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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

Radiological investigation of acute renal colic – Lessons learned from a closed loop audit.

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Abstract

Aims

CT kidney ureter and bladder (KUB) is the diagnostic test of choice for investigating acute renal colic. Although considered a low-dose imaging modality, maintaining an appropriate diagnostic yield is essential.

Methods

CT KUBs performed in University Hospital Limerick during March 2025 and February 2026 were compared to standards established by the Royal College of Radiologists. Seventy five CT KUBs were analysed from both timeframes (150 total). Approximately 1200 CT KUBs are performed annually. Audit standards included 1) calculi positivity rate of 44%, 2) alternative diagnosis in a further 6-18%, 3) imaging acquisition within 24 hours of request (100% target) and 4) no CT KUB within the prior three months.

Results

The mean patient age was 50.3 years (+/-6.5 SD), 82 females and 68 males. The results were presented at departmental teaching and a local conference. Image acquisition times improved from 96% compliance (72) to 100% (75), while repeat CT imaging reduced from 3 patients (4%) to 2 (2.7%). Calculi positivity rate did not meet the RCR standard in either timeframes at 43% (32 patients) and 27% (20) respectively. Alternative diagnosis were documented in 20 (27%) and 24 (32%) reports, above the referenced target range.

Discussion

This closed loop audit cycle does not meet the desired CT KUB positivity rate. However, the frequency of differential diagnoses suggests CT KUBs continue to add diagnostic value.

No conflict of interest declared.

Compliance with referral of designated Virtual Fracture Assessment Clinic (VFAC) conditions to physiotherapy by Ennis Hospital Local Injury Unit (LIU) staff

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2. Local Injury Unit, Ennis Hospital.

Abstract

Aims

An audit was undertaken to assess compliance with referral to physiotherapy in accordance with the protocol for designated conditions which are managed through the Virtual Fracture Assessment Clinic (VFAC) process.

Methods

Over a 5-week timeframe, from 1/5/25 to 3/6/25, the VFAC patients referred to Ennis physiotherapy were checked against the database of all patients referred from Ennis LIU to VFAC. It was then determined how many patients had not been referred.

Results

An average of 9.7% of patients per week whose presenting condition indicated that they should be referred for physiotherapy were not referred. Six to fourteen patients per week on average would meet the criteria for physiotherapy referral, with an average of one patient not referred per week.

Discussion

The Advanced Nurse Practitioner in Emergency Medicine contacted relevant team members to determine if the VFAC referral form could be amended to include physiotherapy referral tick boxes, but this was not possible. It was decided, in consultation with team, that physio staff would check VFAC database weekly for appropriate referrals that may have been missed.

Most recent data indicates that the incidence of missed referrals declined to 2.5%. While an average of 1 patient every fortnight wasn't referred, this is now detected by the physiotherapist checking the database.

Declaration of Conflicts of Interest

No conflict of interest.

Beyond the impairment: Physiotherapists making every contact count for smoking cessation

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Abstract

Aims: To embed brief interventions on smoking cessation into routine physiotherapy care in the Acute Fracture Unit (AFU)

Methods

In-service teaching on Making Every Contact Count was delivered to physiotherapy staff at UHL in May 2024 demonstrating the importance of smoking cessation. The AFU physiotherapy team implemented an updated audit tool to record the intervention and access to referral pathways to QUIT services. From June 2024, smoking status was routinely recorded and referral offered to all patients attending AFU.

Results

In year one, 51 referrals were made by the AFU physiotherapy team to stop-smoking services compared to 0 referrals the year before

Discussion/Conclusion

This project positions physiotherapists as key contributors to behaviour change and secondary prevention in acute care. With appropriate training and supports, physiotherapists can confidently address smoking as a modifiable clinical risk factor influencing recovery and holistically promote positive health outcomes. Scaling this model has the potential to enhance outcomes across a wide range of physiotherapy settings and patient pathways. Tracking compliance with documenting smoker status will be audited in future

Declarations of conflicts of interest - None

To investigate the recording of oral nutritional supplements (ONS) on the oral nutritional supplement (ONS) administration record

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2- Department of Nursing, University Hospital Limerick, Dooradoyle, Co. Limerick

Abstract

Aims

To investigate the recording of oral nutritional supplements (ONS) on the ONS administration record. To compare the standards of practice against the measurable outcome of 100% and introduce quality improvement initiatives if required.

Methods

Two cycles of data collection were obtained. A total of 20 ONS administration records were audited between August to October 2025. The department of Nutrition and Dietetics prescribes approximately 80 – 100 ONS annually. Subsequently, 20 different ONS administration records were re-audited between January to February 2026. Microsoft Excel was used to analyse the results.

Results

Within the first audit, 65% (n=13) of ONS administration records were fully compliant, meaning that these records were signed accurately and consistently. In the re-audit, 90% (n=18) of ONS administration records were fully compliant.

Conclusion/Discussion

There was a 25% improvement in compliance between the two data collection points. Interdisciplinary collaboration between the dietitian and nursing staff resulted in improved documentation on the ONS administration record. This involved dietitian led education sessions focused on documentation improvement coupled with education dissemination by nursing staff. This resulted in more consistent documentation of ONS on the ONS administration records by nursing staff. A further re-audit will need to take place and if required, quality improvement strategies will need to be implemented to meet the required standard of 100%.

Declarations of Conflicts of Interest: None

Audit of Geriatric Emergency Medicine-Unit (GEM-U) staff compliance in providing care in line with the Age Friendly Health Systems Conceptual Framework

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2. Geriatric Emergency Medicine Unit, University Hospital Limerick
3. Occupational Therapy Department, University Hospital Limerick

Abstract

Aims

This audit evaluated documentation compliance (aim >90% for each domain) with the Age Friendly Health Systems Framework for older adults presenting to GEMU.

Methods

A retrospective review was conducted across five audit cycles (January 2023–December 2025). Fifteen charts per cycle (n=75), of approximately 200 patients assessed per month, were randomly selected from the Health and Social Care Professional (HSCP) data system and reviewed via the Therefore Emergency Medicine system.

Results

From first to fifth iterations, highest compliance was seen in the domains of Early Warning Score, mobility, falls history, and 4AT (average compliance >70%). Lowest compliance was observed in lying and standing blood pressure (L&S BP), Timed Up and Go (TUG) and “What Matters” (average compliance <30%). The documentation of care preference, low in initial iterations, showed the greatest improvement in cycle 5 (compliance at iteration 5=27%) following its addition to the proforma. In contrast, L&S BP and TUG declined despite prior prioritisation. Targeted interventions to improve compliance to date included staff education, TUG floor markings, a L&S BP station, and proforma updates.

Discussion/Conclusion

The ED HSCP proforma, aligned with the Age Friendly Health Systems Framework, is embedded in practice

and supports consistent documentation, though targeted improvements remain necessary. The next audit is scheduled for Q2 2026.

Declarations of conflicts of interest -none

A re-audit of the risk of refeeding syndrome identification and management by dietitians at University Hospital Limerick

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Abstract

Aims

Re-assess if refeeding syndrome (RFS) risk was identified, and if appropriate management of RFS risk was recommended by dietitians at University Hospital Limerick (UHL) for patients commencing parenteral nutrition (PN) or enteral nutrition (EN) in line with UHL policies. The standard was the Friedli Algorithm 2018 for RFS management. Aim is 100% compliance against the standard.

Methods

All patients in the adult wards at UHL referred for EN or PN in April 2025 (n=55) were included. The initial audit was completed in August 2023 (n=40). The first dietetic note on the relevant admission was inspected for identification of RFS risk and if identified, recommended management in line with the algorithm.

Results

Results showed that 73% (n=40) had RFS risk documented, decreasing from 93% (n=37) in 2023.

The use of non-standardised terms for risk categorisation reduced from 32% (n=12) to 13% (n=5).

Electrolyte monitoring and replacement were appropriately recommended in 90% (n=36) of cases (97%, n=36, in 2023).

Seventy-eight percent (n=14) of patients were appropriately recommended IV Pabrinex I & II or oral thiamine (100%, n=9, in 2023).

Discussion

Shortfalls were identified in out-of-hours care and transfers into service on EN/PN. Actions taken included standardising terminology, communicating to staff and updating practice sheet to reflect those scenarios. Re-audit in two months to assess the effectiveness of interventions.

No conflict of interest.

An audit of the storage and labelling of insulin products in University Hospital Limerick, Croom Orthopaedic Hospital and University Maternity Hospital Limerick.

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2. Pharmacy Executive Manager, Department of Pharmacy, Mid-West Acute Services, Limerick.

Abstract

Aims

Insulin is a high-risk medicine, it is international best practise that an insulin pen or vial should be assigned to a single patient.

The policy on the storage and labelling of in-use insulin products provides standards for storage of insulin and management of in-use insulin with aim of 100% compliance.

