



**HSE Mid-West Acute Services,
Annual Healthcare Audit Conference 2025**

University Hospital Limerick, St. Nessan's Road, Dooradoyle, Limerick, V94 F858.
Thursday 22nd May 2025

The scoring criteria for the abstracts were based on the following

- 1) Closed loop audit
- 2) Correct sample size
- 3) Timely
- 4) Measuring against standards/guidelines or outcome

An audit of compliance with new guideline for responding to outpatient referrals to Psycho-Oncology

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Cancer Services Department, University Hospital Limerick.

Aim

To ensure outpatient referrals to Psycho-Oncology service receive timely communication (within one week) regarding the opt- in process. Two specialities were included in the audit: Psychology and Nursing.

Method

Patients were those referred to Psycho-Oncology in the month of June 2024. Data were collected from Psycho-Oncology excel database, Medonc and team Outlook emails. A random sample of 30% of referrals (10 patients) were examined. Those who were prioritised at the point of referral were excluded.

Results

There were 30 patients referred to the service in June 2024 so 10 were selected (33%) for the purpose of the audit. Team responses to 7 (70%) of the referrals were deemed fully compliant with the Responding to Outpatient Referrals guideline, while 3 (30%) were not compliant.

Recommendations

For re-audits, “inpatients” should be excluded; a single point of entry for referrals should be considered; a new referrals meeting to be conducted weekly outside of the MDM.

In the 6 months following this audit all three recommendations were implemented. A re audit was then conducted, sampling the months of November 2024, December 2024 and January 2025. Again 33% of referrals were randomly selected (n=20). Results indicated a 95% compliance rate, a significant increase from the previous rate of 70%.

Discussion

Team to continue to follow the audit recommendations and re-audit bi-annually.

Declarations of Conflicts of Interest: None declared.

The impact of a new Psycho-Oncology clinical pathway at University Hospital Limerick on the number of patient opt-ins

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Aim

To examine the numbers actively consenting to Psycho-Oncology service following launch of new patient pathway.

The Psycho-Oncology Service utilises a postal opt-in service to ensure active consent from new patients referred. A review of opt in data from the Psycho-Oncology database from 2023-2024 indicated a relatively high rate of referred patients (up to 40%) not opting into the service. A new patient pathway for patients experiencing cancer related distress at UHL was launched in January 2024 to improve the quality of referrals and also enhance active consent of the patient.

Method

Participants were all patients referred to the Psycho-Oncology service between two time periods. All data were collected from the Psycho-Oncology excel database.

Results

During the time period preceding the new pathway (October 2023-end December 2023), 70% of new referrals opted into the service. Following the launch of the new pathway, 93% of new referrals opted into the service (time period January 2024- 31st March 2024).

Discussion

New patient pathway plus associated staff education and communication with referrers was associated with a 23% increase in opt-ins to the service. A re-audit was completed after 6 months covering time period from April 2024 – 31st September 2024 (Time 3). During this time period, 87% of new referrals opted into the service. The Psycho-Oncology service will continue to re audit this process biannually.

Declarations of Conflicts of Interest: None declared.

Audit to reduce peripheral venous catheter bloodstream infections (BSI)

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Infection Prevention and Control Department, University Hospital Limerick (UHL).

Aims

The purpose of this audit is to improve the management of phlebitis which will in turn reduce line related staff aureus blood stream infections.

Methods

Actions were implemented to increase the efficiency of data collection and monitoring, which involved configuring, ICNET's clinical surveillance programme to support clinical management of peripheral venous catheter Peripheral Venous Catheter (PVC) related phlebitis. Before this intervention information pertaining to phlebitis was gathered by the IVC care team, using a paper based collection tool, with data stored locally on an excel spreadsheet.

The data collection tool was streamlined to generate bespoke local and national reports. Evaluation of reports provided insight into clinical areas meeting standards of care and those in need of further support. Training and education was focused on the areas requiring support and increased monitoring to ensure improvements.

Results

The impact of the strategy was measured using University Hospital Limerick surveillance data on PVC-related BSI. Before the intervention in 2023, there were 10 PVC related infections, which reduced to 7 in 2024, post the intervention. To date there has been no PVC related infection in 2025.

Discussion

Utilising digital technology, to strategise and support clinical practice, the Intravenous Care Team observed improved staff awareness in managing phlebitis. This was demonstrated in the significant reduction in PVC-related BSI.

Declarations of Conflicts of Interest: None declared.

To assess the effectiveness of management of Glucogel for hypoglycaemia on the at risk infants on the postnatal ward

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University Maternity Hospital Limerick (UMHL).

Aims

We aim to comply with guideline “Prevention and Management of Hypoglycaemia in the Newborn”, in order to avoid unnecessary admission to Neonatal Unit.

Re-audit completed over a 2 month period post adjustments and actions.

Methods

Prospective study of 70 infants who had glucogel administered on postnatal wards in UMHL (University Hospital Limerick) following a hypoglycaemic event. Infants at increased risk for hypoglycaemia were tested according to our protocol.

Audit was carried out over 6 months February- August 2023. Re-audit over 2 months included 22 infants. Information obtained included: Infant weight, blood glucose reading before administration 1st and 2nd glucogel, type of feed the infant was receiving, risk factor history.

Results

Overall use of glucogel on the postnatal wards resulted in preventing 53\60 (88%) infants being admitted 1st Audit. 10 infants excluded as were direct admission to NICU.

Of 22 infants receiving glucogel only 4 (18%) required admission to NICU. There was 100% compliance with the guideline.

Discussion

An incidental finding from query from midwifery staff in relation to testing infants of mothers receiving single dose of labetalol resulted in a guideline updated. Re-audit was conducted post education sessions.

There was good compliance of the guideline by medical and midwifery staff.

Ongoing education of new staff and NCHD's.

Declarations of Conflicts of Interest: None declared.

Audit of antenatal and postnatal routine enquiry regarding domestic abuse in the maternity setting

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2 Medical Social Work Department, University Maternity Hospital Limerick.

Aims

To improve the screening, care and management of women experiencing or having experienced domestic abuse during and after pregnancy.

Methods

Three audit iterations of 10 antenatal and 10 postnatal charts from populations - 2023 (n=4,479), Quarter 1 2025 (n=1177) and March 2025 n=465, as per local audit guidance.

Education sessions were carried out with midwives on the postnatal wards regarding the importance of screening for domestic abuse prior to discharge.

Results

There was evidence of improvement from 0% to 70% of compliance in the post-natal period and compliance in the antenatal period sustained at 90% compliance.

Discussion

Audit results from 2023 in University Maternity Hospital Limerick showed evidence of routine enquiry questions for domestic abuse in 90% of charts in the antenatal period and no evidence of routine enquiry questions documented in the postnatal period. All women should be asked questions about domestic abuse as part of the 'routine enquiry'. In UMHL this is carried out (i) At the booking interview as part of the social history, (ii) In Maternity Emergency Unit and (iii) As part of the postnatal discharge assessment (UMHL, 2021). Re-audit showed a huge improvement of 70% questioning in the postnatal period displaying the importance of closed loop audit. Education will continue regarding the importance of routine enquiry questions for domestic abuse in maternity settings.

Declarations of Conflicts of Interest: None declared.

Neonatal prescribing and administration practice - a re-audit

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Aims

Prescription writing in the Neonatal Unit (NNU) at UMHL is on a paper-based neonatal medication record (aka 'kardex').

Aim was to re-assess compliance with good prescribing and administration practice as per local policy.

Methods

An arbitrary day (10.03.2025) was picked. All kardex of neonates admitted to the NNU were included in the audit cycle. Blood products prescriptions were excluded. Data was collected on a standardised audit tool, and analysed using Microsoft Excel.

Results

All 17 (100%) kardex showed sustained compliance with 'names', 'MRN', 'birthweight' documentation.

There was improvement with documenting 'date admitted' (100% from 68.8%), 'Consultant' (11 [64.7%] from 50.0%), 'allergy status' (9 [52.9%] from 12.5%).

Less 'date of birth' documentation (14 [82.4%] from 100%). Less name legibility – prescriber (25 [80.6%] of 31, from 88.0%), and nurse – (85 [49.4%] of 172, from 99.2%).

More parenteral nutrition (PN) was prescribed (39 vs 8), and standard was good and improved. More infusions were prescribed (102 vs 42) with improved practice.

Discussion

The extra dissemination of previous audit findings within the department and at NCHD induction plus teaching sessions has yielded several improvements and maintained good safe prescribing practice. This will be continued for NCHDs and nursing staff.

Electronic prescribing is coming soon with potential to reduce errors further. However, paper-based prescribing is a back-up option and a clinical skill worth maintaining.

Declarations of Conflicts of Interest: None declared.

Hips ultrasound scan referrals for DDH at-risk neonates – practice audit

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Aim

Developmental dysplasia of the hips (DDH) develops anytime at/after birth or early childhood. Newborns 'at risk' with known DDH risk factors – first degree relative treated and breech presentation/birth, are referred for hips ultrasound scan.

Aim was to re-assess referral process to ascertain challenges to achieving national targets (2023 annual report), following induction lectures in July 2024 and January 2025.

Methods

Data about 'at risk' newborns on the neonatal unit (NNU) and postnatal wards (PNWs) between 27.11.2024 and 01.01.2025 was collected prospectively, entered in and analysed using Microsoft Excel.

Results

Hips scan referrals were made for 55 babies – 41 (74.5%) were breech and 14 (25.5%) had positive family history. PNWs had 80.0% (44) and NNU had 20.0% (11) of babies. Preterms were 13 (23.6%).

Newborn exam was documented for 53 (96.4%) – 47 (88.7%) done ≤ 72 hours and 50 (94.3%) were normal.

Late referrals (≥ 2 weeks of age) were 22 (40.0%) vs 113 (21.2%) in 2023.

Normal scans were 53. One had DDH. Babies scanned at ≤ 6 weeks were 70.0% (21) vs 63.4% in 2023, on excluding late referrals and missed first appointment.

Discussion

Late referrals are persisting. DDH risk factors are identifiable earlier, considering 88.7% checks were timely done. Late referrals could potentially be identified earlier and referred soon after newborn exam completion – the next focus, and more timely scans.

Declarations of Conflicts of Interest: None declared.

Cumulative Report of paediatric patients presenting with suspected sepsis and its compliance with International Guidelines for the Management of Septic Shock & Sepsis-Associated Organ Dysfunction in Children (SSCGC) 2021, from 1st Nov 2024 to 28th Feb 2025 in Paediatric Emergency Department UHL

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Aim

To ensure maximum compliance with national guidelines for the management of septic shock and sepsis-associated organ dysfunction for continual improvement.

