

2023

Development of a Framework of Key Metrics with clear triggers and actions to ensure the triage of patients presenting to Emergency Department is in line with best practice and that patients are reviewed with subsequent treatment commencement and placement (accommodation) in a timely and generally appropriate manner

and

Development of a Framework which identifies clear points of escalation of risk aligned with clear governance and responsibility for risk mitigating actions in regard to Unscheduled Care Performance

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1 Introduction

The health system has faced unprecedented pressures in recent times due to a confluent rise in COVID 19, influenza and Respiratory Syncytial Virus (RSV) As part of the ongoing response, the Chief Clinical Officer has commissioned work to give greater focus to the safety of patients within Emergency Departments

1.1 Purpose

The purpose of the work is to develop a set of national principles building on current guidance, development of a framework of key performance metrics with clear triggers and subsequent actions to ensure the triage of patients presenting to ED is in line with best practice and that patients are reviewed with subsequent diagnostics and treatment commencement and placement (accommodation) in a timely and generally appropriate manner.

1.2 Scope

The scope of work has a priority focus on the safety of patients in Emergency Departments and the development of a pan-system framework which identifies clear points of escalation of risk aligned with clear governance and responsibility for risk mitigating actions within the hospital. This framework to be aligned with established relevant HSE procedures, systems and targets:

- *System Wide Escalation Framework and Procedure (HSE 2015)*
- *Performance and Accountability Framework (HSE 2023)*
- *Irish National Early Warning Systems (HSE 2020)*
- existing performance targets both pan-system and Emergency Department specific

and specific findings from:

- *Monitoring Programme against the national standards in Emergency Departments 2022 - Overview report (HIQA 2022)*
- *Hospital Performance: An Analysis of HSE Key Performance Indicators (Clancy et al 2023)*
- *National Clinical Audit of Emergency Department Triage Report (HSE 2023)*
- Recommendations from the Emergency Medicine Programme about formally recognising the post-triage phase of care, often beginning at triage

1.3 Working Group Membership

- | | |
|---------------------|--|
| - Ian Carter | CEO RCSI Hospital Group |
| - Gerry McCarthy | National Clinical Lead, Emergency Medicine Programme |
| - Geraldine McMahon | Professor in Emergency Medicine, St James Hospital |
| - Fiona Brady | General Manager, OLOL Drogheda |
| - Petrina Donnelly | Chief Director of Nursing and Midwifery, RCSI HG |
| - Karen McGowan | Advanced Nurse Practitioner, Beaumont Hospital |
| - Pat Nash | Clinical Director, Saolta Hospital Group |
| - Mike O'Connor | National Clinical Advisor, Acute Operations |
| - Grace Rothwell | Chief Officer, South East Community Healthcare |

As such this paper considers current Unscheduled Care performance, existing general hospital system accountability framework, action triggers, points of risk escalation particularly in regard to the safety of patients in Emergency Departments and articulates a series of recommendations in these regards.

2 Context - Emergency Departments

2.1 International

Multiple studies have identified increased risk event occurrence likelihood and increased mortality associated with Emergency Department overcrowding predominantly arising from a lack of acute bed accommodation (**Sprivulis et al 2006**), (**Richardson 2006**), (**Plunkett et al 2011**), (**Palling et al 2020**), (**Black 2022**) and (**Jones et al 2022**). Sprivulis (2006) specifically identifies errors being more likely when ED systems are stressed, which includes: longer physician waiting time to assess patients, delays in the initiation of care, inadequate patient observation and that this significant risk likelihood potential continues once 'admitted' to non-designated patient accommodation areas

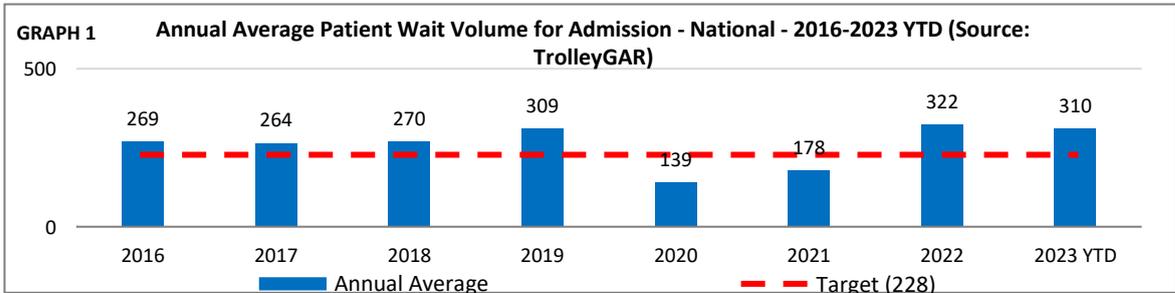
2.2 Ireland

HIQA whilst recognising an increasing number of ED patient presentations resultant from a growing and ageing population, the subsequent direct need to promptly advance building of additional bed capacity and in parallel a requirement to majorly shift health care delivery from hospital-centric to community centric. They also specifically identify with regard to Emergency Departments: (1) insufficient staffing levels (2) HSE Surge Capacity protocol being consistently severely compromised (3) current actions to manage overcrowding in Emergency Departments are not fully effective and (4) the need for ‘a further concerted effort by hospital management..... to ensure tolerance of (continuing) poor performance does not persist’ (HIQA 2022: 32). In this regard, Clancy in a recent review of HSE unscheduled care performance also identifies poor ED wait times and volumes as being persistent and that introduced interventions would appear to have been largely ineffective (Clancy et al 2023: 2) This review also identifies the significant risk potential in regard to uncompleted treatments within Emergency Departments (Did not Wait) with 12 hospitals exceeding HSE target (< 6.5%)

