Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

OVERVIEW REPORT

MONITORING PROGRAMME AGAINST THE NATIONAL STANDARDS IN EMERGENCY DEPARTMENTS IN 2022

December 2022

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services —** Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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Executive summary

The Irish health system is under unprecedented strain. It continues to see an increasing number of patients presenting to emergency departments (EDs) which is significantly higher than in previous years. This is in the context of a growing and ageing population, with increased delays in treatment due to sustained restrictions on non-urgent care throughout 2020/2021 and reduced attendances at general practitioner (GP) services throughout this period. Adding to the growing pressures on the acute care service is the reduced access to primary care services with a predicted shortage of GPs. Consequently, issues such as reduced access to community services, limited acute and community bed capacity, ineffective patient flow, and insufficient staffing levels, continue to cause overcrowding in Irish emergency departments.

In April 2022, HIQA commenced a new monitoring programme of inspections in healthcare services against the *National Standards for Safer Better Healthcare*. As part of the initial phase, HIQA's core assessment in emergency departments focused on key standards relating to Governance, Leadership and Management (National Standard 5.5), Workforce (National Standard 6.1), Person-Centred Care (National Standard 1.6) and Safe and Effective Care (National Standard 3.1).

Findings from this new programme of inspections, as identified through the first seven inspections in emergency departments against the national standards, continues to highlight that overcrowding in emergency departments compromises the dignity and respect of patients, and poses a risk to the health and safety of patients. Opportunities for improvement were identified across the seven emergency departments inspected to a greater or lesser extent. Areas for improvement relate to patient dignity and privacy, ensuring sufficient workforce numbers, and the protection of patients from harm associated with the design of service delivery. Furthermore, improvements were needed to ensure that there is a balanced approach to the daily operational management of patient flow, capacity and appropriate staffing, which is clearly linked to patient safety and activity.

Emergency department overcrowding and insufficient access to acute and primary services will continue to occur unless a system-wide approach is taken to address major structural challenges. There is also a need to develop operational and leadership capability to support more effective management of patient flow and processes within hospitals and between hospitals and community services and respond to, rather than continuing to tolerate or normalise, this problem. The progression of some measures within hospital services is encouraging. This includes

work to promote and resource safer staffing models and increase bed capacity. HIQA has identified four key areas for both immediate and longer-term attention to address safety issues in our emergency departments. These are;

- The need to continue to urgently build additional capacity within the whole healthcare system, both acute and community, through implementation of the recommendations from the Department of Health's 'Health Service Capacity Review', which was published in 2018. In particular, there is a need to assess capacity requirements at a regional basis as recommended in the capacity review and the prioritisation of investment to be informed by the outputs from such assessment. This will also require associated investment in additional supports to aid infrastructural capacity, inclusive of diagnostic services.

- More responsive leadership, governance and management is needed at local, regional and national level, which acts to address performance issues when identified. Such an approach needs to recognise that – notwithstanding contextual challenges – some hospitals cope better than others with the demands placed upon them and that this is often driven by better local operational management. Such an approach should also not only be confined to just acute services. A collective approach to ownership of this problem across both acute and community services in a region, with seamless planning and a shared approach to escalation in the event of overcrowding is needed. In short, emergency department overcrowding needs to be recognised as a whole health system problem, and the normalisation of comparatively poor performance should not be tolerated.

- A need to advance a more effective approach to strategic workforce planning at local, regional and national level that enables effective anticipation and management of manpower shortages. This acknowledges that recent developments to benchmark and enhance nursing and medical consultant staffing levels in our emergency departments represents an important initial step along this road to improvement.

- More effective identification, monitoring and management of patient safety risks associated with overcrowding in emergency departments, with timely escalation and response to risk within hospitals should they occur. Particular areas for focus should aim to address short-term staffing deficits relative to demand, timely responsiveness to surges in presentation, and close attention to treatment times inclusive of triage times and times to medical assessment.

It is clear that emergency department overcrowding will likely be a feature of our health service in the short term as the key areas that require ongoing attention, such as increased capacity and appropriately resourced and trained workforce, are progressed. Indeed, as we emerge from the COVID-19 pandemic, current pressures on the health system indicate emergency department overcrowding may get worse before it has the potential to get better. To sustain efforts in the interim, the health service will need to continue to work in difficult circumstances to ensure the safe and effective care of each patient that seeks care over the pending winter season.

Better understanding of the drivers of demand among an older and more ailing population post-pandemic, coupled with better planning around capacity across the entire healthcare system, are needed to strengthen operational grip on unscheduled care, facilitate elective capacity and support patient-focused service planning. The implementation of the Sláintecare plan also needs to progress at pace. Crucial to the effective implementation of such reforms are efforts to strengthen and sustain the healthcare workforce at a time when there is a shortage of global healthcare workers. This will require a timely and effective response from a health system that adapts to the daily pressures on emergency departments, while at the same time working to tackle the underlying contributory factors that also need to be addressed.

1. Introduction

Under the Health Act 2007, HIQA has a function to monitor the safety and quality of health services. In April 2022, HIQA commenced a new monitoring programme of inspections in healthcare services against the *National Standards for Safer Better Healthcare*. This new monitoring programme was created to build upon HIQA's prior monitoring work in acute hospitals, and further drive quality improvement in all publicly-funded healthcare services in Ireland, while also continuing to respond to concerns as they arise. As part of the initial phase, HIQA's core assessment in emergency departments focused on key standards relating to Governance, Leadership and Management (National Standard 5.5.), Workforce (National Standard 6.1), Person-Centred Care (National Standard 1.6) and Safe and Effective Care (National Standard 3.1).

This report presents HIQA's initial findings from the first seven emergency departments inspected as part of HIQA's new monitoring programme against the *National Standards for Safer Better Healthcare* in 2022. This particular sample of emergency departments is predominantly, but not completely, made up of those that have experienced the worst levels of overcrowding this year. HIQA is publishing this report now, in recognition that the coming winter months threaten to be especially challenging for patients accessing emergency departments and indeed staff who work in them.

This report is aimed at supporting the agreed national plans for unscheduled care and further targeting key improvement opportunities at local and national level. It also aims to provide further clarity for managers, policy-makers and other interested parties in ensuring that efforts to improve conditions are focused on the correct issues. However, this report also highlights that many factors that are at play – even if addressed immediately – will unfortunately not provide an impact within a short enough timeframe to address overcrowding in emergency departments over the coming weeks, and that a more sustained investment in building capacity within acute and primary care services is urgently required.