Methodology

Monthly audits analyzed retrospective data on all (N23) patients aged ≤ 16 years and ≥ 1 month presenting with suspected sepsis/septic shock from November 1st 2024 - February 28th 2025, to the paediatric ED UHL.

Results

The analysis of (N23) patients with suspected sepsis showed a predominance of children aged 5-11 years (30%). Most patients were male (69%). Sepsis forms were initiated for 86% of patients with a notable 100 % achievement in the month of Jan 2025. However, only 47% of forms were completed overall. In terms of "Sepsis 6 Bundle "compliance i.e IV/IO access/Lactate/sensor input compliance was 100 % but urine output measurement occurred in 78% of patients. Antibiotics administration within the required window period of suspected /septic shock was 100%.

Medical review within 10 minutes of time zero was observed in 60% overall, increasing from 25% in November to 80% in February 2025.

Discussion

In conclusion, while timely antibiotic administration shows 100% compliance, areas for improvement include sepsis recognition and sepsis forms completion. For continual improvement, ongoing activities in the department regarding sepsis awareness, education and training of doctors and nurses.

Declarations of Conflicts of Interest: None declared.

Embedding routine brief interventions on smoking cessation in the antenatal clinic at University Maternity Hospital Limerick

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1. University Maternity Hospital, Limerick.

2. Health and Wellbeing, Acute services-HSE Mid West.

3. Health and Wellbeing, Community Services- HSE Mid West.

Aims

Smoking in pregnancy can lead to adverse outcomes for mother and baby. The aim of this audit was to review the delivery of a brief intervention on smoking cessation to pregnant women attending a booking appointment at the Antenatal clinic, in line with National recommendations.

Methods

Maternity notes for patients who attended their antenatal booking appointment with a midwife on 27th November 2023, were reviewed for documentation of smoking status, carbon monoxide breath test (COBT) completion and the offer of referral to the stop smoking service (SSS). Further audits were completed in April and August 2024.

Results

From 11 charts reviewed in the initial audit, 8 (73%) had smoking status recorded, 6 (55%) had COBT results recorded, all identified smokers (3) were offered a referral to SSS. Quality improvements delivered included education and awareness sessions and multimodal communications for patients and staff. 4-monthly re-audits revealed steady improvements and the most recent re-audit of 12 patients on 26th August 2024 showed 11 (92%) had their smoking status recorded, 10 (83%) had COBT completed, and all smokers (1) were referred to SSS.

Discussion

This audit highlighted improvements in delivery of brief interventions on smoking cessation to pregnant women at booking appointment, enabling better access to specialist stop smoking services to support improved outcomes for pregnancy, baby and overall health.

Declarations of Conflicts of Interest: None declared.

Eliminate preventable Hypoxic Ischaemic Encephalopathy (HIE) in University Maternity Hospital Limerick (UMHL)

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Affiliations: University Maternity Hospital Limerick.

Aims

The audit aim is to 'Eliminate Preventable Hypoxic Ischaemic Encephalopathy (HIE) in University Maternity Hospital Limerick (UMHL)' by year end 2019 and maintain this standard indefinitely by implementing fetal physiological driven interpretation of Cardiotocograph (CTG).

Methods

Audit and Quality Improvement methodology were utilised to implement Fetal Physiological Interpretation of Cardiotocograph. All babies transferred for Therapeutic Hypothermia (TH) were audited 100%. TH is a treatment for Hypoxic Ischaemic Encephalopathy. Support was sought from all project key stakeholders. A clinical guideline and resources to support the change (Physiology CTG and FIOG International Federation of Gynaecology and Obstetrics guidelines) was required in addition to regular training for midwives and obstetricians. Funding for central monitoring of CTG was sought.

Results

Data audited over the last seven years 2018 - 2024 indicate a reduction in the number of cases of babies transferred to CUMH for TH in UMHL. In 2022, 2023, and 2024 there no cases of babies requiring TH due to CTG misinterpretation.

Discussion

UMHL rate of TH is now 0.25 per 1,000. The national rate is 1.4 per 1,000. (Neonatal Therapeutic Hypothermia Report 2022). Implementing fetal physiological interpretation of CTG and auditing cases of all babies transferred for TH has helped to reduce the number of babies requiring TH in UMHL. The work to maintain the aim of this project is continued.

Declarations of Conflicts of Interest: None declared.

Optimisation of Nuclear Medicine Diagnostic Reference Levels (DRLs): A seven-year audit (2018-2024)

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1 Medical Physics Department, UHL.

2 Nuclear Medicine Department, UHL.

Aims

Annual establishment, review and comparison of Local DRLs (LDRLs) with National DRLs (NDRLs) is a legal requirement. This audit analysed Nuclear Medicine DRL trends, identifying optimisation periods and their impact on injected activity to ensure patient doses remain As Low As Reasonably Achievable (ALARA).

Methods

A seven-year retrospective analysis of administered radiopharmaceutical activity was conducted. In line with HIQA guidelines, DRLs were evaluated annually using the median administered activity from 50 randomly selected patient studies per scan type. LDRLs for lymphoscintigrams, thyroid scans and MAG3 renograms were determined and compared with NDRLs to track the optimisation process.

Results

This audit demonstrated LDRLs reductions for lymphoscintigrams (88 MBq to 61 MBq in 2019; 62 MBq to 40 MBq in 2021) and thyroid scans (100 MBq to 80 MBq in 2022). Meanwhile, MAG3 renogram LDRLs remained consistent.

Discussion

UK NDRL (20 MBq) was used for lymphoscintigrams due to absence of Irish data. In addition, NDRL for thyroid scans was updated twice during this review period necessitating reassessment of administered activities to balance patient dose and image quality. Although, MAG3 renogram LDRLs remained below the NDRL of 100 MBq, ongoing monitoring remains essential to detect deviations and ensure ALARA adherence. Findings highlight the importance of continuous LDRL monitoring, with staff annually establishing and reviewing LDRLs to support optimisation in nuclear medicine.

Declarations of Conflicts of Interest: None declared.

An audit of the pathway for haematology/oncology patients requiring radiological intervention

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2 Cancer Services, University Hospital Limerick.

Aims

Audit of elective oncology/haematology patients for central venous access devices pathway in Radiology Department. There was an initial 80% compliance aim, with stretch goals towards 100%

Methods

Prospective audit of random cases. Three iterations of the audit were presented, on 02/10/2023 with 17 cases over 6 weeks, on 08/04/2024-20 cases over 4 weeks and on 13/01/2025 with 28 cases over 6 weeks, as per local audit guidance.

Oncology/haematology elective Day Ward cases requiring interventional procedures were included with inpatients and paediatric patients excluded.

Results

The audit aim of 80% was achieved in iterations and the audit now aims for 100% compliance. There were 8 audit tool questions, 3 of which had 100% compliance in all three iterations, with an audit plan for a sustained process. Current quality improvement plans are in progress including ordering of procedures to the dedicated radiology National Integrated Medical Imaging System (NIMIS) -now at 61% compliance and 2) a new audit tool question which was added in iteration 3 around receiving the booking list and compliance here is at 33%.

Discussion

Effective actions implemented included:-

Ongoing multidisciplinary communication between Radiology Department and Cancer Services Department with active planning to improve compliance through education. The audit findings were presented to the Oncology Multi-Disciplinary Meeting and iteration 4 of the audit is planned for Quarter 3 2025.

Declarations of Conflicts of Interest: None declared.

An audit on rheumatoid arthritis patients, completing chest x-ray pre-treatment for methotrexate

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Aim

Rheumatoid arthritis (RA) is associated with interstitial lung disease (ILD) in 3.7% - 7.7% of patients and methotrexate carries a rare risk of pneumonitis leading to withdrawal of treatment in 1:108 patient years. British society of Rheumatology (BSR) guidelines recommend a pre-treatment chest x-ray to screen for lung disease before initiating methotrexate and advise against its use in established ILD cases. This audit evaluated the compliance with BSR guidelines.

Methods

Retrospective audit of 33 RA patients treated with methotrexate, reviewed compliance with chest x-ray screening noting reasons and the subsequent actions. A re-audit of 40 randomly selected patients, as per local audit guidance, assessed the improvements post implemented recommendations.

Results

In the initial audit, 51.5% (n=17) of patients had a pre-treatment chest x-ray, with 100% (n=17) reported as normal. Post recommendation the re-audit showed a 77.5% (n=31) compliance with 85% (n=34) seropositive RA patients and 6.5% (n=2) abnormal x-rays, reflecting a 26% improvement in the x-ray screening rates.

Discussion

Compliance with BSR guidelines improved significantly following targeted recommendations in the department. Pre-treatment chest x-ray screening is imperative for safe methotrexate use.

Declarations of Conflicts of Interest: None declared.

Optimising coagulation screen requests in University Hospital Limerick

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Haematology Laboratory, University Hospital Limerick.

Aims

The Haematology Laboratory in University Hospital Limerick (UHL) provides 24/7/365 diagnostic services to the Mid-West of Ireland. Literature advises against routine coagulation testing in the absence of haemorrhage or suspected coagulopathy. In 2023, $\geq 88\%$ of coagulation tests (Prothrombin Time (PT), Activated Partial Thromboplastin Time (APTT), and fibrinogen assays) from one department in UHL were within normal reference range, suggesting overuse. This closed loop audit assessed the impact of modifying the request form and mandating clinical and anticoagulation details with coagulation requests originating from this same department in UHL.

Methods

In June 2024, the Blood Sciences request form was modified to require clinical and anticoagulation details for adult coagulation requests, and was subsequently introduced into the department. Coagulation requests lacking mandatory clinical details were rejected. Laboratory Information System and IBM® Cognos® Impromptu®, was used to analyse adult coagulation test volumes in the department from April–May 2024 (pre-intervention) and July–August 2024 (post-intervention). Abnormal coagulation parameters were defined as PT ≥ 17 s, APTT ≥ 44 s, and fibrinogen < 2 g/L per UHL reference ranges. Data analysis was performed using Microsoft Excel®.

Results

Since implementation of the new request form and mandating clinical details; coagulation screen requests and fibrinogen testing in this department decreased by 48.5% and 40% respectively.

Discussion

Mandating clinical details for coagulation screen requests significantly reduced unnecessary phlebotomy and coagulation testing of patients.

Declarations of Conflicts of Interest: None declared.

Audit of use of stroke/neurology therapy rehab needs assessment form by the multi-disciplinary team

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1 Department of Physiotherapy, University Hospital Limerick.

