the associated risk assessment and noted that the risk had been added to the departmental risk register. This risk and the potential risks related to staff pregnancy should continue to be monitored closely at a senior level and actioned as appropriate 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.

The AMAU had an assigned complement of medical and nursing staff. Clinical oversight was provided by the on-call medical consultant for the day, supported by two medical registrars. The AMAU's approved and funded nursing staff complement was 4.0 WTE

(including a CNM2) and one WTE HCA. Two staff nurses (including a CNM2) and 1.0 WTE healthcare assistant were rostered daily during AMAU opening hours (8.00am to 6.00pm). At the time of inspection, the unit was fully staffed. On the day of inspection, part of the AMAU was converted to surge capacity and there were five patients admitted in the unit. These patients were under the care of the AMAU staff.

Staff training records provided to inspectors outlined that nursing in the emergency department undertook multidisciplinary team training appropriate to their scope of practice. Inspectors found that compliance with nursing staff attendance and uptake at mandatory training was generally good in the areas of basic life support, triage, hand hygiene, medication safety, the Irish National Early Warning System (INEWS), the Irish Paediatric Early Warning System (IPEWS) and sepsis management. However there were opportunities for improvement in relation to the nursing staff attendance and uptake of training in standard and transmission based precautions, donning and doffing PPE, the Irish Maternity Early Warning System (IMEWS) and the Emergency Medicine Early Warning System (EMEWS).

Staff absenteeism rates at MRHT were monitored and reported monthly as per the HSE's requirements. The CNM3 and ADON-ED had oversight of absenteeism rates for nursing staff in the emergency department. The reported staff absenteeism rate due to sick leave in the emergency department for 2023 was 4.43% excluding COVID-19 related absenteeism. This rate was slightly above the HSE's target of 4% for 2023.

Overall, hospital management were organising and managing their workforce to enable the delivery of high-quality care in the emergency department. On the day of inspection, the hospital was in black escalation with 31 surge beds occupied. The emergency department was short one nurse and one HCA. However inspectors observed that the department was functioning well and was able to meet the demand for unscheduled and emergency care. Attendance at and uptake of mandatory and essential training for nursing staff in the emergency department requires improvement to 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. The risks associated with staff redeployment and pending maternity leave should continue to be monitored closely at a senior level and actioned as appropriate to ensure the that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care in the emergency department

Judgment: Substantially 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 emergency department was found to be compliant with national standard 1.6 and substantially compliant with national standard 3.1. Key inspection findings leading to the judgments of these national standards are described in the following sections.

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

Staff working in the emergency department were committed and dedicated to promoting a person centred approach to care. Staff discussed a number of initiatives that helped to protect the dignity, privacy and autonomy of patients such as, the use of information screens in the waiting room, the frailty at the front door service, the development of a sensory room, the management of patient placement to optimise dignity and privacy when medically possible and the use of morning huddles to emphasise the importance of appropriate communication with patients to ensure they are aware of their plan of care.

Patients were accommodated in a mix of individual rooms and multi-occupancy areas. Privacy and dignity was supported with the use of privacy curtains in multi-occupancy areas. At that time of inspection, there were no patients accommodated on trolleys in the corridor and no patients were admitted or boarding in the department while awaiting an inpatient bed in the main hospital, although inspectors observed patients on trolleys in the corridor for a short time, later in the morning. These patients were observed to be young and mobile and staff told inspectors that, whenever possible, patients were moved from the corridor to a more private area during medical assessment or treatment. These measures were validated by inspectors' observations and by communication with a patient on a trolley on the day of inspection who told inspectors that they were brought to a place of privacy for medical assessment. Risks were also mitigated by the good patient flow in the emergency department which ensured that patient waiting times in the department were within HSE targets and patient time on trolleys in the corridor was minimised as much as possible.

The largest single isolation room was prioritised for use when patients were at an 'end-of-life' stage when possible. Staff told inspectors that they would also liaise with the bed manager to accommodate 'end-of-life' patients appropriately.