Based on the findings to date, this report highlights key areas that require focused attention at a local and national level to support the delivery of safe and effective care in Ireland's emergency departments and achieve compliance with national standards. The four national standards assessed as part of each inspection, associated judgement descriptors and inspection compliance findings are set out in the appendices.

2. Setting the scene

Ireland's population has recently exceeded five million.[1] This growing population is also ageing, resulting in increasing numbers of patients presenting to acute healthcare facilities, including emergency departments, with complex needs requiring admission and input from a wide range of multidisciplinary teams. There are currently 29 emergency departments in the Republic of Ireland that operate 24 hours a day, 365 days a year.[2] Some emergency departments treat adult patients only, while others are specialist paediatric centres. Many emergency departments deliver care to both adult and paediatric patients on the same site. In addition, there are 11 Local Injury Units (LIUs)* and together these units make up the infrastructure of emergency medicine in Ireland.[3]

At present, Ireland has a lower than average number of GPs (4,257 full and part-time) per head of population[4], when compared to European Union norms and does not have enough GPs to meet the current or future needs of our expanding and ageing population with highly complex care needs.[5] The HSE predicts a GP shortage of between 493 – 1,380 by 2025[6], and estimates that an additional 1,260 – 1,660 GPs are needed by 2028.[7] In addition, it has been forecasted that a potential 42% increase in the number of GPs is required to meet the universal free GP care policy.[8] The shortage of GPs across Ireland has resulted in delayed access to GPs and limited access to practices, as many are unable to take on new patients.[8]

Consequently Irish emergency departments may often need to act as a single point of access to healthcare for patients whose needs might be better served by alternative care at their GP or other healthcare services in the community.

Furthermore, the Health Service Capacity Review 2018 published by the Department of Health, forecast a 59% increase in the population aged over 65 and a 95% increase in the population aged over 85 by 2031.[9] The report also stated that for full

* Local Injury Units (LIUs) where patients with non-life-threatening or limb-threatening injuries can receive care.

implementation of capacity reforms, there would be a requirement for 2,590 additional hospital beds by 2031 across inpatient and day case settings. The HSE Winter Plan 2022-2023 published in October 2022 has committed to delivering additional capacity in acute and community services. The plan outlines that 907 acute beds have been delivered in the public healthcare system, and 321 additional beds are funded and due to be delivered by year end 2023.[10] Acknowledging that the Health Service Capacity Review was published prior to the COVID-19 pandemic, the delays in accessing care during the COVID-19 pandemic has likely worsened the pressures for acute and community beds. The Health Service Capacity Review also forecast that the demand for healthcare is expected to grow significantly across the primary, acute and social care settings in the next 15 years as a result of general demographic and non-demographic changes. This included projections of;

- Up to 46% rise in demand for primary care
- A 24% increase in non-elective inpatient episodes in public hospitals.

The composite of issues reflected above is currently manifesting in emergency departments. The Health Service Executive (HSE) has reported a 13.8% increase in emergency department attendances by patients aged over 75 years and a 9.9% increase in emergency department admissions by patients aged over 75 years since 2019.[10]

Throughout COVID-19, emergency departments have been responsive and dynamic in adapting care for both COVID-19 and non-COVID-19 patients without reducing services to incoming patients. Attendances at emergency departments fell notably during the early part of the pandemic in 2020. However, the overall trend since 2021 shows that emergency department presentations are substantially rising.[10] Total attendances at emergency departments in 2021 was 1,294,536. These figures were very similar to pre-pandemic levels. However, emergency department attendances for the first part of 2022 are noted to be greater than previously recorded, with some of the busiest emergency departments recording attendance increases of up to

35% compared with previous years.[11] To date in 2022, the HSE has reported a 5.9% increase in overall emergency department attendances and a 2.5% increase in emergency department admissions compared with 2019.[10] These increases are occurring at a time when the majority of acute care services are already operating at nearly 100% bed capacity on most days. Increased attendances at hospital emergency departments has resulted in an unprecedented increase in the number of patients on trolleys.

While the underlying reasons for a sustained increase in the level of emergency attendances is complex, issues of inadequate capacity across the acute and primary care services, insufficient staffing and the requirement for effective and oversight of these issues continue to be reoccurring features of the Irish healthcare system year after year – although at greater levels of magnitude.

These issues, which are repeatedly identified through HIQA's monitoring activity, are significantly impacting on people who use the service and continues to remain a significant concern to HIQA in the context of providing safe and quality care. Inspection findings relating to these issues will be discussed in greater detail in section four of this report.

3. HIQA's monitoring approach

In 2022, HIQA carried out announced and unannounced inspections to assess compliance with key standards from the *National Standards for Safer Better Healthcare*. To prepare for these inspections, inspectors[†] reviewed relevant information about each hospital. This included any previous inspection findings, information submitted by the individual hospitals, 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

[†] 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.*

- reviewed relevant documents to see if appropriate records were kept and that they reflected practice and what people told inspectors.

Following each inspection, HIQA judged each standard assessed as compliant, substantially compliant, partially compliant or non-compliant (Appendix 1). In circumstances where partial compliance or non-compliance with the standards was identified, a compliance plan was issued by HIQA to hospital management. In response to HIQA findings, hospital management submitted a completed compliance plan to set out the actions taken or planned actions to take in order to come into compliance with the national standards for which they are judged to be partially compliant or non-compliant. It is the healthcare service provider's responsibility to ensure that the actions are implemented in the compliance plan within the set timeframes to address non-compliances identified. Following the inspections, HIQA continues to monitor each hospital's progress in implementing the actions set out in the compliance plan.

A summary of the findings relating to emergency departments and a description of how hospitals performed in relation to each of the national standards assessed are presented in the following section.

4. Findings

HIQA found that while the majority of emergency departments had management arrangements in place to address patient flow through the emergency department, the hospital and onwards to the community, these measures were not always effective in ensuring the delivery of quality and safe services.

With the exception of two of the hospitals in the sample of seven that HIQA inspected, significant opportunities for improvement were identified across hospitals relating to patient dignity, privacy and autonomy, workforce and protecting patients from harm associated with the design of service delivery. All hospitals where non-compliances with standards were identified were issued with compliance plans and three hospitals were issued with high-risk letters in relation to findings.

Overall, HIQA found that the mismatch of demand and capacity alongside insufficient staffing levels were major contributing factors across five emergency departments, which will continue to pose a risk to patient safety unless adequately addressed.

Capacity and Capability of services

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

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.

