University Hospital Limerick
Support Team Report 2024

Introduction

The Support Team wish to acknowledge the engagement, openness and professionalism of all staff encountered over the course of the review. The team met with a wide variety of staff disciplines and grades in both acute and community settings.

Staff are to be commended for their ongoing commitment to patient care despite their levels of fatigue, the ongoing adverse publicity and in the face of persistent overcrowding in University Hospital Limerick (UHL).

Staff are engaged, working to the best of their ability and doing a good job with hundreds of patients receiving excellent care every day in UHL and right across the MidWest.

Notwithstanding the above, it appeared to the Support Team that there was a level of acceptance in relation to the 'intractable' nature of the overcrowding problem in UHL and a corresponding belief that the overcrowding would only be resolved by capacity enhancement.

It is acknowledged that demand for urgent and emergency care in UHL has increased year-on-year. Increases in activity have also been seen in the Model 2 Injury Units and Medical Assessment Units. Increasing demand for urgent and emergency care continues against the backdrop of significant investment in community services in recent years.

The combination of increasing demand, increasing complexity and increasing admissions has resulted in additional pressures on inpatient beds. Undoubtedly with the growing and ageing population, additional bed capacity is required into the future.

HSE Support Team

Under the auspices of the Performance and Accountability Framework, the CEO of the HSE commissioned the Support Team to undertake a review over a 4 week period, to support de-escalation of the site and, in turn, identify any additional improvement actions for inclusion in University Hospital Limerick's 'Quality Improvement Plan' for Urgent and Emergency Care.

The Support Team reviewed the day-to-day functioning of the UHL site and also that of the Model 2 sites and examined the relationship between the Acute Hospital (UHL) and the Mid-West Community Healthcare Organisation (CHO3).

This document sets out high level findings of the review (*pages 2-5*), a proposal to facilitate the de-escalation of the UHL site (*pages 6-7*) together with 10 key actions (pages 8-9) for inclusion in the Improvement Plan for 'Urgent & Emergency Care' in UHL.

High Level Findings

1. Leadership and Governance

The Support Team acknowledges the focus and engagement by the various management teams in respect of patient flow and notes the participation of a significant number of senior staff in the On-Call rota.

The Support Team further recognises the multiples of Meetings / Huddles / Sit Reps that take place over the course of each day and notes the participation of clinical and non-clinical staff from the ULHG sites and CHO3.

Notwithstanding the above, it is unclear from an operational perspective as to who is in charge on the UHL site on any given day. *(Noted that a member of the management team was on leave for the period of the review)*

It is also unclear as to the specific actions identified from the various fora to address patient flow concerns on the day. Furthermore, it is not clear as to what 'Handover Plan' is shared at the day and night interfaces.

2. Pre- Admission

The Support Team notes the range of initiatives / ED avoidance measures in place including Pathfinder, GP at the Front Door, APPCar, ICPOP and signposting to Injury Units and the effect that these have on the ED conversion rate vis- a- vis other Model 4 sites.

Standard Manchester Triage is in use in UHL for adult patients. The Triage Nurse works with the Consultant in Emergency Medicine (EM) to identify potential streaming options for patients. These include referral to the Acute Surgical Assessment Unit (ASAU), Acute Medical Assessment Unit (AMAU) and Geriatric Emergency Medicine Unit (GEMU).

Given the volume of admitted patients in the Emergency Department (overcrowding) and in the various Assessment Units the opportunity for these units to function is non-existent.

There is a separate Paediatric Emergency Department with its own waiting area and triage function. The Support Team noted continued use of the hitherto triage standard for patients under 16 years of age (Manchester Triage) despite the introduction of the Irish Children's Triage System (ICTS) nationally in recent years.

3. Emergency Department (ED)

The Support Team recognise the significant uplift in medical staffing numbers in the ED since 2023 and the positive impact of same in terms of ED operations.

The Support Team acknowledge the introduction of the Emergency Medicine Early Warning System (EMEWS) in January 2024 and the positive impact this has had on patient safety concerns in the department.

The Support Team witnessed the provision of high quality nursing care to patients in very challenging circumstances.

Active engagement and involvement by ANPs and CNSs across all specialties was not visible in the ED.

It was further noted that there are significant vacancies at CNMII level which is a particular concern.