3 Performance - 2016-2023

3.1 TrolleyGAR (HSE) 2016-2023 YTD (Graph 1)

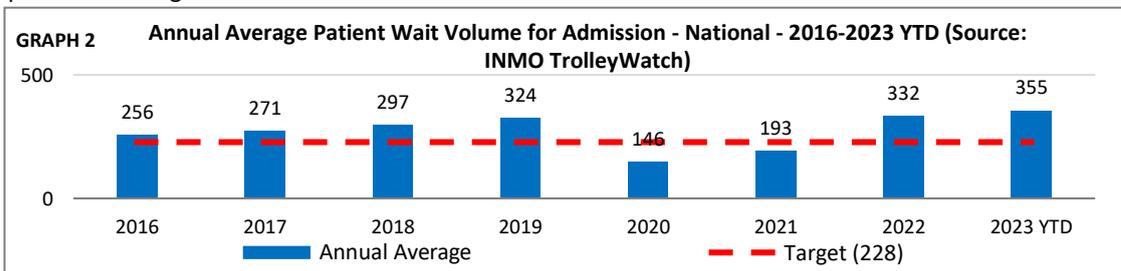
TrolleyGAR (HSE) value is defined as the number of patients awaiting emergency admission to a designated inpatient area @ 08:00, 14:00, 20:00 (measured 7/7) which must include patients awaiting admission in ED, on trolleys, and all non-designated patient accommodation areas (HSE 2022). Graph 1 identifies annual national average patients wait volume for admission 2016-2023 YTD



- demonstrating:
 - national target (n=228) consistently exceeded over reporting period with the exception of peak COVID-19 period
 - 15% increase in number of patients waiting for admission (2016 / 2023 YTD)

3.2 Trolley Watch (IMNO) 2016-2023 YTD (Graph 2)

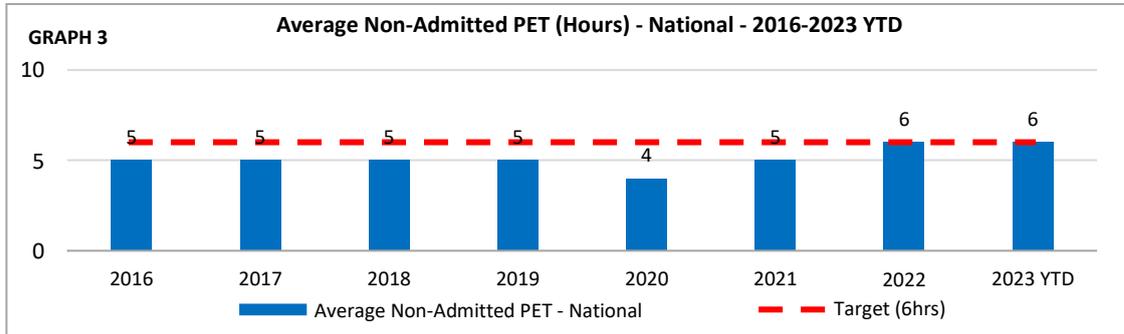
Trolley Watch is defined as the number of patients identified as requiring inpatient accommodation, but who are waiting for a free bed in a designated ward area @ 08:00 (measured 5/7). This includes patients waiting on trolleys in ED, in corridors, on chairs, in waiting rooms and accommodated on wards above designated bed compliment (INMO 2022). Graph 2 identifies current annual national average of patients waiting for admissions 2016-2023 YTD.



- demonstrating:
 - national target (n=228) consistently exceeded with the exception of peak COVID-19 period
 - 3% - 13% range increase in comparison with TrolleyGAR values - this can be attributed to (1) specific variance within 4 hospitals (2) the inclusion in Trolley Watch values of patients waiting for ward bed accommodation in 3 hospitals without Emergency Departments and the exclusion in TrolleyGAR values of patients accommodated in a ‘surge bed space’ (HSE 2022) as opposed to designated ward bed accommodation

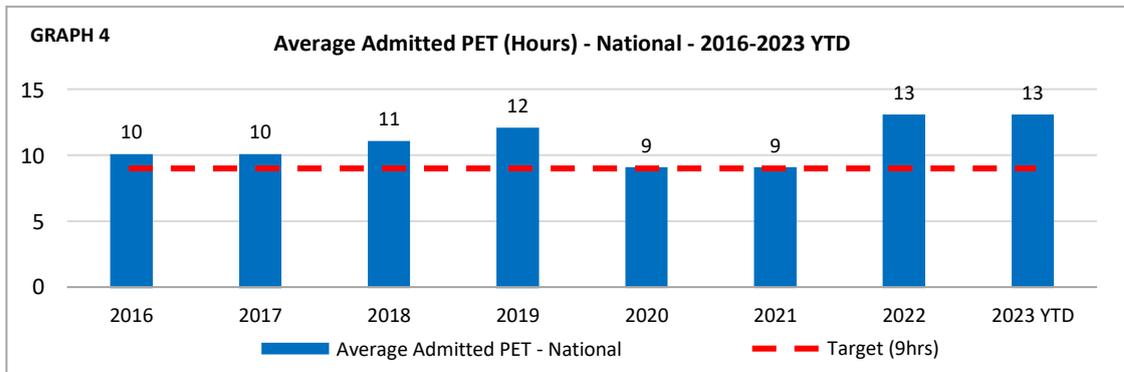
3.3 Patient Experience Time

Patient Experience Time is defined as period commencing when the patient is registered in the Emergency Department to the time the patient leaves the Emergency Department. **Graph 3** identifies national average Patient Experience Time for non-admitted patients.