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. Of the seven hospitals inspected, two were found to be substantially compliant and five were found to be only partially compliant with this standard.

HIQA found all hospitals had defined lines of responsibility and accountability for the governance and management of emergency care. However, opportunities for improvement were identified within five hospitals in relation to the effectiveness of these arrangements to address and escalate specific issues identified on the day of inspection. For example, this included significant delays in the time taken to triage patients, and often inadequate arrangements in place to maintain nurse staffing levels in the context of surges in patient presentations at emergency departments.

In assessing compliance with this standard, HIQA looked at the effectiveness of the measures hospital management had put in place to address patient flow and capacity within emergency departments.

Patient flow and capacity

Continuous and effective flow of patients within and out of the hospital is essential for optimal service delivery in an emergency department. Hospitals that were found

to be substantially compliant with this standard had functioning systems and processes to support continuous and effective patient flow. This was evident in patient flow from the emergency department to inpatient beds and thereafter into the community. For example, in these services, Acute Medical Assessment Units (AMAUs) and Rapid Assessment Units were being used for their intended purposes by providing a dedicated location for the rapid assessment, diagnosis and commencement of appropriate treatment for patients. HIQA also found evidence within one hospital of effective integration and collaborative working arrangements across hospital sites who operated a hub-and-spoke model.[‡]

Of the five emergency departments found to be partially compliant with this standard, 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. Patient flow and capacity issues in the emergency departments were compounded by a number of factors including:

- high numbers of patient presentations
- high average length of stay (ALoS) rates
- delayed discharges
- acute medical assessment units and rapid assessment treatment units not operating as intended
- limited availability of beds in the community

[‡] The hub-and-spoke is a model where service delivery is arranged in a network configuration consisting of an anchor establishment (hub) which offers a full array of services, complemented by secondary establishments (spokes) which offer more limited service, routing patients needing more intensive and critical services to the hub for treatment and care.

- insufficient access to diagnostic services to match demand
- inadequate physical infrastructure within the emergency department.

Five emergency departments reported that they were operating above intended designed capacity on the day of inspection, with some hospitals reporting that they were operating at more than double the occupancy levels they were designed to take. Furthermore, the majority of hospitals were experiencing delays in transfers of care and delays in discharges. This was often attributed to a lack of available beds in the community. Staff who spoke with inspectors described how increased patient acuity was impacting on patients' average length of stay resulting in the need for prolonged hospital admissions. This is also reflective in HSE figures which shows that in the year to date, the average length of stay is 5.1 days which is above the national target of less than or equal to 4.8 days.[10] Increases in average lengths of stay in particular for medical patients are higher than previous years at 7.8 (target ≤7.0), as of June 2022 compared to 7.2 in 2021.[12] This in turn negatively affected inpatient bed availability and capacity, thereby contributing to the boarding of patients and overcrowding in many emergency departments.

In the reports published for each individual inspection, HIQA acknowledged that hospital management in each hospital sought to support patient flow and capacity on a daily basis by enacting short-term measures in keeping with the *HSE's System Wide Escalation Framework and Procedures* (surge capacity protocol).[§] Examples of these measures, included cancelling or curtailing of scheduled care and utilisation of all surge capacity[**13] beds and community beds. However, HIQA found that these short-term measures were not always effective in addressing identified issues and required further action or escalation on the day of inspection. Furthermore, based on our monitoring activity to date, HIQA continues to observe that the HSE's surge capacity protocol, which is designed to act as a safety mechanism when the emergency functioning is severely compromised, has often needed to be routinely enacted in many hospitals. The increasingly routine use of surge protocols demonstrates that the health system is under growing levels of strain. In the context of the increased attendances and additional pressures on emergency departments, surge protocols should be reviewed to ensure their adequacy and deployed appropriately to protect those already in hospital care. However, it also needs to be

[§] The framework is designed to support Hospital Groups and Community Health Organisations in developing integrated escalation plans.
[**] Surge capacity is defined as an ability to evaluate and care for a substantially increased volume of patients that exceeds normal operating capacity.

recognised that these measures often have consequences for patients seeking routine diagnosis and treatment, not least elective care.

Many of the hospitals inspected had proposed further medium and long-term plans to improve patient flow. This included, for example, seeking capital funding to build additional bed capacity in the form of new single bed units and various assessment units. Other plans included reconfiguration to add additional services, increasing workforce and access to diagnostics. Some hospitals were at a more advanced stage than others in relation to their medium and long-term plans, which included sourcing additional local step-down care under their governance. Pending the implementation of long-term plans to improve patient flow and capacity, hospital management needs to ensure that all short-term measures identified to immediately alleviate pressures on hospital capacity and flow are effectively supporting the delivery of safe and effective care within emergency departments.

Ireland has a well-established shortage of acute hospital beds. In 2021, the Organisation for Economic Co-operation and Development (OECD) reported that the number of hospital beds in Ireland in 2019 was the third lowest in the EU (2.9 per 1000 population) [14]. This coupled with one of the highest bed occupancy rates of any developed health system, often running in excess of 100% occupancy[15] are among the key contributory factors to overcrowding in our emergency departments. The Capacity Review highlighted that efficient patient flow, within hospitals and emergency departments, becomes limited when hospital bed or emergency department occupancy levels exceed 85%. This in turn adversely impacts the functioning of emergency departments and poses risks to patient safety.

In summary, HIQA found that while the majority of emergency departments had defined management arrangements in place to address patient flow through the emergency department, the hospital and onwards to the community, these measures were not always effective in ensuring delivery of quality and safe services. Notwithstanding that two hospitals achieved relatively good levels of compliance, all hospitals continue to be challenged in the management of the increasing demands and increasing complex needs of people who use the service. HIQA found repeated circumstances of unprecedented high numbers of attendances in emergency departments combined with issues of ineffective patient flow, limited surge capacity, and inadequate access to diagnostic services. Reduced access to transitional, rehabilitation and step-down beds in the community as reported by hospitals was also cited as having an impact on the continuous and effective flow of patients through emergency departments.

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

For health services to be safe and effective, there needs to be sufficient staff with the right skills to deliver safe, high-quality care. Furthermore, services need to ensure that their workforce is planned, managed and developed to ensure it consistently responds, in a timely manner, to changes in the workload or in the available resources.

HIQA found that the majority of emergency departments inspected were delivering care in an environment where staff shortages exist across all grades. Only one hospital was found to be compliant with this standard while another received substantial compliance. Five out of seven hospitals performed poorly with respect to workforce arrangements, with two hospitals found to be non-compliant and three hospitals found to be only partially compliant with this standard.