2 Department of Occupational Therapy, University Hospital Limerick.

Aims

To audit the use of the Rehab Needs Assessment Form, developed in line with National Clinical Guidelines, by members of the multi-disciplinary team for stroke patients on the Stroke Unit in UHL.

Methods

Rehab Needs Assessment forms in medical charts of stroke patients on the stroke ward were analysed. Data was collected retrospectively. Initial audit in Q1 2024 (n = 15) identified a problem with the Rehab Needs Assessment form that needed to be addressed. Data collection was halted to focus on improvement prior to re-audit Q1 2025 (n = 27) as per local audit guidance. Between these two audits, the Rehab Needs Assessment form was revised as part of a quality improvement project.

Results

Compliance with the Rehab Needs Assessment form increased from 67% to 89%. Overall compliance now exceeds the target rate of 80%. Completion rates of eight out of ten individual elements within the form increased.

Discussion

The revision of the Rehab Needs Assessment form has supported increased compliance with the form among MDT staff on the stroke unit in UHL. Increased compliance indicates that more comprehensive assessment and rehabilitation planning for stroke patients is being documented.

Individual sections of the form with lowest compliance have been highlighted for further training of MDT. Regular re-audits are planned to encourage continued compliance.

Declarations of Conflicts of Interest: None declared.

An audit of compliance with safety recommendations for neuromuscular blocking agents in University of Limerick Hospital Group (ULHG)

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1 Pharmacy Dept, University Hospital Limerick.

2 Pharmacy Dept, Ennis Hospital.

3 Pharmacy Dept, Nenagh Hospital.

Aims

This audit aims to determine compliance with safety recommendations for neuromuscular blocking agents (NMBAs) within ULHG.

Methods

There were 5 hospitals in ULHG were audited; University Hospital Limerick, University Maternity Hospital Limerick, Croom Orthopaedic Hospital, Ennis Hospital and Nenagh Hospital. All areas stocking NMBAs, including the Pharmacy Department were audited against 6 recommendations. Note recommendations in the ISMP checklist that are not applicable to the ULHG organisation were excluded.

Note for standard 2, segregated in a designated shelf was accepted as compliant in areas where large volumes of NMBAs are stored and regularly used e.g. theatres).

Results

The initial audit showed compliance with storage areas, and with access to dantrolene and any required diluent.

There was non-compliance in relation to the segregation of NMBAs from other medicines, and the labelling with the appropriate warnings.

A quality improvement plan was undertaken across the group. Warning labels were introduced, storage of NMBAs reviewed, and labelled storage containers introduced to segregate these medicines.

A policy was developed to outline the requirements.

Following the quality improvement plan a re-audit was carried out which showed 100% compliance with the safety recommendations.

Discussion

Neuromuscular blocking agents (NMBAs) are high-risk medication known to cause catastrophic injuries or death when used in error. This work resulted in full compliance with international safety recommendations.

Declarations of Conflicts of Interest: None declared.

Clinical audit on physiotherapy adherence to the world guidelines for falls prevention and management for older adults admitted to University Hospital Limerick post fall or fall related injury

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Aims

To audit the adherence to the World guidelines for falls prevention and management for older adults admitted post fall or fall related injury in University Hospital Limerick.

Methods

A retrospective documentation review took place from patients admitted to the medical wards in UHL post fall or fall related injury between December 2024 and January 2025. We reviewed 20 patient records using an audit tool based on the World Falls Guidelines. A re-audit was performed 8 weeks later, all fall patients over a 3-week period were included, n = 15.

Results

Compliance varied across all areas from 15% - 85%, with an overall compliance rate of 15%. Compliance was greatest in terms of falls history and fear of falling. Falls education sessions were facilitated following the audit. On re-audit improvements were noted across all areas with an overall compliance rate of 53%.

Discussion

Overall adherence to the physiotherapy falls guidelines was fair. Improvements were noted on re-audit. Compliance with the World Falls Guidelines is vital as there is strong evidence to suggest that multi domain interventions delivered based on findings from a multifactorial falls risk assessment are effective. Another re-audit will take place in 6 months.

Declarations of Conflicts of Interest: None declared.

Impact of monthly educational bladder classes on waiting times for women referred with urinary incontinence

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Aims

The aims of the bladder class is to reduce the pelvic health waiting list while adhering to National Institute of Clinical Excellence (NICE) guidelines (2019). This involves offering education and lifestyle advice as first line treatment for patients with urinary incontinence.

Methods

Data collection methods were Integrated Patient Management System and patient referrals. Inclusion and exclusion criteria were established to identify suitable patients to attend the class. Retrospective data analysis methods were used.

Results

In May 2023 the average waiting time from referral to first clinician contact for patients referred for mixed urinary incontinence to Pelvic Health Physiotherapy was 15.5 weeks. December 2024 average waiting time for this same cohort of patients was 4.8 weeks. Monthly Educational Bladder Classes may have been a contributing factor for reducing waiting times.

Discussion

NICE Guidelines state that women referred with urinary incontinence symptoms, education and lifestyle advice is recommended as first line treatment. Due to building waiting lists and large referral volume, monthly educational bladder classes were established to reduce waiting time to see Physiotherapists, we set class content up to ensure it was providing education and practical lifestyle advice for women to help them to start the process of managing their symptoms. All women were offered a 1:1 appointment with a Pelvic Health Physiotherapist within 3 weeks of attending the class.

Declarations of Conflicts of Interest: None declared.

Impact of a patient infographic on reduction of Did Not Attend (DNA) rates on a monthly Educational Bladder Class

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2 Physiotherapy Department, University Hospital Limerick.

Aims

Reduce DNA rate of the monthly Educational Bladder Class by providing patients with an infographic with their appointment letter.

Methods

Data collection methods used was Integrated Patient Management System to identify patient DNA rates. All patients offered an appointment were provided with the infographic in their appointment letter. Retrospective DNA data analysis was completed.

Results

In 2023 there were a total of 4 classes held from May to October with 26 women booked into the classes and an average DNA rate of 38% (n = 10). In 2024 there were a total of 10 classes held throughout the year, with 48 women booked into the classes and an average DNA rate of 20% (n = 10). The only process difference was provision of an infographic.

Discussion

NICE Guidelines state that women referred with urinary incontinence symptoms, education and lifestyle advice is recommended as first line treatment. Due to building waiting lists and large referral volume, we set up monthly educational bladder classes to reduce waiting time to see a Physiotherapist. Class content was aligned with NICE guidelines (2019). For most women this was their first contact with a Pelvic Health Physiotherapist. We created an infographic targeted at informing these women as a method to help reduce the high DNA rate to the classes during the first six months.

Declarations of Conflicts of Interest: None declared.

Age adjusted d-dimer in diagnosing pulmonary embolism

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Aims

D-dimer measurement with clinical risk scores such as Well's score is the current standard for the diagnostic approach of a patient with clinically suspected pulmonary embolism (PE) when deciding whether a computed tomography pulmonary angiogram (CTPA) is indicated. The aim was to investigate whether the age-adjusted d-dimer, defined as $\text{age} \times 10$ in patients aged ≥ 50 years old, a recognised European standard, would have lead to decreased unnecessary scans.

Methods

A retrospective review of CTPAs conducted over 3 months in our hospital, October to December 2024. This is a re-audit following departmental presentation of findings, the first was performed in 2024, for data October to December 2022.

Results

In this re-audit, 317 diagnostic CTPAs were conducted and 49 were positive for PE (15.5%). Age adjusted d-dimer was negative in 5 patients, none of whom had a PE.

On the initial audit 315 examinations were performed (16.5% positive for PE), with 10 age adjusted negative patients, none of whom had a PE.

Discussion

The amount of age adjusted d-dimer scans, all negative for PE, halved between audits after departmental presentation. The results show that age adjusted d-dimer can decrease unnecessary scans.

Declarations of Conflicts of Interest: None declared.

Comparative analysis of key performance indicators in Cardiac Rehabilitation: A three-year audit at University Hospital Limerick (UHL)

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Aim

The Irish Heart Attack Audit measures key performance indicators (KPIs) related to the treatment and management of heart attack patients across Ireland. This audit aims to improve and sustain the results for KPI – Proportion of patients who have cardiac rehabilitation phase 3 date recorded.

Methodology

Data on heart attack patients presenting to UHL, referring hospitals or Emergency Medicine Services is collected using a nationally defined 76-point dataset by Cardiac Rehabilitation Nurses. Quarterly reports are developed nationally and returned to the Cardiology Team for review and action. Numbers of patients included in the audits were 189 in 2021, 183 in 2022, 195 in 2023 and 190 in 2024.

Results

Key performance indicators within the control of the department (7/8) are consistently achieving and exceeding 90% targets with one exception Phase 3 Rehabilitation date recorded which achieved 15% in 2021, 71% in 2022, 100% 2023 and 98% in 2024.

Discussion

The calculation of cardiac rehabilitation phase 3 data was nationally discussed. Patients who declined or were clinically unfit for Phase 3 Cardiac Rehabilitation were initially included which did not reflect the realities of undertaking Cardiac Rehabilitation. Contraindications are now reflected in the data hence reflecting suitability for Cardiac Rehabilitation.

Ensuring high-quality, reliable data is critical for accurate audit and service improvement.

Declarations of Conflicts of Interest: None declared.

Sodium-glucose cotransporter 2 inhibitors in heart failure with reduced ejection fraction (HFrEF) at University Hospital Limerick

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Aim

Sodium-glucose cotransporter 2 (SGLT2) inhibitors are strongly recommended (Class 1A) by the American Heart Association (AHA), European Society of Cardiology (ESC), and British Cardiology Society (BCS) for patients with Heart Failure with Reduced Ejection Fraction (HFrEF). An initial audit (December 2023 – February 2024) revealed that only 45% of eligible patients were receiving SGLT2 inhibitors. This audit aimed to evaluate the impact of educational and clinical interventions on SGLT2 inhibitor prescription rates.

Methods

Chosen population patients with HFrEF admitted under medicine and allied specialties.

Random selection from different wards. Prospective data collection from patient medical records, Electronic Medical Records (EMR), and Drug Kardex.

Actual sample size: 40 as per local audit guidance.

Tool used: EMR, Drug Kardex, and patient records.

Results

Total Patients Audited: 40

Mean Age: 74.5 years (Range: 43-88 years)

Gender Distribution:

Male: 27 patients (67.5%)

Female: 13 patients (32.5%)

On SGLT2 Inhibitors: 28 patients (70%)

Not on SGLT2 Inhibitors: 12 patients (30%)

Discussion

Significant improvement in SGLT2 inhibitor prescription rates (70% vs. 45%).