All patients who spoke with inspectors were complimentary of staff and said they 'felt listened to'. Patients told inspectors that they received timely triage and access to tests and were aware of their plan of care. A patient who attended the emergency department frequently said it was 'always a very pleasant experience' and found staff to be 'excellent' and 'kind'. Patients were not aware of how they would make a complaint, but said they

found staff 'approachable' and would speak to a staff member if required. The emergency department provided water and regular meals for patients.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the emergency department.

Judgment: Compliant

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

There were systems and processes in place in MRHT to identify, evaluate and manage immediate and potential risks to people attending the emergency department and to monitor, analyse and respond to information relevant to the provision of high-quality, safe services in the emergency department. However the low number of toilets for patients requiring isolation and the occasional use of trolleys in the corridor in the emergency department posed a risk of cross-infection. Inspectors also noted recent variability in performance in hand hygiene and environmental audits which should be monitored closely following this inspection.

Data was collected on a range of quality and safety indicators related to MRHT's emergency department, in line with the HSE's reporting requirements. This included the number of presentations to and admissions from the emergency department, DTOCs, ALOS, ambulance turnaround times, serious reportable events, serious incidents, complaints and risks. These data were reviewed at weekly meetings of the SMT, fortnightly UEC meetings, monthly meetings of the CGG, quarterly meetings of the EDGG and monthly meetings between MRHT and DMHG.

Data on patient experience times (PETs), collected on the day of inspection, showed that at 11.00am, the hospital was aligned with all-but-one of the HSE targets for the emergency department. At that time, of the 29 patients registered in the department:

- 6.8% of attendees to the emergency department were in the department for more than six hours after registration — in line with the national target that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- 3.4% of attendees to the emergency department were in the department for more than nine hours after registration — in line with the national target of 85% of attendees are admitted to a hospital bed or discharged within nine hours of registration.

- No attendees to the emergency department were in the department for more than 24 hours after registration — in line with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration.

At 11.00am, 31% of attendees (9 patients) to the emergency department were aged 75 years and over.

- 11.1% of attendees aged 75 years and over (one patient) were in the department for more than six hours after registration. This was not in line with the national target that 95% of patients aged 75 years and over are admitted to a hospital bed or discharged within six hours of registration
- All patients aged 75 years and over were admitted or discharged within nine hours of registration — in line with the national targets that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours and 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within 24 hours of registration.

This was consistent with the HSE's urgent and emergency care reports and published performance data, where MRHT is consistently one of the top performing hospitals in the country. For example, in 2023 MRHT achieved very high compliance with the HSE target for patients aged 75 years and over who are waiting over 24 hours, recording only five breaches (all of which occurred in the first half of 2023). This was the lowest number and rate nationally, for both model 3 and model 4 hospitals, and is to be commended, especially given the known risk to patient safety posed by prolonged waiting time on trolleys in emergency departments, especially among older patients.

Risk management

Inspectors were satisfied that MRHT had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the emergency department. Risks related to the emergency department and their associated control measures and corrective actions were formally reviewed in line with the HSE's risk management processes. Identified risks were regularly reviewed at meetings of the relevant governance committees. There was a process in place to escalate risks that could not be managed within the emergency department for inclusion in the medical directorate risk register and onwards to corporate or DMHG level as appropriate. The emergency department's risk register was managed by the CNM3 in conjunction with the ADON-ED. Emergency department risks were discussed at meetings of the EDGG. The departmental risk register was extensive and inspectors noted that there was some repetition and overlap between items and that the details and control measures were not completed. The emergency department risk register should be reviewed to ensure that all risks are recorded and managed appropriately over time.

At the time of inspection, there was one high-rated risk related to the emergency department recorded on MRHT's corporate risk register:

- 'Risk of harm to patients and risk of poor patient experience due to emergency department overcrowding including, breach in IPC guidelines, patient harm due to insufficient staffing levels which can lead to medication errors, falls, pressure ulcers, communication errors etc. Staff stress due to inadequate staffing levels'.

The corporate and directorate risk registers were updated to reflect the most recent review dates and recorded the reduction in risk due to existing control measures. The actions required to reduce the risk further were also recorded but were overdue for review at the time of inspection. These included implementation of an emergency department expansion plan, implementation of the safe staffing framework in the emergency department and recruitment into vacant posts as soon as possible.