Medical staffing

All hospitals inspected had a senior clinical decision-maker[††] that was on site in the hospital's emergency department each day, with availability on a 24/7 basis. Staffing levels for medical staff in six of the seven emergency departments were maintained at adequate levels to support the provision of 24/7 emergency care. However, for some hospitals this was only achieved through the appointment of junior non-consultant hospital doctors. Another hospital was experiencing significant challenges in providing non-consultant hospital doctor (NCHD) cover for the department despite recruitment drives which resulted in unfilled senior house officer and registrar shifts. Five hospitals had all consultants in emergency medicine on the specialist register with the Irish Medical Council. However in two hospitals, not all staff employed as consultants were on this register with some services maintained through the employment of medical staff who were not on this register.

Such shortages in medical staffing in emergency departments impacts on patient experience times and compromises the delivery of safe, quality care. In particular

[††] Senior decision-makers are defined here as a doctor at registrar grade or a consultant who has undergone appropriate training to make independent decisions around patient admissions and discharges.

hospital managers need to ensure that there are sufficient staff available at the right time to deliver safe, high-quality care in the emergency department.

Nursing staffing

Nursing staffing levels in four emergency departments were not maintained at adequate levels to meet service need on the day of inspection. While the majority of hospitals were experiencing some levels of nurse vacancy rates, some hospitals were experiencing much higher rates than others. Six emergency departments did not have their approved[‡‡] whole-time equivalent (WTE) numbers for nursing staff in place. The shortfall in emergency department nursing staffing varied with some hospitals experiencing a limited shortfall of 2.4%, while others were experiencing shortfalls of 34%. HIQA found that the deficits in nurse staffing levels across the majority of emergency departments inspected was having a significant impact on the day-to-day functioning of these emergency departments.

On the day of inspection, only three emergency departments had their full complement of nursing staff rostered on duty. Of the other four hospitals that did not have their approved rostered complement, this shortfall ranged from one nurse per shift to six nurses per shift. Inspectors reviewed nurse staffing rosters in the four-week period preceding the inspection in each emergency department, to determine if suitable staffing arrangements were in place to meet the needs of the service. Four emergency departments were consistently experiencing nurse staffing deficits across day and night shifts. The extent to which these departments

[‡‡] It should be noted that most hospitals inspected had not, at the time of inspection, gone through the full process of evaluation of their approved nursing staffing complement as per the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland.* Approved complement of staff in this report therefore predominantly relates to what the hospital had sanction to recruit prior to application of the framework calculations. HIQA note that often the application of this framework results in an uplift in the baseline complement – HIQA's findings in this area therefore need to be considered in this context.

experienced staff deficits varied greatly and ranged from one to nine nurses short per shift. Some emergency departments were experiencing particularly high shortfalls of nursing staffing levels ranging from 33%-50% over this period.

Emergency departments used a number of measures to manage existing nursing staffing shortages to keep emergency departments safe. Such measures relied on ongoing recruitment campaigns, redeployment, the use of agency nurses and existing staff working additional hours. However, given that the vast majority of these emergency departments were operating with deficits in nursing staffing for prolonged periods of times, HIQA believes such arrangements are not sustainable in the long-term and remains concerned about the provision of safe, high-quality care across Ireland's emergency departments.

In 2022, the Department of Health set out the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*.[16] This framework supports emergency department nurse managers and hospital management to assess and plan their nursing and support staff workforce to meet the needs of their specific emergency care setting. At the time of these inspections, the phased introduction of the framework was ongoing and the nurse staff complement for safe care in emergency departments had yet to be determined in some hospitals. Hospitals were either operating as pilot sites for the testing of the framework or were awaiting the roll out of the nursing staffing complement workforce assessment as part of the framework. HIQA strongly supports this initiative which is currently in the process being implemented by the HSE across the 29 emergency departments.

High staff vacancy rates, particularly across the nursing and medical profession, were identified as a risk by many hospitals. Many hospitals inspected were experiencing high staff absenteeism rates ranging from 3.5 - 8% of the total number of staff. For context, the national HSE target for absenteeism in 2022 is 4% or less.[17] High rates of absenteeism presents challenges to comprehensive patient care. Increased reliance on agency staff to cover leave also presents challenges in terms of continuity of care. Hospital management reported that staff were exhausted from dealing with COVID-19 for almost 2 years and the impact of sustained increases in attendances. Emergency department overcrowding has been found to be associated with high levels of stress and burnout among healthcare professionals, all of which can worsen any existing difficulties in recruitment and retention.[18]

Overall, HIQA found that the mismatch of demand and capacity alongside insufficient staffing levels was a major contributing factor to the overcrowding found across many emergency departments and which posed a significant risk to patient

safety. HIQA acknowledges the ongoing recruitment efforts both nationally and internationally made by hospitals to fill key medical and nursing positions. However, there is a need for better strategic workforce planning across the system and across professions with a particular focus on retention and recruitment of staff. Workforce deficits across all disciplines remains a significant concern to HIQA, particularly in the context of the sustainability of emergency department workforce arrangements. Targeted immediate efforts to address current emergency department staffing issues have been outlined in the HSE's Winter Plan 2022/2023,[10] are a welcome development. However, the impact of a growing national and international workforce shortage for health professionals as a result of recruitment and retention challenges suggests that a longer-term strategic approach to addressing this issue is required in addition to those continued in shorter-term action plans.[19,20]

Staff training

It is essential that hospital management ensures 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. HIQA found that nursing and medical staff in emergency departments undertook multidisciplinary team training appropriate to their scope of practice for example, basic life support, early warning score and sepsis training.

Monitoring and recording of staff attendance at training provides assurance to hospital managers that all relevant staff have attended required training appropriate to their scope of practice. While hospitals had systems in place to monitor and report on staff attendance at mandatory and essential training, HIQA found that the percentage of staff attendance and uptake at mandatory and essential training across the majority of hospitals required improvement. In particular, HIQA found that the attendance and monitoring of the attendance of medical staff, in particular at relevant training, required considerable improvement across the majority of hospitals.

Quality and Safety of services

This section describes the experiences, care and support people received in each hospital's emergency department. HIQA specifically looked at whether the service was a quality, caring environment 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.

Theme 1: Person-Centred Care and Support
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 is 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.