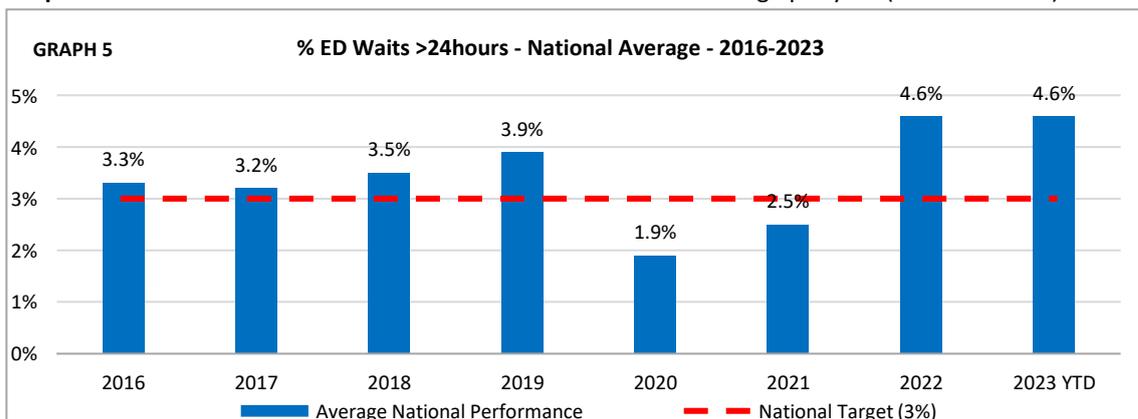
- demonstrating:
 - national average PET generally not exceeding PET target (6 hours)
 - 20% increase in non-admitted PET over reporting period (2016 / 2023 YTD)

Graph 4 identifies national average Patient Experience Time for admitted patients.



- demonstrating:
 - national average PET consistently exceeding target (9 hours) with exception of peak COVID-19 period
 - 30% increase in wait time average over reporting period (2016 / 2023 YTD)

Graph 5 identifies % ED Waits >24 Hours All Patients - National Average per year (2016-2023 YTD)



- demonstrating:
 - national annual average % of patients wait >24hours for admission consistently exceeding national target (3%) with the exception of peak COVID-19 period
 - 39% increase in % waits > 24 hours over reporting period (2016 / 2023 YTD)

As such over the period 2016-2023 performance has significantly deteriorated with a 15% increase in the number of patients waiting in ED for ward bed accommodation, a 30% increase in waiting time for ward bed accommodation and a 39% increase in % patients waits > 24 hours

4 Consideration of HSE System Wide Escalation Framework and Procedures (HSE 2015) and HSE Performance and Accountability Framework (2023)

4.1 HSE System Wide Escalation Framework (HSE 2015)

Framework designed with the intention in supporting Hospitals to develop their own integrated escalation plans.

As such a system wide escalation framework intended to address compliance with national performance indicators and the Escalation Directive. Specifically, that patients are assessed, treated, and admitted or discharged within 6 hours. With a 'Steady State' being described as where there is timely access to emergency care and treatment - 95% < 6 hour wait and 0 waits > 24 hours.

Key triggers, active or threatened, being:

- all breaches of 9 hours waiting for admission
- potential of a red TrolleyGAR return at any point during the day
- patients waiting > 6 hours from time of registration

Framework also identifies application of a 'Special Measure' when all other corrective steps have been undertaken, to ensure performance compliance, without success. This being Final Stage Full Capacity Protocol, which includes the accommodation of patients on "extra beds / trolleys" within inpatient wards.

The Framework requires notification of:

- all levels of escalation via TrolleyGAR reporting system to the SDU
- activation of Full Capacity Protocol to the Joint Chairs of the ED Forum via the SDU and as a notifiable Serious Reportable Event (SRE)

Assessment and Sanction Application

Framework identifies if there have been persistent (but unspecified in terms of actual occurrence volume / time period considered) breaches of > 9 hour for admission target, excessive Patient Experience Times, red TrolleyGAR returns at any of the formal reporting times, the SDU have the authority to conduct a full independent review and if it cannot be determined that all such necessary measures have been undertaken by the Hospital / Hospital Group, then a €10,000 financial deduction will be applied for each event occurrence.