Methods

The 3 standards with least compliance related to storage and labelling of in-use insulin vials and pre-filled syringes.

Annual audit with quality improvements after the first and second audit included reviewing storage of in-use insulin; re-design of flag label; weekly checklist and a poster outlining process for insulin storage and labelling.

Results

In the Q1 2026 re-audit of all clinical areas in UHL (n=45), compliance has decreased in standard 1 from 45% to 30% (n=12); in standard 2 particularly 'date of opening' from 50% to 26% (n=5) and in standard 3 compliance has decreased from 69% to 45% (n=23).

Discussion/Conclusion

We have received positive engagement from nursing to improve compliance, including local audit of in-use insulin storage with completion of weekly checklist.

We will continue to promote vigilance through information, education and re-audit within a shorter timeframe to address non-compliance.

Declarations of conflicts of interest – None

Evaluation of blood transfusion documentation compliance within MN_CMS

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Haemovigilance UMHL & Blood Transfusion Laboratory ULHG

Aim:

In July 2025, the Maternity and Newborn Clinical Management System (MN-CMS) was implemented in University Maternity Hospital Limerick (UMHL), replacing paper-based documentation with an Electronic Health Record (EHR). This retrospective audit was conducted to assess and identify gaps in transfusion-associated data.

Methods

During the following time periods:

Audit 1 - 11th July–30th September 2025

Audit 2 - 17th November–17th December 2025

Transfusion data was extracted from MN-CMS and Blood Track[®] Software with findings collated for analysis.

Results

Audit 1

A review of all Red Cell (RC) administered, the agreed process was not followed for 14 of 59 units (23.7%).

A review of all Anti-D administered, the agreed process was not followed for 86 of 182 (47%).

Quick Reference Guides were developed and circulated to staff.

Audit 2

A review of all RC administered, the agreed process was not followed for 1 of 22 (4.5%) demonstrating a significant improvement.

A review of all Anti-D administered, the agreed process was not followed for 34 of 79 (43%), demonstrating improvement from 47%.

Discussion / Conclusion

Accurate transfusion documentation is a regulatory requirement. Repeated deviations suggest system and human-factor contributors. A further re-audit is planned for May 2026.

There are no conflicts of interest

An allied health professional (AHP) audit of compliance, in Ennis Hospital, with completion of the ASSKING Bundle

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Abstract

Aims

The audit aim is to improve compliance to the ASSKING Bundle (AB), which is **a**ssess risk, **s**kin assessment and skin care, **s**urface, **k**eeP moving, **i**ncontinence and moisture, **n**utrition and hydration and **g**iving information or getting help. The audit measures against local pressure ulceration guidelines with the ASSKING bundle tool, ensuring a standardised multidisciplinary approach. The aim is 80% compliance, for the allied health professional (AHP) cohort, by March 2026.

Methods

Retrospective data (n=20) collected from two inpatient wards, in December 2025 and January 2026. Each entry made from an allied health professional in the healthcare record was reviewed and compared to the AB.

Results

Initial audit achieved 28% and re-audit achieved 75% compliance, for entries made by an AHP. Actions between initial audit and re-audit were audit report communicated to all staff and to the pressure ulcer committee (PUC).

Discussion/Conclusion

Concerns were reported to the PUC regarding poor visibility to access the AB and availability issues. PUC audited presence of AB and ordered the original AB, which has more vibrant colour for visibility. An incidental finding of the audit was that locum staff were not aware of the policy, which highlights the need for education during induction, and plans are in progress to implement same. Re-audit planned for July 2026.

Declarations of conflicts of interest – None

Missed doses in admitted patients in the Emergency Department-an audit and quality improvement cycle.

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2. Emergency Department, University Hospital Limerick.

Abstract

Aims

The aim of this audit cycle is to determine the prevalence of missed doses in the Emergency Department (ED), and to trial quality improvements.

Methods

Random sampling was used in the audit. A baseline audit in August 2024 of 53 medication records showed a prevalence of 6% of medications due were missed. The target was for a prevalence of less than 1%. A working group was set up to review processes around ordering, supply and storage of medicines and changes made. The initial re-audit over a number of days in July 2025 of 63 medication records did not show significant improvement with a prevalence of 5%. Further quality improvements were introduced including a trial of Pharmacy Technician involvement of reviewing orders in ED. A stock locations file for all stock medication in ED was added to the computer in clinical rooms. Specific work was carried out in ED on highlighting diabetic patients to ensure insulin is prescribed and administered on time.

Results

A third audit over a number of days in November 2025 was carried out on 29 medication records showed a significant reduction in missed dose with a prevalence of 0.4%.

Discussion/Conclusion

Missed medication doses in admitted patients in the Emergency Department is a multi-factorial issue requiring ongoing work and monitoring to ensure improvements are sustained.

Declarations of conflicts of interest -none

Audit of Unscheduled Care Cancer Services

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Abstract

Aims

An Unscheduled Care (USC) room was established in the Cancer Services Day Unit in 2022 to assess patients who call the unwell line, attend clinic or pre-assessment to prevent Emergency Department (ED) presentations. An audit (1/12/2024–30/3/2025) targeted 100% compliance against the Standard Operation Procedure (SOP), over 60 operating days across 17 weeks, with an average of seven patients per day.

Methods

A prospective audit of Oncology/Haematology attendances (n=413) to the USC used weekly electronic patient clinic lists, against SOP criteria: with disease-related symptoms or treatment side effects; exclusions included acute medical issues, routine transfusions, and IV saline.

Results

The audit shows the service reduced ED demand and avoided admissions.

The initial audit showed 79% compliance and when capacity was full, 5% attended ED, highlighting the need for infrastructure expansion. A 4-week re-audit in March 2026 (112 patients) showed 100% compliance.

Discussion/Conclusion

The audit shows this as an effective pathway to reduce ED attendances and admissions, despite the unpredictability and complexity of presentations. It identified the need for expanded space and a separate service for supportive therapies; a daily slot is now reserved for unplanned transfusions or IV saline. Re-audit confirms the USC room is now used as intended and aligned with SOP, with ongoing updates reflecting service changes.

Declarations of conflicts of interest

No conflicts of interest declared.

Closed-loop audit assessing the quality of oncology inpatient consults for new malignancies at University Hospital Limerick, three months before and after implementation of a standardised inpatient consult form

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Aims

To assess compliance with locally defined standards for essential information required in inpatient oncology referrals for new malignancies at University Hospital Limerick against a target of 100% compliance, and to evaluate whether implementation of a structured inpatient consult form improves adherence to these standards.

Methods

A closed-loop retrospective audit was conducted in two cycles, each including 48 inpatients referred to oncology for new malignancy at University Hospital Limerick before and after implementation of a structured consult form. During the three-month study period, 72 new inpatient oncology referrals were received, of which 48 met the audit inclusion criteria. Approximately 300 new inpatient oncology referrals are received annually at our institution. Data were extracted from electronic health records and analysed using descriptive statistics and chi-squared testing. Audit standards required documentation of biopsy status, patient and next-of-kin notification, ECOG performance status, and completion of staging investigations.

Results

Documentation of patient notification improved from 7/48 (14.6%) to 46/48 (95.8%), and documentation of next-of-kin notification from 6/48 (12.5%) to 40/48 (83.3%). ECOG documentation increased from 2/48 (4.2%) to 44/48 (91.7%) ($p < 0.001$). No significant difference was observed in biopsy performance, with 8/48 (16.7%) pre-implementation and 13/48 (27.1%) post-implementation lacking biopsy ($p = 0.415$). Biopsy result availability remained unchanged at 13/48 (27.1%) in both groups. Complete staging rates were also similar (30/48 [62.5%] vs 31/48 [64.6%], $p = 0.971$).

Conclusion

The structured form improved documentation and adherence to expected referral standards, but did not influence completion of investigations. Targeted education is required to improve compliance with pre-referral clinical workup.

Declarations of conflicts of interest

None

An audited quality improvement initiative to strengthen pre-assessment documentation for systemic anti-cancer therapy treatment in the Oncology Department

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AIM

To achieve $\geq 95\%$ compliance with documentation standards for systemic anticancer therapy in the pre-assessment unit of Oncology department.

METHODS

A structured booklet, aligned with evidence-based standards and including diagnosis and Common Terminology Criteria for Adverse Events (CTCAE) grading, replaced a single paper record in July 2025. An audit of 30 booklets was conducted after two months. Sections with $<10\%$ completion were removed, and a revised booklet introduced in November 2025, followed by re-audit of 20 booklets. Ongoing cyclical audit is planned.

RESULTS

Initial audit showed high completion for treatment plan (94%), diagnosis (86%), cycle number (82%), toxicity grading (91%), and signature (91%). Low completion included referrals (9%), venous access (11%), and infection (14%); blood results (69%) and treatment decision (69%) were moderate.