As part of each inspection, inspectors spoke with a sample of patients in the emergency department to understand and document their experiences of care received. Generally, patients acknowledged the challenges faced by the environmental circumstances in which they were receiving care, but were generally very complimentary of staff. A sample of patient feedback is included below;

Figure 1. Sample of comments from patients spoken with on inspection

Of the seven emergency departments inspected, only one was found to be fully compliant with this standard. Three were found to be non-compliant, two partially compliant and one substantially compliant with this standard.

On the days of inspection, the majority of emergency departments had a significant volume of patients beyond their intended capacity. The boarding of admitted patients and the increased volume of presentations to the emergency department directly impacted on the timely review of these patients and their overall experience within the emergency department.

For the emergency departments that were found to be non-compliant or partially compliant with this standard, inspectors observed;

- a significant number of patients accommodated on trolleys
- clinical consultations, assessments and the exchange of information being undertaken on the corridor
- a lack of privacy and dignity for patients on trolleys
- a lack of adequate shower and toilet facilities.

Across the majority of emergency departments, HIQA observed that 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. Fundamentally, it is not in line with a human rights-based approach to healthcare promoted and supported by HIQA.

While many of the factors that caused overcrowding in emergency departments were often outside of the direct control of hospital managers locally in each hospital, HIQA also found that at times, more could have been done by management and staff to address deficits of patients' dignity, privacy and autonomy on the day of inspection. For example, 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 within two hospitals and this was not conducive to a human-rights based approach to care.

Inspection findings in relation to privacy dignity and respect were consistent with the findings of the 2021 National Inpatient Experience Survey, where many hospitals scored below the national average in questions related to privacy, dignity and respect, and length of time waiting in the emergency department before being admitted to a ward.

HIQA recognised the person-centred initiatives that hospitals had introduced to improve patient experiences in the emergency department as well as those enabling emergency department avoidance. These included;

- providing comfort packs for patients in the emergency department
- integrating with community initiatives to support patient management in settings other than ED

- recruiting persons to act as an advocate and provide support to patients.

Overall, HIQA found that issues identified in emergency departments such as overcrowding, lack of privacy, ineffective communications and uncomfortable environments, were impacting on patients' experiences of care and compromising patients' dignity and respect. This was reflected in feedback by patients to inspectors during the inspections. Across the majority of emergency departments, it was not possible to maintain, promote and protect patients' dignity, privacy and confidentiality due to overcrowding and inadequate infrastructure within emergency departments. Findings relating to this standard demonstrate the need for significant improvement in order to ensure patients' dignity, privacy and autonomy are respected. The findings also underline the requirement to promote and embed a human-rights based approach to care for those patients attending emergency departments.

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.

A healthcare service that is 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. Safe effective care relies upon arrangements and contingencies being in place to manage any increase in demand for the service. Recognising that the delivery of care has some associated element of risk of harm for people who use the healthcare service, HIQA specifically looked at systems and processes in place to prevent or minimise potential harm for people attending emergency departments. Two hospitals received substantial compliance with this standard. However, of the remaining five hospitals inspected, two received only partial compliance and three were found to be non-compliant with significant opportunities for improvement identified.

HIQA found that all hospitals had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending emergency departments. Of the hospitals found to be substantially compliant with this standard, HIQA was assured that the design and delivery of services in the emergency department protected people from the risk of harm. However, HIQA found that actions and controls implemented to manage identified risks, in particular overcrowding within the emergency department, were not fully effective in the majority of hospitals. Following inspection, three hospitals were issued high-risk letters in response to risks identified on the day. Such risks included significant delays in the time it was taking to triage patients on arrival to the department and inadequate staffing arrangements to respond to increased patient presentations at the emergency department.

Hospitals collected data on a range of different quality and safety indicators related to the emergency departments and in line with the national HSE reporting requirements. Data collected included;

- inpatient capacity and patient flow, including the number of presentations to and admissions from the hospital's emergency department,
- national key performance indicators in line with the national HSE reporting requirements (monitoring Patient Experience Times (PET)[§§])
- inpatient length of stay.

On the day of inspection, HIQA found that only one hospital was compliant with national HSE performance indicators related to PET. The remaining six hospitals did

[§§] The Patient Experience Time (PET) is the time period measured from arrival to emergency department departure time.

not meet some or all of these performance targets. Examples of findings on the days of inspection were as follows:

- attendees were waiting more than six hours from registration for a decision to admit or discharge[***] within six emergency departments. In some departments, this accounted for more than 50% of attendees.
- the percentage of attendees in the emergency department for more than nine hours after registration[†††] ranged from 9% to 51%.
- the percentage of attendees in emergency departments for more than 24 hours after registration[‡‡‡] ranged from 7% to 21%.
- attendees to the emergency department aged 75 years and over were not discharged or admitted within 24 hours of registration[§§§] within some hospitals inspected. Acknowledging the HSE Performance Profile Report from January to June 2022 reported that 89.5% of patients aged 75 years and over were seen within 24 hours in all emergency departments, it indicates that not all services were facing similar challenges when compared to the seven emergency departments that HIQA inspected.

In addition, patients at two hospitals had experienced significant delays in the time it took patients to be triaged following their initial registration at the department reception. HIQA found that at the extreme end of the findings, waits for triage ranged from 60 minutes to 3 hours and 35 minutes. For context, the Emergency Medicine Programme recommends that 95% of emergency department patients should be triaged within 15 minutes of registration.[21] If triage is delayed, this represents a significant patient safety risk, as the department has little awareness of the potential severity of patient illness or the likely urgency with which the patient needs to be medically assessed and treated. Moreover, untriaged patients in the waiting area are not clinically observed should their condition deteriorate. Such a finding often corresponded with deficits in nursing staffing levels and also reflected poor management practices in the departments inspected. HIQA was also concerned about the number of patients boarding in some emergency departments while awaiting an inpatient bed. In one extreme example, a patient was waiting in excess

[***] The HSE monitors the percentage of attendees who are discharged or admitted within six hours of emergency department registration (Target 70%).
[†††] The HSE monitors the percentage of attendees who are discharged or admitted within nine hours of emergency department registration (Target 85%).
[‡‡‡] The HSE monitors the percentage of attendees who are in the emergency department less than 24 hours (Target 97%).
[§§§] The HSE monitors the percentage of attendees aged 75 years and over that are discharged or admitted within six hours of registration (Target 95%).

of 116 hours for an inpatient bed. However, it was not uncommon to find patients in departments inspected who had been waiting 80-90 hours for an inpatient bed.