In these regards it should be noted:

- (1) all hospitals, bar one, are routinely satisfying TrolleyGAR reporting system requirements
- (2) no specific targets within this Framework are identified in regard to Emergency Department registration-triage, triage-patient assessment and patient assessment - treatment commencement times. As such predominant focus is the number of patients waiting for ward accommodation
- (3) there remains significant variance between TrolleyGAR and Trolley Watch values (see Section 3 Performance)
- (4) Full Capacity Protocol appears rarely used regardless of evident ED trolley wait volume
- (5) according to this Framework all Level 4 hospitals and most Level 3 hospitals are in a general state of escalation, as such apparently inappropriately 'managing the normal as a surge' (HSE 2015) (see 6)
- (6) Special Delivery Unit / Performance Management Improvement Unit do not routinely undertake a formal full independent review (published) for all persistent breaches in every hospital
- (7) budget deduction for each individual breach event not applied since introduction of this framework - noting whilst financial penalty not applied, its identification in this manner, would seem to be based on the premise that application of appropriate energies and efforts in regard Control and Capability only are perceived to be sufficient to ensure 'Steady State' access targets
- (8) whilst recently the HSE (HSE 2020) have cited Mears (Mears 2014) as a rationale for TrolleyGAR patient volume measurement as not being a useful measure because it can introduce 'gaming'. This is an erroneous interpretation in that the primary reason for ED related access block internationally is a very specific lack of directly available acute bed accommodation (Sprivluis 2006). As such TrolleyGAR enables routine quantification of a problem where the solution does not lie within the Emergency Department (Richardson 2006)

- (9) current performance presents a quandary, in that setting a challenging, but achievable target is critical, however once a target has been identified as needing to be achieved (politically), regardless of whether it is in fact achievable *'there is no way back after that'* (Berry et al 2015)

Points (2),(3),(4),(5),(6),(7) would suggest a generated general tolerance of current performance

4.2 HSE Performance and Accountability Framework (HSE 2023)

Escalation

Within the Performance and Accountability Framework there are provisions for the formal escalation of Individuals, Hospitals / Hospital Groups that are not achieving National performance expectations as set in the National Service Plan 2022/2023 (see Table 1)

Specific Key Performance Indicators relating to Emergency / Unscheduled Care - National Service Plans 2022 / 2023

TABLE 1 National Service Plan 2022	National Service Plan 2023
<p>Emergency Care and Patient Experience Time</p> <ul style="list-style-type: none"> - % of all attendees at ED who are discharged or admitted within six hours of registration - % of all attendees at ED who are discharged or admitted within nine hours of registration - % of ED patients who leave before completion of treatment - % of all attendees at ED who are in ED <24 hours - % of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration - % of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration - % of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration <p>Ambulance Turnaround Times</p> <ul style="list-style-type: none"> - % of ambulances that have a time interval ≤30 minutes from arrival at ED to when the ambulance crew declares the readiness of the ambulance to accept another call (clear and available) 	<p>ED Patient Experience Time</p> <ul style="list-style-type: none"> - % of all attendees at ED who are discharged or admitted within six hours of registration - % of all attendees at ED who are discharged or admitted within nine hours of registration - % of all attendees at ED who are in ED <24 hours - % of all attendees aged 75 years and over at ED who are discharged or admitted within six hours of registration - % of all attendees aged 75 years and over at ED who are discharged or admitted within nine hours of registration - % of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours of registration <p>NAS to ED Handover Times</p> <ul style="list-style-type: none"> - % of patients arriving by ambulance at ED to physical and clinical handover within 20 minutes of arrival

With underperformance being performance that:

- places patients at risk
- fails to meet required standards for a service
- departs from what is considered acceptable practice

Level of Escalation

Five levels of escalation in regard to hospitals are identified:

TABLE 2 Level 0 [Accountable Officer]	Level 1 [Accountable Officer]	Level 2 [Accountable Officer]	Level 3 [ND. AO]	Level 4 [COO]	Level 5 [CEO]
Steady state Performance is being achieved against plan.	A variance emerges. A variance from plan is identified and intervention and support in response to early signs of difficulty is managed at a provider level	The variance is not improving. The variance from plan is not improving despite intervention and support in response to early signs of difficulty being managed at a provider level.	The problem persists. It becomes harder to fix and potentially spreads to other organisations. Intervention and support are required. The Rule set is: <ul style="list-style-type: none"> • A variance of 20% from plan, and/or • Persistent performance issues, and/or • Strategic issue. 	The problem becomes critical or where prolonged underperformance puts quality, safety and financial sustainability at risk. The performance issue persists and the organisation has failed to reverse underperformance. Significant intervention is required.	Significant governance or organisational risks are identified that affect the functioning or reputation of the health service The actions determined by NPOG do not achieve the necessary impact and action is required by the Chief Executive Officer.
Performance subject to routine performance monitoring by the relevant accountable officer.	Performance subject to focused performance monitoring by the relevant accountable <u>officer</u> .	A decision to escalate an area of underperformance in individual services under their remit <i>is made by</i> HG.CEO	A decision to escalate an area of underperformance in individual Hospital Groups <i>is made by</i> ND. AO. Support from PMIU will typically be deployed at the discretion of the ND	A decision to escalate an area of underperformance <i>is made by</i> the COO. External supports, interventions or sanctions may be required. The PMIU may be commissioned to lead on specific improvement initiatives.	A decision to escalate the significant governance or organisational risks <i>is made by</i> the COO or CEO

Note¹: The levels of escalation do not necessarily indicate the seriousness of a particular performance issue, but rather the need for the organisational response to be led at a more senior level. This may reflect either the capacity or capability of other levels to manage the improvements required. For example, performance issues at LEVEL 1 may be as serious as performance issues at LEVEL 5, however there is confidence that these issues, but rather are being managed appropriately by the relevant accountable officer.