Re-audit showed improvement in treatment plan, toxicity grading, and signature (100%), with high rates for cycle number and fitness to treat (90%). Gaps remained in prescriptions/interactions (0%), imaging (5%), and medical history/medications (10%).

CONCLUSION

Iterative refinement of the booklet improved documentation towards the $\geq 95\%$ target. Ongoing audit and staff education are in place to achieve and sustain full compliance.

Conflict of interest: None

Audit of adherence to sepsis management for adults including maternity.

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2. University Maternity Hospital Limerick.

Abstract

Aims

Maternal sepsis is a life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, childbirth, post abortion or postpartum period (WHO, 2017). Sepsis remains a main cause of Indirect Maternal Death in the 2025 MBRRACE-UK maternal death report. Sepsis audits conducted in University Maternity Hospital Limerick aim to ensure care provided is in line with National Clinical Guidelines.

Methods

Retrospective data collection of 10 random cases per quarter, if available. Identified shortfalls are immediately escalated to a designated Consultant Obstetrician and Sepsis Lead. Quality improvement plans (QIPs) are developed, and quarterly audit results are shared with the Directorate Management Team and Deteriorating Patient Committee.

Results

95% compliance with National Clinical Guidelines was achieved.

Audit of 39 charts in 2025, covering approximately 90% of suspected sepsis presentations, with 5 true sepsis cases identified.

Two missed repeat lactate and five incomplete sepsis forms were identified in Q3.

Quality improvement in the form of communication, information and training was provided by Sepsis Lead and Clinical skills facilitators Midwifery to clinical staff. Repeat lactate was 100% in Q4 and documentation compliance increased to 80% in Q4.

Discussion/Conclusion

The incomplete form could be attributed to unfamiliarity with a recently implemented Electronic Health Record.

We plan to continually audit, sustain our good results and improve for 2026.

Declarations of conflicts of interest – None

Developmental dysplasia of the hips (DDH) at-risk neonates hips ultrasound scan referrals – a further practice re-audit

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5. Neonatology Department, University Maternity Hospital Limerick (UMHL), Limerick, Ireland

Abstract

Aims

Developmental dysplasia of the hips develops anytime peripartum or early childhood. Newborns 'at risk' with risk factors – parent/sibling treated and breech presentation/delivery, are referred for hips ultrasound scan.

Study aimed to re-assess referrals for compliance with national and local targets indicated in 2023 national report, following induction and education sessions.

Methods

Data about 'at risk' newborns at University Maternity Hospital Limerick between 15.05.2025 and 15.06.2025 was collected prospectively, entered and analysed using Microsoft Excel.

Results

Babies referred were 40. Risk factors were breech – 24 (60.0%) and positive family history – 16 (40.0%). Postnatal wards referrals were 70.0% (28) versus 80.0% in first audit. Preterms were 9 (22.5%).

'Day-2' exams documented for 38 (95.0%) – 29 (76.3%) within ≤ 72 hours old, and 37 (97.4%) were normal.

Late referrals (≥ 2 weeks) were 10.0% (4) versus 40.0% (22) in first audit. Gestational age documented for 77.5% (31) versus 58.2% (32).

Scans scheduled were 39 – 84.6% (33) at ≤ 6 weeks versus 60.0% previously.

All 38 scans done were normal. Three missed first appointment – 1 done privately; 1 family reasons; 1 still inpatient.

Discussion

Raising awareness about national targets among multi-disciplinary staff coupled with good collaboration led to improved timely referrals ($<14/7$) and scans ($\leq 6/52$). Regular consultant oversight was crucial.

Declarations of conflicts of interest – None

To audit compliance to a Trisomy 21 checklist in the Neonatal Intensive Care Unit in University Maternity Hospital Limerick.

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Neonatal Intensive Care Unit, University Maternity Hospital Limerick

Abstract

Aims

Aim for 100% compliance with referral to services for all inpatient infants, in the Neonatal Unit, with a confirmed Trisomy 21 diagnosis. This audit is inclusive of the infants admitted to the neonatal unit only.

Methods

Prospective data collection of all infants with Trisomy 21, between 05/09/2022 to 30/03/2026, to be referred to services on discharge home from the neonatal unit. Total infants included is 28.

Results

The audit tool assessed compliance of referral completion to services for this cohort. The services include medical referrals, community follow up, financial information and downs syndrome specific information. Three iterations of the audit took place on 28/11/2022 (n=4), 31/03/2025 (n=20) and 30/03/2026 (n=4). There was 100% compliance with referral to all services where data was available. After the first iteration the checklist was updated to streamline the process. There was a 12.9% gap in the referral data, which has been addressed with the EHR introduction.

Discussion/Conclusion

A dedicated neonatal discharge co-ordinator is in place and a re-audit is planned for 6 months time. An amended Trisomy 21 checklist was developed in 2022 and an updated version is on the electronic health record (EHR) in March 2026. The EHR will provide the audit data going forward with real time data available which will ensure more streamlined audit data capture.

I can confirm no conflict of Interest.

THINC: Treating healthy infants not cord gases

Author(s): I. Beirne, G. Dugaci, R. Philip M. Pierro

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Abstract

Aims

To evaluate compliance with the 2025 guideline for managing abnormal cord blood gases, aiming to reduce unnecessary NICU admissions while ensuring timely identification of infants requiring therapeutic hypothermia. The updated guideline prioritises clinical neurological assessment (Sarnat scoring) over admission based solely on abnormal cord gases in clinically well infants. Target compliance was 90%, with a 100% stretch goal.

Methods

Infants with abnormal cord blood gas values were audited using a six-question tool. Data were collected over multiple cycles: 31 cases over 5 weeks initially, followed by 42 cases over 5 weeks (re-audit), and three real-time audit cycles of 11, 8, and 12 cases over one week each.

An abnormal umbilical cord blood gas result is relatively rare and occurs in only about 3% to 9% of all births globally.

Results

NICU admissions among clinically well infants decreased by seven over 5 weeks in the re-audit, equating to an estimated 73 fewer admissions annually. Two infants required therapeutic hypothermia and were promptly identified and admitted. Overall compliance improved from 86% initially to 97%, 88%, 96%, and 93% across re-audit cycles. Education on Sarnat scoring, improved documentation, and ongoing staff training supported sustained improvement. Appropriate admission decisions achieved 100% compliance throughout.

Discussion/Conclusion

Prioritising neurological assessment reduced unnecessary NICU admissions without compromising safety, improving both resource utilisation and family-centred care.

No conflict of interest

Adherence to medication care plan utilization in an electronic health record system: A Neonatal Unit audit

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2. Department of Pharmacy, University Maternity Hospital Limerick, Limerick, Ireland.

Abstract

Aims

Aim for 100% compliance with medication care plans prescribing.

Methods

Data were collected using a standardized sheet assessing medication prescriptions and corresponding care plan use. Twenty Neonatal Intensive Care Unit (NICU) patients were audited over two separate weeks before and after an educational intervention regarding the use of care plans. Results were analyzed to evaluate trends.

Results

In 2025 there were approximately 800 admissions to the Neonatal Unit. Audits took place over two separate weeks in March and April with a sample size of 20 in each audit iteration and an education intervention after the first iteration. Results indicated improvements, IV fluids, prescribed in 75–90% of cases (15–18/20), showed increased adherence from 60% to 75–80%. EONS antibiotics, used in 60% (12/20), improved from 42% to 50–60%. Vitamin K, prescribed in 70% (14/20), maintained the highest compliance, increasing from 86% to over 90%. TPN, used in 40% (8/20), remained stable at 75–85%. Caffeine citrate, prescribed in 40–50% (8–10/20), improved markedly from 12% to 40–50%. Despite these gains, adherence remained variable and below 100% across all groups.

Despite these gains, adherence remained variable and below 100% across all groups.

Discussion/Conclusion

This audit showed that targeted education improved care plan adherence, though compliance remained variable, especially for caffeine and antibiotics. Ongoing education, better access, prompts, and re-audit are planned for 2026.

Declarations of conflicts of interest: Authors declare no conflict of interest.

Measuring compliance with the referral pathway to the Lavender Clinic

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2. Quality, Risk and Patient Safety Department, University of Limerick Hospital Group
3. Department of Midwifery University Maternity Hospital Limerick.

Aim

The audit aims to measure 100% compliance with the lavender clinic referral pathway. This is a screening, assessment and early intervention service for women at risk of, or experiencing, post traumatic stress symptoms related to birth.

Methods

The caseload for the Advanced Midwife Practitioner (AMP) is approximately, 40-50 patients at a given time. A random sample of the cohort was selected for each audit.

A concurrent anonymised audit of women referred to the lavender clinic in four time periods; October 2024, April 2025, August 2025 and October 2025. There were four iterations of 10 patients, in each. Eleven audit tool questions were devised, from the pathway.

Results

The initial audit in October 2024 showed 90% compliance and improved in April 2025 to 100% compliance, which was sustained in August and October 2025.