Persistent 30% treatment gap, indicating ongoing barriers to full implementation.

More HFrEF cases in the second audit (EF <40% increased from 30 to 35 patients).

Male predominance (67.5%) and mean age of 74.5 years.

Declarations of Conflicts of Interest: None declared.

Reduce hospital admissions, costs and bed days through the Rapid Access Chest Pain (RACP) service at University Hospital Limerick (UHL) over the last 3 years (2022-2024)

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Rapid Access Chest Pain Clinic, Cardiology Department, University Hospital Limerick, Limerick.

Aims

Year on year reduce hospital admissions, bed days and costs through implementation of RACP service.

Methods

We retrospectively audited RACP service demand growth from 2022-2024, assessing financial and bed savings through admission avoidance and expediting discharges. We tracked patient numbers referred to RACP, identifying cases resulting in admission avoidance or expedited discharge. Utilising E-referrals, Integrated Patient Management System, RACP daily log and Planning, Performance and Business Information systems to calculate costs and saving based on national average length of stay.

We excluded virtual appointments, inappropriate referrals, did not attends or rescheduled appointments.

Results

From 2022 to 2024, the service reduced bed days and costs. There was 435.2 bed days saved with €523,110.40 financial savings in 2022. This improved to 638.8 bed days reduced and €807,837.60 saved in 2023. Continuing to improve in 2024 with 1,179.6 bed days and €1,417,879.20 financial savings. Between 2022 to 2024, a total of 2,253.6 bed days were saved, with cost savings of €2,748,827.20. The saved bed days of 744.4 over this period resulted in €894,778.80 in cost savings.

Discussion

We have achieved our aim through advertising, communicating and educating. Growing demand suggests potential for expanding the pathway across ULHG sites or GPs in an outpatient capacity.

We plan future re-audits.

Declarations of Conflicts of Interest: None declared.

Clinical audit of screening, diagnosis and management of delirium in an Acute Medical Unit (AMU) in a model 4 hospital – a re-audit of practice post training and education

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Connor¹².

1 Medicine Directorate, University Hospital Limerick.

2 University of Limerick.

Aims

To establish the rate of delirium screening in patients >65 admitted to AMU and assess the multimodal intervention rates of delirium screening.

Delirium is a common clinical syndrome of acute brain dysfunction due to an organic cause. It is associated with various poor outcomes. Guidelines recommend routine delirium screening in older adult inpatients using the 4AT tool. Our initial audit in October 2023 showed 0% screening rates on AMU admission. We introduced delirium education and incorporated the 4AT into the AMU admission pro-forma.

Methods

Patients >65 admitted to AMU on two days March/April 2025 were identified via ward census. Data was collected from clinical notes and analysed using Microsoft Excel.

Results

Of 23 patients eligible patients, 65% (n=11) were screened for delirium, 78% (n=18) had at least one risk factor for delirium, 61% (14/23) were prescribed >5 medicines. None had a medication reconciliation completed. One patient screened positive for delirium and had two potential causes of delirium addressed. In two incidences, 4AT was recorded as negative while “new confusion” was documented in the admission pro-forma.

One patient had further cognitive assessment completed.

Discussion

Screening improved significantly from 0% to 65% following the intervention. The 4AT tool was used appropriately, with only minor inconsistencies. Screening led to appropriate delirium management in one case.

Declarations of Conflicts of Interest: None declared.

Audit report for assessment of nutritional status in our chronic obstructive pulmonary disease (COPD) patients

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Respiratory Department, Midwest Acute Hospitals, Limerick.

Aim

Increase awareness of assessment of patient's nutritional status where problems are identified.

Method

A prospective audit was conducted across the locations where COPD patients are being assessed. The sample size was 40 patients. Questionnaire was used in audit 1 and 2 with some changes made to identify patients who had already been referred to dietetic services.

Results

Identifying malnutrition and measuring MUST score is important in the COPD patients.

The audits showed a 21.5% improvement in referring those patients to dietician services between the first and second audit.

Referral was identified in 20% of COPD patients to dietician in the obese category.

By doing the MUST measurement it classified where COPD patients were with their nutritional status.

Written information was given to 90% as per their nutritional status meeting the standard that we wanted to achieve.

Discussion

Weighing scales with height measurements are essential. Outpatient Department was identified as one area short of same in University Hospital Limerick and in collaboration with the Clinical Nurse Manager II they were able to correct this. Appropriate equipment to measure MUST now in place.

Referral to dietician services available and patients identified now referred by us.

Great quality improvement to holistic evaluation of COPD and their nutritional status and this must be shared with all disciplines dealing with this cohort of patients.

Declarations of Conflicts of Interest: None declared.

Appropriate oxygen prescribing in adult patients admitted to Ennis General Hospital

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Aims

Oxygen is one of the most commonly prescribed treatments in the acute clinical setting, and ensuring adherence to established guidelines is crucial for patient safety. This audit aims to improve compliance with the Irish Guidelines on the Administration of Oxygen Therapy in the Acute Clinical Setting for appropriate oxygen prescribing in adult patients at Ennis General Hospital, with the goal of achieving 100% compliance by July 2025.

Methods

We conducted a retrospective closed-loop audit of adult patients (≥ 16 years) receiving oxygen therapy at Ennis General Hospital. All eligible patients during two separate cycles (March and April 2025) were included. Data were collected via standardized forms reviewing clinical records, drug kardex, and National Early Warning Score (NEWS) charts.

Results

In Cycle 1 ($n=20$), full compliance was observed in 4 patients (20%). Following an educational intervention, Cycle 2 ($n=21$) showed improved full compliance in 11 patients (52.4%). The majority of patients in both cycles had chronic obstructive pulmonary disease (COPD), particularly with infective exacerbation.

Discussion

An educational intervention, including teaching sessions and direct reminders to Non Consultant Hospital Doctors, significantly improved compliance. However, performance remains below target, particularly in high-risk groups such as COPD patients. Continued education, guideline reinforcement during ward rounds, and a re-auditing are planned to sustain progress.

Declarations of Conflicts of Interest: None declared.

To ensure correct dosage of Apixaban according to Health Service Executive (HSE) guidelines

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Aims

The aim of the audit was to review Apixaban prescribing compliance, with an aim statement of 100% compliance. The correct dosage of Apixaban is crucial for patient safety as under dosing and overdosing can lead to severe complications including bleeding or thrombotic event.

Methods

The sample size was randomly selected patients admitted to medical wards over a one-month period under various medical teams. A re-audit was conducted after six weeks. Apixaban dosage was assessed according to the current HSE guidelines, based on weight, age, and creatinine clearance and reviewed against the drug kardex.

Results

Drug kardexes of n39 were reviewed of which, n35 (90%) were compliant the guidelines. Education took place following the audit on Apixaban to the medical teams. A re-audit was then conducted six weeks later with n20 which showed n17 (85%) compliance.

Discussion

The audit showed high initial compliance with Apixaban dosing. The slight decline in the re-audit suggests variability, possibly due to staff rotation or limited awareness of guidelines. Despite this, overall compliance remained acceptable but ongoing education will be undertaken with periodic re-auditing to move the audit results towards that 100% compliance, as per the aim statement. These findings highlight the importance of ongoing education, clear documentation, and periodic audits to maintain high standards.

Declarations of Conflicts of Interest: None declared.

Audit of pain assessment and pain management on patients admitted to the Ambulatory Gynaecology Unit (AGU)

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Ambulatory Gynaecology Unit, Nenagh Hospital, Tyone, Nenagh.

Aims

Achieve pain scores of 5 or below on discharge following procedure using Numeric Rating Scale (NRS).

Methods

Audit and re-audit over one month using concurrent data collection. All patients (N74) undergoing gynaecological procedures in AGU included. Pain scores were regularly documented. Pain score trends, analgesia use and impact of pain management strategies were assessed.

Results

Prior to admission, 21.6% had an acute or chronic pain condition and the same proportion were using analgesia. Pre- procedure, 31.1% received paracetamol, 21.6% received anti-inflammatory medication (60% received Neurofen, 40% Difene), and 2.7% received Buscopan. The average pre-procedure pain score was 1/0. Six patients (8.1%) reported pain score >5, of which two thirds had chronic pain.

During the procedure, 6.75% received local anaesthetic. One patient received Entonox. Post procedure, the average pain score rose to 2.61. A total of 16.2% reported pain scores >5, with 33% of these having a chronic pain history. Post procedure analgesia included paracetamol (2.7%), anti-inflammatories (1.35%), and Buscopan (21.6%). Prior to discharge, the average pain score reduced to 0.77, with none greater than 5.

Discussion

Although pain management in the AGU meets compliance standards, pain remains a subjective experience. Best practice guidelines emphasise that informed consent must remain central to care, ensuring patients are actively engaged in decisions regarding their treatment and analgesia options (RCOG 2024).

Declarations of Conflicts of Interest: None declared.

An Audit to monitor the efficiency of the Nurse-led Deep Venous Thrombosis (DVT) Service in University Hospital Limerick.

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Anticoagulation Service, University Hospital Limerick.

Nurse Integration and Development, University Hospital Limerick.

Department of Medicine, Nenagh General Hospital.

Aims

The audit aim is to monitor the efficiency of the Nurse-led DVT Service based in University Hospital Limerick against our own local service Key Performance Indicators (KPIs) of admission avoidance and time in service.

Methods

Data was collected retrospectively in Jan 2024 and 2025. The data was collected from a dedicated in-house DVT database around the service number of attendance, source of referral, principle diagnoses, time in service and the number of hospital-acquired thrombosis.

Results

There were 1321 attendances in 2023, with 5.8% (n=33) admitted directly from the service. In 2024, only 2.3% (n=25) were admitted directly from 1107 attendances. The KPI states that the time in service should be 4-6 hours and in 2023, 88% (n=1158) met this KPI and were seen within 6 hours and in 2024, 91% (n=1012) were seen within 6 hours. In 2023, 80% were seen before 4 hours and 72% in 2024, which exceeds the KPI requirement.

Discussion

This unique service has continued to decrease attendances through the ED and eliminate unnecessary hospital admission. The DVT pathway enables GP's and other healthcare services to directly refer patients in a timely and accessible manner. The time in service > 6 hours (n=95 in 2024 and n= 72 in 2023) is currently being reviewed and a follow up audit is planned 6 monthly.

Declarations of Conflicts of Interest: None declared.