Access to ED Diagnostic Imaging was confirmed as an enabler to patient flow. Staff advised that this represents significant improvement on recent years. The Support Team are of the view that a not inconsiderable number of patients, who could and should access Diagnostics as an outpatient, are admitted (and subsequently experience prolonged lengths of stay waiting for diagnostics).

Senior Clinical staff in the ED noted positively their ability to refer suitable patients to the MAUs in the three Model 2 sites as an effective enabler to admission avoidance.

The Support Team noted the presence of effective hospital admission avoidance pathways in UHL's Clinical Decision Unit (CDU), but noted with concern that this unit was more typically used to accommodate admitted patients, including Oncology, 'End of Life' patients and those requiring isolation.

There was much evidence to support the view that 'decision to admit' is largely made by specialty NCHDs and, in turn, that overcrowding and a 'nervousness' amongst the NCHD group results in a higher conversion rate.

It is the strong view of the Support Team that the ED is adversely impacted by the volume of admitted inpatients in situ, often for very prolonged periods of time.

The ED would undoubtedly function very well if it were permitted to do so.

4. Post Admission

Ward trolleys were present in the majority of wards visited. The policy in relation to use of ward trolleys and step-down of patients on ward trolleys was unclear. The continued presence of ward trolleys places additional pressures on busy acute wards and their staff.

Staffing at ward level was variable and, of note, there was inconsistency in relation to the rostering of CNMs.

The 'Red to Green' system was observed, the team are not convinced of its effectiveness as an enabler to patient flow.

A 'Plan for Every Patient' was not in place for every patient and there were notable delays in access to diagnostics and therapy services for some inpatients. It was further noted that some inpatients remained in-house for extended periods awaiting particular types of diagnostics that could have been availed of as outpatients.

Of particular concern is that it was not always known to ward staff how long a patient had been in the ED or another assessment unit as an admitted patient.

Visibility of Consultants, Senior Nursing Management and Hospital Management in the inpatient clinical areas was limited over the course of the review.

Activity undertaken by ANPs and CNSs to support patient flow at ward level was limited in evidence.

In-reach from Community Services was not in evidence in the clinical areas with the exception of the Community Intervention Team (CIT) and Discharge Coordinators.

It is noted that the majority of engagement between the acute hospital and community colleagues is virtual with no impetus for on-site presence and engagement and addressing issues as they arise.

The Support Team are of the view that greater presence and input from senior nursing management and the senior medical workforce is required to enable more timely responsiveness to patient flow needs.

5. Safe and Timely Discharge

Discharges were largely unknown on any given day. At ward level the Nurse-in-Charge could identify a small number of definite discharges together with a number of queries.

The Bed Management team proactively pursue diagnostics for patients identified as query discharge however more often than not these patients are not subsequently discharged.

There is much anecdotal evidence to suggest that patients have quicker access to diagnostics as part of the 'GP Access to Diagnostics Scheme' than in UHL. There is also anecdotal evidence that suggests that many of the scans being undertaken as part of the scheme are not clinically indicated. The Support Team are of the view that current access to diagnostics for inpatients in UHL serves as a disabler to discharge.

At Bed Management level, the team spoke to the usual number of discharges on each day of the week and were confident of achieving same despite the largely unknown nature of PDDs. PDDs need to be accurate to support the teams managing and operationalising patient flow.

Discharges by 11am were very small in number with often only single digit discharges by early afternoon.

Discharges out-of-hours are significant with greater discharges after 5pm than during the core working day. Poor discharging at weekends predictably results in a congested start for the following week.

It appears to the Support Team that there is often a delay associated with specialty handover. Medical patients are admitted under the Medical Consultant on call who may or may not be physically present on site which can lead to delays in senior decision-making, given that patients may not be seen by their primary consultant until the following day.

In turn, there is often further delay associated with handover of medical patients to a more appropriate medical specialty consultant. There is an urgent requirement to review the Medical rota in line with Consultant work schedules to ensure optimal Senior Decision Making on site to support patient flow.

Transfers to Model 2 sites is a key support to patient flow. The Support Team strongly recommend a targeted number of daily discharges from UHL to each Model 2 site. The current transfer process is hampered by late identification of suitable patients, poor quality and/or non-existent clinical handover or discharge planning, missed opportunities to proactively treat those identified for Model 2 sites and late transport to the sites.