Discussion/Conclusion

Compliance with the pathway was achieved and sustained.

Patients requiring multidisciplinary input (e.g.physiotherapy, psychology) during their journey through the Lavender Clinic pathway were not audited as they were not represented in the random samples, a targeted approach to audit these will be included in the next iteration of the audit.

Declarations of conflicts of interest: None

Compliance of the Neonatal (NATT) Alert Trigger & Track observation chart on the postnatal wards

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Abstract

Aims

To audit compliance of the NATT observation chart completion and escalation process, which was a new initiative developed in UMHL in 2025 by a subgroup including Consultant Neonatologist, Neonatal RANP's, Neonatal & Midwifery Clinical Skills Facilitators, Registered Nurses/Midwives and Postnatal CMM's. At the time of introduction there was no national agreed neonatal observation Early Warning Score (EWS) for the postnatal ward. The aim is 100% compliance of the NATT chart.

Methods

Approximately, 2500 babies have their NATT observation chart due to sepsis and hypoglycaemia risk factors annually. A total (n=50) babies' NATTs charts were reviewed in the postnatal period. 10 in initial audit (Oct2025), 20 in re-audit1 (Jan2026) and 20 in re-audit 2 (Feb2026). Electronic healthcare record data was extracted to a dedicated audit tool (no identifiers) which measured compliance against completion of vitals, blood glucose, triggers and escalation process.

Results

100% compliant in audit 1, 90% in re-audit1 and 100% in re-audit2. 100% compliance to the trigger and escalation process (n=3), which was 100% of that patient cohort.

Discussion/Conclusion

In re-audit1, two charts had correct documentation on the iView section but no transcription to the NATT observation chart. Education was provided regarding importance of transcription to the NATT chart and re-audit2 showed 100% compliance. To ensure sustained process a re-audit3 is planned.

No conflict of interest

Retinopathy of prematurity (ROP) screening re-audit of practice at UMHL.

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Abstract

Aims

Retinopathy of prematurity (ROP) a condition common in preterm babies is a preventable cause of blindness. Eligible babies – born <32+0 weeks gestation and/or birthweight <1501g, must be identified and screened for ROP.

Study aimed to re-assess compliance with timely ROP screening as per new guideline, after 2022 audit report.

Methods

Data about eligible babies born 01.01.2024 to 31.12.2024 at University Maternity Hospital Limerick (UMHL) was collected retrospectively, entered and analysed using Microsoft Excel.

Results

Eligible babies were 42 – all identified and timely referred for ROP screening; <31+0 weeks were 24 (57.1%) versus 10 (76.9%) in first audit.

Of 31 first ROP screenings at UMHL, 7 (22.6%) were early, 17 (54.8%) were on-time, and 7 (22.6%) were late (after ROP screening window closed). Outstanding were 11 babies – 5 transferred out before window, and 6 discharged without ROP screening (3 before; 2 during; 1 after window). First screening Ophthalmologist details were missing for 3 babies.

Follow-up plans varied (1-12 weeks). 100% (10) third ROP follow-up plans were 1-2 weeks. One baby had ROP – responded to laser treatment.

Discussion

On-time first ROP screening was 54.8%, despite timely referrals. Need further collaboration to reduce 'outside window' first screening, using 'RCPCCH ROP screening calculator', and follow-up interval variations.

Declarations of conflicts of interest – None

Care pathways for trauma: An audit of rib fracture management in the Emergency Department

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Abstract

Aims

To have 95% compliance with the Irish Association of Emergency Medicine clinical guideline for care and analgesia in adults (>18yrs) presenting to the Emergency Department with rib fractures. Targets within this guideline include pain score documentation and utilization of appropriate analgesic modalities.

Methods

Cycle 1: Retrospective audit of 35 patients aged >18yrs between July & September 2025 using the Emergency Department electronic system. Departmental educational sessions were held following Cycle 1.

Cycle 2: Retrospective audit of 20 patients aged >18 yrs between January & March 2026. Population sampled in both cycles represents all relevant patients in the time period.

Results

Cycle 1: Pain scores were documented for 3 (9%) patients. Pain relief was given as per guidance to 25 (71%) patients: 23 (92%) paracetamol and 20 (80%) morphine. Mean time to analgesia was 166mins. A single patient (3%) received regional anaesthesia and 3 (8.5%) patients had physiotherapy.

Cycle 2: Pain scores were documented for 13 (65%) patients. Pain relief was administered to 18 (90%) patients. Mean time to analgesia was 84 minutes. No patient received regional anaesthesia and 4 (20%) patients had physiotherapy.

Discussion/Conclusion

Pain score documentation and mean time to analgesia improved between cycles, with an 82 minute reduction. However, uptake of regional anaesthesia and physiotherapy remains low. Targeted education for NCHDs is required to improve guideline adherence.

Declarations of conflicts of interest none

Capacity assessment prior to discharge against medical advice (DAMA)

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Abstract

Aim

To assess compliance with guidelines on documented capacity assessments prior to Discharge Against Medical Advice (DAMA) in the Emergency Department (ED) at UHL, and to assess improvement following an educational intervention.

Method

A closed loop retrospective audit was conducted across two cycles. Cycle 1 reviewed all adult ED DAMA patients in December 2025 (n=51). Following an educational intervention with emphasis on the medicolegal aspects, Cycle 2 ran from 30 March to 18 April 2026 (n=40). Did-not-wait, paediatric ED, and patients under other specialties were excluded. Medical records were reviewed to determine whether a formal capacity assessment was documented.

Results

In Cycle 1, 12 (23.5%) of 51 DAMA patients had a documented capacity assessment. Following the educational intervention, Cycle 2 demonstrated: 19 (47.5%) of 40 DAMA patients had documented capacity assessments. This represents a 24% increase. However, compliance with the 100% standard was not met in either.

Discussion/Conclusion

Capacity assessment & documentation improved following targeted education but remains suboptimal. Patient's signature on DAMA form alone does not replace a documented capacity assessment. Recommendations include introducing a mandatory capacity documentation field within the DAMA proforma, continued education, and a third audit cycle following systemic implementation.

Declarations of conflicts of interest: None

Closing the loop: Improving asthma discharge care through guideline implementation in the Emergency Department.

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Abstract

Aims

To assess improvement in asthma discharge care following implementation of guideline-based interventions in the ED.

Methods

Following the initial audit, guideline-based interventions were introduced to improve documentation and standardize discharge care. A re-audit was conducted over a 6-week period (March–May 2026). Adult patients discharged with asthma exacerbation were included. Data were collected from electronic medical records, focusing on PEF documentation, provision of written action plans, and appropriate discharge treatment. Standards were set at 100% in accordance with established guidelines.

Results

A total of 20 patients were included in the re-audit. Peak flow was documented in 80% (16/20) of patients, compared with 57% (16/28) in the initial audit. Written asthma action plans were provided in 55% (11/20), representing an improvement from 21% (6/28) previously. Appropriate discharge medications were prescribed in 45% (9/20) of patients, compared with 18% (5/28) in the initial audit cycle. While substantial improvements were observed across all domains following implementation of guideline-based interventions, compliance remained below the target standard of 100%.

Discussion/Conclusion

Implementation of guideline-based interventions resulted in measurable improvements in asthma discharge care. However, full compliance has not yet been achieved. Ongoing staff education and reinforcement of guideline adherence are required. Further re-audit is planned to ensure sustained improvement and completion of the audit cycle.

The authors declare no conflicts of interest.

Cellulitis in Emergency Department Clinical Decision Unit

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Abstract

Aims

To achieve 100% compliance with UHL Antimicrobial Guidelines for management of cellulitis (>16 y/o) admitted to ED Clinical Decision Unit (CDU) via ED Cellulitis pathway. Average monthly admissions to CDU with cellulitis was 17 (2023) and 13 (2025).

Methods

Retrospective audit of patients admitted to CDU (n=80) June-Dec 2025 compared to (n=104) June-Dec 2023, using electronic system Therefore; measuring antimicrobial compliance, length of stay, tinea pedis documentation, speciality referrals and unscheduled returns.

Results

Average LOS: 2.6 days (3.2 days in 2023). Antimicrobial compliance: 96% (90% in 2023). Tinea pedis documentation: 3.9% (6.7% in 2023). Speciality referrals: 21% (2023), 5% (2025). Unscheduled returns: 6.2% (16% in 2023).

Discussion/Conclusion

Overall improved compliance to UHL Antimicrobial Guidelines; decreased average length of stay, speciality referrals and unscheduled return. Further audit cycles will focus on documentation of tinea pedis, identified as an area requiring improvement.

Intervention The audit results should be interpreted in the context of an updated cellulitis policy being implemented between the two audit periods.