Infection prevention and control

The hospital had a system in place to assess patients for communicable infectious diseases on arrival at the emergency department, including COVID-19 and Influenza A and B as appropriate. Inspectors were informed that targeted surveillance testing of patients was performed on admission for *Carbapenemase-producing Enterobacterales* (CPE)[ǂǂǂǂǂ] and *Methicillin Resistance Staphylococcus Aureus* (MRSA)[§§§§§] in line with national guidance at the time of inspection. Inspectors were told that laboratory services were limited out of hours and this could sometimes increase waiting times in the emergency department overnight. The infection status of each patient was recorded on the emergency department's electronic information system and an alert tag was use to highlight important information on the system.

Patients requiring transmission-based precautions were accommodated in single rooms when possible. There were two ensuite isolation rooms, one of which was also negative pressure. There were a further two isolation rooms without toilet facilities. Patients requiring isolation in these rooms were requested to use a commode but otherwise needed to share one of the two toilets in the main emergency department. This practice posed an infection prevention and control risk and staff described the additional measures used to reduce this risk, such as requesting patients to wear masks while outside the room and increased cleaning of the toilet used. Inspectors were told that although the number of isolation rooms was limited and could be challenging at times, the use of point of care testing and fast turnaround time for laboratory testing usually helped to avoid bottlenecks.

[ǂǂǂǂǂ] Carbapenemase Producing Enterobacterales (CPE) are Gram-negative bacteria that have acquired resistance to nearly all of the antibiotics that would have historically worked against them. They are, therefore, much more difficult to treat.
[§§§§§] Methicillin-resistant Staphylococcus aureus (MRSA) infection is caused by a strain of bacteria that has become resistant to the antibiotics commonly used to treat ordinary staphylococcal infections.

Hospital management described plans to expand the emergency department as part of an acute floor model which will address the infrastructure and capacity of the department.

Inspectors observed wall-mounted alcohol-based hand sanitiser dispensers strategically located and readily available to staff. Hand hygiene signage was also observed to be clearly displayed throughout the emergency department. Staff were observed wearing appropriate personal protective equipment (PPE). Hand hygiene audits were carried out in the emergency department with oversight by the IPC Hygiene team. The emergency department achieved 90% compliance between October and December 2023, however inspectors were told that a recent audit had measured a drop in compliance to 82% and management had developed an action plan including additional training in accordance with MRHT's hygiene audit action plan. Staff in the emergency department had access to the hospital's IPC team on request and had access to a microbiologist 24/7.

MRHT's emergency department was generally observed to be clean and well maintained on the day of inspection. Cleaning schedules were checked by the CNM2 and the cleaning supervisor. Inspectors observed terminal cleaning in progress and were told that the cleaning supervisor also checked the standard of cleaning for rooms that had been occupied by a patient with CPE. There was evidence that monthly environmental and equipment hygiene audits were carried out in the emergency department using a standard approach. There was evidence that quality improvement plans were implemented when necessary to improve the standard of environmental hygiene in the department. For example, recent findings (December 2023) showed a drop in compliance with environmental audits (79%). This was discussed with management during inspection. The findings were partly attributed to the lack of availability of HCAs due to redeployment to accompany patients on transfers and redeployment to other parts of the hospital. The findings were escalated to management in accordance with the MRHT hygiene audit action plan. The most recent audit findings in January had improved to 93.3%, however the continuing redeployment of staff from the emergency department had the potential to impact on environmental and equipment hygiene compliance.

Medication safety

The emergency department did not have a comprehensive pharmacy service, however a pharmacy technician visited daily and staff could request a clinical pharmacist from the main hospital when required. Inspectors were told that the need to request pharmacy support has reduced over time as the number of admitted patients in the emergency department had reduced. Nursing or medical staff performed medical reconciliation as required in the emergency department. Pharmacy-led medication reconciliation was carried out on admitted patients and this was underpinned by a formalised policy on clinical pharmacy. However this policy was observed to be due for review and did not reference the emergency department. The department had a list of high-risk medicines. Staff who spoke with inspectors were knowledgeable about high-risk medicines and associated risk reduction strategies were in place. The use of high risk medications was underpinned by a

formalised policy. The emergency department had a list of sound alike look alike drugs (SALADs) and staff were aware of this list. Staff had access to a pharmacy application (app) which provided prescribing guidelines, antimicrobial guidance and any related updates. Staff in the emergency department had access to an antimicrobial pharmacist on request. The management of medication safety incidents, actions and learning was overseen by the medication safety pharmacist for MRHT and the clinical skills facilitator in the emergency department.