Oxygen Clinic, Nenagh Hospital –Is Bigger Better?

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Aim

The volume of patients attending the Medical Assessment Unit (MAU) Oxygen Clinic, have grown considerably in the past two years. The purpose of this re-audit was to assess if the quality initiatives over the past two years have demonstrated an improvement against the previous audit. These audits measure compliance against British Thoracic Society (BTS) standards regarding Long Term Oxygen Therapy (LTOT) (BTS, 2015). The initiatives included patient information leaflets, Arterial Blood Gas (ABG) competency and analysis, a patient satisfaction survey, and staff education.

Methodology

Data was collected from attendees of the Oxygen Clinic (n=50), over six months during 2024, and compared against data collected over the same period in 2022 (n=20).

Results

Comparative analysis of data against BTS standards, and the previous audit, demonstrated overall improvements. ABG samples withdrawn in clinically appropriate presentations, improved by 13%, oxygen titration after ABG indicated improvement of 10%. While LTOT education and specialist follow up was exemplary (98%), timely follow up saw reduced compliance, from 95% to 74%.

Discussion

Quality initiatives have impacted positively on LTOT standards provided at the Oxygen Clinic. However, reduced compliance with timely follow up was observed, which may be attributed to increased volumes of patients attending the clinic (78% increase since 2021).

The challenge is therefore in trying to maintain clinical standards in the face of increased volume.

Declarations of Conflicts of Interest: None declared.

Oxygen therapy administration in an acute setting

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Respiratory Department, University Hospital of Limerick.

Aim

This study aims for 100% compliance against oxygen therapy management.

Methods

Prospective oxygen therapy audits were conducted over a seven-month period across inpatient wards. A total of 101 patient records were reviewed, including medical notes, drug kardex, and Early Warning Score (EWS) charts. Data collection focused on oxygen prescription, documentation, monitoring practices, and adherence to oxygen therapy guidelines.

Results

The initial audit in August 2024 revealed critically low oxygen prescription compliance at just 5.3% (n=1). Following targeted education initiatives compliance improved substantially, peaking at 72.7% in September before stabilizing at approximately 28% in subsequent months - representing an overall improvement of 22.5% from baseline.

Discussion

The hospital is committed to continuous quality improvement, patient safety, and staff development in line with national oxygen therapy guidelines. The audit has identified significant gaps in oxygen therapy documentation and management practices. To address these findings, a comprehensive education strategy has been implemented, including targeted training for nursing staff and ward teams. Regular communication of audit results and education sessions is embedded into clinical practice supported by a Respiratory Management Study Day and weekly respiratory education. Plans are in the progress for the next re-audit.

Declarations of Conflicts of Interest: None declared.

Peritonitis rates in peritoneal dialysis patients

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Aims

To maintain peritonitis rates below 0.4 episodes per year at risk (as a unit, not per patient) and achieve a rate of greater than 80% of patients who remain peritonitis free, as per the International Society for Peritoneal Dialysis.

Methods

There is ongoing data recording on an excel spreadsheet and the eMED renal system is maintained locally with an annual audit, as per international guidance.

Results

In 2023 the total years of experience was 31.4. In 2024 it was 27 years. This is all patients in the cohort. The peritonitis rates in 2023 were 0.35 and in 2024 it was 0.41. The percentage of patients remaining peritonitis free in both 2023 and 2024 is 72%.

Discussion

The peritonitis rates are in line with international standards. The standard of greater than 80% remaining peritonitis free has not been achieved, remaining at 72%. Implementation of revision of technique for all patients annually was implemented in 2024. This alone was not effective to achieve this standard. The focus in 2025 is biannual revision of technique with ongoing patient education, in line with Infection Prevention and Control techniques, to bring up the standard. Following an episode of peritonitis, patients' skills are reassessed, re-education is commenced, if necessary, and they are further supported with home visits. A re-audit will take place in January 2026.

Declarations of Conflicts of Interest: None declared.

Implementation and compliance of the new Intensive Care Unit (ICU) “No fasting pre-extubation guideline”

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1 Department of Dietetics, University Hospital Limerick (UHL).

2 ICU Department, University Hospital Limerick, Limerick, Ireland.

Aims

To assess compliance with the “No Fasting Pre-Extubation Guideline” implemented on our ICU UHL unit in June 2023.

Methods

All adult endotracheal ventilated ICU patients on Enteral Nutrition were included. Data was collected retrospectively from our ICU computer system over the same three month period October to December in 2022 (pre-guideline) and 2023 (post-guideline). A re-audit was completed over the same period October-December 2024.

Results

Pre-guideline (n=33), 64% fasted pre-extubation. The average fast was 93 minutes (minimum 0mins, maximum 420mins, median 60mins). Post-guideline, 32% fasted pre extubation (n=19). The average fast was 40 minutes (minimum 0mins, maximum 300mins, median 0mins). When re-audited in 2024 (n=29), there was no improvement in compliance with the guideline as 38% fasted pre extubation.

Discussion

It is evident that there is a reduction in the number of patients fasting pre-extubation since the introduction of our new guideline in 2023 (64% versus 32%). This suggests a higher number of patients received their nutritional targets to ensure optimal nutrition in the ICU since the guideline was implemented. Unfortunately, there has been no further improvement in the last year. We aim to get 100% compliance of no fasting pre-extubation through further education and increasing awareness among ICU staff.

Declarations of Conflicts of Interest: None declared. Previously published without the re-audit in Clinical Nutrition ESPEN, Volume 63, October 2024, pages 1281-1282.

Enhancing key performance indicator performance through digital innovations within Outpatient Fracture Services

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Department of Trauma and Orthopaedic Surgery, Health Service Executive, Midwest.

Aims

In January 2025 the HSE Midwest implemented Pathpoint eTrauma, a cloud-based clinical workflow platform designed to digitise and streamline orthopaedic trauma referrals and workflow processes. This system also supports the operation of digital Virtual Fracture Assessment Clinics (VFAC) enabling remote assessment and communication with patients.

The aim of this closed loop audit was to evaluate the impact of digitalising our referral pathway on wait times for first appointments at the HSE Midwest VFAC.

Methods

A retrospective analysis of wait times was conducted comparing data from two time periods: February 2024 (pre-digitalisation, n=406) and February 2025 (post-digitalisation n=300). Median wait times were calculated from the time of referral following ED/IU presentation to the patient's first appointment.

Results

Pre-digitalisation (Feb 2024): Median wait time=135.07 hours (5.6 days) with **1.2%** of patients managed within 72hrs. Post-digitalisation (Feb 2025): Median wait time = 25.24 hours (1.05 days) with 91.64% of patients reviewed at VFAC with 72hrs of presentation. This represents an 81% reduction in median wait time following the implementation of Pathpoint eTrauma.

Discussion

Timely access to specialist appointments remains a critical challenge within healthcare services nationally. The implementation of Pathpoint eTrauma significantly improved the efficiency of our referral pathway for patients. Digital tools like Pathpoint eTrauma align with national policy goals outlined in HSE Digital Health Framework (2024–2030) especially around improving timely access and patient communication.

Declarations of Conflicts of Interest: None declared.

Audit of intended therapeutic benefits of Qutenza treatment for localised peripheral neuropathic pain

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1. Department of Pain Medicine, Pain Excellence Centre, Croom Orthopaedic Hospital, ULHG, Limerick.

Aims

Maintain pain intensity scores at 5 or below during Qutenza treatment, a chilli based therapy, for neuropathic pain and achieve a 20% improvement in all follow up measurements.

Methods

Data was collected on pain intensity, pain interference (PI) and quality of life (QoL) scores for 100 consecutive Qutenza applications. Follow up data was gathered 2 weeks post treatment. Multidimensional analgesic techniques were offered to maintain pain intensity levels below 5 on Numerical Rating Scale (NRS) throughout treatment. Improvement by 20% in measures at follow up was sought. Analysis was performed using Microsoft Excel.

Results

NRS greater than 5 midway through treatment was reported by fifty-eight percent of patients. Resulting in breakthrough analgesia, ice packs or Augmented Reality being offered, 71% of patients acted on recommendations. Upon treatment completion, 35% of patients reported NRS scores greater than 5, with 62% utilising multidimensional analgesic technique. Average NRS prior to treatment was 4.44 (SD 2.22), improving by 51.28% on 2 week follow up, exceeding identified standard. Additionally, PI scores improved by 45.34% from baseline to two-week follow-up with QoL scores improving by 70.83%.

Discussion

Audit revealed the use of multidimensional techniques effectively reduced pain intensity when utilised and Qutenza improved both pain interference and quality of life scores at follow-up. Future strategies implemented prior to treatment will be audited for effectiveness.

Declarations of Conflicts of Interest: None declared.

Audit of a healthcare quality management system

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1. Quality, Risk and Patient Safety Department, Midwest Acute Hospitals, Limerick.

Aims

The goal of this project is to support patient care and outcomes through ongoing audit and improvement of documentary compliance with the National Standards for Safer Better Health care.

We identified 155 areas for ongoing audit and improvement. The aim is for 75% compliance with documentary requirements for the National Standards for Better Safer Healthcare

Methods

A document management system was implemented across 155 areas. An audit tool was developed to measure compliance with the National Standards for Safer Better Healthcare.

Internal self-assessments and external audits were conducted quarterly. Compliance data was analysed, gaps identified, corrective actions triggered, and findings shared to support improvement.

Results

In the first 12 months, 110 of 155 areas adopted the system; average documentary compliance of 37%. By year 2, 130 engaged and average compliance rose to 44%.

Year 3, 153 areas are active, averaging 52% compliance with documents available and in date.

Discussion

The development and implementation of the system has supported the management and audit of documentation.

The system has increased staff engagement, standardised document control process and audit practices, and supported continuous improvement across the Midwest Acute Hospital Group. It has provided transparent, accountable compliance, promoting responsive, quality-driven care culture throughout the organisation.

Declarations of Conflicts of Interest: None declared.

Complaints Management HSE Midwest Acute and Older Peoples Services.

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Aims

Improve management of complaints received within the Mid-West Hospital Group in line with HSE's *Your Service, Your Say* policy. Identify recurring themes, response timelines, to enhance service user satisfaction, promote learning, and ensure timely resolution.

Methods

Complaints data from Quarter 1 2024 (n223) repeated in Quarter 4 2024 (n220) was reviewed. Quantitative and qualitative thematic analysis was conducted to categorise complaint types, response times, and resolution outcomes. Cases were assessed for compliance with HSE policy standards, responded to within recommended timeframes.

Results

Sample size 20 per audit iteration, as per local audit guidance.