Declarations of conflicts of interest. None

A 5-year audit cycle of antibiotic prescribing practices for animal bites in Ennis injury unit: sustaining improvement and closing the loop (2021–2025)

Authors

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Abstract

Aims

To sustain greater than 90% compliance with ULHG antibiotic prescribing guidelines for animal bites through consecutive annual audit cycles.

Methods

Annual audit cycles were conducted from 2021 to 2025. For each cycle, a retrospective chart review was performed for patients' ≥ 5 years presenting to Ennis injury unit (IU) with animal bites. Antibiotic prescribing data were analysed using Excel. Patients not prescribed antibiotics and those meeting exclusion criteria were omitted.

Results

In 2025, 83% (N=97) of patients presenting with animal bites were prescribed antibiotics, a decrease from previous years (92% in 2024, 90% in 2023, 95% in 2022). Compliance with ULHG antibiotic guidelines has remained consistently high over the past five years, ranging from 90% to 96%, with 93% (n=90) adherence achieved in 2025.

Non-adherence (4–10%) was mainly due to paediatric dosing errors, inappropriate antibiotic selection in adults, and incorrect prescribing in penicillin-allergic patients. In 2025, this was associated with locum and GP prescribing not aligning with guidelines.

Discussion

Targeted interventions including staff education, reinforcement of local guidelines, and availability of electronic guidelines have supported high compliance. Reduced antibiotic use alongside maintained adherence suggests improved clinical decision-making and antimicrobial stewardship. This represents a sustained audit cycle with ongoing re-evaluation. Continued education and planned re-audit will support maintenance of standards and further optimisation of patient outcomes.

Declaration of conflicts of interest: None.

The no-clot hip spot: keeping total hip replacement patients clot free

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Abstract

Aims

To achieve 100% of hip fracture procedure notes to document appropriate venous thromboembolism (VTE) prophylaxis at discharge by March 2026.

Methods

We carried out a two-cycle closed-loop audit in University Hospital Limerick. Using the eTrauma system to identify the hip fracture cases, in total, 28 cases from October 2025 and 30 from February 2026 were reviewed. Only hip fracture cases were included and the exclusion criteria comprised of cases outside the study period/month, duplicates, missing operation notes, and paediatric cases. Each procedure note was reviewed for the presence of clear documentation of VTE prophylaxis in the postoperative discharge section, in line with University of Limerick Hospitals (Croom) Guidelines and National Institute for Health and Care Excellence guidance. Findings from the first cycle were presented to the Orthopaedics department, followed by a focused teaching session on current guidelines.

Results

The VTE prophylaxis documentation improved slightly from 75% (21/28) in the first cycle to 80% (24/30) in the second. Among patients on pre-operative direct oral anticoagulants, the inappropriate co-prescribing of aspirin reduced from 2/3 (66.6%) cases to 2/4 (50%).

Conclusion

Although there was some improvement, this was modest and not statistically significant. The findings suggest that education alone may not be enough, and clearer national guidance is likely needed, in line with ongoing work by National office of Trauma Services and the National Clinical Programme in VTE.

Declarations of conflicts of interest -state none or declare same

None.

An audit of post-menopausal bleeding referrals in the Ambulatory Gynaecology Unit, Nenagh Hospital

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2. Maternal & Child Health Directorate, University Maternity Hospital Limerick

Abstract

Aims

Measure compliance to national key indicators (KPIs), including review within 28 days (national compliance standard 90%) of GP referral and receipt of histological diagnosis within 12 weeks of same (95% national compliance standard), for postmenopausal bleeding referral cohort.

Methods

Retrospective data collection (n=172) on initial audit (Aug-Dec 2024) and retrospective (n=108) on re-audit (Apr-Jun 2025), for this cohort, which was 35% total attendance (n=662) to the ambulatory gynaecology unit (AGU) on initial audit and 21% (n=507) in the re-audit. Anonymous data utilising electronic systems and patient charts.

Results

Initial review within 28 days achieved monthly compliance between 93% and 98%. However, compliance of 12-week management ranged from 84% to 91%, failing to achieve national 95% standard. In the re-audit a monthly compliance rate of 99% was achieved for the 28-day KPI and the national 95% standard was achieved for receipt of histological diagnosis within 12 weeks of GP referral.

Discussion/Conclusion

This audit showed that the Ambulatory Gynaecology Unit (AGU) consistently met the national 28-day KPI for assessment of postmenopausal bleeding. Delays in histological diagnosis identified on initial audit were addressed through targeted process improvements, with re-audit confirming compliance and successful closure of the audit cycle.

No conflict of interest declared

multidisciplinary review of UABSI outliers following national audit escalation: a closed-loop audit

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Abstract

Aims

To evaluate unit-acquired bloodstream infection (UABSI) outliers identified through ICNARC/NOCA benchmarking and determine preventability within a high-acuity ICU population, following NOCA quality indicator escalation.

Methods

Following NOCA escalation via the national quality indicator (green/amber/red alert system) and data quality review, all UABSI outliers identified over a 9-month period in 2024 (cycle 1) underwent structured multidisciplinary review. This included intensive care, microbiology, audit, and risk management teams. Cases were assessed for preventability and data accuracy. Quality improvement interventions included staff education, reinforcement of central venous catheter (CVC) care bundles, closed-loop blood sampling, and formalisation of MDT review processes. Re-audit was performed over a 12-month period in 2025 (cycle 2).

Results

Nine outliers were identified in 2024 from 261 eligible admissions (n=9, 9 months), with 0/9 (0%) deemed preventable. In 2025, 12 outliers were identified from 343 eligible admissions (n=12, 12 months), with 0/12 (0%) deemed preventable. Patients demonstrated higher acuity compared to similar units, including increased CVC use (87.5% vs 51.4%) and advanced respiratory support (63% vs 40%). Data validation improved classification accuracy.

Discussion/Conclusion

A structured MDT review process supported completion of the audit cycle. Findings highlight the importance of interpreting benchmarking data alongside patient acuity and clinical context. Outlier status does not necessarily indicate preventable harm.

Declarations of conflicts of interest: None

Evaluation of compliance with pre-operative medication guidelines - Re-audit (September 2025)

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Abstract

Aim

Safe peri-operative medication management is essential to prevent avoidable complications including hypotension, hypoglycaemia, withdrawal syndromes, seizures and thrombotic events. An initial audit in April 2025 demonstrated 40% compliance with ULHG peri-operative medication guidelines (PERI-G-5). Following targeted educational interventions, a re-audit assessed progress towards 100% guideline compliance.

Methods

A retrospective re-audit was conducted at University Hospital Limerick in September 2025. Thirty consecutive adult surgical patients (18 elective, 12 emergency; mean age 68 years, 72% female) were included. A total of 229 medication decisions (continue vs withhold) were analysed using patient records, drug Kardex and anaesthetic charts. Compliance was assessed overall, by surgical pathway, medication class, pre-operative assessment, and compared with the April 2025 audit.

Results

Overall compliance was 39% (90/229), unchanged from the previous audit (40%). Compliance remained higher in elective than emergency cases (43% vs 32%). Documented pre-operative assessment improved compliance (44% vs 31%). Targeted improvements were observed in antidiabetic medication management, with 100% compliance for SGLT2 inhibitors and insulin. Persistent gaps remained in statins (21%), antiplatelets (20%), psychiatric medications (23%) and antiepileptics (55%).

Conclusion

This closed-loop audit demonstrates improvement in high-risk medication management, particularly antidiabetic drugs, but persistent variability in overall compliance. Sustained quality improvement requires improved guideline accessibility, a standardised pre-operative medication checklist and continued multidisciplinary education to enhance peri-operative patient safety.

Conflicts of Interest: None

Improving intraoperative airway management documentation in the Department of Anaesthesia, University Hospital Limerick: A closed loop audit

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Aims:

An audit to evaluate and improve documentation of intraoperative airway management to 100% against audit standards.

Methods:

Airway section of the anaesthetic record sheet and international guidelines were used as audit standards. Airway documentation data were collated from 150 patients between 31-03-2025 and 15-12-2025 across two cycles: n=100 [General Anaesthesia (GA)=88, Regional Anaesthesia (RA)=12] and n=50 [GA=45, RA=5]. Following teaching sessions, the airway section of the anaesthetic record was revised to include essential elements for standardized practice.

Results:

Documentation improved for bag-mask ventilation [12/88 (13.6%) to 18/45 (40%)], type of supraglottic airway device (SAD) [0% to 12/13 (92.3%)], and endotracheal tube (ETT) [0% to 10/32 (31.25%)]. Laryngoscopy type [25/65 (38.46%) to 26/32 (81.25%)], laryngeal grading [14/65 (21.53%) to 23/32 (71.8%)], laryngoscope blade [13/65 (20%) to 11/32 (34.38%)], number of attempts [5/88 (7.69%) to 22/32 (68.75%)], ease of tube delivery [48/65 (69.2%) to 24/32 (75%)], intubator experience [0% to 23/32 (71.8%)], and teeth status [0% to 17/45 (37.78%)] also improved. Documentation declined for supplemental oxygen [10/12 (83.33%) to 3/5 (60%)], SAD and ETT size [25/26 (96.15%) to 12/13 (92.3%)]; [62/65 (95.4%) to 30/32 (93.8%)], and ETT length [48/59 (81.4%) to 23/32 (71.8%)].