Deteriorating patient

The national early warning system, paediatric early warning system and national maternity early warning system were used in the department for admitted patients to support the recognition and response to a deteriorating patient in the emergency department, (INEWS version 2, PEWS and IMEWS respectively). There was a plan in place to fully implement the Emergency Medicine Early Warning System (EMEWS) and inspectors saw evidence of adaptation of relevant document templates to incorporate EMEWS. However at the time of inspection, training was still ongoing and staffing levels were insufficient to facilitate the ongoing measurement of vital signs for patients who were waiting in the waiting room after triage. However there were documented systems and processes in place to ensure that patients were appropriately monitored by an allocated nurse during the post-triage phase of care. Audits of early warning systems had not yet commenced but were planned for later in 2024.

The emergency department used the Sepsis 6[******] form which was commenced at triage. Staff who spoke with inspectors were aware of sepsis protocols and inspectors observed infographics and guidance to increase awareness of sepsis on display in the emergency department. Sepsis guidelines were also available via the pharmacy application (app). Inspectors were told that the use of the sepsis form and protocol was audited but did not receive findings of recent audits.

A wide range of daily safety huddles for both nursing, RAFT and medical staff were held in the emergency department to discuss the status of all patients and to identify any patients of concern.

Transitions of Care

The hospital held daily patient flow huddles. During escalation, three patient flow huddles took place throughout the day and were attended at different times by the senior nursing team, business managers from each directorate, GM, Director of Nursing (DON), Clinical Director, CNMs and evening planner, as required. KPIs were discussed weekly at these meetings and with the GM and DON in attendance. Inspectors were also told that the patient flow team, consisting of the ADON for patient flow, three CNM3s and a CNM3

[******] Sepsis 6 is a care bundle comprising six time-bound tasks, take three (blood cultures, lactate and urine output monitoring) and give three (fluids, antibiotics and oxygen), all to be instituted within one hour of recognition of the potential condition.

discharge planner, also met weekly to review patient plans and discuss alternative discharge pathways. These meetings were not formalised at the time of inspection but staff discussed the possibility of formalising the structures with inspectors. This would be a positive step and would help to capture key information, ideas and improve opportunities for learning. Complex cases and delayed transfers of care (DTOC) were escalated at fortnightly meetings of the UEC which were attended by key decision makers in MRHT and CHO 8. Staff also told inspectors that, when necessary, issues impacting flow had been escalated to DMHG with a positive outcome.

Inspectors were informed that the ISBAR$_3$[††††††] communication tool was used when requesting patient reviews, for clinical handover and when transferring patients from the emergency department. Formal handover forms using ISBAR$_3$ were used for the safe transfer of care within and between hospital departments. The process of clinical handover was underpinned by a formalised policy which was in draft form at the time of inspection and in the process of rollout. Audits of clinical handover (ISBAR$_3$) had not yet commenced but were planned for later in 2024. The hospital had a formal Transitions of Care Committee (TOCC) to oversee and coordinate activities relating to optimising the process of clinical handover, including intra- and inter- hospital clinical handover, discharge to community services and the consistent use of early warning scores and ISBAR$_3$. The committee was in its first year and had developed a new draft clinical handover policy at the time of inspection.