Compliance improved or sustained across three of four KPI's measured, with the fourth remaining above 82% - KPI1 68% - 84.2%, KPI2 68% -73%, KPI3 100% -100%, KPI4 100% - 82%.

Key actions included development of local standard operating procedures, targeted staff training sessions and the integration of learnings into service improvement plans, to ensure a CLEAR Process was followed under Case for Change, Learning Oriented, Evidence, Assign, Review.

Discussion

This audit highlights the importance of robust complaint handling, fostering a culture of transparency, accountability, and continuous improvement. Timely resolution and clear communication emerged as critical factors in complainant satisfaction. Opportunities remain to enhance interdepartmental communication and documentation standards. A project, incorporating continuing audit has commenced to increase efficiencies to improve the key performance indicators.

Declarations of Conflicts of Interest: None declared.

Chasing the impossible dream; a tobacco free campus at University Hospital Limerick

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With support from ULHG Tobacco Free Campus Committee

1 Medical Student, University of Limerick.

2 Health and Wellbeing Department, University Hospital Limerick.

3 Security Department, University Hospital Limerick.

4 Operational Services Directorate, University Hospital Limerick.

Aims

A Tobacco Free Campus (TFC) provides a cleaner, healthier and safer hospital environment but is difficult to maintain. There are 8 Global standards to guide healthcare services on implementing a TFC. The audit aim was to assess compliance with these standards, to guide improvement.

Methods

A self-audit of Global standards was completed in April 2024, key improvement actions implemented and re-audit completed in April 2025.

To assess prevalence of smoking and vaping, 5 observation audits were conducted at the 2 main entrances to UHL, before (November 2023) and after (April 2025) the improvements were implemented.

Results

Initial audit of Global standards scored 112 out of 144 points. Observation audits at main entrances revealed a 60.0% prevalence of smoking and vaping (n=37/63).

Improvement initiatives included submission of a risk assessment, staff survey, wide-reaching communications and promotions, training, redesigning staff smoking hotspots, new signage and business cards, commencement of security patrols and re-establishment of a tannoy. Re-audit demonstrated improvements across key standards with a total score of 115 points. Re-audits at main entrances showed a marked reduction in prevalence of smoking and vaping to 20.1% (n=15/79).

Discussion

A yearly audit of standards informed improvement initiatives that led to reduced smoking and vaping at UHL hospital entrances. Security has embedded regular observation audits into routine patrols to monitor activity and maintain progress.

Declarations of Conflicts of Interest: None declared.

Improving the clinical management of tobacco addiction for admitted surgical patients at University Hospital Limerick

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2 Respiratory Department, University Hospital Limerick.

3 Physiotherapy Department, University Hospital Limerick.

4 NCHD, University Hospital Limerick.

Aims

Routine treatment of tobacco dependency on admission supports patients to have a smoke-free hospital stay to optimize health outcomes, healing and recovery. The audit aim was to assess the management of tobacco addiction for a cohort of surgical patients against National Stop Smoking Guidelines.

Methods

Medical notes were reviewed for documentation of smoking status, offer of brief advice, Nicotine Replacement Therapy (NRT) and referral to stop smoking specialist (SSS) on a selection of surgical wards in April 2024 & 2025.

Results

Out of 116 charts reviewed in the initial audit, 111 (96%) had smoking status recorded, 25 (23%) patients were identified as smokers, of which 3 (12%) were documented as receiving brief advice, 2 (8%) were offered referral to SSS and 6 (24%) were offered NRT.

Quality improvements included education and communications to raise awareness of supports and services available.

Re-audit of 107 charts 1 year later, demonstrated 95 (89%) had smoking status recorded, 16 (17%) patients were identified as smokers, of which 5 (31%) were documented as having received brief advice, 4 (25%) were offered referral to SSS and 5 (31%) were offered NRT.

Discussion

Audit showed some improvements in the offer of specialist support and medication but large scale-culture change and investment is needed to truly embed routine treatment of tobacco addiction as a clinical priority.

Declarations of Conflicts of Interest: None declared.

Stop before the op; optimizing smoking cessation support before surgery at University Hospital Limerick

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2 Medical Student, University of Limerick.

3 Health and Wellbeing Department, Acute services-HSE Mid-West.

Aims

Tobacco smokers are at significantly higher risk for post-surgical complications and impaired wound healing. The audit aim was to review and optimize the delivery of a brief intervention on smoking cessation to patients before surgery, in line with National Stop Smoking Guidelines.

Methods

Medical notes for patients who attended preoperative assessment (POA) in February 2025, were reviewed for documented smoking status, offer of brief advice, Nicotine Replacement Therapy and referral to stop smoking specialist (SSS) by the multidisciplinary team.

Results

Of 65 charts reviewed during initial audit, 64 (98.4%) had smoking status recorded. From the 12 (17.5%) patients identified as smokers, one (9%) patient was documented as having received brief advice, offer of NRT and referral to SSS. Quality improvements delivered included education sessions, development of a brief intervention infographic and a streamlined referral pathway. A real-time rapid cycle re-audit of all POA charts (46) for the 7 consecutive days after training demonstrated 100% recording of smoking status. All 3 patients identified as smokers received advice, offer of NRT and referral to SSS. One patient was prescribed NRT and reviewed by the stop smoking specialist on same day.

Discussion

This audit demonstrated enhanced delivery of brief interventions on smoking cessation during pre-operative assessments, enabling better access to specialist stop smoking services to promote improved surgical outcomes and overall health.

Declarations of Conflicts of Interest: None declared.

To measure compliance with Fundamentals of Patient care in the Emergency Department in UHL.

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Department of Nursing, University Hospital Limerick.

Aims

Managing the fundamentals of patient care in the Emergency Department is essential for the provision of quality patient centred care. This project focuses on aspects of personal care, comfort, communication, pain assessment, escalation of care based on their early warning system and medication management. We aimed at increasing compliance to 90% across all aspects of the patient's fundamental of care principles.

Methods

A random section of documentation is audited daily as per local audit guidance, examining 8 criterion. There were seven audit iterations with 100 cases per iteration, reported quarterly. Senior Nursing Management Team have executed a plan-do-study-act cycle based on multiple interventions. The interventions include staff refresher training on the principles of the fundamentals of care. Reinforcement of required actions daily at the morning staff huddle and as part of our daily audits of patient care and addressing non-compliance with staff immediately. The progress of the project is monitored weekly through audit.

Results

The audit data informed clinical practice and outlined continual improvement across all criterion with 7/8 sustaining >90% for the last 3 audit cycles. There is one criterion requires further work as it remains below 90% compliance it does however show continual improvement.

Discussion

Coordinated interventions were successful in increasing the adherence the principles of the Fundamentals of care while patients are in the Emergency Department.

Declarations of Conflicts of Interest: None declared.

Increase the compliance with the Manchester Triage System key performance indicator (KPI) of 25mins in use in the Emergency Department (ED) at University Hospital Limerick

M. Cooke, J. Khan.

Emergency Department, University Hospital Limerick.

Aims

Manchester Triage system (MTS) is used for prioritizing patient care based on urgency of clinical needs using flow charts based on presenting complaint. This allows rapid assessment based on patient reports and observed signs. Triage KPI of 25 minutes Patient Experience Time (PET) must be achieved. Internal escalation plan supports interventions required ensuring resources are redeployed to triage as patient presentations increase.

Methods

A daily report on numbers of adult patients attending ED from 08.00am daily including average wait times is received. Daily monitoring aligned with nursing numbers allocated to Triage. Senior Nursing Management Team executed a plan-do-study-act cycle with multiple interventions, including staff training, with 60% of nursing staff MTS competent. Nurse Management monitor throughout the shift using Maxims (patient management system) in line with the ED internal escalation plan to ensure compliance. Project progress is audited weekly.

Results

The audit data informed clinical practice and outlined overall compliance to the KPI the first three months of 2025, with January at 48% compliance, February 35% compliance, March 62% compliance and April 77% compliance.

Discussion

Coordinated interventions (education and staffing) are ongoing to ensure adherence with this KPI for our ED. Next steps include identification of additional resources to support the Triage nurse such as electrocardiogram at Triage.

Declarations of Conflicts of Interest: None declared.

Increase the compliance with the Escalation of patient care based on their INEWS/EMEWS Score- University Hospital Limerick Emergency Department

J. Khan, M. Cooke, I. Byrnes, D. Cromwell, J. M. Varghese, A. Scanlon, E. Meagher.

Emergency Department, University Hospital Limerick.

Aims

Escalation of patient care using the Irish National Early Warning System (INEWS) and Emergency Medicine Early Warning System (EMEWS) involves a structured approach to recognising and responding to deteriorating patients (> 16 years). These systems use physiological parameters generating a score that triggers specific action and escalation of care. The aim of both systems is to improve patient outcomes and safety through standardised observation, scoring and escalation protocols. Develop a quality improvement project (QIP) to increase compliance to 90% within 6 months of project initiation.

Methods

Random selection of 40 INEWS and 40 EMEWS charts, as per local audit guidance, are audited weekly since February 2025. Senior Nursing Management Team executed a plan-do-study-act cycle based on multiple interventions. The interventions include staff refresher training on the recognition and management of early warning score system escalations. Project progress is monitored weekly through audit of INEWS and EMEWS patient monitoring systems.

Results

Audit data informed clinical practice outlining compliance ranges from 50-87%. With 90-95% of INEWS and EMEWS patients having their clinical observations recorded as per protocol.

Areas of excellence included refresher education workshops with compliance of 87% 1st week in April. Areas for improvement include additional resources to support high patient presentations.

Discussion

Coordinated interventions resulted in increased adherence to INEWS and EMEWS score escalation protocols in the Emergency Department.

Declarations of Conflicts of Interest: None declared.

Adherence with the administration of prescribed medications within 1 hour of prescribing within University Hospital Limerick, Emergency Department (ED)

M. Cooke, E. Meagher, J. Khan.

Emergency Department, University Hospital Limerick.

Aim

To audit compliance with the administration of prescribed medications within 1 hr of the prescription in the Emergency Department.

Method

A random selection of 100 adult patients ED prescriptions (excluding patients in the Resuscitation Department) have been audited weekly since November 2024 to determine compliance. The Urgent and Emergency Care Directorate Management team executed multiple plan-do-study-act cycles based on multiple interventions. The interventions were designed to ensure that the prescriber and nursing staff are aware of the actions required when a patient is prescribed a medication including the work processes in place in each clinical area of the ED and an allocated nursing cohort to care for ED patients, supported by a team lead to ensure safe quality timely patient care is achieved for all patients attending our ED. The progress of the project is monitored through week auditing.