Conclusions:

Documentation improved but remains below 100%, requiring ongoing education and re-audit.

Conflicts of interest: None

an audit to assess the efficiency of first appointment visits in Fertility Services at Nenagh Fertility hub: Completeness of investigations and timeliness.

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Author(s) Affiliations: Nenagh Fertility Hub, Nenagh Hospital, Co. Tipperary.

Abstract:

Aim: An audit of 85% compliance of lead consultant review, within six months, of couples referred to the Nenagh Fertility Hub, in accordance with national guidelines.

Method: For both retrospective audits, 20 patient charts were randomly selected and Microsoft excel was utilised.

Results: Initial audit (apr-nov 2025) demonstrated 100% compliance with the aim statement. Second audit (nov-feb 2026) showed a shortfall to same with a result of 80%, 5 % below the aim.

Discussion/Conclusion

Initially, 100% compliance was recorded to national targets, achieving consultant review within six months of GP referral. Process involves a structured approach; 6-weekly waiting list reviews, with supported completion of baseline investigations within a 3-month timeframe. Re-audit highlighted the importance of sustaining these processes, identifying reduced compliance with investigation timelines. Delays were primarily related to late submission of screening forms and limited access to semen analysis appointments, particularly over the Christmas period.

Despite this, consultant waiting times remained within target at 4.5 months. Findings from both cycles have informed a local standard operating procedure to improve consistency and investigation completion rates. Ongoing 6-monthly re-audit is planned to monitor performance and ensure sustained adherence to national standards, optimising patient readiness for specialist review and timely initiation of management plans

No conflicts of interest

A process audit evaluating pain prescribing frameworks in medical inpatients aged 65yrs and older.

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2. Pharmacy Department, St. John's Hospital, UHLG, Limerick

Abstract

Aims

This audit aims for 90% compliance with the hospitals Decision Making Frameworks for acute nociceptive pain and neuropathic pain management. The framework was developed following an audit in 2024 which identified variances in the quality of pain management and suboptimal pain scores.

Methods

A point prevalence re-audit in April 2026, of all medical inpatients aged 65 yrs. and older, was undertaken (n=20). Initial audit took place in 2024 (n=48).

Results

In the category of patients reporting moderate to severe pain, 85% (n=9) were prescribed regular paracetamol, in line with the Framework, an improvement from baseline audit results of 71%.

In the categories of least pain and average pain experience, the re-audit demonstrates 0% incidence of severe pain, demonstrating an improvement to baseline audit in which 35% (n = 17) reported severe pain in these parameters.

Discussion/Conclusion

The re-audit suggests implementation of the Decision-Making Framework improved prescribing practices and pain outcomes in medical inpatients 65yrs and older. Increased regular paracetamol use was demonstrated, indicating better adherence to baseline analgesic principles. This may reflect the impact of the Framework and associated education sessions that were provided between the audit iterations. We plan to continually communicate, educate and re-audit to sustain good practice going forward.

Declarations of conflicts of interest -state none or declare same. None

Closing the gap: Reducing medication discrepancies through targeted education

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2. Pharmacy Department, Ennis General Hospital.

Aims:

To quantify medication discrepancies on admission to the Medical Assessment Unit (MAU) and evaluate the impact of a targeted, education-based intervention on reconciliation accuracy.

Methods:

A retrospective closed-loop audit was conducted against HIQA/HSE Mid-West group policy standards. The Medical Assessment Unit reviews approximately 5000 patients annually. A total of 20 consecutive admissions were reviewed in Cycle 1 and 20 consecutive admissions in Cycle 2. Baseline data (October 2025) were compared with re-audit data (March 2026). Discrepancies were categorised by type and source. Following cycle 1, a structured educational intervention was delivered, consisting of a focused presentation that stimulated multidisciplinary discussion and targeted, individualised teaching for admitting clinicians, emphasising Best Possible Medication History (BPMH) and high-risk omission patterns.

Results:

Total discrepancies reduced from 72 to 19 (73.6% reduction). Omitted medications decreased from 63 to 8 (87.3%). Pharmacy-derived discrepancies reduced from 64 to 19 (70.3%), while family-derived discrepancies fell from 8 to 0 (100%). Added medications reduced from 5 to 0.

Discussion/Conclusion:

Targeted clinician education significantly improved medication reconciliation and reduced clinically important omissions. Sustained education sessions and further re-audit cycles are planned to maintain gains, improve compliance, and enhance patient safety at admission.

Declarations of conflicts of interest: None

Collaborative care: Enhancing pressure ulcer prevention together

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Affiliation: HSE Mid-West Acute and Older Persons, Ennis Hospital

Abstract

Aims

Continually reduce pressure ulcers in Ennis Hospital, 16 in 2023 and 15 in 2024 and achieve above 85% compliance with ASSKING care bundle (Assess risk, Skin assessment/care, Surface, Keep moving, Incontinence, Nutrition, Giving information). The hospital has 54 inpatient beds across 2 wards, with 27 patients each.

Methods

Quarterly audits of twenty cases, results were monitored and actioned by the Pressure Ulcer Committee (PUC). Quality improvement (QI) initiatives included ward-level education and training for nurses and Healthcare Assistants (HCA's), led by Clinical Skills Facilitator, focusing on aSSKING and encouraging ownership of practice. Allied Health Professionals (AHPs) began using the aSSKING in patient assessments. Two nurses from each ward were designated as pressure ulcer prevention champions, and staff nurses were involved in the audit process.

Results

The hospital reduced pressure ulcers from 16 in 2023 to 11 in 2025 through education, auditing, and QI-driven recommendations. ASSKING compliance has achieved sustained improvement, rising from 67% (Q3 2023) to above 95% in all subsequent audit iterations through Q1 2026.

Discussion

The PUC had multidisciplinary membership, including ward nurses, HCA reps, and AHP reps, to help monitor outcomes and implement strategies. The committee had a Structure-Process-Outcome approach to reducing pressure ulcers.

Conclusion

The Audit has led to improved multi-disciplinary collaboration, increased patient comfort, and lower care costs.

Declarations of conflicts of interest. No conflict of interest exists

A clinical audit to review inpatient progress note documentation

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2) Medical Department, Ennis General Hospital, Ennis, Co. Clare.

Abstract

Aims

Evaluate whether 100% of key variables were documented in progress notes of inpatient charts (HSE Standards and Recommended Practice for Healthcare Records Management).

Methods

Retrospectively reviewed charts in the first week of January 2026 and re-audited on the first week of March 2026 (n=50). Patients with two or more progress notes were included. Patients admitted less than twenty-four hours were excluded. Identified completeness of entries according to inclusion of the following variables; date, time of note entry, patient identification (MRN or patient name), author identification, diagnosis, grade, Irish Medical Council (IMC) number and signature of author. Findings and how to improve documentation were discussed at a teaching session. Re-evaluated fifty note entries.

Results

Initially, 4%(n=2/50) of entries satisfied the aim and improving to 28%(n=14/50) upon re-evaluation. There was improvement in the majority of documented variables; patient identification 80%(n=40/50) to 98%(n=49/50), author identification 58%(n=29/50) to 80%(n=40/50), grade 54%(n=27/50) to 64%(n=32/50), IMC 36%(n=18/50) to 56%(n=28/50) and signature 86%(n=43/50) to 100%(n=50/50). Diagnosis remained unchanged, included in 94%(n=47/50) of entries evaluated in each cycle. Time was the variable included least, 28% (n=14/50) improved to 70% (n=35/50).

Discussion

Technological advancements in the provision of healthcare is rapidly evolving yet a vital component; clinical documentation upholds a fragmented, handwritten paper-based framework. Digital formatting could lend to inclusion of all key variables in accordance with standards. This study highlights how electronic health records, could provide the basis for a comprehensive note of patient care.

Declarations of conflicts of interest

No conflicts of interest declared.

Re-audit of do not attempt cardiopulmonary resuscitation (DNACPR) documentation in medical inpatients at University Hospital Limerick (UHL)

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Abstract

Aims

To achieve 100% compliance with national DNACPR documentation standards for medical inpatients admitted for >24 hours at UHL and evaluate family discussions, staff awareness of DNACPR leaflets, and nursing handover documentation.

Methods

A concurrent audit of 50 DNACPR forms was conducted on September 12, 2025, across multiple medical wards. Charts were reviewed for 13 parameters: patient identifiers, placement in records, nursing handover, capacity, clinical reasoning, ceilings of care, communications, consultant/nurse/registrar sign-off, family discussions, and EWS completion. Compliance percentages were calculated and compared with the 2024 audit to assess improvements.