There is engagement with Community Services in relation to Delayed Transfers of Care (DTOCs) and patients with lengths of stay (LOS) over 14 days. Discharge Coordinators from the community do go into the hospital to support and coordinate discharges and the CIT proactively support appropriate discharges.

Rehabilitation Units and Community Nursing Units also support acute patient flow. The Support Team were advised of a number of challenges associated with safe and timely discharge to these units including; deficits in staffing and gaps in clinical governance, resulting in an inability to accept patients from UHL in a timely manner.

The team were advised of patients that had waited in an acute bed in excess of 10 days before transfer to the Community setting.

Length of stay has increased in a number of units in the community and this is for a variety of reasons including acuity, complexity and a greater number of hospital transfers. The Support Team strongly recommend that the issues of safer staffing and clinical governance in these units be addressed as a matter of urgency to support improved flow and throughput.

Whilst comparatively speaking, DTOCs are low for a Model 4 site, precious acute bed days are absorbed by this cohort which is increasing in complexity and proving both difficult and costly to place. Equally, support is needed to keep residents well in Nursing Homes and support ED avoidance.

De-Escalation Proposal

The Support Team proposes a 'full reset' of the UHL site over a two week period in Summer 2024 with a gradual resumption of services thereafter, to support scheduled care, unscheduled care and cancer services into the future.

It was observed by the Support Team that week day demand and capacity requirements in UHL were largely balanced i.e. daily admissions and discharges Monday to Friday were similar.

It was further observed by the Support Team that a significant mismatch occurred at weekends with far greater admissions than discharges on Saturdays and Sundays, resulting in a very difficult starting position on a Monday morning.

This ongoing cycle has resulted in an overcapacity build-up which the site is unable to eliminate given the constant high levels of demand and acuity.

The aim of the 'reset' is to address this historical backlog of inpatients (who at present are on trolleys in ED and at ward level, on trolleys and beds in surge areas and on trolleys and beds in assessment units – hence none of these areas can function as they should, nor can they serve as a release valve for the ED), restore balance and enable daily active management of flow (scheduled care, unscheduled care & cancer services).

The reset will allow the ED and Assessment Units and Day Wards to function appropriately. This will result in a reduced daily conversion rate in ED, reduced daily demand for inpatient beds for unscheduled care and 'real' capacity for scheduled care.

Furthermore, addressing the trolleys in the wards and clinical areas would relieve the pressure on frontline staff and create capacity for them to focus on improved patient flow processes together with the overall patient experience.

It is the view of the Support Team that the 'reset ' can support a shift in the level of acceptance in relation to the 'intractable' nature of the overcrowding problem and demonstrate to front line staff a willingness to adopt extraordinary measures in an effort to de-escalate the site.

The full reset will entail a sole focus on inpatients and unscheduled care for a two week period by all staff across the MidWest region to de-escalate the UHL site *(noting some time critical exceptions).*

Having de-escalated the site, scheduled services would then resume on a gradual basis in line with a new rule-set, revised reporting structures and new team ethos whereby all services and specialties support each other and work together.

An experienced, Senior Operations Manager is required to lead and execute the reset and gradual resumption of services thereafter. The Support Team strongly recommends that this be a Senior Manager from outside of the MidWest Region and that this person be onsite for the duration of the reset.

Directors of Nursing (DON) and Assistant Directors of Nursing (ADON) to take charge of and be responsible for an individual inpatient area for the duration of the reset.

The current senior nurse management resource allows for the DONs and ADONs to work directly with front line staff to optimise discharge and address any impediments to patient flow.

The DONs and the ADONs need to lead on the implementation of a 'Plan for Every Patient' in the inpatient area that they are responsible for on a daily basis.

All inpatient areas to be staffed appropriately with redeployment of staff as and when required.

Consultants and their teams to review their patients every day and be responsive in respect of consults to ensure no delays in the patient journey.

All diagnostic resources to be dedicated to UEC and Inpatients for the duration of the reset.

HSCPs to prioritise patients in accordance with clinical need not location, again to ensure no unnecessary delays in the patient journey. All teams to be staffed appropriately with redeployment of staff as and when required.

Senior staff from Community MidWest to be on site in UHL and the Model 2s for the duration of the re-set to ensure discharge plans are in place for those requiring community supports on discharge, support acute staff in engaging with families and work hand-in-hand with colleagues to ensure that the necessary services and supports are in place to facilitate safe and timely discharge over 7 days.