Ireland is particularly challenged with respect to the accessibility and timeliness of hospital-based care. Ten years ago, the National Emergency Medicine Programme in Ireland proposed a six hour limit to the time patients spend in an emergency department from arrival to admission to a ward, transfer or discharge home and that this should be achieved 95% of the time.[21] However, HIQA found that this was not achieved within six out of seven hospitals inspected. The majority of hospitals also fell short of achieving targets for many performance indicators related to PET. Furthermore, all seven hospitals were experiencing delayed transfers of care[****] for patients. This ranged from six to 44 episodes of delayed transfers of care across some hospitals on the day of each inspection.

COVID-19 pathways were in operation across all emergency departments. However, HIQA found that patients were not appropriately screened and managed for COVID-19 on arrival at two hospitals, in line with national guidance and which presented a patient safety risk. These risks were raised with hospital management on the day of the inspection for immediate review.

Services must proactively identify, evaluate and manage risks and identify aspects of care associated with possible increased risk of harm. All hospitals had a risk register in place outlining the risks. However, HIQA found that not all measures listed on each hospital's risk register to address risks in the emergency department, such as overcrowding and capacity issues were enacted by all hospitals on the day of inspection.

Overcrowding in hospitals has also been shown to increase the risk of infection and is of particular concern in the context of COVID-19.[22] Despite many of the emergency departments inspected that were refurbished in recent years, HIQA found that the physical congestion caused by the extra trolleys throughout departments posed a significant risk to the delivery of safe, quality care. It also posed an infection prevention and control risk for patients and staff. In two emergency departments, HIQA observed insufficient space between trolleys noting that the minimum physical spacing of one metre was not possible which presented a potential risk to patient safety. All hospitals should ensure minimal distancing between people receiving care in line with national guidance.

[****] A patient who remains in hospital after a senior doctor (consultant or registrar grade) has documented in the medical chart that the patient can be discharged.

In summary, while acknowledging the many measures that hospital management had implemented to manage overcrowding, patient flow and prolonged waiting times, HIQA found that the measures implemented were not always as effective as they should be in reducing the immediate and potential risk to patient safety across the majority of emergency departments. In short, while growing demand for services and deficits in capacity are very clearly significant factors the contribute to overcrowding, HIQA also found that there were often additional measures that could be implemented by management and staff to alleviate some of the risks posed by such overcrowding. Considering the increase in morbidity and mortality associated with prolonged waiting times in the emergency department, this report outlines some of those areas for wider learning [25]. However, the report also seeks to emphasise that the avoidance of such conditions through more effective targeting of the root causes of overcrowding should represent a critical overarching mission for the health service.

5. Discussion

Throughout our monitoring activity in 2022, HIQA continues to observe the increased pressures on emergency departments which is not sustainable. However, it was also important to note that despite the well-documented challenges, HIQA continues to find examples of excellent care delivered by committed and highly capable healthcare staff.

Acknowledging that the sample of emergency department's inspections conducted in 2022 does not provide a complete evaluation of overall compliance with the national standards, trends have been identified in key areas that require immediate attention from a policy and operational perspective.

HIQA's findings to date have demonstrated that limitations in actual bed capacity and delays in transfers and discharges are significantly impacting the flow of patients through emergency departments. Consequently, this is contributing to the boarding of admitted patients in emergency departments and is impacting negatively on patient waiting times. From a patient perspective, these issues present a risk to safety and are not in accordance with a human-rights based approach to delivery of safe and quality services.

The ability to deliver timely care in emergency departments requires a whole system approach and an appropriately resourced health service. HIQA has identified four key areas that will require focused attention at a local hospital and national level, to support the delivery of safe and effective care within our emergency departments.

Building capacity

The ability to deliver timely care in emergency departments requires a whole system approach to service improvement. It has been repeatedly highlighted that capacity within the health system is insufficient. The primary causes of overcrowding in emergency departments are often due to factors outside the direct control of those working in an emergency department. Consequently, patient flow, both in hospitals and emergency departments, becomes severely restricted when hospital bed capacity and occupancy levels are exceeded. A national shortage of acute hospital beds (as defined by the Capacity Review 2018), persistent high bed occupancy rates, and insufficient access to primary and community care services to meet population demand are among the key contributory factors. In this regard, HIQA welcomes the development of the Three-Year Unscheduled Care (USC) Improvement Programme as set out in the HSE's Winter Plan (2022-2023) that is aimed at addressing many of the problems highlighted in this report. However, primary and acute care services must be adequately resourced and supported at national level to successfully implement the actions outlined in the plan. In the HSE National Service plan 2022, the further planned expansion of home support services is also welcomed to progress the implementation of new integrated models of home and community support.

There remains an urgent requirement to continue to improve capacity both within hospitals and at the acute and primary care interface in order to address the long standing issues which have been highlighted in this report. A key dependency to

accompany additional beds is appropriate medical, nursing and other healthcare staff to support the additional capacity. HIQA recognises the increase in bed capacity across acute and primary care services in 2022. However, HIQA also notes that some of these increases were partly due to the short-term procurement of bed capacity from private providers. While this provides an interim solution, it does not fundamentally address underlying structural deficits in public sector health service capacity in the context of an ever increasing demand for such services. Unless capacity issues are appropriately addressed across primary and acute services, many of our emergency departments will continue to remain significantly overcrowded and patient safety will be compromised.

International evidence shows that greater access to diagnostics for patients in the community reduces referrals to emergency departments and outpatient departments.[23] Healthcare planning must include a detailed assessment of diagnostics, radiology and laboratory service requirements across acute and community care to meet current and future demands.

Reform of health services as set out in Sláintecare[††††]requires the need to move away from the current 'hospital-centric' model of care to an integrated model of care.[24] Alternative care pathways and locations as well as additional step-down capacity, planned based on the health needs of communities on a local and regional basis, must be advanced. This needs to be supported by improved access to primary care services and greater investment and enhanced access to diagnostic services.

HIQA believes that progressing the implementation of the Sláintecare reform plans will support increased capacity and help meet the ever increasing demand for care across the healthcare system. This will in turn potentially ease pressure on emergency departments and acute hospital services more broadly. However, more short-term measures are urgently needed to address the severity of the problem.

Responsive leadership, governance and management arrangements at hospital and group level.

Good governance and leadership is of paramount importance when providing safe, high-quality and reliable healthcare, particularly against the backdrop of the many challenges unique to emergency department. Leadership arrangements within

[††††]The Committee on the Future of Healthcare was established by Dáil Éireann in 2016 with the goal of achieving cross-party, political agreement on the future direction of the health service, and devising a 10-year plan for reform. Sláintecare sets out a vision for a universal single-tier health and social care system where everyone has equitable access to services based on need and not ability to pay.

emergency departments and in other clinical directorates in hospitals need to be clearly defined and should work effectively to enhance patient flow through a comprehensive hospital approach.