Results

High compliance was observed for patient identifiers (49, 98%), placement in records (50, 100%), nursing handover (48, 96%), clinical reasoning (47, 94%), and ceilings of care (48, 96%). Gaps existed in capacity assessment (41, 82%), communication (41, 82%), consultant sign-off (20, 40%), nurse countersignature (4, 8%), registrar/SpR sign-off (33, 66%), and family discussions (33, 66%). EWS completion was absent (0, 0%), and no DNACPR leaflets were available.

Improvements from 2024 were noted in patient identifiers (90→98%), capacity (70→82%), clinical reasoning (86→94%), communication (64→82%), nurse handover (88→96%), consultant sign-off (26→40%), and family discussions (37→66%).

Discussion

Following cycle 1, new patient and family DNACPR information leaflets were designed and disseminated across medical wards. Documentation quality improved; however, deficiencies in staff sign-off and escalation processes remain, warranting further education and planned re-audit.

Declaration of conflicts of interest: None

Comparative analysis of learning outcomes for patients in Phase 11 Cardiac Rehabilitation: An audit at University Hospital Limerick.

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1. Cardiology, University Hospital, Cardiac Rehabilitation,
2. Cardiology, Integrated Care UHL, Cardiac Rehabilitation

Abstract

Aims

All patients attending the Phase11 Cardiac Rehabilitation (CR) Education talk are invited to complete a questionnaire. Aim was for 85% questionnaire compliance, by March 2026, moving to >90% and stretching to 100%. A secondary aim, is evaluating effectiveness of the service education, as the questionnaire is used to measure the Patient Reported Outcome Measures (PROM).

Methods

The questionnaire has two topic questions and each speaker has two presentation related questions. All results were recorded on Microsoft Excel and evaluated. Initial audit took place in May 2025 and re-audit in March 2026.

Results

187 patients attended Phase 11 CR Education. All categories increased or sustained compliance with just one remaining below the aim of 85%. Cardiac Risk Factor responses were (17) 100% and (9) 53%, increasing to (11) 100% on both questions. Wellbeing responses were 15 (88%) and 10(59%), rising to 11 (100%) and 11 (100%). Exercise responses were 14 (82%) and 15 (88%), rising to 10 (91%) and 10 (91%). Pharmacy responses were 15 (88%) and 16 (94%) and achieved 11 (100%) and 11 (100%) on re-audit. The Dietary responses were 10 (59%) and 10 (59%) rising to 9 (82%) and 11 (100%).

Discussion

There has been improvement with most areas achieving compliance. Ongoing improvements are planned to achieve 100% through reaudit & sustainment.

Declarations of conflicts of interest

No conflicts of interest declared.

Respiratory referrals following ED/MAU presentation with suspected asthma: A clinical audit

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Abstract

Aim: Assess compliance standards, aiming for 100%, for appropriate management and follow-up by the respiratory service 6–8 weeks for patient's post-presentation to the Emergency Department (ED)/Medical Assessment Unit (MAU) with asthma (or symptoms suggestive of asthma) who were not admitted.

Methods: A process audit (n=40) was conducted from Nov '25 to Jan '26 and reaudit took place from Feb '26 to April '26. Compliance with Global Initiative for Asthma (GINA) and local asthma ED/MAU guideline was assessed. ED/MAU staff received education, and a re-audit (n=20) evaluated the impact of these changes.

Results: Between baseline and re-audit 1 peak flow meters distribution went from 28% to 63%, discharge leaflets from 20% to 68%, LABA/ICS initiation from 58% to 79%, telephone follow up from 93% to 100% and outpatient appointment offered from 60% to 84%. Peak flow meters sent by post remained at 100%.

Conclusions:

Initial gaps identified in guideline adherence, particularly in discharge information, peak flow meter access and Long-acting beta-agonists (LABAs)/ inhaled corticosteroid (ICS) initiation, while telephone follow-up showed high compliance. Following targeted education, significant improvements were seen in patient information leaflets, peak flow assessment, therapy initiation, and follow-up processes. Continuing staff education on asthma pathway, reinforcing discharge bundle use and access to peak flow meter in ED/MAU, and ongoing supports to timely initiation of LABA/ICS therapy and re-audits are planned.

No declaration of conflict of interest.

Re-audit of do not attempt cardiopulmonary resuscitation (DNACPR) documentation in medical inpatients at University Hospital Limerick (UHL)

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Abstract

Aims

To achieve 100% compliance with national DNACPR documentation standards for medical inpatients admitted for >24 hours at UHL and evaluate family discussions, staff awareness of DNACPR leaflets, and nursing handover documentation.

Methods

A concurrent audit of 50 DNACPR forms was conducted on September 12, 2025, across multiple medical wards. Charts were reviewed for 13 parameters: patient identifiers, placement in records, nursing handover, capacity, clinical reasoning, ceilings of care, communications, consultant/nurse/registrar sign-off, family discussions, and EWS completion. Compliance percentages were calculated and compared with the 2024 audit to assess improvements.

Results

High compliance was observed for patient identifiers (49, 98%), placement in records (50, 100%), nursing handover (48, 96%), clinical reasoning (47, 94%), and ceilings of care (48, 96%). Gaps existed in capacity assessment (41, 82%), communication (41, 82%), consultant sign-off (20, 40%), nurse countersignature (4, 8%), registrar/SpR sign-off (33, 66%), and family discussions (33, 66%). EWS completion was absent (0, 0%), and no DNACPR leaflets were available.

Improvements from 2024 were noted in patient identifiers (90→98%), capacity (70→82%), clinical reasoning (86→94%), communication (64→82%), nurse handover (88→96%), consultant sign-off (26→40%), and family discussions (37→66%).

Discussion

Following cycle 1, new patient and family DNACPR information leaflets were designed and disseminated across medical wards. Documentation quality improved; however, deficiencies in staff sign-off and escalation processes remain, warranting further education and planned re-audit.

Declaration of conflicts of interest: None

Audit on safety screening of pre-biologic and vaccination compliance in patients receiving targeted immunosuppressive therapy in Rheumatology Department in UHL

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Abstract

Aims

To evaluate pre-biologic screening, vaccination documentation and vaccine uptake for patients initiating biologic or tsDMARDs and to improve patient safety through targeted interventions.

Methods

Initial audit retrospectively reviewed 40 patients commencing biologic or tsDMARD therapy at University Hospital Limerick's Rheumatology Department. Data came from electronic patient records, laboratory systems and clinic correspondence. Collected data included demographics, diagnosis, therapy, TB screening (QuantiFERON or Mantoux), hepatitis B/C and HIV serology, vaccination documentation and uptake, and decision-to-treatment time. Following analysis, a mandatory pre-biologic checklist and staff education programme were implemented. A 34-patient re-audit was performed. The project ran August 2025–January 2026.

Results

Initial audit showed 90% (36/40) compliance for tuberculosis, hepatitis B/C, and HIV screening, vaccination documentation was completed in 52% of patients, with appropriate vaccination prior to therapy in 48% of patients. Post-intervention, TB and HIV screening compliance improved to 98%, hepatitis B/C screening to 95%, vaccination documentation improved to 85% and vaccine uptake to 82%.

Discussion

Initial audit showed safety screening was suboptimal, particularly vaccination documentation and delivery, despite a good infection screening performance. Simple targeted interventions showed improvement across all domains, confirming that standardised protocols within routine workflow is essential to minimise infection risk in patients receiving immunosuppressive therapy.

No conflict of interest noted.

Clinical audit of screening and management of delirium in an Acute Medical Unit – a re-audit.

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Aims

Achieve 100% compliance with 4AT screening and delirium management

Methods

Patients aged 65 years or older were reviewed over three days in March 2026. Data collected included 4AT screening completion, risk factor identification, multidisciplinary team involvement, and medication-related contributors.

Results

Of 54 patients, 27 met inclusion criteria (mean age 76). Screening was completed in 89% (n=24), representing improvement compared to previous audit published last year (65%) compliance. Three patients (11%) were not screened. No patient scored ≥ 4 on 4AT; 12.5% (n=3) scored 1. 1 patient was admitted with new confusion but scored 1. All patients had at least two risk factors. Polypharmacy was universal (mean 9.6 medications), however no pharmacist review occurred. 5 patients had multidisciplinary team (MDT) in-put.

Conclusion

Delirium is a common and preventable cause of morbidity in older adults. The HSE guidelines recommends 4AT screening and assessment using PINCH-ME (**P**ain, **I**nfection, **C**onstipation, **H**ydration, **M**edication, **E**nvironment). The Institute for Healthcare Improvement (IHI) framework (2020) for age friendly health systems emphasises delirium prevention and the impacts of medication.