4.2.1 Consequences of Escalation where remedial actions do not work - Interventions.

If performance does not improve, despite on-going monitoring and support, or where plans that have been committed to are not being delivered upon, specific interventions may be put in place by the relevant accountable officer, National Director, the Chief Operations Officer or the Chief Executive Officer. These interventions include;

- enhanced monitoring through formal review meetings with the relevant line manager
- additional controls being put in place
- setting out, in writing, the explicit performance requirements, arrangements for monitoring and consequences where performance does not improve
- commissioning of an external Improvement initiative through the PMIU, performance or governance diagnostic review
- performance meetings with the National Director and the Chief Operations Officer culminating in a set of performance expectations and requirements, which may include additional improvement actions and expectations, supports, interventions or sanctions.

4.2.2 Consequences of Escalation where remedial actions do not work - Sanctions: Service Level

Sanctions which can be applied at a service level include:

- a **formal Performance Notice** will be issued to the relevant service from the appropriate accountable officer. Performance notices will specify the reason for the notice, the performance improvement expectation, timeframe, accountability arrangements and consequences where there is insufficient improvement.
- an **organisational Performance Improvement Plan** will be required on foot of a



Performance Notice.

- where improvement is not seen within the timeframe set out in the first Performance Notice or where actions agreed have not been implemented a Second Performance Notice will be issued. The time between the issuing of the first and second performance notice will vary depending on the nature of the performance issue that has been escalated.
- a decision to issue any Performance Notice must be notified to NPOG.

4.2.3 Consequences of Escalation where remedial actions have not worked - Sanctions: Individual Manager Level

Performance of an individual manager needs to be directly addressed in the following situations:

- performance issues continuance and there is no apparent underlying rational for underperformance
- previously agreed interventions have not been undertaken by the manager

In either of these two circumstances the formal Performance Achievement Process is invoked:

- manager is advised in writing of their specific underperformance
- manager to produce and agree an Individual Performance Improvement Plan
 - this plan sets out **(1)** performance expectations **(2)** support provisions **(3)** specific actions, deliverables and timeframe for achievement **(4)** monitoring provisions **(5)** consequences where performance does not improve in line with Plan
- where there continues to be underperformance following commencement of Performance Achievement Process this can ultimately culminate in disciplinary actions in accordance with HSE Disciplinary Policy which can include removal of manager from post and / or to other duties

As such current unscheduled care national performance during 2022-2023 would appear to match either Level 3 or Level 4 Escalation status criteria in that:

- problem is critical
- under performance puts quality and safety substantially at risk
- prolonged under performance presents significant organisational risk that majorly impacts the functioning of the hospital service

However, in terms of formal escalation or sanction application in regard to Unscheduled Care performance HSE Acute Operations have identified during 2022 - 2023:

- no individual Hospital manager has experienced any sanction application or has been required to develop an agreed individual Performance Improvement Plan
- no individual, Hospital or Hospital Group has been escalated to Level 5
- no individual, Hospital or Hospital Group has been escalated to Level 4
- only 1 hospital out of 26 acute hospitals has been formally escalated to Level 3
- only 2 hospitals were identified as a 'focus site' with an HSE / PMIU team for direct support

5 Considerations of Key Findings from Emergency Department Triage Report (HSE 2023)

The report identifies:

- (1)** a wide range in % of patients triaged within 15 minutes across the hospitals:
 - during daytime hours - 21% - 76%
 - during nighttime hours - 11% - 85%
 - an average 37% of patients were timely triaged during daytime compared to 42% during night time
- (2)** 9% of all cases considered were identified as under-triaged - the main category being associated with under-triage being category 3 which should have been category 2 (61%)
- (3)** 10% of all cases considered were identified as over-triaged
- (4)** in terms of assessing whether correct Triage flowchart was assigned, if the correct Triage category acuity was assigned and if the triage process was complete none of the criteria met the standard of 95%
- (5)** in all hospitals there was a designated trained triage nurse

6 Consideration of HSE Emergency Medicine Early Warning System - EMEWS (DOH 2018)

EMEWS was developed in response to significant concerns that within Irish Emergency Departments there were patients at risk of clinical deterioration between the time triaged and time assessed by Clinician and that there may be delay in recognising this deterioration if the patient is not appropriately monitored. These patients have presented with undifferentiated, undiagnosed conditions with potential for rapid physiological change and have only been assessed once in the Emergency Department at triage.

EMEWS can be used to detect the deterioration of patients after triage when implemented as part of the “*post-triage phase of care*”. The implementation of electronic monitoring technology would assist nursing staff in adhering to monitoring frequency and in alerting them to escalation trigger points. However, wearable technologies cannot replace the therapeutic interaction or clinical decision making of face-to-face contact with the patient. It is intended that the Acute Floor Information System will enable electronic capture of ED monitoring data and the range of patient information included in the EMEWS Chart

A patient’s triage prioritisation can be updated or amended at any point prior to receiving review by Treating Clinician. This may be prompted by a change in a patient’s clinical condition or symptoms identified through the EMEWS review process.

Aim and objectives of EMEWS

The purpose of this standardised Emergency Medicine Early Warning system is to improve the recognition and response to clinical deterioration in adult patients in the ED.

EMEWS will:

- ensure the safe, timely and appropriate monitoring and management of adult patients from triage through to assessment by a Treating Clinician and until they are discharged or admitted
- enhance the quality of adult patient care through a standardised, structured approach to ED patient monitoring
- assist in the overall management of clinical risk and improved quality of patient care
- reduce patient concerns and enhance satisfaction with the service
- represent a standard for service provision and facilitate service auditing and monitoring of the safety and quality of care in the ED.