HIQA notes that many hospitals had developed plans comprising short, medium and long-term measures to address overcrowding in their respective emergency departments. However, they continued to be challenged in the management of the competing demands of increasing numbers of people who use the service seeking emergency services. HIQA found unprecedented high numbers of attendances to emergency departments. This finding was coupled with issues of ineffective patient flow, limited surge capacity, and inadequate access to diagnostic services contributed to overcrowding. In many of these situations, the normalisation or acceptance of the inevitability of overcrowding affected timely and effective responses to operational changes to alleviate pressures.

There should be responsive leadership, governance and management arrangements at local, regional and national level which acts to address performance issues when identified, rather than be tolerated. HIQA found that in order for these to be effective, they need to be driven by key leadership roles that are clinically led and have continuous oversight structures at executive level within hospitals, at group and national level to ensure they are being enacted in a timely and efficient way.

HIQA believes that effective management arrangements and adequate oversight of systems and processes in place to support patient safety is needed to support hospital's emergency departments to achieve compliance with national standards and performance metrics. Rigorous and regular oversight at group and national level is also required to support operational grip in relation to identified risks and non-compliances with performance metrics. Some hospitals cope better than others with the demands placed upon them and that this is often driven by better local operational management. A collective approach to ownership of this problem across both acute and community services is required and the normalisation of comparatively poor performance should not be accepted.

Workforce

The provision of high-quality health and social care services depends on having a resourced and trained workforce in place at national, regional and local levels. HIQA recognises the many challenges that emergency departments are dealing with in the face of significant medical, nursing and other staff shortages. Workforce shortages are prevalent across many specialties, with hospitals highlighting the many recruitment and retention challenges faced by the healthcare sector.

HIQA believes that a sustained commitment to workforce growth across the system and across professions is required, with regular workforce planning involving all stakeholders. 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. HIQA acknowledges the significant difficulty that some services are having to recruit and retain staff. It is important to note that not all emergency departments inspected were affected by resourcing issues relative to their peers. Moreover, the sample of hospitals inspected had a predominant focus on those which were more challenged by overcrowding – but not exclusively so. In one particular hospital that had full nurse staffing on the day of inspection, it was clear to inspectors that safe and sufficient levels of resourcing has the ability to further engage and support the retention of staff. This demonstrated to HIQA the virtuous benefits of working to maintain staffing levels at the required level, in the interest of a promoting better service to provide care in for staff and patients alike.

HIQA welcomes the funding allocated in the HSE's Winter Plan (2022/2023) to progress phase two of the *Safe Nurse Staffing and Skill Mix Framework* and to prioritise the recruitment of additional staffing in emergency departments, including emergency medicine consultants, registrars and nursing staff. An inability to recruit sufficient numbers of staff threatens the effective delivery of any workforce planning initiative and remains one of the most significant risks facing Ireland's healthcare service today. Workforce planning arrangements must outline actions to address a strategic national approach to current recruitment and retention issues in our healthcare system, as well as future planning in line with projected population and geographical demands.

Effective monitoring and management of patient safety risks

One of the most significant risks observed by HIQA across all of our monitoring work is the presence of overcrowding across the majority of emergency departments inspected. This problem continues to impact negatively on patients and on staff. Delivering care in an overcrowded, understaffed environment poses a significant risk to the provision of safe, quality and person-centred care. Prolonged waiting times in the emergency department have been found to be associated with an increased frequency of exposure to error, increased inpatient length of stay, increased morbidity and mortality and decreased patient satisfaction.[25] Unless adequately addressed overcrowding will continue to limit safe care, reduce privacy and dignity and increase the risk of transmission of infection.

Hospitals need to ensure that there are effective robust systems in place to identify, monitor and appropriately respond to patient safety risks. Hospital management must be assured that all short-term measures for reducing harm associated with overcrowding in emergency departments are appropriately and effectively in place.

HIQA found that the majority of hospitals inspected were non-compliant with national performance indicators for patient experiences times on the day of inspection. Hospital management need to ensure all necessary measures are effectively in place and appropriately escalate concerns when poor performance with patient safety indicators continues to impact the delivery of safe and effective care in emergency departments. While acknowledging the many contributory factors that play into the current overcrowding situation in our emergency departments, there needs to be a further concerted effort by hospital management, with support at hospital group and national level, to ensure that tolerance of poor performance with patient safety indicators does not persist. Behind the statistics relating to trolley numbers and excessive waiting times, are individual patients who are impacted by these conditions. Addressing comparative poor performance requires taking timely actions and providing additional support, as required, when persistent non-compliance is identified. These actions should include strengthened internal controls and processes, access to diagnostics and a focus on early discharges. However, efforts to reduce pressure on the acute care services must also be redoubled in shifting the focus of service provision away from its current over reliance on the hospital-centric model by progressing the Slaintecare plan.

6. Conclusion

The Irish health system is under unprecedented strain and continues to see an increasing number of patient presentations to emergency departments which are significantly higher than in previous years. This identified trend is emerging in the context of a growing, ageing population with unmet need arising from inevitable delays in patient care brought about by the pandemic. The Irish healthcare system remains challenged by bed capacity and workforce shortages, and access and capacity issues in primary care. Consequently, patients are waiting longer for the care they need and as a result national performance targets are routinely missed. Notwithstanding these challenges, and in anticipation that emergency department overcrowding will likely be a feature of our health service in the short to medium term, the safe and effective care of each patient should continue to be of paramount importance to hospital management in advance of the pending winter season.

Through analysis of our inspection findings, HIQA has identified four key areas for both immediate and longer-term attention to address safety issues in our emergency departments. These are;

- The need to continue to urgently build additional capacity within the whole healthcare system, both acute and community, through implementation of the recommendations from the Department of Health's 'Health Service Capacity Review', which was published in 2018. In particular, there is a need to assess capacity requirements at a regional basis as recommended in the Capacity Review and the prioritisation of investment to be informed by the outputs from such assessment. This will also require associated investment in additional supports to aid infrastructural capacity, inclusive of diagnostic services.