While screening rates have improved across audit cycles with formal staff education sessions and improvements to documentation to include the 4AT in all relevant proformas, gaps persist in delirium recognition and management. Medication optimisation and multidisciplinary involvement require prioritisation. Ongoing education and system-level interventions are necessary to sustain improvements and enhance staff practice and patient outcomes.

Declaration: This audit is a continuation of an audit published in the 2025 proceedings document and represents a further progression towards compliance

Audit on lipid monitoring in patients receiving tocilizumab at University Hospital Limerick

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Aims

Tocilizumab, an IL-6 inhibitor used for inflammatory conditions such as rheumatoid arthritis, can alter lipid metabolism and potentially increase cardiovascular risk. This audit aimed to improve adherence to British Society for Rheumatology (BSR) guidelines recommending fasting lipid profile monitoring at baseline and 3 months post-initiation in patients receiving tocilizumab at University Hospital Limerick.

Methods

A retrospective medical-record review was conducted among patients aged 18–87 years receiving tocilizumab, with equal gender distribution. Data collection assessed documentation of fasting lipid profiles at baseline and 3 months. The first audit cycle included 35 patients. Following rheumatology staff education and integration of reminders into follow-up protocols, 40 patients were re-audited in the second cycle. The project ran from May 2025 to July 2025.

Results

In the first cycle, 15 of the 35 patients (42.9%) were monitored as per BSR guidelines. After planned intervention, the second cycle showed improvement, with 25 of the 40 patients (62.5%) being monitored as per BSR guidelines.

Discussion

This audit showed an improvement in guideline adherence through simple and targeted measures. Ensuring regular lipid monitoring is crucial to limit cardiovascular risk. Continued staff education and annual re-audits is planned to maintain and further improve compliance.

No conflicts of interest noted.

Sustaining a tobacco free campus in an acute hospital: bridging the gap between standards and practice

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2. Health and Wellbeing, Acute Services HSE Mid West

Abstract

Aims

A Tobacco Free Campus (TFC) provides a cleaner, healthier and safer hospital environment but remains challenging to sustain. The aim of this audit is for 75% compliance with Global Standards for Tobacco Free Healthcare Services and 10% improvement in on-site adherence to TFC policy.

Methods

The Global Network for Tobacco Free Healthcare Services (GNTH) self-audit tool was used to assess compliance with 8 Global Standards. Five observation audits were conducted over a 4-week period in April 2025, at main entrances to University Hospital Limerick, to assess prevalence of staff, patients and visitors smoking and vaping. Re-audit was completed in April 2026

Results

The GNTH self-audit score remained largely unchanged at 110/144 (112/144 in 2025). Quality improvement actions focused on strengthening governance, communication, signage, policy enforcement and training. Observation audits identified increased smoking and vaping, with prevalence of 37.2% (51/137) at the main entrances compared to 19.0% (15/79) in 2025.

Discussion/Conclusion

Findings highlight a gap between reasonable measured compliance with Global Standards and observed poor adherence on hospital grounds. Increasing rates of smoking and vaping emphasise the need for organisational prioritisation and investment in workforce capacity to deliver tobacco dependency services, training, and communication, alongside consistent enforcement of the policy. Re-audit is planned for April 2027.

No conflict of interest

Enhancing compliance with the national standards for safer better healthcare

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Abstract

Aim

To achieve a compliance level of 75% or greater, promote and strengthen organisational understanding, commitment, and compliance with the National Standards for Safer Better Health Care (NSSBH) using a locally developed quality management tool (NSFolder).

Method

The Midwest Acute and Older Persons' NSFolders, alongside the locally established NSSBH Audit Tool (2022), were used to assess compliance through ongoing audits across all directorates and hospitals. In 2025, 299 NSFolders were audited. Findings are monitored to measure average compliance across 12 NSSBH standards and inform targeted education and improvement plans. Quarterly meetings with management review performance, track progress, and agree on actions. This approach has enhanced understanding of compliance requirements, improved workflows, and increased access to key documentation to support regulatory inspections.

Results

Average compliance increased from 47.52% in 2024 (N = 482) to 55.40% in 2025 (N = 299). There was also a marked reduction in non-compliance, with 9.33% in 2024 and 4.68% 2025. This is a 50% reduction in one year, indicating improved effectiveness of processes and implementation.

Discussion

A structured Process–Outcome approach strengthened assurance processes, improving readiness for regulatory review and supporting a culture of continuous quality improvement. A transition towards tracking individual NSSBH results, rather than overall averages, is planned.

Declaration: This audit is a continuation of an audit published in the 2025 proceedings document and represents a further progression towards compliance

An audit against the HSE patient consent form for investigation, treatment, operation or procedure at the HSE Mid-West Acute Hospital (Model 4), HSE Mid-West Model 2 Hospitals and a HSE Mid-West speciality hospital (Orthopaedic)

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Department, Hospital, Location.

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3. Director of Quality, Risk & Patient Safety, University Hospital Limerick, Mid-West Acute

Abstract

Aims

The prospective audit measured compliance against a new initiative, updated Patient Consent Form (serving a population of approximately 413,059), with aim of 100% compliance. The consent policy relates to support of patients to make informed treatment and care decisions.

Methods

An audit tool was devised. Initial audit was 50 in UHL and 25 each in the other three sites (n=125). Re-audit took place at 2 sites (n=20): the acute hospital (n=15) and a model 2 hospital (n=5). Total charts audited 145.

Results

In the initial audit (Feb 2026), there was compliance in 92/125 (74%). 9.6% had absent, blank or incorrect versions of the form. The remaining had incomplete documentation. Education took place at the time of the audit. Re-audit (May 2026) showed 100% compliance with correct form filed (20/20) and 75% (15/20) compliance with documentation completion, the only omission being non documentation of medical council number (5/20).

Discussion/Conclusion

None of the filed forms had documented patient lacked capacity to sign their own consent. This section was therefore not audited, at this time. Education between the initial audit and re-audit resulted in increased awareness of necessity to use correct version of consent form and clear documentation. Intervention: A prompt sheet is under design to accompany the consent form to support the consent process. Re-audit is planned for September 2026.

Conflicts of interest: none

From audit to action: Strengthening infection prevention and control compliance through audit and communication in older persons residential service in HSE Mid-West.

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2. Infection Prevention & Control, HSE Mid West.

Audit Supervisor/Mentor will appear last on the list

Abstract

Aim

To achieve 100% completion of monthly national IPC audits across nine Older Person Residential Services (OPRS) and utilise the resulting data to develop a standardised Monthly IPC Communication Tool.

Methods

A retrospective analysis of one hundred and eight IPC audits, covering twelve national IPC audit topics across nine Older Person Residential Services (OPRS), was undertaken between January and December 2025. Using a healthcare audit system, data from all sites were collated and analysed to produce a monthly communication tool for learning and improvement. A PowerPoint infographic template, developed in line with the HSE Quality Improvement Guide and Toolkit (2024) and HSE Visual Identity Guidelines (2022), was used to present findings.

Results

Completion rates increased from 80% in 2024 to 100% in 2025 through targeted support and education from the IPC Team. The resulting Monthly Communication Tool became an integral part of the audit feedback cycle, promoting transparency, staff engagement, and continuous quality improvement in IPC practices. This approach supports compliance with national standards and contributes to reducing healthcare-associated infections.

Discussion/Conclusion

National IPC audits were introduced in 2023, with the Mid-West region auditing against 12 topics throughout 2025. Findings were collated into a monthly infographic to support communication and shared learning. A

staff survey conducted in Quarter 4, 2025 demonstrated strong engagement with the initiative and supported continuation of the audit programme and quality improvement work in 2026.

There were no conflicts of interest.

Digitising an opt-out smoking cessation pathway in maternity care: a closed-loop audit enabling continuous quality improvement

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Aims

Smoking in pregnancy is a major modifiable risk factor for adverse maternal and neonatal outcomes. The aim of this audit was to achieve > 85% recording of smoking status and delivery of Carbon Monoxide breath test at first antenatal clinic appointment.

Methods

In 2022, an opt-out smoking cessation pathway was introduced, aligning with National Guidelines and incorporating carbon monoxide breath testing (COBT), brief cessation advice and referral to stop smoking services as standard. Initial audits were paper-based and small-scale. Implementation of the Maternal & Neonatal Clinical Management System in July 2025 enabled automated monthly audits of smoking prevalence, COBT completion, and smoking status.

Results

The final paper-based audit (August 2024; n=12) showed COBT completion of 83% (8/12) and smoking status documentation of 92% (11/12). Post-digitisation monthly audits from October 2025 to April 2026 showed improvements in COBT completion rate from 76% to 94%, while recording of smoking status was sustained at 78%

Discussion/Conclusion

Digitisation enabled continuous, whole-population audit and improved data quality. Despite reduced smoking status documentation, addressed through targeted training and standardised prompts, sustained improvements in delivery of brief interventions led to enhanced care for pregnant women who smoke.

No conflict of interest