Management of patient-safety incidents

There was a system in place at MRHT to report, review and manage patient-safety incidents that occur in the emergency department. Staff who spoke with inspectors were aware of the process and received feedback and learning from the CNM3 and ADON-ED. The reporting and management of patient-safety incidents was underpinned by a formalised policy that was in line with the HSE's incident management framework. Incidents related to the department were reported on the hospital's incident management system (NIMS). Patient-safety incidents were tracked and trended by the QPS department and were reviewed at meetings of the EDGG, medical directorate and CGC. Serious patient-safety incidents were reported to the hospital's Serious Incident Management Team (SIMT) for review and escalated to the hospital group as appropriate in line with the HSE's incident management framework. Documentation reviewed by inspectors showed that the SIMT met frequently, reviewed serious incidents that occurred in MRHT and ensured that learning and recommendations arising from review were implemented.

Inspectors reviewed documentation on the reported patient-safety incidents in the emergency department in 2023. The majority of incidents reported were rated minor or

[††††††] Identify, Situation, Background, Assessment and Recommendation (ISBAR$_3$) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

negligible. The most common reported incidents related to staff factors, care management, medication and violence and harassment. MRHT had a higher than average rate of incident reporting compared to other model 3 hospitals and this is generally considered reflective of a positive safety culture. Documentation reviewed by inspectors showed that between August to October 2023, MRHT inputted 96% of incidents to NIMS within 30 days of the incident occurring which is well within the HSE's target set by HSE's incident management framework (70%). However MRHT did not meet the target for completion of 70% of all category 1[‡‡‡‡‡‡] incident reviews within 125 days. Between August and October only 25%-50% of relevant reviews were completed within this timeframe.

Management of complaints

Inspectors found there was a coordinated response to complaints related to the emergency department that was in line with the HSE's 'Your Service You Say'. Hospital management supported and encouraged point of contact complaint resolution, with complaints managed at department level by the CNMs with oversight by the ADON-ED and the complaints officer. Hospital management received 96 complaints related to the emergency department in 2023 and 12 complaints in January 2024. 43% of these complaints were not upheld. Complaints were tracked and trended by the Consumer and Legal Affairs department, and reviewed by the CGC. Feedback was shared with the ADON-ED and the CNM3 who in turn shared the information on complaints resolution with staff. The most common complaints, received in 2023 about the emergency department were about care and treatment, communication and waiting times. MRHT was compliant with the HSE's target of 75% complaints resolution within 30 working days. Although feedback boxes were observed in the waiting room, information relating to MRHT's complaints process, the HSE's 'Your Service, Your Say' and independent advocacy services were not seen in the emergency department and could be displayed in the emergency department following this inspection.

The emergency department also received 63 compliments in 2023 and seven compliments in January 2024. Compliments included thank you cards and letters and specific compliments for a range of professions in the emergency department.

In summary, there were arrangements in place to monitor, analyse and respond to information relevant to the delivery of safe care in MRHT's emergency department. Risks related to the emergency department were identified and managed at department level and escalated to executive management as appropriate. The efforts to minimise the number of admitted patients and patients on trolleys in the emergency department helped to reduce the risks of harm. However, the high level of attendances to the emergency department was recognised as an ongoing risk with broad impact on patients and staff. Inspectors noted this risk was on the hospital risk register and was managed effectively. Inspectors observed patients on trolleys in the corridor for a short time during inspection and the inadequate physical distancing between trolleys located on the corridor was also a

[‡‡‡‡‡‡] Category one incidents are clinical and non-clinical incidents rated as major or extreme as per the HSE's risk impact table.

potential infection risk. A more comprehensive clinical pharmacy service in the emergency department would support safe medication practices in the emergency department. Auditing of environmental, equipment and hand hygiene practices in the emergency department was an area that should be monitored closely to ensure that audits are adequately resourced and improvements are maintained following this inspection.
Judgment: Substantially compliant

Conclusion

HIQA carried out a one-day unannounced inspection of MRHT's emergency department and AMAU on 01 February 2024 to assess compliance with four national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four national standards 5.5, 6.1, 1.6 and 3.1. Inspectors additionally focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care, to ensure adequate protections were in place for patients.

Capacity and Capability

Inspectors found that MRHT was substantially compliant in national standards 5.5 and 6.1 which is a comparatively good performance. MRHT had defined corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare in the emergency department. The hospital had a clinical directorate structure with systems and processes in place to support safe and effective working and communication. There was evidence of good operational grip and an agile management approach in place for example in the development of a new and responsive escalation policy specifically for the emergency department.