- More responsive leadership, governance and management is needed at local, regional and national level, which acts to address performance issues when identified. Such an approach needs to recognise that – notwithstanding contextual challenges – some hospitals cope better than others with the demands placed upon them and that this is often driven by better local operational management. Such an approach should also not only be confined to just acute services. A collective approach to ownership of this problem across both acute and community services in a region, with seamless planning

and a shared approach to escalation in the event of overcrowding is needed. In short, emergency department overcrowding needs to be recognised as a whole health system problem, and the normalisation of comparatively poor performance should not be tolerated.

- A need to advance a more effective approach to strategic workforce planning at local, regional and national level that enables effective anticipation and management of manpower shortages. This acknowledges that recent developments to benchmark and enhance nursing and medical consultant staffing levels in our emergency departments represent an important initial step along this road to improvement.

- More effective identification, monitoring and management of patient safety risks associated with overcrowding in emergency departments, with timely escalation and response to risk within hospitals should they occur. Particular areas for focus should aim to address short-term staffing deficits relative to demand, timely responsiveness to surges in presentation, and close attention to treatment times inclusive of triage times and times to medical assessment.

HIQA recognises that not all issues that emergency departments face can be addressed at a local level. Irish emergency departments are often a window into wider capacity and patient flow issues across the local health service which need to be supported by effective and reactive governance at hospital group, community health area and HSE level. Issues identified in this report require strategic planning to build capacity within our health service and to include alternative pathways in the community to ease pressures on an already strained health service.

A supported and safely staffed emergency department workforce can provide more effective assessment and monitoring of patients and reduce instances of adverse events while patients utilise our healthcare system. The further progression of Sláintecare will help the health service to move away from the current overly hospital centred model of care to an integrated model of care that can support geographically isolated regions of Ireland. The continued development and support of alternative care pathways based on the needs of communities must be advanced. This needs to be supported by improved access to primary care services and greater investment and enhanced access to diagnostic services

HIQA would like to acknowledge the cooperation of hospital staff and patients who spoke with inspectors during the course of our monitoring activity. It was clear that staff in the emergency departments inspected were committed and constantly

striving to provide the best experience to people who use the service in what are very challenging environments. Pressures placed on staff can contribute to burnout, moral injury, and impacts on the health service's ability to retain and recruit staff. Patients met with on inspection emphasised this and reflected the empathy, care and compassion shown to them while in their care.

For patients, overcrowding compromises their dignity, privacy and confidentiality and is not in line with the human-rights based approach to healthcare promoted and supported by HIQA. Delivering care in overcrowded and understaffed environments also poses a significant risk to the provision of safe care. It is for this reason that urgent efforts to progress whole system change to our health service must be progressed.

7. Appendices

Appendix 1: Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance is made under each standard monitored on how the service performed. We include our monitoring judgments in the inspection report and where we identify partial or non-compliance with the standards, we will issue a compliance plan. It is the healthcare service provider's responsibility to ensure that it implements the actions in the compliance plan within the set time frames.

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

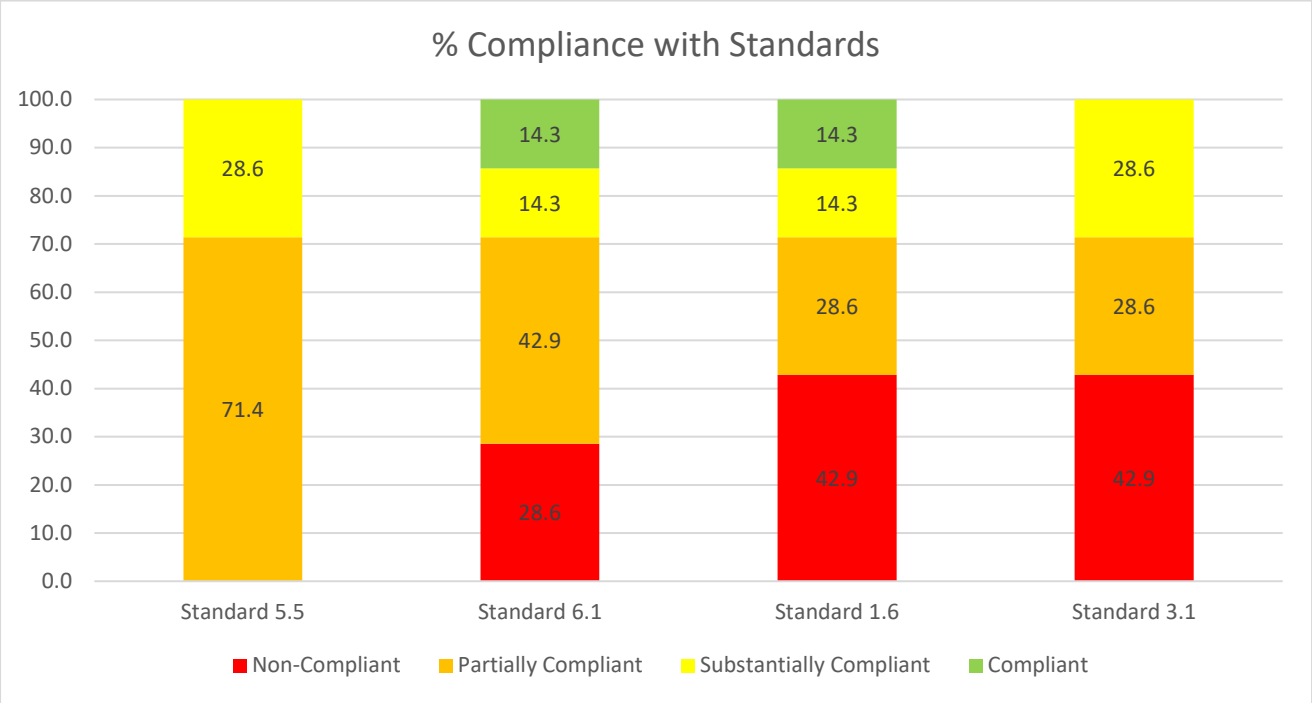
Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant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

Appendix 2: Overview of each emergency department's compliance judgments against the four national standards

Compliant | Substantially Compliant | Partially Compliant | Non-compliant

Standard Number	Standard	Cavan and Monaghan Hospital	Cork University Hospital	Limerick University Hospital	Mayo University Hospital	Sligo University Hospital	St Michael's Hospital	St Vincent's University Hospital
Standard 5.5	Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.							
Standard 6.1	Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.							
Standard 1.6	Service users' dignity, privacy and autonomy are respected and promoted							
Standard 3.1	Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.							

Appendix 3: Summary of percentage compliance judgments of emergency departments against the four national standards



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