Implementation of the Clinical Escalation framework from EMEWS will ensure:

- an agreed approach to the recognition of and response to clinical deterioration for adult patients in all EDs in Ireland
- alignment of Clinical Escalation with triage practice
- a consistent approach to Clinical Escalation from patient triage to discharge or admission
- inclusion of criteria that are particularly clinically significant in the ED setting.

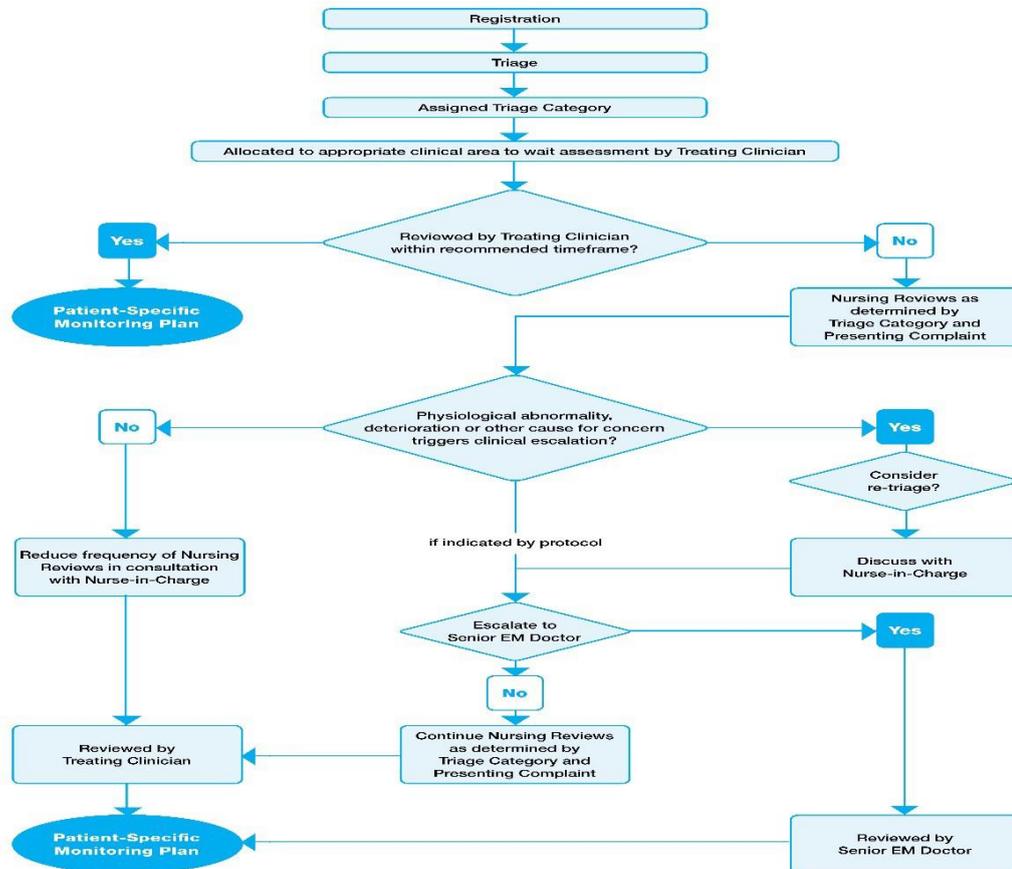
Elements of EMEWS

EMEWS is composed of 5 different elements

- Triage
- a process for Post-Triage Emergency Nursing Reviews
- a method for inter-professional communication using the ISBAR Tool
- a template for prescribing a Patient-Specific Monitoring Plan
- an approach to Clinical Escalation in the ED.

FIGURE 1 outlines how patient care follows a clinical pathway from Triage through Post- Triage Monitoring until the development of a Patient-Specific Monitoring plan following review by a Treating Clinician.

FIGURE 1: Emergency Nursing Review process following triage to time assessed by Treating Clinician



The use of structured communication tools has been shown to improve communication during handover and in stressful situations. ISBAR is the structured communication tool identified for use in Acute and Children’s Hospital Services

Two types of ISBAR are used in the ED:

ISBAR Urgent Escalation of Care		ISBAR ₃ Shift and interdepartmental clinical handover	
I	Identify	I	Identify
S	Situation	S	Situation
B	Background	B	Background
A	Assessment	A	Assessment
R	Recommendation	R	Recommendation
		R	Read back
		R	Risk

Responding to the deteriorating patient in the ED

Providing a timely and effective clinical response to a patient’s physiological condition or deterioration is at the core of EM practice. The ED team will provide immediate resuscitative care for all patients who require it within the ED whether they are under the care of a Consultant in EM, an admitting team or are in the process of referral.