Results

The audit data informs clinical practice and outlines our weekly compliance ranges from 61% to 89%. Audit findings are communicated to all nursing staff monthly at staff meetings and displayed on the staff notice board.

Discussion

Coordinated interventions are supporting increasing our compliance with the administration of prescribed treatments within 1 hr of prescription. Next steps will include examining how we can improve compliance further with the 1hr administration through enhanced work processes and practices.

Declarations of Conflicts of Interest: None declared.

A clinical audit of staff compliance with local policy, national and international guidelines regarding falls assessment in the Geriatric Emergency Medicine Unit (GEM-U) in University Hospital Limerick (UHL)

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1 Department of Occupational Therapy, University Hospital Limerick, Limerick, Ireland.

2 Limerick EM Education Research Training (ALERT), Emergency Department, University Hospital Limerick, Ireland.

Aims

Determine staff compliance with multifactorial falls assessments for older adults in GEM-U.

Methods

Clinical audit of 20 medical charts, as per local audit guidance, of patients attending GEM-U with fall as their index presentation in Quarter 4 2023. Re-audits completed in Quarter 2 2024 and Quarter 1 2025. To ensure inclusion of a representative sample, Manchester Triage System categories included “falls”, “limb problems”, “collapse”, and “back pain”. The audit tool comprising of 11 standards was informed by World Guidelines for Falls Prevention and Management for Older Adults: A Global Initiative (2022) and European Society of Cardiology; Guidelines for Diagnosis/Management of Syncope (2018). Results were analysed using descriptive statistics.

Results

Initial audit cycle, compliance varied across all 11 standards ranging from 15-100%. Clinical practice improvements were implemented including team-based education on assessment practices and introduction of a falls template. Composite compliance increased from 65% in cycle 1 to 90% in cycle 3.

Cycle 2 and 3 results showed a composite increase in compliance in the areas of: careful history taking (55%-100%), completion of an electrocardiograph (60%-90%) and completion of lying and standing blood pressure (25%-65%).

Discussion

This audit identified a range of areas for team-based clinical practice development underpinned by implementation of a quality improvement plan. Future work should focus on maintenance of standards and exploration of evidence-based interventions.

Declarations of Conflicts of Interest: None declared.

Improving compliance with the 2-Hour Medical Referral-to-Admission Standard within zones on the Geriatric Elderly Medicine Unit (GEMU), University Hospital Limerick (UHL), Emergency Department (ED): A closed-loop audit

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1 School of Medicine, University of Limerick.

2 Department of Medicine, University Hospital Limerick.

Aims

This closed-loop audit, conducted within the Zones/GEMU unit of the UHL ED, aimed to assess and improve adherence to the national guideline standard of ≤ 2 hours from referral to admission.

Methods

A three-cycle closed-loop audit was performed. Data were collected prospectively daily from medical handover sheets and supplemented by patient chart reviews over 30-day periods for each cycle. The primary outcome measured was the time interval between referral to the medical team and patient admission. Interventions included increasing the number of Senior House Officers (SHOs) from 3 to 4 on weekday nights in Cycle 1, and further to 4 SHOs plus 1 Registrar for the full week of nights in Cycle 2.

Results

Baseline analysis of 832 referrals showed a 44.1% (367/832) compliance rate. Cycle 1, with 4 SHOs on weekday nights, showed a decrease in compliance to 33.6% (317/944) of referrals. Cycle 2, with 4 SHOs and 1 Registrar covering all nights, resulted in a significant improvement, with compliance rising to 57.7% (629/1090) of referrals.

Discussion

Targeted increases in night-time medical staffing, especially the addition of a registrar throughout the week, significantly improved compliance with the 2-hour referral-to-admission standard within the UHL ED Zones/GEMS unit. These findings highlight the importance of addressing staffing levels during peak demand to sustain improvements in timely patient care and flow.

Declarations of Conflicts of Interest: None declared.

An audit of health and social care professionals (HSCP) documentation in screening for sarcopenia in older adults who present to the Emergency Department (ED)

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2 Occupational Therapy Department, University Hospital Limerick, Limerick.

3 Medical Social Work Department, University Hospital Limerick, Limerick.

Aims

Review HSCP documentation to determine whether sarcopenia was being screened for in the ED.

Methods

Retrospective chart review of adults, over 65 years old, seen by HSCP team in January 2025 was completed using 'Therefore patient information management platform'.

Charts of 20 patients were randomly audited, as per local audit guidance, from the HSCP teams excel data sheet on 27.02.2025.

Audit screening questions included - Was grip strength assessed along with chair stands? (x5 sit to stands timed), Was the SARC-F Screening Tool used?, Was objective gait speed assessed and analysed as having sarcopenia? Examples include 'timed up and go', 400m walk test.

Data was gathered using Microsoft excel, analysed and portrayed visually on a pie chart.

Results were shared with the HSCP team following initial audit, the SARC-F screening tool was implemented. Re-audit was completed on the 04.04.2025.

Results

The initial audit showed a 0% compliance with screening for sarcopenia, compared to 25% with the re-audit following implementation of the SARC-F tool.

Discussion

Screening for sarcopenia is a practice change for the Acute Floor HSCP team. There is currently no formal allocation for recording the SARC-F score within our pro-forma. The pro-forma will be altered in Q2 2025 to reflect the SARC-F score. Further re-audit will be completed in Q3 to evaluate the compliance with screening for sarcopenia.

Declarations of Conflicts of Interest: None declared.

An audit of malnutrition screening completion and accuracy in the Geriatric Emergency Medicine Unit at University Hospital Limerick

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2 Human Nutrition & Dietetics, School of Allied Health, University of Limerick.

Aim

To evaluate the accurate use of the MUST tool to screen for malnutrition in the Geriatric Emergency Medicine Unit (GEMU) at the University Hospital Limerick in line with national Key Performance Indicators (KPI) and assess the prevalence of malnutrition on the unit.

Methods

An audit tool was developed to gather metrics on hospital malnutrition screening policy, procedure and guidelines. The audit was conducted in August 2024 and repeated 6 months later.

Results

Of 68 patients included at index, 54 (79%) patients had malnutrition screening completed. Of these, 47/54 (87%) MUST scores were documented correctly. A risk of malnutrition was identified among 12/68 (17%) patients. Adding a stadiometer to the GEMU improved height measurement accuracy in the repeat audit, leading to more accurate MUST scores. 27 (75%) patients had malnutrition screening completed with 22 (81%) MUST scores documented correctly. A risk of malnutrition was identified among 3 (9%) patients.

Discussion

The audit identified areas for service improvement, resulting in an enhanced screening protocol, reliable data, and improved GEMU teamwork. This led to exceeding the KPI of screening 60% of GEMU presentations for malnutrition within 24 hours, one-year post-implementation.

Declarations of Conflicts of Interest: None declared.

Arterial lines in University Hospital Limerick Intensive Care Unit: “Should they stay or should they go now?”

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2 Intensive Care Unit, University Hospital Limerick.

3 Department of Anaesthetics, University Hospital Limerick.

Aim

Arterial lines in Intensive Care Units (ICUs) are used for blood pressure monitoring and blood sampling (ABG). Prolonged use increases risk of complications. This audit aimed to assess arterial line management in University Hospital Limerick (UHL) ICU. Arterial lines should be removed when there is no indicated use for them – such as when decision-to-discharge has been made.

Method

A retrospective review of patients discharged from ICU to wards from January to May 2024 followed by re-audit from November 2024 to March 2025 using the ICU database. Data included decision-to-discharge (DTD), timely removal of arterial lines, frequency of ABG sampling beyond the DTD and changes in haemoglobin levels over this time.

Results

Initial audit identified 57 patient records; mean number of arterial lines removed on discharge day was 58% with 42% removed before discharge day. Mean ABG count beyond DTD was 3.8 and mean haemoglobin drop was -0.21 g/dL.

Re-audit identified 37 patient records; mean number of arterial lines removed on discharge day was 54% with 46% removed before discharge day. Mean ABG count beyond DTD was 4.8 and the mean haemoglobin drop was -0.13g/dL.

Discussion

Re-audit showed some improvements, indicating that interventions had a positive impact. A limitation of this audit cycle was the sample size between the audit periods.

Declarations of Conflicts of Interest: None declared.

Audit to increase the compliance of Sepsis 6 Bundle within University Hospital Limerick (UHL) Emergency Department

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2 HSE Mid-West Acute Hospitals and National Sepsis Team.

3 Emergency Department, UHL, HSE Mid-West, St. Nessel's road, Dooradyle, Limerick, Ireland.

Aim

We aimed to increase compliance to national clinical guidelines for sepsis to 90% within 6 months of the project's initiation.

Methodology

A 6 month retrospective audit of all patients coded with sepsis and septic shock was completed. Many plan-do-study-act cycles were executed. Interventions were designed for early identification of sepsis, staff education and patient flow modification. Progress is monitored by a monthly retrospective audit of adult and obstetric patients with "suspected sepsis". Exclusion criteria include paediatric and patients not meeting criteria for sepsis and/or septic shock.

Results

Compliance with 12 sepsis indicators were measured, some of which included recognition of at risk patients, time to be seen, sepsis 6 and use of the sepsis form. Total results remained above 87% compliance. Key areas such sepsis recognition achieved 98-100% compliance, seen within an hour 84-94%, antimicrobials within an hour 67-93%. Antimicrobials with 3 hours 94-100%.

Conclusions

The audit data informed clinical practice and highlighted the burden of sepsis on UHL. It identified overall compliance to Sepsis 6 bundle, areas for improvement and excellence and challenges with data capture. Outliers (>3 hrs first dose antimicrobials) were identified with subsequent reporting of all these cases to Senior Governance for review. It also informed many quality improvement initiatives. Targeted quality improvement work continues to achieve aim.

Declarations of Conflicts of Interest: None declared.

A clinical audit of the Pathfinder Service current assessment of falls in the older adult

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2. Occupational Therapy Department, University Hospital Limerick.
3. Physiotherapy Department, University Hospital Limerick.
4. National Ambulance Service.

Aims

Falls and fall related injuries impact approximately 30% of older adults, negatively affecting functional independence and quality of life.

The 2022 World Guidelines for falls prevention and management for older adults (WFG) established international evidenced-based, expert-guided recommendations.

An audit was indicated to benchmark our existing practice against key components of the WFG.

The aim of this audit is to identify existing gaps in our assessment and interventions with patients who have fallen at home, and adopt key recommendations from the WFG.