A targeted number of daily transfers to Model 2 sites to be identified and an SOP to support appropriate transfers to be developed and implemented. Transport to be available to meet demand.

Transfer / Discharge Teams comprising a Porter, a Healthcare Assistant and a Facilities Staff Member to be introduced in UHL to ensure quick turnaround times for acute inpatient beds 24/7.

The Senior Operations Manager is the senior decision maker for patient flow.

The Senior Operations Manager is the singular decision maker who delegates clear actions and timelines and convenes an hourly face to face status huddle with the team.

All staff must be aware of Demand and Capacity on any given day.

Bed Management to have more visible presence in ED and at ward level and be seen as part of the Patient Flow Team working hand-in-hand with Senior Nursing Management and Hospital Management.

Each Model 2 site will be critical to the reset:

- Croom to undertake Trauma only for the two week period with a minimum number of daily transfers to be accepted. No Outpatient or Pre-Assessment activity to be undertaken with all available capacity, including Day Beds, to be utilised to decant from UHL. All diagnostic capacity to be optimised to support UHL.
- Nenagh, Ennis and St. John's to cancel all scheduled activity for the two week period with all available capacity, including Day Beds, to be utilised to decant from UHL. AMU and IU to remain operational and a minimum number of transfers to be accepted daily over the two week period. All diagnostic capacity to be optimised to support UHL.

All community units to ensure maximum capacity with a targeted number of daily discharges in community units, timely transfer of patients from UHL and Model 2 sites and maximum usage of CIT.

Support from the private system to be optimised.

10 Key Workstreams for Action

1. A Hospital CEO, Hospital Director of Nursing and Hospital Clinical Director are required to be on the ground in the hospital to lead and support the various teams in what is a large and very complex organisation, i.e. an onsite Triumvirate Team.

2. A full review of the Medical and Surgical resource is required to ensure that capacity and capability is enabled and optimised right across the MidWest and that appropriate governance and structures are in place to oversee and support same.

3. A full review of the nursing workforce is required to ensure that patient care and patient flow are optimised. Recruitment and retention of front line nursing staff needs to be a priority. Consideration should be given to temporarily pausing the filling of promotional posts to ensure no further denuding of staff nurse and CNM posts.

4. Each 'speciality' to be reviewed by the respective Clinical Director and Directorate Nurse Manager to identify issues of concern that impact on the specialty's ability to proactively see and treat patients and positively impact on patient flow across the MidWest.

   Directorates must work collaboratively to address identified concerns and ensure optimisation of resources and equity of access. (Following the reset significant engagement is required with all clinical and non-clinical stakeholders and their teams to develop short, medium and long term plans for all of the services in the region).

5. A full review of diagnostic demand and capacity is required across the MidWest (acute, community & private). There is no evidence to suggest that available capacity across the MidWest is exhausted to support admission avoidance and safe and timely discharge.

6. All services across the MidWest need to be better integrated to ensure appropriate prioritisation of patients in line with available resource. There are pockets of excellence in both the acute and community settings and yet overcrowding is largely seen as an ED / Medical issue. All staff need to work collaboratively to prioritise, identify, implement and sustain solutions which enhance and support patient flow.

7. In line with the current restrictions in place on recruitment in the HSE each site / location needs to look at existing resources and ensure optimal usage of same. Much concern was expressed to the Support Team regarding front line vacancies at clerical / admin level as well as at HSCP and Nursing levels and in many instances was cited as a disabler to optimal patient flow.

8. The Hospital's 'UEC Escalation Plan' requires revision to ensure that the sequenced actions identified effectively support patient flow, i.e. assessment units need to be able to function, scheduled care needs to continue, use of private capacity needs to be incorporated, staffing resource to focus on patient flow needs to be included etc.

9. The Support Team strongly recommend a review of the use of space in UHL and indeed right across the group to ensure optimisation of the clinical footprint.

10. A review of ICT (Data & Analytics) is required to ensure timely access to and sharing of data amongst key stakeholders. It is clear that there are a number of systems in place but it is equally clear that not all 'talk to one another' and the fact that systems are largely standalone supports a siloed approach in the hospital. Bed Management undertake much manual data work which detracts from visible presence and engagement with the ED and appears to result in 'batch' allocation of inpatient beds. In addition there is concern regarding 'paper lists' used for patient handover.

END