Clinical Escalation across the patient journey through the ED

Escalation after a patient has been seen by a Treating Clinician will be routinely progressed through the Nurse-in-Charge and then directly to the Senior Doctor or to the doctor caring for the patient. This doctor should request Senior Doctor Review if concerned regarding the patient’s condition and management (Figure 1) outlines this process. Registrars / Specialist Registrars should escalate to the Consultant in EM on site / off site if they have any concerns regarding a patient’s care, who may consult with their in-patient Consultant colleagues in response to concerns regarding a patient’s physiological status that is not responding to treatment

7 Recommendations of Working Group

7.1 Operational

Development of a local Hospital Escalation Framework

- ensure development of a local robust Hospital Escalation Framework focusing on the Emergency Department with appropriate triggers, actions, escalation and control. **Table 3** provides a framework in this regard

Table 3 Focus	Triggers	Examples of Actions/Responses	Examples of Further Escalation
Ambulance Turnaround Time	X ambulances waiting longer than 30 minutes for Clinical Handover	Extra wheelchairs and trolleys. Extra Nurse assigned to Clinical Handover. Liaise with Hospital Ambulance Liaison Officer (HALO) ADON Patient Flow	Senior Hospital and NAS Management
Time to Triage	X patients waiting > 20 minutes for Triage	Redeploy extra triage qualified nurse	Escalate to ADON Patient Flow and Consultant in EM
ED Crowding	X Admitted Patients waiting Y time for transfer to an inpatient bed after Decision to Admit X Patients awaiting Y time for First Clinician Assessment after Triage	<ul style="list-style-type: none"> Suitable admitted patients identified by team lead and ADON Patient Flow for transfer to ward area on trolleys. Resources identified to move patients to ward ASAP Team lead to ensure assessment cubicles and assessment teams are available. 	Senior Hospital and NAS Management
Resuscitation room (Resus)	<2 Clinical spaces available for new patient assessment "Standby" received for patient en route to resus with no resus space available	<ul style="list-style-type: none"> Resuscitation team nurse lead informs CNM2 CNM2 to link with Registrar or Consultant in EM to identify patients suitable to move out of Resus CNM2 escalates to CNM3, Consultant in EM and ADON patient flow ADON to consider escalation to senior management 	Urgent escalation as agreed locally e.g. contact Clinical Director to deal with a critical situation
Time to First Clinician Assessment after Triage	Triage category 2 patients X Triage category 2 patients waiting > Y minutes outside of Resus for First Clinician Assessment	<ul style="list-style-type: none"> CNM3 to ensure EMEWS assessment is in operation Safety huddle to ensure all staff aware Registrar in EM & nurse lead to perform desktop review of Category 2 patients – re-triage where appropriate (EMEWS) & establish priorities, including identification of each patient's urgent needs. Allocate resource according to patients' needs: -simple (e.g. reduction of joint dislocation) -intermediate (e.g. patient with chest pain and normal ECG) -complex (apparently high acuity undifferentiated after triage) -direct specialty referral/admission indicated Nursing lead to ensure assessment cubicles are available and doctor/nurse team functional to speed up assessment 	Consultant in EM On-call to review situation. If immediate de-escalation not possible: -allocate waiting Cat 2 patients to: -Simple, intermediate or complex and allocate resource appropriately -Refer directly to particular on call teams to expedite patient review until situation deemed stabilized -Contact Clinical Director
	X++ category 2 patients waiting > Y minutes for First Clinician Assessment	Consider activation of Hospital Major Emergency Plan specifically for ED congestion (see recommendation below this table)	
	Category 3: >X waiting >Y for First Clinician Assessment after Triage	<ul style="list-style-type: none"> CNM3 to ensure EMEWS assessment is in operation Registrar or Consultant in EM to refocus ED NCHDs to reduce assessment times Team lead to ensure assessment cubicles are available and doctor/nurse teams functional to speed up assessment Move patients to wards if congestion trigger applies Formal Risk Assessment to be completed by CNM/ADON 	



Specialty Referral	>xhr from the time of referral for any patient	Escalation within the particular specialty in the first instance	Contact Clinical Director
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Hospital Major Emergency Plan in regard to ED Congestion

- devise a Hospital Major Emergency Plan specifically for ED Congestion incorporating appropriate and effective escalation actions, in the expectation that it will rarely, if ever, need to be used. Existing Major Emergency Plans are designed for incidents external to the ED or infrastructural damage in the ED, not problems with patient flow.

Emergency Medicine Early Warning System

- Emergency Medicine Early Warning System should be introduced across each of the EDs with the use of electronic monitoring technology. IT systems should support and reflect any changes to the triage category - recognising this implementation will require both once off and recurrent funding on a site by site basis

Post-Triage of Care

- formal recognition and development of the post-triage phase of care
 - this includes streaming and rapid assessment process:
 - investigations should be front loaded with necessary 7/7 capacity to enable this
 - straightforward admissions should be fast tracked to the relevant speciality if clinically stable.
 - agreed pathways of care for common clinical presentations such as STEMI, Stroke, DVT, Hip Fracture must be adhered to

7.2 Governance / Control / Accountability

HSE Performance and Accountability Framework

- review current application of this framework in regard to Unscheduled Care Performance particularly concerning requirements for Escalation, Intervention and Sanction

HSE Systemwide Escalation Framework

- review current framework with a general requirement to update particularly in regard to the specific work of the PMIU - nothing this framework should align with the HSE Performance and Accountability Framework

7.3 Measurement / Audit

Patient Experience Time

- Hospitals must be able to readily track in real time, through appropriate ICT supports, wait times between key events within the ED:
 - Registration → Triage
 - Triage → Post-triage assessment/treatment initiation
 - Admission decision → bed placement
- where a patient has left ED, but has been inappropriately placed i.e. corridor or additional to ward complement, the time spent in this space should be included in the total experience time (until the patient is appropriately accommodated in a ward bed)

Patient Awaiting an Inpatient Bed

- TrolleyGAR must be consistently completed by all hospitals
- real-time numbers 24/7 of patients awaiting a bed needed for situation management and escalation without waiting for national TrolleyGAR returns
- undertake validation exercise in regard to evident variance between HSE TrolleyGAR and INMO Trolley Watch and ensure subsequent on-going accuracy particularly in regard to temporary usage of deemed appropriate spaces for patient accommodation

ED Clinical Audit

- all recommendations from the National Clinical Audit of Emergency Department Triage should be progressed particularly in regard to triage training and periodic audit.