Methods

A retrospective analysis of documentation of all 999 calls responded to by the Pathfinder service with (1) presentation of falls (2) did not require hospital admission (3) timeframe August 2023 – January 2024. Sample size: 48.

Key practice changes (N8) were identified and introduced to improve quality and align with the WFG.

The re-audit retrospectively analysed patient's charts who met the original inclusion criteria in the timeframe January- March 2025. Sample size: 15.

Results

Documentation of the 8 key practice changes increased by 34% on re-audit, improving from 37% to 71% on average.

Discussion

The introduction of falls stratification and a set of guidelines amongst the MDT has enhanced consistency with assessment and interventions with patients who have fallen at home. Further education and practice change is indicated to unify practice and standardisation within the MDT.

Declarations of Conflicts of Interest: None declared.

Introducing safety huddle to prevent falls on our ward.

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3 Nursing Department, St John's hospital, Limerick.

4 General Medicine Department, St John's Hospital, Limerick.

Aims

The Health Service Executive strategy to prevent falls and fractures in Ireland's ageing population (2008) highlighted that falls are one of the leading adverse events in acute hospitals. Ineffective communication amongst staff can lead to an increase in falls. Ghoul *et al* (2025) stated that safety huddles are a dynamic, multifaceted intervention with significant potential to foster collaborative safety practices and reduce adverse events. Our aim was to decrease the number of falls by 10% over 6 months through the introduction of a falls safety huddle (FSH).

Methods

The FSH was introduced in September 2024 - February 2025. FSH took place three mornings a week. An FSH script was developed. Regular feedback was sought to establish the FSH. A safety cross was used to capture falls.

Results

The FSH were successfully implemented. We found that a high number of patients were identified as a falls risk. 100% of patients who were identified as a falls risk, received the appropriate care plan for falls prevention. During the 6-month audit period 26 falls were recorded. This was an increase on the previous 6 months where 8 falls were recorded.

Discussion

The introduction of FSH did not decrease the number of falls. We believe falls were previously underreported. We aim to audit the circumstances around falls in order to identify suitable interventions.

Declarations of Conflicts of Interest: None declared.

Did implementing a new electronic system for incident management risk reducing reporting levels due to staffs' lack of knowledge or fear of the new electronic process?

M. Gallagher, L. O'Riordan, N. Kennedy.

Department of Quality Risk and Patient Safety, St. Johns Hospital Limerick.

Aim

To ensure incident reporting remained stable through the process change from a paper based system to an electronic point of entry (ePOE).

Methods

Quantitative review of data of all incidents reported on the National Incident Management system February 2024 and February 2025.

Results

Results show incident reporting has continued with only a minimal reduction in reporting from the previous year. February 2024 saw 69 incidents reported and 67 incidents reported in February 2025. This could be due to variables such as inpatient dependencies.

Discussion

Introduction of ePOE occurred in St. Johns Hospital January 14th, 2025. On this date, hard copy incident forms were removed from departments and ePOE incident reporting went live. Training sessions were provided prior to introduction of the new electronic process and ePOE folders with cheat sheets developed and distributed to all departments. On the go live day there were information sessions outside the canteen at morning, lunch break and rolling information sessions in the classroom after lunch.

The risk was that the incident reporting rate would decrease due to the new system but this was not the case. Comparing incident data reported in February 2024 and February 2025 the difference is minimal and provided validation of the new system. It is planned to continue providing training sessions on the new process and re-audit after 2 months.

Declarations of Conflicts of Interest: None declared.

An audit of the time from onset of deterioration to safe transfer of care of deteriorating patients from St John's Hospital (SJL) to another healthcare facility

S. Carroll, M. O'Connor, F. Wahab.

St John's Hospital, Limerick.

Aims

Early recognition and timely management of deteriorating patients is vital in ensuring high quality safe patient care, leading to reductions in adverse outcomes. SJH is a model 2 hospital with limited resources for managing deteriorating patients, timely and safe transfer to higher levels of care in a model 4 hospital is essential.

The aim was to reduce the time of safe transfer of deteriorating patients from SJH to University Hospital Limerick to < 2hours.

Methods

In September 2024, a retrospective audit of 31 medical notes, as per local audit guidance, was conducted to examine the Irish National Early Warning System (INEWS) score documented for onset of deterioration and time between onset of deterioration to patient transfer.

Results

The audit demonstrated that 42% of patients had an INEWS score of 7 documented with onset of deterioration indicating late recognition of deterioration and 54% of transfers took > 2hrs (Recommendation is <2 hour).

Discussion

Following implementation of quality improvement initiatives to make sustainable improvement changes, led to improving early recognition of deteriorating patients, documentation and collaboration among teams. Re-audit in 2025 demonstrated significant improvements with 50% of patients having an INEWS score of <3 documented with onset of deterioration demonstrating earlier recognition. Transfers occurred in 100% of cases within < 2hrs illustrating improvement in facilitation of inter-hospital transfers.

Declarations of Conflicts of Interest: None declared.

Identify, situation, background, assessment and recommendation (ISBAR) communication tool audit (deteriorating patient)

S. Carroll, C. O'Grady.

Resuscitation Department, St. John's Hospital, Limerick.

Aims

The audit aim is to establish if 85% compliance could be achieved with the use of an updated ISBAR communication tool in patients who had been identified as deteriorating.

Methods

A retrospective snapshot audit was conducted in August 2024 to determine the level of ISBAR sticker use in patients who had been identified as deteriorating, indicated by Irish National Early Warning System (INEWS) score >3.

Following review of 5 healthcare records we identified quality shortfalls with the ISBAR stickers, as per local audit guidance this negated the requirement for further data collection and we progressed to quality improvement and re-audit stage.

Results

There was evidence of the use of an ISBAR sticker in 60% of healthcare records audited.

Discussion

A new updated ISBAR sticker was developed in collaboration with key stakeholders. The sticker was colour co-ordinated and more user friendly. Following a hospital-wide roll out of the sticker and relevant education a re-audit was conducted in December of 2024. In this re-audit of 5 healthcare records, 85% of healthcare records audited had evidence of the use of the updated ISBAR sticker, ensuring the hospital was compliant with recommendation 22 in the National Clinical Guideline no.11 –Communication (Clinical Handover) in Acute and Children's Hospital Services.

To ensure sustainability a re-audit was conducted in April 2025 of 25 healthcare records, demonstrating 88% compliance.

Declarations of Conflicts of Interest: None declared.

Compliance with national standards for safe clinical handover

A. Resimic, L. Quin, E. Hayes.

St. John's Hospital, Limerick.

Aims

The audit aimed to achieve compliance with national standards for safe nursing clinical handover across the hospital.

Continuity of patient care is a critical dimension of healthcare quality, particularly from the patient's perspective. Effective clinical handover processes are essential to ensure uninterrupted care and minimize adverse events risk.

Methods

Observational audit was conducted on all inpatients (n = 89) in July 2024 to evaluate communication practices during morning clinical handover.

Results

Audit demonstrated overall lack of structure in communication across all clinical floors. Data indicated that current Irish National Early Warning System (INEWS) scores were only communicated for 75%, and risk assessments in 50% of patients. Recommendations regarding further care were communicated for 50% of patients and 75% of handovers incorporated a safety pause.

Discussion

Audit results highlight the critical need for structured approaches to clinical handover, such as Identify, Situation, Background, Assessment and Recommendation 3 (ISBAR3) communication tool and incorporating a Safety Pause. We removed pre-printed handover sheets as recommended by (NCEC, DoH, 2015) and replaced with a tailored information sheet.

To ensure successful implementation of recommendations, comprehensive education for nursing staff is crucial. Continuous education and six-monthly re-auditing will foster a culture of improvement, empowering nurses to adapt and respond effectively to evolving practices.

Repeat observational audit (n = 89) in March 2025 revealed improvement in adherence, with compliance rates above 90%.

Declarations of Conflicts of Interest: None declared.

Audit of the 4AT delirium risk assessment tool

S. Liston, L. Quinn, E. Hayes.

St. John's Hospital, Limerick.

Aims

The overall aim of the audit was to adhere to **delirium detection guidelines**, through the implementation of the 4AT Delirium Risk Assessment Tool on patients aged > 65 years, across four different clinical areas within a hospital setting.

Methods

Audits were conducted reviewing 4AT completion rates, scoring accuracy, assessing the impact of 4AT on patient outcomes. Review of documentation in patient records was conducted. Closed loop audit methodology was utilised, with 40 charts audited in December 2024 and a further 40 charts audited, as per local audit guidance, in April 2025. Actions were implemented after the first iteration of the audit based on the findings.

Results

Audit results revealed increased compliance in delirium screening from 80% in December 2024 to 90% in April 2025.

Discussion

The audit data from December 2024 was used for constructive performance feedback, and to engage nurses in collaborative feedback problem solving. Providing unit specific data increased staff agreement that change was required. Nursing documentation was modified to include a delirium care plan. Ongoing education for Nurses reinforced the importance of screening patients for delirium. Re-audit results were used to further refine interventions and improve delirium care.

Continuously auditing delirium screening and management practices is planned to ensure they remain effective.

Declarations of Conflicts of Interest: None declared.

Improving mandatory training uptake through localised interventions

N. Kennedy, E. Hayes.

Quality and Patient Safety Department, St. John's Hospital.

Aims

Increase mandatory training compliance by 20% in St. John's Hospital.

Methods

Hospital mandatory training requirements were revised, agreed and communicated to department heads. This included Health Service Executive and hospital mandated training. Data was collected quarterly from all 15 hospital departments (n = 406 staff), each representing a different discipline or function, measuring against the set standard of 17 mandatory trainings requiring completion. An excel template was developed to capture compliance percentage for each department. Data was collated quarterly and analysed at 6 months. Data was presented allowing for clear visual tracking of training compliance over time.

Results

At six months the data was analysed for Quarter 1 and Quarter 2, training compliance had improved by 10% against the 17-mandatory training. A Quality Improvement Plan was developed at department level, the re-audit of Quarter 3 and Quarter 4 highlighted an improvement of 26% in compliance rates.

Discussion

Central to achieving compliance with mandatory training were innovative and locally implemented strategies. These measures included the allocation of dedicated, structured time during night duty, introduction of a module of the month, delegation of responsibility to supervisors and the integration of mandatory training into the induction process. Equally important was the proactive engagement and support provided by department heads, clinical skills facilitators and patient service supervisors, which proved essential in driving the success of these initiatives.

Declarations of Conflicts of Interest: None declared.