On the day of inspection, the hospital's emergency department was busy, relative to its intended capacity, but was functioning well overall. A significant number of patients in the emergency department were awaiting specialty review which was impacting PET times. This is worthy of further consideration by the emergency department, in collaboration with the wider hospital. It was clear that hospital management were working to optimise capacity within and outside of the hospital. Hospital management had implemented a range of measures to improve the flow of patients through the emergency department such as increased inpatient capacity at MRHT using surge capacity beds and the use of extended rosters for emergency medicine consultants, which was facilitated by the high level of adoption of the new public-only consultant contract in the emergency department. These measures were working well on the day of inspection. The number of DTOCs was lower than average for model 3 hospitals and the ALOS was comparable with other model 3 hospitals. The hospital was in escalation indicating an overall mismatch between the availability and demand for inpatient beds at the time of inspection. The significant use of additional beds for surge capacity helped to maintain patient flow through the emergency department on the day of inspection. However, the use of surge capacity for prolonged lengths of time is not sustainable and places a significant additional demand on services, such as delays in elective procedures, redeployment of staff and higher reliance on agency and overtime. Further integration and collaboration with community services and the NAS should be explored to increase availability of options to support hospital admission avoidance. The progression and full implementation of approved capital initiatives with the HSE at the time of this inspection, has the potential to increase acute capacity, improve the flow of patients through the hospital and reduce the need for surge capacity.

In relation to national standard 6.1, inspectors found that hospital management were planning, organising and managing their nursing, medical and support staff in the emergency department to support the provision of high-quality, safe healthcare. There was a rostered six-day consultant presence in the emergency department. The unit was well staffed on the day of inspection although 14% of nursing posts and 47% of HCA posts were vacant. Hospital management were working to actively recruit staff to fill vacant positions in the emergency department where possible but the hospital was subject to a national recruitment embargo at the time of inspection. Hospital management should continue every effort to progress with recruitment to fill vacant positions and 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. The absenteeism rate due to sick leave in the emergency department for 2023 was 4.43% excluding COVID-19 (HSE target 4%). Attention however, is required to ensure ongoing oversight of the uptake of key training by all relevant staff in the emergency department, appropriate to their scope of practice and at the required frequency, in line with national standards.

Quality and Safety

Inspectors found that MRHT was compliant in national standard 1.6 and substantially compliant in national standard 3.1 which is commendable. There was evidence that hospital management and staff were aware of the need and availed of opportunities where possible to respect and promote the dignity, privacy and autonomy of people receiving care in the emergency department. This is consistent with the human rights-based approach to care supported and promoted by HIQA. While there is more work to do on the infrastructure to afford all patients privacy (for those observed on trolleys in the corridor), inspectors were largely assured that dignity, privacy and autonomy were being respected and promoted on the day of inspection. Patients who spoke to inspectors were complimentary of staff.

There were effective arrangements in place in MRHT to monitor, analyse and respond to information relevant to the delivery of unscheduled and emergency care. Inspectors found that there were robust systems and processes in place to support care and protect patients in the emergency department from the risk of harm. However, the physical environment in the department did not support the delivery of high-quality, safe, reliable care. For example, there was insufficient physical distancing between trolleys located on the corridor, which was an infection risk. The hospital should explore opportunities to increase toilet facilities to reduce the potential risk of cross infection.

Although the hospital had a number of complex delayed discharges, there was opportunity to avail of access to local step down beds and private rehabilitation beds to support access and egress within the service. While it is commendable to see that the hospital is consistently meeting most of the patient experience times, and no patients were waiting 24 hours or more to be admitted or discharged, there is some further work to do to consistently meet the six and nine hour targets.

There was also scope for improvement of staffing and completion of environmental and equipment cleaning and this should be monitored closely to ensure that root causes are identified and areas for improvement continue to be identified and acted on promptly.

Overall, notwithstanding areas that require attention identified in this report, staff and management at MRHT had demonstrated an effective approach to patient care in the emergency department borne out by consistently good and improving performance in metrics since 2023.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Substantially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Substantially Compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	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.	Substantially Compliant