Specific Review of Patients who Leave Before Completion of Treatment (LBCT).

- it is reasonable to infer that there is a correlation between ED congestion/long waiting times and patients choosing to leave before completion of treatment. The Emergency Medicine Programme has published detailed guidance on consideration management of this patient cohort. It is recommended that a review of the records of these patients for one calendar month be performed by all Emergency Departments.

7.4 Emergency Department Staff Recruitment

Whilst arguably not within the terms of reference of this Working Group, it is important to recognise that desired performance improvements are unlikely to be achieved without necessary staff and skill mix. Accordingly there is a requirement to promptly progress, secure and maintain:

- specific recommendations as identified by the Task Force on Staff and Skills Mix for Nurses in Adult Emergency Care Setting (**DOH 2022**)
- full deployment of new tranche of Emergency Medicine consultants identified for progression in 2022
- maintenance of funded NCHD complement as pertaining to each Emergency Department

REFERENCES

- Berry, N.** (2015) *On targets; How targets can be more effective in the English NHS*
The Health Foundations
- Gardner, T.**
- Anderson, I.**
- Black, S.** (2022) *Long delays to admission in Emergency Departments cause higher mortality*
British Journal of Hospital Medicine Volume 83, No 3 Editorial
<https://doi.org/10.12968/hmed.2022.0090>
- Clancy, C.** (2023) *Spending Review 2022*
Hospital Performance: An analysis of HSE Key Performance Indicators
Irish Government Economic and Evaluation Service
Research Services & Policy Unit
Department of Health
<https://assets.gov.ie/249873/6f1ca97d-d151-4475-8b88-8cbec8f9d34c.pdf>
- Shine, C.**
- Hennessy, M.**
- Department of Health** (2018) *Emergency Medicine Early Warning System (EMEWS) National Clinical Guideline No.18*
- Department of Health** (2022) *Final Report and Recommendations by the Taskforce on Staffing and Skillmix for Nursing Framework for Safe Nurse Staffing and Skillmix in Adult Emergency Care Setting in Ireland - 2022*
- Health Information and Quality Authority** (2022) *Overview Report: Monitoring Programme against the national standards in Emergency Departments in 2022*
<https://www.hiqa.ie/sites/default/files/2022-12/Healthcare-overview-report-2022.pdf>
- Health Service Executive** (2015) *HSE System Wide Escalation Framework*
- Health Service Executive** (2020) *Report of the Independent Review of Unscheduled Care Performance (2020)* (unpublished)
- Health Service Executive** (2020) *Performance and Accountability Framework*
<https://www.hse.ie/eng/services/publications/serviceplans/service-plan-2020/performance-and-accountability-framework-2020.pdf>
- Health Service Executive** (2022) *SDU/PMIU TrolleyGAR / SBAR System Guidance Document*
- Health Service Executive** (2023) *National Clinical Audit of Emergency Department Triage Report*
HSE National Centre for Clinical Audit in collaboration with National Emergency Medicine Programme
- Irish Nurses & Midwifery Organisation** (2023) *Trolley Watch*
https://www.inmo.ie/Trolley_Ward_Watch
- Jones, S.** (2022) *Association between delays to patient admission from the emergency and all cause 30-day mortality*
Emergency Medicine Journal 2022; 39; 168 -173
<https://emj.bmj.com/content/emered/39/3/168.full.pdf>
- Moulton, C.**
- Swift, S.**
- Molyneux, P.**
- Black, S.**
- Mason, N.**
- Oakley, R.**
- Mam, C.**
- Mears, A.** (2014) *Gaming and Targets in the English NHS*
Universal Journal of Management 2(7): 293 - 301, 201

- Palling, S** (2020) *Waiting times in emergency department exploring the factors associated with patient wait for emergency care in England routinely collected daily data*
Laundert, J.
Clouting, J. Emergency Medicine Journal 2020 Dec;37(12):781-786
Gonzalez-Esquerre, J. <https://pubmed.ncbi.nlm.nih.gov/32933946/>.
Anderson, T.
- Plunkett, P.K.** (2011) *Increasing wait times predict increasing mortality for emergency medical admission*
Byrne, D.G. European Journal of Emergency Medicine:
Breslin, T. August 2011 - Volume 18 - issue 4.p 192 -196
Bennett, K. <https://pubmed.ncbi.nlm.nih.gov/21317786/>.
Silke, B.
- Richardson, D.** (2006) *Increase in patient mortality at 10 days associated with emergency overcrowding*
 Medical Journal of Australia
 Volume 184 Number 5 6 March 2006
- Sprivulis, P.C.** (2006) *The association between hospital overcrowding and mortality among patients via*
Da Silva, J-A. *Western Australian emergency departments*
Jacobs, I.G. Medical Journal of Australia
Frazer, A.R.L. Volume 184 Number 5. 6 March 2006 pages 208 – 212
Jelinek, G.A. <https://pubmed.ncbi.nlm.nih.gov/16515429/>.